Wage Index, Occupational Mix Survey and Appeals Update

Presented to:

Central New York Chapter

March 18, 2016
AGENDA

• Wage Index
  ➢ Overview
  ➢ Significant Changes
  ➢ Important Timelines
  ➢ Update on Reform
  ➢ Recent OIG Audits
  ➢ Key Areas of Focus
  ➢ Reclassifications

• Occupational Mix Survey
  ➢ Next survey – 2016?
  ➢ Overview

• Appeals

• Cost Report Audit Sampling Methodology
WAGE INDEX:
MEDICARE & MEDICAID REIMBURSEMENT DRIVER
WAGE INDEX: THIS IS A TEAM SPORT

Coming together is a beginning.
Keeping together is progress.
Working together achieves success.
WAGE INDEX:
THIS HAS ALSO EVOLVED INTO AN INDIVIDUAL SPORT FROM A NEW YORK MEDICAID REIMBURSEMENT PERSPECTIVE…
EVERY PENNY COUNTS…

The Wage Index Factor (WIF) has a significant impact to Hospitals’ reimbursement. There are markets in the Upstate New York region where a one percent movement to the collective average hourly rate equates to $1,000,000+ in reimbursement.
The purpose of the WIF is to adjust a provider’s Medicare reimbursement to account for labor cost differences across the country. The WIF also impacts several Hospitals’ Medicaid and HMO reimbursement.

Every acute care hospital's compensation and paid hours are included to develop their labor market’s average hourly wage (AHW) for Medicare.

To arrive at a labor market's WIF:
- ABC labor market's average hourly rate divided by the national average hourly rate.

The Wage Index values are updated annually based on data that is reported by Hospitals on Worksheets S-3 part II through V of their Medicare cost reports.
The WIF is applied to the 'labor' component, which represents approximately **69.6%** of the total standardized amount for markets that have WIFs **greater than 1.0**. For markets with WIFs **less than 1.0**, the labor component represents **62%** of the total standardized amount.
## NEW YORK ILLUSTRATION: IMPACT OF THE MEDICARE WAGE INDEX FACTOR

### HOSPITAL ABC
MEDICARE DISCHARGES = 10,000

SOURCE: Final FFY 2016 Rulings for Medicare Inpatient Prospective Payment System.

<table>
<thead>
<tr>
<th></th>
<th>NEW YORK CITY</th>
<th>ALBANY</th>
<th>SYRACUSE</th>
<th>RURAL NY</th>
<th>UTICA</th>
</tr>
</thead>
<tbody>
<tr>
<td>LABOR RATE</td>
<td>$3,805.30</td>
<td>$3,389.78</td>
<td>$3,389.78</td>
<td>$3,389.78</td>
<td>$3,389.78</td>
</tr>
<tr>
<td>x MEDICARE WAGE INDEX FACTOR</td>
<td>$1.2991</td>
<td>$0.8418</td>
<td>$0.9684</td>
<td>$0.8397</td>
<td>$0.8980</td>
</tr>
<tr>
<td>ADJUSTED LABOR</td>
<td>$4,943.47</td>
<td>$2,853.52</td>
<td>$3,262.66</td>
<td>$2,846.40</td>
<td>$3,044.02</td>
</tr>
<tr>
<td>ADD: NON-LABOR</td>
<td>$1,662.09</td>
<td>$2,077.61</td>
<td>$2,077.61</td>
<td>$2,077.61</td>
<td>$2,077.61</td>
</tr>
<tr>
<td>TOTAL ADJUSTED LABOR AND NON-LABOR</td>
<td>$6,605.56</td>
<td>$4,931.13</td>
<td>$5,360.27</td>
<td>$4,924.01</td>
<td>$5,121.63</td>
</tr>
<tr>
<td>x MEDICARE DISCHARGES</td>
<td>10,000</td>
<td>10,000</td>
<td>10,000</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>MEDICARE PAYMENT RATE FOR INPATIENT STAYS</td>
<td>$66,056,562</td>
<td>$49,311,268</td>
<td>$53,602,730</td>
<td>$49,240,083</td>
<td>$51,216,324</td>
</tr>
</tbody>
</table>

*The reimbursement estimates above do not include the impact to "outpatient" services and are pre-CMI and add-ons (e.g., IME and DSH).*
Overview (continued)

New York Medicaid Reimbursement Rates…

- Our Hospitals’ New York Medicaid Rates are impacted by the wage index information. For Medicaid, the wage index rates are being calculated on a hospital-specific basis (versus the market-wide basis that is used for Medicare). As a result, it is imperative that everyone is paying close attention to their hospital’s data.

- It’s important to reconcile your wage index data that is being used by the State. ERRORS have been identified and successfully appealed.

- FYs 2008, 2009 & 2010 wage index data is currently being used. The State DOH indicated that the rates may be updated every four years.
Over the years, CMS acknowledged that it is an administrative burden for them (Medicare) to receive revisions to wage index schedules after they are originally filed with the Medicare Administrative Contractors (MACs).

All the signs are there, the “window of opportunity” to submit revisions is closing.

A few years ago, the deadline to submit revisions to wage index schedules (nationally) was December 10, 2012. In the Fall 2014, the deadline was October 6, 2014, two months earlier. The deadline to submit wage index revisions to data that will drive Hospitals’ Federal FY 2017 reimbursement was September 2, 2015. For future years, it is unknown if CMS will allow for a formal “window of opportunity” process/timetable for Hospitals to amend their wage index data after it is originally filed with the MACs.
Significant Change:
THE OMB REPORT...

On February 28, 2013, the Executive Office of the President, Office of Management and Budget (OMB) issued Bulletin No. 13-01 for Revised Delineations of Metropolitan Statistical Areas...

