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HEALTH CENTERS AND RURAL CLINICS

State and Federal Implementation Issues for Medicaid's New Payment System

GAO-05-452

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-05-452, a report to congressional committees

Why GAO Did This Study

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a prospective payment system (PPS) for Medicaid payments to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), giving providers a financial incentive to operate efficiently. BIPA requires that BIPA PPS rates be adjusted for inflation and changes in scope of services. States also may use an alternative methodology if it pays no less than the BIPA PPS rate. In response to a BIPA mandate, GAO reviewed states' implementation of the new payment requirements, the need to rebase or refine the BIPA PPS, and the Centers for Medicare & Medicaid Services' (CMS) oversight of states' implementation. GAO surveyed the states about their payment methodologies, did a targeted review in four states, and reviewed indexes used to reflect medical care inflation.

What GAO Recommends

GAO recommends that CMS explore the development of a more appropriate inflation index for the BIPA PPS and improve its guidance for states and its oversight of states' payment methodologies. CMS said it will take steps related to its oversight but disagreed on the need to issue additional guidance. CMS also disagreed on the need to develop an inflation index; GAO maintained the recommendation and also elevated the issue to a matter for congressional consideration.

www.gao.gov/cgi-bin/getrpt?GAO-05-452.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

GAO's review of states' implementation of Medicaid's new payment system—the BIPA PPS and alternative methodologies—for FQHCs and RHCs identified certain issues regarding the appropriateness of some states' methodologies. Most states used the BIPA PPS and about half of states used an alternative methodology—generally cost-based reimbursement or a PPS with features slightly different from those required for the BIPA PPS—to pay at least some of their FQHCs, RHCs, or both. States took an average of slightly more than a year from the legislation's January 1, 2001, effective date to implement their BIPA PPS, and a few states had not completed implementation as of June 1, 2004. GAO identified three significant issues with states' new Medicaid payment systems. First, some states' BIPA PPS payment rates may be inappropriate because they did not include all Medicaid-covered FQHC and RHC services in the rates as required by law. Second, as of June 1, 2004, over half the states using the BIPA PPS had not determined how they would make the required adjustment to BIPA PPS rates for a change in scope of services. Third, some states did not ensure that their alternative methodologies resulted in payments no lower than what the FQHCs and RHCs would have received under the BIPA PPS.

Evidence to date is insufficient to determine the need to rebase or refine the BIPA PPS. Concerns exist that the statutorily specified annual inflation index used to adjust the BIPA PPS is inappropriate because it not only increases more slowly than do many FQHCs' and RHCs' costs but also does not reflect the services these providers deliver. Other indexes GAO reviewed had a similar shortcoming. GAO's analysis determined that no inflation index has been developed that reflects the services typically provided by FQHCs and RHCs. Because many states no longer require FQHCs and RHCs to submit cost reports, comprehensive and current Medicaid cost data are no longer available to help inform an evaluation of the need to rebase or refine the BIPA PPS. Although GAO's comparison of cost-based and BIPA PPS rates from four states showed that cost-based rates generally exceeded BIPA PPS rates, not all factors contributing to the higher rates are known. Differences between cost-based and BIPA PPS rates varied widely within and among the states reviewed, which also limited the ability to draw conclusions about the need to rebase or refine rates.

CMS guidance and oversight regarding the new BIPA payment requirements were inadequate to ensure consistent state compliance with the law. CMS guidance did not fully address certain requirements, and as states developed their new payment systems, they lacked important information clarifying the new requirements. As a result, uncertainties exist regarding how states were to implement some BIPA requirements, such as how to adjust BIPA PPS rates to account for a change in scope of services. CMS has conducted limited oversight of states' implementation and therefore was unaware of compliance issues with some states' payment systems.

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Abbreviations

BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
CPI	Consumer Price Index
FQHC	Federally Qualified Health Center
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
MEI	Medicare Economic Index
PPI	Producer Price Index
PPS	prospective payment system
RHC	Rural Health Clinic
SPA	state plan amendment
UDS	Uniform Data System

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United States Government Accountability Office
Washington, DC 20548

June 17, 2005

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

To increase the accessibility of primary and preventive health services for low-income people living in medically underserved areas, Congress made Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) eligible for payments from Medicaid, a joint federal-state program that finances health insurance for certain low-income adults and children.[1] FQHCs are urban or rural centers that provide comprehensive community-based primary care services to individuals regardless of their ability to pay. In 2003, there were approximately 900 FQHCs. The nation's approximately 3,600 RHCs provide similar primary care services in underserved rural areas, but unlike FQHCs, RHCs are not required to provide services to all individuals, such as those who are uninsured.[2] Medicaid is a significant revenue source for FQHCs and RHCs; according to the most recent data available, it accounted for about 35 percent of total revenues for FQHCs

[1]The Rural Health Clinic Services Act of 1977, Pub. L. No. 95-210, § 2, 91 Stat. 1485, 1488, authorized Medicaid payment for RHCs for covered services; the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6404, 103 Stat. 2106, 2264, established FQHCs as a new provider type and authorized Medicaid payment for covered services.

[2]The number of RHCs is as of August 2004.

and 24 percent for RHCs.[3] In fiscal year 2003, Medicaid payments to FQHCs and RHCs were almost $1.5 billion.

Historically, federal law required state Medicaid programs to reimburse FQHCs and RHCs on the basis of reasonable costs—that is, costs that are not excessive for a type of service provided to Medicaid beneficiaries. While this basis for reimbursement may have ensured that service providers were paid for necessary costs, it was also regarded as potentially inflationary because providers may have increased their payments by raising their costs. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) changed Medicaid payment requirements by establishing a new prospective payment system (PPS) effective for services provided by FQHCs and RHCs on or after January 1, 2001.[4] Unlike cost-based reimbursement, a PPS creates financial incentives for providers to operate more efficiently. Providers that keep their costs below their payment amount profit; conversely, providers lose money if their service costs exceed the payment amount.

Although not typical of other PPSs, the BIPA PPS established a provider-specific rate for the first year's payment rate (2001). Specifically, states were to set the base rate at the average of each FQHC's or RHC's fiscal year 1999 and fiscal year 2000 reasonable costs per visit. In subsequent years, states were to use the Medicare Economic Index (MEI) to increase payment rates annually for inflation and were to adjust rates when necessary to reflect a change in scope of services. States may use an alternative methodology to reimburse some or all of their FQHCs and RHCs if they can demonstrate that the alternative payment methodology would result in payments no lower than under the BIPA PPS payment rate and if the FQHC or RHC agrees to its use.

[3]FQHC revenue data, which are as of 2003, are from the Uniform Data System (UDS), a database of self-reported FQHC data maintained by the Health Resources and Services Administration (HRSA). RHC data are from a 2000 National Rural Health Clinic Survey conducted by the Maine Rural Health Research Center that was sent to a random sample of approximately one-half of the nation's RHCs.

[4]Pub. L. No. 106-554, app. F, § 702, 114 Stat. 2763A-463, 2763A-572. BIPA amended Medicaid requirements to require states to reimburse FQHCs and RHCs under the new PPS or an alternative methodology. (These requirements were originally designated in BIPA as subsection (aa) of section 1902 of the Social Security Act, but technical amendments to BIPA redesignated them subsection (bb). Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001, Pub. L. No. 107-121, § 2(b)(1), 115 Stat. 2384.) Throughout this report we refer to the PPS specifically set out in section 702 of BIPA as the BIPA PPS.

BIPA required that we study the need for, and how to, rebase and refine costs for making Medicaid payments to FQHCs and RHCs.[5] We (1) reviewed states' implementation of the Medicaid payment system under BIPA for FQHCs and RHCs, (2) evaluated the need for rebasing or refining costs for making payment under the BIPA PPS, and (3) reviewed the Centers for Medicare & Medicaid Services' (CMS) oversight of states' Medicaid payment systems for FQHCs and RHCs.

To examine these issues, we surveyed Medicaid officials in the 50 states and the District of Columbia regarding their FQHC and RHC reimbursement policies and practices as of June 1, 2004.[6] States also submitted documentation describing their methodologies, which we reviewed to corroborate their survey responses. In addition to conducting the survey, we reviewed the MEI, the index required by statute to annually adjust BIPA PPS rates for inflation, as well as other indexes often used to reflect changes in medical care inflation. To identify these other indexes, we reviewed literature on medical care indexes and information from organizations typically involved in developing and updating these indexes. We also conducted a targeted review of FQHC and RHC payment rates in four states—Iowa, Vermont, Virginia, and Wisconsin—that used cost-based reimbursement as an alternative methodology. (See app. I for details about the methodology of our targeted review.) We interviewed officials from CMS and its regional offices; CMS is the agency within the Department of Health and Human Services (HHS) that oversees states' Medicaid programs. We also interviewed officials from HHS's Health Resources and Services Administration (HRSA), which is responsible for reviewing FQHC grant applications and disbursing federal public health grant funds to FQHCs. To provide contextual information, we interviewed various stakeholders. Specifically, we interviewed officials from the National Association of Community Health Centers (an organization representing FQHCs), the National Association of Rural Health Clinics, George Washington University's Center for Health Services and Policy (an organization that has conducted research on FQHCs), and a judgmentally selected sample of eight FQHCs and eight RHCs. We performed our work from July 2004 through May 2005 in accordance with generally accepted government auditing standards.

[5]BIPA § 702(d), 103 Stat. 2763A-574.

[6]Throughout this report, the term state refers to the 50 states and the District of Columbia.

Results in Brief

Our analysis of states' implementation of Medicaid's new payment system—the BIPA PPS and alternative methodologies—to pay FQHCs and RHCs identified certain issues about the appropriateness of some states' methodologies. Most states implemented the BIPA PPS and just under half of states used an alternative methodology—generally cost-based reimbursement or a PPS with features differing slightly from the BIPA PPS—to pay at least a portion of their FQHCs or RHCs; and some states used more than one methodology. States took an average of slightly more than a year to implement their BIPA PPS, and a few states had not completed implementation as of June 1, 2004. We noted three significant issues regarding states' payment methodologies—two related to the BIPA PPS and one related to alternative methodologies. First, some states' BIPA PPS payment rates may be inappropriate because the states did not include all Medicaid-covered FQHC and RHC services in determining the rates. Second, over half of states using the BIPA PPS had not determined how they would address the requirement to adjust their BIPA PPS rates for a change in scope of services. Third, not all states with alternative methodologies ensured that they resulted in payment at least equal to what FQHCs and RHCs would have received under the BIPA PPS, as required by statute.

Evidence to date is insufficient to determine the need to rebase or refine the BIPA PPS. Concerns exist about the appropriateness of the MEI, the index required by statute to annually adjust BIPA PPS rates for inflation. For example, the MEI was designed to measure the changing costs for the average physician, which may be different from the costs of FQHCs and RHCs. FQHCs often provide additional services, such as translation, and a significant portion of RHC services may be provided by nonphysician practitioners. Other indexes often used to reflect medical care inflation have a similar shortcoming as they also do not reflect the services typically provided by FQHCs and RHCs. Although the MEI may not be an appropriate index, we determined that no inflation index is currently available that reflects these services. Determining the need for rebasing or refining is further complicated by the increasing lack of comprehensive and current cost data because many states no longer require all FQHCs and RHCs to submit cost reports. Our comparison of cost-based and BIPA PPS rates from four states that used cost-based reimbursement as an alternative payment methodology did not provide conclusive evidence on the need to rebase or refine the BIPA PPS. Specifically, cost-based rates for these states generally were higher than the BIPA PPS rates for most providers, but it is unclear if this is because providers lacked the incentive to deliver services efficiently or because they were operating efficiently but their costs were higher than what the BIPA PPS would pay.

CMS guidance for and oversight of states' implementation of the new BIPA-mandated payment requirements for FQHCs and RHCs were inadequate to consistently ensure states' compliance with the law. Although CMS issued guidance, it did not address how states were to implement some BIPA requirements, such as how to adjust BIPA PPS rates to account for a provider's change in scope of services and the relevance of this requirement to states using alternative payment methodologies. Moreover, CMS has conducted limited oversight of states' implementation of the new payment system for FQHCs and RHCs. Instead, CMS has relied on states' assurances that they were in compliance with BIPA and investigated payment issues only in response to complaints, which CMS said were rare, or when payment issues were raised during a CMS review conducted for other purposes. As a result of its limited oversight, CMS was unaware of certain compliance issues with states' payment methodologies for FQHCs and RHCs, such as that some states' alternative methodologies did not comply with BIPA's requirement that these methodologies result in payment no lower than what FQHCs and RHCs would have received under the BIPA PPS.

This report includes a matter for congressional consideration and several recommendations to the Administrator of CMS. We suggest that Congress consider directing CMS to explore the development of a more appropriate inflation index or develop a strategy to periodically assess the adequacy of the MEI as an inflation index for adjusting BIPA PPS rates. We are recommending that the Administrator of CMS also explore the development of a more appropriate inflation index for the BIPA PPS, take various steps to improve CMS guidance for states, and provide more consistent oversight of states' payment methodologies for FQHCs and RHCs. In commenting on a draft of this report, CMS said it would take certain actions related to its oversight of states' payment methodologies for FQHCs and RHCs, but did not agree that development of another inflation index or issuance of additional guidance were necessary. We believe that the CMS response does not adequately address the issues raised in this report, as its proposed actions may not be sufficient to ensure states' compliance with BIPA. In addition, we continue to believe that CMS should explore developing an inflation index that more appropriately reflects the services provided by FQHCs and RHCs. We therefore maintained this recommendation and also elevated the issue to a matter for congressional consideration.

Background

The FQHC and RHC programs were established to increase access to care for individuals in medically underserved areas. Medicaid, which finances health care for more than 50 million low-income Americans, is a significant revenue source for FQHCs and RHCs, providing, on average, one-quarter to over one-third of these providers' revenues.

Characteristics of FQHCs and RHCs

To be designated an FQHC, a facility generally must meet the requirements of a grant recipient under section 330 of the Public Health Service Act; be a public or private nonprofit entity that provides a statutorily required set of primary care services to any individual, regardless of ability to pay; and serve the medically underserved.[7] In fiscal year 2002, the President launched the Health Center Initiative with the goal of adding 1,200 new or expanded health center sites and increasing the number of patients served from about 10 million in fiscal year 2001 to 16 million by 2006. In 2003, the approximately 900 FQHCs provided services to over 12 million people.[8]

FQHCs include community health centers, migrant health centers, public housing and homeless programs, FQHC look-alikes, and certain facilities operated by tribes or tribal organizations.[9] A distinguishing feature of FQHCs is that they provide enabling services such as outreach, translation, and transportation, which help patients gain access to health care. FQHCs vary considerably in their geographic location; their revenue mix; and the size of the uninsured and Medicaid populations and degree of managed care penetration in the surrounding area. For example, an FQHC may be located in an urban area with a large uninsured or Medicaid population and a high Medicaid managed care penetration, or in a rural area, where it serves as the only source of primary care for several communities.

