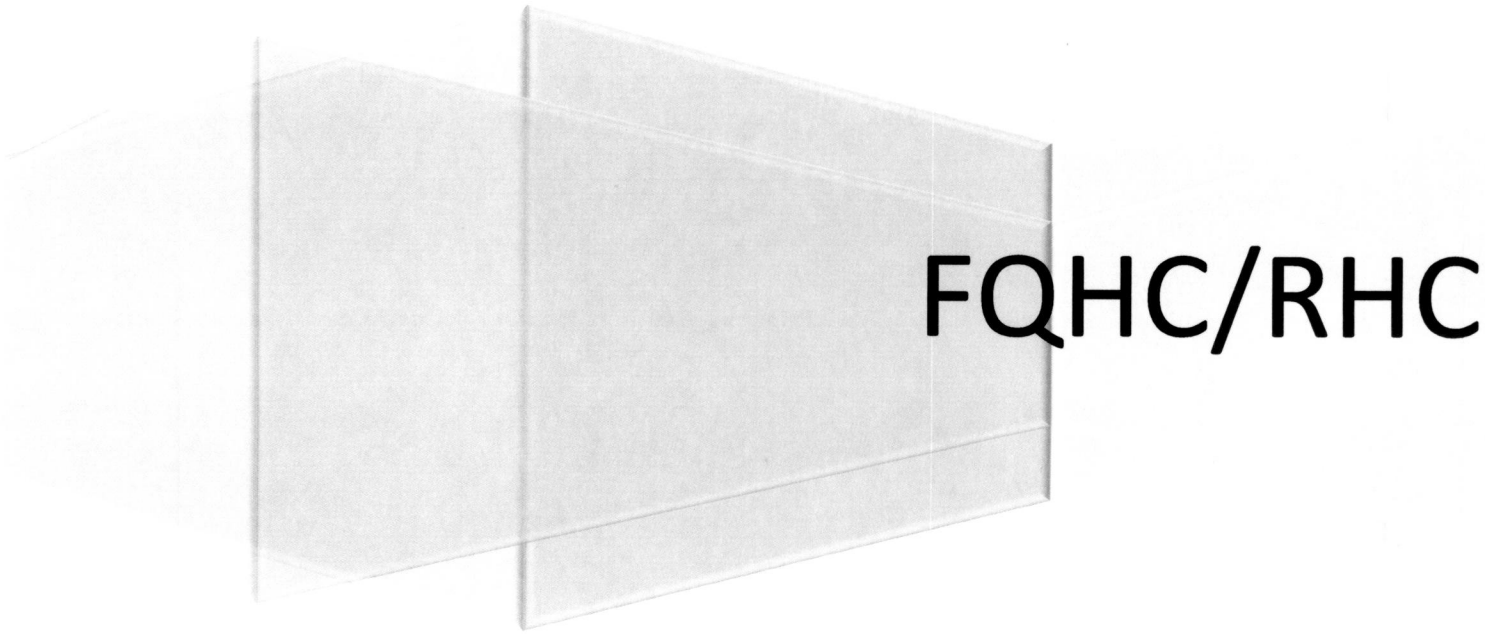
Mississippi Division of Medicaid
Federally Qualified Health Centers and Rural Health Clinics

Change in Scope of Service Forms & Instructions



Change in Scope of Service Request Forms & Instructions

PURPOSE

The following instructions are intended to assist the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers in submitting a request for an adjustment to their Medicaid PPS rate due to an increase or decrease in scope of services.

DEFINITION OF CHANGE IN SCOPE

A change in scope of services is defined as a change in the type, intensity, duration and/or amount of services as follows:

a. The addition of a new service not previously provided by the FQHC/RHC, such as, dental, EPSDT, optometry, OB/GYN, laboratory, radiology, pharmacy, outreach, case management, transportation, etc., or

b. The elimination of an existing service provided by the FQHC/RHC.

However, a change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not constitute a change in the scope of services. Also, a change in the cost of a service is not considered in and of itself a change in the scope of services.

