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Hospital Cost Report Training

October 17–19, 2023

All information provided is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the particular situation.

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TO RECEIVE CPE FOR PARTICIPATION

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- Must be logged in individually
- Must respond to periodic polling questions

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AGENDA

WEBINAR

10–11 a.m.	Session
11–11:15 a.m.	Break
11:15 a.m.–12:15 p.m.	Session
12:15–1:15 p.m.	Lunch
1:15–2:15 p.m.	Session
2:15–2:30 p.m.	Break
2:30–3:30 p.m.	Session

AGENDA

WEBINAR

3:30–3:45 p.m.	Break
3:45–4:45 p.m.	Session

HOSPITAL COST REPORT TRAINING

WEBINAR

Objectives

- Understand the purpose of the cost report & its role in determining payments
- Examine all the primary cost report worksheets
- Understand the Medicare cost report settlement & the various settlement components
- Explore the key factors in hospital reimbursement including Prospective Payment System, Medicare bad debts, & wage index

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MEDICARE PROGRAM HISTORY & ADMINISTRATION OVERVIEW

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MEDICARE PROGRAM HISTORY

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1929 – Blue Cross founded in Dallas, initially offering 21 days of hospital care for $6/year.

Blue Cross Association & Blue Shield Association, founded in 1939, eventually implement practice of paying hospitals based on a “Cost Per Diem” instead of a percentage of charges, which had been most common. Hospital cost reports are prepared to support per diem amounts.

1943 – President Franklin Roosevelt calls for social insurance "from the cradle to the grave" in his State of the Union address.

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MEDICARE PROGRAM HISTORY

1945 – President Harry Truman first proposes establishing a national health insurance plan, & follows up in 1947 & 1949 with similar requests that were also unsuccessful. He eventually backs off from idea of universal coverage, but the seed is planted for the design of health insurance coverage for Social Security recipients.

1961 – President John F. Kennedy convenes task force that eventually recommends national health insurance for people over 65.

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MEDICARE PROGRAM HISTORY

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

President Johnson called Truman

“the real daddy of Medicare.”

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MEDICARE PROGRAM HISTORY

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

The new Medicare program partners with the Blue Cross & Blue Shield companies to help administer the program including developing the Medicare cost report & eventually auditing submitted reports.

1972 – Medicare eligibility extended to individuals under 65 with long-term disabilities or ESRD.

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MEDICARE PROGRAM HISTORY

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

During the ten years prior to the implementation of IPPS, Medicare's overall cost per patient day increased by an average of 14% per year.

For the ten years following IPPS, these overall cost decreased by ~33%.

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MEDICARE PROGRAM HISTORY

January 1, 1992 – Medicare implements the Physician Fee Schedule to reimburse physician services, replacing the “customary, prevailing, & reasonable” (CPR) charge system.

August 5, 1997 – President Clinton signs into law the Balanced Budget Act of 1997 which incorporates numerous Medicare provisions including establishing prospective payment systems for hospital outpatient, inpatient & outpatient rehab, SNF, & HHA.

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MEDICARE PROGRAM HISTORY

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August 1, 2000 – Medicare implements outpatient PPS.

Most other remaining provider types eventually convert to PPS in subsequent years. However, children's & cancer hospitals & hospitals in U.S. Territories continue to receive cost-based reimbursement for inpatient services, & Critical Access Hospitals are reimbursed at 101% of allowable costs.

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MEDICARE ADMINISTRATION OVERVIEW

Medicare is a federally funded health insurance program for:

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

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MEDICARE ADMINISTRATION OVERVIEW

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Medicare has four parts:

- Hospital Insurance (**Part A**)
- Medical Insurance (**Part B**)
- Medicare Advantage (**Part C**)
- Prescription Drug Benefit (**Part D**)

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MEDICARE ADMINISTRATION OVERVIEW

Hospital Insurance (Part A)

- Most people don’t pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.
- Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including CAHs, & SNFs (not custodial or long-term care).
- It also helps cover hospice care & some home health care. Beneficiaries must meet certain conditions to get these benefits.

Source: CMS Website

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MEDICARE ADMINISTRATION OVERVIEW

Medical Insurance (Part B)

- Most people pay a monthly premium for Part B.
- Helps cover doctors' services & outpatient care. It also covers some other medical services that Part A doesn't cover, such as services of physical & occupational therapists, & some home health care.
- Part B helps pay for these covered services & supplies when they are medically necessary.

Source: CMS Website

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MEDICARE ADMINISTRATION OVERVIEW

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Medicare Advantage (Part C)

- Formerly known as Medicare+Choice (M+C), & is sometimes referred to as Medicare HMO.
- People with Medicare Parts A & B can choose to receive all of their health care services through one of these provider organizations under Part C instead of the traditional Medicare plan.
- Medicare Advantage Plans include:
  - + Medicare managed care plans
  - + Medicare preferred provider organization (PPO)
  - + Medicare private fee-for-service plans
  - + Medicare specialty plans

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MEDICARE ADMINISTRATION OVERVIEW

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Medicare Advantage (Part C) (cont.)

- Additional Medicare reimbursement may be available related to Medicare Advantage activity
  - + Medical education reimbursement for Medicare approved residency program
  - + Share of reimbursement “pool” for paramedical education/allied health/school of nursing
  - + Kidney acquisition cost for Medicare Advantage
- Medicare Advantage activity can also have impact on other calculations related to Medicare reimbursement

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MEDICARE ADMINISTRATION OVERVIEW

Prescription Drug Coverage (Part D)

- Most people will pay a monthly premium for this coverage.
- Starting 1/1/06, new Medicare prescription drug coverage became available to everyone with Medicare.
- Everyone with Medicare can get this coverage that may help lower prescription drug costs & help companies provide this coverage. Beneficiaries choose the drug plan & pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

Source: CMS Website

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MEDICARE ADMINISTRATION OVERVIEW

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

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

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

- These contractors were previously known as Fiscal Intermediaries (FIs) for Part A & Carriers for Part B
- As a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS has transitioned to Medicare Administrative Contractors (MACs) which handle both Part A & Part B administration

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MEDICARE ADMINISTRATION OVERVIEW

Initially there were 15 A/B MAC jurisdictions

In 2010 CMS began transition to 10 A/B MAC jurisdictions

+ Three consolidations have been implemented, final two consolidations are currently on hold

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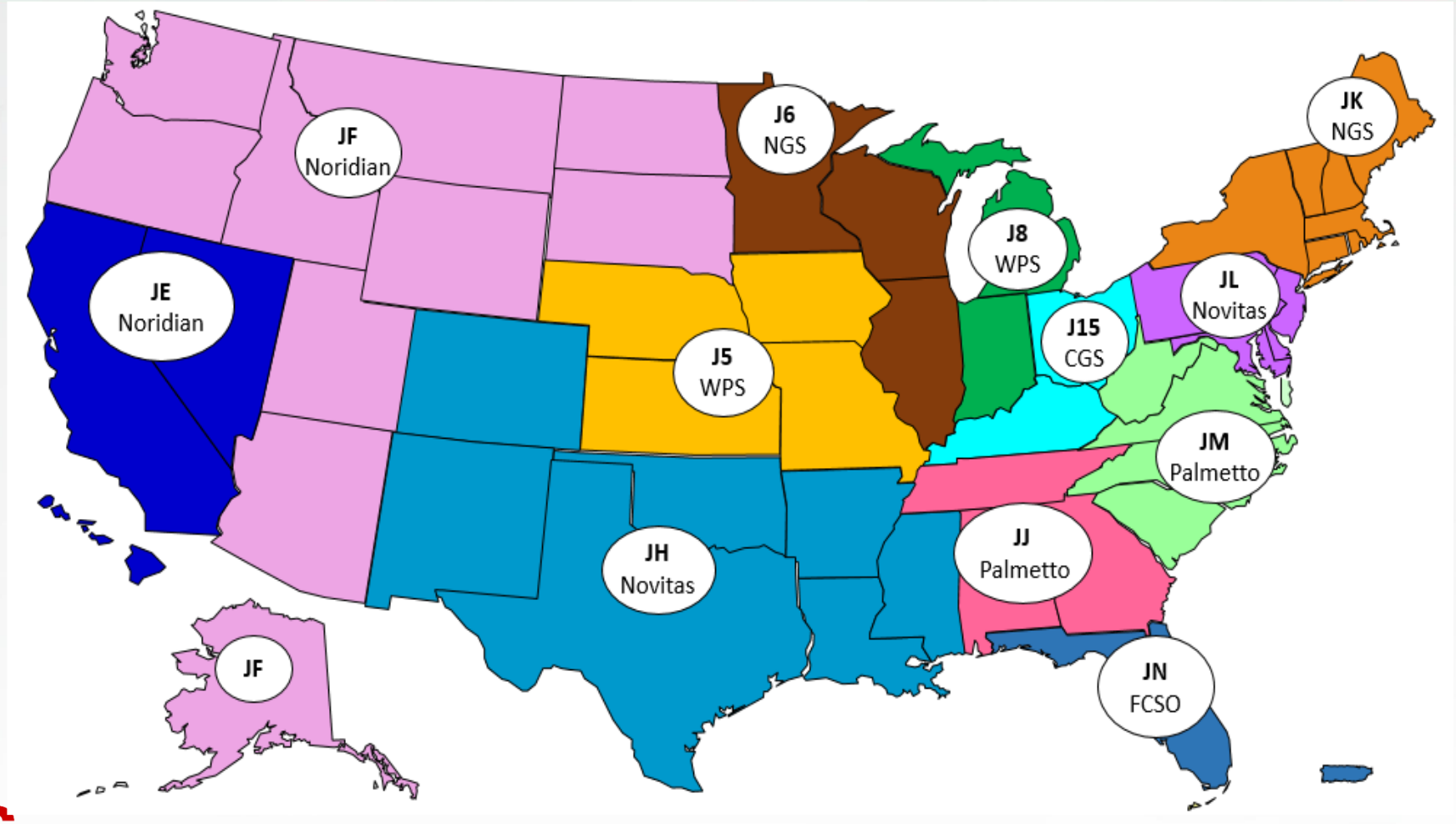
A/B MAC JURISDICTIONS



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Source: CMS Website

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MEDICARE ADMINISTRATION OVERVIEW

Statutes or legislation that are passed by Congress govern the Medicare program, & are codified in the United States Code

+ Example “42 U.S.C. §1395h”

Regulations are the rules that CMS provides to implement statutes passed by Congress

+ Regulations are initially published in the Federal Register for public notice & then are codified upon adoption in the Code of Federal Regulations
+ The regulation adoption process requires public notice of proposed changes before the changes can become final
+ Example “42 C.F.R. §405.1835”
+ CMS also issues proposed & final rules each year to update the various payment systems, such as Inpatient PPS & Outpatient PPS

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MEDICARE ADMINISTRATION OVERVIEW

CMS Manuals are published by CMS & offer the day-to-day operating instructions, policies, & procedures based on statutes & regulations, guidelines, & directives

- CMS Transmittals are used to indicate changes or additions to the manuals – typically there are three types:
  - + Transmittals that announce changes to the manuals
  - + One-Time notification transmittals that communicate information but do not change the manuals
  - + Recurring update notification transmittals that communicate information that changes on a regular schedule that do not make changes to the manual

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MEDICARE ADMINISTRATION OVERVIEW

Provider Reimbursement Manual

(CMS Pub 15)

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- **Part 1 –** Provides guidelines & policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services
  - + Essentially the Principles of Reimbursement
- **Part 2 –** Provides detailed instructions for filing & completing cost reports
  - + Chapter 40 – Hospital cost report instructions

MEDICARE ADMINISTRATION OVERVIEW

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Other Sources of Authority/Information

- Medicare Learning Network – MLN Matters Articles
- Local Coverage Determinations
- Administrative Decisions
- Rulings
- Appeals & Case Decisions
- Joint Signature Memorandums (JSM)
- CMS Open Door Forums // *www.cms.gov/OpenDoorForums/01_Overview.asp*
- Emails from CMS staff

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COST REPORT OVERVIEW

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COST REPORT OVERVIEW

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Purpose of the Cost Report

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

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COST REPORT OVERVIEW

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Purpose of the Cost Report (cont.)

- Is a source of information
  - + Aggregate cost report data used to develop future payment rates
    - > Generally, there is a three-year lag between when cost reports are filed & when the data impact relative weights
  - + Specific information influences payment factors
    - > Wage Index
    - > CCRs for outliers
  - + Some years are used for developing certain base payment rates (SCH & MDH hospital-specific rates)

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COST REPORT OVERVIEW

Purpose of the Cost Report (cont.)

- Is a source of information (cont.)
  - + To guide policymaking
    - > CMS
    - > MedPAC

Example // for FY 2008 CMS made two proposals related to PPS capital payments:

-Increase the standardized capital payment rate for rural hospitals but keep the rate the same for urban hospitals

-Eliminate the 3% "large urban add-on"

CMS had analyzed cost report data & concluded that urban hospitals were being overpaid. Ultimately CMS only implemented the second proposal

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Purpose of the Cost Report (cont.)

- Is a source of information (cont.)
  - + Used by various groups to measure or evaluate performance
- Note that cost reports for all hospitals are accessible to the public
  - + FOI request
  - + Healthcare Cost Report Information System (HCRIS) file
  - + Subscription services:
    - > hcris.hfssoft.com
    - > CostReportData.com

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COST REPORT OVERVIEW

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Forbes

America's Most Profitable Hospitals

David Whelan, 08.31.10, 10:00 AM EDT

Some hospitals make colossal profits. Are they running a tight ship--or using monopoly power to overcharge patients? It's not a discussion hospitals want to have.

Our list, done by the American Hospital Directory, is based on operating income figures that hospitals must report to the federal Medicare program each year.

…

The most profitable hospital in the country, 235-bed Flowers Medical Center in Dothan, Ala., recorded an incredible 53% operating margin. …After this story came out, Flowers Hospital disputed the figures in an e-mail. It says it overstated its revenue by an astonishing $180 million in its official report to Medicare and that its actual margin is 12%.

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America's Most Profitable Hospitals (cont.)

…

Ohio State University Hospital reported a hefty 32% profit margin to the government. When asked about it chief financial officer Jeff Ellison cracked: "I'd like to buy stock in us," but refused to comment further. Later the university wrote an e-mail claiming the Medicare report "does not give a complete picture." It would not explain how.

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COST REPORT OVERVIEW

Health Affairs

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A More Detailed Understanding Of Factors Associated With Hospital Profitability

...

Abstract

To identify the characteristics of the most profitable US hospitals, we examined the profitability of acute care hospitals in fiscal year 2013, measured as net income from patient care services per adjusted discharge. Based on Medicare Cost Reports and Final Rule Data, the median hospital lost $82 for each such discharge. Forty-five percent of hospitals were profitable, with 2.5 percent earning more than $2,475 per adjusted discharge. The ten most profitable hospitals, seven of which were nonprofit, each earned more than $163 million in total profits from patient care services.

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Responses on This Article: Profitability: A Health System's Perspective

Scott Rathgaber, MD, Chief Executive Officer

Dara Bartels, Chief Financial Officer, Gundersen Health System

This article is misleading and challenges Gundersen Health System's position as a high-quality, integrated health system that values continuous examination of expenditures, reduction of waste, and reinvestment in the communities we serve. Using a single year's data (2013) from Medicare Cost Reports and Final Rule Data, the authors assert that "the 239-bed nonprofit Gundersen Lutheran Medical Center in La Crosse, Wisconsin, was the most profitable hospital in the United States, earning a profit of $302.5 million, or $4,241 per patient." The article uses incomplete data taken from our Medicare Cost Report, which doesn't include our full costs as an integrated health system. If the authors had looked at a complete set of data, we wouldn't have been on the list.

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Health Affairs

Responses on This Article:

Profitability: A Health System's Perspective (cont.)

Another important point that strikes at the heart of the article's inaccuracy: Medicare Cost Reports are not uniformly reported, preventing a true "apples to apples" comparison between hospitals and health systems. Analyzing Medicare Cost Reports of a single care center may have been relevant 20 years ago. However, using the same methodology now for an integrated health system network isn't constructive, but is rather a necessary evil as required for Medicare reimbursement.

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COST REPORT OVERVIEW

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HHS used cost report data to determine eligibility & calculate certain COVID Provider Relief Fund payments.

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100 Top Hospitals Methodology Overview

To conduct the **100 Top Hospitals** study, researchers evaluated 2,650 short-term, acute care, non-federal U.S. hospitals. All research was based on the following public data sets: Medicare cost reports, Medicare Provider Analysis and Review (MEDPAR) data, and core measures and patient satisfaction data from the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website. Hospitals do not apply for awards, and winners do not pay to market this honor. For more information, visit **http://www.100tophospitals.com/**.

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COST REPORT OVERVIEW

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General concepts

- The cost report reflects the activity of the hospital itself, & generally should exclude activity (both costs & patient charges) related to Part B professional services
- GL accounts for costs & patient charges are grouped into cost centers (or cost report lines) on the cost report

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COST REPORT OVERVIEW

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General concepts

- Cost report divides cost centers by type
  - + General Service
    - Capital
    - Overhead
  - + Routine
  - + Ancillary
  - + Other Allowable
  - + Nonallowable
- General Service cost centers are allocated to remaining cost centers based on step-down methodology

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General concepts

- Grouping of costs, total patient charges & program patient charges (Medicare & Medicaid) must be consistent.
  - + Necessary to accurately develop & apply cost to charge ratios (CCRs)
  - + CCRs also referred to as ratio of cost to charges (RCCs)
- Costs generally fall into two categories in terms of the cost report – allowable & non-allowable (or unallowable or non-reimbursable)

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Medicare designs the required cost report forms

- Cost report software must be from an approved vendor
- Transitioned from 2552-96 to 2552-10
- 2552-10 currently up to transmittal 18
  - Published December 29, 2022
  - Effective for cost reporting periods beginning on or after October 1, 2022
- CMS recently published optional electronic templates for Medicare bad debt listings for all applicable cost report forms, & the Medicaid eligible days (Exhibit 3A), charity care charges (Exhibit 3B), & total bad debt (Exhibit 3C) exhibits for 2552-10.

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Software includes edit checks required by CMS

- “Level 1” edits must be addressed before cost report can be filed

Electronic filing is required

- Cost report certification statement must be signed by hospital officer or administrator
  - + FY 2018 IPPS Final Rule allowed providers to electronically sign their Worksheet S Certification Page for fiscal year-ends on or after 12/31/2017

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Worksheet S Part II – Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABC HOSPITAL (34-0199) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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COST REPORT OVERVIEW

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- The Medicare cost report represents a claim for purposes of the False Claims Act
- Generally the cost report is due five months after fiscal year-end
- The cost report is submitted to the hospital's MAC
- Failure to file cost report on time will result in reductions in payments
  - + 100% reduction if you have not filed a letter requesting an extension
  - + Providers can request in writing, prior to the due date, a reduced payment suspension rate of 50% which can remain in effect for up to 60 days

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The MAC is responsible for auditing & settling the cost report

- Tentative settlement
- Final settlement & Notice of Program Reimbursement (NPR)

If a hospital disputes a determination from its MAC, an appeal process is in place

- The Provider Reimbursement Review Board (PRRB), administered by CMS, is responsible for handling appeals
- If a hospital is still not satisfied after appealing to the PRRB, it can seek a remedy from the US court system

Cost reports that have been settled are subject to reopenings & revisions by either Medicare or the hospital if certain conditions are met

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COST REPORT OVERVIEW

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Primary cost report sections:

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

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COST REPORT OVERVIEW

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Primary cost report sections (cont.):

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

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COST REPORT WORKSHEET A

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WORKSHEET A

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets, e.g., *on Worksheets A, B, C, and D, the line numbers are consistent. While providers are expected to maintain their accounting books and general ledger in a manner consistent with the standard cost centers/departments identified on this worksheet, not all of the cost centers listed apply to all providers using these forms. For example, IPPS providers may contain a Burn Intensive Care Unit, where CAHs may not furnish this type of service.*

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WORKSHEET A

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- Worksheet A typically includes all the expenses reflected on the hospital's general ledger
- This often includes items not directly related to short-term acute patient care
  - Subproviders (psych, rehab)
  - Other "hospital-based" provider types
    + SNF
    + RHC
    + Other clinics
    + Home Health
    + Hospice
    + Ambulatory Surgical Center

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WORKSHEET A

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- “Freestanding” providers, such as a physician clinic
- Physician salaries or professional fees
- Other non-reimbursable operations
    + Gift shop
    + Medical office building
    + Foundation
- Typically, a hospital will need to reconcile the costs & charges per the cost report to its audited financials
- Costs are separated between salaries & all other

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WORKSHEET A

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All expenses are initially grouped to a specific cost report line or cost center

- Grouping may be based on department function – for example, all expenses from the OR department grouped to line 50 Operating Room
- Grouping may also be based in part on function – for example, all laundry expense account items to line 8 Laundry & Linen Service regardless of department

Standard cost centers are reflected on the cost report, additional cost centers may also be added if necessary & typically are subscripted line numbers following a related cost center – for example line 73.01 OP Pharmacy

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WORKSHEET A

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Cost centers are sub-grouped by category

Lines 1–23 // General Service Cost Centers

"Overhead" costs that will be allocated by the cost report to remaining cost centers

Lines 30–46 // Inpatient Routine Service Cost Centers

"Room & Board"

Lines 50–76 // Ancillary Service Cost Centers

Lines 88-93 // Outpatient Service Cost Centers

Lines 94-101 // Other Reimbursable Cost Centers

Lines 105–117 // Special Purpose Cost Centers

Lines 190–194 // Non-reimbursable Cost Centers

Lines have been skipped by CMS between categories for future use

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WORKSHEET A

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Guidance on exactly where to group expenses varies

- Significant detail in the cost report instructions for lines 1 & 2 Capital Related Costs
- Typically guidance is provided when a new standard cost center is introduced, for example CMS specified line 72 Implantable Devices should reflect activity related to revenue codes 275, 276, 278, & 624
- Other cost centers are less clearly defined & lead to differences between hospitals – for example lines 54 & 55 Radiology-Diagnostic & Radiology-Therapeutic

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WORKSHEET A

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- The primary key – consistency throughout the cost report between costs, gross charges, & program charges
- Changing groupings from year to year can lead to scrutiny during the audit process (especially for cost-based reimbursement)

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COST REPORT WORKSHEET A-6

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WORKSHEET A-6

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This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. For each reclassification adjustment, assign an alpha character in column 1 to identify each reclassification entry, e.g., *A, B, C. DO NOT USE NUMERIC DESIGNATIONS. All reclassification entries must have a corresponding Worksheet A line number reference in columns 3 and 7. In column 10, indicate the column of Worksheet A-7 impacted by the reclassification, where applicable.*

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WORKSHEET A-6

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- Typically used to reclass costs that are embedded in various departments that are grouped on Worksheet A based on their department, but are more appropriate in another cost center on the cost report

  + Common examples – depreciation, laundry, chargeable medical supplies & drugs

- Also commonly used to split functions that apply to multiple cost centers – for example radiology admin might apply to radiology & CT scan lines

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WORKSHEET A-6

Radiology Director Salary Expense	$ 80,000	
Grouped on Line 54		
Patient Revenues:		
CT Scan	$ 2,000,000	20%
MRI	$ 1,000,000	10%
All other Radiology	$ 7,000,000	70%
	$ 10,000,000	
A-6 Reclass		
Increase Line 57 CT Scan	$ 16,000	Salary
Increase Line 58 MRI	$ 8,000	Salary
Decrease Line 54	$ (24,000)	Salary

When we make a reclass involving Salary, need to ensure that hours are also reclassified as well as B-1 statistics related to reclassifications.

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WORKSHEET A-6

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If there is a reclass to or from capital (lines 1 & 2) you must specify the type of capital:

09 // Depreciation

10 // Lease

11 // Interest

12 // Insurance

13 // Taxes

14 // Other

This also applies to A-8 adjustments. These categories correspond with Worksheet A-7 Reconciliation of Capital Cost Centers.

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COST REPORT WORKSHEET A-8

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WORKSHEET A-8

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WORKSHEET A-8 – ADJUSTMENTS TO EXPENSES

...

In accordance with (regulations) if your operating costs include amounts not related to patient care, these amounts are not reimbursable under the program. If your operating costs include amounts flowing from the provision of luxury items or services, i.e., *those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services, such amounts are not allowable.*

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WORKSHEET A-8

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WORKSHEET A-8 – ADJUSTMENTS TO EXPENSES

...

This worksheet provides for the adjustments in support of those listed on Worksheet A, column 6. These adjustments, required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any work papers used to compute a cost adjustment.

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WORKSHEET A-8

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WORKSHEET A-8 – ADJUSTMENTS TO EXPENSES

...

Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost or "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

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WORKSHEET A-8

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WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

...

Types of adjustments entered on this worksheet include (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, etc.; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on Worksheet A-8.

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WORKSHEET A-8

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- Unfortunately, there is not one all-inclusive source for what should or should not be adjusted on A-8
- Allowable cost rules can be complicated; however, there are some general concepts that usually apply:
  - + Prudent & reasonable
  - + Related to patient care
  - + Amount actually paid

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WORKSHEET A-8

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Common adjustments (not an all-inclusive list!):

- Interest expense
- Patient phones & TV
- Contributions & donations
- Marketing & advertising
    - Public awareness generally is allowable, patient solicitation generally is not
- Industry dues for portion related to lobbying
- Certain legal expenses
- Non-operating income

It may be appropriate to reclass certain departments to a non-allowable cost center instead of adjusting on A-8

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WORKSHEET A-8

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Interest expense is typically allowable unless:

- Paid to related party
- Borrowing is unnecessary
- Borrowing is for activity not related to patient care
- Borrowing incurred in making repayments to Medicare program
- Generally reduced to extent of interest income

Board-designated funded depreciation may be a strategy to prevent interest expense from being disallowed

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WORKSHEET A-8

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State provider taxes

- In place in most states, under various program names
- Common purpose is to access additional federal funds
- Hospitals pay tax but receive funding in return – typically aggregate funding > aggregate taxes paid, but in some cases individual hospitals may have a net shortfall
- CMS contends funding received by a hospital should usually be offset against allowable tax expense
  - + Numerous court cases in CMS favor
  - + June 15, 2016 U.S. District Court in Louisville ruled in favor of CMS against group of Kentucky providers
- New line on cost report – S-2 Part I line 122:

  Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If the answer in column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.

