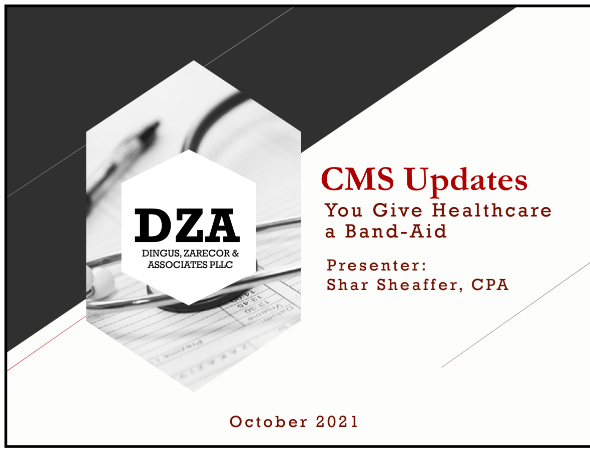


CMS Updates

You Give Healthcare a Band-Aid

Presenter:
Shar Sheaffer, CPA

October 2021

1

Outline

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

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

Other Legislative Considerations

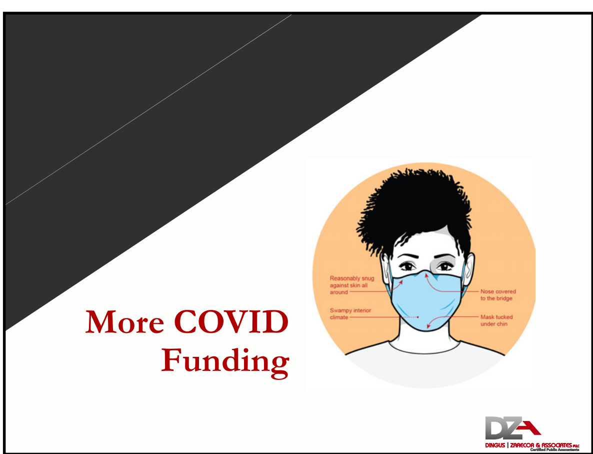
- Democratic President means we care about the deficit again (and should)
- Senate considered democrat majority
- House with democrat majority
- Large COVID spending bills
- Medicare solvency
- No budget
- Fiscal cliff

4

Proposed Legislation

- Expand Medicare to include dental, hearing, and vision
- Permanently fund CHIP
- Funding for health departments
- Funding for rural medical training
- Pandemic preparedness

5



6

USDA Grants

- **Applications due 10-12-21**
- Cost sharing
  - Populations AND
  - Median household income compared to state nonmetropolitan
  - "Up to"
    - 75%
      - Population 5,000 or fewer
      - MHI 60%
    - 55%
      - Population 5,000 or fewer
      - MHI 60%
    - 35%
      - Population 5,000 or fewer
      - MHI 60%
    - 15%
      - Population 5,000 or fewer
      - MHI 60%

7

USDA Grant—Track 1

- Grants between $25,000 and $1,000,000
- Used:
  - In correlation with COVID-19 pandemic
  - Support immediate healthcare needs
  - Prepare for future pandemic event
  - Increase access to quality healthcare
  - Improve community health outcomes

https://www.rd.usda.gov/erhc

8

USDA Grant—Track 1

- Grants between $25,000 and $1,000,000
- Used:
  a) Increase capacity for vaccine
  b) Medical supplies and equipment for surge capacity
  c) Reimburse lost revenue (back to 3-13-20)**
  d) Increase telehealth capabilities
  e) Construct/renovate temporary or permanent structures
  f) Staffing for testing or vaccine administration**
  g) Support expenses associated with food banks or food distribution
  h) Pay professional services fees and charges 😉
  i) Pre-award cost for items above (start 3.13.21)

9

USDA Grant—Track 2

- Grants between $5,000,000 and $10,000,000
- Establish a regional partnership of 3 or more healthcare entities, economic development, tribes, higher learning
- Work on regional healthcare problems
- Promote the long-term sustainability of rural healthcare
- New or tweaked evidence-based models

