Medicare Cost Report Issues
Update & Audit Survival Tips

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2012 Mid-Winter Conference, Orlando, FL
Florida Chapter HFMA
January 18-20, 2012

Learning Objectives

- Update of selective Medicare cost report issues
- Suggestions for cost report preparation and audit survival
Discussion Items

- Enrollment Revalidation
- Wage index
- Bad Debts
- Medicare disproportionate share
- Worksheet S-10
- Cost Report Tips

Enrollment Revalidation

- Applicable to providers enrolled in Medicare prior to March 25, 2011
- Over 1.5 million revalidations will be required over a long-term phased process
- 89,000 letters sent in mid-October
- Contractors will be sending letters and these should be in a different color envelope
- Do not submit a revalidation application until asked to do so by the Medicare Contractor
- Enrollment application fee will apply – 2012 fee is $523
- RESPOND timely to avoid deactivation and delay in payment; 60 day response time
Wage Index

- No current year reimbursement effect but …
- Critical to future payments
- Contractors are currently reviewing and preparing the FY 2013 wage reviews based upon cost reports beginning on or after 10/1/2008 – 9/30/2009

Wage Index Timeline

- October 4, 2011 – CMS release as filed data
- December 5, 2011 – Deadline for hospital to request revision to the released files
- February 8, 2012 – Deadline for MAC to complete reviews
- February 13, 2012 – Deadline for MAC to notify State hospital associations
- February 21, 2012 – Release of revised wage files by CMS
Wage Index Timeline

- **March 5, 2012** – Deadline for hospital to submit corrections to errors in released files
- **April 11, 2012** – Deadline to submit final revised wage files
- **April 18, 2012** – Deadline for hospital to submit intervention request
- **August 1, 2012** – Publication of FY 2013 wage index data
- **October 1, 2013** – Effective date

Wage Index Tips

- File this correctly on the initial cost report
  - Worksheet is usually completed last
  - Directly impacts reimbursement
  - Complex schedule
  - While you may not have a full “audit” on wage index, it is reviewed by many different groups – MACs, CMS, OIG, MedPAC
- Respond timely to any requests
- Ensure that you are getting your share
  - Dollars must have hours
  - Hours – inclusion/exclusion
  - Contract Labor
**Wage Index – What to consider**

- **Hours**
  - Include all **paid** hours
  - Excluded
    - on-call hours
    - shift differential hours
    - bonus hours
    - unpaid hours (leave of absence, disability, family medical leave)
    - buy/sell back PTO
    - hours for capitalized salaries
    - Baylor plan (work 36 but pay 40 – exclude the 4 hours)
    - holiday pay (when they are working the holiday, too – no double counting)

- **Contract Labor and Hours**
  - Documentation to support the dollars and hours
  - Have your vendors specify professional fees and hours on the invoices
    - Audit, tax, consulting, dialysis, legal, cost report preparation, IT, data processing
  - No hours – no cost
  - Ensure you classify the cost correctly – excluded unit cost on proper line
Wage Index – What to consider

- Wage Related Cost
  - Make sure you are looking at all possible wage related cost
  - If in doubt, check with your MAC
- Compare your data from year to year on your report
- Compare your data between years when the public use files are released
- Consider comparing all of the hospitals in your area between years

Wage Index – Changes

- Teaching Facilities – Proper reporting of FICA refund for residents
  - Change Request 7685, dated 12/30/11 and 1/6/12, Transmittal R1014OTN
  - Difference in reporting of cost and of wage index
Wage Index – Changes

- Exception to December 5, 2011 deadline – can only make revision for FICA refund issue
- Hospitals have 30 days from the date of the Change Request to make any changes necessary to the FY 2009 cost report for the wage index change (deadline of January 30, 2012)
- Contractors should be issuing instructions

Medicare Bad Debts

- Must not be at a collection agency for any reason in order to be claimed on the cost report
- Must bill any other party responsible (i.e., Medicaid with remittance advice)
- Must be written off
- Maintain remittance advices and/or access to them
- Medicare Advantage should not be included
- Fee reimbursed services (therapies and ambulance) should not be included
Medicare Bad Debts

- Collection process
  - Documentation, documentation, documentation
  - Deceased person – make sure that you contact probate and document the response
  - Indigent determination – ensure that you have support
    - analysis of assets and liabilities
    - documentation to support income and expenses
    - determined by provider not beneficiary
  - Any payment received restarts the 120 day clock

Medicare Bad Debts – Collection Agency Clarification

- Clarification of Bad Debt Policy related to collection agencies was published 6/30/08 in MLN Matters Article SE0824
- Providers must follow all of the Criteria for Allowable Bad Debts set out at 42 CFR 413.89(e) and Sections 308 and 310 of the Provider Reimbursement Manual (CMS Pub 15-I)
- Provider must establish that reasonable collection efforts were made and that the debt is uncollectible when claimed as worthless and there is no likelihood of recovery in the future
Medicare Bad Debts – Audit Tips

- Listing contains all data that MAC requires
  - Separate identification of Medicare crossovers for reporting
- Foot and crossfoot your listings
- Electronic file needs to be “print ready” when submitted
- Review and test your policy and procedure
  - Is your staff following the written policy?
  - Internal Audit or External Review
  - Pull samples and test
- Look at the listing throughout the year
- Are you capturing everything?
- Have the rules changed?
- Similar collection efforts for all payors - even at the collection agency

Medicare Bad Debts – Future
What will Happen?

- Proposals for years to reduce or eliminate bad debt reimbursement
- There is a House proposal to reduce payments from 70% to 55% over a 3 year period (*Middle Class Tax Relief & Job Creation Act*) – hospitals, SNFs, and other providers
- The President’s proposal to reduce payments to 25%
- Not part of the *Temporary Payroll Tax Cut Continuation Act of 2011* (signed December 23, 2011)
- Best guess – Expect reduction of some type
Disproportionate Share Hospital

- SSI
- CMS Ruling 1498-R issued April 28, 2010
- FY 2011 Final Rule Changed the timeline for issuing future SSI%
- FY 2012 Final Rule Exclusion of Hospice Beds and Patient days from Medicare DSH Payment Calculation
- Future

Disproportionate Share Hospital

SSI
- Cost Reports are still not being final settled due to the CMS Instructions
- FY 2007 SSI – was supposed to have been released by end of calendar year 2011 – not issued as of January 10, 2012
- FY 2008 forward SSI
- FY 2011 Final Rule changed the timeline for issuing future SSI%
- Once the SSI data is released, CMS should issue instructions to the MAC on how the cost reports will be final settled and the timetable by which the MAC should settle the reports.
Disproportionate Share Hospital

CMS Ruling 1498-R

- Issued April 28, 2010
- Applies to three Medicare DSH Issues
  - Data Matching process for SSI%
  - Non-Covered Days prior to FY 2005 (exhausted and Medicare Secondary Payer days)
  - Labor and Delivery days prior to FY 2010
- Applies to appeals as well as open cost reports