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COST REPORT WORKSHEET A-8-1

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WORKSHEET A-8-1

This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to you or costs associated with the home office. In addition, it shows certain information concerning the related organizations with which you have transacted business as well as home office costs.

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WORKSHEET A-8-1

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Part A *// Cost applicable to home office costs, services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost* ***at the cost to the related organizations.*** *However, such cost* ***must not exceed the amount a prudent and cost conscious buyer pays*** *for comparable services, facilities, or supplies that are purchased elsewhere.*

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WORKSHEET A-8-1

***Part B** // Use this part to show your relationship to organizations for which transactions were identified in Part A. Show the requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in CMS Pub. 15-1, chapter 10 in columns 1 through 6, as appropriate.*

Complete only those columns which are pertinent to the type of relationship which exists.

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HOME OFFICE COST REPORT

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HOME OFFICE COST REPORT

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“Chain Operations”

- Medicare defines as “… *a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization*.”
- *The home office of a chain organization is not in itself certified by Medicare. Therefore, its costs may not be directly reimbursed by Medicare.*
- *The relationship of the home office to Medicare is that of a related organization to participating providers.*

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HOME OFFICE COST REPORT

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“Chain Operations” (cont.)

- Reasonable costs for services related to patient care provided by the home office can be included in the provider’s cost report
- Typically the Home Office Cost Statement (287-22) is used to determine allowable costs to be allocated to chain providers
- Generally management fees charged by a chain organization are not allowable costs for the provider
- Typically hospital cost report worksheet A-8-1 is used to adjust for home office costs
    + Management fees are removed
    + Reasonable costs for services related to patient care are added in

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HOME OFFICE COST REPORT

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“Chain Operations” (cont.)

- Costs that are not allowable when incurred directly by the provider are not allowable as home office cost to be allocated
- Chain organizational & startup costs are typically allowable & must be amortized per regulations
- Costs related to an acquisition are typically not allowable, including interest expense
- Home office interest expense related to patient care may be allowable
- Interest expense related to loans between chain components is typically not allowable
- Interest income earned by the home office must be taken into consideration when determining allowable interest expense for chain providers

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HOME OFFICE COST REPORT

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Home Office Cost Statement (287-22)

- Form used for allocating home office costs to chain components
- Home Office Cost Report forms were recently revised & will be used for cost reporting period beginning on or after October 1, 2022
  - + Alternative reporting formats may be used, subject to approval
  - + Must furnish at least the applicable information from 287-22 & following the same allocation methodologies
  - + Request must be submitted at least 90 days prior to year-end
- If a home office fails to file a home office cost statement, its providers are not allowed to claim home office costs
- If a chain has distinct regional offices, the chain may have one home office cost statement allocated to regional offices, which in turn have cost statements to allocate to its providers

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HOME OFFICE COST REPORT

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Home Office Cost Statement (287-22) (cont.)

- Allocation methods:
  - + Direct
  - + Functional
  - + Pooled

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COST REPORT WORKSHEET A-8-2

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WORKSHEET A-8-2

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In accordance with (regulations), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider or which represent availability services in a hospital emergency room under specified conditions. (See 42 CFR 415.150 and 42 CFR 415.164 for an exception for teaching physicians under certain circumstances.) 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

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WORKSHEET A-8-2

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Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report …

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WORKSHEET A-8-2

This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis. Enter the total provider-based physician adjustment for personal care services and RCE limitations applicable to the compensation of provider-based physicians directly assigned to or reclassified to general service cost centers.

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WORKSHEET A-8-2

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RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., *controller. RCE limits also do not apply to CAHs, however the professional component must still be removed on this worksheet. CAHs need only complete columns 1 through 5 and 18. Transfer for CAHs the amount from column 4 to column 18.*

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WORKSHEET A-8-2

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NOTE: The adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 4 through 41, 43, 50 through 76, 90 through 99, 105 through 111, and 115, and subscripts as allowed.

Important to note that adjustments should not be made to nonreimbursable cost centers including freestanding clinics

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WORKSHEET A-8-2

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- In general, costs related to physician patient care billed under Part B professional should be removed from the cost report

- Costs related to hospital administrative functions performed by a physician may be allowable, but generally the salary or contract cost should be supported by the related hours worked by the physician

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WORKSHEET A-8-2

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Column 3 *// Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish a physician in return for the physician's services.*

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WORKSHEET A-8-2

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Column 4 // *Enter the amount of total remuneration included in column 3 applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B contractor …*

Column 5 // *Enter the amount of the total remuneration included in column 3, for each cost center, applicable to general services to you (provider component).*

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WORKSHEET A-8-2

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Column 6 *// For each line of data, enter the RCE limit applicable to the physician's compensation included in that cost center. Obtain the RCE limit from the applicable chart in the Federal Register as listed below. If the physician specialty is not identified in the chart, use the RCE for the "Total" category (from the same chart).*

Final CY 2015 RCE Limits	
Total	$211,500
Final CY 2015 RCE Limits	
General/Family Practice	$179,000
Internal Medicine	$197,500
Surgery	$246,400
Pediatrics	$169,700
OB/GYN	$237,100
Radiology	$271,900
Psychiatry	$181,300
Anesthesiology	$239,400
Pathology	$260,300

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WORKSHEET A-8-2

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Column 7 *// Enter for each line of data the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column …* ***Time records or other documentation that supports this allocation must be available for verification by your contractor upon request.*** (see next slide for time study requirements)

Column 8 *// Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.*

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WORKSHEET A-8-2

Time study requirements from PRM 15-1 2313.2 E:

Periodic Time Studies.--Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria:

1. The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.

2. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

3. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

4. The weeks selected must be equally distributed among the months in the cost reporting period, *e.g.*, for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the second week beginning in the month, 3 weeks the third, and 3 weeks the fourth.

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WORKSHEET A-8-2

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Time study requirements from PRM 15-1 2313.2 E (cont.):

5. No two consecutive months may use the same week for the study, *e.g.*, if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

6. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

7. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.

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WORKSHEET A-8-2

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***Column 9** // Enter for each line of data five percent of the amounts entered in column 8.*

***Column 12** // You may adjust upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by you.*

***Column 14** // You may also adjust upward the computed RCE limit in column 8 to reflect the actual malpractice expense incurred by you for the services of a physician or group of physicians to your patients.*

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WORKSHEET A-8-2

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Column 18 *// The adjustment for each cost center entered represents the PBP elimination from costs entered on Worksheet A-8, column 2, line 10 and on Worksheet A, column 6 to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.*

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COST REPORT WORKSHEET A-7

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WORKSHEET A-7

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Part I // Analysis of Changes in Capital Asset Balances.

Part II // Reconciliation of amounts from worksheet A, column 2, lines 1 and 2.

Part III // Reconciliation of Capital Cost Centers.

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WORKSHEET A-7

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The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

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WORKSHEET A-7

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The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs.

…

NOTE: Part III, column 1, line 3, must agree with the sum of Part I, column 6, line 8.

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COST REPORT WORKSHEETS B PART I & B-1

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WORKSHEET B PART I

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Worksheet B, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within your organization, other general service cost centers, inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, other reimbursable cost centers, special purpose cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 7.

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WORKSHEET B-1

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I. To facilitate the allocation process, the general format of Worksheets B, Part I, and B-1 is identical. Each general service cost center has the same line number as its respective column number across the top. Also, the column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each routine service, ancillary outpatient service, other reimbursable, special purpose, and nonreimbursable cost center are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheet A. If you have subscripted any lines on Worksheet A, subscript the same lines on these worksheets.

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WORKSHEETS B PART I & B-1

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- The main purpose of the B series is to completely allocate the general service cost centers' allowable costs (Worksheet A, column 7, lines 1-23) to the remaining cost centers on the cost report (routine, ancillary, nonallowable, etc.)
- The statistical data that is the bases for the allocation calculations is entered on B-1
  + There should be a logical correlation between the statistical basis & the expense it is used for – for example square footage correlates to building depreciation but not to employee benefits
- The cost report software does the allocation calculations on B Part I
- The cost report uses a step-down allocation methodology

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WORKSHEETS B PART I & B-1

Basic Example

	Worksheet A // Column 7
GENERAL SERVICE COST CENTERS	
Building Deprecation	$200,000
Admin & General	$300,000
Medical Records	$400,000
OTHER COST CENTERS:	
Adults & Peds	$600,000
Lab	$700,000
Gift Shop	$100,000
	$ 2,300,000

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WORKSHEETS B PART I & B-1

	Square Feet (Enter on B-1)
GENERAL SERVICE COST CENTERS	
Building Deprecation	
Admin & General	5,000
Medical Records	1,000
OTHER COST CENTERS	
Adults & Peds	2,000
Lab	1,000
Gift Shop	1,000
	10,000

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WORKSHEETS B PART I & B-1

	Square Feet (Enter on B-1)		Allocation of Building Deprecation (B Part I Calculation)
GENERAL SERVICE COST CENTERS			
Building Deprecation			
Admin & General	5,000	50%	$100,000
Medical Records	1,000	10%	$20,000
OTHER COST CENTERS			
Adults & Peds	2,000	20%	$40,000
Lab	1,000	10%	$20,000
Gift Shop	1,000	10%	$20,000
	10,000		$200,000

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WORKSHEETS B PART I & B-1

	Worksheet A Column 7	Allocation of Building Depreciation	Carried Forward
GENERAL SERVICE COST CENTERS			
Building Deprecation	$200,000	$(200,000)	-
Admin & General	$300,000	$100,000	$400,000
Medical Records	$400,000	$20,000	420,000
OTHER COST CENTERS			
Adults & Peds	$600,000	$40,000	$640,000
Lab	$700,000	$20,000	$720,000
Gift Shop	$100,000	$20,000	$120,000
	$2,300,000	-	$2,300,000

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WORKSHEETS B PART I & B-1

	Accumulated Costs (Automatic on B-1)
GENERAL SERVICE COST CENTERS	
Building Deprecation	
Admin & General	
Medical Records	$420,000
OTHER COST CENTERS	
Adults & Peds	$640,000
Lab	$720,000
Gift Shop	$120,000
	$1,900,000

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WORKSHEETS B PART I & B-1

	Accumulated Cost (Automatic on B-1)		Allocation of Admin & General (B Part I Calculation)
GENERAL SERVICE COST CENTERS			
Building Deprecation			-
Admin & General			
Medical Records	$420,000	22%	$88,421
OTHER COST CENTERS			
Adults & Peds	$640,000	34%	$134,737
Lab	$720,000	38%	$152,579
Gift Shop	$120,000	6%	$25,263
	$1,900,000		$400,000

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WORKSHEETS B PART I & B-1

	Worksheet A Column 7	Allocation of Building Depreciation	Allocation of Admin & General	Carried Forward
GENERAL SERVICE COST CENTERS				
Building Deprecation	$200,000	$(200,000)		-
Admin & General	$300,000	$100,000	$(400,000)	-
Medical Records	$400,000	$20,000	$88,421	$508,421
OTHER COST CENTERS				
Adults & Peds	$600,000	$40,000	$134,737	$774,737
Lab	$700,000	$20,000	$151, 579	$871,579
Gift Shop	$100,000	$20,000	$25,263	$145,263
	$2,300,000	-	-	$2,300,000

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WORKSHEETS B PART I & B-1

	Patient Revenues (Enter on B-1)
GENERAL SERVICE COST CENTERS	
Building Deprecation	
Admin & General	
Medical Records	
OTHER COST CENTERS	
Adults & Peds	$7,000,000
Lab	$3,000,000
Gift Shop	-
	$10,000,000

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WORKSHEETS B PART I & B-1

Patient Revenues (Enter on B-1)			Allocation of Medical Records (B Part I Calculation)
GENERAL SERVICE COST CENTERS			
Building Deprecation			
Admin & General			
Medical Records			
OTHER COST CENTERS			
Adults & Peds	$7,00,000	70%	$355,895
Lab	$3,00,000	30%	$152,526
Gift Shop	-	0%	-
	$10,000,000		$508,421

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WORKSHEETS B PART I & B-1

	Worksheet A Column 7	Allocation of Building Depreciation	Allocation of Admin & General	Allocation of Medical Records	Carried Forward
GENERAL SERVICE COST CENTERS					
Building Deprecation	$200,000	$(200,000)			-
Admin & General	$300,000	$100,000	$(400,000)		-
Medical Records	$400,000	$20,000	$88,421	$(508,421)	-
OTHER COST CENTERS					
Adults & Peds	$600,000	$40,000	$134,737	$355,895	$1,130,632
Lab	$700,000	$20,000	$151, 579	$152,526	$1,024,105
Gift Shop	$100,000	$20,000	$25,263	-	$145,263
	$2,300,000	-	-	-	$2,300,000

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WORKSHEETS B PART I & B-1

Providers must request & be approved for a change in allocation basis

*The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, **90 days prior to the end of that reporting period**. The contractor has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. **The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics.** If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. **The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.***

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WORKSHEETS B PART I & B-1

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- Consider the impact before requesting a change – typically the only way to determine is to return cost report with new stat
- Consider the ease of collecting & maintaining statistic
  + For example, patient revenue is a much easier statistic to track than a time study

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WORKSHEETS B PART I & B-1

Consider appropriateness of directly assigning certain expenses instead of allocating

EXAMPLE:

	Square Footage		Deprecation Expense
Hospital	20,000	67%	1,000,000
Nonallowable MOB	10,000	33%	200,000
	30,000		1,200,000
If MOB depreciation is grouped on line 1:			
Total allocation to hospital	800,000		
Total allocation to MOB	400,000		

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WORKSHEETS B PART I & B-1

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Fragmenting A&G

- Break down A&G into multiple cost centers, with different allocation bases
  - + Examples:
    - > Telecommunications - # of phones
    - > IT - # of computers
- May be difficult to receive approval to undo
- May provide significant benefit for CAHs or other cost-based providers

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COST REPORT WORKSHEET C

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WORKSHEET C

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This worksheet computes the ratio of cost to charges for inpatient services, ancillary services, outpatient services, and other reimbursable services.

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WORKSHEET C

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Columns 6 and 7--Enter on each cost center line the total inpatient and outpatient gross patient charges including charges for charity care patients and, where applicable, standard customary charges for items reimbursed on a fee schedule, e.g., *DME, oxygen, prosthetics, and orthotics. Also include the total inpatient and outpatient gross charges for cost centers which have a credit balance on Worksheet B, Part I, Column 26 and, therefore, do not contain "cost" in Column 1 of Worksheet C, Part I.*

Total charges on Worksheet C, Part I, for each department are for provider services only. Therefore, Medicare charges on Worksheets D, Parts II and IV, D-2, D-3, and D-4 must also include provider services only.

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WORKSHEET C

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- **Starting point is gross patient revenue from GL**
- **Do not include any non-operating/other revenue**
- **Always check cost to charge ratio for reasonableness**
- **Reclasses & adjustments are made to determine net amounts for Worksheet C**
    - Should only reflect hospital activity – Part B professional charges must be excluded
    - Cost center groupings should be consistent with Worksheet A – for example if medical supplies costs are all reclassed to line 71 then the same must be done with medical supplies charges

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MEDICARE PAYMENT METHODOLOGIES

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MEDICARE PAYMENT METHODOLOGIES

From the CMS website:

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

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MEDICARE PAYMENT METHODOLOGIES

- **Every hospital is designated as Urban or Rural for Medicare reimbursement purposes**
- **Important consideration for certain payment factors & in determining eligibility for certain special designations**
- **In general, metro areas with populations > 50,000 (based on Census data & Office Of Management & Budget determinations) are urban, all other areas are rural**
  - + Updated based on 2010 Census effective in FFY 2015
  - + Results of 2020 Census expected to be effective in FFY 2025

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MEDICARE PAYMENT METHODOLOGIES

Generally, a PPS payment is determined by:

Standardized payment amount

x

Adjustment to account for differences in labor costs

x

Adjustment to account for amount of resources required to treat patient

x

Adjustments specific to particular payment methodologies (for example, psych PPS takes into account the patient's age)

=

Prospective payment

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MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient Prospective Payment System (IPPS)

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

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MEDICARE PAYMENT METHODOLOGIES

	Boston CBSA	Rural AL
OPERATING		
Labor-Related Portion	4,392.49	4,028.62
x Wage Index	1.2425	0.7121
Adjusted Labor-Related Portion	5,457.67	2,868.78
+ Nonlabor-Related Portion	2,105.28	2,469.15
Wage Adjusted Base Operating Rate	7,562.95	5,337.93
Hospital-Specific Readmissions Adj. Factor	0.9998	0.9998
Readmissions Adjustment	(1.51)	(1.07)
	7,561.44	5,336.86
Hospital-Specific VBP Adjustment Factor	0.9955555555	0.9955555555
VBP Adjustment	(33.61)	(23.72)
	7,527.83	5,313.14
DSH Add-on Percentage	3%	3%
DSH Add-on	225.83	159.39
Adjusted Operating Base Rate	7,753.66	5,472.53

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MEDICARE PAYMENT METHODOLOGIES

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

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MEDICARE PAYMENT METHODOLOGIES

	Boston CBSA	Rural AL
Adjusted Capital Base Rate	618.50	399.29
Adjusted Operating Base Rate	7,753.66	5,472.53
Total Adjusted Base Rate	8,372.16	5,871.82
MS-DRG 244 Relative Weight	1.8295	1.8295
Medicare Payment	15,316.87	10,742.49

4,574.38 Difference

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

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MEDICARE PAYMENT METHODOLOGIES

FY 2024 FINAL Tables 1A-1E

TABLE 1A. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

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

TABLE 1B. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

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

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TABLE 1D. - CAPITAL STANDARD FEDERAL PAYMENT RATE	
	Rate
National	$503.83

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Table 3- WAGE INDEX TABLE BY CBSA - FY 2024 (CONTAINS THE FOLLOWING DATA: AVERAGE HOURLY WAGE, WAGE INDEXES AND THE GAF. ALSO INCLUDES WAGE INDEXES PRIOR TO APPLICATION OF THE FRONTIER WAGE INDEX AND/OR RURAL FLOOR AS WELL AS AN INDICATOR FOR CBSAs ELIGIBLE FOR THE FRONTIER AND/OR RURAL FLOOR WAGE INDEX)- FY 2024 CORRECTION NOTICE			
CBSA	**Area Name**	**Wage Index**	**GAF**
01	ALABAMA	0.7121	0.7925
14454	Boston, MA	1.2425	1.1603

- Does not reflect Quartile Adjustment for FY 20 - 24

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Table 15: FY 2024 Hospital Readmissions Reduction Program Payment Adjustment Factors*	
Hospital CMS Certification Number (CCN)	FY 2024 Payment Adjustment Factor
010001	0.9961
010005	1.0000
010006	0.9902
010007	0.9984
010008	1.0000
010011	0.9935
010012	0.9989
010016	0.9947
010019	0.9983

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TABLE 16A.—UPDATED PROXY HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM ADJUSTMENT FACTORS FOR FY	
CMS Certification Number (CCN)	Proxy FY 2024 Hospital VBP Adjustment Factor
010001	0.9924189351
010005	0.9965733119
010006	0.9943635370
010007	0.9896051550
010011	0.9937227023
010012	0.9929050856
010016	0.9983632296
010019	1.0007276888
010021	1.0035120052

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TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2024 Final Rule									
MS-DRG	FY 2024 Final Post-Acute DRG	FY 2024 Final Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights - Before Cap	Weights - 10% Cap Applied	Geometric mean LOS	Arithmetic mean LOS
244	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT CC/MCC	1.8295	1.8295	2.1	2.4

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- VBP & RRP adjustments are applied only to operating DRG
- HAC Reduction Adjustment is applied to entire IP payment

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MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient PPS

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

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Hospital Inpatient PPS

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

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Hospital Inpatient PPS

- Outlier Payment
  - + Payment (in addition to the standard DRG payment) designed to protect a hospital from “unusually expensive cases”
  - + Only applies when hospital’s costs for a specific patient significantly exceeds DRG payment
  - + Calculation utilizes hospital specific cost-to-charge ratios based on their most recent settled cost report

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Inpatient PPS

- Outlier Payment Calculation – Four Steps
  - + Determine the operating & capital DRG payments for the case
  - + Determine the hospital's operating & capital costs for the case
  - + Determine the applicable operating & capital outlier thresholds
  - + Determine the total outlier payment for the case

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Hospital Inpatient PPS

- Outlier Payment Calculation Example

  Medicare Patient John Doe's case resulted in an operating DRG payment of $10,000 and a capital DRG payment of $1,000. Due to complications, Mr. Doe was in the hospital for two weeks, and total hospital covered charges were $150,000. The hospital's operating CCR is .50 and its capital CCR is .06. The hospital's wage index is .90000.

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Inpatient PPS

- Outlier Payment Calculation Example

  + **Step 1 – Determine the operating & capital DRG payments for the case:**

    Operating DRG payment = $10,000

    Capital DRG payment = $1,000

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Hospital Inpatient PPS

- Outlier Payment Calculation Example
  - **Step 2 – Determine the hospital's operating & capital costs for the case:**

Operating costs = Total charges of $150,000 x operating CCR of .50 = $75,000

Capital costs = Total charges of $150,000 x capital CCR of .06 = $9,000

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Inpatient PPS

- Outlier Payment Calculation Example
  - **Step 3 – Determine the applicable operating & capital outlier thresholds**

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MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient PPS

- Outlier Payment Calculation Example
  - + **Step 3 continued:**

FY 2022 Fixed Loss Threshold	30,988.00
Operating Portion (Op. CCR/Total CCR) (.50/.56)	89.3%
	27,667.86
Labor-related Share	62%
	17,154.07
Wage Index	0.9000
	15,438.66
Nonlabor-related Share	10,513.79
	25,952.45
Operating DRG Payment	10,000.00
Operating Outlier Threshold	35,952.45

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MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient PPS

- Outlier Payment Calculation Example
  - + **Step 3 continued:**

FY 2022 Fixed Loss Threshold	30,988.00
Capital Portion (Capital CCR/Total CCR) (.06/.56)	10.7%
	3,320.14
Geographic Adjustment Factor	0.9304
	3,089.03
Capital DRG Payment	1,000.00
Capital Outlier Threshold	4,089.03

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MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient PPS

- Outlier Payment Calculation Example
  - **Step 4 – Determine the total outlier payment for the case:**

	Operating	Capital	Total
Total Costs	75,000.00	9,000.00	
Less Outlier Threshold	35,952.45	4,089.03	
	39,047.55	4,910.97	
Marginal Cost Factor	80%	80%	
Outlier Payment	31,238.04	3,928.78	35,166.82
DRG Payment	10,000.00	1,000.00	11,000.00
Total Payment	41,238.04	4,928.78	46,166.82

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Inpatient PPS

- Outlier Payment
  - + Outlier payments are subject to reconciliation
    - > if actual CCR is >10 points different that CCR used in determining payments, & total outlier payments for the year are >$500,000
    - > Effective August 8, 2003 but little activity until December 2010
    - > Inpatient Operating CCR calculation:

$$\frac{\text{Medicare inpatient operating costs from Worksheet D-1 Part II, Line 53 (less positive amount from line 42 if applicable)}}{\text{Total Medicare inpatient charges (routine and ancillary) from Worksheet D-4 (2552-96) or D-3 (2551-10)}}$$

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MEDICARE PAYMENT METHODOLOGIES

Hospital Inpatient PPS

- Payment for Transfer Patients (Transfer DRGs)
  - + Generally applies to patients who transfer to another inpatient PPS hospital, or to a post-acute setting such as a skilled nursing facility or inpatient rehab, & the patient was assigned a qualifying MS-DRG (list updated annually)
  - + Generally, payment = Full MS-DRG Payment/ Average LOS for MS-DRG x (number of days + 1), up to amount of full MS-DRG payment
  - + It is possible that CMS will make reduced payment but patient does not end up in post-acute setting – hospitals should assess opportunity to submit claim for additional payments in these situations

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Hospital Inpatient PPS

- New Technology Add-on
  - + Payment (in addition to the standard MS-DRG payment) intended to account for specific new medical services & technologies whose impact is not reflected in current MS-DRG relative weights
  - + List of qualifying new technologies updated annually
  - + In general, if a hospital's cost of a case involving a qualifying new technology > standard MS-DRG payment, add-on payment = 50% of difference

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MEDICARE PAYMENT METHODOLOGIES

	IPPS	OPPS	IRF PPS	IPF PPS
Fiscal Year	10/1 – 9/30	1/1/ - 12/31	10/1 – 9/30	10/1 - 9/30 (was 7/1 – 6/30)
Standardized Payment Amount	Operating & Capital Standard Rates	OPPS Conversion Factor	Standard Payment Conversion Factor	Federal Per Diem Base Rate
Adjust for Labor Costs	Wage Index Potential for Geo Reclass		Wage Index No Geo Reclass	
Adjust for Resources	MS-DRG Relative Weight	APC Relative Weight	Case-Mix Group Relative Weight	DRG Relative Weight
Other Potential Factors	DSH, IME add-ons	SCH 7.1% add-on	LIP add-on	Patient Age, LOS, Comorbidities, ECT

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Outpatient Prospective Payment System (OPPS)

- Covers most Medicare Part B services provided to hospital outpatients, & Part B services provided to hospital inpatients with Part B, but not Part A, coverage
- Other Payment Factors
  - + Outlier Payment
  - + Transitional Outpatient Payment (TOPs)
  - + Adjustment for Sole Community Hospitals

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Outpatient PPS

- Outlier Payment
  - + Same theory as inpatient outlier – additional payment intended to protect hospital from unusually expensive encounters
  - + Only applies to a small percentage of encounters, when hospital's cost exceeds specified threshold
  - + Calculation utilizes hospital's outpatient cost-to-charge ratio based on its most recent settled cost report
  - + Outlier reconciliation effective for cost report periods beginning on or after 1/1/2009

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Outpatient PPS

- Transitional Outpatient Payments (TOPs)
  - + Additional “hold harmless” payment originally intended to ensure payments under OPPS were not less than what would have been paid pre-OPPS
    - > Was only paid at 85% in recent years
  - + Provision has now expired for IPPS hospitals:
    - > Expired 12/31/12 for rural hospitals with < 100 beds
    - > Expired 2/29/12 for Sole Community Hospitals (SCH)
  - + Still available to TEFRA hospitals

