AGENDA

// Worksheet S Series
// Worksheet A Series
// Worksheet B Series
// Worksheet C Series
// Worksheet D Series
// Worksheet E Series
  // Disproportionate Share Hospital Payments
  // Bad Debts
  // Electronic Health Records
// After the Cost Report Is Filed/Recap
Worksheet S Series
S SERIES

// S – Statistics and settlement summary

S - Settlement summary
S-2 - Provider information

S-3, Part I - Provider statistics
S-4 - Home health statistics

S-8 - RHC data
S-10 – Uncompensated care (for EHR)
WS S CERTIFICATION & SETTLEMENT

// Part I must indicate electronic, manual or amended cost report

// Settlement adds column for HIT settlement

// Certification by officer or administrator of Provider(s)

  // “I hereby certify that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the balance sheet and statement of revenue and expenses prepared by Hospital 45-13xx for the cost reporting period beginning 1/1/15 and ending 12/31/2015 and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.”
S SERIES

// S-2

// Provider numbers
// Type of provider
// Characteristics of hospital operation
S SERIES

// S-3, Part I

// Number of beds
// Days by payer class
// Discharges by payer class
// FTE counts by major category
// Observation days
WORKSHEETS S-3, PARTS II-V: WHAT IS WAGE INDEX (WI)?

// Section 1886(d)(3)(E) of Social Security Act
   // “For area differences in hospital wage levels by a factor”

// Areas defined by Core-Based Statistical Areas (CBSAs)

// Wage index required to be updated annually

// CMS applies a methodology to compute average hourly wage (AHW) compared to national AHW based on

// Review process after cost report is filed
WHAT IS WI?

// CBSA AHW/National AHW = Wage Index
  // Average is aggregate of all hospitals in the area
  // There are multiple issues—midpoint adjustment factor, occupational mix adjustment factor, budget neutrality adjustment

// Considerations
  // What is the impact of change of $0.40 in AHW?
  // Inpatient impact is $___ per Medicare discharge
  // For every change in wage index of 0.01, what is the approximate impact?

// Reclassified
  // Data remains in your base CBSA
  // Your data is included with hospitals in the CBSA to which you are reclassifying
  // Reclassified hospitals still have to meet criteria to reclassify
Worksheet A Series
WORKSHEET A

// Costs must be reasonable and must be related to patient care
// Costs must be recorded on the accrual basis of accounting
// Salaries must be recorded in department that provides service
// Adequate system of internal control should be in place to assure system records transactions as incurred
// Must provide adequate support goods/services were received/provided in order to record as allowable
// May need to expand chart of accounts to better identify costs to minimize risk of error in cost report
// Who is taking responsibility for correct coding of costs?
WORKSHEET A-6

// Reclassifications

// Items not grouped with proper cost center on A

// Common examples:

✓ Chargeable supplies, including oxygen
✓ Implantables
✓ Chargeable drugs
✓ Property costs such as insurance, taxes, interest & depreciation
✓ Shared salaries – including ER, other outpatient services & acute nursing
WORKSHEET A-8

// Adjustments

// Identify and offset costs not related to patient care
✓ HFMA non-allowable costs compliance checklist
✓ If it doesn’t relate to patient care, it probably isn’t an allowable cost
WORKSHEET A-8-2

// Physician costs

// Purpose is to determine allowable physician costs
// Some are not allowable since professional billing is made to Part B
// Common allowable costs are

✓ ER availability
✓ Medical director
Worksheet B Series

- Statistical
- Stepdown
- Overhead
B SERIES

// B-1 - Statistics for Step-down
  // Basis for allocation of the costs of non-revenue-producing cost centers to revenue-producing and non-reimbursable cost centers
  // Non-revenue-producing cost centers – laundry and linen, dietary, housekeeping, etc.
  // Revenue-producing cost centers – routine services, radiology, pharmacy, etc.
  // Non-reimbursable cost centers – physician private offices, meals on wheels, gift shop, wellness, etc.

