COST REPORTS, REIMBURSEMENT, AND STRATEGIES

IOWA HFMA TRACK – SESSION W2

October 5, 2022 – 10:15 am

EideBailly

CPAs & BUSINESS ADVISORS

PRESENTER

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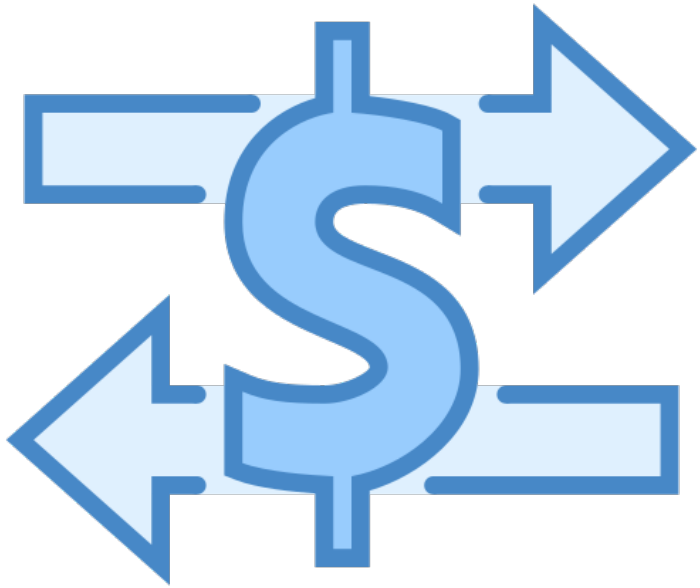
AGENDA

- Cost Report Overview
- Patient Days and Cost Per Day
- Expenses
  - Emergency room
  - Hospitalists
- Overhead Expense Allocation
- Rural Health Clinics
- Medicare Bad Debts
- Other

COST REPORT OVERVIEW

COST REPORT OVERVIEW

1. Determine provider settlements and set reimbursement rates
   - Applies to PPS and PPS exempt providers (Example – CAHs)
2. Used by CMS to develop databases
3. Used by outside entities to evaluate hospitals
   - State agencies, commercial insurers, research organizations, governments, peers/competitors
4. Due 5 months after fiscal year end
5. Subject to annual audits by Medicare Administrative Contractors (MAC)
   - Wisconsin Physician Services (WPS)



COST REPORT OVERVIEW

Cost Reimbursement Explained

Formula	Principle
Hospital Costs	Allowable Costs Related to Patient Care
÷ Hospital Units of Service	Consistent Charge Structure for all Payors
= Cost Per Unit	Cost to Charge Ratio / Per Diem
x Medicare Units of Service	Medical Necessity
= Medicare Costs / Reimbursement	

COST REPORT OVERVIEW

Cost Reimbursement Further Defined

Room & Board	Ancillary	Cost Report Worksheet
Direct Costs	Direct	A
+ Overhead Costs	+ Overhead Costs	B
= Total Department Costs	= Total Department Costs	
÷ Total Patient Days	÷ Revenues	C & D-1
= Per Diem Costs	= Cost to Charge Ratio	
X Medicare Days	X Medicare Revenue	D-1, D-3 & D, V
= Medicare Costs	= Medicare Costs	D-1, D-3 & D, V
- Deductibles/Coinsurance	- Deductibles/Coinsurance	E Series
= Net Due From Medicare	= Net Due From Medicare	E Series

COST REPORT OVERVIEW

Cost Reimbursement - Example #1

		Routine	Ancillary
	Hospital Costs	$1,000,000	$2,000,000
÷	Hospital Units of Service	2,000	5,000,000
=	Cost Per Diem/Charge	$500.00	40.00%
x	Medicare Units of Service	1,400	2,000,000
=	Medicare Costs/Reimbursement	$700,000	$800,000
	Total Medicare Reimbursement		$1,500,000

Assumptions: Medicare Utilization = 70%: Inpatient

Medicare Utilization = 40%: All Ancillary Services

COST REPORT OVERVIEW

Cost Reimbursement - Example #2

		Routine	Ancillary
	Hospital Costs	$1,000,000	$2,000,000
÷	Hospital Units of Service	1,600	4,000,000
=	Cost Per Diem/Charge	$625.00	50.00%
x	Medicare Units of Service	1,120	1,600,000
=	Medicare Costs/Reimbursement	$700,000	$800,000
	Total Medicare Reimbursement		$1,500,000

Assumptions: Patient Volumes Decrease by 20% Including Medicare

Comment: Medicare Utilization Stays the Same. (1,120/1,600 = 70%)

PATIENT DAYS AND COST PER DAY

Are you accurately tracking patient days for cost reporting purposes?

