

Medicare Cost Reporting Rural Health Clinics

Idaho Bureau of Rural Health & Primary Care

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Medicare Cost Reporting for PB RHCs

Presentation Overview

- Medicare Cost Report
- Rural Health Clinic (RHC) Visits
- Physician/Provider Statistics
- Reimbursement Settlement



Medicare Cost Reporting

Medicare Cost Report



Medicare Cost Report

Completing the **Medicare** cost report is the method of reconciling payments made by Medicare with the allowable costs for providing those services.

If total Medicare payments exceed the allowable costs, the provider must pay back the difference. If total Medicare payments are less than the allowable costs, Medicare will make an additional payment to the provider.

Medicaid cost report filing requirements vary by state. Some states require a separately filed Medicaid cost report, whereas others simply request to receive a copy of the Medicare cost report.



Medicare Cost Report

There are two types of RHCs; cost reporting is slightly different for each:

- Independent RHCs submit an RHC cost report to one of five regional fiscal intermediaries (transitioning to MAC).
- Provider-based RHCs submit an RHC cost report as a subset of the host provider (usually a hospital).



Medicare Cost Report

- Cost report is due five months after the close of the period covered. Must be filed electronically.
- Terminating cost reports are due 150 days after the termination of provider agreement.
- Extension to file the cost report may be granted by intermediary only for extraordinary circumstances such as a natural disaster, fire, or flood.



Medicare Cost Report

Allowable RHC Costs:

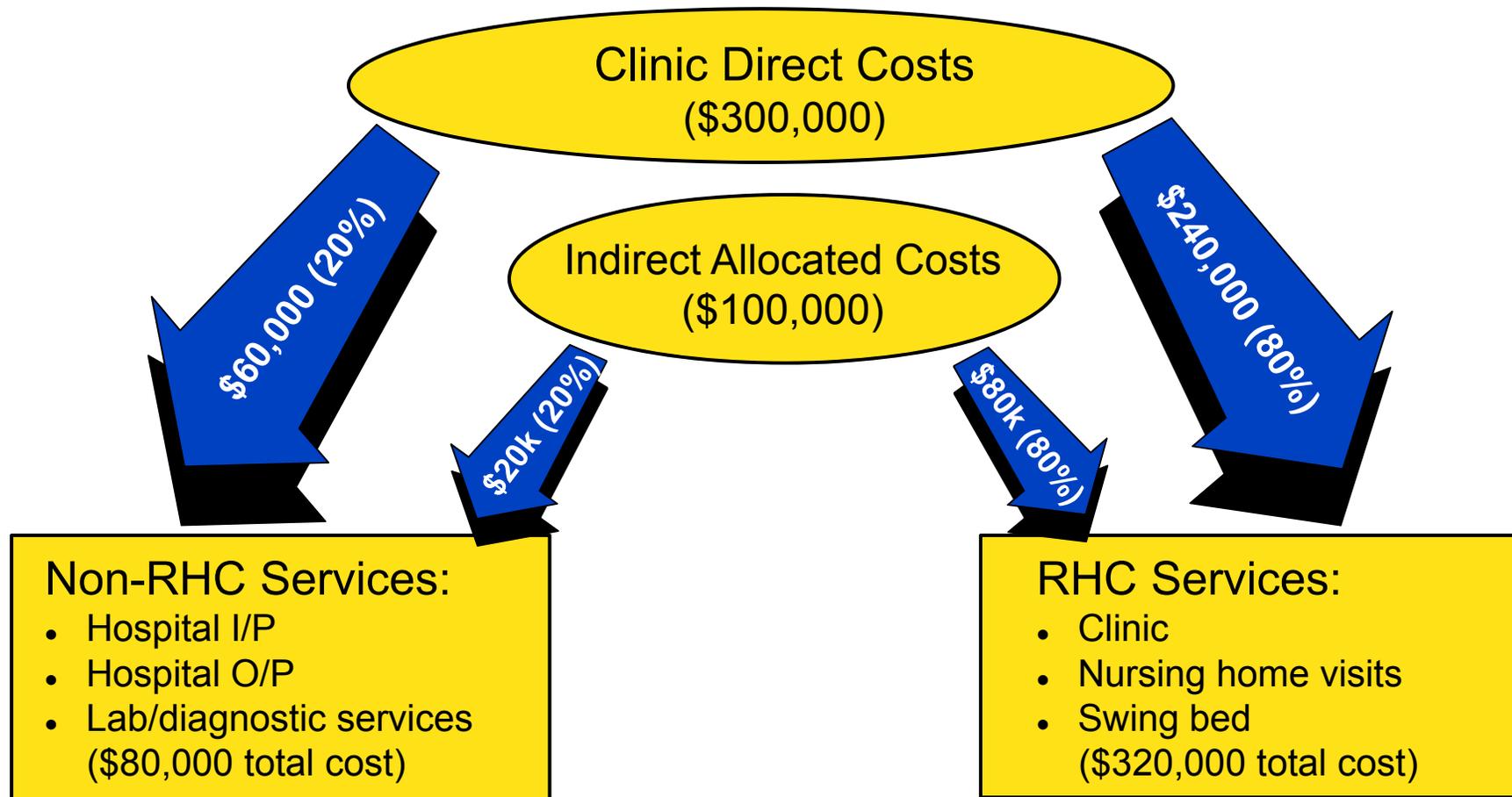
- Defined at 42 CFR 413
- Explained in Provider Reimbursement Manual

