

Medicare Cost Report Settlement



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Agenda

This webinar aims to shed some light on the Medicare cost report settlement

- ▲ **1** Discuss the Medicare Settlement Process
- ▲ **2** Provide and overview of what's included in PPS Settlement
- ▲ **3** Explain Calculation of (PPS) Settlement
- ▲ **4** Describe Cost Based Reimbursement Settlement
- ▲ **5** Introduce some of the key areas driving (CAH) Settlements

Medicare Settlement

FEATURES OF THE MEDICARE PROGRAM PERTINENT TO THE SETTLEMENT PROCESS



Prospective Payment System (PPS)

Why is the Medicare Cost Report important to PPS Hospitals.

Medicare has implemented PPS for most hospitals including acute care, psychiatric and rehabilitation care, skilled nursing and home health services. Nearly all payments are based on predetermined rates.

This makes settlements unnecessary, so reliance on the Medicare Cost Report as a settlement tool has diminished?

This can be an expensive mistake because it still can play an important role in the final settlement

Prospective Payment System (PPS)

Types of information collected to determine PPS settlement

**Diagnostic
Related Groups
(DRG)**

**Hospital
Outpatient
Payment System
(HOPPS)**

Medical Education

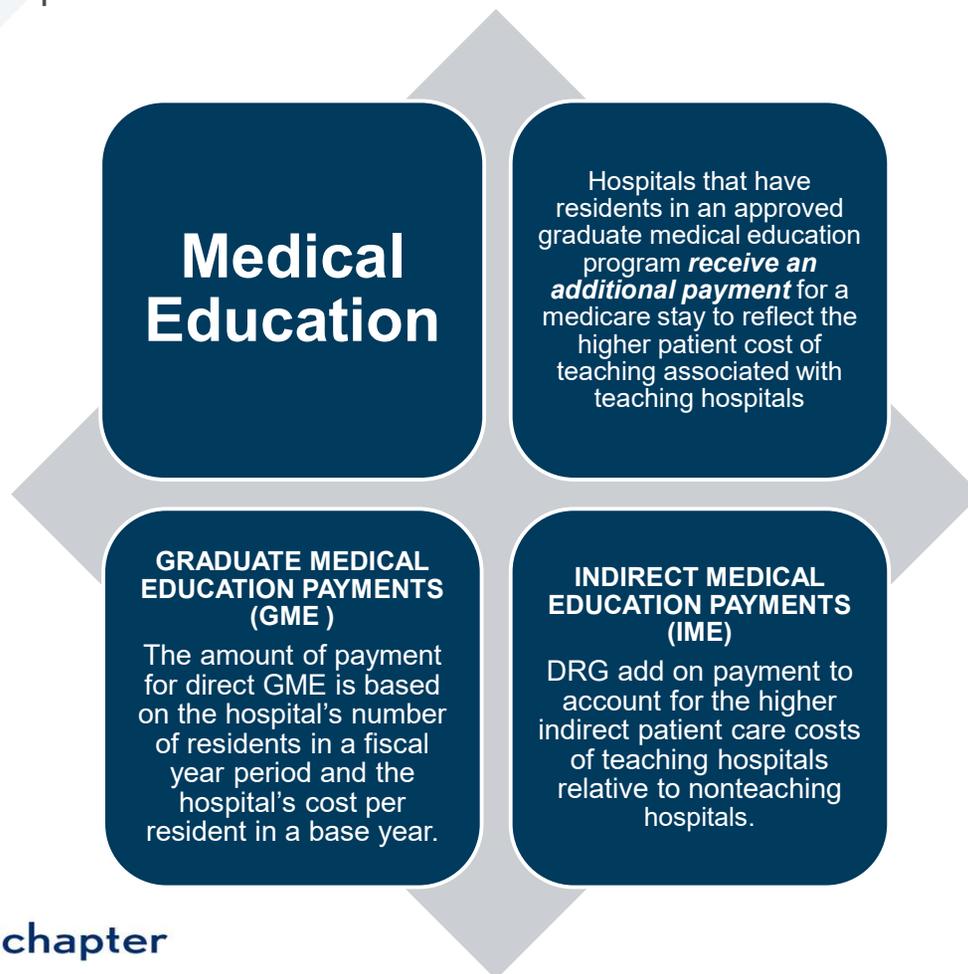
Outlier Payments

**Disproportionate
Share
(DSH)**

**Medicare Bad
Debts**

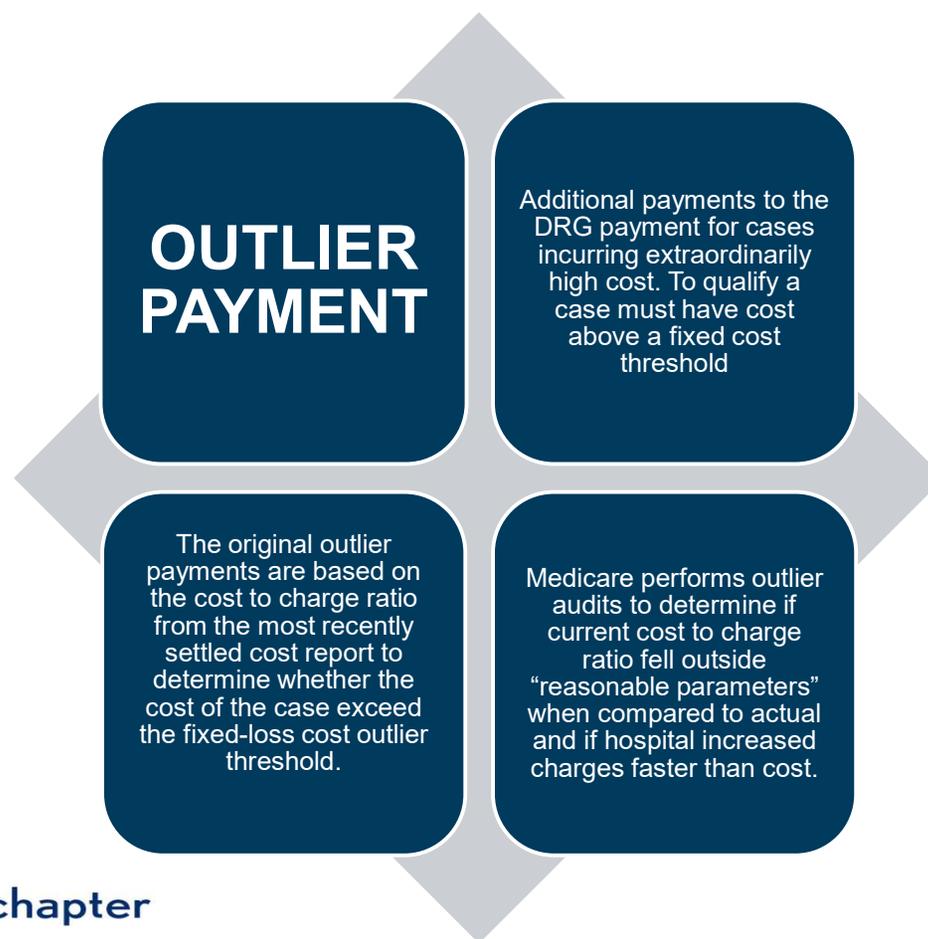
Calculation of PPS Reimbursement Settlement

