Illinois Critical Access Hospital Network Medicare Cost Report – Wellness Centers

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Assurance ▪ Tax ▪ Consulting

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Webinar Objectives

- Quick overview of Wellness Centers
- Ways to structure losses on Wellness Center as an employee benefit cost to the hospital
- Approaches to minimize overhead allocations to the Wellness Center
- Identify if hospital departments use Wellness Center square footage
- Other reimbursement hot topics
- Open discussion regarding any questions

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Quick Overview of Wellness Centers

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Wellness Center Overview

- Definition of a Wellness Center.
  - A Wellness Center is an establishment that offers health services for the body and mind.
  - Wellness Centers usually offer skin care services and body services, such as fitness, personal training and nutrition consulting.
- Many large and small hospitals have or are looking at adding Wellness Centers to their campuses
- There are many reasons for opening a Wellness Center on a hospital campus
  - For the benefit of patients, to house equipment used for services offered by the hospital, such as physical therapy or cardiac rehab
  - For rural providers, can be a benefit to the community when there is no other fitness center available
  - As a benefit to employees, if the hospital offers free or reduced memberships to them

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Wellness Center Overview

- Wellness Centers extend the continuum of health care by implementing sustainable modification of healthy behavior for patients and employees (if offered)
- Wellness Centers can act as a transitional care program encompassing services, such as
  - Physical therapy
  - Cardiac rehabilitation
  - Pulmonary disease management
  - Alternative medicine
  - Post natal care
  - Diabetes management
  - Rheumatology

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Wellness Center Overview

- Treatment of Wellness Center on the Medicare cost report
  - Wellness Centers are traditionally set up as a non-reimbursable cost center similarly to a gift shop or other non-patient care service
    - Usually reported on Lines 190 to 194 of WS A or a subscript of one of these lines
  - If access to the Wellness Center is granted to employees at a reduced or free rate, then an arrangement can be made that a portion of the Wellness Center could be considered a benefit to hospital employees
    - Cost related to employees' use of the Wellness Center should be reclassed to the Employee Benefits (Line 4) of WS A of the cost report

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Wellness Center Overview

- Wellness Center profit/loss
  - If the Wellness Center dues are greater than its direct expenses, then a profit is generated from operations.
    - There will be no cost to claim as an Employee Benefits cost (Line 4) on the cost report, as Medicare regulations require the expenses must be reduced by the related revenue generated.
  - If the Wellness Center dues are less than the direct expenses, then a loss is generated from operations
    - There is then an opportunity to claim the employee portion of the loss on the cost report as an Employee Benefit cost (Line 4), if structured appropriately

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Ways to Structure the WC as a Benefit

- The hospital will want to offer access to the Wellness Center to employees at a reduced cost or nominal rate to be considered a benefit
  - This should be stated in the employee handbook and/or listed as a benefit along with group health insurance, paid time off, 401(K), etc.
    - Making access to the Wellness Center as part of a wellness program is another approach that can be combined with offering access to the Wellness Center
    - A way to entice employees to use the Wellness Center is to offer a discount on health insurance if the employee uses the free or reduced price access
      - This can be structured in a wellness program or stand alone as a benefit
      - This kind of offer to employees will usually have a two-fold benefit, as it will keep employees' health costs down and result in healthier/happier employees

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Ways to Structure the WC as a Benefit

- If a reduction is offered to employees for health insurance for using the Wellness Center, either as part of a wellness program or standalone benefit then:
  - The hospital will want to set a minimal amount of trips and/or time for employees at the Wellness Center per week or per month
  - The minimal amount of trips and/or time should be stated clearly, along with the benefit of reduced health care cost
  - Even if there is no reduction in health care cost for using the Wellness Center, <u>the key is tracking employee usage</u>
    - Which shows that employees are using the benefit

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Ways to Structure the WC as a Benefit

- Tracking usage at the Wellness Center
  - Need to track employee usage, which includes family members usage as well
  - Non-employee usage by the community
  - Usage for patient care (if applicable), such as physical therapy or cardiac rehab
  - This tracking should be consistent between all categories, based on
    - Number of trips
    - Number of hours (if there is a sign in and out)
    - Time study one week per month stratified throughout the year

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Ways to Structure the WC as a Benefit

- Split cost (or loss) of the Wellness Center based on usage
  - First calculate the profit/loss (if profit, no further calculation needed)
  - Then split loss based on usage for Worksheet A-6 reclass as follows
    - Reclass salaries and other cost separately
      - Will need the salary portions for Worksheet B-1 statistics
    - Also reclass hours related to the reclassed salaries for Worksheet B-1 statistics

