STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

PRINCIPLES OF REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS

August 2022

Table of Contents

	Page
RI EOHHS Principles of Reimbursement for Federally Qualified Health Centers	
1.0 Legal Basis for Program	1
2.0 Payment to Community Health Centers	1
3.0 Medicaid Prospective Payment System for Federally Qualified Health Centers	1
3.1 Rate Setting Overview	1
4.0 PPS and Alternative Payment Methodology	1
4.1 Visit/Encounter Definition	1
4.2 Rate Determination	3
4.3 Notification of Rates	4
4.4 FQHC Submission Requirements	4
4.5 New FQHC or FQHC merging	4
5.0 Special Circumstances and Adjustments to Rate Determination	4
5.1 Extraordinary Circumstances	5
5.2 Other Changes in Scope	5
5.2.1 Pay for Performance Programs	5
5.2.2 Capital Improvements	5
6.0 Appeals Process	6
7.0. Demonstrated Error	6
8.0 Record Keeping	6
9.0 Penalties	6
9.1 Penalties for Late Submissions	6
9.2 Penalties for Misrepresentation or Fraudulent Acts	6
10.0 Reconciliation for Managed Care	7
11.0 Signatures and FQHC Statement of Participation	7
Appendices	
Appendix A – FQHC APM and Rate Adjustments Evaluation Criteria for Changes of Scope of Services	8
Appendix B – Cost Report Submission Requirements	9
Appendix C – Medicare/Medicaid Cost Report Crosswalk and Attestations	11
Attachments	
Attachment I – Annual Submission Guidelines for Prospective Payment System Reconciliation Reports	13
Attachment II – Rhode Island EOHHS/FQHC Cost Report Format	22
Attachment III – Classification of FQHC Accounts by Cost Center	29

STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

PRINCIPLES OF REIMBURSEMENT
FOR
FEDERALLY QUALIFIED HEALTH CENTERS

Revised: August 2022

1.0 Legal Basis for Program:

The Rhode Island Medical Assistance program was established on July 1, 1965, under the provision of Title XIX of the Social Security Act as amended by Public Law 89-97, enacted by Congress on July 30, 1965. The enabling State Legislation is to be found in Title 40 of the Rhode Island General Laws (RIGL).

2.0 Payment to Community Health Centers:

Rhode Island General Laws § 40-8-26 governs the payment methodologies for community health centers. These principles of reimbursement reflect those provisions.

3.0 Medicaid Prospective Payment System for Federally Qualified Health Centers

3.1 Rate Setting Overview

The Medicaid prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) became effective January 1, 2001, under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. PPS established a methodology assuring FQHCs a minimum per visit reimbursement rate when providing care to Medicaid beneficiaries. The FQHC rate was to be set based on the average of each health center's reasonable costs per visit in 1999 and 2000. The FQHC rate was then to be adjusted annually for inflation using the Medicare Economic Index (MEI). Payments may also be adjusted based on a recognized change in the scope of services provided.

States have the option of using an alternative payment methodology, if the medical payment rate is not lower than what would be paid under PPS. To be eligible for payment under the alternative payment methodology, the FQHC must agree to participate.

These Principles of Reimbursement set forth the Alternative Payment Methodology (APM) to be used for establishing rates for participating FQHCs. This includes rate setting for medical services and dental services. For these purposes medical services shall include behavioral health services and the established rate applies to both medical and behavioral health services. This document outlines the obligations of both the FQHC and EOHHS to provide timely reporting and rate determination.

4.0 PPS and Alternative Payment Methodology

4.1 Visit/Encounter Definition

The APM is designed to reflect the cost for all the services associated with a comprehensive primary care, behavioral health or dental visit, even if not all the services occur on the same day. Stand-alone billable visits are typically evaluation and management type of services or screenings for certain preventive services. The professional component of a procedure is usually a covered service, but is not a stand-alone billable visit, even when furnished by an FQHC practitioner.

As such, some services do not count as encounters eligible for the PPS or APM rate. These include, but are not limited to the following, as outlined in the Uniform Data System (UDS) Manual for the UDS report filed annually by the FQHCs with the Bureau of Primary Health Care (BPHC) under the Health Resources and Services Administration (HRSA), part of the US Department of Health and Human Services:

Health screenings

- Screenings frequently occur as part of community meetings or group sessions that involve conducting outreach or group education, but do not provide clinical services
- Examples include information sessions for prospective patients; health presentations to community groups, information presentations about available health services at the center; services conducted at health fairs or at schools; immunization drives; services provided to groups or similar public health efforts

Group visits

- Visits conducted in a group setting, except for behavioral health group visits
- The most common non-behavioral health group visits are patient education or health education classes (e.g., people with diabetes learning about nutrition)

Tests and other ancillary services

- Tests support the services of the clinical programs
- Examples of tests include laboratory (including purified protein derivatives (PPD tests), pregnancy tests, Hemoglobin A1c tests, blood pressure tests) and imaging (including sonography, radiology for medical and/or dental services, mammography, retinography, or computerized axial tomography)
- Services required to perform such tests, such as drawing blood or collecting urine, or dental laboratory work (including but not limited to, for example. making items to be used or tried at a subsequent appointment).

Dispensing or administering medications

- Dispensing medications, including dispensing, from a pharmacy (whether by a clinical pharmacologist or a pharmacist) or administering medications (such as buprenorphine or Coumadin) unless an evaluation and management (office visit) code is also assigned to the visit in accordance with CPT guidelines and the visit is provided by a physician, physician assistant or nurse practitioner (i.e. nursing visits are not eligible regardless of CPT codes assigned to visit).
- Giving any injection (including vaccines, allergy shots, and family planning methods) regardless of education provided at the same time unless an evaluation and management (office visit) code is also assigned to the visit in accordance with CPT guidelines and the visit is provided by a physician, physician assistant or nurse practitioner (i.e. nursing visits are not eligible regardless of CPT codes assigned to visit).

Health status checks

- Follow-up tests or checks (such as patients returning for HbA1c tests, blood pressure checks, dental healing checks, or denture adjustments within six (6) months of denture fabrication)
- Wound care (which are following up to the original primary care or dental visit)
- Taking health histories
- Making referrals for or following up on external referrals

Community Health Worker services

- Services delivered by a Community Health Worker and reimbursable pursuant to the Medicaid State Plan as Preventive Services delivered by a Community Health Worker

An encounter must include a face-to-face or telemedicine (telephone-only and tele video services) visit with a physician (including optometrists and psychiatrists), physician assistant, nurse practitioner (advanced practice registered nurses), clinical social worker, clinical psychologist, certified nurse midwife, clinical nurse specialist, licensed mental health counselor, licensed marriage and family therapist, dentist or registered dental hygienist.

Visits with more than one (1) professional on the same day will be deemed as one (1) encounter unless one (1) visit is medical, one (1) is behavioral health, or one (1) is dental, or the patient suffers an additional or different illness requiring another visit. The visit must be documented in the patient's chart and must meet commonly accepted standards for medical record documentation.

