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MEDICARE COST REPORT 101

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AGENDA

- CMS REIMBURSEMENT & CAH HISTORY
- COST REPORT OVERVIEW
- COST REPORT ANALYSIS
  - Construction/Remodel
  - Potential Purchases
  - Financial Review
- REIMBURSEMENT ISSUES
  - Fitness Center
  - CRNA
- QUESTIONS

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REIMBURSEMENT & CAH HISTORY

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CMS REIMBURSEMENT & CAH HISTORY

- **1965**
  - Medicare & Medicaid Program signed into law
  - Hospitals were reimbursed on a retrospective cost basis
- **1983**
  - Reimbursement changed to Prospective Payment System (PPS) from cost based for all providers
  - Intention was to control costs and increase efficiencies
  - Creation of Sole Community Hospital (SCHs)
- **1986**
  - Creation of Medicare Disproportionate Share Hospital
    - *Treat a disproportionate share of low-income patients receive additional operating and capital payments*

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CMS REIMBURSEMENT & CAH HISTORY

- 1987
  - Creation of Medicare Dependent Hospital (MDH)
  - Smaller hospitals that serve a large proportion of Medicare patients
- 1997
  - Critical Access Hospital (CAH) Program created
  - CAHs are reimbursed on a retrospective cost basis
  - Reduce financial vulnerability & improve access to care
- 1991-2001
  - Implementation of capital PPS system
  - After 10/1/01, fully transitioned to capital PPS system

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CMS REIMBURSEMENT & CAH HISTORY

- CAH REQUIREMENTS
  - Have 25 or fewer acute care inpatient beds
  - Be located more than 35 miles from another hospital (exceptions may apply)
  - Maintain an annual average length of stay of 96 hours or less for acute care patients
  - Provide 24/7 emergency care services

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CMS REIMBURSEMENT & CAH HISTORY

- **CAH METHOD II**
  - Inpatient
    - *CMS 1500*
    - *Fee Schedule reimbursement*
  - Outpatient
    - *UB*
    - *Fee Schedule + reimbursement*
  - Election

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COST REPORT OVERVIEW

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TYPES OF COST REPORTS

- CRITICAL ACCESS HOSPITALS
  - Reimbursed on allowable costs for IP, OP, and SB services
- PPS HOSPITALS
  - IP reimbursed on DRG
  - OP reimbursed on APC (Ambulatory Procedure Codes) or Fee Schedule
  - SB reimbursed on RUGS (Resource Utilization Group)
- RURAL HEALTH CLINICS
- SKILLED NURSING FACILITY (SNF)

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TYPES OF COST REPORTS

- COMMUNITY MENTAL HEALTH CLINIC/COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
- FEDERALLY QUALIFIED HEALTH CENTERS
- HOME HEALTH AGENCIES
- HOSPICE
- HOME OFFICE
- END STAGE RENAL DISEASE
- ORGAN PROCUREMENT ORGANIZATION

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COST REPORT OVERVIEW

- **MEDICARE COST REPORTS**
  - **Used to determine settlements**
  - **Used by CMS to develop hospital cost database (HCRIS-Hospital Cost Report Information System)**
    - ***Facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data***
  - **Due five months after cost report period**
  - **Subject to annual audit by Fiscal Intermediary (FI)/Medicare Administrative Contractor (MAC)**

