Medicare Cost Report: What is it?

All Medicare certified institutional providers are required file an annual cost report to their respective Medicare Administrative Contract (“MAC”). But what is a Medicare cost report and what is the process for submitting and finalizing one?

The Medicare cost report is comprised of a series of worksheets and schedules that describe the institutional provider’s characteristics, financial information, costs and charges. The cost report is utilized to set prospective payment rates such as wage index, Disproportionate Share Hospital (“DSH”) adjustment, Indirect Medical Education (“IME”)/Graduate Medical Education (“GME”) and outliers.

- **Who is required to submit the Medicare cost report?** All Part A providers such as hospitals, skilled nursing homes, Home Health Agencies, Hospice and Federally Qualified Health Centers. Physicians, non-institutional providers, and federal hospitals, such as Veterans Hospitals, Indian Health Services Hospitals, some children’s hospitals and emergency hospitals (hospital outside of the U.S.) are not required to submit a cost report.

- **What is included in the cost report?** The cost report details the following (not an exhaustive list):
  - Facility characteristics (ownership status, type of facility, etc.)
  - Financial information (revenue, expenses, bad debt, etc.)
  - Indirect and Direct Medical Education Costs
  - DSH payments
  - Qualification for 340(b) Drug Program
  - Wage data

- **How is the cost report submitted?** The electronic cost report must be created on the Centers for Medicare & Medicaid Services’ (“CMS”) approved software [Electronic Cost Report (“ECR”)]. The ECR, Print Image (an electronic picture image of the entire cost report), and supporting documentation (e.g., Worksheet S, certification page) must be submitted via a floppy disk, CD or flash drive to the MAC. When submitting protected health information, proper steps must be taken to ensure it is encrypted and complies with Federal Information Processing Standards (FIPS) 140-02.

**Note:** For a list of all of items that must be included when submitting the cost report and supporting documentation, please see the Provider Reimbursement Manual – Part 2, chapter 1 §140. The MAC may also provide a checklist of all of the required items that constitute an acceptable cost report submission. Moreover, MACs may have a preference for how to submit the cost report and supporting documentation to them (e.g., NGS’s preferred method is via NGSConnex web application).

- **When is the cost report due?** Institutional providers must annually submit the cost report to its respective MAC within five (5) months after the provider’s fiscal year or thirty (30) days after a valid Provider Statistical and Reimbursement Report is sent to the provider by its MAC, whichever is later.
• **Is there a penalty for late filing?** If the cost report is submitted late (or rejected), the MAC will suspend payments and/or assess interest and penalties, and a demand letter will be issued as soon as possible, but no later than 30 days after the due date of the cost report. The MAC can consider all interim payments since the beginning of the cost reporting period an overpayment.

• **What is the process for finalizing the cost report?** After submitting the cost report, the MAC has thirty (30) days from the date of receipt of the provider’s cost report to make a determination of acceptability. After the determination of acceptability, the MAC must then make every attempt to issue the Notice of Amount Program Reimbursement (“NPR”) within twelve (12) months of receipt of a cost report. The NPR states the total amount of Medicare reimbursement due to the provider. The NPR is considered the MAC’s final determination for the purpose of future appeal rights. For additional information regarding the NPR, please see the Provider Reimbursement Manual – Part 1, §2906.

If the provider is dissatisfied with the NPR, the provider may appeal to the Provider Reimbursement Review Board (“PRRB”), an independent panel, within 180 days of the receipt of the NPR. The PRRB’s decision may be affirmed, modified, reversed or vacated and remanded by the CMS Administrator within 60 days of notification to the provider of that decision.

Additionally, a cost report may be reopened by the provider, MAC or CMS if a written request is received within three (3) years of the date that the NPR was issued. However, if fraud or similar fault is involved, the MAC or CMS can reopen the cost report at any time. For more information regarding the reopening process, please see the Provider Reimbursement Manual – Part 1, §2931.

• **Where are cost reports housed?** The CMS maintains cost report data in the Healthcare Provider Cost Reporting Information System (“HCRIS”). The HCRIS database contains the most recent version (i.e., as submitted, settled, reopened) of each cost report filed with CMS since federal FY 1996. The dataset contains all data elements included in the cost report and is updated quarterly by CMS. The HCRIS is the only national database available for all types of institutional providers (non-profit, for-profit, government).

• **Are there additional uses for the data contained in the cost reports?** Yes, research. Based on the cost reports, research can be conducted to:
  
  o Examine the facility’s characteristics, such as size (beds), ownership, and total number of patient days and discharges;
  
  o Determine the financial health of a facility, like revenue, expenses, net income (or loss), payer mix and bad debt; and
  
  o Calculate cost such as total costs for all patients and Medicare costs.

Research cannot be conducted on physician cost, discharge and cost by MS-DRG (or other specific procedure) and detailed payer mix.

Given the importance of the Medicare cost report on the financial future of an institutional provider, it is critical for healthcare organizations, particularly the Chief Financial Officer, to fully understand the process for completing the ECR and worksheet/forms and filing the cost report. Additionally, it is of more
importance to ensure that the cost report is accurate as it can lead to audits by the Office of Inspector General and/or MAC.

Advantage Healthcare Consulting has developed the right service to meet the needs of Home Health Care Agencies, Hospice Care Providers, Skilled Nursing Facilities, and Hospitals. With our years of experience filing hundreds of cost reports for our clients, we’ve developed:

- Personal touch service designed to take the stress off your team
- Detailed execution which ensures timely present and future reimbursements
- Assistance in analyzing and advising clients current procedures in order to streamline their process and ensure accurate cost reporting
- The fastest turnaround time in the industry
- An affordably priced, all-inclusive flat fee that’s fixed in advance
- Complimentary follow-up with any questions that may arise
- Assistance with any audit from the Medicare or Medicaid Intermediary

With more than 600 reports filed with Medicare and Medicaid, Advantage Healthcare Consulting has never had a rejected cost report and none of our clients’ payments have ever been put on hold as a result of a poorly prepared report. We’ve worked to ensure that our clients’ cost reports are prepared correctly to meet all of the Medicare and Medicaid requirements without any errors or hassles.

Advantage Healthcare Consulting’s Annual Cost Report Preparation Package includes:
- Preparation of the Medicare Cost Report
- Questionnaire for the Medicare Cost Report
- Preparation of the Financial Statements to accompany the Cost Report

If a simple cost report service is what your business is looking for this year, then schedule a call with me and let’s discuss how my company can help.