

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Federally Mandated CHP+ PPS Payments True-up

Priority Number: S-15

Dept. Approval by: John Bartholomew *JB* 12/31/12 Date

OSPB Approval by: [Signature] 12/31/12 Date

<input type="checkbox"/>	Decision Item FY 2013-14
<input type="checkbox"/>	Base Reduction Item FY 2013-14
<input checked="" type="checkbox"/>	Supplemental FY 2012-13
<input type="checkbox"/>	Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	\$182,543,053	\$9,020,710	\$133,286,320	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$21,787,355	\$2,795,899	\$20,781,279	\$0	\$0
	GFE	\$441,600	\$0	\$441,600	\$0	\$0
	CF	\$42,220,291	\$361,350	\$26,007,927	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$118,093,807	\$5,863,461	\$86,055,514	\$0	\$0
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	\$182,543,053	\$9,020,710	\$133,286,320	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$21,787,355	\$2,795,899	\$20,781,279	\$0	\$0
	GFE	\$441,600	\$0	\$441,600	\$0	\$0
	CF	\$42,220,291	\$361,350	\$26,007,927	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$118,093,807	\$5,863,461	\$86,055,514	\$0	\$0

Letternote Text Revision Required? Yes: No: If yes, describe the Letternote Text Revision:

FY 2012-13: Of this amount, \$31,053,239 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1), C.R.S., ~~\$10,945,416~~ \$11,306,766 shall be from the Hospital Provider Fee Cash Fund created in Section 25 5-4-402.3 (4), C.R.S., \$221,386 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 COPRS Fund Number: CF: Children's Basic Health Plan Trust Fund 11G, Health Care Expansion Fund 18K, Hospital Provider Fee Cash Fund 24A and Colorado Immunization Fund; 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

John W. Hickenlooper
Governor

*FY 2012-13 Supplemental Request
January 2, 2013*

Susan E. Birch
Executive Director

Barbara Wilson for Sue Birch 12/31/12
Signature Date

*Department Priority: S-15
Federally Mandated CHP+ PPS Payments True-up*

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Federally Mandated CHP+ PPS Payments True-up	\$9,020,710	\$2,795,899	0.0

Request Summary:

The Department is requesting to increase funding to the Children's Basic Health Plan Medical and Dental Costs line item by \$9,020,710 in FY 2012-13. This is necessary for the Department to comply with federal regulations requiring that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are reimbursed for services provided to CHP+ clients according to a prospective payment system (PPS). The Department requested \$1,650,176 total funds for this purpose in its FY 2011-12 S-11 "Federally Mandated CHP+ PPS Payments." After the request was submitted, the Department became aware that the analysis performed by the CHP+ actuary was incomplete and included several errors. The Department's current request is based on a new analysis conducted by the Department's new CHP+ actuary. This funding is necessary to make additional retroactive payments from the effective date of the federal regulation through the remainder of FY 2012-13.

Problem or Opportunity:

After the submission of the Department's previous request for funding to pay FQHCs and RHCs the federally required minimum, the Department became aware that the analysis performed by the CHP+ actuary was incomplete

and included several errors. To ensure an accurate estimate, the Department's new CHP+ actuary performed a new analysis that correctly calculates the amount of retroactive payments due to these providers. As a result, the Department must make additional retroactive payments to CHP+ FQHCs and RHCs to ensure their reimbursement complies with federal regulation. Using the previous analysis, the Department believed that PPS could be implemented in a budget-neutral fashion going forward. The new analysis, however, indicates that this may no longer be the case, as the additional retroactive payments are substantially larger.

Brief Background:

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 included incentive payments for FQHCs and RHCs based on health outcomes. During a data collection pilot, it was determined that monitoring and tracking the health quality measures for the relatively small CHP+ population was going to be the administratively burdensome for FQHCs and RHCs, so the Medicaid PPS (BIPA) would be implemented. Thus, the Department submitted its FY 2011-12 S-11 "Federally Mandated CHP+ PPS Payments for FQHCs and RHCs" on January 3, 2012 to make retroactive payments that would bring FQHC and RHC encounters to the BIPA minimum.

