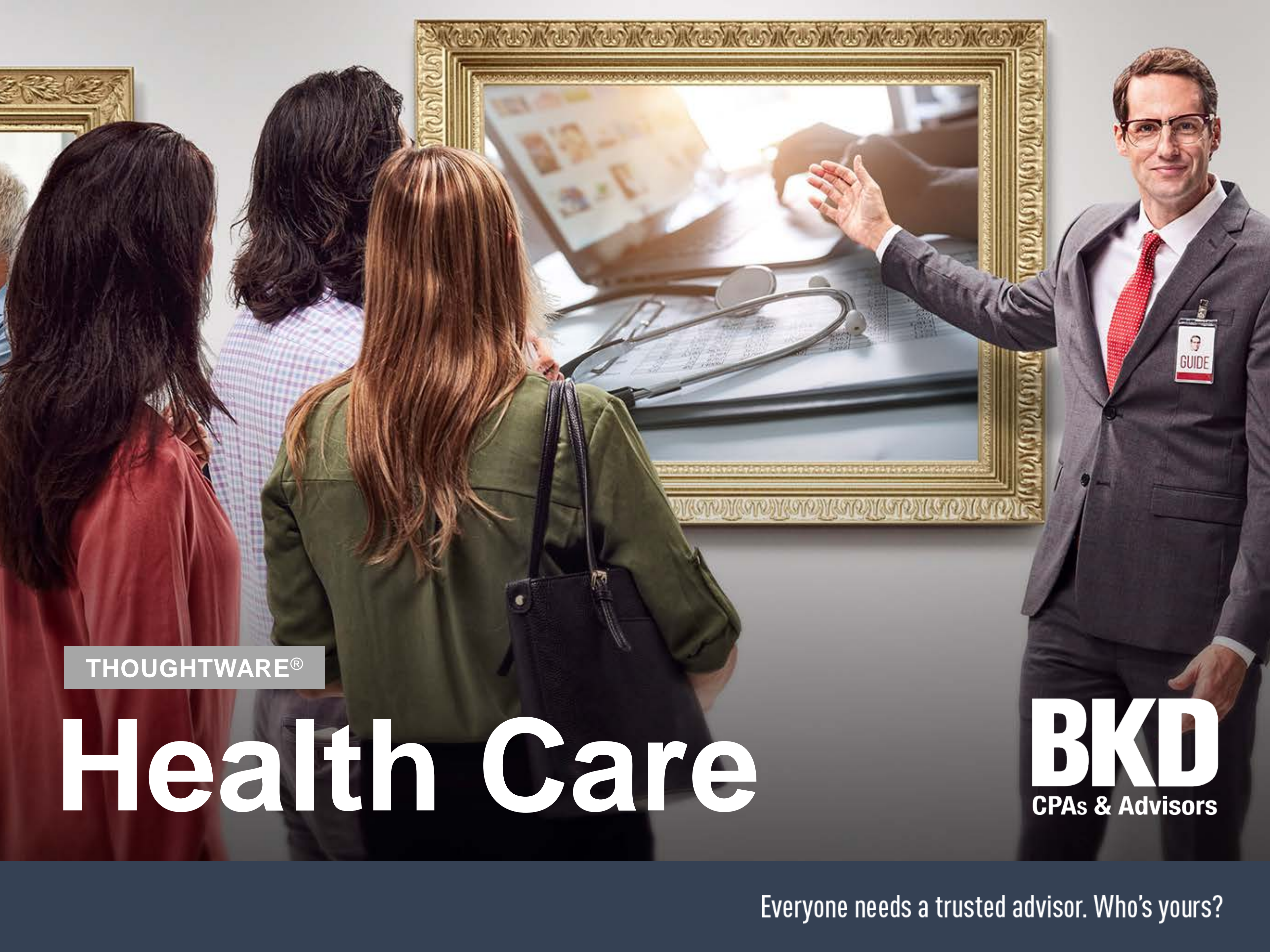
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Medicare Cost Report – Intermediate

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Today's Agenda

- Introduction
- Key Medicare FQHC Issues
- The Medicare FQHC cost report
  - Background issues
  - A look at the individual cost report worksheets
- Final thoughts

