DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 25-AK: Federally Qualified Health Center Change in Scope Revisions and Alternative Payment Methodology.

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 July 1, 2025, based on the information available at this time, SPA 25-AK will amend Attachment 4.19-B of the Medicaid State Plan to make the following proposed changes to the reimbursement for federally qualified health centers (FQHCs).

The change in scope process for FQHCs will be revised to align with the federal definition of a change in scope. A change in the volume of services will be removed and shall not constitute as a change in the scope of services for which a federally qualified health center's encounter rate may be adjusted. When a change in scope request is approved, the rate change shall be effective on the date of the department's approval of said change in scope request or the next calendar date after the end of the federally qualified health center's fiscal year in which the change in scope occurred, whichever is earlier.

Effective July 1, 2025, but not later than October 1, 2025, DSS shall provide an alternative, updated prospective payment methodology for each federally qualified health center that is the same as rates established under the prospective payment system set forth in 42 USC 1396a(bb)(3), as may be amended from time to time, except that the base year for determining the costs of providing such services shall be the average of the reasonable costs incurred in a federally qualified health center's fiscal year ending in 2023, adjusted for any change in scope adjustments approved since the 2023 base year and for inflation as measured by the Medicare Economic Index published by the Centers for Medicare and Medicaid Services, subject to available appropriations. Any rebasing established under such alternative, updated prospective payment methodology shall be phased in over three years, commencing during the fiscal year ending June 30, 2026, and concluded during the fiscal year ending June 30, 2028. Each FQHC shall be given the option to be reimbursed under the provisions of this subsection or under the prospective payment system pursuant to federal law.

Fiscal Impact

There is no fiscal impact from the revision to the change in scope process.
DSS estimates the alternative payment methodology will increase annual aggregate expenditures by approximately $15.2 million in SFY 2026, $36.4 million in SFY 2027.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments. The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 25-AK: Federally Qualified Health Center Change in Scope Revisions and Alternative Payment Methodology."

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than July 30, 2025.

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

(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.

(H) Alternative Payment Methodology

(1) Not later than October 1, 2025, the Department shall provide an alternative, updated prospective payment methodology for each federally qualified health center that is the same as rates established under the PPS set forth in 42 USC § 1396a(bb)(3). The Department shall rebase the health centers base PPS rate based on costs reported in the federally qualified health center's fiscal year ending in 2023 cost report as submitted to the Department. The rebased PPS rate updated to the 2023 cost year shall be adjusted for any change in scope adjustments approved since the 2023 base year and for inflation as measured by the Medicare Economic Index, effective October 1, 2023, and October 1, 2024. Any rebasing established under such alternative, updated prospective payment methodology shall be phased in over the course of three years, commencing during the fiscal year ending June 30, 2026, and concluded during the fiscal year ending June 30, 2028. Each federally qualified health center shall be given the option to be reimbursed under the provisions of this subsection or under the PPS pursuant to federal law.

(2) The following requirements shall apply to any alternative payment methodology developed by the Department for payments to federally qualified health centers:

a. The alternative payment methodology must be consistent with the requirements of 42 USC § 1396a(bb)

b. To the extent federal law requires that federally qualified health centers be allowed to elect to use the PPS set forth in 42 USC § 1396a(bb)(3), any alternative payment methodology developed under this section must be an additional option and not in lieu of the alternative, updated prospective payment methodology;

c. In developing an alternative payment methodology, the Department shall consult with federally qualified health centers prior to implementing any such methodology.

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

(4) 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;

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

(I) Effective July 1, 2025, the Department shall adjust the change in scope process to align with the federal requirements under 42 U.S.C. § 1396a(bb)(3)(B). The Department shall update its regulations to reflect the changes made to the change in scope process. When a change in scope request is approved, the rate change shall be effective on the date of the Department's approval of said change in scope request or the next calendar date after the end of the federally qualified health center's fiscal year in which the change in scope occurred, whichever is earlier.

~~(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) Based upon the Department's review of a variety of factors and documents, including but not limited to the FQHC's original scope of project, subsequent amendments to the scope of project, cost reports and audited financial statements,~~ The department may initiate a ~~review of an FQHC~~ to determine whether there has been a ~~change in the~~ scope of services ~~notifying the FQHC in writing and requesting documentation with respect to the proposed change in scope of service. An FQHC shall submit all requested documentation not later than ninety days after receipt written notification from the Department~~

~~(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.~~