Cost Report Forms 2552-10: Identifying Opportunities and Threats for Critical Access Facilities

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Goals for Session

- Understand the implications of additional provider reporting options
- Identify actions to take advantage of new reimbursement opportunities and to mitigate risks under the new Cost Report Forms 2552-10
- Employ reimbursement strategies and opportunities being successfully used by other critical access hospitals

New 2552-10 Forms - Overview

- Streamlined forms
  - Eliminated many currently unused forms
    - Pre-OPPS
    - Old/New Capital
    - Etc.

New 2552-10 Forms - Overview

- Streamlined forms
  - Reformatted existing forms
    - Reorganized Worksheet S-2
      - Related questions in same section of Worksheet
    - Updated line numbers
      - Eliminates need for many subscripts
      - Provides for gaps between sections for future growth

New 2552-10 Forms - Overview

- Addresses new reimbursement issues
  - HIT Incentives
  - Implantable Devices
- Additional issues for consideration
  - Additional Cost Breakouts
  - ER Availability
  - Overhead Allocations
  - RHC Visits

HIT Incentives

- The new cost report forms will provide for final settlement of the lump sum HIT Incentive payments
  - Involves information from several worksheets
    - S-2 Part I
    - S-3 Part I
    - S-10
    - A-7
    - A-8
    - C Part I
    - E-1 Part II

HIT Incentives : S-2 Part I

- Questions 167-168
  - Is this provider a meaningful user
  - If CAH and meaningful user : enter reasonable costs incurred for HIT assets
  - If PPS and meaningful user : enter transition factor

HIT Incentives : S-2 Part I

- Potential Issues #1
  - Need to understand what cost report year is included in calculation of HIT settlements
    - The cost report period beginning in the federal fiscal year for which the hospital attested for meaningful use
    - Seeing many issues related to providers reporting their first year of meaningful use on the cost report as one year earlier than appropriate

HIT Incentives : S-2 Part I

- Example
  - Provider year end is 12/31/2011
  - Provider demonstrates 90 days of meaningful use on 12/31/2011 and attests to meaningful use
  - Provider answers “YES” to meaningful user question on 12/31/2011 cost report.
  - Since provider meets and attests to meaningful use in federal fiscal year 2012, the first year of meaningful use on the cost report will be 12/31/2012 cost report

HIT Incentives : S-2 Part I

- Potential Issues #2
  - Reporting the proper amount of reasonable cost incurred in reporting period for depreciable assets
    - Previously undepreciated values
    - New values
    - May be different than amount included in the initial request for lump sum payment

HIT Incentives : S-2 Part I

- Example
  - Provider year end is 12/31/2011
  - Provider demonstrates 90 days of meaningful use on 12/31/2011 and attests to meaningful use with $1,000,000 of undepreciated costs as of 12/31/2011
  - Provider spends additional $250,000 in 12/31/2012 year
  - Correct amount on 12/31/2012 cost report is $1,250,000

HIT Incentives : S-3 Part I

- Days and Discharges for Medicare and Medicaid Incentives
  - Medicare Days
  - Medicare HMO Days
  - Medicaid Days
  - Medicaid HMO Days
  - Total Days
  - Discharges

HIT Incentives : S-3 Part I

- Strategies
  - Identify all Medicare, Medicare HMO, Medicaid and Medicaid HMO Days
  - Identify all discharges
  - Do not overstate total days

HIT Incentives : S-3 Part I

- Identify all Medicare, Medicare HMO, Medicaid and Medicaid HMO Days
  - Internal records
    - Do not miss out-of-state Medicaid Days
  - Must bill “informational-only” claims to Medicare for Medicare Advantage patients
    - No “informational-only” claim = no Medicare Advantage days on PS&R
    - Many problems identified on 6/30/2011, 9/30/2011 and 12/31/2012 cost reports

HIT Incentives : S-3 Part I

- Identify all discharges
  - Only includes discharges under CAH provider number
  - Does not impact Medicare incentive for CAHs
  - Can have an impact on Medicaid incentives if discharges exceed 1,149 discharges

HIT Incentives : S-3 Part I

- Do not overstate total days
  - Tie total days to internal records
    - Include revenue tie out for verification
  - Exclude appropriate Labor and Deliver days

HIT Incentives : S-3 Part I

- Labor and Delivery days – new for CR periods beginning 10/1/09
  - 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 PRM-1, section 2205.2). In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum (LDP) 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.

