1

Outline

- Legislative outlook
- Medicare bad debts
- Price transparency
- Miscellaneous

2

President Elect

- COVID-19
  - Utilize defense production act for PPE
  - Push to deregulate telehealth
- Conservative on healthcare
- Backs ACA and wants to build on that
- Backs price transparency (which is from the ACA)

3

Other Legislative Considerations

- Democratic President means we care about the deficit again (and should)
- Senate with slight republican majority
- House with democrat majority
- Large COVID spending bills
- Will see small “patches” not large moves

4

Discussed Proposals

Amounts in Billions Over 10 Years

- $300 — negotiate drug prices directly
- $100 — cap drug prices
- $102 — further site neutral payments
- $164 — decrease UCC payments.
- $ 36 — decrease Medicare bad debts to 25%
- $168 — decrease GME payments
- $870 — total savings over 10 years

5

Discussed Proposals

- CHART Model
  - Voluntary
  - Two tracks
  - Move payment towards value
- Talking about changes to CAH:
  - “Iowa model”
  - Rural emergency hospitals
  - Global budgets

6

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

7

Polling Question 1

- What is an indigent care policy?
  a) Application to write off patient balances of indigent people
  b) Charity care policy

8

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"

9

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)

10

10

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 o the general ledger.

11

11

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

12

12

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 ever time we receive a payment

13

13

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 with in 120 days of the latest of theses

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

14

14

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

15

15

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

16

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 Medicare

17

Polling Question 2

- Price transparency
  a) Applies to CAHs
  b) Includes a machine readable file with all my negotiated rates
  c) Includes 300 shoppable services
  d) Excludes my RHC
  e) All of the above
  f) All of the above except (d)

18

Price Transparency Swole

- ACA requires standard charges to be made public
- 2015 CMS flexy
- 2019 CMS says "must be online in a machine readable format"
- 2020 CMS says, standard charges must be online in a machine readable format for all items and services
  - Then adds some definitions
- 2021 CMS adds: hey let's put your weighted average Medicare advantage payments per DRG on your Medicare cost report!! (cost reports ending on or after 1.1.21)
  - PPS only

19

19

Two Types of Transparency

- Machine readable bulk file
- Patient friendly "shoppable" services

20

20

Definitions

- Standard charge
  - Hospital's chargemaster (gross charge)
  - Payer specific negotiated reimbursements
    - CMS and Medicaid FFS rates are not negotiated
  - Discounted cash price
  - De-identified maximum negotiated charge
  - De-identified minimum negotiated charge

21

21

Definitions

- Items and services
  - All items and services
    - Individual items AND
    - Services and service packages
      - Includes DRG and outpatient bundles
    - Established standard charge

22

22

Format

- Single digital file
- Many columns okay, many tabs okay
- Choose:
  - .XML
  - .JSON
  - .CSV
- MUST be denoted as follows:
  - <EIN>_<hospital-name>_standardcharges.[json|xml|csv]
- Identify location

23

23

Location

- “Publically available website”
- Prohibited
  - Charging for the data
  - User accounts
  - Passwords
  - Personal information

24

24

Data Elements

- Description
- Gross charge amount
- Each insurance's reimbursement amount
- Mix and max of each insurance's reimbursement amount
- CPT code, HCPCs code, DRG, NDC, or other code utilized in billing
- The above "code" descriptions
- Recommended, not required
  - Revenue code
  - Charge quantity (drug example 5 ml)

25

25

Shoppable Services

- Minimum of 300 shoppable services
  - Can be scheduled in advance
- 70 mandated by CMS
- Include plain language description of service
- Other qualifiers are the same as the other
- Difference is really this is grouping the normal charges
- Must be searchable

26

26

Shoppable Services

- Deemed to meet if you have a price transparency tool that estimates patient's liability if meets all of the other shoppable services requirements

27

27

Enforcement

- Consumer complaints
- Audits may be in the future
- Penalty = $300 per day

28

28

Who Must Comply

- All hospitals in the US
  - Except federal hospitals lol

29

29

Polling Question 3

- Where are you all with the new price transparency rules
  a) I have my chargemaster up
  b) Haven't thought about it
  c) It is in the works
  d) It is up and running
  e) I could listen to that melodic voice all day

30

30

Provider Relief Funds

- General (3 phase)
- Targeted
  - Rural
  - Skilled nursing facilities
  - Nursing home infection control
  - Rural health clinic testing
- May be differing uses permitted for each

31

31

PRF—General Funds

Current as of 11/18

- Covid related expenses or lost revenue you can prove relates to:
  - Preventing Covid-19
  - Prepare for Covid-19
  - Responding to Covid-19
- Exclude those that were reimbursed or *should have been reimbursed* by another source

32

32

General Funds—Expenses

Current as of 11/18

- Above and beyond what you would have paid without the pandemic
  - Supplies (I used twice the masks in a day!)
  - Emergency staffing
  - Temporary structures
- Cost-based considerations (Idaho PPS included)
- **Capital costs in entirety**
- Calculation example:
  - Step one: what is the increase (increase in supplies or cost/encounter increase)
  - Step two: how much of that increase is related to COVID?
  - Step three: how much was reimbursed by other sources

33

33

General Funds—Lost Revenue

Current as of 11/18

- Patient services revenue (not retail)
  - Retail pharmacy excluded
  - 340B contract pharmacy included
  - Settlements related to prior years excluded
- Lost due to COVID
  - This can be really any reasonable method
  - Should be auditable
- Capped at the decrease in NPSR from *calendar* year 2020 minus 2019
  - Or first six months of 2021 minus first six months of 2019

34

Cost Report Considerations

Current as of 11/2

- No changes to the cost report
- Cannot claim the portion of COVID expenses paid on a cost basis.

