RURAL HEALTH ASSOCIATION OF TENNESSEE

Rural Health Clinic Cost Reporting
Healthcare Business Specialists
July 8, 2022

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www.ruralhealthclinic.com

What is a Medicare Cost Report?

- Form 222 or 2552- Medicare Cost Report is required by all RHC's to be completed on an annual basis.
- If covers a 12-month period of time with some exceptions: You may have up to a 13-month cost report or you may have a short period if you sell the RHC or change ownership.
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Why is a Cost Report important?

1	Medicare will not pay you if you do not file a cost report and will ask for any Medicare money paid during the year to be refunded.
2	RHC Medicare and Medicaid rates are based upon the cost report.
3	RHCs receive a cost report settlement for flu, pnu, Covid vaccines, MAB, bad debts, preventive co-pays/deductibles and rate settlements.
4	You are responsible for preparing the Cost Report accurately and in compliance with Medicare and Medicaid rules.

What does Medicare Settle on the Cost Report?

Difference between interim and final rate

Medicare Bad Debts

Flu & Pnu Shots – Covid Vaccines, MAB

Co-pays on Preventive services

Let’s do something different!!!

Let's Go Digital

The Goal is to file 95% of our cost reports electronically

What will be different?

1. You will need to designate us as your authorized cost report preparer.
2. Your Medicare cost report will be filed electronically through a portal (think PRF).
3. You Medicaid cost report will be emailed to you, signed and then mailed, but some states allow us to email it to them (Tennessee).
4. You will not get a Fed Exed hard copy of the report.

Identity Management (IDM) System

CMS created the IDM System to provide providers with a means to request and obtain a single User ID, which they can use to access one or more CMS applications.

The IDM System provides the means for users to be approved to access many other CMS systems and applications. IDM governs access to CMS systems by managing the creation of user IDs and passwords, setting up multi-factor authentication (MFA), and the assignment of roles within CMS applications.

When you assign responsibilities assign authorized Cost Report Preparer to Dani Gilbert, CPA (or your cost report preparer).

If you have issues, email Dani Gilbert at dani.gilbert@outlook.com or call (833) 787-2542, extension 1.

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The P S and R is important because it:

A. Allows for an accurate estimate of the Medicare Settlement

B. Provides accurate information on visits, deductibles, and interim payments.

C. Helps avoid unexpected paybacks to Medicare

D. All of the Above

Provider Statistical & Reimbursement (PS&R) System

Providers that file cost reports are required to register for the PS&R system through Individuals Authorized Access to the Centers for Medicare & Medicaid Services (CMS) Computer Services (IDM) to obtain the PS&R reports. The PS&R Redesign will be utilized for all cost reports with fiscal years ending January 31, 2009 and later. These cost reports will be both filed and settled using PS&R Redesign.

An approved PS&R User can order reports.

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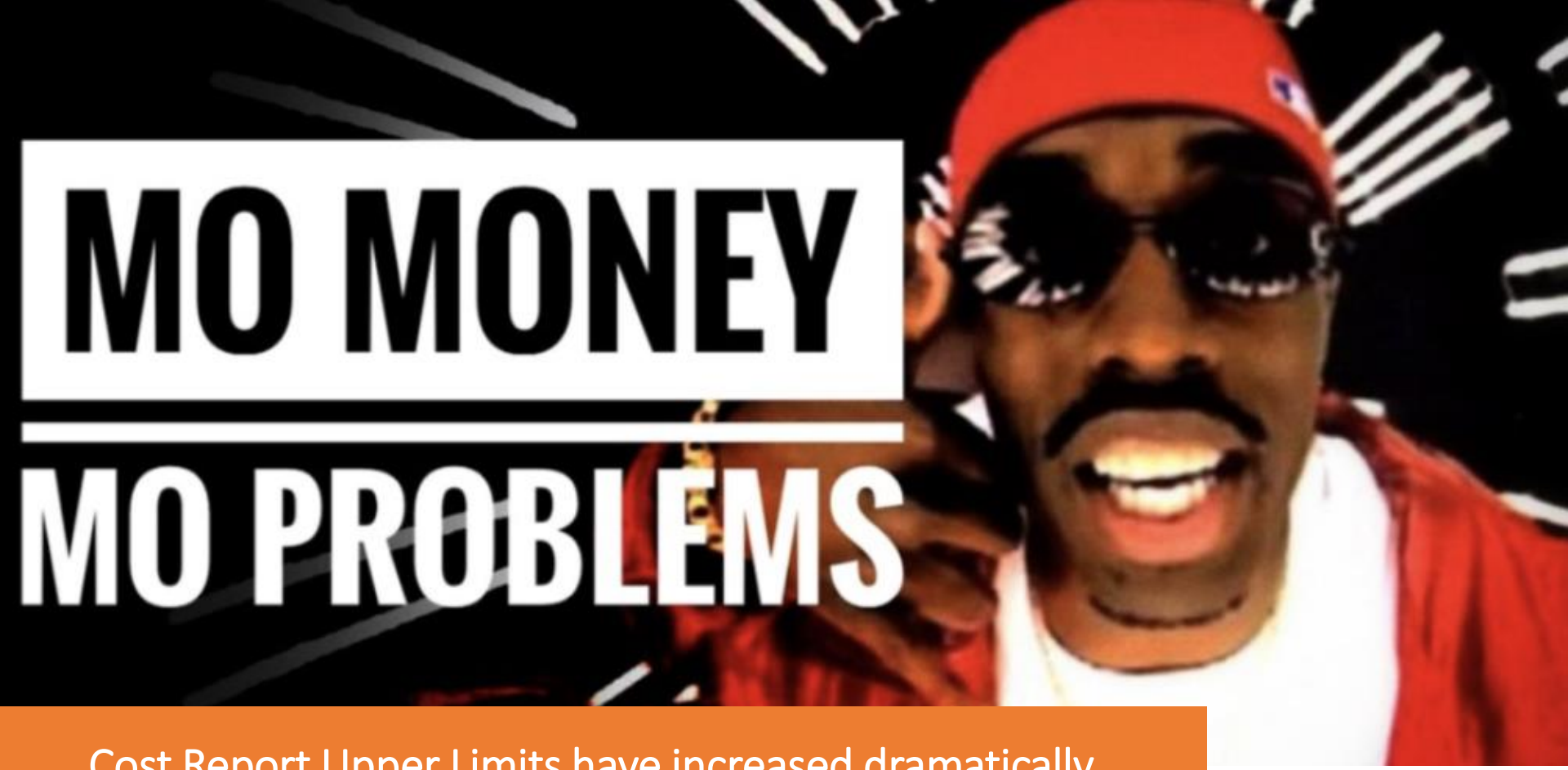
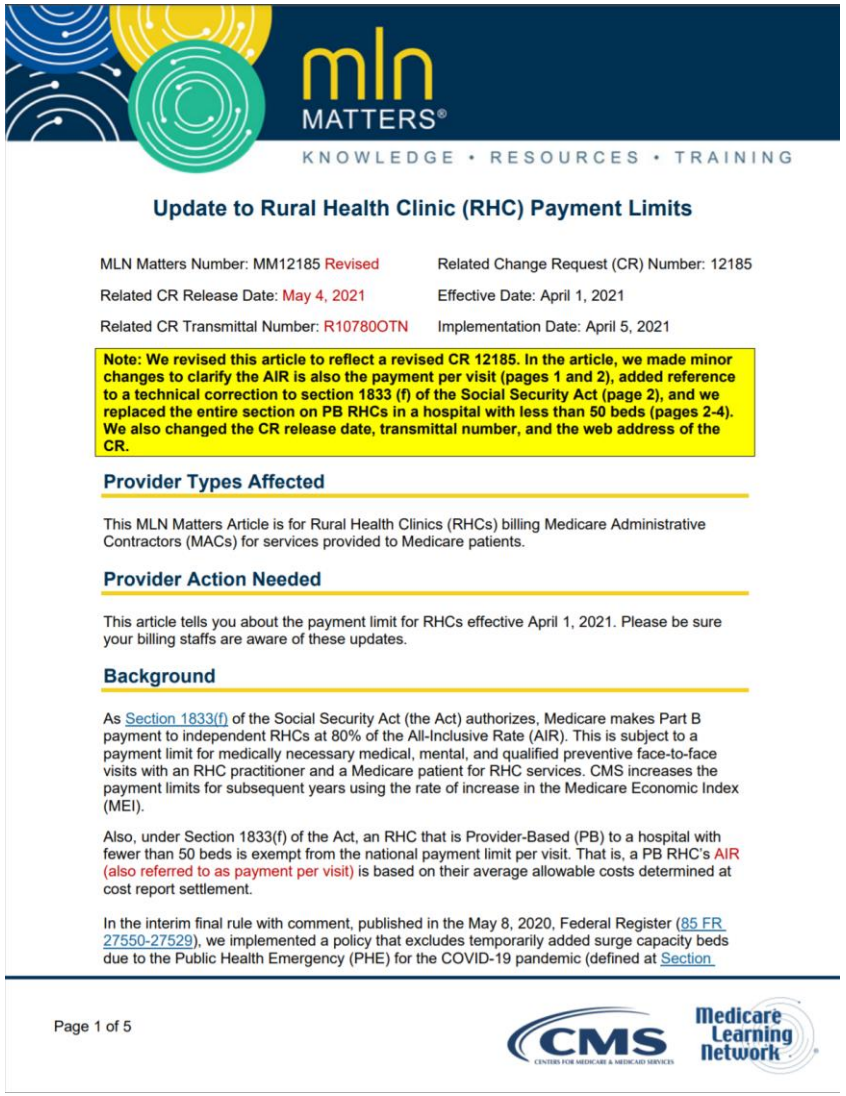


