DZA
DINGUS, ZARECOR & ASSOCIATES PLLC

CMS Updates

You Give Healthcare a Band-Aid

Presenter:
Shar Sheaffer, CPA

September 2021

1

Outline

- Legislative outlook
- Appropriations/Sequester/American Rescue Plan Acts
- Medicare bad debts
- Proposals
- Miscellaneous

DZA DINGUS | ZARECOR & ASSOCIATES PLLC Certified Public Accountants 2

2

Current Administration

- Conservative on healthcare
- Pro vaccination as means to stopping COVID
- Backs ACA and wants to build on that
- Backs VBP
- Backs price transparency (which is from the ACA)
- Intends to keep PHE through end of year

3

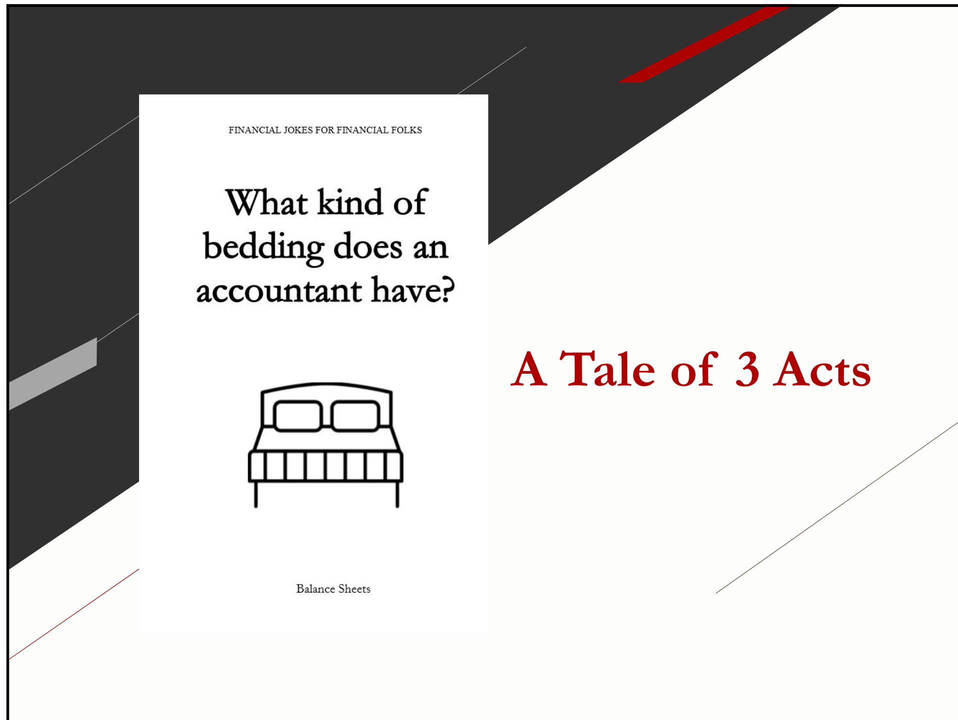
3

Other Legislative Considerations

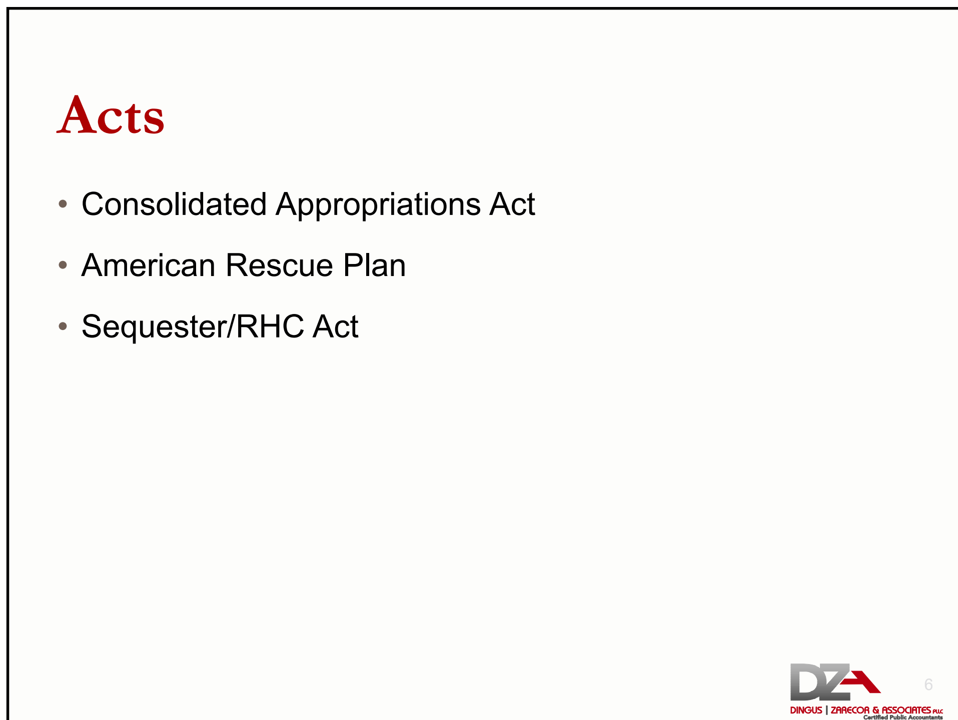
- Democratic President means we care about the deficit again (and should)
- Senate considered democrat majority
- House with democrat majority
- Large COVID spending bills
- Medicare solvency

