Agenda

• Medicare cost report myths
• Common cost reporting errors
• Key data required for Medicare cost report
• Medicare Advantage matters
• Medicare PPS Update
Who would rather be here?
• Bureau of Primary Health Care (BPHC) Key Health Center Program Requirements includes expectation that health centers “maximize collections and reimbursement for costs”
  ▪ Policy Information Notice (PIN) # 98-23 included guidance noting “health centers must participate in favorable enhanced or cost-based reimbursement programs for which they are eligible”

• HRSA Program Assistance Letter 2011-04: “Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit”
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.

- See later slides
Cost Report “Myths”
Myth #1 – Medicare is immaterial to overall patient service revenue

- 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 payer after state Medicaid)
- Payer mix goal for community health centers
  - Maintain and/or grow the percentage of Medicare beneficiaries served
    - Traditional Medicare beneficiaries and Medicare managed care plan beneficiaries
Myth #2 – The cost report will go away once PPS is implemented

• There has been no indication from CMS to support this
• All other provider types that have transitioned to PPS are still required to file cost reports
  ▪ Hospitals (non-CAH)
  ▪ Skilled Nursing Facilities
  ▪ Home Health Agencies

• The cost report is a valuable data collection tool
  ▪ Future increases/decreases to PPS rates
  ▪ Medicare influenza/pneumonia vaccine cost
  ▪ Medicare bad debts
Myth #3 – “I’m Over the Cost Limits so it Doesn’t Matter How the Report is Prepared”

- MACs have increased the level of audit scrutiny
  - Significant adjustments to physician compensation
  - MGMA benchmarks
- Providers have a responsibility to capture all allowable costs
  - Certification statement
  - Cost reports used to analyze proposed PPS amount
- Cost reports can be a useful tool for internal analysis
Myth #4 – “I received a Final settlement – I Guess We Have no Options”

- Review Audit Adjustments as Soon as Received
  - MACs typically only allow 10-15 days to respond
  - Run proposed adjustments through the cost report
  - Medicare auditors are human and make errors

- Reply in writing any disagreements with adjustments
  - Request phone call to discuss
  - Much easier to get adjustments resolved prior to settlement

- Consider appeals process for any unresolved issues
  - Appeal instructions included with NPR letter
Common Cost Report Errors
CR Error #1—Worksheet S—Listing of Facilities

- Consolidated cost reports can be filed for multiple cost report provider-numbers
  - Request permission from MAC when adding new providers
  - Make sure Urban or Rural Designation is correct as it will affect cost limits on Worksheet C

- Certification date should match letter from CMS
  - Providers certified during cost report year should only include activity (expenses, visits, etc) from certification date to end of year
    - Example – Medicare certification date of February 15 and cost reporting year end December 31 should only include activity from February 15 through December 31
CR Error #2 – Worksheet A Grouping of Trial Balance Expenses

Health Care Costs (core)
- Physician
- Phys Asst
- Nurse Pract
- Other nurses
- Clinical Psych
- LCSW
- Medical Supplies
- Deprec Med Equip
- Maint Med Equip

Overhead
- Rent
- Property ins
- Utilities
- Deprec Building & Equip
- Maintenance
- Housekeeping
- Property taxes
- Office salaries
- Legal
- Accounting
- Benefits
- Medical Records

Non FQHC and NRCC
- Pharmacy
- Dental
- Optometry
- Lab/Radiology
- Phys Therapy
- Non-FQHC Phys Time
- 340b Program*
- WIC
- Other non-FQHC activities

Cost per Visit
Allocated based on Cost

- Salaries
- Non-clinical compensation of providers
  - Medical director
  - Hospital
- Equipment Depreciation
- Employee benefits
- 340b drugs
- Rental income
- Related party expenses
  - Physician owns property, etc
CR Error #4 – Worksheet B – Reporting FTEs and Visits

• **FTE**
  - Exclude non-productive hours
    - Vacation, holiday, sick CME
  - Exclude non-FQHC time
    - Hospital
    - Medical director

• **Visits**
  - Only include face-to-face medical encounters
    - Exclude vaccines, lab tests, etc
  - Include nursing home, SNF, swing bed, and patient home visits
  - Exclude hospital visits
CR Error #5 – Worksheet B-1 – Pneumococcal and Influenza Vaccine Cost

- **Ratio of Vaccine Staff Time to Total Staff**
  - Based on average of 5 minutes per vaccine (could vary with MAC)
  - Includes all clinical staff (including nurses)

- **Medical Supplies Cost**
  - Cost per vaccine X total vaccines
    - Provide invoices for support

- **Total and Medicare Vaccines**
  - Maintain vaccine logs
  - Do not include Medicare MCO in Medicare totals
### Pneumococcal Cost Example – Worksheet B-1

