Shaking the Trees - Advanced Cost Reporting

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As the Manager of The Rybar Group's Rural Healthcare Division, Caren has over twenty-five years of Critical Access Hospital (CAH) and Rural Health Clinic (RHC) financial, accounting, revenue cycle and reimbursement experience.

She has worked in a variety of roles in the finance departments of CAHs, including multiple years as a Chief Financial Officer. Caren's prior provider experience and hands-on knowledge of the issues impacting rural hospitals allows her to identify both present and future reimbursement and payment opportunities. Her broad experience has included ensuring that providers optimize their payments under their rural designations.

Caren is a member of the Michigan Great Lakes Chapter of Healthcare Financial Management Association and is also a Certified Healthcare Financial Professional (CHFP).

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CAH CFO-Administrator FORUM

Agenda

Show Me The Money - Advanced Cost Reporting

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1. Medicare Cost Report
2. Impact on Other Cost Reports
3. Using the Cost Report as a Strategic Tool
4. Recent Medicare Cost Report Audit Activity
5. Prior Year Cost Report Opportunities
6. Questions

Disclaimer: The information provided in today's presentation is current as of February 21, 2023.

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Medicare Cost Report

Medicare Cost Reports Overview

- Reimbursement Report – similar to a tax return – will generate a receivable/payable
  - Charges – Volume – Payor Mix
  - Expenses – New Services
  - Service Line changes
  - Statistical Information
  - Interim Lump Sum or Rate Adjustments

- Decision Making – modeling

- Other programs use the data – Medicaid, Medicare HMO, etc.

Cost Based Reimbursement Myths

MYTH: A Medicare cost report payable is a bad sign.

FACT: Important to have been planning for the payable – not surprised.

- A cost report payable is not good if you weren't expecting it and didn't plan for it on your income statement or cash flow.
- Medicare HMO's potentially paid a higher rate.
- Make sure to understand the "why" behind the payable – is it explainable?
- Payable could mean lower expenses or higher volume – both good signs.

- *** Interim Cost Reports or a "mini cost report" crucial ***

Medicare Cost Report Preparation

- Supporting Documents – auditable, retain
- Correctly matching within cost center of revenue to expense
- Computer System Changes/Conversions
  - EHR
  - Billing
  - Financial
  - Payroll

Cost Based Reimbursement Myths

MYTH: As a CAH with 101% Medicare cost reimbursement, you don't lose money on Medicare.

MYTH: As a CAH, we can purchase "X" and put it on the cost report and Medicare will pay for it.

FACT: At 101% you will not even break even. Best case = 98.98% of Medicare allowable costs.

- Sequestration of 2% = 98.98% approved reimbursement
- Not all costs are allowable
  - i.e., Marketing, Physician recruitment, Part B provider expenses
- Medicare Bad Debts are only reimbursed at 65%

Medicare Cost Report Potential Reimbursement Opportunities

- Expenses
  - Fragmenting A&G
  - A-6 – reclassify expenses
  - A-8-2 – Provider (allowable) vs Professional (non-allowable)
  - A-8 – Non-allowable (offsetting expenses or revenue)
- Revenue
  - Charges – remove professional
- Stats
  - Square Footage
  - Medical Records
  - Non-reimbursable Cost Centers (double whammy)
- Bad Debts

Cost Based Reimbursement Myths

MYTH: With the “new” provider based Rural Health Clinic payment rates, the M-series of the cost report is not as important as it was before 04/01/2021.

FACT: Your Provider Based Rural Health Clinic reimbursement could still be impacted by several factors.

- Provider FTE Calculations
- Clinic Visits
- Provider Productivity Exemptions (not just during COVID)
- Vaccine Costs and Logs
- Bad Debts
- Other services

Internal financials – look at full reimbursement including cost report settlement – not just claims paid

Impact on Other Cost Reports

Cost Based Reimbursement Myths

MYTH: Medicare HMO companies reimburse the same as traditional Medicare.

FACT: Medicare HMO companies have their own contract language.

- Medicare HMO companies pay claims generally based on your Medicare interim rate letter
- A few Medicare HMO companies have a separate cost report requirement
- Make sure all your services are reimbursed by the Medicare HMO – Swing Bed, Rural Health Clinics
- Do they reimburse for Bad Debts?
- Know who you are contracted with and what the contract terms are.
- Watch for what needs pre-authorizations

Cost Based Reimbursement Myths

MYTH: Our Medicare Cost Report only impacts that year's traditional Medicare reimbursement.

FACT: The Medicare cost report effects current year, future year and other programs.

- Medicare cost report generally due 5 months after the end of the fiscal year
- For the Medicare HMO companies without a settlement option – reimbursement would be based on the Medicare interim rate letter – which could be almost 9 months into the next fiscal year

Other Potential Cost Based Reimbursement

- Medicare HMO
  - Contracts
  - Cost Reports

- Medicaid
  - State Specific – most have some version of cost-based reimbursement
  - Medicaid HMO Contracts
  - Rural Health Clinic reporting separate from hospital in some states

Using the Cost Report as a Strategic Tool

Cost Based Reimbursement Myths

MYTH: If we need to cut expenses, it doesn't matter which department because the financial impact would be the same.

FACT: Depending on the service line, the bottom-line impact could be considerably different.

- Desired outcome - $100,000 bottom line savings
- OP service line – 45% Medicare – need to cut $181,818 in expenses
- IP service line – 70% Medicare – need to cut $333,333 in expenses
- Very important to model all project changes to see cost-based reimbursement impact – remember other payors will be different.

Cost Based Reimbursement Myths

MYTH: Our charge structure doesn’t matter because we will receive the same reimbursement for Medicare patients regardless of our charges.

FACT: Your actual reimbursement for Medicare patients can be different based on your charge structure.

Critical Access Hospital
OP Charge Copay Example

Outpatient Charges	10,000,000	8,000,000	6,000,000
Cost to Charge Ratio	50%	63%	83%
Medicare Costs	5,000,000	5,000,000	5,000,000
Coinsurance (20% of billed charges)	2,000,000	1,600,000	1,200,000
Medicare Cash	3,000,000	3,400,000	3,800,000

Medicare Cost Report Strategies

- Charges – transparency, bad debt, competitive
- Expense changes
- Service line changes
- Review Cost Based reimbursement by service line and compare to actual reimbursement from other payors – are you making money on your non-Medicare business?

Recent Medicare Cost Report Audit Activity

Medicare Cost Report Audit

- Bad Debts
- Swing Bed – location
- RHC Vaccine Logs/costs
- Charges/Revenue Code mapping
- A-8-2 – provider vs. professional time

Prior Year Cost Report Opportunities

Cost Based Reimbursement Myths

MYTH: Amending or reopening a cost report would subject us to an additional review and not worth it.

FACT: Although is can take time, amending or reopening a cost report is an appropriate process when more accurate information is available.

- Reimbursement value has to exceed $10,000 to amend or reopen a cost report.
- Don't forget the compliance piece – signature certifying all information is correct.
- When a cost report is amended or reopened for a specific item, it doesn't automatically subject the whole cost report to additional scrutiny.

Prior Year Cost Reports

- Amend – prior to the start of desk review (within 2 years after filing)
- Reopen – within 3 years post NPR

When to review – “when more accurate information is available”

- Audit (final TB) not complete when cost report submitted
- Bad Debts missed/understated
- RHC metrics need to be revised
- Updated more accurate stats available

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Questions ?

Contact Us

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