A Look Inside Hospital Reimbursement
Objectives

♦ General overview of Hospital Reimbursement
♦ General overview of Medicare
♦ BRIEF overview of Medicaid
♦ “VERY BRIEF” overview of the future of Reimbursement
Reimbursement Department Responsibilities

- Monitor and Research changes in Federal and State regulations
- Estimated Third Party Liabilities
- Net Patient Revenue Calculations
- Compliance Assistance
- Policy Updates and Process Improvements
- Medicare & Medicaid Cost Report Preparation
Estimated Third Party Liability Accounts

♦ Monthly Settlements
  – Medicare Settlement Account
  – Medicaid Settlement Account

♦ Prior Year Cost Reports
  – have not yet been settled by Medicare and Medicaid,

♦ Current Year Cost Report
  – model reflects an actual cost report using updated statistics; current payment rates; existing and pending regulation; etc…

♦ Gains/Losses
Net Patient Revenue Calculations

- Estimate the net collectible value of patient accounts receivable

- Utilizes both historical trends of charity, bad debt, and contractual write-offs, as well as current payment terms and methods for all payors to estimate how much a hospital will be able to collect on their gross receivables.

- Differences are recorded as reserves on the balance sheet so that patient receivables are stated at expected collectible levels.
Net Patient Revenue Calculations (cont.)

♦ Allowance for Doubtful Accounts
  - a balance sheet account that reduces the reported amount of accounts receivable, providing a more realistic picture of how much of the accounts receivable will turn to cash.
  - a change to the balance in the allowance for doubtful accounts directly affects bad debt expense on the income statement

♦ Bad Debt Expense
  - accounts receivable that is no longer considered collectible

♦ Contractual Adjustments (revenue deduction)
  - The difference between billings at established charges and amounts received or due from third-party payors under contract agreements
Hospital’s procedures should ensure that:

- Costs are not claimed [on the cost report] unless based on appropriate and accurate documentation; allocations of costs to various cost centers are accurately made and supportable by verifiable and auditable data;
- Unallowable costs are not claimed for reimbursement;
- Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;
- Costs are properly classified;
- FI prior year audit adjustments are implemented and are either not claimed for reimbursement or claimed for reimbursement and clearly identified as protested amounts on the cost report;
Reimbursement & Compliance (CONT.)

- All related parties are identified on Form 339 submitted with the cost report and all related party charges are reduced to cost;
- The hospital’s procedures for reporting of bad debts on the cost report are in accordance with federal statutes, regulations, guidelines and policies;
- Allocations from a hospital chain’s home office cost statement to individual hospital cost reports are accurately made and supportable by verifiable and auditable data; and
- Procedures are in place and documented for notifying promptly the Medicare Fiscal Intermediary (or any other applicable payor such as Medicaid or TRICARE) of errors discovered after the submission of the hospital cost report, and where applicable after the submission of a hospital chain’s home office cost statement.
Recent settlement agreements due to non-compliance as it relates to the Medicare cost report

♦ **US vs Meadows Regional Medical Center - $1,200,000**
  – Filed cost reports that included salary expenses for a person who was not performing 100% of her time on reimbursable patient care.

♦ **U.S. v. Penn Med Consultants, Inc. - $2,100,000**
  – Knowingly claimed or caused to be claimed for reimbursement by Medicare and Medicaid false and fraudulent home office expenses in PenMed’s Medicare home office cost statements and in the individual nursing homes’ Medicare and Medicaid cost reports.

♦ **U.S. v. Columbia/HCA - $90,000,000**
  – Submitted Medicare cost reports that improperly included the management fee costs related to the acquisition of the Olsten, ResCare, AbleCare, CareOne and Central home health agencies in Florida, Georgia and Alabama
A brief overview of the Medicare program

♦ Federally Funded program which was enacted as a part of the Social Security Amendments of 1965.