- Acute Days
- Swingbed SNF Days (Medicare + Adv)
- Swingbed NF Days (All other)
- Nursery Days
- Observation Hours (Equivalent Days)
- Labor/Delivery Days

Where do the days you are providing for cost report come from?

Internal manual statistics	Statistical report from EHR	Revenue/Usage report

Imperative that days are reported properly!

COST PER DAY CALCULATION

Acute costs (direct + indirect)		5,700,000
Less: Swing Bed NF Expense		
Swing Bed NF Days	320	
NF Rate	200	
NF Expense		64,000
		5,636,000
Acute days	1,300	
Swing Bed Medicare days	2,050	
Swing Bed Medicare Advantage days	200	
Observation equivalent days (Hrs / 24)	300	
Total days		3,550
Acute cost per day		1,588

SWINGBED DAYS - ISSUE

- Variance between Medicare PSR (paid days) and internal stat Medicare swingbed days.
- Were the days really Medicare, Medicare advantage or NF days?
- Which cost report line?

COST PER DAY – 100 DAYS EXAMPLE

		Incorrect		Correct
Acute costs (direct + indirect)		5,700,000		5,700,000
Less: Swing Bed NF Expense				
Swing Bed NF Days	320		220	
NF Rate	200		200	
NF Expense		64,000		44,000
		5,636,000		5,656,000
Acute days	1,300		1,300	
Swing Bed Medicare days	2,050		2,150	
Swing Bed Medicare Advantage days	200		200	
Observation equivalent days (Hrs / 24)	300		300	
Total days		3,550		3,650
Acute cost per day		1,588		1,550
Acute Medicare days	975		975	
Swing Bed Medicare days	2,050		2,150	
		3,025		3,125
Medicare reimbursement		**4,802,507**		**4,842,466**

EXPENSES

CODING OF EXPENSES

- Imperative to code expenses properly on general ledger to ensure proper reimbursement
- Why? Each department has its own Medicare utilization percentage that is cost reimbursed
- Largest expense for most hospitals is labor, very important to ensure wages are in correct departments for the revenue being generated:
  - Clinics
  - Labor/Delivery/Nursery/OB
  - Emergency Room
- Easier if all labor is coded to correct department on general ledger rather than doing reclassifications on cost report

CODING OF EXPENSE

Cost to Charge Ratio – Impact of expense to reimbursement

Base Line	Radiology
Direct Cost (WS A)	790,000
Depreciation (WS B Part I)	56,700
Benefits (WS B Part I)	100,810
A&G (WS B Part I)	187,381
Plant (WS B Part I)	55,296
Laundry (WS B Part I)	18,211
Housekeeping (WS B Part I)	23,242
Cafeteria (WS B Part I)	31,522
Med Records (WS B Part I)	143,566
Total Costs	1,406,728
Total Charges (WS C)	5,500,000
Cost to Charge Ratio	.2557

Base Line	Radiology
Medicare IP Charges (WS D-3)	300,000
Medicare SB Charges (WS D-3)	15,000
Medicare OP Charges (WS D Pt V)	2,300,000
Total Medicare Charges	2,615,000
Cost to charge ratio	.2557
Medicare Costs	668,656
Medicare Utilization	.476

CODING OF EXPENSE

Cost to Charge Ratio – Add $100K of expense

Base Line	Radiology
Direct Cost (WS A)	890,000
Depreciation (WS B Part I)	56,700
Benefits (WS B Part I)	100,810
A&G (WS B Part I)	193,421
Plant (WS B Part I)	55,296
Laundry (WS B Part I)	18,211
Housekeeping (WS B Part I)	23,242
Cafeteria (WS B Part I)	31,522
Med Records (WS B Part I)	143,566
Total Costs	1,512,768
Total Charges (WS C)	5,500,000
Cost to Charge Ratio	.275

