

Alternative Handling of CAH Overhead Allocations



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Background

- CAH facilities frequently fail to access the reimbursement available under CAH status.
- This is often due to the failure to periodically explore approved alternative methodologies for allocating overhead costs.



Agenda

- Alternative allocation methodologies
- Recordkeeping requirements
- Strategies
- HIT Incentives



Overhead Allocations

- Capital – Buildings
- Capital – Major Moveable Equipment
- Employee Benefits
- Administrative and General
- Operation of Plant
- Laundry
- Housekeeping
- Dietary
- Cafeteria
- Nursing Administration
- Medical Records
- Social Services
- Activities



Allocation Statistics

- Methodologies
 - Medicare allows for alternative allocation methodologies
 - Request for change in methodology must be made 90 days prior to end of affected cost report period
 - Request required for first cost report?



Capital Buildings

- Allocated based on square footage
- Alternatives include the breakout (subscript) of new buildings and/or renovations
 - Hospital versus non-hospital space
 - Inpatient versus outpatient space
 - Verify with MAC
 - Consistency



Capital Buildings

- Square Footage
 - Make sure updated statistics are maintained
 - Increased focus of review by Medicare auditors
 - Use electronic spreadsheets
 - Maintain history



Capital Buildings

- Square Footage
 - Idle Space
 - Monitor
 - Maintain previous records
 - Shared Space
 - Cardiac Rehab
 - Pulmonary Rehab
 - Physical Therapy



Capital Buildings

- Square Footage
 - Gross vs Net
 - Consistency
 - Model impact
 - Frequently minimal impact
 - Placement and amount of common space is determining factor



Capital – Major Moveable Equipment

- Square footage or actual
 - Actual
 - Usually better for facilities with non-reimbursable cost centers
 - Unit multiplier should be near 1.0
 - Check for capital lease information if not near 1.0



Capital – Major Moveable Equipment

- Square footage or actual
 - Actual
 - Need to maintain updated asset listing
 - Deletions
 - Transfers

Capital – Major Moveable Equipment

Example – CAH without NH

Category	Actual	Square Footage
Overhead	28%	46%
Med/Surg	15%	14%
Ancillaries	56%	38%
Non-Reimbursable	1%	2%

Example Impact = (\$5,000)

Capital – Major Moveable Equipment

Example – CAH with NH

Category	Actual	Square Footage
Overhead	8%	24%
Med/Surg	5%	9%
Nursing Home	7%	32%
Ancillaries	79%	21%
Non-Reimbursable	1%	14%

Example Impact = (\$55,000)



Employee Benefits

- Allocated based on Gross Salaries
 - Limited options for alternatives
- Directly assign identifiable benefits
 - FICA
 - Pension
- Allocate
 - Worker's Compensation
 - Healthcare
 - Unemployment Taxes

Administrative and General

- Administrative and General Costs are allocated based on accumulated costs unless this cost center is fragmented
- Opportunities for fragmenting
 - Finance/Accounting
 - Business Office
 - Registration
 - Education
 - Information Technology
 - Purchasing
 - Pastoral Care

A&G – Finance/Accounting

- Accumulated Cost versus Gross Revenues
 - Opportunity arises in facilities with non-reimbursable cost centers with smaller mark-ups on cost than in traditional hospital departments
 - Home Health
 - Hospice
 - Nursing Home
 - Assisted Living
 - Rental Property



A&G – Business Office

- Opportunity arises when Business Office is not involved in billing and collection of services in all departments of the hospital
 - Home Health
 - Hospice
 - Clinics
 - Rental Property



A&G – Business Office

- Allocation methodologies
 - Gross Revenues versus Accumulated Cost



A&G – Business Office

Example – Fragmented A&G

Category	Original	Fragmented
Overhead	13%	0%
Med/Surg	14%	13%
Ancillaries	59%	77%
Non-Reimbursable	14%	10%

Example Impact = \$45,000

A&G – Registration

- Opportunity arises when Registration is not involved in admissions process in all departments of the hospital
 - Home Health
 - Hospice
 - Clinics
 - Rental Property

A&G – Registration

- Allocation methodologies
 - Gross Revenues versus Accumulated Cost

A&G – Registration

Example – Fragmented A&G

Category	Original	Fragmented
Overhead	13%	0%
Med/Surg	14%	15%
Ancillaries	59%	85%
Non-Reimbursable	14%	0%

