

Cost-based Reimbursement Strategies

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Introduction

Why I showed up for class

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Who Pays Based on Cost (CAHs)?

- Medicare (most services)
- Medicaid
 - Idaho (with several exceptions)
 - Washington
 - Montana
 - Texas (with several exceptions)
 - Oregon

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Why is this Important?

- Medicare revenue to total revenue times
total costs = Medicare cost
- Higher percentage of Medicare and Medicaid to
total; the more cost is reimbursed

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Non CAH Services (not cost-based)

- Nursing home
- Assisted living
- Home health
- Hospice
- Physician clinics
(except rural health and provider-based clinics)

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Non CAH Services (not cost-based)

(Continued)

- Ambulances (most)
- Meals on Wheels
- Rented space
- DME
- Off-campus locations that:
 - Don't meet the federal distance requirements
 - Were not in existence prior to January 1, 2008

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Non CAH Services (not cost-based)

(Continued)



Tip:
**Know which departments
are paid cost and by whom**

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Non CAH Services (not cost-based)

(Continued)



**Tip: Know how much of a
department's costs are reimbursed:**

- Some have a greater cost-based percentage
- Some have a zero cost-based percentage

⇒ **Caution:** These can decrease the cost in
other cost-based departments

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Reporting Days

How and what to count

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Counting Patient Days

- Accrual basis
- Discharge/admitting/medical records/actual count/charge count
 - *Which is more accurate?*



Tip: Reconcile reports

- Overstating of days decreases per-diem and, therefore, reimbursement

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Labor and Delivery Days (LDR days)

- Mother in labor at midnight – should not be included in count
(typically they are included if a room charge is generated)
- **Exceptions:**
 - Admitted prior to actual labor
 - Discharged the next day

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Self-insured Days

- Excluded from count



Tip: Ensure these are provided to your cost report preparer!

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Observation Equivalent Days

- Included in total calculation
- ***Update:*** Can now have distinct outpatient observation unit (within reason)!
- Document the location of service (ER vs. ICU vs. acute vs. observation unit)



Tips:

- **Compare hour counts to hourly charge units**
- **Identify observation charges not performed on the acute care floor**

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Hospice Days

- Identify separately
- Count as swing bed NF days
(admit to swing bed program)

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CAH Swing Beds

- Skilled vs. nonskilled level of care
- Skilled = Medicare (*and Medicare Advantage*)
- Medicare pays cost
- Medicaid pays prospectively
- Non Medicare days “carved out”

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CAH Swing Beds *(Continued)*

- *Example swing bed “carve out”*
- Acute care cost = \$1,200,000
- State swing bed rate = \$150
- Acute care days = 1,200
 - Medicare days = 900
- Swing bed days = 400
 - Medicare days = 200
 - Medicare advantage days = 25
 - Other payors = 175
- Total days for calculation = 1,425 vs. 1,600

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CAH Swing Beds *(Continued)*

Swing NF days not identified:

Cost	\$ 1,200,000
Days	1,600
Cost per day	\$ 750
Medicare days	1,100
Medicare cost	\$ 825,000

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CAH Swing Beds *(Continued)*

All Swing NF days identified:

Swing NF days	175
Swing NF rate	150
Swing NF costs	\$ 26,250
Cost	\$ 1,200,000
Less Swing NF costs	(26,250)
Cost for calculation	\$ 1,173,750
Days	1,425
Cost per day	\$ 824
Medicare days	1,100
Medicare cost	\$ 906,400
Increase in reimbursement	\$ 81,400

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CAH Swing Beds *(Continued)*

150 Swing NF days identified:

Swing NF days		150
Swing NF rate		150
Swing NF costs	\$	22,500
Cost	\$	1,200,000
Less Swing NF costs		(22,500)
Cost for calculation	\$	1,177,500
Days		1,450
Cost per day	\$	812
Medicare days		1,100
Medicare cost	\$	893,200
Increase in reimbursement	\$	68,200
Cost of not identifying additional days	\$	13,200

