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Medicare Cost Report – 224-14

Maximize Compliance; Minimize Effort

1.5 CPE Credit Available

- AAFCPAs issues CPE in accordance with NASBA regulations
- To be eligible for CPE you must:
  - Submit answers to all polling questions when they pop up.
  - Complete and submit a written evaluation of the training.
  - Remain logged in to the webinar for the entirety of the program.
- We will email CPE certificates within **two weeks** to the email address you provided.

FQHC (Medicare) Cost Report

- The report is due 5 months after year end
- No extensions unless hardship; Medicare payments shut off after 30 days of insufficient filing
  - *If the report is filed early and is rejected – a grace period is instated for the amount of days early the report was filed.*

Fiscal Year End	Due Date
June 30	November 30
August 31	January 31
September 30	February 28
December 31	May 31

FQHC (Medicare) Cost Report

Purpose of Filing

1. Compare average Medicare cost per visit, by provider type, to the GCode charges established by the Center
   - *Paid prospectively throughout the year; "prove" costs with cost report filing at year end*

2. Final reconciliation of billed visits versus payments to determine any settlements

3. To obtain reimbursement for pneumococcal and influenza injections provided to Medicare beneficiaries (otherwise not reimbursed under Medicare)

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Poll Question #1

The Medicare Cost Report is due:

FQHC (Medicare) Cost Report

Overview – Total Cost per Visit (Medicare Costs)

Total Allowable Costs* / Total Medicare Visits**	=	Total Medicare Cost Per Visit

Total operating expenses per the audited financial statements
Less: Non-reimbursable costs
Less: Non-FQHC programs
Less: Offsetting revenue
Less: Overhead allocated to non-FQHC programs
*** Total Allowable Costs**

FQHC (Medicare) Cost Report

Overview – Total Cost per Visit (Medicare Costs)

Total Allowable Costs* / Total Medicare Visits**	=	Total Medicare Cost Per Visit

Total Medicare Visits billed to CMS (matches the PS&R)
** Total Medicare Visits

FQHC (Medicare) Cost Report

Worksheet S I - III

Multiple reporting questions including information on:

1. Residency programs and grants
2. Teaching programs and grants
3. Malpractice coverage
4. Capital Related Costs (owning or renting space)
5. CMS 339 Questionnaire questions are incorporated, eliminating the need for the separate Questionnaire

FQHC (Medicare) Cost Report

Worksheet S – 1 (Main and Participant)

Name of Main Entity (Main provider number per CMS), Address, Date certified and **CBSA (Core Based Statistical Areas)**

County	State	"New CBSA"	"New CBSA NAME"
BARNSTABLE	MA	12700	Barnstable Town, MA
BERKSHIRE	MA	38340	Pittsfield, MA
BRISTOL	MA	39300	Providence-Warwick, RI-MA
DUKES	MA		
ESSEX	MA	15764	Cambridge-Newton-Framingham, MA
FRANKLIN	MA		
HAMPDEN	MA	44140	Springfield, MA
HAMPSHIRE	MA	44140	Springfield, MA
MIDDLESEX	MA	15764	Cambridge-Newton-Framingham, MA
NANTUCKET	MA		
NORFOLK	MA	14454	Boston, MA
PLYMOUTH	MA	14454	Boston, MA
SUFFOLK	MA	14454	Boston, MA
WORCESTER	MA	49340	Worcester, MA-CT

**Blanks are Rural*

FQHC (Medicare) Cost Report

Worksheet S – 1 (Main and Participant)

- Reporting period (typically fiscal year end)
- Type of FQHC (Urban/Rural)
- Most recent 330 Grant Award number covering the reporting period
- Consolidated Cost report (multiple CCN/Provider #) and the number of the consolidated entities
- Malpractice costs and type of policy
- Capital Related Costs –
  - Rent or own space?

FQHC (Medicare) Cost Report

Worksheet S – 1 (Main and Participant)

Interns and Residents

- Does the Health Center have an approved (by HRSA) graduate medical education program?
- Direct graduate medical education costs are *NOT subject to the limit* in the all-inclusive rate (GCode) and must be reported on the FQHC's cost report under a separate cost center
- Allowable graduate medical education costs are **non-reimbursable** if payment for these costs are received from a hospital, a teaching grant, or a Medicare Advantage organization.