4

4



5



6

RHC Payment Basics

- Cost per encounter
- Subject to productivity standards
- Subject to lower of cost or cap
  - Provider-based with 50 beds or more beds
  - Free standing
- Full cost provider-based to hospital with fewer than 50 beds
- Site neutral started April 1, 2021

7

7

Site Neutral RHC Payments

- Increases RHC per encounter caps
  - Started April 1, 2021–$100
  - 2022 – $113
  - 2023 – $126
  - 2024 – $139
  - 2025 – $152
  - 2026 – $165
  - 2027 – $178
  - 2028 – $190
  - 2029 and thereafter MEI increases

8

8

Site Neutral RHC Payments

- Also applies to provider based RHCs with fewer than 50 beds
- Cap is
  - Greater of the numbers on the previous slide OR
  - 2020 rate
- Example 2020 rate is $350, then, $350 is your cap
- Example 2020 rate is $155
  - Cap is $155 inflated forward through about 2026
  - Around 2026, it hits the published caps

9

9

Site Neutral RHC Payments

- “Mid-build” exception (from a sequester Act)
  - Grandfather those who received or applied for RHC in 2020
  - Rate is
    - 2020 rate OR
    - 2021 if no 2020 rate

10

10

MPFS RHC Proposals

- What is my 2020 rate?
  - Proposed: cost report ending in 2020
- No more consolidations for new RHCs
- If greater than 50 beds during PHE, need to drop back to below after to keep cost cap (instead of statutory)
  - During PHE, we use beds from the cost report before the start of the PHE

11

11

Sequester

- Sequester
  - Appropriations removed through March 31, 2021
  - RHC Act removed through December 31, 2021
- Changed last year of sequester (2030)
  - First 5.5 months at 2%
  - Next 6 months at 4%
  - Last .5 months at 0%
  - Unnecessarily complex

12

12

Extenders/Miscellaneous

- Rural Community Hospital Program—extended another 5 years
- MD geographic floor of 1 extended through January 1, 2024
- MPFS "increases"
  - 2021 saw 3.75% increase (was slated to be 0%)—this is COVID related
  - 2022 through 2025 still at 0% but based off 2020 rates
- Physician assistants—starting January 1, 2022, payment can be made directly to the PA
- RHC attending MD for hospice services can bill AIR starting January 1, 2022 (must be RHC MD not hospice's)

13

13

Extenders/Miscellaneous

- DSH reductions 2021 though 2023 eliminated
- New reporting requirements for State DSH payments
- Rural floor imputed again for all urban hospitals
- GME changes:
  - CMS can distribute 1,000 new resident FTE caps for certain hospitals
  - Eliminates separate accreditation for rural training track programs
  - If less than 1 FTE in a year, it will no longer trigger the cap calculation

14

14

Rural Emergency Hospitals

- Rural hospital with 50 or fewer beds as of the date of the Act
- Licensed as REH under state law
- Staffed 24/7 by MD, NP, PA, or clinical nurse specialist
- Staffing requirements of a CAH
- Document and report on use of subsidy
- Quality reporting required