10

Phase 4 and Rural ARP

- Step one: get in and validate your TIN
  - Exactly how the IRS knows of you. They are picky
- Applications due October 26
- 75% of payment based on changes in revenues and expenses
  - 7.1.20 through 3.31.21 (quarterly reporting, looked at in total)
    compared to
  - Same quarters in 2019
- 25% is for bonus payments based on level of Medicaid, CHIP, and Medicare utilization

11

Phase 4 and Rural ARP

- Rural ARP application:
  - CLICK "YES" I want to be considered.
  - Don't care who you are
  - Based on patients served, not your rural (or not rural) location

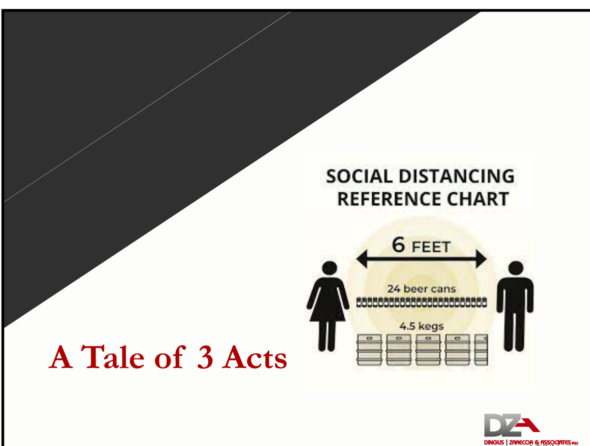
12

Polling Question 1

How many beers apart is 6 feet?

1. 24 cans
2. 4.5 kegs
3. Neither of the above
4. Both of the above

13



A Tale of 3 Acts

14

Acts

- Consolidated Appropriations Act
- American Rescue Plan
- Sequester/RHC Act

15

RHC Payment Basics

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

16

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

17

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

18

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

19

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 afterwards to keep cost cap (instead of statutory)
  - During PHE, we use beds from the cost report before the start of the PHE

20

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

21

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)

22

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

23

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

24

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

25

PRF Reporting

- Due September 30, 2021
- 60-day grace period

26

Polling Question 2

If my RHC rate on my 2020 cost report was $275 and my cost on my 2022 cost report is $300, how much am I paid per encounter?

1. $275
2. $300
3. 80% of the right answer
4. A = π r2

27

28

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

29

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”

30

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)

31

One Policy or Two?

- If your current charity application requires an asset test:
  - Rename charity “indigent” applications
  - Rename charity policies as “indigent” policies
- If 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.

32

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

33

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

34

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 these:

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

35

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

36

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

37

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

38

Other Proposals

39

MPFS Proposals

- Behavioral 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)

40

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 - I think that is 2024

41

OPPS Proposals—Price Transparency

- Current penalty is $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

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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

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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)

44

Polling Question 3

Who is better at talking Medicare bad debts?

1. Kami Matzek
2. Kami Matzek
3. All of the above

45

Miscellaneous

Parting shots

46

State DSH

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

47

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)

48

Hospitals Without Walls

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

49

Cost Report Proposed Changes

- 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

50

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

51

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

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Exhibit 3A — Medicaid Days

- Separate exhibit for each type of day on S-2

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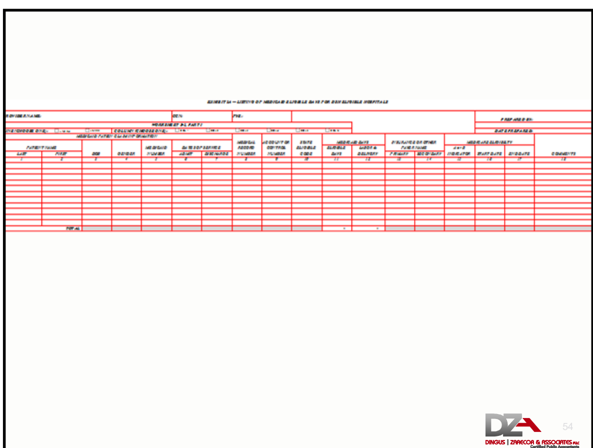