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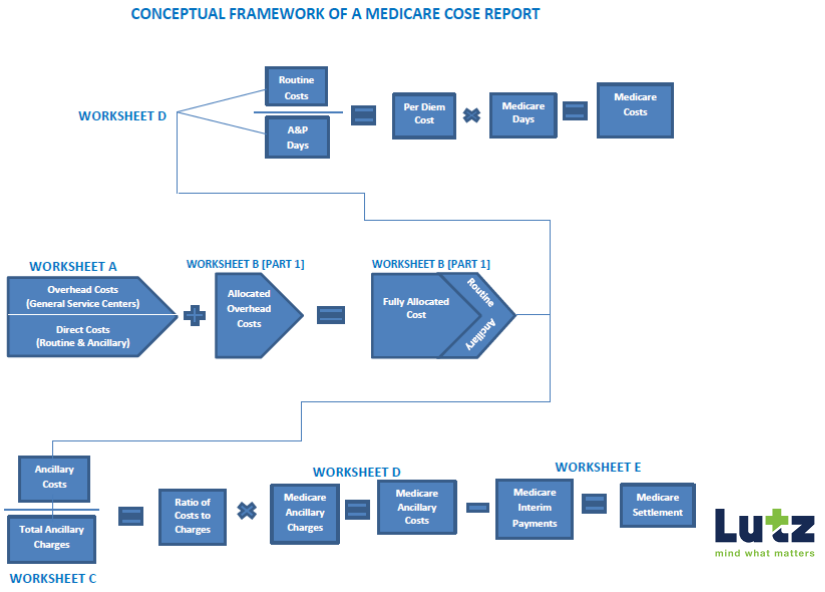
MEDICARE COST REPORT OVERVIEW



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QUESTION

- WHO HAS PREPARED/AUDITED COST REPORTS THE LONGEST?

COST REIMBURSEMENT

ROOM AND BOARD	
DIRECT COSTS	A
+ OVERHEAD COSTS	B
=TOTAL DEPT COSTS	
/ TOTAL PT DAYS	C, D-1
= PER DIEM COSTS	
X MEDICARE DAYS	D-1, D-3, & D,V
= MEDICARE COSTS	D-1, D-3, & D,V
- DEDUCTIBLES/CO-INS	E SERIES
= NET DUE FROM MEDICARE	

ANCILLARY	
DIRECT COSTS	A
+ OVERHEAD COSTS	B
=TOTAL DEPT COSTS	
/ REVENUES	C, D-1
= COST TO CHARGE RATIO	
X MEDICARE REVENUE	D-1, D-3, & D,V
= MEDICARE COSTS	D-1, D-3, & D,V
- DEDUCTIBLES/CO-INS	E SERIES
= NET DUE FROM MEDICARE	

WORKSHEETS

- S – STATISTICS AND SETTLEMENT / CERTIFICATION
- A – TRIAL BALANCE OF EXPENSES
- A-6 RECLASSIFICATIONS OF COSTS
- A-7 SUMMARY OF CAPITAL COSTS
- A-8 - ADJUSTMENTS TO COSTS
- A-8-2 PHYSICIAN COMPENSATION
- A-8-3 CONTRACT THERAPY COSTS
- B - ALLOCATION OF OVERHEAD COSTS
- C – COMPUTATION OF COSTS TO CHARGES
- D – PROGRAM CHARGES & COSTS
- E – PAYMENTS & SETTLEMENT
- G – FINANCIAL STATEMENTS
- H – HOME HEALTH
- I - RENAL DIALYSIS
- M – RURAL HEALTH CLINIC
- O – HOSPICE

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WORKSHEET A SERIES

- **OVERHEAD COSTS**
  - General Service Cost Centers – Capital, Laundry, Housekeeping, etc.
- **DIRECT COSTS**
  - Inpatient Routine Service Centers – Adults & Pediatrics
  - Ancillary Service Cost Centers – Operating Room, Lab, PT
  - Non Reimbursable Cost Centers – Gift Shop
- **NON ALLOWABLE COST ARE EXCLUDED**

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WORKSHEET A-6 RECLASSIFICATIONS

COST TYPE	FROM/TO COST CENTER
• EMPLOYEE BENEFITS	• A&G TO EMPLOYEE BENEFITS
• CRNA EXPENSES	• ANESTH TO NONPHY ANESTH.
• CLINIC ADMIN COSTS	• CLINICS TO A&G, EMP BEN
• LABOR/DELIVERY	• A&P TO DELIVERY AND LABOR

