STROUDWATER

COST REPORT BASICS

Wade Gallon, Senior Consultant

OBJECTIVES

1. Understand the relevant information to prepare a good cost report, whether internally or externally prepared
2. Properly review your cost-report and understand how your reimbursement is tied to your cost report
3. Utilizing your cost report for expense planning

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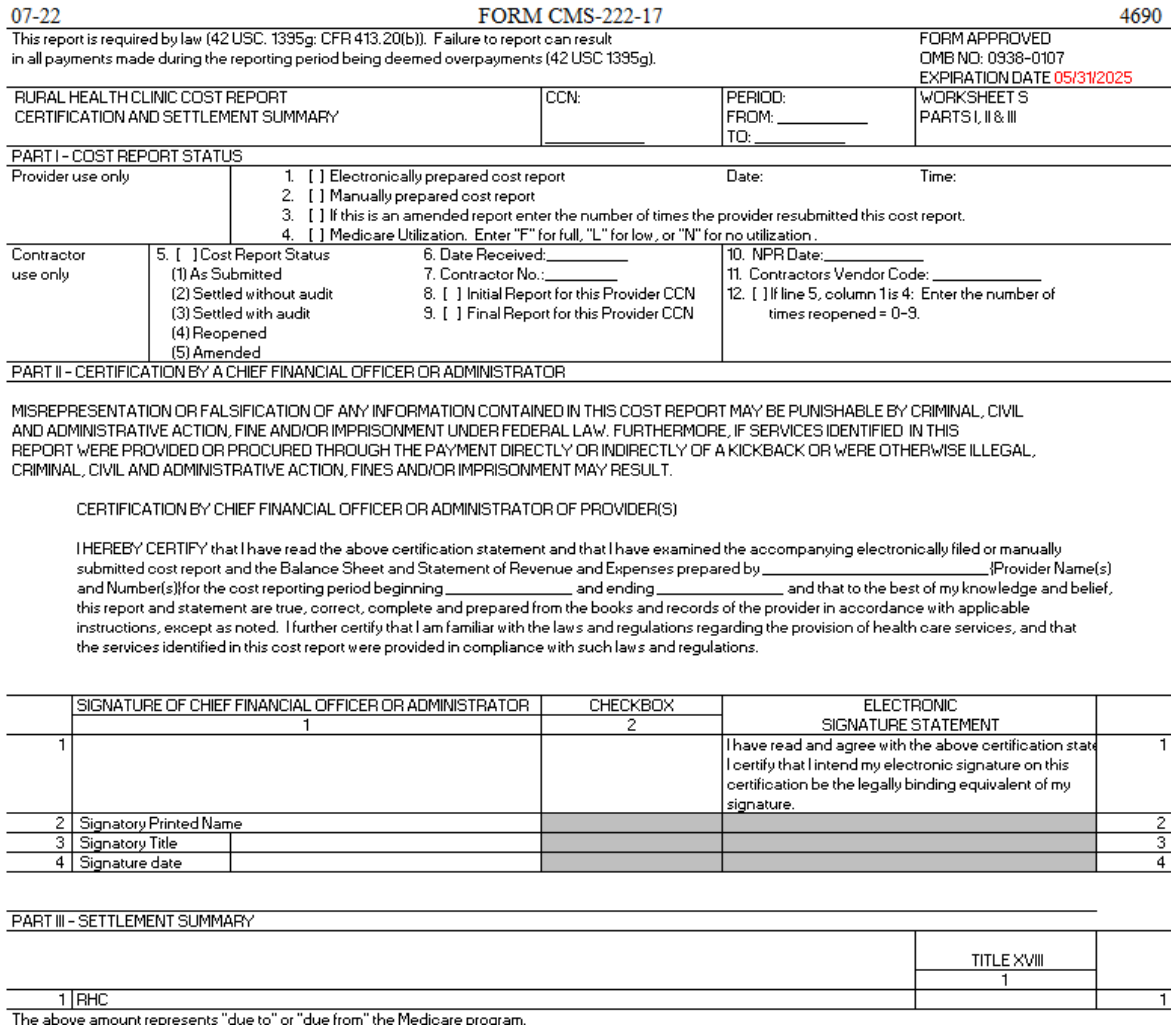
WHAT IS THE MEDICARE COST REPORT?