Example Impact = \$90,000

A&G - Education

- Opportunity arises when Education department does not provide services to non-reimbursable departments and/or highly Medicare utilized departments receive higher levels of educational programming
 - Clinics
 - Rental Property
 - Nursing Departments
- Opportunity may be partially offset if provider has non-reimbursable nursing departments
 - Home Health
 - Hospice



A&G - Education

- Allocation Methodologies
 - Number of employees
 - Number of full-time-equivalents
 - Time records

A&G – Education

Example – Fragmented A&G – Time Records

Category	Original	Fragmented
Overhead	13%	25%
Med/Surg	14%	28%
Ancillaries	59%	40%
Non-Reimbursable	14%	6%

Example Impact = \$35,000

A&G – Information Technology

- Opportunities arise when Information Technology does not provide services to non-reimbursable cost centers of the organization and/or when nursing departments have adopted the use of bedside terminals.
 - Rental Property
 - Nursing Departments
- The opportunities may be partially offset by non-reimbursable cost centers
 - Home Health
 - Hospice

A&G – Information Technology

- Allocation methodologies
 - Terminals versus Accumulated Cost

A&G – Information Technology

Example – Fragmented A&G – Terminals

Category	Original	Fragmented
Overhead	13%	39%
Med/Surg	14%	4%
Ancillaries	59%	43%
Non-Reimbursable	14%	14%

Example Impact = (\$36,000)

A&G – Information Technology

- Health Information Technology – Stimulus Impact
 - Providers are recommended to continue monitoring this cost center for opportunities
 - Implementation of new health information technology may significantly impact the potential benefit of this allocation methodology



A&G - Purchasing

- Opportunity arises when Purchasing does not provide support or provides limited support to non-reimbursable cost centers
 - Rental Property
 - Home Health
 - Hospice
 - Clinics
- Opportunities may be partially offset if provider has non-reimbursable departments utilizing significant amount of Purchasing resources
 - Nursing Home

A&G - Purchasing

- Allocation Methodologies
 - Purchased Requisitions versus Accumulated Costs



A&G – Purchasing

Example – Fragmented A&G – Purchased Requisitions

Category	Original	Fragmented
Overhead	13%	4%
Med/Surg	14%	5%
Ancillaries	59%	86%
Non-Reimbursable	14%	5%

Example Impact = \$68,000



A&G – Pastoral Care

- Opportunity arises when Pastoral Care does not provide support to non-reimbursable cost centers
 - Rental Property
- Opportunities may be partially offset if provider has non-reimbursable cost centers receiving substantial support from Pastoral Care
 - Home Health
 - Hospice



A&G – Other

- Do not be limited by the options presented
 - Look at each individual department reported in Administrative and General



Operation of Plant

- Operation of Plant is typically a combination of Maintenance and Repairs and Operation of Plant (Utilities)
- Cost Center can be split into two cost centers
 - Line 7 – Maintenance and Repairs
 - Line 8 – Operation of Plant



Operation of Plant

- Allocation Methodologies – Maintenance and Repairs
 - Time Study versus Square Footage
- Allocation Methodologies – Operation of Plant
 - Separate Metering of Buildings versus Accumulated Square Footage



Operation of Plant – Time Studies – PRM I 2313.E

- Problems are commonly found with time studies
 - Due to failure to follow the rules
- Time studies used must meet the following criteria:
 - The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.
 - A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.



Operation of Plant – Time Studies – PRM I 2313.E

- Time studies used must meet the following criteria:
 - Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).
 - The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.
 - No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.



Operation of Plant – Time Studies – PRM I 2313.E

- Time studies used must meet the following criteria:
 - The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.
 - The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.



Operation of Plant – Time Studies – PRM I 2313.E

- Time studies used must meet the following criteria:
 - The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.



Operation of Plant – Time Studies – PRM I 2313.E

- Strategies
 - Update tools for gathering time studies on at least an annual basis
 - Excel Worksheet
 - Provide education to staff
 - Staff may provide what they think you are looking for.....
 - Productivity versus reimbursement



Operation of Plant – Time Studies – PRM I 2313.E

- Strategies – ER Physician Example
 - Historical allocation
 - 60% Professional
 - 40% Provider
 - \$1,200,000 Emergency room physician costs
 - 25% Medicare utilization
 - \$120,000 Medicare reimbursement



Operation of Plant – Time Studies – PRM I 2313.E

- Strategies – ER Physician Example
 - Updated allocation
 - 45% Professional
 - 55% Provider
 - \$1,200,000 Emergency room physician costs
 - 25% Medicare utilization
 - \$165,000 Medicare reimbursement



Operation of Plant – Time Studies – PRM I 2313.E

- Strategies – ER Physician Example
 - \$45,000 increase in reimbursement
 - 37.5% increase!



