STROUDWATER

PERFORMANCE IMPROVEMENT BOOTCAMP SESSION 3: PRACTICAL COST REPORT STRATEGIES TO STRENGTHEN FINANCIAL HEALTH

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OBJECTIVES

1

Understand the basic structure and flow of the Medicare cost report

2

Understand how cost reports impact Medicare rates for CAHs

3

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

It 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

Volume statistics are accumulated by service, including:

- Hospital beds
- 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 subunits

Information is also broken out by payer

- Medicare
- Medicaid
- Other

COST REPORT MECHANICS

Organizational costs are grouped (sometimes referred to as “mapped”) into **cost centers** determined by the Centers 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 (“fully allocated cost”) is used in the 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 bed payment basis:

- Average cost per day (i.e., Inpatient cost per diem) = routine costs/total days
  - If a CAH operates a distinct ICU, a 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 + Allowable Bad Debts – Interim Payments

WHERE CAN I FIND THIS INFORMATION?

Inpatient cost per diem: Worksheet D-1, Line 38
Medicare days: Worksheet D-1, Line 9
Medicare routine costs: Worksheet D-1, Line 39
Cost to Charge Ratios (CCR): Worksheet C, Col. 9
Medicare Charges: Worksheet D-3, Col. 2 (Inpatient ancillary) and Worksheet D, Part V, Cols. 3-4 (Outpatient)
Medicare Cost: Worksheet D-3, Col. 3 (Inpatient ancillary) and Worksheet D, Part V, Cols. 6-7 (Outpatient)
Settlement = Worksheet S, Part III (cover page)

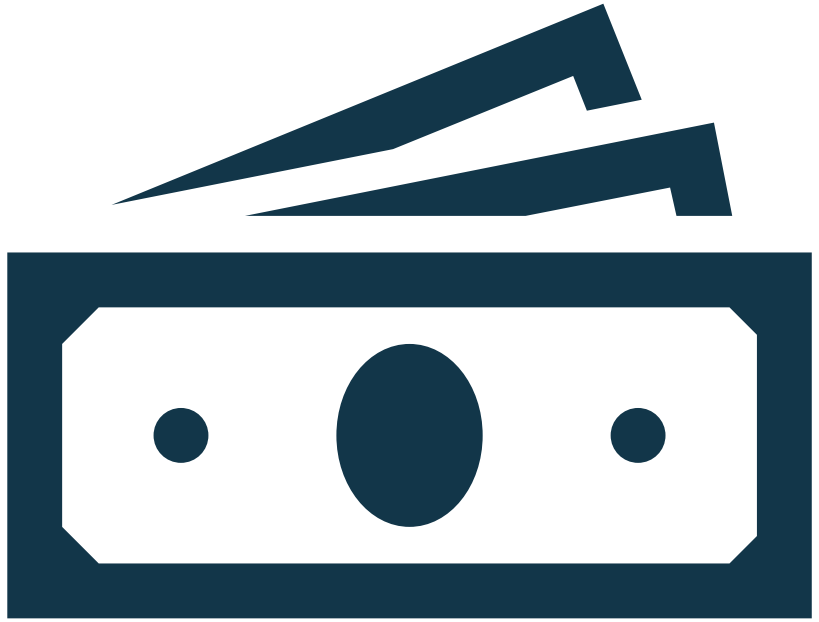
COMMON COST REPORT OPPORTUNITIES

COMMON COST REPORT OPPORTUNITIES

- Interim Cost Reporting/Cost Report Modeling
- Expense and revenue mapping
- Overhead Cost Allocation Statistics
  - Capital Costs
  - Administrative & General
  - Cafeteria
  - Medical Records
- Cost-to-Charge Ratio (CCR) Inconsistencies
- Related Party Cost Allocations
- Physician Standby time in the Emergency Department (ED)
- Medicare Bad Debts

INTERIM COST REPORTING/COST REPORT MODELING

- **General Principle**
  - Due to cost-based reimbursement, CAH Medicare payment rates can fluctuate, sometimes substantially, from year to year
  - CAHs are paid for *current* services based on *previously calculated* rates
    - Common areas that can trigger changes in cost-based rates include:
      - Organizational costs
      - Volumes
      - Service lines (additions *or* discontinuations)
      - Chargemaster updates
  - Because CAHs receive a "true-up" through the Medicare cost report, changes in rates often result in a receivable from *or* payable to the Medicare program
    - Strong financial management for a CAH requires understanding what this anticipated receivable or payable will be *before* cost report filing



INTERIM COST REPORTING/COST REPORT MODELING

Opportunity

- Often, CAHs are surprised by the receivable or payable when filing their Medicare cost report
  - 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)
  - Periodically verifying the calculations and assumptions of an existing cost report model is crucial
  - Data sources should be validated: "garbage in, garbage out"

EXPENSE AND REVENUE MAPPING

- **General Principle**
  - Organizational expenses are “mapped” into cost centers determined by the Centers for Medicare and Medicaid Services (CMS)
  - Organizational gross charges (not including professional) are similarly “mapped” to all revenue-generating departments
    - Expenses and revenues should both be mapped in the appropriate cost center to ensure proper matching

