Missouri
Medicare Cost Reporting for RHCs

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Overview

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Legislative Change

Medicare Cost Report for RHCs

Questions

LEGISLATIVE CHANGE

New RHC Reimbursement Methodology

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- On December 27, 2020, the President signed into law, the "*Consolidated Appropriations Act, 2021 (CAA)*" which changed the reimbursement methodology for Rural Health Clinics (RHC) starting on April 1, 2021
  - Starting on April 1, 2021, all new RHCs established after December 31, 2019, regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit (UPL) set at the following rates:
    - a) In 2021, after March 31, at $100 per visit;
    - b) In 2022, at $113 per visit;
    - c) In 2023, at $126 per visit;
    - d) In 2024, at $139 per visit;
    - e) In 2025, at $152 per visit;
    - f) In 2026, at $165 per visit;
    - g) In 2027, at $178 per visit;
    - h) In 2028, at $190 per visit;
    - i) In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
  - RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2019, will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI
- Since the final legislation varied greatly from the RHC Modernization Act and due to the impact on provider-based RHCs (PB-RHC), efforts are underway to change certain provisions
  - On April 14, 2021, the President signed H.R. 1868 into law which fixed some of the grandfathering issues caused through the change of the RHC reimbursement methodology in the Consolidated Appropriations Act, 2021

MEDICARE COST REPORTS FOR RHCs

Critical Access Hospital Reimbursement

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- Critical Access Hospitals (CAH) are paid for most inpatient and outpatient services at 101 percent of Reasonable Cost
  - Medicare does not include CAHs in the hospital Inpatient Prospective Payment System (IPPS) nor the hospital Outpatient Prospective Payment System (OPPS)
  - Medicare pays CAH services according to Part A and Part B deductible and coinsurance amounts and does not limit most of the 20 percent CAH Part B outpatient services copayment changes by the Part A inpatient deductible amount[1]
- Roughly 890 of the 1,350 CAHs own and operate at least one RHC which represents 66% of the total number of CAHs across the country
  - Those 890 CAHs own and operate roughly 1,650 RHCs
  - Under the prior RHC reimbursement methodology, PB-RHCs owned and operated by a CAH would receive un-capped cost-based reimbursement from Medicare which is in line with most of the other essential, core safety net services offered at the CAH
    - Un-capped cost-based reimbursement subject to meeting the RHC minimum productivity threshold and allowable cost assumptions
- The change in PB-RHC reimbursement methodology means CAHs will no longer receive cost-based reimbursement for a business unit that may represent a large portion of the business and a cornerstone of their rural community's healthcare delivery system
  - Based on FY19 cost report data, roughly 750 RHCs owned and operated by a CAH saw annual cost increases in excess of the 1.4% 2021 Medicare Economic Index (MEI) which will negatively impact the financial performance of those CAHs
    - From 2017 to 2019, the capped RHC rate increased between 1.2% to 1.9% per year
    - The 750 RHCs referenced have been in operation for at least 3 years

1: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsht.pdf

CAH Overhead Cost Allocation

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- The Medicare Cost Report is a systematic method of cost accounting that determines both allowable costs and the costs allocated to each department (such as Med/Surg, ED, PB-RHC, etc.)
  - Since CAHs receive cost-based reimbursement for most other services, the allocation of costs to each department is of importance and the CAH settlement can have a material impact on the financial statements

- Since the Medicare cost-report allocation methodology requires the inclusion of provider compensation when determining the overhead costs allocated to the PB-RHC, PB-RHCs can distribute a disproportionate amount of overhead costs to a now non-cost-based program
  - The following example illustrates the impact of a PB-RHC on the allocation of costs under a CAH:

	Direct Cost	Adjustment	Adjusted Cost	Overhead Allocation	Fully Allocated Cost
PBC	$ 2,123,292	$ (962,156)	$ 1,161,136	$ 518,696	$ 1,679,832
PB-RHC	$ 2,123,292		$ 2,123,292	$ 622,867	$ 2,746,159
				$ 104,171	

  - In the example provided, operating the practice as a PB-RHC led to a $104K increase in overhead cost allocation to the PB-RHC which will negatively impact reimbursements received for other cost-based services

RHC Medicare Cost Reports

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- **CMS-222-17 – Independent RHCs *(replaced CMS-222-92)***
  - This form must be used by hospital-based RHCs for determining Medicare payment for RHC services under 42 CFR 405, Subpart X and includes the following worksheets:
    - Worksheet S, Parts I, II & III - Cost report status/certification statement and settlement summary
    - Worksheet S-1, Part I & II - RHC identification data and data for each RHC that files as part of a consolidated cost report
    - Worksheet S-2 - Provider Cost Report Reimbursement Questionnaire *(Form CMS-339)*
    - Worksheet S-3, Part I - Statistical data regarding the number and types of visits by title
    - Worksheet A - General service and direct patient care costs
    - Worksheet B, Part I & II - Productivity standard and allowable costs of RHC services
    - Worksheet C, Part I & II - Rate per visit and the determination of the total payment
    - Worksheet B-1 - Pneumococcal and influenza vaccine costs.
    - Worksheet C-1 - Analysis of payments to the RHC for services rendered

