



The Heartbeat of Texas Community Health Centers

Weekly Wrap-up - September 11, 2009



*Pharmacy Provider,
Cross Timbers Community Health Center
DeLeon, TX*

Upcoming Events

September OC3 Manuals Training: Supervision and Delegation

WEDNESDAY 9/16/2009 9:00am-12:00 noon CST (Webcast)

This session will cover what and to whom physicians can delegate, the rules for midlevel supervision in an FQHC setting, the differences between physician delegation and nurse delegation, and information on what and to whom Nurse Practitioners, Registered Nurses, and Licensed Vocational Nurses can delegate.

All upcoming events hosted by TACHC are listed here: <http://www.tachc.org/About/Events.asp>

Governance and Finance

Proposed Changes to Texas PPS Rules: On September 10, Jose Camacho, TACHC Executive Director/General Counsel and Cecile Carson, TACHC Associate General Counsel submitted written comments and presented them to the HHSC Medical Care Advisory Committee (MCAC). The comments addressed the proposed revisions to the Texas health center PPS regulations; the revisions as currently proposed are attached. TACHC expressed a number of concerns about them, including that the revisions: 1. Allow HHSC to request a cost report from the health center that is not the already created Medicare cost report, 2. Allow HHSC to request a cost report from a health center at any time, 3. Allow HHSC to decrease a rate based on that cost report but not increase it if 100% of the center's reasonable costs are not covered, 4. Do not provide for a notice and appeals process should a center's rate be decreased, 5. Require a year's worth of data before a rate can be increased, even if a center has added a completely new service for Medicaid patients and has to pay for those costs, 6. Do not increase the cap on fringe benefits, currently 12%, to reflect the increased cost of health insurance, and 7. Do not implement CHIP PPS, which is effective under federal law on October 1. Based on TACHC's presentation, the Committee, including Paula Gomez, Executive Director of TACHC member Brownsville Community Health Center, recommended that HHSC work with TACHC to revise the proposed rule before publishing. We will continue to work with HHSC on this matter. The next MCAC meeting, where the rule will likely be reconsidered is November 12 and the agenda will ultimately be posted here: <http://www.hhsc.state.tx.us/news/meetings.asp>



Annual Conference Clinical Weekend: Medical Directors and Dental Directors were informed last week about the Clinical Weekend at TACHC's 26th Annual Conference. The conference will be held at the Westin City Center Hotel in Dallas, Texas, and the clinical weekend is scheduled for Saturday, October 31st and Sunday, November 1st. This will be an excellent opportunity for your clinicians to network with and learn from outside experts as well as their peers from Community Health Centers across the state. This program was developed based on feedback and training requests. Topics to be covered include: Compliance and Performance Improvement, Improving Access to Meet Growing Demand, UDS Reports, Advanced Clinical Leadership, Managing and Supporting Cancer Patients in the Primary Care Setting, Oral Health Management, Population Health Management, and more. Continuing Education credits will be offered for the conference. Registration information and a draft agenda can be found at <http://www.tachc.org/About/Events.asp>.

Clinical Leadership Network: The next quarterly conference call for the Clinical Leadership Network targeting Chief Medical Officers and Dental Directors will be held Thursday, October 8th from 12:15-1:15pm. The topic will be Managing Conflict and the guest speaker will be Dr. Mark Murray. Registration for CMOs and Dental Directors is available on our website at <http://www.tachc.org/About/Events.asp>.

October Manuals Training on Business Communications: Registration for the October Manuals training, to be held via webcast on Friday, October 16 from 9am to 12noon, is OPEN and available at <http://www.tachc.org/About/Events.asp>. This training will address Business Communications and Customer Service Excellence. Kristin Baird, Customer Service Specialist, will be the guest speaker and the session will focus on giving managers and leaders within the health center a renewed commitment to customer services as a strategy to achieve your mission, vision, and values; developing an understanding of the leader's role in fostering a culture of service excellence; and providing concrete strategies that can be implemented immediately to move towards this Service-Oriented Culture. For centers that register before the early bird deadline of October 1, 2009, you will be provided with a complimentary copy of Kristin's book *Raising the Bar on Service Excellence*.

Cardiovascular Disease Council: TACHC Clinical Staff and representatives from CommUnityCare in Austin presented an Optimizing Comprehensive Clinical Care (OC³) Program Update to the Texas Cardiovascular Disease Council today. Clinical outcome data was presented to the Council. The Council provides support for entities working on the prevention and management of Cardiovascular disease and partners with TACHC to increase access to such prevention and management services. For more information on the Council, please see <http://www.dshs.state.tx.us/wellness/cnclhome.shtm>.



Health Information Technology Technical Assistance: As you are all probably aware, there is an active funding opportunity announcement from HRSA for health information technology regional extension center (HIT REC) grants. We understand that pursuant to the HITECH act, priority for technical assistance under this funding is to be given to primary care providers, including FQHCs. As the federally funded and designated association of FQHCs in Texas, TACHC also understands that our constituency has unique requirements regarding data reporting, workflow analysis and redesign, and implementation. We have written letters of support for the five applicants for the HIT REC grants, and we do expect full inclusion of our association in the planning process and review of materials to be disseminated to FQHCs under this program. TACHC would like to make sure that the HIT RECs are providing training opportunities and materials that are appropriate for CHCs, not just hospitals and private practices. If you are approached for letters of support or inclusion in these regional programs, please contact Jose Camacho or Lori Hooks at TACHC to discuss the matter before signing on. We want to make sure that all efforts and funding are coordinated at the regional and state levels in order to maximize CHC inclusion in this opportunity statewide. The organizations we have provided letters to are:

University of Texas Health Science Center at Houston
Texas Tech University Health Sciences Center
Dallas-Fort Worth Hospital Council Education and Research Foundation
Texas A&M Health Science Center
Texas Medical Association



If you would like to be removed from this mailing, please send a message to ccarson@tachc.org, and we will remove your name from our list as soon as possible.



