

Rural Health Clinic Technical Assistance Webinar

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PERSPECTIVE

A man in a blue suit is looking out from a high-rise building, with the Earth from space in the background. The word "PERSPECTIVE" is written in large, white, 3D letters across the top of the image.

CHANGES EVERYTHING.

National Association of Rural Health Clinics

Rural Health Clinic Medicare Cost Reporting 101

WIPFLI

Presenter



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Overview

RHC Medicare cost report overview

01

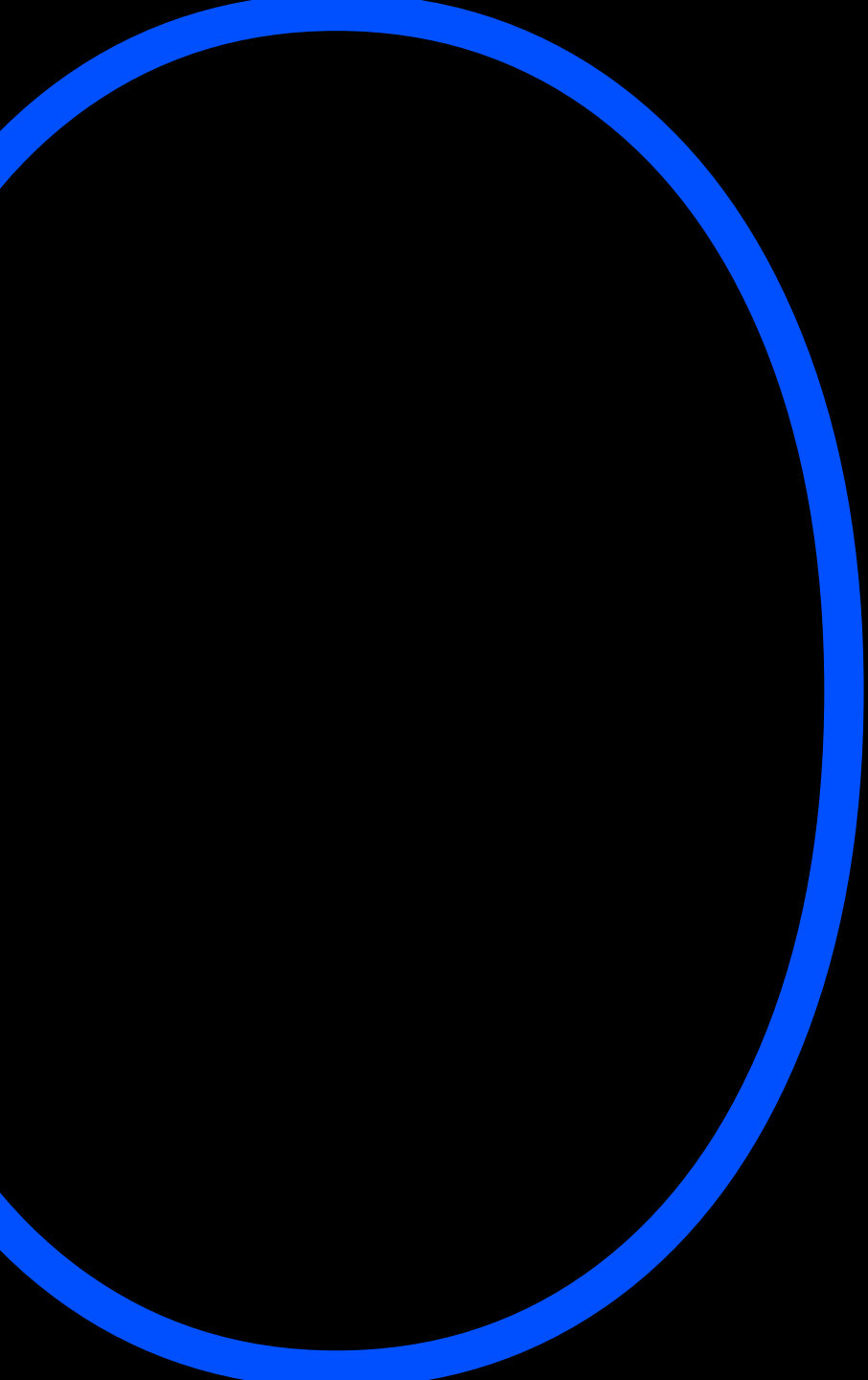
Key cost report drivers

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- Allowable costs
- RHC visits/provider productivity
- Medicare vaccine reimbursement
- Medicare bad debt

Cost report flow

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RHC Medicare cost report overview

