

**Schedule 13  
Funding Request for the 2012-13 Budget Cycle**

Department: Health Care Policy and Financing

Request Title: Federally Mandated CHP+ PPS Payments to FOHCs and RHCs

Priority Number: S-11

Dept. Approval by: John Bartholomew *JTB 12/20/11* Date

OSPB Approval by: Erin M. Baker *12/27/11* Date

Decision Item FY 2012-13  
 Base Reduction Item FY 2012-13  
 Supplemental FY 2011-12  
 Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
Fund		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
<b>Total of All Line Items</b>	<b>Total</b>	\$213,086,149	\$1,650,176	\$187,766,874	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$29,551,808	\$0	\$25,066,119	\$0	\$0
	GFE	\$446,100	\$0	\$446,100	\$0	\$0
	CF	\$44,582,245	\$577,562	\$40,206,188	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$138,505,996	\$1,072,614	\$122,048,467	\$0	\$0
<b>(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs</b>	<b>Total</b>	\$213,086,149	\$1,650,176	\$187,766,874	\$0	\$0
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Letternote Text Revision Required? Yes:  No:  If yes, describe the Letternote Text Revision:  
 Of this amount, \$28,727,097 \$29,266,985 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., \$12,389,580 \$12,427,254 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., \$461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and \$1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A), Children's Basic Health Plan Trust Fund (11G); FF: Title XXI.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes:  No:  Not Required:

Schedule 13s from Affected Departments: N/A.

Other Information:



DEPARTMENT OF  
HEALTH CARE POLICY AND FINANCING

*FY 2011-12 Supplemental Request  
January 3, 2012*

*John W. Hickenlooper  
Governor*

*Susan E. Birch  
Executive Director*

*Department Priority: S-11*

*Request Title: Federally Mandated CHP+ PPS payments for FQHCs and RHCs*

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Federally Mandated CHP+ PPS Payments	\$1,650,176	\$0	0

**Request Summary:**

The Department is requesting to increase funding to the Children's Basic Health Plan Medical and Dental Costs line item in FY 2011-12 in order to comply with federal regulations requiring that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) receive certain reimbursement for services provided to CHP+ clients. The Department is requesting one-time funding of \$1,650,176 total funds in FY 2011-12, of which \$539,888 is cash funds from the CHP+ Trust Fund, \$37,674 is cash funds from the Hospital Provider Fee and \$1,072,614 is federal funds. This funding is necessary to make the required retroactive payments back to the effective date of the federal regulation. Beginning in FY 2012-13, the Department will implement a budget neutral reimbursement methodology that complies with federal requirements.

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) created a new section 1902(bb) in the Social Security Act that requires Medicaid programs to make payments for FQHC and RHC services in an amount calculated on a per-visit basis. This reimbursement methodology is called a prospective payment system (PPS) and requires reimbursement to be set at 100% of the clinic's average cost of providing covered services during certain "base years." These rates are then adjusted annually by a health care costs index. States may also implement an alternative

payment system that reimburses FQHCs and RHCs at or above the PPS rate specified in BIPA.

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended section 2107(e)(1) of the Social Security Act to make section 1902(bb) applicable to CHIP effective October 1, 2009. The Department is thus required to pay FQHCs and RHCs the BIPA PPS rate (or an agreed-upon alternative payment system) for CHP+ services provided from October 1, 2009 forward.

When this federal regulation was passed, the Department received a grant from the Centers for Medicare and Medicaid Services to develop an alternative payment system that would have included incentive payments for FQHCs and RHCs based on health outcomes. After multiple discussions, the Department was unable to reach an agreement with FQHCs and RHCs on an incentive-based alternative payment system. Consequently, the Department is implementing the BIPA PPS rates for FQHCs and RHCs.

Due to the various agreed upon reimbursement levels currently in place between the CHP+ Managed Care Organizations (MCOs) and the FQHCs and RHCs, some of which are above the BIPA PPS rate and some of which are below, the Department anticipates that the future prospective payment methodology would have no net impact on the CHP+ budget. The Department will

implement the BIPA PPS rates going forward beginning in FY 2012-13, and all necessary changes resulting from this new reimbursement methodology will be incorporated into the FY 2012-13 rate setting and contracting processes.

The Department is requesting funding in FY 2011-12 to make retroactive payments to FQHCs and RHCs for services provided between October 1, 2009 and June 30, 2012. Because the Department cannot adjust reimbursement policy for services provided during this retroactive period, the Department has no way of making the retroactive reimbursement budget neutral- this can only be done by decreasing payments where the encounter rate exceeds the BIPA PPS in order to increase those where the payment is less than the BIPA PPS minimum.