Medicare Revenue Statistics

- Based on the 2018 & 2017 UDS Data (Table 9D – Patient Related Revenue)
    - 2018 – 12.4% of aggregate health center revenue (10.0% - traditional Medicare + 2.4 % Medicare managed care)
    - 2017 – 11.3% of aggregate health center revenue (9.4% - traditional Medicare + 1.9 % Medicare managed care)

Medicare FQHC Cost Report - Relevance

- Why is it a big deal to complete the Medicare cost report correctly?
  - Compliance (see attestation statement on WS S)
  - Development of FQHC-specific market basket (relevant in/unique to the new PPS)

FQHC-Specific Market Basket

- FQHC market basket is used to update the Medicare FQHC PPS base payment rate
  - 2019 base payment rate of $169.77 includes application of the final FQHC-specific market basket of 1.9% (versus the 2018 MEI increase factor of 1.5%)
  - 2018 was 1.9% vs. 1.4%

Medicare Program – The Puzzle Pieces

- The Medicare program includes the following components:
  - Part A – Institutional provider reimbursement
  - Part B – Outpatient and physician professional services reimbursement
  - Part C – Medicare Advantage (Medicare managed care)
  - Part D – Medicare prescription drug coverage
- The Medicare program is administered by regional Medicare Administrative Contractors (MACs)

Key Medicare FQHC Issues

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FQHC Certification Issues

- Receiving Section 330 grant funding, Look-Alike designation or approval of a BPHC change in scope to add a site
  - Establishes eligibility to enroll in Medicare as an FQHC
  - Does not initiate the Medicare FQHC enrollment application
- FQHCs are considered “institutional providers”

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FQHC Certification Issues

- Underlying issues of importance
  - Regulations require site-by-site certification
  - Medicare approval granted on a prospective basis
  - Failure to get it right will likely impact your health center negatively

FQHC Certification Issues

- Common problems that have potential significant negative financial implications
  - Multiple sites utilizing one FQHC provider number
  - Failure to decertify sites no longer in existence and/or utilized for health center activities
- Word to the wise – get it right from the start

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Medicare FQHC PPS

- PPS payment rates increased with a market basket adjustment
  - Base rate from January 1, 2019, through December 31, 2019 = **$169.77**
  - Base Rate x Geographic Adjustment Factor (GAF)
    - **Established = $169.77 x GAF**
    - **Higher Intensity = + 34.16%**
- Medicare payment = 80% of **the lesser of** the actual G code charge or the PPS rate
- Beneficiary coinsurance = 20% of **the lesser of** the actual G code charge or the PPS rate
- Medicare payment = 100% of **the lesser of** the actual G code charge or the PPS rate for defined preventive services

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Medicare FQHC PPS

- Medicare FQHC PPS provides an opportunity for FQHCs to improve their overall payer mix as Medicare is often the second best payer in a CHC 2019 PPS rates for (Base Rate $169.77):
  - NC of $164.34 & $220.48 (GAF = .968)
  - SC of $162.81 & $218.43 (GAF = .959)
  - TN of $161.96 & $217.29 (GAF = .954)
  - Rest of GA $161.79 & $217.06 (GAF = .953)
  - Atlanta $169.60 & $227.54 (GAF = .999)

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PPS Background Basics

- Five G codes, each with their own qualifying visit CPT codes
  - G0466 – FQHC visit, new patient
  - G0467 – FQHC visit, established patient
  - G0468 – FQHC visit, IPPE or Annual Wellness Visit
  - G0469 – FQHC visit, mental health, new patient
  - G0470 – FQHC visit, mental health, established patient
- Reporting of same day visits

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Fee Schedule

- Does your fee schedule support your G code?
  - Is it or was it ever your usual and customary fees for your Medicare visits?
  - When is the last time you updated your fee schedule?
  - Can you substantiate your G code?
  - Is your G code too low and you are leaving reimbursement on the table?

