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Reimbursement Strategies for Hospitals and Health Systems

June 14, 2023

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Agenda

- Common Critical Access Hospital (CAH) Reimbursement Opportunities
- Protecting your CAH Reimbursement During Medicare Audits
- Common PPS Hospital Reimbursement Opportunities
- Recent Updates to Forms and Exhibits

Learning Objectives

- Have an enhanced understanding on how to strategically position your facility to assure you are getting reimbursed at an optimal level
- Have a better understanding of recent regulatory changes
- Be able to take thoughts and ideas back to your facility to identify areas where reimbursement can be improved

Common CAH Opportunities

Census Information on Worksheet S-3 Part I

- Worksheet S-3 Part I line 1.00 is used to report Adults & Peds Inpatient Days
- For a CAH, this is used to calculate your Inpatient cost-per-day
- We recommend validating and reconciling your Inpatient days
  - Internal statistical data
  - Room and board charges on your revenue and usage
  - Medicare PS&R and Medicaid claims reports

Common CAH Opportunities
Census Information on Worksheet S-3 Part I

- Common opportunities – Labor & Delivery
  - The time a mother is in active labor is an ancillary service. The costs and charges associated with active labor time should be treated as ancillary.
    - Active labor days are reported on S-3 Part I, line 32.00, these should not be reported on line 1.00
  - Once an infant is born, the mother's care becomes postpartum. The costs and charges associated with postpartum care are considered routine.
    - Routine postpartum days are reported on S-3 Part I, line 1.00

Common CAH Opportunities
Census Information on Worksheet S-3 Part I

- Common opportunities – Labor & Delivery Example
  - Provider has LDRP rooms and charges a patient if they are in a bed at midnight
  - Internal statistics and revenue and usage report show 480 OB days
  - Provider included all days in Worksheet S-3 Part I, line 1.00
  - Cost per day including all 480 OB days in line 1.00 is $1,330.05

Adjusted Routine Cost	$	6,166,107
Routine Days		3,766
Swing Bed Days		63
Observation Days		807
Days Subtotal		4,636
Adjusted Routine Per Diem	**$**	**1,330.05**

Common CAH Opportunities
Census Information on Worksheet S-3 Part I

- Common opportunities – Labor & Delivery Example
  - Of the 480 OB days, only 320 are postpartum. The remaining 160 days were for mothers in active labor and should have been removed from S-3 Part I, line 1.00 and reported on line 32.00.

Adjusted Routine Cost	$ 6,166,107	$ 6,166,107
Routine Days	3,766	3,606
Swing Bed Days	63	63
Observation Days	807	807
Days Subtotal	4,636	4,476
Adjusted Routine Per Diem	$ 1,330.05	$ 1,377.59
Increase		$ 47.54
Medicare Routine Days		1,500
Impact for this cost reporting period		**$ 71,316**

Common CAH Opportunities
Census Information on Worksheet S-3 Part I

- Common opportunities – Swing Bed days
  - Worksheet S-3 Part I, line 5.00 is used to report Medicare covered Swing Bed SNF days
  - Worksheet S-3 Part I, line 6.00 is used to report non-Medicare covered Swing Bed NF days
    - It's important to understand the payor for each swing bed patient

Common CAH Opportunities
Census Information on Worksheet S-3 Part I

- Common opportunities – Swing Bed Example
  - Provider has 544 swing bed days during the year
    - 260 Medicare
    - 120 Medicare Advantage
    - 164 Medicaid
  - Provider reported all swing bed days on S-3 Part I, line 5.00. Because Medicaid days are carved out of the Routine cost at a much lower rate, this can have a material impact on the routine per diem calculation

Common CAH Opportunities
Census Information on Worksheet S-3 Part I

- Common opportunities – Swing Bed Example

	Routine Cost	$ 4,201,693	$ 4,201,693
	Less: NF carve out at MA rate of $262	-	$ (42,968)
	Adjusted Routine Cost	$ 4,201,693	$ 4,158,725
1.00	Routine Days	351	351
5.00	Swing Bed SNF Days, S-3 Part I, line 5.00	544	380
6.00	Swing Bed NF Days, S-3 Part I, line 6.00	0	164
29.00	Observations Days	146	146
	Days Subtotal (lines 1+5+29)	1,041	877
	Adjusted Routine Per Diem	$ 4,036.21	$ 4,741.99
	Increase		$ 705.78
	Medicare Swing Bed Days		260
	Impact for this cost reporting period		**$ 183,503**

Common CAH Opportunities
Worksheet A – Cost Center setup

- Standard overhead cost centers

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)
			1.00	2.00	3.00
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	0
6.00	00600	MAINTENANCE & REPAIRS	0	0	0
7.00	00700	OPERATION OF PLANT	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0
9.00	00900	HOUSEKEEPING	0	0	0
10.00	01000	DIETARY	0	0	0
11.00	01100	CAFETERIA	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0
15.00	01500	PHARMACY	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0

Common CAH Opportunities
Worksheet A – Cost Center setup

- We recommend reviewing the departments that are grouped to overhead cost centers to determine if it would be more accurate to componentize any of the cost report lines.

