



Cost Report Concepts for Critical Access Hospitals and Provider-based Rural Health Clinics

Presenters: Connie Ouellette | Celeste Pitts

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Agenda

- ▲ **1** The Big Picture: An overview of Medicare cost-based reimbursement for CAHs
- ▲ **2** Medicare Allowable Costs
- ▲ **3** Allocation of Overhead Costs
- ▲ **4** Calculation of Medicare's share of allowable costs
- ▲ **5** Provider-based Rural Health Clinic reimbursement



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The Big Picture: Overview
of Medicare cost-based
reimbursement for CAHs

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Critical Access Hospital Reimbursement

- ▲ Cost-based reimbursement for most inpatient and outpatient services
 - 101% of Medicare Allowable Costs
 - Less 2% Sequestration (suspended during PHE)
 - Professional fees paid via Medicare Physician Fee Schedule, not cost-reimbursed
- ▲ Enhanced reimbursement opportunity for professional services, if providers reassign benefits
 - Optional all-inclusive “Method II” Billing – billing professional charges on CAH claim form UB-04 instead of 1500. Allows split billing of:
 - Facility/Technical services reimbursed at 101% of allowable cost
 - Professional services paid at 115% of the Physician Fee Schedule

Cost-based Reimbursement – Not applicable to all CAH services

Reimbursable Services:

- ▲ Acute inpatient care
- ▲ Swing-bed care
- ▲ Provider-based Physician Clinics
- ▲ Emergency services
- ▲ Ancillary services: OR, Radiology, Lab, Therapy, Supplies, Drugs, etc.

Non-Reimbursable on Cost Basis:

- ▲ Distinct Inpatient Rehab or Psych
- ▲ Home Health, Hospice
- ▲ Skilled Nursing Facility, Assisted Living
- ▲ Physician Practices that are not Provider-based clinics
- ▲ Costs unrelated to patient care
- ▲ Other costs deemed not “allowable” for Medicare reimbursement

Critical Access Hospital Payments

▲ Medicare Cost Report Filed Annually

- Compute Medicare's share of allowable cost and settlement due to/from Medicare
- Tentative settlement in approximately 90 days
- Used to set interim payment rates

▲ Interim Payment Rates

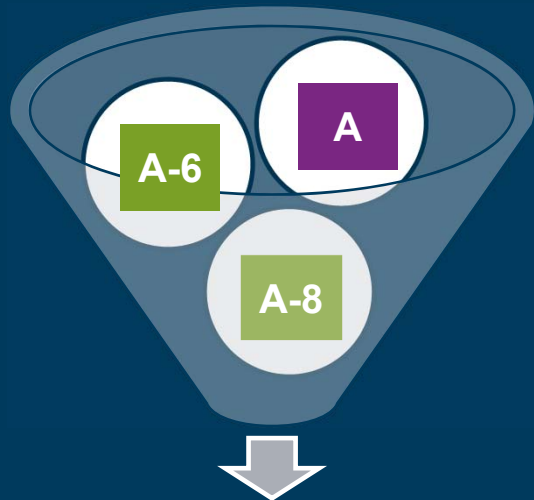
- Inpatient and Swing Bed services paid on per diem basis
- Outpatient services paid on % of charges
- Professional services paid on physician fee schedule (no cost settlement)

Overview of Medicare Cost Apportionment Formula

How the Cost Report calculates Medicare allowable cost

A	Assign direct expenses to cost centers: General (overhead), Inpatient Routine, Ancillary, Outpatient, Special Service, and Non-Reimbursable
A-6	Reclassify costs for appropriate matching with charges or assign to overhead or non-reimbursable cost centers
A-8	Adjust costs to remove amounts not deemed allowable for cost-based reimbursement by Medicare
B	“Step-down” overhead costs to cost centers using a statistical allocation basis as approved by Medicare
C	Assign gross patient charges to cost centers, excluding professional fees. Calculates Ratio of Cost to Charge (RCC) for each cost center
D	Assign Medicare program charges from PS&R to appropriate cost centers. Calculates Medicare cost (Medicare Charges x RCC for each cost center)
E	Settlement = Medicare cost + reimbursable bad debts, less coinsurance & deductibles, primary payor payments, interim payments, and sequestration





Net Allowable Costs
for Allocation

2

Worksheet A Series:
Medicare Allowable Costs

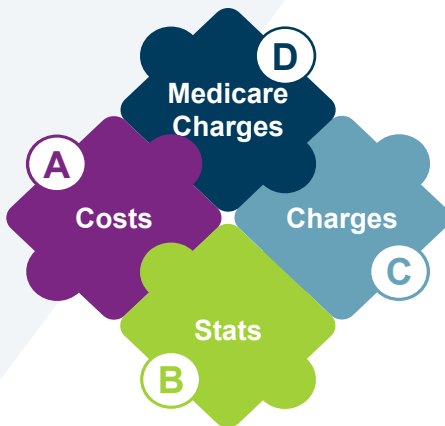
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Worksheet A Series: Mapping the Trial Balance

A

Important to maintain consistent cost center mapping throughout the cost report!



Establish or update a crosswalk of hospital departments to Medicare cost centers (“lines”)

- General Service (Capital, Benefits, Admin, Plant Ops, Housekeeping, Dietary, Nursing Admin, Central Services, HIM, Social Services, etc.)
- Inpatient Routine Costs (Med/Surg, OB, ICU, Nursery, IPF, IRF)
- Ancillary Services (OR, Radiology, Lab, Therapy, Supplies, Drugs, etc.)
- Outpatient Services (Clinics, ED)
- Special Purpose (Interest)
- Non-Reimbursable Cost Centers (Private Phys Practice, gift shop, etc.)

