

HFMA - Government Programs Breakout #2

Marty Lothes and Foster Evans

Provider Audit and
Reimbursement

August 26, 2010



Agenda

- FCSO Background
- WPS Transition to J1
- Disproportionate Share Hospital (DSH)
- Recovery Act of 2009 (HITECH)
- GME/IME proposed rule
- Change request 6821
- Bad Debts
- ESRD and FQHC/RHC
- New at FCSO

First Coast Service Options

- FCSO is a subcontractor to Palmetto GBA
 - Provider Audit and Reimbursement
 - Provider Enrollment

- Primary location is Jacksonville, FL
 - PARD J1 office locations include
 - Tampa, FL
 - Columbus, GA
 - Camarillo, CA

FCSO J1 PARD Organization

Marty Lothes
Director PARD J1

Jacqueline Burke
Senior Manager

Foster Evans
Senior Manager

Anne Westmoreland
Senior Manager

Kelvin Dell
Tampa

Ron Kaufmann
Tampa

Ellen Corwin
Camarillo

Marilyn George
Camarillo

Pam Peffer
Reimbursement

Lisa Travis
Reimbursement

Aryn Linnane
Jacksonville

Brenda Harley
Jacksonville

Donna Wright
Columbus

Star Ortiz
Reimbursement

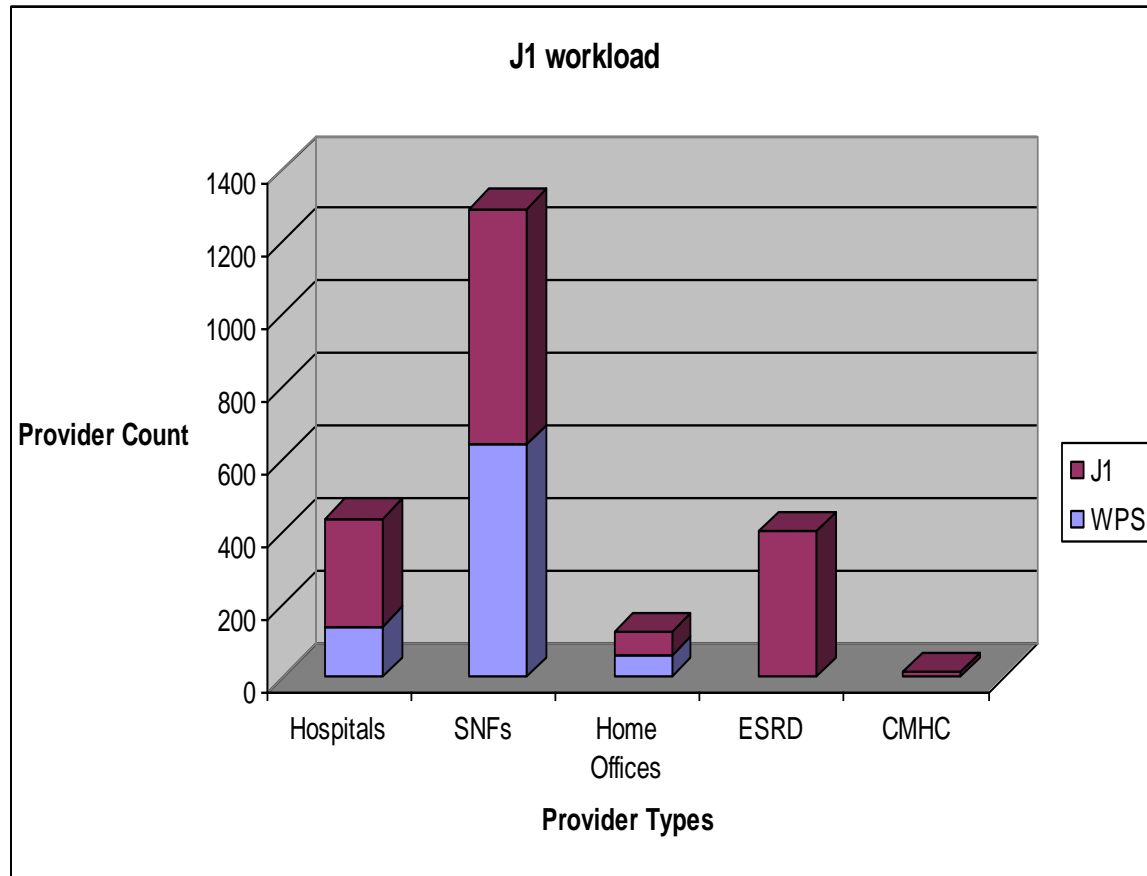
Tony Matos
CRC

WPS Transition

- J1 was the first to transition
- Approximately one-third increase in providers serviced
- Cut over was April 19, 2010
- Transition workload is current
- Contact letter sent to all providers
- Increase staff for new workload
- Files location