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CAH Swing Beds *(Continued)*



Tip: Verify all swing bed days by payor

- Patients change payor status after admission
- To correct at desk review requires additional support
- 2007 PS&R has been overstating days

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CAH Swing Beds *(Continued)*

- Medicare pays **skilled nursing facility** care based on RUGs
- Swing bed care and rules are the same as skilled nursing facility, but provided in acute care setting
 - No MDS for swing bed patients

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Allowable Expenses

Medicare will pay me for that?

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EHR (CAH)

- Can expense in one year
 - “Prompt” interim payment equals MCR % + 20%



**Tip: Timing of purchase is important —
Must show you are meaningful user of EHR**

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Direct Cost Assignment

- Direct costs are assigned based on payroll records and accounts payable coding
- Indirect (support or overhead) costs are allocated in the cost report

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Direct Cost Assignment *(Continued)*

- Payroll should be assigned through time cards, **not** time studies
- Ensure staff working in multiple departments understand how each cost center is defined

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Direct Cost Assignment *(Continued)*

- Where are stand-by costs coded?
- Acute care vs. ER nursing time

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Operational Issues

- **Reimbursement theory must be understood by:**
 - Board
 - Management
 - Department managers
 - Accounts payable

- *Operating decisions impact Medicare and Medicaid reimbursement*

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Allowable expenses

- Grant expenses (*don't net with grant income*)
- Hospital administrative services performed by Foundation
- Collection agency expenses
- Interest charged on patient accounts



Tip: Write off to revenue account, not bad debt

- Employee discounts

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Allowable expenses *(Continued)*

- Interest expense on capital leases
- Costs paid on behalf of hospital by related party



Tip: Don't group nonallowable expenses with allowable expenses

- **Year-end accruals:** If appropriate, we are paid this year instead of next

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Allowable expenses *(Continued)*

- Non-patient revenue – used to offset costs
 - Miscellaneous income:
 - Include detail of income
 - *Example: cafeteria revenue used to offset cafeteria costs*


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Allowable expenses *(Continued)*

- Non-patient revenue – non-offsetable revenues
 - Tax revenue
 - Donations
 - Most grant revenue
 - HPSA payments
 - Think contractual type adjustments
 - Revenue associated with non-allowable cost centers

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Allowable expenses *(Continued)*

- **Tips:** 
 - Record charge rebates against cost on GL
 - Identify rental income related to non-allowable cost centers
- *Ex: physicians' private offices*

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Allowable expenses *(Continued)*

- Interest expense
 - Must first be necessary
 - Regardless of funded depreciation
 - Offset up to the amount of interest income
 - Can borrow against funded depreciation
- Remember: interest imputed for capital leases is not offset

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Allowable expenses *(Continued)*

- Funded depreciation
 - Interest income not required to be offset
 - Requirements:
 - Funding approved by Board
 - Clearly designated in provider records
 - Must be available
 - Provide beginning balance, deposits, withdrawals, and ending balance with cost report
 - Don't use for operations

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Allowable expenses *(Continued)*

■ UTGO bonds

- Interest is paid by taxpayers
- Medicare and Medicaid pay their portion
- Example:
 - Cost based percentage = 40%
 - Interest = \$25,000
 - Paid by hospital = \$0
 - Paid by taxpayers = \$25,000
 - Paid by Medicare and Medicaid = \$10,000
 - Total reimbursement = \$35,000

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Separate Cost Centers

■ Coding supply expenses:

- Medical supplies not separately charged
- Medical supplies charge to a patient using 27X
- Implantables (typically charged using 278)

■ Blood costs:

- Separate from laboratory
 - Direct costs
 - Revenue
 - Other (MME)

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Separate Cost Centers *(Continued)*

