

## INSTRUCTIONS

### Federally Qualified Health Center/Rural Health Clinic Healthy Families Plan Retroactive Reconciliation Request Forms

Please read all instructions carefully before completing these forms.

**HEALTHY FAMILIES PLAN - The Managed Risk Medical Insurance Board (MRMIB) is responsible for the Healthy Families Program. The Department of Health Care Services, Audits & Investigations (A&I), entered into an agreement with MRMIB to facilitate the Healthy Families Plan (HFP) reconciliation process. A&I will collaborate with the Medi-Cal Fiscal Intermediary to insure that all Health Centers and Clinics receive their full PPS rate for all HFP visits that were adjudicated by the Plan(s) during the stated fiscal period.**

These Retroactive Reconciliation Request forms consist of an Identification and Certification page followed by worksheets that reconcile visits and payments applicable to the HFP(s). Reconciliations are mandatory for Prospective Payment System (PPS) final settlement determinations. Allowable visits will be reimbursed at the clinic's PPS rate after subtracting all prior payments.

These forms must be complete and legible; incomplete forms will be returned for correction. If the forms are returned, instructions will be given noting the deficiencies and corrective action needed. Submit electronically to [clinics@dhcs.ca.gov](mailto:clinics@dhcs.ca.gov) and send hard copies to:

Department of Health Care Services  
Financial Audits Branch  
Audit Review and Analysis Section  
1500 Capitol Avenue – MS 2109  
P.O. Box 997413  
Sacramento, CA 95899-7413

## RECONCILIATION PROCESS

California's Medi-Cal State Plan and Amendments (SPA) require the Department of Health Care Services (Department) to reimburse FQHC/RHC providers on an interim basis for Healthy Families Plan beneficiaries. Afterwards the Department must perform an annual reconciliation to determine if those interim payments were greater than or less than the provider's allowable reimbursement. The information gathered here is used to determine the final settlement amount payable to either the clinic or the State, as applicable. The Department will not reconcile Healthy Families Plan visits unless they were billed and paid by the fiscal intermediary.

## DOCUMENTATION

The information entered on these forms is subject to audit by the Department and must be supported by documentation such as remittance advices (RA), explanation of benefits (EOB), or other documentation to verify the reported amounts. The Department will review the Retroactive Reconciliation Request forms and may ask the clinic to provide supporting documentation for any specific period of time, thus minimizing the necessity for onsite reviews.

This information is subject to the Medicare reasonable cost principles found in 42 CFR, Part 413 and in accordance with California's FQHC/RHC reimbursement policies and principles.

### **PAGE 1 - IDENTIFICATION AND CERTIFICATION:**

Complete Part A, Identification, with the requested information. Only enter multiple NPI's if clinics were consolidated for rate setting purposes. See Fiscal Period Review Tab to determine your retroactive period. (If your facility started seeing Healthy Families patients after October 1, 2009 then the first date the facility began seeing Healthy Families patients is the effective date for your Retroactive Reconciliation Request)

Complete Part B, Certification, with the requested information. Individuals signing this statement must be an officer or other authorized representative. These forms will be returned if the certification statement is not complete including the printed name.

### **PAGE 2 – RETROACTIVE RECONCILIATION WORKSHEET DETAIL:**

Complete this page by entering the monthly adjudicated visit count and payment amounts as described below. Be sure to use 'Date of Service' as the basis for reporting this information.

#### **PERIODS 1, 2 and 3:**

**Periods 1, 2 and 3** refer to the three fiscal periods that this retroactive reconciliation process applies to: October 1, 2009 through September 30, 2010; October 1, 2010 through September 30, 2011; and the short year October 1, 2011 through May 31, 2012, irrespective of when the clinic's fiscal year normally ends. All retroactive periods occur this way because the Medicare Economic Index (MEI) factor is implemented on October 1<sup>st</sup> of each year. Only the totals are carried forward to Page 3.

