FEDERALLY QUALIFIED HEALTH CENTERS

DIVISION OF MEDICAL ASSISTANCE

MEDICAID SCHEDULES

2016
INSTRUCTIONS

Effective for 2015 cost report year, the Medicaid schedules for the Medicaid Cost Report and Medicaid PPS Reconciliation have been combined. The instructions identify if specific schedules apply only to Cost Settled Providers or PPS Providers.

These schedules are effective for those FQHC providers whose Cost Reporting Period begins on or after 10/1/2014 and who were required to file the Medicare cost report on the CMS Form 224-14.

Cost Reporting Periods Beginning On or After October 1, 2014 and Ending on or Before:	Original Due Date	Revised Due Date	Extension
09/30/2015	02/29/2016	08/31/2016	184 days
10/01/2015 through 10/31/2015	03/31/2016	08/31/2016	153 days
11/01/2015 through 11/30/2015	04/30/2016	08/31/2016	123 days
12/01/2015 through 12/31/2015	05/31/2016	08/31/2016	92 days
01/01/2016 through 01/31/2016	06/30/2016	08/31/2016	62 days
02/01/2016 through 02/29/2016	07/31/2016	08/31/2016	31 days
03/01/2016 through 03/31/2016	08/31/2016	08/31/2016	0 days

Per the North Carolina State Plan, Attachment 4.19-B, Section 2 for FQHC providers:

Effective for dates of service occurring January 1, 2001 and after, FQHCs are reimbursed on a prospective payment rate. (PPS Provider)

Providers who elected to be reimbursed in accordance to the cost based methodology in effect on December 31, 2000, and who did not change their election prior to January 1, 2005 shall remain with that choice of cost based reimbursement methodology. (Cost Settled Provider)

North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

January 1, 2016

Dear FQHC Provider:

In accordance with the Medicaid Participation Agreement Paragraphs 6 and 7, FQHC providers are required to file an annual year ending cost report with the Division of Medical Assistance. Providers can access the cost reporting forms and instructions on-line at http://www.ncdhhs.gov/dma/cost/fqhcrhcreports.htm and select the appropriate cost report.

Your cost report is due by the end of the fifth month of the year ending service period. The following information **must** be submitted **along with your original Medicaid FQHC cost report**:

- A full copy of your facility's signed and certified Medicare cost report (CMS 224-14).
- A copy of your facility's "crosswalk" working trial balance with sufficient detail to support the Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicaid report.
- Defined chart of accounts.
- Log of bad debts, if applicable.
- Log of pneumococcal and influenza immunizations administered to Medicaid beneficiaries, if applicable.
- Financial Statements, audited or unaudited, at time of submission.
- List of all State and Federal grant revenues including the title of the grant and amount of revenues for the reporting period.

Please submit the above-referenced cost report and information to:

US Mail

Audit Section
Attn: Susan Simmons
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699–2501

Express Mail/Shipping

Audit Section
Attn: Susan Simmons
Division of Medical Assistance
333 East Six Forks Road, Suite 200
Raleigh, NC 27609

If a settlement is due the Medicaid program, make check payable to ***Division of Medical Assistance*** for the amount due and remit it under separate cover to:

DHHS Controller's Office
Accounts Receivable Medical Assistance
2022 Mail Service Center
Raleigh, NC 27699–2022

If you have questions, please contact Susan Simmons at (919) 814-0027 or e-mail Susan.Simmons@dhhs.nc.gov.

Sincerely,

Katherine Cardenas, CPA
Audit Manager

DMA FQHC MEDICAID SCHEDULES
INSTRUCTIONS

RECOMMENDED SEQUENCE FOR COMPLETING MEDICAID SCHEDULES

The Medicaid Schedules are to be completed after the Medicare Cost Reporting Worksheets (FORM CMS-224-14 <01-10>) are completed.

