Advanced Medicare Cost Reporting for Rural Health Clinics

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Today's Agenda

- Rural Health Clinic Medicare Cost Report Overview
- RHC Visits/Provider Productivity
- RHC Benchmarking
- COVID-19 Considerations

Rural Health Clinic Medicare Cost Report Overview – A Review

Medicare Cost Report

The Medicare cost report is the method of reconciling payments made by Medicare with the allowable costs for providing those services.

- If total Medicare payments received exceed the allowable costs, the provider must pay back the difference to Medicare.
- If total Medicare payments received are less than the allowable costs, Medicare will make an additional payment to the provider.

Medicare Cost Report

There are two types of RHCs; cost reporting is slightly different for each.

- Independent RHCs – submit an RHC cost report to one of five regional fiscal intermediaries.
- Provider-based RHCs – submit an RHC cost report as a subset of the host provider (usually a hospital).

Medicare Cost Report

- Cost report is due five months after the close of the period covered.
- Must be filed electronically.
- Terminating cost reports are due 150 days after the termination of provider agreement.
- Extension to file the cost report may be granted by intermediary only for extraordinary circumstances such as a natural disaster, fire, or flood.

Medicare Cost Report

- Three components of the RHC cost report settlement:
  - Medicare All-Inclusive Encounter Rate
  - Medicare Influenza and Pneumonia Vaccinations
  - Medicare Bad Debt

Medicare Cost Report

Medicare All-Inclusive Encounter Rate

$$\frac{\textit{Allowable RHC Costs}}{\textit{Rural Health Clinic Visits}} =$$

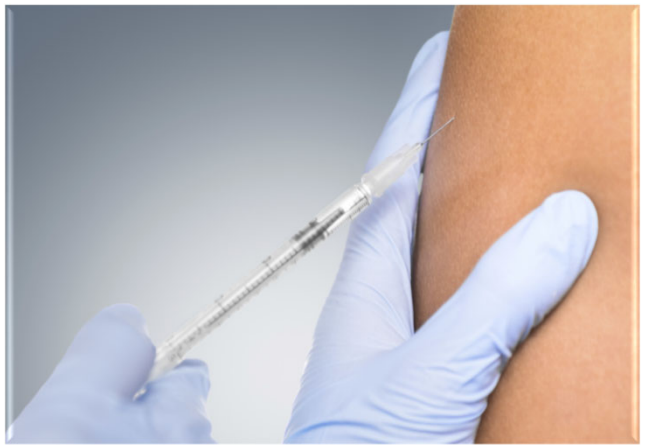
RHC Cost Per Visit (Rate)

(Not to exceed the maximum reimbursement limits for independent and provider-based > 50 beds.)

Medicare Cost Report

Medicare influenza and pneumonia costs are reimbursed on the cost report:

- Cost includes staff, vaccine, and overhead costs
- These services should not be billed
- Listing of Medicare patients must be included with the cost report submission:
  - Name
  - Medicare number
  - Date of service
- Vaccine invoices are submitted with the cost report
- Pneumo/Prevnar vaccinations are reimbursable on the cost report



Medicare Cost Report

Medicare Bad Debt

- Medicare bad debt reimbursement is 65% of allowable bad debt claimed.
- Allowable deductible and coinsurance amounts only.
- Debt must be related to covered services.
  - Do not include lab, radiology, or other non-RHC services on the cost report.
- Provider must be able to establish that reasonable collection efforts were made.
  - Document that a reasonable and consistent collection effort has been made for 120 days from the date of the initial bill to the patient. (CMS is now insisting that if turned over to an outside collection agency, account cannot be claimed until returned from the collection agency.)

Medicare Cost Report

Medicare Bad Debt (continued)

- Denials by Medicaid as secondary payer, as long as actually billed and denied, can be claimed immediately.
- Documented charity care write-offs can be claimed immediately.
- Provider Reimbursement Manual – Part I Chapter 3
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

Medicare Cost Report

Medicare Bad Debt (continued)

Documentation Required With Cost Report:

- Beneficiary name and HIC number
- Date(s) of service
- Date of first bill sent to patient
- Medicare paid date (R/A)
- Write-off date
- Separation of deductible and coinsurance amounts
- Medicaid payment and paid date (if any)

Medicare Cost Report

Medicare Bad Debt (continued)

Documentation Required With Cost Report:

- Beneficiary name and HIC number
- Date(s) of service
- Date of first bill sent to patient
- Medicare paid date (R/A)
- Write-off date
- Separation of deductible and coinsurance amounts
- Medicaid payment and paid date (if any)

Medicare Cost Report

1102.3 (Cont.) EXHIBIT 2 10-14

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____ PREPARED BY _____

NUMBER _____ DATE PREPARED _____

FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) *DATE COLLECTION EFFORT CEASED*	(7) *MEDICARE* REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

