

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



**Center for Medicaid and State Operations**

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SHO # 10-004

CHIPRA # 15

February 4, 2010

**RE: Prospective Payment System for FQHCs and RHCs**

Dear State Health Official:

This letter is part of a series of guidance to States regarding implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA ensures that States are able to continue their existing CHIP programs and provides funding to expand health insurance coverage to additional low-income, uninsured children. The purpose of this letter is to provide general guidance on the implementation of section 503 of CHIPRA, which amends 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. Section 1902(bb) governs payment for federally qualified health centers (FQHCs) and rural health clinics (RHCs). In addition to the general guidance, we have also included a set of questions and answers to provide further information about this provision in CHIP. Section 503 of CHIPRA also authorizes \$5 million in transition grants to assist States in meeting the requirements of this provision.

**Background**

Prior to 2001, Federal law required State Medicaid programs to reimburse FQHCs and RHCs based on reasonable costs. States used Medicare regulations and cost reports to identify the types of allowable costs that would be reimbursed, and established their own definition of what constituted "reasonable costs." 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 a new section 1902(bb) in the Act. This section requires Medicaid programs to make payments for FQHC/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, or to use an alternative payment methodology to pay for FQHC and RHC services.

BIPA (and now CHIPRA) refers to the payment methodology under section 1902(bb) as a prospective payment system (PPS). Likewise, we are using the term "Medicaid PPS" throughout this guidance to capture the language used in BIPA and CHIPRA, and in acknowledgement that PPS is the term of art used by the Medicaid program, FQHCs, and RHCs to describe such

payment. Nothing in this guidance conveys a change in prior Centers for Medicare & Medicaid Services (CMS) guidance pertaining to Medicaid payment for FQHC and RHC services.

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. CMS uses PPSs throughout the Medicare program. Most Medicare PPSs are based on the average costs incurred in furnishing the services by all participating providers of that type (e.g., skilled nursing facilities) and generally include multiple rate adjustment factors. However, the Medicaid PPS specified in section 1902(bb)(3) is determined separately for each individual FQHC or RHC (calculated on a per-visit basis), and does not include any adjustment factors other than a growth rate to account for inflation and a change in the scope of services furnished during that fiscal year. Therefore, we note that the methodology described under 1902(bb)(3) of the Act is significantly different from the PPS methodologies used by the Medicare program.

### **Application of Medicaid FQHC/RHC Payment Requirements to CHIP**

Medicaid programs, including CHIP programs that were implemented as Medicaid expansions, were required to use the methodologies set forth in section 1902(bb) for all FQHC and RHC services provided on or after January 1, 2001. As a result of section 503, separate CHIP programs are now required to use these methodologies for all FQHC and RHC services provided on or after October 1, 2009, and can come into compliance using one of three methods.

#### *(A) Adopting Medicaid PPS Rates*

First, a separate CHIP program can adopt the payment amounts for each FQHC and RHC currently in place for Medicaid. This approach could minimize implementation burdens. However, for this approach to work effectively, each FQHC and RHC would need to provide the same or a similar range of services in both the CHIP program and the State Medicaid program.

#### *(B) Constructing Separate CHIP PPS Rates*

Second, a separate CHIP program can develop a CHIP-specific PPS rate for existing FQHCs and RHCs. In doing so, the State should calculate the average reasonable costs on a per-visit basis for each FQHC and RHC in providing CHIP-covered services during two base years. This process may be accomplished by:

1. Identifying the total costs incurred by each FQHC and RHC in furnishing covered CHIP services under the program during the base years. Costs of non-covered services and costs of State plan administration (outreach, for example) are excluded. The State may require FQHCs and RHCs to complete Medicare cost reporting forms for the period in question in order to determine these amounts.
2. Dividing this amount by the total number of CHIP-covered visits in the base years to establish a cost per visit amount.

3. For succeeding years, increasing the per-visit rate to reflect the percentage change in the Medicare Economic Index applicable to primary care services, and adjust the per-visit rate to take into account any increase (or decrease) in the scope of services furnished by the FQHCs and RHCs between the beginning of the first State fiscal year from which the cost data is drawn and the current year.

Newly designated FQHCs and RHCs, as well as existing FQHCs and RHCs that are new to CHIP will have initial payment amounts established either by reference to payments made to other FQHCs and RHCs in the same or adjacent areas with similar caseloads, or in the absence of such other clinics, through cost reporting methods. After the initial year, payment shall be set using the same Medicare Economic Index method used for established FQHCs and RHCs.