GOAL: TO RECLASSIFY EXPENSES RECORDED ON THE GL TO THE PROPER CMS CR LINE TO MATCH COSTS WITH REVENUE

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WORKSHEET A-8 ADJUSTMENTS

- **BASIS:**
  - A: Cost
  - B: Revenue Received (offset)
- **EXAMPLES:**
  - Patient Telephone and Television Expenses
  - Certain Advertising Expenses
  - CAH HIT Depreciation and Interest
  - Revenue Offsets:
    - *Investment Income*
    - *Cafeteria Revenue*
    - *Sale of billable supplies to non patients*

Goal: To offset cost not related to patient care following principles of reimbursement

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ADVERTISING

ALLOWABLE

- YELLOW BOOK ADS
- JOB POSTINGS
- INFORMATIONAL
- RELATED TO PATIENT CARE
- GOOD PUBLIC IMAGE

NON-ALLOWABLE

- FUND RAISING
- PROMOTIONAL – TV/RADIO
- PUBLICITY COSTS – BROCHURES
- COST INCURRED TO INVITE PHYSICIANS TO SEND PATIENTS
- HEALTH FAIRS
- COMMUNITY EDUCATION
- HEALTH INFO SERVICES

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QUESTION

- WHO WAS THE FIRST HOSPITAL IN NEBRASKA TO BE DESIGNATED A CAH?

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A-8-2 PHYSICIAN COMPENSATION

- **42 CFR 415.60**
  - **(b) General rule… each provider that incurs physician compensation costs must allocate those costs, in proportion to the percentage of total time …among—**
    - ***(1) Physician services to the provider…***
    - ***(2) Physician services to patients…and***
    - ***(3) Activities of the physician…that are not paid under either Part A or Part B of Medicare.***
  - **(f) Determination and payment of allowable physician compensation costs.**
    - ***(1) …the intermediary pays the provider for these costs only if—***
      - (i) The provider submits to the intermediary a written allocation agreement between the provider and the physician that specifies the…time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not payable under either Part A or Part B of Medicare; and
      - (ii) The compensation is reasonable in terms of the time devoted to these services.

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A-8-2 PHYSICIAN COMPENSATION

- **42 CFR 415.60**
  - **(f)(2) In the absence of a written allocation agreement, the intermediary assumes…that 100 percent of the physician compensation cost is allocated to services to beneficiaries …**
  - **(g) Recordkeeping requirements…physicians under this subpart must meet all of the following requirements:**
    - ***(1) Maintain the time records …to allocate physician compensation…to be validated by the intermediary...***
    - ***(2) Report the information on ..physician compensation allocation …to the intermediary …on an annual basis and promptly notify the intermediary ….of any revisions…***
    - ***(3) Retain each…allocation…for at least 4 years after the end of each cost reporting period…***

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A-8-2 PHYSICIAN COMPENSATION

- **ADMINISTRATIVE TIME (PART A)**
  - Any time designed to manage the treatment of patients
    - *Medical Directors*
      - Review contracts to ensure compensation is identified
    - *Utilization/Quality Review*
    - *Department Directorships*
  - Part A time must be documented

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A-8-2 PHYSICIAN COMPENSATION

- **SPLIT OF PROFESSIONAL AND PROVIDER COMPONENT**
- **TREATMENT TIME (PART B)**
  - Time provider is seeing patient
    - *Chart Review*
    - *Intervention*
    - *Progress Notes*
  - All time assumed to be part B unless otherwise documented

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PERIODIC TIME STUDIES

- **USED IN LIEU OF ONGOING TIME REPORTS (PRM 15-I §2313.2.E)**
  - ***Records to be maintained must be specified in a written plan to the MAC no later than 90 days prior to the end of the cost reporting period***
    - Request may be open ended if worded properly, such that it does not need to be made every year
  - ***One full week/month***
  - ***Each week must be a full work week***
  - ***Equal distribution of the weeks***
  - ***No two consecutive months may use the same week***
  - ***Time study must be contemporaneous with the costs to be allocated***
  - ***Provider specific (Not from another provider/facility)***
  - ***Physicians – signed***

