HFMA Rookie Camp – Hospital Reimbursement
October 16, 2024

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1. Brief History of Medicare and Medicaid
2. Medicare Payment Methodologies
3. Medicare Special Designation Hospitals
4. Medicare Cost Report
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6. Medicare DSH
7. Medicare Bad Debt
8. Medical Education

HISTORY OF MEDICARE AND MEDICAID

MEDICARE PROGRAM HISTORY – TITLE XVIII

July 30, 1965 – President Lyndon Johnson signs the Social Security Act of 1965 into law, establishing the Medicare and Medicaid programs. Harry Truman is the first person to enroll in Medicare.

July 1, 1966 – The Medicare and Medicaid programs begin. Hospitals are reimbursed based on their retrospective allowable costs, offering little incentive for cost containment.

1972 – Medicare eligibility extended to individuals under 65 with long-term disabilities or ESRD (End Stage Renal Dialysis).

October 1, 1983 – Medicare implements the inpatient prospective payment system (PPS), converting acute inpatient reimbursement from a cost-based system to a prospective per-case basis.

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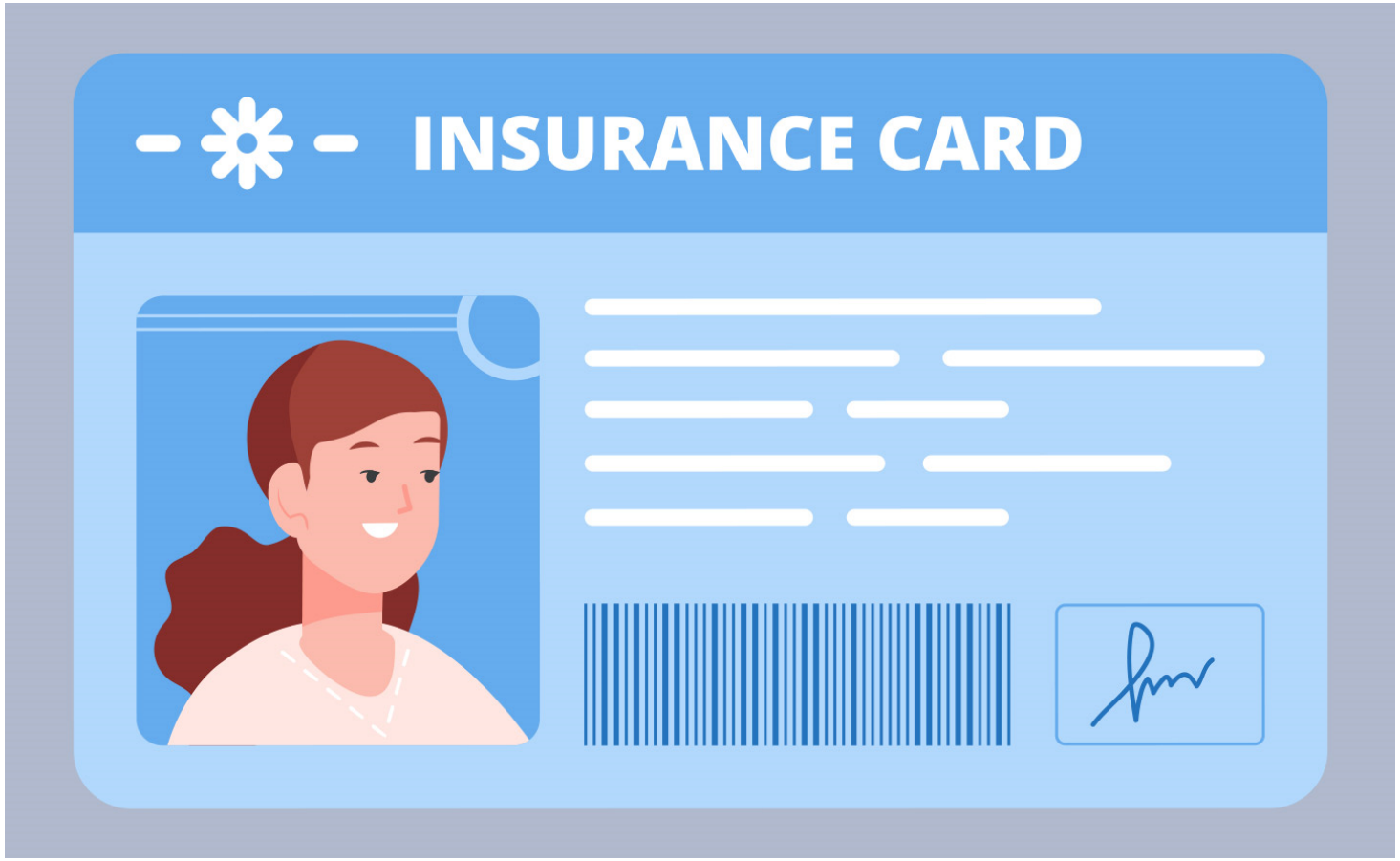
MEDICARE ADMINISTRATION OVERVIEW

