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State of Connecticut
REGULATION
of

NAME OF AGENCY
Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION
Requirements for Payment to Federally Qualified Health Centers

Section 1. The Regulations of Connecticut State Agencies are amended by adding new sections 17b-262-994 to 17b-262-1004, inclusive, as follows:

(NEW) Sec. 17b-262-994. Scope

Sections 17b-262-994 to 17b-262-1004, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services’ requirements for payment to federally qualified health centers for services provided to clients who are eligible to receive such services under Medicaid pursuant to section 17b-261 of the Connecticut General Statutes. Federally qualified health centers shall be reimbursed in accordance with the Medicaid prospective payment system under 42 USC 1396a (bb).

(NEW) Sec. 17b-262-995. Definitions

As used in section 17b-262-994 to section 17b-262-1004, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Additional health services” means services that are not included as required primary health services and that are appropriate to meet the needs of the population served by the federally qualified health center. Additional health services include, but are not limited to:
 - (A) Rehabilitation services, such as physical therapy, occupational therapy, speech, language or hearing services;
 - (B) Behavioral health services;
 - (C) Chiropractic services;
 - (D) Diabetes self-management training;
 - (E) Smoking cessation counseling;
 - (F) Podiatry services;
 - (G) Vision care services; and

- (H) Screening for and control of infectious diseases, including parasitic diseases;
- (2) “Advanced practice registered nurse” or “APRN” means a person licensed under section 20-94a of the Connecticut General Statutes;
- (3) “Allied health professional” or “AHP” means:
- (A) A licensed or certified practitioner performing within his or her scope of practice in any of the professional and occupational license or certification categories in Chapters 376b, 379a, 383a, and 383c of the Connecticut General Statutes and shall include dental hygienists, alcohol and drug counselors, marital and family therapists, and professional counselors; and
- (B) A license-eligible individual as defined in subsection (25) of this section;
- (4) “Baseline encounter rate” means the encounter rate calculated for the initial or first year under the prospective payment system;
- (5) “Behavioral health encounter” means an encounter between a client and a licensed clinical psychologist, a licensed clinical social worker, a psychiatrist or an allied health professional for the provision of covered behavioral health services;
- (6) “Behavioral health services” means health care services for mental health or substance related disorders;
- (7) “Change in the scope of service” means a change in the type, intensity, duration or amount of services provided by an FQHC. A change in the cost of the service alone is not considered a change in the scope of service;
- (8) “Chiropractor” means a person licensed pursuant to section 20-27 of the Connecticut General Statutes;
- (9) “Chiropractic services” has the same meaning as provided in 42 CFR 440.60;
- (10) “Client” means a person eligible for goods or services under Medicaid;
- (11) “Clinical psychologist” means a person licensed pursuant to section 20-188 of the Connecticut General Statutes;
- (12) “Commissioner” means the commissioner of Social Services or the commissioner’s designee;
- (13) “Dental encounter” means an encounter between a client and a dentist for diagnosis and treatment of dental condition, including restoration, or an encounter between a client and a dental hygienist under the supervision of a dentist for the purpose of prevention and assessment;
- (14) “Dental hygienist” means a person licensed pursuant to section 20-126j of the Connecticut General Statutes;
- (15) “Dentist” means a person licensed pursuant to section 20-106 of the Connecticut General Statutes;