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ER TIME STUDY

PATIENT NAME	ACCOUNT #	MEDICAL RECORD #	REGISTRATION DATE	REGISTRATION TIME	DEPART TIME	ER PROVIDER	Admit Time	Depart Time	Total Time	Total Time (minutes)
TEST 1	XXXXXXX	XXXXXX	10/7/2007	4:27	4:57	PROVIDER 1	4:27	4:30	0:03	3
TEST 2	XXXXXXX	XXXXXX	10/7/2007	2:20	4:15	PROVIDER 2	2:30	2:25	0:05	5
TEST 3	XXXXXXX	XXXXXX	10/7/2007	19:55	20:50	PROVIDER 3	20:00	20:05	0:05	5
TEST 4	XXXXXXX	XXXXXX	10/7/2007	22:00	23:30	PROVIDER 4	22:05	22:10	0:05	5
TEST 5	XXXXXXX	XXXXXX	10/7/2007	19:12	22:25	PROVIDER 5	19:12	19:20	0:08	8
TEST 6	XXXXXXX	XXXXXX	10/7/2007	11:30	14:20	PROVIDER 6	11:40	11:50	0:10	10
TEST 7	XXXXXXX	XXXXXX	10/7/2007	15:25	18:35	PROVIDER 7	15:25	15:35	0:10	10
TEST 8	XXXXXXX	XXXXXX	10/7/2007	14:45	15:15	PROVIDER 8	15:00	15:15	0:15	15
TEST 9	XXXXXXX	XXXXXX	10/7/2007	13:29	14:07	PROVIDER 9	13:45	14:07	0:22	22
TEST 10	XXXXXXX	XXXXXX	10/7/2007	14:00	14:35	PROVIDER 10	14:10	14:35	0:25	25
TEST 11	XXXXXXX	XXXXXX	10/7/2007	17:15	17:55	PROVIDER 11	17:15	17:40	0:25	25
TEST 12	XXXXXXX	XXXXXX	10/7/2007	21:00	22:35	PROVIDER 12	21:20	21:50	0:30	30
TEST 13	XXXXXXX	XXXXXX	10/7/2007	0:54	2:38	PROVIDER 13	0:54	1:35	0:41	41
TEST 14	XXXXXXX	XXXXXX	10/7/2007	21:10	22:20	PROVIDER 14	21:25	22:20	0:55	55
TEST 15	XXXXXXX	XXXXXX	10/7/2007	13:05	15:00	PROVIDER 15	13:05	14:45	1:40	100
TEST 16	XXXXXXX	XXXXXX	10/8/2007	1:50	2:45	PROVIDER 16	2:10	2:10	0:00	0
TEST 17	XXXXXXX	XXXXXX	10/8/2007	0:40	1:15	PROVIDER 17	1:10	1:15	0:05	5
TEST 18	XXXXXXX	XXXXXX	10/8/2007	5:20	7:00	PROVIDER 18	5:25	5:30	0:05	5

TOTAL MINUTES	26,525.00
TOTAL HOURS (divided by 60 minutes)	442.08
Anualized (divided by 12 weeks X 52 weeks)	1,915.69
Hour in Year (365 days X 24 hours)	8,760.00
Professional Component	21.87%

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WORKSHEET A-8-3

- A-8-3: DETERMINE ADJUSTMENT NEEDED TO REMOVE EXCESS COST OVER REASONABLE LIMITS/COSTS FOR OUTSIDE THERAPY PROVIDES
  - ST
  - OT
  - PT
  - RT

QUESTION

- WHAT DOES THE STRUCTURE OF MEDICARE PROVIDER NUMBERS REPRESENT? XX-XXXX

WORKSHEET B SERIES

- **STEP-DOWN METHOD OF ALLOCATING COSTS**
  - For every General Service Cost Center on Worksheet A, a corresponding column of Worksheet B exists
  - Each General Service Cost Center is assigned a statistical basis for allocation (Worksheet B-1)
    - *Examples – Capital Related Building – square footage, Laundry - pounds*