TO: Medical Care Advisory Committee
DATE: September 10, 2009
FROM: Kevin Nolting, HHSC Rate Analysis Department

SUBJECT: **AGENDA ITEM NO.: 12**

Amendment to: Title 1, Part 15, Chapter 355, Reimbursement Rates, Subchapter J, Purchased Health Services, Division 14, Federally Qualified Health Center Services (FQHC), §355.8261, Reimbursement

BACKGROUND: Federal Requirement Legislative Requirement Other HHSC Initiative

The proposed amendment to §355.8261 updates the Medicaid reimbursement methodology for Federally Qualified Health Centers (FQHCs). HHSC is updating this rule to: reflect the current reimbursement practice for setting interim rates; adjust the cost settlement methodology for interim rates; clarify a requirement that FQHCs submit cost reports periodically if requested by HHSC; describe the methodology for setting out-of-state FQHC rates; and eliminate duplicative language.

Currently, this rule does not include the detailed methodology that HHSC uses to set interim base rates for new FQHCs. The proposed amendment adds the detailed methodology to the rule. When a new FQHC becomes a Medicaid provider, it is paid an interim base rate until HHSC establishes a final base rate for that facility. Currently, interim base rates for new FQHCs are set at 80 percent of their costs from their initial estimated cost report. Setting the interim base rate at 80 percent of estimated costs for FQHCs helps to avoid overpayments to these FQHCs since the final base rate is unknown. The proposed amendment describes any potential overpayments as the basis for recoupment for FQHCs if the final base rate is lower than the interim base rate.

FQHCs choose whether to be reimbursed under the prospective payment system (PPS) methodology or the alternative prospective payment system (APPS) methodology. Currently, there are only two differences between the two methodologies. First, under the APPS, if an FQHC's interim rate is higher than actual costs, the amount above cost is not recouped. Under the PPS, the interim amount above cost is recouped. Second, FQHCs that choose the APPS methodology receive an additional 1.5 percent rate increase each year while those using the PPS methodology do not. HHSC is proposing to eliminate the practice of only cost-settling the interim rates for those FQHCs that choose the PPS reimbursement methodology. HHSC will now cost-settle interim rates for all new FQHCs, whether they choose the PPS or APPS reimbursement methodology. Therefore, the only remaining difference between the two reimbursement methodologies will be that the FQHCs that choose the APPS rate will receive an additional 1.5 percent rate increase each year while those that choose the PPS rate will not. Since there will be only one difference between the methodologies, the proposed amendment removes duplicative language regarding the APPS and PPS rates to eliminate confusion.

The proposed amendment states that HHSC may periodically request that an FQHC submit a cost report and may place an FQHC on vendor hold for failure to comply with a request for a cost report within 5 months. It is the intent of the state to ensure that each FQHC is reimbursed at one hundred percent (100%) of its reasonable costs or the PPS effective rate, whichever is greater. HHSC may reduce the effective rate of an FQHC that has chosen to be reimbursed under the APPS methodology if warranted based on the audit of the cost report. Payments made under the APPS methodology will be at least equal to what would have been paid under PPS. HHSC will not increase the effective rate for an FQHC based on the outcome of a state initiated cost report audit. If an FQHC believes that its effective rate is less than one hundred percent (100%) of reasonable costs, it is the responsibility of the provider to submit a separate cost report and documentation to HHSC to support a claim that it has undergone a change in scope or is operating in an efficient manner.

Finally, HHSC is adding language to describe the methodology it uses to set the effective rate for out-of-state FQHCs. HHSC pays out-of-state FQHCs based on the PPS methodology.

ISSUES AND ALTERNATIVES:

The alternative is to not update this rule to reflect current practice. The rule is being changed to eliminate duplicate language and align the rule with the current policy and practice for setting interim rates.

Additionally, HHSC is proposing to cost-settle all new FQHCs so that the payments made for the FQHC's first year reflect their actual costs. The new methodology will require HHSC to cost-settle all interim payments, as opposed to the current methodology where HHSC makes settle-up payments only if a new FQHC was underpaid during the interim period.

Language has been added to clarify that HHSC may periodically request a cost report from an FQHC and put a provider on vendor hold if a Medicaid or Medicare cost report is not received in a timely manner. Language also has been modified to enable HHSC to reduce an FQHC's APPS rate to either the PPS effective rate, or 100 percent of reasonable costs, whichever is greater, if an audited cost report shows an FQHC is being reimbursed above reasonable costs.

STAKEHOLDER INVOLVEMENT:

HHSC Rate Analysis staff worked with the Texas Medicaid & Healthcare Partnership (TMHP), HHSC's Medicaid claims administrator, to develop rule language changes to match current FQHC reimbursement practice.

HHSC contacted staff at the Texas Association of Community Health Centers (TACHC) for their response and input after the rule packet had gone through the internal agency review process and prior to the Medical Care Advisory Committee meeting.

