Medicare Cost Report
Hot Topics!

HFMA Region 11  January 2017

Presented by:
Shar Sheaffer, Owner
Outline

• Overview of cost report
• Wage index
• Occupational mix
• Patient days
• Uncompensated care costs
• Common cost report issues
• Provider based clinic revenue tracking
• Bad debt
What is a Cost Report?

• A costing system – pretty insightful, huh?
• Product costing and profitability
  ▪ Products are services
  ▪ Methodology is defined by CMS
• Profitability excludes discounts
Costing System

- Routine costs per day
  - Acute care
  - ICU
  - CCU
  - Nursery
  - NICU
  - Nursing home
  - Rehabilitation
  - Psychiatric

- Cost per encounter or visit
  - RHC
  - Home health

- All others are cost per charge
## Routine Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct ICU costs</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Allocated support costs</td>
<td>650,000</td>
</tr>
<tr>
<td><strong>Total ICU costs</strong></td>
<td><strong>$1,650,000</strong></td>
</tr>
<tr>
<td>ICU days</td>
<td>500</td>
</tr>
<tr>
<td><strong>Cost per day formula</strong></td>
<td><strong>$1,650,000/500</strong></td>
</tr>
<tr>
<td><strong>Cost per day</strong></td>
<td><strong>$3,300</strong></td>
</tr>
</tbody>
</table>
## Ancillary Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct laboratory costs</td>
<td>$ 1,000,000</td>
</tr>
<tr>
<td>Allocated support costs</td>
<td>$ 650,000</td>
</tr>
<tr>
<td><strong>Total laboratory costs</strong></td>
<td><strong>$ 1,650,000</strong></td>
</tr>
<tr>
<td>Total laboratory charges</td>
<td><strong>$ 2,500,000</strong></td>
</tr>
</tbody>
</table>

Cost to charge formula: $1,650/2,500

Cost-to-charge ratio: 0.660000
## RHC Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct RHC costs</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Allocated support costs</td>
<td>650,000</td>
</tr>
<tr>
<td><strong>Total RHC costs</strong></td>
<td><strong>$1,650,000</strong></td>
</tr>
<tr>
<td>Total RHC encounters</td>
<td>10,000</td>
</tr>
<tr>
<td>Cost per encounter formula</td>
<td>$2,500,000/10,000</td>
</tr>
<tr>
<td>Cost per encounter</td>
<td>$165.00</td>
</tr>
</tbody>
</table>
Allocated Support Costs

• Examples: dietary, housekeeping, utilities, CFOs, meeeeeeee!

• How these costs get to the revenue producing departments is one stage of the cost report strategy.
A Cost Report Is

- Departmental summary of
  - Costs
  - Charges
  - Days/encounters/visits

- The relationship between
  - Costs
  - Charges
  - Days
The Matching Game

• Departmental matching
  ▪ Department revenue (general ledger number)
  ▪ Department expense

• Cost report matching
  ▪ Revenues (revenue code)
  ▪ Cost (including support costs)
  ▪ How Medicare was billed – HAHA I mess things up!
Cost Report Focus

- Costs
- Cost allocations
- Charges
- Days
- Encounters
- Matching
It is a Hospital Cost Report

• Hospital services
  ▪ Inpatient services
  ▪ Outpatient services
  ▪ Provider-based departments

• Not part of the cost report
  ▪ Physician services
  ▪ Non provider-based locations

• Partially part of the cost report
  ▪ Provider-based clinics
...PROCEED.
# Cost Report Set Up

<table>
<thead>
<tr>
<th>Worksheet</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-3</td>
<td>Days, wage index</td>
</tr>
<tr>
<td>A</td>
<td>Expenses by departments</td>
</tr>
<tr>
<td>B-1</td>
<td>Allocation of support costs</td>
</tr>
<tr>
<td>C</td>
<td>Charges</td>
</tr>
<tr>
<td>D &amp; E</td>
<td>Settlement</td>
</tr>
<tr>
<td>M</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>H, I, &amp; K</td>
<td>Home health, dialysis, and hospice, respectively</td>
</tr>
</tbody>
</table>
Wage Index

