Rural Health Clinic Cost Reporting 101
Louisiana Rural Health Association
December 8, 2022

HBS
Healthcare Business Specialists

CONTACT INFORMATION

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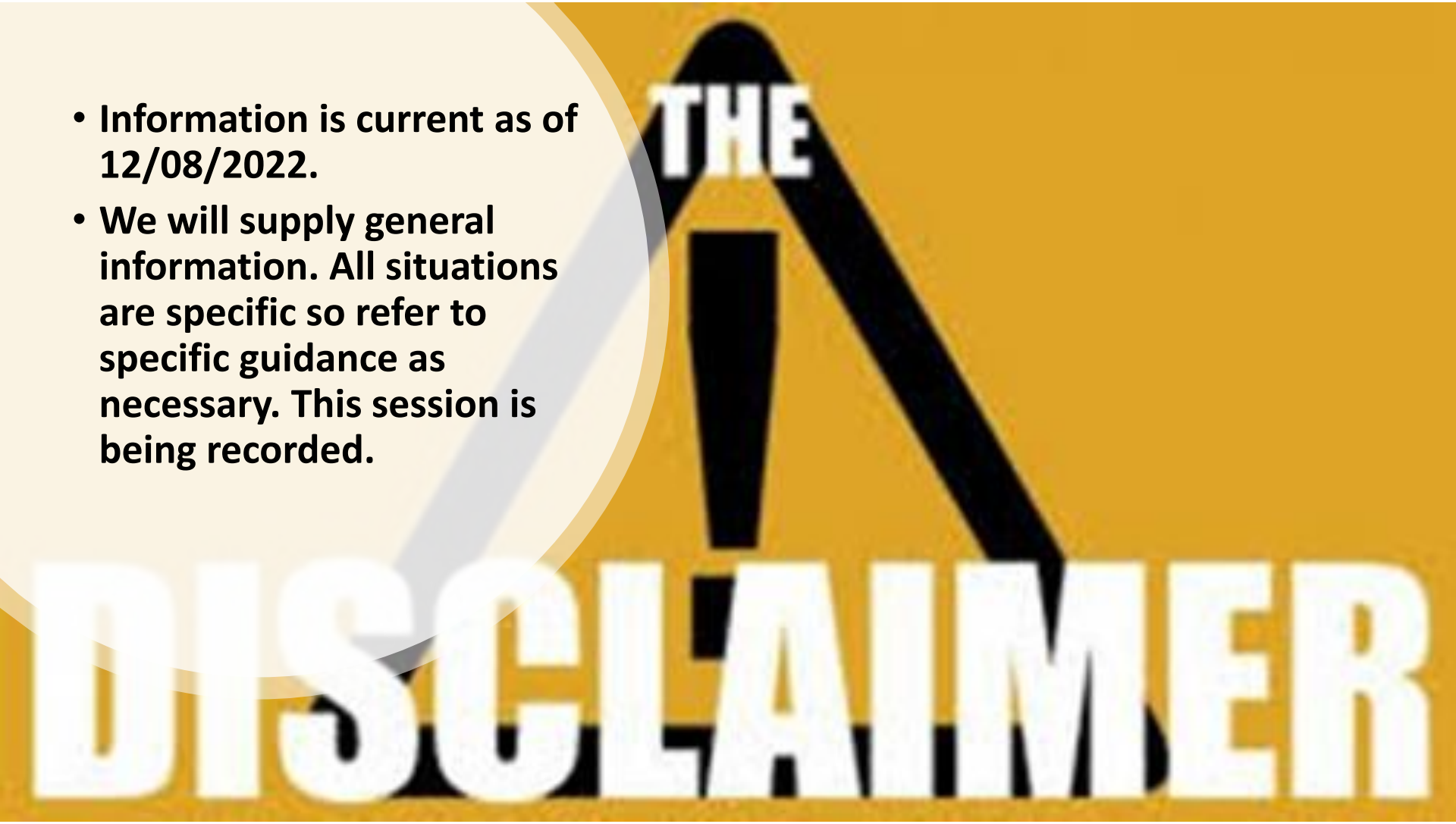
- Information is current as of 12/08/2022.
- We will supply general information. All situations are specific so refer to specific guidance as necessary. This session is being recorded.



Webinar Objective

To provide general information on the RHC cost reporting understandable to RHC managers and providers and focused on impact, timing, and responsibilities of the RHC to prepare timely and accurate Medicare and Medicaid cost reports.

- Cost Report Overview
- Building Blocks – ABCs
  - Expenses
  - Visits
  - Productivity standards
  - Flu & Pnu Reimbursement
  - Bad Debts
- Questions

RHC Cost Report

There are two types of RHCs for cost reporting purposes

Independent RHCs which are typically owned by physicians, NPs, PAs, non-hospital companies and hospitals with 50 or more beds (basically anyone). The entities file an independent or freestanding cost report (Form 222-97). The are subject to the National Statutory Payment Limits.

Provider-based RHCs are owned by hospitals and may have less than 50 beds or more than 50 beds. These RHCs file Medicare cost reports as an integral part of the Hospital cost report (M-series of the Form 2552-10). These clinics are subject to the National Statutory Payment Limits if certified in 2021 and after or the specified provider-based RHC's (Grandfathered) per visit AIR payment if certified in 2020 or earlier.

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.

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Rural Health Clinic All-Inclusive Rate: CY 2023 Update

MLN Matters Number: MM12999 Related Request (CR) Number: 12999

Related CR Release Date: November 23, 2022 Effective Date: January 1, 2023

Related CR Transmittal Number: R11718CP Implementation Date: January 3, 2023

Related CR Title: Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2023

Provider Types Affected

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

Provider Action Needed

Make sure your billing staff knows about:

- RHC per-visit payment limit for CY 2023
- Specified (grandfathered) provider-based RHC payment limits
- Cost report data requirements

Background

Section 1833(f)(2) of the Social Security Act (the Act) requires CMS to increase the payment limit per visit RHCs get for an 8-year period (from 2021-2028). Medicare's Part B payment to RHCs is 80% of the AIR, subject to a payment limit for medically necessary medical, and qualified preventive, face-to-face visits with a practitioner and a Medicare patient for RHC services.

We update the limit by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services provided as of the first day of that year.

Starting April 1, 2021, provider-based RHCs that met the qualifications in Section 1833(f)(3)(B) of the Act are entitled to special payment rules that set a payment limit based on the specified provider-based RHC's per visit AIR payment amount instead of the national statutory payment limit.

For entitlement to the special payment rules, a specified provider-based RHC (grandfathered

RHC) is an RHC that:

- As of December 31, 2020, was in a hospital with less than 50 beds and
- After December 31, 2020, was in a hospital that continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the COVID-19 Public Health Emergency (PHE), and 1 of the following circumstances:
  - As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the PHE) or
  - Submitted a Medicare enrollment application (or a request for temporary enrollment during the PHE) that we got before January 1, 2021.

CR 12185 implemented the increase in the RHC statutory payment limit per visit and the specified provider-based RHC payment limits per visit, which went into effect on April 1, 2021.

