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DATE: September 12, 2001

TO: Associate Regional Administrators
Division of Medicaid and State Operations
Regions I - IV, VI - VIII, X

Associate Regional Administrator
Division of Medicaid and Children's Health
Region V

Associate Regional Administrator
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Region IX

FROM: Acting Director Richard Chamberlain
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SUBJECT: Benefits Improvement and Protection Act (BIPA) of 2000, section 702, Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) - ACTION

Attached are guidance in the form of Questions and Answers (Qs & As) on the new Medicaid PPS FQHCs/RHCs reimbursement requirements enacted into law under section 702 of BIPA. These Qs & As should assist the states in implementing the reimbursement requirements. Please provide copies of these Qs & As to your states and to your HRSA field office contacts. Additionally, these Qs & As will be posted to the CMS website in the near future.

If you have any questions on this guidance, please contact Suzan Stecklein at 410-786-3288.

Attachment

Benefits Improvement and Protection Act (BIPA) of 2000, section 702, Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics

Q's and A's

Affected FQHCs and RHCs

1. Question: The BIPA legislation applies to Medicaid payments to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Does this legislation apply to all RHCs or only to freestanding RHCs and provider-based RHCs with more than 50 beds?

   Answer: The provisions of section 702 of the BIPA apply to Medicaid payments to all RHCs and FQHCs.

2. Question: Does the BIPA legislation apply to Tribal/Urban FQHCs?

   Answer: Yes.

Fiscal Year Definitions

3. Question: Section (b)(2) of BIPA is silent as to the definition of "fiscal year". May fiscal year be defined as being the FQHC's or RHC's individual financial fiscal year, the state fiscal year, or the Federal fiscal year?

   Answer: The states have the option of determining which fiscal year to use. It may be the Federal fiscal year, the state fiscal year or the center/clinic fiscal year. However, the fiscal years used to compute the PPS baseline rate must be 1999 and 2000.

State Plan Requirements

4. Question: Is a state plan amendment required to implement this legislation?

   Answer: Yes. A state plan amendment is required for any change in the state's reimbursement of Medicaid covered services. The approved state plan must comply with all Medicaid statutes and regulations.

5. Question: If a state is selecting to implement an alternative payment methodology, is a State plan amendment required? Is a state plan amendment required if the alternative payment method is the current payment methodology?

   Answer: Yes. A state plan amendment is required for either the new PPS methodology or an alternative payment methodology. A state must submit a plan amendment even if they are proposing to continue to use their current payment methodology since it would be considered an alternative payment methodology.

6. Question: Who will review the payment methodology for conformance to the BIPA legislation?

   Answer: The CMS regional office has the primary agency authority for review and approval of the FQHC/RHC payment methodologies. The CMS regional office may submit a copy of the state's plan amendment to the Health Resources and Services Administration (HRSA) field office for review and comment. In addition, HRSA and other stakeholders may work independently with centers/clinics to assure that the BIPA requirements are met.

7. Question: Is Medicare under the same mandate to develop a PPS?

   Answer: No. The BIPA legislation mandating the PPS methodology for FQHCs/RHCs only applies to Medicaid payments.

Services

8. Question: What services are included in the PPS rate? Does the new rate also include all other ambulatory services paid by Medicaid?

   Answer: The Medicaid PPS rate must include all Medicaid covered services allowed under 1905(a)(2)(B) and (C) of the Social Security Act (the Act) which includes ambulatory services. These are outpatient services provided in an FQHC/RHC and included in the state plan.

Cost Reports and Cost Settlements

9. Question: Are cost reports or some other accounting method for calculating costs and doing cost settlements required under the new PPS after fiscal year 2000?

   Answer: Under the new PPS, neither annual cost reports (or other methods for calculating cost) nor cost settlements are required after fiscal year 2000. The PPS payment rate is prospective.

10. Question: May the state require a cost report or some other accounting method for calculating costs after the base year?

    Answer: The legislation does not require that a cost report or some other accounting method for calculating cost after the base year. The PPS methodology is prospective, and rates are not based on current costs or reconciled with those costs. The purpose of a PPS is to move away from cost reports and cost reconciliation. The legislation requires that a change in the rates under the PPS methodology can only be based on the Medicare Economic Index (MEI) and a change in the scope of services. The state must develop a process necessary for determining a change in scope of services. However, if the state determines it has a continued need for cost reports or other accounting method, it has the flexibility to require such reports.

11. Question: For FQHCs/RHCs with multiple sites, may the FQHC/RHC file a consolidated cost report or some other accounting method for calculating costs or must they file a separate cost report or some other accounting method for calculating costs for each site?