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Ways to Structure the WC as a Benefit

- Example of Wellness Center usage log

Membership Type	Total	%	MCR Ln #
Adult (Single - Corp)	303	1.98%	194.07
Adult (Single)	220	1.44%	194.07
Cardiac Rehab/Med Supr	299	1.96%	65
Commons	95	0.62%	46
Employee/Employee Family	1,998	13.09%	4
Household (Family)	1,500	9.82%	194.07
Household (Family-Corp)	4,488	29.39%	194.07
Household (Family-Senior)	514	3.37%	194.07
Nursing Home	10	0.07%	44
PT-Sports Medicine	34	0.22%	66
Scholarship - Adult	70	0.46%	194.07
Scholarship - Household	300	1.96%	194.07
Scholarship - Med Supr	68	0.45%	194.07
Silver Sneakers	164	1.07%	194.07
Senior Adult	1,118	7.32%	194.07
Senior Couple	2,108	13.81%	194.07
Student	311	2.04%	194.07
Household - Complimentary	24	0.16%	194.07
Adult or Sr - Complimentary	38	0.25%	194.07
EMP	1,607	10.52%	4
Totals	15,269	100.00%	
Total Employee Percentage Above		23.61%	4

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Ways to Structure the WC as a Benefit

- Example of Wellness Center loss split

Wellness Center Salaries		350,000				
Wellness Center Other Exp		100,000				
Total Wellness Center Cost		450,000				
Less: Wellness Center Total Revenue		(350,000)				
Profit/Loss on Wellnes Center		100,000				
Profit/Loss on Wellnes Center Salaries		77,778	Split Below			
Profit/Loss on Wellnes Center Other Exp		22,222	Split Below			
MCR Ln #	**Description**	%	Reclass	Salary	Other Exp	Hours
4	EMPLOYEE BENEFITS	23.61%	23,610	18,363	5,247	1,403
45	NURSING FACILITY	0.07%	65	51	15	4
46	OTHER LONG TERM CARE	0.62%	622	484	138	37
65	RESPIRATORY THERAPY	1.96%	1,958	1,523	435	116
66	PHYSICAL THERAPY	0.22%	223	173	49	13
194.07	WELLNESS CENTER		(26,478)	(20,594)	(5,884)	(1,573)
				To WS A-6	To WS A-6	To WS B-1
				To WS B-1		
	Total Wellness Center Hours					26,211

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Approaches to Minimize Overhead Allocations for the Wellness Center

- The following changes to the allocation methodology of the cost report need to be requested and approved by the fiscal intermediary
  - Report the building cost of the Wellness Center on a subscripted line 1 (Capital Related Costs – Building & Fixtures)
  - Report the equipment cost of the Wellness Center on a subscripted line 2 (Capital Related Costs – Movable Equipment)
  - Report the utilities cost of the Wellness Center on a subscripted line 7 (Operation of Plant)
    - The Wellness Center building will need to be separately metered from the hospital and/or other buildings in order to request

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Approaches to Minimize Overhead Allocations for the Wellness Center

- Split square footage and movable equipment based on actual usage or based on log
  - Square footage will be used for both building and plant operations cost
- Example of a split based on logs

MCR Ln #	Description	%	Sqr Ft	MME
4	EMPLOYEE BENEFITS	23.61%	4,105	3,549
45	NURSING FACILITY	0.07%	11	10
46	OTHER LONG TERM CARE	0.62%	108	94
65	RESPIRATORY THERAPY	1.96%	340	294
66	PHYSICAL THER	0.22%	39	33
194.07	WELLNESS CENTER	73.74%	12,821	11,084
	Total		17,386	15,030

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Approaches to Minimize Overhead Allocations for the Wellness Center

- Make sure to use the salaries reclassed on Worksheet A-6 for the Worksheet B-1 employee benefits (and any other allocations that use salaries)
- Example of reclassed salaries

MCR Ln #	Description	Salaries	Reclass	Net Salaries
4	EMPLOYEE BENEFITS	200,000	16,714	
45	NURSING FACILITY	600,000	46	600,046
46	OTHER LONG TERM CARE	300,000	440	300,440
65	RESPIRATORY THERAPY	300,000	1,386	301,386
66	PHYSICAL THER	500,000	158	500,158
194.07	WELLNESS CENTER	350,000	(18,745)	331,255
	Total	2,250,000	0	2,033,286

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Approaches to Minimize Overhead Allocations for the Wellness Center

- Make sure to reclass hours (calculated on previous slide) for all Worksheet B-1 statistics that use FTEs or hours
- Example of reclassed hours used to calculate FTEs for a cafeteria statistic