#### **BILLING CODES DEFINED:**

The only billing code that will be included on this Retroactive Reconciliation Request is the Healthy Families Plan Code 19 information. Non-Healthy Families beneficiaries are billed using other revenue codes which are *not included here*. *Certain visits may be adjusted during this reconciliation process if the auditor finds that inappropriate payments were made for non-billable services such as injections, screenings or duplicates.*

#### **VISITS DEFINED:**

A "visit" for FQHC or RHC services is defined in regulations and the SPA as any of the following:

- (a) A face to face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable under the Medi-Cal program. A "physician" means:

- (i) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.
- (ii) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.
- (iii) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.
- (iv) A doctor of chiropractic's authorized to practice chiropractic by the State and who is acting within the scope of his/her license.
- (v) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.

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

- (a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.
- (b) When the clinic patient receives ADHC services, or is seen by a health professional or comprehensive perinatal services practitioner, and is seen by a dentist on the same day of service, two visits may be counted.

**COLUMN HEADINGS DEFINED: Important: All payments associated with any reported adjudicated visits must be included in the total payments, including payments by beneficiaries themselves or for payments received for "incident to" services.**

**HEALTHY FAMILIES PLAN PERIOD 1 – October 1, 2009 through September 30, 2010 (Columns 1 through 5): If the clinic has more than one Healthy Families Plan, combine the data for all plans for entry into this section.**

**Column 1 – The Monthly Breakdown** – Shows the 12 months from October 1, 2009 through September 30, 2010 for the first year of the Retroactive Period, unless the healthy families contract was signed after October 1, 2009 then use that date as the starting point.

**Column 2 – Healthy Families Visits** – Include only the Healthy Families Plan adjudicated visits incurred during the stated fiscal period for Medi-Cal beneficiaries.

**Column 3 – Healthy Families Plan Payments** – Report **all** Healthy Families Plan payments (both fee-for-service {FFS} and capitated) in this column.

**Column 4 – Healthy Families Plan Medi-Cal Code 19 Payments** – Report all Medi-Cal Healthy Families Plan Code 19 payments received in this column.

**Column 5 – Patient Deductible for Code 19 Visits** – Report the Patient Deductible payments received from Healthy Families Plan patients during the period.

**HEALTHY FAMILY PLAN PERIOD 2 – October 1, 2010 through September 30, 2011(Columns 6 through 10):** If the clinic has more than one Healthy Families plan, combine the data for all plans for entry into this section.

**Column 6 – Through Column 10 mirrors what is required for Columns 1 through 5**

**HEALTHY FAMILIES PLAN PERIOD 3 (If applicable) – October 1, 2011 through May 31, 2012 SHORT YEAR (Columns 11 through 15):** See Fiscal Period Review Tab to determine the Healthy Families information that the facility should include on the Retroactive Reconciliation Request. If the clinic has more than one Healthy Families Plan, combine the data for all plans for entry into this section.

**Column 11 – Through Column 15 mirrors what is required for Columns 1 through 5**

**PAGE 3 - RECONCILIATION WORKSHEET SUMMARY: (Enter the PPS Rate Information ONLY)**

If completing the forms electronically, only enter the correct PPS rates for Period 1, Period 2 and Period 3. This page summarizes the visits and payments from the detail reported on page 2 and will determine the amount due the clinic or State.

**Note:** If you had a Change in Scope of Services during the retroactive period you must file a separate Retroactive Period Reconciliation starting on the first day the Change in Scope of Services is implemented. Example: If you had a Change in Scope of Services Request effective July 1, 2010 then you will file a Retroactive Reconciliation Request from October 1, 2009 through June 30, 2010 and a Second Retroactive Reconciliation Request from July 1, 2010 through May 31, 2012.

For help completing these forms please submit requests to: [clinics@dhcs.ca.gov](mailto:clinics@dhcs.ca.gov) . You will receive a written response. If you do not have access to email, contact ARAS at (916) 650-6696.