HFS Users Group Meeting 2016

The Future Impact of Your Current Medicare Cost Report

What goes on "behind the scenes"
(and what you should be aware of)

Paul Holden

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

Acumen. Agility. Answers.

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Cost Report Format / Setup / Provider Reimbursement Manual

- Importance of the Medicare cost report
- Information used in the report
- Regulations and guidance

Rate Setting

- DRG Rate Setting
- APC Rate Setting

Ancillary Calculations

- Wage Index (Current & Future State of Reporting)
- Outliers
- Worksheet S-10 (Uncompensated Care Reporting)

Best Practices & Utilizing Decision Support

- Department communication
- Extracting useful/optimal data

THE IMPORTANCE OF YOUR COST REPORT

"Why should I be concerned, there is no settlement impact?"

- You may not see any settlement impact year-to-year, but we are entering a new era in prospective rate setting
- Imperative for providers nationwide to work in unison through:
  - Homogenous completion of the Medicare cost report
  - Aligning costs and charges in the prescribed CMS cost centers
  - Utilizing "best-practices" with UB-04 revenue and CPT/HCPCS codes
- Main focus of today is PPS rate setting, but CAH facilities are even more aware of the issue of proper cost center coding

THE CAVEAT - WHY WE ARE HERE TODAY

- Medicare cost report in its original form not designed to support estimate of costs at DRG and APC level
- To increase integrity of changing & designing new DRG and APC weights, a workgroup of hospital experts was convened by the AHA
- Workgroup's recommendations were:
  - To achieve more accurate DRG cost-based weights -
    - All hospitals should prepare their Medicare cost reports so Medicare charges, total charges and overall costs are aligned with each other and with the categories currently utilized in MedPAR file
  - The workgroup considered changes to -
    - Uniform Bill (UB) formats, revenue codes
    - Cost Report, and
    - MedPAR

THE MEDICARE COST REPORT

- Currently, the Medicare cost report is CMS' only standardized cost finding tool for Hospitals, SNFs, HHAs, etc.
- In lieu of "standard federal general ledger format," CMS believes cost report is reasonable / effective alternative

Food For Thought

- B-1 step down allocation has not been revised since inception
- But... calculations within the cost report contain information beneficial to both Medicare and You

HOW DOES CMS USE COST REPORT DATA?

Three primary areas:

- Revise DRG & APC weights
- Market basket relative weights to update payment rates for the CMS Prospective Payment System
- Analyze payment adequacy (is Medicare paying fair and efficient rates for different classes of providers for different types of services)

MARKET BASKET ADJUSTMENT (AVG WEIGHT)

Major expenditure categories used for update:

1)	Wages and salaries	45.819
2)	Employee benefits	12.713
3)	Contract labor	1.806
4)	Pharmaceuticals	1.330
5)	Malpractice insurance	5.402
6)	Blood and blood products	1.069
7)	Residual (all other)	31.861
	Total	100.000

WHAT DATA DOES CMS USE FROM THE REPORT?

- Wage index information
- Total salary & non-salary costs before allocation & adjustments from WKS A to the various cost components
- Total costs before and after allocation from WKS B
- Capital Market Basket (capital costs directly assigned and capital cost data from WKS A-7)

REPORT DATA FIELDS NOT COMPLETED

- Fields on the report not completed can be problematic (i.e. bias in the cost weight)
  - Example: Blood not separated for the majority of hospitals.
- Could be acceptable if the provider's costs for that field are representative of all other providers
- Although problematic if the blood costs are not representative.

MALPRACTICE COSTS

- WS S-2 reporting of malpractice costs
- 1,200 hospitals reported no costs for malpractice, paid losses and/or self insurance information
- How does this impact the market basket?

CONSEQUENCES OF FLAWED REPORTING

- To the extent that providers do not fill in cost report fields, CMS is compelled to make assumptions about costs
- Resort to judgment based methods (instead of strict computational methods) for deriving representative market basket cost weights.
- Example of blood cost weight in the PPS market basket. Over 1,500 hospitals did not report blood costs separately on the cost report.

CMS RECEIVES SPECIAL REQUESTS

- Payment and Cost Analyses Examples:
  - Simulate margins assuming the implementation of payment policy changes
  - Determine the percentage of hospitals in each margin range by critical access status, ownership type, and bed size to determine if the hospitals could afford to implement measures for influenza or Ebola outbreaks

PROVIDER REIMBURSEMENT MANUAL

- Provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for the Aged Act of 1965, as amended.
- Procedures and methods have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished.
- CMS' interpretation of Federal Regulations/Laws which dictate what and how providers report their operating outcomes to CMS.

COST CENTER DEFINITION

PRM 15-1 § 2302.8 Cost Center

- An organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned.
- Natural expense classifications (e.g., depreciation) and non-allowable cost centers (e.g., research) specifically required by the instructions fall under this definition.

COST CENTERS *vs.* GL DEPARTMENTS

Cost Centers:

- May include more than one GL department
- Non-Allowable Costs vs. NRCCs (e.g. Hospital Based Phys.)

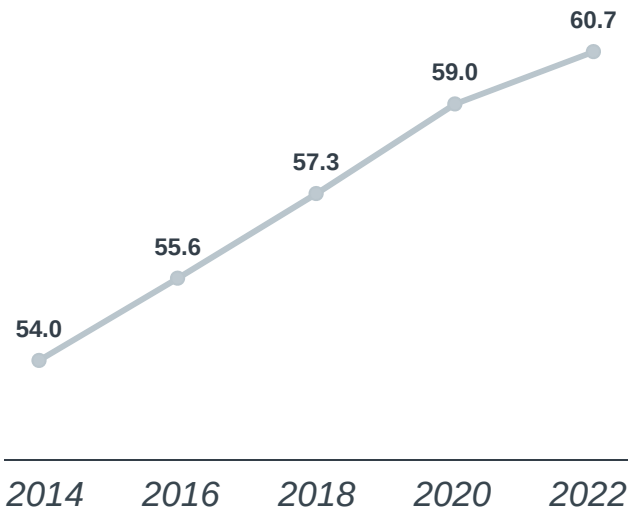
GL Departments:

- Specific to the entity
- Expenses and Revenues may need to be reclassified
  - Examples:
    Blood Products
    Medical Supplies
    Pharmaceuticals

Medicare to Become Majority of Volume by 2022

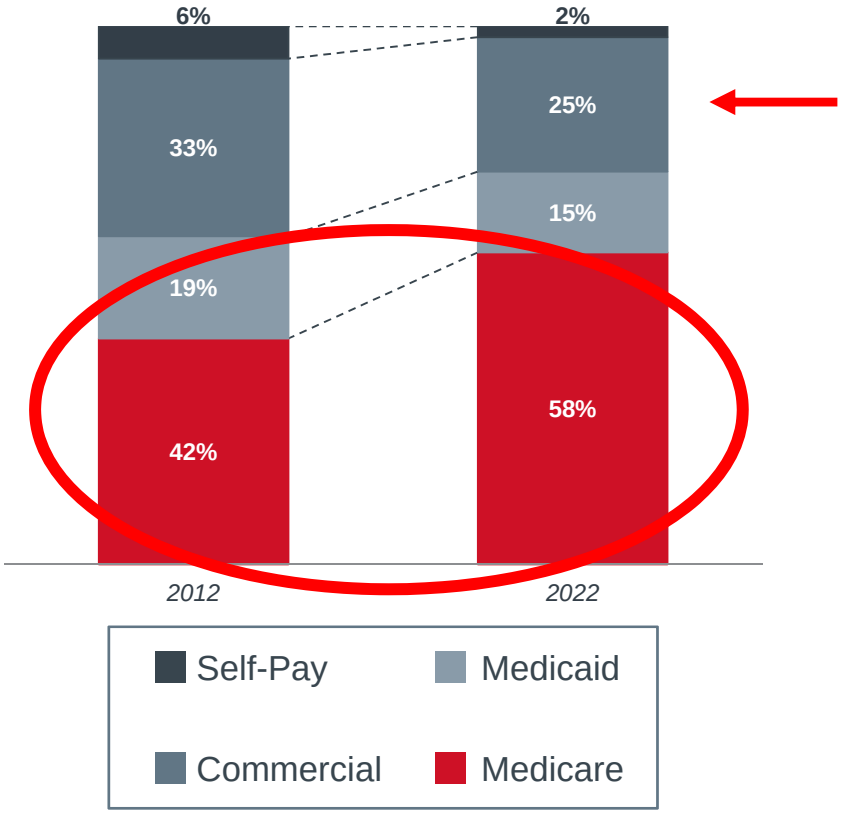
Projected Number of Medicare Beneficiaries

Millions of Beneficiaries



Average Inpatient Case Mix By Volume

n = 785 Hospitals



Source: CMS, "2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," May 31, 2013, available at: http://downloads.cms.gov/files/TR2013.pdf; Health Care Advisory Board interviews and analysis.

DRG RATE SETTING

History and Timeline

- Since1983, Short-Term Acute Care Hospitals have been reimbursed by Medicare under the Inpatient Prospective Payment System (IPPS)
- Under IPPS, all patient illnesses and injuries resulting in admission to a hospital are classified into different diagnosis-related groups (DRGs)
- DRGs should be clinically coherent and relatively homogenous with respect to resources used by a hospital

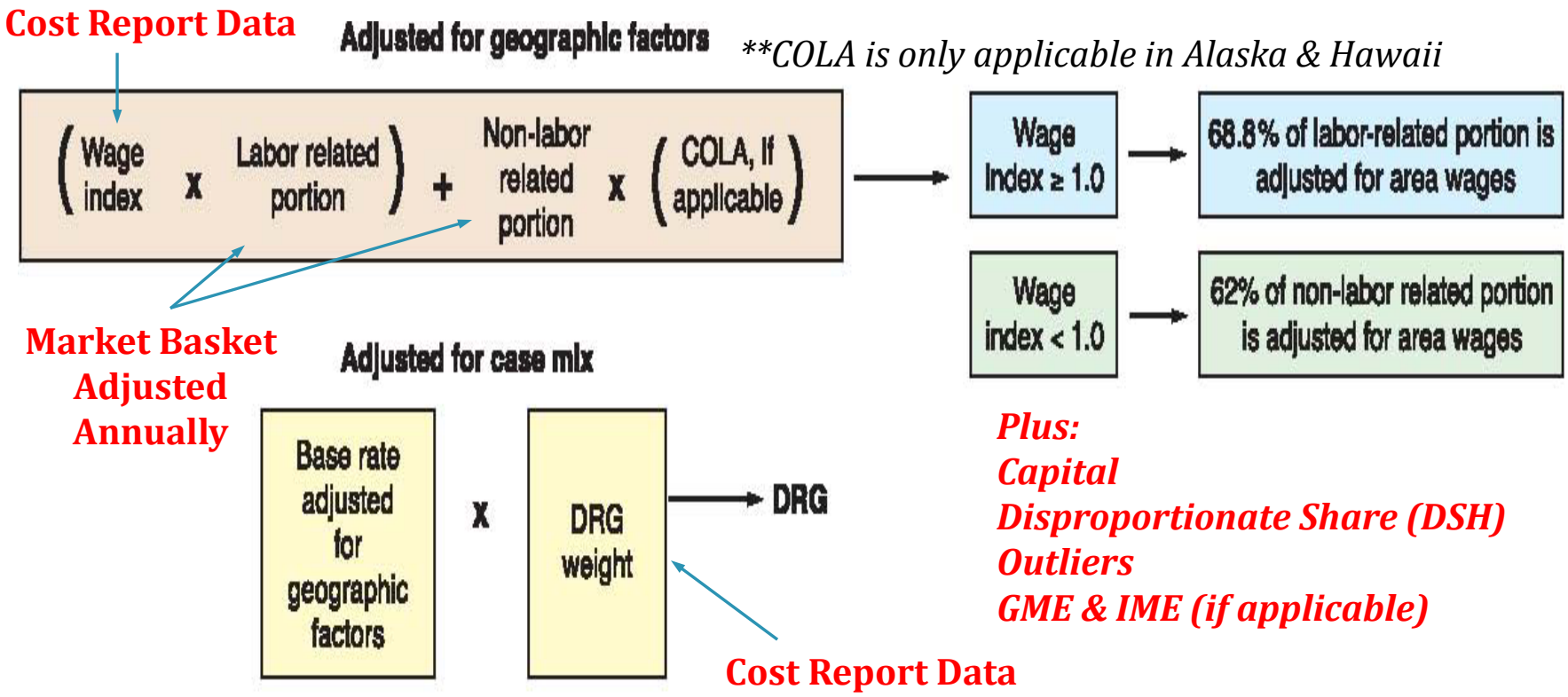
DIAGNOSIS-RELATED GROUPS (DRG)