Medicare cost report overview

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
- Provider-based RHCs – Submit an RHC cost report as a subset of the host provider (usually a hospital)

Medicare cost report overview

- 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
- Note that there is no indication of an automatic extension for 2023 Medicare cost reports

Medicare cost report overview

The Medicare cost report is the method of reconciling payments made by Medicare with the allowable costs for providing those services:

- Medicare payments received > the allowable costs = payable to Medicare
- Medicare payments received < the allowable costs = receivable from Medicare

Three components of the RHC cost report settlement:

- Medicare all-inclusive encounter rate
- Medicare influenza, pneumonia, and COVID-19 vaccinations
- Medicare bad debt

Know how the Medicare cost report affects your clinic's reimbursement

- Whether you prepare the cost report, gather data for the cost report, compile one piece of information for cost report preparation, or are providing medical services for the clinic, it is important to know how the cost report functions and how it is important to your clinic's viability in the future!



Key cost report drivers

Medicare cost report calculation of rate

Medicare All-Inclusive Encounter (AIR) rate

$$\frac{\text{Allowable RHC costs}}{\text{RHC visits}} = \text{RHC cost per visit (rate)}$$

(Not to exceed the maximum reimbursement limits*)

The AIR will be subject to maximum reimbursement limits as a result of the Consolidated Appropriations Act.

Consolidated Appropriations Act, 2021: Section 130

New limitations for independent RHCs, those with hospitals > than 50 beds, and all “new” provider-based RHCs

January 1 – March 31, 2021 the cap is \$87.52. On April 1st, the cap goes to \$100.00 per visit. It then rises at statutorily set increases as follows:

| | |
|------|----------|
| 2022 | \$113.00 |
| 2023 | \$126.00 |
| 2024 | \$139.00 |
| 2025 | \$152.00 |
| 2026 | \$165.00 |
| 2027 | \$178.00 |
| 2028 | \$190.00 |

After 2028 and in subsequent years, the cap goes up by the Medicare Economic Index (MEI)

Allowable costs

Allowable RHC costs:

- Defined at 42 CFR 413 and explained in Provider Reimbursement Manual, Pub. 15.
- *Per RHC Medicare Benefit Policy Manual*, “Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services.”

What is the source document for the “allowable RHC costs”?

- Internally or externally prepared financial statements
- Departmental summary reports
- Hospital cost report data
- Tax returns

Allowable costs

Cost report requires separation of staff and other-than-RHC costs

- RHC healthcare staff costs:
 - ▶ Physician
 - ▶ Physician assistant
 - ▶ Nurse practitioner
 - ▶ Visiting nurse
 - ▶ Other nurse
 - ▶ Clinical psychologist
 - ▶ Clinical social worker
- RHC facility overhead costs:
 - ▶ Office staff
- Costs other than RHC services:
 - ▶ Laboratory
 - ▶ Radiology
 - ▶ Hospital services
 - ▶ Telehealth
 - ▶ Other

Non-RHC costs

- The Medicare cost report reports costs, visits, and FTEs related to RHC services
- Costs associated with non-RHC services are carved out of the RHC Medicare cost per visit:
 - ▶ Lab – Paid at fee schedule for freestanding RHCs or billed under the hospital’s provider number
 - ▶ Technical component of diagnostic services – Paid at fee schedule for freestanding RHCs or billed under the hospital’s provider number
 - ▶ Chronic care management – Paid at fee schedule
 - ▶ Originating site telehealth services
 - ▶ Telehealth services paid based on
- Like the services above, distant site telehealth/virtual services provided during the public health emergency period (PHE) are paid at fee schedule (extended through 12/31/2024); therefore, costs related to these services must also be removed from the cost-per-visit calculation

Telehealth/virtual costs

- How many telehealth/virtual visits were provided during the cost reporting period?
- How much time is spent for each type of visit?
- Average hourly salary of the practitioner providing the service?
- Any other expenses related to providing these visits?
- Telehealth/virtual costs are reported on a separate “costs other than RHC services” line in the cost report

Mental Health Distant Site Telehealth Services (RHC)

- Starting 1/1/2022, distant site mental health services are billed and paid under the AIR and are considered RHC visits
 - ▶ The visits should be included in total visits included in the Medicare cost report
 - ▶ Costs should be included in RHC costs
 - ▶ Any other expenses related to providing these visits?

RHC visits

“A RHC visit is defined as a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be a RHC or FQHC visit. A RHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions.”

