Cost Reporting

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Promoting Access to Health Care

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Objectives

- Why a cost report is needed
- What you need to need to complete the cost report
- Common cost report calculations and where they are located on the cost report
- How to read and interpret the report

Why a Cost Report?

- Medicare will cut off payments to the clinic for an unfiled cost report
  - Cost reports are due 5 calendar months from the clinic's year end
  - Cost reports must be submitted in electronic format (ECR File) on CMS approved vendor software via CD.
  - Signed Hard Copy must also be submitted with an electronic "fingerprint" matching the electronic cost report.

Why a Cost Report?

- **Determines Cost per Visit**: Allowable RHC Costs/RHC Visits = RHC Cost Per Visit = RHC rate; *not to exceed the maximum allowable reimbursement rate for current period*
- **Reconciles** Medicare's interim payment method to actual cost per visit
- Determines **future interim payment** rates
- It is where you **get paid** for:
  - Pneumococcal and Influenza **vaccine costs**
  - Medicare **Bad Debt**

Cost Reporting

Information Needed to Complete the RHC Cost Report

List of information to gather for the cost report:

- Financial Statements
- Visits by type of practitioner
- Clinic hours of operation
- FTE calculations
- Total number of clinical staff hours worked during the cost report period.

List of information to gather for the cost report:

- Salaries by employee type
- Vaccine Information
- Related Party Transactions
- Depreciation Schedule

List of information to gather for the cost report:

- Medicare Bad Debt
- Laboratory Costs
- Non-RHC X-ray Costs
- PSR - obtained on-line through Medicare

Worksheet S – Statistical Data Reporting

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Statistics on Worksheet S – Independent/S-8 Provider Based

- Facility Name
- Entity Status
- Hours of Operation
- If combined cost report for multiple locations, worksheet S, Part III
- If filing a 'No Utilization', "N" for line 13 (independent)

Clinic Hours of Operation

- Should reflect hours practitioners are available to see patients
- Broken between hours operating as an RHC or a Non-RHC, if applicable
- Reported in military time format

Worksheet A / Worksheet M-1 – Expense Reporting

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Expense Reporting – What you need

- Balance Sheet
- Profit and Loss Statement
- Trial Balance

Expense Reporting – How you need it

- Financial Statements must match cost reporting period
  - For most this will be 1/1/xx– 12/31/xx.
  - For new clinics, financial statements must reflect costs from the date of the clinic's certification to the end of their first fiscal year.

Expense Reporting – where is goes

- All costs from the financial statements must be reflected in columns 1 and 2 of worksheet A (independent) or M-1 (provider-based)
  - Column 1: Compensation
  - Column 2: All Other
- Expenses should be detailed enough to properly classify within cost report categories

Expense Reporting – what doesn't belong

- Miscellaneous/Non-Patient Care revenue must be reviewed for possible offsets
- Non-allowable expenses must be reviewed for offset or classification in a non-reimbursable cost center

Cost Report Categories

Cost Report has three main cost classifications:

- Healthcare Costs
- Overhead
- Non-RHC/Non-Allowable

Cost Report Categories

Healthcare Costs

- Compensation for providers, nurses and other healthcare staff
- Compensation for physician supervision
- Cost of services and supplies incident to services of physicians (including drugs & biologicals incident to RHC service)
- Cost related to the maintenance of licenses and insurance for medical professionals

Allowable Cost of Compensation – Health Care Staff

- Salaries & Wages
- Payroll Taxes
- Health & Life Insurance
- Pension Contributions
- Paid vacation or leave, including holidays and sick leave
- Educational courses
- Unrecovered cost of medical services rendered to employees

Other Health Care Costs

- Malpractice and other insurance (Premium can not exceed amount of aggregate coverage)
- Depreciation
- Transportation of Health Center Personal between clinics or other healthcare locations

Overhead

Facility Overhead – Facility Cost

- Rent
- Insurance
- Interest on Mortgage or Loans
- Utilities
- Other building expenses

Overhead

Overhead – Administrative

- Office Salaries
- Office Supplies
- Legal/Accounting
- Contract Labor
- Other Administrative Costs

Non-RHC Costs

Non RHC Costs Examples:

- Lab, X-ray, EKG: Technical component is billed to Medicare Part B
- Items and services not covered under program (e.g. dental, physical, retail pharmacy, etc.)

