Title of Rule: Revision to the Federally Qualified Health Center Rule, Section 8.700
Rule Number: MSB 17-03-23-B
Division / Contact / Phone: Payment Reform / Erin Johnson / 303-866-4370

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).

   The purpose of this Rule is to clarify the Department's payment methodology for services outside of the Federally Qualified Health Center (FQHC) encounter rate. Currently, the rules state that FQHCs are reimbursed a 100% cost-based encounter rate for a one-on-one, face-to-face visit between a client and an eligible provider. This Rule revision is necessary to allow for payments to FQHCs separate from the encounter rate for Long Acting Reversible Contraceptives (LARCs), dentures and partial dentures, services provided at an inpatient hospital setting by the FQHC, dental services provided at an outpatient hospital setting by the FQHC, the Nurse Home Visitor Program, and the Prenatal+ Program. Services provided by a FQHC at an inpatient hospital setting are not FQHC services and therefore should not be reimbursed at the encounter rate. The provision of LARCs, dentures, and partial dentures is costly for FQHCs and therefore an additional payment separate from the encounter rate is necessary to incentivize access and the provision of LARCs. The Prenatal+ Program and Nurse Home Visitor Program currently have payment methodologies that are separate from the encounter rate and are clarified elsewhere in the Rules.

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:

   This rule revision fulfills the necessary requirements to be an Emergency Rule. The purpose of this rule revision is to clarify the Department's payment methodology for Federally Qualified Health Centers (FQHCs), specifically regarding payments separate from the encounter. Currently, our State Plan and rules for FQHCs state that the Department pays the encounter rate for one-on-one, face-to-face visits between a client and eligible provider. However, it is common practice for FQHCs to bill the Department at the Fee Schedule rate for other types of services – such as inpatient hospital services, the cost of LARC devices, dentures, partial dentures, dental services provided at an outpatient hospital location by the FQHC, the Prenatal+ Program, and the Nurse Home Visitor Program. These services should not be reimbursed at the encounter rate and instead should be reimbursed the Fee Schedule rate. However, since our current rules and State Plan do not reference this type of payment there is a large amount of confusion and concern among Department staff and FQHC staff about how to reimburse FQHCs. The Department must revise its rules to reflect payment for these services outside of the encounter rate. If we stop paying for these services outside of the encounter rate they will no longer be provided.

Initial Review	**06/09/17**	Final Adoption	**07/14/17**
Proposed Effective Date	**08/30/17**	Emergency Adoption	

DOCUMENT #04

3. Federal authority for the Rule, if any:

   Section 1902(bb) of the Social Security Act states that State Medicaid Agencies may create an alternative payment methodology for FQHCs as long as the FQHC receives at least their Prospective Payment System (PPS) rate.

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.

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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 420,513 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 $173,425,927.05 or approximately $412.41 per member. This rule change could cause reimbursement to increase for some services delivered at certain FQHCs and to decrease for other services delivered at FQHCs. Many FQHCs are already billing in this manner, and it would have zero budget impact on those FQHCs.

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.

   It is anticipated that the proposed rule will be budget neutral to the Department. This is a change in policy that primarily codifies already existing practices. For those FQHCs that are not billing in line with the proposed rule, there could be a decrease in payment for services that will be determined unallowable under the proposed rule. There could also be an increase in payment for certain services as it clarifies when encounters and fee-for-service claims can be billed in conjunction with each other. The Department assumes that these two impacts will offset each other, resulting in a net budget neutral change.

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

   Since many FQHCs are already billing the Department for these services, and other services, outside of the encounter rate, the costs should be minimal. This rule will eliminate improper billing of services and will give the Department the authority to pay for certain services as fee-for-service claims. Inaction could lead to a disallowance from CMS since these payments were not authorized before they began.

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

It could potentially be less costly to disallow all payments outside of the encounter rate. However, this would lead to less access to important services such as LARCs, dentures, and partial dentures, or result in an increase in utilization of the services from other provider types.