Cost Report Upper Limits have increased dramatically

1. Accurate Cost Reports are more important than ever.
2. You must try to capture all your costs.
3. Medicare requires accrual basis accounting. Use a Modified accrual basis if necessary.
4. The potential for large paybacks have never been greater.
5. Our job just got infinitely harder.

The RHC Cap for 2022 is $113 or an increase of 13% over the $100 cap per visit in 2021. (A 29% increase over the $87.52 rate)

- In 2021, after March 31, at $100 per visit
- In 2022, at $113 per visit
- In 2023, at $126 per visit
- In 2024, at $139 per visit
- In 2025, at $152 per visit
- In 2026, at $165 per visit
- In 2027, at $178 per visit
- In 2028, at $190 per visit



mln MATTERS®

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Update to Rural Health Clinic (RHC) Payment Limits

MLN Matters Number: MM12185 Revised | Related Change Request (CR) Number: 12185

Related CR Release Date: May 4, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10780OTN | Implementation Date: April 5, 2021

Note: We revised this article to reflect a revised CR 12185. In the article, we made minor changes to clarify the AIR is also the payment per visit (pages 1 and 2), added reference to a technical correction to section 1833 (f) of the Social Security Act (page 2), and we replaced the entire section on PB RHCs in a hospital with less than 50 beds (pages 2-4). We also changed the CR release date, transmittal number, and the web address of the CR.

Provider Types Affected

This MLN Matters Article is for Rural Health Clinics (RHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare patients.

Provider Action Needed

This article tells you about the payment limit for RHCs effective April 1, 2021. Please be sure your billing staffs are aware of these updates.

Background

As Section 1833(f) of the Social Security Act (the Act) authorizes, Medicare makes Part B payment to independent RHCs at 80% of the All-Inclusive Rate (AIR). This is subject to a payment limit for medically necessary medical, mental, and qualified preventive face-to-face visits with an RHC practitioner and a Medicare patient for RHC services. CMS increases the payment limits for subsequent years using the rate of increase in the Medicare Economic Index (MEI).

Also, under Section 1833(f) of the Act, an RHC that is Provider-Based (PB) to a hospital with fewer than 50 beds is exempt from the national payment limit per visit. That is, a PB RHC's AIR (also referred to as payment per visit) is based on their average allowable costs determined at cost report settlement.

