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Cost Report Overview from a CAH Perspective

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Director, Provider Payment Analytics

As Director of Provider Payment Analytics, Rick's expertise covers a wide range of strategic initiatives centered on the complexities of reimbursement and payment for all provider types; including specialization in ensuring rural health providers are optimizing their opportunities.

Having worked within numerous health systems and hospitals nationwide in a variety of roles in finance departments, including multiple years as a CFO, Rick has developed a strong understanding of both present and future reimbursement and payment issues and proactively develops strategies to ensure providers are optimizing their opportunities.

CAREN PUVALOWSKI, CHFP
LEAD CONSULTANT, CRITICAL ACCESS HOSPITALS

Caren offers over twenty-three years of CAH and other Rural Hospital financial, accounting revenue cycle and reimbursement experience. She has worked in a variety of roles in the finance departments of CAHs, including multiple years as a CFO.

Caren's broad experience in multiple facilities has included ensuring that they optimize their payments under their CAH and rural designations. Areas of focus have included financial, reimbursement, cash flow analysis, pro-forma scenarios, accounting, general ledger, financial statements, contractual allowance, contract management and negotiations, operational efficiency, and revenue cycle analysis. Caren brings these areas of focus to effectively assist our clients.

Agenda

- Introduction
- Critical Access Hospital – CAH
  - Background, Requirements, Characteristics, Locations
- Medicare Cost Report
  - Purpose, Timing, MCRef, General Information
- Medicare Cost Report Life Cycle
- Costs – Allowable vs. Non-Allowable
- Cost Report Worksheets
- Common Cost Reporting Mistakes
- Recent Cost Report Audit Activity
- Communication
- CAH Strategies
- Other Users
- Legislation – Past, Present, Future
- Resources
- Top 5 Take-Aways
- Questions

Introduction

- Managing reimbursement for Critical Access Hospitals (CAHs) is a constantly changing art
  - Changes in payor rules
  - Changes in payor interpretations
  - Changes in the organization
  - Industry developments
- Requires the administration, finance team and board to monitor new opportunities while managing new risks.
- For a Critical Access Hospital the Medicare cost report impacts your current year reimbursement.

Critical Access Hospitals - CAH

Background

- Designation created by the Balanced Budget Act in 1997
- Requires approval by Centers for Medicare and Medicaid Services (CMS)
- Reduce financial vulnerability
- Improve access to healthcare
- Rural populations – statistically older, poorer and sicker