After the request was submitted, however, the Department realized that this analysis was incomplete and included several errors. Since then, the Department has worked closely with a new actuarial firm to calculate the retroactive payments using all necessary data and the correct parameters. Appendix A explains in more detail the differences between the two analyses. While this new request is significantly higher than previously anticipated, it includes an additional fiscal year of payments; these payments will be the last retroactive payments made to comply with federal regulations regarding CHP+ FQHC and RHC reimbursement.

The Department is thus requesting funding to implement the BIPA PPS rates for FQHCs and

RHCs through June 30, 2013. In order to comply with change of scope regulations, the Department is implementing the Medicaid Alternative Payment Mechanism (APM) going forward, beginning on July 1, 2013.

Proposed Solution:

The Department has estimated the retroactive payments due to FQHCs and RHCs from October 1, 2009 through June 30, 2013 based on the new CHP+ actuary's analysis. The Department estimates that the additional retroactive payments due to FQHCs and RHCs are \$9,020,709 total funds. Once these retroactive payments are made, no additional funding will be needed to make retroactive PPS payments to CHP+ FQHCs and RHCs. Any changes in funding due to the implementation of PPS going forward will be incorporated into the per capita included in the regular biannual budget requests for CHP+. Thus, the Department is not including a budget amendment for FY 2013-14 to avoid potential double counting.

Alternatives:

None. The Department must make retroactive payments to CHP+ FQHCs and RHCs to ensure they are compensated according to federal regulations.

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 2012-13 appropriation includes \$118,093,807 federal funds for CHP+.

Cash Fund Projections:

This request includes Cash Funds from the Children's Basic Health Plan Trust and the Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balances, please see the Schedule 9 "Cash Funds Report" in Section O of this Budget Request.

Relation to Performance Measures:

Federal mandate.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:

New data. Due to technical errors in previous estimates and new data on FQHC and RHC services provided in CHP+, the Department must make additional retroactive payments to ensure CHP+ FQHCs and RHCs receive at least the BIPA minimum on an encounter basis for services rendered since October 1, 2009.

Current Statutory Authority or Needed Statutory Change:

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

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 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 or MEI) and any change in the scope of services furnished during that fiscal year. Medicaid programs may also develop an alternative payment methodology (APM) 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. During a data collection pilot, it was determined that monitoring and tracking the health quality measures for the relatively small CHP+ population was going to be the administratively burdensome for FQHCs and RHCs. Consequently, the Department is making retroactive payments to CHP+ FQHCs and RHCs based on the BIPA PPS rates.

CHP+ is a capitated program that contracts with various Managed Care Organizations (MCOs) which, in turn, subcontract with the providers who provide services to CHP+ clients. As part of its contractual agreements with the CHP+ MCOs, the Department does not have access to MCO claims data and thus cannot calculate the retroactive PPS payments due to FQHCs and RHCs. Instead, the contracted CHP+ actuary, which receives CHP+ MCO claims data as part of their annual capitation rate setting process, performed this analysis during the first part of FY 2011-12. The CHP+ actuary calculated the amount paid to FQHCs and RHCs by individual encounter from October 2009 through October 2011. With help from the Department, the CHP+ actuary then calculated the difference between these payments and the BIPA PPS minimum for each FQHC and RHC. Based on the actuary’s analysis, the Department submitted its FY 2011-12 S-11 “Federally Mandated CHP+ PPS Payments” in January 2012. This request included the amount due to FQHCs and RHCs to bring each encounter to the BIPA PPS minimum, projected through the end of FY 2011-12.

Upon further inspection, the Department and the CHP+ actuary became aware that the analysis excluded several essential parameters and in some cases calculated encounters and dollar amounts erroneously. Initially, the Department attempted to work with the actuary to remedy these issues, but the actuarial contract was rebid for FY 2012-13. Since July 2012, the Department has been working with the new CHP+ actuary to conduct a new analysis that ensures that the retroactive payment amounts are accurate and avoids the mistakes in the previous analysis. As a result of this more robust analysis, the Department is requesting additional funding to make the last retroactive payments to FQHCs and RHCs, which will allow it to implement PPS on an ongoing basis in July 2013.