- Cost of hiring in geographic area
- Based on Core Based Statistical Areas (CBSA)
- Average hourly wage compared to nation average
- Plus or minus 1 — 1 is the average
- Effects approximately 60% of Medicare payments
Wage Index

• Salaries (some areas excluded)
• Contracted wages (costs on GL, hours omitted)
  ▪ Patient services
  ▪ Top level management
  ▪ Other administrative costs
  ▪ Housekeeping
  ▪ Dietary
• Benefits
• Divided by hours
  ▪ Hours are 50% of the calculation
Wage Index Issues

• Financial statement audits are allowable
  ▪ Even those from home office
• Legal costs are allowable (must be related to patient care)
• PTO hours reported in year paid
Wage Index Benefits

• Physician benefits
  ▪ Use actual
  ▪ If actual is not feasible, use benefits per FTE

• Actuary or other pension related costs are part of pension costs (no hours needed)

• Employee discounts are allowable (use CCR)
Common Issues with Hours

- Highly paid contractor hours not reported
  - Tip: insist on hours being reported on the invoice
- Capitalized salaries, hours not removed
- On-call hours
- 3/12 shift hours reported as 40 (Baylor hours)
  - CR instruction require exclusion of bonus hours
  - Issue under appeal (and adverse appeal, so beware)
- PTO paid in lieu or at termination
- Think worked hours
Common Issues with WI Costs

- Contract labor omitted or reported on GL incorrectly
- Capitalized salaries
- Bonuses are reported as salary
  - Bonuses hours are not reported
- Physician Part A time
  - Time study (not required) or in contact, please
- Benefits hidden in departments
**Occupational Mix**

- Meant to adjust for nurse staffing mix
  - Incentivizes for using lower paid nurses
- Every three years – should be 2016
- Calendar reporting
- Likely due July 1, 2017
- Effects 2019, 2020, and 2021 wage index
Occupational Mix Strategy

- Minimize RN category
- Search for positions that can be considered aides
- Maximize aides and medical assistants
- Exclude (not “all other”) positions that are billed separately
Occupational Mix Issues

• Enlist the nurse manager to help brainstorm categories

• RNs doing solely administrative, education, or management functions – all other category

• Aides – provide basic patient care under direction of nursing staff
  ▪ Who changes linens
  ▪ Sitters
  ▪ Who moves patients
  ▪ Telemetry techs
I can picture in my mind a world without war, a world without hate. And I can picture us attacking that world, because they'd never expect it.
Patient Days

• Days effect:
  ▪ DSH payment
  ▪ GME payment
  ▪ Allied health payments
  ▪ Cost calculations
Common Days Issues

- Labor & delivery days not tracked separately
- Test patients: new system or new nurse
- Observation patient included in count
- Hospice days
- Do not reconcile between reports
- Excel errors
- Observation units include items billed as labor and delivery (720 vs 762 revenue code)
CAH Swing Beds

• Skilled swing bed days (SNF) –
  ▪ A Medicare beneficiary in a swing bed and Medicare is picking up the bill
  ▪ A Medicare Advantage beneficiary in a swing bed and the Medicare Advantage company is picking up the bill

• Non-skilled swing bed days (NF)
  ▪ EVERYTHING ELSE
CAH Swing Beds (Continued)

- Issue: skilled vs. non-skilled level of care
- Medicare pays cost
- Medicaid pays prospectively
- Non Medicare days “carved out”
## CAH Swing Beds: the Calculation

