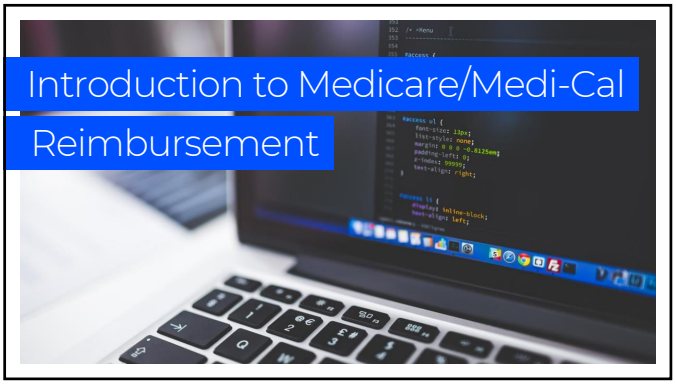
1

Today's agenda

- Cost-Based Reimbursement
- Worksheet Summary
- Service Line Analysis
- Cost-Based Reimbursement "Tool"
- Benchmarking

2



3

Cost-Based Reimbursement

If a non-health care business charges $100 for a good or service it provides, how much does it get paid?


Gas Station


Grocery Store


Plumber


Restaurant


Garbage Service


Clothing Store

4

Cost-Based Reimbursement

5

Cost-Based Reimbursement

If a health care provider charges $100 for a service it provides, how much does it get paid?

6

Cost-Based Reimbursement

7

Cost-Based Reimbursement

Examples of possible payments for health care services

Private pay	**$ 100**
Private pay	**-**
Medicare	**60**
Medicaid	**55**
Insurance #1	**90**
Insurance #2	**85**
Insurance #3	**80**
Etc.	**?**

To determine the estimated amount a health care provider will be paid, three important pieces of information must be known:

1. Payor type
2. Patient type
3. Specific type of service

8

Cost-Based Reimbursement

- Two primary types of hospital reimbursement methodologies for Medicare and Medi-Cal
  - Prospective Payment System (PPS) . . . Similar to Medi-Cal
  - Cost-Based System (CAH) . . . Which means reimbursing . . .

. . . 101% Medicare allowable costs
for inpatient, swing bed, and outpatient services,
except for professional services done in a hospital setting,
certain lab services, screening mammography services,
and some minor medications and supplies.
The Medicare program then applies a 2% reduction in reimbursement
after determining deductible and coinsurance amounts.
Medicare bad debt is reimbursed at 65% (previously 100%).

9

Cost-Based Reimbursement

Type of Service	Medi-Cal	Medicare
Inpatient	DRG Equivalent	101% of Allowable Cost
Outpatient Procedures (surgery, radiology, etc.)	APC Equivalent	101% of Allowable Cost
Lab	Fee Schedule	101% of Allowable Cost (except for reference lab)
Therapies	Fee Schedule	101% of Allowable Cost (subject to therapy cap effective 4/1/2015)
Swing Bed	RUG Equivalent	101% of Allowable Cost
Ambulance Service	Fee Schedule Equivalent	Fee Schedule (unless only one within 35 miles, then 101% of cost)

10

10

Cost-Based Reimbursement

Type of Service	Medi-Cal	Medicare
O/P Clinics (facility component)	APC	101% of Allowable Cost
O/P Clinics (professional component)	Fee Schedule (reduced for site of service)	Fee Schedule Plus 15% for CAHs Electing Method II Billing (reduced for site of service)
CRNA Services	Fee Schedule	Fee Schedule (unless elect cost if less than 800 procedures/year and 1 FTE/year)
Other Professional Services	Fee Schedule – Prospective for RHC	Fee Schedule Plus 15% for CAHs Electing Method II Billing (except for professional services in a rural health clinic setting then generally based on allowable cost)
Outlier Payments/Supplemental	IGT Payments	N/A

11

11

Cost-Based Reimbursement

Type of Service	Medi-Cal	Medicare
Dialysis	Prospective rate Equivalent	Prospective rate, except inpatient dialysis is 101% of allowable cost
Graduate Medical Education (GME)/ Indirect Medical Education (IME)	N/A	If approved, included in 101% of allowable cost
Exempt Units	Rehab Unit – PPS Psych Units – PPS	Limited to 10 exempt unit beds (Same reimbursement as PPS)

12

12

Cost-Based Reimbursement

Type of Service	Medi-Cal	Medicare
Skilled Nursing Facility	Lessor of cost or published prospective rate for rural. Rate adjusted based on Medi-Cal cost report	RUG
Home Health Agency	HHRG Equivalent	HHRG
Hospice	Prospective rate Equivalent	Prospective rate
Provider-Based Rural Health Clinic	Prospective rate (reconciliation for managed care)	Cost/Visit with cap or grandfathered rate

13

13

Cost-Based Reimbursement

- How do CAHs get reimbursed from the Medicare program for services provided to patients?
  - Interim Claim Payments
  - Year-End Cost Report Settlement
- Medi-Cal
  - Prospective (Managed-Care Contracts)
  - Supplemental Payments (AB Forms/IGT)
- Note: the State uses Medi-Cal cost report for DPNF prospective rates, and RHC rate setting.

14

14

Cost-Based Reimbursement

	Part A Cost	Part B Cost	RHC Cost	Part B MFFS	Total
Sample CAH (2010)	15,000,000	30,000,000	5,000,000	3,000,000	**53,000,000**
Sequestration	(300,000)	(600,000)	(100,000)	(60,000)	**(1,060,000)**
Bad Debt (from 100% to 65%)	(135,000)	(270,000)	(45,000)	-	**(450,000)**
Medicare Promoting Interoperability (quality)	(150,000)			(200,000)	**(350,000)**
RHC Caps			(125,000)		**(125,000)**
Sample CAH (Present Day)	**14,415,000**	**29,130,000**	**4,730,000**	**2,740,000**	**51,015,000**
Total Reduction	**(585,000)**	**(870,000)**	**(270,000)**	**(260,000)**	**(1,985,000)**

15

15

Cost-Based Reimbursement

Two primary types of hospital reimbursement Methodologies for Medicare:

- Prospective Payment System (PPS)
- Cost-based system . . . Which means reimbursing . . .

. . . ***Medicare allowable costs***

16

Cost-Based Reimbursement

General Medicare Critical Access Hospital ("CAH") payment overview:

Medicare reimbursement =
101% of Medicare **allowable** cost

Effective April 1, 2013, there is also a governmental budget sequestration adjustment of a 2% reduction in reimbursement after determining deductible and coinsurance amounts applicable to all Medicare claims.

17

Cost-Based Reimbursement

What is "allowable" cost?

- Necessary and proper in providing services
- Must be related to patient care (includes personnel costs, administrative costs, laundry, housekeeping, dietary, etc.)
- Adequate cost data and cost finding support
- Must be "reasonable"; i.e., must follow the "***prudent buyer***" principle

18

Cost-Based Reimbursement

What is the prudent buyer principle?

- The prudent and cost-conscious buyer not only refuses to pay more than the going (market) price for an item or service, he/she also seeks to economize by minimizing cost.
- This is especially so when the buyer is an institution or organization that makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases.
- Another way to minimize cost is to obtain free replacements or reduced charges under warranties for medical devices.
- Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.

