

Title of Rule: Revision to the Medical Assistance Rule Concerning Federally Qualified Health Center Reimbursement, Section 8.700.6
Rule Number: MSB 16-09-21-A
Division / Contact / Phone: Payment Reform / Kevin Martin / 303-866-2842

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule will specify a methodology for calculating an updated Prospective Payment system rate following a change in the scope-of-service for a federally qualified health center. Section 1902(bb) of the Social Security Act specifies that States must adjust the PPS to take into account a change in the scope-of-services. The Colorado State Plan states what qualified a change in the scope-of-services and a general methodology for updating the PPS. It is important to include the specific methodology that the Department plans to use in the State rules so that federally qualified health centers know and understand how their rates are being changed.

2. An emergency rule-making is imperatively necessary

to comply with state or federal law or federal regulation and/or
 for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

BIPA Sec. 702(b) 42 U.S.C. § 1396a (bb)

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2015);
Section 25.5-4-401 (1)(a), C.R.S.

Initial Review

11/10/16

Final Adoption

12/09/16

Proposed Effective Date

01/30/17

Emergency Adoption

DOCUMENT #02

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

This rule will affect the 417,922 Medicaid members that receive medical services at Federally Qualified Health Centers.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Total expenditures for services received at FQHCs during the last fiscal year was \$169,420,600.13 or approximately \$405.39 per member. This rule change could potentially increase the rates paid to FQHCs if the recalculated PPS is greater than the APM since our policy is to choose the greater of the PPS and APM rate. However, Federal regulations stipulate that a change in the scope of services must be taken into account the PPS should be adjusted based on the change in costs and visits seen at an FQHC.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

If the adjusted PPS rate is greater than the APM rate, the rate paid to the FQHC will be higher than it was before the PPS was adjusted.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

The probable costs are that an FQHCs rate could be higher than it previously was due to a PPS rate that is higher than the APM rate. The benefits to the proposed rule are that it will better align the Department with Federal Law and will set a Prospective Payment System rate that is better aligned with the Federally Qualified Health Center's current costs and visits.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

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6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The Department seriously considered a State Plan Amendment to achieve the purpose of this rule. However, it was determined that the State Plan already details the definition and methodology for calculating a rate adjustment due to a change in the scope-of-service so a State Plan Amendment is not necessary. The proposed rule was written to define the exact methodology being used to calculate a rate adjustment due to a change in the scope-of-service.

1 **8.700.6 REIMBURSEMENT**

2 8.700.6.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of
3 reasonable cost. An FQHC may be reimbursed for up to three separate encounters [with](#)
4 [the same client](#) occurring in one day and at the same location, so long as the encounters
5 submitted for reimbursement are any combination of the following: medical encounter,
6 dental encounter, or mental health encounter. Duplicate encounters of the same service
7 category occurring on the same day and at the same location are prohibited unless it is a
8 distinct mental health encounter, which is allowable only when rendered services are
9 covered and paid by a contracted BHO.

10 8.700.6.B A medical encounter, a dental encounter, and a mental health encounter on the
11 same day and at the same location shall count as three separate visits.

12 1. Encounters with more than one health professional, and multiple encounters with
13 the same health professional that take place on the same day and at a single
14 location constitute a single visit, except when the client, after the first encounter,
15 suffers illness or injury requiring additional diagnosis or treatment.

16 2. Distinct mental health encounters are allowable only when rendered services are
17 covered and paid by a contracted BHO.

18 8.700.6.C Encounter rate calculation

19 [a\)](#) Effective July 1, 2014, the encounter rate shall be the higher of the Prospective
20 Payment System (PPS) rate or the alternative payment rate.

21 1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP
22 Benefits Improvement and Protection Act (BIPA) included in the Consolidated
23 Appropriations Act of 2000, Public Law 106-554, [Dec. 21, 2000](#). BIPA is
24 incorporated herein by reference. No amendments or later editions are
25 incorporated.

26 Copies are available [for a reasonable charge and](#) for inspection from the
27 following person at the following address: Custodian of Records, Colorado
28 Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO
29 80203. Any material that has been incorporated by reference in this rule may be
30 examined at any state publications depository library.

31 2. [a\)](#) The alternative payment rate shall be the lower of the annual rate or the base
32 rate. The annual rate and the base rate shall be calculated as follows:

33 [1.a\)](#) Annual rates shall be the FQHCs current year's calculated inflated rate,
34 after audit.

35 [2.b\)](#) The new base rate shall be the calculated, inflated weighted average
36 encounter rate, after audit, for the past three years. Beginning July 1,

1 2004 the base encounter rate shall be inflated annually using the
2 Medicare Economic Index to coincide with the federal reimbursement
3 methodology for FQHCs. Base rates shall be recalculated (rebased)
4 every three years.

