

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

Coverage and Reimbursement Update for Federally Qualified Health Center (FQHC) Services (SPA 16-015)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective on or after March 1, 2016, SPA 16-015 will amend Attachments 3.1-A and 3.1-B of the Medicaid State Plan to update the description of coverage of Federally Qualified Health Center (FQHC) services. The SPA also amends Attachment 4.19-B of the Medicaid State Plan to clarify that FQHCs are reimbursed an all-inclusive encounter rate per client in accordance with a prospective payment system pursuant to 42 USC 1396a (bb) and to delineate the process by which an FQHC may apply for an adjustment of its encounter rate based upon a change in scope of services. DSS is making these changes to ensure consistency with state and federal laws and to provide clarification regarding the existing reimbursement methodology, as well as to make the Medicaid State Plan language more comprehensive, as required by CMS in accordance with the companion letter to approved SPA 13-003.

Fiscal Information

Because the changes proposed by SPA 16-015 are merely to clarify and update language and to ensure consistency with state and federal laws, this SPA is not anticipated to result in any change in Medicaid expenditures.

Information on Obtaining SPA Language and Submission of Comments

In accordance with federal Medicaid requirements, upon request, DSS will provide copies of the proposed SPA. Copies of the proposed SPA may also be obtained at any DSS regional office and on the DSS website: <http://www.ct.gov/dss>. Go to “Publications” and then “Updates”.

Written, phone, and email requests should be sent to Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799, Email: ginny.mahoney@ct.gov). Please reference “SPA 16-015: Coverage and Reimbursement for FQHC Services”. Members of the public may also send DSS written comments about this SPA. Written comments must be received at the above contact information no later than March 9, 2016.

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: No limitations With limitations*
 Not provided.

2. a. Outpatient hospital services.

Provided: No limitations With limitations*
 Not provided.

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

Provided: No limitations With limitations*
 Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: No limitations With limitations*
 Not provided.

3. Other laboratory and x-ray services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

2. a. Outpatient Hospital Services

1. No more than one (1) visit per day to the same outpatient clinic, except for outpatient psychiatric clinic services at acute care hospitals and public or private freestanding psychiatric hospitals. Outpatient hospital psychiatric services are claimed on a service specific basis.

2. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

b. Rural Health Clinic Services

There are no Rural Health Clinics in Connecticut.

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL**

c. Federally Qualified Health Center (FQHC)

1. Federally Qualified Health Center (FQHC) services are defined in section 1905 (a) (2) (C) of the Social Security Act (the Act). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, licensed clinical social workers, and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife.

Encounters with more than one health professional for the same type of service and multiple interactions with the same health professional that take place on the same day constitute a single encounter except when the patient after the first interaction, suffers illness or injury requiring additional diagnosis and treatment. Medicaid pays for one medical encounter, one behavioral health encounter and one dental encounter per day.

Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

2. The Department subjects nonemergency dental services provided by federally qualified health centers to prior authorization. Nonemergency services that are exempt from prior authorization include diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.
3. Federally qualified health center dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.
4. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.
5. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

3. Other Laboratory and X-Ray Services

No limitation on services.

TN # 16-015

Approval Date _____

Effective Date: 3-1-16

Supersedes

TN # NEW

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL**

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b. Rural Health Clinic Services

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Effective Date: 3-1-16

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL**

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut**

in subsection (2)(d) below. PCMH practices are eligible for this payment only if they participate as a PCMH for the entire measurement year. The tiers of performance are as follows:

Performance Percentile	Level of Supplemental Payment
Under 25th percentile	No payment
25th–50th percentile	25% of possible payment
51st–75th percentile	50% of possible payment
76th–90th percentile	75% of possible payment
91st–100th percentile	100% of possible payment

- b. **Supplemental Payment for Performance Improvement:** Outpatient hospital clinic PCMHs that meet all requirements for this supplemental payment will receive a payment totaling a maximum of \$0.81 for each member’s enrollment month attributed to the clinic. Payments will be issued retrospectively in a lump sum on an annualized basis during the quarter ending June 30th for services provided in the previous calendar year. PCMH practices are eligible for this payment only if they have participated as a PCMH for at least two full calendar years. The payment amount will be based on the practice’s performance using the quality performance measures described in subsection (2)(d) below.

The Department will make tiered payments based on each clinic’s degree of improvement compared with the previous year. Performance targets and tiers will be set collectively and for each quality performance measure described in subsection (2)(d) below based on the clinical or social significance of each measure and the practice’s ability and need to improve in each measure. The tiers will be adjusted each year to account for variation in past performance. Clinics performing in the 91st to 100th percentile at both baseline and measurement years will be eligible for this supplemental payment even without any improvement in a given measurement year.

- (b) Rural health clinic services** – not provided.