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care cost</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Swing bed rate</td>
<td>250</td>
</tr>
<tr>
<td>Acute care days</td>
<td>1,200</td>
</tr>
<tr>
<td>Medicare days</td>
<td>900</td>
</tr>
<tr>
<td>Swing bed days</td>
<td>400</td>
</tr>
<tr>
<td>Medicare swing</td>
<td>300</td>
</tr>
<tr>
<td>Medicare advantage swing</td>
<td>25</td>
</tr>
<tr>
<td>Other swing</td>
<td>75</td>
</tr>
<tr>
<td>Days for use?</td>
<td></td>
</tr>
<tr>
<td>Acute plus swing</td>
<td>1,600</td>
</tr>
<tr>
<td>Acute plus Medicare swing</td>
<td>1,525</td>
</tr>
</tbody>
</table>
## CAH Swing Beds

(Continued)

<table>
<thead>
<tr>
<th></th>
<th>No NF days</th>
<th>Some NF Days</th>
<th>All NF Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swing NF days</td>
<td>-</td>
<td>50</td>
<td>75</td>
</tr>
<tr>
<td>Swing NF rate</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Swing NF costs</td>
<td>$</td>
<td>$12,500</td>
<td>$18,750</td>
</tr>
<tr>
<td>Total costs</td>
<td>$2,000,000</td>
<td>$2,000,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Less swing NF (carve out)</td>
<td>-</td>
<td>(12,500)</td>
<td>(18,750)</td>
</tr>
<tr>
<td>Total cost for calculation</td>
<td>$2,000,000</td>
<td>$1,987,500</td>
<td>$1,981,250</td>
</tr>
<tr>
<td>Total days</td>
<td>1,600</td>
<td>1,600</td>
<td>1,600</td>
</tr>
<tr>
<td>Less NF days</td>
<td>-</td>
<td>(50)</td>
<td>(75)</td>
</tr>
<tr>
<td>Days for calculation</td>
<td>1,600</td>
<td>1,550</td>
<td>1,525</td>
</tr>
<tr>
<td>Per diem</td>
<td>$1,250</td>
<td>$1,282</td>
<td>$1,299</td>
</tr>
<tr>
<td>Medicare days</td>
<td>1,200</td>
<td>1,200</td>
<td>1,200</td>
</tr>
<tr>
<td>Medicare cost</td>
<td>$1,500,000</td>
<td>$1,538,400</td>
<td>$1,558,800</td>
</tr>
<tr>
<td>Increase over no NF days</td>
<td>-</td>
<td>$38,400</td>
<td>$58,800</td>
</tr>
</tbody>
</table>
CAH Swing Beds (Continued)

• Verify all swing bed days by payor (not by primary payor field)
• Patients change payor status after admission
• To correct at desk review requires additional support
Common Swing-Bed Issues

• More swing bed days reported on PS&R than internal statistics
• Days counted as Medicare after skilled portion of stay
• Patients reflected as Medicare after benefits exhausted
• Swing-bed charges billed under hospital provider number
• Started as skilled but did not meet qualifications
• Non-Medicare swing beds called Medicare to cost report preparer – usually with much conviction (Medicare beneficiary in non skilled stay)
• Medicare pays skilled nursing facility care based on RUGs

• Swing bed care and rules are the same as skilled nursing facility, but provided in acute care setting
  ▪ No MDS for swing bed patients
Uncompensated Care Payments

- Medicare DSH split between traditional DSH payments and uncompensated care
  - 25% traditional DSH payment
  - 75% uncompensated care calculation
Uncompensated Care Calculation

- Current Calculation
- Hospital’s “insured low-income days”
- Total “insured low-income days”
Uncompensated Care Calculation (Continued)

• 2017 calculation – 3 year average
  ▪ Hospital’s FY 2011 Medicaid days and 2012 SSI days
  ▪ Total FY 2011 Medicaid days and 2012 SSI days
  +
  ▪ Hospital’s FY 2012 Medicaid days and 2013 SSI days
  ▪ Total FY 2012 Medicaid days and 2013 SSI days
  +
  ▪ Hospital’s FY 2013 Medicaid days and 2014 SSI days
  ▪ Total FY 2013 Medicaid days and 2014 SSI days
Uncompensated Care Calculation (Continued)

