Changes for RHCs from DHCS

2018 Update – Topics and Strategies

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PRESENTATION OVERVIEW

Recent Changes for California RHC Issues (2018 version):

- SPA Proposed Changes
  - Scope of service rate request change
  - Inpatient billing
  - Productivity Standards
  - Mobile Units – no new PPS rate
- PPS Rate Setting Changes
- Code 18 changes – *now includes Mental Health*
- A&I's position on moving a clinic
- PPS reconciliation form changes
- Recent audit adjustments
- Billing for MFT's
- No "4 Walls" at this time

STATE PLAN AMENDMENT

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STATE PLAN AMENDMENT – READ IT

"SPA" – California rules - "Operating Manual"

Determines administration of Medi-Cal, California's Medicaid program

Defines eligible Medi-Cal visits

Defines eligible Medi-Cal providers

Defines reimbursement system – "PPS"

Defines initial rate setting methodologies

Defines qualifying events for Scope of Service rate change request

http://www.dhcs.ca.gov/formsandpubs/laws/

Documents/CA SPA 18-003 package.pdf

SPA CHANGES - WORD DEFINITIONS

Adjusted type of service wording to define “increase in the **intensity, type, amount or duration**” – the wording used to describe a triggering event for change in scope of services.

- *Never really been defined*

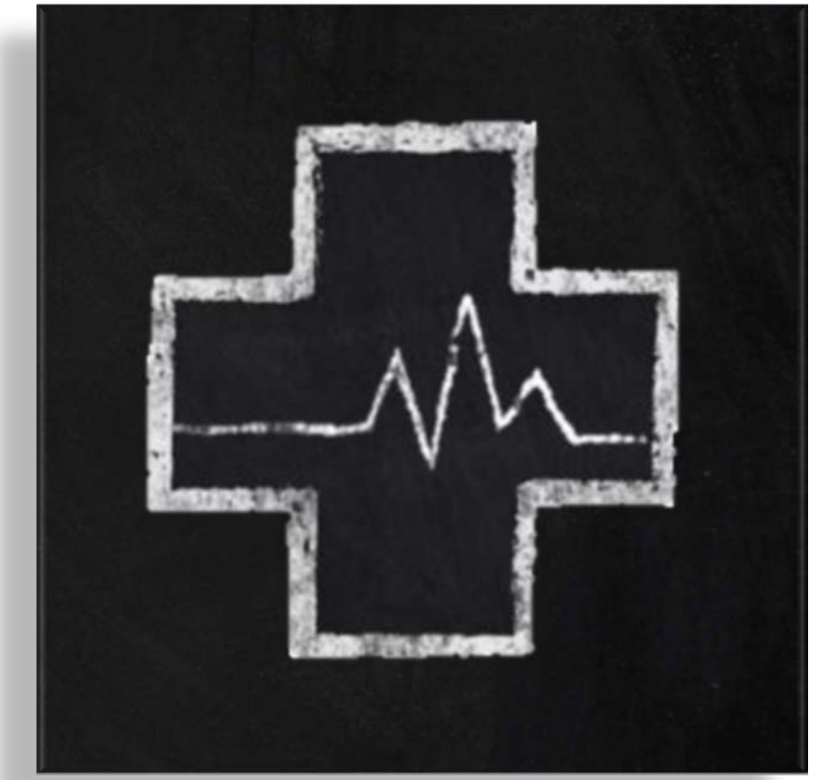
“Lengthy” visit now “longer than the minimum productive standard visit time”

Electronic Health Record (EHR) purchase:

- Is not a triggering event by itself,
- An additional event must have occurred,
- “Not a Medicare benefit”

WHAT'S A "TRIGGERING EVENT"?

- Addition of new service not in baseline PPS rate
- Increase in service intensity due to change in types of patients served (homeless, mental health services, migrant, etc.)
- Change in provider mix
- Relocation or remodeling
- Capital expenditures for modification of services as required for expanded facilities regulatory compliance, or required changes in technology
- Any change in scope approved by HRSA (FQHCs only)



SCOPE OF SERVICE RATE REQUEST CHANGE

Additional copy can go here.

