

Protecting Your Reimbursement Dollars

Crowe[®] Healthcare Webinar Series

Learning Objectives

- Explore potential reimbursement areas at higher risk of government enforcement
- Discuss current reporting methodologies/strategies for obtaining and keeping reimbursement hospitals are entitled to
- Simplify processes surrounding data necessary to support reimbursement

How To Protect Your Reimbursement Dollars

- Understand Enforcement Areas of Focus
- Appeals Litigation Update/Strategy
- Stay Current on Reporting Trends/Hot Topics
 - Areas
 - Uncompensated Care
 - Charity Care
 - DSH
 - MBD
 - Medical Education
 - Wage Index
 - 340B Program Guidance
 - ACA 60-Day Payback Rule
 - OIG Fraud Alert – Physician Compensation Arrangements

Enforcement Areas

DHHS OIG 2015 Work Plan Mid-Year Update – Effective May 2015:

- Describes OIG audits, evaluations, and certain legal and investigative initiatives that are ongoing
- This update removes items that have been completed, postponed, or canceled and includes new items that have started since October 2015
- Also forecasts areas for which OIG anticipates planning and/or beginning work in the upcoming fiscal year and beyond
- OIG will periodically update its online Work Plan, available at www.oig.hhs.gov

Enforcement Areas

Medicare Enforcement Priorities for Hospitals:

- Selected recurring items of interest include:
 - Reconciliation of outlier payments
 - Analysis of salaries included in hospital cost reports
 - Medicare oversight of provider-based status
 - Comparison of provider-based and free-standing clinics
 - Duplicate graduate medical education payments
 - Indirect medical education payments
 - Review of hospital wage data used to calculate Medicare payments

Enforcement Areas

State Management of Medicaid Enforcement Priorities:

- How States Fund Their Medicaid Programs:
 - State use of provider taxes to generate Federal funding
- State Claims for Federal Reimbursement:
 - Medicaid eligibility determinations in selected States

Enforcement Areas

Medicaid Information System Controls and Security Enforcement Priorities:

- Controls To Prevent Improper Medicaid Payments:
 - Duplicate payments for beneficiaries with multiple Medicaid identification numbers
- Controls To Ensure the Security of Medicaid Systems and Information:
 - NEW – Completeness of data in Transformed Medicaid Statistical Information System: early implementation

Enforcement Areas

CMS-Related Legal and Investigative Activities:

- Legal Activities:
 - Provider Self-Disclosure
- Controls To Ensure the Security of Medicaid Systems and Information:
 - NEW – Completeness of data in Transformed Medicaid Statistical Information System: early implementation

Enforcement Areas

Public Health Reviews:

- Health Resources and Services Administration:
 - HRSA – Duplicate discounts for 340B purchased drugs

Cost Report Appeals Litigation Update

Recent CMS Administrator Decisions Regarding DSH Issues:

- **Norwalk Hospital v. BCBSA/NGS (DHHS CMS Admin Dec.) May 21, 2012** [Additional Medicaid Eligible Days (Medicaid Fraction)]
 - 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 days 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

Note: Most contractors have been willing to reopen the cost report for this issue
- **Takeaway:** protest additional Medicaid eligible days you cannot claim when you file your cost report that you anticipate adding before audit.

Cost Report Appeals Litigation Update

Recent PRRB Decisions Regarding DSH Issues:

- **Danbury Hospital v. BCBSA (PRRB Dec. No. 2014-D3) Feb. 11, 2014, declined review, (CMS Admin) March 26, 2014** [Additional Medicaid Eligible Days (Medicaid Fraction)]
 - The provider claimed additional Medicaid eligible days not included on its as-filed 2005 cost report
 - The intermediary challenged jurisdiction because no adjustment was made to Medicaid eligible days on the provider's Notice of Program Reimbursement (NPR)
 - The PRRB concluded that it did have jurisdiction over the appeal, but only if the provider could demonstrate that data to verify the Medicaid eligibility was not available at the time of cost report filing. When the provider could not provide detailed information, the PRRB held that it had no jurisdiction over the case

Note: Most contractors have been willing to reopen the cost report for this issue

Cost Report Appeals Litigation Update

Impact of Danbury Decision:

- On May 23, 2014, PRRB issued Alert 10 which effectively applies the Danbury decision to all pending Medicaid eligible days appeals. Alert 10 can be found at this link: http://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB_Alerts.html#e
 - Orders providers to supplement the record with additional arguments and/or documentation that would be relevant to the Board making a jurisdictional determination within 60 days (July 22, 2014)
 - ❖ A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue
 - ❖ The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation
 - ❖ A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed and how many days are associated with each explanation/reason

Cost Report Appeals Litigation Update

Recent Federal Court Decisions Regarding DSH Issues:

- **Allina v. Sebelius (D.C. Circuit Court of Appeals) April 1, 2014** [Medicare Managed Care (SSI%)]
 - This decision affirmed in part, and reversed in part, the lower court ruling
 - Court of Appeals ruled that Secretary's promulgation of the 2004 final rule violated the Administrative Procedures Act and did not meet the legal standard of being "a logical outgrowth of the proposed rule".
 - The Court of Appeals further stated "the statute unambiguously requires that Part C days be counted in one fraction or the other."
 - The Court of Appeals ruled that the District Court went too far in ordering the Secretary to recalculate DSH payments to include Part C days in the Medicaid fraction, holding that the agency was free to decide "how to resolve the problem" .

Note: The Secretary may order contractors to reopen cost reports or continue to contest through adjudication process

Cost Report Appeals Litigation Update

Recent Federal Court Decisions Regarding DSH Issues Cont'd:

- **Metropolitan Hospital v. U.S. DHHS (6th Circuit Court of Appeals) 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 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 Court of Appeals 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 statute.

Cost Report Appeals Litigation Update

Recent Federal Court Decisions Regarding DSH Issues Cont'd:

- **Catholic Health Initiatives Iowa Corp. v. Sebelius (D.C. Circuit Court of Appeals) June 11, 2013**
[Dual-Eligible Exhausted Benefits (Medicaid Fraction)]
 - The District Court reversed CMS Administrator's decision and ruled in favor of the provider by relying on the plain language of the statute... because 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 cost report at issue.
 - The D.C. Circuit Court of Appeals determined that the Medicare statute's use of the phrase "entitled to benefits under Part A" was ambiguous, at best, requiring deference to CMS' construction.

Cost Report Appeals Litigation Update

Recent Federal Court Decisions Regarding MBD Issues:

- **District Hospital Partners v. Sebelius (D.C. District Court) March 26, 2013** [1987 Bad Debt Moratorium (Issue of Collectibility)]
 - 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 always have 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. Circuit Court

Cost Report Appeals Litigation Update

The Bad Debt Moratorium is effectively overturned:

- **Lakeland Regional Health System v. Sebelius (D.C. District Court) July 16, 2013** [1987 Bad Debt Moratorium (Issue of Collectability)]
 - Court agreed with 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,
but then subsequently withdrew its appeal

Cost Report Appeals Litigation Update

- PRRB followed *District Hospital Partners* and *Lakeland* in recent decisions
 - CHS 2003-06 Bad Debt Groups, PRRB Decision July 1, 2014
 - Methodist Hospitals, PRRB Decision August 29, 2014
- St. John Health 2004-05 Bad Debt Moratorium CIRP Group/Hall Render 2005-06 Bad Debt Moratorium CIRP Group, PRRB Decision, August 27, 2014
 - Here, the Providers prevailed.
 - Board said that because NGS had previously interpreted the Bad Debt Moratorium to allow the providers to recover bad debt payments for accounts that were pending at outside collection agencies in earlier fiscal years, NGS was precluded from denying similar claims for the fiscal years in question
 - Subject to reversal by CMS Administrator

Cost Report Appeals Litigation Update

- Appeals re. “Predicate Facts”
 - Kaiser v. Sebelius (D.C. D.C. 2013) upholds the notion that a MAC can go into a previous year’s cost report to fix an FTE cap that will impact reimbursement in future years.
 - This is not considered a reopening because it doesn’t impact reimbursement for the cost report where the FTE cap is being fixed, only future years
 - Three year limitation on reopenings doesn’t apply

Appeals Strategy

- DHHS published in its Final Rule, dated May 23, 2008, an exhaustion regulation, 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 cost reports ending on or after December 31, 2008. (73 Fed. Reg. 30195-96) The implementing regulations are at 42 C.F.R. §405, Subpart R
- The Provider Reimbursement Review Board (PRRB or Board) issued its new Rules on August 21, 2008 to reflect the aforementioned changes to the regulations and issued subsequent revisions and updates on July 1, 2009 and March 1, 2013. These are available in full on CMS’s website at http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html