♦ Centers for Medicare and Medicaid Services (CMS) is responsible for day-to-day administration of the program

♦ Medicare Eligibility
  – Age 65
  – Disabled Persons – 2 year waiting period from the time the person is deemed disabled
  – ESRD – (End Stage Renal Disease) – Patient has less than 5% functional kidney capability. Medicare kicks in on the 4<sup>th</sup> month after diagnosis
Overview of Medicare reimbursement payment methodologies

♦ Inpatient (Part A) – PPS (Prospective Payment System)
  – MS-DRGs (Medical Severity Diagnosis Related Groups) & Related Rules

♦ Outpatient (Part B) – OPPS (Outpatient PPS)
  – APCs (Ambulatory Payment Classifications)

♦ Capital – PPS

♦ Outlier payments – Formula
  – Add on for extremely costly cases

♦ Outpatient Diagnosis Lab – Laboratory Fee Schedule

♦ Respiratory, Physical, Occupational, and Speech Therapy
  – Fee Schedule
Overview of Medicare reimbursement payment methodologies (cont…)

- Bad Debts – Formula (70% of Medicare deductible and co-insurance)
- DSH (Disproportionate Share) costs – Formula (Medicaid Days % plus SSI percentage)
- Direct Graduate Medical Education – Resident FTE
- Indirect Medical Education – Formula (Resident FTE and Available Beds)
- Paramedical Education – Pass-through Payment
Overview of Medicare reimbursement payment methodologies (cont…)

- Rehab Units – PPS
- Psych Units – PPS
- Skilled Nursing Units – PPS
- Swing Bed Units - PPS
- Home Health Agency – PPS
- Critical Access Hospitals – Cost Based
Critical Access Hospitals

♦ Inpatient, Outpatient, and Swing Bed Units are paid at 101% of costs (not DRG, APC, or PPS)
♦ Bad Debts are paid at 100% of the Medicare deductible and coinsurance
♦ A hospital must meet certain criteria to be designated a CAH
  – Less then or equal to 25 beds
  – Average Length of Stay of 96 Hours
  – Located 35 Miles from the nearest hospital
  – Other Criteria
♦ Every expense will be scrutinized by Medicare!
Costs Not Related To Patient Care

- Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities.
  - Costs of meals sold to visitors
  - Costs of drugs sold to other than patients
  - Cost of operation of a gift shop
  - Cost of alcoholic beverages furnished to employees or to others regardless of how or where furnished, such as at a provider picnic or as a fringe benefit
  - Cost of gifts or donations
  - Cost of entertainment, including tickets to sporting and other entertainment events such as golf outings, ski trips, etc.
  - Cost of personal use of motor vehicles
  - Cost of fines or penalties resulting from violations of Federal, State or local laws
  - Cost of educational expenses for spouses or other dependents
  - Cost of meals served to executives that exceed the cost of meals served to ordinary employees due to the use of separate dining facilities
Costs Not Related To Patient Care (cont…)

- Cost of travel incurred in connection with non-patient care related purposes
- Costs of fund-raising, including advertising, promotional, or publicity costs
- Costs of advertising of a general nature designed to invite physicians to utilize a provider’s facilities in their capacity as independent practitioners
- Costs of advertising to the general public which seeks to increase patient utilization of the provider’s facilities
- Political and lobbying activities
Prospective Payment System
DRG Definition

♦ a system to classify hospital cases into one of approximately 500 groups, equaling 745 MS-DRG’s also referred to as DRGs, developed for Medicare as part of the prospective payment system.

♦ MS-DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or comorbidities.

♦ DRGs have been used since 1983 to determine how much Medicare pays the hospital, since patients within each category are similar clinically and are expected to use the same level of hospital resources.
Prospective Payment System (cont.)
Core Components

- The standardized amounts, which are the basic payment amounts.
- A wage index to account for differences in Core Based Statistical Area (CBSA) labor costs.
- The DRG relative weights, which account for differences in the mix of patients treated across hospitals.
- An add-on payment for hospitals that serve a disproportionate share of low-income patients.
- An add-on payment for hospitals that incur indirect costs of medical education.
- An additional payment for cases that are unusually costly, called outliers.
## Wage Index (DRG Calculation – FY’10 is Proposed)

