




ISSUE DATE December 30, 2025	EFFECTIVE DATE January 1, 2026	NUMBER 99-26-01
SUBJECT Provider Preventable Conditions PROMISe™ Provider Handbook Updates	BY  Sally A. Kozak Deputy Secretary Office of Medical Assistance Programs	

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: <https://www.pa.gov/en/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents.html>.

PURPOSE:

This purpose of this bulletin is to advise providers that the Department of Human Services (Department) is updating the PROMISe™ Provider Handbooks to align language related to provider preventable conditions (PPC), health care acquired conditions (HCAC), and other provider preventable conditions (OPPC).

The updates do not include any changes to current policy or reporting procedures.

SCOPE:

This bulletin applies to Medical Assistance (MA) enrolled providers who render services to MA beneficiaries. Providers rendering services under the MA managed care delivery system should address any questions related to payment policy and reporting requirements to the appropriate managed care organization.

BACKGROUND:

In the response to the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), enacted March 23, 2010, the Department issued MA Bulletin 01-12-30, titled “Provider Preventable Conditions,” on June 15, 2012, informing providers of the Department’s payment policy and reporting requirements for PPCs (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/d_006001.pdf).

On October 2, 2013, the Department issued MA Bulletin 08-13-39, titled “Correction to the Procedures for Reporting of Other Provider Preventable Conditions (OPPCs) for Federally

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
<https://www.pa.gov/agencies/dhs/departments-offices/omap-info>

Qualified Health Centers, Rural Health Clinics and Dentists,” clarifying the manner in which OPPCs are reported to the Department (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/p_036063.pdf).

As a result of final rule 77 FR 53257, published by the Centers for Medicare & Medicaid Services (CMS) on August 31, 2012, the Department issued MA Bulletin 01-15-28, titled “Provider Preventable Conditions,” on September 1, 2015, which added two additional Hospital Acquired Conditions providers are required to report (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_208651.pdf).

DISCUSSION:

The Department is updating the following PROMISe™ Provider Handbooks to provide formatting consistency among sections in the various handbooks. The updates do not change any policy or procedure for reporting PPCs on claims.

- 837 Professional/CMS-1500 Claim Form
- 837 Institutional/UB-04 Claim Form
- 837 Dental/ADA – Version 2024 Claim Form

For Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), the Department also updated “Appendix E – FQHC/RHC Handbook (FQHC/RHC Handbook)” of the PROMISe™ Provider Handbook 837 Professional/CMS-1500 Claim Form with guidance related to OPPCs.

PROCEDURE:

The Department is committed to ensuring that quality health care is provided to MA beneficiaries in all healthcare settings. Providers are required to report PPCs, including HCACs and OPPCs, on or attached to their claims, to the Department. Providers should refer to the attachments to this MA Bulletin, as well as MA Bulletins 01-12-30, 08-13-39, 01-15-28, and their PROMISe™ Provider Handbook for additional information.

FQHCs and RHCs are to refer to the attachments below. In addition, all future updates to the FQHC/RHC Handbook can be found on the Department’s website.

RESOURCES:

- PROMISe™ Provider Handbook 837 Professional/CMS-1500 Claim Form may be accessed at: <https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/837-professional-cms-1500-claim-form.pdf>
- PROMISe™ Provider Handbook 837 Institutional/UB-04 Claim Form may be accessed at: <https://www.pa.gov/content/dam/copapwp->

[pagov/en/dhs/documents/providers/promise-guides/documents/837%20Institutional%20UB-04%20Claim%20Form.pdf](https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/837%20Institutional%20UB-04%20Claim%20Form.pdf)

- PROMISe™ Provider Handbook 837 Dental/ADA – Version 2024 Claim Form may be accessed at: <https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/837-dental-ada-version-2024-claim-form.pdf>
- PROMISe™ Provider Handbook 837 Professional/CMS-1500 Claim Form, Appendix E – FQHC/RHC Handbook may be accessed at: <https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/appendix%20e.pdf>

ATTACHMENTS:

Attachment 1 - Section 10 of the PROMISe™ Provider Handbook 837 Professional/CMS-1500 Claim Form, Effective January 1, 2026

Attachment 2 - Section 10 of the PROMISe™ Provider Handbook 837 Institutional/UB-04 Claim Form, Effective January 1, 2026

Attachment 3 - Section 12 of the PROMISe™ Provider Handbook 837 Dental/ADA – Version 2024 Claim Form, Effective January 1, 2026

Attachment 4 - Appendix E – FQHC/RHC Handbook of the PROMISe™ Provider Handbook 837 Professional/CMS-1500 Claim Form, Effective January 1, 2026

10 Provider Preventable Conditions (PPCs)

This section provides the reporting requirements and the procedures for provider preventable conditions (PPCs), which encompass health care acquired conditions (HCACs) and other provider preventable conditions (OPPCs). This section provides links to Medical Assistance (MA) Bulletins with additional information for providers.

10.1 Requirements

In accordance with 42 CFR 447.26, the Department of Human Services (Department) will not provide payment for services related to PPCs, including HCACs and OPPCs. In addition, the MA Program has the following relevant payment limitations:

- 55 Pa. Code §1101.71 relating to utilization control sets forth the MA Program’s responsibility to establish procedures for reviewing the utilization of and payment for, MA services in accordance with section 1902(a)(3) of the Social Security Act (Act) (42 U.S.C.A. §1396a(a)(30)) as well as the provider’s responsibility to cooperate with such reviews;
- 62 PS. 1407 (a)(6) and 55 Pa. Code §1101.77(a)(10) prohibit the submission of claims for the provision of MA services which the Department’s medical professionals have determined to be harmful or of little or no benefit to the beneficiary, of inferior quality, or medically unnecessary;
- 55 Pa. Code § 1101.83 relating to restitution and repayment, sets forth the Department’s right to restitution for non-compensable services; and 55 Pa. Code §1150.61 relating to general payment policy, sets forth that the Department will pay for covered services that comply with applicable regulations.

42 CFR 447.26(b) provides definitions for PPCs, HCACs, and OPPCs. A PPC is an umbrella term established by the Centers for Medicare & Medicaid Services (CMS) and is defined as “a condition that meets the definition of a HCAC or OPPC”.

A HCAC is defined as “a condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition (HAC) by the Secretary of the United States Department of Health and Human Services under section 1886(d)(4)(D)(iv) of the Act, other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients”.

An OPPC is any condition identified in a state’s Medicaid State Plan occurring in any health care setting that meets the following criteria:

- The condition has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- The condition has a negative consequence for the beneficiary.
- The condition is auditable, and includes, at a minimum:
 - The wrong surgical or other invasive procedure performed on a patient.
 - A surgical or other invasive procedure performed on the wrong patient.

- o A surgical or other invasive procedure performed on the wrong body part.

10.2 Procedure

Providers are required to report PPCs, including HCACs and OPPCs, on or attached to their claims to the Department.

The Department will adjust affected provider payments for HCACs and OPPCs in accordance with federal and state statutory requirements and MA Program payment regulations in the following manner:

10.2.1 Health Care Acquired Conditions (HCACs)

Acute care general hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals paid under the prospective payment system are required to report HCACs by using the applicable “Present On Admission” (POA) indicator for each diagnosis code on their claim(s). POA indicators include the following:

- Y – described as “Diagnosis was present at the time of inpatient admission”.
- N – described as “Diagnosis was not present at the time of inpatient admission”.
- U – described as “Documentation insufficient to determine if condition was present at the time of admission”.
- W – described as “Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission”.
- Blank - described as “Exempt from POA reporting” (electronic or internet claims, must be reported with POA Exempt Diagnosis).
- 1 – described as “Exempt from POA reporting” (paper claims only, must be reported with POA Exempt Diagnosis)

Additionally, rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals are required to report HCACs through the Department’s Concurrent Hospital Review (CHR) Process.

The Department will exclude any HCAC diagnosis code or HCAC diagnosis code/procedure code combination associated with the applicable POA indicator from grouping of the acute care general hospital’s inpatient claim. The Department then will be able to reasonably isolate costs associated with the HCAC and thereby ensure that the hospital receives the appropriate All Patient Refined-Diagnosis Related Group (APR-DRG) payment and does not receive payment for a higher paying APR-DRG or an APR-DRG with a higher severity level.

The Department will deny days associated with HCACs and reduce the number of inpatient covered days by the denied number of days on inpatient rehabilitation and psychiatric hospitals’ and excluded rehabilitation and psychiatric units of acute care general hospitals’ inpatient claims, as determined through physician review under the Department’s CHR process and as reported by the POA indicator on the claim.

10.2.2 Other Provider Preventable Conditions (OPPCs)

When an OPPC occurs, acute care general hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals are required to complete the OPPC Self Reporting Form (MA 551) according to directions and submit the form as an attachment to their claim following the directions for submitting a claim attachment according to the applicable provider's billing guidelines. Acute care general hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals are reminded that they must identify all practitioners involved and provide details relating to the OPPC event.

The Department uses a claims processing edit to post on inpatient claims when one or more of the following diagnosis codes are indicated on the OPPC Self Reporting attachment to the claim:

- Y65.51 defined as “Performance of wrong procedure (operation) on correct patient”;
- Y65.52 defined as “Performance of procedure (operation) on patient not scheduled for surgery”; or
- Y65.53 defined as “Performance of correct procedure (operation) on wrong side or body part”.