✓ One Year Transition (FFY 2015) for Hospitals that were going to be adversely impacted. This goes away for FFY 2016.

✓ Three Year Transition for Hospitals in an urban area that became rural. The first year started in FFY 2015.
### FEDERAL FY 2017 HOSPITAL WAGE INDEX DEVELOPMENT TIMETABLE

**SOURCE: CMS WEBSITE**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2, 2015</td>
<td>Deadline for Hospitals to submit revisions to their FY 2013 wage index and 2013 occupational mix data (&quot;data&quot;).</td>
</tr>
<tr>
<td>November 13, 2015</td>
<td>Deadline for MACs to complete desk reviews of the data.</td>
</tr>
<tr>
<td>January 29, 2016</td>
<td>Release date of revised FY 2017 wage index and occupational mix files as PUFs on the CMS Website.</td>
</tr>
<tr>
<td>February 16, 2016</td>
<td>Deadline for Hospitals to submit requests and supporting documentation for:</td>
</tr>
<tr>
<td></td>
<td>1) Corrections to errors in the January PUFs due to CMS or MAC mishandling of the data, OR</td>
</tr>
<tr>
<td></td>
<td>2) Revisions of desk review adjustments to their data, as included in the January PUFs (and to provide documentation to support the request).</td>
</tr>
<tr>
<td>March 24, 2016</td>
<td>Deadline for MAC to transmit final revised data. In addition, MACs must also send written notifications to hospitals regarding the hospitals' February 16, 2016, correction/revision requests.</td>
</tr>
<tr>
<td>April 5, 2016</td>
<td>Deadline for Hospitals to appeal MAC determinations and request CMS' intervention.</td>
</tr>
<tr>
<td>April 21, 2016</td>
<td>Release date of Final Federal FY 2017 wage index and occupational mix data PUFs. Hospitals have approximately one month to verify their data and submit corrections to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final data.</td>
</tr>
<tr>
<td>May 23, 2016</td>
<td>Deadline for hospitals to submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data as posted in the April 21, 2016 PUF.</td>
</tr>
</tbody>
</table>
Update on Wage Index Reform

A few years ago, the Centers for Medicare and Medicaid Services (CMS) acknowledged that the current “wage index” system is vulnerable to many inaccuracies and that reform was needed. It appears as if CMS has not made any final decisions on an “alternative” way yet. In any event, such proposals would need Congressional approval.

From our perspective…
Why some type of reform is needed:

✓ Things are not simplified and standardized for healthcare organizations.
  ➢ The rules are vague.
  ➢ Inconsistent treatments by MACs continue across the U.S.

✓ Isn’t a primary purpose of the wage index factor to adjust for labor differences across the country?
  ➢ For Example: There are Hospitals that have labor rates 40% below their assigned labor market’s labor rates.

✓ There’s no urgency to “GET IT RIGHT, the first time around…”
  ➢ The wage index information has no impact on my current year cost report settlement and besides, CMS gives Hospitals over 1 year to go back and make revisions.
• Section 3137(b) of the Affordable Care Act required CMS to submit to Congress, a report that includes a plan to reform the wage index.

• Although we believe some type of change is needed, we do not anticipate significant changes to the current wage index system over the next few years.
CMS Considerations for Reform

- CMS and Acumen, LLC proposed to continue to use data from the current methodology. However, there would be transition to more of a hospital-specific wage index that would include additional adjustments to account for the zip codes where each hospital’s employees reside.

- A few of concerns:
  1. The proposal may continue to use the current methodology which CMS realizes is broken and needs to be fixed.
  2. Hospitals may be penalized if they hire their employees from lower wage neighborhoods (zip codes).
  3. This proposal may lead to questionable / unethical behavior. For example, hospitals may begin to recruit their employees from more “affluent” neighborhoods (zip codes).
Reform is inevitable…
Consider participating in the reform process

"The best way to predict the future is to create it!"
Legislators who have proposed bills related to wage index changes…

Meet U.S. House of Representatives: Diane Black (TN) and Kevin Brady (TX)
Recent OIG Wage Index Audits…

In our opinion, the OIG “findings” were based on their interpretation of the vague rules.

✓ PHYSICIANS
✓ MARKETING COSTS
✓ FRINGE BENEFITS
A few examples of key areas of focus:

- WAGE RELATED COSTS (FRINGE BENEFITS)
- CONTRACT LABOR
- PHYSICIANS
FRINGE BENEFITS

Common Findings: Understatement of Core Fringes

* Pension
* I&R FICA Refunds
* FICA (general)
* Allocation Methods
* Consideration of Non-Core Fringes

*Teaming between Reimbursement, Finance, Accounting & HR.
*Understand Worksheet S-3 Part IV
*Consider Salary and FTE allocation methods.
Key Areas of Continued Focus…

PENSION

BACKGROUND OF DEFINED BENEFIT PENSION (DBP) PLAN COSTS
REPORTING ON THE WAGE INDEX...

- When I was a Medicare and Medicaid Auditor back in the mid-1990’s…
  Before CMS started issuing what they called “clarifications”, GAAP was reported by Hospitals and audited/approved by Medicare Fiscal Intermediaries (FIs).

- Mid-to-late 2000’s: CMS issues what they call “clarifications”
  - In December 2009, CMS issues “new” detailed instructions along with a “pension template” to assist Hospitals and FIs in determining allowable DBP plan costs.

- Problem with these CMS “clarifications”
  - These were “changes” in the rules, not clarifications.
  - Proper steps were not taken by CMS to change the rules.
  - Inconsistencies across the U.S. which resulted in no even playing field.

