No. 12-1043

In The Supreme Court of the United States

ATLANTIC MEDICAL CENTER, INC., et al.,

Petitioners,

v.

LORENZO GONZÁLEZ FELICIANO,
Secretary, Commonwealth of Puerto Rico
Department of Health, et al.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The First Circuit

BRIEF IN OPPOSITION FOR RESPONDENTS

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COUNTER-STATEMENT OF QUESTIONS PRESENTED

Whether the First Circuit Court of Appeals correctly held that the Eleventh Amendment protects the Secretary against the entry of an injunction requiring payments for services provided prior to the date of the injunction.

Whether the First Circuit Court of Appeals correctly held that the Secretary did not waive Eleventh Amendment Immunity.

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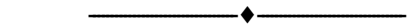
BRIEF IN OPPOSITION

Respondents, hereby oppose the Petition for Writ of *Certiorari*,[1] which seeks review of a portion of the United States Court of Appeals for the First Circuit's opinion and judgment issued in *Consejo de Salud de la Comunidad de la Playa de Ponce, Inc. v. González-Feliciano*, 695 F.3d 83 (1st Cir. 2012) relevant to Eleventh Amendment immunity. (Petition at 1; App. at 38a-47a).



COUNTER-STATEMENT OF THE CASE

A. Introduction

There are no compelling reasons for this Honorable Court to exercise its judicial discretion and review in this case pursuant to Rule 10 of the Rules of the Supreme Court of the United States. The First Circuit's decision is not in conflict with a decision of

[1] Petitioners are fourteen (14) of the nineteen (19) original plaintiffs. (Petition at ii; Petitioners' App. at 39a & n.13). Petitioners filed suit in 2006. (*See* USDC Case Nos. 06-1291; 06-1524). Thus, none of the Petitioners participated in the original suit filed against the Commonwealth in 2003. The original Plaintiffs in 2003 were Concilio de Salud Integral de Loíza, Inc. ("Loíza"), Dr. José S. Belaval, Inc. ("Belaval"), and Río Grande Community Health Center, Inc. ("Río Grande"). Río Grande has since effectively dropped out of the case (Petitioners' App. at 39a n.13; Petition at ii), and Loíza and Belaval already obtained relief. Two additional plaintiffs who filed suit in 2006 have also since obtained relief (Consejo in USDC No. 06-1640; and Toa Alta in USDC No. 06-1524). (*See* Petitioners' App. at 39a n.13).

another court of appeals, nor does it contravene precedent from this Honorable Court. There is simply no need to correct any wrong either as a matter of law or as a matter of justice.

It is settled law that, a federal court cannot ordinarily order money payments by a state to make up for past violations of a federal statute. *See Edelman v. Jordan*, 415 U.S. 651, 668 (1974); *Concilio de Salud Integral de Loíza, Inc. v. Pérez-Perdomo* ("*Belaval V*"), 625 F.3d 15, 19 (1st Cir. 2010). Second, contrary to Petitioners' contentions, the Secretary's litigation conduct did not amount to a waiver of immunity by informing the court that the Department of Health had established an Office for the Calculation and Management of the Prospective Payment System ("PPS Office") that required the cooperation of the federally qualified health centers ("FQHC") in providing information to process the wraparound payments under 42 U.S.C. § 1396a(bb), if required (*see* Response App. at 1-2). (USDC No. 06-1291, Docket No. 158 at 7-8; USDC No. 06-1524, Docket No. 63 at 6-7; USDC No. 06-1260, Docket No. 133 at 4-7; USDC No. 03-1640, Docket No. 363 at 9-11, 13-21, 30-31). The Secretary did not waive the Commonwealth's Eleventh Amendment immunity because he/she did not voluntarily invoke federal jurisdiction, lacked statutory authority to waive immunity, and did not engage in litigation conduct amounting to waiver.

This Honorable Court should deny the petition, thus affirming the decision below. Doing so will not

leave Plaintiffs without a remedy. They can recover whatever money is owed to them for the period prior to the injunction through their lawsuit in state court that is still pending. In light of the above, Respondents file the present opposition in compliance with this Court's directive in its April 17, 2013 letter and pursuant to Rule 15(2) of this Honorable Court.

B. Background

Petitioners – Healthcare providers known as FQHCs – claim that the Commonwealth of Puerto Rico owes them reimbursement for services provided to Medicaid beneficiaries. Controversies anent litigation between the captioned parties have resulted in six appeals before the First Circuit Court of Appeals – the first involving all of the consolidated cases. These appeals have arisen out of the complexity of the issues that have divided the parties for years regarding the intricate procedure to establish the extent of wraparound payments due to FHQ's the Commonwealth of Puerto Rico's Secretary of Health under the Medicaid Act. *See Consejo de Salud de la Comunidad de la Playa de Ponce, Inc. v. González-Feliciano*, 695 F.3d 83 (1st Cir. 2012) ("*Belaval VI*"). However, the intricacies of the wraparound payment reimbursement scheme are not here at issue. Rather, Petitioners would have this Honorable Court review a portion of the latest decision by the First Circuit in *Belaval VI* decision, dealing with Eleventh Amendment immunity.

The complex journey of this litigation started in 2003 when three FQHCs in Case No. 03-1640, to wit, Río Grande, Belaval, Loíza (collectively "*Rio Grande* plaintiffs"), filed suit in the United States District Court for the District of Puerto Rico ("USDC" and/or "district court") alleging that the Secretary of Health had not made the wraparound payments to which they were entitled. In March 2004, the USDC granted Loíza's motion seeking a temporary restraining order, thereby instructing the Secretary to make a wrap-around payment for the first quarter of 2004, namely as to Loíza. (*Río Grande* Case No. 03-1640, Docket No. 48).

The Secretary appealed and the First Circuit affirmed. *Río Grande Community Health Center, Inc. v. Rullán*, 397 F.3d 56 (1st Cir. 2005) ("*Belaval I*"). On November 1, 2004, while *Belaval I* was pending on appeal, the USDC granted a preliminary injunction in favor of all three Río Grande Plaintiffs, ordering defendant to promptly implement the "wraparound" payment system required by 42 U.S.C. § 1396a(bb)(5). (USDC No. 03-1640, Docket No. 82). On March 7, 2005, the USDC issued an order clarifying the preliminary injunction "and establish[ing] the correct mathematical formula to calculate" payments under the Medicaid statute in light of the First Circuit Court's decision in *Belaval I*. (Case No. 03-1640, Docket No. 115). A magistrate judge was appointed to resolve any dispute between the parties. *Id*. On June 24, 2005, the Magistrate Judge issued a report and recommendation. (USDC No. 03-1640, Docket No.

145). Despite Defendants' objections to the report and recommendation (Docket No. 153), on October 6, 2005, the USDC adopted the report and recommendation. (Docket No. 186).

Belaval, the sole appellant, sought review of the USDC's modification of the preliminary injunction in Docket No. 82. *See Belaval v. Pérez-Perdomo*, 465 F.3d 33 (1st Cir. 2006) ("*Belaval II*") (vacating and remanding the appealed portion of the October 6, 2005 order). Belaval later appealed from a December 28, 2006 order and partial judgment determining that "Belaval 'should not have been operating at the time this federal action was commenced,' and so Belaval did not have 'clean hands' to seek the equitable remedy of a preliminary injunction." *See Belaval v. Pérez-Perdomo*, 488 F.3d 11, 15 (1st Cir. 2007) ("*Belaval III*") (reversing the district court's December 28, 2006 judgment and remanding with instructions of reinstating Belaval in the case and restoring and enforcing the October 31, 2006 payment obligation).

In 2006, three additional FQHCs filed suit against the Secretary: *Consejo de Salud de la Comunidad de la Playa de Ponce, Inc.* ("*Consejo*") (06-1260), *Atlantic Medical* (06-1291),[2] and *Gurabo*

[2] The individual *Atlantic Medical* plaintiffs are: Atlantic Medical Center, Inc. ("Atlantic Medical" or "Barceloneta"); Camuy Health Services Inc. ("Camuy"); Centro de Salud Familiar Dr. Julio Palmieri Ferri, Inc. ("Arroyo"); Ciales Primary Health Care Services, Inc. ("Ciales"); Corp. de Serv. Médicos Primarios y Prevención de Hatillo, Inc. ("Hatillo"); Corp. de

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(06-1524).[3] After three years of multi-track litigation, the USDC made *Consejo* the lead case and consolidated it with *Gurabo* (March 10, 2008), *Atlantic Medical* (January 21, 2009), and *Río Grande* (February 9, 2009). (*Consejo* case, USDC No. 06-1260, Docket Nos. 49 & 185; *Rio Grande* case, USDC No. 03-1640, Docket No. 634).

On March 27, 2007, the USDC issued an order lifting the preliminary injunction set in place on November 1, 2004 as to Loíza in the *Río Grande* case, USDC 03-1640, based on mootness "and its understanding that the Commonwealth had come into compliance with Medicaid's reimbursement requirements" by establishing a prospective payment system ("PPS") Office[4] in charge of calculating wraparound payments and that the Office had begun issuing

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Services de Salud y Medicina Avanzada, Inc. ("COSSMA"); Corp. de Servicios Integrales de Salud Integral de la Montaña Inc. ("La Montaña"); El Centro de Salud de Lares Inc. ("Lares"); El Centro de Servicios Primarios de Salud de Patillas, Inc. ("Patillas"); Hospital General Castañer Inc. ("Castañer"); Morovis Community Health Center Inc. ("Morovis"); and Rincón Health Center Inc. ("Rincón"). (*See* Petitioners' App. at 9a n.5).

[3] The individual *Gurabo* plaintiffs are: Gurabo Community Health Center, Inc. ("Gurabo"); Migrant Health Center, Inc. ("Migrant"); and Toa Alta Comprehensive Urban/Rural Advanced Health Services, Inc. ("Toa Alta"). (Petitioners' App. at 10a n.5).

[4] In 2006, the PPS Office became operational and issued checks to nine of the plaintiff FQHCs for July-September 2006. Only Castañer and Ciales retrieved their checks. The others refused to accept the proffered wraparound payments. (Joint App. on appeal at 538-539).

payments to FQHCs that were not a party to the litigation. (*See* Petitioners' App. at 10a ("*Belaval VI*"); USDC No. 03-1640, Docket Nos. 499, 505).[5] However, the district court rejected the Secretary's argument that it should not require future adherence to the PPS base rate (baseline calculation data) set by the court. (Docket No. 499 at 5-6). The USDC issued a similar order as to Belaval on July 3, 2007. (USDC No. 03-1640, Docket No. 553-554).

Both the Secretary and the FQHCs Belaval and Loíza appealed from the district court's March 2007 Order. (*Río Grande* case, USDC No. 03-1640, Docket Nos. 516, 524). On appeal, the parties argued that the USDC had left unresolved certain issues regarding proper calculation of wraparound payments. The First Circuit Court determined that the USDC erred in vacating the preliminary injunction, and concluded that the Secretary raised a dispute about the methodology embodied in the permanent injunction, thus, vacating the permanent injunction. *See Concilio de Salud Integral de Loíza, Inc. v. Pérez-Perdomo*, 551 F.3d 10, 17, 19 (1st Cir. 2008) ("*Belaval IV*"). While the First Circuit Court in *Belaval IV*, 551 F.3d at 19, suggested that the District Court appoint a special master to delve into these payment issues, the district court instead dealt with these matters, and then appointed a special master simply to calculate damages. (Petitioners' App. at 57a).

[5] The USDC later amended the judgment vacating the preliminary injunction. (Docket No. 515).

During a status conference in April 2009 (Docket No. 230), the district court indicated that it shared the view of some plaintiffs that it could, consistent with the Eleventh Amendment, order payments dating back to the time of the complaints. (*See Consejo*, USDC No. 06-1260, Docket No. 232 at 1-2 (Secretary's summary of status conference); and Docket No. 276). At that time the Secretary informed the court that plaintiff Consejo's position was contrary to this Court's decision in *Edelman v. Jordan*, 415 U.S. 651 (*See* Docket No. 232 at 2-4). Prior to the special master proceedings, Consejo argued in response to the Secretary's Motion to Clarify order (Docket No. 232, 276), that the Eleventh Amendment posed no bar to an order requiring the Secretary to make wraparound payments covering the period after Plaintiffs filed their complaints. (Docket Nos. 269, 299). On June 2, 2009, in a sur-reply, all of the Plaintiffs argued for the first time that the Secretary had waived the Commonwealth's immunity three years earlier, on June 27, 2006. (*See Consejo* case, Docket No. 300).