Note: We use the term specified the same as the term grandfathered in CR 12999 and CR 12185.

Policy for CY 2023

The RHC payment limit per visit for CY 2023 is $126.00 for independent RHCs and provider-based RHCs in a hospital with 50 or more beds

Specified (grandfathered) provider-based RHCs with an April 1, 2021, established payment limit that continue to meet the qualifications in Section 1833(f)(3)(B) of the Act, the payment limit per visit for CY 2023 is an amount equal to the greater of:

- The payment limit per visit starting January 1, 2022, increased by the MEI 3.8% for primary care services provided as of the first day of CY 2023 (3.8 %*), or
- The RHC national statutory payment limit per visit for CY 2023 ($126 per visit)

For specified provider-based RHCs that no longer meet the qualifications in Section 1833(f)(3)(B) of the Act, the payment limit per visit for CY 2023 is the national statutory payment limit per visit for CY 2023 ($126 per visit)

Specified provider-based RHCs that don't have an April 1, 2021, established payment limit due to a pending final settled cost report:

- Under Section 1833(f)(3)(A) of the Act, specified provider-based RHCs that didn't have a per-visit payment amount (or AIR) set for services provided in CY 2020 will have a payment limit per visit based on their AIR and set at an amount equal to the greater of:
  - The per-visit payment amount applicable to the provider-based RHCs for services provided in 2021, or
  - The RHC national statutory payment limit per visit for CY 2023 ($126 per visit)

https://www.cms.gov/files/document/mm12999-rural-health-clinic-all-inclusive-rate-cy-2023-update.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.

What is the RHC 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.
-

The Purpose of the RHC Cost Report

The purpose of the Medicare Cost Report is reconciling payments received from Medicare as compared to the allowable costs reported by the RHC. The process will result in a settling of monies owed or due to Medicare for the cost report fiscal year.

Governmental agencies use this information to provide data for future healthcare policies.

Medicaid uses a cost reporting process to establish Medicaid RHC rates and/or settle Medicaid RHC payments with the RHC. Each state is different.

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, 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

Cost Reporting Forms for Independent & Provider-based RHCs

Description	Independent	Provider-based
Cost Reporting Form	CMS-222-17	CMS-2552-10
Link to PDF of Forms	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf
Software Vendors 4 vendors for RHCs and 2 for hospital cost reports	https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing	https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing

Crosswalk of Forms between Provider-based & Independent RHCs

Purpose of Form	Independent	Provider-based
Provider Name, Location, CCN Number, Signature	S Parts I, II & III	**S-2/S-8**
Malpractice Information, Hours of Operation	S-1 Part I & II	**NA**
Replaces the 339 Questionnaire	S-2	**NA**
Payer Mix and mental health visits	S-3	**NA**
Expense information (Trial Balance of total expenses)	A	**A/M-1**
Reclassifications (Salaries to the proper cost center)	A-6	**A-6**
Adjustments (remove non-allowable expenses, straight-line depreciation on assets, value of services)	A-8	**A-8**
Related Party Transaction (adjust RPTs to actual cost)	A-8-1	**A-8-1**
Allocation of Overhead (Hospital or Parent)	NA	**B Part I, B-1**
Visits, FTEs, Overhead allocations to Non-RHC	B, Part 1	**M-2**
Influenza and Pneumonia Costs	B-1	**M-4**
All Inclusive Rate Calculation, Bad Debts, P S & R data	C	**M-3**
Medicare Payments including Interim settlements	C-1	**M-5**

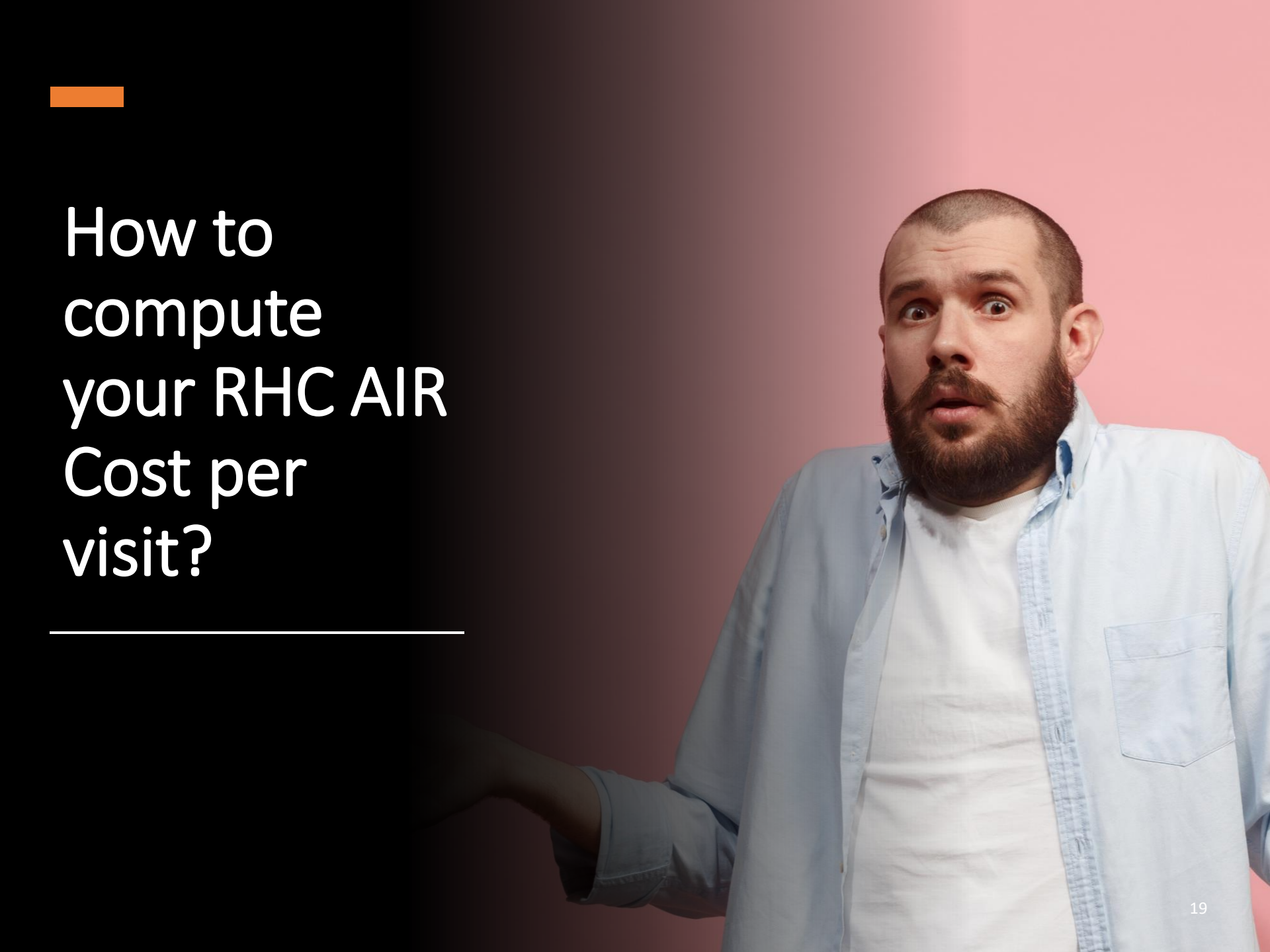
Mandated Cost Reporting Timeframes

Description	Timeframe
Cost Report prepared by the clinic and due to Medicare	5 months year-end
Number of days the MAC has to accept the cost report	30 days
Number of days the MAC has to pay a tentative settlement	60 days
Time to final settle cost report	1 year from acceptance

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c08.pdf

Building Blocks

How to compute your RHC AIR Cost per visit?