In the interim final rule with comment, published in the May 8, 2020, Federal Register (85 FR 27550-27529), we implemented a policy that excludes temporarily added surge capacity beds due to the Public Health Emergency (PHE) for the COVID-19 pandemic (defined at Section

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CMS Medicare Learning Network

https://www.cms.gov/files/document/mm12185.pdf

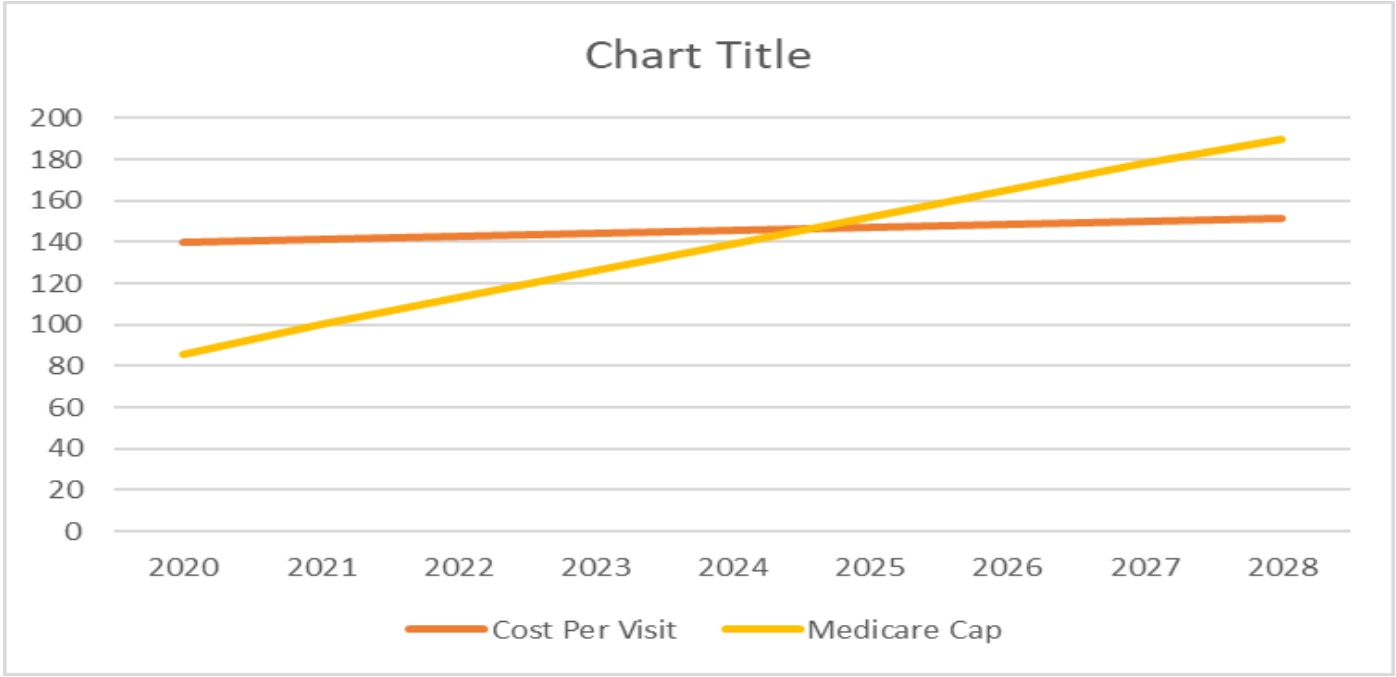
Medicare RHC Cost Report Upper Limits

Begin Date	End Date	Medicare Upper Limit
1/1/2020	12/31/2020	$ 86.31
1/1/2021	3/31/2021	$ 87.52
4/1/2021	12/31/2021	$ 100.00
1/1/2022	12/31/2022	$ 113.00
1/1/2023	12/31/2023	$ 126.00
1/1/2024	12/31/2024	$ 139.00
1/1/2025	12/31/2025	$ 152.00
1/1/2026	12/31/2026	$ 165.00
1/1/2027	12/31/2027	$ 178.00
1/1/2028	12/31/2028	$ 190.00
1/1/2029	12/31/2029	MEI

MEI = Medicare Economic Index

Laboratory, technical components, and hospital services are reimbursed outside the rate.

RHCs may not be paid the Medicare cap in the future



Year	2020	2021	2022	2023	2024	2025	2026	2027	2028
Cost Per Visit	140	141	143	144	146	147	149	150	152
Medicare Cap	86	100	113	126	139	152	165	178	190

NARHC Cost Report Benchmarking Report

Category/Indicator	'2018 Mean MS	'2018 Mean Southern	'2018 Mean Nation	'2019 Mean MS	'2019 Mean Southern	'2019 Mean Nation	5/31/2020 Mean MS	5/31/2020 Mean Southern	5/31/2020 Mean Nation
Number of Facilites	47	662	1,069	44	645	1,025	35	577	952
Encounters per FTE:								Per day	
Physicians	4,482	4,814	4,642	6,711	4,837	4,639	6,476	4,491 18	4,230
Physician Assistants	2,369	3,678	3,571	3,512	3,718	3,574	4,032	3,478 14	3,451
Nurse Practitioners	3,079	3,411	3,299	3,133	3,466	3,330	3,169	3,129 13	3,002
Certified Nurse Midwife	0	0	2,438	0	2,348	2,492	0	1,658	1,903
Clinical Psychologist/Social Worker	610	2,041	1,463	1,484	1,749	1,380	2,009	1,674	1,262
Midlevel Staffing Ratio	68%	61%	60%	67%	64%	62%	73%	66%	63%
Midlevel Visit Ratio	59%	53%	52%	49%	56%	54%	57%	57%	56%
Cost per Encounter:									
Physician	75.90	63.30	66.93	65.15	66.61	71.01	79.14	77.31	83.45
Physician Assistant	49.42	34.44	37.05	40.11	35.77	38.40	32.72	37.71	41.50
Nurse Practitioner	44.43	35.33	37.91	40.01	35.75	39.05	39.94	39.18	42.63
Certified Nurse Midwife	0.00	0.00	44.80	0.00	38.67	51.36	0.00	58.43	75.78
Clinical Psychologist/Social Worker	93.36	51.75	58.10	73.80	51.13	67.07	59.13	55.59	79.23
Total Health Care Staff Cost	11.41	12.02	14.81	8.02	10.88	14.53	14.07	12.03	16.54
Cost per FTE:									
Physician	336,644	298,386	300,731	303,177	308,678	316,205	356,201	334,611	339,797
Physician Asstistant	117,095	126,688	132,280	140,852	133,006	137,256	131,919	131,156	143,184
Nurse Practitioner	136,773	120,513	125,069	125,372	123,912	130,042	126,579	122,575	127,977
Visiting Nurse	21,895	39,340	46,107	82,898	39,633	47,389	6,487	43,332	47,978
Clinical Psychologist/Social Worker	56,926	105,633	84,989	109,480	89,428	92,587	118,804	93,038	99,954
Total Healthcare Staff Costs per Provider FTE	40,627	48,443	58,342	35,473	43,982	57,136	58,917	44,315	59,213
Clinic Cost per Encounter:									
Total Health Care Staff	69.29	61.19	66.67	53.55	61.86	69.33	61.08	69.63	78.60
Total Direct Costs of Medical Services	80.66	70.96	77.79	71.76	73.04	81.60	82.10	82.13	92.71
Facility Cost	9.68	10.08	11.28	8.96	10.13	10.70	11.85	11.59	12.39
Clinic Overhead	53.49	52.13	63.15	50.64	52.39	57.25	63.19	62.61	67.98
Allowable Overhead	51.35	48.65	51.98	48.85	48.91	53.52	59.15	57.69	62.48
Allowable Overhead Ratio	96%	93%	82%	96%	93%	93%	94%	92%	92%
Total Allowable Cost per Actual Encounter	132.01	119.61	129.77	120.61	121.94	135.11	141.24	139.81	155.18
Total Allowable Cost per Adjusted Encounter	126.01	116.70	126.21	116.94	119.09	131.17	136.11	135.00	148.13
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(1.61)	(2.95)	(4.07)	(0.94)	(2.95)	(3.75)	(1.53)	(3.69)	(4.39)
Payment Rate per Adjusted Encounter	124.40	113.75	122.14	116.00	116.14	127.42	134.58	131.31	143.74
Total Encounters	362,440	7,759,353	13,134,384	393,467	7,672,539	13,038,413	297,276	6,527,096	11,166,562
Total Medicare Encounters	123,982	1,721,088	2,909,892	134,259	1,669,305	2,804,760	88,765	1,328,094	2,213,490
Medicare Percent of Visits	34%	22%	22%	34%	22%	22%	30%	20%	20%
Injection Cost:									
Cost per Pneumococcal Injection	200.91	259.45	261.56	205.72	245.51	253.85	269.60	249.34	268.94
Cost per Influenza Injection	62.82	60.08	59.53	61.52	63.35	64.19	67.05	61.11	65.09

