

CARHC Rural Health Conference

Cost Reporting

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HEALTH CARE PRACTICE



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Agenda

- Medicare RHC Reimbursement
- Medicare RHC Cost Report and Provider-based RHC reporting
- Cost Reporting Essentials





Medicare RHC Reimbursement

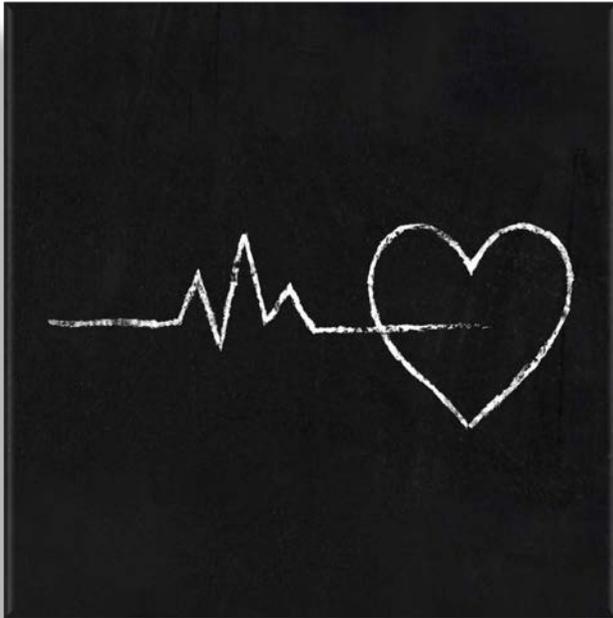
Medicare RHC Reimbursement

- Medicare RHC reimbursement is based on one of three scenarios:
 1. Freestanding RHC
 - Interim rate: The **lower** of the facility's actual cost per visit from the previous year's audited cost report or the national Upper Payment Limit (UPL), which is \$83.45 per visit for calendar year 2018
 - Final rate: The **lower** of the facility's audited cost per visit for the period or the UPL
 2. Provider-based RHC; hospital **over** 50 beds
 - Same methodologies as for freestanding RHCs
 3. Provider-based RHC; hospital **under** 50 beds
 - Interim rate: The **audited** cost per visit from the previous year's cost report
 - Final rate: The **audited** cost per visit for the period

Medicare RHC Reimbursement

- As indicated on the previous slide, cost is still a factor in Medicare RHC reimbursement - particularly for a provider-based facility in a hospital with less than 50 beds
- In the Medicare cost report there are “add-ons” for the cost of flu/pneumonia shots, Medicare bad debts, and Graduate Medical Education (GME)
- Mental health services paid same rate as medical
- The total payments received for the year (net of Coinsurance and Deductibles and excluding the “add-ons” above) are subject to settlement in the annual Medicare cost report

Nationwide, about 80% of RHCs are paid at the UPL maximum because their cost > UPL.



Medicare RHC Cost Report

Medicare RHC Cost Report Basics

The Medicare RHC cost report settlement (freestanding or provider-based) consists of four components:

- Allowable cost (net of Coinsurance and Deductibles) or the lower allowable cost /UPL
- The cost of Flu and Pneumonia vaccinations administered to Medicare patients
- Medicare bad debts (at 65% of the gross amount claimed)
- Graduate Medical Education (GME) costs - **rare**

Cost report due annually five months after the end of your fiscal year.

The freestanding cost report may be for a single site or consolidated – for multiple sites under common ownership (pre-approval required).



Medicare RHC Cost Report – CMS 222-92

Worksheet S: Descriptive and logistic information for each site

Worksheet “A” Series (single site or consolidated):

- A > Trial Balance of expenses, including reclassifications of and adjustments to cost. Primary cost categories are:
 - Facility Health Care Staff Costs
 - Costs Under Agreement
 - Facility Overhead -Facility Cost
 - Facility Overhead – Administrative Costs
 - Cost Other Than RHC Services
 - Non-Reimbursable Costs
- A-1 > Reclassifications (detail)
- A-2 > Adjustments to expenses (detail)
- A-2-1 > Related party or home office costs

