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Hospital Cost Report Training
Level II Critical Reimbursement Strategies // PPS Track

Dallas - Hilton Dallas/Southlake Town Square

JULY 27, 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)

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Medicare DSH

Medicare DSH

The DSH add on is based on the sum of two fractions:

(1) Medicare / SSI Fraction

Days for patients entitled to Medicare Part A and entitled to SSI benefits

Divided By

Days for patients entitled to Medicare Part A

(2) Medicaid Fraction:

Days for patients eligible for Medicaid and not entitled to Medicare Part A

Divided By

Days for patients in acute care areas (including nursery)

Medicare DSH

- Since 2001 hospitals with a DSH patient percentage >15% have qualified for operating DSH add-on

- In FFY 2013 there were ~$12.5 billion in DSH payments and ~80% of hospitals qualified (per CMS)

Medicare DSH

- SSI Fraction
  - Historically SSI %s were published annually and were based on the Federal fiscal year 10/1-9/30
  - 2008 *Baystate Medical Center* court decision – CMS failed to use “best available data”
    - Most obvious flaw - CMS admitted it did not use Social Security numbers in its match process
    - Other issues – excluding SSI records for manual payments, retroactive benefits, non-cash benefits
    - CMS stated that SSI figures might be off by as much as 2%

Medicare DSH

- SSI Fraction (cont.)
  - CMS Ruling 1498-R in April 2010 and FY 11 IPPS Final Rule included changes in SSI calculation process
    - Revised match process
      - Now using Social Security numbers
      - Now using other additional identifiers
      - Additional methods to identify unique situations during the match process
    - Longer window (15 months) for the match process to identify additional retroactive determinations

Medicare DSH

- SSI Fraction (cont.)
  - Significant delays in recent years due to litigation
    - Cost reports were put “on hold” following FY 07
    - In March 2012 CMS published revised files for FY 06 and 07, and initial files for FY 08 and 09
    - FY 10 was published in fall of 2012
    - FY 11 was published in June 2013
    - FY 12 was published in June 2014
    - FY 13 was published in May 2015
    - FY 14 was published in July 2016

Medicare DSH

- SSI Fraction (cont.)
  - Hospitals with year-ends other than 9/30 have option to use SSI % based on hospital's fiscal year
  - Election made annually, and does not have to be consistent from year to year
  - You must assess SSI detail to determine more beneficial approach
    - Multiple Federal FYs required to analyze hospital fiscal year if year-end is not 9/30
    - Providers must submit data request to CMS to receive SSI detail by year

      http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUA_-_DSH.html

Medicare DSH

- SSI Fraction (cont.)

  Example

  - Hospital has 12/31 fiscal year end
  - SSI beneficiary has 50-day stay through December 2015
  - Those 50 days will be included in FFY 16 SSI % published by CMS and used for FY 16 cost report
  - Those same 50 days could also be included in FY 15 SSI % based on hospital FY and used for FY 15 cost report

Medicare DSH

- SSI Fraction - Ongoing legal disputes
  - Part C Days
  - Medicare exhausted benefit days for duel-eligible
  - Medicare as Secondary Payor

  - Basic argument – should these days be included in SSI %, and should the subset of dual-eligible days be excluded from Medicaid %?
    - *Eligible* versus *Entitled*

Medicare DSH

- SSI Fraction - Ongoing legal disputes
  - Part C Days
    - CMS now requires all hospitals to “shadow bill” in order to identify days under Medicare Part C to be included in SSI calculation
    - Legal argument – Are Part C enrollees entitled to benefits under part A?
      - If yes, these days should be reflected in SSI and any dual-eligible days excluded from the Medicaid %
      - If no, any of these days that are dual-eligible should be included in the Medicaid % and excluded from SSI (resulting in higher DSH payments)

Medicare DSH

- SSI Fraction - Ongoing legal disputes
  - Part C Days (cont.)
    - Allina Health Services v. Sebelius (*Allina I*)
      - Relates to FYs 2005-2013
      - November 2012 district court decision – Medicare Part C days should not be included in SSI calculation
        - » CMS appealed
      - April 2014 DC Circuit Court of Appeals ruled in favor of hospitals
        - » CMS did not abide in FY 12 SSI published in June 2014

Medicare DSH

- SSI Fraction - Ongoing legal disputes
  - Part C Days (cont.)
    - August 2014 – Hospitals file complaint in reaction to FY 12 SSI (*Allina II*)
    - October 2015 – District Court denies CMS motion to dismiss Allina II and orders CMS to respond to hospitals' complaints
    - December 2015 – CMS responds but effectively maintains same position as previously argued
    - Currently waiting for district court decision on Allina II and for briefings to begin on reviewing status of Allina I

Medicare DSH

- Medicaid Fraction
  - Include all days eligible for medical assistance under a state approved Title XIX plan and not entitled to benefits under Medicare Part A
  - Eligible days that may be controversial should be indentified and the impact of those days included as a protested amount in the filed cost report.