19

Cost-Based Reimbursement

Computation of "allowable" costs:

- Allowable cost = Total expense *minus* costs not supported by Medicare *minus* cost offsets
  - Costs not supported by Medicare: Bad debt expense, some forms of advertising expense, etc.
  - Cost offsets: Investment income is offset against interest expense, cafeteria meals revenue is offset against dietary expense, etc.

20

Cost-Based Reimbursement

Allowable cost summary based on year-end 20XX, Medicare Cost Report – sample hospital:

Total Expenses			$ 46,000,000
Add:	Related-party add-on	$ 2,500,000	
Less:	Medicare nonallowable expenses:		
	Provider-based physicians	(2,400,000)	
	Investment income	(110,000)	
	Cafeteria	(165,000)	
	Unnecessary borrowing - Nonallowable interest expense	(500,000)	
	Electronic health record system depreciation	(175,000)	
	Other miscellaneous revenue	(250,000)	
	Subtotal		$ (1,000,000)
Allowable Expenses			$ 45,000,000
Less:	Noncost reimbursed expenses:		
	Nursing home and assisted living	(6,000,000)	
	Marketing	(800,000)	
	Specialty clinic	(1,200,000)	
	Subtotal		(8,000,000)
Total cost reimbursed expenses			**$37,000,000**

21

Cost-Based Reimbursement

CAH myths

- All allowable costs will get paid…
- All Medicare allowable costs for Medicare enrollees will get paid…
- We're a critical access hospital; therefore, we should *always* "break even"…

22

Cost-Based Reimbursement

CAH fact

You can't make a profit from Medicare.

23

24

Cost report layout

Worksheet number is at top right-hand corner of each worksheet.

Worksheet Series	
S	Settlement, organization, and patient statistical information
A	Expense assignment
B	Allocation of overhead costs
C	Patient care revenue and cost-to-charge ratio
D	Determination of Medicare's costs
E	Medicare settlement and payment information
G	Financial statements
H	Home health
I	Renal dialysis
K	Hospice
M	Rural Health Clinic

25

Basic CAH Medicare Cost Report mechanics

Worksheet S	Worksheet A	Worksheet B	Worksheet C	Worksheet D	Worksheet E
Informational questions	Expenses	Overhead expense allocation	Charges	Medicare/ Medicaid charges	Medicare/ Medicaid settlement
S, S-2, S-3, S-4, S-5, S-7, S-8, S-9, S-10	A, A-6, A-8, A-8-1, A-8-2, A-8-3	B Part I, B-1	C	D Part V, D-3, D-1 Parts I, II, III	E Part B, E-1, E-2 E-3 Part V
Hospital information, patient days, and other statistics	Costs reclassified, added, and subtracted	Overhead allocated to revenue-producing departments	÷ Dept. revenues = cost-to-charge ratios	X Dept. Medicare charges = Medicare cost	Compared to Medicare payments = Settlement

26

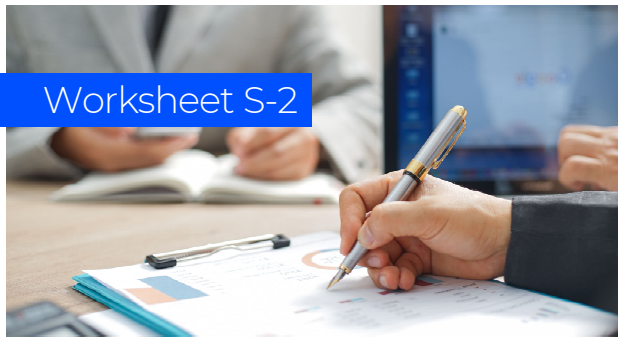
27

Worksheet S

- Cost report settlement worksheet
- Must be signed by officer/ administrator
- Title XVIII Part A and Part B are added together to determine total settlement receivable or payable
- HIT (Health Information Technology) column is informational and will be settled at a different time than the Medicare cost report

28

28



29

29

Worksheet S-2, Part I

- Series of informational questions that provide the cost report "reader" with a wealth of knowledge about the hospital.
  - Provider type and payment system
  - Debt and lease agreements
  - Provider-based physician services
  - Statistical basis
  - Contract therapy
  - Reimbursable bad debts
  - Provider summary report data
- Important to ensure all responses are accurate because they can directly impact the settlement (i.e., data may not flow to a worksheet if the response on worksheet S-2 is not accurate, which may directly impact the final cost report settlement).

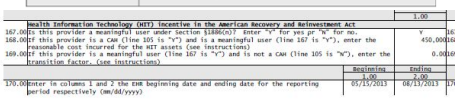
30

30

Worksheet S-2, Part I

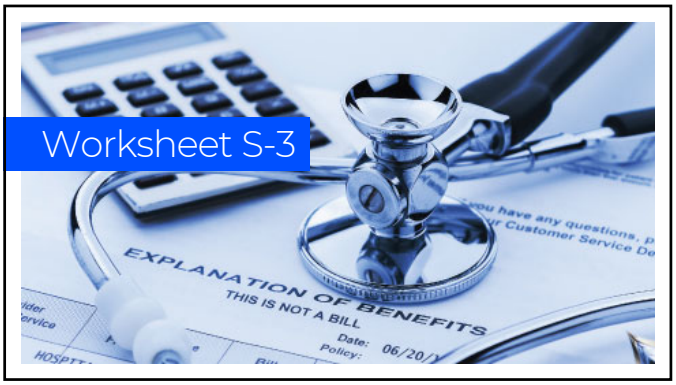
Key lines for CAHs include:

118	Malpractice policy type & amounts
140	Related-party activity
144	Provider-based physicians
146	Change in allocation method
167-170	HIT meaningful use



		1.00
	Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act	
167.00	Is this provider a meaningful user under Section 1886(n)? Enter "Y" for yes or "N" for no.	Y
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	450,000
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00
		Beginning / Ending
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/15/2013 08/13/2013

31



32

Worksheet S-3, Part I

Reporting of statistical data:

- Number of beds
- CAH hours for I/P care, excluding swing bed, nursing home, and observation
  - Critical data along with discharges used to calculate average length of stay for 96-hour rule compliance
  - Important to track hours and not merely use days times 24 hours
- Patient days
  - Report by payor type – Medicare and Medicaid
  - Report total days
- FTEs
- Discharges

33

Worksheet S-3, Part I

- Observation days (be sure to track where observation is occurring in the hospital and maintain logs)
- Discharges (no impact on settlement)

34

Worksheet S-3, Part I: Patient days and discharges

Assuming cost remains constant

↑ Patient days =	↓ Routine cost per day
↑ Patient days =	↓ Routine cost reimbursement per day
↑ Patient days =	↑↓ Profit per day on non-Medicare days (until reach "break-even" payor mix)

35

Other S worksheets

S-3, Part II-V	Wages and hours (CAHs generally exempt from reporting unless required by state Medicaid program)
S-4	Home health data
S-5	Renal dialysis data
S-7	SNF RUG data
S-8	RHC data
S-9	Hospice data
S-10	Hospital Uncompensated and Indigent Care Worksheet

36

37

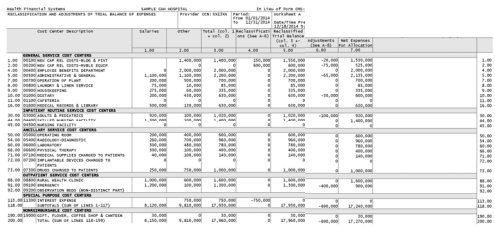
Worksheet A columns

Column 1	Salaries
Column 2	Other expenses
Column 4	Reclassifications flow from Worksheet A-6
Column 6	Adjustments flow from Worksheet A-8
Column 7	Net allowable costs (to Worksheet B)

