STROUDWATER

CAH COST REPORT BASICS, COMMON OPPORTUNITIES & BEST PRACTICES

OBJECTIVES

- Understand how cost reports impact Medicare rates for CAHs
- Understand the basic structure and flow of the Medicare cost report
- Review best practices for cost report preparation
- Identify common cost report opportunities for CAHs

IMPORTANCE OF THE MEDICARE COST REPORT

COST-BASED REIMBURSEMENT

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

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

THE MEDICARE COST REPORT IS IMPORTANT BECAUSE...

- It is used to:
  - True up Traditional Medicare reimbursement at the end of each fiscal year
  - Determine interim payment rates (both Traditional Medicare and Medicare Advantage)
- Some states utilize data from the Medicare cost report to determine Medicaid payment
- Serves as a data point for the government and other non-governmental organizations

COST REPORT MECHANICS

REIMBURSABLE COST

- **42 CFR 413.24(a)**
  - "**Principle.** Providers receiving payment on the basis of reimbursable cost must provide **adequate cost data**. This must be based on their financial and statistical records which must be **capable of verification by qualified auditors**. The cost data must be based on an **approved method of cost finding** and on the accrual basis of accounting

COST REPORT MECHANICS

- Organizational costs are grouped (sometimes referred to as “mapped”) into **cost centers** designated by the Center for Medicare and Medicaid services (CMS)
  - Costs are then reclassified and adjusted based on Medicare regulations and guidance (not all costs are considered reimbursable by Medicare)
  - Overhead costs are allocated, or “stepped down”, to other cost centers
    - The resulting cost by cost center (“full allocated cost”) is used in calculation of Medicare payments for a CAH
- Organizational gross charges (not including professional) are similarly mapped to all revenue generating departments
  - CAHs may need to reclassify gross charges depending on how their GL is structured; unlike costs, these reclassifications are not shown on the cost report

COST REPORT MECHANICS (CONT.)

- Inpatient and swing payment basis:
  - Average cost per day (i.e., Inpatient cost per diem) = routine costs/total days
    - If a CAH operates a distinct ICU, separate cost per day is calculated
  - Medicare costs = Medicare days * Avg. cost per day
- Inpatient ancillary and outpatient:
  - Cost to Charge Ratio (CCR) = Total Costs/Total Charges
    - Calculated by cost center (i.e., department)
  - Medicare Costs = Medicare Charges X CCR
- Settlement = Program Costs – Deductibles & Coinsurance – Interim Payments

COST REPORT MECHANICS (CONT.)

- Key worksheets:
  - Worksheet S-3, Part I
  - Worksheet A
  - Worksheet B, Part I & B, Part II
  - Worksheet C
  - Worksheet D, Part V
  - Worksheet D-1
  - Worksheet D-3
  - Worksheet E, Part B
  - Worksheet E-2
  - Worksheet E-3, Part V

COST REPORT MECHANICS (CONT.)

- Worksheet S-3, Part I: Hospital Statistical Data (pgs. 3 – 5)
  - Purpose: Accumulate key statistical information such as:
    - Hospital Beds
    - Bed Days available
    - Patient Days (Med/Surg, Swing Bed, ICU, Observation, Other)
    - Patient Discharges
    - Rural Health Clinic (RHC) visits, if applicable
    - Home Health Agency (HHA) visits, if applicable
    - Other information

COST REPORT MECHANICS (CONT.)

- Worksheet S-3, Part I: Hospital Statistical Data (pgs. 3 – 5)
  - Payer categories
    - Title XVIII: Traditional Medicare
    - Title XIX: Medicaid

COST REPORT MECHANICS (CONT.)

- Worksheet A: Departmental Expenses (pgs. 8 - 9)
  - Attribute direct expenses (salary and non-salary) to cost centers (i.e., departments)
  - Reclassifications and adjustments to comply with Medicare cost finding principles and program requirements
    - A-6 Reclassifications between departments (pgs. 10 - 13)
      - Match revenue with expenses
    - A-8 Adjustments
      - A-8 Expenses not related to patient care (pgs. 14 - 15)
      - A-8-1 Related Party Adjustments (pg. 16)
      - A-8-2 Provider-based physician adjustments (pg. 17)
      - A-8-3 Reasonable Cost for Therapy Provided by Outside Suppliers (pgs. 18 - 19)

COST REPORT MECHANICS (CONT.)

- Worksheet B-1: Cost Allocation – Statistical Basis (pgs. 24 - 27)
  - Purpose: Used to accumulate the statistics needed to allocate costs on worksheet B, Part I
  - Values are stated based on statistical unit, such as square feet, pounds of laundry, meals served, time spent, etc.
    - Medicare allows for most accurate methodology (you can request changes to methodology!)
    - Reasonableness checks are needed
- Worksheet B, Part I: Cost Allocation – General Service (pgs. 20 - 23)
  - Purpose: Allocates costs from overhead departments to non-overhead departments based on statistics entered on Worksheet B-1
  - Values are all stated in terms of dollars
    - Starts with values from Worksheet A

COST REPORT MECHANICS (CONT.)