- (16) “Department” or “DSS” means the Department of Social Services or its agent;
- (17) "Early and Periodic Screening, Diagnostic and Treatment Services" or "EPSDT services" means the services provided in accordance with the requirements of 42 USC 1396a (a) (43), 42 USC 1396d (r) and 42 USC 1396d (a) (4) (B) and implementing federal regulations found in 42 CFR 441, Subpart B and section 17b-261 (i) of the Connecticut General Statutes;
- (18) “Early and Periodic Screening, Diagnostic and Treatment Special Services” or “EPSDT Special Services” means services provided in accordance with 42 USC 1396d (r) (5), as amended from time to time;
- (19) “Encounter” means a face-to-face visit between a client and health professional or an allied health professional for medically necessary services and includes the client’s visit to the FQHC and all services and supplies incidental to the health professional’s services. Only services provided at the sites approved by HRSA in the FQHC Scope of Project are billable as an encounter. Visits with more than one health professional or allied health professional or multiple visits with the same health professional or allied health professional that take place on the same day shall be considered one encounter, except under either of the following circumstances:
- (A) A client, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment; or
 - (B) A client has different types of encounters (medical, behavioral health and dental) for different diagnoses on the same day. Medicaid pays for one encounter per day for each of these services;
- (20) “Encounter rate” means the all-inclusive PPS rate that the Department reimburses an FQHC for an encounter pursuant to 42 USC 1396a (bb);
- (21) “Federally qualified health center” or “FQHC” has the same meaning as provided in 42 USC 1396d (l) (2) (B);
- (22) “Health professional” means a physician, physician assistant, advanced practice registered nurse, nurse midwife, chiropractor, ophthalmologist, optometrist, podiatrist, dentist, clinical psychologist, licensed clinical social worker or psychiatrist;
- (23) “Health Resources and Services Administration” or “HRSA” means the division of the U.S. Department of Health and Human Services that approves grant awards to and scope of projects for FQHCs;
- (24) “Licensed clinical social worker” or “LCSW” means a person licensed pursuant to section 20-195n of the Connecticut General Statutes;
- (25) “License-eligible” means a person whose education, training, skills and experience satisfy the criteria, including accumulation of all supervised service hours, for any of the professional and occupational license or certification categories in Chapters 370, 376b, 379a, 383a, and 383c of the Connecticut General Statutes, and has applied for but not yet passed the licensure exam;

- (26) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;
- (27) “Medical encounter” means an encounter between a client and a physician, physician assistant, podiatrist, ophthalmologist, optometrist, chiropractor, advanced practice registered nurse, or nurse midwife, for the purpose of diagnosis or treatment of an illness or injury;
- (28) “Medically necessary” and “medical necessity” have the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- (29) “Nurse midwife” means a person licensed under section 20-86c of the Connecticut General Statutes;
- (30) “Off-site services” means services that are provided at a location other than the FQHC or a satellite of the FQHC;
- (31) "Ophthalmologist" means a physician licensed pursuant to chapter 370 of the Connecticut General Statutes, who within his or her scope of practice as defined by state law, specializes in the branch of medicine dealing with the structure, functions, pathology, and treatment of the eyes;
- (32) "Optometrist" means a person licensed pursuant to Chapter 380 of the Connecticut General Statutes to practice optometry as delineated in subsections (a) (1) and (2) of section 20-127 of the Connecticut General Statutes;
- (33) “Physician” means a person licensed pursuant to section 20-13 of the Connecticut General Statutes;
- (34) “Physician assistant” means a person licensed pursuant to section 20-12b of the Connecticut General Statutes;
- (35) “Podiatric services” means services provided by a podiatrist within the scope of practice under Chapter 375 of the Connecticut General Statutes;
- (36) “Podiatrist” means a person licensed to practice podiatric medicine pursuant to section 20-54 of the Connecticut General Statutes;
- (37) “Point-of-care testing” means medical testing at or near the site of patient care and includes, but is not limited to, blood glucose testing, blood gas and electrolyte analysis, rapid coagulation testing, rapid cardiac markers diagnostics, drugs-of-abuse screening, urine strips testing, pregnancy testing, fecal occult blood analysis, food pathogens screening, hemoglobin diagnostics, infectious disease testing and cholesterol screening;
- (38) “Prior authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;
- (39) “Provider enrollment agreement” means the agreement between the department and the FQHC for the provision of covered services to Medicaid clients;