Base Line	Radiology
Medicare IP Charges (WS D-3)	300,000
Medicare SB Charges (WS D-3)	15,000
Medicare OP Charges (WS D Pt V)	2,300,000
Total Medicare Charges	2,615,000
Cost to charge ratio	.275
Medicare Costs	719,125
Medicare Utilization	.476

Reimbursement increased $50,469 on added cost of $106,040 (47.6%)

ALLOWABLE VS. NONALLOWABLE

Worksheet A-8-2: Provider-Based Physician Adjustments

- Provides for the computation of the allowable provider-based physician cost incurred
- Claim as allowable costs if:
  - Physician services that benefit the general patient population of the provider or
  - Availability services in the ER

WORKSHEET A-8-2

In what situations are costs (wages/benefits) paid to a physician or advanced practice provider an allowable cost on our Medicare cost report?

1. Provider-based Rural Health Clinic? (Yes)
2. Provider-based Clinic? (Possibly)
3. Freestanding Clinic (Possibly)
4. Emergency Room Availability? (Yes)
5. Medical Director? (Yes)
6. On-call Surgeon? (No)
7. On-call OB practitioner(s)? (No)
8. Hospitalists? (Possibly)
9. Radiologists? (No)
10. Readings of Sleep Studies or EKGs? (No)

ER STANDBY

- ❑ Medicare will share in cost of ER standby time for ER practitioners
- ❑ Don't need to be onsite, must arrive within 30 minutes
- ❑ Can't be on-call or providing services elsewhere

TIP - Would expect ER professional component (face to face time + dictation) to have a range of around 10% to 40% in most CAH facilities.

ER TRACKING OPTIONS

- Time study – MACS have varying requirements
  - Two, two-week time studies
  - Four, two-week time studies, one each quarter
  - One week per month, alternating weeks
  - Physicians may do two, two weeks, but advanced practice providers one-week per month, rotating weeks
- Provider logs
  - By hand or EMR system
- Worst option – Patient admission time/date and discharge time/date

EXAMPLE ER TIME STUDY/LOG

Be able to identify to patient ID

Time practitioner with patient

Documentation time

Time study signed by practitioner

Month:	January			ER Availability Time Study - Midlevel and Physician (1 Wee						
Week:	1									
Date	Patient ID	Admit Time	Discharge Time	With Patient Start	With Patient End	Total Patient Time	Documentation Begin	Documentation End	Documentation Time	Total Patient Time
1/1/2018	123456	1:10 AM	2:15 AM	1:30	2:00	0:30	2:00	2:15	0:15	0:45
1/1/2018	123457	3:30 AM	4:50 AM	3:45	4:30	0:45	5:20	5:45	0:25	1:10
1/1/2018	123458	4:00 AM	5:30 AM	4:45	5:15	0:30	5:00	5:20	0:20	0:50
1/1/2018	123459	5:45 AM	6:35 AM	6:00	6:25	0:25	6:30	6:45	0:15	0:40
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
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						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00