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine Time per Vaccine</td>
<td>5.00</td>
</tr>
<tr>
<td>Total Number of Injections</td>
<td>436</td>
</tr>
<tr>
<td>Vaccine Staff Time</td>
<td>2,180</td>
</tr>
<tr>
<td>Total Health Care Staff Time (Hours)</td>
<td>223,778.66</td>
</tr>
<tr>
<td>Total Health Care Staff Time (Mins)</td>
<td>13,426,719.60</td>
</tr>
<tr>
<td>Ratio of Vaccine:Total HC Time</td>
<td>0.000162</td>
</tr>
<tr>
<td>Cost per Vaccine</td>
<td>$ 55.01</td>
</tr>
<tr>
<td>Total Number of Injections</td>
<td>436</td>
</tr>
<tr>
<td>Vaccine Cost</td>
<td>23,984</td>
</tr>
<tr>
<td>Medicare Injections</td>
<td>78</td>
</tr>
</tbody>
</table>

- Line 2: Vaccine Time per Vaccine (5.00) and Total Number of Injections (436)
- Line 4: Vaccine Staff Time (2,180)
- Line 11: Cost per Vaccine ($ 55.01) and Total Number of Injections (436)
- Line 13: Medicare Injections (78)
CR Error #6 – Worksheet C – Proper Reporting of Medicare Visits/Charges

• Medicare Visits Excluding Mental Health – Line 11
  ▪ Should include medical visits (report type 710) AND preventive visits (report type 71S/77S)

• Medicare Mental Health Visits – Line 13
  ▪ Mental health treatment limitation
    • 1/1/13 – 12/31/13 = 81.25 percent
    • 1/1/14 – 100 percent

• Total Medicare charges – Line 18.01
  ▪ Includes preventive charges

• Total preventive charges – Line 18.02
CR Error #6 – Worksheet C – Proper Reporting of Medicare Visits/Charges

- Total Medicare Preventive Cost – Line 18.03
  - 100 percent of cost
- Total Medicare Non-Preventive Cost – Line 18.04
  - 80 percent of cost
- Medicare Bad Debts – Line 24
  - Bad debt logs are required
  - Must pursue reasonable collection effort for non-crossover/charity
  - Bad debts reimbursement 88% effective CRPs beginning 10/1/12, 76% effective CRPs 10/1/13 and 65% effective CRPs 10/1/14
Key Data Required for Medicare Cost Report
Key Data for Medicare Cost Report

• Names, addresses, hours of operation, and Medicare certification letters for all sites
• Electronic trial balance
  ▪ Should include all audit adjustments
• Payroll summary that includes name, job title, salary and hours by pay code
• Fixed asset listing
• Explanations of any miscellaneous income
• Total Visits by provider and payer
Key Data for Medicare Cost Report

• Medicare PS&R Summary
  ▪ Run date >90 days
  ▪ Include preventive visits PS&R

• Copies of any Medicare rate adjustment letters
  ▪ Could include lump sum adjustments

• Influenza and pneumococcal vaccine logs
  ▪ Indicate Medicare Part A vaccines

• Invoices for vaccines purchased

• Must have the most current version of cost report software
Medicare Advantage Matters
Medicare Advantage

• Medicare Advantage Plan types
  ▪ Coordinated care plans (network plans)
  ▪ Private fee-for-service plans (generally are non-network plans with services provided by “deemed” providers)
  ▪ Medical savings account plans (non-network plans)

• Examples of coordinated care plans – HMO, PPO, POS, SNP
Medicare Advantage

• CMS Medicare Managed Care Directory can be obtained at the following CMS website

http://www.cms.hhs.gov/HealthPlansGenInfo/01_overview.asp
Medicare Advantage

• Issues of importance - coordinated care plans
  ▪ FQHCs can be a contracting or non-contracting provider - reimbursement issues are different
    • Contracting – total reimbursement at 100% of reasonable cost (subject to the per-visit limit); three parties to bill & collect from
    • Non-contracting – total reimbursement at 80% of reasonable costs plus 20% of actual charge less plan’s cost-sharing amount; two parties to bill & collect from
Medicare Advantage

• Issues of importance – private fee-for-service plans
  ▪ CMS has published an online “MA Payment Guide for Out-Of-Network Payments” applicable to both non-contracting providers of “network plans” & “deemed” providers
  ▪ What is happening in practice today?
Medicare Advantage

- The Medicare FQHC cost report form has not been revised by CMS to accommodate reporting of Medicare Advantage Plan activity
  - No current estimate of when the cost reporting form revisions will be completed
  - No current extensions to file – CMS is willing to exclude this activity from the cost report for now
Medicare Advantage

