Toyon University® Presents
Medicare Cost Reporting
Transmittal 18 Changes

February 23, 2023

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Provider Workgroup

If interested, please contact Fred Fisher to sign up for Toyon's Transmittal 18 peer to peer provider workgroup meetings throughout 2023.

Fred Fisher
Vice President, Service Development
Uncompensated Care Recognition Services
888.514.9312
fred.fisher@toyonassociates.com

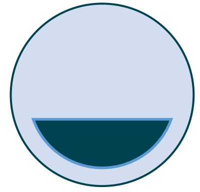
Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Agenda | Contents

Section	Topic	Pages
I	Worksheet S-10 Uncompensated Care	5 - 20
II	Empirical DSH	21 - 26
III	Medicare Bad Debt	27 - 33
IV	Graduate Medical Education	34 - 36
V	Organ Acquisition	37 - 47
VI	Other Notable Updates (i.e., PHE Expiration, Sequestration Calc., etc.)	48 - 51

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Transmittal 18 Background



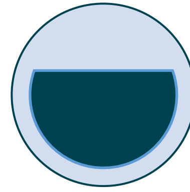
Initial Release
November 2020

- Requirement under the Paperwork Reduction Act (PRA)

- Initial Comments Due Early 2021

OMB Responses Initial Comments Available here

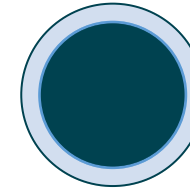
OMBs responses are referenced throughout this presentation



Re-Release
June 6, 2022

- Comments were due July 22, 2022

- Toyon comments are available here



Finalized
December 29, 2022

- Available here on CMS's website

- Effective for cost reporting periods beginning on or after October 1, 2022, unless noted otherwise

OMB Response to Comments on Final Instructions TBD

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Section I

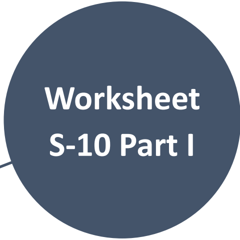
Worksheet S-10

Uncompensated Care

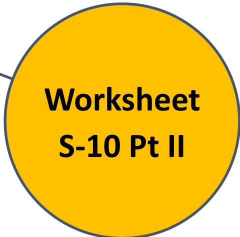
Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Worksheet S-10 Part II

Acute Care Only



- **Inpatient and outpatient services for the entire hospital complex**



- **Inpatient and outpatient services billable under the Hospital CMS Certification Number (CCN)**

…"amount of uncompensated care" for a year in proportion to "the aggregate amount of uncompensated care" for all qualifying hospitals"

"based on **appropriate data**" or other "alternative data" that is "a better proxy for the costs . . . **of treating the uninsured**"*

- Worksheet S-10 Part II is a subset of the data reported on Part I

- **OMB Response** to Initial Comments:

"The Worksheet S-10, Part II data will be collected so that CMS may consider the general short-term hospital inpatient and outpatient detailed information, in future years, in determining the scope of the UCC data for purposes of the uncompensated care payment methodology"

*Per the ACA, Codified at 42 USC 1395ww(r)(2)(C)

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Worksheet S-10 Part II

Est. Break-Even Point *if* CMS Uses Acute Care Only

Providers with 16% subacute (days) would experience a decrease in UC DSH Payments*

Est. % Change in UC DSH Payment
-30.0% to -20.0%
-20.0% to -10.0%
-10.0% to 0.0%
0.0% to 10.0%
10.0% to 20.0%

Washington 1.00%
Montana -6.49%
North Dakota -16.39%
Minnesota -0.47%
Oregon -2.85%
Idaho -0.70%
Wyoming -26.69%
South Dakota -5.32%
Wisconsin 4.55%
Michigan -7.30%
Maine 1.83%
Vermont
New Hampshire 6.72%
New York -15.01%
Massachusetts 4.78%
Connecticut -1.89%
Iowa -10.81%
Nebraska 3.81%
Pennsylvania 0.01%
New Jersey 1.37%
Illinois 3.19%
Indiana 0.12%
Ohio 3.64%
Nevada 6.96%
Utah -1.24%
Colorado 0.45%
Kansas -0.02%
Missouri -10.88%
Delaware 14.55%
West Virginia -4.19%
Kentucky -2.74%
Virginia -6.82%
California -4.32%
Tennessee 6.99%
North Carolina -0.64%
Oklahoma -3.40%
Arkansas -12.09%
Arizona 2.02%
New Mexico -3.76%
South Carolina -7.80%
Mississippi -13.13%
Alabama 1.38%
Georgia -1.57%
Texas 8.66%
Louisiana -8.79%
Florida 4.82%
UNITED STATES OF AMERICA

*Est. change applying each DSH hospital's percentage of non-acute days to UC costs. Days per FFY 2020 Medicare cost report Worksheet S-3 Pt. I.