RHC Medicare Benefit Policy Manual

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 payers
- Total visits should not include hospital visits (either inpatient or outpatient visits), “nurse-only” visits in the RHC setting, or telehealth/virtual visits
 - ▶ Note: During the PHE (or if the clinic has a home health shortage area designation), the clinic could have billed for visiting nurse services to the homebound under the RHC provider number. These visits should be included in the total visits number.

NOTE: The cost-per-visit calculation considers total costs; therefore, all visits (regardless of payer type) should be included in the cost report.

RHC visits

- Counting of “visits” is easier said than done
- Computer-generated reports may be misleading:
 - ▶ Counting units of service instead of visits
 - ▶ Including non-visits (e.g., nurse only 99211)
 - ▶ Including non-RHC visits (e.g., hospital or telehealth/virtual visits)
 - ▶ Excluding non-billable visits (e.g., global visits)
 - ▶ Including duplicate visits
 - Can only count one visit per day, unless completely separate visit or could be billed as two encounters (i.e. – IPPE and another problem-focused visit)

RHC visits

- Counting visits for freestanding or “newly certified” RHCs is going to become even more important as the RHC cap continues to increase

Remember: higher visits = lower cost per visit = lower rate!

Provider staffing

Cost report requires separation of provider time

- Healthcare provider FTEs:
 - ▶ Physician
 - ▶ Physician Assistant (PA)
 - ▶ Nurse Practitioner (NP)
 - ▶ Visiting nurse*
 - ▶ Clinical Psychologist (CP)*
 - ▶ Licensed Clinical Social Worker (CSW)*

*not subject to productivity standards



Addition of RHC-defined practitioners

- Beginning 1/1/2024, the following additional RHC practitioners will be recognized by CMS and with services paid at the AIR
 - ▶ Marriage and Family Therapists
 - ▶ A Mental Health Counselor is recognized as an individual who:
 - ✓ (A) possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services described in paragraph (3);
 - ✓ (B) is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
 - ✓ (C) after obtaining such a degree has performed at least 2 years of clinical supervised experience in mental health counseling;
 - ✓ (D) meets such other requirements as specified by the Secretary.

Provider staffing

Provider productivity:

- Record provider FTE for clinic time only (this includes charting time):
 - ▶ Time spent in the clinic
 - ▶ Time with SNF patients
 - ▶ Time with swing bed patients
- Do not include non-clinic time in provider productivity:
 - ▶ Hospital time (inpatient or outpatient)
 - ▶ Telehealth/virtual time
 - ▶ Administrative and committee time
- Provider time for visits by physicians under agreement **who do not** furnish services to patients on a regular ongoing basis in the RHC are not subject to productivity standards

Provider staffing

Sample reconciliation of provider FTE

| | |
|------------------------|-------------|
| Clinical FTE | 0.70 |
| Administrative FTE | 0.03 |
| Hospital FTE | 0.20 |
| Telehealth/virtual FTE | 0.02 |
| Medical director FTE | <u>0.05</u> |
| Total FTE | 1.00 |



RHC provider productivity

Productivity standards:

- Physician 4,200 visits annually for 1.0 FTE
- Midlevel 2,100 visits annually for 1.0 FTE

Total visits used in calculation of the cost per visit is the greater of the actual visits or minimum allowed (FTEs x productivity standard)

NOTE:

The cost report productivity standards cannot be manually adjusted. Therefore, if a provider worked only a portion of a year or if the cost report represents only a portion of a year, the FTE should be adjusted accordingly.

RHC provider productivity

Example 1 – Visits are greater than productivity standards

| 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 | 4.75 | 22,000 | 4,200 | 19,950 | |
| 2 | Physician Assistants | 0.51 | 1,500 | 2,100 | 1,071 | |
| 3 | Nurse Practitioners | 2.76 | 12,000 | 2,100 | 5,796 | |
| 4 | Subtotal (sum of lines 1-3) | 8.02 | 35,500 | | 26,817 | 35,500 |
| 5 | Visiting Nurse | | | | | |
| 6 | Clinical Psychologist | | | | | |
| 7 | Clinical Social Worker | | | | | - |
| 8 | Total FTEs and Visits (sum of lines 4-7) | 8.02 | 35,500 | | | 35,500 |