Medicare Cost Report

- Medicare Cost Report Worksheets

	Independent	Provider-Based
RHC Basic Information (address, provider number, certification date)	S	S-2/S-8
Expense Information	A	A/M-1
Reclassifications	A-6	A-6
Adjustments	A-8	A-8
Related-Party Adjustments	A-8-1	A-8-1
Allocation of Overhead (Hospital)	-	B Part I
Visits and FTEs; Allocation of Overhead to RHC/Non-RHC	B, Part I	M-2
Influenza and Pneumonia Cost	B-1	M-4
Cost-Per-Visit, Medicare Bad Debt, Settlement	C	M-3
Medicare Payments Entry	C-1	M-5

RHC Visits/ Provider Productivity

RHC Visits

Medicare All-Inclusive Encounter Rate

$$\frac{\textit{Allowable RHC Costs}}{\textit{Rural Health Clinic Visits}} =$$

RHC Cost Per Visit (Rate)

(Not to exceed the maximum reimbursement limits for independent and provider-based > 50 beds.)

RHC Visits

"A RHC visit is defined as 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 a RHC or FQHC visit. A RHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions."

RHC Medicare Benefit Policy Manual

RHC Visits

- Total visits, the denominator in the cost per visit calculation, should include all “visits” that take place in the RHC during hours of operation, home visits, and SNF visits for all payers.
- Total visits should not include hospital visits (either inpatient or outpatient visits) or “nurse-only” visits in the RHC setting.

NOTE: The cost-per-visit calculation considers total costs; therefore, all visits (regardless of payer type) should be included in the cost report.

RHC Visits

- Counting of “visits” is easier said than done.
- Computer-generated reports may be misleading:
  - Counting units of service instead of visits
  - Including non-visits (e.g., nurse-only 99211)
  - Including non-RHC visits (e.g., hospital visits)
  - Excluding non-billable visits (e.g., cash only; global visits)

Remember: higher visits = lower cost per visit = lower rate!

Provider Staffing

Cost report requires separation of provider time

- Health Care Provider FTEs:
  - Physician
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Visiting Nurse
  - Clinical Psychologist (CP)
  - Licensed Clinical Social Worker (CSW)

Provider Staffing

Provider Productivity:

- 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.

Provider Staffing

Sample Reconciliation of Provider FTE

Clinical FTE	0.70
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	0.05
Total FTE	1.00

RHC Provider Productivity

Productivity Standards:

- Physician 4,200 visits annually for 1.0 FTE
- Midlevel 2,100 visits annually for 1.0 FTE

Total visits used in calculation of the cost per visit is the greater of the actual visits or minimum allowed (FTEs x Productivity Standard)

NOTE:

The cost report productivity standards cannot be manually adjusted. Therefore, if a provider only worked a portion of a year or if the cost report only represents a portion of a year, the FTE should be adjusted accordingly.

RHC Provider Productivity

Example 1 – Visits Are Greater Than Productivity Standards

	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	3.50	13,000	4,200	14,700	
2	Physician Assistants	0.80	5,200	2,100	1,680	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	4.30	18,200		16,380	18,200
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	4.30	18,200			18,200

RHC Provider Productivity

Example 2 – Productivity Standards Are Greater Than Visits

	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	3.50	13,000	4,200	14,700	
2	Physician Assistants	0.80	3,000	2,100	1,680	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	4.30	16,000		16,380	16,380
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	4.30	16,000			16,380

RHC Provider Productivity

Effect on Cost-Per-Visit

	Greater of Actual Visits or Productivity Standard Visits	Allowable Costs for Cost-Per-Visit Calculation	RHC Cost-Per-Visit
		$ 1,655,930	
Example 1	18,200		$ 90.99
Example 2	16,380		101.09

- Provider-based RHC to a hospital with less than 50 beds, $10 per visit
- Independent RHC – no effect; cost-per-visit limit

RHC Provider Productivity

Consolidated Appropriations Act, 2021

- Section 130 includes:
- Steadily increased reimbursement limitations for independent RHCs and those with hospitals greater than 50 beds over the next 8 years, beginning April 1, 2021.
- New reimbursement limitations will apply to all new RHCs (both independent and provider-based).
- Existing provider-based RHCs will be subject to new RHC-specific limitations determined on a 2020 “base rate” indexed annually by MEI.

RHC Provider Productivity

Consolidated Appropriations Act, 2021

- New limitations for independent RHCs, those with hospitals greater than 50 beds, and all "new" provider-based RHCs.

January 1 – March 31 $87.52. On April 1, the cap goes to $100.00 per visit. It then rises at statutorily set increases as follows:

2022	$113.00
2023	$126.00
2024	$139.00
2025	$152.00
2026	$165.00
2027	$178.00
2028	$190.00

After 2028 and in subsequent years, the cap goes up by the Medicare Economic Index (MEI)

RHC Provider Productivity

Grandfathered RHCs

- For existing (grandfathered) provider-based RHCs:
  - Future costs vs. base year AIR + MEI rate going forward.
  - Base year rate maybe derived from 2020 cost report, which should include a productivity waiver and higher cost per visit than past or future.
  - However, productivity standard exception requests will also be reviewed during the desk review of the cost report.
  - NARHC's interpretation is that if the RHC's cost-per-visit for any year is less than the cost-per-visit of the base year AIR + MEI, the lesser of the two rates will be used.
  - CMS still has to interpret the law.

