Cost Reporting Update

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Let’s review the basics:

- Due – FIVE months after your year end
- Medicare is currently accepting hard copy or electronically submitted cost reports
- LA Medicaid still obtaining hard copies with reconciliation worksheets by plan.
What does the cost report do for me?

- Reconciles interim payments to actual cost per visit
- Sets future interim reimbursement rates
- Influenza and Pneumococcal vaccines
- Medicare bad debt

Health Services Associates, Inc.
How is the rate calculated?

\[ \frac{\text{COST}}{\text{VISTS}} = \text{RHC RATE} \]

Health Services Associates, Inc.
Is that what I get?

- **Independent RHCs**: Subject to a ceiling/cap. 2019 Cap = $84.70

- **Provider based >50 bed hospital**: Capped same as independent

- **Provider based <50 bed hospital**: Actual cost per visit

Health Services Associates, Inc.
Where are these located:

- **Cost:** Worksheet A/M-1
  - A-6 is where we reclassify cost
  - A-8 is where we take things off and put things on
- **Visits:** Worksheet B/M-2
- **Rate/Settlement:** Worksheet C/M-3
- **Vaccines:** Worksheet B-1/M-4

Health Services Associates, Inc.
COSTS – WORKSHEET A/M-1

- Put all costs on this worksheet
- Must match your financials
- Use supplemental worksheets (A-6/A-8) to reclassify and exclude

Health Services Associates, Inc.
COSTS – WORKSHEET A/M-1

Healthcare Costs

Overhead

Non-RHC

Health Services Associates, Inc.
Healthcare Costs

- Compensation for healthcare staff
- Compensation for physician supervision
- Medical Supplies
- Malpractice/License fees/CME
Overhead

TWO TYPES

FACILITY

ADMINISTRATIVE

Health Services Associates, Inc.
Facility Overhead

- Rent
- Insurance
- Interest on Mortgage
- Utilities
- Other building expenses

Health Services Associates, Inc.
Administrative Overhead

- Office salaries
- Office supplies
- Legal/Accounting
- Telephone/IT costs
- Other administrative costs

Health Services Associates, Inc.
Overhead allocations

Overhead

Healthcare

Non-RHC

Overhead allocated on ratio of Healthcare to Non-RHC costs
Non-RHC

- Only include items that use overhead!

- Most common Non-RHC
  - Technical component of Lab, X-Ray, EKG
  - Other items not covered under the RHC program or paid outside of the RHC rate

- ONLY LEAVE AMOUNTS IN THE NON-RHC SECTION IF THEY NEED TO CAPTURE OVERHEAD

Health Services Associates, Inc.
Exclude or Reclassify?

- Does it use overhead at the clinic? (space, staff, etc.)
  > RECLASSIFY!

- If it is a non-allowable expense that does not use overhead:
  > EXCLUDE!

Health Services Associates, Inc.
Reclassify Lab/X-Ray/EKG

- **Method A: Staff performing lab, X-ray, EKG duties**
  - Allocate % of time for non-RHC carve out for staff performing non-RHC lab/X-ray/EKG duties vs. RHC duties
  - Time studies of staff to support the allocated carve out

- **Method B – Time studies for each specific test**
  - Calculate time per test
  - Multiply by number of tests performed
  - Multiply by average hourly wage

- Reclassify resulting non-RHC wages into non-reimbursable cost center
Chronic Care Management

- Is CCM done in the clinic, by clinic staff?
  - Reclassify direct healthcare staff costs into Non-RHC cost center
  - New line 55.50 on independent reports

- Is CCM handled by an outside company?
  - Exclude direct CCM costs
  - Exclude associated billing costs/incremental overhead costs

Health Services Associates, Inc.
Telemedicine

- RHCs may serve as an originating site for telehealth services
- Originating site is the location of the patient at the time of service
- Cost of providing telehealth services must be classified in the Non-RHC section

Health Services Associates, Inc.
CCM/Telemedicine

If staff performing CCM and/or Telemedicine wear multiple hats in your clinic, use same calculations/methods as Lab/X-Ray/EKG

- Reclassify staff cost
- Report direct costs directly into the Non-RHC cost center
- New line on independent cost report, Line 55.60

Health Services Associates, Inc.
Possible cost additions...