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B- 1 METHODS OF STEPDOWN

- BUILDING CAPITAL COST – SQUARE FEET OR DIRECTLY ASSIGNED
- EQUIPMENT – SQUARE FEET OR DOLLAR VALUE
- EMPLOYEE BENEFITS – SALARIES OR DIRECTLY ASSIGNED
- A & G – ACCUMULATED COST (CAN FRAGMENT)
- MAINTENANCE – SQUARE FEET OR WORK ORDERS
- PLANT – SQUARE FEET OR DIRECTLY ASSIGNED
- LAUNDRY – SOILED POUNDS OR PATIENT DAYS
- HOUSEKEEPING – HOUR SPENT OR SQUARE FEET
- DIETARY – MEALS SERVED OR PATIENT DAYS
- CAFETERIA – MEALS SERVED OR FTE'S
- NURSING ADMIN – HOURS SUPERVISED OR NURSING SALARIES
- CENTRAL SUPPLY – COSTED REQUISITIONS
- PHARMACY – COSTED REQUISITIONS
- MEDICAL RECORDS – TIME SPENT OR GROSS REVENUES

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ALLOCATION OF COSTS

- **STEP DOWN METHOD OF ALLOCATING COSTS (CONT.)**
  - General Service Costs are stepped down (allocated) to each department based on the percentage of the total statistical basis of each cost center (Worksheet B, Part I)
  - Example
    - *Laundry General Service Costs center uses pounds of laundry as a statistical basis*
    - *The Adults & Pediatric department's pounds of laundry is 60,000 lbs*
    - *The Hospital pounds of laundry (statistical Basis) is 100,000 lbs*
    - *Total costs to allocated is $200,000*

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ALLOCATION OF COSTS CONT.

- ***Example (cont.):***
  - Adults & Pediatrics laundry pounds 60,000
  - Total Hospital laundry pounds 100,000
    - » Percentage 60%
  - Total Laundry Department Costs $200,000
    - » Amount allocated to A & P Dept $120,000
  - **Unit cost Multiplier**
  - **Result is fully allocated costs**

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WORKSHEET C SERIES

- COMPUTES THE RATIO OF COSTS TO CHARGES (CCR) FOR EACH ANCILLARY COST CENTER
  - Routine cost per day calculated on WK D Series
- FULLY ALLOCATED COSTS FROM WORKSHEET B, PART I ARE DIVIDED BY TOTAL CHARGES ON WORKSHEET C TO ARRIVE AT CCR FOR EACH ANCILLARY COST CENTER
- CCRS ARE USED ON THE D SERIES TO DETERMINE MEDICARE COSTS
- EXAMPLE: LAB CCR .405952
  - For every $ the Lab earns it costs them 40.5952 cents

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WORKSHEET C SERIES CONT.

- ADJUSTMENT TO MATCH COSTS TO REVENUES:
  - CRNA Revenues
  - RHC Ancillary Services (billed as OP)
  - Physician Professional Charges
  - Self insurance
- ANALYZE CHARGE CENTER USE
  - For example, MRI separate or included in RAD
  - Chargemaster Reviews

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WORKSHEET D SERIES

- **MEDICARE CHARGES AND COSTS**
  - WK D, Part V Purpose: Determine Medicare OP Ancillary Costs
    - *Enter Charges from PS&R*
    - *CCR * PS&R Charges = Medicare OP Cost*
  - WK D-1 Purpose: Compute Medicare IP Cost
    - *=((IP Cost from WK B, Part 1 – SB Adjustment)/Days (IP, SB, Obs) = IP cost per day) * MCR IP and SB days = MCR Routine Cost*
  - WK D-3 Purpose: Determine MCR IP and SB Ancillary Costs
    - *CCR * PS&R Charges = MCR IP and SB Ancillary Costs*
  - Medicare Crosswalk: map GL Charges to PS&R Revenue Codes