- Federal FY 2012 Rulings – CMS goes through proper legal steps to change the rules.
Summary of the CMS rules for reporting DBP Plan costs on the wage index:

Beginning for Federal Fiscal Year (FY) 2013, CMS will be using a rolling 3-year average of the funds that the Hospital contributed to its DBP plan when calculating the wage index. This 3-year average includes the prior year, current year and subsequent year. For example, as it relates to a Hospital’s FY 2013 wage index data, the 3-year average of employer contributions made during the calendar years of 2011, 2012 and 2013 should be used.

In addition, CMS has implemented a transition policy which is based on funding that may have exceeded the amounts reportable for Federal FY 2007 through Federal FY 2012 wage indexes (cost reports with begin dates during the period on or after October 1, 2002 through September 30, 2008). This transition policy will allow hospitals to establish a prefunding balance equal to (A) minus (B). (A) is the sum of the cash contributions made during a period of consecutive provider cost reporting periods, commencing no earlier than October 1, 2002 (the cost reporting period used for the Federal FY 2007 wage index) and ending with the cost reporting period that was used to develop the Federal FY 2012 wage index. (B) is the sum of the pension costs actually reflected in the wage index for the same cost reporting periods. This transition policy will allow hospitals to include 1/10th of the prefunding balance in the wage index each year, commencing with Federal FY 2013 through Federal FY 2022, in 10 equal prefunding instalments.

Important Note: In order for a Hospital to be eligible for the prefunding balance adjustment, they (the Hospital) must quantify it and ask Medicare for this adjustment.
## Key Areas of Continued Focus:
Pension: Adjustment #1 (Required)

<table>
<thead>
<tr>
<th>Cost Reporting Year</th>
<th>Employer Contributions</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$10,000,000</td>
<td>IRS Form 5500</td>
</tr>
<tr>
<td>2012</td>
<td>$15,000,000</td>
<td>IRS Form 5500</td>
</tr>
<tr>
<td>2013</td>
<td>$20,000,000</td>
<td>IRS Form 5500 or Actuary / Accounting Estimates</td>
</tr>
</tbody>
</table>

Total Employer Contributions from above  
$45,000,000

divide by 3  
$3

Allowable Employer Contributions  
$15,000,000  
calc

Add: Allowable Pre-Funding Balance  
$1,500,000  
see tab called Prefunding Balance

Total Allowable DBP Costs for Federal FY 2017  
$16,500,000
### Key Areas of Continued Focus:

**Pension: Adjustment #2 (Optional – Prefunding Balance)**

Important Note: Hospitals must quantify and ask for this adjustment.

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>TOTAL</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Contributions for DBP Plan</td>
<td>$150,000</td>
<td>$500,000</td>
<td>$2,500,000</td>
<td>$5,000,000</td>
<td>$7,500,000</td>
<td>$10,000,000</td>
<td>$25,650,000</td>
<td>IRS 5500 Forms</td>
</tr>
<tr>
<td>DBP plan costs allowed in the Wage Index</td>
<td>$75,000</td>
<td>$475,000</td>
<td>$2,400,000</td>
<td>-</td>
<td>-</td>
<td>$7,700,000</td>
<td>$10,650,000</td>
<td>Hospital's GL/Internal WPs and Medicare auditor WPs</td>
</tr>
<tr>
<td>Difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Difference</td>
<td>$15,000,000</td>
</tr>
</tbody>
</table>

**Divide by 10 (10 year transitional period)**

**Allowable prefunding balance to be added each year**

|                      |      |      |      |      |      |      | $1,500,000 |
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 FICA Refund has two parts. Under Part I, the IRS will refund FICA and Medicare taxes to 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 then return the refund to the residents employed by them (the hospital) between 1994 and 2005. Although both refunds apply for tax periods ending before April 1, 2005, hospitals are not receiving these refunds until 2009 or later.

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). If I&R FICA refunds were received or accrued by a teaching hospital, they should not be used to reduce the allowable wage related costs (fringe benefits) on the wage index.

Everyone should be re-visiting their wage index data to determine how any refunds or accruals were handled. If they were used to reduce your allowable fringes that were reported, you should notify your MAC and request revisions.
Key Areas of Continued Focus: CONTRACT LABOR

CONTRACT LABOR – Examples:

* Administrative & General (A&G)
  - Consulting: Financial, Reimbursement, Regulatory, Tax
  - Audits (internal and external)
  - Legal

* Executive Level – VP or Administrator; C-Suite

* System Level – e.g., legal and consulting

* Human Resources (HR) consulting

* Hands-On Patient Care (Non Physician)
  - Nurses
  - Therapists
  - Wound Care
CONTRACT LABOR – Consideration:

Consider including language in your vendor contracts that requires them (your vendors) to include their fees (professional and other expenses) and hours on their invoices. If the hours are not identified on the invoices, the vendor agrees to provide their actual number of hours worked, in a timely fashion, when requested by the Hospital / Health System.
Key Areas of Continued Focus: PHYSICIAN COMPENSATION

PHYSICIAN COMPENSATION

* The physician compensation (salary, fees and fringes) that is included in Hospitals’ bottom-line averages used to calculate the wage index, is the compensation related to “PART A – Administration (Non-Teaching).”

* Time Studies should be completed on a periodic basis each year.

* Physician contracts should identify Part B versus Part A time.

* Buy-in from Administration – Clinical and Financial.

* Physician Education – time studies still impact reimbursement.

* Salaries and Fees need to be segregated and reconciled.
Wage Index: Traditional Geographic Reclassifications

If a Hospital or Hospital Group can demonstrate that their labor costs are comparable to a different labor market’s labor costs (a labor market with a higher wage index factor) and they are in close proximity of that market, they may be able to reclassify to that market for purposes of the wage index. A traditional geographic reclassification would be for 3 years.

