RHC Cost Reporting- Year End Planning
Healthcare Business Specialists
November 14, 2023

HBS
Healthcare Business Specialists

Our Team

MEET OUR TEAM

Healthcare Business Specialists offers a variety of services designed to assist physician practices and RHCs in providing better primary medical services to underserved, rural residents by enhancing Medicare and Medicaid Reimbursement and staying compliant with Rural Health Clinic program requirements.

Through cost reporting preparation, program evaluations, RHC startups and conversions, Emergency Preparedness Compliance, CHOWs, RHC terminations, and feasibility studies, Healthcare Business Specialists is equipped to serve all your RHC needs.

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HBS Services

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SERVICES

RHC COST REPORTING

RHC PROGRAM EVALUATIONS

RHC STARTUPS & CONVERSIONS

EMERGENCY PREPAREDNESS COMPLIANCE

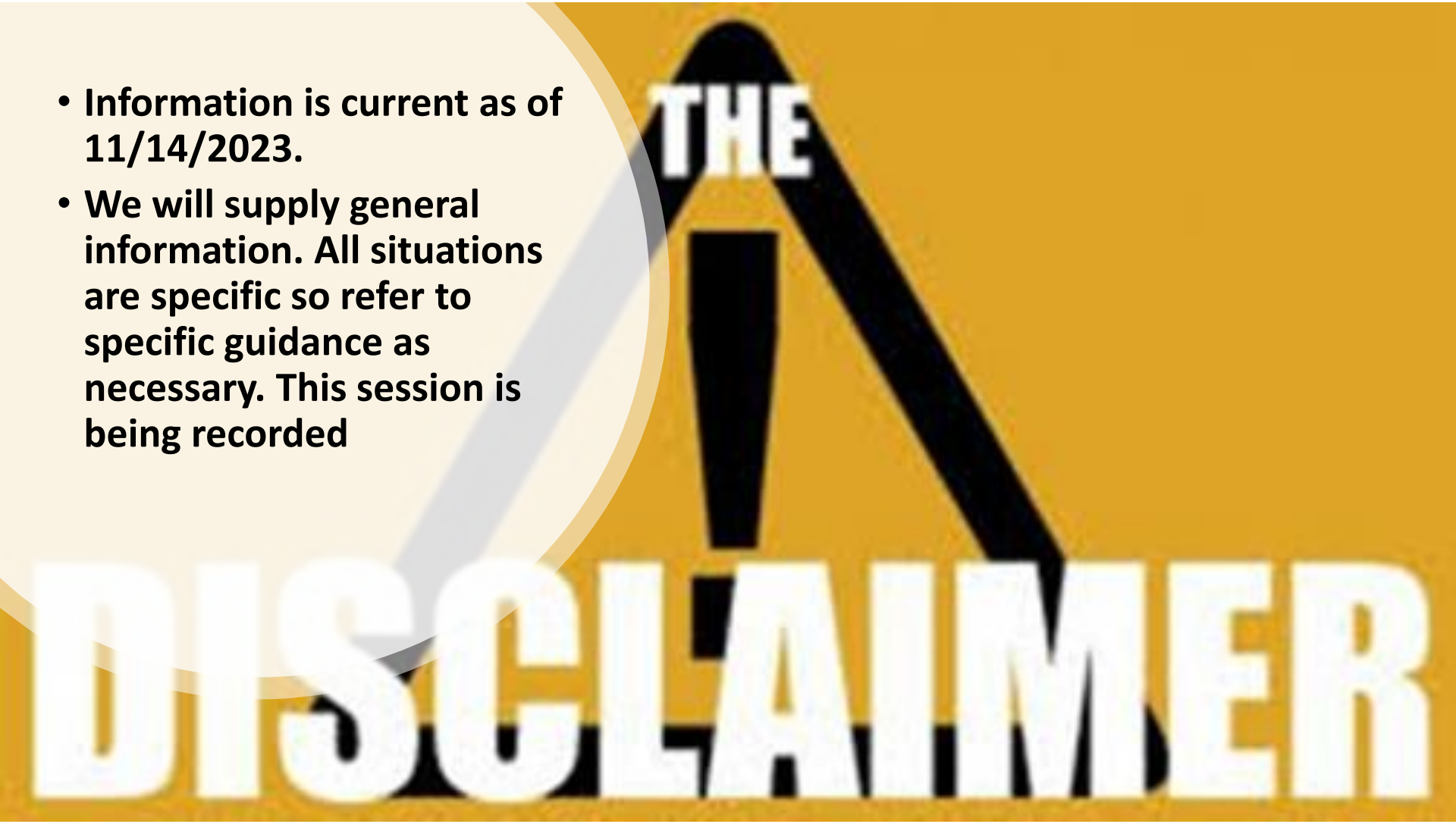
TENNCARE QUARTERLY REPORTING

FOR MORE INFORMATION: 833-787-2542 | www.ruralhealthclinic.com

Rural Health Clinic Information Exchange Facebook Group

https://www.facebook.com/groups/1503414633296362

- Information is current as of 11/14/2023.
- We will supply general information. All situations are specific so refer to specific guidance as necessary. This session is being recorded



Please type your questions in the Question box and submit them and if you raise your hand at the end of the session, we will open your line to ask a question.

Slides and Recording of this session will be posted to the Facebook Group and at www.ruralhealthclinic.com and on the Healthcare Business Specialists Youtube channel https://www.youtube.com/channel/UCXW4pkwNzDXVTMFrFwMy2_A

Upcoming Billing and Cost Reporting Webinars

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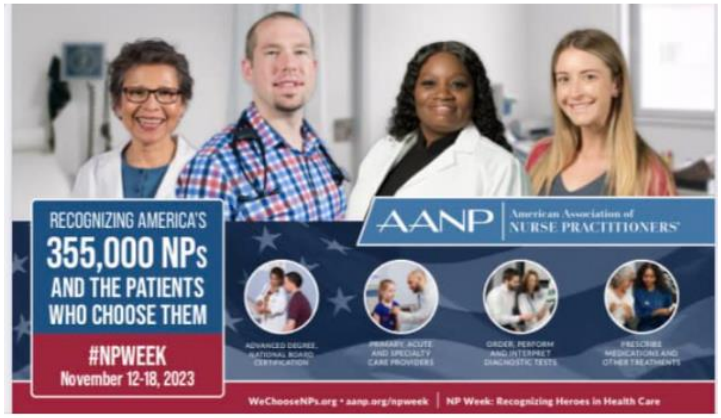

November 13, 2023
HBS Update

A big thank you to our Nurse Practitioners who provide excellent care to our rural and underserved communities through the 5,400 RHCs during Nurse Practitioner week. It is fitting that Nurse Practitioner week and Rural Health day (November 16, 2023) occur during the same week. We appreciate the sacrifice and dedication of nurse practitioners to develop the expertise and excellence to provide amazing healthcare to our rural and underserved residents.

https://conta.cc/3QXlYEI

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RHC Billing 101 – The Basics of Medicare billing for independent and provider-based RHCs with Amanda Dennison, MBA, CPC, CRHCP

Amanda Dennison, MBA, CPC, CRHCP, Senior Consultant from Blue & Co. will go over billing basics for RHCs including claim forms, incident to, definition of a visit, bill types, revenue codes, Medicare Advantage billing, and ancillary services. Medicaid billing will not be covered in this or any of the sessions. This session is sponsored by Blue & Co.

Please register for RHC Billing 101 – The Basics of Medicare billing for independent and provider-based RHCs with Amanda Dennison, MBA, CPC, CRHCP on Dec 5, 2023 1:00 PM EST at:

https://attendee.gotowebinar.com/register/3018262107910897494

RHC Billing 201 Lunch and Learn with Patty Harper RHIA, CHC, Principal, InQuiseek Consulting

In RHC Billing 201 Patty Harper, RHIA, CHC, Principal with InQuiseek Consulting will pick up where RHC 101 left off with more basics of RHC billing including billing examples, negative reimbursement, deductibles, coinsurance, chronic care management, telehealth billing, incident to billing, modifiers, condition codes, occurrence codes, Medicare secondary billing, etc. Sponsored by InQuiseek Consulting.

Please register for RHC Billing 201 Lunch and Learn with Patty Harper RHIA, CHC, Principal, InQuiseek Consulting on Dec 7, 2023 1:00 PM EST at:

https://attendee.gotowebinar.com/register/7385582766596485212

RHC Billing 301 – Advanced Subjects - Charles James, Jr., North American HMS

In this webinar Charles James from North American Healthcare Management Services will go over some advanced topics with billing examples, preventive services, mental health services, Telehealth, Chronic Care Management, etc. Sponsored by North American Healthcare Management Services.

Please register for RHC Billing 301 – Advanced Subjects - Charles James, Jr., North American HMS on Dec 12, 2023 1:00 PM EST at:

https://attendee.gotowebinar.com/register/6827726850548732761

http://www.ruralhealthclinic.com/rhc-webinars

RHC Cost Report

The Medicare Cost Report is a report (think tax return) that is required by Medicare of RHCs which reports expenses, encounters (visits), and other information that provides an annual accounting of RHC payments and costs from Medicare.

The new RHC Fact Sheet

Cost Reports

RHCs must file an annual cost report, including graduate medical education adjustments, bad debt, flu, pneumococcal and COVID-19 vaccines, and vaccine administration payments.

- Independent RHCs must complete Form CMS-222-17, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center (HCLINIC) Cost Report
- Provider-based RHCs located in a hospital must complete the entire M series of worksheets of Hospital Form (CMS-2552-10), Hospital and Hospital Health Care Complex Cost Report
- Provider-based RHCs that aren't located in a hospital must complete the RHC cost report Form CMS-222-17

We won't use costs for providing distant site telehealth to decide the RHC AIR, but you must report these costs on the proper cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services."