An encounter must involve a patient who is Medicaid eligible on the date of service.

The terms "visit" and "encounter" may be used interchangeably.

If a long-acting reversible contraceptive (LARC) is provided as a part of an eligible encounter it can be reimbursed separately from, and in addition to, the encounter fee. This applies to:

- Intrauterine contraceptive devices, including:
  - o J7296 (Kyleena)
  - o J7297 (Liletta)
  - o J7298 (Mirena)
  - o J7300 (ParaGard)
  - o J7301 (Skyla)
- Implants, including: o J7307 (Nexplanon)

4.2 Rate Determination

FQHC APM rates through July 1, 2017 were determined in accordance with the “Principles of Reimbursement for Federally Qualified Health Centers Revised: July 2012”. Such rates will remain in effect through June 30, 2018.

For FQHCs electing the Alternative Payment Method (APM), effective July 1, 2018 and on each July 1st thereafter, each FQHC’s medical and dental rate shall be increased by the amount of the FQHC Market Basket Index net productivity adjustment as published by CMS for that same calendar year. These adjusted rates will also become the respective FQHC’s Fee For Service (FFS) rates for that same rate year.

EOHHS will determine the Medicaid prospective payment system (PPS) rate for each FQHC according to the methodology defined in federal law by March 31, 2019, to be able to notify each FQHC of their PPS rate as outlined below. Should any party elect not to use the APM, the PPS rate will become the effective rate.

Under this APM methodology, the PPS rate and the APM rate will likely be different in future

years.

4.3 Notification of Rates

Each FQHC shall be notified in writing of its adjusted medical and dental APM rates by no later than sixty-one (61) days prior to July 1st of each year (i.e., May 1st). Any FQHC may request its adjusted PPS rate after January 1st of each year, but absent such a request, EOHHS shall not provide the adjusted PPS rate.

4.4 FQHC Submission Requirements

Each FQHC shall submit the following materials annually, five (5) months after the close of each FQHC's fiscal year, to EOHHS' Deputy Director of Finance and Budget:

1. Medicare/Medicaid Cost Report Crosswalk, according to the template in Appendix C
2. Medicare cost report filed with CMS for the same fiscal year
3. Audited financial statements for the same fiscal year (normally submitted to EOHHS five (5) months after the close of the fiscal year but will be submitted immediately upon receipt from the FQHC's independent auditors if issued thereafter)
4. An attestation of the CEO and CFO as per Appendix C

4.5 New FQHC or FQHC merging with another entity

Should there be a new FQHC operating in Rhode Island, EOHHS shall set an interim prospective APM rate for the new FQHC based either on a pro forma cost report in the case of a new entity or actual cost data for the past two (2) fiscal years in the case of merging organizations that have been in operation for at least two (2) years. The interim prospective rate will be utilized until the new or merged FQHC has been in operation for one full fiscal year and has audited financial data for that year that can be used in a cost report as provided for in Appendix B.

5.0 Changes in Scope of Services: Special Circumstances and Adjustments to Rate Determination

Under certain circumstances, based on verifiable data provided by the FQHC, including a pro forma cost report and on favorable review by EOHHS/Medicaid, Medicaid may make adjustments to FQHC's APM encounter rates due to a change in the scope of Medicaid covered services provided by the FQHC.

Rate adjustment requests by FQHCs outside the normal rate setting process are limited to one request per year. Rate adjustment request submissions shall include but are not limited to addressing the Evaluation Criteria identified in Appendix A. Upon receipt of a request for a rate adjustment, EOHHS/Medicaid will review the request and make a determination within sixty (60) calendar days of receipt. If EOHHS/Medicaid does not make a formal determination within sixty (60) calendar days, the rate adjustment as requested will go into effect sixty (60) calendar days after the date of submission. Notwithstanding the above, EOHHS/Medicaid may request additional information from the FQHC pertinent to the analysis of the FQHC's submission. In such case the EOHHS/Medicaid request for additional information shall be in written form. This written request

for information will stop the sixty (60) day clock based on the date of the request. Upon receipt of the additional information from the FQHC a new sixty (60) day clock will resume. In this case, EOHHS/Medicaid will make a final determination within sixty (60) days of receipt of additional information received from the FQHC in response to a formal request.

The reference below to a 5% or more change in the cost per visit shall be calculated by using the FQHC's current APM rate (e.g., if the cost per visit is less than 95% or greater than 105% of the current APM rate, the 5% requirement is satisfied). If a change in scope is made prior to a rate adjustment request, EOHHS may use a 10% threshold instead of the 5% threshold as outlined below.

Rate adjustments where approved may be temporary in nature but only if the rate is adjusted pursuant to 5.1, Extraordinary Circumstances. The criteria for change in scope rate adjustments will include the following:

5.1 Extraordinary Circumstances

A rate adjustment will be considered where there is a material change in the FQHC operations that results in a long- term (six months or more) change in the FQHC's cost per visit of 5% or more (compared to the one year prior to the change in operations) that EOHHS/Medicaid deems to be significant based on verifiable data provided by the FQHC. Such extraordinary situations will be reviewed on a case-by-case basis.

5.2 Other Changes in Scope

A rate adjustment will be considered where there is a demonstrable change in the FQHC scope of services that will result in a long-term (six months or more) change in the FQHCs cost per visit of 5% or more. Such changes shall include, but are not limited to: (1) A change in organizational structure (e.g., merger, acquisition or a change in corporate structure); (2) A change in practice by the FQHC; (3) Addition or elimination of a core FQHC service, which is defined as primary care, dental, behavioral health, pharmacy and enabling services; (4) Or addition or deletion of specialty care services.

5.2.1 Pay for Performance Programs

EOHHS/Medicaid may consider an adjustment to a rate if a FQHC can, in concert with EOHHS, define a performance-based program, which provides clear added value (e.g., health outcomes, cost efficiencies).

5.2.2 Capital improvements

EOHHS may review a rate adjustment request if a FQHC has expended funds for capital improvements that will result in a long-term (six months or more) increase in the FQHCs cost per visit of 5% or more. The review request could apply to either the medical or dental rate as assigned. To be eligible for review, costs must be incurred for a one-month period before a rate change will be initiated. EOHHS will be responsible to determine the materiality of the improvement and the

effect on the rate assigned. A basic minimum of $50,000 for an individual improvement would have to be expended before consideration of the review. Capital improvements shall include but shall not be limited to the opening of a new location, facility expansion/renovation and the acquisition and implementation of health information technology.

6.0 Appeals Process

An FQHC may request an adjustment to the EOHHS calculated Medical or Dental rate by written appeal to the rate setting department within the EOHHS/Medicaid Program. As a result of the review, the rate setting department will provide the FQHC a written decision of the appeal within thirty (30) business days from the receipt of the appeal. Appeals beyond the rate setting department or designee appointed by the Secretary of EOHHS shall be in accordance with the Administrative Procedures Act.