38

38

Worksheet A lines



39

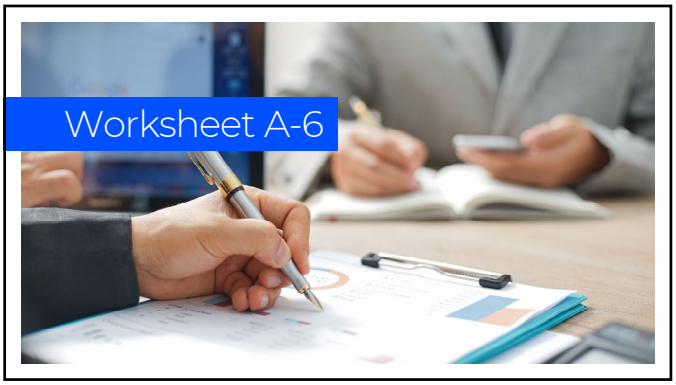
39

Worksheet A lines

Departments organized by:

- General service cost centers (Lines 1 to 23) – *Administration, plant, employee benefits, housekeeping, etc.*
- Inpatient routine service cost centers (Lines 30 to 46) – *Adults and pediatrics, SNFs, etc.*
- Ancillary service cost centers (Lines 50 to 76) – *Laboratory, radiology, pharmacy, etc.*
- Outpatient service cost centers (Lines 88 to 93) – *Provider-based clinics, emergency room (ER), observation*
- Other reimbursable cost centers (Lines 94 to 101) – *Dialysis, DME, ambulance, home health*
- Special purpose cost centers (Lines 105 to 117) – *ASC and hospice*
- Non-reimbursable cost centers (Lines 190 to 194) – *Gift shop, adult day care, medical office building, free standing clinic, research, etc.*

40



41

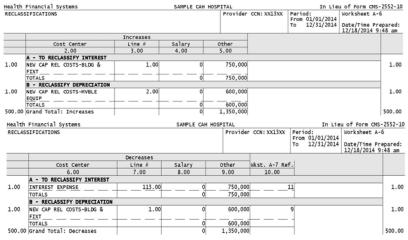
Worksheet A-6

- Worksheet A-6 – Provides opportunity to reclass expenses between cost centers/departments to provide for proper matching of expenses with revenue
- Could result in converting hospital expense groupings to Medicare groupings
- Common reclassifications:
  - Interest expense
  - Depreciation expense
  - Nursing salaries
  - Physician activities (i.e., benefits, rounding)

42

Worksheet A-6

- Try to keep number of reclassifications to a minimum



Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10
RECLASSIFICATIONS — Provider CCN: XXIIXX — Period: From 01/01/2014 To 12/31/2014 — Worksheet A-6 — Date/Time Prepared: 12/18/2014 9:48 am

Increases

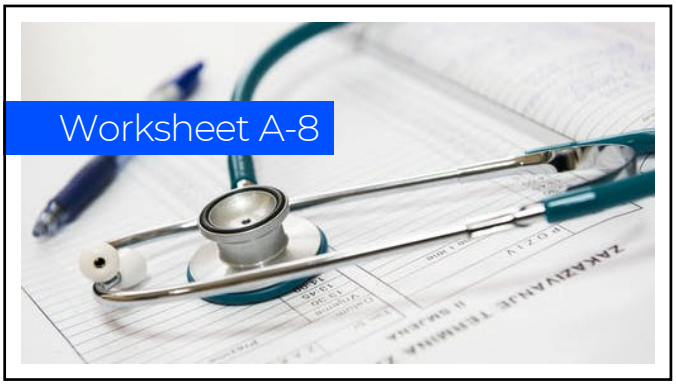
	Cost Center	Line #	Salary	Other	
	1.00	3.00	4.00	5.00	
	A - TO RECLASSIFY INTEREST				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	750,000	1.00
	TOTALS		0	750,000	
	B - RECLASSIFY DEPRECIATION				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	600,000	1.00
	TOTALS		0	600,000	
500.00	Grand Total: Increases		0	1,350,000	500.00

Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10
RECLASSIFICATIONS — Provider CCN: XXIIXX — Period: From 01/01/2014 To 12/31/2014 — Worksheet A-6 — Date/Time Prepared: 12/18/2014 9:48 am

Decreases

	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASSIFY INTEREST					
1.00	INTEREST EXPENSE	113.00	0	750,000	11	1.00
	TOTALS		0	750,000		
	B - RECLASSIFY DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	600,000	9	1.00
	TOTALS		0	600,000		
500.00	Grand Total: Decreases		0	1,350,000		500.00

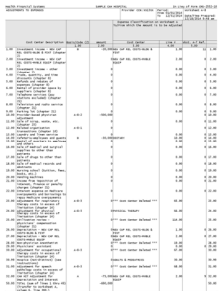
43



44

Worksheet A-8: Adjustments to expenses

- This worksheet provides for adjustments to remove unallowable expenses and offset nonpatient care revenue
- Adjustments increase or decrease reimbursable costs
- Medicare assumes that nonpatient service revenue is equal to the cost of the service provided
- Review all nonpatient income to determine if an offset to expense is required



45

Worksheet A-8: Adjustments

Potential A-8 revenue offsets:

- Realized investment income (funded depreciation)
- Cafeteria revenue
- Rebates
- Hospital assessments
- Medical record fees
- X-ray film revenue
- Miscellaneous income
- Donations received
- Revenue received for non-reimbursable cost centers
- Gain on disposal of fixed assets

Potential A-8 expense offsets:

- Interest expense (unnecessary borrowing)
- Refinancing costs
- Patient phones and cable TV
- Lobbying costs (portion of association dues)
- CRNA cost (unless exception to fee schedule)
- Hospital assessments
- Donations made to other organizations
- CAH HIT adjustment for depreciation and interest
- Advertising
- Losses on disposal of fixed assets

46

Worksheet A-8-1

47

Worksheet A-8-1: Related organizations

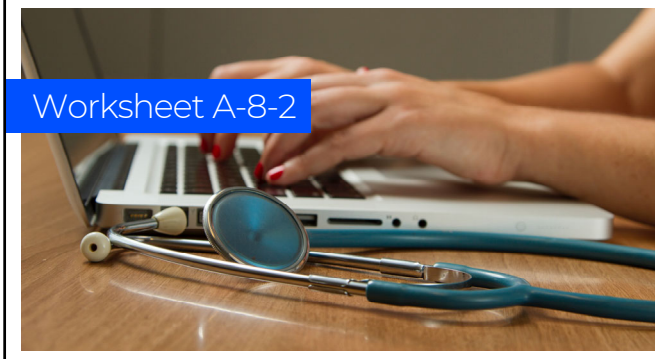
Related parties included on worksheet A-8-1 are organizations related to a hospital by common ownership or control.

The types of cost include:

- Services
- Facilities
- Supplies

The actual cost is reported on worksheet A-8-1.

48



49

Worksheet A-8-2: Physician cost

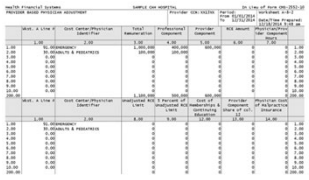
Worksheet A-8-2 calculates allowable provider-based physician costs.

