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**Hospital Cost Report Training**  
**Level II Critical Reimbursement Strategies // CAH Track**  
Dallas - Hilton Dallas/Southlake Town Square

JULY 28, 2016



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- Sign in before the session
- Remain present for the entire session
- If leaving early sign out indicating the time





# Cost Report Training - Level II

- Understand potential issues and opportunities with Medicare bad debts.
- Learn how to reconcile the Medicare cost report settlement and understand the various settlement components.
- Identify opportunities for hospitals to impact the key factors in PPS reimbursement including Medicare DSH, IME/GME, and the wage index. (PPS Track)
- Evaluate the unique challenges for Critical Access Hospital cost reporting. (CAH Track)



# Agenda

- General CAH information
  - Other issues impacting critical access hospitals
- Cost allocation statistics
  - Non-reimbursable & utilization by payer
- Emergency physician reimbursement
- Other physician compensation issues
- Medicare reimbursement for primary care

# CAH Overview and History





# General CAH information

- What is a CAH?
  - A hospital with a special Medicare designation
- When did the program start?
  - With old EACH/RPCH program (7 States) -
    - Essential Access Community Hospital
    - Rural Primary Care Hospital
    - Medical Assistance Facility – Montana demonstration project
  - BBA – 1997 created Rural Hospital Flexibility Program (RHFP)



# General CAH information

- Why RHFP (Flex Program)?
  - Encourages development of rural health networks
  - Offers grants to states to help implement CAH programs in broader initiatives to strengthen rural health care infrastructure
  - Allows hospitals some flexibility through higher Medicare payments to reconfigure operations



