

Scope of Service Changes

1. Qualifying events for a change in scope of services is a change in the type, duration, or amount of services and patients, and may include but is not limited to: adding a new service or service delivery site, deleting a service or service delivery site such as Pharmacy Services, Radiology Services, and Dental Services, or adding a new target population.
 - a. **Type** is defined as the addition or deletion of a Medicaid-reimbursed service outlined in the NC DMA FQHC/RHC Clinical Coverage Policy No. 1D-4, eligible beneficiaries with specific medical challenges, or special population, as defined by the Health Resources Services Administration.
 - *Examples can include adding a dental, behavioral health, pharmacy service, ob-gyn, optometry, podiatry, etc.*
 - *Eligible beneficiaries with specific health or social determinants challenges may include patients with HIV/AIDs, multiple chronic conditions, refugees or others, as identified in the scope of service change application.*
 - *HRSA-defined special populations include people identified as homeless, public housing residents, farmworkers and migrant workers, and lesbian, gay, bisexual, and transgender.*
 - b. **Duration** is defined as a change in the average length of time it takes FQHC/RHC providers to complete an average patient visit due to changing circumstances.
 - c. **Amount** is defined as an increase in the quantity of services that an average patient receives in an average Medicaid-covered visit or the total number of patients served.
 - *Examples can include improvements to technology or facilities that result in increased services to the FQHC/RHC's patients.*
 - *Greater number of patients served, for example utilizing pharmacy, dental, or ob-gyn services.*

Examples of items that are NOT considered changes in scope of services include:

- *Increase or decrease in expenses for salaries, benefits and supplies not directly related to a change in scope of services.*
- *Increase or decrease in facility overhead or administration expenses not directly related to a change in scope of services.*
- *Increase or decrease in assets not directly related to a change in scope of services.*
- *Expenditures for items covered by insurance not directly related to a change in scope of services.*
- *A change in scope of services does not mean the addition or reduction of staff members to or from an existing service.*
- *A change in the cost of a service is not considered in and of itself a change in the scope of services.*

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2. For a change in scope of service requested after January 1, 2019, FQHCs/RHCs may request a change in scope of services once per 12 month period. The request may be based on the first (or subsequent) full fiscal year (12 month cost report) in which the cost for the change in scope of service was present.

Example:

- FQHC is calendar year provider
- Change in Scope of Service initiated 12/1/2016
- Full cost report period in which CISS was present is FYE 12/31/2017

One Time Exception: Prior to January 1, 2019, FQHCs/RHCs may submit a change in scope of service request for each unique 12 month cost reporting period in which a qualifying change in scope of service occurred since the base year(s) used to establish the provider's unique PPS rate. For each change in scope of service requested the provider must be able to fully document costs per Paragraph 3. Requested extensions will be reviewed on a case by case basis.

If the provider has multiple qualifying changes in scope in a single cost report year, the provider must complete the change in scope of service form in full for the primary change in scope of service. The provider must complete Lines 1-3 only on additional forms to document the secondary qualifying change in scope of service. The secondary form Lines 1-3 are necessary because the form calculates the percentage of cost attributable to the Medicaid population served by the specific change in scope.

Example 1:

- In the same cost report year, the provider has a full 12 months of adding an OBGYN scope of service and is the first full 12 month period in which they have added a FQHC Dental practice.
- The provider would complete the CISS form in full to document the addition of the OBGYN service and then would complete lines 1-3 only of a second form to document the CISS requested for the FQHC Dental Practice.

Example 2:

- In the same cost report year, the provider has a full 12 months of adding an OBGYN scope of service and is the first full 12 month period in which they have a qualifying change in scope for their FQHC pharmacy costs.
- The provider would complete the CISS form in full to document the addition of the OBGYN service and then would complete lines 1-3 only of a second form to document the CISS requested for the change in scope of pharmacy costs.