The Department will manually review acute care general hospital claims to determine whether the identified OPPC will result in a higher APR-DRG or increases severity associated with the APR-DRG. If so, the payment will be reduced to the appropriate APR-DRG and severity level and payment will be made to the hospital accordingly. If the acute care general hospitalization is solely the result of an OPPC that occurred upon admission, the Department will not make an APR-DRG payment to the hospital.

The Department will not make a per diem payment to inpatient rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals when an OPPC is reported with the claim as denied through the CHR process.

All other affected providers are required to report the applicable procedure code(s) with one or more of the following modifiers on the claim when an OPPC occurs:

- PA defined as “Surgical or otherwise invasive procedure on the wrong body part”
- PB defined as “Surgical or otherwise invasive procedure on the wrong patient”
- PC defined as “Wrong surgery or otherwise invasive procedure on the patient”.

The Department will deny the per diem payment for nursing facilities, county nursing facilities, state operated nursing facilities, intermediate care facilities for the intellectually disabled, and intermediate care facilities for other related conditions when an OPPC is reported on the claim.

The Department will deny the MA Program Fee Schedule payment for ambulatory surgical centers, hospital short procedure units, clinics, and practitioners when an OPPC is reported on the claim. In instances when an OPPC occurs during an operation involving multiple surgical procedures, anesthesiologists are to submit two separate claims and adhere to the following instructions:

- Submit a claim and report the anesthesia time (in minutes) associated with the procedure code that **is not related** to the OPPC.

- Submit a second claim and report the anesthesia time (in minutes) associated with procedure code and modifiers PA, PB, and/or PC that **are related** to the OPPC.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are to report the applicable procedure code with one or more of the modifiers PA, PB or PC on the CMS-1500 claim form or the 837P electronic claim form when an OPPC occurs. The Department will deny the FQHC's or RHC's provider-specific prospective payment system rate when an OPPC is reported on the claim.

Dentists are to report OPPCs using modifiers PA, PB, and/or PC in the "Remarks" section of the ADA claim form or in the "Billing Note" of the electronic dental (837-D) or Internet dental claim media. The Department will deny the dentist's payment when an OPPC is reported on the claim.

Providers may download the OPPC Self Reporting Form (MA 551), on the Department's website at: <https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/medical-assistance-provider-forms.html>.

MA beneficiaries and/or their families are held harmless, and **the affected provider and/or facility are not permitted to bill the MA beneficiary or their families for PPCs, which includes the billing of any applicable MA copayment, deductible, or coinsurance amount.**

Providers are to refer to the following MA Bulletins, and any subsequent MA Bulletins, for additional information:

- MA Bulletin 01-12-30 et. al, titled "Provider Preventable Conditions": https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/d_006001.pdf
- MA Bulletin 08-13-39 and 27-13-41, titled "Correction to the Procedures for Reporting Other Provider Preventable Conditions (OPPCs) for Federally Qualified Health Centers, Rural Health Clinics and Dentists": https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/p_036063.pdf
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10.2.3 Ordering and Prescribing Requirements

The Patient Protection and Affordable Care Act (ACA) added requirements for provider screening and enrollment, including a requirement that states require physicians and other practitioners who order, refer, or prescribe items or services for MA beneficiaries to enroll as MA providers. The United States Department of Health and Human Services regulation implementing this requirement can be found at 42 CFR 455.410.

Providers should check their PROMISe™ billing guide for further directions on including the National Provider Identifier (NPI) of the MA enrolled provider who ordered or prescribed the item or service on the claim. The billing guides will instruct providers where to populate the NPI of the

ordering or prescribing MA enrolled provider on the claim and can be accessed on the Department's website at: <https://www.pa.gov/en/agencies/dhs/resources/for-providers/promise/promise-provider-handbooks-guides.html>.

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All other affected providers are required to report the applicable procedure code(s) with one or more of the following modifiers on the claim when an OPPC occurs:

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Dentists are to report OPPCs using modifiers PA, PB, and/or PC in the "Remarks" section of the ADA claim form or in the "Billing Note" of the electronic dental (837-D) or Internet dental claim media. The Department will deny the dentist's payment when an OPPC is reported on the claim.

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as determined through physician review under the Department’s CHR process and as reported by the POA indicator on the claim.

12.2.2 Other Provider Preventable Conditions (OPPCs)

When an OPPC occurs, acute care general hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals are required to complete the OPPC Self Reporting Form (MA 551) according to directions and submit the form as an attachment to their claim following the directions for submitting a claim attachment according to the applicable provider’s billing guidelines. Acute care general hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals are reminded that they must identify all practitioners involved and provide details relating to the OPPC event.

The Department uses a claims processing edit to post on inpatient claims when one or more of the following diagnosis codes are indicated on the OPPC Self Reporting attachment to the claim:

- Y65.51 defined as “Performance of wrong procedure (operation) on correct patient”;
- Y65.52 defined as “Performance of procedure (operation) on patient not scheduled for surgery”; or
- Y65.53 defined as “Performance of correct procedure (operation) on wrong side or body part”.

The Department will manually review acute care general hospital claims to determine whether the identified OPPC will result in a higher APR-DRG or increases severity associated with the APR-DRG. If so, the payment will be reduced to the appropriate APR-DRG and severity level and payment will be made to the hospital accordingly. If the acute care general hospitalization is solely the result of an OPPC that occurred upon admission, the Department will not make an APR-DRG payment to the hospital.

The Department will not make a per diem payment to inpatient rehabilitation hospitals, psychiatric hospitals, and excluded rehabilitation and psychiatric units of acute care general hospitals when an OPPC is reported with the claim as denied through the CHR process.

All other affected providers are required to report the applicable procedure code(s) with one or more of the following modifiers on the claim when an OPPC occurs:

- PA defined as “Surgical or otherwise invasive procedure on the wrong body part”
- PB defined as “Surgical or otherwise invasive procedure on the wrong patient”
- PC defined as “Wrong surgery or otherwise invasive procedure on the patient”.

The Department will deny the per diem payment for nursing facilities, county nursing facilities, state operated nursing facilities, intermediate care facilities for the intellectually disabled, and intermediate care facilities for other related conditions when an OPPC is reported on the claim.

The Department will deny the MA Program Fee Schedule payment for ambulatory surgical centers, hospital short procedure units, clinics, and practitioners when an OPPC is reported on the claim.

In instances when an OPPC occurs during an operation involving multiple surgical procedures, anesthesiologists are to submit two separate claims and adhere to the following instructions:

- Submit a claim and report the anesthesia time (in minutes) associated with the procedure code that **is not related** to the OPPC.
- Submit a second claim and report the anesthesia time (in minutes) associated with procedure code and modifiers PA, PB, and/or PC that **are related** to the OPPC.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are to report the applicable procedure code with one or more of the modifiers PA, PB or PC on the CMS-1500 claim form or the 837P electronic claim form when an OPPC occurs. The Department will deny the FQHC's or RHC's provider-specific prospective payment system rate when an OPPC is reported on the claim.

Dentists are to report OPPCs using modifiers PA, PB, and/or PC in the "Remarks" section of the ADA claim form or in the "Billing Note" of the electronic dental (837-D) or Internet dental claim media. The Department will deny the dentist's payment when an OPPC is reported on the claim.

Providers may download the OPPC Self Reporting Form (MA 551), on the Department's website at: <https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/medical-assistance-provider-forms.html>.

MA beneficiaries and/or their families are held harmless, and **the affected provider and/or facility are not permitted to bill the MA beneficiary or their families for PPCs, which includes the billing of any applicable MA copayment, deductible, or coinsurance amount.**

Providers are to refer to the following MA Bulletins, and any subsequent MA Bulletins, for additional information:

- MA Bulletin 01-12-30 et. al, titled "Provider Preventable Conditions": https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/d_006001.pdf
- MA Bulletin 08-13-39 and 27-13-41, titled "Correction to the Procedures for Reporting Other Provider Preventable Conditions (OPPCs) for Federally Qualified Health Centers, Rural Health Clinics and Dentists": https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/p_036063.pdf
- MA Bulletin 01-15-28 et. al., titled "Provider Preventable Conditions": https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_208651.pdf

Appendix E – FQHC/RHC HANDBOOK

This handbook includes the Guidelines and Requirements for Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) for services rendered to Medical Assistance beneficiaries.

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SECTION 1: REQUIREMENTS FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS**A. Federally Qualified Health Center (FQHC)** – An individual health center site location that:

1. Meets all of the requirements and has been granted funds under Section 330 of the Public Health Services Act; or
2. Meets all of the requirements for receiving a grant under Section 330 of the Public Health Services Act; as determined by the Secretary of the U.S. Department of Health and Human Services (i.e., qualifies as an FQHC “look alike”); or
3. Does not currently meet all of the FQHC requirements under the Public Health Services Act, but receives a temporary waiver from the Secretary of the U.S. Department of Health and Human Services allowing the health center to act as a FQHC while it strives to meet the requirements under Section 330 of the Public Health Services Act; and
4. Meets all applicable requirements for Medical Assistance (MA) providers as set forth in 55 Pa. Code Chapter 1101, relating to General Provisions; and
5. Meets all FQHC licensure and certification standards established under federal and Pennsylvania law.

