RHC Cost Reporting- Year End Planning
Healthcare Business Specialists
December 1, 2022

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Our Team

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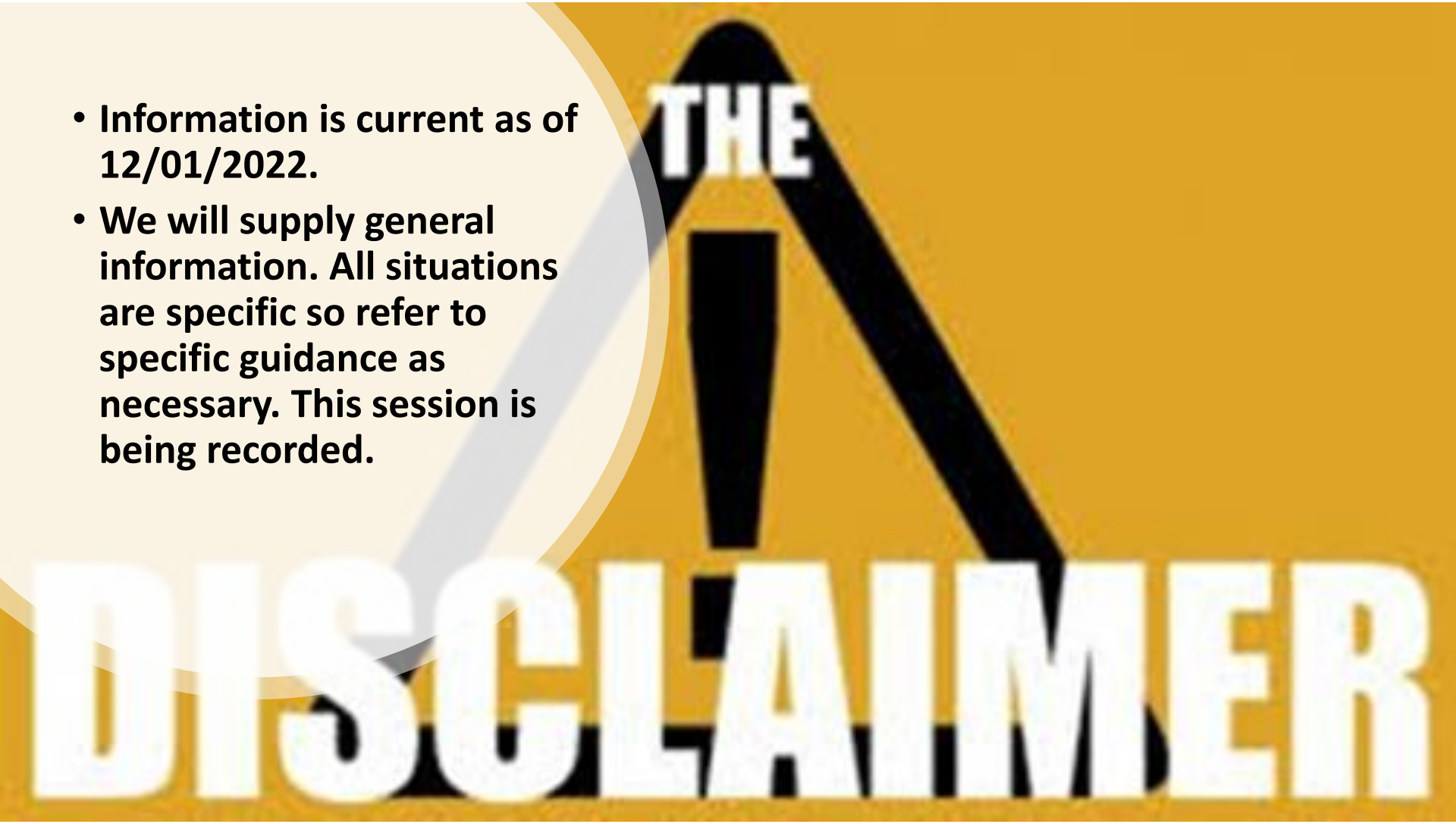
Rural Health Clinic Information Exchange Facebook Group

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

- Information is current as of 12/01/2022.
- We will supply general information. All situations are specific so refer to specific guidance as necessary. This session is being recorded.



Please type your questions in the Question box and submit them and if you raise your hand at the end of the session, we will open your line to ask a question.

Slides and Recording of this session will be posted to the Facebook Group and at www.ruralhealthclinic.com.

