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State/Territory Name: CO

State Plan Amendment (SPA) #: 20-0006

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

March 11, 2022

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

Re: Colorado 20-0006

Dear Ms. Johnson,

We have reviewed the proposed amendment to Attachment 4.19B of your Medicaid State plan submitted under transmittal number (TN) 20-0006. Effective for services on or after July 1, 2021, this amendment modifies the methods and standards for establishing payment rates for Federally Qualified Health Centers (FQHCs). Specifically, CO 20-0006 implements alternative payment methodologies (APMs) to reimburse Federally Qualified Health Centers (FQHCs).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 20-0006 is approved effective July 1, 2021. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at Christine.storey@cms.hhs.gov or Lajoshica Smith at lajoshica.smith@cms.hhs.gov.

Sincerely,

Todd McMillion
Director
Division of Reimbursement Review

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 0 — 0 0 0 6

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2021

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act, Section 1902(bb) / 42 CFR Part 405, Subpart X

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2021 $ 0
b. FFY 2022 $ 0

7. 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
Attachment 4.19-B – Methods and Standards for Establishing Payment Rates – Federally Qualified Health Center (FQHC) Services -- Pages I-J to I-P (NEW)

8. 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-I (TN CO-18-0014)

9. SUBJECT OF AMENDMENT
Changes the payment methodology for Federally Qualified Health Centers (FQHCs) to reimburse FQHCs a per member per month (PMPM) rate instead of an encounter rate for medical services for attributed members.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Governor's letter dated 14 July 2021

11. SIGNATURE OF STATE AGENCY OFFICIAL
Digitally signed by Bettina Schneider, CFO
Date: 2022.02.23 15:13:37 -07'00'

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED
Initial: March 27, 2020; Update No. 1: February 23, 2022

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

Attn: Amy Winterfeld

FOR CMS USE ONLY

16. DATE RECEIVED
March 27, 2020

17. DATE APPROVED
March 11, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2021

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

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 Medicaid cost report with the Colorado Department of Health Care Policy and Financing (Department). The preliminary cost report contains cost and visit data from the new freestanding FQHC's most recent fiscal year. The preliminary cost report is due ninety (90) days after the FQHC enrolls with Colorado Medicaid. The cost data includes the costs of services and associated administrative costs. Cost and visit data from the preliminary report will be used to set the FQHC's reimbursement rate for the first year. If no such cost or visit data is available when a new FQHC enrolls with Colorado Medicaid and there are no FQHCs located in the same or adjacent area with a similar caseload, the state will use cost reports with estimated data as a test of reasonableness as described in BIPA. Subsequent years rates will be set in accordance with Paragraph 6.

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. An 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. An 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-M – I-P, Paragraphs 23-33, 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 from the first full fiscal year after a freestanding FQHC enrolls with Colorado Medicaid to set the finalized PPS rate. Reasonable costs are determined using the State's Medicaid-specific FQHC cost report.

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 Methodologies

10. 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. FQHCs that do not choose an APM will be paid at their PPS per visit rate.

11. 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.

Alternative Payment Methodology (APM) 1

12. Effective July 1, 2021, separate rates shall be calculated for dental services, physical health services, and specialty behavioral health services. The calculation methodology of the APM 1 rates for both freestanding and hospital-based FQHCs is the same, and each FQHC will have its own rates calculated. The Department's contracted cost report auditor will determine each FQHC's APM 1 rates by utilizing the following steps:

    a. Physical Health Rate
    The FQHC Physical Health rates will be effective annually 120 days after the FQHC's Fiscal Year End (FYE). The rates are calculated using the following methodology:

    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 an average of the sum of the total FQHC's costs and visits for Physical Health services for the past three years. Cost data from the previous two years is inflated by the MEI then added to the current year costs. This sum is divided by the sum of the visits from each year. 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 rates determined in Step 1 and Step 2 to establish a rate for 100% of Reasonable Costs. The rate for 100% of Reasonable Costs, the final Physical Health Rate, is calculated as the lesser of the Current Year Physical Health Inflated Rate and the Inflated Physical Health Base Rate.

Step 4: Multiply the final physical health rate by the FQHC's quality modifier to determine the APM 2 Physical Health rate.

