REVENUE INTEGRITY WEBCAST SERIES
PART 2 – REGULATORY UPDATE

January 14, 2016
Service specialization

- Medicare/Medicaid/Blue Cross and Tricare provider cost reporting
- Medical education regulatory compliance reviews
- Compliance programs
- Provider reimbursement review board appeals
- Budget and contractual allowance projections
- Comparative cost analysis
- Provider-based status issues
- Reimbursement training and education
Learning Objectives

• Key regulatory provisions impacting revenue streams including, although not limited to:
  − Medicare IP PPS rate update
  − National cost/charge ratio
  − Medicare DSH and UCC
  − 340B drug pricing program
  − Medicare bad debts
  − OP PPS provider based changes
  − OP PPS overview

• Action Items/Opportunities
FY 2016 IPPS Update Effective Date & Changes

- Discharges on or after 10/1/2015 through 9/30/2016
  - Market Basket Updates
  - Behavioral Modifications
  - Hospital specific factors
FY 2016 IPPS Rate Update – Change Factors

• The increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and demonstrate meaningful use of certified electronic health record (EHR) technology is 0.9 percent; this includes the following:
  
  +2.4  percent hospital market basket update
  
  -0.5  percentage points multi-factor productivity adjustment
  
  -0.2  percentage points Affordable Care Act adjustment
  
  +1.7  Subtotal
  
  -0.8  percentage points documentation and coding recoupment required by the American Taxpayer Relief Act of 2012.
  
  +0.9  Total Increase
Behavioral Modifications

• Adjustments for documentation and coding improvements
  - Adjustments to account for increased payments based on better coding
  - Payment increases not allowed by law because transition to MS DRGs were not supposed to increase or decrease Medicare payments

- Payment adjustments needed to recoup higher payments
Hospital Specific Adjustment Factors

- 4 possible scenarios for payment:
  - For hospitals that do not submit quality data and are not meaningful EHR users, the applicable percentage adjustment is **-0.1 percent** to the operating standardized amount (No, No)
  - For hospitals that submit quality data but are not meaningful EHR users, the applicable percentage adjustment is **0.5 percent** to the operating standardized amount (Yes, No)
  - For hospitals that do not submit quality data but are meaningful EHR users, the applicable percentage adjustment is **1.1 percent** to the operating standardized amount (No, Yes)
  - For hospitals that submit quality data and are meaningful EHR users, the applicable percentage adjustment is **1.7 percent** to the operating standardized amount (Yes, Yes)
## Hospital Specific Adjustments; Table Form

<table>
<thead>
<tr>
<th>Quality Data</th>
<th>Status:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>1.7</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>1.1</td>
<td>-0.1</td>
</tr>
</tbody>
</table>

### Meaningful Use

<table>
<thead>
<tr>
<th>Status:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>1.7</td>
<td>0.5</td>
</tr>
<tr>
<td>NO</td>
<td>1.1</td>
<td>-0.1</td>
</tr>
</tbody>
</table>
End result:
Combined with the FY 2016 documentation and coding recoupment adjustment of -0.8 percent on the national standardized amount under the American Taxpayer Relief Act of 2012, hospitals that submit quality data and are meaningful EHR users will experience a 0.9 percent increase in payments in FY 2016 relative to FY 2015.

Similarly, in FY 2016, there are eight possible IPPS operating standardized amounts depending on if the hospital’s wage index is >1 or ≤1

<table>
<thead>
<tr>
<th>WI &gt;1.0</th>
<th>WI &lt;= 1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>69.6%</td>
<td>62%</td>
</tr>
</tbody>
</table>
### FY 2016 FR Tables 1A-1E

#### TABLE 1A. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (69.6 PERCENT LABOR SHARE/30.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

<table>
<thead>
<tr>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.7 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.1 Percent)</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.5 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.1 Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor-related</td>
<td>Nonlabor-related</td>
<td>Labor-related</td>
<td>Nonlabor-related</td>
</tr>
<tr>
<td>$3,804.40</td>
<td>$1,661.69</td>
<td>$3,781.96</td>
<td>$1,651.89</td>
</tr>
</tbody>
</table>

