



CPAs & BUSINESS ADVISORS

THE HEALTH OF YOUR MEDICARE COST REPORT

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PRESENTER



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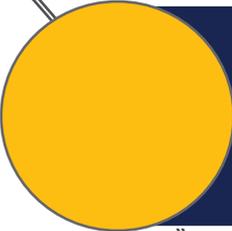
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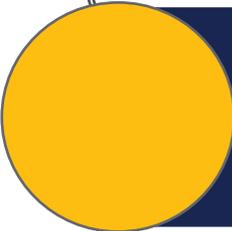
AGENDA

- Cost Report Audits/Reviews
- CAH Hours
- Patient Days
- Swingbed Days
- Cost Centers
- Reclassification of Wages
- Non-Reimbursable Overhead Expenses
- Miscellaneous Costs
- Other Income
- Emergency Room Availability
- B-1 Stats
- Worksheet B-2
- Medicare Bad Debts
- Hospital Revenues

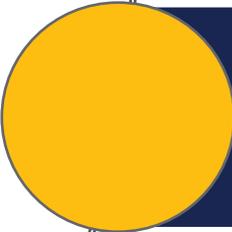
COST REPORT AUDITS/REVIEWS



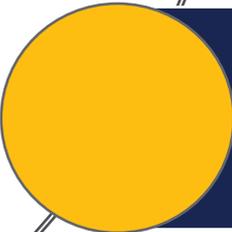
Must complete review within a year of receipt of the cost report unless having an audit.



Specifically seeing more detailed reviews and audits.



Common areas of review – variances, emergency room, Medicare bad debts



Asking for detail of general ledger accounts.

- Ensure they understand what they will get back!



CAH HOURS

CAH HOURS



Required to allow CMS to monitor compliance with CAH conditions of participation (Average length of stay of less than 96 hours).

Should include all inpatient acute hours for all payors.

Hours are calculated from admission to discharge – many providers have software solution to automate the collection of this information.

Not appropriate to report based on 24 hours per inpatient day. CMS is looking for exact for their calculations.

- Edits in cost report software.

Breakout between Adults and Peds and ICU, etc. if days are also broken out on cost report.



PATIENT DAYS



Are you accurately tracking patient days for cost reporting purposes?

- Acute Days
- Swingbed SNF Days
- Swingbed NF Days
- Nursery Days
- Observation Hours/Days
- Labor/Delivery Days

CONDITIONING



IP Routine (Adult/Peds) Direct & Indirect (Allocated) Costs

Adult & Peds Days + Swingbed SNF Days + Observation Days Equivalent

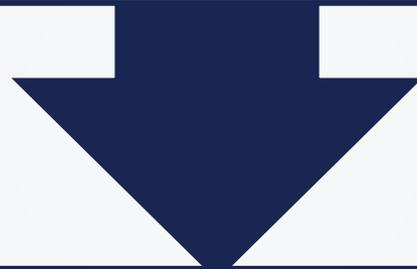
= Routine Cost per Day

Where do the days you are providing for cost report come from?

Internal manual statistics

Statistical report from EHR

Revenue/Usage report



Imperative that days are reported properly!

WORKSHEET S-3, PART I – LABOR AND DELIVERY

Labor and Delivery days – For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see [CMS Pub. 15-1, Chapter 22, section 2205.2](#)). In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum (LDP) room (also referred to as a birthing room), hospitals must determine the proportion of each inpatient stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (post partum) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 32. Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 32. These days must not be reported on Worksheet S-3, Part I, line 1 or line 14.

Ancillary labor and delivery room outpatient days - Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 8, the equivalent days for the entire hospital that are attributable to outpatient services provided in the distinct ancillary labor and delivery room. Calculate the number of days by dividing the total number of hours attributable to the outpatient services by 24, and round to the nearest whole day. These total outpatient hours include the hours for outpatients occupying the distinct ancillary labor and delivery room until they are admitted as inpatients or are discharged from the hospital. For example, one patient is admitted as an inpatient after first occupying the distinct ancillary labor and delivery room bed for 8 hours. Therefore, for this patient, 8 hours would be included in the sum of the total hours used to compute equivalent days to be entered on line 32.01. Another patient is admitted to the distinct ancillary labor and delivery room for monitoring of possible labor or for a sonogram, etc. After spending 6 hours in this department (room), this patient is discharged from the hospital without being admitted as an inpatient. Therefore, for this patient, 6 hours would be included in the sum of the total hours used to compute the equivalent days to be entered on line 32.01. These outpatient labor and delivery days are used on Worksheet E, Part A, to reduce the available bed days reported on line 32 so that only those distinct ancillary labor and delivery room beds which are occupied by inpatients or are unoccupied are ultimately counted as “beds.”



SWINGBED DAYS

- Swingbed SNF – Medicare and Medicare Advantage days only
- Swingbed NF:
 - All other payers swingbed days
 - Carved out at average statewide Medicaid rate



SWINGBED DAYS - ISSUE

- Significant variance between Medicare PSR and reported internal Medicare swingbed days.
- Were they really Medicare days and should be reported on Swingbed SNF line?





SWINGBED DAYS — ISSUE (EXAMPLE)

- Total Acute Days = 1,400
- Medicare Acute Days (PSR) = 760
- Swingbed SNF Days Reported by Hospital = 890
- Swingbed NF Days Reported by Hospital = 100
- **Medicare Swingbed Days PSR = 775**
- Observation Days = 150

SWINGBED DAYS — ISSUE (EXAMPLE)

80 Swingbed days were determined not to be Medicare days.

- Revised Swingbed SNF Days = 810
- Revised Swingbed NF Days = 180
- Medicare Swingbed Days per PSR = 775

Impact on Medicare Reimbursement
for improperly classifying those 80
Swingbed days

\$47,550 Decrease!



Are there outstanding days in accounts receivable at time of PSR for period before end of fiscal year?

Original admit entered as Medicare, but subsequently changed payer source.

Changed payer source part way through stay, but system still listed as Medicare.



COST CENTERS

WORKSHEET A

Historically small departments may have been combined with larger departments:

- Cardiac Rehab
- Cardiology
- EKG
- Holter Monitors

- **Should Imaging be one cost center or multiple cost centers?**
 - CT Scans
 - MRI
 - Nuclear Medicine
 - Ultrasound
- **May gain reimbursement, but is it correct?**
- **Radiology – Imaging, one cost center or multiple?**
 - If multiple, do we have salaries in each of the cost centers? How do we handle the department director salaries?
 - Is revenue separated appropriately for matching?





