

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 from
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. BIPA is incorporated herein by
24 reference. No amendments or later editions are incorporated.

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

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

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

34 2.b) The new base rate shall be the calculated, inflated weighted average
35 encounter rate, after audit, for the past three years. Beginning July 1,
36 2004 the base encounter rate shall be inflated annually using the

1 Medicare Economic Index to coincide with the federal reimbursement
2 methodology for FQHCs. Base rates shall be recalculated (rebased)
3 every three years.

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

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

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

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

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

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

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

36 [f\)](#) All hospital-based FQHCs shall submit separate cost centers and settlement
37 worksheets for primary care services and non-primary care services on the
38 Medicare Cost Report for their facilities. Non-primary care services shall be
39 reimbursed according to Section 8.332.

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

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

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

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

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

17 4. The net change in the FQHC's per-visit encounter rate equals or
18 exceeds 3% for the affected FQHC site. For FQHCs that file
19 consolidated cost reports for multiple sites in order to establish the initial
20 PPS rate, the 3% threshold will be applied to the average per-visit
21 encounter rate of all sites for the purposes of calculating the cost
22 associated with a scope-of-service change.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 7. The addition or removal of administrative staff;

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

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

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

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

9 12. A change in ownership.

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

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

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

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

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

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

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

6 iv. Detailed documentation such as cost reports that substantiate
7 Supporting data that details the change in total costs, total health
8 care costs, and total visits associated with the change(s) in
9 scope; and

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

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

15 ~~23. Any additional documentation requested by the Department. If the~~
16 ~~Department requests additional documentation to calculate the rate for~~
17 ~~the change(s) in scope of service, the FQHC must provide the additional~~
18 ~~documentation within thirty (30) days. If the FQHC does not submit the~~
19 ~~additional documentation within the specified timeframe, this may delay~~
20 ~~implementation of any approved scope-of-service rate adjustment.~~

21 h) The reimbursement rate for a scope-of-service change applied for January 30,
22 2017 or afterwards will be calculated as follows:

23 1. The Department will first verify the total costs, the total covered health
24 care costs, and the total number of visits before and after the change in
25 scope of service. The Department will also calculate the Adjustment
26 Factor (AF = covered health care costs/total cost of FQHC services)
27 associated with the change in scope of service of the FQHC. If the AF is
28 80% or greater, the Department will accept the total costs as filed by the
29 FQHC. If the AF is less than 80%, the Department will reduce the costs
30 other than covered health care costs (thus reducing the total costs filed
31 by the FQHC) until the AF calculation reaches 80%. These revised total
32 costs will then be the costs used in the scope-of-service rate adjustment
33 calculation.

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

38 3. The Department will calculate the difference between the current PPS
39 rate and the adjusted PPS rate. The "current PPS rate" means the PPS

1 rate in effect on the last day of the reporting period during which the most
2 recent scope-of-service change occurred.

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

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

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

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

18 1. If the Department identifies a change in scope of services, the
19 Department may request the documentation as described in ~~Section~~
20 8.700.6.C.5.g from the FQHC. The FQHC must submit the
21 documentation within ninety (90) days from the date of the request.

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

24 3. The Department will review the submitted documentation and will
25 notify the FQHC by written notice within one hundred twenty (120) days
26 from the date the Department received the application as to whether a
27 PPS rate change will be implemented. Included with the notification letter
28 will be a rate-setting statement sheet, if applicable.

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

32 k) A FQHC may request an informal reconsideration, ~~as described in 8.050.6,~~ of
33 the Department's decision regarding a scope-of-service rate adjustment within
34 thirty (30) days of the date of the Department's notification letter. If the
35 Department fails to act on an application for a rate adjustment within one
36 hundred twenty (120) days of submission by the FQHC, the application will be
37 deemed to be denied. To request a reconsideration of the decision, a FQHC
38 must file a written request that identifies specific items of disagreement with the

1 [Department, reasons for the disagreement, and a new rate calculation. The](#)
2 [FQHC should also include any documentation that supports its position.](#)

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4 [65.](#) The performance of physician and mid-level medical staff shall be evaluated
5 through application of productivity standards established by the Centers for
6 Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503;
7 “Medicare Rural Health Clinic and FQHC Manual”. If a FQHC does not meet the
8 minimum productivity standards, the productivity standards established by CMS
9 shall be used in the FQHCs’ rate calculation.

10 8.700.6.D The Department shall notify the FQHC of its rate.

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