

Medicare Cost Reporting Issues

**Wisconsin Office of Rural
Health
Financial Workshop
August 17, 2010**

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Items for Discussion

- ER Stand-By Costs
- Time Studies
- Non-Allowable Advertising Costs
- Reporting Labor & Delivery, & Nursery Costs
- High Cost to Charge Ratios in Clinics
- A-8-4 Therapy Limits
- Crosswalk for Settlement
- Cost Report Form Changes
- Reporting Meaningful Use & EHR Costs
- PS&R Update
- MAC Update



ER Stand-By Costs

- Any physician fees - salaried or contracted must be shown on Worksheet A-8-2
- Direct Patient Care and Administrative split via time studies.
- CAH is exempt from the RCE (Column 6)



ER Stand-By Costs (cont'd)

- Standby Costs are allowable administrative costs if documented
 - NGS recommends time studies two weeks out of each quarter identifying:
 - Direct patient care time
 - Administrative duties
 - Standby Time



ER Stand-By Costs (cont'd)

However NGS will accept:

The ER Patient Logs as a time study for the direct patient care time. If the facility also provides time the ER Dr. spends:

- in house seeing hospital inpatients or
- a signed statement saying the ER Physician had no in house visits.



ER Stand-By Costs (cont'd)

- For C/R periods beginning on or after 10/1/01, costs for E/R physicians who are on call but not present at the facility may be included if:
 - not furnishing physician services
 - not on call at any other provider or facility
 - incurred under a written contract



ER Stand-By Costs (cont'd)

- immediately available by phone or radio
- available to be on site on a 24 hour a day basis within 30 minutes or 60 minutes in areas described in 42 CFR 485.618 (d)(2)



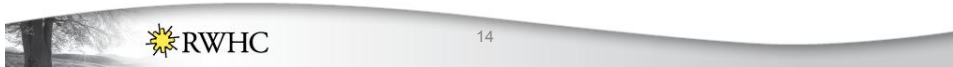
Time Studies for Physicians

- NGS recommends two weeks out of every quarter for a year.
 - must be signed by the physician to be valid
 - describe what they are doing in 15 minute increments
 - Summarize information to develop the split



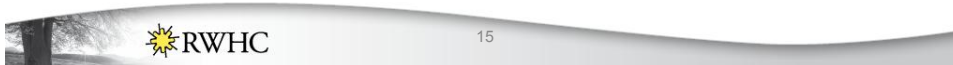
Time Studies – Non-Physician (cont'd)

Periodic Time Studies -Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria:



Time Studies – Non-Physician (cont'd)

- The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.



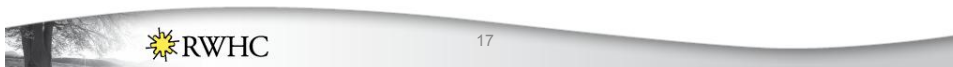
Time Studies – Non-Physician (cont'd)

- A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.
- Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).



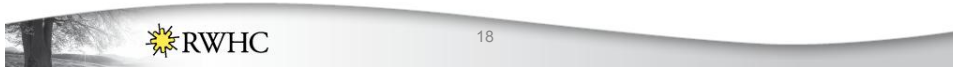
Time Studies – Non-Physician (cont'd)

- The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.



Time Studies – Non-Physician (cont'd)

- No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.



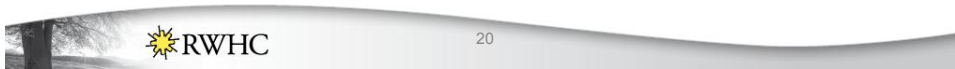
Time Studies – Non-Physician (cont'd)

- The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.



Time Studies – Non-Physician (cont'd)

- The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.



Non-Allowable Advertising Costs

Cost of advertising to the general public which seeks to increase patient utilization of the provider's facilities are non allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. PRM 15-1 Section 2136.1.



Advertising Costs

Non allowable advertising

- Fund raising
- Promotional- TV, radio
- Publicity costs - brochures
- Cost incurred to invite physicians



Reporting Labor & Delivery, & Nursery Costs

We are beginning to review the allocation of costs between - OB, Nursery and Labor Room.