35

Upcoming Dates

Current as of 11/10

- February 15, 2021
  - Opens January 15, 2021
  - First reporting for general funds
- June 30, 2021
  - Date you can expend funds through
- July 31, 2021
  - Last reporting date for general funds

36

Polling Question 4

- Of your general relief funds how much do you think you can keep under the current guidance
  a) $0—100,000
  b) $100,000—$500,000
  c) $500,000—$1,500,000
  d) $1,500,000—$3,000,000
  e) All of it
  f) None of it

37

37

Hospital's Without Walls

- During PHE
  - RHC
    - Can expand location
    - Can continue operations without mid-level (50% rule)
    - Can request productivity waiver
    - Visiting nurses
  - Can expanded 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)

38

38

Hospital's Without Walls

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

39

39

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
- S-2 — percentage of admin consulting from CBSA outside of your own
- S-3 — report COVID-19 expansion beds, bed days, and days
- S-12 — New!!
  - Includes attestation that those DRGs that are zero you didn't provide
- 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

40

40

Changes to S-10

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

41

41

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

42

42

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

43

43

44

44

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

45

45

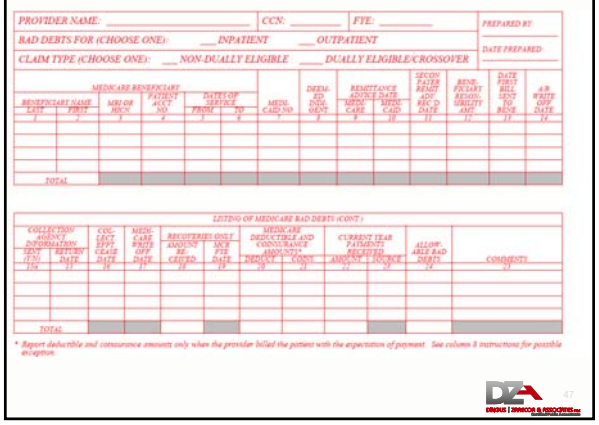
Exhibit 2A — Medicare Bad Debts

- 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"

46

46



47

47

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

48

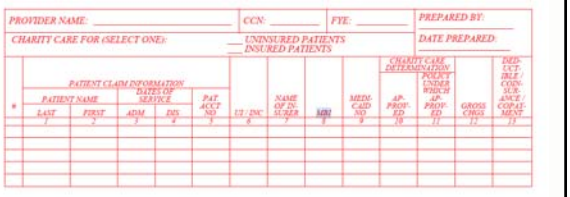
48

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

49

49



50

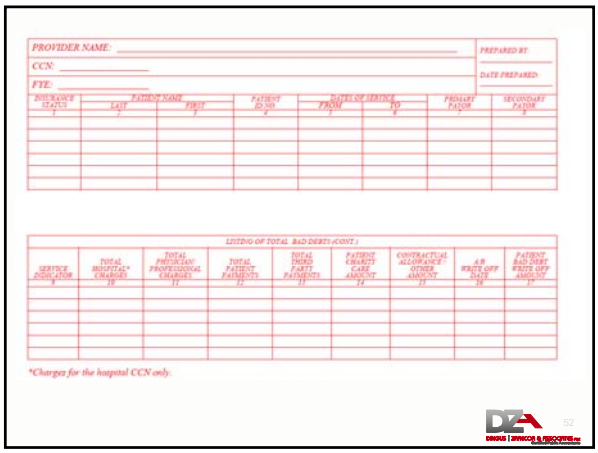
50

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)]

51

51



52

52

Bonus Polling Question

- How much wood could a woodchuck chuck if a wood chuck could chuck wood?
  a. 700 lbs
  b. 2 cords
  c. Depends on the type of wood
  d. Hey you woodchuck! Stop chucking my wood!

53

53

Low Volume Hospitals 2019 to 2022

- Criteria
- Fewer than 3,800 total discharges
- Hospital further than 15 miles from nearest PPS hospital
- Payment
- Linear scale
  - 25% at 500 total discharges
  - 0% at 3,800 total discharges

54

54

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%

55

55

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

56

56

Wage Index Changes

- Wage index disparities
- Belief: magnified by lag in wage data
- Started with 2020 and at least for 4 years

57

57

Wage Index Changes, 2021 IPPS

- Hospitals in lowest quartile (WI less than .8465) to receive 50% of the difference between their WI and the base
- Example:
  - Hospital's wage index is .8265
  - Difference is .0200
  - Half is .0100
  - New wage index is .8365
- Change is budget neutral

58

58

Wage Index—Rural Floor

- States have rural floors
  - Urban hospital not paid less than rural
  - Good rule to work strategically within a state
- Hospitals that reclassed to rural now excluded from the calculation
- Two-year hold harmless
  - Caps decrease to no more than 5% in a year
- Funds redistributed to other states

59

59

More Prior Authorization Required

- 2020 first five services types
- 2021 more proposed
- Will be yearly so monitor the list yearly

60

60

Other OPPS Proposals

- Removing the IPO list over a three year period
  - 2 year exemption for RAC review for these services
- Pay 340B acquired pass-through drugs at ASP minus 28.7%
  - Or stick with 22.5% decrease
  - Rural SCH still exempt

61

2020 MPFS as Finalized

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

62

Polling Question 5

- As a rural hospital, what payment system would you prefer
  a) Global budget
  b) Cost-based
  c) Capitation
  d) Value-based
  e) None of the above

63

Questions?

64

DZA
DINGUS, ZARECOR & ASSOCIATES

Contact Information

Shar Sheaffer, CPA, Owner
509.321.9485
ssheaffer@dzacpa.com
www.dzacpa.com

65