2022 SUMMER CPE SYMPOSIUM: WHAT'S HOT IN HEALTHCARE

# Medicare Margin & Reimbursement Drivers

Session 2 | July 27, 2022

# Agenda and Learning Objectives

- Understand Medicare cost report margin calculation
- Understand key Medicare inpatient PPS reimbursement drivers
- Explore opportunities for improving margin
- Discuss how key drivers can influence cost report settlement

# Medicare Cost Report Margin Calculation

# Margin Analysis

Reimbursement > Cost: Positive Margin

Reimbursement < Cost: (Deficit) or (Shortfall) or (Loss)

# Margin Concepts

- 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)

# Charges and Net Revenue Comparison

- Charges = Net Revenue = Awesome
- Charges > Net Revenue = Typical Situation
  - Difference represents contractual allowance (varies by payer)
  - Pricing transparency?
- Charges < Net Revenue = Possible
  - Rare: May occur with individual situations (likely at the claim level)
  - Impact of “special payments” (federal or state)
  - Payers may have upper limits

***Depends on pricing strategy and contracting***

# Net Revenue and Cost Comparison

- Net Revenue = Cost = Possible
  - Specific cost reimbursement formulas (CAHs; Organ Acquisition)
  - Defensible pricing approximates cost of services provided

- Net Revenue > Cost = Awesome
  - Most commercial payers **do** cover cost of providing care, since rates are often well over 100% of Medicare rates

- Net Revenue < Cost = Typical
  - Governmental payers are the majority of most hospitals' payer mix
  - Most governmental payers reimburse at levels below cost
  - Payments at levels below cost means prospective payment methodologies are working (for Government)

***Depends on definition of costs***

# Medicare Margin Analysis

## Comparison of Medicare cost report information

- Reimbursement/Gross Charge = Medicare Yield
- Charges less reimbursement = Contractual Allowances
- Reimbursement compared to cost = Margin or Shortfall

## Audience

- Cost report review tool for preparers through signers
- Senior executives and governance for planning and strategy purposes
- Trend analysis, benchmarking, and competitive analysis
- Education advocacy (hospital associations and legislators)

## Benefits

- Understanding Medicare margin contributes to situational awareness
- May contribute to managed care contracting or other pricing considerations
- Element of charity care or community benefit reporting

# Margin Template

| Fauci Hospital<br>FYE 06/30/2019 to FYE 6/30/21<br>Medicare Cost Report Comparison | 6/30/19 | 6/30/20 | 6/30/21 |
|---|---|---|---|
| **Charges** | | | |
| Inpatient Acute | 643,980,170 | 610,684,418 | 576,432,199 |
| Organ Acquisition | 28,741,702 | 23,322,148 | 20,076,808 |
| Psych | 5,849,552 | 3,840,687 | 4,765,503 |
| Rehab | 18,561,732 | 14,033,797 | 13,680,111 |
| Outpatient | 516,817,985 | 499,324,565 | 584,114,861 |
| **Total Medicare Charges** | **1,214,000,000** | **1,151,000,000** | **1,199,000,000** |
| **Contractual Allowances** | | | |
| Inpatient Acute | 412,527,508 | 381,765,454 | 335,654,285 |
| Organ Acquisition | 17,688,753 | 12,531,020 | 10,739,616 |
| Medicare Bad Debts | (3,699,602) | (4,754,139) | (5,235,580) |
| Psych | 4,054,416 | 2,583,097 | 2,911,083 |
| Rehab | 10,577,571 | 7,380,529 | 6,609,678 |
| Outpatient | 408,819,451 | 397,083,657 | 466,287,621 |
| **Total Medicare C/A** | **850,000,000** | **797,000,000** | **817,000,000** |
| **Medicare Cost** | | | |
| Inpatient Acute | 188,615,500 | 195,027,829 | 180,877,602 |
| Nursing & Allied Health | 4,126,650 | 3,577,472 | 1,497,768 |
| Graduate Medical Education | 27,643,018 | 28,251,383 | 29,649,702 |
| Medicare Bad Debts | 5,799,206 | 8,482,482 | 8,054,738 |
| Organ Acquisition | 11,261,728 | 10,961,549 | 9,337,192 |
| Psych | 3,204,170 | 2,491,836 | 2,736,961 |
| Rehab | 7,039,401 | 5,887,356 | 5,436,125 |
| Outpatient | 128,230,821 | 135,848,569 | 146,894,902 |
| **Total Medicare Costs** | **376,000,000** | **391,000,000** | **384,000,000** |

| Fauci Hospital<br>FYE 06/30/2019 to FYE 6/30/21<br>Medicare Cost Report Comparison | 6/30/19 | 6/30/20 | 6/30/21 |
|---|---|---|---|
| **Reimbursement (Net of Sequestration)** | | | |
| IP PPS Operating Payments (FFS Only) | 123,970,879 | 119,005,527 | 124,862,561 |
| Indirect Medical Education (FFS) | 48,587,824 | 49,837,783 | 53,339,255 |
| Indirect Medical Education (MCO) | 9,608,969 | 11,940,255 | 15,313,056 |
| IP PPS Capital Payments | 13,841,874 | 13,495,839 | 13,801,461 |
| Direct Medical Education (FFS) | 13,496,415 | 13,624,509 | 13,938,713 |
| Direct Medical Education (MCO) | 2,505,942 | 3,063,004 | 3,890,034 |
| Nursing and Allied Health (FFS) | 4,050,626 | 3,522,997 | 1,497,768 |
| Nursing and Allied Health (MCO) | 321,240 | 252,024 | 358,545 |
| Medicare Bad Debts | 3,699,602 | 4,754,139 | 5,235,580 |
| Organ Acquisition | 11,052,949 | 10,791,128 | 9,337,192 |
| Psych | 1,795,136 | 1,257,590 | 1,854,420 |
| Rehab | 7,984,161 | 6,653,268 | 7,070,433 |
| Outpatient | 107,998,534 | 102,240,908 | 117,827,240 |
| **Total Medicare Reimbursement** | **364,000,000** | **355,000,000** | **382,000,000** |
| **Medicare Margin** | | | |
| Inpatient Acute | 22,462,939 | 13,428,601 | 40,215,252 |
| Nursing & Allied Health | 245,216 | 197,549 | 358,545 |
| Graduate Medical Education | (11,640,661) | (11,563,870) | (11,820,955) |
| Medicare Bad Debts | (2,099,604) | (3,728,343) | (2,819,158) |
| Organ Acquisition | (208,779) | (170,421) | 0 |
| Psych | (1,409,034) | (1,234,246) | (882,541) |
| Rehab | 944,760 | 765,912 | 1,634,308 |
| Outpatient | (20,232,287) | (33,607,661) | (29,067,662) |
| **Total Medicare Margin** | **(12,000,000)** | **(36,000,000)** | **(2,000,000)** |
| | | **(24,000,000)** | **34,000,000** |
| Memo: Total Sequestration Included Above: | (7,000,000) | (6,000,000) | - |