Note: We updated the RHC cost report to show costs related to COVID-19 vaccines, COVID-19 monoclonal antibody products, and their administration.

The Provider Reimbursement Manual – Part 2 has more cost reports and forms.

https://www.cms.gov/files/document/mln006398-information-rural-health-clinics.pdf

Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC)

80.1 - RHC Cost Report Requirements (Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23) RHCs are required to file a cost report annually in order to **determine their payment rate and reconcile interim payments,** including adjustments for **GME payments, bad debt, and influenza, pneumococcal and COVID-19 vaccines, and covered monoclonal antibody products** used as pre-exposure prophylaxis prevention of COVID-19 and their administration. If in its initial reporting period, the RHC submits a budget that estimates the allowable costs and number of visits expected during the reporting period. The A/B MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf

There are two types of RHCs for cost reporting purposes

Independent RHCs which are typically owned by physicians, NPs, PAs, non-hospital companies and hospitals with 50 or more beds (basically anyone). The entities file an independent or freestanding cost report (Form 222-97). **The are subject to the National Statutory Payment Limits.**

Provider-based RHCs are owned by hospitals and may have less than 50 beds or more than 50 beds. These RHCs file Medicare cost reports as an integral part of the Hospital cost report (M-series of the Form 2552-10). These clinics are subject to the National Statutory Payment Limits if certified in 2021 and after or the specified provider-based RHC's (Grandfathered) per visit AIR payment if certified in 2020 or earlier.

Three Types of Medicare Cost report

Full	Low Utilization	No Utilization
Medicare Interim Payments • Required if $50,000 or more in interim payments	**Medicare Interim Payments** • Less than $50,000	**Medicare Interim Payments** • None
Why? • Settles difference in interim and final rate. • **Reimburses Flu, Pnu, and Covid shots** • **Reimburses Bad Debts.**	**Why?** • Simple. • Must submit a letter indicating you qualify and a Balance Sheet and Profit and Loss statement.	**Why?** • Extremely Simple. • Must submit a letter and attach Worksheet S of cost report.
Professional Fees? • High	**Professional Fees?** •Medium	**Professional Fees?** • Low

Some clinics may elect to file a low utilization cost report if they do not have Influenza, Pneumococcal, Covid vaccines, or bad debts and they qualify.

If you think you qualify for a low or no utilization cost report, pull the P S and R early and let’s get it filed in early 2024.

RHCs may still consolidate cost reports except for grandfathered provider-based RHCs with a new RHC.

80.2 - RHC and FQHC Consolidated Cost Reports

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

RHCs and FQHCs with more than one site may file consolidated cost reports if approvedby the A/B MAC in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC or FQHC may not revert to individual reporting without the prior approval of the A/B MAC.

New RHCs (enrolled under section 1866(j) of the Act on or after January 1, 2021) are permitted to file consolidated cost reports with:

- *New RHCs that are provider-based,*
- *New RHCs that are independent,*
- *Existing independent RHCs, and/or*
- *Existing provider-based RHCs that are in a hospital that has more than 50 beds.*

In addition, specified provider-based RHCs are not allowed to file a consolidated cost report with a new RHC.

If an RHC does not submit a Medicare Cost report timely Medicare will stop all payments and demand all Medicare monies paid to the RHC during the fiscal year to be paid back to Medicare. Medicare and Medicaid payment rates are based upon these reports.

What does Medicare Settle on the Cost Report?

Difference between interim and final rate

Medicare Bad Debts

Flu & Pnu Shots Covid Vaccines & MABs*

Co-pays on Preventive services

Graduate Medical Education Costs

* Beginning 1/1/2024 MABs will not be settled on the cost report and are covered under Part B.

The Medicare Cost Report is due 5 months after the end of the Medicare fiscal year (as determined on the 855A). Extensions are rarely granted (the exception being the Covid Public Health Emergency). If your cost report fiscal year ends on 12/31/2023, your cost report is due on 5/31/2024.

Mandated Cost Reporting Timeframes

Description	Timeframe
Cost Report prepared by the clinic and due to Medicare	5 months year-end
Number of days the MAC has to accept the cost report	30 days
Number of days the MAC has to pay a tentative settlement	60 days
Time to final settle cost report	1 year from acceptance

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c08.pdf

Cost Report Deadlines for 12/31/2023 Fiscal Year Ends

#	Requirement	Due Date
1.	To claim Medicare Bad Debts, the bad debt must be written off by the fiscal year end (usually 12/31) – Still use Exhibit 2 – the old form	12/31/2023
2.	Liquidate accrued bonuses or payments to owners	75 days after year-end. March 16, 2024
3.	Liquidate accruals for non-owners.	One year after year-end. December 31, 2024
4.	Sign up with IDM for the P S and R and add Dani Gilbert, CPA as authorized cost report preparer in MCREF.	**12/31/2023**
5.	Cost Report Workpaper submission to HBS	3/1/2024
6.	**Visits and Provider FTE Reports due to Cost Report Preparer if you think you need a Productivity Standard Waiver**	**2/15/2024**

Electronic Cost Report Exhibit Templates updated 10/13/2023

https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/electronic-cost-report-exhibit-templates

Supporting Exhibit	Medicare Bad Debt Listing
Provider Name	
Provider Number (CCN)	
FYE	
Bad Debts For (Choose One)	
Prepared By	
Date Prepared	
Subprovider	

Totals									$0	$0	$0
Beneficiary Name	**MBI or HICN**	**Dates of Service - From**	**Dates of Service - To**	**Medicaid No.**	**Deemed Indigent**	**Remittance Advice Date - Medicare**	**Date First Bill Sent to Bene**	**Collect. Efft. Cease Date**	**Medicare Deductible and Coinsurance Amounts - Deductible**	**Medicare Deductible and Coinsurance Amounts -**	**Allowable Bad Debts**
1	2	3	4	5	6	7	8	9	10	11	12

https://www.cms.gov/files/document/medicarebd-rhc-cmhc-fqhc-esrd-snf-exhibit-1-template.xlsx

Medicare Cost Reports are filed electronically to Medicare using MCREF. This electronic filing is the easiest and most efficient way of fulfilling an RHC's annual cost report requirement. (you can still paper file the report for now)

Here is the link: https://mcref.cms.gov/

Identity Management (IDM) System

CMS created the IDM System to provide providers with a means to request and obtain a single User ID, which they can use to access one or more CMS applications.

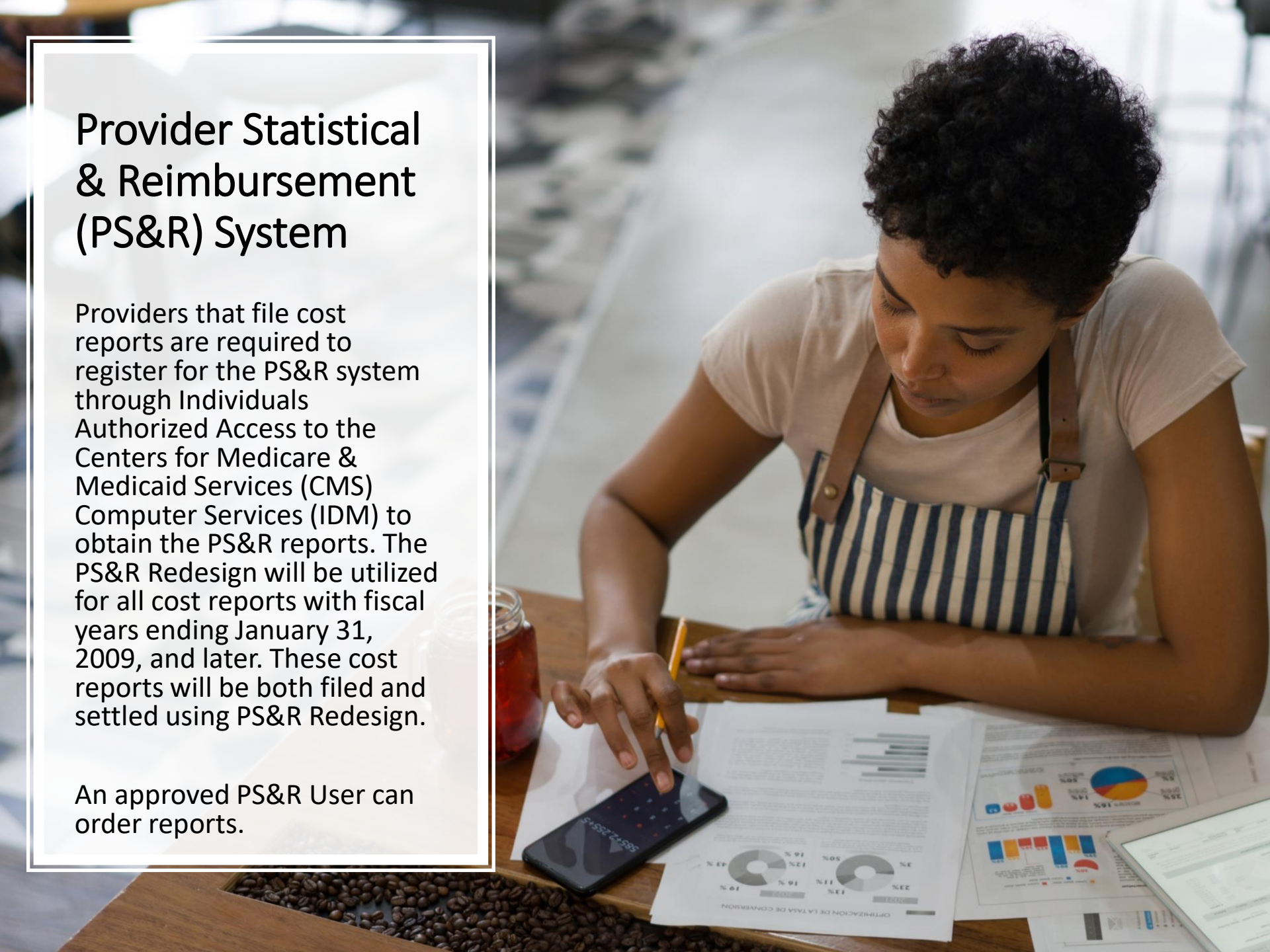
The IDM System provides the means for users to be approved to access many other CMS systems and applications. IDM governs access to CMS systems by managing the creation of user IDs and passwords, setting up multi-factor authentication (MFA), and the assignment of roles within CMS applications.