// Step-down method
  // The cost of the non-revenue-producing center serving the greatest number of other centers is allocated first
WORKSHEET B-1

Methods Used for Step-down

- Building capital costs – square feet or directly assigned
- Equipment – square feet or dollar value
- Employee benefits – salaries or directly assigned
- A & G – accumulated costs (can fragment)
- Maintenance – square feet or work orders
- Plant – square feet or directly assigned
- Laundry – pounds or patient days
- Housekeeping – hours spent or square feet
- Dietary – meals served (caloric equivalents) or patient days
- Cafeteria – meals served or FTEs
- Nursing admin – hours supervised or nursing salaries
- Central Supply – costed requisitions
WORKSHEET B-1

// Statistics
  // Must be accumulated on an actual continuous basis
// Time Studies
  // Must be performed one full week per month, rotating weeks
// The Provider Reimbursement Manual (PRM) section 2313 has been interpreted by CMS such that any hospital that is using a time study related to any Worksheet A-6 reclass, A-8 adjustment or B-1 cost allocation statistic must be requested 90 days prior to the end of the cost reporting period for which it applies.
WORKSHEET B, PART I

// Cost Step-down

// Departmental summary of all costs as allocated by the B-1 statistics

// Allocation data can be used for more than just the cost report

// Review allocations to NRCCs
Worksheet C Series
CHARGES

// Reported by cost center
  // Inpatient
  // Outpatient
// Reclassifications may be necessary
// Adjustments may be necessary, for example:
  // Professional charges
  // Gross up for same service in different locations
  // Self insured domestic charges
// Issue if Medicare & Medicaid exceed total
  // Crosswalked properly?
COST TO CHARGE RATIOS

// Costs from Worksheet B
// Charges from Worksheet C
// Costs/Charges = Cost to Charge Ratio
// Reasonableness checks
  // With prior year
  // With service line

MATCHING PRINCIPLE IS KEY
Worksheet D Series
MEDICARE CHARGES

// Worksheet D-3
  // Inpatient
  // Subprovider(s)
  // Skilled Nursing Unit
  // Swingbed

// Worksheet D, Part V
  // Outpatient services

// PS&R Report
  // What is it?
  // CSV and PDF format
  // Summary versus detail
Worksheet E Series
SETTLEMENT

Worksheet E, Part A: Inpatient
could include:

- Federal Payments
- Outliers
- IME
- DSH
- Hospital specific payments (SCH or MDH)
- Capital
- Pass through costs
- GME
- Low volume payments
- Value based purchasing
- Revenue readmissions
- Hospital acquired conditions
- Medicare bad debts

Less paid by beneficiary deductibles, coinsurance, & MSP

Less interim payments (See E-1) = Settlement
WORKSHEET E PART B

// APC Payments primarily for OPPS
// Some outpatient services are cost reimbursed
// Pass through programs
// GME

// Less beneficiary deductibles, coinsurance & MSP
// Less interim payments (see E-1) =
// Settlement
WORKSHEET E-1

// Part I
   // Interim claim payments
   // Pass through payments
   // Lump sum adjustments

// Part II
   // Electronic health record
E-3, PART II AND III

// IPF and IRF
  // Fully PPS
  // Typically no settlement
SEQUESTRATION

// Required by Budget Control Act of 2011, after Congress & White House failed to agree on deficit reduction measures
// 2% cut in all Medicare payments, effective for services on or after April 1, 2013
// Includes Electronic Health Record payments
// Based on net Medicare payment, not counting deductible & coinsurance
// Theoretically reinstated in 2022
// Compare 2% of your Net Payments per the cost report
// With 2% of Net Payments per the PS&R
// The difference will be settled
Other Medicare Add-Ons / Reductions
VALUE BASED PURCHASING

// Intended to reward hospitals that provide high quality care to Medicare beneficiaries
// Various measures included; this changes each year
// Maximum impact:

<table>
<thead>
<tr>
<th>FFY</th>
<th>Max Impact</th>
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<tbody>
<tr>
<td>2013</td>
<td>1.00%</td>
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<tr>
<td>2015</td>
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<tr>
<td>2016</td>
<td>1.75%</td>
</tr>
<tr>
<td>2017 &amp; beyond</td>
<td>2.00%</td>
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</table>
READMISSIONS REDUCTION / HOSPITAL ACQUIRED CONDITIONS