https://www.narhc.org/narhc/Free_Benchmarking.asp

Tennessee's Three Grand Divisons

West Middle East

Regionally Adjusted Average PPS rates

Caseload Mix Averages - EAST		
	<8,000 Visits	8,000 to 13,999
6/30/2017	167.48	124.05
6/30/2018	169.49	125.54
6/30/2019	171.86	127.30
6/30/2020	174.44	129.21
6/30/2021	177.75	131.66

Caseload Mix Averages - MIDDLE		
	<8,000 Visits	8,000 to 13,999
6/30/2017	137.88	151.94
6/30/2018	139.54	153.77
6/30/2019	141.49	155.92
6/30/2020	143.61	158.26
6/30/2021	146.34	161.27

Caseload Mix Averages - WEST		
	<8,000 Visits	8,000 to 13,999
6/30/2017	143.51	131.03
6/30/2018	145.23	132.60
6/30/2019	147.26	134.46
6/30/2020	149.47	136.47
6/30/2021	152.31	139.06

Tenncare Interim rates for New RHCs

Until there is a full year of operation, the rate would be the regional average used for clinics caught in the moratorium. The average regional rates for dates of service 7/1/2020 to 6/30/2021 are:

East	$142.72
Middle	$135.85
West	$146.34

Cost Report Deadlines for 12/31/2022 Fiscal Year Ends

#	Requirement	Due Date
1.	Keep Logs for Influenza, Pneumococcal, and Covid vaccines	Log when shots are provided. It must be readable and orderly.
2.	To claim Medicare Bad Debts, the bad debt must be written off by the fiscal year end (usually 12/31) – Still use Exhibit 2 – the old form	12/31/2022
3.	Liquidate accrued bonuses or payments to owners	75 days after year-end. March 16, 2023
4.	Liquidate accruals for non-owners.	One year after year-end. December 31, 2023
5.	Sign up with IDM for the P S and R and add Dani Gilbert, CPA as authorized cost report preparer in MCREF.	12/31/2022

Type	Utilization	Settlement	Flu/Pnu	Bad Debts
No	None	No	No	No
Low	> $50,000	No	No	No
Full	<$50,000	Yes	Yes	Yes

There are three types of cost reports

No Utilization Cost Reports

If you have no Medicare utilization, you can file a no utilization cost report. This comes in handy when you are a pediatric clinic with no Medicare utilization.

Tennessee no longer requires a full cost report
Great News for Pediatric Practices

"No Medicare Utilization" Cost Report Criteria

A provider that has not furnished any covered services to Medicare beneficiaries during the entire cost reporting period need not file a full cost report to comply with program cost reporting requirements. The provider must submit to Noridian a statement, signed by an authorized provider official, which identifies the reporting period to which the statement applies and states that (1) no covered services were furnished during the reporting period and (2) no claims for Medicare reimbursement will be filed for this reporting period. This statement must be accompanied by a completed certification page of the applicable cost report forms. The proper form and signed statement must be submitted within 150 days following the close of the reporting period.

Low Utilization Cost Reports

"Low Medicare Utilization" Cost Report Criteria

The contractor may authorize less than a full cost report where a provider has had low utilization of covered services by Medicare beneficiaries in a reporting period and received correspondingly low interim reimbursement payments which, in the aggregate, appear to justify making a final settlement for that period based on less than a normally required full cost report. Effective for all cost reports filed on or after June 19, 2020, in order to file a low utilization cost report, the provider must meet one of the following thresholds:

Criteria	Hospital Threshold	SNF Threshold	RHC/FQHC Threshold
Total Reimbursement	$200,000	$200,000	$50,000

Less than $50,000 in Net Medicare Payments

Low Utilization Cost Reports

The following forms are required when filing a Low Utilization Medicare Cost Report:

- Signed Officer Certification Sheet with applicable "S" Worksheets,
- Balance Sheet
- Income and Expense Statement (the Worksheet G Series may be submitted to satisfy the Balance Sheet and Income and Expense Statement requirements), and
- Various worksheets based on provider type:

FQHC and RHC Facilities filing Form CMS-222-92 and 224-14

- Worksheet S Part I, II and III
- Worksheet C Part I and II

The Provider must submit the forms and data under this alternative procedure within the same time period required for full cost reports. If it is determined at a later date that a cost report does not meet the criteria for a low or no utilization cost report, or if the contractor determines that a full cost report is necessary to serve the best interest of the program, a full cost report will be required.

Low Utilization Cost Report Filers

1. Will not get paid for Flu and pnu shots + Covid and MABS
2. Co-pays on preventive services
3. Medicare Bad Debts
4. Difference in interim rates and final reimbursement rates

Gathering Information for the Cost Report

Your Cost Report Preparer will send you a checklist of information or Excel spreadsheet to submit to your cost report preparer.

Start Early and get the information to the preparer as soon as possible.