- A. There should be a proper allocation of salaries between these areas based on time studies.
- B. There should be a proper allocation of statistics on Wks. B-1. ie sq. ft.

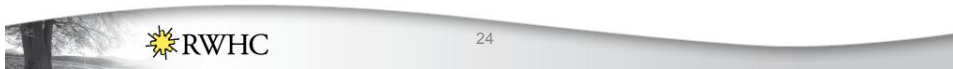


High Cost to Charge Ratios

High cost to charge ratios.

If cost to charge ratios exceed 1.00 – NGS will review and determine if should be scoped for audit based upon materiality and consistency with prior years.

Proper matching of expenses & Revenues is important. If other ancillary expense & revenues are included on the clinic line, the related Medicare charge on the UB must also be on the clinic line.



A-8-4 Therapy Limits

- Some providers have contracted therapy and have not completed the worksheet A-8-4.
- The worksheet is required to compare actual contract costs to the therapy limits.



Crosswalk for Settlement

- CMS wants us to use the PS&R UB codes to identify Medicare Charges by ancillary cost center.
- This is the starting point for our staff. We have new software that groups the UB codes to each ancillary department.



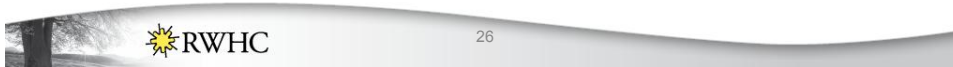
Crosswalk to Settlement

- New Software does not have the ability to factor Medicare Charges based on the as filed numbers.
- It is important to provide a crosswalk between the cost and charges on the trial balance and the UB codes on the PS&R.



Cost Report Form Changes

A notice published by the Centers for Medicare and Medicaid Services (CMS) on July 2, 2009, requests Office of Management and Budget approval for a revised Hospital and Hospital Health Care Complex Cost Report, proposed to take effect for cost reporting periods beginning on or after February 1, 2010 (new form CMS-2552-10 will replace existing form CMS-2552-96).



2552-10

Hospital Identification Data:

- S-2 will also have the FI/Contractor info, and this will become part of the ECR file, as will the E-1 data.
- The term “Intermediary” is replaced with “Contractor”.
- S-2 part II is new for the 339 Exhibit I (“Questionnaire”) – no more separate hard copy Exhibit I. This will now be part of the ECR file. Exhibits 2-5 are still hard copy.
- – S-2 lines 21 and 22 are new for T.19 “paid” and “eligible” days (on S-2 not S-3). This should be for DSH, but there were no instructions for the use of these new lines.



2552-10

Hospital Identification Data:

- S-2 reorganized to group info (e.g. CAH all in one section, PPS all in one section, etc.).
- S-2 now has a column for the “Type” of provider (col. 4, instead of the old lines 19.00 and 20.00).
- S-2 now has a column for each component CBSA (col. 3), previously this was only on two lines (SNF line 28.02, col. 4, and Hospital line 21.03, col. 5).
- All SNF information will be recorded on S-7 (no longer any SNF data on S-2).



2552-10

Statistical and Wage Index Worksheets:

- S-3, parts I, II, III, new column 1 added for W/S A line reference.
- S-3 part I revised to add column “4” for CAH hours (was only instructional in '96 as col. 2.01).
- New line for LTCH non covered days (line 30) was added (was only instructional in '96, as col. 4.01).
- S-3 parts II and III revised to remove 339 references (old col. 6 deleted).
- New S-3 part IV for old 339 wage related costs for Core services (benefits). This is the detail for Part II, lines 17 and 18. Flows to lines 17 and 18 of part II.
- New S-3 part V for Contract Labor and Benefit Cost. Not clear if this is line 11 of Part II.



2552-10

Home Health Agency:

- S-4 lines 21-38, columns 5 and 6 should be removed (shaded?). N/A for 1/1/2008 and after. The SCIC was discontinued as of 1/1/2008.
- S-4 MSA is gone (died 1/1/2006), and only CBSA are now reported in column 1, lines 19 and 20.