- (40) “PPS” means the prospective payment system under 42 U.S.C. 1396a (bb);
- (41) “Registration” means the process of notifying the department of the initiation of a service, which includes providing information regarding the evaluation findings and plan of care. Registration may serve in lieu of prior authorization if a service is designated by the department as requiring registration only;
- (42) “Required primary health services” means services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by a health professional within his or her scope of practice. Required primary health services include, but are not limited to:
- (A) Diagnostic laboratory and radiologic services;
 - (B) Preventive health services, including—
 - (i) Prenatal and perinatal services;
 - (ii) Appropriate cancer screening;
 - (iii) Well-child services;
 - (iv) Immunizations against vaccine-preventable diseases;
 - (v) Screenings for elevated blood lead levels, communicable diseases, and cholesterol;
 - (vi) Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
 - (vii) Voluntary family planning services; and
 - (viii) Preventive dental services;
 - (C) Emergency medical services; and
 - (D) Pharmaceutical services as may be appropriate for particular centers;
- (43) "Routine foot care" means clipping or trimming of normal or mycotic toenails; debridement of the toenails that do not have onychogryposis or onychiauxis; shaving, paring, cutting or removal of keratoma, tyloma or heloma; and nondefinitive shaving or paring of plantar warts except for the cauterization of plantar warts;
- (44) “Scope of project” means the document that delineates the FQHC’s approved service sites, services, providers, service area and target population for which grant funds have been approved by HRSA under section 330 of the Public Health Service Act;
- (45) "Simple foot hygiene” means self-care including, but not limited to: observation and cleansing of the feet; use of skin creams to maintain skin tone of both ambulatory and bedridden patients; nail care not involving professional attention; and prevention and reduction of corns, calluses and warts by means other than cutting, surgery or instrumentation;
- (46) "Systemic condition" means the presence of a metabolic, neurologic, or peripheral vascular disease, including, but not limited to, diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis and peripheral neuropathies involving the feet, which would justify coverage of routine foot care;
- (47) “Under the direct supervision” means that a health professional or a licensed AHP, as established in (3)(A) of this section:

- (A) Provides weekly supervision of the work performed by unlicensed clinical staff or non-certified staff or individuals in training;
- (B) Provides a minimum of monthly supervision for the work performed by certified staff; and
- (C) Accepts primary responsibility for the health services performed by the unlicensed, certified or non-certified staff or individuals in training.

(NEW) Sec. 17b-262-996. Provider Participation

In order to participate in the Connecticut Medicaid program and provide FQHC services eligible for reimbursement from the department, each FQHC shall:

- (1) Comply with all applicable state licensing requirements;
- (2) Comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;
- (3) Ensure that all health professionals employed by or under contract arrangements with the FQHC to provide primary health services or additional health services meet all applicable federal and state licensing and certification requirements;
- (4) Submit a completed copy of the FQHC's grant proposal that was submitted to the HRSA and the FQHC's scope of project and any amendments to the scope of project in accordance with subsection (c) of section 17b-245d of the Connecticut General Statutes; and
- (5) Submit a copy of the HRSA Notification of Grant Award Authorization of Public Health Service Funds.

(NEW) Sec. 17b-262-997. Services Covered

- (a) Covered services include required primary health services and additional health services in the FQHC's scope of project for base years 1999 and 2000 as approved by HRSA, either as amended, or as specifically approved by DSS. Each FQHC shall submit its HRSA-approved scope of project for base years 1999 and 2000, or if established after 2000, for its first year of operation and all subsequent HRSA-approved amendments to the scope of project.
- (b) Medicaid reimbursement shall be limited to medically necessary services that are covered by the Medicaid state plan or are required EPSDT services or EPSDT Special Services.
- (c) The department shall reimburse FQHCs for the following services at the encounter rate determined in accordance with section 17b-262-1003 of the Regulations of Connecticut State Agencies:
 - (1) Medical encounters, including the following:
 - (A) Services provided by a physician, physician assistant, APRN, or nurse midwife;
 - (B) Vision care services provided by an ophthalmologist or optometrist;