WPS Transition PARD Workload

| | WPS | J1 | Total J1 | WPS % |
|--------------|------------|-------------|-------------|------------|
| Hospitals | 140 | 298 | 438 | 32% |
| SNFs | 643 | 649 | 1292 | 50% |
| Home Offices | 60 | 65 | 125 | 48% |
| ESRD | | 400 | 400 | 0% |
| CMHC | | 12 | 12 | 0% |
| Total | 843 | 1424 | 2267 | 37% |



DSH

- JSM/TDL 09379
 - Hold on providers that use FY 2007 SSI%
- FY 2008 SSI% have not been issued
- JSM/TDL 09380 L&D days prior to FY 2004 in 9th Circuit Court of Appeals
- CMS Ruling 1498-R

FY 2011 Notice of Proposed Rulemaking

- Revised Supplemental Security Income (SSI) data Matching Process
 - Model Baystate SSI case
 - Change timing that SSI ratios will be Published (15 months compared to 6 months currently used)
 - FY 2011 SSI% published Spring 2013
 - Default SSI% will be federal fiscal year
 - Providers may request based on cost reporting period

Medicare Advantage

- CR 6821 Hospital attestation and billing for FY 2007 and 2008
- CR applies to non-teaching IPPS hospitals, IRFs and LTCHs
- Hospitals have until 8/31/10 to bill information only claims
- Attestations are due on or before 9/15/10
- Attestations sent to me in Camarillo

CMS Ruling “CMS-1498-R”

- Issued April 28, 2010
- Applies to 3 Medicare DSH issues:
 - Data Matching Process used to calculate SSI ratios
 - Non-covered Medicare Days prior to FY 2005
 - Labor and Delivery days prior to FY 2010
- Applies to appeals but implies it is applicable to all open cost reports

JSM/TDL 09380

- Inclusion of labor/Delivery Patient Days for C/R prior to FY 2004 for providers in 9th Circuit Court of Appeals
- For appeals and Open cost reports
- Question into CMS on whether 1498-R 09380
- We continue to process Appeals for this issue

Recovery Act of 2009

- American Recovery & Reinvestment Act of 2009 (ARRA or Recovery Act)
- Health Information Technology for Economic and Clinical Health Act (HITECH Act)
- Requires CMS provide incentive payments under Medicare and Medicaid to “Meaningful Users” of Electronic Health Records

Recovery Act

- Final Rule has not been issued
- Need to be a “Meaningful User” to receive incentive payment
- First year for payment FY2011
- Payments may be received for multiple years
- If not a “Meaningful User” will eventually be penalized

Recovery Act

- Incentive payment available to subsection (d) hospitals and CAH
- Subsection (d) hospitals
 - Acute Care hospital in 50 States
 - Does not include Puerto Rico and territories
 - Does not include – Psych, Rehab, Cancer, and Children’s hospitals, or any other hospital not paid under IPPS

Recovery Act

- New contractor will determine who is a “meaningful user”
- New payment contractor will make initial and final payments
- MAC/FI will update FISS screens used to calculate initial payment
- MAC/FI will calculate final payment on cost report
 - Some level of review will be required

GME/IME

- FY 2011 Proposed Rule
 - Defining how to determine whether a Resident or Physician
 - Electronic Affiliation Agreements
 - Counting resident time in nonhospital sites
 - Counting resident time for didactic and research activities
 - Cap reductions/increases

Cap Reduction as Proposed

- Review highest FTE count in the last 3 cost report ending before 3/23/2010
- 65% of unused FTE slots
- GME and IME determined separately
- Exceptions –
 - rural with <250 beds
 - Part of voluntary reduction approved under section 1886(h)(6)(B)
 - Hospital under section 1886(h)(4)(H)(v)