3. To request a change in scope of service as described in Section 1 above:

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- a. The FQHC/RHC will notify the state in writing, including a detailed description and documentation of the service change and a completed *NC DMA CISS Form*.
 - For the addition of a service: the descriptions should include the service the FQHC/RHC is adding, the location(s), the date of the FQHC/RHC began providing the service, and a brief description of how the new service will benefit the patient population. If the new service requires the Medicaid enrollment with a new NPI (such as Dental or Pharmacy), the provider must furnish the new NPI and corresponding taxonomy.
 - For a change in duration, or amount: the description should include the service change, the location(s), a description of how the average visit has changed from when the FQHC/RHC's rate was set, along with relevant supporting documentation, and how the change has benefited the patient population.
- b. The FQHC/RHC must provide historical and budgeted cost information showing the facility's expenses **before** and **after** the change in scope of services.
 - i. To be considered, the documentation must fully document the base year cost per unit of service and Change in Scope year cost per unit of service.
 - ii. Depending upon the type of change in scope requested, the documentation may include but shall not be limited to the following from both the base year and the requested change in scope year (payroll information, contracted staff, FTEs, staff qualifications, working trial balance, patient mix, primary diagnosis of patient mix, units / encounters furnished, depreciation schedules, asset listings, external certification requirements and accreditations, submitted Medicare and Medicaid cost reports, all documentation to support reclassifications, adjustments and allocations of cost.) Unless the Change in Scope of Service requested is the addition of a new service which is identified in a self-contained cost center on the CMS 224-14 cost report (i.e. first year of a new Dental or Pharmacy program), the cost report itself shall not be considered a source document to support the Change in Scope of Service.
- c. For an approved CISS rate to be implemented before the beginning of the provider's fiscal year, the FQHC/RHC must submit the CISS request 90 days prior to the beginning of the provider's **next** fiscal year. The State will evaluate the submitted documentation and notify the FQHC/RHC within 90 days whether the proposed change meets criteria for a change in scope.

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Example: **Sample Timeline using 2017 as CISS Requested Year**

Assume Calendar Year Provider

First Full Year Cost Report Containing CISS	1/1/2017—12/31/2017
Due Date of Above Cost Report	5/31/2018
Date by which CISS Form and Documentation must be Received (90 Days Prior)	10/1/2018
Effective Date of new PPS Rate	1/1/2018

- d. Upon approval by the State, the FQHC/RHC will begin receiving the PPS rate for the service effective on the 1st day of the provider's fiscal year in which the cost report was received.
(Example: Provider XYZ's FYE is December 31, 2017. The effective date of the new rate will be January 1, 2018.)
- e. Deletion of a Service: FQHC/RHCs will notify the State that they have discontinued a given service within 60 days of deletion of such service and will cease including the visits on invoices on the date the service was discontinued. The cost of the change in scope will be determined as described in Sections (4).

PPS Rate Adjustments

4. The FQHC/RHC's per-encounter PPS rate will be adjusted to account for increases or decreases in the scope of services and calculated on an incremental basis subject to the following:
- a. The rate adjustment is attributable to an increase or decrease in the scope of the services as defined in Section 1 above. The threshold for changes in scope of services must result in a least a **1%** increase or decrease from base year. DMA will re-evaluate the 1% threshold after 1 year to determine the final threshold percentage.
 - b. To be considered, any cost supporting the rate adjustment must be allowable under the Medicare reasonable cost principles set forth in 42 C.F.R. § 413.
 - c. A change in costs alone without a qualifying change in scope of services as defined in Section 1 above does NOT qualify for a rate adjustment.
 - d. The State will review the submitted documentation, along with claims data to understand the quantity and scope of services, and will notify the FQHC/RHC within 90 days of receiving all necessary documentation whether a PPS rate change will be implemented.

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- e. If implemented, the PPS rate change will reflect the cost difference of the scope of service. The State will implement the new rate upon approval and the interim PPS rate and the new PPS rate will be reconciled back to the beginning of the provider's Fiscal Year **following the Fiscal Year** in which the change in scope took place.
 - f. An FQHC/RHC may appeal a denial of a request for a change in scope or a rate adjustment due to change in scope of services or may appeal the failure of the State to act on a rate adjustment request within 60 days using the process described in 10A NCAC 22J.
5. This policy is subject to change on an as-needed and/or annual basis.