• 2017 – 2020 calculation is a 3-year average

• For those not loving the math:
  ▪ Calculate three years using the old method
    • Add those together
    • Divide by three
    • Boom – UCC factor for your hospital
Uncompensated Care Costs

• Proposal to use 2017 worksheet S-10
  ▪ Effects 2021 UCC payment
• 2017 will likely be part of your calculation for 3 years (as will 2018, 2019, etc.)
• S-10 now officially matters
Uncompensated Care Costs (Continued)

• Uncompensated care cost:
  ▪ Cost of charity care
  +
  ▪ Cost of non-Medicare bad debt
  +
  ▪ Medicaid shortfall

• Or some combination of the above
• Further definitions for S-10 to come from revised cost report workpapers and future rule making
• However, first year is 2017 data, so get at least the charity care portion correct
Other S-10 Proposed Clarifications

- Charity care – claim based on date of write-off (not dates of service)
- “Trims” – to keep hospitals from gaming the CCR
  - Includes statewide averages and knocking out those with higher CCRs (3 over standard deviation)
  - This means ALL HOSPITALS need good S-10 data
  - Analysis was completed comparing IRS data to hospital S-10 data, critical access hospitals, just saying
Charity Care Cost

Insured Patients
• Full deductible and coinsurance amounts (not just the amount written off)
• Partial payments

Uninsured Patients
• Total charge (not the amount written off)
• Partial payments

• Why do total charges matter, you may ask?
Charity Care Cost (Continued)

Uninsured Patients
- Total charge
- Times CCR
- Equals initial cost
- Initial cost
- Less partial payment
- Equals cost of charity care

Insured Patients
- Total deductible or coinsurance
- Times CCR
- Equals initial cost
- Initial cost
- Less partial payment
- Equals cost of charity care
Charity Care Cost – Now With Numbers!

<table>
<thead>
<tr>
<th>Overall RCC</th>
<th>48%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net of Payment</strong></td>
<td><strong>Exclusive of Payment</strong></td>
</tr>
<tr>
<td>Total charge</td>
<td>$500,000</td>
</tr>
<tr>
<td>Partial payment</td>
<td>100,000</td>
</tr>
<tr>
<td>Net</td>
<td>400,000</td>
</tr>
<tr>
<td>Charges for calculation</td>
<td>400,000</td>
</tr>
<tr>
<td>Calculated cost</td>
<td>192,000</td>
</tr>
<tr>
<td>Less partial payments</td>
<td>(100,000)</td>
</tr>
<tr>
<td>Uncompensated care cost</td>
<td>$92,000</td>
</tr>
</tbody>
</table>
Charity Care Reconciles to the GL

• Total charges reported (insured plus uninsured)
  ▪ Less: partial payments
  ▪ Less: unpaid amounts (sliding scale charity likely sitting in bad debt)

• Equals: charity care per general ledger
Common Charity Care Issues

- Total insured charges includes:
  - Total charge (patients portion and insurance’s responsibility)
  - Payment by insurance company
- Total charge report is net of patient payments
- Total charges includes physician charges
Bad Debt Cost

- Bad debts per the general ledger
- Less: Medicare bad debts (these are reported on E,B, E,A or E,III)
- Net bad debt

- Net bad debt
- Times CCR
- Cost of bad debt
S-10 Reminder

• Match charges to worksheet C
• What’s that mean?
• Physician charges are excluded
I throw my hands up in the air sometimes

Singing ayyyyyyyyyoo

I'm a LEGO
Common Issue: Supply Expenses

• Coding supply expenses:
  ▪ Medical supplies not separately charged
  ▪ Medical supplies charged to a patient using 27X
  ▪ Implantables (typically charged using 275, 276, 278, and 624)