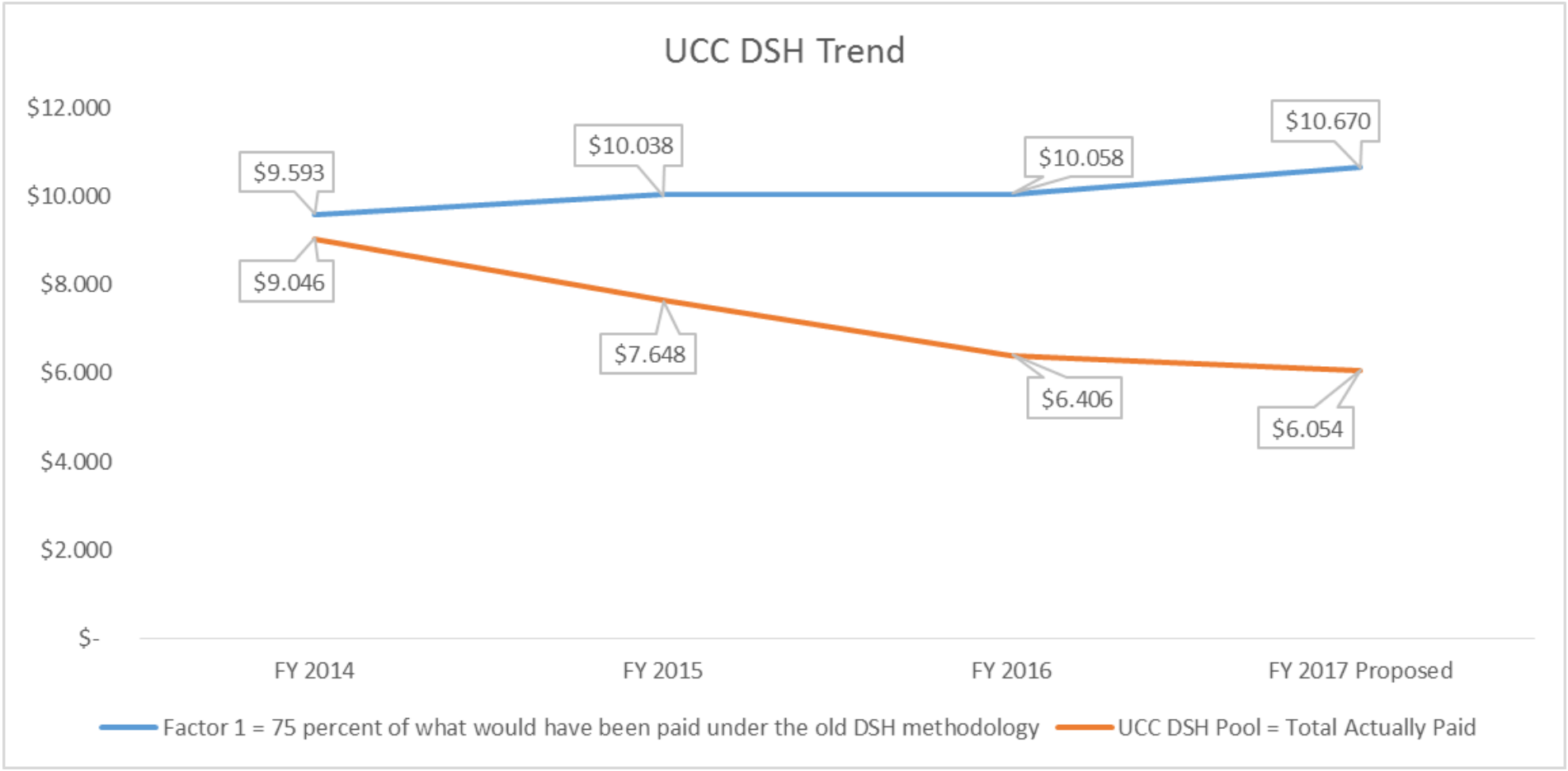
Medicare DSH

- "New" DSH – UCC
  - Section 3133 of PPACA required significant revisions to Medicare operating DSH effective 10/1/13
    - No change in Capital DSH
  - CMS did not provide any plans for implementation until FY 14 IPPS proposed rule published April 2013
    - Final Rule released August 2, 2013

Medicare DSH

- Factor 1 = Estimated DSH payment that would have otherwise been paid under old rules. For FY 16, projected DSH payment under old rule = $13.41B, 75% = $10.06B
- Factor 2 = Reduction applied to Factor 1 to account for decrease in uninsured. Uninsured percentages based on CBO estimates. For FY 16, Factor 2 = 63.69%, resulting in UCC DSH pool of $6.41B
- Factor 3 = Allocation methodology (low income days)

Medicare DSH



Medicare DSH

- Basis of UCC portion – SSI and Medicaid days
  - Same rules apply for counting Medicaid days
  - Source for Medicaid days – *"most recent available filed cost report*"
    - FFY 16 based on cost report period beginning in FFY 2012 for most providers
  - Source for Medicare SSI days – "*most recent available SSI ratios*"

Medicare DSH

- Table published with FY 16 Final Rule includes Medicaid and Medicare SSI days and hospital percentages for allocation
  - Available online at

    https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Data-Files.html
  - If amended cost report was processed by MAC, those appear to be included. If additional Medicaid days submitted for audit, those are not included in table because final settlement is not complete

Medicare DSH

- UCC payment are made on a per claim basis instead of periodic payments
  - Hospitals had commented that amount needs to be reflected in pricer to allow accurate Medicare Advantage payments
  - Per claim payment = total UCC payment for the year/average Medicare discharges in prior 3 years
  - Results in cost report settlement

Medicare DSH

- FY 2017 IPPS Proposed Rule – UCC DSH provisions
  - Proposal to change Factor 3 to be an average of three cost report periods
    - To “smooth over anomalies between cost reporting periods.”
    - If less than 3 periods are available, CMS will use what periods are available and divide by that number
  - Factor 3 proposal for FY 17 – use Medicaid days from hospital cost reports for FY 2011, 2012 & 2013 and SSI days for FY 2012, 2013 & 2014
  - Proposal to advance the cost reporting period by one every year - for FY 18 CMS would use 2012, 2013 & 2014 cost reports

Medicare DSH

- FY 2017 IPPS Proposed Rule – UCC DSH provisions
  - Proposal to begin transition to worksheet S-10 for Factor 3 determination beginning FY 2018
  - Significant change that hospitals should consider addressing immediately
  - Proposed three-year transition
    - FY 18 1/3 Worksheet S-10 2/3 Medicaid & SSI days
    - FY 19 2/3 Worksheet S-10 1/3 Medicaid & SSI days
    - FY 20 Entirely Worksheet S-10
  - Worksheet S-10 amounts to eventually be based on three-year average
    - FY 18 FY 14 Worksheet S-10 only
    - FY 19 FY 14 & FY 15 Worksheet S-10
    - FY 20 FY 14, 15 & 16 Worksheet S-10

Medicare DSH

- FY 2017 IPPS Proposed Rule – UCC DSH provisions
  - Proposal to begin transition to worksheet S-10 for Factor 3 determination beginning FY 2018 (cont.)
    - CMS proposes using Worksheet S-10 line 30 which is cost of charity care plus cost of non-Medicare bad debts
      - » Excludes other information from worksheet including Medicaid shortfall
    - CMS proposes revising S-10 instructions to go from service date to write-off date for determining charity care
    - CMS proposes to continue excluding medical education cost from S-10 cost determinations
    - CMS Transmittal 1681 dated July 15, 2016 – FY 14 S-10 revision requests must be received by 9/30/16