RECLASSIFICATION OF WAGES

ARE ESTIMATES OF WAGES REASONABLE FOR THE COST REPORT?

		from stat sheet/usage report				
	Hours/Birth	# of Days/Births	Hours	Average Salary	Salary Allocation	FICA Portion
Nursery	6	141	846	17.84	\$ 15,093	\$ 1,155
Labor/Delivery	13	68	884	17.84	\$ 15,771	\$ 1,206

RECOMMENDATIONS



Best scenario is to “clock in” to various departments and record wages in general ledger.



Time study kept, one week per month, rotating weeks and general ledger entries made to reclassify time.



Time study kept, one week per month rotating weeks and reclassification made via cost report.



NON-REIMBURSABLE OVERHEAD EXPENSES



Reclass expenses from non-reimbursables or other cost centers to overhead so as not to double allocate costs.

- Capital
- Admin & General
- Maintenance
- Housekeeping
- Medical Records

Primarily salary amounts, but can be “other” amounts also.

Most often additional overhead amounts found in major service lines.

- Clinics
- Nursing Home
- Assisted Living
- Home Health

WHY IS THIS DONE?

- Allocate indirect costs to major service lines to reflect better departmental financial statements throughout the year.
- However, makes it more difficult for accurate cost reporting as need to eliminate these internal allocations.



Overhead reclass, RHC or PB clinic is more than likely less Medicare utilized department than others so by reclassifying overhead cost back up improves reimbursement.

N	Reclass Business Office salaries benefits from RHC	5.03	192,833	68,784	88	192,833	68,784





MISCELLANEOUS COSTS

NON-RHC COSTS

- Relate to compensation of practitioners for time they spend performing services outside of the rural health clinic and not part of the all-inclusive rate.
- **Section 40.1 of Benefit Policy Manual for RHC:**
 - *RHC and FQHC visits may not take place in:*
 - *an inpatient or outpatient department of a hospital, including a CAH, or*
 - *a facility which has specific requirements that preclude RHC or FQHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).*
- **Non-RHC time/services includes the following:**
 - Inpatient visits (acute only)
 - Outpatient visits
 - Observation
 - Outpatient surgical
 - Emergency Room
 - Services to external entities
 - Medical Directors
 - Etc.
- **Paid under the Medicare physician fee schedule for these services, not the RHC AIR.**

SECTION 40.1 OF BENEFIT POLICY MANUAL FOR RHC

RHC or FQHC visits may take place in:

- the RHC or FQHC,
- the patient's residence (including an assisted living facility),
- a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
- the scene of an accident.

Note – Medicare-covered Part A SNF includes Medicare swingbed.

NON-RHC COSTS

Provider Time Study Summary															
	RHC	RHC	RHC	RHC	RHC	RHC	RHC	NRHC	NRHC	NRHC					
	Clinic hours	Clinic hours	SB hours	Nursing Home hours	Clinic mtgs hours	XIX er/ip/op hours	Other mtgs hours	OP/Proc hours	ER hours	IP hours	Worked Hours Total	ER On Call hours	Hours Worked while on Call	ER On Call Stand by	Total Hours
7/17/16 to 7/23/16	24.5			6.5	1		2.5		8.5	2.5	45.5	48	18.5	29.5	75
8/14/2016 to 8/20/16	31								5	8	44	24	19	5	49
9/4/16 to 9/10/16	29.75								12	6.5	48.25	48	26.5	21.5	69.75
10/2/16 to 10/8/16	16			8					11.5	5	40.5	48	24.5	23.5	64
11/13/16 to 11/19/16	29		2.25						2	4	37.25	48	19.25	28.75	66
12/18/16 to 12/24/16	26.5						1.5		6	1	35	24	17	7	42
1/22/17 to 1/28/17	30			7					3	6	46	26	16	10	56
2/5/17 to 2/11/17	27.25		0.5						5.5	7.5	41.75	46	22	24	64.75
3/12/17 to 3/18/17	24		2						3	2.5	31.5	23.5	16	7.5	39
4/9/17 to 4/15/17	28.5		0.5						4	4.75	37.75	26	16	10	47.75
5/7/17 to 5/13/17	38								2.5	1	41.5	53	15	38	79.5
6/18/17 to 6/24/17	35						1		1	0	37	15	2	13	50
	339.5	0	5.25	21.5	1	0	5		0	64	48.75				217.75
	48%	0%	1%	3%	0%	0%	1%		0%	9%	7%				31%
															702.75

Recommend capture information via time study instead of visits. However, sometimes difficult to get time study.

	SALARIES	ER	RHC	IP/OP	Total
Practitioner 1		45,075.78	54,020.78	876.96	99,973.52
Practitioner 2		82,581.20	73,104.67	6,092.06	161,777.92
Practitioner 3		-	-	-	-
Practitioner 4		12,115.22	5,617.67	3,519.51	21,252.40
Practitioner 5		17,039.03	38,598.62	-	55,637.65
Practitioner 6		41,902.19	55,361.45	7,250.16	104,513.80
Practitioner 7		7,345.58	11,780.64	554.38	19,680.60
Practitioner 8		47,768.58	37,857.41	4,549.39	90,175.38
		253,827.57	276,341.25	22,842.45	553,011.27
		253,827.57	276,341.25	22,842.45	553,011.27
				A-8	-

340b Program – Impact on Cost Report

Two Programs

- Reduction in pharmacy expense for drugs dispensed for outpatients in the hospital setting
- Contract pharmacy

340b Contract Pharmacy

Ways to address 340b Contract Pharmacy on cost report.

- Offset expenses related to contract pharmacy
- Offset revenue associated with contract pharmacy
- Include direct expenses related to contract pharmacy as a non-reimbursable cost center (MAC guidance)

340b Contract Pharmacy

Non-Reimbursable Cost Center

- Costs of purchased pharmaceuticals
- Should include any pharmacist direct costs
- Can overstate allocations of indirect expenses
 - Recommend strategizing on allocation of costs
 - Information technology
 - Business Office

340b Contract Pharmacy

If offsetting direct expenses:

- Does it include any pharmacist time monitoring program
- Any A&G expenses for paying invoices, software costs, internal audit costs, external audit costs, administrative time, etc.
- Risk of MAC establishing as a non-reimbursable cost center
 - What is that dollar amount?



OTHER INCOME

OTHER INCOME

Adjustments to Expenses:

Calculated from cost or; when cost cannot be calculated – amount received (revenue)

These adjustments, required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined.

Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods.



OTHER INCOME

All “Other Revenue” accounts should be reviewed to determine if any of the revenue should be offset.

- Grant revenue – not offset
- Incentive payments from other payers – not offset
- Outreach revenue (cost) – offset
- Rent income – offset
- Meal Income – depends
- Laundry Income - depends

Often posting “allowable” revenue with “non-allowable” revenue.



EMERGENCY ROOM AVAILABILITY



ER STANDBY

- Medicare will share in cost of ER standby time for ER practitioners.
- Don't need to be onsite, must arrive within 30 minutes
- Can't be on-call or providing services elsewhere

Would expect ER professional component to have a range of around 8% to 40% in most CAH facilities.