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WORKSHEET E SERIES

- **INTERIM PAYMENTS AND SETTLEMENTS**
- **TAKES TOTAL ALLOWABLE COSTS LESS PAYMENTS**
  - Use Payment amounts from PS&R Reports
    - *Interim Settlements*
    - *Coinsurance*
    - *Deductibles*
  - Enter in Reimbursable Bad Debts
  - Result is settlement amount

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MEDICARE BAD DEBTS

- **42 CFR 413.89(D)**
  - **"Under Medicare, …Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs."**
- **REIMBURSABLE IF REQUIREMENTS ARE MET**
- **CAH HOSPITAL BD REIMBURSEMENT % REDUCTION:**
  - **88% after 10/1/12, 76% after 10/1/13, 65% after 10/1/14**

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MEDICARE BAD DEBTS

- **COLLECTION POLICY**
  - **Have one**
  - **Follow it**
- **CONSISTENCY**
  - **Medicare collection efforts must be similar to other payors**
  - **Collection agency**
- **TIMING**
  - **Allowable when truly uncollectible**
  - **Audit trail**
  - **Claim in the year written off**
  - **120 days from date of first bill**

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MEDICARE BAD DEBTS

- **CHARITY VS. INDIGENCY**
  - **Charity allowances are not allowable bad debts unless the provider has an indigency/charity policy and the policy meets all of the requirements in CMS Pub 15-I §312**

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MEDICARE BAD DEBT TEMPLATE

Medicare Bad Debts
Filing Instructions

	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10	Column 11	Column 12	Column 13
Required Information	Patient Name	HIC. NO.	DATES OF SERVICE FROM	DATES OF SERVICE TO	INDIGENCY & WEL. RECIP	MEDICAID NUMBER	DATE FIRST BILL SENT TO BENEFICIARY	DATE COLLECTION EFFORTS CEASED	MEDICARE REMITTANCE ADVICE DATES	DEDUCT AND CO-INS TOTAL	ACCT TYPE	DEDUCT	CO-INS
Additional Notes			Match Dates on specific claim		"Yes" in dual eligible			Account closed/returned by collection agency	Date Medicare paid initial claim				

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QUESTION

- **HOW MANY FACILITIES HERE COMPLETE THE WAGE INDEX (OR MAYBE EVEN KNOW WHAT IT IS)?**

M –SERIES RURAL HEALTH CLINICS

- **BILLABLE SERVICES 42 CFR 405.2463**
  - Visit qualifications
    - *"A medically-necessary, 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 or FQHC services are rendered"*
    - *"An Initial Preventive Physical Examination (IPPE)"*
    - *"An Annual Wellness Visit (AWV), or Transitional Care Management (TCM) services*
  - Example of services that do not qualify as a visit
    - *A visit solely for the administration of an injection (e.g. B-12, allergy)*
    - *Refilling prescriptions*
    - *Lab results or tests*
    - *Dressing changes*

M –SERIES RURAL HEALTH CLINICS

- **BILLABLE SERVICES**
  - **Productivity Standards**
    - ***Minimum number of visits on an FTE basis that CMS requires; Integrated into reimbursement***
    - ***4,200/FTE – M.D.***
    - ***2,100/FTE – NP, PA, CNM***

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M –SERIES RURAL HEALTH CLINICS

- **PROCEDURAL ISSUES**
  - **Hospital vs. RHC**
    - ***Lab***
      - Drawn and processed in the RHC – Billed on RHC bill; Rolled into visit or not paid
      - Drawn in the RHC & processed in the hospital – Billed as hospital OP; Cost reimbursed
      - Drawn and processed in the hospital – Billed as hospital OP; Cost reimbursed
    - ***EKG & Radiology***
      - Professional component – Bundled with the RHC encounter
      - Technical component – Billed as hospital OP service
    - ***High-cost Services (e.g. Chemo injections)***
    - ***Miscellaneous Injections (B-12, allergy)***

