

**FEDERALLY QUALIFIED HEALTH CENTERS
&
RURAL HEALTH CLINICS**

DIVISION OF MEDICAL ASSISTANCE

MEDICAID SCHEDULES

2010

INSTRUCTIONS





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

2501 Mail Service Center - Raleigh, N.C. 27699-2501

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Craigian L. Gray, M.D., MBA, JD, Director

September 6, 2011

Dear FQHC \ RHC Provider:

In accordance with the Medicaid Participation Agreement Paragraphs 6 and 7, FQHC\RHC 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/fqchrhcreports.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\RHC cost report**:

- A copy of your facility Medicare cost report.
- A copy of your facility "crosswalk" working trial balance to support 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.
- Financial Statements, audited or unaudited, at time of submission.

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

US Mail

**Audit Section
Attn: Constance Baker (for FQHC)
or Joy Liu (for RHC)
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501**

Express Mail/Shipping

**Audit Section
Attn: Constance Baker (for FQHC)
or Joy Liu (for RHC)
Division of Medical Assistance
421 Fayetteville St.
Raleigh, NC 27601**

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 Accounts Receivable
Division of Medical Assistance
325 N. Salisbury Street
2022 Mail Service Center
Raleigh, NC 27699-2022**

If you have questions, please contact Constance Baker at (919) 647-8084 or e-mail Constance.Baker@dhhs.nc.gov for FQHC's, and contact Joy Liu at (919) 647-8081 or email Joy.Liu@dhhs.nc.gov for RHC's.

Sincerely,

Kathy Cardenas
Audit Manager

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

RECOMMENDED SEQUENCE FOR COMPLETING MEDICAID SCHEDULES

The Medicaid Schedules are to be completed after the Medicare Cost Reporting Worksheets (FORM CMS-222-92 <1/10>) are completed.

<u>Step Number</u>	<u>Schedule</u>	<u>Cost Report Page</u>	<u>Instructions</u>
1	Facesheet	1	Page 2. Complete Sections 1 – 6.
2	DMA - 1	2	Page 3. Complete Schedule.
3	DMA - 2	3	Pages 4 - 5. Complete Schedule.
4	DMA - 3	4	Pages 6 - 7. Complete Schedule.
5	DMA - 4	5	Page 8 - 9. Complete Lines 1 - 5.
6	DMA - 5	6	Page 10. Complete Schedule.
7	DMA - 6	7	Page 11. Complete Schedule.
8	DMA - 7	8	Page 11. Complete Schedule.
9	DMA - 4	5	Page 8 - 9. Complete Lines 6 - 11.
10	DMA - 8	9	Page 12. Complete Schedule.
11	Facesheet	1	Pages 2 & 13. Complete Certification Statement.

DMA FQHC/RHC MEDICAID SCHEDULES INSTRUCTIONS

DMA-SCHEDULES

GENERAL INFORMATION AND CERTIFICATION - PAGE 1

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. If you experience problems with using Excel, simply print a blank copy of each schedule and fill it out using a pen or typewriter.

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 Medicaid provider numbers and NPI numbers assigned to facility. If additional space is needed, attach a separate sheet with the additional provider numbers and NPI numbers.
4. Check appropriate box identifying type of control.
5. Enter individual we should contact to answer questions about cost report schedules.
6. Enter address we should mail all Medicaid settlements if different from address of 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.

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

COST OF MEDICAID CORE SERVICES - PAGE 2 / DMA-1

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 1 and 2 must be completed if the rate for Medicare Covered Visits is different between 2009 (Column 1) and 2010 (Column 2). Column 3 is total of Columns 1 and 2. Column 1 should be completed based on visits furnished during 2009. Column 2 should be completed based on visits furnished during 2010. If rate is the **same** for both periods, you may complete Column 3 covering the entire cost reporting period.

The rate is the Medicare settlement rate.

Line 1

Enter from the Medicare Cost Report, Worksheet C, Part I, Line 9, corresponding columns.

Line 2

Enter Medicaid covered visits for Core Services, from provider's records. (See NOTE below.)

Line 3

Compute cost of Core Services. Multiply Line 1 times Line 2.

Line 4

Enter Medicaid covered visits for Mental Health Services from provider's records. (See NOTE below.)

Line 5

Compute cost of visits for Mental Health Services. Multiply Line 1 times Line 4.

