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Experienced Knowledge

Management Overview of RHC Cost Reporting Technical Assistance

July 30, 2019

HRSA Health Resources & Services Administration

HBS Healthcare Business Specialists

NARHC

Agenda

1. Cost Report Overview
2. Building Blocks – ABCs
    1. Expenses
    2. Visits
    3. Productivity standards
    4. Flu & Pnu Costs
    5. P S & R
    6. Bad Debts
3. Questions

Webinar Objective

To provide general information on the RHC cost reporting understandable to RHC managers and providers and focused on impact, timing, and responsibilities of the RHC to prepare timely and accurate Medicare and Medicaid cost reports.

RHC Cost Report

RHC Cost Report Overview

The purpose of the Medicare Cost Report is reconciling payments received from Medicare as compared to the allowable costs reported by the RHC. The process will result in a settling of monies owed or due to Medicare for the cost report fiscal year.

Medicaid uses a cost reporting process to establish Medicaid RHC rates and/or settle Medicaid RHC payments with the RHC. Each state is different.

Why is a Cost Report important?

1	Medicare will not pay you if you do not file a cost report and will ask for any Medicare money paid during the year to be refunded.
2	RHC Medicare and Medicaid rates are based upon the cost report.
3	RHCs receive a cost report settlement for flu, pnu, bad debts, preventive co-pays/deductibles and rate settlements.
4	You are responsible for preparing the Cost Report accurately and in compliance with Medicare and Medicaid rules.

Medicare RHC Cost Report Reimbursement Regulations

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

Cost Reporting Forms for Independent & Provider-based RHCs

Description	Independent	Provider-based
Cost Reporting Form	CMS-222-17	CMS-2552-10
Link to PDF of Forms	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf
Software Vendors 4 vendors for RHCs and 2 for hospital cost reports	https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing	https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing

Crosswalk of Forms between Provider-based & Independent RHCs

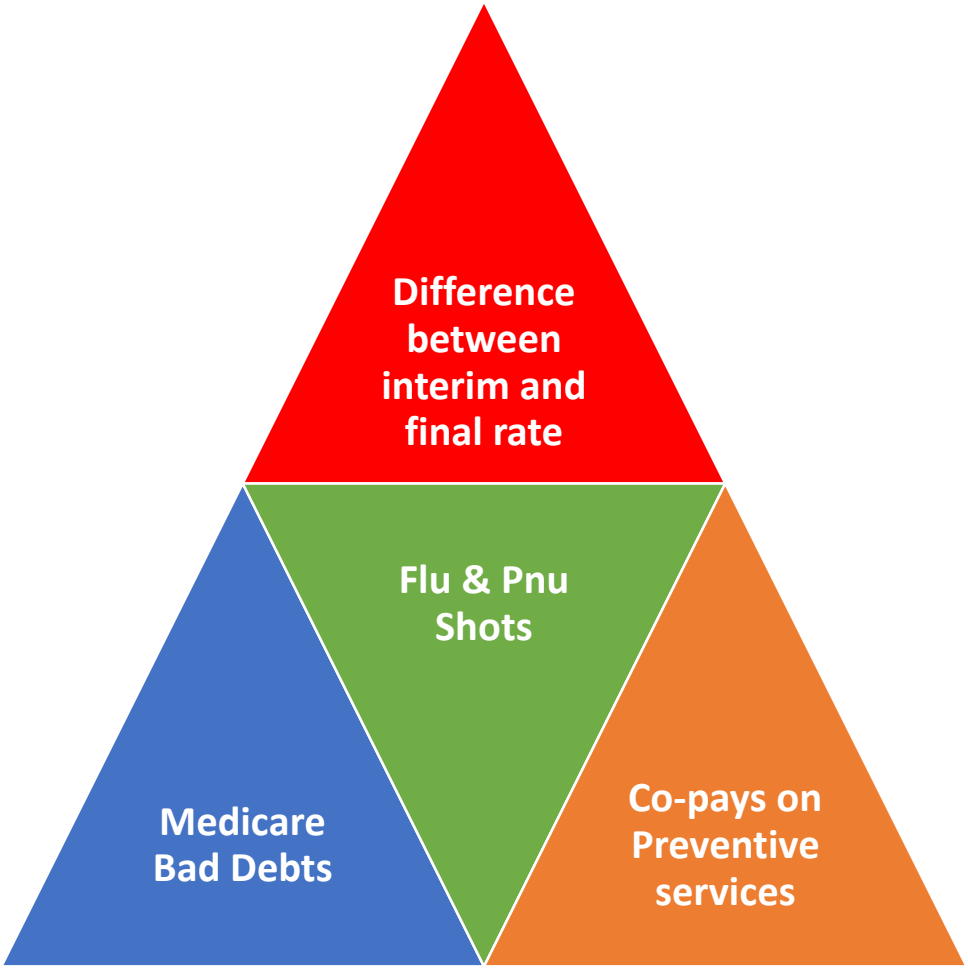
Purpose of Form	Independent	Provider-based
Provider Name, Location, CCN Number, Signature	S Parts I, II & III	**S-2/S-8**
Malpractice Information, Hours of Operation	S-1 Part I & II	**NA**
Replaces the 339 Questionnaire	S-2	**NA**
Payer Mix and mental health visits	S-3	**NA**
Expense information (Trial Balance of total expenses)	A	**A/M-1**
Reclassifications (Salaries to the proper cost center)	A-6	**A-6**
Adjustments (remove non-allowable expenses, straight-line depreciation on assets, value of services)	A-8	**A-8**
Related Party Transaction (adjust RPTs to actual cost)	A-8-1	**A-8-1**
Allocation of Overhead (Hospital or Parent)	NA	**B Part I, B-1**
Visits, FTEs, Overhead allocations to Non-RHC	B, Part 1	**M-2**
Influenza and Pneumonia Costs	B-1	**M-4**
All Inclusive Rate Calculation, Bad Debts, P S & R data	C	**M-3**
Medicare Payments including Interim settlements	C-1	**M-5**

RHC Cost Caps by Year

	2016	2017	2018	2019
Medicare Cap	$81.32	$82.30	$83.45	$84.70
Medicare Economic Index	1.10%	1.20%	1.40%	1.50%

Provider-based RHCs with less than 50 beds are not subject to the above caps.

What does Medicare Settle on the Cost Report?

