

PA PROMIS^e
837 Professional/CMS-1500 Claim Form

Provider Handbook

Appendix E – FQHC/RHC

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Appendix E – FQHC/RHC

This section includes the Guidelines, Procedures and Standards for Federally Qualified Health Centers or Rural Health Clinics (FQHCs/RHCs).

A. Guidelines, Procedures and Standards for Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)

DEFINITIONS:

Federally Qualified Health Center – An individual health center site location that:

1. Meets all of the requirements and has been granted funds under Sections 329, 330, 340, or 340A of the Public Health Services Act; or
2. Meets all of the requirements for receiving a grant under Sections 329, 330, 340, or 340A of the Public Health Services Act; as determined by the Secretary of the U.S. Department of Health and Human Services (FQHC “look alike”); or
3. Does not currently meet all of the FQHC requirements under the Public Health Services Act, but receives a temporary waiver from the Secretary of the U.S. Department of Health and Human Services allowing the health center to act as an FQHC while it strives to meet the requirements under Sections 329, 330, 340, or 340A of the Public Health Services Act; and
4. Meets all applicable requirements for Medical Assistance (MA) providers as set forth in Chapter 1101 of the MA regulations; and,
5. Meets all licensure and certification standards established under Pennsylvania Law for providers of health services.

Rural Health Clinic – an individual health clinic site location that:

1. Has been determined by the Secretary of the U.S. Department of Health and Human Services to meet the requirements to § 1861(aa)(1) of the Social Security Act and 42 Code of Federal Regulations (CFR) Part 491; and
2. Has filed an agreement with the Secretary in order to provide rural health clinic services under Medicare (See 42 CFR § 405.2402).

3. Meets all applicable requirements for Medical Assistance (MA) providers as set forth in Chapter 1101 of the MA regulations; and,
4. Meets all licensure and certification standards established under Pennsylvania Law for providers of health services.

Federally Qualified Health Center Personnel – Physicians, dentists, certified registered nurse practitioners (CRNPs), licensed clinical psychologists, licensed clinical social workers, dental hygienists, public health dental hygiene practitioners (PHDHPs), registered nurses, nurse midwives, licensed physician assistants, or any other duly licensed or certified health care professional whose services are covered under the State Plan, and who by contract or agreement with a FQHC provides medical or dental services for the patients of the FQHC.

Rural Health Clinic Personnel - Physicians, dentists, certified registered nurse practitioners (CRNPs), licensed clinical psychologists, licensed clinical social workers, dental hygienists, public health dental hygiene practitioners (PHDHPs), registered nurses, nurse midwives, licensed physician assistants, or any other duly licensed or certified health care professional whose services are covered under the State Plan, and who by contract or agreement with an RHC provides medical, behavioral or dental services for the patients of the RHC.

Federally Qualified Health Center Service – A medical, dental or allied health service provided by FQHC personnel and services and supplies incident to such services provided by FQHC personnel.

FQHC services are the core services defined at Section 1861(aa)(1)(A)-(C) of the Social Security Act, namely;

- Physician services, (including inpatient physician services and visits). Since physician services are defined by the applicable law as an integral part of FQHC core services, and since only physicians currently have legal authority to prescribe legend drugs, no clinic without a physician on staff may be enrolled as an FQHC under the MA Program.
- Services and supplies incident to physician services (including certain drugs and biologicals that cannot be self-administered).
- Pneumococcal vaccine and its administration and influenza vaccine and its administration.

- Licensed physician assistant services.
- Licensed nurse practitioner services.
- Licensed clinical psychologist services.
- Licensed clinical social worker services.
- Services and supplies incident to clinical psychologist and clinical social work services as would otherwise be furnished by or incident to physician services.

Rural Health Clinic Service - A medical, dental or allied health service provided by RHC personnel and services and supplies incident to such services provided by RHC personnel.

RHC services are the core services defined at Section 1861(aa)(1)(A)-(C) of the Social Security Act, namely;

- Physician services, (including inpatient physician services and visits).
- Services and supplies incident to physician services (including certain drugs and biologicals that cannot be self-administered).
- Licensed physician assistant services.
- Licensed nurse practitioner services.
- Licensed clinical psychologist services.
- Licensed clinical social worker services.
- Services and supplies incident to clinical psychologist and clinical social work services as would otherwise be furnished by or incident to physician services.
- In the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a individual under a written plan of treatment established and periodically reviewed by a physician or established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician, when furnished to an individual as an outpatient of a rural health clinic.

NOTE: Services provided to patients who self-refer to hospital outpatient facilities and who are served by hospital practitioners who “moonlight” as contract employees of an FQHC/RHC (this includes hospital clinic and emergency room services) are not FQHC/RHC covered services. Such services are billed to MA by the hospital, and do not count as FQHC/RHC encounters; and

Any other services included in the federally approved State Plan for Medical Assistance which are provided by the FQHC/RHC and are not included as FQHC/RHC core services; for example, pharmaceuticals, dental, and preventive services. (NOTE: “Other ambulatory services” may include services not in the State Plan when such services are exclusively rendered to persons under 21 years of age as prescribed treatment subsequent to an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screen.)

Charts/Records – The FQHC/RHC must maintain legible, accurate, and complete charts and records in order to support and justify the services provided (Chapter 1101.51). Chart means a compendium of medical records on an individual patient. Record means those dated reports corresponding to office, home, nursing facility, hospital, outpatient, inpatient, and any other place of service supporting claims submitted to the Pennsylvania Medical Assistance Program. Records of service shall be entered in chronological order by the specific practitioner who rendered the service. For reimbursement purposes, such medical and behavioral records shall be legible and shall include but not be limited to:

1. Dates of Service
2. Patient’s name and date of birth
3. Name and title of the licensed provider performing the service
4. Chief complaint/justification or reason for the visit
5. Pertinent medical history
6. Pertinent findings on examination, including length of time spent with the patient (if a group session, the number of patients in the group, should be noted)
7. Medications and/or equipment/supplies delivered or prescribed
8. Description of treatment (when applicable)
9. Recommendations for additional treatments, procedures, or consultations
10. X-rays, tests and results
11. Plan of treatment/care/outcome

For reimbursement purposes, such dental records shall be legible and shall include but not be limited to the above, as well as:

1. Tooth chart indicating the condition of the patient's teeth, as observed on the initial oral examination. The dentist shall clearly indicate on the tooth chart:
 - Missing permanent teeth
 - Permanent teeth to be extracted
 - Teeth to be restored by surface
2. The record shall note the condition of the oral supporting tissues.
3. For each service rendered, the record shall note:
 - The type of service
 - The date the service was rendered
 - The tooth number or letter, if applicable
 - The surfaces restored, if applicable
 - The types of materials used in the final restoration, if applicable
 - The type, concentration and amount of any anesthetic agent used in providing a service, if applicable.
4. If dental radiographs are taken, they shall be part of the patient's record and shall be properly processed, dated and identified with the patient's name.
5. If radiographs are requested by the Department, the radiographs shall be properly mounted and include the patient's name, case number and the provider's name. If radiographs are requested for a record review or an onsite review, sufficient time will be agreed upon between the provider and the Department to allow the radiographs to be properly mounted.
6. If the services of a dental technician or dental laboratory, or both, are used as defined in 55 Pa.Code, §1149.2 (relating to definitions), the dentist shall furnish the dental technician or dental laboratory with a written prescription, which shall contain the following items listed in the Dental Law (63 P.S. §§ 120-130b):
 - The name and address of the dental laboratory technician or dental laboratory.
 - The patient's name or identification number. If a number is used, the patient's name shall be written on the prescription retained by the dentist.
 - The date on which the prescription was written.
 - A prescription for the work to be done, with diagrams if necessary
 - A specification of the type and quality of materials to be used.
 - The signature of the dentist and the dentist's license number.
 - A copy of the prescription shall be maintained as part of the patient's record.
7. Pathology reports are required for surgical excision services.
8. Preoperative x-rays are required for surgical services.
9. Postoperative x-rays are required for endodontic procedures.

Patient charts and records must be available for review by personnel who are legally authorized to audit such confidential records; namely staff of the Department of Public Welfare and its duly authorized subcontractors; the Office of the Pennsylvania

Inspector General; the Office of the Pennsylvania Auditor General; the Office of the Public Health and Human Services Comptroller; the Office of the Pennsylvania Attorney General and/or the United States Department of Health and Human Services, in conformity with the Pennsylvania Medical Assistance FQHC/RHC Provider Agreement and the provisions of the Federal Social Security Act.

Federally Qualified Health Center/Rural Health Clinic Encounter – An encounter is a face-to-face contact between a patient and the physician, dentist or mid-level practitioner who exercises independent judgment in the provision of health care services. Claims for encounters are prepared and submitted for payment according to the billing instructions outlined in the PA PROMIS^e™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form. For a health service to be defined as an encounter, the provision of the health services must be recorded in the patient’s record. Types of encounters are:

A. Medical Service Encounter: An encounter between a medical provider and a patient during which medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Included in this category are physician encounters, mid-level practitioner encounters, and other health encounters. Family planning encounters and obstetrical encounters are a subset of medical encounters.

1. **Physician Encounter**: An encounter between a physician and a patient. For the purpose of these reports, encounters between a podiatrist or psychiatrist and a patient are included in this category as medical encounters;

-or-

2. **Mid-level Practitioner Encounter**: An encounter between a CRNP, midwife or a licensed nurse practitioner or a licensed physician assistant and a patient in which the practitioner acts independently, but under the direction of a physician. Also covers encounters between a speech or physical therapist, audiologist, licensed psychologist, occupational therapist, case manager, or clinical social worker and a patient in which allied health or mental health services are provided. Allied Health Services are those provided by specially trained, certified or licensed health workers, other than medical and dental personnel. Mental Health Services are those of a psychological or crisis intervention nature, or related to alcohol or drug abuse treatment.

-or-

3. Telepsych Encounter (*applicable only to Behavioral Health Managed Care delivery system claims; telepsych encounters are not payable under the fee-for-service delivery system*): An encounter between a psychiatrist or a psychologist licensed by the Commonwealth of Pennsylvania and a patient, in which mental health services are provided through the use of approved electronic communication and information technologies to provide or support clinical psychiatric care at a distance. Qualifying telepsych services utilize real-time, two-way interactive audio-video transmission, and do not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a service recipient, or a consultation between two healthcare practitioners, although these activities may support the delivery of telepsych services. Telepsych services require service providers to have a service description approved by the Office of Mental Health and Substance Abuse Services (OMHSAS) and deliverable through the managed care option.

[Please note that the availability of telepsych services is limited to psychologists and psychiatrists only. Other professionals such as LCSWs may *not* provide services through the telepsych program.]

B. Dental Service Encounter: An encounter between a dentist, a public health dental hygiene practitioner (PHDHP) or dental hygienist, and a patient for the purpose of prevention, assessment or treatment of a dental problem, including restoration. A dental hygienist or PHDHP is credited with an encounter only when (s)he provides a service independently of, i.e., not jointly with a dentist (NOTE: a dentist supervises services rendered by the hygienist). However, two dental encounters may not be counted during a patient's dental visit in one day.

NOTE: FQHCs/RHCs are prohibited from asking the patient to make repeated or multiple visits to complete the typical dental visit, unless it is medically necessary to do so. Medical necessity must be clearly documented in the patient's record.

To determine if a contact with a recipient meets the encounter definition, the following criteria must be used:

- a) To meet the encounter criterion for independent judgment, the physician, dentist or mid-level practitioner must act independently and not assist another practitioner. For example, a mid-level practitioner assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample is not counted as a separate encounter. If a practitioner is seeing a recipient to monitor physiologic signs to provide medical documentation or prior to prescription renewal, etc., and is utilizing standing orders or protocols, that appointment is counted as an encounter.

