



healthcare financial management association

July 10, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1735-P
P.O. Box 8013
Baltimore, MD 21244-1850

File Code: CMS-1735-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Administrator Verma:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals* (hereafter referred to as the Proposed Rule) published in the Federal Register on May 29, 2020. HFMA is a professional organization of more than 58,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the many Medicare payment decisions addressed in the 2021 Proposed Rule. Our members would like to respond in this letter to the proposed rule's "Market-Based MS-DRG Relative Weights." We would like to take this opportunity to provide feedback on the proposed rule's requirement that hospitals report median Medicare Advantage (MA) and 3rd Party "payer specific negotiated charges" as part of their cost report for cost report periods ending on or after January 1, 2021 and CMS's framework (as yet not proposed) to rebase Medicare Fee-for-Service (FFS) MS-DRG weights using median MA "payer specific negotiated charges."

Unfortunately, HFMA's members fail to see how transitioning to a system that uses median MA "payer specific negotiated charges" achieves the stated policy goals or improves the accuracy of the Medicare IPPS. Therefore, we encourage CMS to not propose this policy change in a future IPPS rule. Further, we do not see the utility of requiring hospitals to report their "payer specific negotiated

charges” as part of the Medicare cost report and strongly encourage CMS not to finalize a proposal that increases provider administrative burden – contrary to the administration’s “Patient’s Over Paperwork Initiative” – and collects information that CMS is already requiring hospitals publicly post.

As you are aware, HFMA’s members are strong supporters of efforts to increase transparency. We appreciate the opportunities over the past 18 months to meet with you and your staff to discuss our proposal (discussed below and included in detail in Appendix I) to remove regulatory barriers to creating the conditions for a functioning market for healthcare services by decoupling Medicare payments from charges. **We believe this proposal will address a number of longstanding problems that distort the accuracy of Medicare payments and fix Medicare payment policy issues that increase payments for those patients and payers whose payment is calculated based on gross charges. Therefore, we strongly encourage the administration to work with HFMA, hospitals and health systems, and other key stakeholders to test, refine, and implement this proposal.**

Potential Market Based MS-DRG Relative Weight Methodology Beginning in FY 2024

HFMA’s members appreciate the creativity CMS displayed in developing its concept to rebase MS-DRG weights using the median “payer specific negotiated charge” (hereafter referred to as the “negotiated rate).” Specifically, the proposed rule requests comments on whether to use the data it is proposing that hospital report (discussed below) beginning with cost reporting periods ending in FY 2021 for determining the MS-DRG relative weights, beginning in FY 2024. If CMS adopted this idea, it would propose further details in the FY 2022 IPPS/LTCH PPS final rule.

The proposed rule states CMS is considering this in an effort to identify and implement “approaches to modify Medicare FFS payments to...encourage more robust price competition, and otherwise to inject market pricing into Medicare FFS reimbursement.” CMS also states this proposal is an attempt to reduce the Medicare program’s reliance on the hospital chargemaster. HFMA’s members generally support these goals. However, they struggle to see how transitioning to a system that rebases MS-DRG weights using MA median rates achieves the stated goals or results in improving the accuracy of payments for Medicare Fee-For-Service inpatient services. **We ask that CMS in the final rule describe the specific benefits to beneficiaries, the program, and hospitals it envisions occurring if this proposal was adopted.** Further, Medicare payments for PPS hospital outpatient services (APC weights), outliers, new technology payments, and critical access hospital outpatient payments would still be tied directly to the chargemaster.

The conceptual framework put forth by CMS ignores the outsized role Medicare FFS weights plays in negotiations between hospitals and providers. The circularity introduced should this framework be implemented would ultimately cause Medicare FFS rates to become detached from actual resource use. CMS’s rate rebasing concept using median MA negotiated rates also assumes that MA rates are negotiated under open market conditions, similar to the conditions under which hospitals contract with health plans for rates in the large group, small group, and individual markets. However, nothing could be farther from the truth. As CMS is well aware, there are a number of legal and regulatory constraints that prevent MA rate “negotiations” from occurring in a functioning market environment. These issues are discussed below in detail.

Role of Medicare FFS Weights in Medicare Advantage Negotiations

Using the median negotiated Medicare Advantage rate to re-base MS-DRG weights will introduce a significant element of circularity into the Medicare Fee-for-service payment system and overtime decrease the relationship between Medicare FFS payments and resource use.

In general HFMA members who are paid for inpatient hospital services provided to Medicare Advantage patients using MS-DRGs do not negotiate at a MS-DRG (or even service line level) from a “blank slate” based on the hospital’s cost to produce, demand for the given service in the market, and the plan’s ability to deliver MA volume to the provider in-exchange for price concessions across targeted services. Instead, HFMA’s members report that they typically contract with MA plans based on the Medicare Fee-For-Service MS-DRG weight schedule and the standardized amounts for operating and capital. This finding is similar to the various studies^{1,2,3} cited in the IPPS proposed rule.

Similar to the studies cited in the in the proposed rule, based on discussions with HFMA’s members contracted payment rates at the MS-DRG level are typically one to five percentage points higher than those for Medicare fee-for-service discharge. Typically, the MS-DRG weight schedule used is unmodified from that published in the Medicare IPPS final rule for the most recent fiscal year aligned with the contracting term. Often, MA payments for DSH and other “add-ons” if the hospital is eligible for them in Medicare FFS are included.

Where MA contracted rates are higher than the Medicare FFS rate, the source of variation is typically increased standardized amounts for operating/capital, a prospectively negotiated increase in payment to reimburse providers for bad debt associated with cost sharing for Medicare Advantage members, and/or to cover the increased costs of MA plans administrative utilization management strategies. In instances where contracted MA payments are lower than Medicare FFS payments HFMA’s members report that it is a result of not negotiating add-on payments similar to Medicare FFS. Actual payments for services provided to MA members may be lower than FFS for similar DRGs for a range of reasons, most typically for quality related payment claw-backs or similar penalties.

This qualitative feedback is supported by survey data from HFMA’s members. About 77% of HFMA members responding to a survey on the prevalence of MS-DRGs in MA contracting report that over 50% of their MA revenue flows through MS-DRG contracts. And 100% report that for their MA contracts based on MS-DRGs they report that they use the IPPS MS-DRG weights and the standardized amounts as the basis for the contract. Where there is variance between the amount paid under Medicare FFS and the MA contract 84% of members report that the source of the variation is from adjustments to the standardized amount, not changes to the IPPS MS-DRG weights.

HFMA’s members report their ability to negotiate an increase to the standard amount, the inclusion of add-on payment factors, and/or the inclusion of a prospective amount for Medicare bad debt is predicated on their position in the market relative to the Medicare Advantage plan. Typically, securing these add-ons is more challenging if the Medicare Advantage plan has a large share of the market which is similar to findings in one of the studies cited by CMS in the proposed rule⁴.

If CMS were to propose and finalize rebasing MS-DRG weights using MA median negotiated rates, it would introduce a significant element of circularity into the FFS and MA payment systems. Moving away from calculating MS-DRG weights using a proxy for cost that is directly linked to resource utilization creates two technical challenges that overtime will erode the accuracy of FFS (and MA) payments. As you are aware, HFMA has worked with members representing over 580 hospitals to develop a

¹ <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1427>

² <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1427>

³ <https://journals.sagepub.com/doi/pdf/10.1177/0046958018779654>

⁴ <https://journals.sagepub.com/doi/pdf/10.1177/0046958018779654>

methodology for decoupling hospital payments from Medicare charges that will both improve the accuracy of FFS payments and remove the barriers the FFS system poses to price transparency. We discuss this proposal in detail below.

First, CMS will lack a sufficient mechanism to price new MS-DRGs. Second, as advances in technology and practice patterns change the resource requirements, using the MA median negotiated rate (which is ultimately based on current FFS weights) will not incorporate this reallocation in resource use into rebased weights in FFS. As a result, overtime, CMS's MS-DRG weights will be based less on the actual resources required to deliver inpatient hospital care and slight changes in market power between hospitals and MA plans. HFMA's members believe this is in contrary to section 1886(d)(4) of the Act which requires the Secretary to, "assign an appropriate weighting factor which reflects the relative hospital resources used...within that group compared to discharges classified within other groups."