Unlike FQHCs, RHCs are not required to provide services to all individuals, such as those who are uninsured, but they are required to

[7]42 U.S.C. § 254b (2000). All section 330 health center grantees are designated as FQHCs, making them certified Medicaid providers and therefore eligible for Medicaid reimbursement.

[8]The data only include the federally funded FQHCs that report to the UDS database.

[9]FQHC look-alikes are facilities that HRSA deems have met all of the requirements to be a grant recipient under section 330 of the Public Health Service Act but do not receive the federal grant.

operate in rural areas that are designated as underserved.[10] RHCs can operate either independently or as part of a larger organization, such as a hospital, skilled nursing facility, or home health agency. RHCs can be specialty clinics, focusing their services on particular populations or medical specialties such as pediatrics or obstetrics and gynecology. In addition to being located in a rural, underserved area, to be certified by CMS as an RHC, a provider must primarily offer outpatient primary medical care, employ at least one nonphysician practitioner at least half the time the clinic is open, and have a physician on-site at least once every 2 weeks.[11] As of August 2004, approximately 3,600 RHCs operated in 44 states.[12]

In 2003, Medicaid reimbursement and HRSA grant funds were the two largest single sources of revenue for FQHCs and accounted for 35 percent and 22 percent of these providers' total revenue, respectively. FQHCs also received revenues from state, local, and private grants as well as other insurance programs.[13] In contrast, RHCs received a smaller proportion of their total revenues from Medicaid (24 percent) but a higher proportion from Medicare, commercial insurance, and directly from patients (self-pay).[14] Although Medicaid is a large revenue source for FQHCs and RHCs, payments to these providers represent a very small percentage of overall

[10]RHCs must be located in an area designated by HRSA as either a Health Professional Shortage Area (an area that has a critical shortage of physicians available to serve the people living there), a HRSA-designated Medically Underserved Area (an area or population with a shortage of health care services), or an area designated by the governor of the state as a shortage area.

[11]Nonphysician practitioner refers to a nurse practitioner, physician assistant, or certified nurse midwife.

[12]Connecticut, Delaware, the District of Columbia, Maryland, Massachusetts, New Jersey, and Rhode Island reported that they have no RHCs. We could not identify current or reliable data on the number of people served by RHCs.

[13]State, local, and private grants accounted for approximately 13 percent of FQHCs' total revenues in 2003. Other revenue sources included commercial insurance (6 percent), payments directly from patients (6 percent), Medicare (5 percent), and other public insurance (3 percent). The remaining 10 percent of revenue came from miscellaneous funding sources, including other federal grants, revenue from indigent care programs, and other revenue. These 2003 data are from the UDS database.

[14]RHCs received approximately 30 percent of their revenue from Medicare, 30 percent from commercial insurance, 15 percent directly from patients, and the remaining from other miscellaneous sources. These data, the most recent available, are from a 2000 National Rural Health Clinic Survey. The survey, conducted by the Maine Rural Health Research Center, was sent to a random sample of approximately one-half of the nation's RHCs.

Medicaid expenditures. In fiscal year 2003, Medicaid payments to FQHCs and RHCs totaled almost $1.5 billion combined, which accounted for less than 1 percent of Medicaid expenditures for medical care.

Medicaid Reimbursement for FQHCs and RHCs

Prior to 2001, federal law required state Medicaid programs to pay FQHCs and RHCs using a cost-based reimbursement methodology. To determine cost-based payments, states required FQHCs and RHCs to submit cost reports, which states reviewed to determine which reported costs were allowable (related to providing services to Medicaid beneficiaries) and reasonable (not excessive for the type of service). The Medicaid statute directed states to follow the Medicare statute to reimburse FQHCs and RHCs. This meant that states were to reimburse FQHCs and RHCs according to CMS Medicare regulations, which provide guidance on the types of allowable costs, such as compensation for physicians and other staff, supplies, administrative overhead, and other items. The regulations allowed states to establish their own definition of what constituted "reasonable costs," which could include a ceiling on costs per service, such as a medical visit, or a limit on a type of cost, such as administrative costs.

In December 2000, BIPA established a PPS to pay for Medicaid-covered services provided by FQHCs and RHCs. While BIPA did not specify when states had to implement the PPS, the statute required that the BIPA PPS be effective for services provided by FQHCs and RHCs on or after January 1, 2001. Unlike the prior cost-based reimbursement system, a PPS establishes payment rates in advance of service delivery and creates incentives for providers to operate more efficiently. Generally, the payment is not contingent on an individual provider's actual cost of delivering care. Providers that, on average, deliver care for less than the payment amount can retain the portion of the payment amount exceeding their costs; conversely, providers will lose money if their service costs are higher than the payment. (See app. II for additional general information on PPSs, including how the BIPA PPS compares with selected other PPSs.)

Under the PPS mandated by BIPA, the 2001 payment rate, called the base rate, was effective for services provided beginning January 1, 2001. The 2001 payment rate was to be the average of each FQHC's and RHC's fiscal year 1999 and fiscal year 2000 reasonable costs per visit, which states were allowed to determine using their prior definitions of reasonable costs. Beginning in fiscal year 2002, BIPA PPS payment rates were to be adjusted annually for inflation by the MEI. In addition, BIPA required that payments to FQHCs and RHCs be adjusted for increases or decreases in the scope of

services provided. States also were required to make supplemental payments to FQHCs and RHCs that provide services to Medicaid patients enrolled in a capitated managed care plan.[15] BIPA allowed states to use an alternative methodology to pay an FQHC or RHC as long as the FQHC or RHC agreed to the alternative methodology and the methodology resulted in payment to the FQHC or RHC of an amount that was no lower than the amount otherwise required under the BIPA PPS.[16]

In June 2001, we reported that payments to FQHCs and RHCs under the new BIPA PPS would likely be constrained.[17] The report noted that because states were allowed to continue to use their prior methods for determining reasonable costs in establishing the 2001 base payment rate under the BIPA PPS, the initial PPS rates for FQHCs and RHCs might be below their actual costs. Additionally, the 2001 base PPS rate could be lower than what an FQHC or RHC received in 2000 because the base rate was an average of fiscal years' 1999 and 2000 costs. Furthermore, BIPA did not specify that the initial 2001 payment rates be updated for inflation from 1999 through 2001. We also reported that the specific inflation index BIPA required states to use, the MEI, increased at a lower rate than other measures of inflation that some states had previously used to adjust FQHCs' payment rates.

State Plan Approval Process

To comply with BIPA's January 1, 2001, effective date, states were required to submit a state plan amendment (SPA) for the new FQHC and

[15]Under a capitated managed care model, states contract with managed care organizations and prospectively pay them a fixed monthly fee per patient to provide or arrange for most health services. The managed care organizations, in turn, pay providers either retrospectively for each service delivered on a fee-for-service basis or through prospective capitation payment arrangements. BIPA required states to compare the aggregate managed care plans' payments to the amount that an FQHC or RHC would have received under the BIPA PPS methodology. If the total managed care payments were less, states were required to pay FQHCs and RHCs the difference.

[16]States also may seek a waiver of the BIPA payment requirements. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services has broad authority to approve demonstration projects that the Secretary determines are likely to promote Medicaid objectives. 42 U.S.C. § 1315 (2000). The Secretary may waive certain provisions of the statute if the Secretary finds it necessary for the performance of the experimental, pilot, or demonstration projects. For this report, we refer to demonstration projects approved under section 1115 as 1115 waiver programs.

[17]See GAO, *Health Centers and Rural Clinics: Payments Likely to Be Constrained Under Medicaid's New System*, GAO-01-577 (Washington, D.C.: June 19, 2001).

RHC Medicaid payment requirements by the end of the first quarter of 2001 (March 31, 2001).[18] To aid states in meeting this deadline, CMS provided them with standard language that they could submit as a placeholder SPA that would allow them to comply technically with the submission deadline.[19, 20] According to CMS, states could subsequently update their SPAs with the specifics of their methodology before CMS review.

Once CMS receives a SPA, it has 90 days to approve it, disapprove it, or request additional information from the state.[21] Upon receipt of any additional state information requested, CMS has an additional 90 days to approve or disapprove the SPA.[22] According to CMS, its regional offices have primary responsibility for review and approval of SPAs but coordinate with headquarters, which is responsible for making any final disapprovals.

States' Implementation of BIPA PPS and Alternative Methodologies Raises Certain Issues

Our analysis of states' implementation of the BIPA PPS and alternative methodologies identified certain issues regarding the appropriateness of some states' Medicaid payment systems for FQHCs and RHCs. Most states (39) used the BIPA PPS and just under half of states (25) used the BIPA option of an alternative methodology to pay at least a portion of their FQHCs, RHCs, or both. (See app. III for the portion of FQHCs and RHCs, by state, paid under each methodology.) States took an average of slightly more than a year from the legislation's January 1, 2001, effective date to complete implementation of their BIPA PPS, and a few states had not completed implementation as of June 1, 2004. We found two significant

[18]SPAs may take effect no earlier than the first day of the quarter in which an approvable plan is submitted to CMS. Thus, in order for a SPA to be effective on January 1, 2001, it had to be submitted to the CMS regional office by the end of the first quarter of 2001, which was March 31, 2001.

[19]At the time the standard language was provided to states, the agency was known as the Health Care Financing Administration. On June 14, 2001, the Secretary of Health and Human Services announced that the agency's name would change to the Centers for Medicare & Medicaid Services. Throughout this report, we refer to the agency as CMS.

[20]The standard language said that the state would comply with the BIPA payment requirements by implementing the BIPA PPS, an alternative methodology, or both.

[21]42 C.F.R. § 430.16 (2004).

[22]If the state does not respond to CMS's request for information within 90 days, CMS disapproves the SPA.

issues with states' implementation of the BIPA PPS. First, some states' BIPA PPS payment rates may be inappropriate because the states did not include all Medicaid-covered FQHC and RHC services in the rates. Second, as of June 1, 2004, over half of states using the BIPA PPS had not determined how they would meet the requirement to adjust their BIPA PPS rates for a change in scope of services. States implementing an alternative methodology generally used either cost-based reimbursement or a PPS with features that differed slightly from the BIPA PPS. We found one issue with states' implementation of alternative payment methodologies. In establishing their alternative payment methodologies, some states did not ensure that payments to FQHCs and RHCs were at least equal to what the BIPA PPS would pay, as required by law.

BIPA PPS Implemented in Most States, but Issues Exist

The BIPA PPS was implemented in most states, but we noted issues with the appropriateness of some states' methodologies. Thirty-nine states used the BIPA PPS to pay at least a portion of their FQHCs, RHCs, or both—27 used it for both FQHCs and RHCs, 6 used it for FQHCs only, and 6 for RHCs only. While a few states had yet to completely implement their BIPA PPS as of June 1, 2004, it took the remaining states an average of 15 to 16 months to complete implementation of their methodologies. We found two issues with some states' BIPA PPSs. Of the states using the BIPA PPS, more than a third reported that they did not include all Medicaid-covered FQHC and RHC services in their BIPA PPS payment rates and over half had either not defined procedures for adjusting FQHCs' and RHCs' BIPA PPS rates for a change in scope of services, an adjustment required by BIPA, or not specified what would constitute such a change.

Implementation of BIPA PPS for FQHCs

Thirty-three of 51 states reported using the BIPA PPS to pay some portion of their FQHCs. The BIPA PPS was the only payment methodology used for FQHCs in 27 of the states, while in the remaining 6 states only a portion of FQHCs received Medicaid payments under the BIPA PPS (see table 1).[23]

[23]Since Minnesota intended for all FQHCs to be paid under the BIPA PPS, we have included it in the 27 states that paid FQHCs only under the BIPA PPS. The state, however, had not completed implementation of its BIPA PPS as of June 1, 2004. As such, many FQHCs in Minnesota were being paid under an interim payment method.

Table 1: States' Use of the BIPA PPS to Make Payments to FQHCs, as of June 1, 2004

Portion of FQHCs	Number of states	States
All	27	Alabama, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota,[a] Mississippi, Montana, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Washington, and Wyoming
Most (50% to <100%)	2	New York and North Dakota
Some (>0% to <50%)	4	California, North Carolina, Utah, and Wisconsin

Source: GAO analysis of state survey responses.

[a]Although the state intended to use the BIPA PPS to pay all FQHCs, it had not fully implemented its methodology. As a result, many FQHCs were being paid under an interim payment method.

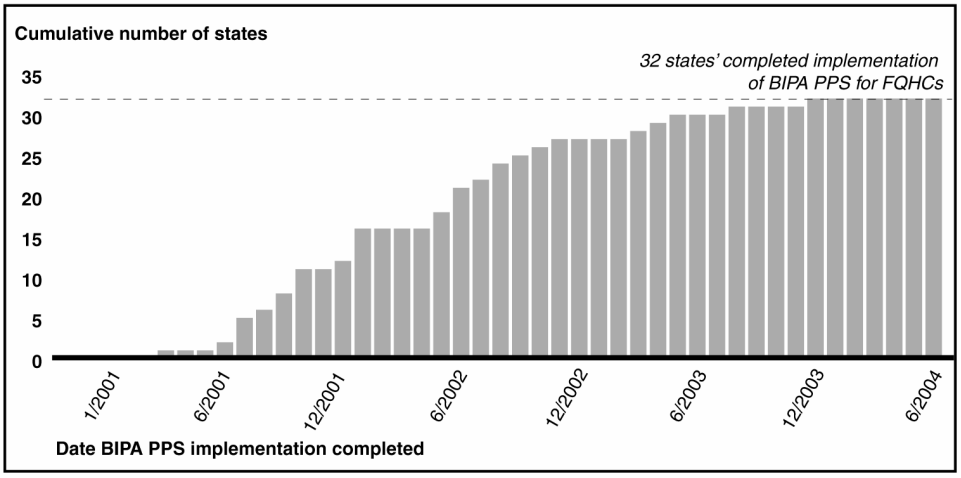
Thirty-two states reported they had completed implementation of their BIPA PPS for FQHCs as of June 1, 2004, while one had not fully implemented its methodology. On average, it took states 15 months from BIPA's effective date—January 1, 2001—to complete implementation of their BIPA PPS for FQHCs. Implementation time periods ranged from 3 months to about 3 years (see fig. 1). Although Minnesota intended to implement the BIPA PPS for all of its FQHCs, as of June 1, 2004, the state had implemented this methodology for only 30 percent of its FQHCs. Minnesota was paying the remaining FQHCs an interim rate until the state determined these providers' BIPA PPS rates.[24] Regardless of the actual implementation date, most states implementing a BIPA PPS (30 of 33 states) made the payment rates retroactive to January 1, 2001.[25] The three

[24]According to a state official, as of September 2004, Minnesota's implementation of the BIPA PPS was delayed because the state had not finished its review of FQHCs' 1999 and 2000 cost reports. Until the cost reports were reviewed, the state was paying FQHCs interim rates, which were based on FQHCs' preliminary 1999 and 2000 cost reports and inflated annually by the MEI. Once the cost reports were reviewed and finalized, the state planned to determine final BIPA PPS rates and settle the differences between the final and interim rates.

