DZA Newsletter January 2023

At the end of 2022, Congress bestowed upon us an Appropriations bill with some fun healthcare "surprises" (hence this newsletter). As an added bonus, CMS also finalized reporting standards for Medicare bad debts, uncompensated care reporting, and reporting of Medicaid days.

CMS Transmittal 18

You can click the handy link here to the new exhibits. Or, just in case, they can also be found on our website under resources.

Medicare bad debts—Since cost reports beginning on or after October 1, 2018, Medicare bad debts have had to be filed with your cost report and match what was actually claimed, with the rejection of the cost report as the penalty. Starting with cost reports beginning on or after October 1, 2022, the form in the link above **must** be utilized and submitted with your cost report (again, the rejection of your cost report is the penalty). This is for you critical access hospitals, hospitals, skilled nursing facilities, rural health clinics, federal qualified health centers, well, anyone claiming Medicare bad debts. I'd recommend pulling down the form now, as there are many new required fields and you'll want to ensure your system is set up to capture each one.

For each component you are claiming Medicare bad debts, a separate workbook is required (as opposed to separate tabs). For example, the hospital will have a workbook separate from the RHC.

Uncompensated care—If you are a PPS hospital requesting payment for uncompensated care and Medicare DSH, your charity care, bad debts, and Medicaid days, **must** be reported on exhibits located on the link above. This is effective for cost reports beginning on or after October 1, 2022. A couple of items to note:

- Medicaid days require a separate exhibit for each type claimed in worksheet S-2. That means we need a separate exhibit for in-state paid, in-state eligible but not paid, out-of-state paid, out-of-state eligible but not paid, and paid and eligible for managed care Medicaid. We must know and report, by patient, which category that patient day falls into.
- Medicaid days in detail have been required to submit with your cost report since cost reports beginning on or after October 1, 2018.
- Indigent charges and bad debts have a few new words added to the instruction:
    - Things like the charges must be "medically necessary," or
    - If a payor makes any payment, even if you are not contracted with them, it's an inferred contract and the patient is therefore insured.
    - You can include uninsured discounts if those are spelled out in your financial assistance policy. These are not the same as prompt pay discounts and other courtesy adjustments, which are to be excluded.

    - Cost reports beginning on or after October 1, 2022, will be reporting only charges associated with its main provider number. This is actually a big change if you have been including things like your rural health clinic, psychiatric unit, dialysis unit, etc. Now you will have a separate exhibit for hospital (main provider number) and a separate exhibit for the other components (for example, rural health clinic or psychiatric unit).
- Finally, if you are a PPS hospital and are requesting uncompensated care or DSH payments, a detail in the above prescribed format must be submitted with the cost report for charity care and bad debts claimed for cost reports beginning on or after October 1, 2022. Failure to do means your cost report will be rejected.

COVID expansion beds and days—This transmittal added in the lines required to properly report expansion beds and the related days on the cost report. Because much of this occurred in 2020 and 2021, adjustments may be necessary on previously filed cost reports.

2023 Consolidated Appropriations Act

In addition to several changes made in this Act, there are various extensions to programs we've relied upon for the last several years (mostly since passing the ACA).

Extensions—

- For small PPS hospitals with fewer than 3800 discharges and who are further than 15 miles from the next nearest hospital (CAHs do not count in this instance), the low-volume program has been extended through federal fiscal year 2024. It was previously extended through December 24, 2022; we're uncertain if that application stays in effect for all of federal fiscal year 2023 or if you will need to reapply, but if you are a DZA client, rest assured we will be putting together all necessary paperwork on your behalf as needed.
- If you are a Medicare dependent hospital, that program has been extended through federal fiscal year 2024.
- If you are providing services to the most rural patients via your home health agency, you can enjoy a 1 percent add on for 2023. This was originally set to expire December 31, 2022.
- For those of you with a rural ground ambulance, if your patient originates in a rural area you can continue to enjoy a 3 percent add on. If the patient originates in an urban area, you will receive a 2 percent add on for calendar years 2023 through 2024.

Physician services—

- Congress has authorized additional increases for those participating in the MIPS program. Base fee schedule payments were set to return to 2020 payment amounts in 2023; instead, your payments will see a 2.5 percent increase for 2023

and a 1.25 percent increase in 2024. Calendar year 2025 is still set to be a zero percent increase.

- If you are participating in an alternative payment methodology, Congress added a year onto the program where you can receive a bonus of the otherwise agreed upon payment amount. Currently, this is at 5 percent through calendar year 2024, but we will now see a 3.5 percent bonus amount in calendar year 2025.

Telehealth—As you may recall, Congress said that for several of the telehealth waivers allowed under the public health emergency (PHE), we would be given an additional 151 days after the end of the PHE to continue to provide said services. Congress has extended that, saying that for those particular services, the end of the waiver is the later of the end of the PHE or December 31, 2024. Items included are:

- Eligible practitioners
- RHCs as distant site providers
- Audio only services
- No in-person visit required for newly-covered mental health encounters (which includes RHCs) provided via audio only. Under the current rules, these require an in-person visit every six-months.

Rural health clinics—

- Currently, only psychiatrist and licensed medical social workers are approved mental health practitioners in an RHC or FQHCs. However, the Appropriations Act adds both marriage and family therapists as well as mental health counselors to the list of covered practitioners. This begins for services provided on or after January 1, 2024.
    - A marriage and family therapist is defined to include a persons with a master's or doctor's degree qualifying them to provide marriage and family therapist services, who has at least "two years of clinical supervised experience in marriage and family therapy," and who is licensed as such in the state.
    - A mental health counselor is defined to include a person who has a master's or doctor's degree qualifying them to provide services as a mental health counselor, who has a least "two years of clinical supervised experience in mental health counseling," and who is licensed as such in the state.
- RHCs and FQHCs can provide intensive outpatient services through the clinic. Payment will be made at hospital rates, and the costs of the services will be pulled out of the all-inclusive rate (e.g. reported in the nonRHC/nonFQHC portion of the cost report).

Closing

As always, if you have questions, please let me, Tristi, or your favorite DZA representative know. May you have a great new year!