WHAT IS THE MEDICARE COST REPORT?

Prepared for:
The CHFP Certification Study Group
Pre-Recorded Webinar Series
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Baker Newman & Noyes, LLC
TODAY’S AGENDA

- Healthcare Expenditures in the U.S.
- Major Healthcare Sectors
- Regulatory Environment
- The Medicare Program
- Medicare Reimbursement in NH/VT
- The Hospital Medicare Cost Report (MCR)
- MCR Preparation Challenges
- The More Things Change, the More They Stay the Same
- The Medicare Hospital Cost Report Worksheets
- Beyond the Filing Requirements
- Other Users of the MCRs
- Why Board Members Should Care
- Questions
HEALTHCARE EXPENDITURES IN THE U.S.

• Healthcare is defined as “the field concerned with the prevention, treatment, and management of illness and the preservation of well-being through the services offered by the medical and allied health professionals.”

• Healthcare entities must achieve financial success—necessary to effectively and efficiently provide quality healthcare services.

• Over 14 million healthcare workers (Clinical and Administrative)
HEALTHCARE EXPENDITURES IN THE U.S.

- Healthcare is the largest industry in the U.S.
- Overall **approx.** spending in 2011
  - $2.67 trillion
  - 17.9% of gross domestic product (GDP)
  - Per capita basis of $8,680
- Continued upward trend to 2018 predicted - $4.3 trillion
  - 19.6% of GDP
  - Per capita amount of $12,782
MAJOR HEALTHCARE SECTORS

- Hospitals (31% of expenditures)
- Physician practices (22% of expenditures)
- Pharmaceutical manufacturers (11% of expenditures)
- Nursing home care (7% of expenditures)
- Home health services (2.4% of expenditures)
REGULATORY ENVIRONMENT

• Healthcare is the second most highly regulated industry in the U.S.
• Federal Agencies Influencing Healthcare
THE MEDICARE PROGRAM

• Federally Administered Program by the Department of Health and Human Services (HHS)-The Centers for Medicare and Medicaid Services (CMS, formerly HCFA)

• Is health insurance for the following:
  - People age 65 and older
  - People under age 65 with certain disabilities
  - People of any age with End-Stage Renal Disease (ESRD) permanent kidney failure
THE MEDICARE PROGRAM

Created by Sec. 1886 of the Social Security Act on July 1, 1965—Title XVIII

The purpose of the Law was to create a program to pay for the reasonable cost of providing patient care to a specific population
THE MEDICARE PROGRAM

Components of Medicare

- Hospital Insurance (Part A)
- Medical Insurance (Part B)
- Medicare Advantage (Part C)
- Medicare Prescription Drug Coverage (Part D)

Part A and Part B Trust Funds
Examples of Major Legislation

- **1965** Social Security Act - Medicare & Medicaid Programs signed into law
- **1983** Tax Equity and Fiscal Responsibility Act (TEFRA)
- **1997** Balanced Budget Act (BBA)
- **1999** Balanced Budget Refinement Act (BBRA)
- **2003** Medicare Modernization Act (MMA)
- **2010** Patient Protection & Affordable Care Act (PPACA)
MEDICARE REIMBURSEMENT SYSTEMS

- Acute Care Hospitals-Inpatient-PPS based on MS-DRGs
- Psychiatric Hospitals-Inpatient-IPF PPS
- Rehabilitation Hospitals-Inpatient-IRF-PPS
- Long Term Care Hospitals-Inpatient-PPS-LTCMS-DRGs
- Outpatient-OPPS-Ambulatory Payment Classifications (APCs)
- Critical Access Hospitals-101% of reasonable costs for Inpatient and Outpatient Hospital Services Retrospective Cost Reimbursement
- Skilled Nursing Facilities-PPS-Resource Utilization Groups (RUGs)
- Physician Services-Fee Schedule Payments
MEDICARE REIMBURSEMENT IN NH/VT

• **19 Acute Care PPS Hospitals**
  – 40-62% Medicare Inpatient Utilization (based on days)
  – 28-35% Outpatient Medicare Utilization (based on gross charges)

• **21 Critical Access Hospitals**
  – 55-75% Inpatient Medicare Utilization
  – 28-35% Outpatient Medicare Utilization

