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Overview

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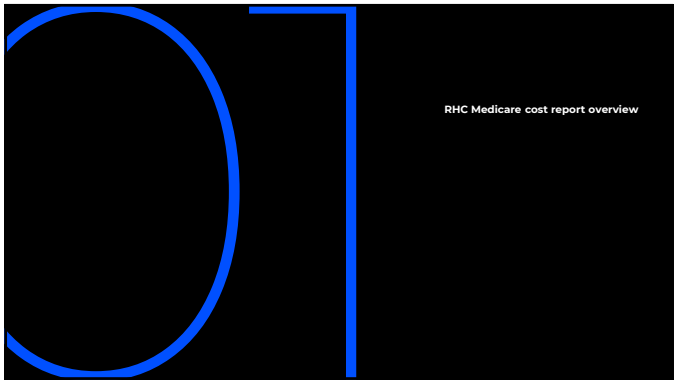

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Medicare cost report overview

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)

4

4

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

5

5

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

6

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Medicare cost report calculation of rate

Medicare All-Inclusive Encounter (AIR) rate

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

(Not to exceed the maximum reimbursement limits*)

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

8

8

Consolidated Appropriations Act, 2021: Section 130

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

The Medicare is set to increase 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).

9

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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

10

10

Allowable costs

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

- RHC health care staff and other 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

11

11

Nonallowable 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
- 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

12

12

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

13

13

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?

14

14

RHC visits

- Medically-necessary medical or mental health visit, or a qualified preventive health visit.
- Face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, LCSW, MHC, or a LMFT during which one or more RHC services are rendered.
  - MHC's and LMFT's are RHC recognized providers effective January 1, 2024.
- Effective January 1, 2022, a mental health visit is a face-to-face encounter, or an encounter furnished using telehealth technologies.
- A Transitional Care Management (TCM) service can also be a RHC visit.
- A RHC visit can also be a visit between a home-bound patient and an RN or LPN with a home health shortage area designation.

15

15

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. Effective January 1, 2022, a mental health visit is a face-to-face encounter, or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only. 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.

Effective January 1, 2024, services furnished by a mental health counselor (MHC) and licensed marriage and family therapist (LMFT) qualify as a RHC visit.

16

16

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

17

17

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)

18

18

RHC visits

- Counting visits now that productivity standards are eliminated for cost reporting periods in ending in 2025 and thereafter, is going to become even more important.

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

19

19

Provider staffing

Cost report requires separation of provider time

- Health care provider FTEs:
  - Physician
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Visiting nurse*
  - Clinical Psychologist (CP)*
  - Licensed Clinical Social Worker (CSW)*
  - Mental Health Counselor (MHC) **
  - Licensed Marriage and Family Therapist (LMFT)**

*not subject to productivity standards

**as of January 1, 2024

20

20

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

21

21

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	0.05
Total FTE	**1.00**

22

22

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.

23

23

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	0.50	1,500	2,100	1,050	
3	Nurse Practitioners	2.00	6,000	2,100	4,200	
4	Subtotal (sum of lines 1-3)	7.25	29,500		25,200	29,500
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					-
8	Total FTEs and Visits (sum of lines 4-7)	7.25	29,500			29,500

24

24

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	0.50	1,000	2,100	1,050	
3	Nurse Practitioners	2.00	5,000	2,100	4,200	
4	Subtotal (sum of lines 1-3)	7.25	21,000		25,200	25,200
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					-
8	Total FTEs and Visits (sum of lines 4-7)	7.25	21,000			25,200

25

25

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	29,500		$ 135.59
Example 2	25,200		$ 158.73

- Grandfathered RHC, $23 per visit
- RHC subject to federal cap (currently $139), $4 per visit

26

26

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.

27

27

RHC productivity standards exception request

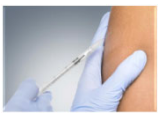
- Note that the ability to request an exception to the productivity standards is not new; however, previously, exceptions granted have been rare
- Only the MAC has the authority to approve exception requests
- No prescribed format is required by MAC

28

28

Medicare vaccine reimbursement

- Medicare influenza, pneumonia, COVID-19, and monoclonal antibody costs are reimbursed on the cost report, including staff, vaccine, and overhead costs.
- Because these vaccines are reimbursed on the cost report, they should not be billed to Medicare.
- All other injections are included in the cost-per-visit calculation and are not separately reimbursed on the Medicare cost report.



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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?

30

30

Medicare vaccine reimbursement

- Beginning 7/1/25, RHC will be able to bill for flu/pneumo/Covid/Hep B vaccines during the year
- Payment will be made initially at fee schedule, with a true up to cost on the year end Medicare cost report.
- Will this be mandatory?

31

31

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

32

32

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.

33

33

Medicare bad debt

Documentation required with cost report

- 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)

34

34

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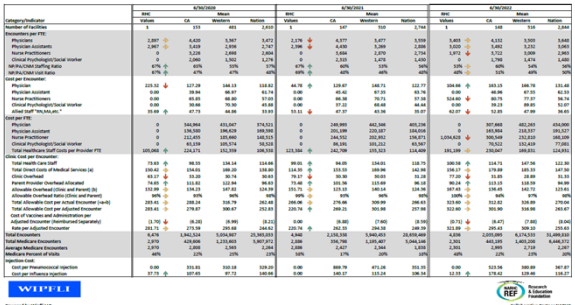
RHC Benchmarking

35

Medicare Benchmark Report



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Questions?

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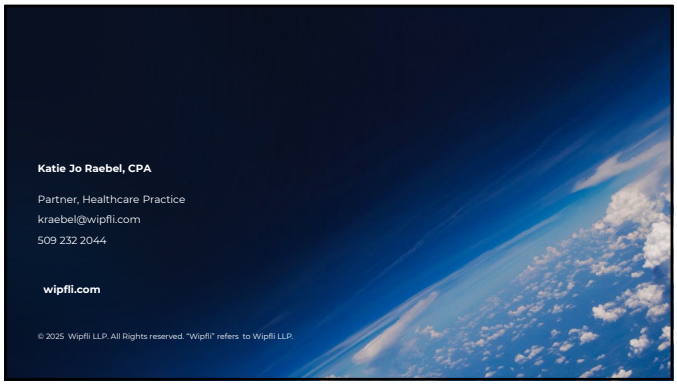

38