FQHC (Medicare) Cost Report

Worksheet S – 1 (Main and Participant)

Interns and Residents

- Did the FQHC receive a Primary Care Residency Expansion Grant?
  - CFDA #93.510
  - If yes, the program is non-reimbursable

- Did the FQHC receive a Teaching Health Center Development Grant?
  - CFDA #93.530
  - If yes, the program is non-reimbursable

FQHC (Medicare) Cost Report

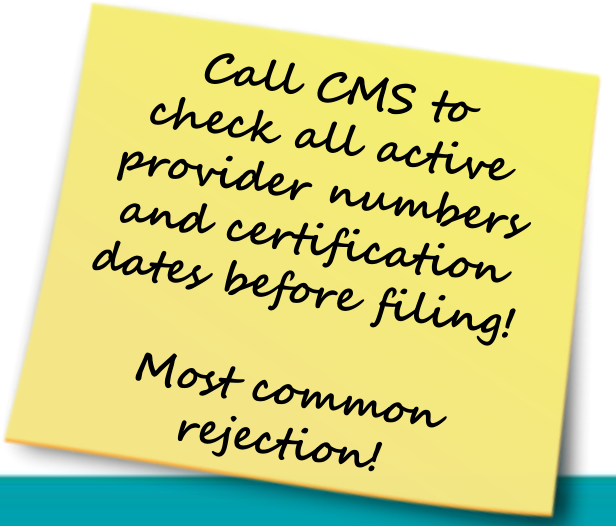
Worksheet S – 1 (Main and Participant)

Complete Worksheet S-1, Part II for each active CMS Provider Number (typically for each site)

- Allocate malpractice premiums by location if applicable, else show same as main site
- Answer intern/resident and capital questions for each site

Complete **Worksheet S-I, Part II** for each additional location/provider number.

Remember: Each location needs a separate Medicare Number! Compare to your PS&R report!



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Poll Question #2

Each site where services are provided must have a separate Medicare Provider number:

FQHC (Medicare) Cost Report

Worksheet S - 2

Worksheet S-2 incorporates Form CMS 339 into a checklist form

- Organizational information, ownership and operations
- Related Party information (Worksheet A-2-1)
- Financial Data
  - CPA financial statements?
  - Audited, Reviewed, or Compiled?
  - Date expected to be available?
  - Expenses and Revenues differ from financial statements?
    - If so, need reconciliation schedules

FQHC (Medicare) Cost Report

Worksheet S - 2

Worksheet S-2 incorporates Form CMS 339 into a checklist form

- GME Activities and location of costs
- Cost Report Preparer Information
- Bad Debts
  - Are you seeking reimbursement for bad debts resulting from Medicare deductible and/or coinsurance amounts which are uncollectible from Medicare beneficiaries.
  - If yes, complete Exhibit 1 (found in the 224-14 instructions)

FQHC (Medicare) Cost Report

Worksheet S – 2

Exhibit 1 – Bad Debts

Patient Name	HIC. No.	Dates of Service		Indigency& Medicaid Beneficiary (Check if applicable)		Date First Bill Sent to Beneficiary	Date Collection Efforts Ceased	Medicare Remittance Advice Dates	Co-Insurance/ Total Medicare Bad Debts*
		From	To	Yes	Medicaid Number				
1	2	3	4	5	6	7	8	9	10

*These amounts must not be claimed unless the FQHC bills for these services with the intention of receiving payment. See instructions for columns 5 and 6 - Indigency/Medicaid Beneficiary, for possible exception.
These amounts must not be claimed if they were included on a previous Medicare bad debt listing or cost report.

FQHC (Medicare) Cost Report

Worksheet S - 2

Worksheet S-2 incorporates Form CMS 339 into a checklist form

- PS&R Report Data (Provider Statistical and Reimbursement Form)
  - PS&R only?
  - PS&R for totals; FQHC records for allocation
  - Adjustments to PS&R?
  - FQHC records only?
- Reconciliation of revenues and visits to the PS&R is required if the FQHC reports different amounts than the PS&R
- CMS automatically adjusts the cost report to match the PS&R if no appropriate reconciliation is provided

