Ohio Association of Community Health Centers

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Achieving the Next Level for Your CHC

Preparing Federally Qualified Health Center (FQHC) Cost Reports

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Presentation Prelude

✓ In order to remain financially viable, health centers must accurately and timely capture available revenues from services provided to Medicare and Medicaid beneficiaries.

✓ Issues of importance include provider enrollment, FQHC rate-setting AND ongoing rate management, FQHC cost reporting, managed care and other FQHC reconciliation, billing, management of relationships with third-party intermediaries, etc.
Presentation Prelude

✓ Health care reform will result in many new opportunities and challenges for health centers – need health center “champions” to shepherd third-party reimbursement processes

✓ Good idea to perform a “self-assessment” of current Medicare and Medicaid FQHC reimbursement issues for your health center
Today’s Agenda

- Introduction – Why focus on Medicare?
- Understanding the Medicare FQHC cost report
- Top 10 Medicare FQHC cost reporting mistakes
- Medicare FQHC reimbursement potpourri
Today’s Agenda

- Health care reform issues affecting Medicare reimbursement for health centers
- Final thoughts
Introduction – Why Focus on Medicare?
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
Reimbursement Issues – Medicare Parts A & B

- Medicare FQHC cost-based reimbursement is applicable to FQHC-core services only
  - Medicare FQHC reimbursement is based on a per-visit rate subject to an upper payment limit (the “cost cap”)
    - 2012 rural limit - $109.90
    - 2012 urban limit - $126.98
  - Services provided by core service providers are billed to National Government Services - the national Medicare FQHC intermediary (a Medicare Part A intermediary) or the appropriate Medicare Administrative Contractor
Reimbursement Issues – Medicare Parts A & B

- Medicare covered services outside of FQHC-core services
  - Services such as laboratory, radiology, EKG, etc.
  - Reimbursement made on the basis of applicable Medicare fee schedules without regard to the health center’s cost of providing such services
Reimbursement Issues – Medicare Parts A & B

- Medicare covered services outside of FQHC-core services (continued)
  - Services are billed to the appropriate MAC
  - Important to compare health center charges for covered services to the Medicare fee schedule amounts (charges should generally be set at or above the approved fee schedule amounts – annual review necessary)
Reimbursement Issues – Medicare Parts A & B

- Many services not eligible for reimbursement under Medicare Parts A & B
  - Services such as dental, prescription drugs, etc.

- Medicare beneficiary out-of-pocket cost limited to Medicare FQHC coinsurance amount for Medicare FQHC-core services (20% of Medicare covered charges)
Reimbursement Issues – Medicare Parts A & B

- Medicare reimbursement for FQHC-core services ultimately determined through submission of Medicare FQHC cost report

  - Reconciliation of interim payments for FQHC-core services with actual health center Medicare reimbursable costs (reimbursement based on the lesser of actual cost or the aforementioned Medicare “cost cap”)

- No reconciliation process for services reimbursed based on a Medicare fee schedule
Common Myths of Medicare FQHC Cost Reporting & Reimbursement

- I followed the prior year cost report - it must be right
- The cost report can’t be complex – it’s a very thin document
- I’m over the cost limits - it really doesn’t matter how the cost report is prepared
- There is no need to challenge intermediary proposed adjustments if the final settlement is not significantly changed
- I received a final settlement - I guess we have no options
Understanding the Medicare FQHC Cost Report
Keys to preparing an accurate Medicare FQHC cost report include:

- Understanding the purposes of the Medicare FQHC cost report
- Understanding Medicare reasonable cost principles
- Maintenance of adequate tracking systems within the health center’s financial reporting and practice management systems for proper data accumulation
- Other
Reimbursement Principles

- Application of Medicare Reasonable Cost Principles
  - Documented in 42 CFR part 413
  - Underlying principle
    - Payments based on reasonable costs must be related to the care of covered beneficiaries
    - Reasonable costs includes all necessary & proper costs incurred in furnishing services subject to principles related to specific items of revenue & cost
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
Purpose of the Medicare Cost Report

- Determination of reimbursable (Medicare allowable) cost per visit
  - Costs (Worksheet A lines noted)
    - Direct reimbursable costs (lines 1 – 11, 13 – 15, and 17 - 23)
    - Direct nonreimbursable costs, including costs other than FQHC (lines 51 – 56 and 58 - 60)
    - Overhead costs
      - Facility costs (lines 26 – 36)
      - Administrative costs (lines 38 – 48)
  - Visits
Purpose of the Medicare Cost Report