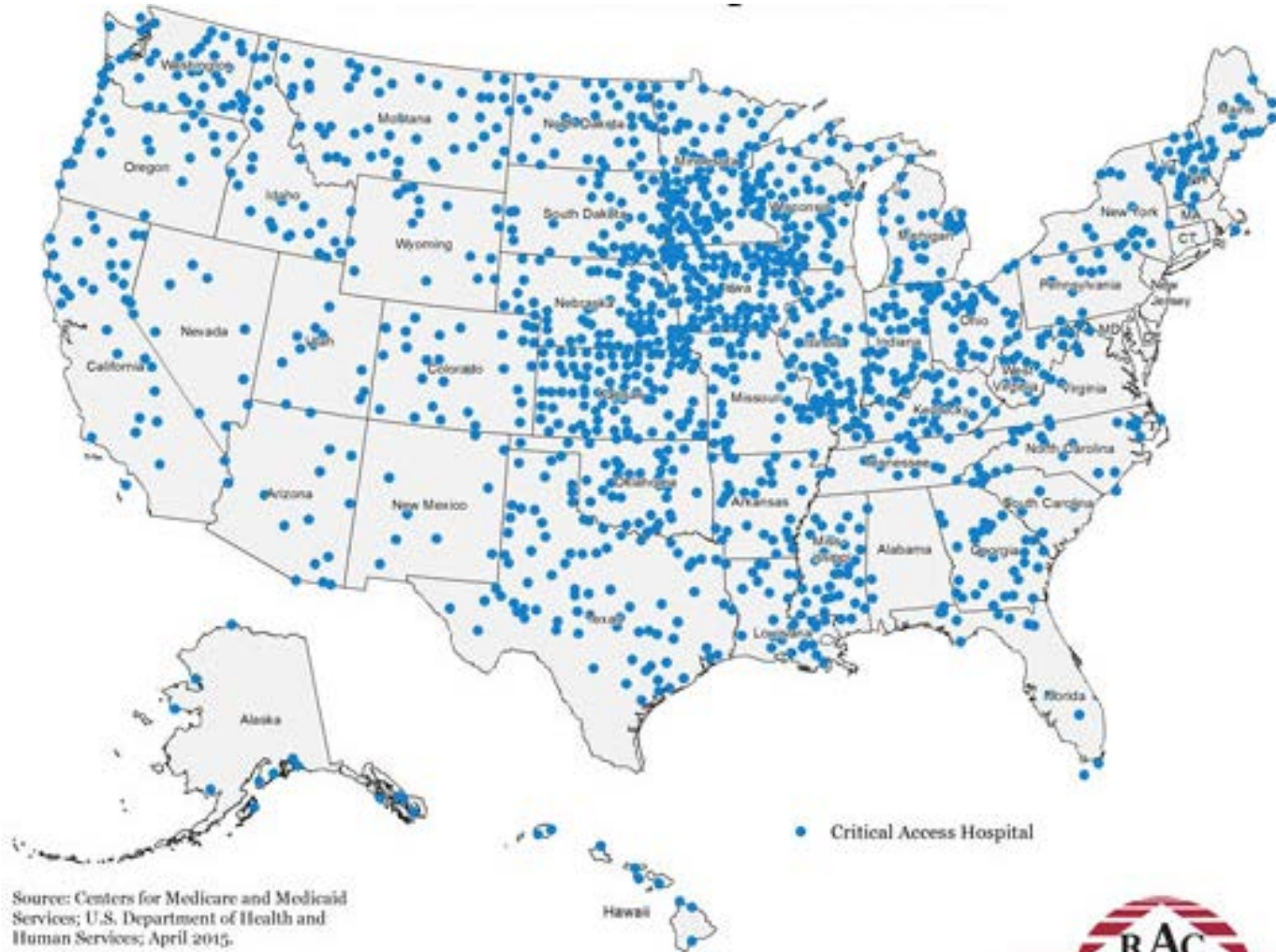


# General CAH information

- What makes it different?
  - Small
  - Usually rural (or in a rural area of an MSA)
  - Cost reimbursement for Medicare
  - Mandate for network affiliation



# Critical Access Hospitals (CAHs)





# CAH Requirements

- Mileage Restrictions –
  - 35 miles from nearest hospital, or
  - 15 miles via secondary road or mountainous terrain



# CAH Requirements

- Average Length of Stay
  - Average during fiscal year not to exceed 4 days
- Emergency services
- 25 total beds
  - Observation beds do not count in beds
    - Reference CMS State Operations Manual Appendix W



# Medicare Prescription Drug, Improvement and Modernization Act of 2003

- CAH Section 405:
  - 101% of cost
  - Covers cost of non-physician emergency on-call providers
  - PIP available for inpatient services



# Medicare Prescription Drug, Improvement and Modernization Act of 2003

- CAH Section 405 (continued):
  - Professional service adjustment (115%) applies only to those physicians who assigned billing rights to hospital
  - Bed limit increased to 25 – interchangeably acute/swing beds
  - Flex grant – applies to state grants
  - Psych & rehab units – allows distinct part units up to 10 beds not counting in 25 limit, payment based on respective PPS (not cost) – cost reports beginning on or after 10/1/04
  - Waiver of “necessary” designation by states – effective 1/1/06



# Affordable Care Act Provisions

- Made CAHs eligible to participate in the 340B Program
- Expanded Area Health Education Centers
- Provided more funding for the National Health Service Corps
  - Eligible provider types are primary care medical, dental and mental/behavioral health clinicians
  - Two-year work commitment at an approved NHSC site (high-need, underserved area)
  - Receive \$50,000 to repay student loan obligations
- Clarified requirements for Physician Certification of CAH Inpatient Services



# Observation Room

- Reimbursement is good - derived from adults and pediatrics
- Don't provide in ER cost center
- Problems
  - Computing observation room days
  - Days vs. revenues not always consistent year to year
  - Be sure to capture all procedure codes in estimating days





# Observation Beds

- CMS Memo #34 – Appendix W – State Operations Manual - 4/4/08
  - Clarified that observation beds (if identified) are not included in 25 bed limit
  - Subject to internal policies and interpretation of surveyor
  - Included in attachments in your handout materials



# Medicare Reimbursement

- Inpatient Acute
  - Cost based
    - Room and Board based on per diem
    - Ancillary charges (i.e. lab, x-ray, etc.) based on ratio of cost to charge for each ancillary service
  - 101% of cost
  - Preadmission not subject to 72-hour bundling rules



# Medicare Reimbursement

- Swing beds
  - Cost based
    - Room & Board based on per diem
    - Ancillary charges (i.e. lab, x-ray, etc.) based on ratio of cost to charge for each ancillary service
  - 101% of cost
  - Days are included in with IP Days (Except Swing Bed Intermediate Care which is carved out at a statewide NF rate)
  - Swing bed patients are treated in the inpatient unit of the hospital by the same staff.



