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Cost reporting in the time of COVID-19 could have an impact on hospital payment

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Hospitals are beginning to wade through an ocean of changes caused by the coronavirus pandemic. The COVID-19 public health emergency (PHE) will have a long-term impact on hospital operations, and an immediate impact on the cost report data that hospitals will file for affected fiscal periods.

Changes stemming from the COVID-19 pandemic that hospitals report through the cost report will be pervasive, impacting nearly every aspect of the reported data. In consideration of these changes, CMS granted automatic filing extensions of at least 60 days to providers filing cost reports potentially impacted by the PHE. Although CMS had previously granted extensions under limited circumstances, it had not issued a blanket extension since the outpatient prospective payment system started nearly 20 years ago.

Even with these extensions, hospitals are challenged to complete cost reports that fully address all of the PHE's impacts, particularly on payment areas such wage index, uncompensated care, cost allocation and apportionment, and settlement data.

The importance of the cost report

Providers had little opportunity to plan for the pandemic's effects on their payment environment, nor could they anticipate its impact on their ability to deliver the type of services that produce the greatest positive margin contribution. The situation is of concern because the annual cost report represents a retrospective look at hospital operations and is used by CMS and some state agencies to

establish future rates. It also is an excellent source of data for competitor analysis for market assessment and transactional due diligence.

These considerations underscore the importance of due diligence in preparing and reviewing the cost report during and after the PHE. Following are some specific areas of concern hospitals should address in preparing cost reports that reflect the PHE's impact. It should be noted that there is no recipe for addressing these concerns, as each hospital's response will be determined by its unique circumstances. (See also the sidebar "Productivity factors for cost-based RHCs" at the end of this article for a discussion of cost reporting considerations for rural health clinics.)

Volume changes

The changes in costs and volume will impact cost-to-charge ratios, which are used to establish future payment amounts, and are the basis of payment for critical access hospitals (CAHs). Volume changes will likely affect several key payment areas, including:

- Reported uncompensated care data
- Wage index values
- Overall cost-to-charge ratios
- Payment adjustments including outliers, indirect medical education (IME) and disproportional share hospital (DSH) payments

Given the current reimbursement formulas for these high-impact areas, the changes may affect multiple cost-reporting periods. Almost all providers will experience some payment impact from volume changes, but the impact will not be equally distributed among them. Providers should carefully plan their payment strategies, accounting for volume changes and how they might affect future payment levels.

Available beds

Available beds is a Medicare term of art used for various payment criteria — including CAH status, sole community hospital and rural referral center. Most significant is the use of this metric for both the IME adjustment and the empirically justified (25%) DSH payment amount. *Available beds* generally refers to beds in service to provide inpatient care (lodging) and excludes "beds" where only ancillary services are provided. It is not the same number as licensed beds, staffed beds or operating beds (https://www.law.cornell.edu/cfr/text/42/412.105).

During the pandemic, hospitals had to pivot quickly to find or "create" beds within their facilities to appropriately manage the care needs of a patient population that, for many reasons, may have been unlike their historical patient mix. For example, in response to the PHE, temporary inpatient beds were set up in ancillary areas and other beds were reconfigured to handle patients requiring ventilators or other special services. In some situations, depending on the services offered, hospitals closed units and reduced beds.

CMS issued emergency waivers to address these unique situations to create the necessary flexibility for patient care needs. CMS also has revised the cost report instructions to capture changes in hospitals' available beds attributable to the COVID-19 pandemic.

Hospitals should conduct a detailed analysis of their available beds so current and future calculations impacted by this value do not adversely affect payment. For example, because the IME adjustment uses *available bed* data from the current and previous cost reports, the calculation will need monitoring for at least the next three years.

As the pandemic eventually begins to wind down, hospitals will need to evaluate whether their bed configurations before and after the pandemic are the same. If a hospital makes a strategic decision to

either increase or decrease its size, it will need to understand how the changes will impact future payment.

Departmental cost finding

Differences in hospitals' cost-to-charge ratios resulting from pandemic-driven shifts in costs, attributable to different types of patients and changing revenue streams, will affect uncompensated care payments, cost reimbursement for CAH facilities and the cost-to-charge ratio used for outlier payments. Potentially aberrant cost findings also could impact CMS's rate-setting for Medicare.

Hospitals that established unique cost centers to capture the COVID-19-related expenses will need to allocate those costs based on Medicare principles of reimbursement to avoid cost-report mismatches. A mismatch can occur when a hospital incurs COVID-19-related administrative expenses in one period but does not record the related expense until the subsequent reporting period when the invoice is received.