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 disallowing all payments for services outside the encounter rate. However, this idea was rejected as it would be too restrictive to FQHCs and decrease access to imperative health services.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

Visit means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker providing the services set forth in 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

8.700.2 CLIENT CARE POLICIES

8.700.2.A The FQHCs health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the FQHC staff.

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See section 8.700.3.A.3.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the FQHC.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

   a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist or clinical social worker as defined in their respective practice acts.

   b. Part-time or intermittent visiting nurse care.

c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.700.3.A.1.a and b.

2. Emergency services. FQHCs furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

3. Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including ~~inpatient hospital care;~~ physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC.

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

8.700.4.A A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.700.5 ALLOWABLE COST

8.700.5.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist and clinical social worker who owns, is employed by, or furnishes services under contract to an FQHC.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist or clinical social worker.

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

5. Costs of services purchased by the clinic or center.

8.700.5.B Unallowable costs include but are not limited to expenses that are incurred by an FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend

funds on unallowable cost items, but these costs may not be used in calculating the per visit encounter rate for Medicaid clients.

Unallowable costs, include, but are not necessarily limited to, the following:

1. Offsite Laboratory/X-Ray;

2. Costs associated with services paid by a contracted Behavioral Health Organization (BHO) are costs for provision of covered services but not allowed in the FQHC costs;

3. Costs associated with clinics or cost centers which do not provide services to Medicaid clients; and.

4. Costs of services reimbursed separately from the FQHC encounter rate as described in Section 8.700.6.B.

8.700.6 REIMBURSEMENT

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

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department. The fee schedule payment includes denture alignments, adjustments, and repairs within the first 6 months after placement of the denture. If the fee schedule amount is less than what would have been reimbursed under the per visit PPS rate, the Department will ensure that full payment has been received by the FQHCs.

4. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

5. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

6. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.

7. A FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.

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

1. 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.

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

8.700.6.D~~C~~ Encounter rate calculation

a) Effective July 1, 2014, the encounter rate shall be the higher of the Prospective Payment System (PPS) rate or the alternative payment rate.

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

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

2. a) The alternative payment rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

1. Annual rates shall be the FQHCs current year's calculated inflated rate, after audit.

2. The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years.

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

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

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

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

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

d) The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year.

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

f) All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.300.6.

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 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;

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;

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

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

7. The addition or removal of administrative staff;

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

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

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

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

12. A change in ownership.

e) A FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

f) Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.C.5.b.4, 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 FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. A FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

g) 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:

1. 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;

iv. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

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

2. 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, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

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

1. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

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

3. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. 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.

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

5. 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.

i) The Department will review the submitted documentation and will notify the FQHC in writing 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.

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

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

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

3. 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.

4. 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.

k) A FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, a FQHC must file a written request 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. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

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

8.700.6.E~~D~~ The Department shall notify the FQHC of its rate.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department. The reasonable cost-per application limit shall be based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall the outstationing payment for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.

8.700.8.B

1. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

8.700.8.C To receive payment, FQHCs shall submit annual logs of applicant information to the Department with their cost report. Applicant logs shall include the applicant's name, date of application, and social security number if available.

8.700.8.D Reimbursement for outstationing administrative costs shall be determined according to the following guidelines:

1. Freestanding FQHCs shall report on a supplementary schedule the administrative and general direct pass-through costs associated with outstationing activities. The Department shall allocate appropriate overhead costs (not separately identified) to calculate the total facility outstationing administrative expenses incurred. Freestanding FQHCs shall receive an annual lump sum retrospective payment based on the audited cost report.

2. Hospitals with hospital-based FQHCs shall submit the administrative and general pass through direct and indirect costs associated with outstationing activities on an extra line on the Medicaid Cost Report and submit all other source documentation to compute allowable outstationing costs. Hospitals with hospital-based FQHCs shall receive payment in accordance with 8.700.8.B. The reimbursement shall be separately identified on the Medicaid Settlement Sheet.