Novitas Solutions
Audit and Reimbursement Update
September 25, 2014

Agenda

- Introduction
- Organizational Structure
- Reimbursement Issues
- Audit Issues
- Wage Index
- FFY 2015 IPPS Changes
Revised Organizational Structure to improve effectiveness and efficiencies of the organization, quality of production, and communications

- Personnel and roles:
  - Steve Holubowicz, Sr. Director over Audit and Reimbursement (JH)
  - Timothy LeJeune, Director of JH Audit
  - Bruce Snyder, Acting Manager of Reimbursement and Settlement
  - Jackie Burke, Manager of Audit (Florida and Georgia)
  - Lisa Travis, Manager of Audit (Dallas and Milwaukee)
  - Jennifer Garrett, Supervisor of Reimbursement
  - Carrie Rudy, Acting Supervisor of Settlement
Reimbursement Issues

- **Interim Rate Reviews**
  - Complete two reviews on: PIP, CAH, RHC, FQHC, TEFRA, GME providers, Children’s and Cancer facilities
  - Complete four reviews on CAH PIP and all other provider types we complete one rate review.
  - We request data from cost providers, GME, RHC, FQHCs, TEFRA, and PIP providers.
  - CMS is stressing current cost data, non-compliance is subject to payment withhold of 25% (always contact prior to a withhold)
  - We request data from PIP providers for each review (since we are required to have discharges)
  - All other providers for the 1st review we typically use the cost report, and for the subsequent review we utilize provider supplied data.

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**Rate Review Timing**

- PIP providers – After three months and after nine months. Information is due back three weeks after the end of the nine-month period. Reminder to remain on PIP, 85% of claims submitted must be “clean claims” billed within 30 days of discharge and be able to project, discharges that will not result in overpayments due to a substantial decline in Medicare utilization.

- Cost providers or those requiring two reviews – GME, RHC, FQHC, TEFRA – After nine months. Information is due back three weeks after the end of the nine-month period.

- CAH providers – After three months and after nine months. Information is due back three weeks after the end of the nine-month period

- Questions on rate reviews can be directed to:
  - jennifer.garrett@novitas-solutions.com
Reimbursement Issues

- MDH and Low Volume Adjustment – Hospitals
  - MDH and Low-Volume adjustment programs will now expire April 1, 2015
  - Provider must inform MAC regarding whether it can meet the Low-Volume adjustment by 9/1/14
  - Low Volume Adjustment reverts to 200 discharges (down from 1,600) in April 2015
    - Only a few hospitals will be qualified after this change
    - Congress is considering an extension and retroactive application
      - May not happen until second quarter of 2015
  - We will issue a listserv and website update when information becomes available

Reimbursement Issues

- Effective for discharges on or after 10/1/2013
- Expands DSH to more hospitals, due to expanded Medicaid programs
  - Empirically Justified Amount – 25% of estimated DSH payments (current method) – no changes
  - Uncompensated Care Amount – 75% of estimated DSH payments - three factors
    - Factor 1 – estimation of 75% of global DSH payment
    - Factor 2 – reduction based on estimated decrease in uninsured
    - Factor 3 – individual hospital’s proportion of uncompensated care to all DSH hospitals’ uncompensated care
  - Uncompensated care payments are based on an estimate
    - CMS not accepting the uncompensated care amounts on WS 5-10
Reimbursement Issues

ACA, Section 3133 (DSH)

- Proxy for 2015 – CMS provides this data
  - Inpatient days of Medicaid patients from March, 2014 Hospital Specific File for the FY 2012 cost report, WS S-2 plus
  - Inpatient days of Medicare SSI patients fro the FY 2012 cost report
  - Not sure how long the proxy will be used
- Essentially a pre-determined amount for the year paid during the year based on Medicare discharges
  - Example – pre-determined that a provider will receive $20M during the FY
  - During the year they only receive $19M, the additional $1M will be a cost report add-on
- Special rules for newly eligible hospitals, merged and new hospitals

CRNA Exception Criteria

- In order for a provider to qualify for the CRNA exception and be paid on a bi-weekly basis, a provider must perform less than 800 surgeries and total CRNA hours work must be less than 2,080.
- Providers are required by law to make a formal request to Novitas and the request MUST be RECEIVED prior to 1/1/2015. Reviews will occur, additional info requested if needed, determination letter sent for Exception effective 1/1/14. Requests received after 1/1/2015 will be denied.
- Information and questions can be directed to Catherine Rushing, Novitas Solutions, 532 Riverside Avenue, Jacksonville FL 32202. Information required includes all current CRNA/AA contracts, CRNA licenses, and surgery logs from 1/1 through 9/30/14 which supports the volume.
Audit Issues