- Determination of Medicare program liability
  - Computed Medicare reimbursement less interim Medicare payments
- Represents formal claim of reimbursement for FQHC services provided to Medicare beneficiaries during a cost reporting period
  - Generally filed on a consolidated basis (versus a site by site basis)
Example for Discussion

- Assumptions
  - Medicare allowed costs - $4,000,000
  - Total visits (as defined by Medicare) – 40,000
  - Computed cost per visit of $100 is less than the cost limit
  - What if visits were 25,000 and the computed cost per visit was $160?
Worksheet S

- Facility location information
  - Urban versus rural designation important
- Medicare provider number information
  - Multiple sites require individual reporting
- Source of federal funds (if applicable)
- Other information
Worksheet A
Trial Balance of Expenses

- Facility health care staff costs (lines 1 – 11)
  - Provider salaries
  - Nurse salaries
  - Other health care staff salaries
    - Clinical psychologist
    - Clinical social worker
    - Other
Trial Balance of Expenses

- Costs under agreement (lines 13 – 15)
  - Contract physician services
- Other health care costs (lines 17 – 23)
  - Medical supplies
  - Depreciation - medical equipment
  - Malpractice insurance
  - Continuing medical education
  - Other
Trial Balance of Expenses

- Facility overhead - facility costs (lines 26 – 36)
  - Rent
  - Depreciation on buildings & fixed equipment
  - Building insurance
  - Interest on mortgage
  - Utilities
  - Housekeeping and maintenance
  - Minor equipment
  - Other
Trial Balance of Expenses

- Facility overhead - administrative costs (lines 38 – 48)
  - Office salaries
  - Office supplies
  - Legal & accounting
  - Depreciation on office equipment
  - Fringe benefits
Trial Balance of Expenses

- Facility overhead - administrative costs (lines 38 – 48)
  - Telephone, postage & other related office expenses
  - Advertising costs
    - Yellow pages
    - Recruitment
    - Promotional
  - Other
Trial Balance of Expenses

- Cost other than FQHC services (lines 51 – 56)
  - Pharmacy
  - Dental
  - Laboratory
  - Optometry
  - Other
Trial Balance of Expenses

- Nonreimbursable costs (lines 58 – 60)
  - ✓ WIC
  - ✓ Non-FQHC approved activity
  - ✓ Other
Worksheet A-1
Reclassifications of Expenses

- **Purpose of worksheet**
  - Align expenses into the correct cost center

- **Common examples**
  - Fringe benefits
  - Depreciation
  - Insurance
  - Continuing medical education (CME)
Reclassifications of Expenses

- Common examples
  - Inpatient hospital costs
  - Medical director costs
Worksheet A-2
Adjustments to Expenses

- Purpose of worksheet
  - Adjust expenses as required under Medicare principles of reimbursement
  - Made on basis of cost (if available) or revenue received

- Common examples
  - Promotional advertising
  - Contract laboratory
Adjustments to Expenses

- Common examples
  - Offset of interest income to the extent of interest expense
  - Offset of miscellaneous income
  - Donated services (generally)
  - Indigent care/specialty referral expenses
Worksheet A-2-1
Related Organization Costs

- Eliminates profit of related organizations - adjusts to cost (generally)
- Related organization defined in Provider Reimbursement Manual - Part 1, Chapter 10
- Check Part 1 “No,” if worksheet does not apply
Worksheet B - Parts I & II
Worksheet B, Part I

- Visits & productivity
  - Column 1 - recap of full time equivalent (FTE) personnel (only the “billers” to the program)
    - FTE calculation
      - Calculated by dividing productive hours by 2080
Worksheet B, Part 1

- FTE calculation
  - Productive hours defined as total paid hours minus:
    - Vacation
    - Sick leave
    - CME
    - Non-FQHC covered services
    - Administrative duties
    - Other
Worksheet B, Part 1

- Column 2 - recap of total visits
  - Definition of a visit
  - Accurate visit count is essential
  - Visits exclude
    - Nurse visits
    - Visits related to non-FQHC covered services (dental, non-FQHC approved sites, etc.)
    - Other program visits (WIC, etc.)
Worksheet B, Part 1

