Medicare Cost Report Margin

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Assurance ▪ Tax ▪ Consulting

Mike Nichols, CPA, FHFMA

- 30 + years of health care experience
  - Cost reporting (auditing, preparing, reviewing)
  - Contractual allowance and settlement analysis determinations
  - Reimbursement opportunities and strategies
- McGladrey LLP
  - Healthcare Advisory Services
  - Partner (health care consulting)
- HFMA
  - First Illinois Chapter
  - Past President
  - Regional Executive Region 7
  - Advanced Member FHFMA

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Concepts

- Define Medicare margin
- Calculate Medicare margin based for PPS hospital
- Connect Margin discussion to current appeal topics

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Tools and Take-aways

- Margin analysis template
  (request Excel version from presenter)
- Margin analysis cost report references
  (2552-96 and 2552-10 form set)
- Key reimbursement drivers opportunity table

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Cost Report Uses

- External (CMS)
  - Standardized data gathering tool
  - Determination of program liability on annual basis by hospital
  - Reconcile interim payments
  - Comparison of Medicare cost vs. reimbursement
  - Develop future payment amounts and methodology
  - Benchmarking across providers
  - Investigative tool (establish patterns)
- Internal (Provider)
  - Same as CMS (individual/local/competitive basis)
  - Operational assessments and management tool
  - Advocacy and education

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Why Does It Take So Much Time?

- Many data sources
- Ongoing accumulation process
- Statistical data is just as important as financial data
- Shared responsibility
- Other projects deemed to be higher priority
- Internal/external review process

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High Impact Focus Areas

Focus Areas	CR Ref	Topics
Provider Characteristic	S-2	Determines cost report set up and flow through (Part I) New questions added each year based on regulatory updates Incorporates provider questionnaire (Part II)
Patient Statistics	S-3	Counting days impacts DSH, GME and cost-based reimbursement
Wage Index	S-3 PT II-V	Matching issues and future state
Uncompensated Care	S-10	Defining elements and implications for DSH and HIT incentives, as well as importance to external users of cost report information
Cost Allocation	A-C	Allowable costs determination and charges as the basis for apportionment
Settlement Data	D-E	Payment methodologies Internal records vs. PSR (automated crosswalk/PSR interface) Interim payment considerations
Medicare Bad Debts	E series	Reporting process and audit issues
Medical Education	E series	Nursing and Allied Health programs (cost-based and MCNAHE) Direct Graduate Medical Education (DGME) Indirect Medical Education (IME)
Financial Statements	G Series	Source and external uses

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Margin Calculation

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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Medicare Cost:
Fully Allocated vs. Marginal?

- Medicare cost report?
- Modified cost report approach?
  - Groupings
  - Adjustments and reclassifications
  - Cost allocation statistics
  - Charge apportionment issues
- Margin cost approach
  - Definition of fixed vs. variable
  - Matching principle
  - Utilization % (higher Medicare makes marginal costing less insightful)

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Example Medical Center
Medicare Cost Report Margin Analysis

	Charges	Cost	Reimb.	Margin (Deficit)	Contractual Allowance	Reimb % of Charges	Contractual % Charges
Inpatient Acute	240,285,149	92,280,715	76,366,181	(15,914,534)	163,918,968	31.78%	68.22%
Inpatient Capital	0	9,392,723	6,892,491	(2,500,232)	(6,892,491)	2.87%	0.00%
IME	0	0	9,682,537	9,682,537	(9,682,537)	4.03%	0.00%
GME (@ load factor)	0	10,419,703	3,462,899	(6,956,804)	(3,462,899)	1.44%	0.00%
Disproportionate Share	0	0	2,279,560	2,279,560	(2,279,560)	0.95%	0.00%
Nursing/Allied Health (full cost)	0	653,004	270,286	(382,718)	(270,286)	0.11%	0.00%
Psych Unit (PPS)	6,537,685	3,522,464	2,753,752	(768,712)	3,783,933	42.12%	57.88%
Rehab Unit (PPS)	8,635,050	4,617,772	3,475,850	(1,141,922)	5,159,200	40.25%	59.75%
Outpatient (in cost report)	134,512,536	31,837,913	36,114,808	4,276,895	98,397,728	26.85%	73.15%
Total	389,970,420	152,724,294	141,298,364	(11,425,930)	248,672,056	36.23%	63.77%