7.0 Demonstrated Error

If an FQHC can verify an error was made in the rate determination process, a rate adjustment due to error would be retroactively effective to the first day of the year for which the rate was effective. EOHHS shall also correct the rate(s) of any other FQHCs whose computed rates were adversely impacted by 2% or more prior to the discovery of the error. Such corrections shall be applied retroactively to the first day of the year for which the rate(s) was effective.

8.0 Record Keeping

FQHCs providing services under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable of substantiating the reasonableness of the FQHC cost report. Records include all ledgers, books, and source documents. All records must be physically available on site during the course of a field audit examination. All documents must be retained for at least seven (7) years following the month in which the materials apply.

EOHHS/Medicaid will maintain all cost reports submitted by FQHCs and all written reports prepared by the Agency and sent to the FQHCs for at least seven (7) years after the month in which the cost report was filed or at least seven (7) years after the month in which the report was sent.

9.0 Penalties

9.1 Penalties for Late Submissions

A cost report filing will be deemed late either due to an incomplete submission to EOHHS, or due to a complete submission received by OHHS/Medicaid after five months from the end of the FQHC's fiscal year. The next APM rate increase due will be delayed by sixty (60) business days when an FQHC's submission is delayed.

9.2 Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act, and Rhode Island General Laws sections 11-41-3, 40-8.2-3, 40-8.2-4, 40-8.2-7, and 40-8.2-1 and any other applicable statues. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of Rhode Island General Laws Chapter 40-8.2, as well as suspension from participation in the program by state or federal authorities.

10.0 Reconciliation Arrangements for Managed Care Enrollees

FQHCs are entitled to overall reimbursement equivalent to the total number of medical or dental encounters provided to persons enrolled in Medicaid managed care programs on the day of the encounter multiplied by the applicable FQHC rate ("attributable revenue"). The applicable FQHC rate is established by the process established through these Principles of Reimbursement.

In the event that, for Medicaid beneficiaries enrolled in managed care plans, the managed care plans do not cover the full applicable FQHC rate for eligible encounters for Medicaid beneficiates enrolled in managed care plans, Medicaid will follow the prospective payment/ reconciliation process set forth in Attachment I: (Annual Submission Guidelines for Prospective Payment System (PPS) Reconciliation Reports).

11.0 Signatures and FQHC Statement of Participation

FQHC STATEMENT OF PARTICIPATION
PPS ALTERNATIVE PAYMENT METHODOLOGY

As an authorized agent for _____, I have fully reviewed these "July 2022 Principles of Reimbursement for Federally Qualified Health Centers" (FQHCs) as published by the State of Rhode Island's Executive Office of Health and Human Services (EOHHS). This health center agrees to participate in the Alternative Payment Methodology described herein with an effective date of July 1, 2022.

Acting as an authorized agent of _____, I hereby affirm our participation subject to the terms and conditions outlined above:

Name of FQHC's Authorized Agent: _____
Title: _____
Signature: _____
Date signed: _____

Kristin Pono Sousa
Medicaid Program Director

APPENDIX A

FQHC APM and Rate Adjustments Evaluation Criteria for Mergers and Changes of Scope of Services

1. Describe the organizational change/project that has resulted in a request for a rate adjustment (e.g. mergers, expanded hours, Electronic Health Records, new operations (ACO), or other as provided for in these Principles).

2. A Medicaid cost report, which quantifies the request, including an identification and explanation of key underlying assumptions must be submitted. Such cost report shall be prepared in accordance with the provisions of Appendix B.

3. Why is the change in operations/scope needed? Please include specific information on the changes in capacity and projected volume as well as a description and quantification of any cost efficiencies.

4. Please identify any HRSA mandates and/or program expectations that the change/project is intending to address.

5. What were alternatives considered and what key factors led to the organization's decision to proceed with this particular change/project?

6. Please explain how the FQHC's changes address the needs of the Medicaid population served. Please highlight how the changes align with CMS' goals to improve to access and quality and to decrease the overall cost of providing healthcare to Medicaid beneficiaries.

7. Please provide a project timeline.

8. Please identify three to five measurable project goals pertaining to access, quality and cost. Baseline data should be provided for these metrics.

9. What actions or alternative solutions will the origination employ if the request is not approved?

10. Identify all other funding, if any, that is being utilized in the initiative (e.g., foundation grants, federal grants)

APPENDIX B

Cost Report Submission Requirements

New and merging FQHCs will submit a cost report using the template included as Attachment II. Additionally, each FQHC when requesting a rate adjustment in accordance with the provisions of APPENDIX A will submit a cost report using the template included as Attachment II. The cost report template consists of:

1. Worksheet A - Reclassification and Adjustment of Trial Balance Expenses,
2. Worksheet A-1 Reclassifications,
3. Worksheet A-2 Adjustments to Expenses,
4. Worksheet A-2-1 Part I and Part II - Acknowledgment and costs due to transactions with related parties,
5. Worksheet B-Part I-Encounters and Productivity Medical,
6. Worksheet B-Part H Encounters and Productivity Dental,
7. Worksheet B-Part III -Determination of Total Allowable Cost,
8. Worksheet C Part I - Determination of Cost for Medical Services,
9. Worksheet C -Part II - Determination of Cost for Dental Services, Attestation

Instructions for completing the FQHC Cost Report

Worksheets A - C in the cost report are to be completed in conformance with CMS 224-14 using the instructions as published by CMS.

Use of Classification Guide of FQHC Accounts by Cost Center

Rate determination will be based on five specific cost centers as set forth below. In order to ensure that costs are linked to cost centers uniformly for all FQHC, the CMS 224-14 will be modified using the classification guide (Attachment III):

1. Direct Productivity	Lines 1 - 3	Medical Section
	Lines 28-30	Dental Section
2. Direct Other	Lines 5-16	Medical Section
	Lines 32-37	Dental Section
3. Other Medical	Lines 19-25	Medical Section
	Lines 40-46	Dental Section
4. Facility	Lines 50-59	Combined Sections
5. Administration	Lines 61-71	Combined Sections

Instructions for Completing Worksheets B and C

Instructions for completion of Worksheets B and C of the FQHC cost report will deviate from CMS guidelines by using the following definitions of encounters and productivity.

Encounters

See definition in Section 4.1.

Productivity

In determining the number of minimum encounters, the productivity screens will be determined by EOHHS using the most recent available UDS Rhode Island Rollup published by the US Department of Health and Human Services, Health Resources and Services Administration. The productivity screens will be determined annually upon availability of updated UDS data and input to the FQHC cost report template made available for use by the FQHCs.

APPENDIX C

Medicare/Medicaid Cost Report Crosswalk and Attestations

ATTESTATION:

Misrepresentation or falsification of any information contained in this crosswalk may be punishable by criminal, civil and administrative action, fine and/or imprisonment under Federal and State law. Furthermore, if services identified in this crosswalk were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

CERTIFICATION BY OFFICERS

I HEREBY CERTIFY that I have read the above statement and that I have examined this crosswalk prepared by _____ (Provider) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this crosswalk were provided in compliance with such laws and regulations.