Before the Secretary could respond to Plaintiffs' new argument, the USDC agreed that the Secretary had waived Eleventh Amendment immunity.[6] The

[6] The Secretary was only able to reply (*Consejo*, Docket No. 276) to Consejo's response (Docket No. 269) to the Secretary's motion (Docket No. 232) requesting the district court to clarify its order awarding wraparound payments. The Secretary argued that the Commonwealth's monetary responsibility for

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court based its finding of waiver on **unspecified** "affirmative conduct in this case from 2006-2008" and "the Secretary's good faith representation that the parties in good faith could resolve this dispute with minimal or no court intervention." (Petitioners' App. at 51a-52a; Docket No. 312). The Secretary immediately filed a motion for reconsideration. *See Consejo*, Docket No. 316. The Secretary argued that the district court's decision was wrong because the Secretary and counsel lacked statutory authority to waive immunity, *id.* at 3-6, and because the conduct at issue did not amount to a waiver, *id.* at 6-8. Although the court denied the motion, the Secretary continued to press the argument that no waiver had occurred, *Consejo*, at Docket No. 559 (4/9/2010); *Consejo*, Docket No. 703 (9/21/2010), and Plaintiffs responded with additional briefing on the issue, *Consejo*, Docket No. 694 (9/18/2010).

On November 8, 2010, the district court entered an Order and Preliminary Injunction, directing the Commonwealth to issue prospective payments to the plaintiff FQHCs,[7] but the court reconsidered its prior

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wraparound payments would accrue at the moment the judgment awarding the permanent injunction is ultimately entered.

[7] The November 8, 2010 Order and Preliminary Injunction excluded Loíza and Belaval, for which the district court had already issued injunctive relief, and – as the district court clarified in a subsequent order issued on November 9, 2010 [USDC No. 06-1260, Docket No. 743, 747; *see also* USDC No. 03-1640, Docket No. 82 (providing preliminary injunction to the 2003 *Rio Grande*

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position on the Eleventh Amendment issue and reversed course, relying on the First Circuit Court's week-old decision in *Concilio de Salud Integral de Loíza, Inc. (CSILO) v. Pérez-Perdomo*, 625 F.3d 15, 19-20 (1st Cir. 2010) ("*Belaval V*") (reversing the district court's May 12, 2009 order (USDC No. 06-1260, Docket No. 258), which denied Loíza and Belaval's request for interim fees). Indeed, most of the plaintiffs first obtained preliminary relief in November 2010.

The district court recognized that the Eleventh Amendment would ordinarily bar Plaintiffs from recovering payments for services furnished prior to the entry of the preliminary injunction. (*See* Petitioners' App. at 49a) (stating that "because no formal injunctive order has yet been issued, the Court is, thus, compelled to deny an injunctive request as to the entire amounts calculated by Special Master Soto Cintrón."). In addition, the court concluded that the Secretary's litigation conduct did not constitute a waiver of Eleventh Amendment immunity such that an award of retrospective relief would be permissible. (*See* Petitioners' App. at 49a) ("disagree[ing] with plaintiffs' contention that defendant in effect waived Eleventh Amendment protection.").

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plaintiff)] – Consejo, which had obtained similar relief on November 13, 2009 [USDC No. 06-1260, Docket No. 429].

On appeal, Petitioners challenged, in what is relevant to this case, the district court's determination that they are not entitled to a judgment for reimbursement of costs prior to issuance of the preliminary injunction. This was the subject of petitioners' cross-appeal in USCA Case No. 11-1126[8] (*see also* USDC Case No. 06-1260 (GAG), Docket No. 774). The First Circuit rejected Petitioner's contention. After analyzing the claim that the Secretary had waived immunity, the First Circuit did not agree with the FQHCs' reasoning that the Secretary "unquestionably consented to make payments from the Commonwealth's coffers as early as the third quarter of 2006." (Petitioners' App. at 46a). The court recognized that "any such waiver would require the Commonwealth to have 'engaged in affirmative conduct during litigation sufficient to evince conduct to suit.'" *Id*. (citing *Bergemann v. R.I. Dep't of Envtl. Mgmt.*, 665 F.3d 336, 340 (1st Cir. 2011)). And in this case, the Secretary has zealously defended against federal jurisdiction whenever possible. (Petitioners' App. at 46a).

[8] Case Nos. 11-1121, 11-1126 and 11-1733 were all consolidated in the sixth appeal before the First Circuit Court. *Belaval VI*, 695 F.3d 83.

C. Deficiencies and Omissions in Petitioner's Statement of Facts and Law

The following facts and findings by the First Circuit are relevant to the issues presented for review:

1. The Secretary's litigation conduct since June 27, 2006 did not amount to waiver of Eleventh Amendment Immunity. (Petitioners' App. at 45a-46a; *see also* Respondent's App. at 1-2).

2. The Secretary's statement in 2006 regarding the establishment of the PPS Office was merely informative and in compliance with the directives in the *Río Grande* case, USDC No. 03-1640 (Docket No. 332), and in no way amounts to waiver of Eleventh Amendment immunity. (Respondent's App. at 1-2; *see also* Petitioners' App. at 45a).

3. Since 2003, the Secretary has asserted the Commonwealth's immunity to suit as to retrospective payments as an invocation of Eleventh Amendment immunity. (Petitioners' App. at 44a).

4. The Secretary never voluntarily invoked the jurisdiction of the federal courts. *Id*.

5. The Secretary lacked statutory authority to waive the Commonwealth's immunity in cases where the Secretary did not invoke federal jurisdiction, and zealously defended against such jurisdiction. (USDC

No. 03-1640, Docket Nos. 28, 37, 44; USDC No. 06-1260, Docket Nos. 232, 276, 316, 559, 703).

6. Petitioner overlooks the fact that, unlike in *Moreno v. University of Maryland*, 645 F.2d 217 (4th Cir. 1981) and *Vargas v. Trainor*, 508 F.2d 485 (7th Cir. 1974), in the present case there was no court order or decree and there had been claims throughout the litigation that the Eleventh Amendment would bar recovery of retroactive wraparound payments.

REASONS FOR DENYING THE WRIT OF *CERTIORARI*

I. Considerations Governing Review on *Certiorari*

"Review on a writ of certiorari is not a matter of right, but of judicial discretion. A petition for writ of certiorari will be granted only for compelling reasons." Rule 10 of the Rules of the Supreme Court of the United States. There are no compelling reasons to grant the present petition as prescribed by the Rules of this Honorable Court. Contrary to the reasons set forth by Petitioners (Petition at 20), the petition fails to present this Honorable Court with a real and material conflict among circuits or a compelling federal question of any nature. Plaintiffs are advancing an unduly broad theory of waiver of Eleventh Amendment immunity with regards to payment of

retrospective damages that has not been sanctioned either by this Honorable Court, or any other appellate court.

The First Circuit Court's decision acknowledged that a State may waive Eleventh Amendment immunity. (Petitioners' App. at 42a). Nonetheless, under the factual backdrop of this case, the district court and the First Circuit correctly concluded that the Secretary's conduct throughout the captioned litigation **did not amount to a waiver**. A perusal of the record reveals that the Secretary repeatedly asserted the Commonwealth's Eleventh Amendment immunity, thereby foreclosing the possibility of a finding of consent or waiver. (Petitioners' App. at 43a).

II. Eleventh Amendment immunity bars the retroactive wraparound payments absent waiver.

"Sovereign immunity is the privilege of the sovereign not to be sued without its consent." *Virginian Office for Prot. & Advocacy v. Stewart*, 131 S.Ct. 1632, 1637 (2011). This Court has established that under the Eleventh Amendment, "States entered the Union with their sovereign immunity intact, unlimited by Article III's jurisdictional grant." *Id.* (citing *Blatchford v. Native Village of Noatak*, 501 U.S. 775, 779 (1991); *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89, 98 (1984); *Hans v. Louisiana*, 134 U.S. 1 (1890)). States have retained their traditional immunity from suit, 'except as altered by

the plan of the Convention or certain constitutional amendments." *Virginian Office for Prot. & Advocacy*, 131 S.Ct. at 1637-1638 (citing *Alden v. Maine*, 527 U.S. 706, 713 (1999)). The First Circuit has consistently recognized that "Puerto Rico enjoys the same immunity from suit that a States has under the Eleventh Amendment." (Petitioners' App. at 41a n.15) (citing *Maysonet-Robles v. Cabrero*, 323 F.3d 43, 53 (1st Cir. 2003)).

Under the Eleventh Amendment, "an unconsenting State is immune from suits brought in federal courts by her own citizens as well as by citizens of another State." *Edelman*, 415 U.S. at 662-663 (citing *Hans*, 134 U.S. 1). It is also well established that even though a State is not named a party to the action, the suit may nonetheless be barred by Eleventh Amendment immunity. *Edelman*, 415 U.S. at 663. In *Ex parte Young*, this Court established an important limit on the sovereign-immunity principle. 209 U.S. 123 (1908) (holding that "the Eleventh Amendment did not bar an action in the federal courts seeking to enjoin the Attorney General of Minnesota from enforcing a statute claimed to violate the Fourteenth Amendment", but the relief awarded was prospective only). Although the *Ex parte Young* rule normally lifts this bar for suits seeking prospective relief against state officials for violations of federal law, such a suit remains barred when the action is, in essence, one for the recovery of money from the State. *Edelman*, 415 U.S. at 663. Under this rule, a party may only seek prospective injunctive or

declaratory relief, but not retroactive monetary damages.

In *Edelman*, this Honorable Court applied Eleventh Amendment principles to a class action complaint alleging that state officials violated federal law by failing to process benefits applications within the timeframe required by federal regulations. *Id.* at 653-655. In a March 1972 judgment, the district court had ordered the state officials to pay class members the benefits wrongfully withheld between the date in 1968 when the regulations took effect and the date in April 1971 when the court entered a preliminary injunction in favor of the plaintiffs. *Id.* at 656 & n.5. The *Edelman* Court held that the Eleventh Amendment denied the district court the authority to enter this "retroactive portion" of its decree. *Id.* at 669. In *Ford Motor Co. v. Department of Treasury*, 323 U.S. 459, 464 (1945) (overruled on other grounds by *Lapides v. Bd. of Regents*, 535 U.S. 613, 621-623 (2002)), this Court stated that "when the action is in essence one for the recovery of money from the state, the state is the real, substantial party in interest and is entitled to invoke its sovereign immunity from suit even though individual officials are nominal defendants." Therefore, "a suit by private parties seeking to impose a liability which must be paid from public funds in the state treasury is barred by the Eleventh Amendment." *Edelman*, 415 U.S. at 663 (citing *Great Northern Life Insurance Co. v. Read*, 322 U.S. 47 (1944)). "'[I]n determining whether the doctrine of *Ex parte Young* avoids an Eleventh Amendment bar to

suit, a court need only conduct a 'straightforward inquiry into whether [the] complaint alleges an ongoing violation of federal law and seeks relief properly characterized as prospective.'" *Virginian Office for Prot. & Advocacy*, 131 S.Ct. at 1639 (citing *Verizon Md. Inc. v. Pub. Serv. Comm'n of Md.*, 535 U.S. 635, 645 (2002)).

Petitioners' position – which requires the payment of a very substantial amount of money prior to the entry of the November 8, 2010 preliminary injunction – stands on quite a different footing from the type of claim that may proceed against a state under the *Edelman* doctrine. There is no controversy that retroactive wraparound payments requested by Petitioners do not satisfy the straightforward inquiry of Eleventh Amendment immunity.

On November 8, 2010, the district court correctly held that it could not compel the Secretary to make wraparound payments for quarters prior to the entry of a preliminary injunction unless the Secretary had waived the Commonwealth's Eleventh Amendment immunity. (App. at 48a-50a). Petitioners do not challenge this holding. Instead, Petitioners challenge the district court's holding, later affirmed by the First Circuit, that under *Edelman*, the court could not enjoin the Secretary to make wraparound payments for the quarters prior to the entry of the preliminary injunction on November 8, 2010, absent a waiver of immunity by the Secretary. (Petitioners' App. at 46a, 49a).

Waiver by a state of Eleventh Amendment immunity may be found by: (1) a clear declaration that it intends to submit itself to the jurisdiction of a federal court or administrative proceeding, *Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 676 (1999); (2) consent to or participation in a federal program for which waiver of immunity is an express condition, *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 246-247 (1985) (abrogated on other grounds); or (3) affirmative conduct in litigation, *Lapides*, 535 U.S. 613, 620; *Gardner v. New Jersey*, 329 U.S. 565, 574 (1947) (filing a proof of claim in a bankruptcy case). None of those instances of waiver may be found in the record of the litigation in this case. As previously discussed, even the representations that Petitioners claim constituted a waiver of sovereign immunity were made in the context of an Eleventh Amendment defense.