All Inclusive Rate (AIR) Per Visit Calculation

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

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

Question – Is there a list of all allowable expenses for the cost report?

Answer – No, there are thousands of pages of reimbursement rules that you find on the next page.

Question – Are all of the expenses of the clinic included in the AIR Total costs?

Answer – No, there are services that are paid on a fee for service basis or not covered in the AIR calculation. Some examples, lab, technical components, hospital services, telehealth, chronic care management, etc.

Medicare RHC Cost Report Reimbursement Regulations

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

How to count visit for RHC AIR Calculations

Why are Visits so Important?

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

Do not count 99211 visits, Injections, lab procedures, hospital visits, non-rhc visits, telehealth (except mental health), CCM. **Be careful not to double count T1015 Medicaid codes.**

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.

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.

Total Visit Counts

2	PROVIDE AT LEAST ONE OF THE FOLLOWING (A. OR B.) TO DETERMINE THE TOTAL PATIENT VISITS OR ENCOUNTERS AND NEED ONE OF THE FOLLOWING.
a.	**CPT Frequency report by Provider from your computer system.**
b.	Written or manual visit count with physician, physician assistant, and nurse practitioner visits provided.

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

Question – Why is a CPT report by Payor not the best way to count visits for the RHC AIR calculation?

Answer – Because many patients have a primary and secondary insurance and these reports tend to overstate the number of visits which hurts your cost per visit.

Let’s take a deeper dive into Allowable Expense for the RHC AIR Cost Per Visit

Total Expense Source Documents (Numerator)

Provide your Expenses
Typically, one of the following:

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

ABC Company

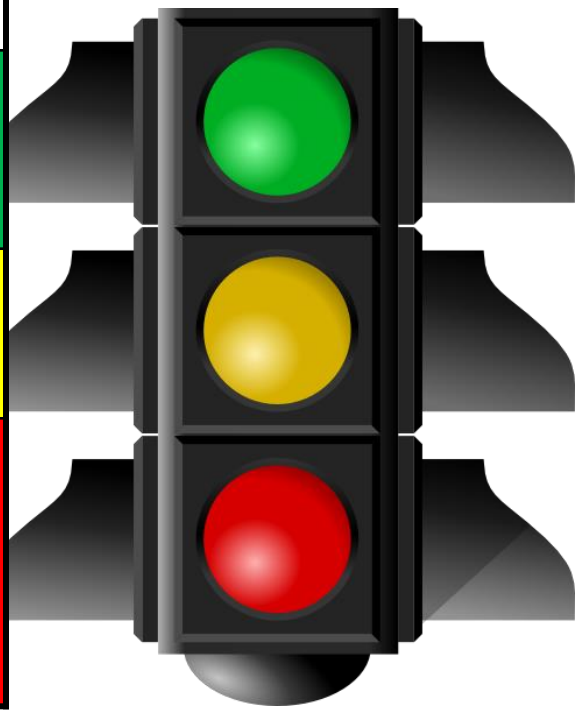
Table: Cash Flow

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

RHC Cost Report can be divided in 3 sections

CR Description- WKS A	CR Line
Healthcare Staff Costs	1-39
Facility Overhead	40-74
Costs other than RHC Services and Non-Reimbursable	75-100



Healthcare Costs – CR Lines 1-39

		Cost Center Description	Salaries	Other	Total (col 1 + col 2)	Reclassifi-cations	Reclassified Trial Balance (col 3 / col 4)	Adjustments	Net Expenses for Allocation (col 5 / col 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
		FACILITY HEALTH CARE STAFF COSTS								
1.00	0100	PHYSICIAN	0	0	0	0	0	0	0	1.00
2.00	0200	PHYSICIAN ASSISTANT	0	0	0	0	0	0	0	2.00
3.00	0300	NURSE PRACTITIONER	0	0	0	180,829	180,829	0	180,829	3.00
4.00	0400	CERTIFIED NURSE MIDWIFE	0	0	0	0	0	0	0	4.00
5.00	0500	REGISTERED NURSE	0	0	0	0	0	0	0	5.00
6.00	0600	LICENSED PRACTICAL NURSE	0	0	0	0	0	0	0	6.00
7.00	0700	CLINICAL PSYCHOLOGIST	0	0	0	0	0	0	0	7.00
8.00	0800	CLINICAL SOCIAL WORKER	0	0	0	0	0	0	0	8.00
9.00	0900	LABORATORY TECHNICIAN	0	0	0	0	0	0	0	9.00
10.00	1000	NURSING SALARIES	437,140	0	437,140	-378,789	58,351	0	58,351	10.00
10.01	1001	HEALTHCARE STAFF: TRANSCRIPTION	0	0	0	0	0	0	0	10.01
10.02	1002	HEALTHCARE STAFF: CONTRACT LABOR	0	0	0	0	0	0	0	10.02
14.00		SUBTOTAL-FACILITY HEALTH CARE STAFF COSTS (sum of lines 1 through 10)	437,140	0	437,140	-197,960	239,180	0	239,180	14.00
		COSTS UNDER AGREEMENT								
15.00	1500	PHYSICIAN SERVICES UNDER AGREEMENT	0	18,600	18,600	0	18,600	0	18,600	15.00
16.00	1600	PHYSICIAN SUPERVISION UNDER AGREEMNT	0	0	0	3,994	3,994	0	3,994	16.00
17.00		SUBTOTAL UNDER AGREEMENT (sum of lines 15 through 16)	0	18,600	18,600	3,994	22,594	0	22,594	17.00
		OTHER HEALTH CARE COSTS								
25.00	2500	MEDICAL SUPPLIES	0	31,694	31,694	-13,882	17,812	0	17,812	25.00
26.00	2600	TRANSPORTATION (HEALTH CARE STAFF)	0	0	0	0	0	0	0	26.00
27.00	2700	DEPRECIATION-MEDICAL EQUIPMENT	0	14,012	14,012	0	14,012	0	14,012	27.00
28.00	2800	MALPRACTICE PREMIUMS	0	5,362	5,362	0	5,362	0	5,362	28.00
29.00	2900	ALLOWABLE GME COSTS	0	0	0	0	0	0	0	29.00
30.00	3000	PNEUMOCOCCAL VACCINES & MED SUPPLIES	0	0	0	0	0	0	0	30.00
31.00	3100	INFLUENZA VACCINES & MED SUPPLIES	0	0	0	1,730	1,730	0	1,730	31.00
32.00	3200	CME, DUES, LICENSES SUBSCRIPTIONS	0	7,653	7,653	0	7,653	0	7,653	32.00
32.01	3201	ELECTRONIC HEALTH RECORDS	0	3,251	3,251	0	3,251	0	3,251	32.01
38.00		SUBTOTAL-OTHER HEALTH CARE COSTS (sum of lines 25 through 32)	0	61,972	61,972	-12,152	49,820	0	49,820	38.00
39.00		TOTAL COST OF SERVICES (OTHER THAN OVERHEAD AND OTHER RHC SERVICES) (sum of lines 14, 17 and 38)	437,140	80,572	517,712	-206,118	311,594	0	311,594	39.00