- b) Provision of emergency services may be billed as an encounter when minimal services are provided and a complete health record is not created; however, the services must be documented in the patient record.
- c) FQHCs/RHCs may not bill for a medical service encounter and a maternity/obstetrical or family planning encounter for the same patient on the same day.
- d) An encounter may take place in the FQHC/RHC or at any other location in which project-supported activities are carried out. Examples of other locations include mobile vans, shelters, hospitals, patients' homes, and schools.
- e) When an individual practitioner renders services to several recipients simultaneously, the FQHC/RHC can count an encounter for each recipient if the provision of services is documented in each recipient's health record. This policy also applies to family therapy and family counseling sessions.
- f) FQHCs/RHCs may bill for more than one encounter (such as a medical encounter, and a dental encounter) for the same patient on the same day. Additional other health encounters may be billed with the applicable type of service; however, medical necessity for the billing of such multiple encounters on the same day must be fully documented (including the time individually spent with the patient during each encounter) and justified in the patient's record. Medical necessity for multiple daily encounters is verified by periodic site audit, and must meet the federal standard mandated at 42 CFR §405.2463.

The allowance of billing for multiple types of encounters in a single day must not interfere with the recipient's freedom in choosing a provider. A recipient may obtain medical, dental or other health services from any institution, agency, pharmacy, person, or organization that is approved by the Department to provide them. Therefore, the FQHC/RHC shall not make any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies but may suggest the services of another clinic provider or practitioner; automatic referrals between providers continue to be prohibited (Chapter 1101.51).

The following are NOT covered by Medical Assistance and do not constitute encounters under this definition:

1. Phlebotomy, specimen collections, laboratory tests, taking x-rays, filling/dispensing prescriptions, visits solely for the purpose of obtaining immunizations, allergy, or other injections, medication "pick ups" and/or

providing durable medical equipment services (crutches, canes, braces, eyeglasses, hearing aids, and the like). Costs for these services and/or supplies and equipment may be included as reimbursable on the cost report, for inclusion in the encounter rate, if not directly provided by an independently enrolled entity associated with the FQHC/RHC.

NOTE: FQHCs/RHCs that wish to dispense durable medical equipment must be certified as a medical supplier by the Pennsylvania Department of Health; FQHCs/RHCs with laboratories must be approved by the Pennsylvania Department of Health and be Clinical Laboratory Improvement Act (CLIA) certified (federal licensure for medical labs); FQHCs/RHCs with pharmacies must have a pharmacy board permit from the Pennsylvania Department of State.

2. Participation in a community meeting or group session which is not solely designed to provide health services. Examples of such activities include: skits and plays, banquets or conferences, media (television, newspaper, or radio) interviews, informational sessions for prospective users, presentations to community groups, high school classes, PTAs, etc. or, informational (marketing) presentations for the purpose of securing additional business for the FQHC/RHC.
3. Health services provided as part of a large-scale “free to the public” or “nominal fee” effort, such as a mass immunization program, mass free health screening programs, community service program or “health fairs”.

Physicians, dentists and mid-level practitioners, including CRNPs, PAs and PHDHPs providing services in FQHCs/RHCs need not be enrolled in the Medical Assistance Program, but must hold valid, current professional licenses and must not be under sanction by either the Medicaid or Medicare programs. A special enrollment is available for physicians and dentists who serve MCO patients. Information regarding this special enrollment may be obtained by calling the Bureau of Fee-for-Service Programs at (717) 265-7830/1-800-537-8862.

Healthy Beginnings Plus (HBP) Program– FQHCs/RHCs may choose to participate in the HBP Program and be reimbursed under the HBP Program fee schedule OR to include costs for comprehensive obstetrical services (including care coordination) in their cost reports and receive reimbursement through the all-inclusive encounter rate. This means that clinics that choose to participate in the HBP program and who bill under the HBP Program fee schedule agree to accept HBP Program fees as payment-in-full for services. If a clinic chooses to enroll in the HBP Program, costs associated with HBP Program are to be reported as non-FQHC/RHC costs on the FQHC/RHC cost report; HBP Program costs will not be included in the encounter rate and will not be involved in any cost settlement.

Medical Supplier Designation – An FQHC/RHC may dispense eyeglasses and other low vision aids, physician-prescribed orthopedic shoes, hearing aids and other durable medical equipment and supplies when medically necessary only if the FQHC/RHC has been certified as a medical supplier by the Pennsylvania Department of Health. Proof of certification must be submitted to the Bureau of Fee-for-Service Programs, or costs related to durable medical equipment will be disallowed. All prior authorization restrictions as listed in the fee schedule apply and need for durable medical equipment must be fully documented in the patient’s record.

Related Party Transactions – A related party is an individual or organization that is associated or affiliated with, or has control of or is controlled by, the FQHC/RHC.

“Control”, as used in this definition, means the power to influence or direct the actions or policies of another. If related parties are enrolled under separate provider types, with separate Medical Assistance Identification Numbers and provide services to MA recipients, payments for services provided to those eligible participants will be based on the appropriate MA fee schedule, without settlement, for the provider type. Related parties who choose to have their costs included in the cost-based FQHC/RHC reimbursement system must close (discontinue) all discrete provider types and provider identification numbers. Cost-Based reimbursement for services provided by related parties who choose to have their costs included in the FQHC/RHC prospective payment reimbursement system is effective beginning the day after the discrete related party provider number is closed by the Office of Medical Assistance Programs.

If an FQHC/RHC chooses to use the services, facilities, or supplies provided by a related party, that FQHC/RHC must enter into a written agreement with the related party and must meet the following requirements:

1. In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the FQHC/RHC by related parties are includable in the FQHC’s/RHC’s reported costs of the related party. However, such costs may not exceed the amount a prudent and cost-conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.
2. Personnel and administration of the related party provider (under contract) are discrete from the FQHC/RHC, that is, staff of the related party provider is separate from FQHC/RHC staff and vice versa.
3. Safeguards are established by the FQHC/RHC to ensure that recipient freedom of choice is not compromised; i.e., “automatic referral” without documented approval and informed consent of the patient is prohibited. (MA Regulation Chapter 1101.)
4. Where the related party has a discrete provider number, the related party must agree in writing, as a term of the contract, not to bill as fee-for-service under its discrete provider number any services rendered to the FQHC’s/RHC’s patients, but to accept the amount paid by the FQHC/RHC, in accordance with the contract, as payment in full.

If all of these conditions are not met, all costs of the related party transaction are not reportable as reimbursable costs on the FQHC's/RHC's cost report.

EPSDT – FQHCs/RHCs enrolled as EPSDT providers will be reimbursed for EPSDT screens at the all-inclusive encounter rate. Mandated EPSDT reporting requirements will continue as usual. FQHCs/RHCs may not receive the fee-for-service rate for EPSDT screens. FQHCs/RHCs may provide EPSDT treatment services whether enrolled as an EPSDT screening provider or not, but must provide documentation as to the types of EPSDT treatment services rendered.

CHANGE IN SCOPE OF SERVICE PROCEDURE FOR FQHCs

FQHCs seeking to change the scope of services they provide must request a change in scope of services through the Health Resources and Services Administration (HRSA). The HRSA Policy Information Notice (PIN) 2008-01 provides that HRSA will either approve or deny the FQHC's request for a change in scope of services within 60 days of the date a complete request is received.

A change of scope for purposes of the HRSA Notice of Grant Award is not the same as change of scope of services for purposes of the MA Program. The Department defines a change in scope of services as the addition of a service that has never been provided or the discontinuance of an existing service. Other changes, including the opening or closing of a service location, a change in the intensity of a particular service, or capital expenditures, do not qualify as a change in scope of services. In addition, an increase or decrease of provider's costs does not constitute a change in scope of services.

The Department has formalized its procedure to adjust the FQHC PPS rate(s) when an FQHC has a change in scope of services as defined in this bulletin. This process does not apply to a newly enrolled FQHC's initial payment rate.

Notification to the Department

If HRSA approves a request for a change in scope of services involving the addition of a service that has never been provided or the discontinuance of an existing service, the FQHC must notify the Department of the change in scope of services within 30 days of the issue date identified in block 1 of HRSA's Notice of Grant Award, so that the Department can begin the PPS rate(s) adjustment process.

Effective Date

The effective date of the rate adjustment based on the change in scope of services will be the effective date specified in the Notice of Grant Award from HRSA, provided the Notice of Grant Award approving the change in scope of services is received by the Department within 30 days of the issue date identified in block 1 of the Notice of Grant Award. If the HRSA Notice of Grant Award is not received by the Department within 30 days of the issue date identified in

block 1, the effective date of the rate adjustment will be determined by the Department.

Until a final rate is determined, the FQHC's existing rate(s) will be considered an interim rate(s).

Final Rate Adjustment

FQHCs must submit a cost report within 120 days after the close of the FQHC's first full fiscal year of operation with the change in scope of services. The cost report must include the FQHC's actual costs for the full fiscal year. If the FQHC is unable to submit a cost report within the 120 day timeframe, the FQHC may request one thirty-day extension for submission of the cost report by notifying the Department in writing at the address listed below at least one business day prior to the cost report submission due date. The request must detail why the extension is necessary. The Department will deny an FQHC's request for a thirty-day extension for submission of the cost report, if the FQHC does not demonstrate good cause for the extension.

The FQHC's final rate(s) will be determined via a desk review and/or audit of the FQHC's cost report. The FQHC will be notified in writing of its final PPS adjusted rate(s), upon completion of the desk review and/or audit. The final rate(s) will be used for final reconciliation and will be the prospective payment rate(s) going forward. The notice will include information regarding the FQHC's appeal rights.

Final Reconciliation

In accordance with 55 Pa.Code § 1101.69 (relating to overpayment-underpayment), the Department will use the final reconciliation process to reimburse the FQHC for any underpayment or to recover any overpayment based on the difference between its final PPS rate(s) and interim rate(s). If the FQHC receives an overpayment, a uniform period will be established for the recoupment of the overpayment from the FQHC, according to the guidelines established in 55 Pa.Code § 1101.69a (relating to establishment of a uniform period for the recoupment of overpayments from providers).

Stub Period

When the effective date of a change in scope of services differs from the first date of an FQHC's fiscal year, a "stub" period is created. The "stub" period is the effective date of the change in scope of services through the last day of the provider's fiscal year. All "stub" periods will undergo final reconciliation to the regular rate(s), established from the first full year of the FQHC's operation with the change in scope of services, less the Medicare Economic Index percentage for the applicable rate year.

Example of a “stub” period:

The FQHC’s request for change in scope of services is approved by HRSA with an effective date of September 1, 2011. The provider’s fiscal year runs from January 1, 2011 through December 31, 2011. In this example, the “stub” period runs from September 1, 2011 through December 31, 2011.

Interim Rate Adjustment

The FQHC may request an interim rate adjustment, pending the determination of final rates based on a change in scope of services. The Department will review the rate adjustment request and the FQHC’s submitted documentation. If the documentation indicates that the PPS rate would be increased by more than 20%, the Department will make an interim PPS rate adjustment. The FQHC will be notified of the Department’s decision on the request for an interim rate adjustment. The notice will include information regarding the FQHC’s appeal rights.

To request an interim rate adjustment, providers should submit a cost report containing the most recent fiscal year’s actual costs, a detailed budget of the projected costs expected to be generated by the new service(s) and the number of projected encounters expected to be generated by the new service(s).

If the FQHC’s request is denied, the Department will determine the final rate after it receives the cost report with the FQHC’s actual costs from the first full fiscal year of operation reflecting the change in scope of services and has performed a desk review, and/or audit of the cost report.

Procedure:

The FQHC must submit the following, within 30 days of the issue date identified in block 1 of HRSA’s Notice of Grant Award:

1. a copy of the HRSA Notice of Grant Award approving a change in scope of services; and
2. a cover letter to the Department that describes the service that has been added or deleted from the FQHC’s scope of service, and the effective date.

All of the above items are to be submitted to the Department at the following address:

DPW/OMAP/BFFSP
DGS Complex
Cherrywood Building
49 Beech Drive
Harrisburg, Pennsylvania 17110
Attention: Division of Rate Setting

FQHC/RHC MEDICAL ASSISTANCE PROGRAM COST REPORTING

I. Required Documents for Filing of Cost Report

- FQHC/RHC Medical Assistance Program Cost Report for each active FQHC/RHC entity;
- Any supplemental documents that might be needed to verify amounts shown as “other”.

