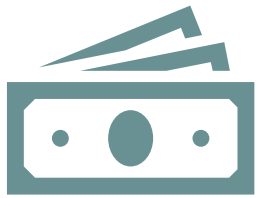
STROUDWATER

COST REPORT BEST PRACTICES AND OPPORTUNITIES

AGENDA



OVERVIEW: CAH REIMBURSEMENT

COST REPORT PREPARATION: BEST PRACTICES

COMMON REIMBURSEMENT OPPORTUNITIES

OVERVIEW: CAH REIMBURSEMENT

COST-BASED REIMBURSEMENT OVERVIEW

CAHs receive cost-based reimbursement for inpatient and outpatient services provided to Medicare, and in some states Medicaid, patients

What cost-based reimbursement **does**

Partially insulates hospitals from financial impacts of significant volume fluctuations

Provides an advantage for financing capital projects (i.e., depreciation)

Helps hospitals to operate in communities with inherently low populations

What cost-based reimbursement **does not** do

Protect the hospital from all financial woes

Negate the need for prudent cost management strategies

The Medicare cost report is a crucial part of ensuring a CAH maximizes reimbursement from cost-based payers

COST REPORT PREPARATION: BEST PRACTICES

BEST PRACTICES

- Review mappings (matching principle)
- Review overhead cost allocations
- Tracking reimbursement
- Understanding service mix
- Incorporating audit findings
- Cost report reviews

BEST PRACTICES: EXPENSE AND REVENUE MAPPINGS

- **Description:** The Medicare cost report requires appropriate “matching” of expenses and revenues to calculate reimbursement accurately
- **Potential Issue:** Without proper matching, Medicare cost-to-charge ratios (CCRs) will be inaccurate, and overall reimbursement will likely be misstated
- Hospitals generally “map” expenses and revenues to the cost report from the following sources
  - Trial balance
  - Revenue detail file
  - Medicare PS&R
- **Best practice:** Review mappings at least annually (more frequently if you are filing interim cost reports) to ensure expenses and revenues are correctly matched

BEST PRACTICES: OVERHEAD COST ALLOCATIONS

- **Description:** Hospital overhead expenses are allocated to inpatient, outpatient, ancillary, and other cost centers on the Medicare cost report, including non-reimbursable cost centers
- **Potential Issue:** Overhead cost allocations do not accurately reflect overhead resource use by department
- Medicare has prescribed cost allocation methodologies; however, certain methodologies can be adjusted if approved by the local Medicare Administrative Contractor (MAC)
  - A formal process exists for seeking MAC approval; it is encouraged to work with your cost report preparer and local MAC if considering cost allocation methodology changes
- **Best practice:** Review cost allocations at least annually (more frequently if you are filing interim cost reports) for accuracy

BEST PRACTICES: TRACKING REIMBURSEMENT

- **Description:** Traditional Medicare settles with CAHs each year, comparing what was paid throughout the year to what was owed based on allowable cost; prudent financial management requires a CAH to estimate anticipated settlements from Medicare and other payers throughout the year
- **Potential Issue:** Given cost-based reimbursement, CAH settlements are a moving target; this requires frequent monitoring to ensure there are no surprises at year-end
  - Additionally, although traditional Medicare settles at the end of each fiscal year, typically Medicare Advantage (MA) plans do not; if costs increase significantly within the fiscal year, absent an interim cost report filing, MA plans will continue to pay at the latest accepted Medicare cost report rate which will not reflect said cost increases resulting in potentially significant lost reimbursement
- **Best practice:** Monitor cost report settlement throughout the year using a developed model, and file an interim cost report as needed to ensure accurate reimbursement

BEST PRACTICES: UNDERSTANDING SERVICE MIX

- **Description:** CAHs that are actively evaluating the needs of their community often make service line changes, which impact reimbursement based on how these changes are handled on the cost report
- **Potential Issue:** When estimating reimbursement changes through the year, an overreliance on the prior year as a base point may result in inaccurate estimates
  - Just because something was the case last year doesn't mean it will be this year!
- **Best practice:** When tracking reimbursement throughout the year via interim cost reporting, ensure any current-year changes in services are reflected accurately