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Outpatient PPS

- Adjustment for Rural Sole Community Hospitals (SCHs)
  - + Since FY 2006 rural SCHs receive a 7.1% add-on for most services paid under OPPS
  - + Intended to account for differences in APC payments between urban & rural hospitals
  - + This additional payment is at the discretion of CMS from year to year – amount not mandated by current law

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MEDICARE PAYMENT METHODOLOGIES

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Hospital Outpatient PPS

- Most outpatient services not paid under OPPS are paid under separate fee schedules
- Examples
  - + Physician & certain other professional services
  - + Clinical diagnostic lab services
  - + Therapy services (PT, OT, & ST)

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MEDICARE PAYMENT METHODOLOGIES

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Inpatient Rehabilitation Facility (IRF) Prospective Payment System

- Payment system similar to IPPS
- Low-Income Percentage (LIP) adjustment – similar to IPPS DSH
- 60 Percent Rule
  - + Regulations require a certain percentage of patients to be treated for 1 of 13 specified medical conditions in order to qualify as a rehab facility & be paid under IRF PPS instead of IPPS
  - + Original provision was a minimum 75%
  - + Congress reduced to 60%
  - + There have been proposals to return to 75%

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MEDICARE PAYMENT METHODOLOGIES

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Inpatient Psychiatric Facility (IPF) Prospective Payment System

- Elements of IPF PPS Payment
  - + Federal Per Diem Base Rate
  - + Wage Index
  - + Rural versus urban
  - + Teaching hospital
  - + Full-service ED
  - + Patient age
  - + Length of stay
  - + DRG relative weight
  - + Existence of comorbidities
  - + Electroconvulsive Therapy (ECT) occurrences

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MEDICARE SPECIAL DESIGNATIONS

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Medicare Special Designations

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

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SECTION 401 HOSPITALS

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- Section 401 of the *Balanced Budget Refinement Act of 1999* allows urban hospitals meeting specific conditions to elect to be redesignated as rural for Medicare payment purposes

  §412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.
- Most common reason is to qualify as SCH, RRC or CAH
- Prior to 2016 regulations prevented Section 401 hospitals from also receiving a wage index geographic reclassification
- In April 2016 CMS withdrew prohibition of 401 hospitals also having a geo reclass after two separate courts ruled that Congress never gave CMS that authority

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SECTION 401 HOSPITALS

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Number of Section 401 hospitals at time of Final Rule:

FY 2016	64
FY 2017	72
FY 2018	166
FY 2019	266
FY 2020	346
FY 2021	467
FY 2022	532
FY 2023	615
FY 2024	**659 (26.7% of all geographically urban PPS hospitals)**

Including hospitals in New York City, Los Angeles, Chicago, Miami, & Detroit

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SECTION 401 HOSPITALS

New York-Presbyterian Hospital
Manhattan NY
2,300+ beds
Rural hospital

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SECTION 401 HOSPITALS

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- Why become a Section 401 hospital?
  - + 30% add-on to IME 1996 cap
  - + Ability to grow additional IME cap space for new programs
  - + Benefits from RRC &/or SCH status
    - > Geo reclass
    - > 340B
- Potential downsides of Section 401 status
  - + Rural wage index unless/until geo reclass is in place or effective
  - ~~+ No Capital DSH for any rural hospital~~
    - + Effective 10/1/23 Section 401 hospitals now receive Capital DSH
  - + Operating DSH capped at 12% unless >500 acute beds or RRC or MDH status

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SOLE COMMUNITY HOSPITAL (SCH)

Eligibility Criteria

- Located at least 35 miles from a like hospital, or
- Located in a rural area, is between 25 & 35 miles from a like hospital, & meets one of the following criteria:
  - + No more that 25% of all IP or 25% of Medicare IP in its service area may be admitted to other like hospitals within 35 miles or its service area if larger.
  - + It must have fewer than 50 beds & would have met the above criteria, except that some patients had to seek care outside the service area due to unavailability of necessary specialty services.
  - + Nearby like hospitals are inaccessible for at least 30 days in 2 out of 3 years because of local topography or severe weather.
- Located in a rural area & is between 15 & 25 miles from a like hospital, but because of local topography or periods of prolonged severe weather conditions, nearby like hospitals are inaccessible for at least 30 days in 2 out of 3 years.

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SOLE COMMUNITY HOSPITAL (SCH)

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Eligibility Criteria (cont.)

- Because of distance, posted speed limits & predictable weather conditions, the travel time between the hospital & the nearest like hospital must be at least 45 minutes.
- If a hospital's circumstances change & it no longer meets eligibility requirements, SCH status is/should be lost
- CMS expects hospitals to self-report changes in circumstances it should be aware of, such as another like hospital opening nearby
- If the hospital does not self-report for changes it should be aware of, & CMS later determines that the hospital no longer qualifies, removal of SCH status can be applied retroactively to the date of the change in circumstances
- CMS has also clarified that if a hospital never should have qualified for SCH status in the first place, SCH status is/should be lost

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SOLE COMMUNITY HOSPITAL (SCH)

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Benefits

- For Medicare IP services, paid the highest of:
  - + The federal rate applicable to the hospital,
  - + Adjusted/updated hospital-specific rate based on
    - > FY 1982,
    - > FY 1987,
    - > FY 1996, or
    - > FY 2006 costs per discharge
- Currently rural SCHs receive additional 7.1% above standard Outpatient PPS payment rates on most services

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SOLE COMMUNITY HOSPITAL (SCH)

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Benefits (cont.)

- Rural SCHs exempt from reduced Medicare payments for 340B drugs effective 1/1/18
- PPACA allows SCHs & RRCs to qualify for 340B with 8% DSH instead of 11.75%
  - Not eligible for 340B pricing for Orphan Drugs
- If applying for geographic reclassification, an SCH does not have to be within 35 miles of the area for which reclassification is sought, as usually required

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MEDICARE-DEPENDENT HOSPITAL (MDH)

Eligibility Criteria

- The Consolidated Appropriations Act of 2023 extended MDH provisions through FY 2024
  - Provision has expired several times only to be reinstated retroactively by Congress
- Hospital must be located in a rural area
- Hospital must not have more than 100 beds
- Hospital can not also be classified as a SCH
- Hospital has at least 60% Medicare for inpatient days or discharges during one of the following:
  - FY 1987, or
  - 2 out of 3 most recent settled cost reports

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MEDICARE-DEPENDENT HOSPITAL (MDH)

Benefits

- For Medicare IP services, paid the highest of:
  - + The federal rate applicable to the hospital,
  - + A blend of 25% of the federal rate & 75% of the adjusted/updated hospital-specific rate based on
    - > FY 1982,
    - > FY 1987, or
    - > FY 2002 costs per discharge
- Effective 10/1/06, MDHs no longer capped at 12% for Medicare DSH

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HOSPITAL-SPECIFIC RATE PAYMENTS

Sole Community Hospitals & Medicare-Dependent Hospitals are eligible to receive the higher of the inpatient operating federal payment or their Hospital-Specific Rate (HSR) payment

- SCH HSR is based on the highest rate from 1982, 1987, 1996, or 2006 trended forward
- MDH HSR is based on the highest rate from 1982, 1987, or 2002 trended forward
- MDH receives only 75% of the difference, if any, between the HSR & federal payment
- Federal payment comes from E Part A line 47
    + Includes DRGs, IME, DSH

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HOSPITAL-SPECIFIC RATE PAYMENTS

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Base rate is calculated from hospital's 12-month cost report that began during the eligible year

- For example, 9/30/06 or 6/30/07 cost report used to determine 2006 base rate

Rate is trended forward by applying Market Update Factor & Budget Neutrality Factor, plus other adjustments deemed necessary by CMS, to each year

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HOSPITAL-SPECIFIC RATE PAYMENTS

FY 2006 Total Program Inpatient Costs	83,500,000	D-1, II line 53
FY 2006 Medicare discharges	9,600	S-3, I column 13 line 1
FY 2006 cost per case	8,697.92	
FY 2006 Medicare CMI	1.6500	PS&R
FY 2006 Hospital-Specific Rate	5,271.46	
FY 2007 Market Update Factor	1.034	
FY 2007 SCH Budget Neutrality Factor	0.974681	
Updated FY 2007 Hospital-Specific Rate	5,312.69	
FY 2008 Market Update Factor	1.033	
FY 2008 SCH Budget Neutrality Factor	0.995743	
Updated FY 2008 Hospital-Specific Rate	5,464.64	
FY 2009 Market Update Factor	1.036	
FY 2009 SCH Budget Neutrality Factor	0.998795	
Updated FY 2009 Hospital-Specific Rate	5,654.55	

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HOSPITAL-SPECIFIC RATE PAYMENTS

Updated FY 2009 Hospital-Specific Rate	5,654.55	
FY 2009 Medicare Discharges	9,800	S-3, I column 13 line 1
FY 2009 DRG Weight	1.6800	PS&R
FY 2009 Hospital-Specific Rate Payment	93,096,508	E Part A line 48
FY 2009 Federal Payments	91,500,000	E Part A line 47
Additional Hospital-Specific Payments	1,596,508	

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VOLUME DECREASE ADJUSTMENT

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- Available to SCHs & MDHs
- Adjustment only possible if total Medicare IP operating cost, excluding passthrough costs, exceeds DRG payments, including outlier payments
- Request must be submitted within 180 days of NPR date

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VOLUME DECREASE ADJUSTMENT

Primary Eligibility Criteria:

- The provider's total discharges for the cost report period must decrease more than 5 percent compared to the preceding cost report period
- The decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital & beyond its control
    + Examples cited by CMS include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious & prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects
- Medicare IP Operating costs per the cost report must be greater than related payments received

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RURAL REFERRAL CENTER (RRC)

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Eligibility Criteria

- Must be applied for during last quarter of hospital's fiscal year
- Located in a rural area AND has 275 or more beds, OR
- The hospital reflects the following three elements
  - + At least 50% of the hospital's Medicare patients are referred from other hospitals or from physicians who are not on the staff of the hospital
  - + At least 60% of the hospital's Medicare patients live more than 25 miles from the hospital
  - + At least 60% of all services the hospital furnishes to Medicare patients are furnished to patients who live more than 25 miles from the hospital, OR

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RURAL REFERRAL CENTER (RRC)

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Eligibility Criteria (cont.)

- The hospital meets items 1 & 2 below & one of items 3, 4, or 5 below:
  1. Have a case mix index (CMI) meeting specified threshold (see next slide)
  2. Has at least 5,000 annual discharges

     (at least 3,000 if an osteopathic hospital)
  3. More than 50% of the hospital's active medical staff are specialists who meet certain conditions.
  4. At least 60% of all discharges are for inpatients who reside more than 25 miles from the hospital
  5. At least 40% of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff

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RURAL REFERRAL CENTER (RRC)

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- Eligibility Criteria (cont.)
  - Case Mix requirement per FY 2024 IPPS final rule – lower of 1.80655 (national value) or:

Region	Proposed Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.5272
2. Middle Atlantic (PA, NJ, NY)	1.5791
3. East North Central (IL, IN, MI, OH, WI)	1.6726
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7392
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.65775
6. East South Central (AL, KY, MS, TN)	1.662
7. West South Central (AR, LA, OK, TX)	1.8348
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.8582
9. Pacific (AK, CA, HI, OR, WA)	1.8094

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RURAL REFERRAL CENTER (RRC)

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Benefits

- Not capped at 12% for Medicare DSH
- If applying for geographic reclassification, an RRC
  - + does not have to be within 35 miles of the area for which reclassification is sought, as usually required
  - + is not required to demonstrate that its average hourly wage (AHW) is at least 106% of the average in the area in which it is located in order to qualify, as usually required
- PPACA allows SCHs & RRCs to qualify for 340B with 8% DSH instead of 11.75%
  - + Not eligible for 340B pricing for Orphan Drugs

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LOW-VOLUME PAYMENT ADJUSTMENT

- Adjustment has existed since 2005, but previous regulations had made it nearly impossible for hospitals to qualify
- Currently set to expire after FY 2024
- Eligibility
    - + At least 15 road miles from nearest hospital
    - + Less than 3,800 total discharges per most recent filed cost report
- Benefit
    - Add-on to Medicare IP operating payments up to 25% based on linear sliding scale:

  Low-Volume Hospital Payment Adjustment = 0.25 – [0.25/3300] x (number of total discharges - 500) = (95/330) - (number of total discharges/13,200).

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CRITICAL ACCESS HOSPITAL (CAH)

Eligibility Criteria

- Located in a rural area
- Average length of stay during fiscal year <4 days
- Furnish 24-hour emergency services
- No more than 25 inpatient beds
- Located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads
- Prior to December 31, 2005, a hospital could qualify if it was certified by state as a “necessary provider” of healthcare services to residents in the area, regardless of proximity to other hospitals

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CRITICAL ACCESS HOSPITAL (CAH)

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Benefit

- In general, Medicare reimbursement is based on 101% of hospital's allowable & reasonable costs for most inpatient & outpatient services

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RURAL EMERGENCY HOSPITAL (REH)

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- Section 125 of *Consolidated Appropriations Act, 2021*
- Effective 1/1/2023
- CAHs & acute hospitals with <50 beds as of 12/27/2020 eligible to convert
- Must be rural
- Does not provide acute IP services
- Emergency & observation care must average <24 hours per patient
- Payments for covered OPD services are increased by 5%
- Provides an additional facility payment based in part on 2019 payments to CAHs – $272,866/month for CY 2023, will be increased by hospital market basket going forward
- Eligible for RHC cost reimbursement
- Can have a provider-based SNF attached

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COST REPORT WORKSHEET D SERIES

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WORKSHEET D SERIES

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WORKSHEET D-3 – INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

...

All providers must complete this worksheet including CAHs. (See Worksheet S-2, line 105.) At the top of the worksheet, indicate by checking the appropriate lines the health care program, provider component, and the payment system for which the worksheet is prepared. When reporting Medicare charges on the appropriate lines and columns, do not include Medicare charges identified as MSP/LCC.

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WORKSHEET D SERIES

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WORKSHEET D-1 – COMPUTATION OF INPATIENT OPERATING COST

…

This worksheet provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment). All providers must complete this worksheet.

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WORKSHEET D SERIES

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Worksheet D Part V – Apportionment of Medical and Other Health Services Costs

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WORKSHEET D SERIES

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PS&R Report Types (not an all-inclusive list):

110 // Hospital Inpatient – traditional Medicare

118 // Hospital Inpatient – Medicare HMO

12P/13P/14P // Hospital Outpatient PPS

120/130/140 // Hospital Outpatient Cost Reimbursed (subject to coinsurance/deductible)

122/132 // Hospital Outpatient Vaccine (not subject to coinsurance/deductible)

125/135/145 // Hospital Outpatient Fee Reimbursed

11R // Inpatient Rehab

11U // Inpatient Psych

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COST REPORT WORKSHEET E SERIES

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WORKSHEET E SERIES

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WORKSHEET E – CALCULATION OF REIMBURSEMENT SETTLEMENT

...

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under inpatient PPS (IPPS) and title XVIII (Part B) settlement for medical and other health services. Worksheet E-3 computes title XVIII, Part A settlement for non-IPPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a prospective payment system. Worksheet E-4 computes total direct graduate medical education costs.

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WORKSHEET E SERIES

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Settlement Worksheets:

- E Part A — Inpatient PPS
- E Part B — Outpatient
- E-2 — Swing Beds
- E-3 Part I — TEFRA
- E-3 Part II — IPF PPS
- E-3 Part III — IRF PPS
- E-3 Part IV — LTCH PPS
- E-3 Part V — Inpatient Cost Reimbursement
- E-3 Part VI — Part A SNF PPS
- E-3 Part VII — All Other for Titles V or XIX

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WORKSHEET E PART A

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DRG amounts from PS&R

- Entire amount on line 1 if no October 1 overlap in cost report year
- Split on lines 1.01 & 1.02 if there is an October 1 overlap

Lines 5-29.01 // only applicable for teaching hospitals

Lines 30-34 // Empirically Justified DSH

Lines 35-36 // Uncompensated Care (UCC) DSH

Lines 64-66 // Medicare Bad Debts

- Software automatically reduces Allowable Bad Debts to 65%

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WORKSHEET E PART A

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Medicare DSH

- Empirically Justified DSH – aka “old” DSH
  - + Based on two percentages
    - > Medicaid % – calculated on cost report
    - > SSI % – published annually by CMS

FY 2021 SSI Ratios

IPPS SSI Calculations: FY 2021 MedPAR 12/2022 Claims Run Out (including MA Claims Submissions)

Provider Number	Provider Name	Total SSI Days	Total Days	Total SSI Ratio
010001	SOUTHEAST HEALTH MEDICAL CENTER	4,971	55,917	0.0889
010005	MARSHALL MEDICAL CENTERS SOUTH CAMP	1,267	19,072	0.0664
010006	NORTH ALABAMA MEDICAL CENTER	2,160	34,545	0.0625
010007	MIZELL MEMORIAL HOSPITAL	190	2,630	0.0722
010008	CRENSHAW COMMUNITY HOSPITAL	154	1,191	0.1293
010011	ST VINCENT'S EAST	2,960	41,319	0.0716
010012	DEKALB REGIONAL MEDICAL CENTER	401	5,998	0.0669

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WORKSHEET E PART A

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Empirically Justified DSH (cont.)

+ SSI % plus Medicaid % = DSH Base % or Patient % (DPP)
+ Operating DSH Payment:
  - > If DPP <15%, then no Operating DSH Payment
  - > If DPP >=15% & <20.2%, then Operating DSH Payment % = 2.5% + [.65 x (DPP – 15%)]
  - > If DPP >=20.2%, then Operating DSH Payment % = 5.88% + [.825 x (DPP – 20.2%)]
  - > Effective 10/1/13 as a result of PPACA, amount is reduced to 25% of calculation

Capital DSH Payment:

- > [e raised to the power of (.2025 x DPP)]– 1
- > e = 2.71828

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WORKSHEET E PART A

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- Only urban hospitals with ≥100 acute beds are eligible for Capital DSH Payments
- An urban hospital with <100 beds is capped at 12% for the Operating DSH Payment %
- Typically, a rural hospital's Operating DSH Payment % is capped at 12%
  + Currently exempt from cap:
    > RRC
    > MDH
    > Greater than 500 acute beds

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Medicare DSH

- Uncompensated Care (UCC) DSH – aka “new” DSH
  - + Result of ACA
  - + Hospital must qualify for Empirically Justified operating DSH to also qualify for UCC DSH for that cost report year
  - + UCC DSH amount by hospital published by CMS each federal fiscal year

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WORKSHEET E PART A

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FY 2024 IPPS Correction Notice Final Rule: Implementation of Section 3133 of the Affordable Care Act- Medicare DSH- Supplemental Data																	
Medicare CCN	Projected to Receive DSH in FY 2024	IHS or PR	Rural Community Hospital Demonstration	New Hospital	2018 UCC (Annualized)	Length of 2018 Reporting Period	2019 UCC (Annualized)	Length of 2019 Reporting Period	2020 UCC (Annualized)	Length of 2020 Reporting Period	Factor 3	Total Uncompensated Care Payment	Total Supplemental Payment	Estimated Per Claim Amount	BILLS 2021	BILLS 2022	Claims Average
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]	[1	[1	[1	[1	[1	[1
010001	YES	NO	NO	NO	$21,782,404.00	365	$25,746,956.00	365	$25,866,530.00	366	0.000719771	$4,274,006.27	N/A	$895.45	4,837	4,709	4,773
010005	YES	NO	NO	NO	$12,786,055.00	365	$13,259,343.00	365	$12,175,773.00	366	0.000374838	$2,225,790.69	N/A	$1,261.07	1,963	1,567	1,765
010006	YES	NO	NO	NO	$7,997,054.00	365	$7,550,252.38	366	$8,985,968.83	365	0.000240915	$1,430,553.81	N/A	$397.16	3,751	3,452	3,602
010007	YES	NO	NO	NO	$1,535,214.00	365	$1,561,365.00	365	$1,871,836.00	366	0.000048781	$289,661.65	N/A	$603.46	490	469	480
010008	YES	NO	NO	NO	$43,689.00	365	$885,068.00	365	$556,399.57	276	0.000014456	$85,840.32	N/A	$635.85	157	113	135
010011	YES	NO	NO	NO	$21,142,988.00	365	$21,315,128.39	366	$21,550,228.41	365	0.000628029	$3,729,237.56	N/A	$1,527.12	2,525	2,358	2,442
010012	SCH	NO	NO	NO	$2,708,981.00	365	$2,870,968.33	366	$3,282,459.47	365	0.000086986	N/A	N/A	$810.87	665	608	637
010016	YES	NO	NO	NO	$12,341,862.00	365	$14,105,412.00	365	$9,313,344.00	366	0.000350150	$2,079,190.40	N/A	$1,159.62	1,919	1,666	1,793
010018	NO	NO	NO	NO	$2,111,830.00	365	$2,716,503.00	365	$2,701,436.00	366	0.000073821	N/A	N/A	N/A	N/A	N/A	N/A
010019	YES	NO	NO	NO	$7,656,959.00	365	$7,236,602.00	365	$7,325,932.00	366	0.000218055	$1,294,814.57	N/A	$686.18	2,079	1,694	1,887
010021	YES	NO	NO	NO	$3,062,653.00	365	$2,158,946.00	365	$2,704,151.00	366	0.000077910	$462,628.11	N/A	$1,506.93	339	275	307
010022	YES	NO	NO	NO	$1,098,497.53	395	$1,796,636.71	366	$1,883,090.05	365	0.000046827	$278,059.53	N/A	$1,463.47	202	178	190
010023	YES	NO	NO	NO	$28,301,755.00	365	$36,243,471.82	366	$27,541,300.45	365	0.000901770	$5,354,715.24	N/A	$1,706.41	3,479	2,796	3,138
010024	YES	NO	NO	NO	$11,600,488.00	365	$10,700,841.00	365	$11,367,402.00	366	0.000330500	$1,962,513.04	N/A	$776.62	2,647	2,407	2,527
010029	YES	NO	NO	NO	$17,951,353.00	365	$15,997,566.00	365	$16,807,719.00	366	0.000498272	$2,958,742.12	N/A	$990.54	3,156	2,818	2,987

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WORKSHEET E PART A

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Healthcare Reform Elements:

Line 70.93 – Value-Based Purchasing adjustment from PS&R

Line 70.94 – Readmission Reduction Adjustment from PS&R

Line 70.95 – HAC adjustment calculated based on other cost report information

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WORKSHEET E PART A

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From HFS E Part A Exhibit 5 Instructions:

The following payment amounts are required to calculate the HAC reduction adjustment by FFY:

- *Operating Federal IPPS payments;*
- *Operating HSR payments;*
- *Operating Outlier payments including any Operating Outlier Reconciliation amounts;*
- *Operating IME payments;*
- *Operating IME payments for Medicare Advantage patients;*
- *Operating DSH payments;*
- *Uncompensated care payments;*
- *ESRD adjustment payments;*
- *Total capital IPPS payment;*
- *New technology payments;*
- *Net organ acquisition costs;*
- *Credits for replaced devices;*
- *Low volume adjustment;*
- *HVBP payment adjustment;*
- *HRR adjustment; &*
- *Capital outlier reconciliation amounts*

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COST REPORT WORKSHEET L

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WORKSHEET L

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WORKSHEET L – CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through III, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with the final rule for payment of capital-related costs on a prospective payment system pursuant to 42 CFR 412, Subpart M.

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COST REPORT WORKSHEET S

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WORKSHEET S

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WORKSHEET S – HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

…

Part II – Certification.--This certification is read, prepared, and signed by an officer or administrator of the provider after the cost report has been completed in its entirety.

Part III – Settlement Summary.--Enter the balance due to or due from the applicable program for each applicable component of the complex.

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PROTESTED AMOUNTS

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PROTESTED AMOUNTS

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Cost Report Protested Items

- Mechanism to go “on record” as disagreeing with CMS treatment of specific issues in order to protect appeal rights
- Appeal rules were revised effective for cost reporting periods ending on or after December 31, 2008 – much more difficult for providers
- Providers must now be very specific as to their argument & the related settlement impact for every issue
- In general terms, we expect it will be difficult to prevail on appeal unless an issue was originally protested or there is an adjustment made during audit

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PROTESTED AMOUNTS

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Protested amounts reflect the reimbursement impact from issues in dispute

- Reflected on cost report settlement worksheets, including E Part A line 75 & E Part B line 44
- Amount in dispute is not included in the cost report settlement
- It results in an adjustment that the hospital can then appeal
- From the instructions – *Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.*
- Covered under PRM 15-11, section 115.2

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INDIRECT & DIRECT MEDICAL EDUCATION REIMBURSEMENT

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INDIRECT & DIRECT MEDICAL EDUCATION

What is Graduate Medical Education (GME)?

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

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INDIRECT & DIRECT MEDICAL EDUCATION

What is a resident?