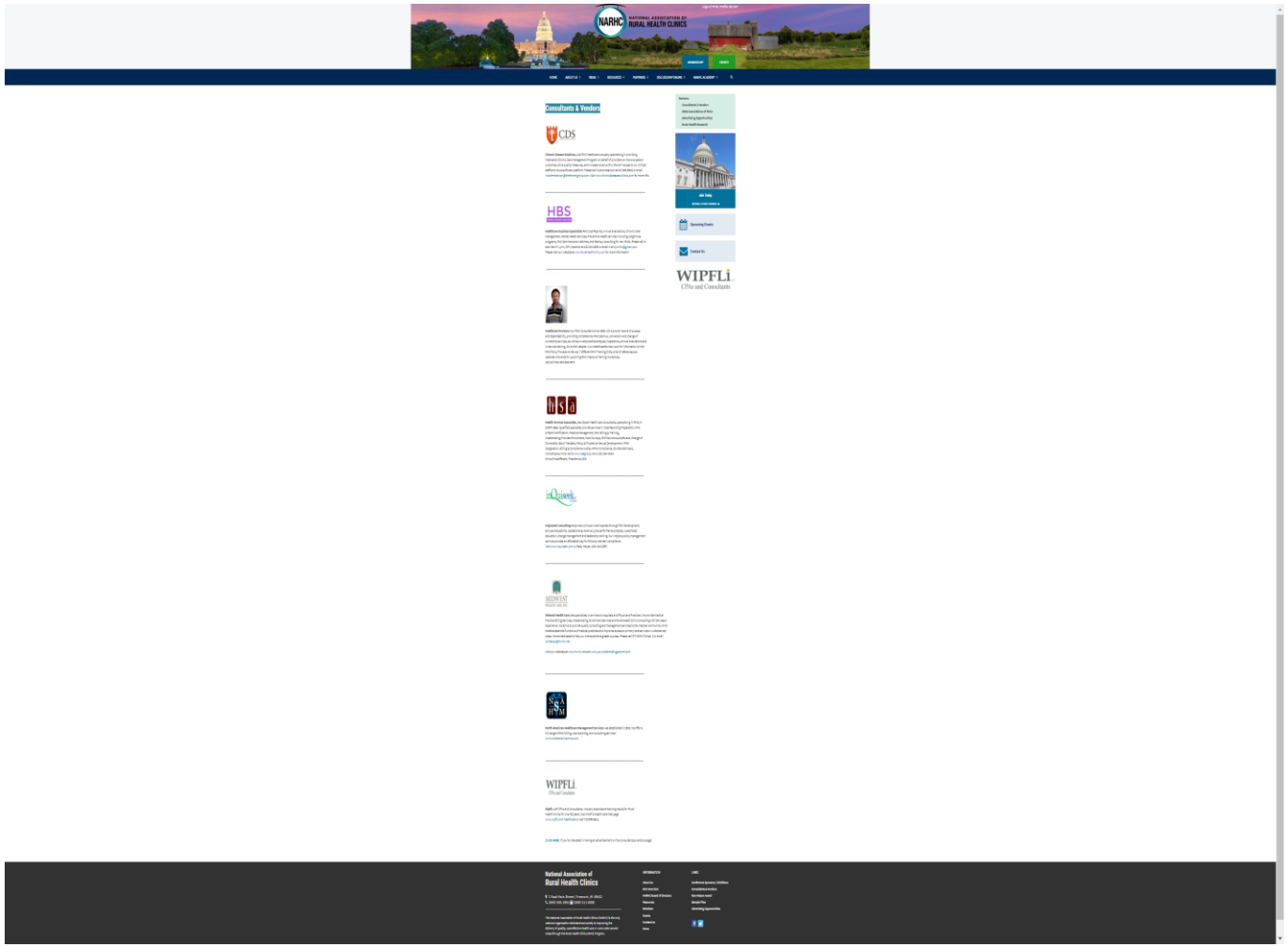


Cost Report Repayments to Medicare

- 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

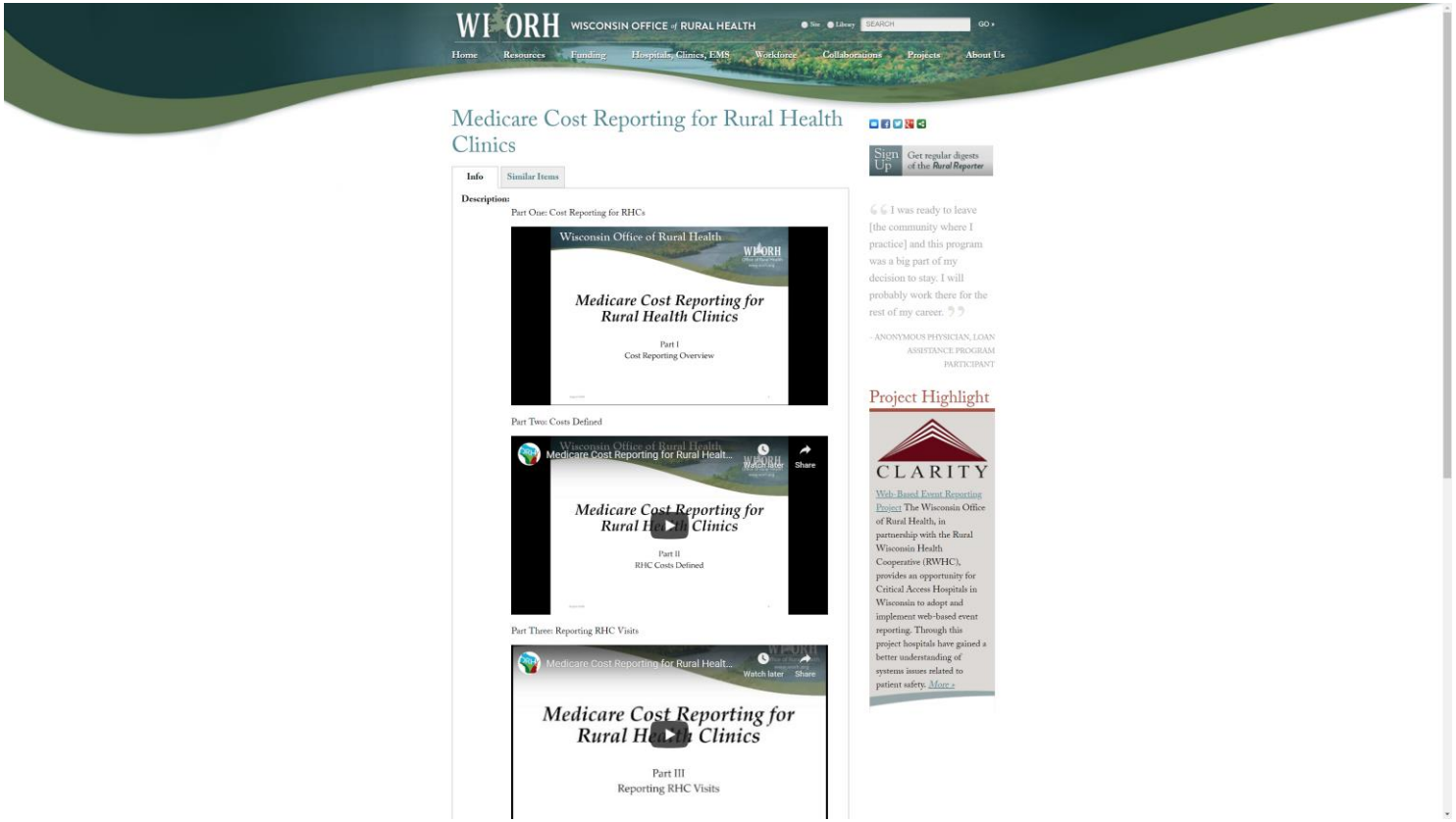
Professional Tip: Get Help

https://www.web.narhc.org/narhc/Consultants__Vendors1.asp

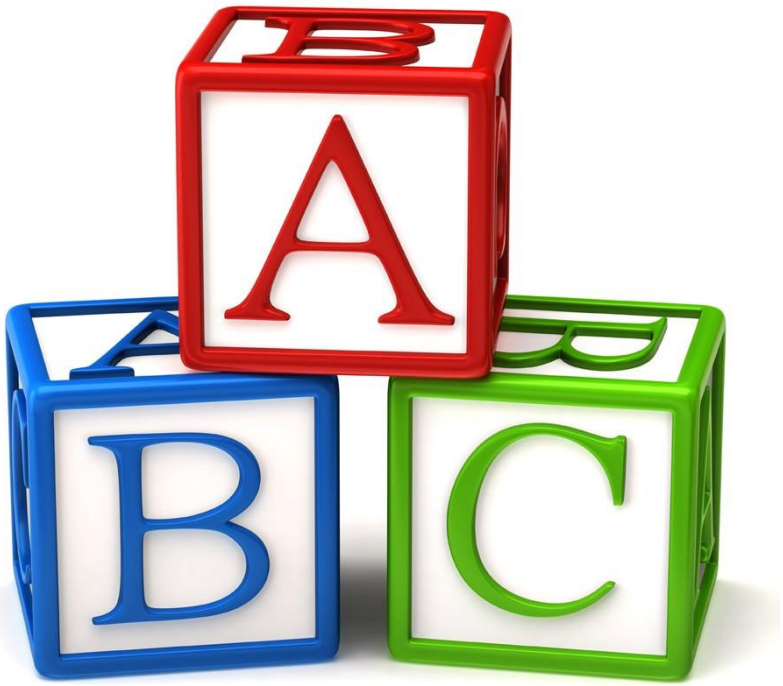


Wisconsin Office of Rural Health - Wipfli

http://worh.org/library/medicare-cost-reporting-rural-health-clinics



Building Blocks



What is a Medicare Cost Report?