- (C) Podiatric services provided by a podiatrist, except for routine foot care, which is only covered if the client has a systemic condition and is limited to one treatment every 60 days; and
 - (D) Chiropractic services provided by a chiropractor, when prescribed by a physician, physician assistant or APRN for medically necessary treatment of diagnoses or disorders on the department's schedule for chiropractic services. Chiropractic services shall require prior authorization and documentation that the services are medically necessary.
- (2) Dental encounters, subject to the following limitations:
- (A) A dental hygienist may bill for an encounter only when the dental hygienist provides a service independently from the dentist and subject to the requirement that an FQHC may not bill for more than one dental encounter per day;
 - (B) In accordance with section 17b-262-1001 of the Regulations of Connecticut State Agencies, an FQHC shall request prior authorization for those dental services that require prior authorization as set forth on the dental fee schedule;
 - (C) The number of dental encounters for certain types of procedures shall be limited at the discretion of the department.
- (3) Behavioral health encounters, including the following:
- (A) Behavioral health services provided by the following health professionals: a clinical psychologist, LCSW, or psychiatrist; and
 - (B) Behavioral health services provided by the following allied health professionals: a certified or licensed alcohol and drug abuse counselor, marital and family therapist, professional counselor or license-eligible individual;
- (4) Smoking cessation counseling when a physician has prescribed it for a client. Smoking cessation counseling may be billed as a medical encounter, behavioral health encounter or dental encounter depending upon the type of health professional providing the service. The following health professionals may provide smoking cessation counseling:
- (A) Physicians;
 - (B) Physician assistants;
 - (C) APRNs;
 - (D) Dentists;
 - (E) Clinical Psychologists;
 - (F) LCSWs; and
 - (G) Allied health professionals.

- (d) The department shall reimburse FQHCs for clinical group psychotherapy services and group counseling sessions, including smoking cessation counseling, at an FQHC group rate determined in accordance with subsection (g) of section 17b-262-1003 of the Regulations of Connecticut State Agencies. All group psychotherapy sessions and group counseling sessions shall be prescribed by a health professional and subject to the following limitations:
- (1) Prior authorization is required for a client to participate in a group psychotherapy or group counseling session;
 - (2) Approval from the department for group sessions that are not related to behavioral health or smoking cessation is required in advance of billing for the group session;
 - (3) All group psychotherapy and group counseling sessions shall be limited to a maximum of eight participants, shall be facilitated by a health professional or allied health professional practicing within his or her scope of practice and shall last at least 45 minutes; and
 - (4) The services provided in the session shall be documented in each client's health record.
- (e) The following services shall be included in the encounter rate and the FQHC shall not bill separately for these services:
- (1) Services and supplies incidental to the services of a health professional when the services and supplies are:
 - (A) Of the type commonly furnished in a physician's office;
 - (B) Of a type commonly rendered either without charge or included in the FQHC's bill;
 - (C) Furnished as an incidental, although integral, part of the professional service; and
 - (D) Provided by FQHC employees under the direct supervision of a physician, clinical psychologist or licensed clinical social worker.
 - (2) Laboratory, point-of-care testing or radiology services provided in conjunction with an FQHC encounter and furnished by FQHC staff;
 - (3) Diabetes self-management training (DSMT) and medical nutrition therapy (MNT), when a physician, physician assistant or APRN has prescribed DSMT or MNT for a client diagnosed with diabetes. DSMT and MNT shall be provided in a DSMT program that meets the following requirements:
 - (A) Accredited or certified by a national organization assessing standards for quality in diabetes self-management education; and
 - (B) Complies with national standards for diabetes self-management education and have an instructional team that consists of a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educators;
 - (4) Vaccines that are available through the Vaccines for Children ("VFC") program for children under 19 years of age;

- (5) Weight check or blood pressure check;
- (6) A clinic visit for immunizations or injections only; and
- (7) Transportation provided by the FQHC.

