

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
01-07

2. STATE
Oregon

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROPOSED EFFECTIVE DATE

~~April 1, 2001~~ January 1, 2001 (P+E)

FILE COPY

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN
- AMENDMENT TO BE CONSIDERED AS NEW PLAN
- AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Medicare, Medicaid, and SCHIP Benefits Improvement &
Protection Act of 2000 (BIPA)

7. FEDERAL BUDGET IMPACT:

a. FFY	2001	\$ 15,500,000	7,775,000 (P+E)
b. FFY	2002	\$ 0	1,775,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 4.19-B, page 6 of 7 (P+E)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Section 4.19-B, page 6 of 7 (P+E)

10. SUBJECT OF AMENDMENT:

This transmittal is submitted to implement the new Medicaid prospective payment system for FQHCs to accommodate the BIPA requirements.

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

Per Attachment 7.3A

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Hersh Crawford *Bobby Mink*

13. TYPED NAME: Hersh Crawford

Bobby Mink

14. TITLE: Administrator, OMAP Director, DHS

16. RETURN TO:

Office of Medical Assistance Programs
Department of Human Services
500 Summer Street NE, 3rd Floor
Salem, OR 97310

15. DATE SUBMITTED:

3-29-01

ATTN: Carole Van Eck

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

APR 2 2001

18. DATE RECEIVED:

APR 2 2001

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JAN 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

ASSIGNED TO...
DIVISION OF MEDICAL...

21. TYPED NAME:

TERESA L. TRIMBLE

23. REMARKS:

P+E changes authorized by the state

TERMINATED 3/30
(DATE)

Salem
(CITY/ST)

FQHC and RHC

A. Reimbursement for FQHC

For dates of service on or after January 1, 2001, payment for FQHC services will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554.

This payment is set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during the center's fiscal year 2001. These costs are divided by the total number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in the center's fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per visit basis) equal to the amount paid in the previous center's fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The center is responsible for supplying the needed documentation to the State regarding increases or decreases in the center's scope of services. The per visit payment rate shall include costs of all Medicaid covered services.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively cost settle FQHCs to the effective date of January 1, 2001, according to the BIPA 2000 requirements.

In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made no less frequently than every 4 months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

For newly qualified FQHCs after the center's fiscal year 2000, initial payments are established based on payments to the nearest center with a similar caseload, or in the absence of such center, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

TN #01-07
SUPERSEDES
TN # 90-13

DATE APPROVED: *6/29/01* EFFECTIVE DATE: ~~April 1, 2000~~

*January 1, 2001
(P+I)*

B. Reimbursement for RHC

For dates of service on or after January 1, 2001, payment for Rural Health Clinic services will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554 .

This payment is set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the total number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in the clinic's fiscal year 2002, and for each fiscal year thereafter, each clinic is paid the amount (on a per visit basis) equal to the amount paid in the previous clinic's fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the clinic during that fiscal year. The clinic is responsible for supplying the needed documentation to the State regarding increases or decreases in the clinic's scope of services. The per visit payment rate shall include costs of all Medicaid covered services.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively cost settle RHCs to the effective date of January 1, 2001, according to the BIPA 2000 requirements.

In the case of any RHC that contracts with a managed care organization, supplemental payments will be made no less frequently than every 4 months to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

For newly qualified RHCs after the clinic's fiscal year 2000, initial payments are established based on payments to the nearest clinic with a similar caseload, or in the absence of such clinic, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics and adjustment for any increase/decrease in the scope of services furnished by the clinic during that fiscal year.

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