The following DHCS forms are required for initial FQHC/RHC rate setting. Please submit complete packages only. Incomplete packages will not be processed timely.

* Prospective Payment System Election Form (pages 5-6)
* Summary of Current Services (page 7)
* Summary of Healthcare Practitioners (page 8)
* DHCS Form 3100 – Managed Care Differential Rate Request (Code 18) (for providers with managed care contracts)
* DHCS Form 3105 - CHIP Differential Rate Request (Code 19) (for providers with Healthy Families Plan – Children’s Health Insurance Program)
* DHCS Form 3104 – Medicare Advantage Plan Differential Rate Request (Code 20) (for providers with capitated Medicare Advantage Plans)
* DHCS Form 3090 – Cost Report (if applicable)
* DHCS Form 3089 – Home Office Cost Report (if applicable)

The NPI number for the facility must be included on all forms to ensure proper processing.

Please access the DHCS forms and instructions from this link <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx> to ensure the most current version FQHC/RHC form is used.

The following additional documents must be included with the FQHC/RHC rate setting application package:

* **FQHC look-a-like only** – the look-a-like approval letter from CMS with the effective date.
* **FQHC only** - documentation from HRSA (HRSA Notice of Grant Award) showing the date the new site was approved for the grant’s scope-of-project.
* **RHC** – not required

For assistance completing these forms please send email to Clinics@dhcs.ca.gov or contact the Audit Review and Analysis Section at (916) 650-6696.

**FQHC Effective Date**

If a provider wants the Medi-Cal FQHC effective date to be the same as the federal effective date from HRSA or CMS they must submit an FQHC rate setting application package to the Department of Health Care Services (DHCS) within 90 days from the original written notification date. Otherwise, the effective date will be the date the FQHC rate setting application package was hand delivered, faxed, or postmarked to DHCS. If the clinic was not enrolled in the Medi-Cal program at the time of the federal approval, then the 90 day period will start with the date of written notification from DHCS of the clinic’s Medi-Cal provider number. The 90-day time period is consistent with all DHCS programs and has been approved by the federal Department of Health and Human Services.

# Rate Determination

You may either choose three comparable clinics or a projected cost report to set the rate for a new site.

## Three Comparable Clinics

Comparable clinics are defined as clinics providing similar services in the same geographic area with similar caseloads. If no comparable clinics are in operation in the same geographic area, then you may choose three comparable clinics in a similar geographic area. If you choose a rate based on three comparable clinics, this will be used to establish a PPS rate and no cost report will be required.

## Projected Cost Report (DHCS Form 3089 and DHCS Form 3090)

If you choose to complete a projected cost report, it will be used to set an interim rate. In order to expedite the rate setting and billing process, we can set your rate on an interim basis at the Medicare Upper Payment Limit until we receive the projected cost report. To establish a PPS rate, you will be required to submit an actual cost report after the first complete fiscal year subsequent to your FQHC/RHC effective date. For example, a new FQHC/RHC with an effective date of 10/1/03 whose fiscal year end is 12/31/03 will need to submit an actual cost report for 12/31/04 to establish a PPS rate. This would be the first complete fiscal year [12 months] subsequent to the FQHC/RHC effective date. The 12/31/04 cost report will be audited and the PPS rate will be set based on the audited data. This rate will be retroactively applied to the effective date and the Medi-Cal claims will be adjusted to reflect a PPS rate.

If you have multiple sites and you elect to submit a projected cost report for a new site, you must submit a home office cost report that shows the allocation of the overhead to the new site as well as an individual cost report for the new site.

**Managed Care Differential-Billing Code “18” (DHCS Form 3100)**

A differential rate code (code 18) was established to provide additional reimbursement to FQHCs and RHCs for the difference between their interim rate or PPS rate per visit and payments made by their managed care plans and Medicare~~.~~

Each FQHC or RHC that participates in the Medi-Cal Managed Care Program should complete the “DHCS Form 3100 – Managed Care Differential Rate Request”. This worksheet provides information regarding managed care plan visits and payments specific to each FQHC and RHC. The Department will use this information to establish each FQHC’s or RHC’s individual code 18 rate. It is important to remember to include the Medicare payments for Medicare/Medi-Cal crossover claims in addition to the managed care plan payments or the code 18 rate will be set too high and result in overpayments. These claims will be denied if billed under any other billing code.

An annual reconciliation process was developed to ensure that the amounts paid for Medi-Cal managed care visits are equal to the full PPS rate that would apply to those visits. The Department will reconcile the amounts paid under the code 18 rate, the PPS rate, and the amounts received from the FQHC’s and RHC’s managed care plan, Medicare, and third party payers. Each clinic will submit their annual reconciliation at the end of their fiscal year. Department will have 3 years from the received date to finalize the clinic’s reconciliation. During this process, the clinic will receive tentative retroactive adjustment (TRA) settlements based on the filed data reported on the reconciliation request. The 60% interim settlement may be subjected to change at the Department’s discretion.