- Reimbursement based on predetermined DRG case rates, from ICD-10 diagnoses assigned to a patient's case
- Additional reimbursement is made on "high cost" cases known as "Outliers"
- Outlier reimbursement is determined based on charges above threshold set by CMS *(discussed later)*

MEDICARE SEVERITY (MS)-DRGS

- Beginning in FFY2008, CMS implemented MS-DRG system
- Created 745 severity-adjusted diagnosis-related groups, or MS-DRGs, to replace the 538 DRGs under original system (now referred to as CMS-DRGs)
- FFY 2017 – now at 757 MS-DRGs
- MS-DRGs expanded complication/co-morbidity (CC) classifications to include CCs and major CCs (MCCs), which are conditions that require double the additional resources of a normal CC

ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM



Extract from CMS "Hospital Inpatient Prospective Payment System" Fact Sheet

ANNUAL PAYMENT UPDATES AND FUTURE CMS FOCUS AREAS

- To receive the market basket update each year hospitals required to submit quality data and be a meaningful user of Electronic Health Records
- CMS also modifies reimbursement for each Hospital to include the following initiatives and quality measures:
  - Value Based Purchasing (incl. Patient Satisfaction)
  - Readmission Reduction
  - Hospital Acquired Conditions and Present on Admission Indicators

"CHARGE BASED" TO "COST BASED" WEIGHT

- With conversion to MS-DRGs in FFY2007, CMS implemented a change in how DRG weights are developed
- DRG weights previously re-calibrated on a "charge-based system" with claims data from MedPAR file
- CMS used 3 year phase-in to re-calibrate the weights based on a "cost-based" system, utilizing both MedPAR charges and the Medicare cost report
- Belief was revision would lead to creation of DRG weights which more accurately reflected resources consumed

CHARGE-BASED TO COST-BASED "THE IMPACT"

(7 DRG INCREASES AND TOP 7 DRG DECREASES)

MS-DRG	100% Charge Weight (2006)	100% Cost Weight (2010)	Change (06-10)	Change % (06-10)	Weight FFY2015	DRG Title
895	0.4872	0.8653	0.3781	77.61%	1.2152	Alcohol/drug abuse or dependence w rehabilitation therapy
946	0.6720	1.0502	0.3782	56.28%	1.0662	Rehabilitation w/o CC/MCC
945	0.8785	1.2770	0.3985	45.36%	1.2709	Rehabilitation w/ CC/MCC
885	0.6156	0.8316	0.2160	35.09%	1.0217	Psychoses
775	0.3598	0.4770	0.1172	32.57%	0.5643	Vaginal delivery w/o complicating diagnoses
886	0.5737	0.7530	0.1793	31.25%	0.8288	Behavioral & developmental disorders
883	0.7419	0.9713	0.2294	30.92%	1.3062	Disorders of personality & impulse control
249	1.9845	1.6839	-0.3006	-15.15%	1.8808	Perc cardiovascular proc w/ non-drug-eluting stent w/o MCC
251	1.8253	1.5746	-0.2507	-13.73%	2.0399	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC
287	1.1996	1.0352	-0.1644	-13.70%	1.1290	Circulatory disorders except AMI, w card cath w/o MCC
716	1.0956	0.9513	-0.1443	-13.17%	1.1857	Other male reproductive system O.R. proc for malignancy w/o CC/MCC
247	2.2867	2.0000	-0.2867	-12.54%	2.0586	Perc cardiovascular proc w/ drug-eluting stent w/o MCC
847	1.0684	0.9350	-0.1334	-12.49%	1.1569	Chemotherapy w/o acute leukemia as secondary diagnosis w CC
96	2.0458	1.8386	-0.2072	-10.13%	2.0726	Bacterial & tuberculosis infections of nervous system w/o CC/MCC