Table 1 below outlines the differences between the two PPS analyses and demonstrates why the latest analysis resulted in a tenfold increase in the number of encounters, compared to the previous analysis.

Table 1 - Differences in calculation methodology between previous and new CHP+ PPS analysis			
Differences	Previous Analysis	New Analysis	Effect on Retroactive Payment Amount
Types of encounters included	One	Three: physical, behavioral, and dental health encounters. This mirrors the three encounters that are allowable in Medicaid per client, per provider, per day.	Increase
Dates of analysis	10/1/2009–10/31/2011	10/1/2009–3/31/2012	Increase
Claims run-out	Not included	90 days of claims run-out	Increase or decrease
Exclusions	None	Immunizations that are generally covered through the Vaccines for Children Program in Medicaid were carved out. Labs, x-rays, dummy procedure codes, and inpatient hospitalizations were also carved out as they are in Medicaid. Surgical codes and immunization administration codes were also excluded, as they did not qualify as an encounter.	Increase or decrease
Retroactive payment calculation for each encounter	Encounter rate <i>less</i> billed amount.	Encounter rate <i>less</i> (the sum of paid amounts, third party payments, and co-payments)	Increase
Claims adjustments	Claims adjustments not factored in.	Claims adjustments factored in.	Increase or decrease
Variable used to identify FQHC and RHC providers	Place of service code	Tax identification number	Increase

Retroactive Payments to Providers

Federal regulation gives states the option to reimburse FQHCs and RHCs the PPS rate as outlined in BIPA regulations, or determine an alternative payment methodology (APM), if every clinic or center agrees to this methodology and it is equal to or greater than the PPS rate. FQHCs and RHCs have agreed to the BIPA PPS for the CHP+ retroactive payments back to 2009. With newly available data, the Department's new CHP+ actuary has calculated the number of encounters and the payments received by FQHCs and RHCs. 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, the Department has omitted from its calculations any encounters for which FQHCs and RHCs received a payment greater than the BIPA PPS rate. Table 2 below summarizes the data used for this request and compares it to the data used in the Department's previous request submitted in January 2012. As a result, the amounts in the Net Due to Providers column do not match the funding requests, which include projections through the end of the fiscal year in which they were requested.

Table 2 - Data for Payments Below the BIPA PPS Rate, FY 2013-14 Request vs. FY 2012-13 Request

	Number of FQHCs and RHCs	Total Number of Encounters	Total Paid to FQHCs and RHCs	Total BIPA PPS Encounter Payments	Net Due to Providers
January 2, 2013 Request ¹	55	164,651	\$17,677,756	\$24,641,419	\$6,963,663
January 3, 2012 Request ²	46	16,054	\$1,921,316	\$2,697,695	\$776,379
Difference	9	148,597	\$15,756,440	\$21,943,724	\$6,187,284

¹ Data from October 1, 2009 through March 31, 2012.

² Data from October 1, 2009 through September 30, 2011.

Based on the analysis conducted with data through March 31, 2012, the Department has projected the payments due to FQHCs and RHCs to ensure all encounters through June 30, 2013 are reimbursed at least at the BIPA minimum. The Department is including projections for FQHCs and RHCs which have recently begun contracting with CHP+ MCOs, along with estimated changes in the MEI. Overall, however, the Department assumes that the utilization and payment patterns in the data would not change significantly by June 30, 2013 as these tend to fluctuate from quarter to quarter. Table 3 below summarizes the Department's estimated retroactive payments by fiscal year and compares this to the retroactive payments made by the Department in FY 2011-12, which were based on the Department's previous request submitted in January 2012. The Department made retroactive PPS payments totaling \$1,650,161 in FY 2011-12, while the analysis was being revised by the Department's previous actuary. As a result, the amount of payments made by the Department is \$15 lower than the Department's January 2012 request.