# Outpatient Margin Impact

| Fauci Hospital<br>FYE 06/30/2019 to FYE 6/30/21<br>Outpatient Analysis | 6/30/2019 | 6/30/2020 | 6/30/2021 |
|---|---|---|---|
| **Charges** | 516,817,985 | 499,324,565 | 584,114,861 |
| **Contractual Allowances** | 408,819,451 | 397,083,657 | 466,287,621 |
| **Medicare Cost** | 128,230,821 | 135,848,569 | 146,894,902 |
| **Reimbursement** | 107,998,534 | 102,240,908 | 117,827,240 |
| **Medicare Margin** | (20,232,287) | (33,607,661) | (29,067,662) |

Outpatient services significantly impact hospital margins

COVID dramatically impacted the OP margin in 2020 & 2021

Sole community hospitals receive a 7.1% increase in OP reimbursement

Continued migration to outpatient services may further erode future Medicare margin results

# Medicare Payment Systems

# IPPS Reimbursement Components

## Included in claim-based payments

- Base operating and capital DRG amounts
- Operating and capital outlier amounts
- Indirect Medical Education (IME) (hospitals with approved intern and resident training programs)
- Empirically justified (traditional) Disproportionate Share Hospital (DSH) adjustment
- Uncompensated Care Cost Pool Payments
- Payment Reform Adjustments/Quality-driven payments (VBP, HAC, HRR)
- Sequestration

## Paid outside claims-based payments (bi-weekly or per diem basis)

- Interns & Residents Direct Medical Education (DGME)
- Nursing & Allied Health Programs (cost-based component)
- Managed Care Nursing & Allied Health (MCNAHE) (pool distribution)
- Organ Transplant (certified transplant hospitals only)
- Medicare bad debts (unpaid deductibles and coinsurance for covered hospital services)

# Medicare Inpatient Prospective Payment Standardized Amounts

**FY 2023 NPRM Tables 1A-1E**

**TABLE 1A. PROPOSED RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)**

| Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.7 Percent) | | Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.375 Percent) | | Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.925 Percent) | | Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.4 Percent) | |
|---|---|---|---|---|---|---|---|
| Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related |
| $4,269.46 | $2,046.31 | $4,172.80 | $1,999.98 | $4,237.24 | $2,030.87 | $4,140.59 | $1,984.54 |

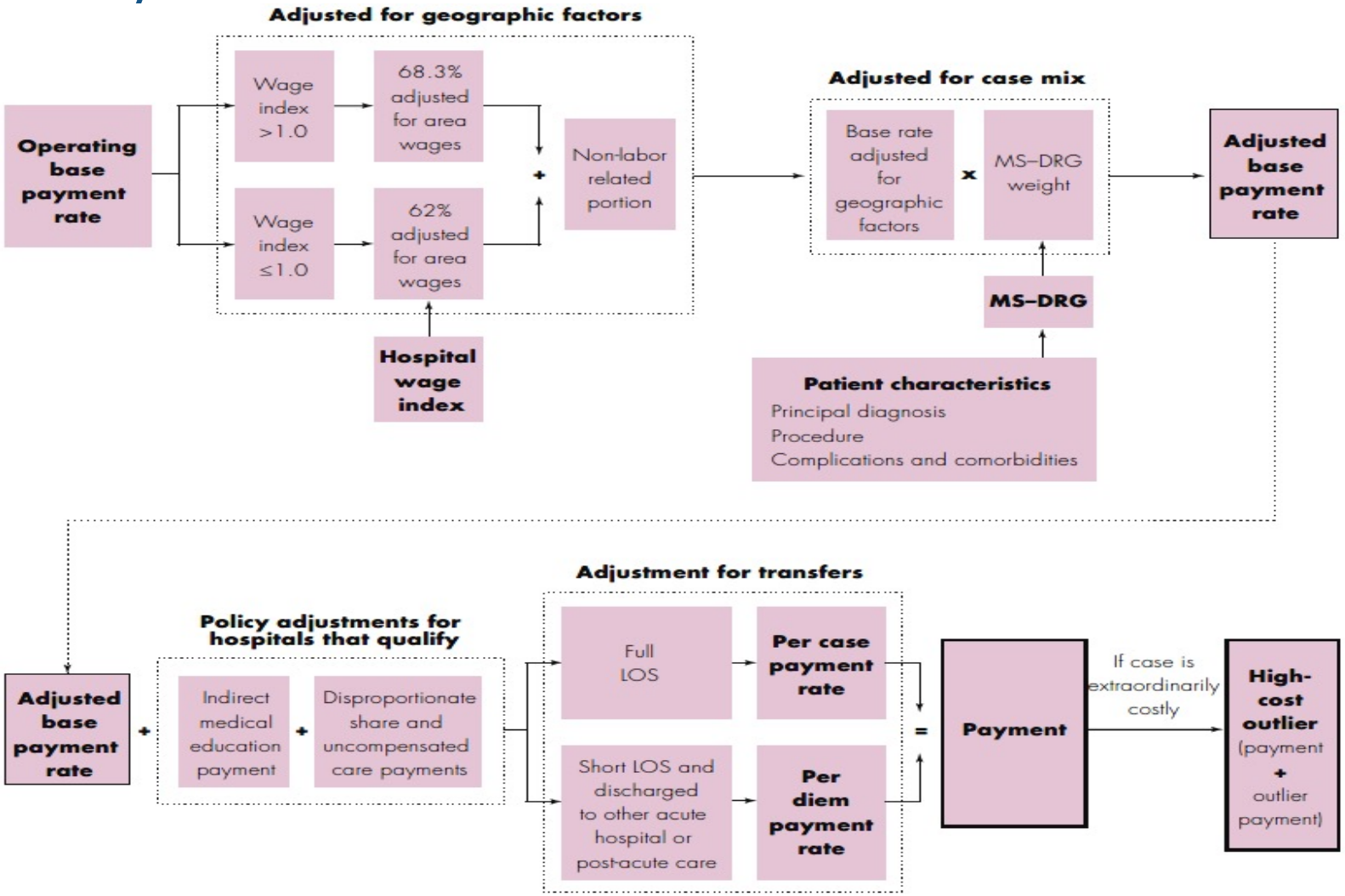
**TABLE 1B. PROPOSED RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)**

| Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.7 Percent) | | Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.375 Percent) | | Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.925 Percent) | | Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.4 Percent) | |
|---|---|---|---|---|---|---|---|
| Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related |
| $3,915.78 | $2,399.99 | $3,827.12 | $2,345.66 | $3,886.23 | $2,381.88 | $3,797.58 | $2,327.55 |