NOTE: The RHC must submit a FQHC/RHC Medical Assistance Program Cost Report only when requesting a dental encounter rate for the provision of dental services.

Filing of FQHC/RHC Medical Assistance Program Cost Report

The FQHC/RHC must file upon request, with the Bureau of Fee-for-Service Programs, an FQHC/RHC Medical Assistance Program Cost Report along with any required supplemental documents, covering costs based on the latest fiscal year of operation of the clinic. The FQHC/RHC Medical Assistance Program Cost Report, on a format prescribed by the Department of Public Welfare, is due 120 days after the end of the normal fiscal period (“the normal fiscal period” for an FQHC/RHC is the clinic’s own fiscal year). A 30 day extension of the due date may, for good cause, be granted if a written request is received by the Office of Medical Assistance Programs prior to the expiration of the original 120 days. FQHC/RHC Medical Assistance Program Cost Reports may be filed for a period other than the clinic’s normal fiscal period only when necessitated by a facility’s termination of their agreement with the Office of Medical Assistance Programs, or by a change in ownership, or by a change in fiscal period.

Improperly completed or incomplete filings will be returned to the facility for proper completion and must be resubmitted to the Office of Medical Assistance Programs within 30 days. For the purpose of these guidelines, any filing that (1) uses any format other than the FQHC/RHC Medical Assistance Program Cost Report format approved by the Department of Public Welfare; (2) does not include all pages of all worksheets; (3) has an incomplete “Provider Identification and Certification” page; or (4) is illegible, will be considered an improperly completed or incomplete filing. Each required FQHC/RHC Medical Assistance Program Cost Report must be signed by the authorized individual who normally signs the FQHC’s/RHC’s federal income tax return or similar reports. If the FQHC/RHC Medical Assistance Program Cost Report is prepared by someone other than an employee of the clinic, the individual preparing the cost report must also sign and indicate his or her status with the FQHC/RHC.

If the requested Cost Report and supplemental documents are not submitted within the required time limit (including approved extensions), all payments will be suspended. This action will remain in effect until proper submission of all required documents.

II. Audit Requirements

- A. The FQHC/RHC provider (provider) shall submit on an annual basis a financial and compliance audit in accordance with the federal and state requirements listed below for all FQHC/RHC services provided pursuant to these standards. All audit reports must contain a schedule of FQHC/RHC reimbursable costs (Worksheet 4 of the FQHC/RHC Medical Assistance Cost Report). Costs incurred by the FQHC/RHC in complying with these audit requirements are reimbursable and should be included in the FQHC/RHC Medical Assistance Program Cost Report.

B. Federal and State Audit Requirements

The Provider must comply with all federal and state audit requirements including the Single Audit Act Amendments of 1996 (31 U.S.C. 7501 et. seq.) as promulgated by the Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Governments and Non-Profit Organizations, and any amendments to these regulations or circular. If the provider expends total federal awards of \$300,000 or more during its fiscal year, received either directly from the federal government or indirectly from a recipient of federal funds, the provider is required to have an audit made in accordance with the provisions of OMB Circular A-133.

The state requires that if the provider is a for-profit organization and expends total federal awards of \$300,000 or more during its fiscal year, received either directly from the federal government or indirectly from a recipient of federal funds, the provider is required to have a program-specific audit made in accordance with the provisions of OMB Circular A-133, and in accordance with the laws and regulations governing the programs in which it participates.

If the provider expends less than \$300,000 in total federal awards during its fiscal year, it is exempt from these audit requirements but may be required to meet the Department of Public Welfare requirements listed below. In either case, the provider is required to maintain records of federal and state funds and to provide access to such records by federal and state agencies or their designees.

C. Department of Public Welfare Audit Requirements

Government, non-profit, or for-profit providers must meet the Department of Public Welfare (Department) audit requirements. Where a single audit or program audit is conducted in accordance with the federal audit requirements detailed above, such an audit will be accepted by the Department provided that: (1) a full copy of the audit report is submitted to the Department as detailed below and (2) the prescribed Independent Accountant's Report on Applying Agreed-Upon Procedures is included in the audit package submitted to the Department.

In the absence of a federally required audit, the provider is responsible for the following audit requirements which shall be based upon the FQHC/RHC cost reporting period.

1. If the provider expends state funds of \$300,000 or more in connection with this agreement during the program year specified in these Guidelines, the provider is required to have a program-specific audit of those funds made in accordance with generally accepted Government Auditing Standards (The Yellow Book) as published by the Comptroller General of the United States and include the Independent Accountant's Report on Applying Agreed-Upon Procedures as prescribed below.
2. If the provider expends state funds of less than \$300,000 in connection with this agreement during the program year specified in these Guidelines, the provider is required to submit an Independent Accountant's Report on Applying Agreed-Upon Procedures as prescribed below.

D. Report on Applying Agreed-Upon Procedures

Where specified above, the provider is required to submit an Independent Accountant's Report on Applying Agreed-Upon Procedures (AUP) for the annual and/or final report(s) required in connection with this agreement. The AUP must be in the format and language provided below. Where an audit is also required, the AUP must be submitted to the Department as a part of the complete audit report package.

INDEPENDENT ACCOUNTANT’S REPORT ON
APPLYING AGREED-UPON PROCEDURES

To (Auditee)

We have performed the procedures enumerated below, which were agreed to by the Commonwealth of Pennsylvania, Department of Public Welfare (DPW) and (Auditee) solely to assist you with respect to the Schedule of Federally Qualified Health Center Reimbursable Costs (Worksheet 4) required by the Federally Qualified Health Center Provider Guidelines. This engagement to apply agreed-upon procedures was performed in accordance with standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the DPW. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures and associated findings are as follows:

- A. That management of the (Auditee) have certified that the Schedule of the Federally Qualified Health Center’s Reimbursable Rates (Worksheet 4) have been accurately compiled in accordance with the provisions of the FQHC Reimbursement Guidelines.
- B. We have verified by comparison to the sample provided that Worksheet 4 reflects the audited books and records of the (Auditee) and is presented, at a minimum, at the level of detail and in the format required by the Guidelines.
- C. We inquired of management regarding any adjustments to reported costs which should be made for the period in question.
- D. The processes detained in paragraphs a., b. and c. above disclosed the following adjustments and/or findings which have (have not) been reflected on the corresponding schedules.

We were not engaged to, and did not, perform an audit, the objective of which would be the expression of an opinion on the specified elements, accounts, or items. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the use of the Department of Public Welfare and should not be used by those who have not agreed to the procedures and taken responsibility for the sufficiency of the procedures for their purposes. However, this report is a matter of public record and its distribution is not limited.

(Date)

(Signature)

E. Audit Report Submission and Technical Assistance

1. Federally Required Audit Reports

For required audit reports containing no current period findings or summary schedule of prior audit findings, the provider shall submit the Certificate of Audit to the Office of the Budget, Single Audit Coordinator at the address listed below.

For federally required audit reports containing period findings or summary schedule of prior audit findings, the provider shall submit five copies of the single audit report package, or three copies of the program-specific report package, to the Office of the Budget, Single Audit Coordinator at the address listed below. The audit report package includes:

- Certificate of Audit;
- Financial statements and schedule of expenditures of federal awards;
- Summary schedule of prior audit findings;
- Auditors' reports on the financial statements and schedule of expenditures of federal awards, internal control and compliance as well as a schedule of findings and questioned costs;
- Corrective action plan; and
- Management letter comments.

In instances where a federal program-specific audit guide is available, the audit report package for a program-specific audit may be different and should be prepared in accordance with the audit guide and OMB Circular A-133.

The audit report package should be submitted to:

Commonwealth of Pennsylvania/Office of the Budget
Comptroller Operations/Bureau of Audits
Division of Subrecipient Audit Review
303 Walnut Street
Bell Tower – Strawberry Square – 6th
Floor Harrisburg, Pennsylvania 17101
Telephone: (717) 783-9210 FAX: (717) 783-0361

After processing of the report by the Bureau of Audits, a copy will be sent to the Department of Public Welfare. Technical assistance on federal requirements will be provided by the Bureau of Audits.

2. Department of Public Welfare Submission Requirements

The provider shall submit one copy of the complete audit report package (not just the Certificate of Audit) to the address listed below for all audits pertaining to

funding provided by or through the Department of Public Welfare regardless of any other submission requirements. Reports on Applying Agreed-Upon Procedures required by the Department should also be sent to this address.

Department of Public Welfare
Bureau of Financial Operations
Audit Resolution Section
Bertolino Building – Third Floor
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Telephone: (717) 787-8890 FAX: (717) 772-2522

Technical assistance on the Department's audit requirements and the integration of those requirements with the federal Single Audit requirements will be provided at this address.

3. Technical assistance regarding issues specific to the FQHC program requirements will be provided by the Office of Medical Assistance Programs.

F. Period Subject to Audit

A federally required audit made in accordance with the federal audit requirements generally encompasses the fiscal period of the provider. Therefore, the period of the federally required audit may differ from the official cost reporting period as specified in these guidelines. Where these periods differ, the required supplemental schedule and Report on Applying Agreed-Upon Procedures must be completed for the official cost reporting period which ended during the period under audit and shall accompany the federally required audit.

G. Corrective Action Plan

The provider shall prepare a Corrective Action Plan (CAP) to address all findings of non-compliance or internal control weaknesses discussed in the audit report. For each finding noted, the CAP should include: (1) a brief description identifying the finding; (2) whether the provider agrees or disagrees; (3) the specific steps to be taken to correct the deficiency or specific reasons why corrective action is not necessary; (4) a time table for completion of the corrective action steps; and (5) a description of monitoring to be performed to ensure that the steps are taken.

H. Auditor Qualifications

The provider is responsible for obtaining the necessary audit and securing the services of a certified public accountant or other independent governmental auditor. Federal regulations preclude public accountants licensed in the Commonwealth of Pennsylvania from performing audits of federal awards.

I. Audit Work in Addition to the Requirements of these Guidelines

The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional audits of a financial or performance nature, if deemed necessary by Commonwealth or federal agencies. Any such additional audit work will rely on work already performed by the recipient agency's auditor, and the costs for any additional work performed by the federal or state agencies will be borne by those agencies at no additional expense to the Provider.

J. Audit Record Retention

The provider's auditor must maintain audit working papers and audit reports for a minimum of three years from the date of issuance of the audit report unless the provider's auditor is notified in writing by the Commonwealth or the cognizant or oversight federal agency to extend the retention period. Audit working papers shall be made available upon request to authorized representatives of the Commonwealth or the Federal Government.

K. Final Settlements

After the audit and the FQHC/RHC Medical Assistance Program Cost Report have been accepted and a final settlement is issued, clinics may not request any future retroactive settlement payment for the audit period.

Accounting and Record Keeping:

FQHC/RHC Medical Assistance Program Cost Reports must be completed by each FQHC/RHC operating a center or clinic in the Commonwealth of Pennsylvania and seeking payment for the provision of FQHC/RHC services. In addition, an audit report which covers the Medical Assistance Program must also be submitted. FQHCs/RHCs in contiguous states which see MA patients must file a Pennsylvania FQHC/RHC Medical Assistance Program Cost Report.

FQHC/RHC Medical Assistance Program Cost Reports must be prepared in conformance with:

1. The accrual basis of accounting.
2. The provisions of these guidelines (HIM-15)
3. Any situations not covered would be based on GAAP.

The FQHC/RHC must maintain, for a period of not less than four years from the end of the fiscal year of the FQHC/RHC Medical Assistance Program Cost Report, financial and clinical records, for the period covered by such cost report, which are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved issues at the end of this four-year period, the records must be maintained until these issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC/RHC or they will be disallowed.

