INSTRUCTIONS
MEDI-CAL COST REPORT
RATE SETTING FREESTANDING
FEDERALLY QUALIFIED HEALTH CENTER
(FQHC)/RURAL HEALTH CENTER (RHC)
PROSPECTIVE PAYMENT SYSTEM (PPS)
FOR FPE AFTER JANUARY 1, 2021

Please read all instructions carefully before completing these forms.

These instructions assist the provider in preparing the FQHC/RHC Medi-Cal Rate Setting Cost Report in conformance with the State Medi-Cal cost reporting requirements. All costs claimed are subject to the Medicare cost reimbursement principles in Title 42 Code of Federal Regulations (CFR), Part 413, California's State Medi-Cal Plan, and current Financial Audits Branch policies.

FILING A COST REPORT

All Medi-Cal providers follow the e-File Medi-Cal Worksheets Submission Protocol for submission of FQHC/RHC Worksheets. Submit the e-file worksheets to the inbox below and include the audited financial statements (if applicable), trial balance, and working papers used to prepare the Worksheets. You will receive an email response.

- Ratesetting.Clinics@dhcs.ca.gov

Documents must be complete. Worksheets will be returned if not completed in accordance with these instructions.

For assistance/questions, please contact the FQHC/RHC Section at (916) 322-1681 or

Clinics@dhcs.ca.gov.

COVER SHEET

This Worksheet will automatically populate based on the information entered on the Certification Sheet.

CERTIFICATION SHEET—GENERAL INFORMATION AND CERTIFICATION

Select from the drop-down menu to indicate if the cost report is based on projected costs for the purpose of setting an interim rate or reporting actual costs for the first full year of operation for the purpose of setting a final PPS rate. Attach additional sheets as necessary.

PART A—GENERAL INFORMATION

1. Enter FQHC/RHC Name
2. Enter the Type of Report (Select from drop-down menu)
3. Enter Date Submitted (mm/dd/yyyy)
4. Enter FQHC/RHC Street Address
5. Enter City
6. Enter State and Zip Code
7. Enter Cost Report Preparers Name
8. Enter Cost Report Preparers Title
9. Enter Cost Report Preparers Phone Number (xxx) xxx-xxxx
10. Enter Cost Report Preparers E-mail
11. Enter Clinic Type (Select from drop-down menu)
12. Enter Date of Qualification (mm/dd/yyyy)
13. Enter NPI Number
14. Enter Reporting Period Begin (mm/dd/yyyy)
15. Enter Reporting Period End (mm/dd/yyyy)
16. Enter Type of Control (Select from drop-down menu)
17. Enter Type of Organization (Select from drop-down menu)
18. Enter Other (Specify Type)

Owners of Facility and Percentage Owned

19. Enter Provider Name
20. Enter Address/Location
21. Enter NPI Number

PART A1—Related Parties and Organizations Disclosure

22. Enter Provider Name
23. Enter Address/Location
24. Enter NPI

Names of Physicians

25. Enter Physician Name
26. Enter Billing/NPI Number

Statement of Compensation

27. Enter Name of Owner/Relatives
28. Enter Title
29. Enter Percentage of Ownership Interest
30. Enter Average Hours Worked per Week (Indicate name in parentheses) ( )
31. Enter Compensation Included in Cost Report

PART B—CERTIFICATION BY OFFICER OF THE HOME OFFICE

You must complete the DocuSign certification statement on all FQHC/RHC Home Office Cost Reports submitted. The form is located on the DHCS.ca.gov website. We will reject any cost report filed without a completed certification statement.

Read the certification statement carefully, and either the administrator, controller, corporate officer, or member of the board of directors must sign it. The official signing the report must have the legal capacity to make commitments for the organization.

