



**North American Healthcare Management
Services**

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Rural Health Clinic Cost Reporting

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Rural Health Clinic Cost Report

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Transmittal 8/9 – Cost Report Software Update

- Effective for Cost Reporting periods With FYE of 10/31/09 and after.
- Major revision is to Worksheet B-1 (Administration of the H1N1 Vaccine)
- Other minor updates and revisions.

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Electronic Filing of Cost Report

- Cost reports ending FYE March 31, 2005 require electronic filing (ECR). Cost report is submitted to Medicare FI on a computer disk.
- ECR files can be created by manually entering cost report data into the CMS fee software.
- There are a number of approved cost reporting software vendors which have the ECR capabilities.

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Medicare Advantage Issues

- Claims: Medicare Advantage claims should NOT be submitted for processing through RHC Medicare FI
- Visits: Medicare Advantage visits should NOT be included as a Medicare visit, but SHOULD be included in total visits

Rate Negotiation:

- Pneumo and flu injections are reimbursed separately from the visit rate, as well as, bad debt expense. These costs should be considered when negotiating Part D rates.

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Medicare Advantage Issues (cont.)

- Complete Medicare Advantage Certification Form and submit with the cost report. This form certifies that the clinic did not include Medicare Advantage patients or (MA) Flu and Pneumo on the cost report for reimbursement. It also certifies that the clinic included Medicare Advantage patients in total visits on the cost report.

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What Is the Medicare Cost Report?

- Medicare cost report is required by all RHC's and FQHC's to be completed on an annual basis.
- It covers a 12-month period with some exceptions: you may have up to a 13 month cost report or you may have a short period if the clinic: is a new RHC, sells the RHC, change ownership or terminate participation.

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What are the two types of rural health clinics?

- Independent rural health clinic which are typically owned by physicians, mid-level practitioners, and not-for-profit entities.
- Provider-based rural health clinic which are owned by hospitals, skilled nursing homes, and home health agencies.

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Independent Vs. Provider Based

- Independent RHCs file cost reporting form CMS-222-92.
- Provider based RHCs are reported as a department of the hospital on the CMS-2552.

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Cost Report Due Dates

- The Medicare Cost report is due five months after the end of the fiscal year-end.
- December 31 year-end cost reports are due on May 31.
- Terminating cost reports or change of ownership cost reports are due 150 days after the change or termination.

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Accrual Based Accounting

- Costs are recorded using Accrual Based Accounting.
- Accrual Based Accounting requires cost be recorded as they are incurred, Not when they are paid.
- Cash based accounting (recorded when paid) is not allowed; Costs must be adjusted to Accrual.

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Accrual Based Accounting

- The federal register clarified accrual accounting for owner and non-owner accruals.
- Accrued payments to owners must be paid within 2 1/2 months after the end of their fiscal year.
- Non-owner accrued costs must be paid within one year.
- You may accrue payroll taxes on accrued payroll.

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RHC Reimbursement Rate

RHC Allowable Costs
 Rural Health Clinic
 Face to Face Encounters

= RHC Reimbursement Rate (up to the reimbursement rate limit)

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RHC Reimbursement Rate

<u>Year</u>	<u>limit</u>	<u>% increase</u>
2011	\$78.07	0.4%
2010	\$77.76	1.2%
2009	\$76.84	1.6%
2008	\$75.63	1.8%
2007	\$74.29	2.1%

Every January 1 the RHC all-inclusive rate increases by the medical economic index. (MEI) typically 2% to 3%

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Allowable Costs

- Allowable RHC costs:
- Defined at 42 CFR 405 and 42 CFR 413
 - Explained in the Provider Reimbursement Manual, pub. 15

“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

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Straight-line Depreciation Required

- Medicare requires assets be depreciated on a straight-line basis.
- The assets estimated useful life is established by Medicare – AHA (American Hospital Association) guidelines. Can be different than tax basis.
- Accelerated depreciation methods and section 179 expense deductions are not allowed.

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Related Party Transactions

- Related through ownership or control (physician owner, key employees)
 - Related party transactions must be reduced to actual cost.
- “The intent is to treat the costs incurred by the supplier as if they were incurred by the provider itself.” CMS Publication 15-1 (PRM)

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Related Party Transactions

- Rental of real estate is the most common example.
- Nothing prohibits these transactions.
- It is extremely important that you disclose this information.
- These transactions are reported on worksheet A-2-1 of the cost report and in the 339 questionnaire.

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Related Party Transactions on A-2-1 of Form 222

Rental expense 60,000

Compared to:

Depreciation expense 20,000

Interest expense 25,000

Property taxes 2,000

Total allowable expense 47,000

Adjust Wkst A-2 Line 6 (13,000)

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Reasonableness of Physician Owners Salary

“Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable service by comparable institutions depending on the facts and circumstances of each case” (PRM 9-3)

- Some Medicare FIs use a reimbursable cost per visit computation.
- The reasonable reimbursement rate per patient is between \$40-\$50.