FISCAL IMPACT:

None Yes (*if yes, please complete table below*)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
State					
Federal					

RULE DEVELOPMENT SCHEDULE:

September 10, 2009 Present to the Medical Care Advisory Committee
October 2009 Present to HHSC Council
December 2009 Publish proposed rule in the *Texas Register*
March 2010 Publish adopted rule in the *Texas Register*
April 1, 2010 Effective date

REQUESTED ACTION:

- The MCAC recommends approval of the proposed rule for publication.
- The Council recommends approval of this rule.
- Information Only

TITLE 1	ADMINISTRATION
PART 15	TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355	REIMBURSEMENT RATES
SUBCHAPTER J	PURCHASED HEALTH SERVICES
DIVISION 14	FEDERALLY QUALIFIED HEALTH CENTER SERVICES
RULE 355.8261	Reimbursement

PROPOSED PREAMBLE

The Health and Human Services Commission (HHSC) proposes to amend §355.8261 of Title 1, Part 15, Chapter 355, Subchapter J, Division 14, to update the Medicaid reimbursement methodology for Federally Qualified Health Centers (FQHC).

Background and Justification

The proposed amendment to §355.8261 updates the Medicaid reimbursement methodology for Federally Qualified Health Centers (FQHCs). HHSC is updating this rule to: reflect the current reimbursement practice for setting interim rates; adjust the cost settlement methodology for interim rates; clarify a requirement that FQHCs submit cost reports periodically if requested by HHSC; describe the methodology for setting out-of-state FQHC rates; and eliminate duplicative language.

Currently, this rule does not include the detailed methodology that HHSC uses to set interim base rates for new FQHCs. The proposed amendment adds the detailed methodology to the rule. When a new FQHC becomes a Medicaid provider, it is paid an interim base rate until HHSC establishes a final base rate for that facility. Currently, interim base rates for new FQHCs are set at 80 percent of their costs from their initial estimated cost report. Setting the interim base rate at 80 percent of estimated costs for FQHCs helps to avoid overpayments to these FQHCs since the final base rate is unknown. The proposed amendment describes any potential overpayment as the basis for recoupment for FQHCs if the final base rate is lower than the interim base rate.

FQHCs choose whether to be reimbursed under the prospective payment system (PPS) methodology or the alternative prospective payment system (APPS) methodology. Currently, there are only two differences between the two methodologies. First, under the APPS, if an FQHC's interim rate is higher than actual costs, the amount above cost is not recouped. Under the PPS, the interim amount above cost is recouped. Second, FQHCs that choose the APPS methodology receive an additional 1.5 percent rate increase each year while those using the PPS methodology do not. HHSC is proposing to eliminate the practice of only cost-settling the interim rates for those FQHCs that choose the PPS reimbursement methodology. HHSC will now cost-settle interim rates for all new FQHCs, whether they choose the PPS or APPS reimbursement methodology. Therefore, the only remaining difference between the two reimbursement methodologies will be that the FQHCs that choose the APPS rate will receive an additional 1.5 percent rate increase each year while those that choose the PPS rate will not. Since there will be only one difference between the methodologies, the proposed amendment removes duplicative language regarding the APPS and PPS rates to eliminate confusion.

The proposed amendment states that HHSC may periodically request that an FQHC submit a cost report and may place an FQHC on vendor hold for failure to comply with a request for a cost report within 5 months. It is the intent of the state to ensure that each FQHC is reimbursed at one hundred percent (100%) of its reasonable costs or the PPS effective rate, whichever is greater. HHSC may reduce the effective rate of an FQHC that has chosen to be reimbursed under the APPS methodology if warranted based on the audit of the cost report. Payments made under the APPS methodology will be at least equal to what would have been paid under PPS. HHSC will not increase the effective rate for an FQHC based on the outcome of a state initiated cost report audit. If an FQHC believes that its effective rate is less than one hundred percent (100%) of reasonable costs, it is the responsibility of the provider to submit a separate cost report and documentation to HHSC to support a claim that it has undergone a change in scope or is operating in an efficient manner.

Finally, HHSC is adding language to describe the methodology it uses to set the effective rate for out-of-state FQHCs. HHSC pays out-of-state FQHCs based on the PPS methodology.

Section-by-Section Summary

HHSC proposes amending §355.8261 by deleting former subsection (b) relating to the Alternative Prospective Payment Methodology (APPS) and incorporating pertinent information from that subsection into the description of the PPS methodology in former subsection (a). The proposed rule is renumbered and reorganized throughout, and internal references are updated. Obsolete language in former subsection (b) concerning cost settlement is deleted because the date indicated has passed.

In the new introductory paragraph, language is added to clarify that all rate terms apply to both the PPS and APPS methodologies unless otherwise stated.

Throughout the rule, HHSC replaces the term “base PPS per visit rate” with “final base rate” and the term “interim PPS per visit rate” with “interim base rate” to distinguish between the final base rate and the interim base rate.

HHSC clarifies in new subsections (a) and (b) that the base rate methodologies described in those subsections apply to FQHCs existing in 2000, and that the base rate methodology for new FQHCs is located in new subsection (k).

New subsection (b) is amended to specify that for FQHCs that agreed to the APPS methodology prior to April 1, 2010, adjustments were made to interim payments only if the interim base rate was less than the final base rate.

In new subsection (e), specific date language is removed. In new subsections (e) and (f), language is incorporated from former subsection (b) related to the yearly Medicare Economic Index (MEI) increase plus 1.5 percent applied to the base rate for FQHCs that choose the APPS reimbursement methodology.

In new subsection (g), language is added from former subsection (b) to allow an FQHC to request an adjustment to its effective rate by submitting a cost report and other documentation showing that it is operating in an efficient manner or had a change in scope. The amount of financial data an FQHC must submit to request a rate adjustment is changed from six months of data to one year of data. New subsection (g) also explains that HHSC may adjust the effective rate of an FQHC if HHSC determines based on cost report data that a change of scope has occurred or the FQHC is operating in an efficient or inefficient manner and an adjustment to the rate is warranted.

In new subsection (h), paragraph (2) is incorporated from former subsection (b) defining how an FQHC can show it is operating in an efficient manner.