If this concept is ultimately proposed and implemented, it will reallocate payments across the MS-DRG schedule. However, this reallocation will be based on the market clout of large Medicare Advantage plans and health systems, not a more accurate reflection of the relative resources used to deliver inpatient care to Medicare beneficiaries.

Second, HFMA's members are also concerned about the completeness of the MA negotiated rate data that would be collected as part of the weight rebasing process. For example, our members question whether data on MA negotiated rates can accurately be "cross-walked" and collected for hospitals who have plans that pay them based on per diems. At the national level MS-DRGs are most frequently used to determine Medicare Advantage payments for inpatient services. However, in at least one state that we are aware of the dominant health plan (which has 94% market share) pays for inpatient services for its non-Medicare Advantage product lines using a system of tiered per diems. The tiered per diem is not based on severity (with the most resource intense cases – cases with the highest CMI in a DRG system – being mapped to the highest per diem), but on length of stay. Under this system cases with longer average lengths of stay are mapped to lower per diems. So, it will not be possible for providers in this state (or other states using similar systems) to report a contracted commercial rate that accurately approximates those paid using MS-DRGs.

Instead, they will either need to provide the actual average amount paid or multiply the average length of stay per MS-DRG times the per diem the MS-DRG is mapped to. Given the complexity of the process, we believe it will be challenging to derive "apples to apples" data that is comparable and can be cross-walked to the negotiated rates or actual payments reported by providers. And for these discharges, payments are based on length of stay and not resource use. Historically, length of stay has been a proxy for resource use, intensive use of high cost technologies, therapeutics, and devices have shortened lengths of stay for many MS-DRGs. Given these changes in practice patterns, we believe incorporating data from a tiered per diem system would reduce the accuracy of the resulting weights.

MA Rates Are Not Negotiated in an Open Market Environment

There are a number of legal and regulatory barriers that place an artificial cap on Medicare Advantage payments. This prevents market forces from acting on MA rate negotiations between plans and providers.

First, regulations place an artificial regulatory ceiling on the prices providers can demand from MA plans. As you are well aware, 42 CFR § 422.214 limits the amount MA plans are required to pay out-of-network providers to the Medicare Fee-For-Service amount. While a hospital could choose not to participate in a

MA plan's network, the economic penalty to the plan for a non-participating hospital is de minimis. Additionally, MA plans are paid a capitated amount based on county level benchmarks calculated using Medicare Fee-For-Service spending. Even if the constraint on payments to out of network providers was removed, basing capitated amounts on FFS benchmarks in effect limits the MA plan's ability to pay market rates (similar to those rates found in the large group, small group, and individual markets) and offer a solvent MA product. Second, MA plan network adequacy requirements act as a countervailing force placing a regulatory floor under rates negotiated by hospitals and health plans.

These artificial, regulatory constraints inhibit the market from working properly to set payments. Similar to the findings in the various studies cited in the proposed rule, HFMA's members report limited variation at the MS-DRG level when comparing prices and payments for services provided to MA and Medicare FFS members. Therefore, MA rates are set in an environment largely sheltered from market forces by the hands of the same governmental regulation the proposed rule seeks to remove from inpatient Medicare FFS payments. Even if MA rates were negotiated in an unfettered market, the statutes related to key facets of the Medicare FFS payment system – specifically the operating standardized amount and budget neutrality requirement for changes in MS-DRG weights – would neuter any market influence that might be injected into the Medicare FFS payment system by rebasing weights using MA median negotiated rates.

Standardized Operating Amount: Section 1886(d)(2) of the SSA required the Secretary to establish the original operating standardized amount using data from the base period (1983). Section 1886(b)(3)(B) of the Act then governs the annual updating of the standardized operating amount using a market basket update factor that is administratively determined as prescribed in statute. Currently, the market basket update includes statutorily required adjustments for quality reporting (Section 1886(b)(3)(B)(viii) of the act), use of qualifying EHRs, (Section 1886(b)(3)(B)(ix) economy wide productivity (Section 1886(b)(3)(B)(xi), and fixed reduction defined in law to the update factor during the years 2010 to 2019 (Section 1886(b)(3)(B)(xii).

The statutory requirements related to the market basket update result in payments from the Medicare program to IPPS hospitals for inpatient hospital services that are well below the market clearing rates (those paid by commercial health plans) in the private market. However, the Medicare program has monopsony power as a purchaser of healthcare services for individuals ages 65 and over and the disabled. It is impossible for a hospital to not participate with the program and be financially sustainable. Therefore, providers are forced to accept payments below their cost to produce these services and well below the market clearing rate. CMS's potential proposal to rebase MS-DRG weights using the median negotiated rates will not rectify this fact. It is well documented that this shortfall acts as a hidden tax on the private sector, increasing the cost of healthcare for privately insured individuals.

Budget Neutrality Adjustment: Section 1886(d)(4)(C)(iii) requires changes to MS-DRG relative weights to be budget neutral. Therefore, even if MS-DRG weights calculated using median MA weights suggested an increase in overall payments for certain services, the DRG recalibration adjustment would result in an across the board reduction to the standardized operating amount. In theory this could be beneficial if changes in inpatient FFS payments resulting from weight rebasing using the median negotiated MA rate resulted a more accurate understanding of the underlying resources necessary to deliver inpatient care to Medicare beneficiaries. However, as discussed above, any shifts in weights that result from a calculation based on median MA rates will instead be reflective of plan or provider market concentration (or lack thereof).

Summary

HFMA's members strongly recommend CMS not propose and finalize any model that rebases MS-DRG weights using median negotiated MA rates. First, as described above, the model CMS is considering will result in MS-DRG weights that are less reflective of the resources necessary to provide care overtime as weights fail to account for changes in technology and are more the result of changes plan/provider market concentration than resources used to deliver care. **HFMA's members believe this is contrary to section 1886(d)(4) of the Act** which requires the Secretary to, "assign an appropriate weighting factor which reflects the relative hospital resources used...within that group compared to discharges classified within other groups" and adjusted to..." to reflect changes in treatment patterns, technology (including a new medical service or technology under paragraph (5)(K)), and other factors which may change the relative use of hospital resources."

Second, while CMS asserts its conceptual model to rebase MS-DRG weights will achieve its policy goal of "modify(ing) Medicare FFS payments to...encourage more robust price competition, and otherwise to inject market pricing into Medicare FFS reimbursement" **the proposed rule does not provide evidence or a compelling argument as to how this proposal will actually achieve this goal.** While MA rates are the product of a negotiation, **HFMA members understand this is a negotiation derived from the Medicare FFS program (based on MS-DRG weights) and smothered by a thicket of Medicare Advantage regulations.** Even if Medicare Advantage rates were unencumbered and truly market based, regulations governing IPPS operating standardized amounts and requiring changes in MS-DRG weights to occur in a budget neutral manner would inhibit injecting market pricing in Medicare FFS IPPS payments.

Third, HFMA's members do not believe this model for rebasing MS-DRG weights would materially reduce Medicare's reliance on the chargemaster. **Medicare payments for PPS hospital outpatient services (APC weights), outliers, new technology payments, and critical access hospital outpatient payments would still be tied directly to the chargemaster. Therefore, the underlying incentives in the Medicare program – specifically through outlier payments – to increase charges faster than underlying cost remain with only limited restraint.**

In a subsequent section of this letter, HFMA's members describe an alternative model for rebasing MS-DRG and APC weights that will fully decouple Medicare payments (including outliers, new technology, and CAH outpatient payments) from charges. Not only will this eliminate any incentive the Medicare program creates for hospitals to increase their charges faster than cost but reduce costs for patients whose services are based on hospital charges. The proposed solution is informed by the cost finding processes used by other countries that pay for inpatient services using DRGs. It is also grounded in Medicare cost finding principles and relies heavily on the existing Medicare cost report.

