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Show Me The Money - Maximizing Value From Your Medicare Cost Report

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Clint is a member of the Blue and Company, CPA's Healthcare consulting team. He has over 15 years' experience in healthcare. His specialties include healthcare reimbursement and revenue cycle solutions. Clint's primary focus includes Medicare and Medicaid Cost Reports, Wage Index Reporting and Revenue Cycle Solutions.

Clint is a member of the American Institute of CPA's, Kentucky Society of Certified Public Accountants and the Kentucky Chapter of the Healthcare Management Association.

Clint is a graduate of the University of Louisville with a Bachelor's degree in accounting. He also has a Masters in Business Administration (MBA) from Indiana University and is also a Certified Healthcare Financial Professional (CHFP).

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Agenda

Show Me The Money - Maximizing Value From Your Medicare Cost Report

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1. What is a Medicare Cost Report?
2. Reimbursement Terms
3. Cost Report Worksheets
4. Importance of Financial Statements
5. Volume and Charges
6. Reimbursement & Decision Making
7. Rural Health Clinics
8. Special Designations
9. Questions

What is a Medicare Cost Report?

- Annual filing required by CMS for various types of healthcare facilities:
  - Hospitals
  - Rural Health Clinics (RHC)
  - Home Health Agencies (HHA)
  - Federally Qualified Health Centers (FQHC)
  - Community Mental Health Centers (CMHC)
- Generally due 5 months after your Fiscal Year End
- Generates a cost report settlement
- Helps set future rates:
  - Often used by Medicaid and other downstream entities

Reimbursement Terms

- Non-allowable vs. Non-reimbursable
- PSR – Provider Statistical Reimbursement
  - Summary vs Detail
- Paid Claims Listing
- Cost Centers
- Revenue Codes
- Routine vs Ancillary
- XVIII = Medicare
- XIX = Medicaid

Cost Report Worksheets

- Wkst S – Settlement Page
- Wkst S-2 – Hospital Questionnaire
- Wkst S-3, Part I – Statistical Data – Beds, Volume
- Wkst S-10 – Uncompensated Care
- Wkst A – Expenses by Cost Center
- Wkst A-6 – Expense Reclasses
- Wkst A-7 – Capital Cost
- Wkst A-8 – Expense Adjustments
- Wkst A-8-2 – Physician Expense Adjustments
- Wkst A-8-3 – Contracted Therapy Expense
- Wkst B, Part I – Overhead Cost Allocations
- Wkst B, Part II – Capital Cost Allocations
- Wkst B-1 – Cost Allocation Statistics
- Wkst C – (Gross) Revenue (Cost to charge)
- Wkst D part I-IV – Cost Apportionment
- Wkst D part V – Outpatient Charges (XVIII & XIX)
- Wkst D-1 – Inpatient Costs (Cost per day)
- Wkst D-3 – Inpatient Charges (XVIII & XIX)
- Wkst E – Settlement Worksheets
  - E, Part A – Inpatient PPS
  - E, Part B – Outpatient
  - E-1 – Interim Payments & Lump Sums
  - E-2 – Swing Beds
  - E-3, Part V – Inpatient CAH
  - E-3, Part VII – Medicaid
- Wkst G – Balance Sheet
- Wkst G-3 – Income Statement
- Wkst H – Home Health Schedules
- Wkst M – RHC Schedules
- Wkst O – Hospice Schedules

Worksheet A

- Should reconcile to the Income Statement
- Examine your expenses to make sure you are claiming what is allowable
  - Physician standby time
  - CRNA Pass Thru
  - Provider Tax
  - Advertising
- Consider your accounting – are you claiming all costs?
- Know the difference between Non-allowables & Non-reimbursables
  - Non-allowable – items not reimbursed by Medicare, should be offset
  - Non-reimbursables – accumulate overhead costs

Worksheet B

- Know the relationship between B part I and B-1
  - B Part I – Actual cost allocation
  - B-1 – Statistical basis behind cost allocation
- Cost Report utilizes step-down cost allocation
- Examine cost allocations to ensure there are no double allocations
  - Capital costs – Square feet, Depreciation, Rented space
  - Employee Benefits
- Are you allocating costs to areas not using the overhead dept?
  - Plant Operations
  - Housekeeping
  - Dietary
  - Cafeteria

Worksheet C

- Cost to Charge Ratios – column 9
  - No CCR for routine areas
  - These are used to calculate Medicare cost
- Reports gross revenue
- Examine reporting to ensure proper match of costs and charges
  - Medical supplies
  - Drugs
  - Observation
- Has professional fee revenue been removed?
- Look for cost centers with cost but no revenue
  - Also look for charges with no cost

Worksheet D

- Cost apportionment schedules (Medicare share)
- Includes calculation of routine and ancillary cost
- Reports Medicare and Medicaid Charges
  - Look for cost centers with charges without cost
  - Also consider cost without charges
- D-1 reports inpatient routine cost
- D-3 reports inpatient charges
- D (part V) reports outpatient charges
- Pay attention to worksheet headers
  - Separate schedules for XIX and XVIII

