HFMA ChAMP Taskforce

California Hospital Association – Medicare Payment Workgroup

February 24, 2020

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Barriers to Rationalizing Charges

Hospitals Face Three Significant Challenges to Rationalizing Their Charge Structures.

Common Challenges to Rebasing Chargemasters

Medicare	Commercial	Medicaid
• Charge Based Payments • Weight Rebasing	• Charge Based Payments	• Charge Based Payments

The taskforce is addressing the Medicare challenge to create an environment conducive to hospitals working with commercial payers and state Medicaid plans to rebase charges.

HFMA ChAMP Taskforce

The ChAMP Taskforce Aims to Eliminate the Use of Medicare Charges in Calculating Medicare Payments to Hospitals.

Taskforce Objectives

Develop alternative methodologies that reduce (or eliminate) the use of Medicare charges in determining Medicare cost-based payments and weight setting.

Resolve ancillary Medicare policy issues that pose a barrier to the elimination of charges in calculating Medicare payments.

Minimize Medicare payment redistribution between different types of hospitals (e.g. rural vs. urban) as a result of proposed alternative Medicare payment methodologies.

Collaborate with the Administration and CMS to implement the new payment and data submission methodologies.

The Taskforce Does Not Intend to Eliminate the Use of Charges for Other Payers or Self-Pay Patients.

Taskforce Participants

- AdventHealth
- Baptist Health
- Baylor Scott & White
- Bon Secours Mercy Health
- Cedars-Sinai
- Geisinger Heath
- HCA Healthcare
- Henry County Health Center
- Henry Ford Health System
- Kaiser Permanente
- Mayo Clinic
- MedStar Health
- Montefiore Medical Center
- Northwell Health
- OSF HealthCare
- Partners Healthcare
- Sharp Healthcare
- Spectrum Health
- SSM Health
- Texas Health Resources
- Trinity Health
- UHealth Miami
- University of Utah Health
- VCU Health

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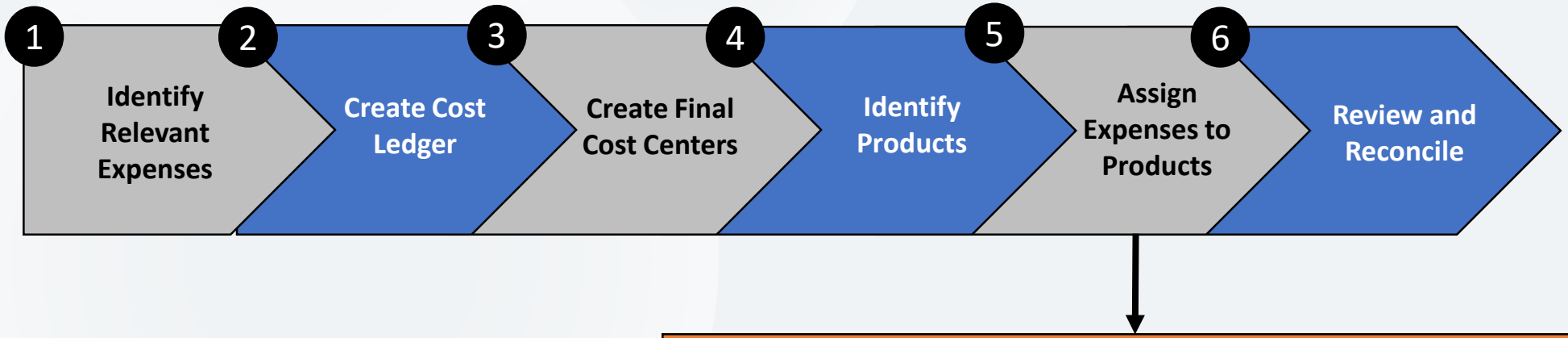
Australian Solution?

Instead of Using Cost-to-Charge Ratios and Submitted Charges to Calculate Payments and Rebase DRG and APC Weights, Australian Hospitals Submit Their Cost Per Discharge or Outpatient Service.

Example: Australian Cost Finding Process



- Intermediate expenses (e.g. MRI) assigned to final product (e.g. ED visit).
- Supplies and other specific items directly assigned.
- Remaining costs assigned by internal RVUs.

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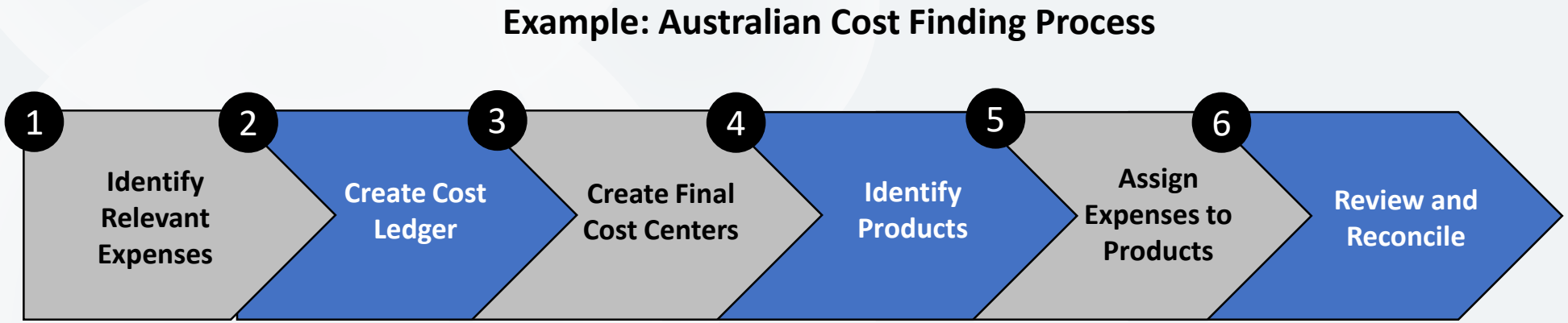
Similar Steps

The Medicare Cost Reporting Process Mirrors Many of the Steps in the Australian Cost Finding Process.



Medicare Analog						
	• W/S A	• W/S A-6 • W/S A-8	• W/S B Series	• MS-DRGs • APCs • Settled Items	**Open Item**	• W/S A Reconciles to Audited F/S

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Benefits

The Taskforce Believes Moving to a “Direct Cost Method” for Submitting Data to CMS Will Improve the Accuracy of Medicare Payments in Two Ways.

Resolve Timing Issues Related to Using Charges and CCRs from Different Periods

Eliminate Charge Compression

Using the Actual Allowable Cost Per MS-DRG and APC Will Improve the Accuracy of Medicare Cost Based Payments and Weights by Fixing Issues Related to Timing and Charge Compression.

Statutory Authority

1) **Inpatient Relative Weights:**
   - Established under section 1886(d)(4) of the Act
   - Requires the Secretary "assign an appropriate weighting factor which reflects the relative hospital resources used…within that group compared to discharges classified within other groups"
   - No requirement to use hospital charges to develop the relative weights
2) **Inpatient Outliers:**
   - Section 1886(d)(5)(A)(ii) states "a subsection (d) hospital may request additional payments in any case *where charges, adjusted to cost*, exceed…"
   - Congress's intent is to make inpatient outlier payments based on the discharge's cost, not charge.
   - This proposal replaces a proxy for cost (billed charges multiplied by the RCC) with the actual allowable cost.

Statutory Authority - Continued

3) **Inpatient New Technology Add-On Payment (NTAP):**
   - Established under section 1886(d)(5)(K)
   - Requires NTAP if "estimated costs…for such service or technology…" exceed a cost threshold.
   - No requirement to use hospital charges to develop technology's costs
4) **Outpatient Relative Weights:**
   - Established under section 1833(t)(2)(C) of the Act
   - Requires the Secretary to "establish relative payment weights…based on median (or, at the election of the Secretary, mean) hospital costs"
   - No requirement to use hospital charges to develop the relative weights

Statutory Authority - Continued

5) **Outpatient Outliers:**
   - Section 1833(t)(5)(A) states "The Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a *hospital's charges, adjusted to cost*, exceed…
   - This proposal eliminates outpatient outliers and incorporates those dollars into APC payments.
   - By using the word "shall" coupled with establishing a ceiling for outlier payments but not a floor for outpatient outlier payments, Congress provided the Secretary the latitude to not make outlier payments and return the dollars to the APC payment system.

Statutory Authority - Continued

6) **Outpatient transitional pass-through payments for medical devices only:**
   - Section 1833(t)(6)(D) states "in the case of a medical device, the amount by which the hospital's *charges for the device, adjusted to cost, exceeds*…"
   - Congress's intent is to make OP transitional pass-through payments for medical devices based on their cost, not charges.
   - This proposal replaces a proxy for cost (billed charges multiplied by the RCC) with the actual device cost submitted on the claim using a value code.

Allocating Allowable Cost to Inpatient Cases: Hospitals with Costing Systems

1. Identify Percentage of Allowable Costs to Allocate to Medicare Inpatient Services: Using data from the hospital's cost accounting system, calculate the percentage of Medicare inpatient cost to the hospital's total cost. Multiply the percentage of Medicare inpatient cost times the total Medicare allowable cost from Worksheet B Part I. See slides that follow this section for an example.

2. Calculate the MS-DRG Specific Allowable Cost Allocation Statistic: Using data from the hospital's cost accounting system divide the cost per Medicare patient by the total Medicare inpatient cost.

3. Allocate Allowable Cost to Each Patient Discharge: Multiply the Medicare allowable cost related to Medicare inpatient discharges (step 1) times the patient specific cost allocation statistic in step 2. This will provide the patient specific cost per MS-DRG.

