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Critical Access Hospitals
Basics of Cost-Based Reimbursement

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Basics of Cost-Based Reimbursement for Critical Access Hospitals (CAHs)

Objective of the discussion: To gain a high-level understanding of cost-based reimbursement for CAHs and it's impact on financial reporting

Discussion agenda:

- Provide understanding of differences in Medicare hospital reimbursement methods
- Understand how CAHs get paid - (Interim rates vs. final settlement)
- Understand the impact of cost-based reimbursement on financial statement reporting

Medicare Overview

Medicare reimbursement depends on the services provided:

Inpatient and swing bed services:

- Based on 101% of average cost per day for inpatient services (as computed in the Medicare cost report):
  - Paid on an interim basis using a per diem rate for routine and ancillary costs
  - Final settlement for each fiscal year is based on the filed Medicare cost report after the intermediary completes their audit

Medicare Overview

Outpatient (OP) services:

- Based on 101% of cost to provide services to Medicare patients (as computed in the Medicare cost report):
  - Paid on an interim basis using a percentage of Medicare charges
    - Percentage calculated by dividing the overall allowable Medicare costs by the overall Medicare charges, Medicare cost-to-charge ratio
  - Final settlement for each fiscal year is based on the filed Medicare cost report after the intermediary completes their audit

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Medicare Overview

Services often tied to a CAH that are not cost-based reimbursed:

- Freestanding clinics
- Professional component physician and non-physician practitioners
- Hospital-based home health agencies
- Hospital-based skilled nursing facility
- Ambulance services (if not the only local provider)
- Distinct part psych and rehab units
- Reference lab

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Summary of Differences Between Prospective Payment (PPS) Hospital vs. CAH Reimbursement

Type of Service	PPS Hospital	CAH
Inpatient	DRG	101% x Cost
OP procedures (Surgery, etc.)	APC	101% x Cost
Lab	Fee schedule	101% x Cost (Except for reference lab)
Radiology	APC	101% x Cost
Other diagnostics	APC	101% x Cost
Therapies	Fee schedule	101% x Cost
Swing bed	MDS	101% x Cost
Ambulance service	Fee schedule	Fee schedule (Unless only one within 35 miles, then cost)
OP clinics (Facility component)	APC	101% x Cost

PPS vs. CAH Reimbursement

Type of Service	PPS Hospital	CAH
OP clinics (Professional component)	Fee schedule (Reduced for site of service)	Fee schedule (reduced SOS) and Method II Billing (if elected)
CRNA services	Fee schedule (Unless elect cost if less than 800 procedures per year)	Fee schedule and Method II Billing (if elected) OR elect cost if less than 800 procedures per year
Outlier payments	Cost (Generally insignificant for rural providers)	N/A
Disproportionate Share Hospital (DSH)	Add-on to DRG payments	N/A

PPS vs. CAH Reimbursement

Type of Service	PPS Hospital	CAH
Indirect medical education (IME)	Add-on to DRG payment	N/A
72-hour rule (DRG window)	Applies	N/A
Exempt units	Rehab units Psychiatric units	Limited to 10 exempt unit beds
Hold harmless provisions (For rural hospitals with fewer than 100 beds and Sole Community Hospitals (SCH)/Essential Access Community Hospitals (EACH))	Applied through December 31, 2012	N/A
Sequestration in effect reducing Medicare payments by 2% through 2025	Applies	Applies

Overview of the Medicare Cost Report

- Medicare (and many Medicaid programs) – CAH services are reimbursed based on cost as computed on the cost report
- The cost report is a systematic method of cost accounting determining allowable cost
- Requires a settlement process at the end of each entity's fiscal year that reconciles cost of providing Medicare services to interim payments made throughout the year
- CAH settlement can have a very dynamic impact on financial statements if not closely monitored
- Cost report is due five months after provider's year-end

Overview of the Medicare Cost Report

Interim reimbursement is not final reimbursement

- Interim reimbursement:
  - Determined from hospital records
  - Based on historical or budgeted information
- Final reimbursement:
  - Determined by cost report "as filed"
  - Tentative settlement
  - Final settlement (may not be determined for two to three years after filing)

Overview of the Medicare Cost Report: CAH Reimbursement Methodologies

Service Line	Interim Rate	Final Settlement
Inpatient – routine & ancillary services	Per diem	101% of cost
Swing Bed – routine & ancillary services	Per diem	101% of cost
SNF – Part A - routine & ancillary services	RUG IV	N/A
SNF – Part B - ancillary services	Fee schedule	N/A
OP Services:		
Radiology & other diagnostics	Ratio of cost to charges (RCC)	101% of cost
ASC & other OP surgeries/procedures	RCC	101% of cost
Emergency room	RCC	101% of cost
Chemotherapy, IV therapy & blood administration	RCC	101% of cost
Observation	RCC	101% of cost
Supplies & drugs	RCC	101% of cost
Clinical lab (Not subject to coinsurance)	RCC	101% of cost
Other OP services (PB clinics, mental health, etc.)	RCC	101% of cost
Non-patient (reference) lab	Fee schedule	N/A
CRNA professional services	Fee schedule	N/A
CRNA – low volume exception (less than800 procedures/year)	Pass-through – bi-weekly	Cost
HHA	HHRG	N/A
Ambulance	Primarily fee schedule	Primarily fee schedule
Provider-based physician services	Fee schedule – SOS reduction	N/A
Provider-based physician services (Method II billing)	115% of fee schedule (SOS)	N/A
Provider-based RHC (less than 50 bed exception)	Per encounter	Cost per visit – not subject to federal limit
Free-standing RHC (not provider-based)		Lower of cost per visit or federal limit

Overview of the Medicare Cost Report

What is reasonable cost?