Medicare is a Federally funded health insurance program for:

- Most Americans age 65 or older (certain stipulations apply),
- People under age 65 with certain disabilities, and
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

MEDICARE ADMINISTRATION OVERVIEW



Medicare has four parts:

1. Hospital Insurance (Part A)
2. Medical Insurance (Part B)
3. Medicare Advantage (Part C)
4. Prescription Drug Benefit (Part D)

MEDICARE ADMINISTRATION OVERVIEW

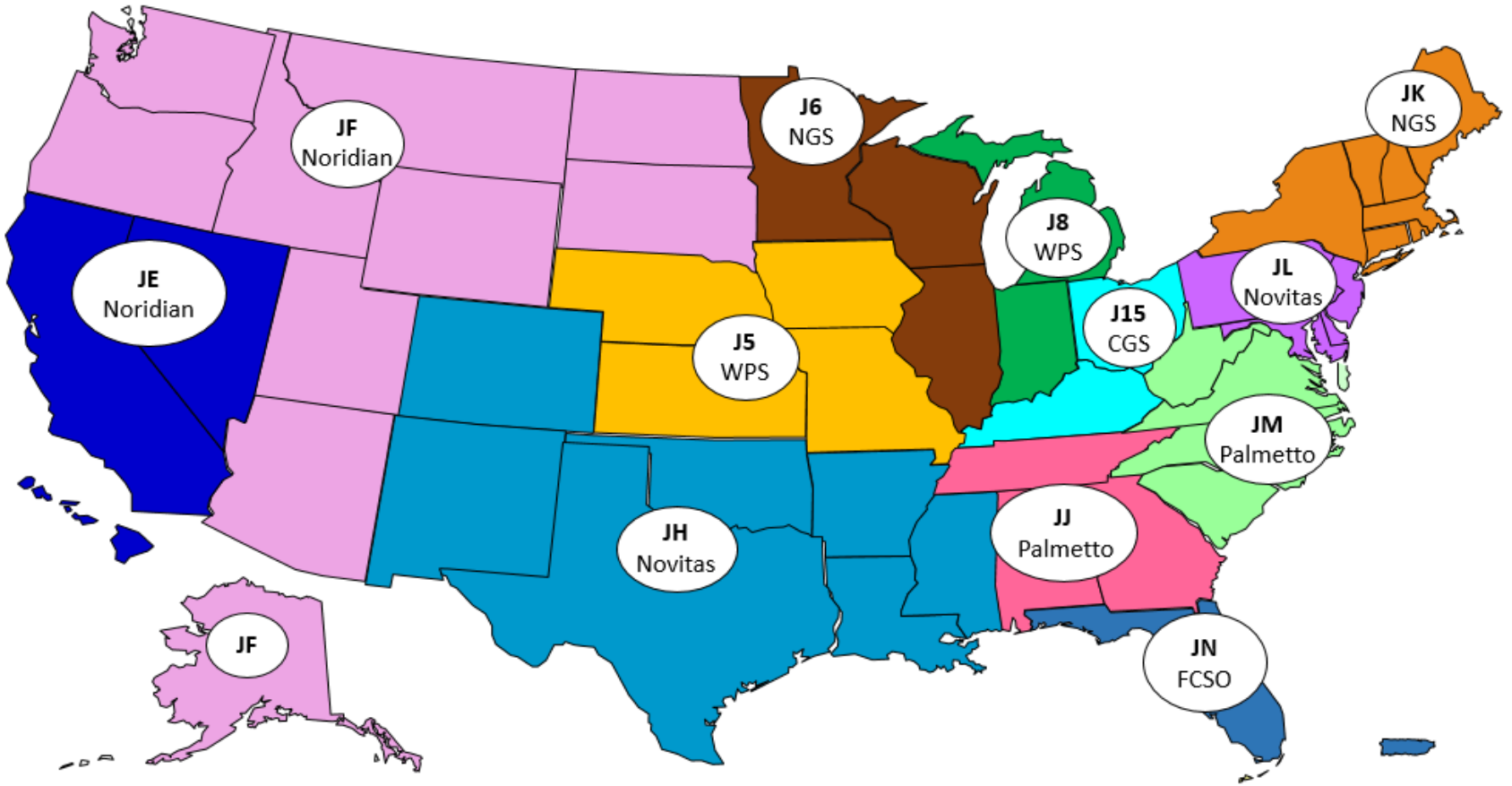
Administered at the Federal level by the Centers for Medicare & Medicaid Services (CMS), which is part of the US Department of Health & Human Services

