



Status of CHIP Prospective Payer System Implementation: An Assessment of State CHIP Directors

The traditional provider cost-based reimbursement system for federally-qualified health centers (FQHCs) was replaced with a new prospective payment system (PPS) under The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The PPS reestablished the federal requirement that FQHCs be reimbursed at a minimum rate for services provided to Medicaid patients.

This payment system provided a unique rate for every FQHC based on the average of each FQHC's fiscal year (FY) 1999 and FY 2000 costs. For FY 2002 and the years thereafter, the per visit rate equals the previous year's per visit rate, adjusted by the Medicare Economic Index (MEI), and any change in the type, intensity, duration, or amount of services provided. BIPA also provided states the option to implement an alternative payment methodology (APM) in place of the PPS for FQHCs, as long as the FQHCs agreed to the APM and it did not pay less than what FQHCs would receive under PPS. The requirements to use a PPS or APM also applied to Children's Health Insurance Program (CHIP) plans that were structured as Medicaid expansions.

In February of 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was signed into law. Section 503 of CHIPRA required all "separate" CHIP plans (i.e., those not structured as Medicaid expansions) to pay FQHCs using a PPS/APM payment methodology modeled after reimbursement laws currently used for Medicaid. The deadline for states to implement the new FQHC PPS rate for separate CHIP plans was October 1, 2009.

Current Status of CHIP PPS

On February 4, 2010, the Centers for Medicare and Medicaid Services (CMS) issued guidance to state health officials providing direction in implementing the statutory requirement that "separate" CHIP plans pay FQHCs using a PPS or APM. [SHO #10-004, CHIPRA #15] The guidance contained three options that states could select in terms of payment rates, adopting Medicaid PPS rates, constructing separate CHIP PPS rates and, using an alternative payment methodology. CMS also reaffirmed the October 1, 2009 implementation date and required that all FQHC CHIP services on and after this date to be paid at the PPS rate. This means that many states will have to make PPS-based payments to FQHCs retroactively to October 1, 2009.

CHIP Director Assessment Findings

On June 29, 2010, the National Association of Community Health Centers (NACHC) surveyed all CHIP directors in states with separate or combination Medicaid/CHIP programs, a total of 45 states. Separate states have a CHIP plan separate from their Medicaid program (i.e. that is not structured as an expansion of Medicaid). Combination states have both a program that expands their Medicaid program to certain CHIP children and a stand-alone program for other CHIP eligibles. Thirty seven states responded. Six did not respond, so information from the state primary care associations was used. Please refer to chart on page three for detailed responses from each state.

Twenty states with separate or combination CHIP plans reported that they already paid the PPS rate for CHIP services at FQHCs prior to the CHIPRA law enactment. Of those 20 programs, six are separate CHIP programs and the rest are all combination.

Eleven states with separate or combination CHIP have implemented an FQHC PPS since CHIPRA was enacted. Eight chose Medicaid PPS rate and three chose APM.

Since the enactment of CHIPRA, 11 additional states implemented CHIP PPS for FQHCs, five of which are separate CHIP programs. Eight of these 11 states use the Medicaid PPS rate with only three states opting for an APM. As with Medicaid, a CHIP FQHC APM would require a payment to each FQHC that is no less



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than what the FQHC would receive under CHIP PPS and must be agreed to by the FQHC. Two of the states using the APM reported that it would be higher than the Medicaid PPS rate. All states reported that they are paying health centers based on the PPS/ APM retroactively to October 1, 2009.

Out of these 11 states that have implemented a CHIP FQHC PPS program since the enactment of CHIPRA, five reported the system working “very well”, five reported it was working “good” and one reported that it “needs improvements”. Kansas reported that their wrap-around payment method and settlement process is working very well. Florida reported an issue with providers not identifying themselves as FQHCs to the managed care organization until they seek payment after the fact.

Lessons Learned

Frequent communication between the state agency and the managed care entity that contracted with the FQHC for the provision of CHIP services was essential to ensure potential issues are worked out prior to implementation date.

