Table of Contents

State/Territory Name: CO

State Plan Amendment (SPA) CO: 22-0038

This file contains the following documents in the order listed:

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

June 13, 2023

Adela Flores-Brennan, Medicaid Director
Attn: Alex Lyons
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

RE: **Colorado State Plan Amendment (SPA) Transmittal Number 22-003**8

Dear Director Adela Flores-Brennan:

We have reviewed the proposed Colorado State Plan Amendment (SPA) to Attachment 4.19-B CO-22-0038, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 28, 2022. This plan amendment adds a Chronic Condition Episode-Based Incentive payment to Alternative Payment Methodology (APM) 1 and APM 2.

Based upon the information provided by the State, we have approved the amendment with an effective date of October 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt via 303-844-6218 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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: 22-0038

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
October 1, 2022

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 2022 $ 0
b. FFY 2023 $ 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-C to I-P, I-Q to I-R (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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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-C to I-P (TN CO-20-0006)

9. SUBJECT OF AMENDMENT
Adds an Alternative Payment Methodology (APM) 2 for Chronic Condition Episode-Based Incentive Payments.

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 24 September 2022

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED
December 28, 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
December 28, 2022

17. DATE APPROVED
June 13, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

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

22. REMARKS
6/6/23 state concurs with pen and ink changes to Box 5, Box 6, and Box 9.
6/7/23 state concurs with pen and ink change to Box 7.

Instructions on Back

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 1 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 athttps://hcpf.colorado.gov/alternative-payment-model-1-apm-1.
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.

Chronic Conditions Episode-Based Incentive Payment

13. The Chronic Condition Episode-Based Incentive Payment (Chronic Conditions Incentive Payment) will be paid when FQHCs provide physical health services to full benefit Medicaid beneficiaries attributed to the FQHC, who are not geographically attributed or dually eligible for Medicare, and must also be diagnosed with one or more the following chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, hypertension, arrhythmia/heart blockage, heart failure, gastro-esophageal reflux disease, Crohn's disease, ulcerative colitis, low back pain, osteoarthritis, and/or diabetes. Beneficiaries that meet this criterion are qualifying patients for the Chronic Conditions Incentive Payment, referred to hereinafter as Qualifying Patients. The listed chronic conditions above are the episodes of care that an FQHC will be held accountable for. An episode, or episode of care, groups all relevant services provided to a patient for the foregoing chronic condition(s) within a confined time range, including a 30-day lookback period to capture services rendered prior to the trigger condition claim. An episode of care serves as a unit of accounting as well as a unit of accountability for providers who take on financial risk for the chronic condition episode. For those FQHCs that voluntarily participate in the Chronic Condition Episode-Based Incentive Payment, revenues from chronic condition episode-based incentive payment shall not be offset from costs on that most recent audited Medicaid cost report. For those FQHCs that do not signify their participation in this Chronic Condition Episode-Based Incentive Payment in writing with a Chronic Conditions Episode-Based Incentive Payment enrollment letter, the amount of this payment is equal to zero

    a. Definitions:
        i. Commendable Threshold: A prospectively determined, FQHC-specific, cost benchmark that must be met, as described below, in order for an FQHC to earn an incentive payment.
        ii. Historical Data Period: Claims experience from the period of July 1, 2020, to June 30, 2021, are used in the calculation of the Chronic Conditions Incentive Payment. To ensure that the historical data used in rate calculation is appropriate to the payment methodology used during the rate effective period, patients that are attributed to the FQHC during the historical period, but that have eligibility for Medicare or who are geographically attributed, are excluded.
        iii. Performance Period: Begins on the calendar quarter effective date (January 1, April 1, July 1, or October 1) agreed to in the Chronic Conditions Incentive Payment enrollment letter signed by the FQHC and approved by the Department, and ends at the end of that calendar year (December 31). The Performance Period may be different for each FQHC. Performance Periods can begin each quarter within a calendar year and are effective until the FQHC terminates its participation, or a new period is outlined in a subsequent quarter. At the end of a Performance Period, or the beginning of a new calendar year, the FQHC and Department may agree to a new Performance Period and memorialize the new effective dates in an updated Chronic Conditions Incentive Payment enrollment letter. Performance Periods always end at the

end of the calendar year on December 31, regardless of the start date. As such, a Performance Period may be 3 months, 6 months, 9 months, or 12 months, depending on when the agreed upon Performance Period in the Chronic Conditions Incentive Payment enrollment letter begins.

