

Nebraska HFMA Meeting WPS Medicare Audit Update

March 16th, 2022

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Agenda

- S-10 Uncompensated Care Audits
- Secure-EDI/File Exchange/MoveIt
- Rural Health Clinics
- Bad Debts
- Nursing and Allied Health
- New Cost Report Documentation Requirements
- WPS Website, Webinars, and YouTube Channel
- Questions

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S-10 Uncompensated Care Audits

- Currently in second year of auditing 100% of DSH eligible hospitals
 - 5th year of S-10 audits overall
- FFY 2023 UCP Factor 3
 - FFY 2019 data???
 - Audited 100% of providers
 - Awaiting final rule
- Potential averaging of years for later
 - Impact of COVID-19 data?

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S-10 Uncompensated Care Audits

- Currently auditing S-10 data for FFY 2020 year
 - Cost reporting periods beginning between 10/1/19 – 9/30/20
 - All Acute hospitals that qualify for DSH
 - Including SCH/MDH hospitals
 - FYEs 9/2020 – 3/2021 sent out 2/4/2022 with 3/4/2022 due date
 - FYEs 4/2021 – 8/2021 will be sent out 3/21/2022 with a 4/21/22 due date
 - All audits must be completed and submitted to CMS by December 31st.

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S-10 Uncompensated Care Audits

- S-10 Lines
 - 20 (Charity care charges for the entire facility)
 - 22 (Partial payments by patients approved for charity care)
 - 25 (Charges for patient days beyond an indigent care program's length of stay)
 - 26 (total bad debt "expense" for the entire hospital complex.)
 - Do not use "bad debt expense" under GAAP (i.e., allowance method)
 - Must be an actual write off
 - Regardless of whether that Medicare bad debt is yet allowable for bad debt reimbursement

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S-10 Uncompensated Care Audits

- **S-10 Audits Info Requests**
- Financial Assistance Policy
 - How hospital personnel determine insurance status and charity care write offs
 - Including uninsured patients
 - Including non-covered services for Medicaid eligible and Indigent patients
 - Including Patients with coverage from an entity without a hospital contractual relationship

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S-10 Uncompensated Care Audits

- **S-10 Line 20 Column 1** is for uninsured patients (including patients with insurance coverage with an entity that does not have a contractual relationship with the provider, as well as non-covered services for Medicaid/Indigent Care Program patients.)
- **S-10 Line 20 Column 2** is for insured patients, (including non-covered charges related to days exceeding the length of stay limit for patients covered by Medicaid/Indigent Care Programs.)

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S-10 Uncompensated Care Audits

- **S-10 must exclude:**
 - Any physician and other professional services.
 - Any amounts related to insurer or other third-party liabilities.
 - Bad Debts (Medicare or Non-Medicare) should not be reported in Line 20, as they factor into the amounts reported in line 26 instead.
 - Courtesy discounts are not the same as charity care discounts and are not allowed in this line.

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S-10 Uncompensated Care Audits

- **S-10 Line 22** (Payments to offset Line 20)
- **S-10 Line 25** (Charges for Patient days beyond a Medicaid or indigent care program's length of stay)
 - These are also part of line 20 column 2.
 - Subject to cost to charge ratio, unlike deductibles and coinsurance that are otherwise reported on line 20 column 2.

S-10 Uncompensated Care Audits

- **S-10 Line 26** (Total Bad Debt Expense for Entire facility)
 - **Less:**
 - Any physician and other professional services.
 - Any bad debts related to insurers or other third parties. Only bad debts related to amounts owed by patients should be included.
- Underlying dates of service are irrelevant
 - Write off date determines what cost reporting period it is reported in.

S-10 Uncompensated Care Audits

- Summary of Initial Info Requests:
 - Charity care policy that was in place for the period
 - A description of the process used when querying the records to identify the charge and payment amounts to be reported on line 20 and 22 (for each column)
 - Actual listing of such charges and payments.
 - Information on how the above rules are applied so that things such as fee schedule services, courtesy discounts, bad debts, etc. are not included as charity care charges.
 - Explanation of significant variances
 - Reconciliation from the amounts reported on the cost report for the various items to corresponding elements on your working trial balance and/or financial statements.

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S-10 Uncompensated Care Audits

- Summary of Follow-up Info Requests:
 - Detailed documentation for a sample selected from a list
 - Detailed bad debt listing for the amounts reported on line 26 (with any corresponding explanation of the process used to gather that data)
 - Potentially detailed documentation for a sample from the bad debt listing.