    Answer: There is nothing in statute or regulation that mandates that the state use a consolidated cost report (or other consolidated method) for calculating costs in computing the per-visit encounter rate for an FQHC or RHC with multiple sites. The state has the flexibility to require a separate cost report or some other accounting method for calculating costs for each site with a Medicaid provider number. The state has the option of using a consolidated analysis for calculating costs for a center/clinic with multiple sites. For years following fiscal year 1999 and 2000, there is no Federal requirement for a cost report or some other accounting method for calculating costs at all.

12. Question: Once the PPS baseline rate is established, the MEI is applied annually to determine the new PPS rate. Does this mean that states will no longer be required to audit the clinics/centers to verify year costs, services delivered, and level of service?

    Answer: There are no federal requirements that states audit the clinics to determine costs. States may, however, develop appropriate methods for auditing or reviewing for changes in the scope of services.

Calculating the PPS Baseline Rate

13. The legislation requires that 100 percent of the reasonable costs incurred during fiscal year 1999 and fiscal year 2000 are used in calculating the PPS baseline rates for existing FQHCs and RHCs. How should states operationalize this legislation when costs for both fiscal year 1999 and fiscal year 2000 are not available and/or have not been reconciled?

    Answer: A state may provide in its state plan that, until it has reconciled costs for each center/clinic fiscal year 1999 and fiscal year 2000, it will establish and pay an interim rate based on the rate currently paid to FQHCs/RHCs. However, if reconciled costs for fiscal year 1999 and 2000 are not available, the state plan amendment should state the basis used to calculate the PPS baseline rate. (Please note that under Medicaid requirements for timely claims processing at 42 CFR 447.45, claims paid under the interim rate would be within the meaning of "clean claims" upon submission of the cost report by the center/clinic, because at that point no further information is required from the center/clinic or a third party to process the claim. The reconciliation must then be performed, and the claims processed and adjusted to reflect interim payments, within 90 days after the center/clinic submits the required cost report. The agency must pay all claims within 12 months of the date of receipt, except those that fall in to the specific exceptions listed at 42 CFR 447.45(d)(4). When the state has completed its final reconciliation of the center's/clinic's initial cost report, the state must promptly calculate and pay or recoup funds (taking into account any interim payments) based on its determination of the actual per visit payment amount to which the center/clinic is entitled under the Medicaid PPS for that year. The auditing and related administrative costs

incurred by a state in calculating the costs are subject to Federal Financial Participation at the 50 percent rate under section 1903(a)(7) of the Act.)

14. Question: Does the FQHC/RHC have the right to appeal the PPS per visit payment rate?

    Answer: This legislation does not preclude FQHCs and RHCs from using any process the state has established for appeal of rates. This appeal right applies to both the baseline rate and subsequent rates.

15. Question: How is the averaging of 100 percent reasonable costs for fiscal year 1999 and fiscal year 2000 computed?

    Answer: The state should use a reasonable averaging method in calculating the PPS baseline rate. The simplest method would be to determine the total costs of Medicaid covered services furnished by the center/clinic during fiscal year 1999 and fiscal year 2000. The total costs would then be divided by the total number of all clinic visits during the two fiscal years. Another reasonable averaging method is to determine the per visit encounter rate for each fiscal year, add the individual fiscal year rates and then divide by two. If a state departs from either of these two methods, it must describe the averaging methodology in the state plan and justify why their averaging methodology is reasonable.

16. Question: The legislation states that the per visit rate shall be an amount that is equal to 100 percent of the average of the costs of the center/clinic of furnishing such services during fiscal year 1999 and fiscal year 2000 which are reasonable. What are the tests of reasonableness?

    Answer: The BIPA legislation requires the states to use tests of reasonableness in effect in fiscal year 1999 and fiscal year 2000 in establishing a PPS rate or, as prescribed in regulations under section 1833(a)(3) of the Social Security Act. This section of the statute allows for the application of caps and productivity screens.

17. Question: May fiscal years other than 1999 and 2000 be used to develop the PPS baseline rate?

    Answer: No. The new legislation requires that states calculate the PPS baseline rate for existing FQHCs and RHCs based on the center/clinic costs of furnishing services during fiscal years 1999 and 2000.

18. Question: If the PPS methodology is used to reimburse FQHCs/RHCs, does the state have the right to implement it without the agreement of the individual clinics?

    Answer: Yes. The state may implement a PPS methodology without obtaining agreement from each of the clinics or centers.

19. Question: The legislation is silent regarding a deadline for calculating the baseline PPS payment rate. Has a deadline been established?

