STROUDWATER

Unlocking Hidden Value:

Identifying Financial Opportunities in the Cost Report

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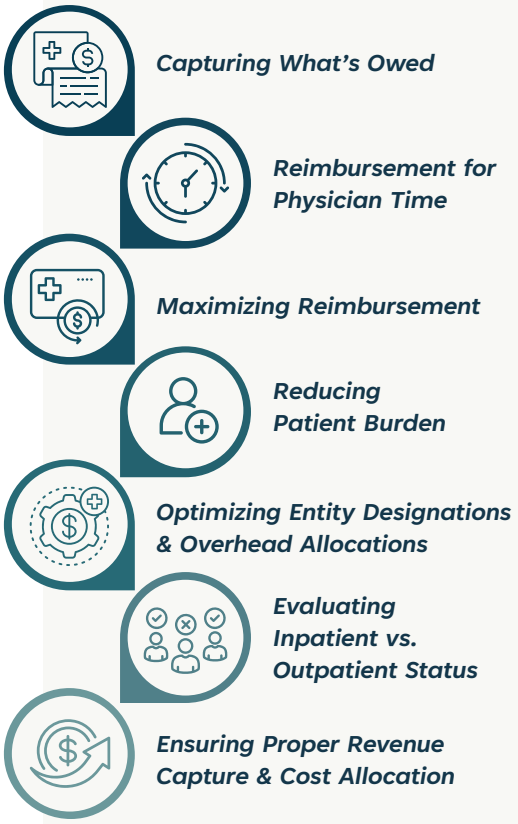
SEVEN KEY COST REPORT INSIGHTS TO STRENGTHEN YOUR CRITICAL ACCESS HOSPITAL'S FINANCIAL HEALTH

For Critical Access Hospitals (CAHs), the Medicare cost report is more than just a compliance requirement—it's a critical tool for financial survival. A well-structured cost report can improve reimbursement, highlight inefficiencies, and help CAHs achieve long-term sustainability. Hospitals that actively review and optimize their cost reports can reinvest in patient care, expand essential services, and secure financial stability.

For hospital leaders, balancing daily operations with financial oversight is no small task. While many CEOs and CFOs sense inefficiencies in their cost reports, the time and expertise required to investigate are limited. Yet, those who take the time to dig deeper often uncover significant financial opportunities that strengthen their hospital's bottom line.

Through years of cost report analyses, several common themes have emerged—areas where hospitals frequently underreport, misallocate, or leave potential reimbursement unclaimed. By understanding these seven key findings, hospital leaders can take proactive steps to ensure they are maximizing the value of their cost report and securing the financial resources necessary to continue serving their communities.



1 Medicare Bad Debts: **Capturing What's Owed**

CAHs often leave money on the table by underreporting Medicare bad debts—coinsurance and deductible amounts for Medicare beneficiaries that remain unpaid and are considered reimbursable under Medicare rules. Without meticulous tracking and documentation, hospitals miss out on funds that could bolster their bottom line.

A thorough review of patient responsibility records and bad debt tracking often reveals that hospitals are not claiming their full allowable reimbursement. Strengthening documentation processes and ensuring that all uncollectible amounts are properly categorized can significantly improve a hospital's ability to claim Medicare bad debts on its cost report, helping the hospital increase reimbursement from Medicare. Simple process improvements—such as better tracking of returned collection agency accounts—can prevent dollars from slipping through the cracks. Additionally, the nuances of collection effort requirements based on the insurance coverage status of a patient can leave CAH operators confused. With additional education and improved processes, CAHs can often realize additional reimbursement for Medicare bad debts.

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2 Emergency Department (ED) Standby Costs: **Reimbursement for Physician Time**

For CAHs, maintaining 24/7 emergency coverage is mandatory, yet many CAHs do not see enough volumes in their ED to cover the cost of 24/7 coverage based solely on fee schedule reimbursement. CMS recognizes the challenges CAHs face in maintaining 24/7 ED coverage and allows them to include physician standby time—when physicians are present but not actively treating patients—as part of their Medicare cost-based reimbursement. CAHs often fail to claim the full cost for ED physician standby time, primarily because of poor time tracking methodologies, reducing CAH reimbursement.

Hospitals that accurately capture and allocate standby costs in their cost report can receive reimbursement for some of these expenses. Many find that minor adjustments in tracking time—such as incorporating electronic time studies—can ensure proper allocation and improved financial outcomes. Given the high staffing costs associated with 24/7 emergency coverage, maximizing this reimbursement stream is crucial for CAHs.