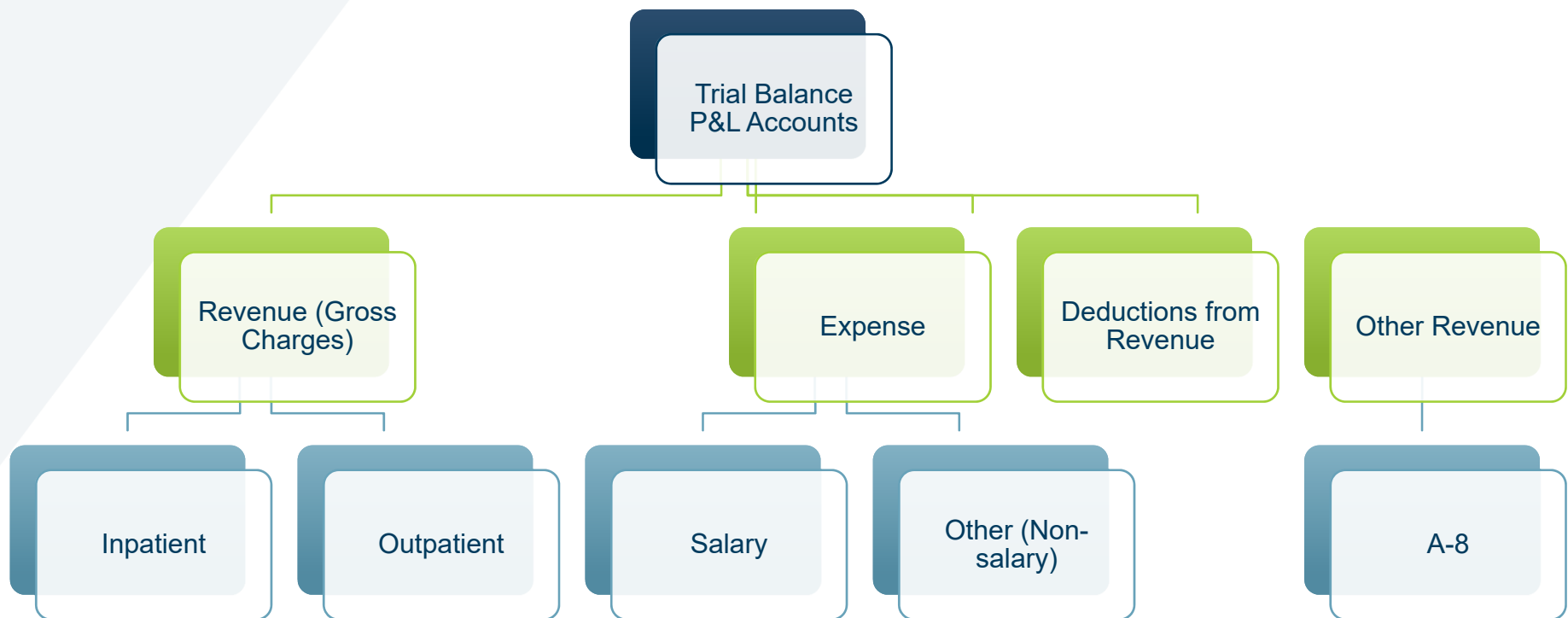
Select the Medicare cost center that:

- Best aligns the department’s costs and charges with Medicare charges by revenue code (revenue codes are the lowest common denominator)
- Results in the most appropriate allocation of general services cost (overhead) and facilitates the application of Medicare’s principles of reimbursement

Worksheet A Series: Mapping the Trial Balance, continued

A

Create a mapping file to assign Trial Balance accounts to cost report worksheets, lines, and columns



Worksheet A: Expenses from Trial Balance

A

Complete using the Mapped Trial Balance file

- ▲ Assign all expense accounts to Worksheet A lines and columns
 - Column 1 = Salaries, Column 2 = Other (all non-salary, including contracted labor)
- ▲ Reconcile Worksheet A Total Expenses to Audit Financial Statements (filing requirement)
- ▲ Review expenses by Medicare cost center line
 - Are mappings consistent with the prior year or most recent Medicare audit or review? If changes are necessary, be sure to follow the mapping change all the way through the cost report (reclassifications, adjustments, stats, charges)
 - Did you invest in new construction or renovation that warrants subscribing of capital cost center(s)?
 - Are overhead costs assigned to non-overhead cost centers? If so, either correct in mapping of expense accounts or reclassify in Worksheet A-6
 - Are all expenses related to patient chargeable supplies, implants, and drugs assigned to Lines 71, 72, or 73? Are supply costs NOT charged to patients assigned to the appropriate department's cost center?
 - Remember: It's important to matching costs with Medicare charges

Worksheet A-6: Reclassification of Expenses

A-6

Match Costs with Charges

- Birthing Center allocated between OB, Nursery, L&D
- Imaging Costs allocated between Radiology, MRI, CT Scan
- Clinic Ancillary Service cost to Ancillary cost center (i.e.. Radiology, Lab)
- Chargeable Supplies and Drugs

Assign Cost to Overhead

- Depreciation to appropriate capital cost centers
- Property insurance to capital cost
- Interest expense allocated to capital and administrative cost centers
- Physician cost for administrative roles (CMO, Director stipends)
- Provider benefits and malpractice insurance

Assign Cost to Non-Reimbursable Cost Centers

- Non-allowable marketing & development
- Employee benefit portion of Wellness, Childcare

