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**Hospital Cost Report Training**  
**Level II Critical Reimbursement Strategies // General Session**  
Dallas - Hilton Dallas/Southlake Town Square

JULY 27 - 28, 2016



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## To Receive CPE for Participation:

- Sign in before the session
- Remain present for the entire session
- If leaving early sign out indicating the time





# Cost Report Training - Level II

- Understand potential issues and opportunities with Medicare bad debts.
- Learn how to reconcile the Medicare cost report settlement and understand the various settlement components.
- Identify opportunities for hospitals to impact the key factors in PPS reimbursement including Medicare DSH, IME/GME, and the wage index. (PPS Track)
- Evaluate the unique challenges for Critical Access Hospital cost reporting. (CAH Track)

# Clinic Strategies





# 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)
  - Exempt from Bipartisan Budget Act of 2015 Section 603

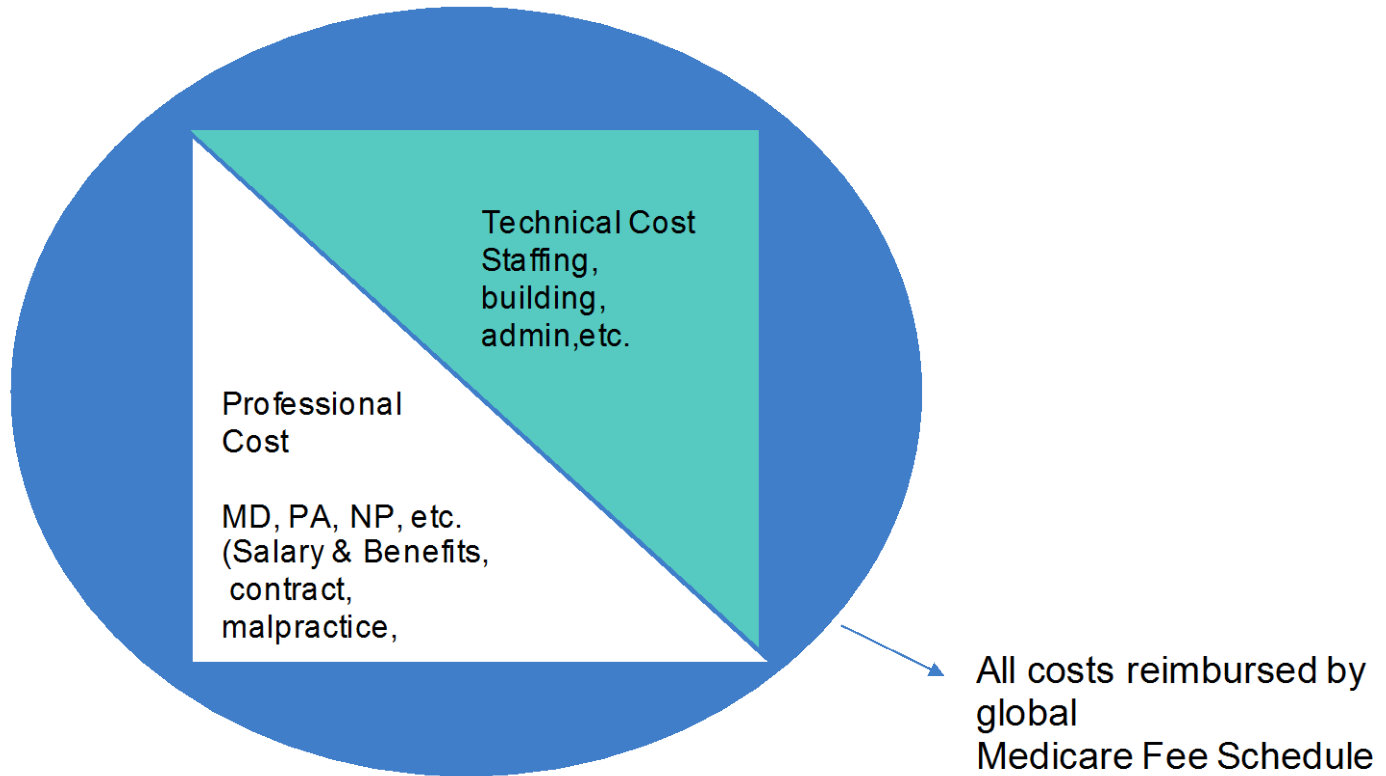


# Freestanding Clinic Medicare Reimbursement

- Technical and Professional Costs paid on full RBRVS payment rate - also known as global Medicare fee schedule.
  - Medicare Fee Schedule (3 Parts)
    - 100% Work component
    - 100% Malpractice component
    - 100% Practice expense component



# Freestanding Clinic Medicare Reimbursement







# Provider-Based Clinic

- What is Provider-Based Status?
  - Relationship between a main provider and 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 415.65 and 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 and/or beneficiary liability for services furnished in the facility



# Provider-Based Attestation Process

- CMS regulation 413.65
  - Voluntary attestation process – we always recommend
  - Must demonstrate integration with the hospital
    - Clinical Service Integration
    - Financial Integration
    - Common Licensure
    - Public Awareness



# Provider- Based Location Requirements

- Campus – within 250 yards of main hospital buildings
- Off campus – within 35 miles (except RHC)
  - Additional Requirements for Off-Campus Sites
    - Ownership and Control
    - Administration and Supervision
    - Location in Immediate Vicinity
    - Management Contracts
- CAUTION for CAH –
  - CMS final OPPI rule FY 2008
  - Any new off-campus provider based location (except RHC) for CAH must meet the CAH location requirements – consequence: loss of CAH designation!