Non-RHC Costs

Overhead is allocated by the ratio of Healthcare Costs to Non-RHC Costs

- Minimize amounts allocated to Non-RHC cost centers
- Ensure all applicable 'healthcare' expenses are properly classified on the cost report

Other Costs

Membership Costs:

Generally

- Professional, technical or business related organization allowable
- Social & Fraternal not allowable

Research costs not allowable

Translation services costs allowable

Other Costs

Advertising Costs:

- Staff recruitment advertising allowable
- Yellow pages advertising allowable
- Advertising to increase patients not allowable
- Fund-raising advertising, not allowable

Taxes:

- Taxes levied by state and local governments are allowable if exemption not available
- Fines and penalties not allowable

Interest Expense

Necessary and proper interest on current and capital indebtedness is an allowable cost.

Definitions:

- Interest – cost incurred for use of borrowed funds. Can be on current or capital indebtedness.
- Necessary – incurred on a loan made to satisfy a financial need of provider. Loans which result in excess funds are not necessary. Incurred on a loan made for a purpose reasonably related to patient care.

Depreciation

An appropriate allowance for depreciation on buildings and equipment used in provision of patient care is allowable cost.

Depreciation must be:

- Identifiable and recorded in accounting records
- Based on historical cost of asset or fair market value of donated assets
- Prorated over the estimated useful of asset

Depreciation

- With few exceptions – straight line method of depreciation only method acceptable
- Depreciation on assets purchased with federal funds an allowable cost
- Depreciation on donated assets allowable
- Fully depreciated assets still in use can have a revised life assigned

Worksheet A-1 / A-2 – Independent (A-6 / A-8 PB) – Adjustments to cost

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Adjustments

- Worksheet A-1:Used to reclassify costs to appropriate cost centers
- Worksheet A-2: Used to include additional or exclude non-allowable costs

Lab/X-ray/EKG Allocations Worksheet A-1

Lab, X-ray, EKG

- Billed to Part B by independent RHCs
- Billed through hospital and included in hospital costs for provider-based RHCs

Lab/X-ray/EKG Allocations

- Method A: Staff performing lab, X-ray, EKG duties
  - Allocate % of time for non-RHC carve out for staff performing non-RHC lab/X-ray/EKG duties vs. RHC duties
  - Time studies of staff to support the allocated carve out
- Method B – Time studies for each specific test
  - Calculate time per test
  - Multiply by number of tests performed
  - Multiply by average hourly wage
- Reclassify resulting non-RHC wages into non-reimbursable cost center

Non-allowable Costs – Exclude on Worksheet A-2

- Entertainment
- Gifts
- Charitable Contributions
- Automobile Expense – where not related to patient care
- Personal expenses paid out of clinic funds

Worksheet A-2-1/A-8-1
Related Party Transactions

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Related Party Transactions

- Most common related party transaction is related party building ownership (e.g. building is owned by the doctors which also own the clinic – clinic pays 'rent' to docs)
- Cost must be reduced to the 'cost of ownership' of the related party
- Cost is adjusted to actual expense incurred by the related party

Related Party Transactions

- Related party building ownership cost items for reporting
  - Mortgage Interest
  - Property Taxes
  - Building Depreciation
  - Property Insurance
  - Repairs & Maintenance paid by building owners
  - Lawn Service, etc. – if not already in clinic expenses

Worksheet B / Worksheet M-2 Visit and fte reporting

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RHC Visits

- Definition: Face-to-face encounter with qualified provider during which covered services are performed.
- Broken down by provider type (MD, PA, NP)
- Count only face-to-face encounters
- Do not include visits for hospital, non covered services, non qualified providers or injections

Hours worked for FTE Calculation

- Only clinical hours should be used in the FTE calculation
- Categorize each practitioner's work into:
  - Administrative (used to reclassify wages of provider)
  - Patient care – Clinic/Nursing Home (used to calculate the FTE input on the cost report for the provider)
  - Inpatient care hours - if inpatient work is part of the provider's clinic compensation package (used to adjust wages of provider)

Visits

- Visits are reported by type of clinician
  - Physician
  - Physician Assistant
  - Nurse Practitioner
- All clinician's working on a regular basis should be included in visits subject to the productivity standard
- Physician Services Under Agreement – for the occasional 'fill in' (locum tenens)

FTE Calculation

How are FTEs calculated?

- FTE is based upon how many hours the practitioner is available to provide patient care
- FTE is calculated by practitioner type (Physician, PA, NP)

Medicare Productivity Standard

- Medicare will charge the clinic with a minimum number of visits per FTE, whether performed or not
- 4,200 visits per employed or independent contractor physician FTE
- 2,100 visits per midlevel FTE
- Physician Services under agreement not subject to productivity standards – limited application (cannot work on a regular basis)

Medicare Productivity Standard

- Productivity Standard applied in aggregate
- Total visits (all providers subject to the FTE calculation) is compared to total minimum productivity standard.
- A productive midlevel with visits in excess of their productivity standard can be used to offset a physician shortfall.