// Readmissions Reduction
   // Intent to reduce payments to IPPS hospitals with excessive readmissions
   // Effective for discharges beginning on October 1, 2012
   // Maximum penalty is 3% (FY 2016)

// Hospital Acquired Conditions
   // Intent is to penalize hospital who have excessive HACs
   // Hospitals in the lowest quartile for medical errors / serious infections that
      patients contract while in the hospital receive a 1% payment reduction

// CMS has estimated the total penalty will decrease slightly in FY 2016 as
   compared to FY 2015
Disproportionate Share Hospital Payments
BACKGROUND & OVERVIEW

Hospitals treating a disproportionate share of low income inpatient patients, receive a special Medicare payment under PPS.

The DSH payment is an add-on to the hospital’s DRG payment.

Designed to compensate hospitals for the higher cost of treating low income patients.
BACKGROUND & OVERVIEW

// Two methods for determining qualification

// “Proxy” method (most common)
// “Pickle” method

✓ Very few hospitals qualify under this method
✓ Urban hospitals w/ > 100 beds
✓ At least 30% of net inpatient revenue must be attributable to State and local subsidies for indigent care
BACKGROUND & OVERVIEW

// Low-Income Proxy: Disproportionate patient percentage of 15.0% or more determined by the sum of two ratios:

✓ Medicaid Ratio: Patient days that are eligible for Medicaid & not entitled to Medicare Part A divided by total patient days

✓ Medicare/SSI Ratio: Total patient days that are entitled to Medicare Part A benefits & federal supplemental security income (SSI) benefits divided by patient days entitled to Medicare Part A benefits
WHAT IS A MEDICAID DAY?

// CMS position

// Numerator of Medicaid ratio should include all eligible Medicaid days in inpatient PPS areas of the hospital

✓ Unpaid days

✓ Nursery days

✓ Labor room days for cost reports beginning on or after 10/1/09 (and for all open cost reports or cost reports with a properly pending appeal)

✓ HMO days
DSH FORMULAS - OPERATING

// Urban Hospitals < 100 beds:

// >=15.0% but <20.2%:  2.5% + [.65 x (DSH % -15%)] capped at 12.00%
// >=20.2%:  5.88% + [.825 x (DSH % - 20.2%)] capped at 12.00%

// Urban Hospitals >= 100 beds:

// >=15.0% but <20.2%:  2.5% + [.65 x (DSH % -15%)]
// >=20.2%:  5.88% + [.825 x (DSH % - 20.2%)]

// Rural Referral Centers

// >=15.0% but <20.2%:  2.5% + [.65 x (DSH % -15%)]
// >=20.2%:  5.88% + [.825 x (DSH % - 20.2%)]
DSH FORMULAS - OPERATING

// Medicare-Dependent Hospitals (as of 10/1/06)
  // >=15.0% but <20.2%: 2.5% + [0.65 x (DSH % -15%)]
  // >=20.2%: 5.88% + [0.825 x (DSH % - 20.2%)]

// Other Rural Hospitals < 499 beds
  // >=15.0% but <20.2%: 2.5% + [0.65 x (DSH % -15%)] capped at 12.00%
  // >=20.2%: 5.88% + [0.825 x (DSH % - 20.2%)] capped at 12.00%

// Other Rural Hospitals >= 500 beds
  // >=15.0% but <20.2%: 2.5% + [0.65 x (DSH % -15%)]
  // >=20.2%: 5.88% + [0.825 x (DSH % - 20.2%)]
UNCOMPENSATED CARE

// Effective 10/1/2014, all DSH qualifying hospitals will have a blend of traditional DSH payment and uncompensated care

// Created big winners and losers and shifted previous DSH reimbursement between hospitals

// Only hospital who qualify for DSH, will qualify for the uncompensated care payment under the new method

// Worksheet S-10 from the cost report will not be used to allocate uncompensated care payments to each hospital