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S-10 Uncompensated Care Audits

- Query Logic Questionnaire
- Much of the audit time is spent up front trying to get a “clean” listing without obvious errors
 - This minimizes having to extrapolate large error rates to the population that we sampled

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S-10 Uncompensated Care Audits

WPS GHA Website

- <https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/worksheet-s-10-charity-care-audits>
- <https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/worksheet-s-10-charity-care-audits>

WPS GHA YouTube

- <https://youtu.be/bWQhRT8KljY> = General training
- <https://youtu.be/NAPTlPsEgNE> = Audit Templates and Questionnaire
- <https://youtu.be/VOm-wmoBReI> = S-10 Webinar Part 1
- <https://youtu.be/tIKNeIhvjzo> = S-10 Webinar Part 2
- Others in later webinar listing

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Secure-EDI/File Exchange/Movelt

- New URL everyone should be using is <https://fe.wpsgha.com>
 - Old secure-edi.wpsic.com accounts deactivated.
 - New portal is otherwise same as old portal
- Benefits
 - Larger file size limit (2GB vs. 15-20 MB)
 - No file type restrictions
 - Allowed for external contacts as well (not limited to providers)
- Drawbacks
 - Due to security requirements, accounts quickly expire if not used
 - Easy to reset though, by auditor that you are working with
 - Each individual auditor that you want to connect with must first send you an “initiation” email.
 - Password only needs to be created by first one

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Secure-EDI/File Exchange/Movelt

- <https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/audit-secure-edi-email-messaging-tool>
- Secure-EDI initiation email
 - Audit contact sends you first email (including your first temporary password)
 - Any other auditor you want to send documents to would have to first send you an initiation email of their own (no new password needed if account is already established.)
 - Accounts active for 20 days, but reset after each use
- No long-term storage of files (usually around 30 days)
- Auditors can handle your password resets, deactivations, etc.

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Rural Health Clinics (RHCs)

- Consolidated Appropriations Act of 2021 (12/27/2020)
- CR 12035 (10/29/2021) and CR 12185 (5/4/2021)
- Newly certified RHCs January 1, 2021, and after are subject to per visit limit

The RHC payment limit per visit over an 8-year period is as follows:

- in 2021, after March 31, at \$100 per visit;
- in 2022, at \$113 per visit;
- in 2023, at \$126 per visit;
- in 2024, at \$139 per visit;
- in 2025, at \$152 per visit;
- in 2026, at \$165 per visit;
- in 2027, at \$178 per visit; and
- in 2028, at \$190 per visit.

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Rural Health Clinics (RHCs)

- Consolidated Appropriations Act of 2021 (12/27/2020)
- CR 12035 (10/29/2021) and CR 12185 (5/4/2021)
- Grandfathered RHCs (less than 50 beds as of 12/31/2020 and continue having less than 50 beds)
 - COVID exceptions
 - No change in certification
- Base year per visit limit (2020 or 2021 if no rate established in 2020)
 - Rate updated each year
- No consolidations of grandfathered and non grandfathered RHCs allowed
- **Questions over what rate to use for consolidated grandfathered units**

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Bad Debts

- 9/18/2020 Federal Register (FFY 221 Inpatient Prospective Payment System Final Rule)
- <https://www.govinfo.gov/content/pkg/FR-2020-09-18/pdf/2020-19637.pdf>
- Codified many bad debt policies into regulation
 - Clarifications of existing policy were retroactively effective
 - Changes in policy were prospective for cost reporting periods 10/1/ and after
- WPS YouTube video going into detail on these changes
 - <https://www.youtube.com/watch?v=LMa4atowlRU>

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Bad Debts-Collection Agency

- Bad debt not allowable for Medicare purposes until it has been completely returned from collection agency
- Full amount collected from patient must be used to offset AR
 - Cannot be reported net of collection fee
 - Collection fee is separate administrative cost
- **Clarification = Retroactive**

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Bad Debts - Dual Eligible Patients

- Must-Bill Policy
 - Must have Medicaid RA to allow a dual eligible bad debt
- In this Federal Register, CMS also incorporated an alternative documentation set to be used in limited circumstances where a State does not process crossover claims or issue Medicaid RAs for certain provider-types.
 - In these cases, the provider must include the following documentation instead:
 - The State Medicaid notification evidencing that the State has no obligation to pay the beneficiary's Medicare cost sharing or notification evidencing the provider's inability to enroll in Medicaid for purposes of processing a crossover cost sharing claim,
 - documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing, and
 - documentation verifying the beneficiary's eligibility for Medicaid for the date of service.
- Clarification = Retroactive

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Bad Debts - Indigent Patients

- **CMS Policy at CMS Pub. 15-1§312**
- The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence
- The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence

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Bad Debts - Indigent Patients, cont.