You can pull your PS&R reports and authorize your cost report preparer to submit the cost report electronically in MCReF.

Provider Statistical & Reimbursement (PS&R) System

Providers that file cost reports are required to register for the PS&R system through Individuals Authorized Access to the Centers for Medicare & Medicaid Services (CMS) Computer Services (IDM) to obtain the PS&R reports. The PS&R Redesign will be utilized for all cost reports with fiscal years ending January 31, 2009, and later. These cost reports will be both filed and settled using PS&R Redesign.

An approved PS&R User can order reports.



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When you assign responsibilities assign authorized Cost Report Preparer to Dani Gilbert, CPA (or your cost report preparer).

If you have issues, email Dani Gilbert at dani.gilbert@outlook.com or call (833) 787-2542, extension 1.

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The Advantages of Filing Cost Reports using MCReF

- The cost report filing process is much simpler and faster.
- You know that Medicare has accepted your cost report immediately.
- Your cost report is settled much quicker if filed electronically.
- You will make your cost report preparer happy.

So, what will be different?

1. You will need to designate someone as your authorized cost report preparer.
2. Your Medicare cost report will be filed electronically through a portal (think PRF).
3. You Medicaid cost report will be emailed to you, signed and then mailed, but some states allow us to email it to them (Tennessee)
4. You will not receive a leather-bound cost report package, but a PDF in your Client Portal.

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Steps for Filing the Medicare Cost Report

1. Sign BA and Cost Report agreements and send retainer

2. Receive Cost Report Checklist from HBS

3. Obtain information from Checklist (P S & R)

4. Upload to portal, Mail, Fax, Email information to HBS

5. HBS prepares the Report and mails to you or files electronically

6. Electronically file or Sign the cost reports and mail to Care/Caid

7. Receive Tentative settlement in 90 days.

8. Desk Review within 1 year of filing date.

We will have another RHC Cost Reporting Webinar in January 2024 with updated checklists and worksheets.

Medicare Cost Reports follow rules as outlined by the Center for Medicare & Medicaid Services (CMS) and instructions for completion of the cost report may be found here:

https://www.cms.gov/files/document/r3p246i.pdf

CFR 413.20 Requires RHCs to maintain good financial records

§ 413.20 Financial data and reports.

(a) ***General.*** **The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.** Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

Question – Is there a list of all allowable expenses for the cost report?

Answer – No, there are thousands of pages of reimbursement rules that you find on the next page.

Medicare RHC Cost Report Reimbursement Regulations

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

Consolidated Appropriations Act of 2021 (CAA) enacted on April 1, 2021

1. Independent and newly established Provider-Based RHCs are subject to Medicare Upper Payment Limits as established in the CAA.
2. Provider-based RHCs enrolled on, or before, December 31, 2020, are grandfathered from being subject to the Medicare Upper Payment limit but have controls on the rate of growth of their Medicare reimbursement rate.

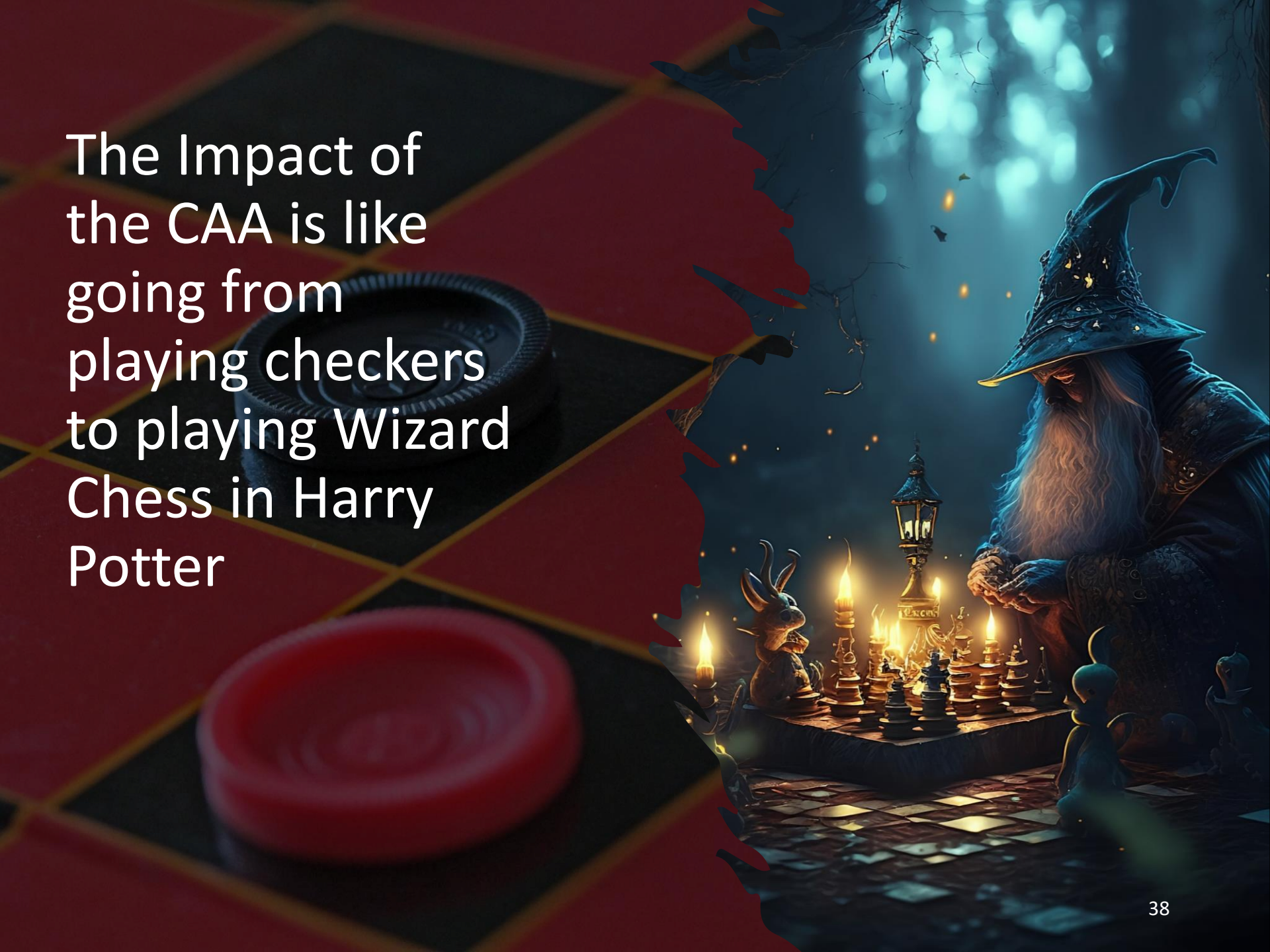
National Statutory Payment Limits for RHCs

Begin Date	End Date	Medicare Upper Limit
1/1/2020	12/31/2020	$ 86.31
1/1/2021	3/31/2021	$ 87.52
4/1/2021	12/31/2021	$ 100.00
1/1/2022	12/31/2022	$ 113.00
1/1/2023	12/31/2023	$ 126.00
1/1/2024	12/31/2024	$ 139.00
1/1/2025	12/31/2025	$ 152.00
1/1/2026	12/31/2026	$ 165.00
1/1/2027	12/31/2027	$ 178.00
1/1/2028	12/31/2028	$ 190.00
1/1/2029	12/31/2029	MEI

MEI = Medicare Economic Index

Laboratory, technical components, CCM, telehealth (except mental health starting in 2022) and hospital services are reimbursed outside the rate.

The Impact of the CAA is like going from playing checkers to playing Wizard Chess in Harry Potter



What has been the impact of the National Statutory Caps on Rural Health Clinics?

- Independent RHCs now can possibly recoup their actual cost of Medicare patients.
- All Provider-based RHCs are subject to a cap, either the National Statutory limit or the clinic's grandfathered rate.
- All RHCs will have to manage their costs better, plan, budget, and keep good cost report records as it does have real impacts on reimbursement from Medicare.

The Impact of Higher Medicare Caps for RHCs

RHCs will have to be much more strategic in the future. Planning will be required to avoid large paybacks and maximize rates.

Most Independent RHCs will have a difficult time keeping their cost per visit above the cap as they have in the past.

Provider-based RHCs may have costs above their 2020 updated AIR rate which will not be reimbursed by Medicare.

Cost reports will be subject to much more scrutiny in the future.

Records of provider time for productivity standards will become more important.

Understand the impact and accuracy of expenses related to cost of non-rhc services or services not computed in the All-Inclusive Rate.

Understand and count visits depending on if they are included in the All-Inclusive rate.

These changes have resulted in:

- Large payments from Medicare to RHCs for cost report settlements.
- Large paybacks by RHCs to Medicare for clinics whose costs did not keep up with National Statutory Limit increases or provider-based RHCs that’s costs outpaced their grandfathered rate
- Cost Reports taking more time and much more information required than in the past.

RHCs need a Plan and a todo or task list for Cost Reporting throughout the year.