A. The Secretary did not voluntarily invoke the jurisdiction of the district court.

Cases from this Court illustrate that a State waives immunity under this standard when it voluntarily invokes the jurisdiction of a federal court. This may be done by removing a case to federal court, *Lapides*, 535 U.S. at 624; filing a federal counterclaim or third-party complaint, *Paul N. Howard Co. v. P.R. Aqueduct Sewer Auth.*, 744 F.2d 880, 886 (1st Cir. 1984); appearing as an intervenor, *Clark v. Barnard*, 108 U.S. 436, 447 (1883); or suing in federal court,

Gardner, 329 U.S. at 573-574 (State waives immunity by filing a proof of claim in a bankruptcy case). Only clear litigation conduct of this kind indicates a voluntary invocation of federal jurisdiction. *See Lapides*, 535 U.S. at 620. The Secretary was involuntarily named as a defendant in Plaintiffs' complaints. It is therefore pellucid that the Secretary's participation in the captioned cases does not give rise to a finding of waiver under *Lapides*.

B. The Secretary lacked authority to waive immunity.

An official may waive the State's immunity under the Eleventh Amendment only when expressly authorized by statute or by the state's constitution. *Ford Motor Co.*, 323 U.S. at 467-470 "In order for a state statute or constitutional provision to constitute a waiver of Eleventh Amendment immunity, it must specify the State's intention to subject itself to suit in federal court." *Atascadero*, 473 U.S. at 241. The Secretary argued below that he and his outside counsel lack statutory authority to waive the Commonwealth's Eleventh Amendment immunity. *See* Response and Reply Brief of Defendants-Appellants/ Cross-Appellees at 13-14. This argument remains undisputed as the Commonwealth has not authorized via its Constitution or legislative enactment, to be sued in federal court for money awards pertaining to the Medicare Act nor has the Commonwealth authorized the Secretary to waive sovereign immunity. Given the absence of such statutory or constitutional

authority, the Commonwealth's sovereign immunity remains intact unless the Secretary has voluntarily invoked federal jurisdiction, which he did not.

C. The Secretary did not waive Eleventh Amendment immunity through conduct in litigation.

"A State may waive its sovereign immunity at its pleasure, *College Savings Bank v. Florida Prepaid Postsecondary Ed. Expense Bd.*, 527 U.S. 666, 675 (1999) (citing *Clark v. Barnard,* 108 U.S. at 447, 2 S.Ct. 878), and in some circumstances, Congress may abrogate it by appropriate legislation. But absent waiver or valid abrogation, federal courts may not entertain a private person's suit against a State." *Virginian Office for Prot. & Advocacy*, 131 S.Ct. at 1637-1638. Consequently, the "test for determining whether a State has waived its immunity from federal-court jurisdiction is a stringent one." *Atascadero*, 473 U.S. at 241.

In April 2009, when the district court indicated that it could, consistent with the Eleventh Amendment, order payments dating back to the filing of the complaints, the Secretary informed the court that such standpoint was contrary to *Edelman*. (*See Consejo* case Docket Nos. 232, 276). In a sur-reply, Plaintiffs argued for the first time that the Secretary had waived the Commonwealth's immunity three years earlier in mid-2006. (*See Consejo* case, Docket 300). The district court initially understood, without any record citation and depriving the Commonwealth

of the opportunity to state its position, that the Secretary's affirmative conduct in this case from 2006-2008 constituted a waiver of the Commonwealth's Eleventh Amendment. (Petitioners' App. at 51a). The Secretary requested reconsideration of such finding, arguing that the Eleventh Amendment barred Petitioners' request. (USDC No. 06-1260, Docket No. 316).

On November 1, 2010, after the decision in *Belaval V*, the Secretary filed a motion informing the district court of the First Circuit's decision. (USDC No. 06-1360, Docket No. 737). Said decision had a direct impact on the Secretary's Eleventh Amendment immunity challenge, relating to Plaintiffs, with the exception of Belaval and Loíza who the First Circuit determined enjoyed a right to a permanent injunction. (*Id*. at 3-5). In *Belaval V*, the First Circuit stated:

> Of course, a federal statute requiring proper wraparound payments existed before, during and after the gap period; but, under recherché Eleventh Amendment precedent, a federal court cannot ordinarily order money payments by a state to make up for past violations of a federal statute, *Edelman v. Jordan*, 415 U.S. 651, 668 (1974): **only if the state were disobeying a forward-looking court order to make such payments could a violation of that order be redressed by a federal court remedial directive to make payments to comply with the preexisting order**.

625 F.3d at 19. As recognized in *Belaval V*, the Secretary argued that, absent a forward-looking order, no

waiver of immunity had occurred. As a result, those plaintiffs – such as Petitioners – who had not been granted injunctions were not entitled to retroactive payments as such remedy clearly impinged upon the Commonwealth's sovereign immunity.

On November 8, 2010, the USDC enjoined the Secretary to make prospective wraparound payment to all fifteen plaintiff FQHCs, excluding Loíza and Belaval. (Petitioners' App. at 48a-50a). However, the court disagreed with Petitioners' contention that the Secretary's litigation conduct constituted waiver of Eleventh Amendment immunity such that an award of retrospective relief would be permissible. (Petitioners' App. at 49a).

Contrary to Petitioners' contention, the Secretary **did not** consent to an award of retrospective relief by making promises of future compliance with his legal obligations. The Secretary simply informed the district court that the Department of Health was in compliance with, or was prepared to comply with, federal law as to an operational system to process payments. (Respondent's App. at 1-2). Indeed, Petitioners Atlantic Medical and Gurabo cannot fairly claim that the Secretary's representations to the district court in mid-2006 caused the court to postpone entry of a preliminary injunction. The court denied the motion for a preliminary injunction filed by the Atlantic Medical plaintiffs as a sanction for discovery abuse – their failure to produce the records the PPS Office requested to calculate its payments.

(USDC No. 06-1291, Docket No. 247). As to Petitioner Gurabo, the record reveals that it did not move for a preliminary injunction until December 2007. (USDC No. 06-1524, Docket No. 54). Moreover, on September 11, 2008, Petitioners filed renewed motions for preliminary injunction that belie their current waiver contention. In 2008, Petitioners argued before the USDC that they would suffer irreparable harm because the Secretary could claim immunity from retrospective relief – an argument that Plaintiffs surely would not have made if they believed that the Secretary had already waived immunity. (*See Consejo,* USDC No. 06-1260, Docket No. 127 at 6-7 (filed by *Gurabo*) (arguing that they do not have an adequate remedy at law for their injuries because "Plaintiffs are precluded from obtaining a judgment for damages to remedy Defendant's [the Commonwealth's] past misconduct" on account of the Eleventh Amendment); *see also id*., Docket No. 51 at 4 (Gurabo) (after being denied motion for summary judgment and preliminary injunction, arguing that Plaintiffs' remedies "are exclusively prospective in nature, and therefore do not implicate any Eleventh Amendment concerns."); *Atlantic Medical*, USDC No. 06-1291, Docket No. 394 at 5-6) (same). In these circumstances, the Secretary's informative motion – filed on June 27, 2006 – apprising the USDC of the establishment of the PPS Office, cannot – as a factual and legal matter – be taken as a demonstration of waiver.

The fact that the district court initially determined on June 4, 2009 (Petitioners' App. at 51a-52a) that the Commonwealth had waived its immunity through litigation conduct from 2006 to 2008 is irrelevant. Interlocutory orders remain open to trial court reconsideration, and do not constitute the law of the case. *Negrón-Almeda v. Santiago*, 579 F.3d 45, 51 (1st Cir. 2009) (citing *Pérez-Ruiz v. Crespo-Guillén*, 25 F.3d 40, 42 (1st Cir. 1994)). The June 4, 2009 "order did not dispose of the rights and liabilities of all the parties and therefore was not a 'final judgment.'" *Negrón-Almeda*, 579 F.3d at 51 (citing *Guillemard-Ginorio v. Contreras-Gómez*, 490 F.3d 31, 37 n.4 (1st Cir. 2007)). Furthermore, the district court did not certify the June 4, 2009 order as a partial judgment under Fed. R. Civ. P. Rule 54(b). Therefore, it had not become appealable.

Although Petitioners claim that the First Circuit erred in declining to find waiver, they have not identified any analogous case in which this Court has found a waiver of Eleventh Amendment immunity in circumstances such as this where the Commonwealth clearly invoked its immunity at all appropriate junctures of the litigation. Petitioners rely on two cases from the Fourth and Seventh Circuits – *Moreno*, 645 F.2d 217 and *Vargas v. Trainor*, 508 F.2d 485. (Petition at 20-24). Although Petitioners claim that the facts of these two cases are "virtually identical" to those presented here, each is quite different. In any event, these decisions hardly present a "circuit split"

that could warrant this Court's discretionary review in this case.

III. The First Circuit decision is not in conflict with decisions by the Fourth and Seventh Circuit Courts of Appeals.

The First Circuit Court's opinion in *Belaval VI* did not create a conflict between circuits nor did it misconstrue this Court's Eleventh Amendment immunity. There is no disagreement between the Fourth and Seventh Circuit and the First Circuit's 2012 decision in *Belaval VI* that requires review from this Court on the constitutional standard for finding waiver of sovereign immunity through conduct litigation.

The foundation for Plaintiffs' waiver argument, as well as their analogy to *Moreno* and *Vargas*, crumbles when the Secretary's statements to the district court are properly viewed in the context of the whole record. The June 27, 2006 informative motion – when the alleged waiver occurred – does not provide for an affirmative conduct sufficient to evince waiver. (Respondent's App. at 1-2). Furthermore, the subsequent statements allegedly constituting a waiver of the Commonwealth's Eleventh Amendment immunity were made in the context of raising an Eleventh Amendment defense. (USDC No. 03-1640, Docket No. 363 at 10-11, 30-31; USDC No. 06-1260, Docket No. 133 at 4-7; USDC No. 06-1291, Docket 158 at 9-14; USDC No. 06-1524, Docket No. 63 at 6-15). The

Secretary did not waive immunity but rather defended his view of the law; he did not waive immunity, but invoked it. (USDC No. 06-1260, Docket Nos. 232, 276, 316, 559, 703).

A. *Moreno* and *Vargas* are readily distinguishable from the present case.

Moreno involved the constitutionality of a policy adopted by the University of Maryland denying "In-State" status to individuals holding "G-4" visas as nonimmigrant aliens, who were consequently charged higher tuition fees. 645 F.2d at 218. The district court granted summary judgment in plaintiffs' favor and ordered the University to allow students with "G-4" visas to prove Maryland domicile in order to qualify for "In-State" status. In these circumstances, the University obtained a stay of the district court's order pending appeal. *Id*. at 219. Said stay was granted because instead of affording "In-State" status to those students who demonstrate Maryland "domicile", the University agreed to refund the difference between the "Out-of-State" tuition and the "In-State" tuition and fees in the event the district court's order was affirmed on appeal.

In the *Moreno* decision that Petitioners invoke, the Fourth Circuit found that the policy was invalid, and further held that the university had waived its Eleventh Amendment immunity when it obtained a stay of the district court's order pending appeal. *Moreno*, 645 F.2d at 220. The *Moreno* Court determined that the university waived its Eleventh

Amendment immunity by agreeing to pay the refunds when it obtained the stay of the original district court order. 645 F.2d at 220. This Court affirmed the judgment of the Fourth Circuit and noted that, in seeking the stay of the July 13, 1976 order, "the university made representations to the District Court that in the event the 1976 order was 'finally affirmed on appeal,' it would make the appropriate refunds." *Toll v. Moreno*, 458 U.S. 1, 17-18 (1982).

In *Vargas*, plaintiffs – recipients of Social Security Income or "SSI" – argued that Illinois had reduced their benefits without proper notice. The question presented was whether plaintiffs could recover the amount wrongfully withheld in the month between the district court's denial of their request for an injunction and the circuit court's entry of an injunction pending appeal. *See id.* at 486-488. In opposing the injunction pending appeal, the state Attorney General maintained that the denial of injunctive relief would not prejudice the plaintiffs because they would "be awarded any benefits wrongfully withheld" in the interim. *Id.* at 492. The Seventh Circuit held that the Attorney General's statement was an affirmative waiver of sovereign immunity because the statement acknowledged that the State would not invoke the Eleventh Amendment to avoid paying benefits for the period during which the appeal was pending. *Id*.

Unlike in *Moreno* and *Vargas*, the Secretary's conduct is not clearly inconsistent with the invocation of Eleventh Amendment immunity from retrospective

monetary relief. A close look at the June 27, 2006 motion to clarify (*see* Respondent's App. at 1-2; USDC 03-1640, Docket No. 332), proves that the Secretary never made a promise of payment and did not agree to a payment in exchange for a stay of an existing order or to avoid the issuance of an order or judgment. The motion served to inform the court of the establishment of a PPS Office to process prospective payment. No acquiescence or waiver of rights or defenses can be ascertained from said motion.

