Navigating The Medicare FQHC cost report

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Arizona Alliance
FOR COMMUNITY HEALTH CENTERS
Primary Healthcare for All

BKD
CPAs & Advisors

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Today's Agenda

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

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

- 2020 PPS rates for Arizona of $168.51 and $226.07 (GAF = .971)

Medicare Revenue Statistics

Based on the 2017 & 2016 UDS Data (Table 9D – Patient Related Revenue)

- 2018 – 12.4% of aggregate health center revenue (10% - 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

- 2020 base payment rate of $173.50 includes application of the final FQHC-specific market basket of 2.2% (versus the 2019 MEI increase factor of 1.9%)
- 2019 was 1.9% vs. 1.5%

The Medicare FQHC Cost Report

An Overview of the Form

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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

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)

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

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

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

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

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

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)

Worksheet S

Walkthrough of Worksheet S

Worksheet is divided into three parts

- Part I – Cost report status
- Part II – Certification
- Part III – Settlement summary

Walkthrough of Worksheet S

Worksheet includes:

- Identification of CMS Certification Number (CCN) and Medicare cost reporting period
  - First two digits of CCN – state specific
  - Last four digits of CCN – type of facility specific

    FQHC = 1000 – 1199 and 1800 - 1989
- Identification of “full”, “low” or “no” Medicare utilization
- Title XVIII settlement amount
  - Most likely dollars due the FQHC, if applicable

Worksheet S-1

Walkthrough of Worksheet S-1

Worksheet is divided into two parts

- **Part I** – FQHC identification data
  - Identify the FQHC (single site)
  - Identify the primary FQHC (consolidated cost reports)
- **Part II** – FQHC consolidated cost report participant identification data
  - Complete for consolidated sites (other than the primary FQHC)

Walkthrough of Worksheet S-1

Part I includes the following information:

- **Line 1** – site name, CCN, core based statistical area (CBSA) code, Medicare certification date and type of control
- **Lines 2 and 3** – address, County and rural/urban designation
- **Line 4** – cost reporting period
- **Line 5** – indicate if FQHC is owned, leased or controlled by an entity that operates multiple FQHCs
  - If yes, complete lines 6 - 8

Walkthrough of Worksheet S-1

Part I includes the following information:

- **Line 9** – indicate if FQHC is part of a *chain organization* as defined by CMS
  - If yes, complete lines 10 – 12
- **Line 13** – indicate if FQHC is filing a consolidated cost report (“yes” or “no”)
  - If yes, enter the date the FQHC **requested approval** to file as part of a consolidated cost report and the date the Medicare contractor **approved** the FQHC’s request
  - Date information applies ***only*** to Medicare FQHC certification dates on or after October 1, 2014

Walkthrough of Worksheet S-1

Part I includes the following information:

- **Line 14 (and its subscripts)** – if a consolidated cost report, enter FQHC site information for each FQHC that is part of the consolidated cost report, ***excluding*** the primary FQHC listed on line 1
  - *Includes information on date consolidated cost report treatment was requested by each individual site and approved by CMS*
  - Date information applies ***only*** to Medicare FQHC certification dates on or after October 1, 2014
  - Each FQHC listed on line 14 and its subscripts must complete a separate Worksheet S-1, Part II

Walkthrough of Worksheet S-1

Part I includes the following information:

- **Lines 15 – 22** – information on “FQHC operations”
  - Type of organization
  - Section 330 grant information, if applicable
  - FTCA information
  - Other questions regarding medical malpractice insurance, if applicable
    - ✓ Policy type
    - ✓ Premiums paid
    - ✓ Total paid losses
    - ✓ Self-insurance paid

Walkthrough of Worksheet S-1

Part I includes the following information

- **Lines 23 – 26** – information on “Interns and Residents”
  - Questions regarding training residents in approved and/or unapproved GME programs
  - Questions regarding receipt of a Primary Care Residency Expansion (PCRE) grant and/or a Teaching Health Center (THC) grant
    - ✓ Identification of the number of FTE residents trained and visits performed by such residents funded by the grant(s) must be specifically reported