**TABLE 1D. - PROPOSED RULE CAPITAL STANDARD FEDERAL PAYMENT RATE**

| | Rate |
|---|---|
| National | $480.29 |

# IPPS Payment Calculation




MEDPAC

HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM

paymentbasics

# Base DRG Operating and Capital Amounts

| IPPS BLENDED MEDICARE SEVERITY DIAGNOSIS RELATED GROUP (MS-DRG) ESTIMATED PAYMENT RATE | 2021 Final Rule - CN | | 2022 Final Rule - CN | | | 2023 Proposed Rule | | |
|---|---|---|---|---|---|---|---|---|
| **Operating Payment Rate** | | **FFY-2021 Amount** | | **FFY-2022 Amount** | **Percent Change** | | **FFY-2023 Amount** | **Percent Change** |
| Labor-Related Base Amount | | $ 4,071.57 | | $ 4,138.28 | 1.64% | | $ 3,915.78 | -5.38% |
| Provider-Specific Wage Index | | 1.0350 | | 1.0326 | -0.23% | | 0.9965 | -3.50% |
| Provider-Adjusted Labor-Related Amount | | $ 4,214.07 | | $ 4,273.19 | 1.40% | | $ 3,902.07 | -8.68% |
| Non-Labor-Related Base Amount | | $ 1,889.74 | | $ 1,983.43 | 5.0% | | $ 2,399.99 | 21.0% |
| **Quality & EHR** | **Y/N** | **Adjustment Factors** **Amount** | **Y/N** | **Adjustment Factors** **Amount** | **Percent Change** | **Y/N** | **Adjustment Factors** **Amount** | **Percent Change** |
| Quality Reduction | N | -0.59% $ - | N | -0.66% $ - | 0.00% | N | -0.75% $ - | 0.00% |
| EHR Reduction | N | -1.76% $ - | N | -1.99% $ - | 0.00% | N | -2.26% $ - | 0.00% |
| **Provider's Adjusted Operating Base Rate** | | **$ 6,103.81** | | **$ 6,256.62** | **2.50%** | | **$ 6,302.06** | **0.73%** |
| **Operating Payment Adjustments** | **Y/N** | **Adjustment Factors** **Amount** | **Y/N** | **Adjustment Factors** **Amount** | **Percent Change** | **Y/N** | **Adjustment Factors** **Amount** | **Percent Change** |
| Disproportionate Share | | 0.056140 $ 342.67 | | 0.056140 $ 351.25 | 2.50% | | 0.054140 $ 341.19 | -2.86% |
| Uncompensated Care Amount Per Discharge | | 792.97 $ 792.97 | | 678.60 $ 678.60 | -14.42% | | 698.29 $ 698.29 | 2.90% |
| Indirect Medical Education | | 0.431860 $ 2,635.99 | | 0.431860 $ 2,701.98 | 2.50% | | 0.454310 $ 2,863.09 | 5.96% |
| Value-Based Purchasing | | 1.0085 $ 52.18 | | 1.0086 $ 53.49 | 2.51% | | 0.9971 $ (18.28) | -134.17% |
| Readmission | | 0.9896 $ (63.48) | | 0.9931 $ (43.17) | -31.99% | | 1.0086 $ 53.88 | -224.81% |
| Hospital-Acquired Condition Reduction | No | -1.00% $ - | No | -1.00% $ - | 0.00% | No | -1.00% $ - | 0.00% |
| **Total Medicare Operating Adjustments** | | **$ 3,760.33** | | **$ 3,742.15** | **-0.48%** | | **$ 3,938.17** | **-0.48%** |
| **Total Adjusted Medicare Operating Amount** | | **$ 9,864.14** | | **$ 9,998.77** | **1.36%** | | **$ 10,240.23** | **1.36%** |
| **Capital Payment Rate** | | **Factors** **Amount** | | **Factors** **Amount** | **Percent Change** | | **Factors** **Amount** | **Percent Change** |
| Capital Standard Federal Payment Rate | | $466.21 | | $472.60 | 1.37% | | $480.29 | 1.63% |
| Geographical Adjustment Factor | | 1.0238 | | 1.0222 | -0.16% | | 0.9976 | -2.41% |
| Adjusted Capital Base Rate | | $ 477.31 | | $ 483.09 | 1.21% | | $ 479.14 | -0.82% |
| | | | | | 0.00% | | | |
| Capital Disproportionate Share | | - $ - | | - $ - | 0.00% | | - $ - | 0.00% |
| Capital Indirect Medical Education Adjustment | | 0.37013 $ 176.67 | | 0.42350 $ 204.59 | 15.80% | | 0.47969 $ 229.84 | 12.34% |
| **Total Adjusted Medicare Capital Rate** | | **$ 653.98** | | **$ 687.68** | **5.15%** | | **$ 708.98** | **5.15%** |
| **Low-Volume Adjustment** | | **Amount** | | **Amount** | **Percent Change** | | **Amount** | **Percent Change** |
| Low-Volume Base Rate | | $ 10,529.42 | | $ 10,676.13 | 1.39% | | $ 10,913.61 | 2.22% |
| Low-Volume Add-On Factor | | - | | - | 0.00% | | - | 0.00% |
| **Total Low-Volume Add-On Amount** | | **$ -** | | **$ -** | 0.00% | | **$ -** | 0.00% |
| | | | | | 0.00% | | | |
| **Total Base MS-DRG Rate** | | **$ 10,518.12** | | **$ 10,686.45** | **1.60%** | | **$ 10,949.21** | **2.46%** |
| | | | | | 0 | | | |
| Estimated Medicare Discharges | | 9,514 | | 9,514 | 0.00% | | 8,134 | -14.50% |
| Medicare Case Mix Index | | 2.2381 | | 2.2381 | 0.00% | | 2.3736 | 6.05% |
| **Estimated Medicare Payments** | | **$ 223,965,310.00** | | **$ 219,556,186.67** | **-1.97%** | | **$ 203,592,992.77** | **-7.27%** |

# Outliers

- Outliers are defined as cases involving atypical costs
- A discharge may qualify as a high-cost outlier if the cost of covered services exceeds the cost threshold established by CMS
- Currently, the cost outlier “fixed loss” threshold is the DRG payment for the applicable DRG plus $30,998 (plus any DSH, IME, or new technology payments), both adjusted for area wage differences; hospitals receive an additional payment (marginal cost factor) equal to 80% of the difference between the hospital’s adjusted cost for the discharge and the cost threshold

- Outlier Payment Factors:
  - Outlier threshold
  - Case-specific MS-DRG
  - Hospital specific adjustments
  - Geographic location
  - Outlier cost to charge ratios

# Outlier Trends

| FY2023 IPPS Proposed Rule Outlier Historlcal Perspective | Historical 2007 | Current 2022 | Proposed 2023 (1) | Proposed 2023 (2) |
|---|---|---|---|---|
| OutlierThreshold | **24,485** | **30,988** | **43,214** | **58,798** |
| Cumulative Change | 15 | 6,503 | | |
| Annual Increase | | 434 | | |
| | | | 12,226 | 27,810 |
| Cumulative Percentage change | | 26.56% | 39.45% | 89.74% |
| Annual Percentage Increase | | 1.77% | **39.45%** | **89.74%** |
| | | | | |
| | | | | |
| Outlier CostThreshhold (example) | **60,082** | **69,047** | **85,899** | **107,381** |
| | 15 | 8,964 | | |
| Annual Increase | | 598 | | |
| | | | 16,853 | 38,335 |
| Cumulative Percentage change | | 14.92% | 24.41% | 55.52% |
| Annual Percentage Increase | | 0.99% | **24.41%** | **55.52%** |

- First 15 years of MS-DRGs modest (manageable) increases in both threshold amount and related amount of cost.
- Either proposed rule option will result in outlier reductions
  - Fewer cases will qualify for outliers
  - Calculated outliers will be less
- Actual results will vary by each hospital and each MS-DRG

