June 2015

Report to Congress

Section 503 of the Children's Health Insurance Program Reauthorization Act: Prospective Payment Systems for Federally Qualified Health Centers and Rural Health Clinics Transition Grants

CONTENTS

INTRODUCTION

In 2000, Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) mandated that Federally Qualified Health Centers (FQHC) and Rural

Health Centers (RHC) be reimbursed by Medicaid using a federal prospective payment system (PPS). Medicaid programs are required to make payments for FQHC and RHC services in an amount calculated on a per-visit basis that is equal to the reasonable cost of such services, documented for a baseline period, with certain adjustments. States can also use an alternative payment methodology (APM) if it does not result in a lower payment than the federal PPS payment, provided that the FQHCs or RHCs agree. The BIPA provisions also applied to Children Health Insurance Programs (CHIP) that were Medicaid expansion programs, but not to separate CHIP programs.

This changed with Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which amended Section 1902(bb) of the Social Security Act (the Act) to make the PPS provisions applicable to separate CHIP programs in the same manner they are applicable to Medicaid, effective on October 1, 2009. In federal fiscal year 2010, 17 states had a separate CHIP and 27 states had combination programs (a blended Medicaid Expansion program and separate program) for a total of 44 separate programs.[1]

To assist with the transition, Section 503 of CHIPRA authorized a total of $5 million in grant funds for fiscal years 2009-2013 expressly for the purpose of assisting states that operate a separate CHIP, including those states that operate a combination CHIP, to comply with section 1902(bb) of the Act.

In February 2010, CMS released a Funding Opportunity Announcement (FOA) entitled "CHIPRA PPS for FQHCs and RHCs Transition Grants (CMS-1Z0-10-003)" to offer funding to assist states with transition activities to come into compliance with the requirements of CHIPRA Section 503. A total of five states applied for this grant opportunity (California, Colorado, Pennsylvania, Michigan, and South Carolina). In June 2010, CMS awarded approximately $2.14 million in grant funds to the five states. South Carolina later withdrew its acceptance of the $209,000 in grant funds because the state was in the process of converting to a Medicaid expansion, rendering the state ineligible for a grant award. South Carolina's withdrawal brought the total amount awarded down to approximately $1.9 million, leaving about $3.1 million in grant funds available.

With the remaining funds, CMS released a second FOA entitled "CHIPRA PPS for FQHCs and RHCs Transition Grants – Second Release (CMS-1Z0-12-001)." Issued on January 11, 2012, this FOA offered the remaining $3,065,655 of the original appropriation in grant funds to again be available to states for a one year budget period. This second FOA was designed to once again provide assistance to states in the transition from the current payment methodology to a PPS or APM to pay for FQHC/RHC services provided to CHIP enrollees. CMS received three applications: Iowa, Pennsylvania (also an awardee from the first cohort) and Montana. All three were awarded for a total for this second round of approximately $1.13 million.

With the release of these three additional awards, $1,939,485 remained unobligated from the federal appropriation. As we have awarded every applicant that has applied for both funding

1 http://www.insurekidsnow.gov/professionals/reports

opportunities and demand for a third funding opportunity remained low, CMS does not anticipate releasing a third grant solicitation.

States could use grant funds to support a variety of activities, including the following:

- Modifying financial systems
- Implementing new audit and reconciliation procedures
- Collecting and analyzing cost reports
- Obtaining contractual assistance for data gathering
- Modifying CHIP state plans
- Renegotiating managed care plan contracts

The CMS made seven grant awards to six states.

- California Managed Risk Medical Insurance Board - $500,000
- Colorado Department of Health Care Policy and Financing - $499,224
- Michigan Department of Community Health Services Administration - $435,121
- Pennsylvania Department of Insurance - $500,000
- Iowa Department of Human Services - $200,000
- Montana Department of Public Health and Human Services - $500,000
- Pennsylvania Department of Insurance (Second Grant Award) - $426,170

PURPOSE OF THE REPORT

This report presents the impact of the application of the new PPS systems on access to benefits, provider payment rates, or scope of benefits offered by the states with a focus on the six states that received Transition Grants as required by section 503 of CHIPRA. The data sources and methodology for this report are discussed in ***Appendix A***.

METHODS CHOSEN BY THE SIX STATES

CMS issued a State Health Official[2] letter on February 4, 2010, describing three methods that states could use in implementing the federal PPS in CHIP to comply with the legislative requirements:

- adopting Medicaid PPS rates;
- constructing separate CHIP PPS rates; or
- using an APM.

Regardless of the approach used, if a state contracts with managed care organizations (MCO) to provide CHIP services, it must make supplemental payments to FQHCs and RHCs if the MCO payment to the health centers is less than it would be under a PPS.

Each of the six states ultimately decided that adopting its Medicaid PPS rate for use in CHIP was the most feasible, although Pennsylvania and Colorado initially considered other options. The grantee in Pennsylvania considered various alternatives—including using the Medicare cost reporting forms to construct a CHIP-specific PPS rate—but determined that using the Medicaid PPS rate was the most cost-effective and easy-to-implement approach. Like the other states, Iowa also adopted the Medicaid PPS rate; however, the state also decided to use an APM for some of its CHIP enrollees.

Child Health Plan *Plus*, the grantee in Colorado, initially planned to develop an APM for FQHCs and RHCs that would provide health centers with incentives to organize and coordinate care to enable improved outcomes. The original plan was to combine two distinct processes into one methodology: (1) a PPS methodology for CHIP consistent with federal guidance and (2) a value-based purchasing methodology that could be used in both CHIP and Medicaid.

Colorado conducted a pilot to determine whether FQHCs and RHCs in the state were able to provide the data needed for implementing this methodology. The pilot demonstrated that the state's data processing system would require significant updating before the state could implement more sophisticated reimbursement methods. Additionally, given the small number of CHIP enrollees served by FQHCs and RHCs in the state—only about 4 percent of total FQHC patients annually—the grantee and the health centers agreed that the administrative burden of implementing a value-based methodology outweighed the potential benefits.