- **INDIVIDUAL HOSPITAL RECLASSIFICATION** – For an individual Hospital to reclassify to a different labor market, they must meet the “84% and 108%” tests and they need to be located within 15 miles of the market they would like to reclassify to.

Specifically, the 84% test means that the Hospital’s 3-year average hourly rate needs to represent 84% of the 3-year average hourly rate of the market they are seeking to reclassify to. The 108% test means that the Hospital’s 3 year average hourly rate needs to represent 108% of the 3-year average hourly rate of the market they are located in.

- **GROUP (COUNTY or STATEWIDE) HOSPITAL RECLASSIFICATION** – A group of Hospitals can reclassify to a different labor market if their collective labor rate (3-year average) represents 85% of the labor rate of the market where they want to reclassify to. The County or State also needs to be adjacent to the market where they want to reclassify to.
Reclassifications:
Dilution Illustration (example of no dilution)

<table>
<thead>
<tr>
<th>SCENARIO: THE FOLLOWING THREE HOSPITALS HAVE BEEN APPROVED BY THE MGCRB TO RECLASSIFY TO ABC MARKET:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL Z</td>
</tr>
<tr>
<td>HOSPITAL Y</td>
</tr>
<tr>
<td>HOSPITAL X</td>
</tr>
</tbody>
</table>

**TEST TO DETERMINE IF THERE WILL BE A DILUTION**

<table>
<thead>
<tr>
<th>ABC MARKET</th>
<th>COMPENSATION</th>
<th>HOURS</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 1,000,000,000</td>
<td>20,000,000</td>
<td>$ 50.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITALS RECLASSIFYING INTO ABC MARKET:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL Z</td>
</tr>
<tr>
<td>HOSPITAL Y</td>
</tr>
<tr>
<td>HOSPITAL X</td>
</tr>
</tbody>
</table>

**TOTAL FOR HOSPITALS RECLASSIFYING INTO ABC MARKET**

|                                                | $ 300,000,000 | 6,208,388 | $ 48.32 |

**TOTALS FOR ABC MARKET AND HOSPITALS RECLASSIFYING INTO ABC MARKET**

|                                                | $ 1,300,000,000 | 26,208,388 | $ 49.60 |

**PERCENT VARIANCE**

\[ \frac{(C-A)}{A} \times 100\% = -0.80\% \]

**DILUTION - YES OR NO?**

NO

DIFFERENCE IS LESS THAN 1%
Reclassifications:
Dilution Illustration (example of a dilution)

RECLASSIFICATIONS: EXAMPLE WHERE THERE WOULD BE A DILUTED RECLASSIFIED WAGE INDEX FACTOR

SCENARIO:
The following three hospitals have been approved by the MGCRB to reclassify to ABC market:
- Hospital Z
- Hospital Y
- Hospital X

<table>
<thead>
<tr>
<th></th>
<th>Compensation</th>
<th>Hours</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Market</td>
<td>$1,000,000,000</td>
<td>20,000,000</td>
<td>$50.00</td>
</tr>
<tr>
<td>Hospital Z</td>
<td>$50,000,000</td>
<td>1,111,111</td>
<td>$45.00</td>
</tr>
<tr>
<td>Hospital Y</td>
<td>$100,000,000</td>
<td>2,173,913</td>
<td>$46.00</td>
</tr>
<tr>
<td>Hospital X</td>
<td>$150,000,000</td>
<td>3,191,489</td>
<td>$47.00</td>
</tr>
<tr>
<td>Total for Hospitals reclassifying into ABC market</td>
<td>$300,000,000</td>
<td>6,476,514</td>
<td>$46.32</td>
</tr>
<tr>
<td>Totals for ABC market and hospitals reclassifying into ABC market</td>
<td>$1,300,000,000</td>
<td>26,476,514</td>
<td>$49.10</td>
</tr>
</tbody>
</table>

Percent Variance: 
\[
\frac{(C-A)}{A} = -1.80\%
\]

Dilution - Yes or No? 
Yes
RECAP: What’s Important…

- This is a TEAM SPORT – Everyone’s wage index data counts. Communication and Sharing Best Practices are important.

- Medicaid rates are calculated on a hospital-specific basis. Therefore, it is imperative that every New York hospital is paying close attention to their own data.

- Consider your reclassification options (if any), especially if the OMB report is implemented by CMS for wage index purposes. Keep in mind, reclassifications are “temporary.”

- Reform is inevitable. Consider participating in reform process.

- Closely monitor CMS proposals.

- Implement Processes to Get It Right the First Time Around…

- At the end of the day, it’s all about ensuring that your organization is receiving it’s “FAIR SHARE” of reimbursement, in a compliant fashion.
Occupational Mix Survey Update
Occupational Mix Survey Background

• Occupational Mix (OM) Survey is conducted every three years.

• Designed to neutralize the effect of staffing decisions on the wage index
  - Labor markets with an expensive occupational mix will have their average hourly wages adjusted downward.
  - Labor markets with a less expensive occupational mix will have their average hourly wages adjusted upward.

• Survey only considers nursing mix.
Occupational Mix Survey

• Last reporting period is calendar year 2013. It was applied to the Federal FY 2016 – FY 2018 wage index

• Survey form is unchanged from the 2010 survey.

• Next survey: Calendar Year 2016? We need to be thinking about the survey now.