RHC COST REPORTING - YEAR-END DEADLINES AND ELECTRONIC FILING OF COST REPORTS

In this webinar, Mark Lynn, CPA (Inactive), CRHCP, CCRS and Dani Gilbert, CPA, CRHCP will go over important year-end Rural Health Clinic cost reporting deadlines and as we migrate to electronic filing of cost reports for 2022, how to ensure you optimize your reimbursement in an environment of increased Medicare caps for Independent or Freestanding RHCs. We will discuss the importance of writing off Medicare bad debts on or before 12/31/2022 in order to file them on the Medicare Cost Report. We will discuss new topics such as Covid-19 vaccines, MABs, telehealth, and more. As we shift to more and more electronic filing of cost reports, our processes for filing will change and this webinar will be a good introduction to these changes.
Please register for RHC Cost Reporting - Year-End Deadlines and Electronic Filing of Cost Reports on Dec 1, 2022 1:00 PM EST at:

https://attendee.gotowebinar.com/register/8979695397871709451

- Recording of session (placeholder)
- Powerpoint Slide Presentation

http://www.ruralhealthclinic.com/rhc-webinars

The Game has changed

Consolidated Appropriations Act of 2021 (CAA) enacted on April 1, 2021

1. Independent and newly established Provider-Based RHCs are subject to Medicare Upper Payment Limits as established in the CAA.
2. Provider-based RHCs enrolled on, or before, December 31, 2020, are grandfathered from being subject to the Medicare Upper Payment limit but have controls on the rate of growth of their Medicare reimbursement rate.

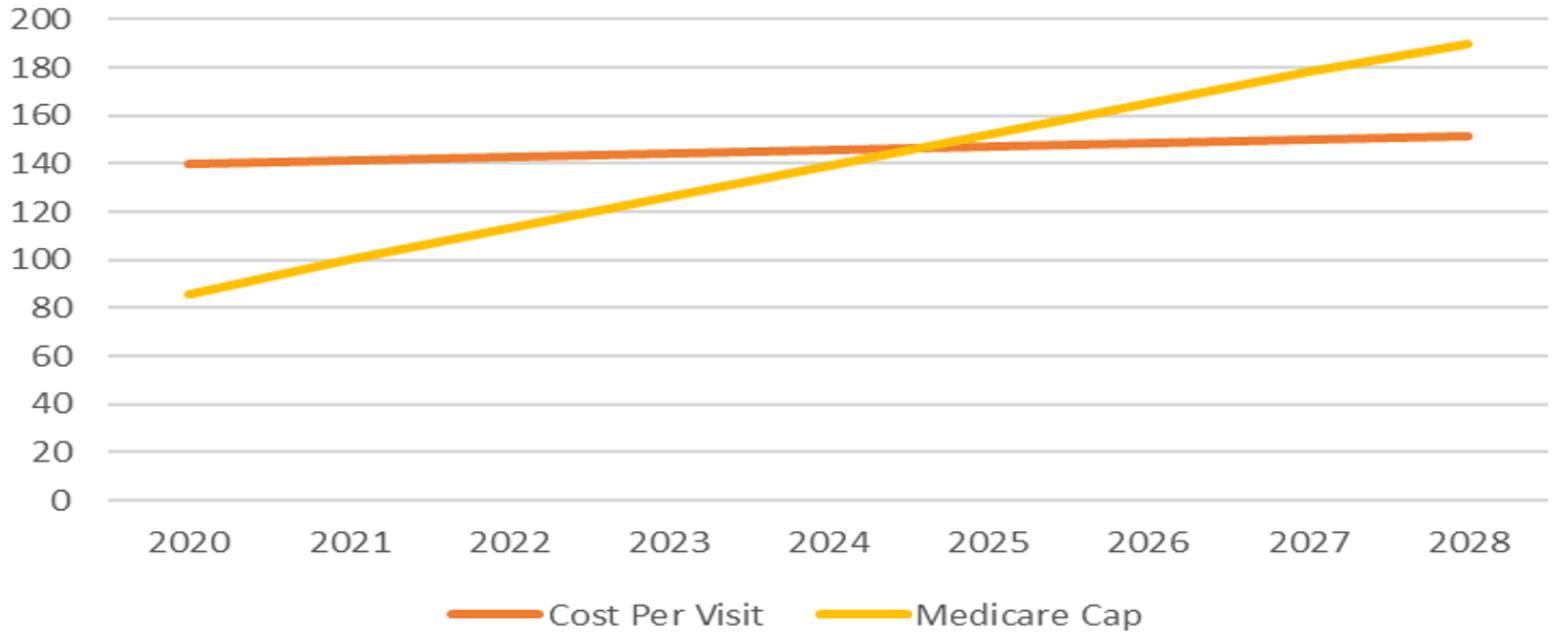
National Statutory Payment Limits for RHCs

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, CCM, telehealth (except mental health starting in 2022) and hospital services are reimbursed outside the rate.