5 3. [a\)](#) New FQHCs shall file a preliminary FQHC Cost Report with the Department.
6 Data from the preliminary report shall be used to set a reimbursement base rate
7 for the first year. The base rate shall be calculated using the audited cost report
8 showing actual data from the first fiscal year of operations as a FQHC. This shall
9 be the FQHCs base rate until the next rebasing period.

10 [b\)](#) New base rates may be calculated using the most recent audited Medicaid
11 FQHC cost report for those FQHCs that have received their first federal Public
12 Health Service grant with the three years prior to rebasing, rather than using the
13 inflated weighted average of the most recent three years audited encounter
14 rates.

15 4. [a\)](#) The Department shall audit the FQHC cost report and calculate the new
16 annual and base reimbursement rates. If the cost report does not contain
17 adequate supporting documentation, the FQHC shall provide requested
18 documentation within ten (10) business days of request. Unsupported costs shall
19 be unallowable for the calculation of the FQHCs new encounter rate.

20 [b\)](#) Freestanding FQHCs shall file the Medicaid cost reports with the Department
21 on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding
22 FQHCs shall use the Medicaid FQHC Cost Report developed by the Department
23 to report annual costs and encounters. Failure to submit a cost report within 180
24 days after the end of a freestanding FQHCs' fiscal year shall result in suspension
25 of payments.

26 [c\)](#) The new reimbursement rate for freestanding FQHCs shall be effective 120
27 days after the FQHCs fiscal year end. The old reimbursement rate (if less than
28 the new audited rate) shall remain in effect for an additional day above the 120
29 day limit for each day the required information is late; if the old reimbursement
30 rate is more than the new rate, the new rate shall be effective the 120th day after
31 the freestanding FQHCs fiscal year end.

32 [d\)](#) The new reimbursement rate for hospital-based FQHCs shall be effective
33 January 1 of each year.

34 [e\)](#) If a hospital-based FQHC fails to provide the requested documentation, the
35 costs associated with those activities shall be presumed to be non-primary care
36 services and shall be settled using the Outpatient Hospital reimbursement rate.

37 [f\)](#) All hospital-based FQHCs shall submit separate cost centers and settlement
38 worksheets for primary care services and non-primary care services on the
39 Medicare Cost Report for their facilities. Non-primary care services shall be
40 reimbursed according to Section 8.300.632.

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5. a) If a FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

b) A FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

1. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

2. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

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

4. 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.

5. The change in scope of service must have existed for at least a full six (6) months.

c) A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must ~~be subject to meet~~ the conditions set forth in Section 8.700.6.C.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

1. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

2. The addition or deletion of a covered Medicaid service under the State Plan;

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3. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

4. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

5. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

6. Changes resulting from a change in the provider mix, including, but not limited to:

i. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

ii. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);

iii. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

iv. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

d) The following items do not prompt a scope-of-service rate adjustment:

1. An increase or decrease in the cost of supplies or existing services;

2. An increase or decrease in the number of encounters;

3. Changes in office hours or location not directly related to a change in scope of service;

4. Changes in equipment or supplies not directly related to a change in scope of service;

1 5. Expansion or remodel not directly related to a change in scope of
2 service;

3 6. The addition of a new site, or removal of an existing site, that offers
4 the same Medicaid-covered services;

5 7. The addition or removal of administrative staff;

6 8. The addition or removal of staff members to or from an existing
7 service;

8 9. Changes in salaries and benefits not directly related to a change in
9 scope of service;

10 10. Change in patient type and volume without changes in type, duration,
11 or intensity of services;

12 11. Capital expenditures for losses covered by insurance; or,

13 12. A change in ownership.

14 e) A FQHC must apply to the Department by written notice within ninety (90)
15 days of the end of the FQHCs fiscal year in which the change in scope of service
16 occurred, in conjunction with the submission of the FQHC's annual cost report.
17 ~~For a scope-of-service rate adjustment to be considered, the change in scope of~~
18 ~~service must have existed for at least a full six (6) months. Only one scope-of-~~
19 ~~service rate adjustment will be calculated per year. However, more than one type~~
20 ~~of change in scope of service may be included in a single application.~~

21 f) Should the scope-of-service rate application for one year fail to reach the
22 threshold described in Section 8.700.6.C.5.b.4, the FQHC may combine that
23 year's change in scope of service with a valid change in scope of service from
24 the next year or the year after. For example, if a valid change in scope of service
25 that occurred in FY 2016 fails to reach the threshold needed for a rate
26 adjustment, and the FQHC implements another valid change in scope of service
27 during FY2018, the FQHC may submit a scope-of-service rate adjustment
28 application that captures both of those changes. A FQHC may only combine
29 changes in scope of service that occur within a three-year time frame, and must
30 submit an application for a scope-of-service rate adjustment as soon as possible
31 after each change has been implemented. Once a change in scope of service
32 has resulted in a successful scope-of-service rate adjustment, either individually
33 or in combination with another change in scope of service, that change may no
34 longer be used in an application for another scope-of-service rate adjustment.