# Obligations of Hospital-Based Entities

- Bill physician services with Correct Site of Service Indicator (11 office versus 22 hospital outpatient)
- Provide Notice of Coinsurance to each Medicare beneficiary
- Treat Medicare patients as hospital outpatients for billing purposes (uniform billing)
- Physician Supervision Requirements
- Comply with EMTALA
- Comply with 3-Day Payment Window
- Comply with all the Terms of the Main Hospital's Provider Agreement
- Comply with all Applicable Medicare Hospital Conditions of Participation (Life Safety Code requirements)

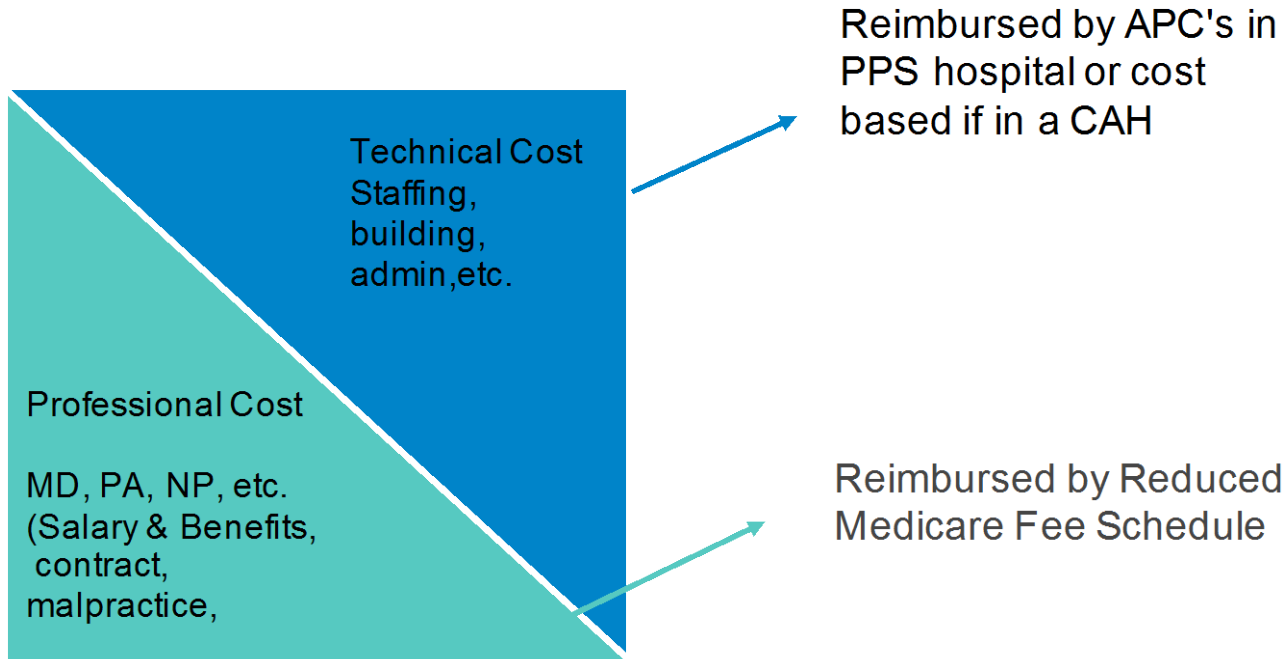


# Provider-Based Clinic Medicare Reimbursement

- Professional Component paid on reduced RBRVS payment rate-also known as reduced Medicare fee schedule.
  - Medicare Fee Schedule (3 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 APC's
  - CAH payment based on allowable cost (no cost limitation)



# Provider-Based Clinic Medicare Reimbursement





# Disclosure

- Must disclose to Medicare beneficiaries that the clinic is provider-based
- If standard billing, must notify them that they will receive two explanation of benefits and have a different payment amount



# Potential Advantages of Provider-Based Designation

- Potential significantly higher reimbursement. (Have to look at all payors in the aggregate)
- Reimbursement for Medicare Bad Debts
- Increased coordination with hospital-physicians
- Increased clinical integration with hospital
- Greater flexibility in financing and efficiencies with admin or shared staff





# Potential Disadvantages of Provider-Based Designation

- Increased costs related to hospital wage and benefit scales, more costly facilities, and less effective cost management.
- Increased billing complexities - negative impact from split billing for patients
- Patient coinsurance may be a big deal
- Decreased physician control of practice staff and accountability for finances and productivity



## Section 603 Off-Campus Provider Based Clinics

- Bipartisan Budget Act of 2015 requires most off-campus provider-based departments not split-billing as of 11/2/15 to receive site-neutral payments beginning 1/1/17
  - CMS has addressed some implementation guidelines – included in CY 2017 OPPS proposed rule issued in July
    - Silent thus far on 340B implications
  - US House recently passed *Helping Hospitals Improve Patient Care Act of 2016* which includes provisions to provide relief to hospital departments that were “mid-build” as of 11/2/15
    - Mid-build = binding written agreement was already in place for the actual construction
    - Likelihood of Senate passage unknown



# Section 603 Off-Campus Provider Based Clinics

- Changes do not apply to
  - On-campus provider-based departments (PBDs)
  - Other off-campus facilities such as remote locations of a hospital (i.e. inpatient campuses of a multicampus hospital)
  - Satellite facilities
  - Provider-Based entities such as RHCs
  - A PBD located with 250 yards of a remote inpatient location
- Specific exemption for all items and services furnished by a dedicated emergency department (as defined in the EMTALA regulations at 42 CFR § 489.24(b). – Discuss Proposed exemptions and related criteria outlined in OP PPS Proposal