Line 6

Compute Total Medicaid Cost. Line 3 plus Line 5.

NOTE: As outlined in the October 2009 Medicaid Bulletin, effective October 1, 2009, a total of three (3) core service visits can be billed only if one of each of the types of visits described below occurs:

1. Bill T1015 for a regular core service visit. (Enter total visits on Line 2.)
2. Bill T1015 with the HI modifier for "other health" visit, such as a behavioral health visit. (Enter total behavioral health visits on Line 4.)
3. Bill T1015 with the SC modifier for a visit subsequent to the regular core visit, in which the recipient appears with, presents with, or suffers illness or injury requiring additional diagnosis. (The provider shall combine these total visits with regular core service visits and enter the total on Line 2.)

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

COST OF OTHER AMBULATORY SERVICES - PAGE 3 / DMA-2

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 / RHC Services excluding overhead from Medicare Cost Report, Worksheet A, Column 7, Line 57 less any cost for Health Check Coordinator. This amount **must** agree with the total of Lines 1a – 1j.

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, Line 51 of the Medicare Cost Report.

Line 1b

Worksheet A, Column 7, Line 52 of the Medicare Cost Report.

Line 1c

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Health Check (formerly EPSDT) Services (*Compensation and fringe benefits of Physician, Nurse Practitioner, or Physician's Assistant and Other) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1d

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Maternity Care Coordination Services (*Compensation and fringe benefits of Social Worker or Nurse and Other) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1e

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Child Services Coordination (*Compensation and fringe benefits of Social Worker or Nurse and Other) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1f

Worksheet A, Column 7 of the Medicare Cost Report. Cost of on-site Radiology Services identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1g

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Norplant Services (*Compensation and fringe benefits of Physicians) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PAGE 3 / DMA-2 continued

Line 1h

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Physician Hospital Services (*Compensation and fringe benefits of Physician and Professional Liability Insurance) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1i

No entry required on this line. Enter total cost of Health Check Coordinator on schedule DMA 4, Line 1i, Column 4.

Line 1j

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Other Medicaid covered services identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

***This is not an all-inclusive identification of costs which may be applicable to this service.**

Line 2

Enter cost of all services excluding overhead from Medicare Cost Report, Worksheet B, Line 12.

Line 3

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

Line 4

Enter Total Overhead from Medicare Cost Report, Worksheet B, Line 14.

Line 5

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

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

ALLOCATION OF OVERHEAD COST - PAGE 4 / DMA-3

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 - 1j

Transfer costs from Schedule DMA-2 / Page 3 to the corresponding cost center.

Line 2

Total of Lines 1a - 1j.

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 Pharmacy Cost (Column 2, Line 1a) and enter amount on Line 1a.

Line 1b

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

Line 1c

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

Line 1d

Multiply Unit Cost Multiplier (Column 2, Line 4) times Maternity Care Coordination Cost (Column 2, Line 1d) and enter amount on Line 1d.

Line 1e

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

Line 1f

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

Line 1g

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

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PAGE 4 / DMA-3 continued

Line 1h

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

Line 1i

No entry required on this line. Enter total cost of Health Check Coordinator on schedule DMA 4, Line 1i, column 4.

Line 1j

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

Line 2

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

Column 4

Lines 1a - 1j

Total of Columns 2 and 3 for each Line.

Line 2

Total of Columns 2 and 3.

Column 5

Lines 1a - 1j

Total number of encounters / units of service for **all** recipients served by the provider. This would include Medicare, Medicaid, private, and insurance recipients.

Number of prescriptions must be used for Pharmacy and encounters / units of service for all other Ambulatory Services.

Column 6

Lines 1a - 1j

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

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

DETERMINATION OF MEDICAID REIMBURSEMENT - PAGE 5 / DMA-4

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 - 1j

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

Column 3

Lines 1a - 1h, and 1j

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.

Line 1i

No entry this block. Enter Total Cost of Health Check Coordinator in Line 1i, Column 4.

Column 4

Lines 1a - 1h, and 1j

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

Line 1i

Enter Total Cost of Health Check Coordinator.

Line 2

Enter Subtotal of Lines 1a - 1j.

Line 3

Enter sum of Medicaid cost for Physician Hospital Services and Health Check Coordinator from Column 4, Lines 1h and 1i.

Line 4

Subtract Line 3 from Line 2.

