1

Polling Question 1

How experienced with the cost report are you?

1. Brand new, very little exposure
2. Somewhat comfortable, I understand parts
3. Very comfortable, I understand most of it
4. Expert, I am only here for the free CPE

2

2

What is the purpose of a Medicare Cost Report?

- Informational
- Determination of Medicare's share of costs
- Determination of cost settlement

3

3

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

4

4

How CAHs Are Paid

1. Inpatient days
2. Expenses
3. Revenue

Inpatient Routine	EXPENSES / DAYS	=	$ per day
Outpatient (& IP ancillary)	EXPENSES / REVENUE	=	Cost-to-charge ratio (CCR %)
RHC	RHC EXPENSES / RHC VISITS***	=	$ PER VISIT

5

5

Cost-based Reimbursement by Department

6

Polling Question 2

Do you have any idea how much of your departments are reimbursed by Medicare/Medicaid?

1. I have no idea
2. I have a general idea
3. I know and use this knowledge in my management decisions; again, I am only here for the free CPE

7

7

Cost-based Reimbursement by Department

- How much of a department is Medicare utilization (or Medicaid, depending on the State)?
- Management tool
- Operational decisions should take reimbursement effects into consideration

8

8

Department description	CMS #	Total allowable expenses	Percentage of total cost reimbursed	Reimbursed expenses
Overhead departments:				
Capital Costs - Clinic building	1.00	70,180	**17.89%**	12,555
Capital Costs - Hospital building	1.01	4,917,009	**32.06%**	1,576,393
Capital Costs - Clinic movable equipment	2.00	165,732	**21.23%**	35,185
Capital Costs - Hospital movable equipment	2.01	721,339	**32.06%**	231,261
Nursing administration	13.00	238,880	**39.10%**	93,402
Central services & supply	14.00	367,146	**32.66%**	119,910
Pharmacy	15.00	1,001,043	**50.15%**	502,023
Medical records	16.00	552,698	**33.47%**	184,988
Revenue producing				
Acute care (acute, swing bed, & observation)	30.00	3,773,289	**50.08%**	1,889,663
Operating room	50.00	1,976,365	**25.81%**	510,100
Labor & delivery	52.00	17,879	**0.00%**	-
Emergency room	91.00	2,019,077	**25.75%**	519,912
NonReimburseable:				
Gift Shop	190.00	-	**0.00%**	-
Physicians' Private Offices	192.00	5,281,290	**0.00%**	-
Provider-based physician adjustment	A-8	3,691,067	**0.00%**	-

9

9

Department description	CMS #	Proposed Expense/ (Savings)	Medicare/ Medicaid Reimburse-ment Effect	Bottom Line Effect
Overhead departments:				
Capital Costs - Clinic building	1.00		-	-
Capital Costs - Hospital building	1.01		-	-
Capital Costs - Clinic movable equipment	2.00		-	-
Capital Costs - Hospital movable equipment	2.01		-	-
Nursing administration	13.00		-	-
Central services & supply	14.00		-	-
Pharmacy	15.00		-	-
Medical records	16.00		-	-
Revenue producing				
Acute care (acute, swing bed, & observation)	30.00	30,000	15,024	(14,976)
Operating room	50.00	(50,000)	(12,905)	37,095
Labor & delivery	52.00		-	-
Emergency room	91.00	(30,000)	(7,725)	22,275
				-
NonReimburseable:				-
Gift Shop	190.00		-	-
Physicians' Private Offices	192.00		-	-
Provider-based physician adjustment	A-8		-	-
		(50,000)	(5,606)	44,394

10

10

Auditable Evidence

11

Auditable Evidence

- Everything on the cost report can be audited
  - Patient days
  - Expenses
  - Revenues
    - Cost-to-charge ratios
  - Allocation statistics

12

12

Auditable Evidence

- Emphasis on costs being claimed as allowable
  - Physician contracts
    - Medical Director
  - Time studies
  - Contracted therapy invoices
  - Advertising detail
  - Bad debt
  - RHC Vaccines

13

13

Patient Days

14

Patient Days

- Small variances have large effects
  - Half the calculation of the per diem
- Includes:
  - Acute care
  - ICU
  - Observation
  - Swing bed (skilled only, more to come)

15

Counting Days: Example

Original day count		900
Medicare days		475
Inpatient costs	$	2,250,000
Per diem	$	2,500
Medicare reimbursement	$	1,187,500

16

Counting Days: Example

Adjusted days		750
Medicare days		475
Inpatient costs	$	2,250,000
Per diem	$	3,000
Medicare reimbursement	$	1,425,000
Additional reimbursement	**$**	**237,500**

17

Common Acute Care Issues

- Swing bed days included in acute care count
- Observation patients included in count
- Hospice days not tracked separately
  - Contracted hospice program
  - Identified and reported separately
- LDR days not tracked separately
  - Mother in labor at midnight – should not be included in count