HOSPITALIST

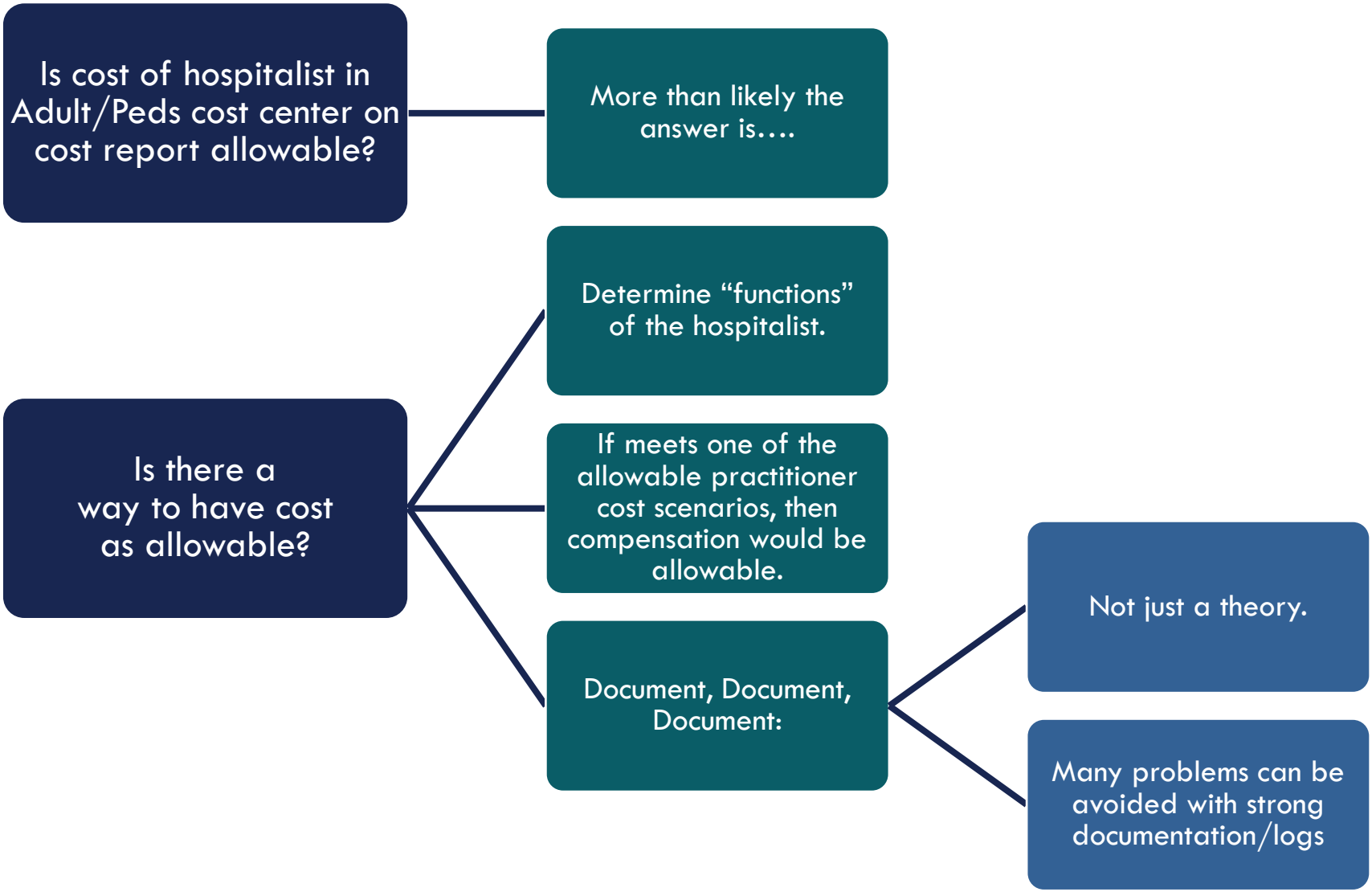
(Definition): *a physician who specializes in treating hospitalized patients of other physicians in order to minimize the number of hospital visits by other physicians.*

~ Merriam-Webster

Services we see hospitalists providing in CAHs:

1. Inpatient visits
2. Swingbed visits
3. Observation visits
4. Emergency room visits
5. Administrative duties

HOSPITALIST



OVERHEAD EXPENSE ALLOCATION

OVERHEAD EXPENSE ALLOCATION

Purpose

- Allocate overhead cost center costs to revenue producing cost centers **and** non-reimbursable cost centers

Process

- Allocate overhead costs via "Step Down“ method
- Allocated based on "statistics" by department

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					
5.00	00500	ADMINISTRATIVE & GENERAL	2,871,798				
7.00	00700	OPERATION OF PLANT	169,450	1,032,351			
8.00	00800	LAUNDRY & LINEN SERVICE	27,765	88,996	258,149		
9.00	00900	HOUSEKEEPING	49,782	53,397	13,369	370,057	
10.00	01000	DIETARY	80,039	17,799	891	7,401	513,718
11.00	01100	CAFETERIA	0	0	0	0	314,522
13.00	01300	NURSING ADMINISTRATION	27,015	8,900	0	3,701	0
14.00	01400	CENTRAL SERVICES & SUPPLY	56,976	53,397	0	22,203	0
16.00	01600	MEDICAL RECORDS & LIBRARY	85,714	35,598	0	14,802	0
17.00	01700	SOCIAL SERVICE	15,296	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	88,368	0	0	0	0

