
Community Clinic Association of Los Angeles County

Demystifying Medi-Cal PPS Issues for Federally Qualified Health Centers

Presented by: Michael B. Schnake, CPA, CGFM

Today's Agenda

- ✓ Rate setting for new facilities (State Plan Amendment Section J)
- ✓ Alternative Payment Methodology for an existing FQHC that relocates (State Plan Amendment Section F)
- ✓ Revisiting the basics of Scope of Service Rate Change Adjustments (SPA Section K)
- ✓ Medicare FQHC Rate Setting and Other Issues
- ✓ Final thoughts

Rate Setting for New Facilities

Myths of Medi-Cal Rate Setting

- ✓ The state has licensed my health center – there is nothing more for the health center to do to receive Medi-Cal FQHC status
- ✓ The state has licensed my health center – the health center's Medi-Cal FQHC effective date will be retroactive to the HRSA effective date
- ✓ The state will automatically set the health center's FQHC PPS rate
- ✓ If my health center is receiving an interim rate, there is nothing more to do

Pre-requisites to Medi-Cal Rate Setting

- ✓ The state must license the health center as a community clinic or the clinic must be exempt from licensure
- ✓ The health center must have a NPI number that is registered with Medi-Cal
- ✓ The health center must have documentation from HRSA showing the date the site was approved in the federal grant's scope of project (or the Look-Alike approval letter from CMS that states the effective date)
- ✓ The health center should contact DHCS to obtain Medi-Cal FQHC enrollment instructions

Rate Setting for New Facilities

- ✓ SPA Section J details options for Medi-Cal rate setting for new facilities
- ✓ “New FQHC” defined as follows (assuming that all applicable licensing requirements are met)
 - Site first qualifies as an FQHC after the fiscal year ending in calendar year 2000
 - A new facility at a new location is added to an existing FQHC

Rate Setting for New Facilities

- ✓ Rate setting options available (a one time option)
 - Identification of three comparable FQHCs
 - Filing of a projected cost report
- ✓ Decision process for rate setting is an important consideration for FQHC management personnel
 - Can be difficult to reach agreement with DHCS personnel on three comparable FQHCs
 - Projected cost report option has some timing issues of importance

Selecting an Option

- ✓ Estimate costs and utilization of the new facility
- ✓ Determine if there is anything unusual about the services provided that will make it difficult to identify comparable clinics

Comparable Clinics

- ✓ The definition of comparable clinics is as follows:
 - An FQHC that is providing similar services in the same or an adjacent geographic area with a similar caseload. If there are none, it is acceptable to identify FQHCs providing similar services in a reasonably similar geographic area with respect to social, health care and economic characteristics

Weighing the Options

- ✓ Advantages to the comparable clinic option include:
 - If the proposed comparable clinics submitted to DHCS are deemed comparable, the FQHC PPS rate is set and there is nothing further to submit
 - The PPS rate is immediately utilized for adjudication of claims
 - It may be possible to identify comparable clinics with higher PPS rates than the health center's anticipated cost per visit

Weighing the Options

- ✓ Disadvantages to the comparable clinic option include:
 - The enrollment process could be delayed while trying to identify comparable clinics
 - The PPS rate could be less than the health center's anticipated cost per visit

Weighing the Options

- ✓ If the comparable clinic option is selected, the information that DHCS requests is:
 - The Summary of Services and Summary of Practitioners forms for the new facility
 - The most recent OSHPD Annual Utilization Report for each of the proposed comparable clinics

Weighing the Options

- ✓ Based on discussions with DHCS personnel, the most common reasons a proposed clinic is not considered by DHCS to be comparable for FQHC PPS rate setting purposes include:
 - The proposed comparable clinic is providing services that the new facility does not provide
 - The proposed comparable clinic has a combined rate that includes services the new facility does not provide
 - The proposed comparable clinic does not have a PPS rate yet established
 - The proposed comparable clinic is not located in a similar geographic area (as defined earlier)

Weighing the Options

- ✓ Advantages of selecting the projected cost report option include:
 - The initial PPS rate will be based on the new facility's actual costs of operation
 - The Medicare Upper Payment limit is acceptable as a “placeholder” interim rate until submission of the projected cost report (this enables the enrollment process to be completed faster)
 - Upon submission of the projected cost report, the “placeholder” interim rate can be reconsidered (adjusted up or down)
 - Services can be added subsequent to enrollment and included in the determination of the initial PPS rate