# CMS Proposes Changes to Provider-Based Departments

- Could significantly limit how hospitals operate off-campus PBDs.
- Already in existence on or before Nov. 1, 2015
  - Continue being paid under OPPS Payments if
    - Remain as the same physical address
    - Furnishes the same services lines as of Nov. 1, 2015
  - Lose exemption status if...
    - Move Physical Address
  - Any new service lines offered paid under Medicare Physician Fee Schedule (MPFS) rates



# CMS Proposes Changes to Provider-Based Departments

- PBD's not billing as hospital departments by Nov. 1, 2015 (“non-excepted” PBDs)
  - CMS proposes to not pay hospitals directly at all during CY 2017
    - Due to insufficient system capabilities to pay a hospital under MPFS
    - Proposes that Physicians that performed work bill for all services furnished within the non-excepted PBDs on CMS-1500 claim form using nonfacility Place of Service (POS) Code.
  - CMS aiming to have mechanism in place by CY 2018 to pay hospitals directly

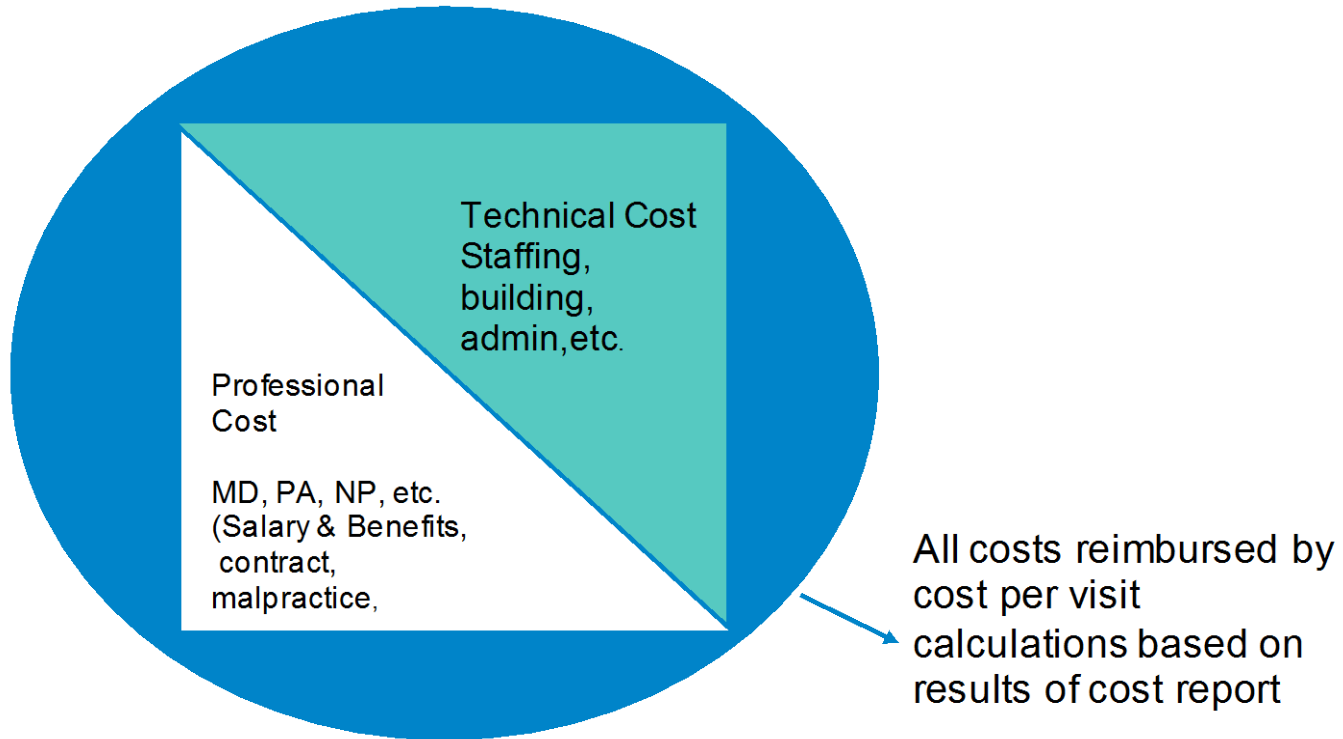


# RHC Reimbursement

- RHC visits - cost-based
  - All-inclusive cost per visit up to a limit
  - Subject to productivity standards that can reduce or limit reimbursement
    - 4,200 encounters per FTE for physician
    - 2,100 encounters per FTE for mid-level practitioner
- AN RHC visit is defined as a medically necessary or mental health, or a qualified health visit. The visit must be a face-to-face encounter between the patient and an RHC practitioner during which time one or more RHC services are furnished. It is not always an E&M HCPCS code. Qualifying visit HCPCS codes are updated on CMS's RHC center webpage periodically.



# RHC Reimbursement





# RHC Reimbursement

- Inpatient Hospital visits - fee schedule
- SNF MD visit cost-based reimbursement
- Clinical laboratory-fee schedule:
  - Until 6/30/09 must be drawn in CAH space for cost reimbursement
  - After 7/1/09 can be drawn in RHC space





# RHC Reimbursement

- Medicaid – Cost based – usually but each state has different rules



# Rural Health Clinic

- General Requirements
  - Must have mid-level practitioner at practice at least 50% of the time that the clinic is operating as an RHC
  - At least one mid-level practitioner has to be an employee of the clinic
  - Basic laboratory procedures are required to be able to be provided
  - Must have written clinical protocols
  - Must have annual evaluation
  - Must have written policies and procedures
  - Subject to certification by Medicare
  - Certification is “space-specific”
  - Can be provider-based or freestanding



# RHC Current Shortage Area Location Requirements

- HPSAs
  - Geographic Primary Care
  - Population-Group
- MUAs
- Governor's Designation
- Automatic HPSAs

The HPSA or MUA designation must be within the last 4 years at least during the initial certification. Providers can get obtain an initial understanding from [www.ruralhealthinfo.org](http://www.ruralhealthinfo.org) under the “Am I rural?” Section. Final verification and validation should be done by the respective state office of rural health.