Facility Overhead CR Lines 40-74

	FACILITY OVERHEAD-FACILITY COST									
40.00	4000	RENT	0	48,800	48,800	0	48,800	0	48,800	40.00
41.00	4100	INSURANCE	0	0	0	0	0	0	0	41.00
42.00	4200	INTEREST ON MORTGAGE OR LOANS	0	0	0	0	0	0	0	42.00
43.00	4300	UTILITIES	0	9,877	9,877	0	9,877	0	9,877	43.00
44.00	4400	DEPRECIATION-BUILDINGS AND FIXTURES	0	0	0	0	0	0	0	44.00
45.00	4500	DEPRECIATION-MOVABLE EQUIPMENT	0	0	0	0	0	0	0	45.00
46.00	4600	HOUSEKEEPING AND MAINTENANCE	0	2,821	2,821	4,500	7,321	0	7,321	46.00
47.00	4700	PROPERTY TAX	0	0	0	0	0	0	0	47.00
48.00	4800	OTHER OVERHEAD-FACIL COSTS (SPECIFY)	0	0	0	0	0	0	0	48.00
59.00		SUBTOTAL-FACILITY COSTS (sum of lines 40 through 48)	0	61,498	61,498	4,500	65,998	0	65,998	59.00
	FACILITY OVERHEAD-ADMINISTRATIVE COSTS									
60.00	6000	OFFICE SALARIES	0	0	0	748,670	748,670	0	748,670	60.00
61.00	6100	DEPRECIATION-OFFICE EQUIPMENT	0	0	0	0	0	0	0	61.00
62.00	6200	OFFICE SUPPLIES	0	30,919	30,919	-5,000	25,919	0	25,919	62.00
63.00	6300	LEGAL	0	0	0	0	0	0	0	63.00
64.00	6400	ACCOUNTING	0	0	0	0	0	0	0	64.00
65.00	6500	INSURANCE	0	0	0	0	0	0	0	65.00
66.00	6600	TELEPHONE	0	0	0	0	0	0	0	66.00
67.00	6700	FRINGE BENEFITS AND PAYROLL TAXES	0	421,436	421,436	-264,749	156,687	0	156,687	67.00
68.00	6800	BILLING SERVICE	0	0	0	0	0	0	0	68.00
68.01	6801	MISCELLANEOUS	0	156,955	156,955	0	156,955	0	156,955	68.01
68.02	6802	NON-ALLOWABLE COSTS	0	126,288	126,288	0	126,288	-126,288	0	68.02
68.03	6803	CORPORATE ADMIN ALLOCATION	0	0	0	0	0	0	0	68.03
73.00		SUBTOTAL-ADMINISTRATIVE COST (sum of lines 60 through 68)	0	735,598	735,598	478,921	1,214,519	-126,288	1,088,231	73.00
74.00		TOTAL OVERHEAD (sum of lines 59 and 73)	0	797,096	797,096	483,421	1,280,517	-126,288	1,154,229	74.00

Cost Other than RHC Services and Non-Reimbursable Costs CR 75-100

	COST OTHER THAN RHC SERVICES									
75.00	7500	PHARMACY	0	0	0	0	0	0	0	75.00
76.00	7600	DENTAL	0	0	0	0	0	0	0	76.00
77.00	7700	OPTOMETRY	0	0	0	0	0	0	0	77.00
78.00	7800	NON-ALLOWABLE GME PASS THROUGH COSTS	0	0	0	0	0	0	0	78.00
79.00	7900	TELEHEALTH	0	0	0	326	326	0	326	79.00
80.00	8000	CHRONIC CARE MANAGEMENT	0	0	0	9,254	9,254	0	9,254	80.00
81.00	8100	OTHER THAN RHC SRVCE COSTS (EPSDT)	0	0	0	8,810	8,810	0	8,810	81.00
81.01	8101	OTHER THAN RHC: HOSPITAL	0	0	0	1,623	1,623	0	1,623	81.01
81.02	8102	OTHER THAN RHC: PRIVATE PRACTICE	0	0	0	0	0	0	0	81.02
81.03	8103	OTHER THAN RHC: LABORATORY	0	0	0	20,272	20,272	0	20,272	81.03
81.04	8104	OTHER THAN RHC: RADIOLOGY	0	0	0	0	0	0	0	81.04
86.00		SUBTOTAL-COST OTHER THAN RHC (sum of lines 75 through 81)	0	0	0	40,285	40,285	0	40,285	86.00
	NON-REIMBURSABLE COSTS									
87.00	8700	OTHER NON-REIMB COSTS (SPECIFY)	0	0	0	0	0	0	0	87.00
88.00	8800	OTHER NON-REIMB COSTS (SPECIFY)	0	0	0	0	0	0	0	88.00
89.00	8900	OTHER NON-REIMB COSTS (SPECIFY)	0	0	0	0	0	0	0	89.00
90.00		SUBTOTAL NON-REIMBURSABLE COSTS (sum of lines 87 through 89)	0	0	0	0	0	0	0	90.00
100.00		TOTAL COSTS (sum of lines 39, 74, 86, and 90)	437,140	412,542	849,682	0	849,682	-16,885	832,797	100.00

If you have an outside contract performing CCM, you will want to adjust the cost of the agreement out of the cost report, so it does not pull more overhead out of your RHC AIR calculation.

Overhead is allocated to the Healthcare Costs area and the Other than RHC area based upon the ratio of Healthcare Costs to the Total of the Healthcare Costs plus Cost of Other than RHC services.

	PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC SERVICES			
		Amount		
12.00	Cost of RHC Services - excluding overhead and allowable GME costs - (Worksheet A, column 7, line 39, minus Worksheet A, column 7, line 29)	311,594	Green	12.00
13.00	Cost of Other Than RHC Services - Excluding overhead (Worksheet A, column 7, sum of lines 86 and 90)	40,285	Red	13.00
14.00	Cost of All Services - excluding overhead - (sum of lines 12 and 13)	351,879	Yellow	14.00
15.00	Ratio of RHC (line 12 divided by line 14)	0.885515		15.00
16.00	Total Overhead - (Worksheet A, column 7, line 74)	480,918		16.00
17.00	Overhead Applicable to RHC Services (line 15 times line 16)(see instructions)	425,860		17.00
18.00	Total Allowable Cost of RHC Services (sum of lines 12 and 17)	737,454		18.00

Separate General Ledger accounts for Non-allowable Expenses

Certain Non-RHC expenses need separate accounting or general ledger accounts.