Line Number	Cost Center Description	Statistical Basis
1	CAP REL COSTS-BLDG & FIXT	SQUARE FEET
2	CAP REL COSTS-MVBLE EQUIP	DOLLAR VALUE
4	EMPLOYEE BENEFITS DEPARTMENT	GROSS SALARIES
5	ADMINISTRATIVE & GENERAL	ACCUM. COST
6	MAINTENANCE & REPAIRS	SQUARE FEET
7	OPERATION OF PLANT	SQUARE FEET
8	LAUNDRY & LINEN SERVICE	POUNDS OF LAUNDRY
9	HOUSEKEEPING	HOURS OF SERVICE
10	DIETARY	MEALS SERVED
11	CAFETERIA	MEALS SERVED
13	NURSING ADMINISTRATION	DIRECT NURS. HRS.
14	CENTRAL SERVICES & SUPPLY	COSTED REQUIS.
15	PHARMACY	COSTED REQUIS.
16	MEDICAL RECORDS & LIBRARY	TIME SPENT
17	SOCIAL SERVICE	TIME SPENT
19	NONPHYSICIAN ANESTHETISTS	ASSIGNED TIME

Common CAH Opportunities
Worksheet A – Cost Center setup

- Common opportunities
  - Line 1.00 Capital Related Building & Fixtures
    - Analyze and request to componentize separate building locations
      - Clinic, Skilled Nursing Facility, Ambulance garage, MOB, etc.
  - Line 5.00 Administrative & General (Accumulated Cost)
    - Analyze and request to componentize departments when another, more accurate statistical basis is available
      - Business Office (gross charges)
      - Information Technology (users or terminals)
      - Admitting (gross inpatient charges)
      - Electronic Health Records (EHR users)
      - Communications (telephones)
      - BioMed (time study)

Common CAH Opportunities
Worksheet A – Cost Center setup

- Common opportunities – Componentization impact by looking at Medicare cost-based reimbursement percentages

$1,000 TABLE						
Medicare Cost Center	Cost Center Description	Impact of Adding $1,000 of Cost To Cost Center	Cost Based Reimbursement Percentage	Expenses Added / (Removed)	Cost Based Reimbursement Impact	Total Increases/ (Decreases) in Net Income
1.00	NEW CAP COSTS-BLDG & FIXT	$ 503	50.3%		-	-
1.01	CAPITAL COSTS - SNF	$ 61	6.1%		-	-
1.03	CAPITAL COSTS - HOSP REMODEL	$ -	0.0%		-	-
2.00	NEW CAP COSTS-MVBLE EQUIP	$ 347	34.7%		-	-
4.00	EMPLOYEE BENEFITS	$ 235	23.5%		-	-
5.01	INFORMATION TECHNOLOGY	$ 306	30.6%		-	-
5.02	BUSINESS OFFICE	$ 539	53.9%		-	-
5.03	ADMINISTRATIVE & GENERAL	$ 248	24.8%		-	-
6.00	MAINTENANCE	$ 171	17.1%		-	-
7.00	OPERATION OF PLANT	$ 202	20.2%		-	-
8.00	LAUNDRY & LINEN SERVICE	$ 19	1.9%		-	-
9.00	HOUSEKEEPING	$ 207	20.7%		-	-
10.00	DIETARY	$ 47	4.7%		-	-
11.00	CAFETERIA	$ 197	19.7%		-	-
13.00	NURSING ADMINISTRATION	$ 812	81.2%		-	-
16.00	MEDICAL RECORDS & LIBRARY	$ 441	44.1%		-	-
17.00	SOCIAL SERVICE	$ 0	0.0%		-	-
19.00	NONPHYSICIAN ANESTHETISTS	$ 668	66.8%		-	-
30.00	ADULTS & PEDIATRICS	$ 848	84.8%		-	-
44.00	SKILLED NURSING FACILITY	$ (29)	-2.9%		-	-
50.00	OPERATING ROOM	$ 849	84.9%		-	-

Common CAH Opportunities
Worksheet B – Statistical Basis

- Worksheet B-1 Statistics should reflect an accurate step-down of overhead costs

Line Number	Cost Center Description	Statistical Basis
1	CAP REL COSTS-BLDG & FIXT	SQUARE FEET
2	CAP REL COSTS-MVBLE EQUIP	DOLLAR VALUE
4	EMPLOYEE BENEFITS DEPARTMENT	GROSS SALARIES
5	ADMINISTRATIVE & GENERAL	ACCUM. COST
6	MAINTENANCE & REPAIRS	SQUARE FEET
7	OPERATION OF PLANT	SQUARE FEET
8	LAUNDRY & LINEN SERVICE	POUNDS OF LAUNDRY
9	HOUSEKEEPING	HOURS OF SERVICE
10	DIETARY	MEALS SERVED
11	CAFETERIA	MEALS SERVED
13	NURSING ADMINISTRATION	DIRECT NURS. HRS.
14	CENTRAL SERVICES & SUPPLY	COSTED REQUIS.
15	PHARMACY	COSTED REQUIS.
16	MEDICAL RECORDS & LIBRARY	TIME SPENT
17	SOCIAL SERVICE	TIME SPENT
19	NONPHYSICIAN ANESTHETISTS	ASSIGNED TIME

Common CAH Opportunities
Worksheet B – Statistical Basis

- Common opportunities
  - Where the statistical basis is a time study
    - Be sure the time study meets the required criteria
      - One full week a month, for all 12 months of the year, rotating weeks
    - Review for accuracy
      - Housekeeping time study compared to hospital square footage
      - Medical records compared to gross charges
  - Changes to the statistical basis must be requested in writing 90 days prior to the end of the cost reporting period and result in a more accurate allocation of overhead costs.

Common CAH Opportunities
Worksheet M – Rural Health Clinics

- Recent Regulatory Changes
  - The Consolidated Appropriations Act (December 2020) put into place payment caps for RHCs that previously received uncapped cost-per-visit payments from Medicare
  - Effective for RHC visits on or after April 1, 2021
  - RHCs as of 12/31/2020 have a clinic specific cap based on historical cost (2020) inflated for the Medicare Economic Index (MEI).
  - New RHCs, established after 12/31/2020 are subject to the federal limit, $126 per visit in 2023.