15

15

Rural Emergency Hospitals

- Provide outpatient services only
  - Can have a nursing home (distinct part)
- Observation allowed
- 24 hours max length of stay
- Paid
  - PPS plus 5% plus
  - Add on "average CAH amount"
    - Based on 2019 payments to CAHs
    - Inflated by MEI

16

16

PRF Lost Revenues

- Lost revenues were calendar year to calendar year.
  - At signing of act anyways…
- Revert to June 2020 guidance
  - Actual to actual
  - Budget to actual (budget approved for calendar year before 3-27-20)
  - Any reasonable method

17

17

Punk accountants

Medicare Bad Debts

May they rest in peace

18

Medicare Bad Debt

- Medicare pays 65% of unpaid Medicare deductibles and coinsurance
- Three types:
  - Reasonable collection efforts
  - Indigent
  - Crossovers
- 2021 IPPS has many changes
  - The first hint was the crossover language from last year stating they must track to bad debt account

19

19

Indigent Care versus Charity Care

- Medicare pays for bad debts
- Medicare sees charity as a discount not a bad debt
  - Charity "allowance" is noted as "reductions of charges"
  - Bad debts are amounts "uncollectible from accounts and notes receivable"

20

20

Indigent Care Requires an Asset Test

- CMS Publication 15-1 §312
  - Medicare defines "should" as "must"
  - Provider **should** take into account a patient's total resources…an analysis of assets"
    - "only those convertible to cash and unnecessary for the patient's daily living"
    - Retroactive
  - Other requirements (not changed)
    - Must be determined by provider
    - No one else is legally responsible
    - Patient's file should contain the documentation supporting the claim of indigency (who determined and documents used)

21

21

One Policy or Two?

- Your current charity application requires an asset test:
  - Rename charity "indigent" applications
  - Rename charity policies as "indigent" policies
- Your current charity application does NOT require an asset test:
  - Devise a separate indigent care policy/Medicare bad debt policy
- In both cases:
  - Devise wording in the patient detail that says "indigent bad debt"
  - Ensure all are in a bad debt account to the general ledger.

22

22

Recommended Steps

- Items should be reflected as indigent bad debt
  - In the patient ledger
  - On the general ledger
  - On the application
  - On the policy

  *** or implicit price concessions*
- Add asset test to policy
  - Remember liquidate-able assets not necessary for their daily living

Reasonable Collection Effort

- Main category of Medicare bad debts
- Must bill expecting payment
- At least 120 days from the day a bill was first sent to beneficiary

New! Starts over every time we receive a payment

Must Bill Patient Within Set Time Frame

- Bad debts are to be "worthless" to be claimed and paid by Medicare
- "Reasonable" was never defined

New! Must bill patient within 120 days of the latest of theses

- Date of Medicare RA
- Date of the secondary payer's RA
- Date of noncoverage by secondary payor

25

25

Recommended Steps

- Update your Medicare bad debt policy to reflect the 120 day rules
  - Starts over each time a patient makes a payment
  - Amount of time from RA to patient
- Devise a way in the patient detail to prove these dates
  - They are both 120 day rules, so devise a way not to get confused on which we are talking about

26

26

Collection Agencies

- Treat Medicare the same as other payors
  - They will lie to you about this
  - Can pull back differing amounts, but not just all Medicare
- Collection agencies must be trying to collect (reasonable collection efforts apply here!!)
- The 120 day rule applies to them too

27

27

Recommended Steps

- Update your collection agency contracts to include:
  - Collection efforts for Medicare and non-Medicare are conducted in the same manner
  - Accounts will not be pulled back until at least 120 days after the last payment
  - Collection efforts will be with the intent to collect
- Request a copy of their collection policy to share with your Medicare Administrative Contractor

28

28

29

MPFS Proposals

- Behavior health
  - Patient's home originating site
    - Audio only okay if beneficiary's limitations (not providers)
  - In person required every 6 months (including within 6 month before telehealth)
- Telehealth RHC mental health encounter
  - Telehealth or audio only (same as above)
  - Paid is in-person visit (counts as encounter)

DINGUS | ZARECOR & ASSOCIATES PLLC Certified Public Accountants

30

30

MPFS Proposals

- MIPS
- 2022 performance year (2024 payment) weights
  - 30% quality
  - 30% cost
  - 15% improvement activities
  - 25% EHR
- Performance threshold 75 points
- Moving to 180 day reporting and I think that is 2024