Walkthrough of Worksheet S-1

Part I includes the following information:

- **Line 27** – information on “Capital Related Costs – Ownership/Lease of Building”
  - Identify if the building is owned or leased
  - If leased, rent/lease expense must be reported

Walkthrough of Worksheet S-1

Part II includes the following information for ***each*** FQHC reported on Worksheet S-1, Part 1, Line 14 and its subscripts

(and a separate Worksheet S-1, Part II must be completed for each FQHC in the identical sequence as reported on Worksheet S-1, Part I, Line 14 and its subscripts)

- **Lines 1 - 3** – site identification information
- **Line 1** – note information request regarding Medicare participation termination and Change of Ownership situations, if applicable

Walkthrough of Worksheet S-1

Part II includes the following information for ***each*** FQHC reported on Worksheet S-1, Part 1, Line 14 and its subscripts

(and a separate Worksheet S-1, Part II must be completed for each FQHC in the identical sequence as reported on Worksheet S-1, Part I, Line 14 and its subscripts)

- **Lines 4 – 10** – "FQHC Operations"
- **Lines 11 – 14** – "Interns and Residents"
- **Line 15** – "Capital Related Costs – Ownership/Lease of Building"

Worksheet S-2

Walkthrough of 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

Walkthrough of Worksheet S-2

Cost report instructions indicate that “when filing a consolidated cost report, this worksheet applies only to the primary FQHC”

- Questions relating to change of ownership and/or certification / decertification of an FQHC included in a consolidated cost report are included on Worksheet S-1, Part II

Worksheet S-3

Walkthrough of Worksheet S - 3

Worksheet is divided into three parts

- Part I – FQHC statistical data
- Part II – FQHC contract labor and benefit cost
- Part III – FQHC employee data

Walkthrough of Worksheet S-3

- Part I includes the following information to be reported separately for Title V, Title XVIII, Title XIX, *Other* and Total
  - **Line 1** – medical visits (including visits performed by interns and residents, if any, and whether on not funded through a HRSA grant)
  - **Line 3** – mental health visits
  - **Line 5** – Visits performed by interns and residents ***not funded*** by a PCRE or THC grant
- For consolidated cost reports, subscript lines 1, 3 and 5 in the identical sequence as reported on Worksheet S-1, Part I, line 14 and its subscripts (use Column 0 to identify each FQHC)
- Only Medicare fee for service program visits are reported within the “Title XVIII” category (including dually eligible beneficiaries)
  - Visits for Medicare Advantage Plan beneficiaries are reported within the “Other” and “Total “categories

Walkthrough of 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

Worksheet A

Walkthrough of 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)?

Walkthrough of Worksheet A

- Worksheet A, Column 4 provides a recap, by cost center, of cost reclassification entries
  - Total of column 4, line 100, should be *zero*

- Worksheet A, Column 5 – *Reclassified Trial Balance*
  - Total of column 5, line 100 will equal total of column 3, line 100

Walkthrough of Worksheet A

- Worksheet A, Column 6, provides a recap, by cost center, of cost adjustments entries

- Worksheet A, Column 7 – *Net Expenses for Allocation*
  - Column 7 expenses represent the “beginning of the rest of the Medicare cost reporting story”

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

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

Additional general service cost centers include:

- Pharmacy
- Medical supplies
- Transportation
- Other (costs of other general service costs not previously identified)

General Service Cost Centers

Instructions include detail of CMS cost center reporting expectations – a few highlights include:

- ***Capital related costs*** include depreciation, interest, insurance and rental costs incurred for depreciable assets used for patient care
  - Excludes repair and maintenance costs
- ***Employee benefits*** – use this cost center if the FQHC's accounting system does not accumulate benefits on a cost center basis
- ***Medical records*** – none of the costs associated with electronic health records systems are reported in this cost center

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)

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)***

General Service Cost Centers

Instructions include detail of CMS cost center reporting expectations – a few highlights include:

- ***Medical supplies***
  - *Excludes* the cost of medical supplies used in administering influenza and pneumococcal vaccines (see later slide for reporting of such vaccine costs)
  - *Includes* the cost of routine supplies (gloves, masks, swabs, etc.) used in the normal course of caring for patients and the non-routine costs of medical supplies that can be traced to individual patients
  - Medicare Benefit Policy Manual, Chapter 13 includes the following examples of “incident to” supplies
    - ✓ Bandages, gauze, oxygen and other supplies

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

Direct Care Cost Centers

Instructions include detail of CMS cost center reporting expectations – a few highlights include:

- ***Physician***
  - Reclassify physician general supervisory services or other administrative activities to A&G
  - Teaching physician costs and interns and residents costs must be reported on GME lines discussed later (allowable or non-allowable GME costs)
- ***Other allied health personnel***
  - RNs and LPNs that provide services incident to another provider
  - Medical assistants
  - Other

Reimbursable Pass Through Costs

"Reimbursable pass through costs" include costs delineated for the following cost categories:

- **Allowable** GME costs
  - Instructions reference 42 CFR 405.2468(f) – *see next slide*
  - Reclassify direct costs of interns and residents funded by a PCRE and/or THC grant to the **non-allowable** GME cost center
  - Includes overhead costs ***directly assigned*** to the interns and residents program (excluding all overhead included in the "general service" cost centers)
- Pneumococcal vaccines and medical supplies
- Influenza vaccines and medical supplies

Reimbursable Pass Through Costs

42 CFR 405.2468(f) includes GME pass through payment if the FQHC incurs “all of substantially all” of the costs for the training program in the nonhospital setting

- Allowable GME costs must be reported on the FQHC’s cost report under a separate cost center
- Allowable GME costs are non-reimbursable if payment for these costs are received from a hospital
- The following costs are allowable GME costs to the extent they are reasonable
  - Residents’ salaries and fringe benefits
  - Portion of teaching physicians’ salary and fringe benefits that are related to the time spent teaching and supervising residents
  - Facility overhead costs that are allocated to direct GME

Other FQHC Services

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

- Medicare excluded services (dental care, eye exams, hearing tests, etc.)
- Diagnostic and screening lab tests (technical component)
- Radiology – diagnostic (technical component)
- Prosthetic devices

Other FQHC Services

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

- Durable medical equipment
- Ambulance services
- Telehealth – distant-site services
  - FQHCs are not authorized to serve as a distant site for telehealth consultations and may not bill or include the cost of a visit on the cost report

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

Non-reimbursable Cost Centers

"Non-reimbursable cost centers" include costs delineated for the following cost categories:

- **Retail pharmacy**
- Non-allowable GME costs
  - Instructions indicate that "this cost center includes the costs associated with an intern and resident program not approved by Medicare"
- Other non-reimbursable

Worksheet A-1

Worksheet A-1

Purpose of worksheet

- Provides for the reclassification of costs to effect proper cost allocation
- Align costs into the correct cost center
- Use where costs applicable to more than one cost center are recorded in the organization's accounting records in one cost center

Worksheet A-1

Layout (format) of worksheet

- Explanation of reclassification (using alpha characters and brief description)
- Increase and decrease columns include
  - Cost center identification (name and line number)
  - Amount by cost center name and line number

Worksheet A-1

- Amounts entered on Worksheet A-1 must be equal in total for each reclassification entry (total cost center increases = total cost center decreases)
- Summary totals by cost center transferred to Worksheet A, column 4
  - Total of column 4 should be zero

Reclassifications of Expenses

Common examples

- Fringe benefits
- Depreciation
- Insurance

Reclassifications of Expenses

Common examples

- Inpatient hospital costs
- Medical director costs
- Other

Reclassifications of Expenses

Fringe benefits costs

- If fringe benefits costs are directly assigned within the organization's accounting records, reclassification entry is not necessary
- For combined (pooled) costs, reclassification entry ***may*** be needed to assign costs to cost centers with identified salary costs
  - Pro-ration method