Not all managed care plans were ready to update their FQHC CHIP payments on October 1. Consequently there was a delay in implementation.

Computer systems required reformatting in order to ensure accuracy, which caused a potential delay in implementation.

Successfully developing a payment methodology that works well for all parties required a collaborative effort between the state agency, FQHCs, the State Primary Care Association and managed care plans.

Thirteen states have not implemented CHIP PPS. Seven plan to use Medicaid PPS rate. Four plan to use APM. One plans to develop a separate rate. One has not decided.

As of July 14, 2010, 13 of the responding states have not implemented CHIP PPS for FQHCs. The timeline varies with the earliest being July, 2010 and the latest being June, 2014. Seven states reported that they are working towards paying the Medicaid PPS rate. Four reported that they are working towards an APM, one reported a separate CHIP PPS rate, and one was unsure at the time. One state reported that it was unsuccessful in developing a separate CHIP PPS. Eleven states confirmed that they plan to pay health centers retroactively to October 1, 2009. Two states (Colorado and Pennsylvania) reported that they received a CMS PPS transition grant, which they are using to help with implementation.

Seeing CHIP PPS Through

As these 13 states continue to move toward implementation of CHIP PPS for FQHCs, additional technical assistance will be needed, whether from their peers at state Medicaid/CHIP agencies or the federal government. PCAs and FQHCs should continue to work with their states to assist in the process. Lessons learned should continue to be collected and shared in order to support those still in the process and for future payment changes.



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State	Type of Program	Has State Applied PPS?	Application Date	Payment Rate	Retroactive to Oct 2009?
Alabama	Separate	No	July, 2010	Medicaid	Yes
Arizona	Separate	Yes	N/A	Medicaid	Yes
Arkansas**	Combination	No	Unknown	Unknown	Unknown
California*	Combination	No	Unknown	Medicaid	Unknown
Colorado	Separate	No	Spring, 2010	PPS	Yes
Connecticut*	Separate	Paid Prior	N/A	N/A	N/A
Delaware	Combination	Paid Prior	N/A	N/A	N/A
Florida	Combination	Yes	N/A	Medicaid	Yes
Georgia	Separate	Paid Prior	N/A	N/A	N/A
Idaho	Combination	Paid Prior	N/A	N/A	N/A
Illinois	Combination	Paid Prior	N/A	N/A	N/A
Indiana	Combination	Paid Prior	N/A	N/A	N/A
Iowa	Combination	No	February, 2011	Medicaid	Yes
Kansas	Separate	Yes	Unknown	APM	Yes
Kentucky	Combination	Paid Prior	N/A	N/A	N/A
Louisiana	Combination	Yes	N/A	Medicaid	Yes
Maine	Combination	Paid Prior	N/A	N/A	N/A
Maryland	Combination	Paid Prior	N/A	N/A	N/A
Massachusetts	Combination	Paid Prior	N/A	N/A	N/A
Michigan	Combination	No	6-12 months	Medicaid	Yes
Minnesota	Combination	Paid Prior	N/A	N/A	N/A
Mississippi	Separate	Yes	N/A	Medicaid	Yes
Missouri	Combination	No	Unknown	APM	Yes
Montana	Separate	No	October, 2010	Medicaid	Yes
Nevada	Separate	Paid Prior	N/A	N/A	N/A
New Hampshire*	Combination	No	Unknown	APM	Unknown
New Jersey*	Combination	Paid Prior	N/A	N/A	N/A
New York	Separate	Yes	N/A	APM	Yes
North Carolina*	Separate	Unknown	Unknown	Unknown	Unknown
North Dakota	Combination	Yes	N/A	APM	Yes
Oklahoma	Combination	Paid Prior	N/A	N/A	N/A
Oregon	Separate	Paid Prior	N/A	N/A	N/A
Pennsylvania	Separate	No	Summer, 2011	APM	Yes
Rhode Island	Combination	Paid Prior	N/A	N/A	N/A
South Carolina	Combination	Yes	N/A	Medicaid	Yes
South Dakota	Combination	Paid Prior	N/A	N/A	N/A
Tennessee	Combination	Yes	N/A	Medicaid	Yes
Texas	Separate	Yes	N/A	Medicaid	Yes
Utah	Separate	No	August, 2010	APM	Yes
Vermont*	Separate	Paid Prior	N/A	N/A	N/A
Virginia	Combination	Yes	N/A	Medicaid	Yes
Washington	Separate	Paid Prior	N/A	N/A	N/A
West Virginia	Separate	No	June, 2014	Separate PPS	Yes
Wisconsin	Combination	Paid Prior	N/A	N/A	N/A
Wyoming	Separate	No	October, 2010	Medicaid	Yes