Cap Increases as proposed

- 70% to hospital in states with resident to population ratio in the lowest quartile and 30% to top 10 states and rural hospitals
- Effective 7/1/2011
- For a 5 year period the primary care residents is not less than the average of the 3 most recent cost reports ending prior to 3/23/2010
- 75% of positions are in primary care or general surgery

CR 6821

- Medicare Advantage claims for FY 2007 and 2008 information only claims filed by August 31, 2010
- Applicable to non-teaching IPPS hospitals, IRFs and LTCHs
- Attestations filed with contractor by 9/15/2010
- If not filed risk receiving a SSI% of zero

Bad Debts

- California has implemented a 10% payment reduction that has not been approved in the State Plan
- Reduction was effective 7/1/2008
- Applies to inpatient services for non-contracting providers all types of service
- Technical direction from CMS confirms reduction is not an allowable for Medicare

ESRD PPS and FQHC/RHC

- ESRD are moving to a bundled PPS effective 1/1/2011
 - Combines payments for composite rate and separately billable services into a single base rate.
- FQHC/RHC filed with current contractor in jurisdiction
 - Potential cost report filing problems

New at FCSO

- Implementing a paperless NPR process
 - Overpayment required to be sent certified mail
- Electronic workpapers
 - Requesting documents be submitted electronically
 - Appeals (J1CostReportAppeals@fcso.com)
- Implementing HFS GME/IME program

New at FCSO

- DSH CWF Review
 - No need for providers to review the CWF, the state eligibility match will be used
 - Providers will only need to review patients turning 65 during the cost report year because the state match doesn't catch all of these
 - Other eligibility qualifiers (i.e., ESRD, disabled) should not be claimed if known but because of infrequency, there is no need for providers

HFMA Meeting

Question #1:

What kind of direction has CMS provided for implementing the Baystate ruling and recalculating impacted SSI ratios?

HFMA Meeting

Response to Q #1:

- No instructions received yet
- DSH Settlements remain on hold for 07 and later for SSI
- Various Communications – (details to follow)
 - JSM 09380
 - CMS Ruling CMS-1498-R
 - CR 6821, transmittal 696

HFMA Meeting

JSM 09380:

- August 14, 2009
- Labor/Delivery days prior to FY 2004 (Prior to 10/1/2003)
- 9th Circuit only (Alaska, Arizona, California, Hawaii, Idaho, Oregon, Montana, Nevada, Washington, Guam, Mariana Islands)
- Medicaid Fraction (no SSI discussion)
- Applies to –
 - Open Cost reports
 - Jurisdictionally proper appeal on LDRP or Labor/Delivery room patients

HFMA Meeting

CMS Ruling – CMS-1498-R:

- April 28, 2010
- Five areas listed in ruling
 1. Appeals of the Data Matching Process Used in Calculating the SSI Fraction
 2. Appeals of the Exclusion from the DPP of Non-Covered Inpatient Hospital Days for Patients Entitled to Medicare Part A, and Days for Which the Patient's Part A Inpatient Hospital Benefits were Exhausted
 3. Appeals of the Exclusion from the DPP of Labor/Delivery Room Inpatient Days
 4. Implementation by the Administrative Appeals Tribunals
 5. Implementation by CMS and the Medicare Contractors
- Actual instructions (JSM or CR) on how to implement ruling have not yet been received.
- Questions are in to CMS on a variety of issues to address when instructions are issued

HFMA Meeting

CR 6821, Transmittal 696:

- May 05, 2010
- Non-teaching IPPS hospitals, IRFs, and LTCH's to submit no-pay bills or attestation
- FY 2007 and FY 2008
- All claims by 08/31/2010 and attestations by 09/15/2010
- CMS may instruct the contractor to use an SSI ratio of 0 percent to calculate Medicare DSH payments or to take other action that may affect payments for the non-compliant providers
- Letter included instructions to send attestations to Martin Lothes in Camarillo, CA
- CMS expects to post revised FY 2007 SSI ratios and FY 2008 SSI ratios by the first quarter of 2011
- Instructions for settlement of cost reports will be issued separately to the Medicare contractors

HFMA Meeting

Question #2:

What kind of sampling tool is FCSO currently using, and can we expect to see larger samples than we have seen in the past few years?