- Depreciation should be adjusted from tax basis to Medicare basis (straight line)
- Owner’s compensation for sole proprietors and partnerships
Owner Compensation

- Provider Reimbursement Manual, Chapter 9 was updated in 2018
- Section 905.7 issued specific guidelines for Rural Health Clinics.
- Owner’s compensation for sole proprietors and partnerships can be added to cost report, whether paid or not
## Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics
### By Census Bureau Regions and Divisions
#### Per FTE

<table>
<thead>
<tr>
<th>Region</th>
<th>Division</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<td></td>
<td>Min</td>
<td>Max</td>
<td>Min</td>
<td>Max</td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>2</td>
<td>Middle Atlantic</td>
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<td>$227,012</td>
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<td>Subtotal - Region 1: Northeast</td>
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<td>3</td>
<td>South Atlantic</td>
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<td>$225,777</td>
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<td>4</td>
<td>East South Central</td>
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<td>$272,658</td>
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<td>5</td>
<td>West South Central</td>
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<td>$265,344</td>
<td>$302,481</td>
<td>$270,651</td>
<td>$308,530</td>
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<td>$304,689</td>
<td>$279,756</td>
<td>$310,782</td>
<td>$285,351</td>
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### Census Bureau Divisions:
- **New England Division**: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
- **Middle Atlantic Division**: New Jersey, New York, Pennsylvania
- **East North Central Division**: Illinois, Indiana, Michigan, Ohio, Wisconsin
- **West North Central Division**: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
- **South Atlantic Division**: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
- **East South Central Division**: Alabama, Kentucky, Mississippi, Tennessee
- **West South Central Division**: Arkansas, Louisiana, Oklahoma, Texas
- **Mountain Division**: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
- **Pacific Division**: Alaska, California, Hawaii, Oregon, Washington

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9-8  
Rev. 476
Exclude...

- Entertainment
- Gifts
- Charitable Contributions
- Automobile Expense – where not related to patient care

Health Services Associates, Inc.
Income offsets...

- Interest income up to interest expense
- Medical Records income
- Income from space rented to others (unless you can identify costs)
- Other miscellaneous income
Related Party Transactions

Medicare allows actual cost (only) for items and services purchased from a related party

Health Services Associates, Inc.
Building rented from related party...

- Example: Clinic owner also owns the building – clinic pays building rent to clinic owner
- Medicare cost report will ‘zero out’ the rent and add back what it costs the building owner:
  - Property Taxes
  - Mortgage Interest
  - Building depreciation and maintenance

Health Services Associates, Inc.
Definition: Face-to-face encounter with qualified provider during which covered services are performed.

- Broken down by provider type (MD, PA, NP)
- Count only face-to-face encounters
- Do not include visits for hospital, non covered services, non qualified providers or injections

Health Services Associates, Inc.
Visits are reported by type of clinician
- Physician
- Physician Assistant
- Nurse Practitioner

All clinician’s working on a regular basis should be included in visits subject to the productivity standard

Physician Services Under Agreement – for the occasional ‘fill in’ (locum tenens)

Health Services Associates, Inc.
MINIMUM VISTS:

- Medicare will charge the clinic with a minimum number of visits per FTE, whether performed or not.

- 4,200 visits per employed or independent contractor physician FTE.

- 2,100 visits per midlevel FTE.

- Physician Services under agreement not subject to productivity standards – limited application (cannot work on a regular basis).

Health Services Associates, Inc.
Productivity Standard applied in aggregate

Total visits (all providers subject to the FTE calculation) is compared to total minimum productivity standard

A productive midlevel with visits in excess of their productivity standard can be used to offset a physician shortfall

Health Services Associates, Inc.
FTE – Clinical Hours only...

- FTE is based upon how many hours the practitioner is available to provide patient care.
- FTE is calculated by practitioner type (Physician, PA, NP).
Seasonal Influenza and Pneumovax reporting has four data elements:

- Vaccine Staff Time Ratio
- Total vaccines given of each to ALL insurance types
- Total Medicare vaccines given of each (Medicare log must accompany cost report)
- Cost of vaccines (include invoices if possible)
Vaccine documentation

- Clinic must maintain logs of Influenza and Pneumococcal vaccines administered
- Invoices for the cost of Influenza and Pneumococcal vaccine should be submitted with the cost report
- Submit vaccine logs electronically if possible
Settlement – Worksheet C/M-3

Data is pulled from the clinic’s PS&R
- Medicare visits – include preventive visits
- Deductibles
- Total Medicare charges
- Medicare preventive charges

Health Services Associates, Inc.
Settlement Data

Data is pulled from the clinic’s PS&R

- Coinsurance – info only
- Medicare payments – be sure to include MSP payments and lump sum settlements, if any.