OVERHEAD EXPENSE ALLOCATION

General Service Cost Center	Typical Basis of Allocation	Other Common Basis
Capital Building & Fixtures	Square Feet	Direct Cost
Capital Equipment	Square Feet	Direct Cost
Employee Benefits	Gross salaries	
Administration & General	Accumulated Costs	
Operation of Plant	Square Feet	Time Study
Laundry/Linen	Pounds of Laundry	
Housekeeping	Square Feet	Time Study
Dietary	Meals served	
Cafeteria	FTE's	
Nursing Administration	Direct Nursing Hours	
Central Supply	Cost Requisitions	
Medical Records	Revenues	Time Study
Social Services	Time Spent	
Non-physician Anesthetists	Assigned Time	

OVERHEAD EXPENSE ALLOCATION

Best Practices -

- Review each allocation method (stat) on top of worksheet B-1
- Review costs allocated to non-reimbursable cost centers and low Medicare utilizing cost centers on worksheet B Part 1
- Do they make sense?

Consider -

- Elect a new allocation method (stat)
- Fragment columns
  - Depreciation
  - Administrative and general
  - Others

OVERHEAD EXPENSE ALLOCATION

Extreme Example – Multiple non-cost based reimbursable cost centers. Takes planning and a detailed trial balance.

Cost Center	Stat	Why?
Building Depreciation – Hospital	Hospital square footage	
Building Depreciation – LTC	LTC square footage	
Building Depreciation – Wellness Center	Wellness square footage	
Equipment Depreciation	Actual depreciation	
A&G – Patient Accounting – Hospital	Hospital revenue	
A&G – Patient Accounting – LTC	LTC revenue	
A&G – Information Technology	Number of devices	
A&G – All Other	Accumulated cost	
Plant – Hospital (direct utilities)	Hospital square footage	
Plant – LTC (direct utilities)	LTC square footage	
Plant – Wellness Center (direct utilities)	Wellness square footage	
Maintenance	Time study – Tickets	
Housekeeping	Time study – Direct time	
Dietary – Hospital	Meals	
Dietary – LTC (direct expense)	Meals	

RURAL HEALTH CLINICS

RHC – UPPER PAYMENT LIMITS

- Rural Health Clinics (RHC) paid based on cost per visit

Clinic Type	Technical Component	Professional Component
Free Standing	Fee Schedule	Fee Schedule
Provider Based	Cost Based	Fee Schedule
Provider Based (PB) RHC	Cost Based*	Cost Based*