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How do you compute allowable compensation on the cost report?

Physician Encounters 6,500

Rate per visit \$45.00

Allowable Costs \$292,500

Sole Proprietors/Partnerships do not have to actually pay this amount.

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Owners Compensation - Corporation

- Compensation is the amount earned throughout the year.
- Compensation must actually be paid.
- S-Corp K-1 income can be claimed as owners compensation.
- Any accruals for the owners must be within 75 days after the Fiscal Year End.

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Sole Proprietor and Partnership Compensation

- The allowance of compensation for sole proprietors and partners is the value of the services rendered by the owner whether or not this compensation is actually paid.
- Common components used to calculate compensation.
 - Physician services.
 - Administrative services.
 - Supervisory services.

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Limited Liability Company

CMS will allow a Limited Liability Company (LLC) to use the Sole Proprietor and Partnership compensation rules as long as the LLC is taxed as a Sole Proprietor or Partnership and the owners are compensated as a Sole Proprietor or a Partner.

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Non-Allowable Costs

- Most Advertising Costs
- Public Relations
- Refunds or Bad Checks (reduction of revenue)
- Donations or contributions, alcohol, gifts
- Country Club Dues, Luxury items, personal items, Personal Travel

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Advertising is generally non-allowable

- Advertising is in most cases non-allowable. Normal sized yellow pages ads are allowable and recruiting personnel is allowable.
- Contributions are not an allowable expense on the cost report.

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Certain taxes are not allowable as Costs

- Certain taxes which are levied on providers are not allowable costs. These are:
 - A. Federal income and excess profit taxes, including any interest or penalties paid thereon.
 - B. State of Local income and excess profit taxes.
 - C. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.
 - D. Taxes from which exceptions are available to the provider.

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Certain taxes are not allowable as Costs

- E. Special assessment on land which represent capital improvements such as sewers, water, and pavement should be capitalized and depreciated over their estimated useful lives.
- F. Taxes on property which is not used in rendering covered services.
- G. Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider.
- H. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

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Cost Other Than RHC

- Laboratory Services
- Diagnostic Services
- Hospital Services (inpatient, ER, procedures, etc.)
- Durable Medical Equipment

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Cost Other Than RHC

- All laboratory services including the six basic lab tests are billed to part B and therefore these costs are excluded from the cost report.
 - Laboratory salaries taxes and benefits.
 - Laboratory supplies.
 - Equipment costs & depreciation.
 - Laboratory space and associated overhead. (Carved out automatically within the cost report).

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Cost Other Than RHC

Venipunctures are billed to part B and therefore these costs are excluded from the cost report.

- Nursing salaries taxes and benefits.
- Venipuncture supplies.
- Office space and associated overhead. (Carved out automatically within the cost report).

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Costs Other Than RHC

→ Diagnostic Testing such as Radiology, Bone Density, Ultrasound, ECG, etc.

→ The technical component is billable to Medicare Part B, therefore these costs will be adjusted out of the cost report. (i.e., staff time, supplies, depreciation, etc.)

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Costs Other Than RHC

→ The professional component for diagnostic services is considered to be part of the RHC visit and is included in the RHC reimbursement rate.

→ The cost associated with the physician reading these tests is an allowable cost.

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RHC Visits

“A visit is a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse.”

42 CFR 405.2463

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RHC Visits

- Visits reported on the cost report should only include all visits for RHC allowable services, including office visits, nursing home visits, home visits.
- The reported visits are for all payers, including Medicare, Medicaid, commercial and self-pay.

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RHC Visits

Most common methods to track visits.

- Manual Logs.
- Internal Billing System CPT Productivity Reports.
- Some Billing systems track face to face encounters.

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Productivity Screens

RHCs have an annual productivity screen per provider which must be met.

- Physicians (1 FTE) 4,200 visits
- Mid-Level Practitioners (1 FTE) 2,100 visits

Use the greater of the actual visits or the calculated minimum visits.

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Full Time Equivalent Calculation

Report only time provider is available to see patients in the FTE calculation.

Physician Hours Avail. 1,820
 Full Time Hours 2,080

 Calculated Physician FTE .875

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Visit Calculation Example

	FTE	Actual Visits	Min Productivity
Physician	0.87	5,600	3,654
PA	1.20	3,200	2,520
NP	0.90	2,700	1,890
Total	2.97	11,500	8,064

In this example, the 11,500 actual visits would be used to calculate the cost report.

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Pneumococcal and Flu Logs

One of the most common problems with cost reports are a lack of information on Pneumococcal and Flu shot logs. The following information is required:

- Beneficiaries Name.
- Beneficiaries HIC Number.
- Date Injection was given.

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Pneumococcal & Influenza

- The average allowable is approximately \$40 for Pneumococcal and \$30 for influenza (influenza may be somewhat higher with the shortages that were experienced in recent years)

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Medicare Bad Debts

On the cost report, Medicare will reimburse RHCs for all uncollectible Medicare deductibles and coinsurance.