FQHC (Medicare) Cost Report

Worksheet S - 2

Gaining Access to the ever illusive PS&R

- Must have rights to the PS&R System (Security Officer)
- If you do NOT have username/password – you'll need to apply through Enterprise Identity Management System (EIDM) (est. 6 week process)
- EIDM Contact Information
  - 1-866-484-8049
  - EUSSupport@CGI.com
- If you are in the process of applying but need your PS&R sooner; provide EIDM ticket # and email Lisa Beatty (Lisa.Beatty@anthem.com)

FQHC (Medicare) Cost Report

Worksheet S – 3, Part I

Visit Statistical Data

(Should tie to PS&R Medicare totals; and by provider (location) number)

(Total Visits and Medicare Visits must tie to Worksheet B allocation by provider)

(Complete BY PROVIDER NUMBER – 4 locations = 4 Schedule S-3)

		CENTER CCN	Title V	Title XVIII	Title XIX	Other	Total All Patients
		0	1.00	2.00	3.00	4.00	5.00
	PART I - FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL						
1.00	Medical Visits (22-1000 - HEALTH CENTER #1)	22-1000	0	0	0	0	0
1.01	Medical Visits (22-1001 - HEALTH CENTER #2)	22-1001	0	0	0	0	0
2.00	Total Medical Visits		0	0	0	0	0
3.00	Mental Health Visits (22-1000 - HEALTH CENTER #1)	22-1000	0	0	0	0	0
3.01	Mental Health Visits (22-1001 - HEALTH CENTER #2)	22-1001	0	0	0	0	0
4.00	Total Mental Health Visits		0	0	0	0	0
5.00	Number of Visits Performed by Interns and Residents (22-1000 - HEALTH CENTER #1)	22-1000	0	0	0	0	0
5.01	Number of Visits Performed by Interns and Residents (22-1001 - HEALTH CENTER #2)	22-1001	0	0	0	0	0
6.00	Total Number of Visits Performed by Interns and Residents		0	0	0	0	0

FQHC (Medicare) Cost Report

	Definitions
Title XVIII	Medicare Part A and Part B (and dually eligible) - must match Medicare
Title XIX	Medicaid
Title V	Maternal Child Health Service Block Grant
Other	Medicare Advantage Plan and all other
Medical Visit	Face to face encounter between an FQHC patient and one of the following: physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse, registered dietician or certified DSMT/MNT educator. *(includes visits for subsequent illness or injury)* *(up to 3 visits in one day)*
Mental Health Visit	Face to face encounter between an FQHC patient and one of the following: clinical psychologist, clinical social worker, physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse for mental health services.

FQHC (Medicare) Cost Report

Worksheet S – 3, Part I

Visit Statistical Data

What about a patient who is seen by a provider other than those listed on the previous slide?

Visit is not included or reported in this schedule. Medicare is measuring only those visits which they deem billable under their definitions (even if other payors may reimburse for those visits).

FQHC (Medicare) Cost Report

Worksheet S – 3, Part I

Visit Statistical Data

What about a patient who is…….?

Patient Type	Column, Reimbursement
Dually Eligible (Medicare and Medicaid)	2, Medicare Title XVIII
Vanilla Medicaid	3, Medicaid Title XIX
Medicaid Managed Care	4, Other
Medicare Advantage	4, Other
All Other	4, Other

FQHC (Medicare) Cost Report

Worksheet S – 3, Part II

Contract Labor, Benefit Cost

- Include LABOR cost of contracted direct care for specified provider types
- Include BENEFIT costs of contracted direct care for specified provider types
  - Wage related costs
  - Example might be a car for a contracted provider

Note: If you include contracted dollars on S-3, you must show matching contracted dollars on the same lines on **Schedule A**

FQHC (Medicare) Cost Report

Worksheet S – 3, Part III

Number of Employees and Contracted Staff (FTE)

- Include FTE for staff (W-2) and contract help by specific provider types
  - No productivity standard so administrative reclass costs are not required BUT may be beneficial to the Center
- **FTE Calc = All hours paid / 2080 (or normal hours in a work week)**
- Unused vacation, unused sick leave are EXCLUDED

FQHC (Medicare) Cost Report

Worksheet A

- 7 Column, 100 Row Worksheet
- A detail schedule is required to support each line on Worksheet A – called “Crosswalk.” It should show each Trial Balance account of the FQHC and how it is categorized on Worksheet A.
- Tabulates all costs of the Health Center (reimbursable and non-reimbursable)

FQHC (Medicare) Cost Report

Worksheet A - *Expenses*

1. **Column 1** – Salaries
   - Must tie to salaries on audited financial statements
   - If benefits or contracted help were combined with salaries on the audited financial statements, they must be separated here
   - *Administrative Breakout* – Physicians on line 23 should have salaries split between administration and medical (FQHC) costs. Supervisory dollars, administrative, and training dollars should be shown in administration Line 4, while the remaining dollars can be shown on line 23.