// CMS has indicated S-10 could be used in future years
UNCOMPENSATED CARE

// Two payments will be calculated for a DSH hospital
// The traditional DSH payments will continue to be computed but only paid at 25% (called the empirically justified Medicare DSH payment)
// A second payment will be based on three factors & is referred to as the “uncompensated care payment”
### FFY 2015 UNCOMPENSATED CARE RATES

**FY 2015 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act---Medicare DSH-Supplemental Data**

<table>
<thead>
<tr>
<th>PROV</th>
<th>Medicaid Days</th>
<th>SSI Days</th>
<th>Insured Low Income Days</th>
<th>Factor 3</th>
<th>Projected to Receive DSH for FY 2015</th>
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</table>
**FFY 2015 DSH Payment Methodology**

<table>
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<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td><strong>FY 2015 DSH Payment</strong></td>
<td>$5,000,000.00</td>
</tr>
<tr>
<td>25% Historical DSH</td>
<td>$1,250,000.00</td>
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<tr>
<td><strong>Federal Uncompensated Care Pool</strong></td>
<td>$7,647,644,885</td>
</tr>
<tr>
<td><strong>Factor 3: (FFY15 Published hospital specific rate)</strong></td>
<td>0.0345624%</td>
</tr>
<tr>
<td><strong>Uncompensated Care Payment</strong></td>
<td>$2,643,000.00</td>
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<tr>
<td><strong>Estimated Total FY 2015 DSH Payment</strong></td>
<td>$3,893,000.00</td>
</tr>
<tr>
<td><strong>Reimbursement Comparison</strong></td>
<td>($1,107,000.00)</td>
</tr>
</tbody>
</table>

Note: Depending on hospital FY, a blend of two FFY uncompensated care payments may be needed.
UNCOMPENSATED CARE

// Medicaid & Medicare SSI days used as a proxy for uncompensated care costs
// Medicaid eligible and SSI enrollment remains a driving force for future DSH payments
// Question is how long will CMS use Medicaid and SSI days rather than S-10 for allocation of uncompensated care payments?
UNCOMPENSATED CARE

// Cause for concern with uncompensated care:

// Federal uncompensated care pool continues to shrink each year as CMS estimate of uninsured population decreases

// Uninsured population decreases do not take into consideration geographical changes in uncompensated care population

// Why did CMS ignore cost of uninsured?

// Varying definitions of uncompensated care

// Lack of consistent reporting (CMS-2552-10 Form S-10)
UNCOMPENSATED CARE

Federal uncompensated care pool amounts

- FFY 2014  $9.0 billion
- FFY 2015  $7.6 billion
- FFY 2016  $6.4 billion
UNCOMPENSATED CARE

// Data table on CMS website should be reviewed by all hospitals – notify CMS if data is in error

// CMS is using as-filed cost reports; this is problematic because of the Medicare Part C issue and Medicaid eligible days updated at audit

// Worksheet S-10 could be used in the future so it is important to complete it accurately

// Formula will continue to punish states that do not expand Medicaid if methodology is used in the future
DSH & 340B IMPACT

How will CMS DSH changes impact PPS hospital eligibility for 340B?

PPS hospitals are eligible for 340B under Public Health Service Act Section 340B(a)(4)(L)(ii) if they have “a disproportionate share adjustment percentage (as determined under section 1886(d)(5)(F) of the Social Security Act) greater than 11.75 percent”

1886(d)(5)(F) was modified by ACA to include the new DSH calculation CMS is proposing to implement.

2 significant components of the DSH calculation

- Medicaid days - DSH “scrubbing”
- SSI – Increase enrollment
Medicare Bad Debts
WHAT IS A MEDICARE BAD DEBT?