Petitioners' contention obscures the fact that the Secretary opposed the request that the preliminary injunction be made permanent because the preliminary injunction was rooted in an inaccurate formula. (USDC No. 03-1640, Docket No. 363 at 29; *see also* Petitioners' App. at 45a). Indeed, the Secretary insisted that "once an injunction ordering that the Commonwealth . . . comply with the Medicaid statute issued, any disputes as to the proper calculation of past payments owed had to be litigated in the Commonwealth's courts" since, albeit "a federal court may indirectly cause State funds to be expended by means of ordering future compliance with federal law, it may not 'impose *upon the State* "a monetary loss resulting from past breach of a legal duty on the part of the defendant state officials."'" *Belaval VI*, 695 F.3d at 104; Petitioners' App. at 45a (citing *Verizon Md. Inc.*, 535 U.S. at 646; *Edelman*, 415 U.S. at 668).

While the state in *Moreno* waived sovereign immunity by unambiguously agreeing to refund

tuition fees that the University would have been required to pay but for the stay that was granted pending appeal, the Commonwealth in this case never offered to issue retroactive refunds but instead pursued its sovereign immunity rights and expressly opposed any form of retroactive payment. Furthermore, the Seventh Circuit in *Vargas* was faced with a deliberate waiver as the state **unambiguously** conceded that it would voluntarily make retroactive payments if the appellate court disagreed with its position on the merits; a clear concession that is entirely absent in any of the Secretary's statements in this case. Also, the Seventh Circuit in *Vargas* took into consideration that the state had not claimed that the Eleventh Amendment would bar the recovery of the deficiency payments at the time the state persuaded the appellate court not to enter an injunction. *Vargas*, 508 F.2d at 492. But here, as the First Circuit correctly held, "[t]he Secretary . . . raised this Eleventh Amendment-based argument in each of the cases brought by the distinct groupings in the not-as-of-yet consolidated actions," including the FQHCs that are now before this Court. (Petitioners' App. at 45a-46a).

In sum, unlike the situations in *Moreno* and *Vargas*, the record in this case is pellucid as to the fact that the Commonwealth and its agents vigorously asserted Eleventh Amendment immunity throughout the litigation. *See, e.g.*, *Rio Grande*, USDC No. 03-1640, Docket 11 (9/10/2003) (raising the Eleventh Amendment as a defense to a suit against the Commonwealth and Department); *Rio Grande*, Docket No.

37 at 12 (3/14/2004) (raising the Eleventh Amendment as a defense to a request for a TRO to the extent plaintiff sought payments corresponding to past quarters); *Atlantic Medical*, USDC No. 06-1291, Docket Nos. 20 (5/2/2006) & 28 (5/12/2006) (same), Docket Nos. 83 & 89 (8/11/2006) (orders ruling that the Eleventh Amendment bars Plaintiffs' request for compensatory and punitive damages).

IV. The First Circuit decision is not at conflict with this Court's precedent.

Petitioners argue that although the First Circuit correctly recognized three ways in which a State may waive its immunity, "[t]he court transgressed this Court's precedent . . . by limiting waivers by litigation conduct to instances in which states 'evince a clear choice to submit [their] rights [to] adjudication by the federal courts.' " (Petition at 26-27) (citing Petitioners' App. at 43a). Petitioners concede that waiver through a statute or constitutional provision must be "unequivocal". (Petition at 27). However, Petitioners expound the theory that waiver through litigation conduct "serves a different purpose and, as a consequence, is implemented through a different legal test." *Id*. In short, Petitioners contend that the State's intention to waive immunity need not be "clear" or "unequivocal". *Id*. (citing *Lapides*, 535 U.S. at 620). This contention does not find support in this Court's case-law and should be rejected.

It is Respondent's contention that the First Circuit correctly concluded that any waiver requires the state – here, the Commonwealth, – "to have engaged in affirmative conduct during the litigation sufficient to "evince a clear choice" to waive its immunity. (Petitioners' App. at 43a, 46a). Such holding does not offend or contradict this Court's decisions regarding the scope and breadth of Eleventh Amendment immunity.

In *Lapides*, this Honorable Court found waiver strictly because "[a]ll defendants joined in removing the case to Federal District Court . . . where they sought dismissal." 535 U.S. at 616. The crux of this Court's finding of waiver in *Lapides* was the fact that the state evinced a clear choice or affirmative waiver when it "voluntarily invoked the federal court's jurisdiction." *Id*. at 614. In keeping with the requirement that waiver of sovereign immunity be accompanied by affirmative and clear conduct, "this Court indicated that a State's voluntary appearance in federal court amounted to a waiver of its Eleventh Amendment immunity." *Id*. at 619 (citing *Clark*, 108 U.S. at 447). Thus, Petitioners err in their interpretation that waiver in the Eleventh Amendment context, need not be clear.

This case does not present any inconsistencies by the Commonwealth that could give rise to a finding of waiver – such as invoking federal jurisdiction and then claiming Eleventh Amendment immunity in federal court. Although Petitioners endeavor to obscure this Court's rulings on this issue, it is clear

that this Court requires that the state's litigation conduct creating waiver be clear ("And that act – removal – is clear."). *Id*. at 620. Unlike in a clear case of waiver whereby a State voluntarily agrees to remove the case to federal court, the Secretary's litigation conduct did not yield waiver of the Commonwealth's sovereign immunity under the Eleventh Amendment.

In *Toll*, the State's representations when seeking to stay an order (that it would make the appropriate refunds if the order was affirmed on appeal) was incorporated in the stay order both in the district court and on appeal. 458 U.S. at 17-18. Therefore, the litigation conduct creating waiver was clear and unequivocal. In stark contrast, the Secretary's June 27, 2006 informative motion – the alleged litigation conduct creating waiver – did not ask the court to refrain from issuing an order. Rather, it informed that the Department of Health established a PPS Office, and also stated that it needed information it had requested from the FQHCs in order to process payments for the third quarter of 2006 "(if any are required)". (Response App. at 1-2; *see also* Petitioners' App. at 45a). It did not amount to a voluntary acceptance of Petitioner's claim nor did the Commonwealth subsequently accept responsibility for retrospective relief. To the contrary, the Commonwealth steadfastly maintained that if the court were to issue an injunction, the district court lacked authority to fashion monetary relief as that would need to be addressed by the Commonwealth's courts. (*Belaval VI*, 695 F.3d at 104; App. at 45a (citing *Verizon Md.*

Inc., 535 U.S. at 646 (citing *Edelman*, 415 U.S. at 668); (Petitioners' App. at 45a)).

The Secretary clearly and consistently argued that any dispute as to the proper calculation was out of the federal court jurisdiction, because it was in essence a collection of money against the Commonwealth barred by the Eleventh Amendment. (USDC No. 03-1640, Docket No. 363 at 9-11, 30-31; USDC No. 06-1260, Docket No. 133 at 4-7; USDC No. 06-1291, Docket No. 158 at 7-8; USDC No. 06-1524, Docket No. 63 at 6-7; Petitioners' App. at 44a-46a). Importantly, the June 27, 2006 informative motion cannot be considered an affirmative or deliberate waiver regarding Petitioners' claims for relief given that it pertained exclusively to the Río Grande plaintiffs and did not involve Petitioners' claims for relief. At the time that the informative motion was filed, the district court had not issued an injunction regarding Petitioners. Thus, any wraparound payment covering the period before the injunction was finally issued on November 8, 2010 would be barred by the Eleventh Amendment. (Petitioners' App. at 44a-45a).

Petitioners attempt to move this Court to grant their petition in order "to clarify more broadly" issues that were allegedly present in *Frew v. Hawkins*, 540 U.S. 431 (2004). (*See* Petition at 34-35). In *Frew*, plaintiffs-petitioners alleged that the Texas Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") Program did not satisfy the requirements of federal law. *Id*. at 434. A suit was filed in federal court against the Texas Department of Health and

Texas Health and Human Services Commission, as well as against various officials – in their official capacities – in charge of implementing the program. *Id*. After the suit was filed, the two state agencies moved to dismiss the claim on Eleventh Amendment grounds. The request went unopposed, and the district court dismissed the state agencies. *Id*. The state officials remained and the court certified the class. After extensive negotiations, the parties "agreed to resolve the case by entering into a consent decree." *Id*. The decree order was a detailed "comprehensive plan for implementing the federal statute." *Id*. at 435. Two years after the consent decree was entered, plaintiffs alleged that it had not been complied with and requested the district court to enforce it. *Id.* at 435. The enforcement of the consent decree – an 80-page-long document – was at the heart of the issues presented before this Court. *Id*.

This Court stated in *Frew* that "[c]onsent decrees have elements of both contract and judicial decrees." *Id*. at 437. Furthermore, "[c]onsent decrees entered in federal court must be directed to protecting federal interests." *Id*. Since the decree was a remedy that state officials accepted and that was later approved by the district court, this Court found that enforcement of the agreement did not violate the Eleventh Amendment. *Id*. at 439. Petitioner's invocation of *Frew* is immaterial as the present case does not involve a consent decree or any other type of agreement approved by the court that would require this Court to expand its precedents on Eleventh Amendment immunity as to retroactive monetary liability.

In *Atascadero*, this Court indicated that the "test for determining whether a State has waived its immunity from federal-court jurisdiction is a stringent one." 473 U.S. at 241; *see also College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board*, 527 U.S. 666, 675 (1999). This Court further explained that "'a State's constitutional interest in immunity encompasses not merely *whether* it may be sued, but *where* it may be sued.'" *Atascadero*, 473 U.S. at 241 (citing *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89, 99 (1984)). Here, the fact that the Secretary was brought to federal court involuntarily and defended himself cannot be considered a waiver of the Commonwealth's Eleventh Amendment immunity. *Fla. Dep't of State v. Treasure Salvors, Inc.*, 458 U.S. 670, 683 n.18 (1982) (stating that "[t]he fact that the State appeared and offered defenses on the merits does not foreclose consideration of the Eleventh Amendment issue. . . .").

The First Circuit correctly determined that waiver of sovereign immunity through litigation requires a clear choice or voluntary action from the state that is not present in this case. Said holding is consistent with this Court's formulation of waiver principles as applied in the context of Eleventh Amendment immunity. There is, therefore, no reason for this Court to intervene with the First Circuit's decision. Petitioners simply cannot meet the stringent test adopted by this Court to find waiver of sovereign immunity.

CONCLUSION

The instant Petition for Writ of *Certiorari* should be denied for the following reasons: (i) there are no differences of view among the lower courts or this Court in the application of the test for determining whether a State has waived its immunity from federal-court jurisdiction under the particular facts of this case; (ii) the appellate court correctly applied the waiver test requiring 'clarity' in the litigation conduct; (iii) there is no clear declaration that the Commonwealth intended to submit itself to the federal jurisdiction; and (iv) this is not the case to resolve or clarify a hypothetical conflict or confusion not present here.

For the foregoing reasons, the Petition for Writ of *Certiorari* should be denied.

Respectfully submitted in San Juan, Puerto Rico, this 3rd day of July 2013.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

RIO GRANDE COMMUNITY HEALTH CENTER, CONCILIO DE SALUD INTEGRAL DE LOIZA, AND DR. JOSE S. BELAVAL, **Plaintiffs** **v.** **HON. ROSA PEREZ PERDOMO, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE DEPARTMENT OF HEALTH** **Defendant**	**CIVIL NO. 03-1640 (JAG/GAG)**

DEFENDANT'S INFORMATIVE MOTION REGARDING THE ESTABLISHMENT OF THE PPS OFFICE

TO THE HONORABLE COURT:

COMES NOW defendant, Dr. Rosa Perez Perdomo, in her official capacity as Secretary of Health for the Commonwealth of Puerto Rico, through the undersigned legal representation, and respectfully states and prays:

1. The Department of Health has established an Office for the Calculation and Management of the Prospective Payment System.

2. On May 26, 2006 the Department of Health sent notices to all FQHC requesting information in order to start payments for the third quarter of 2006. The notice also included a copy of the Instructions Manual to be used by the office to process payments. See exhibits 1 and 2.

3. On March 7, 2006, this Honorable Court stated that the provisional payments would be in place until the defendant had a fully operational system. In order for this system to be fully operational it requires the cooperation of all FQHC in providing the requested information so it can be processed quickly and the payments (if any are required) be made promptly.

WHEREFORE, Defendant hereby requests this Honorable Court to take notice of defendant's compliance.

