

# Indiana FQHC/RHC Change in the Scope of Service Guidelines

## A. Definition of a Change in the Scope of Service

A change in the scope of FQHC/RHC services may occur if a FQHC/RHC experiences any of the following events:

1. The center or clinic has added or has discontinued any service that:
  - a. Meets the definition of FQHC/RHC services as provided in section 1905(a)(2)(B) and (C), and
  - b. Is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary.
2. The center or clinic has experienced a change in the type, intensity, duration and/or amount of current services as described in number one above.
3. The center or clinic has experienced a change in services, as described in number one above, due to the relocation, remodeling, opening of a new clinic site or closing of an existing site.
4. A change due to federal or state regulatory requirements.
5. A change in sites or scope of services that are approved by the Health Resources and Service Administration (HRSA), Bureau of Primary Health Care.

The following examples of changes in the scope of service are offered as guidance to understanding their definition, but are not intended to serve as a comprehensive list of all changes in the scope of service.

- Adding or discontinuing an FQHC-covered service include adding or deleting dental services or optometry services.
- Changes in the type, intensity, duration or amount of currently offered FQHC-covered services may include adding or deleting specialists (facility currently has 1 OBGYN that works one day per week but hires 3 OBGYNs to work 40 hours per week).
- Changes in scope of service due to federal or state regulatory requirements may include:
  - Mandated revisions in the types of practitioners and professional personnel employed by the center (including ratios of assistants or nursing staff to particular practitioners) or
  - Mandated limitations or restrictions of currently provided services.

## B. Change in Scope of Service Adjustment Criteria

The following criteria must be met in order for a center or clinic to qualify for a change in the scope of service:

1. The cost related to a change in the scope of service must account for an increase or decrease to the existing PPS rate of 5% or greater. To determine if the 5% threshold is

met, the portion of the provider's cost-per-visit specifically attributable to the scope change will be divided by the PPS rate in effect at the time the scope change has been fully implemented for six consecutive months.

2. The cost related to a change in the scope of service will be subject to reasonable cost criteria identified in accordance with section 1833(a)(3) of the Social Security Act.
3. The change in the scope of service must have been fully implemented for six consecutive months in order to be considered for a PPS rate adjustment.

If the above criteria are met, the incremental cost-per-visit attributable to the change in scope of service will be applied to the PPS rate in effect at the time the change in scope of services has been implemented for 6 consecutive months. If the filing requirements listed below are met, the adjusted PPS rate will be effective on the earlier of a) the first day of the calendar year following the fiscal year in which the change in scope of service had been implemented for six consecutive months or b) the first day of the provider's fiscal year following the fiscal year in which the change in scope of service had been implemented for six consecutive months.

### **C. Filing Requirements for a Change in the Scope of Service**

1. The center or clinic must notify Myers and Stauffer in writing prior to the occurrence of a planned change in the scope of service that may warrant a potential PPS rate adjustment. In the event the center or clinic experiences an unplanned change in the scope of service, the center or clinic should notify Myers and Stauffer within 90 days of the center or clinic's fiscal year end in which the change occurred.
2. The center or clinic must submit a written request for a change in scope of service PPS rate adjustment to Myers and Stauffer within 90 days after the six month period set out in Section B-3 (above).
3. The center or clinic must submit one or more cost reports that include data for at least a six month period following implementation of the scope change. The provider should indicate on the change in scope of service request form which of the following reporting periods will be submitted for consideration of a PPS rate adjustment:
  - a. A partial year cost report covering a period of at least 6 months, from the beginning of the current fiscal year through the date when the change in scope of service had been implemented for six consecutive months, or
  - b. The current fiscal year cost reporting period (full year) which includes an entire six month period after the implementation of the change in scope of service, or
  - c. The prior fiscal year cost report and a current partial year cost report that accounts, in total, for the 6-month period set out in Section B-3.
4. All required documentation (listed in section D below) must be submitted to Myers and Stauffer no later than 5 months after the reporting period indicated in number 3 above.
5. Myers and Stauffer will request any additional documentation within 30 days of receipt of all required documentation listed in section D below.
6. If additional information is requested by Myers and Stauffer, the center or clinic will have 30 days to submit the additional documentation.