It is the responsibility of the FQHC/RHC to notify the Division of Medicaid of any change in the scope of services and provide the proper documentation to support the rate change. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

Any increases or decreases in scope of services must be related to a Mississippi Medicaid covered FQHC/RHC service.

CHANGE IN SCOPE OF SERVICE ADJUSTMENT CRITERIA

The following criteria must be met in order for a center or clinic to qualify for an adjustment due to a change in the scope of service:

A. The cost related to a change in the scope of service must result in an increase or decrease to the existing PPS rate of 5% or greater.

B. The cost related to a change in the scope of service will be subject to reasonable cost criteria identified in accordance with 42 CFR 405, Subpart X.

C. The change in the scope of service must have been fully implemented for twelve (12) consecutive months in order to be considered for a PPS rate adjustment.

If above criteria are met, the adjustment to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

FILING REQUIREMENTS FOR A CHANGE IN SCOPE OF SERVICE

A. It is the responsibility of the FQHC/RHC to notify the Division of Medicaid of any change in the scope of services and provide proper documentation to support the rate change.

B. If a scope of service change is being requested for a center or clinic, which is part of a chain organization, a home office cost report must be submitted along with the Change in Scope of Service Request. The purpose of this is to ensure that all of the organizational costs associated with a center or clinic request for a scope of service change are included.

C. If a change in scope of service is being requested for more than one center or clinic in the organization, a **separate** scope of service request must be completed for each center or clinic.

D. If additional information is requested by the Division of Medicaid, the center or clinic will have thirty (30) days to submit the additional documentation.

E. Failure to submit all required documentation within the time frames listed above could result in a denial of the change in scope of service request.

REQUIRED SUPPORTING DOCUMENTATION

The required list of supporting documentation includes, but is not limited to, the following items. The time period for all items submitted with the cost report (Board of Director Minutes, Audited Financial Statements, Working Trial Balance, FTEs, etc.) should correspond to the cost reporting period:

A. Change in the Scope of Service Request Form

B. A detailed report of the cost of the new service showing actual costs by line item for the first full fiscal year of operation.

C. Copy of the Medicare cost report that includes the first full year of costs for the new services.

D. Copy of the Medicare cost report for the fiscal year prior to the addition of the new service.

E. Working Trial Balance for the prior year and the first full year of costs.

F. Crosswalk of expenses from the Working Trial Balance to the cost reports.

G. Summary of FTEs and Total Visits for each provider in the center or clinic (physician, nurse practitioner, dentist, etc.).

H. Summary of cost report reclassification and adjustments (including supporting workpapers, if applicable).

I. Home Office Cost Report (including working trial balance and supporting workpapers, if applicable).

J. Form 1, Form 2, Form 4, Form 5, and the Increase/Decrease in Scope of Service form must be completed and signed by the Officer or Administrator.

K. A narrative description of the change in scope of services describing what services were provided before and after the change.

TIMELINESS, ACCURACY & COMPLETENESS

The submission of late, inaccurate, or otherwise incomplete requests shall not be considered. Standards applied for determining adequacy of required data are as follows:

a. **Timeliness:** The FQHC/RHC must file for a rate adjustment due to a change in scope of services no later than one hundred and fifty (150) days after the cost report fiscal year end that includes a full year of costs for the new service, or within a year after the elimination of an existing service.

b. **Accuracy:** Schedules and supporting documents or other required data will be prepared in strict conformity with appropriate authoritative sources and/or DOM standards.

c. **Completeness:** All schedules and supporting documents and other required data should be fully disclosed in a matter that support the rate adjustments requested with no material omissions.

INTERNET ACCESS

The change in scope of service forms and instructions can be downloaded from the Division of Medicaid's website at the address below:

http://www.medicaid.ms.gov/resources/forms/

REFERENCES/RESOURCES

- Mississippi State Plan, Attachment 4.19-B
- Administrative Code, Title 23, Part 211, Federally Qualified Health Centers
- Administrative Code, Title 23, Part 212, Rural Health Clinics
- Code of Federal Regulations, Title 42, 405 Subpart X

INCREASE/DECREASE IN SCOPE OF SERVICES FORM

This form will be used to calculate the center's or clinic's baseline Medicaid PPS rate. Failure to return the completed form will disallow the costs to be included in the scope of service.