B. Rural Health Clinic (RHC) – An individual health clinic site location that:

1. Has been determined by the Secretary of the U.S. Department of Health and Human Services to meet the requirements of Section 1861 of the Social Security Act (42 U.S.C. § 1395x(aa)(1)) and 42 CFR Part 491; and
2. Has filed an agreement with the Secretary in order to provide RHC services under Medicare. See 42 CFR 405.2402; and
3. Meets all applicable requirements for MA providers as set forth in 55 Pa. Code Chapter 1101, relating to General Provisions, and 55 Pa. Code Chapter 1129, relating to Rural Health Clinic Services; and
4. Meets all RHC licensure and certification standards established under federal and Pennsylvania law.

C. FQHC/RHC Services

Federally Qualified Health Center Service – A medical physical health, medical behavioral health, vision, or dental service provided by FQHC personnel capable of generating a billable encounter. FQHC services are identified within Section 1905 of the Social Security Act (42 U.S.C. § 1396d(a)(2)(C)) and in Attachment 3.1A/3.1B of Pennsylvania’s Medicaid State Plan, namely:

- Physician services.
- Services and supplies incident to physician services (including certain drugs and biologicals that may not be self-administered), as specified in 42 CFR 405.2413.
- Physician Assistant (PA) services.
- Certified Registered Nurse Practitioner (CRNP) services.
- Licensed Clinical Psychologist services.
- Licensed Clinical Social Worker (LCSW) services.
- Licensed Professional Counselor (LPC) services.
- Licensed Marriage and Family Therapist (LMFT) services.
- Services and supplies incident to PA, CRNP, Licensed Clinical Psychologist, and LCSW services, as specified in 42 CFR 405.2415, as would otherwise be furnished by or incident to physician services.
- Additional services as approved by the Health Resources and Services Administration (HRSA) in the FQHC’s approved scope of project that are identified on page 1g in Attachment 3.1A/3.1B of Pennsylvania’s Medicaid State Plan.
- Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine, SARS-CoV-2 (COVID-19) vaccine, and their administrations.

In the case of a FQHC located in an area in which there exists a shortage of home health agencies, as defined in 42 CFR 405.2417, part-time or

intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to an individual under a written plan of treatment established and periodically reviewed and approved by a physician.

Rural Health Clinic Service - A medical physical health, medical behavioral health, vision, or dental service provided by RHC personnel capable of generating a billable encounter. RHC services are identified within Section 1905 of the Social Security Act (42 U.S.C.A. § 1396d(a)(2)(B)) and additional services as identified in Attachment 3.1A/3.1B of Pennsylvania’s Medicaid State Plan, namely:

- Physician services.
- Services and supplies incident to physician services (including certain drugs and biologicals that may not be self-administered).
- PA services.
- CRNP services.
- Licensed Clinical Psychologist services.
- LCSW services.
- LPC services.
- LMFT services.
- Services and supplies incident to PA, CRNP, Licensed Clinical Psychologist, and LCSW services as would otherwise be furnished by or incident to physician services.
- Additional services in the RHC’s approved scope of project that are identified on page 1f in Attachment 3.1A/3.1B of Pennsylvania’s Medicaid State Plan.
- Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine, COVID-19 vaccine, and their administrations.
- In the case of a RHC located in an area in which there exists a shortage of home health agencies, as defined in 42 CFR 405.2417, part-time or

intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to an individual under a written plan of treatment established and periodically reviewed and approved by a physician.

D. FQHC/RHC Personnel Capable of Generating a Billable Encounter

Federally Qualified Health Center Personnel – Pennsylvania licensed and/or certified physicians, CRNPs, PAs, certified nurse midwives (CNM), licensed clinical psychologists, LCSWs, visiting nurses, podiatrists, optometrists, audiologists, dentists, dental hygienists, chiropractors, LPCs, LMFTs, pharmacists, and/or any other licensed or certified health care professional as specified in the State Plan, and who by contract or agreement with a FQHC provides health care services to MA beneficiaries are capable of generating a billable encounter. For children under the age of 21 years, the following personnel are also capable of generating a billable encounter for other ambulatory services: physical therapists, occupational therapists, speech-language pathologists, and licensed dietitian-nutritionists (LDNs). In the managed care delivery system, public health dental hygiene practitioners (PHDHP) can generate a billable encounter.

Rural Health Clinic Personnel - Pennsylvania licensed and/or certified physicians, CRNPs, PAs, CNMs, licensed clinical psychologists, LCSWs, visiting nurses, podiatrists, optometrists, audiologists, dentists, dental hygienists, chiropractors, LPCs, LMFTs, pharmacists, and/or any other licensed or certified health care professional as specified in the State Plan, and who by contract or agreement with a RHC provides health care services to MA beneficiaries are capable of generating a billable encounter. For children under the age of 21 years, the following personnel are also capable of generating a billable encounter for other ambulatory services: physical therapists, occupational therapists, speech-language pathologists, and LDNs. In the managed care delivery system, PHDHPs can generate a billable encounter.

E. FQHC/RHC Medical Record Requirements

Medical Records – The FQHC/RHC must maintain legible, accurate, and complete medical records in order to support the services provided, per 55 Pa. Code § 1101.51, for each individual beneficiary. A medical record shall be maintained in chronological order and medical necessity for the service must be clearly documented in the medical record. Physical and behavioral health records shall be legible and shall include, but not be limited to:

1. Dates of service.

2. Beneficiary's name and date of birth.
3. Name and title of the licensed provider performing the service.
4. Setting in which the visit is being held (i.e., in the clinic, beneficiary's home, nursing facility, or hospital).
5. An indication if the visit was conducted using telehealth or telemedicine.
6. Chief complaint/justification or reason for the visit.
7. Pertinent medical history.
8. Pertinent findings on examination, including length of time spent with the beneficiary (if a group session, the number of beneficiaries in the group, must be noted).
9. Medications and/or equipment/supplies delivered or prescribed.
10. Description of treatment (when applicable).
11. Recommendations for additional treatments, procedures, or consultations.
12. Pathology, radiology and laboratory tests and results.
13. Plan of treatment/care/outcome.

Dental records shall be legible and shall include, but not be limited to the above, as well as:

1. Tooth chart indicating the condition of the beneficiary's teeth, as observed on the initial oral examination. The dentist shall clearly indicate on the tooth chart:
 - Missing permanent teeth;
 - Permanent teeth to be extracted; and,
 - Teeth to be restored by surface.
2. The record shall note the condition of the oral supporting tissues.
3. For each service rendered, the record shall note:
 - The type of service;
 - The date the service was rendered;
 - The tooth number or letter, if applicable;
 - The surfaces restored, if applicable;
 - The types of materials used in the final restoration, if applicable; and

- The type, concentration and amount of any anesthetic agent used in providing a service, if applicable.
4. If dental radiographs are taken, they shall be part of the beneficiary's record and shall be properly processed, dated and identified with the beneficiary's name.
 5. If dental radiographs are requested by the Department of Human Services (Department), the radiographs shall be properly mounted and include the beneficiary's name, case number and the provider's name. If radiographs are requested for a record review or an onsite review, sufficient time will be agreed upon between the provider and the Department to allow the radiographs to be properly mounted.
 6. As defined in 55 Pa. Code § 1149.2, relating to definitions, if a dental technician or dental laboratory, or both, are used the dentist shall furnish the dental technician or dental laboratory with a written prescription, a copy of which shall be maintained as part of the beneficiary's record. The prescription shall contain the following items listed in 63 P.S. § 130b:
 - The name and address of the dental laboratory technician or dental laboratory;
 - The beneficiary's name or identification number. If a number is used, the beneficiary's name shall be written on the prescription retained by the dentist;
 - The date on which the prescription was written;
 - A prescription for the work to be done, with diagrams if necessary;
 - A specification of the type and quality of materials to be used; and
 - The signature of the dentist and the dentist's license number.
 7. Pathology reports, which are required for surgical excision services.
 8. Preoperative x-rays, which are required for surgical services.
 9. Postoperative x-rays, which are required for endodontic procedures.

FQHCs/RHCs are required to maintain records in accordance with 55 Pa. Code § 1101.51(e). Beneficiary charts and records must be available for review by personnel who are designated to audit such confidential records; namely staff of the Department and its duly authorized representatives; the Office of the Pennsylvania Inspector General; the Office of the Pennsylvania Auditor General; the Office of the Budget Comptroller Operations; the Office of the Pennsylvania Attorney General and/or the United States Department of Health and Human

Services, in conformity with the Pennsylvania MA FQHC/RHC Provider Agreement and the provisions of the Social Security Act.

SECTION 2: FQHC/RHC SERVICE ENCOUNTER DESCRIPTIONS AND REQUIREMENTS

Federally Qualified Health Center/Rural Health Clinic Encounter – An encounter is a face-to-face in-person, telehealth, telemedicine, or teledentistry visit between a beneficiary and the physician, dentist or licensed non-physician practitioner who exercises independent judgment in the provision of medically necessary health care services that are part of the FQHC’s/RHC’s approved scope of project. (See Section 2 - A and C below for more information regarding telehealth, telemedicine, and teledentistry.) The provision of outpatient services must be recorded in the beneficiary’s medical record. FQHC/RHC personnel, as applicable, must be enrolled in the MA Program, hold valid, current professional licenses/certifications and must not be under sanction by either the Medicaid or Medicare Program. The defined encounter types are: Medical Service Encounter, Vision Service Encounter, and Dental Service Encounter. FQHCs/RHCs should refer to MA Bulletin 99-16-07, titled “Enrollment of Ordering, Referring, and Prescribing Providers” for additional information. (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_224393.pdf)

Claim Submissions – FQHCs/RHCs are to prepare and submit claims for encounters in accordance with the Department’s billing instructions outlined in the PROMIS[™] Provider Handbook for the 837 Professional/CMS-1500 Claim Form.