Appeals Strategy

- Regulatory changes and subsequent PRRB rule changes have restricted providers' ability to preserve appeal rights and have made cost report preparation a key piece of an effective PRRB appeals strategy
- Providers must be aware of the numerous procedural requirements involved with preserving their cost report appeal rights to avoid making errors in filing proper requests for hearing
- Providers need to monitor the ultimate outcome of cases pending in federal court on issues impacting them
- Recent PRRB and CMS Administrator jurisdictional decisions reflect an increased focus on the "dissatisfaction" requirement. Because of their far-reaching implications, providers should consider such decisions and anticipate challenges when preparing protested items and requests for hearing. In December 2013, the PRRB began uploading final jurisdictional decisions on a monthly basis on CMS' website

Appeals Strategy

- Providers should continue to protest issues on cost reports in accordance with the instructions found in the Provider Reimbursement Manual (PRM), Part II Section 115 (CMS Pub. 15-2), but be mindful not to let reopening opportunities lapse
- In light of the potential for numerous regulatory changes stemming from implementation of the Affordable Care Act (ACA) and/or other legislation, it would 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
- Providers should consult with their legal representatives to fully understand the implications of federal court, PRRB, and CMS Administrator decisions and opportunities to appeal from the Federal Register versus cost report settlement

Reimbursement Reporting Tips/Hot Topics

Reporting Tips:

- Uncompensated Care
 - Charity Care
 - DSH
 - MBD
- Medical Education
- Wage Index

Reimbursement Reporting Tips/Hot Topics

Uncompensated Care

Charity Care Reporting Tips:

- Make sure charity care amounts are accurate
- Charity care amounts are important for determining additional EHR incentive payments and will be used for future Medicare “DSH” payments
- Determine best data source to track this data and consistently use it for uncompensated care reporting
 - Separate transaction codes for bad debt and charity cleanly map to general ledger accounts
 - Communicate any new transaction codes or changes in proposed mapping

Reimbursement Reporting Tips/Hot Topics

Uncompensated Care

MBD Reporting Tips:

- Set up processes to:
 - Exclude non-allowable coinsurance and deductible amounts (detailed PS&R vs. individual Medicare remit)
 - 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
 - Create and use a separate transaction code solely used for Medicare bad debt write-offs
 - Examine policies annually (Bad Debt/Charity)
- Prepare bad debt logs correctly before submission (this will take time and effort)

Reimbursement Reporting Tips/Hot Topics

Uncompensated Care

MBD Reporting Tips Cont'd:

- 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

Reimbursement Reporting Tips/Hot Topics

IME/GME and Allied Health Reporting Tips:

- Work with your Med Ed Dept, make sure your Intern/Resident count is accurate
- Make sure that the prior year Int/Res to Bed ratio is calculated per cost report instructions
- Make sure Bed Count is accurate and reflects all beds taken out of service; Remove Hospice patient bed days per new cost report instructions
- Update Per Resident Amount for annual inflation
- Review costs and allocation statistics for Allied Health Cost Centers
- Report Medicare HMO Allied Health Reimbursement on W/S E, Part A, Line 53 (2552-10)

Reimbursement Reporting Tips/Hot Topics

IME/GME and Allied Health Reporting Tips Cont'd:

- Medicare Part C (aka Medicare + Choice, Medicare Advantage, or Medicare HMO) is separate from the traditional Medicare (Medicare Parts A and B)
- Shadow bills activity is captured in PS&R Report Type 118
 - If it's not reflected here, reimbursement could be missed
- Business Office or Reimbursement Department should reconcile PS&R Report Type 118 days to internal patient accounting systems
- Review all steps along the revenue cycle to make sure none are “lost”

Reimbursement Reporting Tips/Hot Topics

Wage Index Reporting Tips:

- Work with your Payroll, HR, Physician Relations, and Accounts Payable departments for your data
- Exclude unnecessary paid hours
- Report all employee benefits as required on W/S S-3, Part IV
- Ensure that Physicians are keeping accurate time studies – include all appropriate Part A time
- Include non-excluded area clinical, and A&G contract labor – work with vendors to obtain hours
- Make sure that Home Office paid hours, benefits, and contract labor are also reported accurately

Reimbursement Reporting Tips/Hot Topics

Hot Topics:

- Proposed 340B Program Guidance
- Affordable Care Act's 60-day Payback Rule
- OIG Fraud Alert – Physician Compensation Arrangements