The Office of Medical Assistance Programs, Bureau of Fee-for-Service Programs will maintain each required FQHC/RHC Medical Assistance Program Cost Report submitted by the clinic for four years following the date of submission of the report. In the event there are unresolved issues at the end of this four-year period, the FQHC/RHC Medical Assistance Program Cost Report will be maintained until such issues are resolved.

The financial and clinical charts, including receipts documenting all transactions of the FQHC/RHC, must be available for review by personnel legally authorized to audit confidential records, such as staff of the Office of the Pennsylvania Inspector General, the Office of the Pennsylvania Auditor General, the Department of Public Welfare, Office of Medical Assistance Programs, the Office of the Public Health and Human Services Comptroller, the Office of the Pennsylvania Attorney General, and/or the United States Department of Health and Human Services in conformity with the provisions of the Federal Social Security Act and Article 3 of the Pennsylvania Medical Assistance FQHC/RHC Provider Agreement.

REASONABLE COSTS

(Sections 2100, 2102 and 2103, HCFA 15-1)

The Medical Assistance Program will determine if costs are reasonable and allowable by applying Medicare cost reimbursement principles, as defined by federal regulations at 42 CFR, Section 413, the Medicare Provider Reimbursement Manual (HCFA 15-1), and any other regulations mandated by the federal government.

Reasonable costs of any services are determined in accordance with Medicare regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the Medical Assistance Program will not be borne by others not so covered, and the costs with respect to individuals not so covered will not be borne by the Medical Assistance Program. In other words, costs related to non-paying patients who are not MA recipients may not be shifted to the Medical Assistance Program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. It is the intent of the Medical Assistance Program that those FQHCs/RHCs will be reimbursed the actual costs of providing health care, except where a particular institution's costs are found to be substantially out of line with other institutions in the same geographic area which are similar in size, scope of services, utilization, and other relevant factors. "Utilization" for this purpose refers not to the FQHC's/RHC's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., patient mix, age of patient, type of illness, location, language barriers, etc.)

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the FQHC/RHC always seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious private-pay buyer pays for a given item or service.

If costs are determined to exceed the level that such buyers incur, in the absence of clear documentary evidence (such as Request for Proposal (RFP) materials, solicitation of bids, price lists and other such materials) that the higher costs were unavoidable, the excess costs are not reimbursable under the Medical Assistance Program. Along these lines, FQHCs/RHCs are required to have written fee schedules. Such fee schedules must be submitted annually along with the cost report for review by authorized personnel of the Department of Public Welfare. (Medicare fee schedules are not acceptable.)

REIMBURSABLE COSTS:

(Sections 2102.2 and 2102.3, HCFA 15-1)

A. Costs Related to Patient Care. These include all necessary and proper costs which are appropriate in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the FQHC's/RHC's activity. They include health care personnel costs, costs of health care employee pension plans, insurance and other such costs. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

B. Direct Health Care Costs. Costs that can be identified specifically with a particular final cost objective. These costs must be related to patient care. Below are examples, but should not be considered all inclusive:

- Medical record and medical receptionist costs;
- Malpractice insurance costs for "Look-Alike" clinics; and
- Dues of personnel to professional organizations that are directly related to the individual's scope of practice. (Limited to one professional organization per professional.)

NOTE: For FQHC entities who are §329, 330, 340 or 340A grantees, and who have malpractice insurance coverage under the Federal Tort Claims Act, only costs related to necessary "tail liability insurance" are allowable.

C. Overhead Costs.

Overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Below are examples of overhead costs, but should not be considered all inclusive:

- Administrative costs;
- Billing department expenses;
- Audit costs;
- Reasonable data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes);

- Space costs;
- Employee transportation and travel expenses (if related to operating the clinic; reimbursement level based on the lesser of actual non-first class/non-luxury costs or dollar limits outlines in the state travel regulations – See Appendix A);
- Dues to industry organizations (limited to that portion of dues that are not grant funded or used by organizations for political or lobbying activities per HCFA 15-1, Section 2139. This is limited to two industry organizations per clinic)*; and
- Liability insurance costs.

***PLEASE NOTE:** Membership dues paid to organizations such as the Pennsylvania Association of Community Health Centers, the National Association of Community Health Centers (NACHC), Pennsylvania Society of Physician Assistants, Pennsylvania Community Providers Association, American Academy of Physician Assistants, Pennsylvania Medical Society, Hospital and Healthsystem Association of Pennsylvania, Pennsylvania Dental Society, American Academy of Family Physicians, Pennsylvania Home Care Association, Pennsylvania Pharmaceutical Association, Pennsylvania Manufacturers Association, and similar associations, as well as specific other political parties and PACS DO include political lobbying costs. Section 2139 of the Medicare Provider Reimbursement Manual specifically warns that political contributions and lobbying costs are not allowable, and that this disallowance includes that portion of contributions and membership fees paid to associations or organizations that directly or indirectly cover campaigns, lobbying, or any other political purpose. It, therefore, is incumbent upon the clinic or center to submit proof that the entire amount of any membership fee paid to such organizations is solely and entirely for educational or other purposes involving the direct or indirect care of patients at the FQHC/RHC. In the absence of such proof, the entire amount of such membership fees will be denied as non-compensable.

Limitation of membership to two industry organizations per clinic may be waived by the Department subsequent to a case-by-case review of the justification submitted by the clinic entity requesting such a waiver.

NON-COMPENSABLE COSTS

Costs will be disallowed if not documented, necessary, ordinary and related to the provision of health care and related services to authorized patients. Below is a list of non-compensable cost. This list should not be considered all inclusive:

- A. Entertainment, i.e., costs for office parties/social functions, costs for event tickets, costs for flowers, cards for illness and/or death, retirement gifts, patient or employee awards, gifts and/or parties/social functions, and related meals and lodging, as well as travel or other activities for employee or patient recreation (such as “youth” or company sports teams, community gardening projects, dance troupes, or clubs). These costs also cannot be included as a part of employee benefits. Spousal/companion travel costs are also not compensable. (Sections 2100 and 2102.3, HCFA 15-1)

- B. Board of Director Fees – Travel expenses related to mileage, meal, and lodging costs to conferences and registration fees for meetings if not directly related to the provision of patient care and the operation of the clinic. When allowable, the reimbursement level is based on the lesser of actual non-first class (non-luxury) costs or the dollar limits specified in the state travel regulations (See Appendix A). Costs associated with board elections and political or lobbying activities are also non-compensable. (Sections 2100, 2102.3 and 2139, HCFA 15-1)
- C. Federal, state, local and other income taxes, and excise taxes. (Section 2122.2, HCFA 15-1)
- D. Professional Licenses – Costs of professional licenses for individual practitioners and other professional employees, when such are not included in employee fringe benefit packages and are not reported to the IRS.
- E. Costs associated with the use of unlicensed unpaid (volunteer) or paid health care practitioners. (Section 704.7, HCFA 15-1)
- F. Costs associated with the acceptance of unrestricted grants, donated monies, goods and services, such as storage costs for donated items, and costs/fees related to accounting for unrestricted grants or endowments. (Since unrestricted grants, gifts and endowments may not be required to be used to reduce operating costs in computing reimbursable cost, the Commonwealth deems costs associated with such as non-compensable.) (Section 600, HCFA 15-1)
- G. Fines, penalties and judgments, including costs associated with paying traffic tickets and the like.
- H. Bad debts and cost of action by outside staff or agencies to collect receivables.
- I. Advertising, except for the recruitment of personnel, procurement of goods and services, and disposal of medical equipment and supplies. Costs associated with promotional marketing/advertising items are non-compensable, but minimal “yellow page” type advertising is reimbursable. (Section 2136.1 and 2, HCFA 15-1)
- J. Contingency reserves except for those items legally mandated or identifiable to a specific allowable liability, or cost center.
- K. Legal, accounting and professional services incurred in connection with hearings and rehearings, arbitrations, or judicial proceedings against the Department of Public Welfare.
- L. Fund raising expenses. (See Item F above.)
- M. Amortization of goodwill.

- N. Membership dues for public relations purposes, including country or fraternal club memberships. (Sections 328 and 2139, HCFA 15-1)
- O. Political or charitable contributions, including courtesy allowances, and lobbyist reimbursement. (Sections 328 and 2139, HCFA 15-1)
- P. Costs allocable to the use of a vehicle for personal use. If an employee typically uses a vehicle to commute, for example, the costs related to commuting must be apportioned out and the proper documentation filed with the Internal Revenue Service. Costs associated with the use of vehicles solely for official clinic business or patient transport only are allowable. (Section 2102.3, HCFA 15-1)
- Q. Costs allocable to the use of a pager, cellular telephone or computer for personal use. (This includes costs related to the use of on-line services such as, America On-Line, Delphi, CompuServe, the Microsoft Network, Internet Service Providers, and others if such charges include linkage to entertainment centers such as Citizens Band (CB) Chat rooms, the Internet Relay Chat (IRC), AOL Chat rooms, games, forums, shopping services, Bulletin Boards, etc.) The supplying of computer game systems such as “Nintendo”, “Sega”, or the like for employee or patient use is non-compensable. Clinics whose cost reports include these items must have copies of all applicable invoices, etc. available for Department review upon request. (Section 2102.3, HCFA 15-1)
- R. Costs applicable to services, facilities, and supplies furnished by a related organization (Related Party Transactions) in excess of the lower of cost to the related organization, or the price of comparable service as rendered by a non-related entity. (Section 1000, HCFA 15-1)
- S. Costs associated with real estate mortgages, rentals or leases for the purpose of residential housing, or the operation, repair and/or maintenance of public or private housing units, boarding homes, group homes, shelter-type housing facilities, “half-way houses”, or “community living arrangements”. (Section 2102.3, HCFA 15-1)
- T. Costs associated with the rental of building or office space to others, including the cost of maintaining space used, rented or leased by other facilities or entities who are not health care providers or who are enrolled in the Medical Assistance Program under another provider type with a discrete MAID number.

NOTE: Costs associated with the operation of Related Parties affiliated with the FQHC/RHC such as laboratories, pharmacies, home health agencies, family planning clinics, and others should be listed on the FQHC/RHC Medical Assistance Program Cost Report as non-FQHC/RHC costs, if these independently enrolled providers share FQHC/RHC space. (This provision does not prohibit the FQHC/RHC from contracting with an affiliated provider type, subject to the limitations under the section, “Related Party Transactions”.)

- U. Vending machine, food and beverage service and/or pay telephone expenses including restocking and repair costs. Such are, by their very nature, self-supporting, and may even provide a profit to the clinic. (Section 2105.2, HCFA 15-1)
- V. Costs associated with the provision of satellite or cable television or radio services. Costs related to the provision of intercom, regular local television, local radio or “muzak” service is reimbursable. (Section 2106, HCFA 15-1)
- W. Costs associated with the provision, acquisition, construction or maintenance of unusual or luxury accommodations and items. Such items may include both costly and ornate office furnishings, (artworks and expensive and extraordinary outdoor or indoor landscaping appointments such as gardens, fountains, architecture, and the like), and cosmetic dentistry or surgery, spa-type facial or body treatments for cosmetic or relaxation purposes, designer eyeglass frames, weight-loss programs and their associated food products (Weight Watchers, Jenny Craig, Diet Workshop or the like), sunglasses, health clubs, medication or treatment for baldness not directly related to a disease process, saunas, etc. (Costs related to the acquisition of usual and customary medical equipment and treatment, ordinary landscaping and ordinary building/parking lot maintenance, are reimbursable.) (Sections 2103 and 2104.3, HCFA 15-1)
- X. Costs associated with the operation of vocational-technical, social rehabilitation or job training programs or employment counseling services for either employees or non-employees of the clinic, and/or educational expenses associated with the pursuit of degrees. Staff training required to enhance the quality of health care provided within the clinic is reimbursable. (Sections 400 and 2104.5, HCFA 15-1)
- Y. Costs associated with the operation of a senior citizen center, Retired Senior Volunteer Program (RSVP), adult day care or child day care/”head start” center. (Section 2102.3, HCFA 15-1)
- Z. Costs associated with the development of “medical models”, research projects, experimental treatments, and any medical services, procedures or drugs related to infertility therapy, including the dispensing of VIAGRATM or any other medication for the treatment of male or female sexual or psychosexual dysfunction, which is not directly related to disease. (Section 500, HCFA 15-1; Section 442.6(f), Pennsylvania Act 1994-49)

In addition to the aforementioned, any other costs not directly or indirectly related to patient care are non-compensable.