#### TABLE 1B. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

<table>
<thead>
<tr>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.7 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.1 Percent)</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.5 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.1 Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor-related</td>
<td>Nonlabor-related</td>
<td>Labor-related</td>
<td>Nonlabor-related</td>
</tr>
<tr>
<td>$3,388.98</td>
<td>$2,077.11</td>
<td>$3,368.99</td>
<td>$2,064.86</td>
</tr>
</tbody>
</table>
### FY 2016 IPPS Update - Changes

#### Wage Index >1.0, 69.6% Labo

<table>
<thead>
<tr>
<th></th>
<th>QD+ MH</th>
<th>MH Only</th>
<th>QD only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor</td>
<td>3804.40</td>
<td>3781.96</td>
<td>3759.51</td>
</tr>
<tr>
<td>Non-Labor</td>
<td>1661.69</td>
<td>1651.89</td>
<td>1642.08</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5466.09</td>
<td>5433.85</td>
<td>5401.59</td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td>-0.5898%</td>
<td>-1.1800%</td>
<td></td>
</tr>
</tbody>
</table>

#### Wage Index <1.0, 62.0% Labo

<table>
<thead>
<tr>
<th></th>
<th>QD+ MH</th>
<th>MH Only</th>
<th>QD only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor</td>
<td>3388.98</td>
<td>3368.99</td>
<td>3348.99</td>
</tr>
<tr>
<td>Non-Labor</td>
<td>2077.11</td>
<td>2064.86</td>
<td>2052.60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5466.09</td>
<td>5433.85</td>
<td>5401.59</td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td>0.0000%</td>
<td>-0.5898%</td>
<td>-1.1800%</td>
</tr>
</tbody>
</table>
• Adopted an IPPS transition to ICD-10 effective Oct 1
• Final rule continues use of Medicare severity diagnosis related group (MS-DRG) classification system, which has been used since FY 2008
  – Number of MS-DRGs increasing from 751 to 758
  – Relative weight for 79 percent of DRGs will change by less then 5 percent in either direction (up or down)
  – Annual update to list of DRGs subject to the post-acute transfer policy

• *Is there a process to review transfer cases?*
Payment Reform Adjustments

• Payment reductions – Hospital acquired conditions (HAC)/readmissions
• Value-based purchasing
• Market basket reductions
HAC

- Hospital Acquired Conditions
  - The HAC Reduction Program imposes a 1 percent reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates
  - Hospitals remain whole or receive payment penalty
  - No changes for the FY 2016 program
Hospital Readmissions

- Mandated by ACA
- Effective 10/01/12
- CAHs and post acute care hospitals are exempt
- Medicare DRG payments reduced for high readmission rates; excludes payment adjustments for DSH, IME and outliers
  - FY 2013: Payment reduction up to 1 percent
  - FY 2014: Payment reduction up to 2 percent
  - FY 2015: Payment reduction up to 3 percent
  - Only about 34 percent of all hospitals will avoid an adjustment
  - CMS estimates hospitals will lose $300 million
- The HRRP assesses penalties on hospitals for having “excess” readmission rates when compared to their expected rates and will continue to impose a maximum payment penalty of 3 percent of base Medicare payments in FY 2016, as required by the ACA.

- Hospitals remain whole or lose and CMS gains.
• Value-based Purchasing (VBP)
  - Established by the ACA, the Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on a set of measures.
  - The amount of base operating MS-DRG payment amount reductions for the FY 2016 program year is 1.75 percent.
  - Therefore, the estimated amount available for value-based incentive payments for FY 2016 discharges is approximately $1.5 billion.
  - Hospitals remain whole or earn more or less than the amount they contribute.
FY 2016 IPPS Update – Outlier Threshold

• Outlier threshold amounts:
  – Final FY 2016 threshold: $22,544
  – Final FY 2015 threshold: $24,626
  • Represents an 8.5 percent decrease in the cost outlier threshold, resulting in more cases being eligible for outlier payments
FY 2016 IPPS Update – Capital PPS