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SCOPE OF SERVICE RATE CHANGES

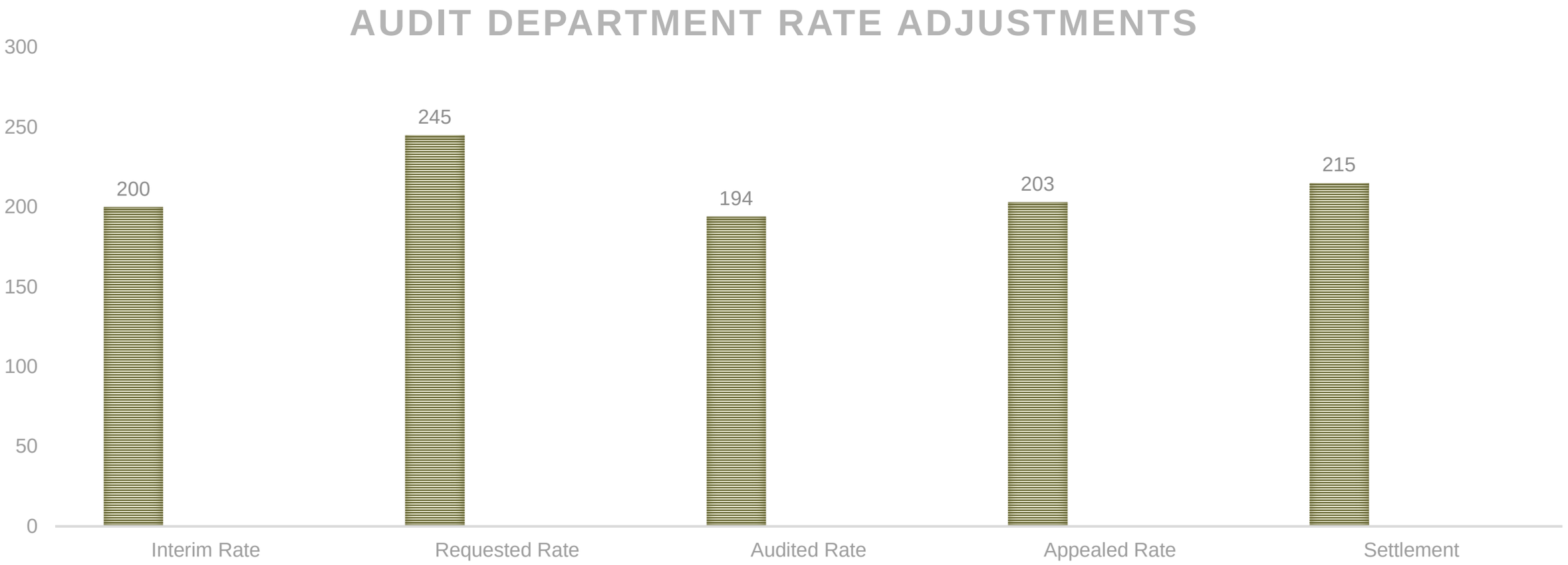
Changes:

- One full year of actual operating expenses before applying
  - *What if you're short a couple days of a full year?*
- Now DHCS is requiring <u>two years</u> (prior year + triggering event year) to compare costs.
- Must prove that increase in cost is "attributable to the scope change" – (versus 1.75% increase in <u>*all costs*</u>)
- If you add provider as "triggering event", no other provider can be performing the added service?

**If you add a provider, then you lose 1-2 others during the year, DHCS says your "physician costs" did not change and deny the scope.

We used to be able to submit projected expenses or partial year annualized out.

SCOPE CHANGE REAL LIFE EXAMPLE



Submission to audit to appeal to hearing to settlement = 2+ years

How much time/money to you want to spend fighting?