[25]Although BIPA did not specify when states had to implement their methodology, it required the methodology to be effective for services provided on or after January 1, 2001. BIPA § 702, 114 Stat. 2763A-573.

remaining states had an alternative payment methodology initially but subsequently implemented the BIPA PPS.[26]

Figure 1: States' Implementation of the BIPA PPS for FQHCs, as of June 1, 2004



Source: GAO analysis of state survey responses.

Note: Thirty-three states paid at least some FQHCs using the BIPA PPS, but the figure does not include Minnesota, which had not completed implementation of its BIPA PPS as of June 1, 2004.

Although BIPA specified how states were to determine the base payment rate and which inflation index to use, states designed their systems differently within these parameters. For example, BIPA specified that beginning in fiscal year 2002, the BIPA PPS base rate was to be increased annually for inflation using the MEI, but the law did not define which 12-month period constituted the 2002 fiscal year.[27] States had the option of using the federal, state, or FQHC fiscal year and varied as to the month they first inflated the PPS rates. Most states first inflated their FQHCs' base payment rates in either October 2001, which corresponds to the

[26]In Kentucky, the change to BIPA PPS rates was effective as of July 1, 2001, in Washington the change was effective as of January 1, 2002, and in Indiana the change was effective as of July 1, 2002. All three states reported that between January 1, 2001 (the effective date of the BIPA PPS legislation), and the effective date of their BIPA PPS rates, they had reimbursed or planned to reimburse the FQHCs the higher of their reasonable costs or their BIPA PPS rate.

[27]Four states—Idaho, Indiana, Kentucky, and Minnesota—reported inflating FQHCs' 1999 and 2000 costs prior to averaging them to determine the base rates. According to CMS, inflating 1999 and 2000 costs prior to averaging them was an acceptable approach to calculating the base rate under the BIPA PPS.

federal and one state's fiscal year, or January 2002, the beginning of the calendar year. A few states inflated FQHC payment rates earlier in 2001, and one state—Louisiana—did not inflate rates until July 2002. (See table 2.) States also varied in the number of PPS rates they established for each FQHC. Specifically, 10 states decided to establish more than one PPS rate for each FQHC, depending on the type of service provided.[28] For example, FQHCs in Maryland had two rates—one for medical services and one for dental services. In Ohio, FQHCs could have as many as nine PPS rates depending on the specific services provided.[29]

Table 2: Timetable for States' Application of the MEI Inflation Index to FQHCs' BIPA PPS Rates

Date MEI first applied	Number of states	States
January 2001	3	North Carolina,[a] Oregon, and Utah
July 2001	2	Delaware and Oklahoma
October 2001	13	Alabama, California, Connecticut, Florida, Georgia, Idaho, Maine, Nevada, New York, Ohio, Pennsylvania, Rhode Island, and Tennessee
January 2002	14	District of Columbia, Hawaii, Illinois, Indiana, Kentucky, Maryland, Minnesota, Mississippi, Montana, North Dakota, South Dakota, Washington, Wisconsin, and Wyoming
July 2002	1	Louisiana

Source: GAO analysis of state survey responses.

[a]January 2001 was the first date that North Carolina may have applied the MEI to any FQHC's BIPA PPS rate. However, the actual date that the MEI was applied varied by FQHC because the state calculated BIPA PPS rates on the basis of each FQHC's cost reporting year.

[28]The 10 states were Connecticut, Hawaii, Idaho, Illinois, Maryland, Minnesota, Ohio, Pennsylvania, Tennessee, and Washington.

[29]The nine PPS rates in Ohio corresponded to the following services: medical, dental, mental health, podiatry, vision, speech, transportation, physical therapy, and chiropractic services.

Implementation of BIPA PPS for RHCs

Of the 44 states with RHCs, 33 states reported using the BIPA PPS to pay some portion of their RHCs. Twenty-five states paid all RHCs and 8 states paid a portion of RHCs under the BIPA PPS.[30] (See table 3.)

Table 3: States' Use of the BIPA PPS to Make Payments to RHCs, as of June 1, 2004

Portion of RHCs	Number of states	States
All	25	Alabama, Arkansas,[a] Florida, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Minnesota,[a] Mississippi, Montana, Nevada, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Utah, Washington, and Wyoming
Most (50% to <100%)	2	Georgia and North Dakota
Some (>0% to <50%)	6	California, Iowa, Kansas,[b] North Carolina, Texas, and Virginia

Source: GAO analysis of state survey responses.

[a]Although the state intended to use the BIPA PPS to pay all RHCs, it had not fully implemented its methodology. As a result, many RHCs were being paid under an interim payment method.

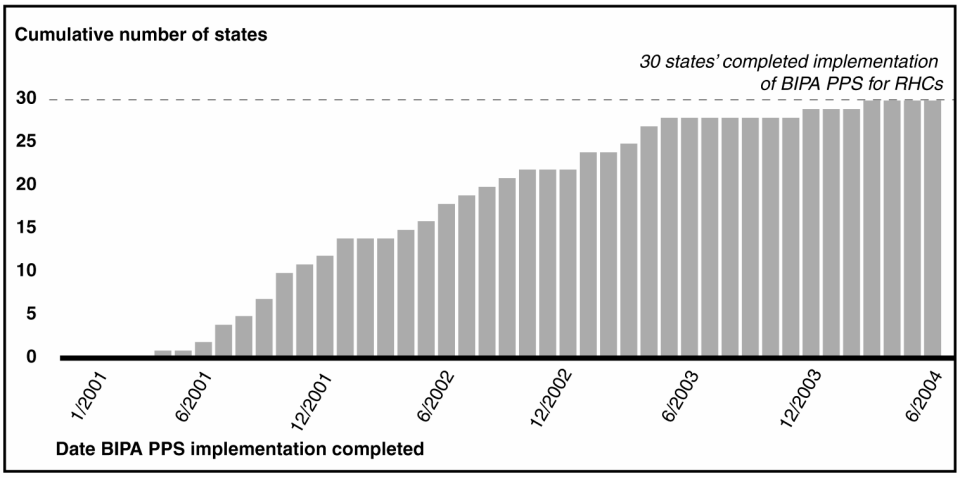
[b]This state had not fully implemented its BIPA PPS; thus, some RHCs were being paid under an interim payment method. Other RHCs in this state opted to be paid under an alternative methodology.

As of June 1, 2004, 30 of the 33 states using the BIPA PPS to pay some portion of their RHCs had completed implementing their payment methodologies, taking an average of 16 months. Implementation time periods ranged from 4 months to over 3 years (see fig. 2). The remaining 3 states were still in the process of implementing their BIPA PPS as of June 1, 2004: over 80 percent of Minnesota's RHCs, about 40 percent of Arkansas's RHCs, and less than 10 percent of Kansas's RHCs did not have finalized BIPA PPS rates. Regardless of when the methodologies were implemented, the BIPA PPS rates were retroactive to January 1, 2001, in

[30]Since Arkansas and Minnesota intended to pay all RHCs under the BIPA PPS, they are included in the 25 states that pay RHCs only under the BIPA PPS. Since these states had yet to complete implementation of their BIPA PPS, as of June 1, 2004, they paid many RHCs under an interim payment method. Kansas also had not completed implementation of its BIPA PPS, but most of its RHCs opted to be paid under an alternative methodology. Thus, only some RHCs in Kansas were to be paid under the BIPA PPS.

all states except Washington, where the rates became effective 1 year later, and Kentucky, where the rates became effective in July 2001.[31]

Figure 2: States' Implementation of the BIPA PPS for RHCs, as of June 1, 2004



Source: GAO analysis of state survey responses.

Note: Thirty-three states paid at least some RHCs using the BIPA PPS, but the figure does not include 3 states—Arkansas, Kansas, and Minnesota—which had not completed implementation of their BIPA PPS as of June 1, 2004.

As with FQHCs, states varied in their design of certain features of their BIPA PPS for RHCs. Specifically, because of differences in when fiscal years began, states varied as to when they first inflated their BIPA PPS base rates.[32] Most states first inflated their RHCs' base payment rates in either October 2001 or January 2002. A few states inflated RHC payment rates earlier in 2001 and one state did not inflate rates until July 2002. (See table 4.) In addition, four states paid RHCs with multiple BIPA PPS

[31]In 2001, Washington paid RHCs under an alternative payment methodology—cost-based reimbursement—in which RHCs were paid 100 percent of their reasonable costs. According to the state, this alternative methodology paid at a rate greater than what the RHCs would have received under the BIPA PPS and thus complied with BIPA requirements. In 2002, the state switched to paying all RHCs under the BIPA PPS methodology. Similarly, prior to the effective date of its BIPA PPS, Kentucky paid RHCs the higher of their reasonable costs or their BIPA PPS rate.

[32]Five states—Arkansas, Idaho, Indiana, Kentucky, and Minnesota—reported using an inflation index when calculating the base payment rate under BIPA. These states inflated RHCs' 1999 and 2000 costs prior to averaging them, which CMS has said is an acceptable approach to calculating the base rate under the BIPA PPS.

payment rates that differed depending on the type of service provided.[33] For example, Illinois RHCs received payment rates that differed depending on whether a visit was for medical, dental, or behavioral health services.

Table 4: Timetable for States' Application of the MEI Inflation Index to RHCs' BIPA PPS Rates

Date MEI first applied	Number of states	States
January 2001	3	North Carolina,[a] Oregon, and Utah
July 2001	2	Arkansas and Oklahoma
October 2001	15	Alabama, California, Florida, Georgia, Idaho, Kansas, Maine, Michigan, Nevada, New York, Ohio, Pennsylvania, Tennessee, Texas, and Virginia
January 2002	12	Hawaii, Illinois, Indiana, Iowa, Kentucky, Minnesota, Mississippi, Montana, North Dakota, South Dakota, Washington, and Wyoming
July 2002	1	Louisiana

Source: GAO analysis of state survey responses.

[a]January 2001 was the first date that North Carolina may have applied the MEI to any RHC's BIPA PPS rate. However, the actual date that the MEI was applied varied by RHC because the state calculated BIPA PPS rates on the basis of each RHC's cost reporting year.

Issues with States' Implementation of BIPA PPS

We identified two issues with states' implementation of the BIPA PPS for FQHCs and RHCs. First, BIPA PPS rates in more than one-third of states may be inappropriate—these states reported that their rates did not include all Medicaid-covered FQHC and RHC services. These states most commonly excluded laboratory, radiology, and dental services. These exclusions are inappropriate because, under BIPA and CMS guidance, the BIPA PPS must include all Medicaid-covered services—specifically, outpatient services provided in an FQHC or RHC and included in the state's plan. Prescription drugs are the one service that states are allowed

[33]The four states were Illinois, Maine, Minnesota, and Tennessee.

to exclude from the BIPA PPS rate, according to CMS.[34] Thus, all other Medicaid-covered outpatient services provided by an FQHC or RHC must be paid for under the BIPA PPS.

Second, as of June 1, 2004, over 3 years after the passage of BIPA, over half of states using the BIPA PPS had either not defined procedures for adjusting payment rates for a change in scope of services or not specified what would constitute such a change; states are required by BIPA to adjust BIPA PPS rates for a change in scope of services. Specifically, according to our survey results, 9 of the 39 states that pay FQHCs, RHCs, or both using the BIPA PPS reported that they had not defined procedures for adjusting payment rates for a change in scope of services. In addition, according to our review of state documents, of the remaining 30 states that reported defining adjustment procedures for a change in scope of services, 12 did not specify what would constitute such a change.

Many States Implemented Alternative Payment Methodologies, but Not All Met BIPA Requirements

Approximately half of the states chose the BIPA option to use an alternative methodology to pay at least some FQHCs, RHCs, or both, but not all states' methodologies met the BIPA requirements. Eighteen states used an alternative methodology for both FQHCs and RHCs, 6 states used it for FQHCs only, and 1 state used it for RHCs only. States with alternative methodologies generally used either a cost-based reimbursement methodology, similar to that used to pay FQHCs and RHCs prior to BIPA, or implemented an alternative PPS methodology with features that differed slightly from the BIPA PPS. Some states' alternative methodologies, however, did not meet BIPA's requirement that alternative methodologies result in payments no lower than what would have been received under the BIPA PPS.

[34]BIPA authorized states to use an alternative methodology, but for those FQHCs and RHCs being paid under the BIPA PPS, the state must use the BIPA PPS methodology to pay for all Medicaid-covered services, except for prescription drugs. Because of a special discount pricing program for which many FQHCs are eligible, a CMS official said that states could pay for prescription drugs under another method. The discount pricing program, known as the 340B drug pricing program after the section of the Public Health Service Act in which it is found, provides federal purchasers and certain grantees of federal agencies access to prescription drugs at reduced prices. 42 U.S.C. § 256b (2000).

Implementation of Alternative Methodologies for FQHCs

Twenty-four of 51 states opted to use one or more alternative payment methodologies to pay at least some of their FQHCs. The type of alternative methodology varied by state. Specifically, to pay at least a portion of their FQHCs, 15 states used a cost-based reimbursement methodology, 8 states used an alternative PPS methodology, and 3 states used an alternative methodology that was neither cost-based reimbursement nor a PPS; 2 of these states used multiple methods.[35] (See table 5.)

Table 5: Alternative Payment Methodologies for FQHCs, as of June 1, 2004

Alternative methodology	Number of states	States
Cost-based reimbursement	15	Arkansas, California,[a] Colorado, Iowa, Kansas,[b] Missouri, Nebraska, New Hampshire, North Carolina, South Carolina, Utah, Vermont, Virginia, West Virginia, and Wisconsin[c]
PPS	8	Alaska, Arizona, California,[a] Michigan, New Jersey, New Mexico, North Dakota, and Texas
Other[d]	3	Massachusetts, New York, and Wisconsin[c]

Source: GAO analysis of state survey responses.

[a]California had two alternative methodologies for paying FQHCs—cost-based reimbursement (only for Los Angeles County FQHCs participating in the county's 1115 waiver program) and an alternative PPS.

[b]State had not fully implemented this methodology.

[c]Wisconsin had two alternative methodologies for paying FQHCs—cost-based reimbursement and another methodology.

[d]Other methodologies were neither purely cost-based nor alternative PPSs.

