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Benchmarking Hospitals using Medicare Cost Report Data

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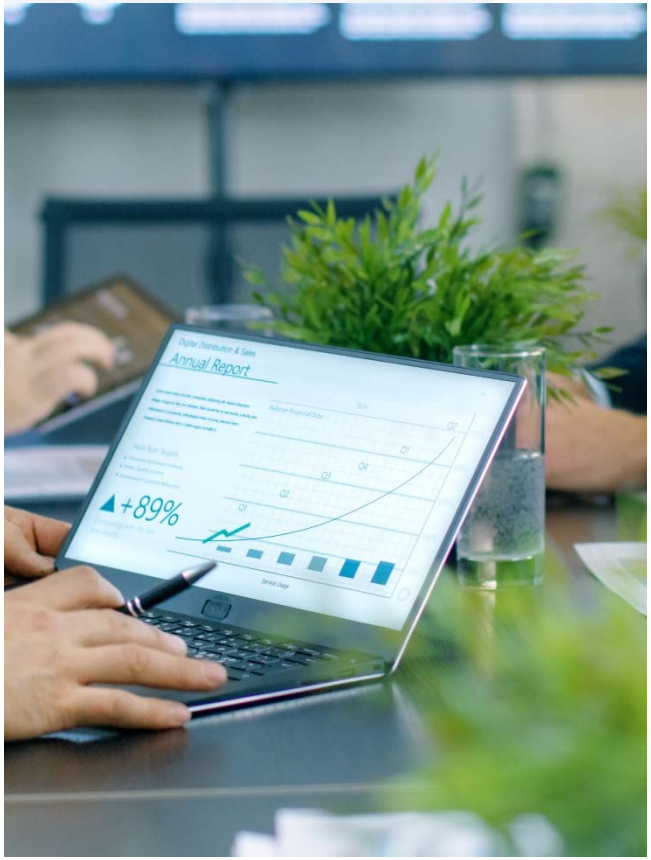
So, you filed your Medicare Cost Report …. Now What?



- Cost reports are a rich source of comprehensive financial and statistical information
- Its all public - CMS updates the HCRIS database quarterly with filed and settled cost reports
- Cost report data can be used to benchmark your financial performance
  - Extract cost report data for all Medicare-certified hospitals in the US that are required to submit
  - Compute a variety ratios and trend selected measures over time
  - Slice and diced the data to select appropriate peer groups – by state, region, type of facility, bed size, or specific peers

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Cost Report Data to Benchmark

Available cost report data is vast. Following are some measures you can start with to help gain perspective and indicate where to further analysis may be warranted.

General

- Total Charges
- Total Expenses
- Adjusted Patient Days
- Average Length of Stay
- Global Ratio of Cost to Charge
- DSH %

Profitability

- Total Margin
- Medicare Cost Coverage Ratio
- Medicare Profitability
- Medicaid Profitability

Volume & Payor Mix

- Inpatient Charges as % of Total
- Payor Mix %
- Occupancy %

Analysis of Cost Allocations

- Inpatient Cost per Day
- Routine Cost as % of Total
- FTE per Adjusted Occupied Bed
- Employee Benefits % of Salaries
- Overhead as % of Total Cost
- Capital as % of Total Cost
- OR, ED, Rad, etc. as % of Total
- Phys Practice Cost %
- ER Availability %
- Ratio of Cost to Charge
- Bad Debt & Charity %
- … and more

Leveraging Benchmarks

- Analyze your cost structure, compared to your peers
  - Are overhead costs too high?
  - Are you making comparable capital investment?
  - How does overall RCC compare to your peers? Are your costs high/low, or are your prices high/low?
- Analyze inpatient capacity and utilization
  - Are your inpatient service areas right-sized? Are you operating too close to capacity to effectively manage peak census times?
  - How does your DSH % compare to others with comparable payor mix?
- Identify reimbursement opportunities
  - How does your ALOS compare to peers with similar case mix?
  - As a CAH, is your ER physician availability time significantly lower?
- Research for merger or acquisition activities