(Signed)

_____

CEO or Administrator of Facility

_____

Date

_____

CFO or Finance Director of Facility

_____

Date

MEDICARE/MEDICAID COST REPORT CROSSWALK

FQHC Name: _____

Year Ended: _____

Line #	Medicare Cost Centers	Totals per CMS 224-14, Worksheet A, Column 7		RECLASSIFICATIONS (1)	(2)	(3)	(4)	(5)	(6)		(7)	Totals as Reclassified to Medicaid Cost Centers	Direct Costs as a Percentage of Total Direct Costs	Allocation of Overhead	Program Costs After Allocation of Overhead	Total Visits (A)	Medicaid Cost Per Visit
	GENERAL SERVICE COST CENTERS																
1	Cap Rel Costs-Bldg & Fix											-					
2	Cap Rel Costs-Mvble Equip											-					
3	Employee Benefits											-					
4	Administrative & General Services											-					
5	Plant Operation & Maintenance											-					
6	Janitorial											-					
7	Medical Records			-								-					
8	Subtotal - Administrative Overhead	-		-	-	-	-	-	-		-	-					
9	Pharmacy							-				-					
10	Medical Supplies						-					-					
11	Transportation											-					
12	Other General Service											-					
13	Subtotal - Total Overhead	-		-	-	-	-	-	-		-	-		-			
	DIRECT CARE COST CENTERS																
37	Subtotal - Direct Patient Care Services (medical/BH)			-	-	-	-				-	-	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
	REIMBURSABLE PASS THROUGH COSTS																
50	Subtotal - Reimbursable Pass through Costs	-										-	#DIV/0!	#DIV/0!	#DIV/0!		
	OTHER FQHC SERVICES																
70	Subtotal - Other FQHC Services		**(C)**									-	#DIV/0!	#DIV/0!	#DIV/0!		
	NONREIMBURSABLE COST CENTERS																
80	Subtotal - Nonreimbursable							-				-	#DIV/0!	#DIV/0!	#DIV/0!		
100	TOTAL (sum of lines 13, 37, 50, 70 and 80)	-		-	-	-	-	-	-		-	-					
	Medicaid Cost Centers																
150	Dental								-	**(B)**		-	#DIV/0!	#DIV/0!	#DIV/0!	19,798	#DIV/0!
175	340(B) Pharmacy							-				-	#DIV/0!	#DIV/0!	#DIV/0!		
200	TOTAL (sum of lines 100, 150 and 175)	-		-	-	-	-	-	-		-	-	#DIV/0!	#DIV/0!	#DIV/0!		
	Total Direct Costs (sum of lines 37, 50, 70, 80, 150 and 175)											-					

(1) To reclassify Medical Records (increase Line 37, decrease Line 7)
(2) To reclassify Depreciation Expense - Medical Equipment (increase Line 37, decrease Line 2)
(3) To reclassify Medical Front Desk Salary & Benefits (increase Line 37, decrease Line 12)
(4) To reclassify Medical Supplies (increase Line 37, decrease Line 10)
(5) To reclassify Pharmacy Expense (increase Line 175, decrease Line 9)
(6) To reclassify Dental (increase Line 150, decrease Line 70)
(7) To reclassify Optometry (increase Line 37, decrease Line 70)

Note: The purpose of this crosswalk is to: (1) Reclassify FQHC costs from the cost centers per the Medicare Cost Report (Form CMS 224-14) to the Medicaid cost centers as outlined in Attachment III (Classification of FQHC Accounts by Cost Center) of the Principles of Reimbursement for Federally Qualified Health Centers; (2) Allocate overhead using Medicaid Cost Report methodologies and; (3) Determine a medical/behavioral health cost per visit and a dental cost per visit in accordance with these Principles of Reimbursement.

(A) Medical/Behavioral Health Visits are per CMS 224-14, Worksheet S-3, Part I, Lines 2 & 4) plus optometry visits per FQHC records if not included on Worksheet S-3. Dental visits are per FQHC records.

(B) Indicate breakdown of dental costs as follows:	
Direct Care Staff Costs (including benefits)	
Supplies	
Other Dental Program Expenses	
Total Reclassification	$ -

(C) Indicate breakdown of costs by service/program type:	
Program 1	
Program 2	
Program 3	
	$ -

Attachment I.

RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Annual Submission Guidelines
For
Prospective Payment System (PPS) Reconciliation Reports Submitted by Federally Qualified Health Centers for Services Provided to Managed Care Enrollees

August 2022

I. Introduction

The reconciliation provisions contained herein are directly a part of the August 2022 Principles of Reimbursement. The purpose of these Submission Guidelines is to set forth the process for PPS/APM reconciliation for services provided by FQHCs to persons enrolled in any managed care program in the event that the managed care plan does not cover the applicable FQHC rate for eligible encounters. These reconciliation provisions apply annually to the state fiscal year (July 1 – June 30). Reconciliation Reports as described herein are due annually beginning July 1, 2006 and constitute the whole of such reconciliation provisions for participating FQHCs. To accomplish the reconciliation, FQHCs are to follow the submission requirements described herein.

Ia. Definitions

The *Activity Year* is the State fiscal year during which the encounters provided by the FQHCs take place and during which monthly, prospective payments are made by Medicaid to the FQHCs.

The *Reconciliation Year* is the State fiscal year during which Medicaid and the FQHCs reconcile the number of encounters provided by the FQHCs and the amount of payments received for these encounters by the FQHCs from the State and the managed care organizations during the previous Activity Year.

Each State fiscal year serves as both an Activity Year in itself and as the Reconciliation Year for the previous Activity Year.

For each twelve (12) month Activity Year (July 1 – June 30), FQHCs are entitled to overall reimbursement equivalent to the total number of medical encounters provided to persons enrolled in managed care on the day of the encounter times the applicable FQHC rate ("attributable revenue"). The applicable FQHC rates are established by the processes presented in these Principles of Reimbursement.

The annual reconciliation encompasses three phases, elaborated below: prospective payments; supplemental payment/recoupment; and final settlement.

II. Reconciliation Phase 1: Prospective Payments

In the event that Medicaid anticipates that managed care plans will not reimburse FQHCs at the full, applicable PPS/APM rates, Medicaid will make prospective payments to the FQHCs during the Activity Year. These prospective payments are designed to minimize the gaps between what the FQHCs are owed for eligible encounters and reimbursed for eligible encounters. The prospective payments are calculated by modifying ongoing payments according to the data provided by the FQHCs on their submitted Prospective Payment Reconciliation Schedules. See Section VIII below for additional details.

If Medicaid and the FQHCs determine that managed care organizations are reimbursing FQHCs at the full, applicable PPS/APM rates, Medicaid will cease making monthly, prospective payments.