Apportioning Medicare Allowable Cost - Inpatient
Hospitals with Costing Systems

	Total Cost at Worksheet A, Col 3, Line 200 Total Cost	Cost Based Allowable Cost Allocation Statistic	Total Allowable, Allocated Medicare Cost from B pt. I Line 118
	$ 10,000,000		$ 9,500,000
Cost Based on Costing System			
Medicare Inpatient	$ 2,500,000	25.00%	$ 2,375,000
Medicare Outpatient	$ 2,500,000	25.00%	$ 2,375,000
Medicare Advantage	$ 500,000	5.00%	$ 475,000
Medicaid/CHIP	$ 1,000,000	10.00%	$ 950,000
Tricare	$ 500,000	5.00%	$ 475,000
Commercial	$ 2,500,000	25.00%	$ 2,375,000
Self-Pay	$ 500,000	5.00%	$ 475,000
Total	$ 10,000,000	100%	$ 9,500,000

Step 1.

Allocating Allowable Cost to MS-DRGs: Hospitals with Costing Systems

Step 2

Step 3

Patient Number	MS-DRG	Cost Per Discharge Based on Costing System	% Total Cost for Allowable Cost Allocation	Allowable Medicare Inpatient Cost Allocation
1	064 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	$ 17,802	0.71%	$ 16,912
72	312 - SYNCOPE & COLLAPSE	$ 8,639	0.35%	$ 8,207
73	312 - SYNCOPE & COLLAPSE	$ 9,503	0.38%	$ 9,028
74	312 - SYNCOPE & COLLAPSE	$ 10,943	0.44%	$ 10,396
75	313 - CHEST PAIN	$ 7,733	0.31%	$ 7,347
76	313 - CHEST PAIN	$ 8,507	0.34%	$ 8,081
77	313 - CHEST PAIN	$ 9,795	0.39%	$ 9,306
78	313 - CHEST PAIN	$ 11,600	0.46%	$ 11,020
230	885 - PSYCHOSES	$ 9,368	0.37%	$ 8,899
Total		$ 2,500,000	100%	$ 2,375,000
Total Medicare Inpatient From Cost Accounting System		$ 2,500,000		
Total Medicare Inpatient Allowable Cost Allocation				$ 2,375,000
Difference		$ -		$ -

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Allocating Allowable Cost to APCs: Hospitals with Costing Systems

1. Identify Percentage of Allowable Costs to Allocate to Medicare Outpatient Services: Using data from the hospital's cost accounting system, calculate the percentage of Medicare outpatient cost to the hospital's total cost. Multiply the percentage of Medicare outpatient cost times the total Medicare allowable cost from Worksheet B Part I. See slides that follow this section for an example.

2. Identify and Separate Internal Costs for Services Paid Based on APCs and Non-APCs: Using either internal data or by running claims data through an APC grouper, identify the internal cost associated with outpatient visits/services that have a single APC, multiple APCs, and are not paid based on APCs. Calculate the percentage of internal cost for Medicare single APC services as a percentage of total Medicare outpatient services.

3. Calculate Total Allowable Medicare Cost to Allocate to Cases with a Single APC: Multiply the amount calculated in step 1 (total Medicare allowable O/P Cost) by the percentage of internal Medicare cost associated with single APC services/visits calculated in step 2.

Allocating Allowable Cost to APCs: Hospitals with Costing Systems

4. Calculate the APC Specific Allowable Cost Allocation Statistic: For Medicare single APC services/visits calculate the total cost for each APC as determined by the hospital's costing system. For each APC divide the summarized total cost (for all "single" units provided) per APC from the hospital's costing system by the hospital's total Medicare outpatient cost for single APC claims based on its costing system (from step 2).

5. Allocate Allowable Cost to Specific APCs: Multiply the Medicare allowable cost related to single APC services/visits from step 3 by the APC specific allocation statistic in step 4.

6. Calculate the Average Medicare Allowable Cost Per APC: Calculate the average cost per APC by dividing the total allowable cost per APC (step 5) by the number of units per APC.

Note: Medicare Outpatient Outliers Would No Longer be Paid on Claims. Those Dollars Would Need to be Included in the OPPS Payments.

Apportioning Medicare Allowable Cost - Outpatient
Hospitals with Costing Systems

	Total Cost at Worksheet A, Col 3, Line 200 Total Cost	Cost Based Allowable Cost Allocation Statistic	Total Allowable, Allocated Medicare Cost from B pt. I Line 118
	$ 10,000,000		$ 9,500,000
Cost Based on Costing System			
Medicare Inpatient	$ 2,500,000	25.00%	$ 2,375,000
Medicare Outpatient	$ 2,500,000	25.00%	$ 2,375,000
Medicare Advantage	$ 500,000	5.00%	$ 475,000
Medicaid/CHIP	$ 1,000,000	10.00%	$ 950,000
Tricare	$ 500,000	5.00%	$ 475,000
Commercial	$ 2,500,000	25.00%	$ 2,375,000
Self-Pay	$ 500,000	5.00%	$ 475,000
Total	$ 10,000,000	100%	$ 9,500,000

Step 1

Apportioning Medicare Allowable Cost - Outpatient
Hospitals with Costing Systems

Step	Description		Amount
From Step 1	Total Allowable Medicare Outpatient Costs	$	2,375,000
	Internal Costs Related to Single APC Visits	$	1,008,749
	Internal Costs Related to Multiple APC Visits	$	1,228,093
	Internal Costs Related to Non-APC Services	$	263,158
Step 2			
	Total Internal Cost Based on Costing System	$	2,500,000
	% Internal Cost Related to Single APC Visits		40.35%
Step 3	Total Allowable Cost for Single APC Visits	$	958,311

Allocating Allowable Cost to APCs: Hospitals with Costing Systems

APC	APC Description	Volume	Step 4: Summarized Cost Per APC Based on Internal Costing System	Step 4: Percentage APC of Total O/P Cost	Step 5: Allowable Medicare Outpatient Cost Allocation	Step 6: Average Allowable Cost Per APC
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	1.00	$ 8,684	1%	$ 8,250	$ 8,250
5123	Level 3 Musculoskeletal Procedures	10.00	$ 50,950	5%	$ 48,402	$ 4,840
5124	Level 4 Musculoskeletal Procedures	4.00	$ 26,043	3%	$ 24,741	$ 6,185
5125	Level 5 Musculoskeletal Procedures	1.00	$ 9,078	1%	$ 8,624	$ 8,624
5165	Level 5 ENT Procedures	3.00	$ 13,573	1%	$ 12,895	$ 4,298
5212	Level 2 Electrophysiologic Procedures	1.00	$ 5,346	1%	$ 5,079	$ 5,079
5213	Level 3 Electrophysiologic Procedures	4.00	$ 68,499	7%	$ 65,074	$ 16,269
5222	Level 2 Pacemaker and Similar Procedures	3.00	$ 16,393	2%	$ 15,573	$ 5,191
5223	Level 3 Pacemaker and Similar Procedures	7.00	$ 53,203	5%	$ 50,543	$ 7,220
5224	Level 4 Pacemaker and Similar Procedures	1.00	$ 13,358	1%	$ 12,690	$ 12,690
5231	Level 1 ICD and Similar Procedures	1.00	$ 15,972	2%	$ 15,174	$ 15,174
5232	Level 2 ICD and Similar Procedures	4.00	$ 86,860	9%	$ 82,517	$ 20,629
5331	Complex GI Procedures	2.00	$ 7,320	1%	$ 6,954	$ 3,477
5361	Level 1 Laparoscopy	11.00	$ 47,413	5%	$ 45,042	$ 4,095
5362	Level 2 Laparoscopy	3.00	$ 20,966	2%	$ 19,918	$ 6,639
5375	Level 5 Urology and Related Services	12.00	$ 43,642	4%	$ 41,460	$ 3,455
8011	Comprehensive Observation Services	90.00	$ 236,234	23%	$ 224,423	$ 2,494
	Total Single APC Per Claim Cost Allocation	195.00	$ 1,008,749	100%	$ 958,311	
	Total Multiple APC Per Claim Cost Allocation		$ 1,228,093		$ 1,166,689	
	Tota Non-APC Allowable Cost		$ 263,158		$ 250,000	
	Total Allowable Cost Allocated				$ 2,375,000	
Total Medicare Outpatient From Cost Accounting System			$ 2,500,000			
Total Medicare Outpatient Allowable Cost Allocation					$ 2,375,000	
Difference			$ -		$ -	

Note: Example based on comprehensive APC data only due to availability.

Cost Based Payments: Modification Required

The taskforce identified five areas where Medicare charges are used to calculate cost-based hospital payments that require modification.

Proposed New Payment Methodology

Payment Mechanism	Charges Currently Used	Proposed Resolution
Inpatient Outlier New Technology Add-On (NTAP)	Medicare, Patient Specific	• Use a periodic interim payment based on the five-year average of outlier/NTAP payments as a cash flow mechanism. • Calculates the actual outlier/NTAP payments for the fiscal year when the cost report is filed and is included as a settlement item.
Outpatient New Device Pass-Through	Medicare, Patient Specific	• Include the cost of the device on the claim in a field associated with the pass-through device value-code. • CMS can base payment off this amount.
CAH – Outpatient	Medicare, Patient Specific	• Use APC based payments coupled with Transitional Outpatient Payments (TOPs) based on the prior year's cost report as a funds flow mechanism. • Outpatient payments are cost settled when the cost report is filed. • This interim payment process is currently used for qualifying cancer hospitals. • Items not paid using the APC schedule would be based on the fee schedule and settled on the cost report. • Beneficiary cost sharing for CAH's in the outpatient setting would be adjusted to the APC cost sharing amount.
Nursing/Allied Health DME Qualified Non-Physician Anesthesiologist Costs	Medicare, Summarized I/P and O/P from PS&R	• Use overall Medicare cost allocation percentage for inpatient and outpatient services to calculate Medicare pass-though cost on worksheet D Part IV that is transferred to worksheets E pt A and pt B.