Interim reimbursement that impacts final settlement



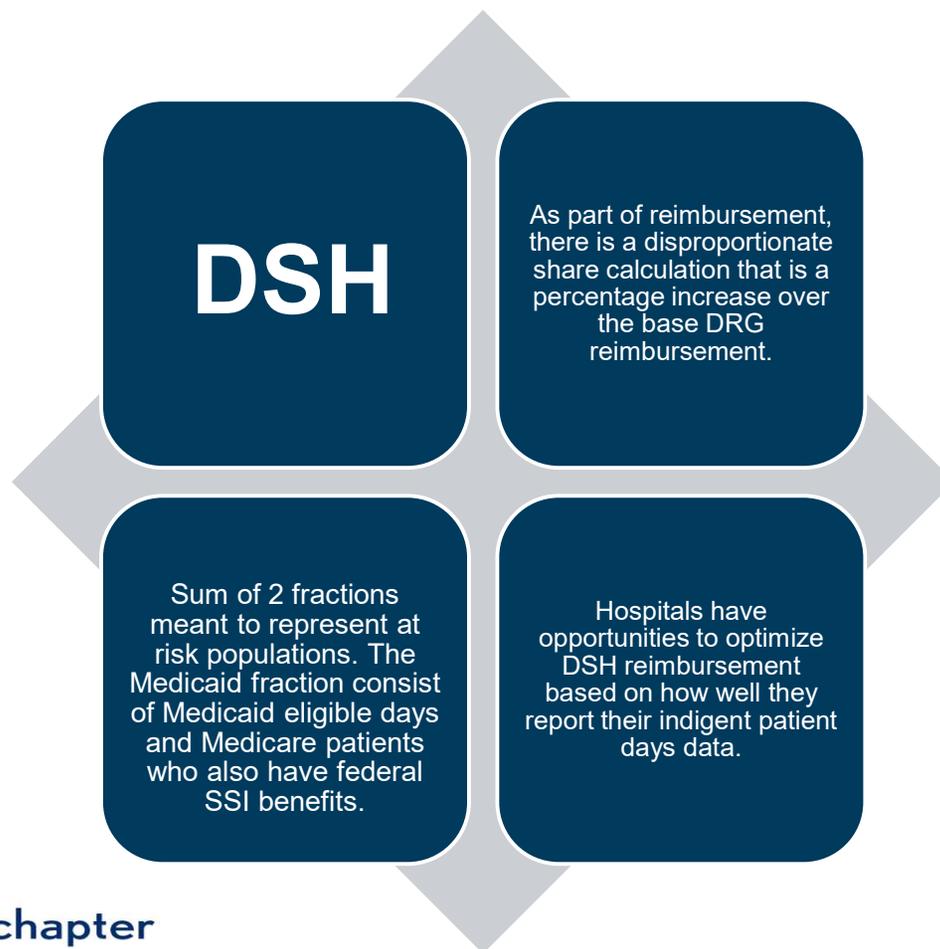
Calculation of PPS Reimbursement Settlement

Interim reimbursement that impacts final settlement (cont.)



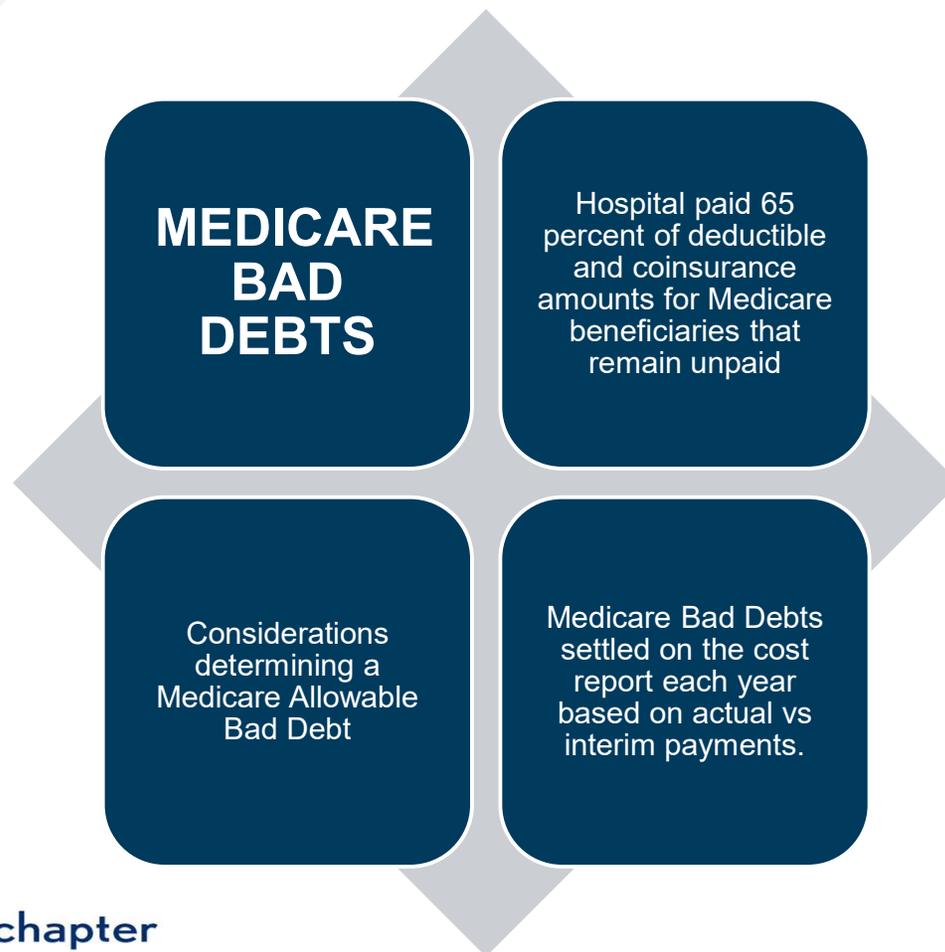
Calculation of PPS Reimbursement Settlement