Non-FQHC/RHC COSTS

Some examples of services/costs which are not reimbursable by the Medical Assistance Program (show as non-FQHC/RHC on FQHC/RHC Medical Assistance Program Cost Report):

- A. Women, Infant and Children (WIC) Program. Any costs related to the WIC Program, or professional services provided as part of the WIC Program by an FQHC nutritionist

(including overhead) are not reimbursable by the Medical Assistance Program. The WIC Program is fully funded by the federal government under the auspices of the Pennsylvania Department of Health. (Clinics experiencing “shortfalls” in WIC Program financing should apply to the Pennsylvania Department of Health for assistance.)

- B. Education except for training and staff development required to enhance job performance for employees of the FQHC/RHC. This category includes costs related to education/conferences for clinic staff involved with legislative and/or lobbying activities. Burden of proof rests with the FQHC/RHC
- C. Healthy Beginnings Plus (HBP) Program - for clinics or centers enrolled as HBP Program providers, costs related to that program are not reimbursable as FQHC/RHC services. The clinic may bill using the HBP Program Fee Schedule only.
- D. Outreach, except for the following types of activities: Informing target population of available services through use of telephone yellow pages, brochures, and handouts and meetings with patient groups to discuss availability of specific health care services. Advertising on or in public transportation vehicles, kiosks, or billboards for outreach purposes is not reimbursable.
- E. Assisting other health care professionals in the provision of off-site training, such as dental screening and blood pressure checks.
- F. Public Relations, such as assisting a client in dealing with another agency and/or provider, when such assistance does not relate to the provision of medical or health services to the client. (Such as helping a client find employment or debt counseling services, housing searches, school/educational/vocational counseling, patient or employee “thank you” gifts or banquets, costs involved with “photo-op” or newspaper social page notices, media interviews, public relations photography, promotional advertising items, public service announcements, publications and newsletters, etc.)
- G. Community Services, such as general presentations to churches, social groups, “health fairs”, skits and plays, etc.
- H. Environmental Activities designed to protect the public from health hazards, such as toxic substances in drinking water, environmental lead detection or abatement services, etc. (Lead screening and treatment costs are reimbursable.)
- I. Except for services provided subsequent to an EPSDT screen, as documented in the patient’s medical record, services that are not included in the federally-approved State Plan.

NOTE: Recipients over age 20 may not be offered non-State Plan services unless they are first informed of their obligation to pay (personally) for such services.

In addition to the aforementioned, any other costs (overhead and administration) related to the operation of other types of providers who are Related Parties of the FQHC/RHC, but who have their own separate MAID number, are also non-FQHC/RHC costs.

Disputes

All questions or disputes arising between the parties hereto respecting payment pursuant to the terms of the Agreement should be referred to the Office of Hearings and Appeals of the Department of Public Welfare for adjudication.

The provisions of the Agreement apply to services rendered by FQHCs/RHCs on or after the date the new FQHC/RHC Provider Agreement was signed. All other provisions of the original Provider Agreement remain in full force and effect.

B. FQHC/RHC Medical Assistance Program Cost Report Form and Instructions (as included in Guidelines, Procedures and Standards for FQHCs/RHCs)

FQHC/RHC WORKSHEET INSTRUCTIONS

OVERVIEW

USE OF WORKSHEETS

All federally-funded 329, 330, 340, and 340A grantee or FQHC “look-alike” health centers desiring reimbursement based on reasonable cost must use the FQHC/RHC worksheets. RHCs desiring reimbursement based on reasonable cost for dental services must use FQHC/RHC worksheets.

These forms are required for the determination of a Medicaid rate of payment for services reimbursable on such a basis.

The FQHC/RHC must complete the Provider Identification and Certification Page and all pages of Worksheets 1, 2, 3, and 4. These worksheets provide general information and summarize the number of encounters furnished and the costs of FQHC/RHC services.

FQHC/RHC Medical Assistance Program cost reports must be submitted one hundred twenty (120) days after the close of the FQHC’s/RHC’s fiscal year.

ALL-INCLUSIVE PAYMENT RATE METHODOLOGY

The worksheets are used to determine the all-inclusive rate of payment for FQHCs/RHCs.

All costs and expenses reported must be in harmony with the principles of reasonable cost reimbursement as found at 42 CFR 413 and HCFA Publication 15-1 (Provider Reimbursement Manual). Clinics and centers must be prepared to give detailed information regarding all cost centers. “Other” and “miscellaneous” cost centers must include supporting lists, schedules, and other explanatory documentation in order to be considered reimbursable. See Schedule 10 of provider handbook.

The FQHC/RHC worksheets delineate the rate calculation process. All calculations must be carried to two decimal places.

PROVIDER IDENTIFICATION AND CERTIFICATION PAGE

GENERAL INFORMATION (These items **MUST** be completed or the cost report will be returned to the FQHC/RHC.)

Item 1: FQHC/RHC NAME AND HOME OFFICE ADDRESS. Enter the full name and the Home Office address of the FQHC/RHC.

Item 2: TELEPHONE NUMBER. Enter the Home Office telephone number. Item

3: FAX NUMBER. Enter the Home Office fax number.

Item 4: PROMIS^eTM NUMBER. Enter the FQHC/RHC PROMIS^eTM provider number. (DO NOT ENTER THE MEDICARE NUMBER.)

Item 5: REPORTING PERIOD. Enter the inclusive dates covered by this report. A reporting period is a period of 12 consecutive months for which the FQHC/RHC must report its costs and utilization. The first and last reporting periods may be less than 12 months.

Item 6: FEDERAL TAX ID NUMBER. Enter your Federal Tax ID Number.

Item 7: TYPE OF CONTROL. Check the type of control or auspices under which the clinic is conducted.

Item 8: GRANT SOURCES. Show the source and amounts of all grants or other income the clinic or center may be receiving. (Includes revenues from physicians and others who assign their fees to the FQHC/RHC.)

Item 9: FQHC/RHC OWNED BY. Enter the name of the organization(s) or individual(s) who are the legal owner(s) of the FQHC/RHC, or if FQHC/RHC is controlled by a non-profit organization, so state.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC. This certification must be signed by the cost report preparer and the Chief Executive Officer or other authorized person.

PREPARER OF REPORT. Enter the name and telephone number of the person who prepared the report in case further information or clarification of the report is required.

DETAILED INSTRUCTIONS

WORKSHEET 1 – CLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

This worksheet provides for recording the trial balance of expense accounts from the FQHC's/RHC's accounting books and records. The worksheet also provides for any necessary reclassification and adjustments to these accounts.

Not all of the listed cost centers will apply to each FQHC/RHC. For example, a FQHC/RHC might not employ radiology technicians and would not, in that case, complete line 6. The worksheet also provides blank lines for clinic costs and cost centers in addition to those listed in the form. If the worksheet does not provide sufficient space, enter aggregate amounts on

Worksheet 1 under “Other”, where appropriate, and furnish a cost breakdown on worksheet 10 to list and identify items included in the aggregate amounts.

WORKSHEET 1 – COLUMN DESCRIPTION

Column 1 through 4 – FQHC/RHC Expenses

The expenses listed in these columns must be compensable and must be in accordance with the FQHC’s/RHC’s accounting books and records.

Enter on the appropriate lines in columns 1 through 4 the total expenses incurred during the reporting period. The expenses must be detailed between compensation (column 1), fringe benefits (column 2), purchased and contract services (column 3), all other costs pertinent to the allowable cost centers (column 4). Any needed reclassifications and adjustments must be recorded in columns 6 and 8, and should be explained on Worksheet 1A and Worksheet 1B, as appropriate.

If there is insufficient space to list all “Other” items, the facility should enter aggregate amounts and complete worksheet 10 listing and identifying those items and the amounts applicable.

Column 5 – Total

This column displays the totals of columns 1 through 4. No entry is required.

Column 6 – Reclassification

This column is used to reclassify expenses among the cost centers for proper grouping of expenses. Reclassifications are used in instances in which the expenses applicable to more than one of the cost centers listed on the worksheet are maintained in the FQHC’s/RHC’s accounting books and records in one cost center. For example, if a physician performs some administrative duties, the appropriate portion of his compensation, and applicable payroll taxes and fringe benefits, would need to be reclassified from “FQHC/RHC Core Health Care Cost” to “FQHC/RHC Overhead Administration”. Reduction to expenses should be shown in parenthesis (). All reclassifications must be explained on Worksheet 1A. The net total of the entries in column 6 must equal zero.

Column 7 – Reclassified Trial Balance

This column is the sum of columns 5 and 6. No entry is required. The total of column 5 on line 80 must equal the total of 7 on line 80.

Column 8 – Adjustments

This column is used to indicate the amount of any adjustments to FQHC’s/RHC’s reclassified expenses. Adjustments may be required to increase or decrease expenses in accordance with the rules on reimbursable costs. All adjustments must be described on Worksheet 1B.

Decreases to expenses are shown in parenthesis ().

Column 9 – Net Expenses

This column is the sum of columns 7 and 8. No entry is required.

WORKSHEET 1 – LINE DESCRIPTIONS

Lines 1 – 21 – A. Direct (Core) Medical Care Costs.

On lines 1 through 21, the costs of the FQHC's/RHC's core health services are entered by cost center. Total compensation received by members of the National Health Service Corps. (NHSC) is a reimbursable cost. Centers should show total actual payments (including what the FQHC/RHC paid) to NHSC staff in column 1 – Compensation. The portion of the NHSC staff compensation paid by the NHSC should be shown as a decrease in column 8.

Include only those items directly related to patient care which have not been included in any other cost center. The following services should be excluded: dental costs, overhead, cost attributable to non-FQHC/RHC cost centers such as community outreach, public relations, etc.

Include on line 10 only those EPSDT services that are not included in the Medicaid State Plan. All EPSDT services which are covered in the Medicaid State Plan should be included on the appropriate line, such as: Dental Services, Worksheet 1, Page 2, lines 29 to 39. Furnish a supporting schedule listing and identifying the types of services provided and their costs.

Line 22 – Total Core Medical Costs

Line 22 is the total cost of FQHC/RHC core health care services equal to the sum of lines 1 – 21. Excludes dental, overhead and non-FQHC/RHC cost centers. No entry is required.

Lines 23 – 26 – B. Other Ambulatory Services (Non-Dental)

Enter on these lines the costs directly related to the provision of pharmacy, optometry, DME, and other ambulatory services provided by the FQHC/RHC. Attach additional sheets if necessary. Include only those items that are directly related to patient care which have not been included in any other cost center.

Line 27 – Total Other Ambulatory Services (Non-Dental) (Sum of lines 23 – 26). No entry is required.

Lines 28 – 37 – C. Other Ambulatory Services – Dental Only

Line 38 – Total Dental Costs (Sum Lines 28 – 37) No entry is required.

Line 39 – Total Direct FQHC Health Care Costs

Displays the sum of lines 22, 27, and 38. No entry is required.

Lines 40 – 47 – D. Non-FQHC/RHC Cost Centers (Excluding Overhead)

Enter on these lines the cost of services that are not reimbursable under the Medical Assistance Program. The cost of these services and encounters attributable to these non-covered services are excluded in determining the total reimbursable health care and overhead costs for the FQHC/RHC rate of payment.

Line 48 – Total Non-FQHC/RHC Costs

Displays the total of lines 40 through 47. No entry is required.

Line 49 – Total Direct Costs

Displays the total of direct (core) medical care costs, other ambulatory services costs, dental costs, and non-FQHC/RHC service costs. It is the sum of lines 39 and 48. No entry is required.