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medically Necessary Services

CMS Proposed Instruction

Charity care and uninsured discounts result from a hospital's policy to provide all or a portion of ***medically necessary*** *health care* services free of charge to patients who meet the hospital's charity care policy or FAP

Industry Opposition

- Subjectivity of "Medically Necessary"
- Reporting and audit variation concerns
- Care provided to low-income patients is medically necessary

Reporting Medically Necessary Claims*

- Care could have been provided in lower cost setting
- Unreasonable E&M
- Excessive therapy or diagnosis procedures
- Unrelated services, screenings, test, etc. for patient diagnosis

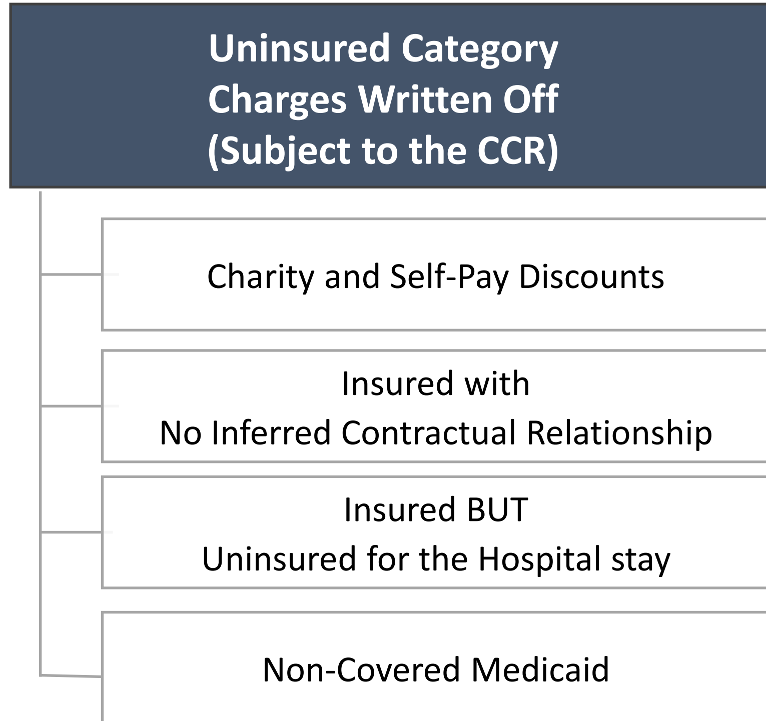
***Items & Services Not Covered Under Medicare:**

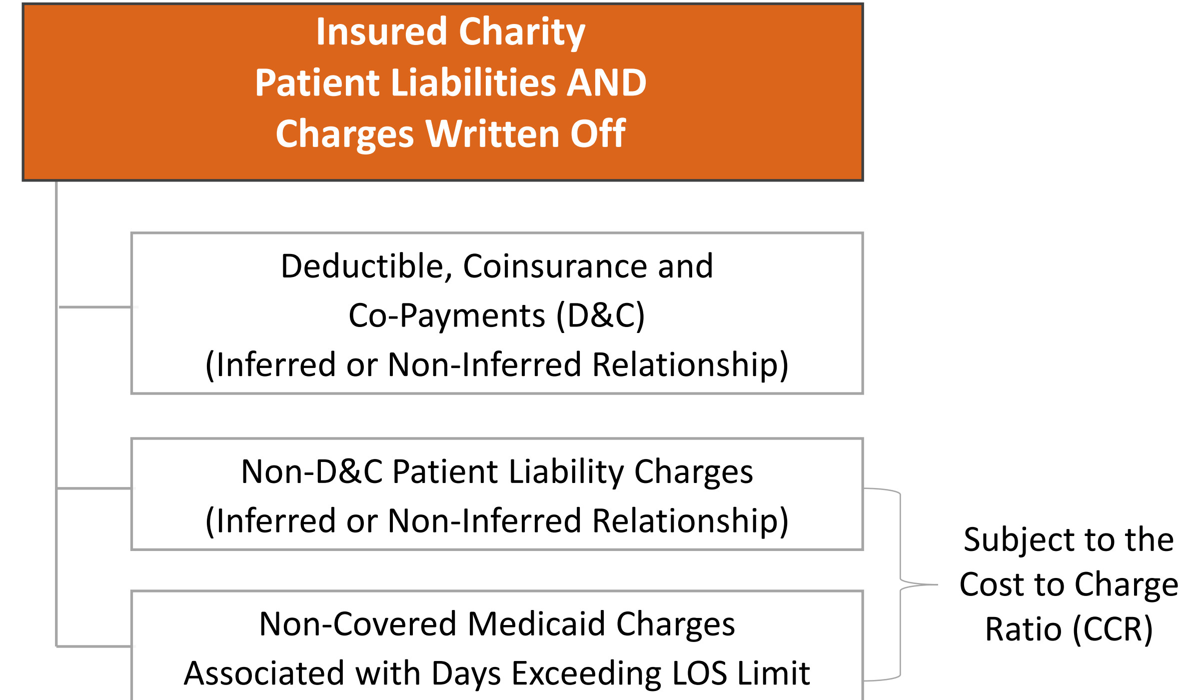
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/items-and-services-not-covered-under-medicare-booklet-icn906765.pdf

Section 1862(a)(1)(A) of the SSA - No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. (https://omb.report/icr/202206-0938-017/doc/122449600)

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Charity Care Clarifications





Updated Requirements for reporting on Worksheet S-10:

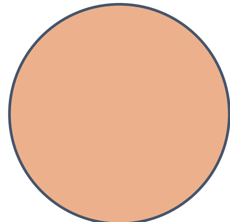
- Procedure follows language in the **written** Financial Assistance Policy (FAP)
- Excludes Medicare bad debt claims, Medicaid shortfalls, professional charges, prompt pay, courtesy discounts, **contractual allowances**
- Excludes charges related to claims paid by **HRSA Uninsured Provider Relief Fund** (CARES Act)
- Services must be **medically necessary**

