HFS USERS CONFERENCE 2016

MEDICARE BAD DEBTS (EARLY BIRD BONUS)

COST REPORT CCRS MARGIN ANALYSIS

October 14, 2016

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Objectives

By the end of this course, you will be able to:

- Understand current issues in Medicare bad debts (Early Bird Bonus)
- Identify the cost/charge ratios in the Medicare cost report and their importance
- Calculate margin analysis based on cost report formats

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Mike Nichols, CPA, FHFMA

- 34 years of nationwide health care experience
  - Cost reporting (auditing, preparing, reviewing)
  - Contractual allowance and settlement analysis determinations
  - Reimbursement opportunities and strategies
- RSM US LLP
  - Healthcare Advisory Services
  - Partner (health care consulting)
- HFMA
  - First Illinois Chapter
  - Past President
  - 2013-2014 Regional Executive Region 7
  - Medal of Honor recipient

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Chad Krcil, MBA, FHFMA

- 25 years of health care experience
  - Cost reporting (auditing, preparing, reviewing)
  - Contractual allowance and settlement analysis determinations
  - Reimbursement opportunities and strategies
  - Third party reimbursement audit and review and due diligence analysis
- RSM US LLP
  - Healthcare Advisory Services
  - Director (health care consulting)
- HFMA
  - Colorado Chapter
  - Chapter Secretary (FY 2015/2016)
  - VP of Education (FY 2016/2017)
  - Recipient of the Bronze Follmer, Reeves Silver and Muncie Gold Merit Awards

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MEDICARE BAD DEBTS

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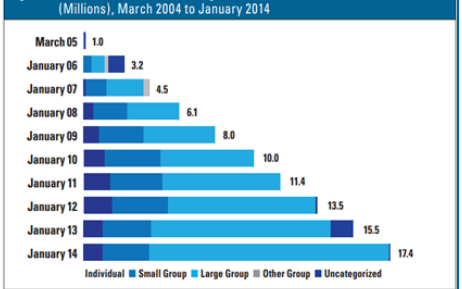
Consumer liability
High deductible health plans increase consumer exposure

Health Care Trends– Statistics

"According to America's Health Insurance Plans (AHIP), the growth in HDHPs is a major contributor to current expectations that out-of-pocket payments for insured patients are expected to grow from $250 billion in 2009 to $420 billion by 2015, a 68 percent increase in five years" "January 2014 Census Shows 17.4 Million Enrollees in Health Savings Account–Eligible High Deductible Health Plans (HSA/HDHPs) © AHIP 2014

- *80% of the public covered by employer-sponsored health insurance must meet an annual deductible. 41% of those workers have a deductible that exceeds $1,000 annually for single coverage.* Price Estimates and Point-of-Service Collections: Initial Steps to Hospital Price Transparency, Tawnya Bisko, MHA, MBHL, MB
- *Larger employers plan to reduce a projected increase in the cost of healthcare coverage in 2015 from 6.5 percent to 5 percent primarily by expanding the use of high-deductible health plans. These employers that plan to offer high-deductible plans as an option for their employees will increase from 72% to 81%.* Employers Use High Deductibles to Cut Costs, Increase Transparency - HFMA.org (Aug 14)
- *The average per-person deductible increased 117% between 2003 and 2011 (from $518 to $1,123).[3] This rate continue to rise each year reaching an average of $1,230 in 2013* When High Deductibles Strike Your Revenue Cycle: Two Counter Strategies (March 13') HFMA ForumBoosting Patient Collections- Chris Wyatt-HFMA Sept. 2014

Figure 1. Growth of HSA-Qualified High-Deductible Health Plan Enrollment, (Millions), March 2004 to January 2014



Sources: AHIP Center for Policy and Research, 2005 - 2014 HSA/HDHP Census Reports
Notes: For this census, companies reported enrollment in the large- and small-group markets according to their internal reporting standards, or by state-specific requirements for each state. The "Other Group" category contains enrollment for companies that could not break down their group membership into large- and small-group categories within the deadline for reporting. The "Uncategorized" category was necessary to accommodate companies that were able to provide information on the total number of people covered by HSA/HDHP policies, but were not able to provide a breakdown by market category within the deadline for reporting.

