Iowa Primary Care Association Regulatory Update

Presented by
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Discussion Topics

- Medicare PPS
- Health Care Reform
- Super Circular (new Federal audit rules)
- ICD-10
- Health Center consolidations
- OIG Audits
- PIN 2013-01
- Fiscal cliff considerations
- 340B Program Audits
- New Lease Rules
- PIN 2014-02

Medicare FQHC Reimbursement

- The Medicare FQHC reimbursement system is scheduled to transition to a Prospective Payment System (PPS) for cost reporting periods beginning on or after October 1, 2014
- You will transition to Medicare PPS based on your cost report year (e.g. if you are a 12/31 year-end, you will start January 1st)
Medicare FQHC Reimbursement

- CMS Issued PPS rule in the Federal Register dated May 2, 2014
  - National payment rate adjusted for geographic location (e.g., for CHC’s in Iowa, rate would be $147.57 ($158.85 (national rate) \* .929 (GAF))
  - Application of lesser of charges or PPS rate provision
  - Introducing the new “G” codes – the crux of PPS
  - Coding and charge structure issues are in focus

PPS is Here – What is our Financial Goal?

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

PPS is Here – What is our Financial Goal?

- **Assumptions** for discussion/illustration
  - Recalculated cost per visit = $125.00
  - Current Medicare reimbursement based on cost limit = $112.00
  - Medicare average charge per visit = $102.00
  - Assumed PPS rate of $160.00
- In order to be revenue neutral for the visits “bucket”, the health center’s average charge will need to **increase** by approximately 8%
- **Full recognition** of PPS reimbursement will not occur unless the health center’s average charge is **increased** to $160.00 (a 57% charge increase in this example)
PPS Implementation – “G” Codes

- Establishes a new set of HCPCS G-codes (five payment codes) for FQHCs to report services
  - Established Medicare patient (medical and mental health) G0467 and G0470
  - A new patient visit (medical and mental health) G0466 and G0469
  - An IPPE or AWV - G0468

Medicaid FQHC Reimbursement

- Medicaid PPS under fire – letter from State Medicaid Directors wanting to end PPS as we know it or rebase everyone’s rate – stay tuned

Health Care Reform

- Potential for changing reimbursement
  - Currently visit basis
  - Potentially fixed revenue model
  - Emphasis on outcomes
- Partnering with other providers in the continuum of care
- Stay informed
Health Care Reform

- Medicaid Expansion – The impact of a state’s decision to expand or not expand Medicaid
- Health Insurance Exchange
  - What is the impact on payer mix?
  - What will net payments be?
  - Grant revenues going forward?
- Plan, Plan, Plan
  - Be ready for a variety of contingencies in an ever changing world

Super Circular - Overview

- Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (commonly referred to as the “Super Circular” was published in the Federal Register on December 26, 2013
- Goes into effect January 2015

Super Circular

- Replaces A-110, A-122 and A-133 and other various circulars and Federal guidance
- Super Circular in three sections
  - Administration requirements (subparts B through D)
  - Cost principles (subpart E)
  - Audit requirements (subpart F)
Super Circular
• Strong emphasis on performance goals and reporting (Section 200.301)
• Strong emphasis on internal controls
• Defines computers as supplies, not equipment, if less than the capitalization threshold or $5,000 (Section 200.94)

Super Circular (Section 200.305)
• Reimbursement method preferred, but interest over $500 (was $250) must be remitted back to granting agency
• Interest bearing accounts are still required with few exceptions
• The granting agency is prohibited from requiring a separate bank account

Super Circular
• Internal controls added to administrative requirements (Section 200.303)
• Grantees that have never had an indirect cost rate can receive an automatic 10% rate, if desired (Section 200.414)
Time and Effort Reporting

- Rules focus on maintaining strong internal controls over allocations of wage-related expenses (flexibility!!) (Section 200.430)
- Personal activity reports may be required if requested by the granting agency, but not mandatory unless requested
- Records must still accurately reflect the work performed

Single Audit Changes

- Single audit threshold raised to $750,000
- Type A program threshold raised to $750,000 as well (calculation still required for larger entities)
- All findings must be reported on in the next period's audit – not just compliance findings

Single Audit Changes

- Changes in coverage threshold
  - High risk auditee – must have 40% coverage
  - Low risk auditee – must have 20% coverage
- Questioned costs threshold raised to $25,000
- Audit reports will be public information
- Some changes made to 14 compliance requirements, but probably won't effect CHCs in any material way
ICD-10

- Effective date of October 1, 2015
- To accomplish needed updates, the amount of codes have increased from 13,500 to 70,000
- Biggest issue will be the loss of productivity through error rates and reworking of claims filed
- CMS estimates that it may take up to six months for error rates and accounts receivable to decrease back to pre-conversion levels