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

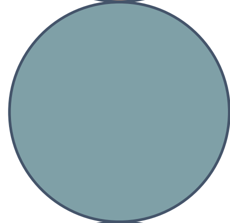
Charity Care Clarifications

Insurance Not Under Contract with Hospital

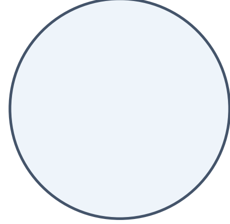
OMB Responses to Initial Comments



Can be more than a deductible, coinsurance or co-payment



Any balance beyond the patient liability is considered a contractual allowance and may not be written off to charity care



Partial patient liability is allowable as charity care where a hospital does not accept the amount as payment in full

Inferred Contractual Relationship - *"…where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient (for example, payments from workman's compensation funds, payments from an automobile insurer for medical benefits, or payments from an insurer for out-of-network services)."*

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Charity Care Updates

Insurance Not Under Contract with Hospital

Provider Example

OMB Responses to Initial Comments

Description	Amount	Worksheet S-10 Line (if specified in FAP)
Total Charges	$20,000	
Payment from Insurer	(12,000)	
Patient Liability of Charges	8,000	*Line 20, Col 2 & Line 25.01 Col 1* *Subject to CCR*
Patient Deductible	1,000	*Line 20, Col 2* *Not Subject to CCR*

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Charity Care Listing (Exhibit 3B)

EXHIBIT 3B

TITLE	CHARITY CARE CHARGES
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
UNINSURED COLUMN 20	
INSURED COLUMN 20	

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

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

*Non-Physician Portion = Col 9/ (Col 9+Col 10) | Not specified in proposed instructions

- DSH eligible hospitals only
- Sole Community Hospitals (SCH) file Exhibit 3B if DRG Payments Exceed Hospital Specific Rate (HSR) Payments
- For each CMS Certification Number (CCN) in the hospital complex
- Must be submitted with cost reports for cost reporting periods beginning on or after October 1, 2022

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Charity Care Listing (Exhibit 3B)

Notable Columns

Insurance Status (Exhibit 3B, Col. 6)

Used to Group and Reconcile to Worksheet S-10 Line 20 Columns 1 and 2

1 – Patient uninsured

2 – Patient insured, but not covered:

- ✓No Contractual Relationship
- ✓Medicaid Not Covered |Exhausted Benefits
- ✓Insured Not Covered
- ✓Insured Exhausted benefits

3 – Patient insured

What if a patient falls under more than one category?

*Insurance status at the time services were provided

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Charity Care Listing (Exhibit 3B)

Notable Columns

Total Charges (Col 9)
- Exclude physician/prof. charges

Professional Charges (Col 10)
- Only report if physician/prof. charges included in Col 9

D&C Amounts (Col 11)
- Patient Liability of patients in Charity listing
- All D&C: charity and non-charity

Insured C/A Amount (Col 13)
- Insured Charity patients only
- C/A amts: primary and secondary payors

Tip

Include a workpaper note on what is considered in the C/A amt

Non-Covered Charges (Non-Allowable) (Col 14)
- Not in FAP
- Not Medically Necessary
- Courtesy Discounts
- Admin. Adjustments
- Denial Adjustments

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Charity Care Listing (Exhibit 3B)

Notable Columns

A	B	C	D = A+B+C	E
Uninsured Discounts (Col 17)	**Charity Care Non-Covered Charges (Col 18)**	**Other Charity Care Charges (Col 19)**	**Charity and Uninsured Discounts (Col 20)**	**Write-Off Date (Col 21)**
Per FAP - Charity and Uninsured Discounts for **Uninsured Patients only**	*Per FAP* - Medicaid Non-Covered per FAP - Charges related to Exhausted Benefits	*Per FAP* - Any other allowable charges	- Ins Codes 1, 2 Reconcile to WS S-10 L 20 C 1 - Ins Code 3 Reconcile to WS S-10 L 20 C 2	**- OMB Response** to Initial Comments: “multiple write-off dates…separated by a semi-colon”

Tip

Indicate patients uninsured for part of the stay in detail

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Total Bad Debt Listing (Exhibit 3C)

- DSH eligible hospitals only
- SCHs file listing if DRG Payments Exceed HSR Payments
- For each CCN in the hospital complex
- Must be submitted with cost reports for cost reporting periods beginning on or after October 1, 2022
  - Per **OMB Responses** to *Initial Comments*: “The proposed Exhibit 3C listing is not required for an acceptable cost report submission…”
- Medicare patients may be included even when an account does not meet the Medicare bad debt criteria

EXHIBIT 3C

TITLE	TOTAL BAD DEBTS
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 17	

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

*F = A – (B+C+D+E)

	A		B	C	D	E		*F
SERVICE INDICATOR (IP / OP)	TOTAL CHARGES	TOTAL PHYS-ICIAN / PROFES-SIONAL 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

*Non-Physician Portion = Col 10/ (Col 10+Col 11))

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Bad Debt Clarification

Worksheet S-10 Line 26

- Medicare and Non-Medicare
- Net of all recoveries received during the cost report Year
- Excludes professional services; amounts reported as charity care; and obligations of insurer
- T18 bad debt Includes Implicit Price Concessions (ASC Topic 606 Revenue Recognition)

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Total Bad Debt Listing (Exhibit 3C)

Notable Columns

Insurance Status (Col 9)

1 – Patient uninsured

2 – Patient insured, but not covered*

3 – Patient insured

Charity Amt (Col 14)

Report all charity care associated with the account, regardless of the charity care write-off date

C/A | Other Amt (Col 15)

Tip:

Include a workpaper note what is included or excluded as the C/A amt

A/R Write-Off Date (Col 16)

Tip:

Include a workpaper clarifying hospital definition of write-off date

Outstanding:

Will CMS clarify if it is needed to report each date separated by a semi-colon?

