Revenue-Focused Performance Improvement and Risk Management Strategies: Part II-Reimbursement Strategy

October 24, 2013

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Course Objectives

- Discuss Affordable Care Act health care reform initiatives and other payment reform
  - Hospital value-based purchasing
  - Hospital readmissions
  - Hospital acquired conditions
  - Market basket update
  - Sequestration
- Examine high reimbursement impact areas
  - Charity care
  - Medicare bad debt
  - DSH/SSI issues
  - Transfer DRG
  - Wage Index

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Affordable Care Act & Other Payment Reform Issues

Current Payment Systems

- Volume-based payment models – Volume/productivity matter
  - Fee for service
    - Charge based: Pricing strategy matters
      - Commercial payers – % discounts
      - Self-pay – Voluntary (or) state mandated discounting
    - Fee scheduled based: CDM coding matters
      - Physicians: RBRVS
      - Lab: Clinical lab
      - Medicare Part D drug coverage
      - Durable medical equipment
      - Ambulance
  - Prospective payment systems: MR & CDM coding matters
    - Medicare, Medicaid, commercial payers
      - Hospitals: IP DRGs/OP APCs
      - Psych-rehab: surgery centers (ASCs) – OP APCs
      - Home health: HHRGs
      - SNF: RUGs
      - Renal: Composite rate/PPS
  - Case rates/packaged payment: CDM coding matters
    - Commercial contract negotiated rates
    - Hospice: Per beneficiary limit – Medicare only
- Cost-based payment models
  - Cost report driven – Costing and structure matters
    - Medicare, some Medicaid and Blue Cross plans
      - Critical access hospitals – Medicare/Medicaid
      - FQHC/RHC – Medicare/Medicaid
      - Children's and cancer hospitals – Medicare
      - Acute care hospitals – Medicaid/certain states

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Payment Reform Mechanism

- **Health care exchanges** – The health care reform bill calls for each state to set up an "exchange," or marketplace, where people not covered through their employers will shop for health insurance at competitive rates

  Impact: Transition to near full insurance for US population will drive HC organizations to serve larger populations with fewer clinical and financial resources based on both anticipated "Medicaid-like" funding and nursing shortfalls

- **Payment reform** – Bundle payment, capitation, pay-for-performance/quality data reporting and cost-saving/sharing initiatives through Medicare demonstration projects and commercial payer contract renegotiation

  Impact: Transition from utilization to medical outcome focused revenue systems require improved information-based decision making via data analytics, management score cards; optimization of existing federal, state and private revenue sources; and leaner operations via process-focused management techniques to anticipated decline in utilization driven fee for service revenue

- **Medicare/Medicaid funding shortfalls through 2018**

  Impact: Increased Medicaid enrollment will require spreading limited state/federal funds even further; planned Medicare decreases, including delayed reductions in Medicare physician payment and DSH funding, will place material pressure on already thin margins

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Effects of Payment Reform

- Transition from utilization to medical outcome focused revenue systems
- Medicare and Medicaid reimbursement model will change from fee-for-service to pay-for-performance
- Significant reimbursement cuts projected
  - By 2018, Medicare reimbursement will cover approximately 30% less of actual costs than under current levels
  - Medicaid enrollment will expand by approximately 16 million beneficiaries which will drive further cuts in order to balance overall state expenditures
  - Health care exchanges projected to pay at Medicaid levels which will be 60-70% of Medicare levels

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Payment Reform Models

- Hospital acquired conditions
  - Effective for FFY 2015, hospitals in lowest-performing quartile for rates of HAC will face a 1.0% reduction in Medicare payments
- Proposed measures of two types (domains)
  - Each weighted as follows:
    A. Domain 1 - 35%
    B. Domain 2 – 65%
- First domain – six patient safety indicators
  - Pressure ulcers rate
  - Foreign objects left in body percent
  - Iatrogenic pneumothorax rate
  - Post-op physiologic/metabolic derangement rate
  - Post-op pulmonary embolism/deep vein thrombosis rate

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Payment Reform Models (cont.)