MCR Ln #	Description	Hours	Reclass	Net Hours	FTE's
4	EMPLOYEE BENEFITS	14,000	1,403	15,403	
45	NURSING FACILITY	38,000	4	38,004	18.27
46	OTHER LONG TERM CARE	22,000	37	22,037	10.59
65	RESPIRATORY THERAPY	13,000	116	13,116	6.31
66	PHYSICAL THER	18,000	13	18,013	8.66
194.07	WELLNESS CENTER	26,211	(1,573)	24,638	11.85
	Total	131,211	0	131,211	55.68

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Approaches to Minimize Overhead Allocations for the Wellness Center

- Other statistics that may be split on the log
  - Maintenance & repairs allocated using a time study or number of work orders
  - Laundry pounds
  - Housekeeping allocated on time study
  - Central supply costed requisitions
  - Potentially any other overhead with allocations to the Wellness Center

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Approaches to Minimize Overhead Allocations for the Wellness Center

- Other areas for consideration that will assist in appropriately allocating cost to the Wellness Center
  - If certain administrative and general departments do not support or provide services to the Wellness Center, may want to request to segregate the A&G cost center
    - Would want to separate out departments who support the Wellness Center and those who do not
    - Report departments who do not support the Wellness Center on their own line (such as Line 5.01)
      - Then block the worksheet B-1 accumulated cost statistic to the Wellness Center cost center
      - Many times these same departments will not support other non-reimbursable cost centers and the statistic to those lines can be blocked, as well
    - This kind of change to the Medicare cost report has to be requested with the fiscal intermediary 3 months prior to year-end the change is to apply

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Approaches to Minimize Overhead Allocations for the Wellness Center

- Need to ensure no overhead costs are being duplicated when allocating overhead costs to the Wellness Center
  - Example would be if a housekeeping employee's salary is recorded to the Wellness Center and housekeeping is getting allocated on square footage, the Wellness Center could be getting double allocated for housekeeping costs if a Wellness Center housekeeping stat is included on WS B-1
    - In this example, the best course of action would be to reclass the housekeeping salary in the Wellness Center to housekeeping on Worksheet A-6 and make sure going forward the employee's salary is recorded in the housekeeping dept on the general ledger

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Identify if Hospital Departments use Wellness Center Square Footage

- Identifying square footage is pretty straightforward, but a couple of other things to consider
  - Are there conference rooms or a general area that is used by hospital employees for meetings?
    - Would want to include all or a portion of the space as A&G or whichever department is using the space
  - Is there storage being used in the Wellness Center by hospital departments?
    - If so, would want to make sure that space is assigned to the correct department and not lumped with Wellness Center square footage
  - If space is shared between two activities may want to use a time study to justify the split
  - If the same equipment is used for Physical Therapy and Cardiac Rehab and a time study is not kept, then may want to use revenue to split the space

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Identify if Hospital Departments use Wellness Center Square Footage

- Other things to keep in mind when assigning the Wellness Center square footage
  - How is the common space (such as hallways, bathrooms, waiting areas, etc.) in the hospital assigned?
    - If these areas in the hospital are excluded from square footage or assigned to A&G, would want to be consistent in the assigning of these areas for the Wellness Center
  - How is the maintenance space (such as heating/cooling area, electrical room, etc.) in the hospital assigned?
    - If these areas in the hospital are excluded from square footage or assigned to maintenance or plant operations, we would want to be consistent in assigning these areas for the Wellness Center

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Other Reimbursement Hot Topics

- Office of Inspector General (OIG) 2014 Work Plan – Areas of interest for CAHs:
  - CAH OP beneficiary coinsurance
    - The OIG will determine the costs to Medicare beneficiaries for outpatient services received at CAHs. Medicare reimburses CAHs at 101 percent of their reasonable costs for services provided. However, beneficiaries who receive outpatient services at CAHs pay coinsurance amounts that are computed on the basis of CAHs' submitted charges, rather than the costs of the services.
      - Note: Coinsurance amounts for OP services at PPS hospitals are computed-based on the OP payment amount (usually APC, fee schedule, etc.) which is usually considerably less than charges for that OP service. Therefore, the beneficiaries' coinsurance amount for that OP service at a PPS hospital will be less than the beneficiaries' coinsurance at a CAH for that same service (assuming the CAH's charge for that procedure is greater than the PPS payment for that procedure).
      - The OIG has recommended to CMS that the coinsurance calculation for CAHs be changed to match how PPS coinsurance is calculated based on payments

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Other Reimbursement Hot Topics