(NEW) Sec. 17b-262-998. Services Not Covered

The following services are not covered:

- (1) Services that are not listed in the FQHC scope of project and not approved by HRSA or DSS;
- (2) Services that are not medically necessary;
- (3) Canceled services or appointments that are not kept;
- (4) Services normally provided free of charge to patients;
- (5) Acupuncture or hypnosis;
- (6) Inpatient services;
- (7) Simple foot hygiene;
- (8) Any service requiring authorization or registration for which the provider did not obtain such authorization or registration;
- (9) Any procedures or services that are solely educational, social, research, recreational, experimental or generally not accepted by medical practice; or
- (10) Visits for the sole purpose of obtaining or refilling a prescription, the need for which was previously determined.

(NEW) Sec. 17b-262-999. Separately Reimbursable Non-FQHC Services

(a) Physicians employed by an FQHC may provide services to clients at a hospital, nursing facility or other off-site location and shall be reimbursed according to the Medicaid physician fee schedule. These services are considered non-FQHC services and include:

- (1) Delivery of a baby;
- (2) Inpatient services; and
- (3) Outpatient surgery.

(b) The following services may be billed for by the provider of the services in accordance with the Medicaid fee schedule:

- (1) Laboratory services beyond point of care testing that are referred to and performed by an independent laboratory; and
 - (2) The technical component of radiology tests that are referred to and performed by an independent radiologist.
- (c) An FQHC shall not seek reimbursement for services provided under subsections (a) and (b) of this section as an FQHC encounter. The non-FQHC services shall not be included in the overall costs of providing services at the FQHC.

(NEW) Sec. 17b-262-1000. Prior Authorization Requirements

- (a) In order to receive payment from the department, each FQHC shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met.
- (b) The department shall designate services that require prior authorization or registration on the department's fee schedule, on the department's website or by other means accessible to providers with advance written notice to providers before establishing or amending such requirements. Registration may serve in lieu of prior authorization only if the department designates a service as requiring registration but not prior authorization. Prior authorization is also required for the following:
 - (1) Dental procedures or services that require prior authorization as set forth on the dental fee schedule;
 - (2) Chiropractic services in excess of 5 encounters per month;
 - (3) EPSDT Special Services; and
 - (4) Any procedure or service that is not listed on the department's fee schedule.
- (c) The provider shall attach a prescription from a licensed practitioner to all prior authorization requests for EPSDT Special Services. The provider may attach a physical or electronic copy of the prescription from the licensed practitioner to the prior authorization request in lieu of the actual signature of the licensed practitioner on the prior authorization request form. The provider shall keep the original prescription on file and subject to the department's review.
- (d) The length of the initial prior authorization or registration period shall be for no longer than three months except as follows:
 - (1) For longer periods as determined by the department on a case-by-case basis;
 - (2) For up to six months for day care, center-based programs; and
 - (3) For up to one year for routine psychotherapy.

- (e) If the client needs a service beyond the initial authorization period, the provider may request authorization to continue services for up to six additional months of continued treatment per request.
- (f) If the department denies a request for prior authorization for continuation of services, the recipient may request an administrative hearing in accordance with section 17b-60 of the Connecticut General Statutes.

(NEW) Sec. 17b-262-1001. Change in Scope of Services

- (a) Each FQHC shall notify the department of any increase or decrease in the scope of services provided by the FQHC in accordance with section 17b-245d of the Connecticut General Statutes. If the FQHC seeks an adjustment to its encounter rate based on the change in scope of services, the FQHC shall submit a written request with the department in accordance with subsection (c) of this section.
- (b) Examples of changes in scope of services by an FQHC for which the department may adjust the encounter rate include, but are not limited to, the following:
 - (1) 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;
 - (2) 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 to the volume, amount, or intensity of services. The cost of a new or expanded building alone would not necessarily qualify;
 - (3) The addition or deletion of any Medicaid covered service eligible under the FQHC reimbursement program;
 - (4) A change in the operational costs attributable to changes in technology or medical practices at the FQHC;
 - (5) 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;
 - (6) A change in federal regulatory requirements that would impact FQHC costs; or
 - (7) A HRSA-approved change in the scope of project, provided that the change is consistent with federal and state Medicaid regulations.
- (c) In the event of a change in scope of service for which an FQHC seeks a rate adjustment, an FQHC shall submit a written request to the Commissioner that includes the following:
 - (1) a description of the change in scope of services and the reason for the change;
 - (2) the impact on capital and operating costs;
 - (3) the requested change in rate;