Each FQHC or RHC should bill a code 18 visit to the fiscal intermediary for each Medi-Cal managed care service **(including Medicare/Medi-Cal crossovers)** that meets the requirements of a billable Medi-Cal visit (codes 01 through 04). FQHCs and RHCs that do not follow this procedure will not have their Medi-Cal managed care visits reconciled. Therefore, any visits that are not billed and paid by the fiscal intermediary will not be included in the annual reconciliation.

**CHIP Differential-Billing Code “19” (DHCS Form 3105)**

The Children’s Health Insurance Program (CHIP) Differential Rate Request forms are designed to establish an interim rate that reimburses a provider for the difference between their prospective payment system (PPS) rate and their Healthy Family Program (HFP) plans average reimbursement per visit for CHIP beneficiaries**.**

Each FQHC or RHC that participates in the Healthy Families Program should complete the “CHIP Differential Rate Request”. This worksheet provides information regarding Health Family Program plan visits and payments specific to each FQHC and RHC. The Department will use this information to establish each FQHC’s or RHC’s individual code 19 rate. It is important to remember to include all (capitated and fee-for-service) Healthy Family Program plan payments in addition to any co-payments received from the patients or the code 19 rate will be set too high and result in overpayments. These claims will be denied if billed under any other billing code.

An annual reconciliation process was developed to ensure that the amounts paid for Healthy Family Program visits are equal to the full PPS rate that would apply to those visits. The Department will reconcile the amounts paid under the code 19 rate, the PPS rate, and the amounts received from the FQHC’s and RHC’s Healthy Family Program plan, patient co-payment, and third party payers.

Each FQHC or RHC should bill a code 19 visit to the fiscal intermediary for each Healthy Families Program visit that meets the requirements of a billable FQHC/RHC Medi-Cal visit. FQHCs and RHCs that do not follow this procedure will not have their Healthy Families Program visits reconciled. Therefore, any visits that are not billed and paid by the fiscal intermediary will not be included in the annual reconciliation.

**Medicare Advantage Plan-Billing Code “20” (DHCS Form 3104)**

Any FQHC or RHC that has a contract with a capitated Medicare Advantage Plan (MAP) for non-managed care Medicare/Medi-Cal (crossover) patients will need to complete a MAP Rate Request Form to establish a Code 20 rate in order to bill these claims to Medi-Cal. These claims will be denied if billed under any other billing code.

The MAP forms are designed to establish a MAP rate that reimburses a provider for the difference between their prospective payment system (PPS) rate and their MAP Plan average reimbursement per visit for **non-managed care plan Medicare/Medi-Cal (crossover) beneficiaries.**

Medi-Cal bulletin #410, issued in November 2008, informed providers of the establishment of billing code 20 for the FQHC/RHC to bill for services provided to non-managed care plan Medicare/Medi-Cal beneficiaries enrolled in a Medicare Advantage Plan Health Maintenance Organization (MAPHMO).

Effective September 1, 2009, FQHC/RHC providers who have not received an Explanation of Medicare Benefits (EOMB), Medicare Remittance Notice (MRN), or Remittance Advice (RA) from their MAPHMO for their crossover patients must bill Medi-Cal using code 20 instead of code 02 and provide a justification for the absence of the EOMB, MRN, or RA. The justification consists of a statement in the remarks section of the claim form stating that no EOMB, MRN, or RA was received from the MAP.

An annual reconciliation process was developed to ensure that the amounts paid for Medicare Advantage Plan visits are equal to the full PPS rate that would apply to those visits. The Department will reconcile the amounts paid under the code 20 rate, the PPS rate, and the amounts received from the FQHC’s and RHC’s Medicare Advantage plan, patient co-payment, and third party payers.

**Only FQHC/RHC providers receiving capitated payments from their Medicare Advantage Plan Health HMO for Medi-Cal non-managed care patients are to bill code 20.**

The information provided on these forms is subject to the Medicare Reasonable Cost Principles in 42 CFR, Part 413 in accordance with the State’s Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC) State Plan Amendment.

**STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS)**

**FEDERALLY QUALIFIED HEALTH CENTER (FQHC) / RURAL HEALTH CLINIC (RHC)**

**PROSPECTIVE PAYMENT RATE**

**ELECTION FORM**

**Name of Clinic:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**National Provider Identifier (NPI):**\_\_\_\_\_\_\_\_\_\_\_\_

The State Plan Amendment effective January 1, 2003, prescribes the Prospective Payment Rate setting process for clinics that qualify for FQHC/RHC status subsequent to fiscal year 2000. At a new facility’s **one time election**, DHCS will establish a rate (calculated on a per visit basis) that is equal to one of the following methodologies:

1. **Using The Average PPS Rate of Three Comparable Clinics Method**

The DHCS will require the facility to identify at least three comparable facilities providing similar services in the same or adjacent geographic area with similar caseloads. If no comparable facilities are in operation in the same or an adjacent geographic area, then the facility will be required to identify at least three comparable clinics in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics. If the facility is unable to identify three comparable facilities, DHCS will identify at least three comparable facilities with respect to relevant social, health care, and economic characteristics. The PPS rate will be based on the average of the rates established for the three comparable facilities as verified by DHCS.