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Protested Amounts

Protested Amounts

- Cost Report Protested Items
  - Mechanism to go “on record” as disagreeing with CMS treatment of specific issues in order to protect appeal rights
  - Appeal rules were revised effective for cost reporting periods ending on or after December 31, 2008 – much more difficult for providers
  - Providers must now be very specific as to their argument and the related settlement impact for every issue
  - In general terms, we expect it will be difficult to prevail on appeal unless an issue was originally protested or there is an adjustment made during audit

Protested Amounts

- Protested amounts reflect the reimbursement impact from issues in dispute
  - Reflected on cost report settlement worksheets, including E Part A line 75 and E Part B line 44
  - Amount in dispute is not included in the cost report settlement
  - It results in an adjustment that the hospital can then appeal
  - From the instructions - *Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.*
  - Covered under PRM 15-11, section 115.2

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Indirect and Direct Medical Education Reimbursement

Indirect and Direct Medical Education

- What is Graduate Medical Education (GME)?
  - Formally approved clinical education and training programs known as residency training programs to physicians who have received a medical degree (M.D. or D.O.) from an accredited or approved school of medicine.
  - To complete a physician's education, at least some GME is necessary to allow the physician to obtain a license to practice medicine.
  - Varying degrees of residency training periods are required depending upon the specialty or sub-specialty board certification desired.
  - Resident training year runs 7/1 – 6/30

Indirect and Direct Medical Education

- What is a resident?
  - A resident has completed medical school and is actively enrolled in an approved program and is actively seeking board certification
    - Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM)
    - Transitioning to single GME accreditation system
      - Transition began on 7/1/15
      - Plans to fully implement by July 2020
      - New system will allow graduates of osteopathic and allopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common milestones and competencies (AOA website)

Indirect and Direct Medical Education

- 110,000+ residents in training each year nationally
- Teaching hospitals' direct cost of training is >$16 billion per year
- Medicare reimburses ~$10 billion per year to hospitals:
  - ~$3.5 billion for direct cost
  - ~$6.5 billion for indirect cost
- Medicaid reimburses ~$4 billion per year

Indirect and Direct Medical Education

- The resident FTE count is a critical component of payment calculations
  - The resident FTE count is capped, generally based on 1996 cost report for programs in place since that time, with periodic adjustments
  - New programs have a cap established after the program has existed for five years
    - Based on the greatest number of program residents times the number of years in the program
    - Must ensure it meets CMS standards for “new” program

Indirect and Direct Medical Education

- Affiliation Agreements
  - From CMS:

    …hospitals that cross-train residents in approved medical residency training programs may enter into Medicare GME Affiliation Agreements to elect to apply their direct GME and/or IME Full Time Equivalent (FTE) resident caps on an aggregate basis, and may adjust their FTE resident caps to reflect the rotation of residents among affiliated hospitals during an academic year.

Indirect and Direct Medical Education

- Affiliation Agreements (cont.)
  - Three eligible scenarios:
    - two or more hospitals that are located in the same or a contiguous metropolitan statistical area and have a shared rotational arrangement
    - two or more hospitals that are listed as the joint sponsors of a residency program and have a shared rotational arrangement
    - two or more hospitals that are under common ownership and have a shared rotational arrangement
  - Written agreement must be in place that has to be provided to CMS and intermediary prior to start of academic year beginning July 1

Indirect and Direct Medical Education

- Required documentation for each resident:
  - Name
  - Social Security Number
  - Medical school and graduation date
  - ECFMG certification date (applicable for foreign graduates)
  - Original residency program
  - Current residency program
  - Number of years completed for all residency programs
    - Usually split if hospital year-end is other than 6/30
  - Dates and locations assigned during the year
    - Must be supported by rotation schedule
    - By department within the hospital
    - Other hospitals – time is excluded from FTE count
    - Non-provider settings

Indirect and Direct Medical Education

- Non-provider settings
  - Any setting outside of a hospital that is primarily engaged in furnishing patient care
  - Excludes any time at another hospital
  - Must be part of the approved residency program
  - Requires written agreement or payment:
    - Written agreement – signed in advance between hospital and non-provider entity
    - Payment - the hospital must incur all or substantially all of the cost for the resident training at the non-provider setting

Indirect and Direct Medical Education

- Counting Time
  - Patient care activities at hospital including outpatient departments as well as non-provider settings
    - Care and treatment for which a physician may bill
    - Orientation activities – activities for preparation of a resident in a particular setting or specialty program
  - Research time in hospital – in general is included in GME count but excluded from IME count
  - Research time in non-provider settings – in general excluded from GME and IME

Indirect and Direct Medical Education

- Counting Time (cont.)
  - Didactic time – time spent in journal clubs, seminars, classroom lectures, and other scholarly pursuits
    - Generally included in GME in any setting – hospital or non-provider - that is engaged in furnishing patient care
    - Generally included in IME only for time in the hospital
  - Vacation or sick time – included in both GME and IME as long as it does not extend the resident's program beyond the normal duration

Indirect and Direct Medical Education

- Initial Residency Period (IRP)
  - The minimum period of training required in a specialty to become eligible for board certification in that specialty, up to a maximum of five years
  - Resident time beyond IRP – reduced to 50% for GME payment calculation
  - Example IRP durations:
    - Family Medicine 3 years
    - Emergency Medicine 3 years
    - Internal Medicine 3 years
    - General Surgery 5 years
  - If a resident is matched in an advanced specialty program that requires a clinical base year prior to resident's first training year then IRP is determined based upon period of board eligibility associated with second year specialty program

Indirect and Direct Medical Education

- IRIS – Intern and Resident Information System
  - DOS-based program
  - Required filing with cost report for teaching hospital:
    - Master file – M3340199.dbf
      - Resident details
    - Assignment file – A3340199.dbf
      - Rotation details

Indirect and Direct Medical Education

- Indirect Medical Education (IME)
  - Hospitals can receive an additional payment to reflect the higher indirect operating costs associated with a Graduate Medical Education program
    - Increased patient complexity not captured by MS-DRG system
    - Other operating cost associated with being a teaching hospital
      - Lower productivity, standby capacity, etc.
  - Payment is a percentage added on to each respective DRG payment
  - Reflected on the cost report on Worksheet E Part A lines 5-29.01 (operating) and Worksheet L lines 3-6 (capital)
  - Generally, IME represents more reimbursement than direct GME
  - Hospitals with special designations such as Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) which receive Hospital Specific Payments (HSP) may not receive the full amount of IME. Financial due diligence is required.