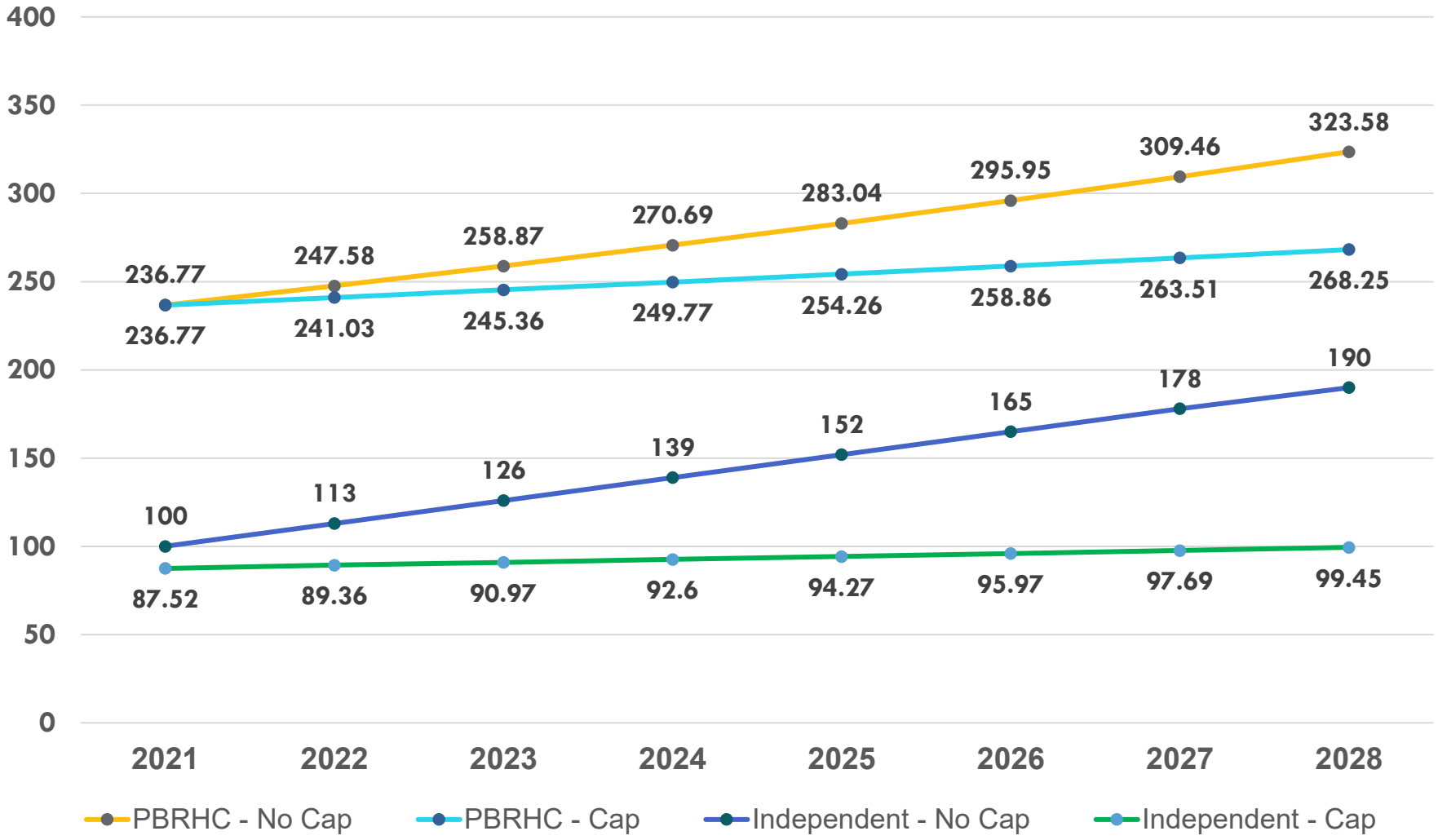
- PBRHC - Subject to provider productivity limits

Provider Type	Productivity Standard
Doc	4,200 visits per FTE
Midlevel	2,100 visits per FTE

- Effective 4/1/2022
  - Upper payment limit caps for grandfathered PBRHC to a hospital with less than 50 beds
  - Increased rates for independent RHC or PBRHC to a hospital with more than 50 beds