Several grantees customized the use of Medicaid PPS to suit specific needs of each state's CHIP program. The grantee in California, Managed Risk Medical Insurance Board (MRMIB), not only decided to use the state's current Medicaid PPS for FQHC and RHC payments, but to process payments using the Medicaid PPS for Indian Health Clinics (IHC) participating in CHIP as well. Montana implemented a PPS in October 2010, based on the state's reimbursement in the Medicaid program for FQHCs and RHCs, but applied for a grant in

[2] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10004.pdf

order to make improvements to its Medicaid PPS methodology for use with CHIP payments to FQHCs and RHCs. The grantee in Michigan used grant funds to make modifications to both the state's CHIP MCO contracts, allowing the MCOs to provide wraparound payments to FQHCs and RHCs in their MCO provider networks providing services to CHIP enrollees. The state expected this would create an increase in the number of CHIP enrollees using FQHCs and RHCs as their primary health care provider.

IMPLEMENTATION OF THE PPS

Implementing a PPS for its separate CHIP proved challenging for each of the six grantee states. Numerous complexities—anticipated and unanticipated—caused project delays, which led three of the six grantees (California, Colorado, and Michigan) to request and receive a 12-month, no-cost extension of the grant period.

California's project was delayed because the amount budgeted for the increased PPS payments was insufficient, and the grantee had to submit a request for additional funding to the State Department of Finance and the Legislature, which was not approved until May 2011. Additional delays occurred because the state had recently hired a new Medi-Cal fiscal intermediary.

In Colorado, when the state actuary's estimates were not considered to accurately reflect FQHCs' costs, the state hired a new actuary, delaying the rate development process by approximately 6 months.

Michigan's project was delayed because of staff turnover and the need to install and test new computer servers. Additionally, some of the changes required by the new payment system required a state plan amendment (SPA), which required time for the state, working with CMS, to get approval before fully implementing the project. While waiting for approval, the state's audit staff performed the administrative work needed to reduce the backlog of CHIP settlements and to update the CHIP interim payments, which enabled the state to pay the FQHCs and RHCs as soon as the SPA was approved. The state began processing CHIP settlement payments in August 2012 for its MIChild Program. The state was not able to begin processing CHIP payments for its MOMS program, a Title XXI program that provides pregnant women with prenatal care while their Medicaid application is pending, until September 2013. In addition to submitting a SPA to CMS, Michigan had to implement a large number of information technology, contract, administrative, and policy changes to effectuate the payment change. For example, the state had to identify and convert CHIP encounters to a per-visit rate and establish a schedule of encounter submissions, enabling staff to incorporate the Medicaid and CHIP rates into one report. The state also had to modify the contracts with the MCOs providing services through FQHCs and RHCs to CHIP enrollees to ensure that they receive the PPS wraparound payment.

The other grantee states also experienced challenges, including identifying some unintended consequences of moving to an encounter-based payment methodology. In Pennsylvania, where the CHIP program is administered completely separately from the Medicaid program, discrepancies were found with Medicaid and CHIP data reported by the FQHCs and RHCs from the data reported by both CHIP and Medicaid MCOs. The methods used by Pennsylvania's Medicaid Agency to accurately count encounters for FQHCs and RHCs resulted

in some loss of detail about the services rendered, conflicting with the objective of having accurate, detailed service data to support quality measures and program integrity efforts. As a result, the grantee adapted the Medicaid PPS methodology for CHIP payments to FQHCs and RHCs, taking into account the differences between the two programs (*e.g.*, type of services covered), by (1) developing a methodology for counting medical and dental encounters covered by PA CHIP at each FQHC and RHC by the respective MCOs and (2) rebranding the CHIP MCO insurance cards to make it easier for the FQHCs and RHCs to identify, track and report on services provided to CHIP enrollees. The state also found it necessary to revamp the MCO report template, modify the ACCESS program and have the MCOs resubmit vaccine reports to more readily verify vaccine product costs versus administrative costs. Resubmission of vaccine reports was necessary because Medicaid PPS rates do not consider vaccine product costs due to the Vaccines for Children program, which provided free vaccines for children covered by Medicaid (but not CHIP) during the reporting period.

Another challenge Pennsylvania experienced was reconciling the different accounting capabilities of the MCOs, FQHCs, and RHCs. Accounting challenges among RHCs made it difficult to determine the validity of data disputes, and the grantee did not have the authority to resolve these disputes. Thus, it had to develop a dispute report to keep track of ongoing discrepancies until they could be resolved by all parties. But, as the Pennsylvania grantee gained more experience with implementation of the new PPS rates, it encountered even more exceptions and discrepancies. For example, Pennsylvania Medicaid made changes in PPS rates at times other than the beginning of calendar quarters, but Pennsylvania CHIP had assumed Medicaid PPS rates would be constant during a calendar quarter. The many data issues required a redesign of the system used to calculate and make payments, and the grantee applied for and received a second PPS grant to support this effort. The grantee anticipates that additional issues will arise as the state's CHIP fully implements the PPS mandate.

In Iowa, health plan availability, obtaining needed data, and health plan preferences caused delays in implementing PPS for CHIP. There are only two health plans serving CHIP enrollees in Iowa, United Healthcare and Wellmark Health Plan of Iowa (WHPI). One of the two health plans indicated that it had limited time and resources to devote to this issue. Given that the health plan was not able to devote the time or resources needed to complete certain activities to identify Healthy and Well Kids in Iowa (*hawk-i*) visits at FQHCs and RHCs, the contractor had to devote additional time to working with previously obtained data in order to tailor it to the state needs. Additionally, the two plans had different preferences for moving forward with implementation, both of which were different from the original methodology proposed by the contractor. Ultimately, United Healthcare decided to adopt and pay the established Medicaid PPS encounter rates; and WHPI decided to continue paying on a FFS basis and complete quarterly supplemental payments to any FQHCs or RHCs that were not paid a rate at least equal to the Medicaid encounter level.