MEDICARE COST REPORT

- Document containing financial, operational, volume, productivity and payment information
  - Generally filed on a yearly basis
  - Filed to your Medicare Administrative Contractor (MAC)
- Ultimately calculates your receivable from or payable to the Medicare program
  - Also used for setting payment rates going forward
- Clinic operators attest to the accuracy of this report



07-22 FORM CMS-222-17 4690

This report is required by law (42 USC. 1395g; CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO: 0938-0107
EXPIRATION DATE 05/31/2025

RURAL HEALTH CLINIC COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically prepared cost report 2. [ ] Manually prepared cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report. 4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	Date:	Time:

Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractors Vendor Code: _____ 12. [ ] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1		CHECKBOX 2	ELECTRONIC SIGNATURE STATEMENT	
1				I have read and agree with the above certification state I certify that I intend my electronic signature on this certification be the legally binding equivalent of my signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Signature date				4

PART III - SETTLEMENT SUMMARY

		TITLE XVIII 1	
1	RHC		1

The above amount represents "due to" or "due from" the Medicare program.

MEDICARE COST REPORT

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COST REPORT STRUCTURE

- Worksheet S - Rural Health Clinic Cost Report Certification and Settlement
- Worksheet S-1 - Rural Health Clinic Identification Data
- Worksheet S-2 - Rural Health Clinic Reimbursement Questionnaire
- Worksheet S-3 - Rural Health Clinic Statistical Data (Visits)
- Worksheet A - Reclassification and Adjustment of Trial Balance of Expenses
- Worksheet A-6 - Reclassification
- Worksheet A-8 - Adjustments to Expenses
- Worksheet A-8-1 - Statement of Costs of Services from Related Organizations
- Worksheet B - Visits and Overhead Cost for RHC Services
- Worksheet B-1 - Computation of Vaccine Cost
- Worksheet C - Determination of Medicare Payment
- Worksheet C-1 - Analysis of Payments to the Rural Health Clinic

KEY INFORMATION FOR COST REPORT PREPARATION

KEY DOCUMENTATION

- **Financial records**
  - Trial Balance
  - Internal Financial statements
  - Medicare Provider Statistical and Reimbursement report (PS&R)
  - Payroll records
  - Vaccine invoices
- **Volume information**
  - Visit records by provider and payer
  - Vaccines administered

KEY DOCUMENTATION

- **Provider information**
  - Total providers including:
    - Physicians
    - Nurse Practitioners (NPs)
    - Physician Assistants (PAs)
    - Certified Nurse-Midwives (CNMs)
    - Clinical Psychologists (CPs)
    - Clinical Social Workers (CSWs)
  - Provider full-time equivalents (FTEs)
- **Supplementary information**
  - Bad debt listing

REIMBURSEMENT: MECHANICS AND OPPORTUNITIES

REIMBURSEMENT

- Medicare reimburses a flat All-Inclusive Rate (AIR) for RHC services
- Payment limit per visit based on national statutory limits:
  - Calendar Year (CY) 2023 = $126.00
  - Calendar Year (CY) 2024 = $139.00
  - Calendar Year (CY) 2025 = $152.00
- Medicare Part B deductible and coinsurance rates apply. This means that once patients meet their Part B deductible, Medicare pays 80% of the AIR and the patient pays the remaining 20%.
- For certain preventive services like the Annual Wellness Visit (AWV) and the Initial Preventive Physical Exam (IPPE), Medicare will pay the full AIR and patients do not have a co-pay
- Non-RHC services paid on the allowed amount for the service

ALL-INCLUSIVE RATE

- The all-inclusive rate for RHCs is calculated as follows:
  - Total allowable RHC cost (vaccines calculated separately) / total RHC visits
    - The result of this calculation is compared to a maximum rate per visit; the lesser of these two is what the RHC is reimbursed for Medicare services
- Example (below cap)
  - Total allowable cost = $2,000,000
  - Total RHC visits = 20,000
  - Cost per visit = $100
  - Maximum rate per visit = $139
  - Total Medicare visits = 10,000
  - Total Medicare allowable cost = $1,000,000
- Example (above cap)
  - Total allowable cost = $2,000,000
  - Total RHC visits = 10,000
  - Cost per visit = $200
  - Maximum rate per visit = $139
  - Total Medicare visits = 5,000
  - Total Medicare allowable cost = $695,000

ALL-INCLUSIVE RATE

- Total costs are reported on Worksheet A, and broken out by:
  - Cost center
  - Salaries and non-salary expense
  - Direct and overhead cost
- Total cost generally comes from the clinic trial balance/financial statements and reported in Col. 1 & 2
  - The clinic can then reclassify expenses into different cost centers
  - Number of reclassifications are dependent on how the clinic trial balance is designed
- Adjustments are made based on reimbursement principles to calculate total “allowable cost”

ALL-INCLUSIVE RATE: PROVIDER PRODUCTIVITY

- The Medicare cost report compares actual visits at the RHC with productivity thresholds based on provider FTEs; FTEs by provider are multiplied by the productivity standard to calculate a minimum number of visits
  - 4,200 visits for physicians
  - 2,100 visits for non-physician providers (PAs, NPs and CNMWs)

