Basic Medicare Cost Reporting for Rural Health Clinics

Katie Jo Raebel
Partner, Healthcare Practice
509.232.2044
kraebel@wipfli.com

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wipfli.com

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Today's Agenda

- Rural Health Clinic Medicare Cost Report Overview
- Allowable Costs
- Non-RHC Costs
- RHC Visits/Provider Productivity
- Provider Staffing
- Medicare Flu and Pneumonia Reimbursement
- Medicare Bad Debt
- Helpful Hints
- COVID-19 Considerations

Rural Health Clinic Medicare Cost Report Overview

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

What if you don’t file the cost report within 150 days?

- Currently there is no penalty imposed for late filing; however, Medicare will stop payments to the RHC.
- Medicare will ask for money paid in interim payments to be paid back.

Medicare Cost Report

Cost Report Components

- Trial Balance of Expenses
- Reclassification and Adjustment of Trial Balance of Expenses
  - Reclassifications
  - Adjustments
  - Related-party adjustments
- RHC Provider Statistics
- Flu/PPV Vaccine Costs
- Visits (part I), Overhead (part II)
- Determination of Medicare Reimbursement (part I) and Payment (part II)

What Is Needed to Prepare the Cost Report?

- Financial statements
- Cost report software
- Provider/practitioner FTE data
- Visits by practitioner
- Wage and benefit summary, by position
- Equipment (fixed asset) records
- PS&R Report (Medicare charges & payments)
- Influenza/pneumococcal vaccines (injection totals and invoices)

What Is Needed to Prepare the Cost Report?

- Laboratory costs
- Radiology/other diagnostic costs
- Advertising costs
- Other items:
  - Medicare bad debt log
  - Additional costs not included in financial statements
  - Costs included in financial statements not related to RHC services

Allowable Costs

Allowable Costs

Allowable RHC Costs:

- Defined at 42 CFR 413.
- Explained in Provider Reimbursement Manual, Pub. 15.

"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."

RHC Medicare Benefit Policy Manual

Allowable Costs

What is the source document for the “allowable RHC costs”?

- For provider-based RHCs
  - Departmental summary reports
  - Internally prepared financial statements
  - Hospital cost report data
- For independent RHCs
  - Financial statements prepared by outside accountants
  - Internally prepared financial statements
  - Tax returns?

Allowable Costs

Not the same as tax deductions:

- Accrual vs. cash basis
- Depreciation
- Related parties
- Provider/Owner compensation

Allowable Costs

Cost Report Requires Separation of Staff Costs

- Health Care Staff Costs:
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Visiting Nurse
  - Other Nurse
  - Clinical Psychologist
  - Clinical Social Worker
- Facility Overhead Costs:
  - Office Staff
- Cost Other Than RHC Services:
  - Laboratory
  - Radiology
  - Hospital Services
  - Other

Allowable Costs

Cost Report Requires Separation of Staff Costs

		COMPEN-SATION	OTHER COSTS	TOTAL	RECLASS-IFICATIONS	:	NET EXPENSES FOR ALLOCATION
		1	2	3	4	:	7
	FACILITY HEALTH CARE STAFF COSTS					:	
1	Physician	850,000	150,000	1,000,000		:	1,000,000
2	Physician Assistant	120,000	40,000	160,000		:	160,000
3	Nurse Practitioner					:	
4	Visiting Nurse					:	
5	Other Nurse	175,000		175,000		:	175,000
6	Clinical Psychologist					:	
7	Clinical Social Worker					:	
8						:	
9	Other Facility Health Care Staff Costs					:	
10	Subtotal (sum of lines 1-9)	1,145,000	190,000	1,335,000	-	:	1,335,000

Allowable Costs

Costs recorded on an accrual basis:

- Recorded when cost incurred, not when paid.
- Payment must be made within 12 months after year-end (unless a more restrictive requirement applies).