■ **Activities:**

- Provides services to both SNF and swing patients
- SNF paid prospectively
- Swing paid cost

- An example:
 - Assume acute care Medicare 75% of total
 - Assume 50% of LTC days in SNF
- Activities costs = \$75,000
- Additional reimbursement = \$28,125

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Hospital-based Physicians

■ **Physician expenses generally nonallowable:**



Tip: Identify separately from other employees in general ledger

■ **Exceptions:**

- RHC
 - CRNA (with exemption)
 - Medical director or administrative duties
 - ER on-call
-
- No statutory RCE limits for CAH

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Hospital-based Physicians *(Continued)*

- Medical director, supervisory and administrative time is an allowable cost



Tip: Update physician contracts with medical director duties:

- **Type**
- **Payment**
- **Hours**
 - *Can be based on time studies
(but must be part of duties in the contract)*

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Hospital-based Physicians *(Continued)*

- Emergency room physician on-call
 - MD, DO, PA, or NP
 - Trained in emergency medicine
 - Must be available to respond within 30 minutes
 - Written contract
 - Not otherwise providing patient services
 - In their own clinic
 - In the hospital's clinic
 - Based on time study (must be auditable and specific to those physicians)

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Hospital-based Physicians *(Continued)*

- Should be based on time study
 - Intermediary beginning to audit and disallow RVU method
 - Actual time best
 - Summary of ER logs is an option



Tips:

- **Actual time maximizes allowable costs**
- **Receptionist or nurse can track the doctor's time**

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Hospital-based Physicians *(Continued)*

- Time studies
 - Noridian currently allows:
 - Physician: two 2-week time studies (24/7)
 - Mid-levels: one week time study each month (24/7)

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Hospital-based Physicians *(Continued)*

- Providing other patient services while on-call
 - In clinic but on-call for ER
 - Time must be carved out as patient time



Tips:

- **Amend contracts to state on-call payments not made during clinic time**
- **Carve out medical director time first**
- **Ensure log summaries exclude clinic time**
- ***Track actual patient time***

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Contracted PT, OT, ST, & RT

- Held to hourly limits (adjusted hourly salary equivalency amounts or AHSEA)
- Hours should include all worked hours, including overtime
 - Report overtime hours separately

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Contracted PT, OT, ST, & RT

■ Require the contractor to:

- Report hours on invoice
- Report overtime hours separately
- Payback amounts lost on cost report for rates in excess of cap



Tips:

- Separate contracted therapists on general ledger
- Identify supervisor, therapist, and assistant separately

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Overhead

What can non-cost based departments do themselves?

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Directly-assigned Overhead (OH) Costs

- Admitting
- Patient billing
- Medical records
- Insurance
- Nurse administration
- Housekeeping or maintenance directly assigned to medical office buildings
- **Avoid double-allocation**

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Directly-assigned OH Costs *(Continued)*



Tips: Identify and communicate any directly assigned OH to your cost report preparer

- Typically, hospitals directly assigned OH to low or non cost-based departments

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Square Footage

- Update regularly (at least quarterly)
- Identify date of change (changes are weighted)
- A person should be assigned to track changes
- Who is assigned to your facility?

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Square Footage *(Continued)*

- Develop a system that can track changes easily through the years



Tip: Use CAD or hard-copy of blueprints

- ***Use Excel spreadsheet with the following columns:***
 - Numerical or alpha code for each room
 - Room use
 - Cost center name
 - Cost center number

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Square Footage *(Continued)*

- The more square feet in acute – ***generally better***
- The less square feet in non cost reimbursed departments – ***way better***
 - ***Exception:***
 - Nursing home capital may be cost-based; subject to occupancy



Tip: Newer portion of buildings and equipment should be used for higher cost-based departments (use separate cost center)

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Square Footage *(Continued)*

- Net vs. gross
- Net excludes hallways and walls
(interior measurements of rooms)
- Gross includes hallways and walls
- Method must be consistent between years and buildings
 - ***Example: Hospital uses net; clinic is reported gross***