In Montana, a departmental reorganization was announced shortly after the state submitted its grant application, causing several delays. Montana's reorganization brought about changes in management within the agency and agency structure, so some of the support staff positions slated to assist with grant activities were no longer available. Despite the challenges, the project was still completed on time.

Supplemental Payments

If a separate CHIP provider contracts with MCOs that in turn subcontract with FQHCs and RHCs to provide covered services to CHIP enrollees, the state is required to make supplemental payments to those providers in the amount of the difference, if any, between the payment received by the FQHC or RHC from the MCO and the amount to which the FQHC or RHC would be entitled under the state's PPS or APM. States have to determine both interim and wraparound payments to make up the differential. For example, an FQHC providing care to CHIP enrollees either bills the CHIP-contracted MCO its standard rate for a visit or receives a capitated monthly payment for patients assigned to its site. Both methods are considered an interim payment to the FQHC. Then the FQHC must also submit a claim to the agency that administers the CHIP program for the wraparound payment, which is the difference between the CHIP-contracted rate (between the health plan and the FQHC) and the full PPS rate. Prior to the implementation of the Medicaid PPS methodology in Michigan, the standard Blue Cross and Blue Shield (BCBS) commercial reimbursement for a detailed office visit with an established patient was $108.86. The PPS encounter rate is $159.87, and thus the FQHC separately bills the state for the $51.01 difference.

Retroactive Payments

States are required to make payments retroactive from October 1, 2009, which proved to be challenging for grantee states. Calculating retroactive payments was particularly challenging because of data and systems limitations for FQHCs and RHCs. In California, some FQHCs and RHCs did not want to submit claims for the retroactive period because of insufficient staffing resources and difficulty finding the necessary data. A few of the smaller clinics were unable to submit claims for the retroactive period—either electronically or on paper—because the clinic had changed its billing systems since 2009. Iowa has also encountered difficulty with receiving data from FQHCs and RHCs needed to process retroactive payments back to October 1, 2009. Iowa currently has a timely filing waiver request pending with CMS.

In Colorado, some RHCs had difficulty finding the data needed for retroactive payments because many had implemented or were in the process of implementing new data systems as part of a transition to electronic health records. Other clinics were unable to differentiate between CHIP and non-CHIP enrollees and could make that distinction only when the health plan that reimbursed the clinic provided the Explanation of Benefits report.

In Pennsylvania, because of a state law intended to prevent provider discrimination against CHIP enrollees, CHIP insurers were not permitted to include a CHIP identifier on enrollees' insurance cards. Consequently, FQHCs and RHCs found it very difficult to identify, track, and report on services provided to CHIP enrollees. This problem was addressed in January 2011 by having the MCOs rebrand and reissue their CHIP insurance ID cards to enable FQHCs and RHCs to indirectly identify CHIP enrollees, while remaining in compliance with state law. For example, Aetna did not write the word CHIP on its ID cards but rebranded the CHIP program by identifying it as Aetna Better Health Kids. When a family member presents the insurance ID card with this name, then the health centers know that the child is a CHIP enrollee.

In Pennsylvania, the $1.2 million in retroactive payments that the state made were based on insurance company data about CHIP encounters because health centers did not have the necessary data. Montana began processing PPS claims October 1, 2010, thereby discovering the unanticipated problems which prompted the state to apply for a CHIPRA PPS grant. All retroactive payments to Montana's FQHCs and RHCs were completed by June 30, 2012.

Another challenge occurred in California when the new payment system, which was activated at the end of September 2011, initially denied claims with service dates from October 1, 2009 through June 30, 2011, because of a change in administrative vendors and payment glitches in the system. In October 2011, California began using the state's Medicaid payment infrastructure to make interim PPS payments to FQHCs and RHCs serving CHIP enrollees. In March 2012, the new vendor ran an erroneous payment correction process based on timeliness edits to correct denied claims that had been submitted prior to March 2012. The California grantee reported that reconciliation payments (from October 1, 2009 through June 30, 2011) did not begin until October 2012.

Colorado made some retroactive payments but required legislative appropriations to pay the remainder, which was provided in January 2013. The state has been working with CMS on the approval of its 2-year timely filing waiver request, which will enable the state to pay the remainder of the retroactive claims due.

Michigan has paid all retroactive claims that FQHCs and RHCs have filed for MIChild beneficiary services. However, only 23 of 34 FQHCs and only 50 of 166 RHCs have submitted claims for retroactive payments.

Payments for Current Claims

The grantees took various approaches to paying current PPS claims. Effective January 2013, California transitioned all children from a separate CHIP to a Medicaid Expansion program; therefore, all FQHCs and RHCs in the state are currently receiving payment through the Medicaid PPS rate. Colorado did not begin paying PPS rates for FQHCs' and RHCs' current claims until July 2013. Pennsylvania reported it implemented the new PPS for FQHCs and RHCs in three stages: (1) payment reconciliation for PPS retroactive to October 1, 2009, through end of first CMS CHIP implementation grant period; (2) payment reconciliation for PPS from the end of the first CMS CHIP implementation grant period through late 2013, when new contracts with CHIP insurers required PPS payment rates for CHIP encounters provided by FQHCs and RHCs; and (3) on a go-forward basis. As of May 2014, Michigan reports it provides an estimated interim quarterly payment based on previous year information. In addition, FQHCs and RHCs in Michigan receive the additional balance of the Medicaid PPS rate in their initial, annual, and final settlements. The Iowa grantee reports it began processing current PPS claims July 1, 2013. Montana began processing PPS claims October 1, 2010; however, once the payment process began unanticipated problems were identified prompting the state to apply for a CHIPRA PPS transition grant.

IMPACT OF IMPLEMENTING THE PPS METHODOLOGY

Provider Payment Rates

Representatives of the FQHCs and RHCs in the six grantee states stated that they were satisfied with the new rates. Although the rates vary by FQHC and RHC, the payment for CHIP enrollees in Colorado increased on average by approximately $42 per encounter. In Michigan, where about 75 percent of CHIP enrollees are served by Blue Cross/Blue Shield (BCBS), the payment increased by approximately $50.

