FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC
ANNUAL RECONCILIATION

Effective Date: 09/01/2022

Staff responsible for policy: Reimbursement

I. Purpose

This policy outlines the procedures necessary to perform the annual reconciliation on AHCCCS reimbursements to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that subcontract, either directly or indirectly, to provide covered services to Medicaid enrollees with a Managed Care Organization (MCO).

Background

Under 42 U.S.C. § 1396a(bb) Medicaid is required to reimburse an FQHC or RHC under the described Prospective Payment System (PPS) methodology for all ambulatory services covered under the Medicaid State Plan. Further, where an FQHC or RHC receives any of that reimbursement under contracts with MCOs, Medicaid is required to make periodic supplemental payments that are "equal to the amount" by which the PPS exceeds payment by the MCO. Under paragraph 6 of that statute, Medicaid may utilize an Alternative Payment Methodology (APM) if the FQHC or RHC elects to be reimbursed under that methodology. An APM may not waive the supplemental payment and reconciliation requirements.

Written CMS guidance in effect since September of 2001 clarifies that 42 U.S.C. § 1396a(bb) requires Medicaid to reconcile FQHC and RHC reimbursements at least annually "to ensure that MCO payments plus state supplemental payments . . . equal the amount calculated" under the PPS or the APM, whichever applies.

II. Definitions

- Administrative denial- Encounter denied for administrative reasons for claims which are for valid Medicaid covered services provided to eligible members that were denied by Contractors for administrative issues.

- Alt HP Value- For service provided through non-capitated payment arrangements, equals the amount paid by AHCCCS health plans to the provider. For services provided through a sub-capitated payment arrangement, the amount is system generated by AHCCCS to equal the health plan allowed rate, less third-party reimbursement paid on the claim.

III. Policy

A. In September each year, AHCCCS will calculate for each FQHC/RHC a Preliminary Reconciliation as follows:
    1. Data to be used will be pulled from the AHCCCS PMMIS in late August each year. At a minimum, data will include:

a. Claims submitted to an AHCCCS contracted Managed Care Organization. If agreed to by AHCCCS and an FQHC prior to pulling the data, Fee for Service claims may also be used in preliminary reconciliation estimates for Urban Indian Health Program FQHCs.
b. All dates of service between October 1st and September 30th of the fiscal year being reconciled including paid/adjudicated and administrative denials (previously defined).

2. The total payable amounts will be calculated from the PMMIS data
    a. Total number of visits will be determined based on utilization of HCPCS code T1015
        i. Counting all such units from the approved/adjudicated data file, and
        ii. Counting any such units from the administrative denial file, except ineligible same day FQHC/ RHC visits identified as duplicate visits under the same primary diagnosis code and with an "Alt HP Value" amount of $0 paid
    b. The total number of qualifying visits multiplied by the PPS rate in effect for the fiscal year being reconciled
3. The total amount paid on visits will be determined by totaling 'Alt HP Value' and amounts paid by third party payers on CPT/HCPCS codes that describe PPS-eligible services and adding quarterly supplemental payments.
    a. For these purposes, non-PPS-eligible services are, e.g., case management, group services, and inpatient services
4. The preliminary Reconciliation payment or recoupment equals total payable amount (2b) less total amount paid (3)

B. No later than the second Friday of September each year, AHCCCS will send to each FQHC and RHC the results of the Preliminary Reconciliation [in the format shown in Appendix C].

C. Following receipt of the Preliminary Reconciliation, and no later than the fourth Friday of September, the FQHC or RHC will inform AHCCCS by email of one of the following:
    1. accepts the Preliminary Reconciliation, or
    2. will submit ARRD/AUP

D. If the FQHC or RHC elects to submit the ARRD/AUP
    1. ARRD instructions
        a. By the first Monday in October, AHCCCS will email AUP and ARRD process instructions to clinics that are electing to submit the ARRD/AUP.
        b. Clinics will be asked to submit all required AUP and ARRD documentation to AHCCCS by the 4th Wednesday in November. Submissions after that date will be subject to delayed payment dates specified later in the document.
        c. See separate documents on the AUP and ARRD process.