# Medicare Reimbursement

- Outpatient – Part B
  - Cost based – except non-patient lab
    - Based on ratio of cost to charge (RCC) for each ancillary service (OR, X-ray, ER, etc.)
  - 101% of cost
  - Coinsurance to patient billed at 20% of charges rather than APC schedule
  - Non-patient lab & mammography still fee schedule
    - See exception on next slide



# Medicare Reimbursement

- Medicare Law 2008 –
  - Effective 7/1/09 - Lab is cost-based regardless of location of patient if in a provider based location including RHC
    - If employee of CAH draws specimen (no matter the location) then it is considered a patient of CAH and is cost based.



# Medicare Reimbursement

- Ambulance- if CAH is only ambulance provider or supplier located within a 35 mile drive of the CAH, 101% cost reimbursed.
- RHC- Provider based rural health clinics to CAHs are not subject to RHC cap limits, but are reimbursed at allowable cost per visit (subject to productivity standards)



# Medicare Advantage

- Medicare contract – “HMO”
  - Medicare Advantage claims are NOT cost based....what you get is all you get!
  - Negotiate 101% of cost as you are paid from regular Medicare (Also negotiate Medicare bad debts in rate or separately)

# Fundamental Financial Principle for CAHs







# Fundamental Financial Principle for CAHs to have Operating Margin

- CAHs must operate with the underlying cost per unit at levels that allow them to make a profit from payors other than Medicare or Medicaid.
  - Cost per diem
  - Ratio of Cost to Charges (RCC)
- Profit has to be great enough on other payors to make up deficits created by self pay and charity care.



# How does a CAH influence their cost per unit?

- Decreasing Cost
- Allocating Cost Accurately/Appropriately
- Increasing Utilization

All of this is easier said than done but you must start somewhere.