PART I - VISITS AND PRODUCTIVITY

	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	2	3	4	5	
1	Physicians			4200			1
2	Physician Assistants			2100			2
3	Nurse Practitioner			2100			3
4	Certified Nurse Midwife			2100			4
5	Subtotal (sum of lines 1 through 4)						5
6	Registered Nurse						6
7	Licensed Practical Nurse						7
8	Clinical Psychologist						8
9	Clinical Social Worker						9
10	Total Staff						10
11	Physician Services Under Agreement						11

ALL-INCLUSIVE RATE: PROVIDER PRODUCTIVITY

- "The FTE on the cost report for providers is the **time spent seeing patients** or **scheduled to see patients** and ***does not include administrative time***." - Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

PART I - VISITS AND PRODUCTIVITY

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ALL-INCLUSIVE RATE: PROVIDER PRODUCTIVITY

- A qualifying RHC visit is a medically-necessary, face-to-face medical or mental health visit, or a qualified preventive health visit with a qualified provider
  - RHC must ensure only qualifying visits are reported

PART I - VISITS AND PRODUCTIVITY

	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	2	3	4	5	
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2	Physician Assistants			2100			2
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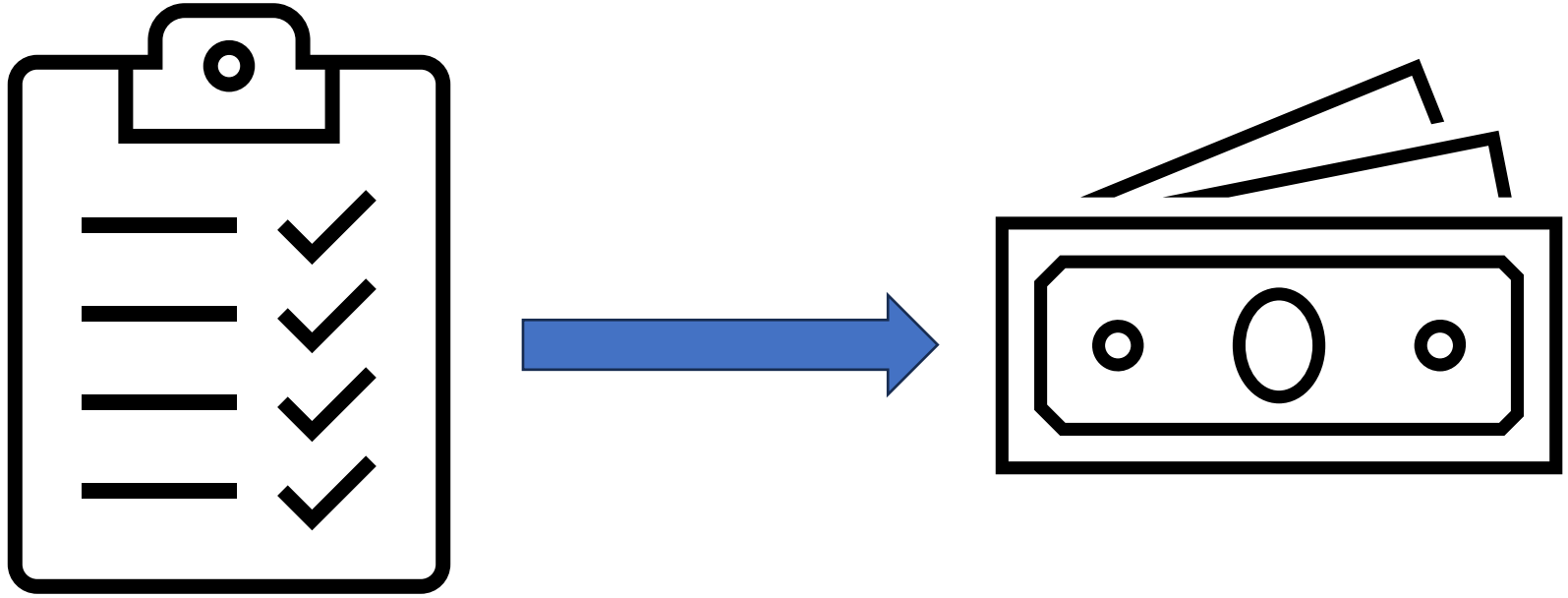
5	Subtotal (sum of lines 1 through 4)						5
6	Registered Nurse						6
7	Licensed Practical Nurse						7
8	Clinical Psychologist						8
9	Clinical Social Worker						9
10	Total Staff						10
11	Physician Services Under Agreement						11

ALL-INCLUSIVE RATE: PROVIDER PRODUCTIVITY

- RHC or FQHC visits may take place in:
  - the RHC or FQHC,
  - the patient's residence (including an assisted living facility),
  - a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
  - the scene of an accident.
- RHC and FQHC visits may not take place in:
  - an inpatient or outpatient department of a hospital, including a CAH, or
  - a facility which has specific requirements that preclude RHC or FQHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.)
- Best practice is to maintain visit records by provider, payer and CPT code

CONSISTENCY IS KEY!