# Medicare Example of Provider-Based Clinic Versus Freestanding Clinic

Provider Type	Provider-Based Clinic		Freestanding Physician Practice
Claim Form	UB-04	CMS 1500	CMS 1500
Site of Service	N/A	22 - Hosp OP	11 – Office
Payment Method	APC	RBRVS Reduced	RBRVS Global
Procedure Code	99213	99213-26	99213
Payment Amounts	\$70.11	\$44.30	\$66.73
Coinsurance Amounts	\$17.53	\$11.07	\$16.68
Total	\$87.64	\$55.37	\$83.41
Total Payment	\$143.01		\$83.41
Total Coinsurance	\$28.60		\$16.68

99213 – Office/outpatient visit established  
Wage Index – 1.3158  
Physician Fee Schedule – Area 02



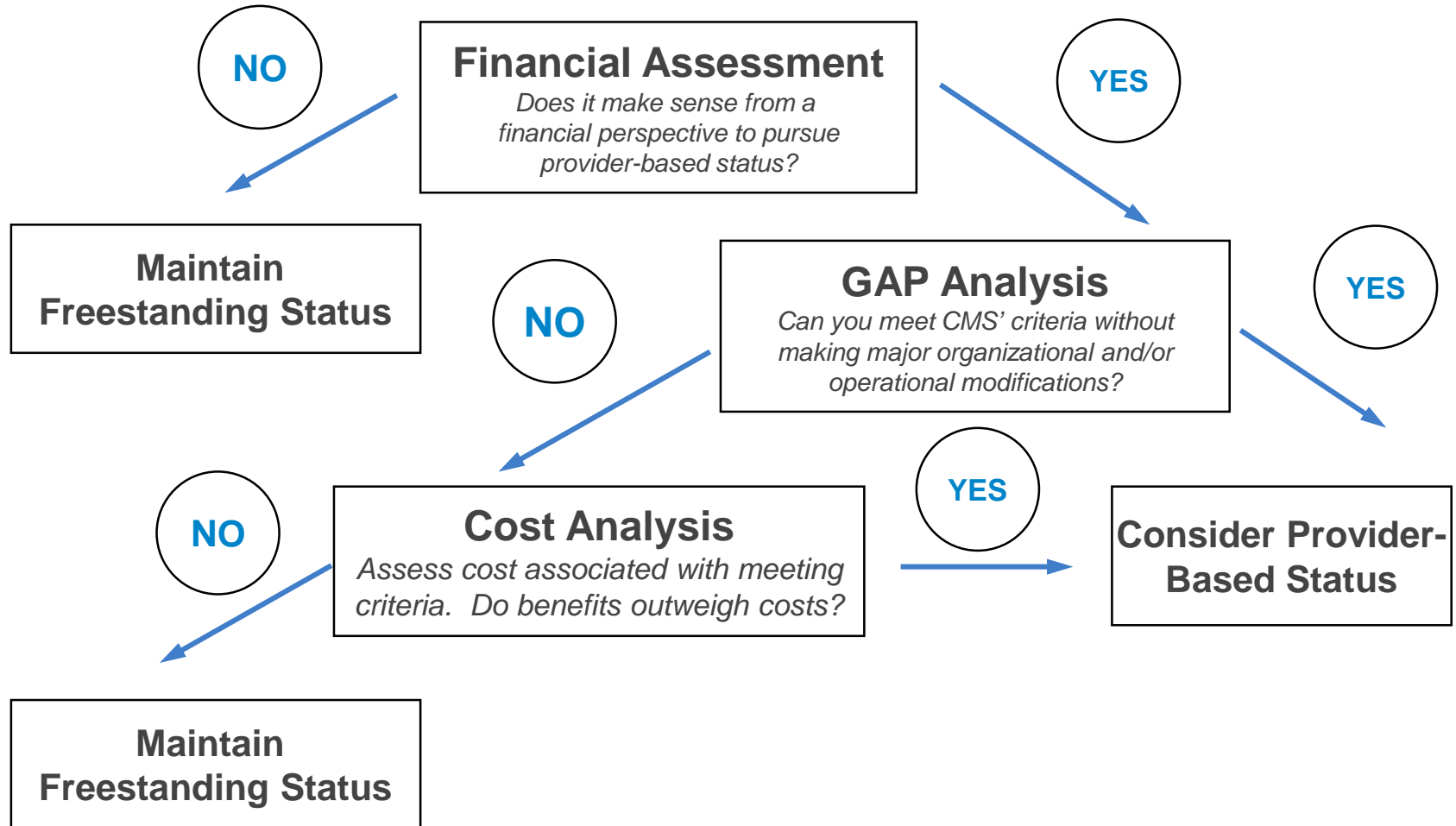
# Medicare Example of Provider-Based Clinic Versus Freestanding Clinic

Provider Type	Provider-Based Clinic		Free-Standing Physician Practice
Claim Form	UB-04	CMS 1500	CMS 1500
Site of Service	N/A	22 - Hosp OP	11 – Office
Payment Method	APC	RBRVS Reduced	RBRVS Global
Procedure Code	78452	78452-26	78452
Payment Amounts	\$646.77	\$67.35	\$480.29
Coinsurance Amounts	\$161.70	\$16.84	\$120.07
Total	\$808.47	\$84.19	\$600.36
Total Payment	\$892.66		\$600.36
Total Coinsurance	\$178.54		\$120.07

78452 – Nuclear Medicine Stress Test  
Wage Index – 1.3158  
Physician Fee Schedule – Area 02



# Hospital Decision Criteria



# Medicare Bad Debts





# Regulatory Guidance

- Medicare bad debts are addressed in:
  - 42 CFR 413.89 (see back of this section)
  - CMS Pub 15-1 (PRM), Chapter 3 (see back of this section)
  - CMS Pub 13, Part IV (Intermediary Manual), Chapter II (Guidelines for Performing Provider Audits)





# Bad Debt Criteria

- Criteria for allowable bad debts:
  - Debt must be related to covered services and 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, and
  - Sound business judgment established that there was no likelihood of recovery at any time in the future.