E. No later than the third Friday of December each year, AHCCCS will notify the FQHC or RHC of the final Reconciliation result, which will be one of the following:
    1. The Preliminary Reconciliation, if the FQHC or RHC accepted
    2. The result derived from the ARRD, subject to appropriate adjustments made by AHCCCS based on findings in the submission, if the FQHC or RHC elected to submit

F. The annual reconciliation will be completed according to the following timeframes:
    1. For FQHCs/RHCs that accept the AHCCCS Preliminary Reconciliation, any amount owed by AHCCCS will be paid by December 31, and any amount owed by the FQHC/RHC will be recouped by December 31.

2. For FQHCs/RHCs that elect to submit the ARRD/AUP and have submitted no later than January 31, any amount owed by AHCCCS will be paid by February 28 and any amount owed by the FQHC/RHC will be recouped by February 28.
3. For FQHCs/RHCs that elect to submit the ARRD/AUP and have not submitted by January 31 and have not received an extension under #5 below, the final reconciliation will be the Preliminary Reconciliation, and any amount owed by AHCCCS will be paid by February 28 and any amount owed by the FQHC/RHC will be recouped by February 28.
4. In the event AHCCCS has not produced or delivered the Preliminary Reconciliation by September 30, all subsequent due dates will be adjusted by the number of days beyond September 30 that the Preliminary Reconciliation was delivered.
5. AHCCCS may grant an extension for the submission of the ARRD/AUP where the FQHC/RHC is unable to submit by January 31 due to circumstances outside the FQHC's/RHC's control and the FQHC/RHC has submitted prior to January 31 a written request for extension with an explanation of the circumstances.
6. If a specific date referenced above falls on a holiday or weekend, the deadline is assumed to be the next business day.

References

- State Plan for Medicaid, Attachment 4.19-B, Page 4a (SPA 18-009)
- Section 1902(bb) of the Social Security Act (42 U.S.C. § 1396a(bb))

Memorandum from Richard Chambers, Acting Director, Family and Children's Health Programs Group, Health Care Financing Administration (now CMS), to Associate Regional Administrators (Sept. 12, 2001), re: BIPA Section 702 PPS for FQHCs.

Appendices

A. AHCCCS Reconciliation and Rebase Data (ARRD Form)
B. Agreed Upon Procedures
C. Sample Format for AHCCCS Preliminary Reconciliation

Appendices A:

AHCCCS Reconciliation and Rebase Data

Clinic Name:

Encounters

Include all eligible visits, do not include Fee-for Service Claims**

	Federal Fiscal Year XXXX
Date of Service Range:	10-01-XXXX through 09-30-XXXX
Title XIX Medicaid, including dual eligible population*	
Kids Care, Title XXI, including dual eligible population*	
Dental Care	
TOTAL	

Revenue

Include all revenue received from all payors (Medicaid and Non-Medicaid) associated with the reported visits. Do not include Fee-for-Service claims revenue**.

	Federal Fiscal Year XXXX
Date of Service Range:	10-01-XXXX through 09-30-XXXX
Title XIX Medicaid, including dual eligible population; AHCCCS managed care organization (MCO), Medicare & third party payments	
Kids Care, Title XXI, including dual eligible population; AHCCCS MCO, Medicare & third party payments	
Dental Care	
Other (AHCCCS Quarterly Supplemental Payments)	
TOTAL	

Clinics to fill in all information in yellow boxes.

*Dual eligible = Eligible for Title XIX or XXI and also eligible under another payer, such as Medicare or third-party insurer
** Fee-for-Service claims represent claims billed directly to AHCCCS and not billed to the AHCCCS managed care organization (MCOs).