HFMA Meeting

Response to Q #2:

- FCSO is currently using a statistical sampling method that is based on sampling techniques designed and approved by the AICPA. You may see different sample sizes than you saw with the previous contractor because the size of the sample is determined based on several statistical factors including population size, risk, and provider history. However; many times we will pull what we refer to as a “pilot sample” to determine if statistical sampling is necessary. This pilot sample is not statistically valid, but will often allow us to avoid having to pull a larger statistical sample, if results of review yield minimal errors.

HFMA Meeting

Question #3:

We have had consistent problems with FCSO being unable to locate previously submitted documentation and audit files since the contract transition. Can you please explain what is being done to resolve this problem?

HFMA Meeting

Response to Q #3:

- NGS issue (files not inventoried accurately)
- Recently hired dedicated records clerks
- Realistically, issue will continue to some extent

HFMA Meeting

- Question # 4 –
- Where will the audit work be performed for the WPS providers that transitioned to FCISO? Will this work be done out of California or out of Florida?

HFMA Meeting

- Response to Q #4 –
- Staff increased for the Transition workload.
- We opened a new office in Columbus, GA so that we could pick up experienced Medicare auditors.
- We added new staff to our other 3 offices.
- The work was split between all 4 offices.

HFMA Meeting

- Question # 5 –
- There has been a negative perception for many years in California regarding reimbursement for Medicare regular bad debts, even when providers are complying with the recall from Collection agency instructions from CMS. Can you speak to this perception and discuss FCSO's position on allowing regular Medicare bad debts?

HFMA Meeting

- Response to Q# 5 -
- Medicare regular bad debts are allowable if they meet CMS requirements. CMS is currently working on revising PRM 15-1 chapter 3 (bad debts). CMS has instructed contractors that passive collection efforts makes the account unallowable until all efforts cease. FCSO follows CMS direction on the allowability of bad debts.

HFMA Meeting

- Question # 6 –
- We have noted inconsistencies in our interim rate reviews with respect to receiving lump sum payments during the year. What is FCSO's current policy on issuing mid-year lump sum adjustments for interim rate reviews?

HFMA Meeting

- Response to Q #6 –
- FCSO issues lump sum adjustments if the interim rate warrants it. Providers are notified of the rate and receive the workpapers (unless there is no change to the rate which is rare). If a provider feels that they are entitled to a lump sum adjustment and didn't receive one and cannot identify the reason in the workpapers submitted please contact the appropriate Reimbursement Manager to discuss.

HFMA Meeting

Question # 7 -

Do you anticipate the MACs having a role in the implementation of the HITECH Act payment program for Electronic Health Records? Will the MACs be responsible for processing and monitoring payments for this program over the coming transition years?

HFMA Meeting

Response to Q #7 -

- Not yet sure of what role the MACs will play or how this will role out
- Amounts will be reported on cost reports
 - W/S S-10, A-7, and E- series
- CAHs will require cost adjustments
- Funding and workload not yet identified or issued

HFMA Meeting

Question # 8 -

Has CMS provided implementation instructions for the MAC regarding the upcoming resident redistribution program required by the Affordable Care Act (ACA)?

HFMA Meeting

Response to Q # 8 -

- No Instructions have been received from CMS
- ARC Highlights – We currently understand the issues included are:
 - Unused Medicare-funded residency training slots
 - Reallocates Medicare resources to primary care residencies in underserved areas of the country
 - Hospital must ensure that the number of primary care residents is not reduced
 - At least 75 percent of the slots received must be in primary care or general surgery for at least five years

HFMA Meeting

Question # 9 -

What is the status of FCSSO's ability to process IRIS files?

HFMA Meeting

Response Q # 9 -

- All FI/MACs must process through CMS' IRIS Edit Program
- If the question “process IRIS files” was more about the ability to get detailed edits, reports, summaries as utilized by prior contractor (NGS) and their vendor (KPMG):
 - FCSO does not utilize KPMG
 - Current vendor's (HFS) IRIS processing program had errors and was not designed for MAC/FI issues like multiple providers, edits, data integrity, multiuser, historic data, and other issues
 - Currently in beta test with vendor (HFS) on a entirely new GME/IME program for FI/MACs and providers

HFMA Meeting

- Question # 10 –
- What is the audit scope for the field audit?
What is the threshold?