Consider Additional Reimbursable Services

- Initial Preventive Physical Exam (IPPE)
  - Goal: (which includes an optional electrocardiogram (EKG)):
    - Health promotion & disease detection & includes education, counseling & referral to screening & preventive services also covered under Medicare Part B
  - Must be rendered within the first 12 months of enrollment
  - Patient coinsurance is waived

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Consider Additional Reimbursable Services

- Annual Wellness Visit (AWV)
  - Benefit allows for an initial AWV & subsequent wellness visits annually
  - Coinsurance is not applicable
  - Initial AWV must occur after the initial 12 months of Medicare eligibility
  - Subsequent AWV can take place 12 months after the initial AWV & so forth

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What is DSMT?

- "Educational and training services furnished…to an individual with diabetes by a certified provider…in an outpatient setting by an individual or entity who meets the quality standards…, but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition."

Diabetes Self Management Training (DSMT)

- Certified FQHCs may bill for DSMT services & are reimbursed on a per visit basis
  - Additional program requirements must be met:
    - Instructions in self-monitoring blood glucose
    - Education about diet & exercise
    - Insulin plan treatment developed
    - Motivation to use skills

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Medicare Advantage (MA) Plans in the PPS Environment

- We are not seeing PS&R form 778 payments of significance
- Money on the table
- Why?
  - Confusion on how to get enrolled
  - Confusion on setting up the payment
  - Intimidation on the negotiation process

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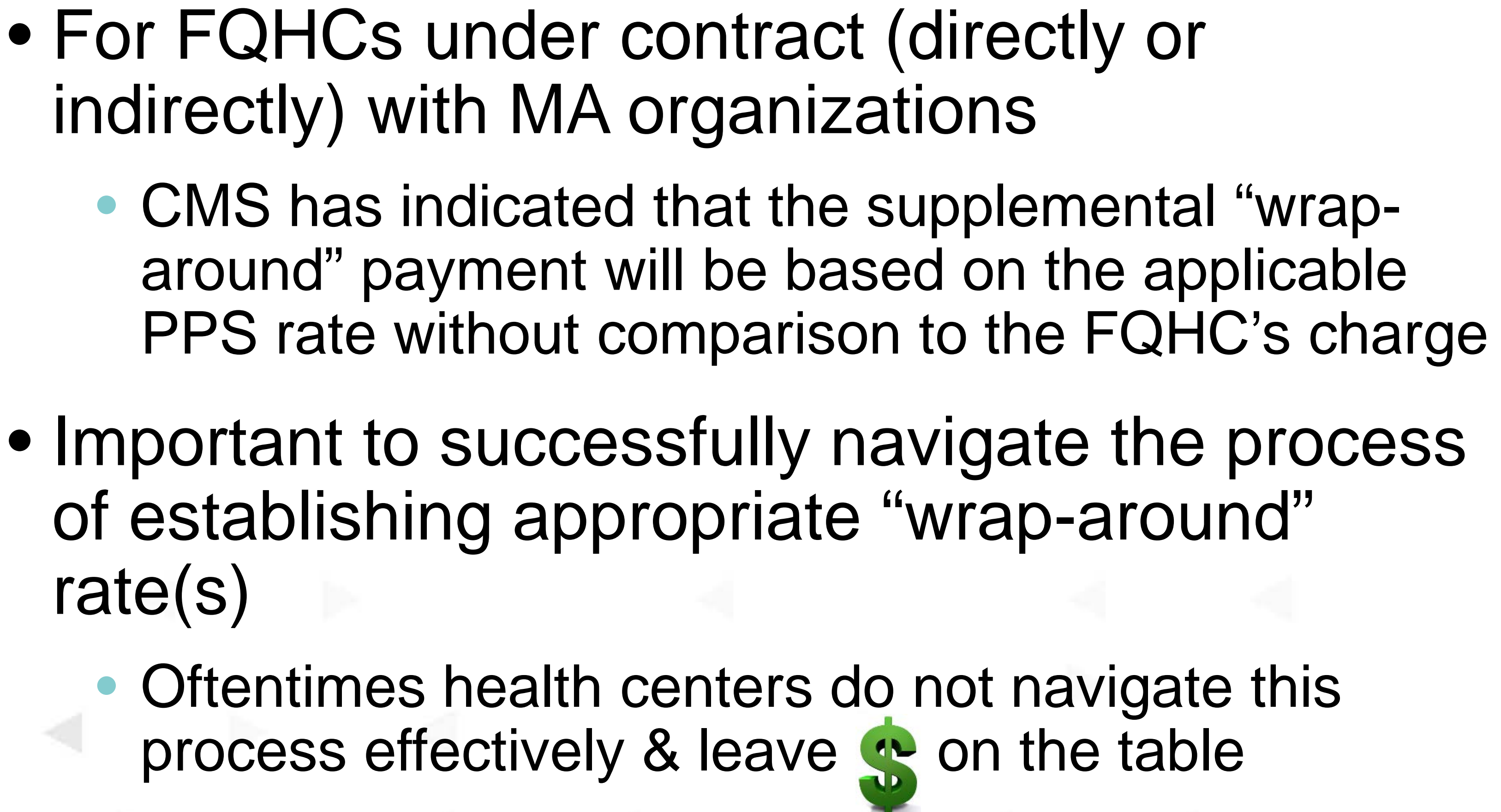
MA Plans in the PPS Environment