- CMS national office is in Baltimore, with 10 regional offices

Local day to day administration of the Medicare program is provided by private insurance companies under contract with CMS

- These contractors were previously known as Fiscal Intermediaries (FIs) for Part A and Carriers for Part B
- As a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS has transitioned to Medicare Administrative Contractors (MACs) which handle both Part A and Part B administration
- CMS considering consolidating 4 MAC jurisdictions into 2 and extending contracts to 10 years

MEDICARE ADMINISTRATION OVERVIEW



MEDICAID PROGRAM HISTORY – TITLE XIX

July 30, 1965 – President Lyndon Johnson signs the Social Security Act of 1965 into law, establishing the Medicare and Medicaid programs – total of 56 different programs (one for each state, territory and the District of Columbia).

At first, Medicaid gave medical insurance to people getting cash assistance. Today, a much larger group is covered:

- Low-income families
- Pregnant women
- People of all ages with disabilities
- People who need long-term care
- States can tailor their Medicaid programs to best serve the people in their state, so there's a wide variation in the services offered.

MEDICARE PAYMENT METHODOLOGIES

MEDICARE PAYMENT METHODOLOGIES

From the CMS website:

A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient Prospective Payment System (IPPS)

- Paid on a per-case basis
- Base rate is adjusted by certain factors for each case
  - Wage Index adjustment
  - Disproportionate Share Hospital (DSH) add-on
  - MS-DRG (Medicare Severity Diagnosis Related Group) relative weight
    - Each case categorized into a MS-DRG based on diagnosis, required procedures, other factors
  - New in FY 2013:
    - Value Based Purchasing (VBP) Adjustment Factor
    - Readmissions Adjustment Factor
  - New in FY 2015:
    - Hospital-Acquired Conditions
  - Federal fiscal year for IPPS = October 1-September 30

MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient Prospective Payment System (IPPS)

- Each Medicare patient is assigned to a specific MS-DRG
  - Medicare contractors and most hospitals use a software program called GROUPER to determine MS-DRG assignment (although it is possible to determine manually)
  - MS-DRG assignment is based on:
    - Principal diagnosis, which is what is determined to be the chief reason for the patient's admission to the hospital, and is expressed in terms of an ICD-10 diagnosis code
    - Additional diagnoses
    - Procedures performed, expressed in terms of ICD-10 procedure codes
    - Gender
    - Discharge status