1. **GENERAL INFORMATION**. Complete this section with the center's or clinic's name, Medicaid identification number, and cost reporting period of the new services.

2. **PART A – ADDITION OF NEW SERVICES NOT PREVIOUSLY PROVIDER BY FQHC/RHC.** List any new services that were not previously provided by the center or clinic including their related costs and total number of visits to coincide with the cost reporting period. The addition of new services does not mean the addition of staff members to an existing service.

3. **PART B – ELIMINATION OF EXISTING SERVICES PROVIDED BY FQHC/RHC**. List any existing services that were previously provided by the center or clinic, but were eliminated during the cost reporting period. Also include the related costs and total number of visits for the service or services that were eliminated.

4. **CERTIFICATION OF INCREASE/DECREASE IN SCOPE OF SERVICES.** This form must be completed and signed by an officer or administrator of the center or clinic after the cost report has been completed in its entirety. The individual signing must be an officer or other authorized responsible person. The cost report will be considered incomplete and returned to the facility if left unsigned.

FORM 1: GENERAL INFORMATION

On Form 1, enter the identification numbers, the provider's full legal name, address, and telephone number of the primary service location of the center or clinic. In addition, provide the name and title of the administrator and chief financial officer at the center or clinic.

1. **FQHC/RHC PROVIDER NUMBERS:** Enter the FQHC/RHC Medicare, Medicaid, and National Provider Identification (NPI) numbers.

2. **FQHC/RHC NAME**: Enter here the full legal name and address of the primary service location of the center or clinic.

3. **FQHC/RHC MAILING ADDRESS:** Enter the FQHC/RHC mailing address, including city, state, county, and zip code.

4. **COST REPORTING PERIOD**: Enter the dates covered by this cost report. A reporting period is a period of 12 consecutive months used for other reporting purposes.

5. **ADMINISTRATION**: Enter the name, title, address, telephone number, and email address of the administrator and chief financial officer at the center or clinic, or authorized personnel.

6. **HOME OFFICE OR MANAGEMENT COMPANY:** Enter the name, address, and telephone number of the organization(s) or individual(s) who are the legal owner(s) of the center or clinic.

7. **SERVICE LOCATIONS (FOR FQHC ONLY):** List **all** the service sites of the FQHC, including the name, Medicaid identification number, address, and indicate whether the site is a school-based location. List additional sites on a separate sheet and attach with this form.

8. **FOR DIVISION OF MEDICAID USE ONLY:** Do not complete this section.

FORM 2: CERTIFICATION BY OFFICER OR ADMINISTRATOR

Form 2 must be completed and signed by an officer or administrator of the center or clinic after the cost report has been completed in its entirety. The individual signing must be an officer or other authorized responsible person. The cost report will be considered incomplete and returned to the facility if left unsigned.

Line 1: **FQHC/RHC PROVIDER NUMBERS:** Enter the FQHC Medicare, Medicaid, and National Providers Identification (NPI) numbers.

Line 2: **FQHC/RHC NAME**: Enter here the full legal name and address of the primary service location of the center or clinic.

Line 3-4: **FQHC/RHC MAILING ADDRESS:** Enter the FQHC mailing address, including city, state, county, and zip code.

Line 5: **COST REPORTING PERIOD**: Enter the dates covered by this cost report. A reporting period is a period of 12 consecutive months used for other reporting purposes.

Line 6: **CERTIFICATION OF OWNERSHIP**: Enter the name of the organization(s) or individual(s) who are the legal owner (s) of the center or clinic.

The Certification by Officer or Administrator is required and must be signed by an authorized officer or the administrator of the center or clinic. The cost report will not be deemed received by the Division of Medicaid if this certification has not been completed.