Fifteen states used a cost-based reimbursement methodology for at least some FQHCs. Under cost-based reimbursement, FQHCs were required to submit cost reports, which the states reviewed to determine whether reported costs were allowable and reasonable.[36] States may set limits on the reasonableness of costs, and 11 of the 15 states reported setting limits

[35]California and Wisconsin each used two alternative methodologies. California paid a portion of FQHCs with cost-based reimbursement (Los Angeles County only) and another portion under an alternative PPS. Wisconsin paid a portion of FQHCs using cost-based reimbursement and another portion with a flat rate set at the Medicare per visit limit.

[36]Four states—Arkansas, California, Nebraska, and New Hampshire—reported relying on Medicare principles to determine allowable costs.

for FQHCs.[37] (Table 6 lists the states using limits, by type of limit.) Some states used more than one limit, as follows:

- **Overall caps**. Six states reported setting limits on how much they would reimburse for a patient's visit, with most basing their limit on that employed by Medicare.[38] For example, three states set their limits at the Medicare upper payment limit, while two states set their limits at 125 percent and 133 percent, respectively, of the Medicare payment limit.
- **Performance or productivity standards**. Seven states limited reasonable costs by setting performance or productivity standards. These states stipulated the number of visits per year that a full-time-equivalent physician should provide; they used similar guidelines for other practitioners. Again, most of the states using performance or productivity standards relied on the guidelines specified by Medicare.[39]
- **Limits on administrative costs**. Three states reported that they disallowed administrative costs exceeding 30 percent of total costs.

[37]Four states—Arkansas, California, Nebraska, and Utah—did not report the use of any specific limits in determining reasonable costs.

[38]In 2004, the Medicare upper payment limit was $106.58 per visit for urban FQHCs and $91.64 per visit for rural FQHCs.

[39]For example, Medicare guidelines specify that a full-time-equivalent physician employed by the FQHC should provide at least 4,200 visits per year.

Table 6: States That Used Limits in Determining Reasonable Costs for FQHCs under Cost-Based Reimbursement Alternative Methodologies, by Type of Limit, as of June 1, 2004

State[a]	Cap or upper payment limit	Performance or productivity standard	Limit on administrative costs
Colorado[b]		X	
Iowa		X	
Kansas	X	X	
Missouri			X
New Hampshire	X		
North Carolina	X	X	
South Carolina		X	X
Vermont	X		
Virginia	X	X	
West Virginia	X	X	
Wisconsin			X
Total	**6**	**7**	**3**

Source: GAO analysis of state survey responses.

[a]Four states—Arkansas, California, Nebraska, and Utah—did not report the use of any specific limits in determining reasonable costs.

[b]Colorado pays an FQHC the lower of the FQHC's current year of costs or a 3-year average of costs.

Eight states had an approved alternative PPS for reimbursing at least a portion of their FQHCs. Generally, these alternative PPSs differed from the BIPA PPS in that they used a different base payment rate, a different inflation factor, or both. For example, California set its alternative PPS base rate at an FQHC's 2000 reasonable costs, as opposed to an average of 1999 and 2000 reasonable costs, which is stipulated under the BIPA PPS; Alaska used an inflation index developed by Data Resources Incorporated instead of the MEI to adjust rates. Arizona plans to rebase its alternative PPS every 3 years, calculating the base rate as the average of costs from the 2 previous years. Arizona also inflated rates using the physician services component of the Consumer Price Index (CPI). Table 7 provides the characteristics of the eight states' alternative PPS methodologies for FQHCs.

Table 7: Characteristics of Alternative PPSs for FQHCs, by State, as of June 1, 2004

State	Base rate	Inflation factor	Other components
Alaska	The inflated average of fiscal years' 1999 and 2000 reasonable costs (inflated to fiscal year 2002).	Inflation index developed by Data Resources Incorporated.	Not applicable.
Arizona	The average of the 2 previous years' costs inflated to the current year.	Physician services component of the CPI.	Rate is rebased every 3 years.
California	Fiscal year 2000 reasonable costs inflated to fiscal year 2001 by the MEI.	MEI.	Not applicable.
Michigan	Fiscal years' 1999 and 2000 costs, converted to calendar year, then averaged and inflated to the calendar year 2001 midpoint by the MEI and compared to the state's Medicaid payment limit (the Medicare per visit payment limit plus $17.41). If costs are greater than the Medicaid payment limit, then the base rate is the Medicaid payment limit plus 66.6 percent of costs above the Medicaid limit.	If the base rate is less than the Medicaid limit, then it is inflated by the MEI; if the base rate is greater than the Medicaid limit, then the rate is inflated by the MEI plus a sliding scale percentage of the difference between the limit and the FQHC's calendar year 2001 costs.	Not applicable.
New Jersey	The greater of the fiscal year 1999 or 2000 final settled costs based on the FQHC's Medicaid cost report.	MEI.	Not applicable.
New Mexico	The average of fiscal years' 1999 and 2000 reasonable costs.	State chooses between the MEI or the CPI for urban consumers, but adjustments can be no less than that provided by the MEI.	Not applicable.
North Dakota	The lesser of the fiscal year 2000 reasonable costs or the maximum Medicare rate per visit for fiscal year 2000.	State-determined, but cannot exceed the MEI.	Not applicable.
Texas	The average of fiscal years' 1999 and 2000 reasonable costs.	MEI + 1.5 percent.	If an FQHC's costs increase more than the inflation factor, then it can request an adjustment equal to 100 percent of costs if the FQHC can show that it is operating in an efficient manner or that the increase is due to a change in scope of services.

Source: GAO analysis of state survey responses.

Note: For the purpose of comparison, the BIPA-specified PPS rate for each FQHC would (1) use the average of fiscal years' 1999 and 2000 reasonable costs per visit as the base rate, (2) use the MEI as the annual inflation factor, and (3) be adjusted as necessary for a change in scope of services.

Three states created alternative payment methodologies that were neither purely cost-based nor an alternative PPS. Specifically, Massachusetts paid most FQHCs the same rate, which was based on the 1998 costs from a sample of FQHCs in the state.[40] New York paid some FQHCs on the basis of diagnosis,[41] and Wisconsin paid two of its FQHCs a flat rate set at the Medicare upper payment limit.

Implementation of Alternative Methodologies for RHCs

Almost half of the states with RHCs (19 of 44 states) paid at least a portion of their RHCs using an alternative methodology. Twelve states paid at least a portion of their RHCs using a cost-based reimbursement methodology, 6 states created an alternative PPS methodology, and 3 states paid at least some RHCs by an alternative methodology that was neither cost-based reimbursement nor a PPS. Two states—New Hampshire and Wisconsin—used both cost-based reimbursement and another payment methodology. (See table 8.)

[40]Massachusetts's FQHCs agreed to a class rate payment system whereby most FQHCs received the same payment rates. The payment rates, which vary by service, were based on an analysis of the 1998 cost reports submitted by 25 FQHCs, which represented approximately 75 percent of the FQHCs in the state. After applying reasonableness tests, such as a limit on administrative costs and productivity standards, the state determined a unit cost for each of the 25 FQHCs sampled, which was inflated by a state-specific inflation factor. The final payment rate was the average of the rates for these 25 FQHCs. In July 2004, the payment rate was increased 13.7 percent to reflect a cumulative adjustment for inflation. The remaining 3 FQHCs, all of which were hospital-affiliated, were paid using an outpatient hospital payment methodology.

[41]New York's alternative methodology consists of 71 preset rates that correspond to outpatient diagnostic categories. Five FQHCs in the state selected this payment option.

Table 8: Alternative Payment Methodologies for RHCs, as of June 1, 2004

Alternative methodology	Number of states	States
Cost-based reimbursement	12	Georgia, Iowa, Kansas,[a] Missouri, Nebraska, New Hampshire,[b] North Carolina, South Carolina, Vermont, Virginia, West Virginia, and Wisconsin[c]
PPS	6	Alaska, Arizona, California, New Mexico, North Dakota, and Texas
Other[d]	3	Colorado, New Hampshire,[b] and Wisconsin[c]

Source: GAO analysis of state survey responses.

[a]The state had not fully implemented this methodology.

[b]New Hampshire had two alternative methodologies for paying RHCs—cost-based reimbursement and another methodology.

[c]Wisconsin had two alternative methodologies for paying RHCs—cost-based reimbursement and another methodology.

[d]Other methodologies were neither purely cost-based nor alternative PPSs.

Twelve states used cost-based reimbursement to pay at least some RHCs and most applied limits when determining reasonable costs (see table 9).

- **Overall caps**. Ten states reported applying limits on how much they would reimburse for a patient's visit. All 10 states set their limit at the Medicare upper payment limit for RHCs, which was $68.65 in 2004.[42]
- **Performance or productivity standards**. Seven states limited reasonable costs by setting performance or productivity standards and all relied on the standards employed by Medicare.
- **Limits on administrative costs**. No state reported setting limits on administrative costs.

[42]In Medicare, RHCs based in hospitals with fewer than 50 beds are eligible to receive an exception to the Medicare per visit payment limit. State Medicaid programs often incorporate this exception into their payment methodologies.

Table 9: States That Used Limits in Determining Reasonable Costs for RHCs under Cost-Based Reimbursement Alternative Methodologies, by Type of Limit, as of June 1, 2004

State[a]	Cap or upper payment limit	Performance or productivity standard
Georgia	X	
Iowa		X
Kansas	X	X
Missouri	X	X
New Hampshire	X	
North Carolina	X	X
South Carolina	X	X
Vermont	X	
Virginia	X	X
West Virginia	X	X
Wisconsin	X	
Total	**10**	**7**

Source: GAO analysis of state survey responses.

Note: No state reported applying limits on administrative costs.

[a]Nebraska did not report the use of any specific limits in determining reasonable costs.

Six states had an approved alternative PPS for reimbursing at least a portion of their RHCs. One state used a base rate that was different from the BIPA PPS, two states either used or reserved the option to use an inflation index other than the MEI, and two states did both. For example, in Arizona, the state plans to rebase its alternative PPS every 3 years and inflate interim years' rates by a component of the CPI. The sixth state (Texas) used an alternative PPS that was virtually the same as the BIPA PPS except that RHCs did not have to return to the state any overpayments that might have occurred during the transition to the new

payment system.[43] See table 10 for details on the six states' alternative PPS for RHCs.

Table 10: Characteristics of Alternative PPSs for RHCs, by State, as of June 1, 2004

State	Base rate	Inflation factor	Other components
Alaska	The inflated average of fiscal years' 1999 and 2000 reasonable costs (inflated to fiscal year 2002).	Inflation index developed by Data Resources Incorporated.	Not applicable.
Arizona	The average of 2 previous years' costs inflated to the current year.	Physician services component of the CPI.	Rate is rebased every 3 years.
California	Fiscal year 2000 reasonable costs inflated to fiscal year 2001 by the MEI.	MEI.	Not applicable.
New Mexico	The average of fiscal years' 1999 and 2000 reasonable costs.	State chooses between the MEI or the CPI for urban consumers, but adjustments can be no less than that provided by the MEI.	Not applicable.
North Dakota	Provider-based RHCs: 100 percent of billed charges in fiscal year 2000. Independent RHCs: fiscal year 2001 Medicare upper payment limit.	State-determined factor not to exceed the MEI.	Not applicable.
Texas	The average of fiscal years' 1999 and 2000 reasonable costs.	MEI.	RHCs did not have to pay back any overpayments at settlement from old cost-based rate.

Source: GAO analysis of state survey responses.

Note: For the purpose of comparison, the BIPA-specified PPS rate for each RHC would (1) use the average of fiscal year's 1999 and 2000 reasonable costs per visit as the base rate, (2) use the MEI as the annual inflation factor, and (3) be adjusted as necessary for a change in scope of services.

Three states reported that their alternative payment methodologies were neither purely cost-based reimbursement nor an alternative PPS. Specifically, most RHCs in Wisconsin were paid the Medicare upper payment limit, and all RHCs in Colorado were paid the Medicare upper payment limit or their Medicare rate if the upper payment limit did not

[43]Between the time that the BIPA requirements were to be effective and the time that Texas implemented its PPS, the state paid RHCs using an interim payment methodology. When its alternative PPS was implemented, the state conducted a reconciliation process to account for differences in the reimbursement under the interim system and what RHCs would have received under the BIPA PPS. While RHCs under the BIPA PPS had to reimburse the state if the settlement process found that the interim payments exceeded what would have been paid under the BIPA PPS, RHCs selecting the alternative PPS did not have to return any overpayments to the state, if they had occurred.

apply.[44] In New Hampshire, hospital-based RHCs were paid approximately 92 percent of allowable charges, which were determined on the basis of the RHCs' Medicare cost reports.

Issue with States' Implementation of Alternative Methodologies

Not all states ensured that their alternative methodologies resulted in payments that were at least equal to what FQHCs and RHCs would have received under the BIPA PPS, as required by statute. Under BIPA, states may use an alternative payment methodology only if the methodology results in payment to an FQHC or RHC that is at least equal to what the FQHC or RHC would have received under the BIPA PPS and if the FQHC or RHC agrees to its use. Of the 25 states with alternative methodologies for either FQHCs, RHCs, or both, 4 states (Missouri, New Hampshire, Vermont, and Wisconsin) paid at least some providers less than what they would have been paid under the BIPA PPS and it was unclear whether the alternative payment methodologies in 2 states (Nebraska and North Carolina) resulted in payments at least equal to what the FQHCs and RHCs would have received under the BIPA PPS.[45]

Four states' alternative methodologies paid at least some FQHCs, RHCs, or both less than what they would have received under the BIPA PPS, but the states continued to pay the providers the lower rate under the alternative methodology. Missouri determined whether its alternative methodology paid at least as much as the BIPA PPS for only a portion of its FQHCs and RHCs and did so only for the first year of the methodology.[46] On the basis of this assessment, Missouri found that over half of the FQHCs reviewed and about 40 percent of the RHCs reviewed would fare better under the BIPA PPS, yet the state continued to pay them under the alternative methodology.[47] In 2001, the FQHCs and RHCs that would have fared better under the BIPA PPS would have received on average about $12 more and

[44]The Medicare upper payment limit does not apply to RHCs based in hospitals with fewer than 50 beds.

[45]The remaining 19 states reported they had determined that their alternative methodologies resulted in payment rates at least equal to what FQHCs and RHCs would have received under the BIPA PPS.

[46]Missouri made the determination for fewer than half of its FQHCs and one-third of its RHCs, which represented those providers for which the state had audited cost reports from fiscal year 1999 through 2001.