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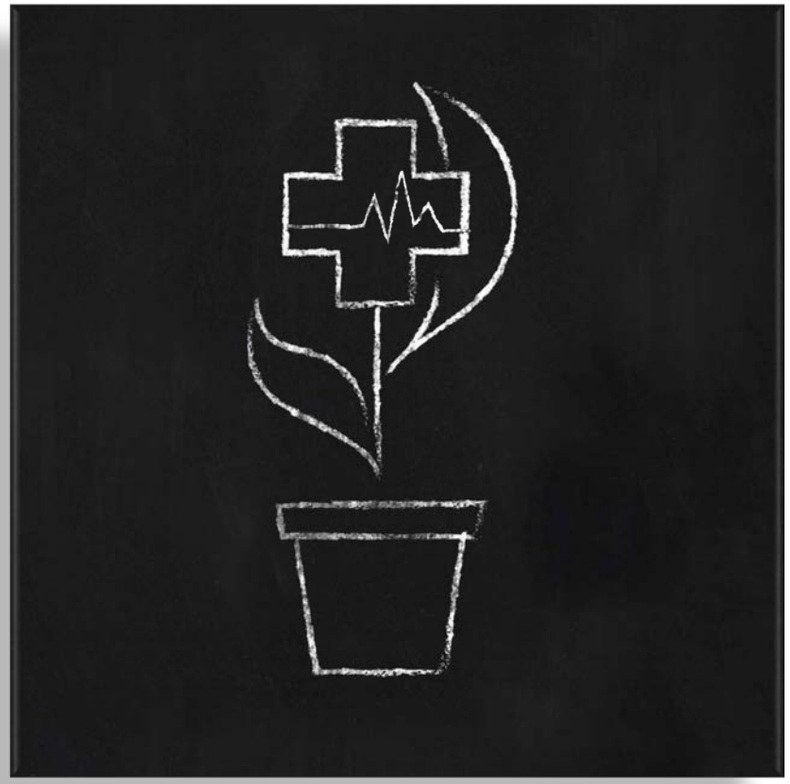

INPATIENT BILLING CHANGES

Additional copy can go here.

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INPATIENT BILLING CHANGES

Proposed for Inpatient Billing:

- "Treat patients only for pre-existing condition"
  - *Patient can't be treated for additional developing diagnosis?*

- "Provider must provide services at the RHC/FQHC a majority of the time"
  - *What about contracted providers that work for you a limited time?*

- Careful how you document inpatient visits: the emphasis will be on proving how long the person has been an RHC patient.

Productivity Standards in the SPA

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PRODUCTIVITY STANDARDS

In SPA to confirm authority to use in rate setting and CSOSR:

- Current: Physicians = 4200 visits/year, Mid-Levels = 2100
- Proposed: Physicians = **3200** visits, Mid-Levels = **2600**

- **But,** clinics must document *direct care, indirect care and Admin/Unavailable time*
  – *DHCS did not remove this burden*

Exceptions to productivity (now in the SPA) – but many auditors aren't aware of them (or acknowledging them)

- Dental Hygienists, Psychiatry, licensed acupuncturist
- Doctors of Osteopathy removed from exceptions (considered same as MD)

PPS Rate Setting Changes

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METHODS TO OBTAIN A NEW MEDI-CAL PPS RATE

Four Methods for adjusted PPS rate:

- New Provider (new clinic site)
- Change of Ownership
- Scope of Service Rate Change Request
  - Cost approach only, not comparables
- Moving or transferring locations

Then decide which method:

1) Three Comparable Clinics
2) Projected Cost Report

NEW PROCESS – “THREE COMP” METHOD

Expect a Backlog, the new process is slow.

FTEs and Services must be in place; no ***projections*** allowed

Drilling down among provider type – MD versus Mid-Level

Contracts – Both BH & Dental contracts must be in place

Remember, you can always go from the 3 comparable method to the cost method but you can’t go from cost method to the 3 comparable method

- Strategy: start with comparable method and see where it leads

“COST REPORT” METHOD

If you are a provider-based RHC, be aware of another change:

Ancillary services provided in hospital outpatient departments:

- Previously those costs were included in rate setting,

Now, A&I says those costs were never intended to be included in expense calculations

- Even though there’s a section in the cost report form (DHCS3092) for reporting said costs.

So, remove those corresponding ancillary revenues from your PPS Recon reporting.

