4/26/07

COST REPORT CHANGES TO IMPROVE THE ACCURACY OF "COST-BASED" WEIGHTS

Recommendations of the Cost Report Workgroup

April 2007

Background

On August 18, 2006, CMS published the final rule for the inpatient Medicare prospective payment system (PPS) implementing a change in how DRG weights would be developed. CMS modified the prior system that relied solely upon hospital charge data, and developed an approach that would establish the weights based upon hospital "cost" data. CMS suggested that this type of revision would lead to the creation of DRG weights that more accurately reflect the relative resource use by DRG. Recognizing the financial impact of changes to the weights on some hospitals and the possible need for further refinements, the final rule allowed for a three-year transition using a blend of the "charge-based" system and the "cost-based" system.

Under the "cost-based" system, the two sources of data that are utilized in establishing the DRG weights are the MedPAR files (an accumulation of claims filed by each hospital), and the Medicare cost report (MCR). Charges are taken from the MedPAR files, grouped into 13 categories, and reduced to cost from cost to charge ratios (CCR) calculated from the MCRs for these same 13 categories. **Appendix 1** provides an outline and example of this new approach for setting weights.

An examination of the cost-based weights developed for fiscal year 2007 revealed that some significant problems occur by using these two different data sources together.

- First, the method used by CMS to group hospital charge for the MedPAR files is different than how hospitals group Medicare charges, total charges and overall costs on the cost report.
- Second, hospitals group their Medicare charges, total charges and overall costs in different departments on their cost reports for various reasons.
- Third, hospitals across the country complete their cost reports in different ways as allowed by CMS.
- Fourth, CMS' new approach for categorizing all charges and costs into thirteen specific categories may not yield the most appropriate cost to charge ratio for each cost category.

This mismatch between MedPAR charges and cost report CCRs can distort the resulting DRG weights. It is important to note that the cost report was not designed to support the estimation of costs at the DRG level.

As a result, the American Hospital Association (AHA), Association of American Medical Colleges (AAMC) and the Federation of American Hospitals (FAH) convened a

workgroup of hospital experts to evaluate the current Medicare cost report, and other elements that provide input into the cost report, such as the Uniform Billing form and related codes, Medicare paid claims summaries (PS&Rs), and hospital accounting structures and reports to discuss how these affect the above issues. The group's charge was to identify what changes might be made to the Medicare cost report and/or other related inputs to ensure CMS' approach yields more accurate weights. **Appendix 2** provides a list of workgroup participants.

Workgroup Recommendations

1. **In order to achieve more accurate DRG cost-based weights, the cost report workgroup recommends that all hospitals prepare their Medicare cost reports so that Medicare charges, total charges and overall costs are aligned with each other and with the categories currently utilized in the MedPAR file.** This allows for a consistent grouping of departments within the thirteen categories identified in the August 18, 2006 final IPPS rule that are used to create the cost-based weights. The workgroup recommends that the primary area of focus for these efforts should be the medical supplies category.

   The workgroup recognizes that hospitals will need to consider how Medicare cost reports are used by Medicare and other payers as they look at how best to make these changes.

2. **The workgroup recommends that this approach be supported by educational materials to be developed and disseminated by the national, state, regional, and metropolitan hospital associations in collaboration with the Healthcare Financial Management Association.** The recommended approach will augment the current cost report instructions, but will still follow existing cost reporting requirements. The workgroup recognizes that some hospitals will be better situated than others to adopt these changes; as a result, it will be more expensive and time-consuming for some hospitals than others to successfully implement this recommendation. However, the workgroup believes that the investment is worth the effort in order to lessen distortions in cost-based DRG weights that affect all PPS hospitals' Medicare reimbursement.

3. **The workgroup suggests the national associations inform CMS of the group's recommendations to ensure fiscal intermediary (FI) cooperation.** While many hospitals will be able to accomplish the recommended changes to the cost report from general ledger data, other hospitals will have to use cost estimation techniques. Without assurance from CMS that they will instruct the FIs to accept these computations, some hospitals may be unwilling to make these changes.