- Bad Debts – Total
- Bad Debt – Dual Eligible

Health Services Associates, Inc.
A copy of your PS&R (Provider Statistical and Reimbursement System report) will need to be obtained by the clinic electronically through CMS’s Enterprise Portal at https://portal.cms.gov/

Go to the following link to access the PS&R: https://psr-ui.cms.hhs.gov

NOTE: If you need access or are having difficulty changing your password, please call their help desk at 866-484-8049
Login using your user ID and password (you may have a two step authentication)

Enter your user ID and Password

“Request Report” (at the top under blue CMS banner)

Select “Request Summary”

It should be defaulted to the “By Report Type” button… select Report Type 710 and hit the >> button to move it into the ‘selected report types’ field

Do the same for report type 71S

Hit “Continue”

Leave interval as “year” and input 01/01/2018 in the start date field

Hit “Apply”

Hit “Continue”

Select PDF, and hit “Continue”

Hit “Submit”

The next hour or two, check back to the report inbox for your report.
PSR

- Compare PSR total to your Medicare visit count. Is this accurate? If not, determine why:
  - Were incidental services included in the visit count
  - Were dual-eligible counted twice
  - Did more than one visit get counted on one day (surgical procedure/office visit)
Obtain EIDR from LeBlanc, Robertson, Chisholm & Associates, LLC (formerly known as Cypress Audit Team, LLC)

- 225-218-6242 (Direct)
- 225-246-8767 (Fax)

lindsay.talley@lrcaudit.com
Visits = T1015 Only
Third Party Liability = Deductibles
Payments = Interim Payments Line T1015 line only
“Traditional Shared” = X-overs, DO NOTHING WITH THESE
<table>
<thead>
<tr>
<th>Line #</th>
<th>Line Description</th>
<th>Amount</th>
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<tr>
<td>10</td>
<td>Rate for Medicaid Covered Visits</td>
<td>$101.17</td>
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<td>11</td>
<td>Medicaid Covered Visits Excluding Clinical Psychologists and Clinical Social Workers</td>
<td>5,662</td>
</tr>
<tr>
<td>12</td>
<td>Medicaid Covered Cost Excluding Cost for Clinical Psychologists and Clinical Social Workers</td>
<td>572,825</td>
</tr>
<tr>
<td>13</td>
<td>Medicaid Covered Visits for Clinical Psychologists and Clinical Social Workers</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>Medicaid Covered Costs for Clinical Psychologists and Clinical Social Workers</td>
<td>0</td>
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<td>15</td>
<td>Limit Adjustment</td>
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<td>16</td>
<td>Total Medicaid Cost</td>
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<tr>
<td>17</td>
<td>Less: Beneficiary Deductible</td>
<td>14,965</td>
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<tr>
<td>18</td>
<td>Net Medicaid Cost Excluding Pneumonia and Influenza Vaccine and its Administration</td>
<td>557,860</td>
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<tr>
<td>18.01</td>
<td>Total Medicaid Charges (PSR Report)</td>
<td>N/A</td>
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<td>18.02</td>
<td>Total Medicaid Preventive Charges Administration</td>
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<td>18.03</td>
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<td>Total Medicaid Non-Preventative Costs Administration</td>
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<td>Net Medicaid Cost Administration</td>
<td>557,860</td>
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<tr>
<td>18.06</td>
<td>Less Beneficiary coinsurance for RHC/FQHC Services Administration</td>
<td>N/A</td>
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<tr>
<td>19</td>
<td>Reimbursable Cost of RHC/FQHC Services, Other than Pneumonia and Influenza Vaccine</td>
<td>557,860</td>
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<tr>
<td>20</td>
<td>Medicaid Cost of Pneumonia and Influenza Vaccine Injections and its Administration</td>
<td>N/A</td>
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<tr>
<td>21</td>
<td>Total Reimbursable Medicaid Cost</td>
<td>557,860</td>
</tr>
<tr>
<td>22</td>
<td>Less Payments to RHC/FQHC During Reporting Period</td>
<td>568,469</td>
</tr>
<tr>
<td>23</td>
<td>Balance Due(To)/From Medicaid Program Exclusive of Bad Debts</td>
<td>(10,610)</td>
</tr>
<tr>
<td>24</td>
<td>Total Reimbursable Bad Debts</td>
<td>N/A</td>
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<tr>
<td>24.11</td>
<td>Sequestration Adjustment</td>
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<td></td>
<td>Less PPS Adjustment</td>
<td>$10,610</td>
</tr>
<tr>
<td>25</td>
<td>Total Amount Due (To)/From the Medicaid Program</td>
<td>$0</td>
</tr>
</tbody>
</table>
Medicare Bad Debt

- Medicare bad debt form must accompany cost report of total bad debt being claimed.

