RHC Cost Reporting 101

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Objectives

- Why a cost report is needed
- What you need to complete the cost report
- Common cost report calculations and where they are located on the cost report
- How to read and interpret the report

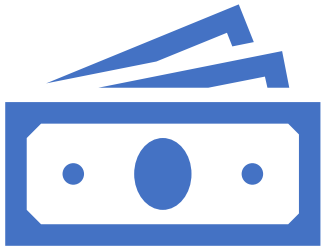
Why a Cost Report?

- Medicare will cut off payments to the clinic for an unfiled cost report
- Cost reports are due 5 calendar months from the clinic's year end
- Cost reports must be submitted in electronic format (ECR File) on CMS approved vendor software via MCReF or Hard Copy.
- Wet signature submissions still required if hard copy is the method used to submit to the MAC

What does the Cost Report do for me?

- **Reconciles** Medicare's interim payment method to actual cost per visit
- Determines **future interim payment** rates
- It is where you **get paid** for:
  - Pneumococcal and Influenza **vaccine costs**
  - Medicare **Bad Debt**

How is the rate calculated?



COST / VISITS = **RHC RATE**

Is that what I get?

- **Independent RHCs THROUGH APRIL 1, 2021**:
  - Subject to a ceiling/cap = $87.52

- **Independent RHCs AFTER APRIL 1, 2021:**
  - Subject to a ceiling/cap = $100.00 4/1-12/31/21
  - Increasing cap through 2028 when cap will be $190.00

Is that what I get?

January 1 –March 31 **$87.52.**

On April 1 – Dec 31 **$100.00**

It then rises as follows:

- **2022 $113.00**
- **2023 $126.00**
- **2024 $139.00**
- **2025 $152.00**
- **2026 $165.00**
- **2027 $178.00**
- **2028 $190.00**

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Is that what I get?

- **Provider based >50 bed hospital**: Capped same as independent

- **Provider based <50 bed hospital**:
  - Actual cost per visit from reports ending in 2020, indexed by MEI for existing RHCs
  - Capped same as others for new provider based RHCs after 12/31/2020

Where are these located:

- **Cost: Worksheet A/M-1**
  - **A-6 is where we reclassify cost**
  - **A-8 is where we take things off and put things on**
- **Visits: Worksheet B/M-2**
- **Rate/Settlement: Worksheet C/M-3**
- **Vaccines: Worksheet B-1/M-4**

What information do I gather for the cost report?

- Financial Statements including depreciation schedules
- Visits by type of practitioner (and how many were telehealth)
- Clinic hours of operation
- FTE calculations
- Total number of clinical staff hours worked during the cost report period.

What information do I gather for the cost report?

- Salaries by employee type
- Vaccine logs and invoices
- Telehealth Volume (and time if kept)
- CCM Volume
- Related Party Transactions

What information do I gather for the cost report?

- Medicare Bad Debt
- Laboratory Costs/Data
- Non-RHC X-ray Costs/Data
- PSR - obtained on-line through Medicare

Statistics on Worksheet S-1 – Independent/S-8 Provider Based

- Facility Name
- Entity Status
- Hours of Operation
- Related Organization information

Statistics on Worksheet S-1 – Independent/S-8 Provider Based

- Malpractice insurance
  - Claims or Occurrence based?
  - Amount paid?
- Part II for additional clinics reported on a consolidated report

Clinic Hours of Operation

Should reflect hours practitioners are available to see patients

Broken between hours operating as an RHC or a Non-RHC, if applicable

Reported in military time format

S-2 Reimbursement Questionnaire

Replaces CMS 339 Questionnaire for independent RHCs

Same questions as old questionnaire

Now embedded into report, no additional signature required

S-3 RHC Visit breakdown

- Medical
- Mental Health (including telehealth from 1/1/22)
- Interns and Residents