4. The workgroup considered changes to the Uniform Bill, cost report, revenue codes and MedPAR, but determined that these types of changes would require a multi-year process with involvement beyond the hospital field. However, the recommendations outlined above do not fix all of the problems identified by the

workgroup. **The workgroup recommends that the hospital field engage with CMS to identify whether changes should be made to the cost report and other inputs to address other areas of potential distortion.**

Recommended Approach for Modifying Cost Reports to Achieve Consistent Reporting

The approach outlined below addresses two problems identified by the workgroup:

- Hospitals do not always consistently categorize their Medicare charges, total charges and total costs into departments on the cost reports causing a mismatch within the cost to charge ratio, and/or a mismatch between the cost to charge ratio and the Medicare charges. Medicare charges, total charges and total costs should be reported consistently.

- A significant number of hospitals do not categorize their Medicare charges, total charges and total costs on the cost report in the same manner as CMS categorizes Medicare charges on the MedPAR file. This creates the mismatch of MedPAR and cost report data that may distort cost-based DRG weights.

The workgroup recommends that hospitals evaluate their reporting of charge and cost data in their cost reports to ensure that they consistently categorize overall hospital costs, charges and Medicare charges.

Currently, cost report instructions included with the CMS Form-339 allow for three methods of reporting Medicare charges. The method selected by each hospital is specific to its information systems and based on the method that most accurately aligns Medicare program charges on Cost Report Worksheet D-4 with the overall cost and charges reported on Worksheets A and C. Many hospitals elect to allocate some or all of the Medicare program charges from the Medicare PS&R to various lines in the cost report based on hospital specific financial system needs. Under this scenario, total hospital ratios of costs and charges (CCRs) are aligned with program charges, but will not match the charge groupings used in MedPAR. This mismatching may distort the resulting DRG weights under the methodology developed by CMS.

The workgroup has identified the reporting of Medical Supplies costs and charges on the cost report as the most significant problem area because of two issues:

- First, many hospitals include medical supply charges in different ancillary departments (e.g. the operating room, the emergency department, etc.) These charges are billed on the UB92 bill using the 27X revenue code series for medical supplies. Ultimately, the medical supply charges for the Medicare program are either mapped to line 55 (the Medical Supply Cost Center) in the cost report or allocated to various other departments. If the 27X charges on the Medicare PS&R are allocated to various departments on the Medicare cost report, and not all of the total charges and total costs have been reclassified to the same departments on

Worksheets A and C, the CCR for Medical Supplies will be misstated (generally understated) which will distort the "cost-based" weights for DRGs containing significant medical supply charges. This is the type of distortion that can occur with inconsistencies in reporting.

- Second, problems can occur when hospitals choose (as allowed by CMS) to allocate total charges and costs on the cost report for some medical supplies to the departments where the supplies are used. Supply costs and charges might be allocated to the operating room (OR) and the emergency department (ED) in addition to the medical supply cost center. Many of these hospitals achieve consistency in their cost reports by allocating the Medicare charges on the PS&R to the OR, ED and Medical Supply Cost Center. This practice is allowed by cost report instructions, but, will result in charge groupings that do not match the way charges are grouped in the MedPAR file. MedPAR groups ALL medical supplies on line 55 of the cost report. Since the MedPAR groupings are used to establish the thirteen categories used to set the "cost-based" DRG weights, the practice described above will result in cost to charge ratios that do not match the charges to which they are applied.

Therefore, we are urging hospitals to examine how they are completing their cost reports and adopt the 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 PS&R only to line 55. While it is preferable to accomplish this within the hospital's accounting systems, it can be accomplished through a reclassification on Worksheet A-6 of the cost report. It is our understanding that most, if not all, hospital revenue accounting systems have the ability to report charges by Revenue Summary code by department. Charges containing the 27X Revenue Summary codes would be reclassified to line 55 from any department mapped to lines other than 55. In addition, the cost of the **billable** medical supplies should also be reclassified to line 55 from any department mapped to lines other than line 55.

APPENDIX 1:
STEPS IN CREATING COST-BASED WEIGHTS

Step 1: After applying all the adjustments and standardizing the charges, all charges were summed by DRG for each of the 13 cost groups such that each DRG had 13 standardized charge totals.

Step 2: Each of the 13 categories of standardized charges is then converted to costs for each DRG by applying the national average cost to charge ratios for each of the 13 categories as calculated below. A Medicare specific cost to charge ratio is calculated for each provider by calculating a Medicare specific cost to charge ratio for each line on Worksheet D-4.