“COST REPORT” METHOD

A&I-MEDI-CAL SUPPLEMENTAL COST REPORT

Schedule 9

Schedule 9 of DHCS3092:

“Ancillary Costs”:

SUMMARY OF MEDI-CAL CHARGES AND ANCILLARY COSTS FOR RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER

Provider name | Provider RHC/FQHC number | Fiscal period From: Through:

Ancillary Service Cost Centers	(1) Cost to Charges Ratio (CMS 2552-96, Worksheet C, Column 9)	(2) RHC/FQHC Charges	(3) Cost Settlement (Column 1 x 2)
Radiology-diagnostic		$	$
Laboratory			
Physical therapy			
Occupational therapy			
Speech therapy			
Electrocardiology			
Medical supplies charged to patients			
Drugs charged to patients			
Total		$	$

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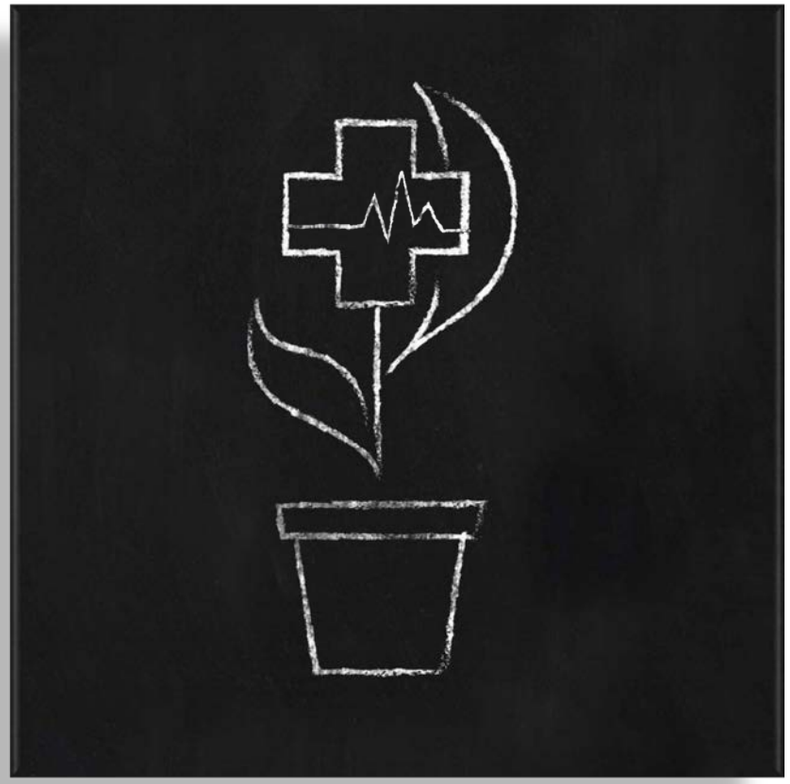
ANOTHER CHANGE – CODE 18

- No more rate setting for mental health services (Code 03):

- “Medi-Cal managed care plans cover behavioral health services. Therefore, beneficiaries enrolled in a Medi-Cal managed care plan should be billed using ***0521 T1015 SE*** for visits related to LCSW, Psychology and Psychiatry services. As a result, the Department will no longer issue a PPS rate…”

- Use form DHCS3100 – create a “Code 18” wrap around rate for mental health
- If the patient is non-managed care Medi-Cal, you can bill as a Code 01.



A&I'S VIEW ON MOVING A CLINIC

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CLINIC RELOCATION

Current Method When Moving a Clinic:

- Keep the current PPS rate, or
- Apply for a new PPS rate using *cost approach* or 3 *comparable method*
- Apply for a new rate using a scope of service rate change request (not the optimal method)

- Lately A&I is saying you **must** apply for new rate **but…**..
  - Apparently CMS issued a directive (in May) to DHCS stating that clinics cannot be mandated to obtain a new rate

PPS Reconciliation Form Changes

Might show up soon?

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RECON FORM CHANGES – RUMOR CONTROL

A&I is changing the annual reconciliation form (DHCS3097):

- Proposed adding section for reporting all Medicare Advantage payments
- DHCS may impute an amount paid per MA claim.
- Proposed adding a section for reporting Managed Care plan incentive payments

- *They are interpreting incentives as part of your Medi-Cal PPS reimbursement.*
- *(It may be reviewed on a case-by-case basis)*

This could be a **MAJOR** reimbursement problem!