  ▪ DZA recommends:
    Record in central supply:
    • One chargeable medical supply expense account
    • One chargeable implantable supply expense account

    Record in individual departments:
    • Non-chargeable medical supplies
    • Office supplies
Common Issue: Other Outpatient Services

- Where are these services provided
  - Acute care
  - Outpatient department
  - ER
  - Mixture
  - If billing separately, must be able to trace time by department
  - TIME STUDIES
Common Issue: Other Outpatient Services (Continued)

- Observation performed in ER and ICU
- IV therapy
- Chemo
- Blood administration
- Treatment room
- Other injections
Common Issues: Miscellaneous Revenue

• General rule: remove expense equal to other revenue amount
• Non-offsettable items included in other income account
  ▪ HPSA payments
  ▪ BC/BS incentive payment
  ▪ Donations
  ▪ Small grants
• Grant expenses netted against grant income
• Other revenue offset and statistic reported on a nonallowable cost center
Common Issues: Miscellaneous Revenue (Continued)

- Collection agency expenses netted with contractual adjustments
- Interest expense on capital leases
- Expenses incurred by related party on behalf of the hospital not reported
  - Snow removal by county
- Uncollected interest charged on patient accounts written off to bad debt
Interest on Patient Accounts – The Example

- Interest charged = $100,000
- Collected = $20,000
- Administration cost-based percentage = 40%

<table>
<thead>
<tr>
<th></th>
<th>Charges Reversed</th>
<th>Charges Written Off to Bad Debt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges reported</td>
<td>$</td>
<td>$ 20,000</td>
</tr>
<tr>
<td>Cost of offset</td>
<td>(8,000)</td>
<td>(40,000)</td>
</tr>
<tr>
<td>Revenue received</td>
<td>20,000</td>
<td>20,000</td>
</tr>
<tr>
<td><strong>Net gain/(loss)</strong></td>
<td>$</td>
<td>$ 12,000</td>
</tr>
<tr>
<td></td>
<td>($)</td>
<td>($) (20,000)</td>
</tr>
</tbody>
</table>
Common Issues With Physician Costs

- Not updating contracts
- Not tracking actual time
- No proof physician not working in clinic
- Log data incomplete
- Log data contains entire stay (observation hours or acute hours)
- Medical director duties not in contract
- Costs grouped with other costs
- Cost does not reconcile to contract
- Not tracking physician time between locations (surgeon time in surgery and free-standing clinic)
Emergency Room Physician Availability

• Back in the hot seat
• Pull out your PRM and ensure you have back-up documentation
• Currently under attack:
  ▪ NAS – time studies
  ▪ WPS – everything
ER Physician Availability Documentation

• Signed contract
  ▪ Consider how often it is updated

• Allocation agreement between patient services, availability, and administration time

• Record of payments made to physicians
  ▪ Must match contract

• Record of time physician on-site
  ▪ Does not apply to CAHs unless you are WPS

• Record of all patients

• Schedule of physician charges

• Evidence of alternative methods
  ▪ NAS will not hold you to this if other items are met (others may)
Common Overhead (OH) Issues

• Directly-assigned OH Costs
  ▪ Admitting
  ▪ Patient billing
  ▪ Medical records
  ▪ Insurance
  ▪ Nurse administration
  ▪ Housekeeping or maintenance directly assigned to medical office buildings
  ▪ Utilities

• Avoid double-allocation
Common OH Issues: Square Feet

- Net method used for hospital building and gross from clinics
- Not updated
- Remeasure periodically
Cafeteria Common Issues

- Off-campus FTEs included
- Other areas that do not use cafeteria (perhaps call sites)
- Issue: these are typically issues outside of cost areas
Central Supply Issues

- Departments reported with supplies not ordered or stored by CS
  - Reagents
  - Food
  - Drugs
  - Films
  - Others?
Allocation Statistics – Watch List

- **A-6 Reclassifications:**
  - Account for any expense reclassifications on the related statistic (e.g. salaries & hours)