Representatives of FQHCs and RHCs also noted that the PPS ensures that FQHC and RHC costs are covered. Two said that it is important to view the PPS rate as a floor rather than a ceiling, so that FQHCs and RHCs have the option to negotiate higher rates if possible.

One grantee reported that an MCO operating in the state had to renegotiate its contracts with FQHCs and RHCs because of adopting the Medicaid PPS rate and that subsequently, several RHCs did not renew their contracts with the MCO.

In regard to the impact of increased payment rates on state budgets, if a state has a large CHIP population and the rates increase significantly, the change could have a large impact on the state budget. A Colorado respondent (*i.e.*, grant project director, key grant staff, or stakeholder) considered the PPS requirement to be an "unfunded mandate" that was difficult for the state to meet during a difficult budget time. However, in Michigan where CHIP enrollment is much lower than Medicaid—only 37,000 enrollees compared with nearly 1 million Medicaid enrollees—the state viewed the increased rates as having little impact on the state budget.

Changes in Scope and Access to Benefits

According to several respondents, it is not possible to assess the impact of adopting the PPS reimbursement methodology in CHIP given the limited scope of the grant, short time frame during which the PPS reimbursement methodology had been in effect, and difficulty in connecting a PPS rate change to concrete changes in benefits and access to benefits.

At this time, none of the states made changes or plan to make changes in the scope of CHIP benefits as a result of adopting the PPS reimbursement methodology. RTI, CMS' evaluation contractor, specifically asked the following questions:

- Did the new PPS rates lead to an increase or decrease in the number of FQHCs and RHCs serving CHIP enrollees?

- Did the new PPS rates lead to an increase or decrease in the number of CHIP enrollees receiving services from FQHCs and RHCs?

- What percentage of FQHCs' and RHCs' patients were CHIP enrollees before the new PPS rates were implemented? Did this percentage increase after implementation?

Some states responded that the new payment system had not been established long enough to see the impact, whereas others said that additional data and/or funds would be required

to conduct follow-up research. Several respondents mentioned that because FQHCs and RHCs do not market themselves to groups based on their insurance source, the new PPS rates would not necessarily lead to an increase or decrease in the number of CHIP enrollees receiving services from FQHCs and RHCs. They also did not think there would be an impact on the number of FQHCs and RHCs contracting with MCO networks in CHIP.

In regard to the effect of the new rates on access to care, a respondent in Michigan noted that one health plan serving CHIP enrollees has 25,000 participating physicians and hospitals, and there are only 32 FQHCs operating132 sites and 143 RHCs operating 154 sites. Given the relatively small number of FQHC and RHC providers in this large network, it is unlikely that this increase in rates would have a significant impact on access.

Two respondents noted that FQHCs and RHCs generally use increased revenue to increase capacity. For example, increased revenue could make it easier for FQHCs to sustain pediatric-focused services and sites—such as school-based clinics—with fewer grant dollars because they are receiving PPS reimbursement to cover their full costs.

One respondent noted that the implementation of Medicaid PPS payment methodology in the state led to a decrease in the number of CHIP enrollees using FQHCs and RHCs as a health care provider.

Questions regarding the impact of the new payment rates in California will be moot in the future, because the state started transitioning its separate CHIP in December 2012 to a Medicaid expansion, and CHIP enrollees have been transitioned into Medi-Cal HMOs.

CONCLUSION

The six states that received grants found it challenging to develop and implement a new FQHC/RHC PPS reimbursement methodology for their CHIP programs. Consequently, each of these states chose to use the established Medicaid PPS rates in its CHIP program, although a couple of states initially considered other options and one state uses an APM in addition to the Medicaid PPS rate. Integrating Medicaid and separate CHIP claims payment is not as easy as it would appear, because Medicaid and CHIP may have different benefits, managed care contracts, and provider payment rates. Although assessing the impact of the PPS on the CHIP program in grantee states is difficult at this point in time, none of the states made or planned to make changes in the scope of CHIP benefits or in access to benefits as a result of adopting the PPS reimbursement methodology.

Appendix A:
Report Methodology

The data sources for this report include grantees' applications and their quarterly, annual, and final reports submitted to CMS. We reviewed these reports and compiled a summary document for each grantee, documenting their goals, major activities, challenges, and outcomes. In each summary, RTI staff included questions to obtain additional information or clarifications of the reports' content. We e-mailed the summary to the grantee for review prior to a scheduled call to discuss their reports and to obtain additional information.

We also sent each grantee evaluation questions focused on the effect of the PPS on payment amounts, benefits provided, and the number of CHIP enrollees seen by health centers.

At their discretion, grant project directors included other key staff and stakeholders in the phone discussion, which lasted an hour on average. After each call, RTI staff revised the summary to incorporate information obtained through the telephone discussion and wrote up the response to the evaluation questions. Both the summary and write-up were sent to the grantee for review and further edits, if needed, to ensure accuracy. The individual grant summaries are in Appendix B of this report.

We also conducted phone interviews with staff from the associations representing FQHCs and RHCs as well as the association representing CHIP-contracted health plans or a health plan that serves a major portion of the CHIP population. Michigan and Pennsylvania do not have dedicated associations representing the interests of RHCs.

We sent these stakeholders several evaluation questions prior to the call, similar to those sent to the grantees. After each call the write-up of their responses was sent to them to review and edit, if needed, to ensure accuracy.

APPENDIX B:
GRANTEE STATE SUMMARIES

CALIFORNIA

At the time of this evaluation, the California grantee, the Managed Risk Medical Insurance Board (MRMIB), administered the Healthy Families Program, the state's separate CHIP. The MRMIB decided to use the state's current Medicaid PPS for FQHCs, RHCs, and IHCs participating in Healthy Families. The State Department of Health Care Services (DHCS) administers the Medicaid program and makes interim payments to providers through its Medicaid managed care program.

