Medicare Cost Report Hot Topics!

HFMA Region 11 *January 2017*

Presented by:

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Outline

- Overview of cost report
- Wage index
- Occupational mix
- Patient days
- Uncompensated care costs
- Common cost report issues
- Provider based clinic revenue tracking
- Bad debt

What is a Cost Report?

- A costing system – pretty insightful, huh?
- Product costing and profitability
  - Products are services
  - Methodology is defined by CMS
- Profitability excludes discounts

Costing System

- Routine costs per day
  - Acute care
  - ICU
  - CCU
  - Nursery
  - NICU
  - Nursing home
  - Rehabilitation
  - Psychiatric
- Cost per encounter or visit
  - RHC
  - Home health
- All others are cost per charge

Routine Example

Direct ICU costs	$	1,000,000
Allocated support costs		650,000
Total ICU costs	**$**	**1,650,000**
ICU days		500
Cost per day formula	=	$ 1,650,000/500
Cost per day	$	3,300

Ancillary Example

Direct laboratory costs	$	1,000,000
Allocated support costs		650,000
Total laboratory costs	**$**	**1,650,000**
Total laboratory charges	$	2,500,000
Cost to charge formula	=	$ 1,650/2,500
Cost-to-charge ratio		0.660000

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RHC Example

Direct RHC costs	$	1,000,000
Allocated support costs		650,000
Total RHC costs	**$**	**1,650,000**
Total RHC encounters		10,000
Cost per encounter formula	=	$2,500,000/10,000
Cost per encounter	$	165.00

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Allocated Support Costs

- Examples: dietary, housekeeping, utilities, CFOs, meeeeeeee!
- How these costs get to the revenue producing departments is one stage of the cost report strategy.

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A Cost Report Is

- Departmental summary of
  - Costs
  - Charges
  - Days/encounters/visits

&

- The relationship between
  - Costs
  - Charges
  - Days

The Matching Game

- Departmental matching
  - Department revenue (general ledger number)
  - Department expense

- Cost report matching
  - Revenues (revenue code)
  - Cost (including support costs)
  - How Medicare was billed – HAHA I mess things up!

Cost Report Focus

- Costs
- Cost allocations
- Charges
- Days
- Encounters
- Matching

It is a Hospital Cost Report

- Hospital services
  - Inpatient services
  - Outpatient services
  - Provider-based departments
- Not part of the cost report
  - Physician services
  - Non provider-based locations
- Partially part of the cost report
  - Provider-based clinics

...PROCEED.

Cost Report Set Up

Worksheet	Purpose
S-3	Days, wage index
A	Expenses by departments
B-1	Allocation of support costs
C	Charges
D & E	Settlement
M	Rural health clinic
H, I, & K	Home health, dialysis, and hospice, respectively

Wage Index

- Cost of hiring in geographic area
- Based on Core Based Statistical Areas (CBSA)
- Average hourly wage compared to nation average
- Plus or minus 1 — 1 is the average
- Effects approximately 60% of Medicare payments

Wage Index

- Salaries (some areas excluded)
- Contracted wages (costs on GL, hours omitted)
  - Patient services
  - Top level management
  - Other administrative costs
  - Housekeeping
  - Dietary
- Benefits
- Divided by hours
  - Hours are 50% of the calculation

Wage Index Issues

- Financial statement audits are allowable
  - Even those from home office
- Legal costs are allowable (must be related to patient care)
- PTO hours reported in year paid

Wage Index Benefits

- Physician benefits
  - Use actual
  - If actual is not feasible, use benefits per FTE
- Actuary or other pension related costs are part of pension costs (no hours needed)
- Employee discounts are allowable (use CCR)

Common Issues with Hours

- Highly paid contractor hours not reported
  - Tip: insist on hours being reported on the invoice
- Capitalized salaries, hours not removed
- On-call hours
- 3/12 shift hours reported as 40 (Baylor hours)
  - CR instruction require exclusion of bonus hours
  - Issue under appeal (and adverse appeal, so beware)
- PTO paid in lieu or at termination
- Think worked hours

Common Issues with WI Costs

- Contract labor omitted or reported on GL incorrectly
- Capitalized salaries
- Bonuses are reported as salary
  - Bonuses hours are not reported
- Physician Part A time
  - Time study (not required) or in contact, please
- Benefits hidden in departments