“Allowable costs are the cost actually incurred by you which are reasonable in amount and necessary and proper to the efficient delivery of your services.” *RHC Manual, Ch.501 (CMS IOM 100-4, Ch. 9, Section 40).*



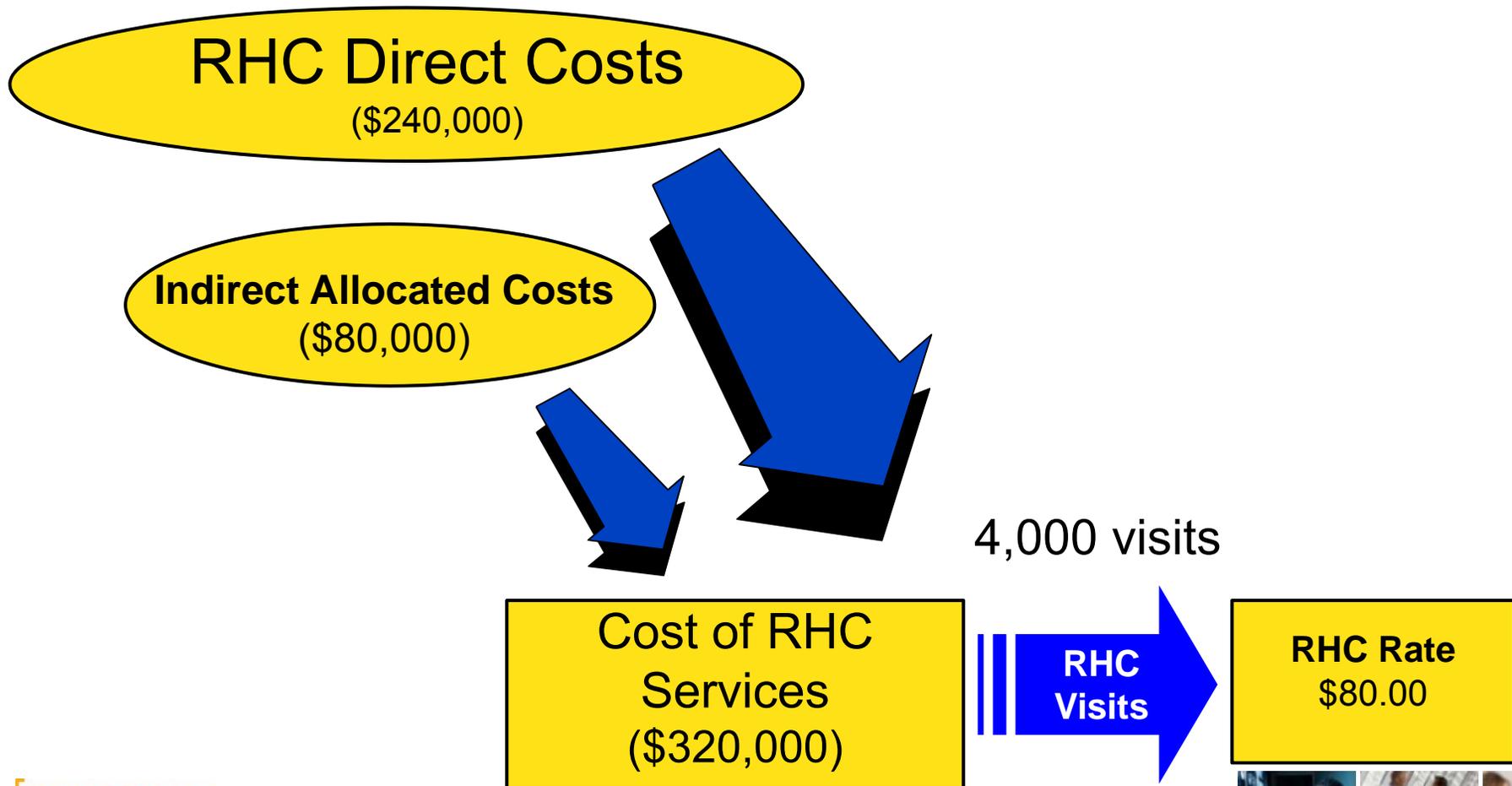
Medicare Cost Report

RHC Cost Reporting Theory



Medicare Cost Report

RHC Cost Reporting Theory



Medicare Cost Report

Cost Report Component Worksheets

Rural Health Clinic Cost Report Worksheet Description	Provider Based	Independent
	Hospital Component (CMS 2552-10) Worksheet M Series	CMS 222-10
RHC/FQHC provider statistics	S-8	S
Trial balance of costs:	M-1	A
- Reclassification of expenses	A-6	A-1
- Adjustments to expenses	A-8	A-2
Productivity and OH allocation	M-2	B
Reimbursement settlement	M-3	C
Flu/PPV vaccine costs	M-4	B-1
Analysis of payments	M-5	N/A (part of C)



Medicare Cost Report

Revised Cost Report Forms

- Provider-based M-Series released August 2011
- Independent RHC cost report released November 2011
- Why new forms? Due to changes from ACA related to preventive services exempt from coinsurance. (*more explanation to follow . . .*)



Medicare Cost Report

Trial Balance of Expenses

Column 1 - Salaries and wages

Column 2 - Other direct expenses including any direct benefits.

	COMPEN- SATION	OTHER COSTS	TOTAL	RECLASS- IFICATIONS	:	NET EXPENSES FOR ALLOCATION
	1	2	3	4	:	7
FACILITY HEALTH CARE STAFF COSTS					:	
1 Physician	850,000	150,000	1,000,000		:	1,000,000
2 Physician Assistant	120,000	40,000	160,000		:	160,000
3 Nurse Practitioner					:	
4 Visiting Nurse					:	
5 Other Nurse	175,000		175,000		:	175,000
6 Clinical Psychologist					:	
7 Clinical Social Worker					:	
8					:	
9 Other Facility Health Care Staff Costs					:	
10 Subtotal (sum of lines 1-9)	1,145,000	190,000	1,335,000	-	:	1,335,000



Medicare Cost Report

Trial Balance of Expenses (Continued)

Provider-based RHCs report facility and overhead costs in aggregate.