# Bad Debt Criteria

- Not Allowable
  - Deductibles and coinsurance from professional fees such as CRNA & physician services. (i.e. billed on a 1500)
  - Deductibles and coinsurance resulting from fee schedule payments (i.e. Therapy, Ambulance, and Lab fee schedule payments)
    - See 42 CFR 413.89(i)



# Bad Debt Criteria

- Not Allowable
  - Deductibles and coinsurance resulting from non-allowable services (service not covered by Medicare)
  - Amounts from Self Administered Drugs and/or Late Charges
  - Deductibles and coinsurance to enrollees of Medicare HMO Plans
    - Reimbursement can be negotiated with Medicare HMO



# Bad Debt Reimbursement

- Hospital (IP/OP), Psych and Rehab, & Regular SNF Bad Debts
  - Beginning in FY 2013, subject to 35% reduction in reimbursement (65% reimbursement)
- CAHs, SNF Crossovers, RHCs & Other Entities
  - Transitioning 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)



# Bad Debt Types

- Regular Medicare bad debts
  - Not crossovers or charity care
  - Subject to reasonable collection effort rules
- Crossover Medicare bad debts
  - Patients dual eligible for Medicare and Medicaid
  - Not subject to reasonable collection effort rules
- Charity Care Medicare bad debts
  - Indigent Patients
  - Not dual eligible patients
  - Not subject to reasonable collection effort rules



# Regular Bad Debts

- History of Claiming Medicare Bad Debts
  - Prior to 5/2/2008 – Most Providers claimed Medicare bad debts after collections efforts ceased internally and when transferred to collection agency. Medicare bad debt claimed on financial statements at this time.
  - Joint Signature Memorandum (JSM) issued to MAC's by CMS on 5/2/2008 clarifying CMS's stance on provider's use of collection agencies.
  - Post 5/22008 – Most providers now conform to JSM and claim Medicare bad debts after return from collections agency and all collection efforts have ceased. Providers still claim bad debt on financial statements when account is turned over to collection agency.



# Regular Bad Debts

- Use of Collection Agencies
  - A collection agency may be used in addition to, or in lieu of provider's reasonable collection efforts.
  - The provider should have a (compliant) written policy concerning the use of collection agencies.
  - Collection agency fees are an allowable A&G cost and should not be claimed as an allowable bad debt.
  - The provider must be able to document that:
    - All uncollected accounts of like amount are referred to the collection agency without regard to patient class.
    - The collection efforts made by the collection agency are genuine and the same for all financial classes of patients.



# Regular Bad Debts

- Credit Reporting – Is it a collection effort?
  - Old Interpretation – Prior to January 2015
    - According to CMS, Yes – If the delinquent account is posted on an individual's credit report by a collection agency, the posting is considered a collection effort.
    - If an account has been posted to the credit report by a Collection Agency, it can be removed from the credit report and returned to the hospital. At this point the hospital can claim the bad debt.
    - If hospital reported the account to the credit agency then CMS did not consider this a form of collections





# Regular Bad Debts

- Credit Reporting – Is it a collection effort?
  - New Interpretation – Prior to January 2015
    - According to CMS, No – CMS no longer considers the reporting of an account to a credit bureau as an ongoing collection effort, regardless of who sent the account to the credit bureau. Therefore, for future reference, the provider may claim the account as bad debt in the year the account was returned from the collection agency as uncollectible regardless of whether the account was reported to the credit bureau. (See document in bad debt handout section)
    - Keep in mind that this may trigger future recoveries.



# Regular Bad Debts

From: Scott Neely, Director, Provider Audit and Reimbursement, Palmetto GBA  
*(this memorandum is intended as a clarification of Palmetto GBA policy interpretation and is not intended as a formal CMS policy issuance)*

RE: BAD DEBT REIMBURSEMENT ISSUE – CREDIT BUREAU REPORTING

Palmetto GBA has previously communicated to the provider community that bad debts could not be claimed as worthless if the debt was referred to a collection agency for additional collection effort and has not been returned to the provider as uncollectible by the collection agency.

As well, if the bad debt had been referred to the credit bureau by the collection agency, the debt could not be claimed as worthless if the collection agency had not deleted the accounts from the patient's credit bureau file. However, an emphasis was made that if the account was at the credit bureau through submission by the provider, the account was not required to be deleted from the credit bureau file before claiming the bad debt as worthless.

## CLARIFICATION:

Palmetto GBA received a clarification from CMS in regards to the issue of reporting accounts to the credit bureau. CMS does not consider the reporting of an account to a credit bureau as an ongoing collection effort, regardless of who sent the account to the credit bureau. Therefore, for future reference, the provider may claim the account as a bad debt in the year the account was returned from the collection agency as uncollectible regardless of whether or not the account was reported to a credit bureau.

The application of this clarification will be applied to any current open cost report. We will not retroactively reopen previously settled cost reports where the previous position was an issue. However, the provider is not precluded from requesting a reopening of any applicable cost report if the cost report is still within the 3-year window of reopening.