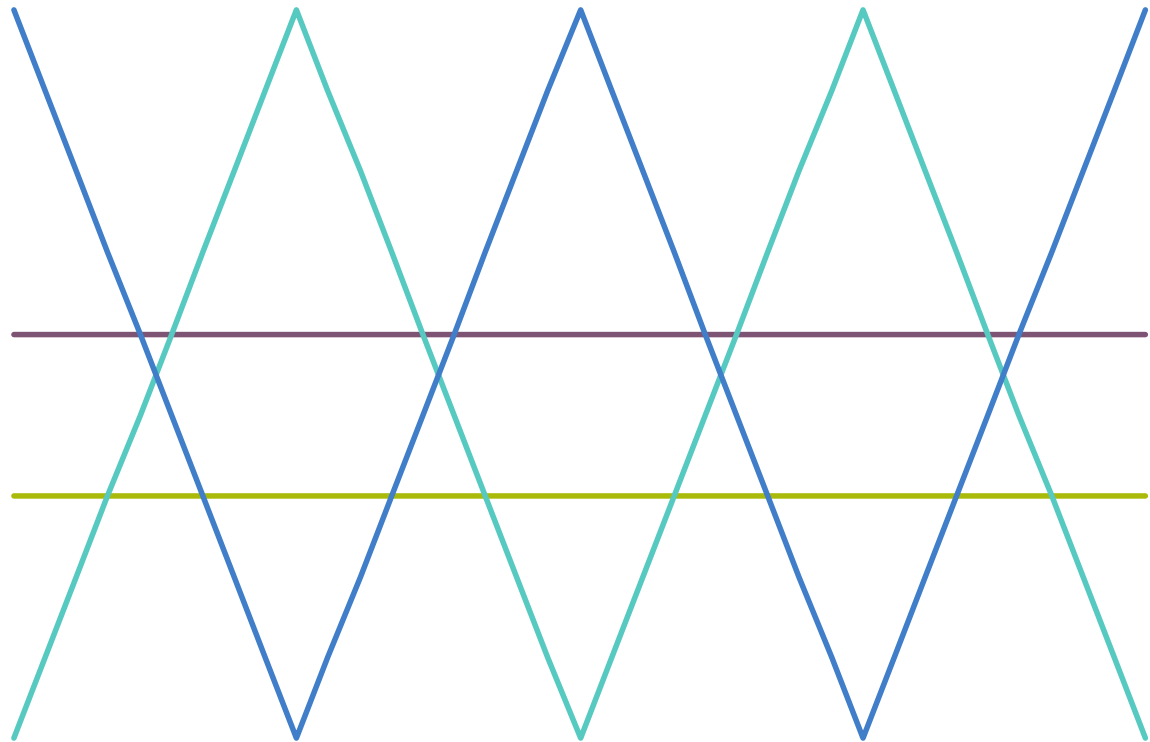
# Effects of Utilization on Costs

Utilization

Medicare Payment

Cost

Cost per Unit





# **Cost Report Settlement Worksheets**





# Inpatient Settlement – W/S E-3, Part V

- Line 1 – program inpatient operating cost - pulled automatically from D-1 Part II, line 49
- Line 5 – enter primary payer payments
- Line 6 calculated – equals 101% of line 4 less line 5
- CAHs do not complete lines 7 through 16
- Line 20 – enter deductibles amounts
- Line 23 – enter coinsurance amounts
- Lines 25 & 27 – Enter applicable bad debt amounts
- Line 30.01 – Sequestration Adjustment – automatically calculated



# Outpatient Settlement – W/S E, Part B

- Line 1 – program outpatient operating cost - pulled automatically from D Part V column 6
- Line 25 – enter deductibles
- Line 26 – enter coinsurance
- Line 27 – automatically calculated:
  - For critical access hospitals (CAHs), enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 200). Add back the aforementioned 101% of lab and 101% of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.
- Line 40.01 – Sequestration Adjustment – automatically calculated



# Swing-Bed Settlement – W/S E-2

- Line 1 & 3 – 101% of allowable cost – automatically calculated
- Line 9 – enter primary payments
- Line 11 – enter deductibles
- Line 13 – enter coinsurance
- Line 19.01 – Sequestration Adjustment – automatically calculated



## RHC Settlement – W/S M-3

- Line 8 – Per Visit Payment Limit
- Line 10 – Program Visits excluding Mental Health Services
- Line 12 – Program Visits for Mental Health Services
- Line 16.01 – Total Program Charges
- Line 16.02 – Total Program Preventative Charges
- Line 18 – Enter deductible amounts
- Line 19 – Enter coinsurance amounts
- Line 23 & 24 – Enter applicable Bad Debt amounts
- Line 26.01 – Sequestration Adjustment – automatically calculated



# Cost Allocations





# Various Methods to Allocate Costs on Cost Report

- Home Office Allocations
- A-6 Reclassifications
- Direct Assignment
- B-1 Allocations
- Providers should understand how each of these items work and which is allowed provided the circumstance.



# Home Office/Related Party Costs

- Overview of Related Party Rules
- Discuss direct allocations options+
  - Salary and Benefits of shared services?
  - Ancillary services?
- Discuss home office allocation options
  - (Direct, Functional and Pooled)

**Very important for this to be monitored. Objective is to capture any costs that are applicable to CAH**



# Cost Allocation Statistics

- Used to allocate overhead costs on cost report
- Accurate and “relational” statistics are imperative
- Single allocation methodology used
  - Once cost center is closed no additional costs can be allocated back to it. Stats that would allocate costs back to a previously allocated cost center are merely excluded



# Cost Allocation Statistics

- Most common problem
  - Statistics are not maintained during the year
    - By the time you find at the end of the year they are not correct – it's too late to fix the problem!
- Remedy:
  - **Take the accumulation seriously!**



# Cost Allocation Statistics

- Time studies should cover one week per month rotating weeks of month
  - If dept. operates 5 days per week, study should cover 5 days
  - If dept. operates 7 days per week, study should cover 7 days



# Cost Allocation Statistics

- Square footage
  - Detailed records should be maintained during year
  - Weighted square footage amounts are used on cost report based upon when in year changes occur
  - Idle square footage will result in non-reimbursable costs



# Cost Allocation Statistics

- Square footage (continued)
  - Should re-measure entire facility if not performed since CAH certification
  - Stairways include with plant
  - Lobbies include with common areas (which can be included or excluded)
    - Possibility to be directly assigned or allocated if appropriate





# Cost Allocation Statistics

- Square footage (continued)
  - Hallways may be excluded or included
  - If hallways are included, square footage for hallway must be allocated between the various departments located on hallway based upon departmental square footage



# Cost Allocation Statistics

- Alternative to time consuming recordkeeping (simplified methodology)
- Statistics
  - Square footage (depreciation, maintenance, plant, and housekeeping)
  - Salaries (employee benefits and cafeteria)



# Cost Allocation Statistics

- Statistics (simplified - continued)
  - Patient days (laundry, dietary, and social service)
  - Nursing Administration (nursing salaries)
  - Central supply & pharmacy (costed requisitions)
  - Medical records (gross revenues)
  - CRNAs (100% to anesthesia)