• Capital amounts (excluding Puerto Rico)
  – Final FY 2016 federal capital rate: $438.65
  – Final FY 2015 federal capital rate: $434.97

  0.85 percent increase
FY 2016 IPPS Update - Sequester

• Operating and capital standardized amounts subject to -2% percent Medicare sequester

• Reduction that began in 2013 and will continue in 2016 and through 2024 absent new legislation
Provider CCRs will vary from national
National average CCRs from FFY 2016 Final Rule
Values:
- Mark-up formula
- Cost center groupings
CMS groupings
Can this information be used to evaluate pricing strategy beyond Medicare?

<table>
<thead>
<tr>
<th>Group</th>
<th>FY 2016 19 CCRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Days</td>
<td>0.480</td>
</tr>
<tr>
<td>Intensive Days</td>
<td>0.393</td>
</tr>
<tr>
<td>Drugs</td>
<td>0.191</td>
</tr>
<tr>
<td>Supplies &amp; Equipment</td>
<td>0.297</td>
</tr>
<tr>
<td>Implantable Devices</td>
<td>0.337</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>0.332</td>
</tr>
<tr>
<td>Laboratory</td>
<td>0.125</td>
</tr>
<tr>
<td>Operating Room</td>
<td>0.199</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.118</td>
</tr>
<tr>
<td>Cardiac Catheterization</td>
<td>0.124</td>
</tr>
<tr>
<td>Radiology</td>
<td>0.159</td>
</tr>
<tr>
<td>MRI</td>
<td>0.085</td>
</tr>
<tr>
<td>CT Scans</td>
<td>0.041</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>0.183</td>
</tr>
<tr>
<td>Blood</td>
<td>0.336</td>
</tr>
<tr>
<td>Other Services</td>
<td>0.368</td>
</tr>
<tr>
<td>Labor &amp; Delivery</td>
<td>0.404</td>
</tr>
<tr>
<td>Inhalation Therapy</td>
<td>0.177</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>0.106</td>
</tr>
</tbody>
</table>
IP PPS Key Drivers

• Revenue Integrity
  – Clinical Documentation Improvement
  – Coding Education and Independent Reviews
  – Charge Master
  – Transfer DRG process

• Financial/Cost Reporting Opportunities
  – Pricing Strategy
    • Impact on Outlier Reimbursement
    • Impact on non-governmental payers
    • Impact on development of national CCRs
  – Cost Reporting
    • Wage Index and Geographic Classification
    • Proper Matching of costs; total charges and program charges
    • Special Payment Provisions
Wage Index Key Areas for Review

• Hours are properly stated
• Benefits are identified and allocated properly
• Physician costs and hours are properly stated
• Contract labor is identified
• All providers must have dietary and housekeeping dollars and hours on S-3 Pt II
• Allowable Defined Benefit Contribution Accounting
CMS Defined Benefit Plan Recognition

- Stated based on a **three-year** average of contributions.
- Contributions included are the prior two years’ and current year’s payments to the plan.
- Allowable costs for the CY are the average contribution of the three years and any additional carryover from prior periods.
Wage Index Other Considerations

• CMS applying additional review to MAC “audit activity”

• OIG will be focusing on Wage Index Issues

• Best Practice:
  – Complete comprehensive Wage Index Data analysis BEFORE cost report is filed!
  – Prepare everything on a comparative basis
  – Use inter-disciplinary team to identify all wage index opportunities
MGCRB Reclassifications

• Opportunity for an increase in Medicare payments
• Individual, group or statewide wage index area can apply for reclassification
• Certain criteria must be met to qualify to reclassify to a new CBSA (42 CFR 412.230 through 412.280)
• Applications are usually submitted by September 1
• Approvals made by the Board are effective for three years
• Withdrawals and terminations of reclassification by the hospital are permitted if received within 45 days of CMS’ annual notice of proposed rulemaking
Additional Criteria

- Proximity rules - The hospital must meet one of two conditions: a rural hospital must be within 35 miles from its own entrance traveling on improved roads to the area to which it seeks to reclassify, urban hospitals must be within 15 miles or at least 50 percent of hospital employees live in the requested area.