- Be aware of departments that may or may not actually utilize the overhead department:
  - Home health maintains their own medical records
  - Housekeeping does not clean rented space
Time Studies

• These tend to be set up and forgotten – issues we have seen:
  - Passive aggressive staff makes up numbers
  - Omits departments
  - Groups departments
    • KEY – Set up the proper departments
    • Another KEY – Monitor, Monitor, Monitor
• Examples include:
  ▪ Laundry pounds
  ▪ Housekeeping
  ▪ Medical record
  ▪ Social service
  ▪ Maintenance
  ▪ Emergency room physician
Time Study Rules

• At least one full week per month
• A full work week (e.g. 7 days)
• Equally distributed among the months (e.g. 3 months use 1st week; 3 months use 2nd week; etc.)
• No two consecutive months may use the same week
• Contemporaneous with the costs
• Provider specific
What if I never find out who’s a good boy?
Off-campus Provider-based Locations

• Budget reconciliation
  ▪ Site neutral payments for PPS
  ▪ Starting January 1, 2017
  ▪ Off-campus provider-based locations

• 340B pharmacy programs
Provider Based Clinic Revenue

• Typically four types of revenues
  ▪ Hospital services tracked back to clinic
  ▪ Global clinic charges
  ▪ Professional clinic charges
  ▪ Technical clinic charges
• Hospital services must be removed first
• Method II split charges to Medicare
• Global charge billed to other payors
• Must make the two match on cost report
  ▪ Basis for split (Medicare)
    • Set amount per charge
    • Percentage of charge
• Example:
  - 99213 standard charge
    • Professional = $100
    • Technical = $25
    • Total = $125
  - Medicare billed 75 patients
  - Blue cross billed 75 patients
## PBC – Clinic Only

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Blue Cross</th>
<th>Rev. Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$7,500</td>
<td>$</td>
<td>983</td>
</tr>
<tr>
<td>Technical</td>
<td>1,875</td>
<td>-</td>
<td>510</td>
</tr>
<tr>
<td>Global</td>
<td>-</td>
<td>9,375</td>
<td>983</td>
</tr>
<tr>
<td></td>
<td>$9,375</td>
<td>$9,375</td>
<td></td>
</tr>
</tbody>
</table>

Total revenue code 983 $16,875

Total revenue code 510 1,875

Total revenue $18,750
### Medicare charges:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$7,500</td>
<td>80%</td>
</tr>
<tr>
<td>Technical</td>
<td>$1,875</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$9,375</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Total charges:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$15,000</td>
<td>80%</td>
</tr>
<tr>
<td>Technical</td>
<td>$3,750</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$18,750</strong></td>
<td></td>
</tr>
</tbody>
</table>
# PBC – Clinic and Hospital

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Blue Cross</th>
<th>Rev. Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$ 7,500</td>
<td>-</td>
<td>983</td>
</tr>
<tr>
<td>Technical</td>
<td>1,875</td>
<td>-</td>
<td>510</td>
</tr>
<tr>
<td>Global</td>
<td>-</td>
<td>9,375</td>
<td>983</td>
</tr>
<tr>
<td>Hospital</td>
<td>4,000</td>
<td>4,000</td>
<td>983</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 13,375</strong></td>
<td><strong>$ 13,375</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total revenue code 983 $ 24,875