Lines 50 – 78 – FQHC/RHC Overhead Cost

Enter on these lines the overhead cost related to the FQHC's/RHC's facility, administration and management of the FQHC/RHC. This includes the cost to own, lease or rent, and to maintain FQHC/RHC buildings and building equipment.

Examples:

Line 58 – Supplies

Enter on this line the supplies for administration, management, and facility. If total supply costs are shown on this line, reclassify the appropriate amounts to the applicable cost center on lines 1 through 49.

Line 60 – Insurance

Enter on this line the liability and other insurance for administration, management, and facility. Do not include medical malpractice insurance. Furnish a supporting schedule listing and identifying the types of insurance held.

Line 65 – Depreciation

Enter on this line depreciation for the building and any other assets utilized by the administration, management, or facility departments. Reclassify all other depreciation to the appropriate cost centers. (Refer to Worksheet 1B.)

If aggregate costs are placed in "Other", line 69, the facility must submit a worksheet 10 listing those items and the applicable amounts. Failure to submit worksheet 10 will render items included in the "Other" cost center non-reimbursable.

Line 79 – Total Overhead

Displays the sum of lines 50 through 78. No entry is required.

Line 80 – Total Cost

Displays the total cost of operating the FQHC/RHC and is the sum of lines 49 and 79. No entry is required. Total costs as reported on line 80 must reconcile to the audited financial statements.

WORKSHEET 1A – SCHEDULE OF COST RECLASSIFICATIONS

This worksheet provides for the reclassification of certain amounts to effect the proper cost allocation. The cost centers affected should be specifically identifiable in the facility's accounting records. Reclassifications are used in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet 1 are maintained in the facility's accounting books and records in one cost center. For example, if a physician performs administrative duties, the appropriate portion of his/her compensation, payroll taxes, and fringe benefits should be reclassified from "Facility Health Care Staff Cost" to "Facility Overhead".

WORKSHEET 1B – SCHEDULE OF ADJUSTMENTS OF EXPENSES

This worksheet provides for the adjustments to the amounts listed on Worksheet 1, column 8.

Types of items to be entered on this worksheet are (1) those needed to adjust expenses incurred, (2) those items which constitute recovery of expenses through sales, charges, fees, etc., and (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement. (See HCFA Pub. 15-1, §2328.)

When an adjustment to an expense affects more than one cost center, the facility must record the adjustment to each cost center on a separate line on this worksheet.

EXAMPLES OF ADJUSTMENTS

Investment Income on Commingled Restricted and Unrestricted Funds – Investment income or restricted and unrestricted funds which are commingled with other funds must be applied together against, but should not exceed, the total interest expense included in allowable costs. (See HCFA Pub. 15-1, §202.2.)

The investment income on restricted and unrestricted funds which are commingled with other funds should be applied against the Administrative, Depreciation – Buildings and Fixtures, Depreciation – Equipment, and any other appropriate cost centers on the basis of the ratio that interest expense charged to each cost center bears to the total interest expense charges to all of the facility's cost centers.

Home Office Costs – Enter on this line allowable home office costs which have been allocated to the facility. Additional sheets of paper should be used to the extent that various facility cost centers are affected. (See HCFA Pub. 15-1, Chapter 21.)

Elimination of Lobbying Costs from Membership Fees – Enter the amount which represents that portion of any dues paid to industry organizations that directly or indirectly covers campaigns, lobbying or any other political purpose. (See HCFA Pub. 15-1, §2139.)

Practitioner Assigned National Health Service Corps – Enter the amount which represents the reasonable value of the services furnished by NHSC personnel above the amounts actually paid by the FQHC/RHC.

Depreciation – Buildings and Fixtures and Depreciation – Equipment – Where depreciation expense computed in accordance with Medicare Principles of Reimbursement differs from depreciation expenses per your books, enter the difference on lines 9 and/or 10.

WORKSHEET 1C – RELATED ORGANIZATIONS

In accordance with 42 CFR 413.17, cost applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your

allowable cost at the cost to the related organization except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the clinic by organizations related to you. In addition, certain information concerning the related organizations with which you have transacted business is shown. (See HCFA Pub. 15-1, Chapter 10.)

PART A If there are any costs included in Worksheet 1 which resulted from transactions with related organizations, as defined in HCFA Pub. 15-1, Chapter 10, check the “Yes” box and complete Parts B and C.

PART B Costs Incurred and Adjustments Required – Cost applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such costs must not exceed the amount a prudent and cost-conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

Complete each line as necessary and complete all columns for each of those lines.

Column 1

Enter the line number from Worksheet 1 which corresponds to the cost center for which the adjustment is being made.

Column 2

Enter the cost center from Worksheet 1 for which the adjustment is being made.

Column 3

Enter the item of service, facility, or supply which you obtained from the related organization.

Column 4

Enter the cost to your organization for the service, facility, or supply which was obtained from the related organization.

Column 5

Enter the allowable cost of the service, facility, or supply which was obtained from the related organization. The allowable cost is the lesser of the cost of the service, facility, or supply to the related organization, or the amount a prudent and cost-conscious buyer pays for a comparable service, facility, or supply purchased elsewhere.

Column 6

Enter the amount in Column 4 minus the amount in Column 5. Transfer the(se) amount(s) to the corresponding line of Worksheet 1, Column 8.

PART C Interrelationship to Organizations Furnishing Services, Facilities, or Supplies – Use this part to show your interrelationship to organizations furnishing services, facilities, or supplies to you. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership to you, or control over you as defined in HCFA Pub. 15-1,

Chapter 10, is shown in Columns 1 through 6, as appropriate.

Only those columns which are pertinent to the type of relationship which exists are completed.

Column 1

Enter the appropriate symbol which describes your interrelationship to the related organization.

Column 2

If the symbol A, D, E, F, or G is entered in Column 1, enter the name of the related individual in Column 2.

Column 3

If the individual indicated in Column 2, or the organization indicated in Column 4 has a financial interest in you, enter the percent of ownership.

Column 4

Enter the name of the related organization, partnership, or other organization.

Column 5

If you or the individual indicated in Column 2 has a financial interest in the related organizations, enter the percent of ownership in such organization.

Column 6

Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen services).

WORKSHEET 2 – FQHC/RHC PROVIDER STAFF, ENCOUNTERS AND PRODUCTIVITY

Worksheet 2 is used by the facility to summarize the number of facility visits furnished by the health care staff and to calculate the number of visits to be used in the rate determination. Productivity standards established by the Centers for Medicare and Medicaid Services are applied as a guideline that reflects the total combined services of the staff. A level of 4,200 visits for each physician and a level of 2,100 visits for each non-physician core service practitioner is applied.

A level of 2,600 visits (equal to about 1.25 patients per hour, for a 40 hour workweek) has been applied for dentists, dental hygienists and public health dental hygiene practitioners.

Lines 1 through 18 list the types of practitioners (positions) for whom facility visits must be counted and reported.

The determination of a “full-time equivalent employee” (FTE) is based on the following:

The number of FTEs of each type (i.e., physician, physician assistants, or nurse practitioners) is determined by dividing the total number of hours worked by all employees of that type by the GREATER OF:

- a. The number of hours per year for which one employee of that type must be

compensated to meet the clinics definition of a full-time employee. (If the center/clinic is open on a full-time basis, the usual definition of a FTE is 2,080 hours per year – 40 hours per week for 52 weeks; $40 \times 52 = 2,080$).

- b. 1,600 hours per year (40 hours per week for 40 weeks; $40 \times 40 = 1,600$).

Column 1

Record the number of all FTE personnel for each of the applicable practitioner types in the facility practice.

Columns 2 and 3

Record the number of on-site and off-site visits actually furnished to all patients by all personnel for each of the applicable practitioner types in the reporting period.

Column 4

Displays the sum of columns 2 and 3. No entry is required.

Column 5

These are the minimum number of visits required for each FTE employee according to established productivity standards. No entry is required.

Column 6

These are the minimum number of facility visits the personnel in practitioner type are expected to furnish. Displays the product of Column 1 multiplied by Column 5. No entry is required.

Column 7

Displays the greater of the visits in Column 4 or Column 6 for each line. This will be the visits used in the determination of a cost per visit for the facility. No entry is required.

LINE DESCRIPTIONS

Lines 1 through 14 of this worksheet are to be used to list statistics for providers of core services who are employees or who have contracted with the FQHC/RHC.

Line 7 – EPSDT Treatment Services

Refers to treatment services prescribed to correct or alleviate conditions uncovered by an EPSDT screen. Include on this line only those EPSDT encounters which have applicable service costs that are not included in the Medicaid State Plan. For EPSDT treatment service costs which are covered in the Medicaid State Plan, the respective hours and encounters of such services should be included on the appropriate line, such as Dentists, Worksheet 2, Line 17.

Line 8 – Physician Services under Agreement

Enter the number of visits furnished to facility patients by physicians under agreement with the facility. “Physicians’ services under agreements” with the facility means: (1) All medical services performed at the facility site by a physician who is not the owner or an employee of the

facility, and (2) Medical services performed at a location other than the facility site by such a physician for which the physician is compensated by the facility. While all physician services at the facility site are included in FQHC/RHC services, physician services furnished in other locations by physicians who are not on the full-time staff of the facility are paid to the facility only if the facility agreement with the physician provides compensation for such services.

Line 15 – Grand Total of all Medical Services

Enter the total of lines 6 through 14.

Lines 6 through 14 are to be used to list statistics for providers of other ambulatory services who are employees or who have contracted with the FQHC/RHC.

Line 16 – Dentists

Line 17 – Dental Hygienists Services

Line 18 – Public Health Dental Hygiene Services

Line 19 – Total Dental Services

Enter the total of lines 16, 17 and 18.

Line 20 – Grand Total Services

Enter the total from lines 15 and 19.

WORKSHEET 3 – TOTAL ENCOUNTERS AND DETERMINATION OF APPLICABLE OVERHEAD

This worksheet is used to calculate both the provider encounters for determining the FQHC/RHC rate of payment and the overhead costs applicable to FQHC/RHC services.

Part A – Provider Encounters for Determination of FQHC/RHC Rate of Payment

This part is used to summarize provider encounters for rate determination. No entry is required.

Part B – Medical Assistance Encounters

This part is used to summarize the number of medical encounters and dental encounters made by Medical Assistance recipients as recorded in the clinic records (see Federally Qualified Health Center Encounter/Rural Health Clinic Encounter under “Definitions”).

Part C – Determination of Overhead Applicable to FQHC/RHC Services

This part is used to calculate the reimbursable overhead costs applicable to FQHC services. No entry is required.

WORKSHEET 4 – SCHEDULE OF FQHC/RHC REIMBURSABLE RATES

This worksheet will be used to calculate reimbursable rates for medical and dental encounters. Overhead costs are distributed between the medical and dental categories based on the distribution of ambulatory costs. This schedule is also to be included in all Auditors’ reports as part of the minimum program specific audit requirements. No entry is required.

WORKSHEET 5 – SALARY AND WAGE ANALYST

This worksheet is used to compile information related to employee salaries and wages

Column 1 – Enter the line number from Worksheet 1 where the employee’s salaries are reported. In cases where an employee’s salary is reported on more than one Worksheet 1 line multiple entries should be made on Worksheet 5 so that each employee’s salary can be traced to Worksheet 1.

Column 2 – Enter each employee’s last name.

Column 3 – Enter each employee’s first name.

Column 4 – Enter each employee’s job title.

Column 5 – Enter the professional license number for applicable employees. Applicable employees include but are not limited to Physicians, Certified Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, Physicians Assistants, Clinical Psychologist, Clinical Social Worker, Dentists, Public Health Dental Hygiene Practitioners and Dental Hygienists.

Column 6 – Enter the full time equivalent (FTE) information for applicable employees. Applicable employees include Practitioner Types as listed on worksheet 2. FTEs reported on this worksheet must support FTEs reported on Worksheet 2.