# Detail Outlier Payment Example

| Step 1: Determine Federal Operating Payment with IME and DSH: | |
|---|---|
| **Federal Rate for Operating Costs =** (DRG Relative Weight x ((Labor Related Amount x CBSA Wage Index) + (Nonlabor Related National Standardized Amount x Cost of Living Adjustment)) x (1 + IME + DSH))+ UCC Amount | |
| **Federal Operating Payment With IME and DSH =** | **$24,407.58** |

| Step 2: Determine Federal Capital Payment with IME and DSH: | |
|---|---|
| **Federal Rate for Capital Costs =** ((DRG Relative Weight x Federal Capital Rate x Geographic Cost Adjustment Factor x COLA) x (1 + IME + DSH)) | |
| **Federal Capital Payment With IME and DSH =** | **$1,923.47** |

| Step 3: Determine Operating and Capital Costs: | |
|---|---|
| **Operating Costs =** Billed Charges x Operating Cost to Charge Ratio | $205,000.00 |
| | 0.38 |
| **Operating Costs =** | **$77,900** |
| **Capital Costs =** Billed Charges x Capital Cost to Charge Ratio | $205,000.00 |
| | 0.04 |
| **Capital Costs =** | **$8,200** |

| Step 4: Determine Operating and Capital Outlier Threshold | |
|---|---|
| **A. Operating CCR to Total CCR =** Operating CCR / (Operating CCR + Capital CCR) | |
| **Operating CCR to Total CCR =** | **0.9048** |
| **B. Capital CCR to Total CCR =** Capital CCR / (Operating CCR + Capital CCR) | |
| **Capital CCR to Total CCR =** | **0.0952** |
| **C. Operating Outlier Threshold =** ((Fixed Loss Threshold x ((Labor related portion x CBSA Wage Index) + Nonlabor related portion)) x Operating CCR to Total) + Federal Payment with IME and DSH: | |
| **Operating Outlier Threshold =** | **$78,275.86** |
| **D. Capital Outlier Threshold =** (Fixed Loss Threshold x Geographic Adj. Factor x Capital CCR to Total CCR) + Federal Payment with IME and DSH | |
| **Capital Outlier Threshold =** | **$7,623.61** |

| Step 5: Determine Operating and Capital Outlier Payment Amount | |
|---|---|
| **A. Determine if Total Costs are Greater than Combined Threshold =** (if (operating costs+ capital costs) > (operating threshold + capital threshold)) | |
| **Determine if Total Costs are Greater than Combined Threshold** | **Continue With The Next Step** |
| **B. Operating Outlier Payment =** (Operating Costs - Operating Outlier Threshold) x Marginal Cost Factor | |
| **Operating Outlier Payment =** | (300.69) |
| **C. Capital Outlier Payment =** (Capital Costs - Capital Outlier Threshold) x Marginal Cost Factor | |
| Note: If Capital Outlier Payment Amount is Negative, we default this amount to 0 | |
| **Capital Outlier Payment =** | **$461.11** |
| | **$160.42** |

# Indirect Medical Education (IME) Payment

- Operating payment formula
  - Lesser of adjusted IME cap amount or current year adjusted count
  - Available PPS beds (excludes nursery, SNF, and beds used for ancillary services)
    (Psych and Rehab formulas only use beds in those units)
    - May be limited based on prior year ratios

  - **Teaching intensity factor (r)**
    **$1.35 \times [(1 + (\text{I\&R count/available beds}))^{.405} - 1] = \text{IME factor}$**

- Payment amount
  - Add-on amount to CMI adjusted DRG payments for Medicare FFS and MCO claims (excludes outliers)
  - Final reimbursement determined through cost reporting process
  - Underlying costs are embedded in individual patient care departments *(but)*
  - Hospital would not get this reimbursement without operating and approved residency program *(so)*
  - Where should this revenue be credited within an organization?

# IME Payment Example

| Description | Formula | Amount |
|---|---|---|
| Residents | A | 584.87 |
| Available Beds | B | 567.11 |
| I&R to Bed Ratio | C=A/B | 1.031317 |
| | | |
| Payment Formula | | |
| CMS Adjustment Factor | D | 1.35 |
| (1+C)^.405-1 | E | 0.332447 |
| IME Payment Factor | F=D*E | 0.448803 |
| | | |
| DRG Payments | | |
| FFS DRG Payments other than Outliers | G | 118,847,812 |
| Managed Care Simulated Payments | H | 34,119,771 |
| Total DRG Payments | I=G+H | 152,967,583 |
| | | |
| IME Payment Adjustment | J= F*G | 53,339,255 |
| IME Payment Adjustment - Adjustment MC | K=F*G | 15,313,056 |
| **Total IME Reimbursement** | **L=J+K** | **68,652,311** |

Key Drivers

- IME resident count
- PPS available beds varies from estimate
- Statutory formula, but limitations from prior year can impact interim payment factor
- DRG volume dependent on quantity of discharges and case-mix index

# Disproportionate Share Hospital (DSH) (Traditional or Empirically Justified)

- Acute PPS Hospitals may qualify for an additional payment per discharge for serving a disproportionate share of low-income patients
- DSH adjustment based on two fractions: Medicare fraction (SSI percentage) and Medicaid fraction
  - Medicare fraction – Days of patients entitled to both Medicare Part A and SSI/total days of patients entitled to Medicare Part A; obtained from CMS, updated annually based on prior year claims submissions (includes Part C days)
  - Medicaid percentage – Days of patients eligible for Title XIX Medicaid, but not entitled to Medicare Part A/total patient days (hospital-specific data for current cost reporting period)
  - Sum ≥15% to qualify (>20.2% higher adjustment factors)
  - Now limited to 25% of calculated amount because a portion of the remaining 75% is paid through the uncompensated care cost pool formula
- Payment is an add-on to FFS DRG amount (separate adjustment for operating and capital portion of DRG)
- No payment (through cost report) is made for MCO DRG amounts
- Similar calculation for rehab hospitals or rehab units called Low-Income Percentage (LIP) based on specific rehab hospital or unit factors for SSI and Medicaid days
- Final settlement through cost reporting process

# DSH Payment Example

| Description | Formula | Amount |
|---|---|---|
| **Medicaid Days** | | |
| Traditional Medicaid | A | 20,243 |
| Manage Care Medicaid | B | 28,333 |
| Total Medicaid Days | C=A+B | 48,576 |

| Description | Formula | Amount |
|---|---|---|
| Total Patient Days | D | 163,723 |

| Description | Formula | Amount |
|---|---|---|
| Medicaid Percentage | E=C/D | 29.67% |
| SSI Percentage | F | 8.22% |
| Total DSH Percentage | G=E+F | 37.89% |

| Description | Formula | Amount |
|---|---|---|
| DSH Adjustment Percentage | H | 20.47% |
| *5.88%+(.825*(E-.20.2%))* | *H.1.1* | |

| Description | Formula | Amount |
|---|---|---|
| FFS DRG Payments | I=H*25% | 118,847,812 |
| Empirical DSH Formula | J=G*H | 24,328,147 |
| | | |
| Empirical DSH Formula * 25% | K=J*25% | 6,082,037 |
| Overall DSH Add-on Percentage | L=K/I | 5.12% |