Clinical Personnel Encounter – An encounter is a face-to-face in-person, telehealth, telemedicine, or teledentistry visit performed by a physician or qualified Mid-Level practitioner, that meets the requirement for an encounter. The clinical personnel can be employed or contracted by the FQHC/RHC.

- A. Medical Service Encounter:** An encounter between a physical health practitioner or a behavioral health practitioner and a beneficiary during which medical physical or behavioral services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Physical health services are those medically necessary services related to the treatment of bodily functions. Behavioral health services are those of a psychological nature or related to substance abuse treatment. The Department does not pay a separate medical physical health encounter for a medical service provided during a behavioral health encounter for the same beneficiary.

There are two types of Medical Service Encounters, described below:

1. A medical physical health encounter is a face-to-face encounter as identified in the Pennsylvania State Plan, between a beneficiary and a:
 - Physician

- Podiatrist
- Audiologist
- Chiropractor
- Pharmacist
- Licensed Non-Physician Practitioner, to include a CRNP, CNM, PA; a LCSW for case management
- Speech-language pathologist, physical therapist, occupational therapist, or LDN for a beneficiary under 21 years of age.

NOTE: A face-to-face encounter may also include a home health visit provided by a FQHC's registered nurse within a designated home health shortage area, as defined in 42 CFR 405.2417, that is approved by the Secretary for the Department of Health and Human Services.

- Telemedicine: An encounter between a practitioner and a beneficiary in which physical health services are provided through the use of approved electronic communication and information technologies to provide medical services at a distance. Telemedicine encounters must be provided according to the same standard of care as if delivered in-person. FQHCs/RHCs providing physical health services are to refer to MA Bulletin 99-23-08, titled "Updates to Guidelines for the Delivery of Physical Health Services via Telehealth," or the current MA Bulletin or Department guidance, for more information (<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2023080201.pdf>).

2. A medical behavioral health encounter is a face-to-face encounter, as identified in the Pennsylvania State Plan, between a beneficiary and a:

- Psychiatrist
- Licensed Clinical Psychologist
- LCSW
- LPC
- LMFT
- CRNP with a mental health certification
- Telehealth: An encounter between a licensed practitioner or provider agency and a beneficiary, in which behavioral health services are provided through the use of approved electronic communication and information technologies to provide behavioral health care at a distance. Telehealth encounters must be provided according to the same standard of care as if

delivered in-person. FQHCs/RHCs providing behavioral health services licensed by OMHSAS are to refer to OMHSAS Bulletin OMHSAS-22-02, titled “Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth,” or the current OMHSAS Bulletin or Department guidance, for more information

(https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/clearances-and-licensing/documents/mh-residential-licensing/Bulletin%20OMHSAS-22-02_Revised-Guidelines-for-Delivery-of-BH-Services-Through-Telehealth-7.1.22.pdf)

- B. Vision Encounter:** An encounter between an ophthalmologist or optometrist and a beneficiary during which medically necessary services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury of the beneficiary’s vision and eye health. The Department pays for a vision encounter in addition to a physical health, behavioral health and dental encounter for the same beneficiary on the same day. For additional information, FQHCs/RHCs should refer to MA Bulletin 08-20-04, titled “Vision Services Provided in the Federally Qualified Health Center and Rural Health Clinic Settings” (<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2020091501.pdf>).

NOTE: Beneficiaries 21 years of age and older are limited to two optometrist encounters per calendar year.

- C. Dental Service Encounter:** An encounter between a dentist, PHDHP or other dental hygienist and a beneficiary during which medically necessary services are provided for the prevention, diagnosis, treatment, or restoration of the beneficiary’s oral and dental health. A dentist must supervise services rendered by a non-PHDHP dental hygienist. For additional information about PHDHPs, FQHCs/RHCs should refer to MA Bulletin 08-17-31, titled “Public Health Dental Hygiene Practitioner Enrollment in the Medical Assistance Program” (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_263842.pdf).

If a dentist and a dental hygienist provide services during an encounter on the same date of service, the dentist is credited with the encounter. A dental service encounter cannot be provided by the same practitioner completing the medical physical health and/or medical behavioral health encounter.

Some dental services can be provided using teledentistry. FQHCs/RHCs are to refer to MA Bulletin 08-22-13, titled “Teledentistry Guidelines and Dental Fee Schedule Updates,” or the current MA Bulletin, for more information

(<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2022061301.pdf>).

Refer to the “Medical Assistance Program Dental Fee Schedule” to determine which services require prior authorization. Services requiring prior authorization must be accompanied by a full mouth periapical or a panorex and current radiograph(s) of the affected area(s). Exceptions to this rule are noted in PROMISE™ Provider Handbook, Section 6.4, titled “Special Guidelines” (<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/837%20Dental%20ADA%20Version%202023%20Claim%20Form.pdf>).

FQHCs/RHCs can request Benefit Limit Exceptions for dental services that are subject to benefit limits. FQHCs and RHCs are to refer to MA Bulletin 27-11-47, titled “Medical Assistance Dental Benefit Changes” for more information about benefit limits (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/d_005794.pdf). FQHCs and RHCs are to refer to MA Bulletin 08-21-01, titled “Dental Benefit Limit Exception Process Update,” or the current MA Bulletin, for more information (<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2021041501.pdf>), and Section 6.8 of the PROMISE™ Provider Handbook, regarding requests and processes.

- D. Allowable Settings for FQHC/RHC Encounter:** An encounter may take place in the FQHC/RHC setting or at any other location in which a FQHC/RHC approved scope of project services are provided. Examples of other settings include, but are not limited to, the beneficiary’s place of residence (home, nursing facility, residential treatment facility), mobile vans, shelters, and hospitals.

If the encounter is a service that could have been performed in the FQHC or RHC, then the hospital is an allowable setting. These encounters are to be billed using place of service 21.

Services may be provided at an approved FQHC/RHC site that provides project supported services. A FQHC/RHC may have a separate site located at a school and enrolled with the MA Program as a separate FQHC/RHC service location.

The Department pays the FQHC the practitioner fee from the MA Program Fee Schedule for an obstetrical delivery service when a FQHC provides perinatal services as part of their HRSA approved scope of project and opts-in to the Department’s Alternative Payment Methodology (APM). The Department pays the FQHC provider-

specific Prospective Payment System (PPS) rate for delivery services rendered in the FQHC setting when perinatal services are included in the FQHC’s HRSA-approved Scope of Project, as set forth in State Plan Attachment 4.19B.

E. Additional Information Regarding FQHC/RHC Encounters:

Group Services: The Department pays a separate encounter when an individual practitioner renders services to several beneficiaries simultaneously, e.g., group therapy. The FQHC/RHC may count an encounter for each beneficiary if the provision of service is medically necessary, appropriate to be provided in a group, and documented in each beneficiary’s health record. FQHCs/RHCs should refer to MA Bulletin 08-20-03, titled “Behavioral Health Group Therapy Provided in the Federally Qualified Health Center and Rural Health Clinic Settings” for additional information. (<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2020091502.pdf>)

Multiple Encounters on the Same Date of Service: The FQHC/RHC may bill for one medical physical health, one medical behavioral health, one vision, and/or one dental encounter per beneficiary per day. The exception to this limit is when the patient suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment in the same day.

NOTE: In the managed care delivery system, in instances when a beneficiary returns to the FQHC/RHC on the same day for a second medical physical health, medical behavioral health, vision or dental encounter that is not scheduled and is diagnostically related to the initial encounter, the managed care plan may opt, as specified in the provider agreement with the FQHC/RHC, to pay a separate rate for the encounter.

Medical Necessity for Multiple Visits: FQHCs/RHCs may not require a beneficiary to make repeated or multiple visits to complete a typical medical physical health, medical behavioral health, or dental visit, unless it is medically necessary to do so. Medical necessity for the additional visit must be clearly documented in the beneficiary’s record.

Freedom of Choice: A beneficiary may obtain medical, dental or other ambulatory health services from any institution, agency, pharmacy, practitioner, or organization enrolled in the MA Program. The Department prohibits FQHCs/RHCs from making any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies, but the FQHC/RHC may suggest the services of another provider or practitioner. Automatic referrals between providers are prohibited. See 55 Pa. Code § 1101.51(a).

Provider Preventable Conditions (PPC): The Department does not provide payment for services related to PPCs, which include Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC), in accordance with 42 CFR 447.26. FQHCs/RHCs are required to report OPPCs associated with any encounter. An OPPC is any condition identified in a state’s Medicaid State Plan occurring in any health care setting that meets the following criteria:

- The condition has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- The condition has a negative consequence for the beneficiary.
- The condition is auditable, and includes, at a minimum:
 - The wrong surgical or other invasive procedure performed on a patient.
 - A surgical or other invasive procedure performed on the wrong patient.
 - A surgical or other invasive procedure performed on the wrong body part.