FORM 4 - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

All expenses for the period are to be listed on the appropriate line and in the appropriate column (l, 2, or 3) and should agree with the expenses recorded on the center's trial balance after accrual adjustments.

Column Descriptions:

Column 1 **Compensation Including Benefits**. This column should include expenses for compensation by salary and should also include any related fringe benefits.

Column 2 **Purchased and Contract Services**. This column should include expenses for purchased and contract services including compensation by contractual agreement.

Column 3 **Other**. This column should include all expenses which do not appropriately go in either column 1 or column 2.

Column 4 **Total**. Column 4 should report the total of columns 1, 2, and 3.

Column 5 **Reclassifications**. This column is used to reclassify expenses among the cost centers for proper grouping of expenses. Reclassifications are used in instances in which the expenses applicable to more than one of the cost centers listed on the form are maintained in the FQHC's/RHC's accounting books and records in one cost center. An example of a reclassification is the allocation of physician compensation from health care cost to overhead administration cost for the portion of his compensation related to overhead administration. Reductions to expenses should be shown in brackets (< >). The net total of reclassifications on line 7 in column 5 should equal zero.

Column 6 **Total Expense (Unadjusted)**. Column 6 should report expenses before adjustments. This column should equal the total of columns 4 and 5.

Column 7 **Adjustments**. Adjustments to expenses should be entered in column 7.

A schedule must be attached to describe any adjustments made. Adjustments should include reductions to expense for non-reimbursable costs. Reductions to expenses should be shown in brackets (< >).

Column 8 **Total Expense**. Column 8 is the FQHC/RHC expense after all reclassifications and adjustments. This column should report the total of columns 6 and 7. The expenses for the purpose of this report are broken down between cost centers for direct health care costs, which includes both core health care costs, line 1, and other ambulatory services, line 2; clinic overhead costs, line 4; non-reimbursable costs, line 5; and outstationed/ eligibility workers cost, line 6. Line 3 is reserved for total direct health care costs and line 7 is reserved for total all costs, both reimbursable and non-reimbursable.

Line 1 **Core Health Care Costs**. Expenses to be reported on lines 1 through 1-07 are those costs directly related to core health care services as defined by 42 CFR 405. Core health care services include the following services: physician services, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Core health care services also includes, in the case of an FQHC/RHC located in an area which is designated by the MSDH to have a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment which meets 42 CFR 405 requirements.

The costs reported on line 1 should include depreciation or rent expense for equipment, as well as, malpractice liability insurance premiums in 42 CFR 405 to the extent that the costs are directly related to core health care services.

Line 2 **Other Ambulatory Services**. These include costs associated with any clinic service other than core health care services allowed in the State Medicaid Plan when offered by the FQHC/RHC. In addition to compensation and other directly related costs, the costs reported on line 2 should include depreciation or rent expense for equipment, as well as, malpractice liability insurance premiums as apportioned in 42 CFR 405 to the extent that the costs are directly related to other ambulatory services provided.

Line 2-01 **Pharmacy**. This line should include only those costs associated with maintaining a pharmacy within the clinic. Any costs associated with a contract agreement between the clinic and an outside pharmacy should be reported on line 5-09.

Line 2-02 **Dental Services**. The allowable cost includes only expenses incurred by a

dentist, employed by salary or by contractual agreement, working as a part of the FQHC/RHC.

Line 2-05 **EPSDT Treatment Services**. The amounts to be reported on this line include the EPSDT treatment services which are otherwise not within the scope of allowable services in the State Medicaid Plan. All services for EPSDT treatment which are covered by the State Medicaid Plan should be included on the appropriate row of lines 1 and 2.

Line 3 **Total Direct Health Care Costs**. This is the total of lines 1-07 and 2-07.

Line 4 **Clinic Overhead Costs**. This line should include those costs associated with managing and maintaining the health center. It should include all allowable costs not directly related to patient care. All costs which can be directly associated to core health care services or other ambulatory services should be reclassified to the proper cost center in column 5.