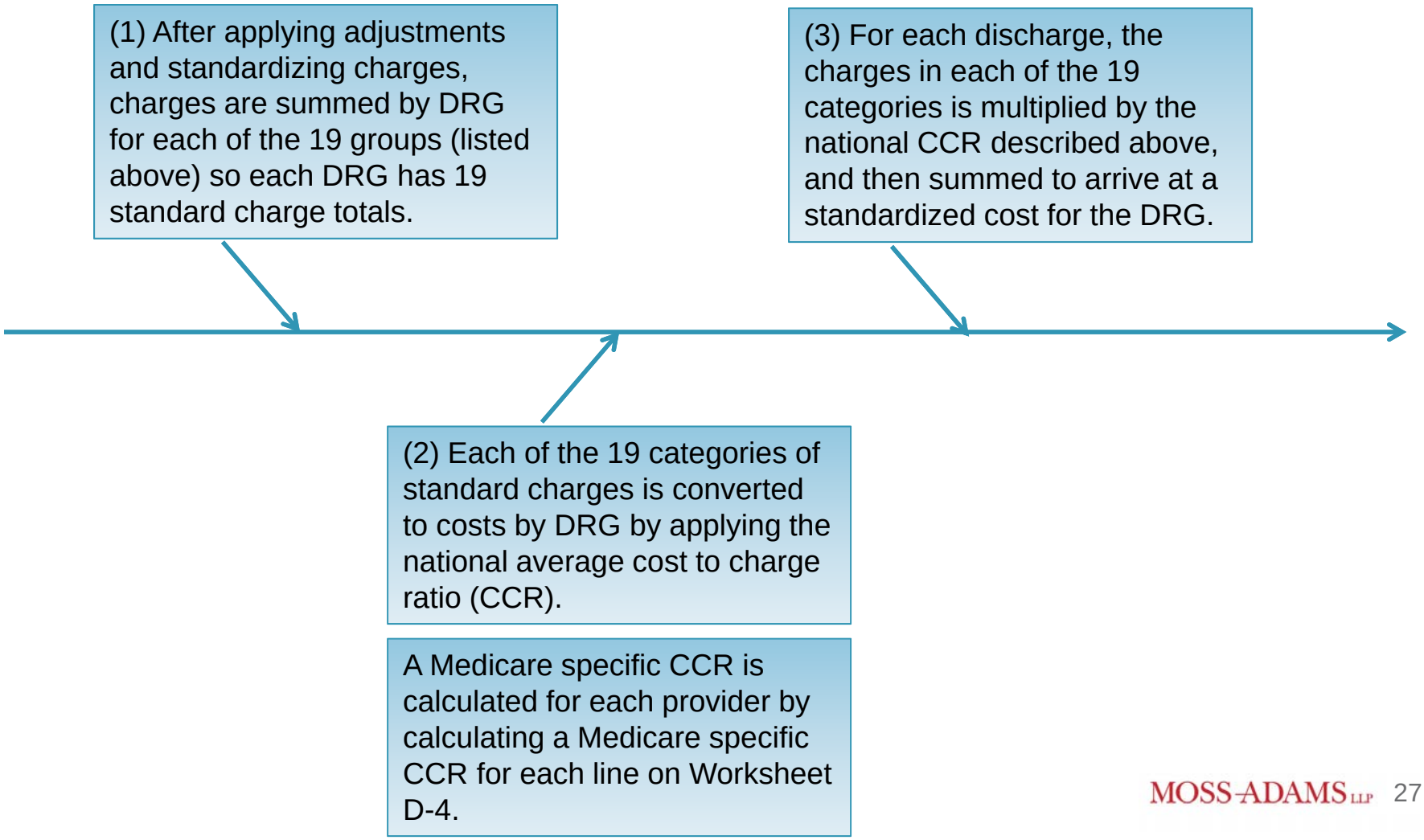
COST BASED WEIGHTING CALCULATION

	Cost Category	Charges	x	CCR	=	Costs
1.	Routine Acute Care	$	x	CCR	=	$
2.	Intensive Care	$	x	CCR	=	$
3.	Drugs	$	x	CCR	=	$
4.	Supplies & Equipment	$	x	CCR	=	$
5.	Therapy Services	$	x	CCR	=	$
6.	Laboratory	$	x	CCR	=	$
7.	Operating Room	$	x	CCR	=	$
8.	Cardiology	$	x	CCR	=	$
	Through					
19.	xxx	$	x	CCR	=	$
	TOTAL	MedPAR Charges		National CCR		Calculated DRG Cost