// Amount reimbursable to Medicare provider
// Unpaid Medicare Part A deductibles & coinsurance
  // Amount patient is obligated to pay after Medicare coverage begins
// Related to Medicare covered services
// Cannot exceed deductible & coinsurance amount after Medicare pays
CRITERIA FOR ALLOWABILITY

// Reasonable collection effort

// Consistent with provider’s established collection policy
// Same effort to collect non-Medicare bad debts

// Referring non-Medicare accounts to a collection agency but not Medicare accounts may be violation

// Genuine, rather than token effort
CRITERIA FOR ALLOWABILITY

// Deemed uncollectible

// After reasonable & customary attempts to collect
// Remains unpaid more than 120 days
√ After date of first bill, or
√ After date last payment received

// Sound business judgment established there was no likelihood of recovery
// Written off in the accounting period (cost reporting period) when deemed worthless
BAD DEBT RECOVERIES

// Previously written off bad debt recouped

// Recovered in subsequent period

// Must reduce other bad debts claimed in the period recovered

// If no other bad debts to offset, must pay back to Medicare
OTHER BAD DEBT ADVICE AND ISSUES

// Provide training to billing clerk on what constitutes an allowable Medicare bad debt

// Documentation is KEY

// If using a collection agency, determine how long to allow agency to pursue before returning, to expedite the ability to claim on the cost report

// Tax Relief Act

// Reimbursement percentage reduced for CRP’s beginning in FFY 2013
   ✓ PPS to 65% vs. 70%
   ✓ Phased in adjustments of 12% reductions per year for providers that were paid at 100% (CAH)
EHR Meaningful Use
EHR MEANINGFUL USE

// Health Information Technology for Economic and Clinical Health (HITECH) Act enacted as part of the American Recovery and Reinvestment Act of 2009
   // Directed the adoption and meaningful use of health information technology (HIT) as a national policy priority
   // Created financial incentives in the Medicare and Medicaid programs to encourage qualifying hospitals to become meaningful users of certified electronic health record (EHR) technology

// “EHR for each person in the U.S. by 2014”
   // Stage 1 final Federal Register published July 28, 2010
   // Stage 2 final Federal Register published August 23, 2012
   // Stage 3 final Federal Register published October 6, 2015
EHR FINAL RULE: 2015 MODIFICATION (CMS)

- **Shortening the 2015 reporting period to any continuous 90 days** to address provider concerns about their ability to fully deploy 2014 Edition software.

- **Realigning hospital reporting periods to the calendar year for program years 2015-2016** to allow eligible hospitals more time to incorporate 2014 Edition software into their workflows and to better align with other quality programs.

- **Modifying other aspects of the programs** to match long-term goals, reduce complexity, and lessen providers’ reporting burden.

- **Attestation did not begin until after 1/1/2016.**

- **Attestation deadline just extended to 3/11/2016.**
PPS EHR MEANINGFUL USE PAYMENTS

// Medicare incentive payment calculation based upon three factors:
  // An initial base amount
  // The hospital’s Medicare share
  // A transition factor applicable to the payment year
PPS EHR MEANINGFUL USE PAYMENTS

// PPS Hospitals - Medicare payment
  // Initial base amount = $2 million
  // Discharge amount = $200/discharge, discharges 1,150 - 23,000
  // Sum of these amounts x Medicare share = gross annual amount
  // Gross annual amount x transition factor = actual payment
PPS EHR MEANINGFUL USE PAYMENTS

// Medicare Share
  // Numerator - Part A days + Part C days
  ✓ Part C days reported on Worksheet S-3 of cost report (Column 6, Line 2)
  ✓ PPS hospitals are required to submit informational only bills for Medicare Advantage beneficiaries to the MAC

// Denominator - Total days x (total charges net of charity ÷ total charges)
  ✓ Charity care based upon Worksheet S-10, Line 20
### SAMPLE PPS MEDICARE INCENTIVE PAYMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Source</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Total Discharges</td>
<td>WS S-3, Pt I, Ln 1, Col 15</td>
<td>10,863</td>
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<tr>
<td>Medicare Inpatient Days Attributable to Parts A and C</td>
<td>WS S-3, Pt I, Ln 1, Col 6 &amp; WS S-3, Pt I, Ln 2, Col 6</td>
<td>24,066</td>
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<tr>
<td>Total Inpatient Days</td>
<td>WS S-3, Pt I, Ln 14, Col 8</td>
<td>42,119</td>
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<tr>
<td>Charity Care Charges</td>
<td>WS S-10, Ln 20, Col 3</td>
<td>48,984,010</td>
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<tr>
<td>Gross Hospital Charges</td>
<td>WS C, Pt I, Ln 200, Col 8</td>
<td>568,048,016</td>
</tr>
<tr>
<td>Total Adjusted Inpatient Days</td>
<td></td>
<td>38,487</td>
</tr>
</tbody>
</table>