- CMS made minor changes when codifying these into regulation.
 - Dropping need for liability and expense review
- Regulatory changes prospective 10/1/20 FYB and after
- Original policy is in place for all periods prior to that

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Bad Debts - Indigent Patients, cont.

- Presumptive indigence not allowed for Medicare bad debt
 - It is allowed for total bad debt on W/S S-10
- Deceased beneficiaries
 - Collection effort required to search for an estate
 - Must have tangible and contemporaneous evidence of estate review
 - Not just a note from provider representative that they searched for the estate
- Bankrupt providers
 - Provider must document they have filed claim with bankruptcy courts where applicable
 - Bankrupt does not equal automatic indigence determination...review financial status at that time

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Bad Debts - 120 Day Rule

- CMS Pub. 15-I 310.2
 - “if after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.”
- Federal Register strengthen that a bit. Turned it into a harder “rule” as opposed to a guideline.
 - Only exception is for indigent patients (including dual eligible) 9/18/2020
- Reiterated long-standing policy that any payment (even \$1) that is made during 120-day period resets the 120-day clock.
- **Clarification = Retroactive**

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Bad Debts - Timely Billing Rule

- Bill must be issued to patient shortly after death or discharge of patient.
 - Federal Register defines “shortly after”
- 120 days after the later of:
 - Date of Medicare RA
 - Date of RA from secondary payor
 - Date of notification that secondary payor does not cover services furnished to beneficiary
- **Revision = Prospective**
- However, WPS is implementing this change immediately
 - Timeframe was previously left up to MACs
 - This new timeframe is more lenient to providers

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Bad Debts - Write-off and GAAP vs. Medicare

- Prior rules required write-off involving an expense account
 - PRM-I §320
 - Allowance method (also required by GAAP)
 - Notably, the Medicare rules require the later write-off against AR to occur, not just the initial charge to expense.
- FASB GAAP has now revised accounting treatment (ASU Topic 606)
 - Previously estimated bad debt amount to charge off against expense
 - Now will estimate bad debt amount to charge off against contra-revenue (implicit price concession)
- **Revision = Prospective**
- What to do about current periods that are not in line with GAAP?

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Bad Debts - Contractual Allowances

- CMS noticed providers writing off bad debts against contractual allowance (a different contra-revenue account)
 - Contractual allowance is amount that provider not legally entitled to
- Should have instead been charged against an expense or now an implicit price concession contra-revenue account
- CMS issued Medicare Learning Network Special Edition on 4/4/2019 to remind providers of this
 - Gave grace period up to last cost reporting periods beginning before 10/1/2019
- Grace period now expired
- CMS codified rule into regulation effective 10/1/2020 FYBs
- **Revision = Prospective**

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Nursing and Allied Health

- CMS continuing to have MACs review Legal Operator requirements for NAH
 - 42 CFR 413.85(f)
 - CMS Change Request 10552 (8/17/2018)
- 1. Directly incur the training costs
- 2. Directly control over program curriculum
- 3. Control administration of the program
- 4. Employ the teaching staff
- 5. Provide both classroom and clinical training
- 6. Issue degree or diploma
- <https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/reasonable-cost-payment-nah-education-programs-cost-report-documentation>

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CR 11642 (NAH Add-On and GME Managed Care Reduction)

- <https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/nah-add-on-payment-and-gme-payment-reduction-for-ma>
- 8/21/2020 Change Request 11642
 - Revised factors for both and required MACs to reopen all that could be reopened
- We have developed calculation forms at the above website.
 - Also a YouTube video explaining the entire process.
- **Recently wrapped up original Reopenings**
 - **Small number of reopenings needed due to recent CMS change of the CY 2018 GME Reduction factor (7% to 4.12%)**
- **Still has prospective impact**

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CR 11642 (NAH Add-On and GME Managed Care Reduction)

- Non-Calendar Year Provider's get two calculations
- Using data from cost reporting periods ending in the federal fiscal year that is two years prior to the current calendar year.
- 1.) Subtract two years from the current calendar year(s) that your cost reporting period spans
 - 12/31/2020 – 2 years = 12/31/2018
- 2.) Find the Federal Fiscal Year End that has the same year as the calendar year above
 - We would use FFY 2018 (10/1/2017 – 9/30/2018)
- 3.) Find the cost reporting period ending in the above Federal Fiscal Year

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CR 11642 (NAH Add-On and GME Managed Care Reduction)

- The factors that are used for the rest of the calculation already incorporate data from two year's prior.
 - As such, if your current cost reporting period is CY 2017, then you need to pull the CY2017 factor
 - Don't try to subtract two years, etc.