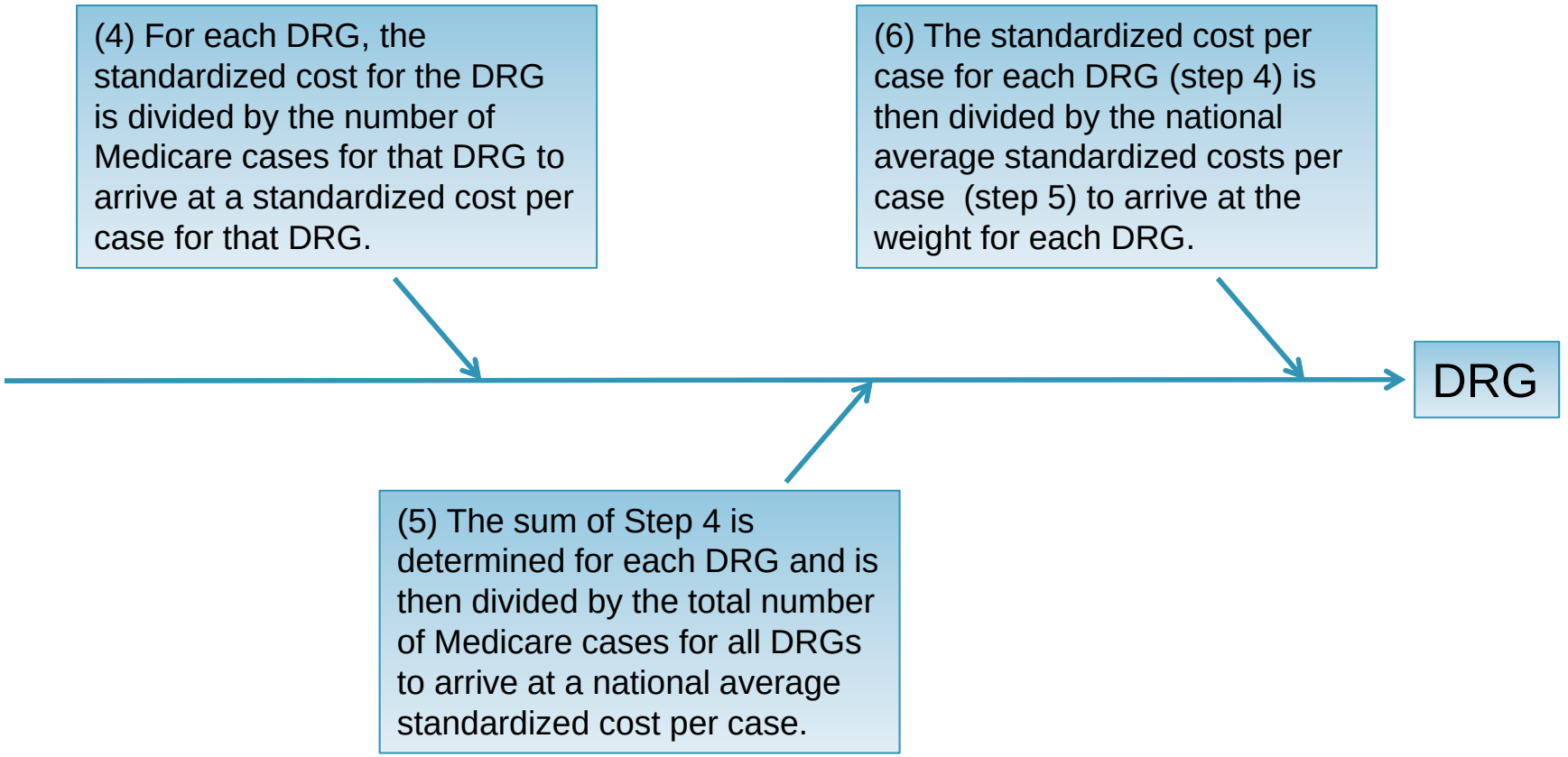
NATIONAL AVERAGE CCRs

Cost Center	WS C CR Lines	Revenue Codes	FFY 2015	FFY 2016	FFY 2017
Routine Services	30	10x, 11x, 12x, 13x, 15x, 16x-19x	.489	.480	.457
Intensive Care/ Coronary Care	31-35	20x, 21x	.407	.393	.375
Drugs	64, 73	25x, 26x, 63x	.192	.191	.194
Supplies & Equipment	71, 96, 97	270-274, 277, 279, 290-299, 621-623	.292	.297	.297
Implantables	72	275, 276, 278, 624	.349	.337	.331
Therapy Services	66-68	42x, 43x, 44x, 47x	.344	.332	.321
Inhalation Therapy	65	41x, 46x	.181	.177	.170
Operating Room	50, 51	36x, 71x	.212	.199	.191
Labor & Delivery (6 MS-DRGs)	52, 93	72x	.398	.404	.410
Anesthesia	53	37x	.114	.106	.089
Cardiology	69	48x, except 481, 73x	.123	.118	.112
Cardiac Cath	59	481	.133	.124	.118
Laboratory	60, 61, 70	30x, 31x, 74x, 75x, 86x	.128	.125	.120
Radiology	54-56	28x, 32x, 331-335, 339, 342-344, 40x	.165	.159	.153
CT Scans	57	35x	.043	.041	.038
MRI	58	61x	.087	.085	.079
Emergency Room	91	45x	.195	.183	.171
Blood & Blood Products	62, 63	38x, 39x	.360	.336	.323
Other Services	75-77, 92	Pretty much all other rev codes	.405	.368	.365

CREATING COST BASED WEIGHTS



CREATING COST BASED WEIGHTS *(cont.)*



ANNUAL RECALIBRATION

- DRG weights re-calibrated on annual basis
- Weights are re-calibrated to reflect resources consumed by each cost-based DRG from most recent MedPAR and Medicare cost report data available
- Updated cost-based weights are then normalized by an adjustment factor, so average case weight after recalibration = to average case weight before recalibration
- Normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS

WORKSHEET C INFORMATION (ILLUSTRATIVE)

(NATIONWIDE-RANKED BY COSTS)

Ranking	State	Costs	Charges	CCR	% of Total
1.	**California**	61,144,809,422	238,703,399,112	**0.256154**	**11.20%**
2.	**New York**	43,172,321,778	112,520,062,407	**0.383686**	**7.91%**
3.	**Texas**	35,054,563,696	143,594,641,583	**0.244122**	**6.42%**
4.	**Florida**	30,875,995,033	140,676,055,328	**0.219483**	**5.66%**
5.	**Pennsylvania**	26,439,497,936	123,589,861,980	**0.213929**	**4.84%**
6.	**Illinois**	24,008,788,635	82,110,692,357	**0.292395**	**4.40%**
7.	**Ohio**	22,277,301,258	77,077,854,655	**0.289023**	**4.08%**
8.	**Michigan**	20,301,398,816	54,566,002,693	**0.372052**	**3.72%**
9.	**New Jersey**	16,289,851,118	77,146,638,917	**0.211154**	**2.98%**
10.	**Massachusetts**	15,802,122,230	42,696,553,869	**0.370103**	**2.90%**
20.	**Washington**	9,956,116,144	30,172,886,390	**0.329969**	**1.82%**
28.	**Oregon**	6,084,196,614	13,997,817,316	**0.434653**	**1.11%**
44.	**Idaho**	2,082,240,255	4,564,152,038	**0.456216**	**0.38%**
	Grand Total	545,807,893,527	1,853,669,432,811	**0.294447**	

CROSS DEPARTMENTAL AGGREGATION BIAS

- A bias which results from consolidation of multiple lines from Medicare cost report in order to limit number of national CCRs used in cost-based DRG weighting calculation

- Mainly an IPPS rate setting issue, as OPPS rates are set using a revenue code crosswalk to the cost center lines from the filed cost reports

- Bias leads to "Weight/Charge Compression," which are CCRs with averages for services with different markup rates. Low-cost MS-DRGs may be systematically over-valued and high-cost MS-DRGs under-valued.