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Example Medical Center
Managed Care and Load Factor Impact

Original Calculated Margin						**(11,425,930)**
Managed Care IME included above (split on level of DRG amount)					(780,601)	
Managed Care GME included above (MCO/total Mcare days)					(271,670)	
Manage Care Nursing & Allied Health included above					0	
Total Managed Care Impact on Medicare Margin						(1,052,271)
			Load Factor	Full	Net	
Load Factor Impact on Margin	GME		10,419,703	18,040,351	(7,620,648)	(7,620,648)
MCO & Load Factor Impact						(8,672,919)
Adjusted Margin/(Deficit)						**(20,098,849)**

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What Opportunities Exist to (Legally) Improve the Hospital's Medicare Margin?

- Cost
- Pricing strategy
- Reimbursement opportunities

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Great Question:
(The Answer)

- Understanding the key reimbursement drivers will identify many potential opportunities
- Asking the right questions will create a strategy for implementing change
- Communicating results to constituencies will influence their behavior and thought process

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Key Drivers and Opportunities: Inpatient Services (Take-away)

	Key Drivers	Opportunity/Question
DRG, Outliers and New Technology & Capital	▪ IP Medicare Volume ▪ CMI ▪ Wage Index ▪ Pricing Strategy	▪ Case management/payment accuracy/transfers? ▪ Documentation/chart audits/MD education? ▪ WI reporting/analysis/improvement processes? ▪ Is pricing strategy impacting outlier reimbursement?
IME	▪ DRG Payments ▪ Count of Residents ▪ Available Beds ▪ Prior Year Ratios	▪ Case management/payment accuracy/transfers? ▪ IME strategy/documentation? ▪ Opportunities through bed management? ▪ Shadow billing for MCO claims?
DSH	▪ DRG Payments ▪ Medicaid Eligible Days ▪ SSI %	▪ Case management/payment accuracy/transfers? ▪ Process to identify, verify and report ALL eligible days? ▪ Should the hospital pursue a de-exemption strategy regarding existing psychiatric services? ▪ Are all efforts explored to identify and validate reported SSI information? ▪ Impact of MCO days in SSI? ▪ Is the reported information correct?

Key Drivers and Opportunities: Special Inpatient Situations (Take-away)

	Key Drivers	Opportunity/Question
MDH (Rural Facilities Only)	▪ DRG Payments ▪ Historical Cost/Discharge ▪ Location/Size/Medicare Utilization	▪ Is the decline in DRG revenue temporary? ▪ Selecting the correct base period? ▪ Does the hospital qualify? Available beds? ▪ MCO days? ▪ Would conversion to CAH be a possibility?
Other Pass-Through (College of Nursing)	▪ Allowable Costs ▪ Cost Allocation ▪ Cost Apportionment	▪ Are all appropriate net costs reflected in this cost center? ▪ Is the College of Nursing receiving all appropriate statistical allocations? ▪ Is the statistic used to allocate the College costs accurate? ▪ Is the hospital's Medicare utilization or pricing strategy impacting reimbursement?
DGME	▪ Per Resident Amounts ▪ Count of Residents ▪ Rotations ▪ Prior Year count	▪ Have all the correct update factors been applied? ▪ GME strategy/documentation? ▪ Where have all the residents gone? ▪ Is the reported information correct? ▪ MCO days?
Bad Debts	▪ Auditable Documentation Supporting Bad Debts	▪ What processes exist to ensure compliance with contractor documentation requirements?

