

## **Responses to Questions on the Primary Care Fund Application Form for FY 2009-10**

1. QUESTION: Can we complete the Certificate to Waive Documentation of Qualified Provider Criteria if we did so last year?
  - RESPONSE: Yes
  
2. QUESTION: If we complete a Certificate to Waive Documentation of Qualified Provider Criteria, should we attach updated Memorandum of Understanding agreements for the purpose of "arranged for" care?
  - RESPONSE: Yes
  
3. QUESTION: In the Waiver of Documentation of Qualified Provider Criteria Item 3, you ask for the application date. Do you mean the date of our last fully completed application (no waiver)? (I ask because last year we completed the waiver.)
  - RESPONSE: No, you may use last year's application date and award amount when completing the waiver this year. The requirement is if you've been awarded funding within the last three years, even if there was a documentation waiver in those three years.
  
4. QUESTION: If we listed a change last year on the waiver, should we list it again (because it is a change from the last fully completed application)?
  - RESPONSE: No, only list changes since your last application, waiver or not. There is no need to resubmit the same change.
  
5. QUESTION: We're completing the Waiver and attaching updated MOU agreements for the purpose of "arranged for" care. If there is a change to the provider of "arranged for" care, should we simply attach the new MOU, or should we also list it as a "change" on the waiver? Nothing has changed as far as our capacity to meet all of the eligibility requirements for the Primary Care Fund.
  - RESPONSE: List the change in provider on the waiver, note that there has been no decrease in capacity, and attach the updated MOU.
  
6. QUESTION: Can undocumented Colorado residents who are considered to be medically indigent and receiving comprehensive primary care services as defined by the Primary Care Fund application be included in the patient count?
  - RESPONSE: Yes.
  
7. QUESTION: The application instructs that if an agency plans to submit a "Certificate to Waive Documentation of Qualified Provider Criteria", the agency is not required to respond to questions 1-6.

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It seems counterintuitive to not have all agencies respond to the very last box under Question 3/part 8. Coordination and Follow-up for Hospital Care, concerning the “Average Cost per Patient Visit for Calendar Year 2008” (see bottom of page 22 of 35). The average cost per patient changes slightly each year and the state is asking for average cost for 2008. Shouldn't all applicants be required to complete this question?

- **RESPONSE:** In general Questions 1 – 6 are there to document that the provider meets the criteria of a Qualified Provider and is eligible to receive funds. If a provider has met the criteria at least once in the last three years, we agreed with the assumption that the provider would still meet the criteria.

Question 3 is looking to document that the provider provides or arranges for comprehensive primary care services. For a new applicant, we would expect them to answer that part of the question with 2008 data since that is the most recent calendar year. We do not use the data in our calculations of award amounts and therefore do not need it from all applicants. I would actually like to look at the usefulness of asking that part of Question 3 at all.

8. **QUESTION:** We have an MOU with a breast cancer surgeon, who assesses irregular mammograms in addition to doing surgeries. Would he be considered a primary care contractor, or does that go outside the scope of the Primary Care Fund.

- **RESPONSE:** The MOU with this surgeon would not count on the Primary Care Fund application in terms of demonstrating that you Provide or Arrange For comprehensive primary care, since he is a specialist.

9. **QUESTION:** If we are talking about a 3 year time frame should we not include the total amount we received and not just last year's amount?

- **RESPONSE:** No, just including last year's amount received is fine. The idea is to let recipients of an award in any of the past three years waive questions 1 - 6.

10. **QUESTION:** Can we count underinsured patients below 200% FPL?

- **RESPONSE:** No, complete the table for question 7 to arrive at your total number of Medically Indigent Patients below 200% FPL. Clients with Medicaid, CHP+, another governmental coverage (except CICP), or any other third party payer do not meet the definition of Medically Indigent Patients and cannot be included.

11. **QUESTION:** What is Appendix E for?

- **RESPONSE:** Appendix E applies only to Sole Proprietors and can be found on page 10 of the application form under Section B., Item 1:

Individual/Sole Proprietor (If this applies, contact Nancy Dolson prior to the application response due date. Citizen and identification documentation required

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by 24-76.5.101 et seq., C.R.S. (2008) should be provided behind a tab labeled Appendix E.)

This only applies to sole proprietors, such as an individual physician who owns and operates an outpatient clinic. Sole proprietors have to complete an affidavit and provide documentation as required under the statute. Sole providers can contact me at [nancy.dolson@state.co.us](mailto:nancy.dolson@state.co.us) or 303-866-3698 for information on the affidavit process.

12. QUESTION: Can you explain the patient count and freeze date?

- RESPONSE: First, find your total unique patient count for calendar year 2008 and report that number on Step 1 of the Q& table on page 30. Decide on a freeze date, which can be anytime between the end of the calendar year and before the release of the application, i.e., December 31, 2008 and May 31, 2009. Categorize the patient by payer at the patient's last visit that is closest, but not past, the freeze date.

For example, if your freeze date is December 31, 2008, the patient's payer would be the payer on the patient's last visit in 2008. The client below would be counted as a Medicaid client:

Freeze date: December 31, 2008

Last visit closest to the freeze date: August 10, 2008. Payer is Medicaid.

If this same client was seen again in March 2009, and the freeze date is May 31, 2009, the client's payer on the visit in March would be where the patient would be counted:

Freeze date: May 31, 2009

Visit on August 10, 2008. Payer is Medicaid

Visit on March 9, 2009. Patient is uninsured below 200% FPL.

Because the patient is uninsured and below 200% FPL on the visit closest to the freeze date, the patient would be included in your uninsured patient count in Step 3 and in the uninsured and below 200% FPL count in Step 4.