Effective June 30, 2019

Arnett Carbis Toothman LLP
CPAs & Advisors

actcpas.com

West Virginia Medicaid Cost Reporting Accounting for Medicare A Ancillary Expenses

Certain Medicare A Ancillary expenses may be reported on the West Virginia Financial & Statistical Report (Medicaid Cost Report) as allowable costs. In previous reporting periods, Medicare A Ancillary expenses were considered non-allowable by the West Virginia Department of Health and Human Resources (WV DHHR). However, WV DHHR has considered the impact of consolidated billing and the philosophy that expenses not separately billed should be included in the total cost of care for the Medicaid Cost Report.

The purpose of this white paper is to provide information to skilled nursing facilities' (SNFs) Medicaid cost report preparers related to Medicare A expenses. Through discussion with the WV DHHR, guidance from Chapter 514 of the WV Medicaid Program, and research from the Centers for Medicare & Medicaid Services (CMS), we have summarized the purpose and methodology of properly accounting for Medicare A expenses and have included two example scenarios that cost report preparers may encounter while preparing West Virginia Medicaid cost reports.

Medicare A ancillary expenses could contain significant reimbursable expenses that have traditionally been mapped to Ancillary Expenses on WV24. Our goal is to identify Medicare A ancillary expenses under consolidated billing and include those amounts that are allowable for reimbursement in an account mapped to Medicaid Chart of Accounts (MCOA) #7090 - Nursing Purchased Services.

Let's examine two scenarios to gain a better understanding of how Medicare A ancillary expenses should be properly reported on the WV Medicaid cost report.

Scenario One

Accounting: A SNF records total pharmacy expenses to a Pharmacy Drugs expense account. This account lumps together expenses of multiple payor types; therefore, Medicare A expenses are not easily identifiable.

Solution: Pharmacy charges for a Medicare A resident are coded appropriately by revenue code on the resident bill sent to Medicare. Because the accounts receivable (and revenue) is detailed, we have revenue broken out by payor. At the end of the month, the pharmacy sends an invoice to the facility. The facility records the total expense for the month into the Pharmacy Drugs expense account. Using the Pharmacy revenue account, we can take the percentage of Medicare A to total revenue and allocate the Medicare A expense based on that percentage.

Considerations: Not every Medicare A expense is included under consolidated billing, such as dialysis and ambulance trips associated with dialysis treatments. The preparer would need to perform a thorough analysis of the transaction detail and remove all Medicare A charges that are not included under consolidated billing. See the following caption, titled "Medicare A Services Excluded from Consolidated Billing," for Medicare A charges NOT included under consolidated billing and, therefore, non-allowable on the Medicaid cost report.

Scenario Two

Accounting: A SNF separately identifies ancillary expense accounts by payor type; for example, general ledger accounts for Rx Drugs Medicare A, Rx Drugs Medicare B, etc.

Solution: Since the Medicare A expenses are already allocated, no allocation by revenue account percentages would be necessary. The cost report preparer would simply adjust the portion of the account that pertains to Medicare A expenses to the allowable Nursing Purchased Services account (MCOA #7090), or, if the entire account includes Medicare A expenses, remap the account to MCOA #7090. Note: Medicare B expenses are separately billed and are, therefore, non-allowable on the Medicaid cost report.

Considerations: If the account is remapped, the preparer will need to examine the account each cost report period to ensure that it still includes only Medicare A expenses.

The preceding two scenarios address concerns related to Medicare Part A Pharmacy prescription drug charges. However, the WV DHHR considers other expenses billed under consolidated billing as allowable, such as labs, radiology, and ambulance. For allowable ambulance charges, the SNF must obtain a written contract with the transportation provider documenting that the facility has negotiated a reasonable rate for the transport.

As a cost report preparer, you may discover a scenario that is not as clear-cut as the above two examples. In this case, we encourage you to reach out to our health care consulting experts at ACT for guidance.

This white paper has been reviewed by the WV DHHR for guidance in preparing West Virginia Medicaid cost reports. However, each West Virginia Medicaid cost report undergoes WV DHHR desk review, and Medicare A ancillary expense allocations are subject to WV DHHR adjustments.

Continued...

West Virginia Medicaid Cost Reporting
Accounting for Medicare A Ancillary Expenses continued...

Please consider these two rules of thumb during cost report preparation:

1. Include adequate supporting documentation for Medicare A ancillary expenses with cost report submission. Adequate supporting documentation typically includes detailed listings, such as expense transactions and ambulance transports. There is an exception for the following:

   For Medicare Part A Pharmacy, WV DHHR requires the facility to review the Medicare Part A Pharmacy costs and submit only a summary verifying where those costs are located on the cost report and that they are all allowable Part A Pharmacy under consolidated billing.

2. When in doubt, ask an expert for guidance!

Medicare A Services Excluded from Consolidated Billing

"The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception: There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.

For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

- Physician's professional services;
- Certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
- Certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and round-trip ambulance services furnished during the stay that transport the beneficiary off-site temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
- Erythropoietin for certain dialysis patients;
- Certain chemotherapy drugs;
- Certain chemotherapy administration services;
- Radioisotope services;
- Customized prosthetic devices.

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services for these beneficiaries can be separately billed to and paid by the Medicare contractor."

The preceding excerpt was taken directly from CMS at the following web address:
https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html

Disclaimer

This white paper reflects our understanding effective June 30, 2019. In acting upon this information, you should reach your own conclusion regarding what is appropriate and what you believe is correct. Specific facts and circumstances may result in different application of the information presented herein. Also, laws, regulations, provider manuals, regulatory guidance, and the interpretation thereof may change from time to time and we have no obligation to update this white paper as a result of such changes.

Arnett Carbis Toothman LLP
CPAs & Advisors

actcpas.com

Stephen Holcomb, MBA, CPA
Health Care Consulting | Supervisor
Arnett Carbis Toothman LLP