- (4) a detailed explanation of why an adjustment to the encounter rate is necessary and evidence in support of the rate adjustment, which shall include the following:
 - (A) A community needs assessment demonstrating that population demographic changes warrant the change in scope of service;
 - (B) A business plan or similar document demonstrating that the change in service is warranted; and
 - (C) Evidence that the change in scope of service is cost effective; and
- (5) All documentation submitted to HRSA regarding a change in scope of project, if applicable.
- (d) If an 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.
- (e) If an 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 change in scope of service. An FQHC shall submit all documentation required or requested by the department with respect to the change in scope of service.
- (f) The department may initiate a change in scope of service and resulting encounter rates following a review of an 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. An FQHC shall submit all requested documentation not later than sixty days after receipt of the notice of the proposed change in scope of services.
- (g) In making its determination with respect to whether an FQHC's encounter rate may be adjusted based upon a change in scope of services, the department shall review the following:
 - (1) The FQHC's Medicaid cost report;
 - (2) An FQHC's audited financial statements; and
 - (3) Any other documentation relevant to the change in scope of services.

(NEW) Sec. 17b-262-1002. Billing Requirements

- (a) Each FQHC shall bill for FQHC services per encounter. Claims are limited to one all-inclusive encounter per day to include all services received by a client on the same day unless the client suffers an illness or injury subsequent to the first encounter that requires additional diagnosis or

treatment or if the client has different types of visits on the same day such as medical and dental or medical and behavioral health.

- (b) Each FQHC shall submit medical and behavioral health claims on the CMS-1500 claims form utilizing both the encounter code and all applicable HCPCS code(s) on the FQHC fee schedule that identify the services provided.
- (c) Each FQHC shall submit dental health claims on the original designated ADA Dental Claim form.
- (d) Each FQHC shall submit claims electronically or on the department's designated form and shall include all information required by the department to process the claim for payment.

(NEW) Sec. 17b-262-1003. Reimbursement

- (a) The department shall reimburse an FQHC an all-inclusive encounter rate per client encounter in accordance with a PPS as required by 42 USC 1396a (bb).
- (b) The department shall establish the baseline encounter rate for each FQHC in existence during fiscal years 1999 and 2000 as follows:
 - (1) Total encounters and costs shall be obtained from the annual reports submitted by the FQHC for fiscal years 1999 and 2000;
 - (2) 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;
 - (3) 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.
- (c) For an 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.
- (d) For a center that first qualified as an 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.
- (e) 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).
- (f) The department may adjust the encounter rate for a change in the scope of services provided by an FQHC in accordance with section 17b-262-1002 of the Regulations of Connecticut State Agencies.
- (g) The department shall reimburse FQHCs for group psychotherapy and group counseling sessions at an FQHC group rate, which shall be calculated by the department for this specific purpose using elements of the Resource Based Relative Value System (RBRVS) promulgated by the

Centers for Medicare and Medicaid Services (CMS) on a per client per group session basis using the Medicare group psychotherapy fee and group counseling session fee adjusted (non-facility) for the state of Connecticut locality. The group psychotherapy fee and group counseling fee will be updated, as necessary, in accordance with the Medicare physician payment schedule updates. All FQHC's will be required to enroll as clinics in order to accommodate fee schedule code billings.

(NEW) Sec. 17b-262-1004. Documentation and Audit Requirements.