[47]The state contends that, in the aggregate, FQHCs and RHCs are better off under the alternative methodology compared with the BIPA PPS. BIPA, however, requires that each FQHC and each RHC receive payment at least equal to that under the BIPA PPS.

about $25 more per visit, respectively. New Hampshire compared only the fiscal year 2001 BIPA PPS rates for its FQHCs and RHCs with the cost-based rates; although the state found that the BIPA PPS rates were higher for some RHCs, a state official told us in October 2004 that the state had not reimbursed these providers for the difference. Vermont only determined the 2001 BIPA PPS rates for its FQHCs and RHCs.[48] On the basis of those rates, we estimated the 2002 and 2003 BIPA PPS rates for Vermont's FQHCs and RHCs and found that some RHCs would likely have fared better under the BIPA PPS.[49] However, the state reported that all FQHCs and RHCs were paid under the alternative methodology. Wisconsin compared the fiscal year 2001, 2002, and 2003 BIPA PPS rates for its FQHCs and RHCs with the cost-based rates used for those fiscal years and found that an RHC would have fared better under the BIPA PPS each year, yet Wisconsin continued to pay that RHC under the alternative methodology. Specifically, across the 3 years, the BIPA PPS rate would have paid that RHC, on average, about $20 more per visit compared with the state's alternative methodology. Since these states did not routinely inform all FQHCs and RHCs of what their BIPA PPS rates would have been, the FQHCs and RHCs may have been unaware that some providers, including themselves, may have fared better under the BIPA PPS.

For the remaining two states, it was unclear whether their alternative payment methodologies complied with the requirement that alternative methodologies must result in payments at least equal to what the FQHCs and RHCs would have received under the BIPA PPS. Nebraska did not determine whether its alternative methodology paid at least as much as the BIPA PPS.[50] North Carolina compared its payment rates under its alternative methodology with preliminary BIPA PPS rates only for the base year (fiscal year 2001) and not for any subsequent years. As of March 2005, the state had not finalized all FQHCs' and RHCs' 2001 BIPA PPS rates, and

[48]According to a state official, Vermont provided each FQHC and RHC with its 2001 BIPA PPS rate. The state did not determine future years' BIPA PPS rates but left this responsibility to the individual providers.

[49]We estimated the 2002 and 2003 BIPA PPS rates for Vermont's FQHCs and RHCs by inflating the 2001 BIPA PPS rates for each FQHC and RHC by the MEI, the annual inflation adjustment required by BIPA. On the basis of our analysis of 2001, 2002, and 2003 cost-based and BIPA PPS rates, we determined that some RHCs would have, on average, received about $3 more per visit in certain years had they been paid under the BIPA PPS.

[50]According to a state official, Nebraska will compare the payment rates under the alternative methodology to BIPA PPS rates. The official did not indicate when such a comparison would be made.

it is therefore unclear whether the state's alternative methodology resulted in payment that was at least as much as the BIPA PPS would offer.[51]

Evidence to Date Is Insufficient about the Need to Rebase or Refine the BIPA PPS

Sufficient evidence is not available to determine whether there is a need to rebase or refine the BIPA PPS. Concerns exist about the appropriateness of the MEI, which was specified in the statute as the index used to annually adjust BIPA PPS rates for inflation. For example, the MEI does not reflect the costs of the services typically provided by FQHCs and RHCs. Other indexes often used to reflect medical care inflation, however, have a similar shortcoming. Although the MEI may not be an appropriate index to adjust BIPA PPS rates, based on our research no inflation index is currently available that reflects FQHC and RHC services. The ability to determine the need for rebasing or refining is further complicated by an increasing lack of comprehensive and current cost data because many states no longer require all FQHCs and RHCs to submit Medicaid cost reports. Our analysis of cost-based and BIPA PPS rates from selected states that used cost-based reimbursement as an alternative payment methodology did not provide conclusive evidence on the need to rebase or refine the BIPA PPS.

MEI May Not Be an Appropriate Index to Adjust BIPA PPS Rates for Inflation

Our prior work, discussions with stakeholders, and our analysis for this report raised questions about the appropriateness of the MEI as the index to annually adjust BIPA PPS rates for inflation. The MEI is designed to estimate the increase in the total costs for the average physician to operate a medical practice for the purpose of updating physician payment rates under Medicare.[52] As such, the MEI is intended to be an equitable measure of cost changes associated with physician time and operating expenses.

We reported in 2001 that the MEI increased at a lower rate than indexes some states had used previously to adjust payment rates for FQHCs.[53]

[51]According to a state official, North Carolina intends to compare the payment rates under the alternative methodology to final BIPA PPS rates once they are determined. If the state finds that the BIPA PPS would have paid a higher rate, it plans to pay the FQHCs and RHCs the difference in the rates.

[52]The MEI is calculated annually by CMS and is also used to annually increase the Medicare upper payment limit for FQHCs and RHCs.

[53]Our prior report contained an analysis of the indexes used by four states that previously set prospective rates for FQHCs using a prior year's costs updated for inflation. The indexes used by each of these four states grew faster than the MEI. See GAO-01-577.

Since the MEI adjustment is the only automatic update of BIPA PPS rates,[54] an FQHC's or RHC's ability to manage under the BIPA PPS depends on its initial payment rate as well as its ability to hold cost growth at or below the MEI.

Some stakeholders we contacted expressed concern about the use of the MEI to update BIPA PPS payments to FQHCs and RHCs. Officials from the National Association of Community Health Centers told us that the MEI was not an adequate measure of FQHCs' increasing costs. These officials pointed to data from the Uniform Data System (UDS), a database of self-reported FQHC data, which suggested that the MEI increased at a lower rate than FQHCs' costs. Specifically, the data showed that FQHCs' total costs per patient encounter increased approximately 5 to 6 percent annually between 2001 and 2003, while the MEI increased about 2 to 3 percent annually during the same time period.[55] This concern was echoed by officials we spoke with from FQHCs and RHCs and by CMS officials from four regional offices. For example, an official from a Florida FQHC reported that his center's costs over the past 3 years had increased by 4.5 to 7 percent a year, while an official from a Florida RHC reported cost increases of over 10 percent annually. An important objective of a PPS, however, is to encourage efficiency, so equivalent increases in a provider's payment adjustments and its cost trends may not be desirable.

The MEI may not be an ideal index to adjust FQHCs' and RHCs' payment rates for inflation, but other indexes often used to reflect medical care inflation also have a similar shortcoming. As mentioned earlier, the MEI was designed to measure the changing costs for the average physician. However, FQHCs' and RHCs' costs may not be comparable to those of the average physician. FQHCs provide additional services, including enabling services (such as outreach and translation), and a significant portion of RHC services may be provided by nonphysician practitioners. Like the MEI, four other indexes commonly used to reflect changes in medical care inflation do not reflect the services typically provided by FQHCs and RHCs. The 2001 to 2003 cumulative increase for the MEI was greater than the cumulative increases of the Producer Price Index (PPI) for Physician Offices and the CPI for Urban Consumers for the same period, although neither of the latter indexes reflect the same services provided by FQHCs

[54]BIPA also required that payments to FQHCs and RHCs be adjusted in the event of a change in scope of services; however, these adjustments are not automatic.

[55]2002 and 2003 UDS data.

and RHCs.[56] The cumulative increase for the MEI was less than the cumulative increases for two other indexes—the PPI for General Medical and Surgical Hospitals and the CPI for Medical Care—but the latter two indexes included a set of hospital-related services that for the most part neither FQHCs nor RHCs provided. (See table 11 for a comparison of these indexes.)

Table 11: Percentage Increase of the MEI Compared to Increases for Other Indexes Commonly Used to Adjust for Medical Care Inflation (2001 to 2003)

	Percentage increase				
Index	**2001**	**2002**	**2003**	**Cumulative increase**	**Average increase**
PPI for Physician Offices	2.85	0.00	1.51	4.36	1.45
CPI for Urban Consumers	2.85	1.58	2.28	6.71	2.24
MEI	**2.10**	**2.60**	**3.00**	**7.70**	**2.57**
PPI for General Medical and Surgical Hospitals	3.01	3.65	5.79	12.45	4.15
CPI for Medical Care	4.60	4.69	4.03	13.32	4.44

Source: GAO analysis of Bureau of Labor Statistics and CMS data.

On the basis of our review of literature on medical care indexes and information from organizations typically involved in developing and updating these indexes, we determined that no inflation index has been developed specifically to reflect FQHC and RHC services. Other PPSs, however, often incorporate an inflation index specifically designed to reflect changes in the cost of services provided by or the price of resources used by the providers paid under that PPS. For example, under the Medicare home health PPS, the payment rate is inflated using a home health market basket that measures the changes in the prices of goods and services bought by home health agencies. CMS has similarly developed update factors for Medicare payment rates for outpatient hospitals and skilled nursing facilities (see app. II).

[56]Although it is used to reflect inflationary changes in medical care, the CPI for Urban Consumers also includes many services unrelated to medical care, such as food and housing.

Lack of Cost-Reporting Requirement Hinders Ability to Determine the Need to Rebase or Refine the BIPA PPS

The lack of a Medicaid cost-reporting requirement for FQHCs and RHCs makes it difficult to determine the need to rebase or refine the BIPA PPS. Under BIPA, state Medicaid programs were no longer required to collect cost reports from FQHCs and RHCs, which was how states had previously collected cost data to help set Medicaid payment rates for these providers.[57] The decision to collect Medicaid cost data via cost reports or other methods was therefore left to each individual state. In response to our survey, many states reported they did not require cost reports from all FQHCs and RHCs (see table 12). Twenty-one of 51 states (over 40 percent) reported not requiring cost reports from all FQHCs. Specifically, 2 states reported no longer requiring any cost reports and another 19 states reported requiring cost reports from some FQHCs, generally only from new FQHCs or those with a change in scope of services. Even fewer states reported requiring cost reports from RHCs. Of the 44 states with RHCs, 22 (50 percent) reported not requiring cost reports from all RHCs—9 states did not require any RHCs to submit cost reports and 13 states only required cost reports from some. States that had implemented the BIPA PPS were especially likely to not have cost-reporting requirements: 20 of the 33 states using the BIPA PPS for FQHCs (over 60 percent) reported not requiring cost reports from all FQHCs and 19 of the 33 states using the BIPA PPS for RHCs (approximately 58 percent) reported not requiring cost reports from all RHCs. Without comprehensive and current cost data, determining whether there is a need to rebase or refine the BIPA PPS is difficult, if not impossible.

[57]Medicare requires FQHCs and RHCs to submit annual cost reports, but Medicare does not cover the same set of services as Medicaid. Furthermore, while some states obtain copies of the Medicare cost reports, others do not.

Table 12: States' Cost Reporting Requirements for FQHCs and RHCs, as of June 2004

Type of provider	Required to submit cost reports	Number of states	Number of states using the BIPA PPS[a]
FQHCs	All	30	13
	At least some, but not all	19	18
	None	2	2
Total		**51**	**33**
RHCs	All	22	14
	At least some, but not all	13	12
	None	9	7
Total		**44**[b]	**33**

Source: GAO analysis of state survey responses.

[a]The 33 states that used the BIPA PPS were not the same for both FQHCs and RHCs.

[b]According to states' survey responses, there are no RHCs in Connecticut, Delaware, the District of Columbia, Maryland, Massachusetts, New Jersey, and Rhode Island.

Analysis of Rates from Selected States Provided Inconclusive Evidence on the Need to Rebase or Refine the BIPA PPS

Our comparison of cost-based and BIPA PPS rates for FQHCs and RHCs from selected states provided inconclusive evidence concerning the need to rebase or refine the BIPA PPS. From 2001 through 2003, most FQHCs' and RHCs' cost-based rates exceeded their BIPA PPS rates in the four states we reviewed—Iowa, Vermont, Virginia, and Wisconsin.[58] Within these four states, cost-based rates, on average, were greater than the BIPA PPS rates for 41 of the 45 FQHCs and 128 of the 163 RHCs included in the analysis. However, the extent of the difference between cost-based and PPS rates varied considerably both within and among the states reviewed (see fig. 3). For example, among the 15 Wisconsin FQHCs we analyzed, cost-based rates across the 3-year period ranged from approximately 30 percent less than to approximately 70 percent more than BIPA PPS rates.[59] For the 104 Iowa RHCs we analyzed, cost-based rates ranged from approximately 35 percent less than to approximately 82 percent more than

[58]We were unable to compare the rates in states that paid FQHCs and RHCs only under the BIPA PPS because many of these states no longer required cost reports and the states were no longer required to determine cost-based rates.

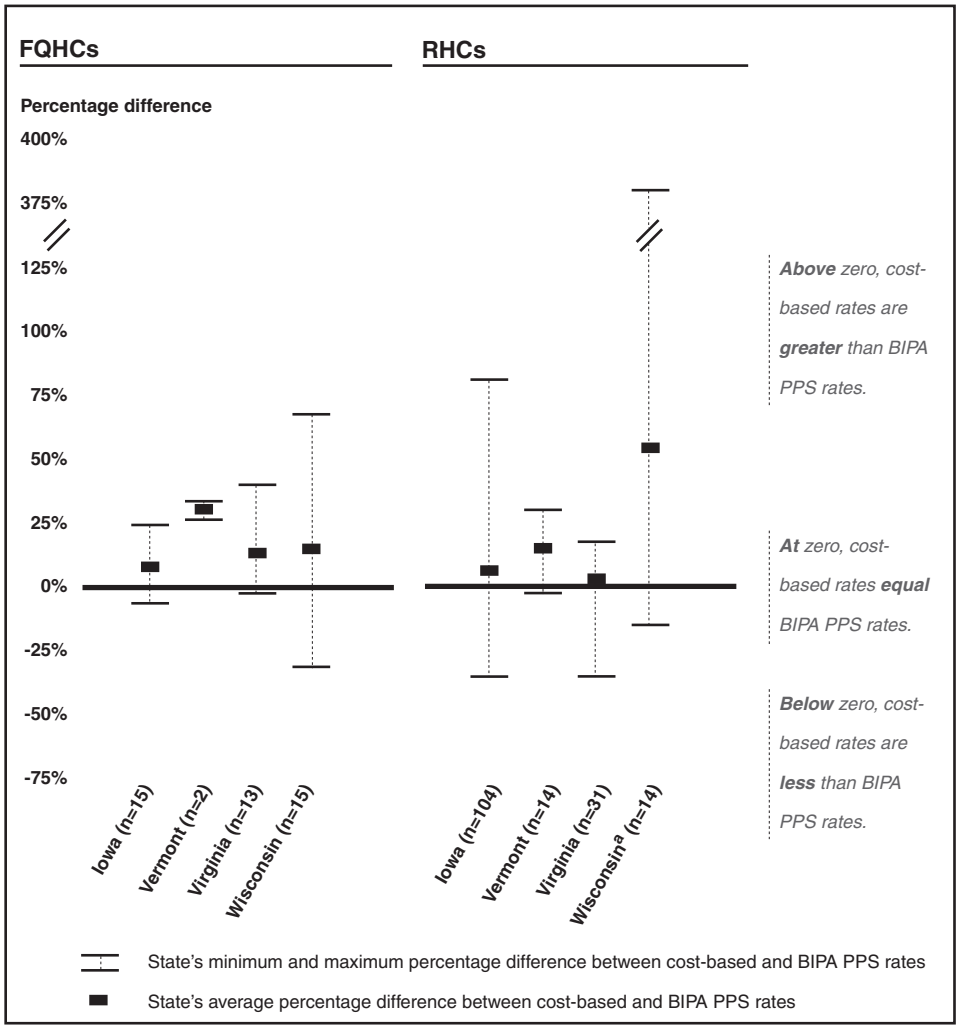
[59]Over the same time period, the average difference between cost-based and BIPA PPS rates for FQHCs in Wisconsin was about $20 per visit. Cost-based rates per visit ranged from about $140 less than BIPA PPS rates to about $166 greater than BIPA PPS rates.