<table>
<thead>
<tr>
<th></th>
<th>FY'09</th>
<th>FY'10</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>Standard Labor Rate (PUBLISHED)</td>
<td>$3,179.61</td>
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<tr>
<td>B</td>
<td>x Wage Index (Based on Area &amp; Wage Index)</td>
<td>0.9884</td>
</tr>
<tr>
<td>C</td>
<td>Adjusted Labor Rate - (A*B)</td>
<td>$3,142.73</td>
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<tr>
<td>D</td>
<td>Non-labor Rate (PUBLISHED)</td>
<td>$1,948.80</td>
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<tr>
<td>E</td>
<td>Federal Rate - (C+D)</td>
<td>$5,091.53</td>
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<tr>
<td>F</td>
<td>Weight Factor (Based on DRG)</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Federal Portion - (E*F)</td>
<td>$5,091.53</td>
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<tr>
<td>H</td>
<td>DSH Factor (FORMULA)</td>
<td>0.207737</td>
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<tr>
<td>I</td>
<td>DSH Portion - (G*H)</td>
<td>$1,057.70</td>
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<tr>
<td>J</td>
<td>Indirect Medical Education Factor (FORMULA)</td>
<td>0.110739</td>
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<td>K</td>
<td>Indirect Medical Education Portion - (G*J)</td>
<td>$563.83</td>
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<tr>
<td>L</td>
<td>Federal Capital Portion (PUBLISHED)</td>
<td>$420.78</td>
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<tr>
<td>M</td>
<td>100% Federal Capital Portion - (F*L)</td>
<td>$420.78</td>
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<tr>
<td>N</td>
<td>Capital DSH Factor (FORMULA)</td>
<td>0.080542</td>
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<tr>
<td>O</td>
<td>Capital DSH Adjustment - (M*N)</td>
<td>$33.89</td>
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<td>P</td>
<td>Capital IME Factor (FORMULA)</td>
<td>0.040699</td>
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<td>Q</td>
<td>Capital IME Adjustment - (M*P)</td>
<td>$17.13</td>
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<tr>
<td>R</td>
<td>Total Per Discharge - (+G+I+K+M+O+Q)</td>
<td>$7,184.85</td>
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Wage Index Review

- Wage Index Review
  - Measures relative differences between each labor market’s average hourly rate and the national average hourly rate (Wage Index Factor)
  - A cost of living differentiator that is a primary driver as to how a hospital will be reimbursed under PPS
  - Applied to the “labor” component of the standardized amount
    - If Factor is $\geq 1$, the labor component is 69.7% of the total standardized amount
    - If Factor is $< 1$, the labor component is 62% of the total standardized amount

- Occupational Mix Filings
  - Medicare requires collection of data every 3 years on the occupational mix of employees for all PPS Hospitals (not applicable for CAHs)
  - Additional adjustment to the Wage Index to ensure that the wage index reflects only geographic differences in the price hospitals pay for labor and not for differences in the mix of their employees (i.e. RN to LPN)
### Wage Index (extreme differences in DRG rates based on greater then or less then a factor of 1)

<table>
<thead>
<tr>
<th>Wage Index Area</th>
<th>FY07 Base Rate</th>
<th>Labor Share</th>
<th>Wage Index</th>
<th>Labor-Related Portion</th>
<th>Non-Labor-Related Portion</th>
<th>Base DRG Payment</th>
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<tbody>
<tr>
<td>Highest</td>
<td>4,874.00</td>
<td>0.697</td>
<td>1.5617</td>
<td>5,305.37</td>
<td>1,476.82</td>
<td>6,782.19</td>
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<tr>
<td>Lowest</td>
<td>4,874.00</td>
<td>0.620</td>
<td>0.7368</td>
<td>2,226.52</td>
<td>1,852.12</td>
<td>4,078.64</td>
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<tr>
<td>Difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,703.55</td>
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</table>

*Source: Final FY07 Federal Register 71, no. 196 (October 11, 2006): 59890*
Wage Index Review (Wage Index Factor Comparison)

Ohio CBSAs

- Cleveland
- Toledo
- Akron
- Cincinnati
- Dayton
- Estimated 2011

Medicare Cost Report

- In accordance with Federal Regulations, providers participating in the Medicare program are required to submit information on an annual basis within 5 months of their FYE to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries.