Source: Implementation of PPS for FQHCs in CHIP: Assessment of CHIP Directors, NACHC, July 2010.



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Implications for 2014 Health Insurance Exchanges

As required under the Affordable Care Act of 2010 (ACA), private insurance plans that operate under the new health insurance exchanges in each state will be required to pay FQHCs no less than their Medicaid PPS rate. In the assessment CHIP directors were asked to describe any opportunities or potential challenges that they anticipated with the PPS requirement when the exchange plans are implemented in 2014.

System Changes

The most common response from the CHIP directors was concern about the potential burden that switching from a code based reimbursement system to a PPS rate would put on private insurers. In order to accommodate PPS, many insurance companies would have to make significant changes to their computer systems, and internal processes which could be time consuming and resource intensive. Many private insurers are not accustomed to working with FQHCs and the unique PPS rate, so the necessary learning curve could result in delayed implementation.

Medicaid PPS took time to implement after it was enacted in 2000. As demonstrated by this assessment, more states have yet to implement CHIP PPS than have implemented to date. This is nearly 9 months after the deadline. Payment system changes take time to execute. This can be expected with the exchange plans as well. However, in order to minimize delays, it is essential that FQHCs, PCAs, and the state Medicaid/CHIP agency, which is more accustomed to working with FQHCs, work together to educate the private plans to ensure a smooth transition.

Rate Changes

PPS is a fixed (per visit) rate payment system and private insurers are used to a payment system that provides them with greater control and flexibility. Comment was made that easy access to rate information for the insurance companies will be essential. Efficient communication between FQHCs and insurance plans will ensure the timely availability of this data.

Separating Services

Due to the multiple health needs of patients who commonly seek care at FQHCs, insurance companies will have to separate out certain services from the PPS rate (behavioral, dental, OB, labwork, etc.) and pay FQHCs separately for these services. This could create a challenge for many health plans because they are used to paying capitated rates for services. The ACA does not require that plans pay FQHCs a PPS rate, but that they reimburse centers no less than they would receive under Medicaid PPS. Similarly to CHIP PPS, plans could choose to pay Medicaid rates rather than calculating a new rate.

Preparing Now for Exchanges

In addition to asking about potential challenges, CHIP directors were asked what type of assistance they anticipated would help them to successfully prepare for the implementation of exchange plans. The most common request was for financial assistance or grants and more technical assistance or guidance from CMS. This concern suggests that CHIP directors may not have been aware that their state could have applied to CMS for part of the \$5 million that Congress appropriated to assist states in implementing the CHIP PPS requirement. Only a few states sought these funds. Other respondents suggested that sharing information on best practice models from other states would be helpful, and hiring consultants that could help facilitate the process with other stakeholders in the state.



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Guidance is still needed from CMS on this provision, among others. However, states have started planning for the exchanges and CMS has begun distributing planning grants, so the time to engage in the process is now.

What can PCAs and health centers do?

- Review current payment systems to ensure PPS rates are in good order.
- Reach out to the state and plans and get involved in the planning for exchanges.

What can states do?

- Share their experiences from Medicaid and CHIP PPS implementation with plans.
- Convene stakeholders to develop plans and keep lines of communication open throughout the process.

What can the federal government do?

- Provide technical assistance and funding to support the transition.
- Conduct focus groups with Medicaid and CHIP directors and compile best practices and lessons learned to share with stakeholders.