ruralMED
MANAGEMENT RESOURCES

Cost Reporting: Basics for Non-Finance Leaders

ruralMED Cooperative CAH Conference

April 16, 2025

Disclaimer

This document/presentation is not to convey or constitute legal advice; it is not a substitute for obtaining legal advice from a qualified attorney of choice. Nothing herein should convey any specialization or certification by a relevant regulatory body unless proof of such certification is specifically provided. Any information given regarding particular regulations or laws is ruralMED's interpretation and is for educational purposes only. Regulations, guidance, and interpretations change. You should consult with appropriate regulatory, statutory, or other guidance to ensure accuracy and completeness.

Critical Access Hospitals (CAHs)

- CAHs receive cost-based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients depending on State policy)
- CAHs are paid 101% of costs on all hospital Medicare business
- Effective April 1, 2014, Medicare reduced all payments by 2% sequestration adjustment
- Cost is estimated using Medicare cost reports

Critical Access Hospitals (CAHs)

- **Inpatient Medicare reimbursement**
  - Paid based on per diem rates during year (interim)
  - Per diem rates computed based on prior year cost report
  - Final settlement based on total reimbursable costs included in the Medicare cost report
  - Includes acute and swing bed patients. “Swing bed” is a special classification of skilled nursing patients in a CAH.

Critical Access Hospitals (CAHs)

- **Inpatient Medicare reimbursement example**

Total IP costs	$3,000,000
Total days	1,000
Total cost per day	$ 3,000
Medicare days	800
Total Medicare cost/reimb	$2,400,000

Critical Access Hospitals (CAHs)

- **Outpatient Medicare reimbursement**
  - Paid based on a percentage of charges during year (interim)
  - Percentage computed based on prior year cost report
  - Final settlement based on total reimbursable costs included in the Medicare cost report

Critical Access Hospitals (CAHs)

- **Outpatient Medicare reimbursement example**

Total OP costs	$3,000,000
Total OP charges	$6,000,000
Cost-to-charge ratio	0.50000
Medicare OP charges	$4,000,000
Total Medicare cost/reimb	$2,000,000

CRNA Pass Through Payments

- **CAH may be eligible to receive reasonable cost payments for Certified Registered Nurse Anesthetist (CRNA) services furnished on or after January 1, 1990**
- **An annual election must be made after September 30th but before January 1st for the following calendar year**
- **Qualifications include:**
  - Hospital employed or contracted CRNA with less than or equal to one full-time employee or 2,080 hours
  - Volume of 800 or less inpatient and outpatient procedures requiring anesthesia services

Optional Method II Billing

- A CAH may elect the Method II payment method to bill for both facility and professional services to outpatients on a single claim
- Applies only to outpatient services and not rural health clinic services
- The CAH must notify the Medicare Administrative Contractor (MAC) to request payment under the Optional (Method II) Payment Method
- No longer an annual election

Optional Method II Billing

- Payment for facility services is 101% of reasonable costs
- Payment for professional services is 115% of the allowable amount per the Medicare Physician Fee Schedule
- Applies to both physicians and non-physician practitioners
- Beneficial as it results in higher reimbursement

Rural Health Clinics (RHCs)

- Medicare reimburses RHCs based on allowable and reasonable costs
- Provider based RHCs work as a department of a CAH, providing services to the same population
- Provider based RHCs are reported on the CAH's cost report as a department of the CAH
- Overhead is allocated to the RHC through the step-down allocation process in the same manner as the CAH's patient care departments

Rural Health Clinics (RHCs)

- **RHC Medicare reimbursement**
  - Paid based on per visit rates during year (interim)
  - Per visit rates computed based on prior year cost report
  - Final settlement based on total reimbursable costs included in the Medicare cost report
  - ~~Subject to productivity standards for minimum visits (4,200 per full-time physician and 2,100 per full-time non-physician practitioner)~~
  - Cost per visit limits for all facilities effective 4/01/2021
    - Adjusted annually 1/1 using Medicare Economic Index
    - Reimbursement lesser of actual cost or base rate per visit

Rural Health Clinics (RHCs)

- **RHC Medicare reimbursement example**

Total RHC costs	$ 2,000,000
Total visits	10,000
Total cost per visit	$ 200
Medicare visits	3,000
Total Medicare cost/reimb	$ 600,000

Medicare Cost Report

- Financial document filed annually by all Medicare providers participating in the program
- Submitted annually to CMS for settlement of costs relating to health care services rendered to Medicare beneficiaries
- Must be filed within five months of fiscal year end
- Records each institution's total costs and charges associated with providing services to all patients, the portion allocated to Medicare patients, and the Medicare payments received

Medicare Cost Report

- Final settlement will equal total reimbursable costs incurred to provide care to Medicare enrollees (less applicable deductibles and coinsurance) less interim payments received from Medicare during the year
- May result in an underpayment if final settlement is greater than interim payments and CMS will make a lump-sum payment to the CAH
- Conversely, if the final settlement is less than interim payments, the CAH has been overpaid and will make a payment to CMS

Medicare Cost Report

- **Final settlement example**

IP per diem rate	$ 2,500		$ 3,500	
Medicare days	800		800	
Interim Medicare payments		$2,000,000		$2,800,000
Actual cost per day	$ 3,000		$ 3,000	
Medicare days	800		800	
Actual Medicare costs		$2,400,000		$2,400,000
Due from/(to) Medicare		$ 400,000		$ (400,000)

Medicare Cost Report

- **Submitted cost reports are subject to audit or review by CMS Medicare Administrative Contractors (MACs)**
  - Wisconsin Physician Services (WPS)
- **Usually occurs 1-2 years after submission**
- **Notice of Program Reimbursement (NPR) is issued with revised settlement based on audit adjustments**

Questions?

Bryce Betke

bbetke@ruralmed.net

308-217-1815