- (a) Each FQHC shall maintain a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid Identification Number, pertinent diagnostic information; treatment notes signed by the provider, documentation of services provided and the dates on which the services were provided.
- (b) Each FQHC shall maintain all required documentation in its original form for at least five years or longer in accordance with statute or regulation, subject to review by authorized departmental personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation until the dispute is resolved.
- (c) The department may disallow and recover any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.
- (d) The department may audit all relevant records and documentation and may take any other appropriate quality assurance measures it deems necessary to assure compliance with all regulatory and statutory requirements.
- (e) Notwithstanding the provisions of subsections (a) through (d) of this section, FQHCs may maintain an electronic medical record system such that medical records for all patients treated within the FQHC shall be available to, and shared by, all health professionals.

Section 2. Sections 17-134d-70 to 17-134d-78, inclusive, of the Regulations of Connecticut State Agencies are repealed.

Statement of Purpose

(A) The purpose of the proposed regulation is to establish, in regulation form, the requirements for payment for federally qualified health center services provided to Medicaid clients. The problems, issues or circumstances that the regulation proposed to address the existing regulations are outdated and inconsistent with the federal requirements for payment to federally qualified health centers under 42 USC 1396a (bb). (B) The main provisions of the regulation propose to: (1) add new definitions as necessary; (2) specify services that are covered and billable as encounters; (3) establish an FQHC group rate for group psychotherapy and group counseling sessions; (4) specify services that are not billable as an encounter but included in the encounter rate; (5) specify services not covered; (6) describe the process by which an FQHC may request an adjustment of its encounter rate based upon a change in scope of services; (7) clarify prior authorization requirements; (8) describe billing requirements and the methodology for calculating the encounter rate; and (9) outline documentation and audit requirements. (C) The legal effect of the regulation is to adopt the department's current policies and procedures regarding the payment for federally qualified health center services provided to Medicaid clients as a regulation and to repeal sections 17-134d-70 to 17-134d-78, inclusive, of the Regulations of Connecticut State Agencies.

CERTIFICATION

This certification statement must be completed in full, including items 3 and 4, if they are applicable.

- 1) I hereby certify that the above (check one) Regulations Emergency Regulations
- 2) are (check all that apply) adopted amended repealed by this agency pursuant to the following authority(ies): (complete all that apply)

a. Connecticut General Statutes section(s) 17b-262 and 17b-245b.

b. Public Act Number(s) _____.
(Provide public act number(s) if the act has not yet been codified in the Connecticut General Statutes.)

- 3) And I further certify that notice of intent to adopt, amend or repeal said regulations was published in the **Connecticut Law Journal** on _____.
(Insert date of notice publication if publication was required by CGS Section 4-168.)

- 4) And that a public hearing regarding the proposed regulations was held on _____.
(Insert date(s) of public hearing(s) held pursuant to CGS Section 4-168(a)(7), if any, or pursuant to other applicable statute.)

- 5) And that said regulations are **EFFECTIVE** (check one, and complete as applicable)
- When filed with the Secretary of the State
- OR on (insert date) _____

| | | |
|------|--|---------------------------------|
| DATE | SIGNED (Head of Board, Agency or Commission) | OFFICIAL TITLE, DULY AUTHORIZED |
|------|--|---------------------------------|

APPROVED by the Attorney General as to legal sufficiency in accordance with CGS Section 4-169, as amended

| | | |
|------|---|---------------------------------|
| DATE | SIGNED (Attorney General or AG's designated representative) | OFFICIAL TITLE, DULY AUTHORIZED |
|------|---|---------------------------------|

Proposed regulations are **DEEMED APPROVED** by the Attorney General in accordance with CGS Section 4-169, as amended, if the attorney General fails to give notice to the agency of any legal insufficiency within thirty (30) days of the receipt of the proposed regulation.
(For Regulation Review Committee Use ONLY)