Common CAH Opportunities
Worksheet M – Rural Health Clinics

- Common opportunities
  - Duplicate allocations of overhead within the general ledger for RHC departments
    - Capital costs
    - Administrative & General
    - Utilities & Maintenance
    - Housekeeping
  - We recommend reviewing wages by job code

Common CAH Opportunities

Worksheet M – Rural Health Clinics

WORKSHEET M-1							
		Salaries	Other	Total	Reclass	Adjustment	Total
FACILITY HEALTH CARE STAFF COSTS		S	O				
1	Physician	2,575,790	-	2,575,790	(52,273)		2,523,517
2	Physician Assistant	309,300	-	309,300	(9,019)		300,281
3	Nurse Practitioner	776,814	-	776,814	(25,124)		751,690
4	Visiting Nurse	-	-	-	-		-
5	Other Nurse	-	-	-	-		-
6	Clinical Psychologist	-	-	-	-		-
7	Clinical Social Worker	-	-	-	-		-
8	Laboratory Technician	-	-	-	-		-
9	Other Facility Health Care Staff Costs	2,030,203	206,389	2,236,592	(60,000)		2,176,592
10	Subtotal	5,692,107	206,389	5,898,496	(146,416)	-	5,752,080
COSTS UNDER AGREEMENT							
11	Physician Services Under Agreement	-	1,357,781	1,357,781	(50,801)		1,306,980
12	Physician Supervision Under Agreement	-	-	-			-
13	Other Costs Under Agreement	-	-	-			-
14	Subtotal	-	1,357,781	1,357,781	(50,801)	-	1,306,980
OTHER HEALTH CARE COSTS							
15	Medical Supplies	-	1,663,543	1,663,543			1,663,543
16	Transportation (Health Care Staff)	-	-	-			-
17	Depreciation-Medical Equipment	-	-	-			-
18	Professional Liability Insurance	-	-	-			-
19	Other Health Care Costs	-	78,470	78,470		-	78,470
21	Subtotal (sum of lines 15 through 20)	-	1,742,013	1,742,013	-	-	1,742,013
22	Total cost of Health Care Service	5,692,107	3,306,183	8,998,290	(197,217)	-	8,801,073

Common CAH Opportunities
Worksheet M – Rural Health Clinics

- Common opportunities
  - Reclassifying $60,000 of clinic scheduler/coordinator wages from direct identification in the clinic increased reimbursement for this provider by about $20,000 each year.

Common CAH Opportunities
Worksheet M – Rural Health Clinics

- Tracking Clinic Visits by provider type
  - Face-to-face medically necessary medical or mental health visit
    - Effective January 1, 2022, some mental health visits can be provided using telecommunications and be paid at the clinics All-Inclusive-Rate (AIR)
      - See MLN Matters Article SE22001 for additional requirements including a previous in-person visit prior to the telecommunications visit
    - Nurse only visits, vaccination for example, should be excluded
    - Telehealth visits paid on the Physician Fee Schedule should be excluded and reported on Worksheet M-1, line 25.01. (2023 rate of $98.27)

Common CAH Opportunities

Worksheet M – Rural Health Clinics

		Compensation	Other Costs	Total (col. 1 + col. 2)
		1.00	2.00	3.00
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0	0
2.00	Physician Assistant	0	0	0
3.00	Nurse Practitioner	0	0	0
4.00	Visiting Nurse	0	0	0
5.00	Other Nurse	0	0	0
6.00	Clinical Psychologist	0	0	0
7.00	Clinical Social Worker	0	0	0
8.00	Laboratory Technician	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	0	0
11.00	Physician Services Under Agreement	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0
13.00	Other Costs Under Agreement	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0
15.00	Medical Supplies	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0
18.00	Professional Liability Insurance	0	0	0
19.00	Other Health Care Costs	0	0	0
20.00	Allowable GME Costs	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	0
24.00	Dental	0	0	0
25.00	Optometry	0	0	0
25.01	Telehealth	0	0	0
25.02	Chronic Care Management	0	0	0
26.00	All other nonreimbursable costs	0	0	0
27.00	Nonallowable GME costs	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0
	FACILITY OVERHEAD			

Common CAH Opportunities
Worksheet M – Rural Health Clinics

- Common Opportunities - FTEs and productivity exceptions
  - FTE – what hours are included? We expect paid time off hours are excluded.
  - Contacted Providers reported on lines 1.00, 2.00, and 3.00 versus Physician Services Under Agreement on line 9.00
    - Notice Physician Services Under Agreements are not subject to productivity standards
    - Review and note if you have other provider types; Psychologist, Social Worker etc.

		Number of FTE Personnel	Total Visits	Productivity Standard (1)
		1.00	2.00	3.00
	VISITS AND PRODUCTIVITY			
	Positions			
1.00	Physician	0.00	0	4,200
2.00	Physician Assistant	0.00	0	2,100
3.00	Nurse Practitioner	0.00	0	2,100
4.00	Subtotal (sum of lines 1 through 3)	0.00	0	
5.00	Visiting Nurse	0.00	0	
6.00	Clinical Psychologist	0.00	0	
7.00	Clinical Social Worker	0.00	0	
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0	
7.02	Diabetes Self Management Training (FQHC only)	0.00	0	
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.00	0	
9.00	Physician Services Under Agreements		0	

Common CAH Opportunities
Medicare Audit Focus Areas

- Expanded Audit Scope
  - Patient Days
  - Location of swing bed services (especially if the hospital has an attached provider based Skilled Nursing Facility)
  - ER Costs, physician contracts, time studies
  - Changes from the prior year
  - RHC Vaccine Logs and cost of vaccines

Common PPS Opportunities
Wage Index

- CMS is required to review the wage index data submitted on Medicare cost reports (Worksheets S-3, Part II through V) annually for Medicare certified short-term, acute care IPPS hospitals
- Revisions to Worksheet S-3 wage index data must be submitted to your MACs by **9/1/23**
  - It is always recommended that as-filed data be closely examined for propriety and completeness
- Wage data for cost reporting periods beginning on or after 10/01/2020 and before 10/01/2021 will be incorporated into wage index values for **FFY 2025**

Common PPS Opportunities
Wage Index

- The purpose of wage index is to shift money from region to region and is budget neutral
- The wage index value is used in every claims payment for PPS hospitals and has a significant impact on reimbursement.