Check your Managed Care plan contract wording on incentives!

How are incentives defined? What are the reporting measures?

Recent Audit Adjustments We've Seen

"Seems like endless adjustments"

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OTHER NEW ADJUSTMENTS WE ARE SEEING

- "Prudent Buyer" - DHCS saying costs are excessive and as such are making arbitrary decisions to adjust actual costs to what they think is reasonable – "you paid too much"
- Using property tax rolls to estimate value of building
  (for virtual purchase calculation to eliminate lease expenses)
- Elimination of RN expense
- Elimination of all X-Ray and Laboratory expenses from rate setting or CSOSR reports
- Executive Compensation limits: using surveys on "non-profits" – but not healthcare related
- "PPS rate is too high as compared to peers" – *what's that mean*?
- Limiting Overhead allocations – "higher than peers", but no data to prove.

BILLING FOR MFTS

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MFT's

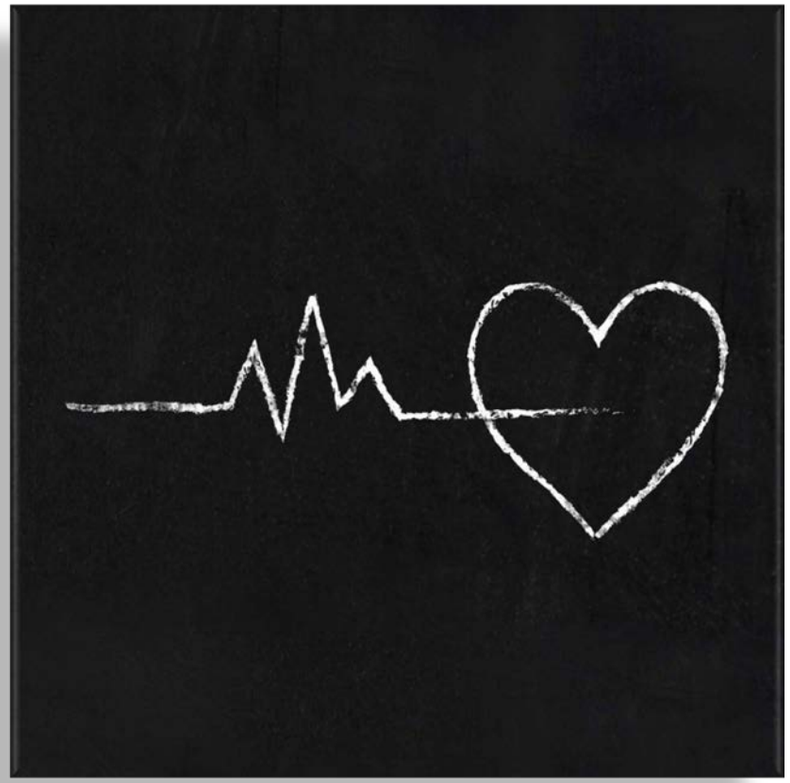
July 1, 2018 – first date to bill for MFT's

Mandatory change of scope rate setting request change

- DHCS cannot say that your scope change is not valid.

- Required to have a full year of operating expenses
- CSOSR would be at 6/30/19 (one year later), but they will make rate retroactive to 7/1/18.

- ***Strategy: if your costs are greater than current PPS rate,***
- ***Start billing for MFT July 1st***
- ***Since you must file scope change, you should be able to obtain a higher rate***



4 WALLS ISSUES ON HOLD

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FOUR WALLS – WHAT'S THE RULE?

- Lots of proposed additional language in the SPA on what providers can bill and how to document the patient visits outside the RHC
- Many more restrictions than for patients seen within the RHC.
- DHCS will delay adding "Four Walls" language until October 1st.

- Again, emphasis on how long has that patient been an RHC patient?
- (just like the Inpatient issue)

LAST COMMENT

“Take me to court”

Questions?

Thank you!

QUESTIONS?

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"No chaos, no creation. Evidence: the kitchen at mealtime"

Mason Cooley – American writer

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