

# CMS Manual System

Department of Health &  
Human Services (DHHS)

## Pub 100-20 One-Time Notification

Centers for Medicare &  
Medicaid Services (CMS)

Transmittal 321

Date: February 29, 2008

Change Request 5928

### **SUBJECT: Refinements in Cost Reporting Due to CMS's Revised Procedures for Recalibrating DRG Relative Weights Under the Inpatient Prospective Payment System**

**I. SUMMARY OF CHANGES:** The purpose of this CR is to inform the fiscal intermediaries and Medicare administrative contractors of the hospital/medical associations initiative on encouraging hospitals to modify their cost reporting practices with respect to costs and charges, in an effort to improve the consistency of the cost-based IPPS DRG relative weights. We agree that it would be beneficial for hospitals to consistently report costs and charges in their appropriate cost centers, and in a manner that is consistent with the way in which charges are grouped in the Medicare Provider and Review (MedPAR).

#### **New / Revised Material**

**Effective Date: Cost reporting periods ending on or after September 30, 2007**

**Implementation Date: March 31, 2008**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

#### **II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)**

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
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N/A	
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#### **III. FUNDING:**

##### **SECTION A: For Fiscal Intermediaries and Carriers:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

##### **SECTION B: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

#### **IV. ATTACHMENTS:**

##### **One-Time Notification**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment – One-Time Notification

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**SUBJECT: Refinements in Cost Reporting Due to CMS' Revised Procedures for Recalibrating DRG Relative Weights under the Inpatient Prospective Payment System**

**Effective Date:** Cost reporting periods ending on or after September 30, 2007

**Implementation Date:** March 31, 2008

## I. GENERAL INFORMATION

**A. Background:** In the FY 2007 Final Rule (71 FR 47882), CMS began to implement significant revisions to Medicare's inpatient hospital rates by basing the relative weights on hospitals' estimated costs rather than on charges. The Medicare Provider and Review (MedPAR) files and the Medicare cost report are the data sources utilized to develop the cost based weights.

Some industry groups have expressed concerns about potential bias in cost weights due to "charge compression," which is the practice of applying a lower percentage markup to higher cost services and a higher percentage markup to lower cost services. There is concern that cost-based weights may undervalue high cost items and overvalue low cost items if a single cost-to-charge ratio (CCR) is applied to items of widely varying costs in the same cost center (e.g., for medical supplies and devices).

CMS commissioned RTI International (RTI) to conduct a study on charge compression. The RTI's draft interim report was posted on the CMS Web site [<https://cms.hhs.gov/reports/downloads/Dalton.pdf>] in March 2007. The RTI report made several recommendations, including a short-term recommendation to expand the number of distinct hospital department CCRs from 13 to 19.

In the FY 2008 IPPS proposed rule (72 FR 24712), CMS did not propose to implement RTI's short-term recommendation for FY 2008 to expand the number of national CCRs from 13 to 19, although CMS solicited public comments on this issue. After considering the public comments, CMS added two national CCRs for a total of 15 CCRs.

The comments received on the proposed rule from several hospital and medical associations included recommendations on how the impact of charge compression might be mitigated through improvement in cost reporting by hospitals. A workgroup convened by the American Hospital Association, the Association of American Medical Colleges, and the Federation of American Hospitals found that CMS groupings of hospital charges on MedPAR differ from how hospitals group Medicare charges, total charges, and overall costs on their cost reports. This mismatch between MedPAR charges and cost report CCRs can distort DRG weights. For example, the workgroup found that reporting of chargeable medical supplies costs and charges on the cost report (line 55 of Worksheets C, Part I and D-4) to be a significant problem area because some hospitals report chargeable medical supply charges and costs in various ancillary departments on the cost reports, but report those charges on the medical supplies revenue code on the claim.

These hospital/medical associations have launched an educational campaign to encourage hospitals to report costs and charges, particularly for supplies, in a way that is consistent with the way that charges are grouped in MedPAR. Their suggestions include that hospitals should adopt an approach of classifying all billable medical

supply costs and charges to line 55 of the cost report and mapping the 27X Revenue Summary codes from the Provider Statistical and Reimbursement Report (PS&R) only to line 55.

Therefore, the purpose of this Change Report is to inform the fiscal intermediaries and Medicare administrative contractors of the hospital/medical associations' initiative on encouraging hospitals to modify their cost reporting practices with respect to costs and charges, in an effort to improve the consistency of the cost-based IPPS DRG relative weights. CMS agrees that it would be beneficial for hospitals to consistently report costs and charges in their appropriate cost centers, and in a manner that is consistent with the way in which charges are grouped in MedPAR.

**B. Policy:** The Provider Reimbursement Manual (PRM), Part I, §2202.4 requires that costs and charges for a given service be matched and placed in the same cost center. Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Furthermore, it states that charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. Transmittal 18 of the hospital cost report will reaffirm this policy through the instruction in §3620 for Worksheet C, on which charge ratios are calculated.

Section 2203 of the PRM I states that in order to assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reporting, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.

**C. Reporting and Review**

Providers may submit cost reports with cost and charges grouped differently than in prior years, so long as the cost and charges are properly matched and Medicare cost reporting instructions are followed. Medicare contractors shall not propose adjustments that regroup costs and charges merely to be consistent with previous year's reporting if the costs and charges are properly grouped on the as-filed cost report. In addition, prior approval from the Medicare contractor is not needed to regroup billable medical supply costs and charges to lines 55 because this is not a change in cost finding methodology. Medicare contractors shall be vigilant to ensure that the costs of items and services are not moved from one cost center to another without moving the corresponding charges. Contractors shall use the applicable desk review thresholds to determine whether a limited or a full desk review needs to be performed on the as-filed cost reports. Contractors shall determine the level of review needed to resolve any material variance noted during the completion of the ADR section of the full desk review. If the contractor suspects that the cost-to-charge ratio reported for any cost center is unreasonable, the contractors can add steps to the limited desk review program to ensure proper matching of cost and charges.

**II. BUSINESS REQUIREMENTS TABLE**

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)
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