Guidance for Inpatient Psychiatric Facilities (IPFs) about All-Inclusive Cost Reporting

Issued: 10-10-24; Effective: 10-01-24, Implementation: 10-01-24

Summary

This guidance provides information to IPF providers about an edit in the cost reporting system that will ensure all IPF providers are using an appropriate cost reporting methodology for cost reporting periods beginning on or after October 1, 2024. Specifically, as CMS discussed in the FY 2025 IPF prospective payment system (PPS) final rule (89 FR 64639 through 64640), only eligible government-owned, IHS facilities, or tribally owned IPF hospitals are permitted to file an all-inclusive cost report. To be an eligible hospital approved to file an all-inclusive cost report, the hospital must have never had a charge structure in place and therefore either uses an all-inclusive rate (one charge covering all services) or a no-charge structure. Our expectation is that any new IPF would have the ability to have a charge structure under which it could allocate costs and charges. Accordingly, all other IPF hospitals must have a charge structure and must report ancillary costs and charges on their cost reports beginning on or after October 1, 2024.

This guidance discusses the following topics:

A. Background
B. Description of new cost reporting edit
C. Targeted outreach to providers
D. Additional guidance related to temporary use of an alternate cost reporting methodology
E. Frequently Asked Questions

A. Background

CMS uses cost-to-charge ratios (CCRs) from Medicare cost reports to establish reasonable costs for hospital services and set payment rates for several hospital prospective payment systems, including for inpatient psychiatric facilities. In general, detailed ancillary cost and charge information is necessary for accurate Medicare ratesetting.

When hospitals identify as all-inclusive, they are excluded from ratesetting because they do not have CCRs but use an alternative basis for apportioning costs. When hospitals erroneously identify as all-inclusive but have a charge structure, data that is necessary for accurate Medicare ratesetting is improperly excluded.

If a provider uses an all-inclusive rate or a no-charge structure, it can elect to file an alternative cost report, which is most often the statistical Method A. Before a provider can elect statistical Method A, the Medicare Administrative Contractor (MAC) must verify that the provider did not, and does not, have a charge structure to assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the MAC, in

determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs (PRM 15-1, §2203).

As described in the Provider Reimbursement Manual (PRM), the statistical method (Method A) is considered the permanent method of cost apportionment for eligible all-inclusive rate providers. Where the permanent method is not used, the MAC may grant specific permission for a hospital to continue to use—on a temporary basis—a less sophisticated method (PRM 15-1, §2208.1). If a provider does not have the ability to use Method A, they must request to use an alternative, which could be Method B or E (PRM 15-1, §2208.1).

As CMS discussed in the FY 2025 IPF PPS final rule (89 FR 64639 through 64640), only eligible government-owned IHS facilities or tribally owned IPF hospitals are permitted to file an all-inclusive cost report. To the extent these hospitals can report ancillary charges on their cost reports, we strongly encourage them to do so to allow CMS to review and analyze complete and accurate data. All other IPF hospitals must have a charge structure and must report ancillary costs and charges on their cost reports.

B. Description of New Cost Reporting Edit

For cost reporting periods beginning on or after October 1, 2024, a new edit in the cost reporting system will check the filing status on Worksheet S-2, Part I, line 115 and compare against a list of eligible all-inclusive rate providers. If a provider is not listed as an eligible all-inclusive rate provider, the cost reporting software will not permit the provider to generate an all-inclusive rate cost report.

At this time, CMS has identified 122 providers (Appendix 1) that are eligible to file an all-inclusive cost report as of October 10, 2024. This list is based on the latest information available to CMS and may be updated in the future.

C. Targeted Outreach to Providers

Providers not listed on Appendix 1 will receive targeted outreach from their MAC to inform them of the new cost report edit and advise that reporting of ancillary charges will be required on cost reports beginning on or after October 1, 2024.

If the provider does not have a charge structure and is unable to track and report ancillary costs and charges beginning October 1, 2024, then MACs will advise the provider of the process for requesting approval to temporarily use an alternate cost reporting methodology, as described in the next section of this guidance.