Weighing the Options

- ✓ Disadvantages of selecting the projected cost report option include:
 - The new facility is required to submit two cost reports (a projected cost report and an actual cost report for the first full fiscal year after the FQHC effective date)
 - There could be a long delay before the new facility receives the initial PPS rate (DHCS has 36 months to audit the rate setting cost report)
 - The interim rate is not adjusted for MEI changes (this rate will remain unchanged until the initial FQHC PPS rate is determined)

Rate Setting for New Facilities

- ✓ If the projected cost report option is selected, a FQHC will not lose out on potential rate adjustments due to scope of service changes that occur between the date the projected cost report is filed and audited by DHS personnel
- ✓ What about an existing FQHC that relocates?
 - Don't forget the alternative payment methodology permitted under SPA Section F (discussed on following slides)

Alternative Payment Methodology

Alternative Payment Methodology

- ✓ SPA Section F contains an alternative payment methodology for an existing FQHC that relocates
- ✓ An entity in this situation may elect to have its PPS rate re-determined
 - Rate setting options in this situation are the same as for new facilities previously discussed (use of three comparable FQHCs or submission of a projected cost report)
- ✓ Generally preferable versus filing a request for rate reconsideration based on a change in scope of service

Scope of Service Rate Change Adjustments

Common Myths of Scope of Service Change Filings

- ✓ The filing of a Change in Scope of Service Request Form cannot have a negative impact on my PPS rate
- ✓ Making this process a priority is unnecessary as DHCS will grant unlimited filing extensions
- ✓ My qualifying event does not have to impact FQHC services
- ✓ Relocation of my FQHC entitles me to a Change in Scope of Service filing opportunity only

Common Myths of Scope of Service Change Filings

- ✓ Coordination of this process with the audit of my financial statements is unnecessary
- ✓ If a HOOCR is required, my general ledger internal cost allocations will replace the need to file the HOOCR
- ✓ I only have an interim PPS rate established - I should still file a Change in Scope of Service Request Form
- ✓ I can reserve my qualifying event for a future filing period

Rate Change Prerequisites

- ✓ The increase or decrease in cost is attributable to an increase or decrease in the scope of covered services, as defined in the SPA (section C.1.)
- ✓ The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413

Rate Change Prerequisites

- ✓ The change in the scope of services is a change in the type, intensity, duration or amount of services or any combination thereof
- ✓ The net change in the rate equals or exceeds 1.75% for the affected site (“net change” means the per-visit rate change attributable to the cumulative effect of all increases & decreases for a fiscal year)

Change in Scope of Service – SPA Definition

- ✓ SPA Section K includes nine defined categories of qualifying events – health center management should be familiar with all categories
- ✓ What are the common attributes of all scope of service changes defined in the SPA?
 - Must be a change in FQHC or RHC services
 - Must meet all four prerequisite conditions
 - Documentation is key to support your claim with the DHCS

Identification of a Change in Scope of Service

- ✓ Accurate identification of qualifying scope of service change event(s) is critical
- ✓ Important to maintain supporting documentation to demonstrate how a qualifying event relates to a change(s) in the type, intensity, duration, or amount of services, or any combination thereof

Identification of a Change in Scope of Service

- ✓ Don't rely on your memory exclusively
 - Review Board of Director meeting minutes
 - Review clinical staff meeting minutes
 - Review federal grant application & HRSA approved changes in scope of project impacting services
 - Review new grants received
 - Review accounting general ledger, fixed asset records & audited financial statements
 - Other

Identification of a Change in Scope of Service

- ✓ Important to identify accurate date (month, day & year) a qualifying event occurred so that any required Medi-Cal payment adjustment can be accurately implemented
 - Identification of date of change in service
 - Identification of date of first patient interaction
 - Other

Documentation of a Change in Scope of Service

- ✓ Word to the wise – Articulate your circumstances in a clear, concise manner & prepare your contact person (identified on the filing) to respond in the event of questions from DHCS personnel
- ✓ Consider discussing qualifying event(s) with DHCS personnel in advance of submission of a Change in Scope of Service Request

Examples of Successful Qualifying Event Submissions

- ✓ Addition/expansion (intensification) of behavioral health services
- ✓ Capital expenditure – bladder scanner added to a health center's urology services program
- ✓ Addition of cardiology services
- ✓ Addition of a dietician for a diabetes program
- ✓ Electronic health records implementation

Examples of Successful Qualifying Event Submissions

- ✓ Addition of new services at an intermittent clinic
- ✓ Addition of mammography services
- ✓ Addition of comprehensive perinatal services
- ✓ Addition of ultrasound services
- ✓ Development of a chronic disease management program – asthma services for children