18

Common Acute Care Issues

- Days do not reconcile to billed days
  - Reconcile monthly/quarterly
  - Detail vs. summary reports
- Test patients (included in summary reports)
  - Use one name for test patients
- Excel spreadsheet does not foot

19

Observation Equivalent Days

- Included in total calculation
- Document the location of service (ER vs. ICU vs acute vs observation unit)
  - Compare hour counts to hourly charge units
  - Identify observation charges not performed on the acute care floor

20

Common Observation Day Issues

- Observation patients counted in ER and cost report preparer not informed
- Observation charges billed using revenue code 720 (L&D) included in observation count
- All hours counted for each block of hours charged

21

Polling Question 3

How often do you review your detail swing bed patient days and reconcile to make sure the payor is correct?

1. Monthly to ensure proper reporting and tracking.
2. Quarterly to ensure proper reporting and tracking.
3. At the end of the year to ensure proper reporting and tracking.
4. Pretty sure that happens when the cost report is prepared.

22

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**

23

CAH Swing Beds

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

24

CAH Swing Beds: the Calculation

- Example swing bed "carve out"

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

25

25

CAH Swing Beds

	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**

26

26

Common Swing Bed Issues

- Difference between swing bed days reported on PS&R and 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 qualification
- Remember – corrections at desk review requires additional support

27

27

Strategies for Routine Areas

- Provide skilled care in acute care (not the nursing home)
- Use traveling nurses in acute care (or ICU) before observation unit, emergency room, or nursing home
- Provide respite care – charge more than the swing NF rate
- Adjust Medicare rates when costs increase (Medicare Advantage)
  - Medicaid, too, depending on your state

28

Physician Cost

29

Polling Question 4

How often are your physician contracts reviewed and updated?

1. Every year
2. Every couple years
3. When we hire a new physician
4. Question 4 is the halfway mark for CPE acknowledgement – weeee!

30

Hospital-based Physicians

- **Physician expenses generally nonallowable**
- ***Exceptions:***
  - RHC
  - CRNA (with exemption)
  - Medical director or administrative duties
  - ER on-call

31

Hospital-based Physicians

- **Physician costs**
  - **Includes** mid-levels: physician assistants and nurse practitioners
  - Salaries
  - Benefits (excluding employment taxes)
  - Contracted labor
  - Possibly malpractice

32

Physician Benefits

- Costs include benefits paid
  - Track actual benefits
- Actual benefits not tracked
  - Salaries % of total
  - FTEs % of total
- Costs exclude payroll taxes
  - Employment related taxes for provider-based physicians are allowable

33

Physicians Expense in Clinics

- Physician expense in provider-based clinic is removed
- Physician expense in free-standing clinic lives in a nonallowable cost center and is not removed

34

Physicians Expense in Clinics – Example

- Physician expense in provider-based clinic removed = $200,000
- Physician expense in free-standing clinic lives in a nonallowable cost center
  - = $200,000 x .22 administration unit multiplier
  - = $244,000 disallowed
- **Strategy**: time study for time at hospital versus time in clinic

35

Medical Director Time

- Medical director, supervisory, and administrative time are allowable costs
- Update physician contracts with medical director duties
  - Type
  - Payment
  - Hours
    - Can be based on time studies (but must be part of duties in the contract)

36

Common Issues With Physician Cost

- Cost does not reconcile to contract
- Costs grouped with other costs
- Not tracking physician time between locations (surgeon time in surgery and free-standing clinic)

37

37

Physician Cost Between Locations

- Assume:

Administration costs (allocated costs)	25%
Surgeon paid, free-standing clinic	$ 300,000
Surgeon spends 50% of time in clinic and 50% of time performing surgeries	
Administration cost based	40%

38

38

Physician Cost Between Locations

- The calculation:

Surgeon costs	$ 300,000
Time spent in hospital	50%
Surgeon costs, hospital portion	$ 150,000
Administration costs (allocated costs)	25%
Administration costs allocated	$ 37,500
Administration cost based	40%
Hospital reimbursement	$ 15,000

39

39

Emergency Room Providers

40

Polling Question 5

How are you tracking ER on call time

1. Time study
2. ER logs
3. Electronic – VersaBadge or something similar
4. Tracking? I thought the cost report preparer did that.

