FQHC & RHC

Q and A session held on December 14, 2017

CHAMPS Facility Settlement Subsystem

1. Are we filing our Medicare cost report through CHAMPS?

   Yes, FQHCs and independent RHCs will be required to upload an electronic copy of the Medicare cost report (CMS-224-14) that is submitted to CMS/WPS in order to successfully submit a Medicaid cost report package. Provider-based RHCs are exempt from this requirement as described in question 8.

2. How do we determine the Magi 1, Magi 2 etc. when completing our data?

   The Program types will automatically flow into the appropriate columns on the worksheets after clicking the 'Populate Claims Data' button. Providers may override these amounts and fill out a validation warning if they disagree with how the claims were generated. When preparing a Medicaid settlement, we will only be using the claims data as retrieved at that time which will be automatically sorted into the proper Program type.

3. Is the Medicare Auditor our Medicaid Auditor?

   No, the Medicare Auditor is not the same role as a provider's Medicaid Auditor. The Medicare Auditor will be the person from the Hospital & Clinic Reimbursement Division who reviews and accepts the Medicare cost report data used in the calculation of the initial/final settlements.

4. When is this report due?

   The Medicaid cost report due date is still the same as before which is five months after the end of a fiscal period. The Cost Report itself won't appear in the new system until three months after a fiscal year-end. A message indicating that a report is ready for submission will be sent to individuals who have applied for access to a Facility ID.

5. Do we no longer have to mail our Medicare cost reports to the NGS/WPS? When this launches we simply send them to MGS/WPS by uploading through this website?

   Providers are still required to submit the Medicare cost report to their intermediary in the manner required by CMS. We are asking for an electronic copy of the report that was submitted to CMS to be uploaded to our system as one of the required items for a Medicaid cost report (except for provider-based RHCs).

6. Do all FQHC's have to submit a Medicaid cost report?

   All FQHCs will need to submit a Medicaid cost report per Medicaid policy. This report is the only means for providers to receive the PPR on encounters for Medicaid services rendered. In addition, the interim payments which serve as advances on the Medicaid settlement need to be accounted for or potentially returned to the State via the reconciliation process.

7. When does this submission process begin?

   The new Facility Settlement (FS) module will launch on January 2, 2018 for which providers will need to apply for access for the "FS Clinic" role if a FQHC or RHCI and "FS Clinic RHCP" if a provider-based RHC.

8. For those with hospitals, will the 2552 have to be submitted first to the hospital division?

   Yes, the Medicare cost report that is uploaded for a Hospital settlement will be used for provider-based RHCs. The hospital's Medicare cost report must be validated and submitted before the RHCP's Medicaid cost report can be submitted. There will not be a Prepare Medicare Cost Report function for RHCPs in the FS system.

9. Does an HMO listing need to be included with the cost report still?

   No, the HMO listing/HP Detail spreadsheet will no longer be a required item for submitting a Medicaid cost report. All HP claims will now be pulled from CHAMPS when automatically populating the cost report.

10. Does this apply to our 3/31/16 submission?

    Medicaid cost reports with fiscal year-end dates before the FS system goes live and haven't yet been accepted can have a special ticket created so that the FS system will generate a cost report for a prior fiscal period.

11. Is it agreed to contractually that if there is a breach of information that occurs the provider is responsible for penalties and fines?

    The legal disclaimer that must be agreed to before accessing CHAMPS has details on this topic.

12. Can 2 users at the same organization generate reports separate without overriding on another if separate CHAMPS accounts are used?

    Each Medicaid cost report is tied to one Facility ID which is how we track and monitor the settlements disbursed and interim payments (advances) paid throughout a fiscal period. Multiple people can access the same cost report at a given time but any updates made to the cost report after clicking 'Save' will overwrite previous data.

13. Where can we find definitions for each of the MAGI categories?

    The definitions for the various MAGI levels are as follows (all are qualified under the Healthy Michigan Plan/expanded Medicaid):

    i.MAGI I Newly Eligible
    ii.MAGI D Old Eligible 19-20 Yr
    iii.MAGI P Old Eligible – Disabled
    iv.MAGI Q Old Eligible – Disabled – Non-Institutional
    v.MAGI R Old Eligible

14. Will Trial Balance Reports still be necessary?

    Yes, the trial balances as of the FYE date being submitted are still required. These will need to be uploaded as a Comment in the Member Count Months worksheet in the Cost Report. Please select Comments (to the right of Validation Errors button) and then Add to create a comment with the text "Trial Balance [insert FYE date]" and selecting ALL for the Line Number and Cost Field dropdowns. Upon clicking OK, select the icon beneath the Comments column to upload the trial balance as an attachment.

15. Are we just uploading our already prepared Medicare Cost Report?

    Yes, we are requiring that the Medicare cost report that was submitted and accepted by a provider's CMS intermediary be uploaded to the FS system.

16. Can we run a detail claims report is CHAMPS before we import? So far we have to request the detail from our auditor.

    Until notified by the Hospital & Clinic Reimbursement department, claims detail reports will still need to be requested to the clinic's assigned auditor. The FS system will eventually allow providers to see the detailed claims data at a later date.

17. Will we be able to pull data throughout the year using this system? Or will we still need to request data pulls for our Medicaid auditor?

    Please refer to question 16 on this topic.

18. What about prenatal packages that haven't been completed by the 5 months after our year end? We have to ask to refile every year, now with this automatic process how does this work?

