KENTUCKY MEDICAL BILLING ASSOCIATES

Azalea HEALTH

RHC Cost Reporting
Birmingham, Alabama
November 17, 2022

MAIN STREET HEALTH

HBS
Healthcare Business Specialists

Please Consult your Cost Report Preparer before Implementing any changes.

Agenda

Consolidated Appropriations Act (CAA) of 2021

What impact does the CAA on RHC cost reporting?

Visit Counts & Telehealth Changes in 2022

Telehealth mental health visits are now payable at the All-Inclusive Rate.

Electronic Filing

How to ensure your cost report preparer can file your cost report electronically.

COVID Vaccines

How to report COVID vaccines on the cost report for 2022.

Owner Compensation

Allowable owner compensation depends upon the type of entity.

Related Party Transactions

How the CAA affects the impact of related party transactions on the cost report.

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.

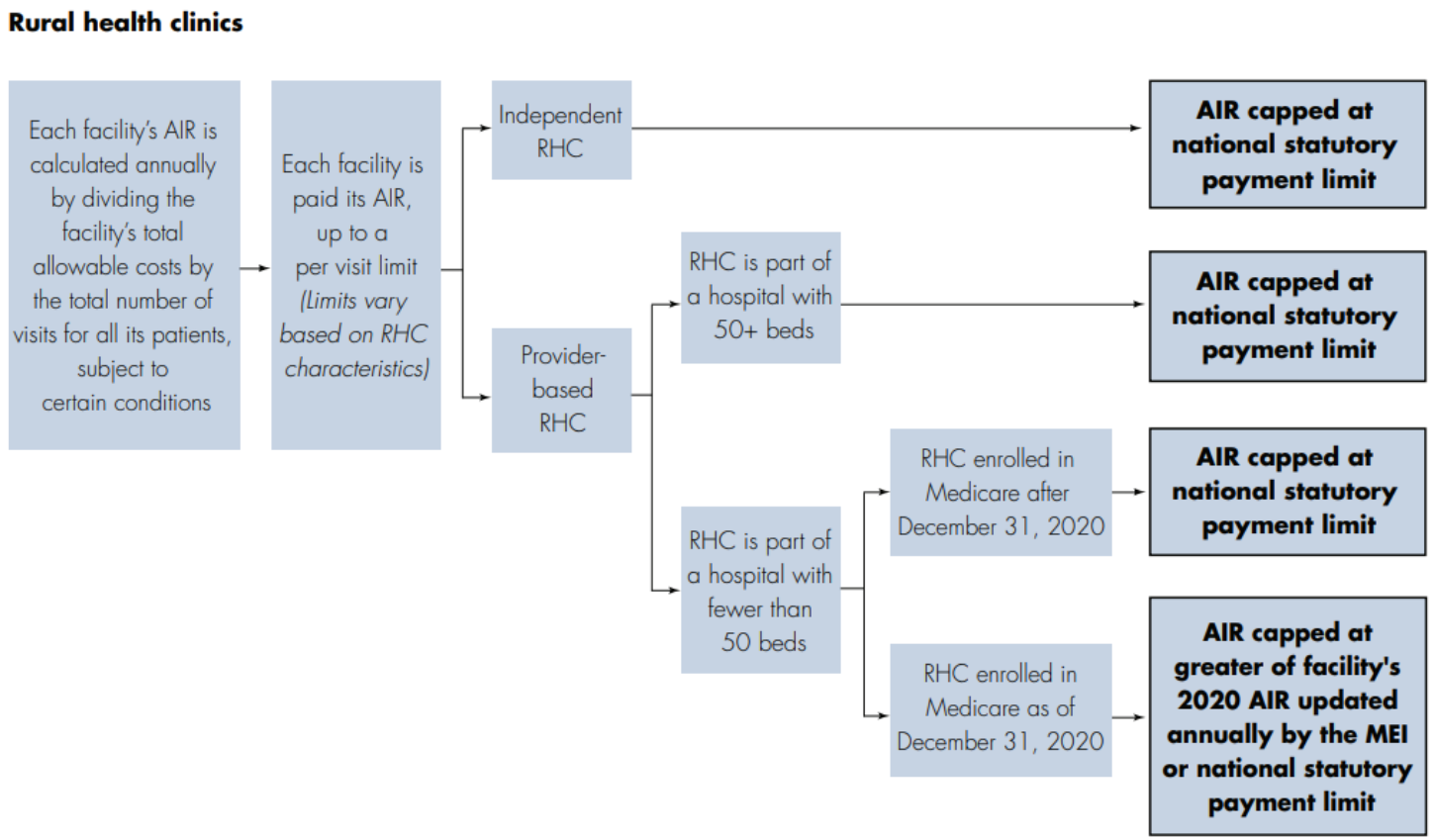
Is your RHC Grandfathered?