Attachment from CR 11642 (NAH Add On Pool Numbers)

CY	MA N&AH POOL	FFS N&AH PAYMENTS	FFS INPATIENT DAYS	MA INPATIENT DAYS	(FFS N&AH/FFS INPT DAYS) X MA INPT DAYS	PERCENT REDUCTION TO MA DGME PAYMENTS	
2001	\$ 43,663,043	\$ 204,780,092	56,794,990	1,701,313	\$ 6,134,256	14.13%	From original PM A-03-043
2002	\$ 8,725,221	\$ 83,140,895	21,966,199	1,218,662	\$ 4,612,571	4.58%	
2003	\$ 11,268,425	\$ 109,188,627	25,244,159	1,389,811	\$ 6,011,353	5.88%	
2004	\$ 10,879,994	\$ 99,630,697	21,871,001	1,158,637	\$ 5,278,031	5.20%	
2005	\$ 14,928,729	\$ 119,167,650	28,120,057	1,390,968	\$ 5,894,668	6.06%	
2006	\$ 12,256,712	\$ 123,774,038	29,537,617	1,438,451	\$ 6,027,666	6.28%	
2007	\$ 23,347,058	\$ 140,263,059	31,217,012	1,500,168	\$ 6,740,496	7.13%	
2008	\$ 36,214,939	\$ 175,262,442	36,482,304	1,799,666	\$ 8,645,667	8.86%	
2009	\$ 44,399,680	\$ 188,570,852	40,169,275	2,380,683	\$ 11,175,891	9.88%	
2010	\$ 60,000,000	\$ 213,862,393	45,409,814	3,114,194	\$ 14,666,631	9.77%	
2011	\$ 60,000,000	\$ 226,645,225	49,217,935	3,825,354	\$ 17,615,494	7.85%	
2012	\$ 60,000,000	\$ 240,958,503	55,551,047	4,376,532	\$ 18,983,667	7.16%	
2013	\$ 60,000,000	\$ 245,304,017	54,965,956	4,945,724	\$ 22,071,952	6.41%	
2014	\$ 60,000,000	\$ 248,506,989	54,405,730	5,360,315	\$ 24,494,107	5.86%	
2015	\$ 60,000,000	\$ 247,076,161	55,223,064	5,907,933	\$ 26,432,967	5.32%	
2016	\$ 60,000,000	\$ 253,272,740	55,717,901	6,376,818	\$ 28,986,630	4.99%	
2017	\$ 60,000,000	\$ 249,546,528	58,599,068	7,241,576	\$ 30,838,548	4.44%	
2018	\$ 60,000,000	\$ 267,714,849	61,066,487	7,888,809	\$ 34,594,457	4.12%	From CR 12586 (2/4/2022) Revised from 7% to 4.12%
2019	\$ 60,000,000	\$ 262,043,840	62,649,285	8,481,459	\$ 35,475,490	4.07%	From CR 12407 (8/19/2021)
2020	\$ 60,000,000	\$ 262,043,840	62,649,285	8,481,459	\$ 35,475,490	4.07%	CMS has not yet issued the rates from 2020 and on, so the 2019 rate will be used as an estimate in the meantime.
2021	\$ 60,000,000	\$ 262,043,840	62,649,285	8,481,459	\$ 35,475,490	4.07%	

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Cost Report Documentation Requirements

- <https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/cost-report-documentation-requirements-templates>
 - Includes electronic templates
- <https://youtu.be/gAAXSTNELy8>
- [83 FR 41677 \(August 17, 2018\)](#)
- Effective for cost reporting periods beginning 10/1/2018 and after
- All provider types; not just hospitals

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Cost Report Documentation Requirements

- GME/IME Interns and Residents (IRIS)
- Medicare Bad Debts
- Disproportionate Share Hospital (DSH) Eligible Days
- Data elements on Worksheet S-10 Uncompensated Care
 - Charity Care and Uninsured Discounts required at acceptance
 - Total Bad Debts required for eventual S-10 audit
- Home Office costs
 - Cost Statement must be filed with MAC that services the Home Office
- All amounts must “correspond to” the data reported on the cost report.