Step Number	Schedule	Cost Report Page	Instructions
1	Facesheet	1	Page 3. Complete **Sections 1 – 6**.
2	DMA - 1	2	Page 4. Complete Schedule.
3	DMA - 2	3	Pages 5 - 6. Complete Schedule.
4	DMA - 3	4	Pages 7 – 8. Complete Schedule.
5	DMA - 4	5	Page 9 - 10. **Complete Lines 1-5.**
6	DMA - 5	6	Page 11. Complete Schedule.
7	DMA - 6	7	Page 12. Complete Schedule.
8	DMA - 7	8	Page 12 – 13. Complete Schedule.
9	DMA - 4	5	Page 9 - 10. **Complete Line 6**.
10	DMA – 8	9	Page 13 Complete Schedule.
11	DMA – 4	5	Page 9 – 10. **Complete Lines 7 - 12**
12	DMA - 9	10	Page 14. Cost-Settled Providers ONLY Complete Schedule.
13	DMA – 10A	11	Page 15. PPS Reconciled Providers ONLY Complete Schedule.
14	DMA-10B	12	Page 16. PPS Reconciled Providers ONLY Complete Schedule.

15	Facesheet	1	Pages 2 & 16. Complete **Certification Statement**.
16	Cost Report Checklist		Page 17. Ensure documents on the list are submitted to DMA.

DMA FQHC MEDICAID SCHEDULES
INSTRUCTIONS

DMA-SCHEDULES

GENERAL INFORMATION AND CERTIFICATION - PAGE 1 (Cost Settled and PPS)

Warning: If you downloaded the Excel spreadsheet and are keying data into a worksheet, please remember you need only key data into the lightly shaded cells. Each worksheet contains formulas that process data only from the shaded cells and will not work correctly if you make entries in unshaded fields.

Note: Please follow the recommended sequence for completing your cost report schedules to assure the data flows correctly for all schedules.

1. Enter name, address, county and telephone number.

2. Enter cost reporting period. This period must coincide with the Medicare Cost Report.

3. Enter all NPI numbers (and Medicaid provider numbers) assigned to facility. If additional space is needed, attach a separate sheet with the additional NPI and Medicaid provider numbers. If no Medicaid Provider Number is assigned after 7/1/2013, enter only the NPI.

4. Check appropriate box identifying type of control.

5. Enter the individual we should contact to answer questions about the cost report schedules, including the person's email address.

6. Enter the address we should mail all Medicaid settlements if different from the address of the facility in Item 1.

Certification Statement

Enter the full name of the facility and reporting period covered by the report.

Statement must be signed by officer or administrator of the facility **after** all schedules have been completed. The statement filed **must** have an original signature.

COST OF MEDICAID CORE SERVICES - PAGE 2 / DMA-1 (Cost Settled and PPS)

The purpose of this schedule is to compute Medicaid Core Cost based on the Medicare Cost Report and Medicaid visits from the provider records.

Columns

The rate is the Medicare settlement rate.

Line 1
Enter Cost per Covered Visit from CMS Form 224-14, W/S B, Part I, Line 13, Column 6.

Line 2
Enter Medicaid covered visits for all Core Services (including Mental Health Services) from provider's records.

Line 3
Compute total cost of all Core Services. Multiply Line 1 times Line 2.

COST OF OTHER AMBULATORY SERVICES - PAGE 3 / DMA-2 (Cost Settled and PPS)

The purpose of this schedule is to identify the cost of Ambulatory Services based on the Medicare Cost Report and compute overhead cost applicable to allowable Medicaid Ambulatory Services.

Line 1

Enter Cost of Other FQHC Services excluding overhead from Medicare Cost Report, Worksheet A, Column 7, Line 70 plus Line 77. This amount **must** agree with the total of Lines 1a – 1f.

Identify the cost of the Ambulatory Services furnished by the facility. Each facility determines which Ambulatory Services it will furnish.

Line 1a

Worksheet A, Column 7, Lines 60-69 of the Medicare Cost Report. Enter the amount corresponding to Cost of Dental Services.

Line 1b

Worksheet A, Column 7, Line 60-69 of the Medicare Cost Report. Enter the amount corresponding to Cost of Health Check Services (formerly EPSDT).