The National Statutory Payment Limits for RHCs will likely exceed the Cost Per visit 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

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

2022 Projections with a $113 Cost Per Visit

Description	Medicare Part A	Medicare Advantage	Medicaid	Commercial	Totals
Payor Mix	20%	25%	30%	25%	100%
Visits	2,000	2,500	3,000	2,500	10,000
Payment per visit	$ 113	$ 105	$ 130	$ 110	$ 115
Total Payments	226,000	262,500	390,000	275,000	1,153,500
Cost per visit	$ 113	$ 113	$ 113	$ 113	$ 113
Total Cost	226,000	282,500	339,000	282,500	1,130,000
Net Income	-	(20,000)	51,000	(7,500)	23,500

2028 Projections with a $190 Cost Per Visit

Description	Medicare Part A	Medicare Advantage	Medicaid	Commercial	Totals
Payor Mix	20%	25%	30%	25%	100%
Visits	2,000	2,500	3,000	2,500	10,000
Payment per visit	$ 190	$ 125	$ 145	$ 120	$ 143
Total Payments	380,000	312,500	435,000	300,000	1,427,500
Cost per visit	$ 190	$ 190	$ 190	$ 190	$ 190
Total Cost	380,000	475,000	570,000	475,000	1,900,000
Net Income	-	(162,500)	(135,000)	(175,000)	(472,500)

The Impact of Higher Medicare Caps for RHCs

RHCs will have to be much more strategic in the future. Planning will be required to avoid large paybacks and maximize rates.

Most Independent RHCs will have a difficult time keeping their cost per visit above the cap as they have in the past.

Provider-based RHCs may have costs above their 2020 updated AIR rate which will not be reimbursed by Medicare.

Cost reports will be subject to much more scrutiny in the future.

Records of provider time for productivity standards will become more important.

Understand the impact and accuracy of expenses related to cost of non-rhc services or services not computed in the All-Inclusive Rate.

Understand and count visits depending on if they are included in the All-Inclusive rate.

Preparing the 2022 Medicare Cost Report

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 & GME

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Steps for Filing the Medicare Cost Report

1. Sign BA and Cost Report agreements and send retainer

2. Receive Cost Report Checklist from HBS

3. Obtain information from Checklist (P S & R)

4. Upload to portal, Mail, Fax, Email information to HBS

5. HBS prepares the Report and mails to you or files electronically

6. Electronically file or Sign the cost reports and mail to Care/Caid

7. Receive Tentative settlement in 90 days.

8. Desk Review within 1 year of filing date.

We will have another RHC Cost Reporting Webinar in January 2023 with updated checklists and worksheets.

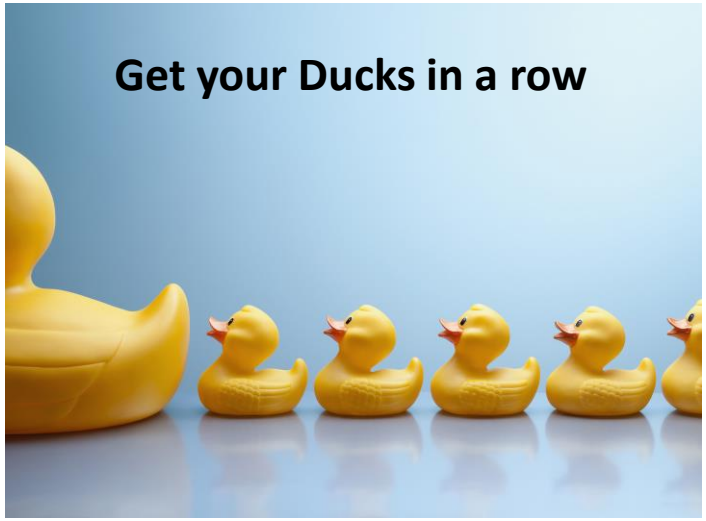
December requires planning and action to maximize reimbursement and minimize taxes

Advice after injury is like medicine after death.