*(C) Using an Alternative Payment Methodology (APM)*

Finally, a separate State CHIP program may use a methodology other than the PPS in paying FQHCs and RHCs for CHIP-covered services, if the following statutory requirements are met:

- The APM should be agreed upon by the State and by each individual FQHC or RHC to which the State wishes to apply the methodology;
- The APM must result in a payment to the FQHC or RHC that is at least equal to the amount to which it is entitled under the PPS; and
- The APM should be described in the approved CHIP State plan.

A State may accept an FQHC's or RHC's written assertion that the amount paid under the APM results in payment that at least equals the amount to which the FQHC or RHC is entitled under the PPS.

**Supplemental Payments to FQHC and RHC Managed Care Subcontractors**

In a separate State CHIP program where FQHCs and RHCs are subcontractors of managed care organizations (MCOs) in furnishing covered services to CHIP managed care enrollees, the State is required to make supplemental payments to these 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 otherwise be entitled for these visits under the State's PPS or APM. The State should make this determination at least every 4 months and must pay the difference to the FQHC or RHC. The CHIP State plan should be amended to include a description of the supplemental payment methodology.

However, the provisions in section 1903(m)(2)(A)(ix) of the Act (which require Medicaid MCO contracts to specify that an MCO pay FQHC and RHC subcontractors no less than it would pay other similar non-FQHC and RHC subcontractors) that apply to Medicaid-expansion CHIP programs do not apply to separate CHIP programs. However, States operating a separate CHIP program may want to consider including such a provision in their MCO contracts to prevent an FQHC or RHC from being underpaid by an MCO, in which case the State would be required to make up the difference with a supplemental payment to the FQHC or RHC.

### **Effective Date**

This payment provision was effective as of October 1, 2009. Although it may take States time to develop payment rates under these requirements, the statute thus provides that the State make payments based on a PPS system as of October 1, 2009. In order to be in compliance with the statutory requirement, each State should submit a CHIP State plan amendment describing how the State will comply with this payment provision within the time limits established under Federal regulations at 42 CFR 457.65(a)(3). To be in compliance, such an amendment should provide for the PPS payment to be made for all FQHC and RHC services furnished to CHIP enrollees on or after October 1, 2009.

### **Transition Grants**

Section 503 of CHIPRA also includes \$5 million to help separate and/or combination CHIP programs transition to a PPS (or an alternative payment methodology agreed to by the FQHCs and RHCs) for FQHCs or RHCs providing CHIP benefits. CMS intends to post an announcement for these grants on [www.grants.gov](http://www.grants.gov) very soon, as well as notify State CHIP programs when the announcement is posted. The announcement will provide details on grant eligibility criteria, the minimum and maximum grant awards, application requirements, grant award criteria, and the deadline for applications.

### **Implementation**

This guidance is offered in order to assist States in applying these provisions, which became effective October 1, 2009, to CHIP payments to FQHCs and RHCs. We plan to issue additional policy guidance on this issue as needed, and CMS will work with States to help them implement this provision consistent with the statute.

Section 3(b) of CHIPRA addresses the situation in which States need to pass legislation in order to bring their CHIP plans into compliance. This section provides that the Secretary of the Department of Health and Human Services may extend the date by which a State must implement any provision, if the Secretary determines that State legislation is required in order for a State's CHIP plan to comply with the provision. For States with annual legislative sessions, this date must be no later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after February 4, 2009 (the date CHIPRA was enacted). For States that have a 2-year legislative session, each year of the session is considered a separate regular session for this purpose.

If your State requires such legislation, please submit a letter indicating this to the CMS Center for Medicaid and State Operations as soon as possible. The letter should include the provision in question, the reason that State legislation is required for compliance, and the date the State will begin implementing the provision. Notwithstanding such a delay in implementation, separate CHIP programs should make payments to FQHCs and RHCs consistent with section 2107(e)(1) retroactive to October 1, 2009.

We encourage any State that operates a separate CHIP program with FQHCs or RHCs in its delivery system to begin a dialogue with its Medicaid agency and with its CMS Regional Office to assess potential coordination between the two programs in order to maximize administrative efficiencies and facilitate more rapid compliance with these requirements.

If you have questions regarding this guidance please send an e-mail to [CMSOCHIPRAQuestions@cms.hhs.gov](mailto:CMSOCHIPRAQuestions@cms.hhs.gov) or contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, who may be reached at (410) 786-5647.

Sincerely,

/s/

Cindy Mann  
Director

Enclosure

cc:

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**Enclosure**

**Questions & Answers**

**Application of Medicaid FQHC and RHC Prospective Payment System to CHIP**

**Question 1: Does this provision apply to all federally qualified health centers (FQHCs), and rural health clinics (RHCs) as well as FQHC “look-alikes” providing CHIP benefits?**

Answer: Yes. This provision applies to all FQHCs and RHCs, including FQHCs that are qualified because they are outpatient health programs or facilities operated by an Indian tribe or an urban Indian health program, or because they have been determined to meet the requirements for a grant that would accord FQHC status.