WE HEREBY CERTIFY: that on this date, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following: James Feldesman, Esq., Feldesman, Tucker, Leifer, Fidell, LLP, 2001 L Street, N.W., Second Floor, Washington, D.C., 20036, and to Ramon A. Alfaro-Alfaro, Ramon A. Alfaro Law Office, PO Box 366592 San Juan, PR 00936-6592.

In Guaynabo, Puerto Rico, this 27th day of June 2006.

ROBERTO SANCHEZ RAMOS
Secretary of Justice

VIVIAN GONZALEZ, ESQ.
Deputy Secretary of Justice
In Charge of Litigation

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ESTADO LIBRE ASOCIADO DE PUERTO RICO
Departamento de Salud
Programa de Asistencia Médica

[LOGO]
Estado Libre Asociado
de Puerto Rico
Departamento de Salud

May 26, 2006

Rio Grande Community Health Center
PO Box 786
Rio Grande, Puerto Rico 00745

Beginning the third quarter of Fiscal Year 2006 the Commonwealth of Puerto Rico Medical Assistance Program will require the Federally Qualified Health Centers (FQHC) to submit financial information in order to comply with the Prospective Payments System reimburstments. In compliance with Federal Government requirements, our office will require from the each FQHC to provide specific financial data from their operations. The requested information must be provided on a quarterly basis using Form CMS-222-92.

Please find attached to this information regarding the necessary documentation that each FQHC should provide our office for the Prospective Payment calculation. Also you will find the instructions explaining how to fill Form CMS-222-92, a copy of the form and information regarding the allowable cost to be included in this documents.

The personnel of the FQHC may use also as a resource the Part One of the Provider Reimbursement Manual that may be reached in the following Internet address:

http://www.cms.hhs.gov/Manual/PBM/list.asp

In case of any questions you may reach me at the (787)765-1280 ext. 205 or you may send me an e-mail at the following address: juliogomez@salud.gov.pr

Thank you

/s/ Julio Gomez Malero

Julio Gomez Mulero
Director of Finance
Medicaid Program

DEPARTMENT OF HEALTH

MEDICAL ASSISTANCE PROGRAM (PAM)

[LOGO]

330 CENTERS PROSPECTIVE PAYMENTS SYSTEM (PPS)

INSTRUCTION MANUAL

MAY 2006

As stated in the January 19, 2001 Timothy M. Westmoreland's letter to Medicaid Directors:

> "The Prospective Payment System (PPS) for the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) was enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000".

BIPA amends section 1902(a) of the Social Security Act by repealing the reasonable cost-based reimbursement requirements for FQHC/RHC services previously at paragraph (13)(C) and instead requiring in paragraph (15) payment for FQHCs/RHCs consistent with a new prospective payment system (PPS) described in section 1902(aa) of the Act.

Under BIPA, the new Medicaid PPS takes effect on January 1, 2001. Provider based and independent

RHCs/FQHCs must furnish their FI with information currently collected on the Medicare cost reporting form for independent FQHC/RHCs (Form CMS-222). This form contains **the minimum statistical visit data and other information necessary to enable the FI to calculate a cost-per-visit, apply FQHC/RHC productivity standards, and apply the FQHC/RHC payment cap**.

Providers must identify all incurred costs applicable to furnishing covered clinic/center services. This includes RHC/FQHC direct costs, any shared costs applicable to the RHC/FQHC, and the RHCs/FQHCs appropriate share of the parent provider's overhead costs. Total RHC/FQHC costs applicable to furnishing covered RHC/FQHC services are to be included in the calculation of the RHC/FQHC cost-per-visit, using the methodology employed on the Form CMS-222 cost reporting forms and instructions. Refer to **Appendix 11 – CMS-222-92 FORM**, for form and instruction manual.

A revision of pertaining Medicaid patient data must be performed **quarterly** in order to determine if any wrap-around payment proceeds and must be granted. The Commonwealth will keep the right to approve of deny any payment based also not only in reasonability, but also in funds availability. Medical Assistance Program (PAM) reserve its right to request any other additional documentation, supporting document or evidence necessary for the calculation of the prospective payment.

1. Necessary Documentation

Following is a list of all necessary documentation for the Prospective Payment wrap-around calculation.

1. Balance Sheet
2. Cash disbursements
3. Chart of Accounts
4. CMS-222-92
5. Contracts of professional services
6. Contract with Physicians
7. Equipment contracts
8. Documentation for the following:
    - Educational expenses
    - Bad debts
    - Grants
    - Gifts
9. Income Subsidiaries
10. Insurance policies
11. Subsidiary Ledgers
12. General Ledger
13. Income Statement
14. Insurances (accident, malpractice, etc.)
15. Leasehold improvement

16. Lease agreements for Facilities and equipment
17. Ledgers
18. Legal expenses, consulting, etc.,
19. Maintenance
20. Mortgage and Loan agreements
21. Payroll documentation
22. Rent contracts
23. All supporting documentation must be in original
24. Trial Balance
25. Medicaid patient visit log
    a. Amount of Medicaid visiting patients per day
    b. Amount of Health Reform Plan visiting patients per day
    c. Amount of Private visiting patients per day
    d. Amount of other visiting patients per day
26. Medicaid patient type of service
    a. Family medicine
    b. Internal medicine
    c. Pediatrics
    d. Obstetrics/gynecologists

e. Laboratories services
f. Radiology services
g. Prenatal services
h. Perinatal services
i. Breast and cervical cancer screening
j. Well-child services
k. Immunizations
l. Screenings for elevated blood lead
m. Communicable diseases
n. Cholesterol screening
o. Pediatric eye screenings
p. Pediatric ear screening
q. Pediatric dental screenings
r. Voluntary family planning services
s. Preventive dental services
t. Emergency medical services
u. Referrals to providers of medical services
v. Pharmaceutical services

27. Annual audits
28. Total quantity of Medicaid patients
29. Total of members per IPA per category (Medicaid, Health Reform)

30. Any other evidence pertaining to Medicaid patient visit related cost

2. Covered Primary Care Services

The Primary Care Services (PCS) to be considered for rate setting are:

1. Diagnostic, treatment and consultant referral services provided by physician
2. Diagnostic labs
3. Radiological services
4. Preventive health services, such as:
    a. children's eyes and ear examinations
    b. pre(peri)natal services
    c. well child
    d. family planning services
    e. preventive dental health
5. Emergency medical services
6. Transportation services as required for adequate patient care (for people with special difficulties of access to services provided at the center)] are to be considered as "medical visit services".

3. Not Covered Primary Care Services

Unallowable costs are expenses, which are incurred by an FQHC, which are not (directly or indirectly) related to the provision of covered services according to applicable laws, rules, and standards.

Any FQHC may expend funds on unallowable cost items, but those costs must not be included in the cost report, survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not necessarily limited to, the following:

1. Compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not (directly or indirectly) related to the provision of covered services.

2. Personal expenses not directly related to the provision of covered services.

3. Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness be demonstrated.

4. Advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement.

5. Business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase

of a business or expenses associated with the sale or purchase of investments.

6. Political costs and contributions.

7. Depreciation amortization of unallowable including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and good will or any excess above the actual of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis be the lesser of the historical but not depreciated cost to the previous owner, or the purchase price of the assets. Any depreciation in excess of this amount is unallowable.

8. Trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services.

9. Donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 CFR Part 413.

10. Dues to all types of political and social organizations, and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and care services.

11. Entertainment expenses except those incurred for entertainment provided to the staff of the FQHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site.

12. Board of Director's fees including travel costs and provided meals for these directors.

13. Fines and penalties for violations of regulations, statutes, and ordinances of all types.

14. Fund raising and promotional expenses except.

15. Interest and expenses on loans, pertaining to unallowable items such as investments. Also the interest expense on that portion of interest paid which is reduced or offset by interest income.

16. Insurance premiums pertaining to items of unallowable cost.

17. Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount.

18. Mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel.

19. Cost for goods or services which are purchased from a related party and which exceed the original cost to the party.

20. Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the FQHC.

21. Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities.

4. Frequency

4.1 Delivery Dates

The 330 Centers will have **five (5) working days** after the end of each trimester to send the **CMS-222-92** form and supporting documentation (**See section 1**) to the PPS Office. The following are the dates:

- First quarter – must be delivered on or before April 6
- Second quarter – must be delivered on or before July 6
- Third quarter – must be delivered on or before October 5
- Fourth quarter – must be delivered on or before January 7

4.2 Delivery Address

All pertaining documentation will be **personally delivered** to the following address:

Medicaid Office
#70 Ponce de Leon Avenue
Second Floor
Hato Rey, PR
Attn: **Sr. Julio Gomez – Director of Finance**

4.3 Revision Period

1. The PPS Office will have **twenty (20) working days** to evaluate and determine the prospect payment. During this time the PPS Office, if necessary, will notify the Centers of any additional information or supporting document necessary to determine the prospective payment rate.

2. The Center will have a reasonable time, which will be specified in the notification, to submit the requested documentation.

3. Non compliance with this requirement will be enough reason for the PPS Office to deny prospective payment for the quarter in question. In addition, the PPS Office reserves the right to request any additional information/evidence that supports the provided information in the **CMS-222-92**.

4. The time needed for the evaluation will be halted until the requested information is **received** at the PPS Office. Once the information is received at the PPS office, the evaluation time will continued until the **twenty (20) working days** have been reached.

5. If the requested information is not received in the PPS Office, at the specified date, it will be understood that no claims will be pursued.

6. Once the PPS Office reviews, and authorizes or denies a prospective payment, a notification will be issued informing of the decision no later than **five (5) working days**.

4.4 Disputes

1. In the event a 330 Center is dissatisfied with the final decision of the PPS Office, i.e. negation of prospective payment, the Center is advice to file a formal grievance within **five (5) working days** addressed to the Director of Medicaid in Puerto Rico.

2. The letter of grievance will present the reasons for the 330 Center to be against the decision of the PPS Office to deny the prospective payment.

3. The grievance letter will be date and time stamped at the moment of receipt.

4. Upon completion of the review by the pertaining personnel, a written notice will be sent to the 330 Center with the result from the verification. This notification will be sent no later than **fifteen (15) working days** after the notification has been received.

5. In the event that the final decision after the grievance revision is still adverse to the 330 Center and are not pleased with the decision, the two parties (PPS Office and the 330 Center) will present themselves to a Court with competence.

This report is required by law (42 USC 1395g; CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g)

FORM APPROVED
OMB NO: 0938-0107

INDEPENDENT RURAL HEALTH CLINIC/ FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER NO.	PERIOD: FROM: _____ TO: _____	WORKSHEET S PART I

Intermediary Use Only:

[ ] Audited Date Received _____ [ ] Initial [ ] Re-opened
[ ] Desk Reviewed Intermediary No. _____ [ ] Final

PART I – STATISTICAL DATE [ ] Projected Cost Report [ ] Actual Final Cost Report

Check applicable box	[ ] Electronic filed cost report [ ] Manually submitted cost report	Date: Time:

1	Name:	1
1.01	Street: P.O. Box:	1.01
1.02	City: State: Zip Code:	1.02
1.03	County:	1.03
2	Provider Number:	2
3	Designation:	3
4	Reporting Period: From: To:	4

		Type of Control (see instructions)	Type of Provider (see instructions)	Date Certified	
	1	2	3	4	
5					5

		Source of Federal Funds (see instructions)	Grant Award Number (see instructions)	Date	
	1	2	3	4	
6					6

7	Names of Physicians Furnishing Services At The Health Facility or Under Agreement (As Described in Instructions) and Medicare Billing Numbers (Include all Part B Billing Numbers)		7
	Name	Billing Number	
	1	2	
7.01			7.01
7.02			7.02
7.03			7.03
7.04			7.04
7.05			7.05

8	Supervisory Physicians		8
	Name	Hours of Supervision For Reporting Period	
	1	2	
8.01			8.01
8.02			8.02
8.03			8.03
8.04			8.04
8.05			8.05

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903 and 2903.1)

INDEPENDENT RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER NO.	PERIOD: FROM: _____ TO: _____	WORKSHEET S PART I (Cont.) & Part II

PART I (CONTINUED) – STATISTICAL DATA

9	Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.			9
10	If yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.)			10
11	Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day.			11
	Days	Hours of Operation		
		From	To	
11.01	Sunday			11.01
11.02	Monday			11.02
11.03	Tuesday			11.03
11.04	Wednesday			11.04
11.05	Thursday			11.05
11.06	Friday			11.06
11.07	Saturday			11.07
12	Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day.			12
	Days	Hours of Operation		
		From	To	
12.01	Sunday			12.01
12.02	Monday			12.02
12.03	Tuesday			12.03
12.04	Wednesday			12.04
12.05	Thursday			12.05
12.06	Friday			12.06
12.07	Saturday			12.07
13	If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization.			13
14	Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section 30.8? Enter "Y" for yes or "N" for no. If yes, see instructions.			14