1 g) The documentation for the scope-of-service rate adjustment is the
2 responsibility of the FQHC. Any FQHC requesting a scope-of-service rate
3 adjustment must submit the following to the Department:

4 1. The Department's application form for a scope-of-service rate
5 adjustment, which includes:

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

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

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

13 iv. Detailed documentation such as cost reports that substantiate
14 ~~Supporting data that details~~ the change in total costs, total health
15 care costs, and total visits associated with the change(s) in
16 scope; and

17 v. An attestation statement that certifies the accuracy, truth, and
18 completeness of the information in the application signed by an
19 duly appointed officer or administrator of the FQHC;

20 ~~2. Detailed documentation such as cost reports that substantiate the~~
21 ~~supporting data in the aforementioned form; and,~~

22 23. Any additional documentation requested by the Department. If the
23 Department requests additional documentation to calculate the rate for
24 the change(s) in scope of service, the FQHC must provide the additional
25 documentation within thirty (30) days. If the FQHC does not submit the
26 additional documentation within the specified timeframe, the Department,
27 at its discretion, may postpone the implementation of the scope-of-
28 service rate adjustment.

29 h) The reimbursement rate for a scope-of-service change applied for January 30,
30 2017 or afterwards will be calculated as follows:

31 1. The Department will first verify the total costs, the total covered health
32 care costs, and the total number of visits before and after the change in
33 scope of service. The Department will also calculate the Adjustment
34 Factor (AF = covered health care costs/total cost of FQHC services)
35 associated with the change in scope of service of the FQHC. If the AF is
36 80% or greater, the Department will accept the total costs as filed by the

1 FQHC. If the AF is less than 80%, the Department will reduce the costs
2 other than covered health care costs (thus reducing the total costs filed
3 by the FQHC) until the AF calculation reaches 80%. These revised total
4 costs will then be the costs used in the scope-of-service rate adjustment
5 calculation.

6 2. The Department will then use the appropriate costs and visits data to
7 calculate the adjusted PPS rate. The adjusted PPS rate will be the
8 average of the costs/visits rate before and after the change in scope of
9 service, weighted by visits.

10 3. The Department will calculate the difference between the current PPS
11 rate and the adjusted PPS rate. The "current PPS rate" means the PPS
12 rate in effect on the last day of the reporting period during which the most
13 recent scope-of-service change occurred.

14 4. The Department will check that the adjusted PPS rate meets the 3%
15 threshold described above. If it does not meet the 3% threshold, no
16 scope-of-service rate adjustment will be implemented.

17 5. Once the Department has determined that the adjusted PPS rate has
18 met the 3% threshold, the adjusted PPS rate will then be increased by
19 the Medicare Economic Index (MEI) to become the new PPS rate.

20 i) The Department will review the submitted documentation and will notify the
21 FQHC in writing within one hundred twenty (120) days from the date the
22 Department received the application as to whether a PPS rate change will be
23 implemented. Included with the notification letter will be a rate-setting statement
24 sheet, if applicable. The new PPS rate will take effect one hundred twenty (120)
25 days after the FQHC's fiscal year end.

26 j) Changes in scope of service, and subsequent scope-of-service rate
27 adjustments, may also be identified by the Department through an audit or review
28 process at the request of the Department.

29 1. If the Department identifies a change in scope of services, the
30 Department may request the documentation as described in Section
31 8.700.6.C.5.g from the FQHC. The FQHC must submit the
32 documentation within ninety (90) days from the date of the request.

33 2. The rate adjustment methodology will be the same as described in
34 Section 8.700.6.C.5.h.

35 3. The Department will review the submitted documentation and will
36 notify the FQHC by written notice within one hundred twenty (120) days
37 from the date the Department received the application as to whether a

1 PPS rate change will be implemented. Included with the notification letter
2 will be a rate-setting statement sheet, if applicable.

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

6 k) A FQHC may request a written informal reconsideration of the- Department's
7 decision of the PPS rate change regarding a scope-of-service rate adjustment
8 within thirty (30) days of the date of the Department's notification letter. The
9 informal reconsideration must be mailed to the Department of Health Care Policy
10 and Financing, 1570 Grant St, Denver, CO 80203. To request an informal
11 reconsideration of the decision, a FQHC must file a written request that identifies
12 specific items of disagreement with the Department, reasons for the
13 disagreement, and a new rate calculation. The FQHC should also include any
14 documentation that supports its position. A provider dissatisfied with the
15 Department's decision after the informal reconsideration may appeal that
16 decision through the Office of Administrative Courts according to the procedures
17 set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

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19 65. The performance of physician and mid-level medical staff shall be evaluated
20 through application of productivity standards established by the Centers for
21 Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503;
22 "Medicare Rural Health Clinic and FQHC Manual". If a FQHC does not meet the
23 minimum productivity standards, the productivity standards established by CMS
24 shall be used in the FQHCs' rate calculation.

25 8.700.6.D The Department shall notify the FQHC of its rate.
26