Worksheet A-6: Reclassification of Expenses – Tips

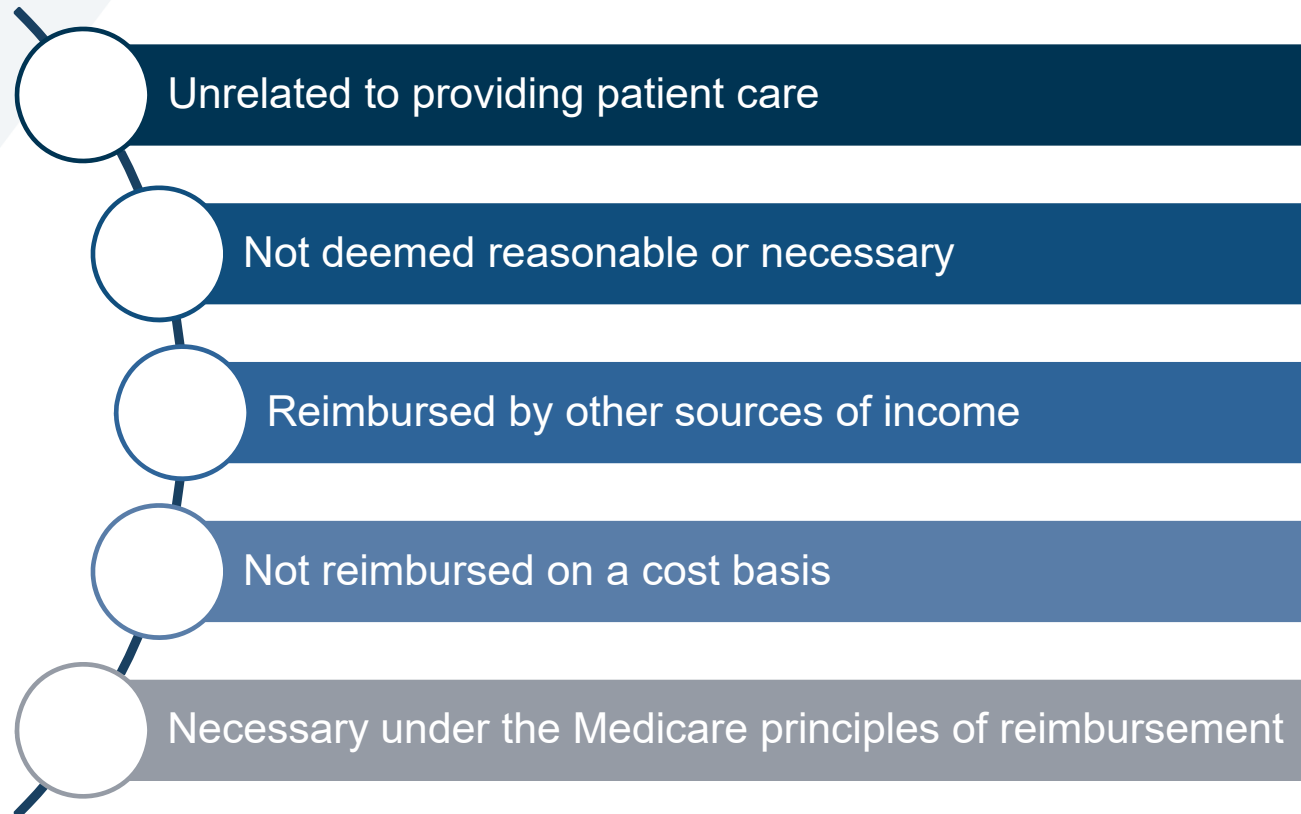
A-6

- ▲ Carefully review departmental charges by UB revenue code
 - Update UB revenue code crosswalk to Medicare cost centers before finalizing your Mapped Trial Balance to have a better picture of how cost and charges align within your GL account structure
- ▲ Consider subscribing Building & Fixtures capital costs for:
 - New building or major renovation
 - Physician practices or RHCs
- ▲ Provider benefit cost reclassification:
 - Be sure to reclassify them to the cost center where the wages are reported *after reclassifications*
 - Use actual benefits rather than a hospital-wide benefit %
- ▲ Determine if non-reimbursable costs need to be reclassified or adjusted off the cost report
 - Reclassify if general service costs (overhead) should be applied
 - Adjust off if direct and any overhead costs attributable are not significant

Worksheet A-8: Adjustments

A-8

Adjustments are necessary to remove costs from the cost report for the following reasons



Worksheet A-8: Adjustments – Investment Income

A-8

Interest expense must be reduced by certain investment income

- ▲ Limit the interest income adjustment to no more than total allowable interest expense
- ▲ Allocate the adjustment ratably to allowable interest by cost center (Admin and Capital cost centers)
- ▲ Investment income from the following sources does not require offset:
 - Grants, gifts, and endowments, whether restricted or unrestricted
 - Funded depreciation account
 - Qualified pension or deferred compensation funds
 - Non-allowable borrowing (separately adjusted)
 - Other exclusion

Worksheet A-8: Adjustments – Other Revenue

A-8

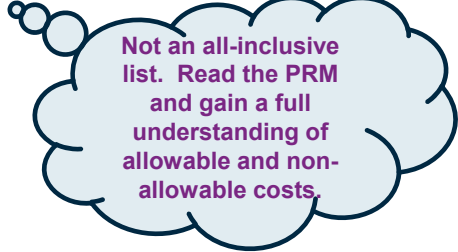
Other operating or non-operating income required to offset cost

- ▲ Carefully review all other operating and non-operating income accounts to determine if they should offset cost. Document reasons for not offsetting
 - Do not offset income related to grants, non-reimbursable cost center, contribution revenue
 - Be careful not to have income adjustments that are greater than the costs you are offsetting
- ▲ Common revenue required to offset cost:
 - Trade discounts, refunds, rebates
 - Cafeteria meals revenue
 - Vending machine income
 - Rental revenue
 - Medical records sales
 - Sale of supplies or drugs to non-patients
 - Other miscellaneous revenue

Worksheet A-8: Unallowable Costs & Other Adjustments

A-8

Costs unrelated to patient care or deemed not allowable for reimbursement



Not an all-inclusive list. Read the PRM and gain a full understanding of allowable and non-allowable costs.

- ▲ Patient convenience or luxury items
- ▲ Lobbying costs included in Hospital Association dues, legal fees
- ▲ Penalties, fines, and/or interest on Medicare overpayments
- ▲ Cost of unnecessary borrowing - deemed to be in excess of financial need or unrelated to patient care
- ▲ Unallowable advertising intended to increase business and attract new patients
- ▲ Defined benefit pension expenses must be adjusted to actual contributions, subject to limitation
- ▲ 340(b) retail drug program costs
- ▲ CAH HIT depreciation adjustment for amounts previously reimbursed via incentive payment

Worksheet A-8: Adjustments – Professional Costs

A-8

Professional costs are not reimbursed on a cost-basis; they are reimbursed under Medicare Part B

- ▲ Part B billing costs – paid on Fee Schedule
 - Don't forget to include benefit cost of employed billing staff
 - If hospital and physician practice billing are all done by the same staff, allocate based on gross charges
- ▲ Non-Physician Providers (NPPs) – CRNAs, PAs, NPs, etc.
 - Salaries, non-statutory benefits, malpractice, CME, dues, contracted NPPs
 - Benefits adjusted should not include FICA, workers' comp, unemployment
 - Note: NPPs adjusted in Wkst A-8, Physicians adjusted in Wkst A-8-2