iv. Total Actual Cost: The calculated costs of all episodes during the Performance Period added together.

v. Total Baseline Threshold: The baseline threshold for each episode are multiplied by the count of the corresponding episode type, and the results are added together to compute the Total Baseline Threshold.

b. Episodes: A defined group of related Medicaid covered services provided to a Qualified Patient over a specific period of time for one of the chronic conditions listed in paragraph 21. An episode, or episode of care, groups all relevant services provided to a patient for a particular condition within a confined time range, including a 30-day lookback period to capture services rendered prior to the trigger condition claim. An episode of care serves as a unit of accounting as well as a unit of accountability for providers who take on financial risk for the episode. The characteristics of an episode will vary according to the medical condition for which a patient has been treated. Detailed descriptions and definitions for each episode are found in the Department's Alternative Payment Model 2 website located at (https://hcpf.colorado.gov/alternative-payment-model-2-apm-2).

i. Effective for those specific episodes with an end date on or after October 1, 2022, the defined scope of services within the following episodes of care are subject to incentive adjustments. Definitions and additional information about each episode are available on the Department's Alternative Payment Model 2 website located at (https://hcpf.colorado.gov/alternative-payment-model-2-apm-2).

c. Payments: Subject to the incentive payments described below, FQHCs deliver care to Qualifying Patients and are paid in accordance with the Medicaid payment methodology in effect on the date of service.

d. Thresholds: Thresholds are upper and lower incentive benchmarks for an episode of care and are established prior to the beginning of a performance period.

i. The Commendable Threshold will be calculated with FQHC-specific data using the average cost for 12 qualifying conditions over the Historical Data Period.

ii. If FQHC-specific data is unavailable, the Department will use a statewide average. Outliers above the 95th percentile will be removed from the threshold calculations.

iii. The Commendable Threshold for positive incentive payments includes a minimum savings rate of 2 percent applied to ensure FQHCs are lowering costs and improving the quality of care delivered.

iv. The thresholds will be updated prior to the final episodes of care calculation to account for any CMS-approved policy changes that are effective during the performance period that impact PPS reimbursement levels. This adjustment

will ensure that the final threshold is on the same PPS basis as the actual expenditures the provider will be measured against.

e. Episode Risk Adjustment: Chronic condition episodes will be risk adjusted from a statewide baseline to reflect the risk of each FQHC's Qualifying Patients. The risk adjustment methodology is based on observed variation in episode cost due to category of aid, gender, number of co-morbid chronic conditions, and the number and presence of behavioral health conditions. The risk adjustment methodology is described on the Colorado Primary Care Payment Reform Payment website at (https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%202%20Chronic%20Condition%20Risk%20Adjustment.docx.pdf.)

f. Incentive Payments Based Upon Episodes (Incentive Payments) promote efficient and economic care utilization by making incentive payments based on the aggregate valid and paid claims across a FQHC's episode of care ending during the performance period specified for chronic condition episodes.
    i. After conclusion of the full performance period, which is agreed upon by the Department and the individual FQHC, eligibility for a positive incentive payment is determined on an annual basis. Payments are made no earlier than three months after the end of the performance period.
    ii. Payments equal 50% of the difference between the actual cost per qualifying chronic condition and the Commendable Threshold, if the actual cost is less than that Threshold. The comparison between the Commendable Threshold and the actual incurred costs will include a modification of the Commendable Threshold to account for any CMS-approved rate changes that are effective between the acceptance of the Commendable Threshold by the provider and the end of the performance period.costs will include a modification of the Commendable Threshold to account for any CMS-approved rate changes that are effective between the acceptance of the Commendable Threshold by the provider and the end of the performance period.
    iii. Because the incentive payments are based on aggregated and averaged claims data for a performance period, payments cannot be attributed to specific provider claims. Performance reports will be sent to the providers on a quarterly basis.

g. Timing of Incentive Payments: Each FQHC that is eligible for a positive incentive payment and meets the performance requirements set out in this section shall receive any earned performance payment no later than 180 days after provider receipt of its prior-year performance report.

h. No Incentive Payments: If the average episode reimbursement is higher than the Commendable Threshold, the FQHC will not receive an Incentive Payment. Eligibility for the incentive payment amount will be determined as a comparison between the results of the total baseline threshold and the total actual costs during the performance period. The Department will not distribute incentive payments for FQHCs who do not meet the 2% minimum savings rate, which is described as the Commendable Threshold.

