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State/Territory Name: CO

State Plan Amendment (SPA) CO: 22-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

October 24, 2022

Bettina Schneider, Chief Financial Officer
Attn: Amy Winterfeld
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

RE: **Colorado State Plan Amendment (SPA) Transmittal Number 22-0002**

Dear Ms. Schneider:

We have reviewed the proposed Colorado State Plan Amendment (SPA) to Attachment 4.19-B of your state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 28, 2022. This plan amendment updates language for Rural Health Center's Alternative Payment Methodology rate setting process, adds a scope of service rate adjustment process, adds a process to ensure Rural Health Centers are paid at least their per visit Prospective Payment System rate by Managed Care Entities, and adds language for setting rates for new Rural Health Centers.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 01, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact LaJoshica (Josh) Smith via 214-767-6453 or lajoshica.smith@cms.hhs.gov.

Sincerely,

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0002

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act, Section 1902(a)(2) / 42 C.F.R. § 447.371

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B – Methods and Standards for Establishing Payment Rates – Item 8 -- Rural Health Clinic Services – Pages 3A to 3B, and 3C to 3E (NEW) of 3E

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B – Methods and Standards for Establishing Payment Rates – Item 8 -- Rural Health Clinic Services – Pages 3A to 3B of 3B (TN CO-15-0002)

9. SUBJECT OF AMENDMENT
Updates the language for Rural Health Center's Alternative Payment Methodology rate setting process, adds a scope of service rate adjustment process, adds a process to ensure Rural Health Centers are paid at least their per visit Prospective Payment System rate by Managed Care Entities, and adds language for setting rates for new Rural Health Centers.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Governor's letter dated 14 July 2021

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted] signed by Bettina Schneider, CFO 22.03.25 08:22:01 -06'00'

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED
March 28, 2022

15. RETURN TO
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Amy Winterfeld

FOR CMS USE ONLY

16. DATE RECEIVED
03/28/22

17. DATE APPROVED
October 24, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/22

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

8. Rural Health Clinic (RHC) Services - Reimbursement shall be made according to the following:

A. All Participating RHCs, including freestanding and hospital-based centers, will be subject to the payment methodologies described in section 702(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554.

B. RHC encounter rates are effective each year on January 1st and shall be the higher of:

a. The Prospective Payment System (PPS), as defined by Section 702 of the Medicare, Medicaid, and SCHIP BIPA of 2000, Public Law 106-554.
b. The Alternative Payment Methodology (APM) rate
    i. The APM rate for hospital-based RHCs shall be based on actual costs.
        1. The interim rate for hospital-based RHCs shall be the greater of the current year PPS rate and the most recent audited and finalized cost per visit from the Medicare cost report.
        2. After a hospital-based RHC's cost report has been audited and finalized, the Department shall perform a reconciliation for the services provided by the RHC during the year the cost report covers. If the Department's interim rate was below the finalized rate, a one-time payment will be made to the RHC. If the Department's interim rate was above the finalized rate and the PPS rate, the Department will recoup the difference from the RHC.
    ii. The APM rate for freestanding RHCs is the Medicare Upper Payment Limit (UPL) for RHCs.

C. If services furnished by an RHC to a Medicaid eligible recipient are paid by a managed care entity at a rate less than the established rate, a supplemental payment equal to the difference between the rate paid by the managed care entity and the established rate times the number of visits shall be made quarterly by the managed care entity. When supplemental payments are made by the managed care entity to the RHC, the individually affected RHC must agree to this

payment methodology. Managed care entities are required to reimburse RHCs at an amount no less than the higher of the APM rate or the PPS rate. The Department will collect reporting no less than quarterly to ensure that full payment has been received by the RHCs.

D. New RHCs shall be reimbursed an interim per visit encounter rate, which shall be calculated as follows:
   a. For new freestanding RHCs, the interim rate will be the average of other freestanding RHC APM rates in the new RHCs Regional Accountable Entity (RAE).
   b. For new hospital-based RHCs, the interim rate will be calculated based on the following options in the following order:
      i. The per visit encounter rate established by a Medicare rate letter; or
      ii. A sister clinic's per visit encounter rate
   c. A hospital-based RHC's interim rate will be updated if the RHC provides an updated Medicare rate letter. The new rate will be effective the following January 1st.