Requirements must be met in order for ER availability to be allowable:

1. Signed written contract between hospital and the physician(s).
2. Written allocation agreement and supporting data depicting distribution of time between services to provider, and services to individual patients. (Exhibit 1) (Time studies).
3. A permanent record of payments made to the physician under agreement.
4. A permanent record of all patients (Medicare and non-Medicare) treated by the practitioner.
5. A schedule of practitioner charges.
6. Evidence of exploring alternative methods for obtaining emergency room coverage before agreeing to compensation.

ER STANDBY



What are you utilizing for a time study?

EMERGENCY ROOM AVAILABILITY

Some MACs have indicated that must have pre-approval 90 days before the start of the fiscal period for your time study.

MACS have varying requirements.

- Two, two-week time studies
- Four, two-week time studies, one each quarter
- One week per month, alternating weeks
- Physicians may do two, two weeks, but advanced practice providers one-week per month, rotating weeks

Time studies must be representative for the period of the cost report, both fiscal period and also for the time that you are compensating the practitioner(s).

What if you have intermingled practitioners, physicians and advanced practice providers covering your emergency room?

- Strongly recommend one week per month, alternating weeks throughout the year to ensure appropriate studies are kept.



Some hospitals utilize
the emergency room logs
for their time study.

Remember to carve out
overlapping time.

ER Length of Stay Report

Admission Datetime	Discharge Datetime	LOS HH/MM	Time Excluding Overlap
7/04/17 21:23:00	7/5/2017 1:10	3:47:00	
7/04/17 21:44:00	7/5/2017 0:10	2:26:00	0:00:00
7/04/17 23:19:00	7/5/2017 0:24	1:05:00	0:00:00
7/05/17 00:16:00	7/5/2017 1:42	1:26:00	1:26:00
7/05/17 08:02:00	7/5/2017 9:30	1:28:00	1:28:00
7/05/17 08:30:00	7/5/2017 13:14	4:44:00	4:44:00
7/05/17 09:30:00	7/5/2017 14:52	5:22:00	5:22:00
7/05/17 13:31:00	7/5/2017 15:05	1:34:00	1:34:00
7/05/17 14:04:00	7/5/2017 15:35	1:31:00	1:31:00
7/05/17 16:00:00	7/5/2017 17:45	1:45:00	1:45:00
7/05/17 16:50:00	7/5/2017 21:07	4:17:00	4:17:00
7/05/17 16:57:00	7/5/2017 22:15	5:18:00	5:18:00



ER COVERAGE CONTRACT(S)

Specifically state compensation

Specifically state hours of coverage

- Differentiate between clinic and ER pay if possible.

Recommend not having contracts where the compensation is production based.

Do you have a provider-based clinic and practitioners from this clinic cover the emergency room?

Remember to update the emergency room coverage compensation



HOSPITALIST

(Definition): a physician who specializes in treating hospitalized patients of other physicians in order to minimize the number of hospital visits by other physicians.

Merriam-Webster



HOSPITALIST

- If truly performing emergency room coverage, then identify this in contract/job description.
- Carve out time spent seeing patients in emergency room and time rounding.
- Have seen hospitalist time claimed as 100% allowable time in Adult/Peds, is this correct?
- What duties are they are performing?
 - Administrative duties
 - Inpatient/Outpatient visits
 - Emergency room coverage

PROVIDER BASED PHYSICIAN OFFSETS

- Be careful with offsets of benefits related to provider based physicians
 - FICA
 - Workers Compensation
 - Unemployment



B-1 STATS

B-1 STATISTICAL ALLOCATIONS

How often are you updating these statistical allocations?

- When Medicare indicates to.
 - Every year
 - Every other year.
 - Not sure, haven't looked at them in a while.
- Statistics need to be representative for the fiscal year your are reporting on.
 - Example:
 - Time study
 - Laundry pounds
 - Costed requisitions
 - Revenues

WORKSHEET B-1

Purpose:

- To provide the statistical basis that the cost report will use to allocate general service cost center costs to revenue-producing and non-reimbursable cost centers on B, Part I.
- This is a major section where money is “found” or “lost”.

Type & source of data:

- General ledger cost data
- Internally generated statistics
- Depreciation schedule
- Wage and hour/FTE reports
- Plant square footage
- Laundry pounds
- Time studies
- Dietary meals
- Revenue statistics
- Patient day statistics



WORKSHEET B-1

General issues:

- Step-down method of cost finding – once a cost center is allocated to others, it may not receive any subsequent allocations.
- No allocations to cost centers receiving no services from the overhead department.
- Idle space gets set up as a non-reimbursable cost center.
- Do not directly expense and allocate to a cost center.
- Understand the effects on allocations when making any changes!!
- Costs are allocated based on unit multiplier.
- Percentage of total allocation more important than actual unit multiplier.
- Medicare recognizes alternative allocation methodologies:
 - Request for change in a methodology must be submitted 90 days prior to the end of the affected cost reporting period.
 - Must possess the necessary statistical information for the whole year (i.e. time studies, etc.)

Buildings and fixed equipment

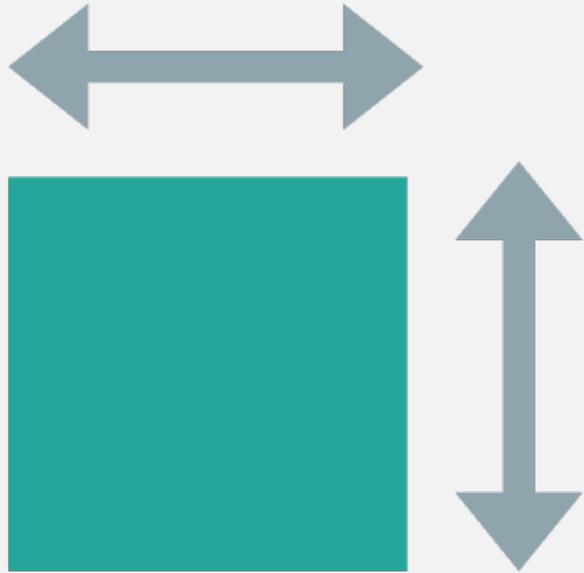
- **Square footage**
 - **Also used for many different areas**
 - **Be sure updated statistics are maintained**
 - **Including supporting documentation**
 - **Electronic spreadsheets work well**

