Indiana Chapter of HFMA
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MEDICARE COST REPORT APPEALS, OTHER APPEALS & PROTECTING YOUR MONEY

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• 40 years of healthcare experience
  ▪ Former Chief Hearing Officer Blue Cross Association
  ▪ Handled hundreds of Medicare cost report appeals
  ▪ Successfully addressed reimbursement opportunities and strategies

• Krieg DeVault LLP
  ▪ Partner in the Health Care Practice Group
  ▪ Membership in HFMA and AHLA, Senior Member HFMA

• Presentations
  ▪ AHLA
  ▪ HFMA
Objectives

• Understand Medicare cost report appeal issues and other appeals

• Develop Medicare opportunities because margins are so vital
Why Do We Care?

• Cost reports are a HUGE part of the reporting

• Hospital CFOs, and Financial Executives should be very interested in this information

• Planning and strategy
Navigating the Medicare Maze...
BRIEF Medicare Legislative History

• 1965: Medicare and Medicaid established
BRIEF Medicare Legislative History

• 2010: The Patient Protection and Affordable Care Act (PPACA)
  ▪ **Primary Purpose:** To decrease the number of uninsured Americans and to reduce the overall costs of health care
  ▪ **MANY Changes:**
    • Changes to Disproportionate Share Hospital Programs (DSH)
    • Hospital Readmissions Reduction Program (§ 3025)
    • Payment Adjustment for Hospital-Acquired Conditions (§3008)
    • Hospital Value-Based Purchasing Program (§ 3001)
    • Among others: Insurance Exchanges; Employer Mandate; Compliance Plans; Overpayments, ETC
What is a Medicare COST REPORT?

• Uniform source of data used by CMS to develop and justify rates paid to providers for covered services

• Annual report required by all Medicare participating providers

• Records:
  ▪ Total costs and charges associated with providing services to all patients
  ▪ Portion of those costs and charges allocated to Medicare patients
  ▪ Medicare payments received
Inpatient Prospective Payment System (IPPS)

- DRG
  - Adjusted:
    - Area wage index
    - Indirect Medical Education
    - Disproportionate Shares
  - Medicare-Severity-DRG established in 2008
    - Highly dependent on physician documentation
- Inpatient Pass-Through Payments (additional payments)
  - Outliers
  - Direct Graduate Medical Examination
  - Organ Acquisition
  - Bad Debts
Graduate Medical Education

- Direct Graduate Medical Education (GME)
  - To compensate for residency education costs
  - Based on a per resident cost amount and Medicare’s patient load
- Indirect Medical Education (IME)
  - % Add-on to Medicare DRG payments
  - Intended to compensate for the higher patient costs due to the presence of teaching programs
Recent Issues with Medicare Reimbursement

- Sequestration
- Health Information Technology/Electronic Health Records Incentive Payments and Penalties
  - 2% Sequestration Reduction
  - For reporting periods on/after April 1, 2013
- Readmissions Reduction Program
  - §3025 of Affordable Care Act
    - Requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.
Recent Issues with Medicare Reimbursement

Hospitals face Medicare payment penalties for high readmission rates

You again?!

I don’t feel well.
Recent Issues with Medicare Reimbursement

- Value-Based Purchasing
  - (versus Volume-Based Purchasing)
- Hospital-Acquired Conditions
- Failure to report outcomes
- Medicare Bad Debts
Recent Issues with Medicare Reimbursement

- Medicare DSH
- Graduate Medical Education (Resident Caps)
- Documentation and Coding offset
- Medicare Administrative Contractors (MAC) and Recovery Audit (RA) Contractors
DSH Additional Payment

- DSH Payments reduced by 75% beginning in 2014
- Portion of the Reduction is returned as an Additional Payment for Continued Uncompensated Care Costs
- Additional Payment is determined by Three Factors
  - Pool of funds created from aggregate reduction in payments to all hospitals
    - Potentially $7.9B
  - Inverse of % Change in Percent Uninsured from 2013
    - Based on Congressional Budget Office estimates
  - Each hospital’s % of Aggregate Amount of Uncompensated Care Costs
    - Estimated by HHS based on reported S-10 data
DSH Additional Payment