i. The quality modifier will be calculated based on FQHC performance on the selected quality measures in the calendar year prior to the rate year. The quality modifier is calculated using the points an FQHC has earned. Each measure is assigned a point value based on the potential value gained by improved outcomes and difficulty of achieving improvement. Points values for individual measures range from 10 to 60 possible points. The points that each practice earns for individual measures are summed to calculate the practice's quality score. Each FQHC must receive a quality score of at least 200 points to receive the highest payment rates. The maximum reduced from an FQHC's physical health rate is 4%. If an FQHC receives lower than 200 points, a portion of their rates are reduced. The reduction is calculated as follows: **4% - (Points Earned/200) * 4%**. The Department will notify each FQHC of their Quality Modifier prior to start of the State Fiscal Year. The FQHCs will select quality measures one calendar year prior to the start of the performance year for measurement.
ii. The FQHCs will report on the selected quality measures in the calendar year prior to the rate year, the performance year.
iii. The Department will notify each FQHC of their Quality Modifier prior to the beginning of the State fiscal year.
iv. The quality measures, quality modifiers, quality indicators, are effective July 1, 2021 and are published at https://hcpf.colorado.gov/primary-care-payment-reform-3.
v. Quality modifiers will be calculated for new FQHCs when enough data is available for valid calculation of the selected quality measures. Until then, new FQHCs will be reimbursed at 100% of their physical health rates.

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 rates will be calculated using costs and visits from the most recent audited Medicaid cost report for specialty behavioral health services and associated administrative costs. The rates are effective annually 120 days after the FQHC's FYE. The rates are calculated using the following methodology:

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

Step 2: Calculate the Inflated Specialty Behavioral Health Base Rate. The Specialty Behavioral Health Base Rate is calculated by taking an average of the sum of the FQHC's total costs and visits for specialty behavioral health services for the past three years. Cost data from the previous two years is inflated by the MEI then added to the current year costs. This sum is divided by the sum of the visits from each year. The Specialty Behavioral Health Base Rate is recalculated every year and is inflated by the MEI to get the Inflated Specialty Behavioral Health Base Rate.

Step 3: Calculate the lower of the rates determined in Step 1 and Step 2 to establish a rate for 100% of Reasonable Costs. The rate for 100% of Reasonable Costs, the final specialty behavioral health rate, is calculated as the lesser of the Current Year Specialty Behavioral Health Rate and the Inflated Specialty Behavioral Health Base Rate.

Step 4: The FQHC will be reimbursed the Specialty Behavioral Health Rate for specialty behavioral health services.

c. Dental Rate
The FQHC Dental Rate will be calculated using costs and visits from the most recent audited cost report for dental health services and associated administrative costs. The rates are effective annually 120 days after the FQHC's FYE. The rates are calculated using the following methodology:

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

Step 2: Calculate the Inflated Dental Base Rate. The Dental Base Rate is calculated by taking an average of the sum of the FQHC's total costs and visits for dental services for the past three years. Cost data from the previous two years is inflated by the MEI then added to the current year costs. This sum is divided by the sum of the visits from each year. The Dental Base Rate is recalculated every year and is inflated by the MEI to get the Inflated Dental 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 final Dental rate, is calculated as the lesser of the Current Year Dental Rate and the Inflated Dental Base Rate.

Step 4: The FQHC will be reimbursed the Dental Rate for dental services.

13. PPS Reconciliation

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 a one-time payment to make up the difference. This payment will be calculated 6 months after the end of the FQHC's rate payment period to account for claims runout. The payment will be sent out 30 days after the PPS reconciliation analysis is completed.

14. 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 an amount equivalent to the Physical Health Rate. A Specialty Behavioral Health Rate and/or Dental Rate will be set once associated costs and visits are included in the FQHC's annual cost report.

15. Wrap Payment for APM 1:

    If services furnished by an FQHC to a Medicaid eligible recipient are paid by a managed care entity at a rate less than the established encounter rate, a supplemental payment equal to the difference between the rate paid by the managed care entity and the established encounter 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.

Alternative Payment Methodology (APM) 2 – Per Member Per Month (PMPM)

16. 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. Any FQHC that elects not to be reimbursed under the APM described in Section "Alternative Payment Methodology (APM) 2 – Per Member Per Month (PMPM)" will receive a payment under the PPS methodology described in Section "Prospective Payment System (PPS)" or an alternative APM that they elect.

17. Effective July 1, 2021, APM 2 will be composed of a Physical Health cost per visit PMPM for non-geographically attributed clients, a Physical Health Rate for geographically attributed and non-FQHC attributed clients, a specialty behavioral health rate, and dental rate.

    a. Physical Health PMPM

    The Physical Health PMPM will be paid when FQHCs provide physical health services to non-geographically attributed members. The PMPM is based on historical patient utilization, historical attribution, and the Physical Health cost per visit rate for

the specific FQHC as described in Paragraph 21. The PMPM rate is determined by the Department by utilizing the following steps:

Step 1: Determine cost per visit for physical health services: The Physical Health cost per visit rate will be obtained from the annual audited FQHC Medicaid cost report. The FQHC's cost report will be utilized to determine total physical health costs and the total physical health episodes, including physical health services provided to Medicaid beneficiaries that are within an FQHC's scope of service. To determine the cost per visit from this cost report, the FQHC's physical health Costs are divided by the number of FQHC visits.