Beware of mismatches

Cost-report mismatches can happen all-too easily. Consider the following, for example:

- **An expense is not matched with period when the item was used.** If this mismatch occurs, expenses in the first cost reporting period are understated and expenses in the second cost reporting period are overstated, resulting in mis-stated cost-to-charge ratios for both periods.
- **An expense is reported out of period.** This type of mismatch could impact the amount of unreimbursed expenses the hospital can report in a particular period with respect to COVID-19 provider relief funds, and it could potentially result in the hospital's being required to repay some portion of those funds.

CAHs, in particular, should exercise due diligence in determining Medicare's share of these costs. Interim rates for CAHs are based on cost report information. If CMS establishes rates using cost reports heavily influenced by the pandemic with incorrect allocations to Medicare, the rates could be misstated, resulting in large cost-report underpayments or overpayments. Such an outcome could exacerbate cash-flow hardships for CAHs, which already struggle with insufficient inpatient beds to respond to volume changes and virtually no outpatient services to help cover fixed operating costs.

Prospective payment system (PPS) providers also should evaluate changes in their overall operating cost-to-charge ratio, which can impact the distribution of uncompensated care pool payments in future cost-reporting periods.

Labor economics and wage index

Medicare payments under various PPS methods are influenced by an area wage index, whereby about two-thirds of the total payment is wage index adjusted. COVID-19 will influence these wage index calculations for several years to come, with both winners and losers. Under the present formula, wage index adjustments are designed to be budget neutral, and the wage index data reported for FY20 and in FY21 cost reports will be used to establish rates for federal FY23 and beyond.

Hospitals should be mindful of the potential impact of COVID-19 on their reported wage index. Those that incurred significant contract labor costs and needed to pay bonuses or *hazard pay* to essential workers during the peak periods of the PHE could report a higher wage index. Alternatively, hospitals that curtailed operations or were not severely impacted by the PHE could see lower wage index values.

Hospitals also will see overall *wage rates* rise due to the PHE, as they compete for the same pool of nursing and allied health professionals. Rising wages due to supply and demand have established a new entry point for future employees. Hospitals will need to pay these wages while having to wait for any potential relief until the higher rates work their way through the wage index calculation, creating a challenge for some providers' long-term viability.

Hospitals seeking reclassification under the Medicare Geographic Classification Review Board (MGCRB) redesignation rules should also be mindful of the COVID-19 wage index years and monitor changes to their wage data, as MGCRB reclassifications are generally based on a three-year average. Thus, providers that already have a reclassification may need to wait one or two years to re-apply with their COVID-19 impact wage index data.

The Medicare wage index also is often used by State Medicaid programs and managed care organizations to reimburse hospitals based on some derivative of wage-index-influenced rates, which can further distort payments to individual providers. Hospitals that effectively spent wage dollars strategically during the PHE will be rewarded, while those that did not will be penalized.

Cost report treatment of COVID-19-related revenues

Hospitals received general and targeted distributions during the initial phases of the pandemic. Some smaller hospitals may also have received funds under the Paycheck Protection Program and other programs. Although all these funds were based on specific formulas, CMS is considering them to be grants, so allowable hospital costs were not reduced by these amounts.

CMS also has added a new line in the income statement (Worksheet G-3, line 24.50) within the cost report, with instructions stating the amount is to represent the aggregate receipts (within a particular cost reporting period) for Provider Relief Funds and Small Business Association loan forgiveness. Some hospitals may have recognized a portion of these funds as income, requiring reconciliation between the cost report income statement and either the internal or external financial statements.

Hospitals also should be mindful of any reimbursements received from the Health Resources & Services Administration (HRSA) for costs associated with treatment for uninsured COVID-19 patients. The HRSA uninsured patient fund (https://www.hrsa.gov/coviduninsuredclaim) revenue is considered net patient service revenue and is neither subject to offset nor includable as uncompensated care. Per CMS's FAQ on COVID-19 flexibilities (https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf), a hospital's acceptance of payment from the HRSA uninsured fund is deemed to be a covered claim, and therefore would not meet the definition of *uninsured* for purposes of the Worksheet S-10.

The non-offset of these HRSA-reimbursed amounts received is a slight glimmer of good news, but the cost report treatment differs from consideration of repayment under the CARES act for COVID-19-related unreimbursed COVID-19 expenses and lost revenues.

Uncompensated care payments and DSH Reporting

Decreased Medicare volumes may result in large reductions in both IME and traditional DSH reimbursements. The reduction in DSH reimbursement may be exacerbated by decreases in Medicaid inpatient volumes. If a hospital's Medicaid volumes decline to a sufficient level, the hospital may lose its eligibility to participate in HRSA's 340B Drug Pricing Program, and possibly its Medicare DSH eligibility altogether.[a] Moreover, because a hospital must be Medicare-DSH-eligible to receive the Medicare uncompensated care-pool payments, it also could lose access to those funds, potentially contributing to a long-term downward financial spiral.