Non-Covered Days Prior to FY 2005

- Patient Discharge before 10/1/2004
- CMS can resolve appeals for non-covered Inpatient Hospital days (i.e., MSP days) or exhausted Part A benefit days for person entitled to Medicare Part A
- Days will be included in the benefits days for the SSI fraction
- Contractors will re-calculate DSH
- Already included in SSI% for discharges on or after 10/1/04
- Will NOT be part of the Medicaid fraction
Disproportionate Share Hospital

Labor and Delivery Room Days (LDR)

- Effective 10/1/2009, LDR days may be included in the total and Medicaid days regardless of whether the patient has occupied a routine bed prior to occupying an ancillary LDR bed.
- CMS-1498-R made this 10/1/09 rule effective for pending appeals and open cost reporting periods beginning prior to 10/1/09.
- If Medicare LDR, they should be considered in the SSI%, if applicable, instead of the Medicaid fraction.
- Auditors should be adding in LDR days during current desk reviews if the DSH eligible days are scoped for review.
- If you need to correct LDR days in a cost report being held for SSI, ask your MAC how to handle. It will most likely be handled as a reopening after the report is settled for SSI.

Disproportionate Share Hospital

FYE 2011 Final Rule

- Revised Supplemental Security Income (SSI) data matching process
  - Model Baystate Case
  - Changing time that SSI% will be published (6 months going to 15 months)
  - Default SSI% will continue to be based on federal fiscal year end but providers may request their cost reporting period
- Medicare Part C days included since FY 2005 Final Rule (change request 6821)
- Medicare Part A Exhausted Benefit Days included
## Disproportionate Share Hospital

### Example of Timeline to Calculate FY 2011 SSI Fractions

<table>
<thead>
<tr>
<th></th>
<th>Former Process</th>
<th>FY 2011 Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost reports that use the FY 2011 SSI ratios</td>
<td>Cost reports beginning 10/1/2010 through 9/30/2011</td>
<td>Cost reports beginning 10/1/2010 through 9/30/2011</td>
</tr>
<tr>
<td>Deadline for timely filing of Claims</td>
<td>December 2012</td>
<td>9/30/2012 or 1 year from DOS, effective DOS 1/1/10</td>
</tr>
<tr>
<td>SSI eligibility file used</td>
<td>March 2012 update of FY 2011 SSI Eligibility</td>
<td>December 2012 update of FY 2011 SSI Eligibility</td>
</tr>
<tr>
<td>Cost reports normally accepted</td>
<td>Generally between March 2012 and February 2013</td>
<td>Generally between March 2012 and February 2013</td>
</tr>
<tr>
<td>Cost report final settlement</td>
<td>Generally between March 2013 and February 2014</td>
<td>Generally between March 2013 and February 2014</td>
</tr>
<tr>
<td>SSI fraction available</td>
<td>Summer 2012</td>
<td>Spring 2013 *</td>
</tr>
</tbody>
</table>

* Would be used to final settle cost reports with cost reporting period beginning 10/1/2010 through 9/30/2011.

Source: 8/16/2010 Federal Register, page 50281-50284

## Disproportionate Share Hospital

### FYE 2012 Final Rule

- Policy change to exclude Hospice beds and patient days from the calculation of the Medicare DSH Payment Adjustment
  - Exclude the patient days associated with hospice patients receiving inpatient hospice services in an inpatient hospital setting
  - Stemmed from the fact that days are not acute care services generally payable under IPPS
- Effective for cost reporting periods beginning on or after October 1, 2011

- (Intern Resident to Bed Ratio effect discussed in Federal Register, August 18, 2011, page 51683)
Disproportionate Share Hospital - Future

- Patient Protection and Affordable Care Act (PPACCA) section 2551(Medicaid) & 3133 (Medicare)
- Health Care Education and Reconciliation Act (section 1104)
- Beginning in FFY 2014, Medicare DSH Payments will be reduced to reflect the lower uncompensated care cost due to increases in the number of insured and decreases to the number of uninsured.
  - Receive 25% DSH payment of what it would receive under pre-PPACCA policy
  - Reduction of 75% is tied to the “uncompensated care cost”
  - Additional payment made for uncompensated care cost based upon a complex formula

Disproportionate Share Hospital - Future

- Additional payment will be made for uncompensated care based upon:
  - Aggregate reduction in DSH payments to all hospitals attributable to the reduction in DSH payments
    - 75% reduction value becomes the uncompensated care pool or
    - difference in the DSH payment before and after the 75% reduction
  - Reduction in uninsured individuals
    - 1 minus the change in the % of individuals under 65 who are uninsured between 2013 and the most recent year for which the data is available minus .1% for 2014 and .2% for 2015 through 2019
  - Each hospital’s share of uncompensated care provided by all hospitals
    - quotient of the amount of uncompensated care for the hospital divided by the amount of uncompensated care for all DSH
    - amount of uncompensated care that the DSH hospital provides as compared to all DSH hospitals
Disproportionate Share Hospital - Future

- Reimbursement computation for additional amount is difficult to quantify at this time as the Secretary has not identified
  - the source of the reduction of uninsured or
  - what makes up uncompensated care
- Worksheet S-10 will most likely be used for calculating the portion of uncompensated care reimbursement
- Further clarification will be issued as we get closer to FFY 2014

DSH – Audit Tips

- Ensure that you are capturing all of your Medicaid Days that are eligible to be included in the computation
  - Make sure your admitting staff understands that it is critical to identify Medicaid and any potential Medicaid patients on admission
  - Babies – make sure you capture the mother’s data in the baby’s records
  - Have the Financial Counselors work with patients potentially eligible for Medicaid while they are in the hospital – apply while there
- Watch SSI as the data is eventually released
  - Released on Federal Fiscal Year basis but you can request your cost reporting year end, if you think that might be different
- Many appeals outstanding on DSH – watch the outcomes
CMS 2552-10, Worksheet S-10

- Worksheet has been completely redesigned
- Data utilized in calculation of HIT reimbursement on worksheet E-1, Part II
- Critical to future DSH payments
- Completing the form correctly and in its entirety is now important
- Expect audits on this worksheet since payments are now involved
- Required for Critical Access Hospitals, too

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CMS 2552-10, Worksheet S-10

- Revised Definition of Uncompensated care
  - 2552-96: Defined as charity care and bad debt
  - 2552-10: Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.
CMS 2552-10, Worksheet S-10

Revised Definition of Charity care

- 2552-96: Health services for which hospital policies determine the patient is unable to pay. Charity care results from a provider’s policy to provide health care services free of charge (or where only partial payment is expected not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. For the purpose of uncompensated care charity care is measured on the basis of revenue forgone, at full-established rates. Charity care does not include contractual write-offs.

- 2552-10: Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. (Additional guidance provided in the instruction for line 20.)

