INSTRUCTIONS
MEDI-CAL COST REPORT
CHANGE IN SCOPE-OF-SERVICE RQUEST (CSOSR)
FREESTANDING
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)/RURAL HEALTH CENTER (RHC)
PROSPECTIVE PAYMENT SYSTEM (PPS)
FOR FPE AFTER JANUARY 1, 2021

Please read all instructions carefully before completing these forms.

These instructions are to assist the provider in preparing the FQHC/RHC Medi-Cal Change in Scope-Of-Service Request Cost Report in conformance with the State Medi-Cal cost reporting requirements. All costs claimed are subject to the Medicare cost reimbursement principles in Title 42 Code of Federal Regulations (CFR), Part 413, California's State Medi-Cal Plan, and current Financial Audits Branch policies.

A provider may request a Change in Scope-Of-Service Request (CSOSR) for a PPS rate revision due to one of the qualifying events as defined in Welfare and Institution Code, Section 14132.100 and the State Plan Amendment attachment 4.19B, Page 6M, Section K.

- It must be filed within 150 days of the close of the fiscal period in which the qualifying change occurred.
- The increase or decrease in PPS rate for the CSOSR is compared PPS rate in effect on the last day of the reporting period during which the CSOSR occurred and compared to thresholds amounts prescribed by the State Plan Amendment(s), and if the thresholds are met, revision of the clinic's PPS rate can proceed. Since this process calculates an aggregate scope change at a point in time, multiple scope changes that occur in any qualifying period are covered and should be reported in the same CSOSR.
- Due to the complexities involved in identifying the incremental costs (direct and indirect cost) of CSOSR, the aggregate cost determination described above is being used.
- In using an aggregate approach, cost increases not necessarily related to a qualifying scope change are also captured. The State Plan Amendment does not provide for the inclusion of cost increases not related to a qualifying scope change. As an expeditious method of eliminating such non-allowable cost increases, the methodology incorporated in the forms provides for an adjustment factor to eliminate such costs.

QUALIFYING CHANGE IN SCOPE-OF-SERVICE

California's Welfare & Institutions Code Section 14132.100(e)(3)(B) clarifies that no change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

1. The increase or decrease in cost is attributable to an increase or decrease in the scope of FQHC or RHC services.

2. The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations or its successor.
3. The change in the scope-of-services is a change in the type, intensity, duration, or amount of services, or any combination thereof.
4. The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular, fiscal year.

California Welfare & Institutions Code Section 14132.100(e)(2) defines a scope-of-service change as:

- The addition of a new FQHC/RHC service that is not incorporated in the baseline prospective payment system (PPS) rate or deletion of an FQHC/RHC service that is incorporated in the baseline rate.
- A change in service due to amended regulatory requirements or rules.
- A change in service resulting from relocating or remodeling an FQHC or RHC.
- A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.
- An increase in service intensity is attributable to changes in the types of patients served, including but not limited to populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.
- Any changes in any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, or in the provider mix of an FQHC or RHC or one of its sites.
- Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.
- Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.
- Any changes in the scope of a project are approved by the federal Health Resources and Service Administration (HRSA).
- The deletion of a Medi-Cal covered service previously provided by the FQHC or RHC (such as deleting pharmacy services and any other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, e.g., laboratory, x-ray, etc.

CONSOLIDATED VERSUS INDIVIDUAL CSOSR

A provider is required to report cost and visit information for the CSOSR consistent with the original cost report filed to establish the PPS rate. If a CSOSR is being requested for more than one clinic in the organization, a separate CSOSR request must be completed for **each** clinic.

INDIVIDUAL CLINIC CSOSR

A provider would need to file an individual site clinic CSOSR if the cost report filed to set the original PPS rate was filed on an individual clinic site basis.

CONSOLIDATED CLINIC CSOSR

A provider would need to file a consolidated clinic CSOSR if the cost report filed to set the original PPS rate was filed based on consolidated clinic sites. For example:

- If the clinic's PPS rate was calculated using the costs and visits of multiple clinic sites, and only one clinic has had a scope change, then the CSOSR should include the cost and visit data for all those clinics included in the previous cost report used to establish the original PPS rate.
- If one or more of the original clinics no longer exists (i.e., clinics have closed), then the remaining clinics should be included in the scope-of-service change request.
- For any new clinics added after the consolidated PPS rate, the cost report for the new clinic must be filed on an individual clinic basis.

HOME OFFICE

If a CSOSR is being requested for a clinic, which is part of a chain organization, a Home Office Cost Report is required to be filed to ensure that all of the home office costs associated with a clinic are included in the rate calculation.