*Medically necessary but not covered, no contractual relationship or exhausted benefits

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Total Bad Debt Listing (Exhibit 3C)

Column 17 Patient Bad Debt Write-Off Amount: Hypothetical Example

Description	Exhibit 3C Col			Amount	Key
Total Charges	Col 10			12,000,000	*A*
Prof. Charges	Col 11			1,300,000	*B*
Total Charges Less Prof Charges				**10,700,000**	***C***
Physician Ratio				**90%**	***D***

		E	*F = C*	*G = E*F*	
Description	**Exhibit 3C Col**	**Amount**	**Physician Ratio**	**Line 17 Calc**	**Key**
Total Third-Party Payments	Col 12	(3,000,000)	90%	(2,700,000)	*H*
Insured C/A Amount	Col 13	(5,000,000)	90%	(4,500,000)	*I*
Other Non-Billable Amounts	Col 14	(500,000)	90%	(450,000)	*J*
Total Patient Payments	Col 15	(1,500,000)	90%	(1,350,000)	*K*
Total		**(10,000,000)**		**(9,000,000)**	***L = Sum H:I***
Total Bad Debt	**Col 17**			**1,700,000**	***M = C+L***

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Uncompensated Care Factor 3

Worksheet E Part A Line 35.01

FFY 2023

Factor 3

- FFY 2018 UC Cost
- FFY 2019 UC Cost

New DSH Hospital On After 10/1/2019

- Numerator = UC Cost from FFY 2023 WS S-10
- Denominator = $34,463,223,233

FFY 2024 and Forward

Factor 3

- Three most recent years of audited UC Costs (i.e., FFY 2018, FFY 2019 and FFY 2020)

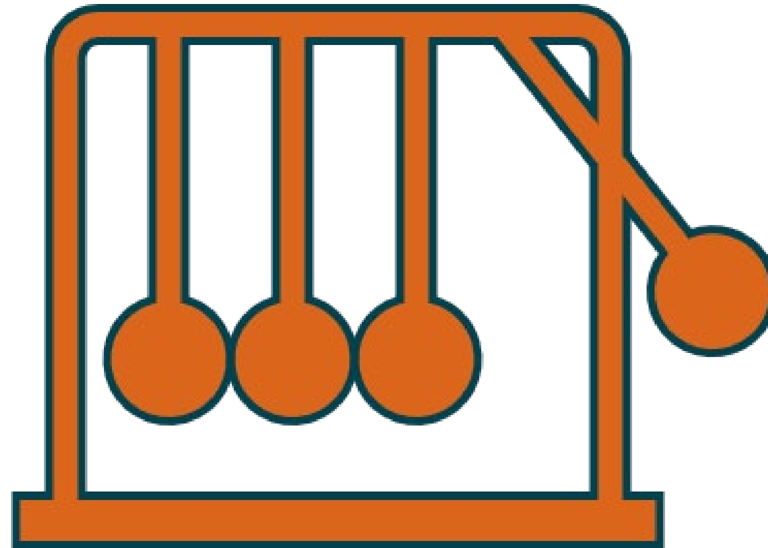
New DSH Hospitals

- DHS eligibility is after most recent UC cost audit
- Numerator = UC Cost from Cost Report
- Denominator = DSH Supplemental public use file

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Section II

Empirical DSH



Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Empirical DSH Medicaid Eligible Days (Exhibit 3A)

EXHIBIT 3A

TITLE	MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL
PROVIDER NAME	
CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
WS S-2, PT. I, LINE #	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMNS 10 &12	
TOTAL COLUMN 11	

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 POPU-LATION 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

- DSH eligible hospitals only
- SCHs file Exhibit 3A if DRG Payments Exceed HSR Payments
- For each CCN with days reported on WS S-2, Part I, line 24 or line 25
- Must be submitted with cost reports for cost reporting periods beginning on or after October 1, 2022

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Empirical DSH Listing (Exhibit 3A)

Notable Columns

Medicaid Number (Col 6)

- For a Medicaid eligible newborn baby, report the Mother's Medicaid Number

State Eligibility Code (Col 7)

- Enter the State plan eligibility code, if available
- Include the valid code per the respective state

Patient Population Code (Col 8)

- Not in the proposed Exhibit 3A
- Unrestricted Medicaid eligible with full benefits

or

- Limited | Restricted Medicaid eligibility

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Empirical DSH Listing (Exhibit 3A)

Notable Columns

WS S-2 Pt. I Column Number (Col 9)

Cols 1 – 6 Reconcile to WS S-2 Line 24 and 25

Eligible Days (Col 10)

- Reconcile to days reported on S-2, lines 24 and 25, columns 1 through 5
- Sum of days in Col 10 must equal WS S-2 Pt I Cols 1-5

L&D Days (Col 11)

- Reconcile to days reported on S-2, line 24, column 6

Newborn Days (Col 12)

Col 12:

Newborn eligible days prior to the Medicaid eligible mother's date of discharge

No direction from CMS to report corresponding days on WS S-2

Col 10:

If the Medicaid eligible mother was discharged and the newborn baby remained in the hospital

A/B Indicator (Col 15)

- If eligible for only Medicare Part A, enter "A"
- If eligible for both Part A and Part B, enter "A"
- If eligible for only Medicare Part B, enter "B"

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Empirical DSH Listing (Exhibit 3A)

Notable Columns – Newborn Days (Col 12)

Example 1

Mother A
Admitted on 6/1/2023 and discharged on 6/3/2023. Two days are reported in column 10.

