Review of New Medicare Hospital Cost Report Forms and Related Changes
CMS 2552-10 replaces CMS 2552-96



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Modifications and Updates

- Fifteen years since CMS has made significant changes to the hospital Medicare cost report
- Prior changes involved adding lines and worksheets to:
  - Reflect changes in laws and regulations
  - Provide CMS with additional information
- Always adding and rarely taking away from the cost report
- Many of the questions, data cost centers and worksheets are obsolete and/or have not been used for years

Modifications and Updates

- CMS made revisions to the hospital cost report for periods beginning on or after May 1, 2010 (April 30, 2011 year end)
- Summary of Changes
  - Removed obsolete worksheets
  - Deleted obsolete cost centers (old capital building and equipment)
  - Renumber lines and eliminate subscripts
  - Add lines for HIT calculation and settlement (worksheet S, S-2, A-7, A-8, E-1 part II, G
  - Each Provider's CBSA must be listed separately (Worksheet S-2)
  - Add lines for IPF (psychiatric) and IRF (rehabilitation) sub-units

Modifications and Updates

- Summary of Changes (continued)
  - Intermediary is now “contractor”
  - Form 339 now worksheet S-2 part II
  - Unknown how CMS intends to incorporate Form 339 exhibits 2 through 5 into cost report
  - Medicaid lines and calculation flexibility (worksheet S-2
  - RHC and FQHC specific lines 88 and 89
  - Implantable devices charged to patients permanent line 72
  - May continue to use subscripts approved previously

Modifications and Updates

- Summary of Changes (continued)
  - Worksheet C added special cost centers (home health, ambulance, hospice, freestanding ASC, DME, freestanding rehabilitation)

    This change will cause the charity care percentage to be reduced since it is based on charity care write-offs divided by revenue reported on worksheet C.

    This reduction of the charity care percentage in turn reduces the HIT charity care adjustment thereby reducing the CMS payments for HIT capital cost.

Modifications and Updates

- Summary of Changes (continued)
  - Not required to use cost centers that were not used in the past except line 72
  - Worksheet S-10 mandatory for hospitals and CAHs
  - Provider-based RHCs may be filed on a consolidated basis (currently permitted but instructions state contractors {intermediary} may approve consolidated reporting)
  - Worksheet A-7 now used for capital cost input into worksheet A
  - Worksheet A-6 reference to worksheet A-7 added
  - Seven worksheet E-3's with different lines and calculations

Worksheet S-10

- CMS Instructions
  - Lines 2 – 8 calculation of Medicaid Net Revenue less Medicaid cost
  - Lines 9 – 12 calculation of SCHIP Net Revenue less SCHIP cost
  - Lines 13 – 16 calculation of Other state and local government indigent program Net Revenue less related cost
  - Lines 17 – 19 identify grants, donations, government transfers, appropriations, and other income used to pay for charity care

Worksheet S-10

- CMS Instructions
  - Line 20 Total initial obligation of patients approved for charity care for the entire facility (**full charges** excluding non-reimbursable cost centers)
    - Line 20 column 1 – Uninsured patients
    - Line 20 column 2 – Insured patients

  Keep in mind that line 20 will be matched with total charges on worksheet C to determine the hospital's charity care percentage. This percentage will be used in the EHR/HIT reimbursement calculation.

  All charity care write-offs related to revenue reported on the new worksheet C should appear on this line.

Worksheet S-10

- CMS Instructions
  - Line 21 Total cost of initial obligation of patients approved for charity care. This is calculated based on the aggregate worksheet C cost to charge ratio applied to the amounts on line 20.
    - Line 21 column 1 – Uninsured patients
    - Line 21 column 2 – Insured patients
  - Line 22 partial payments by patients approved for charity care.
    - Line 22 column 1 – Uninsured patients
    - Line 22 column 2 – Insured patients
  - Line 23 total cost of charity care line 21 minus line 22

Worksheet S-10

- CMS Instructions
  - Line 24 Does line 20 include charges for patient days beyond a length of stay limit on patients covered by Medicaid (Y or N)
  - Line 25 If 24 Y what were the charges
  - Line 26 Total bad debts
  - Line 27 Medicare bad debts claimed on worksheet E's Part A, B, E-3 for CAH. {What about swing bed and other bad debts eligible for Medicare reimbursement?}
  - Line 28 Net Bad Debts – Line 26 minus line 27.
  - Line 29 Cost of Net Bad debts – This is calculated based on the aggregate worksheet C cost to charge ratio applied to the amounts on line 28.

Worksheet S-10

- CMS Instructions
  - Line 30 Cost of non-Medicare uncompensated care - lines 23 plus 29
  - Line 31 Unreimbursed and uncompensated care cost – lines 19 plus 23 plus 30.

This information may eventually be reflected on the hospitals form 990 along with other information that will eventually be used to justify tax exempt status for tax exempt hospitals.

How many hospitals are accurately tracking this information?