- Approved Rejected without prejudice
- Approved with technical corrections Disapproved in part, (Indicate Section Numbers disapproved only)
- Deemed approved pursuant to CGS Section 4-170(c)

| | | |
|---|------|---|
| By the Legislative Regulation Review Committee in accordance with CGS Section 4-170, as amended | DATE | SIGNED (Administrator, Legislative Regulation Review Committee) |
|---|------|---|

Two certified copies received and filed and one such copy forwarded to the Commission on Official Legal Publications in accordance with CGS Section 4-172, as amended.

| | | |
|------|---------------------------------|----|
| DATE | SIGNED (Secretary of the State) | BY |
|------|---------------------------------|----|

(For Secretary of the State Use ONLY)

GENERAL INSTRUCTIONS

1. All regulations proposed for adoption, amendment or repeal, *except* emergency regulations, must be presented to the Attorney General for his/her determination of legal sufficiency. (See CGS Section 4-169.)
2. After approval by the Attorney General, the original and one electronic copy (in Word format) of all regulations proposed for adoption, amendment or repeal must be presented to the Legislative Regulation Review Committee for its action. (See CGS Sections 4-168 and 4-170 as amended by Public Act 11-150, Sections 18 and 19.)
3. Each proposed regulation section must include the appropriate regulation section number and a section heading. (See CGS Section 4-172.)
4. New language added to an existing regulation must be in underlining or CAPITAL LETTERS, as determined by the Regulation Review Committee. (See CGS 4-170(b).)
5. Existing language to be deleted must be enclosed in brackets []. (See CGS 4-170(b).)
6. A completely new regulation or a new section of an existing regulation must be preceded by the word "(NEW)" in capital letters. (See CGS Section 4-170(b).)
7. The proposed regulation must have a statement of its purpose following the final section of the regulation. (See CGS Section 4-170(b).)
8. The Certification Statement portion of the form must be completed, including all applicable information regarding *Connecticut Law Journal* notice publication date(s) and public hearing(s). (See more specific instructions below.)
9. Additional information regarding rules and procedures of the Legislative Regulation Review Committee can be found on the Committee's web site: <http://www.cga.ct.gov/rr/>.
10. A copy of the Legislative Commissioners' Regulations Drafting Manual is located on the LCO website at http://www.cga.ct.gov/lco/pdfs/Regulations_Drafting_Manual.pdf.

CERTIFICATION STATEMENT INSTRUCTIONS

(Numbers below correspond to the numbered sections of the statement)

1. Indicate whether the regulation is a regular or an emergency regulation adopted under the provisions of CGS Section 4-168(f).
2.
 - a) Indicate whether the regulations contains newly adopted sections, amendments to existing sections, and/or repeals existing sections. Check all cases that apply.
 - b) Indicate the specific legal authority that authorizes or requires adoption, amendment or repeal of the regulation. If the relevant public act has been codified in the most current biennial edition of the *Connecticut General Statutes*, indicate the relevant statute number(s) instead of the public act number. If the public act has not yet been codified, indicate the relevant public act number.
3. Except for emergency regulations adopted under CGS 4-168(f), and technical amendments to an existing regulation adopted under CGS 4-168(g), an agency must publish notice of its intent to adopt a regulation in the *Connecticut Law Journal*. Enter the date of notice publication.
4. CGS Section 4-168(a)(7) prescribes requirements for the holding of an agency public hearing regarding proposed regulations. Enter the date(s) of the hearing(s) held under that section, if any; also enter the date(s) of any hearing(s) the agency was required to hold under the provisions of any other law.
5. As applicable, enter the effective date of the regulation here, or indicate that it is effective upon filing with the Secretary of the State. Please note the information below.

Regulations are effective upon filing with the Secretary of the State or at a later specified date. See CGS Section 4-172(b) which provides that each regulation is effective upon filing, or, if a later date is required by statute or specified in the regulation, the later date is the effective date. An effective date may not precede the effective date of the public act requiring or permitting the regulation. Emergency regulations are effective immediately upon filing with the Secretary of the State, or at a stated date less than twenty days thereafter.