Line 1c

Worksheet A, Column 7, Lines 60-69 of the Medicare Cost Report. Enter the amount corresponding to Cost of Radiology Services (on site).

Line 1d

Worksheet A, Column 7, Lines 60-69 of the Medicare Cost Report. Enter the amount corresponding to Cost of Norplant Services.

Line 1e

Worksheet A, Column 7, Lines 60-69 of the Medicare Cost Report. Enter the amount corresponding to Cost of Physician Hospital Services.

Line 1f

Worksheet A, Column 7, Lines 60-69 and Line 77 of the Medicare Cost Report. Enter the amount Corresponding to Cost of Pharmacy Services.
NOTE: Include **all** pharmacy costs (retail pharmacy costs and FQHC pharmacy costs) on this line.

Line 1g

Worksheet A, Column 7, Line 60-69 of the Medicare Cost Report. Enter the amount corresponding to Cost of Other Medicaid Covered Services.

PAGE 3 / DMA-2 continued

Line 2

Enter cost of all services excluding overhead from Medicare Cost Report, W/S A, Column 7, Line 100 minus Line 13 plus Line 9.

Line 3

Enter percentage of Other FQHC Services. Divide Line 1 by Line 2.

Line 4

Enter Net Facility Overhead from Medicare Cost Report, W/S A, Column 7, Line 13 minus Line 9.

Line 5

Compute Overhead applicable to Other FQHC Services. Multiply Line 3 times Line 4. Transfer amount to Schedule DMA-3, Column 2, Line 3.

ALLOCATION OF OVERHEAD COST - PAGE 4 / DMA-3 (Cost Settled and PPS)

The purpose of this schedule is to allocate overhead costs to each ambulatory cost center and compute the average cost per encounter or unit of service.

Column 2

Lines 1a – f.
Transfer costs from Schedule DMA-2 / Page 3 to the corresponding cost center.

Line 2
Total of Lines 1a - g.

Line 3
Enter overhead cost from Schedule DMA-2 / Page 3, Line 5.

Line 4
Divide Line 3 by Line 2. Round this amount to the fifth decimal place (0.00000).

Column 3

Line 1a
Multiply Unit Cost Multiplier (Column 2, Line 4) times Dental Cost (Column 2, Line 1a) and enter amount on Line 1a.

Line 1b
Multiply Unit Cost Multiplier (Column 2, Line 4) times Health Check(formerly EPSDT) Cost (Column 2, Line 1b) and enter amount on Line 1b.

Line 1c
Multiply Unit Cost Multiplier (Column 2, Line 4) times Radiology Services Cost(Column 2, Line 1c) and enter amount on Line 1c.

Line 1d
Multiply Unit Cost Multiplier (Column 2, Line 4) times Norplant Services Cost (Column 2, Line 1d) and enter amount on Line 1d.

Line 1e
Multiply Unit Cost Multiplier (Column 2, Line 4) times Physician Hospital Services Cost (Column 2, Line 1e) and enter amount on Line 1e.

Line 1f

Multiply Unit Cost Multiplier (Column 2, Line 4) times Pharmacy Services Cost (Column 2, Line 1f) and enter amount on Line 1f.

PAGE 4/ DMA 3 continued

Line 1g

Multiply Unit Cost Multiplier (Column 2, Line 4) times Other Specified Cost (Column 2, Line 1g) and enter amount on Line 1g.

Line 2

Total of Lines 1a – 1g. Amount **must** agree with Overhead Cost in Column 2, Line 3.

Column 4

Lines 1a – 1g

Total of Columns 2 and 3 for each Line.

Line 2

Total of Columns 2 and 3.

Column 5

Lines 1a – 1g

Total number of encounters / units of service for <u>all</u> consumers served by the provider, including consumers with Medicare, Medicaid, Health Choice, private, self pay, and insurance.

Enter Encounters for Dental, Healthcheck, and Norplant. Enter units for Radiology, Physician Hospital, Pharmacy (including retail pharmacy), and Other.