AU-Letterhead MAC Form  
Revision 9 01/27/2015

A CMS-Contracted Medicare Administrative Contractor





# Regular Bad Debts

## – Audit Issues

- Auditors are asking for copies of written policies at beginning of Medicare bad debt audit. Make sure you have a compliant policy.
- Bad Debt Moratorium – Medicare is strictly enforcing the JSM dated 5/2/08 that regular bad debts need to be returned from a collection agency and collections efforts ceased before claiming as a Medicare Bad Debt.
- Medicare auditors starting 120 day rule over after last patient payment.



# Regular Bad Debts

## – Audit Issues (cont.)

- Collection Agency Issues – collection agency is subject to providing patient transaction history to document communications to collect debt. Discuss this need with your collection agency prior to placing accounts with them. If you are uncomfortable with the answer, do not risk your bad debts by placing them with that agency.
- Reasonable collection Efforts – Auditors are analyzing Medicare and Non-Medicare accounts to determine that all payers are being treated equally. In addition, they are validating that hospitals are abiding by their written collection policies.
- Exclusion of Fee schedule and Professional coinsurance and deductible – not allowable for Medicare bad debt purposes.



# Regular Bad Debts

## – Audit Issues (cont.)

- Timely Billing – Intermediaries are now attempting to disallow any coinsurance or deductible if the hospital did not bill the patient in a timely manner after Medicare paid. The regulations state “timely manner” but the auditors look for 45 days. This is an area for negotiation with the auditor.
- Audit Extrapolation – Auditors are often extrapolating error rates based on statistical samples that, in our opinion, do not meet valid statistical sampling for extrapolation purposes.
- The size of audit samples are often too small to provide any reasonable confidence level.
- Auditors are grouping bad debt listings by the amount claimed which can generate different error rates.



# Regular Bad Debts

## – Recommendations

- Adjust collection policy to apply with CMS clarification on 5/2/08.
- Great time to reevaluate collection procedures and policies
  - Discuss Various Strategies available
    - » Use of referral date in criteria-How many days @ collections?
    - » Differentiate on account balances
    - » Collection agency scoring



# Regular Bad Debts

## – Recommendations (cont.)

- Document/Document/Document
- Set up process to exclude non-allowable coinsurance/deductible – Medicare Detailed PS&R
- Periodically perform a mock audit (Medicare and Non-Medicare). Consider utilizing your internal audit department.
- Prepare logs correctly before submission. Correct bad debt logs require the proper resources (FTEs and time)



# Crossover Bad Debts

- Crossover Medicare Bad Debts
  - Bad debts applicable to patients who qualify for both Medicare and Medicaid coverage.
  - These patients are deemed indigent based on their Medicaid eligibility and the bad debt may be allowed without applying the reasonable collection efforts outlined in PRM 15-1, §310.
  - However, the provider must bill Medicaid and obtain a paid remittance advice even if the paid amount is zero. Cahaba will disallow crossover claims denied by Medicaid.
  - See PRM 15-1, §312 and §322





# Crossover Bad Debts

- Providers may claim the unpaid portions of the deductible/coinsurance when Medicaid has made a partial payment.
- Providers often miss subsequent corrections to Medicaid remittance advices. You may have multiple remittance advices if the account was refunded and re-billed.
- Providers often miss posting Medicaid payments that overstate the crossover bad debt
  - Often miss other insurance/patient payments as well, if applicable



# Crossover Bad Debts

## – Recommendations

- Outline process for Patient Accounting to timely post crossover write-offs so that write-off date is not significantly different than Medicaid RA date.
- Create a unique posting code to post Medicaid crossover write-offs.
  - Using individual code will assist with potentially automating process
  - Also will help with reprocessed/corrected claims



# Crossover Bad Debts

## – Recommendations (cont.)

- If provider is not comfortable they are capturing all crossovers by extracting from system, then provider should log straight from Medicaid remittance advice.
- Setup process to exclude non-allowable coinsurance/deductible
  - Ways to automate this process utilizing detailed Medicare PS&Rs
  - Individual Medicare RA doesn't always provide enough information to carve out



# Charity/Indigent Bad Debts

- Charity/Indigent Care Medicare Bad Debts
  - Many hospitals have charity care policies but do not attempt to identify the resulting bad debts as Charity Care on their Medicare bad debt list.
  - Doing so would allow the hospital to segregate this subset of bad debts from the criteria outlined in the new clarification regarding collection efforts.
  - Medicaid crossovers and Charity Care are not subject to the new clarification in the JSM.



# Charity/Indigent 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:**



# Charity/Indigent Bad Debts

## §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.



# Charity/Indigent Bad Debts

## §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.)



# Charity/Indigent Bad Debts

- Medicare Bad Debt Recent Cases/Issues
  - Baptist Healthcare vs. U.S. Secretary of HHS in (Civil Action AW-08-0677 in U.S. District Court of Maryland. 8/18/09
    - Court determined that due to the purposeful words “should” and “must”, the current PRM does not require the use of an asset test as a determinant of indigence
    - District court instructed CMS to amend PRM to uniformly define the requirements of charity determination
  - CMS to appeal? – They did not





# Charity/Indigent Bad Debts Bad Debts

## – Recommendations

- Update written charity care policy and provide education on Medicare bad debt rules to patient accounting staff that is responsible for process. Train staff to follow ALL of policy.
- Although not required, incorporate asset test into written charity care policy. (Give CMS what they want)
- Update charity care patient application to match written charity care policy.