• For an Average Hospital that receives DSH in 2014:
  - Uncompensated Pool: $7,900,000,000
  - % Change in Uninsured: 53%
  - Hospital % of Aggregate Uncompensated Care Costs: 0.02985%
  - = Uncompensated Care Payment of $1,249,820
Definition of a Medicare Bad Debt

- Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. “Accounts receivable” and “notes receivable” are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.
• The bad debt must be related to covered services and derived from deductible and coinsurance amounts
• Amounts related to non-covered services or physician professional services are non-allowable
• Reasonable collection effort: PRM 15-1 Section 310
• Use same collection policies for all payers – Uniform Collection Policy
• Bill must be issued shortly after discharge
• Must include collection letters and phone call collection attempts
• Collection efforts must be documented
• 42 CFR 413.89 (E) Charge off in accounting period debt determined to be worthless
• Collection Agency?
UNTIL FY 2013:

- Unpaid deductible and coinsurance amounts related to covered hospital services
- Reimbursed at 70% of the amount
  - 100% if critical access hospital
- Reasonable collection efforts consistent among all payers
- Collection effort must be documented in patient file
  - Can use collection agency and/or
  - Can use subsequent billings
- 120-day rule — beginning on the date of the first bill sent to the patient
  - “Presumed uncollectible” after 120 days
Medicare Bad Debts - 2013

- Medicare/Medicaid crossover patients
- Indigent patients
- Deceased patients
- Bankrupt patients
Medicare Bad Debts - 2013

- Bad Debt Reimbursement cut to 65% in FY 2013; down from 70%
  - For hospitals, CAHs, and SNFs
  - Critical Access Hospitals previously reimbursed at 100%
    - CAHs phased in over 3 years
Volume vs. Value-Based Reimbursement Systems

- Sections 3006 and 3007 of the ACA
  - §3006: SNFs and HHAs
  - §3007: Physician Fee Schedule

Previously:

**Volume-Based**

- Paid for everything you do, BUT:
  - 1. Proof that you did it;
  - 2. Right site of service;
  - 3. Medically necessary?;
  - 4. Adhere to Medicare service volume guidelines?
    - Per diem; fee schedule, etc.
Volume vs. Value-Based Reimbursement Systems

• **Value-Based**
  - You’re paid for everything you do well
    - Quality and efficiency components
  - BUT, look to:
    - 1. Industry standards and benchmarks
    - 2. Re-admissions or HACs (Hospital-acquired conditions)
      - Section 5001(c) of Deficit Reduction Act of 2005
      - § 3025 of ACA (Hospital Readmissions Reduction Program)
      - § 3008 of ACA (HACs)
  - Examples: Value-based purchasing, Bundled Payments, ACO Shared Savings, Capitation
The Modern PRRB Process

- History
- 12,000 case backlog
- CMS taken over the process
- Takes 1 year + to obtain decision after hearing
- CMS Administrator reverses significant PRRB cases
- Court in either local district or in Washington, D.C.
- HHS OGC gotten involved
PRRB APPEALS

• Recent jurisdictional decisions by (PRRB) and (CMS), providers are facing a more restrictive environment than in the past types of reimbursement issues that can be appealed and the timeframes for filing Medicare cost report appeals.
• There is an increased focus on the provider provision its “dissatisfaction” with its Medicare reimbursement.

There are shorter timeframes to add issues to appeals.