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Depreciation Expense

- Use AHA guideline
- Projects:
 - Break projects into their components using AHA guide
- Use shortest useful life available

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Major Moveable Equipment

- Dollar-value:
 - Approximates direct assignment
 - Usually better in CAH with large non-cost-based departments
- Square feet
 - Can be better in straight CAH
- Do you know how much of your costs are reimbursed



Tip: Assigning equipment as fixed or moveable can effect reimbursement

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Employee Benefits

- Track by department
- Separately identify actual benefits paid to or on behalf of physicians
- PRM 2122.3 – Employment related taxes for provider-based physicians are allowable

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Administration

- One cost center
- Multiple cost centers:
 - Admissions
 - Billing
 - Accounting
 - Purchasing
 - Information technology
 - Other

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Administration *(Continued)*

- Admissions
 - Number of admits
 - Gross charges
- Billing
 - Gross charges
- Accounting
 - Accumulated cost
- Purchasing
 - Supply costs/requisitions
- Information technology
 - Number of terminals

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Plant vs. Utilities

- Can combine or report separately
- Utilities for separate buildings
 - Hospital higher per square foot
- Maintenance maintains both buildings

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Dietary

- Meals

Tips:

- Count consistently
- Don't count snacks
- Count equivalent cafeteria meals



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Cafeteria

- FTEs

Tips:

- Identify off-campus FTEs
(these are omitted)
- Identify other areas that do not use
cafeteria (perhaps call sites)



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Housekeeping

- Square feet
- Time studies
 - More time in patient room
 - Less time in offices
 - Other areas may not require housekeeping

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Nurse Administration

- COO, acute care DNS, nursing home DNS, infection control, and education
- Allocation: nurse time in supervised departments
- Can have more than one cost center
- Organizational chart



Tip: Identify departments covered for all five positions listed and note where their expenses are located on the GL

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Medical Records

- **Gross revenue**
 - Allocates more to outpatient laboratory, radiology, and ER
- **Time studies**
 - Allocates more to acute care and emergency room
- **Identify departments:**
 - for whom charts are prepared
 - whom perform their own function

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Changing Allocation Statistics

- **First year** – select any method
- **Subsequent years:**
 - Written request to intermediary 90 days before the end of the cost reporting period
 - Statement or proof that the “change will result in more appropriate and more accurate allocations”
 - Unique cost centers

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Time Studies

- At least one full week per month
- A full work week (e.g. 7 days)
- Equally distributed among the months
(e.g. 3 months use 1st week; 3 months use 2nd week; etc.)
- No two consecutive months may use the same week
- Contemporaneous with the costs
- Provider specific

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Time Studies *(Continued)*

- Designate one responsible person
- Must be prepared accurately and consistently
- Preparers must understand how each “cost center” is defined
- The cost report preparer and/or CFO should provide guidance and then review/monitor

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Time Studies *(Continued)*

- Examples include:
 - Laundry pounds
 - Housekeeping hours
 - Medical record hours
 - Social service hours
 - Maintenance hours

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Other Overhead Strategies

- **Review current allocations:**
 - Does allocated costs match department's utilization?
 - Is there a more accurate method?
 - Does that department really take up that much space?

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Patient Charges

I ♥ Chagemasters!