Form 222 or 2552 - Medicare Cost Report is required by all RHC's to be completed on an annual basis.

If covers a 12-month period of time with some exceptions: You may have up to a 13-month cost report or you may have a short period if you sell the RHC or change ownership.

The First Major Change in the Independent RHC cost report in 25 years

The overall burden to RHCs is estimated at 55 hours compared to the existing burden associated with the CMS-222-92 of 50 hours.

New Information Requirements

Independent Rural Health Clinics will have to provide new information for their annual cost report submissions this year. The Centers for Medicare and Medicaid Services (CMS) has replaced the CMS-222-92 form with the new CMS-222-17 and replaced Chapter 29 of the Provider Reimbursement manual with Chapter 46. Instructions and forms were provided by CMS in Transmittal 1 on May 18, 2018 and the new cost report forms are required for cost report submissions ending on or after September 30, 2018. Alternatively, provider-based RHCs in a hospital healthcare complex, will continue to use Form CMS-2552-10 instead. Below is a link to the new cost report forms and instructions.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf

Why Change?

The reason for the changes to the independent RHC cost report are as follows:

1. To incorporate electronic filing of the cost report using the MCReF system. The following link has information on how MCReF works: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-ACost-Report-Audit-and-Reimbursement/MCReF.html
2. To eliminate unnecessary FQHC information due to the Form 224-14 used by FQHCs
3. To incorporate information previously submitted on the Form 339 Questionnaire (no longer required)

Sources – RHC Cost Reports

Description	Link
Chapter 46, RHC Instructions and Forms, May 18, 2018. (95 page PDF)	**https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf**
Medicare Cost Report E-Filing (MCReF) MLN Matters Number: MM10611 revised November 2, 2018	**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10611.pdf**
MCReF FAQs (5-page PDF)	**https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/Downloads/MCReF-FAQ.pdf**

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

Deadlines for 12/31/2019 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)	12/31/2019
2.	Liquidate accrued bonuses or payments to owners	75 days after year-end. March 16, 2020
3.	Liquidate accruals for non-owners.	One year after year-end. December 31, 2020
4.	Complete Requested Workpapers from your Cost Report Preparer	3 months after the fiscal year end in most cases
5.	Sign up with EIDM/IACS for the P S and R.	ASAP

Gathering Information for the Cost Report

Your Cost Report Preparer will send you a checklist of information or Excel spreadsheet to submit to your cost report preparer.

Start Early and get the information to the preparer as soon as possible.

If you do not have the checklist by your cost report year-end or shortly thereafter contact your cost report preparer.

Medicare Cost Report Table of Contents

1. Medicare Cost Report – Form 222/2552 (ECR File)
2. Medicare Workpapers which include 3 through 9.
3. Trial Balance of expenses that ties to WKS A.
4. Workpapers to support reclassifications or adjustments.
5. How total visits were computed.
6. How Provider FTEs are computed
7. Flu and Pnu logs and invoices
8. P S and R including preventive services
9. Medicare Bad Debt listing in Excel

All Inclusive Rate (AIR) Per Visit Calculation

$$\frac{\text{Total Allowable RHC Costs minus Flu/Pnu costs}}{\text{Total RHC Visits (Includes all payor types)}} = \text{RHC Cost Per Visit (limited to cap if applicable)}$$

Chapter 13, Section 80.4 The A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits.

Allowable Costs

"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."

- Provider Reimbursement Manual, Pub. 15

Total Expense Source Documents (Numerator)

Provide your Expenses
Typically one of the following:

1. Financial Statements
2. Trial balance
3. Tax return

ABC Company

Table: Cash Flow

Source Documents for Cost Report Expenses

- **For provider-based RHCs**
  - Departmental summary reports
  - Internally prepared financial statements (Trial Balance)
  - Hospital cost report data
- **For independent RHCs**
  - Financial statements prepared by outside accountants
  - Internally prepared financial statements (Quickbooks)
  - Tax returns

Worksheet A Form 222-17 for Independent RHCs

05-18 FORM CMS-222-17 4690 (Cont.)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | CCN: | PERIOD: FROM: _____ TO: _____ | WORKSHEET A

		COST CENTER	SALARIES	OTHER	TOTAL	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION	
			1	2	3	4	5	6	7	
		FACILITY HEALTH CARE STAFF COSTS								
1	0100	Physician								1
2	0200	Physician Assistant								2
3	0300	Nurse Practitioner								3
4	0400	Certified Nurse Midwife								4
5	0500	Registered Nurse								5
6	0600	Licensed Practical Nurse								6
7	0700	Clinical Psychologist								7
8	0800	Clinical Social Worker								8
9	0900	Laboratory Technician								9
10	1000	Other (specify)								10
14		Subtotal-Facility Health Care Staff Costs (sum of lines 1 through 10)								14
		COSTS UNDER AGREEMENT								
15	1500	Physician Services Under Agreement								15
16	1600	Physician Supervision Under Agreement								16
17		Subtotal Under Agreement (sum of lines 15 and 16)								17
		OTHER HEALTH CARE COSTS								
25	2500	Medical Supplies								25
26	2600	Transportation (Health Care Staff)								26
27	2700	Depreciation-Medical Equipment								27
28	2800	Malpractice Premiums								28
29	2900	Allowable GME Costs								29
30	3000	Pneumococcal Vaccines & Med Supplies								30
31	3100	Influenza Vaccines & Med Supplies								31
32	3200	Other (specify)								32
38		Subtotal-Other Health Care Costs (sum of lines 25 through 32)								38
39		Total Cost of Services (Other Than Overhead And Other RHC Services) (sum of lines 14, 17, and 38)								39
		FACILITY OVERHEAD-FACILITY COST								
40	4000	Rent								40
41	4100	Insurance								41
42	4200	Interest On Mortgage Or Loans								42
43	4300	Utilities								43
44	4400	Depreciation-Buildings And Fixtures								44
45	4500	Depreciation-Movable Equipment								45
46	4600	Housekeeping And Maintenance								46
47	4700	Property Tax								47
48	4800	Other (specify)								48
59		Subtotal-Facility Costs (sum of lines 40 through 48)								59

Worksheet A Form 222-17 for Independent RHCs

4690 (Cont.) FORM CMS-222-17 05-18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET A

		COST CENTER	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
FACILITY OVERHEAD-ADMINISTRATIVE COSTS										
60	6000	Office Salaries								60
61	6100	Depreciation-Office Equipment								61
62	6200	Office Supplies								62
63	6300	Legal								63
64	6400	Accounting								64
65	6500	Insurance								65
66	6600	Telephone								66
67	6700	Fringe Benefits And Payroll Taxes								67
68	6800	Other (specify)								68
73		Subtotal-Administrative Cost (sum of lines 60 through 68)								73
74		Total Overhead (sum of lines 59 and 73)								74
COST OTHER THAN RHC SERVICES										
75	7500	Pharmacy								75
76	7600	Dental								76
77	7700	Optometry								77
78	7800	Non-allowable GME Pass Through Costs								78
79	7900	Telehealth								79
80	8000	Chronic Care Management								80
81	8100	Other (specify)								81
86		Subtotal-Cost Other Than RHC (sum of lines 75 through 81)								86
NON-REIMBURSABLE COSTS										
87	8700									87
88	8800									88
89	8900									89
90		Subtotal Non-Reimbursable Costs (sum of lines 87 through 89)								90
100		TOTAL COSTS (sum of lines 39, 74, 86, and 90)								100

Provider-Based RHCs Cost Report Forms – M-1

10-12 FORM CMS-2552-10 4090 (Cont.)