III. Reconciliation Phase 2: Supplemental Payment/Recoupment

By October 15th of the Reconciliation Year, each FQHC will submit to Medicaid a Prospective Payment Reconciliation Schedule (see the template below), along with a claims-level data file supporting the numbers provided in the Schedule. This Reconciliation Schedule will include the amount the FQHC believes it is owed by Medicaid or owes to Medicaid, after considering the number of encounters provided, along with payments received from the managed care organizations and the monthly, prospective payments made by Medicaid during the Activity Year. By December 1st of the Reconciliation Year, Medicaid will pay to each FQHC 80% of the amount the FQHC believes it is owed by Medicaid or recoup 80% of the amount the FQHC believes it owes Medicaid, as appropriate. This supplemental payment or recoupment is made in advance of further reconciliation and a final settlement.

IV. Reconciliation Phase 3: Settlement Payment/Recoupment

Using the supporting claims-level data files provided by the FQHCs and claims-level data files provided by the managed care plans, Medicaid will review the information submitted by the FQHCs in the Reconciliation Schedule. This review will include an effort to determine the eligibility of the encounters as per the definition of encounters elaborated in Section 4.1 of these Principles of Reimbursement.

Where Medicaid's review determines that its count of eligible encounters and its summing of total dollars paid for these encounters falls within 3% of the encounter count and payment total reported by the FQHC in its Reconciliation Schedule, the State will accept the number of encounters and sum of received payments reported by the FQHC and make the corresponding settlement payment or recoupment.

Where Medicaid's review determines that its count of eligible encounters and its summing of total dollars paid for these encounters exceeds 3% of the encounter count and payment total reported by the FQHC in its Reconciliation Schedule, Medicaid will seek to clarify with the FQHC and resolve any discrepancies.

Once Medicaid and the FQHC agree to a final settlement, by the end of the third quarter of the Reconciliation Year, Medicaid will, as appropriate, make a final payment to the FQHC or final recoupment from the FQHC.

V. Requirement of Submission of Prospective Payment Reconciliation Schedule and Supporting Data File

FQHCs must submit the annual Prospective Payment Reconciliation Schedule and supporting data file on a timely basis. This supporting file will provide claims-level data to confirm the numbers reported on the Prospective Payment Reconciliation Schedule.

The supporting data file must include the following pieces of information:

- recipient name;
- recipient date of birth;
- recipient SSN;
- date of encounter;
- encounter identification number;
- amount of payment received from managed care organization;
- indication of type of service (Medical, Behavioral Health);
- indication of whether or not encounter was covered by a managed care capitation arrangement; and
- all procedure codes billed for each encounter.

If the recipient SSN is unavailable, the FQHC should provide another marker of identification, such as Managed Care Plan ID, or Medicaid or Medicare ID number.

The PPS reconciliation process requires confirmation of *both* the number of eligible encounters provided and the amounts of payments received by the FQHCs. The supporting data must provide enough information, including all procedure codes, to facilitate both of these confirmation processes.

VI. Timeline for Submission of Reconciliation Report

On an annual basis, each FQHC must file the Prospective Payment Reconciliation Schedule and supporting documentation to Medicaid within 107 days following the close of the state fiscal year (June 30th), that is, by October 15.

In the event that a completed Prospective Payment Reconciliation Schedule is not filed timely, monthly prospective payments will be suspended for that FQHC until the filing is received.

VII. Instructions for Submission of Prospective Payment Reconciliation Schedule

The electronic submission should be sent to:
katie.alijewicz@ohhs.ri.gov

The signed paper submission shall be mailed to:

Katie Alijewicz
EOHHS/Medicaid Program
5 West Road
Cranston, RI 02920

VIII. Instructions for Completion of Prospective Payment Reconciliation Schedule

a. Part I: Attributable Revenue for Period

This section is used to recognize all revenue to the FQHC for services provided during the Activity Period to persons enrolled in RIte Care or other EOHHS authorized managed care programs on the dates of service. The line definitions below include the language

"payments received." In some instances, services will have been provided but actual payments are pending and have not yet been received. Such receivables are to be included in the "payments received" calculation. Medicaid's intention is that the payments reported in Part I of the Reconciliation Schedule correspond directly and fully to the encounters reported in Part II of the Schedule, that is, for dates of service between July 1 and June 30. Furthermore, any receivable dollars should be reported NET of any contractually obligated write-offs or reduction from charges.

The various sources of this reimbursement are to be itemized as follows:

Line I.1: NHPRI Capitation – Payments received by FQHC on a monthly basis from Neighborhood Health Plan of Rhode Island for primary health care services to individuals for whom the FQHC serves as the primary care provider. Payments to be included are those made for the periods July through June of the Activity Year.

Line I.2: NHPRI Reimbursement – Payments received by FQHC from Neighborhood Health Plan of Rhode Island for non-capitated health care services to its RIte Care members or other contracted managed care enrollees. Payments to be included are those FFS payments made for the periods July through June of the Activity Year.

Line I.3: Tufts Reimbursement-RIte Care – Payments received by FQHC from Tufts Health Plan for health care services to its RIte Care members or other contracted managed care enrollees.

Line I.4: UHC Reimbursement-RIte Care – Payments received by FQHC from United Health Care of New England for health care services to its RIte Care members or other contracted managed care enrollees.

Line I.5: Other Net Patient Revenue – Any other revenue received, from any source (please specify source), for health care services provided to RIte Care eligible individuals or enrollees of any other EOHHS contracted managed care program.

Line I.6: Subtotal of Health Plan Payments to FQHC – This line is the subtotal of all capitation and fee-for-service based payments made to the FQHC by health plans.

Line I.7: EOHHS PPS Monthly Payments – Monthly payments for managed care enrollees received from EOHHS or its fiscal agent,

Line I.8: Total Amounts Received/Receivable – The sum of lines I.6 and I.7 identifies total payments to the FQHC for RIte Care enrollees or other contracted managed care enrollees.

Note: Revenue associated with OB deliveries, LARC devices, and GYN surgical procedures (i.e. colposcopy and loop electrosurgical excision procedure) is excluded from the above totals. Revenue associated with prenatal and LARC visits is

included in the above totals.

b. Part II: Allowable Encounters for Persons Enrolled with a RIte Care Health plan or other EOHHS contracted managed care program on Date of Service.

This section of the Reconciliation Schedule will identify all encounters with managed care enrollees on dates of service within the specified period. This includes all Medicaid enrollees covered by a Medicaid managed care plan, including Children with Special Needs, children in Subsidized Care, and adults covered under the Rhody Health Partners program. All payments (both received and receivable) associated with these encounters should be reported in Part I. Encounters should be reported as follows:

Line II.1: NHPRI Capitated Encounters – - Allowable encounters for Medicaid recipients enrolled in Neighborhood Health Plan of Rhode Island (NHPRI) on the date of service, and whose reimbursement for primary care is paid on a capitated basis by NHPRI to the FQHC.

Line II.2: NHPRI Encounters (Other) – Allowable encounters for Medicaid recipients enrolled in Neighborhood Health Plan of Rhode Island (NHPRI) on the date of service, and whose reimbursement is paid on a fee-for-service basis by NHPRI to the FQHC.

Line II.3: Tufts Encounters –Allowable encounters for Medicaid recipients enrolled in Tufts Health Plan on the date of service, and whose reimbursement is paid on a fee-for-service basis by Tufts to the FQHC.

