
Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-17-0039

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294



REGION VIII - DENVER

December 1, 2017

Tom Massey, Acting Executive Director
Department of Health Care Policy & Financing
303 East 17th Avenue, 7th Floor
Denver, CO 80203

RE: Colorado #17-0039

Dear Ms. Birch:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 17-0039. This Amendment clarifies the Department's payment policy to pay the fee schedule rate for Federally Qualified Health Centers for Long Acting Reversible Contraceptives (LARCs), inpatient hospital services, the Prenatal Plus Program, the Nurse Home Visitor Program, dentures and partial dentures, and dental services provided in an outpatient hospital.

Please be informed that this State Plan Amendment was approved today with an effective date of July 1, 2017. We are enclosing the CMS-179 and the amended plan page(s).

In order to track expenditures associated with this amendment, Colorado should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM). For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage, expenditures should be reported on the Form CMS-64.9 VIII; for those not enrolled in the new adult group, claims thereon should be reported on the Form CMS-64.9 Base.

This amendment would affect expenditures reported on Line 28 - Federally-Qualified Health Center.



If you have any questions concerning this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,



Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Gretchen Hammer John Bartholomew
David DeNovellis Russell Ziegler

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 17 - 0039	2. STATE: COLORADO
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		4. PROPOSED EFFECTIVE DATE: July 1, 2017	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Title XIX of the Social Security Act, Section 1902 (bb); 42 CFR Part 405, Subpart X		7. FEDERAL BUDGET IMPACT: a. FFY 2016-17: \$ 0.00 b. FFY 2017-18: \$ 0.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19 B - Methods and Standards for Establishing Payment Rates - Federally Qualified Health Center (FQHC) Services (Pages 1-A to 1-G)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19 B - Methods and Standards for Establishing Payment Rates - Federally Qualified Health Center (FQHC) Services (Pages 1-A to 1-E) (15-0042)	
10. SUBJECT OF AMENDMENT: This State Plan Amendment clarifies the Department's payment policy to pay the fee schedule rate for Federally Qualified Health Centers for Long Acting Reversible Contraceptives (LARCs), inpatient hospital services, the Prenatal Plus Program, the Nurse Home Visitor Program, dentures and partial dentures, and dental services provided in an outpatient hospital.			
11. GOVERNOR'S REVIEW (<i>Check One</i>): GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Governor's letter dated 15 January, 2015 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 Attn: David DeNovellis	
13. TYPED NAME: Gretchen Hammer			
14. TITLE: Medicaid Director			
15. DATE SUBMITTED: September 21, 2017			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED September 21, 2017		18. DATE APPROVED December 1, 2017	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2017		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME Richard C. Allen		22. TITLE ARA, DMCHO	
23. REMARKS			

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B

State of Colorado

Page I-A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

General:

1. All participating FQHCs, including freestanding and hospital-based centers, will be subject to the payment methodologies described in section 702(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106 – 554.
2. New freestanding FQHCs will file a preliminary FQHC cost report with the Colorado Department of Health Care Policy and Financing (Department). Cost and visit data from the preliminary report will be used to set the FQHC's reimbursement rate for the first year.
3. A medical encounter, a dental encounter, and a mental health encounter on the same day and at the same location shall count as three separate visits. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.
4. A FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for the pharmacy and shall be reimbursed for prescriptions through this number. A FQHC that operates its own pharmacy that serves Medicaid clients will not be reimbursed using the Prospective Payment System (PPS) described in the following section for pharmacy services.

Prospective Payment System (PPS):

5. PPS rates are increased annually by the Medicare Economic Index (MEI) inflation factor and adjusted to account for any increase or decrease in the scope of such services furnished by the center or clinic. Reference Approved State Plan Amendment, attachment 4.19-B, methods and standards for establishing payment rates – FQHCs, pages I-D – I-G, Paragraph 13-21, for methodology for obtaining change to the PPS for a scope of service change.
6. Certain services provided by a FQHC are not eligible for PPS rate reimbursement. These services provided by the FQHC are not considered FQHC services and are not to be considered in calculations pertaining to the PPS. In such cases, the Department will reimburse the FQHC at the Colorado Medicaid Fee Schedule rate. These services are:

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B

State of Colorado

Page I-B

- a. Services rendered in an inpatient hospital setting, reference Approved State Plan Amendment, attachment 4.19-B, item 5a, Physician Services, and attachment 4.19-B, item 6d, Services Provided by Non-Physician Practitioners, for respective payment methodologies;
- b. Dental services provided in an outpatient hospital setting, reference Approved State Plan Amendment, attachment 4.19B, item 10, Dental Services, for dental services payment methodology;
- c. The Prenatal Plus Program, reference Approved State Plan Amendment, attachment 4.19-B, item 20, extended services for pregnant women, for the Prenatal Plus Program payment methodology; and
- d. The Nurse Home Visitor Program, reference Approved State Plan Amendment, attachment 4.19-B, item 19, methods for establishing payment rates for Nurse Home Visitor Program targeted case management services, for payment methodology.
- e. Dentures and partial dentures, reference Approved State Plan Amendment, attachment 4.19-B, item 12b, Dentures, for dentures and partial dentures payment methodology.

Reimbursement for Items Outside of PPS

7. FQHCs are reimbursed for Long Acting Reversible Contraceptives (LARCs) separate from their PPS encounter rate. In addition to payment at the FQHC encounter rate for the insertion of the device(s), FQHCs are eligible to be reimbursed for the cost of the device(s); reference Approved State Plan Amendment, attachment 4.19-B, item 12a, Pharmaceutical Services, for payment methodology. The cost of LARC device(s) billed separate from the encounter rate will not be used to calculate the FQHC's APM rate.

