



ISSUE BRIEF # 6

DEFINING AN EFFECTIVE CHANGE IN SCOPE PROCESS

Introduction

In a recent report¹ by the National Association of Community Health Centers on the status of the Medicaid Prospective Payment System (PPS), 16 Primary Care Associations (PCAs) reported that the state has no definition of scope of service, and of those with a definition, the majority said they would like to see it changed. In addition, 12 states do not have a rate adjustment process and of those that do, the majority of PCAs said they would like to see it changed.

Federally Qualified Health Centers (FQHCs) can work with their respective State Medicaid agencies to establish or improve upon the rules for change-in-scope rate adjustments. Well-crafted rules – that clearly define the events that trigger a change and explain the methodologies for calculating an adjustment – can provide health centers (and state officials) with a reliable basis to account for cost increases associated with the addition or expansion of services.

The following provides an overview of the applicable federal law and discusses the components of an effective change-in-scope process.

Statutory and Regulatory Requirements around Change in Scope

Under the federal Medicaid statute, states are required to establish (for existing FQHCs) a per-visit baseline payment rate equal to 100 percent of each center's average costs incurred during 1999 and 2000 which are reasonable and related to the cost of furnishing such services. Because the payment system (known as the prospective payment system or "PPS") sets rates based on historical costs of providing Medicaid services (in 1999 and 2000), the Medicaid statute requires states to adjust the per-visit rate for two reasons:

1) inflation, and 2) "to take into account any increase or decrease in the scope of such services furnished by the center . . . during that fiscal year."² With respect to the latter, the Medicaid statute does not define a change in scope of services, nor a process for adjusting rates based on such changes.

CMS has stated that a *change* "shall occur if" the center "has added or has dropped any service that meets the definition of FQHC services . . . [or] the service is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary." By comparison, CMS's definition of "scope of services" is more vague. It has stated that the scope of services means "the type, intensity, duration and/or amount of services."³ Taken together, a *change in scope of services* would be the addition or reduction of the type, intensity, duration and/or amount of services.

Given the absence of a statutory definition and the vague CMS definition, states have considerable latitude in how they implement the Medicaid statute's change in scope requirement. As courts have long recognized, however, there are limits to such latitude. In particular, states cannot act contrary to the Medicaid statute or arbitrarily in their implementation. Regulations can serve as an effective safeguard against arbitrary agency decision-making because, under settled principles of administrative law, an agency is obligated to follow its own regulations and any action contrary to such regulations can be set aside.

Recommendations for Establishing a Change in Scope Process

CMS has stated that a "state must develop a process necessary for determining a change in scope of services."⁴ An effective change in scope process has two basic dimensions: 1) a definition of a qualifying event for a change in scope; and (2) a description of the methodology to compute the change in rate.

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Defining “Qualifying Events”

With respect to the qualifying event, there are at least three factors to consider. First, it is useful to distinguish a change in “type” of service from a change in “intensity, duration and amount” of a service. The reason for this distinction is that a change in type – *i.e.* the addition or deletion of a service – is generally intentional which means start or stop dates are easily specified, advance notice of the change to the state is possible, and the impact is relatively easy to quantify. In this regard, it is important to tie a change in type to the calculation of the PPS rate. The following sample definition of a “type” change illustrates this point:

The addition of a new FQHC service that is not incorporated in the baseline PPS or Alternative Payment Methodology (APM) encounter rate, or a deletion of an FQHC service that is incorporated in the baseline PPS or APM encounter rate.

Second, with respect to changes of intensity, duration and amount, it is important to have a list of qualifying events included in the state Medicaid plan. A good example is the approved California state plan⁵, which lists a number of events that could qualify as a change in scope of services, such as changes in population served, implementation of new technology, construction or renovation of facilities, and changes in the law, to name a few. A detailed description of what is and is not a change allows health centers to know when they can and when they cannot seek a rate adjustment. Any such list should not be considered comprehensive (*i.e.*, that the list of events “includes, but is not limited to....”).

Third, when defining qualifying events, many states have applied a threshold percentage change in costs both for increases and decreases in services. This threshold must be met in order for a rate change to be implemented. Depending on a particular situation, such a threshold can either help or harm a health center’s financial interests. For example, a five percent threshold would be difficult to cross when applied to an all-inclusive rate which takes into account the cost of all covered services. In other words, the cost impact of any change in scope of services would have to be substantial before it would affect a center’s overall PPS rate by five percent.

Thus, the threshold figure can operate as both a protection against a rate decrease (and having to report a decrease in services) and barrier against a rate increase. California requires a 1.75% increase in costs to trigger a rate increase but a 2.5% decrease to trigger a rate reduction. Such a system creates the right incentives to promote efficiency without unfairly penalizing a health center for adding new services or trying new models of care (as it absorbs the costs of these new services pending a rate adjustment above the threshold).

Describing the methodology to compute the rate change

With respect to determining how the rate will be changed, states generally employ two different methods to calculate the cost of any scope changes. One is to calculate the incremental cost of the new service or services. The other is to use a cost report to “rebase” the rate for the health center using the total cost of providing Medicaid covered services. While the total cost/rebasing approach captures all changes and is easily administered, it can be advantageous or disadvantageous depending on how a center’s costs have evolved since its PPS rate was calculated. For example, a health center that has been particularly effective in managing its costs in the years since the PPS rates were set could be “penalized” due solely to gains in efficiency if its rate were to be rebased using the total costs of the center (as opposed to the costs associated with just the change in scope of services). From a health center perspective, the ideal change in scope process would afford each center the option to choose between the two rate-adjusting methodologies.

Conclusion

An inadequate or non-existent process for determining changes in scope of services can result in health centers not getting reimbursed as federal law requires. If health centers were to conclude that an existing system is inadequate, and a new or substantially modified one is needed, they can pursue that objective with the Medicaid agency (and a state plan amendment) rather than litigation. While courts have the power to set aside existing change in scope procedures (and a resulting rate adjustment) that are contrary to law or arbitrary, they do not have the authority to instruct a state on how to exercise its discretion in crafting and implementing *new* ones.

References

¹National Association of Community Health Centers, State Policy Report #40: “2011 Update on the Status of the Medicaid Prospective Payment System in the States”

<http://www.nachc.com/client//2011%20PPS%20Report%20SPR%2040.pdf>

² 42 U.S.C. § 1396a(bb)(3)(B).

³ Letter dated Sept. 12, 2001 from HCFA to Medicaid Regional Administrators with “Q’s and A’s” on BIPA/PPS implementation.

⁴ *Id.*

⁵ <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/StatePlan%20Attachment%204.19B%206-V.pdf> (p 15-20)



NATIONAL ASSOCIATION OF
Community Health Centers

EMERGING ISSUES SERIES

January 2012

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National Association of Community Health Centers

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About NACHC

Established in 1971, the National Association of Community Health Centers (NACHC) serves as the national voice for America's Health Centers and as an advocate for health care access for the medically underserved and uninsured.

NACHC's Mission

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

This publication was supported by Grant/Cooperative Agreement Number U30CS16089 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.