CMS 2552-10, Worksheet S-10

- Carefully review the requirements of this worksheet at the beginning of your cost report preparation
  - You may have to capture data that you have not been capturing

- Current: HIT lines that carry relate to worksheet E-1 payments

- Future: DSH payments will most likely be tied to the information on this worksheet

- Expect future clarifications on the instructions
Cost Report Tips

- Read the certification before signing – know and understand what is in the report
- Compare the cost report data elements between years: Are there big shifts – positive or negative? Determine why.
- Complete the cost report package as early as possible so that you can review. Is the information being sent what the MAC requires?
- Assign one person to handle all responses to the auditor/MAC – promotes continuity and accurate data

Cost Report Tips

- Respond timely and accurately
- Ask that you be notified of proposed adjustments as they are identified instead of all at the end
- Count to 100 before responding to the auditor
- Review all documentation sent by the auditor before calling them or their supervisor
- Audits that are final settled are still subject to review and possible reopening by the MAC
Cost Report Tips

- When sending the information in electronic format, send the files in print ready format. Always print preview the page before sending. In most cases, send pdf – except bad debts, DSH, depreciation schedule, etc. that are usually requested in Excel.
- MACs are scanning data upon receipt. In sending hard copy documentation, send it so that if it gets “dropped” it can be easily put back together for scanning (worksheet at the top of each page)
- Treat the MAC staff with respect – the way you would want to be treated

PS&R

- Concern that contractors distributing PS&R caused providers not to register in IACS
- Contractors have been told to stop distributing PS&Rs
- Need to register for IACS to be able to get the PS&R
  - Receive summary within 24 hours
  - Receive summary as many times as you like throughout the year
  - Request detail, if necessary
- Try to use a PS&R with a run date not more than 30 days prior to the cost report due date
  - PS&R run date required on worksheet S-2, Part II, lines 16-21
## Medicare Cost Report Filing Extensions

All providers with full 12 months or greater cost reporting periods, which begin on or after May 1, 2010 (and end on or after April 30, 2011), shall file on the Form CMS 2552-10 subject to the following filing extension schedule:

<table>
<thead>
<tr>
<th>Cost Reporting FYE</th>
<th>Current Due Date</th>
<th>Revised Due Date</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/30/2011</td>
<td>9/30/2011</td>
<td>11/30/2011</td>
<td>60 days</td>
</tr>
<tr>
<td>5/31/2011</td>
<td>10/31/2011</td>
<td>11/30/2011</td>
<td>30 days</td>
</tr>
<tr>
<td>6/30/2011</td>
<td>11/30/2011</td>
<td>1/31/2012</td>
<td>60 days</td>
</tr>
<tr>
<td>7/31/2011</td>
<td>12/31/2011</td>
<td>1/31/2012</td>
<td>30 days</td>
</tr>
<tr>
<td>8/31/2011</td>
<td>1/31/2012</td>
<td>2/29/2012</td>
<td>30 days</td>
</tr>
<tr>
<td>9/30/2011</td>
<td>2/29/2012</td>
<td>3/31/2012</td>
<td>30 days</td>
</tr>
<tr>
<td>10/31/2011</td>
<td>3/31/2012</td>
<td>3/31/2012</td>
<td>None</td>
</tr>
<tr>
<td>11/30/2011</td>
<td>4/30/2012</td>
<td>4/30/2012</td>
<td>None</td>
</tr>
</tbody>
</table>

- Hospitals with hospital-based end-stage renal disease (ESRD) facilities and/or departments are subject to the same filing extension schedule as indicated above. Hospitals with hospital-based ESRDs shall submit their cost reports, using the current Form CMS 2552-10 with the existing Worksheet I series. The cost reports of hospitals with hospital-based ESRDs that claim Medicare bad debts shall not be settled until a revised Worksheet I series is published incorporating the new bad debt calculation.

- All providers with less than a 12-month cost reporting period, beginning on or after May 1, 2010, but ending prior to April 30, 2011, must file on Form CMS 2552-96, and will be final settled on Form CMS 2552-96. These cost reports are due the latter of 30 days from the date of the notification or five months following the close of the cost reporting period. This includes hospitals with hospital-based ESRDs.
Questions and Contact Information

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email mcalfee@matheneystees.com
website www.matheneystees.com
Medicare Cost Report Timelines

<table>
<thead>
<tr>
<th>Cost Report</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Received</td>
<td>Postmark or Receive Date</td>
</tr>
<tr>
<td>Accepted</td>
<td>within 30 days of receipt</td>
</tr>
<tr>
<td>Tentative Settlement</td>
<td>within 60 days of acceptance</td>
</tr>
<tr>
<td>Final Settlement of</td>
<td></td>
</tr>
<tr>
<td>Desk Review</td>
<td>if not scheduled for Audit, within 12 months of acceptance or within 6 months of the prior year Audited NPR</td>
</tr>
<tr>
<td>Audit</td>
<td>60 days from Exit Conference</td>
</tr>
<tr>
<td>Appeal</td>
<td>Must be filed within 180 days of NPR date</td>
</tr>
<tr>
<td>Reopened</td>
<td>within 3 years of NPR date</td>
</tr>
</tbody>
</table>

A desk review is completed to determine if

1. the cost report is settled as filed;
2. the cost report is settled with just PS&R update;
3. the cost report is subject to desk review exception resolution; or
4. the cost report is subject to audit.

Desk Review Exception Resolution Requests

- Providers have 3 weeks to provide the information from the date of the request.
- MACs are to send a final adjustment report to the provider representative who will have 10 business days to send any written concerns and documentation to the auditor.
- The adjustments will become final after any necessary modifications are made based on the written concerns and documentation supporting the adjustments.
- Typically, if no communication is received, they will finalize the report.

Audit Process

- Engagement letter will be sent between 4 and 6 weeks prior to the audit start date. (Typically, an agreement to the start date is arranged prior to the engagement letter being sent.)
- Engagement letter confirms start date of audit, lists all required documents that must be available on the first day of the audit, states tentative date of pre-exit conference, and states audit timeframes.
- An Entrance conference will be conducted to enhance the communications and explain the purpose of the field audit.
- A pre-exit conference will be scheduled on the last day of the field audit. Provider will be given a copy of all proposed adjustments and supporting workpapers including those proposed due to lack of documentation. The providers will be given a list of outstanding documentation and the information must be received by the auditors within 4 weeks of the date of the pre-exit conference.
- Auditor will establish an exit conference date, to be held within 8 weeks of the end of the 4 week response period.
- All providers must be given an exit conference unless the provider specifically waives the exit. A waiver of the formal exit conference must be in writing by the provider.
- All documentation submitted by the provider by the end of the 4 week response period will be reviewed during the 8 week period and resolution must be made on new or modified audit adjustments proposed after leaving the provider site.
- Prior to the exit conference, the provider will be given 10 business days to review any new or modified adjustments and notify the auditor in writing with any concerns and supporting documentation.
- The auditor does not have to consider information submitted by the provider after the established timeframes, including at the exit conference.
- Notice of Program Reimbursement (NPR) will be issued
  - Within 60 days of the exit conference, or
  - Within 60 days after the adjustments are finalized if an exit conference is waived.
Wage Index Files

Details for FY 2013 Wage Index Home Page

Return to List

Shown below are the details for the item you selected from the list.