Laundry

- Limited opportunity to elect alternative methodology
 - Patient Days – Simplified Methodology
- Verify new departments are added to tool used to gather statistic

Housekeeping

- Opportunity arises when Housekeeping does not clean non-reimbursable cost centers or spends more time per square foot in reimbursable cost centers
 - Rental Property
 - Offsite Locations



Housekeeping

- Allocation methodologies
 - Time Study versus Square Footage
 - Verify tool used to gather statistic contains all departments
 - Provide ongoing education to staff regarding use of tool
 - Verify time studies follow Medicare rules



Dietary

- Opportunities arise when staff and preparers fail to communicate as contents of meal counts
 - Administrative Meals
 - Internal business related meals
 - Outside meals
 - Update tool used to gather statistics to ensure accuracy of data



Cafeteria

- Opportunities may arise when some departments are located offsite
 - Departments offsite should not receive allocation
- Opportunities may arise when there are contracted staff
 - Include contracted staff onsite



Nursing Administration

- Opportunities may arise when the current organizational chart has non-reimbursable cost centers reporting to Nursing Administration or the DON is acting in a CNO role
 - Home Health
 - Hospice



Nursing Administration

- Changes in reimbursement can occur when there are changes in the organizational structure
 - Must be actual changes in reporting and operations



Nursing Administration

Example – Fragmented A&G – Time Records

Category	DON w/ HH and H	DON	CNO
Overhead	0%	0%	0%
Med/Surg	41%	50%	27%
Ancillaries	40%	49%	72%
Non-Reimbursable	19%	1%	1%

Example Impact = \$41,000 moving HH and Hospice to CEO

Example Impact = \$47,000 moving HH and Hospice to CEO and adopting CNO role



Medical Records

- Time Studies are often used
 - Difficult to maintain
 - Impact of non-reimbursable cost centers
 - Nursing Homes



Medical Records

- Allocation methodologies
 - Gross Revenues versus Time Studies
 - May benefit from subscribing Medical Records into departments
 - Hospital
 - Nursing Home
 - Wrap together with Business Office and Registration



Social Services

- Verify costs not buried in Nursing Home
 - Provides support to Hospital and Nursing Home
- Allocation methodologies
 - Patient Days

Impact of Pricing on Allocations

- Pricing changes typically have a minor impact on Medicare reimbursement, except:
 - Allocations of statistics on cost report by gross revenue
 - Most providers could benefit from consistent markup throughout organization
 - Minimal or lack of mark up on room costs
 - Larger mark ups on services with lower Medicare utilization
 - Overly aggressive pricing may impact beneficiary responsibility

Impact of Pricing on Allocations

- Charges reported on Worksheet C of cost report are used to calculate cost to charge ratio which is used to calculate Medicare share of costs
 - Inappropriate reporting of charges will result in inappropriate reimbursement
 - Overstatement of revenues common
 - Results in lost reimbursement

Impact of Pricing on Allocations

- Professional Charges
 - Verify all professional costs/charges removed from cost report as appropriate
 - Operating Room
 - Radiology
 - Emergency Room
 - Clinics

Impact of Pricing on Allocations

- Provider Based Clinics
 - Be sure provider and preparer both understand make up of revenue in Provider Based Clinic
 - Professional revenue in clinic (all payors)
 - Technical revenue in clinic (Medicare and possibly Medicaid)
 - Professional revenue provided outside clinic

Impact of Pricing on Allocations

- Provider Based Clinics
 - Worksheet C
 - Must include the technical revenue that would have been generated for services **in the clinic** if all payors would have been billed in same manner as Medicare
 - Frequently overstated

Impact of Pricing on Allocations

- Provider Based Clinics
 - Cause of overstatement
 - Technical fees are calculated for all services regardless of where they were provided.
 - Average error costs provider \$150,000 - \$250,000 per year.

HIT Incentive Payments

- Cost based payments available for CAHs for implementation of Meaningful Use EHR technology.

