Changes to Medicare Cost Reporting

Medical Devices & Supplies:
Submitting Appropriate Cost Report Data

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HFMA Oregon Chapter – Winter Meeting

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- This presentation and related training materials are intended to assist you with regard to changes in cost reporting related to charge compression. While we have endeavored to provide accurate information and assistance, these cost reporting changes are new and may be subject to different interpretations as they are implemented. We recommend that you consult with your own advisors regarding any questions or issues about the application of these changes to your facility's cost reporting obligations.

Agenda

- Presentation Overview
  - Background: What is charge compression and why is it an issue?
  - Accounting Systems: How can hospitals capture the data that is required to accurately complete their cost reports for supplies and implantable devices?
  - Cost Report, Audit Issues
  - Actual Results

Background

- Charge Compression Defined
  - Charge compression results from common hospital pricing practices
  - The process of assigning a lower mark-up percentage to high cost items and a higher mark-up percentage for items of lower cost

Background

- Charge Compression Concerns
  - Charge compression leads to bias and inaccuracy in estimating costs from Medicare cost report cost-to-charge ratios
  - Cost-to-charge ratios are an important component in determining Medicare payments
  - Most significant impact of charge compression is when all medical supplies charged to patients are grouped together

Background

- Impact on Hospital Medicare Reimbursement
  - Aggregate Medicare cost-to-charge ratios have been used to calculate APC relative value weights since 2000, and MS-DRG weights since 2006
  - Analyses have found that relative value weights for APCs which include Implantable Medical Devices are understated based on all-supplies average Medical Supply cost-to-charge ratio

Background

- Device Concerns Prompt CMS to Address Charge Compression Through Cost Report Refinement
  - CMS engaged contractor (RTI) in 2006
    - RTI studied the impact of charge compression on MS-DRG and APC payments
    - RTI research cited two significant reasons for charge compression: (1) data accuracy; (2) data aggregation
    - RTI recommended using regression analysis to disaggregate national cost to charge data

Background

- CMS Solution to Address Charge Compression
  - Add a new standard cost center for “Implantable Devices Charged to Patients”
    - CMS Transmittal #20:

      Hospitals with fiscal years beginning on or after May 1, 2009 are to separate the Medical Supplies cost center into two lines

      - » Line 55 = Medical Supplies Charged to Patients
      - » Line 55.30 = Implantable Devices Charged to Patients

Background

- CMS Solution to Address Charge Compression
  - Notification issued July 2, 2009, now being finalized, for hospitals with fiscal years beginning on or after May 1, 2010:
    - Separate the Medical Supplies cost center into two lines
      - » Line 71 = Medical Supplies Charged to Patients
      - » Line 72 = Implantable Devices Charged to Patients

Background

FY Begin Date	FY End Date	Cost Report Form
5/1/09	4/30/10	CMS 2552-96
6/1/09	5/31/10	CMS 2552-96
7/1/09	6/30/10	CMS 2552-96
8/1/09	7/31/10	CMS 2552-96
9/1/09	8/31/10	CMS 2552-96
10/1/09	9/30/10	CMS 2552-96
11/1/09	10/31/10	CMS 2552-96
12/1/09	11/30/10	CMS 2552-96
1/1/10	12/31/10	CMS 2552-96
2/1/10	1/31/11	CMS 2552-96
3/1/10	2/28/11	CMS 2552-96
4/1/10	3/31/11	CMS 2552-96
5/1/10 and After		CMS 2552-10

Accounting & Data Collection

- Assessment
  - Hospital accounting systems are not always conducive to meeting Medicare reporting requirements
  - Hospitals use various approaches to match revenues and expenses within appropriate cost centers for management and reporting purposes

Accounting & Data Collection

- Assessment
  - Decentralized cost/charge capture
    - Supply Cost & Charges assigned to multiple departments
  - Centralized cost/charge capture
    - Billable Supply Cost & Charges assigned to one department

Accounting & Data Collection

- Assessment
  - Hospital Financial Systems
    - General Ledger
    - Revenue Usage Reports
    - Materials Management/Inventory System
    - Accounts Payable
    - Cost Accounting
    - Other

Accounting & Data Collection

- Assessment
  - Hospital accounting systems should be assessed to identify cost and charge methods
  - Identification of necessary data is a crucial first step.
    - Meet with key hospital stakeholders who will be involved in capturing necessary cost and charge data

Accounting & Data Collection

- Assessment
  - Costs for billable supplies may be mixed with non-billable items
  - Revenues related to billable supplies may not be recorded in the same department as the cost
  - Methods to identify the costs & charges associated with “bundled” supplies and where to report them

Accounting & Data Collection

- Capturing Charges
  - Data source should be the Revenue Usage Report
  - Goal is to Identify charges for all Medical Supplies and Implantable Devices

Accounting & Data Collection

- Capturing Charges
  - Extract all medical supply charges using revenue codes
    - 270-279, 621 - 624
  - Create a sub-set for implantable devices using revenue codes
    - 275, 276, 278 and 624

Accounting & Data Collection

- Capturing Charges
  - Use extracted revenue code data to reclassify G/L revenue from various departments to C/R worksheet C, lines 55 and 55.30
  - Mapping the same revenue codes from the PS&R to lines 55 and 55.30 results in matching Medicare revenues to total revenues

Accounting & Data Collection

- Capturing Costs
  - Goal is to align supply costs with supply revenue
    - Supply costs are located in multiple departments and within multiple sub-accounts
    - Supply cost may include both billable and non-billable items
    - Costs for Implantable Devices may be bundled

Accounting & Data Collection

- Capturing Costs
  - Calculations Not Required
    - General ledger may have sufficient detail within departments and sub-accounts
    - Other financial system reports may also be available to provide sufficient detail