- Special access rules (CFR 412.230(a)(3)) the Board can reclassify a rural SCH or RRC to the closest urban area, if a rural area is closer than an urban area the hospital can be reclassified to the closest urban or rural area.
County Reclassifications

• All IPPS hospitals in a county that believe they should receive a wage index competitive with a nearby area may request to reclassify as a group to a nearby MSA

• The following criteria must be met
  – Proximity: The county must be adjacent to the requested designation area
  – Rural counties must qualify as an “outlying county” to the requested area

• At least 25 percent of employed county residents commute to the core counties in the requested area or at least 25 percent of workers in the county reside in the requested area; and urban counties must be located in the same combined statistical area or core-based statistical area as the requested area

• The aggregate AHW of the county group must be no less than 85 percent of the AHW in the requested area, and the requested area wage index must be greater than the current area wage index

Source: Medicare Learning Network, ICN 907243 July 2012
DSH Payments for Uncompensated Care

• Winners and losers
  – Previous DSH IPPS add-on
  – New DSH “uncompensated care”

• Results in payment swings
  – Old DSH awarded hospitals with high Medicare utilization
  – New DSH awards hospitals with high uncompensated care (Medicaid due to use of SSI/Medicaid ratio)
DSH Payments for Uncompensated Care

• Looking forward
  – As uninsured population decreases, the uncompensated care “pool” will decrease
  – S-10 data is not currently being used, but “may in the future”
    • When used, will probably be from a previous filed cost report
    • May involve wage index type review
  – Medicaid expansion impacts both empirically justified and uncompensated care payments
    • Potentially decreases UCC pool
    • States with expanded Medicaid receive higher percent of pool based on current methodology
    • Higher Medicaid utilization increases empirical DSH
Uncompensated Care Costs Payments

- **ACA impact on DSH payment**
  - Reduced 75 percent beginning in FFY 2014
  - “Savings” returned as an additional payment for continued uncompensated care costs

- **ACA DSH impact criteria**
  - Updated annually via Federal Register Notice (i.e., FFY 2016 Final IP rule)
    - Includes Indian Health Service hospitals in Factors 1 and 3
    - Prorates uncompensated care on cost reports for hospitals without a 9/30 federal fiscal year-end

- Hospital’s amount of uncompensated care costs relative to the amount of uncompensated care for all DSH hospitals
Calculation of Factor 1 for FFY 2016

- Represents CMS’ estimate of 75 percent of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

<table>
<thead>
<tr>
<th></th>
<th>FY 9/30/2014</th>
<th>FY 9/30/2015</th>
<th>FY 9/30/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1:</td>
<td>$9,593,192,092</td>
<td>$10,037,596,647</td>
<td>$10,058,322,396</td>
</tr>
<tr>
<td>Factor 2:</td>
<td>94.3%</td>
<td>76.19%</td>
<td>63.69%</td>
</tr>
<tr>
<td>Pool amount for distribution</td>
<td>9,046,380,143</td>
<td>7,647,644,885</td>
<td>6,406,145,534</td>
</tr>
</tbody>
</table>

-15.46%                   -41.21%
Calculation of Factor 2 for FFY 2016

- Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment; specifically, section 1886(r)(2)(B)(i) of the Act provides that for each of FYs 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 who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act.