Home Office is:

- A chain organization consists of two or more facilities that are owned, leased, or by some device controlled by one organization. A chain organization may include more than one type of program in addition to the FQHC/RHC program.
- The home office of a chain organization is typically not a provider of health care. The relationship of the home office to the FQHC/RHC clinics is that of a related organization to a participating provider(s). Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, payroll, personnel services, management direction and control, and other services.
- In the case of clinics, it may be the main clinic that provides administrative and shared services to other clinics, in addition to providing health care services. In other words, the main clinic may also serve as the "home office" for the other clinics in the chain and may contain costs (direct or allocable) pertaining to the other clinics in the chain. In these situations, the Home Office Cost Report will still need to be filed. However, the Home Office cost report will only include direct or shared costs subject to allocation to the clinics. The costs related directly to the main clinic only and are not allocable to other clinics and should be excluded. The main clinic, however should be included in the Home Office Cost Report as one of the clinics to receive cost allocations.

FILING A COST REPORT

All Medi-Cal providers follow the e-File Medi-Cal Worksheets Submission Protocol for submission of FQHC/RHC Worksheets. Submit the e-file worksheets to the inbox below and include the audited financial statements (if applicable), trial balance, and working papers used to prepare the Worksheets. You will receive an email response.

- ChangeInScope.Clinics@dhcs.ca.gov

Documents must be complete. We will return cost reports not completed in accordance with these instructions.

For questions or assistance in completing these forms, please contact CRTS at (916) 322-1681 or Clinics@dhcs.ca.gov.

COVER SHEET

This Worksheet will automatically populate based on the information entered on Statistical Data Certification Sheet.

PART A—GENERAL INFORMATION

The individual signing this statement must be an officer or other authorized representative. An original signature is required. The cost report will be returned if it is not signed.

A change in the reporting period must be requested in writing and can be made only after approval by the Department of Health Care Services (DHCS), Cost Reporting and Tracking Section (CRTS), which establishes that the reason for a change is valid. Should there be a change in the cost reporting period as a result of a change of ownership, then the fiscal period of the Home Office Cost Report should be consistent with the clinics/facilities being reported.

1. Enter FQHC/RHC Name
2. Enter Date of Earliest Scope-of-Service Change (mm/dd/yyyy)
3. Enter Date Submitted (mm/dd/yyyy)
4. Enter FQHC/RHC Street Address
5. Enter City, State, and Zip Code
6. Enter NPI Number
7. Enter Preparer Name or Contact Person
8. Enter Title
9. Enter E-mail Address
10. Enter Telephone Number (xxx) xxx-xxxx
11. Enter Fiscal Year Begin (mm/dd/yyyy)
12. Enter Fiscal Year End (mm/dd/yyyy)
13. Select Type of Control from drop-down menu
14. Enter Other: Specify (Type of Control)
15. Select Clinic Type from drop-down menu

Owners:

16. Enter Provider Name
17. Enter Address/Location
18. Enter NPI Number

Related Parties:

19. Enter Provider Name
20. Enter Address/Location
21. Enter NPI Number

22. Enter Physician Name
23. Enter Billing/NPI Number

Statement of Compensation:

24. Enter Name
25. Enter Title
26. Enter % of Ownership Interest
27. Enter Average Hours Worked per Week (Name in parentheses ( ))
28. Enter Compensation Included in Cost Report

Select Type of Scope-of-Service Change (Select from the drop-down menu 29-38)

29. Select Yes/No/NA
30. Select Yes/No/NA
31. Select Yes/No/NA
32. Select Yes/No/NA
33. Select Yes/No/NA
34. Select Yes/No/NA
35. Select Yes/No/NA
36. Select Yes/No/NA
37. Select Yes/No/NA
38. Select Yes/No/NA
39. Describe the Change(s) in Scope-of-Service Provided. Attach a separate sheet if necessary.

PART B—CERTIFICATION BY OFFICER OF THE HOME OFFICE

You must complete the DocuSign certification statement on all FQHC/RHC Home Office Cost Reports submitted. The form is located on the DHCS.ca.gov website. We will reject any cost report filed without a completed certification statement. The individual eSigning this statement must be an officer or other authorized person.

Read the certification statement carefully, and either the administrator, controller, corporate officer, or member of the board of directors must sign it. The official signing the report must have the legal capacity to make commitments for the organization.