- Second domain – two infection measures
  - Central line-associated blood stream infection (CLABSI)
  - Catheter-associated urinary tract infection (CAUTI)
- Hospital readmissions
  - 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%
    - FY 2014: Payment reduction up to 2%
    - FY 2015: Payment reduction up to 3%

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Payment Reform Models (cont.)

- Value-based purchasing
  - VBP is a program changing how care is paid for by going to paying based on value and outcomes instead of volume
  - VBP links payment directly to quality of care and transforms the current system by rewarding for delivery of high quality, efficient quality care
  - Program will pay based on quality of care by rewarding hospitals with high performance based on quality by redistributing Medicare payments
  - Incentives funded through DRG payment reductions: excludes DSH, IME and outlier payments
    FFY 2013: DRG payment reduction of 1.00%
    FFY 2014: DRG payment reduction of 1.25%
    FFY 2015: DRG payment reduction of 1.50%
    FFY 2016: DRG payment reduction of 1.75%
    FFY 2017: DRG payment reduction of 2.00%
  - Estimated value of incentive payment pool for FY 2014 – $1.1billion
  - Suspended the effective dates of 8 HAC measures, 2 AHRQ composite measures and a Medicare spending per beneficiary measure for FY 2014
  - Finalized adoption of a Medicare spending per beneficiary measure and an AHRQ composite measure for FY 2015

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Market Basket Updates

- Reductions to market basket updates and productivity adjustments total $112 billion in Medicare savings (reduced payments to hospitals) from FY10-FY19
- Productivity adjustment for FY12-FY20: FY13 adjustment is set at -.07%
- 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

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Market Basket Updates – FFY 2014

- Calculation of FFY 2014 IPPS market basket update:

IPPS market basket update	2.5
Reduction mandated by ACA	(0.3)
Productivity adjustment	(0.5)
IP admission/medical review	(0.2)
Documentation and coding	(0.8)
Net payment increase	0.7 Market basket increase for FFY 2014

- Additional reductions are anticipated; providers should look for opportunities to reduce waste inefficiencies
- This will represent a $1.2 billion increase in payments for hospitals

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Sequestration

- Effective for discharges on or after 04/01/2013
- Medicare will face a 2% cut in Medicare payments – $9 billion reduction in Medicare payments in calendar year 2013
- Medicare providers will continue to bill in the normal way but will be reimbursed at a rate of 98 cents on the dollar
- Reductions in 2014 and subsequent years; Medicare payments will be cut by 2% for the nine-year period 2013-2021; because Medicare costs are projected to rise from 2013 through 2021, the dollar amount in reduced payments to providers increases each year

What Will Happen in 2014 through 2021? In billions of dollars								
	2014	2015	2016	2017	2018	2019	2020	2021
2% Medicare sequestration, dollars	11.4	12.2	12.9	13.4	14.2	15.4	16.5	17.8

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Polling question number one

- *To achieve budget neutrality regarding the Inpatient Admission Guidance, CMS has instituted a -.2% reduction to the federal operating and capital rates.*
  - True
  - False

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Uncompensated Care

S-10 Importance

- Cost reports are a HUGE part of the reporting
- Timely, accurate and complete information is KEY
  - Consider BI tools to create standard S-10 dashboards that pull data from current systems and reports
- Hospital CFOs very interested in this information
- Planning and strategy and public perception
- EHR incentive payment
- Future use for DSH uncompensated payment

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Cost Report Form 2552-10
W/S S-10 (Section 4012)

- Submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated (BBRA)
- Charity care charge data (section 4102 of ARRA 2009) may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and critical access hospitals (CAHs)
- CAHs, as well as §1886(d) hospitals, will be required to complete this worksheet
- Note that this worksheet does not produce the estimated cost of treating uninsured patients required for disproportionate share payments under the Medicaid program