Key Drivers

- Actual count of Medicaid eligible days (A) and total days (B) used in calculation
- Published SSI (D) percentage
- Change in DSH factor triggers different payment factor
  - Must have minimum to qualify
  - Different payment formula
  - 340B eligibility at 8% or 11.75% based on type of hospital

# Uncompensated Care Cost Payments

- Affordable Care Act (ACA)
- Impact on DSH payment
  - Reduced 75% beginning in FFY 2014
  - “Savings” returned as an additional payment for continued uncompensated care costs
- ACA DSH impact criteria
  - Updated annually via Federal Register Notice (i.e., FFY 2023 Final IP rule)

Hospital’s amount of uncompensated care costs relative to the amount of uncompensated care for all DSH hospitals

**Hospital must qualify for empirically justified DSH payment to receive distribution of uncompensated care cost pool payments.**

# S-10 Uncompensated Care

## Winners and losers

- Original DSH formula favored hospitals with large DRG base, or larger Medicaid percentages (add-on percentage applied to larger base)
- Uncompensated care pool payment formula awards hospitals with higher reported uncompensated care amounts (hospital uncompensated share of total uncompensated care costs for all hospitals (PPS nationwide) applied to total distribution amount)
- UCC distribution not dependent on DRG volume
- No opportunity to appeal (challenge) results of calculations related to UCC  pool
- *Impact on State funding mechanisms*

# Factor explanations

Factor 1

- Represents CMS' estimate of 75% (100% minus 25%) of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year

Factor 2

- Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment; specifically, section 1886(r)(2)(B)(i) of the Act provides that for each of FYs 2014, 2015, 2016 and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act
- Percent of individuals without insurance for 2013 (March 2013 CBO estimate): 18%
- 1-((0.0815-0.14)/0.14)=1-.4179=0.5821-.002=0.5801-Applicable factor (.1% for 2014, .2% for FY 2015 – FY 2017)

Factor 3

- Factor 3 distribution to each DSH Hospital (Hospital that qualifies for traditional DSH reimbursement) is based on the following: "For FY 2018, a hospital's Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2012, FY 2013, and FY 2014. The individual Factor 3s for FY 2012 and FY 2013 are based on Medicaid days and Medicare SSI days, while the Factor 3 for FY 2014 is based on hospital uncompensated care costs." (FY 2018 DSH Supplemental File, tab 1). For cost reports beginning in FY 2012 and FY 2013, the CMS Factor 3 table is taking Medicaid days for FY 2012 and SSI days in FFY 2014 and Medicaid days for FY 2013 and SSI days in FFY 2015 to be used in the overall average for each Hospital. For cost reports beginning in FY 2014, CMS is taking Line 30 on W/S S-10. This is the cost of uncompensated care (cost of charity care on line 23 + cost of non-Medicare and non- reimbursable Medicare bad debt expense-Ln 29). This is compared to total uncompensated care for all DSH Hospitals to determine the portion related to a given DSH Hospital (FY 2012 and FY 2013 Medicaid/SSI days are also compared to the total for each of the respective years).

# Medicare UCC Pool Calculation

| Year | DSH Pool | UCC Pool at 75% | % W/O Insurance | UCC Factor 2 | UCC Amount | $ Variance to PY | % Change | UCP v 75% of DSH Funding Gap |
|---|---|---|---|---|---|---|---|---|
| 2014 | $ 12,772,000,000 | $ 9,579,000,000 | 17.00% | 94.30% | $ 9,032,997,000 | $ - | 0.00% | $ (546,003,000) |
| 2015 | $ 13,383,462,196 | $ 10,037,596,647 | 13.75% | 76.19% | $ 7,647,644,885 | $ (1,385,352,115) | -15.34% | $ (2,389,951,762) |
| 2016 | $ 13,411,096,528 | $ 10,058,322,396 | 11.50% | 63.69% | $ 6,406,145,534 | $ (1,241,499,351) | -16.23% | $ (3,652,176,862) |
| 2017 | $ 14,396,635,710 | $ 10,797,476,783 | 10.00% | 55.36% | $ 5,977,483,147 | $ (428,662,387) | -6.69% | $ (4,819,993,636) |
| 2018 | $ 15,552,939,524 | $ 11,664,704,643 | 8.15% | 58.01% | $ 6,766,695,165 | $ 789,212,018 | 13.20% | $ (4,898,009,478) |
| 2019 | $ 16,339,055,838 | $ 12,254,291,879 | 9.48% | 67.51% | $ 8,272,872,447 | $ 1,506,177,283 | 22.26% | $ (3,981,419,431) |
| 2020 | $ 16,583,455,657 | $ 12,437,591,743 | 9.40% | 67.14% | $ 8,350,599,096 | $ 77,726,649 | 0.94% | $ (4,086,992,647) |
| 2021 | $ 15,170,673,476 | $ 11,378,005,107 | 10.20% | 72.86% | $ 8,290,014,521 | $ (60,584,575) | -0.73% | $ (3,087,990,586) |
| 2022 | $ 13,984,752,729 | $ 10,488,564,547 | 9.60% | 68.57% | $ 7,192,008,710 | $ (1,098,005,811) | -13.24% | $ (3,296,555,837) |
| **2023** | **$ 13,265,678,075** | **$ 9,949,258,557** | **9.20%** | **65.71%** | **$ 6,537,657,798** | **$ (654,350,912)** | **-9.10%** | $ (3,411,600,759) |
| **Cumulative** | **$ 144,859,749,734** | **$ 108,644,812,300** | **10.83%** | **68.55%** | **$ 74,474,118,302** | **$ (2,495,339,202)** | | **$ (34,170,693,998)** |

# Medicare UCC Payments: States with Largest Variances

| TOP 5 STATES WITH THE LARGEST DOLLAR VARIANCE (DECREASE) | | | | |
|---|---|---|---|---|
| State | UCC FY22 | UCC FY23 | $ Variance | % Change |
| Texas | $ 1,279,832,484 | $ 1,197,867,592 | $(81,964,892) | -6.40% |
| New York | $ 479,425,943 | $ 419,783,891 | $(59,642,052) | -12.44% |
| Illinois | $ 326,392,609 | $ 277,800,994 | $(48,591,615) | -14.89% |
| Virginia | $ 225,639,895 | $ 181,493,605 | $(44,146,291) | -19.56% |
| Florida | $ 706,069,161 | $ 668,624,174 | $(37,444,987) | -5.30% |

| TOP 5 STATES WITH THE LARGEST DOLLAR VARIANCE INCREASE | | | | |
|---|---|---|---|---|
| State | UCC FY22 | UCC FY23 | $ Variance | % Change |
| Hawaii | $ 5,362,628 | $ 6,293,951 | $ 931,322 | 17.37% |
| Kansas | $ 48,842,348 | $ 49,416,447 | $ 574,099 | 1.18% |
| Minnesota | $ 39,266,810 | $ 38,964,380 | $ (302,429) | -0.77% |
| Vermont | $ 3,662,623 | $ 3,446,585 | $ (216,037) | -5.90% |
| Wyoming | $ 409,554 | $ 395,367 | $ (14,187) | -3.46% |