BEST PRACTICES: INCORPORATING AUDIT FINDINGS

- **Description:** CAH cost reports are subject to audits and desk reviews by local MACs
- **Potential Issue:** Given the amount of time between cost report filings and the audit or desk review of that cost report, it is possible to carry on practices that can generate MAC scrutiny for an extended time before realizing there is an issue
  - This may have implications when it comes to setting adequate reserves and potentially lead to surprises come audit time
- **Best practice:** Look to incorporate applicable audit findings into future cost report years, and when audit adjustments occur, understand their relevance (or lack thereof) to other cost report filings

BEST PRACTICES: COST REPORT REVIEWS

- **Description:** CAHs are required to file an annual Medicare cost report based on the CAH's fiscal year-end, and attest to the accuracy of the information presented in the cost report
- **Potential Issue:** The cost report is complex, with hundreds of calculations required, and ties to many regulatory references
  - Given the complexity of completing a cost report, there are plenty of opportunities for errors and inconsistencies; although certain preparation software helps to mitigate the risk of errors there are still many areas that can be missed
- **Best practice:** Ensure a multi-tiered review (internal or external) of the Medicare cost report ***before filing***

BEST PRACTICES: COST REPORT REVIEWS

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-246,466	-97,787	0	-1,044,136	1.00
2.00	SUBPROVIDER - IPF	0	2,841	-14		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-96,824	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-340,449	-97,801	0	-1,044,136	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 674 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
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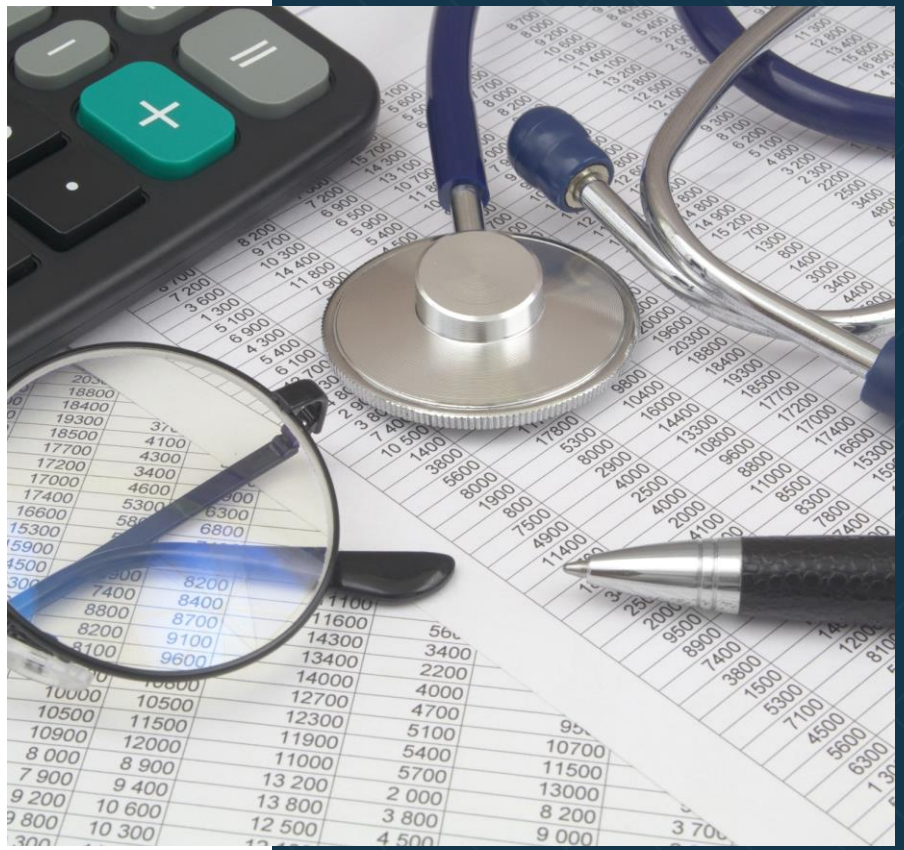
COMMON REIMBURSEMENT OPPORTUNITIES

COMMON REIMBURSEMENT OPPORTUNITIES

- Medicare Bad Debts
- Overhead Cost Allocation Statistics
- Related Party Cost Allocations
- Physician Stand-by Costs in the Emergency Department (ED)
- Provider-Based Rural Health Clinic (RHC) Data Reporting