PART II – CERTIFICATION BY OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by _____ (Provider Name and Number) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)

Officer or Administrator of Facility Title Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0107. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850

FORM CMS-222-92 (12-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903 and 2903.2)

INDEPENDENT RURAL HEALTH CLINIC/ FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER NO.: _____ CLINIC NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S PART III

PART III – STATISTICAL DATA FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING

1	Name:			1
2	Street:		P.O. Box:	2
3	City:	State:	Zip Code:	3
4	County:			4
5	Provider Number:			5
6	Designation:		Date Certified:	6

7	Names of Physicians Furnishing Services At The Health Facility or Under Agreement (As Described in Instructions) and Medicare Billing Numbers (Include all Part B Billing Numbers)		7
	Name	Billing Number	
	1	2	
7.01			7.01
7.02			7.02
7.03			7.03
7.04			7.04
7.05			7.05

8	Supervisory Physicians		8
	Name	Hours of Supervision For Reporting Period	
	1	2	
8.01			8.01
8.02			8.02
8.03			8.03
8.04			8.04
8.05			8.05

9	Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.			9
10	If yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.)			10
11	Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day.			11
	Days	Hours of Operation		
		From	To	
11.01	Sunday			11.01
11.02	Monday			11.02
11.03	Tuesday			11.03
11.04	Wednesday			11.04
11.05	Thursday			11.05
11.06	Friday			11.06
11.07	Saturday			11.07
12	Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day.			12
	Days	Hours of Operation		
		From	To	
12.01	Sunday			12.01
12.02	Monday			12.02
12.03	Tuesday			12.03
12.04	Wednesday			12.04
12.05	Thursday			12.05
12.06	Friday			12.06
12.07	Saturday			12.07

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903.2)

01-05 Form CMS 222-92 2990 (Cont.)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Facility No.		Reporting Period From To		WORKSHEET A Page 1		

		COST CENTER	Compensation	Other	Total (Col. 1 + 2)	Reclassifications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)	
			1	2	3	4	5	6	7	
		FACILITY HEALTH CARE STAFF COSTS								
1	0100	Physician								1
2	0200	Physician Assistant								2
3	0300	Nurse Practitioner								3
4	0400	Visiting Nurse								4
5	0500	Other Nurse								5
6	0600	Clinical Psychologist								6
7	0700	Clinical Social Worker								7
8	0800	Laboratory Technician								8
9	0900	Other (Specify)								9
10	1000									10
11	1100									11
12		Subtotal – Facility Health Care Staff Costs								12
		COSTS UNDER AGREEMENT								
13	1300	Physician Services Under Agreement								13

14	1400	Physician Supervision Under Agreement								14
15	1500									15
16		Subtotal Under Agreement (Lines 13-15)								16
		OTHER HEALTH CARE COSTS								
17	1700	Medical Supplies								17
18	1800	Transportation (Health Care Staff)								18
19	1900	Depreciation – Medical Equipment								19
20	2000	Professional Liability Insurance								20
21	2100	Other (Specify)								21
22	2200									22
23	2300									23
24		Subtotal – Other Health Care Costs (Lines 17-23)								24
25		Total Cost of Services (Other Than Overhead And Other RCH/FQHC Services) Sum of Lines 12, 16, And 24								25
		FACILITY OVERHEAD – FACILITY COST								
26	2600	Rent								26
27	2700	Insurance								27
28	2800	Interest On Mortgage Or Loans								28
29	2900	Utilities								29

2990 (Cont.) Form CMS 222-92 01-05

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	Facility No.	Reporting Period From To	WORKSHEET A Page 2

		COST CENTER	Compen-sation	Other	Total (Col. 1 + 2)	Reclassi-fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)	
			1	2	3	4	5	6	7	
30	3000	Depreciation – Buildings And Fixtures								30
31	3100	Depreciation – Equipment								31
32	3200	Housekeeping And Maintenance								32
33	3300	Property Tax								33
34	3400	Other (Specify)								34
35	3500									35
36	3600									36
37		Subtotal – Facility Costs (Lines 26-36)								37
		FACILITY OVERHEAD ADMINISTRATIVE COSTS								
38	3800	Office Salaries								38
39	3900	Depreciation – Office Equipment								39
40	4000	Office Supplies								40
41	4100	Legal								41
42	4200	Accounting								42
43	4300	Insurance								43
44	4400	Telephone								44

45	4500	Fringe Benefits And Payroll Taxes								45
46	4600	Other (Specify)								46
47	4700									47
48	4800									48
49		Subtotal – Administrative Cost (Lines 38-48)								49
50		Total Overhead (Lines 37 And 49)								50
		COST OTHER THAN RHC/FQHC SERVICES								
51	5100	Pharmacy								51
52	5200	Dental								52
53	5300	Optometry								53
54	5400	Other (Specify)								54
55	5500									55
56	5600									56
57		Subtotal – Cost Other Than RHC/FQHC (Lines 51-56)								57
		NON-REIMBURSABLE COSTS (Specify)								
58	5800									58
59	5900									59
60	6000									60
61		Subtotal Non-Reimbursable Costs (Lines 58-60)								61
62		TOTAL COSTS (Sum Of Lines 25, 50, 57, And 61)								62

03-02 Form CMS 222-92 2990 (Cont.)

RECLASSIFICATIONS	Facility No.	Reporting Period From To	WORKSHEET A-1

	EXPLANATION OF ENTRY	CODE	INCREASE			DECREASE			
		(1)	COST CENTER	LINE NO.	AMOUNT (2)	COST CENTER	LINE NO.	AMOUNT (2)	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20

21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36	TOTAL RECLASSIFICATIONS (Sum of Column 4 must equal sum of Column 7)								36

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, Col 4, line as appropriate.

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2905)

ADJUSTMENTS TO EXPENSES	Facility No.		Reporting Period From To	WORKSHEET A-2

Description (1)	Basis for Adjustment (2)	Amount	Expense Classification on Worksheet A from which amount is to be deducted or to which the amount is to be added	
			Cost Center	Line No.
	1	2	3	4
1 Investment income on commingled restricted and unrestricted funds (chapter 2)				
2 Trade, quantity and time discounts on purchases (chapter 8)	B			
3 Rebates and refunds of expenses (chapter 8)	B			
4 Rental of building or office space to others				
5 Home office costs (chapter 21)				
6 Adjustment resulting from transactions with related organizations (chapter 10)	From Supp. Wkst. A-2-1			
7 Vending machines				
8 Practitioner Assigned by National Health Service Corps				
9 Depreciation – Buildings and Fixtures			Depreciation	30
10 Depreciation – Equipment			Depreciation	31
11 Other (Specify)				
12 Total				62

(1) Description – all line references in this column pertain to CMS Pub. PRM 15-1.

(2) Basis for adjustment (SEE INSTRUCTIONS)

A. Costs – if cost, including applicable overhead, can be determined.

B. Amount Received – if cost cannot be determined.

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 2906)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	Facility No.	Reporting Period From To	SUPPLEMENTAL WORKSHEET A-2-1 PARTS I-III

Part I. Introduction. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, Chapter 10?

[ ] Yes [ ] No (If "Yes", complete Parts II and III.)

Part II. Costs incurred and adjustments required (as result of transactions with related organizations):

LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 6				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (COL. 4 MINUS COL. 5)	
Line No.	Cost Center	Expense Items	AMOUNT			
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5	TOTALS (sum of lines 1-4) Transfer col. 6, line 1-4 to Wkst. A.col.6 as appropriate) (Transfer col.6, line 5 to Wkst. A-2, col.2, line 6, Adjustment to Expenses)					5

Part II. Interrelationship of facility to related organization(s):

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the provider to furnish the information requested on Part III of this worksheet.

This information is used by the Centers for Medicare & Medicaid Services and its intermediaries in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control, represent reasonable costs as determined under section 1861 of the Social Security Act. If the provider does not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

SYMBOL (1)		Name	Percentage of Ownership	RELATED ORGANIZATION(S) Name	Percentage of Ownership	Type of Business	
1		2	3	4	5	6	
1							1
2							2
3							3
4							4

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the provider;

B. Corporation, partnership, or other organization has financial interest in the provider;

C. Provider has financial interest in corporation, partnership, or other organization(s);

D. Director, officer, administrator, or key person of the provider or relative of such person has financial interest in related organization;

E. Individual is director, officer, administrator, or key person of the provider and related organization;

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the provider;

G. Other (financial or non-financial) specify _____

VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	Facility No.	Reporting Period From To	WORKSHEET B PARTS I & II

PART I – VISITS AND PRODUCTIVITY

	Part A – Visits And Productivity				
	1	2	3	4	5
Positions	Number of FTE Personnel	Total Visits	Productivity Standard	Minimum Visits (Col. 1 x Col. 3)	Greater of Col. 2 or Col. 4
1. Physicians			4200		
2. Physician Assistants			2100		
3. Nurse Practitioners			2100		
4. Subtotal (Sum of lines 1-3)					
5. Visiting Nurse					
6. Clinical Psychologist					
7. Clinical Social Worker					
8. Total Staff					
9. Physician Services Under Agreement					

PART II – DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

	Amount
10. Cost of RHC/FQHC Services – excluding overhead – (W/S A,Col. 7, Line 25)	
11. Cost of Other Than RHC/FQHC Services – Excluding overhead (W/S A, Col. 7, Sum of Lines 57 and 61)	
12. Cost of All Services – excluding overhead – (Sum of Lines 10 and 11)	
13. Ratio of RHC/FQHC Services (Line 10 Divided by Line 12)	
14. Total Overhead – (W/S A, Col. 7, Line 50)	
15. Overhead Applicable to RHC/FQHC Services (Line 13 x Line 14)	
16. Total Allowable Cost of RHC/FQHC Services (Sum of Lines 10 and 15)	

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2907 THRU 2907.2)

DETERMINATION OF MEDICARE PAYMENT	Facility No.	Reporting Period From To	WORKSHEET C PART I

	PART I – DETERMINATION OF RATE FOR RHC/FQHC SERVICES	AMOUNT	
1	Total Allowable Costs(Worksheet B, Part II, Line 16)		1
2	Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (From Supplemental Worksheet B-1, Line 15)		2
3	Total Allowable Cost Excluding Pneumococcal and Influenza Vaccine (Line 1 – Line 2)		3
4	Greater of Minimum Visits or Actual Visits by Health Care Staff (Worksheet B, Part I, Column 5, Line 8		4
5	Physicians Visits Under Agreements (Worksheet B, Part I, Column 5, Line 9)		5
6	Total Adjusted Visits (Line 4 – Line 5)		6
7	Adjusted Cost Per Visit (Line 3 divided by Line 6)		7

		1	2	2.01	3	
8	Maximum Rate Per Visit (See Instructions)	Rate Period 1	Rate Period 2	Rate Period 3		8
9	Rate For Medicare Covered Visits (Lessor of Line 7 or Line 8)					9

DETERMINATION OF MEDICARE PAYMENT	Facility No.	Reporting Period From To	WORKSHEET C PART II

	PART II – DETERMINATION OF TOTAL PAYMENT	1	2	2.01	3	
		Rate Period 1	Rate Period 2	Rate Period 3		
10	Rate for Medicare Covered Visits (Part I, Line 9)					10
11	Medicare Covered Visits Excluding Mental Health Services (From Intermediary Records)					11
12	Medicare Cost Excluding Costs for Mental Health Services (Line 10 multiplied by Line 11)					12
13	Medicare Covered Visits for Mental Health Services (From Intermediary Records)					13
14	Medicare Covered Cost for Mental Health Services (Line 10 multiplied by Line 13)					14
15	Limit Adjustment (Line 14 multiplied by 62 ½%) (see instructions)					15
16	Total Medicare Cost (Line 12 plus line 15)					16
17	Less: Beneficiary Deductible (From Intermediary Records)					17
18	Net Medicare Cost Excluding Pneumococcal and Influenza Vaccine and Its (Their) Administration (Line 16 minus line 17)					18
19	Reimbursable Cost of RHC/FQHC Services. Other Than Pneumococcal and Influenza Vaccine (80% multiplied by line 18, Column 3)					19
20	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (From Supp. Worksheet B-1, Line 16)					20
21	Total Reimbursable Medicare Cost (Line 19 plus Line 20)					21
22	Less Payments to RHC/FQHC During Reporting Period					22
23	Balance Due To/From The Medicare Program Exclusive of Bad Debts (Line 21 less Line 22)					23
24	Total Reimbursable Bad Debts, Net of Bad Debt Recoveries (From Provider Records)					24
24.01	Total Gross Reimbursable Bad Debts for Dual Eligible Beneficiaries (From Provider Records)					24.01
25	Total Amount Due To/From The Medicare Program (Line 23 plus Line 24)					25

FORM CMS-222-93(08/04) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2908 AND 2908.2)

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Facility No.	Reporting Period From To	SUPPLEMENTAL WORKSHEET B-1

	PART I – CALCULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
1	Health Care Staff Cost (Worksheet A, Column 7, Line 12)			1
2	Ratio of Pneomococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time			2
3	Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2)			3
4	Medical Supplies Cost – Pneumococcal and Influenza Vaccine (From Your Records)			4
5	Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4)			5
6	Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25)			6
7	Total Facility Overhead (Worksheet A, Column 7, Line 50)			7
8	Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6)			8
9	Overhead Cost – Pneumococcal and Influenza Vaccine (Line 7 x Line 8)			9
10	Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9)			10
11	Total Number of Pneumococcal and Influenza Vaccine Injections (From Provider Records)			11
12	Cost Per Pneumococcal and Influenza Vaccine Injection (Line 10 divided by Line 11)			12
13	Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare Beneficiaries			13
14	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Line 12 Multiplied by Line 13)			14
15	Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 10, Columns 1 and 2) Transfer to Wkst. C, Part I, Line 2			15
16	Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 14, Columns 1 and 2) Transfer to Wkst. C, Part II, Line 20			16

FORM CMS-222-92(8/04) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2910)

EXHIBIT 1 – Form CMS-222-92

The following is a listing of the Form CMS-222-92 worksheets and the page number location.