- The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data.

- When a provider fails to file a timely and accurate cost report, all payments since the beginning of the cost reporting period can be deemed overpayments.
Medicare Cost Report Worksheets

- Worksheet S – General Provider Information
- Worksheet A – Operating Expenses vs. Reimbursable Expenses
- Worksheet B – Cost Allocation: Overall Costs & Capital Costs
- Worksheet C – Ratios of Costs to Charges
- Worksheet D – Pass-Through Costs
- Worksheet E – Reimbursement Settlements
- Worksheet F – Return On Equity Capital
- Worksheet G – Financial Statements
- Worksheet H – Home Health Agency Cost Report
- Worksheet I – Renal Dialysis Cost Report
- Worksheet J – CORF Cost Report
- Worksheet K – Hospice cost report
Significant Medicare Cost Report settlement components

♦ Bad Debts
♦ DSH
♦ Direct Graduate Medical Education
♦ Indirect Medical Education

The above items represent additional payments to hospitals over and above DRG payments.
Bad Debts

- Paid at 70% of outstanding Medicare deductible and/or co-insurance (CAHs are paid at 100%), net of any recoveries from bad debts already claimed in a prior year.

- Must meet the following criteria to be deemed a bad debt:
  - Related to covered services and derived from Medicare deductible and coinsurance amounts.
  - Documentation exists to establish that a genuine and reasonable collection effort was made (not a token effort).
  - Documentation exists to establish that the collection effort was consistent with other payers.
  - At least 120 days between date of first billing (or date of last payment) and date of write off to bad debt.

- Bad Debts arising from services paid under a fee-schedule (i.e. therapy services) or professional services (physician) are not reimbursable.
Disproportionate Share Hospital (DSH) Payments

♦ Additional payment to PPS Hospitals (not applicable for CAHs) that serve a large number of low-income patients

♦ Payment determined through a formula driven by a DPP (Disproportionate Patient Percentage)
  – Medicaid % of patient days (including nursery days) which is calculated by dividing Medicaid Days into Total Days **PLUS**
  – SSI % (Supplemental Security Income) which is provided by Medicare
    • federally funded program that makes payments to people with low income who are age 65 or older or are blind or have a disability

♦ A hospital’s DPP must equal 15% to qualify for DSH
Direct Graduate Medical Education (GME)

♦ GME payments compensate teaching hospitals for the costs directly related to educating residents:
  – Residents’ stipends/fringe benefits
  – Salaries/fringe benefits of physician faculty who supervise the residents
  – Other direct costs associated with resident training costs, such as the cost of clerical personnel that work in the graduate medical office
  – Allocated overhead costs
Direct Graduate Medical Education (GME) (cont…)

♦ GME Payment

- Based on hospital-specific per resident amounts determined according to the hospital’s 1984 direct GME costs updated by inflation to current year
- Per resident amounts may differ for primary care residents and non-primary care residents
  - Primary care is defined as family medicine, general internal medicine, general pediatrics, preventive and geriatric medicine, osteopathic general practice, and OB/GYN
- The updated per resident amounts are multiplied by a “weighted count” of residents
Indirect Medical Education (IME)

♦ Reflects a % adjustment to the Medicare PPS per case payment that teaching hospital’s receive
  – Due to higher patient care costs relative to non-teaching hospitals
    • The patient severity of illness is not fully captured by the DRG system
    • Lower staff productivity
    • Additional diagnostic tests that residents may order as part of their learning process
Indirect Medical Education (IME) (cont…)

♦ IME Payment
  – Amount depends on a hospital’s teaching intensity as measured by the ratio of the number of interns and residents per bed (IRB)
  – Formula was changing each FY through 2008 due to Modernization Act of 2003
  – For every Medicare case paid under I/P operating PPS, a % add-on is applied to the base DRG payment
  – The amount of the percentage add-on is determined by inserting the hospital’s IRB ratio into a formula determined by Medicare statute
Cost Report Processes

♦ Filing Process
  – required to submit information on an annual basis within 5 months of their FYE

♦ Refiling Process
  – Filed after original cost report filing
  – Subject to Medicare approval (not required to review or accept)
  – Written Request
    • Includes: Explanation for refiling, Regulatory quotation, Supporting documentation
Cost Report Processes (cont...)