- A resident has completed medical school & is actively enrolled in an approved program & is actively seeking board certification
- Past – Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), & American Association of Colleges of Osteopathic Medicine (AACOM)
- Current – Single GME accreditation system
  - + Effective 7-1-2020
  - + New single GME accreditation system will allow graduates of osteopathic & allopathic medical schools to complete their residency &/or fellowship education in ACGME-accredited programs & demonstrate achievement of common milestones & competencies (AOA website)

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INDIRECT & DIRECT MEDICAL EDUCATION

Statistical overview of GME

- 12,740 total accredited programs (5,579 specialty & 7,161 subspecialty); Academic Year 2021-2022
- 154,000 active residents in training each year nationally[1]
  - Specialties with the highest percentage of total active residents
    - + Internal Medicine (20.1%)
    - + Family Medicine (9.5%)
    - + Pediatrics (6.2%)
    - + Surgery (6.0%)
- Teaching hospitals' cost of training is >$23 billion per year (includes overhead)[2]
- Medicare reimburses ~$18.2 billion per year to hospitals:
  - + ~$13.0 billion for IME (71% of total Medicare GME payments)
  - + ~$5.2 billion for DGME
- Medicaid reimburses ~$7.4 billion per year (2022)[3]

[1] https://www.acgme.org/About-Us/Publications-and-Resources/Graduate-Medical-Education-Data-Resource-Book

[2] HCRIS data for cost report ending 10/1/2021 thru 9/30/2022

[3] https://store.aamc.org/medicaid-graduate-medical-education-payments-results-from-the-2022-50-state-survey.html

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INDIRECT & DIRECT MEDICAL EDUCATION

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Medicaid Payments

- Medicaid reimburses ~$7.39 billion per year (2022)[1]
  - 44 States including D.C. provided some reimbursement related to GME to hospitals
  - Nearly 96% increase since 2009
    + FY 2009 = $3.78 Billion
    + FY 2012 = $4.00 Billion
    + FY 2015 = $4.26 Billion
    + FY 2018 = $5.58 Billion

[1] https://store.aamc.org/medicaid-graduate-medical-education-payments-results-from-the-2022-50-state-survey.html

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Sponsoring Institution

- The organization (or entity) that assumes the ultimate financial & academic responsibility for a program or graduate medical education consistent with the ACGME (or AOA until the organizations fully merge). Sponsoring institutions have the primary purpose of providing educational programs &/or healthcare services
- When the sponsoring institution is not actually a rotation site, there is normally a major associated hospital for the program is the **Primary Clinical Site** (the primary place designed for the clinical training & instruction of the program). If the sponsoring institution is indeed a hospital, it is by definition the primary clinical site for the program

Examples of Sponsoring Institutions

University	Medical School	Hospital	School of Public Health	Health Department
Public Health Agency	Healthcare Delivery System	Consortium	Educational Foundation	Medical Examiner's Office

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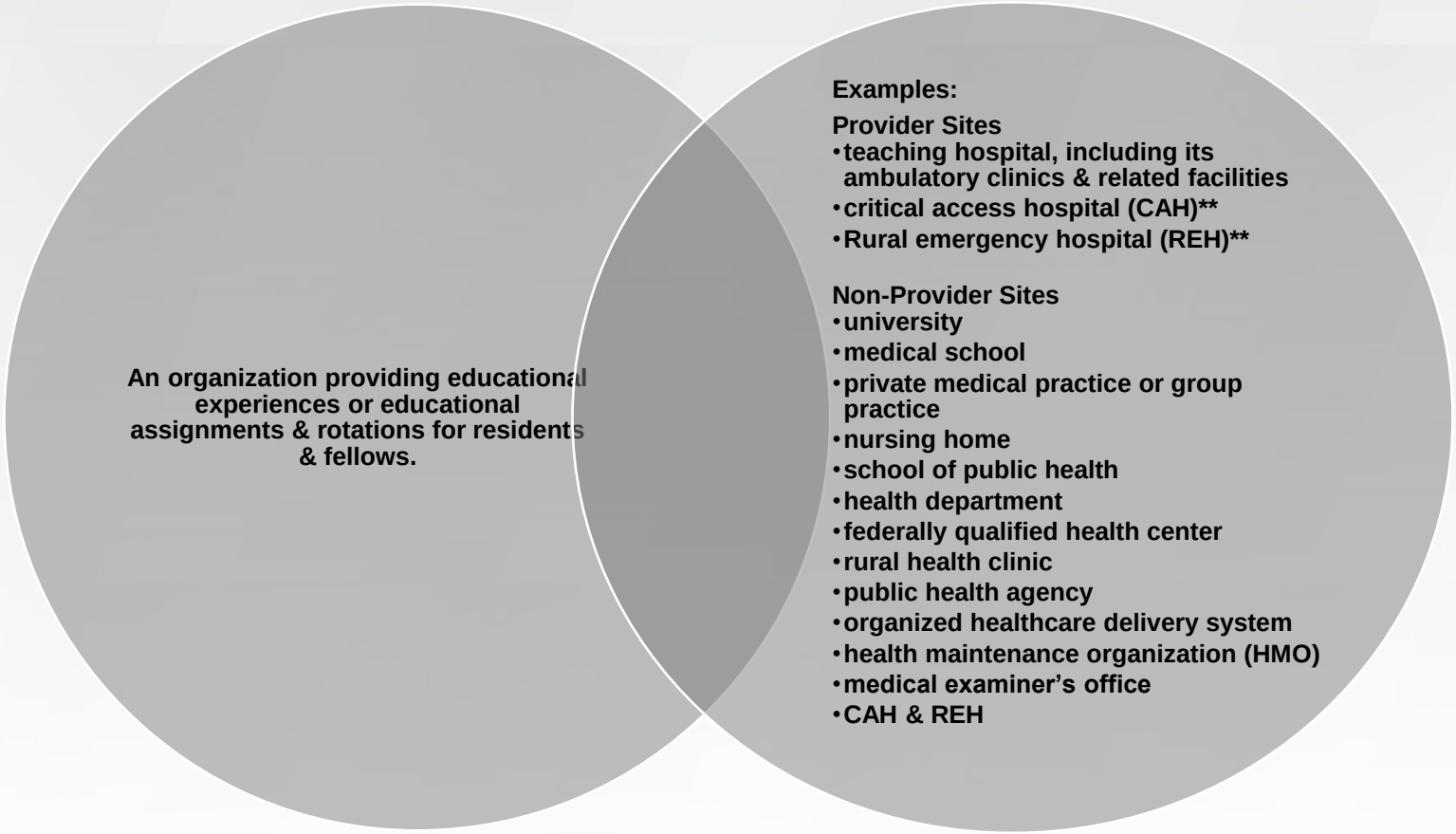
Participating Sites – Provider & Non-Provider



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Non-provider settings

Any setting outside of a hospital that is primarily engaged in furnishing patient care

Excludes any time at another hospital
(exception is CAH)

Must be part of the approved residency program

Requires written agreement or payment:

- Written agreement – signed in advance between hospital and non-provider entity (PLA)
- Payment – the hospital must incur all or substantially all of the cost for the resident training at the non-provider setting

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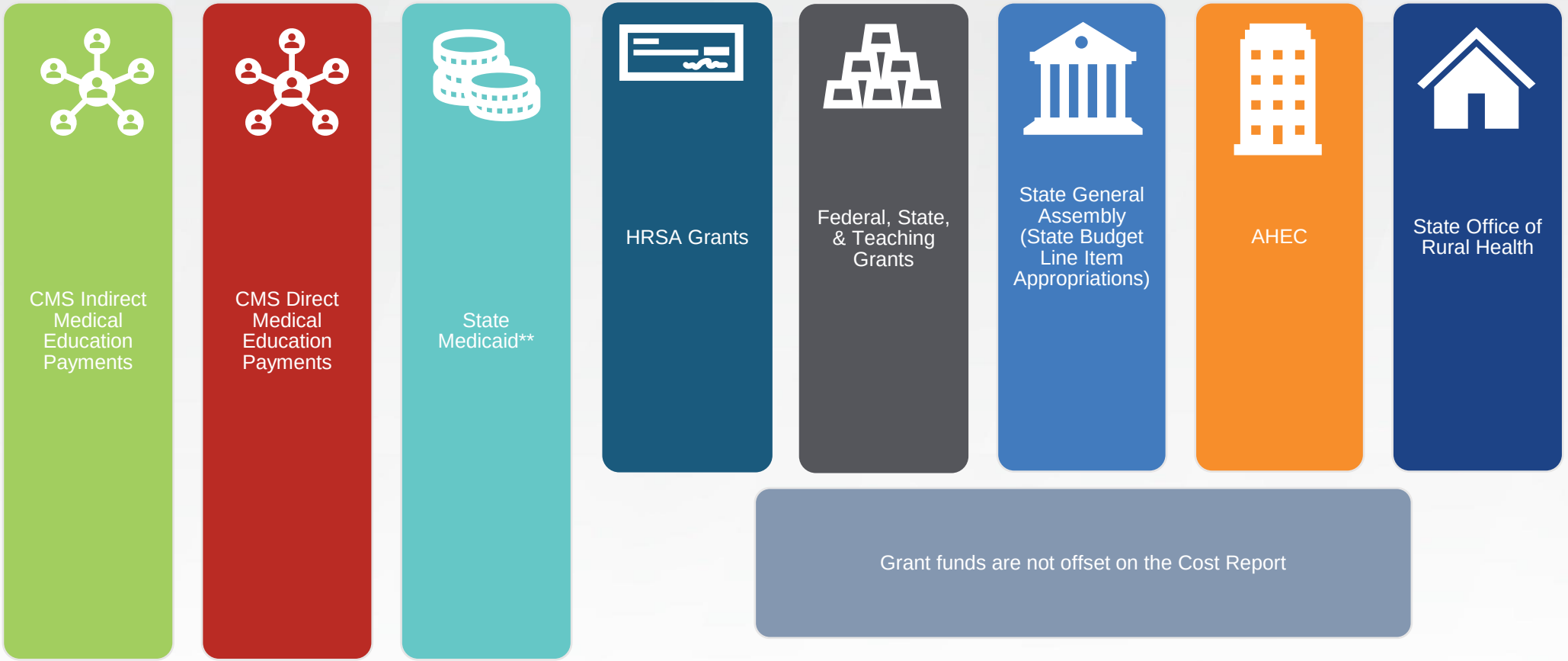
Funding Sources



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Reimbursement for Teaching Hospitals - Medicare

IME PAYMENT + **DGME PAYMENT** + **MEDICARE ADVANTAGE PAYMENT** = **TOTAL MEDICARE GME PAYMENT**

- To recognize the indirect costs of GME programs borne by the teaching hospital due to inefficiencies
- To compensate teaching hospitals for higher inpatient costs due to patient severity of illness not fully captured by diagnosis related groups (DRGs)
- Add-on to Medicare IP DRGs
- Limited by IBR & FTE Cap

- To recognize the direct GME-related costs incurred by the teaching hospital
- Medicare's share (Based on Days) of direct costs:
- Resident salary & fringe benefits
- Faculty compensation for resident teaching & supervision
- Other direct, allowable costs
- Paid outside of patient payments (bi-weekly)
- Limited by FTE Cap & PRA

- To recognize the direct & indirect costs of GME programs associated with Medicare Part C population
- IME add-on % applied to Part C simulated DRG payments (cost report)
- DGME payment based on the share of Medicare Part C days
- Paid by Medicare via cost report, not included in payment from managed care payor

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IME Payment Calculation

IME PAYMENT

$$1.35 \times \left[\left(1 + \frac{\text{Number of Residents}}{\text{Number of Available Beds}} \right)^{0.405} - 1 \right] \times$$

Medicare DRG-Based Payments, Including Outliers

IME Coefficient

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Cost Report Requirements – Bed Days Available

- Beds = (*Available* Bed Days)/(Days in Cost Report)
- Bed Days *Available* – Defined by 42 CFR 412.105(b)
  - Exclude bed days that are:
    + Beds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital IPP at any time during the 3 preceding months (the beds in the unit or ward are to be excluded form the determination of available bed days during the current month);
    + Beds in a unit or ward that is otherwise occupied, & provides a PPS level of care, that could NOT be made available to IP occupancy within 24 hours for 30 consecutive days;
    + Beds in excluded distinct part hospital units;
    + Beds otherwise countable under this section used for OP Observation services, skilled nursing swing-bed services or ancillary labor/delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute IP care, in which case the beds & days would be included in those counts;
    + Beds or bassinets in the healthy newborn nursery; &
    + Custodial care beds.

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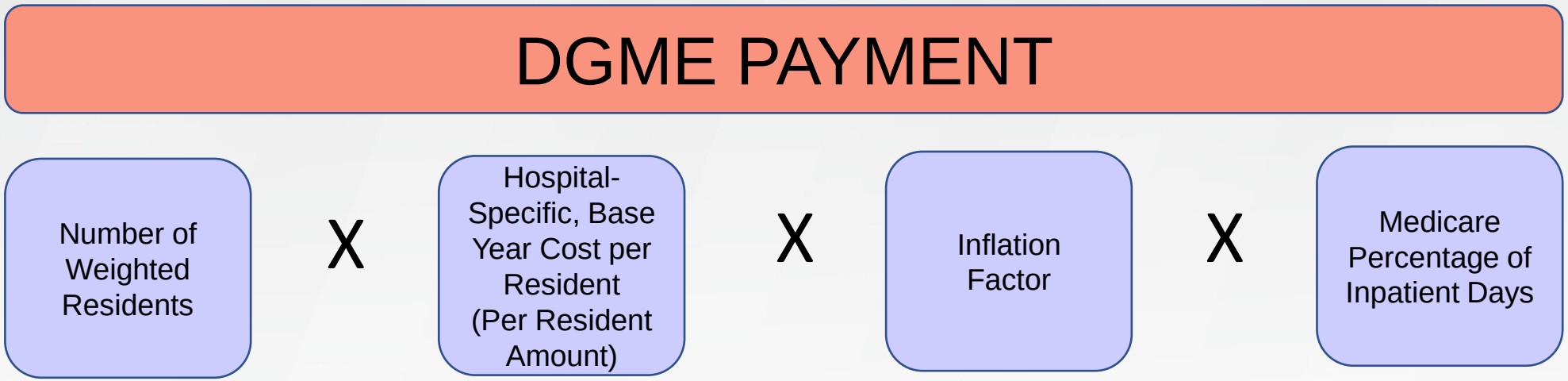
Direct GME Payment Calculation



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Indirect Medical Education (IME)

- Hospitals can receive an additional payment to reflect the higher indirect operating costs associated with a Graduate Medical Education program
    - Increased patient complexity not captured by MS-DRG system
    - Other operating cost associated with being a teaching hospital
        - Lower productivity, standby capacity, etc.
- Payment is a percentage added on to each respective DRG payment
- Reflected on the cost report on Worksheet E Part A lines 5-29.01 (operating) & Worksheet L lines 3-6 (capital)
- Generally, IME represents more reimbursement than direct GME
- Hospitals with special designations such as Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) which receive Hospital Specific Payments (HSP) may not receive the full amount of IME. Financial due diligence is required.

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INDIRECT & DIRECT MEDICAL EDUCATION

Direct Graduate Medical Education (DGME)

- Medicare pays hospitals for the direct costs of DGME. Objective is to compensate teaching hospitals for the direct costs of having a teaching program (Worksheet A, Lines 22 & 23)
  - + Resident stipends & fringe benefits
  - + Teaching & Supervising Faculty salary & fringe benefits
  - + Administrative costs to operate program
  - + Other operating expenses
  - + Allocated overhead costs
- Paid outside of Inpatient Prospective Payment System (pass through payments)

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Direct Graduate Medical Education (DGME) (cont.)

- Factors impacting payment:
  - + Three-year average of resident FTEs
    - < The three-year averaging does not begin to occur until the FTE cap is established for the hospital
  - + Medicare share – based on days on cost report for each respective year
- Formula
  - + DGME payments = Resident FTEs x Per Resident Amount x Medicare share
  - + Reflected on the cost report on Worksheet E-4 with results carried to Worksheet E Part A line 52 & E Part B line 28
  - + Reimbursed on an interim basis through the year through pass-thru payments

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Factors impacting payment (cont.):

Per Resident Amount - Cost up to per resident amount (PRA) limitations

- For new teaching hospitals, Lower of:
  - + Direct GME costs or
  - + Weighted average of PRAs of surrounding teaching hospitals
- For new hospitals PRA is the same for Primary Care & Non-Primary Care
- Calculated using first full cost reporting period with residents
- Floor PRA – Starting in FY 2002 & beyond the PRA could be no less than 85% of national PRA
- Once established, the PRA is permanent

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Payments for Medicare Advantage (Part C or Managed Care) activity

- IME add-on % applied to Part C simulated DRG payments from PS&R report type 118
- Payment for FTEs resulting from additional cap space under MMA Section 422 is a reduced amount
- GME payment based on the share of Part C days
    + 3.27% reduction factor is applied (formally 14.13%)
- Important to make sure that hospital is shadow billing for claims. There is a specific CMS billing memo that explains how to bill for Medicare advantage plans
    + Interim IME reimbursement is paid through shadow billing with appropriate modifiers

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Change Request 11642 (Effective September 21, 2020) impacts CY 2002 forward

- Impacts Medicare Advantage DGME percent reduction
  - + CMS-2552-96 lines 6.05 & 6.08 of Worksheet E-3 Part IV
  - + CMS-2552-10, line 30, of Worksheet E-4
- Reduction factor varies based on calendar year

CY	2014	2015	2016	2017	2018	2019	2020P	2021	2022
Percent reduction to MA DGME	5.86	5.23	4.99	4.44	4.12	4.07	3.71	3.22	3.27

  - + See Attachment A of the transmittal for reduction factors starting in CY 2002.

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Counting Time

	Hospital		Hospital Non-Acute IP OP		Non-Hospital Site		Another Hospital	
	GME	IME	GME	IME	GME	IME	GME	IME
Patient Care	✓	✓	✓	✗	✓	✓	✗	✗
Didactics	✓	✓	✓	✓	✓	✗	✗	✗
Research	✓	✗	✓	✗	✗	✗	✗	✗
Orientation	✓	✓						
Vacation Time	✓	✓						

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Counting Time cont.

- Patient care activities at hospital including outpatient departments as well as non-provider settings
  - + Care & treatment for which a physician may bill
  - + Orientation activities – activities for preparation of a resident in a particular setting or specialty program
- Research time in hospital – in general is included in DGME count but excluded from IME count
- Research time in non-provider settings – in general excluded from DGME & IME
- Didactic time – time spent in journal clubs, seminars, classroom lectures, & other scholarly pursuits
  - + Generally included in DGME in any setting – hospital or non-provider – that is engaged in furnishing patient care
  - + Generally included in IME only for time in the hospital
- Vacation or sick time – included in both DGME & IME as long as it does not extend the resident's program beyond the normal duration

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Initial Residency Period (IRP)

- The minimum period of training required in a specialty to become eligible for board certification in that specialty, up to a maximum of five years
- Resident time beyond IRP – reduced to 50% for GME payment calculation
- Example IRP durations:
  - + Family Medicine 3 years
  - + Emergency Medicine 3 years
  - + Internal Medicine 3 years
  - + General Surgery 5 years
- If a resident is matched in an advanced specialty program that requires a clinical base year prior to resident's first training year then IRP is determined based upon period of board eligibility associated with second year specialty program

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New Residency Programs cont.

- Section 401 Rural Hospitals – once initial cap is established, additional cap for new programs effective for IME only

Urban

- 5 years to get ALL programs ramped up

Rural

- 5 years to get EACH respective program ramped up

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New Residency Programs & FTE CAP Calculation – Urban

	2026	2027	2028	2029	Year 5 2030	2031	2032	2033	2034	Highest No. FTEs in Year 5	IRP of Program	Calc. CAP
General Surgery												
PGY 1	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00			
PGY 2	-	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00			
PGY 3	-	-	2.00	2.00	2.00	2.00	2.00	2.00	2.00			
	2.00	**4.00**	**6.00**	**6.00**	**6.00**	**6.00**	**6.00**	**6.00**	**6.00**	**2.00**	**5**	**10.00**
OB/Gyn												
PGY 1	-	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00			
PGY 2	-	-	4.00	4.00	4.00	4.00	4.00	4.00	4.00			
PGY 3	-	-	-	4.00	4.00	4.00	4.00	4.00	4.00			
	-	**4.00**	**8.00**	**12.00**	**12.00**	**12.00**	**12.00**	**12.00**	**12.00**	**4.00**	**4**	**16.00**
Transitional Year												
PGY 1	-	-	8.00	8.00	8.00	8.00	8.00	8.00	8.00			
PGY 2	-	-	-	8.00	8.00	8.00	8.00	8.00	8.00			
PGY 3	-	-	-	-	8.00	8.00	8.00	8.00	8.00			
	-	**-**	**8.00**	**16.00**	**24.00**	**24.00**	**24.00**	**24.00**	**24.00**	**8.00**	**1**	**8.00**
Emergency Medicine												
PGY 1	-	-	-	8.00	8.00	8.00	8.00	8.00	8.00			
PGY 2	-	-	-	-	8.00	8.00	8.00	8.00	8.00			
PGY 3	-	-	-	-	-	8.00	8.00	8.00	8.00			
	-	**-**	**-**	**8.00**	**16.00**	**24.00**	**24.00**	**24.00**	**24.00**	**8.00**	**3**	**24.00**
Neurology												
PGY 1	-	-	-	-	2.00	2.00	2.00	2.00	2.00			
PGY 2	-	-	-	-	-	2.00	2.00	2.00	2.00			
PGY 3	-	-	-	-	-		2.00	2.00	2.00			
	-	**-**	**-**	**-**	**2.00**	**4.00**	**6.00**	**6.00**	**6.00**	**2.00**	**4**	**8.00**
Totals												
PGY 1	2.00	6.00	14.00	22.00	24.00	24.00	24.00	24.00	24.00			
PGY 2	-	2.00	6.00	14.00	22.00	24.00	24.00	24.00	24.00			
PGY 3	-	-	2.00	6.00	14.00	22.00	24.00	24.00	24.00			
	2.00	**8.00**	**22.00**	**34.00**	**42.00**	**42.00**	**42.00**	**42.00**	**42.00**	**24.00**		**66.00**

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New Residency Programs & FTE CAP Calculation – Section 401

	2024	2025	2026	2027	2028	2029	2030	2031	2032	Highest No. FTEs in Program Year 5	IRP of Program	ACGME Accr. Slots	IME CAP	GME CAP
Family Medicine					**Year 5**									
PGY 1	13.00	13.00	13.00	13.00	13.00	13.00	13.00	13.00	13.00					
PGY 2	-	13.00	13.00	13.00	13.00	13.00	13.00	13.00	13.00					
PGY 3	-	-	13.00	13.00	13.00	13.00	13.00	13.00	13.00					
	13.00	**26.00**	**39.00**	**39.00**	**39.00**	**39.00**	**39.00**	**39.00**	**39.00**	**13.00**	**3**	**13.00**	**39.00**	**39.00**
OB/Gyn						**Year 5**								
PGY 1	-	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00					
PGY 2	-	-	3.00	3.00	3.00	3.00	3.00	3.00	3.00					
PGY 3	-	-	-	3.00	3.00	3.00	3.00	3.00	3.00					
PGY 4					3.00	3.00	3.00	3.00	3.00					
	-	**3.00**	**6.00**	**9.00**	**12.00**	**12.00**	**12.00**	**12.00**	**12.00**	**3.00**	**4**	**3.00**	**12.00**	**12.00**
Transitional Year							**Year 5**							
PGY 1	-	-	13.00	13.00	13.00	8.00	13.00	13.00	13.00					
PGY 2	-	-	-											
PGY 3	-	-	-											
	-	**-**	**13.00**	**13.00**	**13.00**	**8.00**	**13.00**	**13.00**	**13.00**	**13.00**	**1**	**13.00**	**13.00**	**13.00**
Internal Medicine								**Year 5**						
PGY 1	-	-	-	10.00	10.00	10.00	10.00	10.00	10.00					
PGY 2	-	-	-	-	10.00	10.00	10.00	10.00	10.00					
PGY 3	-	-	-	-	-	10.00	10.00	10.00	10.00					
	-	**-**	**-**	**10.00**	**20.00**	**30.00**	**30.00**	**30.00**	**30.00**	**10.00**	**3**	**8.00**	**24.00**	**24.00**
Clinical Informatics									**Year 5**					
PGY 1	-	-	-	-	1.00	1.00	1.00	1.00	1.00					
PGY 2	-	-	-	-	-	1.00	1.00	1.00	1.00					
PGY 3	-	-	-	-	-									
	-	**-**	**-**	**-**	**1.00**	**2.00**	**2.00**	**2.00**	**2.00**	**1.00**	**2**	**1.00**	**2.00**	**2.00**
Totals														
PGY 1	13.00	16.00	29.00	39.00	40.00	35.00	40.00	40.00	40.00					
PGY 2	-	13.00	16.00	16.00	26.00	27.00	27.00	27.00	27.00					
PGY 3	-	-	13.00	16.00	16.00	26.00	26.00	26.00	26.00					
	13.00	**29.00**	**58.00**	**61.00**	**64.00**	**59.00**	**64.00**	**64.00**	**64.00**	**40.00**		**38.00**	**90.00**	**90.00**

cannot exceed ACGME accredited slots

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New Residency Programs

Regulations allow new programs only under certain circumstances

- For hospitals that had a residency program in 1996, generally only rural hospitals are now allowed to start new programs
- One potential exception for an urban hospital is to establish a program with a rural track
  - + The urban hospital has to work in conjunction with other rural hospitals or rural non-hospital settings to provide the training
  - + At least 50% of the resident time must be in rural settings

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New Residency Programs cont.

- A hospital that did not have a residency program in place in 1996 is typically eligible to start a new program (Urban or Rural)
- Effective for new programs that began to train residents after 10/1/12, resident FTE cap is established after first five years of operating
  - + Was previously three years prior to change in FY 13 IPPS final rule
- PRA for new program based on the lower of actual cost per resident or the weighted average PRAs from existing teaching hospitals in CBSA
  - + If there are <3 existing teaching hospitals in CBSA, average of all teaching hospitals in Census Region is applied
- Hospitals must be careful to evaluate “new program” status – there are examples of CMS deeming a program as previously existing at another location, & applying the existing cap to the new hospital

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New Residency Programs cont.

- General rule is the cap equals the highest number of FTEs in any program year during the first five years of the program's existence multiplied by number of years for the initial residency period (IRP)
  - + Family Practice – IRP is 3 years
  - + Emergency Medicine – IRP is 3 years
  - + Surgery – IRP is 5 years
- If residents rotate to other hospitals during the first five years, cap must be adjusted based on prorated time across all hospitals over the initial five years

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The resident FTE count is a critical component of payment calculations

- The resident FTE count is capped, generally based on 1996 cost report for programs in place since that time, with periodic adjustments
- New programs have a cap established after the program has existed for five years
  - + Based on the greatest number of program residents times the initial residency period of the program
  - + Must ensure it meets CMS standards for “new” program
    - < New program director
    - < New faculty
    - < New residents

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Other Cap Exceptions

- Temporary & permanent adjustments from closed hospitals & programs
- Affiliation Agreements
- Consolidated Appropriations Act of 2021 (1,000 slots over five years)

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Affiliation Agreements

"...hospitals that cross-train residents in approved medical residency training programs may enter into Medicare GME Affiliation Agreements to elect to apply their direct GME and/or IME Full Time Equivalent (FTE) resident caps on an aggregate basis, and may adjust their FTE resident caps to reflect the rotation of residents among affiliated hospitals during an academic year."