-Danish Proverb

You should have discussions in December with the following:

1. Your Tax Accountant
2. Your Cost Report Preparer
3. Your PRF and Grant funds advisor.



Things that must be done in December

- Write off bad debts if you are claiming bad debts and have a 12/31/2022 fiscal year end.
- Spend or use for lost revenues any unused PRF Funds with a 12/31/2022 deadline for use of the funds. **Note: Lost revenues will not count as an allowable expense on the cost report and using the funds to pay expenses may help you receive a higher settlement and rate from Medicare.**
- Cash accounts should be reviewed with your tax accountant and as much as possible bonused out to owners in corporations and S-Corps.
- The deadline to make contributions for an employer-sponsored 401(k) plan for 2022 is **December 31**
- **Other retirement plans will differ so check with your tax CPA.**
- **You may want to adjust your rent if it is a related party transaction – Discuss with your tax CPA.**

Accrual of Expenses

- Medicare cost reports are filed using accrual basis accounting which means costs are recorded when incurred and not when actually paid.
  - Accruals of compensation to owners and certain self funded insurance programs must be liquidated within 75 days of year-end.
  - Accruals to non-owners must be liquidated within 12 months of the fiscal year end.
  - Some Examples:
    - Expenses incurred in 2022 and not paid until 2023 (look at your January and February check register for December 2022 expenses)
    - Pension plan contributions for 2022 not paid until 2023
    - Payroll due to employees not paid in 2022 and paid in 2023.
    - Accrued Vacation and Sick pay for employees.

  - https://www.law.cornell.edu/cfr/text/42/413.100

Provider Relief Fund Terms and Conditions

What is the definition of Executive Level II pay level, as referenced in the Terms and Conditions? –

The Terms and Conditions state that none of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other mechanism, at a rate in excess of Executive Level II. The salary limitation is based upon the Executive Level II of the Federal Executive Pay Scale. Effective January 5, 2020, the Executive Level II salary is $197,300. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Funds may pay an individual's salary amount in excess of the salary cap with non-federal funds.

(Added 5/29/2020)

Year	Salary	Year	Salary	Year	Salary
2022	$203,700	2021	$199,300	2020	$197,300

- PRF Funds have a limits on compensation that can be claimed as PRF expenses

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

#	Requirement	Due Date
1.	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
2.	Liquidate accrued bonuses or payments to owners	75 days after year-end. March 16, 2023
3.	Liquidate accruals for non-owners.	One year after year-end. December 31, 2023
4.	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**
5.	Cost Report Workpaper submission to HBS	3/31/2023
6.	**Visits and Provider FTE Reports due to Cost Report Preparer if you think you need a Productivity Standard Waiver**	**2/15/2023**

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.

You can pull your PS&R reports and authorize your cost report preparer to submit the cost report electronically in MCReF.