• CMS estimates time to complete the survey at 480 hours per response.
Occupational Mix Survey

• Hospitals required to submit survey
  - Hospitals subject to Inpatient Prospective Payment System (IPPS), including Sole Community and Medicare Dependent Hospitals

• Hospitals not required to submit survey
  - Critical Access Hospitals
  - IPPS exempt Rehabilitation, Psychiatric and Long-term Care Hospitals
  - Cancer Hospitals
  - Children’s Hospitals
### Sample Survey Data

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Paid Salaries</th>
<th>Paid Hours</th>
<th>Average Hourly Wage (Salaries/Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Occupations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>109,857,061</td>
<td>2,319,705</td>
<td>47.36</td>
</tr>
<tr>
<td>LPNs and Surgical Technologists</td>
<td>4,541,110</td>
<td>181,610</td>
<td>25.00</td>
</tr>
<tr>
<td>Nursing Aides, Orderlies, &amp; Attendants</td>
<td>26,355,438</td>
<td>1,273,430</td>
<td>20.70</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>3,068,712</td>
<td>155,481</td>
<td>19.74</td>
</tr>
<tr>
<td><strong>Total Nursing</strong></td>
<td>143,822,321</td>
<td>3,930,226</td>
<td>36.59</td>
</tr>
<tr>
<td><strong>All Other Occupations</strong></td>
<td>202,282,316</td>
<td>6,243,439</td>
<td>32.40</td>
</tr>
<tr>
<td><strong>Total (Nursing and All Other)</strong></td>
<td>346,104,637</td>
<td>10,173,665</td>
<td>34.02</td>
</tr>
</tbody>
</table>
# Sample Occupational Mix Adjustment Calculation

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Paid Hours</th>
<th>Percent by AHW</th>
<th>Adjusted AHW</th>
<th>Occ Mix Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Occupations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>2,319,705</td>
<td>59.02%</td>
<td>37.43</td>
<td>22.09</td>
</tr>
<tr>
<td>LPNs and Surgical Technologists</td>
<td>181,610</td>
<td>4.62%</td>
<td>21.77</td>
<td>1.01</td>
</tr>
<tr>
<td>Nursing Aides, Orderlies, &amp; Attendants</td>
<td>1,273,430</td>
<td>32.40%</td>
<td>15.32</td>
<td>4.96</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>155,481</td>
<td>3.96%</td>
<td>17.21</td>
<td>0.68</td>
</tr>
<tr>
<td>Total Nursing</td>
<td>3,930,226</td>
<td>100.00%</td>
<td>28.74</td>
<td>31.80</td>
</tr>
</tbody>
</table>

**Formula:**

\[
\text{Occ Mix Adjustment Factor} = \frac{\text{FY 14 C x D F}}{E}
\]
## Sample Occupational Mix Adjustment Application

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Paid Salaries</th>
<th>Provider % by Total</th>
<th>Total Wages &amp; Benefits from S-3</th>
<th>Allocated Wages</th>
<th>Occupational Mix Adjustment</th>
<th>Occupational Mix Adjusted Wages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Nursing</td>
<td>143,822,321</td>
<td>41.55%</td>
<td>539,827,868</td>
<td>224,323,192</td>
<td>23,877,629</td>
<td>248,200,821</td>
</tr>
<tr>
<td>All Other Occupations</td>
<td>202,282,316</td>
<td>58.45%</td>
<td>539,827,868</td>
<td>315,504,676</td>
<td>-</td>
<td>315,504,676</td>
</tr>
<tr>
<td>Total</td>
<td>346,104,637</td>
<td>100.00%</td>
<td>539,827,868</td>
<td>23,877,629</td>
<td>563,705,497</td>
<td></td>
</tr>
</tbody>
</table>
# Occupational Mix Adjustment and Impact

<table>
<thead>
<tr>
<th></th>
<th>Unadjusted Wage Data</th>
<th>Occupational Mix Adjusted</th>
<th>Occupational Mix Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages and Benefits from S-3</td>
<td>539,827,868</td>
<td>563,705,497</td>
<td>23,877,629</td>
</tr>
<tr>
<td>Paid Hours from S-3</td>
<td>11,107,683</td>
<td>11,107,683</td>
<td>11,107,683</td>
</tr>
<tr>
<td>Average Hourly Wage</td>
<td>48.60</td>
<td>50.75</td>
<td>2.15</td>
</tr>
<tr>
<td>Percentage Change in Average Hourly Wage</td>
<td></td>
<td></td>
<td>4.4%</td>
</tr>
</tbody>
</table>
These are the occupational mix adjustment factors that were applied to the nursing percentage of wages for the applicable Federal fiscal years for the NY Markets.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>Rural NY</td>
<td>1.0361</td>
<td>1.0692</td>
<td>0.0331</td>
</tr>
<tr>
<td>10580</td>
<td>Albany-Schenectady-Troy, NY</td>
<td>1.0228</td>
<td>1.0293</td>
<td>0.0065</td>
</tr>
<tr>
<td>13780</td>
<td>Binghamton, NY</td>
<td>1.0926</td>
<td>1.0285</td>
<td>-0.0641</td>
</tr>
<tr>
<td>15380</td>
<td>Buffalo-Cheektowaga-Niagara Falls, NY</td>
<td>1.0023</td>
<td>0.9847</td>
<td>-0.0176</td>
</tr>
<tr>
<td>20524</td>
<td>Dutchess County-Putnam County, NY</td>
<td>1.0339</td>
<td>1.0367</td>
<td>0.0028</td>
</tr>
<tr>
<td>21300</td>
<td>Elmira, NY</td>
<td>1.0215</td>
<td>1.0277</td>
<td>0.0062</td>
</tr>
<tr>
<td>24020</td>
<td>Glens Falls, NY</td>
<td>1.0449</td>
<td>1.057</td>
<td>0.0121</td>
</tr>
<tr>
<td>27060</td>
<td>Ithaca, NY</td>
<td>0.9985</td>
<td>0.9823</td>
<td>-0.0162</td>
</tr>
<tr>
<td>28740</td>
<td>Kingston, NY</td>
<td>1.0407</td>
<td>1.0535</td>
<td>0.0128</td>
</tr>
<tr>
<td>35004</td>
<td>Nassau County-Suffolk County, NY</td>
<td>1.043</td>
<td>1.0432</td>
<td>0.0002</td>
</tr>
<tr>
<td>35614</td>
<td>New York-Jersey City-White Plains, NY-NJ</td>
<td>1.0228</td>
<td>1.0289</td>
<td>0.0061</td>
</tr>
<tr>
<td>40380</td>
<td>Rochester, NY</td>
<td>1.0258</td>
<td>1.0185</td>
<td>-0.0073</td>
</tr>
<tr>
<td>45060</td>
<td>Syracuse, NY</td>
<td>1.0051</td>
<td>0.9889</td>
<td>-0.0162</td>
</tr>
<tr>
<td>46540</td>
<td>Utica-Rome, NY</td>
<td>1.026</td>
<td>1.0126</td>
<td>-0.0134</td>
</tr>
<tr>
<td>48060</td>
<td>Watertown-Fort Drum, NY</td>
<td>1.0604</td>
<td>1.0711</td>
<td>0.0107</td>
</tr>
</tbody>
</table>
Key Considerations