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Cost Report Documentation Requirements

- Specific templates not yet required
 - Recommended though
- Paperwork Reduction Act (PRA) Proposed Rule
 - Expected to come out again with another comment period
- Possible these will be in Transmittal 18 (2552-10 Form Set)

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CMS Portal (MCRef)

- Used for cost report submissions ONLY
 - Cannot submit documentation for desk review, audit, reopenings, etc.
- E-signature vs. E-submission

PART II - SIGNATURE INFORMATION			
96.00	By placing an "X" in this field, I certify that I have read and agree with the certification statement of this report. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.		
	First Name	Last Name	Email Address
97.00	Officer or Administrator of the Provider(s) (to be placed on the Certification Statement).		
98.00	Title of Officer or Administrator (to be placed on the Certification Statement).		
99.00	Date/Time signed (Placed on the Certification Statement at time of report signing.)		

- Please make sure to send cover letter, rather than just a CD by itself.
 - If E-signed, the worksheet S should be at the front of the package

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WPS Website, Webinars, and YouTube Channel

- WPS Website
 - <https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/guides-and-resources>
- WPS YouTube Audit Playlist
 - https://www.youtube.com/playlist?list=PLmWbOYPskBJa8M_ylZQc4WYfRN2P7Q3M

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WPS Website, Webinars, and YouTube Channel

- Worksheet S-10 Uncompensated Care Training - 9/18/2019 60 mins.
- <https://youtu.be/bWQhRT8KliY>
- Cost Report Documentation and Templates Training - 1/14/2020 40 mins.
- <https://youtu.be/gAAXSTNELy8>
- Medicare Bad Debt Requirements - 3/3/2020 59 mins.
- <https://youtu.be/LMa4atowIRU>
- Rural Health Clinic Productivity Standard Exceptions - 8/3/2020 19 mins
- <https://youtu.be/hXFoQuFQQYo>
- Worksheet S-10 Audit Templates and Questionnaire - 8/5/2020 37 mins
- <https://youtu.be/NAPTIPsEgNE>
- Change Request 11642 (Medicare Advantage Factors for NAH and Graduate Medical Education) - 10/13/2020 – 42 mins.
- https://youtu.be/tS_3IgoNlIQ

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WPS Website, Webinars, and YouTube Channel

- October 2020 WPS Quarterly Provider Audit Webinar Recording - 10/19/2020 92 mins.
- <https://youtu.be/UXiKrySLWow>
- Secure-EDI Messaging Portal - 12/1/2020 12 mins.
- <https://youtu.be/hXWxqrTrFWk>
- January 2021 WPS Quarterly Provider Audit Webinar Recording - 1/29/2021 95 mins.
- <https://youtu.be/RjpszaKLnwK>
- Nursing and Allied Health (NAH) Legal Operator Status 3/15/2021 35 mins.
- <https://youtu.be/PrmOupXFvjE>
- S-10 Provider Webinar Part 1 (3/24/2021) – 4/1/2021 119 mins.
- <https://youtu.be/VOM-wmoBReI>
- S-10 Provider Webinar Part 2 (3/30/2021) - 4/1/2021 85 mins.
- <https://youtu.be/tIKNelhvizo>

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WPS Website, Webinars, and YouTube Channel

- Provider-Based Physicians on the Cost Report - 8/17/2021 65 mins.
- <https://youtu.be/2UavorAILgY>
- Audit Sampling - 8/26/2021 30 mins.
- <https://youtu.be/WsMY5NQR3fk>
- September 2021 WPS Quarterly Provider Audit Webinar Recording - 9/17/2021 118 mins.
- <https://youtu.be/jXUsWVkfAoo>
- WPS Audit – Cost Assignment and Allocation - 10/1/2021 59 mins.
- <https://youtu.be/FmWFF2HWXXk>
- ESRD High Discharge Provider Training– 2/9/2022 32 mins.
- <https://youtu.be/5fCMBC6mrIs>
- 2/17/22 WPS Provider S-10 Audit Webinar - 2/17/2022 121 mins.
- <https://youtu.be/eseYugPmqnA>

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WPS Website, Webinars, and YouTube Channel

- Planned for future
 - RHC Rates
 - SCH/MDH Volume Decrease Adjustments
 - Swingbed Nursing Facility (SNF/NF) Rates

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WPS Website, Webinars, and YouTube Channel

- WPS Audit Webinars
 - October 2020
 - January 2021
 - March 2021 (2-part S-10 specific)
 - September 2021
 - February 2022 (2-part S-10 specific)
 - Will be scheduling one May-June 2022

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