- Percent of individuals without insurance for 2013 (March 2013 CBO estimate): 18 percent
- Percent of individuals without insurance for FY 2016 (weighted average): 11.5 percent
  \[
  1 - \frac{(0.115 - 0.18)}{0.18} = 1 - 0.3611 = 0.6389 \text{ (63.89 percent)}
  \]
  
  0.6389 (63.89 percent) - .002 (0.2 percentage points for FY 2016 under section 1886(r)(2)(B)(i) of the Act) = 0.6369, or 63.69 percent

- Factor 2 = 0.6369

- The FY 2016 Estimated Uncompensated Care Amount is: $10,058,322,396.04 x 0.6369 = $6,406,145,534.04 (the FY 2015 final uncompensated care amount is $10,037,596,646.78 x 0.7619 = $7,647,644,885.18

Source: Washington Perspectives by Larry Goldberg
Calculation of Factor 3 for FFY 2016

- Factor 3 is applied to the product of Factors 1 and 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY 2016 and subsequent fiscal years; i.e., the pool amount of $6.406 billion

- CMS says it believes it would be premature to propose the use of Worksheet S-10 data for purposes of determining Factor 3 for FY 2016; CMS is continuing to employ the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients, as defined in § 412.106(b)(4) and § 412.106(b)(2)(i), respectively, to determine Factor 3 for FY 2016

Source: Washington Perspectives by Larry Goldberg
## DSH Example

**Example Hospital**

**Calculation of DSH and Uncompensated Care Reimbursement**

**FY 2013 - FY 2016 Comparison**

<table>
<thead>
<tr>
<th></th>
<th>FY 9/30/2013</th>
<th>FY 9/30/2014</th>
<th>FY 9/30/2015</th>
<th>FY 9/30/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG Amount</td>
<td>$165,000,000</td>
<td>$165,000,000</td>
<td>$165,000,000</td>
<td>$165,000,000</td>
</tr>
<tr>
<td>Traditional Allowable DSH Percentage</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>(Sample Hospital) Factor 3 Percentage:</td>
<td>0.22%</td>
<td>0.22%</td>
<td>0.21%</td>
<td></td>
</tr>
<tr>
<td>DSH Reimbursement</td>
<td>$37,950,000</td>
<td>$9,487,500</td>
<td>$9,487,500</td>
<td>$9,487,500</td>
</tr>
<tr>
<td>Uncompensated Care Reimbursement</td>
<td>$19,816,503</td>
<td>$16,522,312</td>
<td>$13,582,718</td>
<td></td>
</tr>
<tr>
<td>Total DSH and UC Reimbursement</td>
<td>$37,950,000</td>
<td>$29,304,003</td>
<td>$26,009,812</td>
<td>$23,070,218</td>
</tr>
<tr>
<td>Percent of DRG Amount</td>
<td>23%</td>
<td>18%</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>Percent Change from FY 2013</td>
<td>-22.8%</td>
<td>-31.5%</td>
<td>-39.2%</td>
<td></td>
</tr>
</tbody>
</table>

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DSH Key Drivers

- Hospital must qualify for “Traditional” DSH in order to receive UCC payments (pool distribution amount)
- Capture of All Eligible Medicaid Days including HMO and Expansion
- DSH is a significant MAC audit focus area

<table>
<thead>
<tr>
<th>Key Drivers</th>
<th>Action Items</th>
</tr>
</thead>
</table>
| DSH/LIP     | • Case management/payment accuracy/transfers?  
|             | • Process to identify, verify and report ALL eligible days?  
|             | • Validate reported SSI data  
|             | • Psych Unit De-Exemption Strategy?  

- DRG payments
- Medicaid eligible days
- SSI %
FY2016 OP PPS Update Payment Rate Overview

- Decreases HOPD payments -0.3%
  - Projected to save $133M
  - Similar update factors as the IP PPS update

- Quality Data Reporting
  - Maintaining -2.0% adjustment for Hospitals not reporting quality data (98.0% factor applied to payments and coinsurance amounts)

- Rural Hospital Adjustment
  - Maintaining +7.1% adjustments to SCHs and EACHs for all items paid under the OP PPS system
FY2016 OP PPS Update Payment Rate Overview

- Cancer Hospitals
  - Adjusts Payment to Cost Ratio (PCR) to 92% applied to cost settlement.
  - Designed to equal payment level for other OP PPS providers.

- Drugs, Biologicals, and Radiopharmaceuticals:
  - Separately payable drugs and biologicals that do not have pass-through status are set at the statutory default of average sales price (ASP) plus 6 percent.