Medicare RHC Cost Report – CMS 222-92

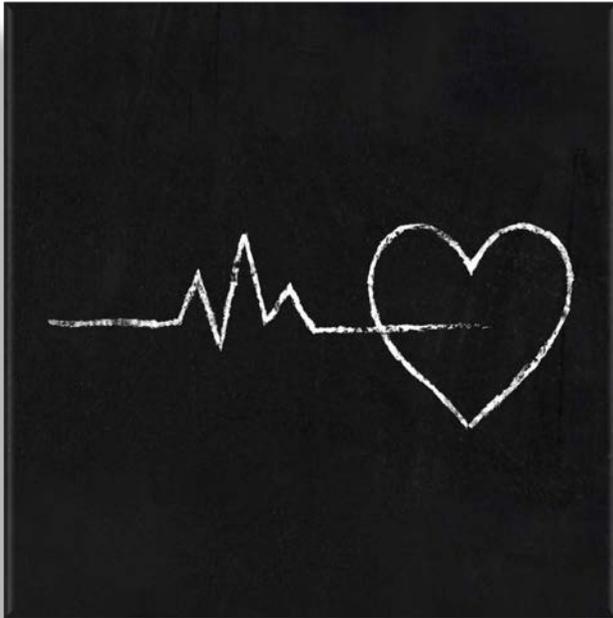
Worksheet “B” Series (single site or consolidated):

- B, Part I > Practitioner productivity calculation
 - Practitioners subject to the standards: Physicians, Physician Assistants (PA), and Nurse Practitioners (NP)
 - Other practitioners: Visiting Nurse, Clinical Psychologist, and Clinical Social Worker; also Physician Services Under Agreement
 - FTEs (worked) by practitioner
 - Total Visits by practitioner
- B, Part II > Calculation of the total allowable cost of RHC services. This “carves out” the overhead cost attributable to non-RHC and non-reimbursable services.
- B-1 > Cost of flu/pneumonia vaccinations attributable to Medicare

Medicare RHC Cost Report – CMS 222-92

Worksheet “C” Series (single site or consolidated):

- C, Part I > Calculation of total allowable RHC cost per visit
- C, Part II> Settlement calculation
 - UPL (if applicable)
 - Medicare visits for Medical and Mental Health Services (split by calendar year if UPL applicable)
 - Allowable GME cost
 - Deductibles and Coinsurance
 - Preventative charges
 - Flu/pneumonia vaccination cost attributable to Medicare
 - Interim payments received (from Worksheet D-1)
 - Medicare bad debts



Provider-based RHC - Hospital Cost Report

Provider-based RHC: Hospital Cost Report

Worksheet “S” Series:

- S-2, Part I > Demographic information for each RHC site
- S-3, Part I > Visits: Medicare, Medi-Cal, Other by site
Total FTE’s by site
- S-8 > Additional demographic information for each RHC site

Worksheet M-1 (One for each clinic site):

- M-1 > Trial Balance of expenses, including reclassifications of and adjustments to cost. Primary cost categories are:
 - Facility Health Care Staff Costs
 - Cost Other Than RHC Services (Non-Reimbursable)
 - Facility Overhead

Worksheet M-1 amounts for the RHC must tie to Worksheet A.

Provider-based RHC: Hospital Cost Report

Worksheet M-2 (One for each clinic site):

- Practitioner productivity calculation
 - Practitioners subject to the standards: Physicians, Physician Assistants (PA), and Nurse Practitioners (NP)
 - Other practitioners: Visiting Nurse, Clinical Psychologist, and Clinical Social Worker; also Physician Services Under Agreement
 - FTEs (worked) by practitioner
 - Total Visits by practitioner
- Calculation of the total allowable cost of RHC services. This “carves out” the overhead cost attributable to non-reimbursable services.

Provider-based RHC: Hospital Cost Report

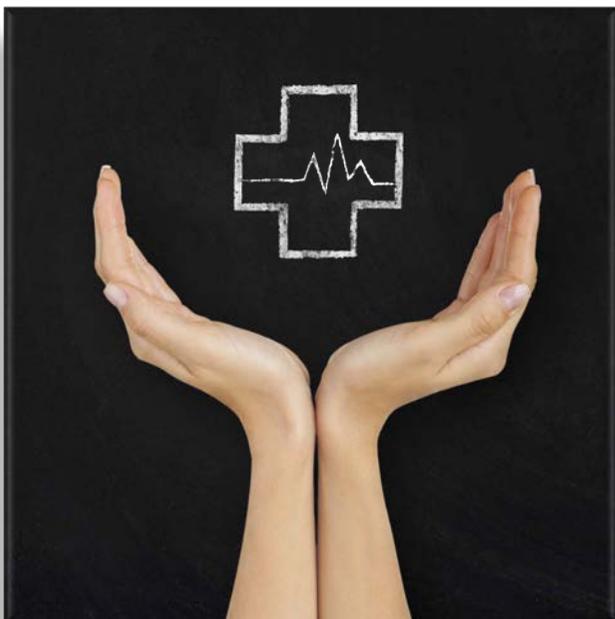
Worksheet M-3 (One for each clinic site):

- Calculation of total allowable RHC cost per visit
- Settlement calculation
 - UPL (if applicable)
 - Medicare visits for Medical and Mental Health Services (split by calendar year if UPL applicable)
 - Allowable GME cost
 - Deductibles and Coinsurance
 - Preventative charges
 - Flu/pneumonia vaccination cost attributable to Medicare (from Worksheet M-4)
 - Interim payments received (from Worksheet M-5)
 - Medicare bad debts

Questions

About Medicare cost reporting?