- Total remuneration (salaries, certain benefits, contracted services) is split into two components:
  1. Professional component – services provided directly to patients
  2. Provider component – services provided to support patients such as availability/on-call, directorships, etc.

50

Worksheet A-8-2: Physician cost

- Report total remuneration (salaries, benefits*, contracted services) in column 3
- Report professional component in column 4
- Report provider administrative costs and ER availability in column 5



*Are certain benefits of employed physicians not required to be offset?

51

Worksheet A-8-2: ED availability requirements

- Emergency department (ED) logs or time study
- Contract language addressing non-patient-related time
- 30-minute physician response time to emergency departments (do not need to be on premises)

*Are certain benefits of employed physicians not required to be offset?

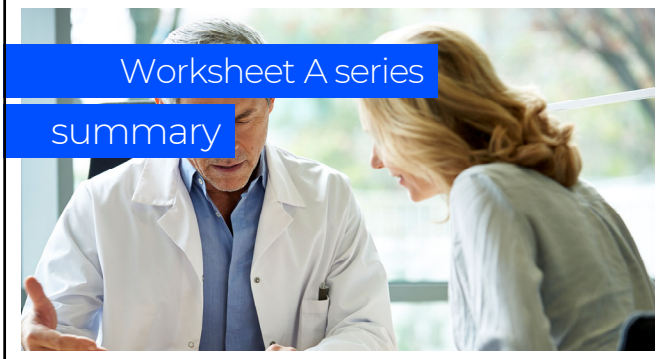
52

53

Worksheet A-8-3: Purchased PT, OT, ST, RT

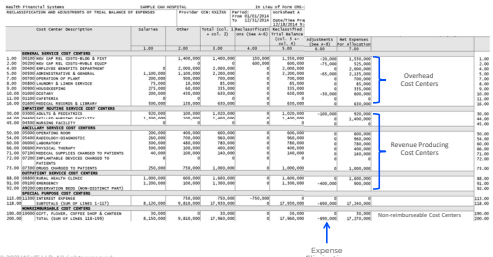
- Report only contracted PT, OT, ST, and RT
- Employed therapists are exempt from reasonable cost limits
- Reasonable cost is determined based on hourly limits and other factors
- Costs in excess of limits are eliminated on worksheet A-8

54



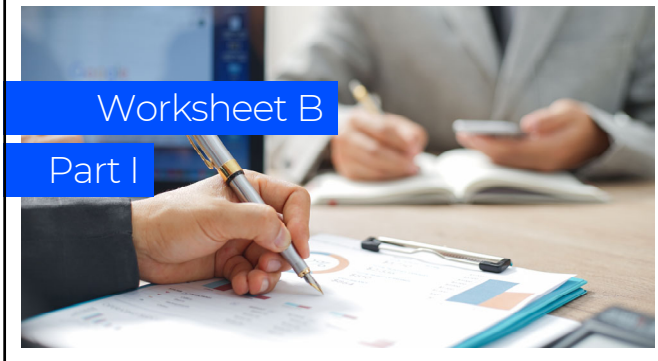
55

Worksheet A lines



56

56



57

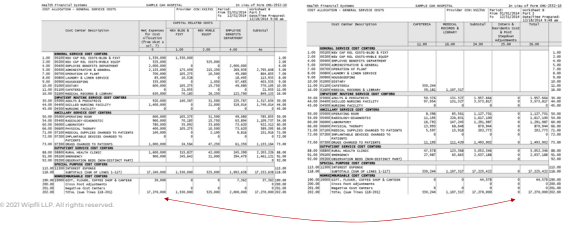
Worksheet B – Allocation of overhead costs

- Allocation of overhead costs to revenue-producing and non-reimbursable cost centers/departments using statistics.
- Costs cannot be allocated to an "earlier" cost center.
- The order of the allocation cannot be changed.
- Overhead departments include:
  - Capital-related costs – Depreciation and interest expense
  - Employee benefits
  - Administration and general
  - Plant and maintenance
  - Laundry
  - Housekeeping
  - Dietary
  - Cafeteria
  - Nurse administration
  - Medical records

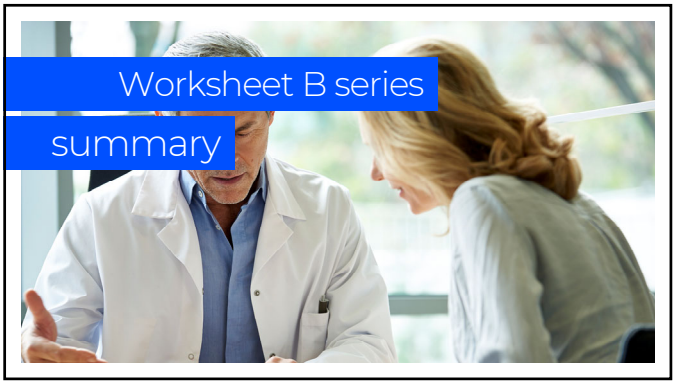
58

Worksheet B, Part I – Allocation of all costs

- Column 0 equals Worksheet A Column 7
- Column 26 equals Column 0 in total with no costs reported on Lines 1 through 23



59



60

Worksheet B, Part I – Fully allocated costs

Line #	Dept.	Wks A, Col 7	Allocations from general service cost centers	Total fully allocated costs. Wks B, Part I, Col 26	% of costs allocated
	General service cost centers				
1	New capital–bldg and fixt	1,530,000	(1,530,000)	-	
2	New capital–equip	520,000	(520,000)	-	
4	Employee benefits	2,000,000	(2,000,000)	-	
5	Administrative and general	2,134,555	(2,134,555)	-	
7	Operation of plant	7,000,000	(700,000)	-	
8	Laundry and linen service	85,000	(85,000)	-	
9	Housekeeping	335,000	(335,000)	-	
10	Dietary	600,000	(600,000)	-	
16	Medical records and library	630,000	(630,000)	-	
	Inpatient routine service cost centers				
30	Adults and pediatrics	920,000	1,037,700	1,957,700	53%
44	Skilled nursing facility	1,400,000	2,173,800	3,573,800	61%
	Ancillary service cost centers				
50	Operating room	600,000	527,700	1,127,700	47%
54	Radiology–diagnostic	960,000	657,100	1,617,100	41%
60	Laboratory	780,000	512,000	1,292,000	40%
66	Physical therapy	400,000	470,900	870,000	54%
71	Medical supplies charged to patients	140,000	62,800	202,800	31%
73	Drugs charged to patients	1,000,000	493,900	1,493,900	33%
	Outpatient service cost centers				
88	Rural health clinic	16,000,000	1,452,300	3,052,300	48%
91	Emergency	900,000	1,137,200	2,037,200	56%
	Nonreimbursable cost centers				
	Subtotal	17,340,000	(14,600)	17,225,400	
190	Gift, flower, coffee shop and canteen	30,000	14,600	44,600	33%
	Total	17,270,000	-	17,270,000	

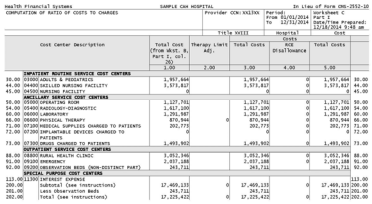
61

62

Worksheet C – Cost-to-charge ratio

Worksheet C reports gross patient service revenue by cost center/department:

- Cost-to-charge ratio is calculated
- Cost-to-charge ratio used for ancillary reimbursement
- Key concept: Matching of revenue and expenses



