

SPECIAL NOTICE: The period for the submission of public comments has been extended until Wednesday, November 18, 2015.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

Alternative Payment Methodology to Provide for Supplemental Payments for Federally Qualified Health Centers (FQHCs) and Look-Alike FQHCs (SPA 15-040)

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

Changes to Medicaid State Plan

Effective on or after October 1, 2015, SPA 15-040 will amend Attachment 4.19-B of the Medicaid State Plan to set forth an alternative payment methodology (APM) that provides for supplemental payments to FQHCs in addition to the existing prospective payment system (PPS) reimbursement methodology that is paid to each FQHC. This change is being made in order to reflect the state budget transfer of state funds from the Department of Public Health to DSS. Previously, DPH used those state funds to make payments to FQHCs. This SPA enables DSS to make Medicaid payments to FQHCs as an APM to provide supplemental payments in addition to the PPS for each FQHC. In accordance with section 17b-349 of the Connecticut General Statutes, as amended by section 403 of Public Act 15-5 of the June 2015 special session, DSS will allocate these funds, within available appropriations, to FQHCs based on cost, volume and quality measures determined by DSS and as set forth in the SPA.

A public notice for this SPA was previously published in the Connecticut Law Journal on June 30, 2015. This notice supersedes that notice.

Fiscal Information

Based on available information, DSS estimates that this SPA will increase annual aggregate Medicaid expenditures by approximately \$3,890,000 each for State Fiscal Years 2016 and 2017.

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Information on Obtaining SPA Language and Submitting 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 web site: <http://www.ct.gov/dss>. Go to “Publications” and then “Updates”.

Written, phone, and email requests should be sent to Christopher A. LaVigne, Office of Reimbursement & Certificate of Need, Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105, Telephone: 860-424-5719, Email: Christopher.Lavigne@ct.gov. Please reference: “SPA 15-040 – Alternative Payment Methodology to Provide for Supplemental Payments to FQHCs”. Members of the public may also send written comments to DSS about the proposed SPA. Written comments must be received at the above contact information no later than October 14, 2015.

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(e) Federally Qualified Health Centers (FQHC) Alternative Payment Methodology (APM) Payments – FQHC Medicaid APM payments shall be equal to each clinic's PPS plus two additional payments, Part A and Part B as defined below. The APM payments for both Part A and Part B shall total up to \$3,890,000 for the period of October 1, 2015 through June 30, 2016 and up to \$3,890,000 for the state fiscal year ending June 30, 2017. Payments shall be issued by the Department on a quarterly basis.

Part A: APM Payments

Part A additional APM payments shall be based on the number of FQHC medical encounters for dates of service from July 1, 2013 through June 30, 2014 and July 1, 2014 through June 30, 2015. An eligible FQHC will qualify for payment based the number of paid Medicaid medical encounters as determined by the count of paid T1015 claims through the MMIS. Cross-over claims will be included in the final count.

For the period of October 1, 2015 through June 30, 2016:

- i. For each FQHC with a medical encounter rate below \$143.00, the total number of medical encounters for the period of July 1, 2013 through June 30, 2014 shall be totaled and doubled.
- ii. For each FQHC with a medical encounter rate of \$143.00 and above, the total number of medical encounters for the period of July 1, 2013 through June 30, 2014 shall be totaled.
- iii. For each FQHC, the number of medical encounters identified under Part A items i and ii. shall be divided by the total number of medical encounters for all FQHCs identified under Part A items i and ii.
- iv. For each FQHC, the results of Part A item iii. shall be multiplied by up to \$1,945,000. This will result in the FQHC specific payment.

For the period of July 1, 2016 through June 30, 2017:

- i. For each FQHC with a medical encounter rate below \$143.00, the total number of medical encounters for the period of July 1, 2014 through June 30, 2015 shall be totaled and doubled.
- ii. For each FQHC with a medical encounter rate of \$143.00 and above, the total number of medical encounters for the period of July 1, 2014 through June 30, 2015 shall be totaled.

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- iii. For each FQHC, the number of medical encounters identified under Part A items i and ii. shall be divided by the total number of medical encounters for all FQHCs identified under Part A items i and ii.
- iv. For each FQHC, the results of iii. shall be multiplied by up to \$1,945,000. This will result in the FQHC specific payment.

Providers are required to make adequate documentation available to the Department as necessary to allocate the additional payment used for this APM. After timely filing limits have been reached, any subsequent negative adjustments related to overpayments shall be applied on a FQHC specific basis and will not result in any redistributions or additional payments.