CHARGE COMPRESSION

- Assigning a lower mark-up percentage to high cost items and a higher mark-up percentage for items of lower cost
- Charge compression results from common hospital pricing practices
- Medical supply cost and charges represented the most significant problem area of mismatch
- Reporting Medical Supplies in same cost center as Implantable Medical Devices resulted in a composite ratio of cost to charges for all chargeable supplies
  - Not all hospitals group supply revenue codes to Patient Chargeable Supply cost center

CHARGE COMPRESSION

- Hospitals frequently include supply charges in different ancillary departments (i.e. Operating Room, Emergency, ICU)
- Supply charges are billed on UB-04 claim form using revenue code 27x
- Medical supply charges may be mapped on cost report to line 71 or allocated to various departments where supplies were used
  - CMS wants all supply charges to be reported on Lines 71 and 72
- Other departments of potential concern include:
  - Radiology (Radioisotope, Ultrasound)
  - Pharmacy (High Cost Chemotherapy/Low Cost Aspirin)
  - Infusion Services

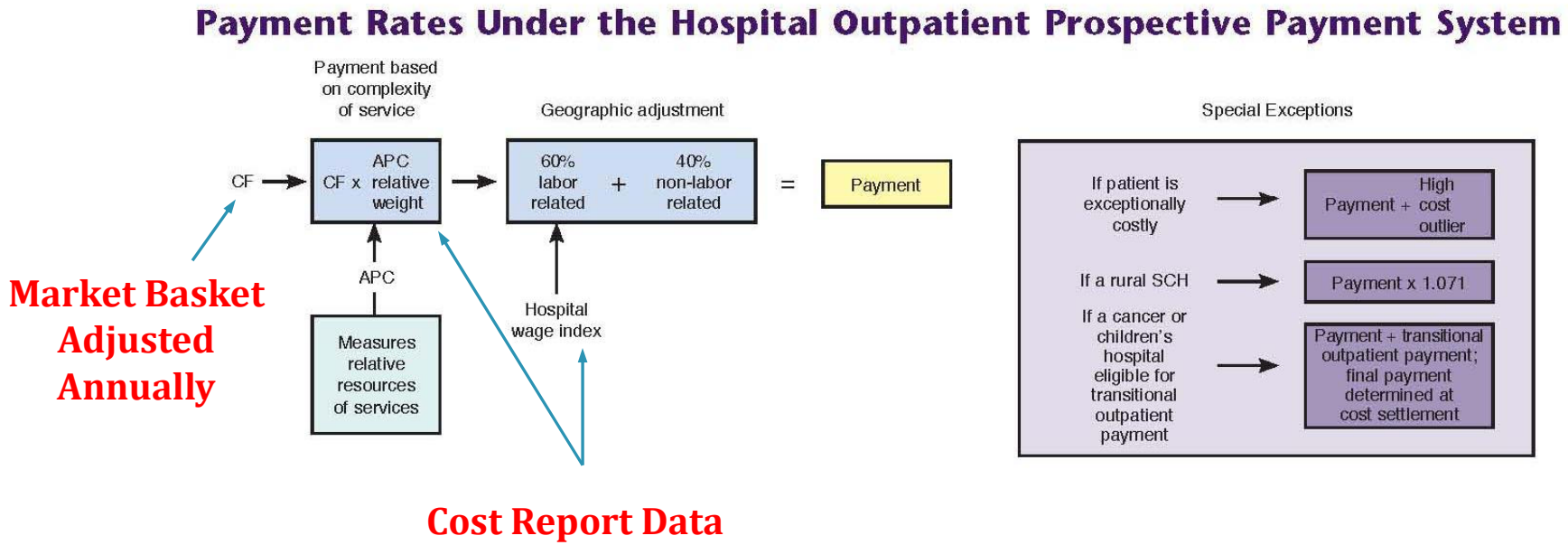
APC RATE SETTING AND WEIGHTINGS

- Payments are calculated by multiplying the relative weight for the service's APC by a conversion factor ($74.909 in CY2017; without submitting quality measures factor is $73.411)
- As with DRGs, the relative weight for an APC measures the resource requirements for the service
- The APC weights are calculated annually by mapping the outpatient charges with their corresponding cost center using the CMS Revenue Code Crosswalk
  - APC weights, particularly device intensive codes, will be more susceptible to changes due to modifications of the cost report's structure and attention to charge compression

AMBULATORY PAYMENT CLASSIFICATIONS (APC)

- Services grouped into classifications that are clinically similar and require similar resources
- Grouping of services into Ambulatory Payment Classification (APC) based on the Current Procedural Terminology (CPT) services provided
- Each APC has separate weighting that is also adjusted by provider's geographic wage index
- Provider may be paid for more than one APC per encounter, however, incremental APCs paid at a discount
- APC rates and weightings updated annually based on provider cost report data
- Patient is responsible for a co-pay of the APC

ACUTE CARE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM



Extract from CMS "Hospital Outpatient Prospective Payment System" Fact Sheet

MEDIAN COSTS TO GEOMETRIC MEAN-BASED

- CMS changed methodology to calculate the APC weightings in CY2013
- Previously, costs per APC case were calculated on Median Cost Basis
- For CY2013, APC case costs calculated using Geometric Mean
- Definitions:
  - Median: The 'middle number' in a population dataset
    - 1, 2, 3, (4), 5, 6, 7
  - Arithmetic Mean: The 'traditional average' of a population dataset
    - (3%+5%+4%)/3
  - Geometric Mean: Similar to Arithmetic (but different as seen below)
    - (3%+5%+4%)^(1/3)

CLINIC AND EMERGENCY VISITS

Level	Type A ED	Type B ED	Clinic
1 – 99281, G0380, G0463	$61.78	$87.42	$105.31
2 – 99282, G0381, G0463	$111.85	$78.91	$105.31
3 – 99283, G0382, G0463	$202.40	$127.08	$105.31
4 – 99284, G0383, G0463	$335.52	$177.91	$105.31
5 – 99285, G0384, G0463	$492.72	$370.75	$105.31