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E Series Medicare bad debts

- Unpaid deductible and coinsurance amounts related to covered hospital services
  - Excludes pro fees and fee screen amounts
  - Excludes MCO amounts
- Reimbursed @ 65% of actual Medicare bad debt write-offs
- Reasonable collection efforts consistent among all payers
- Debt actually uncollectible when claimed as worthless
  - Cannot be claimed as bad debt until returned from collection agency

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Medicare bad debts

- May 2, 2008 CMS memorandum
- Contractors to disallow bad debts if not returned from collection agency
- Settlements issued after May 2, 2008

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Medicare bad debts

- Collection effort must be documented in patient file
- Collection may include use of a collection agency, in addition to or in lieu of subsequent billings
- Traditional accounts turned over to collection cannot be claimed until returned from agency
- MAC auditors are now reviewing collection agency activity
- 120-day rule – Beginning on the date of the first bill sent to the patient (indicating deductible or coinsurance owed by the beneficiary)
  - "Presumed uncollectible" after 120 days

Who owns bad debt process? Reimbursement or PFS?

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Medicare bad debts

- Medicare/Medicaid crossover patients (must bill requirement) (actual voucher vs. notice)
  - *Prove that no other insurance exists*
- Indigent or medically indigent patients (hospital must establish and document indigence)
- Charity accounts for Medicare beneficiaries
- Deceased patients (must document lack of estate)
- Bankrupt patients (must document court filings, etc.)
- May all be claimed without collection effort (no 120-day rule) (varies with contractor)

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Medicare bad debts

- Recoveries must be netted against bad debt expense claimed, even if the claim was originally included in a prior year bad debt submission
  - *Caution: Re-starts 120-day counting period*
- Prorated recoveries not specifically identified as payment for covered/non-covered services

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Bad debt – Review workplan

- Trace amounts from the detailed listings (by hospital) to the summaries and actual cost report files
- Develop a small sample from the detailed listings in order to validate the required Medicare bad debt attributes
- Pay close attention to large dollar amounts included in listings
- Read and understand Medicare bad debt policies in place for the cost reporting periods included in the review
- Obtain collection agency agreements
- Interview PFS personnel responsible for the Medicare bad debt process
- Test accounts identified in each list for the required attributes based on the available documentation
- Develop a log of observations related to the small scale sampling list
- Estimate a range of potential financial impacts by applying sample results to the entire population

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COST-TO-CHARGE RATIOS IN THE MEDICARE COST REPORT

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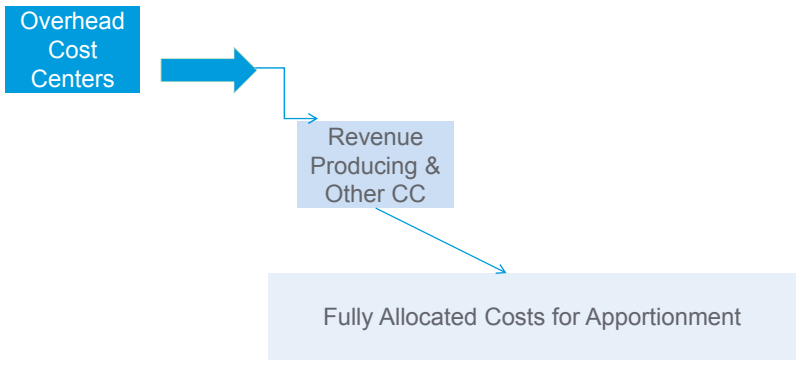
B Series step-down process



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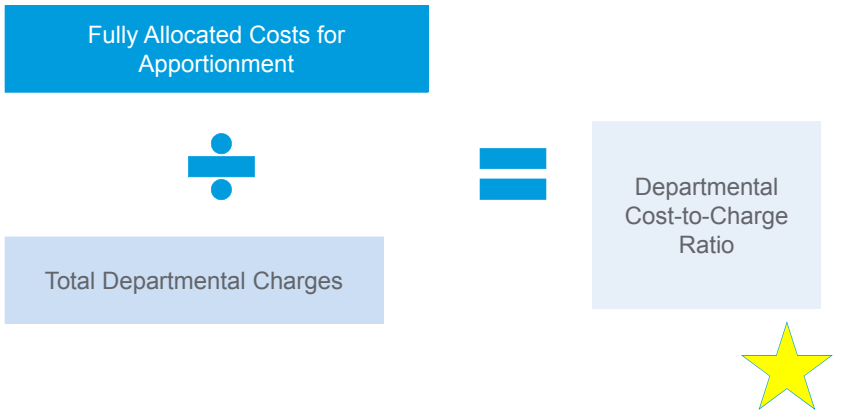
Worksheet C cost/charge ratio