Health Financial Systems — SAMPLE CAH HOSPITAL — In lieu of Form CMS-2552-10

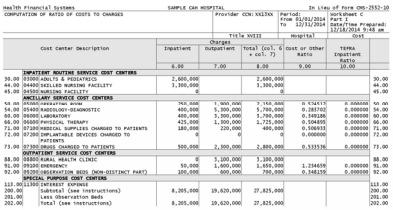
COMPUTATION OF RATIO OF COSTS TO CHARGES — Provider CCN: XX1XXX — Period: From 01/01/2014 To 12/31/2014 — Worksheet C Part I — Date/Time Prepared: 12/16/2014 9:46 am

Cost Center Description	Title XVIII Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII Total Costs	Hospital Costs RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,957,644		1,957,644	0	1,957,644	30.00
44.00 04400 SKILLED NURSING FACILITY	3,573,817		3,573,817	0	3,573,817	44.00
45.00 04500 NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,127,741		1,127,741	0	1,127,741	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,617,100		1,617,100	0	1,617,100	54.00
60.00 06000 LABORATORY	1,291,587		1,291,587	0	1,291,587	60.00
66.00 06600 PHYSICAL THERAPY	870,944	0	870,944	0	870,944	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	202,773		202,773	0	202,773	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,493,902		1,493,902	0	1,493,902	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	3,052,346		3,052,346	0	3,052,346	88.00
91.00 09100 EMERGENCY	2,037,188		2,037,188	0	2,037,188	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	343,711		343,711		343,711	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 LIMITED CARE EXPENSE						113.00
200.00	Subtotal (see instructions)	17,469,133	0	17,469,133	0	17,469,133	200.00
201.00	Less Observation Beds	243,711		243,711		243,711	201.00
202.00	Total (see instructions)	17,225,422	0	17,225,422	0	17,225,422	202.00

63

Worksheet C – Cost-to-charge ratio

- Column 6 and 7 equal the hospital's inpatient and outpatient service revenue per the general ledger, less any revenue billed for professional services
- Column 8 total must be reconciled to internal or audited financial statements
- Cost-to-charge ratios are computed for ancillary departments (Column 9)



Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES — Provider CCN: XX1TXX — Period: From 01/01/2014 To 12/31/2014 — Worksheet C Part I — Date/Time Prepared: 12/16/2016 9:58 am

Title XVIII — Hospital

	Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTING SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,600,000		2,600,000			30.00
44.00	04400 SKILLED NURSING FACILITY	1,300,000		1,300,000			44.00
45.00	04500 NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 ANESTHESIOLOGY	740,000	1,900,000	2,640,000	0.674417	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	400,000	5,300,000	5,700,000	0.287302	0.000000	54.00
60.00	06000 LABORATORY	400,000	3,300,000	3,700,000	0.540186	0.000000	60.00
66.00	06600 RESPIRATORY THERAPY	425,000	1,300,000	1,725,000	0.594695	0.000000	66.00
72.00	07200 MEDICAL SUPPLIES CHARGED TO PATIENTS	180,000	220,000	400,000	0.550000	0.000000	72.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	900,000	2,900,000	2,800,000	0.535536	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	3,100,000	3,100,000			88.00
91.00	09100 EMERGENCY	50,000	1,600,000	1,650,000	1.234659	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,000	600,000	700,000	0.348195	0.000000	92.00
	OTHER REIMBURSEMENT COSTING						
113.00	11300 LAUNDRY EXPENSE						113.00
200.00	Subtotal (see instructions)	8,205,000	19,620,000	27,825,000			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,205,000	19,620,000	27,825,000			202.00

64

Worksheet D and E

65

Worksheet D series – Determines Medicare's costs

- Worksheet D Series calculates Medicare's cost for services provided to Medicare patients
- Applies cost-to-charge ratio by department from Worksheet C to Medicare charges to estimate the Medicare cost
- Medicare patient days, charges, payments, and other processed claims information are provided by Medicare on the provider statistical and reimbursement (PS&R) report
- Group PS&R revenue by revenue code to match cost centers where related revenue and expenses recognized on Worksheet A series and Worksheet C series

66

Medicare PS&R

- Suggestions for running PS&R:
  - Attempt to run reports well in advance (at least 45 days) to ensure you can access data needed for your cost report
  - For cost report PS&R, we suggest you use a paid-through date that is as close as possible to the due date of your cost report (be sure to review that claim billing is not behind or the final settlement could change significantly)
  - Passwords in the online PS&R system expire every 60 days

67

Medicare PS&R

Cost report worksheet	Related PS&R schedule
	Statistical data
S-3	Reports 110, 118, 180, 210, 399, 710
	Charges
D-3 Hospital	Report 110 – Inpatient Part A (charges)
D-3 SNF	Report 210 – SNF - Inpatient Part A (charges)
D-3 S/B SNF	Report 180 – Swing bed SNF (charges)
D Part V	Report 850 – Outpatient (charges)
S-4	Report 399 – Home health

68

Medicare PS&R

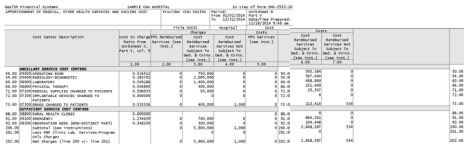
Cost report worksheet	Related PS&R schedule
	Payments
E-1, Hospital, Col 2	Report 110 – Inpatient Part A (net reimbursement)
E-1, Hospital, Col 4	Report 850 – Outpatient (net reimbursement)
E-1, SNF, Col 2	Report 210 – Inpatient Part A (net reimbursement)
E-1, S/B - SNF, Col 2	Report 180 – Swing bed SNF (net reimbursement)
M-5	Report 710 – Rural health clinic (net reimbursement)
H-4	Report 399 – Home health

69

Worksheet D, Part V (outpatient)
Worksheet D-3 (Inpatient, SNF, swing bed)

Ancillary Hospital Costs Allocated to Medicare Services

- Cost-to-charge ratio from Worksheet C
- Outpatient Medicare charges from PS&R
- Ratio times charge equals Medicare cost



Overall Cost-to-charge ratio: 47.6%
2,808,587 / 5,900,000 before 101%

70

70

Worksheet D-1, hospital

$1,957,664 (1) less NF SB Cost of $12,400 = $1,945,264 / (2,275 I/P days – 80 NF SB days) = $886.23 (A)

SNF SB 720 days x $886.23 = $638,085 (B)

NF SB: 80 days x $155 = $12,400 (B)

$650,486 Sum (B)'s = Total SB cost

(1) I/P routine allowable costs, Wks B, Part 1, Col 26

(B)'s

(A)

Worksheet D-1 Medicare Line 38, Inpatient Routine Service Cost Per Diem

71

71

Worksheet E Series – Medicare settlements

Medicare settlements:

101% of costs (routine and ancillary)

Less:

- Deductible
- Coinsurance

Plus + Medicare bad debts

Less – sequestration adjustment (2% of 101% of cost less deductible and coinsurance lines)

= Total Medicare reimbursable cost

Less – payments received from Medicare (Worksheet E-1)

= Medicare settlement

72

72

Medicare bad debts

Bad debts are allowable if:

- Amount pertains to uncollectible Medicare deductible and coinsurance amounts
- Does not relate to physician professional services
- Only for traditional Medicare bad debts (do not include Medicare HMO beneficiaries)
- Unless patient has been determined to be indigent, write-off should not be less than 120 days after first billing to beneficiary
- Amount written off within cost reporting period and considered worthless when returned from collection agency (if sent to a collection agency)
- Collection efforts must be the same for all payor types
- Any recoveries of bad debts claimed in prior years are offset against amounts claimed in current year

73

Medicare bad debts

May be claimed without collection effort if:

- Medicare/Medicaid crossover claim, except Medicare has a must bill policy – Therefore, if you claim a Medicare bad debt, it must be billed to the State even if you know it will not be paid
- Indigent patients with supporting proof of indigence
- Bankrupt patients with supporting proof of bankruptcy

Bad debts currently reimbursed at 65% of allowable cost

74

Medicare bad debts

Documentation required to support claimed amounts may include:

- Medicare remittance advice
- Medicaid remittance advice
- Supplementary insurance remittance advice
- Copy of UB
- Patient history information
- Copies of bills sent to patients
- Documentation supporting collection efforts (i.e., considered worthless when returned from collection agency)
- Electronic listing of bad debts claimed that includes patient name, Medicare number, dates of service, indigence, write-off date, amounts, etc.