Cost-Based Payments: No Change Needed

While calculated using charges, the taskforce believes the following items do not require modification under the direct cost model.

Payment Items that Do Not Require Modification

Payment Mechanism	Charges Currently Used	Proposed Resolution
Medicare UC DSH	Total Facility Charges	• Remains unchanged as it uses the overall facility ratio of cost to charges and uncompensated care charges to calculate the cost of uncompensated care.
Organ Acquisition Ancillary Costs	Total Facility Charges	• Continue using the total hospital cost to charge ratio and accumulated pre-transplant charges to calculate ancillary costs for organ acquisition/pre-transplant services.
Outpatient Outlier	Medicare Patient Specific	• Changes are unnecessary. • Taskforce recommends eliminating outpatient outlier payments and incorporating those dollars into APC payments through an adjustment to the conversion factor.

Cost Based Payments: Not Charge Based

The following cost-based payments are not calculated based on charges and therefore do not require any change to accommodate the "direct cost model."

Cost-Based Payment Models that Do Not Require Retrofitting

Payment Mechanism	Approach	Payment Source	Currently Cost Report Settled
CAH - Inpatient	No-Change	Per Diem/Claims/Cost Report	Yes
Cancer Hospital Inpatient	No-Change	Per Diem/Claims/Cost Report	Yes
Cancer Hospital Outpatient (APC/TOPS)	No-Change	Claims/Cost Report/PIP	Yes
Children's Hospital Inpatient	No-Change	Per Diem/Claims/Cost Report	Yes
Medicare Dependent Hospital	No-Change	Historic Rate/Claims/Cost Report	Yes
Sole Community Hospital	No-Change	Historic Rate/Claims/Cost Report	Yes
Organ Acquisition Routine Costs	No-Change	Per Diem/Cost Report/PIP	Yes
High Percentage ESRD Patients	No-Change	National Rate/Cost Report	Yes

Hospitals without Costing Systems
Proposed Transition

Key Transition Details: Hospitals without Costing Systems

Item	Details
Timing: 3 Year Transition	• Hospitals without costing systems would have a three-year transition period to develop the capabilities necessary to submit data under the "Direct Cost Model."
Process:	• During the 3-year transition period, qualifying hospitals would continue to submit charges on Medicare bills. • Cost based payments would continue to be calculated using billed charges and the CCR. • MS-DRG and APC weights would be calculated using billed charges and the CCR. • Beginning in year 4, hospitals must file their cost reports using the "Direct Cost" method.
Transition Resources Provided by CMS:	• Minimally viable costing system for those without an adequate cost accounting system. • APC grouper with capacity to re-process all outpatient claims from all hospitals without access to a costing system.

Next Steps: Modeling

HFMA, with a Grant from the Robert Woods Johnson Foundation, Has Retained Wakely Consulting to Model the Direct Cost Method Using Data from Taskforce Participants.

Anticipated Outputs from Modeling

Calculate Basic Statistics

- **MS-DRG based**, Per patient, allocation statistics using internal cost data.
- **APC** specific allocation statistics using internal cost data.

Compare Cost Per Case

- **Cost per case** comparison of allowable cost using current and proposed cost finding method.
- **Replicate** and compare MS-DRG and APC weights*.

Analyze Payment Impact

- **Outliers**: Inpatient
- **NTAP**
- **CAH** Outpatient Payments

*If the number of hospitals participating is sufficient for a statistically significant sample.

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Medicare Implementation Support: Tools

The program needs to provide participants with software utilities to implement the direct cost model.

Basic Cost Accounting Utility

- Minimally viable software as a service provided to hospitals that can't otherwise afford sophisticated cost accounting packages to accurately determine cost per discharge or service (HCPCS/CPT code) level.

APC Grouper

- Allows hospitals to reprocess claims through a grouper to assign APCs to outpatient visits/services for cost determination.

Medicare Implementation Support: Data

CMS will need to provide additional data, reconciliation instructions, and protect the confidentiality of hospital specific cost data.

1) Detailed PS&R – Inpatient: Provide a detailed listing of patients, including an identifier (e.g. patient account number) the hospital can use to match the patient/discharge to the applicable discharge in the hospital's patient financial accounting system, who meet the definition of a Medicare patient for cost reporting purposes.

2) Detailed PS&R – Outpatient: Provide a summary of APCs that includes the total payment and count of APCs paid. Include an identifier (e.g. patient account number) that can be used to match the patient/service back to the APCs included in the PS&R for cost allocation.

3) Reconciliation Threshold: It will be challenging (if not impossible) to exactly reconcile data from both inpatient and outpatient PS&Rs to internal data due to timing issues. CMS will, with the help of the industry, need to develop a "reconciliation range" that if the hospital's case count is within this range it will be acceptable.

4) Confidentiality of Cost Data: All cost data submitted by participants to CMS as part of an allocation methodology must be held confidential – like clinical lab private payer payment rates. If it is made available to the public or researchers, it needs to be released in a way that makes identifying the specific hospital impossible.

Medicare Implementation Support: Definitions

Clear definitions for the following items will need to be defined for purposes of implementing the direct costing model.

1) A Medicare Patient: HFMA's Workgroup suggests defining anyone who has Medicare as the primary payer (including those with exhausted eligibility) as a Medicare patient for the direct cost model.

2) Final Costing Model: HFMA's Workgroup suggests defining the "final costing model" as cost model for a given year that incorporates adjustments from the facility's annual audit of financial statements.

3) Audit Criteria for Costing Models: Providing the cost per discharge or visit would not be overly burdensome. However, if providers were asked to provide revenue code level detail the volume of data required to be manipulated and sent would be prohibitive.

Medicare Implementation Support: Cost Report

The following changes to the Medicare Cost Report are necessary to implement the direct cost model.

Anticipated Cost Report Revisions

Impacted Worksheet(s)	Change
• S-2	• Add question(s) related to the method hospitals use to allocate allowable cost during the transition period.
• D Part II • D Part IV • D Part V • D-2 Parts I – III • D-3	• Each worksheet uses program charges from the PS&R multiplied by the CCR to determine allowable program cost. • Replace the current RCC as the allocation statistic with the ratio of Medicare cost to total cost. • See Appendix I for "downstream" impacts.
• E Series	• Revise outlier settlement instructions in the Provider Reimbursement Manual to accommodate the new outlier payment methodology. • Create settlement mechanism for NTAP payments.
• New "Off Cost Report" Log	• Like bad debt, UC DSH, and DSH logs, create an "off cost report log" to submit detailed, per discharge or outpatient service cost from the hospital's cost accounting, create the allocation statistic, and calculate the Medicare allowable cost for Medicare patients.

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Cost Report Impact – Worksheet D Part II

Worksheet D Part II Calculates Ancillary Cost Center Capital Cost.

4090 (Cont.) FORM CMS-2552-10 11-17

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D PART II

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [ ] IPF [ ] IRF | [ ] Subprovider (Other) | [ ] PPS [ ] TEFRA

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26) 1	Total Charges (from Wkst. C, Part I, col. 8) 2	Ratio of Cost to Charges (col .1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (column 3 x column 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan						57
58	Magnetic Resonance Imaging (MRI)						58
59	Cardiac Catheterization						60
60	Laboratory						60
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing						63
64	Intravenous Therapy						64
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Implantable Devices Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
77	Allogeneic Stem Cell Acquisition						77
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency						91
92	Observation Beds						92
93	Other Outpatient Service (specify)						93
93.99	Partial Hospitalization Program						93.99
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)						200

(A) Worksheet A line numbers

Uses RCCs in Column 3…

…multiplied by Medicare Inpatient Program charges from worksheet D-3 in column 4…

…to calculate Medicare capital costs in column 5.