S-3 RHC Visit breakdown

1

Title V – Maternal and Child Health Services Block Grant

2

Title XVIII – Medicare

- Regular Medicare
- Not Medicare Advantage
- Must agree to PS&R

3

Title XIX – Medicaid

4

Other -
Commercial
Self Pay
Medicare Advantage

Worksheet A / Worksheet M-1 – Expense Reporting

Expense Reporting – What you need

BALANCE SHEET

PROFIT AND LOSS STATEMENT

TRIAL BALANCE

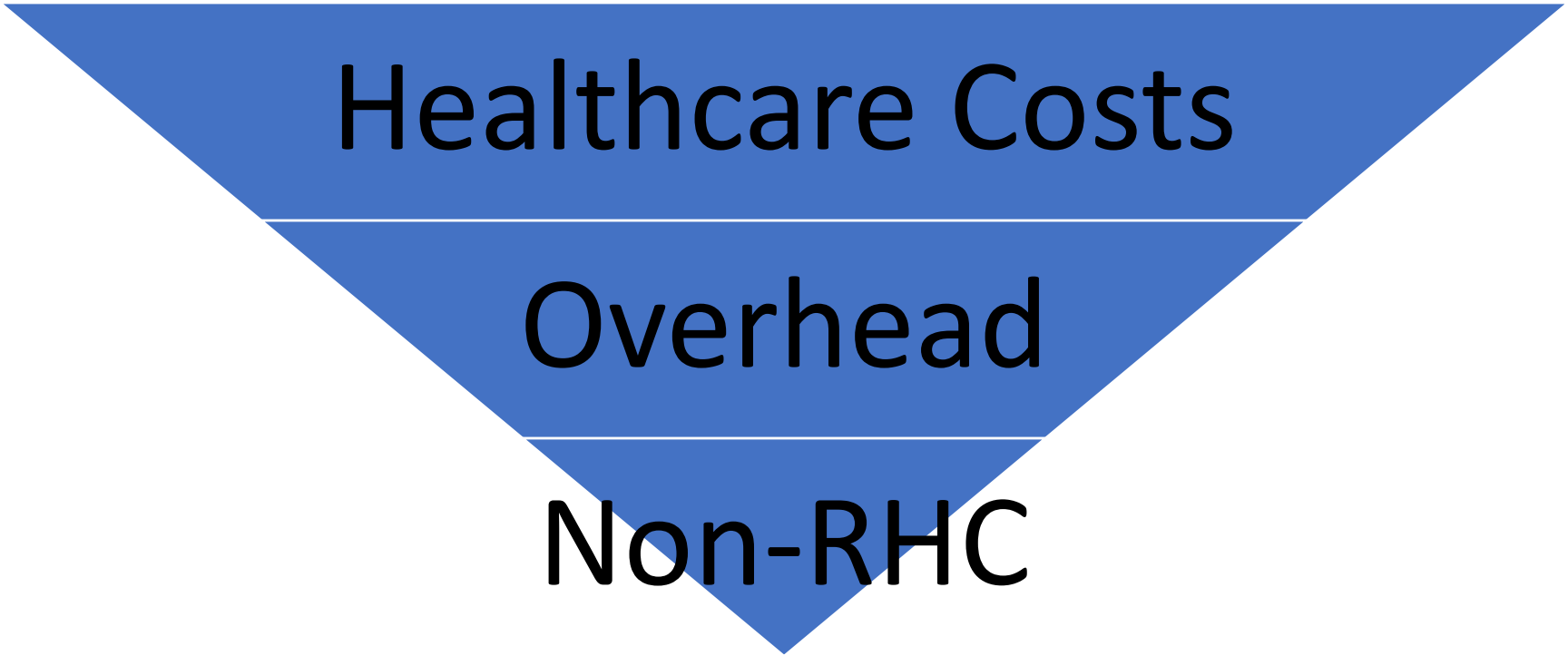
Expense Reporting – How you need it

- Financial Statements must match cost reporting period
  - For most this will be 1/1/xx–12/31/xx.
  - For new clinics, financial statements must reflect costs from the date of the clinic's certification to the end of their first fiscal year.