In new subsection (i), a requirement is added for all items to be complete and accurate on a workable cost report. New subsection (i) also is amended to clarify the requirement for an officer or administrator to certify the accuracy of cost report data.

In new subsection (j), language is added to explain that HHSC may periodically request a cost report from an FQHC and HHSC may place an FQHC on vendor hold for failure to comply with a request for a cost report.

New subsection (k) contains the provisions of former subsection (b)(19). The new subsection explains the process by which HHSC may prospectively reduce the effective rate of an FQHC that has chosen the APPS reimbursement methodology to the greater of 100 percent of its reasonable costs or the PPS effective rate. Former subsection (b)(19) required that the effective rate be greater than 102 percent of costs before an adjustment could be made.

New subsection (l) is amended to describe the current practice of paying a new FQHC at 80 percent of the estimated reasonable costs submitted on a projected cost report until a final base rate is set. New language is added related to the cost settlement process for interim payments once a final base rate is set. Language is also added stating that HHSC or its designee may delay or withhold vendor payments for failure to submit a cost report.

In new subsection (n), language is added stating that HHSC or its designee may delay or withhold vendor payments for failure to submit a copy of the audited Medicare cost report to the state.

New subsections (o) and (p) incorporate language that had been in subsection (a), paragraphs (5) and (6) and former subsection (b), paragraphs (7) and (8).

New subsection (q) describes the methodology used to compute payments to out-of-state FQHCs. HHSC pays out-of-state FQHCs based on the PPS methodology.

Previous subsection (b), related to the APPS methodology, is deleted since most of the language is an exact duplicate of previous subsection (a) related to the PPS methodology. All language that was not duplicative was incorporated into the proposed amended rule as indicated above.

Fiscal Note

Thomas M. Suehs, Deputy Executive Commissioner for Financial Services, has determined that for each of the first five years the amendment is in effect, there will be no fiscal impact to the federal and state government. Additionally, the proposed rule will not result in any fiscal implications for local health and human services agencies. Local governments will not incur additional costs.

Small and Micro-business Impact Analysis

Carolyn Pratt, Director of Rate Analysis, has determined that there is no adverse economic effect on small businesses or micro-businesses as a result of enforcing or administering the amendment since providers will be reimbursed for their Medicaid services based upon the cost of providing those services. HHSC does not anticipate that there will be any economic costs to persons who are required to comply with the proposed amendment. HHSC does not anticipate any negative impact on local employment.

Public Benefit

Ms. Pratt has determined that for each year of the first five years the amendment is in effect, the anticipated public benefit, as a result of enforcing the section, will be to adopt Medicaid reimbursement methodology language for Federally Qualified Health Centers that clarifies and simplifies current practice so that the methodology is more easily understood, and that ensures that FQHCs are reimbursed at least 100 percent of their reasonable costs.

Regulatory Analysis

HHSC has determined that this proposal is not a “major environmental rule” as defined by §2001.0225 of the Texas Government Code. “Major environmental rule” is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

Takings Impact Assessment

HHSC has determined that this proposal does not restrict or limit an owner’s right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under §2007.043 of the Government Code.

Public Comment

Written comments on the proposal may be submitted to Andrew Wolfe, by mail at HHSC Rate Analysis-Hospital Services, Mail Code H-400, P.O. Box 85200, Austin, Texas, 78758, by fax to 512-491-1998, or by e-mail to andrew.wolfe@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

Statutory Authority

The amendment to the rule is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient operation of the Medicaid program; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursement.

The proposed rule amendment affects Texas Human Resources Code, Chapter 32, and Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed and approved by legal counsel and found to be within the agency's legal authority to adopt.

Legend: (Proposed Amendments)

Single Underline = Proposed new language

~~[Strikethrough and Brackets]~~ = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 14 FEDERALLY QUALIFIED HEALTH CENTER SERVICES
RULE 355.8261 Federally Qualified Health Center Services
Reimbursement

~~[(a)]~~ Prospective Payment System Methodology and Alternative Prospective Payment System Methodology. Federally qualified health centers (FQHCs) employing the Prospective Payment System (PPS) methodology or the Alternative Prospective Payment System (APPS) methodology, in accordance with section 1902(aa) of the Social Security Act, as amended by the Benefits Improvement and Protection Act (BIPA) of 2000 (42 U.S.C. §1396a(aa)), ~~[effective for the FQHC's fiscal year that includes dates of service occurring January 1, 2001, and after,]~~ will be reimbursed a prospective [PPS per visit] rate for Medicaid covered services. FQHCs are reimbursed a prospective per visit encounter rate for a visit that meets the requirements of subsections (o) and (p) of this section. ~~[There will no longer be a cost settlement for FQHCs for dates of service on or after January 1, 2001.]~~ All references to rates throughout this section apply to both the PPS and APPS methodologies unless otherwise stated.

(a)~~[(1)]~~ The final base [PPS per visit] rate for each FQHC existing in 2000 was ~~[will be]~~ calculated based on one hundred percent (100%) of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years. The final base [PPS per visit rates] rate was ~~[will be]~~ calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods.

(b)~~[(2)]~~ Prior to the Health and Human Services Commission (HHSC) setting a final base [PPS] rate pursuant to this section for each FQHC existing in 2000~~[-subsection]~~, each FQHC was ~~[will be]~~ reimbursed on the basis of an interim base [per visit] rate. The interim base [per visit] rate for each FQHC was ~~[will be the encounter rate]~~ calculated from the latest finalized cost report settlement, adjusted as provided for in subsection (e) [paragraph (7)] of this section~~[-subsection]~~. When HHSC ~~[has]~~ determined a final base [PPS] rate, interim payments were ~~[will be]~~ reconciled back to the beginning of the interim period. ~~[January 1, 2001.]~~ For FQHCs that agreed to the APPS methodology prior to April 1, 2010, adjustments were made to the FQHCs' interim payments only if the interim payments were less than what would have occurred under the final base rate. Subsection (l) of this section contains the interim and final base rate methodology for new FQHCs. The final base [PPS] rate, as adjusted, applies ~~[will apply]~~ prospectively from the date of the final approval.