Critical Access Hospitals - CAH

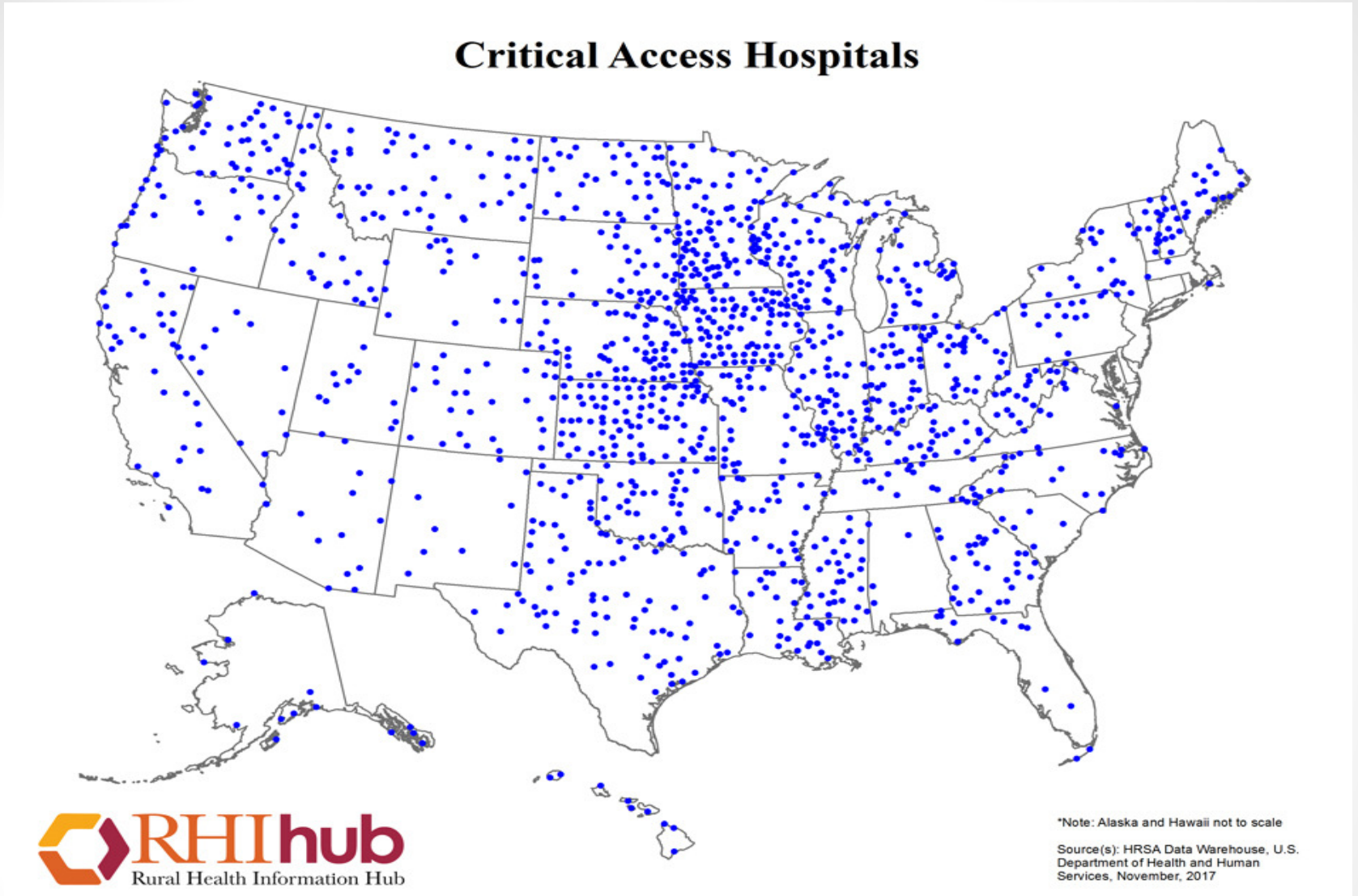
Requirements

- CAH must have 25 or fewer acute care inpatient beds.
- Located more than 35 miles from another hospital – 15 miles from another hospital in mountainous terrain or areas with only secondary roads (unless met State necessary provider exception prior to 01/01/06)
- Average length of stay of 96 hours or less for acute care patients (swing bed have no length of stay limit)
- Must Have Relationship with another Hospital to Transfer Patients to.
- Must provide 24/7 emergency care services

Critical Access Hospitals - CAH

Services provided:

- 24/7 ER Care
- Trauma Center
- Operating Room
- OB
- Swing Beds
- Skilled Nursing Facility
- Ancillary – Lab, X-ray, Sleep Lab
- Therapy – IV, Respiratory, Physical, Occupational, Speech
- Physician Services – Clinics – RHC, Provider Based, Free-Standing
- Rental Space – Specialists – Neuro, Urology, Podiatry, Oncology, Allergy, Cardiology, etc.
- Anything that any hospital can provide – As long as the average LOS is under 96 hours and Meets the Community Need



As of April 16, 2018, there are **1,346** CAHs located throughout the United States.

Medicare Cost Report

- Purpose is to determine the settlement of costs relating to health care services of Medicare patients.
- Annual report submitted to CMS within 5 months of fiscal year end.
- As of 07/01/18 the cost report must be submitted electronically.
- Hospitals, SNF, HHA, RHC, FQHC, Hospice, Renal and home office.
- Medicare liability estimated using “cost report” data.

Medicare Cost Report

- As of 07/01/18 it is recommended that providers use Medicare Cost Report e-Filing system- MCReF. https://mcref.cms/gov
- Access is controlled by EIDM
  - PS&R Security Officer
  - PS&R Backup Security Officer
  - MCReF authorized cost report filer
- Logins – Keep current and in good standing
- Check your Provider (CCN) # and FYE date
- Upload files – do not password protect – secure portal
- Immediate feedback on the receivability of your cost report
- Signatures

Medicare Cost Report

- The Medicare Cost Report is a provider specific informational gathering tool of the Federal Government.
- During the year the hospital receives payments based on historical costs as claims are processed.
- If the final settlement is greater than payments already made, an underpayment exists and the MAC will make a lump sum payment to Hospital.
- If the final settlement is less than payments already made, Hospital has been overpaid and the MAC must recover the overpayment.
- Important of up-to-date charges, billing, coding, cost allocation to ensure accuracy and maximize allowable payment.