HIT Incentives : S-3 Part I

- Labor and Delivery days – new for CR periods beginning 10/1/09
  - 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 lines 14.

HIT Incentives : S-10

- Reporting of Charity Care
  - Impacts HIT incentive calculation
  - Ensure all charity care is appropriately reported

HIT Incentives : S-10

- Charity Care
  - Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt.

HIT Incentives : S-10

- Charity Care
  - Separately identify uninsured from insured patients
  - Includes charity care for all services except physician or other professional services
  - Separately report partial payments by patients approved for charity care
    - Original balance for patients with insurance is the deductible and coinsurance payments required by the insurer.
  - The greater the amount of charity care that is report, the greater the HIT incentive

Worksheet A-7

- General points
  - New requirement to separately identify HIT designated assets
    - Make sure there is good discussion on HIT assets with preparer.
    - Expect Medicare to review this information to support and reconcile dollars reported on Worksheet S-2.

HIT Incentives : A-8

- New offset – CAH HIT adjustment for depreciation and interest
  - Offset of current year depreciation and interest for assets claimed as reasonable cost for HIT incentives
  - Monitor guidance from CMS related to what interest must be offset

HIT Incentives : C Part I

- Column 7 Line 200 used in calculation of HIT incentive
  - Verify physician and other professional charges are omitted
  - RHC charges are not considered physician or professional charges

Implantable Devices

- Worksheet S-2 Line 121 asks “Did this facility incur and report costs for implantable devices charged to patients?”
  - Implantable devices defined as devices reported under the following revenue codes
    - 275 (pacemaker)
    - 276 (IOLs)
    - 278 (other implantables)
    - 624 (FDA investigational devices)
  - Answering “YES” will require facility to breakout revenues and expenses

Implantable Devices : A & C

- New cost centers
  - Medical supplies charged to patients
    - Required if Revenue Code 275, 276, 277, 278 reported (new requirement)
  - Implantable devices charged to patients
    - Required if Revenue Code 275, 276, 277, 278 reported (new requirement)

Implantable Devices : Strategies

- Report correctly on submitted cost report
- If you answer “No” and the PS&R includes any charges with revenue codes 275, 276, 278 or 624 you should expect to be required to identify the information during final settlement

Additional Cost Center Breakouts

- New cost centers
  - CT Scan
  - MRI
  - Cardiac Cath

Additional Cost Center Breakouts

- Additional cost centers are not a new issue
  - Radiology – diagnostic
  - Radiology – therapeutic
  - Radioisotope
  - Blood storage, processing, and transfusion
- Changes driven by PPS MS-DRG payment system

Additional Cost Center Breakouts

- Considerations for new cost centers
  - Ability to properly segregate revenues and expenses
    - Shared staff?
    - Shared Director?
    - Overhead allocations?
  - Impact on reimbursement
  - Required?

Additional Cost Center Breakouts

- Historically small departments may have been combined with larger departments
  - Cardiac Rehab
  - Cardiology
  - EKG
  - Holter Monitors
  - Imagining

Additional Cost Center Breakouts

- Many of these small departments have grown
  - Separately staffed
  - Varying cost markups
  - Varying Medicare utilization

Additional Cost Center Breakouts

- May be a benefit of segregating these departments into multiple cost centers
  - Financial impact
  - Shared cost issues must be addressed

ER Availability : A-8-2

- Purpose
  - To provide for the splitting of ER on-call costs between allowable provider component and offset professional component