- Packaging Policies:
  - certain ancillary services when they are integral, ancillary, supportive, dependent, or adjunctive to a primary service.
  - Expanding the set of conditionally packaged ancillary services to include three new APCs.
FY2016 OP PPS Update Two Midnight rule

- Two Midnight Rule
  - Originally Effective October 1, 2013

  - inpatient admission is generally appropriate for Medicare Part A payment based upon the expectation that the patient will need hospital care that crosses at least 2 midnights.

- FY2016 (New) Exception:
  - Exceptions to the 2-midnight benchmark on a case-by-case basis by the physician responsible for the care of the beneficiary.
  - subject to medical review.
  - Expectation is that stays under 24 hours would rarely qualify for an exception to the 2-midnight benchmark.
- Increasing payment rates under the ASC payment system by 0.3% percent for ASCs that meet the quality reporting requirements under the ASCQR Program.
  
  - Projected CPI–U update of 0.8% 
  - Multifactor productivity adjustment (ACA) -0.5% 
  - Increase of approximately $128 million compared to estimated CY 2015 Medicare payments.
  
  - Similar to OP PPS savings of $133M
  - Reflects continual effort to reduce program spending through delivery in lower cost settings
MC Bad Debts – Reasonable Collection

- Collection effort must be documented in patient file
- Collection may include use of a collection agency in addition to or in lieu of subsequent billings
- Traditional accounts turned over to collection cannot be claimed until returned from agency
- 120-day rule – Beginning on the date of the first bill sent to the patient (indicating deductible or coinsurance owed by the beneficiary)
  - “Presumed uncollectible” after 120 days

*Who owns bad debt process? Reimbursement or PFS?*
Medicare Bad Debts Special Situations

• Medicare/Medicaid crossover patients (must bill requirement) (actual voucher vs. notice)
  – Prove that no other insurance exists
• Indigent or medically indigent patients (hospital must establish and document indigence)
• Charity accounts for Medicare beneficiaries
• Deceased patients (must document lack of estate)
• Bankrupt patients (must document court filings, etc.)
• May all be claimed without collection effort (no 120-day rule) (varies with contractor)
**Revenue Cycle Data Elements: Medicare Bad Debt Reporting**

### Required Fields
- Last Name
- First Name
- M.I.
- HIC. NO.
- DOS from MM/DD/YYYY
- DOS to MM/DD/YYYY
- Indigency & Wel. Recip. (Ck If Appl)
- Medicaid Number
- Date 1st Bill to Beneficiary
- Write-off Date
- Remittance Advice Date (MC)
- Deductibles (excludes PC and FS amounts)
- Co-Ins (excludes PC and FS amounts)
- Total

### Suggested Additional Fields
- Patient Account Number
- Medical Record Number
- Total Covered Charges
- Non Covered Charges (includes PC and FS)
- Hospital Charity Care Determination
- 120-Day (from last payment) Test (non X/0)
- Date Ret. from Coll. Agencies (non X/O)
- MA Remittance Date and/or MA RA #
- Document No Other Insurance Exists
Bad Debt – Process Considerations

• Accounts claimed in one year may be very old based on “returned from collection” criteria
  − Locate underlying documentation
  − Have multiple accounts for the same patient been combined
  − Different collection personnel, processes and policies may result in reporting challenges
  − Accounts included on Medicare bad debt listings cannot also be included on HCAP reports
  − Large “clean-up” projects may result in increased contractor audit scrutiny

• Develop separate listings
  − Inpatient (Part A) vs. outpatient (Part B) for each program component
  − Traditional vs. crossover
  − Any special circumstances (appeal issues; “clean up project listings,” etc.)

• Use of contract auditors may lengthen the audit process and result in more questions
The 340B drug pricing program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.

The 340B program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.

Eligible health care organizations/covered entities are defined in statute and include HRSA-supported health centers and look-alikes, Ryan White clinics and state AIDS drug assistance programs, Medicare/Medicaid disproportionate share hospitals, children's hospitals and other safety net providers; see the full list of eligible organizations/covered entities.