		COMPEN- SATION	OTHER COSTS	TOTAL	RECLASS- IFICATIONS	:	NET EXPENSES FOR ALLOCATION
		1	2	3	4	:	7
	FACILITY OVERHEAD					:	
29	Facility Costs		40,000	40,000		:	40,000
30	Administrative Costs	130,000	125,000	255,000		:	255,000
31	Total Facility Overhead (sum of lines 29 & 30)	130,000	165,000	295,000	-	:	295,000



Medicare Cost Report

Trial Balance of Expenses (Continued)

Column 4 – Reclassifications used to move costs from line to line.
 (For independent RHCs, reclasses always net to “zero”)

					:	NET
					:	EXPENSES
	COMPEN-	OTHER		RECLASS-	:	FOR
	SATION	COSTS	TOTAL	IFICATIONS	:	ALLOCATION
	1	2	3	4	:	7
	FACILITY HEALTH CARE STAFF COSTS				:	
1	Physician	850,000	150,000	1,000,000	:	1,000,000
2	Physician Assistant	120,000	40,000	160,000	:	160,000
3	Nurse Practitioner				:	
4	Visiting Nurse				:	
5	Other Nurse	175,000		175,000	50,000	225,000
6	Clinical Psychologist				:	
7	Clinical Social Worker				:	
8					:	
9	Other Facility Health Care Staff Costs				:	
10	Subtotal (sum of lines 1-9)	1,145,000	190,000	1,335,000	50,000	1,385,000



Medicare Cost Report

Trial Balance of Expenses (Continued)

- Column 6 - Adjustments to RHC costs:
 - For provider-based, adjustments may include both A-6 and A-8 adjustments
 - Examples:
 - Shared (non-RHC) facility costs
 - Advertising used to promote clinic utilization
 - Purchased lab services
 - Interest income (limited to interest expense)
 - Misc. income



Medicare Cost Report

Productivity and Overhead

Visits and Productivity:

- Column 1 - Record provider FTE for clinic services only
- Column 2 - Record total visits by provider type
- Column 3 - Enter productivity standard:
 - Physician 4,200 visits annually for 1.0 FTE
 - Midlevel 2,100 visits annually for 1.0 FTE
 - Standard is adjusted by FTEs entered in column 1
 - Total visits for use in calculation of cost per visit is the greater of the actual or minimum visits
- Total visits are the sum of above plus visits related to services under agreement



Medicare Cost Report

Productivity and Overhead (continued)

Visits and Productivity (continued)

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
Positions	1	2	3	4	5
1 Physicians	3.80	13,000	4,200	15,960	
2 Physician Assistants	0.90	5,200	2,100	1,890	
3 Nurse Practitioners			2,100	-	
4 Subtotal (sum of lines 1-3)	4.70	18,200		17,850	18,200
5 Visiting Nurse					
6 Clinical Psychologist					
7 Clinical Social Worker					
8 Total FTEs and Visits (sum of lines 4-7)	4.70	18,200			18,200
9 Physician Services Under Agreements					



Medicare Cost Report

Facility Overhead costs allocated between RHC and non-RHC services based on the ratio of direct costs

Cost of RHC Services - excluding overhead	<i>from work sheet</i>	1,385,000
Cost of Other Than RHC Services - excluding overhead	<i>from work sheet</i>	50,000
Cost of All Services - excluding overhead	<i>calculated</i>	1,435,000
Ratio of RHC Services	<i>calculated</i>	0.9652
Total Overhead (Admin. + Facility + Parent)	<i>from work sheet</i>	289,000
Overhead Applicable to RHC Services	<i>calculated</i>	278,930
Total Allowable Cost of RHC Services	<i>calculated</i>	1,663,930
<i>Total Overhead (Admin. + Facility + Parent)</i>		<i>289,000</i>
<i>Overhead Applicable to RHC Services</i>		<i>(278,930)</i>
<i>Overhead Applicable to non-RHC Services</i>		<i>10,070</i>



Medicare Cost Report

Computation of Flu/PPV Costs

Pneumococcal and flu (including H1N1) vaccines have “special” treatment for cost-based reimbursement.

Do not file claims for flu/PPV.

Requires maintaining a log with the patient’s name, Medicare number, and date of service. *Hint: Automate!*

Reported and paid separately on the RHC cost report.



Medicare Cost Reporting

Rural Health Clinic (RHC) Visits



RHC Visits

RHC Cost Per Visit (Rate) =

$$\frac{\textit{Allowable RHC Costs}}{\textit{Rural Health Clinic Visits}}$$

(Not to exceed the reimbursement limits when applicable.)