HIT Stimulus Payment Years

- Defined:
 - CAH – Cost Reporting Period
 - First available payment year begins with first cost report beginning on or after October 1, 2010



Stimulus Payments – Medicare Share

- Medicare Share
 - Based on inpatient volume
 - Numerator
 - Medicare days + Medicare Advantage patient days
 - IP, Specialty Care
 - Excludes Swing Bed
 - Medicare Advantage patient days based on no-pay bills
 - New rules released October 15, 2010



Stimulus Payments – Medicare Share

- Based on inpatient volume
 - Denominator
 - Total inpatient days TIMES
 - Hospital charges less charity care DIVIDED BY hospital charges
 - Worksheet C Part I Line 200 Column 8



Stimulus Payments – Medicare Share

- Based on inpatient volume
 - Denominator
 - Charity Care
 - As identified on Worksheet S-10 of the Medicare cost report for PPS Hospitals
 - New reporting requirement for CAH's



Critical Access Hospitals – Medicare

- Payments available 2011 – 2015
- Fiscal year after FY 2010, but before FY 2016
 - Example – If December 31st year end, first year begins January 1, 2011.
- No payments after 2015
- Up to 4 consecutive payment years



Critical Access Hospitals - Medicare

- Allowed to expense their costs associated with the purchase of certified EHR technology in a single year
 - Versus depreciating these costs on the cost report
 - Current year and prior year purchases (undepreciated value)
 - Includes only purchases for hospital specific EHR technology



Critical Access Hospitals – Medicare

- Continued
 - Reimbursement based on Medicare Share + 20 percentage points (not to exceed 100%)
 - Lump sum prompt payment subject to reconciliation
 - Initial based on last filed 12 month cost report
 - Final based on final cost report
- Deferred Revenue Issues?



Critical Access Hospitals - Medicare

- Continued
 - Payments up to 4 consecutive years
 - Stages (3 stages)
 - Replacement equipment



Critical Access Hospitals - Medicare

- Allowable expense
 - Reasonable cost – “computers and associated hardware and software necessary to administer EHR technology”
 - No changes in capitalization rules
 - Communicate with MAC/FI with any questions
 - Impact on Trade-ins?
 - Review capitalization policies



Critical Access Hospitals - Medicare

- Allowable expense
 - Incentive payment in lieu of depreciation AND interest
 - “Be smart about your interest”
 - MAC/FI to review cost reports to ensure the assets associated with the acquisition of certified EHR technology are expensed in a single period and that depreciation and interest expenses associated with the acquisition are not allowed
 - Subject to reconciliation



Critical Access Hospitals – Medicare

- Strategy
 - Place EHR assets in use and become meaningful user in same fiscal year

Stimulus Payments – Physician

- Physician defined
 - Doctor of Medicine
 - Doctor of Osteopathy
 - Doctor of Dental Surgery
 - Doctor of Podiatric Medicine
 - Doctor of Optometry
 - Chiropractor

Stimulus Payments – Physician

- Payment Year and Year of Payment defined
 - Any calendar year beginning with 2011
- Incentive
 - 75% of Secretary's estimate of allowed charges for covered services furnished by eligible professional during relevant payment year.
 - Paid claims no later than 2 months after relevant year
 - Up to 5 years
 - No incentive after 2016

Stimulus Payments – Physician

- Incentives do not apply to:
 - Provider based physicians
 - Substantially all professional services provided in hospital setting
 - 90% of covered services in calendar year preceding payment year
 - Place of Service 21 – Inpatient
 - Place of Service 23 – Emergency Room
 - How will Medicare handle Method II providers?
 - RHC/FQHCs

Stimulus Payments – Physician

Calendar Year	First CY in which EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015 +
2011	\$18,000	---	---	---	---
2012	\$12,000	\$18,000	---	---	---
2013	\$8,000	\$12,000	\$15,000	---	---
2014	\$4,000	\$8,000	\$12,000	\$12,000	---
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	---	\$2,000	\$4,000	\$4,000	\$0
Total	\$44,000	\$44,000	\$39,000	\$24,000	\$0

Stimulus Payments – Physician

- Healthcare Provider Shortage Area (HPSA) Incentive
 - 10% increase in incentive
 - Provides services predominately in HPSA
 - Defined as greater than 50%
 - January 1 – December 31 frequency
 - If HPSA by December 31 of prior year
 - No impact if HPSA lost during current year
 - No impact if HPSA obtained during current year

HPSA Stimulus Payments – Physician

Calendar Year	First CY in which EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015 +
2011	\$19,800	---	---	---	---
2012	\$13,200	\$19,800	---	---	---
2013	\$8,800	\$13,200	\$16,500	---	---
2014	\$4,400	\$8,800	\$13,200	\$13,200	---
2015	\$2,200	\$4,400	\$8,800	\$8,800	\$0
2016	---	\$2,200	\$4,400	\$4,400	\$0
Total	\$48,400	\$48,400	\$42,900	\$26,400	\$0