- Worksheet C: Computation of CCRs (pgs. 28 - 29)
  - Purpose: Used to accumulate gross charges (excluding professional) by cost center for the purposes of calculating Medicare CCRs
    - Fully-allocated cost is pulled from Worksheet B, Part I

COST REPORT MECHANICS (CONT.)

- Worksheet D, Part V: Outpatient costs (pgs. 30 - 31)
  - Purpose: Applies outpatient program ancillary department charges to CCRs to determine outpatient ancillary costs
- Worksheet D-1: Inpatient routine costs (pgs. 32 - 33)
  - Purpose: Determines inpatient routine costs per day
    - Acute (Med/Surg & ICU, if applicable), swing, and observation bed costs (outpatient)
- Worksheet D-3: Inpatient ancillary costs (pgs. 34 - 35)
  - Purpose: Applies inpatient program ancillary department charges to CCRs to determine inpatient ancillary costs
    - CAH
    - Swing-bed SNF

COST REPORT MECHANICS (CONT.)

- Worksheet E: Reimbursement Settlements
  - Worksheet E, Part B: Medical and Other Health Services (pg. 36)
    - Purpose: Compares interim outpatient payments with outpatient program costs, net of deductibles and coinsurance, and determines the amount due to, or from, the Medicare program
  - Worksheet E-2: CAH Swing Services (pg. 37)
    - Purpose: Compares interim payments with SB SNF costs, net of deductibles and coinsurance, and determines the amount due to, or from, the Medicare program
  - Worksheet E-3, Part V: CAH Inpatient Hospital Services (pg. 38)
    - Purpose: Compares interim payments with acute inpatient costs, net of deductibles and coinsurance, and determines the amount due to, or from, the Medicare program

COST REPORT MECHANICS (CONT.)

- Other worksheets
  - Worksheet G series (pgs. 39 – 42)
    - Hospital financial statements
  - Worksheet M series (pgs. 43-47)
    - Calculates reimbursement for any provider-based Rural Health Clinics (PB-RHCs)
    - PB-RHCs may be reported individually or consolidated

COMMON COST REPORT OPPORTUNITIES

COMMON COST REPORT OPPORTUNITIES

- Interim Cost Reporting/Cost Report Modeling
- Medicare Bad Debts
- Overhead Cost Allocation Statistics
  - Capital Costs
  - Administrative & General
  - Cafeteria
  - Medical Records
- Cost-to-Charge Ratio (CCR) Inconsistencies
- Related Party Cost Allocations
- Physician Stand-by time in the Emergency Department (ED)
- Provider-Based Rural Health Clinic (RHC) Data Reporting

INTERIM COST REPORTING/COST REPORT MODELING

- General Principle
  - Due to cost-based reimbursement, CAH payment rates can fluctuate, sometimes substantially year to year
  - Because CAHs receive a “true-up” payment from Medicare with the filing of the cost report, changes in rates often result in receivables from/payables to the Medicare program
- Opportunity
  - Often CAHs are surprised when filing their Medicare cost report about the receivable or payable
  - Use of a cost report model to estimate rates throughout the year can help CAHs:
    - Understand any fluctuations in rates due to operational changes
    - Book adequate reserves throughout the year
    - Determine if filing an interim cost report is favorable for payers that don’t “true-up” at year end (e.g., Medicare Advantage plans)

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
    - Determination of when a bad debt is considered uncollectible depends on the scenario of the patient
  - 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

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 [redacted] | 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

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

OVERHEAD COST ALLOCATIONS

- General Principle
  - 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…”
  - 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
- 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 or low-cost based departments (e.g., gross charges for medical records overhead cost)

OVERHEAD COST ALLOCATIONS

- Opportunity (cont.)
  - Common overhead allocation opportunities:
    - Capital Costs
      - Typical basis: Square Footage
      - Issue: Often inaccurate; no consistent square footage review despite operational changes
    - Administrative & General (A&G)
      - Typical basis: Accumulated Cost
      - Issue: Wide range of administrative functions reported within A&G; no direct correlation between costs and administrative oversight
    - Cafeteria
      - Typical basis: Employee Full-Time Equivalents (FTEs)
      - Issue: Not all employees utilize hospital cafeteria; often includes FTEs for employees who are located in a satellite facility, resulting in inaccurate cost allocations

OVERHEAD COST ALLOCATIONS

- Opportunity (cont.)
    - Medical Records
        - Typical basis: Gross charges
        - Issue: Disproportionately skews allocation to departments that have higher gross charges, but don't necessarily require significant time from medical records staff (e.g., Drugs Charged to Patients, Operating Room, etc.)
    - CAHs can request changes to their statistical basis for overhead cost allocations
        - Must submit requests to the Medicare Administrative Contractor (MAC) at least 90 days prior to the end of the reporting period
        - MAC will have 60 days to make a determination
        - Can't switch methodologies until approval is received from the MAC
    - Additional issues: double counting, exclusion of information, etc.