# Cost Allocation - Alternatives

- Fragmenting A&G into several cost centers
  - Generally increases reimbursement when CAH has distinct - part units and/or significant non-reimbursement cost centers
  - Must work numbers, each case different



# Cost Allocation - Alternatives

- Fragmenting A&G into several cost centers
  - Human Resources
  - Non-Patient phones
  - Admitting
  - Patient accounting
  - Data processing
  - A&G
  - Prior approval required



# Cost Allocation - Alternatives

- Direct Assignment of costs
  - Utilities based upon metered use
  - Hours of service
- Multiple Buildings
  - Allocate facility costs separately for each building



# Changes to Order or Statistical Bases

- Must make written requests
- 90 days prior to end of cost reporting period
- FI has 60 days to respond
- Simplified methodology
  - Justification, reduce expense of cost report preparation
  - Must remain under methodology for 3 years

# Non-Reimbursable and Non-Core Services







## Non-Reimbursable/Non-Core Hospital Services

- Analyze Direct Contribution Margin and Indirect Contribution Margin on these type of cost report lines
  - Determine if allocation of overhead is being covered by direct contribution margin
  - Or would hospital be better served to potentially restructure to take off cost report (i.e. Home Office Allocation only)
  - Or could allocations statistics be adjusted to redirect allocated amounts to reimbursable areas.



# Non-Reimbursable/Non Core Hospital Services

- Example of Types of Cost Report Lines to Analyze
  - Skilled Nursing Facilities
  - Psych/Rehab
  - Home Health and/or Hospice
  - CAP(Home Care) Programs
  - Freestanding Physician Offices
  - Gift Shop

*See handout*



# Analysis of Payer Mix

*See Handout*

# Financial Illustrations of Utilization Changes





# Swing-bed Reimbursement

- Skilled versus NF swing-bed days
  - Respite/personal care (swing-bed carve-out of statewide NF rate per day)
    - May have significant impact on reimbursement
  - Pub 15-1, Section 2230.5
    - Non-Medicare Swing-bed days classified as S/B-NF days
  - Medicare Advantage days counted as SNF-type

*See handout*



# Impact of Additional Inpatients

*See Handout 4–9*

# Interim Rate Setting





# Interim Medicare Payments

- Interim payments set on a per patient day and or percentage of charge basis. This interim payment is only an estimate with the final payment based on the settled cost report submission.
- Intermediary responsible for:
  - Setting payment rates
  - Neither over-paying or under-paying the Provider in the interim