**Or**

1. **Using The Projected Cost Report Method**

Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility’s first full fiscal year of the facility’s operation at the new site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on the actual cost per visit. The prospective payment reimbursement rate, so established, will apply to all services provided at the new site. After the facility’s first fiscal year of operations at the new site, the prospective payment reimbursement rate established would be subject to annual Medicare Economic Index (MEI) increases. This method requires the filing of a cost report utilizing projected costs and visits.

If this method is elected, this election form should be submitted along with the projected cost report.

For assistance completing these forms pleases email: Clinics@dhcs.ca.gov to receive a written response, or if you do not have access to email, you may contact the Audit Review and Analysis Section at (916) 650-6696.

**Election**

Please elect either Method 1 (three comparable clinics) or Method 2 (projected cost report) by checking the appropriate method below. It is recommended that the fiscal impact of both methodologies be carefully analyzed and considered by your facility’s management prior to making this election. **As noted above, this is a one-time election and once made, cannot be reversed.**

Name of Facility/Clinic Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County:\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_

NPI Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent Organization (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Fiscal Period Ending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1)\_\_\_\_Three Comparable Clinics**

Please list below the comparable clinics your facility has identified:

Name Address City

Clinic 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Clinic 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Clinic 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

**2)\_\_\_\_ Projected Cost Report**

Note: If this election is selected please indicate if you would like the DHCS to establish an interim rate using the Medicare Upper Payment Limit until such time as DHCS receives the projected cost report necessary to set the projected PPS rate. Projected cost reports are to be filed within 150 days from the date of this election. This will allow the clinic to begin billing immediately.

\_\_\_\_\_\_\_\_\_ Yes, set an interim rate using the Medicare Upper Payment Limit

\_\_\_\_\_\_\_\_\_ No, do not set an interim rate using the Medicare Upper Payment Limit.

**Certification**

**Intentional misrepresentation or falsification of any information contained in this request resulting in reimbursement by the Department may be punishable by fine and/or imprisonment under federal and state laws. (42 CFR 1003.102 "Basis for Civil Money Penalties and Assessments", 18 U.S.C 1347 "Health Care Fraud", California Welfare and Institutions Code 14123.25 "Civil Penalties for Fraudulent Claims", and Title 22 of the California Code of Regulations 51485.1 "Civil Money Penalties"). That I am an official of the subject clinic and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare and Institutions Code.**

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **SUMMARY OF CURRENT SERVICES PROVIDED BY CLINIC** | | | | |
|  |  |  |  |  |
| **Clinic Name:** | | | | |
| **National Provider Identifier (NPI):** | | | | |
|  |  | **YES** | **NO** | **CONTRACTOR NAME** |
| 1. | Medical |  |  |  |
| 2. | Dental |  |  |  |
| 3. | X-ray |  |  |  |
| 4. | Laboratory |  |  |  |
| 5. | Pharmacy |  |  |  |
| 6. | Nutritional |  |  |  |
| 7. | Psych/Social |  |  |  |
| 8. | Education |  |  |  |
| 9. | CPSP |  |  |  |
| 10. | Outreach |  |  |  |
| 11. | Norplant Implants |  |  |  |
| 12. | Optometry |  |  |  |
| 13. | Chiropractic |  |  |  |
| 14. | Podiatry |  |  |  |
| 15. | Physical Therapy |  |  |  |
| 16. | Occupational therapy |  |  |  |
| 17. | Treatment Room |  |  |  |
| 18. | Surgery/Recovery |  |  |  |
| 19. | Anesthesiology |  |  |  |
| 20. | Radiology |  |  |  |
| 21. | Nuclear Med/CT |  |  |  |
| 22. | Clinical Lab |  |  |  |
| 23. | Central Supplies |  |  |  |
| 24. | Pathology |  |  |  |
| 25. | Radioisotope |  |  |  |
| 26. | Electrocardiology |  |  |  |
| 27. | Electroencephalograph |  |  |  |
| 28. | Ultrasound |  |  |  |
| 29. | Speech Therapy |  |  |  |
| 30. | Audiology |  |  |  |
| 31. | Acupuncture |  |  |  |
| 32. | Other (Please List) |  |  |  |
|  |  |  |  |  |
| Yes = Service is provided on-site by the clinic. | | | |  |
| No = Service is not provided by the clinic. | | | |  |

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| --- | --- | --- | --- |
| **SUMMARY OF HEALTHCARE PRACTITIONERS** | | | |
|  |  |  |  |
| **Clinic Name:** | | | |
| **National Provider Identifier (NPI):** | | | |
|  | **FTEs** | **VISITS** | **CONTRACTOR NAME** |
| Physician |  |  |  |
| Physician Assistant |  |  |  |
| Nurse Practitioner |  |  |  |
| Psychologist |  |  |  |
| LCSW |  |  |  |
| CPHW |  |  |  |
| Optometrist |  |  |  |
| Dentist |  |  |  |
| Chiropractor |  |  |  |
| Physical Therapist |  |  |  |
| Acupuncturist |  |  |  |
| Podiatrist |  |  |  |
| Other (Specify) |  |  |  |
| Dental Hygienist |  |  |  |
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