		**Assume hospitals submitted quality data and are meaningful users					
OPERATING:		**Urban Vallejo, CA**		**Rural Alabama**		**Frontier State**	
	Labor Portion	4,310.00		3,952.96		3,952.96	
	Wage Index	1.8939		0.6551		1.0000	
	Subtotal	8,162.71		2,589.58		3,952.96	
	Nonlabor Portion	2,065.74		2,422.78		2,422.78	
	Operating Portion (Federal)	10,228.45		5,012.36		6,375.74	
	Times: DRG Weight	1.0000		1.0000		1.0000	
	Operating Portion (Federal)	**10,228.45**		**5,012.36**		**6,375.74**	

Common PPS Opportunities
Wage Index: Payroll Data

- MAC audits of wage index have intensified. Here are common questions/requests on payroll data:
  - Confirmation of whether your hospital recently implemented a special capital or IT project (e.g., installation of a new IT system) that affects the current cost reporting year – ensure if salaries are not on W/S S-3, Part II, line 1, hours are removed for wage index purposes
  - Reconciliation of the labor distribution report to amounts reported on the cost report. This should be a reconciliation of both salaries and hours and should reconcile within 1% of the reported amounts. Submit the documentation to support all reconciling items.
- Recommend a detail review of payroll reports wages and trial balance by department to ensure accurate reporting
- Ensure tracking and excludable hours are removed for wage index
  - Shift differential or other tracking hours
  - On call hours
  - PTO buyback/sell back

Common PPS Opportunities
Wage Index: Physicians

- Physician Questions via MAC audits:
  - List of physician and non-physician salaries and hours. The list must include type of personnel, description of service rendered, labor cost and associated paid hours, average hourly rate, trial balance account number, and Worksheet A cost center in which the cost is included. Support for the physicians' A/B split must include the supporting time studies and physician contracts.
- Recommend having time study and physician contract support available for Part A time as this can have a significant impact on your average hourly wage

Common PPS Opportunities
Wage Index: Contract Labor

- Contract Labor Questions via MAC audits:
  - Detailed list(s) to support the contract labor cost and hours which must include date of service, vendor, type of personnel, description of service rendered, labor cost and associated paid hours, average hourly rate, trial balance account number, and Worksheet A cost center in which the cost is included.
    - Please include the breakout of the Dietary and Cafeteria cost and hours that are reported on line 35.
    - An attestation from a vendor of the total cost and hours is not sufficient documentation to support amounts reported as contract labor cost/hours; the contract labor list must include the amounts for each vendor invoice.
  - **ALL contracts** in force during the reporting period to support amounts included on the detailed list of contract labor.
- Recommend data mining to ensure all contract labor is reported if can support dollars and hours.

Common PPS Opportunities
Wage Index: Wage Related Costs

- Wage Related Cost Questions via MAC audits:
  - If the provider is self-insured, submit support for the amount claimed as health insurance cost. ***Include the TPA report*** of paid claims data if using a third-party administrator.
  - If the provider has a defined benefit pension plan: a) Completed CMS Allowable Pension Worksheet covering the base cost reporting period plus the prior two cost reporting periods, b) Prefunding Worksheet (if applicable), c) documentation such as the actuarial report, Schedule B or SB of IRS form 5500 to support contributions made to the plan, and d) Documentation to support payment of actuarial fees, claim administration fees, and IRS form preparation fees directly associated with the plan.
- Recommend ensuring that you are capturing all wage-related costs – benefit plan administration fees; employee flu shots and physicals not covered under insurance and provided free or at a reduced cost.

Common PPS Opportunities
Wage Index: AHW

	A	B	C	D	E	F	G	H	I	J	K
1						Provider CCN:	24-0000	Period			
2	HOSPITAL WAGE INDEX INFORMATION							From:	01/01/2022	Worksheet S-3, Part III	
3								To:	12/31/2022		
4					Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
5					1.00	2.00	3.00	4.00	5.00	6.00	
6		PART III - HOSPITAL WAGE INDEX SUMMARY									
7	1.00	Net salaries (see instructions)				48,800,000	0	48,800,000	1,572,000.00	31.04	1.00
8	2.00	Excluded area salaries (see instructions)				300,000	0	300,000	10,000.00	30.00	2.00
9	3.00	Subtotal salaries (line 1 minus line 2)				48,500,000	0	48,500,000	1,562,000.00	31.05	3.00
10	4.00	Subtotal other wages & related costs (see inst.)				6,600,000	0	6,600,000	72,000.00	91.67	4.00
11	5.00	Subtotal wage-related costs (see inst.)				14,500,000	0	14,500,000	0.00	29.90	5.00
12	6.00	Total (sum of lines 3 thru 5)				69,600,000	0	69,600,000	1,634,000.00	42.59	6.00
13	7.00	Total overhead cost (see instructions)				13,700,000	0	13,700,000	416,000.00	32.93	7.00

Note: AHW on W/S S-3, Part III, line 6 is a good marker of a hospital's overall AHW. However, we recommend also looking at the AHW calculator which factors in back end calculations and occupational mix adjustments which is how CMS utilizes a hospital's data in setting wage index values. FY 2022 Wage Index Home Page | CMS

Common PPS Opportunities
Occupational Mix Survey

- CMS is required to collect data every 3 years on the occupational mix of employees for Medicare certified short-term, acute care IPPS hospitals
  - Occupational Mix categories: RN, LPN & Surgical Technologists, Nursing Aides & Orderlies, Medical Assistants, and All Other
- Calendar Year 2022 Occupational Mix Survey is due to MACs on **6/30/23**
  - Data collected is for pay periods ending in calendar year 2022 regardless of a hospital's fiscal year end
- Occupational Mix Adjustment Factors from CY 2022 data will be incorporated into wage index values for **FFYs 2025, 2026, and 2027**

Common PPS Opportunities
Occupational Mix Survey

- Purpose of the occupational mix adjustment factor is to control the impact of hospitals' employment choices on the wage index
  - Employment choices are deemed management decisions rather than geographical differences in costs of labor
  - Intent is to have wage index reflect price differences in markets
  - From the FFY 2024 PUF, the following is the breakout of nursing categories based on CY 2019 occupational mix surveys. How does your facility compare to CY 2019?