Home Health Agency:

- S-7 now includes all SNF information (vs. old S-2 and S-7).
- New line 58 asks for CBSA at beginning and end of FY, to identify changes in status.
- Columns for split of days removed, as not used since 2003.



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2552-10

Rural Health Clinic (RHC)/ Federally Qualified Health Center (FQHC):

- S-8, for RHC/FQHC, should delete lines 10 and 11 (old lines 9 and 10), for Physician info, as it is HIPPA protected.

Uncompensated and Indigent Care Data:

- S-10 was virtually totally redesigned, and AHA comments asked CMS to make even more changes. Will have to await final forms to see if CMS changes S-10 even more.



2552-10

Significant Changes:

- The primary reason for the 2552-10, was to clean up the “2552-96”.
- Obsolete lines/columns/worksheets, were deleted, and the forms renumbered.
- “Standard” Subscripts were eliminated.
- The report will have “standard” lines for the IPF and IRF subprovider, in this order, and will have separate settlement worksheets (E-3 parts II and III).
- There will be an “Other Subprovider” standard line added (line 42).
- New or revised worksheets will be added (e.g. S-2 and S-10 revised, new E-4).
- More Title XIX specificity is expected (e.g. columns on S-2 for T.5, T.18, and T.19 – see lines 30-56).



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2552-10

Reclassification & Adjustment of Trial Balance of Expenses:

- W/S A renumbered 1-200.
- W/S A line 30 now Adults & Peds (old line 25).
- W/S A line 50 now begins Ancillary (old line 37).
- W/S A line 90 now begins Outpatient (old line 60).
- W/S A line 94 now begins Other Reimbursable (old line 64).
- W/S A line 105 now begins Special Purpose (old line 83).
- W/S A line 190 now begins Non Reimbursable (old line 96).
- W/S A line 200 is Total (old line 101).



2552-10

Cost Allocation:

- W/S A lines 1-24 used to equate to B and B-1, lines/columns 1-24 for Overheads. Now line 3 is dropped, so B, B-1 skip line/column 3 (1, 2, 4, 5,).
- “Old Capital” was eliminated (as was the term “new”), so B part II was removed and old B part III is now Part II. All references are just “Capital”.



2552-10

Cost Allocation:

- W/S B-1 is to allow additions to accumulated cost stats (previously, only reductions were allowed). ECR Spec.
- More B-1 “automatic stats” expected to be allowed in the ECR file (e.g. Gross Salary, Gross Charges, etc.). Currently, only accumulated cost is an “automatic stat”.
- ECR to add “repeat stat” identifier (e.g. square feet).



2552-10

Reclassification & Adjustment of Trial Balance of Expenses:

- W/S A line 69 new for Implantable Devices (added in Transmittal 20 as line 55.30).
- W/S A line 90 moved to line 3 (Other Capital).
- W/S A lines skipped in each category for future use (e.g. 24-29, 47-49, etc.).
- IPF and IRF, as well as all Organ Acquisition now “standard lines” – 40.00 and 41.00, and 105.00 – 112.00).



2552-10

Reconciliation of Capital Cost Centers:

- A-7 eliminated “old” capital, or Part I, and renumbered new form as Parts I, II, and III – no part IV. Old part II is now Part I. Old part IV is now Part II. Old part III is new Part III.

Adjustments to Expenses:

- W/S A-8 mostly the same – only eliminated obsolete references to A-8-3 and A-8-4, as now only A-8-3 (old A-8-4) remains for Therapy adjustments (CAH).



2552-10

Post Stepdown Adjustments:

- W/S B-2 added new “standard” lines for Aranesp drug carve out (from W/S S-5, same as EPO). Thus, drug “cost” must be in line 71 or 94 (old 57 or 64), so carve out applies to correct cost.

Ratio of Cost to Charges:

- W/S C part II eliminated, but still used by States for Medicaid.
- W/S C parts III, IV, and V, eliminated.