2. **Column 2** – Other (everything else)
   - Contracted providers classified with salaries on the audited financial statements would be shown in this column, and shown as a reconciling item on the crosswalk

3. **Column 3** – Total Expenses (Column 1 plus Column 2)
   - Should tie to total operating expenses on the audited financial statements

FQHC (Medicare) Cost Report

Worksheet A - *Expenses*

4. **Column 4** – Reclassifications
   - Automatically filled in based on information entered in Worksheet A-1

5. **Column 5** – Reclassified TB
   - Automatically calculates taking Column 3 (Total Expenses) plus or minus Column 4 (Reclassifications)

6. **Column 6** – Adjustments
   - Automatically filled in based on information entered in Worksheet A-2

7. **Column 7** – Net Expenses
   - Automatically calculates taking Column 5 (Reclassified TB) plus or minus Column 6 (Adjustments)
   - Will NOT tie to the financial statements

FQHC (Medicare) Cost Report

Worksheet A - *Expenses*

Rows (Lines) separated into **Five Main Sections**:

1. **General Service Cost Centers (1 -13)** – Costs that support all programs of the Center (reimbursable or not)
   - Example would be Rent that covers Medical and Dental areas

   Includes Pharmacy Costs (340B only)

2. **Direct Care Cost Centers (23 – 37)** – Labor costs of direct care staff only

3. **Reimbursable Pass Through Costs (47 – 50)** – GME, Injection Costs

   Injection costs should be reclassified here and should tie to Schedule B-1

FQHC (Medicare) Cost Report

Worksheet A - *Expenses*

Rows (Lines) separated into **Five Main Sections**:

4. **Other FQHC Services (60 - 69)** – Medicare excluded services such as Dental, hearing tests, Optometry, State Funded Programs (WIC, HIV). Also, DME, Telehealth, Certain Diagnostic and Screening Lab Tests and Drugs Charged to Patients

   Drugs to Patients include prescription and over the counter drugs traced to individual patients that are paid separately (Medicare B, C and D)

   Venipuncture should be included in Pharmacy

5. **Non-Reimbursable Costs (77 - 79)** – such as Fundraising, Patient Transportation, Retail Pharmacy costs and Bad Debt. Also, reimbursed GME program costs.

   Retail Pharmacy Costs – Administration costs allocable to this program should be DIRECTLY allocated to Non-Reimbursable lines in column 1 and 2, or using column 4 (reclassifications). The entire program should then be adjusted off using column 6 (adjustments).

FQHC (Medicare) Cost Report

Worksheet A - *Expenses*

Direct Care – Other Allied Health Personnel (ie – Support Staff)

Line 36 - Other Allied Health Personnel.--This cost center includes the costs of RNs and LPNs who provide services incident to a physician, PA, NP, CNM, CP or CSW in accordance with CMS Pub. 100-02, chapter 13, §§110, 120 or 140 and the costs of other allied health personnel that provide diagnostic, technical, therapeutic and direct patient care and support services to the other health professionals they work with and the patients they serve. An example of other allied health personnel is a medical assistant.

Note: Other Allied Health Personnel are part of the direct cost of care rate calculation. This line usually represents direct care staff who are non-billable and/or not covered in prior direct care lines on schedule A.

FQHC (Medicare) Cost Report

Worksheet A - *Expenses*

School Based Health Center programs qualify as an FQHC allowable program and should be included in lines 1 – 37 **if**:

- Patient billing is completed by the Health Center and
- The Health Center provides medical and mental health services at the SBHC site and
- Expenses to operate the program are funded by the Health Center

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Poll Question #3

Supervisory costs of direct care providers should be shown:

FQHC (Medicare) Cost Report

Worksheet A -1 – *Reclassifications (Col. 4 of Worksheet A)*

Use:

Worksheet typically used to reclassify expenses combined in one trial balance account that should be separated, or expenses that are not detailed out in the trial balance in accordance with the lines on Worksheet A.