Line 5

Enter Total Medicaid Core Cost transferred from Schedule DMA-1 / Page 2, Column 3, Line 7.

Line 6

Enter Total Medicaid Cost of Pneumococcal and Influenza Vaccine Injections transferred from Schedule DMA-7 / Page 8, Column 2, Line 4.

Line 7

Enter Total of Lines 4, 5, and 6.

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PAGE 5 / DMA-4 continued

Line 8

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

Line 9

Subtract Line 8 from Line 7.

Line 10

Enter Amount of Bad Debts from Schedule DMA-6 / Page 7, Line 5.

Line 11

Compute Amount Due Provider (Program). Add Lines 9 and 10.

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

SUMMARY OF MEDICAID PAYMENTS - PAGE 6 / DMA-5

The purpose of this schedule is to identify Medicaid Received / Receivable amounts and provider numbers for which HP (EDS) rendered payments. These amounts are applicable to Core and Ambulatory Services furnished during the cost reporting period. **Carolina Access and Medicaid crossover amounts are not included. Co-payments for Ambulatory Services are included.**

Column 2

Lines 1a - 1j

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 the facility's records.

Line 4

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

Line 5

Enter Received / Receivable amount for Physician Hospital Services and Health Check Coordinator from Lines 1h and 1i.

Line 6

Compute Total Medicaid Payments. Subtract Line 5 from Line 4. Transfer this amount to Schedule DMA-4 / Page 5, Column 4, Line 8 and Schedule DMA-8 / Page 9, Line 6.

Column 3

Lines 1a - 1j

Enter provider numbers used by HP 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 provider numbers used by HP to make payments for Core Services.

Line 3

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

Comments

Use this section as needed. For example, cost reports with multiple providers may list the provider numbers here if column 3, lines 1a-1j has insufficient space.

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

BAD DEBTS - PAGE 7 / DMA-6

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

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. Transfer this amount to Schedule DMA-4 / Page 5, Column 4, Line 10.

COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES - PAGE 8 / DMA-7

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 recipients.

NOTE: Effective for services rendered on or after September 1, 2009, the administration of influenza H1N1 vaccines furnished by RHCs and FQHCs are cost reimbursed. However, no cost will be incurred for influenza H1N1 vaccine as this is provided free of charge to providers/suppliers. To account for the cost of administering seasonal influenza vaccines, influenza H1N1 vaccines and/or both vaccines administered during the same patient visit, column 3 is for seasonal influenza vaccines, column 4 is added for administration of only H1N1 vaccines and column 5 is for the administration of both the seasonal influenza and H1N1 vaccines during the same patient visit.

Columns 2 and 3

Line 1

Enter cost of Pneumococcal and Influenza Vaccine Injections and its (their) administration and the administration of H1N1 vaccines 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 recipients in the applicable column. This information is from the provider's records.

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, 3, 4, and 5, Line 3. Transfer this amount to Schedule DMA-4 / Page 5, Column 4, Line 6.

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PPS RECONCILIATION SCHEDULE – PAGE 9 / DMA-8

The purpose of this schedule is to compute PPS payments 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 Medical Prospective Payments. Multiply Line 1 times Line 2.

Line 4

Enter Total Mental Health Encounters from DMA-1, Line 4, column (3).

Line 5

Compute PPS rate for Outpatient Mental Health Services. Multiply Line 2 times Line 4.

Line 6

Compute Total Prospective Payments with PPS. Add Line 3 plus Line 5.

Line 7

Enter Total Reimbursable Costs from DMA-4. Sum of Line 7 and Line 10.

Line 8

Enter Greater of Line 6 or Line 7.

Line 9

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

Line 10

Subtract Line 9 from Line 8. 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 Accounts Receivable
Division of Medical Assistance
325 N. Salisbury Street
2022 Mail Service Center
Raleigh, NC 27699-2022**

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

**DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS**

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 Kathy Cardenas at (919) 647-8068 or e-mail Kathy.Cardenas@dhhs.nc.gov, and contact Joy Liu at (919) 647-8081 or email Joy.Liu@dhhs.nc.gov for questions regarding preparation of the RHC cost reporting forms.

**DMA FQHC/RHC
MEDICAID COST REPORT
CHECKLIST**

The following information **must** be submitted **along with your original Medicaid FQHC\RHC cost report**:

- _____ A copy of your facility Medicare cost report.

- _____ 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.

- _____ 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.