WORKSHEETS 1, 1A, & 1B—TRIAL BALANCE OF EXPENSES—RECLASSIFICATION & ADJUSTMENT

Worksheet 1, Columns 1 and 2 are used to record the trial balance of expenses from the clinic's accounting books and records. The cost report must reconcile to the provider's general ledger and the audited financial statements. **All amounts should be rounded to the nearest dollar. Attach additional sheets if necessary.**

Enter in Column 4 any reclassifications needed for proper cost allocation. For example, if a physician's duties include some administrative duties, the appropriate portion of compensation and applicable payroll taxes and fringe benefits may be reclassified from Line 1 to Line 42, Office Salaries. All reclassifications in Column 4 must be detailed on Worksheet 1A. Worksheet 1A provides an explanation of the reclassifications and indicates the amount allocated to each of the affected cost centers. The net total of Column 4 must equal zero.

Enter in Column 6 any adjustments to the reclassified expenses. Adjustments are required for **home office costs** and to adjust expenses in accordance with allowable costs as defined in 42 CFR, Part 413. All adjustments in Column 6 must be detailed on Worksheet 1B. Worksheet 1B provides a description of the adjustment, the basis of adjustment (cost or amount received), dollar amount, and the affected cost center(s). Reductions to expenses are shown in brackets. **(Transferred Home Office costs must agree with the amounts from DHCS 3089 or 3089.1 Home Office Cost Report—Schedule 6)**

WORKSHEET 2: PARTS A & B—DETERMINATION OF FQHC/RHC COSTS AND RATE PER VISIT

This worksheet is used to determine the total costs of health care services and to determine the PPS reimbursement rate. The numbers used in this Worksheet flow from other Worksheets. Once all of the Worksheets are completed, this schedule will be automatically calculated due to formulas contained in the Worksheet.

PART A—DETERMINATION OF OVERHEAD APPLICABLE TO FQHC/RHC SERVICES (Lines 1–8)

The purpose of this section is to allocate overhead costs (capital and administrative) reported on Worksheet 1, Page 2, Line 55 to the FQHC/RHC Health Care Services Costs and Nonreimbursable Cost centers. Costs are allocated based to each component based on the percentage of total costs (excluding overhead).

PART B—DETERMINATION OF FQHC/RHC RATE (Lines 1–5)

The purpose of this section is to determine the FQHC/RHC PPS rate per visit payable by the Medi-Cal program. The PPS rate is computed by dividing the total reimbursable costs computed in PART A by total reimbursable visits from Worksheet 6. Total visits include all visits for all payor types meeting the definition of a "visit" as outlined below REGARDLESS of whether such visits were billed and/or paid. The same definition for patient visits must be used for both billing and rate-setting purposes.

A "visit" for purposes of reimbursing FQHC/RHC services is based on the following:

1. A face-to-face encounter between an FQHC or RHC patient and a physician, a resident in a Teaching Health Center Graduate Medical Education Program under the supervision of a teaching physician (effective 4/1/18), physician assistant, nurse practitioner, acupuncturist, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits described in section 1905(a)(2)(C) of the Social Security Act (the Act) that are furnished by an FQHC or services described in section 1905(a)(2)(B) of the Act that are furnished by an RHC.

The definition of "physician" includes the following:

a. A doctor of medicine or osteopathy is authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.
b. A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.
c. A doctor of optometry is authorized to practice optometry by the State and who is acting within the scope of his/her license.
d. A doctor authorized to administer chiropractic services by the State and who is acting within the scope of his/her license.
e. A doctor of dental surgery (dentist) is authorized to practice dentistry by the State and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per-visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

2. Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner as defined in the California Code of Regulations, Title 22, Section 51179.7.

Encounters with more than one health professional and multiple encounters with the same health professional, which take place on the same day and at a single location, constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

a. When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, then two visits may be counted.
b. The clinic patient is seen by a dentist or registered dental hygienist and sees any one of the following providers: Physician (as defined above in PART B (a)(i)-(v)), physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, or comprehensive perinatal services, practitioner.

Line 1: Reimbursable FQHC/RHC costs (Part A, Line 8)

Line 2: Total FQHC/RHC visits (as defined above) from Worksheet 6, Column 5, Line 20.

Line 3: FQHC/RHC PPS rate per visit (Part B, Line 1 divided by Part B, Line 4)

PART C—DETERMINATION OF PPS RATE ADJUSTMENT (Lines 1—3)

The purpose of this part is to determine the PPS rate adjustment where a clinic has experienced either an increase in the scope-of-service change only or a mixture that includes both increases and decreases during the reporting period. This section will compute a net change between the reported cost per visit and the PPS current rate. (Reductions to expenses should be shown in brackets.) The

net change in the PPS rate must be equal to or exceed 1.75 percent in order to be eligible for a scope-of- service rate adjustment.

