CARHC Rural Health Conference

Cost Reporting

Carlos Jimenez, Senior Manager

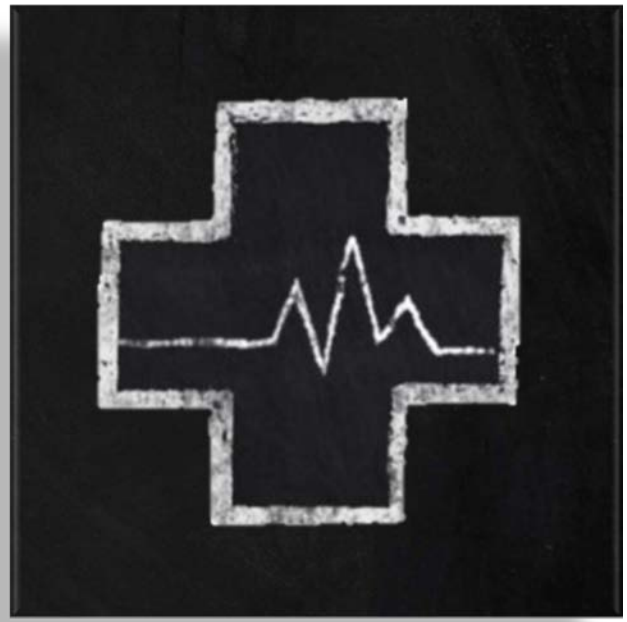
WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

Materials/Disclaimer

Please note that these materials are incomplete without the accompanying oral comments by the trainer(s). These materials are informational and educational in nature and represent the speakers' own views. These materials are for the purchasing agency’s use only and not for distribution outside of the agency or publishing on a public website.

Agenda

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



Medicare RHC Reimbursement

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

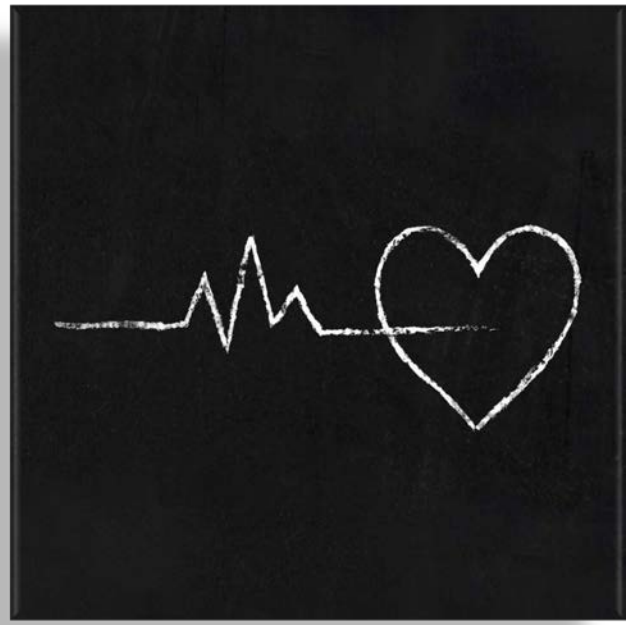
Medicare RHC Reimbursement

- 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

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

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

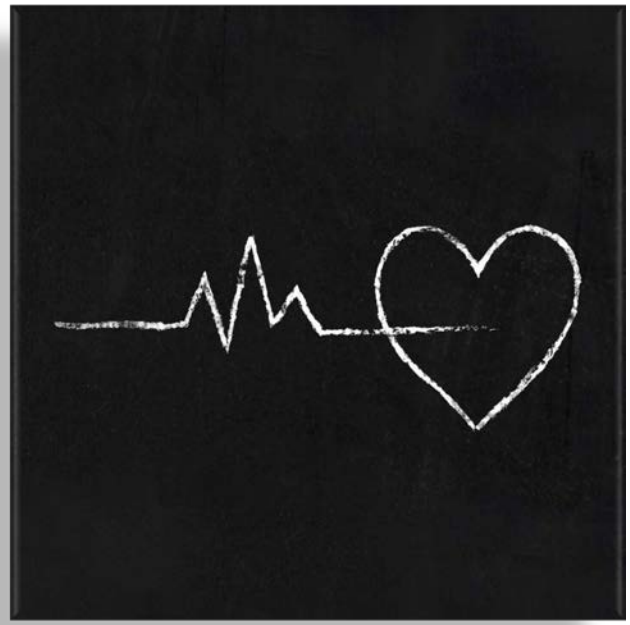
Worksheet "B" Series (single site or consolidated)**:**

- 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

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

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

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

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

Carlos Jimenez
Senior Manager
Health Care Practice
415-584-1400
cjimenez@wipfli.com