7. Failure to submit all required documentation within the time frames listed above could result in a denial of the change in scope of service request or a delay in the rate effective date.

**D. Required Supporting Documentation**

The required list of supporting documentation includes but is not limited to the following items. The time period for all items submitted with the cost report (Board of Director Minutes, Audited Financial Statements, Working Trial Balance, FTEs, etc.) should correspond to the cost reporting period:

1. Change in the Scope of Service Request Form
2. Hard copy of the FQHC cost report signed by the center or clinic administrator or appropriate personnel.
3. Electronic cost report
4. Board of Directors Meeting Minutes
5. Audited Financial Statements
6. Working Trial Balance
7. Crosswalk of expenses from the Working Trial Balance to the cost report
8. Summary of FTEs and Total Visits for each provider in the center or clinic (physician, nurse practitioner, dentist, etc.)
9. Summary of cost report reclassification and adjustments (including supporting workpapers if applicable)
10. Donated Labor Summary (applicable only if provider is reporting donated labor as an allowable expense on the cost report, shows imputed value calculation)

**E. Review of Submitted Documentation**

Myers and Stauffer will review the submitted documentation and notify the provider in writing, within 90 days of the receipt of all required documentation, as to whether a PPS rate change will be implemented. As previously stated, the above list of documentation is not exhaustive and Myers and Stauffer may require additional information to process the request for a rate change due to a change in scope of service.

If a change in scope of service request is filed timely in accordance with the guidelines outlined herein and meets the criteria for a PPS rate adjustment, the new rate will be effective on the earlier of a) the first day of the calendar year following the fiscal year in which the change in scope of service had been implemented for six consecutive months or b) the first day of the provider's fiscal year following the fiscal year in which the change in scope of service had been implemented for six consecutive months. For adjusted PPS rates effective at the beginning of the provider's fiscal year, the annual calendar year MEI adjustment will still be applied at the beginning of each subsequent calendar year.

If a change in scope of service request is not filed timely in accordance with these guidelines, each request will be considered individually and may be denied. If the request for a change in scope of service PPS rate adjustment is granted further review, and meets the criteria for a PPS rate adjustment, the new rate will be effective prospectively on the first day of the

calendar year following the calendar year in which the change in scope of service request was received by Myers and Stauffer.

**F. Annual Reporting**

FQHCs are required to submit a cost report to Myers and Stauffer no later than 5 months after the center or clinic's fiscal year end. RHCs are required to submit the finalized Medicare cost report upon receipt from the Medicare Intermediary. A change in the scope of service may also be identified through a review of the center or clinic's cost report.

**G. Example Calculation**

A clinic experienced a change in scope by adding dental services to the current list of services provided at the facility. The clinic began offering dental services on March 1, 2005. The clinic has a December 31 fiscal year end. After the scope change was implemented for 6 consecutive months, the clinic submitted a change in scope request form to Myers and Stauffer in a timely manner.

The following would satisfy the above filing requirements:

1. The provider must notify Myers and Stauffer in writing before March 1, 2005 that the clinic will begin dental services at the facility.
2. The last day of the sixth consecutive month after the facility implemented dental services is September 30, 2005. The center or clinic would then have until December 29, 2005 (90 days) to submit the change in scope of service request form to Myers and Stauffer.
3. In the request mentioned above, the center or clinic must indicate which one of the following reporting periods will be submitted for consideration of a PPS rate adjustment:
  - a. January 1, 2005 to September 30, 2005 or
  - b. January 1, 2005 to December 31, 2005
4. Based on the reporting period selected above, the center or clinic must submit all required calculations and documentation to Myers and Stauffer no later than
  - a. February 28, 2006 or
  - b. May 31, 2006

Using the above scenario, below is an example calculation of a change in scope adjustment. Assuming the clinic selected their full-year 12/31/05 cost report as the cost report for the change in scope review, Myers and Stauffer's review would take place in 2006 after receipt of the cost report.