Line 1: FQHC/RHC cost per visit from Part B, Line 3.

Line 2: Enter current PPS rate per visit. This is the PPS rate per visit in effect on the last day of the reporting period during which the scope-of-service change occurred.

Line 3: FQHC/RHC net increase or decrease in rate. (Line 1 less Line 2)

If Line 3 is greater than zero, i.e., the FQHC/RHC Cost per Visit on Line 1 is more than the current PPS Rate on Line 2, then proceed to Line 4 to determine whether the increase meets or exceeds the 1.75% threshold amount.

If Line 3 is less than zero, i.e., the FQHC/RHC Cost per Visit on Line 1 is less than the current PPS rate on Line 2, then proceed to Line 5 to determine whether the decrease is greater than the 2.5% threshold amount.

Line 4: Threshold Amount for rate increases equals Line 2 multiplied by 1.75%. If the increased amount (Line 3) is more than the threshold amount, proceed to Part D. If the increase (Line 3 amount) is less than the threshold amount, no scope of service change is to be calculated. It is not necessary to submit the forms.

Line 5: Threshold Amount for rate decreases equals Line 2 multiplied by 2.5%. If the decreased amount (Line 3) is more than the threshold amount, proceed to Part D. If the decrease (Line 3 amount) is less than the threshold amount, no scope of service change is to be calculated. It is not necessary to submit the forms.

PART D—FQHC/RHC RATE CHANGE (Lines 1—5)

The purpose of this section is to determine the FQHC/RHC PPS rate after the scope-of-service change. (Rate reductions are to be shown in brackets/parenthesis)

Line 1: FQHC/RHC rate increase or decrease from Part C, Line 3.

Line 2: FQHC/RHC rate increase or decrease adjustment amount (Line 1 multiplied by the 20% adjustment factor)

Line 3: FQHC/RHC rate increase or decrease amount after the adjustment factor (Line 1 less Line 2).

Line 4: Current PPS rate per visit (from Line C2)

Line 5: New PPS rate per visit (total of the current PPS rate from Line 4 plus the increase or decrease from Line 3).

WORKSHEET 3—VISITS, REVENUES, AND EXPENDITURES

Total Visits: Enter the total number of visits recorded by the funding source. Please include all programs and visit statistics specific to your organization.

Note: Total visits reported in Column 1 must agree with total visits reported on Worksheet 6, Column 2, and Line 20.

Related Revenues: Enter the total revenue received by the funding source. Enter all categories for which revenues are received for patient services provided even when the services do not constitute a "visit," such as grant/contract funding received for outreach programs. The "Other" category may also include any non-patient revenues.

Note: Total revenues reported in Column 2 must agree with the total patient and non-patient revenues recorded in the clinic's general ledger or reported in the independently audited financial statements if completed at the time of filing the cost report.

Related Expenditures: Enter the expenditures recorded by funding source with the exception of Lines 1 through 14.

WORKSHEET 4—SUMMARY OF SERVICES PROVIDED BY CLINIC

List all services available at, or provided by, the clinic.

Place an "X" in the "NO" column if the service is not available or provided by the clinic.

Place an "X" in the "ON-SITE" column if the service is provided on-site by the clinic.

Place an "X" in the "OFF-SITE" column if the service is provided off-site under a contractual arrangement. Please provide the contractor's name.

WORKSHEET 5—SUMMARY PRODUCTIVE FTEs AND VISITS OF HEALTHCARE PRACTITIONERS

Column 1— **FTE's:** Record the total number of healthcare practitioner positions by Full-Time Equivalent (FTE) using 2,080 hours as the standard. Calculate for each person in each category their ANNUAL PRODUCTIVE time worked. The FTE should only include productive time. Do not include non-productive time. For further guidance on Productivity Standards and definitions of productive and non-productive time, see below "**Full-Time Equivalent Productivity Standards Guidelines**." Divide the annual productive time by 2,080 to determine the percentage of time each person is actively engaged in patient care activities. For example, if a physician spent 1,040 hours seeing patients, the FTE would be calculated as (1,040/2080 = .5 FTEs). Compile the FTE's by category. Do not include mental health staff in the minimum standards assessment.

Column 2—# of VISITS: Record the total visits (as previously defined) furnished to all patients for each of the applicable health care staff categories.