MEDICARE PAYMENT METHODOLOGIES

FY 2024 FINAL Tables 1A-1E

TABLE 1A. 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 = 3.1 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.625 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 2.275 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.2 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,392.49	$2,105.28	$4,287.05	$2,054.74	$4,357.34	$2,088.43	$4,251.90	$2,037.89

TABLE 1B. 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 = 3.1 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.625 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 2.275 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.2 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,028.62	$2,469.15	$3,931.91	$2,409.88	$3,996.38	$2,449.39	$3,899.67	$2,390.12

TABLE 1D. - CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$503.83

Table 3- WAGE INDEX TABLE BY CBSA - FY 2024 (CONTAINS THE FOLLOWING DATA: AVERAGE HOURLY WAGE, WAGE INDEXES AND THE GAF. ALSO INCLUDES WAGE INDEXES PRIOR TO APPLICATION OF THE FRONTIER WAGE INDEX AND/OR RURAL FLOOR AS WELL AS AN INDICATOR FOR CBSAs ELIGIBLE FOR THE FRONTIER AND/OR RURAL FLOOR WAGE INDEX)- FY 2024 FINAL RULE

CBSA	Area Name	Wage Index	GAF
01	ALABAMA	0.7121	0.7925
14454	Boston, MA	1.2425	1.1603

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2024 Final Rule

MS-DR	FY 2024 Final Post-Acute DRG	FY 2024 Final Special Pay DRG	MDC	TYPE	MS-DRG Title	Weight	Geometric mean LOS	Arithmetic mean LOS
244	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT CC/MCC	1.8295	2.1	2.4

MEDICARE PAYMENT METHODOLOGIES

WAGE INDEX ADJUSTMENT COMPARISON

	Boston CBSA	Rural AL
OPERATING		
Labor-Related Portion	4,392.49	4,392.49
x Wage Index	1.2425	0.7121
Adjusted Labor-Related Portion	5,457.67	3,127.89
+ Nonlabor-Related Portion	2,105.28	2,105.28
Wage Adjusted Based Operating Rate	7,562.95	5,233.17
Hospital-Specific Readmissions Adj. Factor	0.9998	0.9998
Readmissions Adjustment	(1.46)	(1.46)
	7,562.49	5,232.71
Hospital-Specific VBP Adjustment Factor	1.00	1.00
VBP Adjustment	-	-
	7,562.49	5,232.71
DSH Add-on Percentage (Urban Only)	3.00%	3.00%
DSH Add-on	226.87	156.98
Adjusted Operating Base Rate	7,789.36	5,389.69

MEDICARE PAYMENT METHODOLOGIES

GEOGRAPHICAL ADJUSTMENT COMPARISON

	Boston CBSA	Rural AL
CAPITAL		
Standardized Rate - Capital	503.83	503.83
x Geographic Adjustment Facor	1.1603	0.7925
Adjusted Capital Base Rate	584.59	399.29
+ Capital DSH Add-on	5.80%	0.00%
Adjusted Capital Base Rate	618.50	399.29

MEDICARE PAYMENT METHODOLOGIES

	Boston CBSA	Rural AL
TOTAL PAYMENT		
Adjusted Capital Base Rate	618.50	399.29
Adjusted Operating Base Rate	7,789.36	5,389.69
Total Adjusted Base Rate	8,407.86	5,788.98
MS-DRG 244 Relative Weight	1.8295	1.8295
Medicare Payment	15,382.19	10,590.94

NOTE: This example calculation does not the affect HAC Reduction Adjustment or Sequestration

MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient PPS

- Other Payment Factors
  - Outlier Payment
  - Payment for Transfer Patients
  - Adjustment to MS-DRGs for Hospital-Acquired Conditions