Examples:

- Employee profit sharing contributions recorded in 2019 but contributions made in 2020.
- Expenses incurred in December 2019 but paid in January 2020.

Allowable Costs

Depreciation

- Accelerated depreciation for tax § 179 write-offs
- CMS allows capital assets expensed up to $5,000
- Differences in useful life

Examples:

- First year tax write-off (§ 179) of $500,000 not allowable on RHC cost report.
- Three-year useful life for tax purposes; may be 5- or 7-year life according to AHA.

Allowable Costs

Related parties:

Related through ownership or control (board of directors, key employees)

"The intent is to treat the costs incurred by the supplier as if they were incurred by the provided itself."

CMS Pub. 15-1 (PRM)

Allowable Costs

Related parties:

- Building and equipment leases
- Contracted employees
- Purchased services (e.g., cleaning, billing, etc.)

Examples:

- Clinic shareholders own clinic building through separate real estate partnership. Lease to RHC.
- Clinic management forms separate billing service and contracts with RHC.

Allowable Costs

Related-Party Example – Building Lease:

- RHC pays $4,000 per month ($48,000 per year) to owner's partnership for building rent.
- Actual annual cost of building incurred by partnership:
  - Interest on mortgage = $20,000
  - Depreciation on building = $8,000
  - Property taxes = $6,000
  - Insurance on building = $1,000
  - Total annual costs = $35,000
- RHC costs must be reduced by $13,000

Allowable Costs

Related-Party Example – Building Lease:

Worksheet A-2-1

Part II Costs incurred and adjustments required (as result of transactions with related organizations):

	Line No	Cost Center	Expenses Items	Amount	Amount Allowable in Cost	Net Adjustments (Col 4 minus Col 5)
	1	2	3	4	5	6
1	26	RENT	RENT	48,000	-	48,000
2	26	RENT	INTEREST	-	20,000	(20,000)
3	30	DEPRECIATION-BUILDINGS AND FIXTURES	DEPRECIATION	-	8,000	(8,000)
4	33	PROPERTY TAX	PROPERTY TAXES	-	6,000	(6,000)
4.01	27	INSURANCE	BUILDING INSURANCE	-	1,000	(1,000)
5	Totals			48,000	35,000	13,000

Non-RHC Costs

Non-RHC Costs

Identify Costs of Non-RHC Services

- Chronic Care Management
- DME
- Hospital services (inpatient/ER/ASC)
- Laboratory services
- Radiology services
- Mammography
- Telehealth
- Medical directorships

Non-RHC Costs

Laboratory Services

Most common direct costs associated with lab:

- Lab tech salaries/benefits
- Nursing salaries/benefits
- Reagent costs
- Other lab supplies
- Lab equipment depreciation
- CLIA licensure/reference lab fees

Non-RHC Costs

Reclassification worksheets (A-1/A-6) move costs from one classification to another:

RECLASSIFICATIONS Worksheet A-1

Increase			Decrease		
Cost Center	Line No.	Amount	Cost Center	Line No.	Amount
LAB	54	4,681	OTHER NURSE	5	5,039
LAB	54	358		-	-
RADIOLOGY	55	3,270	OTHER NURSE	5	3,390
	55	120		-	-

Non-RHC Costs

Non-allowable costs must be removed through an adjustment (A-2/A-8):

Example:

- Shared (non-RHC) facility costs
- Advertising used to promote clinic utilization
- Purchased lab services
- Interest income
  (limited to interest expense)
- Miscellaneous income

Non-RHC Costs

Carve-Out/Commingling Arrangements

- Services would be considered RHC if furnished during RHC hours and in RHC space.
- "Carve-outs" sometimes used to financially triage Medicare RHC services to Medicare Part B reimbursement (e.g., procedures).
- Carve-outs may be either space- and/or time-based.