HFMA Meeting

- Response to Q # 10 –
- The scope and thresholds used by a contractor are confidential.

HFMA Meeting

- Question # 11 –
- How many audits per year for every hospital will be scheduled to NPR since NGS was so far behind in finalizing cost reports?

HFMA Meeting

- Response to Q #11 –
- We are completing a number of multiple 2 year audits and one provider as high as 4 years.
- We will continue to work with the providers to reduce the backlog of audits.

HFMA Meeting

Question # 12 -

For Medicare Managed Care in the SSI, since CMS will now include the days in the SSI ratio will they also be including the Managed Care DRG Payments in the DSH calculation?

HFMA Meeting

Response to Q # 12 -

- CMS Ruling 1498-R not explicit regarding the managed care days
- Providers instructed to bill managed care in CR 6821
 - Early implications are that Managed Care may not be in the revised SSI%
 - Questions to CMS on 1498-R
- Calculation of DSH payments are not addressed in 1498-R or CR 6821
- Inclusion of Managed Care days would be based on days for which a patient is Part A eligible, no reference to payment

HFMA Meeting

Question # 13 -

A notice was issued to include a 2% adjustment to Crossover Bad Debts when filing the cost report. What information will audit need for a Provider to show the 2% standard adjustment is not applicable?

HFMA Meeting

Response to Q # 13 -

- Proof that no Share of Cost applies to the bad debt accounts being claimed for which the state made no payment (codes 401 and 442)
 - Describe system used to eliminate the amounts related to SOC
 - Audit will test based on the system
- Must be based on entire population

HFMA Meeting

Question # 14 -

Is there an update on the CMS review of FY 2007 SSI factors? When do they anticipate the final SSI ratio to be published?

HFMA Meeting

Response to Q # 14 -

- No definitive completion date at this time
- Originally, was to be last quarter of 2010, latest indication is spring, 2011

HFMA Meeting

- Question # 15 –
- Can we get an organization chart that includes contact information? It is difficult to know who to call.

HFMA Meeting

- Response to Q # 15 –
- See contact listing handout

HFMA Meeting

Question # 16 -

What kind of education has there been for FL auditors on CA issues? They don't seem to know that we can't even submit data to the State until 13 months after our FYE. I've had the requested made for a DSH package at least 4 times so I have to explain to the auditor every time about the timing issue. I would think they would educate the other auditors on this issue and the Managers should already know.

HFMA Meeting

Response to Q # 16 -

- FL auditors have received extensive training on CA issues and auditors are very much aware that providers cannot submit data to the State until 13 months after their FYE. (cont.)

HFMA Meeting

Response to Q # 16 (cont.):

- CMS require that FCSO review DSH data when certain thresholds are exceeded and areas of concerns are not properly resolved. CMS has instructed that in the absence of final data from the State that we should review the data provider used to prepare the cost report. Therefore, if final DSH data is not available the documentation used to prepare the cost report is to be used.

HFMA Meeting

Question Q # 17 -

FL auditors have disallowed crossover bad debts because \$0 payment was posted after the FYE even though the Medi-Cal RA was dated before the FYE. Historically, CA hospitals have used the RA date for the log. Why is FCSO changing this?

HFMA Meeting

Response to Q # 17:

- FCSO has not changed it's policy in reviewing crossover bad debts. Bad debts are allowed in the cost reporting period in which accounts are deemed to be uncollectible. If the accounts have not been determined to be uncollectible at cost report year end then account will not be allowed as a Medicare bad debt.

HFMA Meeting

- Question # 18 –
- Provide an explanation of how the new pension cost calculation worksheets work, how to properly complete them on an ongoing basis, and specifically what amount is to be included as pension expense on the cost report.

HFMA Meeting

- Response to Q # 18 –
- The worksheet was developed by CMS to help providers and contractors calculate allowable pension expense for a defined benefit plan.
- Not applicable to Defined contribution plan
- Suggest any questions be directed to your Audit Manager