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2552-10 Worksheet S-10

- Overall cost-to-charge ratio applied to various uncompensated care program changes to impute costs
- Detailed information about (various) Medicaid and other state indigent care payment systems and charity care programs
- Line 20 – Charity charges for HIT payment
  - Total patient charges, which include bad debts (i.e., before any write-offs)
- Bad debt information is for the entire complex (excludes professional component)

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W/S S-10 Definitions

- Uncompensated care – Charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt; uncompensated care does not include courtesy allowances or discounts given to patients
- Charity care – Health services for which a hospital demonstrates that the patient is unable to pay; charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria; for Medicare purposes, charity care is not reimbursable, and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt (additional guidance provided in the instruction for line 20)

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W/S S-10 Definitions (cont.)

- Non-Medicare bad debt – Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claims (additional guidance provided in the instruction for line 25)
- Non-reimbursable Medicare bad debt – The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1 (additional guidance provided in the instruction for line 25)

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Polling question number two

- *Uncompensated Care includes what components?*

A. Charity Care
B. Non-Medicare Bad Debt
C. Non-Reimbursable Medicare Bad Debt
D. Medicare Allowable Bad Debt
E. A, B & C
F. All of the Above

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Timing/Recognition Issues

- Lines 2, 9, 13: Net revenue
  - Actual payments received or expected to be received from a payer (including coinsurance payments from the patient) for services delivered during this cost reporting period; net revenue will typically be charges (gross revenue) less contractual allowance (applies to lines, 2, 9 and 13)

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Timing/Recognition Issues (cont.)

- Line 20 – Charity care criteria
  - Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges) for care delivered during this cost reporting period for the entire facility

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Timing/Recognition Issues (cont.)

- Line 26 – Bad debt criteria
  - Changed in September transmittal to remove the “services delivered during cost reporting period” language
  - Enter the total facility (entire hospital complex) amount of bad debts written off on balances owed by patients during this cost reporting period; include such bad debts for all services except physician and other professional services

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Calculated Uncompensated Care Cost

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

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Worksheet C CCR for Uncompensated Care Cost Calculation

COMPUTATION OF RATIO OF COSTS TO CHARGES				
	WORKSHEET C	COSTS	CHARGES	CCR
INPATIENT ROUTINE SERVICE COST CENTERS				
3000	ADULTS & PEDIATRICS	38,742,481	63,364,151	
3100	INTENSIVE CARE UNIT	3,022,182	4,881,797	
3101	NICU	747		
3400	SICU	28,428,010	70,465,348	
4100	IRF	5,266,922	8,562,031	
ANCILLARY SERVICE COST CENTERS				
5000	OPERATING ROOM	19,728,938	122,399,894	0.161184
5100	RECOVERY ROOM	3,557,693	13,522,080	0.263102
5200	DELIVER & LABOR	647	0	#DIV/0!
5400	RADIOLOGY-DIAGNOSTIC	13,773,509	47,191,513	0.291864
5401	ULTRA SOUND	2,975,113	11,539,901	0.257811
5500	RADIOLOGY	5,766,009	2,151,702	2.679743
5501	GAMMA KNIFE	561,155	1,957,170	0.286718
5600	RADIOISOTOPE	890,095	6,375,931	0.139602
5700	CT SCAN	3,053,542	110,886,192	0.027538
5800	MRI	687,871	19,554,607	0.035177
6000	LABORATORY	16,529,940	81,510,863	0.202794
6500	RESPIRATORY THERAPY	4,575,957	27,003,607	0.169457
6600	PHYSICAL THERAPY	3,000,071	7,708,297	0.389200
6700	OCCUPATIONAL THERAPY	1,612,505	5,817,463	0.277184
6800	SPEECH PATHOLOGY	855,343	2,811,149	0.304268
6900	ELECTROCARDIOLOGY	11,252,015	73,666,375	0.152743
6901	CARDIAC REHAB	916,433	520,281	1.761419
7000	EKG	859,590	3,736,470	0.230054
7100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,619,249	37,648,815	0.414867

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Worksheet C CCR for Uncompensated Care Cost Calculation