Reimbursement Reporting Tips/Hot Topics

Proposed 340B Program Guidance :

- Health Resources and Services Administration (HRSA) published new guidance August 28, 2015 (Comments due October 27, 2015)
- Created in 1992, requires manufacturers to make outpatient drugs available at a substantial discount to “covered entities”
- Eligibility – minimum DSH percentage of 11.75% and 8% for RRCs and SCHs
- Proposed definition of a patient of a covered entity creates more restrictive standards
- Clarifies impact of losing eligibility
- Requires quarterly reviews and annual independent audits of contract pharmacy locations
- Relative to HRSA audits of covered entities – creates notice and hearing process for responding to adverse findings, instances of noncompliance, and loss of eligibility

Reimbursement Reporting Tips/Hot Topics

ACA 60-Day Payback Rule:

- Fraud Enforcement and Recovery Act of 2009 and ACA 2010 give government new tools
 - Obliges providers to timely report and return Medicare and Medicaid overpayments
 - Failure to do so means potential civil monetary penalties and FCA liability
- ACA requires providers to report and return Medicare and Medicaid overpayments within 60 days after the date on which the overpayment was identified
- CMS and OIG have issued proposed rules regarding the 60-day rule but not finalized
- Leaves many questions unanswered:
 - What does “identification” mean under the 60-day rule and how long can the identification period last?
 - What type of written notification will suffice?
 - Are these requirements retroactive?

Reimbursement Reporting Tips/Hot Topics

OIG Fraud Alert – Physician Compensation Arrangements:

- June 9, 2015 fraud alert issued regarding potential for medical directorships to violate the anti-kickback statute
- Medicare and Medicaid Patient Protection Act of 1978
- Compensation arrangements must reflect fair market value for bona fide services that physicians actually provide
- Looking at both sides (physicians and hospitals) of these arrangements for potential civil and criminal liability
- Supporting documentation, time studies and job descriptions, should reconcile to contract terms
- Automated time study systems can be mutually beneficial to all parties in ensuring regulatory compliance and mitigating risk

Leverage Technology – Periodic Time Studies

Policy

Regulations

- 42 CFR §415.55(a)(2) – (General Payment Rules)
- 42 CFR §415.60(b)(1 -3) – (Allocation of Physician Costs)
- 42 CFR §413.70(b)(4) – (Payment for Services of a CAH)

Program Instructions

- CMS Pub. 15-1 §2109.3 C (Allowability of ED Physician Availability Service Costs)
- CMS Pub. 15-1 §2113.2 E (Special Applications)

Leverage Technology – Periodic Time Studies

Limitations of Existing Time Study Processes:

- Increased workloads and demands on time
- Excessive paperwork
- Low participation
- Incomplete/Difficult to interpret
- Logistical nightmare

Leverage Technology – Periodic Time Studies

Key Vulnerabilities of Existing Time Study Processes:

- Input and signatures not contemporaneous
- Physician activities do not reconcile to underlying contracts
- Adherence to Stark Law Exceptions
- Effect of Contractor Reform

Leverage Technology – Periodic Time Studies

Benefits of Technology:

- Seamless and Integrated Process
- Automated, paperless process
- Easy-to-use and flexible input options
- No manual entry
- Organized database and reporting
- Reduces audit risk
- Increased reimbursement potential

