Medicare Cost Report
Why it Matters

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Overview

- What is CAH?
- What is PPS?
- What is the Medicare cost report?
- Significance of the Medicare cost report to hospitals
- Designations impacting payments
- Importance of maximizing allowable costs
- Cost report forms
  - Focus areas
- Resources
- Useful websites

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What is a CAH?

Critical access hospitals (CAH) are a separate Medicare provider type

- Created by the Balanced Budget Act of 1997
- CAHs have their own payment methodology
- CAHs have their own conditions of participation

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What is a CAH?

Current requirements

- Be located in State that has established a State Medicare Rural Hospital Flexibility Program
- Be designated by State as a CAH
- Be located in a rural area or an area treated as rural
- Be located more than 35 miles from the nearest hospital or CAH (15 miles for mountainous terrain or only secondary roads); OR prior to January 1, 2006, was certified as a CAH based on State designation as a "necessary provider"
- Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed and distinct part units)
- Demonstrate compliance with CAH conditions of participation
- Furnish 24-hour emergency care services 7 days a week

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What is PPS?

- PPS stands for the Prospective Payment System (PPS)
- PPS is a reimbursement mechanism
  - Predetermined fixed amount
  - Derived based on classification system for that service
- Separate PPS for reimbursement of
  - Acute inpatient hospitals
  - Hospital outpatients
  - Inpatient psychiatric facilities
  - Inpatient rehabilitation facilities
  - Long-term care hospitals
  - Skilled nursing facilities
  - Home health agencies
  - Hospice
  - RHC / FQHC

No location requirements

No service limitations

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What is PPS?

- Acute inpatient PPS
  - Reimbursement for operating costs of acute care hospital inpatient stays under Medicare Part A
  - Referred to as the inpatient prospective payment system (IPPS)
  - Case is categorized based on DRGs
  - Base payment rate composed of labor and non-labor share
  - Labor share is adjusted by the wage index
- Outpatient PPS (OPPS)
  - Reimbursement for outpatient services under Medicare Part B
  - Paid based on APCs
  - Base payment rate composed of labor and non-labor share
  - Labor share is adjusted by the wage index

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What is the Medicare cost report?

- CMS prescribed forms for Medicare-certified institutional providers
  - Hospital Form: CMS-2552-10
- Annual submission required
  - Due five months after year-end
- Contains:
  - Facility characteristics
  - Utilization data
  - Cost and charges by cost center (in total and Medicare)
  - Medicare settlement data
  - Financial statement data

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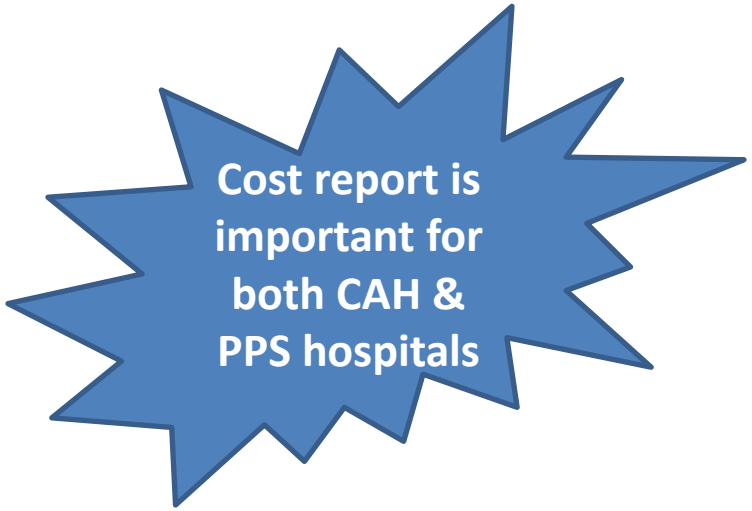
Significance of Medicare Cost Report