**Calculations**

- **Base Amount**: $2,000,000
- **Qualifying Discharges (amount over 1,149, capped at 23,000)**: 9,714
- **Discharge-Related Amount ($200 per qualifying discharge)**: 1,942,800
- **Medicare Share Ratio**: 62.5%

**Results**

<table>
<thead>
<tr>
<th>Total Payment -- Year 1</th>
<th>Percentage</th>
<th>Amount</th>
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<tbody>
<tr>
<td>100%</td>
<td></td>
<td>$2,465,442</td>
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<tr>
<td>Total Payment -- Year 2</td>
<td>75%</td>
<td>$1,849,081</td>
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<tr>
<td>Total Payment -- Year 3</td>
<td>50%</td>
<td>$1,232,721</td>
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<tr>
<td>Total Payment -- Year 4</td>
<td>25%</td>
<td>$616,360</td>
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**Total Medicare Incentive Payment Over Four Years**: $6,163,604
# EHR Meaningful Use Timeline

## Table 3: Stage of Meaningful Use Criteria by First Year

<table>
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<tr>
<th></th>
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<td>2018 and Future Years</td>
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</tbody>
</table>

*Please note, a provider scheduled to participate in Stage 2 in 2014, who instead elected to demonstrate stage 1 because of delays in availability of EHR technology certified to the 2014 Edition, is still considered a stage 2 provider in 2014 despite the alternate demonstration of meaningful use. In 2015, all such providers are considered to be participating in their second year of Stage 2 of meaningful use.*
## PPS EHR MEANINGFUL USE PAYMENTS

### PPS EHR Incentive Payment Transition Factor

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>0.75</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>0.50</td>
<td>0.75</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>0.25</td>
<td>0.50</td>
<td>0.75</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>0.25</td>
<td>0.50</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td>0.25</td>
<td>0.25</td>
<td>0.25</td>
</tr>
</tbody>
</table>
PPS EHR MEANINGFUL USE PAYMENTS

//Payment Process

// After submitting attestation, the MAC issues an interim payments computed from most recently submitted 12-month cost report

// Final payments computed from the 12-month Medicare cost report that begins in the FFY payment year

//Applicable transition factor applied to payments

//A final EHR incentive payment receivable or payable may exist depending upon:

  //Changes in the Medicare share between the cost report utilized to determine the interim EHR incentive payments and the cost report filed utilized to determine the final EHR incentive payments

//Payment audits will occur
PPS MEDICARE PAYMENT PENALTIES

PPS hospitals that are not meaningful users for FFY 2013 will be subject to a payment adjustment.

If a PPS hospital has not demonstrated meaningful use for an applicable reporting period, its update to the PPS payment rate will be reduced by the following adjustment factors:

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% Decrease</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Example: If the increase to the PPS rate was 2% in 2015, then a PPS non-meaningful user would only receive a 1.5% increase (2% increase X 25% = .5% payment adjustment).

Adjustment is a two-year lag between not meeting meaningful use and the payment adjustment.
MEANINGFUL USE AUDITS

// Figliozzi & Company – Garden City, New York
// Minimum 5% of nation’s hospitals that attested to Medicare EMR program each program year
// Contacted by email address used during Medicare attestation
// Even though all Core measures & the facility’s choice of 5 Menu measures are attested to, only a certain number of Core & Menu measures are selected for audit
// Consider performing a mock audit
After the cost report is filed
UNDERSTANDING THE COST REPORT – AFTER IT’S FILED

Cost report provides valuable information to assist management:

// Monitoring Medicare margins
  // Service line or contribution margin analysis
  // Assist in margin analysis for other payers

// Understand impact of any cost based arrangements (Medicaid DSH, etc.)

// Understanding reimbursement by program amounts

// Cost report includes reimbursement from wide variety of programs and arrangements
  // All have unique methodologies and drivers

// Understanding the amounts by program will help prepare for future changes

// Understanding drivers for each program could lead to opportunities
THANK YOU

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