The specific impact of such changes on any hospital are difficult to determine. There may be both "winners" and "losers" over a period, as the results of COVID-19 impacts are "feathered in" to the rate-

setting process. The uncompensated care and DSH calculations are good examples of where modifications to existing regulations and cost report instructions will be needed to address the pandemic's unique impacts on different hospitals.

The loss of 340B status conceivably could become a long-term issue for hospitals until hospital volumes, particularly an entity's Medicaid payer mix, return to pre-COVID-19 levels. A change in a hospital's 340B status changes is applied only prospectively, but it can still substantially affect operations, as 340B savings may be significant to an organization's ability to provide much-needed charity care to the community.

HRSA's concessions related to the current PHE do not include a full "waiver" of cost report threshold requirements. Instead, HRSA has said (https://www.hrsa.gov/opa/COVID-19-resources) it is "unable to waive the disproportionate share adjustment percentage requirements that are set in the 340B statute for certain hospitals seeking to participate as 340B covered entities." HRSA has posted the following responses to FAQs related to what it refers to as 340B "flexibilities" during the PHE.

Record keeping. HRSA notes that a patient's health record may be abbreviated and include less information than previously required. For example, insurance cards, photo identification and detailed medical histories may not be readily available during the PHE. Also, with an understanding that volunteer providers may be rendering services during the PHE, HRSA expects covered entities to maintain:

- Documentation to confirm the relationship between the provider and the covered entity
- Responsibility for patient care
- Compliance with the definition of a covered entity *patient* (https://www.hrsa.gov/sites/default/files/opa/programrequirements/federalregisternotices/patientandentityeligibility102496.pdf)

Group purchasing organization (GPO) prohibition. HRSA relaxed the GPO prohibition. Hospital covered entities subject to the GPO prohibition may not use a GPO for covered outpatient drugs. However, during the PHE, HRSA stated that "if a hospital is unable to purchase a covered outpatient drug at the 340B ceiling price, the covered entity should first try to obtain the drug at wholesale acquisition cost (WAC). If it is also unable to purchase the product at WAC due to shortages, a hospital may use a GPO (or GPO private label products). Hospitals do not need to report this information to HRSA." HRSA expects covered entities to keep a record of these events and continue to maintain auditable records.

Audits. HRSA's 340B audit contractor has conducted audits only remotely during the PHE.

Medicare bad debts

At first glance, hospitals might find it difficult to see how the pandemic might have affected their ability to identify and report reimbursable Medicare bad debts. But there were clear impacts from hospitals' changes in policies and business processes during the pandemic.

For example, hospitals may have modified their charity care and collection processes to give patients more time to liquidate outstanding balances. Hospitals would need to document that the changes in their processes were applied uniformly to all patients, regardless of a patient's financial class. If deductibles and coinsurance were waived for some patients, there would be no collection activity, and if the amounts waived were attributable to Medicare patients, those amounts would not be includable as reimbursable Medicare bad debts.

As another example, hospitals and vendor partners that adopted remote working arrangements may have had to alter their process workflows, which almost certainly would have lengthened the time frame for internal and external collection activity. The additional time needed to complete the collection process may require hospitals to defer recognizing the Medicare bad debts to a later cost reporting period because such bad debts cannot be claimed until the collection process is finalized and

the account is deemed worthless. Although the payment amount may not change, recognition in a subsequent period may subject the hospital to additional documentation requirements and audit scrutiny.

With self-pay bad debt, time also is of the essence for billing patients because providers must apply "reasonable collection efforts." For example, patients must be billed in a timely manner to encourage receipt of the deductible or co-insurance before it becomes bad debt, and the pandemic may have lengthened the time needed for such billing.

One final consideration relates to allowable Medicare bad debts for the dual-eligible population. If hospitals experienced declines in Medicare patient activity volumes, this volume decline also is likely to extend to dual-eligibles. Fewer patients mean hospitals have less deductible and coinsurance amounts to claim under current Medicare bad debt rules. Beyond the actual decline in payment, the reduction will impact interim rates and final payment because Medicare administrative contractors use information in the most recently filed cost report to establish future rates. Similarly, hospitals may experience cost report overpayments when amounts claimed in a particular year are less than the interim payments received for that year. In general, it was hard enough for hospitals to successfully realize an appropriate amount of Medicare bad debt reimbursement before the PHE, and doing so during the PHE will likely be more challenging.

Takeaways

The COVID-19 PHE will impact current cost reporting and influence Medicare fee-for-service payment in many ways for several years to come. To prepare for this impact, hospitals should thoroughly assess their payment environment and model potential outcomes.

The assessment findings should be used to educate hospital leadership to facilitate improved financial planning.