Proposed Market-Based Data Collection

In support of its potential proposal to rebase MS-DRG weights in 2024 using the median negotiated MA rate, CMS proposes that hospitals would be required to report the median:

- payer-specific negotiated charge that the hospital has negotiated with all of its MA plans, by MS-DRG; and
- payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA plans, by MS-DRG.

Hospitals would be required to report this information on their Medicare cost report for cost reporting periods ending on or after January 1, 2021.

HFMA's members strongly oppose this proposal as they do not believe it is necessary. Ostensibly, the purpose of this proposal is to collect data that would allow CMS to rebase MS-DRG weights using median MA rates should such a proposal be put forth and finalized by the agency. However, given the technical and legal shortcomings HFMA's members have identified coupled with ill-defined policy merits we do not believe CMS should propose its framework for rebasing MS-DRG weights using median MA rates. Collecting this data without a clear purpose will add administrative burden to hospitals without a clear goal which is contrary to the administration's Patients Over Paperwork Initiative. If the administration seeks data with which to model its conceptual framework for rebasing FFS MS-DRG weights using median negotiated MA rates, HFMA believe there are more efficient (and faster) ways to obtain the data than altering cost report forms and waiting for hospitals to file revised cost reports. MA claims data is widely available (as noted in the studies referenced in the proposed rule). If CMS seeks to understand the redistributive impacts of its model (which it must before proposing it) it could obtain data from an organization like the Health Care Cost Institute for use in preliminary modeling.

Finally, HFMA's members note that requiring them to report this data would be similar to (and duplicative of) CMS's requirement to post its negotiated rates that is effective on January 1, 2021.

Alternative Mechanism for Decoupling All Medicare Payments from Hospital Charges

Since 2009, acute hospital charges have increased by 31%⁵ relative to their Medicare allowable cost to provide care. This charge inflation has negatively impacted certain types of patients whose payments are based on hospital charges. Acute hospitals and health systems recognize this and seek to rebase their charges to better align them with the cost to provide care plus a reasonable margin to invest in future services that will benefit the communities they serve. However, rebasing charges requires a hospital to coordinate any reduction in charges with Medicare, Medicaid and commercial health plans to ensure that this occurs in a revenue-neutral manner. Otherwise, the hospital will be financially harmed, thus diminishing its ability to serve the broader community, in its efforts to reduce costs for patients whose payments are based on charges.

Based on discussions with members representing over 580 hospitals HFMA believes it is possible to use data from acute hospitals' internal costing systems to calculate and submit the allowable cost per discharge for inpatient discharges and per ambulatory payment classification (APC) for outpatient services as part of the Medicare cost reporting process – hereafter the Direct Cost Model (DCM). This data would replace CMS's imputed cost per discharge or outpatient service in the calculation of certain cost-based payments and annual weight rebasing. The proposed solution is informed by the cost-finding processes used by other countries that pay for inpatient services using DRGs. It is also grounded in Medicare cost-finding principles and relies heavily on the existing Medicare cost report. HFMA has engaged a health economics modeling firm to validate the DCM, ensuring the data produced is reliable and does not result in changes to total program spending or reallocate spending across different types of acute hospitals.

Implementing the DCM for acute hospitals allows CMS to decouple payments for outliers, new technology and CAH outpatient payments, and weight rebasing from charges, thus eliminating the most significant barrier hospitals face when attempting to rebase charges. HFMA anticipates once this barrier

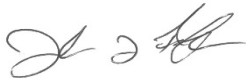
⁵ HFMA analysis of FY2020 IPPS Final Rule impact file.

is removed, hospitals will rebase their charges. **This will not only provide immediate relief for patients whose payments are based on charges but also will create an environment where price transparency can flourish.** Beyond creating an environment where price transparency can flourish, HFMA believes moving to the DCM has ancillary benefits for CMS. **The data provided by the DCM represents an improvement over the current data used by CMS to calculate payments and rebase MS-DRG/APC weights. This will increase the accuracy of Medicare payments by reducing sources of distortion.**

Included in Attachment I is a detailed discussion of the DCM. HFMA looks forward to any opportunity to provide CMS with assistance to reduce administrative burdens and create an environment where price transparency and market-based competition can flourish in Medicare. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 42,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

Attachment I: Detailed Discussion of the HFMA Direct Cost Model

Background. Since the implementation of the acute inpatient prospective payments in 1983, the relationship between hospital charges and the underlying cost to provide services to patients has progressively weakened. One indicator of that relationship is the national average hospital Medicare cost-to-charge ratio (CCR). Below, Table 1 presents the national average operating CCR from the 2009 and 2020 IPPS final rules⁶ and compares the implied charges for a hypothetical case that costs \$10,000.

Table 1: Medicare CCR and Implied Charges/Cost
2009 Compared to 2020

Item	2009	2020	Percentage Change
CCR	0.3340	0.2546	-23.79%
Cost per Case	\$10,000	\$10,000	0%
Implied Gross Charges per Case	\$29,932	\$ 39,274	31.21%

The 23.79% decrease in the Medicare national average CCR implies that hospital charges for a case that costs \$10,000 have increased by 31.21%.

Given that over 90%⁷ of Americans have some form of third-party health insurance coverage, conventional wisdom holds that “no one pays gross charges.” However, that is misleading and over time these increased charges have increased the out-of-pocket price of care for patients who are asked to pay some portion of gross charges for the services they have received. The list below provides examples of common, but not comprehensive, circumstances when gross charges directly impact the amount patients are asked to pay.

- Uninsured but ineligible for financial assistance
- Individuals who receive partial financial assistance
- Services received from out-of-network providers
- Cost sharing for percent-of-charge contracts

In light of this, many acute hospitals and health systems would like to rebase their charge structures so they more accurately reflect the fully loaded cost to provide care (both direct and indirect costs) and a reasonable margin to allow for capital replacement and investments in services that will improve the health of the populations these hospitals and health systems serve.

However, charges are also used to calculate a range of commercial, Medicare and Medicaid payments and rebase DRG and APC weights in PPSs. If acute hospitals were to unilaterally reduce their charges, without coordinating with all payers who use charges in some capacity to determine payments to hospitals, these hospitals would suffer irreparable financial harm from reduced payments.

Based on conversations with HFMA, members whose organizations have attempted to rebase their charges, indicate that Medicare, as discussed below, poses the most significant barrier. Therefore, HFMA and Leavitt Partners have convened an alliance of its members with the purpose of removing

⁶ Weighted national average operating CCR, as calculated by HFMA using the 2009 and 2020 IPPS final rule impact files.

⁷⁷ 2020 IPPS Final Rule

billed Medicare charges from the calculation of Medicare payments and rebasing MS-DRG/APC weights for acute hospitals.

We believe that once this constraint is removed, acute hospitals and health systems that want to rebase their charges will be able to collaborate with commercial plans, managed care organizations and state Medicaid programs to renegotiate contracts and rebase Medicaid payment rates. This will allow for an orderly restructuring of charges that occurs in a budget-neutral manner for both the health plans/Medicaid programs and acute hospitals involved.

1. Medicare’s Use of Charges. Charges billed by hospitals are used by the Medicare program in two ways that have a direct impact on hospital financial performance.

First, for the cost-based payments listed in Exhibit 1, Medicare calculates payments to the hospital by multiplying the charges billed times the hospital specific cost-to-charge ratio (CCR). Unless there is an exception, the CCR used to calculate these payments is from two years prior to the date of service for the billed charges (hereafter the “lagging CCR”).