Line II.4: UHC Encounters –Allowable encounters for Medicaid recipients enrolled in United Health Care (UHC) on the date of service, and whose reimbursement is paid on a fee-for-service basis by UHC to the FQHC.

Line II.5: Other Allowable Encounters – Any other allowable Encounters for Medicaid recipients enrolled with a RIte Care Plan or other EOHHS contracted managed care program on the Date of Service (please specify).

Line II.6: Total Encounters – The sum total of lines II.1 through II.5.

Note: Visits for OB deliveries and GYN surgical procedures (i.e. colposcopy and loop electrosurgical excision procedure) are excluded from the above totals. Prenatal and LARC visits are included in the above totals.

c. Part III: Payment Calculation.

Part III of this schedule is used to calculate the imputed revenue the FQHC would have received had reimbursement been paid on a fee for service basis at the applicable FQHC rates for recipients eligible for Medicaid managed care. Amounts received or receivable are factored to arrive at the balance due to the FQHC or the amount of overpayment to the FQHC. The results of the reconciliation will be used to (a) identify an estimate of the

monthly payment due to the FQHC and (b) make any adjustment to that amount for reconciliation.

Line III.1: Applicable FQHC Reimbursement Rate – This is the encounter rate as established by EOHHS and in effect during the Activity Year.

Line III.2: Imputed PPS Revenue Total – The product of lines III.1 and II.6 (encounter rate multiplied by total encounters).

Line III.3: Total Amount Required in EOHHS Payments (Line III.2 minus I.6) – This line is the difference between line III.2, total imputed PPS revenue, and Line I.6, total health plan payments to FQHC. This result represents the amount due from EOHHS to meet PPS requirements.

Line III.4: Actual EOHHS Payments – This line shows the actual amount received by the FQHC for the period, based on EOHHS payments.

Line III.5: Balance Due/(Recoupment) – This line equals Line III.3 minus Line III.4 – It represents the amount either owed to the FQHC or due to EOHHS to reconcile the PPS. This reconciliation relates to services provided only to managed care recipients who are enrolled in a qualified RIte Care health plan or other EOHHS contracted managed care program on the dates of service.

While the Prospective Payment Reconciliation Schedule is formatted for submission of information in monthly increments, it is acceptable for individual FQHCs to report this information on an annual basis only.

IX. Method for Payment

Under the prospective payment system, the monthly payment to each health center shall be based (a)on the estimated amount that would come as close as possible to making Line III.5 equal zero for the next reconciliation period and (b) any adjustment to that amount based on the results of the current reconciliation.

To achieve this, payment shall occur as follows:

- The result for the year from Line III.3 represents a best estimate of EOHHS payment obligations for the next year. This amount will be used to establish base EOHHS monthly payments.
- Results from Line III.5 show the results for the reconciliation period. This 12-month total divided by the number of months remaining in the then current fiscal year will be taken as an adjustment (+ or -) to the EOHHS monthly payment to the FQHC.

X. Assurance

Each annual submission must be (a) accompanied by a letter of assurance as to the accuracy of the information, and (b) signed by the Chief Executive Officer and Chief Financial Officer of the FQHC.

It is the understanding of EOHHS that all participating FQHCs are subject to an annual audit in accordance with the provisions described in the U.S. Office of Management and Budget's Uniform Guidance. Such audit is conducted by a firm of independent certified public accountants.

Since payments under the PPS will be considered material to the financial operations of the FQHC, each FQHC's independent auditor shall review any data submitted to EOHHS for PPS reconciliation during the fiscal year as part of the scope of their annual audit of the financial statements.

XI. Other Data Submission Requirements

Together with the PPS Reconciliation and supporting claims detail, each FQHC shall submit to EOHHS the following:

a) A copy of its most recent desk audited Medicare Cost Report; and

b) A copy of its UDS (Uniform Data System) Report as submitted to the Bureau of Primary Health Care for the previous calendar year.

By no later than forty-five (45) days following the end of each quarter, each FQHC shall submit to EOHHS, its total number of Medicaid managed care medical and behavioral health encounters for the quarter.

	Attachment I a. - PPS Reconciliation Report														
	Health Center Name:	**(Please input name here)**					**State Fiscal Year**								
	Medicaid - Medical Only	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Accrual for Unpaid Encounters	Total
I.	**Actual PPS Attributable revenue for Period (based on dates of service)**														
I.1	NHP Capitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.2	NHP Reimbursement (other)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.3	Tufts Reimbursement - RIte Care	$ -	$ -	$ -	$	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.4	UHC Reimbursement - RIte Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.5	Other Net Patient Revenue (if applicable)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
	EDS														$ -
I.6	**Subtotal**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		$ -
I.7	DHS PPS PMPM Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
															$ -
I.8	**Total Amounts Received/Receivable:**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**
II.	**Allowable Encounters for Persons Enrolled with a RIte Care Plan on the Date of Service**														
II.1	NHP Capitated Encounters				-										
II.2	NHP Encounters (other)				.										
II.3	Tufts Encounters - RIte Care				-										
II.4	UHC Encounters - RIte Care				-										
II.5	Other allowable Encounters (EDS)				-										
II.6	**Total Encounters**	-	-	-	-	-	-	-	-	-	-	-	-		-
III.	**Payment Calculation**														
III.1	Applicable FQHC Reimbursement Rate	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
III.2	**Imputed PPS Revenue total**	$	$	$	$	$	$	$	$ -	$	$	$	$		$ -
III.3	Total Amount Required in DHS Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
III.4	Actual DHS Amounts Paid on Interim Basis	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
III.5	**Balance due (credit)**	$	$	$	$	$	$	$	$ -	$	$	$	$		$ -