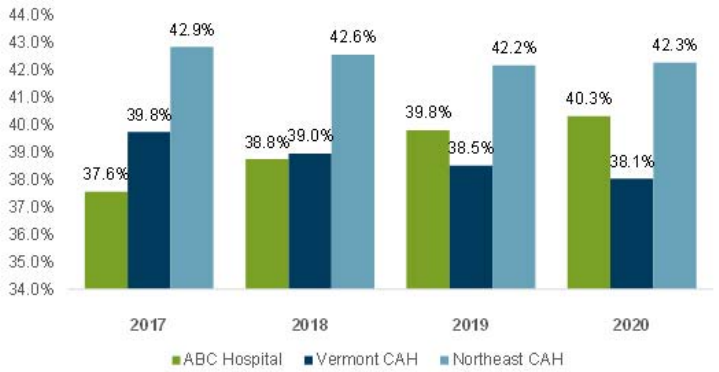
Example: Analysis of Cost Structure

This hospital's overhead % is growing, while its peers are decreasing or flat

Overhead as a % of Total Cost

What is an appropriate level of overhead for the size of your hospital? How do you compare to your peer groups?

Overhead as a % of Total Cost



Desired Trend: *Down*
Definition: *Capital, administrative and general service costs as a percent of total costs*
Calculation: *(Overhead costs / total costs) x 100*
Source: *Worksheet A, Trial Balance of Expenses*

- Dive deeper to explore components of overhead cost compared to your peers – where do you differ:
  - Capital cost, plant operations
  - Employee benefits costs
  - Administrative cost

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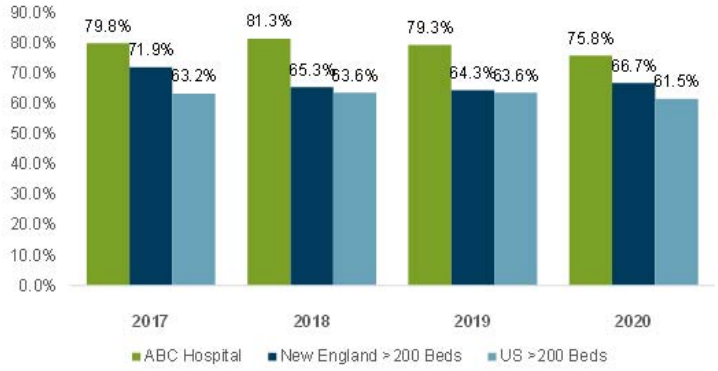
Example: Analyze Inpatient Capacity & Utilization

This hospital with >200 beds has operated at higher occupancy rates than its peer groups

Occupancy %



Desired Trend: *Up (Being at or over capacity is not desirable)*
Definition: *The proportion of beds occupied*
Calculation: *(Total adult & pediatric days / total available bed days) x 100*
Source: *Worksheet S-3 Pt I, Statistical Data*

Occupancy %

Occupancy generally indicates greater revenue. As indicated, being at or over capacity can be problematic.

- ❑ Compare staffed beds with licensed beds – have more capacity? Have flexibility in staffing model?
- ❑ Challenges managing beds during peak census times?
- ❑ Consider need for more beds or how capacity at other facilities in community/network can be best utilized

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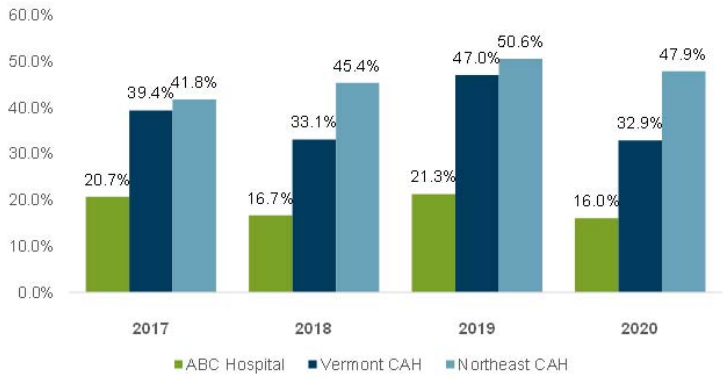
Example: Identify Reimbursement Opportunities

For this Critical Access Hospital, ER Physician Availability time is significantly lower than its peers

ER Availability

Medicare pays cost-reimbursed hospitals for time in which ER physicians are on standby, not treating patients. This is a great opportunity for additional reimbursement for Critical Access Hospitals with lower percentages.

ER Availability



Desired Trend: *Up if cost reimbursed*
Definition: *Portion of physician downtime that is being captured and reimbursed at cost*
Calculation: (ER provider reimbursable cost / total ER physician cost) x 100
Source: *Worksheet A-8-2, Provider Based Physician Adjustment*

- ❑ Evaluate adequacy of method used to track availability time – ER log data, time studies?
- ❑ Explore options for using RTLS to track available time

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Questions?

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