Exhibit 1: Cost-Based Payment Mechanisms that Use Medicare Billed Charges
Multiplied Times the Hospital-Specific CCR

Hospital Type	Setting	Payment Type
Acute PPS	Inpatient	Outlier
Acute PPS	Outpatient	Outlier
Acute PPS	Inpatient	Inpatient New Technology Add-on Payment
Acute PPS	Outpatient	New Technology Pass-Through
Critical Access	Outpatient	Outpatient Services

While there are other Medicare payment calculations⁸ that rely on a hospital’s gross charges multiplied by the hospital’s CCR, these do not present the same challenge to hospitals, or the program, as the payment mechanisms listed in the table above. As discussed in more detail below, these items are settled on the Medicare cost report and use a CCR from the same period as the billed charges which does not create opportunities for distortion.

Second, Medicare uses billed charges multiplied by the hospital-specific CCR from a period two years prior to the date of service on the billed claims to calculate the cost of services. This cost of service is then used as an input for the annual rebasing of Medicare MS-DRG and APC weights.

The use of billed Medicare charges multiplied by a lagging CCR to calculate payments poses financial challenges to both hospitals and the program. The resulting imputed cost per discharge or outpatient service is skewed – due to timing issues and “charge compression,” calling into question the accuracy of MS-DRG and APC weights, thus presenting challenges to the Medicare program.

2. Challenges to Hospitals. Both the acute PPS and CAH cost-based reimbursement system pose unique financial and administrative challenges to hospitals that wish to rebase their charges.

⁸ Examples include Medicare Uncompensated Care DSH and Apportionment of Ancillary Organ Acquisition Costs.

Acute PPS hospitals that rebase charges without resetting their cost-to-charge ratios will face a two-year period where they will be underpaid for inpatient/outpatient outliers, the inpatient new technology add-on and outpatient new technology pass-through payments.

The Medicare cost report provides for a reconciliation⁹ of a hospital's outlier payments if:

- The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and
- Total outlier payments in that cost reporting period exceed \$500,000.

However, this is seldom triggered, as only 22 hospitals' outlier payments were "reconciled" for FY14.¹⁰ First, assuming a hospital's operating CCR is at the national average (.2546), a hospital would have to reduce its charges by approximately 28% (to increase) or increase them by 60% (to decrease)¹¹ to cause a 10-percentage point fluctuation in their CCR. Second, approximately 1,800 hospitals have inpatient outlier payments in 2017 of less than \$500,000 per year¹². Therefore, many hospitals do not meet the threshold criteria to have their outlier payment reconciled, even if they experienced a 10-percentage point change in their CCR. Even if this were more frequently used to provide accurate outlier payments after a hospital reduces its charges, there still isn't a mechanism to address inpatient and outpatient payments related to qualifying new technologies. Using an alternative, more accurate source of data cost per discharge or service data would ameliorate this problem.

CAHs face a different challenge related to their outpatient payments, were they to rebase their charges without resetting their CCR. The cost-based payments (interim payments) calculated using the reduced billed charges on outpatient claims filed in the current period multiplied by the lagging CCR will result in a significant underpayment to *CAHs* during its fiscal year. When the *CAH* files its cost report, the interim payments are compared to the actual cost to provide care resulting in a positive settlement that will (unlike *PPS* hospitals) make up the difference in interim underpayments it was entitled to but did not receive because it reduced its charges. However, few *CAHs* have the financial wherewithal (e.g., days cash on hand) to experience a temporary reduction in payments. Given the precarious finances of *CAHs*, many would likely be bankrupt by the time settlement occurred, resulting in reduced access to care for Medicare beneficiaries and increases in unemployment in the local community.

The Medicare regulations also permit a hospital to request that its Medicare Administrative Contractor (MAC) use a different (higher or lower) CCR based on substantial evidence presented by the hospital.¹³ Accordingly, there is a mechanism for hospitals to have their CCR adjusted to reflect significant reductions in charges. However, this mechanism is infrequently used for two reasons. First, it is not uncommon for HFMA's members to report that MACs are unwilling to reprocess a hospital's cost report refiled with lower charges to calculate a revised CCR. Often, intervention by

⁹ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf>, page 29

¹⁰ 2020 IPPS final rule

¹¹ HFMA analysis of 2020 IPPS final rule data.

¹² Approximately 3,000 hospitals in FY17 had outpatient outlier payments of less than \$500,000.

¹³ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03058.pdf>

the hospital's state hospital association and/or staff from Medicare's regional and national offices is required.

Second, there is a timing issue. Given the number of health plan contracts potentially involved, most health systems will rebase their charges in stages over multiple years. This typically focuses on services that are either highest volume and/or have charges least aligned with cost. A staged approach provides for the maximum consumer benefit while allowing both health plans and the hospital to monitor the impact to payments to ensure budget neutrality.

However, given the role of Medicare charges in the current payment system, it is administratively burdensome for a hospital to take a staged approach. A hospital would need to obtain a new CCR from its MAC (calculated with the new, reduced charge structure) prior to each phase of charge reduction to mitigate the potential negative financial impact on Medicare payments. If a hospital's billed charges were not used in the calculation of payments for outliers, new technology, or CAH outpatient services, this barrier would be mitigated.

3. Challenges to CMS: The use of charges multiplied by the lagging CCR provides CMS inaccurate data to make payments to hospitals and rebase weights. This misallocates payments – in the form of potentially overstated outlier payments and inaccurate MS-DRG/APC weights – to providers based on the actual resources used to provide care to Medicare beneficiaries.

First, the use of charges in the calculation of outlier payments creates an opportunity for hospitals to overstate outlier payments by increasing charges faster than the cost to provide care. Prior to 2003, CMS did not have a mechanism in place to reconcile outlier payments when it identified hospitals that increased their charges faster than their costs to maximize outlier payments.

As described above, a reconciliation mechanism has been implemented. However, if the practice of rapidly increasing charges to maximize outlier payments still exists, few practitioners are currently being identified. In the 2020 IPPS rule, all the hospitals whose outlier payments were reconciled received an increase in outlier payments as a result of an increasing cost-to-charge ratio. Hospitals that are increasing charges faster than their costs to increase outlier payments would be expected to have a declining CCR.

HFMA believes the current reconciliation mechanism would not identify these providers for two reasons. First, many hospitals do not have outlier payments in excess of \$500,000. Second, a hospital with a national average CCR would need to increase its charges by more than 60% to trigger a 10-percentage point increase in its CCR. This creates a situation where a small number of actors may be receiving increased Medicare payments at the expense of reduced payments to all other PPS providers who do not engage in this behavior. If CMS eliminated the use of billed charges in the calculation of outlier payments, it would also eliminate the potential for hospitals to increase their outlier payments, at the expense of other hospitals, by rapidly increasing their charges. Second, CMS and other stakeholders have expressed concern that MS-DRG and APC weights may be inaccurate for services that include high cost drugs, devices, or other technologies as a result of a practice known as “charge compression.”

Admissions that involve CAR T therapy provide an illustrative example of “charge compression.” Given the high acquisition cost of CAR T therapies, many of HFMA’s members at the institutions that provide these lifesaving therapies are not setting their charges at a level that equals the acquisition price, once the charge is multiplied by the hospital’s cost-to-charge ratio. Consider Yescarta, with a list price of \$373,000.¹⁴ Assuming a hospital’s drug cost-to-charge ratio is at the 2020 national average (.189), it would need to charge approximately \$2 million for the full acquisition cost of the drug (which does not include the cost of special handling) to be incorporated into the formula used to set MS-DRG weights.

While setting charges at this level (\$2 million) would allow for accurate reporting of the input cost for the therapy, most hospitals are unwilling to include a seven-figure line-item charge on a patient’s bill. Even though the charge is accurate from the standpoint of arriving at the cost to provide the service, based on CMS’s reimbursement and weight-setting formulas, the optics of such a charge are incongruent with these organizations’ missions to serve patients and the communities in which they’re located.

As a result, the payment calculation for NTAP and outlier payments for each case do not cover the cost to provide the service. Future MS-DRG weights calculated with this data will not accurately reflect the resource use necessary to provide the service. Therefore, access to life- saving therapies will be limited under CMS’s current methodology. Further, because the MS-DRG system is a relative weighting system, CMS will overpay for lower cost cases because the expense of high-cost therapies (like Yescarta) was not accurately reflected in the data used to set MS-DRG and APC weights. If CMS could collect the actual allowable cost per case from hospitals, instead of deriving it from the lagging CCR and Medicare billed charges, it would result in more accurate data for MS-DRG weight setting.