Gross versus Net Square Footage

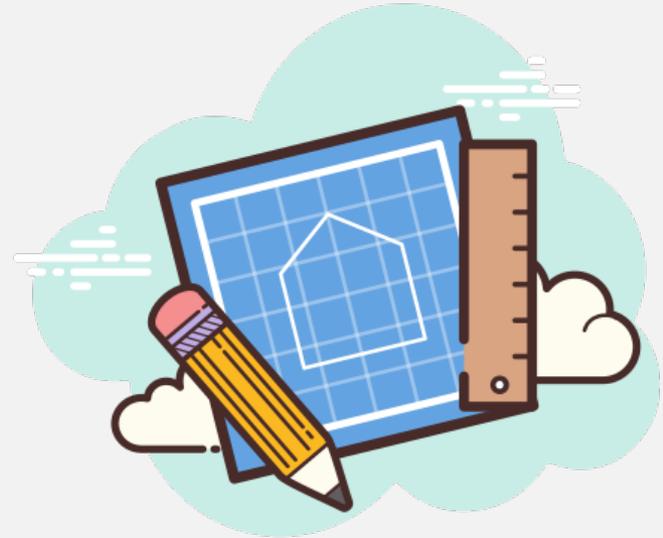
- **Frequently little difference between the two.**
- **Need a process for splitting shared common space (i.e. shared hallways)**
- **Consistency is the key – Common problem areas**
 - **Hospital using net – Nursing home using gross**
 - **Hospital using net – Clinic using gross**

Subscripting for new buildings/remodeling

- **Can help prevent dilution of cost allocations when lower cost per foot buildings are added**
- **May help improve allocations with high cost remodels in high Medicare utilization areas**
- **MAC will be looking for consistency**



Update statistic each year with any changes in square feet.



Keep statistic on a spreadsheet that agrees back to blueprints (if possible).

MOVABLE EQUIPMENT



- Square footage or actual (dollar value) are the two methodologies.
- Actual tends to work best if facility has numerous non-reimbursable cost centers or nursing home.
- If actual is used the unit multiplier should be near 1.0:
 - Difference is for interest expense.
 - Adjust for any Worksheet A-8 and A-8-1 adjustments.
- Need to maintain updated asset listing.

EMPLOYEE BENEFITS

- Allocated based on gross salary.
- Do not report contracted amounts in salary accounts.
- Have seen some preparers/providers attempt to allocate benefits for non-practitioners with the costs for practitioners reported directly:
 - Would tend to reduce costs to non-reimbursable or lower Medicare utilization areas.
 - Historically MACs have pushed to allocate all costs in a category in the same manner (i.e. direct or allocate).
- Direct in all departments is difficult/impossible:
 - Floating staff.



ADMINISTRATIVE & GENERAL

- Accumulated Cost if one cost center.
- Fragmented A&G may provide opportunities to improve overall reimbursement:
 - Management fee
 - Business Office
 - Accounting
 - Purchasing & receiving
 - Communications
 - Admissions
 - Information Technology
 - Population Health
 - Administrative & General



FRAGMENTED A&G

Management fee:

- Outside management firm.
- Actual fees per arms length agreement:
 - Hospital.
 - Nursing Home.
 - Home Health.
 - Etc.

Business Office:

- Gross revenues.
- Eliminates inappropriate allocations to cost centers not supported by the Business Office:
 - Assisted Living?
 - Rental properties.
- Operational strategies:
 - Split business office functions into two:
 - Hospital/Physicians.
 - Nursing Home/Home Health/etc.
 - Pricing strategy can also drive reimbursement through allocations.

Accounting:

- Accumulated cost.
- Gross revenues:
 - Could push costs towards hospital with less to NH and HH:
 - Would better match efforts as the hospital and physician areas take the most time.

Purchasing & receiving:

- Purchases by department.
- Can push toward hospital and away from clinics, NH and HH.

Communications:

- Actual phones by department.
- Eliminates inappropriate allocations to departments without phones/communications:
 - Assisted Living.
 - Nursing Homes.
 - Rental property.

FRAGMENTED A&G (CONT.)

Admissions:

- Gross revenues
- Eliminates inappropriate allocations to cost centers not supported by Admissions
 - Assisted Living?
 - Rental properties
- Operational strategies
 - Internalize admission process in NH, HH, Hospice, etc.

Population Health:

- New area to tackle
- Thoughts
 - Patient care areas
 - Accumulated cost
 - Revenues

Information Technology

- Newer opportunity as cost grow in this area
 - Financial Software
 - EHR
 - Business Intelligence
- Terminals
- Componentize and direct?

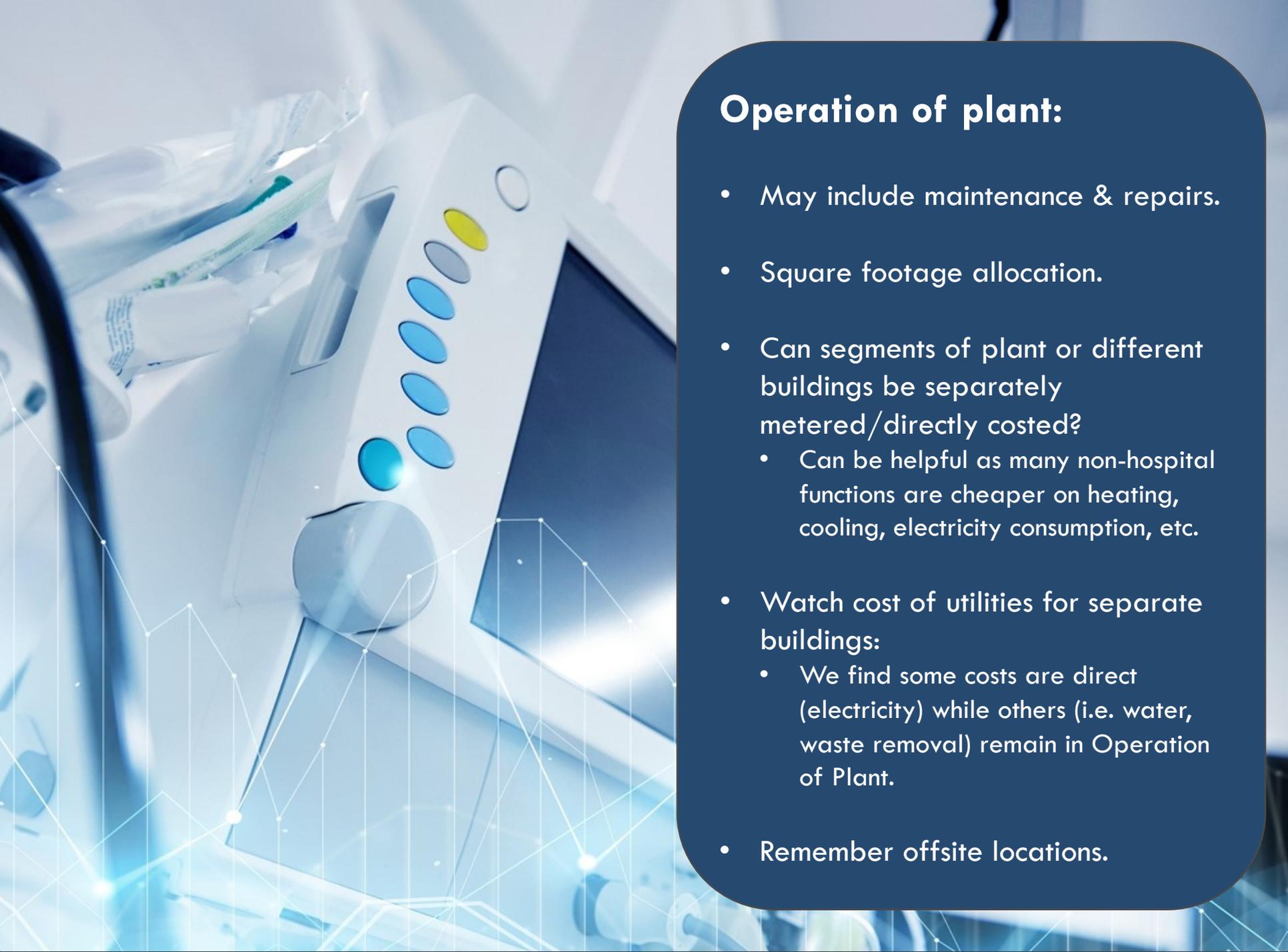
Administrative & General other?