Leverage Technology – Periodic Time Studies

Crowe Physician Links – The Process

Capture

Administration

- Load end user data
- Mapping
- Establish schedules

E-mail reminders

Easy user input

- Smart phones
- Tablets
- PCs
- Laptops

Document

Allocation

Agreements

Time Studies

- Administrative
- Teaching
- ED availability
- Transplant
- Research

Other Time Reporting Needs

- Productivity/Effort

Report

Cost Report

S-3, Part II **
A-8-012
B-1
D-4

Home Office

Grant Applications

Operations

*** Automatic link to Crowe®
Wage Index Navigator*

Leverage Technology – Periodic Time Studies

Crowe Physician Links – Customized for Your Hospital

Time Study Weeks

Time Entry
Windows

Tasks and
Descriptions

Attestation
Statement

Review Process

Notifications

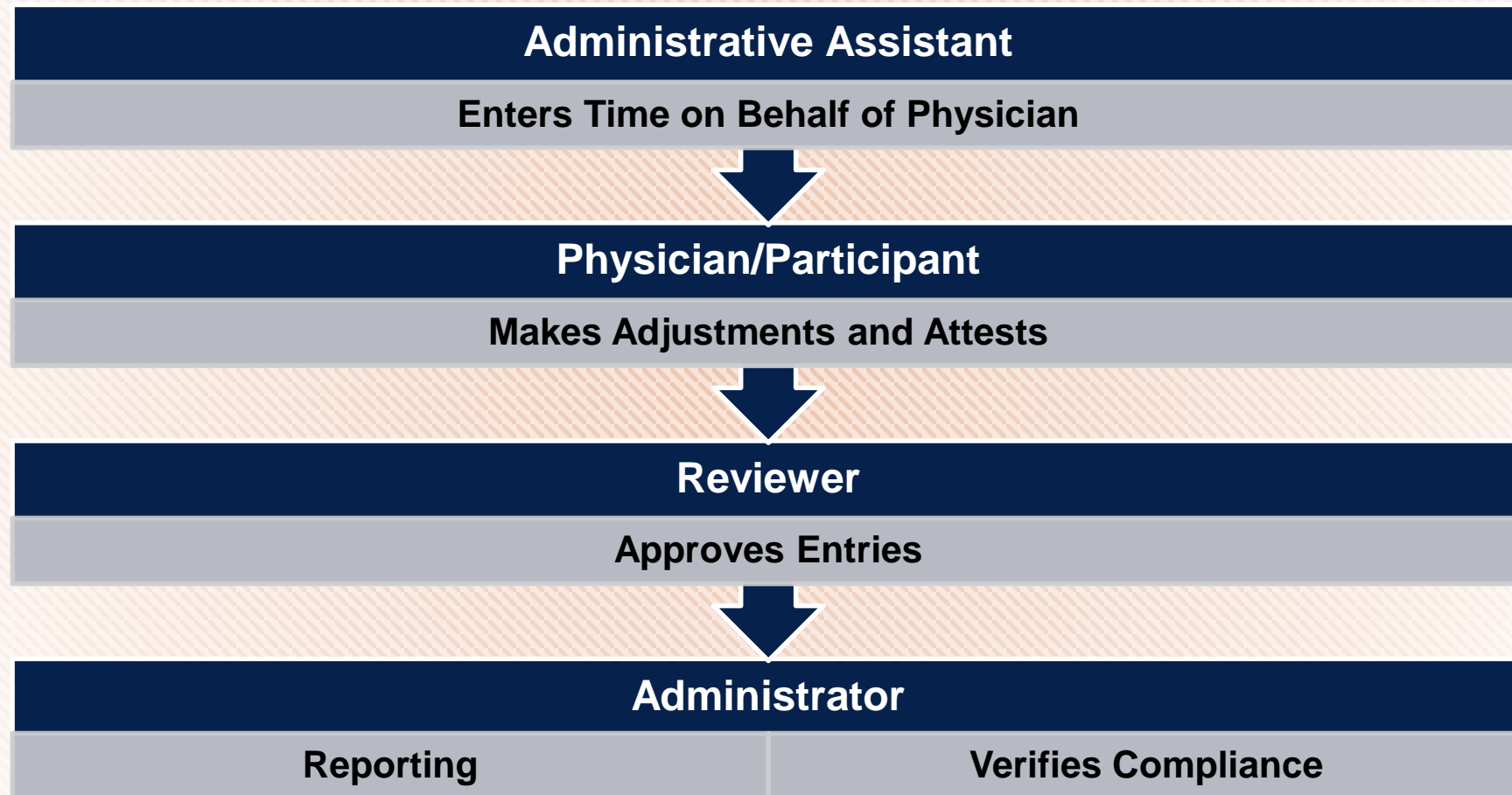
Reports

Instructions

Help Documents

Leverage Technology – Periodic Time Studies

Crowe Physician Links – Time Study Workflow



Leverage Technology – Periodic Time Studies

Crowe Physician Links – Simple to Administer



Wage Index Navigator

Home | Reports | My Account | Administration

Physician Links Administration - Crowe Workspace

Workspace Dashboard | Time Study Management | Staff Management | Department Management | Group Management | Task Management | Subtask Management | Reporting | Workspace Management


Time Study Management: This page can be used to manage time studies and assign staff.