31

31

OPPS Proposals—Price Transparency

- Current penalty's $300 per day
- Proposed:
  - 30 or fewer beds: $300 per day
  - 31-550 beds: number of beds times $10 per day
  - 551 or more beds: $5,500 per day
  - Updated based on CPI-U
- Beds—last finalized cost report
  - Fun fact: no cost report, we'll ask nicely. No response, we assume 551
- Alternative method: using NPSR

32

32

OPPS Proposals

- Halt elimination of the IPO list
  - Adding back all 298 set to be removed starting 2022
- Thoughts on long term goal of no IPO list?
- Continue payment of ASP minus 22.5% for pass-through drugs under 340B program
- Also requesting comments on REH
  - Quality measures
  - Services allowed

33

33

IPPS

- GME IRIS disk switching to XML format
  - CR beginning on or after 10-1-21
  - Old method: reject MCR
- Continuing wage index increase for bottom quartile
  - .8437 and lower get half of the difference
  - Budget neutrality -.20 percent
- Rural floor to continue to exclude those reclassed rural *except* if reclassed through MGCRB
- Wyoming/Montana floor to remain at 1.00 (frontier floor)

34

34

35

State DSH

- Fiscal years beginning on or after October 1, 2021, can exclude costs and charges if Medicaid not primary payor

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

36

Hospitals Without Walls

- During PHE
  - RHC
    - Can expand location
    - Can continue operations without mid-level (50% rule)
    - Can request productivity waiver
    - Visiting nurses
  - Can expand over licensed or allowed beds
    - RHC beds over 50 okay
  - Waived 3-day qualifying stay for SNF
  - Non-swing bed hospitals can provide swing bed services (no nursing home willing or able to take the patient)
  - Can exceed the CAH 96 hour CoP (participation)

37

37

Hospitals Without Walls

- Expanded telehealth
  - RHC as distant sites
  - Expanded technology
    - Audio only for some services
  - Expanded practitioners

38

38

Cost Report Proposed Changes

- S-2— question ask if PPS hospital
  - Yes means fill out S-12 median payer-specific charge data by MS DRG
  - #goingaway
- S-2 — percentage of admin consulting from CBSA outside of your own
- S-3 — report COVID-19 expansion beds, bed days, and days
- A — new standard line for opioid treatment program
- E-5 — new workpaper for outlier reconciliation at tentative settlement
- G3 — adds line 24.50 for COVID-19 PHE funding

39

39

Changes to S-10

- Only list services billed under main hospital number
  - CCR will be just those services too
- Exclude charges paid with PRFs
- CCR applied to insured patients not covered for the whole stay

40

40

Standard Reporting

- Exhibit 3A — listing of Medicaid eligible days for DSH eligible hospitals
- Exhibit 2A — Medicare bad debt instructions and form
- Exhibit 3B — charity care listing for S-10
- Exhibit 3C — listing of total bad debts for S-10

Cost report periods beginning

on or after October 1, 2020

41

Exhibit 3A — Medicaid Days

- Separate exhibit for each type of day on S-2
- Columns:
  1. Last name
  2. First name
  3. Date of birth
  4. Gender
  5. XIX ID
  6. Date admitted
  7. Date of discharge
  8. Medical record number
  9. Patient account/control number
  10. State plan eligibility code number
  11. Number of Medicaid eligible days
  12. Number of labor and delivery days
  13. Primary payer
  14. Secondary payer
  15. “A” if eligible for part A; “B” if eligible for part B, “A” if eligible for both

42

PROVIDER NAME: ____________ | CCN: ________ | FYE: ________ | PREPARED BY: ________

WORKSHEET S-2, PART I,
LINE (ENTER 24 OR 25 ONLY): ____ | COLUMN (ENTER 1, 2, 3, 4, 5, or 6 ONLY): ____ | DATE PREPARED: ________

MEDICAID PATIENT CLAIM INFORMATION										MEDICAID DAYS		INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			
PATIENT NAME					DATES OF SERVICE												
LAST	FIRST	DOB	GEN-DER	MEDI-CAID ID NO	ADM	DIS	MED REC NO	ACCT OR CTRL NO	STATE ELIG CODE	ELIG-IBLE DAYS	LA-BOR & DEL ROOM DAYS	PRIM	SEC	A/B IND	START DATE	END DATE	COM-MENT
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
TOTAL																	