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M –SERIES RURAL HEALTH CLINICS

- **INFORMATION TRACKING**
  - **Time**
    - ***RHC/Rounds/On-call/ER seeing patients***
    - ***Time Study – One week/month, alternating weeks***
      - e.g. 1st week of January/2nd week of February/3rd week of March…..
      - Crucial for productivity standard purposes

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PROVIDER TIME STUDY

ABC Hospital
Provider Time Studies

Time Period	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	TOTAL	% Alloc.
John Doe, MD														
RHC (time available to see patients)														
Administrative (outside of RHC time)													-	#DIV/0!
Vacation, Holiday and Sick													-	#DIV/0!
Education/CPE/CME													-	#DIV/0!
ER On-call													-	#DIV/0!
Hospital Rounds													-	#DIV/0!
Other Part B/Professional Services													-	#DIV/0!
TOTAL	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!
Joe Smith, PA-C														
RHC (time available to see patients)														
Administrative (outside of RHC time)													-	#DIV/0!
Vacation, Holiday and Sick													-	#DIV/0!
Education/CPE/CME													-	#DIV/0!
ER On-call													-	#DIV/0!
Hospital Rounds													-	#DIV/0!
Other Part B/Professional Services													-	#DIV/0!
TOTAL	-	-	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!

Note: Valid Medicare Time Study

1. Time records must be specified in a written plan submitted to the MAC no later than 90 days prior to the end of the cost reporting period.
2. Must encompass at least one full week per month of the cost reporting period
3. Each week must be a full work week
4. The weeks must be equally distributed among the months in the cost reporting period
5. No two consecutive months may use the same week for the study (e.g. cannot use first week of March and first week of April)
6. Must be contemporaneous with the costs to be allocated (current year)

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M –SERIES RURAL HEALTH CLINICS

- **42 CFR 405.2410 – COINSURANCE PENALTY**
  - **b) Application of coinsurance. Except for preventive services for which Medicare pays 100 percent under §410.152(l) of this chapter, a beneficiary's responsibility is either of the following:**
    - ***(1) For RHCs that are authorized to bill on the basis of the reasonable cost system—***
      - (i) A coinsurance amount that does not exceed 20 percent of the RHC's reasonable customary charge for the covered service; and
      - (ii)(A) The beneficiary's deductible and coinsurance amount for any one item or service furnished by the RHC may not exceed a reasonable amount customarily charged by the RHC for that particular item or service

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M –SERIES RURAL HEALTH CLINICS

- **42 CFR §410.57 PNEUMOCOCCAL VACCINE AND FLU VACCINE.**
  - **(a) Medicare Part B pays for pneumococcal vaccine and its administration when reasonable and necessary for the prevention of disease, if the vaccine is ordered by a doctor of medicine or osteopathy.**
  - **(b) Medicare Part B pays for the influenza virus vaccine and its administration.**
- **WHY DOES IT MATTER?**
  - **Directly impacts reimbursement on the cost report**
- **TWO FACTORS**
  - **Medical supply costs of vaccine purchased**
  - **Cost of medical staff to administer vaccines**

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COST REPORT ANALYSIS

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STRATEGIES

- ASSIGN COSTS TO APPROPRIATE COST CENTERS
  - Direct & indirect costs
- REVIEW COST ALLOCATION STATS (SQUARE FOOTAGE)
- REVIEW COST ALLOCATIONS TO NON-REIMBURSABLE COST CENTERS
- EVALUATE IMPACT OF FRAGMENTING ADMIN & GENERAL COSTS

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STRATEGIES CONT.

- EVALUATE IMPACT OF ELECTING THE SIMPLIFIED METHOD FOR ALLOCATING OVERHEAD COSTS
- REVIEW PHYSICIAN CONTRACTS & EVALUATE TIME STUDIES
- CLAIM ER AVAILABILITY & ON-CALL COSTS
- PROTECT FUNDED DEPRECIATION
- CLAIM PROPER DEPRECIATION
  - Capitalization policy, election of useful life, separate building components, idle sq ft

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STRATEGIES CONT.