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET M-1

Check applicable box: [ ] RHC [ ] FQHC

		COMPEN-SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1-9)								10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15-20)								21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)								22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

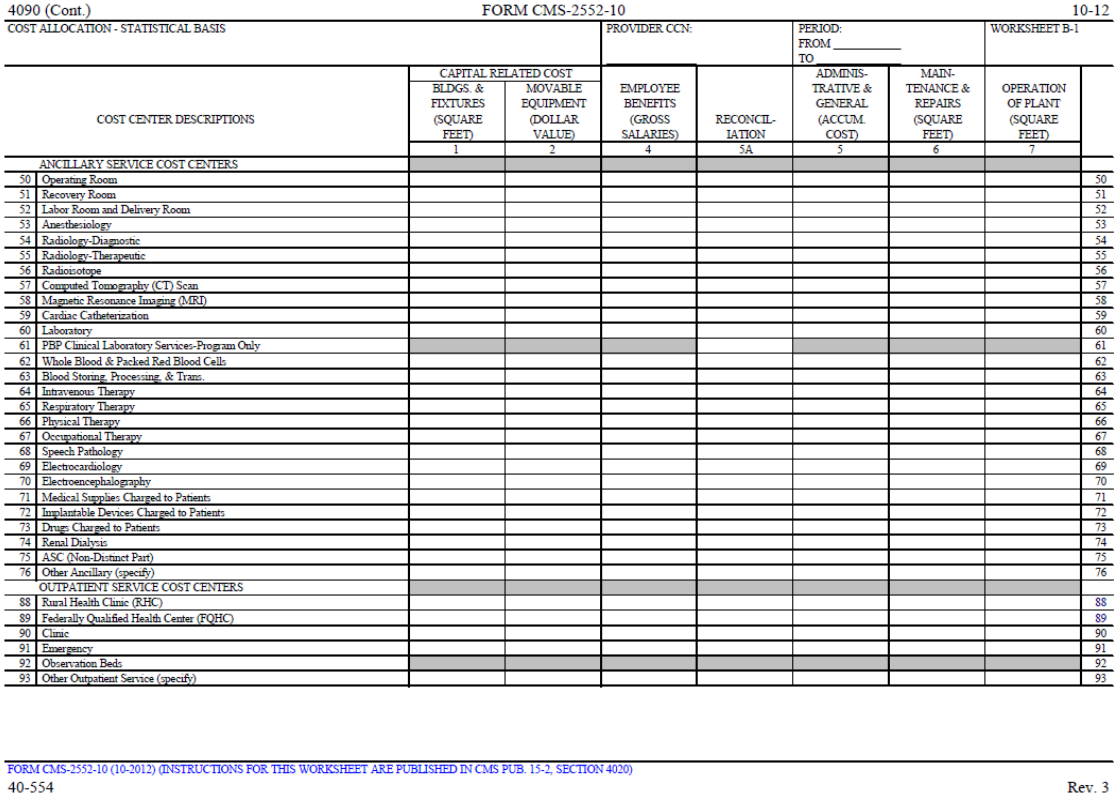
FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4066)

Rev. 3 40-659

Worksheet B-1 Provider-based RHC Cost Statistics

Provider-based RHCs receive an allocation of parent overhead from the hospital. The provider-based RHC must maintain statistics to support the allocation of overhead. Such statistics may include:

1. Square Footage
2. Time Studies
3. Gross Salaries
4. Accumulated Costs
5. Pounds of Laundry



4090 (Cont.) FORM CMS-2552-10 10-12

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		1	2	4	5A	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Labor Room and Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Beds								92
93	Other Outpatient Service (specify)								93

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

40-554 Rev. 3

Using Benchmark Data

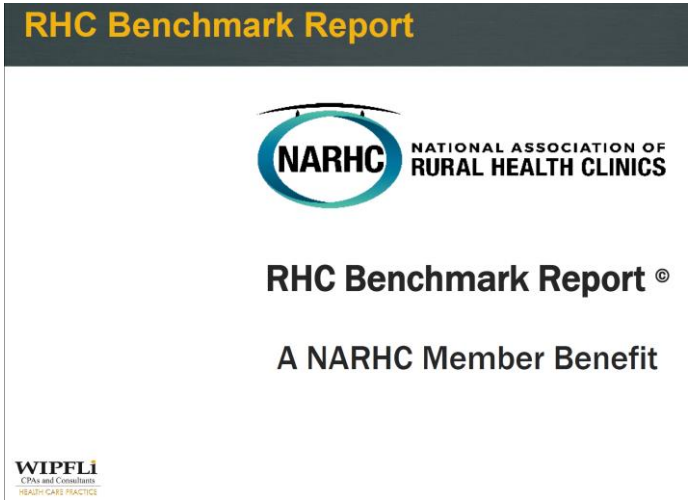
What elements of cost are causing the variance: provider, support staff, overhead, parent allocation?

	2018			
	RHC		Mean	
Category/Indicator	Values		MI	Midwest	Nation
Number of Facilities	1		61	383	837
Clinic Cost per Encounter:					
Total Health Care Staff	130.04	↓	79.09	98.42	92.91
Total Direct Costs of Medical Services	146.41	→	123.21	129.20	117.97
Allowable GME Overhead	0.00		0.00	0.00	0.00
Clinic Overhead	59.88	↓	27.57	22.73	24.09
Parent Provider Overhead Allocated	122.44	↓	81.28	81.91	78.20
Allowable Overhead (Clinic and Parent)	182.32	↓	108.34	104.07	101.54
Allowable Overhead Ratio (Clinic and Parent)	100%	→	100%	99%	99%
Total Allowable Cost per Actual Encounter	328.74	↓	230.60	233.00	218.67
Total Allowable Cost per Adjusted Encounter	328.74	↑	221.89	222.99	208.51

WIPFLI CPAs and Consultants HEALTH CARE PRACTICE

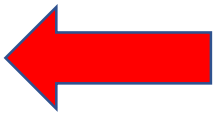
Professional Tip: Benchmark your Cost Report