Worksheets	Page(s)
Wkst. S, Part I	29-303
Wkst. S, Parts I (Cont.) & II	29-304
Wkst. S, Part III	29-304.1
Wkst. A, Page 1	29-305
Wkst. A, Page 2	29-306
Wkst. A-1	29-307
Wkst. A-2	29-308
Wkst. B, Parts I & II	29-309
Wkst. C, Part I	29-310
Wkst. C, Part II	29-311
Supp. Wkst. A-2-1, Parts I-III	29-312
Supp. Wkst. B-1	29-313

2900. GENERAL

These forms must be used by all independent rural health clinics (RHCs) and freestanding Federally qualified health centers (FQHCs). These forms are required for determining Medicare payment for RHC and FQHC services under 42 CFR 405, Subpart X.

An RHC/FQHC must complete all applicable items on the worksheets. For its initial reporting period, the facility completes these worksheets with estimates of costs and visits and other information required by the reports. The intermediary uses the estimates to determine an interim rate of payment for the facility. Following the end of the facility's reporting period, the facility is required to submit its worksheets using

data based on its actual experience for the reporting period. This information is used by the intermediary as the basis for determining the total Medicare payment due the RHC/FQHC for services furnished Medicare beneficiaries.

2900.1 *Rounding Standards for Fractional Computations*. – Throughout the Medicare cost report, required computations result in the use of fractions. Use the following rounding standards for such computations:

1. Round to 2 decimal places:
   a. Rates
   b. Cost per visit
   c. Cost for pneumoccocal vaccine
2. Round to 6 decimal places:
   a. Ratios
   b. Limit adjustments

2901. RECOMMENDED SEQUENCE FOR COMPLETING FORM HCFA-222-92

Part I – General Statistics and Expense Reclassification and Adjustments

Step No.	Worksheet	Page(s)	
1	S, Part I	1	Read §§2903 and 2903.1. Complete Part I.
2	A	3 & 4	Read §2904. Complete columns 1 through 3, lines 1 through 62.

3	A-1	5	Read §2905. Complete entire worksheet if applicable.
4	A	3 & 4	Read §2904. Complete columns 4 and 5, lines 1 through 62.
5	Supp. A-2-1,	6	Read §2909. Complete entire Parts I-III worksheet as applicable.
6	A-2	7	Read §2906. Complete entire worksheet.
7	A	3 & 4	Read §2904. Complete columns 6 and 7, lines 1 through 62.

Part II – Computation of Medicare Cost

Step No.	Worksheet	Page(s)	
1	Supp. B-1	8	Read §2910. Complete if applicable.
2	B, Parts I-II	9	Read §§2907 through 2907.2. Complete entire worksheet.

Part III – Calculation of Reimbursement Settlement

Step No.	Worksheet	Page(s)	
1	C, Parts I-III	10	Read §§2908 through 2908.3. Complete entire worksheet.
2	S, Part II	2	Read §2903.2. Complete certification statement.

2902. SEQUENCE OF ASSEMBLY

The following list of assembly of worksheets is provided so all facilities are consistent in the order of submission of their annual cost report. All facilities using Form HCFA-222-92 are to adhere to this sequence. Where worksheets are not completed because they are not applicable, blank worksheets are *not* included in the assembly of the cost report.

2902.1 *Sequence of Assembly – Worksheets*. –

Worksheet	Page(s)
S	I & II
A	N/A
A-1	N/A
A-2	N/A
Supp. A-2-1	I, II, & III
B	I & II
B-1	N/A
C	I, II, & III

2903. WORKSHEET S – INDEPENDENT RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA AND CERTIFICATION STATEMENT

2903.1 *Part I – Statistical Data*. – At the top of the worksheet, indicate by checking the appropriate box whether the cost report being filed is a projected or an actual/final cost report.

Line 1. – Enter the full name of the RHC/FQHC. If the cost report is for multiple sites, see worksheet S, Part III.

Line 1.01. – Enter the street address and P.O. Box (if applicable) of the RHC/FQHC.

Line 1.02. – Enter the city, state and zip code of the RHC/FQHC.

Line 1.03. – Enter the county of the FQHC.

Line 2. – Enter the RHC/FQHC identification number that was provided by CMS.

Line 3. – For FQHCs only, enter your appropriate designation ("U" for urban or "R" for rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. Do not complete this line for RHCs.

Line 4. – Enter on the appropriate lines the inclusive dates covered by these worksheets. A reporting period is a period of 12 consecutive months for which a clinic must report its costs and utilization. The first and last reporting periods may be less than 12 months but not less than one month or greater than 13. A cost reporting period exceeding 13 months are subject to the provisions of CMS Pub. 15-2, section 102.1A.

Line 5. –

Column 1 – Type of Control – Indicate the ownership or auspices of the RHC/FQHC by entering the number below that corresponds to the type of control of the RHC/FQHC.

Voluntary Non Profit	Proprietary	Government
1=Corporation	3=Individual	7=Federal
2=Other (specify)	4=Corporation	8=State
	5=Partnership	9=County
	6=Other (specify)	10=City
		11=Other (specify)

If item 2, 6, or 11 is selected, "Other (specify)" category, specify the type of provider in column 2 of the worksheet.

Column 3. – Type of Provider – Enter the number which corresponds to the type of provider as defined in the conditions of participation. Enter 1 for a RHC and 2 for a FQHC.

Column 4. – Date Certified – Enter the date the RHC/FQHC was certified for participation in the Medicare program.

Line 6. –

Column 1 – Source of Federal Funds – Indicate the source of Federal Funds by entering the number below that corresponds to the applicable source.

1=Community Health Center (Section 330(d). Public Health Service Act)

2=Migrant Health Center (Section 329(d), Public Health Service Act)

3=Health Services for the Homeless (Section 340(d), Public Health Service Act)

4=Appalachian Regional Commission

5=Look-Alikes

6=Other (Specify)

If item 6 is selected, "Other (Specify) category, specify the source in Column 2 or the worksheet.

Column 3 – Enter the grant award number.

Column 4 – Enter the date the grant was awarded.

Line 7. – In Column 1, list all physicians furnishing services at the RHC/FQHC and in Column 2 list the physician's Medicare billing number. Also in Column 2, list any other Medicare Part B billing number used by the RHC/FQHC.

Line 8. – In Column 1, enter the name of all supervisory physicians and in Column 2 enter the number of hours spent in supervision.

Line 9. – Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.

Line 10. – If the answer on line 9 is yes, enter the type of operation (i.e., laboratory or physicians services).

Line 11. – Enter the hours of operation (from/to) based on a 24 hour clock next to the appropriate day that the facility is available to provide RHC/FQHC services. For example 8:00am is 0800 and 5:30pm is 1730.

Line 12. – If the answer on line 9 is yes, enter the hours of operation (from/to next to the appropriate

day that the facility is available to provide other than RHC/FQHC services.

Line 13. – Indicate whether this is a low or no Medicare utilization cost report. Enter an "L" for low Medicare utilization or "N" for no Medicare utilization. (See 42 CFR 413.24(h)).

Line 14. – Indicate whether this facility is filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section 30.8. Enter "Y" for yes or "N" for no. If yes, complete a separate Worksheet S, Part III for each clinic filing on the consolidated cost report.

2903.2 *Part II – Certification Statement*. – The certification statement must be prepared and signed after the worksheets have been completed. The individual signing this statement must be an officer or other administrator.

2903.3 *Part III – Statistical Data for Clinics Filing Under Consolidated Cost Reporting*. – This worksheet must be completed by each clinic filing under consolidated cost reporting. Indicate on each worksheet the corresponding clinic identification number under which the facility is certified to furnish Medicare services. Do not re-enter clinic information already entered on Worksheet S, Part I for the primary clinic.

Line 1. – Enter the full name of the RHC/FQHC.

Line 2. – Enter the street address and P.O. Box (if applicable) of the RHC/FQHC.

Line 3. – Enter the city, state and zip code of the RHC/FQHC.

Line 4. – Enter the county of the FQHC. RHCs are not required to provide this information.

Line 5. – Enter the RHC/FQHC identification number that was provided by CMS.

Line 6. – For FQHCs only, enter your appropriate designation (urban or rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. Do not complete this line for RHCs.

Line 7. – On subscripts of line 7, in column 1, list all physicians furnishing services at the RHC/FQHC and in Column 2 list the physician's Medicare billing number. Also in Column 2, list any other Medicare Part B billing number used by the RHC/FQHC.

Line 8. – On subscripts of line 8, in column 1, enter the name of all supervisory physicians and in Column 2, enter the number of hours spent in supervision.

Line 9. – Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.

Line 10. – If the answer on line 9 is yes, enter the type of operation (i.e., laboratory or physicians services).

Line 11. – Enter the hours of operation (from/to) next to the appropriate day that the facility is available to provide RHC/FQHC services.

Line 12. – If the answer on line 9 is yes, enter the hours of operation (from/to) next to the appropriate day that the facility is available to provide other than RHC/FQHC services.

2904. WORKSHEET A – RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Use Worksheet A to record the trial balance of expense accounts from your books and records. The worksheet also provides for the necessary reclassification and adjustments to certain accounts. All cost centers listed do not apply to all RHCs/FQHCs using this worksheet. For example, a facility might not employ laboratory technicians and does not, in that case, complete line 8. In addition to those lines listed, the worksheet also provides blank lines for other facility cost centers.

If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your intermediary.

Under certain conditions, a provider may elect to use different cost centers for allocation purposes. These conditions are stated in CMS Pub. 15-1, §2313.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If a provider needs to use additional or different cost center

descriptions, it may do so by adding additional lines to the cost report. Added cost centers must be appropriately coded. Identify the added line as a numeric subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general services cost centers.

Also, submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. The Form CMS 222-92 provides for 33 preprinted cost center descriptions that may apply to RHC/FQHC services on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These 27 cost center descriptions are hereafter referred to as the standard cost centers. One additional cost center description with general meaning has been identified. This additional description will hereafter be referred to as a nonstandard label with an "Other . . . " designation to provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, line 9.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. The preparer is required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in Table 5 of the electronic reporting specifications.

Column Descriptions

Columns 1 through 3. – The expenses listed in these columns must be in accordance with your accounting books and records.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1) and Other (column 2). The sum of columns 1 and 2 must equal column 3. Record any needed reclassification and adjustments in columns 4 and 6, as appropriate.

Column 4. – Enter any reclassification among cost center expenses which are needed to effect proper cost allocation.

Worksheet A-1 is provided to compute the reclassification affecting the expenses specified therein. This worksheet need not be completed by all facilities but must be completed only to the extent that the

reclassification is needed and appropriate in the facility's circumstances.

NOTE: The net total of the entries in column 4 must equal zero on line 62.

Column 5. – Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5, line 62, must equal the total of column 3, line 62.

Column 6. – Enter on the appropriate lines the amounts of any adjustments to expenses indicated on Worksheet A-2, column 2. The total on Worksheet A, column 6, line 62, must equal the amount on Worksheet A-2, column 2, line 12.

Column 7. – Adjust the amounts in column 5 by the amounts in column 6 (increases or decreases) and extend the net balances to column 7.

Transfer the amounts in column 7 to the appropriate lines on Worksheet B and Supplemental Worksheet B-1.

Line Descriptions

Lines 1 through 11. – Enter the costs of your health care staff on the appropriate line by type of staff.