E. PPS rates for new RHCs shall be calculated as follows:
   a. For new freestanding RHCs, the PPS rate shall be calculated based on the average of other freestanding RHC's PPS rates in the new RHC's RAE.
   b. For new hospital-based RHCs, the PPS rate shall be calculated based on an average of two year's audited cost and visit data from the RHC's Medicare cost report.

F. Effective April 1, 2015, the Department of Health Care Policy and Financing will reimburse Long Acting Reversible Contraception (LARC) and Non-Surgical Transcervical Permanent Female Contraceptive Devices separate from the Rural Health Clinic per visit rate. Reimbursement will be the lower of: 340B acquisition costs; Submitted charges; or fee schedule for LARC or transcervical permanent contraceptive devices as determined by the Department. of Health Care Policy and Financing. Rural Health Clinics will be paid using the Medicaid fee schedule rates effective for services on or after the date listed on the Attachment 4.19-B Introduction Page.

Scope of Service Rate Adjustments:

G. If an RHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the RHC's PPS rate to adhere to Section 702(b) of BIPA.

H. An RHC 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 RHC, subject to all of the following:
   a. 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 RHC.

b. The reported cost adheres to the reasonable cost principles set forth in 42 CFR §413 and 45 CFR §75.
c. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.
d. The net change in the RHC's per-visit encounter rate equals or exceeds 3% for the affected RHC site.

I. An RHC must apply to the Department by written notice within one hundred twenty (120) days of the end of the fiscal year in which the change in scope of service occurred. For a scope-of-service rate adjustment to be considered, the change in scope of service must have existed for at least a full six (6) months. 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.

J. Should the scope-of-service rate application for one year fail to reach the threshold described in Paragraph H.d. above, the RHC 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 FY2022 fails to reach the threshold needed for a rate adjustment, and the RHC implements another valid change in scope of service during FY2023, the RHC may submit a scope-of-service rate adjustment application that captures both of those changes. An RHC 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.

K. The documentation for the scope-of-service rate adjustment is the responsibility of the RHC. Any RHC requesting a scope-of-service rate adjustment must submit the following to the Department:

a. 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; and

iv. An attestation statement.

b. The Department' s data section form for a scope-of-service rate adjustment;

c. Detailed documentation and/or cost reports that substantiate the data in the aforementioned forms; and,

d. 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 RHC must provide the additional documentation within thirty (30) days. If the RHC does not submit the additional documentation within the specified timeframe, this may delay implementation of any approved scope-of-service rate adjustment.

L. The reimbursement rate for a scope-of-service change will be calculated as follows

a. The Department will verify the total reasonable costs and visits associated with the change in scope, and use those data to develop a costs/visits rate associated with the change in scope.

b. The Department will calculate an adjusted PPS rate. This adjusted PPS rate will be the average of the current PPS rate and the rate associated with the change in scope, weighted by visits. 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.

c. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate, and verify that the adjusted PPS rate meets the 3% threshold described in Paragraph H.d. above. If it does not meet the 3% threshold, no scope-of service rate adjustment will be implemented.

d. 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.

M. The Department will review the submitted documentation and will notify the RHC 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. The new PPS rate will take effect on the following January 1st.

N. Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified and calculated through an audit or review process.

a. If this occurs, the Department may request the relevant documentation, as described in Paragraph K above, from the RHC. The RHC will then have ninety (90) days from the date of the request in which to provide the requested documentation.

b. The rate adjustment methodology will be the same as described in Paragraph L above.

c. The Department will review the submitted documentation and will notify the RHC 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.
d. The effective date of the scope-of-service rate adjustment will be the following January 1st.

O. An RHC may appeal the Department' s decision regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department' s notification letter. If the Department fails to act on an application for a rate adjustment within one hundred twenty (120) days of submission by the RHC, the application will be deemed to be denied. To appeal the decision, An RHC must file a written appeal that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The RHC should also include any documentation that supports its position.