COLORADO
Department of Health Care Policy & Financing

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Federally Qualified Health Center Alternative Payment Methodology 2 Billing Guidance – July 2022

The Colorado Department of Health Care Policy and Financing (Department) reimburses Federally Qualified Health Centers (FQHCs) a cost-based encounter rate for medical, dental, and specialty behavioral health visits with qualified providers. This payment methodology is called Alternative Payment Methodology (APM) 1, as allowed under Section 1902(bb) of the Social Security Act.

The Centers for Medicare and Medicaid Services (CMS) has approved a second APM for Colorado FQHCs. Under this reimbursement methodology, FQHCs are reimbursed a per member per month (PMPM) payment to cover the physical health services for certain Accountable Care Collaborative (ACC) attributed members.

Changes Overview

FQHCs may provide care in new ways under APM 2, but many aspects of billing and reimbursement will not change:

- Traditional FQHC visits with billable providers will still be billed via the Medicaid Management Information System (MMIS),
- Dental visits will continue to be billed to DentaQuest,
- Specialty behavioral health visits will continued to be billed to MMIS and/or the Regional Accountable Entity (RAE),
- Managed Care Entities (such as RAEs, CHP+ entities, and HMOs) will continue to pay for their client's visits as usual,
- If an APM 2 patient goes to another provider, that provider will be reimbursed as usual by Colorado Medicaid,
- Psychiatry encounters billed directly to Medicaid for services not included under the RAE capitation or under the Short-Term Behavioral Health Benefit will be reimbursed under APM 2.

Some aspects of billing will change under APM 2:

- Non-traditional services that are covered under Colorado Medicaid like nurse and group visits must also be billed via MMIS with revenue code 520,
- FQHCs will have to create a new process to reconcile PMPM payments, and
- Other services will be reported via the Colorado Community Managed Care Network (CCMCN).

Which Patients are Part of APM 2?

Only clients attributed through claims, family, and member choice are included in APM 2. Geographically attributed patients are not included in the PMPM payment.

This table shows the reimbursement methodology for different attribution types and service types:

Attribution Type	Physical Health	Dental	Specialty Behavioral Health
Claims	PMPM	Encounter Rate	Encounter Rate
Family	PMPM	Encounter Rate	Encounter Rate
Choice	PMPM	Encounter Rate	Encounter Rate
Geographic	Encounter Rate	Encounter Rate	Encounter Rate
Non-Attributed	Encounter Rate	Encounter Rate	Encounter Rate

For more information about attribution and how utilization from other providers impacts attribution, see page 6.

What is a Traditional Service?

A traditional service refers to a visit that is currently billable for encounter rate reimbursement by FQHCs.

Per 10 CCR 2505-10 8.700.1.b. "*Visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife,*

visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor."

What is a Non-Traditional Service?

A Non-Traditional Service must meet the following four criteria:

- Codeable activity,
- Medicaid covered service,
- Performed by staff, according to billing guidance, that are not billable providers, and
- With appropriate documentation.

These services are billed with a 520 revenue code for non-geographically attributed clients. The claims will pay zero.

Example Non-Traditional services:

Service	Procedure Code(s)	Notes
Nurse Visits	99211	If a billable provider performs these services, bill with 529 revenue code
Group Visits	97804, 96153, 98961, 98962, 99078 HQ modifier with any appropriate, covered procedure code	
Medical Case Management	98969	Does not include BH/SA services
Nutritional Assessment and Intervention	97802, 97803, 97804	If a billable provider performs these services, bill with 529 revenue code
Other	Any Medicaid covered service performed by a non-billable provider	

Revenue Codes and Payment for Physical Health Services

This table shows the differences between APM 1 and APM 2 payment for traditional and non-traditional visits:

Visit Type	APM 1	APM 2
Traditional Visits	• Bill using revenue code 529 • Pays encounter rate	• Bill using revenue code 529 • Pays zero
Non-Traditional Visits	• Do not bill • Claim will deny	• Bill using revenue code 520 • Pays zero

Carved Out Services

Certain services are 'carved out' from encounter rate reimbursement. These services will continue to be paid based on fee schedule reimbursement and are not included under the PMPM payment.