APC "REV CODE – CC" CROSSWALK

2011 Revenue center ID	Description (applicable to CY 2011 claims)	Used in 2013 OPPS NPRM (2011 claims)	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0250	Pharmacy	Y	5600	Drugs Charged to Patients				
0251	Pharmacy: Generic	Y	5600	Drugs Charged to Patients				
0252	Pharmacy: Nongeneric	Y	5600	Drugs Charged to Patients				
0253	Take home drugs	N						
0254	Pharmacy: Incident to other diagnostic services	Y	5600	Drugs Charged to Patients				
0255	Pharmacy: Incident to radiology	Y	5600	Drugs Charged to Patients				
0256	Pharmacy: Experimental drugs	Y	5600	Drugs Charged to Patients				
0257	Pharmacy: Non-prescription	Y	5600	Drugs Charged to Patients				
0258	Pharmacy: IV solutions	Y	5600	Drugs Charged to Patients				
0259	Pharmacy: Other	Y	5600	Drugs Charged to Patients				
0260	IV Therapy	Y	4800	Intravenous Therapy				
0261	IV Therapy: Infusion pump	Y	4800	Intravenous Therapy				
0262	IV Therapy: IV Therapy, pharm services	Y	4800	Intravenous Therapy				
0263	IV Therapy: IV Therapy/drug/supp/delivery	Y	4800	Intravenous Therapy				
0264	IV Therapy: supplies	Y	4800	Intravenous Therapy				

Extract from CY2013 OPPS Final Rule Data Files

ANCILLARY CALCULATIONS

- Wage Index
- Outlier Reimbursement
  - Operating & Capital CCRs (PUF)
- Uncompensated Care & DSH
- Hospital Specific Rate Updates (SCH)
- Others (i.e. GME/IME)

WAGE INDEX-CURRENT MANDATE

- The Social Security Act requires "the Secretary to adjust standardized amounts for ***area differences*** in hospital wage levels **by a factor** (established by the Secretary), reflecting the relative hospital wage level in the ***geographic area of the hospital*** compared to the national average hospital wage level."

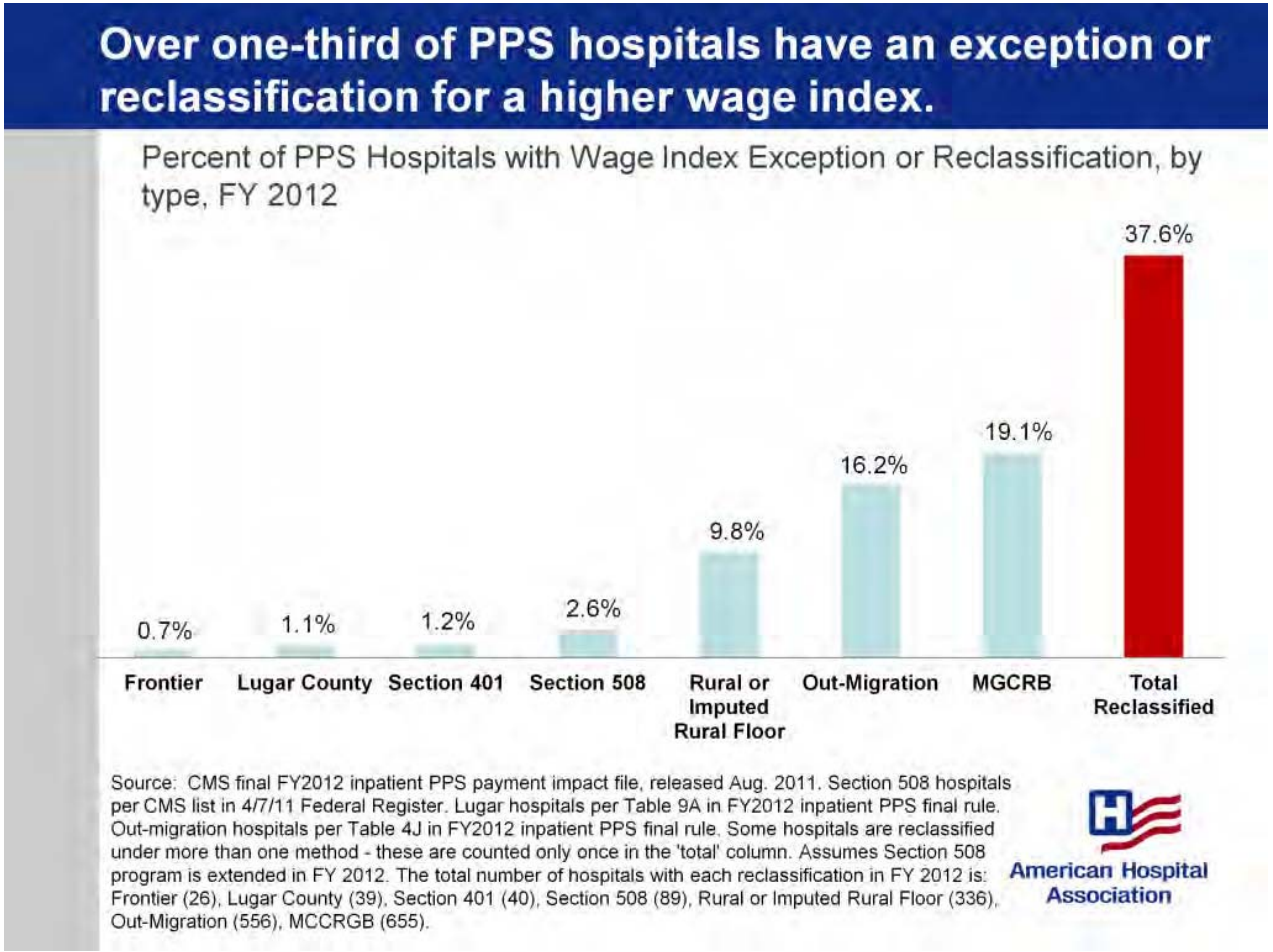
- Area Wage Indices adjust Hospital IP & OP payments for approximately 3,500 PPS Hospitals nationwide.