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

43

43

Exhibit 2A — Medicare Bad Debts

- Separate exhibit for each type (regular, indigent, crossover) and by IP/OP/RHC
- Columns:
  1. Last name
  2. First name
  3. Medicare number
  4. Patient account/control number
  5. Admission date
  6. Discharge date
  7. Medicaid number (if crossover)
  8. “Y” for indigent but not crossover; “N” for all other
  9. Medicare remittance advice date
  10. Medicaid remittance advice date; “AD” if using alternative documentation
  11. Date remittance advice was received from secondary payer
  12. Amount the beneficiary is responsible
      1. Type “QMB” for a qualified Medicare beneficiary
      2. For Medicaid crossovers, the amount of state required cost-sharing

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

44

44

Exhibit 2A — Medicare Bad Debts

- Columns continued

13. Date bill first sent to beneficiary; if QMB type “QMB”
14. Date written off
15. “Y” if sent to collections; if yes the data collection agency returned it
16. Date all collection efforts ceased (internal and external)
17. Date written off as a Medicare bad debt (date should match patient detail)
18. Recoveries for amounts previously claimed
19. Fiscal year the item in 18, if any, applies
20. Medicare deductible
21. Medicare coinsurance
22. Partial payments
23. Source of payment in #22
24. Allowable Medicare bad debt amount
25. Informational comments “wow was this a lot of work”

45

PROVIDER NAME: ______________________	CCN: ________	FYE: __________	PREPARED BY: ____________
BAD DEBTS FOR (CHOOSE ONE): ___ INPATIENT ___ OUTPATIENT			DATE PREPARED: ____________
CLAIM TYPE (CHOOSE ONE): ___ NON-DUALLY ELIGIBLE _____ DUALLY ELIGIBLE/CROSSOVER			

MEDICARE BENEFICIARY						MEDI-CAID NO.	DEEM-ED INDI-GENT	REMITTANCE ADVICE DATE		SECON. PAYER REMIT. ADV. REC'D DATE	BENE-FICIARY RESON-SIBILITY AMT.	DATE FIRST BILL SENT TO BENE.	A/R WRITE OFF DATE
BENEFICIARY NAME		MBI OR HICN	PATIENT ACCT. NO.	DATES OF SERVICE									
LAST	FIRST			FROM	TO			MEDI-CARE	MEDI-CAID				
1	2	3	4	5	6	7	8	9	10	11	12	13	14
TOTAL													

LISTING OF MEDICARE BAD DEBTS (CONT.)												
COLLECTION AGENCY INFORMATION		COL-LECT. EFFT. CEASE DATE	MEDI-CARE WRITE OFF DATE	RECOVERIES ONLY		MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS*		CURRENT YEAR PAYMENTS RECEIVED		ALLOW-ABLE BAD DEBTS	COMMENTS
SENT (Y/N)	RETURN DATE			AMOUNT RE-CEIVED	MCR FYE DATE	DEDUCT.	COINS.	AMOUNT	SOURCE		
15a	15	16	17	18	19	20	21	22	23	24	25
TOTAL											

* Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.

46

Exhibit 3B — Charity for UCC

- Columns:
  1. Last name
  2. First name
  3. Admission date
  4. Discharge date
  5. Patient account number
  6. “UI” if uninsured; “INC”; if insured but not covered; blank if insured
  7. Primary payer (even if you are not contracted with them)
  8. Patient’s Medicare number
  9. Patient’s Medicaid number
  10. “Y” if approved under FAP or charity policies; otherwise “N”
  11. “Charity” if charity; “FAP” if FAP
  12. Total charged to uninsured patients ~~(excludes physician charges)~~
  13. Amount of deductible, coinsurance, and copay; zero for uninsured patients
  14. Charges for non-coved services