Column 6

Lines 1a – 1g

Compute the average cost for each Ambulatory Service. Divide Column 4 by Column 5. Transfer amounts to Schedule DMA-4 / Column 2, Lines 1a – 1g.

DETERMINATION OF MEDICAID REIMBURSEMENT - PAGE 5 / DMA-4 (Cost Settled and PPS)

The purpose of this schedule is to compute the Medicaid cost of each Ambulatory Service based on the number of **Medicaid** encounters / units of service, Total Reimbursement Cost (Core and Ambulatory), and Amount Due Provider or Program.

Column 2

Lines 1a – 1g

Transfer costs from Schedule DMA-3 / Page 4 to the corresponding cost center.

Column 3

Lines 1a – 1g

Enter total number of **Medicaid** encounters / units of service furnished by the provider for each Ambulatory Service. This information is from the provider's records.

Enter Encounters for Dental, Healthcheck, and Norplant. Enter units for Radiology, Physician Hospital, Pharmacy, and Other.

Column 4

Lines 1a – 1g

Multiply Cost per Encounter (Column 2) times Number of Medicaid Encounters (Column 3).

Line 2

Enter Subtotal of Lines 1a – 1g.

Line 3

Enter sum of Medicaid cost for Physician Hospital Services from Column 4, Line 1e.

Line 4

Subtract Line 3 from Line 2.

Line 5

Enter Total Medicaid Core Cost transferred from Schedule DMA-1 / Page 2, Column 1, Line 3.

Line 6

Enter Total Medicaid Cost of Pneumococcal and Seasonal Influenza Vaccine Injections transferred from Schedule DMA-7 / Page 8, Column 3, Line 4.

Line 7

Enter Total Medicaid Cost of Graduate Medical Education Pass Through from DMA-8, Line 5.

Line 8

Enter Total of Lines 4, 5, 6 and 7.

PAGE 5 / DMA-4 continued

Line 9

Enter Amount Received / Receivable from Medicaid based on Core and Ambulatory Services furnished to Medicaid beneficiaries. Amount transferred from Schedule DMA-5, Page 6, Column 2, Line 6.

Line 10

Subtract Line 9 from Line 8.

Line 11

Enter Amount of Adjusted Reimbursable Bad Debts from Schedule DMA-6 / Page 7, Line 6.

Line 12

Compute Amount Due Provider (Program). Add Line 10 and Line 11.

DMA FQHC MEDICAID SCHEDULES
INSTRUCTIONS

SUMMARY OF MEDICAID PAYMENTS - PAGE 6 / DMA-5 (Cost Settled and PPS)

The purpose of this schedule is to identify Medicaid Received / Receivable amounts and provider numbers for which NC TRACKS rendered payments. These amounts are applicable to Core and Ambulatory Services furnished during the cost reporting period. **Carolina Access, Medicaid crossover and Medicaid Pregnancy Medical Home Incentive Payments (S0280 / S0281) are excluded. Co-payments for Ambulatory Services are included**.

Column 2

Lines 1a – 1g

Enter Received / Receivable amount for each Ambulatory Service based on the facility's records.

Line 2

Enter Received / Receivable amount for Core Services based on the facility's records

Line 3

Enter Received/Receivable Third Party Liability amount for Ambulatory and Core Services based on facility's records.

Line 4

Subtotal Lines 1a-1g, Line 2, and Line 3.

Line 5

Enter Received/Receivable amount for Physician Hospital Services from Line 1e.

Line 6

Compute Total Medicaid Payments. Subtract Line 5 from Line 4. Transfer this amount to Schedule DMA-4/Page 5, Column 4, Line 9 and Schedule DMA 9/Page 10, Line 6.

Column 3

Lines 1a – 1g

Enter NPI numbers used by NC TRACKS to make payments for each Ambulatory Service. Please note, if more space is needed, provider numbers may be listed in the comments section at the bottom of the page.

Line 2

Enter NPI numbers used by NC TRACKS to make payments for Core Services.