Common entries:

- Payroll tax and fringe benefits (allocated based on salary by line)
- Non-FQHC program expenses included in FQHC program accounts
- Administration or Supervision Time
- Injection supply costs

Other:

Requires an attachment detailing the entries and the reasons for the entries to be submitted with the cost report

FQHC (Medicare) Cost Report

Worksheet A -2 - *Adjustments*

1. **Offset non-operating revenue against expenses**
   - Medical records revenue
   - Vending machine revenue
   - Donated goods and services
   - Rental income
   - Interest income against interest expense
   - Other or Misc. Revenue on the financial statements

Percentage of dues relating to lobbying

Clarification from NACHC noting that dues attributable to lobbying do not have to be adjusted off as they are de minims

FQHC (Medicare) Cost Report

Worksheet A -2 - *Adjustments*

2. Non-Reimbursable Cost Centers

- Consider adjusting off All Non-Reimbursable Cost Centers in their entirety
- All costs that remain will be allocated a portion of general service cost centers
- If you directly allocated overhead to a non-reimbursable program; the entire cost center should be adjusted off to avoid duplicate overhead allocation

3. Material Pharmaceutical Costs

- If the Center has a material cost of pharmaceuticals (cost of goods sold) or high management fees, consider adjusting off the cost of goods sold
- If cost of goods sold remain, it is allocated to direct care cost centers significantly inflating (and falsely stating) the average cost per visit

FQHC (Medicare) Cost Report

Worksheet A -2 - *Adjustments*

4. Add back: Amortization of Start Up Costs

- If costs are incurred in the reporting year to “start-up” a new facility or site, those costs cannot be completely expensed on the Form 224-14 in the year incurred.
- These costs must be amortized over a reasonable period (typically 5 years) and the expense added back over time.
- The audited financial statements may expense the entire “start-up” costs in the reporting year so this may be a reconciling item.

FQHC (Medicare) Cost Report

Worksheet A -2 - *Adjustments*

Common Errors:

1. Basis of A to adjust an expense (bad debt expense)
2. Basis of B to adjust an offsetting revenue (medical records income)
3. If unsure what line to adjust off, (misc. income), adjust off general service costs (1 – 13)
4. Remember to enter adjustments as negative if applicable
5. Remember to provide an attachment detailing all adjustments and the trial balance accounts they are included in.

FQHC (Medicare) Cost Report

Worksheet A -2 -1 – *Related Organizations*

Part I – Include costs paid to a related organization defined below:

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the FQHC by organizations related to the FQHC by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the FQHC by organizations related to the FQHC or costs associated with the home office. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

Column 1 - Enter the line number on Worksheet A including the expense to the related organization

Column 3 – Enter the total cost incurred

Column 4 - Enter the allowable portion of cost (amount not exceeding amount a prudent buyer would pay)

Column 5 – Enter the total amount included in Worksheet A, Column 5

Column 6 - If there is a net adjustment (expense exceeding prudent buyer), amount will flow to Worksheet A-2

FQHC (Medicare) Cost Report

Worksheet A -2 -1 – *Related Organizations*

Consideration:

- A related Realty Corporation through which the Health Center rents space

- Transactions between companies with which the Board of Directors has a relationship

FQHC (Medicare) Cost Report

Worksheet A -2 -1 – *Related Organizations*

Part II – Define the relationship

Column 1 – Type of relationship

Symbol	Relationship
A	Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider
B	Corporation, partnership or other organization has financial interest in provider
C	Provider has financial interest in corporation, partnership, or other organization
D	Director, officer, administrator or key person of provider or organization
E	Individual is director, officer, administrator or key person of provider and related organization
F	Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider
G	Other (financial or non-financial) -- specify

FQHC (Medicare) Cost Report

Worksheet A -2 -1 – *Related Organizations*

Part II – Define the relationship

Column 2 and 3 – If an individual, the name of the individual and percentage ownership, if applicable (else leave blank)

Column 4 and 5 – If other than an individual, the name of the related entity and percentage ownership, if applicable (else leave blank)

Column 6 - Enter the type of business (rent, supplies, etc.) if Column 4 and 5 are used

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Poll Question #4

Adjustments on Schedule A-2 can only be negative (meaning costs are removed from Schedule A):