A. Laboratory supplies/reagents/licenses
B. Radiology supplies/ film/ licenses
C. EKGs tracing supplies or Part B technical component costs.
D. Any service billed to Part B and there is a supply cost.
E. Chronic Care Management
F. Tele-Health

Cost Centers – Independent RHCs

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)**

Provider-Based RHCs Cost Report Forms – M-1

10-12 FORM CMS-2552-10 4090 (Cont.)

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET M-1

Check applicable box: [ ] RHC [ ] FQHC

		COMPEN-SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1-9)								10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15-20)								21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)								22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

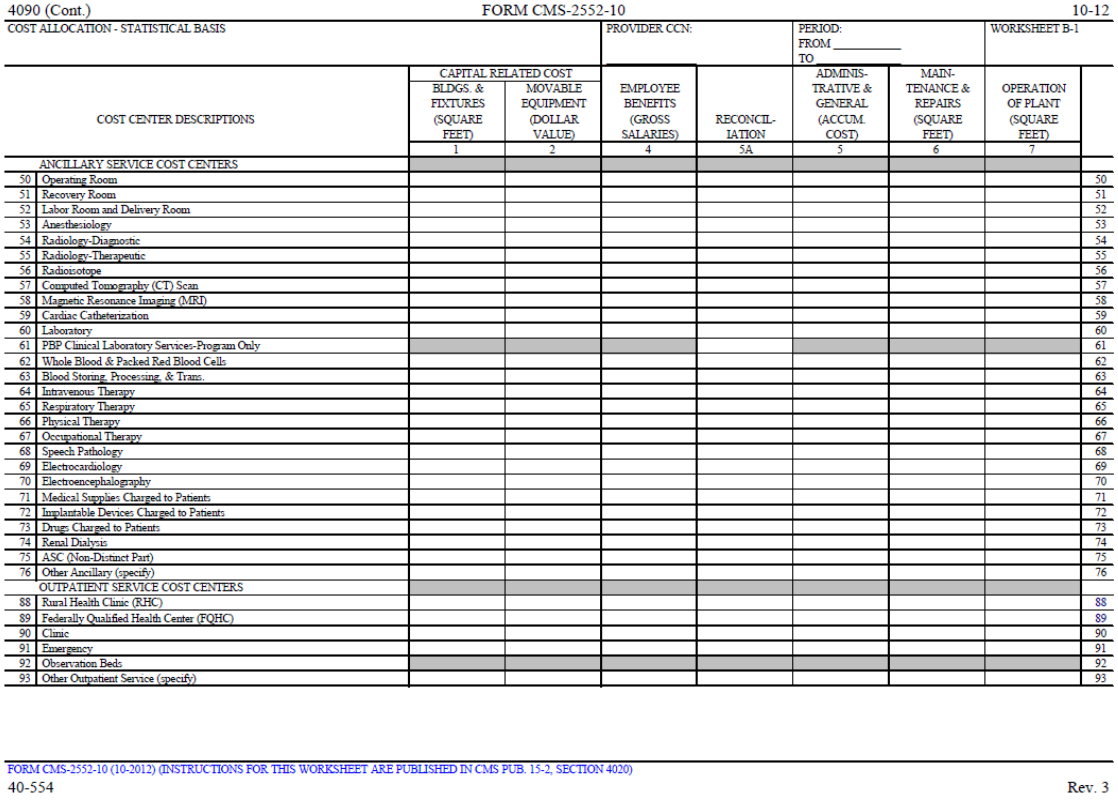
FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4066)

Rev. 3 40-659

Worksheet B-1 Provider-based RHC Cost Statistics

Provider-based RHCs receive an allocation of parent overhead from the hospital. The provider-based RHC must maintain statistics to support the allocation of overhead. Such statistics may include:

1. Square Footage
2. Time Studies
3. Gross Salaries
4. Accumulated Costs
5. Pounds of Laundry



4090 (Cont.) FORM CMS-2552-10 10-12

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		1	2	4	5A	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Labor Room and Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Beds								92
93	Other Outpatient Service (specify)								93

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

40-554 Rev. 3

Using Benchmark Data

What elements of cost are causing the variance: provider, support staff, overhead, parent allocation?

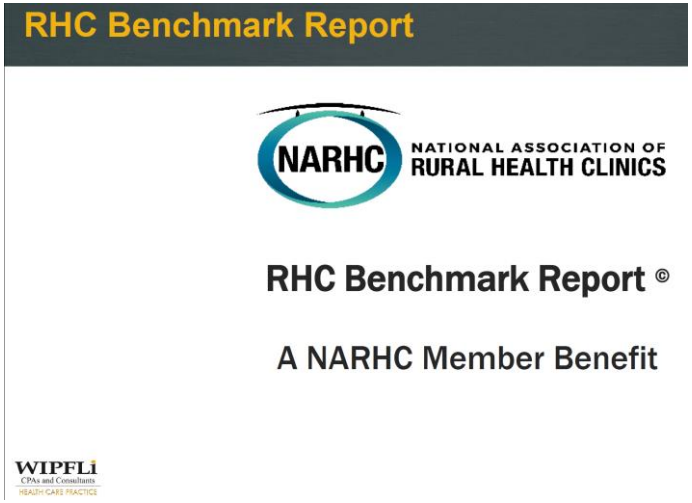
	2018			
	RHC		Mean	
Category/Indicator	Values		MI	Midwest	Nation
Number of Facilities	1		61	383	837
Clinic Cost per Encounter:					
Total Health Care Staff	130.04	↓	79.09	98.42	92.91
Total Direct Costs of Medical Services	146.41	→	123.21	129.20	117.97
Allowable GME Overhead	0.00		0.00	0.00	0.00
Clinic Overhead	59.88	↓	27.57	22.73	24.09
Parent Provider Overhead Allocated	122.44	↓	81.28	81.91	78.20
Allowable Overhead (Clinic and Parent)	182.32	↓	108.34	104.07	101.54
Allowable Overhead Ratio (Clinic and Parent)	100%	→	100%	99%	99%
Total Allowable Cost per Actual Encounter	328.74	↓	230.60	233.00	218.67
Total Allowable Cost per Adjusted Encounter	328.74	↑	221.89	222.99	208.51