COST-TO-CHARGE RATIO (CCR) INCONSISTENCIES

- General Principle
  - Revenues and expenses must be in the same department to produce the correct CCR
  - Unreasonable values result from:
    - Charges in different department
    - Inadequate charge capture
    - Inappropriate allocation of overhead (e.g., within radiology)
    - No reclassification of staff costs

COST-TO-CHARGE RATIO (CCR) INCONSISTENCIES

- CCR Inconsistencies (continued)

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 51-0026 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 7/2(I WORKSHEET C PART I

WKST LINE	A NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	3,847,759		3,847,759			
26		INTENSIVE CARE UNIT	726,173		726,173			
33		NURSERY	666,552		666,552			
34		SKILLED NURSING FACILITY	774,020		774,020			
35		NURSING FACILITY						
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	774,220	1,395,667	2,169,887	.484608	.484608	.484608
38		RECOVERY ROOM	123,626	591,445	715,071	.490940	.490940	.490940
39		DELIVERY ROOM & LABOR ROO	139,299	1,176	140,475	1.473479	1.473479	1.473479
40		ANESTHESIOLOGY	221,274	465,830	687,104	.396931	.396931	.396931
41		RADIOLOGY-DIAGNOSTIC	648,662	2,096,734	2,745,396	.651949	.651949	.651949
41	01	CAT SCAN	730,749	4,087,291	4,818,040	.017962	.017962	.017962
41	02	NUCLEAR MEDICINE	65,645	580,672	646,317	.137344	.137344	.137344
41	03	MRI	147,365	2,341,324	2,488,689	.348036	.348036	.348036
42		RADIOLOGY-THERAPEUTIC						
43		RADIOISOTOPE						
44		LABORATORY	2,835,206	6,305,049	9,140,255	.223511	.223511	.223522
45		PBP CLINICAL LAB SERVICES						
46		WHOLE BLOOD & PACKED RED						
47		BLOOD STORING, PROCESSING						
48		INTRAVENOUS THERAPY						
49		RESPIRATORY THERAPY	2,163,298	222,920	2,386,218	.248671	.248671	.248671
49	01	CARDIAC REHABILITATION	14,338	195,069	209,407	.501392	.501392	.501392
50		PHYSICAL THERAPY	198,244	182,863	381,107	.962042	.962042	.962042
51		OCCUPATIONAL THERAPY	62,397	93,818	156,215	.618609	.618609	.618609
52		SPEECH PATHOLOGY						

COST-TO-CHARGE RATIO (CCR) INCONSISTENCIES

- CCR Inconsistencies (continued)
  - Opportunities
    - Evaluate CCRs against “critical values” typical to small, rural hospitals:
      - Operating Room: 0.6 – 0.8
      - Radiology and Lab: 0.2 - 0.4
      - Physical Therapy: 0.5 – 0.75
      - ER: 0.75 – 1.25
        - Professional fees excluded from Charges
    - Evaluate charge master
      - Formal external charge master review
      - Blue Cross fee schedule inflated by a certain %
      - Medicare APCs
    - Grow patient volume by working with physicians
    - Consider productivity incentives for physical therapists
    - Reduce expenses
      - Purchasing organizations, networks, etc.

RELATED PARTY COSTS

- 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

RELATED PARTY COSTS

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

PHYSICIAN STAND-BY TIME IN THE EMERGENCY DEPT (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 Reasonable Compensation Equivalent (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

PHYSICIAN STAND-BY TIME 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 [redacted] To | 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

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 to calculate the AIR which is used to reimburse for Medicare visits
  - "The FTE on the cost report for providers is the **time spent seeing patients** or **scheduled to see patients** and ***does not include administrative time***." - Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
  - Additionally, RHCs must count visits in accordance with in 42 CFR 405.2463(a) defining a visit

PROVIDER-BASED RURAL HEALTH CLINIC (RHC) REPORTING

- Opportunity
  - Often hospitals do not accurately calculate provider FTE counts and/or visit totals
    - Provider FTE and visit counts should be reviewed to ensure they align with regulation requirements
    - Reporting often not built around Medicare regulations, thus requiring manual intervention to get required data for an accurate cost report

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 | 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

Q&A