- Other breakdowns – look at this creatively
 - Education
 - Other??

Maintenance & repairs:

- Often included with operation of plant.
- Can be separated:
 - Square footage or time studies.
- Remember offsite locations.
- Separate staffing teams?
 - NH versus Hospital?
- Recommend analysis if square footage:
 - Especially after major renovations.
 - Don't recommend prior to or during major projects.





Operation of plant:

- May include maintenance & repairs.
- Square footage allocation.
- Can segments of plant or different buildings be separately metered/directly costed?
 - Can be helpful as many non-hospital functions are cheaper on heating, cooling, electricity consumption, etc.
- Watch cost of utilities for separate buildings:
 - We find some costs are direct (electricity) while others (i.e. water, waste removal) remain in Operation of Plant.
- Remember offsite locations.

LAUNDRY & LINEN SERVICE

- Allocation by Pounds.
- There should be a statistic for every department receiving laundry services.
- Develop methodology to maintain statistic if laundry performed by outside entity:
 - Outside entity doesn't always track by department.
 - Many use weights per item sent out to departments.
- Review data gathering tool annually for changes:
 - New outpatient areas tend to be the areas missed:
 - Cardiac Rehab.
 - Infusion Therapy.
 - Occupational Therapy (lumped in with Physical Therapy).
 - Labor and Delivery.
 - Nursery.



HOUSEKEEPING

- Square footage or time studies:
 - Weighted?
- Time studies:
 - The requirement is one week per month, rotating weeks (intermediary requirements may vary).
 - May be more beneficial if periodically cleaning non-reimbursable areas.
- There should be a statistic for every department with square feet unless cleaned by department or purchased service:
 - Operating room.
 - Offsite locations.
- Direct costing.
- Review data gathering tool annually:
 - Staff only report what they are asked to report.
 - Staff frequently don't know what areas are assigned to each line of the tool.



DIETARY

- Meal counts used for allocation:
 - Allocate between Med/Surg, specialty care, NH, cafeteria, & outside meals.
- Administrative meals should be included in the cafeteria.
- Weighting of meals:
 - Weighting is a productivity issue – not an allocation issue.
 - Meal count for cafeteria versus dollar value:
 - Strategies for using a dollar value:
 - Cost per meal?
 - Average price for patient meal.
- Outpatient meals:
 - Understand what they are for.
- Non-reimbursable meals:
 - Free to staff versus free to public.
 - Meals on Wheels:
 - Understand reimbursement impact.
 - Other outside meals:
 - Allocate versus revenue offset?
- Divide patient/resident meals by number of days – should be close to 3.0.
- As a provider:
 - Understand each category of meals being reported.
 - Avoid using terms that may sound like they are non-allowable even though they may be – i.e. “free meals”.

CAFETERIA

FTEs (adjusted for A-6 reclassifications):

- Include contracted staff:
 - Nursing;
 - Therapies;
 - Etc.

Don't allocate to departments that don't receive services:

- Offsite locations



NURSING ADMINISTRATION



- Understand what is all in here.
- Hours of service for staff in departments managed.
- Nursing FTEs most common:
 - Many changes in this area due to the role of Chief Nursing Officers:
 - Larger span of control.
 - Potentially large reimbursement impacts.
 - May have a CNO AND a DON? – Now what?
- Needs to match organizational chart:
 - Analyze opportunities to change organizational chart:
 - Clinics.
 - Diagnostic departments.
 - Home Health.
 - Changes must address operational issues.

NURSING ADMINISTRATION – EXAMPLE

Single or dual DONs?

**Before –
one cost
center**

- \$100,000 Hospital DON
- \$75,000 Nursing Home DON
- \$175,000 total
- Hospital 30% / Nursing Home 70%
- Hospital allocated \$52,500
- Nursing Home allocated \$122,500

**After – two
cost centers**

- Hospital allocated \$100,000
- Nursing Home allocated \$75,000
- Increased hospital reimbursement =
 - \$47,500 * Medicare utilization
- Need to understand State Nursing Home reimbursement methodology

Question to ponder...

Do we have any other areas of the hospital with a similar structure to nursing that could benefit from an “administration” overhead allocation methodology?



Central services & supply

- Frequently not used and Worksheet A costs bundled into Medical supplies charged.
- If used, allocated based on costed requisitions:
 - Model the potential impact
 - May be significant with all of the bundling of supplies into procedure charges
 - Mostly likely required if the provider is billing for implantables



Pharmacy

- Typically not used and Worksheet A costs bundled into drugs charged to patients – Line 73:
 - Impact of RHCs?
- If this cost center is used, allocate by costed requisitions.
- Impact of 340B?



Medical Records & Library

- Gross Revenues vs Time Studies
 - Gross revenues
 - Easiest
 - Allocate only to those departments receiving services from medical records
 - Pricing strategies?
 - Time studies
 - How do you do a time study in this department?
- Separate staffing??
 - Hospital
 - Physicians
 - Nursing Home
 - Etc.

WORKSHEET B-1

- **Social services/activities:**
 - Be careful not to bury within nursing home
 - Swing bed program requires social services and activities
 - Time studies
 - Patient days
 - Don't allocate and directly expense
- **Non physician Anesthetists:**
 - 100% to Anesthesia – line 53
- **Nursing school:**
 - Assigned time
- **I&R services – salary & fringes:**
 - Assigned time to areas
 - Use rotation schedule
- **I&R services – other program costs:**
 - Assigned time
 - Use rotation schedule
- **Paramedical education programs:**
 - Assigned time

SIMPLIFIED COST METHOD

- Allows for alternative method of cost finding.
- Requires less maintenance of statistics.
- Once elected, the provider must continue to use this method for no less than 3 years (unless change of ownership occurs).
- Mandatory allocation statistics.