Goals

- To ensure that all 873 FQHCs and RHCs are compensated for their actual costs.
- To establish an interim payment rate for CHIP services.
- To successfully modify the payment system so that revenue flow is not interrupted.
- To validate auditing and reconciliation processes to verify that actual costs are fully paid and to avoid overpayments.

Activities

- Because of differences between Healthy Families and Medicaid, system modifications took longer than expected.
- MRMIB communicated with the California Primary Care Association (CPCA) and the health centers regarding the payment of PPS claims. CPCA worked with the grantee to develop cost estimates. The grantee's contractor (DHCS) holds quarterly meetings with CPCA and other stakeholders, and these meetings were used to both provide information and obtain their input.
- To develop the interim rates, each Healthy Families insurance plan provided data, including expenditure and visit data for the FQHC- and RHC-contracted clinics, which was used to validate the data that DHCS received from the health centers.
- The new system was activated at the end of September 2011 when clinics began submitting PPS claims, retroactively from October 2009, the effective date of the legislation.
- MRMIB requested a 12-month, no-cost extension of its grant because addressing the differences between CHIP and Medicaid and modifying the payment system took longer than initially anticipated. Although some work was completed by August 2011, additional time was needed to: (1) complete testing of all modified systems; (2) ensure that interim rate payments were correct and timely; (3) ensure timely reconciliation of incurred costs and revenue; and (4) ensure a consistent payment methodology by both CHIP and Medicaid for FQHCs and RHCs.

Challenges/Issues

- Because the DHCS changed administrative vendors, payment glitches occurred. For example, some claims were initially denied or held in suspense for various reasons (*e.g.*, claims in 2009 were received after the 1-year maximum billing limit). DHCS's

vendor, Affiliated Computer Services (ACS), ran an erroneous payment correction process in March 2012 to correct claims that had been submitted prior to March 2012 for these timeliness edits.

- When the Healthy Families PPS was set up, it did not include a separate billing code for dental services. DHCS and MRMIB worked with the vendor to implement a process in which clinics can claim dental services via the Healthy Families PPS system.

Outcomes

- MRMIB is using DHCS's payment system infrastructure to make interim payments to FQHCs and RHCs serving Health Families enrollees. PPS payments to FQHCs and RHCs began in October 2011.
- Reconciliations did not begin until October 2012 for the period of October 1, 2009, through June 30, 2011.
- Effective January 1, 2013, the state transitioned all children from a separate CHIP to a Medicaid Expansion. All FQHCs and RHCs in the state are currently receiving payment through the Medicaid PPS rate.

COLORADO

Colorado's combination CHIP, marketed as Child Health Plan *Plus* (CHP+), contracts with five MCOs to provide services throughout the state. All 15 of the state's FQHCs contract with one or more of the MCOs, and most of the state's 53 RHCs also contract with the MCOs. The state also has an MCO for dental services. Both children and pregnant women without access to an MCO, are enrolled in the state's self-funded Managed Care Network.

Prior to the enactment of CHIPRA, MCOs paid individually-negotiated fee-for-service rates to all providers with whom they contracted, including FQHCs and RHCs serving CHIP enrollees. Complying with the PPS requirement necessitated a significant change in how CHP+ reimbursements were made, including the development of a "wraparound" payment, which makes up the difference between the MCO payment and the FQHC and RHC payment required under the PPS.

Goal

- To develop an APM, PPS *Plus*, that would provide incentives to FQHCs and RHCs including the coordination of care to enable improved outcomes.

Activities

- The grantee, the Colorado Department of Health Care Policy and Financing (HCPF), executed a contract with JSI Research to: (1) identify options for transitioning to the APM; (2) develop a process for paying FQHCs and RHCs wraparound and incentive payments; (3) identify, assess, and propose solutions to potential transition challenges; and (4) facilitate stakeholder collaboration in the project.
- HCPF engaged in extensive outreach to all entities that would be affected by the new APM.
- JSI researched and produced several reports to inform the project:
  - *Research and Review Report*, February 14, 2011
  - *Stakeholder Summary Report*, February 14, 2011
  - *Gaps and Options Report*, February 22, 2011
  - *Methodology for PPS Plus Payments for CHP+ Services Provided by FQHCs and RHCs*, May 25, 2011
  - *Data Collection Pilot Findings and Implications*, January 30, 2012
- HCPF awarded competitive mini-grants to FQHCs, RHCs, and MCOs to help build the infrastructure to support the transition to the APM.

Challenges/Issues

- Coming to agreement on how the PPS encounter rate will be paid has been difficult, either as a wrap payment by the Department to the health centers or a direct payment from the MCO to the health centers. Traditionally, CHP+ MCOs paid FQHCs and RHCs a fee-for-service rate.
- Legislative appropriations were required for retroactive payments, and the new rates have had a significant impact on the state's budget.

Outcomes

- The FQHCs, RHCs, and MCOs agreed that the administrative burden of implementing a value-based methodology outweighed the potential incentives, given the small number of CHP+ enrollees they serve.
- Reconciliation payments to FQHCs/RHCs (*i.e.,* retroactive payments) began in June 2012 and totaled $1.6 million.
- Currently, the MCOs pay the FQHCs and RHCs on a fee-for-service basis and the state makes the FQHCs and RHCs whole using the reconciliation process. In December 2013, the state's SPA was approved for the payment methodology, and some reconciliations are waiting for approval of a good cause waiver request.
- At the state's last report in May 2014, the state projects full implementation of the CHP+ MCOs paying the FQHCs and RHCs the PPS rate at the time of service this year.

MICHIGAN

Michigan's CHIP program, MIChild, covers services provided through nine licensed HMOs and one licensed PPO contracted with the Michigan Department of Community Health (MDCH). Medicaid and CHIP are administered by the same agency, the Medical Services Administration, a division of MDCH.

