THE HEALTH OF YOUR MEDICARE COST REPORT
May 2019
AGENDA

➢ Cost Report Audits/Reviews
➢ Patient Days
➢ Swing-bed Days
➢ Reclassification of Wages
➢ Other Income
➢ Emergency Room Availability
➢ B-1 Stats and Square Feet
➢ Medicare Bad Debts
➢ Preparing and Reviewing the Cost Report – a Group Effort
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!
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
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!
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 they be reported on Swingbed SNF line?
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
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 the time the PSR is run for the period before the end of the fiscal year?

Original admission entered as Medicare, but payor source was subsequently changed.

Payor source changed part way through the stay, but still listed as Medicare in the system.
ARE ESTIMATES OF WAGES REASONABLE FOR THE COST REPORT?

<table>
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<tr>
<th>Hours/Birth</th>
<th># of Days/Births</th>
<th>Hours</th>
<th>Average Salary</th>
<th>Salary Allocation</th>
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<td>6</td>
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<td>Labor/Delivery</td>
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**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.
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 — 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.
What are you utilizing for a time study?
Some MACs have indicated that facilities 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.

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<th>Admission Datetime</th>
<th>Discharge Datetime</th>
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# WHAT IS NEEDED IN THE ER TIME STUDY?

- Be able to identify to patient ID
- Time practitioner with patient
- Documentation time
- Time study signed by practitioner

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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
B-1 STATS AND SQUARE FEET
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
Probably most important allocation statistic on cost report.

1. Building Capital costs
2. Major Movable Capital costs
3. Maintenance and Repairs
4. Operation of Plant
5. Housekeeping

Which departments should be getting an allocation of which costs? Do you already directly assign some costs?
Update statistic each year with any changes in square feet.

Keep statistic on a spreadsheet that agrees back to blueprints (if possible).
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<th>LOCATION AREA</th>
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<th>ADMIN/GE</th>
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SQUARE FEET

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<td>OLD HOSP NORTH WING</td>
<td>269.62 MAINTENANCE STORAGE - ROOM 107</td>
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<td>268.39 STORAGE-SAFETY - ROOM 108</td>
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<td>OLD HOSP WEST WING</td>
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<td>238.86 OUTPATIENT - ROOM 112</td>
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<td>OLD HOSP WEST WING</td>
<td>82.91 OUTPATIENT - ROOM OFF NRS STATION</td>
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<td>210.10 OUTPATIENT - NURSES STATION</td>
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SQUARE FEET

• 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

• Should not have idle space.

• Remember to keep updated records of square footage changes as this statistic allocates a significant amount of cost.
MEDICARE BAD DEBTS
## Exhibit 2
Listing of Medicare Bad Debts and Appropriate Supporting Data

<table>
<thead>
<tr>
<th>Provider</th>
<th>Prepared By</th>
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<tbody>
<tr>
<td>Prov. Number</td>
<td>Date Prepared</td>
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<tr>
<td>FYE</td>
<td>Inpatient</td>
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<td></td>
<td>Outpatient</td>
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<tr>
<td>SNF</td>
<td>RHC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(1) Patient Name</th>
<th>(2) HIC NO.</th>
<th>(3) Dates of Service From</th>
<th>(4) Indigency &amp; Wel. Recip (ck if apply)</th>
<th>(5) Date First Bill Sent To Beneficiary</th>
<th>(6) Date Collection Efforts Ceased</th>
<th>(7) Medicare Remittance Advice Date</th>
<th>(8) Deduct</th>
<th>(9) Co-Ins</th>
<th>(10) Total</th>
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</thead>
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</table>
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.
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.
Those preparing data for the cost report must understand what it is being used for and its importance.

Group meeting to discuss different aspects of the cost report (finance, maintenance/housekeeping, nursing, business office, dietary, laundry).

Are things still operating the same way the were 5 (even 10) years ago?

Communication between different departments is key!
QUESTIONS?

This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general information purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.
THANK YOU!

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563.557.6170