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Matching issues

- WS A and B-1/B Pt II
  - Match Medicare allowable costs with related cost allocation statistics to accurately determine fully allocated costs for apportionment purposes
- WS C
  - Match total hospital charges with the cost
- WS D-3 and D Pt V
  - Match program charges with total charges
- Result:
  - ***Accurate fully allocated departmental costs for apportionment for payment purposes (CAH) and rate setting (PPS)***

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Implantable devices

- Did this facility incur and report costs for high cost implantable devices charged to patients?
  - Charge capture
  - CDM update
  - Billing
  - Documentation
  - Follow up

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Provider-based status

- Applies to both PPS and CAH facilities
- Relationship between an entity and the main hospital
- Additional reimbursement related to facility services reimbursed under OPPS
- May be additional patient coinsurance responsibilities
- Professional services reimbursed under reduced physician fee schedule
- Sites may be identified for inclusion in 340B program
- Potential issues for GME reimbursement
- Future of PBS?

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Provider-based status charging issues

- May only apply to Medicare (Medicaid and commercial payers not likely to recognize two bills (technical and facility component charges))
- Chargemaster should identify both professional and technical component charge elements
- Hospital should develop a charge split that covers the fee screen amounts for most prevalent procedures
- Need to develop methodology to include correct charges for cost apportionment

Future of Provider-based Status

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Worksheet C: "The Bridge"

- Worksheet C – Revenues – Cost-to-charge ratios:
  Fully allocated departmental costs
  Total department charges
  = Cost-to-charge ratio for each ancillary department
- *Although Worksheet C is total costs, same approach is used for capital costs identified on B Pt II*
- *Overall objective is PROPER MATCHING: costs, total charges, program charges*

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Cost report Worksheet C

2552-10	Description	Source
C Part I	Summary of Allocated Costs and Charges (Cost/Charge Ratios)	Cost from Worksheet B part I; charges are input from grouping
C Part II	Outpatient Service Cost/Charge Ratio	Calculated; may be used for state purposes

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Cost report Worksheet C

4023.1 Computation of Ratio of Cost to Charges

This worksheet computes the ratio of cost to charges for inpatient services, ancillary services, outpatient services and other reimbursable services

All charges entered on this worksheet must comply with CMS Pub. 15-I, chapter 22, §§2202.4 and 2203

This ratio is used on Worksheet D, Part V, for titles V and XIX and for title XVIII; Worksheet D-3; Worksheet D-4; Worksheet H-3, Part II; and Worksheet J-2, Part II, to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53

This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1 because of your status as IPPS, TEFRA or other

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Cost report Worksheet C

Columns 6 and 7—
Enter on each cost center line the **total** inpatient and outpatient **gross** patient charges, including charges for charity care patients and, where applicable, standard customary charges for items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics and orthotics)

Also include the total inpatient and outpatient gross charges for cost centers which have a credit balance on Worksheet B, Part I, column 26 and, therefore, do not contain “cost” in column 1 of Worksheet C, Part I

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Cost report Worksheet C

Column 9, lines 50 through 98--Always complete this column

Divide the cost for each cost center in column 1 by the total charges for the cost center in column 8, to determine the ratio of total cost-to-total charges (referred to as the "Cost or Other" ratio) for that cost center

Enter the resultant departmental ratios in this column; round ratios to six decimal places