41

41

Emergency Room Providers

- Emergency room providers on-call
  - MD, DO, PA, or NP
  - Trained in emergency medicine
  - Must be available to respond within 30 minutes
  - Written contract
  - Not otherwise providing patient services
    - In their own clinic
    - In the hospital's clinic

42

Emergency Room Providers

- **Actual time best**
  - Actual time maximizes allowable costs
- Time study
  - Receptionist or nurse can track the provider's time
- Summary of ER logs is an option
  - Add in/out on emergency room log

43

Emergency Room Providers

- Time studies
  - Noridian currently allows:
    - Physician: two 2-week time studies (24/7)
    - Mid-levels: one week time study each month (24/7)
  - Other MACs:
    - One week time study each month (24/7)

44

Proper ER Time Study

- Patient identifier (be able to crosswalk from the ER logs to the ER time study)
- Date
- Time physician starts
- Time physician finishes
  - There may be multiples of these
- Time physician is charting

45

Proper ER Time Study

- Correct
  - Time in: 13:42
  - Time out: 13:49
  - Charting: 13:49-13:50
- Incorrect
  - Time: 7 minute
  - Charting: 1 minute

46

Emergency Room Providers

- Providing other patient services while on-call
  - In clinic but on-call for ER
  - Time must be carved out as patient time

47

Emergency Room Coverage Types

- Billing – ER company versus hospital
  - If ER company is billing, the only thing you can be paying for is administrative services
  - If hospital is billing, you need an allocation agreement

48

B-1 Statistics - Tracking

49

Polling Question 6

Do you know what statistics are used to allocate expenses on your cost report?

1. Statistics? The only statistic I know is how much of this CPE is left
2. I know square feet is one of them!
3. I know most of them
4. I know all of them and know who is tracking them at our facility

50

50

B-1 Statistics - Tracking

- Used to allocate all overhead costs to revenue producing departments
- Must be tracked/updated every year
- Often an afterthought
  - Time studies completed?
  - Laundry pounds counted?
  - Changes to square feet?
  - Do we know what statistics our cost report is using?

51

51

B-1 Statistics - Tracking

- DZA recommendations:
  - Square feet
    - Update regularly
    - Use a spreadsheet that tracks changes easily
    - Have a designated person tracking
    - Review quarterly that this is happening

52

52

B-1 Statistics - Tracking

- DZA recommendations:
  - Time studies
    - Plan ahead for what weeks to use
    - Teach those tracking how to track and why it's important
    - Have a designated person reviewing monthly

53

53

B-1 Statistics - Tracking

- DZA recommendations:
  - General
    - Review B-1 for what statistics your facility is using
    - Make sure there is a designated person tracking each statistic
    - Is there a better statistic to use?
      - Changes must be requested 90 days before year end

54

54

B-1 Statistics - Review

55

Allocation Statistics – Items to Watch For

- Typically, hospitals directly assigned OH to low or non cost-based departments
- Directly-assigned OH costs
  - Admitting (reception)
  - Patient billing
  - Medical records
  - Housekeeping or maintenance directly assigned to medical office buildings
  - Electronic medical records
- Avoid double-allocation

56

Allocation Statistics – Items to Watch For

- **A-6 Reclassifications**
  - Account for any related statistic for any expense reclassifications. (i.e. salaries and 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

57

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

58

58

Central Supply Common Issues

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

59

59

Nurse Administration Common Issues

- Costs may include:
  - COO
  - Acute care DNS
  - Nursing home DNS
  - Infection control
  - Education
- Identify departments that are supervised by the DNS
- Exclude professional hours from allocation
- Does the DNS need to supervise home health, hospice, clinics, ambulance?

60

60

Worksheet B-1 – Statistics Operational Issues

- Educate department heads
- Maintain/accumulate statistics monthly
  - Part of routine month end close
- Review the stats monthly
- Evaluate for accuracy:
  - Do the statistics reflect actual operations?
  - Are the stats reasonable?

61

Rural Health Clinics Fees and Encounters

62

Polling Question 7

Do you track your productivity by provider?

1. Only at year end when the cost report is prepared
2. Once in a while during the year
3. Every quarter we update our matrix and follow up on any unusual items
4. I'm still here! CPE credit acknowledgement button pressed!

63

RHC Productivity

- Minimum visits for per visit calculation
  [Productivity standard x FTE]
- Productivity standard
  - Consistent between facilities and years
  - 4,200 visits per physician FTE
  - 2,100 visits per mid-level FTE
  - Viewed in aggregate
- COVID-19?