Medicare Cost Report

- Comprised of a series of worksheets and schedules.
- CMS estimates several hundred hours to prepare.
- Each cost report's life cycle is normally up to a 48 month process. This makes planning and operational strategy challenging.
- Every transaction performed (clinical services and administrative action) in the hospital has an impact on the cost report and your reimbursement.

Medicare Cost Report Life Cycle

- File Medicare Cost report with MAC using MCReF.
- Cost report is received and then accepted by MAC.
- Filed cost reports are subject to review by the Medicare Administrative Contractor (MAC).
- Desk review or field audit.
- Send additional documentation.
- Audit adjustments are prepared by MAC.
- A Notice of Program Reimbursement (NPR) is issued with an amount due Program/Provider.
- Hospitals have 180 days to appeal the NPR.
- Providers have 3 years from NPR date to request reopening.
- Appeal resolution is a lengthy process – up to 12 years.

Allowable costs

Must be related to patient care:

- Wages/salaries
- Education
- Employee Recruitment
- Tax – Sales and Property
- Consulting Fees
- Collection agency fees
- Home Office Costs
- Related Party Costs

Non-allowable costs

Costs not related to patient care:

- Physician Recruitment
- Non provider based services – clinics
- Entertainment including alcohol
- Political/lobbying costs
- Gift shop
- Meals served to visitors
- Charitable Contributions
- Meals on Wheels program
- Fitness Center
- Fund Raising – Foundation Expenses

Allowable vs. Non-Allowable

Depends on activity and purpose:

- Legal Fees
- Advertising
- Provider Wages
- Malpractice Insurance
- Pension Expense
- Interest Expense

Medicare Cost Report Worksheets

- S Series — Certification, Informational & Statistical Data
- A Series — Expenses, Reclassifications, Adjustments
- B Series — Cost Allocation – Statistical Bases
- C Series — Computation of Cost to Charge Ratios
- D Series — Cost Apportionments to Program
- E Series — Reimbursement Settlements
- G Series — Financial Statements
- H Series — Home Health Agencies
- I Series — Renal Dialysis
- L Series — Capital Payment (PPS Hospitals)
- M Series — Rural Health Clinics

Worksheets – S Series

- Certification
- Identification
- Questions – LOTS
- Patient Statistics
- Wages, Benefits, Contract Labor
- RHC Stats
- Uncompensated Care – Still need to complete for potential future use

Worksheets – A Series

- Worksheet A: Trial Balance of Expenses
- Worksheet A-6: Reclassification of Expense
- Worksheet A-7: Capital Assets and related costs
- Worksheet A-8: Adjustments to Expenses
- Worksheet A-8-1: Costs from related organizations and home office costs
- Worksheet A-8-2: Provider Based Physician Adjustments
- Worksheet A-8-3: Reasonable Cost for Therapy services furnished by contracts

Worksheets – B Series

- Worksheet B Part I: Cost Allocation General Service Costs
- Worksheet B Part II: Allocation of Capital Related Costs
- Worksheet B-1: Cost Allocation – Statistical Basis
  - All stats must be current, accurate and meet the tests of audit

Worksheets – B-1 Series

Simplified Statistics

- Square Footage – Building, Equipment, Operation of Plant, Housekeeping
- Salaries – Employee Benefits
- Charges – Patient Accounting, Admitting/Registration/Med Records
- Accumulated Costs – Administrative and General
- Patient Days – Laundry, Dietary, Social Services
- FTE Count – Cafeteria
- Nursing Hours – Nursing Administration

Worksheets – C Series

- Inpatient, Outpatient and Swing Bed charges
- Computes the ratio of cost to charges by cost center (CCR)

Worksheets – D Series

- Computes the reimbursable Medicare costs using the CCRs from Worksheet C
- Use a Provider Statistical and Reimbursement (PS&R) report for Medicare days and charges or modify based on outstanding AR.
- PS&R are provided by Medicare compiling all the Medicare paid claims data and summarizes for use in the Medicare Cost Report.
- Uses Medicare days and charges to compute Medicare costs

Worksheets – E Series

- Reimbursement Settlement
  - E – Part B - Outpatient
  - E – 2 – Swing Bed
  - E – 3 - Inpatient

- Deductibles/coinsurance, Payments (including lump sum adj.)

