**The Medicare Cost Report – An Information Pipeline For The Future:**

While the Medicare Cost Report is no longer used to determine final settlement for individual Home Health Agencies it is still a very vital source of information. This information is used by Medicare in various ways:

To determine market basket updates – In the November 8, 2012 Federal Register, which set the Calendar Year 2013 Home Health Agency Rates, the Home Health Market Basket was updated using the 2010 Medicare Cost Reports.

To determine costs per visit – In the Home Health Study on Reimbursement of February 2012, by the National Bureau of Economic Research, the Medicare Cost Report was used to compute costs per visit to determine the adequacy of reimbursement.

To determine Profit Margins – In the MedPac Medicare Payment Policy 2010, based on the Medicare Cost Reports it was determined that freestanding Home Health Agencies averaged a 17.8% profit margin.

To determine Service Mix – In the MedPac Medicare Payment Policy 2010, based on the Medicare Cost Reports, it was determined that a patients clinical and functional characteristics did not always relate to the services provided. According to MedPac, financially better performing agencies tended to provide fewer visits per episode.

The Effect of Overhead Costs – The Government Accounting Office (GAO) reported that HHAs with low margins tended to have the highest per episode costs, driven primarily by high costs, (and specifically overhead) and secondarily by the difference in the number of visits provided per episode. Overhead accounted for approximately two thirds of the differences in costs, with the lower margin agencies having a cost per visit of $130, while the higher margin agencies had a cost of $75 per visit.

Re-basing – In the 2015 Home Health Agency Final Rules, the 2012 cost reports were used to determine if the cost per episode were higher than 2011 to confirm the need for re-basing.

The various schedules of the Medicare Cost Report contain a wealth of information that Medicare can and will use to determine future policy. While these decisions may not always be to our liking, it is essential that they be based on the best data possible. Taking the time on the front end to insure that the data in the Medicare Cost Report is as accurate as possible, will pay off in the future when rates are set, payment systems are established, and policy decisions are made.

The Medicare Cost Report- What does all this data mean?

Worksheet S-3 Part I – This schedule contains the number of patient visits, the number of patients served, the unduplicated census, and Home Health Aide hours.

 Number of visits – This can be used to determine:

 Costs and revenue per visit and profitability.

 Visit Mix – The number and type of visits as compared to other agencies.

 Number of Patients and Unduplicated Census – These can be used to

 determine:

 Costs and revenue per patient.

 Number of average visits per patient.

 Service Mix – to determine the average number of visits per patient by

 payor. This information can be used to determine any variation in services

 between Medicare and non-Medicare patients.

 Home Health Aide Hours – This can be used to determine:

 Home Health Aide hours per visit.

 Home Health Aide costs per hour.

Worksheet S-3 Part II – This schedule contains the Full Time Equivalents (FTE) information. This information is broken out by job title/classification and whether an employee or a contractor. With this information on the total number of FTEs by job title/classification the following can be determined:

 Average costs per FTE.

 Average visits per FTE

 Average visits by service, that is for nurses, therapists, aides.

 Average costs per visit by service.

Worksheet A – This worksheet is one of the most important schedules in the Medicare Cost Report. This schedule is our one and only chance to properly state our costs for Medicare. Worksheet A contains three types of costs.

Overhead costs – These are costs that support the departments that serve clients. This would be costs such as rent, utilities, and administration. In the cost report process these costs are allocated to the departments providing services to our clients.

Reimbursable Patient Care costs – These would be the Home Health Agency direct costs for services such as Skilled Nursing, therapies, social services, aides, supplies, drugs, vaccination administration costs, and durable medical equipment. These direct costs, along with allocated overhead will determine the costs per visit for each discipline.

Non-Reimbursable costs – These are the direct costs for services other than Home Health, provided to clients. These services include private duty nursing, homemakers, Meals on Wheels, day care, etc.

 While properly stating and classifying costs in the Medicare cost report is vital, everything depends on the quality of the information from our accounting records. The purpose of our accounting records is to give us the tools and information needed for the many internal and external users. To meet these goals the following are necessary:

Clear and concise descriptions – Department titles, account titles, and entries descriptions should clearly describe the activity. This will leave a clear trail for both internal and external users and provide them with accurate information in an efficient timely manner. For example, if an entry reflects the building rent paid on the HomeMakers building at 212 Main Street, the department title, account title, and entry description should clearly show this, not just “rent-HM”.

Proper classification – To insure that our accounting records properly reflect our operations, we must make sure that costs are classified into the proper departments. This will insure that our overhead costs are accurate and will be allocated to the departments they serve, and that the direct costs of our service providing departments are correctly stated. This requires that we take the time to determine that costs are coded into the proper accounts. As can be seen below, if Medicare is unable to use our Medicare Cost Reports, they will be forced to come up with a proxy.

 In the Home Health Market Basket rebasing in 2013, Medicare was unable to use the Operation and Maintenance of Plant cost information from the 2010 Medicare Cost Reports. It was determined that these costs were lower than those from the 2003 Medicare Cost Reports. Based on the increase in energy costs from 2003 to 2010, Medicare knew this information was not valid. If we wish to have our rates properly reflect our operations, then our Medicare Cost Reports must do the same.