Cost Reporting Essentials

Cost Reporting Essentials



As noted, some Medicare RHC providers are paid on a “cost-basis” and Medi-Cal also utilizes cost reporting methodologies in its rate setting and rebasing processes.

Some important considerations:

- Keep good records. How you record patient activity, labor utilization, revenue, and expenses matter.
- Cost is not cost. There is actual cost (expense) as recorded in your records and “allowable cost” as determined under the Medicare regulations (also applicable to Medi-Cal).
- Get and keep good supporting documentation.
- If asked, can you provide a document supporting a specific expenditure or recurring expense? Do you keep detailed payroll records? How do you compile and report patient activity?

Accounting Basics

- A good accounting system, including a general ledger and internal financial statements; sound fiscal policies and controls; and a competent financial staff are must-haves.
- Accrual vs. cash-basis accounting.
- Expenses must be sufficiently detailed to allow for grouping into cost report cost centers (e.g. staff costs by personnel category, contract labor, medical supplies, insurance, interest, rent/lease, depreciation).
- Medicare has many rules governing what constitutes “allowable cost”; these are also utilized by Medi-Cal.
- At minimum, the financial statements must include a Balance Sheet and Statement of Revenue and Expense.
- The accounting system should be able to produce a trial balance that can be downloaded in a usable format.

Common Expense-Related Issues



- Depreciation: Straight-line method required
- Physician/practitioner compensation/documentation
- Personal “business” expenses (e.g. Executives, Physicians)
- Related party costs (e.g. building lease, administrative or other support services) have special documentation requirements
- Cost of non-RHC services performed at or purchased by the Clinic
- Cost of services covered only by Medi-Cal (e.g. Dental)
- Certain types of nonpatient revenue must be offset against expense (e.g. rebates and refunds, interest income)
- Expenses “not related to patient care” (e.g. advertising, marketing)
- Non-allowable costs that are “known” must be eliminated or classified as non-reimbursable when filing the cost report

Visits

- Defined exclusively as a face-to-face encounter
- Only one visit per day per location allowed. Exceptions:
 - A second illness or injury
 - A visit to a Dentist or other practitioner (as previously defined)
- “Allowable” visits exclude hospital services (some exceptions apply), nurse only, ancillary service (Lab, Radiology, etc.) only, vaccinations, etc.
- Home visits and nursing home visits are counted
- Visits should be compiled/tracked by practitioner, type of service, location, and program

Visits

- ALL visits should be counted so that nonbillable, nonallowable visits can be identified and excluded from the cost report
- Mental Health visits should be counted separately from medical visits.
 - Common data sources for visits are:
 - ~ Internal: Billing system (claims actually billed)
 - ~ Internal: Patient registration/utilization reports generated by system
 - ~ External: Paid claim reports downloaded/ordered from Medicare and Medicaid
- At the time of audit, program auditors will utilize their corresponding paid claim reports as the basis for total program visits.
- Documentation for total visits is often one of the most contentious issues during program audits.

Labor Reporting

- In the Medicare cost report, labor hours are used to determine Medicare's share of vaccine cost, to allocate cost to non-RHC services, and they are also used by Medi-Cal in applying productivity standards to practitioners in the rate setting and/or rate rebasing processes.
 - Data sources:
 - ~ Payroll records (employees)
 - ~ Practitioner staffing schedules or other time records utilized by contracted practitioners
- When applicable, Productive/Worked Hours are the basis for calculating the reported Full-Time Equivalents (FTEs).
- The Productive/Worked Hours for Practitioners should ONLY include time spent in direct patient care activities.

Labor Reporting

- Within the Medicare regulations, there are productivity standards applicable to the following types of practitioners in an FQHC/RHC setting: Physicians (MD, DO, DPM, etc.), Physician Assistants, and Nurse Practitioners. They are:
 - 4,200 visits per Physician FTE per year
 - 2,100 visits per PA or NP FTE per year
- Medi-Cal also utilizes these productivity standards in their rate setting and/or rate rebasing processes.
- Although there is no specific state Medi-Cal regulation supporting this practice, it has been justified as a “proxy” for determining reasonable cost.

Labor Reporting

- For nonpractitioner employees:
 - Nonproductive (excluded) hours include:
 - ~ Paid Time-Off (PTO)
 - ~ All other types of paid leave (Jury Duty, Maternity, etc.)
 - ~ Education
 - ~ Time spent on-call
 - Premium hours such as Overtime and Call-Back are included in Productive Hours.



Questions



Resources

- Medicare RHC Fact Sheet – January 2018

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf>

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