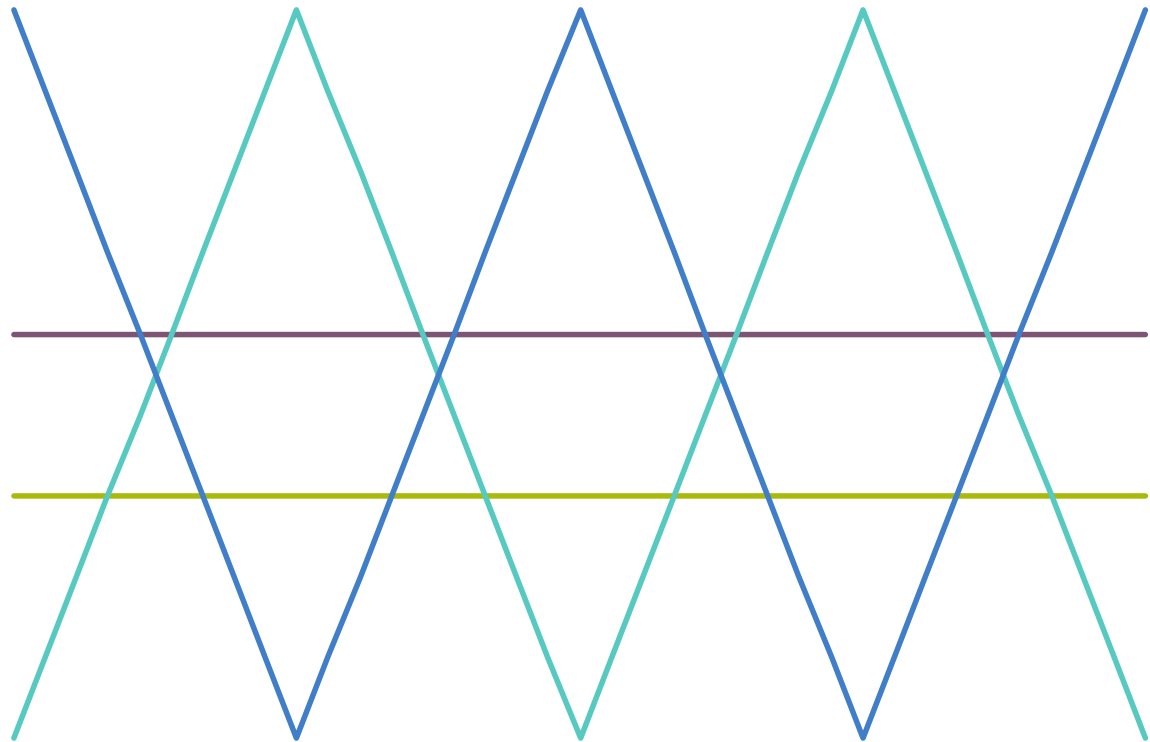
# Effects of Utilization on Costs

Utilization

Medicare Payment

Cost

Cost per Unit





# Interim Rate Computations

- Fiscal intermediary will compute based upon prior year's per diems or cost/charge ratios from prior year
- Use current year Medicare claims & apply percentages above to determine gross Medicare reimbursement



# Interim Rate Computations

- Recommended Methodology
  - Interim Cost Reports
    - B-1 Stats based upon prior year if current year is not available
    - Majority of reclassifications and adjustments can be based upon actual current year amounts
    - Other reclassifications and adjustments based upon prior year amounts



# Interim Rate Computations

- Recommended Methodology
  - Frequency
    - Quarterly
    - Six months and year-end
    - Monthly using excel template

# Physician Compensation





# Types of Arrangements- Pub 15-1, Section 2109.4

- Total Compensation
  - Professional
  - Administrative
  - Availability
- Hourly/Fixed Amounts
  - Availability
  - Administrative
- Minimum guarantee



# CAH Physician Services

- Not subject to RCE limitations
- Subject to “prudent buyer” regulations



# Physician Recruiting

- Recruiting costs and guarantees are not allowable
  - Except RHC recruiting
  - Be sure that recruiting account contains only true recruiting costs and not public education/relations





# Physician Services

- Costs related to direct patient care must be removed (except RHC)
  - Paid under fee schedule
  - Regardless of billing method
- Administrative costs are allowable
  - Medical director
  - Committee time



# Emergency Physician Services

- Call pay – allowable
  - Not on campus & not seeing patients at other locations such as clinic
- Availability time – allowable
  - “Down time” while on campus



# ER Physician Availability Costs

- Section 2109.3 of Pub 15-1
  - No feasible alternative way to obtain physician coverage (fee-for-service)
    - Contractor feasibility study
  - Must be on premises
  - Written contract
  - Written allocation agreement-Pub 15-1, 2182.3



# ER Physician Availability Costs

- Schedule of physician charges
- Record of payments made to physicians
- Record of time physician was actually on premises
- Permanent record of all patients treated by physicians



# Documentation of Availability Time

- Time studies-Pub 15-1, 2312.2
  - Regulations (one week per month rotating weeks of month)
  - Two weeks per quarter may be acceptable (Obtain in writing from FI)
  - Intermediaries vary on amount of time acceptable



# Documentation of Availability Time

- Sample of Patient Time
  - Track admission & discharge time to compute total patient time
  - Know total hours (subtract patient time from total to determine availability time)
  - Better methodology (track time physician spends with patient plus chart documentation time) Will result in more availability time



# ER On-Call Costs

- Coverage of ER On-Call Costs
  - All providers including mid-level practitioners
  - CMS Transmittal 285, dated August 27, 2004



# ER On-Call Costs

- Emergency room On-Call Costs
  - Must be off campus
  - Time must be documented
  - Physician not otherwise furnishing physician services and is not on-call elsewhere





# ER On-Call Costs

- Emergency room On-Call Costs
  - Immediately available by phone or radio
  - Must be available on site within 30 minutes on a 24-hour per day basis
  - Physician must report to CAH when presence is medically required (must be included in contract)
  - Costs must be reasonable