The state has 32 FQHCs that operate 132 certified sites and 143 RHCs that operate 154 certified sites. Before the PPS was mandated for CHIP, the contracted health plans reimbursed FQHCs and RHCs on either a fee-for-service or capitation basis. For FQHCs and RHCs in the provider's network, this rate was considered payment in full.

Goals

- Implement a PPS rate for the MIChild program.
- Incorporate the MIChild PPS rate and the payment reconciliation process for FQHCs and RHCs in the same manner as is done for the Medicaid PPS rate.
- Successfully identify and convert the MIChild managed care plan's encounter detail to a MIChild per-visit FQHC and RHC rate.
- Establish a schedule for encounter detail submissions, enabling staff to incorporate the Medicaid and MIChild PPS rates into one report. Modify the contracts with the 10 MIChild MCOs providing services to CHIP enrollees through FQHCs and RHCs in their provider network to receive the PPS wraparound payment.
- Increase the number of MIChild enrollees enrolled with FQHCs and RHCs as their primary health care provider.

Activities

- The state decided to use the Medicaid PPS rate in CHIP.
- The project included a large number of information technology, contract, administrative, and policy changes, including the submission of a SPA to CMS.
- While awaiting CMS approval of CHIP SPA, the state's audit staff was doing work needed to reduce the backlog of MIChild settlements and update the MIChild interim payments so that they could be paid as soon as the SPA was approved.

Challenges/Issues

- Staff turnover during the first three-quarters of the grant year.
- Delays in the implementation of new servers and in the time needed for CMS's approval of the SPA.
- There was not enough time built-in the project schedule to allow for problems and issues encountered during the project period.

Outcomes

- All IT goals were achieved, although the grantee needed a no-cost extension of the grant to address server problems.
- The state lacks baseline data to determine whether the following outcomes occurred after the PPS implementation: (1) a change in the number of FQHCs and RHCs in the contracted MCOs' networks, (2) a change in the number of MIChild enrollees assigned to

an FQHC or RHC acting as the primary care provider, and (3) a change in the number of encounters with MIChild enrollees.

- Twenty-three of 34 FQHCs and 50 of 166 RHCs have filed for MIChild retroactive payments and all have been paid.
- The state increased payment amounts to FQHCs and RHCs.
- Looking back on the grant process, the grantee stated that there was significantly more work involved with the implementation of PPS for FQHCs and RHCs than they had anticipated.

PENNSYLVANIA

Pennsylvania's CHIP program covers almost 200,000 children through commercial MCOs. The state has 36 Section 330-funded health centers and 6 FQHC Look-Alike Centers with more than 200 service delivery sites. Pennsylvania's Medicaid program recognizes 44 FQHC business entities operating at 183 separate sites and 29 RHC business entities operating at 57 different sites. All FQHCs use the same Medicaid PPS rate at every site, whereas many RHCs' PPS rates differ by site. (The different rates may be based on differences in the type of services provided at the different sites.). The state has a combination of commercial and Medicaid insurers. At the beginning of the grant period, the grantee had no data on how many FQHCs and RHCs were providing services to CHIP enrollees and no information on the rates that they were being paid by MCOs.

Project Goal

- To develop and document a CHIP PPS or APM compliant with the requirements of CHIPRA/BIPA, which includes both interim and wraparound payments.

Project Activities

- The Pennsylvania Insurance Department (PID), the grantee, contracted with Mercer Government Human Services Consulting, an actuarial firm, to develop and document a PPS or APM for Pennsylvania CHIP.
- PID also contracted with the Pennsylvania Association of Community Health Centers (PACHC) to provide outreach and education to the FQHCs and RHCs and facilitate discussions about data collection, payment reconciliation, and policy development among the FQHCs, RHCs, and CHIP MCOs.
- PID provided training and other assistance to the staff of PACHC on the processes and software developed during the grant. PACHC staff then facilitated discussions between individual FQHCs and RHCs and CHIP insurance contractors about the encounter and payment calculations that the contractors make as part of the state's CHIP PPS methodology.
- PID also developed computer-based training materials for state CHIP program staff and the MCOs.

Challenges/Issues

- It was difficult to identify, track, and report on services provided to CHIP enrollees.
- PID conducted a pilot survey to examine several billing data issues and found that: (1) the FQHCs and RHCs were unable to identify total payments received from the CHIP MCOs for CHIP-related encounters and (2) the process to identify CHIP encounters and payments made to the FQHCs and RHCs by the CHIP MCOs took significant resources and time.
- Many discrepancies were found with Medicaid and CHIP data reported by FQHCs and RHCs with data from the MCOs. Considerable time was needed to create a master list with all of the required information. Many of the discrepancies may be based on the lack of an insurance card that identified CHIP enrollees until the grant project.
- The biggest challenge was reconciling the different accounting capabilities of the MCOs and the FQHCs and RHCs.

- Staff members at many FQHCs and RHCs did not understand the CHIPRA PPS mandate despite outreach and educational efforts by PCHCA.
- The methods used by Medicaid to accurately count encounters by FQHCs and RHCs resulted in some loss of details about the services rendered. This result conflicts with the objective of having accurate, detailed service data to support quality measures and program integrity efforts.
- The state encountered more exceptions and discrepancies as implementation continued. For example, some RHCs participate in Medicare but not Medicaid and so do not have Medicaid PPS rates. Also, Medicaid changes in PPS rates occur at times other than the beginning of calendar quarters while the state's CHIP assumed that Medicaid PPS rates would be constant during a calendar quarter.
- The grantee anticipates that additional issues will arise as CHIP fully implements the PPS mandate. The many data issues required a redesign of the system used to calculate and make payments, and the grantee was awarded a second PPS grant to do the redesign.

Project Outcomes

- The state adapted the Medicaid PPS methodology for CHIP payments to FQHCs and RHCs, taking into account differences between the programs (*e.g.*, in the type of services covered) and the cost-effectiveness of modifications.
- The state also developed and documented an efficient and cost-effective process to determine the need for wraparound payments to each FQHC and RHC.
- The grantee conducted a survey of 78 FQHC and RHC sites about their experience with the new PPS and their views regarding its effects, but only 17 responded.