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Occupational Mix

- Meant to adjust for nurse staffing mix
  - Incentivizes for using lower paid nurses
- Every three years – should be 2016
- Calendar reporting
- Likely due July 1, 2017
- Effects 2019, 2020, and 2021 wage index

Occupational Mix Strategy

- Minimize RN category
- Search for positions that can be considered aides
- Maximize aides and medical assistants
- Exclude (not “all other”) positions that are billed separately)

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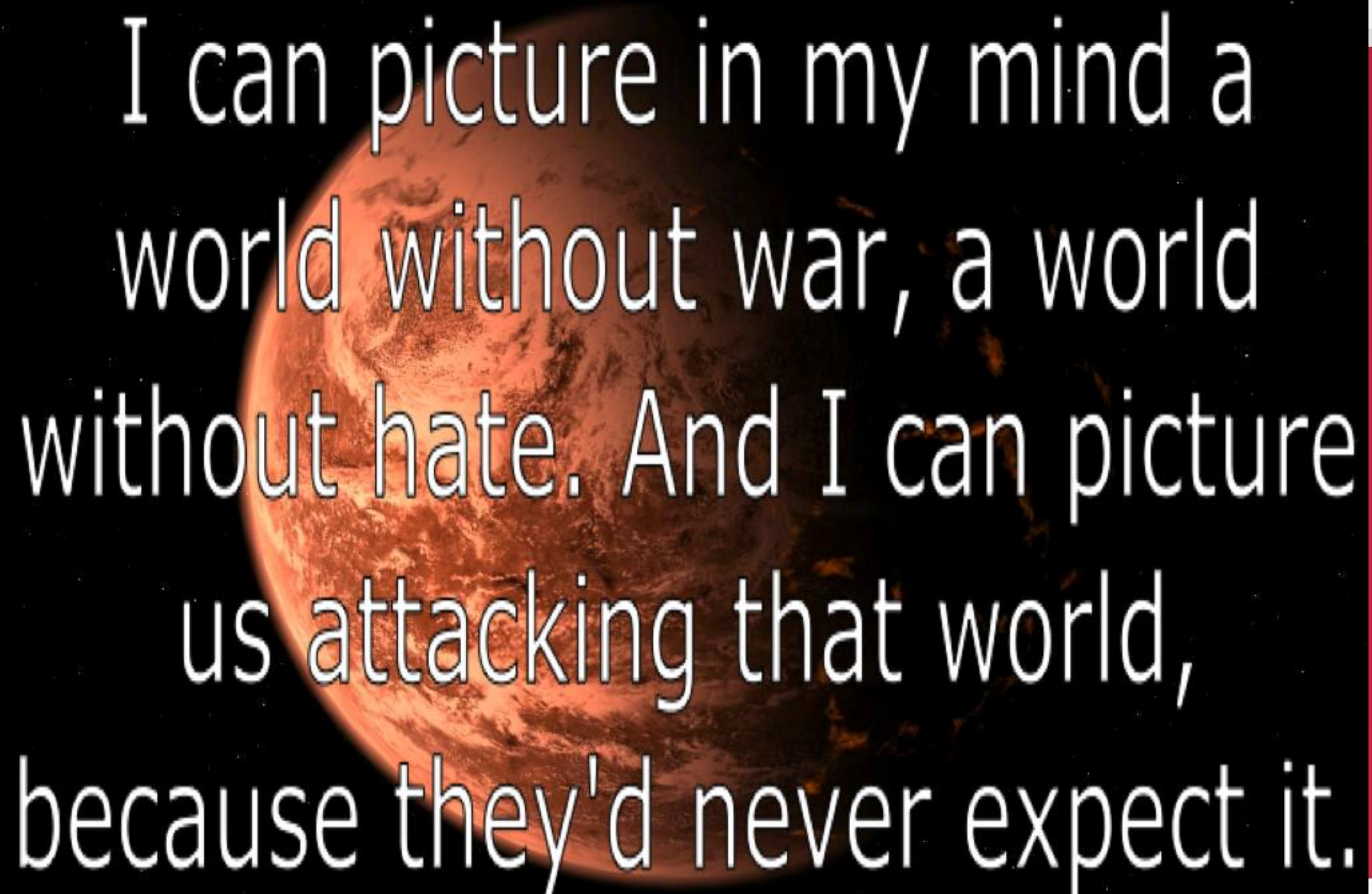
Occupational Mix Issues

- Enlist the nurse manager to help brainstorm categories
- RNs doing solely administrative, education, or management functions – all other category
- Aides – provide basic patient care under direction of nursing staff
  - Who changes linens
  - Sitters
  - Who moves patients
  - Telemetry techs


I can picture in my mind a world without war, a world without hate. And I can picture us attacking that world, because they'd never expect it.