If you do not have the checklist by your cost report year-end or shortly thereafter contact your cost report preparer.

https://static1.squarespace.com/static/53c5f79de4b0f4932a3942a8/t/61f2c96096c8570c18c1dd54/1643301216741/2022+Medicare+Cost+Report+Checklist+for+2021+Cost+Reports+Checklist+Only+%283+pages%29.pdf

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RHC Cost Report Checklist
Summer 2022

Electronic Filing of Cost Report

- Please keep your IDM (Identity Management) credentials current by changing the password within the prescribed time frames. You will also need to assign the roles of PS&R User and Authorized Cost report Preparer to Dani Gilbert from HBS. This will allow us to pull the PS&R report and electronically file the cost report.
- **NOTE: These roles will need to be re-certify annually. Dani will send notifications for recertification for those who have already assigned her to those roles in the past.**

Expense Information

- Please provide an Income Statement (Profit & Loss) and Balance Sheet or trial balance for the cost report period.
- If the clinic has completed the Federal Tax Return for the cost report period, you may provide a copy of the tax return (in lieu of the trial balance).

Payroll Information

- If the cost report is 1/1/20XX to 12/31/20XX, please provide the W-2s and W-3.
- If the cost report period is something other than 1/1/20XX to 12/31/20XX, please provide a Payroll Summary report with gross pay for the cost report period.
- Please provide a description of what each employee does (i.e., MD, PA, NP, nursing staff, janitorial, administrative staff, etc).
- Please provide the total number of hours work by each employee during the cost report period.

RHC Cost Report Checklist (Page 2)

Visits

- Please provide a CPT Frequency report broken down by provider for the cost report period – this report should **not** be broken down by payor. This report will be used to determine visits on Worksheet B.
- Please provide a payer mix breakdown by percentage in the following categories, which in total should agree with the CPT Frequency report above:
    - CHIP
    - Medicare
    - Medicaid
    - All Other (i.e., commercial, self-pay, no-pay, etc)

Vaccines

- Please maintain a log throughout the year of flu/pnu/covid vaccines given to traditional Medicare patients that includes the following information:
    - Patient Name
    - Date of Service
    - HIC #
- Please provide a copy of an invoice where the vaccines were purchased for the year OR an estimate of the cost per dose that you paid?

Malpractice

- Does the clinic carry commercial malpractice insurance?
    - If so, is it a claims-made or occurrence policy?
    - Please provide the total amount of malpractice premiums paid during the cost report period.

Miscellaneous

- Please confirm whether there are any related party transactions that need to be disclosed on the cost report?
- Please confirm whether there are any Medicare bad debts that need to be claimed on the cost report? If so, please provide us with a listing in the prescribed format to include on the cost report.
- Please provide the name, email address, and title of the individual who will be signing the cost report.

Medicare Cost Report Table of Contents

1. Medicare Cost Report – Form 222/2552 (ECR File)
2. Medicare Workpapers which include 3 through 9.
3. Trial Balance of expenses that ties to WKS A.
4. Workpapers to support reclassifications or adjustments.
5. How total visits were computed.
6. How Provider FTEs are computed
7. Flu and Pnu logs and invoices
8. P S and R including preventive services
9. Medicare Bad Debt listing in Excel

All Inclusive Rate (AIR) Per Visit Calculation

$$\frac{\text{Total Allowable RHC Costs minus Flu/Pnu costs}}{\text{Total RHC Visits (Includes all payor types)}} = \text{RHC Cost Per Visit (limited to cap if applicable)}$$

Chapter 13, Section 80.4 The A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits.

Allowable Costs

- "Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services."
- - Provider Reimbursement Manual, Pub. 15

Total Expense Source Documents (Numerator)

Provide your Expenses
Typically one of the following:

1. Financial Statements
2. Trial balance
3. Tax return

ABC Company

Table: Cash Flow

Source Documents for Cost Report Expenses

- •**For provider-based RHCs**
- –Departmental summary reports
- –Internally prepared financial statements (Trial Balance)
- –Hospital cost report data
- •**For independent RHCs**
- –Financial statements prepared by outside accountants
- –Internally prepared financial statements (Quickbooks)
- –Tax returns

New Cost Centers – Independent RHCs

The new Form CMS-222-17 expands the number of cost centers and add specific cost centers for costs such as:

a. **Pneumococcal vaccines (CR 30) Must be entered here or you will not get paid.**
b. **Influenza vaccines (CR 31) Same Here.**
c. **Telehealth (CR 79)**
d. **Chronic Care Management (CR 80)**