RHC Provider Productivity

Grandfathered RHCs

- Will productivity standards matter in future years?
  - Yes!
  - We want to ensure that grandfathered clinics still receive their base rate+MEI in future years!

RHC Provider Productivity

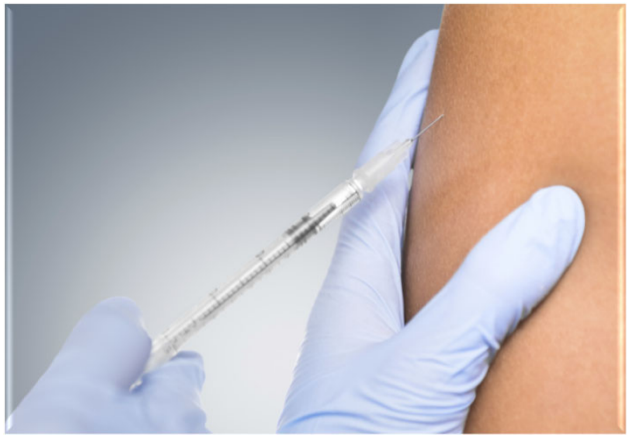
Oregon Medicaid RHC PPS Rate

- The initial rate setting process for Oregon Medicaid RHCs does not utilize the CMS productivity standards; however, the productivity standards are used when reviewing the rates for reasonableness.
- Be prepared to discuss differences between productivity standard visits and actual visits.
- Could affect Medicaid rate yearly or indefinitely

Medicare Vaccine Reimbursement

Medicare Vaccine Reimbursement

- Medicare influenza and pneumonia costs are reimbursed on the cost report, including staff, vaccine, and overhead costs
- CMS has also indicated that for COVID-19 vaccine administrations for Medicare AND Medicare Advantage patients, that these will also be reimbursed through the Medicare cost report and should not be billed.
- All other injections are included in the cost-per-visit calculation and are not separately reimbursed on the Medicare cost report.



Medicare Vaccine Reimbursement

- How are you tracking cost?
  - Staff time – Is all of your staff time coded to the RHC department? How much time is spent per injection?
  - Vaccine costs – where are your vaccine costs on the general ledger? Are they in a hospital department or in the RHC?
  - Listing of Medicare patients must be included with the cost report submission:
    - Name
    - Medicare number
    - Date of service
    - We are assuming that the above will also be required for COVID-19 vaccine administrations, as well. Can this report be automated?

Flu and Pneumonia Reimbursement

Worksheet B-1/M-4:

CALCULATION AND TOTAL OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

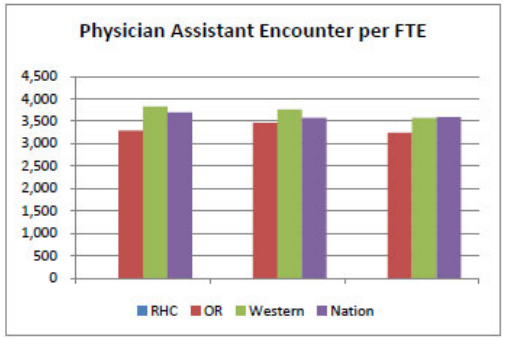
	Part I - Calculation of Cost	Pneumococcal	Seasonal Influenza
		1	2
1	Health Care Staff Cost	537,821	537,821
2	Ratio of Pneumococcal & Influenza Vaccine Staff Time To Total HC Staff Time	0.000651	0.006340
3	Pneumococcal & Influenza Vaccine Health Care Staff Cost	350	3,410
4	Medical Supplies Cost - Pneumococcal & Influenza Vaccine	2,981	3,648
5	Direct Cost of Pneumococcal & Influenza Vaccine	3,331	7,058
6	Total Direct Cost of the Facility	581,931	581,931
7	Total Facility Overhead	349,902	349,902
8	Ratio of Pneumococcal & Influenza Vaccine Direct Cost to Total Direct Cost	0.005724	0.012129
9	Overhead Cost - Pneumococcal & Influenza Vaccine	2,003	4,244
10	Total Pneumococcal & Influenza Vaccine Cost & Its Administration	5,334	11,302
11	Total Number of Pneumococcal & Influezna Vaccine Injections	35	341
12	Cost Per Pneumococcal & Influenza Vaccine Injection	152	33
13	# of Pneumococcal & Influenza Vaccine Injections Admins To Medicare Beneficiaries	-	169
14	Medicare Cost of Pneumococcal & Influenza & Its Administration	-	5,601
15	Total Cost of Pneumococcal & Influenza Vaccine & Its Administration		16,636
16	Total Medicare Cost of Pneumococcal & Influenza Vaccine and Its Administration		5,601