Attachment II

Rhode Island EOHHS/FQHC Cost Report Format

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet A

Reclassification and Adjustment of Trial Balance of Expenses

	Cost Center	Compensation 1	Other 2	Total 3	Reclassi-factions 4	Reclassified Trial Balance 5	Adjustments 6	Net Expenses 7
	MEDICAL CARE STAFF COSTS							
1	Physician		-	-	-		-	
2	Physician Assistant			-	-			-
3	Nurse Practitioner			-	-			-
4	Subtotal - Direct Productivity	-	-	-	-	-	-	-
5	Visiting Nurse		-		-		-	
6	Other Nurse		-		-		-	
7	Clinical Psychologist			-		-		-
8	Clinical Social Worker			-		-		-
9	Laboratory Technician			-		-		-
10	Medical Assistants			-	-			-
11	Front Desk		-		-		-	
12	Medical Records		-		-		-	
13	Subtotal-Medical Care Staff Cost	-	-	-	-	-	-	-
	COSTS UNDER AGREEMENT							
14	Physician Services Under Agreement			-		-		-
15	Physician Supervision Under Agreement			-		-		-
16	Other Costs Under Agreement			-		-		-
				-		-		-
17	Subtotal Under Agreement	-	-	-	-	-	-	-
18	**Subtotal Direct Other**	-	-	-	-	-	-	-
	OTHER HEALTH CARE COSTS							
19	Medical Supplies		-		-		-	
20	Transportation (Health Care Staff)			-		-		-
21	Depreciation-Medical Equipment			-		-		-
22	Professional Liability Insurance			-		-		-
23	Other Direct Medical			-		-		-
24	Medical waste		-		-		-	
25	Medical record supplies			-		-	-	-
26	Subtotal-Other Medical Care	-	-	-	-	-	-	-
27	Subtotal - Medical Costs	-	-	-	-	-	-	-
	DENTAL CARE STAFF COSTS							
28	Dentist		-		-		-	
29	Dental Hygienist			-		-		-
30	Dental Assistant			-		-		-
31	Subtotal Direct Productivity	-	-	-	-	-	-	-
32	Front Desk		-		-		-	
33	Dental Records	-	-	-		-		-
34	Subtotal- Dental Care Staff Cost	-	-	-	-	-	-	-
	COSTS UNDER AGREEMENT							
35	Dentist Services Under Agreement			-		-		-
36	Dentist Supervision Under Agreement			-		-		-
37	Other Costs Under Agreement			-		-		-
				-		-		-
38	Subtotal Under Agreement	-	-	-	-	-	-	-
39	**Subtotal Direct Other**	-	-	-	-	-	-	-
	OTHER DENTAL CARE COSTS							
40	Dental Supplies		-		-		-	
41	Transportation (Dental Care Staff)			-		-		-
42	Depreciation-Dental Equipment			-		-		-
43	Professional Liability Insurance			-		-		-
44	Other Direct Dental			-		-		-
45	Dental record supplies			-		-		-
46	Equipment maintenance			-		-		-
47	Subtotal-Other Dental Care	-	-	-	-	-	-	-
48	Subtotal - Dental Costs	-	-	-	-	-	-	-
49	Total Cost of Health Care Services	-	-	-	-	-	-	-

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet A

Reclassification and Adjustment of Trial Balance of Expenses

	Cost Center	Compensation	Other	Total	Reclassi-factions	Reclassified Trial Balance	Adjustments	Net Expenses
		1	2	3	4	5	6	7
	FACILITY OVERHEAD - FACILITY COST							
50	Rent		-	-			-	
51	Insurance		-		-		-	
52	Interest on Mortgage or Loans			-		-	-	-
53	Utilities		-		-		-	
54	Depreciation-Building and Fixtures			-		-	-	-
55	Housekeeping and Maintenance			-		-		-
56	Property Tax		-		-		-	
57	Other Facility Cost (contracted security)			-		-		-
58		-		-		-		
59		-		-		-		
60	Subtotal-Facility Costs	-	-	-	-	-	-	-
	FACILITY OVERHEAD - ADMINISTRATIVE COSTS							
61	Office Salaries		-	-	-		-	
62	Depreciation-Office Equipment			-		-		-
63	Office Supplies		-		-		-	
64	Legal		-	-			-	
65	Accounting		-		-		-	
66	Insurance		-		-		-	
67	Telephone		-		-		-	
68	Fringe Benefits and Payroll Taxes			-		-		-
69	Other Admin Costs (Conferences & Meetings)			-		-		-
70	Contracted Admin Svcs.			-		-		-
71.01	Bad Debt Expense			-	-		-	-
71.02	Interest Expense		-					-
71.03	Dues and Licenses			-	-			-
71.04	Equipment maintenance			-		-		-
71.05	Miscellaneous Admin. Costs			-		-	-	-
71.06	Postage & Delivery			-	-			-
71.07		-		-		-		
72	Subtotal-Administrative Costs	-	-	-	-	-	-	-
73	Total Overhead	-	-	-	-	-	-	-
	COST OTHER THAN RHC/FQHC SERVICES							
74	Pharmacy							
75			-		-	-	-	
76	Other Cost (Specify) radiology		-		-		-	
77	Enabling services			-		-		-
78	Subtotal-Cost Other Than RHC/FQHC			-		-		-
		-	-	-	-	-	-	-
	NON-REIMBURSABLE COSTS							
79	Non-Reimbursable Cost (Specify)			-		-		-
80	Subtotal Non-Reimbursable Cost			-		-		-
		-	-	-	-	-	-	-
81	Total Costs	-	-	-	-	-	-	-

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet A-1

Reclassifications

	Explanation of Entry	Code	Increase Cost Center	Increase Line No	Increase Amount	Decrease Cost Center	Decrease Line No	Decrease Amount
		1	2	3	4	5	6	7
1	Physician Admin Time	A	Office Salaries			Physician		
2								
3								
4								
5								
	TOTAL RECLASSIFICATIONS				-			-

Worksheet A-2

Adjustments to Expenses

	Description	Basis	Amount	Cost Center	Line No
		1	2	3	4
1	Investment income on commingled restricted and unrest funds				
2	Trade, quantity and time discounts on purchases	B			
3	Rebates and refunds of expenses	B			
4	Rental of building or office space to others	B			
5	Home office costs				
6	Adjustment resulting from transactions with related orgs.	A-2-1	-		
7	Vending machines				
8	Practitioner Assigned by National Health Service Corps				
9	Depreciation - Building and Fixtures	A	-	Depreciation	
10	Depreciation - Equipment	A	-	Depreciation	
11	Meals & Entertainment	A	-	Office Supplies	
11.01	Telephone-Cellular	A	-	Office Supplies	
11.02	In Kind Donations	A	-	Physician Services under Agree	-
11.03	Pharmacy costs not requiring allocation of oh	A	-	Pharmacy	-
11.04	Bad debt expense	A	-	Other administrative costs	-
11.05	Advertising/fundraising Costs	A	-	Other administrative costs	-
11.06	Medical records revenue	B	-	Medical records supplies	-
11.07	Miscellaneous income	B	-	Other administrative costs	-
11.08	DCYF grant revenue for reimbursement of salary	B	-	Enabling services	-
12	Total	-			

Worksheet A-2-1

Part I

Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part 1, chapter 10?

Yes [ ] No [ ]

Part II - Cost incurred and adjustments required as result of transactions with related organizations

Line No	Cost Center	Expense Items	Amount	Amount Allowable In Cost	Net Adjustment
1	2	3	4	5	6
1					
2					
3					
4					
5	TOTALS			-	-

Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the provider;
B. Corporation, partnership, or other organization has financial interest in the provider;
C. Provider has financial interest in corporation, partnership, or other organization(s);
D. Director, officer, administrator, or key person of the provider or relative of such person has financial interest in related organization;
E. Individual is director, officer, administrator, or key person of the provider and related organization;
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the provider;
G. Other (financial or non-financial)

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet B

Part I - ENCOUNTERS AND PRODUCTIVITY-MEDICAL

	Positions	Number of FTE Personnel 1	Total Encounters 2	Productivity Standard 3	Minimum Encounters 4	Greater of Col.2 or Col. 4 5
1	Physicians		-			
2	Physician Assistants			-		
3	Nurse Practitioners			-		
4	Subtotal	-	-		-	-
5	Visiting Nurse		-			
6	Clinical Psychologist			-		
7	Clinical Social Worker			-		
8	Total Staff	-	-			-
9	Physician Services Under Agreement			-		