Newborn A
Admitted on 6/1/2023 and discharged on 6/3/2023. Two days are reported in column 12.

Example 2

Mother B

Admitted on 6/1/2023 and discharged on 6/3/2023. Two days are reported in column 10.

Newborn B

Admitted on 6/1/2023 and discharged on 6/7/2023. This newborn stay will be reported on two separate lines.

- The first three days are reported in column 12 (6/1, 6/2, 6/3).
- The three days that occurred after the mother's discharge date are reported in column 10 (6/4, 6/5, 6/6) on a separate line.
- Both lines will use the same patient account number in column 5.

S-2 Days (Days for DSH calculation) are Sum of Exhibit 3A Cols 10, 11 and 12.

However, T18 instructions appear to inadvertently exclude Col 12 (Newborn Days). Toyon anticipates CMS to clarify with something like:
For example, if the listing supports days for Worksheet S-2, Part I, line 24, then the sum of the days reported in column 10 (***plus newborn days in column 12)*** must equal the days reported on Worksheet S-2, Part I, line 24, sum of columns 1 through 5

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medicare DSH Eligible Days

Worksheet S-2 Line 24 (IPPS) and Line 25 (IRF)

Includes 1115 Waiver Days

- Col 1 - In State Paid Medicaid Days
- Col 2 – In State Medicaid Unpaid Eligible Days
- Col 3 – Out of State Medicaid Paid Days
- Col 4 – Out of State Medicaid Unpaid Eligible Days
- Col 5 – Medicaid HMO Paid and Eligible Days (In State and Out of State)
- Col 6 – Other Medicaid Days (Labor and Delivery)

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Section III

Medicare Bad Debt

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medicare Bad Debt Listing

EXHIBIT 2A

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY 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 COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE AMOUNT*	MEDI-CARE CO-INSUR-ANCE AMOUNT*	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medicare Bad Debt Summary (Exhibit 2A)

This requirement is for a cost report beginning on or after October 1, 2022

Complete separate exhibits for inpatient and outpatient bad debt

A separate exhibit needs to be completed for each CCN

Total dual eligible is the sum of amount in ~~column 24~~ ***column 23*** where column 7 has an entry

EXHIBIT 2A

TITLE	*MEDICARE BAD DEBTS*
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medicare Bad Debt Listing (Exhibit 2A)

Patient Demographics (Cols 1 – 6)

- Per Medicare Beneficiary's bill

Medicaid Number (Col 7)

-Only required for dual-eligible (Medicare/Medicaid crossover) patients.

- If this column is populated, column 10 will be populated as well.

Provider Deemed Indigent (Col 8)

- "Y" if the Medicare beneficiary was not eligible for Medicaid but determined to be indigent/charity.

- If not, "N"

Remittance Advice Detail (Cols 9 – 11)

- Medicare Remittance Advice Date (Col 9)

- Medicaid Remittance Advice Date (Col 10*)

- Secondary Payer RA Received Date (Col 11)

Providers may enter "AD" in column 10 if alternate documentation was used to determine the state liability for the Medicare/Medicaid dual-eligible patient

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medicare Bad Debt Listing (Exhibit 2A)

Beneficiary Resp. Amt (Col 12)

- Medicare beneficiary D&C responsibility
- If Quality Medicare Beneficiary, then enter "QMB"
- If Dual Eligible, and not QMB, then enter amt per state cost sharing agreement*
- If indigent ("Y" in Col 8), then $0

Date Sent to First Beneficiary (Col 13)

- Report blank if the patient was not billed
- If the beneficiary is a QMB, enter "QMB."
- Date of the first bill must be issued within 120 days of the latter:

a. Date of Medicare R/A that results from processing the claim for services furnished to the beneficiary and generates the beneficiary's cost sharing amounts

b. Date of the R/A from the beneficiary's secondary payer, if any

c. Date of notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary

*Bad debts, charity, and courtesy allowances at 42 CFR 413.89(e)(2)(iii))
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.89

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medicare Bad Debt Listing (Exhibit 2A)

Collection Efforts and Write-Off Dates May be the Same (Cols 14 – 17)

- A/R Write Off Date
(Col 14)

Date that the beneficiary's liability was written-off A/R

- Sent to Collection Agency (Y/N)
(Col 15 A)

If Col 15A is "Y," a date must be entered in Col 15

- Return from Collection Agency Date
(Col 15)

- Collection Effort Ceased Date
(Col 16)

- Date all collection efforts ceased, including efforts to collect from Medicaid and/or the state

- Medicare Write-Off Date
(Col 17)

- Date D&C were written off as a Medicare bad debt (written off as bad debt against the A/R); all collection efforts ceased; and a Medicaid remittance advice was received from the state for Medicaid patients

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Medicare Bad Debt Listing (Exhibit 2A)

Recoveries (Cols 18 – 19)

- Recoveries Only: Amount Received (Col 18)
- Recoveries Only: MCR FYE Date (Col 19)
- Enter any recovery or payment received for a patient balance that was already written off

C&D (Cols 20 – 21)

- Medicare Deductible Amount (Col 20)
- Medicare Coinsurance Amount (Col 21)
- Report only if provider billed patient with expectation of payment
- Do not report for dual eligible or indigent patients as providers do not expect payment
- Additional clarification needed as Col 23 needs to be less than amounts in this column

Pmts Prior to Write-Off (Col 22)

- Report any payment received, from the patient, an estate, third-party insurance, etc.