To participate in the 340B program, eligible organizations/covered entities must register and be enrolled with the 340B program and comply with all 340B program requirements; once enrolled, covered entities are assigned a 340B identification number that vendors verify before allowing an organization to purchase 340B discounted drugs.

New registrations are accepted October 1-15, January 1-15, April 1-15 and July 1-15.

Activity subject to audit.
- HRSA/OPA increasing audit activity
- Audit Results are published on HRSA/OPA website
- Manufacturers also may initiate audit
- Audit findings may result in disqualification from participation or amounts due to the manufacturer

HRSA (340B program); http://www.hrsa.gov/opa/
### Hospital Regulation Summary

<table>
<thead>
<tr>
<th>Entity Type</th>
<th>Non-Profit/Government Contract Requirement</th>
<th>DSH%</th>
<th>Subject to GPO Prohibition</th>
<th>Subject to Orphan Drug Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disproportionate share hospital DSH</td>
<td>Yes</td>
<td>&gt; 11.75%</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Children’s hospital PED</td>
<td>Yes</td>
<td>&gt; 11.75%</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Freestanding cancer hospital</td>
<td>Yes</td>
<td>&gt; 11.75%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Critical access hospital (CAH)</td>
<td>Yes</td>
<td>NA</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Rural referral center (RRC)</td>
<td>Yes</td>
<td>≥ 8 %</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sole community hospital (SCH)</td>
<td>Yes</td>
<td>≥ 8 %</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
340B Eligible Entities

Federal Grantees/Designees Certain Hospitals
- Federally qualified health centers
- Federally qualified health center look-alikes
- Title X family planning grantees
- State AIDS drug assistance programs
- Ryan White care act grantees (A,B,C,D,F)
- Black lung clinics
- Hemophilia treatment centers
- Native Hawaiian health centers
- Urban Indian organizations
- Sexually transmitted disease grantees
- Tuberculosis grantees

Certain Hospitals
- Disproportionate share hospitals
- Children’s hospitals
- Critical access hospitals
- Freestanding cancer hospitals
- Rural referral centers
- Sole community hospitals

340 B University (Apexus); www.340Bpvp.com
HRSA (340B program); http://www.hrsa.gov/opa/
340B HRSA Database: Statistics (as of March 2015)

- HRSA 340B database
  (http://opanet.hrsa.gov/opa/default.aspx)
  - 29,706 registered sites; 14,526 are non-hospital sites
  - 16,007 unique contract pharmacies
- >$9B/year in 340B program purchases
Provider-based Status

- Applies to both PPS and CAH facilities
- Relationship between an entity and the main hospital
- Additional reimbursement related to facility services reimbursed under OPPS
- May be additional patient coinsurance responsibilities
- Professional services reimbursed under reduced physician fee schedule
- Sites may be identified for inclusion in 340B program
- Potential issues for GME reimbursement
- Future of PBS?
Provider-based Status Charging Issues

- May only apply to Medicare (Medicaid and commercial payers not likely to recognize two bills (technical and facility component charges))
- Chargemaster should identify both professional and technical component charge elements
- Hospital should develop a charge split that covers the fee screen amounts for most prevalent procedures
- Need to develop methodology to include correct charges for cost apportionment

Future of Provider-based Status
Polling Question 6

• Is your organization a meaningful user of electronic health record technology?
  a. Yes
  b. No
  c. Yes, but our system isn’t currently living up to its potential
  d. Non Hospital or Physician participant
Three Steps to Meaningful Use

Acquire a certified EHR system

Use the system as the rules require

Attest the data was submitted as rules require
Meaningful Use Reporting Periods

Stage 2 won’t end until 2016 and Stage 3 will now begin in 2017

EHRs required to be certified to 2014 Edition Criteria
What are the Penalties for Non-compliance?

• If the EH does not attest to Stage 1 by October 1, 2014
  - Loss of incentive payments
  - IPPS payment reduction
    • Applies to the percentage increase to the IPPS rate (market basket increase)
    • Payment adjustment is cumulative for each year that the hospital is not a meaningful EHR user

<table>
<thead>
<tr>
<th>% Decrease</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>
What are the Penalties for Non-compliance?