75

Worksheet G

Financial Statements

G	Balance sheet
G-1	Fund balance
G-2	Patient revenues
G-3	Revenue and expense

76

77

Service Line Analysis

Who uses the cost report:

- Medicare
  - Settlement
  - Rate adjustments and interim rate setting
- Medi-Cal/Managed Care
  - Prospective rate setting (DPNF/Initial RHC rate)
  - Supplemental Reimbursement (AB forms/IGT)
  - Managed care rate setting (RHC Reconciliation)
  - OSHPD Report
- Private Insurance Companies
  - Payment structure
    - Percentage of charges
    - Fee schedule

78

Service Line Analysis

Who uses the cost report (continued)

- Your Facility – Some possible uses:
  - Monthly contractual adjustment
  - Service line analysis
  - Budgeting
  - Rate or price setting
  - Contract negotiations
- Other Organizations
  - OIG
  - State and regional health care groups
  - Financial indicators/benchmarks

79

79

Service Line Analysis

The modern Critical Access Hospital (CAH) in most cases provides not only basic hospital and health care services but also provides a wide variety of extended health care services and community-based services.

In order to provide these additional services as well as to remain profitable to provide these services into the future, a CAH is constantly evaluating these services in a variety of methods. These services can also have a significant impact on the Medicare reimbursement that a CAH receives as many of the services are "non-hospital" services and not considered a reimbursable service by the Medicare program.

We took a sample poll of 10 CAHs and reviewed a variety of services provided by various CAHs on the following page to demonstrate traditional and non-traditional service offerings.

80

80

Service Line Analysis

Hospital	OPU	SNF	SNF Bed Size	HHA	Hospice	PB Clinics	RHCs	Other Clinics	Dialysis	Other
A	Yes (Psych)	Yes	86	No	Yes (opened in prior year)	No	No	No	No	Joint ownership of CBRF & AL
B	No	Yes	44	Yes	Yes	Yes - 2	No	Yes - 2	Yes (opened in prior year)	Assisted living and DME
C	No	Yes	57	No	No	Yes - 1	No	No	No	Assisted living, adult day care, fitness center
D	No (closed psych in prior year)	No	closed NH in prior year	No	No	Yes - 3	No	No	No	Senior meal site
E	No	No	N/A	No	No	No	Yes - 4	No	No	3 retail pharmacies and fitness center
F	No	Yes	50 (downsized from 68 beds in PY) (only 4 beds T18 certified)	No	No	No	No	No	No	Assisted living
G	No	No	N/A	No	No	No	Yes - 1	Yes - 1	No	Partnership for HHA and hospice
H	No	No	Spun off NH in 2006 to separate corporation	No	No	No	No	No	No	Meal service to NH
I	No	No	N/A	No	No	No	Yes - 2	No	No	Child day care center
J	Yes (Psych)	Yes	50	No	No	No	No	No	Yes (opened in prior year)	Ambulance service
K	No (closed psych in prior year)	No	Sold nursing home in prior year	No	No	Yes - 1	Yes - 2	No	No	
L	No	No	Leased nursing home in prior year	No	No	Yes - 1	No	Yes - 1	No	Fitness Center
M	No	Yes	50	No	No	No	Yes - 1	No	No	
N	No	No	N/A	Yes (opened in 2007)	Yes	No	No	No	No	Meals on wheels, jail meals, supportive home care
O	No	No	Sold nursing home in prior year	Yes	No	No	Yes - 3	No	No	CBRF
P	Yes (Psych) (opened psych in prior year)	No	N/A	No	No	Yes - 1	Yes - 1	No	No	Fitness center, senior housing

81

81

Service Line Analysis

Direct Reimbursement Impact Examples:

- Medical Services which are able to be billed to the Medicare Program
- Higher Utilization of Medicare Patients due to Mix of Service Offerings

Indirect Reimbursement Impact Examples:

- Allocation of Overhead to "Non-Reimbursable" Service Lines or Cost Centers
- Non-Allowable Expenses to Promote or Operate Non-Medical Services

82

82

Service Line Analysis

In reviewing additional service line options, have we considered "Mission" vs. "Margin"?

83

83

Service Line Analysis

Sample Margin Services	Sample Mission Services
Orthopedic surgery	Meals on Wheels services
General surgery	Laundry services
Radiation therapy	Maintenance services
Retail pharmacy*	Community education sessions
Skilled nursing facility (SNF)	*SNF*
Assisted living facility (AL)	*AL*
Eye clinics	Dialysis centers
Laboratory	Home Health Agency
Radiology	Hospice

* With the expansion of Section 340B Drug Pricing Program, many hospitals' retail pharmacy operations have become profitable.

84

84

Service Line Analysis

In today's CAHs, there are many service lines that do not generate a profit but are essential for support and development of the "margin" service lines. Several examples include:

- Primary care clinics (including provider-based and provider-based rural health clinics (RHCs))
- Emergency department (ED)
- Urgent care

On the previous slide, why was the SNF and AL in both the mission and margin column? Could this also be considered a supporting service of the hospital?

85

85

How can we use the Medicare cost report to analyze the profitability of our hospital departments and other payors?

86

86

Service Line Analysis

On an "allowable cost" basis, the Medicare cost report computes an average cost per day for routine inpatient care. This information can be used for year-end price setting, comparisons to other facilities, profitability review, as well as a variety of other reviews.

In order to review this information, we should consider:

Inpatient routine cost per day < = > Net charge received per day

General definitions of "allowable cost" equal total expense minus costs not supported by Medicare.

87

87

Service Line Analysis

Can the cost report be used to do

a high-level profitability review?

YES

88

88

Service Line Analysis

Sample Routine Cost-Per-Day Calculation Using the Medicare Cost Report:

WS B, Part I, Col. 26, Line 30 (total acute care cost)	$	1,959,185	Wkst D-1, Part I, line 21
Less: Swing bed NF (NF days x state rate (20 days x $155/day))		3,100	Wkst D-1, Part I, lines 24 & 25
= Acute care costs for per diem		1,956,085	
÷ Number of acute care days (Acute care, swing bed-SNF, & observation equivalent days)		2,200	Wkst D-1, Part I, line 1 less lines 7-8
= Routine service cost per diem	$	889.13	Wkst D-1, Part II, line 38

Based on the "allowable costs" in the cost report, our sample hospital would expect that on average it costs $889.13 per inpatient day to care for patients in the inpatient unit, excluding ancillary services.