https://www.wipfli.com/healthcare



https://www.ruralhealthinfo.org/assets/762-2349/slides-121415.pdf

Category/Indicator	2015 Mean TN	2015 Mean Southern	2015 Mean Nation	2016 Mean TN	2016 Mean Southern	2016 Mean Nation	2017 Mean TN	2017 Mean Southern	2017 Mean Nation
Number of Facilites	62	708	1,242	71	672	1,154	74	628	1,056
Encounters per FTE:									
Physicians	5,209	4,970	4,729	5,167	4,941	4,651	4,577	4,725	4,577
Physician Assistants	3,435	3,677	3,639	3,574	3,834	3,740	2,967	3,911	3,738
Nurse Practitioners	3,215	3,487	3,327	3,267	3,497	3,332	3,242	3,469	3,286
Visiting Nurses	0	119	375	0	200	525	595	538	815
Clinical Psychologist/Social Worker	980	1,658	1,876	1,620	1,356	1,478	1,140	1,643	1,746
Midlevel Staffing Ratio	80%	55%	54%	80%	57%	57%	81%	59%	58%
Midlevel Visit Ratio	72%	46%	46%	72%	49%	49%	74%	52%	51%
Cost per Encounter:									
Physician	56.84	55.83	59.10	63.93	58.88	62.04	69.22	62.80	64.96
Physician Assistant	36.38	33.84	33.82	31.04	31.25	33.06	36.05	31.91	34.63
Nurse Practitioner	32.81	32.05	34.37	34.54	33.23	35.19	34.45	34.21	37.09
Visiting Nurse	#DIV/0!	313.49	97.39	0.00	263.49	103.50	117.07	111.29	69.26
Clinical Psychologist/Social Worker	165.53	89.32	52.67	96.58	92.61	69.71	53.73	72.72	55.53
Total Health Care Staff Cost	11.47	12.51	14.19	10.78	12.78	14.74	11.17	13.34	15.23
Cost per FTE:									
Physician	264,333	266,709	269,434	306,012	279,334	276,635	292,911	290,846	288,698
Physician Asstistant	124,961	124,427	123,069	110,934	119,809	123,661	106,947	124,798	129,446
Nurse Practitioner	105,480	111,750	114,345	112,868	116,211	117,254	111,682	118,694	121,874
Visiting Nurse	28,001	37,413	36,524	0	52,791	54,352	69,655	59,818	56,466
Clinical Psychologist/Social Worker	162,220	148,073	98,810	156,460	125,626	103,017	61,251	119,484	96,944
Total Healthcare Staff Costs per Provider FTE	42,539	52,546	57,439	40,642	53,339	58,968	39,858	54,220	59,977
Clinic Cost per Encounter:									
Total Health Care Staff	51.69	57.24	61.57	53.60	58.35	62.87	55.26	61.28	65.82
Total Direct Costs of Medical Services	63.14	67.38	72.52	66.27	68.57	74.17	69.76	71.36	76.99
Facility Cost	13.89	9.59	10.19	11.96	9.69	11.10	12.23	9.70	11.17
Clinic Overhead	58.49	47.41	54.20	55.36	48.54	58.44	57.95	48.90	59.63
Allowable Overhead	54.16	43.97	47.63	50.77	44.96	49.02	54.90	45.65	50.02
Allowable Overhead Ratio	93%	93%	88%	92%	93%	84%	95%	93%	84%
Total Allowable Cost per Actual Encounter	117.30	111.02	119.97	117.04	113.51	123.18	124.66	116.60	126.77
Total Allowable Cost per Adjusted Encounter	113.26	108.92	116.96	113.58	111.25	119.82	119.42	114.12	123.30
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(2.65)	(2.62)	(3.47)	(2.73)	(2.89)	(3.99)	(2.01)	(3.24)	(4.13)
Payment Rate per Adjusted Encounter	110.61	106.30	113.49	110.85	108.36	115.83	117.41	110.88	119.17
Total Encounters	469,666	8,501,938	15,452,512	558,284	8,198,077	14,340,172	592,558	7,780,195	13,469,393
Total Medicare Encounters	75,336	2,029,889	3,634,757	83,802	1,846,994	3,210,685	92,153	1,648,929	2,895,111
Medicare Percent of Visits	16%	24%	24%	15%	23%	22%	16%	21%	21%
Injection Cost:									
Cost per Pneumococcal Injection	220.94	173.43	188.83	282.22	201.14	229.88	274.63	245.80	270.32
Cost per Influenza Injection	44.09	48.89	49.13	43.52	48.15	51.14	54.66	68.29	66.41



New Cost Centers – Independent RHCs

The new Form CMS-222-17 expands the number of cost centers and add specific cost centers for costs such as:

a. **Pneumococcal vaccines (CR 30) Must be entered here or you will not get paid.**
b. **Influenza vaccines (CR 31) Same Here.**
c. **Telehealth (CR 79)**
d. **Chronic Care Management (CR 80)**

Form 222–17 Cost Center Conversion Cheat sheet

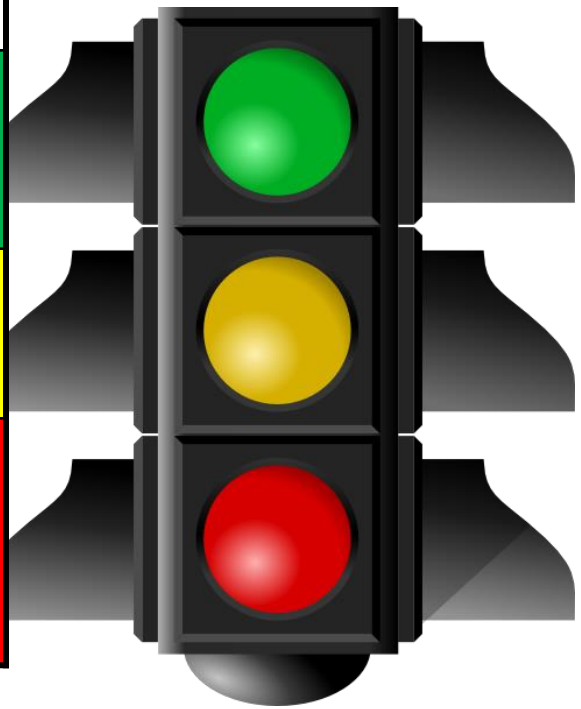
[Cost Report Conversion from Form 222-92 to Form 222-17 Trial Balance Cheat Sheet]

Cost Report Trial Balance Coding for Cost Centers

Account Type	Form 222-92 (Old)	Form 222-17 (New)
Health Care Staff: Physician	1	1
Health Care Staff: Physician Assistant	2	2
Health Care Staff: Nurse Practitioner	3	3
Health Care Staff: Certified Nurse Midwife		4
Health Care Staff: Visiting Nurse	4	5 (RN) and 6 (LPN)
Health Care Staff: Other Nurse	5	10
Health Care Staff: Clinical Psychologist	6	7
Health Care Staff: Social Worker	7	8
Health Care Staff: Laboratory Technician	8	9
Health Care Staff: Transcription	9	10.01
Health Care Staff: Contract Labor	10	10.02
Costs Under Agreement: Physician Services	13	15
Costs Under Agreement: Physician Supervision	14	16
Other Health Care: Medical Supplies	17	25
Other Health Care: Transportation	18	26
Other Health Care: Depreciation (Medical Equipment)	19	27
Other Health Care: Professional Liability Insurance	20	28
Other Health Care: Allowable GME	20.50	29
Other Health Care: Pnuemococcal Vaccine & Med Supplies		30
Other Health Care: Influenza Vaccine & Med Supplies		31
Other Health Care: Other Health Care Costs (Specify)	21	
Other Health Care: CME, Dues, Licenses, Subscritions	22	32
Other Health Care: Electronic Health Records	23	32.01
Other Health Care: Small Equipment		32.02
Facility Overhead: Rent	26	40
Facility Overhead: Insurance	27	41
Facility Overhead: Interest	28	42
Facility Overhead: Utilities	29	43
Facility Overhead: Depreciataion (Building & Fixtures)	30	44
Facility Overhead: Depreciataion (Equipment)	31	45
Facility Overhead: Housekeeping & Maintenance	32	46
Facility Overhead: Property Tax	33	47
Facility Overhead: Other Overhead Facility Costs (Specify)	34	
Facility Overhead: Other Overhead Facility Costs (Specify)	35	
Facility Overhead: Other Overhead Facility Costs (Specify)	36	
Facility Overhead (Administrative): Office Salaries	38	60
Facility Overhead (Administrative): Depreciation (Office Equipment)	39	61
Facility Overhead (Administrative): Office Supplies	40	62
Facility Overhead (Administrative): Legal	41	63
Facility Overhead (Administrative): Accounting	42	64
Facility Overhead (Administrative): Insurance	43	65
Facility Overhead (Administrative): Telephone	44	66
Facility Overhead (Administrative): Fringe Benefits & Payroll Taxes	45	67
Facility Overhead (Administrative): Billing Service	46	68
Facility Overhead (Administrative): Miscellaneous	47	68.01
Facility Overhead (Administrative): Non-Allowable Costs	48	68.02
Facility Overhead (Administrative): Corporate Administrative Allocation		68.03
Costs Other than RHC: Pharmacy	51	75
Costs Other than RHC: Dental	52	76
Costs Other than RHC: Optometry	53	77
Costs Other than RHC: Non-Allowable GME Pass Through Costs	53.50	78
Costs Other than RHC: EPSDT/Physicals	54	81
Costs Other than RHC: Hospital	55	81.01
Costs Other than RHC: Chronic Care Management	55.50	80
Costs Other than RHC: Telehealth	55.60	79
Costs Other than RHC: Private Practice	56	81.02
Costs Other than RHC: Laboratory		81.03
Costs Other than RHC: Radiology		81.04

RHC Cost Report can be divided in 3 sections

CR Description- WKS A	CR Line
Healthcare Staff Costs	1-39
Facility Overhead	40-74
Non-RHC and Non-Reimbursable	75-100



