Critical Access Hospitals

Cost Report
General Requirements

- 25 acute inpatient beds or less
- Located more than 35 miles from another hospital (exceptions may apply for mountainous terrain)
- Maintain an average length of stay of 90 hours or less for acute care patients (excludes swing bed)
- Must provide 24/7 emergency care services
Medicare reimburses CAH’s based on **allowable costs +1%**

- Costs reported on Medicare Cost Report
  - Similar to a tax return
  - Filed 5 months after year end

- Interim payments
  - Based on historical costs as claims processed

- Final settlement
  - Based on Medicare Cost Report
Allowable versus unallowable

- Unallowable if not related to patient care
  - Patient phones/televisions
  - Advertising
  - Physician recruitment
  - Lobbying
Cost-based reimbursement from Medicare

- Allowable cost centers
  - Medical/Surgical Therapy
  - Operating Room
  - Lab
  - Radiology
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Provider Based Clinic
  - Respiratory
  - Emergency Room
  - Cardiology
  - Pharmacy
  - Supplies
  - Cardiac Rehab
  - Swing Bed
Non-reimbursable examples

- Home Health
- Hospice
- Skilled Nursing Facility (different from swing bed)
- Assisted Living
- Meals on Wheels
- Daycare
- Non Provider-based clinics
- Wellness Centers
Medicare reimburses costs on a department by department basis (called cost centers)

- Inpatient reimbursement: Daily per diem
- Ancillary departments: % of charges
Misunderstandings

- **Common misunderstanding**
  - All CAH’s get 101% of their costs paid back from Medicare
    - Offsets (unallowable) are typically 5-10% of total cost so reimbursement is more like 91% or 96%
  - Why not increase costs?
    - Medicare/Medicaid are the only payors who pay this cost
    - Must be able to be profitable in other services provided to other payors
Another misunderstanding

- Increasing allowable costs will increase revenues and profitability.
- As costs go up, the increase in reimbursement is limited to the Medicare utilization of that department:
  - Medicare profitability is stable.
  - Profitability of other payors goes down since costs are up.
- As costs go down, the decrease in reimbursement is limited to the Medicare utilization of that department:
  - Medicare profitability is stable.
  - Profitability of other payors goes up since costs are down.
Ambulance Reimbursement

- If no other ambulance service within 35 miles, CAH can get reimbursed 101% of cost.
- If ambulance service within 35 miles, considered non-reimbursable service and get paid fee schedule per run.
Examples

- **Current**
  - Supply Expense = $100,000
  - Supply Revenue = $400,000
  - CCR = .25
  - Medicare Utilization = 50% ($200,000)
  - Medicare Pays = $50,000
Examples

- Updated
  - Supply Expense = $100,000
  - Supply Revenue = $500,000
  - CCR = .20
  - Medicare Utilization = 40% ($200,000)
  - Medicare Pays = $40,000
Examples

- Current
  - Costs: $10,000
  - Revenue: $20,000
  - Cost to Charge Ratio: .5
  - Medicare Utilizations: $5,000 (25%)
  - Medicare Reimbursement: $2,500
Examples

- If costs go up by $10,000, revenue stays the same
  - Costs: $20,000
  - Revenue: $20,000
  - Cost to Charge Ratio: 1.0
  - Medicare Utilizations: $5,000 (25%)
  - Medicare Reimbursement: $5,000

- Reimbursement up by $2,500 but costs up by $10,000 for negative effect of $7,500.
Examples

- If Medicare revenue goes up by $10,000, costs stays the same
  - Costs: $10,000
  - Revenue: $30,000
  - Cost to Charge Ratio: .333
  - Medicare Utilizations: $15,000 (50%)
  - Medicare Reimbursement: $4,995

- Revenue up by $10,000 for positive effect of $14,995 (additional Medicare revenue plus reimbursement)
Shared Savings Opportunities

- Transitional Care Management
- Chronic Care Management
- Increasing swing bed utilization
- Improving access
- Saving time in an office visit
- Becoming a team member of the Patient Centered Medical Home (PCMH)