DINGUS | ZARECOR & ASSOCIATES PLLC Certified Public Accountants

47

47

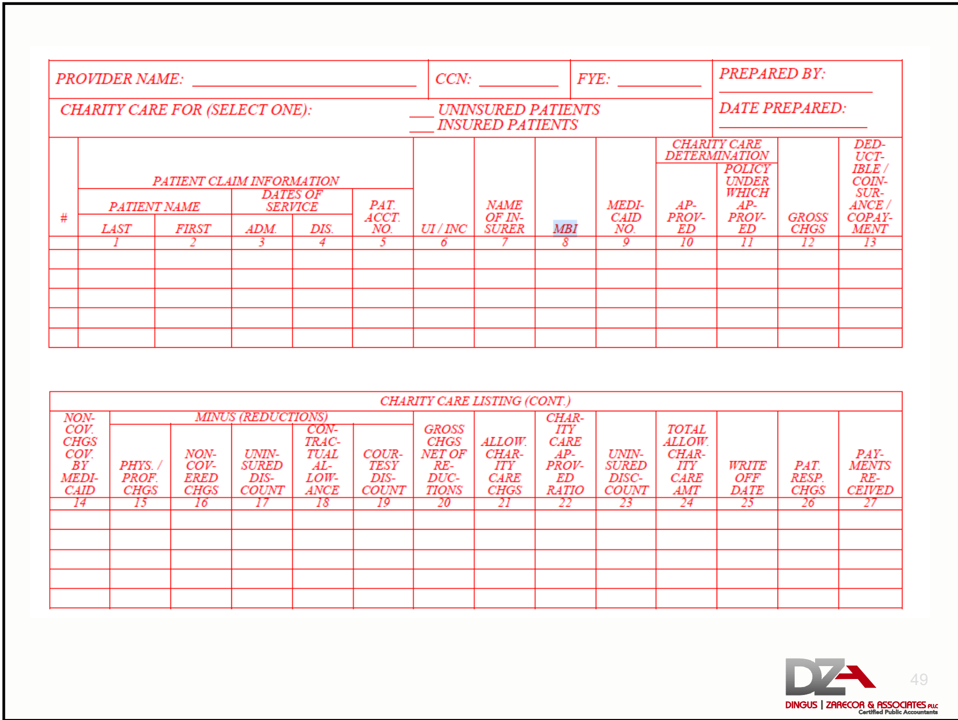
Exhibit 3B — Charity for UCC

- Columns (continued):
  15. Total charges related to physician fees
  16. Charges not medically necessary and not covered by charity or FAP
  17. Uninsured discount (n/a for insured)
  18. Contractual allowance for insured patient
  19. Courtesy discount provided, if any
  20. Formula – gross charges less deductions
  21. Allowable charity care or FAP charges
  22. Formula – column 21 / column 20 (percentage of charge approved)
  23. Set equal to line 17
  24. Formula – column 21 plus 23 (total allowable)
  25. Date charity or uninsured discount was written off
  26. Amount of patient responsibility (column 20 minus column 21)
  27. Payments received from patients during this cost report period for amounts previously claimed

DINGUS | ZARECOR & ASSOCIATES PLLC Certified Public Accountants

48

48



PROVIDER NAME: ____________	CCN: ______	FYE: ______	PREPARED BY: ______
CHARITY CARE FOR (SELECT ONE): ___ UNINSURED PATIENTS ___ INSURED PATIENTS			DATE PREPARED: ______

#	PATIENT CLAIM INFORMATION					UI / INC	NAME OF IN-SURER	MBI	MEDI-CAID NO.	CHARITY CARE DETERMINATION		GROSS CHGS	DED-UCT-IBLE / COIN-SUR-ANCE / COPAY-MENT
	PATIENT NAME		DATES OF SERVICE		PAT. ACCT. NO.					AP-PROV-ED	POLICY UNDER WHICH AP-PROV-ED		
	LAST	FIRST	ADM.	DIS.									
	1	2	3	4	5	6	7	8	9	10	11	12	13

CHARITY CARE LISTING (CONT.)													
NON-COV. CHGS COV. BY MEDI-CAID	MINUS (REDUCTIONS)					GROSS CHGS NET OF RE-DUC-TIONS	ALLOW. CHAR-ITY CARE CHGS	CHAR-ITY CARE AP-PROV-ED RATIO	UNIN-SURED DISC-COUNT	TOTAL ALLOW. CHAR-ITY CARE AMT	WRITE OFF DATE	PAT. RESP. CHGS	PAY-MENTS RE-CEIVED
	PHYS. / PROF. CHGS	NON-COV-ERED CHGS	UNIN-SURED DIS-COUNT	CON-TRAC-TUAL AL-LOW-ANCE	COUR-TESY DIS-COUNT								
14	15	16	17	18	19	20	21	22	23	24	25	26	27