FQHCs/RHCs are to refer to the PROMISE™ Provider Handbook 837 Professional/CMS-1500 Claim Form, Section 10: Provider Preventable Conditions, for additional information on OPPCs, including the procedure for reporting an OPPC on a FQHC/RHC claim (<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/837-professional-cms-1500-claim-form.pdf>).

F. Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services:

FQHCs and RHCs must provide EPSDT screening and treatment services for children under 21 years of age in accordance with the Department’s EPSDT Periodicity Schedule. FQHCs/RHCs may provide EPSDT treatment services regardless of whether the FQHC/RHC provided EPSDT screening service(s). The FQHC/RHC must document in the medical record the EPSDT screening and treatment services rendered. The Department pays a provider-specific PPS rate to FQHCs/RHCs that provide EPSDT services when a medical physical health encounter occurs with FQHC/RHC personnel capable of generating an encounter. The FQHC/RHC may not require multiple visits for EPSDT screening services that may be completed during one visit. The Department does not make a separate payment to the FQHCs/RHCs for EPSDT screening and treatment services in addition to the provider-specific PPS rate.

EPSDT screening services are medical physical health encounters reported on the quarterly Managed Care Organization (MCO) Settlement Report as medical physical health encounters by physicians, CRNPs, PAs, and CNMs. EPSDT treatment services

are medically necessary services and must be reported on the quarterly MCO Settlement Report.

NOTE: In the managed care delivery system, FQHCs/RHCs are to follow billing instructions as directed by the applicable MA MCO.

G. Services That Are Not Billable as Encounters:

1. Phlebotomy, specimen collections, laboratory tests, taking x-rays, allergy or other injections, and visits solely for obtaining immunizations, except for the following:
 - Pneumococcal, influenza, and hepatitis B vaccine-only visits are considered billable encounters.
 - COVID-19 vaccine-only visits are paid under the Department’s APM for COVID-19 vaccine administration. FQHCs/RHCs should refer to MA Bulletin 08-24-15, titled “Federally Qualified Health Center and Rural Health Payment for SARS-CoV-2 Vaccine Administration”, or the current MA Bulletin for additional information (<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2024101601.pdf>).

NOTE: FQHCs/RHCs with laboratories must have a permit from the Pennsylvania Department of Health and meet Clinical Laboratory Improvement Act (CLIA) certification requirements as applicable for the laboratory tests performed by the FQHC/RHC.

2. Filling/dispensing prescriptions and medication pick-ups of physician dispensed medications.

NOTE: Pharmacy costs are considered part of compensable costs on the FQHC MA Program Cost Report, and are therefore part of the all-inclusive provider-specific PPS rate.

3. Application of topical fluoride varnish.

NOTE: FQHC/RHC physicians and CRNPs must meet the training requirements identified in MA Bulletin 09-16-10, titled “Required Training for the Application of Topical Fluoride Varnish” (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_222718.pdf).

Additional Information

The Department publishes MA Bulletins to advise providers about updates to the MA Program. FQHCs/RHCs may access the MA Bulletins on the Department’s website at:

<https://www.pa.gov/en/agencies/dhs/resources/for-providers/bulletin-search.html#sortCriteria=%40copapwpissuedate%20descending>

SECTION 3: HEALTHY BEGINNINGS PLUS (HBP) PROGRAM

The HBP Program provides coverage and payment of expanded pregnancy-related services. FQHCs/RHCs may choose to participate in the HBP Program and be paid for those services, according to the MA Program Fee Schedule. FQHCs/RHCs that choose to participate in the HBP Program enroll with the MA Program as a HBP Provider and agree to accept the MA Program Fee Schedule rate(s) as payment-in-full for services. See 55 Pa. Code § 1140.41(1).

Under freedom of choice, the MA beneficiary may elect to receive obstetrical services through a FQHC/RHC HBP Program provider or receive pregnancy-related services in the traditional MA system.

HBP Program costs are not included in the PPS rate. If a FQHC chooses to enroll in the HBP Program, costs associated with HBP Program are to be reported as non-FQHC costs on the FQHC MA Program Cost Report. If a RHC chooses to enroll in the HBP Program, costs associated with obstetrical services included on the FQHC MA Program Cost Report are excluded from the rate calculation.

SECTION 4: FQHCs/RHCs WITH A MEDICAL SUPPLIER DESIGNATION

A FQHC/RHC may dispense durable medical equipment (DME) and medical supplies when medically necessary and prescribed by a physician or qualified prescriber employed by the FQHC, when the FQHC/RHC is certified as a dispenser by the Pennsylvania Department of Health in accordance with 28 Pa. Code § 25.113 requirements.

Dispensed DME and medical supplies are not FQHC services when the FQHC is enrolled separately in the MA Program as a medical supplier (provider type 25). FQHCs that dispense DME and medical supplies must secure prior authorization as required by the Department or MCO. The medical need for DME and/or medical supply must be fully documented in the beneficiary's record.

SECTION 5: FQHC/RHC MEDICAL ASSISTANCE PROGRAM PROSPECTIVE PAYMENT SYSTEM (PPS) RATE SETTING

Provider Specific Payment Rate Overview

The FQHC MA Program Cost Report is used to determine the provider-specific rate for payment to FQHCs or to RHCs for dental and/or vision services.

FQHCs/RHCs must report all costs in compliance with the principles of reasonable cost reimbursement as found at 42 CFR 405.2468 and Part 413, the Medicare Provider Reimbursement Manual, and Generally Accepted Accounting Principles (GAAP). FQHCs/RHCs must provide detailed information regarding all costs reported for reimbursement upon request of the Department. The FQHC/RHC must submit supporting documentation to the Department that details the specific line-item costs reported under the cost center(s) noted as “other” and/or “miscellaneous”.

The Department considers costs for services and/or supplies and equipment included on the FQHC MA Program Cost Report for calculation of the FQHC’s/RHC’s PPS rate except for costs of supplies or equipment when provided by an independently enrolled MA Program medical supplier, pharmacy, or laboratory.

The FQHC MA Program Cost Report calculates the proposed PPS rate for medical, dental, and vision services based on the cost information entered. PPS rates are calculated to two decimal places. The Department reviews and applies adjustments when determining the rate to apply to the FQHC’s enrollment or HRSA approved change in scope of services.

FQHC Interim Prospective Payment System Rate Setting

A. FQHC Interim Rate – New Enrollments

Newly enrolled FQHC providers may request an interim rate by submitting a budgeted FQHC MA Program Cost Report prior to the completion of the first full fiscal year of service. The Department will review the rate request, the FQHC’s budgeted cost report, the most recent audited financial statements, and any other supporting documentation as requested by the Department. The Department notifies the FQHC of the interim rate. There must be a rate in PROMISe™ for the FQHC to receive payment.

B. FQHC Interim (Final) Rate and FQHC MA Program Cost Report Submission

The FQHC must submit a FQHC MA Program Cost Report, along with any required supplemental documents, covering costs based on the first full fiscal year after

enrollment. The FQHC MA Program Cost Report is due 120 days after the end of the first full fiscal year and must be in the format required by the Department. The FQHC may request an extension of the 120-day submission. FQHC MA Program Cost Reports may be submitted for a period other than the clinic’s normal fiscal period only when there is a change in fiscal period.

The Department returns improperly completed or incomplete filings to the FQHC for proper completion, and these filings must be resubmitted within 30 days. A filing that includes the following is considered to be improperly completed or incomplete:

1. Uses any format other than the FQHC MA Program Cost Report format approved by the Department;
2. Does not include all pages of all worksheets;
3. Has an incomplete “Provider Identification and Certification” page; or
4. Is illegible

Each required FQHC MA Program Cost Report must be signed by the authorized individual who normally signs the FQHC’s Federal income tax return or Medicare cost report. In addition, the individual preparing the cost report must also sign and indicate the preparing entity’s name, preparer’s name, and job title.

The Department suspends all payments when the Department does not receive the requested FQHC MA Program Cost Report and supplemental documents within the required time limit (including approved extensions). This action remains in effect until the Department receives all required documents.

The requirements for “Regular (Final) Rate Setting and FQHC MA Program Cost Report Submission” related to a change in the scope of services are outlined in Section 8 of this Handbook.

RHC Interim Prospective Payment System Rate Setting

A. RHC Interim Rate

The Department establishes an interim PPS rate for the RHC equal to the Medicare PPS rate. The RHC is required to provide the Department with the Medicare PPS rate letter that is effective at the time of enrollment.

NOTE: In instances when the RHC provides dental and/or vision services, the RHC is required to submit a budgeted FQHC MA Program Cost Report since the Medicare Cost Report does not address dental or vision services.

B. RHC Interim (Final) Rate and Medicare Cost Report Submission

The Department is required to use a Medicare Intermediary Reviewed Cost Report in accordance with 55 Pa. Code §§ 1129.51 through 1129.53, relating to General Payment Policy and Payment Policy for RHCs. RHCs must submit their Medicare rate letter to the Department to finalize the rate for the first full fiscal year after enrollment of the service location with the MA Program.

NOTE: In instances when the RHC provides dental or vision services and seeks a dental or vision PPS rate for payment of those services, the RHC is required to submit a FQHC MA Program Cost Report since the Medicare Cost Report does not address dental or vision services. The Department sets a provider-specific PPS dental and/or vision encounter rate for the provision of dental and/or vision services using the FQHC MA Program Cost Report, subject to the requirements for the FQHC MA Program Cost Report.