Step A: The Medicare charges for each line on Worksheet D-4 are multiplied by the overall cost to charge ratio (obtained from Worksheet C) for each line to obtain the Medicare costs for each line. Each line on Worksheet D-4 is grouped into its appropriate category (one of the thirteen).

Step B: For each of the 13 categories, the sum of the Worksheet D-4 costs, by appropriate line, for all providers is then divided by the sum of the Worksheet D-4 charges, by appropriate line, for all providers to arrive at the national cost to charge ratio for the specific category.

Step 3: For each discharge the charges in each of the 13 categories is multiplied by the national cost to charge ratio described above, and then summed to arrive at a standardized cost for the DRG.

Step 4: For each DRG the standardized cost for the DRG is then divided by the number of Medicare cases for that DRG to arrive at a standardized cost per case for that DRG.

Step 5: The sum of Step 4 is determined for each DRG and is then divided by the total number of Medicare cases for all DRGs to arrive at a national average standardized cost per case.

Step 6: The standardized cost per case for each DRG (step 4) is then divided by the national average standardized costs per case (step 5) to arrive at the weight for each DRG.

Cost-Based Weight Calculation Methodology

DRG #1

	Cost Category	Charges	X	Cost to Charge Ratio (CCR)	=	Costs
1.	Routine	$	X	CCR	=	$
2.	Intensive	$	X	CCR	=	$
3.	Drugs	$	X	CCR	=	$
4.	Supplies/Equip	$	X	CCR	=	$
5.	Therapy Services	$	X	CCR	=	$
6.	Inhalation Therapy	$	X	CCR	=	$
7.	O/R	$	X	CCR	=	$
8.	Labor & Delivery	$	X	CCR	=	$
9.	Anesthesia	$	X	CCR	=	$
10.	Cardiology	$	X	CCR	=	$
11.	Laboratory	$	X	CCR	=	$
12.	Radiology	$	X	CCR	=	$
13.	Other	$	X	CCR	=	$
Total		MedPAR	X	National Cost/Charge Ratio [(1)]	=	$

[(1)] Cost Report: Based on a Medicare specific cost to charge ratio calculated for all providers

Calculated for each Provider using Supplies/Equipment as an Example of one of the 13 Departments
Calculating the Medicare-specific Cost-to-charge Ratio

Cost Report Line #	Wks D-4 Charges	X	Wks D-4 Cost to Charge Ratio (2)	=	Wks D-4 Costs
55	$	X	CCR	=	$
66	$	X	CCR	=	$
67	$	X	CCR	=	$
	Sum Charges				Sum Costs

[(2)] Calculated from Wks C, using overall costs and charges

Example above will be calculated for all providers: then Sum All Costs/Sum All Charges for Category 4 (Supplies) to equal the National Cost to Charge Ratio for Supplies/Equip

DRG #1 Cost per Case/National Avg. (All DRGs) Cost per Case* = Weight

*Sum of all charges for all DRGs for each of the 13 categories x national CCR for each of the 13 categories to equal summed costs for all DRGs for each of the 13 categories: Summed Costs/All Cases = National Avg. (All DRGs) Cost/Case

APPENDIX 2:
Cost Report Workgroup Participants

Facilitator

Steve Clark
Clark, Koortbojian and Associates
Phone: (916) 673-2020
E-mail: sclark@ckainc.net

Sponsoring Organizations

American Hospital Association
Danielle Lloyd
Don May
Caroline Steinberg

Association of American Medical Colleges
Karen Fisher

Federation of American Hospitals
Steve Speil

Participants

Pat Andersen
Oklahoma Hospital Association

George Arges
American Hospital Association/National Uniform Billing Committee

Norman Belcher
HCA

Susan Friedman
Montefiore Medical Center

Bob Halinski
Universal Health Services, Inc.

Steve Harwell
Healthcare Association of New York State

Karen Heller
Greater New York Hospital Association

Clara Kridle/Jose Robles
Price Waterhouse Coopers

Todd Nelson
Grinnell Regional Medical Center

Kathy Reep
Florida Hospital Association

Trisha Schirmers
Allina Health System

Mike Smith
Catholic Healthcare West

Cecil Terry
BJC Healthcare

Tim Wolters
BKD, LLP