Indirect and Direct Medical Education

- Indirect Medical Education (IME) (cont.)
  - Factors impacting IME payment – three-year average of resident FTEs, bed days available, and average daily census
    - Bed count is critically important to the bed days available calculation
    - The three year averaging does not begin to occur until the IME FTE cap is established for the provider
  - Formula
    - Operating IME calculation:
      - {1.35*[1+Resident:Bed ratio]^.405 -1}
        - » (1.35 factor has been in place since 2008 but is subject to change by Congress)
    - Capital IME calculation:
      - {2.7183 ^(.2822*Resident:ADC ratio)} -1

Indirect and Direct Medical Education

- Indirect Medical Education (IME) (cont.)
  - Beds = (*Available* Bed Days)/(Days in Cost Report)
  - Bed Days *Available* – Defined by 42 CFR 412.105(b)
    - Exclude bed days that are:
      - Beds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital IPP at any time during the 3 preceding months (the beds in the unit or ward are to be excluded form the determination of available bed days during the current month;
      - Beds in a unit or ward that is otherwise occupied, and provides a PPS level of care, that could NOT be made available to IP occupancy within 24 hours for 30 consecutive days;
      - Beds in excluded distinct part hospital units;
      - Beds otherwise countable under this section used for OP Observation services, skilled nursing swing-bed services or ancillary labor/delivery services,. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute IP care, in which case the beds and days would be included in those counts;
      - Beds or bassinets in the healthy newborn nursery; and
      - Custodial care beds.

Indirect and Direct Medical Education

- Graduate Medical Education (GME)
  - Medicare pays hospitals for the direct costs of GME. Objective is to compensate teaching hospitals for the direct costs of having a teaching program
    - Resident stipends and fringe benefits
    - Teaching and Supervising Faculty salary and fringe benefits
    - Administrative costs to operate program
    - Other operating expenses
    - Allocated overhead costs
  - Paid outside of Inpatient Prospective Payment System

Indirect and Direct Medical Education

- Graduate Medical Education (GME) (cont.)
  - Formula
    - GME payments = Resident FTEs x Per Resident Amount x Medicare share
    - Reflected on the cost report on Worksheet E-4 with results carried to Worksheet E Part A line 52 and B line 28
    - Reimbursed on an interim basis through the year through pass-thru payments
  - Factors impacting payment:
    - Three-year average of resident FTEs
      - The three year averaging does not begin to occur until the FTE cap is established for the provider
    - Medicare share – based on days on cost report

Indirect and Direct Medical Education

- Factors impacting payment (cont.):
  - Per Resident Amount - Cost up to per resident amount (PRA) limitations
    - For new teaching hospitals, Lower of:
      - » Direct GME costs or
      - » Weighted average of PRAs of surrounding teaching hospitals
    - For new hospitals PRA is the same for Primary Care and Non-Primary Care
    - Calculated using first full cost reporting period with residents
    - Floor PRA – Starting in FY 2002 and beyond the PRA could be no less than 85% of national PRA
    - Once established, the PRA is permanent

Indirect and Direct Medical Education

- Payments for Medicare Part C activity
  - IME add-on % applied to Part C simulated DRG payments from PS&R report type 118
  - Payment for FTEs resulting from additional cap space under MMA Section 422 is a reduced amount
  - GME payment based on the share of Part C days
    - 14.13% reduction factor is applied
  - Important to make sure that hospital is shadow billing for claims. There is a specific CMS billing memo that explains how to bill for Medicare advantage plans
    - Interim IME reimbursement is paid through shadow billing with appropriate modifiers

Indirect and Direct Medical Education

Sample Calculation for Sample Hospital

Illustration of GME Reimbursement Calculation

Resident FTE Count	A	52		(Subject to FTE Cap and Three year Rolling Average at appropriate time)
Per Resident Amount	B	80,000		(Established by Medicare Administrative Contractor)
Approved amount for Resident Costs	C	4,160,000		A times B
Medicare Acute Care Days	D	27,994		From Worksheet S-3 Part I
Medicare HMO Days	E		4,036	From Worksheet S-3 Part I
Medicare ICU Days	F	2,175		From Worksheet S-3 Part I
	G	30,169	4,036	From Worksheet S-3 Part I
Total Days	H	64,457	64,457	Includes Adult and Peds, ICU, Sub-Providers and L&D from Worksheet S-3 Part I
Medicare Share	I	46.80%	6.26%	G divided by H
Medicare GME Payment	J	1,946,880	260,416	I Times C
14.13% Reduction for Medicare HMO	K		(36,797)	J Times .1413
Adjusted Medicare GME Payment	L	1,946,880	223,619	J Plus K
Total Adjusted Medicare GME payment	M		2,170,499	Total of L Both Columns

Indirect and Direct Medical Education

- Balanced Budget Act of 1997 created a cap for resident hospital FTE counts at FY 1996 levels for all hospitals
  - There were separate caps for IME and GME due to weighting (but they can also be the same)
  - BBRA of 1999 provided that rural hospitals receive 30% increase to cap
  - Excludes dental and podiatry FTEs
  - Includes allopathic and osteopathic
- Caps have been adjusted periodically by Congress
  - MMA Section 422 redistributed some slots effective 7/1/05
  - PPACA redistributed slots effective in 2012
    - Hospitals in only a limited number of states were eligible for additional slots

Indirect and Direct Medical Education

- New Residency Programs
  - Regulations allow new programs only under certain circumstances
    - For hospitals that had a residency program in 1996, generally only rural hospitals are now allowed to start new programs
    - One potential exception for an urban hospital is to establish a program with a rural track
      - The urban hospital has to work in conjunction with other rural hospitals or rural non-hospital settings to provide the training
      - At least 50% of the resident time must be in rural settings

Indirect and Direct Medical Education

- New Residency Programs (cont.)
  - A hospital that did not have a residency program in place in 1996 is typically eligible to start a new program (Urban or Rural)
  - Effective for new programs that began to train residents after 10/1/12, resident FTE cap is established after first five years of operating
    - Was previously three years prior to change in FY 13 IPPS final rule
  - PRA for new program based on the lower of actual cost per resident or the average PRAs from teaching hospitals in surrounding areas
  - Hospitals must be careful to evaluate “new program” status – there are examples of CMS deeming a program as previously existing at another location, and applying the existing cap to the new hospital

Indirect and Direct Medical Education

- New Residency Programs (cont.)
  - General rule is the cap equals the highest number of FTEs in any program year during the first five years of the program's existence multiplied by number of years for the initial residency period (IRP)
    - Family Practice – IRP is 3 years
    - Internal Medicine - IRP is 3 years
    - Emergency Medicine – IRP is 3 years
    - Surgery – IRP is 5 years
  - Urban hospitals have five years to get all programs ramped up
  - Rural hospitals have five years to get each respective program ramped up

Indirect and Direct Medical Education

- New Residency Programs (cont.)
  - Current Cost Report Instructions (E Part A Line 10):

For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years, see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012 under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on that new program. Therefore, for rural hospitals, do not include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that specific new program started (see 79 FR 50110 (August 22, 2014)). For both urban and rural hospitals, report FTE residents in the initial years of the new program on line 16.