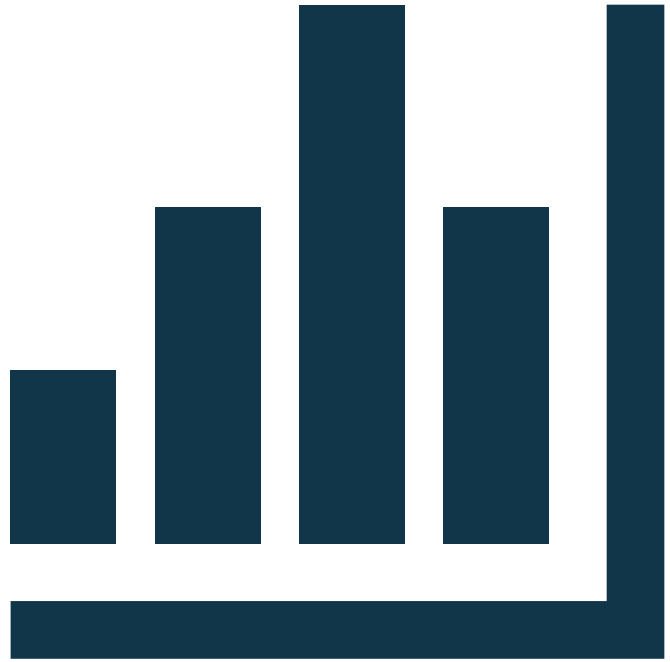
EXPENSE AND REVENUE MAPPING

Opportunity

- Matching expenses with revenues is easier said than done
- Common opportunities include:
  - Nursing Administration – often includes non-nursing administration salaries (e.g., charge nurses, others)
  - Labor & Delivery – for LDRPs, often, all costs are assigned to the Labor & Delivery cost center; should only report time associated with labor and delivery, not postpartum
  - Provider-Based RHCs – non-RHC provider salaries are sometimes reported in the RHC cost center

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 costs



OVERHEAD COST ALLOCATIONS

Opportunity

- Though there are prescribed methods of cost allocation, CAHs can request changes to current cost allocation methodologies that more appropriately reflect overhead utilization by department
- Many hospitals utilize methods of cost allocation 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

OVERHEAD COST ALLOCATIONS

Opportunity (cont.)

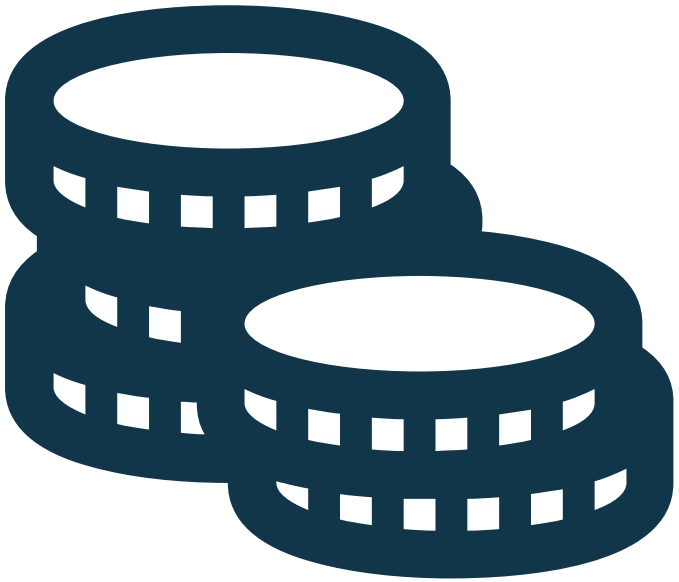
- Common overhead allocation opportunities:
  - Capital Costs
    - **Typical basis:** Square Footage
    - **Issue:** Often inaccurate; no consistent square footage review despite operational changes
  - Administrative & General (A&G)
    - **Typical basis:** Accumulated Cost
    - **Issue:** A wide 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 the 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 with higher gross charges, but doesn'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 before 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.
  - Many CAHs still see misallocated costs even when the allocation basis may be appropriate

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 incorrect departments
    - Inadequate charge capture
    - Inappropriate allocation of overhead (e.g., within radiology)
    - No reclassification of staff costs

COST-TO-CHARGE RATIO (CCR) INCONSISTENCIES

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

Opportunity

- 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 volumes by partnering with providers
- 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**
  - CMS Pub. 15-I, §2109: "When a provider compensates emergency physicians for being available to render services to individual patients in the ED, the provider may be reimbursed Medicare's share of allowable costs incurred by the provider to the extent that the costs are deemed reasonable."
  - 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

MEDICARE BAD DEBTS

- **General Principle**
- Medicare reimburses **65%** of total allowable Medicare Bad Debts (42 CFR § 413.89)
  - Bad debts:
    - must be related to covered services and derived from deductible and coinsurance amounts
    - can only be claimed after a reasonable collection effort has been established
    - must be actually uncollectible when claimed as worthless
    - can only be claimed when sound business judgment has established that there was no likelihood of recovery at any time in the future
  - Excludes physician professional services

Opportunity

- Many hospitals do not track Medicare Bad Debts or record them on the cost report
- 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
- Oftentimes hospitals utilize collection agencies, but lack a process for returning accounts from collections

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

QUESTIONS?

COMING UP...

4

Swing Bed Bootcamp

- This session provides leaders with a hands-on, interactive overview of swing bed programs, covering compliance, care quality, financial performance, and growth strategies.
- Gain practical insights on regulatory requirements, care planning, program optimization, financial impact, and marketing strategies.

October 16th at 11am EDT

5

340B Programs

- The 340B Drug Pricing Program continues to evolve rapidly, with new manufacturer actions, rebate models, and regulatory changes reshaping how covered entities approach savings and program compliance.
- Identify opportunities to optimize program performance, evaluate pharmacy models, and anticipate emerging trends.

October 23rd at 11am EDT

6

Revenue Cycle Deep Dive

- Strong revenue cycle performance requires intentional strategy, collaboration, and, above all, cross-functional leadership support.
- Identify strategies to engage leaders, align key performance indicators with organizational goals, and apply real-world practices to drive sustainable revenue cycle improvements.

October 30th at 11am EDT

STROUDWATER

THANK YOU

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