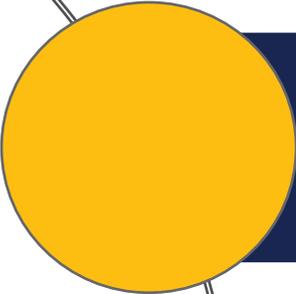
Mandatory Allocation Statistics

Statistics include:

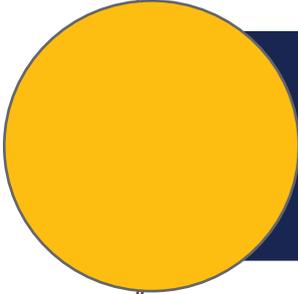
▪ Building and Fixtures	Square Footage
▪ Movable Equipment	Square Footage
▪ Maintenance and Repairs	Square Footage
▪ Operation of Plant	Square Footage
▪ Housekeeping	Square Footage
▪ Employee Benefits	Salaries
▪ Cafeteria	Salaries
▪ Administrative and General	Accumulated Costs
▪ Laundry and Linen	Patient Days
▪ Dietary	Patient Days
▪ Social Service	Patient Days
▪ Maintenance of Personnel	Eliminated
▪ Nursing Administration	Nursing Salaries
▪ Central Services and Supply	Costed Requisitions
▪ Pharmacy	Costed Requisitions
▪ Medical Records and Library	Gross Patient Revenue
▪ Interns and Residents	Assigned Time
▪ Nonphysician Anesthetists	100% to Anesthesia

Some preparers using this to attempt to forego cost offsets in areas such as dietary, laundry, etc.

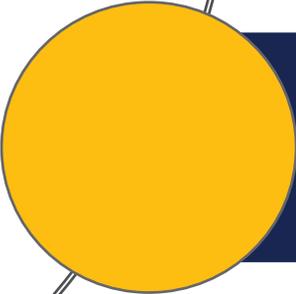
WORKSHEET B-1 OVERVIEW



Do not ignore impact on potential changes in allocation methodology.



Review opportunities periodically and whenever there are changes in organization.



When adding/removing a service line, understand this will have an effect on other cost centers and will impact Medicare reimbursement also, model the impact.



WORKSHEET B-2

WHAT IS WORKSHEET B-2 USED FOR?

Used to offset cost of Epotien and Aranesp from dialysis cost centers.

Also frequently used to reclassify costs from Med/Surg for non-observation outpatient services performed in Med/Surg:

- Cost report program does not adequately address issue:
 - Only addresses Observation.
 - Potential Issues:
 - Infusion therapy;
 - Injections;
 - Blood administration;
 - Chemotherapy;
 - Recovery (Phase 2);
 - Dressing changes;
 - Miscellaneous procedures.

- Can also be used for:
 - Observation performed in the ICU.
- Most common area of revenue/expense mismatching on cost report:
 - Facilities;
 - Preparers;
 - MACs.

HOW IS IT CALCULATED? – (OUTPATIENT SERVICES)

Replicates the observation carve out process that occurs on worksheets S-3 and D-1.

- **Step 1** – Calculate equivalent days:
 - Infusions and Chemo are billed by the hour.
 - Blood administration:
 - Billed in units of service.
 - Recommend charges based on hours to assist with data capture.
 - Recovery often billed by the hour.
 - Injections – need an estimate (often 15 minutes).
 - Other – Need to develop estimate with support to be confirmed each year.
- **Step 2** – Add equivalent days to Worksheet S-3 Line 28 Column 8 (Observation Days).
- **Step 3** – Recalculate.
- **Step 4** – Record cost per diem from Worksheet D-1 Line 38.
- **Step 5** – Calculate amount to reclassify on Worksheet B-2:
 - Equivalent days for outpatient services * cost per diem.
- **Step 6** – Reclass costs on Worksheet B-2 (frequently line 76).
- **Step 7** – Remove equivalent days added to Worksheet S-3 Line 28 Column 8.
- **Step 8** – Recalculate.
- **Step 9** – Compare current cost per diem from Worksheet D-1 Line 38 with rate recorded in Step 4:
 - Rates should be comparable.

HOW IS IT CALCULATED? – (OBSERVATION IN ICU)

- **Step 1** – Calculate equivalent days.
- **Step 2** – Add equivalent days to Worksheet S-3 Line 8 Column 8 (Observation Days).
- **Step 3** – Recalculate.
- **Step 4** – Record cost per diem from Worksheet D-1 Line 43 Column 3.
- **Step 5** – Calculate amount to reclassify on Worksheet B-2:
 - Equivalent days for outpatient services * cost per diem.
- **Step 6** – Reclass costs on Worksheet B-2 (line 8).
- **Step 7** – Remove equivalent days added to Worksheet S-3 Line 8 Column 8 and add to Worksheet S-3 Line 28 column 8.
- **Step 8** – Recalculate.
- **Step 9** – Compare current cost per diem from Worksheet D-1 Line 43 column 3 with rate recorded in Step 4:
 - Rates should be comparable.

How is it calculated? – (Recovery, etc. in ICU)

- Many variations can exist:
 - Stop and map out the situation.
 - Create the plan:
 - Start with ICU and then to Med/Surg.
 - Implement the plan.





MEDICARE BAD DEBTS

Definition – Allowable Bad Debts

...bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set for in Section 308.

Amounts arising from professional charges can not be claimed as Medicare bad debts.

IN ORDER TO QUALIFY, BAD DEBT MUST...

The debt must be related to covered services and derived from deductible and coinsurance amounts.

The provider must be able to establish that reasonable collection efforts were made.

The debt was actually uncollectible when claimed as worthless.

Sound business judgment established that there was no likelihood of recovery at any time in the future.

ISSUES

Timely billing from date of discharge/service – 90 or 120?

Cease collection effort date in wrong period.

Cease collection effort date less than 120 days from date of first bill.

Cease collect date is when account is returned back to provider from collection agency.

Professional amounts included.