BACKGROUND

• Under the Supreme Court’s holding in *Bethesda Hospital Ass’n v. Bowen*, a Provider does not need to submit a "cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations" as a condition of claiming dissatisfaction with its reimbursement amount.
• The Court found that (HHS) may not rely on a rule that requires providers to present regulatory challenges to their intermediaries in order to obtain the PRRB’s jurisdiction for review. [485 US 399, 404 (1988)]
• More recent policy changes have effectively restricted provider’s ability to preserve their appeal rights.
• Cost report preparation is a key piece of a PRRB appeal strategy.
• On May 23, 2008, the HHS adopted a final regulation (see 42 C.F.R. §405, Subpart R) requiring that a provider claim all costs to which it is entitled, or protest or “self-disallow” amounts that may not be in accordance with Medicare payment policy.
• Failure to do so may mean that the provider will not meet the jurisdictional prerequisite of dissatisfaction.
• This exhaustion rule was effective for Medicare cost reports ending on or after 12/31/2008 (73 FR 30195-96).
• PRRB new rules issued 8/21/2008 and in subsequent rule revisions and updates on 07/01/2009 and 03/01/2013. (These are available in full on CMS website.)
• The PRRB jurisdictional decisions are also posted monthly on CMS’Website.
District Hospital Partners v. Sebelius (D.C. District Court) March 26, 2013

1987 Bad Debt Moratorium (Issue of Collectability)

Court ruled that the moratorium prohibits the HHS Secretary from:

- Changing the HHS Secretary’s own bad debt policies in place in 1987, and
- Changing a provider’s established bad debt policy

Court granted summary judgment in favor of hospitals and reversed a CMS Administrator determination that Medicare beneficiaries’ bad debts have always been presumed collectible if sent to a collection agency, and therefore not reimbursable under 42 CFR 413.89.

Note: CMS elected not to appeal the decision to D.C. District Court

Lakeland Regional Health System v. Sebelius (D.C. District Court) July 16, 2013

1987 Bad Debt Moratorium (Issue of Collectability)

Court agreed with the CMS Administrator that the policy of not allowing reimbursement for bad debts pending at a collection agency was consistent with the regulations. Specifically the court focused on the requirements that the debts be “actually uncollectible” and that “sound business judgment” demonstrates no likelihood of recovery. The court determined that if a collection agency pursued the debts, these criteria could not be met.

Note: Lakeland filed an appeal to D.C. Circuit Court on September 13, 2013
This decision vacate HHS’ 2004 rule changing Medicare’s formula for calculating DSH payments for hospitals treating Medicare Advantage patients. Court said it was procedurally flawed and stated in part, “The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation announced in 2004 and not added to CFR until Summer of 2007, was not a ‘logical outgrowth’ of the 2003 [notice of proposed rulemaking].”

Finding that the reasoning for the change was “brief and unconvincing,” the Court also held that the rulemaking was arbitrary and capricious. The case was remanded to the HHS Secretary “for further action consistent with this opinion.”

Note: HHS subsequently appealed this to the D.C. Circuit Court of Appeals on January 15, 2013. Oral arguments commended in February 2014, with a decision anticipated by mid-year.
COURT DECISIONS DSH/SSI APPEAL ISSUES

Metropolitan Hospital v. U.S. DHHS (6th Circuit C of A) March 27, 2013

Dual-Eligible Exhausted Benefits – Medicaid Fraction

In 2010 the District Court ruled in favor of the provider determining that CMS’ interpretation of 42 CFR 412.106 (b) was invalid as contrary to the plain meaning of the DSH statute, reasoning that “entitled” requires payment for hospital services, rather than mere eligibility. Thus, dual-eligible patients with exhausted benefits would be included in the numerator of the Medicaid fraction.

The 6th Circuit reversed the decision of the District Court reasoning that Congressional intent of “eligible” versus “entitled” was not clear and that CMS’ current interpretation was a permissible construction of the ambiguous DSH statute.

Catholic Health Initiatives Iowa Corp. v. Sebelius (D.C. Circuit C of A) June 11, 2013

Dual-Eligible Exhausted Benefits – Medicaid Fraction

The District Court reversed the CMS’ Administrator decision and ruled in favor of the provider by relying on the plain language of the statute because of patients with exhausted benefits do not receive payment for hospital services, they are not “entitled to benefits under Part A.” Also, the District Court determined that CMS’ 2004 interpretation to exclude such days was a substantive policy change and invalid as applied to the 1997 cost report at issue.

The D. C. Circuit determined that the Medicare statute’s inconsistent use of the phrase “entitled to benefits under Part A” was ambiguous, at best, requiring deference to CMS’ construction.