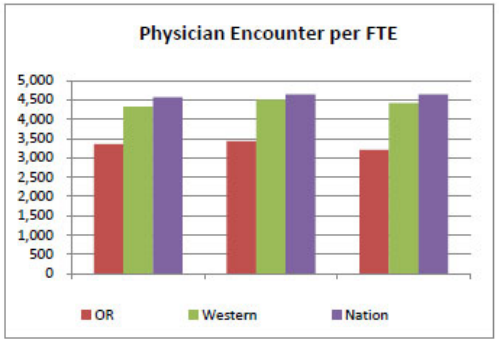
RHC Benchmarking

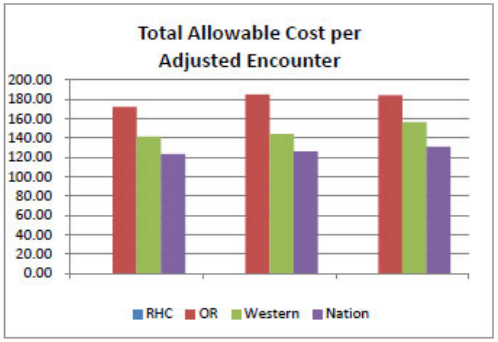
RHC Benchmarking Independent RHCs

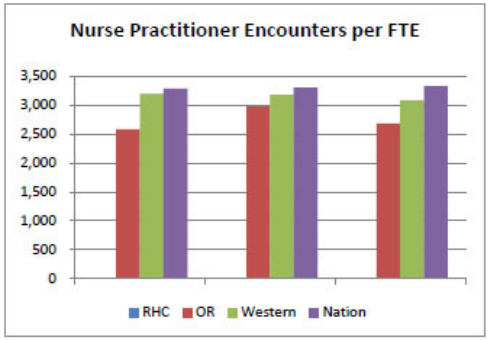
Category/Indicator	12/31/2017 Mean OR	12/31/2017 Mean Western	12/31/2017 Mean Nation	12/31/2018 Mean OR	12/31/2018 Mean Western	12/31/2018 Mean Nation	12/31/2019 Mean OR	12/31/2019 Mean Western	12/31/2019 Mean Nation
Number of Facilites	31	173	1,103	30	156	1,069	31	146	1,010
Encounters per FTE:									
Physicians	3,356	4,325	4,561	3,435	4,500	4,642	3,202	4,412	4,642
Physician Assistants	3,296	3,821	3,701	3,459	3,764	3,571	3,243	3,573	3,589
Nurse Practitioners	2,582	3,194	3,283	2,974	3,177	3,299	2,676	3,082	3,329
Certified Nurse Midwife	0	0	0	0	1,527	2,438	0	1,483	2,492
Visiting Nurses	0	0	746	0	727	281	328	201	115
Clinical Psychologist/Social Worker	726	1,048	1,746	793	1,352	1,463	798	1,155	1,385
Midlevel Staffing Ratio	56%	56%	58%	56%	59%	60%	57%	61%	62%
Midlevel Visit Ratio	53%	51%	51%	54%	52%	52%	55%	54%	54%
Cost per Encounter:									
Physician	97.53	70.43	65.01	112.47	73.97	66.93	108.91	79.05	71.07
Physician Assistant	46.91	35.34	34.71	45.00	38.12	37.05	51.68	41.17	38.30
Nurse Practitioner	74.35	44.78	37.11	71.48	47.78	37.91	71.05	49.58	39.12
Certified Nurse Midwife	0.00	0.00	0.00	0.00	65.24	44.80	0.00	83.03	51.36
Visiting Nurse	0.00	0.00	73.05	0.00	103.20	163.85	810.43	560.69	412.87
Clinical Psychologist/Social Worker	209.96	98.47	55.53	146.54	91.42	58.10	135.48	98.19	67.16
Total Health Care Staff Cost	27.57	20.68	16.61	28.52	20.42	14.81	28.12	21.09	14.56
Cost per FTE:									
Physician	320,604	277,344	287,769	365,399	298,107	300,731	336,745	317,718	316,641
Physician Asstistant	154,599	135,026	128,461	155,642	143,495	132,280	167,592	147,089	137,470
Nurse Practitioner	191,963	143,020	121,835	212,580	151,821	125,069	190,099	152,830	130,224
Visiting Nurse	0	0	54,465	0	74,996	46,107	265,791	112,922	47,317
Clinical Psychologist/Social Worker	152,403	103,165	96,944	116,153	123,623	84,989	108,094	113,429	93,052
Total Healthcare Staff Costs per Provider FTE	86,748	80,320	65,187	95,143	80,291	58,342	87,410	79,837	57,307
Clinic Cost per Encounter:									
Total Health Care Staff	103.56	72.12	65.85	108.95	74.87	66.67	112.24	80.53	69.42
Total Direct Costs of Medical Services	115.72	87.26	76.81	124.75	90.40	77.79	126.42	97.15	81.72
Facility Cost	12.03	16.90	11.13	12.23	16.09	11.28	14.12	11.94	10.69
Clinic Overhead	83.63	104.19	60.03	88.61	114.42	63.15	95.12	73.73	57.22
Allowable Overhead	79.04	60.67	50.43	83.14	60.19	51.98	88.86	67.57	53.47
Allowable Overhead Ratio	95%	58%	84%	94%	53%	82%	93%	92%	93%
Total Allowable Cost per Actual Encounter	194.76	147.92	127.23	207.89	150.59	129.77	215.28	164.72	135.19
Total Allowable Cost per Adjusted Encounter	172.44	141.79	123.65	184.96	144.12	126.21	184.43	156.60	131.29
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(7.13)	(5.09)	(4.05)	(5.89)	(6.01)	(4.07)	(6.11)	(4.44)	(3.78)
Payment Rate per Adjusted Encounter	165.31	136.70	119.60	179.07	138.11	122.14	178.32	152.16	127.51
Total Encounters	381,478	2,172,722	13,862,282	393,043	2,025,295	13,134,384	400,797	2,017,108	12,961,664
Total Medicare Encounters	73,866	414,566	3,094,173	74,817	399,601	2,909,892	79,126	377,951	2,776,842
Medicare Percent of Visits	19%	19%	22%	19%	20%	22%	20%	19%	21%
Injection Cost:									
Cost per Pneumococcal Injection	277.20	245.39	266.60	284.38	259.45	261.56	243.58	242.71	254.17
Cost per Influenza Injection	55.06	67.27	65.65	48.29	60.08	59.53	60.45	63.39	64.51