Encounter (or Visit) – A face to face encounter with a licensed AHCCCS registered practitioner during which an AHCCCS covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline or with the same practitioner and which take place on the same day and at a single location constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately. An AHCCCS covered service is a service described by A.A.C. Title 9, Chapter 22, Article 2 or Title 9, Chapter 28, Article 2 and shall not include case management or group therapy services. Services that were billed directly to AHCCCS and their associated revenues should not be included in amounts reported on this form.

Services "incident to" a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician's or practitioner's professional service (examples: medical supplies; venipuncture; assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (examples: x-ray; medication; laboratory test).

Site of Services – AHCCCS is required to follow federal guidelines as set forth in 42 CFR Ch IV. Accordingly, federally qualified health center services are covered when provided in outpatient settings only, including a patient's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a patient's home. Federally qualified health center services are not covered in a hospital. – see 42 CFR § 405.2446(1)(c) and (d).

CEO & CFO Verification

This is to certify that the information contained on this page is true, accurate and complete. I understand that payment of Title XIX, Title XXI, and KidsCare services comes from Federal and State funds. I further understand that any falsification or concealment of material fact may be prosecuted under Federal and State laws.

CEO Signature _____ Date: _____

CFO Signature _____ Date: _____

Appendices B:

Agreed Upon Procedures

FY 2020 & FY 2021 & FY 2022 Reconciliations

1. Agree visits reported on the AHCCCS Reconciliation and Rebase Data (ARRD) form to supporting reports generated from the Center's patient management system, verifying that only eligible AHCCCS visits are included.

2. Agree reimbursements reported on the ARRD form to supporting reports generated from the Center's patient management system, verifying that all AHCCCS and other payor reimbursements are included for the eligible AHCCCS visits in procedure #1.

3. Review the visit detail from the Center's payment management system and make a selection of AHCCCS eligible visits to ensure the sample size is statistically significant, consistent with the AICPA Audit Guide, Government Auditing Standards and Single Audits (GAS-SA Guide), and test the following:

   a. Review the superbill verifying that a face-to-face or valid tele-health visit occurred on that date.

   b. Review the superbill verifying that the visit occurred in an outpatient setting only.

   c. Verify that the patient was AHCCCS-enrolled on the date of service by reviewing the AHCCCS insurer's online enrollment records.

   d. Verify the service provided during the visit was an AHCCCS-covered service.

   e. Verify that the encounter meets the FQHC/RHC visit definition from Ch. 10 FQHC/RHC addendum to the AHCCCS FFS Provider Billing Manual.

4. Agree that the sample tested includes no visits that were billed directly to AHCCCS.

5. Verify that all payments received for the selected visits are included in the reimbursements reported on the ARRD.

6. Test the Center's methodology for allocating obstetrician gynecologists' delivery packages to reimbursements to determine its reasonableness.

7. Confirm that visit revenues and capitation payments track back to the clinic's financial system and reports.

Any finding from the AUP will be extrapolated to the total number of visits and revenue to determine the final reconciliation amount.

Not part of the AUP: Requires the health center's auditor to submit the complete list of claims that tie to the ARRD and identify the claims that were part of the sample. The list of claims should include the Claim 1 Number, AHCCCS Health Plan, Medicaid Paid Amount, and Medicare/Other Insurance Paid Amount.

Appendices C:

Sample Format for AHCCCS Preliminary Reconciliation

XYZ FQHC

Visit Counts		
T1015 Paid & Adjudicated Visit Count		4,321
T1015 Administrative Denial Visit Count		543
Total Visits		4,864
PPS Rate	$	250.00
Visits * Rate	$	1,216,000.00
Amounts Reported to AHCCCS as Paid		
Health Plan - Paid & Adjudicated Amount	$	1,100,100.00
Health Plan - Administrative Denial Amount	$	1,111.00
Third Party - Paid & Adjudicated Encounters	$	56,789.00
Third Party - Administrative Denial Amounts	$	9,876.00
Total Amount Paid through Encounters	$	1,167,876.00
Supplemental Payments	$	80,000.00
Total Amount Paid	$	1,247,876.00
		$
Balance due from (to) AHCCCS		**(31,876.00)**