Examples of Rejected Qualifying Event Submissions

- ✓ Inability to substantiate submitted change in provider mix
- ✓ Addition of nurse practitioner with no change in FTEs
- ✓ Addition of nonreimbursable services
- ✓ Addition of a new computer system

Understanding the Appropriate Filing Requirement

Change in Scope of Service Request Form

- ✓ Submission of the filing will be required on a consolidated or individual site basis consistent with the manner in which the PPS rate(s) was/were initially established
- ✓ Many possibilities exist – be sure that you clearly understand the filing requirements so that a complete & accurate submission(s) will be made timely

Change in Scope of Service Request Form

- ✓ Possible scenarios
 - Individual site filing without a HOCR
 - Single FQHC site with no other chain components
 - Individual site filings with a HOCR
 - Single FQHC site with other chain components
 - Single FQHC site at date of PPS implementation (PPS implementation occurred on or after January 1, 2001 – know your situation) with additional sites added after PPS implementation

Change in Scope of Service Request Form

- ✓ Possible scenarios (continued)
 - Consolidated filing without a HO CR
 - Consolidated sites with no new sites after implementation of PPS
 - Consolidated filing with a HO CR & additional individual site filings
 - Consolidated sites with other chain components
 - Consolidated sites with new sites established after implementation of PPS

Change in Scope of Service Request Form

- ✓ Consideration of satellite sites that operate less than 20 hours per week & mobile satellite facilities
- ✓ Completion of the form(s) is necessary to properly evaluate filing strategy
 - No requirement to file for rate increases (evaluate impact based on the increase in cost versus the threshold amount)
 - Filing required if rate decrease exceeds 2.50% AND the clinic has experienced a decrease in the scope of services provided
 - Filing required if onsite dental or pharmacy services are discontinued

Understanding the PPS Rate Change Calculation

Change in Scope of Service Request Form (2004 & thereafter)

- ✓ DHCS will compare the computed rate to the “current PPS rate” in effect on the last day of the fiscal year during which the scope of service change occurred
- ✓ Difference in aforementioned rates discounted by 20% to determine amount to add to the “current PPS rate” to determine the adjusted rate reflective of changes in scope of service

Change in Scope of Service Request Form (2004 & thereafter)

- ✓ Adjusted rates will be retroactive to the first day of the FQHC's or RHC's fiscal year beginning after the fiscal year in which the change in scope of service occurred

Change in Scope of Service Request Form (2004 & thereafter) – Example

- ✓ Assume that the 2009 rate = \$115 & the current PPS rate = \$95 for a difference of \$20 (\$115 - \$95)
- ✓ The rate difference of \$20 equals or exceeds the aforementioned 1.75% threshold ($\$95 \times 1.75\% = \1.66)

Change in Scope of Service Request Form (2004 & thereafter) – Example

- ✓ Discount the difference of \$20 by 20%
- ✓ End result is an adjusted rate of \$111 ($\$95 + \16) that will be effective beginning the first day of fiscal year 2010 (the first day following fiscal year 2009 in which the scope of service change occurred)
- ✓ As you can see, Medi-Cal covered services may be provided for a period of time without compensation

Medicare FQHC Rate Setting and Other Issues

Medicare FQHC Rate Setting

- ✓ Don't forget that there is a distinct process for new FQHC rate setting for the Medicare program
 - Involves the Medicare FQHC intermediary – National Government Services, LLC and Palmetto Government Benefit Administrators (the applicable Medicare Administrative Contractor)
 - Different process than the Medi-Cal process described previously
 - The Medicare program does not have a “satellite clinic” definition similar to Medi-Cal

Other Medicare FQHC Issues

- ✓ Increase in Medicare cost limits for dates of service on or after January 1, 2010 (\$5 + MEI adjustment)
- ✓ Medicare Advantage Plan opportunities exist
 - Private fee-for-service plans
 - Coordinated care plans
 - Myths of Medicare managed care wrap-around payments
- ✓ Timely and accurate Medicare FQHC cost report completion is necessary
 - BPHC scope of project issues

Final Thoughts

Final Thoughts

- ✓ The process of Medi-Cal rate setting for FQHCs requires significant communication between the health center and others:
 - Licensing and Certification personnel
 - DHCS Audits and Investigations personnel
- ✓ Health center personnel must understand and manage the rate setting, scope change, and reconciliation processes proactively to have good outcomes
- ✓ Remember – only you look out for you (each health center must consider its individual facts and circumstances to successfully navigate Medi-Cal and Medicare reimbursement issues/opportunities)

Thank You!
We welcome your
comments and questions

mschnake@bkd.com

BKD, LLP

417 865-8701