Indirect and Direct Medical Education

Example IME/GME CAP Calculation

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	CAP	
Internal Medicine							
PGY 1	8	6	6	8	8		
PGY 2		8	6	6	8		
PGY 3			8	6	6	**24**	(PGY 1 or 2 Residents (8) time 3 IRP)
	8	14	20	20	22		
Emergency Medicine							
PGY 1	9	9	9	8	8		
PGY 2		9	9	9	8		
PGY 3			9	9	9	**27**	(PGY 3 Residents (9) time 3 IRP)
	9	18	27	26	25		
Family Medicine							
PGY 1	6	6	6	6	6		
PGY 2		6	6	6	6		
PGY 3			6	6	6	**18**	(PGY 1, 2 or 3 Residents (6) time 3 IRP)
	6	12	18	18	18		
Total Counts	**23**	**44**	**65**	**64**	**65**	**69**	

Indirect and Direct Medical Education

Example IME/GME CAP Calculation-Rural Scenario

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	CAP	
Internal Medicine					Fifth Year							
PGY 1	8	6	6	8	8	8	6	6	8	8		
PGY 2		8	6	6	8	8	8	6	6	8		
PGY 3			8	6	6	8	8	8	6	6		
	8	14	20	20	22	24	22	20	20	22	**24**	(Set at end of FY 2020)
												(PGY 1 or 2 Residents (8) time 3 IRP)
Emergency Medicine						Fifth Year						
PGY 1			9	9	9	8	8	9	9	10		
PGY 2				9	9	9	8	8	9	9		
PGY 3					9	9	9	8	8	9		
			9	18	27	26	25	25	26	28	**27**	(Added to CAP at end of FY 2022)
												(PGY 3 Residents (9) time 3 IRP)
Family Medicine										Fifth Year		
PGY 1						6	6	6	6	6		
PGY 2							6	6	6	6		
PGY 3								6	6	6		
						6	12	18	18	18	**18**	(Added to CAP at end of FY 2025)
												(PGY 1, 2 or 3 Residents (6) time 3 IRP)
Total Counts	**8**	**14**	**29**	**38**	**49**	**56**	**59**	**63**	**64**	**68**	**69**	

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Nursing and Allied Health Education Reimbursement

NAHE Reimbursement

- Medicare reimburses qualifying hospitals for costs related to Nursing and Allied Health Education (NAHE)
  - General requirements
    - Approved educational activity recognized by a national approving body or State licensing authority
    - Enhance the quality of healthcare at the provider
    - Directly incur the training costs
    - Direct control of the program curriculum
    - Control the administration of the program
    - Employ the teaching staff
    - Provide and control both classroom instruction and clinical training

NAHE Reimbursement

- Medicare reimburses allowable costs based on Medicare utilization
  - Allowable costs must be net of tuition and fees charged
  - Costs not allowable:
    - Patient care costs
    - Costs incurred by a related organization
    - Costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support
  - CRNA education programs are subject to additional requirements to avoid NAHE reimbursement for professional services

NAHE Reimbursement

- Four Types of Allowable Costs
  - Classroom costs
  - Clinical training costs
  - Direct costs (net)
  - Indirect costs allocated on cost report

NAHE Reimbursement

- NAHE cost report treatment
  - Worksheet S-2 Part I, line 62 – Are costs claimed for nursing and allied health costs?
  - Are you claiming nursing school and allied health costs for a program that meets the provider-operated criteria under 42 CFR 413.85? Enter “Y” for yes or “N” for no. If yes, you must identify such costs in the applicable column(s) of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs.
  - Cost centers:
    - 20 Nursing School
    - 23 Paramedical Ed. Program (specify)

NAHE Reimbursement

- NAHE cost report treatment (cont.)
  - Worksheet D Part III
    - Calculates inpatient program pass-through costs for NAHE
      - NAHE costs for routine cost centers times Medicare share
      - Result is carried to Worksheet E Part A line 57
  - Worksheet D Part IV
    - Calculates ancillary program pass-through costs for NAHE
      - Calculates NAHE ancillary costs and apportions between inpatient and outpatient
      - Results are carried to Worksheet E Part A line 58 (IP) and Worksheet E Part B line 9 (OP)

NAHE Reimbursement

- NAHE reimbursement for Medicare Part C activity
  - Reflected on worksheet E Part A line 53
  - Introduced by CMS Transmittal A-00-86 dated 11/22/00, but not widely implemented by hospitals until recent years
  - Many qualifying hospitals are still not claiming
  - Some contractors have began calculating amount and adding on as an audit adjustment
  - Amount is based on the pass-through amounts per Worksheets D Parts III and IV, ratio of Medicare Part C days to total days, and a fixed national payment pool which has not been updated since the program was implemented
    - Two/Three-year lag between when calculations components are reported and when they are used in the calculation
  - Is budget-neutral in theory – paid for by 14.13% reduction in GME payments for Part C activity

NAHE Reimbursement

- NAHE reimbursement for Medicare Part C activity (cont.)
  - Example calculation

1.	Total payments for nursing and allied health from **cost report two years prior** (Worksheet D Part III, Line 101, Col 8 + Worksheet D Part IV, Line 101, Col 7)	500,000
2.	Total inpatient days from **cost report two years prior** (Worksheet S-3 Part I sum of lines 1, 6–10,14,14.01, Col 6)	80,000
3.	Managed care days from **cost report two years prior** (PS&R report type 118 + any non-IPPS managed care days)	8,000
4.	Hospital portion of ratio ((Line 1/Line 2) × Line 3)	50,000
5.	CMS portion of ratio*	6,134,256
6.	Ratio of hospital payments to total Medicare Payments (Line 4/Line 5)	.0082
7.	Total spending (pool)*	43,663,043
8.	Total additional payment (Line 6 × Line 7)	355,895

