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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 18-0014

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

REGION VIII - DENVER

June 22, 2018

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Bimestefer:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 18-0014. This amendment modifies the reimbursement methodology for Federally Qualified Health Centers that participate in the Colorado Medicaid program.

Please be informed that this State Plan Amendment was approved June 21, 2018, with an effective date of July 1, 2018. 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,

[redacted]

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

cc: Gretchen Hammer
David DeNovellis
Whitney McOwen
John Bartholomew
Russell Ziegler

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **18 – 0014**

2. STATE: **COLORADO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2018**

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS A NEW PLAN | **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

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 2017-18: $ $0.00
b. FFY 2018-19: $ $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 I-A to I-I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B – Methods and Standards for Establishing Payment Rates – Federally Qualified Health Center (FQHC) Services (Pages I-A to I-G) (17-0039)

10. SUBJECT OF AMENDMENT:

This State Plan Amendment changes the Department's Federally Qualified Health Center payment methodology by changing the current Alternative Payment Methodology (APM) to reimburse different cost based rates for physical health, dental, and specialty behavioral health services; adding a quality component to FQHC rates that will be effective July 1, 2020; add a methodology for setting reimbursement rates for out-of-state FQHCs; modifying the methodology for setting FQHC base rates; clarifying the methodology for setting initial Prospective Payment System (PPS) rates; and creating a new PPS reconciliation process.

11. GOVERNOR'S REVIEW *(Check One)*:

GOVERNOR'S OFFICE REPORTED NO COMMENT | **X 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:

[redacted]

13. TYPED NAME:
Gretchen Hammer

14. TITLE:
Medicaid Director

15. DATE SUBMITTED: Initial: March 30, 2018
1st Update: June 5, 2018

16. RETURN TO:

Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: David DeNovellis

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
March 30, 2018

18. DATE APPROVED
June 21, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Richard C. Allen

22. TITLE
ARA, DMCHO

23. REMARKS

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 physical health encounter, a dental encounter, and a specialty behavioral 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-F – I-I, Paragraphs 19-27, for methodology for obtaining change to the PPS for a scope of service change.

6. The Department will use reasonable cost and visit data from the first cost report submitted with cost and visit data from the first full fiscal year after a freestanding FQHC enrolls with Colorado Medicaid to set the finalized PPS rate.

7. Reimbursement rates for out-of-state FQHCs will be their PPS per visit rate established by the state Medicaid agency in the state the FQHC is located.

8. 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 include, but are not limited to, the following:

    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

9. 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) 1 – Value Based Payment:

10. 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.

11. 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.

12. Effective July 1, 2018, the APM rates are 100% of Reasonable Cost. Separate rates shall be calculated for dental services, physical health services, and specialty behavioral health services.

13. Beginning in State Fiscal Year 2020-2021, the State will change payment for the Physical Health and Specialty Behavioral Health encounter rates for FQHCs. A portion of the Physical Health and Specialty Behavioral Health cost based rates are at-risk based on the FQHC's quality modifier. A FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year. The quality indicators and calculation of the quality modifier are published at www.colorado.gov/hcpf. The baseline for the quality performance is the Calendar Year before the performance period. The State will provide a tool that FQHCs can use to determine the final Physical Health and Specialty Behavioral Health rates at www.colorado.gov/hcpf using the FQHC's quality modifier. An example timeline for the application of the quality modifier is listed below for State Fiscal Year 2020-2021:

    a. In Calendar Year 2018, FQHCs will select quality measures through an online tool.

    b. A Quality Modifier will be calculated based on performance on the selected quality measures in Calendar Year 2019.

    c. The Department will notify each FQHC of their Quality Modifier prior to July 1, 2020.

    d. In State Fiscal Year 2020-2021, the Quality Modifier will be multiplied to the Final Physical Health Rate and Specialty Behavioral Health rate to increase, maintain, or decrease the encounter payment for Physical Health and Specialty Behavioral Health Services.

14. The calculation methodology of the APM rate for both freestanding and hospital-based FQHCs is the same, and each FQHC will have its own rates calculated. The Department's hired cost report auditor will determine each FQHC's APM rates by utilizing the following steps:

    a. Physical Health Rate

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

Step 2: Calculate the Inflated Physical Health Base Rate. The Physical Health Base Rate is calculated by taking a weighted average of the FQHC's costs and visits for the past three years. The Physical Health Base Rate is recalculated every year, and is inflated by the MEI to get the Inflated Physical Health 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, the Physical Health APM rate, is calculated as the lesser of the Current Year Physical Health Inflated Rate and the Inflated Physical Health Base Rate.

Step 4: Effective July 1, 2020, adjust the Physical Health APM rate based on the FQHC's quality modifier.

Step 5: The FQHC will be reimbursed the Physical Health APM rate for physical health services.

b. Specialty Behavioral Health Rate: The Specialty Behavioral Health rate shall be calculated utilizing the same methodology described in 14.a Physical Health utilizing costs and visits from the most recent audited cost report for specialty behavioral health services and associated administrative costs.

c. Dental Rate: The Dental rate shall be calculated utilizing the same methodology as described in 14.a Physical Health using costs and visits from the most recent audited cost report for dental services and associated administrative costs. The Dental Rate shall not be adjusted by the FQHC's current quality modifier as described in Step 4.

d. PPS Reconciliation

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 for all services reimbursed by the Department and associated administrative costs and inflating that figure by the MEI inflation factor.

Step 2: Calculate the Inflated Base Rate. 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 year, and is inflated 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, the APM rate, is calculated as the lesser of the Current Year Inflated Rate and the Inflated Base Rate.

Step 4: Effective July 1, 2020, adjust the APM rate based on the FQHC's quality modifier.

Step 5: Compare the APM rate to the PPS rate. If the APM rate is lower than the PPS rate, the Department will compare the amount paid under APM 1 to what would have been reimbursed under the PPS per visit encounter rate. If the amount paid is lower than the amount that would have been paid under the PPS per visit encounter rate, the Department will make an annual, one-time payment 6 months after the FQHC's rate period has ended to make up the difference.

15. FQHCs with no associated costs or visits for specialty behavioral health services and/or dental services shall be paid for these services, if provided, at the Physical Health Rate. A Specialty Behavioral Health Rate and/or Dental Rate will be set when associated costs and visits are included in the FQHC's annual cost report.

16. For new freestanding FQHCs, data from the preliminary cost report is used to set preliminary APM rates. Final APM rates will be set based on the FQHCs first full audited cost report showing actual data from its first fiscal year of operations as a FQHC.

17. 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.

18. FQHCs that do not choose APM 1 will be paid their PPS per visit rate.

Scope-of-Service Rate Adjustments:

19. 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.

20. 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.

21. 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.

22. Should the scope-of-service rate application for one year fail to reach the threshold described in Paragraph 20d 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 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.

23. 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:

        i. The provider number(s) that is/are affected by the change(s) in scope of service;

        ii. A date on which the change(s) in scope of service was/were implemented;

        iii. A brief narrative description of each change in scope of service, including how services were provided both before and after the change; and

        iv. 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.

24. The reimbursement rate for a scope-of-service change will be calculated as follows:

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 20d 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.

25. 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.

26. 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 23 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 24 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 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.

27. 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.