RHC Benchmarking Independent RHCs









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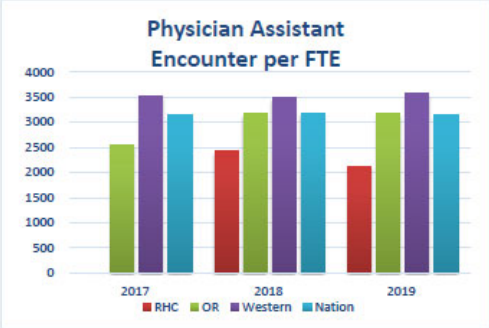
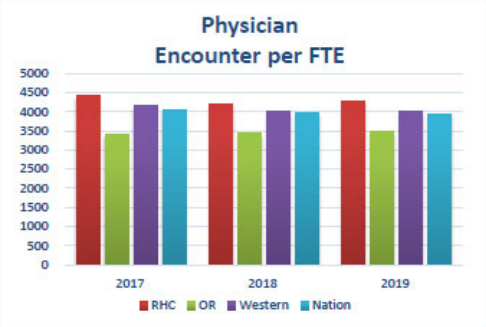
RHC Benchmarking Provider-Based RHCs

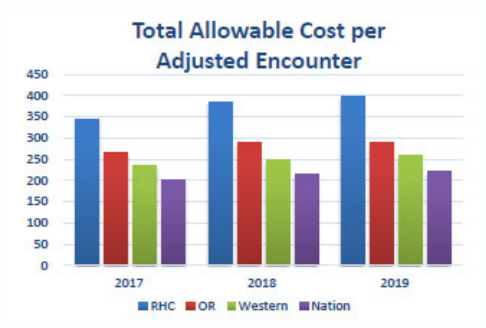
Provider-based RHC Benchmark Report©

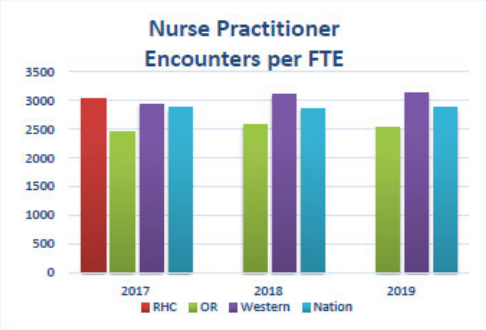
Category/Indicator	12/31/2017 Mean OR	12/31/2017 Mean Western	12/31/2017 Mean Nation	12/31/2018 Mean OR	12/31/2018 Mean Western	12/31/2018 Mean Nation	12/31/2019 Mean OR	12/31/2019 Mean Western	12/31/2019 Mean Nation
Number of Facilities	38	420	2,190	51	461	2,362	47	405	2,379
Encounters per FTE:									
Physicians	3,406	4,167	4,062	3,439	4,020	3,976	3,470	4,015	3,946
Physician Assistants	2,559	3,521	3,139	3,166	3,483	3,188	3,169	3,567	3,135
Nurse Practitioners	2,464	2,928	2,874	2,589	3,106	2,864	2,527	3,131	2,872
Visiting Nurses	0	715	225	0	508	153	0	734	131
Clinical Psychologist/Social Worker	3,888	1,596	1,578	1,900	1,630	1,498	1,713	1,609	1,500
Total Encounters	448,892	5,310,782	23,378,560	539,496	5,639,341	25,259,517	564,499	5,013,125	25,990,594
Midlevel Staffing Ratio	48%	55%	55%	49%	54%	55%	50%	54%	56%
Midlevel Visit Ratio	39%	43%	45%	43%	45%	46%	43%	45%	48%
Cost per Encounter:									
Physician	126.04	109.52	95.74	131.59	117.16	100.70	133.55	120.22	104.69
Physician Assistant	66.84	47.58	47.45	57.55	56.55	50.35	46.97	47.59	51.16
Nurse Practitioners	67.23	61.53	45.97	82.62	60.55	49.08	78.95	63.97	50.37
Visiting Nurse	0.00	242.68	342.04	0.00	181.73	245.28	0.00	152.48	387.52
Clinical Psychologist/Social Worker	40.04	66.79	40.31	46.31	41.37	41.89	53.38	50.63	40.83
Total Health Care Staff Cost	38.17	34.65	26.51	42.26	36.90	28.47	42.51	38.29	29.12
Cost per FTE:									
Physician	425,826	385,551	339,067	455,566	400,033	353,964	459,571	447,254	378,041
Physician Assistant	171,072	167,529	148,940	182,165	196,983	160,513	148,846	169,728	160,375