Line 5 **Non-Reimbursable Costs**. These include FQHC/RHC expenses which are not directly or indirectly related to core and other ambulatory services allowed by the State Medicaid Plan or as a result of services provided as a part of an EPSDT treatment. Non-reimbursable costs include, but are not limited to, the cost centers listed on Form 4, page 3 of 3. It is possible that a cost center listed on line 5 does not apply to a particular facility. For example, if an FQHC/RHC pharmacy cost is allowed on Form 4, line 2-01, then it is possible that no pharmacy cost would be included on line 5-09.

Line 6 **Outstationed/Eligibility Workers Cost**. This line should report the center's share of costs to employ assigned outstationed/eligibility workers.

Line 7 **Total Costs**. This line should report for each column the total of Form 4, lines 3, 4-17, 5-13, and 6.

FORM 5 - PROVIDER STAFF, VISITS, AND PRODUCTIVITY

Please provide the provider name, and number and the report period. The data reported on Form 5 must be based on actual center or clinic records.

Form 5 is used to record the provider full-time equivalents (FTE's) of FQHC/RHC services personnel and to summarize the number of FQHC/RHC visits furnished by the health care staff. The all-inclusive rate for FQHC/RHC's is subject to test of reasonableness. One test is productivity screening guidelines intended to identify situations where costs will not be allowed without acceptable justification by the center and limits on the amount of payment. Data is reported in Part A of the form. Parts B and C are used to apply the productivity

screen on determination of provider visits to be used for rate determination. This form's data must EXCLUDE statistics for on-site hours and visits for non-reimbursable cost centers and the overhead cost centers.

PART A – FQHC/RHC PROVIDER STAFF AND VISITS

FTE Personnel. Enter the full-time equivalent (FTE) personnel of each type of center health care staff. The number of full-time equivalent employees of each type of staff is determined by the following formula: divide the total number of hours per year worked by all employees of that type by the greater of: 1) the number of hours per year one staff member of that type must be compensated to meet the center's definition of a full-time employee, or 2) 1,600 hours per year. Fractional equivalents should be shown to the first decimal place. Column 1 is for health care personnel employed under contract, and column 2 is for health care personnel who are permanent salaried employees of the center. Column 3 should show the sum of columns 1 and 2.

Visits. Enter the actual number of visits provided to center patients for health services during the reporting period. The visits should be separated for reporting between on-site and off- site. Columns 4, 5, and 6 should include the data for all center patients, including Medicaid patients. Columns 7, 8, and 9 should include data for Medicaid patients only. A visit is defined as a face-to-face encounter between a center patient and a health professional during which an FQHC/RHC service is furnished. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Off-site visits include hospital initial visits, as well as, follow-up visits within the hospital including, but not limited to, obstetrical deliveries and surgical procedures by center physicians for center patients. Off-site visits include also home health visits by FQHC/RHC staff where home health visits are deemed an allowable FQHC/RHC service.

Positions.

Line 1 **Physicians**. This includes all medical doctors (M.D.'s).

Line 2 **Midlevels**. This includes all staff involved in patient care. Midlevel staff includes the nurse practitioners.

Line 3 **Subtotal**. This should reflect the sum of lines 1 and 2 in all columns.

Line 6 **EPSDT Service Personnel**. This includes the full-time equivalents of personnel who perform EPSDT services which are not otherwise allowed by the State Medicaid Plan.

Line 14 **Total**. Total lines 3 through 13 and record the total on this line.

PART B – MINIMUM MEDICAL TEAM PRODUCTIVITY

After completion of Part A on Form 5, fill in the number of visits and full-time equivalents as instructed on line 1 through 4 of Part B.

Line 1 **Total Physician and Midlevel Visits**. Enter the number of physician and midlevel staff visits recorded on Part A, column 6, line 3.

Line 2 **Total Medical Team FTE's**. Enter the number of full-time equivalents for the physician and midlevel medical team. For purposes of this determination, record the sum of the physician FTE's recorded on Part A, column 3, line l plus one-half the midlevel FTE's recorded on Part A, column 3, line 2.