These bad debts have to follow a number of requirements to qualify.

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Medicare Bad Debts

- Debt must be related to covered services and derived from deductible and coinsurance amounts.
- Provider must be able to establish that reasonable collection efforts were made.

42 C.F.R. Section 413.80(e)

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Medicare Bad Debts

- The Debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

42 C.F.R. Section 413.80(e)

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Medicare Bad Debts

- To be considered a reasonable collection effort a provider must:
- Have a similar collection effort for Non-Medicare Patients.
 - Issue a bill to beneficiary or responsible party.
 - Cannot Write-Off before 120 days from the date the first bill is sent to the beneficiary.

CMS Pub. 15-1 Section 310

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Medicare Bad Debts (Dual Eligible)

Beneficiary is eligible for Medicare and Medicaid:

- If Medicaid is obligated either by statute or by plan to pay all or part of the coinsurance or deductible, cannot claim to Medicare.
- Any portion which Medicaid is not obligated to pay can be included as bad debt for Medicare.
- Must bill Medicaid and receive a denial.

CMS pub. 15-1 section 322

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Medicare Bad Debts (Indigent Patients)

- Provider can claim bad debt before 120-day period if it is determined patient is indigent.
- Determination of indigence must be documented in patient's file.
- Must determine that no other party is legally responsible for payment.

CMS pub. 15-1 section 312

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Medicare Bad Debts

- Any recoveries of bad debts written off in prior cost reporting periods are offset against those written off in the current cost reporting period.
- Write-off of bad debt has to occur in the current cost reporting period
- Any bad debt that has been sent to collections must be removed from collections prior to claiming on the cost report.

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PS & R Reports

- The PS & R report is used to establish Medicare visits, Deductibles, net payments on the cost report.
- Medicare will no longer send out the PS&R report to the RHC starting with cost reports ending June 30, 2009.
- The RHC must register in the IACS with their Fiscal Intermediary in order to obtain the PS&R report.

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PS & R Reports

- <http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA6519.pdf>
- www.com.hhs.gov/PSRR

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Receipt of Cost Report

- The due date of the cost report is 150 days following the last day of the fiscal year end
- The cost report is checked in Medicare within 7 days of its receipt. The report is reviewed for completeness and should be accuracy.

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Receipt of Cost Report

- If the cost report information is not complete additional information is requested.
- If money is owed a request for a check is mailed.
- If no cost report is received, RHC payments are stopped immediately.

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The Medicare Cost Report Has Three Settlement Processes

Reimbursement Rate - Cost Per Visit

Pneumococcal and Influenza Vaccine Reimbursement

Bad Debts Reimbursement

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The Settlement Process

- The (capped) reimbursement rate is limited to \$78.07 for 2011 and is settled with a Tentative Settlement from Medicare FI. (difference between what was due and what was paid)
- Pneumococcal & Influenza vaccines are paid outside the rate and are settled at final audit.
- Bad Debts are only settled at final audit

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Tentative Settlement/Rate Review

- Once the completed cost report is received a Tentative settlement is made within 90 days after receiving the completed cost report.
- The Final Settlement is now required to be completed within One year from the receipt of the cost report.

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Cost Report Information List

- Clinic financial statement (IS, BS, TB).
- Breakdown of salaries (phys, PA, NP, nursing, office).
- Depreciation schedule.
- Procedure productivity report or manual count of patients.
- Medicare Pneumococcal and Influenza logs.
- Pneumo & influenza total shots and cost.

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Cost Report Information List

- Cost of Outside Laboratory
- Cost of Internal Lab Salaries and Lab Supply costs
- Cost of Professional Liability Insurance
- Information on Related Party Transactions
- Physician, PA & NP clinic time information
- Medicare Bad Debt Logs
- Provider Statistical & Reimb Report

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Medicare Cost Report Tips

- Collect as much data as possible on an ongoing basis.
- Set up accounting procedures to collect as much financial data in the form and level of detail required for year end reporting. Use the cost report forms for reference.

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Medicare Cost Report Tips

- Determine early if the clinic will need to collect special data for the cost report.(i.e. related party expense)
- Check the cost report for mathematical accuracy.
- Be consistent from year to year.

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Medicare Cost Report Tips

- Complete the entire cost report.
- Use the PS&R report provided by the intermediary to report Medicare visits, deductibles and payments.
- Use correct and current forms.

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Medicare Cost Report Tips

- Send adequate documentation to support information on the cost report.
 - Injection logs
 - Bad debt logs
 - Working Trial Balance
 - CMS 339 Questionnaire
 - Work papers to explain reclasses on W/S A-1 and adjustments on W/S A-2

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Medicare Cost Report Tips

- Review the cost report for reasonableness. (i.e. \$300 cost per Pneumococcal injection is not reasonable)

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