COLLECTION AGENCY

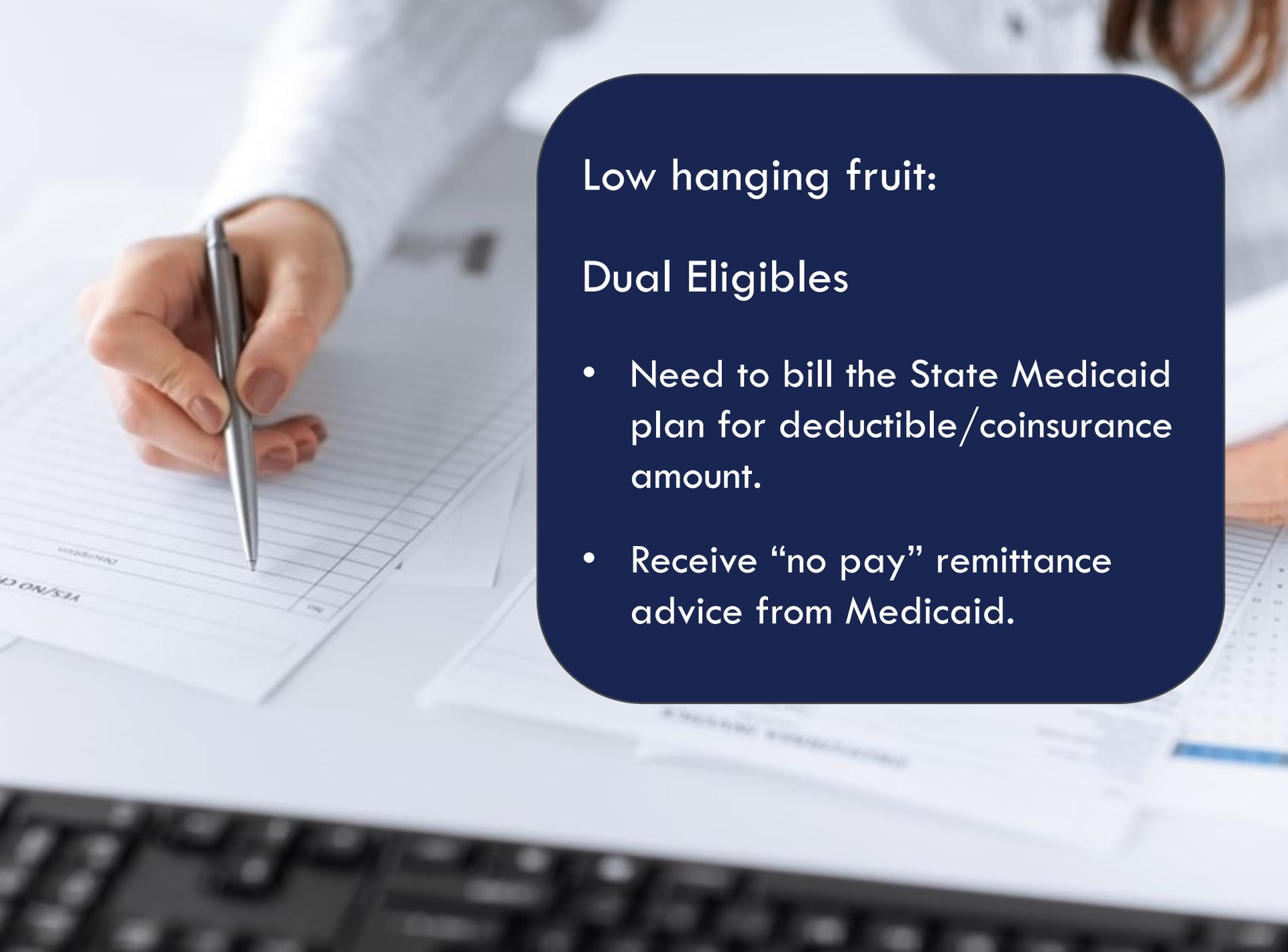
Provider must refer all uncollected patient charges of similar amount without regard to payer.

Must apply same processes for all payers.

Collection fees are an allowable administrative cost and not part of the bad debt allowable amount.

Adequate documentation should be kept to record all accounts sent to and returned from the agency for all accounts deemed uncollectible.

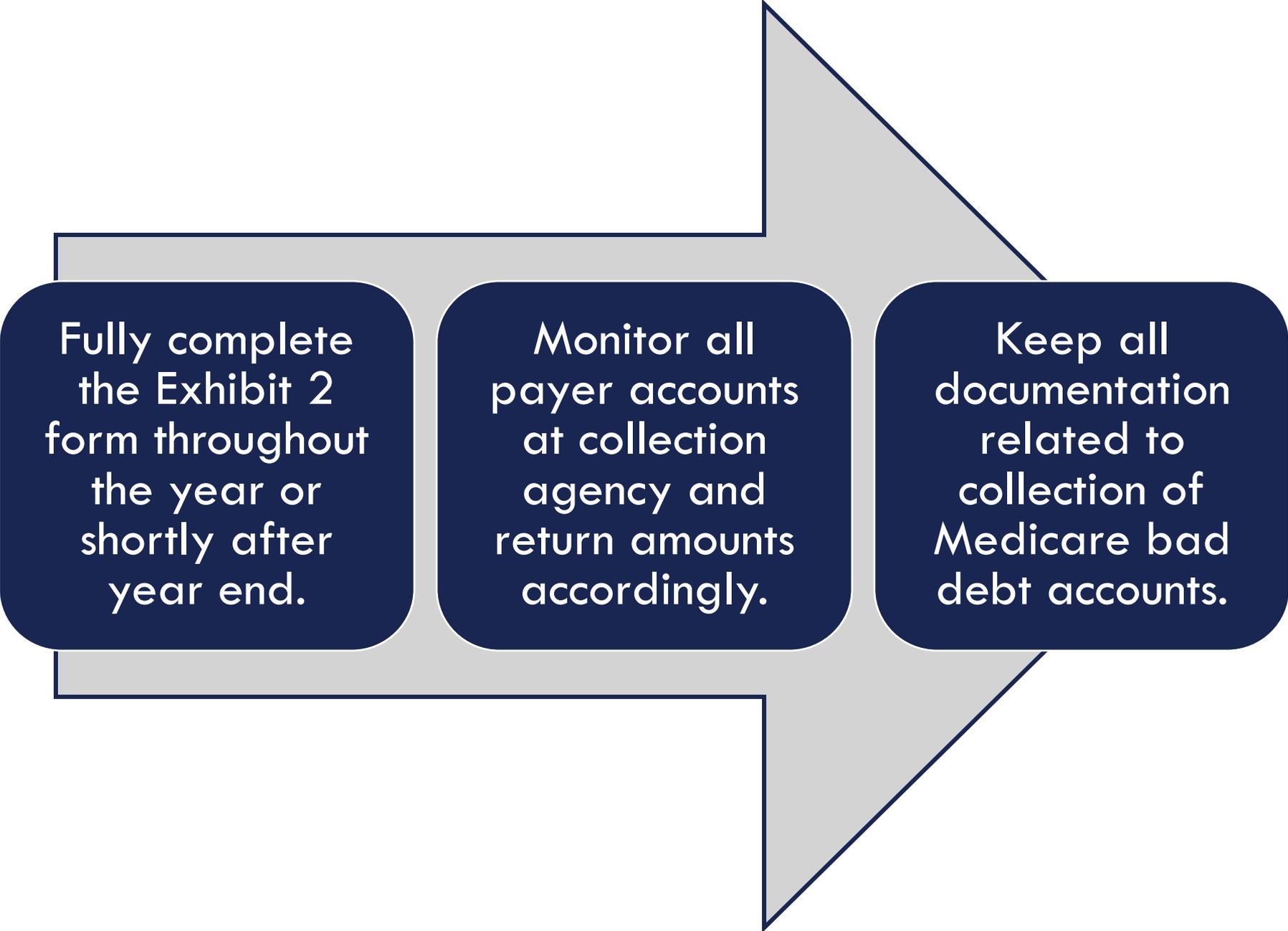


A close-up photograph of a person's hand holding a silver pen, poised to write on a document. The document has a grid pattern and some text, including "MS/NO" and "ON". The background is blurred, showing a desk and a keyboard.