(c)~~[(3)]~~ Reasonable costs, as used in setting the interim or final base rate ~~[,the PPS rate,]~~ or any subsequent effective rate, is defined as those costs that are allowable under Medicare Cost Principles, as outlined in 42 C.F.R. part 413, with no productivity screens and no per visit payment limit. Administrative costs will be limited to ~~[The administrative cost limit of]~~ thirty percent (30%) of total costs ~~[that was in place on December 31, 2000, will be retained]~~ in determining reasonable costs. Reasonable costs do not include unallowable costs.

(d)~~[(4)]~~ ~~[Unallowable costs.]~~ Unallowable costs are expenses that are incurred by an FQHC and that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules, and standards. An FQHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating ~~[a]~~ an interim or final base rate determination. Unallowable costs include, but are not necessarily limited to, the following:

- ~~(1)(A)~~ compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;
- ~~(2)(B)~~ personal expenses not directly related to the provision of covered services;
- ~~(3)(C)~~ management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;
- ~~(4)(D)~~ advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;
- ~~(5)(E)~~ business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;
- ~~(6)(F)~~ political contributions;
- ~~(7)(G)~~ depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;
- ~~(8)(H)~~ trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;
- ~~(9)(I)~~ donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 C.F.R. part 413;
- ~~(10)(J)~~ dues to all types of political and social organizations and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs or the rendering of patient care services;
- ~~(11)(K)~~ entertainment expenses, except those incurred for entertainment provided to the staff of the FQHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;
- ~~(12)(L)~~ board of director's fees, including travel costs and meals provided for directors;
- ~~(13)(M)~~ fines and penalties for violations of statutes, regulations, and ordinances of all types;
- ~~(14)(N)~~ fund raising and promotional expenses, except as noted in paragraph~~[subparagraph]~~ ~~(4)(D)~~ of this subsection~~[paragraph]~~;
- ~~(15)(O)~~ interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid that is reduced or offset by interest income;
- ~~(16)(P)~~ insurance premiums pertaining to items of unallowable costs;
- ~~(17)(Q)~~ any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;
- ~~(18)(R)~~ mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;
- ~~(19)(S)~~ cost for goods or services that are purchased from a related party and that exceed the original cost to the related party;
- ~~(20)(T)~~ out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses that increase the quality of medical care and/or the operating efficiency of the FQHC;
- ~~(21)(U)~~ over-funding contributions to self-insurance funds that do not represent payments based on current liabilities;
- ~~(22)(V)~~ overhead costs beyond the thirty percent (30%) limitation established by ~~the~~ HHSC.

~~(5) A visit is a face to face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, a qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:~~

~~—(A) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or~~

~~—(B) the FQHC patient has a medical visit and an “other” health visit.~~

~~—(6) A medical visit is a face to face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse mid wife, or visiting nurse. An “other” health visit includes, but is not limited to, a face to face encounter between an FQHC patient and a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a Texas health Steps Medical Screen.]~~

~~_(e)[(7)] [Effective for each FQHC’s fiscal year that includes dates of services occurring on or after October 1, 2001, subsequent] Increases [increases] in an FQHC’s final base [per visit] rate or the effective rate shall be the rate of change in the Medicare Economic Index (MEI) for primary care for PPS, or the rate of change in the MEI plus one and one-half percent (1.5%) for APPS for each fiscal year. If the increase in an FQHC’s reasonable costs is greater than the MEI for PPS, or MEI plus one and one-half percent (1.5%) for APPS, an FQHC may request an adjustment of its effective rate equal to one hundred percent (100%) of reasonable costs.~~

~~_(f)[(8)] The effective rate is the rate paid to the FQHC for the FQHC’s [current] fiscal year. The effective rate equals the final base rate plus the MEI for PPS, and MEI plus one and one-half percent (1.5%) for APPS, for each of the FQHC’s fiscal years since the setting of its final base rate. The effective rate shall be calculated at the start of each FQHC’s fiscal year and shall be applied prospectively for that fiscal year.~~

~~_(g)[(9)] An adjustment shall be made to the effective rate if the FQHC can show that it is operating in an efficient manner as defined in subsection (h)(2), or show that the increase is due to a change in scope as defined in subsection (h)(1). An FQHC [or the commission] may request an adjustment of the effective rate equal to one hundred percent (100%) of reasonable costs by submitting [filing] a cost report to HHSC and including the necessary documentation to support a claim that the FQHC has undergone a change in scope or is operating in an efficient manner. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an FQHC’s fiscal year, but no later than five (5) calendar months after the end of the FQHC’s fiscal year. All requests for adjustment in the FQHC’s effective rate must include one (1) year [at least 6 months] of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost report and documentation supporting the FQHC’s claim that it has undergone a change in scope or is operating in an efficient manner. Within sixty (60) days of receiving [submitting] a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. HHSC also may adjust the effective rate of an FQHC on its own initiative if it is determined that a change of scope has occurred or the FQHC is operating in an efficient or inefficient manner and an adjustment to the effective rate is warranted based on the audit of the cost report defined in subsection (i). The new effective rate shall become effective the first day of the month immediately following its determination and shall not be applied retroactively. All subsequent increases will be calculated using the new effective rate. Payments made under the APPS methodology will at least be equal to what would have been paid under PPS. [All adjustments shall be calculated using the effective rate and shall be applied prospectively.]~~