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Wage Index

Wage Index

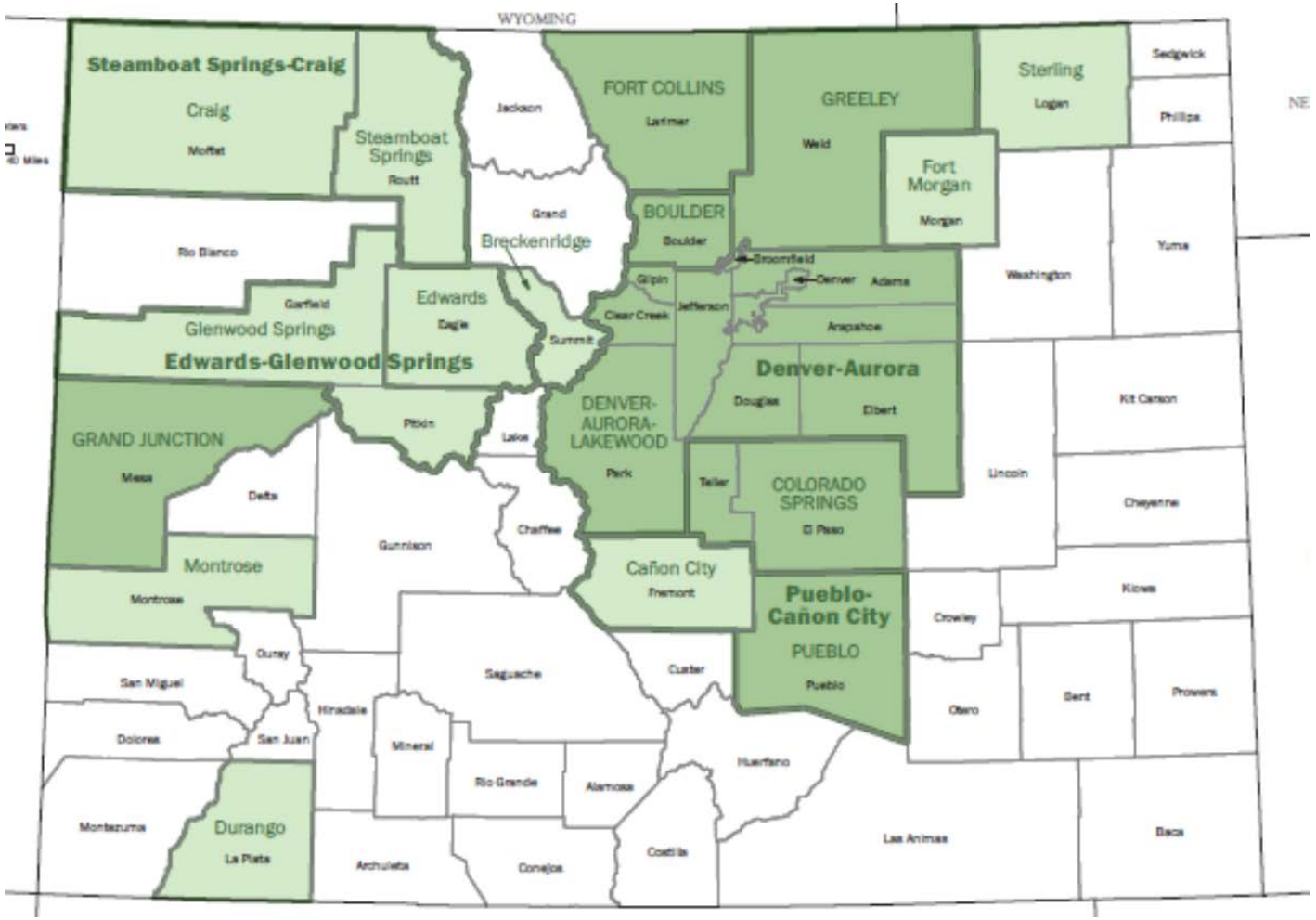
- Wage Index reflects the relative hospital wage level for each geographic area compared to the national average
- Geographic areas are based on the Core Based Statistical Areas (CBSA) defined by the Office of Management and Budget
  - Through FY 14 – CBSAs based on 2000 Census with some interim revisions
  - Beginning FY 15 – implementation of updated CBSAs based on 2010 Census
- Data used to calculate the wage index is the aggregate of all PPS hospitals located within each CBSA

Wage Index

- Metropolitan Statistical Areas (MSAs) – CBSAs with populations > 50,000
- Micropolitan Areas – CBSAs with populations >10,000 but < 50,000
- MSAs = urban for CMS purposes, while Micropolitan Areas and areas outside of any CBSA = rural
- There are several CBSAs with populations > 2.5 million that meet the definition of Metropolitan Divisions – these CBSAs have been divided into multiple CBSAs for wage index purposes (an example is Miami-Fort Lauderdale-West Palm Beach, which is technically one CBSA but is split into three CBSAs for wage index)

Wage Index

Example CBSA state map (Colorado)



Wage Index

- Sources of data for Wage Index:
  - Cost Report
    - Worksheet S-3 Parts II and III
  - Occupational Mix Survey

- There is a four-year lag prior to wage data being included in the AHW
  - FY 2016 wage index is based on wage data from cost reporting periods beginning in Federal Fiscal Year 2012
  - The first day of a cost report period determines what FY it falls into – FFY 2012 includes 9/30/12, 12/31/12 and 6/30/13 cost reports

Wage Index

- Occupational Mix Survey
  - Adjustment applied to a provider's wage index to adjust for that provider's choice of staff
  - FY 16 wage index adjusted by Occ Mix Surveys submitted in 2014
    - 93.2% response rate – CMS continues to threaten to punish providers that do not comply
    - Can make a big difference - largest impacts on FY 16 wage index from Occ Mix Survey:
      - Lebanon, PA – 17.4% increase
      - San Luis Obispo-Paso Robles-Arroyo Grande, CA – 4.7% decrease
  - Current Survey based on calendar year 2013 and will be applied to FY 16-18 wage index
  - New survey based on calendar year 2016 will be due 7/1/17, to be applied to FY 19-21 wage index

Wage Index

- The process of calculating the Wage Index
  - There is a time lag between when data is reported and when it is used for the wage index. FY 2016 is based on wage data from all short-term acute care hospital cost reports beginning on or after 10/1/11 and before 10/1/12.
  - If a hospital had multiple cost reports that began during this period, use the report that covers the longest period, or the most recent if the length of the multiple reports are the same.
  - The salary total on Worksheet A is revised to include contact A&G, housekeeping, and dietary as reported on the wage survey to give the starting point for the wage index calculation.

