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Overview and Agenda

- Productivity Standards
- PPS Change In Scope
- Intermittent Clinic
- Billing for Dental Hygienists and CSOSRs
- Billing for MFTs and required CSOSR
- Three Comparable Clinic
- Appeals
- Medi-Cal - Payer of Last Resort and Implications
- COVID Impact for PPS Rate Setting
- APM

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Medi-Cal PPS Rate Setting Introduction

- Plan for a haircut on allowable costs on cost report (7%)
  - In future, % of adjustments likely to increase
- Interim rate on projected cost report: 0% disallowances, 90% of calculated rate (up from 80%)
- Cannot file actual cost report until completion of first FULL fiscal year. State has up to 3 years to audit
- New rate from Change In Scope (cost report cost per visit – old rate) * 80%
- State may request extension on audit of Change In Scope

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Medi-Cal PPS Rate Setting Timing: Current

- No PPS rate until licensed & in HRSA scope
- Medicare as interim rate: 1 month or so for PED to enter in rate
- Projected cost report for interim rate: 3 to 4 months
- Full fiscal year cost report final audit: DHCS has 3 years to finalize once received
- Three comparable clinic (considering 2 or 3 rounds of rejection): 3 to 4 months
- Change In Scope (considering giving State requested extension): 4 to 5 months initially, then lots of questions –

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- New productivity standards are scheduled to go into effect on 1/1/2021 (*dependent on CPCA board approval*) that will be:
  - 3,200 visits for physicians (decreased from current 4,200 visits)
  - 2,600 visits for mid level providers (increased from 2,100 visits)
  - Need to understand how to calculate provider FTE
  - State considers 2080 hours a full time equivalent employee (FTE)

    - Future Impact: These new standards will affect clinics decision as to which rate methodology to use and whether to file a CSOSR.

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Generally, should you file a CSOSR?

- Just because you have an eligible triggering event – doesn't necessarily mean you want to file a CSOSR
- Based on costs/visits for fiscal year, not the scope change itself
  - Voluntary versus mandatory
- Costs/Visits > PPS rate (costs should be at least 15% greater than PPS rate)
  - Numerator/Denominator

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- Other factors to consider:
  - 20% haircut off the difference in adjusted costs versus current PPS rate
  - DHCS adjustments - its just a matter of how much?
  - Productivity adjustments
  - PPS rate could actually decrease
  - Can't pull CSOSR back once it is submitted
  - Health Center will have to demonstrate valid triggering event
    - Future Impact: Demonstrating valid triggering events will become more difficult in the future due to DHCS's interpretation of regulations and pending SPAs

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Look Back Procedure on CSOSRs

- DHCS reviews the prior year physician expenses, visits and FTEs to negate triggering events and CSOSRs
  - Underground rule but open to interpretation
  - Waivers under COVID being discussed
  - Clinics need to understand "look back" procedure before submitting CSOSRs
  - Started to see trend about a year or two ago and will affect future of CSOSRs
    - Future Impact: Look Back Procedure will come more important going forward in PPS rate setting and CSOSRs

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Intermittent clinics

- Entails billing intermittent clinic from parent clinic. Intermittent clinic does not have a license, and thus does not have a PPS rate. PPS-payable services are paid at the parent clinic rate
- Requires notification to the State. Need to keep good workpapers: notification to State, date that intermittent billing commenced, new license (which should list any intermittent clinics)
- While CPSP and CHDP are paid at the PPS, there are also notification/enrollment rules for those programs
- Note that this structure is not applicable for services not paid at Medi-Cal PPS: Family PACT, Medicare,

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Intermittent clinics impact on rate setting

- Addition of an intermittent site can be (but is not required to be) a triggering event
- Removal of an intermittent site is not a required triggering event, unless the intermittent clinic cost was included in the original rate set
- Addition/removal of a site during a rate setting year requires allocating cost/visits
- Presence of intermittent clinic should not influence 3 comparable clinic rate setting
- Future Impact: May result in fewer clinics going

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June 30 FYE	Parent Clinic	Intermittent Clinic Added 1/1	Prorated Intermittent Clinic	For Cost Report
Allowable Cost	$ 6,000,000	$ 2,000,000	$ 1,000,000	$ 7,000,000
Visits	30,000	8,000	4,000	34,000
Cost/Visit	$ 200.00	$ 250.00		$ 205.88

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Billing for Dental Hygienists and Required CSOSR

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Dental Hygienists Billing

- SB 238 authorized FQHCs and RHCs to bill for Dental Hygienist services, effective 1/1/2008
- Mandatory CSOSR
- Full years worth of DH billing
- Billing of and not the hiring of triggers a CSOSR
- Supervision by Dentist per the H&S code

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Dental Hygienists Billing

- If the clinic included the costs and visits for a DH during a rate setting year, there is no requirement to submit a CSOSR
- However, the clinic chose the three comparable method to set the rate during the rate setting year, a CSOSR would still be required because the three comparable clinics most likely didn't have DH costs or visits in their PPS rate