D. Additional Guidance Related to Temporary Use of an Alternate Cost Reporting Methodology

Providers that are currently filing an all-inclusive cost report generally do not use charges to apportion Medicare and non-Medicare portions of their costs. Instead, as stated in the PRM §2208.1, where the permanent method is not used, the MAC may grant specific permission for a hospital to continue to use—on a temporary basis—a less sophisticated method. Typically, this involves apportionment by an alternative statistic such as, for example, patient days.

As explained in the FY 2025 IPF PPS final rule, IPF hospitals that are not eligible government-owned, tribally owned, or IHS facilities will need to have a charge structure and report costs and charges for cost reporting periods beginning on or after October 1, 2024. Providers that are unable to complete the transition to separate ancillary and routine cost and charges for cost reporting periods beginning between October 1, 2024, and May 31, 2025, may request to be approved to use an alternate cost reporting methodology, on a temporary basis, during the affected cost reporting period. For example, if a provider with a cost reporting period beginning October 1, 2024, cannot fully transition their IT systems to comply until January 1, 2025, the MAC may approve the temporary use of an alternate cost reporting methodology for the period of October 1 to December 31, 2024.

If approved by the MAC, a provider may report estimated charges for the purposes of apportioning the provider's Medicare and non-Medicare costs. This methodology would include the following components:

1. For Medicare charges, extrapolate the charge per day for ancillary services included on the PS&R report. Bifurcate the PS&R report into two separate reports based on when the ancillary charge structure was implemented.
2. Use the extrapolated charge per day for each ancillary cost center and apply that to the applicable PS&R Medicare days prior to the ancillary charge structure being in place.
3. Where the ancillary charge issue exists for outpatient, the above methodology would be used except that it would be a percentage of charge extrapolation rather than on per-day basis.
4. For total charges, extrapolate the charge per day for ancillary services included on the hospital's general ledger for the period when the ancillary charge structure was implemented and apply that charge per day to the total days prior to the date the ancillary charge structure was implemented.
5. For Medicare charges and Total charges, adjust the applicable worksheets, including Worksheets D-3, Worksheet D-Part V, and Worksheet C.
6. Where extrapolated ancillary charges are calculated, reclassify these charges from the Routine cost center on the cost report to ensure overall charges (routine and ancillary) remain unchanged in the aggregate for both Medicare and Total.

CMS expects providers to report actual charges as soon as is feasible, and that estimated charges would only be reported for the portion of the provider's cost reporting period that begins between October 1, 2024, and May 31, 2025, during which the provider is unable to report actual charges. CMS anticipates that by June 1, 2025, IPF hospitals will have made the appropriate

changes to their systems to begin tracking and reporting actual charges. This alternative methodology will not be permitted for cost reporting periods beginning on or after June 1, 2025.

E. Frequently Asked Questions

Q1: Will a provider's use of a temporary alternative cost reporting methodology affect the provider's licensure?

A1: The use of a temporary alternative cost reporting methodology will not affect a provider's license as long as all other applicable Medicare requirements have been and continue to be met.

Q2: To what extent must IPFs report ancillary charges to private payers that still allow all-inclusive billing? How is this currently handled for IPFs that are not in the all-inclusive category?

A2: Total routine and ancillary charges are needed to calculate the Medicare apportionment. A facility's Medicare portion of total routine and ancillary cost is based on the reported Medicare and non-Medicare charges. The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. In other words, in order to appropriately apportion Medicare and non-Medicare costs, IPFs that do not file as all-inclusive will need to report ancillary charges to payers other than Medicare, including Medicaid, CHAMPUS, private, etc.

Q3: For IPFs transitioning from all-inclusive cost reporting to traditional reporting of ancillary charges, what cost reporting elements will be mandatory to avoid being rejected by a MAC?

A3: As discussed in the FY 2025 IPF PPS final rule (89 FR 64638), based on the nature of IPF services and the conditions of participation applicable to IPFs, we expect to see ancillary services and correlating charges, such as labs and drugs, on most IPF claims. Existing cost reporting edits require all IPFs, except for those that file all-inclusive cost reports, to report ancillary costs and charges on Form CMS-2552-10, Worksheets C and D. As discussed, effective for cost reporting periods beginning on or after October 1, 2024, a new edit in the cost reporting system will automatically validate the provider's approval to identify on Form CMS-2552-10, Worksheet S-2, Part I, line 115 as filing all-inclusive cost reports. If not approved, the provider will be unable to generate an all-inclusive rate cost report.

