

Prior authorization is not applicable to FQHC services.

**By Chris Tighe at 2:48 pm, Nov 26, 2014****250.000 REIMBURSEMENT****251.000 Reimbursement Methodology for Dates of Service before January 1, 2001 10-13-03**

Reimbursement methodology in Sections 251.100 through 251.510 regards dates of service before January 1, 2001. See Sections 252.000 through 252.241 for reimbursement methodologies in effect for dates of service on and after January 1, 2001.

**251.100 Cost Report Form CMS-222-92 (formerly HCFA-222-92) 10-13-03**

According to the law that established Federally Qualified Health Centers (FQHCs), Medicaid must reimburse, at 100% of reasonable cost, services that meet the FQHC service definition. Medicaid will establish an FQHC encounter rate unique to each center, based on each center's Medicare cost report. The encounter rate will be reimbursed for all allowable encounters performed by all of the center's qualified clinics. Each FQHC will submit to the Division of Medical Services (DMS), a copy of the CMS-222-92 cost report (all pages) submitted to Medicare. [View or print DMS Financial Activities contact information](#). The centers will complete the CMS-222-92 cost reports according to Medicare principles of reimbursement for Federally Qualified Health Centers, found at 42 CFR 405, subpart X and 42 CFR 413. Desk review and/or on-site audit by the Medicare intermediary and the Division of Medical Services will determine a center's allowable and reasonable costs. Medicaid will make settlement at 100% of allowable and reasonable costs reported on Worksheet A of the CMS-222-92, as verified by audit staff. Reasonable costs are those applicable costs that are allowable under Medicare cost principles as outlined in 42 CFR 413. Medicaid cost settles with FQHCs only for services that the FQHC service definition includes and that Medicaid covers.

**251.200 Adjustments to the Cost Report 10-13-03**

Direct compensation per each line is determined from Column 1 reported compensation net of Column 4 reclassifications (Column 1  $\pm$  Column 4).

- A. DMS will calculate the ratio of non-FQHC compensation (Worksheet A, Lines 51-61) to total direct compensation (Worksheet A, Lines 1-3; plus Worksheet A, Lines 51-61). The Division will apply this ratio to total overhead costs (Worksheet A, Line 50, Column 7), allocating the result to non-FQHC costs (the center reports non-FQHC costs on Worksheet A, Lines 51-61).
- B. The managed care expense will equal the managed care fees paid to the FQHC under the Arkansas Medicaid Primary Care Case Management Program (PCCM). The center may correctly document its PCCM managed care adjustment by reclassifying (from Worksheet A, Line 1, Column 4, to Worksheet A, Lines 58-60, Column 4) an amount equal to PCP managed care fees paid for the months within the cost reporting period. The center should adequately identify this adjustment on Worksheet A-1. If the center does not reclassify PCCM managed care costs on the cost report, DMS will perform an adjustment to remove managed care costs from the FQHC costs.
- C. The costs of non-related and unallowable FQHC Program services will be identified and eliminated.
- D. In lieu of determining and eliminating each detailed line item cost of these non-related and unallowable costs, the related income may be used to offset the costs if the center can justify and document (calculations to be retained by the center) that the revenue received is reasonably equivalent to the costs incurred.