Worksheet A-8-2: Provider Based Physicians Adjustment

A-8

- ▲ Reports allowable provider-based physician (PBP) costs and adjusts Part B physician costs on Worksheet A-8
 - Excludes Professional component – services provided directly to patients (reimbursed under Part B, Physician Fee Schedule)
 - Allows Provider component (Part A) – administrative support services such as directorships, supervision, availability/on-call, quality management, committee assignments, etc.
 - CAH's not subject to limitation based on reasonable compensation equivalents (RCE) established for various specialties
- ▲ Total Remuneration includes salaries, certain benefits, CME, dues, licensure, malpractice, contracted physicians
 - Benefits – do not include statutory benefits (FICA, unemployment, workers' comp)
 - Obtain actual benefit costs for each physician rather than using hospital wide percentage

Worksheet A-8-2: Provider Based Physicians Adjustment

A-8

- ▲ All PBP cost/time is considered Professional Part B time unless adequately documented as Provider Part A time
- ▲ Time study requirements:
 - One full work week per month of the year
 - Must use alternating weeks, not consecutive weeks (example: Week 1 in Month 1, Week 3 in Month 2, Week 2 in Month 3, etc.)
 - Must be signed by the physician or physician's chief
 - Complete Exhibit 1: Allocation of PBP Time for each physician or group of physicians in the same specialty
 - Ensure that Exhibit 1 agrees to the % of Part A time used to derive Provider component remuneration and hours on Wrkst A-8-2
- ▲ CAH's Emergency Department physician availability time
 - Time that ED physicians are not providing patient care services, but are on-call or available for patient care
 - Time study, ED log, Real-time location system (RTLS) to track availability

Slide 20

DD8

More on ED Physician Availability Time

Deb Dorain, 12/10/2021

DD10

RHC

Deb Dorain, 12/10/2021

Worksheet A-8-3: Contracted Therapy Adjustment

A-8

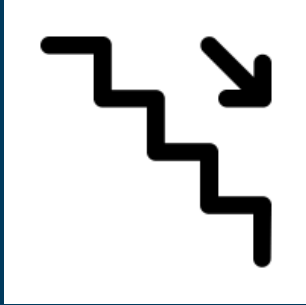
Limitation on Therapy Services provided by an outside supplier to CAHs

- ▲ PT, OT, Speech Therapy, and Respiratory Therapy
- ▲ Accumulate invoice level details for cost, hours worked, travel time, mileage, # of days onsite, etc.
- ▲ Uses Average Hourly Salary Equivalency Amount (AHSEA)
 - CMS Pub. 15-1, Chapter 14, §1412.5, Exhibit C-1 per State
 - Monthly inflation factor from Exhibit C-3 (as of beginning of period)
- ▲ Additional allowance for travel, overtime, supplies, and equipment

Worksheets A-8-1: Related party costs

A-8

- ▲ Home Office Cost Statement
 - Don't forget to properly allocate by cost center
 - Often adds allowable cost to Worksheet A-8 for CAHs
- ▲ Other related party costs adjusted to actual allowable cost
 - Intercompany Rent
 - Shared Administrative Services



3

Worksheet B Series:
Allocation of General
Service Costs (Overhead)

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Worksheet B Series: Allocation of General Service Costs

B

Referred to as the “step-down”, General Services costs are allocated to Routine, Ancillary, Outpatient, and Non-Reimbursable Cost Centers using a statistical allocation.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 20-1303 Period
From: 1/1/2020
To: 12/31/2020 Worksheet B, Part I

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Res	Total
	0	NEW BLDG & FIXT 1	MOB 1.01	EQUIP 2	4	4A	5	7	7.01	8	9	10	11	13	15	16	17	24	25	26
GENERAL SERVICE COST CENTERS																				
1 100 NEW CAP REL COSTS-BLDG & FIXT	240,729	240,729																		
1 101 CAP REL COSTS-MOB	33,006	0	33,006																	
2 200 NEW CAP REL COSTS-MVBLE EQUIP	159,323			159,323																
4 400 EMPLOYEE BENEFITS DEPARTMENT	1,341,078	1,551	0	0	1,342,629															
5 500 ADMINISTRATIVE & GENERAL	2,615,591	13,814	0	26,013	244,078	2,899,496	2,899,496													
7 700 OPERATION OF PLANT	791,431	22,561	0	2,179	46,939	863,110	201,808	1,064,918												
7 701 OPERATION OF PLANT-MOB	6,284	0	0	0	0	6,284	1,469	0	7,753											
8 800 LAUNDRY & LINEN SERVICE	38,609	2,267	0	0	5,060	45,936	10,741	11,902	0	68,579										
9 900 HOUSEKEEPING	184,369	1,781	0	265	30,407	216,822	50,696	9,351	0	19,758	296,627									
10 1000 DIETARY	179,889	9,980	0	1,364	30,405	221,638	51,822	52,407	0	1,294	14,714	341,875								
11 1100 CAFETERIA	0	0	0	0	0	0	0	0	0	0	0	0	0							
13 1300 NURSING ADMINISTRATION	17,414	0	0	0	3,392	20,806	4,865	0	0	0	0	0	0	25,671						
15 1500 PHARMACY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
16 1600 MEDICAL RECORDS & LIBRARY	210,860	4,403	0	0	32,704	247,967	57,978	23,118	0	0	5,189	0	0	0	0	334,252				
17 1700 SOCIAL SERVICE	131,984	820	0	0	20,212	153,016	35,777	4,306	0	0	1,207	0	0	0	0	0	194,306			
INPATIENT ROUTINE SERVICE COST CENTERS																				
30 3000 ADULTS & PEDIATRICS	1,453,418	50,999	0	18,905	243,774	1,767,096	413,174	267,793	0	21,253	74,862	341,875	0	13,810	0	20,659	175,712	3,096,234	0	3,096,234
ANCILLARY SERVICE COST CENTERS																				
50 5000 OPERATING ROOM	479,461	45,494	0	65,461	67,973	658,389	153,941	238,888	0	5,988	66,967	0	0	3,791	0	34,227	0	1,162,191	0	1,162,191
53 5300 ANESTHESIOLOGY	369,821	0	0	0	0	369,821	86,470	0	0	0	0	0	0	0	0	0	0	456,291	0	456,291
54 5400 RADIOLOGY-DIAGNOSTIC	806,520	12,095	0	15,247	51,468	885,330	207,003	63,513	0	2,936	17,805	0	0	0	0	25,593	0	1,202,180	0	1,202,180
57 5700 CT SCAN	158,227	2,444	0	0	30,623	191,294	44,727	12,834	0	62	3,598	0	0	0	0	0	0	252,515	0	252,515
58 5800 MAGNETIC RESONANCE IMAGING (MRI)	204,597	0	0	0	0	204,597	47,838	0	0	788	0	0	0	0	0	0	0	253,223	0	253,223
60 6000 LABORATORY	1,140,067	8,293	0	6,257	101,286	1,255,903	293,649	43,549	0	0	11,993	0	0	0	0	38,544	0	1,643,638	0	1,643,638
63 6300 BLOOD STORING, PROCESSING, & TRANS.	31,807	0	0	0	0	31,807	7,437	0	0	0	0	0	0	0	0	0	0	39,244	0	39,244
65 6500 RESPIRATORY THERAPY	38,116	3,139	0	2,042	4,493	47,790	11,174	16,482	0	0	3,421	0	0	0	0	7,092	0	85,959	0	85,959
66 6600 PHYSICAL THERAPY	655,220	35,153	0	5,202	132,442	828,017	193,603	184,589	0	4,145	0	0	0	0	0	0	0	1,210,354	0	1,210,354
71 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	352,275	7,479	0	0	26,161	385,915	90,233	39,271	0	0	10,939	0	0	0	0	0	0	526,358	0	526,358
72 7200 IMPL. DEV. CHARGED TO PATIENT	26,132	0	0	0	0	26,132	6,110	0	0	0	0	0	0	0	0	0	0	32,242	0	32,242
73 7300 DRUGS CHARGED TO PATIENTS	765,319	4,773	0	475	8,731	779,298	182,212	25,065	0	0	7,026	0	0	0	0	0	0	993,601	0	993,601
OUTPATIENT SERVICE COST CENTERS																				
88 8800 RURAL HEALTH CLINIC	525,141	0	11,996	1,482	87,733	626,352	146,450	0	2,818	0	21,279	0	0	0	0	0	0	796,899	0	796,899