BIPA PPS rates.[60] Because the FQHCs and RHCs included in our analysis were paid cost-based rates, they may have had less incentive to operate efficiently than if they had been paid under the BIPA PPS.[61] However, it is unclear whether the difference between cost-based and PPS rates may be attributed to this possible lack of incentive or if these providers were operating efficiently but their costs remained higher than what the BIPA PPS would pay. Given these unknowns and the variability in the extent of rate differences, the fact that BIPA PPS rates were generally less than these providers' cost-based rates is not compelling evidence that BIPA PPS rates need to be rebased or refined at this time.

[60]Over the same time period, cost-based rates for RHCs in Iowa were, on average, $4 per visit more than BIPA PPS rates. Cost-based rates per visit ranged from about $48 less than BIPA PPS rates to about $57 greater than BIPA PPS rates.

[61]Cost-based payment methods have been criticized because increases in costs result in increased payments, thus weakening providers' incentives for efficiency. Under a PPS, cost increases would not necessarily result in an increase in payment because payment is not contingent on an individual provider's actual cost of delivering care. See, for example, Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 1999).

Figure 3: Percentage Difference in Cost-Based and BIPA PPS Rates, by State and Provider Type, 2001 through 2003



Source: GAO analysis of state data.

[a]The change in the organizational structure of one RHC in Wisconsin resulted in a large difference between its cost-based and BIPA PPS rates, which is reflected as the maximum percentage difference for RHCs in the state.

CMS Guidance and Oversight Did Not Ensure Consistent State Compliance with BIPA

CMS guidance to states and regional offices and its oversight of states' implementation of the new BIPA-mandated payment requirements for FQHCs and RHCs did not ensure consistent state compliance with the law. CMS guidance did not adequately address certain BIPA requirements and thus uncertainties exist about whether and how some requirements for BIPA compliance have been implemented, such as states' methodologies to adjust BIPA PPS rates to account for any change in scope of services. Since CMS initially approved states' plans to implement BIPA's Medicaid payment provisions for FQHCs and RHCs, its oversight of states' implementation has been limited. CMS has relied on states' assurances that they were in compliance with BIPA and investigated payment issues only in response to complaints, which CMS said were rare, or when concerns were identified during a CMS review conducted for other purposes. As a result, CMS was unaware of certain compliance issues, including that some states' BIPA PPS rates and alternative methodologies were inconsistent with the law.

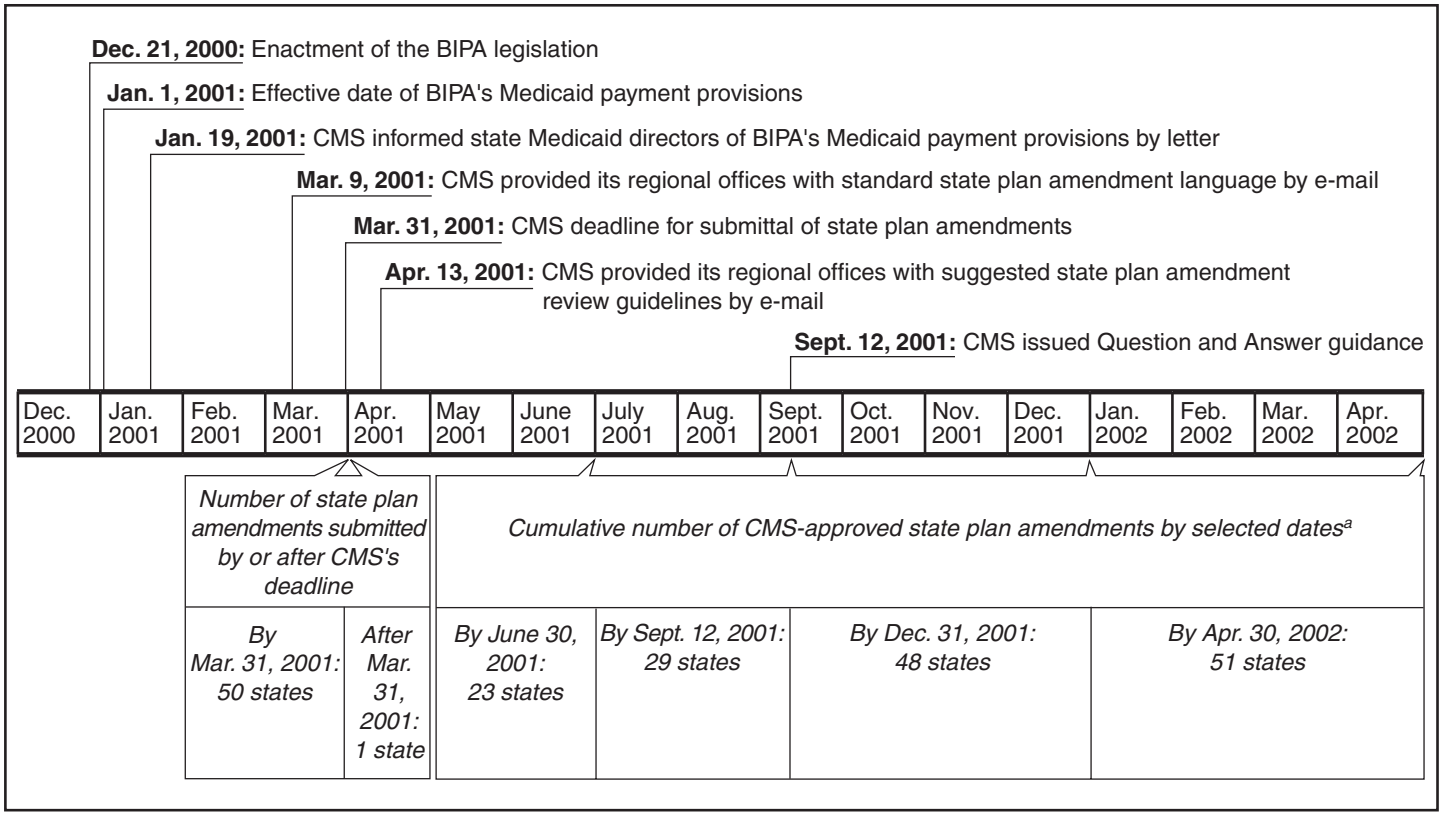
CMS Guidance Did Not Adequately Address Certain BIPA Requirements

CMS's guidance to its regional offices and the states did not adequately address certain BIPA requirements and thus did not ensure that states had enough information to develop payment systems that were consistent with BIPA. CMS provided its regional offices and states with preliminary information regarding the new payment requirements for FQHCs and RHCs within the first 3 months following the enactment of BIPA; however, the regional offices did not use all of this information consistently.[62] (Fig. 4 provides the timeline of the issuance of CMS guidance.) On January 19, 2001, CMS issued a letter to state Medicaid directors summarizing BIPA's new FQHC and RHC payment provisions, but the letter provided no interpretation of the legislation or clarification as to how CMS expected states to implement the new payment provisions. The letter also instructed states to submit SPAs that conformed to the BIPA requirements before the end of the first calendar quarter of 2001 (March 31, 2001). To assist states in meeting this deadline, CMS provided regional offices with standard BIPA-compliant SPA language on March 9, 2001. According to CMS, prior to approving the SPAs, the regional offices were to work with each state to ensure that the SPA reflected the specifics of the state's payment methodology. While most of CMS's 10 regions followed this protocol, 1 region approved the SPAs for its six states even though most of these

[62]As of March 2005, CMS had not issued regulations regarding states' implementation of BIPA's new payment requirements for FQHCs and RHCs.

SPAs still contained only the standard language initially provided by CMS. These SPAs indicated that states intended to conform to BIPA, but most contained no details as to how each state planned to implement the new payment system. Although these states reported to us in response to our survey the details of how they were paying FQHCs and RHCs, CMS did not require these states to update their SPAs. As a result, CMS did not have an official record detailing how FQHCs and RHCs were paid in most of the states in this region.

Figure 4: Timeline Showing CMS's Issuance of Guidance and Approval of States' Plans to Implement BIPA's Medicaid Payment Provisions



Source: GAO analysis of CMS data.

[a]A state is included in the count if CMS approved the state plan amendment for both FQHC and RHC payment by the date noted.

While CMS later provided the states and regional offices with more detailed guidance, this guidance was issued after many states' SPAs were submitted and approved. On April 13, 2001, 2 weeks after the deadline for SPA submission, a CMS official provided regional office staff with

suggested SPA review guidelines by e-mail. By the time this guidance was provided, all states had submitted their SPAs and CMS had approved 2 states' SPAs. The April 2001 guidance outlined key points that each SPA was to include to ensure compliance with BIPA. For example, the guidance recommended that each SPA explain the averaging methodology used to determine the base PPS rate.[63] Additional guidance from CMS was not issued until 5 months later, by which time 57 percent of SPAs (SPAs for 29 of 51 states) had been approved. Specifically, on September 12, 2001, CMS sent a Question and Answer document to regional office administrators, who were instructed to provide the guidance to states. This document provided the most comprehensive guidance to date and answers to commonly asked questions about BIPA, including what services should be included in the BIPA PPS rate, ongoing requirements for the collection and review of cost reports, and the development of BIPA PPS rates for new centers and clinics.

CMS guidance overall left some requirements for compliance with BIPA unclear, particularly with regard to the adjustment of BIPA PPS rates due to a change in scope of services. Although CMS has defined a change in scope of services as one that affects the type, intensity, duration, and amount of services, it has not clearly defined these elements or developed further guidance regarding how change in scope of service adjustments should be applied. As a result, at the time of our survey, over one-half of the 39 states using the BIPA PPS had either not defined procedures for adjusting FQHCs' and RHCs' BIPA PPS rates for a change in scope of services or not specified what would constitute such a change. Among states with defined procedures, definitions of what constituted a change in scope of services varied considerably and several included factors that are not directly related to the provision of services. For example, documentation from 5 of these states specified relocation, remodeling, the opening of a new site, or a combination of these as criteria to adjust the BIPA PPS rate under this provision. However, CMS told us that factors such as relocation do not constitute a change in scope of services unless there is a corresponding change in the type, intensity, duration, or amount of services. Furthermore, CMS has not offered guidance regarding the requirement for states to adjust base BIPA PPS rates of FQHCs and RHCs that are paid under an alternative payment methodology in the event of a

[63]The guidance also included recommendations that each SPA contain language stating that the plan conforms to the provisions of BIPA, specify when the MEI would be applied to update the PPS rates, describe the methodology used to reimburse FQHCs and RHCs participating in Medicaid managed care, and define the state's use of the term fiscal year.

change in scope of services. If BIPA PPS rates are not appropriately adjusted for a change in scope of services, states cannot accurately compare payments under those rates to payments under an alternative methodology to ensure payment that is at least equal to the payment under the BIPA PPS, as BIPA required.

CMS Oversight Has Been Limited

CMS oversight of states' Medicaid payment systems for FQHCs and RHCs has been limited since the approval of the SPAs. CMS officials explained that they have relied upon states' assurances that they are in compliance with BIPA and have not asked states to provide supporting documentation to verify their compliance with the new payment requirements. For example, CMS has not required states using an alternative payment methodology to provide evidence that payment was at least equal to what would have been paid under the BIPA PPS. Additionally, CMS officials stated that they would only initiate reviews of FQHC and RHC payment issues in response to a complaint or if an issue was identified during a CMS review conducted for other purposes. Regional office officials reported rarely receiving complaints about Medicaid payments to FQHCs and RHCs. Furthermore, only one regional office official told us that a CMS review identified issues related to Medicaid payments for FQHCs and RHCs.[64] CMS regional office officials reported surveying state Medicaid offices during the summer of 2003 to determine the status of states' implementation of the new Medicaid payment system. However, it is unclear how this information was used since CMS regional office officials involved with the survey were, on several occasions, unable to accurately identify the type of payment system—a basic element required for oversight—used by states within their jurisdiction.

As a result of this limited oversight, CMS was unaware of several compliance issues we identified regarding payment to FQHCs and RHCs. Specifically, CMS did not know that more than one-third of the 39 states using the BIPA PPS may have incorrectly determined the base PPS rates by inappropriately excluding certain Medicaid-covered services. While this detail was not included in all SPAs, CMS approved at least two SPAs that

[64]As part of a review of Washington's Medicaid managed care program, Region 10 officials reviewed the state's methodology for making supplemental payments to FQHCs and RHCs. According to a CMS regional office official, the review found that the state may have inadequate documentation to support the value of supplemental payments made to FQHCs and RHCs and thus may be overpaying some facilities. As of February 2005, CMS had not finalized its report on this review.

listed such exclusions. Additionally, a CMS official with responsibility for overseeing Medicaid payments to FQHCs and RHCs acknowledged to us that one state had not included the costs of all appropriate Medicaid services in the calculation of the base rates, but was unaware of the other states we identified that had similarly excluded certain services from their base rate calculation. CMS was also unaware that 6 of the 25 states with alternative methodologies were not routinely ensuring that they were paying at least as much as what would have been paid under the BIPA PPS. Furthermore, CMS did not know if states using an alternative payment methodology were updating their BIPA PPS rates for a change in scope of services, as required by law, before performing this comparison, but believed that most were not.

Conclusions

BIPA changed the way that states pay FQHCs and RHCs for services provided to Medicaid beneficiaries by establishing a PPS to pay these providers. The BIPA PPS encouraged FQHCs and RHCs to operate more efficiently than did the prior cost-based reimbursement system. Additionally, BIPA provided states with the flexibility to implement an alternative payment methodology, which many states opted to use, but it also established a minimum level of payment for FQHCs and RHCs.

Although BIPA required states to use the MEI to annually adjust BIPA PPS rates for inflation, the MEI may not be an appropriate index because it was designed to estimate the increase in the total costs for the average physician to operate a medical practice, not the increase in costs associated with providing FQHC and RHC services. PPSs for other providers often incorporate an inflation index specifically designed to reflect changes in the cost of services delivered by those providers, but no such inflation index has been developed to reflect the services typically provided by FQHCs and RHCs.