COMMON REIMBURSEMENT OPPORTUNITIES: **MEDICARE BAD DEBTS**

General Principle

42 CFR 413.89(d): ".. the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs."

- Reasonable collection effort (defined in the regulation)
- Debt was uncollectible, *and claimed as uncollectible*, within the period it was deemed worthless
  - Often involves having a bad debt returned from a collection agency
- Sound business judgment established no likelihood of recovery
- Excludes physician professional services

Opportunity

Often hospitals do not track Medicare Bad Debts or record them on the cost report (Medicare reimburses **65%** of total allowable Medicare Bad Debts)

Hospitals frequently do not maintain adequate documentation that withstands the test of audit, resulting in bad debt disallowance

Hospitals frequently do not prepare bad debt listings in the proper format, resulting in rework and potential disallowance of Medicare bad debts

COMMON REIMBURSEMENT OPPORTUNITIES: **MEDICARE BAD DEBTS**

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: [redacted] | Period: From [redacted] To | Worksheet E-3 Part V Date/Time Prepared: 4/21/2023 2:27 am

Title XVIII | Hospital | Cost

	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,985,923	19.00
20.00	Deductibles (exclude professional component)	339,511	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,646,412	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,646,412	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	153,172	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	99,562	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	129,003	27.00

COMMON REIMBURSEMENT OPPORTUNITIES: **MEDICARE BAD DEBTS**

Health Financial Systems [redacted]			In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: [redacted]	Period: From [redacted] To	Worksheet E Part B Date/Time Prepared: 4/21/2023 2:27 am
	Title XVIII	Hospital	Cost

	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0
34.00	Allowable bad debts (see instructions)	669,095
35.00	Adjusted reimbursable bad debts (see instructions)	434,912
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	463,641

COMMON REIMBURSEMENT OPPORTUNITIES: **MEDICARE BAD DEBTS**

Solution

Ensure all bad debts are properly tracked and that collection efforts have truly ceased (including efforts by collection agencies!)

Prepare bad debt listings in the prescribed CMS format

Ensure proper documentation is maintained; Medicare Administrative Contractors (MACs) frequently audit Medicare bad debts

COMMON REIMBURSEMENT OPPORTUNITIES: **OVERHEAD COST ALLOCATION STATISTICS**

General Principle

Hospitals are required to allocate overhead costs to non-overhead cost centers on the Medicare cost report

Hospitals must follow Medicare principles for reimbursement when allocating overhead cost

- 42 CFR 413.24(a): "Providers receiving payment on the basis of reimbursable cost must provide adequate cost data…The cost data must be based on an approved method of cost finding and on the accrual basis of accounting…"

Opportunity

Though there are prescribed methods of cost allocation (cost finding), CAHs can request changes to current cost allocation methodologies that more appropriately reflect overhead utilization by department

Many hospitals utilize methods of cost finding that have no direct correlation with actual overhead usage and do not proactively work with their MAC to propose an alternative methodology

Using an inappropriate allocation method has several risks, including the potential overallocation of overhead costs to non-reimbursable cost centers (e.g., gross charges for medical records overhead cost)

Additional issues: double counting, exclusion of information, etc.

COMMON REIMBURSEMENT OPPORTUNITIES: **OVERHEAD COST ALLOCATION STATISTICS**

Solution

Thoroughly review cost allocation methodologies at least annually to ensure they make sense

Ensure cost is not double counted between direct costing and overhead cost allocations

Work with cost report preparer and local MAC to request methodology change if favorable based on analysis

COMMON REIMBURSEMENT OPPORTUNITIES: **RELATED PARTY COST ALLOCATIONS**

General Principle

Costs of services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations

- Cost allocations are often made through a Home Office Cost Statement prepared by the related organization; this structure is very common with CAHs that are members of a healthcare system

Opportunity

Significant variation in the treatment of related party costs throughout the industry

- Often, CAHs do not proactively work with related party organizations to ensure cost allocations from the Home Office are accurate
- Often, related party organizations do not completely understand the reimbursement implications of cost allocations to CAHs