49

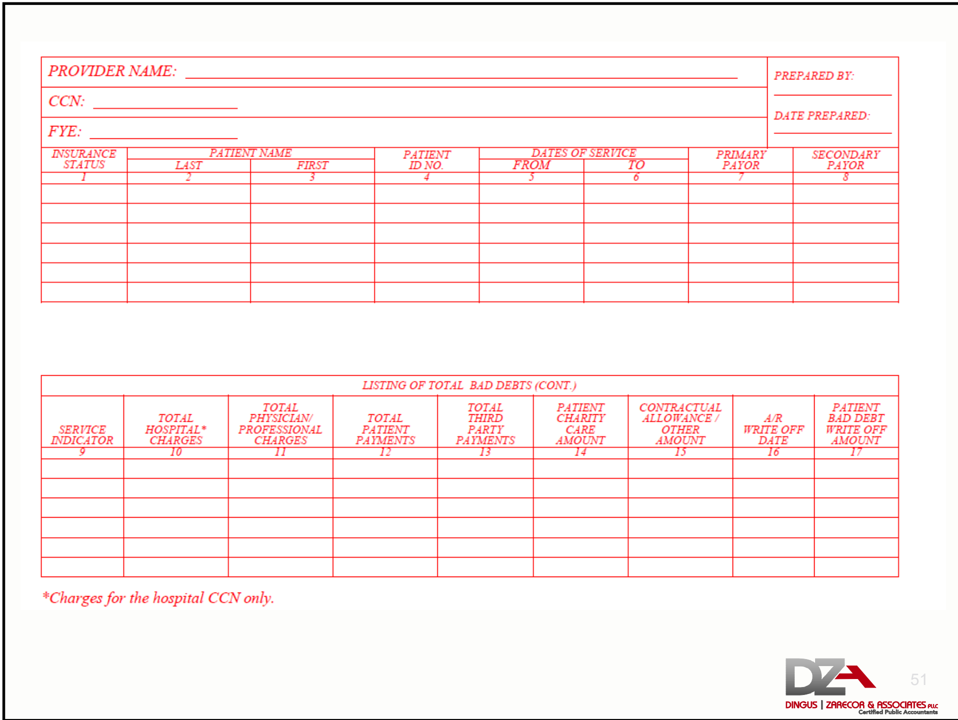
Exhibit 3C — Bad Debt for UCC

- Columns:
  1. "I" for insured; "U" for uninsured—indicates insured at time services provided
  2. Last name
  3. First name
  4. Patient account number
  5. Admission date
  6. Discharge date
  7. Primary payer
  8. Secondary payer
  9. "IP" for inpatient; "OP" for outpatient
  10. Total charges (only main provider number)
  11. Total professional charges
  12. Total payments from patient
  13. Total third party payments
  14. Amount written off to charity care
  15. Amount of contractual allowance; courtesy discounts, and employee discounts
  16. Date written off as bad debt
  17. Formula – total charges – [total charges*(professional charges/total charges)]