- Medicare bad debt is claimed on the cost report based on the fiscal year in which the bad debt was written off, not date of service.
Medicare Bad Debt

Medicare Bad Debt IS:

- Deductibles and Coinsurance amounts uncollectible from Medicare beneficiaries after reasonable collection efforts

Health Services Associates, Inc.
Medicare Bad Debt IS NOT:

- Uncollected deductibles and coinsurance from:
  - private pay patients, or any other non-Medicare beneficiary
  - Medicare Advantage or Medicare Part B
- Charity, Courtesy, and Third-Party Payer Allowances
- Uncollected amounts due from other payers
- Disputed Medicare claims
Criteria for Allowable Bad Debts

- Debt must be related to covered services and derived from deductible and coinsurance amounts.
- Provider must establish that reasonable collection efforts were made.
- 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.
When to write off a Medicare Bad Debt

- The CFR at 42 CFR 413.89(f) requires that the uncollectible Medicare deductible and coinsurance be charged off as bad debts in the accounting period when the bad debt is determined to be worthless.
When to write off a Medicare Bad Debt

- Bad debt log is for Medicare deductibles and coinsurance deemed uncollectible and written off clinic’s books during the cost reporting period.

- It can, and most often does, contain dates of service prior to the current cost reporting period.

- Based on write off date, not date of service!
Two types of Medicare bad debts:

- Indigent or Medically Indigent Patients
  - No collection efforts required for Medicaid beneficiaries. Must bill Medicaid and retain remittance advice as documentation

- Patients not deemed to be indigent:
  - Collection efforts required
Indigent Patients

- Automatic indigence determination for Medicare/Medicaid dual-eligible beneficiaries

- **Must bill** Medicaid for proof of eligibility and apply any Medicaid payments, if applicable.

- Must have a processed State Medicaid remittance advice before allowing dual eligible bad debts
Indigent Patients

Indigent patients not eligible for Medicaid:

- Indigence must be **determined by the provider**, not by the patient (i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence).
- Take into account a patient's **total resources** which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses.

Health Services Associates, Inc.
Indigent Patients

Indigent patients not eligible for Medicaid:

- Determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency, or guardian and

- Patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
Reasonable Collection Efforts

- First bill must be sent within reasonable timeframe – 90 days for most MACs

- **SAME EFFORT** applied to any bill:
  - Collection letters
  - Phone calls
  - Collection agency (if used for non-Medicare patients)
Presumption of Noncollectability (120 Day Rule)

- If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.
- Any payments received from the beneficiary re-starts the 120 uncollectability timeframe.
Collection Policy

- Must be consistent among all payer types
- Must involve the issuance of a bill on or shortly after the date of service
- Should include other actions such as:
  - Subsequent billings
  - Collection Letters
  - Telephone Calls or personal contacts with this party
- Must constitute a GENUINE, rather than a token, collection effort.
Collection Policy

- May involve the use of a Collection Agency in addition to or in lieu of subsequent billing by the clinic. If used:
  - Refer all uncollected patient charges of **like amount** regardless of class of patient
  - If the collection agency collects from the beneficiary, the FULL AMOUNT collected must be applied to the Medicare bad debt
  - Collection agency fees applicable to the collection of the debt can be recorded as an administrative expense on the clinic’s financial statements

Health Services Associates, Inc.
Collection Policy

Do **NOT** include a “**MEDICARE COLLECTION POLICY**” section within your collection policy. (This will indicate different treatment/procedures for the collection of Medicare bad debts and cause your bad debts to be disallowed at audit)

Health Services Associates, Inc.
Within the section of the collection policy that outlines the procedure for bad debt write off (consistent among all patient classes), include a section that explains how to complete the Medicare bad debt log:

› How to fill out the log
› Documentation maintenance
› Referral to the cost report
Audit Documentation

Indigent Patients

- Medicaid dual-eligible beneficiary: Medicaid remittance advice indicating payment or denial of payment.
- Indigent, not Medicaid eligible: Documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
Non-Indigent Patients

Collection efforts must be documented in the patient’s file

› Copies of bills
› Documentation of phone calls/personal contact
› Follow up letters
Bad Debt Log

- Patient Name
- HIC number
- Date of service
- Whether the patient has been deemed indigent and their Medicaid number if this was the method utilized to determine indigence
- Date the first bill was sent to the beneficiary
- Date the bad debt was written off
- Remittance advice date
- Deductible and coinsurance amount
- Total Medicare bad debt (reduced by recoveries)
# Medicare Bad Debt

## Listing of Medicare Bad Debts and Appropriate Supporting Data

**Worksheet 9 - Medicare Bad Debt Log**

<table>
<thead>
<tr>
<th>Column</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- **Beneficiary Name**
- **Type of Service**
- **Date First Bill Sent to Beneficiary**
- **Write-Off Date**
- **Medicare Part B**
- **Medicare Part A**
- **Other Payments and Patient Total**

*These amounts must not be claimed unless provider bills for these services with the intention of payment. See instructions for outline 4 - Indigent/welfare recipient, for possible exceptions.*
Questions?

Health Services Associates, Inc.