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Gross Patient Revenue

- Charges removed from cost report
 - Professional charges
 - Compare A-8-2 with C
 - Admit kits
 - Call-back charges



Tip: If charge is nonallowable to Medicare, please notify your cost report preparer of the location (GL) and amount

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Revenue Code Report

- By revenue code **and**
- By department
- Matching
- Revenue code 270 – medical supplies
- Professional charges

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Outpatient Services in Acute

- Blood admin
- Infusions
- Chemo
- Injections
- Treatment room

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No Revenue Code Report

- Separately identify all:
 - Professional charges
 - Supply charges
 - Implantable supply charges
 - Blood charges

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Provider-based Clinics

- Billed Method II to Medicare (split charge)
- Global charge billed to other payors
- Must make the two match on cost report
 - Basis for split (Medicare)
 - Set amount per charge
 - Percentage of charge
- Professional fees: Hospital vs. Clinic



Tip: Ensure your cost report preparer understands how you bill these services

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Outpatient Laboratory

- Must be registered as an outpatient
- “Draw stations” in non-CAH facilities paid fee schedule (example: nursing facility)
- **Update: Drawn in PBC, RHC, NF, or SNF paid cost beginning July 1, 2009!**

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Other Elections

Forget-me-nots

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CRNA Pass-through

- Elect annually prior to January 1 (exemption is on a calendar year)
- Less than 800 procedures requiring anesthesia and less than 2,080 productive CRNA hours
- Nearly all that qualify should elect CRNA exemption

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Method II Billing

- **Outpatient** professional services
- If the CAH bills the physicians' charges, it must bill this method
 - **Exception:**
 - **CRNA pass-through**
- 115% of facility fee schedule (professional component):
 - Patient not charged 15% on their portion
- Cost (technical component) (was 10% of cost)
- Both technical and professional components are billed on the UB04
- Elect **annually** 30 days before the cost report period begins

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Medicare Bad Debts

Good vs. Bad: An Epic Medicare Adventure

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Medicare Bad Debts

- **Medicare deductibles and/or coinsurance:**
 - Hospital services (not physician)
 - RHCs
- **Reimbursed 100% of uncollected amount**
- **Excludes professional charges and any other fee schedule payments:**
 - Method II billing
- **Three types:**
 1. Reasonable collection efforts
 2. Medicaid secondary payor (crossovers)
 3. Written off under charity care policy (indigent)

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Reasonable Collection Effort

- **Deemed uncollectible using the hospital's normal collection efforts**
- **Treated similarly to other payors, and billed with the intention of receiving payment for at least 120 days:**
 - 120 days from date the bill was first sent to beneficiary, to date it was deemed uncollectible and written off of the Hospital's books
 - Collection agencies strategy
- **Sound business judgment established that there was no likelihood of recovery at any time in the future**

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Crossovers

- **Type of indigent bad debt:**
 - Medicaid is responsible for payment of deductible and coinsurance
 - **Must be billed and denied by Medicaid:**
 - Not subject to the 120-day rule



Tip: Can claim partial and full write-offs

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Medicare Bad Debt – Charity Care

■ Type of indigent bad debt:

- Written off under the hospital's charity care policy
- This is often overlooked by hospitals
- Not subject to the 120-day rule



Tip: Can claim partial and full write-offs

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Required Exhibit 5 Fields

1. Patient name
2. Medicare HIC number
3. Dates of service (from/to)
4. Indigency and welfare (charity section):
 - a. Mark indigent for charity care
 - b. Include beneficiary's Medicaid number for crossovers
5. Date first bill sent to beneficiary
6. Write-off date
7. Remittance advice date
8. Deductible amount
9. Co-insurance amount
10. Total amount (may be different than the sum of 8 and 9 if partial payment was received)

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Clinics

Doctor, doctor, gimme the news

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Types of Clinics

- Freestanding clinic
- Freestanding RHC
- Provider-based clinic
- Provider-based RHC
- *Which is best for your hospital?*




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Freestanding Clinic

- Paid fee schedule (global fee):
 - Medicare:
 - 2009 payment 99213 = \$58 (will account for most visits)
 - 2009 payment 99214 = \$87
 - Medicaid:
 - 2009 payment 99213 = \$57 (Idaho) \$42 (WA)
 - 2009 payment 99214 = \$86 (Idaho) \$64 (WA)
- Typically the lowest reimbursement of the clinic types
- Mid-levels paid 80% of physician fee schedule amount