• **5 “Other” Hospitals (Psychiatric, Rehabilitation)**
  – 10%-25% Inpatient Medicare utilization, minimal Outpatient utilization
MEDICARE COST REPORT (MCR)

• Requirement For Facilities Participating in the Medicare Program:
  - Hospitals
  - Skilled Nursing Facilities (SNFs)
  - Home Health Agencies (HHAs)/Hospices
  - Mental Health Facilities
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health Clinics (RHCs)
  - End Stage Renal Disease Facilities (ESRDs)
  - Comprehensive Outpatient Rehab Facilities (CORFs)
  - Outpatient Therapy Facilities (OPTs) (non-fee schedule services only)
MEDICARE COST REPORT (MCR)

Requirements-Hospitals

- Due the last day of the 5th month following the end of the facility’s cost reporting period to the assigned Medicare Administrative Contractor (MAC)
- Medicare Part A and Part B Reimbursement
- Form CMS-2552-10 effective for all cost reporting periods beginning on or after May 1, 2010
- Comprised of a series of worksheets and schedules
- Hospital Cost Reports must be filed electronically using CMS approved vendor software, in accordance with Provider Reimbursement Manual 15-II Instructions
- Payments due the Program must be submitted by the due date of the MCR
MEDICARE COST REPORT (MCR)

Final Reimbursement- Acute Care PPS Hospitals

- Medicare bad debts (at 70%)
- Indirect and Direct Medical Education Costs
- Allied Health Costs
- Disproportionate Share Medicare Hospital payments
- Additional payments for Medicare Dependent Hospitals
- Additional payments for Sole Community Hospitals
- Organ Transplant Costs
- Outpatient Transitional Corridor Payments (TOPs)
- Qualification for 340 (b) Drug Program
- Calculation of Health Information Technology Reimbursement
- Wage data (used for future period PPS payments)
- Application of sequestration (4-1-13 and after)
- Calculation of final annual HIT payments
Final (Retrospective) Reimbursement-CAHs

Final Reimbursement of Part A and Part B Medicare Costs--calculated at 101% of reasonable costs for hospital services rendered to Program beneficiaries minus applicable deductible and coinsurance amounts billed and sequestration applied 4-1-13 and after)

Hospital Medicare Bad Debts reimbursed at 100% (PPS Hospital-Based Providers of CAHs at 70%)
MCR Preparation Challenges

- The preparation of the cost report goes far beyond the technical exercise of data entry into the software program.
- The preparer (CFO) must be up-to-date on Hospital operations, financial accounting, changes in Medicare Laws and Regulations, the Principles of Medicare Reimbursement and MCR Instructions.
- CMS estimates several hundred hours to prepare.
- Preparation begins before the beginning of the facility’s fiscal year. Ensure written procedures are updated. Source documentation must be maintained.
- All departments must be educated and on-board.
- Consistent communication and monitoring required.
- Meaningful Use $ ramifications.

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MCR PREPARATION CHALLENGES

DOCUMENT! DOCUMENT! DOCUMENT! DOCUMENT!
MEET ALL DEADLINES!

Failure to do either will result in reductions in Medicare Reimbursement
MCR PREPARATION CHALLENGES

• All filed Medicare cost reports are subject to review by the servicing MAC
  - May be reviewed as a desk review or field audit
  - Maintain all documentation used in the preparation so it is readily available
  - The MAC prepares an audit adjustment report (AAR)
  - A Notice of Program Reimbursement (NPR) is issued with an amount due Program/Provider
MCR PREPARATION CHALLENGES
CHANGES FOR HOSPITALS

• Form CMS-2552-10 Cost Reporting Forms have replaced Form CMS-2552-96, effective for cost reporting periods beginning on or after May 1, 2010
  - Worksheet S-10 Uncompensated Care (expanded and now required for CAHs)
  - Increased reporting to replace information formerly included on Form CMS-339, which is no longer required
  - New and eliminated worksheets
  - New section of E-1 added for collection of data necessary to calculate HIT payments
  - Numerous cost center and line number changes
The More Things Change, the More They Stay the Same

FFY 1967 Environment

FFY 2013 Environment
THE MORE THINGS CHANGE, THE MORE THEY STAY THE SAME

HCFA
- CMS

Carriers and Fls
- MACs

Provider Numbers (With intelligence)
- NPIs
  - (no intelligence)
THE MORE THINGS CHANGE, THE MORE THEY STAY THE SAME