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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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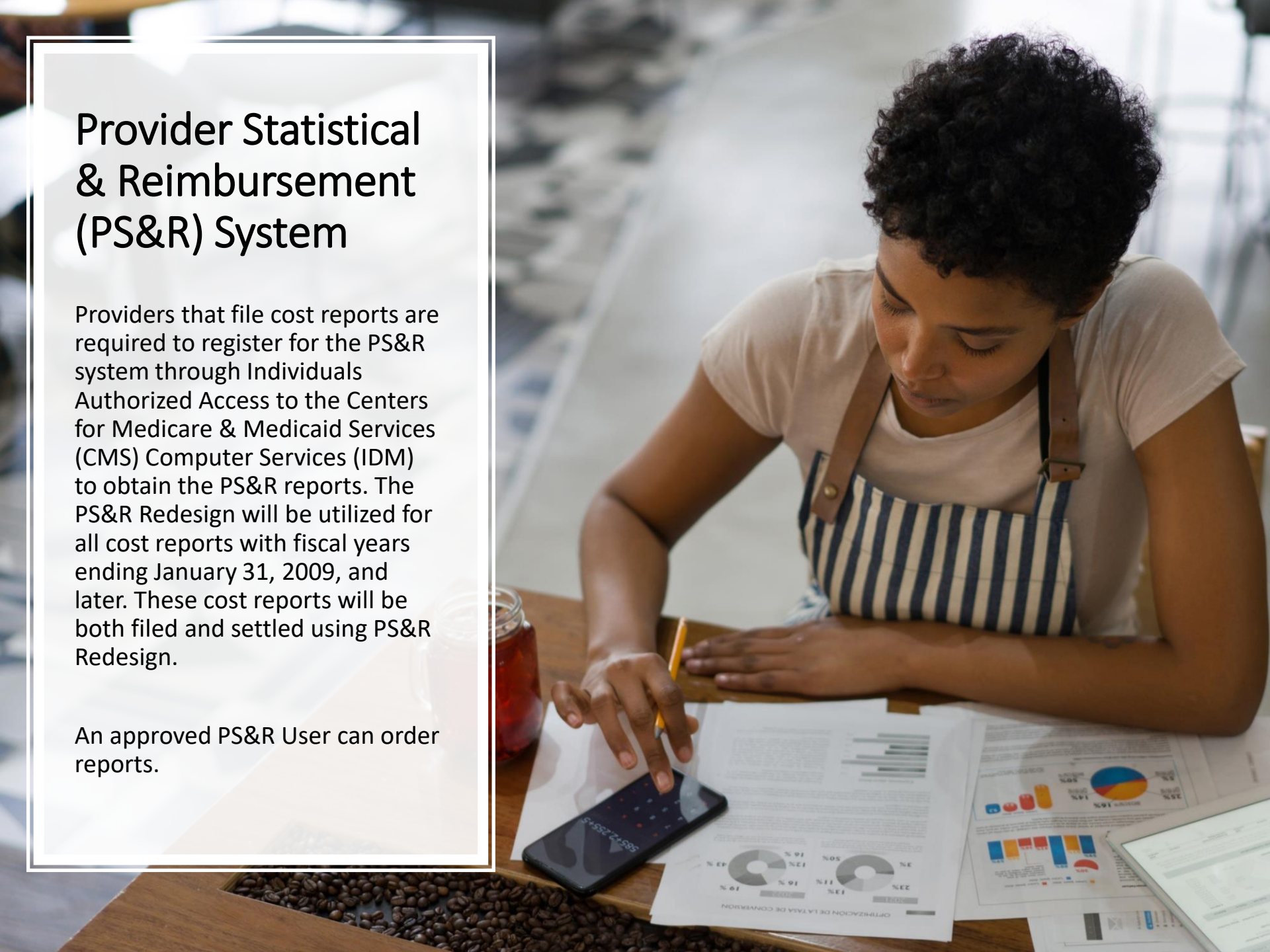
Provider Statistical & Reimbursement (PS&R) System

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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The Advantages of Filing Cost Reports using MCReF

- The cost report filing process is much simpler and faster.
- You know that Medicare has accepted your cost report immediately.
- Your cost report is settled much quicker if filed electronically.
- You will make your cost report preparer happy.

So what is will be different?

1. You will need to designate someone 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 receive a leather bound cost report package, but a PDF in your Client Portal.

There are Three Types of Cost Reports

RHCS may file three types of cost report

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

Three Types of Medicare Cost report

Full	Low Utilization	No Utilization
Medicare Interim Payments • Required if $50,000 or more in interim payments	**Medicare Interim Payments** • Less than $50,000	**Medicare Interim Payments** • None
Why? • Settles difference in interim and final rate. • Reimburses Flu, Pnu, and Covid shots • Reimburses Bad Debts.	**Why?** • Simple. • Must submit a letter indicating you qualify and a Balance Sheet and Profit and Loss statement.	**Why?** • Extremely Simple. • Must submit a letter and attach Worksheet S of cost report.
Professional Fees? • High	**Professional Fees?** •Medium	**Professional Fees?** • Low

Some clinics may elect to file a low utilization cost report if they do not have Influenza, Pneumococcal, Covid vaccines, or bad debts and they qualify.

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**

If you think you qualify for a low or no utilization cost report, pull the P S and R early and let’s get it filed in early 2023.

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.