~~_(h)[(10)] Any request to adjust an effective rate must be accompanied by documentation showing that the FQHC is operating in an efficient manner or that it has had a change in scope. A change in scope of services provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC’s sites. [A change in scope includes:]~~

~~_(1) A change in scope includes:~~

~~(A) an increase in service intensity attributable to changes in the types of patients served, including [] but not limited to, patients with HIV/AIDS, the homeless, the elderly, migrants, those with other chronic diseases or special populations;~~

~~(B) any changes in services or provider mix provided by an FQHC or one of its sites;~~

~~(C) changes in operating costs that have occurred during the fiscal year and which are attributable to capital expenditures, including new service facilities or regulatory compliance;~~

~~(D) changes in operating costs attributable to changes in technology or medical practices at the FQHC;~~

(E) indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(F) any changes in scope approved by the Health Resources and Service Administration (HRSA).

(2) Operating in an efficient manner includes:

(A) showing that the FQHC has implemented an outcome-based delivery system that includes prevention and chronic disease management. Prevention includes, but is not limited to, programs such as immunizations and medical screens. Disease Management must include, but not be limited to, programs such as those for diabetes, cardiovascular conditions, and asthma that can demonstrate an overall improvement in patient outcome;

(B) paying employees' salaries that do not exceed the rates of payment for similar positions in the area, taking into account experience and training as determined by the Texas Workforce Commission;

(C) providing fringe benefits to its employees that do not exceed twelve percent (12%) of the FQHC's total costs;

(D) implementing cost saving measures for its pharmacy and medical supplies expenditures by engaging in group purchasing; and

(E) employing the Medicare concept of a "prudent buyer" in purchasing its contracted medical services.

(i)[(H)] A complete and workable cost report includes the following;

(1)[(A)] an FQHC Statistical Data Coversheet with Certification by an Officer or Administrator certifying the accuracy of the attached data;

(2)[(B)] Medicaid Cost Report consisting of three (3) worksheets:

(A)[(i)] Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses;

(B)[(ii)] Worksheet 2 – FQHC Provider Staff,[-and] Encounters and Productivity; and

(C)[(iii)] Worksheet 3 – FQHC Computation of Allowable Cost and Cost

Settlement;

(3)[(D)] Trial Balance with account titles. If the provider's Trial Balance has only account numbers, a Chart of Accounts will need to accompany the Trial Balance;

(4)[(E)] a Mapping of the Trial Balance that shows the tracing of each Trial Balance account to a line and column on worksheet 1 of the Cost Report;

(5)[(F)] documentation supporting the provider's reclassification and adjustments;

(6)[(G)] a Schedule of Depreciation of depreciable assets;

(7)[(H)] listing of all satellites, if applicable;[-and]

(8)[(I)] Federal Grant Award notices or changes in scope approved by HRSA; and

(9) all items complete and accurate.

(j)[(12)] Once the final base rate for an FQHC has been calculated, the FQHC will be paid its effective rate without the need to file a cost report unless requested by HHSC. [Except as specified in paragraph (13) of this subsection, a] A cost report will be required [only] if the FQHC is seeking to adjust its effective rate. The state also may request, on a periodic basis, that an FQHC file a cost report for its most current fiscal year, within five (5) months of notification by HHSC or its designee. HHSC or its designee may delay or withhold vendor payment to a provider for failure to submit a requested cost report until a complete and workable cost report has been received by HHSC or its designee.

(k) It is the intent of the state to ensure that each FQHC is reimbursed at one hundred percent (100%) of its reasonable costs or the PPS effective rate, whichever is greater. For FQHCs that have chosen the APPS methodology, the state may reduce the FQHC's effective rate to an effective rate that reflects one hundred percent (100%) of its reasonable costs or the PPS effective rate, whichever is greater, based on audited cost reports. Any such adjustment to an FQHC's effective rate may only be applied prospectively. The new effective rate will become effective the first day of the month immediately following its determination. All subsequent increases will be calculated using the adjusted effective rate. It is the responsibility of the FQHC to request HHSC to adjust the effective rate if the FQHC can show that it is operating in an efficient manner as defined in subsection (h)(2), or show a change in scope as defined in subsection (h)(1). HHSC will not increase the effective rate for an FQHC based on the outcome of a state initiated cost report audit.

(l)[(13)] New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an interim base [initial payment]rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The interim base rate shall be set at

eighty percent (80%) of the anticipated reasonable costs. Each FQHC must file a cost report with HHSC or its designee within five (5) months of the end of the FQHC's initial fiscal year. The cost settlement must be completed within eleven (11) months of receipt of a cost report. The [cost per visit]-rate established by the cost settlement process shall be the final base rate. When HHSC has determined a final base rate, interim payments will be reconciled back to the beginning of the interim period. If the final base rate is greater than the interim base rate, HHSC will compute and pay the FQHC a settlement payment that represents the difference in rates for the services provided during the interim period. If the final base rate is less than the interim base rate, HHSC will compute and recover from the FQHC a recoupment payment that represents the difference in rates for the services provided during the interim period. Any subsequent increases shall be calculated as provided herein. A new FQHC location established by an existing FQHC participating in the Medicaid program will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location. If a provider fails to submit a cost report, HHSC or its designee may delay or withhold vendor payment to the provider until a complete and workable cost report has been received by HHSC or its designee.

(m)[(14)] In the event that the total amount paid to an FQHC by a managed care organization is less than the amount the FQHC would receive under PPS, the state will reimburse the difference on a quarterly basis. The state's quarterly supplemental payment obligation will be determined by subtracting the baseline payment under the contract for services being provided from the effective rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient costs, or bonuses.