Accounting & Data Collection

- Capturing Costs
  - Calculations Required
    - Calculate cost using the volume for each item contained in the Revenue Usage Report

      OR
    - Calculate cost using the charges for each item contained in the Revenue Usage Report

Accounting & Data Collection

- Capturing Costs
  - Calculations Required Using Volume
    - Utilize cost data from various hospital accounting systems

      Materials Management/Inventory System

      Surgery Supply Management System

      Chargemaster

      Accounts Payable

Accounting & Data Collection

- Capturing Costs
  - Calculations Required Using Charges
    - Deflate revenue by the supply “mark-up” formula
    - Not as exact an approach as the volume estimates
    - May require the use of averages
    - Issues related to bundling of costs

Cost Report Preparation

- Cost Reporting Objectives
  - Ensure that total costs, total charges and Medicare charges are reported consistently
  - Segregate Medical Supplies Charged to Patients and Implantable Devices Charged to Patients on Lines 55 and 55.30 for all relevant worksheets

Cost Report Preparation

- Impacted Worksheets
  - Worksheets A – Mapping
  - Worksheet A-6 – Reclassification
  - Worksheets B and B-1 – Allocations
  - Worksheet C – Revenue Reclassification
  - Worksheet D Series – Medicare Revenue Mapping

Cost Report Preparation

- Worksheet A – Expenses
  - Data obtained directly from the general ledger
  - Medical supplies will be initially reported on numerous lines
  - Need to ensure that billable supply costs are ultimately reported on line 55 and 55.30

Cost Report Preparation

- Worksheet A–6 Reclassification of Expenses
  - Option 1: Moving supplies from various lines on worksheet A to lines 55 and 55.30
    - Either actual G/L or other system reports may be used to identify the supply costs that need to be reclassified

      OR
    - Calculations developed from the Revenue Usage Report

Cost Report Preparation

- “Financials and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedure, provided that full disclosure of significant change is made to the intermediary.”

  Medicare Provider Reimbursement Manual Part I, Section 2304

Cost Report Preparation

- Worksheets B and B-1– Allocations
  - Option 2: Allocate supplies from Line 15 to all cost centers benefiting from Central Supply, including Lines 55 and 55.30
    - Not Recommended
    - Consistent with current CMS cost report instructions, but problematic
    - Assumes that hospital has reported all supplies on line 15 Central Supply, including Medical Supplies Billed

Cost Report Preparation

- Worksheets B and B-1– Allocations
  - If billable supply expenses are decentralized into many departments, an A-6 reclassification to move those costs to line 15 is needed
  - Need to develop the statistic to allocate the costs
  - Traditional statistics of costed requisitions or supply expenses from the general ledger will not work
  - Result is 100% of cost on line 55, or cost is allocated to many lines, understating lines 55 and 55.30

Cost Report Preparation

- Worksheets B and B-1– Allocations
  - A-6 reclassification moves medical supply cost properly to lines 55 and 55.30
  - Allocate only Central Supply costs (not medical supplies) from line 15

Cost Report Preparation

- Worksheet C – Revenue Reclassification
  - Data obtained directly from the general ledger
  - Revenue Usage Report is the basis for reclassifying charges from various lines to lines 55 and 55.30
  - Results in matching total medical supply cost and charges

Cost Report Preparation

- Worksheet D Series – Medicare Revenue Mapping
  - From the PS&R, map revenue codes 275, 276, 278 and 624 to line 55.30
  - Map all remaining medical supply codes – 270-274, 277, 279, 621-623 -from the PS&R to line 55

Cost Report Audit

- Disclosure Letter
  - Need to disclose changes made in preparing the cost report
  - The cover letter creates a first important step in documenting changes
  - Describe the overall hospital approach and cost report worksheets that changed

Cost Report Audit

- CMS Instructions to FI/MACs
  - Issued Transmittal 321 on February 29, 2008 to provide guidance on cost report changes related to “charge compression”
  - Directed Medicare contractors not to make adjustments merely to be consistent with prior years
  - Allowed hospitals to make these changes without seeking prior approval from a Medicare contractor

Cost Report Audit

- Supporting Documentation for Auditors
  - Retain all source documents
  - Provide understandable and transparent workpapers supporting any reclassifications and/or allocations
  - PLAN & MAINTAIN AN AUDIT TRAIL
    - Ensure that data shown on all workpapers tie to source documents

Cost Report Audit

- Transmittal 23 – for HCFA 2552-96
  - Worksheet S-2 Question #64 added (# 121 on 2552-10)
  - Did this facility incur and report costs .. on line 55.30 as indicated in the 8/19/08 Federal Register… for revenue codes 275, 276, 278, and 624. Enter “Y” for yes or “N” for no
  - If yes, you must report on line 55.30
  - If no, make sure you don’t have those revenue codes in the Medicare PS&R, or there is potential fraud and abuse

HCRIS Data – Quarter Ended 9/30/11

- 3,125 IPPS Hospitals with FYB May, 2009 and later

- 1157 (37%) did not report on line 55.30
  - No significant change in CCR

- 1,968 (63%) did report on line 55.30
  - Costs increased 26%
  - Charges increased 25%
  - Line 55 CCR decreased from .3360 to .3057
  - Line 55.30 CCR = .3701

HCRIS Data – Quarter Ended 9/30/11

- Room for Improvement for those reporting
- 1,295 of 1,968 (66%) reported higher CCR on line 55.30 compared to line 55
- However, 673 (34%) had lower CCR on line 55.30
  - Data errors ?
  - Actual mark-ups higher on highest cost items

Questions & Answers

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Thank You!