Low hanging fruit:

Dual Eligibles

- Need to bill the State Medicaid plan for deductible/coinsurance amount.
- Receive “no pay” remittance advice from Medicaid.



Fully complete
the Exhibit 2
form throughout
the year or
shortly after
year end.

Monitor all
payer accounts
at collection
agency and
return amounts
accordingly.

Keep all
documentation
related to
collection of
Medicare bad
debt accounts.



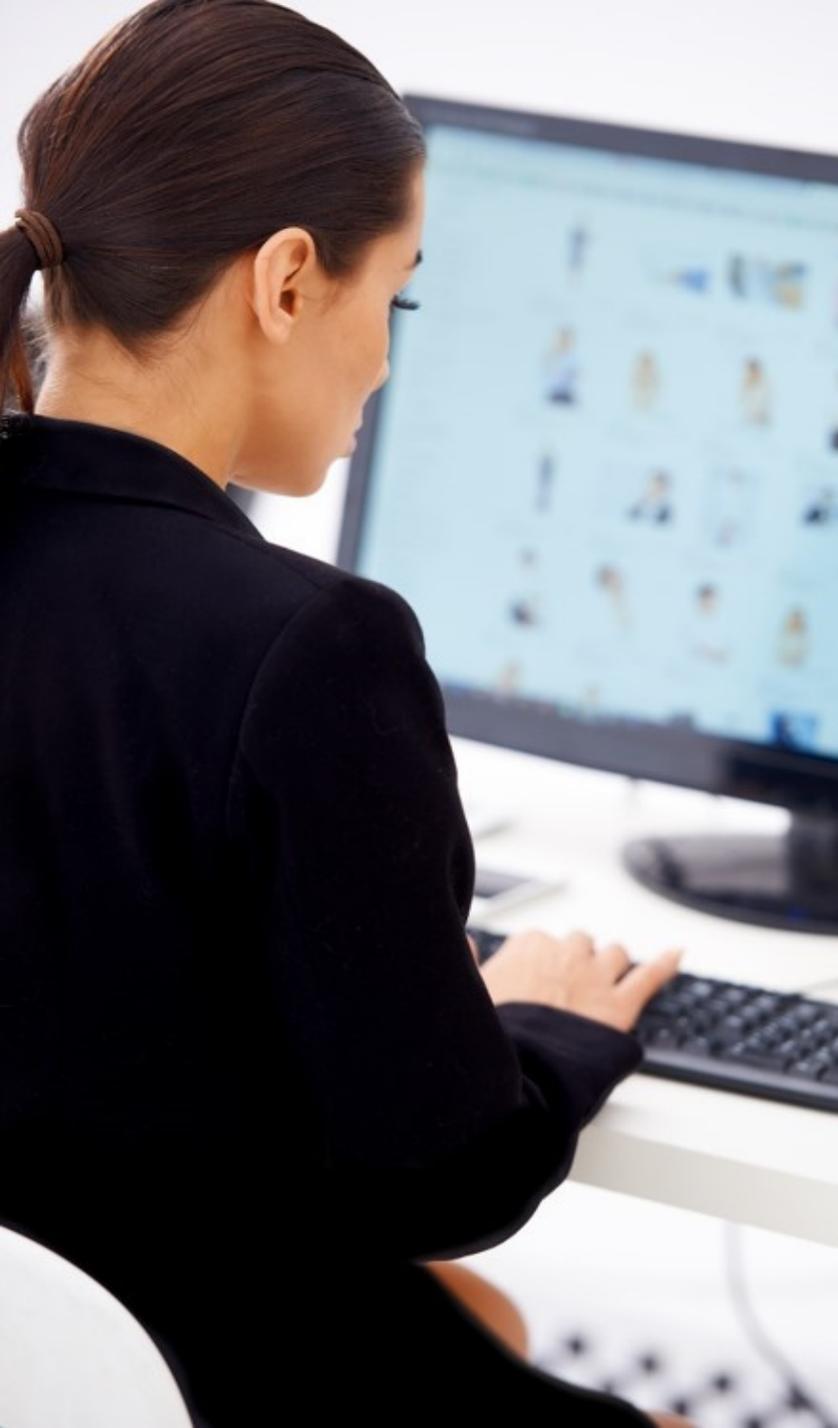
HOSPITAL REVENUES

- **Must eliminate all professional charges:**
 - Identify all professional charges.
 - Worksheet A-8-2 offsets should be matched with professional charge offsets:
 - EKG and Imaging interpretations are common problem areas.
 - Look for “professional fees” in general ledger as revenues may be buried in departmental revenues.
 - Look for revenue codes 96x, 97x and/or 98x in crosswalks.
- **Reclass revenues to match any reclasses noted in Worksheets A-6 and/or B-2.**
- **Must gross up charges if services are offered at a lower fee to payers other than Medicare (e.g., laboratory done for a local clinic when hospital bills the clinic directly):**
 - May also require gross up of charges on PS&R if billed lower for all payors.
 - Lab in clinic.
 - Pharmacy in nursing homes and/or inpatient versus outpatient.
 - Inpatient versus outpatient pricing differentials have seemed to be growing.

Provider based clinic, must show technical charges for all payers even though not billing a technical charge.
– So what are we trying to get at here?

- Providers may have all professional fees for services rendered by these physicians/physician assistants/nurse practitioners, etc.
 - Clinic
 - Inpatient hospital
 - Outpatient hospital (including ER)
 - Swing bed
 - Nursing home
 - Home
 - Etc.





Providers bill as follows in clinic:

- **Commercials**
 - Professional only
- **Medicare**
 - Professional and technical
- **Medicaid**
 - Varies by State – one of the two options above

Need to calculate the technical fee that would have been billed for clinic only if all payors would have been billed in the same manner as Medicare

QUESTIONS?

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THANK YOU!

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