Title
FY 2013 Wage Index Home Page

Description
See Below

Fiscal Year
2013

Type
Other

1. FY 2013 Hospital Wage Index Development Time Table
2. FY 2013 October Preliminary PUF: Contains the October preliminary S-3 cost report wage data and the occupuational mix data.
3. FY 2013 Wage Index Pension Cost Guidelines: Contains guidelines and a spreadsheet to assist hospitals and PAs/MACs in developing pension costs for the FY 2013 wage index. See zip file below in the downloads section which contains guidelines (PDF) and spreadsheet (Excel Spreadsheet). The excel spreadsheet contains four tabs: 1. Instructions for reporting pension costs with the automated pension cost worksheet; 2. Instructions for reporting unfunded pension costs for the automated unfunded pension cost worksheet; 3. An automated worksheet to report pension costs; and 4. An automated worksheet for reporting pension costs.

Downloads

FY 2013 Hospital Wage Index Development Time Table (PDF, 48KB)
FY 2013 October Preliminary PUF [ZIP, 4.3MB]
FY 2013 Wage Index Pension Cost Guidelines [ZIP, 103KB]

Related Links Inside CMS

There are no Related Links Inside CMS

Related Links Outside CMS

There are no Related Links Outside CMS

Last Modified Date: 11/21/2011
Help with File Formats and Plug-Ins
Transmittal 1010, dated December 30, 2011, is being rescinded and replaced by Transmittal 1014, dated January 6, 2012, to correct an error in a date included in section I. B. IV – the date is changed from January 30, 2011 to January 30, 2012. In addition, the date of January 30, 2012 is inserted in BR 7685.2. All other information remains the same.

SUBJECT: Instructions to Teaching Hospitals for Reporting the Internal Revenue Service (IRS) Refund of Medical Resident FICA Taxes

I. SUMMARY OF CHANGES: The purpose of these instructions is to instruct the contractors to inform teaching hospitals of the proper way to report the FICA refund for medical residents on the Medicare cost report.

EFFECTIVE DATE: February 6, 2012
IMPLEMENTATION DATE: : February 6, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>CHAPTER / SECTION / SUBSECTION / TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One-Time Notification
*Unless otherwise specified, the effective date is the date of service.
Attachment – One-Time Notification

Transmittal 1010, dated December 30, 2011, is being rescinded and replaced by Transmittal 1014 dated January 6, 2012, to correct an error in a date included in section I. B. IV – the date is changed from January 30, 2011 to January 30, 2012. In addition, the date of January 30, 2012 is inserted in BR 7685.2. All other information remains the same.

SUBJECT: Instructions to Teaching Hospitals for Reporting the Internal Revenue Service (IRS) Refund of Medical Resident FICA Taxes

Effective Date: February 6, 2012

Implementation Date: February 6, 2012

I. GENERAL INFORMATION

A. Background: On March 2, 2010, the IRS made an administrative determination that medical residents are exempt from FICA taxes based on the student exception for tax periods ending before April 1, 2005. Recently, the IRS began contacting hospitals, universities, and medical residents who filed FICA (Social Security and Medicare tax) refund claims for these periods. The purpose of these instructions is to instruct the contractors to inform teaching hospitals (defined in section I.B. below) of the proper way to report the FICA refund for medical residents on the Medicare cost report. The FICA refund must be reported in such a way that it does not impact a hospital’s wage-related costs used to compute the wage index under the Hospital Inpatient Prospective Payment System (IPPS). However, cost reimbursement principles for cost reporting purposes must be followed on worksheet A.

The FICA Refund has two parts. Under Part I, the IRS will refund FICA and Medicare taxes to the hospitals for the employer's share. Under Part II, the IRS will refund FICA and Medicare taxes to the hospitals for the resident employee’s share and the hospitals must return the refund to the residents employed by the hospital between approximately 1994 and 2005. Although both refunds apply for tax periods ending before April 1, 2005, hospitals are receiving these refunds during cost reporting periods that occur during FYs 2009, 2010, or 2011. It is important that a hospital’s wage-related costs are properly reported in these fiscal years, so as not to impact the calculation of the IPPS wage index for FYs 2013, 2014, or 2015.

B. Policy: In accordance with TDL-11452, issued on September 2, 2011, cost reports that end prior to April 30, 2011 would still be filed on the Form 2552-96. Cost reports ending on or after April 30, 2011 are to be filed on the Form 2552-10. Contractors shall provide the following cost reporting instructions to the teaching hospitals that they service. For purposes of this instruction, a “teaching hospital” is defined as a hospital that completed worksheet E, Part A for IME and/or worksheet E-3, Part IV for direct GME (or worksheet E-4 if applicable) on its cost report that was most recently submitted as of the time of issuance of this CR.

I. FICA Refund Part I—Hospital Employer’s Share

a. Cost Reporting on Worksheet A:

For cost reporting purposes, on worksheet A of both Forms 2552-96 and 2552-10 of the Medicare cost report, the FICA employer’s portion of the refund must follow Medicare reimbursement principles in accordance with 42 CFR §413.98. Refunds of the employer portion of FICA costs from previous periods are to be treated as a reduction of the current cost reporting employer portion of FICA costs. If the teaching hospital reported the FICA employer’s portion of expense net of the FICA refund on worksheet A, column 2, no adjustment is
necessary on worksheet A-8. However, if the teaching hospital did not report the employer’s portion of the FICA expense net of the FICA refund on worksheet A, column 2, the teaching hospital shall ensure that the employer’s portion of the FICA refund is identified as a revenue offset on worksheet A-8. The FICA employer portion of expenses is classified as an Employee Benefit and shall be reported on worksheet A, in the Employee Benefits cost center. The refund of the FICA employer’s portion shall be offset against the expense reported on worksheet A. If the FICA employer’s portion of expenses is directly assigned to individual cost centers other than Employee Benefits, the teaching hospital shall offset the refund, not to exceed the total current year FICA expense, against the Employee Benefits cost center, as the residual costs of this cost center will be allocated through step-down accordingly.

b. **Wage-Related Cost for the Wage Index:**

1. It is possible that teaching hospitals filing on the Form 2552-96 and receiving their employer’s share of the FICA refund have subtracted the refund amount from their current year FICA expense on line 17 (FICA-Employer’s Portion Only) of the Form 339. For wage index purposes, the FICA refund to a teaching hospital for its employer’s share is **not** to be used to reduce the current year employer’s portion of FICA expense on worksheet S-3, Part II and Form 339 of Form 2552-96. Therefore, the employer’s portion of the FICA refund must be added back to line 17 of the Form 339 so that line 17 and worksheet S-3, Part II reflect the full FICA employer’s portion of the expense incurred for that year.