RHC – UPPER PAYMENT LIMITS

NARHC – Projected Rates Under Current and New Law



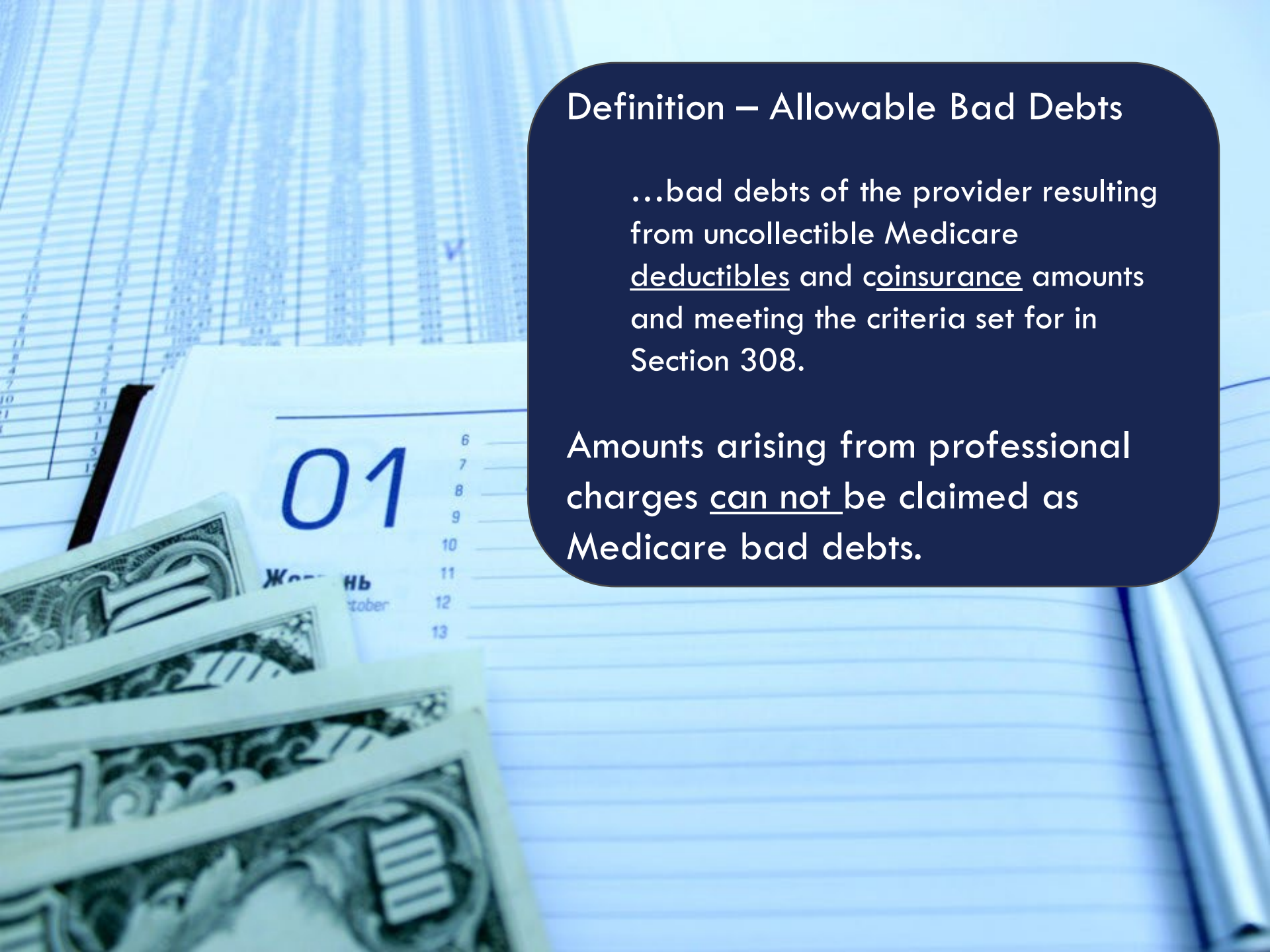
RHC – UPPER PAYMENT LIMITS

Review provider productivity

Review the types of services being provided in the RHC setting

Review overhead expense allocation methods

MEDICARE BAD DEBTS



Definition – Allowable Bad Debts

> …bad debts of the provider resulting from uncollectible Medicare deductibles and coinsurance amounts and meeting the criteria set for in Section 308.

Amounts arising from professional charges can not be claimed as Medicare bad debts.

IN ORDER TO QUALIFY, BAD DEBT MUST…

The debt must be related to covered services and derived from deductible and coinsurance amounts.

The provider must be able to establish that reasonable collection efforts were made.

The debt was actually uncollectible when claimed as worthless.

Sound business judgment established that there was no likelihood of recovery at any time in the future.

Exhibit 2

Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________________

Prov. Number____________________

FYE ____________________

Prepared By ____________________

Date Prepared ____________________

Inpatient ____________________ Outpatient ____________________

SNF ____________________ RHC____________________

(1) Patient Name	(2) HIC NO.	* (3) Dates of Service		(4) Indigency & Wel. Recip (ck if apply)		(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
		From	To	Yes	Medicaid #						
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ISSUES WE SEE

- Timely billing from date of discharge/service – 90 or 120?
- Cease collection effort date in wrong period.
- Cease collection effort date less than 120 days from date of first bill.
- Cease collect date is when account is returned back to provider from collection agency.
- Professional amounts included.