Expense Reporting – Where it goes

- All costs from the financial statements must be reflected in columns 1 and 2 of worksheet A (independent) or M-1 (provider-based)
  - Column 1: Compensation
  - Column 2: All Other
- Expenses should be detailed enough to properly classify within cost report categories

COSTS – WORKSHEET A/M-1



Healthcare Costs

- Compensation for healthcare staff
- Compensation for physician supervision
- Medical Supplies
- Malpractice/License fees/CME

Other Health Care Costs

- Malpractice and other insurance (Premium can not exceed amount of aggregate coverage)
- Professional Dues and Subscriptions
- Medical Supplies
- Flu and Pneumo Vaccines
- Transportation of Health Center Personnel between clinics or other healthcare locations

Overhead

TWO TYPES

- FACILITY
- ADMINISTRATIVE

Facility Overhead

RENT

INSURANCE

INTEREST ON MORTGAGE

UTILITIES

OTHER BUILDING EXPENSES

Administrative Overhead

Office salaries

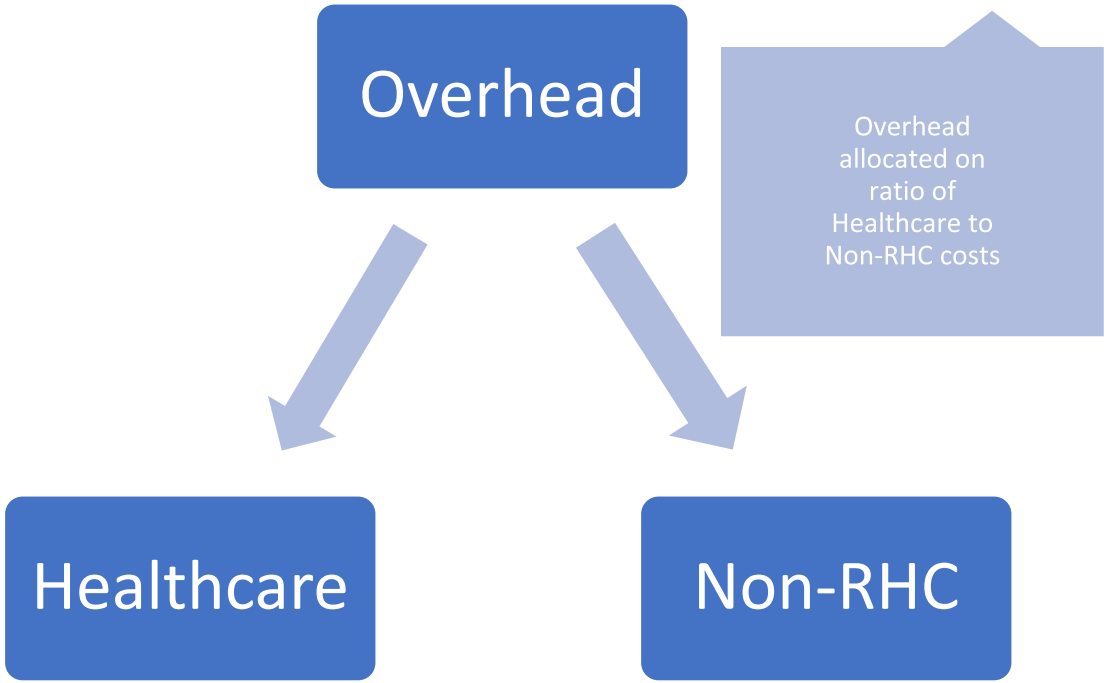
Office supplies

Legal/Accounting

Telephone/IT costs

Other administrative costs

Overhead allocations



Non-RHC

- Only include items that use overhead!
- Most common Non-RHC
  - Technical component of Lab, X-Ray, EKG
  - CCM and Telemedicine
  - Other items not covered under the RHC program or paid outside of the RHC rate
- **ONLY LEAVE AMOUNTS IN THE NON-RHC SECTION IF THEY NEED TO CAPTURE OVERHEAD**

Expense Reporting – what doesn't belong

Miscellaneous/Non-Patient Care revenue must be reviewed for possible offsets

Non-allowable expenses must be reviewed for offset or classification in a non-reimbursable cost center