CMS is responsible for overseeing states' Medicaid programs, including states' implementation of the BIPA payment requirements, but its guidance and oversight have not consistently ensured that states properly implemented the new requirements. Specifically, CMS approved SPAs that did not contain sufficient detail to convey basic information, such as whether the state intended to implement the BIPA PPS or an alternative methodology, which hindered CMS's ability to properly oversee states' payment systems. In addition, CMS guidance did not address certain BIPA requirements such as how rates were to be adjusted for a change in scope of services. As a result, some states included factors in their definitions of change in scope of services that are not directly related to the provision of

services, and other states did not specify what would constitute such a change or did not define procedures for making the adjustment. Furthermore, CMS's oversight has not ensured that states' BIPA PPSs have included all Medicaid-covered services as required or ensured that states' alternative payment methodologies met the legal requirement that payments be at least as much as they would have been under the BIPA PPS. Limited CMS oversight may be warranted given the relatively low share of total Medicaid spending represented by FQHCs and RHCs and the agency's many other competing priorities. However, CMS oversight must be sufficient to ensure compliance with the law. Without such oversight, CMS is unable to assure Congress that all FQHCs and RHCs are receiving the level of payment to which they are entitled, which is especially important in the absence of available evidence to determine whether there is a need to rebase or refine the BIPA PPS for these providers.

Matter for Congressional Consideration

In our draft report, we recommended that the Administrator of CMS explore the development of an inflation index that better captures the cost of services provided by or price of resources used by FQHCs and RHCs and propose to Congress, as appropriate, any needed revisions to the statute. CMS responded that there is currently no evidence or data to reflect that the need for a revised inflation factor is warranted at this time. Because we continue to believe that CMS should explore developing an index that more appropriately reflects the services provided by FQHCs and RHCs, we maintained this recommendation to CMS and elevated the issue to a matter for congressional consideration.

Congress may wish to consider directing CMS to explore the development of an inflation index that better captures the cost of services provided by or price of resources used by FQHCs and RHCs or develop a strategy to periodically assess the adequacy of the MEI as an inflation index for adjusting PPS rates for FQHCs and RHCs.

Recommendations for Executive Action

To provide for a more appropriate basis for adjusting BIPA PPS payment rates for FQHCs and RHCs, we recommend that the Administrator of CMS explore the development of an inflation index that better captures the cost of services provided by or price of resources used by FQHCs and RHCs and propose to Congress, as appropriate, any needed revisions to the statute.

In addition, to better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, we recommend that the Administrator of CMS take the following four actions:

- Ensure that states' Medicaid plans provide sufficient information describing their methodologies for paying FQHCs and RHCs for Medicaid services, including, at a minimum, whether the state is using the BIPA PPS or an alternative methodology.
- Develop guidance for states describing what constitutes a change in scope of services provided by FQHCs and RHCs, including the definition of the specific elements that affect such a change.
- Ensure that states' FQHC and RHC BIPA PPS payment rates do not inappropriately exclude the costs of Medicaid-covered services.
- Ensure that states' alternative payment methodologies are paying FQHCs and RHCs at least as much as what would be paid under the BIPA PPS, including any needed adjustments due to a change in scope of services.

Agency and State Comments and Our Evaluation

We provided a draft of this report for comment to the Secretary of Health and Human Services and Medicaid directors in Iowa, Missouri, Nebraska, New Hampshire, North Carolina, Vermont, Virginia, and Wisconsin. We received written comments from CMS that represented the views of both CMS and HRSA. We also received technical comments from CMS and the states, which we incorporated as appropriate. CMS comments are included in appendix IV.

CMS commented that it disagreed with the characterizations made in our report regarding the implementation of the BIPA legislation. CMS commented that it had little time to address implementation issues between the enactment of the BIPA legislation in December 2000 and the January 1, 2001, effective date of BIPA's new Medicaid payment provisions. Our draft report acknowledged these dates, and we agree that there was limited time between the law's enactment and its effective date. However, our report addresses a broad range of BIPA implementation activities, including CMS oversight since BIPA was enacted in 2000. CMS noted, and the draft report acknowledged, that it issued guidance to the states in both January 2001 and September 2001. While CMS commented and our draft report noted that all SPAs have been approved, we disagree with the CMS assertion that all SPAs are BIPA-compliant. As we noted in the draft report, at least two states' approved SPAs documented that certain Medicaid-covered services would be excluded from the BIPA PPS rate, a practice that is not compliant with the law and related CMS guidance. Furthermore, although other states' SPAs may be

BIPA-compliant, we found several compliance issues with states' payment methodologies for FQHCs and RHCs. For example, as noted in the draft report and acknowledged by CMS in its comments, some states did not include all Medicaid-covered services in their BIPA PPS rate. With regard to the requirement that alternative payment methodologies pay at least as much as the BIPA PPS, CMS commented that it had not received complaints from FQHCs and RHCs about the amount of payment received under an alternative methodology. We do not believe that the number of complaints should be the criteria to evaluate compliance with the statute. Regardless of whether providers in these states complained, CMS is responsible for ensuring that states are complying with BIPA requirements.

On the basis of our recommendations that CMS better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, CMS said that it would take the following actions:

- request that SPAs clearly identify whether states intended to implement a BIPA PPS or an alternative methodology,
- contact states to ascertain which Medicaid services they are excluding from the BIPA PPS rate determination and assist each state in complying with BIPA requirements for determining the BIPA PPS rate or in establishing alternative payment methodologies, and
- remind states that BIPA requires that alternative payment methodologies pay at least as much as the BIPA PPS rate.

Although these steps are important, they do not adequately ensure that states are complying with BIPA requirements. For example, while it is important to remind states that alternative payment methodologies must pay at least as much as the BIPA PPS, CMS needs to ensure that states' alternative methodologies actually pay as much as the BIPA PPS.

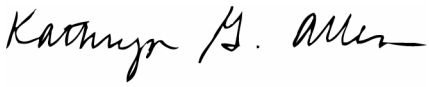
In response to our recommendation that CMS explore the development of an inflation index that better captures the cost of services provided by or price of resources used by FQHCs and RHCs, CMS said that the MEI was selected because it is used by Medicare for these providers and that no evidence currently exists to reflect the need for a revised inflation factor. As we noted in the draft report, the MEI was designed to measure the changing costs for the average physician, which may not be comparable to cost changes experienced by FQHCs and RHCs. For example, FQHCs often provide additional services, such as translation. Because we continue to believe that CMS should explore developing an index that better captures the inflationary changes experienced by FQHCs and RHCs,

we are also elevating this issue to a matter for congressional consideration.

CMS also did not concur with our recommendation that it develop guidance for states describing what constitutes a change in scope of services provided by FQHCs and RHCs. In our draft report we acknowledged that, in its guidance, CMS defined a change in scope of services as "a change in type, intensity, duration and/or amount of services." The guidance also stated that "a change in the cost of a service is not considered in and of itself a change in the scope of services." However, as noted in our draft report, many states have yet to define procedures for changes in scope of services and those with defined procedures sometimes included factors, such as remodeling or relocation, that were not directly related to the provision of services. Therefore, we continue to believe that additional guidance, including the definition of the specific elements that affect a change in scope of services, is necessary.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of CMS, the Administrator of HRSA, and other interested parties. We will also make copies available to others on request. This report also will be available at no charge on GAO's Web site at http://www.gao.gov.

Please call me on (202) 512-7118 or Debra Draper on (202) 512-5152 if you have questions about this report. Major contributors to this report are listed in appendix V.



Kathryn G. Allen
Director, Health Care

Appendix I: Methodology for Review of Selected States Using Cost-Based Reimbursement

To determine the need for rebasing or refining costs for making payments under the Medicaid prospective payment system (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), we obtained detailed information from 5 of the 11 states that used cost-based reimbursement as their alternative payment methodology for both FQHCs and RHCs. We followed this approach since the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required states using an alternative payment methodology to ensure that their methodology resulted in payment no lower than payment under the BIPA PPS. We therefore assumed that these states would have data available on their cost-based payment rates as well as comparative BIPA PPS rates. Having both rates for each FQHC and RHC in the selected states would enable us to assess the extent to which FQHCs' and RHCs' reasonable costs were covered under the PPS.[1]

We selected states for the targeted review if, according to their responses to our survey, they met the following four criteria for both FQHCs and RHCs:

- implemented cost-based reimbursement as their alternative payment methodology,
- required FQHCs and RHCs to submit cost reports and the state audited them,
- had at least 1 year of audited cost reports following the implementation of their alternative payment methodologies, and
- determined what the FQHCs' and RHCs' payments would have been if the state had implemented the BIPA PPS.

According to their survey responses, five states met all of these criteria—Iowa, Missouri, Vermont, Virginia, and Wisconsin.

[1]Providers paid under a cost-based reimbursement methodology may not have the same financial incentives to operate as efficiently as those providers paid under a PPS. As a result, our analysis may overestimate what the difference in providers' reasonable costs and BIPA PPS rates would be if the providers had been paid under the BIPA PPS. However, because many states that pay providers under the BIPA PPS no longer required cost reports and because states' definition of reasonable costs varied, we were unable to compare the BIPA PPS rates to the reasonable costs of FQHCs and RHCs in these states.

We requested that the five states provide us the 2001, 2002, and 2003 cost-based and BIPA PPS payment rates for each of their FQHCs and RHCs.[2] On the basis of their responses we excluded Missouri from further analysis. Missouri had determined the 2001 BIPA PPS rates for only a portion of FQHCs and RHCs in the state and had not determined the 2002 or 2003 BIPA PPS rates for any FQHCs or RHCs. Additionally, Missouri was unable to provide us with 2002 and 2003 per visit cost-based rates. While we found that Vermont had not determined the 2002 and 2003 BIPA PPS rates for its FQHCs and RHCs, we were able to estimate those rates by inflating the 2001 BIPA PPS rates for each FQHC and RHC by the Medicare Economic Index (MEI), the annual inflation adjustment required by BIPA.

For our analysis, we included FQHCs and RHCs in the four states for which 3 full years of data were available—2001, 2002, and 2003. While we generally relied on and did not independently verify the data provided to us by the states, we did review the data for reasonableness and to identify unusual patterns, including outliers. We identified some data that required follow-up with state Medicaid officials to obtain a better understanding of the reason for these patterns. As a result of these additional inquiries, one RHC was excluded from the analysis.

We analyzed the data by state and type of provider (FQHC or RHC). We assessed (1) the percentage and dollar difference between the cost-based and BIPA PPS rates and (2) the number of providers whose cost-based rates exceeded their BIPA PPS rates. This analysis allowed us to compare reasonable costs with BIPA PPS rates in the selected states. The results of this analysis for the four states reviewed cannot be generalized to other states.

[2]Wisconsin also provided the payment rates for RHCs paid under another alternative payment methodology; however, our analysis only included the RHCs paid under cost-based reimbursement.

Appendix II: Overview of Prospective Payment Systems

Under prospective payment, a health care provider's payment is based on predetermined rates and is unaffected by the provider's actual costs or the amount of money charged for products or services. An important objective of a PPS is to create incentives for providers to operate more efficiently. This is done by making providers responsible for the difference between what they are paid and their actual costs. Therefore, providers whose costs exceed the predetermined payment rate will experience a loss and those whose costs are less than the payment rate will profit.

PPS Structure

In a PPS, the payment rate for a product or service may be determined by the following general formula:

Payment rate = *Initial base payment amount* **x** *update factor* **x** *input-price adjustment factor* **x** *relative value of the product or service* **x** *other rate adjustment factors*

- The initial base payment amount is usually a dollar amount for a specific year that reflects policymakers' decisions on the unit of payment for the unit of service (e.g., visit, episode of care, day) and the appropriate initial level of payment for the average unit.
- The update factor adjusts the initial base amount for inflation and other factors to set the base level of payment for the rate year.
- The input-price adjustment factor raises or lowers the base amount to reflect geographic price differences, such as differences in wages.
- The relative value adjusts the base amount to reflect the expected relative costliness of the particular product or service compared with that of the average unit of that product or service.
- One or more additional rate adjustment factors designed to reflect certain characteristics of the provider, the service, or the specific patient may be applied to the payment rate. For example, the payment rate may be adjusted on the basis of patients' severity of illness or condition treated by a provider, referred to as case-mix. Additionally, some systems include an adjustment to mitigate the financial risk of providers who incur unusually large costs. This adjustment may be in the form of an outlier payment in which additional payments are made to the provider for cases that exceed a specified threshold.

BIPA PPS

BIPA established a new PPS to reimburse FQHCs and RHCs for services provided to Medicaid beneficiaries on or after January 1, 2001.[1] Under the new PPS, the base payment amount—the payment for 2001—was set at each FQHC's or RHC's average cost per visit for fiscal years 1999 and 2000. Future years' payment rates were to be adjusted annually for inflation by the MEI and, when necessary, to reflect a change in scope of services. Therefore:

Payment rate = *Initial base payment amount* **x** *update factor* **x** *other rate adjustment factor*

Comparison of BIPA PPS with Selected Other PPSs

While it contains some of the features common in other PPSs, the BIPA PPS differs in other respects. For example, the initial base payment rate under the BIPA PPS is determined for each provider individually, and not for a group of providers as is the case for most other PPSs we reviewed. The BIPA PPS base rate is the average of each individual FQHC's or RHC's reasonable cost per visit in 1999 and 2000.[2] Additionally, the BIPA PPS does not include an input-price adjustment factor or a calculation of the relative value of the product. Table 13 compares the key features of the BIPA PPS to selected other PPSs, specifically those used by states to make Medicaid payments to nursing homes and those used in Medicare to pay for home health, hospital outpatient, and skilled nursing home services.[3]

[1]Prior to the passage of BIPA, federal law required state Medicaid programs to pay FQHCs and RHCs on a cost-related basis. Such cost-based payment methods can be resource-intensive because they require the submission of cost reports and annual reconciliation, can result in unpredictable payments and spending for providers and payers, and can weaken providers' incentives for efficiency.

[2]Each state defines which of its FQHCs' and RHCs' reported costs are reasonable.

[3]Medicare is the federal program that helps pay for health care services for approximately 40 million elderly and disabled individuals.

Table 13: Comparison of Key Features of BIPA PPS to Selected Other PPSs

PPS	Initial base payment amount		Update factor	Input-price adjustment factor (geographic adjustment)	Relative value	Other rate adjustment factors			
	Provider group	Individual provider				Case-mix	Change in scope of services	Outlier payment[a]	Other[b]
Medicaid FQHC and RHC (BIPA PPS)		X	X[c]				X		
Medicaid nursing home[d]		X	X[e]	X		X			X
Medicare home health	X		X[f]	X	X	X		X	X
Medicare outpatient hospital	X		X[g]	X	X			X	X
Medicare skilled nursing facility	X		X[h]	X	X	X			

Source: GAO summary of information from BIPA, previous GAO work, CMS, and the Medicare Payment Advisory Commission.