Worksheet E

- Settlement worksheets
- Settlement is the difference between:
  1. Amounts paid by CMS to provider
     - PSR
     - Rate Letters (Lump Sums)
     - Biweekly Payments
     - PIP Payments
  2. Amount earned thru the cost report
     - 101% of Medicare Cost
     - Medicare Bad Debts claimed (65%)

Importance of Financial Statements

- Income Statement drives the cost report
  - Gross Revenue
  - Operating Expenses
- Pay special attention to year over year changes
  - Outpatient Charges
- Sensitive to changes in pricing
- Cost Report payable does not mean bad financial health
- Be prepared for a Medicare payable
- Due to / Due from accounts/Reserves
- Provider Relief Reporting

Volume and Charges

- Inpatient reimbursement is mainly driven by days / volume
  - Wkst D-1 – Cost per day
  - Are subunits helping or hurting reimbursement
- Outpatient reimbursement is driven by charges
  - Increase in charges helps net income but dilutes CCRs

	Volume			Charges	
Days	100	125	Charges	1,000,000	1,250,000
Costs	100,000	100,000	Costs	200,000	200,000
Cost per Day	$ 1,000.00	$ 800.00	Cost to Charge	$ 0.20	$ 0.16

Reimbursement & Decision Making

- Rule of thirds – know your payor mix
- Departmental budgeting – consider Medicare subsidized cost
  - Does service line utilize Medicare? Medicaid?
- Invest in patient care areas
- Consider the nature of the costs
  - Is cost allowable or non-allowable?
- What is below the line on Worksheet A?
  - Are there opportunities for PB clinics?
  - Are the opportunities for RHCs?
- Does consolidation help or hurt?
- More detail is generally better, to an extent

Rural Health Clinics

- M Worksheets
- Reimbursement based on cost per visit
- Medicare productivity standards
  - Not meeting productivity impacts cost per visit
- Tracking productive time – time studies
  - Know the difference between productive time and total time
- You can still claim Medicare bad debt!
- Vaccine Logs
  - Flu / Pneumo
  - Covid / Monoclonal Antibodies
- Significant reimbursement opportunities often overlooked
- Examine overhead cost allocations

Sole Community Hospital

- <u>42 CFR § 412.92 criteria:</u>
  1. Located more than 35 miles from other like hospitals
  2. Located between 25 and 35 miles and meets one of the following:
     - No more than 25% of your inpatients are admitted to other hospitals within 35 miles of hospital or service area
     - Hospital has fewer than 50 beds and would meet 25% criteria
  3. Hospital is rural and located between 15 and 25 miles, but inaccessible due to local topography/severe weather
  4. Hospital is rural and because of speed limits or weather, travel time to nearest like hospital, is at least 45 minutes
- Sole Community Hospital triggers a hospital specific payment
- Also triggers a 7.1% adjustment to OPPS payments
- Loosens requirements for Wage Index Geographic Reclass

Medicare Dependent Hospital

- 42 CFR § 412.108 criteria:
  1. The hospital has 100 or fewer beds
  2. The hospital is not also classified as a sole community hospital
  3. At least 60 percent of the hospital's inpatient days or discharges were attributable to Medicare patients
- Read the fine print - At least 2 of the last 3 most recent audited cost reports must meet 60% threshold
- Medicare Dependent Hospital triggers a hospital specific payment
- If greater than the IPPS rate, MDH is paid 75% of the difference between the IPPS rate and the hospital specific rate

Low Volume Adjustment

- 42 CFR § 412.101
- FY 2019 – FY2022 – Fewer than 3,800 total discharges
- Distance requirement of 15 miles from nearest like hospital
- Formula driven adjustment
  - [(95/330)−(number of total discharges/13,200)]
- Pay close attention to regional competition – their status with CMS could help or hinder this opportunity.

Rural Referral Center

- 42 CFR § 412.96 criteria:

    1. 275 or more beds available
    2. Meets one of the following
        - 50% of Medicare patients are referred from other hospitals
        - 60% of the hospitals Medicare patients live more then 25 miles from hospital
        - 60% of all services rendered to Medicare patients who live more than 25 miles from the hospital
    3. See regulations for additional qualifying criteria

- RRC is exempt from the 12 % cap on DSH payments

- RRC designation also factors into Wage Index Geographic Reclasses

340b Covered Entity

- Section 340B of the Public Health Service Act
- Permits sale of drugs at discounted prices
- Benefit comes from cost savings
- HRSA website is an excellent resource
- DSH Hospitals – 11.75%
- SCH or RRC – 8%
- CAH – no DSH requirement

Rural Emergency Hospital

- Effective January 1, 2023
- CAH and small rural PPS providers will be eligible to convert
- Must comply with conditions of participation set forth by CMS
  - Similar to those in effect for CAH
- Cannot provide inpatient services
- Must have a 24/7 staffed Emergency Room
- Must have a transfer agreement in place with a trauma center
- Payments are set at OPPS rate + 5% add on
- Providers will also receive a fixed monthly payment

Questions ?

Contact Us

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