Answer: CMS expects the baseline PPS payment rates for each center/clinic to be calculated by December 31, 2001.

Adjustments

20. Question: The legislation states that the PPS rate must be "adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during the fiscal year." What is meant by a 'change in the scope of services'?

    Answer: A change in the scope of FQHC/RHC services shall occur if: (1) the center/clinic has added or has dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a)(2)(B) and (C); and, (2) the service is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary. A change in the 'scope of services' is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services. In making such an adjustment, state agencies must add on the cost of new FQHC/RHC services even if these services do not require a face-to-face visit with a FQHC/RHC provider, e.g., laboratory, x-rays, drugs, outreach, case management, transportation, etc.

21. How are adjustments (increases/decreases) to be recognized?

    Answer: The state may require that the center/clinic be responsible for informing the state of a change (increases and decreases) in the scope of services in the fiscal year. Or, the state itself may want to assume the responsibility for identifying an increase or decrease in the scope of services. The state should describe the adjustment process in the state plan.

Subsequent Fiscal year Payment Methodology Under a PPS

22. Question: For services furnished during fiscal year 2002 and succeeding fiscal years, the PPS rate will be increased by the MEI and adjustments will be made for any increases/decreases in the scope of services during the preceding fiscal year. When would the MEI be applied? When are the adjustments applied?

    Answer: The MEI is published in the 4th quarter (Nov/Dec) in the Federal Register and applies to services provided in the following year. The MEI for primary care services must be applied to the PPS rate. The State has the option of applying the MEI to the next fiscal year services or to the calendar year services following the publication of the MEI. Adjustments for increases/decreases in the scope of services are reflected in the PPS rate for services provided in the fiscal year following the fiscal year in which the change in scope of services took place.

23. Question: Is there any planned rebasing of the PPS baseline rate or are the FQHCs/RHCs limited to the fiscal year 1999 and fiscal year 2000 costs for the PPS baseline rate?

Answer: The legislation does not allow for any rebasing of the PPS baseline rate. However, the state may rebase the payment rates under an alternative payment methodology.

Alternative payment methodology

24. Question: What are the statutory requirements for an alternative payment methodology?

    Answer: Under BIPA, the state has the option of developing an alternative payment methodology. If the state decides to implement an alternative payment methodology, there are two statutory requirements: 1) it must be agreed to by the state and the individual center/clinic, and, 2) it must result in a payment rate to the center/clinic that is at least equal to the Medicaid PPS rate. The alternative payment rate cannot exceed what would be paid under the applicable upper payment limit provisions. If a center/clinic agrees to the alternative payment methodology that results in a payment amount that is lower than the amount the center/clinic would receive under the Medicaid PPS, the state may not implement the alternative payment methodology because to do so would be to violate the statutory requirement of BIPA.

25. Question: May the state continue to reimburse FQHCs/RHCs using their payment methodology prior to BIPA?

    Answer: Yes. The state may continue with its existing payment methodology as long as it meets the legislative requirements for an alternative payment methodology. The state must also compute a PPS baseline rate even if it implements an alternative payment methodology.

26. Question: What happens if the state is unable to reach agreement with some of the centers/clinics on its alternative payment methodology? Can the alternative payment methodology still be used?

    Answer: Yes. The state may develop an alternative payment methodology to be applied to only to those centers/clinics. For any centers/clinics that do not agree to this alternative payment methodology, the state must develop a prospective payment system that conforms to the statutory requirements.

27. Question: Is the state required to provide documentation that the payment rate under the alternative payment methodology meets the BIPA legislative requirements?

    Answer: The state should make an assurance in the state plan that the payment rate for the alternative payment methodology is at least equal to the PPS payment rate. The alternative payment rate cannot exceed what would be paid under the applicable upper payment limit provisions. The actual calculation of the payment rate does not need to be in the state plan.

28. Question: May a state implement an alternative payment methodology and change to a PPS methodology at a later date?

Answer: Yes. The state may implement an alternative payment methodology and change to a PPS methodology in the future. If the state changes to a PPS methodology at a later date, the BIPA legislative requirements would apply.

29. Question: If a state chooses an alternative payment methodology, does it have to prove every year that the payment rate is equal to or more than the PPS payment rate?

    Answer: Yes. The state must develop a process that compares what the PPS rate would be to their alternative payment rate. The legislation requires that the alternative payment rate be equal to or more than the PPS rate in the fiscal year.

Initial Year Payment Amount for New Centers or Clinics

30. Question: If a center/clinic came into existence in fiscal year 1999 or fiscal year 2000, will the per visit rate be based on fiscal year 1999 and 2000 reasonable costs?