2. If a teaching hospital is filing on the Form 2552-10, then for wage index purposes, the employer’s portion of the FICA refund must be excluded from line 17 of worksheet S-3, Part IV so that line 17 reflects the FICA employer’s portion of the expense incurred for that year.

After ensuring that the FICA employer’s portion of the expense incurred for the cost reporting year is properly reflected on line 17 of the Form 339 or worksheet S-3, Part IV as applicable, a teaching hospital shall also ensure that the FICA employer’s portion of the expense for the year is properly reflected in its allocation of wage-related costs to lines 13 through 20 of worksheet S-3, Part II of the respective cost report.

II. **FICA Refund Part II—Hospital Resident Employee’s Share**

a. If a teaching hospital has already reported the Resident employee’s share of the FICA refund as an accrued expense on worksheet A, column 2, then the teaching hospital shall ensure that a revenue offset equal to that accrued expense is submitted on worksheet A-8. A teaching hospital shall identify this offset on worksheet A-8 as the “Resident employee FICA refund.” The amount is accrued as an expense on worksheet A and the offset on worksheet A-8 must net to zero.

b. If a teaching hospital has not reported the “Resident” employee’s share of the FICA refund as an accrued expense on worksheet A, or has not filed a cost report in which the employee’s portion of the FICA refund is received, then upon receipt of the refund, the proper reporting for such refund is an offset of the actual or accrued employee portion of the FICA refund expense, resulting in a net of zero.

III. **Interest Earned on FICA Refunds**

The interest income earned on the employee and employer portions of the FICA refund is considered non-capital related and shall be offset against the interest expense that will be incurred in refunding the residents as well as any additional non-capital related interest expense.

IV. **Timeline and Instructions for Implementation**

Contractors shall inform teaching hospitals that the teaching hospitals shall work with their contractors to make any necessary changes within 30 days after issuance of this CR to their FY 2009 cost reports (that is, cost reports beginning on or after October 1, 2008) to be used in the FY 2013 wage index, so that the wage index will be calculated correctly for the FY 2013 Inpatient PPS proposed rule. This CR makes an exception to the
December 5, 2011 deadline specified in CR 7450 to allow hospitals to submit revisions to the contractors after December 5, 2011, but only for the purpose of this CR 7685 to properly report the FICA tax refund. CR 7450 is otherwise unchanged. Under this CR 7685, teaching hospitals must submit the revisions to their FY 2009 cost reports to their contractors by January 30, 2012. Upon receipt of the revisions to the cost report, contractors are not required to perform a review of the revisions relating to the FICA tax refund. Contractors shall submit revised HDT files to their CMS wage index analyst reflecting the changes resulting from the FICA refund by February 8, 2012. If contractors had previously submitted an HDT file for a particular teaching hospital, but that HDT file did not reflect the changes resulting from the FICA tax refund, the contractors shall submit the HDT file by February 8, 2012 to their CMS wage index analyst again, to ensure that CMS has received the file with the latest FICA tax refund revisions. However, if more time is needed, CMS will accept revisions to HDT files by no later than April 11, 2012, in accordance with the FY 2013 Wage Index Timetable.

There are 2 possible circumstances under which the contractor shall be required to review the changes the teaching hospital submitted regarding the FICA tax refund. First, as explained in TDL-11482, dated September 29, 2011, CMS conducts its own review of the wage data and flags hospitals that fail certain edits, some of which are the same as the edit thresholds specified in the desk review program. Approximately four times during the FY, FIs and A/B MACs shall receive an e-mail notification from their CMS wage index analyst requesting explanations as to why hospitals failed particular edits. At each time, the FIs and A/B MACs shall review their desk review findings to determine the cause of the edit failure, provide an explanation of the edit failure and/or correct the edit failure, and submit a revised HDT file or occupational mix spreadsheet, as applicable to the CMS wage index analyst. Under this CR 7685, if CMS finds that a hospital fails the edit relating to Wage-related Costs on line 13 of Worksheet S-3, Part II, the contractor shall determine if the hospital is a teaching hospital. If so, the contractor shall perform a second desk review of that teaching hospital’s wage-related costs, focusing on any revisions the provider made related to the FICA tax refund, to determine if the changes relating to the FICA tax refund caused the hospital to fail the wage-related cost edit. As part of the normal editing procedures, the contractor shall take steps to adjust the teaching hospital’s wage-related costs accordingly.

The second circumstance under which the contractor would be required to review the changes relating to the FICA tax refund is for a provider appeal. If under normal appeals procedures, the teaching hospital appeals any adjustment the contractor may have made to the teaching hospital’s wage-related costs, then, as part of reviewing the teaching hospital’s appeal, the contractor shall also perform a second desk review of that teaching hospital’s wage-related costs, focusing on any revisions the provider made related to the FICA tax refund, and make any adjustments as appropriate.

II. BUSINESS REQUIREMENTS TABLE
Use “Shall” to denote a mandatory requirement

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<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
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|                | A / B M A C | D / M A C | F I C A R R I E R | R H F | S h a r e d - S y s t e m M a i n t a i n e r s | F I S S | M C S | V M S | C W F | O T H E R |

28
Disproportionate Share Hospital (DSH) Acute Inpatient PPS

Disproportionate Share Hospital (DSH)

Medicare DSH Eligibility Data

CMS has developed a limited view of the HIPAA Eligibility Transaction System (HETS) to allow hospitals that receive Medicare DSH payments to view Medicare enrollment information for their hospital inpatients.

The data available via HETS 270/271 DSH will allow hospitals to verify that patients eligible for Medicaid are not also entitled to Medicare Part A benefits. In addition, hospitals can verify Medicare enrollment for their hospital inpatients, including whether a patient is entitled to Medicare Part A benefits, enrolled in a Medicare managed care plan, or has Medicare as its secondary insurance.

HETS 270/271 is an electronic data interchange (EDI) system that uses current ANSI X12 formatting standards. Submitters must connect to HETS 270/271 via the Medicare Data Communication Network (MDCN). Additional information about the HETS 270/271 system, including connectivity and file formatting requirements, is available online at: http://www.cms.hhs.gov/healthelp.

Applicants interested in receiving the HETS 270/271 DSH view can contact the MCARE Help Desk Monday – Friday 7:00 A.M. to 2:00 P.M. EST at 1-866-324-7315, or send an email to moare@cms.hhs.gov for additional information. The MCARE Help Desk will work with you and provide you with all documentation necessary to obtain access to the Medicare DSH view.

The Medicare DSH Adjustment (42 CFR 412.105)

The Medicare DSH adjustment provision under section 1885(d)(5)(F) of the Act was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986. According to section 1885(d)(5)(F) of the Act, there are two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method is for a hospital to qualify based on a complex statutory formula that results in the DSH-discount percentage. The DSH-discount percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid by not Medicare Part A. The DSH-discount percentage is defined as:

DSH Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)

The alternate special exception method is for large urban hospitals that can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local governments for indigent care (other than Medicare or Medicaid).