Note: Since the decisions of the D.C. Circuit Court are very influential on all of the other districts, this narrows the opportunity for providers seeking additional reimbursement by appealing this issue.
Norwalk Hospital v. BCBSA/NGS (HHS CMS Admin Dec.) May 21, 2012

Additional Medicaid Eligible Days – Medicaid Fraction for which there was no adjustment made

The CMS Administrator found that the Board did not have jurisdiction over the provider’s request for hearing and therefore vacated the Board’s earlier decision. Since the provider did not claim the days in question on its cost report, it did not preserve its right to appeal the issue. The days in question are new das for which the intermediary made no determination; therefore, the dissatisfaction requirement was not met.

Despite this issue ultimately being settled out of court in this case, CMS is instructing contractors to challenge jurisdiction on the issue by taking the position that eligible Title XIX days are not a valid self-disallowed item because there is no authority that prevents the provider from receiving reimbursement for these days.

Many contractors have been willing to reopen the cost report to allow providers to claim these days.
Case Law

1. PRRB

A. Bad Debts

a. Dual Eligible Beneficiaries

Maine Medical Center v. BCA  PRRB 2013-D3

The PRRB found neither the regulation nor the PRM required the Provider to bill Medicaid as a prerequisite to the bad debt.

b. Indigency Determination

Doctors Hospital v. BCA/NGS, 2012-D18, Reversed by CMS – September 11, 2012

The Board reversed the inventory adjustment and found the Provider’s claimed bad debt supported by adequate documentation. The Administration reversed finding that patient account histories did not constitute adequate documentation.
Case Law

PRRB
Allocation of Costs

- a. HCR Manor Care 1999 Laundry and Central Supply Groups v. BCA/Highmark Medical Services, PRRB DC 2012-D14 (July 19, 2012)
  - PRRB upheld Intermediary adjustment to SNF’S statistical bases for allocation of Linen Laundry and Central Supply. Provider failed to support allocation.

- b. Lemel Shattuck Hospital v. BCA/NGS, PRRB Hearing December 2012, Decision 2012-D’22
  PRRB found the intermediary allocation of the physician costs between A & B improper. As a teaching hospital, hospital allocation physician costs between parts A & B; Hospital paid on reasonable cost basis. No allocation agreement used; average allocation cost to other hospitals.
Case Law

• Courts

A. DSH
   1. Charity/General Assistance Day
      All found for Program QRS – 1996 Colorado DSH/General Assist v. BCA D 2012-D17

B. Hospice Payment 1135 waiver
   Medicare regulations imposed a limit for inpatient hospice day cannot exceed jurisdiction

C. Outlier Payments

D. Recovery Audit Contractors (RAC)
   Palomar Medical Center v. Sebelius (2012), For Government

E. Bad Debt
   The "Must" Bill Policy

F. DSH – Part C Days
   Columbia St. Marys Hospital v. Sebelius, (D.C.D.C.) For Provider, retroactive application of regulation
      a. Pre-Part C, Medicare
      b. HMO Days
      c. Exhausted Dual Eligible

   Catholic Health Initiatives /Mercy Medical Center v. Sebelius

G. Medical Education
   No allocation agreement. First Hospital program closed. Residents transferred to remaining hospital. Swedish American Hospital claimed all residents. Provider lost. Program wrong - ACGME
H. Wage Index Paid Hours
   - Provider argued certain hours not worked but paid shall be excluded from wage index. Valid argument, no documentation. Found for Intermediary
     \textit{Ft. Wayne FFY MSA Wage Index v. BCA} 2012 D-13

I. Loss on Sale
     No recognized, because not between unrelated parties

   \textit{Memorial Hospital v. Sebelius} (2012)
   No bona fide sale, no loss on sale

J. Tax Assessment
   \textit{Kindred Hospital East v. Sebelius} Court disallowed FSA

K. Rural and Sole Community Hospital: MS-DRG Adjustment
   \textit{Adirondack Medical Center v. Sebelius} (2012)
   Downward adjustment to IPPS as applied to community hospital/rural hospital, Court approved intermediary adjustment
PRRB—2012 Decisions