- MA Plan reminders
  - Coordinated Care plans (CCPs)
    - Primarily HMOs & PPOs
    - Provide care through established provider networks
  - Private Fee-for-Service (PFFS) plans
    - May or may not have an established provider network

MA Plans in the PPS Environment, Cont.



- For FQHCs under contract (directly or indirectly) with MA organizations
  - CMS has indicated that the supplemental "wrap-around" payment will be based on the applicable PPS rate without comparison to the FQHC's charge
- Important to successfully navigate the process of establishing appropriate "wrap-around" rate(s)
  - Oftentimes health centers do not navigate this process effectively & leave $ on the table

Additional Medicare Revenue Streams

- Medicare covered services outside of FQHC-core visit services
  - Services such as laboratory; technical component of diagnostic tests such as radiology and EKG; & the technical component of many preventive services (such as pap smears & prostate cancer screenings)
  - Reimbursement made on the basis of applicable Medicare fee schedules without regard to the health center's cost of providing such services (Medicare payment based on the lesser of actual charge or the Medicare fee schedule)

Medicare Bad Debts; CMS Final Rule – November 9, 2012

- Medicare bad debt reimbursement is reduced as follows:
  - CRPs beginning on or after October 1, 2012 – 88%
  - CRPs beginning on or after October 1, 2013 – 76%
  - **CRPs beginning on or after October 1, 2014 and subsequent – 65%**

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Medicare Bad Debts

- Reimbursable (“allowable”) Medicare bad debts must meet four basic criteria:
  - Must be related to covered services and derived from coinsurance amounts
  - Reasonable collection effort must be made by the FQHC
  - The debt was actually uncollectible when claimed as worthless
  - Sound business judgment established that there was no likelihood of recovery at any time in the future

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Medicare Bad Debts

- Reasonable collection effort requires that Medicare and non-Medicare patients be treated comparably
- Collection effort should include
  - Issuance of an initial and subsequent billings
  - Collections letters and telephone calls
  - Use of a collection agency (optional)
  - Totality of actions should demonstrate a genuine, rather than token, collection effort
- Important to follow collection policy and document efforts throughout period of collection effort

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Medicare Bad Debts

- If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible
  - Excerpt taken from CMS Publication 15-1 (Provider Reimbursement Manual), Section 310.2; "Presumption of Non-collectability"
- Any payments received re-starts the aforementioned 120 day time clock

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Medicare Bad Debts

- So, what is “in play” for FQHCs?
  - Amounts due solely from the patient
    - Amounts adjusted in accordance with the health center’s sliding fee scale policy are not eligible
    - Any remaining amount due should be eligible
  - Dual eligible bad debts
    - Medicare’s “must bill” policy
  - Supplemental insurance policy patient residual balances

Medicare Bad Debts

- CMS final rule dated 11/9/2012 **reduced** the amount of Medicare bad debts that are reimbursed
  - **Cost reporting periods beginning on or after October 1, 2014 and subsequent – 65%**

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Medicare Bad Debts

- Action items for management consideration
  - Check prior Medicare FQHC cost report to determine if Medicare bad debt reimbursement is reported on Worksheet C, Line 24 (Form CMS-222-92)
    - **Details must be reported on Worksheet S-2, Exhibit 1 of the new Medicare FQHC cost report (Form CMS-224-14)**
  - Review policy, procedure and process for documenting collection efforts and tracking/reporting of Medicare bad debts (and any subsequent recoveries)
  - Consider proactive discussion with MAC personnel if this is a “new” issue for the health center