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Key Drivers and Opportunities: Sub-Provider Services (Take-away)

	Key Drivers	Opportunities/Questions
Psychiatric Units **IPF PPS**	▪ IP Volume ▪ Length of Stay ▪ Patient Acuity ▪ Operating Cost (through transition period routine)	▪ Case management/documentation/transfers? ▪ Is the actual length of stay clinically appropriate? ▪ Are the diagnosis codes reported accurately? ▪ Are the costs apportioned to the Medicare psychiatric unit appropriate? ▪ Is a de-exemption strategy appropriate?
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? ▪ How does the SNF advance the overall organizational strategy?

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Key Drivers and Opportunities: Outpatient & HHA Services (Take-away)

	Key Drivers	Opportunities/Questions
Outpatient PPS (sub-providers may also have OP PPS services)	▪ OP Volume ▪ Patient Acuity ▪ Operating Cost (TOPS providers)	▪ Case management/documentation? ▪ Are the diagnosis codes reported accurately? ▪ Are the costs apportioned to Medicare outpatient services appropriate? ▪ Is pricing strategy impacting reimbursement?
Fee Screen Services: **Lab** **Mammography** **Therapy**	▪ OP Volume ▪ External Referrals ▪ Patient Acuity ▪ Fee Screen Amounts	▪ Case management/documentation? ▪ Any opportunities created through clinical alliances? ▪ Are the diagnosis codes reported accurately? ▪ Is the correct fee screen being applied? ▪ What can the hospital do to improve the reimbursement level?
Home Health Agency	▪ 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? ▪ How does the HHA advance the overall organizational strategy?

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2552-10 References

Inpatient Acute	Charges	Cost	Reimbursement
DRG, Outliers and New Technology	D-3, line 202 plus Routine and SCUs	D-1, line 53	E pt A, lines 1 through 3, plus E pt A line 54
IME			E pt A, line 29
DSH			E pt A, line 34
Capital		D-1, line 52 minus other pass-through costs (below)	E pt A, line 50
MDH			E, pt A, line 49 minus line 47
Other Pass-Through		D part III plus D part IV	E pt A, lines 57 plus 58
DGME		B Pt I, Col. 21+22, * •E-4, line 28 •(load factor) apportioned to part A & B	E pt A, line 52
Bad Debts			E pt A, line 65

2552-10 References

Sub-providers	Charges	Cost	Reimbursement
Psychiatric Units IPF PPS	D-3, line 202 plus Psychiatric Unit Routine	D-1, line 53, Psychiatric Unit Sub-provider	E-3 pt II, line 31 for IPF PPS component
Rehabilitation Units IRF PPS	D-3, line 202 plus Rehab Unit Routine	D-1, line 53, Rehab Unit Sub-provider	E-3 pt III, line 32 for IRF PPS component
Skilled Nursing Units	D-3, line 202 plus SNF Unit Routine (add as these are not on CR)	D-1, part III, line 86	E-3 pt VI, line 4 for SNF PPS component (this includes SNF RUGs payments, plus any pass-through costs) (College of Nursing)
Home Health Agency	S-4, line 35	H-3, Col 12, line 7 (plus medical supplies)	H-4, Col. 1 & 2, line 29

2552-10 References

Outpatient	Charges	Cost	Reimbursement
Outpatient PPS (sub-providers may also have OP PPS services)	D pt V, col. 2 line 202 (hospital and any sub-providers)	D pt V, Col. 5 line 202 (hospital and any sub-providers)	E pt B, line 3 plus line 8 (hospital and any sub-providers)
Cost Based Services	D pt V, col. 3 line 202 (hospital and any sub-providers	D pt V, Col. 6 line 202 (hospital and any sub-providers	E pt B, line 1 plus line 9 (pass-through costs) (hospital and any sub-providers)
DGME		B pt I, Col. 21+22, * • E-4 line 28 • (Load factor) apportioned to Parts A & B	E pt B, line 28
Bad Debts			E pt B, line 35