Worksheet B-1 / Worksheet M-4 Vaccine Reporting

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Vaccine Information

Seasonal Influenza and Pneumovax reporting has four data elements:

- Vaccine Staff Time Ratio
- Total vaccines given of each to ALL insurance types
- Total Medicare vaccines given of each (Medicare log must accompany cost report)
- Cost of vaccines (include invoices if possible)

Vaccine staff time ratio

- Total number of clinical staff hours worked per year becomes the denominator in the vaccine ratio. **All clinical staff** are included, as all clinical salaries are used in the cost report calculation
  - Physicians
  - RN/LPN
  - MA

Vaccine staff time ratio

- Ten minutes is the accepted time per vaccine administration
- Total Vaccines x 10 minutes/60 minutes = 'total vaccine administration hours'
- Divide 'total vaccine administration hours' by total clinical hours worked for **Staff Time Ratio**

Vaccine Cost documentation

- Clinic must maintain logs of Influenza and Pneumococcal vaccines administered
- Invoices for the cost of Influenza and Pneumococcal vaccine should be submitted with the cost report
- Submit vaccine logs electronically if possible

Influenza Log

INFLUENZA VACCINATION
LOG

Provider Name:	
Provider Number:	
FYE:	

Patients Name	Medicare or Ins. Number	Date of Service (DOS)	Charge Fill Out Certification Notice

Pneumo Log

PNEUMOCOCCAL VACCINATION (PPV) LOG

Provider Name:	
Provider Number:	
FYE:	

Patients Name	Medicare or Ins. Number	Date of Service (DOS)	Charge Fill Out Certification Notice

Worksheet C / Worksheet M-3 Settlement data

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Settlement Data

Data is pulled from the clinic's PS&R

- Medicare visits – include preventive visits
- Deductibles
- Total Medicare charges
- Medicare preventive charges

Settlement Data

Data is pulled from the clinic's PS&R

- Coinsurance – info only
- Medicare payments – be sure to include MSP payments and lump sum settlements, if any.
- Bad Debts – Total
- Bad Debt – Dual Eligible

PSR

- A copy of your PS&R (Provider Statistical and Reimbursement System report) will need to be obtained by the clinic electronically through CMS's Enterprise Portal at https://portal.cms.gov/
- This link will open the user guide for registering and using the portal: https://portal.cms.gov/wps/wcm/connect/de842efb-0fcb-48c6-9b8c-acda14d10c14/CMS+EIDM+User+Guide.pdf?MOD=AJPERES&CVID=lxK7qaa

PSR

- Compare PSR total to your Medicare visit count. Is this accurate? If not, determine why:
  - Were incidental services included in the visit count
  - Were dual-eligible counted twice
  - Did more than one visit get counted on one day (surgical procedure/office visit)

Medicare Bad Debt

- Medicare bad debt form must accompany cost report of total bad debt being claimed.

- Medicare bad debt is claimed on the cost report based on the fiscal year in which the bad debt was **written off**, not date of service.

Medicare Bad Debt

- Medicare Bad Debt IS:
  - Deductibles and Coinsurance amounts uncollectible from Medicare beneficiaries after reasonable collection efforts

Medicare Bad Debt

- Medicare Bad Debt IS NOT:
  - Uncollected deductibles and coinsurance from:
    - private pay patients, or any other non-Medicare beneficiary
    - Medicare Advantage or Medicare Part B
  - Charity, Courtesy, and Third-Party Payer Allowances
  - Uncollected amounts due from other payers
  - Disputed Medicare claims

Criteria for Allowable Bad Debts

- Debt must be related to covered services and derived from deductible and coinsurance amounts.
- Provider must establish that reasonable collection efforts were made.
- Debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

When to write off a Medicare Bad Debt

- The CFR at 42 CFR 413.89(f) requires that the uncollectible Medicare deductible and coinsurance be charged off as bad debts **in the accounting period when the bad debt is determined to be worthless.**

When to write off a Medicare Bad Debt

- Bad debt log is for Medicare deductibles and coinsurance deemed uncollectible and **written off clinic's books** during the cost reporting period.
- It can, and most often does, contain **dates of service** prior to the current cost reporting period.
- Based on write off date, not date of service!