Patient Days

- Days effect:
  - DSH payment
  - GME payment
  - Allied health payments
  - Cost calculations

Common Days Issues

- Labor & delivery days not tracked separately
- Test patients: new system or new nurse
- Observation patient included in count
- Hospice days
- Do not reconcile between reports
- Excel errors
- Observation units include items billed as labor and delivery (720 vs 762 revenue code)

CAH Swing Beds

- Skilled swing bed days (SNF) –
  - A Medicare beneficiary in a swing bed and Medicare is picking up the bill
  - A Medicare Advantage beneficiary in a swing bed and the Medicare Advantage company is picking up the bill
- Non-skilled swing bed days (NF)
  - EVERYTHING ELSE

CAH Swing Beds (Continued)

- Issue: skilled vs. non-skilled level of care
- Medicare pays cost
- Medicaid pays prospectively
- Non Medicare days “carved out”

CAH Swing Beds: the Calculation

Acute care cost	$2,000,000
Swing bed rate	250
Acute care days	1,200
Medicare days	900
Swing bed days	400
Medicare swing	300
Medicare advantage swing	25
Other swing	75
Days for use?	
Acute plus swing	1,600
Acute plus Medicare swing	1,525

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CAH Swing Beds (Continued)

	No NF days	Some NF Days	All NF Days
Swing NF days	-	50	75
Swing NF rate	$ 250	$ 250	$ 250
Swing NF costs	$ -	$ 12,500	$ 18,750
Total costs	$ 2,000,000	$ 2,000,000	$ 2,000,000
Less swing NF (carve out)	-	(12,500)	(18,750)
Total cost for calculation	$ 2,000,000	$ 1,987,500	$ 1,981,250
Total days	1,600	1,600	1,600
Less NF days	-	(50)	(75)
Days for calculation	1,600	1,550	1,525
Per diem	$ 1,250	$ 1,282	$ 1,299
Medicare days	1,200	1,200	1,200
Medicare cost	$ 1,500,000	$ 1,538,400	$ 1,558,800
Increase over no NF days	**$ -**	**$ 38,400**	**$ 58,800**

CAH Swing Beds (Continued)

- Verify all swing bed days by payor (not by primary payor field)
- Patients change payor status after admission
- To correct at desk review requires additional support

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Common Swing-Bed Issues

- More swing bed days reported on PS&R than internal statistics
- Days counted as Medicare after skilled portion of stay
- Patients reflected as Medicare after benefits exhausted
- Swing-bed charges billed under hospital provider number
- Started as skilled but did not meet qualifications
- Non-Medicare swing beds called Medicare to cost report preparer – usually with much conviction (Medicare beneficiary in non skilled stay)

CAH Swing Beds (Continued)

- Medicare pays skilled nursing facility care based on RUGs
- Swing bed care and rules are the same as skilled nursing facility, but provided in acute care setting
  - No MDS for swing bed patients

Uncompensated Care Payments

- Medicare DSH split between traditional DSH payments and uncompensated care
  - 25% traditional DSH payment
  - 75% uncompensated care calculation

Uncompensated Care Calculation

- Current Calculation
- Hospital’s “insured low-income days”
- Total “insured low-income days”

Uncompensated Care Calculation (Continued)

- 2017 calculation – 3 year average
  - Hospital's FY 2011 Medicaid days and 2012 SSI days
  - Total FY 2011 Medicaid days and 2012 SSI days

    \+
  - Hospital's FY 2012 Medicaid days and 2013 SSI days
  - Total FY 2012 Medicaid days and 2013 SSI days

    \+
  - Hospital's FY 2013 Medicaid days and 2014 SSI days
  - Total FY 2013 Medicaid days and 2014 SSI days

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Uncompensated Care Calculation (Continued)