Total to Report	2019 Total Hours	2019 Total Avg.
RN	2,461,649,011.20	70.49%
LPN, LVN, and ST	223,399,432.99	6.40%
Nursing Assistants and Orderlies	677,226,543.88	19.39%
Medical Assistants	129,998,385.89	3.72%

Common PPS Opportunities
Occupational Mix Survey

- Each hospital's occupational mix adjusted AHW is used in the calculation of the hospital's/CBSA wage index value.
  - Ensuring wages and hours are properly reported is key in the occupational mix survey.
    - Staffing with higher level (RN) nursing than the national average has a negative impact on occupational mix and ultimately wage index
  - Occupational mix reporting follows similar guidelines as wage index reporting

Provider Hours % by Subcategory in Survey x National AHW = $33.81

Provider % by Subcategory	FY 2019 Final National AHWs by Subcategory	Provider Adjusted AHW	Final FY 2019 National Adjusted Nurse AHW	Nurse Occ Mix Adjustment Factor
51.376%	$44.45	22.84		
22.936%	$26.83	6.15		
19.266%	$18.53	3.57		
6.422%	$19.50	1.25		
		33.81	$37.42	1.10677

Positive Occupational Mix Adjustment Compared to National AHW of $37.42

Common PPS Opportunities
Occupational Mix Survey Tips

- Categorize payroll similar to wage index
  - Identify cost report grouping by employee category by department
    - Nursing staff is only to be reported in nursing categories if grouped in specified cost centers
    - Identify all staff in excluded cost centers (e.g., SNF, Ambulance, Nursing & Allied Health, RHC, HHA, non-reimbursable cost centers – excluded from the survey
    - Identify Part A and Part B providers – Part B is removed from the survey
  - Add the following wages and hours to the occupational mix survey
    - Home Office/Related Organization wages and hours - attributable to the individual facility with an excluded hour % removed
    - Contract Labor wages and hours – do not include if related to an excluded cost center or Part B provider
      - Only include contracted A&G, housekeeping and dietary if in a general service cost center

Common PPS Opportunities
Occupational Mix Survey Tips

- Example of how occupational mix reporting can impact the overall AHW using 2019 occupational mix details.

			step 1	step 2	step 3	step 5	step 6	in step 7
	Provider Occ Mix Hours	Provider Occ Mix Salaries	Provider % by Subcategory	FY 2019 Final National AHWs by Subcategory	Provider Adjusted AHW	Final FY 2019 National Adjusted Nurse AHW	Nurse Occ Mix Adjustment Factor	Provider % by Total
RN	40,000	2,000,000	51.376%	$44.45	22.84			
LPN and Surgical Technicians	17,857	500,000	22.936%	$26.83	6.15			
National Nurse Aides, Orderlies, and Attendants	15,000	300,000	19.266%	$18.53	3.57			
Medical Assistants	5,000	100,000	6.422%	$19.50	1.25			
Total Nurse Hours and Salaries	77,857	2,900,000			33.81	$37.42	1.10677	26.36%
ALLOTHER	180,000	8,100,000			step 4			73.64%
TOTAL	257,857	11,000,000						

Wage Data from Cost Report		
Wages (From S-3, Parts II and III)	$10,000,000	(These are inflated wages, from cell B101 from AHW calculator).
Hours (From S-3, Parts II and III)	200,000	(Revised hours from cell B102 from AHW calculator).
Unadjusted AHW	50.00	(Should match AHW in cell B104 from AHW calculator).
Nurse Occ Mix Wages	$2,917,848	step 7 — 1.10677 x 26.36% x $10,000,000
All Other Unadjusted Occ Mix Wages	$7,363,636	step 7 — 73.64% x $10,000,000
Total Occ Mix Wages	$10,281,485	step 8
		$10,281,485/200,000 hours ---------->
Final Occ Mix Adjusted AHW	51.4100	step 8 — Occupational Mix Increased AHW from $50 to $51.41

Common PPS Opportunities
Medicaid Disproportionate Share (DSH) Payment

- Medicaid DSH is a payment paid to hospitals by the state to help cover the uncompensated care cost for treating Medicaid eligible and uninsured patients
- Hospitals must meet certain requirements as outlined in the Social Security Act §1923 to qualify for Medicaid DSH
- If a hospital receives Medicaid DSH, the hospital will be required to either participate in an audit to confirm they had enough uncompensated care cost to cover the DSH payment received or pay back the DSH payment to the state

Common PPS Opportunities
Medicaid DSH Qualifications

- Hospital is deemed qualified for DSH if:
  - Hospital's Medicaid Inpatient Utilization Rate (MIUR) is at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state; OR
  - Hospital's Low Income Utilization Rate (LIUR) exceeds 25 percent
- Hospitals may qualify for DSH if:
  - Have two obstetricians who have staff privileges and have agreed to provide obstetric services to Medicaid eligible individuals
    - Note: There are some exceptions to this requirement
  - Hospital's MIUR is greater than 1%

Common PPS Opportunities
Medicaid DSH Uncompensated Care Cost

- The following populations are included in the uncompensated care cost calculation:
  - Medicaid Fee-for-Service
  - Medicaid Managed Care
  - Medicare Fee-for-Service Crossovers
  - Other Medicaid Eligibles
  - Uninsured
- The days and charges for each of these populations is used to calculate the cost, then the payments received are subtracted to arrive at the cost of uncompensated care
  - Note: The Medicaid CCRs and per diems are used to calculate cost