DINGUS | ZARECOR & ASSOCIATES PLLC Certified Public Accountants

50

50



PROVIDER NAME: ______________________

CCN: ____________

FYE: ____________

PREPARED BY: ____________

DATE PREPARED: ____________

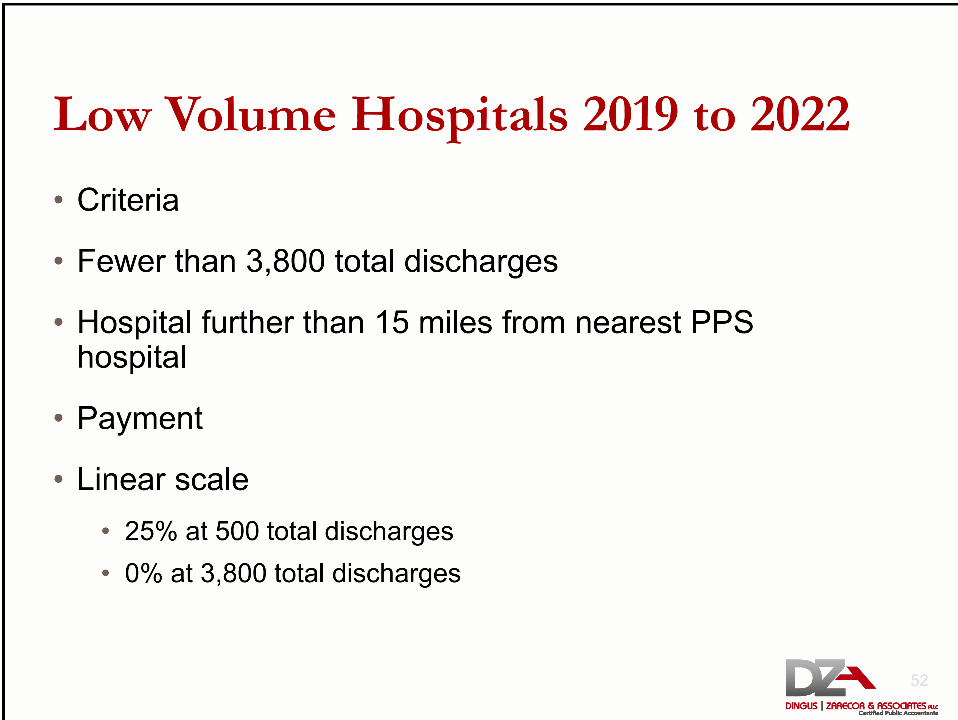
INSURANCE STATUS 1	PATIENT NAME LAST 2	PATIENT NAME FIRST 3	PATIENT ID NO. 4	DATES OF SERVICE FROM 5	DATES OF SERVICE TO 6	PRIMARY PAYOR 7	SECONDARY PAYOR 8

LISTING OF TOTAL BAD DEBTS (CONT.)

SERVICE INDICATOR 9	TOTAL HOSPITAL* CHARGES 10	TOTAL PHYSICIAN/ PROFESSIONAL CHARGES 11	TOTAL PATIENT PAYMENTS 12	TOTAL THIRD PARTY PAYMENTS 13	PATIENT CHARITY CARE AMOUNT 14	CONTRACTUAL ALLOWANCE / OTHER AMOUNT 15	A/R WRITE OFF DATE 16	PATIENT BAD DEBT WRITE OFF AMOUNT 17

*Charges for the hospital CCN only.

51



52

Other Extenders

- Rural home health add-on—three types of counties
  - Six or fewer per square mile
    - 2019-2022: 4-1% add-on
  - Rural counties in highest quartile (home health episodes per 100 Medicare eligible)
    - 2019-2020: 1.5-.5% add-on
  - All other rural counties
    - 2019-2021: 3-1%

DINGUS | ZARECOR & ASSOCIATES PLLC Certified Public Accountants 53

53

Ambulance

- Five-year extension of ambulance add-on
  - Urban: 2%
  - Rural: 3%
  - Super rural: 22.6% (based on originating zip code)
  - Expires December 31, 2022

DINGUS | ZARECOR & ASSOCIATES PLLC Certified Public Accountants 54

54

More Prior Authorization Required

- 2020 first five services types
- 2021 two more services types added
- Will be yearly, so monitor the list

55

55

Other OPPS Changes—2021 Style

- Removing the IPO list over a three year period
  - 2 year exemption for RAC review for these services
  - See proposal to remove this removal
- Pay 340B acquired pass-through drugs at ASP minus 22.5%
  - Tested the waters with a 28.7% decrease
  - Rural SCH still exempt
- Report inventory of COVID-19 therapeutics

56

56

2020 MPFS as Finalized

- Beginning January 1, 2021
- AMA updates E/M coding and interpretive guidance
- Lost E/M code 99201

57

57

OIG Workplan

- Audit of ER E&M services (provider)
- Medicare-related capital costs reported by new hospitals
- CAREs Act PRF payments to healthcare providers
  - Correctly calculated
  - Supported
  - Made to eligible providers
- PRF/PPP amounts to hospitals (meet criteria?)
- Duplicate professional billings by CAH and MD
- Medicare Part B telehealth services during PHE
- Audit of inpatient payment with COVID diagnosis

58

58

59

60