Healthcare Costs – CR Lines 1-39

		COST CENTER	SALARIES 1	OTHER 2
ACILITY HEALTH CARE STAFF COSTS				
1	0100	Physician		
2	0200	Physician Assistant		
3	0300	Nurse Practitioner		
4	0400	Certified Nurse Midwife		
5	0500	Registered Nurse		
6	0600	Licensed Practical Nurse		
7	0700	Clinical Psychologist		
8	0800	Clinical Social Worker		
9	0900	Laboratory Technician		
10	1000	Other (specify)		
14		Subtotal-Facility Health Care Staff Costs (sum of lines 1 through 10)		
OSTS UNDER AGREEMENT				
15	1500	Physician Services Under Agreement		
16	1600	Physician Supervision Under Agreement		
17		Subtotal Under Agreement (sum of lines 15 and 16)		
THER HEALTH CARE COSTS				
25	2500	Medical Supplies		
26	2600	Transportation (Health Care Staff)		
27	2700	Depreciation-Medical Equipment		
28	2800	Malpractice Premiums		
29	2900	Allowable GME Costs		
30	3000	Pneumococcal Vaccines & Med Supplies		
31	3100	Influenza Vaccines & Med Supplies		
32	3200	Other (specify)		
38		Subtotal-Other Health Care Costs (sum of lines 25 through 32)		
39		Total Cost of Services (Other Than Overhead And Other RHC Services) (sum of lines 14, 17, and 38)		

Facility Overhead CR Lines 40-74

FACILITY OVERHEAD-FACILITY COST		
40	4000	Rent
41	4100	Insurance
42	4200	Interest On Mortgage Or Loans
43	4300	Utilities
44	4400	Depreciation-Buildings And Fixtures
45	4500	Depreciation-Movable Equipment
46	4600	Housekeeping And Maintenance
47	4700	Property Tax
48	4800	Other (specify)
59		Subtotal-Facility Costs (sum of lines 40 through 48)
FACILITY OVERHEAD-ADMINISTRATIVE COSTS		
60	6000	Office Salaries
61	6100	Depreciation-Office Equipment
62	6200	Office Supplies
63	6300	Legal
64	6400	Accounting
65	6500	Insurance
66	6600	Telephone
67	6700	Fringe Benefits And Payroll Taxes
68	6800	Other (specify)
73		Subtotal-Administrative Cost (sum of lines 60 through 68)
74		Total Overhead (sum of lines 59 and 73)

Non-allowable Expenses CR 75-100

COST OTHER THAN RHC SERVICES		
75	7500	Pharmacy
76	7600	Dental
77	7700	Optometry
78	7800	Non-allowable GME Pass Through Costs
79	7900	Telehealth
80	8000	Chronic Care Management
81	8100	Other (specify)
86		Subtotal-Cost Other Than RHC (sum of lines 75 through 81)
NON-REIMBURSABLE COSTS		
87	8700	
88	8800	
89	8900	
90		Subtotal Non-Reimbursable Costs (sum of lines 87 through 89)
100		TOTAL COSTS (sum of lines 39, 74, 86, and 90)

Separate General Ledger accounts for Non-allowable Expenses

Certain Non-RHC expenses need separate accounting or general ledger accounts.

A. Laboratory supplies/reagents/licenses
B. Radiology supplies/ film/ licenses
C. EKGs tracing supplies or Part B technical component costs.
D. Any service billed to Part B and there is a supply cost.
E. Chronic Care Management
F. Tele-Health

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

Definition of an RHC Visit per Section 40 of Chapter 13 of the Medicare Benefits Policy Manual

An RHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or practitioner are considered RHC visits.

Total Visit Counts

2	PROVIDE AT LEAST ONE OF THE FOLLOWING (A. OR B.) TO DETERMINE THE TOTAL PATIENT VISITS OR ENCOUNTERS AND NEED ONE OF THE FOLLOWING.
a.	**CPT Frequency report by Provider from your computer system.**
b.	Written or manual visit count with physician, physician assistant, and nurse practitioner visits provided.

Additional Information Required for Independent RHCs Only

To capture additional information from the RHC such as:

a. Malpractice premiums, paid losses, and self-insurance
b. Medical visits, mental health visits, and visits by interns and residents
c. Visits by payor mix (Worksheet S-3)
    a. i. Title V- CHIP
    b. ii. Title XVIII – Medicare
    c. iii. Title XIX – Medicaid
    d. iv. Other – Commercial, self-pay, etc.

Additional Visit Information for Independent RHCs Only

TAB 2

Worksheet S-3 – Total Visits by Payor Mix

Please provide the RHC Total Visits as follows. If the clinic does not provide mental health visits or visits by interns and residents, you do not have to complete this form.

#	Description	CHIP	Medicare	Medicaid	Other	Total
1	Medical Visits					
2	Total Medical Visits					
3	Mental Health Visits					
4	Total Mental Health Visits					
5	Number of Visits Performed by Interns and Residents					
6	Total Number of Visits Performed by Interns and Residents					
7	Total Visits					

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	Visits
Physician	4,200
Physician Assistant	2,100
Nurse Practitioner	2,100

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

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							

Influenza and Pneumoccoal

4	PROVIDE ALL OF THE FOLLOWING INFORMATION TO CLAIM INFLUENZA AND PNEUMOCCCOCAL REIMBURSEMENT ON THE COST REPORT.
a.	Medicare logs with patient name & HIC number and date of service for pneumoccocal and influenza patients.
b.	A count, listing, or log on non-Medicare patients in order for us to determine total flu shots provided.
c.	Invoices supporting influenza and pneumoccocal purchases during the year. This will help us to determine the cost of the supply cost.

Influenza and Pnemoccocal Shot Logs

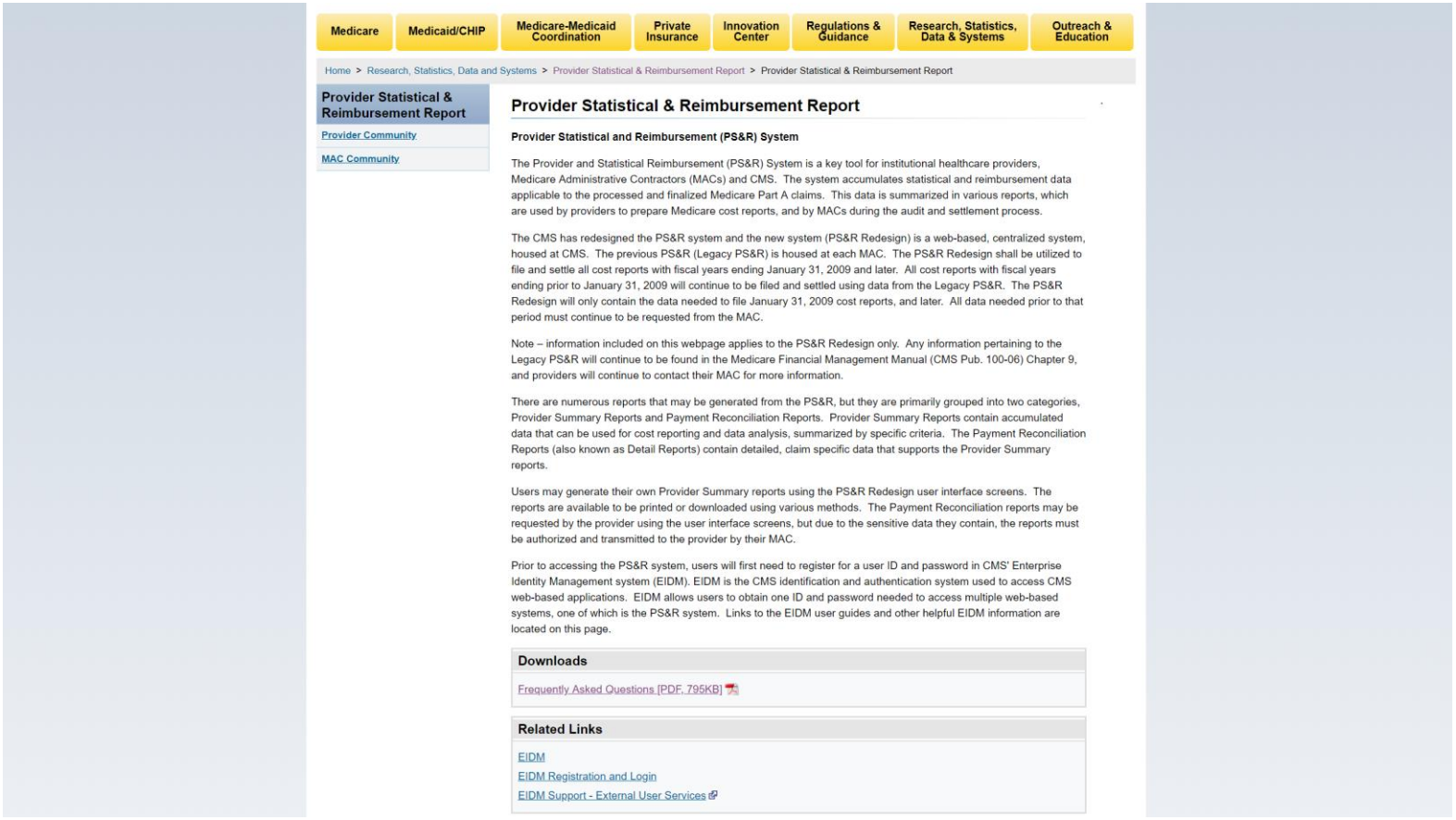
Patient Name	HIC Number	Date of Service
John Smith	411992345A	12/31/2013
Steve Jones	234123903A	12/31/2013
Ashley Taylor	903214934A	12/31/2013