WIPFLI
CPAs and Consultants
HEALTH CARE PRACTICE

Cost Report Benchmarking Report from NARHC

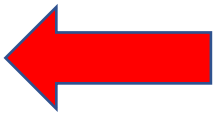
Professional Tip: Benchmark your Cost Report

https://www.wipfli.com/healthcare



https://www.ruralhealthinfo.org/assets/762-2349/slides-121415.pdf

Category/Indicator	2015 Mean TN	2015 Mean Southern	2015 Mean Nation	2016 Mean TN	2016 Mean Southern	2016 Mean Nation	2017 Mean TN	2017 Mean Southern	2017 Mean Nation
Number of Facilites	62	708	1,242	71	672	1,154	74	628	1,056
Encounters per FTE:									
Physicians	5,209	4,970	4,729	5,167	4,941	4,651	4,577	4,725	4,577
Physician Assistants	3,435	3,677	3,639	3,574	3,834	3,740	2,967	3,911	3,738
Nurse Practitioners	3,215	3,487	3,327	3,267	3,497	3,332	3,242	3,469	3,286
Visiting Nurses	0	119	375	0	200	525	595	538	815
Clinical Psychologist/Social Worker	980	1,658	1,876	1,620	1,356	1,478	1,140	1,643	1,746
Midlevel Staffing Ratio	80%	55%	54%	80%	57%	57%	81%	59%	58%
Midlevel Visit Ratio	72%	46%	46%	72%	49%	49%	74%	52%	51%
Cost per Encounter:									
Physician	56.84	55.83	59.10	63.93	58.88	62.04	69.22	62.80	64.96
Physician Assistant	36.38	33.84	33.82	31.04	31.25	33.06	36.05	31.91	34.63
Nurse Practitioner	32.81	32.05	34.37	34.54	33.23	35.19	34.45	34.21	37.09
Visiting Nurse	#DIV/0!	313.49	97.39	0.00	263.49	103.50	117.07	111.29	69.26
Clinical Psychologist/Social Worker	165.53	89.32	52.67	96.58	92.61	69.71	53.73	72.72	55.53
Total Health Care Staff Cost	11.47	12.51	14.19	10.78	12.78	14.74	11.17	13.34	15.23
Cost per FTE:									
Physician	264,333	266,709	269,434	306,012	279,334	276,635	292,911	290,846	288,698
Physician Asstistant	124,961	124,427	123,069	110,934	119,809	123,661	106,947	124,798	129,446
Nurse Practitioner	105,480	111,750	114,345	112,868	116,211	117,254	111,682	118,694	121,874
Visiting Nurse	28,001	37,413	36,524	0	52,791	54,352	69,655	59,818	56,466
Clinical Psychologist/Social Worker	162,220	148,073	98,810	156,460	125,626	103,017	61,251	119,484	96,944
Total Healthcare Staff Costs per Provider FTE	42,539	52,546	57,439	40,642	53,339	58,968	39,858	54,220	59,977
Clinic Cost per Encounter:									
Total Health Care Staff	51.69	57.24	61.57	53.60	58.35	62.87	55.26	61.28	65.82
Total Direct Costs of Medical Services	63.14	67.38	72.52	66.27	68.57	74.17	69.76	71.36	76.99
Facility Cost	13.89	9.59	10.19	11.96	9.69	11.10	12.23	9.70	11.17
Clinic Overhead	58.49	47.41	54.20	55.36	48.54	58.44	57.95	48.90	59.63
Allowable Overhead	54.16	43.97	47.63	50.77	44.96	49.02	54.90	45.65	50.02
Allowable Overhead Ratio	93%	93%	88%	92%	93%	84%	95%	93%	84%
Total Allowable Cost per Actual Encounter	117.30	111.02	119.97	117.04	113.51	123.18	124.66	116.60	126.77
Total Allowable Cost per Adjusted Encounter	113.26	108.92	116.96	113.58	111.25	119.82	119.42	114.12	123.30
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(2.65)	(2.62)	(3.47)	(2.73)	(2.89)	(3.99)	(2.01)	(3.24)	(4.13)
Payment Rate per Adjusted Encounter	110.61	106.30	113.49	110.85	108.36	115.83	117.41	110.88	119.17
Total Encounters	469,666	8,501,938	15,452,512	558,284	8,198,077	14,340,172	592,558	7,780,195	13,469,393
Total Medicare Encounters	75,336	2,029,889	3,634,757	83,802	1,846,994	3,210,685	92,153	1,648,929	2,895,111
Medicare Percent of Visits	16%	24%	24%	15%	23%	22%	16%	21%	21%
Injection Cost:									
Cost per Pneumococcal Injection	220.94	173.43	188.83	282.22	201.14	229.88	274.63	245.80	270.32
Cost per Influenza Injection	44.09	48.89	49.13	43.52	48.15	51.14	54.66	68.29	66.41



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

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	Visits
Physician	4,200
Physician Assistant	2,100
Nurse Practitioner	2,100

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

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							

Name of Clinic

Worksheet B: FTE Calculation

Fiscal Year End

On this page we need information about the amount of time spent by providers and nursing staff providing patient care. Please fill out the **name of each provider** in your clinic, as well as the number of **hours per wee**
they spend providing patient care, the number of **hours they spend per week on other tasks** such as administrative work, and the number of **months worked through the fiscal year**.

In the section labeled "FTEs for Nursing Staff" please give the number of Nurses and Medical Assistants which work in your clinic, as well as the total number of hours that those employees worked during the year.

FTEs for Providers								
Provider Type	Name	Hours per week performing patient care	Hours per week performing admin tasks	Hours Per week in Non-RHC activities	Total hours worked per week	Number of months worked during fiscal year	Total Hours Worked Per Year	FTE
Physicians								
Physician Assistants								
Nurse Practioners								
Mental Health								

FTEs for Nursing Staff		
Number of Nurses and Medical Assistants	Total Hours Worked by Nurses and Medical	Nursing Staff FTE

Productivity Standards

VISITS AND OVERHEAD COST FOR RHC SERVICES				From: 01/01/2022 To: 12/31/2022		Worksheet B, Parts I & II	
	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (Col. 1 x Col. 3)	Greater of Col. 2 or Col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART I - VISITS AND PRODUCTIVITY						
1.00	Physicians	0.00	0	4,200	0		1.00
2.00	Physician Assistants	0.00	0	2,100	0		2.00
3.00	Nurse Practitioners	1.52	5,109	2,100	3,192		3.00
4.00	Certified Nurse Midwife	0.00	0	2,100	0		4.00
5.00	Subtotal (Sum of lines 1 through 4)	1.52	5,109		3,192	5,109	5.00
6.00	Registered Nurse	0.00	0			0	6.00
7.00	Licensed Practical Nurse	0.00	0			0	7.00
8.00	Clinical Psychologist	0.00	0			0	8.00
9.00	Clinical Social Worker	0.00	0			0	9.00
10.00	Total Staff	1.52	5,109			5,109	10.00
11.00	Physician Services Under Agreement		172			172	11.00
	(1) Productivity standards established by CMS are: 4200 visits for each physician and 2100 visits for each nonphysician practioner. If an exception to the productivity standard has been granted, (Wkst. S-1, Part I, line 20 equals "Y"), input in col. 3, lines 1 through 4, the productivity standards derived by the contractor.						

1. Productivity standards are counted in aggregate (a high producing provider may help a lower producing provider meet the standards as they are computed in total.
2. Due the pandemic and PHE waivers of productivity standards are relatively easy to obtain. Apply for them if necessary.