Q. How are new RHCs defined for purposes of the applying the national per-visit limit and provider-based exceptions? Is it the date on the 855 enrollment form or some other date?
A. New RHCs, that is, those that enrolled on or after January 1, 2021, receive the national statutory payment limit. Some provider-based RHCs are entitled to a special payment rule; however, they needed to be, as of December 31, 2020, enrolled in Medicare (including temporary enrollment during the PHE for COVID-19) or have submitted an application for enrollment in Medicare (or a request for temporary enrollment during the PHE for COVID-19) that was received not later than December 31, 2020.

1. **Enrolled in Medicare as a Provider-based RHC as of December 31, 2020, or**
2. **Submitted an 855A application to Medicare that was received by Medicare not later than December 31, 2020**

https://www.cms.gov/files/document/rhcs-pfs-faqs.pdf

National Statutory Payment Limits



https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_fqhc_final_sec.pdf

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.

CAA Changes the potential impact of Cost Report

The Old RHC Cost Reporting Cycle

1

1. Think About Cost Report

Two months before Cost Report is due.

2

2. Figure Out You Need Help

Engage someone to prepare the cost report.

3

3. Submit Cost Report Information

Wait until the last minute to submit to cost report information.

4

4. Prepare Cost Report

Prepare and submit the cost report at the last minute.

5

5. Settlement

Independent RHCs receive about $40 per visit less than your actual cost. Provider-based RHCs receive your actual cost.

The Game has changed

RHCs should have a Cost Report Strategy

1. Before you begin business, what is the most favorable entity type for cost reporting?
2. How does Medicaid work in your state? How are Medicaid rates established?
3. Identify your cost reporting year-end and initial time period if you are newly certified.
4. Educate your staff on the cost reporting process and data requirements as early as possible.
5. Monitor cost per visit throughout preparing interim cost reports at 6 months and 11 months.
6. Improve internal accounting and accrual of expenses.
7. Hospitals may want to move services to an RHC with a higher Grandfathered RHC rate.

Some States Limit Medicaid PPS Rates to the Medicare Cap

Some states have limited the Medicaid PPS rates to the Medicare Upper Payment Limit, which has resulted in low Medicaid PPS rates. Exiting and re-entering the RHC program is a strategy that could substantially increase your Medicaid rate.

Description	2023
Medicare Upper Payment Limit	126
Current Medicaid PPS rate	87
Increase in Medicaid rate	39
Number of Medicaid visits	1,000
Increased Medicaid Payment	39,000

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.