Under the primary method to qualify for DSH adjustments, the first computation includes the number of hospital patient days used by patients who, for those days, were entitled to both Medicare Part A and SSI (excluding State supplementation). This number is divided by the number of patient days used by patients under Medicare Part A for that same period. The second computation includes hospital patient days used by patients who, for those days, were eligible for medical assistance under a state plan approved under title XIX (Medicaid), but who were not entitled to Medicare Part A. This number is divided by the total number of hospital patient days for that same period.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment based on another statutory formula. The formula varies for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospital that qualify as rural referral centers or sole community hospitals, and other hospitals.

Note to Providers:

May 3, 2010: CMS recently published CMS Ruling "CMS-1498-R" pertaining to three Medicare Disproportionate Share Hospital (DSH) issues. Specifically, the Ruling addresses jurisdictionally proper pending appeals and open cost reports on the issues of Medicare non-covered days (such as exhausted benefit days and Medicare secondary payer days), the data matching process for Supplemental Security Income "SSI" fractions, and "labor and delivery" days. The Ruling became effective on April 28, 2010. To view the Ruling, please visit the link below in the downloads section.

https://www.cms.gov/AcuteInpatientPPS/05_dsh.asp

1/10/2012
CMS is currently in the process of reviewing the FY 2008 SSI ratios. Since the FY 2006 SSI ratios are currently under review, as of May 5, 2008, a hospital may elect to use either its FY 2005 or its FY 2006 SSI ratio from the files published below for submission of its cost report that would otherwise be submitted with the FY 2006 SSI ratio. While a hospital has the option of submitting its cost report using either its FY 2005 or FY 2006 SSI ratio, once CMS has completed its review of the FY 2006 SSI ratios, such cost reports will be settled using the appropriate SSI ratios. This option does not affect future cost reporting periods and SSI ratios (i.e., once the FY 2007 SSI ratios are published on this website, a hospital must use its FY 2007 SSI ratio for applicable cost reporting periods). If a hospital has already submitted its cost report using its FY 2006 ratio and would like to use its FY 2005 SSI ratio instead, it should contact its Fiscal Intermediary or Medicare Administrative Contractor.

Note to Providers on the FY 2007 SSI Ratios

On June 24, 2009, we published the FY 2007 SSI ratios for the Medicare Disproportionate Share Hospital adjustment on our website. At the request of several hospitals, we have posted additional information on the FY 2007 SSI ratios. The FY 2007 SSI ratios remain unchanged. The additional information we have provided includes the number of Medicare Part A Fee-for-Service (FFS) patient days and the number of Medicare Advantage (MA) patient days in the numerator and denominator of the SSI ratios. We note that there is no legal or policy distinction between the Medicare FFS and MA patient days in the SSI ratios, and that it has been our longstanding policy to include both categories of Medicare patient days in the SSI ratios. This additional detail is for informational purposes only so that hospitals can have a better understanding of the data that comprises their SSI ratios.

Under the instructions of Change Request 6821, applicable hospitals that have not submitted all of their Medicare Advantage data for FY 2007 have until August 31, 2010, to submit data to be included in the FY 2007 SSI ratios. We expect that the FY 2007 SSI ratios will be revised and reposted on this page in 2011.

Note to Providers on the FY 2008 SSI Ratios

As required by Change Request 6821, applicable hospitals that have not submitted all of their Medicare Advantage data for FY 2008 have until August 31, 2010, to submit data to be included in the FY 2008 SSI ratios. Once we have collected the data, the FY 2008 SSI ratios will be calculated, and we expect to post the FY 2008 SSI ratios on this page in 2011.

For more information, please refer to Change Request 6821:

Downloads

Memorandum to Medicare Advantage plans regarding Change Request 6329 (PDF, 49KB)

DSH Adjustment and 2006-2007 File - Updated May 2010 (ZIP, 423KB)

DSH Adjustment and 2006-2006 File (ZIP, 76KB)


DSH Adjustment and 2003-2004 File [Excel file zipped 188KB]

DSH Adjustment and 2002-2003 File [Excel and txt file zipped 300KB]

DSH Adjustment and 2001-2002 File [Excel and txt file zipped 311KB]

DSH Adjustment and 2000-2001 File [Txt file zipped 218KB]

Related Links Inside CMS

Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation (PM A-01-13) (PDF, 22KB)

Related Links Outside CMS

There are no Related Links Outside CMS

Page Last Modified: 08/08/2011 1:03:07 PM
Help with File Formats and Plug-ins

https://www.cms.gov/AcuteInpatientPPS/05_dsh.asp

1/10/2012
COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT

[As Amended Through May 1, 2010]

INCLUDING

PATIENT PROTECTION AND AFFORDABLE CARE ACT
HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010

PREPARED BY THE
Office of the Legislative Counsel
FOR THE USE OF THE
U.S. HOUSE OF REPRESENTATIVES

MAY 2010
This document is of the Patient Protection and Affordable Care Act ("PPACA"; Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111–152). The text of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790), as enacted (in amended form) by section 10221 of PPACA, is shown in a separate, accompanying document.

Preparation of document.—This document was prepared by the attorneys and staff of the House Office of the Legislative Counsel (HOLC) for the use of its attorneys and clients. It is not an official document of the House of Representatives or its committees and may not be cited as "the law". At the request of the Leadership, it is being made available to the public through Congressional websites and may be downloaded at http://docs.house.gov/energycommerce/ppacacon.pdf. Errors in this document are solely the responsibility of HOLC. Please email any corrections to "hlccomments@mail.house.gov". This document (originally dated May 24, 2010) may be updated to reflect corrections of errors or subsequent changes in law.

United States Code citations.—United States Code section numbers assigned to sections in PPACA are specified in brackets after the section numbers in the heading of each section, viz., 2711 [42 U.S.C. 300gg–11].
services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.”.

(b) Adoption of MedPAC Hospice Program Eligibility Recertification Recommendations.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (B), by striking “and” at the end; and

(2) by adding at the end the following new subparagraph:

“(D) on and after January 1, 2011—

“(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

“(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and”.

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking “For” and inserting “Subject to subsection (r), for”;

(2) by adding at the end the following new subsection:

“(r) Adjustments to Medicare DSH Payments.—(As revised by section 1104 of HCERA)

“(1) Empirically Justified DSH Payments.—For fiscal year 2014 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

“(2) Additional Payment.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

“(A) Factor One.—A factor equal to the difference between

“(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection
(d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

“(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

“(B) FACTOR TWO.—[As revised by section 10316]

“(i) FISCAL YEARS 2014, 2015, 2016, AND 2017.—For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

“(I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and

“(II) who are uninsured in the most recent period for which data is available (as so calculated), minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.

“(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

“(I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

“(II) who are uninsured in the most recent period for which data is available (as so estimated and certified), minus 0.2 percentage points for each of fiscal years 2018 and 2019.

“(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

“(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and
“(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

“(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

“(B) Any period selected by the Secretary for such purposes.”.