3 Provider-Based Rural Health Clinics (PB-RHCs): **Maximizing Reimbursement**

Many CAHs utilize PB-RHCs to ensure that patients in rural areas receive much-needed outpatient care. RHCs are reimbursed by Medicare, and in some states by Medicaid, based on the lesser of their allowable cost per visit and an established "payment limit" ("PL"). This rate for qualified RHC services is referred to as the "All-Inclusive Rate" ("AIR"). Although many CAHs have PB-RHCs, there are often opportunities for them to take a strategic approach to service delivery in these settings based on their reimbursement structure, which differs depending on when the PB-RHC was established.

Due to changes initiated through the Consolidated Appropriations Act of 2021, starting April 1, 2021, RHCs established on or after January 1, 2021, are all subject to the same PL set at $152 in 2025. This rate will increase annually based on a set schedule, eventually reaching $190 in 2028, and thereafter will increase based on the Medicare Economic Index (MEI). Additionally, PB-RHCs in a hospital with fewer than 50 beds (such as CAHs) that were established before January 1, 2021 (referred to as "grandfathered") became subject to a PL generally based on their cost per visit on their FY 2020 Medicare cost report. Before the Consolidated Appropriations Act of 2021, PB-RHCs in a hospital with under 50 beds (such as CAHs) received an AIR that was equivalent to their allowable cost per visit, which in many cases was substantially higher than previous PLs for freestanding RHCs and PB-RHCs in a hospital with greater than 50 beds.

Many CAHs nationwide now have a mix of “grandfathered” and “non-grandfathered” PB-RHCs. Generally, “grandfathered” PB-RHCs have much higher PLs than “non-grandfathered” PB-RHCs, creating an opportunity for CAHs to consider what services each PB-RHC offers and if there is an opportunity to leverage their higher PL “grandfathered” PB-RHCs. Additionally, due to recent changes implemented via the 2025 Medicare Physician Fee Schedule Final Rule, RHCs are no longer required to be “primarily engaged in primary care,” which was a longstanding compliance concern for RHCs and hospitals with PB-RHCs. This change has opened the door for many CAHs operating PB-RHCs to feel more comfortable offering specialty outpatient services in these settings, which further emphasizes the need for a strategic approach for those CAHs operating both “grandfathered” and “non-grandfathered” PB-RHCs.

Although decisions around the provision of patient care are not primarily financial, if the opportunity exists to leverage current reimbursement systems, CAHs must consider these opportunities to remain financially sustainable. CAHs can use the Medicare cost report to help understand how best to leverage “grandfathered” and “non-grandfathered” PB-RHCs.

4 Medicare Patient Responsibility & Charge Structure: **Reducing Patient Burden**

CAHs face challenges in structuring their chargemaster to maximize reimbursement from third-party payers while keeping Medicare patient costs manageable. Since Medicare outpatient coinsurance is calculated based on a CAH’s gross charge amount, except for specific approved laboratory services, Medicare patients are often disproportionately affected by chargemaster increases. Since Medicare reimburses CAHs based on reasonable costs rather than a fixed percentage of charges, inflating charges may have unintended consequences for a CAH.

Further complicating this issue, many chargemaster reviews fixate on CAH charges compared to other facilities in their area and focus on ensuring that a CAH remains “price competitive” with comparable local facilities. Given the differences in reimbursement between a CAH and a Prospective Payment System (PPS) hospital, these comparisons often result in suboptimal conclusions and recommendations for a CAH. Since CAHs are at a disadvantage by default when it comes to Medicare patient responsibility, it is imperative that they carefully evaluate any changes to their chargemaster.

As a reasonableness test, CAHs can divide total outpatient responsibility on their Medicare cost report by the total outpatient allowable cost. If the result exceeds 40%, CAHs may be passing on too much cost to their Medicare patients. CAHs that take a strategic approach to chargemaster reviews can reduce Medicare patient out-of-pocket costs without affecting overall reimbursement. Aligning pricing strategies with Medicare guidelines ensures a balance between financial sustainability and equitable patient responsibility.

5 Non-Reimbursable Cost Centers: **Optimizing Entity Designations & Overhead Allocations**

Many hospitals unknowingly misclassify expenses in non-reimbursable and low-cost-reimbursed cost centers, leading to unnecessary financial losses. One common opportunity for CAHs is to designate clinics that are owned and operated by the CAH as provider-based, which can often improve overall financial performance through additional cost-based reimbursement and access to the 340B drug pricing program.