64

64

Practitioner FTEs

- Determination of FTEs
  - Actual hours worked vs. paid hours
  - Time excluded:
    - Supervisory
    - Hospital time
    - ER time
  - Lower FTEs lowers the minimum visits
  - Lower minimum visits reduces the risk of having productivity issues

65

65

Overstated FTEs: the Calculation

Medicare visits		1,300				
Total costs	$	675,000				
Situation		Hours	FTEs	Productivity Visits	Actual Visits	Cost/Visit
Physician works "full time"		2,080	1.00	4,200	3,800	160.71
Physician 5 days, 7 hours, less 1 hour lunch		1,560	0.75	3,150	3,800	177.63
Decrease in cost-per-visit						(16.92)
Times Medicare visits						1,300
Cost of misstated FTEs						**$(21,996)**

66

66

Practitioner FTEs Recommendations

- Compare to schedule
- Think about breaks and lunch
- Review scheduling proactively or throughout the year for productivity issues
- Use matrix monthly

67

67

Productivity Matrix

Position	Name	FTE	Total Visits	Productivity Standard	Minimum Visits	Over (Under) Productivity
		1	2	3	4	5
PHY	Dr. A	1.00	4,000	4,200	4,200	(200)
PHY	Dr. B	0.75	4,000	4,200	3,150	850
PA	C	1.00	2,000	2,100	2,100	(100)
PA	D	0.75	3,000	2,100	1,575	1,425
NP	E	1.00	4,000	2,100	2,100	1,900
NP	F	0.75	3,000	2,100	1,575	1,425
		5.25	**20,000**		**14,700**	**5,300**

68

68

RHC Encounters

- Visits (encounters) are *medically-necessary, face-to-face* visits with the following practitioners:
  - Physician
  - Physician assistant
  - Nurse practitioner
  - Certified nurse-midwife
  - Clinical psychologist
  - Clinical social worker
  - Visiting nurse in home health shortage areas
- Nurse visits are not included as RHC visits

69

69

RHC Encounters

- Visits may take place at:
  - RHC
  - Patient's residence
    - Assisted living facility
    - Skilled Nursing Facility
  - The scene of an accident
- Visits that do no qualify as RHC visits:
  - Hospital (ER, observation, inpatient)

70

70

RHC Encounter Recommendations

- Patient detail
- Nurse visits
- Same day visits (use modifiers)
- Test patients

71

71

Effect of Including Nurse Visits

Medicare visits per the PS&R		4,210
Total encounters		9,500
Nurse visits		750
Total if nurse included		10,250
Total costs	$	1,662,500
Medicare cost per visit	$	175.00
Medicare cost per visit with nurse	$	162.20
Decrease in cost-per-visit	$	12.80
Times Medicare visits		4,210
Cost of nurse visits	**$**	**53,888**

72

72

Professional Revenue

73

Physician Revenue

- Follows expenses
  - Removed from cost report
- Ensure all physician revenue is removed before entered on worksheet C

74

74

Provider-based Clinic Revenue

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

75

75

Provider-based Clinic Revenue

- 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

76

Provider-based Clinic Revenue

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

77

Provider-based Clinic Revenue

- Example:

	Units	Per Unit	Revenue	Revenue Code	Breakout
Medicare charges:					
Professional	75	100	7,500	983	80%
Technical	75	25	1,875	510	20%
Total Medicare charges	75	125	9,375		
Blue Cross charges:					
Professional	75	125	9,375	983	
Technical	-	-	-	510	
Total Medicare charges	75	125	9,375		
Hospital charges	25	350	8,750	983	

	Unadjusted Charges	Less Hospital Charges	Adjusted Charges	Breakout	Adjusted Charges
Total revenue code 983	25,625		25,625	80%	22,000
Total revenue code 510	1,875		1,875	20%	5,500
	27,500	-	27,500	100%	27,500

78

Provider-based Clinic Revenue

- Example:

	Units	Per Unit	Revenue	Revenue Code	Breakout
Medicare charges:					
Professional	75	100	7,500	983	80%
Technical	75	25	1,875	510	20%
Total Medicare charges	75	125	9,375		
Blue Cross charges:					
Professional	75	125	9,375	983	
Technical	-	-	-	510	
Total Medicare charges	75	125	9,375		
Hospital charges	25	350	8,750	983	

	Unadjusted Charges	Less Hospital Charges	Adjusted Charges	Breakout	Adjusted Charges
Total revenue code 983	25,625	(8,750)	16,875	80%	15,000
Total revenue code 510	1,875		1,875	20%	3,750
	27,500	(8,750)	18,750	100%	18,750

79

79

PBC Recommendations

- Identify all by place of service
- Review which payors are being split billed
- Crosswalk of CPT codes by professional and technical charges (standard charge)
- Compare CPT place of service to physician's place of service

80

80

Manage Business Office

81

Polling Question 8

How often do you check in with your business office?

1. Every once in a while
2. At least once a month
3. When things look like they are going wrong
4. I work in the business office, no one said this was just for accountants

82

82

Manage Business Office

- It all comes down to billing and collecting
- Training
  - Turnover
- Chargemaster
- Charge capture

83

83

Manage Business Office

- Managing all third-party contracts
  - Negotiate contracts
  - Know if you are being paid correctly
- Review receivable agings by payor and by service type for trending
- Review denials for trending
- Manage collection agencies
  - Review collection policies
  - Review collection efforts

84

Questions?

85

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86