7200	IMPL. DEV. CHARGED TO PATIENT	20,318,871	127,169,680	0.159778
7300	DRUGS CHARGED TO PATIENTS	21,249,794	161,179,782	0.131839
7600	GI SERVICES	1,936,932	10,015,395	0.193395
7601	RENAL SERVICES	1,270,935	2,555,298	0.497373
7603	OPTHOMOLOGY	31,799	369,567	0.086044
7604	DIABETES MGMT	73,322	8,445	8.682297
OUTPATIENT SERVICE COST CENTERS				
9000	CLINIC	2,648,539	50,629	52.312686
9001	SENIOR HEALTH CLINIC	2,882,634	940,313	3.065611
9002	OP ONCOLOGY	210,074	242,437	0.866510
9004	PAIN MGMT CLINIC	965,186	4,846,898	0.199135
9005	ORTHO CLINIC	22,978	473,405	0.048538
9007	PRIMARY CARE SERVICES	490,929	37,940	12.939615
9100	EMERGENCY	20,349,894	161,827,794	0.125750
9200	OBSERVATION BEDS (NON-DISTINCT PART)	4,368,196	6,921,525	0.631103
OTHER REIMBURSABLE COST CENTERS				
9500	AMBULANCE SERVICES	27,062,963	37,928,738	0.713521
	SUBTOTAL (SEE INSTRUCTIONS)	**285,559,063**	**1,237,843,483**	
	LESS OBSERVATION BEDS	4,368,196		
	TOTAL (SEE INSTRUCTIONS)	281,190,867	1,237,843,483	
			0.227162	

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S-10

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio	0.227162	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,326,070	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes" , does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no" , then enter DSH or supplemental payments from Medicaid	588,886	5.00
6.00	Medicaid charges	29,998,469	6.00
7.00	Medicaid cost (line 1 times line 6)	6,814,512	7.00
8.00	Difference between net revenue and costs for Medicaid Program (line 7 minus sum of lines 2 and 5; if < zerro then enter zero)	-	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	-	9.00
10.00	Stand-alone SCHIP charges	-	10.00
11.00	Stand-alone SCHIP costs (line 1 time line 10)	-	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP program (line 11 minus line 9; if < zero then enter zero)	-	12.00
	Other state or local governement indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5, or 9)	-	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	-	14.00
15.00	State or local indigent care program cost (line 1 times 14)	-	15.00
16.00	Difference between net revenue and costs for state and local indigent care program (line 15 minus line 13; if < zero then enter zero)	-	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	-	17.00
18.00	Gernement grants, appropriations or transfers for support of hospital operations	-	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	-	19.00

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S-10 (Cont.)

				1.00	
	Uncompensated and indigent care cost computation				
		Uninsured Patients	Insured Patients	Total (Col. 1 + Col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	8,827,358	3,245,376	12,072,734	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,005,240	737,226	2,742,466	21.00
22.00	Partial payment by patients approved for charity care	64,184	492,997	557,181	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,941,056	244,229	2,185,285	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes", charges for patient days beyond an indigent care program's length of stay limit			-	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			5,580,146	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			124,425	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			5,455,721	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			1,239,332	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			3,424,618	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,424,618	31.00

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Charity Care Log

- Essential components for documenting charity care write-offs
  - Patient name
  - Hospital identification number
  - Charity application status
  - Service from/to dates
  - Patient days
  - Primary/secondary payer
  - Total gross charges
  - Contractual adjustments
  - Denied days/changes
  - Payments
  - Full or partial charity
  - Charity write-off amount
  - Patient amount due after charity discount
  - Patient payment plan: Yes or no

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Action Items for S-10

- Review and update all hospital policies relating to uncompensated care, charity care, compassionate care, uninsured or underinsured – do internal audit
- Differentiate non-covered services from C/A for Medicaid, SCHIP and state/local indigent care programs
- Segregate SCHIP/state only claims from Medicaid
- Create and update payer participation matrix on a quarterly basis to identify, report and support non-par claims OR use 835 EDI to make this distinction
- Start planning now for claim level – 835/CDM analysis to create supportable audit filing
- Identify dual-eligible claims where patient has exhausted lifetime reserve days or other scenarios where no payment from Med A
- Update S-10 reported values on a periodic basis and file amended WS S-10 immediately prior audit