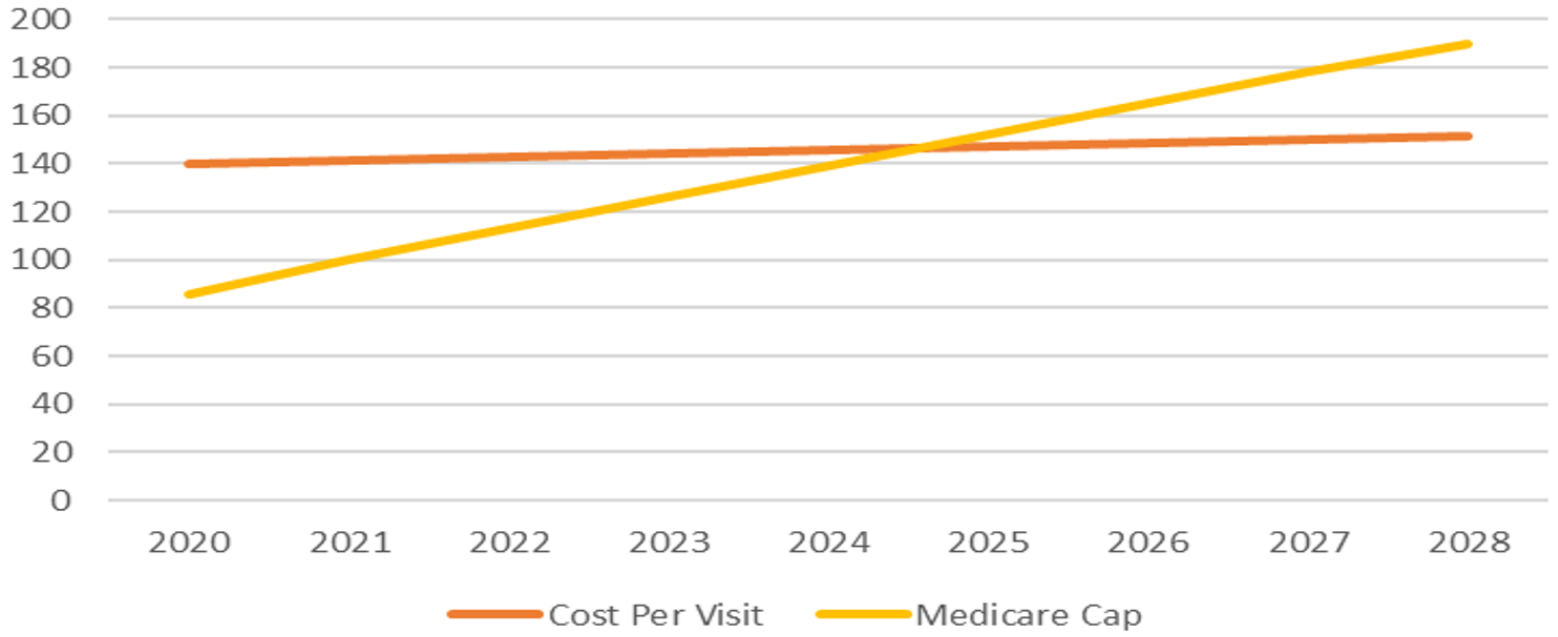
Cost reports will be subject to much more scrutiny in the future.

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.

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

Counting Cost Report Visits Will Become Even More Important

The Difference between Coding and Billing

Description	Coding	Billing
Creator	AMA	CMS
Types of Codes *ICD-10-CM (AMA/AHA/CMS/ NCHS) Why did you perform the service? Do you have current coding guidelines?*	CPT Codes – Current Procedural Terminology (What did you do)	HCPCS II Codes Healthcare Common Procedure Coding System (What you did and what supplies were used)
Definition	It was designed to describe medical, surgical, and diagnostic services accurately. It is also used as a form of uniform communication among physicians, coders, patients, accreditation organizations, and those who pay for administrative, financial, and analytical purposes about certain medical procedures and services.	is a set of health care procedure codes based on CPT. It was designed to provide a standardized coding system in order to describe specific items and services that are provided when health care is delivered. It is a necessary form of coding for anyone who carries Medicare, Medicaid, and other health insurance programs in order to ensure that insurance claims are processed efficiently.
Example:	An RHC provides a 99213 via telehealth. The CPT Code is 99213.	The 99213 converts to a G2025 when billed to Medicare plus any required modifiers (CG/95/FQ)
Responsibility	Physicians, NPs, PAs, providers, Coders	Billers, Office Manager, CFO, Administrator

Billing and Coding Crosswalk Cheat Sheet

Service	Example Coding CPT	Example Billing HCPCS	Payment	Cost Report Visit?	Allowable Medicare Cost?	Notes
Medicaid Visit (in some states)	99213 (QVL)	T1015	AIR	Yes	Yes	Only count 1 visit on your RHC Cost Report
Telehealth Visit	99213	G2025	$97.24	No	No	Medicaid may pay AIR
Mental Telehealth Visit (starting in 2022)	90834	90834 CG 95	AIR	Yes	Yes	Keep records on the costs of two different types of telehealth visits
Virtual Communication Services (G0071)	99421	G0071	$23.88	No	No	Exclude cost on cost report.
Chronic Care Management	99484	G0511	79.25	No	No	Exclude cost on cost report.