- **Grossmont Hospital Corp. v. Sebelius**, D.D.C. Nov. 9, 2012
- **Abraham Lincoln Memorial Hospital v. Sebelius**, 7th Cir. October 16, 2012
- **Columbia St. Mary’s Hospital Milwaukee, Inc. v. Sebelius**, D.D.C., September 28, 2012
- **Hospital of the University of Pennsylvania v. Sebelius**, D.D.C., March 20, 2012
- **Adirondack Medical Center v. Sebelius**, D.D.C., January 31, 2012
- **Catholic Health Initiatives – Iowa, Corp. d/b/a Mercy Medical Center – Des Moines v. Sebelius**, D.D.C., January 30, 2012
PRRB—2012 Year In Review
CMS Administrator Decisions

• Ober Kaler DSH Charity Care Groups v Blue Cross Blue Shield Association Highmark Medicare Services and Cahaba Government Benefit Administrators, (Review of PRRB Decision No. 2012-D17), August 15, 2012
• Canon Healthcare Hospice v. CMS (Review of PRRB Decision No. 2012-D15), June 6, 2012
• Norwalk Hospital v. BCBS/ National Government Services Inc., (Review of PRRB Decision No. 2012-D14), May 21, 2012
• Research Medical Center v. Wisconsin Physician Service (Review of PRRB Decision No. 2012-D12), May 14, 2012
• Alameda Hospital SNF v. BCBS/First Coast Service Options, Inc. (Review of PRRB Decision No. 2012-D10), April 10, 2012
• Rush University Medical Center v. BCBS/ National Government Services Inc. (Review of PRRB Decision No. 2012-D9), April 4, 2012
• Rush University Medical Center v. BCBS/ National Government Services Inc., (Review of PRRB Decision No. 2012-D8), April 4, 2012
• Lakeland Regional Medical Center v. Blue Cross Blue Shield Association/National Government Services(Review of PRRB Decision No. 2012-D3), February 16, 2012
PRRB—2012 Year In Review
PRRB Decisions

- Pennsylvania General Assistance Days Group v BlueCross BlueShield Association/Novitas Solutions, Inc., Decision No. 2013-D1, November 20, 2012
- San Joaquin Community Hospital v. BCBS/First Coast Service Options Inc., Dec. No. 2012-D21, August 8, 2012
- Doctors Hospital Columbus Ohio v. BCBS CGS Administrators, Dec. No. 2012-D18, July 18, 2012
- Doctors Medical Center of Modesto (Modesto, Calif) v. Wisconsin Physician Services, Dec. No. 2012-D11, February 24, 2012
SUMMARY

• There are numerous procedural requirements involved with preserving Medicare cost report appeal rights to avoid making errors in filing proper requests for hearing.

• Monitor the ultimate outcome of cases pending in federal court on issues impacting providers, as well as key PRRB and CMS Administrator decisions with jurisdictional implications.

• Continue to protest issues on their cost reports in accordance with the instructions in the Provider Reimbursement Manual, Part II, Section 115 (CMS Pub. 15-2), but be mindful not to let reopening opportunities lapse.

• Numerous regulatory changes stemming from implementation of the ACA and/or other legislation.

• May be prudent for hospitals to pay close attention to Federal Register issuances in order to take advantage of opportunities to appeal from the date of publication, which can be much more efficient and expedient than appealing from a cost report settlement with its associated pitfalls.