Reclassifications of Expenses

Depreciation costs

- Medicare regulations require use of American Hospital Association (AHA) Depreciable Lives Guidelines for assets acquired on or after January 1, 1981
- Straight-line methodology required
- Costs must be reported for buildings & fixtures as well as moveable equipment

Reclassifications of Expenses

Insurance costs

- For combined (pooled) costs, reclassification entry needed to assign costs to appropriate cost centers
  - Professional liability insurance – A&G
  - Property, plant & equipment insurance
    - ✓ Buildings and fixtures
    - ✓ Moveable equipment
  - General liability insurance – A&G
  - D&O insurance – A&G

Reclassifications of Expenses

Inpatient hospital costs

- For FQHC providers that perform work in a hospital setting, costs (salary and related fringe benefits costs) must be reported in a separate cost center
- Presumably a reclassification of such costs must be made from the applicable “direct care cost centers” to a cost center line created within “other FQHC services”

Reclassifications of Expenses

Medical director costs

- For FQHC providers that perform health care director services, such costs (salary and related fringe benefits costs) should be reported as a component of facility overhead – A&G services
- Generally a reclassification entry is necessary

Reclassifications of Expenses

Other possible cost reclassification issues

- Salary costs
- Continuing medical education (CME)
- Costs of locations that are not approved as FQHC sites for the entire cost reporting period
- Pharmacy costs (costs of drugs that are not self-administered)
- Contract services costs (administrative versus medical versus non-reimbursable costs)
- Other

Worksheet A-1

Points to remember when completing Worksheet A-1:

- Generally this worksheet will not be blank
- No limit on the number of reclassification entries that can be reported
- Consideration can be given to more detailed reporting in an organization's accounting records to limit the number of reclassification entries needed
- Cost center increases reported must equal cost center decreases reported

Worksheet A-2

Worksheet A-2

Purpose of worksheet

- Provides for the adjustment of costs which are required under the principles of Medicare reimbursement
- Made on basis of cost (if available) or amount received
- Adjustments are generally made to reduce reported costs
  - Can have positive adjustments in certain fact circumstances

Worksheet A-2

Layout (format) of worksheet

- Column for description of adjustment
- Column to report basis of adjustment
  - Cost = A
  - Amount received = B
- Amount of adjustment (cost decreases are shown as a negative number)
- Worksheet A cost center impacted

Worksheet A-2

Summary totals by cost center transferred to Worksheet A, column 6

- Total of Worksheet A, column 6 should match the total adjustment amount reported on Worksheet A-2, line 50

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

Adjustments to Expenses

Examples – cost matters

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

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

Adjustments to Expenses

Examples – revenue matters

- Offset of interest income to the extent of interest expense
  - Split between categories where interest expense is reported (see lines 1 – 3)
  - Offset of miscellaneous income
- Grants, gifts, and income from endowments are NOT required to be offset against expenses

Worksheet A-2

Points to remember when completing Worksheet A-2:

- Generally this worksheet will not be blank
- No limit on the number of adjustment entries that can be reported
- Cost report preparer should have a solid understanding of Medicare reasonable cost principles, including application of the Provider Reimbursement Manual, in order to achieve appropriate reimbursement

Worksheet A-2-1

Related Organization Costs

Related organization defined in Provider Reimbursement Manual - Part 1, Chapter 10

- Relationship can be through common ownership or control

Worksheet A-2-1

Purpose of worksheet

- Provides for the reporting of related organization costs incurred, if any
- Related organization costs may include costs applicable to services, facilities and supplies furnished by the related organization

Worksheet A-2-1

Purpose of worksheet

- Provides for the adjustment of related organization costs to the *actual* cost incurred by the related organization
- Medicare reasonable cost principles require the elimination of related organization *profit*
- In addition, allowable costs cannot exceed the cost of services, facilities or supplies that can be obtained from an unrelated party

Worksheet A-2-1

Layout (format) of worksheet

- Worksheet includes Part I and Part II
- Part I – Provides detail of related organization cost; amount of cost includable in allowable cost; and, any required adjustment to total cost incurred
- Part II – Provides detail of related organization relationship