Appendix 1 - Providers Approved to File All-Inclusive
Effective 10-10-24

Provider Number	*Provider Name*
014017	EASTPOINTE HOSPITAL
024002	ALASKA PSYCHIATRIC INSTITUTE
034021	ARIZONA STATE HOSPITAL
054124	SEMPERVIRENS
054125	SANTA BARBARA COUNTY PSYCHIATRIC HEALTH FACILITY
064001	COLORADO MENTAL HEALTH HOSPITAL IN PUEBLO
064003	COLORADO MENTAL HEALTH HOSPITAL IN FORT LOGAN
074003	CONNECTICUT VALLEY HOSP
074011	CONNECTICUT MENTAL HEALTH CENTER
074012	SOUTHWEST CONNECTICUT MENTAL HEALTH
084001	DELAWARE PSYCHIATRIC CENTER
094001	ST ELIZABETHS HOSPITAL
104001	SOUTH FLORIDA STATE HOSPITAL
104007	NORTHEAST FLORIDA STATE HOSPITAL
144010	CHICAGO-READ MENTAL HEALTH CENTER
144016	ALTON MENTAL HEALTH CENTER
144021	ANDREW MCFARLAND MENTAL HLTH CTR
144028	JOHN J MADDEN MENTAL HEALTH CENTER
144037	ELGIN MENTAL HEALTH CENTER
144038	CHOATE MENTAL HEALTH & DEVELOPMENT CTR
154018	RICHMOND STATE HOSPITAL
154019	MADISON STATE HOSPITAL
194008	EASTERN LA MENTAL HEALTH SYSTEM
194025	CENTRAL LOUISIANA STATE HOSPITAL
214002	EASTERN SHORE HOSPITAL CENTER
214004	SPRINGFIELD HOSPITAL CENTER
214012	THOMAS B FINAN CENTER
214018	SPRING GROVE HOSPITAL CENTER
224001	TAUNTON STATE HOSPITAL
224028	DR JOHN C CORRIGAN MENTAL HEALTH CENTER
224031	CAPE COD & ISLANDS COMMUNITY MENTAL HEALTH CENTER
224032	WORCESTER RECOVERY CENTER AND HOSPITAL
224040	DR SOLOMON CARTER FULLER MENTAL HEALTH CENTER
244002	ANOKA METRO REGIONAL TREATMENT CENTER

244005	CHILD AND ADOLESCENT BEHAVIORAL HEALTH HOSPITAL
244011	COMMUNITY BEHAVIORAL HEALTH HOSPITAL ANNANDALE
244012	COMM BEHAVIORAL HEALTH HOSPITAL ALEXANDRIA
244013	COMMUNITY BEHAVIORAL HOSPITAL FERGUS FALLS
244014	COMMUNITY BEHAVIORAL HEALTH HOSPITAL - BEMIDJI
244015	COMMUNITY BEHAVIORAL HEALTH HOSPITAL - BAXTER
244017	COMMUNITY BEHAVIORAL HEALTH HOSPITAL ROCHESTER
254009	NORTH MISSISSIPPI STATE HOSPITAL
254010	MS STATE HOSPITAL-WHITFIELD
264008	CENTER FOR BEHAVIORAL MEDICINE
294000	DINI-TOWNSEND HOSPITAL AT NNMH
294002	SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
304000	NEW HAMPSHIRE HOSP-PSYCH UNIT
314005	ANCORA PSYCH HOSP
314013	TRENTON PSYCHIATRIC HOSP
314016	GREYSTONE PARK PSYCH HOSP
314020	ESSEX COUNTY HOSPITAL CENTER
314024	HUDSON COUNTY MEADOWVIEW PSYCHIATRIC H
334001	HUTCHINGS PSYCHIATRIC CTR
334003	ST LAWRENCE PSYCHIATRIC CENTER
334004	CREEDMOOR PSYCHIATRIC CENTER
334009	NEW YORK STATE PSYCHIATRIC INSTITUTE
334012	GREATER BINGHAMTON HEALTH CENTER
334013	PILGRIM PSYCHIATRIC CENTER
334015	ROCKLAND PSYCH CTR
334020	ROCHESTER PSYCHIATRIC CENTER
334021	MOHAWK VALLEY PSYCHIATRIC CENTER
334043	SOUTH BEACH PSYCHIATRIC CENTER
334045	ELMIRA PSYCH CENTER
334046	CAPITAL DISTRICT PSYCH CENTER
334052	BUFFALO PSYCHIATRIC CENTER
334053	BRONX PSYCHIATRIC CENTER
334054	MANHATTAN PSYCHIATRIC CENTER
334060	KIRBY FORENSIC PSYCHIATRIC CENTER
334061	MID HUDSON FORENSIC PSYCHIATRIC CTR
334063	KINGSBORO PSYCHIATRIC HOSPITAL
344004	CENTRAL REGIONAL HOSPITAL

