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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-22-0027

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

May 13, 2024

Jennifer Strohecker
State Medicaid and CHIP Director
Director, Division of Integrated Healthcare
P.O. Box 143101
Salt Lake City, UT 84114-3101

Dear Jennifer Strohecker:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), UT-22-0027, submitted on November 9, 2022, with additional information submitted on April XX, 2024, has been approved. This SPA has an effective date of July 1, 2022.

Through SPA UT-22-0027, Utah updates its CHIP reimbursement methodologies for Federally Qualified Health Centers and Rural Health Clinics and clarifies the Prospective Payment System and Alternative Payment Methodologies used by the state. Through this SPA, the state also updates reimbursement methodologies for Indian Health Services and 638 Tribal Health Facilities. These updates were made to align CHIP reimbursement methodologies with Medicaid reimbursement methodologies, as outlined in Medicaid SPA UT-22-0001, approved on January 25, 2023.

Your Project Officer is Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

Reimbursement for Indian Health Service and Tribal 638 Health Facilities

Payment for Services

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Centers for Medicare & Medicaid Services (CMS) and the IHS and which are published in the Federal Register or Federal Register Notices.

A tribal health program selecting to enroll as a FQHC and agreeing to an alternate payment methodology (APM) will be paid using the APM, which is the all-inclusive rate (AIR).

Utah CHIP will establish a Prospective Payment System (PPS) methodology for Tribal FQHCs. The PPS rate shall be the average rate of other FQHCs in the state. Annually, Utah CHIP will compare the APM rate to the PPS rates to ensure the APM is equal to or greater than the PPS rate. The Tribal FQHCs are not required to report their costs for the purposes of establishing a PPS rate.

Federally Qualified Health Centers

a. FQHCs located in Utah that serve Utah CHIP clients

FQHCs may elect to be paid under one of two payment methods – the Prospective Payment Method (PPS) or the Alternative Payment Method (APM). Each FQHC must elect its payment methodology preference and give notice to the CHIP agency. If an FQHC elects to change payment methods, an election to do so must be made no later than thirty (30) calendar days prior to the beginning of the FQHC's fiscal year by written notice to the Department.

FQHCs are reimbursed for one encounter per day per patient. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day constitute a single encounter.

i. Prospective Payment System (PPS).

Payment under PPS methodology conforms to the Federal methodology as contained in section 702 of the Benefits Improvement and Protection Act of 2001. PPS is the only approved methodology for the period January 1, 2001, through February 2, 2004, under the State Plan in effect for that time period.

PPS rates for each FQHC are determined based on their 1999 and 2000 fiscal years' reasonable costs, adjusted for any subsequent change in scope of

services. The average of the two-year costs are divided by the average number of visits (physician services as defined by the State Plan,) for the same two-year period. The resulting prospective rate is increased on January 1 of each subsequent year by the applicable Medicare Economic Index for primary care services. Effective calendar year 2022, the annual increase will occur each April 1 rather than January 1. The updated rates are effective for services on or after that date (April 1 of the applicable year). Payment will be based on the established PPS rates. Supplemental payments may be paid to ensure the PPS rate is received if, due to claims system limitations, the State isn't able to pay the PPS rate.

1. PPS Rate Establishment for new FQHCs

   New FQHCs established after fiscal year 2000 will have their PPS rate established for their first year using 100 percent of the reasonable costs used in calculating the rates of like or similar FQHCs in the same or adjacent areas with similar caseload.

   If there are no FQHCs in the same or adjacent area with a similar caseload, their PPS rate will be calculated from a cost report, based on projected costs, after applying a test of reasonableness. For year two, the year one PPS rate is inflated by the MEI. For year three, once the first full fiscal year's actual costs are established, the baseline PPS is re-calculated by dividing the total actual FQHC costs by the number of FQHC visits. The result is then inflated by the MEI for two periods to properly trend the PPS to the year three period.

   The resulting PPS rate is annually trended by the MEI and adjusted for any subsequent change in scope of services. The resulting prospective rate is increased on January 1 of each subsequent year by the applicable Medicare Economic Index for primary care services. Effective calendar year 2022, the annual increase will occur each April 1 rather than January 1. The updated rates are effective for services on or after that date (April 1 of the applicable year). Payment will be based on the established PPS rates.

2. Scope of Service Changes

   A change in the 'scope of 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. Scope of service changes must be substantiated by adequate documentation. FQHCs electing the PPS method must submit documentation with an estimate of the cost of the change in scope of service to receive consideration for an adjustment to the FQHC's PPS rate. Once approved, the modified PPS rate will be effective for the prospective fiscal period. Approximately two years after as PPS rate change for

scope of service changes, cost reports will be reviewed to verify the PPS rate update. If the scope of service change costs were over or under-estimated, a prospective, not retro-active, correction will be made to the PPS rate. There will be no retroactive correction made.

