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TENNESSEE MEDICAID COST REPORTING
August 1, 2019

The State of Tennessee is very aggressively trying to limit the number of RHCs in Tennessee and payments to RHCs. In October, 2017 Tenncare sought and obtained a moratorium on new RHCs in Tennessee and began working on new RHC regulations on cost reporting and stopped paying new RHCs. Eventually in January, 2019 Tenncare began paying new RHCs again and issued final regulations for RHC cost reporting effective 7/13/2019. Before those new rules became effective Tenncare rescinded the regulations and will start the process all over.

Tenncare is looking closely at base year cost reports and are trying to disallow costs. The best way to combat this is prepare an Evidence Binder or Comprehensive Workpaper Binder ahead of time and to accumulate the data throughout the year with proper cost centers for the cost report. We have included in this report instructions for maximizing your base year costs, examples of the documents requested by Tenncare from recent audits, and a listing of cost centers that should be established for accounting purposes.

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This report includes data requirements, common mistakes, and depreciation regulations as well. Please review this report closely as you plan your accounting system, budgeting, and cash flow planning as you can expect to have cash issues during the base year if you want to really invest in a Medicaid rate that will benefit you for years and years to come. For example, in our table on page 3 the base year creates a loss of $175,000, but that increase of $56 per visit would generate additional Medicaid reimbursement of $2,240,000 over 10 years.

RURAL HEALTH
ASSOCIATION OF TENNESSEE

TennCare to Withdraw RHC & FQHC Reimbursement Rules

Good afternoon,

During a conversation with leadership at TennCare it was shared that **TennCare's pending rules on RHC & FQHC Medicaid Reimbursement will be withdrawn and a formal announcement will be made next week.**

TennCare did not elaborate further but said that the move was being made for a variety of reasons and they still plan to pursue "clarity and transparency" to PPS, however they have not specified what format that would take (i.e. formal rules or other guidance). I will keep you up to date as we learn more information. If you have any questions, feel free to contact me. Have a great weekend.

Rebecca Jolley | Executive Director | Rural Health Association of TN

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So what does it mean

1. If true Tenncare will withdraw pending regulations with an effective date of April 25, 2019 and enforceable 75 days thereafter. The rule changes related to the setting of PPS rates for RHCs and FQHCs and the processing of RHC cost reports including a process which required RHCs to submit much more cost report information and rebasing RHC prospective rates at least once every five years.
2. **It is not changing the RHC program as we currently know it as the regulations had not been implemented at this time (75 days after the effective date has not occurred yet).**
3. The process of codifying RHC and FQHC regulations will begin again and the process will be much more transparent and participatory. RHCs should watch the process closely by becoming a member of the Rural Health Association of Tennessee, the newly formed Tennessee Association of RHCS, and join our the Facebook group RHC Information Group at https://www.facebook.com/groups/1503414633296362/.

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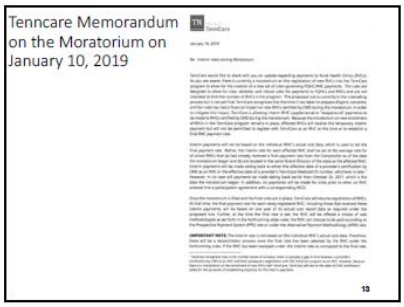

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Base Year Cost Report Planning

Some states have special rules for establishing payment rates from Medicaid in rural health clinics. Tennessee, Kentucky, Alabama, and Arkansas all have similar rules and it is important to maximize your cost per visit during these base years.

In Tennessee, the base year is the first full year the clinic is a RHC as of now. You will be required to act strangely in the base year to maximize your reimbursement as you will need to build your cost now to help offset future cost increases.

First, the world will be upside down. You will want your costs high and your visits low. You do not want to have a ton of visits, otherwise it will be difficult to keep your reimbursement rate up to the highest level it could be. If there was ever a year to take that two-week dream vacation, this is the year. Also, you will want to pay yourself as much as possible. This is not the year to minimize your tax liability, by having a low salary. You want to pay yourself as much as possible as Tennessee and most states do not recognize the value of services regulations

How are you going to do this?

1. First your interim Tenncare rate is established by the State of Tennessee based upon average cost per visit in each Grand Division. In West Tennessee the interim rate is $141.49 per visit, in Middle Tennessee it is $131.35 and in East Tennessee it is $137.99.

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2. Go to the bank and get a line of credit for as much as you possible can. $100,000 to $250,000 is a good starting place. The more the better. You will lose money during the base year due to the cost per visit you need to create. Here is the methodology:

   The cost report computes your cost per visit by dividing your total allowable cost by your total visits including Medicare, Medicaid, Commercial, and self-pay. If you maximize your Medicaid rate in the base year, you will lose money because the other payers will rarely reimburse you at the rate the Medicaid will pay you under the RHC program. The idea is to get your cost up during the base year and then try to lower them after the base year is over.