Part II - ENCOUNTERS AND PRODUCTIVITY-DENTAL

	Positions	Number of FTE Personnel 1	Total Encounters 2	Productivity Standard 3	Minimum Encounters 4	Greater of Col.2 or Col. 4 5
10						
11						
12	Dentists		-			
13	Hygienists		-			
	Subtotal					
	Dental Assistants					
		-	-		-	-
14	Dental Services Under Agreement					

Part III - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC

		Amount	Overhead	
				Screen
				Not applicable
15	Cost of Medical Service - excluding overhead	-		
16	Cost of Dental Service - excluding overhead	-		
17	Cost of Other Than RHC/FQHC Service - excluding overhead		-	
18	Cost of Connect Care Choices - excluding overhead		-	
19	Cost of All Services	-		
20	Ratio of Medical Services			
21	Ratio of Dental Services			
22	Total Overhead	Facility		Admin / Total
23	Overhead Applicable to Medical Services	-	-	-
24	Overhead Applicable to Dental Services	-	-	-
25	Total Overhead Applicable to Medical and Dental Services:			
26	Not applicable			
27	Not applicable			
28	28 Total Allowable Cost of Medical Services			
29	Total Allowable Cost of Dental Services			

(Provider Name)
Template of FQHC Medical/Dental Cost Report
YEAR ENDED JUNE 30, _____

Worksheet C

Part I - DETERMINATION OF COST FOR MEDICAL SERVICES

		Amount
1	Total Allowable Costs	-
2	Greater of Minimum or Actual Encounters By Health Care Staff	-
3	Physicians Encounters Under Agreements	-
4	Total Adjusted Encounters	-
5	Adjusted Cost Per Encounter	
6	Adjusted Cost per Encounter - Dir Prod. Medical	
7	Adjusted Cost per Encounter - Dir Other Medical	
8	Adjusted Cost per Encounter - Other Medical	
9	Adjusted Cost per Encounter - Medical Facility	
10	Adjusted Cost per Encounter - Medical Admin.	

Part II - DETERMINATION OF COST FOR DENTAL SERVICES

		Amount
11	Total Allowable Costs	-
12	Greater of Minimum or Actual Encounters By Health Care Staff	-
13	Dental Encounters Under Agreements	-
14	Total Adjusted Encounters	-
15	Adjusted Cost Per Encounter	
16	Adjusted Cost per Encounter - Dir Prod. Dental	
17	Adjusted Cost per Encounter - Dir Other Dental	
18	Adjusted Cost per Encounter - Other Dental	
19	Adjusted Cost per Encounter - Dental Facility	
20	Adjusted Cost per Encounter - Dental Admin.	

Template of FQHC Medical/Dental Cost Report

Worksheet D

Part I - DETERMINATION OF NET EXPENSE RELATED TO CONNECT CARE CHOICES

1	Nurse Case Manager	-
2	Fringe Benefits & Payroll Taxes	-
3	Equipment	-
4	Other Direct Expenses related to Connect Care Choices	-
5	Expense of Connect Care Choices - Excluding Overhead	-
6	Overhead Applicable to Connect Care Choices	-
7	Total Expense Applicable to Connect Care Choices	-
8	Revenue Received	-
9	Net Expense Applicable to Connect Care Choices	-

(Provider Name)
Template of FQHC Medical/Dental Cost Report
YEAR ENDED JUNE 30, _____

ATTESTATION:

Misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under Federal and State law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

CERTIFICATION BY OFFICERS

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by _____ (Provider) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
CEO or Administrator of Facility

_____
Date

_____
CFO or Finance Director of Facility

_____
Date

Attachment III

Classification of FQHC Accounts by Cost Center

Attachment III

CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER

LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
1	Physician	Salary, fees and benefits.	Direct Productivity
2	Physician Assistant	Salary, fees and benefits.	Direct Productivity
3	Nurse Practitioner	Salary, fees and benefits.	Direct Productivity
5	Visiting Nurse	Salary, fees and benefits.	Direct Other
6	Other Nurse	Salary, fees and benefits.	Direct Other
7	Clinical Psychologist	Salary, fees and benefits.	Direct Other
8	Clinical Social Worker	Salary, fees and benefits.	Direct Other
9	Laboratory Technician	Salary, fees and benefits.	Direct Other
10	Medical Assistants	Salary, fees and benefits.	Direct Other
11	Front Desk/Reception	Salary, fees and benefits.	Direct Other
12	Medical Records	Salary, fees and benefits.	Direct Other
14	Physician Services Under Agreement	Salary, fees and benefits.	Direct Other
15	Physicians Supervision Under Agreement	Salary, fees and benefits.	Direct Other
16	Other Costs Under Agreement	Salary, fees and benefits.	Direct Other
19	Medical/Lab Supplies		Other Medical
20	Transportation (Health Care Staff)		Other Medical
21	Depreciation-Medical Equipment		Other Medical

	CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER		
LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
22	Professional Liability Insurance		Other Medical
23-25	Other Direct Medical (CME/license, direct staff		Other Medical
	repairs of med. Equip., uniforms, beepers)		
28	Dentist	Salary, fees and benefits.	Direct Productivity
29	Dental Hygienist	Salary, fees and benefits.	Direct Productivity
30	Dental Assistant	Salary, fees and benefits.	Direct Productivity
32	Front Desk	Salary, fees and benefits.	Direct Other
33	Dental Records	Salary, fees and benefits.	Direct Other
35	Dentist Services Under Agreement	Salary, fees and benefits.	Direct Other
36	Dentist Supervision Under Agreement	Salary, fees and benefits.	Direct Other
37	Other Costs Under Agreement	Salary, fees and benefits.	Direct Other
40	Dental Supplies		Other Dental
41	Transportation (Dental Care Staff)		Other Dental
42	Depreciation-Dental Equipment		Other Dental

	CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER		
LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
43	Professional Liability Insurance		Other Dental
44-46	Other Direct Dental (CME/license, direct repairs of med. Equip., uniforms, beepers)		Other Dental
50	Rent		Facility
51	Insurance		Facility
52	Interest on Mortgage or Loans		Facility
53	Utilities		Facility
54	Depreciation- Building & Fixtures		Facility
55	Housekeeping and Maintenance		Facility
56	Property Tax		Facility
57-59	Other Facility Cost (Specify)		Facility
61	Office Salaries (CEO, CFO, HR, Billing, IT, (admin asst., QI Mgr., Med Dir,)		Administration
62	Depreciation- Office Equipment		Administration
63	Office Supplies		Administration
64	Legal		Administration
65	Accounting		Administration
66	Insurance		Administration
67	Telephone		Administration
68	Fringe Benefits & Payroll Taxes		Administration
69-71	Other Administrative Costs (travel,		Administration

	CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER		
LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
74	Pharmacy		
76-77	Other Costs (Specify - Enabling)		