Cost Reporting Resources at https://www.ruralhealthclinic.com/rhc-cost-reporting

RHC COST REPORTING

Healthcare Business Specialists, LLC prepares approximately 280 RHC cost reports annually for Independent RHCs. Mark R. Lynn, CPA, CRHCP, CCRS has over 35 years' experience working with RHCs and Dani Gilbert, CPA, CRHCP is a Certified Rural Health Professional accredited by the NARHC. Our team also includes Page Chambers, CIA, CRHCP, and Trent Jackson, CCRS goal is to prepare your Medicare cost reports as accurately and timely as possible within the constraints of tight independent RHC budgets. The following is a link that will open our RHC Cost Reporting brochure if you are interested in more information related to cost reporting services for RHCs.

Medicare cost reports for independent RHCs have become much more important since the passage of the Consolidated Appropriations Act of 2021 which dramatically increased the Medicare upper payment limits for rural health clinics. These large increases in the upper payment limits allow RHCs that properly prepare the Medicare Cost Report to obtain much more Medicare reimbursement; however, it could result in large paybacks to Medicare if interim rates are higher than the actual cost per visit. Interim cost reports are an effective way to monitor the actual cost per visit and plan for ways to maximize your Medicare reimbursement within Medicare cost reporting rules.

If you would like Healthcare Business Specialists to help prepare your cost reports, please email Mark Lynn or Dani Gilbert at ruralhealthclinic@outlook.com and we will put together a proposal for this service.

September 1, 2023: We have developed an RHC Cost Report Plan and Todo List that will help you to understand what you need to know to file a timely, accurate, and optimized cost report.

- RHC Medicare Cost Report Plan for 2024 in PDF format
- RHC Medicare Cost Report Plan for 2024 in Word format (editable)
- RHC Medicare Todo List for 2024 in PDF format
- RHC Medicare Todo List for 2024 in Word format
- Updated RHC Medicare Cost Reporting Instructions from CMS (July, 2022)
- HBS RHC Cost Report Client Electronic File to enter data for 12 31 2023 cost reports (Excel)

Our Cost Report Checklist for 2022 cost reports and other cost report resources can be found as follows:

- RHC Medicare Cost Report Checklist with Forms for 2022 (23-page PDF)
- RHC Medicare Cost Report Checklist Only (3-page PDF)
- RHC Medicare Visit Count Sheet for 2022 (7-page PDF)
- Healthcare Business Specialists Brochure for Cost Report Services
- MCReF User Manual (45 page PDF)
- MCReF FAQs (5 page PDF)
- Provider Reimbursement Manuals CMS Listing by Chapter
- Cost Report Waiver of Productivity Screen Worksheet from WPS (Excel Spreadsheet)
- Sample Chart of Accounts for a Rural Health Clinic

We have prepared a webinar to help gather the information to prepare the cost report which will occur on January 19, 2023 at 1:00 PM Eastern time. Please register below to attend the webinar. The session will be recorded for later viewing if the time.

Sample RHC Cost Report Plan and ToDo List

RHC Cost Reporting Plan

12/31/2024

Objective: The objective of this plan is to facilitate the completion of the Rural Health Clinic cost report that results in:

1. The Medicare Cost Report filed timely, accurately, and optimizing Medicare reimbursement while following all Medicare guidance regarding the allowability of costs and accounting for the number of patient encounters.
2. The Medicaid Cost Report filed timely, accurately, and optimizing Medicaid reimbursement while following all Medicaid guidance regarding the allowability of costs and accounting for the number of patient encounters.
3. The Form 838 Credit balance reports will be submitted timely each quarter to avoid Medicare stopping RHC payments.

Plan: The RHC will do the following during the year to achieve the objectives mentioned above:

1. Establish an accrual-based accounting system that captures information as required in the cost report including the following:
    A. Salaries of physicians, NPs, PAs, RNs, LPNs, MAs, CPS, CSWs, Lab personnel, Radiology personnel, Chronic Care Management personnel, Office personnel, and other categories of employees if applicable.
    B. Accounts to record the expenses of Influenza, Pneumococcal, and Covid vaccines in the general ledger.
    C. Accounts to track the expenditures not included in the computation of the RHC All-Inclusive rate including:
        a. Telehealth (exception Mental Health Telehealth)
        b. Laboratory services including the six required lab tests.
        c. Hospital services
        d. Any time that is non-RHC such as a spa and Botox that is not covered by Medicare, sports physicals, weight-loss services including semaglutide and similar type products.
        e. Technical components of radiology services including EKGs.

http://www.ruralhealthclinic.com/rhc-cost-reporting

f. The cost of providing Chronic Care Management services.
g. Other services that may not be covered under the RHC benefit.

D. Account for Outside contracts or Professional Services by including the costs in the general ledger account that most closely identifies what the professional service was for i.e.
   a. Chronic Care Management
   b. Medical Director Professional Fees
   c. Contracted NPs or PAs
   d. Contracted Management services
   e. Any other professional service

2. Develop a system to create records of time spent for the following services.
   a. Physician time includes medical direction, patient time, supervision of NPs/PAs, administrative tasks, and other duties.
   b. Conduct time studies to determine the amount of time it takes to administer influenza, pneumococcal, and Covid vaccinations.
   c. Conduct time studies to determine the amount of time lab and technical components of radiology services takes to complete.
3. Maintain logs for Influenza, Pneumococcal, and Covid vaccinations with the patient's name, MBI number, and date of the injection. You only need logs for Medicare patients and possibly Medicaid patients. You will need to keep up with the total shots and submit a copy of the invoices where you paid for the shots.
4. Review the Medicare rules for Related Party Transactions and identify any vendor or person that may be a related party and keep good records on time spent and the actual cost of services.
5. Develop a capitalization policy for purchases of assets including real estate, equipment, technology, and other expenses assets that have a useful life of more than one year, implementing and following these policies when making purchases.
6. Engage experienced RHC cost report consultants to prepare the cost report. A list of vendors with experience in this area is provided on the NARHC website: https://www.narhc.org/narhc/Consultants Vendors1.asp
7. Begin registering and updating your credentials updated in the IDM system, so the clinic has access to the P S and R report and can file the Medicare cost report electronically. https://home.idm.cms.gov/signin/login.html
8. Plan on producing a CPT Frequency Report by Provider for the cost report fiscal year to submit to the cost report preparer. Do not use a report by insurance companies as that will overstate visits.
9. Inform your cost report preparer of any lump sum settlements or paybacks to Medicare for the current fiscal year as they must be included in the cost report settlement.

10. If you plan on claiming Medicare Bad Debts on the cost report, the accounts must be written off and collection efforts cease before the end of the fiscal year if you want them to be claimed on the current cost report.
11. During the fiscal year, prepare interim cost reports that project the estimated cost per visit. This will help you determine if any action can be taken to improve your rate or help you anticipate any lump sum payment.

Finally, the RHC should plan on getting the cost report information into the cost report preparers early. The cost report is due 5 months after the fiscal year end and the cost report preparers need the cost report workpaper submission no later than 60 days before the cost report submission deadline. Cost Reports take more time than they did in the past due to the complexity of increased rates and the number of services that must be carved out as they are paid on a fee for service basis and not included in the All-Inclusive rate calculation.

Good luck with your Medicare and Medicaid cost reporting. We understand it is becoming more and more of a burden as more information is being requested to accurately prepare Medicare and Medicaid Cost Reports.

Resources

- RHC Medicare Cost Report Checklist with Forms for 2022 (23-page PDF)
- RHC Medicare Cost Report Checklist Only (3-page PDF)
    - RHC Medicare Visit Count Sheet for 2022 (7-page PDF)

Cost Report Checklist or Todo List - Calendar

RHC Cost Report Todo Listing for 12/31/2024

Cost Report Todo Listing

January, 2024

1. Review changes in Medicare RHC payment and cost reporting policies and make changes to the Chart of Accounts (typically Quickbooks) to record expenses of services that are not included in the AIR calculation.
2. Start keeping logs for Flu, Pnu, and Covid vaccinations (Patient Name, MBI, and date of injection)
3. For one week, have your providers keep up with their time and log it for cost reporting purposes.
4. Watch for a new rate letter from your MAC as the National Statutory rates increase on January 1 of each year.
5. Identify any related party transactions

April, 2024

1. Prepare and submit the Form 838 Credit Balance report for quarter ending 3/31/2024 for Medicare.
2. For one week, have your providers keep up with their time and log it for cost reporting purposes.

July, 2024

1. Prepare an interim Medicare Cost Report (and possibly a Medicaid cost report if applicable) estimating the cost per visit and compare the result to interim Medicare payment rate.
2. Prepare and submit the Form 838 Credit Balance report for quarter ending 6/30/2024 for Medicare.
3. Order Flu, Pnu, and Covid vaccines. Keep the invoices and record in a general ledger account. Make sure to use Flu, Pnu, and Covid Logs.
4. For one week, have your providers keep up with their time and log it for cost reporting purposes.

October, 2024

1. Prepare and submit the Form 838 Credit Balance report for quarter ending 9/30/2024 for Medicare.
2. Reach out to your cost report preparer or find one to prepare your 2024 cost report and ask them to be your Authorized Cost Report Preparer.
3. If the clinic does not have access to the IDM system, go ahead and start that process so you have access to the P S & R and can appoint an Authorized Cost Report Preparer.
4. If you have Medicare Bad Debts start reviewing your accounts receivable and start completing the Excel spreadsheets to claim Medicare bad debts for debts, you have ceased collection efforts and have written off.
5. For one week, have your providers keep up with their time and log it for cost reporting purposes.

December, 2024

1. Prepare a second interim cost report to determine your cost per visit as compared to the interim payments.
2. If the clinic is a corporation and plans on paying a bonus for owners determine the bonus amount and document in a meeting for payment within 75 days of year-end.
3. Finalize writing off any bad debts and completing the Excel spreadsheet before 12/31/2024.
4. Review the clinic's cash position and pay as many bills as possible to eliminate the need to accrue a lot of expenses.