Line 3

Enter NPI numbers which Third Party Liability payments were made for Medicaid covered services.

BAD DEBTS - PAGE 7 / DMA-6 (Cost Settled and PPS)

The purpose of this schedule is to compute the amount of Net Bad Debts incurred by the facility.

Column 2

Line 1

Enter the total co-payment amount billed to Medicaid patients from the facility's records.

Line 2

Enter the co-payment amounts received from Medicaid patients from the facility's records.

Line 3

Compute Medicaid Bad Debts. Subtract Line 2 from Line 1.

Line 4

Enter any recovery of previous Medicaid amounts written off as Bad Debts from the facility's records.

Line 5

Compute Net Bad Debts. Subtract Line 4 from Line 3.

Line 6

Compute the Adjusted Reimbursable Bad Debts. Multiply Line 5 by 65 percent. Transfer to DMA-4, Line 11.

COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES - PAGE 8 / DMA-7 (Cost Settled and PPS)

The purpose of this schedule is to compute the Medicaid cost of Pneumococcal and Influenza Vaccine Injections based on the number of injections for Medicaid beneficiaries aged 19 years and older.

Columns 2 and 3

Line 1

Enter cost of Pneumococcal and Influenza Vaccine Injections and its (their) administration in the applicable column from the Medicare Cost Report, Supplemental Worksheet B -1, Line 12.

Line 2

Enter the number of Pneumococcal and Influenza Vaccine Injections administered to Medicaid beneficiaries in the applicable column. This information is from the provider's records.

NOTE: Do NOT include injections for the following beneficiaries on Line 2:

- Children aged 0 – 18 years who receive vaccines in addition to a Health Check assessment or if vaccine administration is the only service provided on the date of service;
- Children enrolled in the Health Choice program

PAGE 8, DMA-7, Continued

Line 3

Multiply Cost per Vaccine Injection (Line 1) times number of Medicaid Vaccine Injections (Line 2).

Line 4

Enter the Medicaid cost of Pneumococcal and Influenza Vaccine Injections. Sum of Columns 2 and 3, Line 3. Transfer this amount to Schedule DMA-4 / Page 5, Column 4, Line 6.

COST OF ALLOWABLE GRADUATE MEDICAL EDUCATION – PAGE 9 / DMA-8

The purpose of this schedule is to compute the Medicaid cost of Allowable Graduate Medical Education (GME) based on the number of Intern and Resident visits administered to Medicaid beneficiaries.

Column 2

Line 1

Enter the number of Intern and Resident Visits to Medicaid Beneficiaries from the CMS Form 224-14, Worksheet S-3, Column 3, Line 6.

Line 2

Enter the total number of all Intern and Resident visits from Worksheet S-3, Column 5, Line 6.

Line 3

Compute the Medicaid percentage of Intern and Resident visits by dividing Line 1 by Line 2.

Line 4

Enter the Allowable GME costs from Worksheet A, Column 7, Line 47.

Line 5

Compute the Total Medicaid Allowable GME costs by multiplying Line 3 by Line 4. Transfer to DMA-4, Line 7.

PPS RECONCILIATION SCHEDULE – COST-SETTLED PROVIDERS– PAGE 10 / DMA-9

The purpose of this schedule is to compute PPS payments for cost-settled providers only based on the number of Medicaid Encounters and identify Gross Amount Due Provider or Program.

Lines a - e
Enter total number of **Medicaid** encounters furnished by the provider for each Ambulatory Service. This information is from the providers records.

Line 1
Compute Total Medicaid Encounters. Enter subtotal of lines a - e.

Line 2
Enter PPS rate from DMA Rate Setting.

Line 3
Compute Total Prospective Payments. Multiply Line 1 times Line 2.

Line 4
Enter Total Reimbursable Costs from DMA-4. Sum of Line 8 and Line 11.

Line 5
Enter Greater of Line 3 or Line 4.

Line 6
Enter Amount Received from Medicaid from DMA-5, Line 6.