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Polling question number three

- *Revenue reported on S-10 is equal to what amount?*

A. Net revenue=Gross revenue less Contractual Allowance
B. Gross Revenue
C. Contractual Allowance
D. All of the Above

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Medicare Bad Debts

Medicare Bad Debts

- Unpaid deductible and coinsurance amounts related to covered hospital services
  - Excludes pro fees and fee screen amounts
  - Excludes MCO amounts
- Reimbursed @ 65% of the amount reduced from 70% (phased down to 65% for CAH over three years) CAHs will see reductions of 12% in FY 2013, 24% in FY 2014 and 35% in 2015; thus, by FY 2015, CAHs and acute care hospitals will both be reimbursed at 65%
- Reasonable collection efforts consistent among all payers
- Debt actually uncollectible when claimed as worthless
  - Cannot be claimed as bad debt until returned from collection agency
  - Even under the Bad Debt Moratorium, the DC District Court has issued inconsistent rulings on claiming returned from collection accounts (Lakeland)

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Medicare Bad Debts – Other Audit Considerations

- Accounts claimed in one year may be very old based on “returned from collection” criteria
  - Locating underlying documentation
  - Have multiple accounts for the same patient been combined
  - Different collection personnel, processes and policies may result in reporting challenges
  - Large “cleanup” projects may result in increased contractor audit scrutiny
- Develop separate listings
  - Inpatient (Part A) vs. outpatient (Part B) for each program component
  - Traditional, cross-over, charity (only applied to deductible/coinsurance)
  - Cross-match available data sources (logs, PSR, cross-overs, download with transaction codes, etc.)
  - Any special circumstances (appeal issues, “clean up project listings,” etc.)
- Use of contract auditors may lengthen the audit process and result in more questions

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Medicare Bad Debts – Suggested Review Format

- Trace amounts from the detailed listings (by hospital) to the summaries and actual cost report files
- Develop a small sample from the detailed listings in order to validate the required Medicare bad debt attributes
- Pay close attention to large dollar amounts included in listings
- Read and understand Medicare bad debt policies in place for the cost reporting periods included in the review
- Obtain collection agency agreements
- Interview PFS personnel responsible for the Medicare bad debt process
- Test accounts identified in each list for the required attributes based on the available documentation
- Develop a log of observations related to the small scale sampling list
- Estimate a range of potential financial impacts by applying sample results to the entire population

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Documentation/Listing (Take-away)

Required Fields per 339 Exhibit 5	Suggested Additional Fields
Last Name	Patient Account Number
First Name	Medical Record Number
M.I.	Total Covered Charges
HIC. NO.	Non-covered Charges (includes PC and FS)
DOS from MM/DD/YYYY	
DOS to MM/DD/YYYY	
Indigency & Wel. Recip. (Ck If Appl)	Hospital Charity Care Determination
Medicad Number	
Date 1st Bill to Beneficiary	120-Day (from last payment) Test (non X/0)
Write-off Date	Date Ret. from Coll. Agencies (non X/O)
Remittance Advice Date (MC)	MA Remittance Date and/or MA RA #
Deductibles (excludes PC and FS amounts)	Document no other insurance exists
Co-Ins (excluded PC and FS amounts)	
Total	

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Polling question number four

- *Cross-over bad debts can be claimed on a listing using the Medicaid remittance advice date as the write-off date?*
  - True
  - False

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Disproportionate Share

Actionable Items

- Determine hospital's DSH status for current and prior cost reporting periods
- Review DSH data sources, as well as accumulation and analysis processes
- Identify additional value through this data
- Preserve appeal rights through amended cost reports or protested item disclosure
- Understand new DSH payment formula