Note: The CPT Code column is not an all-inclusive list of CPT codes.

Types of Services Provided in an RHC

Part of the All-Inclusive Rate (AIR) Calculation	Not Part of the All-Inclusive Rate Calculation	Pass-though Costs paid above the AIR
Office Visits	Laboratory Services (except 36415)	Influenza Vaccinations
Incident-to Services	Hospital Services	Pneumococcal Vaccinations
Mental Health Telehealth Visits	Telehealth Visits (medical, not mental health)	Covid-19 Vaccinations & MABS
Lab Draws (36415)	Private Practice Time (Non-RHC hours)	Bad Debts
Radiology Services (Professional Portion)	Radiology Services (Technical Portion)	Graduate Medical Education

Summary Table for Counting Visits

Description	UB-04	1500*	Incident to	CR Visit	CR Allowable Cost	AIR
Office Visits – See QVL for CPT Codes	X			X	X	X
Lab Services		X				
Technical Components		X				
Hospital Services		X				
Telehealth (Not Mental Health)	X					
Telehealth – Mental Health	X			X	X	X
Chronic Care Management (G0511)	X					
Lab Draw (36415)	X		X		X	
Allergy Shots, Injections, Home Care Plan oversight, Diabetic & Nutritional counseling	X		X		X	
Medicare Preventive Services # (See Table)	X			X	X	X

* Provider-based RHCs will bill using the UB-04 and the hospital's outpatient NPI.

Preventive Services that qualify for the AIR are listed here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

Mental Health Visits via Telehealth in 2022

Beginning January 1, 2022, RHC mental health visits will include visits furnished using interactive, real-time telecommunications technology. This change will allow RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology. In order to bill for mental health visits furnished via telecommunications for dates of service on or after January 1, 2022, RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only.

1. Mental Health Visits via Telehealth in 2022:
    a. Telehealth visits for medical reasons and paid via G2025 are not paid at the AIR and are not included in the RHC total visit counts.
    b. Telehealth visits for mental health visits beginning January 1, 2022 are paid at the AIR and are included in the RHC total visit counts.
    c. It is going to be important to have a system to keep up with the different types of telehealth visits in the future.
    d. https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf

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.

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.