- **HITECH**
  - Matching your EHR payment period to the correct cost report period
    - The Medicare Cost Report is used to determine the final payment amount for the EHR Incentive so it is important to use the correct cost report period
    - Must be a 12-month cost report period (between 360 and 371 days)
  - The cost report period is determined using the hospital’s meaningful use effective date and the federal fiscal year.
    - As specified by the HITECH UDR Program, we select the correct cost report period by determining “which cost reporting period for the Hospital begins during the Federal Fiscal Year that the Hospital’s Meaningful Use Effective Date falls in.”
    - Example provided on the next slide

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Audit Issues HITECH:
FISS Data for 6/30 Provider

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MAP08903  NOVITAS SOLUTIONS
FS79078  FINANCIAL MASTER - EHR INCENTIVE PAYMENTS

PROVIDER:   NPI:   PMT YR: 1 TRNS NUM:
INITIAL PAYMENT:
INP PART A:  29966  INP PART C:  7394  TOT INP:  63352
CHAR CHRG:  5050276  TOT DISCHRG:  13904  TOT CHRG:  62966538
MED SUB D %: .5945  CAH %:  TRANS %:  1.00
DISCHRG AMT:  2551000  BASE AMT:  2000000  CAH COST:

PMT CATEGORY:  APPEAL CASE NUM:  AUDIT CASE NUM:
COST RPT B DT:  07/01/10  COST RPT E DT:  06/30/11

ACTUAL PMT/RECOUP AMT:  2705569  PRE-RED PMT/RECOUP AMT:
RED PMT %:  RED AMT:  
MU STATUS:  MU XDTP :  10/01/12  MU TERM DT:  
RECORD STATUS:  TRAN INP:  12/21/12  TRANS DATE:  
```
Example: Choosing the Correct Cost Report Period for HITECH

**Example: FYE 06/30 Provider**

A Provider with a Meaningful Use Effective Date of 10/01/2011 occurs in Federal Fiscal Year (FFY): 2012

**Which Cost Report Period Begins During FFY 2012?**

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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<td>2012</td>
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</tr>
</tbody>
</table>

- The FY 2010 SSI Ratios shall be used for all cost reporting periods beginning on or after October 1, 2009.
- The FY 2011 SSI Ratios shall be used for all cost reporting periods beginning on or after October 1, 2010.
- The FY 2011 SSI Ratio shall also be used for interim payment purposes.
- Cost reports that use the FY 2010 or FY 2011 SSI Ratios will be NPR’d between now and November, 2014.
- 2012 SSI Ratios issued in June 2014.

Audit Issues

- 2010 and 2011 Cost Reports (SSI Ratios)
  - CMS has published the FY 2010 and FY 2011 SSI Ratios
  - The FY 2010 SSI Ratios shall be used for all cost reporting periods beginning on or after October 1, 2009
  - The FY 2011 SSI Ratios shall be used for all cost reporting periods beginning on or after October 1, 2010.
  - The FY 2011 SSI Ratio shall also be used for interim payment purposes.
  - Cost reports that use the FY 2010 or FY 2011 SSI Ratios will be NPR’d between now and November, 2014.
  - 2012 SSI Ratios issued in June 2014.
Audit Issues

- PS&R Negative Charges
  - Hospital O/P claims paid after 4/1/10 with a 51 MUE denial code
  - We have a complete list of all affected providers (many have a small dollar impact)
  - There are less than 20 total providers with significant impact
  - CMS has instructed MACs to re-price claims by 1/15/14
  - Cost reports with re-priced claims were to be finalized by 4/17/14 (assuming there is no other hold on the report). There are still claims issues that are holding up the process to finalize the cost reports impacted.
  - If you are impacted, you would see negative or reduced charges on PS&R in “other” column.

Audit Issues

- Other issues
  - Sub-contractors are in place through the end of February 2015
    - Currently utilizing Figliozzi & Company as well as Heftler, Radetich & Saitta to complete Desk Reviews and some Audits.
  - Subsequent payments are NOW included in your NPR letter and final settlement
    - Reflects all payments included with the filed cost report
    - Tentative settlement amounts now included
    - Eliminates confusion, much cleaner
Audit Issues

- Wage Index notices or activity planned
  - For FY 2016, CMS has changed the Wage Index Development Timetable.
  - The process now starts in early to mid July with the preliminary CY 2013 Occupational Mix Survey Data, based on the FY 2013 occupational mix surveys submitted by the hospital to MACs by July 1, 2014.