Wage Index

- The process of calculating the Wage Index (cont.)
  - A portion of overhead salaries and hours and wage-related costs are allocated to excluded areas such as subproviders or non-allowable cost centers.
  - Each hospital's salaries and wage-related costs are adjusted based on the midpoint of the cost report period.

Wage Index

- The process of calculating the Wage Index (cont.)
  - Each hospital's salaries and wage-related costs are adjusted by the occupational mix.
    - The occupational mix adjustment factor is based on the national nursing average hourly rate divided by the hospital's nursing average hourly rate.
    - A portion of each hospital's salaries and wage-related costs are adjusted for the occupational mix, based on the hospital's nursing category salaries as a percentage of total salaries.
    - If a hospital did not submit an occupational mix survey, currently it automatically receives the average adjustment for the other hospitals in the area.
    - If no hospitals in an area submit a survey, all hospitals receive an adjustment factor of 1.0.

Wage Index

- The process of calculating the Wage Index (cont.)
  - The adjusted salaries and hours for each hospital in a CBSA are combined to provide the totals for the CBSA, supporting the adjusted average hourly wage for the area.
  - The adjusted salaries and hours for every hospital nationally are combined, supporting the national adjusted average hourly wage - $40.2555 for FY 16.
  - Each area's adjusted average hourly wage is divided by the national adjusted average hourly wage to provide the unadjusted wage index.
  - Each area's unadjusted wage index then receives the rural floor budget neutrality adjustment to give the adjusted wage index.

Wage Index

FY 2016 Final wage index

Highest:	Santa Cruz-Watsonville, CA	1.7771
Lowest:	Rural Alabama	0.6872

Wage Index

- Rural Floor
  - Regulations stipulate that wage index for any urban CBSA cannot be lower than that state's rural wage index
  - For FY 2016 there are 346 hospitals receiving a rural floor wage index
  - Calculation is budget neutral

Wage Index

- Rural Floor (cont.)
  - Originally the budget neutrality adjustment was applied nationally
  - CMS began transitioning to a state-level rural floor budget neutrality adjustment in FY 2009
  - Section 3141 of PPACA mandates CMS revert back to the national budget neutrality adjustment
    - Originally driven by Massachusetts hospitals
      - FY 16 benefit for Massachusetts - $98 million
      - FY 16 benefit for California - $221 million

Wage Index

- Wage Index Floor of 1.0 for “Frontier States”
  - Last-minute provision in PPACA
  - Frontier State is defined as a state with at least 50% of counties with a population per square mile of less than six
  - Specifically excludes Alaska and Hawaii
  - Is not budget neutral

FY 2011 Frontier States	FY 11 Proposed (before PPACA)	FY 11 Final (after PPACA)
Rural Montana	0.8439	1.0000
Rural Nevada	0.9555	1.0000
Rural North Dakota (would have been lowest in US)	0.7018	1.0000
Rural South Dakota	0.8435	1.0000
Rural Wyoming	0.9392	1.0000

Wage Index

- Out-Migration Adjustment
  - Rural counties with at least 10% of resident hospital employees who commute to an urban CBSA are eligible for add-on to wage index
  - Also known as Section 505 Wage Adjustment
  - Providers that are reclassified are not eligible to receive out-migration adjustment

Wage Index

- Lugar Counties
  - Rural counties that meet certain conditions (including specific commuting patterns) are considered Lugar Counties, and hospitals located in those counties are paid as if they are urban
  - Receive the reclassified wage index of the urban area to which they are re-designated
  - Receive the large urban add-on if applicable, not subjected to 12% operating DSH cap and eligible for capital DSH payments
  - Number of Lugar Counties increasing from 99 to 127 under new CBSAs
  - Technically known as “Rural Counties Re-designated as Urban under Section 1886(d)(8)(B) of the Act”

Wage Index

- Section 401 Hospitals
  - Urban hospitals meeting specific conditions can be re-designated as rural
  - Most common reason is to qualify as SCH, RRC or CAH
  - Until recently regulations prevented Section 401 hospitals from also receiving wage index geo reclass

Wage Index

- Section 401 Hospitals (cont.)
  - CMS issued separate Interim Final Rule on same day as FY 17 proposed rule
    - Effective April 21, 2016 although CMS did accept comments through June 17
    - Section 401 hospitals are now eligible to receive a geo reclass
    - Hospitals with an existing geo reclass can retain if newly approved for Section 401
  - Results from two separate court rulings in the past year that Congress never gave CMS the authority to forbid Section 401 geo reclasses
  - Rather than continue fighting in court, CMS reversed their policy “In the interest of creating a uniform national reclassification policy”
  - Additionally, CMS recently approved geo reclass applications from existing Section 401 hospitals allowing a reclass back to the hospital’s original geographic urban area

Wage Index

- Wage index assessment
  - Providers have the opportunity to request corrections to their wage data
    - CMS has moved up wage index timeline
    - Requests for FFY 2018 revisions due to MAC by 9/1/16
  - Hospitals should perform an assessment each year to take advantage of the opportunity for a second look
    - Compare to hospital's prior year data
    - Compare to other hospitals in area
    - Review adjustments made in prior years, including both revisions and audit adjustments
    - Involve others in the organization such as payroll and HR personnel

Wage Index

- Wage index assessment (cont.)
  - There is no “one size fits all” approach, but there are some issues that are common:
    - Identifying correct hours to include
    - Physician Part A admin – must be able to support related hours
    - Contract A&G – typically high AHW
    - Other contract labor – support for $ and hours
    - Allocation bases for benefits – salaries versus hours
    - Pension expense
    - Benefits buried in other GL accounts
    - Hours for contract dietary and housekeeping