# Medicare UCC Payments By the Numbers

| | FY2022 Final Rule | | | FY2023 Proposed Rule | | | FY2023 v FY2022 | |
|---|---|---|---|---|---|---|---|---|
| | All Hospitals | Qualifying Hospitals | Qualifying Percent | **All Hospitals** | **Qualifying Hospitals** | **Qualifying Percent** | **Qualifying Hospitals Only Variance** | **Percent** |
| Demographic | | | | | | | | |
| Number of Hospitals | 3,579 | 2,350 | 65.66% | **3,516** | **2,348** | **66.78%** | (2) | -0.09% |
| Number of Claims | 8,298,657 | 7,662,704 | 92.34% | **7,796,776** | **7,182,211** | **92.12%** | (480,493) | -6.27% |
| Average Claims/Hospital | 3,109 | 3,261 | 104.87% | **2,904** | **3,059** | **105.34%** | (202) | -6.19% |
| Financial | | | | | | | | |
| Total Uncompensated Care Costs | $37,063,176,150 | $33,208,266,108 | 89.60% | **$37,639,012,731** | **$34,056,619,319** | **90.48%** | 848,353,211 | 2.55% |
| Average Cost/Hospital | $10,355,735 | $14,131,177 | 136.46% | **$10,705,066** | **$14,504,523** | **135.49%** | 373,346 | 2.64% |
| Total Uncompensated Care Payments | $7,192,008,710 | $7,192,008,710 | 100.00% | **$6,537,657,798** | **$6,537,657,798** | **100.00%** | (654,350,912) | -9.10% |
| Average Payment/Hospital | $2,009,502 | $3,060,429 | 152.30% | **$1,859,402** | **$2,784,352** | **149.74%** | (276,078) | -9.02% |
| Estimated Amount per Claim | $1,476 | $1,574 | 106.65% | **$1,410** | **$1,462** | **103.69%** | ($112) | -7.12% |
| Pool Payments Percent of Cost | 19.40% | 21.66% | 111.61% | **17.37%** | **19.20%** | **110.52%** | -2% | -11.36% |
| Total Gap | | | | | | | | |
| Increased Uncompensated Care Cost | | | | | | | 848,353,211 | |
| Decrease in Distribution | | | | | | | (654,350,912) | |
| Additional Payment Gap | | | | | | | **(1,502,704,124)** | |
| | | | | *12 of 2348 hospitals equals 10% of total pool* | | | | |

# UCC Payment Example

| FY 2020 IPPS Final Rule Correction Notice: Implementation of Section 3133 of the Affordable Care Act Medicare DSH Supplemental Data | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Projected to Receive DSH in FY 2020 [2] | Medicaid Days 2013 (Annualized) [6] | Length of 2013 Reporting Period [7] | 2017 SSI Days [8] | 2015 UCC (Annualized) [9] | Length of 2015 Reporting Period [10] | Factor 3 [11] | Total Uncompensated Care Payment [12] | Estimated Per Claim Amount [13] |
| YES | 47,397 | 365 | 4,872 | $27,680,628.66 | 366 | 0.000920585 | $7,687,433.87 | $795.97 |
| | | | | | | ***FY 2020 Allocation*** | ***25%*** | |
| | | | | | | ***FY 2020 Amount*** | ***1,932,360*** | |

| FY 2021 IPPS Correction Notice: Implementation of Section 3133 of the Affordable Care Act Medicare DSH Supplemental Data | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Projected to Receive DSH in FY 2021 [2] | Medicaid Days 2013 (Annualized) [6] | Length of 2013 Reporting Period [7] | 2018 SSI Days [8] | 2017 UCC (Annualized) [9] | Length of 2017 Reporting Period [10] | Factor 3 [11] | Total Uncompensated Care Payment [12] | Estimated Per Claim Amount [13] |
| YES | 47,397 | 365 | 5,590 | $30,209,589.00 | 365 | 0.000930993 | $7,717,946.80 | $792.97 |
| | | | | | | ***FY 2021 Allocation*** | ***75%*** | |
| | | | | | | ***FY 2021 Amount*** | ***5,762,124*** | |

- Actual payment is based on portion of cost reporting period (days) within a particular federal fiscal year (hospitals with 09/30 year-end have no proration)
- Payment is based on information from prior cost reporting periods and share of pool is based on all hospitals reported data
- Interim payments are based on hospital specific average discharge count
- Settlement based on differences in cases compared to estimate
- Ultimately hospital will receive full calculated amount through cost report settlement
- No payment (through cost report) based on MCO activity

| | |
|---|---|
| ***FYE 06/30/2021 UCC Payment*** | ***7,694,484*** |
| ***Empirical DSH Formula * 25%*** | ***6,082,037*** |
| ***Total UCC & DSH Payment*** | ***13,776,521*** |
| ***Empirical DSH Formula*** | ***24,328,147*** |
| ***Total DSH & UCC Shortfall*** | ***(10,551,626)*** |

# Payment Reform Adjustments

- Hospital acquired conditions (HAC)
  - Always negative
  - Based on quality data
  - Conditions that develop during hospitalization for other purposes
- Hospital readmissions reduction program (HRRP)
  - Always negative
  - Based on national data (lowest quartile)
  - Can change on a yearly basis
- Value-based purchasing
  - Applied at DRG level
  - Based on quality scores
  - Can be positive or negative for any individual hospital

# Medicare Pass-through “Costs”

- Direct Medical Education
- Medicare Bad Debts

# Direct Medical Education

## Direct medical education (DME) (E-4)

- Compensates hospital for facility specific allowable program costs (including overhead costs)
  - Institutional
  - Program
  - Faculty
  - Interns and residents' stipends (compensation)
- Reimbursement not tied to current period costs
  - Current training levels exceed adjusted cap amount
  - Residents training beyond initial residency period are weighted
  - CMS inflation factors not reflective of actual program cost increases
  - Reimbursement levels only based on current Medicare load factor

# DME Payment

## DME

- Payment formula
  - Number of GME residents (split between primary care and non-primary care and weighted for beyond initial residency and FMG status)
    - Lesser of adjusted cap or current year resident count
  - Hospital-specific (or national) per resident amount (different between primary and non-primary care)
  - Medicare load factor (includes Medicare FFS and MCO days for acute hospital, psych unit, and rehab units, but excludes nursery and SNF days)
  - Apportioned between Part A and Part B hospital services
- Payment amount
  - Once program is established, MAC will estimate reimbursement amount and pay via bi-weekly payments
  - Final amount due to hospital is determined through cost report submission and settlement process