FQHC (Medicare) Cost Report

Worksheet B I and II

Statistical data-

- Must track Medical versus Mental Health visits for all direct care billable providers
- Must separate Title XVIII visits from all visits
- Does not require reporting of modifiers (new patient, annual visits, and etc.)
- Visits provided by non-billable providers are NOT included here or on S-3

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

- 12 Columns, 13 Rows
- Rows are Direct Care Staff as follows:

1.00	PHYSICIAN
2.00	PHYSICIAN SERVICES UNDER AGREEMENT
3.00	PHYSICIAN ASSISTANT
4.00	NURSE PRACTITIONER
5.00	VISITING REGISTERED NURSE
6.00	VISITING LICENSED PRACTICAL NURSE
7.00	CERTIFIED NURSE MIDWIFE
8.00	CLINICAL PSYCHOLOGIST
9.00	CLINICAL SOCIAL WORKER
10.00	REG DIETICIAN/CERT DSMT/MNT EDUCATOR

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 1: Direct Costs by Practitioner

Flows from Worksheet A – Direct Costs lines 23 – 31 and 33
(labor costs and contracted labor costs)

Column 2: Total Medical and Mental Health Visits

Flows from Worksheet B, Part I, Columns 7 and 8

Total Medical and Mental Health Visits done by the Center (Ties to Schedule S-3, Part I)

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 3: Other Direct Care Costs

Flows from Worksheet A – Lines 9, 32 and 34 – 36

These are direct care costs not included in column 1.

Allocated to each listed provider based on a Unit Cost Multiplier (UCM) of Column 2 (total visits).

Column 4: General Service Costs

Flows from Worksheet A – Line 13 minus 9

These are general service costs not previously allocated.

Allocated to each listed provider based on a UCM of percentage of total Health Center costs per Worksheet A.

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 5: Total Costs by Practitioner

Flows from Worksheet B, Columns 1,3 and 4
These are the total allowable costs by provider

Column 6: Average Cost per Visit by Practitioner

Flows from Worksheet B (Column 5 divided by Column 2)
This is the average allowable cost per visit by provider

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 7: Total Medical Visits by Practitioner

Entered on Worksheet B

These are the total visits performed by provider (Ties to Worksheet S-3, Part I)

Column 8: Total Mental Health Visits by Practitioner

Entered on Worksheet B

These are the total visits performed by provider (Ties to Worksheet S-3, Part I)

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 9: Medicare Medical Visits by Practitioner

Entered on Worksheet B

These are the Medicare visits done by provider (Ties to Worksheet S-3, Part I, and the PS&R)

Column 10: Medicare Mental Health Visits by Practitioner

Entered on Worksheet B

These are the Medicare visits done by provider (Ties to Worksheet S-3, Part I, and the PS&R)

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 11: Medicare Medical Cost by Practitioner

Flows from Worksheet B (Multiply the average cost per visit in Column 6 by the Medicare visits in Column 9)

This represents the average cost by provider for Medicare Medical visits

Column 12: Medicare Mental Health Costs by Practitioner

Flows from Worksheet B (Multiply the average cost per visit in Column 6 by the Medicare visits in Column 10)

This represents the average cost by provider for Medicare Mental Health visits

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 11, Row 13: Total Medicare Medical Cost Per Visit

Flows from Worksheet B (Column 11, Row 11 divided by Column 9, Row 11)
This represents the average cost (all providers) for Medicare Medical visits

Compare this to Gcode charges

FQHC (Medicare) Cost Report

Worksheet B Part I – *Visits and GME*

Column 12, Row 13: Total Medicare Mental Health Cost per Visit

Flows from Worksheet B (Column 12, Row 11 divided by Column 10, Row 11)
This represents the average cost (all providers) for Medicare Mental Health visits

Compare this to Gcode charges

FQHC (Medicare) Cost Report

GCode Analysis – Medicare Medical (Line 13, Col. 11)

*What if my average cost is calculated at **higher** than my GCode charges?*

Medicare Medical Cost Per Visit	GCode	GCode Description	GCode Charge	Difference
$283.55	G0466	FQHC Visit New Patient	$219.67	($63.88)
	G0467	FQHC Visit Established Patient	$163.15	($120.40)
	G0468	FQHC Visit IPPE Or AWV	$219.67	($63.88)

Using the mock report, the average Medicare Medical Cost per visit is higher than the current GCode charge. In this scenario, the FQHC may be **missing out on potential revenue** (depending upon the PPS rate cap) and should revisit the charge structure in order to identify if charges are appropriate.