WORKSHEETS 1, 1A, & 1B—TRIAL BALANCE OF EXPENSES—RECLASSIFICATION & ADJUSTMENT

Worksheet 1, Columns 1 and 2 are used to record the trial balance of expenses from the clinic's accounting books and records. The cost report must reconcile to the provider's general ledger and the audited financial statements. **Round all amounts to the nearest dollar. Attach additional sheets if necessary.**

Enter in Column 4 any reclassifications needed for proper cost allocation. For example, if a physician's duties include some administrative duties, the appropriate portion of compensation and applicable payroll taxes and fringe benefits may be reclassified from Line 1 to Line 42, Office Salaries. All reclassifications in Column 4 must be detailed on Worksheet 1A. Worksheet 1A provides an explanation of the reclassifications and indicates the amount allocated to each of the affected cost centers. The net total of Column 4 must equal zero.

Enter in Column 6 any adjustments to the reclassified expenses. Adjustments are required for **home office costs** and to adjust expenses in accordance with allowable costs as defined in 42 CFR, Part 413. All adjustments in Column 6 must be detailed on Worksheet 1B. Worksheet 1B provides a description of the adjustment, the basis of adjustment (cost or amount received), dollar amount, and the affected cost center(s). Reductions to expenses are shown in brackets. **(Transferred Home Office costs must agree with the amounts from DHCS 3089 or 3089.1 Home Office Cost Report—Schedule 6)**

WORKSHEET 2: PARTS A & B—DETERMINATION OF FQHC/RHC COSTS AND RATE PER VISIT

This Worksheet is used to determine the total costs of health care services and to determine the PPS reimbursement rate. The numbers used in this Worksheet flow from other Worksheets. Once all of the Worksheets are completed, this schedule will be automatically calculated due to formulas contained in the Worksheet.

Part A—Determination of Overhead Applicable to FQHC/RHC Services (Lines 1 through 8)

The purpose of this section is to allocate overhead costs (capital and administrative) reported on Worksheet 1, Page 2, Line 55 to the FQHC/RHC Health Care Services Costs and Nonreimbursable Cost centers. Costs are allocated based to each component based on a percentage of total costs (excluding overhead).

Part B—Determination of FQHC/RHC Rate Per Visit (Lines 1 through 5)

The purpose of this section is to determine the FQHC/RHC PPS rate per visit payable by the Medi-Cal program. The PPS rate is computed by dividing the total reimbursable costs computed in PART A by total reimbursable visits from Worksheet 6 per the provider's records. Total visits include

all visits for all payor types meeting the definition of a "visit" as outlined below REGARDLESS of whether such visits were billed and/or paid. The same definition for patient visits must be used for both billing and rate-setting purposes.

A "visit" for purposes of reimbursing FQHC/RHC services is based on the following:

1. A face-to-face encounter between an FQHC or RHC patient and a physician, a resident in a Teaching Health Center Graduate Medical Education Program under the supervision of a teaching physician (effective 4/1/18), physician assistant, nurse practitioner, acupuncturist, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits described in section 1905(a)(2)(C) of the Social Security Act (the Act) that are furnished by an FQHC or services described in section 1905(a)(2)(B) of the Act that are furnished by an RHC. The definition of "physician" includes the following:

    a. A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.

    b. A doctor of podiatry is authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.

    c. A doctor of optometry is authorized to practice optometry by the State and who is acting within the scope of his/her license.

    d. A doctor authorized to administer chiropractic services by the State and who is acting within the scope of his/her license.

    e. A doctor of dental surgery (dentist) is authorized to practice dentistry by the State and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per-visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

2. Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner as defined in the California Code of Regulations, Title 22, Section 51179.7.

Encounters with more than one health professional and multiple encounters with the same health professional, which take place on the same day and at a single location, constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

a. When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, then two visits may be counted.

b. The clinic patient is seen by a dentist or registered dental hygienist and sees any one of the following providers: physician (as defined above in PART B (a)(i)-(v)), physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, or comprehensive perinatal services, practitioner.