January, 2025

1. Review checks paid and payroll paid in January 2025 and accrue expenses appropriately and reverse any prior year accruals.
2. Prepare and submit the Form 838 Credit Balance report for quarter ending 12/31/2024 for Medicare.
3. Begin accumulating information to submit for the cost report including provider time studies which should be done at least quarterly.

March, 2025

1. Liquidate any accrual to the owner of the RHC by March 15th.
2. Submit your cost report information to your cost report preparer by March 31, 2025 including a detailed general ledger and summary of payment to all outside contracts and what services were procured.

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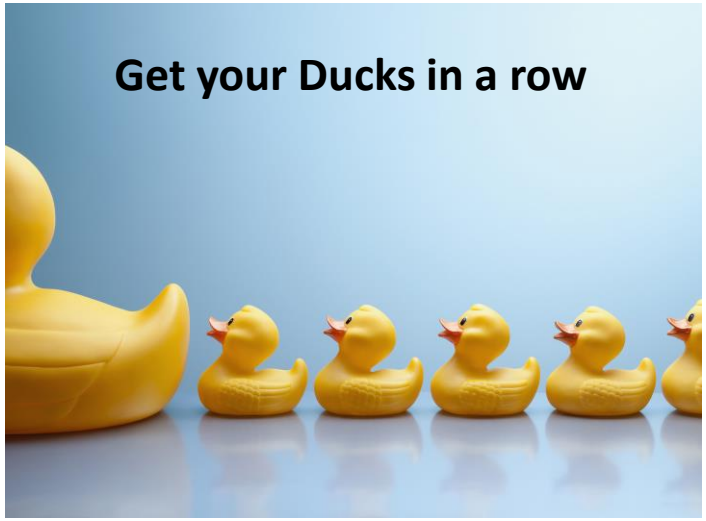
December requires planning and action to maximize reimbursement and minimize taxes

Advice after injury is like medicine after death.

-Danish Proverb

You should have discussions in December with the following:

1. Your Tax Accountant
2. Your Cost Report Preparer
3. Your PRF and Grant funds advisor.



Things that must be done in December

- Write off bad debts if you are claiming bad debts and have a 12/31/2023 fiscal year end.
- Spend or use for lost revenues any unused PRF Funds with a 12/31/2023 deadline for use of the funds. **Note: Lost revenues will not count as an allowable expense on the cost report and using the funds to pay expenses may help you receive a higher settlement and rate from Medicare.**
- Cash accounts should be reviewed with your tax accountant and as much as possible bonused out to owners in corporations and S-Corps.
- The deadline to make contributions for an employer-sponsored 401(k) plan for 2022 is **December 31**
- **Other retirement plans will differ so check with your tax CPA.**
- **You may want to adjust your rent if it is a related party transaction – Discuss with your tax CPA.**

Accrual of Expenses

- Medicare cost reports are filed using accrual basis accounting which means costs are recorded when incurred and not when actually paid.
  - Accruals of compensation to owners and certain self funded insurance programs must be liquidated within 75 days of year-end.
  - Accruals to non-owners must be liquidated within 12 months of the fiscal year end.
  - Some Examples:
    - Expenses incurred in 2022 and not paid until 2023 (look at your January and February check register for December 2022 expenses)
    - Pension plan contributions for 2022 not paid until 2023
    - Payroll due to employees not paid in 2022 and paid in 2023.
    - Accrued Vacation and Sick pay for employees.

  - https://www.law.cornell.edu/cfr/text/42/413.100

Allowable Owner Compensation

Medicare Allowable Owner Compensation depends on the type of Entity

- Owner compensation allowances for the different entity types:
  - Sole proprietor - Schedule C = value of services
  - LLC (single member) - Schedule C = value of services
  - LLC (multiple member) - K-1 from Form 1165 = value of services
  - Corporation – K-1 from Form 1120 = **Actual compensation paid or accrued and paid within 75 days of FYE.**
  - S-Corporation – "Under Federal income tax law, certain corporations can elect to be treated for tax purposes as a partnership. This election, however, has no effect on reimbursement under the Medicare program, and an owner of a Subchapter S corporation is not considered a partner for purposes of this principle."
  - Some states do not recognize these Medicare rules for allowable compensation, so consult with someone who knows your state Medicaid rules on allowable owner compensation.

Summary of Owner Compensation Treatment for Medicare Cost Reports

Description	Value of Services	Comp Must be Paid	75 Day Accrual
Sole Proprietor	X		
LLC (Single or Multiple Member)	X		
Corporation		X	X
Sub-S Corporation		X	X

Medicare rules related to Owner Compensation may be found here:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R474PR1.pdf

907. COMPENSATION-SOLE PROPRIETORSHIPS AND PARTNERSHIPS

A. General.--The allowance of compensation for sole proprietors and **partners is the value of the services rendered by the owner. Such an amount may or may not be represented as actual payments made to the owner. There is no direct relationship between the compensation allowance of the owner and the amount of operating profit (or loss) of the facility. I**n determining the allowance, the contractor is responding to a claim for the value of the services of the owner. That is, the institution will include in its statement of reimbursable cost an allowance for the value of the owner's services and the contractor evaluates the reasonableness of this claim by applying the criteria in this chapter.

B. Actual Payments Made.--Where a provider has claimed as some other cost (for example, see §906.1) an amount paid to a sole proprietor or partner, such amount is combined with the allowance claimed by the provider for the owner's services. This total is then used for determining the reasonableness of the compensation allowance claimed.

Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics
By Census Bureau Regions and Divisions
Per FTE

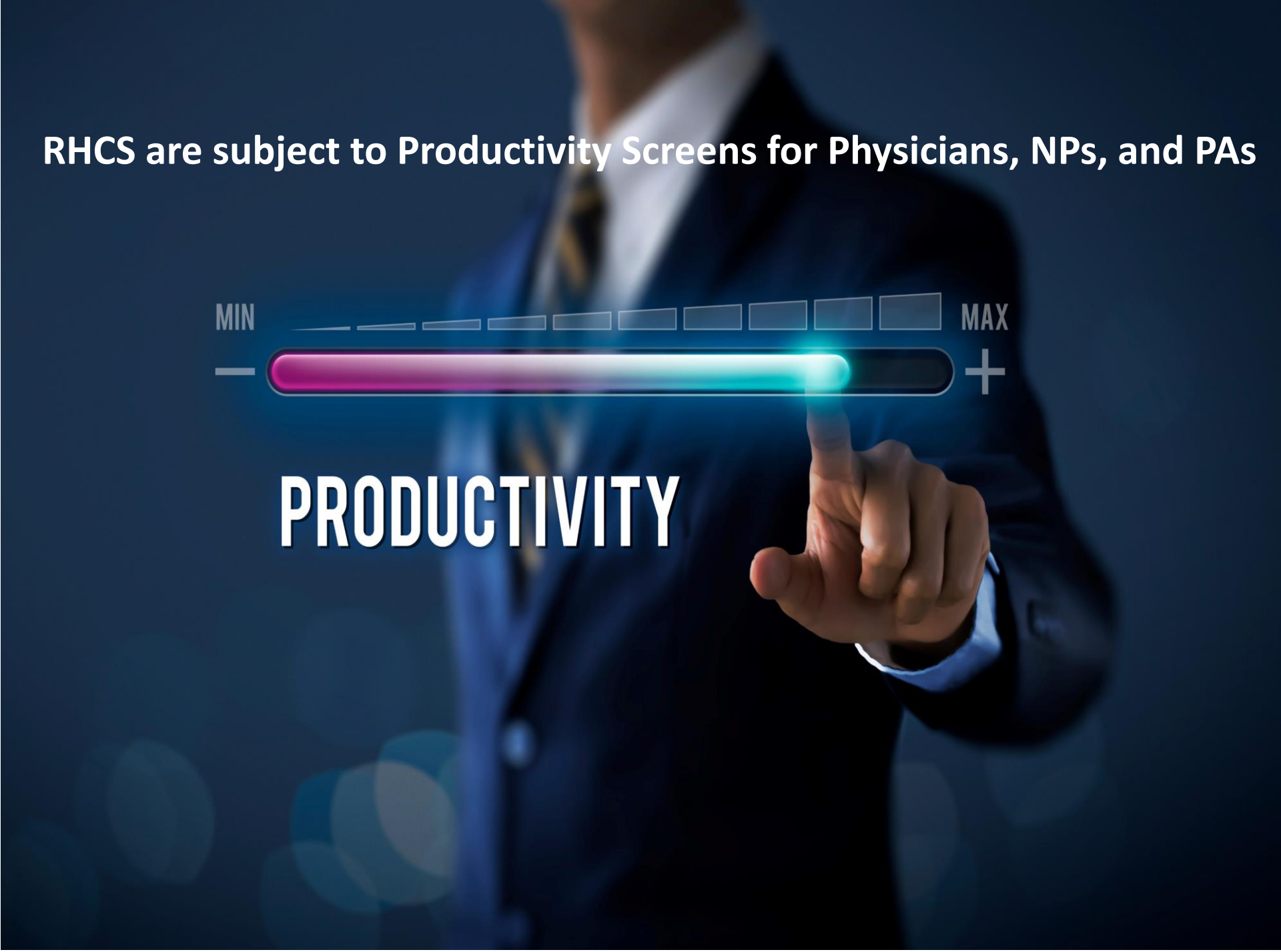
Region	Division		2009		2010		2011		2012		2013		2014	
		Factor*: →	0.017		0.015		0.020		0.020		0.019		0.019	
		* Source: §905.6.	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
1	1	New England	$275,890	$306,762	$280,029	$311,364	$285,629	$317,591	$291,342	$323,943	$296,877	$330,098	$302,518	$336,370
	2	Middle Atlantic	$213,095	$223,657	$216,292	$227,012	$220,618	$231,552	$225,030	$236,183	$229,306	$240,670	$233,663	$245,243
Subtotal - Region 1: Northeast			$252,636	$264,593	$256,425	$268,562	$261,554	$273,933	$266,785	$279,412	$271,854	$284,721	$277,019	$290,131
2	3	East North Central	$251,684	$276,027	$255,459	$280,167	$260,569	$285,771	$265,780	$291,486	$270,830	$297,024	$275,976	$302,667
	4	West North Central	$266,258	$285,384	$270,252	$289,665	$275,657	$295,458	$281,170	$301,367	$286,512	$307,093	$291,956	$312,928
Subtotal - Region 2: Midwest			$260,249	$281,442	$264,153	$285,663	$269,436	$291,376	$274,825	$297,204	$280,047	$302,851	$285,368	$308,605
3	5	South Atlantic	$218,079	$233,894	$221,350	$237,402	$225,777	$242,150	$230,293	$246,993	$234,669	$251,686	$239,128	$256,468
	6	East South Central	$250,876	$268,628	$254,640	$272,658	$259,732	$278,111	$264,927	$283,673	$269,961	$289,063	$275,090	$294,555
	7	West South Central	$233,620	$244,568	$237,124	$248,236	$241,867	$253,201	$246,704	$258,265	$251,391	$263,172	$256,167	$268,172
Subtotal - Region 3: South			$236,132	$245,690	$239,674	$249,375	$244,468	$254,363	$249,357	$259,450	$254,095	$264,380	$258,923	$269,403
4	8	Mountain	$261,423	$298,011	$265,344	$302,481	$270,651	$308,530	$276,064	$314,701	$281,309	$320,680	$286,654	$326,773
	9	Pacific	$275,667	$301,697	$279,802	$306,223	$285,398	$312,347	$291,106	$318,594	$296,637	$324,647	$302,273	$330,815
Subtotal - Region 4: West			$270,217	$300,186	$274,270	$304,689	$279,756	$310,782	$285,351	$316,998	$290,773	$323,021	$296,298	$329,158