Stimulus Payments – Physician

- Single Consolidated Payment
 - Ascertain professional has demonstrated meaningful use
 - Reaches maximum payment limit
 - If maximum payment limit is not reached payment is processed 2 months after relevant payment year
- Multiple Employers/Contractual Arrangements
 - Assign incentive to 1 employer or entity

Medicaid Eligible Hospitals

- Acute care hospital (including CAH) must have at least 10 percent Medicaid Patient Volume based on patient encounters
 - Inpatient
 - Emergency Room
 - Any representative continuous 90-day period in most recent fiscal year
- Like other Medicaid Eligible Hospitals, CAHs may receive both Medicare and Medicaid EHR incentive payments

Medicaid Eligible Hospitals

- PPS and CAHs reimbursed under same methodology as Medicare PPS
 - Medicaid Share versus Medicare Share
 - Calculate 4 year payment
 - Discharges based on hospital's experience in past three years

Medicaid Eligible Hospitals

- PPS and CAHs reimbursed under same methodology as Medicare PPS
 - Payment made over 3 – 6 years
 - No more than 50% of payment in 1 year
 - No more than 90% of payment in 2 years
 - “Adopt, implement or upgrade certified EHR technology”
 - No meaningful use requirement in year 1
 - Meaningful use required for future years



Medicaid Hospitals

- Initial Amount
 - Base payment for each PPS hospital = \$2,000,000
 - Adjusted for discharges 1,150 to 23,000
 - \$200 additional per discharge in this range
 - Times Medicare Share



Medicaid Hospitals

- Transition Factor (FFY 2011 – 2013)
 - Year 1 = 1
 - Year 2 = $\frac{3}{4}$
 - Year 3 = $\frac{1}{2}$
 - Year 4 = $\frac{1}{4}$
 - Subsequent Years = 0

- Transition Factor (FFY 2014 – 2015)
 - If the facility's first year of eligibility is after FFY 2013, the transition factor is assumed that 2013 was the first year (facility loses transition factor)
 - If the first payment year is after FFY 2015, the transition factor is zero

Medicaid Eligible Professionals

- Eligible providers must elect (Medicare or Medicaid), with option for one change
 - Medicaid Eligible Professionals must select one state
- Medicaid EPs are the following professionals (other than hospital-based professionals):
 - Physicians and dentists
 - nurse practitioners
 - certified nurse-midwives
 - physician assistants practicing in FQHCs or RHCs that are led by a physician assistant

»»» Medicaid Eligible Professionals

- A PA leads an FQHC or RHC under any of the following circumstances:
 - when a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA)
 - when a PA is a clinical or medical director at a clinical site of practice
 - PA is an owner of the RHC

Medicaid Eligible Professionals

- Medicaid EP must satisfy one of three Patient Volume thresholds:
 - Have $\geq 30\%$ Patient Volume attributable to Medicaid recipients
 - Have $\geq 20\%$ Patient Volume attributable to Medicaid recipients and be a pediatrician
 - practice predominantly in a FQHC or RHC and have $\geq 30\%$ Patient Volume attributable to Needy Individuals

Medicaid Eligible Professionals

- Needy Individuals are persons who:
 - received medical assistance from Medicaid or the Children's Health Insurance Program
 - were furnished uncompensated care *or*
 - were furnished services either at no cost or reduced cost based on a sliding scale determined by individuals' ability to pay



Medicaid – Eligible Professionals

- Incentive payment to EP equals Net Average Allowable Costs for EHR
- NAAC is Average Allowable Costs (capped at \$25K in yr 1 and \$10K in yrs 2-6) net of cash payments attributable to EHR technology or support services from sources other than state and local governments, subject to 15% EP responsibility
- Pediatricians qualifying under the 20% limit receive 2/3rds of the incentive



Medicaid – Eligible Professionals

Calendar Year	Maximum Incentive Payment for Medicaid EPs Who Are Meaningful Users in the First Payment Year					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	---	---	---	---	---
2012	\$8,500	\$21,250	---	---	---	---
2013	\$8,500	\$8,500	\$21,250	---	---	---
2014	\$8,500	\$8,500	\$8,500	\$21,250	---	---
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	---
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	---	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	---	---	\$8,500	\$8,500	\$8,500	\$8,500
2019	---	---	---	\$8,500	\$8,500	\$8,500
2020	---	---	---	---	\$8,500	\$8,500
2021	---	---	---	---	---	\$8,500
Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750



Questions??