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Cost report Worksheet C

		Worksheet C	Total Cost			Charges			Cost	PPS	
		Cost Center Description	(from Wkst. B, Part I, col. 26)	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (col. 6 + col. 7)	Ratio	Ratio	
			1	4	5	6	7	8	9	11	
		INPATIENT ROUTINE SERVICE COST CENTERS									
30	3000	ADULTS & PEDIATRICS	52,797,153	29,688	52,826,841	110,412,044		110,412,044			30
31	3100	INTENSIVE CARE UNIT	10,700,090	5,223	10,705,313	41,711,356		41,711,356			31
31.01	3101	PEDIATRIC ICU	0		0	0		0			31.01
40	4000	SUBPROVIDER - IPF	5,226,072	5,911	5,231,983	9,652,096		9,652,096			40
43	4300	NURSERY	5,147,666	1,597	5,149,263	14,834,523		14,834,523			43
		ANCILLARY SERVICE COST CENTERS									
50	5000	OPERATING ROOM	32,187,558	44,066	32,231,624	73,926,320	108,439,969	182,366,289	**0.176499**	**0.176741**	50
50.2	3340	GASTRO INTESTINAL SERVICES	2,278,536	6,736	2,285,272	3,065,379	6,944,529	10,009,908	**0.227628**	**0.228301**	50.2
52	5200	DELIVERY ROOM & LABOR ROOM	8,240,859	0	8,240,859	25,592,430	1,321,433	26,913,863	**0.306194**	**0.306194**	52
53	5300	ANESTHESIOLOGY	601,007	52,489	653,496	8,031,375	7,896,283	15,927,658	**0.037734**	**0.041029**	53
54	5400	RADIOLOGY-DIAGNOSTIC	23,039,900	22,530	23,062,430	39,630,447	111,018,003	150,648,450	**0.152938**	**0.153088**	54
54.1	3480	ONCOLOGY	49,938,198	242,712	50,180,910	1,078,068	46,649,772	47,727,840	**1.046312**	**1.051397**	54.1
54.2	5401	CT	3,121,829	0	3,121,829	16,625,222	58,433,879	75,059,101	**0.041592**	**0.041592**	54.2
54.3	5402	MRI	2,423,662	0	2,423,662	4,876,068	26,925,910	31,801,978	**0.076211**	**0.076211**	54.3
60	6000	LABORATORY	16,560,386	0	16,560,386	52,924,003	147,212,776	200,136,779	**0.082745**	**0.082745**	60
60.01	6001	BLOOD	2,328,968	0	2,328,968	8,641,275	2,516,306	11,157,581	**0.208734**	**0.208734**	60.01
65	6500	RESPIRATORY THERAPY	4,967,773	0	4,967,773	11,310,583	6,840,449	18,151,032	**0.273691**	**0.273691**	65
66	6600	PHYSICAL THERAPY	8,782,450	0	8,782,450	10,922,416	23,462,612	34,385,028	**0.255415**	**0.255415**	66
69	6900	ELECTROCARDIOLOGY	2,996,543	299,117	3,295,660	13,657,027	25,401,155	39,058,182	**0.07672**	**0.084378**	69
70	7000	ELECTROENCEPHALOGRAPHY	331,453	0	331,453	819,559	1,861,025	2,680,584	**0.12365**	**0.12365**	70
71	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,181,296	0	10,181,296	55,830,979	42,648,479	98,479,458	**0.103385**	**0.103385**	71
72	7200	IMPL. DEV. CHARGED TO PATIENTS	17,927,297	0	17,927,297	112,485,167	44,572,354	157,057,521	**0.114145**	**0.114145**	72
73	7300	DRUGS CHARGED TO PATIENTS	18,338,990	0	18,338,990	118,501,805	170,103,302	288,605,107	**0.063544**	**0.063544**	73
75	7500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	**0**	**0**	75
75.01	7501	SLEEP LAB	1,576,254	0	1,576,254	12,005	8,944,039	8,956,044	**0.175999**	**0.175999**	75.01
75.1	3950	NUTRITIONAL SUPPORT	126,624	0	126,624	337	465,123	465,460	**0.272041**	**0.272041**	75.1
75.2	3951	HEMODIALYSIS	1,009,210	0	1,009,210	2,291,751	365,467	2,657,218	**0.379799**	**0.379799**	75.2
76.97	7697	CARDIAC REHABILITATION	2,106,900	8,930	2,115,830	107,481	1,872,120	1,979,601	**1.064305**	**1.068816**	76.97
76.98	7698	HYPERBARIC OXYGEN THERAPY	1,937,023	8,795	1,945,818	33,990	4,123,591	4,157,581	**0.465901**	**0.468017**	76.98
76.99	7699	LITHOTRIPSY	0	0	0	0	0	0	**0**	**0**	76.99
		OUTPATIENT SERVICE COST CENTERS									
90	9000	CLINIC	0	0	0	0	0	0	**0**	**0**	90
90.01	9001	CHILDRENS CLINIC	0	0	0	0	0	0	**0**	**0**	90.01
90.02	9002	DIABETES CLINIC	862,412	0	862,412	49,298	354,618	403,916	**2.135127**	**2.135127**	90.02
90.03	9003	STATELINE CLINIC	1,743,290	0	1,743,290	0	7,596,791	7,596,791	**0.229477**	**0.229477**	90.03
91	9100	EMERGENCY	20,084,860	17,247	20,102,107	26,060,804	109,172,572	135,233,376	**0.14852**	**0.148648**	91
91.05	9101	AMBULATORY CARE	393,999	0	393,999	699	153,315	154,014	**2.558203**	**2.558203**	91.05
91.1	9102	PSYCHIATRIC PARTIAL	445,515	0	445,515	0	1,494,519	1,494,519	**0.298099**	**0.298099**	91.1
92	9200	OBSERVATION BEDS (NON-DISTINCT PART	6,341,648		6,341,648	60,199	15,211,521	15,271,720	**0.415254**	**0.415254**	92
		OTHER REIMBURSABLE COST CENTERS									
101	10100	HOME HEALTH AGENCY	8,113,548		8,113,548	0	5,650,436	5,650,436			101
200		Subtotal (see instructions)	322,858,969	745,041	323,604,010	763,144,706	987,652,348	1,750,797,054			200
201		Less Observation Beds	6,341,648		6,341,648						201
202		Total (see instructions)	316,517,321	745,041	317,262,362	763,144,706	987,652,348	1,750,797,054		**0.180785**	202