• Exhaustion Requirement/_______________________
The annual Work Plan provides valuable insight into anticipated OIG plans and initiatives. OIG released the 2014 Work Plan on January 31, 2014

- **Overview of the 2014 Work Plan**
  - Continued focus on fraud vulnerabilities identified through data analysis of billing practices and within the electronic health records system
  - Fight against fraud, waste and abuse as its top priority
  - Utilization of physical therapy services and hospital inpatient requirements continues to generate interest
  - OIG also plans to implement new programs to monitor billing for power mobility devices, pharmaceutical compounding, Medicare Part A billing practices in nursing homes, and a variety of pharmaceutical and medical supply practices
Hospitals
  • New inpatient admission criteria;
  • Medicare costs associated with defective medical devices;
  • Analysis of salaries included in hospital cost reports;
  • Comparison of provider-based and free-standing clinics; and
  • Outpatient evaluation and management services billed at the new-patient rate

Nursing Homes
  • Medicare Part A Billing

Hospices
  • Hospice and assisted living facilities
Medical Equipment and Supplies

- Power mobility devices—lump-sum purchase versus rental;
- Competitive bidding for diabetes testing supplies;
- Nebulizer machines and related DME compliance with payment requirements; and
- Diabetes testing supplies compliance with payment requirements for blood glucose test strips and lancets.
OIG RELEASES 2014 WORK PLAN

Other Providers and Suppliers
• Ambulance services portfolio report on Medicare Part B payments
• Ambulatory surgical center payment system
• End-stage renal disease facility payment system for rental dialysis services and drugs; and
• Portable X-ray equipment compliance with transportation and setup fee requirements

Prescription Drugs
• Manufacturer reporting of average sales prices for Part B drugs
• Part B payments for drugs purchased under the 340B Program
• Payment for compounded drugs under Part B
• Comparison of Medicare Part D and Medicaid pharmacy reimbursement and rebates; and
• Documentation of Part D drug event data
CMS Again Delays Implementation of “2 Midnights Rule”

- On January 31, 2014, CMS announced a further delay in the implementation of the regulations and review criteria contained in its recently implemented “2 Midnights Rule” (Rule)

- Medicare administrative contractors (MACs) are not to audit for compliance with the Rule until October 1

- The Rule’s previous effective date of September 2013 was first delayed until December 31, 2013--and further postponed to March 31, prior to this most-recent delay
CMS Again Delays Implementation of “2 Midnights Rule”

As part of IPPS rules for FY2014, the Rule provides that an admission would qualify for Part A reimbursement where the physician admits the patient with the expectation that the treatment will require a two-night inpatient stay—hence the reference as the “2 Midnights Rule”

• The Rule was enacted, accordance to CMS, to modify and clarify the agency’s “longstanding policy on how Medicare contractors review inpatient hospital … admissions for payment purposes” and to “respond[ ] to … hospital calls for more guidance about when a beneficiary is appropriately treated … as an inpatient,” rather than as an observation patient or other outpatient status

• Certain procedures, tests and services would only be viewed as “medically necessary” and payment made as part of a Part A inpatient stay if the requirements of the Rule were met

• Otherwise, the episode of care might be paid as an “observation” stay or other outpatient status.

• MACs will continue to perform “probe and educate” reviewed by selecting between ten to 25 claims per hospital with admission dates of March 31 through September 30.

• MACs will conduct outreach and education efforts based on their findings.

• CMS will also hold educational sessions with hospitals through September 30.

• Of importance to hospitals, MACs and RA will not conduct pre- or post-payment status reviews for compliance with the Rule for inpatient hospital claims with admission dates between October 1, 2013 and October 1, 2014.
CMS Releases the CY2014 Hospital OPPS/ASC Final Rule

On November 27, 2013 CMS released the OPPS and ASC Payment Systems Final Rule with comment period for calendar year (CY) 2014. Most provisions are effective on January 1, 2014.

- **Payment Rates.** OPPS payment rates for CY2014 will increase by an increase factor of 1.7%, which represents the final 2.5% market basket percentage increase, minus the multifactor productivity adjustment required by the ACA. Total payments under the OPPS are estimated to be approximately $50.4 billion (including beneficiary cost-sharing), an increase of approximately 9.5% over CY2013 payments.

- **Comprehensive APCs.** CMS will establish 29 “comprehensive Ambulatory Payment Classifications (APCs)” to replace the 29 existing device-dependent APCs for the most costly device-dependent services, but CMS is delaying implementation until CY2015.