Nurse Practitioner	165,619	180,138	132,106	213,878	188,086	140,573	199,477	200,266	144,627
Visiting Nurse	0	173,438	76,945	0	92,299	37,489	0	111,984	50,584
Clinical Psychologist/Social Worker	155,640	106,574	63,593	88,015	67,460	62,760	91,436	81,446	61,259
Total Healthcare Staff Costs per Provider FTE	116,560	142,649	96,194	135,761	149,905	101,986	137,107	154,935	102,909
Clinic Cost per Encounter:									
Total Health Care Staff	137.95	101.64	90.62	146.55	108.43	96.18	143.26	114.95	100.53
Total Direct Costs of Medical Services	170.20	132.65	114.07	180.03	140.47	119.80	178.88	143.49	122.33
Clinic Overhead	27.44	25.32	23.69	25.68	24.18	24.69	29.20	26.31	26.74
Parent Provider Overhead Allocated	109.31	87.86	75.91	113.32	96.79	81.06	115.11	104.17	84.16
Allowable Overhead (Clinic and Parent)	136.68	112.13	98.68	138.89	119.74	104.83	143.50	127.88	109.78
Allowable Overhead Ratio (Clinic and Parent)	100%	99%	99%	100%	99%	99%	99%	98%	99%
Total Allowable Cost per Actual Encounter	306.88	244.30	212.41	318.92	259.58	223.78	322.38	271.37	231.40
Total Allowable Cost per Adjusted Encounter	267.01	233.87	202.63	289.50	248.80	213.76	290.63	258.59	220.84
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(5.74)	(5.11)	(5.60)	(4.85)	(5.66)	(6.21)	(6.24)	(6.82)	(7.08)
Rate per Adjusted Encounter	261.27	228.76	197.03	284.65	243.14	207.55	284.39	251.77	213.76
Total Medicare Encounters	116,351	1,276,458	5,908,972	146,328	1,396,321	6,362,949	137,445	1,224,828	6,370,064
Average Medicare Encounters	3,062	3,039	2,698	2,869	3,029	2,694	2,924	3,024	2,678
Medicare Percent of Visits	26%	24%	25%	27%	25%	25%	24%	24%	25%
Injection Cost:									
Cost per Pneumococcal Injection	246.67	273.79	270.51	253.49	298.73	280.61	304.26	312.03	298.41
Cost per Influenza Injection	66.32	82.06	76.12	62.45	92.14	79.87	71.06	97.00	87.34