**Question 2: Do Medicaid prospective payment system (PPS) requirements under section 1902(bb) of the Social Security Act (the Act) apply only to independent RHCs, and not to provider-based RHCs?**

Answer: Medicaid PPS requirements under section 1902(bb) of the Act apply to all RHCs.

**Question 3: Does section 503 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) require that States cover FQHC and RHC services under a separate CHIP program?**

Answer: States operating a separate CHIP program are not required to cover FQHC and RHC services (except to the extent that the coverage is needed for the State to meet the benchmark or benchmark-equivalent coverage requirements of section 2103 of the Act).

**Question 4: Can States define FQHC and RHC services differently for purposes of CHIP than for Medicaid?**

Answer: FQHC and RHC services for Medicaid are defined in section 1861(aa) of the Act, and Medicaid programs must use these definitions. However, States are not required to use these definitions for CHIP.

**Question 4: Does the process for making prospective payments to FQHCs and RHCs have to be the same for a State’s CHIP program as it is for a State’s Medicaid program?**

Answer: No. As long as the requirements for payment in section 1902(bb) are met, the process by which such requirements are met is up to the State CHIP program.

**Question 5: Does this provision require application of all Medicaid FQHC and RHC policies to CHIP programs?**

Answer: No. Where applicable, States may adopt policies from the Medicaid program (i.e., requiring out-of-network access in circumstances where FQHC or RHC services are not

available in an MCO service area); however, these will not be required. Only the payment provisions described in section 1902(bb) of the Act are required.

**Question 6: Are CHIP programs required to have FQHC or RHC contracts?**

Answer: No.

**Question 7: Are CHIP programs required to ensure that their contracted managed care entities have FQHCs and RHCs in their provider networks?**

Answer: No.

**Question 8: Does the title XIX requirement to use "Medicare reasonable cost principles" for the prospective payment system apply to CHIP?**

Answer: Yes. Medicare reasonable cost principles apply to CHIP and are a part of the process in developing PPS rates, if the State chooses this approach to establishing payment rates for FQHCs and RHCs.

**Question 9: Section 1902(bb) of the Act states that the PPS rate must be “adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during the fiscal year.” What is meant by “any increase or decrease in the scope of such services”?**

Answer: A change in the scope of FQHC and RHC services should normally occur if: (1) the center/clinic has added or has dropped any service that meets the definition of FQHC and RHC services (i.e., that the FQHC or RHC is qualified to provide in the State); and, (2) the service is included as a covered CHIP service under the CHIP State plan. Additionally, a change in the scope of services could also occur when a service is added or dropped as a covered CHIP service. A change in the “scope of such services” is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services. The State must develop a process for determining a change in the scope of services.

**Question 10: Does the delayed implementation date exception described in section 3(b) of CHIPRA (when the State requires legislation to implement) apply to section 503 of CHIPRA?**

Answer: Yes. However, it is important to note that this exception applies only if the Secretary determines that “State legislation” is required to implement the provision. If this exception applies, States should follow the process outlined in this guidance to provide notice to CMS. However, the exception would not be triggered by a need for administrative action, including administrative rulemaking. Nor would the exception be triggered by estimates that increased spending might exceed State appropriations.

**Question 11: Can CMS advise States that FQHC and RHC providers do not need to receive the PPS rate until the provision is effective for a particular State?**

Answer: No. The exception at section 3(b) of CHIPRA does not change the effective date of this provision. It simply provides that, if the conditions for the exception were met, the State would not be regarded as failing to comply with the new requirement until the State has implemented the provision. Regardless of when implementation occurs, the State should make PPS payments to FQHCs and RHCs as required under section 2107(e)(1) of the Act retroactive to October 1, 2009.

**Question 12: Do States need to submit a CHIP State plan amendment (SPA) to implement this change? If so, what is the timeline for that?**

Answer: Yes. A SPA is required any time there is a change in Federal law that affects a State's CHIP plan. The timeline for SPA submissions has not changed. However, due to the high volume of SPAs expected to be generated from this legislation, CMS encourages States to submit all SPAs as quickly as administratively feasible.

**Question 13: Will CMS be sending out a preprint for the State plan regarding compliance with FQHC and RHC payment requirements?**

Answer: Yes. CMS will work with States to implement the requirements of section 1902(bb) of the Act. Operational aspects regarding the documentation of those requirements will be included in future CMS guidance, including but not limited to, the State plan preprint.

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