Other Costs

- Advertising Costs:
- Staff recruitment advertising allowable
- Yellow pages advertising allowable
- Advertising to increase patients not allowable
- Fund-raising advertising, not allowable
- Taxes:
- Taxes levied by state and local governments are allowable if exemption not available
- Fines and penalties not allowable

Worksheet A-6 / A-8 – Adjustments to cost

Adjustments

Worksheet A-6: Used to reclassify costs to appropriate cost centers

Worksheet A-8: Used to include additional or exclude non-allowable costs

Lab/X-ray/EKG Allocations Worksheet A-6

Lab, X-ray, EKG

Billed to Part B by independent RHCs

Billed through hospital and included in hospital costs for provider-based RHCs

Lab/X-ray/EKG Allocations

- Method A: Staff performing lab, X-ray, EKG duties
  - Allocate % of time for non-RHC carve out for staff performing non-RHC lab/ X-ray/EKG duties vs. RHC duties
  - Time studies of staff to support the allocated carve out
- Method B – Time studies for each specific test
  - Calculate time per test
  - Multiply by number of tests performed
  - Multiply by average hourly wage
- Reclassify resulting non-RHC wages into non-reimbursable cost center

CCM/Telehealth

If staff performing CCM and/or Telehealth wear multiple hats in your clinic, use same calculations/methods as Lab/X-Ray/EKG

- Reclassify staff cost
- Report direct costs directly into the Non-RHC cost center

Chronic Care Management

- Is CCM done in the clinic, by clinic staff?
  - Reclassify direct healthcare staff costs into Non-RHC cost center
  - New line 80 on independent reports
- Is CCM handled by an outside company?
  - Exclude direct CCM costs
  - Exclude associated billing costs/incremental overhead costs

Telehealth

- Pre-COVID: RHCs may serve as an originating site for telehealth services
- During PHE: RHCs may serve as either the originating or distant site
- Originating site is the location of the patient at the time of service.

Where do we put Telehealth?

Cost of providing telehealth services must be classified in the Non-RHC section on Line 79 for Independent, Line 25.01 Provider Based

Possible cost additions…

- Depreciation should be adjusted from tax basis to Medicare basis (straight line)
- Owner’s compensation for sole proprietors and partnerships

Exclude…

ENTERTAINMENT

GIFTS

CHARITABLE CONTRIBUTIONS

AUTOMOBILE EXPENSE – WHERE NOT RELATED TO PATIENT CARE

Income offsets…

INTEREST INCOME UP TO INTEREST EXPENSE

MEDICAL RECORDS INCOME

INCOME FROM SPACE RENTED TO OTHERS (UNLESS YOU CAN IDENTIFY COSTS)

OTHER MISCELLANEOUS INCOME

Worksheet A-8-1 Related Party Transactions

Related Party Transactions

Medicare allows actual cost (only) for items and services purchased from a related party

Related Party Transactions

Most common related party transaction is related party building ownership (e.g. building is owned by the doctors which also own the clinic – clinic pays ‘rent’ to docs)

Cost must be reduced to the ‘cost of ownership’ of the related party

Cost is adjusted to actual expense incurred by the related party

Related Party Transactions

Clinic Name:	ABC Family Practice			
F.Y.E.:	12/31/2020			
A-8-1 Related Party Transaction				
	Column 5 A-8-1			**Column 4 A-8-1**
	Manually fill in these three columns only			
	Worksheet A	**Allowable Cost**	**Allowable Cost**	**Total**
	Cost Report	**included in Worksheet A**	**not included in Worksheet A**	**Allowable Cost**
Related Building Expenses	**Trial Balance**	**Trial Balance**	**Trial Balance**	**Column 4**
Depreciation	$ -	$ -	$ 15,935	$ 15,935
Interest	0	0	37,203	37,203
Insurance	4,407	4,407	0	4,407
Property Taxes	9,908	9,908	0	9,908
Repairs and Maintenance	1,222	1,222	456	1,678
Building Rent	115,200	0	0	0
Total Building Expenses	$130,737	$15,537	$53,594	$69,131

Worksheet B / Worksheet M-2 Visits and FTE reporting

RHC Visits

Definition: Face-to-face encounter with qualified provider during which covered services are performed.