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State Connecticut

(c) **Federally Qualified Health Centers (FQHC)** The rate setting methodology conforms to the prospective payment system under Medicare, Medicaid and SCHIP Benefits Improvement and Protections Act (BIPA) of 2000.

(1) The department shall reimburse a FQHC an all-inclusive encounter rate per client encounter in accordance with a PPS as required by 42 USC 1396a (bb).

((2) The department shall establish the baseline encounter rate for each FQHC in existence during fiscal years 1999 and 2000 as follows:

(A) Total encounters and costs shall be obtained from the annual reports submitted by the FQHC for fiscal years 1999 and 2000;

(B) Each year's total costs shall be divided by the total encounters. The FQHC shall include the costs of all Medicaid covered services provided by the FQHC;

(C) A two-year average of the calculated cost per encounter rates for fiscal years 1999 and 2000 will be used for each facility. The department shall determine the two-year average for each FQHC by calculating the average cost per encounter rate separately for each year, then adding the averages together and dividing by two.

(D) For a FQHC that did not file a 1999 annual report, the baseline encounter rate shall be based upon the annual report submitted for fiscal year 2000.

(E) For a center that first qualified as a FQHC after fiscal year 2000, the department shall determine the baseline encounter rate based upon the encounter rate established under this section for FQHCs located in the same area with similar services.

(F) The department shall adjust annual encounter rates by applying the percentage increase in the Medicare economic index (MEI) as defined in 42 USC 1395u (i)(3) to the previous fiscal year's encounter rate in accordance with 42 USC 1396a (bb) (3) (A)

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(G) The department may adjust the encounter rate for a change in the scope of services provided by a FQHC in accordance with section 17b-262-1001 of the Regulations of Connecticut State Agencies.

(2) Examples of changes in scope of services by a FQHC for which the department may adjust the encounter rate include, but are not limited to, the following:

(A) A change in the volume or amount of services as a result of a significant expansion or reduction of an existing clinic, or the addition or discontinuance of a satellite or new site;

(B) A change in operational costs that is attributable to capital expenditures, including new service facilities or regulatory compliance, provided that the additional costs result in a change in the volume, amount, or intensity of services. The cost of a new or expanded building alone would not necessarily qualify;

(C) The addition or deletion of any Medicaid covered service eligible under the FQHC reimbursement program;

(D) A change in the operational costs attributable to changes in technology or medical practices at the FQHC;

(E) A change of costs due to recurring taxes, malpractice insurance premiums, or workers' compensation premiums that were not recognized and included in the PPS baseline calculation;

(F) A change in federal or state regulatory requirements that would impact FQHC costs; or

(G) A HRSA-approved change in the scope of project, provided that the change is consistent with federal and state Medicaid regulations.

(3) In the event of a change in scope of service for which a FQHC seeks a rate adjustment, a FQHC shall submit a written request to the Commissioner that includes the following:

(A) A description of the change in scope of services and the reason for the change;

(B) The impact on capital and operating costs;

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- (C) The requested change in rate; and
- (D) All documentation submitted to HRSA regarding a change in scope of project, if applicable.
- (5) An FQHC shall file a preliminary cost report to support its request for a rate adjustment not later than 90 days after the date on which the FQHC submitted its request for a rate adjustment.
- (6) If a FQHC has received approval for a change in scope of project from HRSA for which it seeks a rate adjustment for a change in scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the FQHC has received approval from HRSA for the change in scope of project. The FQHC shall submit all documentation submitted to HRSA regarding the change in scope of project.
- (7) If a FQHC is not required to file a change in scope of project with HRSA but plans an increase or decrease in services or sites to be offered by the FQHC that result in a change to the FQHC's scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the end of the FQHC's fiscal year. A FQHC shall submit all documentation required or requested by the department with respect to the change in scope of service.
- (8) The department may initiate a change in scope of service and resulting encounter rates following a review of the FQHC's scope of project, subsequent amendments to the scope of project, cost reports and audited financial statements by notifying the FQHC in writing and requesting documentation with respect to the proposed change in scope of service. A FQHC shall submit all requested documentation not later than ninety days after receipt of the notice of the proposed change in scope of services.
- (9) In making its determination with respect to whether a FQHC's encounter rate may be adjusted based upon a change in scope of services, the department shall review the following:
- (A) The FQHC's Medicaid cost report;
- (B) The FQHC's audited financial statements; and
- (C) Any other documentation relevant to the change in scope of services.
- (10) The department shall issue a decision on a request for an adjustment to the FQHC's encounter rate not later than 120 days after the date on which the FQHC submits the request to the department.

Effective only from January 1, 2012 through December 31, 2012, Person Centered Medical Home (PCMH) practices are individual FQHC sites that have met National Committee for

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