RHC Benchmarking Provider-Based RHCs









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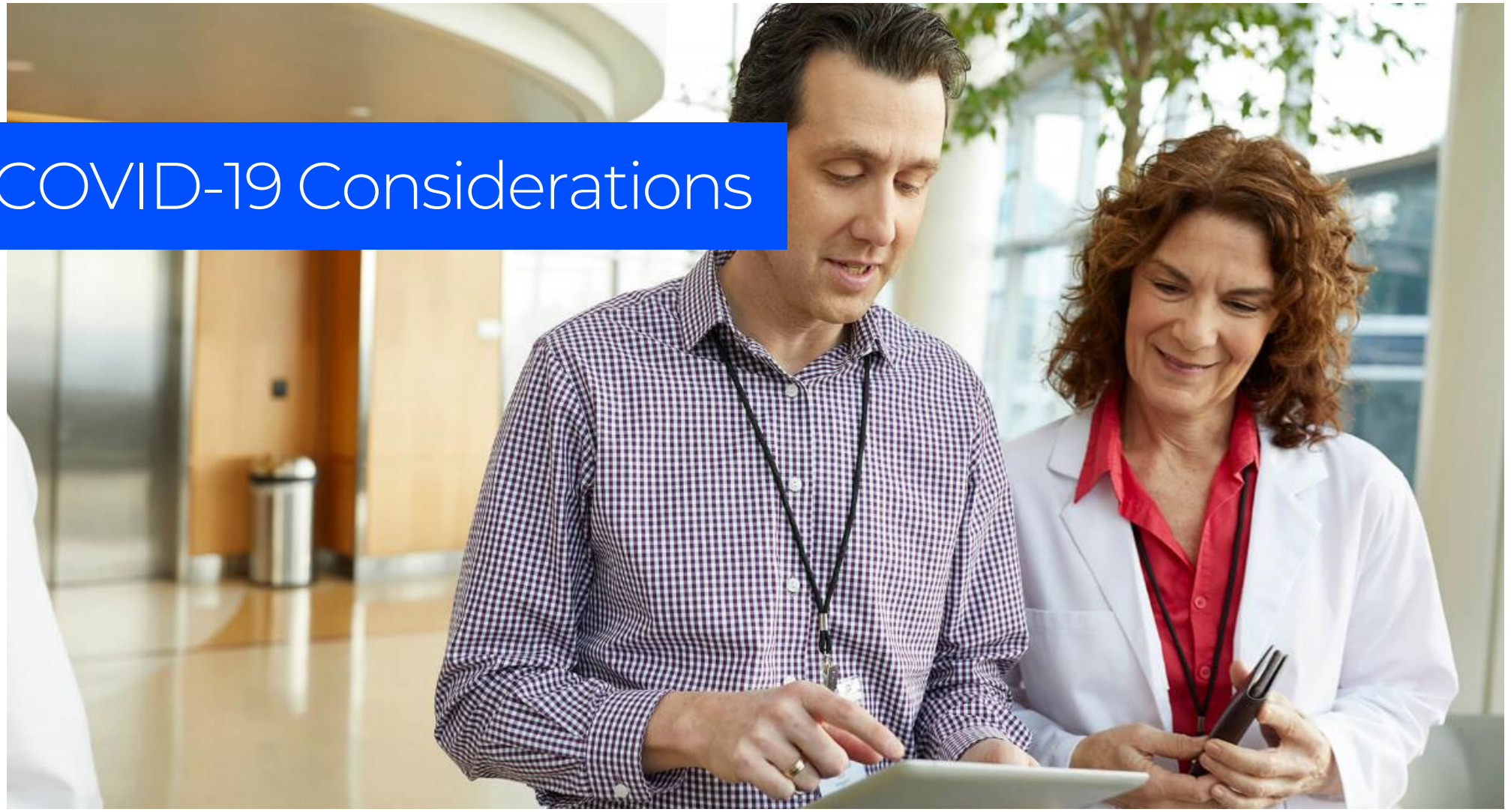
COVID-19 Considerations



Cost Report Considerations – Telehealth/Virtual Visits

- The Medicare cost report reports costs, visits, and FTEs related to RHC services.
- Costs associated with non-RHC services are carved out of the RHC Medicare cost-per-visit:
  - Lab (paid at fee schedule for freestanding RHCs or billed under the hospital's provided number)
  - Technical component of diagnostic services (paid at fee schedule for freestanding RHCs or billed under the hospital's provided number)
  - Chronic care management (paid at fee schedule)
- Like the above services, distant site telehealth services during the PHE are paid at fee schedule; therefore, the costs related to these services must also be removed from the cost-per visit calculation.

Cost Report Considerations – Telehealth/Virtual Visits (continued)

- FTEs related to telehealth/virtual visits should be not be included the FTEs reported on the cost report.
- RHC visits reported on the cost report should not include telehealth/virtual visits.
  - Note that the greater of actual visits or productivity standard visits is used in the denominator of the calculation for the Medicare cost per visit. As the denominator increases, the cost-per-visit decreases. Overstating either number results in a decreased cost-per-visit.
- Costs associated with non-RHC services are carved out of the RHC Medicare cost-per-visit

Cost Report Considerations – Telehealth/Virtual Visits (continued)

- How many telehealth/virtual visits were provided during the cost reporting period?
- How much time is spent for each type of visit?
- Average hourly salary of the practitioner providing the service.
- Any other expenses related to providing these visits?

Cost Report Considerations – Visiting Nurse Services

- If these services are provided during the PHE under the blanket waiver, these visits should be reported in the total visits numbers that were provided.

Cost Report Considerations – FTE Exception Request

- Rural health clinics (RHC) are currently subject to productivity standards for physician, PA, and NP providers
  - 4,200 visits for each 1.0 physician FTE
  - 2,100 visits for each PA/NP FTE.

  When calculating the RHC rate at year-end on the Medicare cost report, the greater of actual visits or productivity standard visits will be used in the denominator of the calculation.