♦ Audit Process
  – Medicare Fiscal Intermediary
  – Desk Review or Field Review
  – Usually within 1 year
  – Length of time of the audit and inquiries/requests vary by hospital and even by auditor
  – Proposed adjustments
    • These need to be reviewed by our department for errors

♦ Settlement Process
  – Notice of Program Reimbursement (NPR)
    • Includes: Adjustments, Revised cost report, Appeal instructions
  – Timeframe for appeals & reopenings begins with the date of the NPR (not the date it is received)
Cost Report Processes (cont…)

♦ Reopening Process
  – File within 3 years of NPR date
  – Correct material error in report
  – Settlement of contested items or appeal issues
  – May be initiated by Hospital or Medicare
  – Subject to Medicare approval (not required to review or accept)
  – Written request
    • Includes: Reason for reopening, Regulatory quotation, Supporting documentation

♦ Appeal Process
  – File appeal letter within 180 days of NPR date
  – Appeal can be related to:
    • Audit adjustments made by Fiscal Intermediary
    • Protested amounts adjusted by Fiscal Intermediary
A brief overview of the Medicaid program

- State and Federally Funded program which was also enacted as a part of the Social Security Amendments of 1965.

- Ohio Department of Job and Family Services (ODJFS) is responsible for day-to-day administration of the program.

- Medicaid coverage to the following who have limited income:
  - Children
  - Pregnant Women
  - Families
  - Adults age 65 and older
  - Disabled Persons
Medicaid Cost Report

- Providers participating in the Medicaid program are required to submit information on an annual basis either by June 30th or December 31st depending on their FYE.

- Majority of the information taken from the Medicare Cost Report, in addition to utilization data and Medicaid settlement data.

- Significant settlement component is Capital Costs.

- Uncompensated Care Data which must be verified by an independent party and directly relates to HCAP payments.
The Ohio Hospital Care Assurance Program (HCAP)

- This program provides additional payment to hospitals that provide services to the indigent and uninsured.
- If patients do not have insurance or do not qualify for Medicaid they are eligible to qualify for HCAP if they meet certain income levels and other requirements.
- Disability assistance
- <100% Federal Poverty Level
- >100% Federal Poverty Level
- Payment
  - Cost to charge ratio driven
  - 73% of DA & HCAP cost for FY 2008
Passed the 2010-11 State Budget which will tax hospitals by assessing their operating expenses 1.52% in 2010 and 1.61% in 2011

To reduce the impact of this new tax, there will be a 5% increase to Medicaid payments (effective Oct. 1, 2009) and supplemental Medicaid payments for inpatient and outpatient services (Upper Payment Limit program)

Ohio Hospital Association estimates a net loss of approximately $145 million for Ohio Hospitals.

HCAP remains intact
Future of Reimbursement - Federal

- All legal residents would be required to enroll in a health insurance plan meeting certain minimum standards or face a tax penalty.
- Surcharge on high income individuals ($350,000 for married filing jointly and $280,000 for single) to support the new “public” plan.
- Eligibility to Medicaid would be expanded to all nonelderly individuals and families with income below a certain level.
- Medicaid Payment rates would increase.
- Medicare inpatient/outpatient update reductions over 10 years.
- DSH payment reductions over 10 years (will not start till 2015).
- Permanent ban on new specialty hospitals.
- Medicare Indirect Medical Education will not be cut.
- No charity care threshold for hospitals to receive tax exemption.