- 2017 – 2020 calculation is a 3-year average
- For those not loving the math:
  - Calculate three years using the old method
    - Add those together
    - Divide by three
    - Boom – UCC factor for your hospital

Uncompensated Care Costs

- Proposal to use 2017 worksheet S-10
  - Effects 2021 UCC payment
- 2017 will likely be part of your calculation for 3 years (as will 2018, 2019, etc.)
- S-10 now officially matters

Uncompensated Care Costs (Continued)

- Uncompensated care cost:
  - Cost of charity care

    +
  - Cost of non-Medicare bad debt

    +
  - Medicaid shortfall
- Or some combination of the above

Uncompensated Care Costs (Continued)

- Further definitions for S-10 to come from revised cost report workpapers and future rule making
- However, first year is 2017 data, so get at least the charity care portion correct

Other S-10 Proposed Clarifications

- Charity care – claim based on date of write-off (not dates of service)
- “Trims” – to keep hospitals from gaming the CCR
  - Includes statewide averages and knocking out those with higher CCRs (3 over standard deviation)
  - This means ALL HOSPITALS need good S-10 data
  - Analysis was completed comparing IRS data to hospital S-10 data, critical access hospitals, just saying

Charity Care Cost

Insured Patients

- Full deductible and coinsurance amounts (not just the amount written off)
- Partial payments

Uninsured Patients

- Total charge (not the amount written off)
- Partial payments

- Why do total charges matter, you may ask?

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Charity Care Cost (Continued)

Uninsured Patients

- Total charge
- Times CCR
- Equals initial cost

- Initial cost
- Less partial payment
- Equals cost of charity care

Insured Patients

- Total deductible or coinsurance
- Times CCR
- Equals initial cost

- Initial cost
- Less partial payment
- Equals cost of charity care

Charity Care Cost – Now With Numbers!

Overall RCC	48%	
	Net of Payment	Exclusive of Payment
Total charge	$ 500,000	$ 500,000
Partial payment	100,000	100,000
Net	400,000	400,000
Charges for calculation	400,000	500,000
Calculated cost	192,000	240,000
Less partial payments	(100,000)	(100,000)
Uncompensated care cost	$ 92,000	$ 140,000

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Charity Care Reconciles to the GL

- Total charges reported (insured plus uninsured)
  - Less: partial payments
  - Less: unpaid amounts (sliding scale charity likely sitting in bad debt)

- Equals: charity care per general ledger

Common Charity Care Issues

- Total insured charges includes:
  - Total charge (patients portion and insurance's responsibility)
  - Payment by insurance company
- Total charge report is net of patient payments
- Total charges includes physician charges

Bad Debt Cost

- Bad debts per the general ledger
- Less: Medicare bad debts (these are reported on E,B, E,A or E,III)
- Net bad debt

- Net bad debt
- Times CCR
- Cost of bad debt

S-10 Reminder

- Match charges to worksheet C
- What’s that mean?
- Physician charges are excluded

I THROW MY HANDS UP IN THE AIR SOMETIMES
LEGO
SINGING AYYYYYYYYYO
I'M A LEGO

Common Issue: Supply Expenses

- Coding supply expenses:
  - Medical supplies not separately charged
  - Medical supplies charged to a patient using 27X
  - Implantables (typically charged using 275, 276, 278, and 624)
  - DZA recommends:

Record in central supply:

- One chargeable medical supply expense account
- One chargeable implantable supply expense account

Record in individual departments:

- Non-chargeable medical supplies
- Office supplies

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Common Issue: Other Outpatient Services

- Where are these services provided
  - Acute care
  - Outpatient department
  - ER
  - Mixture
  - If billing separately, must be able to trace time by department
  - TIME STUDIES

Common Issue: Other Outpatient Services (Continued)

- Observation performed in ER and ICU
- IV therapy
- Chemo
- Blood administration
- Treatment room
- Other injections

Common Issues: Miscellaneous Revenue

- General rule: remove expense equal to other revenue amount
- Non-offsetable items included in other income account
  - HPSA payments
  - BC/BS incentive payment
  - Donations
  - Small grants
- Grant expenses netted against grant income
- Other revenue offset and statistic reported on a nonallowable cost center

Common Issues: Miscellaneous Revenue (Continued)