# Hospital-Based Physician Costs

- Employment related taxes are not allocated to professional component.
- Considered employer related costs and not fringe benefit
- Costs stay on cost report
- Pub 15-1, Section 2122.3



# CRNA Reimbursement

- CRNA reimbursement
  - Fee schedule
  - May qualify for exemption and receive cost-based reimbursement
    - No more than 800 surgical procedures requiring anesthesia - August 1, 2002 Federal Register
    - Effective January 1, 1990
    - Based upon calendar year - Annual Election in December of each year, based upon volumes through September 30th



## Option II Billing

- Receive 115% of reduced fee schedule for OP physician services
  - All physicians are not required to assign billing rights before CAHs can become eligible for optional methodology
  - Select physicians may participate



## Option II Billing

- Professional Services Under All-Inclusive Rate
  - Technical component - 101% of costs
  - Professional component - fee schedule plus 15% for physician services
  - 115% of 85% of physician fee schedule for non-physician practitioners
  - Option II Election will void exemption from fee schedule for both IP and OP services for CRNA unless excluded from election



## Option II Billing

- Copy of 855R Form reassigning billing rights to CAH - must be submitted to FI
- Signed certification from physician that physician will not bill program for services that have been reassigned (copy of attestation on file at CAH)



## Option II Billing

- Bill professional fees on UB 92 also (do not bill on 1500)
- Bill type 85X (Outpatient Services only)
- UB revenue codes
  - 96X – Psych
  - 97X - Laboratory, diagnostics, nuclear medicine, RT, PT, OT, ST, and OR
  - 98X - ER, OP services, EKG, EEG, private duty nursing



## Option II Billing

- CMS 2011 IPPS rule
  - Federal Register Final Rule 8/16/10
  - Fixed the Option II election snafu, CAH will get 1% add-on for outpatient cost – resulted from fix in ACCA
  - CAH no longer have to file the annual election unless to terminate – begins with cost report periods beginning on or after 10/1/2010
    - Must file change for physicians





# Information Technology & Bad Debt Issues

- Potential Dual billing systems
  - Posting cash receipts can be problematic
- Professional deductible & coinsurance bad debts not reimbursable



# Hospitalist

- Physician Employed by CAH to Coordinate Care of Inpatients
  - Professional component - fee schedule
  - Administrative - cost allowable
- If also emergency or RHC – maintain time study documentation

# Clinic Strategies





# Clinic Comparisons for CAHs

	Provider Based RHC	Provider Based Clinic	Free Standing RHC	Free Standing Practice
Billing	UB for RHC services; UB-CAH ancillary & 1500 for non-RHC services	UB for facility services & ancillary; 1500 for pro fees (unless Option II)	UB for RHC services; 1500 non-RHC	1500 for all
Payments	Cost for RHC portion; cost for CAH ancillary; fee schedule for non-RHC services	Cost for facility portion + reduced fee schedule for pro fee	Cost for RHC; fee for non-RHC	100% of fee schedule
Productivity & mid-level	Yes	No	Yes	No
Option II & HPSA	No	Yes	No	Yes

# Case Study





Payment Comparison for CPT 99213 - Office Visit

	Free Standing Practice 2009			Provider Based Clinic 2009			Rural Health Clinic				
	Medicare Charge	Patient Non Facility	Medicare Pay	Medicare Payment	Medicare Charge	Patient Facility	Medicare Pay	Medicare Payment	Patient Charge	Medicare Pay	Medicare Payment
Office visit	\$ 100.00	\$ 58.89	\$ 11.78	\$ 47.11							
Clinic charge (rev code 510)					\$ 50.00		\$ 10.00	\$ 52.50			
Professional portion					\$ 50.00	\$ 43.54	\$ 8.71	\$ 34.83			
					<u>\$ 100.00</u>		<u>\$ 18.71</u>	<u>\$ 87.33</u>			
RHC visit									\$ 100.00	\$ 20.00	\$ 88.00
<b>Assumptions:</b>											
Provider based clinic RCC	1.25				<b>SUMMARY - TOTAL PAYMENTS</b>						
RHC visit cost	\$ 110.00				Free standing	\$ 58.89					
					Provider based	\$ 106.04					
					RHC	\$ 108.00					





# Cost Reporting Issues between Types

- Freestanding Clinic
  - Treated as non-reimbursable cost center on cost report
- Provider-Based Clinic
  - Setup as clinic line on cost report
  - All professional cost and revenue excluded from calculations in cost report.
- Rural Health Clinic
  - Additional schedules need to be completed on cost report
  - Additional reporting/compilation of data required