RHC Medicare Cost Reports

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- **CMS-2552-10 Worksheet M – Hospital-Based RHC**
  - This form must be used by hospital-based RHCs for determining Medicare payment for RHC services under 42 CFR 405, Subpart X and includes the following worksheets:
    - M-1 Analysis of Provider-Based RHC
    - M-2 Allocation of Overhead to RHC
    - M-3 Calculation of Reimbursement Settlement for RHC
    - M-4 Calculation of Pneumococcal and Influenza Cost
    - M-5 Analysis of Payments to Hospital-Based RHC
  - It is unknown what specific interpretive guidelines CMS will provide regarding the changes in the RHC reimbursement methodology
    - The interpretive guidelines may cause changes to the information reported on the RHC cost reports

RHC Medicare Cost Reports

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- **Opportunities**
  - The following are the opportunities/recommendations from the 100+ Stroudwater CAH/RHC site visits conducted over the last three years
    - **Cost Report Improvements**
      - Establish a bad debt policy that pulls claims back from the collection company, after a certain period of inactivity, for inclusion on the cost report
        - Target outpatient Bad Debt 10% of patient responsibility
      - Work with cost report preparer to determine if investment funds can be designated as funded depreciation to avoid significant offset
      - Implement a time study process and conduct medical record time studies to accurately capture true worked time by department for inclusion on the cost report
      - Monitor Worksheet E, Part B (Outpatient) to ensure the hospital is not passing on greater than 40% of the cost of care to the beneficiaries in the way of co-insurance and/or deductibles

RHC Medicare Cost Reports

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- **Cost Report Improvements**
  - Implement systems and evaluate at least quarterly the applicable FTEs used for minimum productivity calculations
    - PB-RHCs will often experience reductions in reimbursement due to the overstatement of FTEs minimum productivity purposes

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ALLOCATION OF OVERHEAD TO HOSPTIAL-BASED RHC/FQHC SERVICES	PROVIDER CCN: ______ COMPONENT CCN: ______	PERIOD: FROM ______ TO ______	WORKSHEET M-2

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1-3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4-7)						8
9	Physician Services Under Agreements						9

RHC Medicare Cost Reports

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- **<u>Cost Report Improvements</u>**
  - Evaluate the salaries included in Nursing Administration and ensure only the Chief Nursing Officer (CNO) and direct administrative support staff are included in this category
    - Ensure Nursing Administration costs are allocated only to departments that involve nursing functions – exclude departments such Imaging, Therapy, Laboratory, Pharmacy
  - Establish an internal threshold (such as a due from Medicare in excess of $200K) that would drive the completion and filing of an interim cost report
  - Evaluate LDPR vs Med/Surg room usage based on observation status vs. active labor time status time studies to accurately allocate square footage
    - Ensure costs for LDRP include only the time assigned to “active” delivery otherwise these costs should be allocated to the Med/Surg cost center
  - Monitor departments with low charges relative to cost to ensure they are not missing charge opportunities, as this has a direct impact on ‘bottom line’

RHC Medicare Cost Reports

- **Cost Report Improvements**
  - Consider consolidating RHCs for cost report purposes to remove reimbursement variances

	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Clinic 7	Combined Totals	Consolidated Totals	Variance
RHC Allowable Cost	$ 397,089	$ 451,751	$ 309,335	$3,014,634	$4,326,832	$2,978,745	$ 349,383	$ 11,827,769	$ 11,827,769	$ -
Visits	1,432	1,883	1,761	15,845	23,906	8,967	1,731	55,525	55,038	(487)
Cost / Visit	$ 277.30	$ 239.91	$ 175.66	$ 190.26	$ 180.99	$ 332.19	$ 201.84	$ 193.61	$ 214.90	$ 21.29
Medicare Visits	395	498	512	4,061	6,260	315	249	12,290	12,290	-
Totals	$ 109,532	$ 119,475	$ 89,937	$ 772,637	$1,133,020	$ 104,640	$ 50,258	$ 2,379,499	$ 2,641,144	$ 261,645

    - It is unknown how the change in RHC reimbursement will impact the ability of RHCs to consolidate their cost reports

  - Conduct time studies to track provider time spent on Medical Directorships and other administrative functions

  - Monitor Ratio of Cost to Charge (RCC) levels to potentially indicate revenue cycle process improvement opportunities such as charge setting and/or charge capture improvement opportunities

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RHC Medicare Cost Reports

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- **Cost Report Improvements**
  - Apply for a waiver to the RHC minimum productivity thresholds for 2020
  - Evaluate the proportion of Pneumococcal and Influenza vaccines administered to each payor class to ensure accurate reporting of vaccine costs and volumes for cost report purposes

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COMPUTATION OFHOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN: ______ COMPONENT CCN: ______	PERIOD: FROM ______ TO ______	WORKSHEET M-4
Check applicable boxes: [ ] Hospital-based RHC [ ] Hospital-based FQHC	[ ] Title V [ ] Title XVIII [ ] Title XI		

		PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Worksheet M-1, column 7, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, column 7, line 22)			6
7	Total overhead (from Worksheet M-2, line 19)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)			15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)			16

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