Create New Time Study

Name	Description	Start Date	End Date	Reviewer Approval Required	Time Study Type	Copy	Edit	Delete
Q2 2014	Add a memo here to describe the time study.	04/01/2014	07/31/2014	Yes	Standard Time Study			
Q1 2014	Add a memo here to describe the time study.	01/05/2014	03/29/2014	Yes	Standard Time Study			
March 2014 - Clinical Director	March 2014 - Clinical Director	03/09/2014	03/15/2014	Yes	Standard Time Study			

Leverage Technology – Periodic Time Studies

Crowe Physician Links – Web Entry






Physician Links









[Contact Us](#) | [Change Password](#) | [Change Username](#) | [Log Out](#)

Overview

Help

Choose Role: Admin Assistant


The following grid displays all time studies for your participants. It should give you high-level information about each time study, including time currently entered and time waiting to be submitted for approval. To work on behalf of one of the participants, click on the  icon in the grid. This will allow you to enter time, edit and remove time, and attach documents as if you were working on their behalf. On all other pages, please use the dropdown menu in the top-right corner to work on behalf of a different participant or come back to this page by clicking the 'Overview' button. Click on the  icon to remind the participant to submit their time.

		Last Name	First Name	Time Study	Time Study Start Date	Time Study End Date	Contract Hours	Time Entered	Current Status
▶		Freud	Sigmund	September 2014	08/31/2014	09/06/2014	40.00	0.00	No Activity
▶		Jung	Carl	September 2014	08/31/2014	09/06/2014	40.00	0.00	No Activity
▶		Jung	Carl	August B 2014	08/17/2014	08/23/2014	40.00	52.00	Entered
▶		Freud	Sigmund	August B 2014	08/17/2014	08/23/2014	40.00	60.00	Awaiting Reviewer Approval
▶		Jung	Carl	August 2014	08/10/2014	08/16/2014	40.00	63.00	Awaiting Reviewer Approval
▶		Freud	Sigmund	August 2014	08/10/2014	08/16/2014	40.00	49.00	Fully Approved*
▶		Freud	Sigmund	July 2014	06/29/2014	07/05/2014	40.00	48.00	Fully Approved*
▶		Jung	Carl	July 2014	06/29/2014	07/05/2014	40.00	56.00	Fully Approved*

1

50 items per page

1 - 8 of 8 items

Leverage Technology – Periodic Time Studies

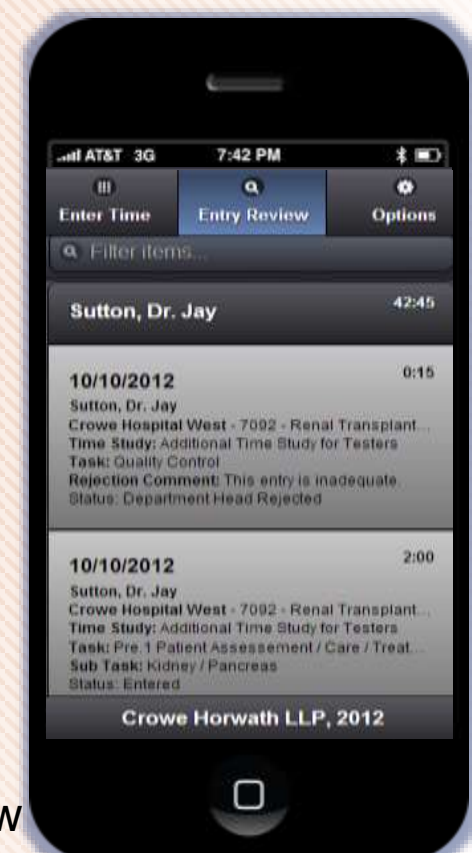
Crowe Physician Links – Mobile Entry



Home Screen



Time Entry



Entry Review

For more information, contact:

Jay Sutton

Direct 317.706.2738

jay.sutton@crowehorwath.com

Ron Wolf

Direct 636.346.9871

ron.wolf@crowehorwath.com

Crowe Horwath LLP is an independent member of Crowe Horwath International, a Swiss verein. Each member firm of Crowe Horwath International is a separate and independent legal entity. Crowe Horwath LLP and its affiliates are not responsible or liable for any acts or omissions of Crowe Horwath International or any other member of Crowe Horwath International and specifically disclaim any and all responsibility or liability for acts or omissions of Crowe Horwath International or any other Crowe Horwath International member. Accountancy services in Kansas and North Carolina are rendered by Crowe Chizek LLP, which is not a member of Crowe Horwath International. © 2015 Crowe Horwath LLP