(n)[(15)]~~[Submission of Audited Medicare Cost Reports.]~~ An FQHC must submit a copy of its audited Medicare cost report to the state within fifteen (15)[15] days of receipt[-] of the report from Medicare. If a provider fails to submit its audited Medicare cost report, HHSC or its designee may delay or withhold vendor payment to the provider until a complete and workable cost report has been received by HHSC or its designee.

(o) A visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, a qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

(A) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(B) the FQHC patient has a medical visit and an "other" health visit, as defined in subsection (p).

(p) A medical visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse mid-wife, or visiting nurse. An "other" health visit includes, but is not limited to, a face-to-face encounter between an FQHC patient and a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a Texas Health Steps Medical Screen.

(q) HHSC will pay out-of-state FQHCs based on the PPS methodology. HHSC will compute an effective rate based on approved costs provided by the FQHC on its most recent Medicare filed cost report. The effective rate will reflect the rate that would have been calculated for an in-state FQHC based on the approved scope of services that the out-of-state FQHC provides in Texas. If a provider fails to submit a cost report, HHSC or its designee may delay or withhold vendor payment to the provider until a complete and workable cost report has been received by HHSC or its designee.

~~(b) Alternative Payment Methodology. Federally qualified health centers (FQHCs) employing the alternative to the Prospective Payment System (PPS) methodology, in accordance with section 1902(aa) of the Social Security Act, as amended by the Benefits Improvement and Protection Act (BIPA) of 2000(42 U.S.C. §1396a(aa)), effective for the FQHC fiscal year that includes dates of service occurring January 1, 2001, and after, will be reimbursed a per visit rate for Medicaid-covered services with cost settlement at the greater of one hundred percent (100%) of reasonable costs or the allowable per visit rate, as determined under the prospective payment system. Cost settlements will be determined from provider submitted cost reports.~~

- (1) Written and signed agreements will be obtained from all FQHC providers agreeing to the alternative methodology.
- (2) The alternative PPS per visit rate for each FQHC will be calculated based on one hundred percent (100%) of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years.
- (3) The alternative PPS per visit rates will be calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods.
- (4) Prior to HHSC's setting a final base rate pursuant to the alternative PPS methodology outlined in this subsection, each FQHC shall be reimbursed on the basis of an interim per visit rate. The interim per visit rate for each FQHC will be the encounter rate from the latest finalized cost report settlement, as adjusted pursuant to paragraph (9) of this subsection of the alternative PPS methodology. When HHSC has determined a final alternative PPS rate, interim payments will be reconciled back to January 1, 2001. If the total payments under the interim rates are less than the total amount calculated pursuant to this subsection, an adjustment will be made to account for the difference. If the interim payments are greater than the base rate calculation, no reconciliation will occur. The final base rate, as adjusted, will apply prospectively from the date of final approval.
- (5) Reasonable costs, as used in setting the base rate, the alternative PPS rate, or any subsequent effective rate, is defined as those costs that are allowable under Medicare Cost Principles as outlined in 42 C.F.R. part 413 with no productivity screens and no per visit payment limit. The administrative cost limit of thirty percent (30%) of total costs that was in place on December 31, 2000, shall be maintained in determining reasonable costs. Reasonable costs shall not include unallowable costs.
- (6) Unallowable costs are expenses that are incurred by an FQHC and that are not directly or indirectly related to the provision of covered services according to applicable laws, rules, and standards. An FQHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not necessarily limited to, the following:
 - (A) compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;
 - (B) personal expenses not directly related to the provision of covered services;
 - (C) management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;
 - (D) advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;
 - (E) business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;
 - (F) political contributions;
 - (G) depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;
 - (H) trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;
 - (I) donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 C.F.R. part 413;
 - (J) dues to all types of political and social organizations and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services;

- (K) entertainment expenses except those incurred for entertainment provided to the staff of the FQHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;
 - (L) board of director's fees including travel costs and meals provided for directors;
 - (M) fines and penalties for violations of statutes, regulations, and ordinances of all types;
 - (N) fund raising and promotional expenses, except as noted in subparagraph (D) of this paragraph;
 - (O) interest expenses on loans pertaining to unallowable items, such as investments. Also, the interest expense on that portion of interest paid that is reduced or offset by interest income;
 - (P) insurance premiums pertaining to items of unallowable cost;
 - (Q) any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;
 - (R) mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;
 - (S) cost for goods or services that are purchased from a related party and that exceed the original cost to the related party;
 - (T) out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses that increase the quality of medical care and/or the operating efficiency of the FQHC;
 - (U) over-funding contributions to self-insurance funds that do not represent payments based on current liabilities;
 - (V) overhead costs beyond the thirty percent (30%) limitation established by HHSC.
- (7) A visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exists:
- (A) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or
 - (B) the FQHC patient has a medical visit and an "other" health visit.
- (8) A medical visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse midwife, or visiting nurse. An "other" health visit includes, but is not limited to, a face-to-face encounter between an FQHC patient and a clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a Texas Health Steps Medical Screen.
- (9) Effective for each FQHC's fiscal year that includes dates of services occurring on or after October 1, 2001, subsequent increases in an FQHC's base per visit rate or the effective rate shall be the rate of change in the Medical Economic Index (MEI) for primary care plus one and one-half percent (1.5%). If the increase in an FQHC's reasonable costs is greater than the MEI plus one and one-half percent for any fiscal year, an FQHC may request an adjustment of its effective rate equal to one hundred percent (100%) of reasonable costs.
- (10) The effective rate is the rate paid to the FQHC for the current fiscal year. The effective rate equals the base rate plus the MEI plus one and one-half percent (1.5%) for each of the FQHC's fiscal years since the setting of its base rate. The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year.
- (11) An adjustment will be made to the effective rate if the increase in an FQHC's reasonable costs are greater than the MEI plus one and one-half percent (1.5%) for any fiscal year in which the FQHC can show that it is operating in an efficient manner or that the increase is due to a change in scope. An FQHC or HHSC may request an adjustment of its effective rate equal to one hundred percent (100%) of reasonable costs by filing a cost report and the necessary documentation to support a claim that it is operating in an efficient manner or has undergone a change in scope. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an FQHC's fiscal year but no later than five (5) calendar months after the end of the FQHC's fiscal year. All requests for adjustment in the FQHC's effective rate must include at least 6 months of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost

report and documentation supporting the FQHC's claim that it is operating in an efficient manner or has undergone a change in scope. Within sixty (60) days of submitting a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All subsequent increases shall be calculated using the adjusted effective rate.

—(12) Any request by an FQHC to adjust its effective rate must be accompanied by documentation showing that the FQHC is operating in an efficient manner or that it has had a change in scope.

—(13) Operating in an efficient manner shall include a showing that: the FQHC has implemented an outcome based delivery system that includes prevention and chronic disease management. Prevention includes, but is not be limited to, programs such as immunization and medical screens. Disease Management must include, but not be limited to, programs such as those for diabetes, cardiovascular conditions, and asthma that can demonstrate an overall improvement in patient outcomes; and

—(A) paying employee's salaries that do not exceed the rates of payment for similar positions in the area, taking into account experience and training as determined by the Texas Workforce Commission;

—(B) providing fringe benefits to its employees that do not exceed 12% of the FQHC's total costs;

—(C) implementing cost saving measures for its pharmacy and medical supplies expenditures by engaging in group purchasing; and

—(D) employing the Medicare concept of a "prudent buyer" in purchasing its contracted medical services.

—(14) A change in scope of services provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC's sites. A change in scope includes:

—(A) an increase in service intensity attributable to changes in the types of patients served, including but not limited to, HIV/AIDS, the homeless, elderly, migrant, other chronic diseases or special populations;

—(B) any changes in services or provider mix provided by an FQHC or one of its sites;

—(C) changes in operating costs that have occurred during the fiscal year and that are attributable to capital expenditures, including new service facilities or regulatory compliance;

—(D) changes in operating costs attributable to changes in technology or medical practices at the FQHC;

—(E) indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents;

—(F) any changes in scope approved by the Health Resources and Service Administration (HRSA).

—(15) A workable cost report includes the following:

—(A) an FQHC Statistical Data Coversheet with Certification by an Officer or Administrator;

—(B) Medicaid Cost Report consisting of three (3) worksheets:

—(i) Worksheet 1—Reclassification and Adjustment of Trial Balance of Expenses;

—(ii) Worksheet 2—Provider Staff and Encounters; and

—(iii) Worksheet 3—Computation of Allowable Cost and Cost Settlement;

—(C) Trial Balance with account titles. If the provider's Trial Balance has only account numbers, a Chart of Accounts will need to accompany the Trial Balance;

—(D) a Mapping of the Trial Balance that shows the tracing of each Trial Balance account to a line and column on worksheet 1 of the Cost Report;

—(E) documentation supporting the provider's reclassification and adjustments;

—(F) a Schedule of Depreciation of depreciable assets;

—(G) listing of all satellites, if applicable; and

—(H) Federal Grant Award notices or changes in scope approved by HRSA.

—(16) Once the base rate for an FQHC has been calculated, the FQHC will be paid its effective rate without the need to file a cost report. Except as specified in paragraph (17) of this subsection, a cost report will be required only if the FQHC is seeking to adjust its effective rate.

—(17) New FQHCs must file a projected cost report within 90 days of their designation as a FQHC to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. FQHC must file a cost report within five (5) months of the end of FQHC's initial fiscal year. The cost settlement must be completed within eleven (11) months of receipt of a cost report. The cost per visit rate established by the cost settlement process will be the base rate. Any subsequent increases will be calculated as provided herein. A new FQHC location established by an existing FQHC participating in the Medicaid program will receive the same effective rate as the

FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

~~-(18) In the event that the total amount paid to an FQHC by a managed care organization is less than the amount the FQHC would receive under section 1902(aa)(1-4) of the Social Security Act, as applicable, the state will reimburse the difference on a quarterly basis. The state's quarterly supplemental payment obligation will be determined by subtracting the baseline payment under the contract for services being provided from the effective rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient cost, or bonuses.~~

~~-(19) It is the intent of the state to assure that centers are reimbursed at one hundred percent (100%) of their reasonable costs or the adjusted alternative PPS rate, whichever is greater. If the state can show that an FQHC is being reimbursed at an effective rate that exceeds one hundred and two percent (102%) of its reasonable costs, it may reduce the FQHC's effective rate to a rate that reflects one hundred percent (100%) of its reasonable costs or the alternative PPS rate without adjustments, whichever is greater. Any such adjustment in an FQHC's effective rate may only be applied prospectively. The state may request that an FQHC file a cost report for its most current fiscal year, plus any revisions to the cost report, within five (5) months of notification, when evidence indicates that an FQHC is receiving excess reimbursement. The adjusted alternative PPS rate means the base rate plus subsequent increases as defined herein, excluding any adjustment in the effective rate. The new effective rate will become effective the first day of the month immediately following its determination. All subsequent increases will be calculated using the adjusted effective rate. Payments made under this alternative methodology will at least be equal to what would have been paid under PPS.~~

~~-(20) Submission of Audited Medicare Cost Reports. An FQHC shall submit a copy of its audited Medicare cost report to the state within 15 days of receipt.]~~