- There are two primary drivers of the Occupational Mix adjustment.
  - Hours by nursing category
  - Ratio of nursing salaries to total salaries
- The OM survey should not be completed without coordination between Reimbursement, Clinical Nursing Administration, HR and Payroll.
  - CMS definitions of nursing categories may differ from hospital clinical definitions, which may vary from unit to unit.
  - Provide CMS definitions to clinical administration to help in the determination of the nurse category groupings.
Items to Include in Survey

• Last survey (2013) - Employee salary and hours for pay periods ending between Jan. 1, 2013, and Dec. 31, 2013:
  - Payroll Register / Labor Distribution by worked department
  - Paid amounts only
  - Hours determined consistently with wage index
  - Consider salary adjustments and associated hours

• Contract labor (Patient and Non-patient)
  - Labor expense only
  - Hours

• Home office salary, hours and contract labor
Items to Exclude from Survey

• Excluded areas: Same grouping of non-PPS cost centers as Worksheet S-3, Part II, Lines 9 & 10
  - Sub-providers (Psychiatric, Rehabilitation)
  - Other non-hospital services (SNF, Long-term care, HHA, Hospice, Ambulance, etc.)
  - Nursing and allied health cost centers
  - Organ acquisition
  - Non-reimbursable cost centers

• Fringe Benefits

• Physician Part A Teaching

• Physician Part B

• Non-physician Part B

• Interns and Residents
Nursing Categories: General Guidelines

• Include the following as nursing:
  - Personnel on specified nursing cost report lines
  - Employed and contracted personnel, subject to nursing category definitions
  - Personnel must be reported on Worksheet S-3, Part II

• Do not include nurses who:
  - Function solely in administrative or leadership roles,
  - Do not directly supervise staff nurses who provide patient care, and
  - Do not provide direct patient care.
## Nursing Cost Report Lines

<table>
<thead>
<tr>
<th>COST CENTER DESCRIPTIONS</th>
<th>Lines for 2552-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Administration</td>
<td>13</td>
</tr>
<tr>
<td>Adults and Pediatrics (General Routine Care)</td>
<td>30</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>31</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>32</td>
</tr>
<tr>
<td>Burn Intensive Care Unit</td>
<td>33</td>
</tr>
<tr>
<td>Surgical Intensive Care Unit</td>
<td>34</td>
</tr>
<tr>
<td>Other Special Care (specify)</td>
<td>35</td>
</tr>
<tr>
<td>Nursery</td>
<td>43</td>
</tr>
<tr>
<td>Operating Room</td>
<td>50</td>
</tr>
<tr>
<td>Recovery Room</td>
<td>51</td>
</tr>
<tr>
<td>Delivery Room and Labor Room</td>
<td>52</td>
</tr>
<tr>
<td>Electrocardiology</td>
<td>69</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>74</td>
</tr>
<tr>
<td>Ambulatory Surgical Center (Non-Distinct Part)</td>
<td>75</td>
</tr>
<tr>
<td>Other Ancillary</td>
<td>76</td>
</tr>
<tr>
<td>Clinics</td>
<td>90</td>
</tr>
<tr>
<td>Emergency</td>
<td>91</td>
</tr>
<tr>
<td>Observation Beds</td>
<td>92</td>
</tr>
</tbody>
</table>

Note: Subscripted cost centers that would normally fall into one of these cost centers should be included on the survey.
There may be a problem with the CMS list of approved nursing cost centers...

The problem is that there are inconsistencies across the United States, because there are hospitals that have nursing professionals that fall outside of the CMS list of approved nursing cost centers. For example, New York hospitals are required to report compensation for Supervising Physicians and their support staff (which includes nursing professionals) in CMS cost center 18 series for Supervising Physicians. This cost center is not included on the CMS list of approved cost centers. In other regions across the country, hospitals report these costs in the inpatient routine and ancillary cost centers that are included on the CMS list of approved nursing cost centers.
Nursing Categories: Registered Nurses

- Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to patients. May advise patients on health maintenance and disease prevention or provide case management.
- Licensing or registration required
- Examples: Staff Nurse, Case Manager, Nursing Educator, Infection Control Nurse
- Include salaries and hours for Advanced Practice Nurses (NP, Midwives, CRNA, etc.) if not billable under Part B
Nursing Categories: Licensed Practical Nurses and Surgical Technologists

• Licensed Practical Nurses
  - Licensing required after state-approved nursing program
  - Basic bedside care
  - May be supervised by registered nurse
  - May supervise assistants or aides