Allowable Bad Debts (Col 23)

- Must be less than or equal to the D&C in Cols 20 and 21, less any payment reported in columns 18 and 22
- For each CCN, the amount in Col 23 must equal bad debt on the Medicare cost report

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Section IV

Graduate Medical Education

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Graduate Medical Education

- **Transmittal 18 includes new cost report lines & instructions on Worksheets S-2 and E-4 for the new DGME weighted FTE count**

  Based on the ruling in Hershey v. Becerra, for cost reporting periods beginning on or after October 1, 2001, CMS will change a hospital's weighted FTE count to equal the FTE cap if a hospital's:

  - ❑ unweighted FTE count exceeds the FTE cap, and
  - ❑ weighted FTE count also exceeds the FTE cap.

Description	Prior Calculation (Weighted Count Reduced Via Formula)		New Calculation (Weighted Count Allowed Up To Cap)	
Unweighted FTE Cap	100.00	A	100.00	A
Unweighted FTE Count	120.00	B	120.00	B
Ratio of Cap to Total FTEs	**0.83**	**C=A/B**	**0.83**	**C=A/B**
Weighted FTE Count	105.00	D	105.00	D
Allowed Weighed FTEs	**87.50**	**E = C*D**	**100.00**	**E = Capped at A**

- **Worksheet S-2, line 68 asks if permission was obtained from the MAC to apply the formula correction on cost reports <u>prior to FFY 2023</u>.**
- Toyon recommends teaching providers impacted by this change –
  - ❑ Determine the eligible years and impacts of all cost reports with no Notice of Program Reimbursement (NPR), as well as cost reports within the **180-day** appeal window.
  - ❑ Set expectations that open cost reports will be corrected for the new weighted FTE calculation before the MAC issues an NPR.

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Graduate Medical Education

Changes per the Consolidated Appropriations Act, 2021

CAA Section	T18 Cost Report Update
Sect 126 - Provides 1,000 new resident FTE cap slots over five years (200 per year) to qualifying teaching hospitals that begin new programs or formally expand programs.	Worksheet E part A Line 8.21 (Indirect GME) and Worksheet E-4 Line 4.21 (Direct GME) to record and recognize the awarded Sec. 131 slots.
Sec. 127 - Makes changes to the rural training track (RTT) rules to increase flexibility in the partnership of urban and rural hospitals in order to expand the use of RTT programs in family medicine and other specialties.	Worksheet E part A Lines 6.26 and Worksheet E-4 (Direct GME) Line 2.26 are established to record the rural track program FTE cap limitation adjustment after the cap-building window has closed for the particular rural track program. Worksheets E Part A Line 16 and E-4 Line 15 adjust current year FTEs for these FTEs during the cap building process.
Sec. 131 - Provides opportunities for certain qualifying hospitals to reset per-resident amounts (PRA) and/or FTE caps (PRAs and caps established using less than 1 FTE before FFY 1998, or less than 3 FTEs after FFY 1998).	Worksheet E part A Lines 5.01 and 16 (Indirect GME) and Worksheet E-4 Lines 1.01, 15 and 18.01 (Direct GME) capture these adjustment to the FTE caps and PRA.

Worksheet E Part A Line 7.02 (Indirect GME) and Worksheet E-4 Line 3.02 are established to adjust for a hospital’s rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement (per 87 FR 49075, August 10, 2022).

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Section V

Organ Acquisition

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

WS D-4, Solid Organ Acquisition Costs

12-22 FORM CMS-2552-10 4090 (Cont.)

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM	PROVIDER CCN: ______ OPO CCN: ______	PERIOD: FROM ______ TO ______	WORKSHEET D-4, PARTS III & IV

Check applicable box: [ ] HEART [ ] KIDNEY [ ] LIVER [ ] LUNG [ ] PANCREAS [ ] INTESTINE [ ] ISLET

PART III - SUMMARY OF COSTS AND CHARGES

		Cost		Charges		
		Part A	Part B	Part A	Part B	
		1	2	3	4	
56	Routine and ancillary from Part I					56
57	Interns and Residents (inpatient)					57
58	Interns and Residents (outpatient)					58
59	Direct organ acquisition (see instructions)					59
60	Cost of physicians' services in a teaching hospital (see instructions)					60
61	Total (sum of lines 56 through 60)					61

			Usable Organs			
		1	2	3	4	
62	Total usable organs (see instructions)					62
63	Medicare usable organs (see instructions)					63
64	Ratio of Medicare usable organs to total usable organs (*see instructions*)					64

		Cost		*Charges*		
		Part A	*Part B*	*Part A*	*Part B*	
		1	*2*	*3*	*4*	
65	Medicare Cost *and* Charges (see instructions)					65
66	Revenue for organs sold (*see instructions*)					66
66.01	*Partial primary payor amounts applicable to organ acquisition*					*66.01*
66.02	*Partial primary payor amounts applicable to transplants (informational only)*					*66.02*
67	Subtotal (*see instructions*)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)					69

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

WS D-4, Solid Organ Acquisition Costs

PART IV - STATISTICS

70	Organs excised in provider [1]
71	Organs purchased from other transplant hospitals [2]
72	Organs purchased from non-transplant hospitals
73	Organs purchased from OPOs *(see instructions)*
74	Total (sum of lines 70 through 73)
75	Organs transplanted
75.01	*Organs transplanted into Medicare beneficiaries*
75.02	*Kidneys transplanted into MA beneficiaries*
75.03	*Organs transplanted, Medicare secondary payer*
75.04	*Organs transplanted, Other (see instructions)*
76	Organs sold to other *(non-transplant)* hospitals
77	Organs sold to OPOs
78	Organs sold to transplant hospitals
79	Organs sold to MRTC *without an agreement* or VA hospitals
79.01	*Kidneys sold to MRTC with an agreement*
80	Organs sold outside the U.S.
81	Organs sent outside the U.S. (no revenue received)
82	Organs used for research
83	Unusable/Discarded organs *(see instructions)*
84	Total *(see instructions)*

[1] Organs procured outside your center by a procurement team from your center are not included in the count.
[2] Organs procured outside your center by a procurement team from your center are included in the count.