PENNSYLVANIA (Second Grant Award)

Pennsylvania operates a separate CHIP (Pa CHIP). Pennsylvania was originally awarded $500,000 in grant funds during the original round of grant awards. The state used the first round of grant funding to procure the services of an actuarial firm to develop the PA CHIP PPS methodology, the policies and procedures for collecting the relevant information, the specifications for the software to receive the relevant information, and to calculate both the CHIP encounter rates and any shortfall payments to each FQHC and RHC. In addition, Pennsylvania used some of the grant funds to partner with Pennsylvania Association of Community Health Centers (PACHC) to provide outreach and education to the FQHCs and RHCs and to facilitate discussions with these organizations about the PA CHIP PPS methodology and rates. The state also used grant funds to replace the current PA CHIP identification cards with cards that include a CHIP indicator for easy identification for FQHC and RHC office staff.

Goals

- To obtain IT professional services to develop a new computer system to implement the Pa CHIP PPS methodology that incorporates appropriate policies and procedures for collecting the relevant information from Pa CHIP insurance contractors, the Pa Medical Assistance program, and FQHCs and RHCs.
- To calculate the aggregate Pa CHIP encounters and reimbursement by date of service each calendar quarter and federal fiscal year for every FQHC and RHC; calculate any appropriate interim and final Pa CHIP supplemental PPS payments to be paid to each FQHC and RHC; and maintain records of the data and algorithms used to make each interim and final calculation of each Pa CHIP supplemental PPS payment.
- To enable PACHC to provide outreach and communication services for Pennsylvania FQHCs and RHCs, as well as assist Pa CHIP and its IT team in the development and implementation of the new IT system.

Activities

- PA CHIP contracted with the Department of Public Welfare (DPW), for IT services to develop a more robust system for calculating PPS payments to FQHCs and RHCs, such as tracking changes in PA Medical Assistance Rates.
- PA CHIP also continued its contract with PACHC, to provide outreach, education and facilitation services to assist FQHCs and RHCs during the development and transition to the PA CHIP PPS or APM.

Challenges/Issues

- Ongoing challenges faced from the influx of Affordable Care Act related initiatives prompting various business process enterprise information system changes that must be identified and prioritized accordingly.
- Transitioning business and system knowledge from departing to incoming staff because of the CMS grant expiration on June 30, 2013.
- Maintaining an updated contact list of FQHC and RHC personnel, due to the changes in staffing and the changes in ownership/affiliations, particularly RHCs.

Project Outcomes

- DPW and MCO Data Management including organization, contact and PPS rates. The new system allows a centralized location for all MCO, FQHC, and RHC contact and billing information. The new system houses the current PPS rates for each FQHC and RHC as well. The DPW has also specified data input and management roles within the new system for PID and MCOs.
- Encounter and Payment Data Management including: PPS reporting schedule automation to manage MCO quarterly submissions and the data collection screens used by MCOs for the input of their encounter and payment information.
- DPW generated and distributed FQHC and RHC Summary Reports, Wrap Payment Calculation Summary, Assignment Tracking, and Invoice Tracking. Payments to MCOs were calculated and made for services in FFYs 2010 and 2011.
- The PID reviewed and analyzed the use of "payment templates" and other means of designating MCO payment responsibility for the new CHIP PPS System.
- Payment data dispute tracking: Quarterly PPS reimbursement amounts owed/paid are being tracked in order to determine over/underpayments for possible recoupment purposed and/or to augment future payment amounts.
- PACHC continues to assist PID with getting permission from their individual members to include the FQHCs and RHCs as a contact, which allows the FQHC or RHC the ability to continue to receive the FQHC or RHC contact templates for updating their profile in the new system.
- The grantee reports the new system was slated to go live in June 2014.
- PPS payments have been made using the old system and these payments have helped to ensure CHIP enrollees continue to receive health care services at FQHCs and RHCs.

IOWA

Iowa has a combination CHIP comprised of Medicaid expansion and a separate program called Healthy and Well Kids in Iowa (*hawk-i*). Between the two components, there are approximately 63,000 children currently enrolled. While Iowa Medicaid enrolls FQHCs and RHCs as providers and pays for services on an encounter basis, the commercial plans participating in the *hawk-i* program contract directly with individual or group providers for the provision of services and pay based on claims submitted on a fee-for-service basis. Fees are negotiated between the plans and providers and are not based on the Medicaid fee schedule.

Goals

- To contract for the services of an actuary to develop an APM compliant with the provision.
- To calculate an encounter rate for each FQHC and RHC site, as well as any needed supplemental payments by the state to the FQHCs and RHCs.
- To analyze and potentially implement *hawk-i* health plan system changes that will be required once the PPS methodology is determined.
- To develop and document the method the *hawk-i* program should use to calculate any shortfall between the total payments to each FQHC and RHC site for all services provided by that FQHC and RHC site to children while they are covered by the *hawk-i* program.
- To develop a database capable of calculating and storing the shortfall, if any, for each FQHC and RHC site during at least a calendar quarter and calendar year.
- To develop and document the appropriate process to be used to further adjust CHIP payments to an FQHC and RHC if Iowa Medicaid's PPS rates are adjusted after a payment has been made by the CHIP program during a specific period, in order to make aggregate CHIP payments consistent with the CHIP PPS rate methodology.

Activities

- The grantee worked with a contractor (Milliman) to determine the methodology to identify *hawk-i* FQHC and RHC visits and then to calculate the adjusted Medicaid equivalent PPS rates.
- Milliman developed an implementation plan that identified the annual process for applying the rate-setting methodology, the data/ reports needed annually, the parties responsible for providing and collecting data annually, and timeframes for completing tasks.
- Instead of adopting the APM developed by the contractor, both health plans proposed alternative methodologies. United Healthcare indicated they would prefer to adopt and pay established Medicaid encounter rates instead of the proposed APM, while WHPI determined that they would like to continue to pay on a fee-for-service basis and complete quarterly supplemental payments to any FQHCs or RHCs that were not paid at least equal to the Medicaid encounter level.