RHC Cost Report Sample Chart of Accounts

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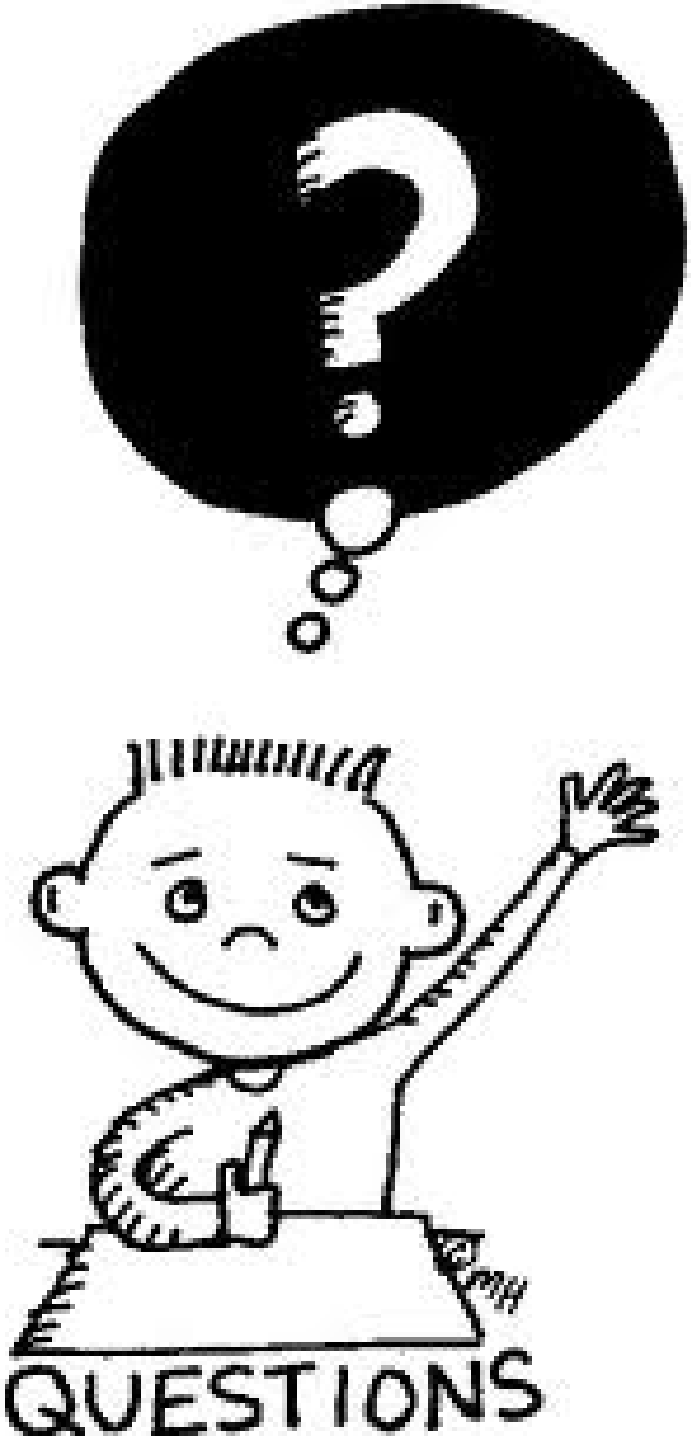
Example Chart of Accounts		
For Year 20XX		
Account Type	**Account Name**	**Account Number**
Asset	Bank Account	100-00-0000
Asset	Secondary Bank Account	100-00-0001
Asset	Accounts Receivable	100-00-0010
Asset	Medical Equipment	100-00-0020
Asset	Medical Equipment - Accumulated Depreciation	100-00-2720
Asset	Building & Fixtures	100-00-0021
Asset	Building & Fixtures - Accumulated Depreciation	100-00-4421
Asset	Equipment	100-00-0022
Asset	Equipment - Accumulated Depreciation	100-00-4522
Asset	Office Equipment	100-00-0023
Asset	Office Equipment - Accumulated Depreciation	100-00-6123
Asset	Land	100-00-0024
Asset	Petty Cash	100-00-0030
Asset	Refundable Deposits	100-00-0040
Liability	Accounts Payable	200-00-0000
Liability	941 Tax Payable	200-00-0010
Liability	FUTA	200-00-0011
Liability	SUTA	200-00-0012
Liability	Federal Income Taxes Payable	200-00-0020
Liability	State Income Taxes Payable	200-00-0021
Liability	Loans Payable	200-00-0030
Liability	Payroll Liabilities	200-00-0040
Equity	Capital Stock	300-00-0010
Equity	Treasury Stock	300-00-0020
Equity	Retained Earnings	300-00-0030
Equity	Partner Distributions	300-00-0040
Revenue	Fees	400-00-0010
Revenue	Fees: Patient Fees	400-00-0011
Revenue	Fees: Consultation Fees	400-00-0012
Revenue	Refunds	400-00-0020
Expenses	Physician Salaries	500-00-0100
Expenses	Physician Assistant Salaries	500-00-0200
Expenses	Nurse Practioner Salaries	500-00-0300
Expenses	Visiting RN Compensation	500-00-0500
Expenses	Visiting LPN Compensation	500-00-0600
Expenses	Clinical Psycologist Salaries	500-00-0700
Expenses	Social Worker Salaries	500-00-0800
Expenses	Laboratory Technichian Salaries	500-00-0900
Expenses	Other Nurse Salaries	500-00-1000
Expenses	Transcription Salaries	500-00-1001
Expenses	Contract Labor	500-00-1002
Expenses	Agreed Upon Physician Services	500-00-1500
Expenses	Agreed Upon Physician Supervision	500-00-1600
Expenses	Medical Supplies	500-00-2500
Expenses	Transportation	500-00-2600
Expenses	Depreciation of Medical Equipment	500-00-2700
Expenses	Professional Liability Insurance	500-00-2800
Expenses	Allowable GME	500-00-2900
Expenses	Pnuemococcal Vaccine & Med Supplies	500-00-3000
Expenses	Influenza Vaccine & Med Supplies	500-00-3100
Expenses	CME, Dues, Licenses, and Subscriptions	500-00-3200
Expenses	Electronic Health Records	500-00-3201
Expenses	Small Equipment	500-00-3202
Expenses	Rent	500-00-4000
Expenses	Insurance	500-00-4100
Expenses	Interest	500-00-4200
Expenses	Utilities	500-00-4300
Expenses	Depreciation of Building and Fixtures	500-00-4400
Expenses	Depreciation of Equipment	500-00-4500
Expenses	Housekeeping and Maintenance	500-00-4600
Expenses	Property Tax	500-00-4700
Expenses	Office Salaries	500-00-6000
Expenses	Depreciation of Office Equipment	500-00-6100
Expenses	Office Supplies	500-00-6200
Expenses	Legal	500-00-6300
Expenses	Accounting	500-00-6400
Expenses	Administrative Insurance	500-00-6500
Expenses	Telephone	500-00-6600
Expenses	Fringe Benefits & Payroll Taxes	500-00-6700
Expenses	Billing Service	500-00-6800
Expenses	Miscellaneous	500-00-6801
Expenses	Non-Allowable Costs	500-00-6802
Expenses	Corporate Administrative Allocation	500-00-6803
Expenses	Pharmacy	500-00-7500
Expenses	Dental	500-00-7600
Expenses	Optometry	500-00-7700
Expenses	Non-Allowable GME Pass Through Costs	500-00-7800
Expenses	Telehealth	500-00-7900
Expenses	Chronic Care Management	500-00-8000
Expenses	EPSDT/Physicals	500-00-8100
Expenses	Hospital	500-00-8101
Expenses	Private Practice	500-00-8102
Expenses	Laboratory	500-00-8103
Expenses	Radiology	500-00-8104



The Best way to count visits is ?

A. A manual hand count

B. A computer report broken down by payor

C. A CPT Frequency Report broken down by provider.

Why are Visits so Important?

Visits are important because
They are the denominator in
The cost per visit calculation.

Do not count 99211 visits,
Injections, lab procedures,
hospital visits, non-rhc visits

Definition of an RHC Visit per Section 40 of Chapter 13 of the Medicare Benefits Policy Manual

- An RHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or practitioner are considered RHC visits.

