MEDICARE AND MEDICAID REIMBURSEMENT UPDATE
TODAY’S AGENDA

- Introductory comments
- Medicare FQHC Prospective Payment System (PPS) issues
  - Implementation overview/reminders
  - Primary focus areas/experience to date
- Medicaid FQHC PPS update
- Final thoughts
INTRODUCTION
In order to remain *financially viable*, health centers must accurately and timely capture available revenues from services provided to Medicaid, Medicare and other third-party payer beneficiaries.
Based on a July 2014 publication by the Congressional Budget Office (CBO), projected Medicare program enrollment statistics include the following:

- The number of people age 65 or older will:
  - Increase by one-third over the next ten years
  - Increase by 80% by 2039
  - Represent 21% of the total population by 2039

Reasons for the above include:

- Baby boomer generation retirements
- Longer life spans
MEDICARE AS A “BOOK OF BUSINESS”

- The Medicare program, while small as a percentage of overall health center patient related revenues, is an important third-party payer of services
  - Generally the *second best third-party* payer after state Medicaid
MEDICARE AS A “BOOK OF BUSINESS”

- Given Medicare program growth projections, should consideration be given to the development of an organization strategy for Medicare patients?

- **Goal** for community health centers
  - Maintain and/or grow the percentage of Medicare beneficiaries served
    - Traditional Medicare patients
    - Medicare Advantage Plan enrollees
MEDICARE FQHC PPS IMPLEMENTATION OVERVIEW/REMINDERS
MEDICARE PPS – WHEN DOES THIS CHANGE HAPPEN?

➢ Health care reform legislation mandates a transition from the current Medicare FQHC cost-based reimbursement system effective for cost reporting periods beginning on or after October 1, 2014
MEDICARE PPS – THE HEADLINE ISSUES

- The Affordable Care Act mandated that the initial PPS rates be set based on 100% of the estimated amount of reasonable costs if the PPS had not been implemented (the 100% must be calculated before application of copayments, per visit limits, or productivity adjustments)
  - Final data set includes cost report periods ended June 30, 2011 through June 30, 2013

- Impact analysis indicates an increase in total Medicare payments to FQHCs of approximately 32% (31.9%)
  - Does not take into account the “lesser of” provision
MEDICARE PPS – THERE’S WORK TO DO

Final rule notes that if an assumption is made that FQHCs’ charge structures remain the same, approximately **65%** of FQHCs would be paid **LESS** under the FQHC PPS rate methodology than they are currently paid.

- Establishment of health center unique G-code *bundled* charges is an *art rather than a science*.
OVERVIEW OF FINAL RULE

- Final rule includes a MEI-adjusted base payment rate of $158.85
  - Initial update to PPS payment rates will be effective January 1, 2016
  - Includes concept of a geographic adjustment factor based on the locality of the delivery site
  - Establishes two geographically adjusted PPS rates per period for each delivery site (see next slide)
OVERVIEW OF FINAL RULE

- PPS rates are established for
  - Patient that is **not new** to the FQHC **and** is not receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV)
  - Patient that **is new** to the FQHC **or** service furnished is an IPPE, initial AWV or subsequent AWV (PPS rate will reflect the 34.16% increase in costs accounting for the greater intensity and resource use associated with these types of visits)
  - PPS rates are established for each delivery site
OVERVIEW OF FINAL RULE

- Establishes a new set of HCPCS G-codes (five payment codes) for FQHCs to report services – for purposes of parity when comparing PPS rates with health center charges (the “lesser of” provision)
  - Established Medicare patient (medical and mental health)
    - G0467 and G0470
  - A new patient visit (medical and mental health)
    - G0466 and G0469
  - An IPPE or AWV
    - G0468
OVERVIEW OF FINAL RULE

➢ The “lesser of” provision:
  ▪ Medicare payment will be 80% of the lesser of the actual charge reported for the specific payment code or the PPS rate (for each claim)
  ▪ Beneficiary coinsurance will be 20% of the lesser of the actual charge reported for the specific payment code or the PPS rate (for each claim)

➢ Detailed HCPCS coding with the associated line item charges will continue to be required
OVERVIEW OF FINAL RULE

- Commentary provided regarding the setting of charges for the new Medicare G-codes references Medicare reimbursement principle of *uniformity of charges*

- Medicare will continue to pay 100% for preventive services (there will be no beneficiary coinsurance requirement)
OVERVIEW OF FINAL RULE

- Annual Medicare FQHC cost report is still required
  - Reasonable costs of the following services will continue to be determined and paid through the Medicare FQHC cost report
    - Influenza and pneumococcal vaccines and their administration
    - Allowable graduate medical education costs
    - Bad debts
  - CMS notes that cost report information will be used to update cost estimates and to facilitate the potential development of a FQHC market basket (for update to PPS payment rates that will be effective January 1, 2017)
OVERVIEW OF FINAL RULE

➢ Provides for “wrap-around” payments from Medicare Advantage (MA) organizations, where the FQHC has a written contract with the MA organization