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National cost/charge ratios

- Provider CCRs will vary from national
- National average CCRs from FFY 2016 Final Rule
- Values:
  - Mark-up formula
  - Cost center groupings
- CMS groupings
- Can this information be used to evaluate pricing strategy beyond Medicare?
- Why is the CCR for MRI and CT so much different from the radiology diagnostic CCR?

Group	FY 2016 Final 19 CCRs	FY 2017 Proposed 19 CCRs
Routine Days	0.480	0.459
Intensive Days	0.393	0.378
Drugs	0.191	0.194
Supplies & Equipment	0.297	0.298
Implantable Devices	0.337	0.336
Therapy Services	0.332	0.322
Laboratory	0.125	0.120
Operating Room	0.199	0.192
Cardiology	0.118	0.113
Cardiac Catheterization	0.124	0.119
Radiology	0.159	0.154
MRI	0.085	0.079
CT Scans	0.041	0.039
Emergency Room	0.183	0.172
Blood	0.336	0.325
Other Services	0.368	0.368
Labor & Delivery	0.404	0.411
Inhalation Therapy	0.177	0.170
Anesthesia	0.106	0.090

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S-10 Uncompensated care cost

- Overall cost-to-charge ratio applied to various uncompensated care program charges to impute costs (based on Medicare defined costs)
- Cost report instructions:
  - ***Line 1--Enter the of cost-to-charge ratio resulting from Worksheet C, Part I, line 202, column 3 divided by Worksheet C, Part I, line 202, column 8***
  - ***For all inclusive rate no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208***
- Other mechanisms can be used for GAAP and IRIS reporting purposes

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Outliers

- Additional payment for extremely costly cases under Medicare PPS systems:
  - Inpatient PPS operating
  - Inpatient PPS capital
  - Outpatient PPS
  - Inpatient psychiatric (IPF PPS)
  - Inpatient rehabilitation (IRF PPS)
  - LTCH PPS

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Outliers

- Payment formula based on hospital specific Medicare cost/charge ratio, or statewide average
- Most recently filed or settled cost report may be used by MAC for interim rate setting process
- Applied to potential outlier claims during claims adjudication process
- ***Subject to retroactive reconciliation at cost report settlement (including time value of money penalty)***

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Outliers CCR data sources

Type	Medicare Cost	Medicare Charge
IP PPS Operating	Title XVIII IP PPS W-S D-1 Line 53	D-3 Total Routine and ancillary charges Hospital IP PPS
IP PPS Capital	W-S D part I Col 7, line 200 + D part II col 5 line 200 (Can Use D-1 line 52 if no Med Ed or Paramedical programs	Same as above
OP PPS	E part B Line 2	Title XVIII Hospital D part V Col 2, Line 200

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Outliers CCR data sources

Type	Medicare Cost	Medicare Charge
IPF PPS	Title XVIII IPF (Sub I) W-S D-1 Line 53	D-3 Total Routine and ancillary charges Title XVIII IPF (Sub I)
IRF PPS	Title XVIII IRF (Sub II) W-S D-1 Line 53	D-3 Total Routine and ancillary charges Title XVIII IRF (Sub II)
LTCH PPS	Title XVIII LTCH (or hospital) W-S D-1 Line 53	D-3 Total Routine and ancillary charges LTCH component or entire LTCH hospital