Columns 3, 4—Place an "X" in the column "ON-SITE" or "OFF-SITE" to identify where the staff is located.

WORKSHEET 6—PRODUCTIVITY STANDARDS ASSESSMENT

The purpose of this worksheet is to determine if the provider has met the minimum number of visits standards and to determine the visit count for the PPS rate determination.

Worksheet 6 will automatically calculate the visits based on the information entered from Worksheet 5 and apply the productivity standards. The calculation will determine if the provider has met the minimum number of visits standard and can therefore use actual visit counts for its PPS rate determination.

Minimum productivity standards are used to help determine the average cost per FQHC or RHC patient visit, reimbursed at the PPS rate. The minimum productivity standard for a facility is equal to the facility's total expected visits in a year for health care provider types that are subject to the minimum productivity standard. A facility's total expected visits reflect the minimum productivity requirement of 3,200 visits per full-time equivalent (FTE) physician and 2,600 visits per FTE nurse practitioner, physician assistant, or certified nurse-midwife (NP, PA, and CNM) per year, based on a 40 hour work week (2,080 hours per annum). For any Provider's fiscal year ending after January 1, 2021, the minimum productivity standard has been revised to reflect 3,200 and 2,600 visits per FTE. The following healthcare staff is not subject to minimum productivity standards: Dentist, Registered Dental Hygienist (RHD), Doctor of Podiatric Medicine (DPM), Doctor of Optometry (OD), Doctor of Chiropractic (DC), Psychiatrist, Clinical Psychologist (CP), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), Licensed Acupuncturist, Visiting Nurse, Comprehensive Perinatal Health Worker, non-primary care specialists.

For purposes of initial rate setting or change in scope of service requests, the FQHC's or RHC's total visits shall be calculated as follows:

> The FQHC's or RHC's total visit count will be calculated by adding the number of visits allocated to health care staff subject to the minimum productivity standard adjustment plus the actual number of visits rendered by health care staff that are not subject to the minimum productivity standards. For example, consider a facility that has 2.4 physicians FTE's, 3.0 NP FTEs, 0.8 CNM FTEs, and 1.5 clinical psychologist FTEs. The minimum productivity standard would require the facility to have 17,560 ((2.4 x 3,200) + (3.0 x 2,600) + (0.8 x 2,600)) visits plus the actual clinical psychologist visits. If the total number of physician, NP, and CNM visits in the rate-setting or change in scope of service year did not equal or exceed 17,560, the visit count would be increased to 17,560. The total visits would include the 17,560 and the actual number of clinical psychologist visits.

Columns 1, 2—Summarizes the number of FTE's and visits furnished by the health care staff from Worksheet 5.

Column 3—The productivity standards are screening guidelines to determine reasonable service levels furnished by certain healthcare staff. Payments for services are subject to these guidelines used to test the reasonableness of the productivity of the clinic/center's health care staff. These guidelines are applied to staff for FQHC/RHC services furnished both at the clinic/center's site and in other locations. They are as follows:

- At least 3,200 visits annually per full time equivalent physician employed by the clinic or contracted on an on-going basis.
- At least 2,600 visits per year per full time equivalent physician assistant, nurse practitioner or certified nurse midwife employed by the clinic or contracted on an on-going basis.

Column 4—The minimum visits are computed for Lines 1 through 6 by multiplying FTEs in Column 1 by productivity standards in Column 3. These are minimum visits that personnel are expected to furnish cumulatively.

Column 5—Lines 1 through 6 are evaluated for minimum productivity standards per CMS guidelines. On Line 7, Column 5, the actual visits on Column 2, Line 7 are compared to the minimum visits on Column 4, Line 7. The greater of the two is used as the visit number on Column 5, Line 7.

- For Lines 7 through 21, the actual number of visits is carried forward to Column 5 from Column 2.
- The reimbursable visits from Lines 7 through 19 are summed on Column 5, Line 20 and carried to Worksheet 2, Part B, Line 2 to calculate the PPS rate per visit
- The total visits on Column 5, Line 22 are the sum of reimbursable visits on Line 20 and the nonbillable/nonreimbursable visits on Line 21 and should match with total visits on Worksheet 5.

Full Time Equivalent Productivity Standards Guidelines:

The physician, NP, PA, and CNM FTEs on the cost report is a productive FTE that is defined as, "the time spent seeing patients or scheduled to see patients." All hours that a physician, NP, PA, and CNM spend seeing patients or are scheduled to see patients must be included in the productive FTE calculation. The productive FTE does not include any hours for non-productive activities when a provider is not seeing patients or scheduled to see patients.