14. Summation of Payments under APM 1 and PPS Reconciliation

The APM 1 payment will be determined by comparing the payments made to the FQHC under this methodology. Total APM 1 reimbursement will be either the combined payments to FQHCs described in paragraph 12 plus the Chronic Condition Episode-Based Incentive Payment described in paragraph 13, or the combined payments to FQHCs made through PPS plus the Chronic Condition Episode-Based Incentive Payment described in paragraph 13, whichever is greater. 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.

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 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.

16. 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)

17. 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.

18. 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 22. 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. PMPM Attribution Methodology

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 choice of a PCMP made with the enrollment broker;
B. Member's utilization with a PCMP, which assigns a member to a PCMP based on the member's claims or service utilization records during the most recent eighteen months
C. Member's family connection in which a member of the same household has a claim history with a PCMP that is appropriate for the member.

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.

19. 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 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.
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 athttps://hcpf.colorado.gov/alternative-payment-model-1-apm-1.
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 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.

20. 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.

21. 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.

Chronic Condition Episode-Based Incentive Payment

22. The Chronic Condition Episode-Based Incentive Payment (Chronic Conditions Incentive Payment) will be paid when FQHCs provide physical health services to full benefit Medicaid beneficiaries attributed to the FQHC, who are not geographically attributed or dually eligible for Medicare, and must also be diagnosed with one or more the following chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, hypertension, arrhythmia/heart blockage, heart failure, gastro-esophageal reflux disease, Crohn's disease, ulcerative colitis, low back pain, osteoarthritis, and/or diabetes. Beneficiaries that meet this criterion are qualifying patients for the Chronic Conditions Incentive Payment, referred to hereinafter as Qualifying Patients. The listed chronic conditions above are the episodes of care that an FQHC will be held accountable for. An episode, or episode of care, groups all relevant services provided to a patient for the foregoing chronic condition(s) within a confined time range, including a 30-day lookback period to capture services rendered prior to the trigger condition claim. An episode of care serves as a unit of accounting as well as a unit of accountability for providers who take on financial risk for the chronic condition episode. For those FQHCs that voluntarily participate in the Chronic Condition Episode-Based Incentive Payment, revenues from chronic condition episode-based incentive payment shall not be offset from costs on that most recent audited Medicaid cost report. For those FQHCs that do not signify their participation in this Chronic Condition Episode-Based Incentive Payment in writing with a Chronic Conditions Episode-Based Incentive Payment enrollment letter, the amount of this payment is equal to zero.

    a. Definitions:

i. Commendable Threshold: A prospectively determined, FQHC-specific, cost benchmark that must be met, as described below, in order for an FQHC to earn an incentive payment.
ii. Historical Data Period: Claims experience from the period of July 1, 2020, to June 30, 2021, are used in the calculation of the Chronic Conditions Incentive Payment. To ensure that the historical data used in rate calculation is appropriate to the payment methodology used during the rate effective period, patients that are attributed to the FQHC during the historical period, but that have eligibility for Medicare or who are geographically attributed, are excluded.
iii. Performance Period: Begins on the calendar quarter effective date (January 1, April 1, July 1, or October 1) agreed to in the Chronic Conditions Incentive Payment enrollment letter signed by the FQHC and approved by the Department, and ends at the end of that calendar year (December 31). The Performance Period may be different for each FQHC. Performance Periods can begin each quarter within a calendar year and are effective until the FQHC terminates its participation, or a new period is outlined in a subsequent quarter. At the end of a Performance Period, or the beginning of a new calendar year, the FQHC and Department may agree to a new Performance Period and memorialize the new effective dates in an updated Chronic Conditions Incentive Payment enrollment letter. Performance Periods always end at the end of the calendar year on December 31, regardless of the start date. As such, a Performance Period may be 3 months, 6 months, 9 months, or 12 months, depending on when the agreed upon Performance Period in the Chronic Conditions Incentive Payment enrollment letter begins.
iv. Total Actual Cost: The calculated costs of all episodes during the Performance Period added together.
v. Total Baseline Threshold: The baseline threshold for each episode are multiplied by the count of the corresponding episode type, and the results are added together to compute the Total Baseline Threshold.