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IP PPS outlier CCRs SR917

1	Ref:		Change Req #9253 and Fed Reg 8-17-15 pg 49785
	I. COST TO CHARGE RATIO FOR PPS HOSPITALS		
11	Total program (Title XVIII) inpatient operating cost excluding capital related, nonphysici		43,975,095
12	Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus ar		277,490,174
13	Ratio of cost to charges (Line 1/Line 2) (Operating Max is 1.210)	0.249	0.158
	II. COST TO CHARGE RATIO FOR CAPITAL		
21	Total medicare inpatient PPS capital related costs (W/S D Part I, Lines 30-35, column 7;		3,755,153
22	Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus ar		277,490,174
23	Ratio of cost to charges (Line 21/Line 22) (Capital Max is 0.175)	0.022	0.014
	III. MEDICAID PATIENT DAYS TO TOTAL DAYS		
31	Medicaid Patient Days (S-2, Part I Columns 1-6 Line 24)		20,929
32	Total Days (S-3, Part I Column 8 Line 14 + Column 8 Line 32 minus sum of Lines 5-6, plus		63,857
33	Medicaid Ratio (Line 1 divided by Line 2)		0.3277
	IV. BED SIZE		
41	Bed Size (W/S E, Part A, Line 4 Logic)		267.17

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OP PPS outlier CCRs SR916

						Charges			Cost	
202	Total					224,261,221	0	224,261,221	46,362,213	202
	RCC Calculation (B)									
211	Total Cost (Col 4, Line 202 which equals D Pt V col 5, Line 200)								46,362,213	211
212	Total Charges (Col 3, Line 202 which equals D Pt V col 2 and subscripts, Line 200)								224,261,221	212
213	OPPS / Charge Ratio (OPPS Cost/Charge Ratio Max is 1.600)								0.207	213
	Statewide Average Operating RCC									
214	Urban								0.217	214
215	Rural								0.252	215
	Section II - Bed Size									
221	Bed Size (E Pt A line 4 logic)								267.17	221
	Section III - Non Opps RCC for FISS-Core, 41 Screen, Page 3									
231	W/S E Part B, line 1, col 1								30,999	231
232	W/S E Part B line 12, col 1								486,611	232
233	Non OPPS RCC (line 231 / line 232)								0.064	233
(A) Cost/Charge Ratio Calculated after omitting the Costs for Paramed Ed & Allied Health										
(B) Worksheet A line numbers. If lines 96-97 present, review to ensure that "Non Implantable DME" is Excluded										
(C) Wks A lines 61, 66-68, 74, 88, 89, 94, 95 are not included in Totals										

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Revenue cycle KPIs in cost report

Performance Indicator	CR Ref	Target Range
Days Revenue Outstanding in Total Accounts Receivable	((G, L4) – (G, L6)) Days in CR period	≤ 40 days (net)
Bad Debt Write-off % of Gross Patient Revenue	(S-10,L26) (G-2, L28, C3)	≤ 2%
Charity Care Write-offs % of Gross Patient Revenue	(S-10,L20, C3) (G-2, L28, C3)	≤ 3% HFMA comment: Charity target should be provider specific based on community needs and provider's financial assistance policy
Cash Collections % of Net Patient Revenue	(G, L1) (G-3, L3)	100% Caution: Consider GAAP presentation of bad debts in this calculation

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MARGIN ANALYSIS

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Key definitions: Margin

- Difference between net revenue (expected payment) and allocated costs for a particular procedure, department, product line or financial class
- Different from financial statement net income due to the treatment of other operating and non-operating items included in the entity's operations
- Margin calculation under management principles will be different from amount determined under payer specific rules (such as Medicare principles of reimbursement)

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Charges and net revenue/payment comparison

- Charges = Net Revenue/Payment = Awesome
  - Never happens because there are still bad debt and charity care adjustments
- Charges > Net Revenue/Payment = Typical Situation
  - Contractual allowance
  - Pricing transparency?
- Charges < Net Revenue/Payments = Possible
  - Rare: May occur with individual situations (see also the prior points
  - Impact of “special payments (federal or state)
- ***Depends on pricing strategy and contracting***

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Net revenue/payment and cost comparison

- Net Revenue/Payment = Cost = Possible
  - Specific cost reimbursement formulas
  - Defensible pricing approximates cost of services provided
  - Luck
- Net Revenue/Payment > Cost = Awesome
  - Most commercial payers do cover cost of providing care
- Net Revenue/Payments < Cost = Typical
  - Governmental payers are the majority of most hospitals payer mix
  - Most governmental payers reimburse at levels below cost
  - They say their prospective payment methodologies are working
- ***Depends on definition of costs***

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What is the hospital's Medicare margin?

- Who calculates the margin?
- What mechanism is used?
- When is it updated?
- Where is the information distributed?
- Why do we calculate the margin?