WAGE INDEX-CURRENT LANDSCAPE

- Under current wage index system, geographically distant hospitals having different labor costs often receive same wage index value when located within the same broad CBSA or county
- As many as 1/3 of IPPS hospitals receive wage index not based on their geo location, but thru many of the current exceptions or adjustment provisions
- Current wage index system doesn't reflect true variation in labor costs for large # of hospitals
  - Requires substantial reform

WAGE INDEX RECLASSIFICATIONS

FROM AMERICAN HOSPITAL ASSOCIATION



WAGE INDEX-COST FINDING

- Worksheet S-3 parts II & III
- Average Hourly Wage information is obtained from the following sources:
  - General ledger payroll dollars (reported on WKS A), net of employed physician compensation, excluded areas, etc.
  - Payroll system hours relating to the above dollars, net of hours relating to differential pay and accrued PTO
  - Contract labor for patient care, physician compensation, A&G, housekeeping and dietary services
  - Wage related Core Costs (i.e. benefits)

WAGE INDEX-COMMON OVERLOOKED ITEMS

- Salaries should include all hourly and salary pay including bonuses and severance pay (which may not have associated hours).
- Accrued PTO dollars should be included on Line 1, Column 2, but only hours relating to PTO paid in the current year should be included in Line 1, Column 5.
- Any allowable contract labor with associated hours should be reported on the Wage Index Survey.
- Core Costs related to the administration of a pension plan, etc. outside of "normal" benefits should be included on the Wage Index Survey.

WAGE INDEX CALCULATION TIMELINE

- The Wage Index for each Federal Fiscal Year is based on information 3 years prior (i.e. FFY2018 Wage Index values are derived from FFY2015 cost report data)
- Each year, MACs notify Hospitals of 2 month review period of Wage Index information for the year in question
- Every 3 years, CMS updates the Occupation Mix Adjustment through a survey process, which was last completed in 2014

WAGE INDEX REFORM

- Section 3137(b) of the Affordable Care Act (ACA) requires comprehensive reform of the Medicare wage index. Reform proposal submitted to Congress on 4/11/2012
- Establish new system to -
  - Use BLS or other data
  - Minimize wage index adjustments between/within MSAs and rural areas
  - Minimize volatility
  - Account for impact on implementation to providers
- Acumen, LLC reviewed and determined a Commuting-Based Wage Index (CBWI) may accomplish intended result to reform the current system

MS-DRG OUTLIER CALCULATIONS

- One of the most sensitive reimbursement mechanisms to changes in cost reporting and submitted charges
- Additional reimbursement for High-Cost Cases are calculated using Outlier Calculation
- Calculation includes the following which are determined by information from Medicare cost report:
  - Wage Index adjustments
  - Hospital Specific CCRs (operating & capital)
  - Uncompensated Care/DSH ddjustment factors, and
  - DRG Weight (as discussed)

MS-DRG OUTLIER CALCULATIONS

- Outlier payment also influenced by significant changes in a Hospital's submitted charges
- CDM increases perpetually in excess of others in the marketplace may create a red flag as Outlier cases may become more frequent for that facility
- Outliers exist to "protect" hospitals from unforeseen financial hardship due to extraordinary High-Cost Cases
- Hospitals should review "IPPS Public Use Impact File" to validate Operating and Capital CCRs and continually monitor their CDMs for appropriate pricing

SECTION 3133 OF THE ACA

Improvement to Medicare disproportionate share hospital (DSH) payments -

- CMS believed DSH reimbursement to hospitals could be reduced in FFY2014 and later due to increase in number of insured
- DSH payments were cut back to 25% of existing amounts, with remaining 75% allocated to hospitals based on uncompensated care provided/reported

REPORTING UNCOMPENSATED CARE

Potential sources for uncompensated care information include -

- Worksheet S-10 (Medicare cost report forms 2552-10)
- IRS Form 990-Schedule H
- Publicly available State reporting, such as OSHPD reports completed by California facilities
- Other, including information from the CBO beginning in FY2018 and after
  - "Other" could be surveys of uninsured populations through various means outside the cost report process

CMS AND UNCOMPENSATED CARE

Uncompensated care has different meanings for CMS, IRS and Financial Statement purposes -

- CMS is calculating uncompensated care on costs, not charges
- Uncompensated care cost calculated using Worksheet C cost to charge ratio X reported uncompensated care charges

WORKSHEET S-10 (DSH IMPLICATIONS)

S-10 only publicly available data source for capturing uncompensated care as described in the following slides –

- **Uncompensated care** — Charity care and bad debt, including non-Medicare bad debt and non-reimbursable Medicare bad debt. *Does not include courtesy allowances or discounts given to patients.*
- **Charity care** — Health services for which hospital demonstrates patient is unable to pay either all or a portion of services. Results from patients who meet certain financial criteria. Unpaid amounts associated with charity care are not considered an allowable Medicare bad debt.

WORKSHEET S-10 IMPLICATIONS

- **Cost to Charge Ratio —** Taken from Worksheet C, Part I, Line 200, Columns 3 and 8, *flow thru calculation in cost report*
  - Notable as WS C excludes hospital-based physicians and NRCC cost centers, including hospital's free-standing clinics
  - Does not include GME costs incurred by hospital
- **Charity Care Charges**
- **Payments on Charity Care Services**
- **Reporting of Bad Debts**

BEST PRACTICES

- Report Preparation
  - Documentation is first priority
    - Maintaining accurate reports throughout year
    - Staff turnover creates confusion & uncertainty
    - Consistency and efficiency are key
  - Begin the process as early as possible
  - DILLY/SALY no longer are acceptable
  - Incorporating prior MAC adjustments

BEST PRACTICES

- Reimbursement Optimization
  - Keeping up with regulations
  - Flexibility of mindsets and cost/benefit considerations
- Department communication
  - Accounting and business office staff need to work in unison on cost report items

EXTRACTING USEFUL/OPTIMAL DATA

- Revenue Usage Reports
- Job Costing Detail (Labor Distribution Reports)
- Time-Study Logs
- Using PS&R for internal use

CONCLUSIONS / QUESTIONS?

- Disparity in payment due to geographic variations is now a national agenda item
- As long as providers are paid based on methods outlined above, providers should pay close attention to both coding and cost containment
- Providers should work with their suppliers to ensure proper invoice coding and cost capture in accounting system
- Providers, to best of their ability, should follow prescribed cost report forms and code their GL accordingly for input in the report
- Continue to review the change in Medicare utilization in your facility between Part A and Part C plans.

Thank you!

Contact Information:
Paul Holden
(503) 478-2108
paul.holden@mossadams.com