Worksheet A-2-1

- Any required adjustment to related party cost identified on Worksheet A-2-1 is reported on Worksheet A-2, line 7
- Adjustment can be positive or negative (generally any such adjustment will reduce reported costs)
- Does the organization’s audited financial statements report related party transactions?
- Discussion of example

Worksheet B

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 …"

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

Walkthrough of Worksheet B

Part I includes the following information:

- 13 lines and 12 columns
- ***Total costs*** are accumulated in 4 columns
  - Column 1 – “direct cost” by “position”/practitioner from Worksheet A
  - Column 3 – “other direct care costs and pharmacy costs” by practitioner (total from Worksheet A is allocated)
  - Column 4 – “general service cost” by practitioner (total from Worksheet A is allocated)
  - Column 5 – “total costs by practitioner” – sum of columns 1, 3 and 4

Walkthrough of Worksheet B

Part I includes the following information:

- 13 lines and 12 columns
- ***Total visits*** are accumulated in 3 columns
  - Column 2 – “total medical and mental health visits by practitioner”; ***please note that all visits performed by interns and residents*** **are included in total visits by practitioner** ***(CMS states “that is, if the intern or resident is providing services under the direction of a teaching physician, the visit would be included as a physician visit”)***
  - Column 7 – “total ***medical*** visits by practitioner”
  - Column 8 – “total ***mental health*** visits by practitioner”

Walkthrough of Worksheet B

Part I includes the following information:

- 13 lines and 12 columns
- Column 6 – “average cost per visit by practitioner”
  - Total costs by practitioner divided by total medical and mental health visits by practitioner
- Columns 9 and 10 – ***Split of Title XVIII visits by practitioner***
  - Medical visits
  - Mental health visits
- Columns 11 and 12 – Calculation of Title XVIII cost by practitioner
  - Medical cost
  - Mental health cost
  - Line 13 (columns 11 and 12) – Medicare average cost per medical and mental health visit

Walkthrough of Worksheet B

Part II includes the following information:

- Line 14 – contains five columns
  - Column 1 – “total cost” from Worksheet A, column 7, line 47 (“allowable GME costs”)
  - Columns 2 and 3 – interns and residents visits from Worksheet S-3, Part I
    - ✓ Total visits from line 6, column 5
    - ✓ Title XVIII visits from line 6, column 2
  - *Remember that visits reported in columns 2 and 3 are those visits **not** funded by a PCRE or THC grant from HRSA*

Walkthrough of Worksheet B

Part II includes the following information:

- Line 14 – contains five columns
  - Column 4 – “Ratio of Title XVIII visits to Total visits”
    - ✓ Column 3 divided by column 2
  - Column 5 – “Allowable Title XVIII direct GME costs”
    - ✓ Column 1 multiplied by column 4
    - ✓ This is the amount that Medicare will reimburse the FQHC for its direct GME activities

Worksheet B-1

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

Walkthrough of Worksheet B-1

- Health care staff cost ***excludes*** physician services under agreement
- Line 2, columns 1 and 2 – “ratio of staff time to total health care staff time”
  - Computation of these ratios has historically utilized a standard of ***five minutes*** per vaccine
- Line 4, columns 1 and 2 – “vaccine and related supplies cost”
  - Transfers from applicable “reimbursable pass through costs” lines on Worksheet A

Walkthrough of Worksheet B-1

- Line 10 – total cost of pneumococcal and influenza vaccines and their administration
- Line 11 – total number of pneumococcal and influenza vaccine injections
- Line 12 – Cost per pneumococcal and influenza injection (line10/line11)
- Line13 – Number of pneumococcal and influenza injections administered to Medicare beneficiaries

Walkthrough of Worksheet B-1

- Line 14 – Cost of pneumococcal and influenza vaccines and their administration costs furnished to Medicare beneficiaries
  - Line 12 multiplied by line 13
- Line 16 – Total Medicare cost
  - Sum of columns 1 and 2, line 14
  - Amount transfers to Worksheet E, line 3