Common PPS Opportunities
Medicaid DSH – Consolidated Appropriations Act

- Effective October 1, 2021 – Only the cost and payments associated with Medicaid Fee-for-Service, Medicaid Managed Care, or Uninsured patients will be allowed to be included in the uncompensated care cost calculation
- There is an exception where dual eligibles will be allowed to be included in the uncompensated care cost calculation
  - If a hospital is in the 97th percentile or above for the number of Medicare SSI days or percentage of Medicare SSI days to total inpatient days, the hospital will have the ability to calculate their uncompensated care cost by taking the greater of the cost calculated by including dual eligibles or without dual eligibles

Common PPS Opportunities
Medicaid DSH – Consolidated Appropriations Act

- It is extremely important to review the primary and secondary payors on claims and to make sure payors are updated to the correct and/or active payors to ensure all eligible claims under this revised calculation are included during the Medicaid DSH Payment audit
  - It will also be extremely important to ensure these eligible claims are included in the correct category (Medicaid Fee-for-Service, Medicaid Managed Care, etc.) for the Medicaid DSH Payment audit
- Additional guidance for applying the Consolidated Appropriations Act is still pending from CMS

Recent Updates to Forms and Exhibits

- Effective for cost reporting periods beginning on/after October 1, 2022, the following exhibits are required.
  - Exhibit 2A: Medicare Bad Debts for all providers
  - Exhibit 3A: Medicaid Eligible Days for hospitals claiming Medicare Disproportionate Share (DSH) or Low Income Payment (LIP)
  - Exhibit 3B: Charity Care for hospitals claiming Medicare DSH
  - Exhibit 3C: Total Bad Debts for hospitals claiming Medicare DSH

Recent Updates to Forms and Exhibits
Exhibit 2A: Medicare Bad Debts

- For cost reporting periods beginning on or after October 1, 2022, the following exhibit 2A is required to support Medicare bad debts.

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDICAID NUMBER	PROVIDER DEEMED INDIGENT	MEDICARE REMITTANCE ADVICE DATE	MEDICAID REMITTANCE ADVICE DATE	SECONDARY PAYER RA RECEIVED DATE	BENEFICIARY RESPONSIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13

A/R WRITE OFF DATE	SENT TO COLLECTION AGENCY (Y/N)	RETURN FROM COLLECTION AGENCY DATE	COLLECTION EFFORT CEASED DATE	MEDICARE WRITE OFF DATE	RECOVERIES ONLY: AMOUNT RECEIVED	RECOVERIES ONLY: MCR FYE DATE	MEDICARE DEDUCTIBLE AMOUNT*	MEDICARE COINSURANCE AMOUNT*	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOWABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

Recent Updates to Forms and Exhibits
Exhibit 2A: Medicare Bad Debts

- Complete a separate Exhibit 2A for inpatient and outpatient for each separate CMS certification number.
- Ensure Exhibit 2A, column 23 ties to Medicare bad debts reported on the cost report settlement pages.
- Changes from Exhibit 2:
  - Added fields (from 10 fields in Exhibit 2 to 24 fields in Exhibit 2A):
    - Patient account number
    - Provider deemed indigent
    - Medicaid RA date
    - Secondary payer RA date
    - Beneficiary responsibility amount
    - A/R write off date
    - Sent to collection agency (y/n)
    - Return from collection agency (date)
    - Medicare write off date
    - Recoveries – amount received
    - Recoveries – Medicare FYE
    - Payments received prior to write-off; and
    - Comments

Recent Updates to Forms and Exhibits
Exhibit 2A: Medicare Bad Debts

- Completing Exhibit 2A: Get your business office involved early to ensure gathering this additional data and understanding any changes will not be an issue.
  - If there is a patient Medicaid number in column 7, there must be a Medicaid RA date indicated in column 10 or "AD" entered if alternate documentation was obtained to support the state liability.
    - MAC will look at Medicaid RA for the state's cost sharing liability
    - If no Medicaid RA, "AD" must include:
      - The State Medicaid documentation indicating they have no obligation to pay Medicare's share or provider's inability to enroll in Medicaid to produce a crossover claim;
      - Documentation on the state's liability for Medicare cost sharing; and
      - Support for the beneficiary's eligibility for Medicaid for the dates of service.
    - Any amount that the state is obligated to pay under statute or Medicaid state plan cannot be included as a Medicare bad debt regardless of whether Medicaid paid the obligated amount.

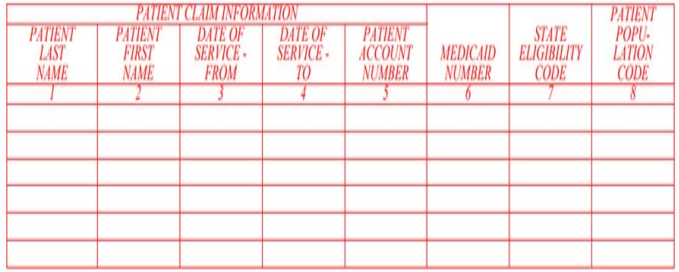
Recent Updates to Forms and Exhibits
Exhibit 2A: Medicare Bad Debts

- Beneficiary responsibility amount (column 12): Enter the amount of coinsurance and deductible for which the Medicare beneficiary is responsible.
  - If a QMB, enter "QMB." Will also enter "QMB" in column 13 for date first billed to beneficiary as provider's are prohibited from attempting to collect any unpaid Medicare deductible and coinsurance amounts.
  - For dual eligible, non QMB beneficiaries, enter the amount the beneficiary is required to pay under the state cost sharing agreement.
  - For a beneficiary deemed indigent by the provider, enter $0
- Reasonable collection efforts
  - Non-Indigent beneficiaries: Bill must be issued to the beneficiary or responsible party on or before 120 days after date of the Medicare RA, secondary payer RA, or notification that the secondary payer does not cover the service. A new 120 day collection period starts each time a payment is received.
  - Indigent non-dual eligible beneficiaries: Codified acceptable methods of determining indigency.