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Provider-based Clinic

- Meet outpatient construction code.
- Licensed as part of CAH.
- **Don't forget off-campus, provider-based rule!** 
- Submit 855A to Intermediary
- Method II billing
- Same total charge (global charge) split:
 - Technical component
 - Professional component:
 - Think of your emergency room as a provider-based clinic

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Provider-based Clinic *(Continued)*

- Reimbursement 2X that of free-standing clinic
 - Medicare:
 - 2009 payment 99213 = \$76
 - 2009 payment 99214 = \$100
 - Estimated \$20 technical portion and CCR of 1.5
 - Medicaid
 - 2009 payment 99213 = \$57 (Idaho) \$42 (WA)
 - 2009 payment 99214 = \$86 (Idaho) \$64 (WA)

- Mid-levels paid 80% of physician fee schedule amount

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Provider-based Clinic *(Continued)*

- Method II allows for one bill:
 - Professional component paid fee-schedule plus 15% (Medicare's portion only)
 - Use 98X revenue code
 - Technical component paid cost:
 - Based on cost report and cost-to-charge ratio
 - Use 510 revenue code

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Provider-based Clinic *(Continued)*

Charges only split for Medicare:

- Need method to split remaining charges for cost report.
- Washington and Idaho don't recognize PBC
- Montana does



Tip: Code physician hospital charges in separate account from clinic charges

- Hospital admits, observation, procedures
- Medicare clinic visits
- Other payers, clinic visits

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RHCs

- Mid-level 50% rule
 - Mid-level must be employed
- HPSA or MUA
- Rural

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RHCs *(Continued)*

- Paid a cost-per visit (includes physician and mid-level costs)
 - Subject to productivity standards
 - 4,200 per physician FTE
 - 2,100 per mid-level FTE
 - Viewed in aggregate
 - Contracted physicians subject to productivity standard (except locums)

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RHCs *(Continued)*

- Paid cost-per flu and pneumonia injection
 - Must be performed in the RHC
 - Must be paid through cost report
 - Cannot bill patient or Medicare

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RHCs *(Continued)*

- Encounter (RHC visit): a medically necessary, face-to-face encounter between a physician or mid-level and the patient
 - Nurse visits performed by practitioner do not count
 - Nurse visits performed by nurse do not count



Tip: Ensure visit count excludes nurse visits

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RHCs *(Continued)*

- Paid cost-per-visit = visit count important
- Things to omit:
 - Nurse visits
 - Hospital visits
 - Emergency room
 - Observation
 - Inpatient

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RHCs *(Continued)*

- Paid cost-per-visit = visit count important
- Things to include and bill as RHC
 - Office visits
 - Home visits
 - Assisted living visits
 - Nursing home visits
 - **Swing bed visits**

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RHCs *(Continued)*

- Example:
 - RHC visits = 10,000
 - Nurse and hospital visits = 500
 - Medicare visits = 4,000
 - RHC costs = \$1,500,000
 - Cost per visit with nurse and hospital = \$142.86
 - Cost per visit without nurse and hospital = \$150.00
 - Difference = \$7.14
 - Difference time Medicare visits = \$28,560

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RHCs *(Continued)*

- Held to productivity standards = FTE count important

- Hours to omit from FTE count
 - Hospital time
 - Emergency room time
 - Administrative time

- Time available to see patients

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RHCs *(Continued)*

- Held to productivity standards = FTE count important

- Hours to include from FTE count
 - Clinic patient time
 - Swing bed, nursing home, assisted living time
 - Proration of PTO time

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Freestanding RHC

- Subject to RHC rules:
 - Midlevel
 - Productivity standards, etc.
- Per-visit limit = \$76.84 (2009)
- Paid cost prospectively by Medicaid (estimated \$90 - \$110 per visit)
- Physicians and mid-levels paid the same

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Freestanding RHC *(Continued)*