“Canada, for example, saw a roughly 40 percent decrease in coder productivity at the outset. Although the productivity levels in Canada have improved over time, they have never returned to those sustained while using ICD-9, instead stabilizing at a long-term productivity loss of about 20 percent”

George Abajoglou, CEO, IOD Incorporated

Consolidations

- Already starting in the FQHC industry in some markets
- There are many FQHCs that are in serious financial distress
- BPHC seems to be becoming more aggressive on sending the grant out for competition. Those best suited to compete are the large FQHCs that have financially stable organizations
Office of Inspector General Audits

- Increased Scrutiny of FQHCs
- FQHCs with seven figure federal recoupments
- Time Card Approval & Coding
- Strengthened Policies
- Improved Documentation
- PIN 2013-01

OIG Audits of Community Health Centers

- OIG focus on financial indicators include
  - Days operating cash on hand (goal: >60)
  - Current ratio (goal: >1.50)
  - Cash ratio (cash/current liabilities; goal is to see a stable or increasing trend)
  - Working capital (goal: >2 months expenses)
  - Days revenue in accounts receivable (goal: <65 days)
  - Earnings trend (seek positive trend for sustaining core health center functions)

Policy Information Notice 2013-01

- Expectations gap
  - How are FQHCs doing things?
  - How the Bureau & OIG want FQHCs to do things?
- Documentation is key
- Segregate grant expenditures from non-grant funds
- All Section 330 grant expenditures have to be documented in your accounting records
Current Environment – What About the Future?

- Work needs to start now toward elimination of the FFY '16 "funding cliff"
- Absent a legislative act of Congress to fix this issue, health center federal grant funding will be reduced by 70%!
- Cost to fix this issue is $20B over a five year period that NACHC is pursuing (FFY '16 – FFY'20)
- Health centers now receive two streams of funding:
  - Mandatory funding under the Affordable Care Act
  - Base discretionary funding from Congress

Health Center “Funding Cliff”

Community Health Center Funding:
FY 2010 – FY 2016

340b Program Audits

- Policies & Procedures
- Office of Pharmacy Affairs (OPA) Database – Match EHB Scope of Project
- Diversion
  - Managing & Tracking Inventory & Disbursements
  - Patient Definition
- Duplicate Discounts – State Medicaid Getting Rebates
**New Lease Rules**
- No beginning date announced
- Requires that all leases, other than short-term leases, to be recognized on the balance sheet and includes a “dual model” income and expense recognition approach which will depend on lease classification
- Will require more monitoring and record keeping

**PIN 2014-02 – Sliding Fee PIN**
- Purpose of Sliding Fee Discount Program
  - Assure that no patient will be denied ACCESS to health care services due to inability to pay
- 3 Components to a compliant Sliding Fee Discount Program
  - Fee Schedule
  - Sliding Fee Discount Schedule
  - Billing and Collections Policies

**PIN 2014-02 – Fee Schedule**
- Intended to generate revenue to cover reasonable costs health center incurs for providing services
- Should be reviewed annually
- Considerations when developing fee schedule
  - Services off on form 5a
  - Locally prevailing rates or charges for services
    - Medicare, Optum (formerly Ingenix)
  - Cost to provide required and additional services
Sliding Fee Discount Schedule

- Federal property guidelines updated annually
- SFD Policies should be approved by board and address the following:
  - Family & Income Documentation – Unique to Health Center
  - Grace periods, temporary eligibility, discount cash payment
  - Consideration for population should be considered
    - Homeless, Migrant, etc.

Sliding Fee Discount Schedule

- Must have multiple pay classes tied to graduations in income
  - At least 3
  - Nominal fee (full discount or similar cost) for patients below 100%
  - Patients between 100% - 200% should not receive full discount – Over 200% no discount
  - Fixed fee or percentage of fee
  - Multiple for services i.e. Medical, Dental, BH

Sliding Fee Discount Schedule

- Underinsured individuals may not pay more than uninsured patients in same income category
- Co payments and deductibles must be slid using Sliding Fee Discount Schedule
- Related charges “not incident to” service (eyeglasses)
  - Not required to apply SFDS
  - Charges should be noted on SFDS
Billing and Collections Policies

- Health center required to maximize revenue from Public and Private payers
- Health Centers can not turn away patients with third party insurance
- Health Centers can not require patients to enroll in Medicaid / Medicare. If a patient chooses not to enroll, a Health Center should put the patient on the SFDS if the patient is eligible

Payment incentives for prompt payment

- May be offered to patients if accessible to all patients (including individuals below 200% of FPG receiving SFDS)
- Refusal to pay
  - Established policies should define “refusal to pay” & steps to be followed
  - Patient discharge should be reviewed as last resort & re-admittance policy should also be in place
THANK YOU

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