-CMS

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Affiliation Agreements cont.

- Three eligible scenarios:
  - + two or more hospitals that are located in the same or a contiguous metropolitan statistical area & have a shared rotational arrangement
  - + two or more hospitals that are listed as the joint sponsors of a residency program & have a shared rotational arrangement
  - + two or more hospitals that are under common ownership & have a shared rotational arrangement
- Written agreement must be in place that has to be provided to CMS & intermediary prior to start of academic year beginning July 1 (January 1, 2022 for the academic year starting July 1, 2021)

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Consolidated Appropriations Act, 2021 - Provisions

Section 126

Makes available 1,000 new Medicare-funded GME positions (but not more than 200 new slots per fiscal year)

Section 127

Makes statutory changes to the determination of both an urban & rural hospital's resident FTE cap for IME & DGME for residents training in accredited rural training programs (RTPs)

Section 131

Makes statutory changes to the determination of the PRA & the IME & DGME FTE caps for hospitals that had a small number of residents for a short period duration

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Transmittal 18 – GME

- Issued December 29, 2022
- Implements FY 2023 IPPS Final Rule Changes
- Effective for cost reporting periods beginning on or after October 1, 2022

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Transmittal 18 – GME cont.

Worksheet S-2, Part I, Lines 56-57 (Section 131, CAA-2021)

Worksheet S-2, Part I, Line 68* (FY 2023 IPPS Final Rule)

Worksheet B, Part I, Column 25 (Section 131, CAA-2021)

Worksheet D, Part III, Column 3 & 4 (Section 131, CAA-2021)

Worksheet D-2, Parts II & III (Section 131, CAA-2021)

Worksheet E, Part A (Section 126,127,131, FY 2023 IPPS Final Rule)

- Revised Lines 6,8,9,10,16,20
- Added Lines 5.01,6.26,7.02,8.21

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Transmittal 18 – GME cont.

Worksheet S-2, Part I, Lines 56-57 (Section 131, CAA-2021)

- Cost reporting periods beginning on or after December 27, 2020
- Determines when initial Per Resident Amount is set
- Did the hospital train at least 1.0 FTE?
- Did the hospital train less than 1.0 FTE & participated in a Medicare GME affiliation agreement?

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S-2, Part I

			1.00	2.00
		Teaching Hospitals		
Section 131	56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Y	Y
Section 131	57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	Y	
	58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N	
	59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N	

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Transmittal 18 – GME cont. …

Worksheet S-3, Part I, Line 34 ((FY 2023 IPPS Final Rule)

- Beds, bed days available, & all patient days for temporary expansion COVID-19 PHE (March 1, 2020 – May 11, 2023)
  - + Subset of days reported on Lines 1, 8-12; enter zero if not included in these Lines.
  - + Amounts are excluded from patient days on E, Part A, Line 4

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available
		1.00	2.00	3.00
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0

Note: Worksheet E, Part A, Line 4 (Bed Days Available / No. Days in Cost Reporting Period)

- *Reduce the bed days available by the number of temporary expansion COVID-19 PHE acute care bed days (Worksheet S-3, Part I, column 3, Line 34).*

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Transmittal 18 – GME cont.

Worksheet E, Part A (Section 126, 127, 131, FY 2023 IPPS Final Rule)

- Revised Lines 6, 8, 9, 10, 16, 20
- Added Lines 5.01, 6.26, 7.02, 8.21

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E, Part A – IME

Section 131

Section 127

RTP Cap Share

Section 126

	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)		0.00		5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00		6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00		7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00		8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00		8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01

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Transmittal 18 – GME cont.

Worksheet E-4 (Section 126, 127, 131, FY 2023 IPPS Final Rule)

- Revised Lines 2, 4, 5, 6, 8, 9, 12, 13, 15, 19, 22
- Added Lines 1.01, 2.26, 3.02, 4.21, 18.01

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E-4 – DGME

Section 131

Section 127

RTP Cap Share

Section 126

		1.00	2.00	3.00	
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00			1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)	0.00			1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00			2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00			2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00			3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00			3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00			3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00			4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00			4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00			4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00			4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27	0.00			5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.00			6.00
7.00	Enter the lesser of line 5 or line 6	0.00			7.00
		Primary Care	Other	Total	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	0	0	0	19.00

Section 131

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Transmittal 18 – GME cont. …

Worksheet E-4, Line 9 “Fellow Penalty”

- Retroactive to ‘open’ cost reports beginning October 1, 2001
- Hospitals with reported weighted & unweighted FTEs above the resident FTE cap:
  - + Before the ruling, allowable weighted FTEs were below the cap
  - + After the ruling, allowable weighted FTEs are held harmless at the cap
- Worksheet S-2, Part I, Line 68 – a ‘Yes’ response will make the software apply the revised methodology to the weighted FTEs

	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	Y	

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FY 2024 IPPS Final Rule Changes

- REHs (Rural Emergency Hospitals) – Section 125 of CAA-2021
  - Effective with cost reporting periods beginning on/after October 1, 2023
  - Use as a non-provider site for resident rotations (similar to CAHs)
    + Hospitals can include residents training in its IME & DGME FTE counts
  - May decide to incur training costs & receive payment based on 100% of reasonable costs
    + No hospital can include residents in its IME & DGME FTE counts in this instance

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FY 2024 IPPS Final Rule Changes cont.

Calculation of PY IME Intern-to-Bed Ratio When There is a Medicare GME Affiliation Agreement:

1. CY FTE cap increased = difference between CY Line 7.02+Line 8 and PY Line 7.02+Line 8 is positive and
2. CY allowable FTE count increased = difference between CY Line 12 *(excluding Line 11 dental & podiatry)* and PY Line 12 *(excluding Line 11 dental & podiatry)* is positive then identify
3. Lower of:
    a. Difference between CY Line 15 and PY Line 12
    b. Difference between sum of CY Line 7.02+Line 8 and sum of PY Line 7.02+Line 8
4. Add lower of (a) or (b) to PY Line 12 as a component of the to the PY Intern-to-Bed Ratio formula

Example

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Example:

GME Affiliation

Line	Description	Penultimate Year	PY	CY	Difference
4	Bed days available	300	305	302	(3)
5	1996 FTE Cap	32	32	32	0
7	Rural Track GME Affiliated FTEs	0	0	0	0
8	GME Affiliated FTEs	8	8	20	12
9	Adjusted FTE Cap	40	40	52	12
10	CY Allopathic & Osteopathic FTEs	50	50	62	12
11	CY Dental & Podiatry FTEs	0	0	0	0
12	CY Allowable FTEs	40	40	52	12
13	PY Allowable FTEs	40	40	40	0
14	Penultimate Year Allowable FTEs	40	40	40	0
15	3-Year Rolling Average FTEs	40	40	44	4
16	FTEs in Initial Years	0	0	0	0
17	Displaced FTEs	0	0	0	0
18	Adjusted Rolling Average FTEs	40	40	44	4
19	CY Intern-to-Bed Ratio	0.133333	0.131148	0.145695	0.014548
20	PY Allowable FTEs	0.133333	0.133333	see below	

Step 1 - Diff between sum of CY Line 7.02 and Line 8 and sum of PY Line 7.02 and Line 8 is positive 12

Step 2 - Diff between CY Line 12 *(excluding Line 11)* and PY Line 12 *(excluding Line 11)* is positive 12

Step 3 - Identify the lower of:

(a) Diff between CY Line 15 and PY Line 12 4

(b) Diff between sum of CY Line 7.02 and Line 8 and sum of PY Line 7.02 and Line 8 12

Lower = *4*

Step 4 **If positive**, add lower of (a) or (b) to Line 12 of PY Intern-to-Bed Ratio formula

(PY Line 12 + Step 3) / PY Beds OR (40 + 4) / 305 = **0.144262**

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INDIRECT MEDICAL EDUCATION

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Worksheet L, Part I:

	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,292,207	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	70,036	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	292.98	3.00
4.00	Number of interns & residents (see instructions)	24.00	4.00
5.00	Indirect medical education percentage (see instructions)	2.34	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	77,038	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	6.62	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	36.92	8.00
9.00	Sum of lines 7 and 8	43.54	9.00
10.00	Allowable disproportionate share percentage (see instructions)	9.22	10.00
11.00	Disproportionate share adjustment (see instructions)	303,541	11.00
12.00	Total prospective capital payments (see instructions)	3,742,822	12.00

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INDIRECT & DIRECT GRADUATE MEDICAL EDUCATION

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Pass-Through Payments

9/30/2020 MED. DAYS 21,867 BAD DEBT AAF = 100.00% MED. ED. AAF = 100.00% Org. Acq. AAF = 100.00%	COL 1 PASSTHROUGH PER DIEM (T18 COST/ T18 DAYS)	COL2 TOTAL ALLOWABLE COST	COL 3 TOTAL ALLOWABLE T-18 COSTS	Before GME COL 4 PASSTHROUGH PAYMENT ALLOCATION 26.07	After GME COL 5 PASSTHROUGH PAYMENT ALLOCATION 26.07	COL 6 SEQUESTRATION % REDUCTION ALLOCATION
NET ORGAN ACQUISITION COST	$0.00	$0	$0	$0		$0
CAPITAL COSTS	$0.00	$0	$0	$0		$0
BAD DEBTS (reimb at 65%):	$29.26	$639,913	$639,913	$24,546	$24,546	$24,055
CRNA:	$0.00	$0	$0	$0		$0
ALLOGENEIC HEMATOPOIETIC STEM CELL	$0.00	$0	$0	$0		$0
MEDICAL EDUCATION COSTS:						
INTERNS/RESIDENTS:	$17.00	$371,721				
ROUTINE:	$0.00	$0				
ANCILLARY:	$0.90	$19,672				
NAH MANAGED CARE:	$2.33	$51,028				
TOTAL MED ED COSTS:	$20.23	$442,421	$442,421	$2,712	$16,970	$16,631
NEW BIWEEKLY (Sum of COL 4)				$27,258	**$41,516**	$40,686
# OF PMTS TO DATE				19.71	6.36	0.00
CORRECT PASSTHROUGH PAYMENTS				$537,372	$263,923	$0
PAYMENTS PER PASSTHROUGH SCHEDULE				$346,715	$181,939	$0
UNDER/(OVER) PAYMENT DUE				$190,657	$81,984	**$272,641**

PART A PASSTHROUGH SCHEDULE

EFFECTIVE DATES	BIWEEKLY AMOUNT
9/18/2020	$17,557
2/5/2021	$17,604
3/31/2021	$17,252
4/13/2021	$17,604

Date of Last Issued Check
DAYS FIRST CHECK
DAYS LAST CHECK

CHECK DATE	PERIOD ENDED	NO. OF PMTS	BIWEEKLY PAYMENT	GME NO. OF PMTS	GME BIWEEKLY PAYMENT
10/16/2020	9/29/2020	0.14	2,508		
10/30/2020	10/13/2020	1.00	17,557		
11/13/2020	10/27/2020	1.00	17,557		
11/27/2020	11/10/2020	1.00	17,557		
12/11/2020	11/24/2020	1.00	17,557		
12/25/2020	12/8/2020	1.00	17,557		
1/8/2021	12/22/2020	1.00	17,557		
1/22/2021	1/5/2021	1.00	17,557		
2/5/2021	1/19/2021	1.00	17,604		
2/19/2021	2/2/2021	1.00	17,604		
3/5/2021	2/16/2021	1.00	17,604		
3/19/2021	3/2/2021	1.00	17,604		
4/2/2021	3/16/2021	1.00	17,252		
4/16/2021	3/30/2021	1.00	17,604		
4/30/2021	4/13/2021	1.00	17,604		
5/14/2021	4/27/2021	1.00	17,604		
5/28/2021	5/11/2021	1.00	17,604		
6/11/2021	5/25/2021	1.00	17,604		
6/25/2021	6/8/2021	1.00	17,604		
7/9/2021	6/22/2021	1.00	17,604		
7/23/2021	7/6/2021	0.57	10,059	0.43	7,545
8/6/2021	7/20/2021			1.00	17,604
8/20/2021	8/3/2021			1.00	17,604
9/3/2021	8/17/2021			1.00	17,604
9/17/2021	8/31/2021			1.00	41,516
10/1/2021	9/14/2021			1.00	41,516
10/15/2021	9/28/2021			0.93	38,551
TOTAL BIWEEKLY PAYMENTS		19.71	346,363	6.36	181,939

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Pass-Through Payments

Before GME COL 4 PASSTHROUGH PAYMENT ALLOCATION 26.07	After GME COL 5 PASSTHROUGH PAYMENT ALLOCATION 26.07	COL 6 :QUESTRATION % REDUCTION ALLOCATION
$0		$0
$0		$0
$24,546	$24,546	$24,055
$0		$0
$0		$0
$2,712	$16,970	$16,631
$27,258	**$41,516**	$40,686
19.71	6.36	0.00
$537,372	$263,923	$0
$346,715	$181,939	$0
$190,657	$81,984	$0
		$272,641

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PRA Letter Excerpt

Projected - Floor & Ceiling

Part I: Computing Locality Adjusted National Average PRA

1.	Weighted Average per resident amount for cost reporting periods ending during FY 1997: (Source: CMS Transmittal A-01-38)	68,464	68,464
2.	CPI(U) to current cost report period	1.659453202	1.659453202
3.	National average PRA	113,612.80	113,612.80
4.	Geographic Adjustment Factor (as specified in the 10/31/97 Federal Register (62 FR 529257)	0.928	0.928
5.	Locality Adjusted National Average PRA	105,432.68	105,432.68
	Part II: Determining Floor	Primary Care	Non Primary Care
6.	Locality Adjusted National Average PRA for 2004	105,432.68	105,432.68
7.	Floor Percentage (FY 2001 Floor was 70%, FY 2002 and later Floor is 85%)	85.00%	85.00%
8.	**Floor --- 85% of locality adjusted average PRA**	**89,617.78**	**89,617.78**
9.	**Fiscal year 9/30/2021 Hospital specific GME cost per FTE**	**$105,814.04**	**$105,814.04**
10.	**Greater of Floor or hospital specific GME**	**105,814.04**	**105,814.04**
	Part III: Determining the Ceiling:		
11.	Locality Adjusted National Average PRA	105,432.68	105,432.68
12.	Ceiling Percentage	140.00%	140.00%
13.	**Ceiling --- 140% of locality adjusted average PRA**	**147,605.75**	**147,605.75**
14.	**Line 10 Greater of Floor or hospital specific GME**	105,814.04	105,814.04
15.	**GME - Per Resident Amount - 9/30/2021** Lessor of Ceiling or Floor	**105,814.04**	**105,814.04**

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NURSING & ALLIED HEALTH EDUCATION REIMBURSEMENT

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NAHE REIMBURSEMENT

Medicare reimburses qualifying hospitals for costs related to Nursing & Allied Health Education (NAHE)

- General requirements
  - + Approved educational activity recognized by a national approving body or state licensing authority
  - + Enhance the quality of healthcare at the provider
  - + Directly incur the training costs
  - + Direct control of the program curriculum
  - + Control the administration of the program (day-to-day operations)
  - + Employ the teaching staff
  - + Provide & control both classroom instruction & clinical training
- CMS has directed MACs to increase scrutiny on pass-through eligibility during audit

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NAHE REIMBURSEMENT

WEBINAR

Medicare reimburses allowable costs based on Medicare utilization

- Allowable costs must be net of tuition & fees charged
- Costs not allowable:
  - + Patient care costs
  - + Costs incurred by a related organization
  - + Costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support
- CRNA education programs are subject to additional requirements to avoid NAHE reimbursement for professional services

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NAHE REIMBURSEMENT

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Four Types of Allowable Costs

- Classroom costs
- Clinical training costs
- Direct costs (net)
- Indirect costs allocated on cost report

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NAHE REIMBURSEMENT

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NAHE cost report treatment

- Worksheet S-2 Part I, line 62 – Are costs claimed for nursing and allied health costs?
- Are you claiming nursing school and allied health costs for a program that meets the provider-operated criteria under 42 CFR 413.85? Enter “Y” for yes or “N” for no. If yes, you must identify such costs in the applicable column(s) of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs.
- Cost centers:

+20	Nursing School
+23	Paramedical Ed. Program (specify)

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NAHE REIMBURSEMENT

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NAHE cost report treatment cont.

Worksheet D Part III

- Calculates inpatient program pass-through costs for NAHE
  - + NAHE costs for routine cost centers times Medicare share
  - + Result is carried to Worksheet E Part A line 57

Worksheet D Part IV

- Calculates ancillary program pass-through costs for NAHE
  - + Calculates NAHE ancillary costs & apportions between inpatient & outpatient
  - + Results are carried to Worksheet E Part A line 58 (IP) & Worksheet E Part B line 9 (OP)

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NAHE REIMBURSEMENT

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NAHE cost report treatment cont.

Worksheet D Part III

- Calculates inpatient program pass-through costs for NAHE
  - NAHE costs for routine cost centers times Medicare share

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost
			9.00	13.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,226	0
31.00	03100	INTENSIVE CARE UNIT	5,247	0
32.00	03200	CORONARY CARE UNIT	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,289	0
35.00	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0
35.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0
40.00	04000	SUBPROVIDER - IPF	311	0
41.00	04100	SUBPROVIDER - IRF	0	0
42.00	04200	SUBPROVIDER	0	0
43.00	04300	NURSERY	0	0
44.00	04400	SKILLED NURSING FACILITY	0	
45.01	04510	ICF/MR	0	
200.00		Total (lines 30 through 199)	14,073	0

  - Line 200 less excluded units (14,073 – 311 = 13,762)

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NAHE REIMBURSEMENT

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NAHE cost report treatment cont.

Worksheet D Part IV

- Calculates ancillary program pass-through costs for NAHE
  - + Calculates NAHE ancillary costs & apportions between inpatient & outpatient
  - + Results are carried to Worksheet E Part A line 58 (IP) & Worksheet E Part B line 9 (OP)

76.00	03950	ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	519,347	0	1,263,914	0	76.01
76.02	03951	CARDIOVASCULAR LAB	0.000000	4,208,486	0	2,472,798	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	3,086,113	0	14,542,526	0	90.00
90.01	09001	SATELLITE CLINICS	0.000000	68,743	0	3,078,559	0	90.01
91.00	09100	EMERGENCY	0.007777	22,472,216	174,766	19,018,835	147,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000135	176,267	24	335,244	45	92.00
92.01	09202	OBSERVATION BEDS (DISTINCT PART)	0.000000	171,512	0	778,932	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	COVID-19	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		304,308,608	380,896	136,776,160	274,993	200.00

D, Part IV Col 10 Col 12

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NAHE REIMBURSEMENT

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NAHE reimbursement for Medicare Advantage activity

- Reflected on worksheet E Part A line 53
- Introduced by CMS Transmittal A-00-86 dated 11/22/00, but not widely implemented by hospitals until recent years
- Many qualifying hospitals are still not claiming
- Some contractors have began calculating amount & adding on as an audit adjustment
- Amount is based on the pass-through amounts per Worksheets D Parts III & IV, ratio of Medicare Part C days to total days, & a fixed national payment pool which has not been updated since the program was implemented
    + Two-/Three-year lag between when calculations components are reported & when they are used in the calculation

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NAHE REIMBURSEMENT

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Change Request 11642 (Effective September 21, 2020) impacts CY 2002 forward.

- Change impacts the methodology used to calculated Medicare Advantage NAHE payments
  - + CMS-2552-96, line 11.01 of Worksheet E, Part A
  - + CMS-2552-10, line 53 of Worksheet E, Part A
- Established a Medicare Advantage NAHE payment pool not to exceed $60 million

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NAHE REIMBURSEMENT

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NAHE reimbursement for Medicare Advantage activity cont.

- Example calculation (OLD METHOD)

1	Total payments for nursing and allied health from **cost report two years prior** (Worksheet D Part III, Col 9, Line 200 + Worksheet D Part IV, Col 11, Line 200)	100,000
2	Total inpatient days from **cost report two years prior** (Worksheet S-3, Part I, Col 6 sum of Lines 1, 6-10, 14, 14.01)	28,000
3	NAHE payment per day (Line 1/Line2)	3.57
4	Medicare advantage days from **cost report two years prior** (PS&R report type 118)	2,800
5	Hospital portion of ratio (Line 3 x Line 4)	9,996
6	CMS portion of ratio*	6,134,256
7	Ratio of hospital payments to total Medicare Payments (Line 5 /Line 6)	0.001600
8	Total spending (pool)*	43,663,043
9	Total additional payment (Line 7 × Line 8)	**69,861**

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NAHE REIMBURSEMENT

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NAHE reimbursement for Medicare Advantage activity cont.

- Example calculation (NEW METHOD)

1	Total payments for nursing and allied health from **cost report two years prior** (D, Part III, Column 9, Line 200 + D, Part IV, Column 11, Line 200)	100,000
2	Total inpatient days from **cost report two years prior** (Worksheet S-3, Part I, Col 6 sum of Lines 1, 8-12, 16-18.01, 32)	28,000
3	Medicare advantage days from **cost report two years prior** (Worksheet S-3, Part I, Col 6 Lines 2-4 or PS&R report type 118)	2,800
5	Hospital payment-to-days ratio (Line 1 / Line 2)	357%
6	Hospital portion of Medicare advantage inpatient days for pool (Line 3 x Line 5)	**10,000**
7A	Medicare advantage nursing and allied health pool	60,000,000
7B	Total FFS nursing and allied health payments	267,714,849
7C	Total inpatient days	61,066,487
7D	Total Medicare advantage days	7,888,809
8	National portion of ratio (Line 7B / Line 7C)	438.3990%
9	National Medicare advantage inpatient days for payment (Line 7D x Line 8)	**34,584,457**
10	Hospital Medicare advantage payment ratio (Line 6 / Line 9)	0.0289%
11	Total additional payment (Line 7A x Line 10)	**17,349**

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NAHE Reimbursement

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NAHE Medicare Advantage Payments

- Budget Neutral:
  + Reductions in DGME MA payments must equal ‘estimated’ total additional NAHE MA payments
- Change Request (CR) 11642 – effective 9/21/2020:
  + CMS instructed MACs to adjust payments for CY 2002–2019
  + Applied to hospitals open & cost reports within three-year reopening period
  + Established a NAHE Medicare Advantage (MA) pool not to exceed $60 million
- Section 4143 of the Consolidated Appropriations (CAA), 2023:
  + Adjusts payments made under Change Request 11642, 12596 & 12407
  + Implemented by CR 13122 (effective 12/29/2022)
  + Impacts calendar years (CYs) 2010 – 2019

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NAHE Reimbursement

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NAHE Medicare Advantage Payments

	MA N&AH POOL	FFS N&AH PAYMENTS	FFS INPATIENT DAYS	MA INPATIENT DAYS	(FFS N&AH/FFS INPT DAYS) X MA INPT DAYS	PERCENT REDUCTION TO MA DGME PAYMENTS
CY 2002	$ 8,725,221	$ 83,140,895	21,966,199	1,218,662	$ 4,612,571.00	4.58%
CY 2003	$ 11,268,425	$ 109,188,627	25,244,159	1,389,811	$ 6,011,353.00	5.88%
CY 2004	$ 10,879,994	$ 99,630,697	21,871,001	1,158,637	$ 5,278,031.00	5.20%
CY 2005	$ 14,928,729	$ 119,167,650	28,120,057	1,390,968	$ 5,894,668.00	6.06%
CY 2006	$ 12,256,712	$ 123,774,038	29,537,617	1,438,451	$ 6,027,666.00	6.28%
CY 2007	$ 23,347,058	$ 140,263,059	31,217,012	1,500,168	$ 6,740,496.00	7.13%
CY 2008	$ 36,214,939	$ 175,262,442	36,482,304	1,799,666	$ 8,645,667.00	8.86%
CY 2009	$ 44,399,680	$ 188,570,852	40,169,275	2,380,683	$ 11,175,891.00	9.88%
CY 2010	$ 60,000,000	$ 213,862,393	45,409,814	3,114,194	$ 14,666,631.00	9.77%
CY 2011	$ 60,000,000	$ 226,645,225	49,217,935	3,825,354	$ 17,615,494.00	7.85%
CY 2012	$ 60,000,000	$ 240,958,503	55,551,047	4,376,532	$ 18,983,667.00	7.16%
CY 2013	$ 60,000,000	$ 245,304,017	54,965,956	4,945,724	$ 22,071,952.00	6.41%
CY 2014	$ 60,000,000	$ 248,506,989	54,405,730	5,360,315	$ 24,484,107.00	5.86%
CY 2015	$ 60,000,000	$ 247,076,161	55,223,064	5,907,933	$ 26,432,967.00	5.32%
CY 2016	$ 60,000,000	$ 253,272,740	55,717,901	6,376,818	$ 28,986,630.00	4.99%
CY 2017	$ 60,000,000	$ 249,546,528	58,599,068	7,241,576	$ 30,838,548.00	4.44%
CY 2018	$ 60,000,000	$ 267,714,849	61,066,487	7,888,809	$ 34,584,457.00	4.12%
CY 2019	$ 60,000,000	$ 262,043,840	62,649,285	8,481,459	$ 35,475,490.00	4.07%

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NAHE Reimbursement

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NAHE Medicare Advantage Payments

- CR 13122, MACs shall halt processing of NPRs that used CRs 11642, 12596, & 12407. Instead, this CR provides a new table attachment with recalculated pool amounts for CYs 2010 through 2019
- MACs will first determine whether hospitals that received revised payments under CR 11642 were still receiving NAH MA payments on an interim basis as of 12/29/2022 (effective date of this adjustment)
  + If a hospital closed its NAHE programs as a result of CR 11642, it wouldn't be eligible for the Section 4143 adjusted payments
  + MACs have to adjust & issue revised NPRs within 1-year of effective date of 12/29/2022 & 60-days to correct cost reports for NPRs in progress as of issuance of CR 13122
- Applies to open or reopenable cost reports

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NAHE Reimbursement

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NAHE Medicare Advantage Payments