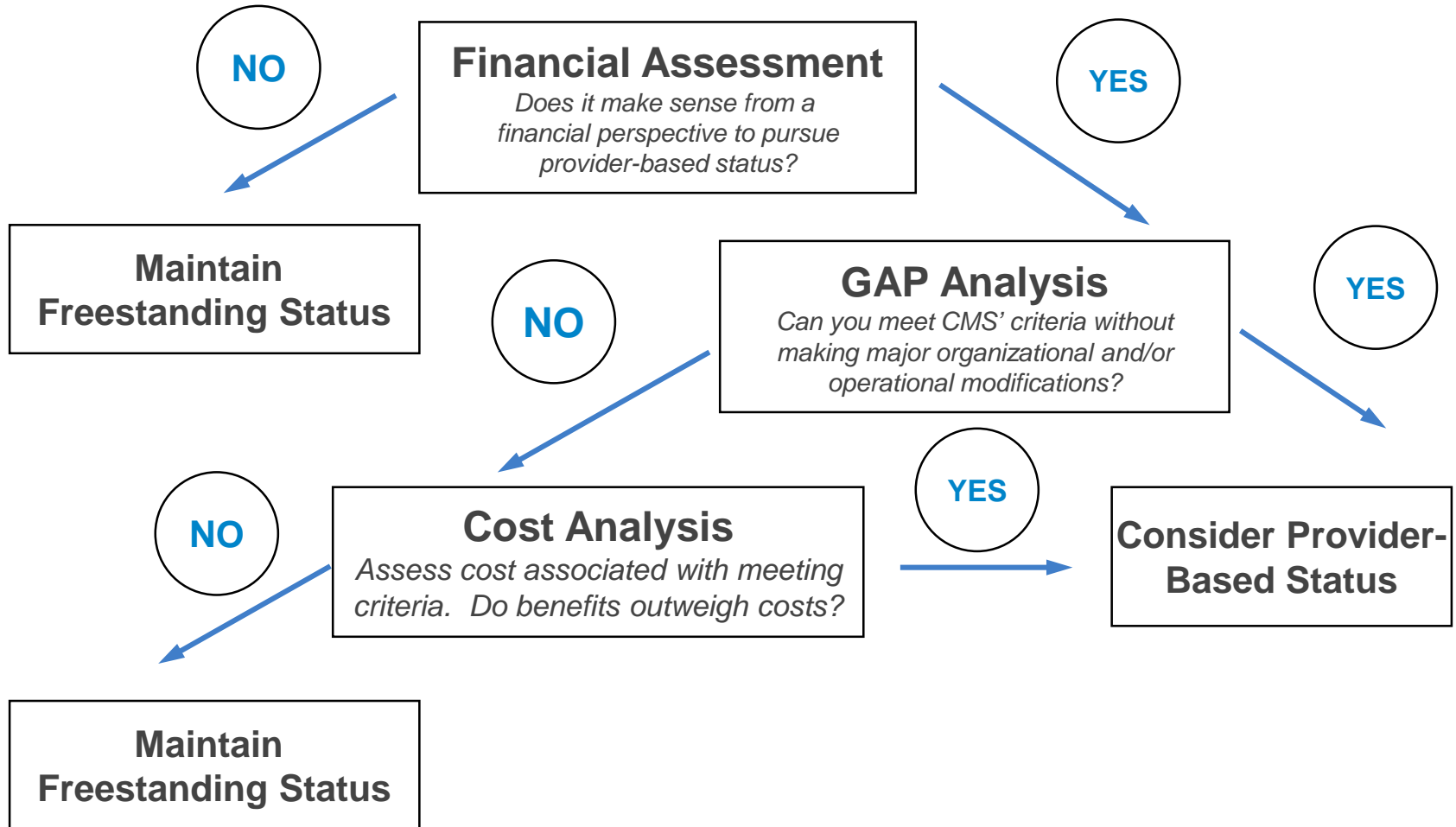
# Summary of Clinic Scenarios

- Which is the best scenario for my clinic?
- THAT ALL DEPENDS!
- To accurately determine most advantageous scenario, you have to calculate the financial impact provided the clinic details.





# Hospital Decision Criteria



# Review and Final Questions



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