- Bills encounters using RHC rate
- Bills using physician number
 - EKGs
 - Radiology
 - Laboratory

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Provider-based RHC

- Subject to RHC rules:
 - Midlevel
 - Productivity standards
- No per-visit limit for hospitals with less than 50 beds = approx. \$120 - \$150 per visit
- Paid cost prospectively by Medicaid (estimated \$90 - \$110 per visit)
- Physicians and mid-levels paid the same

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Provider-based RHC *(Continued)*

- Bills encounters using RHC rate
- Bills using hospital number
 - EKGs
 - Radiology
 - Laboratory

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Clinic Payments – Medicare

- Freestanding clinic \$ 58 - 87
- Freestanding RHC \$ 77
- Provider-based clinic \$ 76 - 100
- Provider-based RHC \$ 120 - \$150
 - Which is best for your hospital?



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Clinic Payments – Medicaid

- Freestanding clinic \$ 42 - 86
- Freestanding RHC \$ 90 - 110
- Provider-based clinic \$ 42 - 86
- Provider-based RHC \$ 90 - 110
 - Which is best for your hospital?
- Based on Washington and Idaho
- Based on common E&M codes
 - Results vary based on each clinic's CPT code usage



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Strategic

Wait, I'm awake! Do what now?

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Strategic

- Reimbursement theory should be understood by:
 - Board
 - CFO
 - CEO
 - AP
 - Payroll
 - Department managers

- Remember operating decisions affect Medicare reimbursement

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Strategic *(Continued)*

- Medicare pays cost = can't make a profit

- Look at expanding outpatient services
 - Typically lower cost-based
 - Typically higher third-party payors

- Remember: our profit comes from other third-party payors
- Our cost report strategies only increase one payor to its actual share of cost

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Strategic *(Continued)*

- Medicare pays cost = can't make a profit
 - Still must have good payment rates from third-party payors
 - Still must collect from self-pay patients

- Must accumulate, bill, and collect charges for all services provided

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Strategic *(Continued)*

- Cost-to-charge ratios and per-diems: Is higher better?
 - Yes
 - DZA objective to maximize rates
 - Operational decisions must account for the effect on these rates
 - No
 - Cost-based = breakeven on *allowable* costs
 - Lower rate
 - Lower unit cost and likely higher utilization (think economies of scale)
 - Means higher margin on other payors

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Strategic *(Continued)*

- CAHs are a business
 - Good business principles still determine financial viability
 - Lower cost per unit is still goal:
 - More critical in departments with lower Medicare and Medicaid utilization

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Strategic *(Continued)*

- Example – Rural Health Clinic:
 - Average charge-per-visit – \$75

 - Medicare reimbursement per visit – \$100
 - Actual cost-per-visit may be higher if minimum productivity standards not met

 - Total visits – 10,000

 - Medicare visits – 4,000

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Strategic *(Continued)*

■ Medicare net income:	
■ Average reimbursement	\$100
■ Average cost	<u>100</u>
■ Net income per visit	0
■ Medicare visits	<u>4,000</u>
■ Net income	<u>0</u>

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Strategic *(Continued)*

■ Other payor net loss:

■ Average reimbursement	\$ 75
■ Average cost	<u>100</u>
■ Net loss per visit	25
■ Medicare visits	<u>6,000</u>
■ Net loss	<u>\$150,000</u>

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Strategic *(Continued)*

Total Net Loss – \$150,000

- CAH only guarantees breakeven on *allowable* Medicare (and Medicaid in some states) costs.
- High Medicare utilization = low exposure
- Low Medicare utilization = higher exposure, BUT higher opportunity for profit
 - Laboratory
 - Radiology
 - ER, and other ancillary departments

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Financial Goals

- If your goal is 4% to 6% total margin
- Then you need 6% commercial and self pay margin
 - (plus taxes, donations, and other income)
- Medicare and Medicaid are less than break even

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