	MA N&AH POOL	FFS N&AH PAYMENTS	FFS INPATIENT DAYS	MA INPATIENT DAYS	(FFS N&AH/FFS INPT DAYS) X MA INPT DAYS	PERCENT REDUCTION TO MA DGME PAYMENTS
CY 2010	$ 62,997,033	$ 213,862,393	45,409,814	3,114,194	$ 14,666,631	9.77%
CY 2011	$ 66,438,422	$ 226,645,225	49,217,935	3,825,354	$ 17,615,494	7.85%
CY 2012	$ 76,035,672	$ 240,958,503	55,551,047	4,376,532	$ 18,983,667	7.16%
CY 2013	$ 84,753,118	$ 245,304,017	54,965,956	4,945,724	$ 22,071,952	6.41%
CY 2014	$ 92,598,893	$ 248,506,989	54,405,730	5,360,315	$ 24,484,107	5.86%
CY 2015	$ 102,448,386	$ 247,076,161	55,223,064	5,907,933	$ 26,432,967	5.32%
CY 2016	$ 110,412,962	$ 253,272,740	55,717,901	6,376,818	$ 28,986,630	4.99%
CY 2017	$ 119,165,456	$ 249,546,528	58,599,068	7,241,576	$ 30,838,548	4.44%
CY 2018	$ 130,335,289	$ 267,714,849	61,066,487	7,888,809	$ 34,584,457	4.12%
CY 2019	$ 140,589,366	$ 262,043,840	62,649,285	8,481,459	$ 35,475,490	4.07%
CY 2020	$ 60,000,000	$ 264,332,386	64,285,989	9,473,935	$ 38,955,111	3.71%
CY 2021	$ 60,000,000	$ 276,790,522	66,512,964	10,702,732	$ 44,538,908	3.22%
CY 2022	$ 60,000,000	$ 289,284,244	67,407,803	11,859,978	$ 50,897,739	3.27%
CY 2023	$ 60,000,000	$ 289,890,999	67,427,704	11,865,080	$ 51,011,375	3.27%

Worksheet E, Part A, Line 53

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MEDICARE BAD DEBTS

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REGULATORY GUIDANCE

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Medicare bad debts are addressed in:

- 42 CFR 413.89
- CMS Pub 15 – 1 (PRM), Chapter 3
- CMS Pub 13, Part IV (Intermediary Manual), Chapter II (Guidelines for Performing Provider Audits)

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BAD DEBT CRITERIA

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Criteria for allowable bad debts

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

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BAD DEBT CRITERIA

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Not Allowable

- Deductibles & coinsurance from professional fees such as CRNA & physician services, *i.e.*, billed on a 1500
- Deductibles & coinsurance resulting from fee schedule payments, *i.e.*, Therapy, Ambulance, & Lab fee schedule payments

  + See 42 CFR 413.89(i)
- Deductibles & coinsurance resulting from non-allowable services (service not covered by Medicare)
- Amounts from Self Administered Drugs &/or Late Charges
- Deductibles & coinsurance to enrollees of Medicare Advantage Plans
- Unpaid amounts written off to charity care or a contractual allowance account

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BAD DEBT CRITERIA

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Normal Accounting Treatment

- For cost reporting periods beginning before October 1, 2020
  - + Bad debts, charity, & courtesy allowances represent reductions in revenue
  - + Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts
- For cost reporting periods beginning on or after October 1, 2020
  - + Bad debts, also known as “implicit price concessions”, charity, & courtesy allowances represent reductions in revenue
  - + Medicare bad debts must not be written off to a contractual allowance account but must be recorded as an implicit price concession that results in a reduction in revenue

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BAD DEBT REIMBURSEMENT

Hospital (IP/OP), Psych & Rehab, & Regular SNF Bad Debts	• Beginning in FY 2013, subject to 35% reduction in reimbursement (65% reimbursement)

CAHs, SNF Crossovers, RHCs & Other Entities	• Transitioned to 35% reduction in reimbursement
	  • **FY 2013** subject to 12% reduction in reimbursement (88% reimbursement)
	  • **FY 2014** subject to 24% reduction in reimbursement (76% reimbursement)
	  • **FY 2015** subject to 35% reduction in reimbursement (65% reimbursement)

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BAD DEBT TYPES

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Excerpt from FY 2021 IPPS Final Rule: "… we believe that as we clarify and codify these longstanding bad debt policies, it is important to set forth the definition of each of these three beneficiary categories so that it is clear which bad debt collection effort policy applied, and continue to apply, to each."

Regular Bad Debts

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

Crossover Medicare Bad Debts

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

Indigent Medicare Bad Debts

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

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REGULAR BAD DEBTS

Commonly referred to as traditional bad debts or valid efforts

Bad debts following internal collection process

Subject to reasonable collect effort standards outlined in PRM 15-1, §310

Accounts must be returned from the collection agency & all collection efforts ceased prior to being claimed as a Medicare bad debt

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REGULAR BAD DEBTS

FY 2021 IPPS Final Rule – Reasonable Collection Effort Updates for Non-Indigent Beneficiaries

Effective for cost reporting periods beginning before, on, & after the effective date of this rule:

- A provider's reasonable collection effort requirement for a non-indigent beneficiary must also start a new 120-day collection period each time a payment is received within a 120-day collection period
  - +Partial payment restarts the 120-day minimum collection period
- A provider's effort to collect Medicare deductible & coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients
  - +Referring "like amounts" to outside collection agencies
  - +Providers are responsible for ensuring collection agencies use similar collection practices
- Provider's must maintain &, upon request, furnish verifiable documentation to its contractor that includes all of the following:
  - +(i) The provider's bad debt collection policy
  - +(ii) The patient account history, showing collection efforts
  - +(iii) The beneficiary's file with copies of the bill(s) & follow-up notices

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REGULAR BAD DEBTS

FY 2021 IPPS Final Rule – Reasonable Collection Effort Updates for Non-Indigent Beneficiaries

Effective for cost reporting periods beginning on or after October 1, 2020:

- a provider's collection effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the latter of one of the following:
  - (1) the date of the Medicare remittance advice that is produced from processing the claim for services furnished to the beneficiary that generates the beneficiary's cost sharing amounts
  - (2) the date of the remittance advice from the beneficiary's secondary payer, if any
  - (3) the date of the notification that the beneficiary's secondary payer does not cover the service(s) furnished to the beneficiary

Effective for cost reporting periods beginning before October 1, 2020:

- a provider's collection effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary

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CROSSOVER BAD DEBTS

Bad debts applicable to patients who qualify for both Medicare & Medicaid coverage.

These patients are deemed indigent based on their Medicaid eligibility

However, the provider must bill Medicaid & obtain a paid remittance advice even if the paid amount is zero

- FY 2021 IPPS Final Rule allows for alternate documentation in limited circumstances

Providers may claim the unpaid portions of the deductible/coinsurance when Medicaid has made a partial payment

See PRM 15-1, §312 & §322

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FY 2021 IPPS FINAL RULE SUMMARY – CROSSOVERS

The provider must bill the State for the QMB's Medicare cost sharing & submit the resulting Medicaid RA the provider receives to Medicare to evidence the State's Medicare cost sharing liability, so that any State Medicare cost sharing liability can be deducted from the Medicare bad debt reimbursement

Alternative documentation to the Medicaid RA:

1) State Medicaid notification evidencing that the State has no obligation to pay the beneficiary's Medicare cost sharing or notification evidencing the provider's inability to enroll in Medicaid for purposes of processing a crossover sharing claim
2) Documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing, &
3) Documentation verifying the beneficiary's eligibility for Medicaid for the date of service.

Financial reporting

- For cost reporting periods before October 1, 2020, Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts
- For cost reporting periods on or after October 1, 2020, Medicare bad debts must not be written off to a contractual allowance account but must be charged to an uncollectible receivables account that results in a reduction in revenue

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INDIGENT BAD DEBT

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Indigent Medicare Bad Debts

- §312. INDIGENT OR MEDICALLY INDIGENT PATIENTS
  In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

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Indigent Medicare Bad Debts – Prior to 10/01/2020

§312. INDIGENT OR MEDICALLY INDIGENT PATIENTS (cont.)

A. The patient's indigence **must** be determined by the provider, not by the patient; *i.e.*, a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigency;

B. The provider **should** take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. The provider **must** determine that no source other than the patient would be legally responsible for the patient's medical bill; *e.g.*, title XIX, local welfare agency and guardian; and

D. The patient's file **should** contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

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INDIGENT BAD DEBT

Indigent Medicare Bad Debts – Prior to 10/01/2020 (cont.)

- §312. INDIGENT OR MEDICALLY INDIGENT PATIENTS (cont.)

  Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. (See §322 for bad debts under State Welfare Programs.)

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INDIGENT – FY 2021 IPPS FINAL RULE SUMMARY

Indigence Determinations – Effective 10/01/2020 and forward

- **42 CFR 413.89 (e)(2)(ii) – to define an indigent non-dual eligible beneficiary as a Medicare beneficiary who is determined to be indigent by the provider and not eligible for Medicaid as categorically or medically needy.**
  - New paragraph (e)(2)(ii)(A) specifies that in order to conclude that a beneficiary is an indigent non-dual eligible beneficiary, the provider:
    - **Must** not use a beneficiary's declaration of their inability to pay their medical bills or deductibles and coinsurance amounts as sole proof of indigence or medical indigence,
    - **Must** take into account the analysis of both the beneficiary's assets (only those convertible to cash and unnecessary for the beneficiary's daily living) and income,
    - **May** consider extenuating circumstances that would affect the determination of the beneficiary's indigence or medical indigence which may include an analysis of both the beneficiary's liabilities and expenses, if indigence is unable to be determined under (ii)(A)(2),
    - **Must** determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill, such as a legal guardian or State Medicaid program, and
    - **Must** maintain and, upon request, furnish its Medicare contractor with the provider's indigence determination policy describing the method by which indigence or medical indigence is determined and all the verifiable beneficiary specific documentation which supports the provider's determination of each beneficiary's indigence or medical indigence.

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RECOVERIES

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Medicare bad debt recoveries include patient payments, but also include insurance payments & changes in patient responsibility due to Medicare reprocessing

- Patient payment recoveries should be relatively uncommon because accounts should not be receiving any collection efforts once claimed as a Medicare bad debt & in many cases, the account balance has been adjusted to zero

Greater emphasis being placed on Medicare recoveries during audit process. Can be difficult to satisfy audit requirements of recoveries.

- Auditors are scrutinizing recoveries & requesting reconciliation to total recoveries in the G/L
- Even a thorough process of capturing recoveries does not eliminate potential audit issues because recovery G/L accounts do not coincide with Medicare bad debt recoveries

Global recovery percentages may be used to impute recovery amounts against entire Medicare bad debt log totals when recovery logs are not provided or verified as accurate.

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REGULAR BAD DEBTS – COMMON AUDIT ISSUES

Collection & Policy Audit Issues

- Must provide copies of written policies at beginning of Medicare bad debt audit
  - Policy provided should be what was in place at time of bad debt log preparation, which may have changed since then
- Difference between written collection policy & actual hospital process.
  - Specific example: Actual number of letters sent to a patient vs. how many letters policy specifies
- Dissimilar treatment of Medicare & non-Medicare accounts
  - Audit will select a sample of non-Medicare accounts to look for evidence of dissimilar treatment
  - Accounts sent to different agencies based on payer or Medicare accounts not referred at all
    - Secondary agencies
  - Timeframes for collections vary by primary financial class, *i.e.*, 90 days of internal efforts for non-Medicare primary accounts & 120 days for Medicare primary accounts
  - Collection actions vary by payor, *i.e.*, more letters, calls for non-Medicare accounts

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REGULAR BAD DEBTS – COMMON AUDIT ISSUES

Documentation Audit Issues

- Lack of documentation of bankruptcy or no estate
- Collection efforts not documented in patient accounting system
  - Explanation for gaps in collection process
- Collection agency is subject to providing patient transaction history to document communications to collect debt
  - Consider ability to obtain documentation from collection agencies that are no longer in use by provider
- Lack of proper or adequate documentation of return of account from the collection agency prior to the fiscal year-end
- Lack of documentation to support that other payors or responsible parties were billed
- Account notes show potential continued collection efforts after account was returned as ceased collections

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CROSSOVER BAD DEBTS – COMMON AUDIT ISSUES

Subsequent Medicaid Remittance Advices may not be taken into account if the claim is reprocessed.

Crossover accounts are often duplicated when Medicaid reprocesses the claim

Providers often miss posting Medicaid payments that overstate the crossover bad debt

- Often miss other insurance/patient payments as well, if applicable
- Medicaid payments can be recoveries

Use of Medicaid contractual adjustment to adjust the balance after Medicaid pays, rather than a separate transaction code mapping to bad debt in the GL

Collecting on account balance as opposed to writing off balance after Medicaid pays, *i.e.*, balance billing

- 42 C.F.R § 447.15 – Acceptance of State payment as payment in full

No good adjustment codes on Medicaid remittance advice – Medicaid processed claim with a code that did not indicate the balance should be written off because Medicare paid more than Medicaid allows

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INDIGENT BAD DEBT – COMMON AUDIT ISSUES

The indigence determination was not made using full resource analysis – test of income, assets, expenses & liabilities – Cost report periods beginning prior to 10/1/2020

"Comparison of the beneficiary's income to the federal poverty guidelines alone does not qualify the beneficiary as indigent." *Excerpt from MAC Audit Workpaper*

Not supplying complete backup documentation to support provider's indigence determination:

-Bankruptcy

-Deceased with no estate

-Support of information in financial assistance application – W-2s, check stubs, banking information, tax returns, etc.

Issues with patient's financial assistance application:

-Outdated (per provider's policy)

-Not signed

-No approval letter available

The indigence determination was not made using income & assets – Cost report periods beginning on or after 10/1/2020

"Comparison of the beneficiary's income to the federal poverty guidelines alone does not qualify the beneficiary as indigent." *Excerpt from MAC Audit Workpaper*

Unable to provide documentation of checking for other responsible parties

Use of predictive indexing as primary source of indigent approval

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WORKSHEET S-2, Part II EXHIBIT 2 – Previous CMS Format

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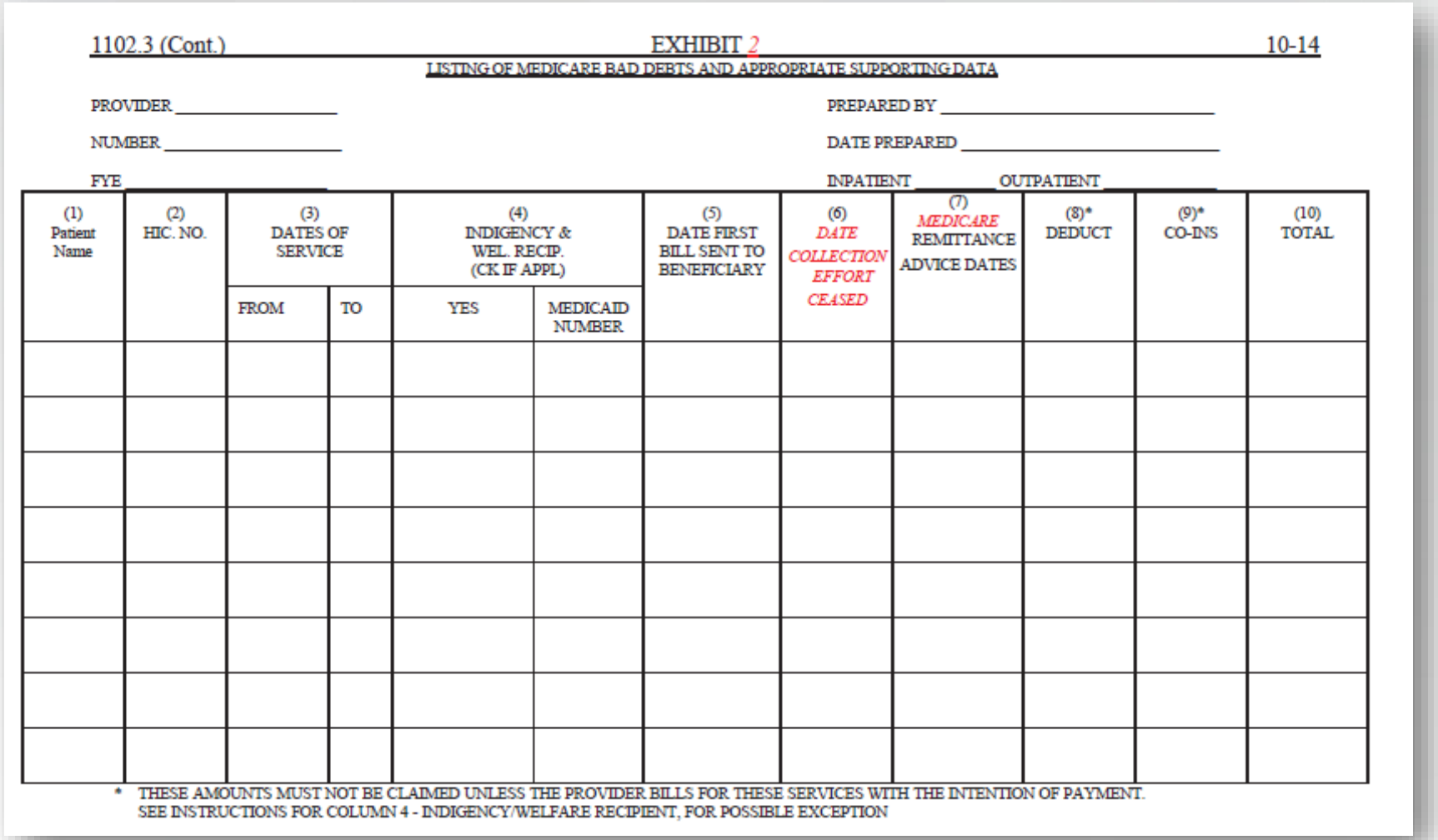

1102.3 (Cont.) EXHIBIT 2 10-14

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____ PREPARED BY _____

NUMBER _____ DATE PREPARED _____

FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) *DATE COLLECTION EFFORT CEASED*	(7) *MEDICARE* REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION

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Exhibit 2A – Effective for cost reports beginning on or after 10/1/2022

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13

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Exhibit 2A – Effective for cost reports beginning on or after 10/1/2022

A/R WRITE OFF DATE	SENT TO COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE AMOUNT*	MEDI-CARE CO-INSUR-ANCE AMOUNT*	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

NOTE FOR COLUMNS 14 THROUGH 17: *The dates reported in column 14 (the date that the Medicare beneficiary's liability was written off of the provider's accounts receivable), column 15 (the date that the collection agency ceased collection effort), column 16 (the date that all collection efforts ceased), and column 17 (the date that deductible and coinsurance amounts were written off as a Medicare bad debt), may be the same date.*

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Bad Debt Logs – Operational Considerations

Bad debt amount exceeds allowable Medicare coinsurance & deductible – Check formulas or run a formula to look for instances where final bad debt amount is greater than coinsurance & deductible less payments

Bad debt amounts include fee schedule &/or professional coinsurance & deductible – Can be hard to identify, but small coinsurance amounts on Inpatient log can be an indicator

Payments were not netted against accounts before being claimed on the Medicare bad debt log

Medicare bad debt logs do not contain all of the required information. (CMS Exhibit 2 & 2A)

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Bad Debt Logs – Operational Considerations (cont.)

- Timely Billing – Check for 120 days from Medicare RA date to first bill date &/or secondary payer remittance advice/denial date
- Bad debt amount was claimed on a previous cost report
- Bad debt log contains duplicate accounts – Count if formula on account number can be a quick check
- Not collected for 120 days after last patient payment – Unclear why last patient payment date was not included in new Exhibit 2A to allow for this calculation on entire log

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COST REPORT WORKSHEET G SERIES

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WORKSHEET G SERIES

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FINANCIAL STATEMENT WORKSHEETS

Prepare these worksheets from your accounting books and records.

…

Complete all worksheets in the "G" series. ... Cost reports received with incomplete G worksheets are returned to you for completion. If you do not follow this procedure, you are considered as having failed to file a cost report. Where applicable, Worksheets G, G-1, G-2, and G-3 must be consistent with financial statements prepared by Certified Public Accountants or Public Accountants.

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WORKSHEET G SERIES

WEBINAR

WORKSHEET G // *Balance Sheet*

WORKSHEET G-1 // *Statement of Changes in Fund Balances*

WORKSHEET G-2 // *Parts I & II – Statement of Patient Revenues and Operating Expenses*

WORKSHEET G-3 // *Statement of Revenues and Expenses*

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COST REPORT WORKSHEET S-2, PARTS I & II

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WORKSHEET S-2, PARTS I & II

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Part I – Hospital and Hospital Health Care Complex Identification Data

The information required on this worksheet is needed to properly identify the provider. The responses to all lines are Yes or No unless otherwise indicated by the type of question.

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WORKSHEET S-2, PARTS I & II

Part II – Hospital and Hospital Health Care Complex Reimbursement Questionnaire

The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all hospitals submitting cost reports to the Medicare contractor under Title XVIII of the Social Security Act (hereafter referred to as "The Act"). Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of cost reports. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

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WORKSHEET S-2, PARTS I & II

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Never just roll forward responses from prior year

- CMS periodically revises questions resulting in need for different response
- Circumstances may dictate a need for a different response this year
- Prior year's response may have been wrong!

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COST REPORT WORKSHEET S-3 PART I

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WORKSHEET S-3 PART I

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- WORKSHEET S-3 – HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION
- Part I – Hospital and Hospital Health Care Complex Statistical Data. – This part collects statistical data regarding beds, days, FTEs, and discharges

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WORKSHEET S-3 PART I

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- S-3, Part I, Beds
  - + Number of beds available for use by patients at the end of the cost reporting period. Not necessarily licensed beds
  - + Beds utilized for only a portion of stay not included (Emergency Room, Ancillary, Post-Op, Recovery, Outpatient areas)
  - + Distinct Part Units such as Psych or Rehab reported separately
  - + Line 24 Hospice is for a distinct inpatient hospice unit

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WORKSHEET S-3 PART I

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- Labor and Delivery Beds
  - +Labor and Delivery – Distinct unit labor and delivery beds are to be reported on Line 32. Inpatient portion, unoccupied portion, as well as labor portion to be reported as part of the bed count
  - +Labor and Delivery beds are to be reduced by outpatient portion on Lin 32.01
  - +Labor Delivery Post-Partum (LDP) all-inclusive beds are included on Line 1.

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WORKSHEET S-3 PART I

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- Labor and Deliver IP versus OP
  - Line 32 Labor and Delivery Days:
    - In the case of an LDRP, instructions indicate to proportion ancillary portion of labor delivery versus post partum and report labor delivery days on this line
    - Hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP or have L&D log to count time before birth.
  - Line 32.01 Labor and Delivery Outpatient Days
    - Enter the equivalent days attributable to OP services in DISTINCT L&D
    - Calculate the number of days by dividing the total number of hours (labor delivery for outpatients) by 24.
    - Includes the hours for outpatients occupying the distinct ancillary labor and delivery room until they are admitted.
    - The outpatient days reported on this line will be used to reduce the available bed days reported on line 32 so that only distinct ancillary labor and delivery beds which are occupied by an inpatient or unoccupied are ultimately counted as beds.

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WORKSHEET S-3 PART I

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- Critical Access Hospital (CAH) Hours
  - + CAH Hours are reported on S-3, Part I Column 4
  - + CAH accumulation of hours for patient in Line 1 (excluding swing beds) & Line 8.
  - + These are informational only
  - + Most CAH's do not track these hours.
  - + Typically, use 24 hours multiplied by the number of day in each category.

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WORKSHEET S-3 PART I

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- Discharges
  - + For patients directly discharged “released” from the hospital ICU or death in the ICU, these discharges should also be included on Line 1
  - + Non distinct hospice days in the general inpatient unit line 24.1, discharges should not be reported on line 1.
  - + Swing bed discharges should be excluded from line 1 since costed out separately
  - + Include Medicare & Medicaid discharges for HMO/eligible days on line 2 if available

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WORKSHEET S-3 PART I

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- Observation Days
  - + Observation days should only be computed if observation patient is in a routine patient care area.
  - + Observation cost derived from per diem cost in the inpatient unit.
  - + Distinct observation units should be costed out separately (specific cost center like other outpatient cost centers)
  - + Divide total observation bed hours by 24
  - + Compare the hospital observation days from the stats used against the hospitals detailed revenue file.