Broken down by provider type (MD, PA, NP…)

Count only face-to-face encounters

Do not include visits for hospital, non covered services, non qualified providers or injections

Do not include MEDICAL TELEHEALTH (Mental Health telehealth included as of 1/1/22)

Visits

Visits are reported by type of clinician

Physician

Physician Assistant

Nurse Practitioner

All clinician's working on a regular basis should be included in visits subject to the productivity standard

Physician Services Under Agreement – for the occasional 'fill in' (locum tenens)

FTE Calculation

How are FTEs calculated?

- FTE is based upon how many hours the practitioner is available to provide patient care
- FTE is calculated by practitioner type (Physician, PA, NP)

Medicare Productivity Standard

- Medicare will charge the clinic with a minimum number of visits per FTE, whether performed or not
- 4,200 visits per employed or independent contractor physician FTE
- 2,100 visits per PA and NP FTE
- Physician Services under agreement not subject to productivity standards – limited application (cannot work on a regular basis)

Medicare Productivity Standard

- Productivity Standard applied in aggregate
- Total visits (all providers subject to the FTE calculation) is compared to total minimum productivity standard.
- A productive PA/NP with visits in excess of their productivity standard can be used to offset a physician shortfall.

FTE – RHC Clinical Hours only…

- If after carving out teleheath hours you still have COVID related FTE productivity standard issues, please contact your MAC.
- Each MAC has indicated their intent to waive the productivity standard for 2020, when requested
- Reminder - Exclude telehealth time from RHC FTE calculations, THEN, if still needed request an exception

Worksheet B-1 / Worksheet M-4 Vaccine Reporting

Vaccine Information

Seasonal Influenza, Pneumovax and Covid Vaccines and Monoclonal Antibody reporting have four data elements:

- Staff Time Ratio
- Total given of each to ALL insurance types
- Total Medicare given of each (Medicare log must accompany cost report)
- Cost of vaccines/antibodies must be reported in (or reclassified to) the appropriate cost centers on A for independent RHCs.

Vaccine staff time ratio

- Total number of clinical staff hours worked per year becomes the denominator in the vaccine ratio. **All clinical staff** are included, as all clinical salaries are used in the cost report calculation
  - Physicians
  - RN/LPN
  - MA

Vaccine staff time ratio

- Ten minutes is the accepted time per vaccine administration for Flu and Pneumo
- Time Studies recommended for Covid vaccines & antibody treatments
- Total Vaccines x 10 minutes/60 minutes = ‘total vaccine administration hours’
- Divide ‘total vaccine administration hours’ by total clinical hours worked for **Staff Time Ratio**

Vaccine Cost Documentation

Clinic must maintain logs of Influenza, Pneumococcal, and Covid vaccines and Monoclonal Antibody Products administered

Invoices for the cost of Influenza and Pneumococcal vaccine should be submitted with the cost report

Submit vaccine logs electronically if possible

Covid Vaccine Documentation

- Clinic must maintain logs of Covid vaccines administered

- For Medicare beneficiaries (Regular and Med. Advantage)
  - Patient Name
  - Medicare Number
  - Date of Vaccine
  - Vaccine brand

Worksheet C / Worksheet M-3 Settlement data

Settlement Data

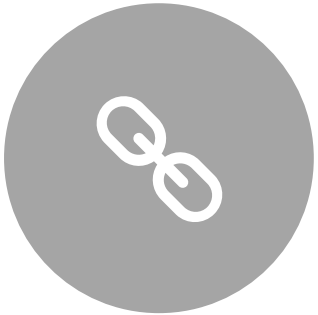
- Data is pulled from the clinic's PS&R
- Medicare visits – include preventive visits
- Deductibles
- Total Medicare charges
- Medicare preventive charges

Settlement Data

- Data is pulled from the clinic's PS&R
- Primary Payer Payments – MSP payments
- Medicare payments
- Bad Debts – Total
- Bad Debt – Dual Eligible