Another common issue is misallocating overhead expenses to non-reimbursable and low-cost-reimbursed cost centers, particularly for CAHs. CAHs often unnecessarily suffer financially due to inappropriate overhead cost allocations to non-reimbursable and low-cost-reimbursed cost centers, which are easily avoidable. One example is the allocation of Administrative & General (A&G) costs. CAHs often use a simplified "accumulated cost" methodology to allocate their A&G costs, resulting in higher-cost departments receiving a greater share of total A&G costs regardless of whether those departments are overseen by or utilize the employees in the A&G cost center. With simple analysis and changes to cost reporting, CAHs can more accurately allocate their A&G costs away from non-reimbursable and low-cost-reimbursed cost centers and ensure compliance with Medicare regulations.

Another example is the allocation of costs to the Labor & Delivery/Recovery/Postpartum (LDRP) unit. CAHs offering LDRP services often allocate all costs associated with that unit to the Labor & Delivery cost center on the Medicare cost report, which generally has a very low cost-based reimbursement payer mix. This practice contradicts cost report regulations and guidance, which indicate that CAHs utilize time studies to track when a mother is in active labor and delivery vs. postpartum and recovery. The time that a mother is not in active labor and delivery should be reported in the Med/Surg department, which is generally the highest cost-reimbursed department in a CAH. Therefore, CAHs may receive suboptimal reimbursement due to simple accounting inconsistencies.

Hospitals can shift expenses into reimbursable categories and improve financial performance by reviewing cost center classifications and making strategic adjustments to entity designations. Ensuring that clinics and outpatient departments are properly designated enhances reimbursement potential and supports long-term financial sustainability. Additionally, simple changes to how CAHs allocate their overhead costs can improve reimbursement and promote financial sustainability.

Common Oversights

- x *Misclassify Expenses*
- x *Mislabeling Clinics*
- x *Misallocating Overhead Expenses to Cost Centers*

> ***Hospitals can shift expenses into reimbursable categories and improve financial performance by reviewing cost center classifications and making strategic adjustments to entity designations.***

6 Observation Days: **Evaluating Inpatient vs. Outpatient Status**

Medicare Advantage (MA) and Commercial plans have driven a surge in observation stays due to denial of inpatient care, even when hospital medical staff have determined that an inpatient stay is best from a patient care standpoint.

Aggressive denial tactics hinder patient care and reduce rural hospital reimbursement, as observation stays often pay less than inpatient stays. Fearing denials, some hospitals overuse observation care, while others lack clear admission criteria, further increasing observation rates. Hospitals can refine admission processes to ensure proper classification and push back against insurer tactics.

Hospitals can use their cost report to identify their observation days as a percentage of Acute (Med/Surg) care days. Observation days exceeding 30% of acute care may indicate the opportunity to evaluate hospital admission criteria and processes to ensure internal alignment.

Hospitals that implement stronger documentation processes and admission criteria reviews can ensure appropriate classification and better combat aggressive insurer tactics, maximizing reimbursement and ensuring patients receive the correct level of care.

7 Cost-to-Charge Ratio (CCR): **Ensuring Proper Revenue Capture & Cost Allocation**

Because Medicare reimburses CAHs based on reported costs, it is essential to ensure accurate cost-to-charge ratio calculations. An egregiously high or low ratio may signal inefficiencies in charge capture or cost allocation methods or opportunities to consider strategic chargemaster adjustments. Although each department is different and a nuanced approach is necessary, departmental CCRs below 0.20 or above 0.80 may indicate an opportunity to review in greater detail to ensure accuracy.

Regular assessments of charge practices and cost allocations help hospitals maintain financial stability while ensuring compliance with evolving regulations. When cost-to-charge ratios are properly calculated, hospitals can ensure that the reimbursement they receive is appropriate.

A PROACTIVE APPROACH TO FINANCIAL SUSTAINABILITY

For CAHs, cost report reviews are not just about compliance—they are about financial survival. Those that take a proactive approach to cost reporting can uncover substantial reimbursement opportunities, optimize financial performance, and sustain essential services.

Hospitals that invest in regular cost report evaluations create a foundation for long-term success, ensuring they are not missing critical reimbursement opportunities. Whether it's refining charge structures, optimizing entity designations, or improving cost allocations, a strategic approach to cost reporting can position hospitals for stability and growth.

By regularly analyzing and refining cost reports, rural hospitals can secure the financial resources necessary to continue providing high-quality care to their communities—today and into the future.

To leverage cost report expertise, connect with our team.