- Collection agency expenses netted with contractual adjustments
- Interest expense on capital leases
- Expenses incurred by related party on behalf of the hospital not reported
  - Snow removal by county
- Uncollected interest charged on patient accounts written off to bad debt

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Interest on Patient Accounts – The Example

- Interest charged = $100,000
- Collected = $20,000
- Administration cost-based percentage = 40%

	Charges Reversed	Charges Written Off to Bad Debt
Charges reported	$ 20,000	$ 100,000
Cost of offset	(8,000)	(40,000)
Revenue received	20,000	20,000
Net gain/(loss)	**$ 12,000**	**$ (20,000)**

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Common Issues With Physician Costs

- Not updating contracts
- Not tracking actual time
- No proof physician not working in clinic
- Log data incomplete
- Log data contains entire stay (observation hours or acute hours)
- Medical director duties not in contract
- Costs grouped with other costs
- Cost does not reconcile to contract
- Not tracking physician time between locations (surgeon time in surgery and free-standing clinic)

Emergency Room Physician Availability

- Back in the hot seat
- Pull out your PRM and ensure you have back-up documentation
- Currently under attack:
  - NAS – time studies
  - WPS – everything

ER Physician Availability Documentation

- Signed contract
  - Consider how often it is updated
- Allocation agreement between patient services, availability, and administration time
- Record of payments made to physicians
  - Must match contract
- Record of time physician on-site
  - Does not apply to CAHs unless your are WPS
- Record of all patients
- Schedule of physician charges
- Evidence of alternative methods
  - NAS will not hold you to this if other items are met (others may)

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Common Overhead (OH) Issues

- Directly-assigned OH Costs
  - Admitting
  - Patient billing
  - Medical records
  - Insurance
  - Nurse administration
  - Housekeeping or maintenance directly assigned to medical office buildings
  - Utilities
- Avoid double-allocation

Common OH Issues: Square Feet

- Net method used for hospital building and gross from clinics
- Not updated
- Remeasure periodically

Cafeteria Common Issues

- Off-campus FTEs included
- Other areas that do not use cafeteria (perhaps call sites)
- Issue: these are typically issues outside of cost areas

Central Supply Issues

- Departments reported with supplies not ordered or stored by CS
  - Reagents
  - Food
  - Drugs
  - Films
  - Others?

Allocation Statistics – Watch List

- A-6 Reclassifications:
  - Account for any expense reclassifications on the related statistic (e.g. salaries & hours)
- Be aware of departments that may or may not actually utilize the overhead department:
  - Home health maintains their own medical records
  - Housekeeping does not clean rented space

Time Studies

- These tend to be set up and forgotten – issues we have seen:
  - Passive aggressive staff makes up numbers
  - Omits departments
  - Groups departments
    - KEY – Set up the proper departments
    - Another KEY – Monitor, Monitor, Monitor

Time Studies (Continued)

- Examples include:
  - Laundry pounds
  - Housekeeping
  - Medical record
  - Social service
  - Maintenance
  - Emergency room physician

Time Study Rules

- At least one full week per month
- A full work week (e.g. 7 days)
- Equally distributed among the months (e.g. 3 months use 1st week; 3 months use 2nd week; etc.)
- No two consecutive months may use the same week
- Contemporaneous with the costs
- Provider specific

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What if I never
find out who's a
good boy?

Off-campus Provider-based Locations

- Budget reconciliation
  - Site neutral payments for PPS
  - Starting January 1, 2017
  - Off-campus provider-based locations
- 340B pharmacy programs

Provider Based Clinic Revenue

- Typically four types of revenues
  - Hospital services tracked back to clinic
  - Global clinic charges
  - Professional clinic charges
  - Technical clinic charges

Provider Based Clinic Revenue (Continued)

- Hospital services must be removed first
- Method II split charges to Medicare
- Global charge billed to other payors
- Must make the two match on cost report
  - Basis for split (Medicare)
    - Set amount per charge
    - Percentage of charge

Provider Based Clinic Revenue (Continued)

- Example:
  - 99213 standard charge
    - Professional = $100
    - Technical = $25
    - Total = $125
  - Medicare billed 75 patients
  - Blue cross billed 75 patients

PBC – Clinic Only

	Medicare	Blue Cross	Rev. Code
Professional	$ 7,500	$ -	983
Technical	1,875	-	510
Global	-	9,375	983
	$ 9,375	$ 9,375	