Australian Patient Costing Standards. Like the United States, Australia¹⁵ has a prospective payment system for inpatient and outpatient services that bases MS-DRGs and outpatient payment bundles by site of service. However, Australia does not use billed charges multiplied by a lagging CCR to impute costs for weight setting. Instead, each hospital submits fully loaded (includes direct and indirect cost) patient-level cost data for each discharge and outpatient visit to the Australian Independent Hospital Pricing Authority¹⁶ (IHPA). The IHPA then uses that data to develop weights for inpatient (MS-DRG) and outpatient services.

The IHPA’s cost-finding process¹⁷, as illustrated below, is conceptually similar to the Medicare cost report.

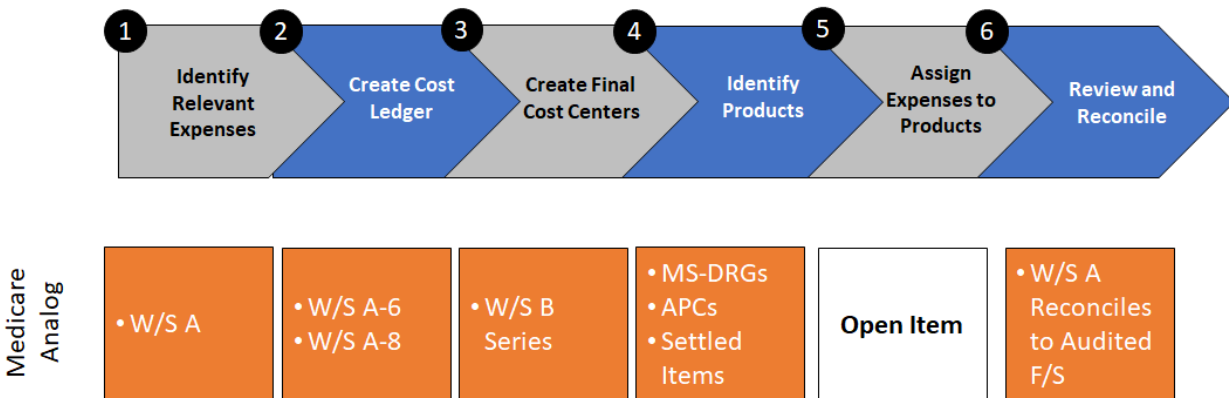
¹⁴ Schoenberg, S., “[Gene therapy: Revolutionary health care with a blockbuster price tag.](#)” MassLive, January 27, 2019.

¹⁵ <https://www.ihipa.gov.au/publications/national-pricing-model-technical-specifications-2018-19>

¹⁶ <https://www.ihipa.gov.au/who-we-are>

¹⁷ <https://www.ihipa.gov.au/publications/australian-hospital-patient-costing-standards-version-40>

Comparison of Medicare Cost Report to Australian Cost Finding Process



Below is a discussion of each step of the Australian cost-finding process and how it relates to the Medicare cost report.

- 1) Identify Relevant Expenses. Like the Medicare cost report Worksheet A, this step uses a hospital's general ledger to identify all expenses related to patient care for a given year.
- 2) Create the Cost Ledger. Like the Medicare cost report, this step reclassifies expenses to the cost centers where the revenue-producing activity occurred (e.g., Worksheet A-6) and eliminates (e.g., Worksheet A-8) non-allowable expenses (e.g., expenses related to non-patient care revenue) or incorporates expenses that do not reside on the hospital's general ledger (e.g., home office costs).
- 3) Create Final Cost Centers. Using standardized statistics, this step allocates expenses in overhead cost centers to direct patient care cost centers. The output from this is analogous to Worksheet B, Part I of the Medicare cost report.
- 4) Identify Products. The Australian system is organized around patient products – which include admitted patients (e.g., MS-DRGs), non-admitted patients (e.g., APCs), and emergency department patients (e.g., APCs). It also recognizes non-patient products such as teaching and training which are cost settled on the Medicare cost report.
- 5) Assign Expenses to Products. In this step, the Australian system matches all expenses accumulated in final cost centers in the cost ledger to an organization's final products (inpatient discharges and outpatient visits/services) on a basis which emphasizes causality.
- 6) Review and Reconcile. Financial and nonfinancial data are reconciled to source systems to identify and correct any errors, ensuring the accuracy of cost finding. The Medicare cost reporting process is similar in that Worksheet A is reconciled to a hospital's audited financial statements. Further, MACs audit the submitted cost report.

Currently, step five in the Australian cost-finding process (as described above) does not exist within the Medicare cost reporting system. This is largely attributed to hospitals' lack of cost accounting systems

that could accurately calculate the fully loaded (direct and indirect) cost per discharge and/or outpatient service at the time the PPS was developed. Since that time, cost accounting systems' capabilities have advanced considerably, and their adoption has steadily increased. Most hospitals and health systems can now, with reasonable accuracy, calculate the fully loaded cost per discharge and/or outpatient service. And, given the financial pressures facing hospitals, HFMA anticipates over the next three years many hospitals without the ability to calculate their fully loaded cost per discharge or outpatient service will acquire and implement this capability.

Hospitals with cost accounting systems can accurately allocate allowable costs to specific discharges or APCs, which is analogous to step 5 in the Australian process. This new data source would mitigate the issues related to timing and charge compression that plague CMS's current charge-based payment mechanisms and weight-rebasing methodology. HFMA's members strongly encourage CMS to modify the Medicare cost reporting process to a DCM.

DCM. Based on work with hospitals and health systems participating in HFMA's ChAMP alliance, we believe it is possible to use data generated from a hospital's cost accounting system to develop a statistic for inpatient discharges and outpatient APCs. This statistic would be used to allocate Medicare allowable cost to each Medicare discharge and calculate an average cost per APC. This data would then be submitted to CMS as part of the Medicare cost report (specific steps for inpatient/outpatient services described in detail below) and used to rebase MS-DRG/APC weights and calculate charge-based payments.

Implementing the DCM for acute care hospitals allows CMS to decouple payments for outliers, new technology and CAH outpatient payments (proposed payment mechanisms described in detail below) and weight rebasing from charges. As described above, this eliminates the most significant barrier hospitals face when attempting to rebase charges so they are more aligned with cost. HFMA anticipates that once this barrier is removed, hospitals will rebase their charges, creating an environment where price transparency can flourish.

Beyond creating an environment where price transparency can flourish, HFMA believes moving to the DCM has ancillary benefits for CMS. The data provided by the DCM represents a significant improvement over the current data used by CMS to calculate certain payments (e.g., outliers, NTAP) and rebase MS-DRG/APC weights.

First, the DCM addresses issues with using charges to impute cost related to the timing of charge data by providing CMS with allowable cost data from the current period that is calculated based on the hospital's expenses from the internal costing systems from the same period. Therefore, any potential for hospitals to increase outlier payments as a result of the time lag between data sources (e.g., submitted charges and the CCR) is eliminated. Similarly, we anticipate that it will increase the accuracy of MS-DRG and APC weights, as any distortion due to different time period of the inputs to calculating the relative weights is eliminated as well.

Second, the DCM addresses the issue of charge compression. Under the model, CMS will no longer determine the cost of services (including new, high-cost technologies) based on the lagging CCR multiplied by billed charges. Instead, hospitals will directly submit the cost per case. This will result in more accurate data, as CMS will rely on the actual cost data for high-cost drugs and devices instead of imputing the cost based on artificially low charges (due to the optics of having high-charge single line items as described above) multiplied by the lagging CCR.

Below, please find a detailed discussion of the proposed solution’s technical details, payment model changes, implementation requirements and next steps.

Technical Details. Under the DCM, the amount of total allowable Medicare cost allocated to a Medicare beneficiary’s discharge or outpatient service would be determined based on the hospital’s internal costing system and submitted as part of the Medicare cost report.