Interim reimbursement that impacts final settlement (cont.)



Calculation of PPS Reimbursement Settlement – applies to Critical Access Hospitals also

Interim reimbursement that impacts final settlement (**cont.**)



INTERIM RATE REVIEW CALCULATION FORM EXAMPLE

Interim Rate Reviews are performed based on the providers fiscal year

Medicare interim rate request form -- hospital

Provider name:

Provider number:

FYE from: to:

Rate review period if different from FYE:

Medicare bad debts - For the period to:

Report total amount written off in this period, net of recoveries, not reduced for BBA. Attach the bad debt list or support for your estimate.

1. Medicare Part A allowable bad debts

2. Medicare Part B allowable bad debts

Medicare disproportionate share adjustment - Attach supporting summary schedules from your records.

1. In-state Medicaid days (include healthy newborn)

2. + Out-of-state Medicaid days

3. + Medicaid eligible days

4. + Medicaid HMO days

5. + Non-concurrent nursery Medicaid days

6. +/- Medicaid observation days (refer to cost report instructions for WIS S-3 line 26)

7. - Medicaid labor & delivery days (if included in any lines above)

8. - Dually eligible days (if included in any lines above)

9. - Distinct part unit (excluded unit) days (if included in any lines above)

10. = Total hospital Medicaid days

Critical Access Hospitals – Cost settlement for Facility charges

Interim Payments throughout the year, settled with the Cost Report

Unlike PPS Hospitals, CAH's are cost reimbursed by Medicare for the facility portion of their services. Medicare Advantage Plans may also use the calculated Cost Report rates to structure their payments. Review your contracts!

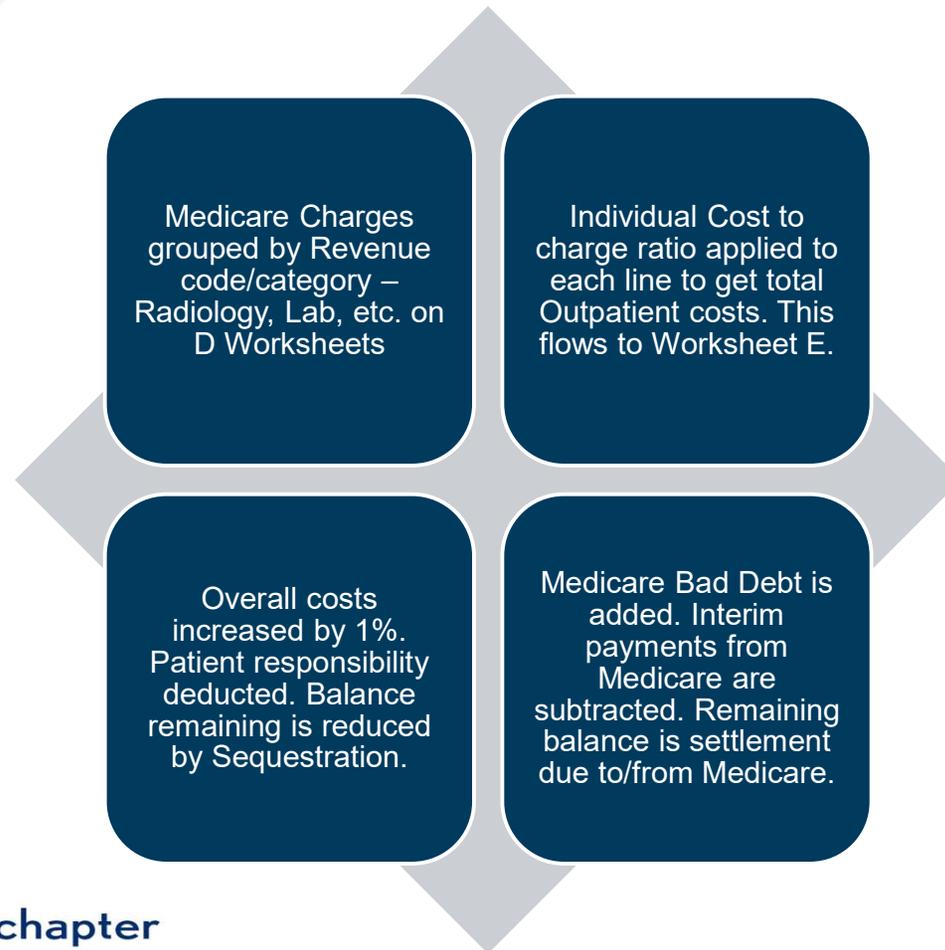
For Medicaid, NH uses the Cost Report to settle non-HMO activity for most Outpatient Ancillary services. The HMO's may also use the Cost Report rates for their payments. Maine has its own Cost Report but uses the cost to charge calculation from the Medicare Cost report. Vermont uses the Cost Report to determine future PPS rates.