[a]An outlier payment is an adjustment that mitigates the financial risk to providers by allowing additional payments for high-cost services or beneficiaries.

[b]Examples of other rate adjustment factors include adjustments for the costs of new technology and for beneficiaries who experience a significant change in their condition.

[c]Under the BIPA PPS, states are to update payment rates annually using the MEI, which measures the change in cost of providing physician services.

[d]The features noted reflect those commonly found in states' Medicaid nursing home payment methodologies based on our analysis of 19 states, although the specific features varied by state. See GAO, *Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressure*, GAO-04-143 (Washington, D.C.: Oct. 17, 2003).

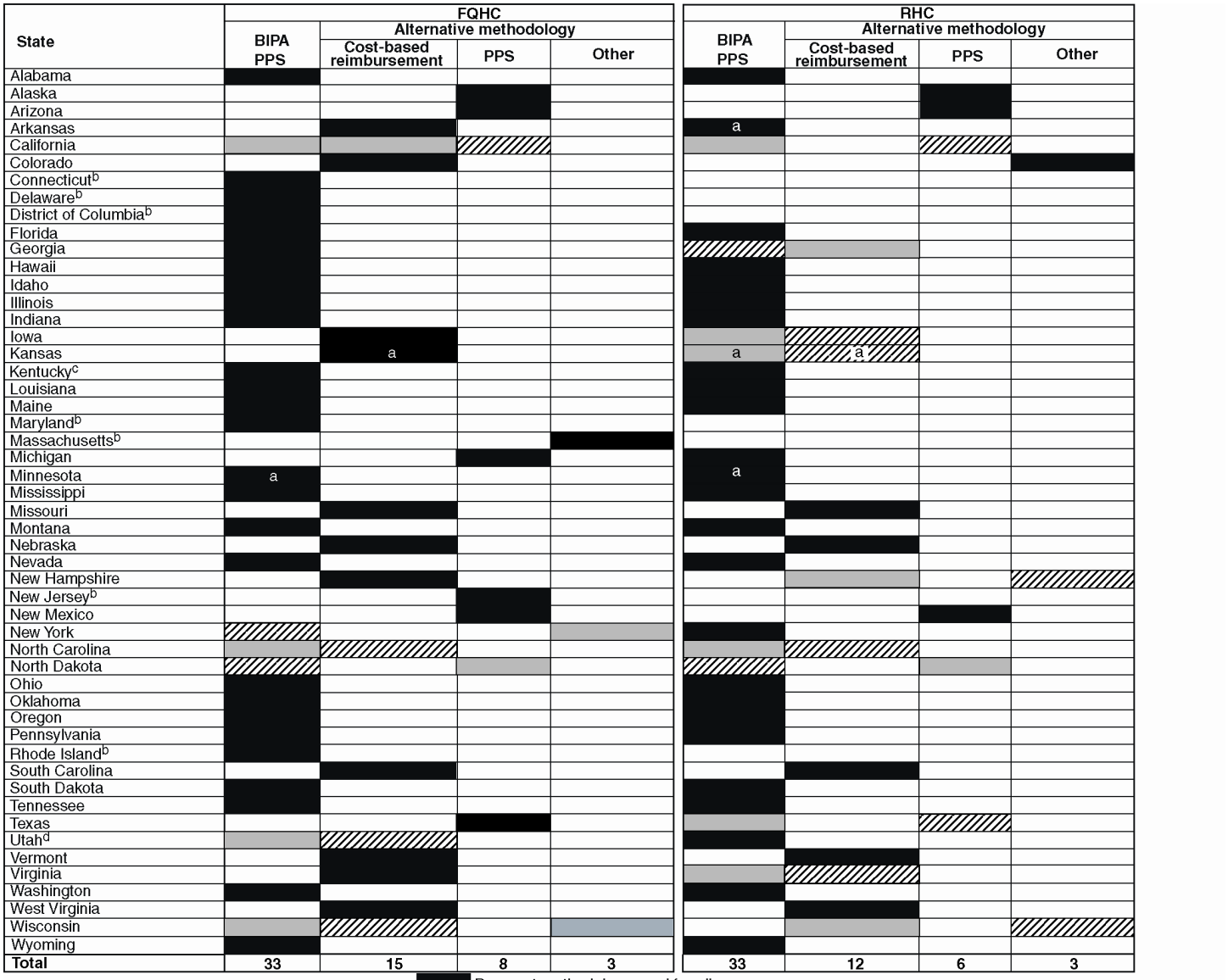
[e]While the specific update factor used varied among the 19 states analyzed in GAO-04-143, the two most commonly used factors were the Consumer Price Index and the skilled nursing facility market basket index developed by CMS.

[f]Under the Medicare home health PPS, CMS updates the payment rate annually by the projected change in the home health market basket, which measures changes in the prices of goods and services bought by home health agencies.

[g]Under the Medicare outpatient hospital PPS, CMS updates the payment rate annually by the hospital market basket index, unless Congress stipulates otherwise.

[h]Under the Medicare skilled nursing facility PPS, CMS updates the payment rate annually using a skilled nursing facility market basket index, which measures the national average price level for the goods and services purchased by these providers.

Appendix III: Medicaid Payment Methodologies for FQHCs and RHCs, by State, as of June 1, 2004



State	FQHC				RHC			
	BIPA PPS	Alternative methodology			BIPA PPS	Alternative methodology		
		Cost-based reimbursement	PPS	Other		Cost-based reimbursement	PPS	Other
Alabama	■				■			
Alaska			■				■	
Arizona								
Arkansas		■			a			
California	▒	▒	▨		▒		▨	
Colorado		■						■
Connecticut[b]	■							
Delaware[b]	■							
District of Columbia[b]	■							
Florida	■				■			
Georgia	■				▨	▒		
Hawaii	■				■			
Idaho	■				■			
Illinois	■				■			
Indiana	■				■			
Iowa		■			▒	▨		
Kansas		a			a	a		
Kentucky[c]	■				■			
Louisiana	■				■			
Maine	■							
Maryland[b]	■							
Massachusetts[b]				■				
Michigan			■					
Minnesota	a				a			
Mississippi	■				■			
Missouri		■				■		
Montana	■				■			
Nebraska		■				■		
Nevada	■				■			
New Hampshire		■				▒		▨
New Jersey[b]			■					
New Mexico			■				■	
New York	▨			▒	■			
North Carolina	▒	▨			▒	▨		
North Dakota	▨		▒		▨		▒	
Ohio	■				■			
Oklahoma	■				■			
Oregon	■				■			
Pennsylvania	■				■			
Rhode Island[b]	■							
South Carolina		■				■		
South Dakota	■				■			
Tennessee	■				■			
Texas			■		▒		▨	
Utah[d]	▒	▨			■			
Vermont		■				■		
Virginia		■			▒	▨		
Washington	■				■			
West Virginia		■				■		
Wisconsin	▒	▨		▒		▒		▨
Wyoming	■				■			
Total	33	15	8	3	33	12	6	3

■ Payment methodology used for all
▨ Payment methodology used for most (50% to <100%)
▒ Payment methodology used for some (>0% to <50%)
□ Payment methodology not used

Source: GAO analysis of state survey responses.

[a]At the time of our survey, the state had not completed implementation of its BIPA PPS or alternative methodology. As such, at least some FQHCs or RHCs were being paid an interim payment rate.

[b]State does not have any RHCs.

[c]Kentucky has the authority to use a payment methodology other than the BIPA PPS for paying FQHCs and RHCs in the counties operating under the state's 1115 waiver managed care program.

[d]Under Utah's 1115 waiver, the state has the authority to use a payment methodology other than the BIPA PPS for paying FQHCs for beneficiaries enrolled in the state's Primary Care Network program. According to state officials, FQHCs are reimbursed on a fee-for-service basis for any services provided to beneficiaries in this 1115 waiver program.

Appendix IV: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

Date: MAY 20 2005

To: Kathryn G. Allen
Director, Health Care—Medicaid
And Private Health Insurance Issues

From: Mark B. McClellan, M.D., Ph.D
Administrator
Centers for Medicare & Medicaid Services

Subject: Government Accountability Office's (GAO) Draft Report: *HEALTH CENTERS AND RURAL CLINICS: State and Federal Implementation Issues for Medicaid's New Payment System* (GAO-05-452)

The GAO conducted this study in response to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000 (Pub.L. 106-554) requiring GAO to study the Medicaid payment provisions for services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The Centers for Medicare & Medicaid Services (CMS) appreciates the efforts that went into this report and the opportunity to review and comment on the issues it raises and on the implementation of the BIPA legislation.

CMS disagrees with the characterizations made in this report regarding the implementation of the BIPA legislation. The BIPA legislation enacted and signed in December 2000 revised the payment methodology to FQHCs and RHCs. The enactment of the legislation in December 2000 did not allow the Center for Medicare & Medicaid Services (CMS), states, FQHCs, RHCs or other interested parties adequate time to address implementation concerns prior to the effective date of January 1, 2001, for services provided on or after that date. Nevertheless, CMS worked diligently and successfully with all of the affected parties to implement the legislation.

State agencies were notified in January 2001 that their state plans would need to be revised and submitted to CMS by March 31, 2001 to reflect these BIPA priorities. All states complied with the guidance issued. In some states, legislative action was required to implement reimbursement revisions. In addition, many states' payment systems required extensive changes to comply with the prospective payment system (PPS) requirements. These were only two of the problems encountered in the first months after the passage of the BIPA legislation. The final approval of state plans was delayed in order for the states to resolve the implementation concerns. However, all plan amendments stated that the new payment methodology would be effective for services provided on or after January 1, 2001: thus states were and are making retroactive

payments to FQHCs and RHCs. With the extensive technical assistance provided by CMS, all state plans have been approved and all plans are in compliance with the BIPA legislation. Some states provided more detailed description in their plans while others provided the basic required language of adherence to the BIPA requirements.

The CMS issued formal guidance in the form of Questions and Answers (Qs & As) in September 2001. Previous technical assistance was based on draft Qs & As. The September 2001 41 Qs & As were developed based on input from the states, the Health Resources and Services Administration (HRSA), National Association of Community Health Centers (NACHC), National Association of Rural Health Clinics (NARHC) and primary care associations (PCAs). This guidance provides broad parameters to the states in developing their own state specific procedures to comply with BIPA. The most difficult concept was the 'change in scope of services'. Our guidance provided a broad definition of a change in scope of services that has allowed states the flexibility in developing more precise procedures for this provision. CMS continues to provide technical assistance to the states in all areas of the BIPA legislation.

The guidance CMS issued in regards to the calculation of the PPS base rate made clear that all Medicaid services as provided for under the statute were to be included in the calculation. Some states misunderstood the requirements and did not include those services that the Medicare program excludes from their per visit encounter such as laboratory and radiological services. Through our regional offices, CMS will actively assist those states in re-calculating their PPS base rates to assure compliance with the BIPA requirements.

The BIPA legislation also permitted states to calculate a payment rate based on an alternative payment methodology. The two statutory requirements that the states must comply with if using an alternative methodology are: 1) each facility (center/clinic) must agree to the methodology, and 2) the rate must be at least equal to the PPS rate. The states that elected to implement an alternate payment methodology had to assure CMS in their state plans that this requirement was met for each FQHC and RHC. In no case has a center/clinic that agreed to an alternative payment methodology complained about the amount of its reimbursement. We are in contact with the states and will be following up on this BIPA implementation requirement.

The input CMS received from HRSA, NACHC, NARHC and the PCAs has been invaluable. The exchange of information on community health centers and rural health clinics is vital to providing health care to vulnerable populations. CMS and HRSA will work together to address issues related to payment and ensure that any systemic complaints are identified and addressed.

Thank you again for the opportunity to respond to the findings and recommendations in this report. We believe our efforts have been highly successful, given the short timeframe, in implementing the BIPA provisions. Attached are our comments on the recommendations, as well as our technical comments.

Centers for Medicare & Medicaid Services' Comments to the GAO Draft Report:
***HEALTH CENTERS AND RURAL CLINICS: State and Federal Implementation Issues for Medicaid's New Payment System* (GAO-05-452)**

GAO Recommendation
Explore the development of an inflation index that better captures the cost of services provided by or price of resources used by FQHCs and RHCs and propose to Congress, as appropriate, any needed revisions to the statute.

CMS Response
The Medicare Economic Index was selected as the inflation factor for the BIPA PPS because it is also the inflation factor used for FQHCs and RHCs in the Medicare program. There is currently no evidence or data to reflect that a need for a revised inflation factor is warranted at this time.

GAO Recommendation
Ensure that states' Medicaid plans provide sufficient information describing their methodologies for paying FQHCs and RHCs for Medicaid services, including, at a minimum, whether the state is using the BIPA PPS or an alternative methodology.

CMS Response
CMS will request that the six states in question (New Hampshire, Vermont, Rhode Island, Massachusetts, Connecticut, and Maine) clearly identify whether the plans are BIPA, PPS or an alternate methodology. The plans of the other states are sufficiently detailed in their payment methodology.

GAO Recommendation
Develop guidance for states describing what constitutes a change in scope of services provided by FQHCs and RHCs, including the definition of the specific elements that affect such a change.

CMS Response
The CMS defined a change in scope of services in the guidance issued in September 2001 as "a change in 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." We believe that this provides sufficient guidance to allow the states to develop change in scope of service procedures/guidelines appropriate to their states' needs. CMS continues to assist states in developing their state specific procedures/guidelines for changes in scope of services.

GAO Recommendation

Ensure that states' FQHCs' and RHCs' BIPA PPS payment rates do not inappropriately exclude the costs of Medicaid-covered services.

CMS Response

The CMS will contact the states identified by GAO to ascertain what Medicaid services they are excluding from the PPS rate calculation. We believe that states may be following Medicare policy which requires some services, i.e., laboratory and radiological services, to be reimbursed outside the Medicare all-inclusive per visit rate. We will assist each state in complying with the BIPA requirements in calculating the PPS rate or in establishing alternative payment methodologies consistent with BIPA requirements.

GAO Recommendation

Ensure that the states' alternative payment methodologies are paying FQHCs and RHCs at least as much as what would be paid under the BIPA PPS, including any needed adjustments due to a change in scope of services.

CMS Response

The CMS will remind the states that the BIPA 2000 legislation requires the alternative payment methodologies rate must be at least equal to the BIPA PPS rate for FQHCs/RHCs.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Debra Draper (202) 512-5152

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Major contributors included Michelle Rosenberg, Patricia Roy, Janice Raynor, Elizabeth T. Morrison, and Daniel Ries.

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