    Answer: Yes. The legislation states that, for facilities that qualify in or before fiscal year 2000, the PPS per visit must be calculated using 100 percent of the average costs of furnishing services during those fiscal years. If the center/clinic only participated in fiscal year 2000, that is the only year the state should use as the base for PPS rate for that center/clinic.

31. Question: The BIPA legislation requires that the PPS rate established for a new FQHC/RHC that qualifies as a FQHC/RHC after fiscal year 2000 shall be equal to100 percent of the reasonable costs used in calculating the rates of like FQHCs/RHCs located in the same or an adjacent area during the same fiscal year. How are the payment rates to be calculated?

    Answer: The costs that must be considered in calculating the payment rate are those reasonable costs used in calculating the rates for neighboring clinics with similar caseloads. The key issue is similarity of caseload. If there are no FQHCs/RHCs located in the same or an adjacent area with a similar caseload, the state may then calculate the rate for the new FQHC/RHC based on projected costs after applying tests of reasonableness as the Secretary may prescribe under section 1833(a)(3) of the Act.

FQHC/RHC Managed Care Payment Provisions

32. Question: May states still receive a waiver of section 1902(a)(13)(C) of the Act, which provides for a phase-out of cost-based reimbursement for FQHCs/RHCs, under section 1115 demonstration authority?

    Answer: No. Section 1902(a)(13)(C) of the Act has been deleted. Any waiver of the requirements of that section that was previously granted is no longer meaningful after the effective date of section 702 of BIPA. However, a state may submit a request to waive the

new FQHC/RHC BIPA PPS payment provisions in sections 1902(a)(15) and 1902(aa) of the Act for CMS review which replaced section 1902(a)(13(C).

33. Question: Do special terms and conditions need to be modified to delete a previous grant of a waiver of section 1902(a)(13)(C) of the Act?

    Answer: No. Those waivers are automatically discontinued. During the review of the state's next extension request, we will delete references to any waiver related to section 1902(a)(13)(C).

34. Question: Are states still required to make supplemental payments to FQHCs/RHCs contracting with Medicaid managed care organizations (MCOs) under BIPA?

    Answer: Yes, the statute continues to require that states make supplemental payments to these centers/clinics to the extent that payments made by MCOs are less than the amount determined using the BIPA methodology.

35. Question: How often must states make supplemental payments under BIPA?

    Answer: The state and the FQHC/RHC must agree to a payment schedule, but in all cases supplemental payments must be made at least every four months.

36. Question: How will the state ensure that FQHCs/RHCs contracting with Medicaid MCOs receive supplemental payment amounts in accordance with BIPA?

    Answer: The state must perform a reconciliation at least annually, or more often at the state option, to ensure that MCO payments plus state supplemental payments to these centers/clinics equal the amount calculated under the BIPA methodology.

37. Question: As it relates to FQHCs/RHCs contracting with Medicaid MCOs, what specifically must be included in the state plan?

    Answer: The state plan must include a provision for supplemental payments, a methodology for calculating such payments, and a timeline for payment.

38. Question: Do policies outlined in the State Medicaid Directors Letter (SMDL) dated September 27, 2000 regarding financial incentives and MCO insolvency still apply?

    Answer: Yes, BIPA did not change anything in the law that would nullify the policies regarding financial incentives and MCO insolvency outlined in this SMDL.

39. Question: May a state apply the supplemental payment provisions in section 702 of BIPA to Prepaid Health Plans (PHPs) in the same manner as for MCOs?

    Answer: Yes.

40. Question: Since CMS can no longer waive section 1902(a)(13)(C) of the Act under section 1115 demonstration authority, how will the PPS baseline rate be computed for states which formerly had this waiver authority? For these states, will the PPS baseline rate be based on the 1999-2000 rate effective under waiver authority, which may have been well below costs due to such authority?

    Answer: The PPS baseline rate is calculated using 100 percent of the reasonable costs incurred during fiscal year 1999 and fiscal year 2000. Therefore, the rate that was in effect under section 1115 waiver authority is irrelevant and should not be used. States are allowed to use an alternative payment methodology, instead of the PPS methodology, as long as the payment rate under the alternative payment methodology is at least equal to the PPS-based rate. The upper payment limit provisions apply.

41. Question: If a state chooses to use an alternative methodology which results in a higher payment level than that of a PPS, is the state required to make supplemental payments to ensure that the FQHC/RHC receives the PPS amount or the alternative amount?

    Answer: If a state chooses to use the alternative methodology, the supplemental payment must equal the difference between the amount calculated using the alternative methodology and the MCE payments received by the FQHC/RHC.