Modeling out the expected settlement for a CAH is important to properly gauge financial performance throughout the year.

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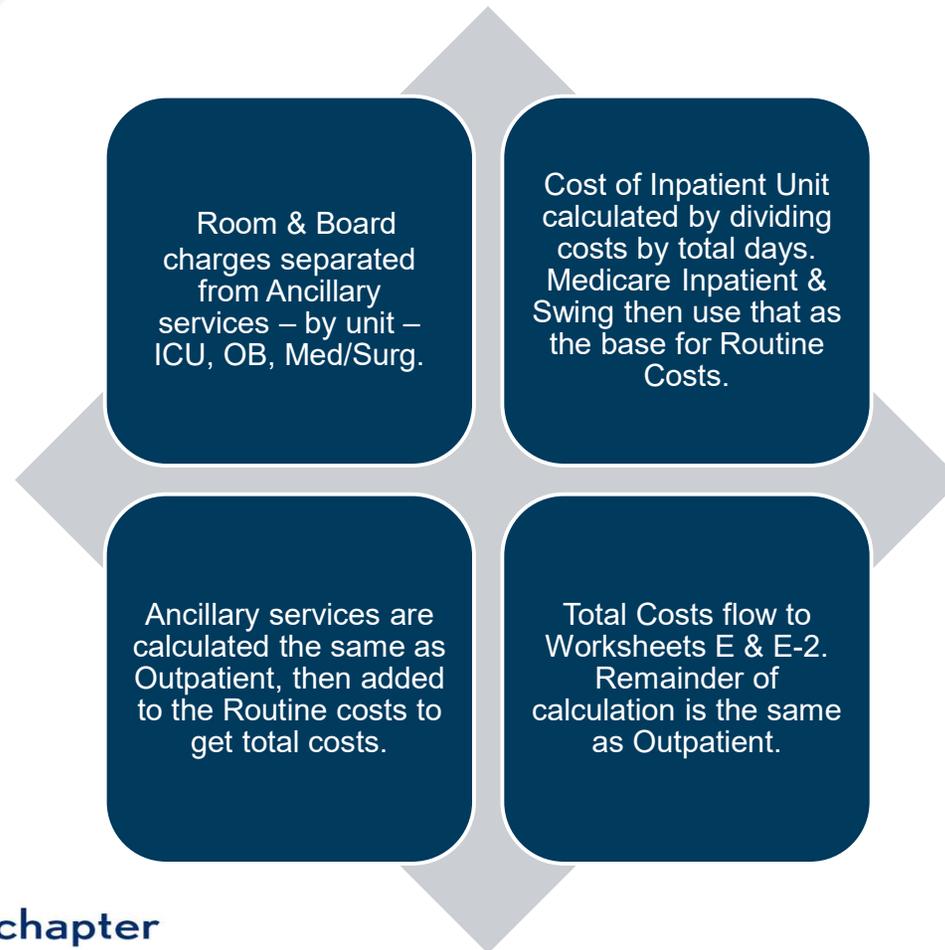
Calculation of Outpatient Reimbursement Settlement