Additional Information Required for Independent RHCs Only

To capture additional information from the RHC such as:

a. Malpractice premiums, paid losses, and self-insurance
b. Medical visits, mental health visits, and visits by interns and residents
c. Visits by payor mix (Worksheet S-3)
    a. i. Title V- CHIP
    b. ii. Title XVIII – Medicare
    c. iii. Title XIX – Medicaid
    d. iv. Other – Commercial, self-pay, etc.

Keeping good Provider Time records is important because?

A. It could lower the number of visits to meet minimum productivity.

B. It may be needed in case of an audit.

C. It could increase your payment from Medicare

D. All of the above.

Health Care Provider FTEs

- Cost report requires separation of provider visits, time, (and cost):
- Physician
- Physician Assistant
- Nurse Practitioner
- Visiting Nurse
- Clinical Psychologist
- Clinical Social Worker

The Provider FTE calculation is important For Productivity Calculations (based up a 2,080 Hour work year)

Provider Type	Minimum Annual Productivity based upon 40-hour work week	Daily Productivity based upon 250 work days	Monthly Productivity
Physician	4,200	16.8	350
Nurse Practitioner/ Physician Assistant	2,100	8.5	175

Productivity Standards Documentation – FTE Calculations

- Record provider FTE for clinic time only (this includes charting time):
  - –Time spent in the clinic
  - –Time with SNF patients
  - –Time with swing bed patients
- Do not include non-clinic time in provider productivity:
  - –Hospital time (inpatient or outpatient)
  - –Administrative time
  - –Committee time
  - **- Telehealth or Telemedicine time**
- Provider time for visits by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC are not subject to productivity standards.

Time Studies for Provider FTEs

Rural Health Clinic Physician Time Study

Physician Name: _____ Date: _____

Physician Signature: _____

To complete, place an "X" in the appropriate box for each 15-minute increment to identify the activities performed.

		Part A - Provider Component					RHC Component	
		Supervision	Committee Work	Administration of Department	Quality Control	Emergency Room Availability	Patient Services	Documentation
0:00	0:15							
0:15	0:30							
0:30	0:45							
0:45	1:00							
1:00	1:15							
1:15	1:30							
1:30	1:45							
1:45	2:00							
2:00	2:15							

Important: Time doing Telemedicine does not Count in your FTE Count

Influenza, Pneumococcal and Covid vaccine logs must include?

A. Patient Name

B. Patient MBI Number

C. Date of Injection

D. All of the Above

Influenza, Pneumococcal, & COVID Vaccines

4	PROVIDE ALL OF THE FOLLOWING INFORMATION TO CLAIM INFLUENZA, PNEUMOCCOCAL & COVID REIMBURSEMENT ON THE COST REPORT.
a.	Medicare logs with patient name & HIC number and date of service for pneumococcal, influenza patients, & Covid vaccines.
b.	A count, listing, or log on non-Medicare patients in order for us to determine total flu shots provided.
c.	Invoices supporting influenza and pneumoccocal purchases during the year. This will help us to determine the cost of the supply cost.

Influenza, Covid and Pneumococcal Shot Logs

Patient Name	HIC Number	Date of Service
John Smith	411992345A	12/31/2013
Steve Jones	234123903A	12/31/2013
Ashley Taylor	903214934A	12/31/2013

Medicare Influenza and Medicare Pneumococcal shots should be maintained on separate logs. Pnumo pays around $250 per shot and influenza is $60 or so.

Covid Vaccine & Monoclonal Injections/shots

1. Both are reported on the cost report like flu and pnu and reimbursed at cost. Keep a log.
2. In 2021 include Medicare Advantage/Replacement Plan patients as well (**not so for flu and pnu, or 2022 Covid shots.**
3. Keep up with Medicare Advantage/Replacement plans separately and do not include in the Medicare line on the cost report.
4. Keep up with your cost of supplies and direct expenses in a separate general ledger account.
5. Keep good time records for administration time.

https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion?fbclid=IwAR0b56IOR4fYBDh53ex2Ifrg3OC9dd1hHCm7e6aibbQNWt-D1YaLAy-VWF8

Advantage Plans go on the cost report in 2021 (but not 2022) for Covid Vaccines and MABs

Year	Pnu	Flu	Covid Vaccine	MABs
2021	Originial	Originial	Originial & Advantage	Originial & Advantage
2022	Originial	Originial	Originial	Originial

- **COVID-19 Vaccines in RHCs**

  COVID-19 vaccines and their administration will be paid the same way influenza and pneumococcal vaccines and their administration are paid in RHCs. Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The beneficiary coinsurance and deductible are waived. For patients enrolled in Medicare Advantage, COVID-19 vaccines and their administration costs, as well as, monoclonal antibody products and their administration costs should be included on the RHC cost report. For additional information, please see https://www.cms.gov/covidvax.

https://www.cms.gov/covidvax

InQdocs 600-I

COVID-19 VACCINE LOG

Facility Name: _____

Date	Patient Name and/or Identifier (MBI or Acct/MR#)	Insurance or Financial Class	Pfizer Dose 1 0001A	Pfizer Dose 2 0002A	Moderna Dose 1 0011A	Moderna Dose 2 0012A	Astra Zeneca Dose 1 0021A	Astra Zeneca Dose 2 0022A	Jannsen J&J One Dose 0031A	Consent	Staff Initials

Page _____ of _____

https://www.narhc.org/Document.asp?DocID=9441

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Medicare Influenza Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Page Number		Page Total		Total Medicare Flu Shots	

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Medicare Pnemococcal Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Page Number		Page Total		Total Medicare Pnu Shots	

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Medicare COVID-19 Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Page Number		Page Total		Total Medicare Covid Shots	

Cost Report Repayments to Medicare

- Many of the MACs did the following:
  - Increased the interim rate above the cap
  - Paid Interim Settlements during the year.
- This resulted in the following:
  - Much smaller settlements to RHCs
  - Some RHCs paying back monies to Medicare
  - RHC Consultants having to do a lot of explaining
  - **If you do not tell us you received an interim settlement, we will not know, and you may end up paying back Medicare money.**

Report any Interim Payments to us so we can include on the cost report

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Worksheet C-1
Analysis of Payments to RHCs for Services Rendered

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

Interim Lump Sum Payments to RHCs

In recent years, the MACs are issuing interim lump sum payments (and occasionally a withhold of payment) to RHCs which are a part of the annual Medicare Cost Report Settlement. These payments or withholds must be recorded on Worksheet C-1 or it may result in a payback to Medicare on settlement of the cost report. If you received an interim payment or withhold please report this information to us below and provide the letter emailed to you documenting the payment or withhold.