To calculate the allowable cost per inpatient discharge (MS-DRG), each hospital would:

1. Identify the Percentage of Allowable Costs to Allocate to Medicare Inpatient Services. Using data from the hospital’s cost accounting system, calculate the percentage of Medicare inpatient cost to the hospital’s total cost. Multiply the percentage of Medicare inpatient cost by the total Medicare allowable cost from Worksheet B, Part I to calculate the allowable cost to allocate to Medicare inpatient discharges.
2. Calculate the MS-DRG-Specific Allowable Cost Allocation Statistic. Using data from the hospital’s cost accounting system, divide the cost per Medicare patient by the total Medicare inpatient cost.
3. Allocate Allowable Cost to Each Patient Discharge. Multiply the Medicare allowable cost related to Medicare inpatient discharges (step 1) by the patient-specific cost allocation statistic in step 2. This will provide the patient-specific cost per MS-DRG.

The following simplified example illustrates the steps above. An example hospital has \$10 million in total cost, based on its cost accounting system. Twenty-five percent of that cost (\$2.5 million) is related to providing care to Medicare inpatients. Therefore, under the DCM, 25% of the Medicare allowable cost as determined by the cost report on Worksheet B, Part I would be allocated to each Medicare beneficiary, calculating an allowable cost by MS-DRG.

Continuing the example, the hospital has \$9.5 million in Medicare allowable costs, as determined by Worksheet B, Part I. As described above, 25% of the hospital’s internal cost is associated with providing care to Medicare inpatients. Therefore, \$2.375 million (\$9.5m*.25) is allocated to Medicare inpatient discharges. Exhibit 2 illustrates the first step in the process described above.

Exhibit 2: Apportioning Medicare Allowable Cost – Inpatient Services

	Total Cost at Worksheet A, Col 3, Line 200 Total Cost	Cost Based Allowable Cost Allocation Statistic	Total Allowable, Allocated Medicare Cost from B pt. I Line 118
	\$ 10,000,000		\$ 9,500,000
Cost Based on Costing System			
Medicare Inpatient	\$ 2,500,000	25.00%	\$ 2,375,000
Medicare Outpatient	\$ 2,500,000	25.00%	\$ 2,375,000
Medicare Advantage	\$ 500,000	5.00%	\$ 475,000
Medicaid/CHIP	\$ 1,000,000	10.00%	\$ 950,000
Tricare	\$ 500,000	5.00%	\$ 475,000
Commercial	\$ 2,500,000	25.00%	\$ 2,375,000
Self-Pay	\$ 500,000	5.00%	\$ 475,000
Total	\$ 10,000,000	100%	\$ 9,500,000

Step 1.

Next, the hospital will calculate a statistic to allocate allowable cost to each discharge using internal cost data. For patient 1 in Exhibit 3 below (MS-DRG 064), the internal cost for this discharge is \$17,802. This amount is divided by the total Medicare inpatient cost from the hospital's cost accounting system (\$2.5 million) to arrive an allocation statistic of 0.71% (\$17,802/\$2,500,000). Multiplying the allocation statistic for patient 1 (MS-DRG 064) by the Medicare inpatient allowable cost results in an allowable cost per case of \$16,912 (0.71% x \$2.375 million).

Exhibit 3: Apportioning Medicare Allowable Cost to Medicare Beneficiary Discharges

Patient Number	MS-DRG	Step 2		Step 3
		Cost Per Discharge Based on Costing System	% Total Cost for Allowable Cost Allocation	Allowable Medicare Inpatient Cost Allocation
1	064 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	\$ 17,802	0.71%	\$ 16,912
72	312 - SYNCOPE & COLLAPSE	\$ 8,639	0.35%	\$ 8,207
73	312 - SYNCOPE & COLLAPSE	\$ 9,503	0.38%	\$ 9,028
74	312 - SYNCOPE & COLLAPSE	\$ 10,943	0.44%	\$ 10,396
75	313 - CHEST PAIN	\$ 7,733	0.31%	\$ 7,347
76	313 - CHEST PAIN	\$ 8,507	0.34%	\$ 8,081
77	313 - CHEST PAIN	\$ 9,795	0.39%	\$ 9,306
78	313 - CHEST PAIN	\$ 11,600	0.46%	\$ 11,020
230	885 - PSYCHOSES	\$ 9,368	0.37%	\$ 8,899
Total		\$ 2,500,000	100%	\$ 2,375,000
Total Medicare Inpatient From Cost Accounting System		\$ 2,500,000		
Total Medicare Inpatient Allowable Cost Allocation				\$ 2,375,000
Difference		\$ -		\$ -

For *outpatient services*, the cost allocation process under the DCM is similar to the steps described for inpatient discharges. However, it is modified in two ways. First, due to the significant number of outpatient services provided by hospitals, the DCM calculates an average cost per APC (instead of a patient-specific cost).¹⁸ Second, the process calculates the average cost per APC using only APCs from "single APC claims." Hospitals struggle to attribute ancillary CPT/HCPCs codes (and their associated costs) to the primary CPT/HCPCs code that triggered the APC payments on claims with multiple APCs. This challenge is same as faced by CMS when it attempts to rebase APC weights, which results in CMS using approximately half of all claims (91 million out of 175 million) processed by fiscal intermediaries to rebase APC weights.¹⁹

¹⁸ Without patient specific costs per APC, CMS will no longer be able to make outlier payments. The proposal to address this is discussed in in the section on payment model changes.

¹⁹ Medicare CY 2019 Outpatient Prospective Payment System (OPPS) Final Rule Claims Accounting

To calculate the average allowable cost per outpatient service (APC), the steps are as follows:

1. Identify Percentage of Allowable Costs to Allocate to Medicare Outpatient Services. Using data from the hospital's cost accounting system, calculate the percentage of Medicare outpatient cost to the hospital's total cost. Multiply the percentage of Medicare outpatient cost by the total Medicare allowable cost from Worksheet B Part I.
2. Identify and Separate Internal Costs for Services Paid Based on APCs and Non-APCs: Using either internal data or by running claims data through an APC grouper, identify the internal cost associated with outpatient visits/services that have a single APC, those that have multiple APCs and those that are not paid based on APCs. Calculate the percentage of internal cost for Medicare single APC services as a percentage of total Medicare outpatient services.
3. Calculate the Total Allowable Medicare Cost to Allocate to Visits with a Single APC. Multiply the amount calculated in step 1 (total Medicare allowable O/P Cost) by the percentage of internal Medicare cost associated with single APC services/visits calculated in step 2.
4. Calculate the APC-Specific Allowable Cost Allocation Statistic. For Medicare single APC services/visits calculate the total cost for each APC, as determined by the hospital's costing system. For each APC, divide the summarized total cost (for all "single" units provided) per APC from the hospital's costing system by the hospital's total Medicare outpatient cost for single APC claims based on its costing system (from step 2).
5. Allocate Allowable Cost to Specific APCs. Multiply the Medicare allowable cost related to single APC services/visits from step 3 by the APC-specific allocation statistic in step 4.
6. Calculate the Average Medicare Allowable Cost Per APC: Calculate the average cost per APC by dividing the total allowable cost per APC (step 5) by the number of units per APC.

The following is a continuation of the simplified example to illustrate the steps above. The example hospital has \$10 million in total cost, based on its cost accounting system. Twenty-five percent of that cost (\$2.5 million) is related to providing care to Medicare outpatients. Therefore, under the DCM, 25% of the Medicare allowable cost as determined by the cost report on Worksheet B, Part I would be allocated to services provided to Medicare beneficiaries for outpatient services.

In the example, the hospital has \$9.5 million in Medicare allowable costs based on Worksheet B, Part I of the Medicare cost report. As described above, 25% of the hospital's internal cost is associated with providing care to Medicare outpatients. Therefore, \$2.375 million ($\$9.5m \times .25$) is allocated to Medicare outpatient services. Exhibit 4 illustrates the first step in the process described above.