3. State wrap for managed care payments

   For FQHCs which contract with CHIP Manage Care Entities (MCEs) to provide in-scope medical, dental and mental health services for CHIP Enrollees:

   a. Supplemental payment amounts will be estimated and paid quarterly to the FQHCs for the difference between the negotiated contracted amounts paid by the MCEs and the amounts the FQHCs are entitled to under the PPS.

      i. Quarterly interim payments will be made approximately thirty (30) days after the end of the quarter.

      ii. The quarterly amount may be less than the calculated amount if requested by the FQHC.

   b. Annual reconciliations to ensure FQHCs are paid up to the PPS rate will be made and settled. If CHIP over-paid, pay-back to the State of the settlement amount is required from the FQHC. If underpaid, a payment for the settlement amount will be made to the FQHC.

   c. The PPS cost settlement reports MCE patient claims records in summary and in detail.

      i. Summary Cost Settlement Payment Report - This report presents the total amount due to or from the FQHC. There are two parts to this calculation. First, a calculation of the difference between the total amount that would have been paid under PPS principles and the total actual payment amount. Second, the sum of the quarterly interim payments made to the provider is then subtracted from the amount from step one. The difference is the settlement amount.

      ii. Claim Detail Cost Settlement Report – This report contains medical and dental managed care claim detail

and is the source for the summary report described in section (a) above.

ii. Alternative Payment Method (APM) – Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable cost (RCCAC).

The Alternative Payment Methodology Cost Settlement (APM) – The APM is available for providers that elect to receive the APM methodology. FQHCs must agree to receive the APM and the total amount paid under the APM must be at least what would be paid under the PPS methodology. The APM pays 100% of billed charges as an interim rate for FQHC services on a per claim basis as well as a one-time annual settlement amount that is the greater of the settlement amounts calculated under either (a) the cost-based methodology or (b) what would have been paid under PPS.

a. **Cost basis methodology**

FQHCs electing to receive the APM shall provide the Department with annual cost reports and audited financial statements required by the Department within twelve months of the close of their fiscal year period. The Department will conduct a review of submitted cost reports and calculate a cost settlement amount as follows:

All of the provider's annual billed CHIP charges for FQHC services are divided by all of the provider's annual billed charges for FQHC services to calculate a CHIP charge percentage. The CHIP charge percentage is then multiplied by the provider's total annual allowable costs for FQHC services to calculate the provider's CHIP allowable costs for FQHC services. The difference between the provider's CHIP allowable cost for FQHC services and the total CHIP payments made for FQHC services, including all quarterly interim payments, is the APM cost settlement amount.

The amounts billed for services cannot exceed the usual and customary charge to private pay patients.

b. **Prospective Payment System (PPS) Equivalent methodology**

The PPS payment equivalent is calculated in two parts. For FQHC services performed outside a hospital setting, that PPS equivalent is calculated by multiplying the provider's established PPS rate by the number of CHIP FQHC encounters that qualify for the PPS rate. For FQHC services performed in a hospital setting, the amounts calculated for the PPS equivalent is the greater of PPS or the number of CHIP claims for FQHC services provided in a hospital setting multiplied by the Utah

Medicaid rate for each CPT code since Utah CHIP does not have a fee-for-service program nor a CHIP rate for CPT codes.

Total CHIP payments for FQHC services are subtracted from the sum of the total PPS payment equivalent (PPS payment equivalent for CHIP FQHC services provided inside a hospital + PPS payment equivalent for CHIP FQHC services provided outside of a hospital setting) to arrive at the settlement amount under the PPS payment methodology.

c. The settlement amount calculated under the cost basis methodology is compared to the settlement amount calculated under the PPS equivalent methodology. The most advantageous settlement amount for the provider is the settlement amount that will be paid under this APM. If CHIP over-paid, pay-back to the State of the settlement amount is required from the FQHC. If under-paid, a payment for the settlement amount will be made to the FQHC.

d. FQHCs electing the APM method may receive supplemental payment amounts which are estimated annually and paid quarterly to the FQHCs based on the difference between amounts paid by the MCEs and amounts the FQHCs are entitled to under the PPS.

   i. Quarterly interim payments will be made approximately thirty (30) days after the end of the quarter.
   ii. The quarterly amount may be less than the calculated amount if requested by the FQHC.

b. FQHCs located outside of Utah that serve Utah CHIP Clients.

i. FQHCs located out-of-state that serve Utah CHIP clients will be paid the reimbursement rate applicable to the state in which services are provided.

ii. These FQHCs shall annually provide the PPS rate applicable to the FQHC to the Utah CHIP agency’s FQHC lead.

Rural Health Clinics (RHCs)

RHCs are subject to same provisions as FQHCs (see section above) except for the Alternative Payment Methodology section, which is not applicable to RHCs.