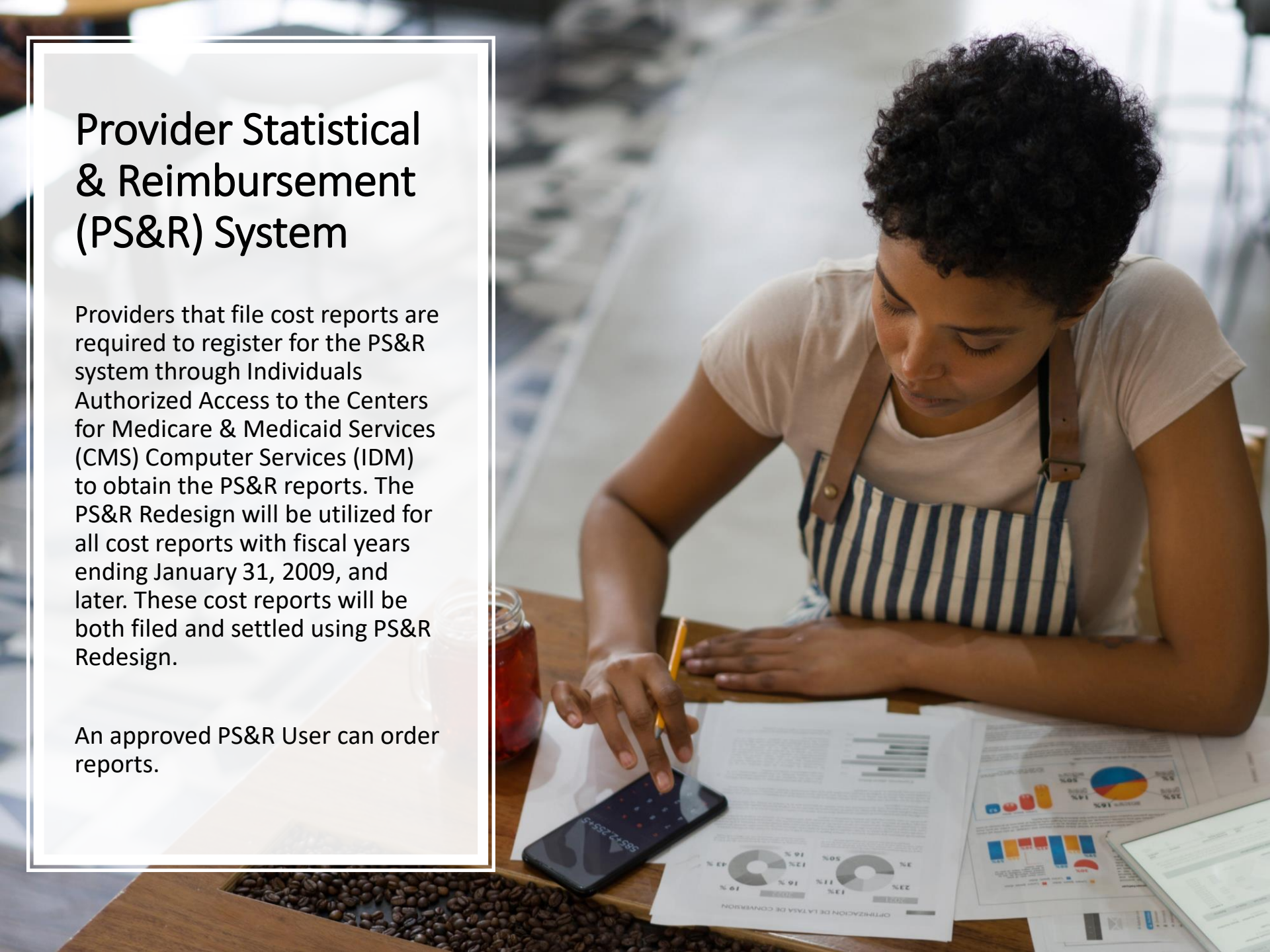
The IDM System provides the means for users to be approved to access many other CMS systems and applications. IDM governs access to CMS systems by managing the creation of user IDs and passwords, setting up multi-factor authentication (MFA), and the assignment of roles within CMS applications.

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

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.



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

Write the last sentence of your novel first – John Irving

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.

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).

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.

Accruals, PRF Funding, and CCM Bad Debts

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
    - Pension plan contributions for 2022 not paid until 2023
    - Payroll due to employees not paid in 2022 and paid in 2023.

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

Should PRF Funds and SBA loan forgiveness offset expenses on the RHC Cost Report?

4. **Question:** Should PRF payments offset expenses on the Medicare cost report?
   Answer: No, providers should not adjust the expenses on the Medicare cost report based on PRF payments received. However, providers must adhere to HRSA's guidance regarding appropriate uses of PRF payments, in order to ensure that the money is used for permissible purposes (namely, to prevent, prepare for, or respond to coronavirus, and for health care related expenses or lost revenues that are attributable to coronavirus) and that the uses of the PRF payments do not violate the prohibition on using PRF money to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

   Recipients may find additional information on the terms and conditions of the PRF at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html. Questions regarding use of the funds, pursuant to the Fund Terms and Conditions and any questions about overpayments should be directed to HRSA.
   New: 8/26/20

5. **Question:** Should SBA loan forgiveness amounts offset expenses on the Medicare cost report?
   Answer: No. Do not offset SBA Loan Forgiveness amounts against expenses unless those amounts are attributable to specific claims such as payments for the uninsured. The Paycheck Protection Program loan administered by the SBA is a loan designed to provide a direct incentive for small businesses to keep their workers on the payroll. The terms and conditions of the SBA loan forgiveness, overseen by the SBA, include employee retention criteria, and the funds must be used for eligible expenses.