OTHER REIMBURSEMENT ITEMS

- The cost report also reimburses RHCs for
  - Cost of vaccines and vaccine administration
    - Key inputs
    - Cost of vaccines
    - Total vaccine administration time
  - Medicare bad debts
    - Key inputs
    - Bad debt log
    - Supporting documentation

VACCINES/VACCINE ADMINISTRATION

- “The cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries are 100 percent reimbursable by Medicare.” CMS Form 227-17 cost report instructions
  - Calculated on Worksheet B-1
  - The cost report calculates direct and indirect cost of vaccines and vaccine administration
- Worksheet requires an estimated time for each vaccine administration
  - This estimate is used to calculate healthcare staff time to include in total cost calculation
- Should maintain a log of vaccines as well as documentation substantiating vaccine cost (e.g., invoices)

VACCINES/VACCINE ADMINISTRATION

4690 (Cont.)	FORM CMS-222-17			04-21
COMPUTATION OF VACCINE COST	CCN: _____	PERIOD: FROM: _____ TO: _____		WORKSHEET B-1

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1	2	2.01	2.02	
1	Health care staff cost (from Worksheet A, column 7, line 14)					1
2	Ratio of injection/infusion staff time to total health care staff time					2
3	Injection/infusion health care staff cost (line 1 multiplied by line 2)					3
4	Injections/infusions and related medical supplies cost (from Worksheet A, column 7, lines 30, 31, 31.10, and 31.11, respectively)					4
5	Direct cost of injections/infusions (sum of lines 3 and 4)					5

VACCINES/VACCINE ADMINISTRATION

4690 (Cont.)	FORM CMS-222-17			04-21
COMPUTATION OF VACCINE COST	CCN: _____	PERIOD: FROM: _____ TO: _____		WORKSHEET B-1

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1	2	2.01	2.02	
6	Total direct cost of the RHC (from Worksheet A, column 7, line 39)					6
7	Total facility overhead (from Worksheet A, column 7, line 74)					7
8	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)					8
9	Overhead cost - injections/infusions (line 7 multiplied by line 8)					9
10	Total injection/infusion cost and administration (sum of lines 5 and 9)					10
11	Total number of injections/infusions (from provider records)					11
12	Cost per injection/infusion (line 10 divided by line 11)					12

MEDICARE BAD DEBTS

- 42 CFR 413.89(d): ".. the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs."
  - Reasonable collection effort (defined in regulation)
  - Debt was uncollectible, *and claimed as uncollectible*, within the time period it was deemed worthless
    - Often involves having a bad debt returned from a collection agency
  - Sound business judgment established no likelihood of recovery
  - Excludes physician professional services
- Medicare reimburses **65%** of total allowable Medicare Bad Debts
  - In addition to a reasonable collection effort, RHCs must substantiate their allowable bad debts with a detailed listing of information for each bad debt claimed
  - Broken out between dual-eligible and non-dual eligible patients
- Reported on Worksheet C, Part II

MEDICARE BAD DEBTS

04-21	FORM CMS-222-17		4690 (Cont.)
DETERMINATION OF MEDICARE PAYMENT	CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET C PARTS I & II

26	Allowable bad debts (see instructions)		26
27	Adjusted reimbursable bad debts (see instructions)		27
28	Allowable bad debts for dual eligible beneficiaries (see instructions)		28

MEDICARE BAD DEBTS

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

RHC Name _____
RHC CCN _____
FYE _____

Prepared By _____
Date Prepared _____

Patient Name	MBI. No.	Dates of Service		Indigency& Medicaid Beneficiary (Check if applicable)		Date First Bill Sent to Beneficiary	Date Collection Efforts Ceased	Medicare Remittance Advice Dates	Co-Insurance/ Total Medicare Bad Debts*
		From	To	Yes	Medicaid Number				
1	2	3	4	5	6	7	8	9	10

*These amounts must not be claimed unless the RHC bills for these services with the intention of receiving payment.
See instructions for columns 5 and 6 - Indigency/Medicaid Beneficiary, for possible exception.
These amounts must not be claimed if they were included on a previous Medicare bad debt listing or cost report.

IMPORTANT TAKEAWAYS

- Documentation is key!
- Know your facility operations
- Understand your reimbursement drivers
- Reconcile, reconcile, reconcile
- Develop reasonableness tests
- Multi-tiered cost report review process is best practice

Q&A

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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THANK YOU

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