344023	JULIAN F KEITH ALCOHOL & DRUG ABUSE TX
344025	BROUGHTON HOSPITAL
344027	RJ BLACKLEY ALCOHOL AND DRUG ABUSE TREATMENT CTR
354003	NORTH DAKOTA STATE HOSPITAL
364007	TWIN VALLEY BEHAVIORAL HEALTHCARE
364011	NORTHCOAST BEHAVIORAL HEALTHCARE NORTHFIELD CAMPUS
364014	NORTHWEST OHIO PSYCHIATRIC HOSPITAL
364015	APPALACHIAN BEHAVIORAL HEALTH CARE
364031	HEARTLAND BEHAVIORAL HEALTHCARE
364035	SUMMIT BEHAVIORAL HEALTHCARE
374000	GRIFFIN MEMORIAL HOSPITAL
374001	NORTHWEST CENTER FOR BEHAVIORAL HEALTH (NCBH)
374006	CARL ALBERT COMMUNITY MENTAL HEALTH CENTER
374008	JIM TALIAFERRO COMM MENTAL HEALTH CTR
374026	TULSA CENTER FOR BEHAVIORAL HEALTH
394001	NORRISTOWN STATE HOSPITAL
394004	DANVILLE STATE HOSPITAL
394012	CLARKS SUMMIT STATE HOSPITAL
394014	WERNERSVILLE STATE HOSPITAL
394016	WARREN STATE HOSPITAL
394026	TORRANCE STATE HOSPITAL
434003	SOUTH DAKOTA HUMAN SERVICES CENTER
444001	MEMPHIS MENTAL HEALTH INSTITUTE
444002	MOCCASSIN BEND MENTAL HEALTH INSTITUTE
444008	WESTERN MENTAL HEALTH INSTITUTE
444010	PATHWAYS OF TENNESSEE, INC
444014	MIDDLE TN MENTAL HEALTH INSTITUTE
454000	BIG SPRING STATE HOSPITAL
454006	TERRELL STATE HOSPITAL
454008	NORTH TEXAS STATE HOSPITAL
454009	RUSK STATE HOSP
454011	SAN ANTONIO STATE HOSPITAL
454084	AUSTIN STATE HOSPITAL
454088	RIO GRANDE STATE CENTER
454093	STARCARE SPECIALTY HEALTH /SUNRISE CANYON HOSPITAL
454100	EL PASO PSYCHIATRIC CENTER

464001	UTAH STATE HOSPITAL
474004	VERMONT PSYCHIATRIC CARE HOSPITAL
494010	NORTHERN VIRGINIA MENTAL HEALTH INSTI
494017	SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
494021	WESTERN STATE HOSPITAL
494029	SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
524001	MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
524002	WINNEBAGO MENTAL HEALTH INSTITUTE
524008	MENDOTA MENTAL HEALTH INSTITUTE
524014	BROWN COUNTY COMMUNITY TREATMENT CTR
524019	NORWOOD HEALTH CENTER
524025	FOND DU LAC COUNTY ACUTE PSYCH UNIT
524026	WAUKESHA COUNTY MENTAL HEALTH CTR
534001	WYOMING STATE HOSPITAL
494033	CATAWBA HOSPITAL