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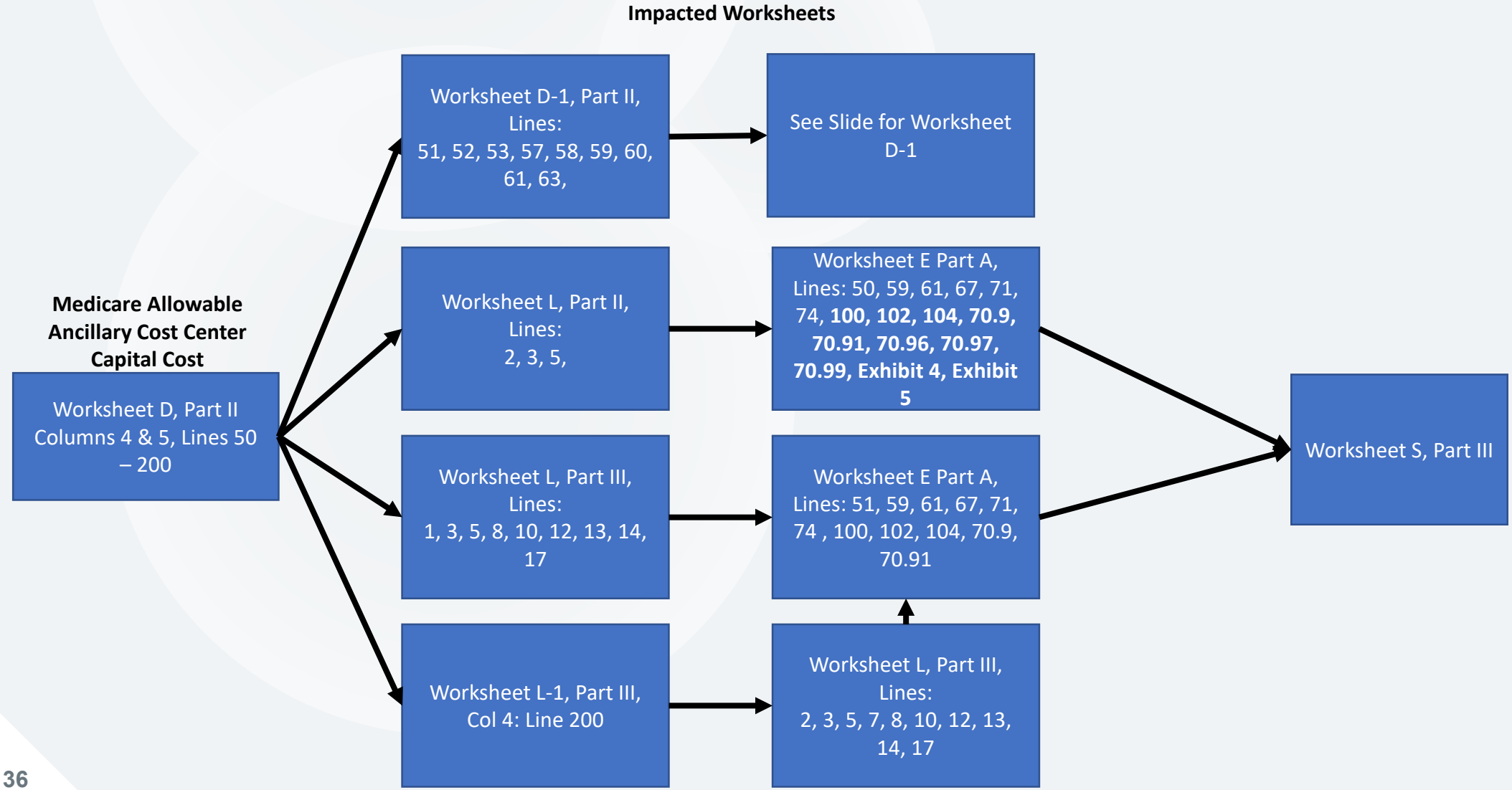
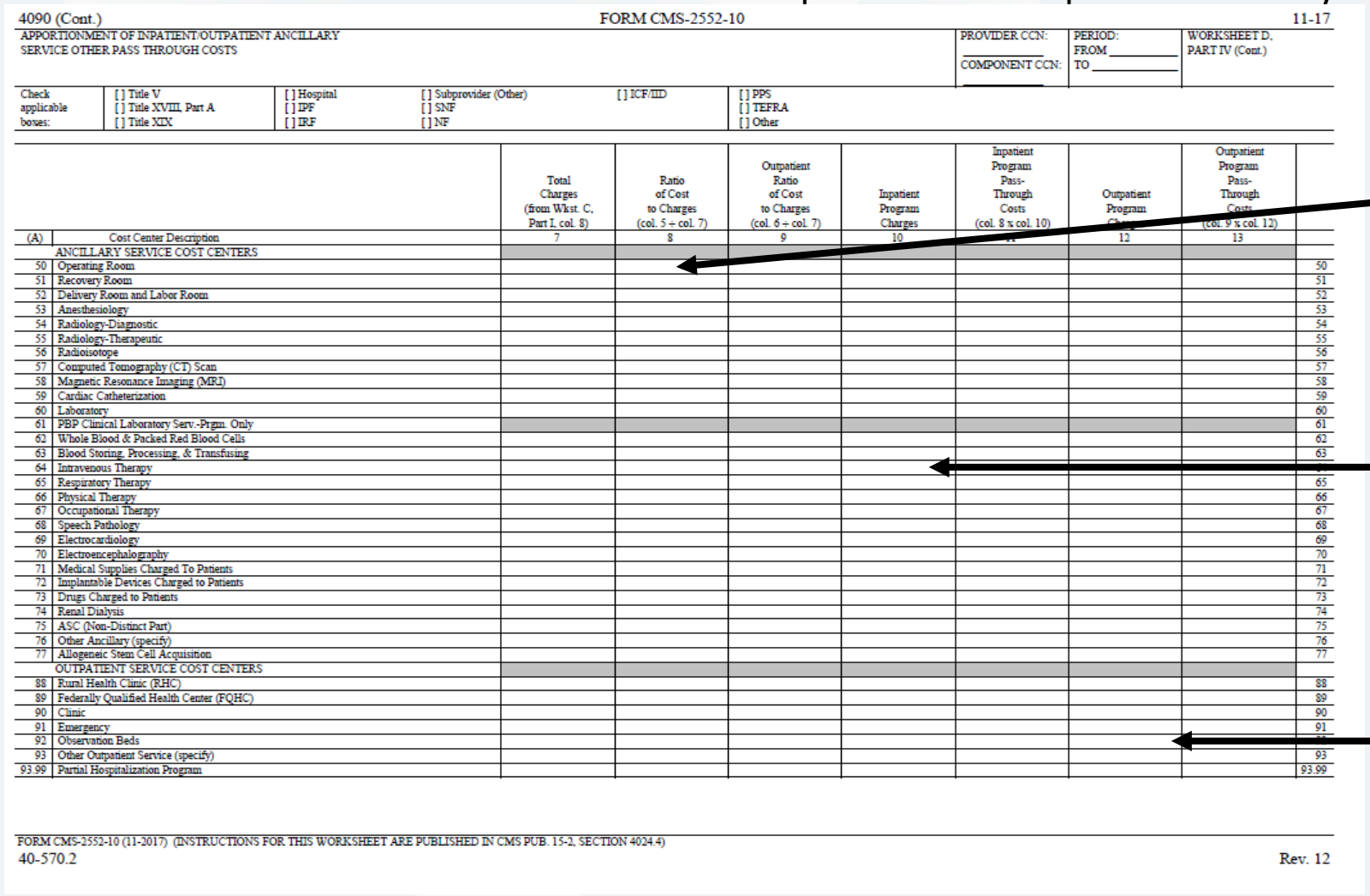
Cost Report Impact – Worksheet D Part II

Worksheet D, Part II Flows to the Following Worksheets:



Cost Report Impact – Worksheet D Part IV

Worksheet D Part IV Calculates Inpatient and Outpatient Ancillary Service Pass-Through Costs.



4090 (Cont.) FORM CMS-2552-10 11-17

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER CCN: _____ COMPONENT CCN: _____ PERIOD: FROM _____ TO _____ WORKSHEET D, PART IV (Cont.)

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX [ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [ ] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Delivery Room and Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Serv.-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
77	Allogeneic Stem Cell Acquisition								77
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
93.99	Partial Hospitalization Program								93.99

FORM CMS-2552-10 (11-2017) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.4)

40-570.2 Rev. 12

Uses RCCs in Columns 8(inpatient) and 9 (outpatient)…

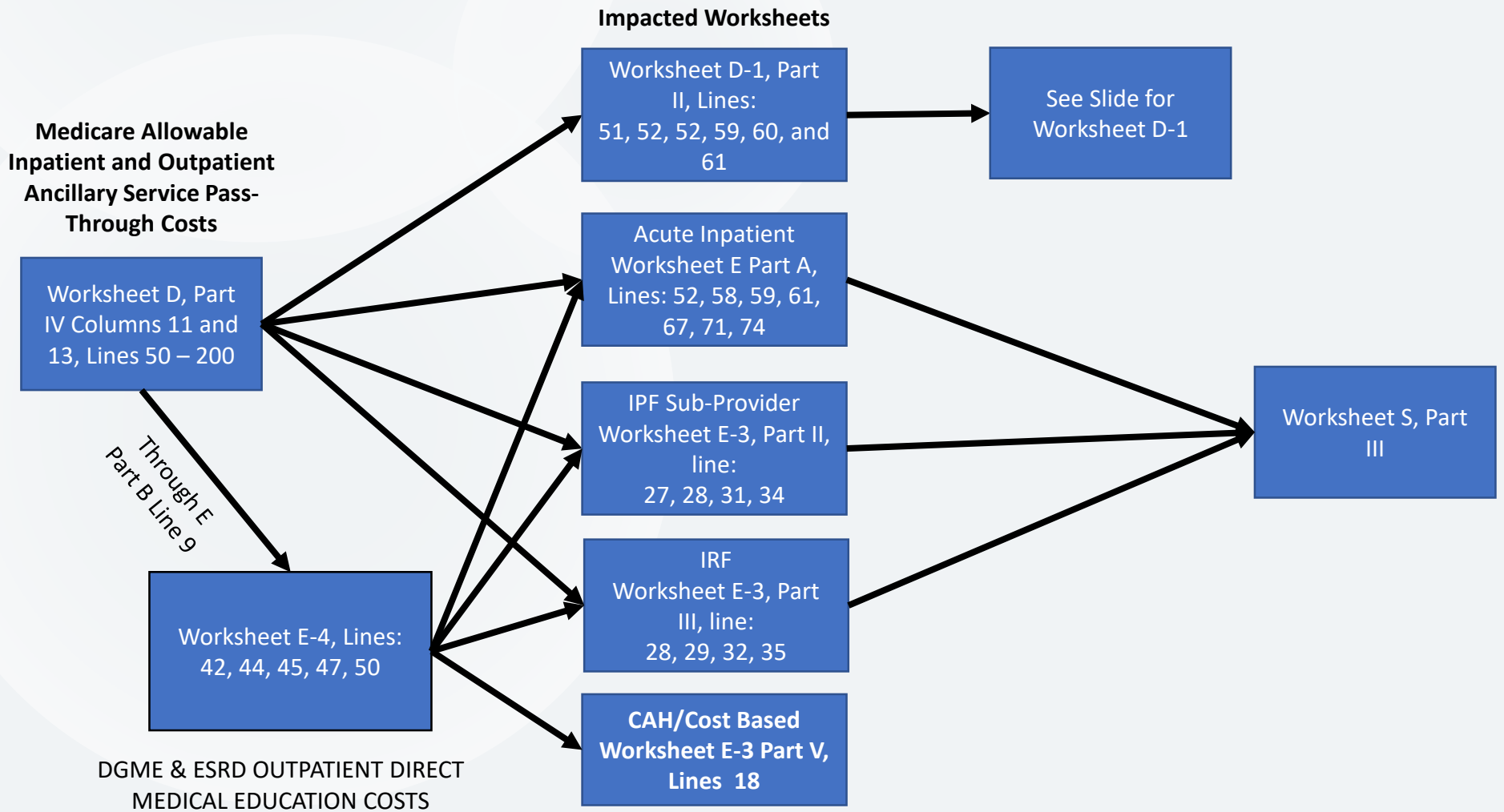
…multiplied by Medicare Inpatient (col 10 – from w/s D-3) and Outpatient (col 12)Program charges in column 4…