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Disproportionate Share (DSH)

- Hospitals may qualify for an additional payment per discharge for serving a disproportionate share of low income patients
- DSH adjustment based on two fractions: Medicare fraction (SSI percentage) and Medicaid fraction
  - Medicare fraction – Days of patients entitled to both Medicare Part A and SSI/total days of patients entitled to Medicare Part A; obtained from CMS
  - Medicaid percentage – Days of patients eligible for Title XIX Medicaid, but not entitled to Medicare Part A/total patient days
  - Sum ≥ 15% to qualify (> 20.2% higher adjustment factors)
- 340B Drug pricing program
  - Eligible with DSH adjustment percentage of 11.75%
  - SCHs and RRCs eligible at 8%
- Similar calculation for rehab units (LIP)

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IPPS: DSH

- Medicaid utilization **(Data from S-2; not S-3)**
  - Medicaid paid days (per provider or state records)
  - Medicaid HMO paid days
  - Out-of-state Medicaid paid days
  - Additional eligible days (in and out of state)
- SSI component recalculation
  - Recalculated to include MCO days
  - Based on provider fiscal year
  - Based on internal verification or validation process (compared to CMS calculation)

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DSH Extract

Required Data Fields		Suggested Additional Fields
Account Number		Discharge Status Indicator
Medical Record Number		Discharge Location
Name		DRG
Social Security Number		Room Number
Sex		Total Charges
Admit Date		For Babies - Mother's Account Number
Discharge Date		Medicare HIC # (if not in policy #)
Length of Stay		
Patient Type		
Date of Birth		
Financial Class		
Insurance Plan Codes (3 fields)		
Insurance Plan Policy Numbers (3 fields)		
Medicaid Recipient # (if not in policy #)		

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Patient Days: Medicaid Fraction

- Title XIX includable days (S-2)
  - Paid and eligible
    - In state
    - Out of state
    - Traditional
    - HMO
    - Section 1115 waiver days
- Three counting methods (FFY2010)
  - Date of admission
  - Date of discharge
  - Dates of service (notify contractor 30 days prior to cost reporting period)

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Patient Days

- Medicare and Medicaid dual eligible days
  - Medicare Advantage (must shadow bill)
  - Exhausted benefits
  - Both currently included in SSI fraction instead of Medicaid fraction
  - Protest items on Medicare cost report
  - Request detailed CMS SSI data

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Cost Report Schedules Impacting DSH/SSI

Focus Areas	CR Ref	Topics
Provider Characteristic	S-2	Determines cost report set up and flow through (Part I) Incorporates provider questionnaire (Part II)
Patient Statistics	S-3	Reconcile data between S2 and S3 Impacts GME and and other payments as well as DSH
Uncompensated Care	S-10	Defining elements and implications for DSH and HIT incentives
Settlement Data	E Part A, L E-3 Pt II	Where DSH and LIP percentages are applied to DRG amounts to determine add on payment
Medicare Bad Debts	E series	Reporting process and audit issues

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DSH Cost Report S-2

S-2 Column	DSH Patient Day Category	IPPS LN 24
1	In State Medicaid Paid Days	3,934
2	In State Medicaid Eligible Unpaid Days	1,458
3	Out of State Medicaid Paid Days	71
4	Out of State Medicaid Eligible Days	-
5	Medicaid HMO Days	743
6	Other Medicaid Days	-
	Total Medicaid Days	6,206
	S-3 Total Acute Patient Days	51,534
	Medicaid Percentage	12.04%

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DSH Cost Report E PT A

E PT A	Description	Value
1	DRG Amt	31,257,354
30	SSI % From CMS	8.30
31	Medicaid %	12.04
32	DSH % (30+31)	20.34
>15%	(Ln 32-15%)*65%+2.5%	
>20.02	(Ln32-20.2%) *82.5%+5.88%	
33	Allowable DSH % (Manually Entered)	6.14%
34	DSH Adjustment (Ln 1* Ln 33)	1,920,452