CMS Form 2552-10

HCFA Form 2551

HCFA Form 2552-83 through HCFA Form 2552-92

CMS Form 2552-96
# Hospital MCR Worksheets

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## Hospital MCR Worksheets

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# Hospital MCR Worksheets

## Worksheet A Series

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<td>Reasonable Cost Determination for Therapy Services Furnished by Outside Suppliers (CAHs)</td>
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[HFMA Logo]
Worksheet B Series

- Worksheet B Part I - Cost Allocation General Service Costs
- Worksheet B Part II - Allocation of Capital-Related Costs
- Worksheet B-1 - Cost Allocation-Statistical Bases

- **Worksheet B**
  - Provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services

- **Worksheet B-1**
  - Provides for the proration of the statistical data needed to allocate the expenses of each general service cost center on Worksheet B
  - All statistics must be current, accurate and meet the tests of audit
Worksheet B-1 – General Service Cost Centers/Recommended Statistics

- Buildings and Fixtures/Square Footage
- Movable Equipment/ Square Footage or Dollar Value
- Employee Benefits/Gross Salaries
- Other Capital Related Costs/Square Footage
-Administrative and General/ Accumulated costs
- Maintenance and Repair/Square Footage
- Operation of Plant/Square Footage
- Laundry and Linen/Pounds of Laundry
- Housekeeping/Square Footage/Hours of Service
- Dietary/Meals Served
- Cafeteria/Full Time Equivalents
HOSPITAL MCR WORKSHEETS

Worksheet B-1 General Service Cost Centers/Recommended Statistics (continued)

- Maintenance of Personnel/Number Housed
- Nursing administration/Nursing Time Spent
- Central Services and Supply/ Costed Requisitions
- Pharmacy/Costed Requisitions
- Medical Records/Time spent
- Social Service/Time Spent
- Allied Health/Assigned Time
- Interns & Residents/Assigned Time
HOSPITAL MCR WORKSHEETS

• Worksheet C Series
  – Worksheet C Computes the ratio of costs to charges (RCCs) for inpatient and outpatient ancillary services by cost center
  – Noteworthy comment – “My favorite MCR Worksheet”
**HOSPITAL MCR WORKSHEETS**

**Worksheet D Series**

Reimbursable Medicare costs are calculated (using the CCRs from Worksheet C)

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HOSPITAL MCR WORKSHEETS

- PS&R is a national provider statistical and reimbursement reporting system developed in 1984 by CMS (formerly HCFA)
- The PS&R reports compile each provider’s Medicare paid claims data and summarizes it for use in the Medicare Cost Report
Hospital MCR Worksheets

- Medicare data is summarized on the PS&R reports.
  - Medicare data necessary for the MCR is summarized on the PS&R reports as applicable:
    - Inpatient days, private and semi-private
    - Discharges
    - Ancillary charges-IP & OP
    - Total charges
    - Federal specific and hospital specific portions
    - Outlier payments
    - Disproportionate Share Hospital Payments
    - GME/IME/Capital Payments
    - Deductibles/Coinsurance
    - Primary Payer Payments
    - Net Reimbursement & Sequestration
Hospital MCR Worksheets

Worksheet E-Series-Reimbursement Settlement

- W/S E Part A-Inpatient Hosp. Services under PPS
- W/S E part B-Medical and Other Health Services
- W/S E-1-Analysis of payments to/from providers
- W/S E-2-Swing bed settlement
- W/S E-3 Parts I-IV-Sub-provider settlements
- W/S E-3 Part V-Medicare Part A Services-CAHs
- W/S E-3 Part VI-Medicaid Services or Medicare SNF PPS
- W/S E-3 Part VII-Title V and Medicaid SNF Reimbursement
- W/S E-4 –Direct Graduate Medical Education & ESRD Outpatient Direct Medical Education Costs
**Hospital MCR Worksheets**

- **Worksheet G Series**
  - **Financial Statements**

This series of worksheets are prepared using provider accounting books and records. Completion of these worksheets in their entirety is required for an acceptable cost report.

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Hospital MCR Worksheets

- Worksheet L Series

<table>
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<td>Fully Prospective Method</td>
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<td>Indirect Medical Education Adj.</td>
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### Hospital MCR Worksheets

#### Worksheet H Series

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## Hospital MCR Worksheets

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<td>Analysis of Payments to Hospital-Based RHCs/FQHCs</td>
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COMMUNICATE! COMMUNICATE! COMMUNICATE!