Total revenue code 510 1,875

Total revenue $ 26,750
<table>
<thead>
<tr>
<th>Charges</th>
<th>Less Hospital</th>
<th>Net</th>
<th>%</th>
<th>Charges for C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total revenue code 983</td>
<td>$24,875</td>
<td>- $24,875</td>
<td>80%</td>
<td>$21,400</td>
</tr>
<tr>
<td>Total revenue code 510</td>
<td>1,875</td>
<td>-</td>
<td>20%</td>
<td>5,350</td>
</tr>
<tr>
<td>Total revenue</td>
<td>$26,750</td>
<td>- $26,750</td>
<td>26,750</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Charges</th>
<th>Less Hospital</th>
<th>Net</th>
<th>%</th>
<th>Charges for C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total revenue code 983</td>
<td>$24,875</td>
<td>$8,000</td>
<td>$16,875</td>
<td>80%</td>
</tr>
<tr>
<td>Total revenue code 510</td>
<td>1,875</td>
<td>-</td>
<td>1,875</td>
<td>20%</td>
</tr>
<tr>
<td>Total revenue</td>
<td>$26,750</td>
<td>$8,000</td>
<td>$18,750</td>
<td>18,750</td>
</tr>
</tbody>
</table>
Medicare Bad Debts

• Medicare deductibles and or coinsurance:
  ▪ Hospital services only (not physician)
  ▪ RHCs

• Paid at 65% of the amount claimed

• Excludes professional charges and any other fee schedule payments
  ▪ Method II billing

• High audit probability
Medicare Bad Debts (Continued)

• Three types:
  - Reasonable collection efforts
  - Medicaid secondary payor (crossovers)
  - Written off under charity care policy (indigent)
Reasonable Collection Effort

• Deemed uncollectible using the hospital’s normal collection efforts

• Treated similarly to other payors, and billed with the intention of receiving payment for at least 120 days:
  - 120 days from date the bill was first sent to beneficiary to date it was deemed uncollectible and written off of the Hospital’s books
  - Collection agencies strategy

• Sound business judgment established that there was no likelihood of recovery at any time in the future

• Must have auditable support
Crossovers

• Type of indigent bad debt:
  ▪ Medicaid is responsible for payment of deductible and coinsurance
  ▪ Must be billed and denied by Medicaid
  ▪ Not subject to the 120-day rule

• Can claim partial and full write-offs
Medicare Bad Debt – Charity Care

- Type of indigent bad debt:
  - Written off under the hospital’s charity care policy
  - This is often overlooked by hospitals
  - Not subject to the 120-day rule
- Can claim partial and full write-offs
- Auditable support
  - Are you following your charity care policy
  - Do you have copies of patient data
  - Is there support it was approved?
Other Rules

• Must write off in the same manner as other payors
• Must be returned from collections
  ▪ Remember the first “other” rule
• Must be supported by auditable evidence
• Must be claimed in the year it is written off (or returned from collections)
Same Method as Other Payors

• Issue: collection on $50-$1,400 Medicare coinsurance or deductible compared to $10,000 self-pay amount

• Sent to collections

• Payment schedule

• Called back from collections
Medicare the Same Strategies

• Call back from collections based on amount
• Call back based on account activity (120-180 days of no activity)
• Max amount of time to collect on an account (above is better, of course)
Documentation

• CMS’ Exhibit 5
  - Beneficiary’s name
  - Beneficiary’s number
  - Medicaid number (if applicable)
  - Identified as indigent (if written off under charity care)
  - Dates of service
  - Date a bill was first sent to beneficiary
  - Date bill was written off
  - Amount of coinsurance
  - Amount of deductible
  - Amount of partial patient (or 3rd party) payment
  - Amount of bad debt claimed
Documentation Issues

- Date written off not in cost report year
- Date written off missing
- Reasonable collection effort for fewer than 120 days
- Not billed to Medicaid
- Includes coinsurance for physicians (method II issues)
Recommendations

• Track throughout the year
• Use identifier in system
• Keep back up data
• Use excel formulas
• Devise return from collection plan to optimize collections and payment on Medicare bad debts
• Have formal policies
Questions

MAYBE HOT CHOCOLATE WANTS TO BE CALLED

BEAUTIFUL CHOCOLATE JUST ONE TIME
Contact Information

Shar Sheaffer, CPA, Owner
Dingus, Zarecor & Associates PLLC
ssheaffer@dzacpa.com
509.321.9485
www.dzacpa.com