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 and Pneumoccoal

4	PROVIDE ALL OF THE FOLLOWING INFORMATION TO CLAIM INFLUENZA AND PNEUMOCCCOCAL REIMBURSEMENT ON THE COST REPORT.
a.	Medicare logs with patient name & HIC number and date of service for pneumoccocal and influenza patients.
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 and Pnemoccocal Shot Logs

Patient Name	MBI Number	Date of Service
John Smith	411992345A	12/11/2022
Steve Jones	234123903A	12/21/2022
Ashley Taylor	903214934A	12/31/2022

Medicare Influenza and Medicare Pnemoccocal shots should be maintained on separate logs. Pnumo pays around $270 per shot and influenza is $66 or so.

HBS
Healthcare Business Specialists

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	

Medicare Bad Debts

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

Medicare Bad Debt Summary

1. Medicare coinsurance 20% of charges.
2. Medicare deductible of $233 in 2022 & $226 is 2023.
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.

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.

Exhibit 2

Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________________

Prov. Number________________

FYE _______________________

Prepared By ____________________

Date Prepared ___________________

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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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.

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*

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

Question – How far can we go back and claim Medicare Bad Debts?

Answer – A Medicare Bad debt is reimbursable in the fiscal year the RHC ceases all collection efforts and writes the account off in its receivable system, so you can go back as far as you have records.

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

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

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

Fiscal Year-End Cost Report

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

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.

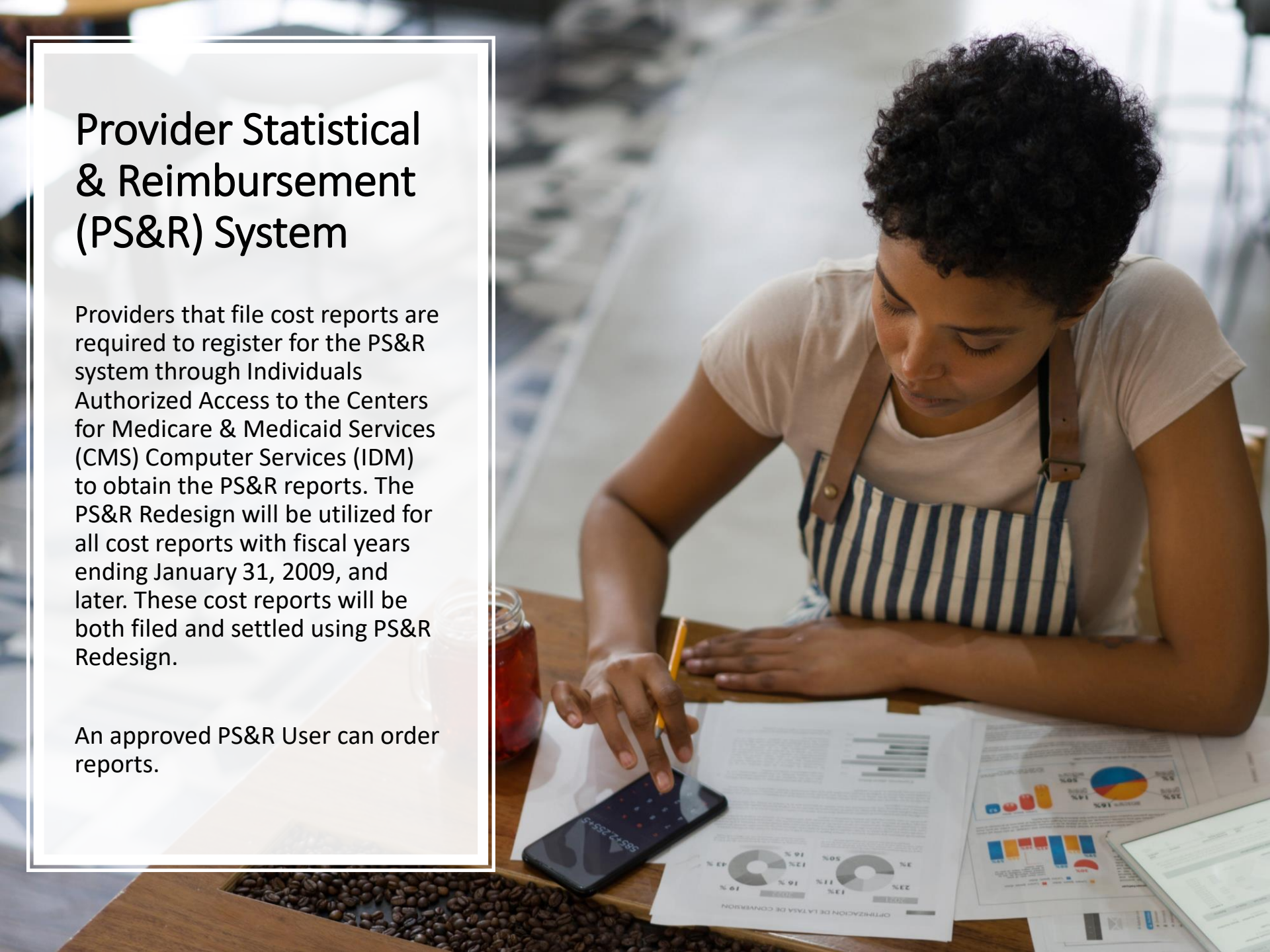
The IDM System provides the means for users to be approved to access many other CMS systems and applications. IDM governs access to CMS systems by managing the creation of user IDs and passwords, setting up multi-factor authentication (MFA), and the assignment of roles within CMS applications.