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

NP and PA Owner Compensation Allowances are not published. MGMA Surveys or Medicaid Audit Allowances will be a good guideline.

RHCS are subject to Productivity Screens for Physicians, NPs, and PAs



Health Care Provider FTEs

- Cost report requires separation of provider visits, time, (and cost):
- Physician
- Physician Assistant
- Nurse Practitioner
- Visiting Nurse
- Clinical Psychologist
- Clinical Social Worker

The Provider FTE calculation is important For Productivity Calculations (based up a 2,080 Hour work year)

Provider Type	Minimum Annual Productivity based upon 40-hour work week	Daily Productivity based upon 250 work days	Monthly Productivity
Physician	4,200	16.8	350
Nurse Practitioner/ Physician Assistant	2,100	8.5	175

Productivity standards are computed in aggregate, so a high performing provider and make up the difference if any of the providers productivity falls below the productivity standard.

Productivity Standards Documentation – FTE Calculations

- 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)
  - –Administrative time
  - –Committee time
  - **- Telehealth or Telemedicine 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.

Time Studies for Provider FTEs

Rural Health Clinic Physician Time Study

Physician Name: _____ Date: _____

Physician Signature: _____

To complete, place an "X" in the appropriate box for each 15-minute increment to identify the activities performed.

		Part A - Provider Component					RHC Component	
		Supervision	Committee Work	Administration of Department	Quality Control	Emergency Room Availability	Patient Services	Documentation
0:00	0:15							
0:15	0:30							
0:30	0:45							
0:45	1:00							
1:00	1:15							
1:15	1:30							
1:30	1:45							
1:45	2:00							
2:00	2:15							

Important: Time doing Telemedicine does not Count in your FTE Count

Related Party Transactions

Related Party Transactions Major Points

- Transactions between family members or entities with common ownership may be considered related parties.
- Because the Medicare caps have increased dramatically related party transactions may now negatively affect the Medicare settlement.
- Identify related parties and reduce expense to actual expense.
- Do not try to create a large profit as that will cause otherwise allowable expense to be disallowed and will lower your cost per visit.
- Some cost report issues are failure to identify all related party transactions and not applying the Section 1010 exception when applicable.

Related Party Regulations per the Oregon CRF

- Current through Register Vol. 61, No. 4, April 1, 2022
- (1) **A "related party" is an individual or organization that is associated or affiliated with, or has control of, or is controlled by the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) furnishing the services, facilities, or supplies:(a) "Common ownership" exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;**
- (b) "Control" exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.
- (2) The Division allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, to the extent that they:(a) Relate to Title XIX and Title XXI client care;
- (b) Are reasonable, ordinary, and necessary; and
- (c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.
- (3) **The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.**
- (4) Clinics must disclose a related party who is separately enrolled as a provider with the Division and furnish the provider's NPI and associated taxonomy code(s).
- (5) Documentation of costs to related parties shall be made available at the time of an audit or as requested by the Division. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.
- (6) **The Division will allow rental expense paid to related individuals or organizations for facilities or equipment to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the FQHC and RHC Administrative Rules.**
- (7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC's cost statement report.

https://www.law.cornell.edu/regulations/oregon/OAR-410-147-0540

Related Party Transactions will be more impactful in the future.

- Provide the actual cost of the transaction. For example, related party rent would produce mortgage interest, repairs, insurance, property taxes and depreciation. Your cost report preparer will need a Schedule E from the tax return (1 owner) or the rental company's tax return (2+ owners).
- Identify employees who are related (family members) to the owners and the compensation paid to these related family members.

Example of Related Party Rent Impact

Assumptions

Rent	200,000
Actual Cost	50,000
Disallowed	150,000

Revised Rent Assumptions

Rent	50,000
Actual Cost	50,000
Disallowed	0

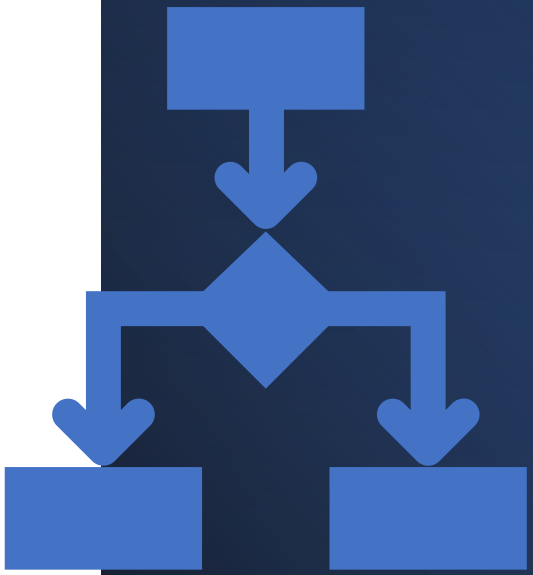
			Revised Rent
Description	2021	2022	2022
Total Expenses	1,500,000	1,500,000	1,500,000
Related Party Costs Disallowed	150,000	150,000	-
Allowable Expenses	1,350,000	1,350,000	1,500,000
Total Cost Report Visits	12,500	12,500	12,500
Cost Per Visit	108	108	120
Medicare Cap	100	113	113
Medicare Visits	3,000	3,000	3,000
Reimbursement Impact	-	(15,000)	-

Revised Rent Assumption: Instead of rent, allowable compensation is paid to the owners of the building and their compensation is increased on the cost report.

Talk to your Tax CPA: Rental income is not subject to FICA taxes; however, FICA taxes are only paid on the first $160,200 of earnings in 2023 (no limit on Medicare portion).

1010 Exception

- **(d) *Exception.***
- **(1)** An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the contractor, that—
- **(i)** The supplying organization is a bona fide separate organization;
- **(ii)** A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;
- **(iii)** The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and
- **(iv)** The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.
- **(2)** In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.



https://www.law.cornell.edu/cfr/text/42/413.17

How to count visits or encounters on an RHC Cost Report

Counting cost report visits is more of an Art than a science

What do we need to count visits?

A CPT Frequency Report by provider for the time period of the cost report. We need visits by Physicians, NPs, PAs and mental health providers

What is needed to count Visits

- We need a CPT Frequency report broken down by provider only (not payor). If you have a lot of physicians and only one NP, you can run a CPT frequency report for the practice and then one for the NP or vice versa (you have several NPs and only one physician) We do need physicians, NPs, PAs, LCSWs, and CPs broken out for cost reporting purposes.

Question – Why is a CPT report by Payor not the best way to count visits for the RHC AIR calculation?

Answer – Because many patients have a primary and secondary insurance and these reports tend to overstate the number of visits which hurts your cost per visit.