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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

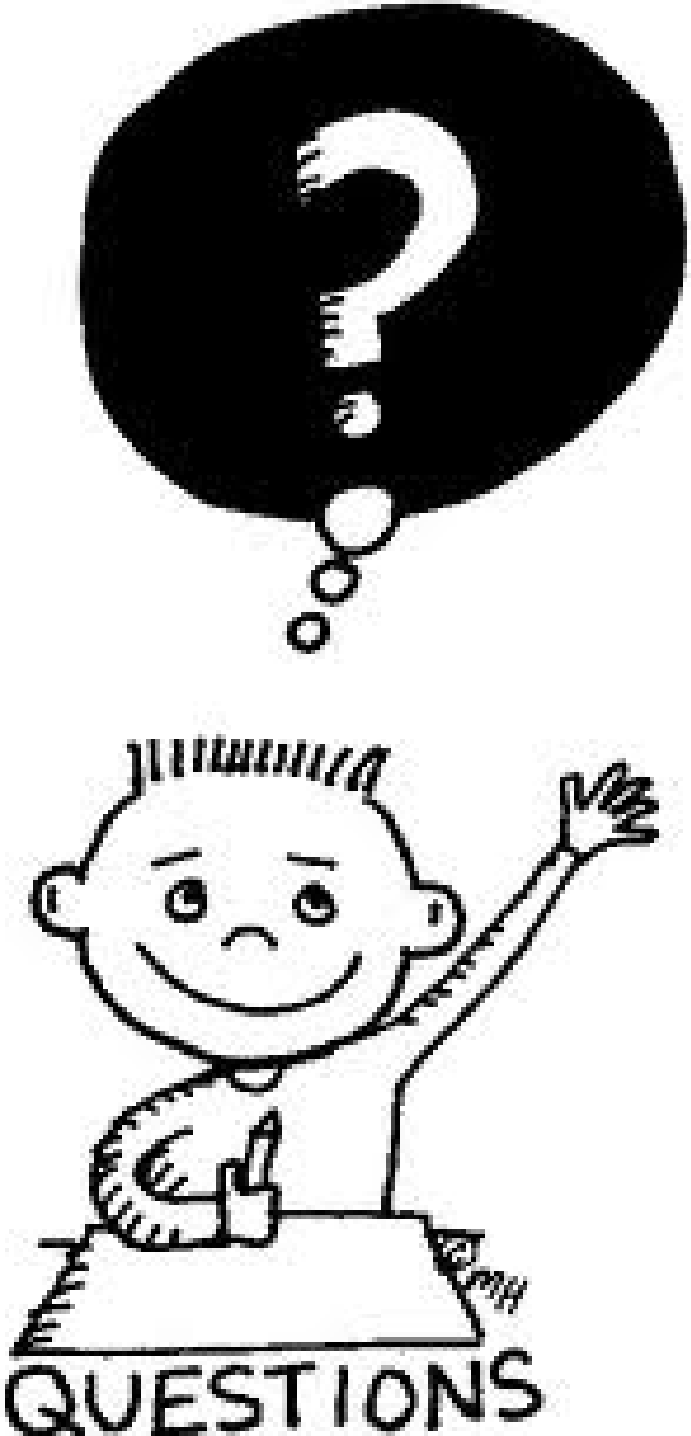
- Please maintain a log throughout the year of flu/pnu/covid vaccines given to traditional Medicare patients that includes the following information:
    - Patient Name
    - Date of Service
    - HIC #
- Please provide a copy of an invoice where the vaccines were purchased for the year OR an estimate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



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.

What is needed to count Visits

- We need a CPT Frequency report broken down by provider only (not payor). If you have a lot of physicians and only one NP, you can run a CPT frequency report for the practice and then one for the NP or vice versa (you have several NPs and only one physician) We do need physicians, NPs, PAs, LCSWs, and CPs broken out for cost reporting purposes.

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

Allowable Owner Compensation

Medicare Allowable Owner Compensation depends on the type of Entity

- Owner compensation allowances for the different entity types:
  - Sole proprietor - Schedule C = value of services
  - LLC (single member) - Schedule C = value of services
  - LLC (multiple member) - K-1 from Form 1165 = value of services
  - Corporation – K-1 from Form 1120 = **Actual compensation paid or accrued and paid within 75 days of FYE.**
  - S-Corporation – "Under Federal income tax law, certain corporations can elect to be treated for tax purposes as a partnership. This election, however, has no effect on reimbursement under the Medicare program, and an owner of a Subchapter S corporation is not considered a partner for purposes of this principle."
  - Some states do not recognize these Medicare rules for allowable compensation, so consult with someone who knows your state Medicaid rules on allowable owner compensation.