AAF is available to review the current charge and cost structures of the FQHC to aid in the determination of appropriate rates. Generally, the GCode charges should exceed the cost per the cost report given the current market.

FQHC (Medicare) Cost Report

GCode Analysis – Medicare Medical (Line 13, Col. 11)

*What if my average cost is calculated at **lower** than my GCode charges?*

Medicare Medical Cost Per Visit	GCode	GCode Description	GCode Charge	Difference
$283.55	G0466	FQHC Visit New Patient	$319.67	$36.12
	G0467	FQHC Visit Established Patient	$293.15	$9.60
	G0468	FQHC Visit IPPE Or AWV	$319.67	$36.12

Using the mock report, the average Medicare Medical Cost per visit is lower than the current GCode charge. In this scenario, the FQHC would be capped at the PPS rate during reimbursement. The FQHC should review the calculation of charges to ensure their adequacy if the average cost per visit is calculated significantly lower than the charges.

AAF is available to review the current charge and cost structures of the FQHC to aid in the determination of appropriate rates.

FQHC (Medicare) Cost Report

GCode Analysis – CMS desk audits

AAF has reviewed various desk audits of filed 224-14 reports where the reported cost per Medicare visit is **lower** than the GCode, or where the reported charge is **higher** than the GCode.

In both cases, we have not seen adjustment or further investigation into the GCode charge structure.

However, AAF expects questions from CMS in the future for GCode charges which appear to be misaligned with costs calculated on the cost report.

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Poll Question #5

The cost report calculates:

FQHC (Medicare) Cost Report

Worksheet B-1 – *Vaccine Analysis*

- Worksheet is NOT required (bonus money!)
- Highest rate of correction during desk audit

Line 1 – Flows from Worksheet A, line 37 less line 24 (All Direct Care Staff less Contracted Physicians)
Line 2 – Calculated by the FQHC • Calculate total minutes worked by all staff and contracted staff listed on lines 23 and 25 – 36 • Estimate amount of time spent on each injection (typically no more than 5 minutes) • Calculate total minutes spent giving injections to determine ratio

Note: *Some salaries are capped for the calculation. An adjustment to average salaries per the bureau of labor statistics is recommended in order to ensure consistency of the calculation!*

FQHC (Medicare) Cost Report

Worksheet B-1 – *Vaccine Analysis*

Every year CMS issues its maximum reimbursement limits by procedure code for visits.

These maximum limits are available here:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html

For 2018, average maximum reimbursement for influenza vaccines is $22.793. No maximum on Pneumococcal.

FQHC (Medicare) Cost Report

Worksheet B-1 – *Vaccine Analysis*

Line 3 – Automatically calculated by taking line 1 multiplied by line 2

Line 4 – These costs flow directly from Worksheet A, lines 48 and 49

Be sure you have included all costs for injections on lines 48 and 49:

- Actual cost of injections, if purchased
- Cost of cotton swabs, Band-Aids, and other supplies used

Line 5 – Total Cost (labor and supplies): Automatically calculated by taking line 3 plus line 4

Lines 6 – 9 – Calculation of Administrative overhead to injections: Automatically calculated by using data on Worksheet A

Line 10 – Total Cost (labor and supplies and overhead): Automatically calculated by taking the sum of lines 5 and 9

FQHC (Medicare) Cost Report

Worksheet B-1 – *Vaccine Analysis*

Line 11 – Total number of injections done for all patients: **Completed by the FQHC**

Line 12 – Total cost per injection (labor, supplies and overhead): Automatically calculated by dividing line 10 by line 11

Line 13 – Total number of MEDICARE injections done (should be a part of line 11): **Completed by the FQHC**

Lines 14 – 15 – Calculation of the total costs of injections performed: Automatically calculated using data on lines 10 - 13

Line 16 – Automatically calculates total expense of injections for Medicare beneficiaries by taking the sum of columns 1 and 2 for line 14

- Unreimbursed cost carries to **Schedule E, line 3**, as an increase PPS Revenue earned