Worksheet B-1: Cost Allocation Statistics

B

Purpose: Statistical basis used for allocating General Service costs to various cost centers

Standard Order and Medicare-approved Statistics

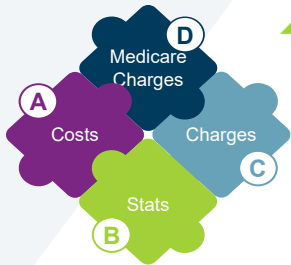
- Approval for changes may be requested through the MAC at least 90 days prior the close of your fiscal year
- Must demonstrate that change is more accurate, easier to maintain

Must be current, accurate, and capable of being audited

- Remember to maintain consistent cost center mapping for departmental statistics, including reclassifications and adjustments from Wrkst A Series
- Review and update statistics every year. Collect stats monthly or quarterly to ensure they are being properly documented.
- Include department heads on your stat collection team and provide them with the tools and formats you require

Consider direct costing vs. cost allocations of expense

- Understand your cost structure and purpose of statistical allocations
- Example: If you allocate IT by number of computers, do not also directly cost IT equipment to individual departments



Worksheet B-1: Cost Allocation Statistics, continued

- Square Feet – Building & fixed equipment, Maintenance, Plant Operations, and Housekeeping*
 - Plant Operations should maintain a log of square footage changes including effective date of room movement, room closure/vacancy, additions from renovation or new construction, etc.
 - Be sure to weigh changes in square footage for mid-year space changes, and don't forget to adjust the weighted square footage of prior year changes
 - Exclude any non-owned square footage
 - Consider fragmentation to separately allocate the cost of new building additions or renovations, or physician practice sites
 - Square footage statistics used to allocate maintenance, plant operations, and housekeeping* can be different than square footage for depreciation
 - Include rented areas if they are maintained by hospital facilities staff
 - Review square footage – question the accuracy of cost centers that have FTEs or equipment, but no square feet

Worksheet B-1: Cost Allocation Statistics, continued

B

▲ Major Movable equipment – Dollar value of Depreciation

- Obtain a fixed asset detail by department that reconciles to the trial balance
- Map departments to Medicare cost centers consistent with mapping of Worksheet A and adjust for A-6 reclassifications and A-8 adjustments

▲ Employee Benefits – Gross Salaries

- Begin with Salaries in Worksheet A, Column 1, and adjust for A-6 reclassifications and A-8 adjustments
- Exclude all physician and non-physician provider salaries – their benefits should have already been reclassified to cost centers in Worksheet A-6

▲ Admin & general – accumulated cost

- Analyze the financial impact of fragmented A&G cost centers – can result in more accurate costing and less cost allocation to non-reimbursable cost centers
 - Common examples: PFS allocated on gross charges, Patient Access allocated on outpatient admissions, IT costs allocated by number of computers serviced

Worksheet B-1: Cost Allocation Statistics, continued

B

▲ Laundry – pounds of laundry

- If outsourcing laundry, make sure your invoices include pounds and not pieces. Alternatively, estimate pounds from pieces or request a change a statistical allocation method

▲ Dietary – Meals served

- Review patient meals – are they more than 3 meals a day?

▲ Cafeteria – FTEs

- Adjust FTE counts for A-6 reclassifications
- Be sure to exclude FTEs for staff that are not located on campus or those who for other reasons do not utilize the cafeteria

▲ Nursing Admin – Nursing Hours or FTEs

- Only include staff being managed by Nursing Administration. If you have a nursing home or physician practices managed by a separate admin team, they should be excluded
- Incorporate any A-6 reclassifications

Worksheet B-1: Cost Allocation Statistics, continued

B

▲ Central Supply – Costed Requisitions

- Use internal records for cost of supplies requisitioned from material management by ordering department
- If using trial balance supplies expense, exclude departments that do their own ordering (i.e.. lab, pharmacy, etc.)