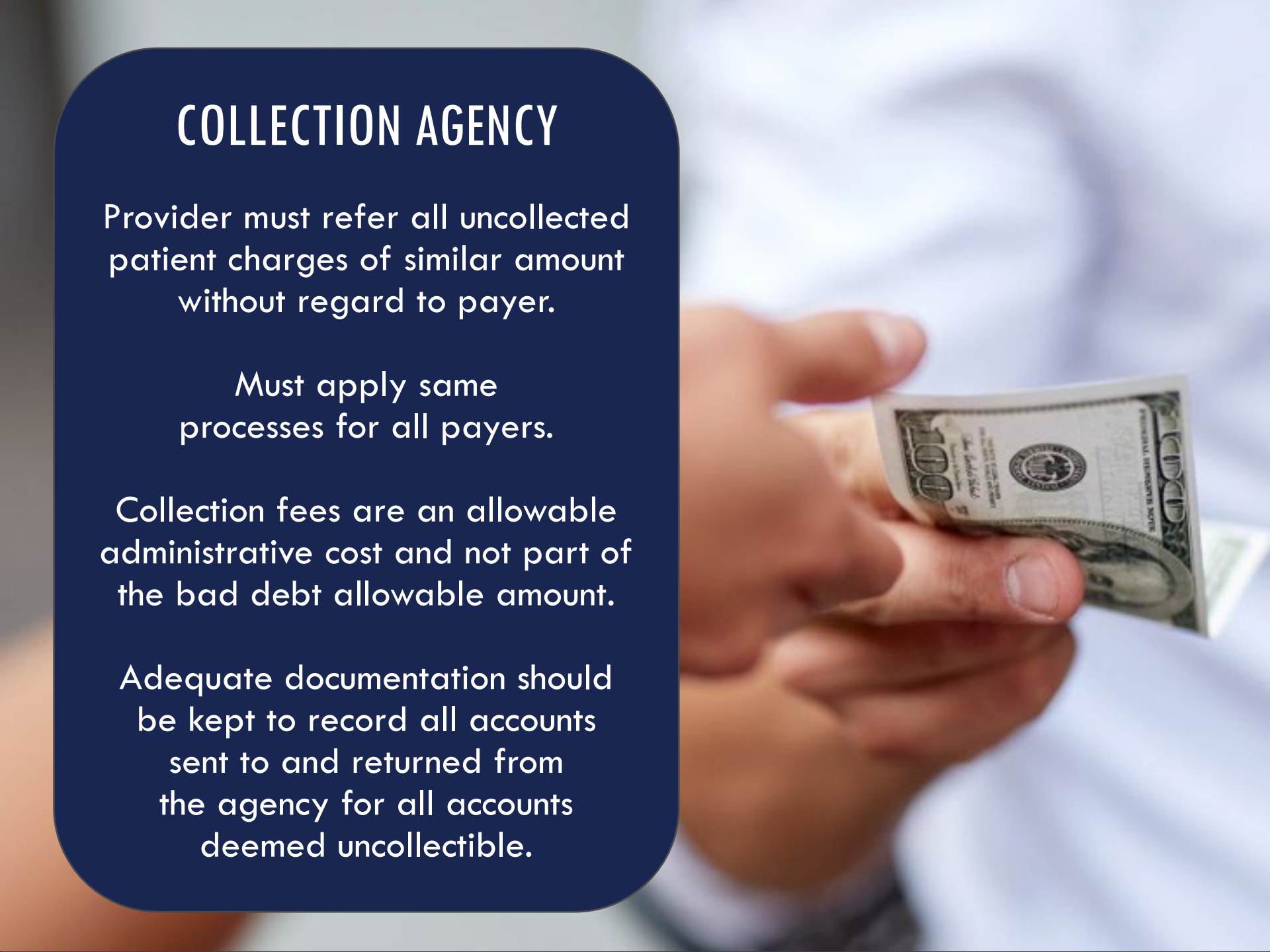
COLLECTION AGENCY

Provider must refer all uncollected patient charges of similar amount without regard to payer.

Must apply same processes for all payers.

Collection fees are an allowable administrative cost and not part of the bad debt allowable amount.

Adequate documentation should be kept to record all accounts sent to and returned from the agency for all accounts deemed uncollectible.



QUESTIONS?

THANK YOU!

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