Column 7 – Enter total wages paid to each employee. The total of Column 7 should support total salary and wages as reported on line 80 of column 1 on worksheet 1.

WORKSHEET 6 - SITE LOCATIONS

This worksheet is used to compile information related to your various FQHC/RHC site locations.

Column 1 – No entry is required.

Column 2 – Enter the 4 digit service location number for each FQHC/RHC site location.

Column 3 – Enter your Medicare Number for each FQHC/RHC location.

Column 4 – Enter the site name for each FQHC/RHC site location.

Column 5 – Enter the street address for each FQHC/RHC site location.

Column 6 – Enter the city for each FQHC/RHC site location.

Column 7 – Enter the State for each FQHC/RHC site location.

Column 8 – Enter the zip code for each FQHC/RHC site location.

Column 9 - Enter the county for each FQHC/RHC site location.

WORKSHEET 7 – SITE INFORMATION

This worksheet is used to compile information related to your various FQHC/RHC site locations.

Column 1 – No entry is required.

Column 2 – No entry is required.

Column 3 – Enter the site telephone number for each FQHC/RHC site location.

Column 4 – Enter a contact person for each FQHC/RHC site location.

Column 5 – Enter the contact person’s job title.

Column 6 – Does the site location provide medical services to MA patients? Enter Yes or

No. Column 7 – Does the site location provide dental services to MA Patients? Enter Yes or

No. Column 8 – Is the FQHC/RHC site location Owned or Leased?

Column 9 – Enter the annual lease payments for each leased FQHC/RHC site location. Submit a copy of the lease along with the name and address of the landlord, for each leased FQHC/RHC site location, as supporting documentation.

WORKSHEET 8 – SITE HOURS

Column 1 – No entry is required.

Column 2 – No entry is required.

Columns 3 through 16 - Enter the hours of operation for each FQHC/RHC site location.

WORKSHEET 9 – COST BREAKDOWN OF OUTSIDE SERVICES

This worksheet is used to provide detailed information regarding cost reported in column 3 of worksheet 1.

Column 1 – Enter the cost report line you are providing detail for.

Column 2 – Enter the name of the vendor that provided the service.

Column 3 – Enter a brief description of the purchased service.

Column 4 – Enter the cost of each service purchased. Please note that the sum of column 4 must support the sum of column 3 on worksheet 1.

Column 5 – Enter the professional license number if service is provided by a professional practitioner.

Column 6 – Enter the word contract if you have a formal written contract with the vendor providing the service. Enter FFS if the service is provided on a fee-for-services basis. **Do not send in copies of your contracts.**

WORKSHEET 10 - COST BREAKDOWN OF OTHER EXPENSES AND MISCELLANEOUS EXPENSE

The purpose of this worksheet is to provide detailed information regarding costs with generic descriptions in the trial balance.

Column 1 – Enter the cost report line you are providing detail for.

Column 2 – Name of the vender providing the goods or services purchased.

Column 3 – Enter a brief description of the goods or services purchased.

Column 4 – Enter the cost paid for the goods or services.

WORKSHEET 11 – LABORATORY INFORMATION

The purpose of this worksheet is to provide information regarding provider operated laboratories

Column 1 – Enter the CLIA number for all provider operated laboratories.

Column 2 – Enter the effective date of each CLIA certification.

Column 3 – Enter the end date of each CLIA certification.

Note – Submit copies of all CLIA certifications as supporting documentation.

Column 4 – Enter the PA Department of Health Laboratory (PDHL) license number.

Column 5 - Enter the effective date of the PA Department of Health Laboratory license.

Column 6 – Enter the end date of the PA Department of Health Laboratory license.

Note – Submit copies of all PA Department of Health Laboratory Licenses as supporting documentation.

Column 7 – Enter the street address of the laboratory.

Column 8 – Enter the city where the laboratory is located.

Column 9 – Enter the state where the laboratory id located.

Column 10 – Enter the zip code where the laboratory is located.

WORKSHEET 12 RELATED QUESTIONS.

Please answer each question on this worksheet and submit supporting documentation as requested.

SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THE FQHC/RHC MEDICAL ASSISTANCE PROGRAM COST REPORT

1. A trial balance. A trial balance which is cross referenced to worksheet 1 must be submitted.
2. A depreciation schedule which supports the amount of depreciation reported on worksheet 1 must be submitted.
3. A copy of all leases disclosed on worksheet 7 must be submitted. Please make sure that landlord contact information is included.

4. A copy of all loan documents related to interest expense reported on worksheet 1 must be submitted.
5. A copy of your audited financial statement which is reconciled to line 80 of worksheet 1.
6. A copy of all CLIA certificates for each laboratory reported on worksheet 11
7. A copy of the Pennsylvania Department of Health Laboratory license for each reported on Worksheet 11.
8. A copy of your Department of State Board of Pharmacy Permit if applicable.
9. A copy of your Pennsylvania Department of Health Medical Supplier Certificate of Registration if applicable.
10. A copy of your Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs (BDAP) approval notice if applicable.
11. A copy of your Medicare Home Health Agency / Hospice Certificate if applicable.
12. A copy of your Out-Patient Mental Health Clinic License if applicable.
13. A cost breakdown of line 15 and 33 professional organization dues. Please include the following information: the professional's name, job title, name of the organization joined, purpose of the organization and cost of membership.
14. A cost breakdown of line 59 Dues to Industry Organizations. Please include the following information Name of the industry organization, purpose of the organization and the cost of membership.

Add New Cost Report to File

To obtain a free version of the FQHC/RHC Medical Assistance Program Cost Report in Microsoft Excel format, please e-mail the Bureau of Fee-for-Service Programs within the Office of Medical Assistance Programs at FQHCRHC@state.pa.us.

SETTLEMENT REPORT

Dear Administrator:

Attached is a revised copy of the FQHC/RHC monthly MCO Settlement Report and Instructions.

ALL PRIOR VERSIONS OF THE MCO SETTLEMENT REPORT AND INSTRUCTIONS ARE NOW VOID AND SHOULD BE DISCARDED.

This report (Worksheet 5, Schedules A and B) and instructions have been revised to:

1. Include Rural Health Clinics as approved providers who may submit the MCO Settlement Report;
2. Change the requirements for reporting adjustments that may occur throughout the clinic fiscal year;
3. Specify that MCO settlements will be paid on the basis of the prospective payment system rate.

You are to use these revised worksheets for reporting all MCO encounter and payment activity effective October 1, 2002 (third quarter 2002). Prior versions of the MCO form will no longer be accepted by the Office of Medical Assistance Programs. The new MCO settlement form may be copied as necessary, but may not be modified in any way.

Please direct questions regarding this form and its instructions to the Division of Rate Setting within the Bureau of Fee-for-Service Programs to Mr. Samuel D. Caramela (scaramela@state.pa.us) or via telephone at (717) 265 – 7831.

OFFICE OF MEDICAL ASSISTANCE PROGRAMS
FEDERALLY QUALIFIED HEALTH CENTER/RURAL HEALTH CLINIC
MONTHLY MCO SETTLEMENT REPORT INSTRUCTIONS

The Office of Medical Assistance Programs will provide reimbursement for the difference between the established Prospective Payment System Rate and the amounts paid to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for encounters provided to Medical Assistance recipients.

The purpose of these instructions is to inform FQHCs and RHCs of the quarterly reporting requirements that must be followed for Managed Care (MCO) encounters.

REPORT FORMAT

A separate Report Worksheet for Managed Care encounters and receipts must be completed for each **month** of the calendar quarter. These reports are to be filed on Worksheet 5, the “Federally Qualified Health Center/Rural Health Clinic MCO Settlement Report”. This Worksheet will become part of the FQHC/RHC Medical Assistance Program Cost Report and will be subject to

the same audit requirements as the FQHC/RHC Medical Assistance Program Cost Report. A copy of the “Federally Qualified Health Center/Rural Health Clinic MCO Settlement Report”, Worksheet 5, Schedule A is attached. Please make copies of this Worksheet as needed.

The supporting documentation for the encounters and receipts will be the records maintained by the FQHC/RHC. The verification of Managed Care encounters and receipts will be a component of periodic audits performed by the Office of the Public Health and Human Services Comptroller.

REPORTING TIME PERIODS

PLEASE SEE THE WARNING ABOUT LATE SUBMISSION OF THESE REPORTS UNDER THE SECTION ENTITLED “DATE OF QUARTERLY REPORT”.

Regular calendar year quarters will constitute reporting time periods. For example, all managed care encounters provided to Medical Assistance recipients from October 1, 2002 through December 31, 2002 will be included on the Medical Assistance MCO Settlement Reports for the calendar quarter ending December 31, 2002. In total there will be three (3) Settlement Report Worksheets for this calendar quarter, each Report Worksheet detailing encounters and receipts for each month within the quarter.

DETAILED INSTRUCTIONS

Worksheet 5, Schedule A, Page 1

An encounter is a face-to-face contact between a patient and the physician, dentist, PHDHP, nurse, or mid-level practitioner who exercises independent judgment in the provision of health care services. A telepsych encounter is a real-time, two-way interactive audio-video transmission between a patient and only the FQHC/RHC psychiatrist or psychologist, who is licensed by the Commonwealth of Pennsylvania to provide mental health services. A telepsych encounter is only payable under the Behavioral Health Managed Care delivery system. To meet the encounter criterion for independent judgment, ***the physician, dentist, nurse or mid-level practitioner must act independently and not assist another practitioner.*** RHCs and FQHCs may report only one encounter per patient, per day. Clinics may not report a medical services encounter (physician, CRNP/CRNA, midwife, other nurse, psychologist or physician assistant) and a family planning encounter or EPSDT screen encounter for the same patient on the same day. Clinics may not report a dentist encounter and a dental hygienist encounter for the same patient on the same day. A PHDHP or a dental hygienist is credited with an encounter only when (s)he provides services independently, not jointly with a dentist.

Due to regulatory requirements, FQHCs/RHCs may not report Mobile Therapy, Therapeutic Staff Support, or Behavioral Health Consultant encounters unless they have obtained special licensure from the Office of Mental Health and Substance Abuse Services (OMHSAS) and obtained Special Enrollment indicators from the Office of Medical Assistance Programs.

HMO Columns 2 – 15: Report the number of MA beneficiary encounters by practitioner type for each HMO with which the FQHC/RHC has participated within the reporting month.

Do not list encounters from affiliated providers that have their own PA PROMIS^eTM Provider Numbers and that are enrolled in PA PROMIS^eTM as provider types other than an FQHC/RHC whether or not the affiliated provider has a separate MCO contract. Do not report encounters associated with rejected MCO claims, such as claims for ineligible persons.

Column 16 (Total MA MCO Encounters): This column is the sum of rows for HMO columns 2 – 15.

Line 1: List the number of encounters for which physician services were rendered for each HMO. Physician services include services by obstetricians, gynecologists and psychiatrists (including telepsych encounters).

Line 2: List the number of encounters for which CRNP/CRNA services were rendered for each HMO. Include services provided by midwives. Do not include RN services.

Line 3: List the number of encounters for which RN services were rendered.

Line 4: List the number of encounters for which licensed psychologist services were rendered (including telepsych encounters).

Line 5: List the number of encounters for which licensed clinical social worker services were rendered. The definition for “clinical social worker” as stated in Chapter IV, Section 419.2 of the Centers for Medicare and Medicaid Services RHC/FQHC Manual applies. *Do not list non-clinical social services encounters.*

Line 6: List the number of encounters for which physician assistant services were rendered.

Line 7: List the number of any other type of medical services-related encounter rendered by a licensed practitioner. Specify the type of encounter (add additional sheets if necessary).

Line 8: Sum of lines 1 – 7.

Line 9: List the number of encounters for which dentist services were rendered.