- Columns 3 - 5 - productivity standard calculation
  - Physician - 4,200 visit productivity standard
  - Mid-level providers - 2,100 visit productivity standard
  - Productivity standard does not apply to services of clinical psychologists and social workers
  - Productivity standard does not apply to services under agreement (unless such providers are used routinely at the health center – recent CMS change)
  - Calculation is cumulative, not line-item specific
Example for Discussion

- Staffing assumption
  - Physician FTEs of 7.5 (x 4,200 visits = productivity standard of 31,500 visits)
  - Mid-level FTEs of 2.5 (x 2,100 visits = productivity standard of 5,250 visits)
  - Combined productivity standard of 36,750 visits (31,500 + 5,250)

- Denominator of cost per visit fraction is the greater of actual visits or 36,750
Worksheet B, Part II

- Determination of total allowable cost including the allocation of overhead
  - Overhead cost centers are allocated to FQHC services
Worksheet C –
“The Rest of the Story”
Worksheet C

- Worksheet C provides for the calculation of the Medicare cost report settlement amount
  - Paid and unpaid Medicare visits and related reimbursement (payment)
    - Use of PS&R summary
  - Medicare visits
    - Medical versus mental health
Determination of Medicare Reimbursement

- Determination of rate for FQHC services
  - Adjusted cost per visit
    - Total Allowable Cost
    - Total Adjusted Visits
  - Compare calculated total to maximum rate per visit (payment limit is calendar year specific)
    - 2012 rural limit - $109.90
    - 2012 urban limit - $126.98
  - Lesser of the two is allowed
Determination of Medicare Reimbursement

- Determination of Medicare program liability
  - Allowed rate per visit times Medicare visits equals Medicare allowed cost
  - Medicare reimbursement @ 80% of allowed cost
  - Add vaccine cost reimbursement and Medicare bad debt reimbursement
Example for Discussion

- Assumptions
  - Computed cost per visit of $100 (below the cost limits)
  - Medicare visits of 5,000
- Medicare reimbursable cost of $400,000
  \( (5,000 \times $100 \times 80\%) \)
- Less interim payments received during the year
- Add vaccine and reimbursable bad debts (if any)
Settlement Process

- The cost report settlement process involves:
  - Initial submission by the deadline (5 months following the end of a health center’s cost reporting period/fiscal year)
  - Acceptance of the cost report by the intermediary/MAC
  - Interim (tentative) settlement
  - Intermediary desk review or field audit
  - Preliminary proposed adjustment report & related communications
  - Final settlement through issuance of a Notice of Program Reimbursement (NPR)
Medicare FQHC Cost Reporting Mistakes – Top 10
Top Ten Mistakes in Medicare FQHC Cost Reporting

- 10. No reclassifications and/or adjustments reported to align costs properly
- 9. Not properly listing clinic locations which may affect per-visit payment limit(s)
- 8. No tracking & reporting of influenza, pneumococcal & H1N1 vaccines and/or other Part B billing issues
Top Ten Mistakes in Medicare FQHC Cost Reporting

- 7. No reporting of Medicare bad debts
- 6. Lack of review of intermediary proposed adjustments during settlement process
- 5. FQHC provider number issues
- 4. No reconciliation of expenses reported on cost report with total expenses per the audited financial statements
Top Ten Mistakes in Medicare FQHC Cost Reporting

- 3. Not reporting expenses correctly in the proper “buckets”
  - Direct cost – reimbursable services
  - Direct cost – non-reimbursable services
  - Overhead costs

- 2. Incorrect computation of FTEs & related productivity standard

- 1. Inaccurate reporting of visits
Medicare FQHC Reimbursement Potpourri
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
Medicare Bad Debt Reimbursement

- Reimbursable Medicare bad debts
  - Completion of exhibit 5 of cost report questionnaire (Form CMS 339)
    - Uncollected Medicare co-payments are potentially eligible for reimbursement
    - Reasonable collection efforts must be documented
    - Generally, write-off must occur no earlier than 120 days after the date the patient is first billed
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.
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 (similar situation for state Medicaid programs also).

- 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.
Health Care Reform Issues Affecting Medicare
Health Care Reform Issues

- Expanded coverage of Medicare preventive services provided by health centers on or after January 1, 2011
- Replaces current Medicare FQHC cost-based payment methodology with a PPS
  - Cost reporting periods beginning on or after October 1, 2014
Final Thoughts
Final Thoughts

✓ Health center personnel must understand and manage Medicare and Medicaid FQHC reimbursement processes 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 and Medicaid FQHC reimbursement issues/opportunities)
Thank You!
We welcome your comments and questions

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