…to calculate Medicare inpatient and outpatient ancillary pass through costs in columns 11 and 13.

hfma

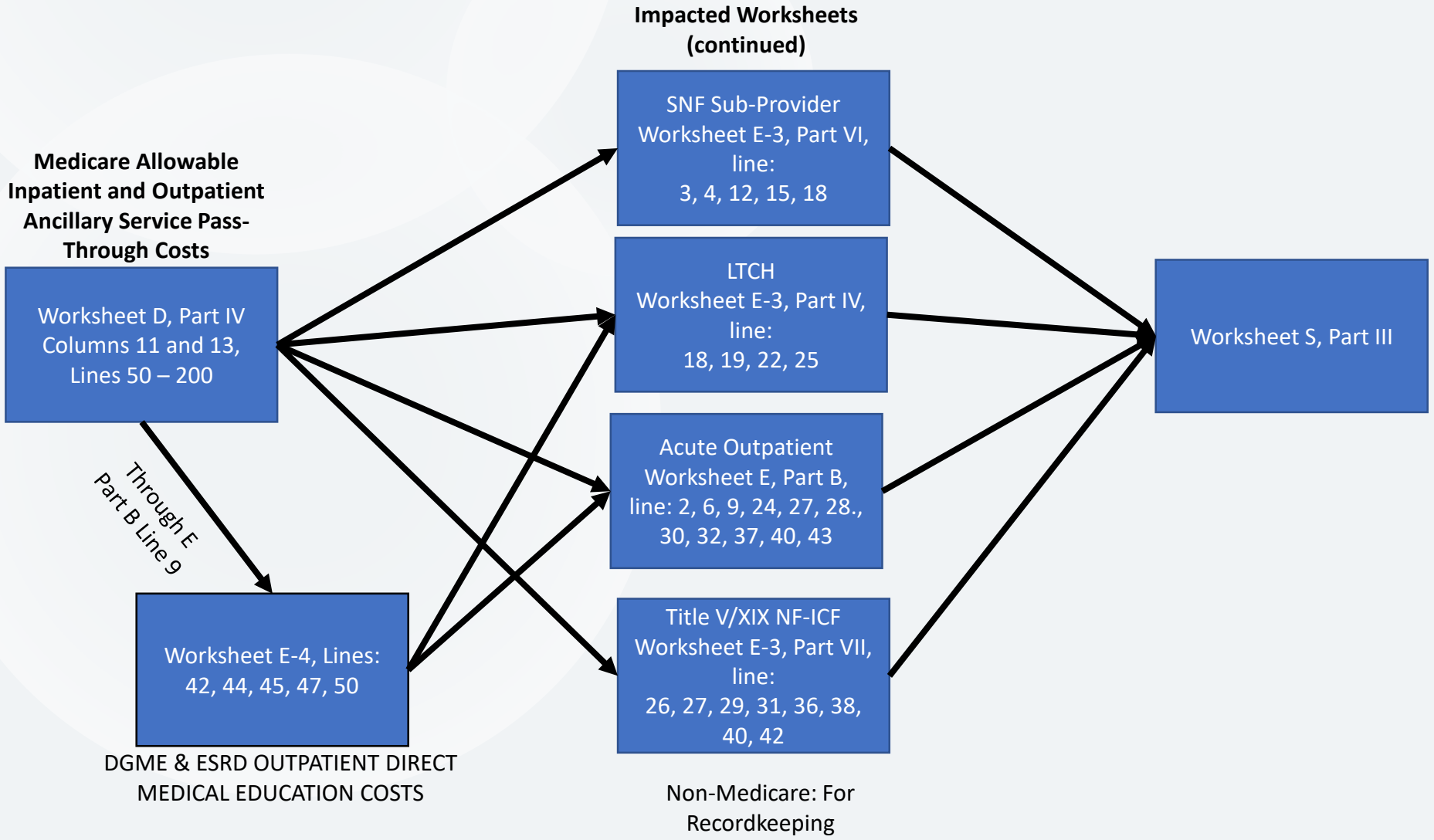
Cost Report Impact – Worksheet D Part IV

Worksheet D, Part IV Flows to the Following Worksheets:



Cost Report Impact – Worksheet D Part IV (cont.)

Worksheet D, Part IV Flows to the Following Worksheets:



Cost Report Impact – Worksheet D Part V

Worksheet D Part V Apportions Medicare Outpatient Costs.

4090 (Cont.) FORM CMS-2552-10 11-17

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	PROVIDER CCN: / COMPONENT CCN:	PERIOD: FROM / TO	WORKSHEET D, PART V

Check applicable boxes: [ ] Title V - O/P; [ ] Title XVIII, Part B; [ ] Title XIX - O/P; [ ] Hospital; [ ] IPF; [ ] IRF; [ ] Subprovider (Other); [ ] SNF; [ ] NF; [ ] Swing Bed SNF; [ ] Swing Bed NF; [ ] ICF/IID

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

			Program Charges			Program Cost			
		Cost to Charge Ratio from Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.)	PPS Services (see (see inst.)	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Serv.-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
77	Allogeneic Stem Cell Acquisition								77
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Bed								92
93	Other Outpatient Service (specify)								93
93.99	Partial Hospitalization Program								93.99
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

Uses RCCs in Columns 1…

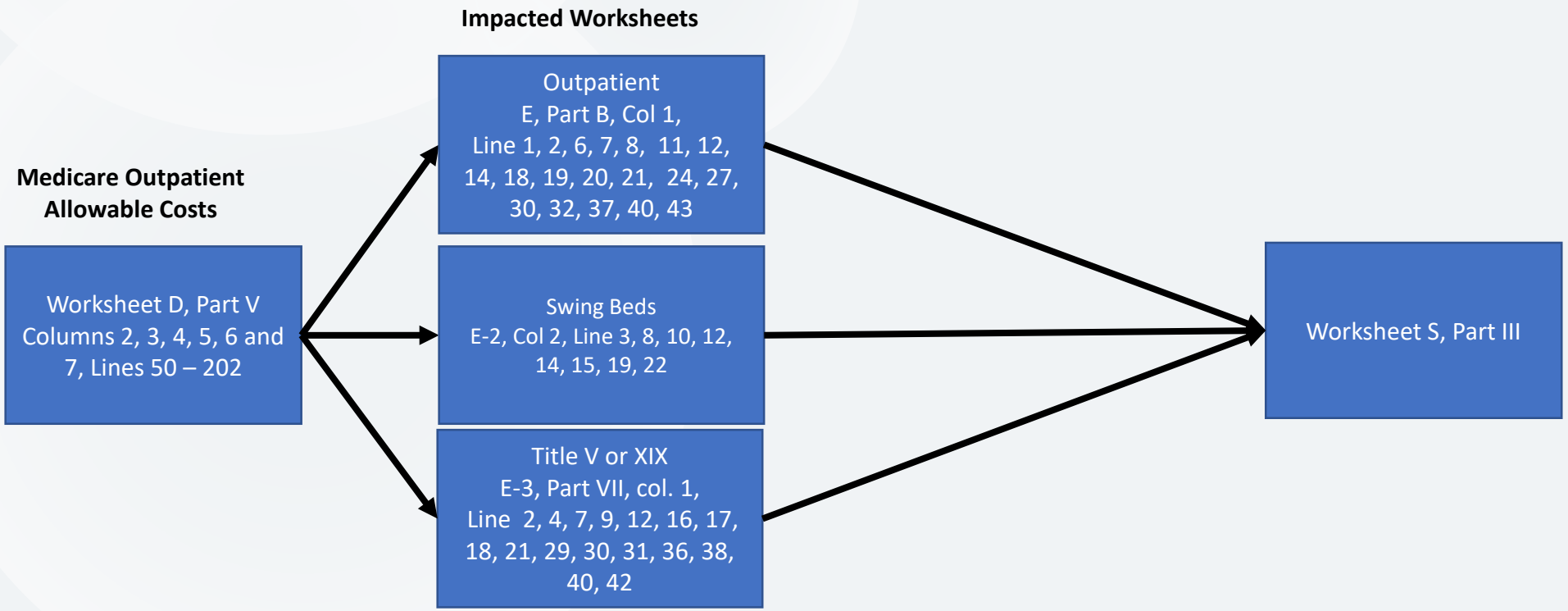
…multiplied by Medicare Program charges in column 2, 3, and 4…

…to calculate Medicare allowable outpatient costs in columns 5, 6, and 7.

hfma

Cost Report Impact – Worksheet D Part V

Worksheet D, Part V Flows to the Following Worksheets:

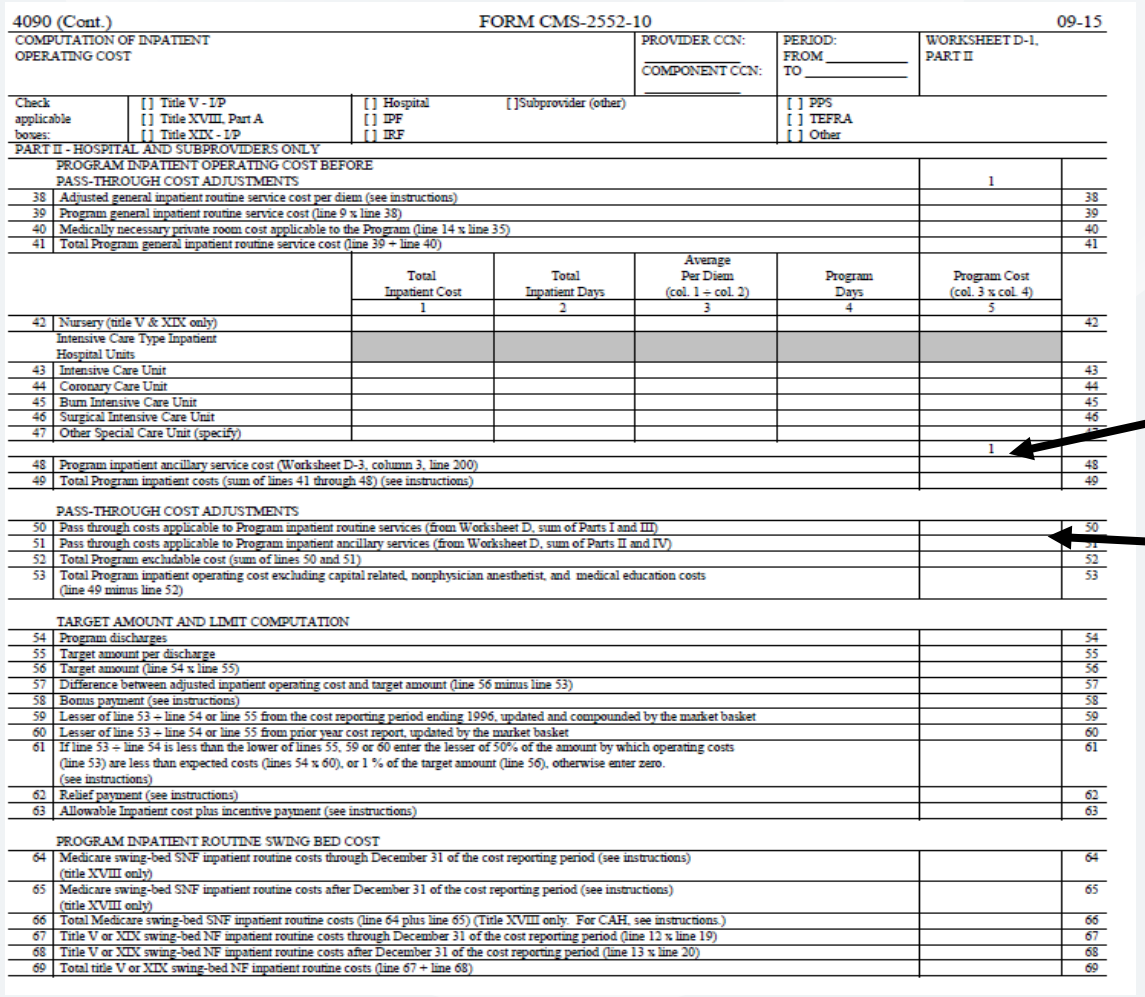


Non-Medicare: For Recordkeeping

hfma

Cost Report Impact – Worksheet D-1 Part II

Worksheet D-1 Part II Apportions Medicare Inpatient Operating Costs



4090 (Cont.) FORM CMS-2552-10 09-15

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER CCN: / COMPONENT CCN:	PERIOD: FROM / TO	WORKSHEET D-1, PART II

Check applicable boxes: [ ] Title V - I/P; [ ] Title XVIII, Part A; [ ] Title XIX - I/P; [ ] Hospital; [ ] IPF; [ ] IRF; [ ]Subprovider (other); [ ] PPS; [ ] TEFRA; [ ] Other

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						38
39	Program general inpatient routine service cost (line 9 x line 38)						39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
						1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)						48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)						49
	PASS-THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket						60
61	If line 53 ÷ line 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Line 48 uses data from Worksheet D-3, which calculates Medicare inpatient program cost by multiplying program charges times the CCR.

Line 51 uses data from Worksheets D pts II and IV which calculates Medicare inpatient program cost by multiplying program charges times the CCR.

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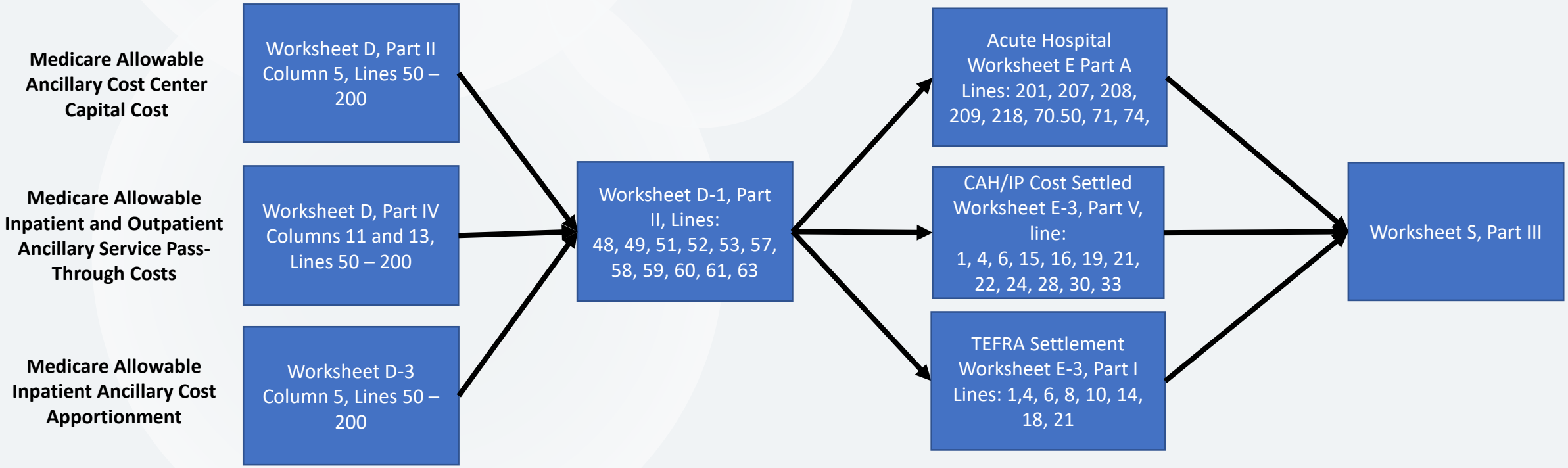
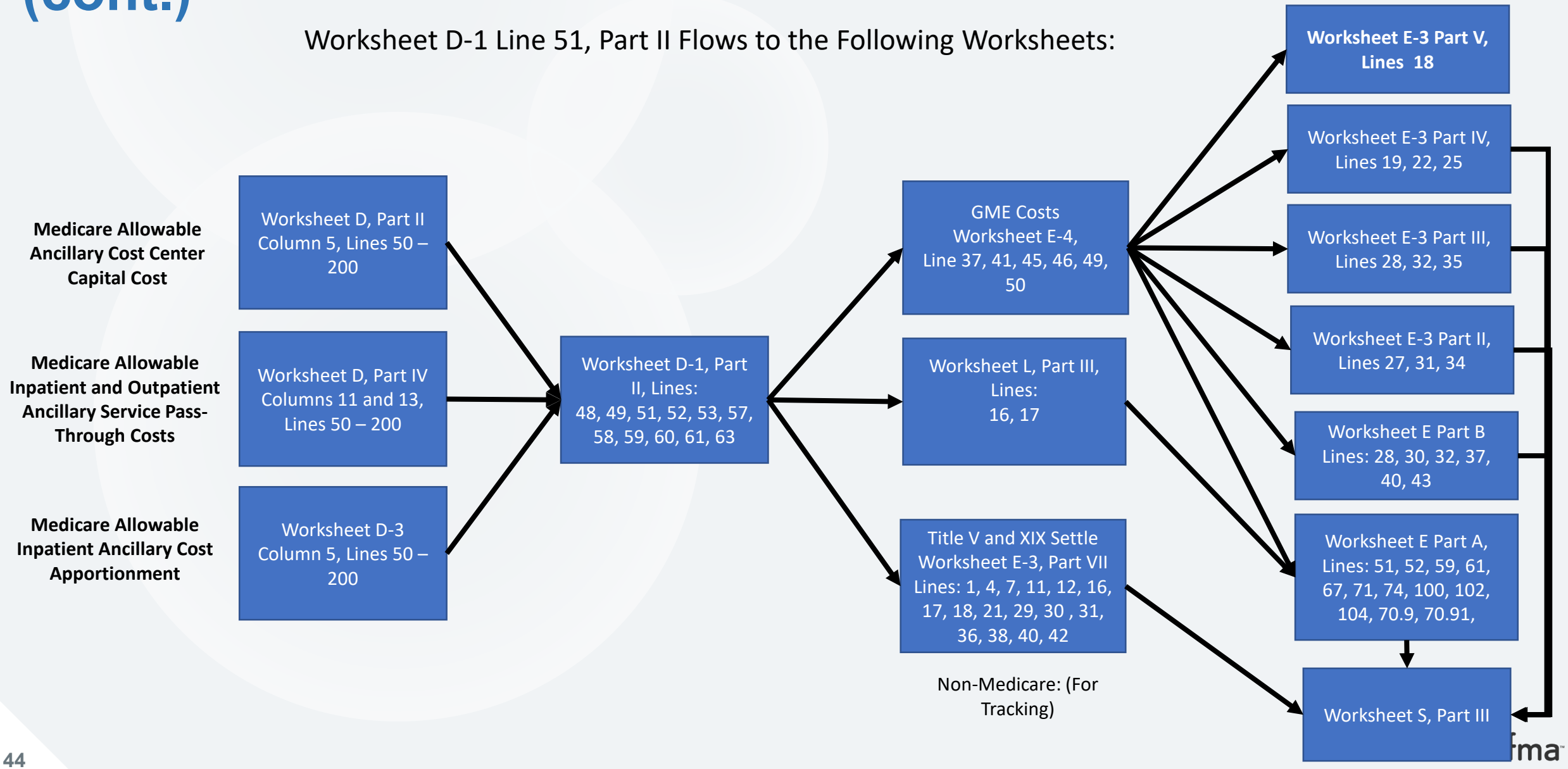
Cost Report Impact – Worksheet D-1 Part II

Worksheet D-1 Line 51, Part II Flows to the Following Worksheets:



Cost Report Impact – Worksheet D-1 Part II (cont.)