These services are:

- Services provided in an inpatient hospital setting,
- The Prenatal Plus Program,
- The Nurse Home Visitor Program,
- Long-Acting Reversible Contraception (LARC) devices,
- Services provided in an inpatient hospital setting,
- The provision of complete dentures and partial dentures,
- Dental services provided in an outpatient hospital setting,
- Vivitrol,
- COVID-19 vaccine administration,
- Monoclonal antibody therapy treatment of COVID-19,
- COVID-19 antiviral medication (remdesivir), and
- Pharmaceuticals dispensed to patients through an FQHC operated pharmacy.

PMPM Payments

The monthly PMPM payments will be made the night of the first Monday after the first Thursday of the month for clients non-geographically attributed on or before the 17th of the current month. Payments will be made utilizing the 834 roster pulled on the afternoon of the first Thursday of the month at 4 PM.

Eligibility changes during the month are reflected weekly. Changes during the week are reflected in the enrollment roster pulled every Thursday afternoon. Any changes to PMPM payments will be made the following Monday. If a client is retroactively ineligible, their ACC attribution will be updated and the system will recoup PMPM Payments up to two months (including the current month). If a client is retroactively eligible, their ACC attribution will be updated and the system will make PMPM payments for up to two months previously (including the current month).

Roster Dispute Process – an FQHC that has a dispute regarding a member enrolled to them should contact their RAE. Members are able to call the Enrollment Broker Maximus or go to https://enroll.healthfirstcolorado.com/ to have their PCMP enrollment changed.

Claims Submission and Remittance Advice

All APM 2 claims will be submitted on the UB-04 claim form.

Revenue codes 520 and 529 can either be billed on the same claim or separate claims. The Department will track utilization by revenue code and not by claim count.

FQHCs may develop charges for 520 services. However, these services will pay zero regardless of the associated charge.

The adjustment code 9928 will be used to identify APM 2 claims (billed with a 520 and/or 529 revenue code), which will read “Pricing Adjustment – Amount paid is zero.”

The weekly remittances will list the capitation payments under “Capitation Payments” in the summary section.

The EOB 1017 will appear on shadow billed claims that deny because the provider or client is not part of APM 2.

The claims dispute process has not changed and will follow the same process used under APM 1. APM 1 payment schedules are unchanged.

Same Day Services

The existing edits around duplicate claims will apply to APM 2 FQHCs and members.

For example, if an FQHC provides a telemedicine service and an in-person service to the same client on the same day, only one claim will pay (at the encounter rate for non-APM 2 members and at zero for the APM 2 clients). If both claims paid zero it would indicate that both claims were eligible for Prospective Payment System (PPS) reimbursement for the PPS reconciliation process.

ACC Attribution Basics

The below table provides a brief summary of how attribution works under the Department's ACC program. Please see this document for more details.

Attribution Type	Timing of Assignment or Reassignment
Claims	Upon enrollment, claims look back 18 months with attribution to provider ID with preponderance of paid Evaluation & Management (E&M) codes, then other claims. For members <21 years old, 10 preventive service codes have priority.
Family Affiliation (no claims in the past 18 months)	Upon enrollment, based on family member's claims history if PCMP is appropriate.
Geographic (no claims in the past 18 months)	Upon Enrollment *Prior to June 2020: Based on proximity to an appropriate provider*

	June 2020 and after: Based on proximity to list of safety-net providers including FQHCs.
Patient Request	1st of the following month, patient choice overrides claims.
Reassignment for geographic that remain non-users	Never.
Reassignment for geographic that become users	Every six months, HCPF runs reattribution in December and June for January and July.
Assignment for churners that regain <60 days	Prior provider, even if only geographic assignment.
Assignment for churners that regain >60 days	Reviewed for prior claims, if none then they are geographically attributed.

Newborn Attribution:

A newborn's attribution will follow the methodology above, with the following notes:

- Because the newborn will not have any claims history, the system will look at family members' attribution and if that PCMP is appropriate for the newborn the attribution will be made there.
- If no family members are Medicaid members, or they are not attributed to a PCMP appropriate for a newborn, the newborn will likely be geographically attributed to the nearest appropriate PCMP.
- Timing is dependent on when the newborn is added to the parent's case, and/or when the baby is enrolled in Medicaid. HCPF will generally attribute the newborn the day following receipt of the newborn's eligibility information.
- HCPF runs reattribution for children under two on a monthly basis. Therefore, if a newborn develops a claims history with a provider after initial attribution, they will be reattributed to the new provider.