# Charity/Indigent Bad Debts

## – Recommendations (cont.)

- Make sure that charity care policy has methodologies to obtain documentation to verify charity care criteria is met and KEEP documentation (hard copy or electronic).
- If provider is going to utilize predictive indexing, then make sure it is secondary to attempts to document indigence.



# Charity/Indigent Bad Debts

- Recommendations (cont.)
  - Setup process to exclude non-allowable coinsurance/deductible
    - Ways to automate this process utilizing detailed Medicare PS&Rs
    - Individual Medicare RA doesn't always provide enough information to carve out



# Overall Advice

- Overall Advice for Bad Debt Audit
  - Establish one point of contact as a liaison with the Medicare auditor. All communication and correspondence should flow through this one main contact.
  - Start with a compliant bad debt policy for all categories of Medicare bad debts. Understand the different rules for claiming the different categories of bad debts.
  - Create a system that provides for accurate data collection.
  - Test the accuracy of logs prior to submission.
  - Respond timely with the Medicare auditor. If due dates cannot be met, communicate with auditor to request additional time if necessary. Don't ignore the Medicare auditor.



# Overall Advice

- Overall Advice for Bad Debt Audit (cont.)
  - Once auditor selects sample, identify internal team responsible for assembling information.
  - Assemble documentation in a clear manner to make the auditor's work easier. For example:
    - Sort and order all applicable information for each patient
    - Highlight relevant items so auditor will go right to answer



# Overall Advice

- Overall Advice for Bad Debt Audit (cont.)
  - Review documentation prior to sending to auditor. Disclose any errors that you find or provide explanations for any exceptions identified during your internal review.
  - After you have confirmed the documentation has been delivered to the auditor, follow up with the auditor. Get them on the record as having the package and having everything they need.



# Overall Advice

- Overall Advice for Bad Debt Audit (cont.)
  - Work with auditor in a respectful manner throughout the process. Be prepared to be frustrated by the auditors requests. Don't let them get under your skin.
  - Be patient, polite and persistent.
  - Determine settlement impact of issues so that you can choose your battles.
  - Continue to be respectful, but don't be afraid to stand up for what you feel is right. Use threat of appealing as leverage in discussions with auditor.

# Worksheet S-10 and Charity Care







# Worksheet S-10 and Charity Care

- Worksheet S-10
  - Completely revised in 2552-10
  - Is now required to be completed by CAHs
  - Data should exclude physician/professional services
  - Charity Care charges (Line 20) utilized for EHR payment
  - CMS has proposed using S-10 data for UCC DSH determination beginning in FFY 2018, initialing using data from FY 2014 cost reports
    - CMS states in FY 2017 Proposed Rule *“We encourage hospitals to work with MACs to complete and revise, as appropriate, their 2014 Worksheet S-10 as soon as possible.”*



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Revised definitions:

- Uncompensated care

- Old - Defined as charity care and bad debt.

- New - *Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. **Uncompensated care does not include courtesy allowances or discounts given to patients.***



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Revised definitions:

- Charity care

- Old - Health services for which hospital policies determine the patient is unable to pay. Charity care results from a provider's policy to provide health care services free of charge (or where only partial payment is expected not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. For the purpose of uncompensated care charity care is measured on the basis of revenue forgone, at full-established rates. Charity care does not include contractual write-offs.*



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Revised definitions:

- Charity care (cont.)

- New - Health services for which a hospital demonstrates that the patient is unable to pay.** Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. (Additional guidance provided in the instruction for line 20.)



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - “Net Revenue” for Medicaid, SCHIP, and other indigent care programs defined as *Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance.*
  - Line 1 - cost-to-charge ratio based on Worksheet C Total Costs / Total Charges
    - Per instructions, ...*this worksheet does not produce the estimate of the cost of treating uninsured patients required for disproportionate share payments under the Medicaid program.*



# Worksheet S-10 and Charity Care

- Medicaid Observations and Recommendations
  - A majority of hospitals will have PS&Rs (or a similar summary report) from Medicaid. These PS&Rs will have paid Medicaid data with approximately two to three months accrual. Hospitals can utilize these amounts for inclusion on S-10, but the provider should understand that this may not include all Medicaid data for all includable components of the hospital. In addition, the Medicaid PS&Rs typically do not include any Medicaid HMO data.
  - If applicable, the provider should have supporting documentation for any Medicaid DSH payments and related provider taxes that are applicable for the cost report filing period.



# Worksheet S-10 and Charity Care

- Medicaid Observations and Recommendations (cont.)
  - If the provider would like to provide additional Medicaid charges and payments for any Medicaid accruals, other components included on Worksheet C (i.e. Home Health, hospice, SNF), or Medicaid HMO data not included on the Medicaid PS&Rs, we recommend the provider summarize this data in the cost report supporting workpapers. Information will need to include both charges and net revenue based on the definitions previously mentioned.
  - Don't forget that all of the information is service date specific.



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Charity Care reflected on lines 20-23
  - Line 20 - Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility
  - Line 21 - Cost of initial obligation of patients approved for charity care (line 1 times line 20)
  - Line 22 - Partial payment by patients approved for charity care
  - Line 23 - Cost of charity care (line 21 minus line 22)
  - Three columns:
    - Uninsured patients
    - Insured patients
    - Total (col. 1 + col. 2)





# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

## Line 20

- ***Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges),***
- ***for care delivered during this cost reporting period for the entire facility.***
- ***For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges.***
- ***For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer.***



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

Line 20 (cont.) —

- ***Include charity care for all services except physician and other professional services.***
- ***Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts.***
- ***Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.***