FQHC/RHC Regular (Final) Rate and Audit Requirements

A. FQHC MA Program Cost Report Audits

The Department and/or its authorized representative audits the initial FQHC MA Program Cost Report submitted by FQHCs upon initial MA Program enrollment. In addition, the Department and/or its authorized representative audits any subsequent FQHC MA Program Cost Report submitted as required related to a change in the scope of services as outlined in Section 8 of this Handbook. The FQHC must make available all source documentation upon request of the Department or its authorized representative, within 21 calendar days from the date of the written request. This may include beneficiary level information including beneficiary's medical records. This documentation is necessary to ensure compliance with the requirements set forth in this handbook. See 55 Pa. Code §§ 1101.51(e)(1)(2).

NOTE: These audit requirements also apply when the RHC is required to use the FQHC MA Program Cost Report.

B. Corrective Action Plan

The Department may require the FQHC/RHC to prepare a Corrective Action Plan (CAP) to address any or all findings contained within the submitted audit report. If required, the FQHC/RHC must include the following in the CAP:

1. A brief description identifying the finding;
2. Whether the provider agrees or disagrees;

3. The specific steps to be taken to correct the deficiency or specific reasons why corrective action is not necessary;
4. A time table for completion of the corrective action steps; and
5. A description of monitoring to be performed to ensure that the steps are taken.

The Department notifies the FQHC/RHC if a CAP is required, which findings require a CAP and the due date for submission. In addition, the Department may require a CAP for other program noncompliance identified through regular program management and monitoring. The Department approves and monitors CAPs.

C. Additional Audits

Commonwealth and Federal agencies or their authorized representatives may perform additional audits of a financial or performance nature. The costs for any additional work performed by the Commonwealth or Federal agencies are borne by those agencies at no additional expense to the provider.

D. Audit Record Retention

The provider's auditor must maintain audit working papers and audit reports for a minimum of three (3) years from the date of issuance of the audit report unless the provider's auditor is notified in writing by the Commonwealth, the cognizant or oversight Federal agency to extend the retention period. Audit working papers must be made available upon request to authorized representatives of the Commonwealth or the Federal agencies. If there is an unresolved appeal or litigation at the end of the record retention period noted above, the FQHC/RHC must maintain the record(s) until the appeal is resolved.

E. Post-Audit Final Reconciliation – New FQHC/RHC Provider Enrollments

The Department uses an independent auditor's report to establish a regular PPS rate and issue a final reconciliation payment, if applicable. An independent auditor's report is also used for RHCs that are required to use the FQHC MA Program Cost Report. The Department's post-audit final reconciliation payment is retroactive to the date of MA Program enrollment. The requirements for post-audit final reconciliations related to a change in the scope of services are outlined in Section 8 of this Handbook.

The Department uses the Medicare Cost Report that has been approved by CMS' intermediary to establish the RHC's regular PPS rate for medical services. When the RHC provides dental and/or vision services, the RHC must submit a FQHC MA Program Cost Report. The Department establishes a regular PPS rate and issues a final reconciliation payment, if applicable.

Once the audit is complete, the Department will not make any future reconciliation payments for that audit period.

F. Appeals

FQHCs/RHCs that disagree with the Department’s determination of the regular PPS rate and/or final reconciliation payment may file an appeal. Information regarding filing an appeal is included in the PPS rate letter.

SECTION 6: FQHC MA PROGRAM COST REPORT OVERVIEW

In order for the Department to determine a PPS rate, all FQHCs who seek payment under the MA Program, must use and submit the FQHC MA Program Cost Report. FQHCs will receive the FQHC MA Program Cost Report template upon their enrollment into the MA Program. RHCs that seek payment under the MA Program for dental and/or vision services that have been added as a part of the RHC's scope of services, must use and submit the FQHC MA Program Cost Report template in order for the Department to determine a PPS rate for dental and/or vision services only. The requirement for the submission of an FQHC MA Program Cost Report apply to FQHCs/RHCs that only provide services in the MA Program's managed care delivery system.

The Department provides each FQHC that newly enrolls in the MA Program with the following:

- Access to the FQHC MA Program Cost Report;
- The dates of service for the first full fiscal year after enrollment; and
- The due date for the cost report's completion and submission.

Additionally, FQHCs/RHCs will receive a FQHC MA Program Cost Report after submission of the required HRSA Change in Scope of Services approval.

FQHCs/RHCs may request access to the current FQHC MA Program Cost Report template from the Department by emailing a request to RA-PWOMAPFQHC-RHC@pa.gov.

The FQHC MA Program Cost Report must be submitted electronically to the Department.

The FQHC/RHC must complete the Provider Identification and Certification Section and all other applicable sections of the FQHC MA Program Cost Report. This report provides general information and summarizes the number of encounters completed and the costs of rendered FQHC/RHC services.

The completed FQHC MA Program Cost Report must be submitted no later than 120 days after the close of the FQHC's/RHC's first full fiscal year of service (12 consecutive months) following enrollment into the MA Program.

Required Supporting Documentation

The Department requires the following documents when a FQHC/RHC submits the FQHC MA Program Cost Report:

- HRSA grant award notice or HRSA notice of coverage under the Federal Tort liability if the FQHC is a ‘look-alike’;
- The FQHC MA Program Cost Report for each enrolled FQHC/RHC entity; and,
- Any supplemental documents, as required or requested by the Department.

A complete FQHC MA Program Cost Report submission for the fiscal year under the Department’s review must include the following:

1. A copy of the FQHC’s/RHC’s audited financial statements for the fiscal year of the cost report.

NOTE: If two audit reports cover the fiscal year of the cost report, the FQHC must provide the one that covers the most months of that cost report year, unless directed otherwise by the Department. Example: The fiscal year end is September 30, 2024. There are two audits: one completed on June 30, 2024, and one completed June 30, 2025. The FQHC must provide the June 30, 2024 report since it covers 9 months of the fiscal year ending September 30, 2024.

2. The trial balance used to prepare the audited financial statements for the fiscal year reported. The Department may request that the FQHC/RHC cross reference the trial balance to the line numbers in the FQHC MA Program Cost Report.
3. A depreciation schedule for the fiscal year reported, that includes the amount of depreciation reported under Section 5.
4. A copy of the Medicare Cost Report that aligns to the fiscal year of the cost report submitted. In instances when a RHC provides dental and/or vision services, the RHC must submit the Medicare Intermediary Reviewed Medicare Cost Report.
5. Any supplemental documentation identified in the FQHC MA Program Cost Report.

NOTE: The Department may reject a submitted cost report when the FQHC/RHC does not submit the supporting documentation above.

FQHC/RHC Changes of Ownership

FQHC/RHC that have a change of ownership must notify MA Program Enrollment. A change of ownership for a FQHC requires the submission of the HRSA approval letter and FQHC MA Program Cost Report. A change of ownership for an RHC requires the submission of a new Medicare rate letter or the FQHC MA Program Cost Report when the RHC provides dental and/or vision services.

Out-Of-State FQHCs/RHCs

Out-of-State FQHCs/RHCs located in contiguous states that treat PA MA beneficiaries must enroll in Pennsylvania's MA Program and complete and submit the required Medicare or FQHC MA Program Cost Report, if they wish to receive payment from the MA Program for services to MA beneficiaries. FQHCs that wish to enroll in the MA Program must provide their HRSA Notice of Award, any other documentation as required by 55 Pa. Code Chapter 1101 and the MA Program Provider Enrollment Application. RHCs that wish to enroll in the MA Program must provide their Medicare PPS rate letter.

SECTION 7: FQHC MA PROGRAM COST REPORT GUIDANCE

The FQHC (and RHCs that provide dental and/or vision services) must complete the required FQHC MA Program Cost Report upon enrollment in the MA Program in order to receive payment. The FQHC MA Program Cost Report covers the FQHC's/RHC's first full fiscal year after initial date of MA Program enrollment. The Department completes an audit on this FQHC MA Program Cost Report as identified above.

The FQHC's/RHC's MA Program Cost Report must be prepared in conformance with:

1. The accrual basis of accounting;
2. The provisions of the Medicare Provider Reimbursement Manual; and
3. Any situations not covered under Medicaid Provider Reimbursement Manual guidelines are based on GAAP.

The FQHC/RHC must maintain accurate financial and clinical records. The records must include sufficient detail to support the costs included on the cost report and that the costs are for the period covered by the applicable cost report. The records are to be maintained in accordance with state and federal record keeping requirements.

The financial and clinical records, including receipts documenting all transactions of the FQHC/RHC, must be available for review by personnel designated to audit records, such as staff of the Office of the Pennsylvania Inspector General, the Office of the Pennsylvania Auditor General, the Department, the Pennsylvania Office of the Budget Office of Comptroller Operations, the Office of the Pennsylvania Attorney General, and/or the United States Department of Health and Human Services in conformity with the state and federal laws and MA FQHC/RHC Provider Agreement.

The Department renders a decision on audit findings within 120 days of receipt of the final audit report of the FQHCs/RHCs MA Program Cost Report. FQHCs/RHCs are notified of the Department's decision by letter. FQHCs/RHCs may appeal the Department's decision by following the directions in the letter. If there is an unresolved appeal at the end of the record retention period noted above, the FQHC/RHC must maintain the record(s) until the appeal is resolved.

NOTE: The Department maintains the FQHC's/RHC's most recently completed audit report. In instances when a FQHC submits a revised HRSA-approved scope of project that reflects a change in service, the Department maintains the initial final audit report until a new audit report is completed.