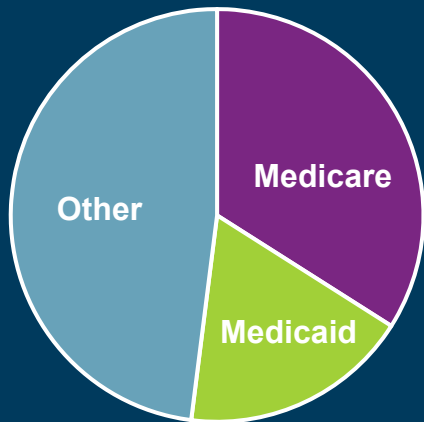
▲ Pharmacy – Costed Requisitions or %

- Most commonly all allocated to Line 73 where all chargeable drugs are reported

▲ Medical Records – Time Study or Gross Revenue

- Report observation on Line 30 instead of Line 92
- If using Gross Revenue, exclude any cost centers that HIM does not provide services to (i.e.. does clinic have their own coding staff?)

▲ Social Service – Time Study or Patient Days



4

Calculation of Medicare's share of allowable costs

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Medicare's share of allowable costs

- ▲ Medicare determines its share of allowable costs using:
 - Cost per Day for Routine Services x Medicare Days
 - Ratio of Cost to Charges for Ancillary Services x Medicare Ancillary Charges

Routine Cost per Day

Calculated in Worksheet D-1, Using days reported in S-3, Part I

$$\frac{[\text{Fully Allocated Routine Costs} - \text{Cost of Swing Bed NF Days}]}{[\text{Acute Days} + \text{Swing Bed SNF Days} + \text{Observation Days Equivalent}]}$$

Ancillary Ratio of Cost to Charges

Calculated in Worksheet C, Part I for each individual cost center

$$\frac{[\text{Fully Allocated Costs} - \text{Therapy Adjustments}]}{[\text{Inpatient Charges} + \text{Outpatient Charges} - \text{Professional Fees}]}$$

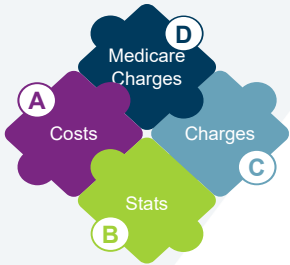
S-3, Part I: Statistical Data – Patient Days

- ▲ Patient Days reported by payor
 - Medicare (Title XVIII) – Days from PS&R
 - Medicaid (Title XIX) – Days from Medicaid utilization report
 - Total days from internal records – accurate days is critical to proper cost calculations
- ▲ A&P Days (Line 1)
 - Separately report Medicare Advantage or other Medicare/Medicaid HMO days on Line 2
 - Excludes Swing Bed, Hospice, Observation, Labor & Delivery days
 - Boarding days where no acute care is provided – consider reporting as NF days
- ▲ Swing Bed Days – SNF vs NF (Lines 5 & 6)
 - SNF = Traditional Medicare swing bed days plus HMO swing bed days
 - NF = All other swing bed days
- ▲ Observation Days (Line 28) - Convert hourly charges to days

Worksheet C, Part 1: Ancillary Ratio of Costs to Charges

C

Input inpatient and outpatient charges, excluding professional fees



Start with your Mapped Trial Balance

- Revenue departments should be mapped consistently with Wrkst A expenses and align with reporting of Medicare charges
- Assign gross revenue accounts to Worksheet C columns
 - Column 6 = inpatient charges Column 7 = outpatient charges

Obtain a detailed revenue report that breaks down charges by:

- Patient status (i.e.. inpatient, outpatient, physician clinic, etc.)
- UB revenue code – categorizes type of service billed and helps identify professional fees that need to be excluded
- Department where charges were posted in the Trial Balance
 - Reconcile to the Trial Balance

Worksheet C, Part 1: Ratio of Costs to Charges, continued

- ▲ Establish or update a crosswalk of UB revenue codes to Medicare cost centers
 - Also used with Medicare charges from PS&R to maintain consistent mapping
 - Medicare has a standard revenue code crosswalk – better to tailor it to hospital
 - Person responsible for assigning UB Revenue Codes in the Chargemaster should be in tune with the cost center structure in the Cost Report
 - Common challenges for CDM manager: Minor Procedure, Treatment Room, Clinics, Other Diagnostic Service, Other Therapeutic Services
- ▲ Review cost center assignment for UB revenue code vs Department
 - Identify reclassifications necessary to align Costs with Charges and Medicare Charges. Common reclassifications:
 - Chargeable Supplies and Implants, Drugs Sold
 - Observation charges to Line 92
 - Laboratory charges, EKG technical charges
 - Ancillary charges within clinics (Radiology, Lab)

Worksheet C, Part 1: Ratio of Costs to Charges, continued

- Remove all professional fees reimbursed under Part B Fee Schedule
 - UB Revenue codes 960-989 are professional fees
 - If all professional fees are not eliminated, reimbursement will be impaired
- Provider-based Clinics (Revenue Code 510)
 - CAH optional “Method II” Billing – billing clinic charges on UB-04 claim form instead of 1500. Allows split billing of:
 - Facility/Technical services reimbursed at 101% of allowable cost (RC 510)
 - Professional services paid at 115% of the Physician Fee Schedule (RC 960-989)
 - Split billing is often only done for Medicare claims, but total facility portion of charges for *all payors* should be reported for accurate RCC
 - Study Medicare Charges - Compute % of Medicare 510 Charges compared to Total Medicare Clinic Charges with Revenue codes 510 or 960-989
 - If split-billing is occurring in your billing system, but not in your revenue report, use the assumptions built into the billing tables / Chargemaster

Worksheet C, Part 1: Ratio of Costs to Charges, continued

Review calculated Ratios of Cost to Charge, including comparison to prior year

RCC Greater than 1.0

- ▲ Means costs are greater than charges
- ▲ Review costs in Wkst A Series
 - Consistent mapping of department with Medicare cost center?
 - Missing adjustment for professional cost?
- ▲ Review overhead allocations in Wkst B, Part I
 - Does overhead assigned to that cost center make sense?
- ▲ Is it a low-volume and/or high-cost cost service?

RCC Close to 0

- ▲ Means charges greatly exceed cost
- ▲ Review cost structure of the service
 - Ensure that all necessary reclassifications are made to properly match costs with charges
- ▲ Review charges by revenue code
 - Missing a reclassification of charges?
 - Missing an adjustment to remove professional fees from Wkst C?
- ▲ Is it a high-volume and/or low-cost cost service?