"Productive Time" is defined as time spent seeing patients or scheduled to see patients. It does not include non-productive time. The facility must report its FTE on the cost report for physicians and NPs, PAs and CNMs, which is all the time spent seeing patients or scheduled to see patients. All activities related to the provision of health care, such as, but not limited to, reviewing test results, authorizing refills, care-related emails, and follow-up calls, are included in the time scheduled to see patients and must be included in the FTE on the cost report.

"Non-productive Time" is defined as the time that is spent not seeing patients or scheduled to see patients, such as, but not limited to, administrative time, paid time off (PTO), continuing medical education (CME), supervision, teaching activities, and other training and meetings, that occur when the physician, NP, PA or CNM is not seeing patients or scheduled to see patients.

"Administrative Time" is defined as time spent on activities related to the overall administration of the clinic and performed when not seeing patients or not scheduled to see patients, which includes, but may not be limited to, the following types of activities: medical protocol evaluation

and implementation, ensuring compliance with state and federal statutes and regulations, resource allocation, utilization review, quality assurance, and improvement, planning and administrative meetings, supervisory oversight and coordination between clinic departments, and inventory control.

The FQHC or RHC is expected to maintain adequate documentation to enable DHCS to verify each physician, NP, PA, and CNM Productive Time, Administrative Time, and Non-productive Time. Adequate documentation requires accurate and sufficient detail that is capable of verification by an auditor of the hours spent rendering Productive Time, Administrative Time, and Non-productive time.

Process for requesting an exemption to productivity standards:

The FQHC or RHC may apply for an exemption to the minimum productivity standards requirement by submitting an exemption or partial exemption request to DHCS. A request for an exemption should be provided with the rate-setting cost report or with the CSOSR. The request must be supported with verifiable documentation demonstrating the FQHC's or RHC's unique circumstance(s) that prevents the clinic from meeting the minimum productivity standards. Exemption or partial exemption requests shall include the following documentation, as applicable:

- The specific reason(s) for the exemption and the number of times the specific reason(s) occurred that prevented the clinic from meeting the minimum productivity standards.
- An explanation of why the FQHC or RHC believes that good cause for an exemption will continue in future years.
- If the specific reason(s) for an exemption is related to longer than the minimum productive standard visit time (including multiple encounters on the same day that may only count as a single visit), the FQHC or RHC must submit verifiable documentation of the time spent seeing the patients and scheduled to see patients at the time the visits occurred. The documentation submitted must be capable of being audited and be in sufficient detail to allow for the verification of the actual time spent.
- If the specific reason(s) for an exemption is not related to time spent on patient visits, the clinic must submit documentation in sufficient detail so that DHCS may audit the occurrence of the specific reason(s) for the exemption and when the specific reason(s) occurred. The documentation must demonstrate the specific occurrence or permanent circumstances that negatively affect the utilization of a clinic.

Verifiable documentation for fiscal year(s) subsequent to the rate-setting fiscal year may be requested to determine if and to the extent the reason for the exemption continues to exist and still result in the inability to meet the minimum productivity standards. If in a subsequent year, the exemption no longer exists, the provider is required to complete an analysis to determine if the change reduces the PPS rate by 2.5%; therefore, requiring a Change in Scope of Service Request in accordance with Welfare & Institutions Code Section 14132.100.

Documentation Guidelines:

As noted above, the FQHC or RHC is expected to maintain adequate documentation to enable DHCS to verify each physician, NP, PA, and CNM Productive Time, Administrative Time, and Non-productive Time. Adequate documentation requires accurate and sufficient detail that is capable of verification by an auditor of the hours spent rendering Productive Time, Administrative Time, and Non-productive time.

In addition, if an exemption is requested, supporting documentation must be supported by verifiable documentation, as noted above and in accordance with Medi-Cal rules and regulations.

Documentation may include, but is not limited to, the following:

- Employment contracts
- Timesheets
- Patient schedules
- Payroll schedules
- Provider prepared working paper supporting provider's reported FTE calculation
- EHR system supports time spent seeing patients. However, this may not be complete documentation to support all activities related to the provision of health care. These activities include, but are not limited to, reviewing test results, authorizing refills, care-related emails, and follow-up calls.
- Time studies – Time studies must meet the requirements under cost-reimbursement principles (CMS Publication 15-1, Section 2314).
- Any other reasonable method developed by Provider to document Productive Time, Administrative Time, or Non-productive Time.