RHC Visits

“The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an RHC service is rendered.”
RHC Manual, Ch.504 CMS IOM 100-4, Ch. 9, Section 20.1.



RHC Visits

- Total visits, the denominator in the cost per visit calculation, should include all “visits” that take place in the RHC during hours of operation, home visits, and SNF visits for all payors.
- Total visits should not include hospital visits (either inpatient or outpatient visits) or “nurse-only” visits in the RHC setting.



RHC Visits

The method of counting visits should be clearly defined and documented in the RHC. The visit statistics reported on the RHC cost report must be supported by documentation used to generate the totals.

Suggestion: Prepare a written policy and procedure for counting visits.



RHC Visits

RHC visits are defined as medically necessary, face-to-face encounters with RHC practitioner. Actual visits are lower than the minimum visits in the example below.

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	3.80	12,000	4,200	15,960	
2	Physician Assistants	0.90	5,200	2,100	1,890	
3	Nurse Practitioners			2,100		
4	Subtotal (sum of lines 1-3)	4.70	17,200		17,850	17,850
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	4.70	17,200			17,850
9	Physician services under agreements					



RHC Visits

Productivity screens limit the actual visits to 17,850 “adjusted” visits.

If allowable costs were \$1,663,930, then actual cost per visit = $\$1,663,930 / 17,200 = \96.74 .

However, Medicare reimbursement would be based on $\$1,663,930 / 17,850 = \93.22 .

If Medicare is about 40% of the total visits (7,000), the actual loss per Medicare visit would be $\$96.74 - \$93.22 = \$3.52$ x 7,000 visits x 80% Medicare share = \$19,712.



RHC Visits

Note, MACs have the ability to provide a waiver of the productivity screens based on requests submitted by the RHC.



Medicare Cost Reporting

Physician/Provider Statistics



Physician/Provider Statistics

Full-Time Equivalent (FTE)

- Actual number of hours worked divided by the greater of:
 - The hours considered to be full time, or 1,600 hours per year.

(RHC Manual Ch. 503 CMS IOM 100-4, Ch. 9, Sec. 40.3)



Physician/Provider Statistics

FTEs (Continued)

- A physician may be considered > 1.0 FTE if the documented hours are $> 2,080$:
 - This will increase the compensation allowance, but
 - Will also increase the productivity standards
- Compensation allowance includes total physician time:
 - May be 1.0 or more FTE



Physician/Provider Statistics

Reconciliation of FTEs Reported on M-2

Clinical FTE (w/s M-2)	0.70
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	<u>0.05</u>
Total FTE	1.00



Physician/Provider Statistics

Required to conduct time study for providers - Sample Time Study Format:

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					

a



Physician/Provider Statistics

Some FI/MACs are applying maximum limits on physician compensation

- Standards used may vary.
- Cahaba reportedly using \$200,000 limit per physician FTE.
- Limits are not adjusted based on productivity.
- May reduce RHC reimbursement.



Medicare Cost Reporting

Reimbursement Settlement



Reimbursement Settlement

The final step in completing the Medicare cost report is reconciling payments made by Medicare with the allowable costs for providing those services.

If total Medicare payments exceed the allowable costs, the provider must pay back the difference.

If total Medicare payments are less than the allowable costs, Medicare will make an additional payment to the provider.



Reimbursement Settlement

The PS&R is an essential component of cost report reconciliation. This report summarizes all paid claims. It was previously mailed to providers.

The PS&R Redesign System:

- Allows/requires users to download summary PS&R reports via the Internet
- All users must first establish an Individuals Authorized Access to CMS Computer Systems (IACS) account

Refer to *MLN Matters MM6519* on the CMS website.



Reimbursement Settlement

Adjusted Cost per Visit

Reflects total allowable cost divided by total RHC clinic visits equals cost per encounter. Allowable costs adjusted for PPV/FLU costs.