- Settlements between providers and the Medicare program
  - Interim payments versus final payments
    - CAH cost reimbursement
    - SCH, MDH, DSH, UCC, low-volume, etc.
  - Uncollectible Medicare deductibles and coinsurance
  - RHC cost reimbursement, etc.
- Affects future reimbursement
  - Wage index
  - Geographic reclassification
  - Determination of MDH status
  - Volume decline adjustments
  - UCC, etc.
- Data collection to support policy making decisions
- Other uses (CARES Act PRFs)



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Designations impacting payments

- Medicare disproportionate share hospital (DSH)
  - Additional payments available to hospitals treating disproportionate share of low-income patients
  - Eligible if DSH patient percentage exceeds 15%
    - Exception for large urban hospitals

DSH patient percentage =
SSI ratio + (Medicaid, Non-Medicare Days / Total Days)

SSI ratio = Medicare SSI days / Total Medicare days

Important to report days correctly on Worksheet S-3, Part I on the cost report

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Designations impacting payments

- Medicare disproportionate share hospital (DSH)
  - DSH payment adjustment is based on statutory formula
    - Varies based on hospital type
  - ACA - DSH payment adjustment provision was amended and additional payment for uncompensated care was established
    - Receive 25% of amount based on statutory formula (DSH payment)
    - Remaining 75% available as uncompensated care (UCC) payments
      - UCC payments based on the following:
        - FY 2023 - average of 2018 and 2019 UCC from W/S S-10
        - FY 2024 - average of 2018 - 2020 UCC from W/S S-10

Important to capture data on Worksheet S-10 correctly

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Designations impacting payments

- Sole community hospital (SCH)
  - Receives special payment provisions
    - Higher of its hospital specific rate (HSR) or federal operating rate plus DSH and UCC payments
  - Criteria for classification (after October 1, 1983)
    - Located in a rural area and meets certain criteria
    - Not available to hospitals located within 15 miles of another like hospital
    - Not available to urban hospitals
- Medicare dependent hospital (MDH)
  - Receives special payment provisions
    - Higher of its federal rate or federal rate plus 75% of difference between the federal rate and HSR
  - Criteria for classification
    - Located in a rural area (with certain exceptions)
    - No more than 100 beds
    - Is not a SCH
    - High % of Medicare discharges

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Designations impacting payments

- Low volume hospital
  - Additional payments available for low volume hospitals
  - Originally implemented in FY 2005; original criteria:
    - More than 25 road miles from another subsection(d) hospital
    - Have less than 200 discharges **total**
  - Criteria modified by ACA beginning FY 2011 - FY 2017
    - More than 15 road miles from another subsection(d) hospital
    - Less than 1,600 discharges for individuals entitled to Medicare Part A benefits
  - BBA 2018 extended and modified the low-volume payments criteria
    - FFY 2018 criteria same as criteria under ACA
    - FFY 2019 – FY 2022 criteria
      - More than 15 road miles from another subsection(d) hospital
      - Less than 3,800 **total** discharges
      - Payment based on linear sliding scale
  - Further Continuing Appropriations Act of 2023
    - Extended through September 30, 2024

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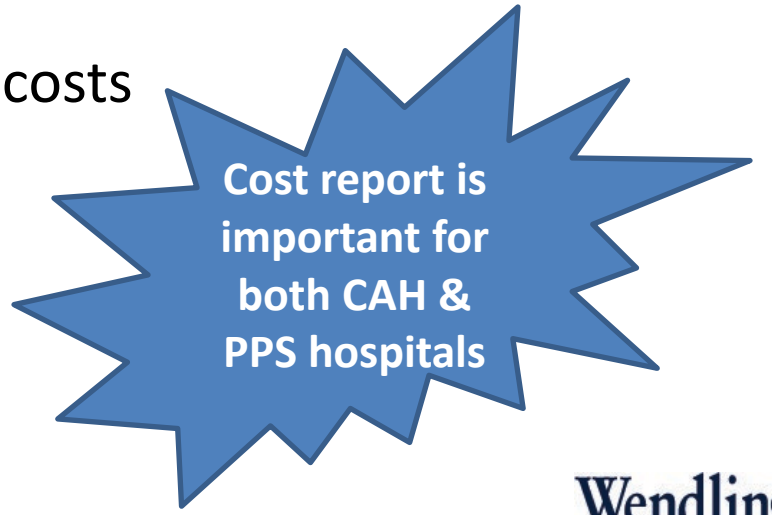
Designations impacting payments

