Medi-Cal PPS Reconciliation
Treatment of Medi-Cal Managed Care Payments
for Services/Costs Denied by DHCS – A&I in
Rate Setting & Change in Scope Cost Report Audits

Approximately five years ago, A&I reversed its longstanding (informal) policy regarding the inclusion of "Incident-to" ancillary service cost in PPS rate setting and change in scope cost reports. These typically represented simple Laboratory and Imaging services that were diagnostic in nature, performed in-house, and rendered in conjunction with a patient visit or sometime shortly thereafter (24-48 hours). For some providers, these ancillary service costs were included in their initial Medi-Cal PPS rates (based on historical cost reports) back when the payment system was implemented. It should also be noted that these basic diagnostic ancillary services are required by HRSA although not separately billable as "visits" under Medi-Cal PPS.

HRSA also requires FQHCs to offer other services to their "clients" that are performed by personnel such as registered nurses, health educators, social workers/case managers, and dieticians/nutritionists. These services include but are not limited to: health screening, voluntary family planning, case management, health education (including diet and nutrition), and outreach. Although required by HRSA, they are not separately billable as "visits" under Medi-Cal PPS.

In both cases, FQHCs have long contended that the cost of these HRSA-required services must be included in their new/revised PPS rates; as determined in rate setting and change in scope cost reports. Unfortunately, A&I has taken an increasingly aggressive approach in recent years, eliminating most or all such costs in their cost report audits.

Depending on the clinic's agreement with its local Medi-Cal Managed Care Plan (MCP), some or all the services described above may be separately billable to the MCP on a fee-for-service basis or included in the capitation payments received by the clinic.

For the past several years, FQHCs have contended that if the cost of a specific service is excluded from their PPS rate, any payment received from the MCP for that service should be correspondingly excluded from the PPS Reconciliation. A&I disagrees, insisting that all payments received from the MCP must be included in the reconciliation. Furthermore, A&I has been unwilling to discuss the issue of matching "disallowed" costs to the corresponding MCP payments for purposes of the PPS Reconciliation.

Another issue regarding the PPS reconciliation is DHCS's practice of assessing late penalties associated with late filings of the Code 18 being applied to the entire PPS rate versus just the Code 18 claim that was filed late. For instance, if a clinic happens to file a Code 18 claim seven months late, they would be hit with a late penalty on the PPS reconciliation of 50%. Even if the

clinic filed the claim on a timely basis with the health plan or IPA, but forgot about filing the Code 18 claim, the department still levies the late claim penalty on the entire PPS rate rather than just the actual claim amount that was late. This practice incorrectly assesses a late penalty on clinics for approximately 20% to 40% of the clinics PPS rate, even though the there was no late filings for the primary portion of the claim.

Another argument can be made to eliminate the late penalty all together if the clinic bills the Medi-Cal managed claim on a timely basis. Because DHCS considers the health plan or IPA as the primary insurance and the state is secondary (meaning if there is no primary care payment, the state does not believe they owe a secondary payment).

Given this reasoning, if the clinic bills the primary insurer on a timely basis DHCS has no basis for assessing late penalties on these claims since the primary paid 100% and the secondary insurer should follow suit, just as they would if the primary insurer didn't pay. DHCS shouldn't be allowed to say on one hand we are not paying because the primary insurer didn't pay but on the other hand be able to say we are assessing late penalties even though you billed the primary on a timely basis.