Line 12. – Enter the sum of the amounts on lines 1 through 11.

Line 13. – Enter the cost of physician medical services furnished under agreement.

Line 14. – Enter the expenses of physician supervisory services furnished under agreement.

Line 16. – Enter the sum of the amounts on lines 13 through 15.

Lines 17 through 23. – Enter the expenses of other health care costs.

Line 24. – Enter the sum of the amounts on lines 17 through 23.

Line 25. – Enter the sum of the amounts on lines 12, 16, and 24. Transfer this amount to Worksheet B, Part II, line 10.

Lines 26 through 36. – Enter the overhead expenses related to the facility.

Line 37. – Enter the sum of the amounts on lines 26 through 36.

Lines 38 through 48. – Enter the expenses related to the administration and management of the clinic.

Line 49. – Enter the sum of the amount on lines 38 through 48.

Line 50. – Enter the sum of lines 37 and 49. Transfer the total amount in column 7 to Worksheet B, Part II, line 14.

Lines 51 through 56. – Enter the cost centers applicable to services other than RHC/FQHC services (excluding overhead).

Line 57. – Enter the sum of the amounts on lines 51 through 56.

Lines 58 through 60. – Enter the cost of services that are not reimbursable under Medicare.

Line 61. – Enter the sum of the amounts on lines 58 through 60.

Line 62. – This is the total cost of the facility. It is the sum of the amounts on lines 25, 50, 57, and 61.

2905. WORKSHEET A-1 – RECLASSIFICATION

This worksheet provides for the reclassification of certain amounts to effect the proper cost allocation. The cost centers affected must be specifically identifiable in your accounting records. Use reclassifications in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet A are maintained in your accounting books and records in one cost center. For example, if a physician performs administrative duties, the appropriate portion of his/her compensation, payroll taxes and fringe benefits must be reclassified from "Facility Health Care Staff Cost" to "Facility Overhead", line 38 for the office salaries and line 45 for the benefits and taxes.

2906. WORKSHEET A-2 – ADJUSTMENTS TO EXPENSES

This worksheet provides for adjusting the expenses listed on Worksheet A, column 5. Make these adjustments, which are required under the Medicare

principles of reimbursement, on the basis of cost, or amount received. Enter the total amount received (revenue) only if the cost (including the direct cost and all applicable overhead) cannot be determined. However, if total direct and indirect cost can be determined, enter the cost. Once an adjustment to an expense is made on the basis of cost, you may not, in future cost reporting periods determine the required adjustment to the expense on the basis of revenue. Enter the following symbols in column 1 to indicate the basis for adjustments: "A" for costs and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of items to be entered on this worksheet are (1) those needed to adjust expenses incurred, (2) those items which constitute recovery of expenses through sales, charges, fees, etc, and (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement. (See HCFA Pub. 15-1, §2328.)

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on this worksheet.

Line Descriptions

Line 1. – Investment income on restricted and unrestricted funds which are commingled with other funds must be applied together against the total

interest expense included in allowable costs. (See HCFA Pub. 15-1, §202.2.)

Apply the investment income on restricted and unrestricted funds which are commingled with other funds against the Administrative, Depreciation – Buildings and Fixtures, Depreciation – Equipment, and any other appropriate cost centers on the basis of the ratio that interest expense charged to each cost center bears to the total interest expense charges to all of your cost centers.

Line 5. – Enter the allowable home office costs which have been allocated to the facility. Use additional lines to the extent that various facility cost centers are affected. (See HCFA Pub. 15-1, chapter 21.)

Line 6. – Obtain the amount to be entered on this line from Supplemental Worksheet A-2-1, Part II, column 6, line 5. Note that Worksheet A-2-1, Part II, lines 1 through 4, represent the detail of the various cost centers to be adjusted on Worksheet A.

Line 8. – Enter the amount which represents the allowable cost of the services furnished by National Health Service Corp (NHSC) personnel. Obtain this amount from your intermediary.

Lines 9 and 10. – If depreciation expense computed in accordance with Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 9 and/or 10.

2907. WORKSHEET B – VISITS AND OVERHEAD COST FOR RHCs/FQHCs

Worksheet B is used by the RHC/FQHC to summarize (1) the visits furnished by your health care staff and by physicians under agreements with you, and (2) the overhead costs incurred by you which apply to RHC/FQHC services.

2907.1 *Part I – Visits and Productivity*. – Use Part I to summarize the number of facility visits furnished by the health care staff and to calculate the number of visits to be used in the rate determination. Productivity standards established by HCFA are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner.

Lines 1 through 9 of Part I list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column 1. – Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility practice (See HCFA Pub. 27, §503 for a definition of FTEs).

Column 2. – Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3. – This is the number of visits required by productivity standards. No entry is required.

Column 4. – This is the minimum number of facility visits the personnel in each staff position are expected to furnish. Enter the product of column 1 and column 3.

Column 5. – Enter the greater of the visits from column 2 or column 4. Intermediaries have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the intermediary could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the intermediary need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

Line 4. – Enter the total of lines 1 through 3.

Line 8. – Enter the total of lines 4 through 7.

Line 9. – Enter the number of visits furnished to facility patients by physicians under agreement with you. Physicians services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other

locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

2907.2 *Part II – Determination of Total Allowable Cost Applicable To RHC/FQHC Services*. – Use Part II to determine the amount of overhead cost applicable to RHC/FQHC services.

Line 10. – Enter the cost of RHC/FQHC services (excluding overhead) from Worksheet A, column 7, line 25.

Line 11. – Enter the cost of services (other than RHC/FQHC services) excluding overhead from Worksheet A, column 7, sum of lines 57 and 61.

Line 12. – Enter the cost of all services (excluding overhead). It is the sum of lines 10 and 11.

Line 13. – Enter the percentage of RHC/FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of RHC/FQHC services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14. – Enter the total overhead costs incurred from Worksheet A, column 7, line 50. It is the sum of facility costs and administrative overhead costs.

Line 15. – Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the percentage of RHC/FQHC services) by the amount on line 14 (total overhead).

Line 16. – Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC services other than overhead services) and line 15 (overhead services applicable to RHC/FQHC services).

2908. WORKSHEET C – DETERMINATION OF MEDICARE PAYMENT

Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

2908.1 *Part I – Determination of Rate For RHC/FQHC Services*. – Use Part I to calculate the cost per visit for RHC/FQHC services and to apply the screening guideline established by CMS on your health care staff productivity.

Line 1. – Enter the total allowable cost from Worksheet B, Part II, line 16.

Line 2. – Enter the total cost of pneumococcal and influenza vaccine from Supplemental Worksheet B-1, line 15.

Line 3. – Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4. – Enter the greater of the minimum or actual visits by the health care staff from Worksheet B, Part I, column 5, line 8.

Line 5. – Enter the visits made by physicians under agreement from Worksheet B, Part I, column 5, line 9.

Line 6. – Enter the total adjusted visits (sum of lines 4 and 5).

Line 7. – Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 through 18. – Complete columns 1 and 2 of lines 8 through 18 to identify costs and visits affected by different payment limits during a cost reporting period. For lines 11 through 18, enter in column 3 the sum of columns 1 and 2 (and 2.01, if applicable). Enter the rates and the corresponding data chronologically in the appropriate column as they occur during the cost reporting period. For example, if only one payment limit is applicable during the cost reporting period complete column 1 only. Column 2 can be subscripted to accommodate the possibility of three per visit limits during a cost reporting period.

Line 8. – Enter the maximum rate per visit that can be received by you. Obtain this amount from PM A-03-21 or from your intermediary.

Line 9. – Enter the lesser of the amount on line 7 or line 8.

2908.2 *Part II – Determination of Total Payment*. – Use Part II to determine the total Medicare payment due you for covered RHC/FQHC services furnished to Medicare beneficiaries during the reporting period.

Line 10. – Enter the rate for Medicare covered visits from line 9.

Line 11. – Enter the number of Medicare covered visits excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 12. – Enter the subtotal of Medicare cost. This cost is determined by multiplying the rate per visit on line 10 by the number of visits on line 11 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the reporting period).

Line 13. – Enter the number of Medicare covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 14. – Enter the Medicare covered cost for outpatient mental health services by multiplying the rate per visit on line 10 by the number of visits on line 13.

Line 15. – Enter the limit adjustment. This is computed by multiplying the amount on line 14 by the outpatient mental health treatment service limit 62 ½ percent. This limit applies only to therapeutic services not initial diagnostic services.

Line 16. – Enter the total Medicare cost. This is equal to the sum of the amounts on lines 12 and 15.

Line 17. – Enter the amount credited to the RHC's Medicare patients to satisfy their deductible liabilities on the visits on lines 11 and 13 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the

intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18. – Enter the net Medicare cost. This is equal to the result of subtracting the amount on line 17 from the amount on line 16. Enter in column 3 the sum of the amounts in columns 1 and 2.

Line 19. – Enter 80 percent of the amount on line 18, column 3.

Line 20. – Enter the Medicare cost of pneumococcal and influenza vaccines and their administration from Worksheet B-1, line 16.

Line 21. – Enter the total reimbursable Medicare cost. This is equal to the sum of the amounts on lines 19 and 20.

Line 22. – Enter the total payments made to you for covered services furnished to Medicare beneficiaries during the reporting period (from intermediary records).

Line 23. – This is equal to the result of subtracting the amount on line 21 from the amount on line 22.

Line 24. – Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 24.01. – Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts also are included on line 24. (4/1/2004b)

Line 25. – Enter the total amount due to/from the Medicare program (sum of lines 23 and 24). This is the amount of the payment reconciliation.

2909. SUPPLEMENTAL WORKSHEET A-2-1 – STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

In accordance with 42 CFR 413.17, cost applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization subject to the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to you by organizations related to you. In addition, certain information concerning the related organizations with which you have transacted business is shown. (See CMS Pub. 15-1, chapter 10.)

2909.1 *Part I – Introduction*. – If there are any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10, check the "Yes" box and complete Parts II and III.

If there are no costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10, check the "No" box and do not complete the rest of the form.

2909.2 *Part II – Costs Incurred and Adjustments Required*. – Cost applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

Complete each line as necessary and complete all columns for each of those lines.

Column 1. – Enter the line number from Worksheet A which corresponds to the cost center for which the adjustment is being made.

Column 2. – Enter the cost center from Worksheet A for which the adjustment is being made.

Column 3. – Enter the item of service, facility, or supplies which you obtained from the related organization.

Column 4. – Enter the cost to your organization for the service, facility, or supplies which were obtained from the related organization.

Column 5. – Enter the allowable cost of the service, facility, or supplies which were obtained from the related organization. The allowable cost is the lesser of the cost of the service, facility, or supplies to the related organization or the amount a prudent and cost conscious buyer pays for a comparable service, facility or supply purchased elsewhere.

Column 6. – Enter the amount in column 4 minus the amount in column 5. Transfer the(se) amount(s) to the corresponding line of Worksheet A, column 6.

2909.3 *Part III – Interrelationship of Facility to Related Organization(s)*. – Use this part to show your interrelationship to organizations furnishing services, facilities, or supplies to you. The requested data relative to all individuals, partnerships, corporations or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in CMS Pub. 15-1, chapter 10, is shown in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship which exists.

Column 1. – Enter the appropriate symbol which describes your interrelationship to the related organization.

Column 2. – If the symbol A, D, E, F or G is entered in column 1, enter the name of the related individual in column 2.

Column 3. – If the individual indicated in column 2 or the organization indicated in column 4 has a financial interest in you, enter the percent of ownership.

Column 4. – Enter the name of the related organization, partnership or other organization.

Column 5. – If you or the individual indicated in column 2 has a financial interest in the related

organization, enter the percent of ownership in such organization.

Column 6. – Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service.)

2910. SUPPLEMENTAL WORKSHEET B-1 – COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of the pneumococcal vaccine.

Line 1. – Enter the health care staff cost from Worksheet A, column 7, line 12.

Line 2. – Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3. – Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4. – Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5. – Enter the sum of lines 3 and 4.

Line 6. – Enter the amount on Worksheet A, column 7, line 25. This is your total direct cost of the facility.

Line 7. – Enter the amount from Worksheet A, column 7, line 50.

Line 8. – Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9. – Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10. – Enter the sum of the amounts on lines 5 and 9. Transfer this amount to Worksheet C, Part I, line 2.

Line 11. – Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12. – Enter the cost per pneumococcal and influenza vaccine injections by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13. – Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14 – Enter the cost per pneumococcal vaccine injection by multiplying the amount on line 12 by the amount on line 13.

Line 15 – Enter the total cost of pneumococcal and influenza vaccine and its (their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10. Transfer this amount to Worksheet C, Part I, line 2.

Line 16 – Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet C, Part II, line 20.