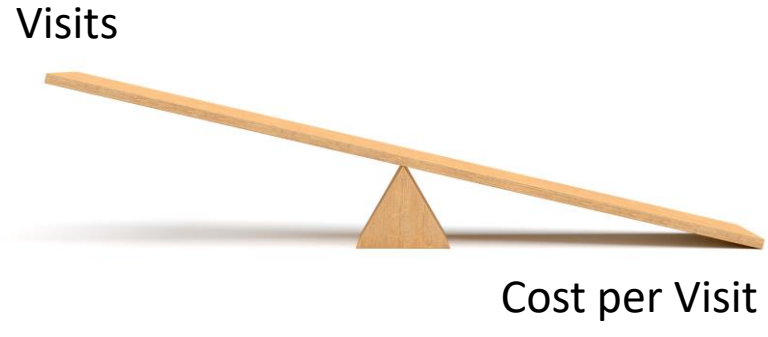
Health Care Provider FTEs

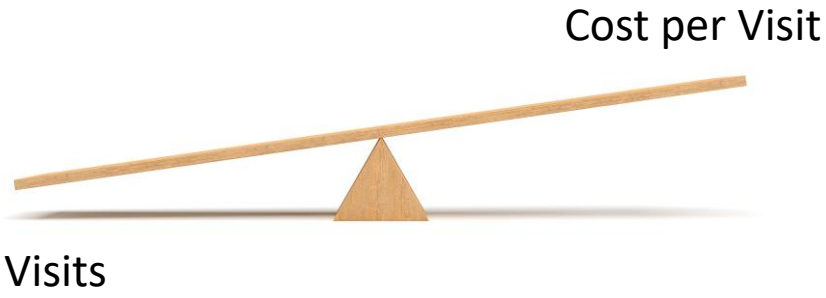
Cost report requires separation of provider visits, time, (and cost):

Physician
Physician Assistant
Nurse Practitioner
Visiting Nurse
Clinical Psychologist
Clinical Social Worker

Cost Per visit is computed as follows?

Total Allowable expenses divided by Total Visits (face to face encounters with Physicians, NPs, PAs, etc). Total visits includes all payor types. The best source of this information is a CPT Frequency report by provider.





What happens if you overcount Visits?

Billing and Coding Crosswalk Cheat Sheet

Service	Example Coding CPT	Example Billing HCPCS	Payment	Cost Report Visit?	Allowable Medicare Cost?	Notes
Medicaid Visit (in some states)	**99213 (QVL)**	**T1015**	**AIR**	**Yes**	**Yes**	**Only count 1 visit on your RHC Cost Report**
Telehealth Visit	99213	G2025	$97.24	No	No	Medicaid may pay AIR
Mental Telehealth Visit (starting in 2022)	90834	90834 CG 95	AIR	Yes	Yes	Keep records on the costs of two different types of telehealth visits
Virtual Communication Services (G0071)	99421	G0071	$23.88	No	No	Exclude cost on cost report.
Chronic Care Management	99484	G0511	79.25	No	No	Exclude cost on cost report.

Note: The CPT Code column is not an all-inclusive list of CPT codes.

Why are Visits so Important?

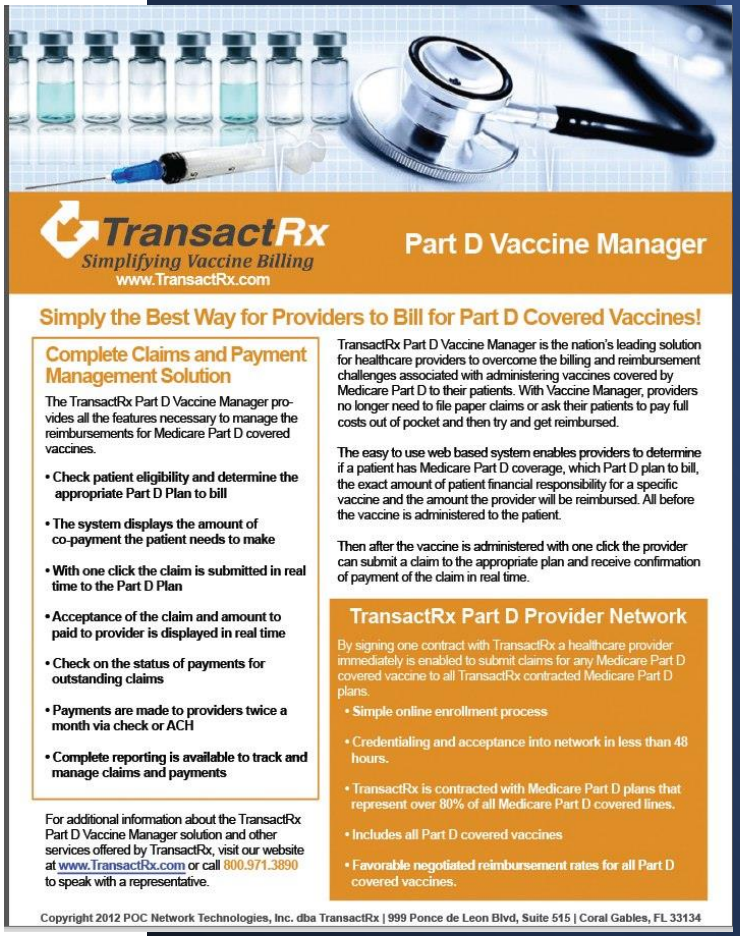
Visits are important because
They are the denominator in
The cost per visit calculation.

Do not count 99211 visits,
Injections, lab procedures,
hospital visits, non-rhc visits

Covid-19 Vaccine Changes in 2022

RSV Vaccine does not go on the cost report

- If you attend the Virtual NARHC office hours, you will hear a lot of questions regarding Medicare Part D and the new RSV vaccine. Here are some resources that will help you understand the complicated process of getting paid for these vaccines. The Inflation Reduction Act made adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) available at no cost for people with Medicare prescription drug coverage.
- https://fortune.com/.../does-medicare-cover-vaccines.../
- https://www.cms.gov/.../vaccines-part-d-factsheet...
- https://www.transactrx.com/medicare-part-d-billing



MABs will be reimbursed through the cost report AIR starting January 1, 2024

COVID-19 Monoclonal Antibody Therapies & Vaccines

For COVID-19 monoclonal antibodies used for post-exposure prophylaxis or treatment of COVID-19, we'll continue to pay at 100% of reasonable cost through the cost report through the end of the CY in which the Emergency Use Authorization (EUA) declaration for COVID-19 drugs and biologicals ends. The EUA declaration is distinct from, and not dependent on, the COVID-19 public health emergency (PHE).

Starting January 1 of the year after the EUA declaration ends:

- We'll pay you for monoclonal antibody products used for **post-exposure prophylaxis or treatment** of COVID-19 in the same way we pay for other Part B drugs and biological products through the RHC AIR
- We'll continue to pay for covered monoclonal antibody products and their administration when used as **pre-exposure prophylaxis for prevention** of COVID-19 at 100% of reasonable cost through the cost report

An RHC can't bill a visit when the practitioner only sees a patient to administer a vaccine. Instead, the RHC includes vaccines and their administration on the annual cost report, and we reimburse them at cost settlement. Patients pay no Part B deductibles and coinsurance for these services.

https://www.cms.gov/files/document/mln006398-information-rural-health-clinics.pdf

Covid-19 Vaccines and MABs by Medicare Advantage Plan Patients are no longer reimbursed on the Cost Report

Year	Pnu	Flu	Covid Vaccine	MABs
2021	Originial	Originial	Originial & Advantage	Originial & Advantage
2022	Originial	Originial	Originial	Originial
			No changes to in 2023	No changes to in 2023

- **COVID-19 Vaccines in RHCs**

  COVID-19 vaccines and their administration will be paid the same way influenza and pneumococcal vaccines and their administration are paid in RHCs. Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The beneficiary coinsurance and deductible are waived. For patients enrolled in Medicare Advantage, COVID-19 vaccines and their administration costs, as well as, monoclonal antibody products and their administration costs should be included on the RHC cost report. For additional information, please see https://www.cms.gov/covidvax.

https://www.cms.gov/covidvax

Covid Vaccine & Monoclonal Injections/shots

- Both are currently reported on the cost report like flu and pnu and reimbursed at cost. Keep a log. In 2024 MABs are reimbursed as a part of the AIR (incident to).
- Keep up with Medicare Advantage/Replacement Covid shots separately and do not include in the Medicare line on the cost report.
- Keep up with your cost of supplies and direct expenses in a separate general ledger account.
- Keep good time records for administration time.

- https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion?fbclid=IwAR0b56IOR4fYBDh53ex2Ifrg3OC9dd1hHCm7e6aibbQNWt-D1YaLAy-VWF8

Influenza, Covid and Pneumococcal Shot Logs

Patient Name	MBI Number	Date of Service
John Smith	411992345A	11/30/2022
Steve Jones	234123903A	12/15/2022
Ashley Taylor	903214934A	12/31/2022

Medicare Influenza and Medicare Pneumococcal shots should be maintained on separate logs. Pnumo pays around $250 per shot and influenza is $60 or so.

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Medicare Influenza Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Page Number		Page Total		Total Medicare Flu Shots	

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Healthcare Business Specialists

Medicare Pnemococcal Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
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20			

Page Number		Page Total		Total Medicare Pnu Shots	

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Healthcare Business Specialists

Medicare COVID-19 Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Page Number		Page Total		Total Medicare Covid Shots	

Capitalization and Depreciation Expense

Differences in Tax and Medicare Depreciation

Description	Tax	Medicare
Method	Accelerated - MACRS	Straight-Line
Capitalization Threshold	$2,500 or $5,000	$5,000
Section 179 Deduction	1,080,000, automobiles is less	Not Applicable
Useful Life	Typically, 3 years	Use the AHA guidelines. Typically, 5 to 7 years

- Capital purchases of less than $5,000 may be expensed under Medicare rules.
- Medicare assets will be depreciated on a straight-line basis using the AHA useful life guidelines.

Cost Report Repayments to Medicare

- Many of the MACs did the following:
  - Increased the interim rate above the cap
  - Paid Interim Settlements during the year.
- This resulted in the following:
  - Much smaller settlements to RHCs
  - Some RHCs paying back monies to Medicare
  - RHC Consultants having to do a lot of explaining
  - **If you do not tell us you received an interim settlement, we will not know, and you may end up paying back Medicare money.**

Report any Interim Payments to us so we can include on the cost report

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Worksheet C-1
Analysis of Payments to RHCs for Services Rendered

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

Interim Lump Sum Payments to RHCs

In recent years, the MACs are issuing interim lump sum payments (and occasionally a withhold of payment) to RHCs which are a part of the annual Medicare Cost Report Settlement. These payments or withholds must be recorded on Worksheet C-1 or it may result in a payback to Medicare on settlement of the cost report. If you received an interim payment or withhold please report this information to us below and provide the letter emailed to you documenting the payment or withhold.

