Department of Human Services
QUEST Integration (QI)

Financial Summary File

Federally Qualified Health Centers (FQHC)
Rural Health Clinics (RHC)

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Services	
Purpose	Financial Summary Information for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) including incentive, capitation, administrative and fee for service payments. Submit one report to include all providers of this type. The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	Excel .xls file
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: Accumulate all data based on date of service. **For Fee-For-Service based payments**, information on all claims with service during the time period specified and paid as of the report run date. Paid claims are to include reversals, voids and or adjustments. Note: The sum of FFS payments (Data Element 13 and 14) must equal the respective detail claims/encounter data file. **For all capitation based payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report. All performance incentives (excluding dollars paid as capitation or fee-for-service reimbursement) which accrued or was paid during the reporting period. Total capitation payments made to the provider for the reporting period. Total administrative fees paid

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Federally Qualified Health Centers (FQHC)
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Data Elements	
Include a header for each data element.	
1.) MCO ID	Insert the MCO identification number
2.) MCO Name	Insert the MCO Name
3.) Report Date	Indicate the date the report data was generated from the management information system.
4.) Provider Number	Insert the Medicaid Provider identification number on which the MCO is reporting.
5.) Provider Name	Indicate the name of the FQHC or RHC on which the MCO is reporting.
6.) Begin Period	Indicate the beginning date of the reporting period for which the MCO is submitting the report.
7.) End Period	Indicate the ending date of the reporting period for which the MCO is submitting the report.
8.) Count of FFS claims/encounters	Enter the count of Fee-For-Service paid claims/encounters.
9.) Count of CAP claims/encounters	Enter the count of Capitation paid claims/encounters.
10.) CAP Payments	Enter the capitated paid amount.
11.) Admin Fees	Enter the amount of paid administrative fees.
12.) Incentive Payments	Enter the total amount paid for incentives.
13.) Primary FFS Payments	Enter the Fee-For-Service paid amount for claims in which Medicaid was the primary payer.
14.) Secondary FFS Payments	Enter the Fee-For-Service paid amount for claims in which Medicaid was the secondary payer.
15.) Total Health Plan Payments	Enter the Sum of CAP Payments, Admin Fees, FFS Payments, and Incentive Payments.
16.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.

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Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Medicaid Primary Services	
Purpose	Medicaid Primary Detail Claims and Encounter Services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Submit one report per provider The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	Excel .xls file
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: **Include the line level detail of all claims in which Medicaid is the primary payer.** **For Fee-For-Service based payments**, information on all claims with service during the time period specified and paid as of the report run date. Paid claims are to include reversals, voids and or adjustments. **For all capitated based FQHC/RHC claims payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report.

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Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

Data Elements	
Include a header for each data element.	
1.) Item No.	Consecutively number each member item for the report.
2.) MCO ID	Insert the MCO identification number
3.) MCO Name	Insert the MCO Name
4.) Report Date	Indicate the date the report data was generated from the management information system. Enter MM/DD/YYYY format.
5.) Billing Provider Number	Insert the Medicaid Provider identification number on which the MCO is reporting.
6.) Billing Provider Name	Insert the name of the billing FQHC/RHC on which the MCO is reporting.
7.) Rendering Provider Number	Insert the identification number of the rendering provider listed on the claim.
8.) Rendering Provider Name	Insert the name of the rendering provider listed on the claim.
9.) Begin Date	Indicate the beginning date of the claim/encounter. Enter MM/DD/YYYY format
10.) End Date	Indicate the ending date of the claim/encounter. Enter MM/DD/YYYY format
11.) Member First Name	Indicate the member's first name as listed on the referenced claim item.
12.) Member Last Name	Indicate the member's last name as listed on the referenced claim item.
13.) Member ID Number	Insert the member's Medicaid identification number that is associated with the reported claim.
14.) Patient Account Number	Identify the billing provider patient account number being submitted for the report.
15.) Claim Status	Identify the status of the claim (paid, denied, pending, reversal, void, adjustment, etc.)

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Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

16.) Claim Number	Identify the claim identification number being submitted for the report.
17.) Claim Number Detail Line	Insert the numeric detail line number of the claim.
18.) Place of Service Code	Insert the place of service code.
19.) Procedure Code	Insert the procedure code as listed for the detail line number on the claim.
20.) Procedure Code Description	Insert the procedure code description for the detail line number on the claim.
21.) Diagnosis Code	Insert the diagnosis code as listed for the detail line number on the claim.
22.) Date Paid	Indicate the date the submitted claim was adjudicated as "paid". Enter MM/DD/YYYY format
24.) Co-Payment	Enter the portion of the medical expense that the member was responsible for.
25.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.
26.) Paid Amount	Indicate the paid amount of the detail line number of the claim.

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Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Medicaid Secondary Services	
Purpose	Medicaid Secondary Detail Claims and Encounter Services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Submit one report per provider The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	Excel .xls file
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: **Include the line level detail of all claims in which Medicaid is the secondary payer.** **For Fee-For-Service based payments**, information on all claims with service during the time period specified and paid as of the report run date. Paid claims are to include reversals, voids and or adjustments. **For all capitated based FQHC/RHC claims payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report.

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Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

Data Elements	
Include a header for each data element.	
1.) Item No.	Consecutively number each member item for the report.
2.) MCO ID	Insert the MCO identification number
3.) MCO Name	Insert the MCO Name
4.) Report Date	Indicate the date the report data was generated from the management information system. Enter MM/DD/YYYY format.
5.) Billing Provider Number	Insert the Medicaid Provider identification number on which the MCO is reporting.
6.) Billing Provider Name	Insert the name of the billing FQHC/RHC on which the MCO is reporting.
7.) Rendering Provider Number	Insert the identification number of the rendering provider listed on the claim.
8.) Rendering Provider Name	Insert the name of the rendering provider listed on the claim.
9.) Begin Date	Indicate the beginning date of the claim/encounter. Enter MM/DD/YYYY format
10.) End Date	Indicate the ending date of the claim/encounter. Enter MM/DD/YYYY format
11.) Member First Name	Indicate the member's first name as listed on the referenced claim item.
12.) Member Last Name	Indicate the member's last name as listed on the referenced claim item.
13.) Member ID Number	Insert the member's Medicaid identification number that is associated with the reported claim.
14.) Patient Account Number	Identify the billing provider patient account number being submitted for the report.
15.) Claim Status	Identify the status of the claim (paid, denied, pending, reversal, void, adjustment, etc.)

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Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

16.) Claim Number	Identify the claim identification number being submitted for the report.
17.) Claim Number Detail Line	Insert the numeric detail line number of the claim.
18.) Place of Service Code	Insert the place of service code.
19.) Procedure Code	Insert the procedure code as listed for the detail line number on the claim.
20.) Procedure Code Description	Insert the procedure code description for the detail line number on the claim.
21.) Diagnosis Code	Insert the diagnosis code as listed for the detail line number on the claim.
22.) Date Paid	Indicate the date the submitted claim was adjudicated as "paid". Enter MM/DD/YYYY format
24.) Co-Payment	Enter the portion of the medical expense that the member was responsible for.
25.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.
26.) Paid Amount	Indicate the paid amount of the detail line number of the claim.