- Subscripts for line 75 for transplant statistics
- Separate reporting for:
  - Medicare
  - Medicare Advantage
  - Medicare Secondary Payer
  - All Other

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Allogeneic Bone Marrow Transplant

Inpatient

- One week prior and 2-3 weeks after the procedure
- High doses of chemotherapy to prepare for transplant
- Transplant involves receiving donated cells through an IV catheter or tube

Outpatient

- Patients stay at home (or nearby hotel)
- Determination on a case-by-case basis
- On transplant day, patient undergoes full course of treatment
  - Pre-transplant evaluation
  - Conditioning
  - Infusion of stem cells
  - Engraftment and recovery

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

IPPS Payment

MS-DRG	Description	FY 2021	FY 2022	FY 2023
14	Allogeneic BMT	12.7788	10.6770	11.1930
16	Autologous BMT W CC/MCC or T-Cell	6.7262	6.7363	6.0844
17	Autologous BMT W/O CC/MCC	4.8302	4.8557	4.3701

Allogeneic = Stem cells collected from a donor

Autologous = Uses one's own stem cells

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

OPPS Payment

CPT	Description	APC	FY 2023 *
38240	Transplant Allo HCT/Donor	5244	$42,233.40
38241	Transplant Autol HCT/Donor	5242	$1,359.84

Allogeneic = Stem cells collected from a donor

Autologous = Uses one's own stem cells

* January 2023 Addendum B

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Allogeneic Bone Marrow Transplant

Local Donors

OR

Unknown Donors

BE THE MATCH®

Transplant Recipient

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

WS D-6, Allogeneic Stem Cell Acquisition Costs

- Effective for cost reporting periods beginning on or after October 1, 2020
- Enter Live Donor hospital days/charges associated with the collection procedure
- Preparation/processing of stem cells derived from:
  - Bone marrow
  - Peripheral blood stem cells
  - Cord blood
  - Excludes embryonic stem cells

PART I - INPATIENT ROUTINE AND ANCILLARY SERVICES CELLULAR THERAPY ACQUISITION COSTS

	Inpatient Routine Services Acquisition Costs	Routine Services Acquisition	Per Diem Costs (see instructions)		Inpatient Acquisition Days	Acquisition Costs (col. 2 x col. 3)
		1	D-1	2	3	4
1	Adults and Pediatrics	125,000	38	1,265.00	25	31,625
2	Intensive Care	80,000	43	1,969.00	10	19,690
3	Coronary Care		44			
4	Burn Intensive Care Unit		45			
5	Surgical Intensive Care Unit		46			
6	Other Special Care (specify)		47			
7	Total (sum of lines 1 through	205,000			35	51,315

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

WS D-6, Allogeneic Stem Cell Acquisition Costs

- Enter Live Donor hospital charges associated with the collection procedure
  - O/R and other ancillary services
  - Apheresis services
  - Post-operative/ post-procedure evaluation of donor

PART I - INPATIENT ROUTINE AND ANCILLARY SERVICES CELLULAR THERAPY ACQUISITION COSTS

	Ancillary Services Acquisition Costs		Ratio of Cost to Charges (from Wkst. C, Pt. I, col. 9)	Inpatient Ancillary Services Acquistion Charges	Outpatient Ancillary Services Acquistion Charges	Inpatient Ancillary Services Acquistion Cost	Outpatient Ancillary Services Acquistion Cost
		C	1	2	3	4	5
8	Operating Room	50	0.223572	100,000	7,500	22,357	1,677
9	Recovery Room	51	0.392939	12,000	3,000	4,715	1,179
10	Labor Room & Delivery Room	52					
11	Anesthesiology	53	0.078721	20,000	2,500	1,574	197
12	Radiology-Diagnostic	54	0.159487	6,000	1,000	957	159
18	Laboratory	60	0.107503	10,000	3,000	1,075	323
20	Whole Blood & Packed Red Blood Cells	62	0.234070	25,000	5,000	5,852	1,170
24	Medical Supplies Charged to Patients	71	0.156421	8,000	1,200	1,251	188
25	Drugs Charged to Patients	73	0.129599	11,500	1,600	1,490	207
28	Total (sum of lines 8 through 27)			192,500	24,800	39,272	5,100

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

WS D-6, Allogeneic Stem Cell Acquisition Costs

COMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS		PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-6, PART III	
PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS					
			Amount		
1	Acquisition cost from Worksheet B, col. 26 (see instructions)		1,200,000		1
	Acquisition Services Total Costs		Inpatient	Outpatient	
			1	2	
2	Routine and ancillary		90,587	5,100	2
3	Interns and residents				3
4	Apportionment of acquisition cost from line 1		826,230	373,770	4
5	Cost of physicians' services in a teaching hospital (see instructions)				5
6	Total acquisition cost (sum of lines 2 through 5)		916,817	378,870	6
	Determine Ratio of Medicare Transplants to Total Transplants	Inpatient	Outpatient	Total	
		1	2	3	
7	Total transplants (see instructions)	42	19	61	7
8	Medicare transplants (see instructions)	5	2		8
9	Ratio of Medicare to total (line 8 ÷ line 7)	0.119048	0.105263		9
10	Medicare cost (see instructions)	109,145	39,881		10
PART IV - STATISTICS					
1	Number of recipients intended for allogeneic HSCT where the acquisition cost was incurred but the transplant did not occur (see instructions)			3	