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Medicare margin analysis: General definitions

- Margin/(deficit)
  - Reimbursement > Cost: Margin
  - Reimbursement < Cost: (Deficit)

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Medicare margin analysis

- Comparison of Medicare cost report information
  - Charges
  - Medicare defined fully allocated cost
  - Reimbursement
- Reports
  - Contractual allowance
  - Margin or deficit
- High level executive summary
  - Senior financial executives
  - Corporate governance
  - Education advocacy

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What opportunities exist to (legally) improve the hospital's Medicare margin?

- Cost
- Pricing strategy
- Reimbursement opportunities

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Import Cost Report Data	HFMA Hospital FPE 12/31/2015 As-Filed Cost Report Analysis							
	Charges	Cost	Reimb. Gross	Reimb. Net of Seq.	Margin (Deficit)	Contractual Allowance	Reimb % of Charges	Contractual % Charges
Inpatient Acute	112,694,842	28,993,982	27,749,708	27,268,961	(1,725,021)	85,425,881	24.20%	75.80%
Operating I M E	0	0	3,520,513	3,459,522	3,459,522	(3,459,522)	3.07%	-3.07%
Disproportionate Share / Uncompensated Care	0	0	3,568,267	3,506,449	3,506,449	(3,506,449)	3.11%	-3.11%
Inpatient Capital	0	2,790,646	2,475,909	2,433,015	(357,631)	(2,433,015)	2.16%	-2.16%
G M E (@ load factor)	0	1,823,826	1,491,107	1,465,274	(358,551)	(1,465,274)	0.63%	-0.63%
Reimbursable Bad Debts	0	3,589,831	2,333,390	2,292,965	(1,296,866)	(2,292,965)	1.00%	-0.98%
Outpatient	120,629,673	26,860,994	33,428,708	32,849,575	5,988,581	87,780,098	27.23%	72.77%
Total	233,324,515	64,059,279	74,567,602	73,275,762	9,216,483	160,048,753	31.41%	68.59%
Total Sequestration (reflected above)				(1,291,840)				
Managed Care IME included above:					(957,084)			
Managed Care GME included above:					(373,094)			
Total Managed Care Impact on Medicare Margin					(1,330,177)			
Load Factor Impact on Margin		Full		Load Factor	Net			
GME		3,344,887		1,823,826	(1,521,061)			
Nursing/Allied Health		0		0	0			
	Total	3,344,887		1,823,826	(1,521,061)			
MCO & Load Factor Impact					(2,851,239)			
Adjusted Margin/(Deficit)					6,365,245			

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Import Cost Report Data	HFMA CAH Hospital FPE 12/31/2015 As-Filed Cost Report Analysis							
	Charges	Cost	Reimb. Gross	Reimb. Net of Seq.	Margin (Deficit)	Contractual Allowance	Reimb % of Charges	Contractual % Charges
Inpatient Acute	879,268	472,668	477,395	470,485	(2,183)	408,783	53.51%	46.49%
Reimbursable Bad Debts	0	436,452	283,694	279,588	(156,864)	(279,588)	3.30%	-3.25%
Outpatient	7,715,372	2,109,269	2,130,362	2,099,526	(9,743)	5,615,846	27.21%	72.79%
Swing Bed	2,608,575	1,785,469	1,803,345	1,777,242	(8,227)	831,333	68.13%	31.87%
Rural Health Clinic	0	0	0	0	0	0	0.00%	0.00%
Total	11,203,215	4,803,858	4,694,796	4,626,841	(177,017)	6,576,374	41.30%	58.70%
Total Sequestration (reflected above)				(67,955)				