Worksheet D-1 Line 51, Part II Flows to the Following Worksheets:



Cost Report Impact – Worksheet D-2 Parts I - III

Worksheet D-2 Parts I - III Apportions the Medicare Cost for Services Provided By Interns and Residents

11-17 FORM CMS-2552-10 4090 (Cont.)

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | PROVIDER CCN: | PERIOD: FROM ____ TO ____ | WORKSHEET D-2, PARTS I-III (Cont.)

PART I - NOT IN APPROVED TEACHING PROGRAM

	Average Cost Per Day	Health Care Program Inpatient Days: Title V	Title XVIII, Part B	Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	4	5	6	7	8	9	10	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20

	Ratio of Cost to Charges (column 2 ÷ column 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges: Title V	Title XVIII Part B	Title XIX	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title V	Title XVIII Part B	Title XIX	
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)

	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)				
	4	5	6	7				
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36
37								37
38								38
39								39
40								40
41								41
42								42

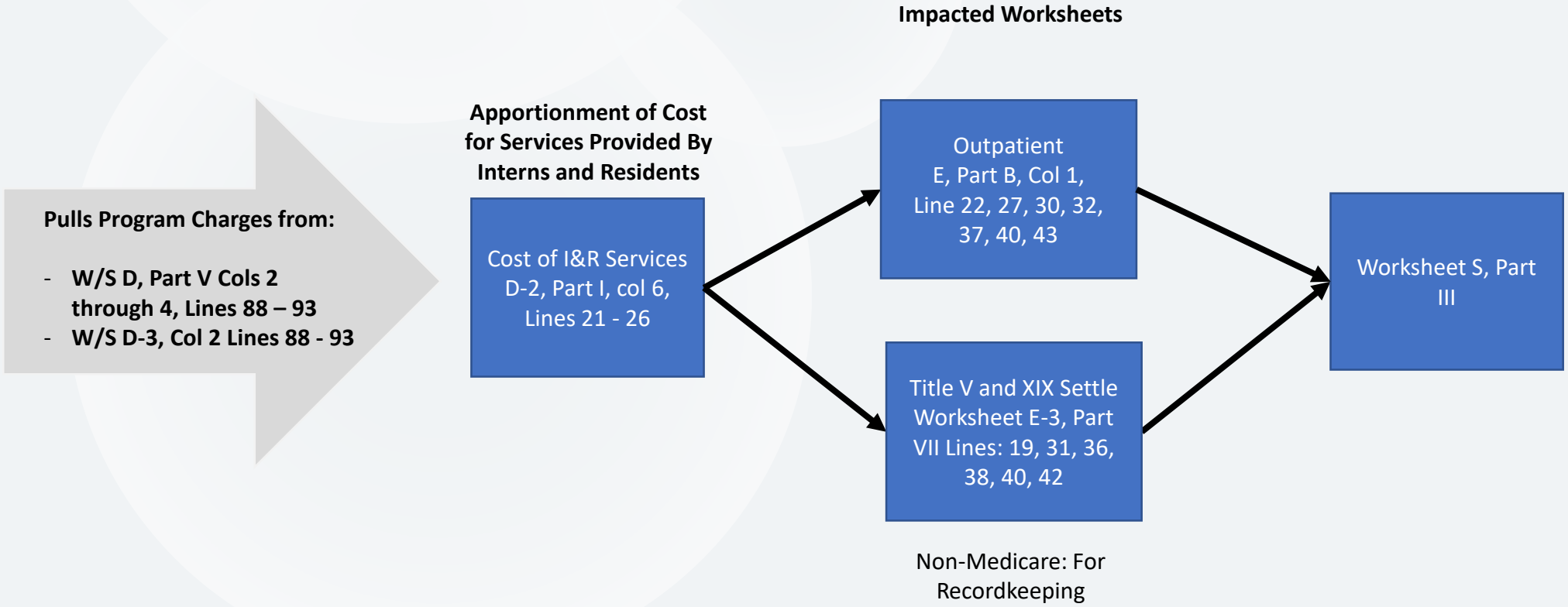
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

	In Approved Teaching Program (from Part II, col. 7)	Amount	Total Title XVIII Costs (to Wkst. E, Part B)	(col. 2 + col. 4)				
	3	4	5	6				
43	line 37							43
44								44
45			line 22					45
46	line 38		line 22					46
47	line 39		line 22					47
48	line 40		line 22					48
49	line 41		line 22					49

Uses Program Charges from Worksheet D Part V, Columns 2 through 4, Lines 88 – 93 multiplied by the CCR to calculate program cost.

Cost Report Impact – Worksheet D-2

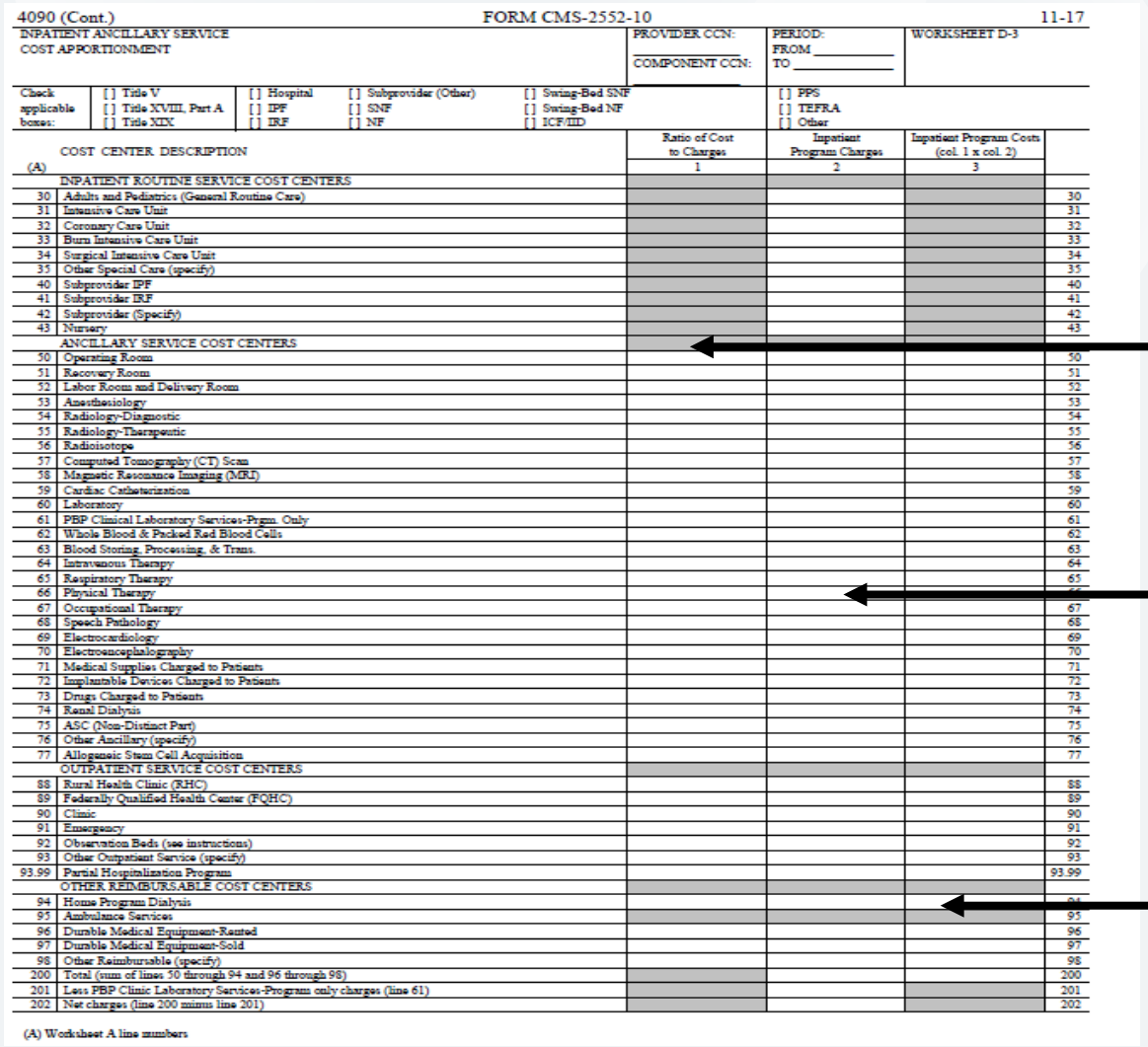
Worksheet D-2, Part I Flows to the Following Worksheets:



hfma

Cost Report Impact – Worksheet D-3

Worksheet D-3 Apportions Medicare Allowable Cost for Inpatient Ancillary Services.