    The prenatal visit packages (59425 and 59426) that haven't yet been completed by the fiscal year-end date of a Medicaid cost report will not require a refiling of the data since the MHP claims data comes directly from CHAMPS. The claims may not be included in an initial Medicaid settlement.

    However, the prenatal claims should be included in the final settlement which cannot be created until 12 months after a cost report's FYE date. It is assumed that any unfinished prenatal packages will be completed, billed to a payer, and

reimbursed by this time. All claims data will be repopulated when calculating the final settlement to capture any late or rebilled claims.

19. We uploading the “encrypted Medicare file” of what was submitted to our Medicare intermediary, correct?

    The Medicare cost report (CMS-224-14) that is submitted to CMS should be the one that is uploaded for a Medicaid cost report. The file itself will need to follow the naming convention shown in the presentation. Nancy – I don’t know what would be used for format – do you? I like Adam’s comment here to refer back to presentation.

20. Will there be a FD622 style summary in CHAMPS for the clinics?

    There will be claims and encounter summary and detail reports available in the new system at a later date. Also, please refer to question 16 on this topic.

21. Is this replacing the MMF program?

    The MMF program will be replaced with the new FS system in order to document the Medicaid visits and payments received during a fiscal period and reconcile the amounts due to or from a provider.

22. If there are discrepancies between CHAMPS Health Plan data and the Health Center’s, how should a Health Center go about addressing/reconciling variances?

    The provider will need to reach out to the MHPs in order to resolve discrepancies with how the MHP claims are presented on CHAMPS. A provider’s assigned auditor has a list of contacts at the MHPs who can update the data on CHAMPS.

    When completing the cost report, you are welcome to override the amounts that were automatically populated by the FS system. Be warned that a validation warning will be generated that will require a comment box to be filled out along with offering an option to upload documents in support of comments.

23. We still need to upload a detail through July 31, 2017 but claims after August 1, 2017 should automatically populate, correct?

    I believe that this question is referring to institutional claims billing which only applies to FFS claims billed directly to CHAMPS. This methodology started for FFS claims with DOS on or after 8/1/2017 which will automatically populate into a Medicaid settlement.

24. We have 2 facilities we have closed and the payments for those did not reflect on the CHAMPS file transfers. If you are only using the data in CHAMPS, how will that work?

    The interim payments disbursed to a provider are associated to a Facility ID for which a settlement will be generated upon successful submission of a Medicaid cost report for said Facility. Facility IDs are the Medicare ID for a provider with two letters replacing the leading ‘23’; FQ for FQHCs, RP for RHCPs, and RI for

RHCIs. Billing NPIs with FQHC/RHC specialty on CHAMPS will be associated to a particular Facility ID. For sites that have closed and had payments issued under a billing NPI different from one now used, the interim payments will be recovered under the Facility ID associated to the old NPI.

25. What would some reasons to edit data? A large AR due to a billing issue for example.

    Providers are allowed to override the data that is populated into a settlement if they feel the amounts are materially different from their internal records. Doing this will result in a validation warning being generated after clicking the 'Validate' button which must have comments entered in the comments box along with potentially uploading any support documentation.

26. Will our contracts still be necessary?

    Yes, the contracts that providers establish with MHPs will need to be uploaded along with the MHP's Provider ID to the Associated MCO dropdown under a billing NPI in the Provider List in CHAMPS. Provider Support has more info on this process. Lines for particular MHPs will only appear on the worksheets for those that have contracts on file on CHAMPS.

    As a suggestion, the MHP claims detail reports that are routinely generated by our department contain the seven digit Provider IDs that were created by the MHPs to track certain patient populations. We don't filter the results at this time for contracts to be present with MHPs but this will be in effect when preparing the Medicaid cost report in the FS system.

27. Our November CHAMPS data sent to us only contains claims with services dates through 3/31/17, will the CHAMPS data be available more timely since we need to begin preparation in April?

    The MHP claims detail that contained data with DOS through 3/31/2017 was generated as support for the new interim payment amount to be disbursed in January 2018 unless a specific request was made to a provider's auditor. Likewise, providers can contact their assigned auditor to run the MHP query for claims over a date range of the provider's selection to compare with internal records.

28. Are we able to change the Medicaid encounter numbers for the health plans within this system? So far, only 4% of our dental health plan claims appear on the SOM report.

    As mentioned in the response to question 26, providers can override any values in the worksheets that they would like in order to report their anticipated visits/payments amounts. Please be prepared to explain why the modified values are more accurate in reflecting the fiscal period's activity in the validation warning comment boxes.

29. Will you accept any claims data from us or will claims data only come from the insurance carriers?

    The only MHP claims that will be used in a Medicaid settlement must come from the data uploaded by the MHPs to CHAMPS. Providers can upload examples or summaries of paid claims missing from CHAMPS as support for validation warnings but the data will eventually need to be present in CHAMPS in order to pay the PPR on MHP claims.

30. Our Medicare and Medicaid cost reports are due the same time. If CHAMPS kicks [out] our Medicare cost report with an error and the auditor needs to review, how long will this take?

    The Medicare Auditor will typically review the files within 7 business days. If software updates are required, this process could extend further which would require an extension request to be submitted.

31. Will we be receiving notification from CMS if this is how we are submitting our Medicare cost reports?

    Providers will still need to follow established procedures with their Medicare intermediaries for submitting cost report data to CMS. The State is not involved at all with this process and is only asking for an electronic copy of the report sent to CMS.

32. How do you want encryption unlock codes to be sent?

    If necessary, it is suggested to send the unlock codes to the clinic's assigned auditor in a separate email message.