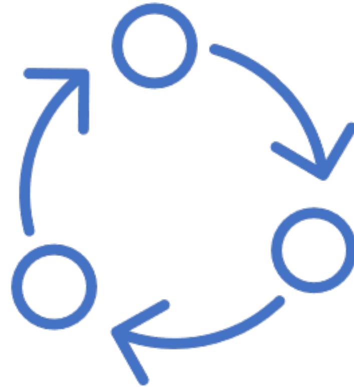
Direct costs are apportioned based on Line 7 total transplants

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

WS D-6, New Processes

Hospital Days/Charges

- Flag hospital accounts for living donors
- All payors (guarantor is recipient's insurance)
- Account for all days/charges related to the donation
- Segregate between inpatient and outpatient services



Transplant Counts

- Total BMT Allogeneic Transplants by patient
- Identify as IP or OP
- Identify as Medicare and non-Medicare
- Obtain number of aborted BMT Allo Transplants where acquisition costs were incurred

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Section VI

Other Notable Updates

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Other Proposed Cost Report Changes

PHE Expiration **May 11, 2023**	An Announcement on February 9, 2023 from HHS (Transition Roadmap) states to the PHE is planned to expire at the end of the day on May 11, 2023. *"Certain Medicare and Medicaid waivers and broad flexibilities for health care providers are no longer necessary and will end."* Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19 and CMS COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers tracks each of the flexibilities that has ended or will end at the expiration of the PHE.
Cost Reporting: **Beds**	Providers report COVID-19 PHE acute care beds on Worksheet S-3 Part I, Line 34. Reduce the bed count on Worksheet E Part A (used for IME reimbursement) by *"the number of temporary expansion COVID-19 PHE acute care bed days (Worksheet S-3, Part I, column 3, line 34)."*
Cost Reporting: **Subacute Teaching Adjustments**	Inpatient Psychiatric Facility (IPF) and Inpatient Rehabilitation Facility (IRF) teaching adjustments result from the higher of the calculated teaching adjustment factor or the teaching adjustment factor for the cost reporting period immediately preceding February 29, 2020.

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Other Notable T18 Cost Report Changes

TEFRA Adjustment **WS S-2 L 188 and 189** **WS D-1 Pt. I L 55.01 and 55.02**	Recording of permanent adjustments to the TEFRA target amount per discharge.
Purch. Admin Services **WS S-2 Line 123**	Identification of providers purchasing greater than fifty percent of its professional services from an unrelated organization located outside the main hospital's local area labor market. Per OMB – ***"to obtain a more recent estimate of the proportion of legal, accounting and auditing, engineering, and management consulting services that meet our definition of labor-related services"***
Sequestration Calculations Updated	Formulas in respective settlement schedules are updated to prorate sequestration during and after the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021 (PAMA).
Medicare Opioid Costs **WS A Line 102**	Cost reporting periods ending on or after January 1, 2022. CMS Pub. 100-02, Medicare Benefit Policy Manual, chapter 17.
Outlier Recon at Tentative Settlement **WS E-5**	MAC use only | Cost reporting periods beginning on or after October 1, 2020.

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Other Notable T18 Cost Report Changes

Drugs Charged to Patients **WS A L 73**	If the working trial balance and GL directly allocates the costs of non-chargeable drugs to the departments/cost centers in which they are used, and these expenses are reported in those cost centers on Worksheet A rather than in the pharmacy cost center (line 15): - report the expenses included in the GL account/sub-account identified as chargeable drugs in column 2. - In this situation, only the operating costs of the pharmacy will remain in the pharmacy cost center and will be equitably allocated in col 15 of WS B (Drugs Charged to Patients) and other cost centers that used the non-chargeable drugs using the recommended statistical allocation basis of costed requisitions.
CHART Model Reimbursement	Information collected throughout Information collection for the Community Health Access and Rural Transformation (CHART).
Renal Dialysis Costs	Worksheet I-1 Costs for cost of total dialysis supplies used in furnishing dialysis services (Line 14) and supplies used exclusively for pediatric patients (Line 14.01) .
End Stage Renal Disease (ESRD) Pmts	Worksheet I-5 Part III Lines 16 through 20 payment information on the T*ransitional Drug Add-on Payment Adjustment Amount* similar programs (from the PS&R).
Low Volume Adjustment (LVA) **Medicare Dependent Hospital (MDH) Status**	**UPDATED:** LVA extended through 9/30/2025; and MDH extended through 9/30/2024 https://www.congress.gov/bill/117th-congress/house-bill/2617/text

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved

Thank you

Fred Fisher
Vice President, Service Development
Uncompensated Care Recognition Services
fred.fisher@toyonassociates.com

Tom Hubner
Vice President
Graduate Medical Education
tom.hubner@toyonassociates.com

Dylan Chinea
Senior Director
Medicare DSH and Bad Debt
dylan.chinea@toyonassociates.com

Robert Howey
Senior Director
Cost Reporting | Organ Acquisition
robert.howey@toyonassociates.com

toyonassociates.com

888.514.9312

Copyright © 2023 Toyon Associates, Inc., All Rights Reserved