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HFMA Hospital												
Third Party Settlement Estimate												
FYE 12/31/15		Estimated				Per Cost Report			Diff		
	Estimated	Interim	Diff-			Estimated	Interim	Diff-	Estimated	Interim	Diff-
Reimbursement Issue	Entitlement	Payments *	Rec/(Pay)	Notes for Estimate	Payment Methodology	Entitlement	Payments *	Rec/(Pay)	Entitlement	Payments *	Rec/(Pay)
DSH - Old (IE 25% of Trad DSH)	1,196,155	1,177,478	18,677	Used Prior Year DSH Ratio (includes most recent SSI)	Paid Per Claim Plus Lump Sum	1,067,922	1,148,445	(80,523)	(128,234)	(29,033)	(99,200)
DSH - New (Uncompensated Care Pool)	2,478,552	2,027,164	451,388	Compared UCC Pool in CMS Table for FFY15 & FFY 16 to Estimated Paid Amount from PS&R	Paid Per Claim	2,428,980	1,989,992	438,988	(49,572)	(37,172)	(12,400)
IME (Incl Medicare Advantage)	2,180,835	1,308,026	872,808	Use CY I/R Count = to Prior Count, CY Bed Count = to PY Bed Count, PY Int/Bed Ratio Limit, both I/R count and Bed Count adjusted for 2013 audit adjustments	Paid Per Claim Plus Lump Sum	3,450,120	1,260,284	2,189,836	1,269,285	(47,742)	1,317,027
Capital IME	143,812	107,849	35,963	Use Trad Medicare IME from above in Capital IME formula	Paid Per Claim Plus Lump Sum	201,895	105,462	96,433	58,083	(2,387)	60,470
GME (Part A& Part B Combined) Incl Medicare Adv	964,815	713,365	251,450	Use CY I/R Count = to Prior Count, I/R count adjusted for 2013 audit adjustments	Paid Bi-Weekly Plus Lump Sum	1,461,284	713,365	747,920	496,469	-	496,469
Medicare Bad Debt	506,141	481,160	24,982	Used PY original amount, adjusted for 2013 audit adjustments	Paid Bi-Weekly Plus Lump Sum	2,286,722	481,160	1,805,563	1,780,581	-	1,780,581
Total	7,470,311	5,815,042	1,655,269			10,896,922	5,698,707	5,198,215	3,426,612	(116,335)	3,542,946

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Key drivers

Inpatient PPS and Outpatient Services	Key Drivers	Opportunity/Question
DRGs & Outliers; TDRG APCS Specialized Payments	• Medicare Volume • CMI • Wage Index • Pricing Strategy	• Case management/payment accuracy/transfers? • Post payment reviews (TDRG analysis)? • CDI/documentation/chart audits/MD education? • Provider-based status analysis? • Is pricing strategy impacting outlier reimbursement?
IME (IP Only)	• DRG Payments • Count of Residents • Available Beds • Prior Year Ratios	• Case management/payment accuracy/transfers? • Opportunities through bed management? • Shadow billing for MCO claims?
DSH (IP Only)	• DRG Payments • Medicaid Eligible Days • SSI %	• Case management/payment accuracy/transfers? • Process to identify, verify and report ALL eligible days? • Impact of MCO days in SSI?

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Key drivers

Post Acute Services	Key Drivers	Opportunities/Questions
Psychiatric Units **IPF PPS**	• IP Volume • Length of Stay • Patient Acuity	• Case management/documentation/transfers? • Is the actual length of stay clinically appropriate? • Are the diagnosis codes reported accurately?
Rehabilitation Units **IRF PPS**	• IP Volume • Length of Stay • Patient Acuity • LIP%	• Case management/documentation/transfers? • Is the actual length of stay clinically appropriate? • Are the diagnosis codes reported accurately? • What process exists to validate the reported Medicaid and SSI % attributable to the rehab unit?
Skilled Nursing Units	• IP Volume • Length of Stay • Patient Acuity • Strategy	• Is the actual length of stay clinically appropriate? • Is the patient being treated in the most appropriate setting? • Are there opportunities to improve reimbursement through accurate coding?

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Net margin pressure

- **Contractual (Commercial insurance and other)**
  - Accountability to stakeholders
  - Reduced payment levels through tighter contracting
  - Increase focus on paying for quality over quantity
  - Implementation of ICD-10 coding
  - Reduced employer participation in employee health insurance (less coverage; high deductible plans)
  - Increased patient obligations resulting in larger bad debt and charity care adjustments
- **Regulatory (Governmental)**
  - Same as contractual
  - Extreme public awareness and oversight (state and federal matters)
  - Increased budgetary concerns (too many beneficiaries and insufficient resources) Sequester
  - Threat of increased enforcement activities related to overpayments and “fraudulent activities” (RAC;MIC:ZPIC)
- **Economic (All payers)**
  - Higher bad debt and charity adjustments due to general economic conditions in certain markets
  - Improvements in technology not adequately reflected in payment rates
  - Aging physical plant replacement needs
  - Alternative delivery models
  - Industry consolidation

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Strategic questions

- Have you projected how payment reform will impact your future profitability/viability?
- Have you projected how payment reform will impact your patient mix and volumes?
- Do you have a mechanism in place to meet the pay-for-performance reporting guidelines?
- What structure will be your best opportunity?
- How will you reduce costs to serve patients?
- Have you implemented revenue cycle improvement initiatives?

Conclusion

- Understanding the key reimbursement drivers and their connection to the revenue cycle will identify many potential opportunities
- Asking the right questions will create a strategy for implementing change
- Revenue cycle and reimbursement collaboration contributes to financial viability and success for your organization

Questions?

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