• Supplemental payments to FQHCs
  ▪ Required only if the FQHC is contracting with a Medicare Advantage Plan
  ▪ Applicable only to Medicare FQHC-core services
  ▪ Generally referred to as Medicare “wrap-around” payments
“Wrap-around” payment example

Assume the following set of facts:

- FQHC actual cost of $100 per visit (below the urban “cost cap” of $129 per visit)
- Medicare Advantage Plan estimated average payment of $70 per visit (including a beneficiary copayment of $20 per visit)

Based on the above, the interim “wrap-around” payment should be set at $30 per visit ($100 - $70)
Medicare Advantage

• What is the effect if the actual cost per visit is $135?
• Remember – the “wrap-around” payment is required to consider the beneficiary cost-sharing amount a FQHC could collect vs. the amount, if any, actually collected
Medicare Advantage

Given that the “wrap-around” payment is limited to Medicare FQHC-core services, a FQHC must analyze & evaluate “the rest of the story”

- Medicare non-FQHC services
- Medicare non-covered services
- Medicare Advantage Plan incentive payments
Medicare FQHC PPS Reimbursement
Medicare FQHC PPS Reimbursement

- Medicare FQHC cost report reimbursement can be divided into three “buckets” – reimbursement for visits, vaccine administration costs, and bad debts.
- The PPS reimbursement system impacts two of the three “buckets” – reimbursement for visits and (potentially) for bad debts.
- “One Size Fits All” Methodology
- PPS amount is for all services in a particular day
  - Medical vs. behavioral health (health home)?
Medicare FQHC PPS Reimbursement

- National Medicare FQHC PPS rate of $155.90 per beneficiary per day
  - Adjusted for geographic differences
  - 1.33X higher for new Medicare patient or an initial visit
- Patient coinsurance based on 20% of the lesser of PPS payment or actual covered charges
- Medicare reimbursement based on 80% of the lesser of PPS payment or actual covered charges
Medicare FQHC PPS Reimbursement – A Simplistic Example

• Assume example health center is located in Ohio (listing of geographic adjustment factors identifies Ohio = 0.959)

• Daily PPS rate for established patients would then be $155.90 \times 0.959 = $149.51
  ▪ What if the health center’s daily charge = $110.00? 
  ▪ What if the health center’s daily charge = $175.00? 
  ▪ How is Medicare payment and patient coinsurance calculated?
Medicare FQHC PPS Reimbursement

• Proposed rule issued September 23, 2013
  ▪ PPACA § 10501

• CMS open door forum call was held on Monday November 4, 2013
  ▪ Corinne Axelrod of CMS was the call leader
  ▪ Many examples shared – statement was made that call would be archived for future reference (may be a good homework assignment for health center management)
  ▪ Unequivocal confirmation of Medicare payment in the new PPS being based on the *lesser* of the applicable PPS rate or actual covered charges
Preparing for the Medicare PPS

• Presumably health center management seeks a “revenue neutral” or better outcome

• While the proposed rule cites an overall impact of +30.2% for “All FQHCs”, the “devil is in the details” and must be analyzed by health centers individually
  ▪ Application of the lesser of PPS payment or actual covered charges is potentially very negative for health centers

• NACHC and many state PCAs have drafted a comment letter requesting the proposed rule be withdrawn
Preparing for the Medicare PPS

• Steps for consideration
  ▪ Compute the health center’s cost per visit without application of the reimbursement screens and limits currently applied
  ▪ Compute the health center’s average Medicare charge per visit (remember the information reported on Worksheet C)
  ▪ Determine any reimbursement “gap” that may occur (see following example)
    • Problem if health center’s ratio of cost to charges exceeds 1.00
Preparing for the Medicare PPS

• Assumptions for discussion/illustration
  - Recalculated cost per visit = $125.00
  - Current Medicare payment based on cost limit = $111.00
  - Medicare average charge per visit = $102.00
  - Assumed PPS rate of $149.51 (from the earlier example)

• In order to be revenue neutral for the visits “bucket”, the health center’s average charge will need to increase by approximately 7%
  - Coding assessment opportunities
  - Charge structure and capture opportunities

• Full recognition of PPS reimbursement will not occur unless the health center’s average charge per visit is increased to $149.51 (a 47% charge increase in this example)
Conclusion

• Health center personnel must understand and manage the Medicare FQHC reimbursement process proactively to have good outcomes.

• Remember – only you look out for you (each health center must consider its individual facts and circumstances to successfully navigate Medicare FQHC reimbursement issues/opportunities).
And on the Bright Side...

- 9 Days Until First Day of Spring
- 20 Days Until Reds Home Opener
- 17 Days Until My Vacation
- Have a wonderful Spring and Summer!
Thank You!

Comments and Questions

ggrigsby@bkd.com

BKD, LLP

502.581.0435