Recent Updates to Forms and Exhibits
Exhibit 3A: Medicaid Eligible Days

- Patient level detail has been required to be submitted with the cost report as of cost reporting periods beginning on/after October 1, 2018. Exhibit 3A standardizes the patient data that must be submitted to support Medicaid eligible days.
- Exhibit 3A: For cost reporting periods beginning on or after October 1, 2022, Exhibit 3A is required to support Medicaid eligible days.
  - 42 CFR 413.24(f)(5)(C): "for hospitals claiming a disproportionate hospital payment adjustment, a detailed listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's cost report" must be submitted.
  - If reporting Medicaid days on Worksheet S-2, Part I, lines 24 or 25, complete a separate Exhibit 3A listing for each CCN.
  - Exception: SCHs eligible for DSH but where W/S E, Part A, line 48 is greater than line 47.
- Required new format will be resource intensive!

Recent Updates to Forms and Exhibits
Exhibit 3A: Medicaid Eligible Days



PATIENT CLAIM INFORMATION					MEDICAID NUMBER	STATE ELIGIBILITY CODE	PATIENT POPULATION CODE
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER			
1	2	3	4	5	6	7	8

MEDICAID DAYS				INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			
WKST S-2, PART I COLUMN NUMBER	ELIGIBLE DAYS	LABOR & DELIVERY ROOM DAYS	NEWBORN BABY DAYS	PRIMARY	SECONDARY	A/B INDICATOR	START DATE	END DATE	COMMENTS
9	10	11	12	13	14	15	16	17	18

- Medicaid Number (Column 6):
  - Enter the Medicaid identification number, or
  - For a newborn baby born to a Medicaid eligible mother, enter the mother's Medicaid identification number.
- State Eligibility Code (Column 7):
  - If available, enter the state plan eligibility code
  - If more than one code, report additional codes in column 18 (Comments)
- Population Code (Column 8): Enter a unique patient population code to identify restricted or unrestricted Medicaid eligible days.
  - Restricted: R1 = pregnancy/labor and delivery services; R2 = emergency services; R3-R9 = user defined
  - Unrestricted: U1 = general unrestricted; U2-U9 = user defined

Recent Updates to Forms and Exhibits
Exhibit 3A: Medicaid Eligible Days

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	MEDICAID NUMBER	STATE ELIGIBILITY CODE	PATIENT POPULATION CODE
1	2	3	4	5	6	7	8

MEDICAID DAYS				INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			
WKST S-2, PART I COLUMN NUMBER	ELIGIBLE DAYS	LABOR & DELIVERY ROOM DAYS	NEWBORN BABY DAYS	PRIMARY	SECONDARY	A/B INDICATOR	START DATE	END DATE	COMMENTS
9	10	11	12	13	14	15	16	17	18

- Eligible Days (Column 10):
  - Medicaid eligible days during dates of service
  - Newborn baby days after Medicaid eligible mom's discharge
  - **Sum of days in this column must match W/S S-2, Part I, line 24 or 25, columns 1 through 5.**
- Labor & Delivery Days (Column 11):
  - Days maternity patient in labor/delivery as of midnight census.
  - **Sum of days in this column must match W/S S-2, Part I, line 24, column 6.**
- Newborn Baby Days (Column 12):
  - Report newborn baby days occurring prior to the Medicaid eligible mother's date of discharge for a baby born to a Medicaid eligible mother
  - **Why not part of column 10 and eligible days????**

Recent Updates to Forms and Exhibits
Worksheet S-10: New Exhibits 3B & 3C

- Part I: Total facility (ALL CCNs)
  - Worksheet S-10, Part I must contain all hospital CCN charity care, total bad debt, and other data reporting.
- Part II: Hospital ONLY
  - W/S S-10, Part II must contain hospital only charity care and total bad debt information
    - Input fields start at line 20 for charity care data
  - CCR on line 1 removes non-hospital expenses and revenues (to the extent possible)

Worksheet S-10 provides for the collection of uncompensated and indigent care data for the entire hospital complex. Effective for cost reporting periods beginning on or after October 1, 2022, Worksheet S-10 is Worksheet S-10, Part I; and, effective for cost reporting periods beginning on or after October 1, 2022, Worksheet S-10, Part II, provides for the collection of uncompensated and indigent care data for inpatient and outpatient services billable under the hospital CCN. The data reported on Part II is a subset of the data reported on Part I.

Recent Updates to Forms and Exhibits
Exhibit 3B: Charity Care

- Exhibit 3B: For cost reporting periods beginning on or after October 1, 2022, Exhibit 3B is required to support charity care at patient level detail.
  - Instructions do not exempt non-DSH qualifying hospitals from completing Exhibit 3B. However, per 42 CFR 413.24(f)(5)(D), "for DSH eligible hospitals reporting charity care and/or uninsured discounts, a detailed listing of charity care and/or uninsured discounts that corresponds to the amounts claimed in the DSH eligible hospital's cost report" is required.
  - Exception: SCHs eligible for DSH but where W/S E, Part A, line 48 is greater than line 47.
  - Complete a separate Exhibit 3B for each CCN.
  - Fields in Exhibit 3B is less than required in some previous audit templates – will auditors request these additional fields at S-10 audit?
    - Revenue code detail
    - No separation of events prior, during or after the FYE in question (e.g., patient charity contractual amount)