• Surgical Technologists
  - Assist in operations under physician or surgical personnel supervision
  - OR preparation
  - Patient preparation and transport to/from surgery
Nursing Categories: Nursing Aides, Orderlies and Attendants

• Provide basic patient care under nursing supervision
  - Feeding
  - Bathing, grooming and dressing
  - Patient transport
  - Changing linens

• Examples:
  - Certified Nursing Assistant
  - Hospital Aide
  - Infirmary Aide
Nursing Categories: Medical Assistants

• Administrative Duties
  - Scheduling, medical record maintenance, documentation for billing and coding

• Clinical duties, under physician supervision
  - Vital signs and medical histories, patient preparation, blood draws and administration of medicine

• Instructions state to exclude:
  - Phlebotomists, information technology, health information management, medical secretaries, ward clerks and general office personnel
  - Use judgment and discuss roles with clinical leadership and floor personnel.
All Other Occupations

• Personnel outside of nursing cost report lines
• Employed or contracted personnel outside nursing category definitions
• Nurses performing solely administrative and leadership functions, who do not supervise patient care nursing staff and who do not provide direct patient care
• Home Office and Related Party
• Overhead Cost Centers
Allocations to Excluded Areas

• Salaries and hours for the following components must be allocated between PPS areas and excluded areas:
  - General service cost centers
  - Home office (if not assigned to General service)
  - Related party (if not assigned to General service)

• Allocate salaries and hours based on the ratio of excluded area hours to total hours.
  - Allocations to PPS areas are included in the All Other category.
  - Allocations to excluded areas are excluded from the survey.
Review Considerations

- Mix of registered nurses to other nursing categories.
- Ratio of nursing salaries to all total salaries.
- Have administrative personnel been excluded from the nursing categories?
- Have hours been analyzed to eliminate excludable pay types (on-call, shift differential, etc.)?
- Have overhead and home office amounts been allocated between acute PPS and excluded areas?
### 2013 vs 2010 OCCUPATIONAL MIX SURVEYS

<table>
<thead>
<tr>
<th></th>
<th>% TO TOTAL FOR FEDERAL FY 2015 (USING 2010 OM SURVEY)</th>
<th>% TO TOTAL FOR FEDERAL FY 2016 (USING 2013 OM SURVEY)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL NATIONAL NURSING PERCENTAGES BY CATEGORY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>72.00%</td>
<td>71.63%</td>
</tr>
<tr>
<td>LPNs and SURGICAL TECHS</td>
<td>7.42%</td>
<td>6.86%</td>
</tr>
<tr>
<td>NURSE AIDES, ORDERLIES AND ATTENDANTS</td>
<td>17.55%</td>
<td>17.94%</td>
</tr>
<tr>
<td>MEDICAL ASSISTANTS</td>
<td>3.03%</td>
<td>3.57%</td>
</tr>
<tr>
<td>TOTAL NURSING</td>
<td><strong>100.00%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>NATIONAL NURSING VS ALL OTHER PERCENTAGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSING</td>
<td>39.63%</td>
<td>40.12%</td>
</tr>
<tr>
<td>ALL OTHER OCCUPATIONS</td>
<td>60.37%</td>
<td>59.88%</td>
</tr>
<tr>
<td>TOTAL</td>
<td><strong>100.00%</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>
APPEALS
Historically, if the Medicare auditors made an adjustment that a provider did not agree with and it was material in nature ($10,000+ impact), the provider would be able to file an appeal with the Department of Health & Human Services’ Provider Reimbursement Review Board (PRRB) within 180 days of the Notice of Program Reimbursement (NPR) date.

The PRRB would not always agree with a provider’s position; however, it was the provider’s right to disagree with the adjustment.
Why is it becoming more difficult for a provider to file an appeal?

There are approximately 10,000 “open” appeals, nationally. This is a significant burden for our government; therefore, they are making it more challenging (difficult) for providers to file an appeal.
What’s the significant change?
Medicare Changes to Cost Report and Appeal Rules

The Outpatient Prospective Payment System (OPPS) final rule was published in the Federal Register on November 13, 2015 and there were revisions to the Medicare cost report and appeal rules. The final rule has moved the appeal requirements from the appeal section of the regulations to the cost reporting section at 42 C.F.R. 413.24(j).

Per 42 C.F.R. 413.24(j), if the provider seeks payment that it believes may not be allowable or may not conform to Medicare policy, the provider must follow the procedures in this regulation to properly self-disallow the specific item in the provider’s cost report as a protested amount. These procedures are:

- Include an estimated reimbursement amount for each specific-disallowed item in the protested amount line of the provider’s cost report.

- Attach a separate work sheet to the provider’s cost report for each specific disallowance item, explaining why the provider self-disallowed each specific item and how the provider calculated the estimated reimbursement amount for each specific disallowed amount.
Medicare Changes to Cost Report and Appeal Rules (continued)

If the contractor determines that the provider did not make an appropriate cost report claim for a specific item, the final contractor determination **must not** include any reimbursement for the specific item.

During an administrative review, the PRRB will follow the procedures in this regulation to determine if the provider’s cost report included an appropriate claim for the specific item under appeal.
APPEALS

SPECIFICITY IS KEY…

CMS has increasingly required greater specificity from providers when reviewing cost report claims and have required that separate issues be individually identified and claimed. Providers need to be aware of issues that they may consider as “one issue,” while the contractor may consider them “several issues,” each of which must be identified separately and described in detail. This has been an issue in the past for DSH, IME and GME issues.