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

Line 22—

*Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.*



# Worksheet S-10 and Charity Care

- Charity Care Observations and Recommendations
  - Line 20 utilized in EHR incentive calculation
  - Recommend that starting point for providers is to extract any patients with a charity care write-off during the year. This is assuming that providers utilize specific charity care write-off transaction codes when subjecting the patient to the hospital's written charity care policy
  - For each patient that received a charity care write-off, the provider will need to extract certain additional information. One of the more difficult items may be the anticipated patient liability (i.e. Coinsurance and Deductible)



# Worksheet S-10 and Charity Care

- Charity Care Observations and Recommendations (cont.)
  - The data extracted will include charity care write-offs for service dates from prior year and current year. In addition, it may include patients who are uninsured and insured. Provider will probably want to separate the data pulled into four categories:
    1. Uninsured Patients with current year service dates
    2. Uninsured Patients with prior year service dates
    3. Insured Patients with current year service dates.
    4. Insured Patients with prior year service dates



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Line 24:

*Enter “Y” for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter “N” for no.*
  - Line 25:

*If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.*



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Bad Debts

- Line 26 : (red = change in Transmittal 9)

*Enter the total facility (entire hospital complex) amount of bad debts written off **during this cost reporting period** on balances owed by patients **regardless of the date of service**. Include such bad debts for all services except physician and other professional services. The amount reported must also include the amounts reported on Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, columns 1 and 2; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; E-3, Part VII, line 34; I-5, line 5 (line 5.05, column 2 for cost reporting periods that overlap or begin on or after or January 1, 2011); J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.*



# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

Bad Debts (cont.):

- Line 27 – *Medicare bad debts for the entire hospital complex* (automatically pulled from applicable E-series worksheets)
- Line 28 - Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)
- Line 29 - Cost of non-Medicare bad debt expense (line 1 times line 28)





# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Line 30 – *Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)*
  - Line 31 – *Total unreimbursed and uncompensated care cost (line 19 plus line 30)*



# Worksheet S-10 and Charity Care

From the EHR Incentive Payment final rule  
published July 28, 2010:

Page 44457

***Comment:*** We received some comments asking if CMS will adopt standards to determine if a hospital's charity care policy is sufficient to qualify for the inclusion of charges in the formula for EHR and whether that same policy would suffice to meet the criteria to determine the eligibility for Medicare bad debt.



# Worksheet S-10 and Charity Care

***Response:** Currently for bad debt purposes, section 312 of the PRM requires the provider to perform asset/income tests of patient resources for non-Medicaid beneficiaries. These tests will be used to determine if the beneficiary meets the provider's indigent policy to qualify an unpaid deductible and/or coinsurance amount as a Medicare bad debt. The provider is responsible for developing its indigent policy. Currently, the Medicare contractor will determine if the indigent policies are appropriate for determining allowable Medicare bad debt under section 312 of the PRM and §413.89 of the regulations. We believe that the Medicare contractor will continue to determine if the provider's indigent policy for bad debt purposes is appropriate and can determine if the same policy would be sufficient to use for charity care purposes.*



# Worksheet S-10 and Charity Care

From e-mail from MAC audit manager in response to questions on use of presumptive charity related to EHR incentive payments:

*The question was brought up at a recent (CMS) technical conference that I attended and I then discussed again with our (MAC) contacts.*

*The presumptive charity determinations that were (in question) were determinations made by a third party, such as TransUnion. If the use of a third party is included in the provider's policy and is uniformly applied, the determinations made by the third party could be reviewed and found acceptable if the third party details its process and methodology for how the determinations are made. All supporting documentation used would have to be provided to us.*

*In some cases, we had been told that the third party would not release this information because it was considered proprietary. In cases where the third party will not provide the above noted information, the charity determinations will not be acceptable.*

*Please note that this only applies to charity charges for HITECH purposes and does not apply to charity determinations for Medicare bad debts claimed on the Medicare cost report.*



# Understanding the Cost Report Settlement Process





# 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



# 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, and to determine settlement impact
- Adjustments are finalized
- Notice of Program Reimbursement (NPR) issued in final settlement of cost report



# 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 3 years of NPR date
- Appeals are typically only pursued for issues with significant settlement impact
  - Appeals can take up to tens 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





# Understanding the Cost Report Settlement Process

- Change in rules effective July 1, 2015 regarding withdrawal and reinstatement of appeals
  - PRRB Rule 46.2
  - 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



# Understanding the Cost Report Settlement Process

- Change in rules effective July 1, 2015 regarding withdrawal and 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



# Understanding the Cost Report Settlement Process

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



# Understanding the Cost Report Settlement 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 and 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



# 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



# Understanding the Cost Report Settlement Process

- CMS acknowledges one potential exception – Medicaid-eligible DSH days (cont.)
  - 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 and accumulate the Medicaid-eligible patient days that were reported and filed in the hospital's Medicare cost report at issue, and
    - 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

# Reconciling the Cost Report Settlement





# Reconciling the Cost Report Settlement

- 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





# Reconciling the Cost Report Settlement

	Reimbursement	Interim Pmnts/ Pass Through	Settlement For Cost Report
<b>Inpatient</b>			
Bad Debts	1,850,000		
35% Reduction	647,500		
Reimbursable Bad Debts	<u>1,202,500</u>	1,050,000	152,500
GME IP	<u>2,100,000</u>	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			-
<b>IP Settlement</b>			<b>113,709</b>



# Reconciling the Cost Report Settlement

	Reimbursement	Interim Pmnts/ Pass Through	Settlement For Cost Report
<b>Outpatient</b>			
Bad Debts	682,000		
35% Reduction	<u>238,700</u>		
Reimbursable Bad Debts	443,300	430,000	13,300
GME OP	<u>337,000</u>	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			<u>-</u>
<b>OP Settlement</b>			<b>21,770</b>

# Review and Final Questions



# DHG

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healthcare

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