Total revenue code 983	$ 16,875
Total revenue code 510	1,875
Total revenue	$ 18,750

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PBC – Clinic Only (Continued)

Medicare charges:			
Professional	$	7,500	80%
Technical		1,875	20%
Total Medicare charges	$	9,375	
Total charges:			
Professional	$	15,000	80%
Technical		3,750	20%
Total charges	$	18,750	

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PBC – Clinic and Hospital

	Medicare	Blue Cross	Rev. Code	
Professional	$ 7,500	$ -	983	80%
Technical	1,875	-	510	20%
Global	-	9,375	983	
Hospital	4,000	4,000	983	
	$ 13,375	$ 13,375		

Total revenue code 983	$ 24,875
Total revenue code 510	1,875
Total revenue	$ 26,750

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PBC – Clinic and Hospital (Continued)

	Charges	Less Hospital	Net	%	Charges for C
Total revenue code 983	$ 24,875	$ -	$ 24,875	80%	$ 21,400
Total revenue code 510	1,875	-	1,875	20%	**5,350**
Total revenue	$ 26,750	$ -	$ 26,750		$ 26,750

	$ Charges	Less Hospital	Net	%	Charges for C
Total revenue code 983	24,875	$ 8,000	$ 16,875	80%	$ 15,000
Total revenue code 510	1,875	-	1,875	20%	**3,750**
Total revenue	$ 26,750	$ 8,000	$ 18,750		$ 18,750

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FLY HERE!

Medicare Bad Debts

- Medicare deductibles and or coinsurance:
  - Hospital services only (not physician)
  - RHCs
- Paid at 65% of the amount claimed
- Excludes professional charges and any other fee schedule payments
  - Method II billing
- High audit probability

Medicare Bad Debts (Continued)

- Three types:
  - Reasonable collection efforts
  - Medicaid secondary payor (crossovers)
  - Written off under charity care policy (indigent)

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Reasonable Collection Effort

- Deemed uncollectible using the hospital's normal collection efforts
- Treated similarly to other payors, and billed with the intention of receiving payment for at least 120 days:
  - 120 days from date the bill was first sent to beneficiary to date it was deemed uncollectible and written off of the Hospital's books
  - Collection agencies strategy
- Sound business judgment established that there was no likelihood of recovery at any time in the future
- Must have auditable support

Crossovers

- Type of indigent bad debt:
  - Medicaid is responsible for payment of deductible and coinsurance
  - Must be billed and denied by Medicaid
  - Not subject to the 120-day rule
- Can claim partial and full write-offs

Medicare Bad Debt – Charity Care

- Type of indigent bad debt:
  - Written off under the hospital's charity care policy
  - This is often overlooked by hospitals
  - Not subject to the 120-day rule
- Can claim partial and full write-offs
- Auditable support
  - Are you following your charity care policy
  - Do you have copies of patient data
  - Is there support it was approved?

Other Rules

- Must write off in the same manner as other payors
- Must be returned from collections
  - Remember the first “other” rule
- Must be supported by auditable evidence
- Must be claimed in the year it is written off (or returned from collections)

Same Method as Other Payors

- Issue: collection on $50-$1,400 Medicare coinsurance or deductible compared to $10,000 self-pay amount
- Sent to collections
- Payment schedule
- Called back from collections

Medicare the Same Strategies

- Call back from collections based on amount
- Call back based on account activity (120-180 days of no activity)
- Max amount of time to collect on an account (above is better, of course)

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Documentation

- CMS' Exhibit 5
  - Beneficiary's name
  - Beneficiary's number
  - Medicaid number (if applicable)
  - Identified as indigent (if written off under charity care)
  - Dates of service
  - Date a bill was first sent to beneficiary
  - Date bill was written off
  - Amount of coinsurance
  - Amount of deductible
  - Amount of partial patient (or 3rd party) payment
  - Amount of bad debt claimed

Documentation Issues

- Date written off not in cost report year
- Date written off missing
- Reasonable collection effort for fewer than 120 days
- Not billed to Medicaid
- Includes coinsurance for physicians (method II issues)

Recommendations

- Track throughout the year
- Use identifier in system
- Keep back up data
- Use excel formulas
- Devise return from collection plan to optimize collections and payment on Medicare bad debts
- Have formal policies

Questions

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