Cost Report Sections

A. Reasonable Costs

The MA Program determines if costs are reasonable and allowable by applying Medicare cost reimbursement principles as defined by federal regulations at 42 CFR 405.2468 and Part 413, the Medicare Provider Reimbursement Manual, and any other regulations mandated by Federal or state law.

Reasonable costs of any services are determined in accordance with Medicare regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs with respect to beneficiaries covered by the MA Program are not borne by other individuals not so covered, and the costs with respect to individuals not so covered are not borne by the MA Program. Costs related to non-MA beneficiaries are not covered by the MA Program.

Costs may vary from one FQHC/RHC to another. In instances when a particular FQHC's/RHC's costs are found to be substantially out of line with other FQHCs/RHCs in the same geographic area that are similar in size, scope of services, productivity, and other relevant factors, the Department may set the interim PPS rate at a level consistent with another FQHC/RHC determined to be similar based on the above factors. The Department will retroactively adjust the PPS rate after an audit of the FQHC MA Program Cost Report has been completed.

The Department expects that FQHCs/RHCs always seek to minimize costs incurred to provide HRSA approved services. Costs incurred by the FQHC/RHC must not exceed what a prudent and cost-conscious private-pay buyer pays for a given item or service, as required in 45 CFR § 75.404, relating to reasonable costs. If the Department determines that the FQHC's/RHC's costs exceed the level that such prudent buyers incur, the Department adjusts the FQHC's/RHC's actual costs to a reasonable cost in accordance with the regulations above and the costs of another FQHC/RHC determined to be similar.

B. Related Party Transactions

In calculating the FQHC's/RHC's PPS rate, the Department follows the definitions and directions of the Medicare Provider Reimbursement Manual regarding related party transactions that are included on the cost report. "Related Party" is defined as an individual or organization that is associated or affiliated with, or has control of or is

controlled by, the FQHC/RHC. “Control,” as used in this definition, means the power, directly or indirectly, to influence or direct the actions or policies of another.

The FQHC/RHC must execute a written and signed agreement with the related party that meets the following requirements:

1. Costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities or supplies that could be purchased elsewhere. See 42 CFR 413.17(c).
2. Personnel and administration of the related party provider (under contract) are separate and apart from the FQHC/RHC. Staff of the related party provider is separate from FQHC/RHC staff and vice versa.
3. Ensures beneficiary freedom of choice. The FQHC/RHC may not make “automatic referrals.” See 55 Pa. Code § 1101.51(a).
4. For sub-contracted services provided by a related party, the related party agrees to accept as payment in full the agreed upon rate with the FQHC/RHC. The FQHC/RHC may bill for eligible encounters rendered by the sub-contracted related party’s provider. The Department does not pay the related party’s provider a PPS rate.
5. When the related party has a separate Medical Assistance Identification (MAID) number, the related party must agree in writing, as a term of the agreement, not to bill the Department under its separate MAID number for any services rendered on behalf of the FQHC/RHC to the beneficiary. The payment arrangement in these circumstances is between the FQHC/RHC and the related party. The Department makes payment to the FQHC/RHC only. The Department, at its discretion, audits to ensure no duplicate billing by the FQHC/RHC and the related party.

C. Compensable Costs

The Department utilizes the Medicare cost principles as established by Federal regulations and instructions set forth in Medicare Provider Reimbursement Manual as a basis for determining what cost items are included on the FQHC MA Program Cost Report as Compensable Costs. The Department also recognizes costs for direct or indirect chaplaincy expenses related to beneficiary care, excluding training costs associated with the chaplaincy program.

1. Costs related to beneficiary care include all necessary and proper costs that are appropriate in developing and maintaining the operation of beneficiary care facilities and activities. Necessary and proper costs related to beneficiary care are usually costs which are common and accepted occurrences within the FQHC's/RHC's scope of services. They include health care personnel costs, costs of health care employee pension plans, insurance and other such costs. Allowed costs are subject to the specific items detailed in the Medicare Provider Reimbursement Manual, Chapter 21, unless otherwise specified in this handbook.
2. Direct costs are identified specifically with a particular final cost objective (medical, vision, dental, and non-FQHC service). These costs must be related to beneficiary care. Examples include but are not limited to:
 - Medical record and medical receptionist costs;
 - Malpractice insurance costs for FQHC “look-alike” clinics only; and
 - Dues of personnel to professional organizations that are directly related to the individual's scope of practice. (Limited to one professional organization fee per FQHC/RHC provider or personnel.)

NOTE: For FQHC grantees under Section 330 of the Public Health Services Act, and that have malpractice insurance coverage under the Federal Tort Claims Act, the FQHC may not claim any malpractice insurance obligation as actual cost.

3. Overhead costs (administrative costs) are those that are incurred for common or joint objectives and may not be readily identified with a particular final cost objective. Examples include but are not limited to:
 - Management of the FQHC/RHC;
 - Reasonable data processing expenses (not including computers, software or databases not used solely for beneficiary care or FQHC/RHC administration purposes);
 - Building and equipment costs (not to include cost of vehicle purchases);
 - Employee transportation and travel expenses (must be related to operating the FQHC/RHC; payment level is based on the lesser of actual non-first class/non-luxury costs or dollar limits outlined in the state travel regulations); and,
 - Fees and/or dues paid to industry organizations, limited to that portion of fees and/or dues that are not grant funded or used by organizations for political or lobbying activities (Medicare Provider Reimbursement

Manual, Chapter 21, Section 2139), and are limited to fees and/or dues payable to not more than two separate organizations per FQHC/RHC.

NOTE: Membership dues, including country or fraternal club memberships, used for public relations purposes are not allowable (Medicare Provider Reimbursement Manual, Chapter 21, Sections 2138 and 2139).

D. Noncompensable FQHC/RHC Costs

Noncompensable costs are costs that are incurred by the FQHC/RHC, but do not relate to one of the cost objectives (medical, vision, dental, administrative, and non-FQHC services) listed above. Noncompensable costs are those costs not related to the provision of health care services and reflect costs that are not usual and customary. Noncompensable costs are not included in the FQHC/RHC PPS rate. The Department identifies noncompensable costs in compliance with the Medicare Provider Reimbursement Manual, Chapter 21.

Additionally, the Department includes the following as noncompensable costs:

- Participation in a community meeting or group session which is not solely designed to provide health care services. Such activities include, but are not limited to: skits and plays, banquets or conferences, media (television, newspaper, or radio) interviews, informational sessions for prospective users, presentations to community groups, high school classes, PTAs, etc. or, informational (marketing) presentations for the purpose of securing additional business for the FQHC/RHC;
- Health care services provided as part of a large-scale “free to the public” or “nominal fee” effort, such as a mass immunization program, mass free health screening programs, community service program or “health fairs;”
- Costs related to professional licensure for individual practitioners and other professional employees;
- Costs associated with the use of both licensed and unlicensed volunteer staff employed by the FQHC/RHC or provided by a contracted entity;
- Bad debts and costs of action by outside staff or agencies to collect receivables;
- Contingency reserves;
- Legal, accounting and professional services incurred in connection with hearings and re-hearings, arbitrations, or judicial proceedings that involve the Department;
- Amortization of goodwill;
- Costs associated with the rental of building or office space to others, including the cost of maintaining space used, rented or leased by other facilities or

entities who are not health care providers or who are enrolled in the MA Program under another provider type with a different MAID number;

NOTE: For FQHCs/RHCs that share space with related parties, the related party's costs associated with that space and staffing are included as non-FQHC/RHC costs on the FQHC MA Program Cost Report.

E. Non-FQHC/RHC Costs

Non-FQHC/RHC costs are medical service costs not included in the FQHC's/RHC's PPS rate calculation. Examples of services/costs that are not included in the PPS rate calculation include but are not limited to:

1. Women, Infant and Children (WIC) Program – any costs related to or professional services provided as part of the WIC Program by a FQHC/RHC nutritionist/dietician.
2. HBP Program – any costs related to the HBP Program, which are enhanced prenatal, perinatal, and postnatal services, and are separately payable under the MA Program.
3. Medical outreach – any costs related to assisting other health care professionals in the provision of off-site services, such as dental screening and blood pressure checks.
4. Beneficiary relations and supports – any costs including but are not limited to: assisting a beneficiary with the provision of non-health care related services from another agency and/or provider, assisting a beneficiary to find employment or with debt counseling services, housing searches, school/educational/vocational counseling.
5. Public relations – any costs including, but are not limited to: beneficiary or employee “thank you” gifts or banquets, costs involved with “photo-op” or newspaper social page notices, media interviews, public relations photography, promotional advertising items, public service announcements, publications and newsletters, etc.
6. Environmental Activity – any costs associated with activities designed to protect the public from health hazards, such as toxic substances in drinking water, environmental lead detection services, etc.

Note: Costs associated with beneficiary lead screening and treatment are compensable as medical costs on the cost report.
7. Non-MA services – MA services are identified in the Department's Medicaid State Plan, Attachment 3.1A/3.1B. Beneficiaries under 21 years of age are entitled to all medically necessary Medicaid covered services.

FQHCs/RHCs are not to offer beneficiaries non-State Plan services unless the beneficiary is informed in advance of the service being rendered that the service is not covered in the MA Program and the beneficiary is responsible for payment of the service. FQHCs/RHCs are to document this in the beneficiary's record.

