INSTRUCTIONS
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
RURAL HEALTH CLINIC (RHC)
INITIAL RATE-SETTING APPLICATION PACKAGE (DHCS 3106)

Please read all instructions carefully before completing these forms.

The following Department of Health Care Services (DHCS) forms are required for the initial FQHC/RHC Rate Setting. Please submit complete packages only. Incomplete packages will be returned.

- Prospective Payment System Election Form (pages 5-6)
- Summary of Current Services (page 7)
- Summary of Healthcare Practitioners (page 8)
- DHCS Form 3100—Differential Rate Request Code 521 T1015 SE (for providers with managed care contracts)
- DHCS Form 3104—Medicare Advantage Plan Codes 529 G0466 G0470 (for providers with capitated Medicare Advantage Plans)
- DHCS Form 3090—Rate Setting Cost Report (if applicable)
- DHCS Form 3089—Home Office Cost Report 6 or Less(if applicable)

The following additional documents must be included with the FQHC/RHC Rate Setting application package:

- FQHC
  - HRSA Notice of Grant Award or HRSA Look-Alike Designation
  - HRSA Electronic Hand Book (EHB) Form 5A
  - HRSA Detailed EHB Form 5B
  - License to operate a clinic issued by California Department of Public Health Licensing and Certification District Office
  - DocuSign Certification Statement for each Cost Report
- RHC
  - CMS-approval letter
  - Issued license for hospital if the RHC is associated with hospital
  - DocuSign Certification Statement for each Cost Report

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:

- A Certification Statement, which is located on the DHCS Forms & Publications webpage. We will reject any cost report filed without a completed certification statement signed Electronically.

The individual E-signing this statement must be an officer or other authorized person.

For assistance completing these forms, please send an email to Clinics@dhcs.ca.gov or contact the Cost Reporting and Tracking Section (CRTS) 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. In that case, 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 OR DHCS 3089.1 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 October 1, 2003, whose fiscal year-end is December 31, 2003 will need to submit an actual cost report for December 31, 2004, to establish a PPS rate. This would be the first complete fiscal year (12 months) subsequent to the FQHC/RHC effective date. The December 31, 2004 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.

DIFFERENTIAL RATE REQUEST CODE 521 T1015 SE (DHCS FORM 3100)

A differential rate Code 521 T1015 SE (Formerly 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 521 T1015 SE (Formerly 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 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 521 T1015 SE (Formerly 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 its annual reconciliation at the end of its fiscal year. Department will have three (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 521 T1015 SE (Formerly 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 (Formerly 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.

MEDICARE ADVANTAGE PLAN CODES 529 G0466-G0470 (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 Codes 529 G0466-G0470 (Formerly 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 (Formerly Codes 529 G0466-G0470) 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 Codes 529 G0466-G0470 instead of Codes 520 & 900 with HCPCS/CPT Codes G0466 TO G0470 (Formerly 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 Codes 529 G0466-G0470 (Formerly 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 Codes 529 G0466-G0470 (Formerly 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 May 1, 2006, prescribes the Prospective Payment Rate Setting process for clinics that qualify for FQHC/RHC status subsequent to the 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

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

2. 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, please email: Clinics@dhcs.ca.gov to receive a written response, or if you do not have access to email, you may contact the Cost Reporting and Tracking Section at (916) 650-6696.

Election

Please select 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 DHCS receives the projected cost report necessary to set the projected PPS rate. You must file a projected cost report 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.

Type Name:		**Title:**		**Date:**	
Signature:		**Telephone Number:**			

SUMMARY OF CURRENT SERVICES PROVIDED BY CLINIC				
Clinic Name:				
National Provider Identifier (NPI):				
		YES	**NO**	**CONTRACTOR NAME**
1.	Medical	○	○	
2.	Dental			
3.	Dental Hygienist	○	○	
4.	X-Ray			
5.	Laboratory	○	○	
6.	Pharmacy			
7.	Nutritional	○	○	
8.	Psychology			
9.	Psychiatry	○	○	
10.	Social/Behavioral Health Services			
11.	Drug Counseling	○	○	
12.	Education			
13.	CPSP	○	○	
14.	Outreach			
15.	Optometry	○	○	
16.	Chiropractic			
17.	Podiatry	○	○	
18.	Physical Therapy			
19.	Occupational Therapy	○	○	
20.	Treatment Room			
21.	Surgery/Recovery	○	○	
22.	Anesthesiology			
23.	Radiology	○	○	
24.	Nuclear Med/CT	○	○	
25.	Central Supplies	○	○	
26.	Radioisotope			
27.	Electrocardiology	○	○	
28.	Marriage Family Therapy			
29.	Acupuncture	○	○	
30.	Women, Infants, and Children (WIC)	○	○	
31.	Other (specify)	○	○	
Yes = Service is provided on-site by the clinic.				
No = Service is not provided by the clinic.				

SUMMARY OF HEALTHCARE PRACTITIONERS				
Clinic Name:				
National Provider Identifier (NPI):				
		FTEs	**VISITS**	**CONTRACTOR NAME**
1.	Physicians; MD			
2.	Physicians-Contracted			
3.	Physician Assistants; PA			
4.	Nurse Practitioners; NP			
5.	Certified Nurse Midwife; CNM			
6.	Doctor of Dental Surgery; DDS			
7.	Registered Dental Hygienist; RDH			
8.	Doctor of Podiatric; DPM			
9.	Doctor of Optometry; OD			
10.	Doctor of Chiropractic's; DC			
11.	Doctor of Psychiatry; MD			
12.	Visiting Nurse			
13.	Clinical Psychologist			
14.	Licensed Clinical Social Worker; LCSW			
15.	Comprehensive Perinatal Health Worker			
16.	Acupuncturist			
17.	Marriage Family Therapist			
18.	Other (Specify):			