Line 1: Reimbursable FQHC/RHC costs (Part A, line 8)

Line 2: Total FQHC/RHC visits (as defined above) from Worksheet 6, column 5, line 20.

Line 3: FQHC/RHC PPS rate per visit (Part B, line 1 divided by Part B, line 2)

WORKSHEET 3—VISITS, REVENUES, AND EXPENDITURES

Total Visits: Enter the total number of visits recorded by the funding source. Please include all programs and visit statistics specific to your organization.

Note: Total visits reported in Column 1 must agree with total visits reported on Worksheet 6, Column 2, and line 20.

Related Revenues: Enter the total revenue received by the funding source. Enter all categories for which revenues are received for patient services provided even when the services do not constitute a "visit," such as grant/contract funding received for outreach programs. The "Other" category may also include any non-patient revenues.

Note: Total revenues reported in Column 2 must agree with the total patient and non-patient revenues recorded in the clinic's general ledger or reported in the independently audited financial statements if completed at the time of filing the cost report.

Related Expenditures: Enter the expenditures recorded by the funding source with the exception of lines 1 through 14.

WORKSHEET 4—SUMMARY OF SERVICES PROVIDED BY CLINIC

List all services available at, or provided by, the clinic. Identify any provider's contractor name and location.

Place an "X" in the "NO" column if the service is not available or provided by the clinic.

Place an "X" in the "ON-SITE" column if the service is provided on-site by the clinic.

Place an "X" in the "OFF-SITE" column if the service is provided off-site under a contractual arrangement. Please provide the contractor's name.

WORKSHEET 5—SUMMARY PRODUCTIVE FTEs AND VISITS OF HEALTHCARE PRACTITIONERS

Column 1—FTE's:
Record the total number of healthcare practitioner positions by Full-Time Equivalent (FTE) using 2,080 hours as the standard. Calculate for each person in each category their ANNUAL PRODUCTIVE time worked. The FTE should only include productive time. Do not include non-productive time. For further guidance on Productivity Standards and definitions of productive and non-productive time see below "**Full Time Equivalant Productivity Standards Guidelines**". Divide the annual productive time by 2,080 to determine the percentage of time each person is actively engaged in patient care activities. For example, if a physician spent 1,040 hours seeing patients, the FTE would be calculated as (1,040/2080 = .5 FTEs). Compile the FTE's by category. Do not include mental health staff in the minimum standards assessment.

Column 2—# of VISITS: Record the total visits (as previously defined) furnished to all patients for each of the applicable health care staff categories.

Columns 3 & 4—ON-SITE/OFF-SITE: Place an "X" in the column "ON-SITE" or "OFF-SITE" to identify where the staff is located.

WORKSHEET 6—PRODUCTIVITY STANDARDS ASSESSMENT

The purpose of this worksheet is to determine if the provider has met the minimum number of visits standards and to determine the visit count for the PPS rate determination.

Worksheet 6 will automatically calculate the visits based on the information entered from Worksheet 5 and apply the productivity standards. The calculation will determine if the provider has met the minimum number of visits standard, and can therefore use actual visit counts for its PPS rate determination.

Minimum productivity standards are used to help determine the average cost per FQHC or RHC patient visit, reimbursed at the PPS rate. The minimum productivity standard for a facility is equal to the facility's total expected visits in a year for health care provider types that are subject to the minimum productivity standard. A facility's total expected visits reflect the minimum productivity requirement of 3,200 visits per full-time equivalent (FTE) physician and 2,600 visits per FTE nurse practitioner, physician assistant, or certified nurse-midwife (NP, PA, and CNM) per year, based on a 40 hour work week (2,080 hours per annum). For any Provider's fiscal year ending after January 1, 2021, the minimum productivity standard has been revised to reflect 3,200 and 2,600 visits per FTE. The following healthcare staff is not subject to minimum productivity standards: Dentist, Registered Dental Hygienist (RHD), Doctor of Podiatric Medicine (DPM), Doctor of Optometry (OD), Doctor of Chiropractic (DC), Psychiatrist, Clinical Psychologist (CP), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), Licensed Acupuncturist, Visiting Nurse, Comprehensive Perinatal Health Worker, non-primary care specialists.