2552-10 References

Fee Screen	Charges	Cost	Reimbursement
Clinical Laboratory	PSR: Report types 125,135,145: Laboratory revenue codes only (300-310)	D pt V, Col. 3 line 44, multiplied by the related charges	PSR: Report types 125,135,145: Laboratory revenue codes only (300-310) ((REIMB)
Screening Mammography	Report types 125,135,145: Mammography revenue codes only (400-403)	D pt V, Col. 3, line 41 (or wherever total costs and charges are grouped), multiplied by the related charges	Report types 125,135,145: Mammography revenue codes only (400-403) (REIMB)
PT(50)/(42x) **OT (51)/(43x)** **SP(52)/(44x)** **Therapy Services**	Report types 125,135,145: PT/OT/SP revenue codes only (420-440)	D part V, Col. 3, lines 50, 51, 52 (or wherever total costs and charges are grouped), multiplied by the related charges	Report types 125,135,145: PT/OT/SP revenue codes only (420-440) (REIMB)
Bad Debts			None

2552-96 References

Inpatient Acute	Charges	Cost	Reimbursement
DRG, Outliers and New Technology	D-4, line 103 plus Routine and SCUs	D-1, line 53	E pt A, lines 1 through 1.08, plus E pt A, line 2.10, plus E pt A line 11.02
IME			E pt A, line 3.24
DSH			E pt A, line 4.04
Capital		D-1, line 52 minus other pass-through costs (below)	E pt A, line 9
MDH			E, pt A, line 8 minus line 6
Other Pass-Through		D part III plus D part IV	E pt A, lines 14 plus 15
DGME		B Pt I, Col. 22+23, * •E-3 pt IV, line 6 •(load factor) apportioned to part A & B	E pt A, line 11
Bad Debts			E pt A, line 21.01

2552-96 References

Sub-providers	Charges	Cost	Reimbursement
Psychiatric Units IPF PPS	D-4, line 103 plus Psychiatric Unit Routine	D-1, line 53, Psychiatric Unit Sub-provider	E-3 pt I, line 1.23 for IPF PPS component
Rehabilitation Units IRF PPS	D-4, line 103 plus Rehab Unit Routine	D-1, line 53, Rehab Unit Sub-provider	E-3 pt I, line 1.06 for IRF PPS component
Skilled Nursing Units	D-4, line 103 plus SNF Unit Routine (add as these are not on CR)	D-1, part III, line 82	E-3 pt III, line 30 for SNF PPS component (this includes SNF RUGs payments, plus any pass-through costs) (College of Nursing)
Home Health Agency	S-4, line 35	H-6, Col 12, line 7 (plus medical supplies)	H-7, Col. 1 & 2, line 18

2552-96 References

Outpatient	Charges	Cost	Reimbursement
Outpatient PPS (sub-providers may also have OP PPS services)	D pt V, col. 5.01 line 104 (hospital and any sub-providers)	D pt V, Col. 9.01 line 104 (hospital and any sub-providers)	E pt B, line 1.02 plus line 1.06 (hospital and any sub-providers)
Cost Based Services	D pt V, col. 5 line 104 plus D pt VI, line 2 (hospital and any sub-providers	D pt V, Col. 9 line 104 plus D pt VI, line 3 (hospital and any sub-providers	E pt B, line 1 plus line 1.07 (pass-through costs) (hospital and any sub-providers)
DGME		B pt I, Col. 22+23, * •E-3 pt IV, line 6 • (Load factor) apportioned to Parts A & B	E pt B, line 21
Bad Debts			E pt B, line 27.01

Conclusion

- Understanding the key reimbursement drivers will identify many potential opportunities
- Asking the right questions will create a strategy for implementing change
- Communicating results to constituencies will influence their behavior and thought process

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