Overhead Costs – Overhead costs are defined as those shared costs that support other departments. For example, rent, depreciation, utilities, and administration costs that relate to all the services provided by an agency. The key here are costs that are shared and serve all departments. This does not preclude us from identifying and assigning costs in our accounting system when appropriate. For example, in a multiple building scenario, if the building costs (rent, depreciation, utilities, etc.) and departments in each building can be identified, then the costs should be assigned to the departments to which they relate, instead of assigning them to an overhead department to be allocated on the basis of square feet. This allows a more accurate assignment of costs. In identifying overhead costs we must keep in mind that the goal is proper identification. Medicare frowns on a situation that results in identifying and assignment of overhead costs for reimbursable departments, but not for non-reimbursable.

The Medicare Cost Report breaks the overhead costs into the following cost centers.

Capital Related Costs-Buildings & Fixtures and Capital Related Costs Moveable Equipment – These are costs related to capital assets. These would include depreciation, rent, equipment leases, interest, taxes, and insurance related to land, buildings, or equipment. These cost centers should only include those costs that cannot be identified as to specific departments and/or serve the entire or most of an agencies departments. For example, if an agency is located in one building, then the related building costs are shared and should be included in these cost centers to be allocated on the basis of square feet.

Plant Operation and Maintenance - These are costs incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors and agency property. These would include utility costs, cost of maintenance supplies, salaries and benefits for maintenance employees, cleaning staff and security staff. As with all overhead costs, only those that cannot be identified to specific departments should be included in this cost center.

Transportation – This cost center should only include costs related to transportation that is not regular in nature. For transportation that is regular in nature such as Home Health personnel visiting patients, HomeMakers visiting clients, and Meal on Wheels delivering meals, these costs should be identified and assigned to the relevant department. If the agency has a central transportation department that serves all departments a log of miles driven and time spent should be used to assign cost to the proper departments.

Administration and General – This cost center should include cost such as fiscal services, legal services, accounting, data processing, non-capital related taxes and insurance. Medicare allows A&G to be broken out and identified further as Componentized A&G. There are two methods allowed, one that breaks A&G into separate departments, (Accounting, data processing, etc) and one that breaks A&G into three categories, Shared A&G, Reimbursable A&G, and Non-Reimbursable A&G. For a Home Health Agency the three category method appears to be the most appropriate.

Shared A&G – This cost center should only contain costs that serve the entire facility. For example the salaries and benefits of management personnel that oversee all departments, the salaries and benefits of accounting personnel that serve all departments, costs for insurance, legal services, and taxes that relate to the entire agency.

Reimbursable A&G – This cost center should contain overhead costs that serve only the Home Health Agency. For example the salaries and benefits of the Home Health Agency Administrator and support staff, supplies used only by the Home Health Agency, and any other support costs that can be identified that relate solely to the Home Health Agency. A Medicare certified Home Health Agency that is part of an agency that provides many other social services has unique identifiable costs. These would include scheduling home health visits, completion of the OASIS data, billing patients and third parties, preparation of the Medicare Cost Report, travel and continuing education.

Non-Reimbursable A&G – This cost center should contain overhead costs that do not relate to the Home Health Agency, but to all of the other departments of the agency. For example, a Meals on Wheels program may have its own identifiable administrative personnel, costs to comply with Federal, State and Local rules and regulations, food service and transportation related inspections.

 The goal of componentizing Administration and General is to insure that overhead costs are allocated only to the departments they relate to.

Worksheets B and B-1 – These worksheets are used to allocate the overhead cost centers to the service providing cost centers they serve. The overhead costs are allocated as follows:

Square Feet – The cost centers for Capital Related Building and Fixtures, Capital Related Moveable Equipment and Plant Operation and Maintenance are allocated on the basis of square feet. As the cost relate primarily to buildings, (depreciation, utilities, housekeeping) square feet is an appropriate basis. To obtain the correct allocation of these costs, it is important to maintain the related statistics. While the square feet of departments may not change very often, an annual review to determine any material changes can insure that these costs are properly allocated.

Mileage – The Transportation cost center is allocated on the basis of mileage. As a Home Health Agency has material transportation costs, mileage logs should be maintained for all traveling employees to insure that transportation costs are properly assigned.

Accumulated Costs – Administrative and General costs are allocated on the basis of the accumulated costs (direct department costs plus allocated overhead). This statistic is a function of the cost report and requires no information from the Agency.

 Worksheets F, F-1, and F-2 – These schedules duplicate the balance sheet and income statement. As these schedules are a snapshot of the Agencies financial health, they should be as detailed as possible. Based on this information Medicare can determine the financial situation for the Home Health industry and make appropriate policy decisions.

 As we have now seen, far from being just bothersome government paperwork, the Medicare Cost Report is Medicare’s window on our operations. If we wish to have our Medicare payments fairly reflect our operations, this window must be as clear as we can make it.