RHC provider productivity

Example 2 – Productivity standards are greater than visits

| 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 | 4.75 | 15,000 | 4,200 | 19,950 | |
| 2 | Physician Assistants | 0.51 | 1,000 | 2,100 | 1,071 | |
| 3 | Nurse Practitioners | 2.76 | 5,000 | 2,100 | 5,796 | |
| 4 | Subtotal (sum of lines 1-3) | 8.02 | 21,000 | | 26,817 | 26,817 |
| 5 | Visiting Nurse | | | | | |
| 6 | Clinical Psychologist | | | | | |
| 7 | Clinical Social Worker | | | | | - |
| 8 | Total FTEs and Visits (sum of lines 4-7) | 8.02 | 21,000 | | | 26,817 |

RHC provider productivity

Effect on cost-per-visit

| | Greater of Actual Visits or Productivity Standard Visits | Allowable Costs for Cost-Per-Visit Calculation | RHC Cost-Per-Visit |
|-----------|----------------------------------------------------------------|------------------------------------------------------|--------------------|
| | | \$ 4,000,000 | |
| Example 1 | 35,500 | | \$ 112.68 |
| Example 2 | 26,817 | | \$ 149.16 |

- Grandfathered RHC, \$36 per visit
- RHC subject to federal cap (currently \$126), \$14 per visit

RHC productivity standards exception request

- RHCs have the ability to request an exception to these standards yearly from the Medicare Administrative Contractor (MAC). The decision to grant the request is at the discretion of the MAC.
- With the reduction of visits at most clinics due to the COVID-19 emergency, MACs may be more apt to grant an exception.
- We suggest each RHC review the actual RHC visits performed when compared with the Medicare productivity standards to determine whether a request to the exception should be requested.

RHC productivity standards exception request

- Note that the ability to request an exception to the productivity standards is not new; however, previously, exceptions granted have been rare
- Only the MAC has the authority to approve exception requests
- No prescribed format is required by MAC

Medicare vaccine reimbursement

- Medicare influenza and pneumonia costs are reimbursed on the cost report, including staff, vaccine, and overhead costs
- CMS has also indicated COVID-19 vaccine administrations for Medicare patients are reimbursed through the Medicare cost report and should not be billed.
- All other injections are included in the cost-per-visit calculation and are not separately reimbursed on the Medicare cost report



Medicare vaccine reimbursement

How is your facility tracking cost?

- Staff time – Is all staff time coded to the RHC department? How much time is spent per injection? Is time different for COVID vaccinations?
- Vaccine costs – Where are vaccine costs on the general ledger? Are they in a hospital department or in the RHC?
- Listing of Medicare patients must be included with the cost report submission:
 - ▶ Name
 - ▶ Medicare number
 - ▶ Date of service
 - ▶ Can these reports be automated?

Medicare bad debt

- Medicare bad debt reimbursement is 65% of allowable bad debt claimed
- Allowable deductible and coinsurance amounts only
- Debt must be related to covered services
 - ▶ Do not include lab, radiology, or other non-RHC services on the cost report
- Provider must be able to establish that reasonable collection efforts were made
 - ▶ Document that a reasonable and consistent collection effort has been made for 120 days from the date of the initial bill to the patient.
- Denials by Medicaid as secondary payer, as long as actually billed and denied, can be claimed immediately
- Documented charity care write-offs can be claimed immediately

Medicare bad debt

CMS has provided clarification that debts referred to a collection agency ***are not*** considered uncollectible and may not be reimbursed until the bad debt is ***returned*** from the collection agency as uncollectible.

Medicare bad debt

Documentation required with cost report (Exhibit 2):

- Beneficiary name and HIC number
- Date(s) of service
- Date of first bill sent to patient
- Medicare paid date (R/A)
- Write-off date
- Separation of deductible and coinsurance amounts
- Medicaid payment and paid date (if any)



Cost report flow

Cost Report Flow

Worksheets (Independent RHCs)

- S Section – Basic Clinic Information
- A – Summary of Expenses
- A6 – Reclassification of Expenses Detail
- A8 – Addition/Subtraction of Expenses Detail
- A8-1 – Related Party Adjustments Detail
- B – FTE/Visit Data/Overhead Allocation
- B-1 – Medicare Flu/Pneumo/Monoclonal Antibody Reimbursement
- C – Calculation of Settlement

Cost Report Flow

Worksheets (Provider-based RHCs)

- S Section – Basic Clinic Information
- A/M-1 – Summary of Expenses
- A6 – Reclassification of Expenses Detail
- A8 – Addition/Subtraction of Expenses Detail
- A8-1 – Related Party Adjustments Detail
- M-2 – FTE/Visit Data/Overhead Allocation
- M-4 – Medicare Flu/Pneumo/Monoclonal Antibody Reimbursement
- M-3 – Calculation of Settlement

Questions?

NARHC

RHC Medicare Cost Reporting 101

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