TAHFA / HFMA Lone Star Road Show
Lubbock, Tx.
February 17, 2017

Presented by
Discovery Healthcare Consulting Group, LLC

Healthcare Finance & Reimbursement
A Voyage or Destination
Travelling toward the Future in Hospital Finance – Agenda

- Positioning for the Future – Reporting and Reimbursement
  - Electronic Health Records Payment Audits
  - Medicare Low Volume and MDH legislation
  - Ambulance UPL Program
  - Additional RHC Qualifying Visits
  - Provider Based Rules Revisions
  - Medicare Bad Debts
  - 2013 Medicaid DSH Audit Update

- Update on Texas 1115 Waiver
Electronic Health Records Incentive - Audits

- **Opportunity in Medicare Incentive Payments**

- **Potential Correction in Utilization - (Adj Medicare %)**
  - Managed Care Claims billed/ Processed through Traditional Medicare System
  - Attestation / initial pmt. may be based on total Mcare Volume / Utilization
  - Reconciliation of tentative and final payment is based on Medicare P S & R logs - which may not (will not unless shadow billed) include MCO data.

- **Opportunity** - Ensure that all MCO claims have been shadow billed through Medicare system.

- Follow-up processing and correction of E H R payment calculation, based on most current claims volume.

- Ensure that final E H R payments include all Medicare utilization
Medicare Payment Extenders – H.R. 2 Passed 4/16/2015

Medicare Low Volume Payment Adjustment (LVPA)

- Extender provisions - LVPA
  - less than 1600 discharges
  - greater than 15 miles

- Legislation is currently set to fall back to pre-2011 provisions beginning Oct 1, 2017 (FFY 2018).

Medicare Dependent Hospital (MDH)

- Hospitals - 60% or more Medicare over 2 of the last 3 years
- Add-on payment of 75% of the Variance between Hosp Spec Amount and Federal DRG
- Not subject to 12% pmt. cap for Medicare DSH payment

Current Legislation sunsets on September 30, 2017 (FFY 2018)
Ambulance Uncompensated Care

- Designed to supplement Governmental EMS providers for shortfall in Medicaid and uninsured trips

- Shortfall is Cost less Payments (Fee schedule)
  - Demonstration Program - Gaining support
  - and participation throughout the state.
  - No IGT necessary - Funded through Coalition of funding Hospitals

Based on Pool of Appropriated Funds and reimbursement payments will be based on weighted amount of shortfall compared to Pool availability.
Ambulance Uncompensated Care

- **Application Process**
  - Letter of Request for Supplemental Ambulance Payments
    - List of Criteria required to be included in Request
    - Eligibility is one month after approval of Request
    - Not actually paid until you file your first Cost Report
  - Ambulance Cost Report - detailing Ambulance Cost and amount of Medicaid Utilization
    - Payment is based on shortfall of Cost vs Payments
Rural Health Clinic - Add’l Qualifying Visit List - 08/01/2016

- CMS issued the RHC Qualifying Visit List in August

- Effective for Visits after April 2016, billable in October 2016

- Includes a comprehensive list of procedures that are now inclusive as an RHC encounter that historically have had to be billed under the hospital number to be paid.

- Professional Component cost must be offset on the hospital cost report, but the professional cost is an allowable part of the RHC cost structure.

- Some services historically performed at the hospital may be better and/or more efficiently performed in the RHC now.

- May even be a cause for consideration to look at certification of a hospital based clinic to an RHC.
Maximize the efficiency of the RHC through utilization of “Urgent Care” procedures.

For many CAH hospitals and most PPS facilities, the RHC’s should be reviewed for operational and reimbursement optimization.

RHC Relocation or new location - Ensure new practice location meets and has current HPSA / MUA designation through HRSA.
Changes in Medicare Payment – Provider-Based Entity

Department of a provider

- A facility or organization that is either created by or acquired by the main provider.

- The health care services provided in the facility would be the same type as those furnished by the main provider.

- Services provided under the name, ownership, financial and administrative control, and marketing of the main provider. A department of a provider comprises both the specific physical facility that—
  - serves as the site where services are performed, and
  - the personnel and equipment needed to deliver the services at that facility.