Line 3 **Minimum Medical Team Productivity**. Multiply the number of FTE's recorded on line 2 times the productivity level of 4,200 visits per full-time equivalent and enter the product here.

Line 4 **Physician and Midlevel Visits to be Used in Rate Determination**. Enter the greater of the number recorded on line 1 or line 3 to determine the physician and midlevel visits to be used in combination with Part C, line 1 in the rate computation.

PART C - PROVIDER VISITS FOR RATE DETERMINATION

Line 1 **Total Provider Visits Less Physician and Midlevel Visits**. Enter the difference between total provider visits recorded in Part A, column 6, line 14 (Total) and Part A, column 6, line 3 (Subtotal).

Line 2 **Total Provider Visits for Rate Determination**. Enter on this line the sum of Part B, line 4 and Part C, line 1. This number is the total provider visits to be used in the rate computation on Form 6.

GENERAL INFORMATION

PROVIDER NAME:		
Medicare Number:	Medicaid Number:	NPI Number:
Provider Name:		
Mailing Address:		
City/State:	County:	Zip:
Phone Number:	Fax Number:	
Type of Facility:	Hospital-based:	Freestanding:

ADMINISTRATION:		
Administrator:	Title:	
Address:		
City/State:	County:	Zip:
Phone:	Fax:	E-mail:
Chief Financial Officer:	Title:	
Address:		
City/State:	County:	Zip:
Phone:	Fax:	E-mail:

OWNERSHIP/MANAGEMENT SERVICES:		
Home Office:		
Address:		
City/State:	County:	Zip:
Phone:	Fax:	E-mail:
Management Company:		
Address:		
City/State:	County:	Zip:
Phone:	Fax:	E-mail:

SATELLITE CLINICS (IF APPLICABLE): List all satellite clinics location. List additional sites on a separate sheet and attach with this form.

Provider Name	Medicaid Number	Address	City/State/Zip	Is Site school-based?
				( ) Yes ( ) No
				( ) Yes ( ) No
				( ) Yes ( ) No

FOR DIVISION OF MEDICAID USE ONLY:	
Cost Report Postmark Date:	Cost Report Received Date:

CERTIFICATION BY OFFICER OR ADMINISTRATOR

PROVIDER INFORMATION:			
Medicare Number:		Medicaid Number:	
Provider Name:			
Physical Address:			
City/State:		County:	Zip:
Cost Report Period:	From:	To:	

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER THE STATE OR FEDERAL LAW.

This Cost Report is submitted as part of the request by this Federally Qualified Health Center or Rural Health Clinic for reimbursement under the Mississippi Medicaid Program.

I, HEREBY CERTIFY, that I have examined the contents of the accompanying cost report to the State of Mississippi, Office of the Governor, Division of Medicaid for the period stated above and certify to the best of my knowledge and belief that the said contents are true and correct statements prepared from the books and records of this center/clinic in accordance with applicable instructions.

Signature (Officer or Administrator of Provider)	Title
Printed Name	Date

Cost Report Prepared By:	
Name:	
Address:	
Name of Contact Person:	
Telephone Number:	

(NOTE: Please attach Accountants' Report, if applicable.)

COST REPORTING PERIOD:	FROM:	TO:
PROVIDER NAME:	PROVIDER NUMBER:	

RECLASSIFICATION & ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Line No.	DIRECT HEALTH CARE COSTS COST CENTER	Compensation Including Benefits (Col. 1)	Purchased, Contract Services & Other (Col. 2)	Total (Col. 3)	Reclass-ifications (Col. 4)	Total Expense (Unadjusted) (Col. 5)	Adjustments (Col. 6)	Total Expense (Col. 7)
1	**CORE HEALTH CARE COSTS:**							
1-01	Medical							
1-02	Laboratory – Medical							
1-03	X-ray – Medical							
1-04	Medical Social Service							
1-05	Psychology							
1-06	Other (Attach Schedule)							
1-07	**Total Core Health Care Costs**							
2	**OTHER AMBULATORY SERVICES:**							
2-01	Pharmacy							
2-02	Dental Services							
2-03	Optometry							
2-04	Durable Medical Equipment							
2-05	EPSDT Treatment Services							
2-06	Other (Attach Schedule)							
2-07	**Total Other Ambulatory Services**							
3	**Total Direct Health Care Costs**							