8. FQHC ownership of a retail pharmacy that is enrolled separately in the MA Program – any costs associated with operating the retail pharmacy.

The Department assesses an appropriate amount of overhead allocated to each of the non-FQHC/RHC costs identified above. Compensable costs are reduced by this overhead allocation amount.

SECTION 8: FQHC/RHC CHANGE IN SCOPE OF SERVICE

FQHCs seeking to change the scope of services they provide must request a change in scope of services through the HRSA. The HRSA Policy Information Notice 2008-01 provides that HRSA either approves or denies the FQHC's request for a change in scope of services within 60 days of the date a complete request is received.

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

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

A. Notification to the Department

If HRSA approves a request for a change in scope of services involving the addition of a service that has never been provided or the discontinuance of an existing service, the FQHC must notify the Department of the change in scope of services within 30 days of the issue date identified in block 1 of HRSA's Notice of Grant Award so that the Department may begin the PPS rate(s) adjustment process. FQHCs will receive a FQHC MA Program Cost Report template after submission of the HRSA approval of the change in scope.

B. Effective Date

The effective date of the rate adjustment based on the change in scope of services is the effective date specified in the Notice of Grant Award from HRSA, provided the Notice of Grant Award approving the change in scope of services is received by the Department within 30 days of the issue date identified in the Grant Specific Term(s) section of the Notice of Grant Award. If the HRSA Notice of Grant Award is not received by the Department within 30 days of the issue date identified in the Grant Specific Term(s) section, the effective date of the rate adjustment is determined by the Department. Until a final rate is determined, the FQHC's existing rate(s) are considered interim rate(s).

C. Interim Rate Adjustment

The FQHC may request an interim rate adjustment, pending the determination of final rates based on a change in scope of services. The Department reviews the rate adjustment request and the FQHC's budgeted MA Program Cost Report and submitted documentation. If the documentation indicates that the PPS rate will be increased by more than 20%, the Department makes an interim PPS rate adjustment. The Department notifies the FQHC of the Department's decision on the request for an interim rate adjustment.

To request an interim rate adjustment, providers must submit a budgeted FQHC MA Program Cost Report containing the most recent fiscal year's actual costs, a detailed budget of the projected costs expected to be generated by the new service(s) and the number of projected encounters expected to be generated by the new service(s).

If the FQHC's request is denied, the Department determines the interim rate after it receives the MA Program Cost Report with the FQHC's actual costs from the first full fiscal year of operation reflecting the change in scope of services.

D. Regular (Final) Rate Adjustment

FQHCs must submit the MA Program Cost Report within 120 days after the close of the FQHC's first full fiscal year of operation with the change in scope of services. The cost report must include the FQHC's actual costs for the full fiscal year. If the FQHC is unable to submit a cost report within the 120 day timeframe, the FQHC may request one 30 day extension for submission of the cost report by notifying the Department in writing at least one business day prior to the cost report submission due date. The request must detail why the extension is necessary. The Department may deny a FQHC's request for a 30 day extension for submission of the cost report if the FQHC does not demonstrate good cause for the extension.

The FQHC's final rate(s) will be determined via a desk review and/or audit of the FQHC's MA Program Cost Report. The Department notifies the FQHC in writing of the FQHC's final PPS adjusted rate(s) upon completion of the desk review and/or audit. The Department uses the final rate(s) for final reconciliation and the prospective payment rate(s) going forward. The notice includes information regarding the FQHC's appeal rights.

E. Post-Audit Final Reconciliation

In accordance with 55 Pa. Code § 1101.69, relating to overpayment-underpayment, the Department uses the final reconciliation process to pay the FQHC for any

underpayment or to recover any overpayment based on the difference between its final PPS rate(s) and interim rate(s). If the FQHC receives an overpayment, the Department establishes a uniform period for the recoupment of the overpayment from the FQHC, according to the guidelines established in 55 Pa. Code § 1101.69a.

The Department notifies the MA MCOs of retroactive PPS rate changes that have been completed each quarter. The MA MCOs have ninety (90) days from the date of the Department’s notification to complete claims reprocessing for any paid encounter with a date of service back to and including the effective date of the PPS retroactive rate change. The obligation for payment to the FQHC/RHC, or to collect overpayments from the FQHC/RHC, is maintained by the MA MCO.

F. Stub Period

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

NOTE: Example of a “stub” period: The FQHC’s request for change in scope of services is approved by HRSA with an effective date of September 1, 2023. The provider’s fiscal year runs from January 1, 2023, through December 31, 2023. In this example, the “stub” period runs from September 1, 2023, through December 31, 2023.

G. Procedure

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

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

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

Division of Hospital and Outpatient Rate Setting
DHS Bureau of Fiscal Management
393 Walnut Street, 11th Floor
Harrisburg, Pennsylvania 17120
Division email: RA-PWOMAPFQHC-RHC@pa.gov

SECTION 9: ALTERNATIVE PAYMENT METHODOLOGIES (APM) FOR FQHC/RHC SERVICES

The Department utilizes APMs to pay FQHCs/RHCs for select services, as set forth in State Plan Attachment 4.19B, starting at page 2b (for RHC APMs) and page 2c (for FQHC APMs). Payments made under an APM are paid at a rate that is at least equal to the FQHC's/RHC's provider-specific PPS rate.

FQHCs/RHCs must opt-in to receive payment under an APM. In order for a FQHC/RHC to opt-in and participate in an APM, the FQHC's/RHC's Chief Financial Officer must submit a request via email to the Department at RA-PWOMAPFQHC-RHC@pa.gov and must include the FQHC's/RHC's nine-digit provider identification number and four-digit service location number to which the opt-in applies.

A FQHC/RHC may opt-out of an APM, after initially opting in, by following these same directions.

SECTION 10: QUARTERLY MCO SETTLEMENT (WRAPAROUND) REPORT REQUIREMENTS

Quarterly MCO Settlement (Wraparound) Report Overview

FQHCs and RHCs are required to submit the quarterly MCO settlement report seven (7) months after the end of each calendar year quarter. This quarterly report is sometimes referred to as the Wraparound Report.

MA MCOs are required to make payment to the FQHCs/RHCs in their provider networks at the minimum of the FQHC/RHC provider-specific PPS rate set by the Department, provided that the FQHC/RHC opts-in to this APM.

The Department may pay or recover the difference between the FQHC/RHC provider-specific PPS rate and the payments made by each MA MCO to the FQHC/RHC in the MA MCO provider network for each eligible MA encounter that was not denied by the MA MCOs.

Report Templates

The FQHCs and RHCs must submit MA MCO paid encounters and receipts through a web-based provider portal maintained by the Department. The FQHCs/RHCs must submit this information for each encounter type: HealthChoices physical health medical, HealthChoices behavioral health medical, HealthChoices dental, HealthChoices vision, Community HealthChoices physical health medical, Community HealthChoices dental, and Community HealthChoices vision.

FQHC Maintenance of Documentation

FQHCs and RHCs must maintain documentation, which includes supplemental encounter documentation, supporting medical records, and supplemental fiscal records related to MA MCO paid encounters and receipts for a minimum of seven (7) years from the date the Department completes review of the Wraparound Report. The Department periodically monitors the documentation. The FQHC/RHC must provide the required supplemental documentation upon request of the Department.

Reporting Time Periods

The Wraparound Report uses standard calendar year quarters. FQHCs/RHC must report MA MCO paid encounters in the quarter in which they occur and match the receipts that were paid by the MA MCOs to those encounters. The quarterly report is due within seven (7) months of the end of the calendar year quarter.

Wraparound Report Submission

Unless the Department notifies the FQHCs or RHCs in writing that the requirement to submit a report is suspended, the report is due to the Department seven (7) months after the end of the calendar year quarter.

Reporting of MCO Denied Encounters

FQHCs/RHCs should report denied MA MCO encounters on the Wraparound Report in the Denials Section only. Denied MA MCO encounters are not able to be counted as paid encounters on the report. The FQHC/RHC should submit a revised Wraparound Report when denied encounters are subsequently paid by the MA MCO.

Adjustments for Prior Periods

FQHCs/RHCs must, at the Department's direction, submit adjustments to a prior period Wraparound Report. If payment is received from the MA MCO for prior period encounters, after the Wraparound Report has been completed, FQHCs/RHCs must revise the appropriate report and submit to the Department.

Timely Filings

The Department will not accept a Wraparound Report or revision to a prior period Wraparound Report for quarters that are more than two years beyond the required submission date. The Department limits to the two-year timely filing per 45 CFR 95.7. The Department will reject Wraparound Report adjustments that the FQHC submits outside of the two-year timely filing requirement period.

Reconciliation Process

Based on the FQHC's/RHC's Wraparound Report for a given calendar quarter, the Department calculates the difference between the MA MCO receipts and the amount the FQHC/RHC would have received under the MA PPS for each paid encounter. If the difference results in an obligation due to the FQHC/RHC, the Department pays the FQHC/RHC the total amount of the difference.

If there is an obligation due to the Department in connection with the reconciliation process, the FQHC/RHC must pay the Department the total amount due. When the FQHC/RHC owes a payment to the Department, the Department may choose to enter an adjustment against future claims payment into the Medicaid Management Information System (MMIS) claims adjudication system in the total amount of the difference. The Department notifies the FQHC/RHC of this adjustment.