Non-RHC Costs

Carve-Out/Commingling Arrangements

According to CMS Publication 100-02, Chapter 13, Section 100:

Commingling refers to the sharing of RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an on-site Medicare Part B or Medicaid fee-for-service practice operated by the same RHC physician(s) and/or non-physician practitioner(s). Commingling is **prohibited** in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- Selectively choosing a higher or lower reimbursement rate for the services.

Non-RHC Costs

Carve-Out/Commingling Arrangements

According to CMS Publication 100-02, Chapter 13, Section 100:

- RHC practitioners may not furnish RHC-covered professional services as a Part B provider in the RHC or in an area outside of the certified RHC space, such as a treatment room adjacent to the RHC, during RHC hours of operation.
- If an RHC practitioner furnishes an RHC service at the RHC during RHC hours, the service must be billed as an RHC service. The service cannot be carved out of the cost report and billed to Part B.

Non-RHC Costs

Carve-Out/Commingling Arrangements

According to CMS Publication 100-02, Chapter 13, Section 100:

- If an RHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC space must be clearly defined. If the RHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.
- RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to ensure that all costs claimed for Medicare reimbursement are only for the RHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC and non-RHC usage to avoid duplicate reimbursement.

Non-RHC Costs

Carve-Out/Commingling Arrangements

According to CMS Publication 100-02, Chapter 13, Section 100:

- This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency or prohibit an RHC practitioner from providing on-call services for an emergency room, as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the practitioner with the hospital emergency department would not be a common occurrence.

RHC Visits/ Provider Productivity

RHC Visits

Medicare Cost Report

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

RHC Cost Per Visit (Rate)

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

RHC Visits

Non-RHC Costs

"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!