- A department of a provider is subject to the Medicare conditions of participation of the main provider (e.g. hospital).
  - e.g.; O/P Surgery Centers (not ASCs), O/P Radiology Centers (not IDTFs), Physician clinics (not RHCs, FQHCs, or clinic locations billed with POS code 11, office)
Game Changer - Office of Inspector General (OIG) Report to CMS

- OIG Report (June 2016) findings.
  - 50% of all hospitals tested had at least one PB facility.
  - With a voluntary rule, many hospitals were found to have not completed a PBA.
  - 75% of hospitals reviewed that did NOT complete a PBA for an off-campus facility were found to not even meet one single PB requirement for an off-campus location.
  - CMS does not have any sentinel review/audit process in place by off-campus PB departments.
  - Those facilities reviewed that did submit a PB did not maintain records to support their attestation.
Medicare Provider-Based (PB) Provisions

- Criteria to be aware of in new PB Rules:
  - Not “within four walls of the main hospital building”
  - Not “on campus”
  - More than 250 yards from the main hospital building but within 35 miles of the main provider’s campus, or
  - Meets all of the other off-campus location criteria.
CMS Revision to Provider Based Facility Rules

- CMS’s New Rules Affecting Outpatient “Off-Campus” Provider-Based Payment Rules
- Effective 01/01/2017, payments will be made entirely on the Medicare Physicians Fee Schedule (MPFS) and NOT on OPPS for all services provided at Off-Campus PB locations, except for the following:
  - Qualified Emergency Dept.
  - Facilities within 250 yards of main hospital - “On-campus Facilities”
  - Existing Services provided at existing ”Off-Campus” PB facilities after November 2, 2015 (Grandfather date).
    - New Services offered or change in Off-campus practice location will nullify Grand-fathering provision.
    - Change of Ownership where new owner accepts existing certification of hospital with existing “Off-campus” facilities offering same on-going services.
  - New Services provided on an existing off-campus PB entity after November 2, 2015 will be paid on the fee schedule.
Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:
  - What can we claim?
  - What information should my Bad Debt List include?
  - When can I claim Medicare Bad Debts on Cost Report?

- 42 CFR 413.89(f) requires that the uncollectible Medicare **deductible** and **coinsurance** be charged off as bad debts in the accounting period when the bad debt is determined to be worthless. Jan 18, 2017

- Two Categories of Bad Debt: Indigent / Medicaid and Non-Indigent (i.e. Medicare)
  - No collection effort required for indigent / Medicaid but must bill Medicaid to ensure there is no obligation by the State to pay
  - Regular Medicare bad debt must exhaust all collection efforts before it can be claimed for reimbursement on the Medicare cost report
## Medicare Bad Debt

<table>
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<tr>
<th>Provider Type</th>
<th>Period Began 10/1/2012</th>
<th>Periods Began 10/1/2013</th>
<th>FFY 2015 (10/1/2014) and After</th>
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<tr>
<td>Hospitals</td>
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<td>SNFs, Non Dual Eligibles</td>
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<td>65%</td>
</tr>
<tr>
<td>Swing-Bed Hospitals, Non Dual Eligibles</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>SNFs &amp; Swing-Bed Hospitals, Dual Eligibles</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
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<tr>
<td>CAHs</td>
<td>88%</td>
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<td>ESRDs</td>
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<td>CMHCs</td>
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<td>76%</td>
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<tr>
<td>FQHCs/RHCs</td>
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<td>76%</td>
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<td>Cost Based HMOs</td>
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<tr>
<td>Health Care Pre-Payment Plans</td>
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<tr>
<td>Competitive Medical Health Plans</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
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</tbody>
</table>
Medicare Reimbursement Reporting Tips

Medicare Bad Debt Reporting Regulations:

- 42 CFR 413.89(e) Criteria for allowable bad debt. A bad debt must meet the following criteria to be allowable:
  
  1. The debt must be related to covered services and derived from deductible and coinsurance amounts.
  2. The provider must be able to establish that reasonable collection efforts were made.
  3. The debt was actually uncollectible when claimed as worthless.
  4. Sound business judgment established that there was no likelihood of recovery at any time in the future.
Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:

  - Reasonable Collection Effort - 120 days without payment being made
  - Collection Efforts can include the combination of in-house efforts and outside collection agency
  - Bad Debt logs should include - Patient demographics, 1st Bill date, W.O. Date and/or returned from collection agency, Medicaid Number (appl), recoveries or payments made, unpaid deductible / coinsurance amounts
Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:
  - Set up processes to:
  - Exclude non-allowable coinsurance and deductible amounts (Part B physician amounts)
  - Track associated coinsurance for recurring patients
  - Claim out of state Medicaid patients (includes validating other state EOB codes)
  - Bill Medicaid for total charges (charges must match those billed to Medicare)
  - Claim Medicaid Managed Care patients
  - Examine policies annually (Bad Debt/Charity)
  - Prepare bad debt logs correctly before submission
Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:
  - Organize and store supporting documentation for audit
  - Medicare and Medicaid remits
  - Patient account detail
  - Proof of write-off date
  - Proof of collection attempts
  - **Proof of accounts returned from collection agencies**

- Charity Financial application and support
  - Proof fee reimbursed amounts have been removed from bad debt log
  - Proof consistently treating Medicare and non-Medicare accounts the same – this should be included into your Policy.
SFY 2013 DSH / UC Audit Update

- Myers and Stauffer in completion of the initial results of the UC reconciliation for the 2012 and 2013 (DY 1 and DY 2)
- M&S has started sending out initial notifications of over / under payment.
- Hospitals will have 10 days to work with M&S on any discrepancies
- Findings will be submitted to HHSC - reconciliations are expected to be complete by March 31, 2017 for DY 1 and 2
- HHSC will issue final recoupment letters - probably Spring 2017.
- Actual Recoupment will be based on final determination of UC / DSH amounts and IGT amounts.