Medicare Influenza and Medicare Pnemoccocal shots should be maintained on separate logs. Pnumo pays around $270 per shot and influenza is $66 or so.

EIDM Access – P S and R

Start here first. This takes the longest and is the most confusing.

P S & R Reports



Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > Research, Statistics, Data and Systems > Provider Statistical & Reimbursement Report > Provider Statistical & Reimbursement Report

Provider Statistical & Reimbursement Report

Provider Community

MAC Community

Provider Statistical & Reimbursement Report

Provider Statistical and Reimbursement (PS&R) System

The Provider and Statistical Reimbursement (PS&R) System is a key tool for institutional healthcare providers, Medicare Administrative Contractors (MACs) and CMS. The system accumulates statistical and reimbursement data applicable to the processed and finalized Medicare Part A claims. This data is summarized in various reports, which are used by providers to prepare Medicare cost reports, and by MACs during the audit and settlement process.

The CMS has redesigned the PS&R system and the new system (PS&R Redesign) is a web-based, centralized system, housed at CMS. The previous PS&R (Legacy PS&R) is housed at each MAC. The PS&R Redesign shall be utilized to file and settle all cost reports with fiscal years ending January 31, 2009 and later. All cost reports with fiscal years ending prior to January 31, 2009 will continue to be filed and settled using data from the Legacy PS&R. The PS&R Redesign will only contain the data needed to file January 31, 2009 cost reports, and later. All data needed prior to that period must continue to be requested from the MAC.

Note – information included on this webpage applies to the PS&R Redesign only. Any information pertaining to the Legacy PS&R will continue to be found in the Medicare Financial Management Manual (CMS Pub. 100-06) Chapter 9, and providers will continue to contact their MAC for more information.

There are numerous reports that may be generated from the PS&R, but they are primarily grouped into two categories, Provider Summary Reports and Payment Reconciliation Reports. Provider Summary Reports contain accumulated data that can be used for cost reporting and data analysis, summarized by specific criteria. The Payment Reconciliation Reports (also known as Detail Reports) contain detailed, claim specific data that supports the Provider Summary reports.

Users may generate their own Provider Summary reports using the PS&R Redesign user interface screens. The reports are available to be printed or downloaded using various methods. The Payment Reconciliation reports may be requested by the provider using the user interface screens, but due to the sensitive data they contain, the reports must be authorized and transmitted to the provider by their MAC.

Prior to accessing the PS&R system, users will first need to register for a user ID and password in CMS' Enterprise Identity Management system (EIDM). EIDM is the CMS identification and authentication system used to access CMS web-based applications. EIDM allows users to obtain one ID and password needed to access multiple web-based systems, one of which is the PS&R system. Links to the EIDM user guides and other helpful EIDM information are located on this page.

Downloads

Frequently Asked Questions [PDF, 795KB]

Related Links

EIDM

EIDM Registration and Login

EIDM Support - External User Services

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/PSRR/index.html

EIDM: Change Password FAQ

Q: How do I change my SPOT/EIDM password, and how often do I need to change it?

A: You must log in to the EIDM portal once **every 60 days** to change your password.
You **may** change your **Password** as well as **personal information** associated with your Enterprise Identity Management (EIDM) account through the **My Profile** menu on the EIDM website.

Change Password

1. Navigate to CMS' EIDM portal: https://portal.cms.gov

Important: Keep a written record of the log-in and Passwords in the RHC Policy and Procedure Manual at all times since the EIDM Security Officials may change. You will need to access the system to print the P S and R and you will need to change the password every 60 days.

Important – Ask for Preventive Charge Report
Report Type: 710 and 71S (Summary) not Detailed

Ask for the P S and R report that has preventive charges on it.

It is a separate report from the P S and R.

It is important to enter these charges as this is were you get your co-pays paid.

P S & R Reports – 710 Visits, Charges, Deductibles, Payments

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 01/03/19
Report Run Date: 01/03/19
Provider FYE: 12/31
Provider Number: [redacted]

PROVIDER SUMMARY REPORT
CLINIC - RURAL HEALTH

Page: 1
Report #: OD44203
Report Type: 710

	SERVICES FOR PERIOD 01/01/18 - 12/31/18		SERVICES FOR PERIOD No Data Requested		SERVICES FOR PERIOD No Data Requested		SERVICES FOR PERIOD No Data Requested	
STATISTIC SECTION								
CLAIMS		2,633						
CHARGE SECTION								
REV CODE DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0521 RURAL/CLINIC	2,452	$322,876.00						
0524 RHC/FQHC PT A SNF	2	$640.00						
0525 RHC/FQHC SNF	184	$31,988.00						
TOTAL COVERED CHARGES	2,638 WKS C Line 10	$355,504.00	WKS C Line 17					
REIMBURSEMENT SECTION								
GROSS REIMBURSEMENT		$246,255.01						
LESS								
CASH DEDUCTIBLE		$10,898.13	WKS C Line 15					
BLOOD DEDUCTIBLE		$0.00						
COINSURANCE		$64,653.10						
NET MSP PAYMENTS		$0.00						
PRE-SEQUESTRATION DEMO REDUCTION		$0.00						
SEQUESTRATION		$3,488.28		$0.00		$0.00		$0.00
POST-SEQUESTRATION DEMO REDUCTION		$0.00						
REBILLING ADJUSTMENT		$0.00						
NET REIMBURSEMENT		$167,215.50	C-1 Line 1					