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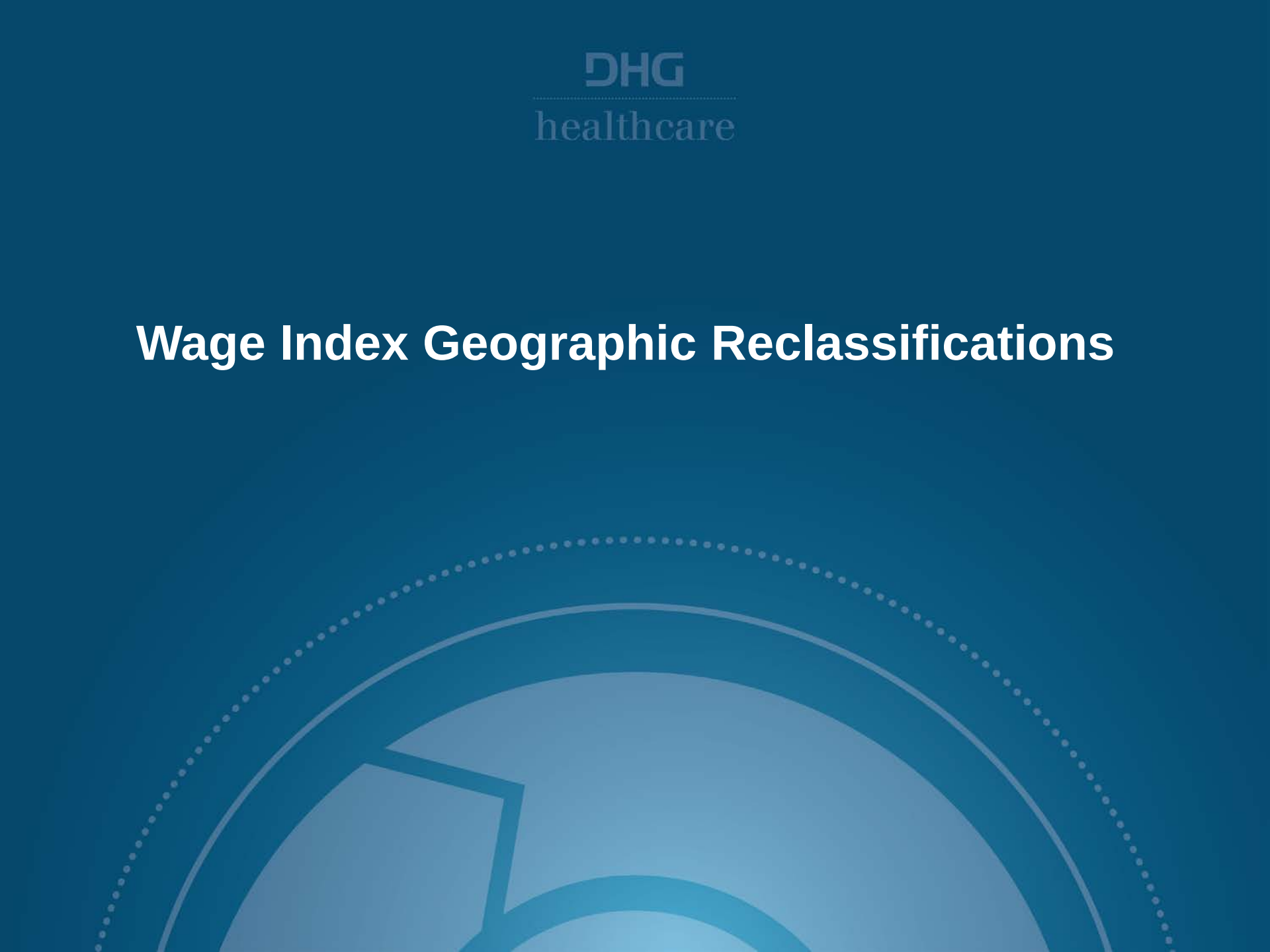
Wage Index Geographic Reclassifications



Wage Index Geographic Reclassifications

- Geographic Reclassification
  - Allows providers meeting specific requirements to reclass to another geographic area for purposes of receiving higher wage index
  - Application is submitted to Medicare Geographic Classification Review Board (MGCRB) and is due 13 months prior to when reclassification would go into effect (deadline for FY 18 – September 1, 2016)
  - Reclassifications are in effect for three years, but provider can elect to withdraw reclassification during the three-year period, and also elect to reinstate reclassification the following year if still within the three-year window
    - Election to withdraw must be submitted to MGCRB within 45 days of publication of Proposed Rule

Wage Index Geographic Reclassifications

- Geographic Reclassification (cont.)
  - General requirements
    - Proximity – hospital must be within 35 miles (rural)/15 miles (urban) of targeted CBSA
    - Hospital's average hourly wage must be at least 82% (rural)/ 84% (urban) of targeted CBSA
    - Hospital's average hourly wage must be at least 106% (rural)/ 108% (urban) of all other hospitals in current CBSA
    - New policy for FY 2013 reclassifications per FY 12 IPPS final rule – if a hospital is the only hospital in its MSA, it does not have to meet the 108% requirement

Wage Index Geographic Reclassifications

- Geographic Reclassification (cont.)
  - All hospitals within a county can apply for a group reclass
    - Overall AHW must be at least 85% of targeted CBSA
    - Rural county must be adjacent to targeted CBSA
    - Rural county must also meet certain commuting patterns - in general 25% of workers in county must commute to targeted CBSA or vice-versa
    - Urban area must be in the same Combined Statistical Area as targeted CBSA as defined by US Census Bureau

Wage Index Geographic Reclassifications

- Geographic Reclassification (cont.)
  - Exceptions to requirements
    - SCHs do not have to meet proximity rule – eligible to reclass to nearest urban or rural CBSA
    - Hospitals with RRC status at the date of review by the MGCRB do not have to meet proximity rule – eligible to reclass to nearest urban or rural CBSA
    - Hospitals that ever held RRC status do not have to meet 106%/108% test
    - Urban hospitals that ever held RRC status only have to be 82% of targeted CBSA instead of 84%

Wage Index Geographic Reclassifications

- Geographic Reclassification (cont.)
  - Hospitals that are reclassified receive the reclassified wage index of the targeted CBSA
    - Reclassified wage index is often lower than base wage index for each CBSA

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Review and Final Questions

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