89

89

Service Line Analysis

How do we determine if we are charging enough for routine inpatient care?

We should consider the following:

- Days by payor
- Expected payment received by payor
- Efficiency and potential expense changes in the future
- Potential changes in average daily census or patient volumes
- Do we have a profit on ancillary services supporting inpatient services such as surgical services?

90

90

Service Line Analysis

Review of Payor Mix and Reimbursement Expected per Payor for Routine Care:

Days by Payor:	Medicare	Medicaid	Other Payors	Total
Adults and Peds Days per S-3, Part I line 1	1,432	285	483	2,200
x Routine Average Cost Per Day (previously calculated)	$ 889.13	$ 889.13	$ 889.13	$ 889.13
Average Annual Routine Costs by Payor	$ 1,273,234	$ 253,402	$ 429,450	$ 1,956,086
Routine Charges:				
Average Room Charge per Day	$ 850.00	$ 850.00	$ 850.00	$ 850.00
Gross Annual Charges by Payor	$ 1,217,200	$ 242,250	$ 410,550	$ 1,870,000

Reimbursement Rate Sample	"Allowable" Cost per Day	Average DRG Pmt	10% Discount on Billed Charges	
Contractual Adjustment (Premium or (Discount))	$ 43,047.17	$ (72,675)	$ (41,055)	$ (70,683)
Net Annual Revenue by Payor	$ 1,260,247	$ 169,575	$ 369,495	$ 1,799,317
Profit (Loss) for Routine Services	$ (12,987)	$ (83,827)	$ (59,955)	$ (156,769)

(includes sequestration)

91

91

Service Line Analysis

What are the concerning outcomes of the routine charges and costs comparison?

Average charge per day: $850.00 per inpatient day
Discount per day: Varies by payor
Average cost per day: $889.13

What can be done in this situation?

- Review of patient room charge? Consider payor contracts, patient experience, price in the market/region, etc.
- Review of contract terms with payors? This may be the most difficult to negotiate with many different insurance payors or networks.
- How do we expect patient volumes or costs to change in the next year?
- What hospital services are supplementing/supporting inpatient care?

92

92

Service Line Analysis

Why is the swing bed program important to inpatient care?

- Medicare program reimburses "SNF level care" through the swing bed program on the "allowable cost" method.
- A robust swing bed or "transitional care" program can include swing bed nursing facility (NF) days.

What are swing bed NF Days?

- Defined per federal register 42 CFR 413.53(a)(2) as:
  - NF-type services, formerly known as ICF and SNF-type services, are routine services furnished by a swing bed hospital to Medicaid and other non-Medicare patients.

93

93

Service Line Analysis

How do we treat NF days on the Medicare cost report?

- NF days are carved out at a "state rate" per day, which is in most cases significantly lower and shifts costs back to the Medicare reimbursable costs of adults and pediatrics and swing bed NF costs.

Who benefits from swing bed NF care:

- Patients who are nontraditional skilled nursing or rehabilitation patients.
- CAHs providing services due to the cost calculation on the cost report.

Swing bed NF care is a "Win Win!"

94

94

Service Line Analysis

What modern service of a CAH that is growing by leaps and bounds also impacts our consideration of costs and ability to care for patients in the inpatient unit?

- Hospitalist program

How are hospitalist services reimbursed?

- Most often, hospitalist services are reimbursed on a fee-based methodology similar to professional services from Medicare, Medicaid, and many commercial insurance health plans.

When considering its charge structure for inpatient rooms, does a hospital need to consider the hospitalist program?

95

95

Service Line Analysis

What additional data is found on the cost report that can be used to evaluate other hospital departments:

Cost-to-Charge Ratios

What is a "cost-to-charge" ratio?

$$\frac{\text{Direct Costs per Department (excluding professional costs)} \pm \text{Reclassifications and Adjustments} + \text{Allocated Overhead Costs}}{\text{Gross Hospital Charges per Department (excluding professional charges)}} = \text{Cost-to-Charge Ratio}$$

Where can cost-to-charge ratios be found?

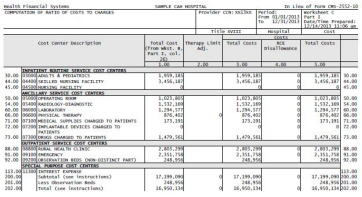
- Medicare cost report: Worksheet C, Part I, Column 9

96

96

Service Line Analysis

Worksheet C of the Medicare cost report shows gross patient service revenue and calculates the cost-to-charge ratio by department.



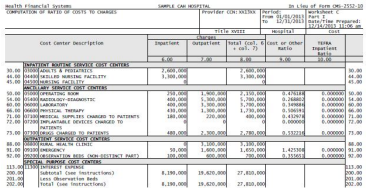
Column 1 equals cost from Worksheet B, Part 1, Column 26.

97

97

Service Line Analysis

Below is a sample of Page 2 of Worksheet C, Part I, showing the gross charges and calculated cost-to-charge ratios from a sample Medicare cost report.



How can we use the cost-to-charge ratios in Column 9?

98

98

Service Line Analysis

Comparison of three sample CAHs cost-to-charge ratios by selected departments:

Cost Centers	Sample CAH 1 CCRs	Sample CAH 2 CCRs	Sample CAH 3 CCRs
Operating room	0.350409	0.818695	0.982771
Radiology-diagnostic	0.164251	0.412490	0.652277
Laboratory	0.181033	0.344558	0.452772
Respiratory therapy	0.631174	0.215670	0.721440
Physical therapy	0.323562	0.925510	1.322770
Occupational therapy	0.267368	0.994645	1.415288
Speech pathology	0.383660	1.150835	1.218436
Electrocardiology	0.113512	0.352114	0.432185
Medical supplies charged	0.270247	0.917240	0.982441
Implantable supplies and devices	0.897038	0.852223	0.931940
Drugs charged to patients	0.391307	0.522381	0.512851
Cardiac rehab	0.541354	0.942237	1.425887
Chemotherapy	0.414898	0.741253	0.882443
Provider-based clinic	0.952500	1.851178	2.057281
Emergency	0.303709	1.316193	1.851170
Observation beds	0.924776	1.584567	2.145887

What observations can be made?

How can we use this information? Next step . . . additional analysis?

99

99

Service Line Analysis

What are some points to consider from the cost-to-charge ratio reviews?

- Are the cost allocations in the cost report up-to-date and accurate?
- What are the business plans in the future for the CAH?
- If no immediate changes in operations, costs, or revenue are planned, what departments should we focus on if all we have for information is the cost-to-charge ratios of the ancillary departments?
- Next steps to consider:
  - High cost-to-charge ratio departments
  - How do the cost-to-charge ratios compare to the prior year ratios?
  - Payor mix of high cost-to-charge ratio departments

100

100

Service Line Analysis

Using the cost-to-charge ratios from the three sample CAHs, how can we determine if we have any issues?

- We should consider what the payor and service mix is of the CAH and at the department level.
- Important to remember the concept of "net" patient service revenue:

Gross Patient Service Revenue	-	Contractual Adjustments ("Discounts")	=	Net Patient Service Revenue

101

101

Service Line Analysis

How are we reimbursed by payor for most hospital services?

