RHC Cost Reporting 101

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Promoting Access to Health Care

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Objectives

- Learn cost report flow and inputs
- Review common cost report calculations and where they are located on the cost report
- Discuss recent cost report changes

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**
  - **NEW: Covid vaccine administration & Monoclonal Antibody Products**

How do I file it?

- 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

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 2029 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**

Is that what I get?

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

- **Provider based <50 bed hospital**:
  - Actual cost per visit from 2019 indexed by MEI for existing RHCs
  - Capped same as others for new provider based RHCs after 12/31/2020

How does the cost report flow?

- 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

Information Needed to Complete the RHC Cost Report

- Financial Statements
- Visits by type of practitioner
- Clinic hours of operation
- FTE calculations
- Total number of clinical staff hours worked during the cost report period.

Information Needed to Complete the RHC Cost Report

- Salaries by employee type
- Vaccine Information
- Related Party Transactions
- Depreciation Schedule

Information Needed to Complete the RHC Cost Report

- Medicare Bad Debt
- Laboratory Costs
- Non-RHC X-ray, EKG, CCM, Telehealth Costs
- PSR - obtained on-line through CMS Portal

Worksheet S – Statistical Data Reporting

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
- Interns and Residents

S-3 RHC Visit breakdown

- Title V – Maternal and Child Health Services Block Grant
- Title XVIII – Medicare
  - Regular Medicare
  - Not Medicare Advantage
- Title XIX – Medicaid
- Other (Include Medicare Advantage in Other)

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 – On A for Independent RHCs
- Transportation of Health Center Personnel between clinics or other healthcare locations

Overhead

TWO TYPES

- FACILITY
- ADMINISTRATIVE

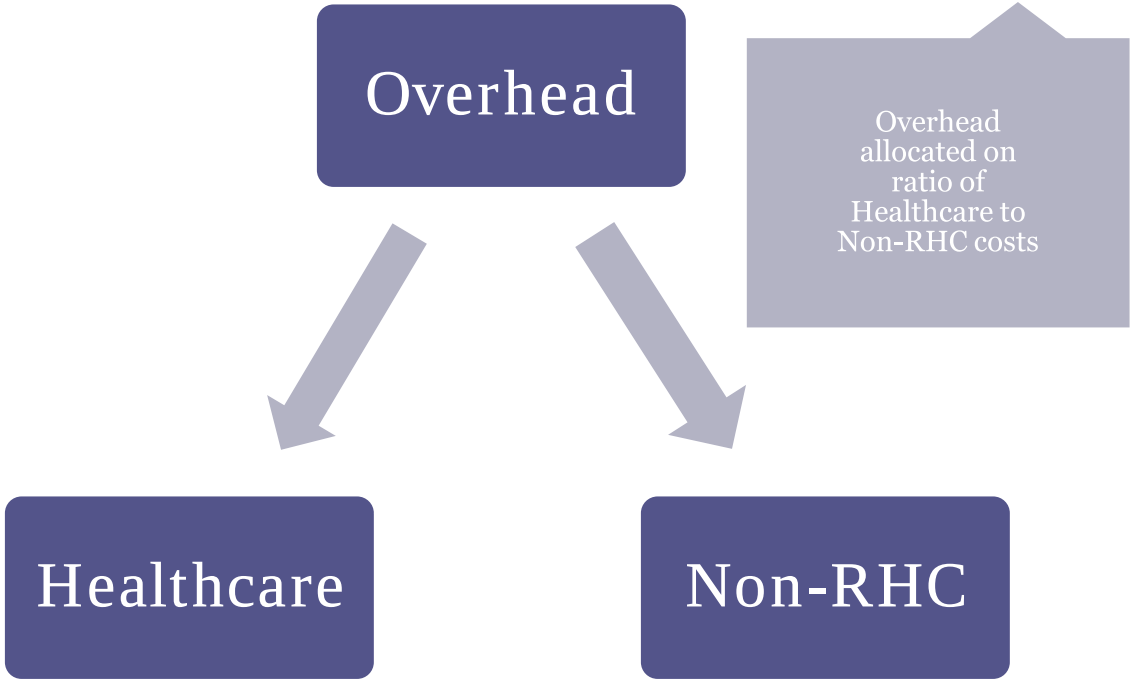
Facility Overhead

- 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 Worksheet A-6

- Method A: Time the person
- Method B: Time the test

Lab/X-ray/EKG Allocations

- Method A: Time the person
  - 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

Lab/X-ray/EKG Allocations

- Method B – Time the test
  - Calculate time per test
  - Multiply by number of tests performed

Lab/X-ray/EKG Allocations

- Take hours calculated from Method A or B
- Multiply by average hourly wage
- Reclassify resulting non-RHC wages into non-reimbursable cost center

Chronic Care Management

- Is CCM handled by an outside company?
  - Exclude direct CCM costs
  - Exclude associated billing costs/incremental overhead costs

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

Chronic Care Management

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

- Method A: Time the person
- Method B: Time the service

Chronic Care Management

- Take hours calculated from Method A or B
- Multiply by average hourly wage
- Reclassify resulting non-RHC wages into non-reimbursable cost center

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

Telehealth Allocations

- Method A: Time the person
  - Complete time studies
- Method B: Time the visit
  - Average per partial time studies
  - Average using CPT

Telehealth Allocations

- Method A: Time the person
  - Allocate % of time for non-RHC carve out for staff performing telehealth visits
  - Time studies of staff to support the allocated carve out

Telehealth Allocations

- Method B – Time the average visit
  - Partial time studies
  - CPT codes basis
  - Other
  - Multiply by number of tests performed

Telehealth Allocations

- Take hours calculated from Method A or B
- Calculate telehealth hours as a percent of total healthcare hours
- Multiply by total healthcare wages
- Reclassify resulting non-RHC wages into non-reimbursable cost center

A-8 Possible cost additions…

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

A-8 Exclude…

- Entertainment
- Gifts
- Charitable Contributions
- Automobile Expense – where not related to patient care

A-8 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

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

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

**Break into periods with different cap rates

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
- **NEXT YEAR: Change the intervals to “01/01/2021 – 03/31/2021” and “04/01/2021 – 12/31/2021”. Hit “Apply” (Clear all other intervals to avoid errors)**
- 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

NEW FOR COST REPORTS BEGINNING ON OR AFTER 10/1/19

- Must charge bad debt write offs to an expense account
- Cannot write off to a contractual allowance (Contra-revenue) account
- This provision has always been in the rules, but enforced after 10/1/19.

- Medicare Bad Debt IS:
  - Deductibles and Coinsurance amounts uncollectible from Medicare beneficiaries after reasonable collection efforts
  - Paid at 65% on the Medicare Cost Report

- 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)

Questions?