- Allowable Bad Debt reimbursed at 65%
  - Cross overs
  - Charity Care
  - Bankruptcy
  - Deceased
  - Self Pay returned from collection agency
  - Follow your policy
  - DOCUMENTATION, DOCUMENTATION, DOCUMENTATION

Worksheets – G Series

- Financial Statements
  - Worksheet G - Balance Sheet
  - Worksheet G-1 - Changes in Fund Balance
  - Worksheet G-2 - Statement of Patient Revenues and Expenses
  - Worksheet G-3 - Statement of Revenue and Expenses

Worksheets – M Series

- Worksheet M-1 - Analysis of Hospital Based RHC Costs
- Worksheet M-2 - Allocation of Overhead to RHC
  - Accurate Provider FTEs and Visits
  - Productivity Limits
- Worksheet M-3 - Calculation of Reimbursement Settlement
- Worksheet M-4 - Computation of Pneumococcal and Influenza Vaccine Costs
- Worksheet M-5 - Analysis of Payments to Hospital Based RHC

Common Cost Reporting Mistakes

- Not reviewing all edits – just Level I
- No signature and/or box checked if not e-signed
- Only running one cost report per year
- Not appropriately reporting NF swing bed days
- Incorrect reporting of Provider vs Professional
- Not capturing all allowable Medicare bad debts
- Having Medicare charges in RCC department with a 0.00 value
- Inaccurate PS&R crosswalk
- Inappropriate and/or unapproved statistics for each B-1 allocation
- Not matching of revenue and expense
- Overstating RHC provider FTE time and visits

Recent Cost Report Audit Activities

- Bad Debts
  - Collection activities – returned to CAH as uncollectible
  - Documentation, Documentation, Documentation
  - Deceased Patients – Estate activity
  - Medicare Secondary Payor (MSP) questionnaires
- ER provider stand by time
  - Documentation
  - Contracts – alternative options
  - Time Studies
  - Charting Time
- Home Office
  - Allocation Method
- Related Party Costs
  - Ownership or Control
- Other

Communicate, Communicate, Communicate

- Communication is very important between the Finance Staff and the Clinical and Operations Staff.

- Hospital must consider cost report implications:
  - Strategic Planning
  - Budget Process
  - Contracting with other payers
  - Purchase of building and equipment
  - Leasing Arrangements
  - Staffing
  - Physician Contracts
  - New Services/Cessation of Services
  - Provider Based Entities

CAH Strategy
Use Cost Report as a Tool

- Model proposed decisions through the cost report
- Prepare Interim Cost Report

CAH Strategy
Other Reimbursement Options

- Medicare HMO contracts
- Out of State Medicaid
- Commercial Insurance
- Impact on Medicaid Supplemental Payments

CAH Strategy

Impact of Gross Charges on Patient Co-Insurance

Outpatient Charges	10,000,000	8,000,000	6,000,000
Cost to Charge Ratio	50%	63%	83%
Medicare Costs	5,000,000	5,000,000	5,000,000
Coinsurance (20% of billed charges)	2,000,000	1,600,000	1,200,000
Medicare Cash	3,000,000	3,400,000	3,800,000

Other users of the cost report

- Medicare Contractors
- Federal Agencies (CMS, OIG, DOJ, IRS, FBI)
- State Medicaid Programs
- Competing entities
- Commercial Payers and Part C Contractors
- Available under Freedom of Information Act (FOIA)

Legislation Impact – Past/Present/Future

- Balanced Budget Act (BBA) of 1997
- Balanced Budget Refinement Act (BBRA) of 1999
- Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
- Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003
- Medicare Improvements to the Patients and Providers Act (MIPPA) of 2008
- American Recovery and Reinvestment Act
- Affordable Care Act
- REACH Proposal, Farm Bill, Medicaid work rule
- ????????

Resources

- **Rural Health Information Hub** https://www.ruralhealthinfo.org
  - https://www.ruralhealthinfo.org/am-i-rural
- **National Rural Health Resource Center** https://www.ruralcenter.org
- **National Association of Rural Health Clinics** https://narhc.org
- **Medicare Learning Network** http://go.cms.gov/MLNGenInfo
- **Flex Monitoring Team** http://www.flexmonitoring.org
- **National Rural Health Association** https://www.ruralhealthweb.org

Top 5 Take-Aways

- Make sure you get what you are entitled to
- Proper Matching of Revenue and Expense
- Communication and Education
- Only thinking about the cost report at year end – prepare for it all year long
- Use the cost report as a decision making tool

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QUESTIONS?

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