“The family circus

By Bill Keane

“Billy says he doesn’t hafta go to meetings anymore ’cause his phone has an app for that!”

Financial Staff (CFO) Clinical Staff
Operations, COO/ Director of Nursing

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OTHER USERS OF MEDICARE COST REPORTS

Other Users of Filed/Settled Cost Reports

• Medicare Contractors
• Federal Agencies (CMS, OIG, DOJ, IRS, FBI)
• State Medicaid Programs
• Competing entities
• Other non-hospital Providers
• Commercial Payers and Part C Contractors
• Others

Note: Filed and Settled Medicare Cost Reports are available under the Freedom of Information Act (FOIA)
OTHER USERS OF MEDICARE COST REPORTS

Medicare Contractors

The Statement of Work requires specific procedures and deadlines for the submission and settlement of all cost reports for serviced providers

• Timely acceptance and submission to HCRIS
• Performance of audits, desk reviews
• Issue NPRs timely and process appeals timely
• Establish interim rates and perform interim rate reviews
• Performance of wage index audits of W/S S-3 Parts II & III
• Complete deliverables issued by CMS, OIG etc.
• Timely complete FOI requests

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Medicare Administrative Contractors (MACS)

- All filed Medicare cost reports are subject to review by the servicing MAC.
- The MAC prepares an audit adjustment report (AAR).
- Maintain all documentation used in the preparation so it is readily available.
- May be reviewed as a desk review or field audit.
- A Notice of Program Reimbursement (NPR) is issued with an amount due Program/Provider.
PROVIDER TIMELINE

Original submission → Refile → Tentative Settlement → Interim Rate Changes → WAIT → Desk Review

Field Audit → AAR → WAIT → NPR → Reopening → PRRB
Beyond the Filing Requirements

The MCR influenced current Hospital Structures
BEYOND THE FILING REQUIREMENTS

Provider Use as a Management Tool
• Cost Analysis-Routine and Ancillary Services
• Cost Analysis-Non-Reimbursable Expenses
• Profitability by Cost Center
• Use for Completion of Schedule H of Form 990
• Managed Care Contracting
• Inpatient Hospital Utilization
• Evaluate Performance
• Financial Modeling
• Identify Opportunities for Financial Improvement
• Comparison to prior year data
• Analysis of Medicare Reimbursement
• PPS Hospitals-compare Medicare calculated reasonable costs to actual payments on PPS and OPPS systems
• Medicare Bad Debts—Actual vs. claimed
• Benchmarking
• Future Wage Index implications
BEYOND THE FILING REQUIREMENTS

Provider must consider MCR implications:
• Strategic Planning
• Budget Process
• Contracting with other payers
• Purchase of buildings, major movable equipment
• Leasing Arrangements
• Staffing
• Physician Contracts
• Introduction of New Services
• Cessation of Services
• Provider Based Entities
OTHER USERS OF THE MEDICARE COST REPORT

New Hampshire Medicaid

• Inpatient costs are developed in accordance with Medicare Principles of Reimbursement. No settlement is performed as inpatient costs are paid prospectively.

• Outpatient Medicaid costs are calculated in accordance with Medicare Principles of Reimbursement (with some exceptions). A settlement is performed for most outpatient costs.

• Outpatient Final Medicaid Payments
  PPS Hospitals-are paid 54.04% of reasonable Medicaid costs
  CAHs-are paid 91.27% of Medicaid reasonable costs (As of September, 2013)
OTHER USERS OF THE MEDICARE COST REPORT

Vermont Medicaid

- Inpatient Medicaid costs are calculated in accordance with Medicare Principles of Reimbursement. No settlement is performed as inpatient costs are paid prospectively.
- Outpatient Medicaid costs are calculated in accordance with Medicare Principles of Reimbursement (with some exceptions). No settlement is performed as outpatient costs, are paid prospectively effective May 1, 2008.
WHY BOARD MEMBERS SHOULD CARE

- Challenges of Governance
- Fiscal Responsibility
- Uncompensated Care
- Committee Goals
- Fiduciary Responsibility
- Hospital Mission
- Healthcare Reform
QUESTIONS?

Thank you for listening and have a great day!

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