b. Episodes: A defined group of related Medicaid covered services provided to a Qualified Patient over a specific period of time for one of the chronic conditions listed in paragraph 21. An episode, or episode of care, groups all relevant services provided to a patient for a particular condition within a confined time range, including a 30-day lookback period to capture services rendered prior to the trigger condition claim. An episode of care serves as a unit of accounting as well as a unit of accountability for providers who take on financial risk for the episode. The characteristics of an episode will vary according to the medical condition for which a patient has been treated. Detailed descriptions and definitions for each episode are found in the Department's Alternative Payment Model 2 website located at (https://hcpf.colorado.gov/alternative-payment-model-2-apm-2).
    i. Effective for those specific episodes with an end date on or after October 1, 2022, the defined scope of services within the following episodes of care are subject to incentive adjustments. Definitions and additional information about

each episode are available on the Department's Alternative Payment Model 2 website located at (https://hcpf.colorado.gov/alternative-payment-model-2-apm-2).

c. Payments: Subject to the incentive payments described below, FQHCs deliver care to Qualifying Patients and are paid in accordance with the Medicaid payment methodology in effect on the date of service.
d. Thresholds: Thresholds are upper and lower incentive benchmarks for an episode of care and are established prior to the beginning of a performance period.
    i. The Commendable Threshold will be calculated with FQHC-specific data using the average cost for 12 qualifying conditions over the Historical Data Period.
    ii. If FQHC-specific data is unavailable, the Department will use a statewide average. Outliers above the 95th percentile will be removed from the threshold calculations.
    iii. The Commendable Threshold for positive incentive payments includes a minimum savings rate of 2 percent applied to ensure FQHCs are lowering costs and improving the quality of care delivered.
    iv. The thresholds will be updated prior to the final episodes of care calculation to account for any CMS-approved policy changes that are effective during the performance period that impact PPS reimbursement levels. This adjustment will ensure that the final threshold is on the same PPS basis as the actual expenditures the provider will be measured against.
e. Episode Risk Adjustment: Chronic condition episodes will be risk adjusted from a statewide baseline to reflect the risk of each FQHC's Qualifying Patients. The risk adjustment methodology is based on observed variation in episode cost due to category of aid, gender, number of co-morbid chronic conditions, and the number and presence of behavioral health conditions. The risk adjustment methodology is described on the Colorado Primary Care Payment Reform Payment website at (https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%202%20Chronic%20Condition%20Risk%20Adjustment.docx.pdf)
f. Incentive Payments Based Upon Episodes (Incentive Payments) promote efficient and economic care utilization by making incentive payments based on the aggregate valid and paid claims across a FQHC's episode of care ending during the performance period specified for chronic condition episodes.
    i. After conclusion of the full performance period, which is agreed upon by the Department and the individual FQHC, eligibility for a positive incentive payment is determined on an annual basis. Payments are made no earlier than three months after the end of the performance period.
    ii. Payments equal 50% of the difference between the actual cost per qualifying chronic condition and the Commendable Threshold, if the actual cost is less than that Threshold. The comparison between the Commendable Threshold and the actual incurred costs will include a modification of the Commendable Threshold to account for any CMS-approved rate changes that are effective between the acceptance of the

Commendable Threshold by the provider and the end of the performance period.costs will include a modification of the Commendable Threshold to account for any CMS-approved rate changes that are effective between the acceptance of the Commendable Threshold by the provider and the end of the performance period.

iii. Because the incentive payments are based on aggregated and averaged claims data for a performance period, payments cannot be attributed to specific provider claims. Performance reports will be sent to the providers on a quarterly basis.

g. Timing of Incentive Payments: Each FQHC that is eligible for a positive incentive payment and meets the performance requirements set out in this section shall receive any earned performance payment no later than 180 days after provider receipt of its prior-year performance report.

h. No Incentive Payments: If the average episode reimbursement is higher than the Commendable Threshold, the FQHC will not receive an Incentive Payment. Eligibility for the incentive payment amount will be determined as a comparison between the results of the total baseline threshold and the total actual costs during the performance period. The Department will not distribute incentive payments for FQHCs who do not meet the 2% minimum savings rate, which is described as the Commendable Threshold.

23. Summation of APM 2 Payments and Reconciliation to PPS

a. The APM 2 payment will be determined by comparing the payments made to the FQHC under this methodology. Total APM 2 reimbursement will be either the combined PMPM payments to FQHCs described in paragraph 16 through 20, plus the Chronic Condition Episode-Based Incentive Payment described in paragraph 21, or the combined payments to FQHCs made through PPS plus the Chronic Condition Episode-Based Incentive Payment described in paragraph 21, whichever is greater. 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, 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.

24. 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:

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.