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Medicaid PPS

- Federal law implementing a Prospective Payment System (PPS) for state Medicaid payments to RHCs/FQHCs effective January 1, 2001
  - Medicare, Medicaid & SCHIP Benefits Improvement and Protection Act (BIPA)

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Medicaid PPS

- BIPA legislation required (continued):
  - Permitted establishment of an alternative payment methodology (APM) as long as the APM resulted in Medicaid payment equal to (or greater than) the PPS methodology AND the APM was agreed to by affected organizations

Medicaid FQHC reimbursement

- Services and operating site must be in scope to be eligible for FQHC reimbursement
- If an FQHC has multiple sites, then each site must be enrolled separately

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Key Thoughts

- Given the scope and complexity of the "puzzle pieces", consideration of a health center "champion" to shepherd third-party reimbursement processes is important
- Good idea to perform a "self-assessment" of current Medicare & Medicaid FQHC reimbursement issues for your health center

Key Thoughts

- Health center personnel must understand & manage Medicare & Medicaid FQHC reimbursement & other third-party payer processes proactively to have good outcomes
- Remember – only you look out for you (each health center must consider its individual facts & circumstances to successfully navigate FQHC & other reimbursement issues/opportunities)

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The Medicare FQHC Cost Report – An Overview of the Form

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Medicare Cost Report Consolidation

- If multiple FQHCs are owned, leased or through any other device controlled by one organization, an election may be made to file a consolidated Medicare FQHC cost report
- The election must be made **in advance** of the cost reporting period for which the consolidated cost report is to be used
  - New organizations with multiple Medicare FQHC enrolled sites?
- Once the consolidation option is elected, reversion to site specific reporting is not permitted without the prior written approval of the Medicare contractor

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Low Medicare Utilization Cost Report

- The intermediary/MAC may authorize less than a full cost report where a provider has had a low utilization of covered services by Medicare beneficiaries in a cost reporting period
- The threshold to file less than a full Medicare cost report is at the discretion of the intermediary/MAC
  - NGS - $50,000; and, submission of a “waiver of electronic filing” form in advance of submission of a “low utilization cost report”
  - Noridian - $25,000; no pre-approval requirement at present

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Medicare Credit Balance Report

- FQHCs are required to file a Medicare credit balance report (CMS Form 838) on a quarterly basis (calendar year quarters) – even if no credit balances exist
- Submission of the report must be made within 30 days following the end of the calendar quarter (January 30th, April 30th, July 30th & October 30th)
- Failure to submit will result in a 100% suspension of Medicare payments
- Establish a tickler list and make sure this report is timely filed

BPHC Scope of Project Considerations

- Important to remember that the FQHC reimbursement benefit is applicable to a health center location that is part of the BPHC approved scope of project and that is certified to participate in the Medicare program as a FQHC
- When considering site modifications (additions, moves, etc.), it is important to deal with the BPHC change in scope of project matters proactively
- Failure to navigate this process correctly can have significant negative financial consequences for a health center organization

Form CMS-224-14 – Worksheet Series "S"

- S (FQHC certification and settlement summary)
- S-1 (FQHC identification data)
  - Single site versus consolidated cost reports
- S-2 (FQHC reimbursement questionnaire)
- S-3 (FQHC statistical and other data)
  - Visit detail
  - Information to inform development of FQHC market basket

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Worksheet S-2

- Worksheet collects information previously reported on the Provider Cost Report Reimbursement Questionnaire (Form CMS-339)
  - Provider Organization and Operations
  - Financial Data and Reports
  - Approved Educational Activities
  - **Bad Debts** (see later slides for additional discussion)
    - **Requires completion of Exhibit 1**
  - PS&R Report Data
    - **Please note the requirement to submit a crosswalk to match PS&R revenue codes and visits with cost center groupings – CMS notes this is necessary to ensure proper payments**
  - Cost Report Preparer Contact Information

