Strategic and Operational Considerations in the Medicare Cost Report

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Presented by
Lawrence A. Fogel
President
Fogel Consulting, LLC

Strategic and Operational Questions

1. Have you weighed community benefit against what the hospital can afford?
2. Do you have any sacred cows and should they be treated in that manner?
3. Do you know which programs are profitable and which ones are not?
4. If the programs are not profitable, can they be improved?
5. Is your hospital receiving the Medicare and Medicaid reimbursement to which it is entitled?

Cost Report Oversight Questions

1. Do you have a person who reviews the cost report before it is submitted?
2. Do you believe that the cost report is prepared in a fresh and objective manner?
3. Do you have a person who monitors your Medicare reimbursement during the year?
4. Do you have a person who is responsible for the accuracy of the information which is used in the cost report?
5. Do you use the Medicare cost report as a diagnostic tool?
6. Do you view Medicare reimbursement as a critical element to your Hospital's strategic planning process?

Alignment of Operating Expenses with Job Functions and Responsibilities

1. Are your salaries and non-salary expenses properly aligned in the general ledger?
2. Have you changed job responsibilities, reporting responsibilities, etc. but not changed the expense assignments on the general ledger?
3. Do you have employees working in multiple departments?
4. If so, how do your employees account for their time while working in multiple departments?
5. Are your revenues and expenses properly matched?

Alignment with Organizational Structure

1. Is the cost report prepared according to your hospital's organizational structure?
2. Is your organizational structure current or does it need to be updated?
3. Examples include:
   a. DON does not supervise HHA or RHC but cost allocations are made in cost report
   b. Clinics are on org chart but not on general ledger
   c. Marketing is on org chart but not general ledger

Diagnostic Indicators

1. Low swing bed utilization
2. High cost to charge ratios. Could indicate:
    a. Low prices
    b. Lost charges
    c. Low volume
    d. Excessive costs
    e. Cost report issues with mismatches or misallocations
3. Excessive non-reimbursable cost centers
4. Excessive non-allowable costs
5. Excessive overhead allocations
6. Illogical overhead allocations

Departmental Operating Analysis (DOA)

1. Compare direct costs to gross charges for gross margin.
2. Compare fully allocated overhead costs to gross charges for adjusted gross margin.
3. Allocate contractual allowances to departmental charges.
4. Calculate net contribution margin for each department.
5. Investigate all unfavorable results above tolerance level.

Common Reasons for Errors and Distortions

1. Not recognizing changes in operations
2. Not recognizing changes in organizational structure
3. Not recognizing changes in accounting process
4. Not understanding hospital's operations
5. Preparing the cost report the same as prior years' cost reports
6. Making bad assumptions or misapplying information

Reconnaissance Tactics

1. Board Retreats
2. Strategic Management Reimbursement Retreats
3. Financial Analysis of New Programs and Services
4. Strategic and Operational Cost Report Assessment
    a. Fresh and objective review
    b. Alignment with operations
    c. Alignment with organizational structure
    d. Excessive cost eliminations
    e. Detection of unprofitable services
    f. Identification of opportunities for improvement

Swing Bed Reimbursement

1. Paid at 101% of costs
2. Very important for the success of a CAH's Medicare reimbursement
3. Is your Swing bed Program capturing all eligible admissions?
4. Are you keeping patients as long as they qualify for the SNF benefit?
5. Do physicians, clinicians and staff fully understand the SNF benefit?

Medicare Bad Debts

1. Are bad debt policies current and effective?
2. Is your Hospital following its policies?
3. Do your policies and practices meet the Medicare reimbursement requirements?
4. How is your collection agency performing?
5. How long do they keep the bad debt accounts?
6. Is your hospital claiming all eligible bad debts?

Monitoring Medicare Payments

1. Is your hospital monitoring its Medicare interim payment rates?
2. Is your hospital preparing monthly or quarterly interim rate calculations?
3. Is your hospital preparing interim cost reports?
4. Is your hospital watching for warning signals such as volume fluctuations, price increases, cost fluctuations and inpatient/outpatient fluctuations?