2552-10

Program Cost and Charges:

- D worksheets, Parts I, II, III, and IV, for Pass Through Costs, eliminated “old” capital, so new forms have fewer columns – basically renumbered, and no material changes.
- D part III eliminated CRNA (old col. 1), and added Allied Health and All Other – col. 2 and 3. 2552-96 added these via Instruction (subscripts col. 2.01, 2.02).
- W/S D part IV revised to display Allied Health and All Other columns (added via Instruction in '96 – subscripted col. 2.01, 2.02).
- D part IV has new column 6 to display Total Outpatient Cost.
- D part IV columns renumbered, but essentially the same as 2552-96.



2552-10

Program Cost and Charges:

- D part VI eliminated for Vaccine.
- D part V, new column 4, is now for Vaccine charges.
- D part V columns 2 and 3 are like the old columns 5.01 and 5.02.
- If charges need to be split as of January 1st, then column 2 is subscripted as 2.01 – i.e. for TOPS, if it is extended.



2552-10

Program Cost and Charges:

- D-1 part III for SNF, eliminated per diem calc for T.19.
- D-1 part IV, line 80 in Draft, will reflect Post Stepdown Adjustments (PSA), if entered on B-2 for line 92, Observation Beds. This was actually clarified in Transmittal 20 of the 2552-96 (HFS ver. 20.0.118.0).
- W/S D-3 (old W/S D-4) added Nursery line – line 43 (for T.19).
- New W/S D-4 (old D-6), added Form for Islet Transplant. Also, new “standard” lines on W/S A for Pancreas, Intestinal, and Islet (lines 109, 110, 111), as well as “check boxes” on new W/S D-4, for Kidney, Heart, Liver, Lung, Pancreas, Intestinal, and Islet.



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- If charges need to be split as of January 1st, then column 2 is subscripted as 2.01 – i.e. for TOPS, if it is extended.



2552-10

Calculation of Reimbursement Settlement:

- IME and DSH were to be moved to separate (new) worksheet, versus E part A. Draft did NOT do this.
- W/S E part A line 3, Bed Days Available, was to be moved to S-3, as this is used for all “bed size” calculations. Draft did NOT.
- No more “splits” of payments on E part A.
- IME adjustment “factor” - no change (1.35).
- DSH – no more reduction factor.
- If allowable DSH percentage changes during FY, then subscripting will be needed (generally no change).
- Section 422 add on I&R FTE, old W/S E-3 part VI, was incorporated into E part A (see lines 21-25), and new W/S E-4.



2552-10

Calculation of Reimbursement Settlement:

- W/S E part B moved I&R and Teaching Phys. “cost” out of LCC (Transmittal 18 retroactive change).
- E part B new lines 22 and 23 (old line 2 and 4), moved I&R and Teaching Physician “cost” out of the LCC calc as there were no comparable “charges”.
- E part B new lines 90-94 for Outlier Reconciliation (Contractor Use Only) (added in T.20 as lines 50-54, stated as lines 90-94 on 2552-10).



2552-10

Calculation of Reimbursement Settlement:

- Old E-3 part I, II, III to be revised for each component (CAH, IPF, IRF, LTCH), so there is a new settlement page for each.
- New E-3 part I = TEFRA.
- New E-3 part II = IPF.
- New E-3 part III = IRF.
- New E-3 part IV = LTCH.
- New E-3 part V = CAH.
- New E-3 part VI = SNF (Medicare).
- New E-3 part VII = Title 5 or 19.
- New E-4 = IME/GME (old E-3 part IV and VI).



2552-10

Home Health Agency:

- W/S H series for HHA, eliminated old H-1, H-2, and H-3.
- New H-1 part I, is old H-4 part I.
- New H-1 part II, is old H-4 part II.
- New H-2 part I, is old H-5 part I.
- New H-2 part II, is old H-5 part II.
- New H-3 is old H-6.
- New H-4 is old H-7.
- New H-5 is old H-8.



2552-10

Other:

- W/S L Capital Payment eliminated Part II (hold harmless), and renumbered so old Part III is Part II, and old Part IV is now Part III.
- The I, J, K, L, L-1, and M worksheets are virtually the same as in the 2552-96.
- Any subscribed lines were simply made “whole number” lines.



Questions?

Thank you