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

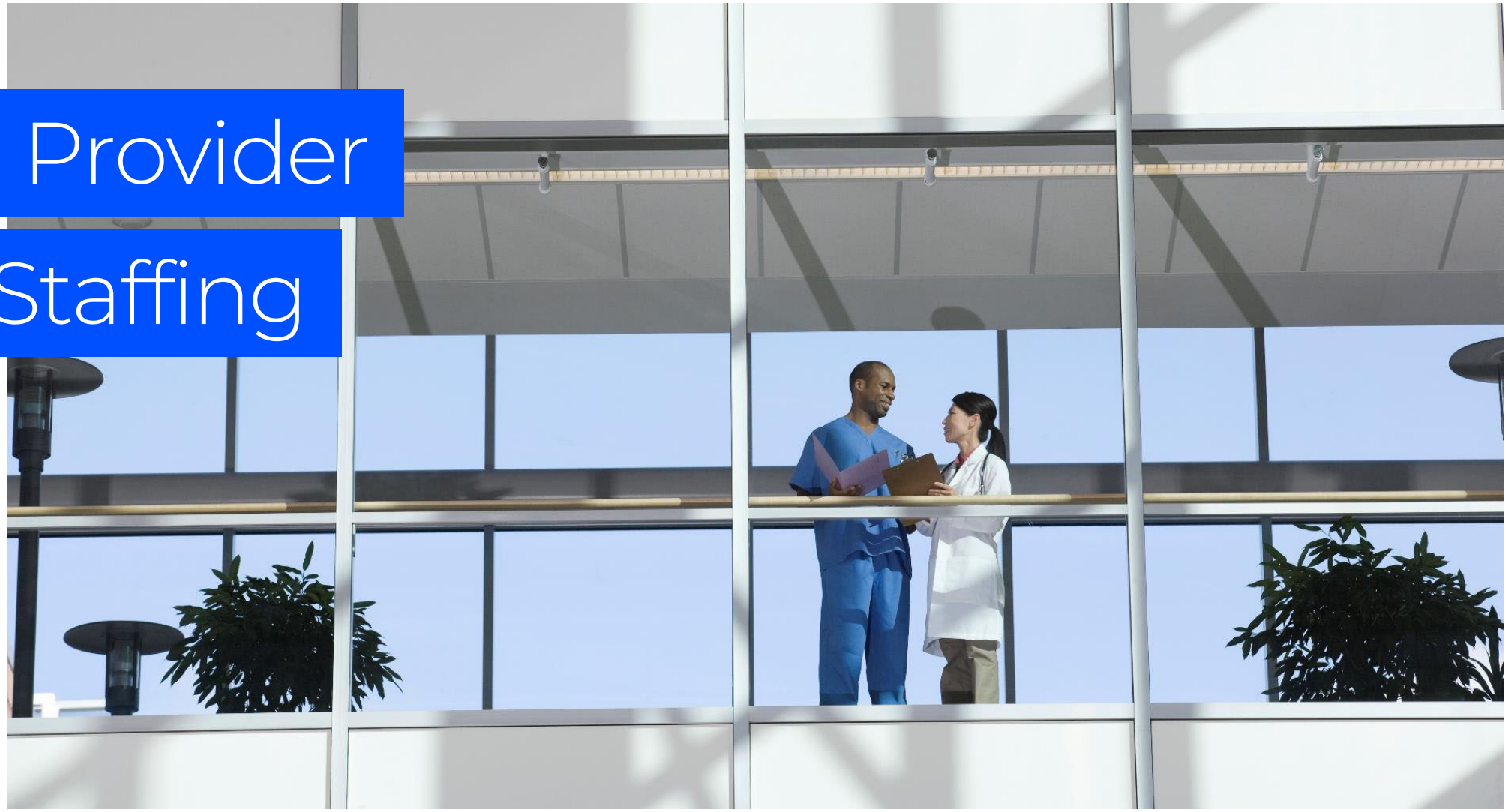
RHC Provider Productivity

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
- Could affect Medicaid rate yearly or indefinitely

Provider Staffing



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

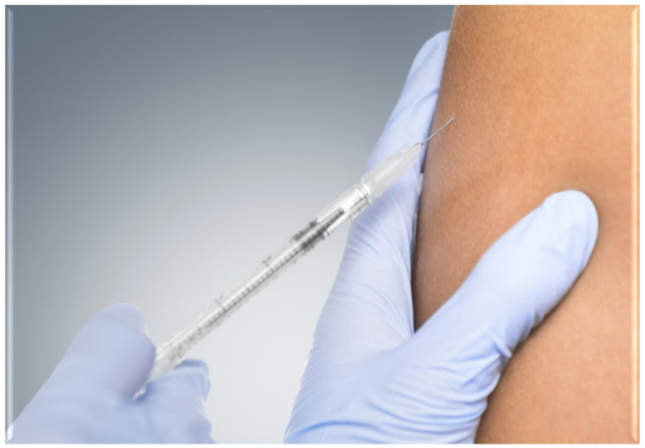
Clinical FTE	0.70
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	0.05
Total FTE	1.00

Medicare Flu and Pneumonia Reimbursement

Flu and Pneumonia Reimbursement

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



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

Medicare Bad Debt

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 Bad Debt

- 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 Bad Debt

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)

Helpful Hints

Helpful Hints

- Collect as much data as possible on an ongoing basis.
- Set up accounting procedures to collect as much financial data in the form and level of detail required for year-end reporting. Use the cost report forms for reference.
- Determine early whether the clinic will need to collect special data for the cost report (i.e., related-party expense).
- Be consistent from year to year.
- Use the PS&R report provided by the intermediary to report Medicare visits, deductibles, and payments.

