NACHC Issue Brief: Summary of CHIP FQHC PPS Reimbursement Guidance

February, 2010

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This publication was supported by Grant/Cooperative Agreement Number U30CS16089 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). The contents of this publication are solely the responsibility of the author(s) and do not necessarily represent the official views of HRSA/BPHC.

Introduction

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), enacted in February, 2009, extended authorization and funded expansion for the CHIP program. In section 503 of CHIPRA (42 USC 1397gg(e)(1)(E)), Congress applies section 42 USC 1396a(bb) of the Medicaid statute to the CHIP program, effective October 1, 2009. Section 1396a(bb) requires that FQHCs be reimbursed based on a Prospective Payment System (PPS) which is specifically delineated in 1396a(bb) or based on an appropriate Alternative Payment Methodology(APM) . On February 4, 2010, CMS issued guidance to State Health Officials providing direction in implementing the CHIP FQHC PPS statutory requirement. The CMS guidance (SHO # 10-004, CHIPRA #15, Feb. 4, 2010) and CMS's Questions and Answers attached to this SHO can be found in the following link: http://www.cms.hhs.gov/smdl/downloads/SHO10004.pdf

Differences in FQHC-related requirements under Medicaid and CHIP .

There are two important differences between FQHC provisions in the Medicaid statute and the CHIP statute. In the Medicaid statute, FQHC services are a required service, which means that states must make these services available to Medicaid recipients. (See 42 USC 1396d(a)(2)(C) and 1396a(a)(10)(A)). Consequently, state Medicaid agencies must contract with FQHCs as providers and must also insure that if recipients are required to receive their Medicaid services through Managed Care Organizations (MCOs), at least one MCO in each service area must contract with an FQHC, so that the patient has access to FQHC services. In contrast, in the CHIP statute, FQHC services are not a required service, so CHIP programs need not contract with FQHCs as long as there are other providers to deliver CHIP services to recipients (See CMS's Q's and A's attached to the FQHC CHIP SHO).

Equally important, the Medicaid statute defines FQHC services as including all rural health clinic services as defined in the **Medicare** statute as well as any other ambulatory services that are included in the state's Medicaid plan. (See 42 USC 1396d(a)(2)(C) and 1396d(l)(2)(A)) In contrast, in the CHIP statute, FQHC services are not defined or even listed as a service.

These two differences provide states with less guidance and, arguably, more flexibility in the CHIP program and therefore require PCAs and health centers to engage and work closely with their state CHIP agencies to insure that health centers and their patients are able to make full use of the CHIP program in their states.

Applicability of Section 503

It is important to note that section 503 of CHIPRA, which is the subject of this Issue Brief and the recent CMS SHO, impacts only separate CHIP programs, not Medicaid-expansion CHIP programs . Also, Section 503 only addresses payment rates to FQHCs. In contrast, States which have opted to provide CHIP services through an expansion of their Medicaid program are required to provide FQHC services to their CHIP recipients as those services are defined in the Medicaid statute and are already reimbursing centers on the basis of a PPS FQHC per visit rate or an appropriate APM.. Some states have both a Medicaid-expansion CHIP program for certain children (for example, lower income children) and a CHIP separate CHIP program for others (for example, higher income children)--**in which case the Medicaid FQHC service**

definition, service mandate, and PPS payment apply in the former but only the PPS payment is mandated in the latter program.

PPS Payment to FQHCs in CHIP

In the Feb. 4 SHO, CMS provides states with three choices as to how to pay FQHCs under separate CHIP plans.

1. States can adopt the per visit payment rates "already in place in Medicaid". The SHO notes that this approach would minimize implementation burdens, but notes that for it “to work effectively” an FQHC would have to provide "the same or a similar range of services in both the CHIP and Medicaid programs". CMS’ point here appears to be that if a state CHIP program is paying an FQHC its Medicaid per visit rate, that FQHC should be providing the same or similar services to its CHIP patients as it is to its Medicaid patients. Using this payment approach, would be the easiest for both centers and states and seems to be the gold standard for PCAs and centers to negotiate for in their state. Since CHIP now requires (as of Oct.1, 2009) dental services as a CHIP service, PCAs may not have difficulty in showing that the services they provide their Medicaid and CHIP patients are the "same or a similar range of services". The language in the SHO seems to lend itself to the state in its state plan assuring CMS that this is the case. We have not yet seen CMS' state plan pre-print on this issue, which should provide a clearer idea of how this assurance might be handled.

2. The second payment option is the most problematic because it appears to require FQHCs and the state to go through a process similar to what they went through when Medicaid reasonable cost payment for health centers was implemented in the states in 1991 and years that followed. Centers would have to determine their reasonable costs for CHIP covered services during two base years and divide these costs by CHIP visits to come up with a per visit rate for these base years. That per visit rate would be the health centers CHIP per visit rate for the first year of CHIP PPS, which would then be increased by the MEI and changes (increases or decreases) in scope of service in subsequent years.

   While such a process would be tedious and time-consuming in any case (possibly requiring cost reports, etc), it is particularly problematic under CHIP since the SHO does not establish the two base years that states should be using and because CHIPRA expanded CHIP to include dental services—the costs of which would not be reflected in the health center’s PPS base years if the base years are prior to 2010. In this instance, at a minimum, states and FQHCs would have to establish a clear change of scope process so centers providing dental services could add these costs in if they begin providing dental services. Other obvious complications can crop up since there is no definition of FQHC services in CHIP.