- Providers cannot claim excessive costs:
  - Follows "prudent buyer" principle
  - Necessary and proper in providing services
  - Must be related to patient care
  - Adequate cost data and cost finding support

Overview of the Medicare Cost Report

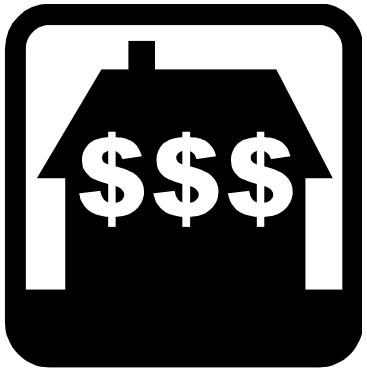
Certain costs are always not allowable:

- Non-Medicare bad debts
- Certain advertising
- Other revenue collected needs to be offset against costs:
  - Cafeteria revenue
  - Investment income (except on funded depreciation investments)
  - Space rental income

Overview of the Medicare Cost Report

Cost centers:

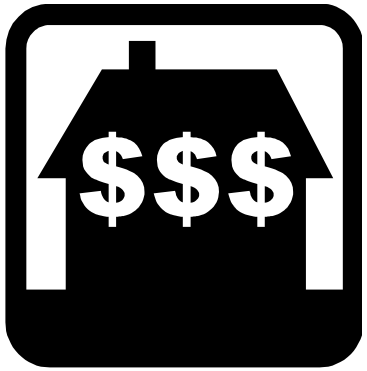
- Overhead cost centers/departments examples:
  - Capital (i.e., depreciation, interest expense)
  - Employee benefits
  - Administration
  - Maintenance
  - Laundry
  - Housekeeping
  - Dietary
  - Nursing administration



Overview of the Medicare Cost Report

Cost Centers:

- Examples of patient care cost centers:
  - Adults and pediatrics
  - Operating room
  - Lab
  - Radiology
  - Physical therapy
  - Drugs charged to patients
  - Medical supplies charged to patients
  - Emergency room



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Medicare Cost Report and Financial Reporting

Hospitals need to be proactive - Avoid surprises!

- Monitor financial statements regularly
- Prepare interim cost reports
- Review allowances and settlements (payables vs. receivables)
- Request interim rate adjustments

Resources

- CAH Finance 101 Manual: Designed to be as non-technical as possible and to provide answers to frequently asked questions regarding finance and financial performance.
- Rural Assistance Center
- Flex Monitoring Team
- CMS Online Manuals:
  - Pub 100-4, Chapter 3, Section 30, Inpatient Part A Hospital Manual
  - Pub 100-4, Chapter 4, Section 250, Part B Hospital (including Inpatient Hospital Part B and OPPS)
  - Pub 100-4, Chapter 6, Section 20, SNF Inpatient Part A Billing
  - Pub 100-4, Chapter 16, Sections 30.3 & 40.3.1, Laboratory Services from Independent Labs, Physicians & Providers

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Appendix: Cost Report/ Reimbursement Acronyms

A&G	Administrative and General
AHSEA	Adjusted Hourly Salary Equivalency Amount
ASC	Ambulatory Surgery Center
APC	Ambulatory Payment Classification
BBA	Balanced Budget Act
BIPA	Benefits Improvement and Protection Act
CAH	Critical Access Hospital (10/97)
CCU	Coronary Care Unit
CFR	Code of Federal Regulations
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid
CMS Pub.	Health Care Financing Administration Facility
CORF	Comprehensive Outpatient Rehabilitation Facility
CRNA	Certified Registered Nurse Anesthetist
CTC	Certified Transplant Center
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospital
EACH	Essential Access Community Hospital
FI	Fiscal Intermediary – Medicare Part A
FQHC	Federally Quality Health Center
FR	Federal Register
FTE	Full Time Equivalent
GME	Graduate Medical Education
HHA	Home Health Agency
HMO	Health Maintenance Organization
ICF/MR	Intermediate Care Facility for the Mentally Retarded (9/96)
ICU	Intensive Care Unit
IME	Indirect Medical Education
IP	Inpatient
LCC	Lesser of Reasonable Cost or Customary Charges
LTC	Long Term Care
MAC	Medicare Administrative Contractor (i.e. FI)
MDH	Medicare Dependent Hospital (10/97)
MSA	Metropolitan Statistical Area (10/97)
MSP	Medicare Secondary Payer
NF	Nursing Facility
OBRA	Omnibus Budget Reconciliation Act
OT	Occupational Therapy
OP	Outpatient
OPPS	Outpatient Prospective Payment System
OHCI	Office of Healthcare Information
PBP	Provider-Based Physician
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PS&R	Provider Statistical and Reimbursement System
PT	Physical Therapy
RCC	Ratio of Costs to Charges
RCE	Reasonable Compensation Equivalent
RHC	Rural Health Clinic
RPCH	Rural Primary Care Hospital
RT	Respiratory Therapy
RUG	Resource Utilization Group
SCH	Sole Community Hospitals
SNF	Skilled Nursing Facility
ST	Speech Therapy
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TOPPS	Transitional Corridor Payment for Outpatient Prospective Payment System
WKST	Worksheet