Summary of Owner Compensation Treatment for Medicare Cost Reports

Description	Value of Services	Comp Must be Paid	75 Day Accrual
Sole Proprietor	X		
LLC (Single or Multiple Member)	X		
Corporation		X	X
Sub-S Corporation		X	X

Medicare rules related to Owner Compensation may be found here:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R474PR1.pdf

907. COMPENSATION-SOLE PROPRIETORSHIPS AND PARTNERSHIPS

A. General.--The allowance of compensation for sole proprietors and **partners is the value of the services rendered by the owner. Such an amount may or may not be represented as actual payments made to the owner. There is no direct relationship between the compensation allowance of the owner and the amount of operating profit (or loss) of the facility. I**n determining the allowance, the contractor is responding to a claim for the value of the services of the owner. That is, the institution will include in its statement of reimbursable cost an allowance for the value of the owner's services and the contractor evaluates the reasonableness of this claim by applying the criteria in this chapter.

B. Actual Payments Made.--Where a provider has claimed as some other cost (for example, see §906.1) an amount paid to a sole proprietor or partner, such amount is combined with the allowance claimed by the provider for the owner's services. This total is then used for determining the reasonableness of the compensation allowance claimed.

Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics
By Census Bureau Regions and Divisions
Per FTE

Region	Division		2009		2010		2011		2012		2013		2014	
		Factor*: →	0.017		0.015		0.020		0.020		0.019		0.019	
		* Source: §905.6.	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
1	1	New England	$275,890	$306,762	$280,029	$311,364	$285,629	$317,591	$291,342	$323,943	$296,877	$330,098	$302,518	$336,370
	2	Middle Atlantic	$213,095	$223,657	$216,292	$227,012	$220,618	$231,552	$225,030	$236,183	$229,306	$240,670	$233,663	$245,243
Subtotal - Region 1: Northeast			$252,636	$264,593	$256,425	$268,562	$261,554	$273,933	$266,785	$279,412	$271,854	$284,721	$277,019	$290,131
2	3	East North Central	$251,684	$276,027	$255,459	$280,167	$260,569	$285,771	$265,780	$291,486	$270,830	$297,024	$275,976	$302,667
	4	West North Central	$266,258	$285,384	$270,252	$289,665	$275,657	$295,458	$281,170	$301,367	$286,512	$307,093	$291,956	$312,928
Subtotal - Region 2: Midwest			$260,249	$281,442	$264,153	$285,663	$269,436	$291,376	$274,825	$297,204	$280,047	$302,851	$285,368	$308,605
3	5	South Atlantic	$218,079	$233,894	$221,350	$237,402	$225,777	$242,150	$230,293	$246,993	$234,669	$251,686	$239,128	$256,468
	6	East South Central	$250,876	$268,628	$254,640	$272,658	$259,732	$278,111	$264,927	$283,673	$269,961	$289,063	$275,090	$294,555
	7	West South Central	$233,620	$244,568	$237,124	$248,236	$241,867	$253,201	$246,704	$258,265	$251,391	$263,172	$256,167	$268,172
Subtotal - Region 3: South			$236,132	$245,690	$239,674	$249,375	$244,468	$254,363	$249,357	$259,450	$254,095	$264,380	$258,923	$269,403
4	8	Mountain	$261,423	$298,011	$265,344	$302,481	$270,651	$308,530	$276,064	$314,701	$281,309	$320,680	$286,654	$326,773
	9	Pacific	$275,667	$301,697	$279,802	$306,223	$285,398	$312,347	$291,106	$318,594	$296,637	$324,647	$302,273	$330,815
Subtotal - Region 4: West			$270,217	$300,186	$274,270	$304,689	$279,756	$310,782	$285,351	$316,998	$290,773	$323,021	$296,298	$329,158

Census Bureau Divisions:

New England Division: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic Division: New Jersey, New York, Pennsylvania
East North Central Division: Illinois, Indiana, Michigan, Ohio, Wisconsin
West North Central Division: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
South Atlantic Division: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East South Central Division: Alabama, Kentucky, Mississippi, Tennessee
West South Central Division: Arkansas, Louisiana, Oklahoma, Texas
Mountain Division: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific Division: Alaska, California, Hawaii, Oregon, Washington

NP and PA Owner Compensation Allowances are not published. MGMA Surveys or Medicaid Audit Allowances will be a good guideline.

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 are computed in aggregate, so a high performing provider and make up the difference if any of the providers productivity falls below the productivity standard.