Providers should be as detailed as possible in identifying each issue of a reimbursement claim on their cost report, especially when self-disallowing costs that they anticipate appealing, and to describe each issue with considerable detail.
SELF DISALLOWED & PROTESTED ITEMS

Effective for cost reporting periods ending on or after December 31, 2008, items not being “self disallowed” must be adjusted through the protested cost report process.

If the provider is appealing an item that was not claimed on the cost report because of a regulation, manual or some other legal authority that was predetermined that the item would be disallowed, then the following information would need to be submitted:

1. A concise issue statement describing the self-disallowed item.
2. The reimbursement or payment sought for the item.
3. Why the provider self-disallowed the item instead of claiming reimbursement for the item.
APPEALS

PROTESTED ITEMS

• Protect future appeal rights on the as-filed Medicare cost report.
• The PRRB has recently denied appeals where there was no claim made on the cost report and there was no MAC adjustment to remove that claim.
• If an item is self-disallowed, include a claim in protested items.

Examples of protested items to consider:

1. DSH
2. Medicare Bad Debts
3. HIT
4. Outliers
Unable to Receive Timely Information for Cost Report Submission

In the federal register, there were discussions regarding the hospitals being unable to receive timely information for the cost report submission. The Hospitals mentioned the difficulty in obtaining the most updated information for issues such as Bad Debts, IME, GME and DSH by the cost report submission date. CMS responded:

- CMS respectfully disagrees with the Hospitals’ assertion that the time period of 5 months between the end of the provider’s fiscal year and its cost report due date was too short to capture necessary data.
Unable to Receive Timely Information for Cost Report Submission (continued)

- CMS identified only one circumstance where a provider may have difficulty obtaining sufficient information to make an appropriate cost report claim. The circumstance is when a Hospital experiences difficulty obtaining sufficient information from state agencies about Medicaid-eligible patient days, which is necessary to claim a DSH payment adjustment. CMS, in this limited circumstance, will instruct contractors through new instructions that they must accept one amended cost report submitted within 12 months after the due date of the hospital’s cost report. This is solely for the specific purpose of revising Medicaid-eligible days after receiving updated days information from the state. In the past, it was at the discretion of the contractor to accept an amended cost report.
Unable to Receive Timely Information for Cost Report Submission (continued)

In submitting such an amended cost report for Medicaid-eligible days the Hospital must include:

- The number of additional Medicaid-eligible patient days seeking to include in the DSH calculation.
- A description of the process that the hospital used to identify and accumulate the Medicaid-eligible patient days that were reported and filed in the cost report.
- An explanation of “why” the additional Medicaid-eligible patient days at issue could not be verified by the State by the time the hospital’s cost report was submitted.
ADDING ISSUES TO AN APPEAL

• After filing a hearing request a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the PRRB.

• The request to add issues needs to comply with the same requirements that were necessary for the initial hearing request.

• The specific items raised in the initial hearing request and the specific items identified in subsequent requests to add issues, when combined, satisfy the necessary requirements.

• The PRRB must receive the provider’s request to add issues no later than 60 days after the expiration of the applicable 180-day period.
In a recent letter National Government Services (NGS) sent to a hospital with a 9/30/15 FYE (related to a cost report due in February 2016), it read…

“You must disclose in a cover letter disputes you have with any regulatory and /or policy interpretations (e.g., prior year adjustments) that will be appealed and are included in the protested amounts, along with details and computations of program effect.”
The Board has made revisions to the PRRB Rules (See ALERT 11 under Current Alerts). These instructions are effective July 1, 2015 and supersede previous instructions [Issued August 21, 2008; Revised July 1, 2009, March 1, 2013, and July 1, 2015]. The specific changes to the PRRB Rules have been highlighted and dated with the effective date of the change. The Board may further revise these Rules to reflect changes in the law, regulations or the Board's policy and procedures. PRRB model forms are available in a fillable PDF format for ease of use. Please begin using the revised model forms as soon as possible to ensure all documentation requirements have been met.

COST REPORT REOPENINGS

Per 42 C.F.R. 405.1885 a cost report may be reopened if a written request to reopen is received within three years from the date that the Notice of Amount of Program Reimbursement (NPR) was issued. A cost report reopening may be initiated by:

- The provider within three years from the date that the NPR was issued.
- The Centers for Medicare & Medicaid Services (CMS).
- The Medicare administrative contractor (MAC) where it is:
  - Initiated by the audit branch from a directive from CMS via a finding from the peer review process or other event.
  - Initiated by the appeals unit from findings from CMS or the Office of the Inspector General (OIG).
  - Initiated by the final settlement unit where there is a material error in subsequent payments.
COST REPORT REOPENINGS (continued)

If fraud or similar fault is involved, CMS or the MAC, can reopen the cost report at any time.

All provider-initiated requests must contain proper supporting documentation and be submitted in writing (letter, fax or email) to the MAC. Whether or not the intermediary will reopen a cost report, otherwise final will depend on:

- Whether new and material evidence has been submitted.
- A clear and obvious error was made.
- Determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Information submitted in support of an amended cost report or the audit findings on a previously unaudited cost could provide new and material evidence on which to base a reopening.
COST REPORT AUDIT
SAMPLING METHODOLOGY
Cost Report: Audit Sampling Methodology

- Medicare is using an audit sampling methodology called “Poisson.”

- Back when I was a Medicare auditor, random sample testing was used and the failure rate (%) of the population reviewed was applied to the entire population. There was a trail for the conclusions (audit results) that were arrived at.

- With the Poisson approach, minor audit findings are resulting in significant adverse financial results to many Hospitals. For example, a one day disallowance for DSH purposes may have an adverse impact of $250k.

- Approved by CMS; however, the trail for the conclusions (audit results) arrived at are questionable.
Questions?

Tracey Roland, Principal

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Email:    troland@reimbursementalliance.com