Worksheet E

Walkthrough of Worksheet E

The cost report instructions indicate that this worksheet:

- Provides for the reimbursement calculation of FQHC services rendered to Medicare patients under the FQHC PPS
- Provides for the accumulation of cost reimbursable direct GME, pneumococcal and influenza vaccine reimbursement, and Medicare Advantage supplemental payments
  - Note that Medicare bad debts are not mentioned but are reported on Worksheet E, line 10

Walkthrough of Worksheet E

Worksheet includes the following information:

- Line 1 – FQHC PPS amount
  - Instructions note to obtain this amount from the PS&R report ("total PPS payments paid for FQHC visits rendered during the cost reporting period")
- Line 2 – Medicare costs for direct GME from Worksheet B, Part II
- Line 3 – Medicare costs for pneumococcal and influenza vaccines and their administration from Worksheet B-1
- Line 4 – Medicare advantage supplemental payments
  - *For information only* – does not impact cost report settlement
  - Obtain from the PS&R, report type 778

Walkthrough of Worksheet E

Worksheet includes the following information:

- Line 5 – Sum of lines 1 through 3
- Line 6 – Primary payer amounts obtained from the PS&R report
- Line 7 – Line 5 minus line 6
- Line 8 – Part B coinsurance
- Line 9 – Line 7 minus line 8
- Line 10 – Medicare allowable bad debts, net of bad debt recoveries
- Line 11 – Line 10 multiplied by 65%
- Line 12 – Gross reimbursable bad debts for dual eligible beneficiaries
  - Amount is for statistical purposes only
  - Amount is also included on line 10

Walkthrough of Worksheet E

Worksheet includes the following information:

- Line 13 – Subtotal (sum of lines 9 and 11)
- Line 16 – Sequestration adjustment
  - *2% reimbursement reduction*
- Line 18 – *Amount of interim payments from Worksheet E-1*
- Line 20 – Total amount due to/from the Medicare program (the “settlement amount”)
  - Amount transfers to settlement summary reported on Worksheet S, Part III

Worksheet E Issues

- How does aggregate PPS reimbursement compare to Medicare program costs reported on Worksheet B, Part 1?
- How does the average PPS reimbursement per visit compare to applicable PPS rates per visit?
- Line 4 is available for reporting of Medicare Advantage Plan supplemental payments (for information only – does not impact the cost report settlement)
- Settlement amount, if any, is reported on Line 20
  - Does the answer make analytical sense?

Worksheet E-1

Walkthrough of Worksheet E-1

- This worksheet reports Medicare interim payments paid by the Medicare Administrative Contractor
  - Excludes interim payments for titles V and XIX
- FQHCs complete lines 1 through 4 only
  - Line 1 – total Medicare interim payments paid to the FQHC
    - Exclude Medicare advantage supplemental payments
  - Line 2 – opportunity to report expected payments for unpaid claims
    - Claims billed but not yet paid
    - Claims not yet billed and, therefore, not yet paid
  - Line 3 – retroactive lump sum adjustment payments, if any
  - Line 4 – sum of lines 1 through 3

Worksheet F-1

Walkthrough of Worksheet F-1

Reminder - Worksheet F-1 is a worksheet that captures the revenues and expenses of the FQHC

- CMS notes that this data collection is “to provide estimates of total facility and Medicare margins that are used in payment update activities and discussions with the Medicare Payment Advisory Commission (MedPAC)”

Walkthrough of Worksheet F-1

- This worksheet is to be prepared from the FQHC's accounting books and records
  - Should reconcile with the FQHC's audited financial statements for the "total" column
- Line 1 – ***gross patient revenue*** by payer source (Medicare, Title XIX, Other and Total)
- Line 18 – net income from services to patients
  - Quasi measure of operating margin
- Line 33 – net income or loss for the cost reporting period

Medicare FQHC

Reimbursement Potpourri

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

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

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

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

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

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

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%**

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

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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