Base Year Cost Reporting

Description	Medicare	Medicaid	Other	Total
Payor Mix	25%	40%	35%	100%
Total Visits	2,500	4,000	3,500	10,000
Cost Per Visit	$130	$130	$130	$130
Collections per Visit	$95	$130	$105	112.50
Loss Per Visit	$35	0	$25	$17.50
Loss per Payer	($87,500)	0	($87,500)	($175,00)

3. Pay yourself. Increase your salary to the highest amount you can pay and still pay the bills. You must pay yourself for Medicaid to allow the payments in most states. (Medicare has special rules for the value of services for sole proprietors and partners; however, Medicaid in some cases does not honor this type of reimbursement. To be safe, pay yourself)

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4. Accrue a bonus to yourself to be paid within 75 days of year-end. This amount should be as much cash flow as you can justify for the 75 days after year-end. Even if you do not take a salary for the first two months of the following year. Remember, that money will not help you set your rate.
5. Pay bonuses, set up a retirement plan for your employees and fund it as an accrual. Remember owners must pay themselves for accrued expenses within 75 days of year-end, but entities other than owners (employees, consultants, etc.) you have 12 months (one year) from year-end to pay accruals.
6. **If you have a related party transaction. For example, if you rent a building from yourself or a relative, reduce that payment as low as possible during the base year. Remember, this amount is non-allowable. This could cripple your rate if you pay a large rent payment as a related party and it is disallowed**. You can use the actual cost as an allowable expense. You will want to lower your rent and increase your compensation to the highest amount possible.

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Appendix A

Cost Report Data Requirements

Trial balance of expenses

- Most important document on the cost report
- Accrual based accounting (not tax)
- Assets must be capitalized
- Identify salaries by job title (MD, ARNP, PA, Admin, etc)

Labor Summary

- Salaries and hours by employee including job title
- Separately identify physician medical director comp and time vs clinic
- Expense and hours for contracted providers

Fixed Asset Schedule

- Book depreciation instead of cash
- Identify medical equipment vs office equipment

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Examples of non-allowable expenses

- Marketing/PR
- Donations
- Start-up costs (must be amortized)
- Political and lobbying activities
- Bad debts
- Other non-RHC costs – (Laboratory, Technical components, and hospital visits)

Non-operating (misc) revenue

Identify source of revenue (rent, medical records sales, etc)

Be aware of any related-party costs

Physician (or physician's family) owns RHC building and leases back to the clinic

Visits

- Only include face-to-face visit with a MD, midlevel or other qualified provider
- Do not include nurse only visits
- Do not include injection or lab only visits
- Identify site of service (clinic, nursing home, hospital, etc) Identify by month if possible

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Medicare visits – must have access to Provider Statistical and Reimbursement (PS&R) Summary
Must have active login id
Report types 710 and 71S

Productive Hours (FTE)

Do not include holiday, sick, CPE, etc

MEDICAID COST REPORT

Purpose – To determine a Medicaid Prospective Payment System (PPS) rate to be used going forward
Subject to annual MEI increases

Worksheets Similar to Medicare Cost Report

- Certification page
- Statistical and other data
  - Date licensed as RHC
  - Type of control
  - Number of visits
  - Title XIX
  - Title XVIII
  - All Other

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Schedule A – Expenses
- General Service Costs
- Direct Service Costs
- Other Non-Reimbursable Costs

Schedule A-1 Adjustments
Schedule A-2 Reclasses
Schedule A-3 Related Party Costs
Schedule A-4 Staffing
Costs and FTEs
Schedule A-4-1 –
Purchased Services
Schedule A-5
Depreciation
Questionnaire
Schedule A-6 – Grants, Gifts and Endowments
Schedule B – Cost Allocation
- Must break out medical & nursing sq ft, lab, radiology, pharmacy, etc

Schedule C – Apportionment of Costs to Title XIX
Include Medicaid and total lab and radiology tests

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COMMON COST REPORT MISTAKES

Cash vs accrual Method

Provider compensation

Medicare and Medicaid typically uses MGMA benchmarks*

- KY is part of Southern Region
- Family Medicine (without OB)
- Physician - $229,900 and 3,894 encounters ($59.03 per encounter)
- NP - $93,213 and 2,779 encounters ($33.54 per encounter)

Expenses not liquidated

Must be paid within one year

Related party expenses not adjusted

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Appendix B

Cost Report Cost Centers

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

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