  Should the clinic's total actual visits equal less than productivity standard visits, a reduction in the cost-per-visit will result.

Cost Report Considerations – FTE Exception Request (continued)

- RHCs have the ability to request an exemption to these standards yearly from the Medicare Administrative Contractor. The decision to grant the request is at the discretion of the MAC.
- With the reduction of visits at most clinics due to the COVID-19 emergency, we believe that the MACs may be more apt to grant an exception.
- We suggest that each RHC review the actual RHC visits performed when compared with the Medicare productivity standards to determine if a request to the exemption should be requested.

Cost Report Considerations – FTE Exception Request (continued)

- Q: Will RHCs be held to the RHC productivity requirements during the COVID-19 PHE?
  - A: Many RHCs have had to change the way they staff their clinics and bill for RHC services as a result of the COVID-19 PHE and may have difficulty in meeting the productivity standards.
  - Under existing policy in Chapter 13 of the Medicare Benefit Policy Manual, A/B MACs can provide an exception to any RHC that has had difficulty in meeting the productivity standards as a result of the COVID-19 PHE; A/B MACs may choose to proactively grant productivity exceptions to RHCs who have experienced disruptions in staffing and services as a result of the COVID-19 PHE.
  - https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Cost Report Considerations – FTE Exception Request (continued)

- Note that the ability to request and exception to the productivity standards is not new; however, exceptions granted have been rare.
- CMS grants the MACs the authority to approve exception requests.
- No criteria is given to the MACs to grant an exception.
- No prescribed format is required by CMS; however, each MAC may have a required format.

Cost Report Considerations – FTE Exception Request (continued)

RHC Productivity Standard Exception Requests

Background: Providers are held to a minimum number of visits per FTE that their Physicians and/or mid-level practitioners are expected to be able to perform in the Rural Health Clinics. These standards are 4,200 visits per Physician FTE and 2,100 visits per mid-level practitioner FTE.

Failure to meet this minimum number of visits may indicate that the facility is operating at an excessive staffing level compared with the patient level they are currently operating at, thus incurring excessive cost. This excessive cost would not be considered reasonable, and thus would not be allowable for reimbursement on the cost report.

When the minimum number of visits is not met, the minimum number is used in lieu of actual visits on worksheet M-2, Column 5, Lines 1-7 and subscripts. This increased number of visits in turn decreases the cost per visit, thus reducing the Medicare reimbursement.

CMS Policy at CMS Pub. 100-02, Chapter 13, §80.4 allows for providers to request an exception to these minimum standards, subject to the MACs discretion. This checklist has been developed as a guide to address some of the more common situations that, taken in combination, may potentially be considered adequate for an exception to these standards. This checklist should not be construed as a guarantee that any individual criterion, or combination of criteria, will result in approval.

Note that the manual does not include a specific time frame on when these RHC Productivity Standard Requests should be submitted by the provider, nor does it include a required timeframe for review and approval by the MAC. If the RHC Productivity Standard Request is submitted after the start of the desk review, the results may not necessarily be incorporated into that final settlement. In such a case, the additional documentation can be submitted as part of a request for consideration of a reopening. Ultimately, the decision as to whether or not to reopen will be left up to the MAC.

Cost Report Considerations – FTE Exception Request (continued)

Main Hospital Name:	
Main Hospital Provider Number (CCN):	
RHC Provider Number (a separate tab should be completed for each clinic):	
Impacted FYE:	
RHC City:	
RHC County:	
Date of Submission of Request:	

1.) What is the current number of FTEs and visits for the RHC for this cost reporting period for each category of staff?

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

2.) What was the number of clinic visits for the RHC in the prior year, and did the RHC request and receive approval for an RHC standard in that prior year?

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

3.) What visit count are you requesting as an exception to the standards of 4,200 (Physicians) and 2,100 (Mid-Level Practitioners)?

Cost Report Considerations – FTE Exception Request (continued)

For questions 4 through 8, you only need to complete the ones that relate to your request, and that you believe may help justify the request for an exception to the RHC Productivity Standards.

4.) Explain and demonstrate whether the clinic employs no more than the minimum number of staff (physician and mid-level practitioners) necessary to meet applicable certification requirements. Include details on what the current staffing level is for each type and what the minimum certification requirements are.

5.) Is the clinic listed in a Primary Care Health Professional Shortage Area (HPSA)? If so, provide documentation from the below link or another similar resource.
https://data.hrsa.gov/tools/shortage-area/hpsa-find

6.) Document how the population base of the service area is significantly lower than would be needed to generate sufficient visits meet the minimum number of visits required of the RHC Productivity Standards. This generally requires evidence for #4 as well.

7.) Document whether any new physicians or mid-level practitioners were added during the cost reporting period in question and when they started. Explain why you believe this may require a temporary reduction to the RHC Productivity Standards.

8.) Explain and document any other justification for an exception to the RHC Productivity Standards.

Questions?

Thank you!

Your presenters

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