  - Process now starts in September, with the posting of the September PUF (previously posted in October and known as the October PUF)
  - Certain subsequent dates in the FY 2016 Wage Index Development process are also earlier than in previous years.
  - Please pay careful attention to the new due dates and deadlines. See the revised 2016 Wage Index Timetable at:
    http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2016-Tentative-Hospital-Wage-Index-Development-Time-Table.pdf

Audit Issues: Wage Index Key Dates

<table>
<thead>
<tr>
<th>2015 Date</th>
<th>2016 Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 21, 2013</td>
<td>October 6, 2014</td>
<td>Deadline for Hospitals to request revisions to CMS Data and Wage Index. Deadline for only hospitals with FY 2012 cost reporting periods that begin on or after August 15, 2012 or have defined benefit pension plans.</td>
</tr>
<tr>
<td>Dec 10, 2014</td>
<td>December 8, 2014</td>
<td>Deadline for MACs to notify State Hospital Associations re: hospitals that failed to respond to audit issues</td>
</tr>
<tr>
<td>Jan 29, 2014</td>
<td>December 16, 2014</td>
<td>Deadline for MACs to complete all desk reviews of Wage Index</td>
</tr>
<tr>
<td>Feb 20, 2014</td>
<td>February 15, 2015</td>
<td>CMS releases revised Wage Index and occupational data on PUF on website</td>
</tr>
<tr>
<td>Mar 3, 2014</td>
<td>March 2, 2015</td>
<td>Deadlines for Hospitals to dispute PUF data or MAC errors</td>
</tr>
<tr>
<td>April 8, 2014</td>
<td>April 8, 2015</td>
<td>Deadline for MACs to transmit final wage index data</td>
</tr>
</tbody>
</table>
Audit Issues: Wage Index Key Dates

<table>
<thead>
<tr>
<th>2015 Date</th>
<th>2016 Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16, 2014</td>
<td>April 15, 2015</td>
<td>Deadline for Hospitals to appeal MAC determinations or seek CMS intervention</td>
</tr>
<tr>
<td>May 2, 2014</td>
<td>May 1, 2015</td>
<td>CMS releases the final FY 2016 Wage Index on CMS website</td>
</tr>
<tr>
<td>June 2, 2013</td>
<td>June 1, 2015</td>
<td>Deadline for hospitals to submit correction requests to both CMS and MACs: any errors of the final wage index or occupational mix data</td>
</tr>
<tr>
<td>August 1, 2014</td>
<td>August 1, 2015</td>
<td>CMS' estimated date for publishing the final rule with all corrections</td>
</tr>
<tr>
<td>October 1, 2014</td>
<td>October 1, 2015</td>
<td>Effective date of the FY 2016 wage index</td>
</tr>
</tbody>
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FFY 2015 IPPS

- Two-Midnight IPPS Reduction
  - Effective 10/1/2014
  - Stays less than two midnight are considered to be for an OP stay, with those greater than two being considered as IP stay.
  - Permanent adjustment will be (0.2%) taken against the Standardized Amount.

- Uncompensated Care Data to be used for DSH
  - CMS will be using Worksheet S-10 data, but there are many noted errors being made in the as-filed data.
    - Many Hospitals have not completed the worksheet.
    - Many Hospitals are claimed Medicare Bad Debts but did not include any bad debt data on the worksheet.
    - More Gross Charges reported on S-10 than that reported on Worksheet C.
    - Uninsured vs. Charity
      - Charity must be determined during the cost-reporting period.
      - Bad Debt write-off timing issues.
FFY 2015 IPPS

• FFY 2015 Operating Outliers
  - The proposed Threshold will increase from $21,748 to $24,758
  - The increase is due to the larger than expected increase in outlier payments as a percentage of DRG payments rose from 4.86% in FFY 2013 to 5.71% in FFY 2014. CMS had targeted a rate of 5.1% in FFY 2014.

• FFY 2015 Standard Rate Updates
  ✓ Acute Hospital update: 1.4% net increase
  ✓ Excluded Hospital update: 2.9%
  ✓ LTCH update: 2.2%
    - LTCH One-Time Prospective Adjustment of .98374 (Year 3)

Payment Update

• IPPS Hospital Payment Adjustments
  - Market Basket: Starting point: 2.9%
  - Update to IPPS standardized rate (due to adjustments) 1.4%

• Performance-Based Adjustments
  - Failure to submit quality data - .75%
  - Failure for HER meaningful use: -.75%
  - Readmission reduction program -3.0%
  - Hospital Acquired condition reduction -1.0%
  - Value-Based Purchasing Hospital Specific Adjustment
    ✓ Hospital could have negative update factor, depending on performance
FFY 2015 IPPS