For purposes of initial rate setting or change in scope of service requests, the FQHC's or RHC's total visits shall be calculated as follows:

The FQHC's or RHC's total visit count will be calculated by adding the number of visits allocated to health care staff subject to the minimum productivity standard adjustment plus the actual number of visits rendered by health care staff that are not subject to the minimum productivity standards. For example, consider a facility that has 2.4 physicians FTE's, 3.0 NP FTEs, 0.8 CNM FTEs, and 1.5 clinical psychologist FTEs. The minimum productivity standard would require the facility to have 17,560 ((2.4 x 3,200) + (3.0 x 2,600) + (0.8 x 2,600)) visits plus the actual clinical psychologist visits. If the total number of physician, NP, and CNM visits in the rate-setting or change in scope of service year did not equal or exceed 17,560, the visit count would be increased to 17,560. The total visits would include the 17,560 and the actual number of clinical psychologist visits.

Effective for any fiscal year ending after January 1, 2021, the minimum productivity standard of 3,200 and 2,600 visits per FTE is applied.

Columns 1 & 2—Summarize the number of FTE's and visits furnished by the health care staff from Worksheet 5.

Column 3—The productivity standards are screening guidelines to determine reasonable service levels furnished by certain healthcare staff. Payments for services are subject to these guidelines used to test the reasonableness of the productivity of the clinic/center's health care staff. These guidelines are applied to staff for FQHC/RHC services furnished both at the clinic/center's site and in other locations.

They are as follows:

- At least 3,200 visits annually per full-time equivalent physician employed by the clinic or contracted on an ongoing basis.
- At least 2,600 visits per year per full-time equivalent physician assistant, nurse practitioner, or certified nurse-midwife employed by the clinic or contracted on an ongoing basis.

Column 4—The minimum visits are computed for Lines 1 through 6 by multiplying FTEs in Column 1 by productivity standards in Column 3. These are minimum visits that personnel is expected to furnish cumulatively.

Column 5—Lines 1 through 6 are evaluated for minimum productivity standards per CMS guidelines. On line 7, column 5, the actual visits on Column 2, Line 7 are compared to the minimum visits on Column 4, line 7. The greater of the two is used as the visit number on Column 5, Line 7.

- For lines 7 through 21, the actual number of visits is carried forward to Column 5 from Column 2.

- The reimbursable visits from Lines 7 through 19 are summed on Column 5, Line 20 and carried to Worksheet 2, Part B, Line 2 to calculate the PPS rate per visit

- The total visits on Column 5, Line 22 are the sum of reimbursable visits on Line 20 and the nonbillable/nonreimbursable visits on Line 21 and should match with total visits on Worksheet 5.

Full Time Equivalent Productivity Standards Guidelines:

The physician, NP, PA, and CNM FTEs on the cost report is a productive FTE that is defined as, "the time spent seeing patients or scheduled to see patients." All hours that a physician, NP, PA, and CNM spend seeing patients or are scheduled to see patients must be included in the productive FTE calculation. The productive FTE does not include any hours for non-productive activities when a provider is not seeing patients or scheduled to see patients.

"Productive Time" is defined as time spent seeing patients or scheduled to see patients. It does not include non-productive time. The facility must report its FTE on the cost report for physicians and NPs, PAs and CNMs, which is all the time spent seeing patients or scheduled to see patients. All activities related to the provision of health care, such as, but not limited to, reviewing test results, authorizing refills, care-related emails, and follow-up calls, are included in the time scheduled to see patients and must be included in the FTE on the cost report.