3. The third option is for states to apply an alternative payment methodology (APM) similar to the option available in Medicaid. An APM in Medicaid and CHIP PPS law can be most any payment methodology as long as it is agreed upon both by the State and by each individual FQHC "to which the state wishes to apply the methodology," and "which must result in a payment to the FQHC...that is at least equal to the amount to which it is entitled under the PPS." This option also seems to be a good way to go, although it is difficult to know how a State or FQHC could determine that the APM is paying no less than what the FQHC would receive under CHIP PPS, since there seem to be so many vagaries in how the state is to establish a PPS per visit rate. However, the last sentence in this section of the SHO may provide an easy approach for the FQHC and the State: it provides that a **State may accept an FQHC's written assertion** that the amount paid under the APM "at least equals the amount to which the FQHC... is entitled under the PPS." Consequently, if the state and FQHC can agree on a fair APM and agree on a fair PPS methodology, this may not be such a great hurdle.

   One possible approach to PPS FQHC payment under this third option might be the state and the FQHC agreeing to the state paying the **Medicaid FQHC PPS rate as an APM**. The FQHC probably could assure that this rate is no less than it would receive under the first two options, but might not have to show that it is providing the same or similar range of services in both CHIP and Medicaid since that is not a requirement in option 3. Discussion with CMS on this issue is probably necessary before FQHCs and states consider this option.

<u>New Health Centers</u>

Similar to Medicaid PPS legislation, new FQHCs "as well as existing FQHCs...that are new to CHIP" will have their initial CHIP per visit payment established "either by reference to payments made to other FQHCs in the same or adjacent areas with similar caseloads". If no such comparable FQHC exists, then the state can set a per visit rate for that center "through cost reporting methods." The last provision is a concern since it seems to not allow a new center to be paid based on options 1 or 3. Again, further clarification from CMS may necessary.

<u>Supplemental Payments to FQHCs in Managed Care</u>

Appropriately, CMS applies the Medicaid FQHC managed care supplemental (wrap-around) provisions to PPS payment in CHIP. Essentially, this means that when a health center is contracting with a MCO to serve CHIP patients, the state CHIP program must reimburse the FQHC the difference (if any) between what it would have been paid under PPS and the amount it is paid by the MCO. The intent of this wrap-around or supplemental payment is to insure that the center receives no less payment when it contracts with an MCO than it would if it were contracting directly with the state and being paid full PPS from the state CHIP program. Presumably the same kinds of problems that arise in Medicaid PPS will arise in CHIP PPS supplemental payments, such as: insuring that the state requires the CMO to provide timely, clear and accurate records regarding how much the CMO has paid the center so that the state can accurately calculate the supplemental payments it owes the center; and insuring that the state

does not include certain “shared savings” or bonuses from the CMO to the center in calculating the amount the state owes the center in supplemental payments..

Effective Date of CHIP PPS: October 1, 2009

The CMS CHIP SHO, and the provision in CHIPRA on which it is based are clear that the effective date of CHIP PPS reimbursement to FQHCs was Oct. 1, 2009. The SHO provides that section 3(b) of CHIPRA does allow a state a certain amount of time to delay CHIP PPS implementation if the Secretary of HHS agrees with a state that in that state a change in state legislation is necessary to bring its CHIP plans into compliance with CHIPRA. The SHO states unequivocally, however, that “[n]otwithstanding such a delay in implementation, separate CHIP programs should make payments to FQHCs consistent with section 2107(e)(1) [the CHIP PPS payment requirement] retroactive to October 1, 2009.” This would also clearly be the case for States that have put off implementing PPS in CHIP until they received this Feb.4th SHO/ guidance.

Next Steps

At the end of its guidance, CMS encourages any state that operates a separate CHIP program with FQHCs to begin a dialogue with its Medicaid agency and it CMS Regional Office to assess potential coordination between Medicaid and CHIP in order to maximize administrative efficiencies and facilitate more rapid compliance with the CHIP FQHC PPS requirements. The federal agency also notes that CHIPRA provided $5 million in grants funds to assist states in this transition. PCAs and health centers should become similarly engaged in this process. There are a number of important service and payment issues for the states to resolve related to FQHC services in CHIP, PPS reimbursement options, implementation, retroactivity.etc—and certain directions taken by a state are much more preferable than others. In addition, a number of FQHC payment issues that are already problematic in Medicaid FQHC will arise in CHIP as well (what services are billable visits, number of billable visits per day, etc.).Hence the need for PCAs and health centers to meet ASAP with the appropriate state agencies and to be conversant with and prepared for the issue sthat are likely to, and should, be raised at these meetings.

NACHC will seek further clarification from CMS on a number of the CHIP PPS issues raised in this IB and others that will no doubt come up in the upcoming months. We will also develop further IBs and relevant publications as needed and cover CHIP FQHC PPS issues and strategies in upcoming NACHC conferences, webinars and through other means of communication.

If you have any questions regarding this IB or otherwise related to CHIP FQHC PPS, call or email Roger Schwartz, rschwartz@nachc.org or Colleen Boselli at cboselli@nachc.org.