Line 7
Subtract Line 5 from Line 6. If this is a negative amount (Due Program), the total amount due **must** be remitted under separate cover with check made payable to ***Division of Medical Assistance*** to the address below:

DHHS Controller's Office
Accounts Receivable Medical Assistance
2022 Mail Service Center
Raleigh, NC 27699–2022

PPS RECONCILIATION SCHEDULE – PPS PROVIDERS– PAGE 11 / DMA-10A

The purpose of this schedule is to compute PPS payments for PPS-reconciled providers only based on the number of Medicaid Encounters and identify Gross Amount Due Provider or Program.

NOTE: In accordance with the North Carolina State Plan, Attachment 4.19-B, Section 2, a provider is a PPS reconciled provider if one of the following conditions apply:

- **The FQHC provider was enrolled in the Medicaid program prior to January 1, 2001, elected to be PPS reconciled, and did not change their election prior to January 1, 2005.**
- **The FQHC provider was newly enrolled in the Medicaid program on or after January 1, 2001.**
- **A Cost-settled Provider had a change of ownership on or after January 1, 2005**.

Lines a - e

Enter total number of **Medicaid** encounters furnished by the provider for each Ambulatory Service. This information is from the providers records.

Line 1

Compute Total Medicaid Encounters. Enter subtotal of lines a - e.

Line 2

Enter PPS rate from DMA Rate Setting.

Line 3

Compute Total Prospective Payments. Multiply Line 1 times Line 2.

Line 4

Enter Amount Received from Medicaid from DMA-5, Line 6.

Line 5

Subtract Line 4 from Line 3 If this is a negative amount (Due Program), the total amount due **must** be remitted under separate cover with check made payable to ***Division of Medical Assistance*** to the address below:

DHHS Controller's Office
Accounts Receivable Medical Assistance
2022 Mail Service Center
Raleigh, NC 27699–2022

SCOPE OF SERVICE CHANGES SCHEDULE – PPS RECONCILED PROVIDERS ONLY- PAGE 12 / DMA-10B

The purpose of this schedule is for the FQHC PPS Reconciled provider to notify DMA of any change(s) in the scope of services provided during the cost reporting period.

Please complete Schedule DMA-10B for each NPI.

Lines 1.a. through 1.j.
Indicate if there was No Change (column 2), an Added Service (column 3), and the date the service was added (column 4), or a Discontinued Service (column 5) and date the service was discontinued (column 6) for each service.

After completing all schedules, print and complete the Certification Form as instructed below:

CERTIFICATION STATEMENT

Enter the full name of the facility and reporting period covered by the report.

Ensure the Certification Statement is signed by an officer or administrator of the facility after all schedules have been completed. The Audit Section **must** have an original signature on the submitted form or the cost report will be considered incomplete.

QUESTIONS ABOUT COST REPORT PREPARATION:

If you have questions about the preparation of the **FQHC** cost reporting forms, please contact Susan Simmons at (919) 814-0027 or e-mail Susan.Simmons@dhhs.nc.gov

DMA FQHC/RHC
MEDICAID COST REPORT
CHECKLIST

PPS-Reconciled providers must submit a full copy of your signed and certified facility Medicare cost report (CMS 224-14) **along with your original Medicaid FQHC cost report.**

For **Cost-Settled providers**, the following information **must** be submitted **along with your original Medicaid FQHC cost report**:

_____ A full copy of your signed and certified facility Medicare cost report (CMS 224-14).

_____ A copy of your facility "crosswalk" working trial balance to support Medicare report.

_____ Supporting documentation and working papers including calculation of costs for the Medicare cost report.

_____ Supporting documentation and working papers including calculation of costs for the Medicaid cost report.

_____ Defined chart of accounts.

_____ Log of bad debts, if applicable.

_____ Log of vaccines administered to Medicaid beneficiaries included on DMA-7. This log must include each beneficiary's Medicaid ID number.

_____ Financial Statements, audited or unaudited, at time of submission.

_____ List of all State and Federal grant revenues. Please list the title of the grant and amount of revenues received during the reporting period.