- CAHs that do not demonstrate meaningful use by 2015 will face payment reductions
  - 2015: 0.33 percent reduction in Medicare reimbursement
  - 2016: 0.66 percent reduction in Medicare reimbursement
  - 2017 and beyond: 1.0 percent reduction in Medicare reimbursement
- If CAH adopts meaningful use after 2014, normal cost-based reimbursement applies; no incentives available
What are the Penalties for Non-compliance?

- Medical group (EPs)
  - Decrease in physician fee schedule
  - Loss of provider incentive payments

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Penalty Year</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
<td>-1%</td>
</tr>
<tr>
<td>2014</td>
<td>2016</td>
<td>-2%</td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
<td>-3%</td>
</tr>
<tr>
<td>2016</td>
<td>2018</td>
<td>-4%</td>
</tr>
<tr>
<td>2017</td>
<td>2019</td>
<td>-5%</td>
</tr>
</tbody>
</table>
Additional Payment Reform Considerations

- Reduce to 25 percent, down from 65 percent, payments for Medicare bad debts
- Reduce IME adjustment by 10 percent beginning in FY 2013
- Reduce CAH reimbursement to 100 percent vs. current 101 percent
- End CAH reimbursement for facilities located 10 miles or less from another hospital
- Limit the use of provider taxes beginning in FY 2015, but do not eliminate entirely
Annual OIG Work Plan

1. Hospital Inpatient Admission Criteria – “Two Midnight Rule”
2. Oversight of Payment and Delivery Reform
3. Reconciliation of Outlier Payments
4. Analysis of Salaries Included in Hospital Cost Reports
5. Medicare Oversight of Provider-Based Status
6. Duplicate GME Payments
7. IME Payments
8. Hospital Wage Data Used to Calculate Medicare Payments
OIG Work Plan Details

• **Two Midnight Rule**
  - Substantial change to criteria physicians must use when deciding to admit patients
  - Determine extent of variation of use of OP and IP stays among hospitals

• **Oversight of payment and delivery reform**
  - Address changes to Medicare programs designed to improve efficiency and quality of care to promote integrity and transparency
  - Examine the transition from volume to value-based payments and the effectiveness of payment structures, care coordination and administration of new payment models

• **Reconciliations of outlier payments**
  - Additional payments that Medicare provides hospitals for beneficiaries who incur unusually high costs
  - CMS reconciles outlier payments based on most recent cost-to-charge ratios from hospital’s cost reports
  - Determine if timely reconciliations and final settlements occur so that funds may be properly returned to the Medicare trust fund

• **Analysis of salaries included in hospital’s cost reports**
  - Determine potential impact on Medicare trust fund if employee compensation had limits
  - Employee compensation may be included as allowable costs to the extent it represents reasonable compensation for managerial, administrative, professional and other services related to the operation of the facility and furnished in connection with patient care
OIG Work Plan Details

- **Medicare oversight of provider based status**
  - Allows facilities owned and operated by hospitals to bill as hospital outpatient departments
  - Provider-based status can result in higher Medicare payments for services furnished at provider-based facilities
  - MedPAC has expressed concerns about financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services

- **Duplicate GME payments**
  - Review IRIS information to determine whether hospitals receive duplicate or excessive GME payments
  - Access effectiveness of IRIS in preventing duplicate payments for GME costs
  - Prior OIG reviews have determined that hospitals have received duplicate reimbursement for GME

- **IME payments**
  - Prior OIG reviews have determined that hospitals have received excess reimbursement for IME
  - Teaching hospitals with residents in approved GME programs receive additional payments for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals compared to those of nonteaching hospitals
  - Additional payments are calculated using the hospital’s ratio of resident FTEs to available beds

- **Hospital wage index data**
  - Prior OIG audits have identified hundreds of millions of dollars in incorrectly reported data
  - As a result, policy changes have occurred by CMS with regards to how deferred comp is reported