PS&R

A COPY OF YOUR PS&R (PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM REPORT) WILL NEED TO BE OBTAINED BY THE CLINIC ELECTRONICALLY THROUGH CMS'S ENTERPRISE PORTAL AT HTTPS://PORTAL.CMS.GOV/



GO TO THE FOLLOWING LINK TO ACCESS THE PS&R: HTTPS://PSR-UI.CMS.HHS.GOV

NOTE: IF YOU NEED ACCESS OR ARE HAVING DIFFICULTY CHANGING YOUR PASSWORD, PLEASE CALL THEIR HELP DESK AT 866-484-8049

PS&R

- Login using your user ID and password (you may have a two step authentication)
- Enter your user ID and Password
- “Request Report” (at the top under blue CMS banner)
- Select “Request Summary”
- It should be defaulted to the “By Report Type” button…**select Report Type 710** and hit the >> button to move it into the ‘selected report types’ field
- Do the same for **report type 71S**
- Hit “Continue”
- Leave interval as “year” and input 01/01/2020 in the start date field
- Hit “Apply”
- Hit “Continue”
- Select PDF, and hit “Continue”
- Hit “Submit”
- The next hour or two, check back to the report inbox for your report.

PS&R

- Compare PS&R total to your Medicare visit count. Is this accurate? If not, determine why:
  - Were incidental services included in the visit count
  - Were dual-eligible counted twice
  - Did more than one visit get counted on one day (surgical procedure/office visit)

Medicare Bad Debt

- Medicare bad debt form must accompany cost report of total bad debt being claimed.
- Medicare bad debt is claimed on the cost report based on the fiscal year in which the bad debt was **written off**, not date of service.

When to write off a Medicare Bad Debt

- The CFR at 42 CFR 413.89(f) requires that the uncollectible Medicare deductible and coinsurance be charged off as bad debts **in the accounting period when the bad debt is determined to be worthless.**

Medicare Bad Debt

- Medicare Bad Debt IS:
  - Deductibles and Coinsurance amounts uncollectible from Medicare beneficiaries after reasonable collection efforts

Medicare Bad Debt

- Medicare Bad Debt IS NOT:
  - Uncollected deductibles and coinsurance from:
    - private pay patients, or any other non-Medicare beneficiary
    - Medicare Advantage or Medicare Part B
  - Charity, Courtesy, and Third-Party Payer Allowances
  - Uncollected amounts due from other payers
  - Disputed Medicare claims

Bad Debt Log

Patient Name
HIC number
Date of service
Whether the patient has been deemed indigent and their Medicaid number if this was the method utilized to determine indigence
Date the first bill was sent to the beneficiary
Date the bad debt was written off
Remittance advice date
Deductible and coinsurance amount
Total Medicare bad debt (reduced by recoveries)

Medicare Bad Debt

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

CLINIC NAME:	
PROVIDER NUMBER:	
FYE:	

WORKSHEET 9 - MEDICARE BAD DEBT LOG

1	2	3	4		5	6	7	8	9	10	11	12
											Other Payments and Patient	COLUMNS (8+9-10-11=12)
			Indigency & Med. Recip. (check if applicable)		Date First Bill Sent to Beneficiary	Write-Off Date	Medicare Paid Date	Medicare Deductible	Medicare Co-Ins	Medicaid Payment	Payment	
Beneficiary Name	Beneficiary HIC No.	Date(s) of Service	Yes	*must supply Mod. #				Bad debt	Bad debt	Amount	Amounts	Total Bad debt

* These amounts must not be claimed unless provider bills for these services with the intention of payment. See instructions for outline 4 - indigency/welfare recipient, for possible exception.

Bad Debt Reduction Schedule

- Beginning in 2013, RHCs were subject to a reduction in the amount of allowable bad debt reimbursement. These reductions, mandated by section 3201 of the Middle Class Tax Extension and Job Creation Act of 2012, took effect in cost reporting periods beginning in FY2013. FY2015 and later reports are reimbursed at 65% of allowable bad debts.

Questions?

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