Worksheet C, Part 1: Ratio of Costs to Charges, continued

Review calculated Ratios of Cost to Charge, including comparison to prior year

- ▲ Be able to explain significant changes from year to year
 - Increased/decreased volume
 - new service, winding down a service
 - provider turnover impacting referrals/orders
 - Increased/decreased cost
 - Staff recruitment, turnover
 - Investment in technology and equipment
 - Cost containment efforts
 - Home office cost allocation changes
- If you can't explain a significant trend, go back and review alignment of costs, stats, charges, and Medicare charges

Medicare Days & Charges from the PS&R

PS&R data comes from Institutional (Part A) Medicare claims processed. For each Type of Bill, it summarizes patient days, gross charges by revenue code, payments, deductibles and coinsurance, sequestration, and more.

- ▲ Run the PS&R as late as possible to ensure you have enough lag time for claims processing
 - In some circumstances, you may need to run an additional PS&R with different service dates to capture activity relevant to a rate change or other reasons
- ▲ Map PS&R charges by revenue to Medicare cost centers
 - Be sure to use the same crosswalk as you used for Worksheet C charges
 - Some revenue codes may require allocation to various cost centers to properly match with costs. Use internal records of Medicare charges to allocate PS&R charges. Common examples:
 - Clinic Charges – allocate among various provider-based clinics reported on separate cost report lines
 - Therapy charges – allocate to offsite rehab departments on subscribed lines
 - IV Therapy – allocate to various cost centers because you don't have dedicated IV Therapy unit/staff

Worksheet D Series: Medicare Charges, Cost Apportionment

D

Calculates Medicare's cost for service provided to Medicare beneficiaries

Worksheet D Part V: Outpatient & Vaccine Cost

- Applies Ancillary RCCs by cost center from Worksheet C to Medicare's outpatient charges by cost center to calculate Medicare's outpatient cost
- Input Medicare outpatient charges

Worksheet D-3: Inpatient Ancillary Cost

- Applies Ancillary RCCs by cost center from Worksheet C to Medicare's inpatient ancillary charges by cost center to calculate Medicare's inpatient ancillary cost
- Separate Worksheet D-3 for Swing Bed ancillary cost computation
- Input Medicare inpatient charges and swing bed ancillary charges

Worksheet D-1: Inpatient Cost

- Calculates the Routine Cost per Day
- Uses PS&R days that were entered on Worksheet S-3, Part I
- Input applicable Medicaid NF rate
- Adds in inpatient ancillary cost from Worksheet D-3 to calculate total inpatient Medicare cost

Medicare Ancillary Cost Apportionment

Ancillary Department	Medicare Charges				Total Medicare	Medicare Utilization	C, I Col 9 RCC	Medicare Ancillary Cost
	C, I Col 8 Total Charges	D, V Outpatient	D-3 Inpatient	D-3 Swing Bed				
	(A)				(B)	(B)/(A)	(C)	(B)*(C)
50 OPERATING ROOM	13,923,000	5,252,000	501,000		5,753,000	41%	0.396666	2,282,019
53 ANESTHESIOLOGY	4,421,000	1,373,000	99,000		1,472,000	33%	0.135800	199,898
54 RADIOLOGY-DIAGNOSTIC	8,878,000	2,139,000	105,000	8,000	2,252,000	25%	0.360528	811,909
57 CT SCAN	7,195,000	2,976,000	200,000		3,176,000	44%	0.166367	528,382
58 MAGNETIC RESONANCE IMAGING (MRI)	3,137,000	1,135,000	67,000		1,202,000	38%	0.541310	650,655
60 LABORATORY	13,384,000	3,889,000	437,000	35,000	4,361,000	33%	0.402207	1,754,025
65 RESPIRATORY THERAPY	3,969,000	1,803,000	310,000	10,000	2,123,000	53%	0.124294	263,876
66 PHYSICAL THERAPY	2,238,000	666,000	93,000	18,000	777,000	35%	0.777047	603,766
67 OCCUPATIONAL THERAPY	873,000	60,000	95,000		155,000	18%	0.314927	48,814
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,253,000	240,000	199,000	5,000	444,000	35%	0.485414	215,524
72 IMPL. DEV. CHARGED TO PATIENT	4,520,000	1,270,000	169,000		1,439,000	32%	0.588936	847,479
73 DRUGS CHARGED TO PATIENTS	15,788,000	5,196,000	284,000	35,000	5,515,000	35%	0.613043	3,380,932
90 CLINIC	3,091,000	1,055,000	4,000		1,059,000	34%	2.274857	2,409,074
91 EMERGENCY	6,194,000	2,031,000	128,000		2,159,000	35%	0.608753	1,314,298
92 OBSERVATION BEDS (NON-DISTINCT PART)	1,576,000	598,000	22,000		620,000	39%	0.881749	546,684
TOTALS	90,440,000	29,683,000	2,713,000	111,000	32,507,000	36%		15,857,333

Worksheet E Series: Medicare Reimbursement

E

Calculates the Medicare Settlement

Medicare Cost Report Settlement	E-3, V	E-2	E, B	
	Acute	Swing	Outpatient	Total
Calculated Cost	\$ 7,077,000	\$ 951,000	\$ 14,768,000	\$ 22,796,000
1% of Cost	70,770	9,510	147,680	227,960
Less Coinsurance & Deductibles	(656,000)	(46,000)	(5,456,000)	(6,158,000)
Less Sequestration *	(129,835)	(18,290)	(189,194)	(337,319)
Plus Medicare Bad Debts	10,000	-	98,000	108,000
Medicare's Obligation	\$ 6,371,935	\$ 896,220	\$ 9,368,486	\$ 16,636,641
Medicare Payments (E-1)	(6,250,000)	(930,000)	(8,940,000)	(16,120,000)
Settlement Receivable (Liability)	\$ 121,935	\$ (33,780)	\$ 428,486	\$ 516,641