PROVIDER NAME:		PROVIDER NUMBER:
COST REPORTING PERIOD:	FROM:	TO:

RECLASSIFICATION & ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Line No.	COST CENTER	Compensation Including Benefits (Col. 1)	Purchased, Contract Services & Other (Col. 2)	Total (Col. 3)	Reclass-ifications (Col. 4)	Total Expense (Unadjusted) (Col. 5)	Adjustments (Col. 6)	Total Expense (Col. 7)
4	**CLINIC OVERHEAD COSTS:**							
4-01	Administration							
4-02	Depreciation & Amortization							
4-03	Financial							
4-04	Insurance – General							
4-05	Insurance – Malpractice							
4-06	Interest – Mortgage							
4-07	Interest – Other							
4-08	Legal							
4-09	Maintenance & Repairs							
4-10	Medical Records							
4-11	Rent							
4-12	Security							
4-13	Supplies							
4-14	Telephone							
4-15	Utilities (Electricity, Gas, Water)							
4-16	Other (Attach Schedule)							
4-17	**Total Clinic Overhead Costs**							

PROVIDER NAME:		PROVIDER NUMBER:
COST REPORTING PERIOD:	FROM:	TO:

RECLASSIFICATION & ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Line No.	COST CENTER	Compensation Including Benefits (Col. 1)	Purchased, Contract Services & Other (Col. 2)	Total (Col. 3)	Reclass-ifications (Col. 4)	Total Expense (Unadjusted) (Col. 5)	Adjustments (Col. 6)	Total Expense (Col. 7)
5	**NON-REIMBURSABLE COSTS:**							
5-01	Bad Debts							
5-02	Community Services							
5-03	Contributions							
5-04	Education – Health & Other							
5-05	Environmental & Research							
5-06	Hearing							
5-07	Other							
5-08	Patient Transportation							
5-09	Pharmacy							
5-10	Podiatry							
5-11	Therapies							
5-12	Other (Attach Schedule)							
5-13	**Total Non-Reimbursable Costs**							
6	**Outstationed/Eligibility Workers**							
7	**TOTAL COSTS**							

PROVIDER STAFFING, VISITS & PRODUCTIVITY

PROVIDER NAME:		PROVIDER NUMBER:
COST REPORTING PERIOD:	FROM:	TO:

PART A: PROVIDER STAFF AND VISITS

POSITIONS	FTE PERSONNEL			VISITS					
				ALL VISITS			TITLE XIX VISITS		
	Under Agreement 1	Staff 2	Total 3	On Site 4	Off Site 5	Total 6	On Site 7	Off Site 8	Total 9
1. Physicians									
2. Mid-Levels									
3. Subtotal									
4. Dentists									
5. Dental Hygienists									
6. EPSDT Services									
7. Family Planning									
8. Medical Social Workers									
9. Pharmacy									
10. Psychiatrists									
11. Psychologists									
12. Therapists									
13. Other (Schedule)									
14. TOTAL									

PART B: MINIMUM MEDICAL TEAM PRODUCTIVITY		AMOUNT
1. Total Physician and Mid-Level Visits	(Form 5, Col.6, Line A3)	
2. Total Medical Team FTEs	(Form 5, Col. 3, Line A1 plus one-half Line A2)	
3. Minimum Medical Team Productivity	(Line B2 times 4,200)	
4. Physician and Mid-Level Visits to be Used in Rate Determination	(Greater of Line B1 or B3)	

PART C: PROVIDER VISITS FOR RATE DETERMINATION		AMOUNT
1. Total Provider Visits Less Physician and Mid-Level Visits	(Form 5, Col. 6, Line A14 less Form 5, Col. 6, Line A3)	
2. Total Provider Visits for Rate Determination	(Form 5, Line C1 plus Line B4)	