Payment Update

- Failure to submit quality data - .75%
  - Previously, hospitals that do not participate successfully in the Hospital IQR Program have their applicable percentage increase reduced by two percentage points. Since the implementation of this financial penalty, hospital participation has increased to well over 99 percent of Medicare-participating hospitals that are paid under the IPPS.
  - Starting for the FY 2015 payment determination, however, that reduction will be approximately one quarter of a hospital’s annual payment increase that would otherwise apply
  - Majority of hospitals do participate in the Quality Reporting Program
  - 63 Measures Reported
    - 47 Required; 16 Voluntary

FFY 2015 IPPS

Payment Update

- Failure for EHR Meaningful Use - .75%
  - CMS is preparing a comprehensive list of several hundred providers who have failed meaningful use
  - CMS will notify Novitas and we will send a letter to the provider informing them of the failure and reduction of .75% to their rate of increase
  - CAH’s who fail the MU standard will have see their payments reduced from the current 101% to 100.66%
    - Not material, but we are required to enter this into FISS
FFY 2015 IPPS

Payment Update

- Readmissions Reduction Program - 3.0%
  - Third year of the program (ACA, Section 3025)
  - CMS will assess hospitals’ readmission penalties using five readmissions measures endorsed by the National Qualify Forum (NQF):
    - heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and hip/knee arthroplasty.
    - CMS has finalized an updated methodology to take into account planned readmissions for these five existing readmissions measures, as well as refinement in the hip/knee arthroplasty readmission measure methodology.
    - CMS will add a new readmission measure beginning in FY 2017: readmissions for coronary artery bypass graft (CABG) surgical procedures
  - Adjustments are made on a per claim basis; does not include IME, DSH, outlier, or low-volume adj. The cost report was modified to handle this.

- Preventable Hospital-Acquired Conditions - 1.0%
  - FY 2015 - Lowest performing quartile will have their inpatient payments reduced by 1%
  - CMS estimates that 753 hospitals will be affected
  - Overall payments would decrease $330 million, or an estimated $438,000 per affected hospital
FFY 2015 IPPS

Payment Update

- Value-Based Incentive Payments
  - Third year of the program – funded through payment reduction to operating DRG payments FY 2015 - .5% (approximately $1.4 billion)
  - Redistributed to IPPS hospitals based on performance compared to peers
  - 80% of the measures assess health outcomes, patient experience and cost
  - Final rule updates the FY 2017 measure set by adding two new Safety measures and one new Clinical Care and removing six “topped-out” clinical process measures
    - Hospital-onset methicillin-resistant Staphylococcus aureus (MRSA) bacteremia and Clostridium difficile infection
    - Clinical Care - Process measure: early elective deliveries
    - Adjustment factors for each hospital released 10/2014 – CMS website

RCE Limitations

FY 2015 CMS Updated the RCEs

- Based on American Hosp. Assoc. of Periodic Survey of Physicians data
- Effective for cost reporting periods beginning on or after January 1, 2015
- Applies to salaried physicians for providers that are payable on a reasonable cost basis under Medicare – Part A component
  - Does not apply to Critical Access Hospitals
  - Minimal impact to a IPPS facility unless they have a cost-based component
RCE Limitations

FY 2015 CMS Updated the RCEs

<table>
<thead>
<tr>
<th>Total</th>
<th>$211,500</th>
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<tbody>
<tr>
<td>General/Family Practice</td>
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<tr>
<td>Internal Medicine</td>
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<td>Anesthesiology</td>
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<tr>
<td>Pathology</td>
<td>$260,300</td>
</tr>
</tbody>
</table>

Questions and Contact Information

QUESTIONS??????

For any additional Questions - Please Contact:

Sr. Director – Audit and Reimbursement
steve.holubowicz@novitas-solutions.com

Director of Audit -
timothy.lejeune@novitas-solutions.com

Manager of Reimbursement and Settlement -
bruce.synder@novitas-solutions.com