Worksheet S-3

- Part II includes information identifying contract labor **and** benefit costs relating to **direct patient care services**
  - 14 specified personnel reporting categories, as applicable
  - DO NOT include non-labor costs
- Part III includes information identifying data related to the human resources of the FQHC for the aforementioned 14 specified personnel reporting categories
  - FTE employees (those receiving a Form W-2)
  - FTE contacted and consultant staff
  - FTE = paid hours divided by 2,080
    - See instructions for certain paid hours to be excluded

Form CMS-224-14 – Worksheet Series "A"

- A (Reclassification and adjustment of trial balance of expenses)
- A-1 (Reclassifications)
- A-2 (Adjustments to expenses)
- A-2-1 (Related party costs)

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Worksheet A

- Columns 1, 2, and 3 of Worksheet A report:
  - Salaries costs
  - Other costs
  - Total costs
- Total costs included in column 3 should reconcile with the audited financial statements
  - Is general ledger detail sufficient for accurate completion of Worksheet A (beyond column 3)?

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Trial Balance of Expenses

- Worksheet A includes reporting of costs **differently** than previously reported on the original Medicare FQHC cost report (Form CMS-222-92)
- Primary cost "bucket" categories as follows:
  - General Service Cost Centers
  - Direct Care Cost Centers (reported by personnel category)
  - Reimbursable Pass Through Costs
  - Other FQHC Services
  - Non-reimbursable Cost Centers

General Service Cost Centers

- Instructions define these cost centers to:

"include expenses incurred in operating the FQHC as a whole that are not directly associated with furnishing patient care"

- Includes certain costs that were previously reported as direct patient care costs or costs other than FQHC on Form CMS-222-92

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General Service Cost Centers

- **“Administrative overhead”** cost centers include:
  - Capital related costs
    - Buildings and fixtures
    - Moveable equipment
  - Employee benefits
  - Administrative & general services
  - Plant operations & maintenance
  - Janitorial
  - Medical records

General Service Cost Centers

- Instructions include detail of CMS cost center reporting expectations – a few highlights include:
  - **Pharmacy** – there are additional cost centers discussed later for **“retail pharmacy”** and **“drugs charged to patients”**
    - Excludes the cost of influenza and pneumococcal vaccines (see later slide for reporting of such vaccine costs)
    - Instructions (page 44-29, Line 61) indicate that venipuncture supplies costs are included in the pharmacy cost center
      - Medicare FQHC PPS final rule clarified that venipuncture services are included in the FQHC’s PPS per-diem payment
    - **Medicare Benefit Policy Manual, Chapter 13** - references drugs and biologicals that **are not usually self-administered** as “incident to” services and supplies; in addition, references inclusion in the FQHC’s PPS per-diem payment (see following slide)

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General Service Cost Centers

- Instructions include detail of CMS cost center reporting expectations – a few highlights include:
  - **Pharmacy**
    - This cost center “includes only the costs of routine drugs, pharmacy supplies, pharmacy personnel and pharmacy services provided “incident to” an FQHC visit”
    - Drugs and pharmacy supplies traced to individual patients that are paid separately under Part B, C or D of Medicare must be included on line 67 **(drugs charged to patients)**

Direct Care Cost Centers

“**Direct care cost centers**” include costs delineated for health care service personnel categories:

- Physicians
- Physician services under agreement
- Physician assistant
- Nurse practitioner
- Visiting RN
- Visiting LPN
- Certified nurse midwife

Direct Care Cost Centers

"Direct care cost centers" include costs delineated for health care service personnel categories

- Clinical psychologist
- Clinical social worker
- Laboratory technician
- Registered dietician/Certified DSMT/MNT Educator
- Physical therapist
- Occupational therapist
- Other allied health personnel

Other FQHC Services

“Other FQHC services” include costs delineated for the following cost categories:

- **Drugs charged to patients**
  - Instructions state that this cost center will include “costs associated with pharmacy services paid separately (outside the FQHC PPS national encounter rate) under Medicare Parts B, C and D”
- **Chronic care management**
  - CCM payments are outside of (in addition to) PPS payments received
- Other (Specify) – Line 69

Reclassifications of Expenses

- Common examples
  - Fringe benefits
  - Depreciation
  - Insurance

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Reclassifications of Expenses