	<i>(example of a provider-based RHC from M-series)</i>	AMOUNT
DETERMINATION OF RATE FOR RHC SERVICES		
1	Total Allowable Costs (Worksheet M-2, line 20)	1,663,930
2	Cost of Pneumococcal and Influenza Vaccine (W/S M-4, line 15)	8,000
3	Total Allowable Costs Excluding Pneumococcal and Influenza Vaccine	1,655,930
4	Greater of Minimum Visits or Actual Visits by Health Care Staff (W/S M-2, column 5, line 8)	18,200
5	Physician Visits Under Agreement (W/S M-2, column 5, line 9)	-
6	Total Adjusted Visits (line 4 + line 5)	18,200
7	Adjusted Cost Per Visit (line 3 divided by line 6)*	\$ 90.99
	<i>* May be subject to maximum limit.</i>	



Reimbursement Settlement

RHC Reimbursement Limits*

	2007	2008	2009	2010	2011	2012	2013	2014
Maximum	\$ 74.29	\$ 75.63	\$ 76.84	\$ 77.76	\$ 78.07	\$ 78.54	\$ 79.17	\$ 79.80
Increase	2.8%	1.8%	1.6%	1.2%	0.4%	0.6%	0.8%	0.8%

* *Effective 7/1/2001, all RHCs that are provider-based to a hospital of <50 beds (staffed) regardless of MSA (but are in rural area as defined by Census Bureau) are not limited to independent reimbursement limit.*



Reimbursement Settlement

RHC Reimbursement Limits (exceptions)

The number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.

A hospital-based RHC can receive an exception to the per-visit payment limit if its hospital has fewer than 50 beds as determined by using the hospital's average daily census count and the hospital meets all of the following conditions:

- A) It is a sole community hospital.
- B) It is located in an 8-level or 9-level nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture.
- C) It has an average daily patient census that does not exceed 40.



Reimbursement Settlement

Medicare Program Costs

Program visits (per PS&R or provider records) times rate per encounter equals program costs.

		AMOUNT
8	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	
9	Rate for Program covered visits (see instructions)	\$ 90.99
CALCULATION OF SETTLEMENT		
10	Program covered visits excluding mental health services (from contractor records)	7,280
11	Program cost excluding costs for mental health services (line 9 x line 10)	662,407
12	Program covered visits for mental health services (from contractor records)	-
13	Program covered cost from mental health services (line 9 x line 12)	-
14	Limit adjustment for mental health services (see instructions)	-
15	Graduate Medical Education pass-through cost (see instructions)	-
16	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3)	662,407



Reimbursement Settlement

Reimbursable Cost

Program visits (per PS&R) times rate per encounter equals program costs. Medicare pays 80% of cost to allow for coinsurance. New lines (16.xx) added in 2011 to exclude preventive services from coinsurance calculation.

		AMOUNT
16	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3)	662,407
16.01	Total program charges (see instructions)(from contractor's records)	728,000
16.02	Total program preventive charges (see instructions)(from provider's records)	15,000
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)	13,648
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)	519,007
16.05	Total program cost (see instructions) (line 16.03 + line 16.04)	532,655
17	Primary payer amounts	
18	Beneficiary deductible (see instructions) (from contractor records) (informational)	30,000
19	Beneficiary coinsurance for RHC services (from contractor records) (informational)	142,600
20	Net Medicare cost excluding vaccines (see instructions)	532,655
21	Program cost of vaccines and their administration (from Worksheet M-4, line 16)	8,000
22	Total reimbursable Program cost (line 20 plus line 21)	540,655



Reimbursement Settlement

Settlement equals Medicare's share of payment less interim payments received, plus any Medicare bad debts claimed.

		AMOUNT
22	Total reimbursable Program cost (line 20 plus line 21)	540,655
23	Reimbursable bad debts (see instructions)	3,000
24	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	1,000
25	Other adjustments (specify) (see instructions)	
26	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)	544,655
27	Interim payments	454,272
28	Tentative settlement (for contractor use only)	
29	Balance due component/program (line 26 minus lines 27 and 28)	90,383



Questions

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Thank you!



Speaker Information

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