- Medicare: "Allowable cost"
- Medicaid: "Allowable cost" or other state-specific method
- Commercial Insurance Plans: Negotiated discount or rate
- Private Pay: Self-pay discount or limited payments (i.e., charity or bad debt)

102

102

Service Line Analysis

Since Medicare, Medicaid, and private pay are determined primarily on methods that are out of the control of an average CAH, commercial insurance plans and profitability on commercial health plans have become an increasingly important area of focus due to cutbacks on payments from Medicare and Medicaid in particular.

Examples of these cut-backs include Medicaid plans paying below cost, assessments to hospitals for state Medicaid plans, Medicare sequestration, etc.

How does a CAH consider the profitability of commercial health plans?

103

103

Service Line Analysis

Example profitability review by payor using net patient service revenue and cost-to-charge ratios at a high level:

	Sample CAH 1	Sample CAH 2	Sample CAH 3
Average commercial insurance discount rate	50%	25%	10%
Average percentage of business for CAH from commercial insurance plans	40%	30%	20%

Which of the sample hospitals above would we consider to be the most profitable on average in ancillary departments from commercial health plans?

104

104

Service Line Analysis

Sample CAH #1:

	Sample CAH #1 Calculations Related to Commercial Insurance Plans			
Cost Centers	Cost-to-Charge Ratios	Estimated Costs*	Net Revenue	Estimated Profit (Loss)
Operating room	0.350409	$1,967,544	$2,807,494	$839,950
Radiology-diagnostic	0.164251	2,174,901	6,620,650	4,445,749
Laboratory	0.181033	1,559,607	4,307,518	2,747,911
Respiratory therapy	0.631174	415,781	329,371	(86,410)
Physical therapy	0.325362	1,248,791	1,919,080	670,290
Occupational therapy	0.267368	434,791	813,094	378,303
Speech pathology	0.383660	165,130	215,203	50,073
Electrocardiology	0.113512	54,667	240,800	186,133
Medical supplies charged	0.270247	692,556	1,281,340	588,784
Implantable supplies and devices	0.897039	1,164,092	648,853	(515,239)
Drugs charged to patients	0.391307	1,884,662	2,408,160	523,498
Cardiac rehab	0.541354	105,108	97,079	(8,029)
Chemotherapy	0.414898	164,934	156,741	(8,193)
Provider-based clinic	0.952500	1,300,710	682,787	(617,922)
Emergency	0.303709	1,924,832	3,168,876	1,244,044
Observation beds	0.924776	648,436	350,591	(297,845)
				$10,141,095
Average discount rate			50%	
Amount of business related to commercial insurance plans		40%	40%	

* Based on Medicare "allowable costs." Actual costs would generally be greater than Medicare "allowable costs."

105

105

Service Line Analysis

Sample CAH #2:

Cost Centers	Sample CAH 2 Calculations Related to Commercial Insurance Plans Cost-to-Charge Ratios	Estimated Costs*	Net Revenue	Estimated Profit (Loss)
Operating room	0.818695	$572,289	$524,269	($48,020)
Radiology-diagnostic	0.412490	474,167	862,143	387,976
Laboratory	0.344558	461,464	1,004,470	543,006
Respiratory therapy	0.215670	35,817	124,554	88,737
Physical therapy	0.925510	576,557	467,221	(109,336)
Occupational therapy	0.994645	127,610	96,223	(31,387)
Speech pathology	1.150835	64,400	41,969	(22,430)
Electrocardiology	0.352114	3,679	7,836	4,157
Medical supplies charged	0.917240	157,250	128,578	(28,671)
Implantable supplies and devices	0.852223	147,337	129,664	(17,673)
Drugs charged to patients	0.522381	323,642	464,663	141,022
Cardiac rehab	0.942237	37,786	30,077	(7,709)
Chemotherapy	0.741253	36,316	36,745	429
Provider-based clinic	1.851178	172,811	70,014	(102,797)
Emergency	1.316193	646,734	368,525	(278,209)
Observation beds	1.584567	95,531	45,216	(50,314)
				$468,780
Average discount rate			25%	
Amount of business related to commercial insurance plans		30%	30%	

* Based on Medicare "allowable costs." Actual costs would generally be greater than Medicare "allowable costs."

106

106

Service Line Analysis

Sample CAH #3:

Cost Centers	Sample CAH #3 Calculations Related to Commercial Insurance Plans Cost-to-Charge Ratios	Estimated Costs*	Net Revenue	Estimated Profit (Loss)
Operating room	0.982771	$234,030	$214,319	($19,710)
Radiology-diagnostic	0.652277	381,748	526,728	144,981
Laboratory	0.452772	211,871	421,148	209,277
Respiratory therapy	0.721440	11,119	13,871	2,752
Physical therapy	1.322770	365,080	248,397	(116,683)
Occupational therapy	1.415288	26,563	16,892	(9,671)
Speech pathology	1.218436	7,584	5,602	(1,982)
Electrocardiology	0.432185	16,483	34,325	17,842
Medical supplies charged	0.982441	69,440	63,613	(5,827)
Implantable supplies and devices	0.931940	23,645	22,835	(810)
Drugs charged to patients	0.512851	89,280	156,678	67,397
Cardiac rehab	1.425887	16,423	10,366	(6,057)
Chemotherapy	0.882443	28,533	29,101	568
Provider-based clinic	2.057281	564,724	247,050	(317,674)
Emergency	1.851170	496,077	241,182	(254,895)
Observation beds	2.145887	41,402	17,364	(24,038)
				($314,531)
Average Discount Rate			10%	
Amount of Business Related to Commercial Insurance Plans		20%	20%	

* Based on Medicare "allowable costs." Actual costs would generally be greater than Medicare "allowable costs."

107

107

Service Line Analysis

- What are some observations from profitability by payor review?
- High-level review – There may be reimbursement differences by commercial insurance contract by department or procedures:
  - Are there areas where the sample CAHs should look to increase or decrease services?
  - Are there opportunities to review insurance contracts and renegotiate rates?
- What can also be observed for Medicare reimbursement based on the higher cost-to-charge ratios?
- What departments or areas should be reviewed based on this?
  - General charge and reimbursement structure
  - Overhead allocations
  - Expense optimization on the Medicare cost report. Consider a review of expenses by payor. Who is really using overhead or support departments?

108

108

CAH Reimbursement "Tool" for Decision Making

Know What Portion of Each Department is Cost-Based Reimbursed

CAH Tool?

109

109

CAH Reimbursement "Tool" for Decision Making

THE TOOL	Medicare Medicaid	Cost-Based
Department	Utilization	Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

110

110

CAH Reimbursement "Tool" for Decision Making

- Where would you want to expense the EHR expense that was not eligible for the incentive payment?
- Capital reimbursement is 40%.
- Medical Records is 60%.

THE TOOL	Medicare Medicaid	Cost-Based
Department	Utilization	Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

111

111

CAH Reimbursement "Tool" for Decision Making

- Where would you want to expense new patient beds?
- Adults and Peds = 75%
- ICU = 90%

THE TOOL Department	Medicare Medicaid Utilization	Cost-Based Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

112

112

CAH Reimbursement "Tool" for Decision Making

- Where would you want to expense new patient monitors?
- Adults and Peds = 75%
- ER = 25%

THE TOOL Department	Medicare Medicaid Utilization	Cost-Based Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

113

113

CAH Reimbursement "Tool" for Decision Making

- Given the option, where would you want to expense any new purchases?
- Adults and Peds/ICU = 75%-90%
- Majority of all other cost centers < Adults and Ped/ICU%

THE TOOL Department	Medicare Medicaid Utilization	Cost-Based Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

114

114

Questions?

115

116