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) In General.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraphs:

“(K) POTENTIALLY MISVALUED CODES.—

“(i) IN GENERAL.—The Secretary shall—

“(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

“(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

“(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called ‘Harvard-valued codes’); and such other codes determined to be appropriate by the Secretary.

“(iii) REVIEW AND ADJUSTMENTS.—

“(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

“(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).
(b) [Amended section 114(d) of such Act, as amended by section 3106(b)]

SEC. 10313. REVISIONS TO THE EXTENSION FOR THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM [AMENDMENTS FULLY INCORPORATED ABOVE].

(a) [Replaced subsection (g) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as added by section 3123(a)]

(b) [Amended subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended by section 3123(b)]

SEC. 10314. ADJUSTMENT TO LOW-VOLUME HOSPITAL PROVISION [AMENDMENTS FULLY INCORPORATED ABOVE].

[Amended subparagraphs (C)(i) and (D) of section 1886(d)(12) of the Social Security Act, as amended by section 3125]

SEC. 10315. REVISIONS TO HOME HEALTH CARE PROVISIONS [AMENDMENTS FULLY INCORPORATED ABOVE].

(a) [Amended section 1895(b)(3)(A)(iii) of the Social Security Act, as added by section 3131]

(b) [Replaced section 3131(d)]

SEC. 10316. MEDICARE DSH [AMENDMENTS FULLY INCORPORATED ABOVE].

[Amended section 1886(r)(2)(B) of the Social Security Act, as added by section 3133]

SEC. 10317. REVISIONS TO EXTENSION OF SECTION 508 HOSPITAL PROVISIONS [AMENDMENTS FULLY INCORPORATED ABOVE].

[Replaced section 3137(a)]

SEC. 10318. REVISIONS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE [AMENDMENTS FULLY INCORPORATED ABOVE].

[Amended section 1853(p)(3)(A) of the Social Security Act, as added by section 3201(h); section 3201 and its amendments was subsequently repealed by section 1102(a) of HCERA]

SEC. 10319. REVISIONS TO MARKET BASKET ADJUSTMENTS [AMENDMENTS FULLY INCORPORATED ABOVE].

(a) INPATIENT ACUTE HOSPITALS.—[Amended section 1886(b)(3)(B)(xii) of the Social Security Act, as added by section 3401(a); subsequently amended by section 1105(a) of HCERA]

(b) LONG-TERM CARE HOSPITALS.—[Amended section 1886(m)(4) of the Social Security Act, as added by section 3401(c); subsequently amended by section 1105(b) of HCERA]

(c) INPATIENT REHABILITATION FACILITIES.—[Amended section 1886(j)(3)(D)(i) of SSA, as added by section 3401(d); subsequently amended by section 1105(c) of HCERA]

(d) HOME HEALTH AGENCIES.—[Amended section 1895(b)(3)(B)(ii)(II) of SSA, as added by section 3401(e)]

(e) PSYCHIATRIC HOSPITALS.—[Amended section 1886(s)(3)(A) of SSA, as added by section 3401(f); subsequently amended by section 1105(d) of HCERA]

(f) HOSPICE CARE.—[Amended section 1814(i)(1)(C) of the Social Security Act, as amended by section 3401(g)]
**Uncompensated and indigent care cost computation**

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<td>2</td>
<td>Medicaid (see instructions for each line)</td>
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<td>Net revenue from Medicaid</td>
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<td>Did you receive DSH or supplemental payments from Medicaid?</td>
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<td>Medicaid charges</td>
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<td>Medicaid cost (line 1 times line 6)</td>
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<td>Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)</td>
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<td>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</td>
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<td>Net revenue from stand-alone SCHIP</td>
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<td>Stand-alone SCHIP cost (line 1 times line 10)</td>
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<td>Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)</td>
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<td>Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)</td>
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<td>State or local indigent care program cost (line 1 times line 14)</td>
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<td>Uncompensated care (see instructions for each line)</td>
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<td>Private grants, donations, or endowment income restricted to funding charity care</td>
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<td>18</td>
<td>Government grants, appropriations or transfers for support of hospital operations</td>
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<td>Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)</td>
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**Uninsured and Insured Patients Total Cost**

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<th>Insured Patients</th>
<th>Total (col. 1 + col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Cost of initial obligation of patients approved for charity care (line 1 times line 20)</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Partial payment by patients approved for charity care</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Cost of charity care (line 21 minus line 22)</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Total bad debt expense for the entire hospital complex (see instructions)</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Medicare bad debts for the entire hospital complex (see instructions)</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Cost of non-Medicare bad debt expense (line 1 times line 28)</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Total unreimbursed and uncompensated care cost (line 19 plus line 30)</td>
<td>31</td>
<td></td>
</tr>
</tbody>
</table>
Definitions:

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

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

Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim. (Additional guidance provided in the instruction for line 25.)

Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1. (Additional guidance provided in the instruction for line 25.)

Net revenue--Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Instructions:

Cost to charge ratio:

Line 1--Enter the cost-to-charge ratio resulting from Worksheet C, Part I, line 200, column 3 divided by Worksheet C, Part I, line 200, column 8.

For all inclusive rate providers that do not complete Worksheet C, Part I, enter your cost-to-charge ratio as calculated in accordance with CMS Pub. 15-1, section 2208.

Medicaid

NOTE: The amount on line 18 should not include the amounts on lines 2 and 5. That is, the amounts on lines 2 and 5 are mutually exclusive from the amount on line 18.

Line 2--Enter the inpatient and outpatient payments received or expected for Title XIX covered services delivered during this cost reporting period. Include payments for an expansion SCHIP program, which covers recipients who would have been eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include payments received from Medicaid managed care programs. If not separately identifiable,
disproportionate share (DSH) and supplemental payments should be included in this line. For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.

Line 3—Enter “Y” for yes if you received or expect to receive any DSH or supplemental payments from Medicaid relating to this cost reporting period. Otherwise enter “N” for no.

Line 4—If you answered yes to question 3, enter “Y” for yes if all of the DSH or supplemental payments you received from Medicaid are included in line 2. Otherwise enter “N” for no and complete line 5.

Line 5—If you answered no to question 4, enter the DSH or supplemental payments the hospital received or expects to receive from Medicaid relating to this cost reporting period that were not included in line 2, net of associated provider taxes or assessments.

Line 6—Enter all charges (gross revenue) for Title XIX covered services delivered during this cost reporting period. These charges should relate to the services for which payments were reported on line 2.

Line 7—Calculate the Medicaid cost by multiplying line 1 times line 6.

Line 8—Enter the difference between net revenue and costs for Medicaid by adding line 2 plus line 5 minus line 7.

State Children’s Health Insurance Program:

Line 9—Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. Stand-alone SCHIP programs cover recipients who are not eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include any payments received from SCHIP managed care programs.

Line 10—Enter all charges (gross revenue) for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. These charges should relate to the services for which payments were reported on line 9.