FQHC (Medicare) Cost Report

Worksheet E – *Reimbursement Settlement*

*Lines 1 – 8 on Worksheet E are derived from the **PS&R***

Line Number	PS&R Report Type	PS&R Section	Line Description
1	77P*	Reimbursement	Gross APC/PPS Payment
4	778**	Reimbursement	Net Reimbursement
6	77P*	Reimbursement	Net MSP Payments
8	77P*	Reimbursement	Coinsurance

**77P Report - All billable charges*

***778 Report - Medical Advantage Supplemental Payments*

FQHC (Medicare) Cost Report

Worksheet E – *Reimbursement Settlement*

Lines 10 - 21 on Worksheet E are derived from the ***FQHC records***

Line Number	Line Description
10	Medicare gross allowable bad debt claims*
12	Medicare allowable bad debt for dual eligible beneficiaries**
14	Enter adjustments needed to PS&R Data if necessary***
21	Protested amounts***

**Medicare allowable bad debt less recoveries. This will be multiplied by 65% for reimbursable bad debt amounts.*

***Gross reimbursable bad debts for dual eligible beneficiaries. (already included on line 10, statistics only)*

****Detailed backup reconciliations are required to substantiate corrections to the PS&R data and protested amounts*

FQHC (Medicare) Cost Report

Worksheet E-1 – *Payment Analysis*

*Worksheet E-1 information is derived from the **PS&R***

Line Number	PS&R Report Type	PS&R Section	Line Description
1	77P*	Reimbursement	Net Reimbursement
3	N/A	N/A	N/A for FQHC

**77P Report - All billable charges*

Line 6.01 – Total settlement due to Provider

Line 6.02 – Total settlement due from Provider

FQHC (Medicare) Cost Report

Worksheet F-1 – *Statement of Revenue and Expenses*

Line 1: Gross Patient Revenues – From FQHC records (or audit) (match visit allocation on S-3)

- Title XVIII Medicare
- Title XIX Medicaid (Vanilla)
- Other

Line 2: Allowances/Discounts – From FQHC records (or audit) including:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Lines 3 and 4: Automatically calculated or derived from Worksheet A

FQHC (Medicare) Cost Report

Worksheet F-1 – *Statement of Revenue and Expenses*

Lines 6 - 15: Additions or Subtractions from Operating Expenses
(Worksheet A, Column 3, Line 100)

– Include non operating revenues and expenses per the audited financial statements or internal records

Line 18: Calculated Net Income from patient services

Lines 19 - 31: Other operating income

– Include other operating revenue not included on line 1:
  - Grants and Contributions
  - Interest and investment income
  - Special event revenue
  - Other

Line 33: Calculated Net Income for the fiscal year

– Should tie to the audited financial statements based on changes in TOTAL net assets or provide reconciliation

FQHC (Medicare) Cost Report

Filing – Requirements – Paper Filing

Hard Copy:

Encrypted and signed in blue ink Worksheet S, Part II

Cost Report Checklist

Full copy of the cost report with all required attachments including a Crosswalk

Electronic (DVD or CD accepted):

Encrypted cost report file

Copy of the Trial Balance

Copy of the Audited Financial Statements

FQHC (Medicare) Cost Report

Filing – Requirements – Electronic Filing

Beginning in May, 2018, electronic upload of cost report files was approved.

https://mcref.cms.gov

The log-in credentials are controlled by EIDM (same credentials as PS&R).

Upload:

1. Encrypted cost report file (ECR)
2. Full copy of the cost report with all required attachments including a Crosswalk (PDF)
3. Signed certification page
4. Copy of the Trial Balance, Copy of the Audited Financial Statements, Bad Debt Listing
5. Cover Page

FQHC (Medicare) Cost Report

Audit and Adjustments

Desk Audit

- Typically 1 – 2 weeks to respond
- Review adjustments for reasonableness
- Re-enter the adjustments into the report in order to determine the change in settlement from the previously filed report
- Call the desk auditor for clarification on any questioned items, or changes in settlement

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Poll Question #6

Your agency has begun gathering the information needed for the cost report:

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Questions?

1.5 CPE Credit Available

- AAFCPAs issues CPE in accordance with NASBA regulations
- To be eligible for CPE you must:
  - Submit answers to all polling questions when they pop up.
  - Complete and submit a written evaluation of the training.
  - Remain logged in to the webinar for the entirety of the program.
- We will email CPE certificates within **two weeks** to the email address you provided.

Thank You!