Step 2: Determine the PMPM rate: Historical patient attribution and utilization data from MMIS will be used to calculate an estimated total episodes per attributed member per year for the rate payment period. For example, if it is estimated the FQHC will have an average of 2 episodes per attributed member during the rate payment period and their current Physical Health cost per visit rate is $150, the FQHC's PMPM rate will be ($150 * 2.0)/12 = $25 per member, per month.

Step 3: Inflate the PMPM rate by the current MEI.

Step 4: The FQHC is reimbursed the PMPM for physical health services for non-geographically attributed members.

i. <u>PMPM Attribution Methodology</u>

All full-benefit Medicaid eligible beneficiaries who are enrolled to the Accountable Care Collaborative are attributed to a Primary Care Medical Provider (PCMP), except the following excluded population:

A. Beneficiaries enrolled in the Program for All-Inclusive Care for the Elderly (PACE).

Members that are not enrolled to an Accountable Care Collaborative limited managed care capitation initiative, such as PACE, are attributed to a Primary Care Medical Provider (PCMP).

At least every six months member attribution is reprocessed to potentially reattribute members who have received services at PCMPs other than the PCMP to which they were previously attributed. For the purposes of the FQHC APM 2, only member designated attributions are used to calculate or pay the PMPM. Each month, the Department generated FQHC attribution lists will be made available to the FQHCs through the Statewide Data Analytics Portal. PMPM payments to FQHCs will change based on the number of attributed members each month. Members may choose a new PCMP at any time. Attributions

will be done using a hierarchical process as follows:

A. Member's claims history with a PCMP;
B. Member requesting a PCMP through the Enrollment Broker. The Enrollment Broker helps members select a PCMP when they would like to switch health plans or move to a new PCMP.

Members who have not designated a PCMP are attributed based on geographic location.

ii. Quality Factor

Beginning July 1, 2021, The PMPM rate will be adjusted annually by the Quality Modifier described in Paragraph 18. The PMPM rate will be multiplied by the quality modifier to get the final PMPM rate.

iii. Shadow Billing

FQHCs will bill for incident-to services not eligible for PPS reimbursement at an FQHC. These services will receive a zero-dollar payment and will be used to track access and utilization.

iv. Claims Billing

FQHCs will continue to bill for services provided to clients covered under the PMPM rate. The Department's MMIS will pay zero for these services to both avoid duplication of payment and to track what services are provided to FQHC clients.

v. Data Monitoring

The Department will collect preliminary data related to an FQHC's quality, outcomes, and access prior to participation in APM 2. This data will be compared to performance during the APM 2 rate payment period to ensure quality, outcomes, and access are not decreasing.

vi. PMPM rates will be calculated and effective July 1, 2021 when APM 2 becomes effective. PMPM rates will be updated annually and will be made available to FQHCs along with their finalized cost reports once the cost report has been audited and finalized Cost reports are due 90 days after an FQHC's FYE. PMPM rates are effective annually 120 days after the FQHC's FYE. The PMPM rates will cover all physical health utilization across an FQHC system. Year two rates for FQHCs participating in APM 2 will be set prospectively by inflating the year one

rates by the MEI. After year two, PMPM rates will be set using updated cost, visit, and utilization data as specified in Paragraph 21.

18. For services provided to non-FQHC attributed clients, clients attributed based on geography, or for dental and specialty behavioral health services, the Department's hired cost report auditor will determine each FQHC's APM encounter rates by utilizing the following steps:

   a. Physical Health Rate for Geographic and Non-FQHC Attributed Clients

   The FQHC Physical Health rates will be effective annually 120 days after the FQHC’s FYE. The rates are calculated using the following methodology.

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 an average of the FQHC's costs and visits for the past three years. Cost data from the previous two years is inflated by the MEI then added to the current year costs. This sum is divided by the sum of the visits from each year. 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 rates determined in Step 1 and Step 2 to establish a rate for 100% of Reasonable Costs. The rate for 100% of Reasonable Costs, the final physical health rate, is calculated as the lesser of the Current Year Physical Health Inflated Rate and the Inflated Physical Health Base Rate.

Step 4: Multiply the final physical health rate by the FQHC's quality modifier to determine the APM 2 Physical Health rate.

   i. The quality modifier will be calculated based on FQHC performance on the selected quality measures in the calendar year prior to the rate year. The quality modifier is calculated using the points an FQHC has earned. Each measure is assigned a point value based on the potential value gained by improved outcomes and difficulty of achieving improvement. Points values for individual measures range from 10 to 60 possible points. The points that each practice earns for individual measures are summed to calculate the

ii. practice's quality score. Each FQHC must receive a quality score of at least 200 points to receive the highest payment rates. The maximum reduced from an FQHC's physical health rate is 4%. If an FQHC receives lower than 200 points, a portion of their rates are reduced. The reduction is calculated as follows: **4% - (Points Earned/200) * 4%**. The Department will notify each FQHC of their Quality Modifier prior to the beginning of the State Fiscal Year. The FQHCs will select quality measures one calendar year prior to the start of the performance year for measurement.

iii. The FQHCs will report on the selected quality measures in the calendar year prior to the rate year, the performance year.

iv. The Department will notify each FQHC of their Quality Modifier prior to the beginning of the State fiscal year.

v. The quality measures, quality modifiers, quality indicators, are effective July 1, 2021 and are published at https://hcpf.colorado.gov/primary-care-payment-reform-3.

vi. Quality modifiers will be calculated for new FQHCs when enough data is available for valid calculation of the selected quality measures. Until then, new FQHCs will be reimbursed at 100% of their physical health rates.