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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*

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.

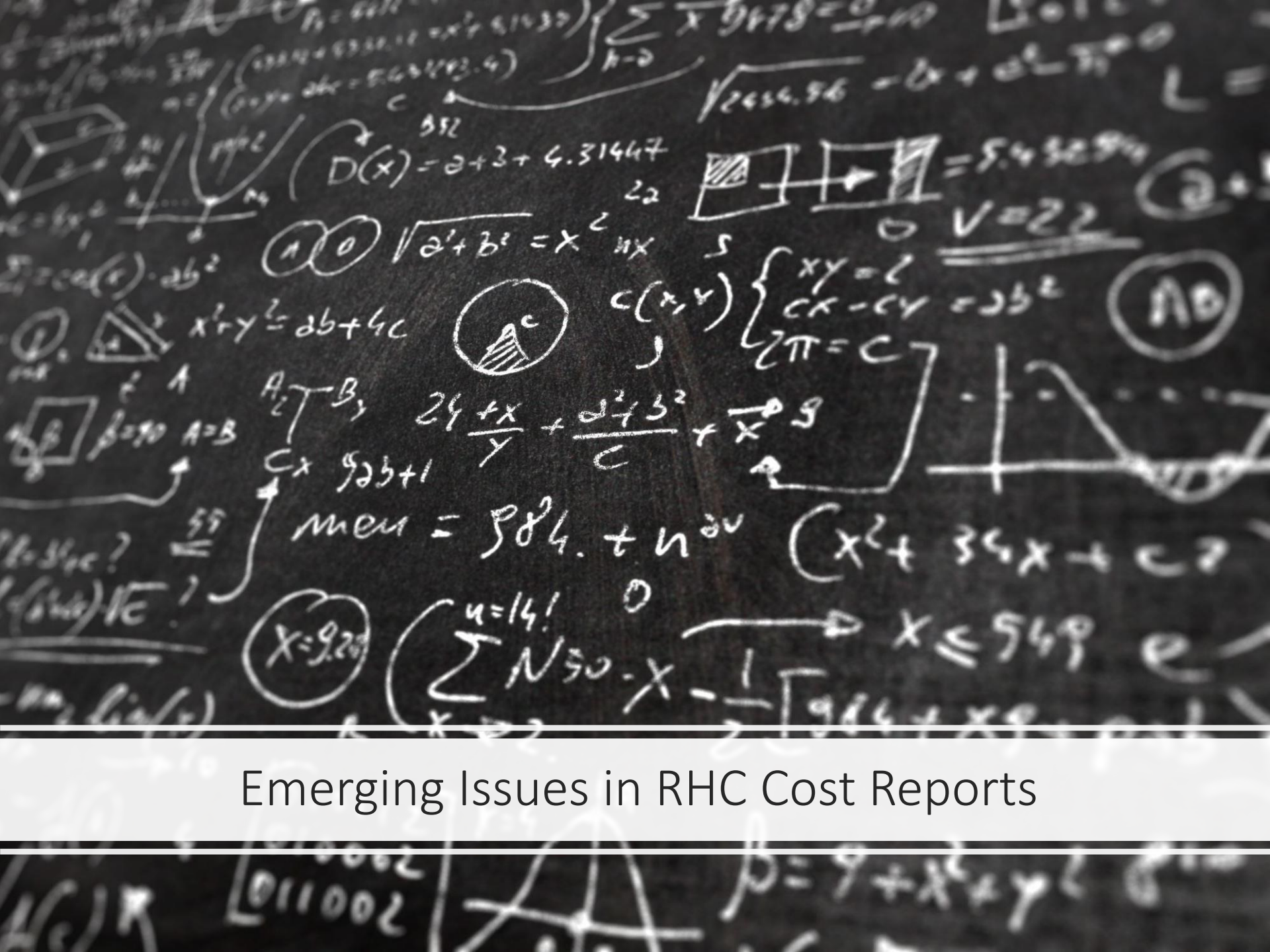
Low Utilization Cost Reports

"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



Emerging Issues in RHC Cost Reports

Nursing Home Visits paid through the RHC

- The increased volume will make it difficult to maintain your Medicare rate.
- Keeping track of providers time and schedules at each nursing home and which RHC (if you have multiple RHCs) the nursing home visit goes with along with the cost is difficult
- Will the continued growth of this practice cause greater scrutiny or regulation of this service line?

Mental Health Services in RHCs

- An RHC "cannot be primarily engaged in treatment of behavioral health" (the 51% primary care rule)
  - Keeping the primary care/mental health ration at 51% is critical
    - Inspectors typically count CPT codes to get this ratio. (some use ICD-10 codes or provider schedules)
- Kentucky Medicaid does not pay two AIRs on one day for an office visits with an E & M service and a mental health visit by two different providers (Medicare will pay two AIRs) (Watch your base year counts)
- Confusion regarding Section 170 of Chapter 13 of the RHC Manual – Medication Management & Mental health visits on the same day is not separately billable.
- The vast difference in provider types that can provide mental health services between Medicare and Medicaid.
    - Medicare is currently limited to Doctorate Clinical Psychologists (Section 150, Chapter 13) and Clinical Social Workers (Masters or Doctorate in social work)
    - Medicaid in each state typically has many more covered behavioral health provider types. (ie: A licensed clinical social worker; licensed psychologist; licensed marriage and family therapist; licensed professional clinical counselor; licensed psychological practitioner; a certified psychologist with autonomous functioning; etc.

Service Lines not payable by Medicare (ie Botox)

- RHCs do not have to have separate non-rhc hours to do these services.
- RHCs do have to keep up with your direct cost of providing the service and keep up with provider & nursing time providing the service.