MEDICARE SPECIAL DESIGNATIONS

MEDICARE SPECIAL DESIGNATIONS

- Sole Community Hospital (SCH)
- Medicare Dependent Hospital (MDH)
- Rural Referral Center (RRC)
- Low Volume Payment Adjustment
- Critical Access Hospital (CAH)
- Rural Emergency Hospital (REH)
  - *For each of these special designations, a hospital must meet certain requirements and submit an application or request in order to be approved*
  - *In most instances a hospital will need to be rural (or re-designated as rural)*

MEDICARE COST REPORT

COST REPORT OVERVIEW

Purpose of the Cost Report

- Basis for reimbursement settlements between provider and Medicare or Medicaid
  - Determine overall amount due to provider
  - Compare to interim payments made during the year
  - Similar in concept to a tax return
- Basis of reimbursement drives audit focus
  - PPS – auditors typically focus on DSH, bad debts, etc. and pay little or no attention to the cost side
  - Cost reimbursement – focus on cost and charges
- The cost report is a mandatory submission for participation in the Medicare program
  - Full, Low or No Utilization cost reports

COST REPORT OVERVIEW

Purpose of the Cost Report (cont.)

- Is a source of information
  - Aggregate cost report data used to develop future payment rates
    - Generally, there is a three-year lag between when cost reports are filed and when the data impacts relative weights
  - Specific information influences payment factors
    - Wage Index
    - CCRs for outliers
  - Some years are used for developing certain base payment rates (SCH and MDH hospital-specific rates)
  - To guide policymaking (Ex: CMS, MedPAC)

COST REPORT OVERVIEW

1. Hospital files the cost report
    - Typically, due five months after year-end
2. Contractor accepts (or rejects) cost report submission
3. Contractor issues tentative settlement
    - Typically, should be done within 60 days of acceptance
4. Contractor updates current interim payment rates based on new tentatively settled cost report
5. Contractor conducts review or audit
6. Contractor may request additional information or explanations from the hospital
7. Proposed adjustments issued for hospital review
8. Adjustments are finalized
9. Notice of Program Reimbursement (NPR) issued in final settlement of cost report

COST REPORT OVERVIEW

Primary cost report sections:

Series	Purpose(s)
S	• Summary “cover sheet” (S) • Hospital specifics, to assist in determining reimbursement treatments and other details (S-2) • Hospital bed and census data (S-3) • Wage survey (S-3 II, III, IV) • Uncompensated care data (S-10)
A	• Summary of Costs (A) • Reclasses to costs (A-6) • Adjustments to costs (A-8, A-8-1) A-8-2) • Analysis of capital assets (A-7)

Primary cost report sections (cont.):

Series	Purpose(s)
B	• Cost allocation statistics (B-1) • Cost allocations (B I)
C	• Gross patient charges and RCC calculations
D	• Program Charges
E	• Program settlements
G	• Hospital financial statements

WAGE INDEX

WAGE INDEX

- Wage Index reflects the relative hospital wage level for each geographic area compared to the national average
- Geographic areas are based on the Core Based Statistical Areas (CBSA) defined by the Office of Management and Budget
- Data used to calculate the wage index is the aggregate of all PPS hospitals located within each CBSA

Table 3- WAGE INDEX TABLE BY CBSA - FY 2025 (CONTAINS THE FOLLOWING DATA: AVERAGE HOURLY WAGE, WAGE INDEXES AND THE GAF. ALSO INCLUDES WAGE INDEXES PRIOR TO APPLICATION OF THE FRONTIER WAGE INDEX AND/OR RURAL FLOOR AS WELL AS AN INDICATOR FOR CBSAs ELIGIBLE FOR THE FRONTIER AND/OR RURAL FLOOR WAGE INDEX)- FY 2025 FINAL RULE

CBSA	Area Name	Wage Index	GAF	Reclassified Wage Index
01	ALABAMA	0.7578	0.8270	0.7578
14454	Boston, MA	1.3124	1.2046	1.3124

WAGE INDEX

Sources of data for Wage Index:

- Cost Report
  - Worksheet S-3 Parts II - V
- Occupational Mix Survey

There is a four-year lag prior to wage data being included in the AHW

- FFY 2026 wage index is based on wage data from cost reporting periods beginning in Federal Fiscal Year (FFY) 2022
- The first day of a cost report period determines what FFY it falls into – FFY 2022 includes 9/30/22, 12/31/22 and 6/30/23 cost reports

Wage Index Timeline:

- File wage index schedules with cost report filing date
- The deadline to update and provide additional documentation for FFY 2026 was September 3, 2024
- Currently in the MAC audit process
- Final Adjusted data will be included in the FFY 2026 rates

MEDICARE DSH

MEDICARE DSH

- Disproportionate Share Hospital
- Authorized by Congress as part of IPPS enactment
- Mandated by Congress in 1986
- Intended to provide additional reimbursement for hospitals that serve a disproportionate share of low-income patients
    - In general, low-income patients tend to have more health issues and do less health maintenance, which increases the number of resources required to serve their health needs
- Historically DSH paid as a percentage add-on to inpatient Medicare DRG payments
- Section 3133 of PPACA required significant revision effective for discharges on or after 10/1/13
        - Traditional Medicare DSH Payment is reduced by 75%
        - Established new DSH Payment for Uncompensated Care (DSH UCC)

MEDICARE BAD DEBT

MEDICARE BAD DEBT

Criteria for Medicare Bad Debt

- Debt must be related to covered services and derived from deductible & coinsurance amounts
- Provider must be able to establish that reasonable collection efforts were made
- Debt was actually uncollectible when claimed as worthless, and
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

MEDICARE BAD DEBT

Regular Bad Debt

- Non-indigent Medicare beneficiaries
- Not Medicaid eligible and not determined indigent by provider’s customary methods
- Follows the provider’s typical collection process outlined in the policy

Crossover Medicare Bad Debt

- Dual eligible Medicare beneficiaries, eligible for Medicare and Medicaid
- Reasonable collection efforts involve billing the State Medicaid plan, not the patient

Indigent Medicare Bad Debt

- Indigent non-dual eligible Medicare beneficiaries
- Indigence is determined by the provider, not Medicaid eligible
- Follows the provider’s financial assistance policy

MEDICAL EDUCATION

MEDICAL EDUCATION

What is Graduate Medical Education (GME)?

- Formally approved clinical education and training programs known as residency training programs to physicians who have received a medical degree (M.D. or D.O.) from an accredited or approved school of medicine.
- To complete a physician's education, at least some GME is necessary to allow the physician to obtain a license to practice medicine.
- Varying degrees of residency training periods are required depending upon the specialty or sub-specialty board certification desired.
- Resident training year runs 7/1 – 6/30

MEDICAL EDUCATION

What is a resident?

- A resident has completed medical school and is actively enrolled in an approved program and is actively seeking board certification (ACGME, AOA, AACOM)

- **Specialties with the highest percentage of total residents**
  - Internal Medicine (24.4%)
  - Family Medicine (11.5%)
  - Pediatrics (7.8%)
  - Surgery (7.4%)
- **Teaching hospitals' direct cost of training is >$16 billion per year**
- **Medicare reimburses ~$10 billion per year to hospitals:**
  - ~$3.5 billion for direct cost
  - ~$6.5 billion for indirect cost
- **Medicaid reimburses ~$5.6 billion per year[2]**

MEDICAL EDUCATION

Graduate Medical Education (GME)

- Indirect Medical Education (IME)
  - To recognize the cost of GME programs by the teaching hospital due to inefficiencies
  - Reimbursement paid to hospital on a per claim basis
- Direct Graduate Medical Education (DGME)
  - To recognize the direct GME related costs incurred by the teaching hospital (Salary, Benefits, Faculty Compensation)
  - Reimbursement paid through bi-weekly payments to the hospital

Meet the Presenters

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Thank You!