Ancillary Services cost calculation – important to continue lining up costs to perform a service with the charges for that service, all the way through to Medicare & Medicaid charges

- **Worksheets A through C will calculate a cost to charge ratio by Cost report Line/department.**
- **Medicare PS&R (Provider statistical & reimbursement report) will give you the totals billed to Medicare by revenue code. For cost report purposes the revenue code is Medicare's lowest common denominator.**
 - **Those revenue codes must be mapped to the appropriate cost report line for that service in your organization. Be aware of what revenue codes are included in your charges for each department.**
 - **This may require some custom mapping or even splitting of charges on the PS&R if you have a revenue code used in more than one department. For example, Revenue code 260 for IV Therapy, 730 for EKG's or 510 for Provider based clinics.**
- **The Medicare charges by line are input on Worksheet D. The cost to charge ratio from Worksheet C then calculates the cost for that line which then rolls up to a total Medicare cost for ancillary services.**

Calculation of Inpatient & Swing Reimbursement Settlement



Room & Board cost based on daily rate, not cost to charge ratio – calculated on D-1

- Worksheets A through B will calculate a total cost for your Inpatient departments – Medical Surgical, Obstetrics/Maternity, ICU.
- The total days in each unit are input on S-3, lines 1-14. Observation “days” are also included in the calculations – take the total hours, divided by 24 and input on line 28.
 - The PS&R from Medicare will have the days billed – use this for your calculations. You will need to also enter these days on D-1, separated by days before and after 12/31.
 - Swing Bed days are reported on Line 5 for Medicare & Medicare Advantage patients. All others are reported on Line 6.
- Total cost for Worksheet A, lines 30 through 46 (Inpatient Routine Service Cost Centers) then rolls over to Worksheet D-1, parts I & II for per diem cost calculation. This total cost first shows up on line 21.
- Swing Beds costs are calculated first. Non-Medicare days reported on line 6 are multiplied by the cost input on lines 24 & 25 – use the Medicaid payment rate here. This cost is then removed from the remaining cost per day calculations.
- Other specific unit costs, such as ICU, are calculated on lines 42 through 47. Observation costs are calculated by taking the daily routine cost and multiplying it by the days from S-3, line 28 . This cost is then transferred to the Outpatient Ancillary calculation for Observation, line 92.
- What is left is then divided by total routine days and multiplied by Medicare days from the PS&R to get Medicare’s routine service cost.

You've maintained your model and have an estimate – then you complete the Cost report and it's different – and your boss wants to know why!

Review Payer Mix by department – did you have a significant change to one with a high cost to charge ratio? Or did the cost to charge ratio for a large Medicare driven department change?

Pay attention to added non-reimbursable costs such as Marketing or Providers and exclude significant changes from your overall allowable cost. Most models assume “business as usual” for many of these costs.

Be aware of departmental changes within your organization and how they might impact your organization. Did you add a new ancillary service or discontinue one? What costs are normally removed from Worksheet A and have there been large changes to those?

The ability to answer questions about the impact of operational changes to cost reimbursement can be a valuable skill for a CAH Financial Analyst!

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Medicare Cost Report Settlement Worksheets – Appendix

- **Worksheet E Parts A and B calculate settlement for PPS Hospitals Line Descriptions**
 - **Line 2.04 – Outlier Payments**
- **Worksheet D-1 calculates routine cost per day for Inpatient, ICU, Swing, etc.**
- **Worksheets D, Part V and D-3 calculate Medicare Ancillary Costs**
- **Worksheet E, Part I for A and B calculates Hospital Settlement for CAH's – two separate worksheets**
- **Worksheet E-2 calculates Part A Swing Bed SNF Settlement for CAH's**

Questions?

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