Case Studies

1. Home Health Agency

A CAH operated a home agency that lost $60,000 per year and absorbed an additional $50,000 in overhead costs. The CAH was able to find a health care organization that was willing to take over and operate the HHA.

2. Long Term Care Facility

A CAH operated a LTC that provided ICF services to Medicaid and private patients. The LTC lost nearly $100,000 per year and absorbed approximately $250,000 in overhead costs. The CAH was able to find a buyer to operate the LTC.

3. Retail Pharmacies

A CAH operated 4 retail pharmacies in outlying communities. The pharmacies lost money and absorbed approximately $100,000 in non-reimbursable overhead costs. The CAH closed 3 of the retail pharmacies.

4. Specialty Clinics

A CAH operated a specialty clinic and leased the space to the physicians. The

Case Studies

leases were unprofitable, created compliance issues and the specialty clinic was treated as a non-reimbursable cost center. The CAH terminated the leases and changed the arrangement to where the physicians billed the professional component and the hospital billed the technical component.

5. Geri-Psych Unit

A CAH operated a Geri-Psych unit that lost significant dollars due to low volume and also absorbed significant overhead costs. The CAH decided to close the unit.

6. Public Relations

A CAH established a non-reimbursable cost center for its Public Relations Department. However, the PR Director actually performed functions that were allowable but did not prepare time studies. By maintaining time studies, the CAH was able to claim approximately 60% of the PR costs as allowable costs.

Case Studies

7. Physician Clinics

A CAH operated physician clinics that were losing money and were absorbing significant overhead costs as non-reimbursable cost centers. By converting these Clinics to provider based clinics, the CAH's Medicare reimbursement was significantly increased and the non-reimbursable cost centers were eliminated.

8. Nursing Salaries

A CAH assigned nurses to the ER but, when there were no patients in the ER, the nurses floated to the Med/Surg. Unit. However, the CAH did not transfer the salaries to the Med/Surg. Unit. By capturing the actual time that the nurses floated to the Med/Surg Unit, the CAH's reimbursement was increased.

9. ER Physicians

A CAH staffed its ER with physicians who had a significant amount of availability time. However, the physicians did not keep time studies and the ER log did not capture the necessary information. As a result, the entire amount of availability compensation

Case Studies

was lost. By keeping time studies, the CAH was able to preserve over 60% of the ER Physicians' compensation as allowable costs.

10. Nursing Administration

A CAH allocated nursing administration costs to the HHA and RHC in the cost report. However, the organizational chart showed that the DON did not supervise the HHA and RHC. By correcting these allocations, Medicare reimbursement was improved.

11. Meals on Wheels

A CAH operated a meals on wheels program that had a loss of $50,000 per year and absorbed over $120,000 in overhead costs. The CAH determined that it could no longer afford the program and closed it, thereby avoiding the loss and unreimbursed overhead.

12. Off-site Operations

A CAH operated a HHA in a separate building off-campus. Even though the Housekeeping staff did not clean the space, overhead costs were allocated to the HHA in the cost report. By correcting this allocation, Medicare reimbursement was improved.

Top 10 “Take Home” Strategies

1. Perform a functional review to determine if salaries are assigned to the cost centers where the employees actually work.
2. Perform an organizational review to determine if the cost report is prepared according to the CAH’s current organizational chart.
3. Review the cost report before it is signed and submitted.
4. Ask the preparer for a Medicare management letter and discuss the issues.
5. Educated board members on basic Medicare and financial issues.
6. Integrate reimbursement issues into the strategic planning process.
7. Conduct a Strategic Reimbursement Retreat for the CAH’s management team.
8. Evaluate the reimbursement impact of new programs and services.
9. Evaluate the reimbursement impact of non-reimbursable cost centers and programs not reimbursed on a cost basis.
10. Conduct a diagnostic review of the cost report and utilize results to evaluate operations.

Thank You!

Lawrence A. Fogel
President
Fogel Consulting, LLC
10207 Delmar
Overland Park, Kansas 66207
913-381-0579
lafsr47@aol.com