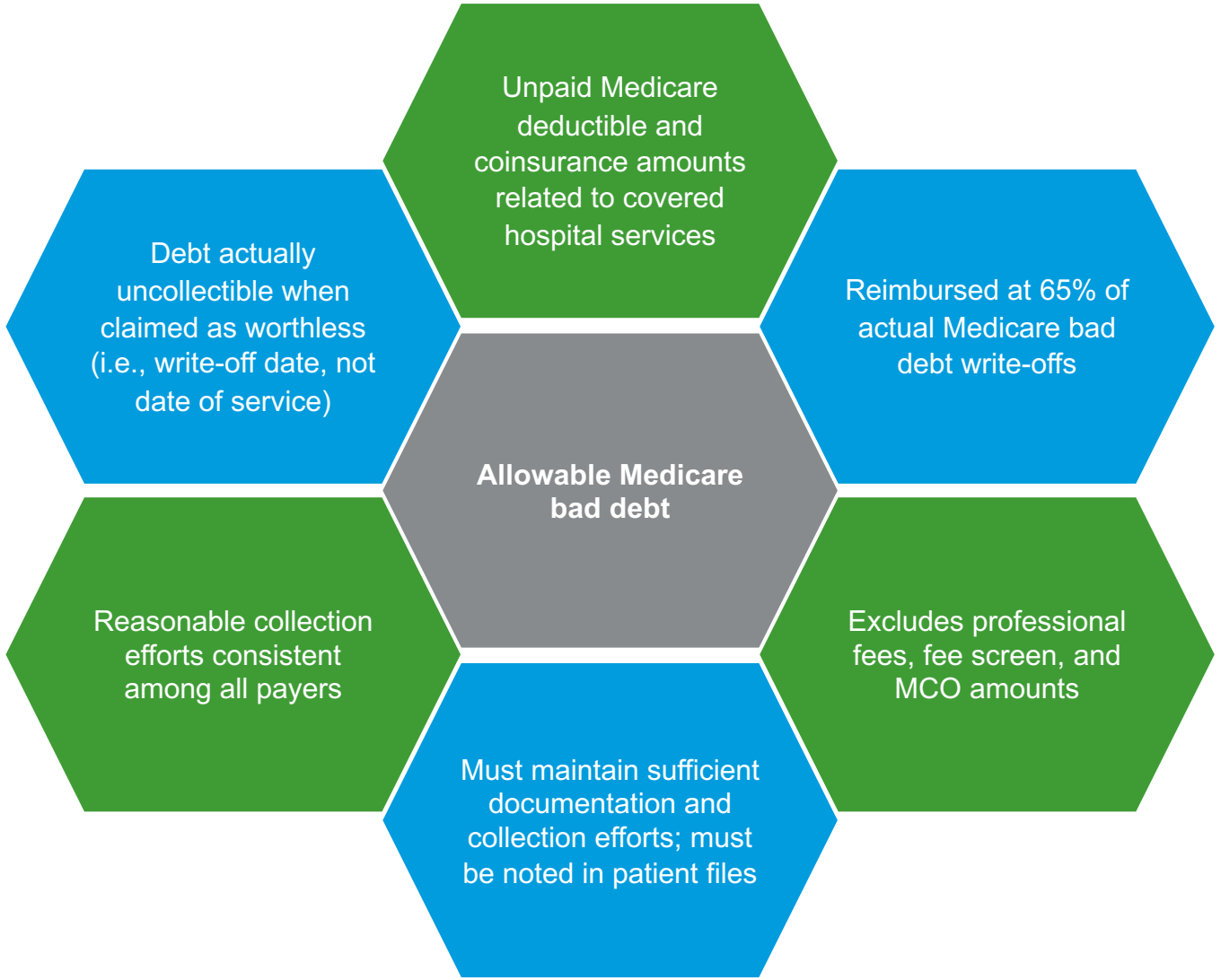
# DME Reimbursement Example

| Description | Formula | Amount |
|---|---|---|
| Residents - Adjusted rolling average FTE count | A | 450.74 |
| Per Resident Amount | B | 104,959.34 |
| Approved GME Amount | C=A*B | 47,309,373 |
| | | |
| Medicare FFS Days | D | 51,436 |
| Medicare MCO Days | E | 14,964 |
| Total Medicare Days | F=D+E | 66,400 |
| | | |
| Total Hospital Days | G | 174,579 |
| | | |
| Load Factor | | |
| Medicare FFS Ratio | H=D/G | 0.294629 |
| Medicare MCO Ratio | I=E/G | 0.085715 |
| Total Load Factor | J | 0.380344 |
| | | |
| Medicare FFS Amount | K=C*H | 13,938,713 |
| Medicare MCO Amount | L=C*I*2 | 4,055,123 |
| Reduction for direct GME payments for Medicare Advantage | M | (165,089) |
| Direct GME Reimbusement | N=K+L+M | 17,828,747 |
| | | |
| Part A Medicare GME payment | O | 10,221,167 |
| Part B Medicare GME payment | P | 7,607,580 |
| Direct GME Reimbusement | Q=O+P | 17,828,747 |

Key Drivers

- Actual count of allowable DME residents
- Per resident amount (Hospital-specific or National Locality adjusted value
- Actual load factor (Medicare FFS and MCO days)

# E Series Medicare Bad Debts



# Types of Medicare Bad Debt

**Traditional (Regular, non-indigent)**

- Traditional Medicare beneficiary is not eligible for Medicaid
- Traditional Medicare beneficiary does not meet charity policy guideline
- Reasonable collection effort required

**Dual-eligible (Medicaid crossover)**

- Traditional Medicare beneficiary is eligible for Medicaid
- Meets standard of CMS' "must-bill policy" (prove that no other insurance exists)
- No collection effort

**Indigent/charity (Uncompensated)**

- Traditional Medicare beneficiary deemed indigent and meets charity policy guidelines
- Traditional Medicare beneficiary is not eligible for Medicaid
- No collection effort

*Medicare HMO bad debts do not qualify for reimbursement on the Medicare cost report*

# Medicare Bad Debt Criteria

## TRADITIONAL

- Cannot be claimed as bad debt until returned from collection agency
- 120-Day rule: Write-off must be at least 120 days from date of first bill; starts on the date of the first bill sent to the patient indicating deductible or coinsurance is owed
- Collection efforts must be documented in patient records
- Similar collection efforts for non-Medicare accounts
- Bill issued shortly after discharge or death (within 90 days from discharge or 60 days from Medicare payment)

## DUAL-ELIGIBLE

- Must bill Medicaid for eligibility and apply any payments, as applicable
- Must retain Medicaid remittance advice
  - Medicaid must be correctly billed (no denials)
  - Medicaid must accept liability (regardless of payment)

## INDIGENT/CHARITY

- Indigence must be determined by the provider, not the patient
- Should take into account a patient's total resources
- Must determine that no other source would be legally responsible for the patient's bill
- Indigence determination must be documented in patient records
- Collection policy must be consistent among all payers
- Presumptive charity: automatically approved for charity without income/asset verification (i.e., homeless); reimbursement is debatable

- Recoveries need to be prorated for covered and non-covered services, if the payment does not indicate
- Recoveries must be netted against bad debt expense claimed, even if it related to claims from prior years (Restarts 120-day period, regardless of materiality)