Helpful Hints

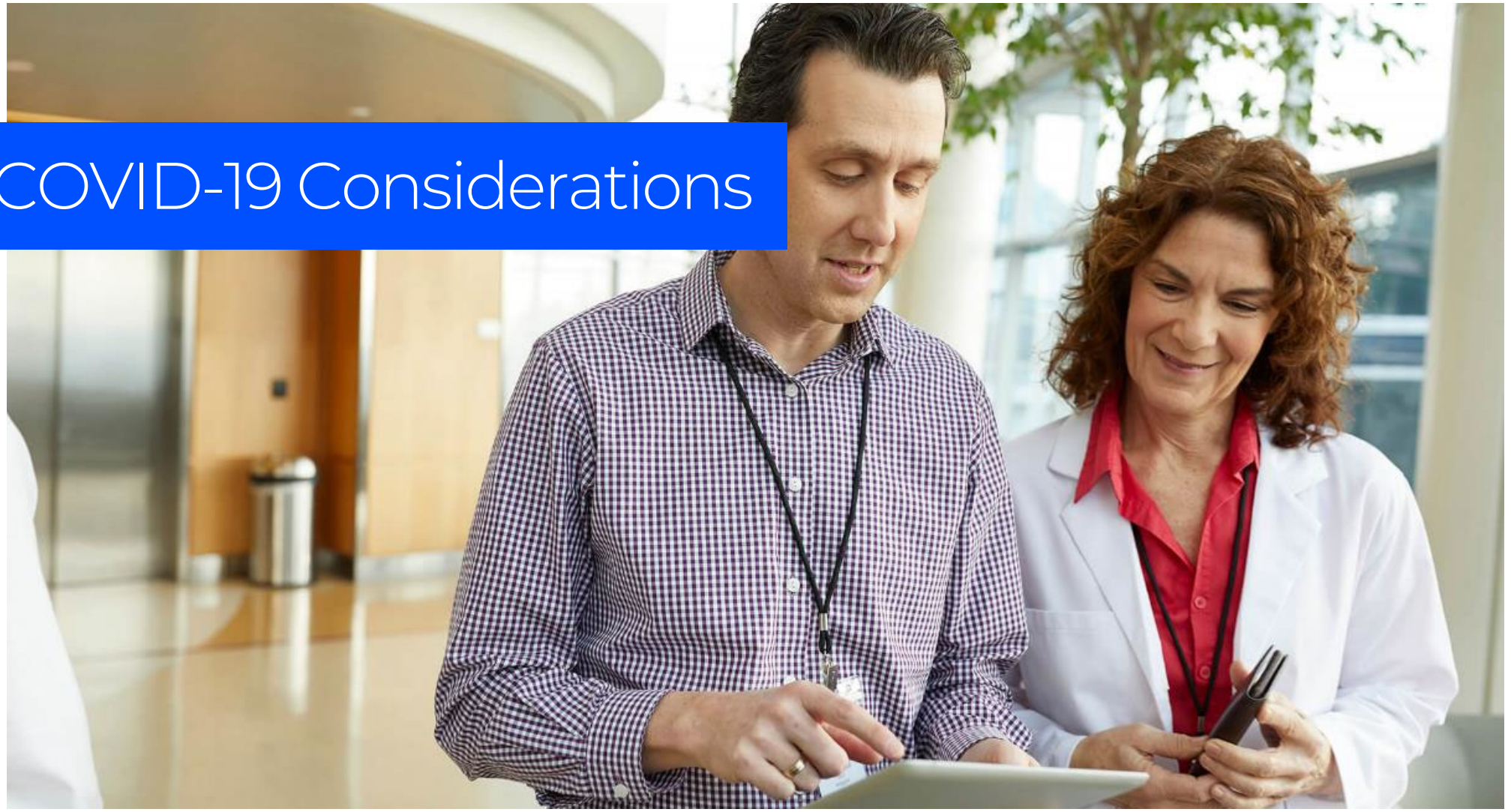
- Medicare Cost Report Worksheets

	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

Helpful Hints

- Send adequate documentation to support information on the cost report.
  - Injection logs
  - Bad debt logs
  - Working trial balance
  - Workpapers to explain reclasses on W/S A-1 and adjustments on W/S A-2
- Review the cost report for reasonableness (i.e., $700 cost per pneumococcal injection is not reasonable).

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

Katie Jo Raebel

Partner, Healthcare Practice

- 509.232.2044
- kraebel@wipfli.com