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

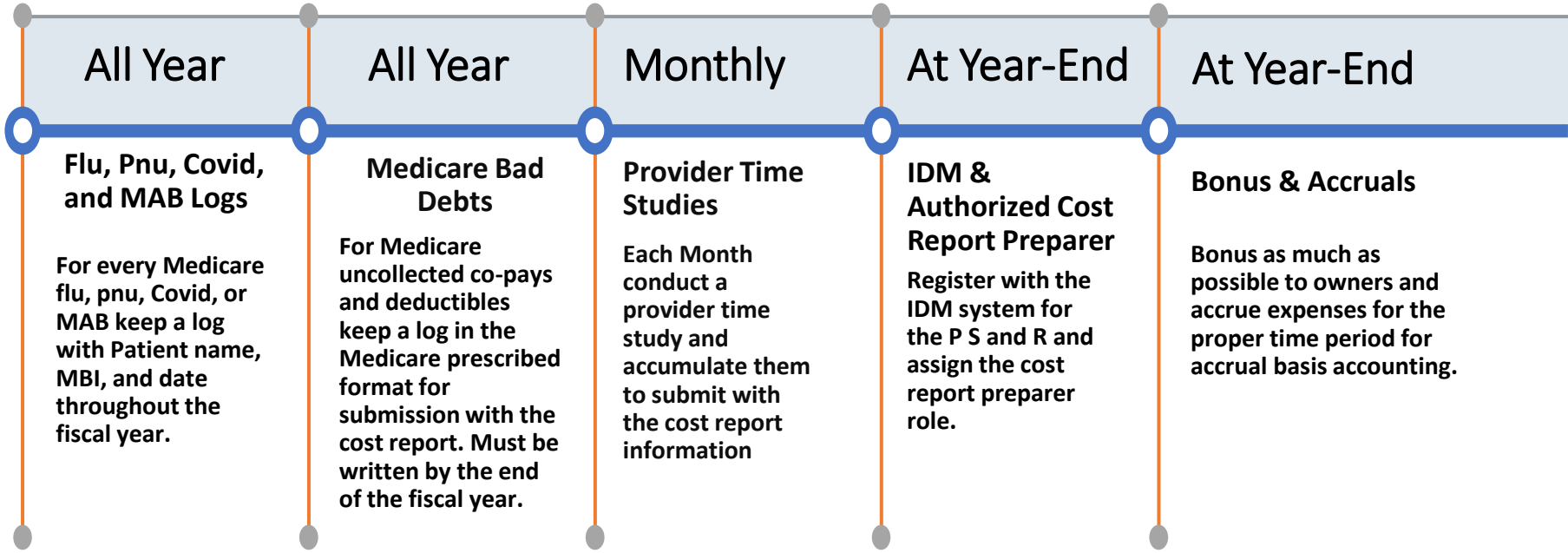
Provider Statistical & Reimbursement (PS&R) System

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.



RHC Cost Report Timelines



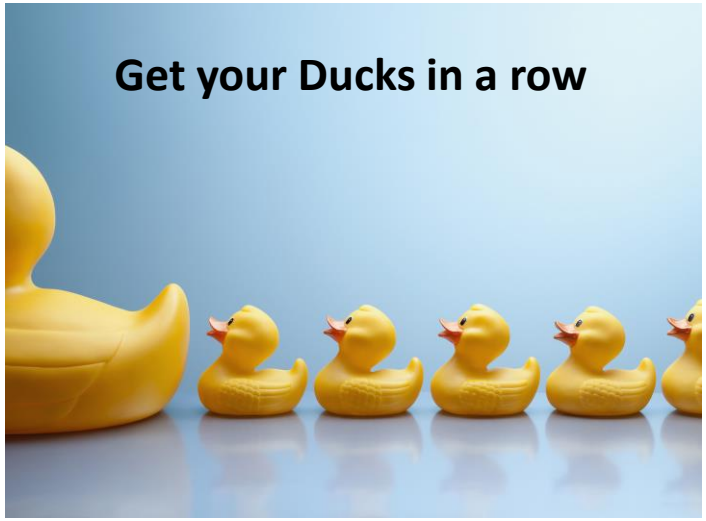
December requires planning and action to maximize reimbursement and minimize taxes

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.**

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

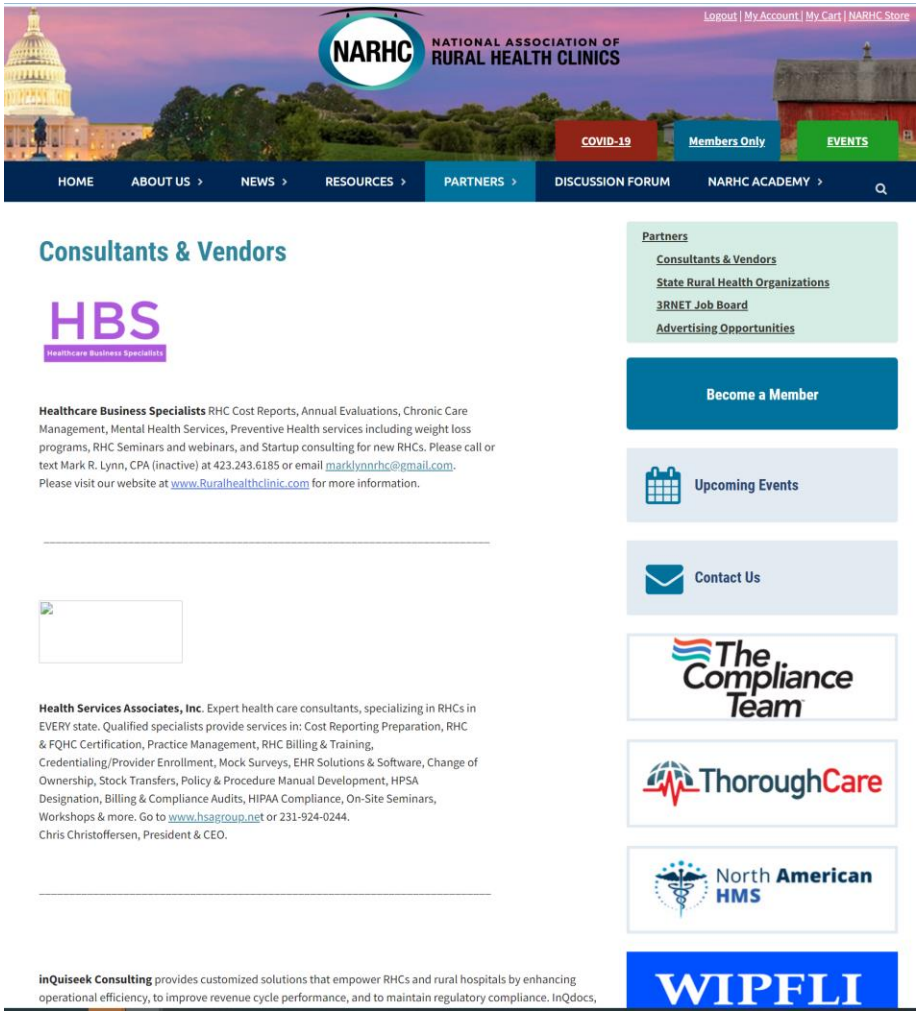
#	Requirement	Due Date
1.	To claim Medicare Bad Debts, the bad debt must be written off by the fiscal year end (usually 12/31) – Still use Exhibit 2 – the old form	12/31/2022
2.	Liquidate accrued bonuses or payments to owners	75 days after year-end. March 16, 2023
3.	Liquidate accruals for non-owners.	One year after year-end. December 31, 2023

Helpful Links to Cost Report Information

http://www.ruralhealthclinic.com/rhc-cost-reporting

- Recording of the January 27, 2022 Cost Report webinar
- Recording of the December 16, 2021 webinar with information on how to register in IDM by Dani Gilbert
- Slides used for the January 27, 2022 Presentation
- Cost Report Checklist for 12/31/2021 (3-page PDF)
- Cost Report Checklist & Workpapers for 12/31/2021 (21-Page PDF)
- Cost Report Visit Count Sheet for 12 31 2021 (5 pages)
- Sample Chart of Accounts for a Rural Health Clinic

Professional Tip: Get Help



https://www.narhc.org/narhc/Consultants__Vendors1.asp

Thank You!

Mark Lynn, Healthcare Business Specialists

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