Department of Medical Assistance Services

FQHC Change in Scope Policy

This policy applies to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) and outlines the eligibility and process for incrementally adjusting a FQHC's Medicaid Prospective Payment System (PPS) rate to reflect a change in scope pursuant to **Section 1902(bb)(3)** of the Social Security Act or **42 U.S. Code 1396a (bb)(3)**. For ease of reference, this policy may refer to FQHCs and RHCs collectively as "providers".

CHANGE IN SCOPE DEFINED

A change in scope of services applies only to Virginia Medicaid-covered services and may allow for an adjustment of the provider's Medicaid PPS rate if the FQHC implements a qualifying event. A change in scope is implemented on the first date that patients start receiving care under the new service or at the new site. Qualifying events for a change in scope of services is a change in type, intensity, duration or amount of services and may include the following:

- An addition or reduction of a facility that is not present in the existing PPS rate and meets the requirements of a change in scope.
- The relocation or renovation of a facility that is present in the existing PPS rate if the relocation was to accomplish either an increase or decrease in the volume of services (a change to capacity).
- The closure of a facility that is present in the existing PPS rate.
- The merger or acquisition of an FQHC/RHC that involves a change in scope.
- The addition of a service that is not present in the existing PPS rate.
- The deletion of a service that is present in the existing PPS rate.
- A change in intensity, type or duration of a service resulting from federal or state regulatory requirements specific to FQHCs.

The following shall NOT be considered a qualifying event:

- Any increases or decreases in costs for existing services present in the Medicaid PPS rate without a change in intensity, type, or duration of service. A change in costs alone does not constitute a change in scope of service.
- Any increases or decreases in expenses for salaries, benefits, supplies, facility overhead or administration expenses not directly related to a change in scope of services.
- Any addition or reduction of staff members to or from an existing service.
- Any increases or decreases in assets not directly related to a change in scope of services.

CHANGE IN SCOPE ADJUSTMENT

The Medicaid PPS base rate will be calculated using 12 months of cost data related to the qualifying event using actual historical data based on the Medicaid cost report. The change in scope may result in an increase or a decrease in the Medicaid PPS base rate, depending on the total allowable costs attributed to the change in scope. State Plan Amendment Attachment 4.19-B pages 4.6, 4.7 and 4.8 outlines the methods and standards of reimbursement for FQHCs / RHCs.

The new Medicaid PPS base rate will be calculated using the provider's reasonable total allowable cost of furnishing core and non-core covered services divided by the total number of encounters for the change in scope year. The new Medicaid PPS base rate shall be determined using the provider's reasonable costs provided under 42 CFR 413.

REQUESTING A CHANGE IN SCOPE

A FQHC will be eligible to receive approval for only one change in scope request per provider fiscal year. One request may include multiple qualifying change in scope items.

1. INITIAL NOTIFICATION

Notification of changes in scope of services must be received within 12 months of the increase or decrease in the scope of services by the FQHC. However, notification of changes in scope of services may be received prior to the implementation of the qualifying event when feasible.

2. SUBMITTING CHANGE IN SCOPE REQUESTS

Once the provider has implemented the qualifying event for a provider's full fiscal year, the provider shall submit the following information within five months after the end of the qualifying fiscal year.

A. Narrative documentation of the qualifying event describing the change in scope.
B. Documentation to support the implementation timing of the qualifying event including board of directors meeting minutes, committee meeting minutes, organization's annual reports, contracts or any other relevant documents.
C. A completed Change in Scope calculation report for the change in scope period using the template provided by DMAS. The change in scope period will be defined as the first full cost report year after the change in scope was implemented.
D. The organization's general ledger trial balance of costs that crosswalk to the Completed Medicaid cost report for the cost reporting period.
E. The organization's Practice Management System report of billable encounters for the cost reporting period.

3. <u>SUBMITTING INTERIM CHANGE IN SCOPE RATE REQUESTS</u>

Providers may submit a request for an interim rate for the period after the qualifying event occurs and prior to submitting the Change in Scope request outlined in section 2, above. If the provider elects to request an interim rate for a change in scope, the provider shall submit the same information as required for the change of scope request with the following modifications:

A. A completed Change in Scope calculation report for the change in scope period using the template provided by DMAS. The change in scope period will be defined as the first full cost report year after the change in scope was implemented. *The rate will be calculated using 12 months of cost data related to the qualifying event, and can use either actual historical data, pro-forma (projected) data, or a combination of actual historical data and pro-forma data*. *An interim PPS rate will be calculated using this submission.*
B. Additional documentation: The provider shall submit documentation related to the pro-forma data, to include narration of assumptions made, to support the determination of

the amounts used. Additional information may be requested by DMAS when reviewing the change in scope request.

Any interim rate established using pro-forma costs will be re-calculated at the time of the cost settlement of the first cost report containing twelve months of costs of actual data. The provider will be required to submit the change in scope calculation report at that time using actual data.

DMAS REVIEW OF CHANGE IN SCOPE REQUESTS

DMAS will make all reasonable attempts to review and either approve or deny a provider's change in scope request within 180 calendar days after the request has been received by DMAS with all sufficient documents required by this policy. For interim change in scope requests, DMAS will make all reasonable attempts to review and either approve or deny a provider's change in scope request within 90 calendar days after the request has been received by DMAS with all sufficient documents required by this policy. If DMAS denies a request, the provider may file an appeal.

If all notification timeframes are met, and a qualifying event is established, the approved PPS rate will be retroactively applied back to the date the change in scope was implemented. Failure to meet all the notification timeframes may result in the DMAS determination that the effective date of the approved rate is the first day following the fiscal year-end that the provider submitted the documentation for the change in scope.

APPEAL RIGHTS

If you wish to appeal this action, you must file a written notice of appeal with the DMAS Appeals Division within 30 days of the date of this letter. The notice of appeal must identify your NPI and what you are appealing. You can file an appeal with DMAS through any of the following methods:

- **Through the Appeals Information Management System ("AIMS")** at https://www.dmas.virginia.gov/appeals/. From there, you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

- **Through mail, email, or fax.** You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider appeal process is governed by Virginia Code Section 32.1-325.1 and regulations at 12 VAC 30-20-500 *et seq.*