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Worksheet S-10 & Charity Care

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Uncompensated Care Payment

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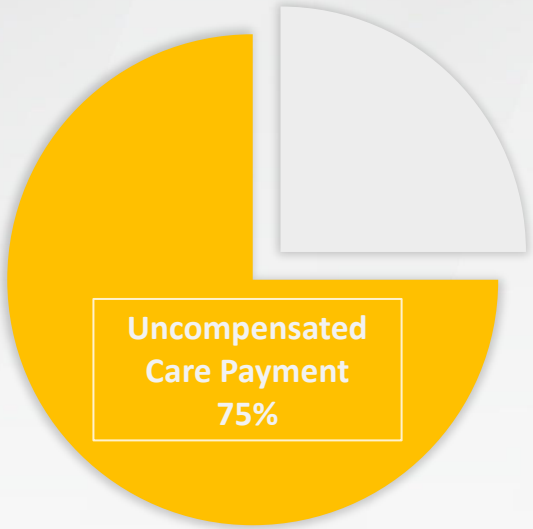

1. 75% of the estimated DSH payment that would otherwise be made under the old DSH Methodology

2. 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured as compared to uninsured prior to ACA

3. A hospital's amount of uncompensated care relative to the amount of uncompensated care for all DSH hospitals expressed as a percentage

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FY 2024 IPPS Final Rule

- Estimated DSH (Factor 1)
  + FFY 2022 = $10,488,564,546
  + FFY 2023 = $10,461,731,029
  + FFY 2024 = $10,015,191,022
- Factor 2
  + FFY 2022 = 68.57%
  + FFY 2023 = 65.71%
  + FFY 2024 = 59.29%
- Uncompensated Care Pool
  + FFY 2022 = $7,192,008,710
  + FFY 2023 = $6,874,403,459
  + FFY 2024 = $5,938,006,757

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FY 2024 IPPS Final Rule

Future uncompensated care payments will be based on:

FY2023	FY2024	FY2025
Factor 3 = Average of FY2018 & FY2019 Reports	Factor 3 = Average of FY2018, FY2019 & FY2020 Reports	TBD

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Data Requirements

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- Transmittal 18
  - Several additional columns on the data requirements
    - + Medicare DSH
    - + Worksheet S-10
  - Worksheet S-10: 2 Parts
    - + Part I: entire hospital complex.
    - + Part II: inpatient & outpatient services billable under the hospital CCN
  - Effective for cost reports beginning on or after 10/1/2022

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Exhibit 3B — Charity Care Listing

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Supporting Exhibit	Charity Care Charges

Provider Name:	
Provider Number (CCN):	
Component CCN:	
FYB:	
FYE:	
Prepared By:	
Date Prepared:	
Uninsured Column 20	$0.00
Insured Column 20	$0.00

Patient Name - Last	Patient Name - First	Date of Service - From	Date of Service - To	Patient Account Number	Insurance Status	Primary Payor	Secondary Payor	Total Charges for Claim	Physician / Professional Charges
1	2	3	4	5	6	7	8	9	10

Deductible / Coinsurance / Copay Amounts	Total Third Party Payments	Insured Contractual Allowance Amount	Other Non-Allowable Amounts	Total Patient Payments	Amounts Written Off as Bad Debt	Uninsured Discount Amounts	Charity Care Non-Covered Charges	Other Charity Care Charges	Amounts Written Off to Charity Care and Uninsured Discounts	Write Off Date
11	12	13	14	15	16	17	18	19	20	21

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Charity Care Charges

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- **Uninsured**
  - + Reduced to cost
  - + Exhausted benefits
- **Insured**
  - + Coinsurance, copay, deductible, coinsurance
- **COVID Treatment**
  - ***Adjustments must reconcile to policies!***

Worksheet S-10	Included
Charity Care	✓
Courtesy Discounts	✗
Uninsured Discounts	✓
Non-contract	✓
Presumptive Eligibility	✓

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Exhibit 3C — Listing of Total Bad Debt

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Supporting Exhibit	Total Bad Debt

Provider Name	
Provider Number (CCN)	
Component CCN	
FYB	
FYE	
Prepared By	
Date Prepared	
Total Column 17	$0.00

Patient Last Name	Patient First Name	Date of Service - From	Date of Service - To	Patient Acct. Number	Insurance Status	Primary Payor	Secondary Payor
1	2	3	4	5	6	7	8

Service Indicator	Total Charges	Total Physician / Professional Charges	Total Patient Payments	Total Third Party Payments	Patient Charity Care Amount	Contractual Allowance / Other Amount	A/R Write Off Date	Patient Bad Debt Write Off Amount
9	10	11	12	13	14	15	16	17

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Worksheet S-10

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Reporting Challenges

- Policy Review
- Data Reconciliations

Audits

- S-10 Audit Preparation
- S-10 Audit Sample Documentation Review

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Example: Adjustment Impact on Line 30

Line #	Line Description	2022 S-10 Audit Support			Final Adjustments		
Uncompensated and indigent care cost computation							
1.00	Cost to Charge Ratio			0.184369			0.184369
Uncompensated Care		**Uninsured**	**Insured**	**Total**	**Uninsured**	**Insured**	**Total**
20.00	Total initial obligation of patients approved for charity care	13,753,996	3,103	13,757,099	13,328,709	3,103	13,331,812
21.00	Cost of initial obligation of patients approved for charity care	2,535,810	3,103	2,538,913	2,457,401	3,103	2,460,504
22.00	Partial payment by patients approved for charity care	-	-	-	-	-	-
23.00	Cost of charity care	2,535,810	3,103	2,538,913	2,457,401	3,103	2,460,504
25.00	Charges for patient days beyond an indigent care program's length of stay limit			-			-
26.00	Total bad debt expense			6,588,197			6,588,197
27.00	Medicare reimbursable bad debts			114,264			114,264
27.01	Medicare allowable bad debts			175,790			175,790
28.00	Non-Medicare bad debt			6,412,407			6,412,407
29.00	Cost of non-Medicare bad debt expense			1,243,775			1,243,775
30.00	Cost of uncompensated care			3,782,688			3,704,279
31.00	Total Unreimbursed and uncompensated care cost			4,561,193			4,704,975

Decrease in Line 30	**(78,409)**	**-2.07%**

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Impact on Uncompensated Care

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	Uncompensated Care Payment Calculation			Impact of change in S-10 Line 30		
Factor 1 - FFY 2024 Proposed Rule	$ 13,948,974,706			$ 13,948,974,706		
Factor 1 - ACA Reduction	75%			75%		
Factor 1	$ 10,461,731,029			$ 10,461,731,029		
Uninsured for 2013	14%			14%		
Uninsured for 2024	9.2%			9.2%		
Factor 2	65.71%			65.71%		
Total Uncompensated Care Amount	$ 6,874,403,459			$ 6,874,403,459		
	2018 S-10	**2019 S-10**	**2020 S-10**	**2018 S-10**	**2019 S-10**	**2020 S-10**
Uncompensated Care Costs - Per CMS Table in FFY 2024 Proposed Rule	$ 4,776,750	$ 5,200,777	$ 4,380,905	$ 4,776,750	$ 5,200,777	$ 4,380,905
Decrease in Worksheet S-10, Line 30				-2.07%	-2.07%	-2.07%
Adjusted 2019 S-10, Line 30				$ 4,677,736	$ 5,092,974	$ 4,290,096
Total Uncompensated Care Costs	$ 33,545,755,189	$ 34,596,832,178	$ 33,536,290,005	$ 33,545,755,189	$ 34,596,832,178	$ 33,536,290,005
Factor 3	0.000142395	0.000150325	0.000130632	0.000139443	0.000147209	0.000127924
Factor 3 Average			0.000141117			0.000138192
Factor 3 Adjustment			97.59%			97.59%
Hospital Uncompensated Care Payment			$ 946,722			$ 927,098

Estimated Impact - Decrease in Worksheet S-10, Line 30	**$ (19,624)**

Note: Total impact averaged over 3 years.

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Medicare DSH Program & Policy

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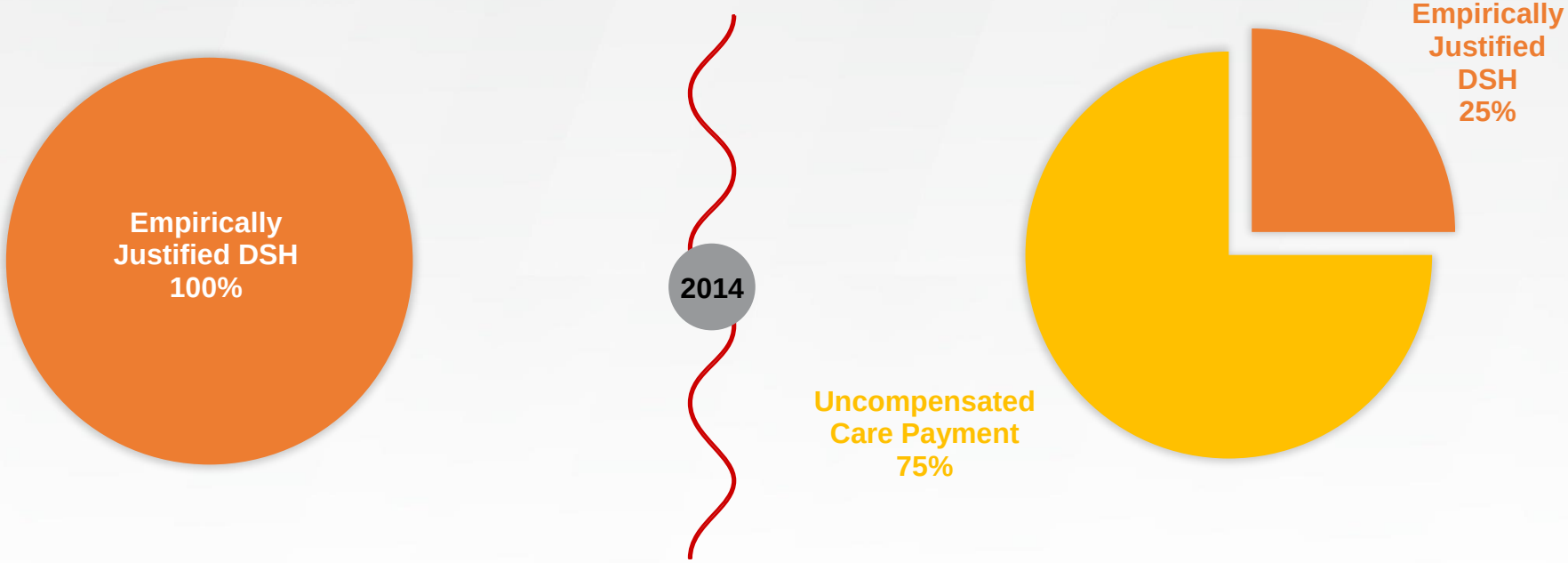
Disproportionate Share Hospital (DSH) Program

Established by Congress in 1986

Purpose

To provide additional reimbursement for hospitals that serve a disproportionate share of ***low-income*** patients.



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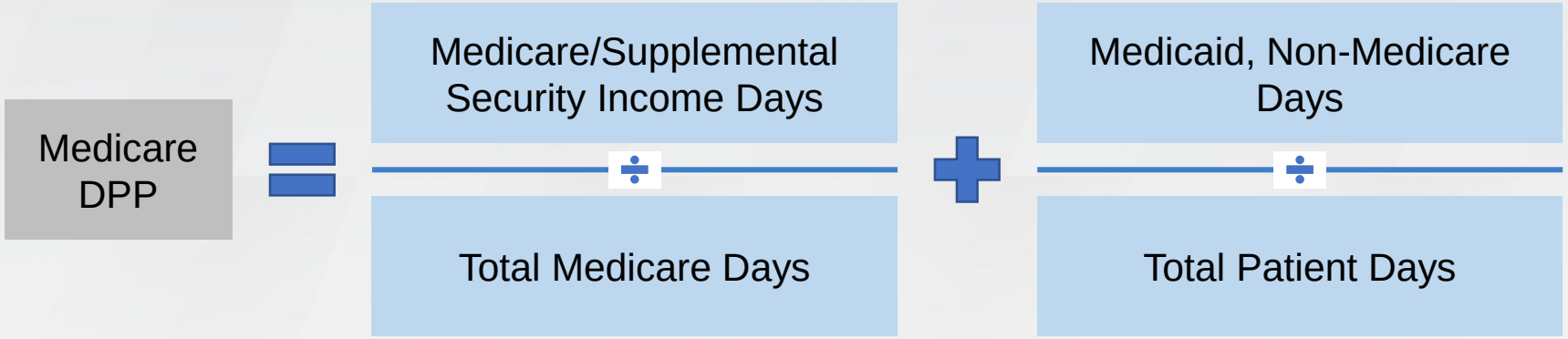
Empirically Justified DSH



SSI Fraction

- Entitled to both Medicare Part A & C
- Supplemental Security Income (SSI)

Medicaid Fraction

- Medicaid-eligible patient days
- Not covered under Part A
- Not covered under Part C

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Medicare DSH Payment Adjustment Formulas

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Disproportionate Patient Percentage (DPP)	Federal DRG Adjustment %
DPP < 15%	Does Not Qualify
15 < DPP < 20.2%	2.5% + [.65 × (DPP – 15%)]
DPP > 20.2%	5.88% + [.825 × (DPP – 20.2%)]

Other factors affecting DSH adjustment formula:

- Rural/Urban status
- Number of beds

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Medicare DSH

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- SSI Fraction – Supplemental Security Income

Medicare/Supplemental Security Income Days

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Total Medicare Days

Administered by the Social Security Administration (SSA)

Monthly benefits paid to individuals with limited income & resources & the following characteristics:

- Disabled
- Blind or
- Age 65 or older

Benefit provides minimum requirements for food, shelter, & clothing

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Medicare DSH

- SSI Fraction (cont.)

$$\frac{\text{Medicare/Supplemental Security Income Days}}{\text{Total Medicare Days}}$$

Hospitals with year-ends other than 9/30 have option to use SSI % based on hospital's fiscal year

Election are made annually, & do not have to be consistent from year to year

Hospitals should assess SSI detail to determine more beneficial approach

- Providers can submit data request to CMS to receive SSI detail by year

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Medicaid Fraction

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- What is a Medicaid Day?

Medicaid, Non-Medicare Days

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Total Patient Days

Include all days eligible for medical assistance under a state approved Title XIX plan & not entitled to benefits under Medicare Part A or C

Eligible days that may be controversial should be identified & the impact of those days included as a protested amount in the filed cost report

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Medicaid Fraction

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- What is a Medicaid Day?

Medicaid, Non-Medicare Days

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Total Patient Days

INCLUDABLE DAYS	EXCLUDED DAYS
Low-Income Families	Dual Eligible
Transitional Medical Assistance	General Assistance
Extended Medicaid due to Child or Spousal Support Collections	Other State-Only Health Programs
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Charity Care
Qualified Pregnant Women and Children	Separate CHIP
Mandatory Poverty Level Related Pregnant Women	Medicaid DSH
Mandatory Poverty Level Related Infants	
Mandatory Poverty Level Related Children Aged 1-5	
Mandatory Poverty Level Related Children Aged 6-18	
Deemed Newborns	
Individuals Receiving SSI	
Aged, Blind and Disabled Individuals in 209(b) States	
Individuals Receiving Mandatory State Supplements	
Individuals Who Are Essential Spouses	

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Medicare DSH

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HOT ISSUES

- SSI Realignment
- Section 1115 Waiver Days
- Retroactive Eligible Days
- Part C Final Rule
- Capital DSH

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DSH Federal Regulation

DSH Implemented under Section 1886(d)(5)(F) of the Social Security Act

- Affordable Care Act, Sec 3133: amendment to add1886(d)(5)(R) Additional payment for uncompensated care established.
- 80 Federal Register(FR) 70298 (Section 413.24(j)): 2016 OPPS Final Rule, established requirements for amending cost reports for revised eligible days
- 83 Federal Register(FR) 41144(Section 413.24(f)(5)(i)(C)): 2019 IPPS Final Rule for supporting documentation requirement

  + MLN SE19015
- Transmittal 18: New reporting requirements for cost reporting periods beginning on or after October 1, 2022
- 88 Federal Register(FR) 37772 (Section 412.24(j)): Treatment of Medicare Part C Days
- 88 Federal Register(FR) 58640 (Section 412.106(f)(1)) 2024 IPPS Final Rule: Policy Change on Section 1115 Waiver Days

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Exhibit 3A — Listing of Medicaid-Eligible Days for a DSH-Eligible Hospital

Supporting Exhibit	Medicaid-Eligible Days

Provider Name	
Provider Number (CCN)	
FYB	
FYE	
Worksheet S-2, Part I Line (Enter 24 or 25 only)	
Prepared By	
Date Prepared	
Total Columns 10 and 12	0
Total Column 11	0

Patient Name - Last	Patient Name - First	Date of Service - From	Date of Service - To	Patient Account Number	Medicaid Number	State Eligibility Code	Patient Population Code	Worksheet S-2, Part I Column Number
1	2	3	4	5	6	7	8	9

Medicaid Days - Eligible Days	Medicaid Days - Labor & Delivery Room Days	Medicaid Days - Newborn Baby Days	Insurance or Other Payer Name - Primary	Insurance or Other Payer Name - Secondary	Medicare Eligibility - A/B Indicator	Medicare Eligibility - Start Date	Medicare Eligibility - End Date	Comment
10	11	12	13	14	15	16	17	18

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COST REPORT WORKSHEET S-3

PARTS II, III, & IV

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WORKSHEET S-3 PARTS II, III, & IV

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WORKSHEET S-3 – HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

…

Part II – Hospital Wage Index Information. – This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the prospective payment system. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II, III, and IV are accurate.

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WORKSHEET S-3 PARTS II, III, & IV

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WORKSHEET S-3 – HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

…

Part III - Hospital Wage Index Summary. – This worksheet provides for the calculation of a hospital's average hourly wage (without overhead allocation, occupational mix adjustment, and inflation adjustment) as well as analysis of the wage data.

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WORKSHEET S-3 PARTS II, III, & IV

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WORKSHEET S-3 – HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

…

Part IV – Wage Related Costs. – The hospital must provide the contractor with a complete list of all core wage related costs included in Part II (section 4005.2), lines 17 and 19 through 25. This worksheet provides for the identification of such costs.

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WAGE INDEX

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WAGE INDEX

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- Wage Index reflects the relative hospital wage level for each geographic area compared to the national average
- Geographic areas are based on the Core-Based Statistical Areas (CBSA) defined by the Office of Management & Budget
    - + Beginning FY 15 // implementation of updated CBSAs based on 2010 Census
    - + Keep eye out for future CBSA changes based on the 2020 Census
- Data used to calculate the wage index is the aggregate of all PPS hospitals located within each CBSA

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- **Metropolitan Statistical Areas (MSAs)** – CBSAs with populations > 50,000
- **Micropolitan Areas** – CBSAs with populations > 10,000 but < 50,000
- **MSAs** = urban for CMS purposes, while Micropolitan Areas & areas outside of any CBSA = rural
- There are several **CBSAs with populations > 2.5 million** that meet the definition of Metropolitan Divisions – these CBSAs have been divided into multiple CBSAs for wage index purposes (an example is Miami-Fort Lauderdale-West Palm Beach, which is technically one CBSA but is split into three CBSAs for wage index)

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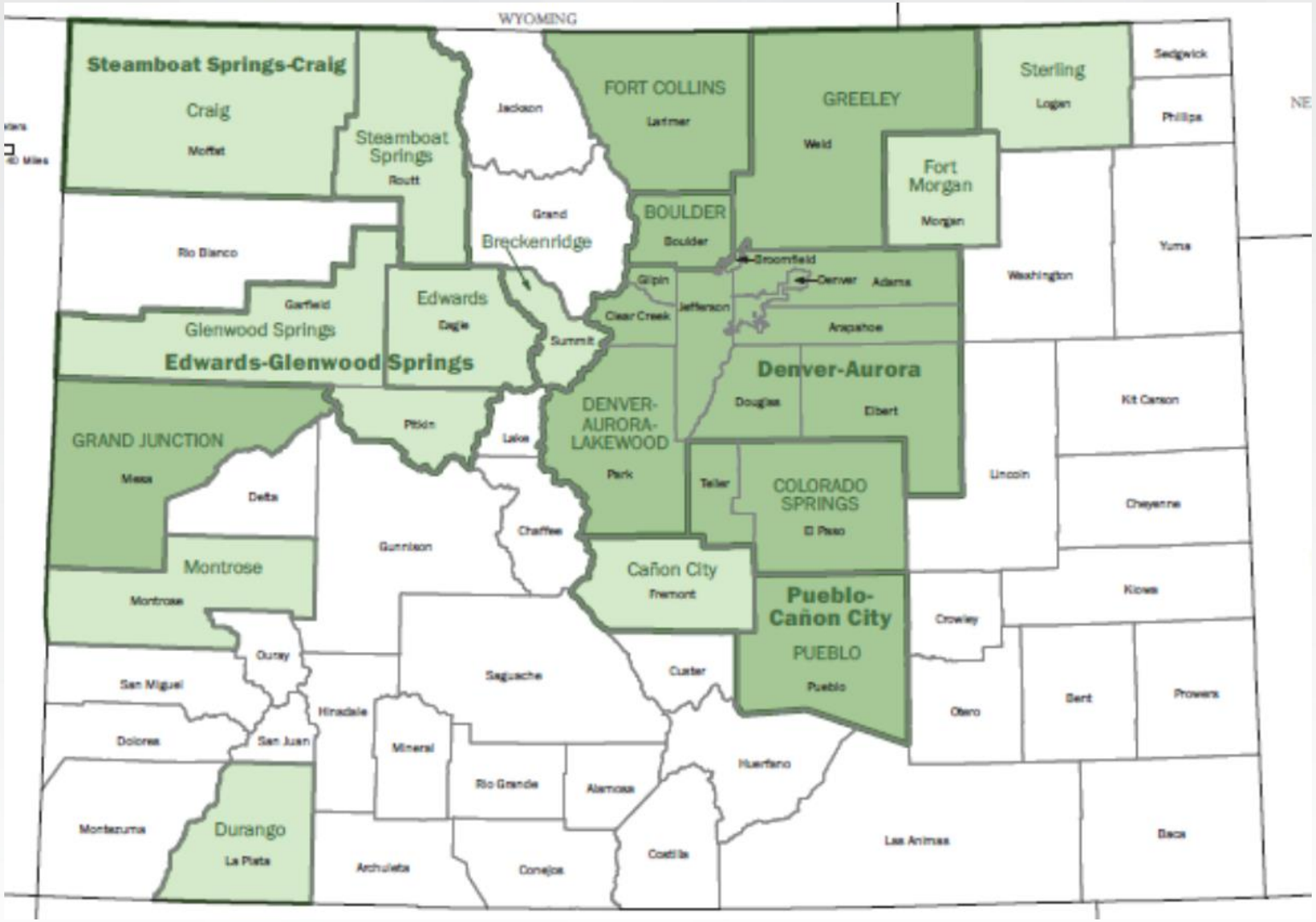
WAGE INDEX



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WAGE INDEX

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Sources of data for Wage Index:

- Cost Report
  - + Worksheet S-3 Parts II & III
- Occupational Mix Survey

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

- FY 2025 wage index is based on wage data from cost reporting periods beginning in Federal Fiscal Year 2021
- The first day of a cost report period determines what FY it falls into – FFY 2021 includes FYE 9/30/21, 12/31/21, & 6/30/22 cost reports

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WAGE INDEX

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Occupational Mix Survey

- Adjustment applied to a provider's wage index to adjust for that provider's choice of staff
- FY 2025 wage index adjusted by Occupational Mix Surveys submitted for CY 2022
  - + Data from CY 2022 OMS used for three years
  - + CMS continues to threaten to punish providers that do not comply
- The calendar year 2022 Occupational Mix Survey submitted 7/1/2023 will be applied to FY 2025-2027 wage index

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Occupational Mix Survey (cont.)

- Each hospital's salaries & wage-related costs are adjusted by the occupational mix.
  - + The occupational mix adjustment factor is based on the national nursing average hourly rate divided by the hospital's nursing average hourly rate.
  - + A portion of each hospital's salaries & wage-related costs are adjusted for the occupational mix, based on the hospital's nursing category salaries as a percentage of total salaries.
  - + If a hospital did not submit an occupational mix survey, currently it automatically receives the average adjustment for the other hospitals in the urban or rural area.
  - + If no hospitals in an area submit a survey, all hospitals receive an adjustment factor of 1.0.
- Occupational mix adjusted national average hourly wage for FFY 2024 is $50.34

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WAGE INDEX

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Rural Floor

- Regulations stipulate that wage index for any urban CBSA cannot be lower than that state's rural wage index
- For FFY 2024 there are 646 hospitals receiving a rural floor wage index
- Calculation is budget neutral

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Rural Floor (cont.)

- Originally the budget neutrality adjustment was applied nationally
- CMS began transitioning to a state-level rural floor budget neutrality adjustment in FY 2009
- Section 3141 of PPACA mandates CMS revert back to the national budget neutrality adjustment
    - Originally driven by Massachusetts hospitals
        - FY 18 benefit for Massachusetts – $44 million
        - FY 18 benefit for California – $134 million
- Beginning with FFY 2024 Rural floor will be computed **with** redesignated hospitals under §412.103
    - This reverts to the calculation prior to FY 20

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Rural Floor & Rural Wage Index

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Pre 2020

One Calculation

One calculation used for both

Rural Floor = Rural Wage Index

Rural Wage Index = wage data for ALL RECLASSIFIED rural hospitals & NATURAL rural Hospitals

2020–2024

Separate Calculations

Rural Wage Index = NATURAL rural plus RECLASSIFIED rural

Rural Floor = NATURAL rural

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WAGE INDEX

Wage Index Floor of 1.0 for “Frontier States”

- Last-minute provision in PPACA
- Frontier State is defined as a state with at least 50% of counties with a population per square mile of less than six
- The floor wage index for hospital in those areas is set at 1.00
- Specifically excludes Alaska and Hawaii and is not budget neutral

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Out-Migration Adjustment

- Rural counties with at least 10% of resident hospital employees who commute to an urban CBSA are eligible for add-on to wage index
- Also known as Section 505 Wage Adjustment
- 225 counties are eligible for the out-migration adjustment in FFY 2024
- Providers that are reclassified are not eligible to receive out-migration adjustment
- Estimated that 173 provider would receive out-migration

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Lugar Counties

- Rural counties that meet certain conditions (including specific commuting patterns) are considered Lugar Counties, & hospitals located in those counties are paid as if they are urban
- Receive the reclassified wage index of the urban area to which they are re-designated
- Receive the large urban add-on if applicable, not subjected to 12% operating DSH cap & eligible for capital DSH payments
- Technically known as “Rural Counties Re-designated as Urban under Section 1886(d)(8)(B) of the Act”

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WAGE INDEX

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Section 401 Hospitals

- Urban hospitals meeting specific conditions can be re-designated as rural for Medicare payment purposes

  §412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

- Most common reason is to qualify as SCH, RRC, or CAH
- Previously, regulations prevented Section 401 hospitals from also receiving wage index geo reclass
- In April 2016 CMS reversed, allowing hospitals to simultaneously be Section 401 & geo reclassed

- Number of Section 401 hospitals is 659 in FFY 2024

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WAGE INDEX

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Changes to address wage index disparities

- Increase wage index for hospitals below the 25th percentile “Low Wage Index Hospital Policy”
  - 4 years FY 2020 to 2024
  - FY 2024, 25th percentile wage index value is .8667 prior to adjustment
  - Budget neutral – per Final Rule these wage index increases will be funded by all hospitals through budget neutrality adjustment to the standardized amount
  - The 2020 low wage index hospital policy & related **budget neutrality** are the subject of pending litigation
  - Example of impact – Rural AL wage index was .7121 before adjustment, .7894 after adjustment
- Continued evolvement for handling of Section 401/412.03
  - FFY 2024 final to now include the wage index data into the calculation of rural wage index & rural floor even if an existing MGCRB reclassification (“dual reclass” status)
- Permanent cap on wage index decrease to continue (5%)

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Wage index assessment

Providers have the opportunity to request corrections to their wage data

- Requests for FFY 2025 revisions were due to MAC by 9/3/2023

Hospitals should perform an assessment each year to take advantage of the opportunity for a second look

- Compare to hospital's prior-year data
- Compare to other hospitals in area
- Review adjustments made in prior years, including both revisions & audit adjustments
- Involve others in the organization such as payroll, HR personnel, & accounts payable

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Wage index assessment (cont.)