Line 11—Calculate the stand-alone SCHIP cost by multiplying line 1 times line 10.

Line 12—Enter the difference between net revenue and costs for stand-alone SCHIP by subtracting line 11 from line 9.

Other state or local indigent care program:

Line 13—Enter all payments received or expected for services delivered during this cost reporting period for patients covered by a state or local government indigent care program (other than Medicaid or SCHIP), where such payments and associated charges are identified with specific patients and documented through the provider's patient accounting system. Include payments for all covered services except physician or other professional services, and include payments from managed care programs.

Line 14—Enter all charges (gross revenue) for services delivered during this cost reporting period for patients covered by a state or local government program, where such charges and associated payments are documented through the provider's patient accounting system. These charges should relate to the services for which payments were reported on line 13.
Line 15--Calculate the costs for patients covered by a state or local government program by multiplying line 1 times line 14.

Line 16--Calculate the difference between net revenue and costs for patients covered by a state or local government program by subtracting line 15 from line 13.

Uncompensated care:

Line 17--Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.

Line 18--Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds were allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.

Line 19--Calculate the total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs by entering the sum of lines 8, 12 and 16.

Line 20--Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

Line 21--Calculate the cost of initial obligation of patients approved for charity care by multiplying line 1 times line 20. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 22--Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.
Line 23--Calculate the cost of charity care by subtracting line 22 from line 21. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 24--Enter “Y” for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter “N” for no.

Line 25--If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26--Enter the total facility (entire hospital complex) charges for bad debts (bad debt expense) written off or expected to be written off on balances owed by patients for services delivered during this cost reporting period. Include such charges for all services except physician and other professional services. Include the sum of all Medicare allowable bad debts appearing in the Worksheet E, H, I, J, and M series including: E, Part A, line 64; E, Part B, line 34; E-2, line 17; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; Part VII, line 34; H-4, Part II, line 27; I-5, line 5; J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to as adjusted) bad debts as the sum of Worksheet E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2; E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; H-4, Part II, line 27; I-5, line 5; J-3, line 21; and M-3, line 23.

Line 28--Calculate the non-Medicare and non-reimbursable Medicare bad debt expense by subtracting line 27 from line 26.

Line 29--Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense by multiplying line 1 times line 28.

Line 30--Calculate the cost of non-Medicare uncompensated care by entering the sum of lines 23, column 3 and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care and by entering the sum of lines T9 and 30.
Form CMS-2552-10
Worksheet S-10, Line 27

E, Part A, Line 65: Hospital Part A adjusted bad debts (net of recoveries and 30% reduction)
E, Part B, Line 35: Hospital Part B adjusted bad debts (net of recoveries and 30% reduction) *this reduction does not apply to CAHs. *bad debts associated with ambulance services rendered are not allowable.
E-2, Line 17, c 1 & 2: Swing bed Part A & B reimbursable bad debts (net of recoveries) (excluding bad debts for physician professional services and those from services paid under reasonable charge based methodology or fee schedule)
E-3, Part I, Line 12: TEFRA adjusted bad debts (net of recoveries and 30% reduction)
E-3, Part II, Line 24: IPF PPS adjusted bad debts (net of recoveries and 30% reduction)
E-3, Part III, Line 25: IRF PPS adjusted bad debts (net of recoveries and 30% reduction)
E-3, Part IV, Line 15: LTHC PPS adjusted bad debts (net of recoveries and 30% reduction)
E-3, Part V, Line 26: Medicare Part A services – cost reimbursement (CAHs) adjusted bad debts (net of recoveries and 30% reduction) (no reduction is required for CAHs)
E-3, Part VI, Line 10: Part A SNF adjusted bad debts (dual eligible (L 9) not subject to 30% reduction)
H-4, Part II, Line 27: HHA reimbursable bad debts (net of recoveries)
J-3, Line 21: CMHC reimbursable bad debts (net of recoveries)
M-3, Line 23: RHC/FQHC reimbursable bad debts (net of recoveries)
News Release

FOR IMMEDIATE RELEASE
December 16, 2011

HHS to give states more flexibility to implement health reform

Approach will help ensure consumers have quality, affordable coverage starting in 2014

The Department of Health and Human Services today released a bulletin outlining proposed policies that will give states more flexibility and freedom to implement the Affordable Care Act.

The Affordable Care Act ensures all Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures that health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as "essential health benefits."

The bulletin released today describes an inclusive, affordable and flexible proposal and informs stakeholders about the approach that HHS intends to pursue in rulemaking to define essential health benefits. HHS is releasing this intended approach to give consumers, states, employers and issuers timely information as they work toward establishing Exchanges and making decisions for 2014. This approach was developed with significant input from the public, as well as reports from the Department of Labor, the Institute of Medicine, and research conducted by HHS.

"Under the Affordable Care Act, consumers and small businesses can be confident that the insurance plans they choose and purchase will cover a comprehensive and affordable set of health services," said HHS Secretary Kathleen Sebelius. "Our approach will protect consumers and give states the flexibility to design coverage options that meet their unique needs."

Under the Department's intended approach announced today, states would have the flexibility to select an existing health plan to set the "benchmark" for the items and services included in the essential health benefits package. States would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state's commercial market.

The benefits and services included in the health insurance plan selected by the state would be the essential health benefits package. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. Consistent with the law, states must ensure the essential health benefits package covers items and services in at least ten categories of care, including preventive care, emergency services, maternity care, hospital and physician services, and prescription drugs. If a state selects a plan that does not cover all ten categories of care, the state will have the option to examine other benchmark insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that will be included in the essential health benefits package.

The policy proposed today by HHS would give states the flexibility to select a plan that would be equal in scope to the services covered by a typical employer plan in their state. States and insurers would retain the flexibility to evolve the benefits package with the market as innovative plan designs are developed and advancements in care become available, and meet the needs of their citizens.

"More than 30 million Americans who newly have insurance coverage in 2014 will have a comprehensive benefit package," said Sherry Glied, PhD, assistant secretary for planning and evaluation. "In addition to assuring comprehensive coverage for the newly insured, millions of Americans buying their own insurance today will gain valuable new coverage, including more than 8 million Americans who currently do not have maternity coverage, and more than 1 million who will gain prescription drug coverage."

The bulletin issued today addresses only the services and items covered by a health plan, not the cost sharing, such as deductibles, copayments, and coinsurance. The cost-sharing features will be addressed in future bulletins and cost-sharing rules will determine the actuarial value of the plan.

Public input on this proposal is encouraged. Comments are due by Jan 31, 2012 and can be sent to:

EssentialHealthBenefits@cmi.hhs.gov

For the essential health benefits bulletin, visit: http://cclm.cms.gov/resources/regulations/index.html#he


For a summary of individual market coverage as it relates to essential health benefits, visit:


For information comparing benefits in small group products and state and Federal employee plans, visit:


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Note: All HHS press releases, fact sheets and other press materials are available at http://www.hhs.gov/news.

Last revised: December 16, 2011