- SFY 2017 DSH / UC application was issued in January 2017 - February 10th Deadline, some did receive extensions for filing.
SFY 2013 DSH Audit Update

- Seems to be More Recoupments this year than past years.
- Differences in Cost and Payment calculations between Application and Audit.
  - 2013 UC Tool used a distribution of Mcaid charges, based on total charges; audit used actual revenue code cross-walk (direct assignment of charges).
  - Inclusion of the Medicare Low Volume Payments
- Collaborative Effort among several rural hospitals and TORCH to verify Medicaid payments made by the collection of MCO payers.
New Legislation

HR ?? – Save Rural Hospitals Act

- H.R. 3225 last session – S. Graves (R-Missouri)

- Reverse Bad Debts reimbursement reductions to CAHs.
- Make permanent – Low Volume Adj and Mcare Dependent Pmt.
- Delaying application of penalties for failure to be Meaningful Electronic Health record user.
- Make permanent increased Medicare Payments for ground Ambulance services in rural areas.
- Elimination of reductions / ceiling on DSH payments for Rurals
- Elimination of 96-hour physician certification requirement for IP CAH services.
- Reinstates OP Hold Harmless Payments for rural Hospitals
- Reforming RAC audits under Medicare.
- Eliminates 2% Sequestration for Rural Hospitals
New Legislation
Rural Emergency Acute Care Hospital Act

- S. ?? - C. Grassley – (R- Iowa) – formerly S.1648

A bill was filed recently by Iowa Senator Chuck Grassley to create a new type of rural hospital which is similar to a free standing emergency room.

S. 1648 called for the Centers for Medicare and Medicaid Services (CMS) to create a program where Critical Access Hospitals and other rural hospitals of 50 beds and less have an option to drop inpatient services but continue with their emergency room and outpatient services, plus receive 110% of allowable cost on Medicare.
New Legislation
A few Healthcare Funding Bills

- Advancing Medical Education Resident Training in Rural and Community Hospitals Act of 2017
  - H.R Bill 284 – E. Stefanik (R-NY)
  - Establishes new payment rules for GME cost for hospitals in a new medical residency training program for hosting resident rotations for short durations in community hospitals.
  - Reimbursement would pass outside of teaching hospital resident caps

- Senate J. R. – Discontinuation of the Medicare IPAB
  - S. J Res 17, 16, and 51 – (J Cornyn- R – Texas, et all)
  - Discontinuation of the portion of the ACA that established the Independent Payment Advisory Board (IPAB)
  - 15 member Board that can reduce Medicare spending based on too much and too rapid growth in spending.
1115 Waiver Update?
Waiver History

- Replaced the Upper Payment Limit Program (UPL)
- Consist of Delivery System Reform Incentive Payments (DSRIP) and Uncompensated Care Payments (UC).
- Began as a 5 year demonstration period in October 2011 and ended September 2016.
- Has been extended for an additional 15 months through December 2017.
Issues with the Waiver

- CMS doesn’t like the way Private Hospitals are being funded.

- For DY5, the total HSL after DSH was approx 6 billion dollars. Enough IGT was committed to produce $6 billion. The State’s cap was $3 billion resulting in a 50% haircut.
Deferral vs. Disallowance

- The distinction between a deferral and a disallowance is significant.
- A deferral does not allow for an appeal.
- A final decision of a disallowance does allow for an appeal.
Waiver Deferral of 2014

- In September 2014, CMS issued a deferral of about $75m in Federal Participation.
- The deferral was issued by the Dallas Regional Office.
- The deferral was lifted on January 2015 and gave Texas until December 2015 to correct the public-private funding method.
- In June 2015, the deadline was extended until September 2017.
In September 2016, CMS issued a letter of disallowance of 27 million dollars. Less than 1% of the total UC payments. This allows Texas to appeal to the HHS Departmental Appeals Board.
Will there be a Renewal?
If so, what will it look like?

- For Uncompensated Care
- Status Quo. (Highly Unlikely)
- Medicaid Expansion (Even More Unlikely)
- Local Provider participation Funds (LPPF) (Provider Tax)
- Requires Legislative Action
Will there be a Renewal? If so, what will it look like?

- For DSRIP
- Incentive Based
- Start up
- Building Capacity
- Not for ongoing programs
- HHSC has requested a two year extension (through 2019)
- A lot of negotiations still to take place
Medicaid Rate Enhancement

- Not part of the 1115 waiver program
- Only for Managed Care Medicaid
- Has been approved by HHSC and CMS
Thank You!