4090 (Cont.) FORM CMS-2552-10 11-17

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | PROVIDER CCN: | COMPONENT CCN: | PERIOD: FROM TO | WORKSHEET D-3

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [ ] IPF [ ] IRF | [ ] Subprovider (Other) [ ] SNF [ ] NF | [ ] Swing-Bed SNF [ ] Swing-Bed NF [ ] ICF/IID | [ ] PPS [ ] TEFRA [ ] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost to Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults and Pediatrics (General Routine Care)				30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider IPF				40
41	Subprovider IRF				41
42	Subprovider (Specify)				42
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room				50
51	Recovery Room				51
52	Labor Room and Delivery Room				52
53	Anesthesiology				53
54	Radiology-Diagnostic				54
55	Radiology-Therapeutic				55
56	Radioisotope				56
57	Computed Tomography (CT) Scan				57
58	Magnetic Resonance Imaging (MRI)				58
59	Cardiac Catheterization				59
60	Laboratory				60
61	PBP Clinical Laboratory Services-Prgm. Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.				63
64	Intravenous Therapy				64
65	Respiratory Therapy				65
66	Physical Therapy				66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients				71
72	Implantable Devices Charged to Patients				72
73	Drugs Charged to Patients				73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)				76
77	Allogeneic Stem Cell Acquisition				77
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency				91
92	Observation Beds (see instructions)				92
93	Other Outpatient Service (specify)				93
93.99	Partial Hospitalization Program				93.99
	OTHER REIMBURSABLE COST CENTERS				
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 30 through 94 and 96 through 98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

Uses RCCs in Columns 1…

…multiplied by Medicare Program charges 2…

…to calculate Medicare allowable inpatient ancillary costs in column 3.

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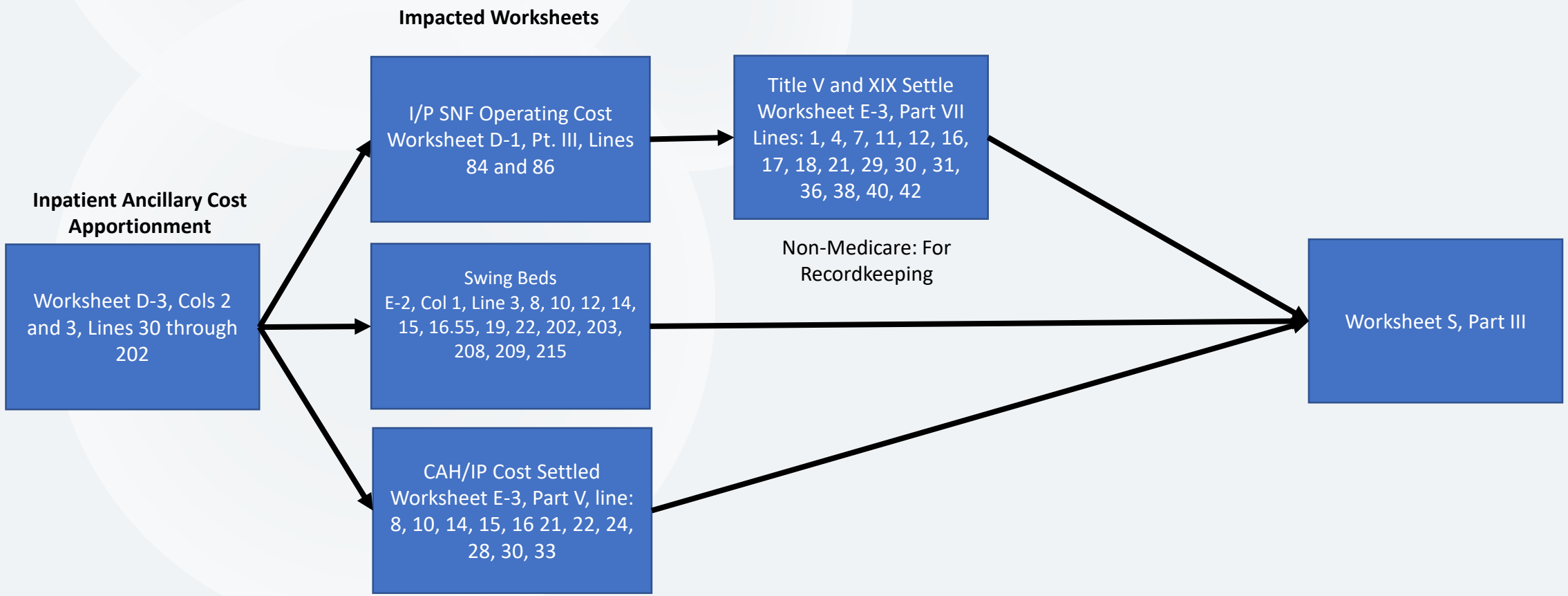
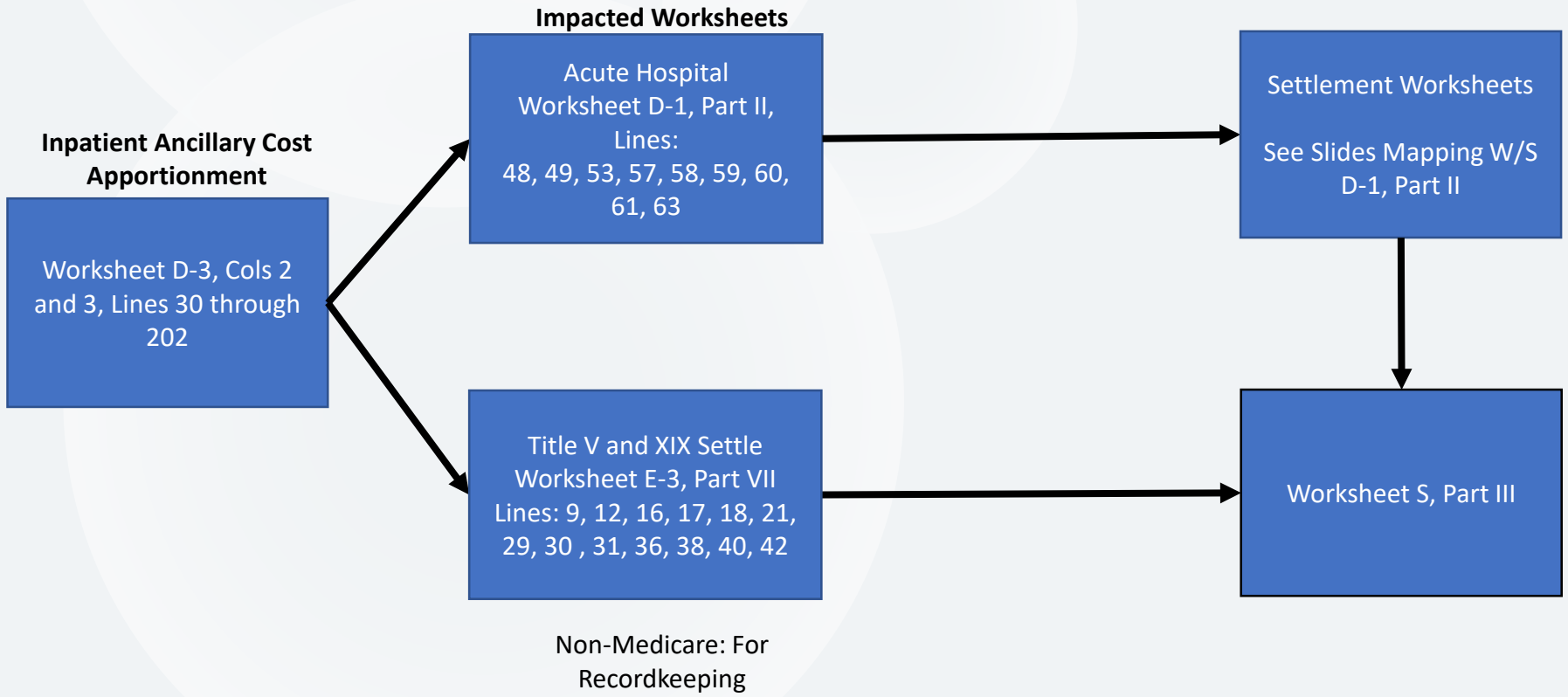
Cost Report Impact – Worksheet D-3

Worksheet D-3, Part I Flows to the Following Worksheets:



Cost Report Impact – Worksheet D-3 (cont.)

Worksheet D-3, Part I Flows to the Following Worksheets:



Outlier Reconciliation

The Outlier Reconciliation Instructions for IPPS and OPPS, Need to be Revised to Reflect the Outlier Settlement Under the Direct Cost Model.

	IPPS	OPPS	Psych PPS	Rehab PPS	LTCH PPS
Worksheet	Worksheet E, Part A lines **2.10**, 47, 49, 59, 61, 67, 69, 70.9, 70.91, 71, 74, , **92,** 93, 95, 96, 100, 102, 104, Exhibit 4, Exhibit 5	Worksheet E, Part B Lines 4.01, 7, 8, 24, 27, 30, 32, 37, 40, 43, **93**, 94	Worksheet E-3, Part II Lines 29, 29, 31, 34, **51**, 53	Worksheet E-3, Part III Lines 30, 32, 35, **51,** 53	Worksheet E-3, Part IV Lines 20, 22, **51,** 53,
Claims Processing Manual	CMS Pub. 100-4, chapter 3, §§20.1.2.5-20.1.2.7.	CMS Pub. 100-04, chapter 4, §§10.7.2.2-10.7.2.4.	CMS Pub. 100-04, chapter 3, §§190.7.2.3-190.7.2.5	CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10	CMS Pub. 100-04, chapter 3, §150.26 - §150.28.

Psych, Rehab, and LTCH will not need to be modified as these provider types will continue to bill Medicare charges.

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