- Common examples
  - Inpatient hospital costs
  - Medical director costs
  - Other

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Worksheet A-2

- Types of items reported include:
  - Adjustment (removal) of non-allowable costs from the cost report
  - Adjustment for revenues that constitute a recovery of costs through sales, charges, fees, etc.
  - Adjustment of expenses in accordance with the principles of Medicare reimbursement

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Adjustments to Expenses

- Examples – cost matters
  - Promotional advertising
  - Contract laboratory
  - Pharmacy cost of goods sold?
  - Donated services (generally)

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Adjustments to Expenses

- Examples – cost matters
  - Indigent care/specialty referral expenses
  - Related party costs (see later slides)
  - Bad debt expense if reported on Worksheet A, column 2
  - RCE adjustment to teaching physicians' cost

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Form CMS-224-14 – Worksheet Series "B"

- B, Part I (Calculation of FQHC cost per visit)
- B, Part II (Calculation of allowable direct GME)
- B-1 (Calculation of vaccine cost)
  - Pneumococcal and influenza vaccines

Worksheet B

- As discussed earlier at Worksheet A (direct care cost centers), in response to public comment, CMS is seeking to obtain a:
- “more accurate account of the costs associated
- with the type of visits that are covered in
- an FQHC and the actual cost of such visits
- attributable to Medicare beneficiaries”
- CMS also notes that:
- “the types of practitioners included in
- Worksheet B, Part 1, are all permitted to provide and
- bill for a visit to a beneficiary in an FQHC …”

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Walkthrough of Worksheet B

- Worksheet is divided into two parts:
  - Part I – Calculation of FQHC cost per visit
    - CMS-222-92 (old form) – single calculation on Worksheet C, Part I
    - CMS 224-14 (new form) – **Thirteen calculations on Worksheet B, Part I**
      - **By “position” – ten calculations**
      - **Total (aggregate) – one calculation**
      - **Medicare (medical and mental health) – two calculations**
  - Part II – Calculation of allowable direct GME costs

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Walkthrough of Worksheet B-1

- Provides for the calculation of the cost (vaccine cost, administration cost and allocable administrative overhead cost) of pneumococcal and influenza vaccines provided to Medicare beneficiaries – **such cost is 100% reimbursable by Medicare**
- Requires maintenance of vaccine logs
  - Total injections given
  - Medicare injections given

Form CMS-224-14 – Worksheet Series "E"

- E (Calculation of reimbursement settlement)
- E-1 (Analysis of payments to the FQHC)

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Form CMS-224-14 – Worksheet Series “F”

- F-1 (Statement of revenue and expenses)

Medicare Reasonable Cost Principles – Reminders for Consideration

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Quick Recap of Authoritative Guidance

- 42 CFR (Code of Federal Regulations) Part 413 – Medicare Reasonable Cost Principles
- CMS Publication 15 – Provider Reimbursement Manual
- CMS Publication 100-02 – Medicare Benefit Policy Manual, Chapter 13
- CMS Publication 100-04 – Medicare Claims Processing Manual, Chapter 9

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Reimbursement Principles

- Application of Medicare Reasonable Cost Principles:
  - Documented in 42 CFR part 413
  - Underlying principle
    - Reasonable costs are those costs that are necessary and related to the care of covered beneficiaries

Application of Medicare Reasonable Cost Principles

- Medicare Provider Reimbursement Manual (CMS publication 15)
  - Provides guidelines & policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services
  - Includes application of the prudent buyer principle as a means to investigate situations where costs seem excessive

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Application of Medicare Reasonable Cost Principles

- Prudent buyer principle:
  - A prudent & cost conscious buyer seeks to minimize cost
  - Amounts paid for costs incurred must be commercially reasonable
  - Provides intermediary discretion to exclude potentially excess cost (documentation is the key)

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Final Thoughts

- The Medicare program represents an important payer for health centers
- Success requires ongoing performance evaluation & implementation of necessary changes/adjustments
  - Health center internal "champions" can be helpful
- Maintaining & growing the Medicare "book of business" is a good goal
  - Traditional Medicare patients
  - Medicare managed care plan enrollees

Questions?

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Thank You!