Recent Updates to Forms and Exhibits
Exhibit 3B: Charity Care

PATIENT CLAIM INFORMATION					INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR	TOTAL CHARGES FOR CLAIM	PHYSICIAN / PROFES-SIONAL CHARGES	DEDUCT-IBLE / COINSUR / COPAY AMOUNTS
PATIENT NAME - LAST	PATIENT NAME - FIRST	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER						
1	2	3	4	5	6	7	8	9	10	11

TOTAL THIRD PARTY PAYMENTS	INSURED CONTRAC-TUAL ALLOWANCE AMOUNT	OTHER NON-ALLOWABLE AMOUNTS	TOTAL PATIENT PAYMENTS	AMOUNTS WRITTEN OFF AS BAD DEBT	UNINSURED DISCOUNT AMOUNTS	CHARITY CARE NON-COVERED CHARGES	OTHER CHARITY CARE CHARGES	AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS	WRITE OFF DATE
12	13	14	15	16	17	18	19	20	21

- Insurance Status (Column 6):
  - *Enter 1 to indicate the patient was uninsured (did not have any insurance coverage).*
  - *Enter 2 to indicate the patient was insured but not covered when the patient:*
    - *had insurance coverage through an insurance company with which you do not have a contractual relationship,*
    - *had insurance coverage and the services provided were medically necessary but not covered,*
    - *had insurance coverage and the patient had exhausted their benefits, or*
    - *had general coverage through Medicaid but was not covered for this particular stay due to exhausted benefits or noncoverage.*
  - *Enter 3 to indicate the patient was insured.*
- Amounts Written off to Charity Care and Uninsured Discounts (Column 20):
  - Sum of discounts in column 20 for those patients identified in column 6 with status codes of 1 and 2 must equal W/S S-10, Part I, line 20, column 1
  - Sum of discounts in column 20 for those patients identified in column 6 with status code of 3 must equal W/S S-10, Part I, line 20, column 2

Recent Updates to Forms and Exhibits
Exhibit 3B: Charity Care

PATIENT CLAIM INFORMATION										
PATIENT NAME - LAST	PATIENT NAME - FIRST	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR	TOTAL CHARGES FOR CLAIM	PHYSICIAN / PROFESSIONAL CHARGES	DEDUCTIBLE / COINSUR / COPAY AMOUNTS
1	2	3	4	5	6	7	8	9	10	11

TOTAL THIRD PARTY PAYMENTS	INSURED CONTRACTUAL ALLOWANCE AMOUNT	OTHER NON-ALLOWABLE AMOUNTS	TOTAL PATIENT PAYMENTS	AMOUNTS WRITTEN OFF AS BAD DEBT	UNINSURED DISCOUNT AMOUNTS	CHARITY CARE NON-COVERED CHARGES	OTHER CHARITY CARE CHARGES	AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS	WRITE OFF DATE
12	13	14	15	16	17	18	19	20	21

Column 17--Complete this column only for uninsured patients; do not complete this column for insured patients. Enter the amount of the uninsured discount given to the uninsured patient pursuant to the hospital's written charity care policy or FAP.

Column 18--For insured patients, enter the portion of the medically necessary non-covered charges considered for charity care, if such inclusion is specified in the hospital's written charity care policy or FAP and the patient meets the hospital's policy criteria, as follows:

- *enter the charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs.*
- *enter the charges for non-covered days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs.*
- *enter the portion of charges where the patient has exhausted their benefits.*

Column 19--Enter any other allowable charges (not reported in column 17 or column 18) and written off as charity care pursuant to the provider's written charity care policy or FAP.

Column 20--Enter the sum of the amounts in columns 17, 18, and 19.

Recent Updates to Forms and Exhibits
Exhibit 3C: Total Bad Debts

- Exhibit 3C: For cost reporting periods beginning on or after October 1, 2022, Exhibit 3C is required to support bad debts and implicit price concessions at patient level detail.
  - Instructions indicate that DSH qualifying hospitals must complete Exhibit 3C.
  - Exception: SCHs eligible for DSH but where W/S E, Part A, line 48 is greater than line 47.
  - A separate Exhibit 3C is to be completed by CCN with only inpatient and outpatient services included.
  - Fields in Exhibit 3C is less than required in some previous audit templates – will auditors request these additional fields at S-10 audit?
    - Revenue code detail
    - No separation of events prior, during or after the FYE in question (e.g., patient bad debt write off)
    - How to report recoveries?

Recent Updates to Forms and Exhibits
Exhibit 3C: Total Bad Debts

PATIENT CLAIM INFORMATION					INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCT NUMBER			
1	2	3	4	5	6	7	8

SERVICE INDICATOR (IP / OP)	TOTAL CHARGES	TOTAL PHYSICIAN / PROFESSIONAL CHGS	TOTAL PATIENT PAYMENTS	TOTAL THIRD PARTY PAYMENTS	PATIENT CHARITY CARE AMOUNT	CONTRACTUAL ALLOWANCE / OTHER AMOUNT	A/R WRITE OFF DATE	PATIENT BAD DEBT WRITE OFF AMOUNT
9	10	11	12	13	14	15	16	17

- Insurance Status (Column 6):
  - *Enter 1 to indicate the patient was uninsured (did not have any insurance coverage).*
  - *Enter 2 to indicate the patient was insured but not covered when the patient:*
    - *had insurance coverage through an insurance company with which you do not have a contractual relationship,*
    - *had insurance coverage and the services provided were medically necessary but not covered, or*
    - *had insurance coverage and the patient had exhausted their benefits.*
  - *Enter 3 to indicate the patient was insured.*

- The sum of Patient Bad Debt Write Off Amount (Column 17) must tie to the amount reported on W/S S-10, line 26.

Column 17--Calculate the net patient bad debt amount by computing the ratio of total charges to total charges plus physician/professional charges (column 10 divided by the sum of columns 10 and 11). Apply the ratio to the total payments, discounts, and allowances (columns 12 through 15) and subtract the resulting amount from total charges (column 10).

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