Table 3 - Retroactive Payments due to FQHCs and RHCs, Payments Made in FY 2011-12 vs. FY 2012-13 Request

	FY 2009-10*	FY 2010-11	FY 2011-12	FY 2012-13	TOTAL
January 2, 2013 Request	\$2,318,476	\$2,571,405	\$2,794,032	\$2,986,957	\$10,670,870
Payments Made in FY 2011-12	\$275,027	\$1,100,107	\$275,027	\$0	\$1,650,161
Difference	\$2,043,449	\$1,471,298	\$2,519,005	\$2,986,957	\$9,020,709

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

The Department is requesting \$9,020,709 total funds to finalize retroactive payments to FQHCs and RHCs for services provided from October 1, 2009 through FY 2012-13, when the Department will implement PPS going forward. The Department assumes it will receive the same 65% federal financial participation it receives for all other CHP+ premiums expenditures to make these retroactive payments. Thus, \$5,863,461 of the total funds requested are federal funds. The Department is currently discussing with CMS the requirements for the Department to comply with Section 503 of CHIPRA and receive the appropriate federal funding despite the delay in making these payments.

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 have the same funding source. Using historical caseload data and the caseload forecast from its November 1, 2012 FY 2013-14 R-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," the Department has applied the average caseload distribution to this estimate by quarter to accurately reflect the financing for these payments. As a result, the Department assumes that 11.3% of the state's share of retroactive payments, or \$361,350, would be funded through the Hospital Provider Fee. Due to the insolvency of the CHP+ Trust Fund, the Department is requesting General Fund to backfill expenditures or populations funded through the CHP+ Trust. 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, \$2,795,899, is General Fund

Table 4 below provides the Department's final calculations, including funding splits, and takes into account the PPS payments the Department made during FY 2011-12 according to its January 3, 2012 Supplemental Request.

Table 4 - Summary of Request Calculations					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Retroactive Payments per New Analysis	\$10,670,870	\$3,339,520	\$395,285	\$0	\$6,936,066
Retroactive Payments Made During FY 2011-12	\$1,650,161	\$543,621	\$33,935	\$0	\$1,072,605
Net Retroactive Payments Due	\$9,020,709	\$2,795,899	\$361,350	\$0	\$5,863,461

Implementation of PPS Going Forward

Although the CHP+ FQHCs and RHCs agreed to the BIPA PPS reimbursement for retroactive payments, these encounter rates do not include any adjustments for changes in scope of services provided by FQHCs and RHCs. Section 702(b)(aa)(3) of BIPA requires that state Medicaid agencies adjust the average costs

for services furnished during fiscal year 2002 or a succeeding fiscal year (that form the basis for PPS) according to the following criteria:

1. An increase in the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services, and;
2. An adjustment to take into account any increase or decrease in the scope of such services furnished by the clinic or center during that fiscal year.

To ensure that any changes in scope have been included in the encounter rates paid to FQHCs and RHCs, the Department will implement the Medicaid APM going forward. The Medicaid APM rates include adjustments for changes in the scope of services and take into account more current costs.

The calculation methodology of the APM for FQHCs participating in Colorado Medicaid uses the following data points:

- A. An annual encounter rate is determined using the clinic's current annual costs according to an audited cost report submitted to the Department's cost report auditor.
- B. A base encounter rate is determined through an inflated and weighted average of costs for the past three years. This base rate is recalculated every three years.
- C. The federal floor, or PPS rate, which is adjusted based on the MEI each year. This rate is not adjusted based on an increase or decrease in scope of services at this time.

After calculating these three encounter rates, the Department's cost report auditor takes the following steps to establish the effective rate:

- A. The lower of the annual encounter rate and the base encounter rate is determined.
- B. The higher of the rate determined in (A) and the federal floor, or PPS rate is determined to verify that the rate exceeds the PPS rate.
- C. If the rate determined in (A) is higher than the PPS rate, the average between the PPS rate and the rate determined in (A) will be applied.

RHCs' APM rates are calculated based on the higher of the Medicare rate and the federal PPS floor. For provider-based RHCs with less than fifty beds, the Medicare rate is based on actual costs. For all other RHCs, the Medicare rate is the upper payment limit.

The Department is currently in the process of coordinating with CHP+ MCOs to implement Medicaid APM for each of their subcontracted FQHCs and RHCs going forward. The Department will implement arrangements to ensure these rates are paid to FQHCs and RHCs beginning on July 1, 2013 so that retroactive payments will not be necessary after FY 2012-13.