- **Packaged Items and Services.** CMS finalized 5 new categories of ancillary or supportive “dependent” items and services for which payment will be packaged into payment for the primary diagnostic or therapeutic service:
  - Drugs, biologicals and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure;
  - Drugs and biologicals that function as supplies when used in a surgical procedure;
  - Certain clinical diagnostic laboratory tests;
  - Certain procedures described by add-on codes; and
  - Certain device removal procedures.
CMS Releases the CY2014 Hospital OPPS/ASC Final Rule

- **Single Payment Level for Hospital Outpatient Clinic Visits.** CMS has eliminated the existing five levels of visit codes for hospital outpatient clinic visits and replaced them with a new code representing a single level of payment for clinic visits for all patients.

- **Outlier Payments.** The fixed-dollar threshold for hospital outpatient outlier payments will be $2,990 over the APC payment rate.

- **Quality Reporting.** CMS removed two measures (OP-19 and OP-24) from the Hospital Outpatient Quality Reporting Program effective with the CY2015 payment determination. CMS adopted 4 new measures effective with the CY2016 payment determination:
  
  *Influenza Vaccination Coverage among Healthcare Personnel (OP-27);*
  
  - **Endoscopy/Polyp Surveillance:** Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (OP-29);
  
  - **Endoscopy/Polyp Surveillance:** Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use (OP-30); and
  
  - **Cataracts:** Improvement in Patient’s Visional Function within 90 Days Following Cataract Surgery (OP-31).
CMS Releases the CY2014 Hospital OPPS/ASC Final Rule

- **Value-Based Purchasing.** CMS finalized its proposal to create an additional, 90-day “independent review” process for hospitals that have exhausted the appeal process under 42 C.F.R. § 412.167(b) to challenge CMS’s determination of their Value-Based Purchasing scores.

- **Physician Supervision.** The non-enforcement period that exempts CAHs and small rural hospitals from having to furnish all hospital outpatient therapeutic services under direct supervision by a physician will be allowed to expire at the end of CY2013.

- **Outpatient Therapeutic Services.** CMS has made it an express condition of Medicare Part B payment that outpatient “incident to” services must be personally provided by an individual who is qualified to furnish such services under the scope of practice laws of the state.

- **Predicate Facts.** CMS adopted its proposal to cut off providers’ appeal and reopening rights with respect to “predicate facts” that were first established or first used to determine a provider’s reimbursement prior to the three-year reopening window.
Among the many changes contained in the PFS Final Rule are the following:

- **Payment Rates**: CMS finalized the conversion factor of $27.2006 for CY 2014. Decrease of 20.1% attributable to application of the SGR, but CMS expects Congress will intervene to repeal this reduction prior to the start of CY 2014.

- **Primary Care and Complex Chronic Care Management**: CMS finalized its proposal “to pay for non-face-to-face complex chronic care management services for Medicare beneficiaries who have multiple, significant chronic conditions (two or more) …” These additional payments to physicians for managing Medicare patients’ chronic care needs will begin CY 2015. Care management includes the development and implementation of a care plan, patient and caregiver communication, and medication management.

- **Telehealth Services**: CMS finalized its proposal “to modify its regulations describing eligible telehealth originating sites to include health professional shortage areas located in rural census tracts of urban areas as determined by the Office of Rural Health Policy.”

- **Application of Therapy Caps to Critical Access Hospitals**: Consistent with the ATRA (2013), CMS finalized its proposal to apply the “per beneficiary limits to outpatient therapy services” to outpatient therapy services furnished in CAHs.
CMS Issues Medicare Physician Fee Schedule Final Rule

- **Misvalued Codes**: CMS has identified and reviewed potentially misvalued codes and finalized values for around 200 codes including codes for services for hip and knee replacements, mental health services and gastrointestinal endoscopy services.

- **Physician Quality Reporting System (PQRS)**: Adding 58 new measures, CMS made several other changes to the PQRS including allowing participating physicians the option to report quality measures through qualified clinical data registries and aligning quality measures across all reporting programs.