Please provide the date and amount of Interim Payments or Withholds

Date of Interim Payments	Amount

Note: Failure to report these payments or withholds will affect the settlement of your cost report and may result in a payback to Medicare when the cost report is final settled. Please make an effort to identify any such payments to avoid the potential payback to Medicare.

Interim Payments to be reported on the Cost Report

Lump Sum/Rate Change Summary

RE: Provider: [redacted]
Provider Number:
Fiscal Year End: 12/31/2023
Subunit Name: n/a
Subunit Number: n/a

Payment Type	Effective Date	New Rate	Current Rate	LSA	Determination Date
Part B Per Visit	*	106.13	106.13	$ 1,719	
TOTAL				$ 1,719	11/14/2023

* = No Change

Why are you having to payback Medicare on the cost report?
You did not give as many Medicare flu and pnu as the previous year.
Your Interim Rate was too high as estabilished by the MAC (above the cap)
Your Medicare visits increased substantially during the year.
You did not claim bad debts or have a smaller amount of bad debts.
You received an interim settlement and did not tell your CR preparer.

Medicare Bad Debt Reimbursement is 65% of uncollected Medicare Co-insurance and Deductibles

Medicare Bad Debt represents money on the table

Medicare Bad Debt Summary

A provider's bad debts resulting from Medicare *deductible and coinsurance* amounts that are uncollectible from Medicare beneficiaries are considered in the program's calculation of reimbursement to the provider if they meet the criteria specified in 42 CFR 413.89.

Per 42 CFR 413.89(e), a bad debt must meet the following criteria to be allowable:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts.
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

https://med.noridianmedicare.com/web/jea/audit-reimbursement/audit/bad-debt

A Medicare Bad Debt must meet the following Criteria:

1. The debt must be related to a covered service and derived from the Deductible and Coinsurance amounts.
    A. No Fee for Service. IE. Hospital, Technical Components.
    B. No Medicare Advantage plans.
2. The provider must be able to establish that reasonable collection efforts were made.
    A. At least 120 days of collection after first bill.
    B. First Bill as least within 120 days after the date of the Medicare RA or the RA from the beneficiary's secondary payer, if any; whichever is latest.
    C. Four documented collection efforts made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment indicated there was little likelihood of recovery in the future.

Source: 42 CFR 413.89(e)

Bad Debt Classification

Providers claiming Medicare bad debt must meet 42 CFR 413.89 and all requirements from Chapter 3 of the Provider Reimbursement Manual (https://go.usa.gov/xEuwD).

9-74 BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES 300

300. PRINCIPLE
Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program.

302. DEFINITIONS

302.1 Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

302.2 Allowable Bad Debts.--Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.

What Constitutes Reasonable Collection Efforts?

- Subsequent billings
- Telephone calls
- Collection letters
- Use of collection agency
  - A collection agency can be used in addition to or in lieu of other reasonable collection efforts
  - Any costs associated with the collection agency are allowable to be included as expenses on the cost report but are not allowed to be claimed as part of the bad debt.
    - The full amount recovered by the collection agency must be deducted from what is claimed on the log, even if a percentage of that was kept by the agency as payment.
- Must continue for at least 120 days and any payments received restart the clock

Sometimes Reasonable Collection Efforts are Unnecessary

There are two reasons for which RCE can be skipped

- Determined indigency via provider internal policy
  - Must be determined by provider not the patient
  - Must consider a patient's total resources including assets, liabilities, income, and expenses
  - Must determine no source other than the patient would be legally responsible
  - Must maintain documentation of how the patient's indigence was determined
- State Medicaid refusing payment (crossover bad debt)
  - If the patient is covered by Medicaid, then Medicaid must be billed first
  - Once payment is refused at the state level via a Medicaid Remittance Advice, the account can be included on the Medicare Bad Debt log

Crossover or Dual-Eligible Bad Debt

•If Medicaid does not pay the complete coinsurance or deductible; a RHC can include this difference as an allowable bad debt on the cost report and Medicare will reimburse you for this bad debt. Keep up with in a separate file.

Medicare Bad Debt Listing – Write off

Medicare Bad Debts must be written off by the end of the fiscal year to be claimed on the cost report.

Collection efforts must cease.

Medicare Bad Debt Summary

1. Medicare coinsurance 20% of charges.
2. Medicare deductible of $226.00 in 2023. ($240 in 2024)
3. Billed to the Part A MAC.
4. Nothing else is allowed.
5. Must meet Reasonable Collection Efforts
(or be determined indigent/Medicaid patient)
6. Must treat everyone the same.
7. Do not have to turn over to collection agency.
8. Must be written off in the fiscal year of the cost report.
9. Collection efforts must cease.

Capturing the information for Bad Debt

1.Use an Excel Spreadsheet
2. Keep Regular and Crossover Bad Debt in separate spreadsheets
3. Provide Medicare with the spreadsheet.
4. Start early. Start NOW.
5. Provide it to the Preparer ASAP.

Recoveries of Bad Debt

- Sometimes recoveries are made after the Bad debt has been claimed. When this happens, bad debt claims in the current period must be reduced by the amount recovered.
- Identify the amount recovered and the amount previously reimbursed by Medicare (65% of the amount originally claimed). You do not have to reduce your current year claims by more than you were initially reimbursed.

Exhibit 2

Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________________

Prov. Number________________

FYE _______________________

Prepared By ____________________

Date Prepared __________________

Inpatient ____________________ Outpatient ________________

SNF ____________________ RHC____________________

(1) Patient Name	(2) HIC NO.	(3) Dates of Service		(4) Indigency & Wel. Recip (ck if apply)		(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
		From	To	Yes	Medicaid #						
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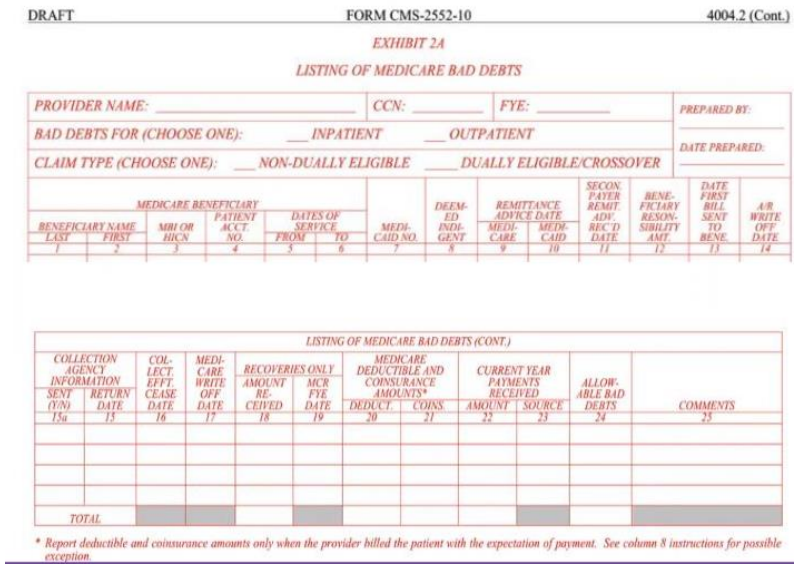
Common Problems

- Bad debts not written off in fiscal year
  - Date collection efforts ceased should fall within the period of the cost report being filed
- Deductible and Coinsurance columns not matching the total column
  - If a payment is made, record it on the log as well. Include it as an additional column if necessary.
- Keyed in dates
  - Timely billing (date of first bill – Medicare RA date < 120 days)
  - Complete Reasonable Collection Efforts (date collection efforts ceased – date of first bill >= 120 days)

Exhibit 2A for Hospitals – For Provider based RHCs ask your cost report preparer



DRAFT FORM CMS-2552-10 4004.2 (Cont.)

EXHIBIT 2A

LISTING OF MEDICARE BAD DEBTS

PROVIDER NAME: _____ CCN: _____ FYE: _____ PREPARED BY: _____

BAD DEBTS FOR (CHOOSE ONE): ___ INPATIENT ___ OUTPATIENT DATE PREPARED: _____

CLAIM TYPE (CHOOSE ONE): ___ NON-DUALLY ELIGIBLE ____ DUALLY ELIGIBLE/CROSSOVER

MEDICARE BENEFICIARY													
BENEFICIARY NAME		MBI OR HICN	PATIENT ACCT. NO.	DATES OF SERVICE		MEDI-CAID NO.	DEEM-ED INDI-GENT	REMITTANCE ADVICE DATE		SECON. PAYER REMIT. ADV. REC'D DATE	BENE-FICIARY RESON-SIBILITY AMT.	DATE FIRST BILL SENT TO BENE.	A/R WRITE OFF DATE
LAST	FIRST			FROM	TO			MEDI-CARE	MEDI-CAID				
1	2	3	4	5	6	7	8	9	10	11	12	13	14

LISTING OF MEDICARE BAD DEBTS (CONT.)

COLLECTION AGENCY INFORMATION		COL-LECT. EFFT. CEASE DATE	MEDI-CARE WRITE OFF DATE	RECOVERIES ONLY		MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS*		CURRENT YEAR PAYMENTS RECEIVED		ALLOW-ABLE BAD DEBTS	COMMENTS
SENT (Y/N)	RETURN DATE			AMOUNT RE-CEIVED	MCR FYE DATE	DEDUCT.	COINS.	AMOUNT	SOURCE		
15a	15	16	17	18	19	20	21	22	23	24	25
TOTAL											

* Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.

Thank You!

Mark Lynn, Healthcare Business Specialists

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