1. The costs attributable to the scope change (addition of dental services) were \$200,000, consisting of salaries of \$120,000, other expenses of \$50,000, and overhead of \$30,000.
2. The costs attributable to the scope change are divided by total visits to determine the cost-per-visit impact of the scope change, \$10.00.

	<b>A</b>	<b>B</b>	<b>C (A-B)</b>
	Cost Report As Filed	Cost Report Without Dental	Costs/Visits Attributable to Scope Change
Total Allowable Costs	2,800,000	2,600,000	200,000
Visits	20,000		20,000
Cost Per Visit	140.00		10.00

3. In this example, the change in scope had been implemented for 6 consecutive months on September 1, 2005 (6 months after the clinic began providing dental services); therefore, the PPS rate used in the calculation would be the PPS rate in effect on September 1, 2005. The provider's PPS rate at the time the scope change had been implemented for 6 consecutive months was \$115.00. The cost per visit specifically relating to the scope change (\$10.00) is divided by the PPS rate at the time the scope change had been implemented for 6 consecutive months (\$115.00) to determine if the 5% threshold is met. Because the 5% threshold is met in this example ( $\$10.00 / \$115.00 = 8.70\%$ ), the clinic qualifies to receive a PPS rate adjustment resulting from the change in scope of services (addition of dental services).
  
4. The incremental cost-per-visit attributable to the change in scope of service (\$10.00) will be added to the clinic's PPS rate in effect at the time the change in scope had been implemented for 6 consecutive months. The 2005 PPS rate of \$115.00 will be increased by \$10.00, resulting in a new PPS rate due to the change in scope of services of \$125.00. Assuming the request was filed in a timely manner, this new rate will become effective the first day of the calendar year following the fiscal year in which the change in scope of services took place (January 1, 2006).

	Change In Cost Per Visit	% Increase / Decrease	5% Threshold Met	Revised PPS Rate Effective 1/1/2006
2005 PPS Rate	10.00	<b>8.70%</b>	Yes	<b>125.00</b>

**FQHC/RHC CHANGE IN SCOPE OF SERVICE REQUEST FORM**

**Provider Name:** \_\_\_\_\_  
**Provider Number:** \_\_\_\_\_  
**Fiscal Year End:** \_\_\_\_\_

**Beginning Date of Scope Change:** \_\_\_\_\_  
**Cost Report Submitted for Review:** \_\_\_\_\_

Please indicate which of the following type(s) of change in scope of service your facility has experienced (reference the Indiana FQHC/RHC Change In Scope of Service Guidelines for detailed instructions).

- \_\_\_\_\_ The clinic has added or has dropped any service that meets the definition of FQHC/RHC services.
- \_\_\_\_\_ The clinic has experienced a change in the type, intensity, duration and/or amount of current services.
- \_\_\_\_\_ The clinic has experienced a change in services due to the relocation, remodeling, opening, or closing of a clinic site.
- \_\_\_\_\_ A change due to federal or state regulatory requirements.
- \_\_\_\_\_ A change in applicable technologies and medical practices.

Please provide a narrative description of the scope change (e.g., addition of service, clinic expansion, regulatory requirements, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate what cost center(s) on the cost report were affected by the change in scope of service:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach the following required items along with your request:

1. Hard copy of the FQHC/RHC cost report signed by the center or clinic administrator or appropriate personnel.
2. Electronic cost report
3. Board of Directors Minutes
4. Audited Financial Statements
5. Working Trial Balance
6. Crosswalk of expenses from the Working Trial Balance to the cost report
7. Summary of FTEs and Total Visits for each provider in the center or clinic (physician, nurse practitioner, dentist, etc.)
8. Summary of cost report reclassification and adjustments (including supporting workpapers if applicable)

Please describe any other documentation attached:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Notes/Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I attest and affirm that the information provided above is true and accurate to the best of my knowledge and that the change in scope of services occurred in the manner described above.

\_\_\_\_\_  
Print Name  
\_\_\_\_\_  
Signature Date  
\_\_\_\_\_  
Phone Number

Please Submit This Form And All Documentation To: Mr. Timothy Guerrant Myers and Stauffer LC 9265 Counselors Row Suite 200 Indianapolis, IN 46240-6419
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