The findings also should be used for advocacy in order to obtain relief provided through permanently enacted emergency waivers. Hospitals also should use the findings to advocate for regulations aimed at mitigating any potential, multiple year payment effects influenced by the temporary impact of the PHE.

Footnote

a. Hospitals qualifying for 340B as a DSH must maintain a Medicare DSH add-on percentage of greater than 11.75%, as reported on their most recent Medicare cost reports. Rural referral centers and sole community hospitals also eligible to participate in the program as long they meet certain program requirements, including a DSH percentage of at least 8% or greater.

Cost-based RHC productivity factors to consider during the pandemic

Rural health centers (RHCs) operated by hospitals with less than 50 beds receive cost-based payment from Medicare. This methodology generally is more favorable than the per-visit payment for other types of rural health clinics. In determining the cost-based payment, Medicare applies a productivity limitation based on an estimated annual number of visits provided by each level of practitioner (e.g., physician, nurse practitioner, advanced practice nurse). Facilities that have too few visits per level of professional staff are penalized because their actual cost-per-visit is reduced by the application of the calculated limit. When this lower cost-per-visit is multiplied by the Medicare visits, the facility receives lower payment.

This cost-finding principle posed a challenge for RHCs even before the pandemic. During the pandemic, many experienced significant declines in volume as patients elected to defer

receiving care or facilities cancelled non-emergent services to reduce the risk of spreading the virus. By the time the facilities' cost reports were filed, the RHC component of the hospital would likely have a significant overpayment, perhaps resulting in a rate adjustment. When the Medicare administrative contractor (MAC) receives a cost report with an overpayment, future interim payments are reduced. Now in subsequent cost reporting periods, as volumes are restored, the RHC would have a cash flow problem until the rates are restored either by filing a rate change request or submitting that subsequent cost report.

The application of the productivity limit could be easily adjusted by amending the cost-reporting instructions so the calculated limitation is not considered and the facilities' actual costs-per-visit would be allowed to flow through the payment calculation. CMS also could instruct MACs to disregard the application of the productivity limitation in their rate-setting determinations, thereby providing temporary relief to the RHCs. Since the cost report information is used to develop the per-visit limitations for all RHCs, the impact of any COVID-19 relief could influence rates for several years.

To some extent, RHCs were able to request and potentially receive productivity exemptions during the COVID-19 pandemic. RHCs could request a percentage decrease to their productivity standard, but it would apply only to a certain reporting period and the relief might only be temporary. The relief also was subject to MAC approval, and providers were required to submit qualitative data to justify the exemption. In light of the recent changes to the RHC per-visit limitations under the 2021 Consolidated Appropriations Act, an RHC should thoroughly analyze its cost finding to ensure the cost is appropriately claimed, given the possibility that its 2020 year could become its base year going forward.[a]

Footnote

a. The 2021 Consolidated Appropriations Act created the statutory requirement that grandfathered RHCs are to receive the higher of the mandated $100 per visit as authorized by the 2021 CAA or their actual 2019 base year cost. HR 1868 passed in March 2021 provided a technical correction to update the base year comparison to be 2020 instead of 2019, and that a grandfathered RHC must have been in operation as of Dec. 31, 2020.

About the Author

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AUGUST 25, 2021

By Matthew Bates

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Financial Sustainability Report: July 2021

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The July 2021 issue of the Financial Sustainability Report, sponsored by Kaufman Hall, includes an account of how one health system assessed the benefits and risk associated with moving its 340B covered-entity pharmacy enterprise to a Limited Liability Company. The issue also includes a commentary on CMS's new Acute Hospital Care at Home program and a discussion of a new metric, equivalent net patient revenue (ENPR), which organizations can use to assess the relative value of proposed investments in alternative revenue sources.

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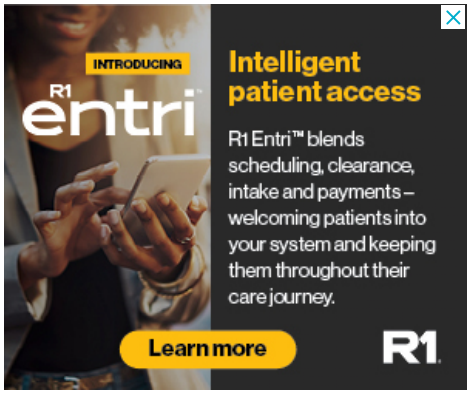
Health system CFOs today should be actively guiding their organizations toward strategic investments in alternative revenue sources that can strengthen the bottom line. An effective and relatable metric for evaluating such investments is equivalent net patient revenue (ENPR).

JULY 21, 2021

By Jami Youmans, MHA, Kyle Hathaway, and Ryan Smith, CFA



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