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Exhibit 2A — Medicare Bad Debts

- 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

55

55

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"

56

56

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						MEDICAID NO.	DEEMED INDIGENT	REMITTANCE ADVICE DATE		SECON. PAYER REMIT. ADV. REC'D DATE	BENEFICIARY RESONSIBILITY AMT.	DATE FIRST BILL SENT TO BENE.	A/R WRITE OFF DATE
BENEFICIARY NAME		MBI OR HICN	PATIENT ACCT. NO.	DATES OF SERVICE				MEDICARE	MEDICAID				
LAST	FIRST			FROM	TO								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
TOTAL													

LISTING OF MEDICARE BAD DEBTS (CONT.)												
COLLECTION AGENCY INFORMATION		COLLECT. EFFT. CEASE DATE	MEDICARE WRITE OFF DATE	RECOVERIES ONLY		MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS*		CURRENT YEAR PAYMENTS RECEIVED		ALLOWABLE BAD DEBTS	COMMENTS
SENT (Y/N)	RETURN DATE			AMOUNT RECEIVED	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.

57

57

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

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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

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

CHARITY CARE FOR (SELECT ONE): ___ UNINSURED PATIENTS ___ INSURED PATIENTS DATE PREPARED: ________

#	PATIENT CLAIM INFORMATION									CHARITY CARE DETERMINATION			
	PATIENT NAME		DATES OF SERVICE		PAT. ACCT. NO.	UI / INC	NAME OF INSURER	MBI	MEDICAID NO.	APPROVED	POLICY UNDER WHICH APPROVED	GROSS CHGS	DEDUCTIBLE / COINSURANCE / COPAYMENT
	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 MEDICAID	MINUS (REDUCTIONS)					GROSS CHGS NET OF REDUCTIONS	ALLOW. CHARITY CARE CHGS	CHARITY CARE APPROVED RATIO	UNINSURED DISCOUNT	TOTAL ALLOW. CHARITY CARE AMT	WRITE OFF DATE	PAT. RESP. CHGS	PAYMENTS RECEIVED
	PHYS. / PROF. CHGS	NON-COVERED CHGS	UNINSURED DISCOUNT	CONTRACTUAL ALLOWANCE	COURTESY DISCOUNT								
14	15	16	17	18	19	20	21	22	23	24	25	26	27

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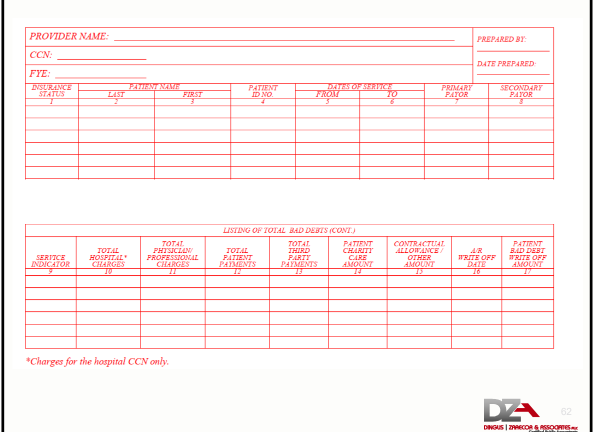
Exhibit 3C — Bad Debt for UCC

- 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)]

61



PROVIDER NAME: ____________________

CCN: ____________

FYE: ____________

PREPARED BY: ____________

DATE PREPARED: ____________

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

LISTING OF TOTAL BAD DEBTS (CONT.)

SERVICE INDICATOR	TOTAL HOSPITAL* 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

*Charges for the hospital CCN only.

62

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

63

Polling Question 4

Which is correct regarding the new detail reporting for charity care charges, Medicare bad debts, and Medicaid days?

1. Both PPS and CAH must file the new form for Medicare bad debts
2. All PPS hospitals must file all three
3. PPS hospital who do not get paid Medicare DSH only have to worry about the Medicare bad debt one
4. CAHs must file all three
5. All of the above
6. All of the above except 4

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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%

65

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

66

More Prior Authorization Required

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

67

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

68

2020 MPFS as Finalized

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

69

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

70

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72