- There is no “one size fits all” approach, but there are some issues that are common
  - + Identifying correct hours to include
  - + Physician Part A admin – must be able to support related hours with time studies &/or time sheets
  - + Contract A&G – typical high AHW
  - + Other contract labor – support for dollars & hours
  - + Allocation bases for benefits – salaries versus hours
  - + Defined Benefit Pension expense
  - + Benefits buried in other GL accounts
  - + Hours for contract dietary & housekeeping

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WAGE INDEX GEOGRAPHIC RECLASSIFICATIONS

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WAGE INDEX GEOGRAPHIC RECLASSIFICATIONS

Geographic Reclassification

- Allows providers meeting specific requirements to reclass to another geographic area for purposes of receiving higher wage index
- Application is submitted to Medicare Geographic Classification Review Board (MGCRB) & is due 13 months prior to when reclassification would go into effect (deadline for FY 2025 was September 1, 2023)
- Applications for individual & group hospitals must be file electronically via the Office of Hearings Case & Document Management System (OH CDMS)
- Reclassifications are in effect for three years, but provider can elect to withdraw reclassification during the three-year period, & also elect to reinstate reclassification the following year if still within the three-year window
    + Election to withdraw must be submitted to MGCRB within 45 days of publication of Proposed Rule

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WAGE INDEX GEOGRAPHIC RECLASSIFICATIONS

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Geographic Reclassification (cont.)

- General requirements
  - + Proximity – hospital must be within 35 miles (rural)/15 miles (urban) of targeted CBSA
  - + Hospital's average hourly wage must be at least 82% (rural)/84% (urban) of targeted CBSA
  - + Hospital's average hourly wage must be at least 106% (rural)/108% (urban) of all other hospitals in current CBSA
  - + If a hospital is the only hospital in its MSA, it does not have to meet the 108% requirement

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WAGE INDEX GEOGRAPHIC RECLASSIFICATIONS

Geographic Reclassification (cont.)

- All hospitals within a county can apply for a group reclass
  - + Overall AHW must be at least 85% of targeted CBSA
  - + Rural county must be adjacent to targeted CBSA
  - + Rural county must also meet certain commuting patterns – in general 25% of workers in county must commute to targeted CBSA or vice-versa
  - + Urban area must be in the same Combined Statistical Area as targeted CBSA as defined by U.S. Census Bureau

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WAGE INDEX GEOGRAPHIC RECLASSIFICATIONS

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Geographic Reclassification (cont.)

- Exceptions to requirements
  - + Sole Community Hospitals do not have to meet proximity rule – eligible to reclass to nearest urban or rural CBSA
  - + Section 401 hospitals use the rural guidelines for proximity & AHW comparison.
  - + Hospitals with RRC status at the date of review by the MGCRB do not have to meet proximity rule // eligible to reclass to nearest urban or rural CBSA
  - + Hospitals that ever held RRC status do not have to meet 106%/108% test
  - + Urban hospitals that ever held RRC status only have to be 82% of targeted CBSA instead of 84%

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Geographic Reclassification (cont.)

- Hospitals that are reclassified receive the reclassified wage index of the targeted CBSA
  - + Reclassified wage index is often lower than base wage index for each CBSA

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CLINIC STRATEGIES

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REIMBURSEMENT FOR PRIMARY CARE PHYSICIAN SERVICES

Freestanding physician practices

- Owned by hospital
- Under contract with hospital

Provider based clinics

- See Bipartisan Budget Act of 2015 Section 603 regarding Off-Campus Provider-Based Clinics
- CAH PB Clinics/Departments are not subject to Section 603

Rural Health Clinics (RHC)

- H.R. 133, the Consolidated Appropriations Act of 2021 (COVID Relief Package)

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FREESTANDING CLINICS

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FREESTANDING CLINIC MEDICARE REIMBURSEMENT

Technical & Professional Costs paid on full RBRVS payment rate – also known as global Medicare fee schedule

- Medicare Fee Schedule (Three Parts)
  - + 100% Work component
  - + 100% Malpractice component
  - + 100% Practice expense component

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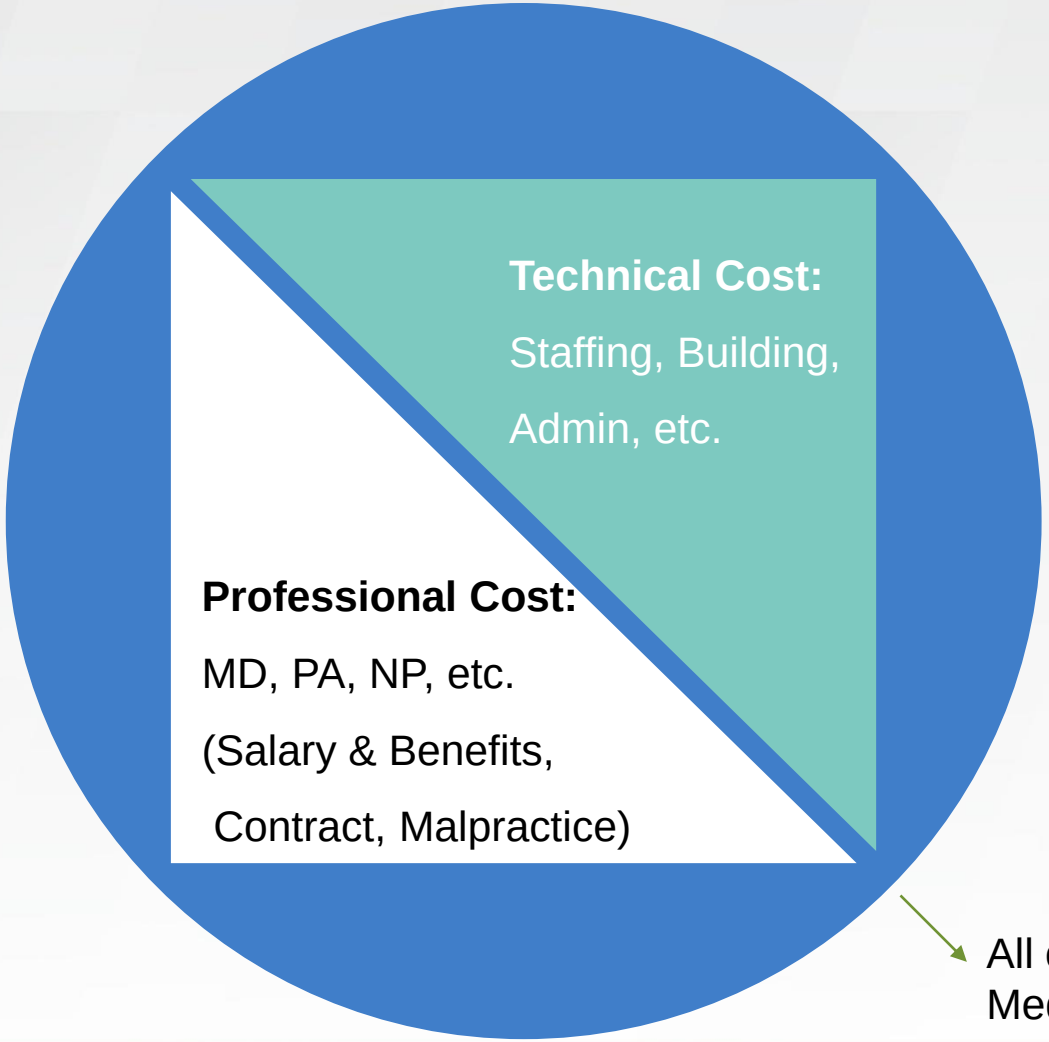
FREESTANDING CLINIC MEDICARE REIMBURSEMENT



All costs reimbursed by global Medicare Fee Schedule

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PROVIDER-BASED CLINICS

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PROVIDER-BASED CLINIC

What is Provider-Based Status?

- Relationship between a main provider & another facility whereby the other entity is considered a subordinate part of the main provider
- Determination of provider-based status is governed by the regulation at 42 CFR 413.65 & further explained in Program Memorandum Transmittal A-03-030
- General Rule – Requirements apply to a facility if its status as provider-based or freestanding affects Medicare payment amounts &/or beneficiary liability for services furnished in the facility

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SITE-NEUTRAL CLINIC PAYMENTS

Recent shift in regulatory climate:

- Items & services furnished by a non-excepted off-campus Provider-Based department (PBD) are not eligible for payment under the Hospital Outpatient Prospective Payment System (OPPS) & are instead paid under the Medicare Physician Fee Schedule. Excepted items & services are items & services furnished after January 1, 2017
  - + By a dedicated emergency department (2019 final rule further addresses freestanding EDs with modifier “ER”);
  - + By an off-campus PBD that was billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015, *i.e.*, the date of enactment of section 603 of the Bipartisan Budget Act of 2015 (Section 603), that has not impermissibly relocated or changed ownership;
  - + By an off-campus PBD that qualifies for an exception under section 16001 or 16002 of the 21st Century Cures Act*; or
  - + In a PBD that is “on the campus,” or within 250 yards, of the hospital or a remote location of the hospital
- The 2019 OPPS final rule further expanded neutralized payment for E/M services at excepted off-campus PBDs at an equivalent fee schedule rate paid to non-excepted off-campus PBDs
- Non-E/M services at the excepted off-campus PBD continue payment under OPPS

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Site-Neutral Clinic Payments – Current State Reductions

	On Campus	Off Campus Excepted	Off Campus Non-Excepted
Dates of Service	N/A	Before 11/2/2015	On or After 11/2/2015 (Or Relocation)
Applicable Services	N/A	G0463 (E&M)	All Services
Reduced Rate	N/A	40% of APC Payment	40% of APC Payment
340B Eligible?	Yes	Yes	Yes
Professional Fee Impact?	No	No	No

On Campus Definition:

The physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS Regional Office, to be part of the provider's campus.

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PROVIDER-BASED CLINIC

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Three types of provider-based facilities/organizations

- Department of a provider (hospital outpatient departments)
- Provider-based entities
  - + Rural health clinics (RHC)
  - + Skilled Nursing Facilities (SNF)
  - + Home Health Agencies (HHA)
- Remote location of a hospital
  - + Furnishes IP services under a hospital's certification & CMS certification number

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PROVIDER-BASED CLINIC (413.65)

On-Campus vs. Off-Campus	Licensure	Clinical Service Integration	Financial Integration
Public Awareness	Outpatient Department Obligations (EMTALA, correct site of service, split billing, three-day payment window, etc.)	Ownership & Control	Administrative & Supervision – Reporting Relationship
Administration & Supervision – Administrative Functions	Location	Management Contracts	Beneficiary Co-Pay

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PROVIDER-BASED CLINIC MEDICARE REIMBURSEMENT

Professional Component paid on reduced RBRVS payment rate – also known as reduced Medicare fee schedule.

- Medicare Fee Schedule (Three Parts)
  - + 100% Work component
  - + 100% Malpractice component
  - + 50% Practice Expense component

Plus, they receive a facility fee payment for the Technical Component.

- Non-CAH payment based on APCs
- CAH payment based on allowable cost (no cost limitation)

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PROVIDER-BASED CLINIC MEDICARE REIMBURSEMENT

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PROVIDER-BASED CLINIC MEDICARE REIMBURSEMENT

Level 4 Established Patient - 99214
Hospital Outpatient Clinic Visit - G0463

	Physician Fee Schedule	Facility Fee (Hospital OP)	Medicare Payment (80%)	Co-Pay (20%)	Total	
Freestanding Clinic						
Global Rate	$ 123.47		$ 98.78	$ 24.69	**$ 123.47**	**Freestanding**
Hospital Outpatient						
Professional Fee	$ 99.09		$ 79.27	$ 19.82		
Facility Fee		$ 99.78	$ 79.82	$ 19.96		
Total Hospital OP Reimbursement			$ 159.09	$ 39.77	**$ 198.87**	**Hospital OP - On Campus**
Difference per unit if billed as Hospital Outpatient			**$ 60.32**	**$ 15.08**	**$ 75.40**	

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PROVIDER-BASED STATUS

Advantages:

- Potential higher reimbursement
- Reimbursement for Medicare Bad Debts (Only if excepted …)
- Increased coordination with hospital-physicians & clinical integration with hospital
- Greater flexibility in financing & efficiencies with admin or shared staff
- More overhead cost remains allowable in ratio of cost to charge calculations
- 340B Drug Discount Program
- ***Must meet accreditation & life safety standards (quality)***

Disadvantages:

- Increased costs related to hospital wage & benefit scales, more costly facilities, & less effective cost management
- Perceived billing complexities – potential customer service impact from split billing for patients
- Patient coinsurance (depends on payer contracts to recognize as a physician practice or hospital location)
- Decreased physician control of practice staff & accountability for finances & productivity
- Must meet accreditation & life safety standards (potential cost)

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RURAL HEALTH CLINICS

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RURAL HEALTH CLINIC OVERVIEW

- Two main goals:
  - + Improve access to primary healthcare in rural, underserved communities through enhanced reimbursement to support financial sustainability
  - + Promote a collaborative model of healthcare delivery using physicians, nurse practitioners, & physician assistants
- Two types
  - + Provider-Based (approximately 48% of RHCs)
  - + Independent (approximately 52% of RHCs)
- Over 4,500 RHCs located throughout the U.S.

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RURAL HEALTH CLINIC LOCATION REQUIREMENTS

- Must be located in communities that are both “rural” & “underserved” shortage area
- Rural as defined by census bureau as “non-urbanized”
- Shortage area (HPSA, MUA, Governor’s Designation) in last four years for initial qualification

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Comprehensive RHC Payment Reform

- H.R. 133, the Consolidated Appropriations Act of 2021 (COVID Relief Package)
- Passed in December 2020, Section 130 of the CCA included a provision that increased the Medicare cost per visit cap over an eight-year period
- Subjects all “new” RHCs to the new per-visit cap
  - 2021 $100
  - 2022 $113
  - 2023 $126
  - 2024 $139
  - 2025 $152
  - 2026 $165
  - 2027 $178
  - 2028 $190
- After 2028 & in subsequent years, the cap increases by the Medicare Economic Index (MEI)

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Comprehensive RHC Payment Reform

- H.R. 133, the Consolidated Appropriations Act of 2021 (COVID Relief Package)
- Provider-Based RHCs that meet the criteria in section 1833(f)(3)(B) are considered to be “grandfathered” & will not be subject to the new per-visit cap
- As of December 31, 2020 was in a hospital with less than 50 beds & after December 31, 2020, in a hospital that continues to have less than 50 beds
- As of December 31, 2020 was enrolled in Medicare or submitted an application for enrollment in Medicare
- Grandfathered RHCs that did not have a full 12-month cost report by January 1, 2021 will have their per-visit cap set after their first full 12-month cost report

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RURAL HEALTH CLINIC COST REPORTING

WEBINAR

- Settlement Components
  - +RHC Payment Limit
  - +Medicare Influenza, Pneumonia & COVID-19 Vaccinations
  - +Medicare Bad Debt

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RURAL HEALTH CLINIC COST REPORTING

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- Allowable Costs
  - + Allowable costs must be reasonable & necessary & include RHC practitioner compensation, overhead, equipment, space, supplies, personnel, & other costs incident to furnishing RHC services
- Costs for “Non-RHC” services
  - + Laboratory supplies/reagents/licenses
  - + Radiology supplies/film/licenses
  - + Chronic care management
  - + Any other service billed to Part B
  - + Chronic Care Management
  - + Telehealth

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RURAL HEALTH CLINIC COST REPORTING

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- Visits
  - + Can be a challenge to count for cost report
  - + Denominator in RHC rate calculation
  - + RHC visits are defined as medically-necessary medical or mental health visits, or qualified preventive health visit. Must be a face-to-face encounter between the patient & RHC practitioner during which time one or more RHC services are rendered.
  - + RHC visits can take place at RHC, patient's home, SNF, scene of an accident & hospice

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RURAL HEALTH CLINIC COST REPORTING

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- Provider FTE
  - +Medicare cost report requires separation of provider time (physician, PA, NP, LCSW, etc.)
  - +Record provider FTE for RHC time only
    - <Time spent in the RHC, time with SNF patients
    - <Time spent charting for RHC patients
  - +Exclude non-RHC time
    - <PTO/Sick, administrative, hospital (IP/OP), committee, telehealth

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CLINIC STRATEGY OPTIMIZATION

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- Focus on on-campus expansion
  +Biggest opportunity
  +Within 250 yards of main provider or remote location
- Expand services in existing Provider-Based locations
- Relocate off-campus Provider-Based locations to on-campus
- Evaluate off-campus primary care locations for Rural Health Clinic
- Optimize 340B opportunity through additional Provider-Based clinics &/or contract pharmacy

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RURAL HEALTH CLINIC COST REPORTING

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Example # 1	FTE	Total Visits (Actual)	Productivity Standard	Minimum Visits (col 1 x col 3)
	1	2	3	4
WS M-2 Line 1 Physician	1.00	3,100	4,200	4,200
WS M-2 Line 2 Physician Assistant	-	-	2,100	-
WS M-2 Line 3 Nurse Practitioner	3.00	4,500	2,100	6,300
	4.00	7,600		**10,500**

Example # 2	FTE	Total Visits (Actual)	**Productivity Standard**	Minimum Visits (col 1 x col 3)
	1	2	3	4
WS M-2 Line 1 Physician	0.70	3,100	4,200	2,940
WS M-2 Line 2 Physician Assistant	-	-	2,100	-
WS M-2 Line 3 Nurse Practitioner	1.50	4,500	2,100	3,150
	2.20	**7,600**		6,090

	Greater of Actual or Minimum Visits	Allowable Costs $ 1,500,000	Cost per Visit
Example # 1	10,500		$ 142.86
Example # 2	7,600		$ 197.37

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RURAL HEALTH CLINIC COST REPORTING

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- Medicare flu, pneumonia & COVID-19 costs are reimbursed on the cost report
- Tracking cost
  - +Staff time (time per injection)
  - +Vaccine cost (where are costs booked on GL?)
  - +Vaccine cost per injection
  - +Total vaccine count
  - +Medicare vaccine logs (Patient name, Medicare number, DOS)

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RURAL HEALTH CLINIC COST REPORTING

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- Medicare Bad Debt
  - +Reimbursement is 65% of allowable bad debt claimed
  - +Bad debt must be related to covered services (deductible & coinsurance amounts)
  - +Exclude lab, radiology, etc. non-RHC services
  - +Reasonable collection efforts must be made

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RHC BILLING / REIMBURSEMENT

- Billed on UB claim form for professional & technical component
- Medicare reimbursement
  +Freestanding & PB RHC – per visit payment limit
  +Grandfathered PB RHC – All-inclusive rate
- Medicare Advantage
- Medicaid reimbursement typically based on cost but varies by state
- Commercial payors billed same as freestanding physician practice

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RHC Advantages/Disadvantages

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POTENTIAL ADVANTAGES

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- Higher reimbursement compared to freestanding physician practice
- Reimbursement for Medicare Bad Debts
- Recruiting & retaining existing physicians & APPs in rural areas
- Potential to include specialty services/visiting providers for cost reimbursement
- Provider-Based RHC 340B eligibility
- Provider-Based RHC must meet accreditation & life safety standards (quality)

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POTENTIAL DISADVANTAGES

- Increased Medicare coinsurance (based on charge structure)
  + Supplemental coverage can mitigate
  + Unpaid portal eligible for Medicare bad debt reimbursement
- Difference in billing from current practices
  + System modification & internal training
- .5 FTE APP at each RHC
- Timeframe for conversion (typically 6-9 months)
- Provider-Based RHC must meet accreditation & life safety standards (cost)

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UNDERSTANDING THE COST REPORT SUBMISSION & SETTLEMENT PROCESSES

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

- Hospital files the cost report
  - + Typically, due five months after year-end
- Contractor accepts (or rejects) cost report submission
  - + Rejection typically due to problem with ECR file, but can also be for other missing items that are required
- Contractor issues tentative settlement
  - + Typically, should be done within 60 days of acceptance
  - + Adjustments can be made for any obvious errors
  - + Some contractors apply an “audit withhold” factor, reducing components of the tentative settlement by certain percentages based on prior years’ audit adjustments
- Contractor updates current interim payment rates based on new tentatively settled cost report

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

- Documentation requirements for filing Medicare cost reports
  - + Applies to cost report submission for periods beginning on or after 10/1/18
  - + Requirements were included in FY 19 IPPS Final Rule
  - + CMS published additional guidance in August 2019
  - In summary, CMS will require detailed support that ties to the cost report to be submitted with the cost report for the following items, otherwise the cost report is to be rejected:
    - + Teaching hospitals – IRIS data
    - + Bad debts – detailed listing
    - + DSH – detailed listing of Medicaid-eligible days
    - + S-10 – detailed listing of charity care &/or uninsured discounts
    - + Home Office – support for costs that are allocated from a home office or chain organization

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

- **Providers can revise their cost report after filing**
  - + CMS & some MACs have indicated they may limit the ability to revise filed cost reports
  - + Typically, the revision must be submitted prior to the start of the review or audit process
- **In the CY 2016 OPPS final rule CMS finalized certain provisions that were originally included in FY 2015 IPPS proposed rule**
  - + Effective for cost report periods beginning on or after 1/1/16
  - + Prevailing concept – in order to be reimbursed for any item, a hospital must include either a claim for payment in the original cost report or self-disallow & include as a protested item if the provider disagrees with CMS policy
  - + CMS concedes there may be circumstances that require an amendment or reopening, but in most instances, hospitals should be able to include all necessary information in its original as-filed cost report

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

- CMS acknowledges one potential exception – Medicaid-eligible DSH days
  - CMS will now require MACs to accept one amended cost report submitted within 12-months of the original due date solely to revise Medicaid-eligible days for Medicare DSH
  - CMS notes “Hospitals cannot claim Medicaid-eligible patient days that have not been verified by State records” but recognizes verification may not be possible within five months after year-end
  - Amendment request must include:
    + The number of additional Medicaid-eligible patient days that the hospital is seeking to include in the DSH calculation,
    + A description of the process that the hospital used to identify & accumulate the Medicaid-eligible patient days that were reported & filed in the hospital’s Medicare cost report at issue, &
    + An explanation of why the additional Medicaid-eligible patient days at issue could not be verified by the State by the time the hospital’s cost report was submitted

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

- Contractor conducts review or audit
  - + Limited or full desk review
  - + In-house or field audit
- Contractor may request additional information or explanations from the hospital
- Proposed adjustments issued for hospital review
  - + Hospital should analyze proposed adjustments to determine if appropriate, & to determine settlement impact
- Adjustments are finalized
- Notice of Program Reimbursement (NPR) issued in final settlement of cost report

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

- Any appeal must be filed within 180 days of issuance of NPR
  - + Filed with Provider Reimbursement Review Board (PRRB)
- Reopening request has to be filed within three years of NPR date
- Appeals are typically only pursued for issues with significant settlement impact
  - + Appeals can take up to ten years due to backlog of cases with PRRB
  - + Medicare program has recovered all monies while appeal in process
  - + Appeals can be costly unless settled
  - + Majority of appeals are settled prior to getting to the actual hearing process

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

Change in rules effective July 1, 2015 regarding withdrawal & reinstatement of appeals

- Part of PRRB Alert 11
- PRRB Rule 46.2 – *Withdrawals As a Result of Administrative Resolution or Agreement to Reopen*
- MACs would frequently deny reopening requests if the issue was subject to an active appeal, stating they would consider reopening if the appeal was withdrawn
    + Note that MACs are not prohibited from reopening for an issue under appeal
- New rule allows provider to reinstate an appeal issue if the MAC had agreed to reopen but failed to do so
    - Provider must provide written evidence of MAC's agreement to reopen on the condition of the appeal being withdrawn

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

Change in rules effective July 1, 2015 regarding withdrawal & reinstatement of appeals (cont.)

- Provider must present a “copy of the correspondence from the Intermediary where the Intermediary agreed to reopen the final determination for that issue(s).”
- The request for reinstatement must be filed within three years of the date the PRRB received the withdrawal from the provider

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UNDERSTANDING THE COST REPORT SETTLEMENT PROCESS

- Even if Provider prevails at PRRB level, the Secretary can, & often does, reverse decisions based on preserving the integrity of the Medicare program
- Courts become the final jurisdiction regarding cost reporting issues

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RECONCILING THE COST REPORT SETTLEMENT

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RECONCILING THE COST REPORT SETTLEMENT

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Hospitals should reconcile their cost report settlement upon completion of the report

- Provides better understanding of what is driving settlement
- Could assist in identifying errors in the cost report

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RECONCILING THE COST REPORT SETTLEMENT

	Reimbursement	Interim Payments/ Pass Through	Settlement For Cost Report
Inpatient			
Bad Debts	1,850,000		
35% Reduction	647,500		
Reimbursable Bad Debts	1,202,500	1,050,000	152,500
GME IP	2,100,000	2,215,000	(115,000)
Total Pass Through	3,302,500		
Operating IME	5,895,000	5,650,000	245,000
Capital IME	240,000	232,000	8,000
Operating DSH	4,650,000	4,700,000	(50,000)
Capital DSH	642,000	663,000	(21,000)
UCC DSH	9,850,000	9,900,000	(50,000)
Routine Service Pass Throughs	221,000	229,000	(8,000)
Ancillary Pass Throughs	11,000	16,500	(5,500)
Allied Health - Medicare HMO	21,500	-	21,500
Sequestration	(1,374,023)	(1,310,232)	(63,791)
Rounding			-
IP Settlement			**113,709**

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RECONCILING THE COST REPORT SETTLEMENT

	Reimbursement	Interim Payments/ Pass Through	Settlement For Cost Report
Outpatient			
Bad Debts	682,000		
35% Reduction	238,700		
Reimbursable Bad Debts	443,300	430,000	13,300
GME OP	337,000	340,000	(3,000)
Total Pass Through	780,300		
Items Reimbursed on Cost	21,500	18,400	3,100
Outpatient Pass Throughs	4,800	1,500	3,300
Sequestration	(759,032)	(764,102)	5,070
Rounding			-
OP Settlement			**21,770**

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REVIEW & FINAL QUESTIONS

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Assurance / Tax / Advisory

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