The Department has estimated the retroactive payments based on newly available data on FQHC and RHC services. The Department estimates that the total aggregate retroactive payments due to FQHCs and RHCs are \$1,650,176 total funds. Once the retroactive payments are made, the Department does not anticipate a need for any additional funding resulting from this request.

**Anticipated Outcomes:**

The approval of this proposal would result in reimbursement to FQHCs and RHCs for CHP+ services that complies with existing federal regulations.

**Assumptions for Calculations:**

Please see Appendix A for the Department's assumptions and calculations for this request.

**Consequences if not Funded:**

This request is for funding to implement federally mandated changes. If this request is not funded, federal financial participation in CHP+ will be at risk. The Department's FY 2011-12 appropriation includes \$141,179,458 federal funds for CHP+.

**Relation to Performance Measures:**

*Federal mandate.*

**Cash Fund Projections:**

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	\$43,062,875	\$426,069,052
FY 2010-11 End of Year Cash Balance	\$7,745,026	\$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	\$9,332,096	\$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	\$8,036,989	\$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	\$6,924,385	\$22,198,436

**Supplemental, 1331 Supplemental, or Budget Amendment Criteria:**

New data on FQHC and RHC services provided in CHP+ has become available which allows the Department to estimate the retroactive payments from paying BIPA PPS rates on a per-encounter basis since October 1, 2009.

**Current Statutory Authority or Needed Statutory Changes:**

The federal Children's Health Insurance Program is established in the Social Security Act, Title XXI (42 U.S.C. 1397aa et seq.) and amended by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

42 U.S.C. 1397GG (e)(1)(E) applies Medicaid law at 42 U.S.C. 1396a (bb) relating to payment for services provided by Federally-qualified health centers and rural health clinics to CHP+.

25.5-8-101 C.R.S. (2011) et seq. authorizes the Children's Basic Health Plan.

## **Appendix A: Assumptions and Calculations for this Request**

### **Detailed Background**

Prior to 2001, federal law required State Medicaid programs to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) based on reasonable costs. States were allowed to establish their own definition of “reasonable costs” based on Medicare regulations and cost reports. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) changed the payment requirements for FQHCs and RHCs. Section 702 of BIPA (“New Prospective Payment System For Federally-Qualified Health Centers and Rural Health Clinics”) created section 1902(bb) in the Social Security Act (the Act). This section requires Medicaid programs to make payments for FQHC and RHC services using a prospective payment system (PPS). Unlike a cost-based reimbursement system, a PPS establishes a provider’s payment rate for a service before the service is delivered; the rate is not dependent on the provider’s actual costs or the amount charged for the service. The Medicaid PPS specified in section 1902(bb) is determined separately for each individual FQHC or RHC (calculated on a per-visit basis) using 1999 and 2000 as the baseline period. These rates do not include any adjustment factors other than a growth rate to account for inflation (Medicare Economic Index) and any change in the scope of services furnished during that fiscal year. Medicaid programs may also develop an alternative payment methodology that reimburses at least at the BIPA PPS rates for FQHC and RHC services.

Section 503 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended section 2107(e)(1) of the Act to make section 1902(bb) of the Act applicable to CHIP in the same manner as it applies to Medicaid. This payment provision became effective October 1, 2009. As outlined in State Health Official Letter #11-004 released by the Centers for Medicare and Medicaid Services (CMS) on February 4, 2010, any States that did not implement this payment methodology by its effective date must make retroactive payments to FQHCs and RHCs based on the BIPA PPS rates back to that date.

When this regulation was passed, the Department considered it an opportunity to implement an alternative payment system that would improve the quality of health care provided by FQHCs and RHCs and contain costs for services provided in CHP+. The Department received a grant from CMS to develop an alternative payment system that would have included incentive payments for FQHCs and RHCs based on health outcomes. After multiple discussions, the Department was unable to reach an agreement with the FQHCs and RHCs on an incentive-based alternative payment system. Consequently, the Department is implementing the BIPA PPS rates for FQHCs and RHCs in CHP+.

The Department does not contract directly with FQHCs and RHCs for CHP+, rather it contracts with several managed care organizations (MCOs) which subcontract with providers, including FQHCs and RHCs, to provide services to clients. The Department is currently in the process of coordinating with these MCOs to implement the BIPA PPS rate for each of their subcontracted FQHCs and RHCs going forward. The Department will implement contractual arrangements to ensure these rates are paid to FQHCs and RHCs beginning on July 1, 2012 so that retroactive payments will not be necessary after FY 2011-12.