HIT (EHR) – PPS Hospital Funding

Step 1 – Determine Medicare and Medicare Advantage inpatient acute care days
Step 2 – Determine total inpatient acute care days
Step 3 – Determine charity care revenue as percent of total revenue

Medicare reimbursement percentage = Medicare and Medicare Advantage inpatient acute care days / [total inpatient acute care days * (1- charity care percentage)] (may not exceed 100%)

HIT (EHR) PPS Hospital Funding

Medicare reimbursement percentage = CAH Medicare reimbursement percentage without 20% add-on

Maximum base amount $2,000,000

Not based on cost!

Additional $200 added to maximum base amount for each discharge between 1,150 and 23,000

HIT (EHR) PPS Hospital Funding

Qualified for the periods from October 1, 2010 to September 30, 2013

Year 1 – Maximum base amount * Medicare reimbursement percentage * 100%

Year 2 – Maximum base amount * Medicare reimbursement percentage * 75%

Year 3 – Maximum base amount * Medicare reimbursement percentage * 50%

Year 4 – Maximum base amount * Medicare reimbursement percentage * 25%

HIT (EHR) Hospital Funding

Qualified on or after October 1, 2013

Year 1 – Maximum base amount * Medicare reimbursement percentage * 75%

Year 2 – Maximum base amount * Medicare reimbursement percentage * 50%

Year 3 – Maximum base amount * Medicare reimbursement percentage * 25%

Year 4 – Maximum base amount * Medicare reimbursement percentage * 0%

HIT Hospital Funding

Qualified on or after October 1, 2014

Year 1 – Maximum base amount * Medicare reimbursement percentage * 50%

Year 2 – Maximum base amount * Medicare reimbursement percentage * 25%

Year 3 – Maximum base amount * Medicare reimbursement percentage * 0%

Year 4 – Maximum base amount * Medicare reimbursement percentage * 0%

HIT - CAH Funding

Step 1 – Determine Medicare and Medicare Advantage inpatient acute care days
Step 2 – Determine total inpatient acute care days
Step 3 – Determine charity care revenue as percent of total revenue

Medicare reimbursement percentage = Medicare and Medicare Advantage inpatient acute care days / [total inpatient acute care days * (1- charity care percentage)] plus 20%

(may not exceed 100%)

HIT (EHR) CAH Funding

Step 1 – Medicare and Medicare Advantage inpatient acute care days = 750
Step 2 – Total inpatient acute care days = 1,000
Step 3 – Charity care revenue = $50,000
Total revenue = $1,000,000

Medicare reimbursement percentage = 750 /[1,000 * (1-(50,000/1,000,000))] plus 20%

98.95%

HIT CAH Funding – Cost reporting periods beginning on or after October 1, 2010

Medicare reimbursement percent applied against:

Capital cost of qualified EHR purchased in cost reporting years beginning on or after October 1, 2010 –plus–

Undepreciated qualifying EHR cost carried over from prior cost reporting periods

May request interim payment from CMS at start of cost report period beginning on or after October 1, 2010

HIT (EHR) CAH Funding – Hospital cost reporting period beginning on or after October 1, 2014

Medicare reimbursement percent applied against:

Capital cost of qualified EHR purchased during period only if EHR purchase began in hospital cost report periods beginning on or after October 1, 2011, or later (four year maximum)

HIT (EHR) CAH Funding – Hospital cost report period beginning on or after October 1, 2010

Medicare reimbursement percent 98.95%

Undepreciated qualifying EHR cost carried cost of $500,000 less $100,000 depreciation taken equals $400,000

Capital cost of qualified EHR purchased during period - $500,000

$890,550

HIT (EHR) CAH Funding – Subsequent cost reporting periods beginning on or after October 1, 2011, and before September 30, 2014

Medicare reimbursement percent applied against

Capital cost of qualified EHR purchased during these time periods

CAH Funding – Hospital cost report periods beginning on or after October 1, 2011, and before September 30, 2014

Medicare reimbursement percent - 98.95%
(may change from year to year)

Capital cost of qualified EHR purchased during these periods - $100,000

$98,950 each year

CAH Funding – All Years

Capital cost is defined as depreciable cost.

Medicare regulations use AHA guidelines to assist with the definition of depreciable cost.

Some costs are obviously capital cost: hardware and software.

Some costs may or may not be capital cost: installation cost and training cost. We have heard that CMS would like to exclude that cost from the definition.

Some costs are not capital cost: annual maintenance fees and staffing cost associated with operating a system.

HIT (EHR) CAH Funding – All Years

Noncapital costs are run through the Medicare cost report and paid based on normal cost-based reimbursement, which may be fairly small if the CAH has services that are not cost-based reimbursed like a nursing home.

For CAHs there may be a variance of 30% between the percentage of EHR capital cost reimbursed using the inpatient formula and the normal reimbursement determined on the cost report.

HIT (EHR) Medicare Advantage

Medicare and Medicaid managed care inpatient acute care days are important to HIT reimbursement. Make sure they are being reported.

Medicare requires Medicare Advantage inpatient acute care shadow claims to be filed with Medicare contractor (Intermediary). The shadow claims are filed using

condition code or exception code 04

HIT (EHR) Medicare Advantage

Based on these shadow claims, Medicare Advantage inpatient acute care days will be reflected on a separate page of your PS&R

We encourage you to maintain an auditable internal record of Medicare Advantage days and validate the Medicare Advantage days reflected on the PS&R before the cost report is filed. There is a good chance that the days are wrong.

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