Solution

Partner with related party organization to develop reasonable cost allocations

COMMON REIMBURSEMENT OPPORTUNITIES: **RELATED PARTY COST ALLOCATIONS**

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: [redacted] | Period: From [redacted] To [redacted] | Worksheet A-8-1 | Date/Time Prepared: 4/21/2023 2:27 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE MANAGEMENT	702,558	808,466	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	C SUITE PAYROLL TAXES	-26,518	0	2.00
3.00	14.00	CENTRAL SERVICES & SUPPLY	HPG PURCHASING	10,678	20,934	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	117,961	172,096	4.00
4.01	60.00	LABORATORY	SUMNER LAB EXPENSES	212,613	212,613	4.01
4.02	58.00	MRI	SUMNER RADIOLOGY	7,492	7,492	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	REGIONAL HR	21,995	21,995	4.03
4.04	15.00	PHARMACY	REGIONAL HR	59,805	59,805	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	REMOTE CODER ALLOCATION	50,117	50,117	4.05
4.06	113.00	INTEREST EXPENSE	HOME OFFICE INTEREST	0	5,921	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,156,701	1,359,439	5.00

COMMON REIMBURSEMENT OPPORTUNITIES:
PHYSICIAN STAND-BY/ON-CALL COSTS IN THE EMERGENCY DEPARTMENT (ED)

General Principle

Provider Reimbursement Manual 2109: "When ED physicians are compensated on an hourly or salary basis, or under a minimum guarantee arrangement, providers may include a reasonable amount in allowable costs for ED physician availability services..."

Certain Requirements

- No feasible alternative to obtaining physician coverage
- Immediate response to life-threatening emergencies
- Documentation
- Subject to RCE limits

Provider time spent delivering patient care is not allowable on the Medicare cost report

Opportunity

Often hospitals underestimate applicable stand-by time, resulting in suboptimal reimbursement

Solution

Perform ED provider time studies, or utilize alternative MAC-approved time measurement option to ensure reported time is accurate, such as electronic solutions

COMMON REIMBURSEMENT OPPORTUNITIES:
PHYSICIAN STAND-BY/ON-CALL COSTS IN THE EMERGENCY DEPARTMENT (ED)

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN [redacted] | Period: From To [redacted] | Worksheet A-8-2 | Date/Time Prepared: 7/22/2021 11:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	644,291	644,291	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	9,974	9,974	0	0	0	2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	293	293	0	0	0	3.00
4.00	90.00	AGGREGATE-CLINIC	229,666	229,666	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	1,924,399	1,411,739	512,660	0	0	5.00

COMMON REIMBURSEMENT OPPORTUNITIES:
PROVIDER-BASED RURAL HEALTH CLINIC (RHC) REPORTING

General Principle

Provider-based RHCs are paid an all-inclusive rate (AIR) for qualified services; total allowable cost is divided by a visit count (see right) to calculate the AIR which is used to reimburse for Medicare visits

The Medicare cost report calculates a minimum number of visits per provider type (MD, PA NP, Other) based on productivity standards which are compared to actual visits in the provider-based RHC and used in the AIR calculation

- Standard productivity amounts (4,200 visits per physician FTE, 2,100 visits per non-physician practitioner FTE)

Opportunity

If actual visits are less than the minimum productivity standard, the AIR is calculated based on the minimum number of visits

- Example: Total RHC Allowable Cost = $1M, Actual RHC Visits = 2,000, Minimum Productivity Standard = 3,000
  - Reimbursable Cost per Visit = $333.33 ($1M / 3,000)

Often hospitals do not accurately calculate provider FTE counts and/or visit totals

- Provider FTE and visit counts should be developed to include only RHC services; administrative, vacation, hospital rounding, etc. should not be included

COMMON REIMBURSEMENT OPPORTUNITIES
PROVIDER-BASED RURAL HEALTH CLINIC (RHC) REPORTING

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: [redacted] Component CCN: [redacted] | Period: From [redacted] To [redacted] | Worksheet M-2 Date/Time Prepared: 4/28/2021 1:54 pm

					RHC I	Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.22	7,758	2,200	7,084		1.00
2.00	Physician Assistant	1.80	4,659	2,000	3,600		2.00
3.00	Nurse Practitioner	0.20	556	2,000	400		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.22	12,973		11,084	12,973	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.22	12,973			12,973	8.00
9.00	Physician Services Under Agreements		0			0	9.00

COMMON REIMBURSEMENT OPPORTUNITIES:
PROVIDER-BASED RURAL HEALTH CLINIC (RHC) REPORTING

Solution

Review provider FTE and visit counts for accuracy, ensuring time for non-RHC services is appropriately removed

Work with clinic managers when applicable to verify the accuracy and reasonableness of reports

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THANK YOU

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