### **Retroactive Payments to Providers**

With newly available data, the Department’s contracted actuary has calculated the number of encounters and the payments received by FQHCs and RHCs for these encounters. Due to varying payment

arrangements between MCOs and FQHCs and RHCs, some payments for individual encounters were below the BIPA PPS rate for that FQHC or RHC, while others were above the rate. Per the federal regulations in section 1902(bb) of the Act described above, the Department must ensure that FQHCs and RHCs receive *at least* the BIPA PPS rate for each encounter. As a result, for the retroactive payments, the Department has omitted from its calculations any encounters for which FQHCs and RHCs received a payment greater than the BIPA PPS rate. Table 1 below summarizes the data provided by the CHP+ actuary.

Number of FQHCs and RHCs	Total Number of Encounters	Total Paid to FQHCs and RHCs	Total BIPA PPS Encounter Payments	Net Due to Providers
46	16,054	\$1,921,316	\$2,697,695	\$776,379

While the available data includes some encounters through October 2011, it is not a complete list of all FQHC and RHC encounters through that date. The Department has taken this into account in its projection of the total retroactive payments for services provided through June 30, 2012. The Department assumes that the utilization and payment patterns in the data would not change significantly by June 30, 2012. Table 2 below summarizes the Department's estimated retroactive payments by year.

FY 2009-10*	FY 2010-11	FY 2011-12	TOTAL
\$449,150	\$600,514	\$600,512	\$1,650,176

\* Includes 9 months of payments as the regulation is effective October 1, 2009.

The Department is thus requesting \$1,650,176 total funds to make retroactive payments to FQHCs and RHCs for services provided up to FY 2012-13, when the Department will implement BIPA PPS rates going forward. The Department will receive the same 65% federal financial participation it receives for all other CHP+ premiums expenditures to make these retroactive payments. Thus, \$1,072,614 of the total funds requested would be federal funds. Since CHP+ families with incomes between 206% of the Federal Poverty Level (FPL) and 250% FPL are funded through the Hospital Provider Fee implemented in May 2010 pursuant to HB 09-1293, the Department assumes that a proportion of these retroactive payments would have the same funding source. Using historical caseload data and the caseload forecast from its November 1, 2011 FY 2012-13 Budget Request, R-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," the Department estimates that 6.5% of the total CHP+ caseload is between 205% and 250% FPL for the retroactive period of October 2009 through June 2012. Hence, the Department assumes that 6.5% of the state's share of retroactive payments, or \$37,674, would be funded through the Hospital Provider Fee. Since CHP+ families with incomes below 206% FPL are funded through the CHP+ Trust Fund, the Department assumes that the remaining portion of the state's share of retroactive payments, \$539,888, would also be from the CHP+ Trust Fund.

### **Implementation of BIPA PPS Going Forward**

While the Department pays each CHP+ MCO a monthly capitation for enrolled clients, it does not control the level of reimbursement from MCOs to each provider. MCOs may reimburse different providers, including different FQHCs and RHCs, varying rates for the same services. According to the data from the Department's actuary, actual reimbursement amounts calculated on an encounter basis vary widely. In fact, the total reimbursement received by FQHCs and RHCs for all encounters (including reimbursements above the BIPA PPS rate) is significantly higher than what it would be if BIPA PPS rates were paid for all encounters. When all encounter and payment data available from the CHP+ actuary for services provided

by FQHCs and RHCs from October 2009 through October 2011 is aggregated, FQHCs and RHCs were actually reimbursed an estimated \$1,000,000 above the BIPA PPS rates. Since the available data is not an exhaustive account of all encounters over this time period, the actual aggregated payments for this two year time period may be even greater than this initial estimate. This suggests that the capitation payments the Department has made to MCOs have allowed them, on average, to reimburse FQHCs and RHCs at a rate above the BIPA PPS rate. As a result, the Department is working towards a budget neutral implementation of BIPA PPS rates going forward.

Since CHP+ is a separate state CHIP program rather than a Medicaid expansion or combination program, the Department has additional flexibility in implementing BIPA PPS rates. Federal CHIP regulations, for example, do not define "encounters" nor include a definition of the scope of services for FQHCs and RHCs. In order to implement its payment methodology going forward, the Department will amend its contracts with MCOs to ensure that each FQHC and RHC receives the BIPA PPS rate at the time of service. At the same time, the Department will work with its CHP+ actuary so that capitation rates for FY 2012-13 forward reflect the BIPA PPS rates. The Department has been in continued conversations with the CHP+ MCOs and FQHCs and RHCs regarding the implementation of BIPA PPS rates going forward beginning in FY 2012-13. Once implemented, the Department would provide FQHCs and RHCs and MCOs with a list of BIPA PPS rates for CHP+ services on an annual basis, adjusted by the Medicare Economic Index as specified in 1902(bb)(3)(A) of the Act.