- The cost of the service & provider/nursing salaries should be reclassified to a non-allowable cost center & overhead allocated to the area.

Multiple Clinics with one Tax ID number and one NPI number (Urgent Care Model)

- **Each RHC must have a separate NPI number by location.** Organizations with multiple RHCs under one Tax ID must have a robust accounting system by location to track costs and an EMR system that can provide CPT Codes by location and Provider.

What is a Credit Balance (838) Report?

(Must be filed every quarter of Medicare will stop paying.)

Providers use the quarterly CMS-838 report to disclose Medicare credit balances. Medicare credit balance is an amount determined to be refundable to Medicare. The CMS -838 is specifically used to monitor identification and recovery of 'credit balances' owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors.

When is the credit balance report due?

A completed CMS-838 must be submitted within 30 calendar days after the close of each calendar quarter.

https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms838.pdf

Cost Report Benchmarking Report from NARHC

NARHC Benchmarking Webinar on November 9th, 2022

Through our continued partnership with Wipfli, LLP, valued consultants in the RHC community, NARHC is excited to offer an RHC benchmarking webinar on Wednesday, November 9th, 2022, at 2 PM ET. Annual benchmarking provides a comparison of your RHC to state, regional, and national averages and increases your ability to track and optimize your cost per visit. In this webinar, Nathan Smith and Erik Prosser from Wipfli will provide an overview of the benchmarking process and share valuable examples from past consults with clinics. This webinar is free and open to all members of the RHC community. Additionally, NARHC members are eligible for free, annual benchmarking reports!

- Date: Wednesday, November 9, 2 PM Eastern
- To register, go to

https://us06web.zoom.us/webinar/register/WN_AA9Q29SzTeGXhURlf0a-KQ .

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

“So we beat on, boats against the current, borne back ceaselessly into the past.” F. Scott Fitzgerald

Thank You!

Mark Lynn, Healthcare Business Specialists

marklynnrhc@gmail.com