- CAPTURE ALL QUALIFYING MEDICARE BAD DEBTS
- PROPERLY MATCH TOTAL COSTS TO TOTAL CHARGES & MEDICARE CHARGES TO TOTAL CHARGES
- EVALUATE DIRECT ASSIGNMENT OF COSTS FOR OFFSITE LOCATIONS
- ANALYZE MARKETING/PUBLIC RELATIONS COSTS FOR NON-REIMBURSABLE VS. REIMBURSABLE COSTS

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QUESTION

- ON WHAT DATE DID WPS ASSUME THE PART A CONTRACT FOR NEBRASKA HOSPITALS?

CONSTRUCTION/REMODEL

- COMPLETE PROJECTION OF MEDICARE REIMBURSEMENT IMPACT
  - Before you begin project
  - Can have material impact to Medicare reimbursement through the B-1 square footage allocation stat
  - Analyze architect floorplan in design stage to ensure any unneeded negative Medicare reimbursement impacts are avoided

IMPACT OF LARGE PURCHASES

- **PURCHASE OF CT MACHINE**
  - How will this purchase impact Medicare reimbursement?
  - How will expenses be recorded on the general ledger and flow through to the cost report?

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FINANCIAL REVIEW

- **USE MEDICARE COST REPORT AS A FINANCIAL TOOL TO IDENTIFY:**
  - Low volume Medicare departments with a high cost to charge ratio
    - *Impact of expense reductions will not impact Medicare reimbursement as much as those departments with high Medicare utilization*
  - High volume commercial departments with a low cost to charge ratio
    - *Expand focus on expanding commercial services in those departments*
    - *Higher reimbursement potential with lower costs incurred*

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REIMBURSEMENT ISSUES

CRNA EXEMPTION/COST REIMBURSEMENT

- 42 CFR 412.113(C)
  - "For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, payment is determined on a reasonable cost basis for anesthesia services provided in the hospital or CAH by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologist's assistants) employed by the hospital or CAH or obtained under arrangements."
- EXEMPTION TO THE FEE SCHEDULE – COST REIMBURSEMENT
- METHOD II

CRNA EXEMPTION/COST REIMBURSEMENT

- **QUALIFICATIONS**
  - Geographically located in rural area
  - Employ or contract with CRNA; Total service hours furnished not to exceed 2,080/year
  - Annual volume of IP & OP procedures requiring anesthesia less than 800
  - CRNA agrees in writing not to bill

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CRNA EXEMPTION/COST REIMBURSEMENT

- **ON-CALL**
  - MAC audit program specifically notes to carve these costs out – disallow
  - Review contracts
  - PRRB Case 2014-D29
    - *Board sided for the provider – on-call is allowable (9/24/2014)*
    - *Reversed by the CMS Administrator 11/18/2014*
- **MINIMUM GUARANTEE**
  - MAC audit program specifically notes to carve these costs out

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CRNA EXEMPTION/COST REIMBURSEMENT

- **DOCUMENTATION**
  - Bid process and documentation
    - *Commensurate with the applicable year*
  - Contracts
  - Hours at the facility
  - Signed statement by CRNA
  - Surgical log
    - *Surgery date*
    - *Patient name*
    - *Surgeon name*
    - *CRNA name*
    - *Type of anesthesia*
    - *Type of surgical procedure*
  - ***MAC APPROVAL LETTER***

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FITNESS CENTER

- **ANALYZE IMPACT OF MEDICARE REIMBURSEMENT COMPARED TO COMMUNITY BENEFIT**
  - Non-reimbursable cost center
  - Through B-1 allocations, large amount of square footage brings capital related costs down to fitness center
  - Medicare will not reimburse for those costs
  - Possible strategies?

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QUESTIONS?
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