Line 10: List the number of encounters for which dental hygienist services were rendered. *Do not include encounters during which the hygienist assisted the dentist or rendered services to the same patient on the same date as the dentist.*

Line 11: List the number of encounters for which PHDHP services were rendered. *Do not include encounters during which the PHDHP assisted the dentist or rendered services to the same patient on the same date as the dentist.*

Line 12: EPSDT treatment services include encounters only for services rendered as the result of an EPSDT screen and that are not included in the State Plan for Medical Assistance. Due to regulatory requirements, FQHCs/RHCs may not report Mobile Therapy, Therapeutic Staff

Support, or Behavioral Health Consultant encounters unless they have obtained special licensure from the Office of Mental Health and Substance Abuse Services (OMHSAS) and obtained Special Enrollment indicators from the Office of Medical Assistance Programs.

EPSDT services that are covered in the State Plan should be included on the appropriate line, such as dentist services, Line 9. Furnish a supporting schedule listing and identifying the types of services provided.

Line 13: Other: List any other type of ambulatory services encounters that cannot be specifically included in lines 1 – 12. Do not list laboratory tests, X-rays and pharmacy visits as encounters.

Line 14: Total Other Ambulatory Services: Sum lines 9 – 13.

Line 15: Total Medical Assistance MCO Encounters: Sum lines 8 and 14. ***ENTER THE TOTAL NUMBER OF MCO ENCOUNTERS HERE.***

Line 16: Total Medical Encounters for All MA Recipients: List the total monthly number of medical encounters for **ALL** Medical Assistance recipients served at Column 16, whether or not those recipients were enrolled in an HMO or other Managed Care Organization. Generally, this number should not be the same as the total entered on Line 15, Column 16. ***DO NOT ENTER THE TOTAL NUMBER OF HMO/MCO MEDICAL ENCOUNTERS,*** unless your clinic or center sees only HMO/MCO patients.

Line 17: Total Dental Encounters for All MA Recipients: List the total monthly number of dental encounters for **ALL** Medical Assistance recipients served at Column 16, whether or not those recipients were enrolled in an HMO or other Managed Care Organization. Generally, this number should not be the same as the total entered on Line 15, Column 16. ***DO NOT ENTER THE TOTAL NUMBER OF HMO/MCO DENTAL ENCOUNTERS,*** unless your clinic or center sees only HMO/MCO patients.

Worksheet 5, Schedule A, Page 2

Columns 2 – 15: HMO #: Enter the amount of dollars received by payment classification (Lines 1 – 6) for each HMO with which the FQHC/RHC has participated within the reporting month. For Line 7 in these Columns, add Lines 1 – 6.

Column 16: TOTAL MA HMO RECEIPTS: Sum of line entries for Columns 2 - 15.

NOTE: Worksheet 5, Schedule A, Page 2 should be accompanied by copies of Remittance Advice Documents or checks from the MCO that support the reported dollars paid.

Date of Quarterly Report: Providers will submit the MA MCO Settlement Reports for the given quarter of the calendar year not later than 25 days following the end of that quarter. This will allow for most, if not all, MCO receipts for the quarter to be received by the submission date of the report.

Up to three (3) five-day extensions (for a total of 15 days) will be granted by the Office of Medical Assistance Programs **for cause** if an FQHC/RHC submits a request for such prior to the end of the 25 day period. Requests for extension of time to file may be submitted by either mail or fax.

WARNING – LATE SUBMISSION: ALL REPORTS MUST BE RECEIVED BY THE OFFICE OF MEDICAL ASSISTANCE PROGRAMS/BUREAU OF FEE-FOR-SERVICE PROGRAMS BY THE 40TH DAY FOLLOWING THE END OF THE APPLICABLE CALENDAR QUARTER. SUBMISSIONS AFTER THE 40TH DAY MUST BE ACCOMPANIED BY A COVER LETTER FULLY EXPLAINING THE REASON FOR THE LATE SUBMISSION. CONTINUED FAILURE TO SUBMIT THE REPORTS ON TIME WILL RESULT IN SUSPENSION OF INTERIM PAYMENTS.

No Payment for Services Not Covered or Reimbursed by the MCO: According to Section 4712(b) of the federal Balanced Budget Act of 1997 and the federal SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, DPW is required to make supplemental payments to FQHCs/RHCs equal to the difference, if any, between the amounts *paid* to FQHCs/RHCs by MCOs with which they have a contractual relationship and the amount that the FQHC/RHC would have received under the Prospective Payment System (PPS). This means that the FQHC/RHC must have received an MCO payment for every encounter claimed on Schedule A of the MCO Settlement Report.

If no MCO payment has been received by your FQHC/RHC for the services provided (service not covered; patient not eligible at time of service; claim rejected by MCO), you may not claim encounters for those services on Schedule A. Furthermore, if the MCO has refused payment to your FQHC/RHC because your clinic does not have a contract with the MCO or your clinic or center is not the primary care provider for the patient(s) in question, DPW is not required to make Section 4712(b) supplemental payments to your clinic. You may not include such encounters on Schedule A of the MCO Settlement Report.

Adjustments for Prior Periods: An adjustment or revision for a prior period is a correction to an earlier report. Adjustments for prior periods will only occur as necessary to separate MCO encounters by rate period. Providers must post all MCO encounters that relate to services rendered during a particular rate period on the MCO Settlement Reports that related to that rate period. For most providers the typical rate period is October 1 through September 30. However, rate periods can vary for newly enrolled providers or previously enrolled providers who have had a change in scope of services. Providers are required to submit MCO Settlement Report Worksheets for all such revisions.

Example: A provider with a rate period beginning October 1, 2005 and ending September 30, 2006, provides services that meet the definition of an encounter to an MA recipient on September 28, 2006. The provider should report this encounter on the September encounter schedule submitted with their Quarterly MCO Settlement Report for the quarter ending September 30, 2006. The receipts for this encounter should be reported in the month received regardless of rate period. If the MCO denies payment for this encounter on November 18, 2006, the provider must revise their Quarterly MCO Settlement report for the quarter ending September 30, 2006.

Within any given rate period, FQHCs/RHCs must report encounters in the month in which they

occur and report receipts in the month in which they are paid. Also, within a given rate period, providers are not required to prepare revised MCO Settlement Reports if the MCO denies encounters in a subsequent quarter within the same rate period. In these cases the provider should reduce encounters in that quarter. All such reductions should be documented in a cover letter accompanying the Quarterly MCO Settlement submission.

Reconciliation Process: Based on the provider's MCO Settlement Reports for a given calendar quarter, the Office of Medical Assistance Programs will compare the MCO dollars received by the FQHC/RHC to what the FQHC/RHC would have received under the Medical Assistance Program's Prospective Payment System. If the overall aggregate payment based on the Prospective Payment System rate is higher than the total amount of MCO dollars received, the provider will receive the difference within four to eight weeks of the Office of Medical Assistance Programs' receipt of the provider's report. If the total MCO dollars paid for the quarter exceed what would have been paid based upon the Prospective Payment System rate, the Commonwealth will initiate recovery of the difference.

The monthly MCO Settlement Reports for each month of the FQHC's/RHC's own fiscal year will be included in the FQHC's/RHC's annual overall settlement. Final settlement will be determined as the difference between the overall aggregate payment due based upon the provider's Prospective Payment rate and all Medical Assistance payments made on behalf of all Medical Assistance recipients served. If the final settlement results in an underpayment, the Commonwealth will pay the difference. If the final settlement results in an overpayment, the Medical Assistance Program will arrange repayment from the FQHC/RHC.

Retroactive Revisions of Final Settlements Prohibited: Unless appeals have been timely filed, the Department will not consider any requests for retroactive revision of any final settlement processed for prior rate periods. FQHCs/RHCs must notify the Office of Medical Assistance Programs, Bureau of Fee-for-Service Programs, Division of Rate Setting within 30 days of any discrepancy involving claims or payments included in cost settlement.

PA PROMISE™
837 Professional/CMS-1500 Claim Form

Provider Handbook

Appendix E – FQHC/RHC

FEDERALLY QUALIFIED HEALTH CENTER/RURAL HEALTH CLINIC MCO SETTLEMENT REPORT

WORKSHEET 5, SCHEDULE A

FQHC/RHC NAME:

REPORTING MONTH:

MAID#

| ENCOUNTER DETAIL-SHOW ALL MEDICAL ASSISTANCE REIMBURSABLE MCO ENCOUNTERS (See Instructions) | | | | | | | | | | | | | | | |
|---|----------|----------|----------|----------|----------|----------|----------|----------|-----------|-----------|-----------|-----------|-----------|-----------|---------------|
| | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 | Column 7 | Column 8 | Column 9 | Column 10 | Column 11 | Column 12 | Column 13 | Column 14 | Column 15 | Column 16 |
| | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | Total HMO Enc |
| Direct (Core Med Svcs) | | | | | | | | | | | | | | | |
| HMO Name(s) | | | | | | | | | | | | | | | |
| 1. Physician | | | | | | | | | | | | | | | |
| 2. Cert Reg. Nurse Pract/Midwife | | | | | | | | | | | | | | | |
| 3. Other Nurse | | | | | | | | | | | | | | | |
| 4. Licensed Psychologist | | | | | | | | | | | | | | | |
| 5. Licensed Clinical/Social Worker | | | | | | | | | | | | | | | |
| 6. Physician Assistant | | | | | | | | | | | | | | | |
| 7. Other (Specify) | | | | | | | | | | | | | | | |
| 8. Total Core Med Svcs (Lines 1-7) | | | | | | | | | | | | | | | |
| Other Ambulatory Services | | | | | | | | | | | | | | | |
| 9. Dentist | | | | | | | | | | | | | | | |
| 10. Dental Hygenist | | | | | | | | | | | | | | | |
| 11. Public Health/Dental Hygenist | | | | | | | | | | | | | | | |
| 12. EPSDT Treatment Svcs | | | | | | | | | | | | | | | |
| 13. Other (Specify) | | | | | | | | | | | | | | | |
| 14. Total Other Amb Svcs (Lines 9-13) | | | | | | | | | | | | | | | |
| 15. Total Medical Assistance MCO Encounters (Sum Lines 8 and 14) | | | | | | | | | | | | | | | |
| 16. Total Med Encounters for ALL MA Recipients | | | | | | | | | | | | | | | |
| 17. Total Dental Encounters for all MA Recipients | | | | | | | | | | | | | | | |

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

Intentional misrepresentation or falsification of any information contained on these worksheets may be punished by fine and or imprisonment under Federal and/or State laws.

I hereby certify that I have examined the accompanying Worksheets prepared by: _____ for the reporting 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 FQHC in accordance with applicable instructions except as noted: _____.

Signature/Officer or Administrator of FQHC _____ Title _____ Date _____ Telephone _____

Revised 09/2010 BFFSP/OMAP/DPW

FEDERALLY QUALIFIED HEALTH CENTER/RURAL HEALTH CLINIC MCO SETTLEMENT REPORT

WORKSHEET 5, SCHEDULE A

Page 2 of 2

FQHC/RHC NAME:

REPORTING MONTH:

MAID#

| PENNSYLVANIA MEDICAL ASSISTANCE MANAGED CARE RECEIPTS - DETAIL ALL MEDICAID MANAGED CARE RECEIPTS | | | | | | | | | | | | | | | |
|---|----------|----------|----------|----------|----------|----------|----------|----------|-----------|-----------|-----------|-----------|-----------|-----------|--------------|
| | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 | Column 7 | Column 8 | Column 9 | Column 10 | Column 11 | Column 12 | Column 13 | Column 14 | Column 15 | TOTAL MA |
| | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO # | HMO RECEIPTS |
| HMO Name(s) | | | | | | | | | | | | | | | |
| Date of Contract: | | | | | | | | | | | | | | | |
| 1. Capitation Payments | | | | | | | | | | | | | | | |
| 2. Case Management Fees | | | | | | | | | | | | | | | |
| 3. Fee-For-Services | | | | | | | | | | | | | | | |
| 4. Dental | | | | | | | | | | | | | | | |
| 5. Other (Specify) | | | | | | | | | | | | | | | |
| 6. Other (Specify) | | | | | | | | | | | | | | | |
| 7. Total Receipts (Lines 1-6) | | | | | | | | | | | | | | | |

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