- Office of Inspector General (OIG) 2015 Work Plan – Areas of interest for CAHs:
  - Critical access hospitals – Payment policy for swing-bed services
    - The OIG will compare reimbursement for swing-bed services at critical access hospitals (CAHs) to the same level of care obtained at traditional skilled nursing facilities (SNF) to determine whether Medicare could achieve cost savings through a more cost effective payment methodology. Unlike CAHs, traditional SNFs are reimbursed under a PPS through case-mix, adjusted per-diem prospective payment rates for all SNFs. The payment rates represent payment in full for all costs associated with furnishing covered SNF services to Medicare beneficiaries. (McGladrey note: Payment rates under a PPS payment system are rarely, if ever, greater than payments under a cost based payment system.)
      - If the reimbursement to CAHs change for swing-bed patients to a PPS methodology, this could result in the closing of many CAHs

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Other Reimbursement Hot Topics

- Office of Inspector General (OIG) 2015 Work Plan – Areas of interest for CAHs (Continued):
  - Analysis of salaries included in hospital cost reports
    - The OIG will review data from Medicare cost reports and hospitals to identify salary amounts included in operating costs reported to and reimbursed by Medicare. The OIG will determine the potential impact on the Medicare Trust Fund if the amount of employee compensation that could be submitted to Medicare for reimbursement on future cost reports had limits. Employee compensation may be included in allowable provider costs only to the extent that it represents reasonable remuneration for managerial, administrative, professional and other services related to the operation of the facility and furnished in connection with patient care. However, Medicare does not provide any specific limits on the salary amounts that can be reported on the hospital cost report.
      - Note: This review seems targeted at CAHs, since CAHs are cost reimbursed.

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Other Reimbursement Hot Topics

- Office of Inspector General (OIG) 2015 Work Plan – Areas of interest for CAHs (Continued):
  - Comparison of provider-based and freestanding clinics
    - The OIG will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on the Medicare program of hospitals claiming provider-based status for such facilities. Provider-based facilities often receive higher payments for some services than do freestanding clinics
      - Note: Related to eliminating any site-of-service payment difference for the same service.

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Other Reimbursement Hot Topics

- Areas of focus on recent Medicare cost report audits:
  - Allowability of emergency department physician availability services costs
    - No feasible alternative way to obtain physician coverage is available - In order for physician availability services costs to be allowable**, the provider must demonstrate that it explored alternative methods for obtaining physician coverage but was unable to do so. An alternative might include negotiating a straight fee-for-service arrangement. Evidence of such an effort could consist of advertisements for emergency physicians to be compensated on a fee-for-service basis, placed in appropriate professional publications**. It is not necessary for a provider to demonstrate that it explored alternative methods for obtaining emergency physician coverage annually. The requirement is applicable prior to the renegotiation of expiring arrangements or the initiation of new arrangements for physician coverage of the emergency department.
      - Note: The fiscal intermediary (FI) has been requesting the latest ER physician contracts and evidence that before the contract was signed, the provider explored alternatives for coverage. If the FI finds that the hospital did not explore alternative for coverage, they can disallow the ER availability cost and also reopen prior years affected to disallow the ER availability cost in those years, as well.

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Other Reimbursement Hot Topics

- Areas of focus on recent Medicare cost report audits (continued):
  - Medicare bad debt listing\log compliance:
    - The FI has been focusing on Medicare bad debt listings and, in particular, requiring they contain all required fields
    - The FI has been disallowing entire listings for just one missing field stating the listing is not in compliance with Medicare regulations
      - The FI has allowed hospitals to request a reopening with an updated bad debt listing containing all required fields, but reopening requests are at the discretion of the FI so could be denied
      - Need to ensure bad debt listings contain all Medicare required fields and should consider including additional fields that are not required

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Other Reimbursement Hot Topics

Required Fields per 339 Exhibit 5	Suggested Additional Fields
Last Name	Patient Account Number
First Name	Medical Record Number
M.I.	Total Covered Charges
HIC. NO.	Non Covered Charges (includes PC and FS)
DOS from MM/DD/YYYY	
DOS to MM/DD/YYYY	
Indigency & Wel. Recip. (Ck If Appl)	Hospital Charity Care Determination
Medicad Number	
Date 1st Bill to Beneficiary	120-Day (from last payment) Test (non X/0)
Date Collection Efforts Ceased	Date Ret. from Coll. Agencies (non X/O)
Remittance Advice Date (MC)	MA Remittance Date and/or MA RA #
Deductibles (excludes PC and FS amounts)	Document No Other Insurance Exists
Co-Ins (excluded PC and FS amounts)	
Total	

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Open Discussion Regarding any Questions

- Q & A

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