ER Availability : A-8-2

- Physician contracts
  - Review contracts for responsibilities and compensation
  - Provider based clinic physicians

ER Availability : A-8-2

- Time Studies
  - For Emergency Room most MACs require two two-week time studies
    - Mid-levels required one week per month with rotating weeks
    - Concerns when physician and mid-levels both included in calculation
    - Make sure providers understand the purpose of the time studies
      - Common Error – Too much time is identified as professional costs and offset on cost report

ER Availability : A-8-2

- Is not required to be onsite
- Can not be on-call for another provider or providing professional services in another location during time reported as allowable on-call costs

ER Availability : A-8-2

- Regulations for standby
  - Signed contract between hospital and physicians
  - Written allocation agreement and support documentation
  - Permanent payment records
  - Permanent record of all treated patients
  - Schedule of charges
  - Documentation of attempts to obtain alternative coverage

ER Availability : A-8-2

- Review all contracts for existing opportunities to carve out Part A costs
- Consider cost report implications when negotiating new contracts

Overhead Allocations : B-1

- Inaccurate Statistics = Inaccurate Reimbursement
- Frequently ignored issue
- 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

Overhead Allocations : B-1

- 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

Overhead Allocations : B-1

- Movable equipment
  - Square footage or actual
  - 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
  - Need to maintain updated asset listing

Overhead Allocations : B-1

- Employee benefits
  - Allocated based on gross salary
  - Do not report contracted amounts in salary accounts
  - Look at option to directly assign benefits

Overhead Allocations : B-1

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

Overhead Allocations : B-1

- Fragmented A&G
  - Business Office
    - Gross revenues
    - Eliminates inappropriate allocations to cost centers not supported by the Business Office
      - Assisted Living?
      - Rental properties
      - Nursing Home/Home Health/etc.

Overhead Allocations : B-1

- Fragmented A&G (cont.)
  - Accounting
    - Accumulated cost
    - Gross revenues
  - Purchasing & receiving
    - Purchases by department

Overhead Allocations : B-1

- Fragmented A&G (cont.)
  - Communications
    - Actual phones by department
    - Eliminates inappropriate allocations to departments without phones/communications
      - Assisted Living
      - Nursing Homes
      - Rental property

Overhead Allocations : B-1

- Fragmented A&G (cont.)
  - Admissions
    - Gross revenues
    - Eliminates inappropriate allocations to cost centers not supported by the Business Office
      - Assisted Living?
      - Rental properties
  - Information Technology
    - Terminals
    - HIT impact
  - Administrative & General other?

Overhead Allocations : B-1

- Maintenance & repairs
  - Often included with operation of plant
  - Square footage or time studies
  - Remember offsite locations
  - Recommend analysis
    - Consider long term versus short term implications

Overhead Allocations : B-1

- Housekeeping
  - Square footage
  - 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
  - Review data gathering tool annually

Overhead Allocations : B-1

- Nursing administration
  - Hours of service
  - Nursing FTEs
  - Needs to match organizational chart
    - Analyze opportunities to change organizational chart
      - Clinics
      - Diagnostic departments
      - Home Health
    - Changes must address operational issues

Overhead Allocations : B-1

- Central services & supply
  - Frequently not used and Worksheet A costs bundled into Medical supplies charged
    - Changes will be required with breakout of supply costs into two cost centers
  - If used, allocated based on costed requisitions

Overhead Allocations : B-1

- Medical records & library
  - Gross revenues – allocate only to those departments receiving services from medical records
  - Time studies
  - Separate staffing??

Overhead Allocations : B-1

- Social services/activities
  - Be careful not to bury within nursing home
  - Time studies
  - Patient days
  - Don’t allocate and directly expense

RHC Visits : M-2

- Frequently overstated
- Results in underpayment
- Determining the visit numbers
  - RHC visits versus non RHC visits
  - Understanding definition of RHC Visit
    - Face-to-face encounter between a clinic patient and a physician, physician assistant or nurse midwife

Questions?

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