Please provide the date and amount of Interim Payments or Withholds

Date of Interim Payments	Amount

Note: Failure to report these payments or withholds will affect the settlement of your cost report and may result in a payback to Medicare when the cost report is final settled. Please make an effort to identify any such payments to avoid the potential payback to Medicare.

Interim Payments to be reported on the Cost Report

PO BOX 100307 | COLUMBIA, SC 29202-3307 | PALMETTOGBA.COM/JJA | ISO 9001
AB MAC JURISDICTION J
Alabama, Georgia and Tennessee

PALMETTO GBA

October 9, 2018

[redacted]

[redacted]

We have recently completed your Year End rate review for the year ending December 31, 2018. These reviews were based on previous audit history for your facility, the provider statistical and reimbursement report and the December 31, 2017 as-filed cost report.

As required by law, President Obama issued a sequestration order on March 1, 2013 requiring across-the-board reductions in Federal spending. In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payments. Therefore, to prevent making overpayments, interim and pass-through payments related to the Medicare cost report will be reduced by 2 percent. Beginning April 1, 2013 the 2 percent reduction will be applied to Periodic Interim Payments (PIP), Critical Access Hospital (CAH) and Cancer Hospital interim payments, and pass-through payments for Graduate Medical Education, Organ Acquisition, and Medicare Bad Debts.

The results of these reviews are as follows:

Provider	Type of Review	New Rate $/Per Diem	New Biweekly	Effective Date	Lump Sum
	Cost Based Charges:				
[redacted]	RHC 1	96.38		1/1/2018	$36,798
	TOTAL:				$36,798

WKS C-1 Line 3

The net result of these reviews is a lump sum underpayment of $36,798. This amount will be issued on or before October 19, 2018. Enclosed are the computations and payment schedule(s) for your reviews.

If you have any questions please call me at (803) 763-1392 or e-mail me at brenda.williams@palmettogba.com.

Sincerely,

Brenda Williams

Brenda Williams
Accountant II, Provider Reimbursement
Provider Reimbursement

Why are you having to payback Medicare on the cost report?
You did not give as many Medicare flu and pnu as the previous year.
Your Interim Rate was too high as estabilished by the MAC (above the cap)
Your Medicare visits increased substantially during the year.
You did not claim bad debts or have a smaller amount of bad debts.
You received an interim settlement and did not tell your CR preparer.

Medicare Bad Debt Reimbursement is 65% of the uncollected of Medicare Co-pays and Deductibles

https://www.alabamapublichealth.gov/ruralhealth/assets/webinar.medicarebaddebt.12.10.13.pdf

Medicare Bad Debt Summary

A provider's bad debts resulting from Medicare *deductible and coinsurance* amounts that are uncollectible from Medicare beneficiaries are considered in the program's calculation of reimbursement to the provider if they meet the criteria specified in 42 CFR 413.89.

Per 42 CFR 413.89(e), a bad debt must meet the following criteria to be allowable:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts.
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

https://med.noridianmedicare.com/web/jea/audit-reimbursement/audit/bad-debt

Crossover or Duel Eligible Bad Debt

- If Medicaid does not pay the complete coinsurance or deductible; a RHC can include this difference as an allowable bad debt on the cost report and Medicare will reimburse you for this bad debt. Keep up with in a separate file.

Medicare-Medicaid Crossover Bad Debt Classification

Providers claiming Medicare bad debt must meet 42 CFR 413.89 and all requirements from Chapter 3 of the Provider Reimbursement Manual (https://go.usa.gov/xEuwD). Correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in your accounting records. For bad debt amounts:

- Do not write off to a contractual allowance account
- Charge to an expense account for uncollectible accounts (bad debt)

Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.

Medicare Bad Debt Summary

1. Medicare coinsurance 20% of charges.
2. Medicare deductible of $185.00 in 2019.
3. Billed to the Part A MAC.
4. Nothing else is allowed.
5. Must try to collect for 120 days from first bill.
6. Must treat everyone the same.
7. Do not have to turn over to collection agency.
8. Must be written off in the fiscal year of the cost report.
9. Collection efforts must cease.

Medicare Bad Debt Listing – Write off

Medicare Bad Debts must be written off by the end of the fiscal year to be claimed on the cost report.

Collection efforts must cease.

A Medicare Bad Debt must meet the following Criteria:

1. The debt must be related to a covered service and derived from the Deductible and Coinsurance amounts.
    A. No Fee for Service. IE. Hospital, Technical Components.
    B. No Medicare Advantage plans.
2. The provider must be able to establish that reasonable collection efforts were made.
    A. At least 120 days of first bill.
    B. First Bill as least within 45 to 60 days of service.
    C. Four documented collection efforts made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment indicated there was little likelihood of recovery in the future.

Source: 42 CFR 413.89(e)

Capturing the information for Bad Debt

1.Use an Excel Spreadsheet
2. Keep Regular and Crossover Bad Debt in separate spreadsheets
3. Provide Medicare with the spreadsheet.
4. Start early. Start NOW.
5. Provide it to the Preparer ASAP.

What to submit

The provider should submit the Exhibit 2 [Excel], Bad Debt Listing, with the cost report. In order to expedite the review process, the provider may also want to consider submitting the state Medicaid remittance advices showing each uncollected co-insurance and deductible amount.

Exhibit 2
Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________________ Prepared By ____________________

Prov. Number____________________ Date Prepared ____________________

FYE ____________________ Inpatient ____________________ Outpatient ____________________

SNF ____________________ RHC____________________

(1) Patient Name	(2) HIC NO.	(3) Dates of Service		(4) Indigency & Wel. Recip (ck if apply)		(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
		From	To	Yes	Medicaid #						
											-
											-
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Bad Debt – Excel Spreadsheets

Description	Link
Bad Debt Policy for Medicare Cost Report and Policy and Procedure Manuals	https://www.dropbox.com/s/0xjrovohy5q6532/2016%20Sample%20Bad%20Debt%20Policy%20for%20Rural%20Health%20Clinics.pdf?dl=0
Medicare Bad Debt Log in Excel	https://www.dropbox.com/s/1o6zh90uxhhxmzd/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20Only%20in%20September%202016.xls?dl=0
Medicare/Medicaid Crossover Bad Debt Log in Excel	https://www.dropbox.com/s/auf8w5dsu49q1v5/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20and%20Medicaid%20Crossovers%20in%20September%2C%202016.xls?dl=0

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www.ruralhealthclinic.com

https://www.facebook.com/groups/1503414633296362/

Questions, Comments, Thank You

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