Exhibit 4: Apportioning Medicare Allowable Cost – Outpatient Services

	Total Cost at Worksheet A, Col 3, Line 200 Total Cost	Cost Based Allowable Cost Allocation Statistic	Total Allowable, Allocated Medicare Cost from B pt. I Line 118
	\$ 10,000,000		\$ 9,500,000
Cost Based on Costing System			
Medicare Inpatient	\$ 2,500,000	25.00%	\$ 2,375,000
Medicare Outpatient	\$ 2,500,000	25.00%	\$ 2,375,000
Medicare Advantage	\$ 500,000	5.00%	\$ 475,000
Medicaid/CHIP	\$ 1,000,000	10.00%	\$ 950,000
Tricare	\$ 500,000	5.00%	\$ 475,000
Commercial	\$ 2,500,000	25.00%	\$ 2,375,000
Self-Pay	\$ 500,000	5.00%	\$ 475,000
Total	\$ 10,000,000	100%	\$ 9,500,000

Step 1

Continuing the example, the hospital uses data from its internal cost accounting system to identify the cost associated with “single claim APC” visits provided to Medicare beneficiaries. As illustrated in Exhibit 5 below, in step 2, the hospital divides the cost associated with the “single claim APC” services by the total internal cost associated with Medicare outpatient services to determine the percentage of outpatient allowable cost to allocate to Medicare “single claim APC” visits ($40.35\% = \$1.008\text{m} / \2.5m). In Step 3 the hospital determines the amount of Medicare allowable outpatient cost to allocate to “single claim APC” visits by multiplying the “single claim APC” allocation percentage times the Medicare outpatient allowable cost ($\$958,311 = .4035\% \times \2.375m).

Exhibit 5: Apportioning Medicare Allowable Cost – Single Claim APC Visits

Step	Description	Amount
From	Total Allowable Medicare Outpatient Costs	\$ 2,375,000
Step 1		
Step 2	Internal Costs Related to Single APC Visits	\$ 1,008,749
	Internal Costs Related to Multiple APC Visits	\$ 1,228,093
	Internal Costs Related to Non-APC Services	\$ 263,158
	Total Internal Cost Based on Costing System	\$ 2,500,000
	% Internal Cost Related to Single APC Visits	40.35%
Step 3	Total Allowable Cost for Single APC Visits	\$ 958,311

To allocate Medicare allowable cost for single APC visits to specific APCs, the hospital calculates (using data from its internal costing system) the total cost of single visit services for each APC. That amount is then divided that by the total cost from the hospital’s internal costing system for all Medicare single APC services. Below, in step 4 in Exhibit 6, APC 5123’s allocation statistic is 5% (\$50,950 divided by \$1,008,749). Then in step 5, the allocation statistic is multiplied by the Medicare allowable cost for “Single Claim APC” visits to calculate APC 5123’s allowable cost of \$48,402 (5% x \$958,311). The average cost for APC 5123 is calculated by dividing the allowable cost by the number of units service provided to Medicare patients (\$4,840 = \$48,402 divided by 10 units of service) in step 6.

Exhibit 6: Calculating Average Medicare Allowable for Single APC Claim Visits

APC	APC Description	Volume	Step 4		Step 5	Step 6
			Summarized Cost Per APC Based on Internal Costing System	Percentage APC of Total O/P Cost	Allowable Medicare Outpatient Cost Allocation	Average Allowable Cost Per APC
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	1.00	\$ 8,684	1%	\$ 8,250	\$ 8,250
5123	Level 3 Musculoskeletal Procedures	10.00	\$ 50,950	5%	\$ 48,402	\$ 4,840
5124	Level 4 Musculoskeletal Procedures	4.00	\$ 26,043	3%	\$ 24,741	\$ 6,185
5125	Level 5 Musculoskeletal Procedures	1.00	\$ 9,078	1%	\$ 8,624	\$ 8,624
5165	Level 5 ENT Procedures	3.00	\$ 13,573	1%	\$ 12,895	\$ 4,298
5212	Level 2 Electrophysiologic Procedures	1.00	\$ 5,346	1%	\$ 5,079	\$ 5,079
5213	Level 3 Electrophysiologic Procedures	4.00	\$ 68,499	7%	\$ 65,074	\$ 16,269
5222	Level 2 Pacemaker and Similar Procedures	3.00	\$ 16,393	2%	\$ 15,573	\$ 5,191
5223	Level 3 Pacemaker and Similar Procedures	7.00	\$ 53,203	5%	\$ 50,543	\$ 7,220
5224	Level 4 Pacemaker and Similar Procedures	1.00	\$ 13,358	1%	\$ 12,690	\$ 12,690
5231	Level 1 ICD and Similar Procedures	1.00	\$ 15,972	2%	\$ 15,174	\$ 15,174
5232	Level 2 ICD and Similar Procedures	4.00	\$ 86,860	9%	\$ 82,517	\$ 20,629
5331	Complex GI Procedures	2.00	\$ 7,320	1%	\$ 6,954	\$ 3,477
5361	Level 1 Laparoscopy	11.00	\$ 47,413	5%	\$ 45,042	\$ 4,095
5362	Level 2 Laparoscopy	3.00	\$ 20,966	2%	\$ 19,918	\$ 6,639
5375	Level 5 Urology and Related Services	12.00	\$ 43,642	4%	\$ 41,460	\$ 3,455
8011	Comprehensive Observation Services	90.00	\$ 236,234	23%	\$ 224,423	\$ 2,494
	Total Single APC Per Claim Cost Allocation	195.00	\$ 1,008,749	100%	\$ 958,311	
	Total Multiple APC Per Claim Cost Allocation		\$ 1,228,093		\$ 1,166,689	
	Total Non-APC Allowable Cost		\$ 263,158		\$ 250,000	
	Total Allowable Cost Allocated				\$ 2,375,000	
	Total Medicare Outpatient From Cost Accounting System		\$ 2,500,000			
	Total Medicare Outpatient Allowable Cost Allocation				\$ 2,375,000	
	Difference		\$ -		\$ -	

Payment Model Changes. While acute care hospitals will continue to file claims to Medicare for inpatient and outpatient services, those claims will no longer include billed charges. CMS uses billed patient-specific charges multiplied by the cost-to-charge ratio to calculate cost-based payments for outliers, new technology and CAH outpatient services. Given that charges will no longer be available in the DCM, HFMA’s ChAMP alliance proposes CMS make these payments using the methods described in the table below.

Payment Mechanism	Proposed Resolution
Inpatient Outlier	<ul style="list-style-type: none"> Use a periodic interim payment based on the five-year average of outlier payments as a cash flow mechanism. Calculate the actual outlier payments for the fiscal year using the allowable cost per discharge data provided by the DCM when the cost report is filed. A reconciliation would occur comparing the interim payment to the actual payment based on cost data. A settlement payment would be made based on the reconciliation.

Outpatient Outlier	<ul style="list-style-type: none"> • Under the DCM, the patient-specific cost per APC will no longer be available. • Alliance recommends eliminating outpatient outlier payments and incorporating those dollars into APC payments through an adjustment to the conversion factor.
Inpatient New Technology Outlier Payment (NTAP)	<ul style="list-style-type: none"> • Use a periodic interim payment based on the five-year average of NTAP payments as a cash flow mechanism. • Calculate the actual NTAP payments for the fiscal year when the cost report is filed and is included as a settlement item.
Outpatient New Technology Device Pass-Through	<ul style="list-style-type: none"> • Include the cost of the device on the claim in a field associated with the pass-through device value-code. • CMS can base payment off this amount.
CAH Outpatient	<ul style="list-style-type: none"> • Use APC-based payments coupled with Transitional Outpatient Payments (TOPs) based on the prior year’s cost report as a funds flow mechanism. • Outpatient payments are cost settled when the cost report is filed. • Items not paid using the APC schedule would be based on the fee schedule and settled on the cost report. • Beneficiary cost sharing for CAHs in the outpatient setting would be adjusted to the APC cost-sharing amount. • This interim payment process is currently used for qualifying cancer hospitals.