- Rural referral center (RRC)
- Geographically reclassified
  - Redesignation to a higher wage area
  - Increases IPPS and OPPS payments
  - Requirements for reclassification
    - Proximity
    - Comparison of AHW
- Rural Community Hospital Demonstration Program
  - Inpatient hospital services are paid under reasonable cost-based methodology

True or False

Importance of maximizing costs

- Uncompensated care costs on W/S S-10 are calculated using the overall cost to charge ratio from W/S C
- HSR computed based on highest rate attained in applicable base year inpatient costs and inflating forward
- Medicaid DSH payments
- RHC services are cost reimbursed (up to payment cap) for small rural hospitals
- Organ acquisition costs
- Future uses



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Hospital cost report forms

- Basic forms present for all hospitals
  - Worksheet S series
  - Worksheet A series
  - Worksheet B series
  - Worksheet C series
  - Worksheet D series
  - Worksheet E series
  - Worksheet G series
- Specific forms
  - Worksheet L – Capital
  - Worksheet M – RHC
  - Worksheet H – HHA
  - Worksheet O – Hospice
  - Worksheet N – FQHC
  - Worksheet I – Renal dialysis
  - Worksheet J – CMHC

Form CMS 2552-10

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Worksheet S series

- Worksheet S – Settlement summary
- Worksheet S-2, Part I – Hospital identification
  - Answers properly identify provider
  - Answers identify specific payments hospital qualifies for
- Worksheet S-2, Part II – Hospital reimbursement questionnaire
- Worksheet S-3, Part I – Hospital statistic data
  - Beds, beds available, days, discharges, visits, trips, FTEs
  - CAH hours
- Worksheet S-3, Part II – Part V – Wage index & wage costs
  - Only applicable to PPS hospitals
- Worksheet S-10 – Uncompensated Care Data
- Other specific worksheets included in S series

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Worksheet S-3, Part I

- Reports statistical data
- Column 2 – number of beds
- Column 3 – bed days available
  - Important for determining ALOS
- Column 4 – CAH hours
  - Important for determining ALOS (96-hour rule)
- Column 5 – Medicaid days
- Column 6 – Medicare days
  - From Provider & Statistical Report (PS&R)
- Column 8 – Total days
  - Important for calculation of cost per day
- Column 10 – FTEs
- Column 13 thru 15 – Discharges

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Worksheet S-3, Part II

- Applicable to PPS hospital only
- Critical to future payments
  - Basis for construction of wage indexes
  - Basis for geographic reclassification requests to MGCRB
- Section for employees, benefits, and contract labor
- Salary and hours are reported on an accrual basis
- Physician Part B dollars and hours removed from the wage index
- Physician Part A dollars and hours are included
- Services excluded from IPPS are excluded from the wage-index
- Determine appropriate methodologies for allocating benefits
- Important to identify administrative contract labor

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Worksheet S-10

- Worksheet used to compute uncompensated care costs
- Line 1 – Cost to charge ratio from Worksheet C
- Line 2 – 16 – Net revenue information for Medicaid, CHIP, and other state and local indigent care programs
- Line 17 – Private grants and donations to fund charity care
- Line 18 – Government grants and appropriations for operations
- Line 20 – Charity care charges
  - Uninsured charges written off to charity care and non-covered services for patients eligible for Medicaid if inclusion specified in charity care policy
  - Insured deductible and coinsurance payments required by payor that were written off to charity care.
    - Do not include amounts claimed as XVIII bad debt
- Line 26 – Total bad debt expense
  - Written off during cost report period
  - Net of recoveries
- Exclude professional services from amounts on W/S S-10