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Dental Hygienists Billing

- Mandatory CSOSR for billing DH visits could be a good strategy to use for those clinics where the cost per visit is significantly higher than the current PPS rate
- Why?
- Look back procedure is not applicable for DH services
- If a clinic is using a DH but not billing for them, the clinic can't bill under the dentist if the patient isn't seen by a dentist for a "face to face" visit for a required diagnosis
  - Future Impact: A&I cross checking if to see if clinic submitted a CSOSR when clinics submit a rate setting or CSOSR and lists dental hygienist visits as part of utilization data

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Billing for dental hygienists during COVID

- If a clinic decided to bill for DH during the COVID period and discovered that a CSOSR would be detrimental because of a stoppage of DH services or low utilization, if can avoid a mandatory CSOSR if they submit a CIF (*claims inquiry form)* and return the money back to DHCS
- A reasonable explanation would need to be identified to avoid the mandatory CSOSR during the COVID period versus just saying the PPS rate would have decreased

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MFT latest & greatest

- AB 1863 added MFTs as a FQHC eligible provider
  - Effective dates was January 1, 2017
  - DHCS is in process of opening-up the window for MFT billing to allow clinics to retro back MFT claims to 1/1/2017 for those providers that have already billed the Medi-Cal managed plan
  - Would effectively allow clinics to bill back the T10105 or Code 18 rate
  - It lets clinic decide on CSOSR date if clinic plans on retro billing
  - Or clinics could just bill going forward – but remember it's a mandatory CSOSR, after the 1st full year worth of MFT claims

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Base year to file a CSOSR?

- A&I and CPCA still working out final details as to which year will be the base year to file a CSOSR
- Most likely scenario will be scope changes will be due for 6/30/19 FYE or 12/31/19 FYE, (or clinics actual FYE), regardless of the retro billing date
  - assumes clinic already billed Beacon (or other entities) for these services and has one year's worth of billings

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Exceptions for filing a scope change for MFT's

- The billing for MFT's (full year), happens the same time as a rate setting cost report
- Doing another mandatory CSOSR in same year, e.g. carving out pharmacy costs
- The three comparable clinic method for setting a PPS rate in base won't suffice as a way to avoid a CSOSR for MFT's
  - Future Impact: A&I will be cross checking to see if health centers filed a CSOSR when they submit a new rate setting or CSOSR and list MFTs as a provider.
  - Forecast an increasing number of CSOSRs using MFTs as the triggering event

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Getting Out of a Mandatory CSOSR During COVID

- If a clinic decided to bill for MFTs during the COVID period and discovered that a CSOSR would be detrimental because of a stoppage of MFT services or low utilization, if can avoid a mandatory CSOSR if they submit a CIF (*claims inquiry form)* and return the money back to DHCS
- A reasonable explanation would need to be identified to avoid the mandatory CSOSR during the COVID period versus just saying the PPS rate

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ACSWs and AMFTs

- Associate Clinical Social Worker and Associate Marriage and Family Therapist were added as eligible providers
- Services are billed under a LCSW or LMFT
- Does not trigger a CSOSR unless…….

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Summary: Should you or Shouldn't you Bill for MFTs?

- Don't bill for MFT's unless you know the following:
  - When did you start billing the MCO or plan to start billing for MFT's?
  - Did Beacon pay you for these MFT visits?
  - What is the current PPS rate for base year?
    - Is it a final rate
- What is the actual or projected costs per visit for base year?
- Did you factor in a 10 to 15% adjustment for A&I and a 20% haircut adjustment?
  - Number of potential MFT visits
  - History of audit adjustments for other CSOSRs or rate setting CR's
  - Do you have a potential productivity issue?
  - Are you planning to carve out pharmacy costs in same year?
- Now – Do you want to bill

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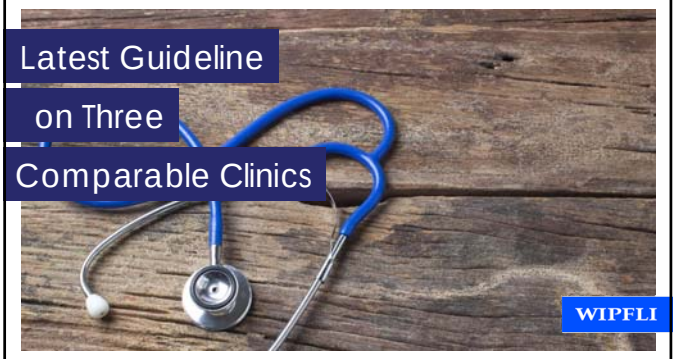
Latest Guideline on Three Comparable Clinics



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Latest News on the Three Comparable Methodology

- Has become difficult to do recently
- Too many landmines!!!
- This methodology although still viable, has become somewhat impossible to get thru unless you are willing to take a low PPS rate!
- New underground rules for the three comparable methodology
  - Closest clinic
  - Split out of visits by physician/mid level
  - Using "other provider" category