* Sequestration of 2%, suspended during the Public Health Emergency

Worksheet E Series: Medicare Bad Debts

E

- ▲ Allowable bad debts are reimbursed at 65%
- ▲ Bad debt is allowable if
 - Pertains to uncollectible Medicare deductibles and coinsurance for covered services, NOT rejected claims or other denied amounts
 - Is NOT related to professional fees billed under Part B
 - Is Traditional Medicare, NOT Medicare Advantage or other HMO
 - Write-off occurred during the cost reporting period after all reasonable collection efforts exhausted, no sooner than 120 days from the first bill (exception for indigent patients)
 - If sent to a collection agency, write-off when returned from agency. Retain documentation
 - Collection efforts must be the same for all payor types
 - Recoveries of bad debts previously claimed must be offset against amount claimed in current cost report period

Worksheet E Series: Medicare Bad Debts, continued

E

- ▲ Bad debt may be claimed without collection efforts if:
 - Medicare/Medicaid crossover claim – must bill to Medicaid and receive remittance advice in order to claim bad debt
 - Indigent patients with supporting proof of indigence
 - Bankrupt patients with supporting proof of bankruptcy
- ▲ Documentation required to support claimed amount:
 - Form 339 Exhibit 2 listing of bad debts – complete ALL required fields including patient name, Medicare HIN, dates of service, indigence status, date collection efforts ended (write-off date), amounts, etc.
 - Remittance advice from Medicare and any supplementary insurance, including Medicaid if applicable
 - Copies of bills sent to the patient
 - Documentation of collection efforts (i.e.. evident of phone calls, reminder letters and notices, return from collection agency when all efforts are exhausted)



5

Worksheet M Series: Provider-based Rural Health Clinics

hfma[™]

northern new england chapter

Provider-based (PB) Rural Health Clinic (RHC) Reimbursement

PB RHC's receive cost-based reimbursement from Medicare for qualified primary care and preventative health services

- ▲ Medicare pays based on an all-inclusive rate (AIR) per visit
 - Rate per visit based on actual allowable cost per visit in the cost report, subject limitation, except if hospital has less than 50 beds
 - New to PB RHCs effective 4/1/21 – Rate per visit is limited to greater of
 - Cost per visit from 2020 Cost Report + 1.4% increase based on the CY2021 Medicare Economic Index (MEI), or
 - Payment limit per visit applicable to independent RHCs of \$100 on 4/1/21
 - After 2021, PB RHC payment per visit limit will be the greater of:
 - Previous year's rate plus the applicable MEI% for that year, or
 - Payment limit applicable to independent RHCs for that year
- ▲ Subject to annual minimum productivity thresholds for RHC physicians and non-physician providers
 - If minimum visit threshold per FTE is not met, the allowable costs are divided by the minimum visits, thus reducing reimbursement

Worksheet M Series: RHC Cost Report Components

- ▲ Trial balance expenses, including necessary reclassifications and adjustments, breaking down Worksheet A Line 88 between:
 - Salaries and benefits for Physicians, Nurse Practitioners, Physician Assistants, Clinical Psychologists, Clinical Social Workers, and other health care staff
 - Cost of physician medical services furnished under agreement
 - Expenses of physician supervisory services furnished under agreement
 - Other healthcare costs (e.g. facility overhead costs)
 - Cost of telehealth distant-site services
 - Cost for Chronic Care Management
- ▲ RHC provider FTEs and Visit statistics used to calculate the productivity adjustment, if applicable
- ▲ Vaccine costs reimbursement

Worksheet M-1: RHC Cost Distribution

- ▲ RHC costs reported on Worksheet M-1 must agree to amounts reported on Worksheet A, Line 88(s)
 - Reclassifications do not need to balance to \$0
- ▲ Important to identify all costs of non-RHC services that should be reclassified to Hospital cost centers:
 - Laboratory services
 - Diagnostic imaging – radiology, mammography
 - Hospital patients – inpatient, emergency, etc.
 - Medical directorships, physician administrative time
 - Do your providers split their time between RHC and hospital's provider-based clinics?
- ▲ Reclassify RHC costs for services not included in the AIR
 - Telehealth cost
 - Chronic Care Management

Worksheet M-2: RHC Visits & Productivity

- ▲ RHC FTEs and Visits are reported for each applicable position
- ▲ Productivity standards
 - 4,200 visits per FTE for Physicians (other than physicians under agreement)
 - 2,100 visits per FTE for PA's and NP's
 - Exemption may be requested for unusual circumstances (i.e.. PHE) and subject to approval by the MAC
- ▲ RHC FTEs should only include the time available to provide patient care for qualified RHC services. Exclude:
 - Administrative time
 - Time with hospital inpatients and outpatients
 - Telehealth services time
 - Any other non-RHC service that will not be included in RHC visit count

Worksheet M-2: RHC Visits

Include:

- ▲ Medically necessary services
- ▲ Face to face (one-on-one) medical or mental health visit or a qualified preventive health visit
- ▲ Visits with more than 1 RHC practitioner on the same day count as a single visit, some exceptions
- ▲ Qualified transitional care management service
- ▲ Home and Nursing Home visits

Exclude:

- ▲ Nursing only visits
- ▲ Inpatient or Outpatient hospital department
- ▲ Telehealth visits
- ▲ Visits with non-RHC practitioner

Worksheet M-4: RHC Vaccine Costs

In addition to the all-inclusive rate per visit, RHC's are reimbursed for the cost of certain vaccines

- ▲ Flu, pneumococcal, COVID-19, Monoclonal Antibody Products injections, and their administration, paid at 100% of reasonable cost
- ▲ The vaccine injections are reported on Wkrst M-4 under the appropriate column for each vaccine type
- ▲ Vaccine logs are to be maintained to support the reported number of injections. Include patient name, Medicare number or Insurance number, payor, date of service, units, and charge
- ▲ Ratio of injection staff time to total healthcare staff time is used to estimate the staff cost of administering applicable vaccines
 - Example: $(\text{total vaccines} \times 10 \text{ minutes} / 60 \text{ minutes} = \text{total vaccine administration hours. Divided by total clinical hours worked} = \text{Staff Time Ratio})$
 - Exclude time of Physician services under agreement
- ▲ Report the actual cost of applicable vaccine supplies using internal records and/or an estimate of the average actual cost/vaccine

Questions?

Connie Ouellette

Principal, Healthcare Group
BerryDunn
207.541.2201
couellette@berrydunn.com

Celeste Pitts

VP of Finance
North Country Healthcare
603.788.5321
celeste.pitts@northcountryhealth.org



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