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

b. <u>Specialty Behavioral Health Rate</u>:

The FQHC Specialty Behavioral Health rates will be calculated using costs and visits from the most recent audited cost report for specialty behavioral health services and associated administrative costs. The rates are effective annually 120 days after the FQHC's FYE. The rates are calculated using the following methodology:

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

Step 2: Calculate the Inflated Specialty Behavioral Health Base Rate. The Specialty Behavioral Health Base Rate is calculated by taking an average of the FQHC's costs and visits for the past three years for specialty behavioral health services. Cost data from the previous two years is inflated by the MEI then added to the current year costs. This sum is divided by the sum of the visits from each year. The Specialty Behavioral

Health Base Rate is recalculated every year and is inflated by the MEI to get the Inflated Specialty Behavioral Health Base Rate.

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

Step 4: The FQHC will be reimbursed the Specialty Behavioral Health Rate for specialty behavioral health services.

c. Dental Rate:

The FQHC Dental Rate will be calculated using costs and visits from the most recent audited cost report for dental health services and associated administrative costs. The rates are effective annually 120 days after the FQHC's FYE. The rates are calculated using the following methodology:

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

Step 2: Calculate the Inflated Dental Base Rate. The Dental Base Rate is calculated by taking an average of the FQHC's costs and visits for the past three years for dental services. Cost data from the previous two years is inflated by the MEI then added to the current year costs. This sum is divided by the sum of the visits from each year. The Dental Base Rate is recalculated every year and is inflated by the MEI to get the Inflated Dental 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 final Dental Rate, is calculated as the lesser of the Current Year Dental Rate and the Inflated Dental Rate

Step 4: The FQHC will be reimbursed the Dental Rate for dental services.

19. 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 APM 2 Physical Health Rate for Non-FQHC Attributed Clients.

20. 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.

21. APM 2 Reconciliation to PPS
    a. Annually, 6 months after the end date of the FQHC's PMPM rate year the Department will perform a PPS reconciliation on APM 2 payments in order to monitor whether the payments were in accordance with section 1902(bb) of the Social Security Act. This reconciliation will cover all payments made to an FQHC for PPS visits during their rate payment year. The Department will compare the amount paid under APM 2 (payments received for physical health PMPM for attributed clients, physical health rate for non-FQHC attributed clients, specialty behavioral health, and dental rates) to what would have been reimbursed under the PPS per visit encounter rate. The data for fee-for-service PPS visits will come from MMIS. The state will include all visits for physical health services provided to attributed and non-FQHC attributed clients, specialty behavioral health, and dental. 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 a one-time payment to make up the difference between what was paid through APM 2 and what should have been paid under the PPS per visit encounter rate. This payment will be calculated 6 months after the end of the FQHC's rate payment period to account for claims runout. The payment will be sent out 30 days after the PPS reconciliation analysis is completed. The Department will not recover any PMPM payments from the FQHC for amounts that have been paid above the PPS per visit rate.
    b. The Department shall perform additional PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC. The State and FQHC will track monthly costs and visits. If the monthly costs and/or visits exceed two standard deviations from the FQHC's previous year's average monthly costs and/or visits, the Department will perform a PPS reconciliation. This reconciliation will cover the month(s) under which the deviation occurred.

22. Wrap Payment for APM 2

    If services furnished by an FQHC to a Medicaid eligible recipient are paid by a managed care entity at a rate less than the established encounter rate, a supplemental payment equal to the difference between the encounter rate times the number of visits and the total amount paid by the managed care entity 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.

Scope-of-Service Rate Adjustments:

23. If an 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.

24. An 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 reported cost adheres to the reasonable cost principles set forth in 42 CFR §413 and 45 CFR §75; and

    b. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof of a 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; and.

    c. 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.

25. An 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, if necessary. However, more than one type of change in scope of service may be included in a single application.

26. Should the scope-of-service rate application for one year fail to reach the threshold described in Paragraph 24.c 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. An 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.

27. 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.

28. 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 24c 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.

31. 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.

32. 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.

    b. The rate adjustment methodology will be the same as described in Paragraph 28 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.

33. An 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, an 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.