Initially, HFMA’s alliance believed that changes would need to be made to the methodology for calculating payments related to uncompensated care disproportionate share hospitals and costs for organ acquisition ancillary services. However, as described in the table below, the alliance does not believe this is necessary.

Payment Mechanism	Rationale for Not Modifying the Payment Mechanism
Medicare UC DSH	<ul style="list-style-type: none"> • Calculation uses the overall facility cost-to-charge ratio and uncompensated care charges to calculate the cost of uncompensated care. • Therefore, there is no timing issue between the CCR and charges that could distort payments. • Also, the charges in the calculation are not Medicare-specific charges.
Organ Acquisition Ancillary Costs	<ul style="list-style-type: none"> • Calculation uses the overall facility cost-to-charge ratio and qualifying, accumulated pre-transplant charges to calculate the cost of pre-transplant services. • Therefore, there is no timing issue between the CCR and charges that could distort payments. • Also, the charges in the calculation are not Medicare-specific charges.

Implementation Requirements. Implementing the DCM requires all hospitals to have a basic cost accounting system that can calculate the average cost per discharge or outpatient service. A transition window is necessary to allow those hospitals that still do not have a basic cost accounting system to implement one. Further, to effect the DCM, CMS will need to provide data in different ways than it currently does, clearly define certain items for purposes of the DCM and revise select Medicare cost report worksheets. As discussed below, the DCM is largely based on existing data and processes

currently used by hospitals and CMS. Therefore, we do not believe that implementation will be administratively burdensome.

Hospital Cost Accounting Systems. Each hospital that submits data under the DCM will need a minimally viable cost accounting system that can calculate “fully loaded” (both direct and indirect) cost per MS-DRG (inpatient) and per outpatient service (HCPC/CPT code that can be attributed to an APC). Most hospitals that are part of a health system or above a specific bed size have this capability today. Many hospitals that currently do not have this capability intend to acquire it (absent the DCM) in response to ongoing structural changes in healthcare financing and delivery that are putting significant downward pressure on hospital margins.

While the DCM may result in scorable expense related to hospitals without cost accounting systems acquiring them, we believe this expense will be minimal. Given the ongoing structural changes within healthcare financing and delivery, the DCM will only accelerate purchases of cost accounting systems for hospitals that don’t have them, not stimulate demand for products that hospitals would not have otherwise acquired.

Typically, hospitals that are not planning on acquiring cost accounting software that can calculate “fully loaded” (both direct and indirect) cost per MS-DRG (inpatient) and per outpatient service (HCPC/CPT code) have fewer beds and account for a small percentage of discharges nationally. CMS’s options for reducing the scorable cost related to implementing the DCM for these hospitals include (1) providing these hospitals with access to a minimally viable “software as a service” cost accounting system or (2) excluding them from submitting data using the DCM.

Transition Window. HFMA’s ChAMP alliance recommends providing hospitals without costing systems a three-year transition period to develop the capabilities necessary to submit data under the DCM. During the three-year transition period, qualifying hospitals would continue to submit charges on Medicare claims. Cost-based payments would continue to be calculated by multiplying billed charges by the lagging CCR. Similarly, MS-DRG and APC weights would continue to be calculated using billed charges multiplied by the lagging CCR during this period. Beginning in year 4, all qualifying hospitals must file their cost reports using the DCM. After the three-year phase in period, any qualifying hospital that cannot file via DCM would be penalized in some manner (e.g., reduced market basket update).

CMS could assist hospitals with this transition by providing (as discussed above) a minimally viable costing system, using a software-as-a-service model, for hospitals without an adequate cost accounting system. Additionally, some hospitals will need an APC grouper with capacity to re-process all Medicare outpatient claims to facilitate the calculation of the single APC claim allocation statistic to attribute allowable cost to individual APCs.

Updated Medicare Data. CMS will need to provide hospitals with the following data elements, definitions and protections to implement the DCM.

- 1) *Detailed PSR – Inpatient.* Provide a detailed listing of patients, including an identifier (e.g., patient account number) the hospital can use to match the patient/discharge to the applicable discharge in the hospital’s patient financial services system, who meet the definition of a Medicare patient for cost reporting purposes.

- 2) *Detailed PSR – Outpatient.* Provide a summary of APCs that includes the total payment and count of APCs paid. Include an identifier (e.g., patient account number) that can be used to match the patient/service back to the APCs included in the PSR for cost allocation.
- 3) *Reconciliation Threshold.* It will be challenging (if not impossible) to exactly reconcile data from both inpatient and outpatient PSRs to internal data, due to timing issues. CMS will, with the help of the industry, need to develop an acceptable case count “reconciliation range,” within which a hospital’s filing will be deemed acceptable.
- 4) *Confidentiality of Cost Data:* All cost data submitted by participants to CMS as part of an allocation methodology must be held confidential. The process of submitting clinical lab private payer payment rates provides precedence for this. If this data is made available to the public or researchers, it needs to be released in a way that makes identifying the specific hospital impossible.

New Medicare Definitions: CMS will need to clearly define specific items to implement the DCM. Below are recommended definitions from HFMA’s ChAMP alliance.

- 1) *A Medicare Patient.* HFMA’s workgroup suggests defining anyone who has Medicare as the primary payer (including those with exhausted eligibility) as a Medicare patient for the DCM.
- 2) *Final Costing Model.* HFMA’s workgroup suggests defining the “final costing model” as cost model for a given year that incorporates adjustments from the facility’s annual audit of financial statements.
- 3) *Audit Criteria for Costing Models.* Providing the cost per discharge or visit would not be overly burdensome. However, if providers were asked to provide revenue code-level detail, the volume of data required to be manipulated and sent would be prohibitive.

Medicare Cost Report Revisions. Several acute facility Medicare cost report worksheets will need to be revised to accommodate the DCM. The table below identifies the worksheets and provides a high-level description of the necessary edits.

Impacted Worksheet(s)	Change
<ul style="list-style-type: none"> • S-2 	<ul style="list-style-type: none"> • Add question(s) related to the method hospitals use to allocate allowable cost during the transition period.
<ul style="list-style-type: none"> • D Part II • D Part IV • D Part V • D-2 Parts I – III • D-3 	<ul style="list-style-type: none"> • Each worksheet uses program charges from the PS&R multiplied by the CCR to determine allowable program cost. • Replace the current RCC as the allocation statistic with the ratio of Medicare cost to total cost.
<ul style="list-style-type: none"> • E Series 	<ul style="list-style-type: none"> • Revise outlier settlement instructions in the Provider Reimbursement Manual to accommodate the new outlier payment methodology. • Create settlement mechanism for NTAP payments.
<ul style="list-style-type: none"> • New “Off Cost Report” Log 	<ul style="list-style-type: none"> • Like bad debt, UC DSH, and DSH logs, create an “off cost report log” to submit detailed, per discharge or outpatient service cost from the hospital’s cost accounting, create the allocation statistic, and calculate the Medicare allowable cost for Medicare patients.

Next Steps. Participants in HFMA's ChAMP alliance believe the conceptual framework (described above) for the DCM is technically correct, based on cost accounting and Medicare reimbursement principles. To validate this framework HFMA, with funding support from the Robert Wood Johnson Foundation, has retained the Wakely Group to model the DCM. As part of the validation process, the modeling will ensure that the DCM is budget neutral and does not redistribute payments across different types of hospitals. Therefore, the modeling effort will test three areas of the framework. First, using historical data, the modeling will verify that hospital costing systems can generate the data necessary to calculate per MS-DRG/APC allowable cost allocation statistics. Second, the modeling will compare the cost per case calculated using data from the DCM to the actual cost per case calculated using CMS's current methodology and, if there is a sufficient sample size, replicate MS-DRG and APC weights for the years modeled. Third, the modeling will analyze the payment impact by hospital type on outlier, new technology and CAH outpatient payments.