- **Physician Value-Based Payment Modifier**: In 2016, CMS will apply a Value-Based payment modifier to groups of 10 or more eligible professionals based on the group’s performance under the PQRS. Physician groups with 100 or more eligible professionals will have both upward and downward modifiers applied as appropriate.

- **Policies Regarding the Clinical Laboratory Fee Schedule**: CMS defined technological changes as changes to the tools, machines, supplies, labor, instruments, skills, techniques and devices by which laboratory tests are produced and used.

- **Medicare Coverage of Investigational Devices and Clinical Trials**: CMS proposed significant modifications to its regulations governing Medicare coverage of investigational devices and the routine items and services furnished to the beneficiaries during the clinical studies or trials conducted under the Food and Drug Administration Investigational Device Exemption regulations.
Value-Based Purchasing Data Released

On November 14, 2013, CMS published hospital value-based purchasing incentive payment adjustment factors for fiscal year (FY) 2014

- During the FY, 1.25% of Medicare base-operating DRGS paid under the IPPS go into a value-based purchasing pool
- The nearly $1.1 billion is then passed on to hospitals based on their performance on certain health care quality and patient satisfaction measures
- 40% of each hospital's score is based on basic clinical standards of care; 30% on patient satisfaction; and 25% on mortality rates

Key results of the FY 2014 data

- More than 1,300 hospitals will “essentially break even” according to CMS (receive reimbursement increases no more than 0.2% or decreases no more than 0.2%)
- 1,451 hospitals will be paid less under this year’s program
- 1,231 hospitals will receive higher payments
- Gallup Indian Medical Center in New Mexico received the largest decrease—about 1.14% less for each patient; and
- Arkansas Heart Hospital in Little Rock received the largest increase—about 0.88% more for each patient
OTHER APPEALS

• A. Claims Appeals
  ▪ 5 Step Process
    • Redetermination
    • Reconsideration
    • ALJ Appeals
    • DAB Appeal
    • Courts
  ▪ CMS Announces it is suspending process appeals 55 ALJ’s, 370,000 appeals

• B. RAC and Other Appeals
Future Changes
Future Changes

• Federal Deficit Reduction
  ▪ Medicare money at issue:
    • Continued Documentation and coding offsets
    • Site-neutral payments
      ▪ Hospitals v. doctor’s office
    • Graduate Medical Education
    • Rural Hospital programs
      ▪ CAHs, sole community
    • Post-Acute provider programs
      ▪ home health, rehab, skilled nursing, long-term care
    • Bad Debt payments
    • Bundling
      ▪ Versus: bill for hospital; bill for doctor; bill for rehab, etc.
    • Physician “Fix”
      ▪ Delay cuts to reimbursement rates for physicians; temporary
Hot Topic in Medicare Reimbursement: Future Changes

• Sequestration
  ▪ Since April 1, all Medicare Providers are facing a mandatory 2% cut to reimbursements
  ▪ The cut will be applied to the payment itself, not the allowed charge in the Medicare fee schedule
  ▪ Costs for physician-administered drugs included on the physician claim will also be subject to the cut

• Sequestration is scheduled to last for 9 years if Congress does not act to repeal it before then
Possible Future Changes Affecting Hospitals

- Cap certain hospital payments at physician office payments
- Bad debts - reduce to 25%
- Critical Access Hospitals
  - Eligibility grandfather protection
  - Reduce reimbursement to 100% of reasonable costs
Possible Future Changes Affecting Hospitals

- Discontinue Medicare Dependent Hospitals (MDHs)
- Independent Payment Advisory Board (IPAB)
  - Created by §§ 3403, 10320 of ACA
  - Reduce Trigger Threshold
- GME
  - Convert to grant program
  - Limit GME to 120% of national average resident salary
  - Lower IME from 5.5% to 2.2%
- Market Basket – reduce by 1%
Possible Future Changes Affecting Medicare Beneficiaries

- Raise eligibility age from 65 to 67
- Require beneficiaries to pay more copays
- Increase Part B deductibles
- Limit Medigap plans
- Increase beneficiary premiums
- Shift from a Defined Benefit model to a Defined Contribution Model
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