# Fauci Hospital
## Medicare Cost Report Settlement Reconciliation

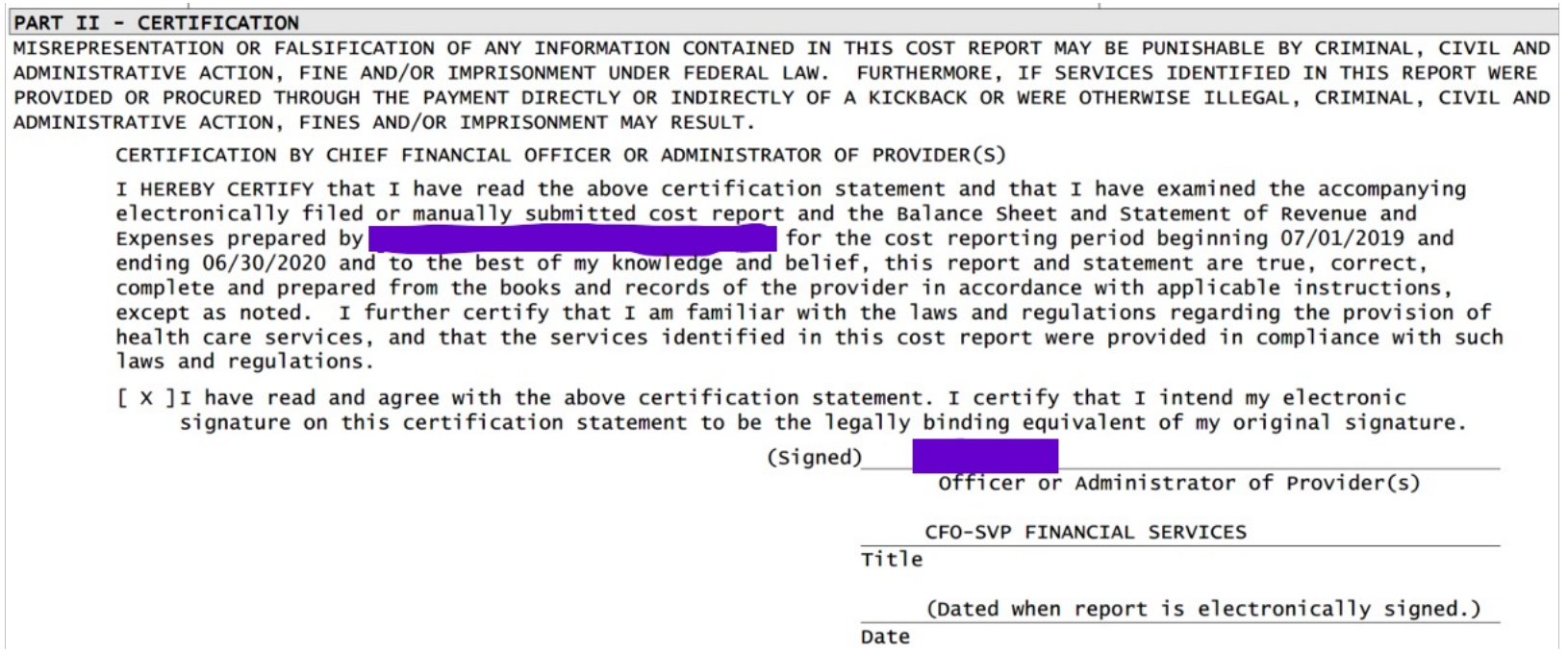
| | E, Part A IPPS | | | Title XVIII | Operating Payments | Separate Cash | Biweekly Payments |
|---|---|---|---|---|---|---|---|
| | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | | | | |
| 1.02 | DRG amounts other than outlier payments | | | 118,847,812 | 118,847,812 | | |
| 2.04 | Outlier payments for discharges | | 4.12% | 4,893,957 | | 4,893,957 | |
| 22.00 | IME payment adjustment | Page 19 | 44.88% | 53,339,255 | 53,339,255 | | |
| 22.01 | IME payment adjustment - Managed Care | Page 19 | 44.88% | 15,313,056 | | 15,313,056 | |
| 34.00 | Disproportionate share adjustment | Page 21 | 5.12% | 6,082,037 | 6,082,037 | | |
| 36.00 | Total uncompensated care | Page 28 | 6.47% | 7,694,484 | 7,694,484 | | |
| 46.00 | Total additional payment ESRD | | | 4,312,249 | | 4,312,249 | |
| 47.00 | Subtotal | | | 210,482,850 | 185,963,588 | 24,519,262 | |
| 50.00 | Payment for inpatient program capital | | | 13,801,461 | 13,801,461 | | |
| 52.00 | Direct graduate medical education payment | Page 33 | 8.60% | 10,221,167 | | | 10,221,167 |
| 53.00 | Nursing and Allied Health Managed Care Payment | | | 358,545 | | 358,545 | 0 |
| 54.00 | Special add-on payments for new technologies | | | 333,946 | | 333,946 | |
| 55.00 | Net Organ Acquisition Costs | | | 9,337,192 | | | 9,337,192 |
| 57.00 | Routine Service Pass-through costs | | | 257,357 | | | 257,357 |
| 58.00 | Ancillary Service Pass Through costs | | | 462,212 | | | 462,212 |
| 59.00 | Total (sum of amounts on lines 47 through 58) | | | 245,254,730 | 199,765,049 | 25,211,753 | 20,277,928 |
| 60.00 | Primary payer payments | | | (33,879) | (33,879) | 0 | |
| 62.00 | Deductibles billed to program beneficiaries | | | (7,818,704) | (7,818,704) | | |
| 63.00 | Coinsurance billed to program beneficiaries | | | (682,749) | (682,749) | | |
| 65.00 | Adjusted reimbursable bad debts | | | 2,328,921 | | | 2,328,921 |
| 67.00 | Subtotal (line 59 plus line 65 minus lines 60, 62, and 63) | | | 239,048,319 | 191,229,717 | 25,211,753 | 22,606,849 |
| 70.00 | MSP Pass through reconciliation | | | (3,726) | (3,726) | | |
| 70.93 | HVBP payment adjustment amount | | | 786,846 | 786,846 | | |
| 70.94 | HRR adjustment amount | | | (930,495) | (930,495) | | |
| 71.00 | Amount due provider | | | 238,900,944 | 191,082,342 | 25,211,753 | 22,606,849 |
| 71.01 | Sequestration adjustment | | 0% | 0% | 0% | 0% | 0% |
| 72.00 | Interim payments | | | (243,113,458) | (196,252,898) | (20,010,668) | (26,849,892) |
| 74.00 | Balance due provider/program | | | (4,212,514) | (5,170,556) | 5,201,085 | (4,243,043) |

# Cost Report Worksheets G Series (Financial Statements)

- "Mirror-image" of audited financial statements
  - G Balance Sheet
  - G-1 Fund Balances
  - G-2 Part I Income Statement (revenue detail)
  - G-2 Part II Income Statement (expense reconciliation)
  - G-3 Income Statement

- Cost reports are public information and can be used for comparative and strategic analyses by competitors.

# Friendly Reminder



**PART II - CERTIFICATION**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by [redacted] for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ X ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) [redacted]
Officer or Administrator of Provider(s)

CFO-SVP FINANCIAL SERVICES
Title

(Dated when report is electronically signed.)
Date

- Chief Financial Officer or Administrator reads, prepares, and signs this certification after cost report completion
- May be beneficial to complete an “independent” cost report review prior to filing or prior to MAC audit as part of overall compliance plan

# How Can We HELP?


A national healthcare advisory services firm providing consulting, audit, and tax services

**Mike Nichols**
mnichols@pyapc.com

Casey Wilburn
cwilburn@pyapc.com