P S & R Reports – 71S Preventive Visits, Charges, Payments

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

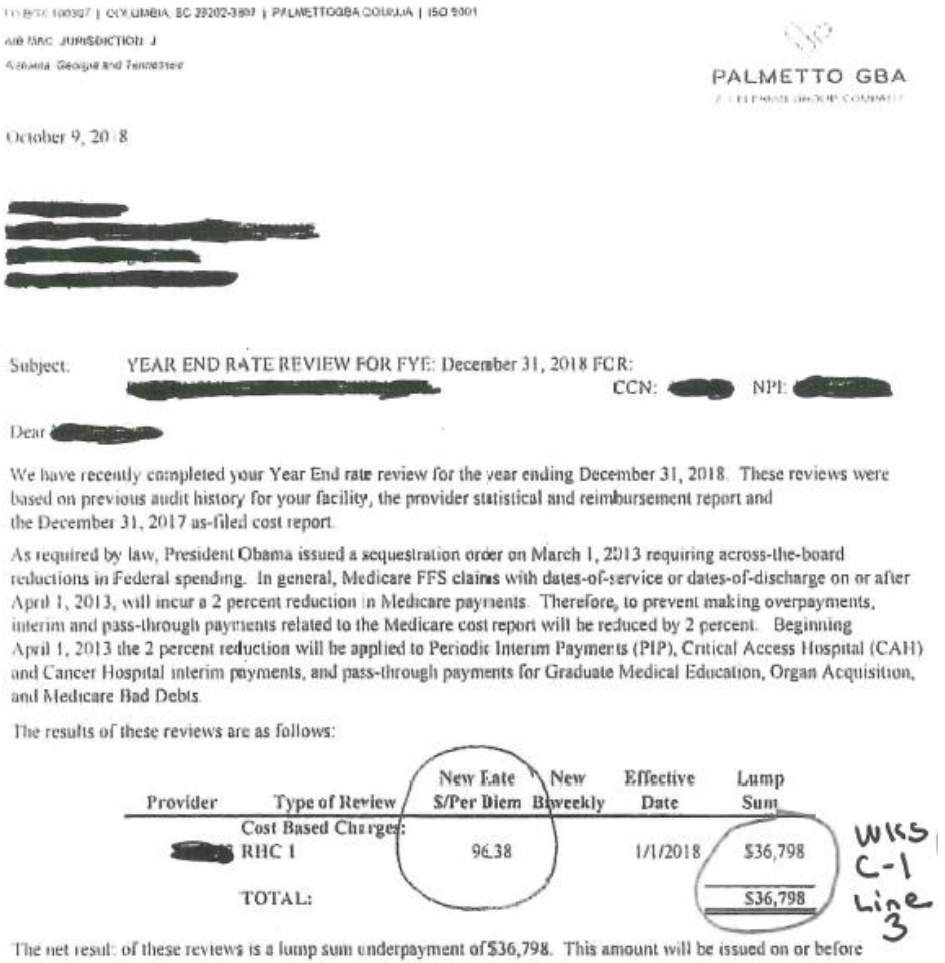
Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 01/03/19
Report Run Date: 01/03/19
Provider FYE: 12/31
Provider Number: 448966 Mid-South Convenient Care

PROVIDER SUMMARY REPORT
CLINIC - RURAL HEALTH - PREVENTIVE SERVICES

Page: 1
Report #: OD44203
Report Type: 71S

	SERVICES FOR PERIOD 01/01/18 - 12/31/18	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	1,079			
CHARGE SECTION				
REV CODE DESCRIPTION	UNITS / CHARGES	UNITS / CHARGES	UNITS / CHARGES	UNITS / CHARGES
0521 RURAL/CLINIC	920 $98,656.00			
TOTAL COVERED CHARGES	920 $98,656.00			
	WKS C Line 10	WKS C Line 15 & WKS C Line 18		
REIMBURSEMENT SECTION				
GROSS REIMBURSEMENT	$76,774.00			
LESS				
CASH DEDUCTIBLE	$0.00			
BLOOD DEDUCTIBLE	$0.00			
COINSURANCE	$0.00			
NET MSP PAYMENTS	$0.00			
PRE-SEQUESTRATION DEMO REDUCTION	$0.00			
SEQUESTRATION	$1,533.06	$0.00	$0.00	$0.00
POST-SEQUESTRATION DEMO REDUCTION	$0.00			
REBILLING ADJUSTMENT	$0.00			
NET REIMBURSEMENT	$75,240.94	C-1 Line 1		
ADDITIONAL INFORMATION SECTION				
CLAIM INTEREST PAYMENTS	$0.20			

Interim Payments to be reported on the Cost Report



PALMETTO GBA

October 9, 20 8

[redacted]

Subject: YEAR END RATE REVIEW FOR FYE: December 31, 2018 FCR: [redacted] CCN: [redacted] NPI: [redacted]

Dear [redacted]

We have recently completed your Year End rate review for the year ending December 31, 2018. These reviews were based on previous audit history for your facility, the provider statistical and reimbursement report and the December 31, 2017 as-filed cost report.

As required by law, President Obama issued a sequestration order on March 1, 2013 requiring across-the-board reductions in Federal spending. In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payments. Therefore, to prevent making overpayments, interim and pass-through payments related to the Medicare cost report will be reduced by 2 percent. Beginning April 1, 2013 the 2 percent reduction will be applied to Periodic Interim Payments (PIP), Critical Access Hospital (CAH) and Cancer Hospital interim payments, and pass-through payments for Graduate Medical Education, Organ Acquisition, and Medicare Bad Debts.

The results of these reviews are as follows:

Provider	Type of Review	New Rate $/Per Diem	New Biweekly	Effective Date	Lump Sum
	Cost Based Charges:				
[redacted]	RHC 1	96.38		1/1/2018	$36,798
	TOTAL:				$36,798

WKS C-1 Line 3

The net result of these reviews is a lump sum underpayment of $36,798. This amount will be issued on or before October 19, 2018. Enclosed are the computations and payment schedule(s) for your reviews.

If you have any questions please call me at (803) 763-1392 or e-mail me at brenda.williams@palmettogba.com.

Sincerely,

Brenda Williams

Brenda Williams
Accountant II, Provider Reimbursement
Provider Reimbursement

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

https://www.alabamapublichealth.gov/ruralhealth/assets/webinar.medicarebaddebt.12.10.13.pdf

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

Medicare-Medicaid Crossover 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). Correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in your accounting records. For bad debt amounts:

- Do not write off to a contractual allowance account
- Charge to an expense account for uncollectible accounts (bad debt)

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

Medicare Bad Debt Summary

1. Medicare coinsurance 20% of charges.
2. Medicare deductible of $185.00 in 2019.
3. Billed to the Part A MAC.
4. Nothing else is allowed.
5. Must try to collect for 120 days from first bill.
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.

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.

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 first bill.
    B. First Bill as least within 45 to 60 days of service.
    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)

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.

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 From	To	(4) Indigency & Wel. Recip (ck if apply) Yes	Medicaid #	(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
											-
											-
											-
											-
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Crossover or Duel 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.

Bad Debt – Excel Spreadsheets

Description	Link
Bad Debt Policy for Medicare Cost Report and Policy and Procedure Manuals	https://www.dropbox.com/s/0xjrovohy5q6532/2016%20Sample%20Bad%20Debt%20Policy%20for%20Rural%20Health%20Clinics.pdf?dl=0
Medicare Bad Debt Log in Excel	https://www.dropbox.com/s/1o6zh90uxhhxmzd/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20Only%20in%20September%202016.xls?dl=0
Medicare/Medicaid Crossover Bad Debt Log in Excel	https://www.dropbox.com/s/auf8w5dsu49q1v5/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20and%20Medicaid%20Crossovers%20in%20September%2C%202016.xls?dl=0

Electronic Filing of Cost Reports

Electronic Filing of RHC Cost Reports

Currently 50,000 cost reports claiming $200 billion of Medicare funds are filed annually to 12 different MACs

Effective July 2, 2018 Cost Reports may be filed by the following methods:

1. Via mail or express delivery services
2. Via MCReF portal in the EDIM system

Electronic filing is not Required

Electronic Filing Details

MCReF – a new application allows you to electronically transmit (e-File) your Medicare Cost Report

- Available as of 5/1/2018
- Usage is optional. Mail and hand-delivery remain filing options.
- Accessible by your EIDM (Enterprise Identity Management System) PS&R Security Official (SO) and Backup Security Official (BSO)
- Your MAC will have access to e-Filed cost report materials

MCReF (M-Cref) Detailed Overview

System Login: https://mcref.cms.gov

- Access is controlled by EIDM
- Restricted to EIDM PS&R SO / BSO
- Existing PS&R SOs / BSOs already have access
- Any organization without access to PS&R must register a PS&R SO with EIDM.

MCReF Authorized Cost Report Filer

CMS has created within EIDM a dedicated MCReF role that the EIDM Security Official of your organization or Backup Security Official could delegate out to a particular person that they want for cost report filing. And the SO or BSO will be able to approve that role. And it's called the **MCReF authorized cost report filer** role.

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Questions, Comments, Thank You

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