Alternative Payment Methodology (APM):

8. All participating FQHCs, including freestanding and hospital-based centers, are required to file annual cost reports with the Department. Audited cost data from these reports will be used to set yearly FQHC reimbursement rates under an alternative payment method. The Department will determine and assure that the payments are based upon, and cover, the reasonable costs of providing services to Medicaid beneficiaries.
9. The alternative payment methodology will be agreed to by the Department and the FQHC, and will result in payment to the FQHC of an amount that is at least equal to the Prospective Payment System (PPS) rate.

TN No. 17-0039
Supersedes TN No. 15-0042

Approval Date December 1, 2017
Effective Date July 1, 2017

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B

State of Colorado

Page I-C

10. Effective July 1, 2014, the APM rate is 100% of Reasonable Cost. The calculation methodology of the APM rate for both freestanding and hospital-based FQHCs is the same, and each FQHC will have its own rate calculated. The Department's hired cost report auditor will determine each FQHC's APM rate in relationship to each FQHC's PPS rate by utilizing the following steps:

Step 1: Calculate the Current Year Inflated Rate. The Current Year Inflated Rate is calculated by using the FQHC's current annual costs and visits from the most recent audited Medicaid cost report and inflating that figure by the MEI inflation factor.

Step 2: Calculate the Inflated Base Rate from the prior year. The Base Rate is calculated by taking a weighted average of the FQHC's costs and visits for the past three years. The Base Rate is recalculated every three years, but is inflated annually by the MEI to get the Inflated Base Rate.

Step 3: Calculate the lower of the rate determined in Step 1 and Step 2 to establish a rate for 100% of Reasonable Costs. The rate for 100% of Reasonable Costs is calculated as the lesser of the Current Year Inflated Rate and the Inflated Base Rate.

Step 4: Calculate the current inflated PPS rate.

Step 5: The FQHC will be reimbursed the higher of the APM rate or the PPS rate.

11. For new freestanding FQHCs, data from the preliminary cost report is used to set a reimbursement rate for the first year. A base rate will be calculated using the FQHC's first audited cost report showing actual data from its first fiscal year of operations as a FQHC. This base rate will be the FQHC's base rate until the next rebasing period.

12. If services furnished by a FQHC to a Medicaid eligible recipient are paid by a managed care entity at a rate less than the established rate, a supplemental payment equal to the difference between the rate paid by the managed care entity and the established rate times the number of visits shall be made quarterly by the managed care entity. When supplemental payments are made by the managed care entity to the FQHC, the individually affected FQHC must agree to this payment methodology. Managed care entities are required to reimburse FQHCs at an amount not less than the higher of the APM rate or the PPS rate. The Department will collect reporting no less than quarterly to ensure that full payment has been received by the FQHCs.

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B

State of Colorado

Page I-D

Scope-of-Service Rate Adjustments:

13. If a FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate to adhere to Section 702(b) of BIPA.
14. A FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC, subject to all of the following:
 - a. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.
 - b. The reported cost adheres to the reasonable cost principles set forth in 42 CFR §413 and 45 CFR §75.
 - c. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.
 - d. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.
15. A FQHC must apply to the Department by written notice within ninety (90) days of the end of the fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. For a scope-of-service rate adjustment to be considered, the change in scope of service must have existed for at least a full six (6) months. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.
16. Should the scope-of-service rate application for one year fail to reach the threshold described in Paragraph 14d above, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B

State of Colorado

Page I-E

application that captures both of those changes. A FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

17. The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:
- a. The Department's application form for a scope-of-service rate adjustment, which includes:
 - 1) The provider number(s) that is/are affected by the change(s) in scope of service;
 - 2) A date on which the change(s) in scope of service was/were implemented;
 - 3) A brief narrative description of each change in scope of service, including how services were provided both before and after the change; and
 - 4) An attestation statement;
 - b. The Department's data section form for a scope-of-service rate adjustment;
 - c. Detailed documentation and/or cost reports that substantiate the data in the aforementioned forms; and,
 - d. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, this may delay implementation of any approved scope-of-service rate adjustment.
18. The reimbursement rate for a scope-of-service change will be calculated as follows:

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B

State of Colorado

Page I-F

- a. The Department will verify the total reasonable costs and visits associated with the change in scope, and use those data to develop a costs/visits rate associated with the change in scope.
 - b. The Department will calculate an adjusted PPS rate. This adjusted PPS rate will be the average of the current PPS rate and the rate associated with the change in scope, weighted by visits. The “current PPS rate” means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.
 - c. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate, and verify that the adjusted PPS rate meets the 3% threshold described in Paragraph 14d above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.
 - d. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.
19. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC’s fiscal year end.
20. Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified and calculated through an audit or review process.
- a. If this occurs, the Department may request the relevant documentation, as described in Paragraph 17 above, from the FQHC. The FQHC will then have ninety (90) days from the date of the request in which to provide the requested documentation.
 - b. The rate adjustment methodology will be the same as described in Paragraph 18 above.
 - c. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B

State of Colorado

Page I-G

received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

- d. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

21. A FQHC may appeal the Department's decision regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. If the Department fails to act on an application for a rate adjustment within one hundred twenty (120) days of submission by the FQHC, the application will be deemed to be denied. To appeal the decision, a FQHC must file a written appeal that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position.