► Without application of the “lesser of” provision
MEDICARE PPS – ONGOING MYTHS

- Implementation of the new PPS will not require much time and preparation
- Health centers will always be paid at the applicable PPS rate
- The Medicare FQHC cost report will no longer have significance
MEDICARE FQHC PPS – PRIMARY FOCUS AREAS
**FINANCIAL IMPACT “REALITY” – A GOOD PLACE TO START**

- **Assumptions** for discussion/illustration
  - Cost per visit (excluding caps and screens) = $125.00
  - Current Medicare reimbursement based on cost limit = $112.00
  - Medicare average charge per visit = $102.00
  - Assumed PPS rate of $160.00

- In order to be **revenue neutral** for the visits “bucket”, the health center’s average charge will need to **increase** by approximately 8%

- **Full recognition** of PPS reimbursement will not occur unless the health center’s average charge is **increased** to $160.00 (a 57% charge increase in this example)
Establishment of charges for HCPCS G codes requires thought & analysis

- Final rule indicates that a charge for a specific payment code would reflect the *sum of regular rates* charged to both beneficiaries (Medicare) and other paying patients for a *typical bundle* of services that would be furnished per diem to a Medicare beneficiary.
CHARGE ESTABLISHMENT METHODOLOGY

- Final rule includes references to charge setting requirements in section 330(k)(3)(G) of the Public Health Services Act and HRSA guidance
  - Related to the costs of operation
  - Consideration of local prevailing rates
  - See also Section V (Fee Schedule) of PIN 2014-02 dated September 22, 2014
DEFINING THE “TYPICAL BUNDLE” OF SERVICES

- Defining and documenting the health center’s “typical bundle” of services per Medicare G code is a mission-critical process
  - Underpins the determination of the appropriate G code charge
- Complete listing of the qualifying G code visit codes located at CMS FQHC PPS website:
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html
A COUPLE OF LESSONS LEARNED TO DATE

- It is unlikely that a health center’s historical charge structure and/or coding practice will support the establishment of Medicare G code charges at or above the applicable PPS rates
  - Most health centers do, however, anticipate improved financial performance versus the old all-inclusive rate payment methodology

- Coding practices are now in focus
  - Helpful to involve medical director in this process
MEDICAID FQHC PPS UPDATE
MEDICAID PPS HISTORY

- December 2000 – Congress required states to change payment methodology from retrospective to prospective payment system (PPS).
  - Average cost per visit for years 1999 and 2000
  - States could also develop an Alternative Payment Methodology (APM)

- Eliminated annual filing of Medicaid cost reports

- Provides an incentive for centers to become more efficient
  - Control costs
  - Increase productivity
MEDICAID PPS HISTORY

- Cost reports ARE required when
  - New site
  - New category of service (Method 1)
- Must contain 12 months beginning first day of first month after new site or new service has been added
- Due 90 days after the 12 month period has ended.
- Each site must obtain its own PPS rate
MEDICAID PPS HISTORY

➢ Newly Qualified FQHCs
   ▪ Start–up rate based on rates for other FQHCs in adjacent area similar in size, caseload, and scope of services or
   ▪ Statewide urban or rural 60th percentile
   ▪ Base rate cost report filing required
     o Allowable cost per visit subject to:
       • Administrative cost ceiling
       • Test of Reasonableness (visits)
       • Wage adjusted 60th percentile
MEDICAID PPS HISTORY

- Ohio FQHC PPS Services
  - Medical
  - Dental
  - Mental Health
  - Podiatry
  - Transportation
  - Vision
  - Speech and Hearing
  - Chiropractic
  - Physician Therapy
MEDICAID PPS HISTORY

PPS Rates Effective 10/1/14

- Urban
  - Medical - $128.93
  - Dental - $129.81
  - Mental Health - $140.50
  - Podiatry - $48.72
  - Chiropractic - $64.16
  - Vision - $85.29
  - Physical Therapy - $60.48
  - Speech Therapy - $67.03
  - Transportation - $19.79
MEDICAID PPS HISTORY

- PPS Rates Effective 10/1/14
  - Rural
    - Medical - $114.91
    - Dental - $137.50
    - Mental Health - $159.92
    - Podiatry - $65.38
    - Chiropractic - $75.83
    - Transportation - $19.79
MEDICAID PPS HISTORY

❯ Scope Changes

 Method one – adding a new category of service (common)
 Method two
  o Addition of a service mandated by a governmental entity
  o Addition of OB/GYN physician, nurse midwife or APRN
  o Addition of dentist to a site that only offered hygienist services

 The following are not scope changes:
  o Wage increases
  o Renovations or capital expenditures
  o Increase in staff
  o Increase in volume
  o Increase in office hours
MEDICAID PPS STRATEGY

- Compare current PPS rate to cost of providing services and identify gaps
- Increases in Medicaid volume due to expansion and expiration of Medicare/Medicaid parity (12/31/14)
- Scope change opportunities
FINAL THOUGHTS
FINAL THOUGHTS

- Proper planning and ongoing program evaluation should enhance a health center’s chance for a successful Medicare FQHC PPS experience.

- Successful implementation of Medicare FQHC PPS is not a “one and done” process – periodic reevaluation and adjustments will most likely be necessary.
DISCLAIMER

The information contained in this presentation is not intended to cover all situations or all rules & policies. Reimbursement laws, regulations & policies are subject to change.
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