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Legal Cases

- Baystate decision found CMS did not use the best available data in the match process
- In Borgess Medical Center, PRRB allowed evidence of an invalidly calculated SSI fraction
- Norwalk case in federal court over including Medicaid eligible days on appeal
  - Complete detailed DSH review with filed cost report and protest remaining pending days
- Several recent adverse decisions on dual eligible days
  - Exhausted dual eligible days likely to remain in Medicare fraction
  - Argument that patients with exhausted Part A benefits are not "entitled to benefits under Part A" was not successful
  - Allina 1993-2003 case, DC District Court said "…it bears emphasis that the DSH proxy is just that – a proxy, not an exact calculation. Thus, to the extent that some patient days were not captured by the Secretary's calculation of the hospital's DSH adjustments, this does not necessarily render her interpretation impermissible or unreasonable."

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Medicare DSH Appeals

- Medicare Advantage
  - Northeast court held that once a beneficiary elects Medicare Part C, the beneficiary is no longer entitled to receive benefits under Part A; therefore, M+C days should be included in the numerator of Medicaid fraction (periods prior to 2004)
  - Favorable Allina decision for periods after 2004 due to “retroactive rulemaking” by CMS
    - CMS appealed and clarified position in FY14 IPPS Final Rule
- Other issues
  - SSI data match
  - Labor and delivery days
  - Observation days

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DSH Payments

- ACA impact on DSH payment
  - Reduced 75% beginning in FFY 2014 (now)
  - "Savings" returned as an additional payment for continued uncompensated care costs
- ACA DSH impact criteria
  - Updated in 10/3/13 Federal Register
    - 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
  - Funds available – $9,593,000,000 calculated DSH less 25% paid
  - Percentage change in uninsured population from 2013 (1 minus the % change of individuals under age of 65 who are uninsured - minus .1 % for 2014, .2% for FY 2015 – FY 2017)
  - Hospital's amount of uncompensated care costs relative to the amount of uncompensated care for all DSH hospitals

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DSH Payments

- Summary of uncompensated care payment
  - Factor 1
    - CMS estimates empirically justified Medicare DSH payments for FY 2014 in total to be $12,791,000,000; 25% of this is $3,198,000,000; Factor 1 is then the difference between these two estimates; pool for 2014 will be $9,593,000,000
  - Factor 2
    - CMS is proposing factor 2 to be 94.3% for FY 2014; CMS is proposing the amount available for uncompensated care is $9,046,000,000 (.943*Factor 1 estimate of $9,593,000,000)
  - Factor 3
    - For FY 2014, this factor would reflect the Medicaid and Medicare SSI patient days for all hospitals that CMS estimates would receive DSH payments in FY 2014; CMS posted proposed Factor 3 for the hospitals that would receive DSH in FY 2014
- Limited/no appeal opportunity on the 75% portion
  - Factors are considered “estimates” and “proxies”
- CMS will likely use S-10 data in the future for the uncompensated care payment
  - Winners and losers based on amount of actual uncompensated care compared to Medicaid days
  - Complete S-10 accurately now and watch for instruction changes (ex. recent Line 26 update)

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Polling question number five

- *Interim uncompensated care payments are being made on what basis?*
  - Quarterly
  - Bi-weekly
  - Per discharge

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Transfer DRG

Transfer DRG

- Under Medicare's Post Acute Care Transfer (PACT) policy (42 CFR 412.4), a discharge is considered to be a transfer when the patient's discharge is assigned to a qualifying MS-DRG and the discharge is made under certain circumstances
  - Policy protects Medicare from paying for the same care twice
  - Prorated DRG payment where patient discharged less than the geometric length of stay
    - To a hospital or distinct part hospital unit excluded from the prospective payment system (i.e., rehab or psych).
    - To a Medicare-certified skilled nursing facility
    - To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge
- Applies to the approximately 275 Qualifying MS-DRGs

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Transfer DRG (cont.)