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

Related Party Transactions

Related Party Regulations per the Oregon CRF

- Current through Register Vol. 61, No. 4, April 1, 2022
- (1) **A "related party" is an individual or organization that is associated or affiliated with, or has control of, or is controlled by the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) furnishing the services, facilities, or supplies:(a) "Common ownership" exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;**
- (b) "Control" exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.
- (2) The Division allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, to the extent that they:(a) Relate to Title XIX and Title XXI client care;
- (b) Are reasonable, ordinary, and necessary; and
- (c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.
- (3) **The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.**
- (4) Clinics must disclose a related party who is separately enrolled as a provider with the Division and furnish the provider's NPI and associated taxonomy code(s).
- (5) Documentation of costs to related parties shall be made available at the time of an audit or as requested by the Division. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.
- (6) **The Division will allow rental expense paid to related individuals or organizations for facilities or equipment to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the FQHC and RHC Administrative Rules.**
- (7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC's cost statement report.

https://www.law.cornell.edu/regulations/oregon/OAR-410-147-0540

Related Party Transactions will be more impactful in the future.

- Provide the actual cost of the transaction. For example, related party rent would produce mortgage interest, repairs, insurance, property taxes and depreciation. Your cost report preparer will need a Schedule E from the tax return (1 owner) or the rental company's tax return (2+ owners).
- Identify employees who are related (family members) to the owners and the compensation paid to these related family members.

Example of Related Party Rent Impact

Assumptions

Rent	200,000
Actual Cost	50,000
Disallowed	150,000

Revised Rent Assumptions

Rent	50,000
Actual Cost	50,000
Disallowed	0

			Revised Rent
Description	**2021**	**2022**	**2022**
Total Expenses	1,500,000	1,500,000	1,500,000
Related Party Costs Disallowed	150,000	150,000	-
Allowable Expenses	1,350,000	1,350,000	1,500,000
Total Cost Report Visits	12,500	12,500	12,500
Cost Per Visit	108	108	120
Medicare Cap	100	113	113
Medicare Visits	3,000	3,000	3,000
Reimbursement Impact	-	(15,000)	-

Revised Rent Assumption: Instead of rent, allowable compensation is paid to the owners of the building and their compensation is increased on the cost report.

Talk to your Tax CPA: Rental income is not subject to FICA taxes; however, FICA taxes are only paid on the first $147,000 of earnings in 2022 (no limit on Medicare portion).

Covid-19 Vaccine Changes in 2022

Covid-19 Vaccines and MABs by Medicare Advantage Plan Patients are no longer reimbursed on the Cost Report

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

Covid Vaccine & Monoclonal Injections/shots

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

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

Influenza, Covid and Pneumococcal Shot Logs

Patient Name	MBI Number	Date of Service
John Smith	411992345A	11/30/2022
Steve Jones	234123903A	12/15/2022
Ashley Taylor	903214934A	12/31/2022

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

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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			
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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			
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20			

Page Number		Page Total		Total Medicare Covid Shots	

Capitalization and Depreciation Expense

Differences in Tax and Medicare Depreciation

Description	Tax	Medicare
Method	Accelerated - MACRS	Straight-Line
Capitalization Threshold	$2,500 or $5,000	$5,000
Section 179 Deduction	1,080,000, automobiles is less	Not Applicable
Useful Life	Typically, 3 years	Use the AHA guidelines. Typically, 5 to 7 years

- Capital purchases of less than $5,000 may be expensed under Medicare rules.
- Medicare assets will be depreciated on a straight-line basis using the AHA useful life guidelines.

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

Bad Debts related to CCM and Virtual Communications may be claimed on the cost Report

An allowable bad debt for Medicare cost reporting purposes is the portion of the deductible and coinsurance amounts deemed to be uncollectible. Allowable bad debts must relate to specific deductibles and coinsurance amounts that can be verified through the PS&R. Deductible and coinsurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding physician fees. Additional amounts beyond the deductible and coinsurance for covered services would not be allowable as a Medicare bad debt on the cost report.

To summarize, the bad debts claimed on the cost report cannot be the uncollected portion of the deductible and coinsurance for covered services plus amounts for CCM (G0511) and Virtual Communication (G0071). **However, if CCM and Virtual Communication are a covered service, then a portion of the amounts for CMM and Virtual Communication could be a deductible or coinsurance, but they have to have gone through the billing process for that determination to have been made.**

- *Ralph W. Sloan, CPA*
- *Centers for Medicare & Medicaid Services*

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)

Medicare Bad Debt Summary

1. Medicare coinsurance 20% of charges.
2. Medicare deductible of $233 in 2022.
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

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.

Thank You!

Mark Lynn, Healthcare Business Specialists

marklynnrhc@gmail.com