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Worksheet A series

- Worksheet A – Trial balance of expenses
- Worksheet A-6 – Reclassifications
- Worksheet A-7 – Analysis of capital
- Worksheet A-8 – Adjustments to expenses
- Worksheet A-8-1 – Related organization and home office costs
- Worksheet A-8-2 – Physician adjustments
- Worksheet A-8-3 – Therapy reasonable costs (CAH only)

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Worksheet A

- Reporting of expenses per trial balance based on cost center
  - Segregated by salary and other expenses
- Standard listing of cost centers
- Non-standard cost centers can be added
- Capital-related cost opportunities
  - Fragmentation by location / building
  - Funded depreciation
  - Capitalization threshold
  - Componentization of capital projects
  - Evaluation of repairs and maintenance versus betterments
- Fragmentation of A&G

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Worksheet A-6 - Reclassifications

- Worksheet used to reclassify costs between cost centers to effect proper cost allocation
- Common reclassifications
  - Medical supplies charged to patients
  - Drugs charged to patients
  - Implantable devices
  - CT and MRI costs
  - Capital related costs
  - A&G costs
    - Avoid double allocation of overhead costs (i.e., administrative and billing)

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Worksheet A-8 - Adjustments

- Worksheet used to add or remove costs from Worksheet A
- Worksheet A-8-1, A-8-2, and A-8-3 feed into W/S A-8
- General types of adjustments
  - Reductions of expenses for items that constitute recoveries of sales, charges, fees, etc.
  - Remove costs unrelated to patient care
  - Remove costs of physician, MLP, and CRNAs paid under fee schedule
  - Remove Part A costs in excess of RCE limits (PPS only)
  - Remove therapy costs in excess of limits (CAH only)

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Emergency room stand-by costs

- Applies only to physicians (not MLPs)
- Physician must be physically present on hospital premises (cannot be on-call)
- Allowable costs must be in ER cost center
- Allowable cost is lesser of compensation paid for availability, supervisory and administrative services in ER **or** aggregate RCE limit based on hours for which compensation was paid
- Written time records required
- **Exceptions for CAHs**
  - RCE limits do not apply
  - Compensation paid to on-call physicians allowable in determining stand-by costs
  - Compensation paid to on-call MLPs also included in allowable stand-by costs

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Emergency room stand-by costs

- **Exceptions for CAHs**
  - Costs **must** be incurred under terms of a **written** contract that requires physician or MLP to come to CAH within specified time frames (generally 30 minutes) when the physician's presence is medically required
  - Physician or MLP must be immediately available by phone or radio while on call
  - Physician or MLP cannot be furnishing services elsewhere while on-call
    - Not in office practicing medicine
    - Not on-call for another hospital at the same time

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Worksheet B series

- Worksheet B – Allocation of costs
  - Column 26 – Represents total costs after all general service costs have been allocated
- Worksheet B-1 – Statistics used to allocate general service cost
  - Recommend bases are preprinted on cost report
  - Must receive approval to change statistical basis for a cost center or change order in which costs are allocated
- Worksheet B-2 – Post-step down adjustments

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Worksheet C series

- Worksheet C – Ratio of Cost to Charges
  - Costs flow from W/S B
  - Revenues are reported from trial balance with necessary reclassifications and adjustments
  - Grouping of revenues by department should be consistent with grouping of expenses on W/S A
    - Reclassifications might be needed
    - Adjustments needed to remove PC charges
    - Do not report non-reimbursable cost centers
- Review ratio of cost to charge ratios for reasonableness and consistency

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Worksheet D series

- Used to apportion costs to Medicare program
- Medicare charges entered per Provider Statistical Report (PS&R)
- Grouping of Medicare charges should be consistent with grouping of expenses on W/S A and charges on W/S C
  - May need to reclassify on W/S D or W/S C charges to align
- Worksheet D-1 – Be sure to report days correctly
- Worksheet D-3 – Report Medicare inpatient charges
- Worksheet D, Part V – Report Medicare outpatient charges
  - PPS – Important to enter in correct column