- Medicare and RAC auditors can easily review the common working file (CWF) for transfer claims with incorrect discharge disposition codes that resulted in overpayments
- For underpayments, hospitals must review the same CWF data to ensure patients received the intended care
  - Consider reviewing overpayments, as well, to avoid audit extrapolation

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Transfer DRG (cont.)

- Hospitals can rebill claims within timely filing (one year from service date) with the corrected discharge disposition code
- Steps to help ensure accurate discharge disposition codes
  - Review CWF data (internally or with the help of a vendor)
  - Call the intended providers and/or establish a template to routinely query discharge status with the other facilities
  - Call patients directly to confirm discharge plans were executed as planned
  - Hold the bills for several days to review all discharge documentation

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Polling question number six

- *Medicare identifies and corrects all transfer DRG overpayments and underpayments?*
  - True
  - False

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Wage Index

S-3 Pts II and II

- Measures relative differences between each labor market's average hourly rate and the national average hourly rate
- Data is accumulated at hospital level, aggregated into CBSA groupings and indexed against the nationwide dataset
- Key drivers of ultimate Medicare Prospective Payment System (PPS) payment
  - Inpatient DRG payments
  - Disproportionate share (DSH)
  - Indirect medical education (IME)
  - Outpatient APCs
  - Skilled nursing facility
  - Home health
  - Inpatient rehabilitation
  - Psychiatric

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CMS Wage Index Timeline – FFY 2015

	Wage Index Task	Date
1	Initial wage index submission	FFY 2011 cost report filing
2	Preliminary public use file (PUF) release	September 13, 2013
3	Wage index and occupational mix changes submission deadline	November 21, 2013
4	Revised PUF release	February 20, 2014
5	Deadline for requests for corrections to errors and revisions to desk review adjustments	March 3, 2014
6	Appeal and request CMS intervention deadline	April 16, 2014
7	Proposed rule PUF release	May 2014
8	Deadline for requests for corrections to errors and MAC mishandling	June 2, 2014
9	Final rule PUF release	August 2014

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Future State?

- Report submitted to Congress on 4/11/2012 on a plan to reform the wage index system
- Highlights
  - Addresses the goals of broad-based Medicare wage index reform
  - Based upon actual employment patterns of hospitals
  - Will reduce large wage index differences between nearby hospitals
  - More accurately reflect the true labor market forces of individual hospitals
  - Takes into account hospital hiring patterns by using commuting data to define hospital labor market areas
  - Develops a wage index value for each hospital vs. labor market area (CBSA/MSA)
  - WI value would be based upon the labor markets from which that hospital hires its workers

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Occupational Mix Survey

- Required to be completed every three years
- Collects data regarding the occupational mix of employees (i.e., RNs vs. LPNs vs. aides, etc.)
- Purpose is to control the effect of the hospital's employment choices on the wage index
- Any hospital subject to the Inpatient Prospective Payment System (IPPS), or any hospital that would be if not granted a waiver, is required to complete the survey

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Occupational Mix Survey (cont.)

- Exclusions include
  - Critical access hospitals
  - No or low Medicare utilization providers
  - Any hospital that has terminated participation in the Medicare program prior to 1/1/13
- Data used to calculate an occupational mix adjustment factor to be applied to the wage index data

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Occupational Mix Survey (cont.)

- Occupational mix survey
  - Survey is due July 1, 2014
  - Survey will include data from a 12-month period, pay periods ending between January 1, 2013 and December 31, 2013
  - Survey will apply to the FFY 2016-2018 wage index data; as such, payments beginning October 1, 2015 through September 30, 2018 will be impacted
  - Instructions similar to prior survey

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Polling question number seven

- *For FFY 2015 wage index development, requests for revisions to WS S-3 PT II must be received by the FI/MACS by this date:*
  A. 12/06/13
  B. 11/18/13
  C. 11/21/13
  D. 12/15/13

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Questions?

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A survey will soon appear. If you haven't already, please **disable your pop-up blocker**, so you can participate. (Tools - Internet Options - Privacy)

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Thank you!

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