When to write off a Medicare Bad Debt

Two types of Medicare bad debts:

- Indigent or Medically Indigent Patients
  - No collection efforts required for Medicaid beneficiaries. Must bill Medicaid and retain remittance advice as documentation
- Patients not deemed to be indigent:
  - Collection efforts required

Indigent Patients

- Automatic indigence determination for Medicare/Medicaid dual-eligible beneficiaries
- **Must bill** Medicaid for proof of eligibility and apply any Medicaid payments, if applicable.
- Must have a processed State Medicaid remittance advice before allowing dual eligible bad debts

Indigent Patients

Indigent patients not eligible for Medicaid:

- Indigence must be **determined by the provider**, not by the patient (i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence
- Take into account a patient's **total resources** which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses

Indigent Patients

Indigent patients not eligible for Medicaid:

- Determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian and
- Patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Reasonable Collection Efforts

- **SAME EFFORT** applied to any bill:
  - Collection letters
  - Phone calls
  - Collection agency (if used for non-Medicare patients)

Presumption of Noncollectibility (120 Day Rule)

- If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than **120 days** from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.
- Any payments received from the beneficiary re-starts the 120 uncollectability timeframe

Collection Policy

- Must be consistent among all payer types
- Must involve the issuance of a bill on or shortly after the date of service
- Should include other actions such as:
  - Subsequent billings
  - Collection Letters
  - Telephone Calls or personal contacts with this party
- Must constitute a GENUINE, rather than a token, collection effort.

Collection Policy

- May involve the use of a Collection Agency in addition to or in lieu of subsequent billing by the clinic. If used:
  - Refer all uncollected patient charges of **like amount** regardless of class of patient
  - If the collection agency collects from the beneficiary, the FULL AMOUNT collected must be applied to the Medicare bad debt
  - Collection agency fees applicable to the collection of the debt can be recorded as an administrative expense on the clinic's financial statements

Collection Policy

Do **NOT** include a "**MEDICARE COLLECTION POLICY**" section within your collection policy. (This will indicate different treatment/procedures for the collection of Medicare bad debts and cause your bad debts to be disallowed at audit)

Collection Policy

Within the section of the collection policy that outlines the procedure for bad debt write off (consistent among all patient classes), include a section that explains how to complete the Medicare bad debt log:

- How to fill out the log
- Documentation maintenance
- Referral to the cost report

Audit Documentation

Indigent Patients

- Medicaid dual-eligible beneficiary: Medicaid remittance advice indicating payment or denial of payment.
- Indigent, not Medicaid eligible: Documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination

Audit Documentation

Non-Indigent Patients

- Collection efforts must be documented in the patient's file
  - Copies of bills
  - Documentation of phone calls/personal contact
  - Follow up letters

Bad Debt Log

- Patient Name
- HIC number
- Date of service
- Whether the patient has been deemed indigent and their Medicaid number if this was the method utilized to determine indigence
- Date the first bill was sent to the beneficiary
- Date the bad debt was written off
- Remittance advice date
- Deductible and coinsurance amount
- Total Medicare bad debt (reduced by recoveries)

Medicare Bad Debt

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

CLINIC NAME:	
PROVIDER NUMBER:	
FYE:	

WORKSHEET 9 - MEDICARE BAD DEBT LOG

1	2	3	4		5	6	7	8	9	10	11	12
											Other Payments and Patient	COLUMNS (8+9-10-11=12)
	Beneficiary	Date(s) of Service	Indigency & Med. Recip. (check if applicable)		Date First Bill Sent to Beneficiary	Write-Off Date	Medicare Paid Date	Medicare Deductible Bad debt	Medicare Co-Ins Bad debt	Medicaid Payment Amount	Payment Amounts	Total Bad debt
Beneficiary Name	HIC No.		Yes	*must supply Mod. #								

* These amounts must not be claimed unless provider bills for these services with the intention of payment. See instructions for outline 4 - indigency/welfare recipient, for possible exception.

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Other Topics

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Grants & Gifts

- Unrestricted grants and gifts not deducted from operating costs.
- Post October 1983 – restricted grants also not deducted from operating costs.
- Donated supplies and space not allowable cost (except if center is unit of state or local government).
- Grants made to cover all or portion of specific costs or groups of costs for a stated period of time are seed – money grants – not deducted from operating costs.

Revenue Maximization Strategies

- Annually update fee schedule
- Coinsurance reimbursement
- Minimize non-reimbursable costs
  - Reduce overhead attributable to non-reimbursable costs
- Carve-out hours
- Medicare Advantage paying RHC rate?

Revenue Maximization Strategies

Include all allowable costs

- Accrued vacation and sick pay.
- Depreciation - * donated assets
  * fully-depreciated assets

Properly record and count encounters

- **If you cannot bill for it – do not count it!**

Questions?