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Worksheet E series

- Used to determine settlements with Medicare program
- Worksheet E, Part A – Calculation of reimbursement for inpatient services under IPPS
- Worksheet E, Part B – Calculation of reimbursement for outpatient services
- Worksheet E-1, Part I – Analysis of payments
  - Be sure that lump sum payments included
- Worksheet E-2 – Calculation of reimbursement for swing-bed-SNF services
- Worksheet E-3, Part V – Calculation of reimbursement for inpatient services for CAHs
- Other worksheets depending on services

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Worksheet G series

- Worksheet G – Balance Sheet
- Worksheet G-1 – Statement of Changes in Fund Balances
- Worksheet G-2 – Statement of Patient Revenues and Operating Expenses
- Worksheet G-3 – Statement of Revenues and Expenses

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Worksheet L series

- Only applicable to PPS hospitals
- Calculation of capital payment
- Amounts from the Medicare PS&R

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Worksheet M series - RHC

- Worksheet M-1 – Analysis of hospital-based RHC costs
  - A break-out of the expenses, reclassifications, and adjustments as reported on W/S A, W/S A-6, and W/S A-8
  - Total must tie back to Worksheet A
- Worksheet M-2 – Report FTEs and visits by provider type
  - FTEs represent time the providers are available to see patients in the RHC
    - Adequate time records need to be kept
    - Exclude tele-health services
  - Visits represent face-to-face visits with a provider
    - Adequate visit records need to be maintained
    - Exclude tele-health visits
- Worksheet M-3 – Calculation of settlement for RHC services
- Worksheet M-4 – Pneumonia and influenza vaccine costs
- Worksheet M-5 – Analysis of payments (include lump sums)

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Worksheet M series - RHC

- Per-visit cap on RHC services, beginning April 1, 2021

Year	Limit/visit	Year	Limit/visit
2021	$100	2025	$152
2022	$113	2026	$165
2023	$126	2027	$178
2024	$139	2028	$190

- Provider based RHCs in hospital with less than 50 beds
  - Prior to April 1, 2021, cost reimbursement with no payment cap
  - Effective April 1, 2021
    - Grandfathered RHCs - 1st year - greater of per visit payment amount applicable to RHC services furnished in 2020 increased by MEI for 2021 or payment limit per visit cap
    - Grandfathered RHCs - 2nd year - greater of payment limit per visit established from the previous year increased by MEI or payment limit per visit cap
    - Not-grandfather RHCs - subject to per-visit cap

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Uncollectible deductibles & coinsurance

- Reimbursement for Medicare uncollectible deductibles and coinsurance at 65% of uncollectible amount
  - Extensive rules and regulations must be followed
  - For hospital services only
  - Charges paid on fee schedule are not eligible
  - Non-covered charges are not eligible
  - Medicare Advantage patients are not included
- Three categories: Bad debt Crossovers Charity
  - Bad debt - 120 day rule
  - Crossovers - must bill and receive denial; write-off must be reported as bad debt and not a contractual adjustment
  - Charity care - must be in accordance with policy
- Rules are not the same as what is reported on W/S S-10

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Resources

- Social Security Act, as amended
- Specific statutes (ACA, MMA, BBA18, etc.)
- Medicare regulations
- Federal Register
- Medicare manuals
  - Program reimbursement manual
    - CMS Pub 15 Part 2 contains cost report instructions
- Program memoranda
- PRRB decisions
- Medicare/Medicaid reporting services (CCH, BNA, etc.)

Websites

- Centers for Medicare and Medicaid Services (CMS)
  - https://www.cms.gov
- WPS - Medicare administrative contractor
  - https://www.wpsgha.com
- United States Code
  - https://www.govinfo.gov
- Federal registers
  - https://www.govinfo.gov

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Questions

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Providing accounting, auditing, and reimbursement services for over 50 years.

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