Challenges/Issues

- Determining the methodology to develop a Medicaid equivalent PPS rate. Essentially, determining how *hawk-i* health plan claim payments to FQHCs/RHCs would be

compared and equated to Medicaid encounter payments as this process has not been done before by the program.

- Obtaining data from one of the two *hawk-i* health plans that was needed to complete a cross-walk exercise identifying *hawk-i* visits at FQHCs and RHCs. Ultimately, the needed data was obtained and the contractor was able to identify *hawk-i* visits to FQHCs and RHCs serving as one of the first steps in the methodology used to determine Medicaid equivalent PPS rates.
- Both plans had a different preference for moving forward with implementation and both were different from the original methodology proposed by Milliman.
- It is administratively difficult to determine which patient was under which health plan in order to apply the two different methodologies appropriately. In hindsight, the grantee would have required both health plans to use the same methodology.

Project Outcomes

- By the end of the grant, both *hawk-i* health plans were in the process of implementing the reimbursement changes required by CHIPRA.
- The grantee amended the state plan and prepared to submit to CMS after receiving the needed approvals from the FQHCs and RHCs.
- Determined health plan preferences for moving forward:
    - United Healthcare adopted existing Medicaid encounter rates.
    - Wellmark Health Plan of Iowa (WHPI) continued to pay on a fee-for service basis and complete quarterly supplemental payments to any FQHC or RHC that were not paid at least the Medicaid PPS level.
- The grantee reported that because of the new PPS methodology, United Healthcare had to re-contract with FQHCs and RHCs, but because of the new methodology several RHCs did not renew their contracts.
- The new PPS methodology led to a decrease in the number of CHIP enrollees using FQHCs and RHCs enrolled in the United Healthcare Plan. No changes, in the number of CHIP enrollees, were reported for WHPI.

MONTANA

Montana's separate CHIP funded program, Healthy Montana Kids (HMK), housed in the Montana Department of Public Health and Human Services (DPHHS), proposed to improve its PPS. In October 2010, HMK implemented a PPS based upon its Medicaid reimbursement methodology for paying FQHCs and RHCs as required by the CHIPRA. Time and experience have provided an opportunity for the state to evaluate how this PPS affects the children served and the providers relied upon for those services.

Goals

- To make improvements to the HMK PPS methodology by updating the Medicaid Management Information System (MMIS) to process HMK claims for FQHCs correctly and efficiently.
- To set up new auditing and reconciliation processes for program integrity with assistance from Montana DPHHS utilization and auditing staff including requesting additional reports from Blue Cross Blue Shield of Montana (BCBSMT), HMK's third party administrator
- To evaluate the need for a cost-reporting system separate from the Montana Medicaid's system for RHCs.
- To invest in a decision support system/data warehouse (DSS/DW) tool and programmed reports for program integrity purposes.

Activities

- Contracted with ACS to make system changes to the MMIS ensuring HMK providers are paid appropriately and the system issues were corrected.
- Montana contracted with Deloitte to program the eligibility system DSS/DW, called Montana-BEAR (MT-Bear). Deloitte was also the contractor completing the new integrated eligibility system, CHIMES-EA.
- Design sessions for the reporting system MT-Bear took place in March 2013.
- Data Warehouse and preliminary reports were completed by June 2013.
- A detailed programming plan was delivered and approved by DPHHS and all programming was completed by June 19, 2013.

Challenges/Issues

- A department re-organization was announced shortly after Montana submitted the grant application for this project. There were changes in management, departmental structure and some of the support positions available to assist with the grant were eliminated.
- Major variation from the original timeline: the updates to the MMIS were scheduled to be completed by September 1, 2012, but were not delivered until June of 2013.

Project Outcomes

- Benefit plan updates in MMIS were completed in June 2013. These updates allowed for payment for circumcisions, mental health visits, family planning, services for infants born to teen moms enrolled in HMK, and the ability to pay for vaccinations in MMIS instead of requiring providers to bill BCBSMT for those vaccines and MMIS for the office visit at FQHCs/RHCs.
- The DPHHS determined that the CHIP claims did not need their own cost reporting system.

- Shortly after the beginning of the grant project, BCBSMT began sending quarterly reports of all claim lines to DPHHS. This is significant because the DPHHS has never had direct access to BCBSMT's claim system before the new reports were received.
- The DPHHS was able to institute some new payment and auditing procedures that reduced the chance for double payment to providers.
- The new MT-Bear reporting system allows DPHHS to identify children enrolled in both CHIP and Medicaid. This allows cross-checking with BCBSMT claims to prevent double payments. It also allows the department to make sure that HMK is not being charged for Medicaid-only services.
- The goal of Montana's project is the improvement of both the PPS payment system and eligibility reporting systems for HMK. Claims data for HMK PPS will continue to be analyzed to determine if the reimbursement system is working appropriately.
- Dual enrolled children's claims are also being analyzed for proper payment.
- The BCBSMT's reports for non-RHC and non-FQHC claims helped to establish a more robust auditing and reconciliation procedures.
- Baseline vaccine expenditure reports have been requested from BCBSMT to compare with FQHC and RHC institutional claims. With the update to the MMIS, this opportunity for overpayment has been eliminated.
- The first version of MT-Bear was completed in June of 2013. MT-Bear includes eligibility information for four Montana public assistance programs: Medicaid and its associated waivers, CHIP, Temporary Aid to Needy Families, and SNAP. This version includes all basic demographic data for enrollees, information about eligibility and enrollment activities for all associated programs, and enrollment reports for the CHIP-specific extended dental and extended mental health programs.
- MT-Bear continues to be updated in an ongoing process and the state continues to propose additions for each new version of MT-Bear.