Part B: APM Payments

Part B additional APM payments shall be based on the methodology below

Quality Adjustment: Calculating the FQHC Quality Score

- i. For the period of October 1, 2015 through June 30, 2016, quality rankings will be based on calendar year 2014 quality performance measures (HEDIS 2015) and SFY 2014 medical encounters. For the period of July 1, 2016 through June 30, 2017, overall quality rankings will be based on calendar year 2015 quality performance measures (HEDIS 2016) and SFY 2015 medical encounters. Medicaid medical encounters shall be determined by counting paid T1015 claims through the MMIS. Cross-over claims will be included in the final count.
- ii. For each time-period identified in Part B item i, FQHCs will receive a rank for each of the following five quality measures.
 - (1) Respiratory Conditions: Medication Management for People with Asthma - age 5-64 for HEDIS 2015 and 5-85 for HEDIS 2016 (75% of Component of MMA HEDIS Measure)
 - (2) Ambulatory Care-ED Visit per 1000 MM (HEDIS)
 - (3) Readmission within 30 Days - age 0 to 64 (MMDLN)
 - (4) Comprehensive Diabetes Care - Eye Exam - age 18 to 75
(a component of the CDC HEDIS measure)

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- (5) Adolescent Well Care Visits - age 12 to 21 (AWC HEDIS Measure)
- iii. Quality ranks for the five measures shall be totaled for each FQHC. This will calculate an FQHC's quality score. The lower the score the higher the overall quality score.

DST Care Analyzer Relative Risk Score: Calculating the FQHC Care Analyzer Adjustment

- iv. For the period of October 1, 2015 through June 30, 2016, the DST Care Analyzer adjustment will be based on the FQHC's calendar year 2014 DST Care Analyzer Relative Risk Score. For the period of July 1, 2016 through June 30, 2017, the DST Care Analyzer adjustment will be based on the FQHC's calendar year 2015 DST Care Analyzer Relative Risk Score.
- v. Each FQHC's overall quality score as determined in Part B item iii shall be adjusted by the FQHC's DST Care Analyzer Relative Risk Score according to the following schedule:
- Equal or greater than 1.6 = -2 points (to reflect a bonus)
 - Greater than 1.28 and less than 1.6 = -1 point (to reflect a bonus)
 - Equal to 1.28 = 0 points (median score)
 - Less than 1.28 and equal or greater than 0.95 = +1 point (to reflect a penalty)
 - Less than 0.95 = +2 points (to reflect a penalty)

Calculating an FQHC's Overall Rank and Payment

- vi. An FQHC's overall rank shall be based on the result of Part B items iii and v.
- vii. For each of the time-periods identified in Part B item i, FQHCs shall be assigned a Per Medical Encounter Weight based on the results of Part B item vi and Part B item viii. The FQHC's Per Medical Encounter Weight shall be multiplied by the Medical Encounters and the APM Base Rate.
- viii. The APM Base Rate will be calculated so that the aggregated payments to all FQHCs will total up to \$1,945,000.

$$\text{APM Base Rate} = \$1,945,000 \div \text{sum of P} = \$B$$

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Column:	A	E	P	B	T
Rank per Part B item v	Per Medical Encounter Weight	Medical Encounters per Part B item i	Product of A X E	APM Base Rate	Total of A X E X B
1	100%	E1	P1	\$B	T1
2	100%	E2	P2	\$B	T2
3	100%	E3	P3	\$B	T3
4	75%	E4	P4	\$B	T4
5	75%	E5	P5	\$B	T5
6	75%	E6	P6	\$B	T6
7	75%	E7	P7	\$B	T7
8	50%	E8	P8	\$B	T8
9	50%	E9	P9	\$B	T9
10	0%	E10	P10	\$B	T10
11	0%	E11	P11	\$B	T11
12	0%	E12	P12	\$B	T12
13	0%	E13	P13	\$B	T13
14	0%	E14	P14	\$B	T14
15	0%	E15	P15	\$B	T15
16	0%	E16	P16	\$B	T16
		sum of E	sum of P	\$B	\$1,945,000

- viii. For each time period identified in Part B item i, FQHC APM additional payments (column T) shall be calculated as follows: the FQHC's per medical encounter weight (column A) X the FQHC's medical encounters (column E) X the APM Base Rate (column \$B).

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