"Non-productive Time" is defined as the time that is spent not seeing patients or scheduled to see patients, such as, but not limited to, administrative time, paid time off (PTO), continuing medical education (CME), supervision, teaching activities, and other training and meetings, that occur when the physician, NP, PA, or CNM is not seeing patients or scheduled to see patients.

"Administrative Time" is defined as time spent on activities related to the overall administration of the clinic and performed when not seeing patients or not scheduled to see patients, which includes, but may not be limited to, the following types of activities: medical protocol evaluation and implementation, ensuring compliance with state and federal statutes and regulations, resource allocation, utilization review, quality assurance and improvement, planning and administrative meetings, supervisory oversight and coordination between clinic departments, and inventory control.

The FQHC or RHC is expected to maintain adequate documentation to enable DHCS to verify each physician, NP, PA, and CNM Productive Time, Administrative Time, and Non-productive Time. Adequate documentation requires accurate and sufficient detail that is capable of verification by an auditor of the hours spent rendering Productive Time, Administrative Time, and Non-productive time.

Process for requesting an exemption to productivity standards:

The FQHC or RHC may apply for an exemption to the minimum productivity standards requirement by submitting an exemption or partial exemption request to DHCS. A request for an exemption should be provided with the rate-setting cost report or with the CSOSR. The request must be supported with verifiable documentation demonstrating the FQHC's or RHC's unique circumstance(s) that prevents the clinic from meeting the minimum productivity standards. Exemption or partial exemption requests shall include the following documentation, as applicable:

- The specific reason(s) for the exemption and the number of times the specific reason(s) occurred that prevented the clinic from meeting the minimum productivity standards.

- An explanation of why the FQHC or RHC believes that good cause for an exemption will continue in future years.

- If the specific reason(s) for an exemption is related to longer than the minimum productive standard visit time (including multiple encounters on the same day that may only count as a single visit), the FQHC or RHC must submit verifiable documentation of the time spent seeing the patients and scheduled to see patients at the time the visits occurred. The documentation submitted must be capable of being audited and be in sufficient detail to allow for the verification of the actual time spent.

- If the specific reason(s) for an exemption is not related to time spent on patient visits, the clinic must submit documentation in sufficient detail so that DHCS may audit the occurrence of the specific reason(s) for the exemption and when the specific reason(s) occurred. The documentation must demonstrate the specific occurrence or permanent circumstances that negatively affect the utilization of a clinic.

Verifiable documentation for fiscal year(s) subsequent to the rate-setting fiscal year may be requested to determine if and to the extent the reason for the exemption continues to exist and still result in the inability to meet the minimum productivity standards. If in a subsequent year, the exemption no longer exists, the provider is required to complete an analysis to determine if the change reduces the PPS rate by 2.5%; therefore, requiring a Change in Scope of Service Request in accordance with Welfare & Institutions Code Section 14132.100.

Documentation Guidelines:

As noted above, the FQHC or RHC is expected to maintain adequate documentation to enable DHCS to verify each physician, NP, PA, and CNM Productive Time, Administrative Time, and Non-productive Time. Adequate documentation requires accurate and sufficient detail that is capable of verification by an auditor of the hours spent rendering Productive Time, Administrative Time, and Non-productive time.

In addition, if an exemption is requested, supporting documentation must be supported by verifiable documentation.

Documentation may include, but is not limited to, the following:

- Employment contracts
- Timesheets
- Patient schedules
- Payroll schedules
- Provider prepared working paper supporting provider's reported FTE calculation

- EHR system supporting time spent seeing patients. However, this may not be complete documentation to support all activities related to the provision of health care. These activities include, but are not limited to, reviewing test results, authorizing refills, care-related emails, and follow-up calls.
- Time studies – Time studies must meet the requirements under cost-reimbursement principles (CMS Publication 15-1, Section 2314).
- Any other reasonable method developed by Provider to document Productive Time, Administrative Time, or Non-productive Time.