Medi-Cal Scope of Service Rate Change Requests

During the last several years, clinics began receiving letters from A&I instructing them to prepare an analysis to demonstrate that their costs didn't decrease by more than 2.5% from their current PPS rate. The letter went on to say that if in the event the costs did decrease by this amount, they would need to file a formal scope of services rate change request.

The various reasons clinics were being instructed to prepare this analysis included the following:

- Clinics that moved from one location to another (this specific instance is no longer being enforced but is shown as an example of the various situations where A&I was requesting this analysis)
- Clinics that reconfigured their space and leased out a portion of their lobby or even a closet and offered this space to an external pharmacy. Even if the clinic never offered pharmacy services or had pharmacy expenses in their PPS rate were being requested to do this analysis;
- Clinics that once had an intermittent clinic but now that the intermittent clinic received licensure – the host clinic was being requested to prepare this analysis. Again, if even the intermittent clinic was not part of the host clinic's original PPS rate or subsequent scope of service filing, they were being asked to submit these analyses.

If one reads the SPA, there needs to be a decrease in services to trigger a scope of services rate change request like the deletion of pharmacy or dental services as documented in the SPA. In the above- mentioned examples, none of these situations (for clients that I have worked with), experienced any decrease in services. If there isn't a decrease in the type, intensity, duration or amount of service, there can't be a situation where a clinic if forced to submit an analysis to determine if their costs decreased as DHCS is requesting.

A&I always insists on a scope of services rate change request, that there needs to be an addition of a specific service to trigger a rate change and that a triggering event by itself, e.g., renovation, addition of a EHR system does not qualify as a triggering event. That being said, I think the onus should be on DHCS in demonstrating which specific service the clinic deleted when they converted a closet to an external pharmacy provider. If they are requiring a specific service when a clinic is trying to add a triggering event, it only makes sense then for the department to show which service is being deleted when clinics are being requested to submit a mandatory analysis.

<u>Solution</u>: Re-clarify the rules when clinics have to demonstrate that their costs went down by more than 2.5% even though there was no change in services, type, intensity, duration or amount of service.