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- Rise of Intermittent Clinics:
  - fewer comps to choose from as you cannot use intermittent sites, but…
- Parent Sites to Intermittent Clinics:
  - they can be used, but some analysts are pushing back.
- OSHPD Reports:
  - used to determine FTE/Visits/Services, but reports are sometimes inaccurate or are not complete until end

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- Visit Variances – must be within 3,000 (+/-) between physicians, midlevels and other provider types as well as visit totals within categories (PC/BH/Dental/Total Visits)
- Dental – DH must be apples to apples
- Behavioral Health – psychiatrist must be apples to apples
- Emphasis on median rates in county
  - Last update was 2018, rate needs to be updated by MEI
  - Future Impact: the three comparable rate setting

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- Appeals are being headed off by section chief before clinic gets opportunity to present "informal appeal" – enforcing compliance with W&I Code with submission of informal appeal
- Future Impact: This could ultimately lower the PPS rate for rate setting cost reports and CSOSRs if appeals are not 100% compliant at time of submission

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Medi-Cal - Payer of Last Resort

- DHCS will treat Medi-Cal as payer of last resort and will ensure Medicare pays first for the Medi Medi patients:
  - For Medicare HMO patients, A&I imputes the national G code amount for the Medi Medi patients:
  - Assess monies the clinic never received
  - 519 rates will be increasingly required due to growth of HMO plans
  - You will also need to check if A&I is ignoring the Medicare sequestration cuts on the reconciliation
    - Future Impact: DHCS is ensuring all Medicare payments are accounted for first before crediting cross-overs - impact on

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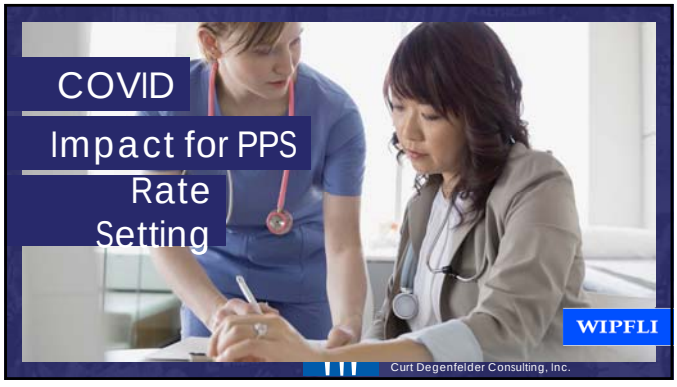

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PPS Rate Setting Implications During COVID

- Productivity per provider FTE is depressed
- Dental visits down
- Mental health visits per FTE and in total may be up
- DHCS not doing onsite visits
- New costs: testing, vaccination, CARES & Rescue Act funds – all allowable?
  - Future Impact: Rate settings and CSOSRs not financially viable during COVID
  - Forecast of significant PPS reconciliation liabilities during COVID due

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COVID impact for final PPS rate

- Permanent Closure: If a health center permanently closed during the final rate-setting year and thus only has partial cost data, DHCS would require the health center to choose one of two options before proceeding with setting the rate:
- Partial Year Cost Report:
  - DHCS will use the data from the time period that the health center was open and moves based solely on the time period that the clinic was open or:
- Retroactive 3 Comparable Clinics Method:
  - In light of COVID-19, DHCS will also offer another option, which is to utilize the 3 comparable clinics method instead of using the partial cost data. This option would only be available during the public health emergency period. Supposedly, DHCS will be more flexible in accepting comparable clinics

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COVID impact – For those clinics that chose the cost report method

- Temporary Closure:
  - For health centers who temporarily closed during the public health emergency but are reopening or will reopen
  - DHCS would utilize the data of their next full FY of cost data after reopening as the basis for the rate
  - and then retroactively apply that rate back to the first day that the health center was open (before they had to temporarily close)

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- APM
  - Converts per visit rate to a per member per month (PMPM) rate
  - Rate historically based, on PPS rate and historical utilization (and member months)
  - Need a good PPS rate/Change In Scope
  - Still requires a good PPS rate if services are carved out
  - May start out as a pilot program

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Considerations in APM rate setting

- Rate period for historical data – don't want to base it on COVID-depressed period
- Attribution – is it based on patients seen, or plan assigned members (including those that the health center has never seen)
- Single rate for organization or rates for each site (harder for APM because patients don't always go to same/assigned site)
- What services are carved out? Dental? Mental health?
- May be different triggers for an APM Change In Scope

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How APM would impact current

- Substantially less/no visits would be paid on the per-visit rate
- Utilization (visits per member/patient per year) becomes more important than productivity (visits per provider FTE per year)
- Medi-Cal reconciliation may focus more on determining if the health center was overpaid, with potentially no payback for "overpayment" (APM revenue > rate x visit)
  - Future Impact: APM would significantly affect rate settings and CSOSRs and

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QUESTIONS?

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Your presenters

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