

# Medicare Update

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**Overview**

- American Recovery & Reinvestment Act of 2009 (ARRA, or Recovery Act)
- Includes the Health Information Technology for Economic and Clinical Health Act (HITECH ACT)
- Requires that CMS provide incentive payments under Medicare and Medicaid to "Meaningful Users" of Electronic Health Records (EHRs)




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**Overview**

- If Hospital is deemed a "Meaningful User" during a "Reporting Period", they are eligible to receive an incentive payment.
- First year for hospital payments is FY 2011
- Payments may be made for multiple years (100% for the first and then decreasing amounts)
- If hospital doesn't become a "Meaningful User" they will eventually be penalized.
- Hospitals will receive a preliminary (interim or initial) payment, and it will be reconciled on the cost report.




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**Payment Formula**

- Information is available on the CMS web site regarding the payment formula including tip sheets and frequently asked questions. (FAQ's)




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**Payment**

- Preliminary (Initial) Payment will be based on the information contained in the latest filed cost report at the time of the calculation
- Final Payment will be based on the information contained in the cost report that begins during the payment year




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**Critical Access Hospitals**

- Incentive Payment is different – as CAHs are paid on reasonable cost.
- Incentive –
  - CAHs will be able to expense the EHR costs in the year incurred
  - The Medicare Share (same as Subsection(d)) will be increased 20 percentage points, but can't exceed 100%
- EHR costs = costs incurred for the purchase of depreciable assets, such as computers and associated hardware and software.




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**Critical Access Hospitals**

- In order for the CAH to receive its interim incentive payment, upon attestation, it must submit supporting documentation for its incurred costs of purchasing certified EHR technology to its Medicare contractor. The Medicare contractor will then calculate the allowable amount. The interim incentive payment is then subject to reconciliation to determine the final incentive payment amount. The final payment amount constitutes payment in full for the reasonable costs incurred for the purchase of certified EHR technology in the single payment year.




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**Overview of Payment Process – Subsection (d)**

- Hospital registers
- Hospital attests as a Meaningful User
- Monthly “trigger file” sent from NLR to obtain FISS/MCS info for those who attested that month
- Payment info sent to Payment File Development Contractor (PFDC)
- PFDC prepares the file
- Payments are distributed to providers (EFT, check)
- Adjustments – at final settlement, and others as needed




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**Overview of Payment Process – CAH**

- CAH registers
- CAH attests as a Meaningful User
- CAH supplies documentation to their FI/MAC
- FI/MAC enters allowable amount and Medicare Share into FISS
- Monthly “trigger file” sent to obtain FISS/MCS info for those who attested that month
- Payment info sent to PFDC
- PFDC prepares the file
- Payments are distributed to providers (EFT, check)
- Adjustments – at final settlement, and others as needed




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**Hospital Questions**

- **FAQ Document on CMS website:**
  - <http://www.cms.gov/EHRIncentivePrograms/>
  - FAQ link on left margin




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**Other issues**

- **If provider has questions:**
  - Electronic Health Record (EHR) Information Center - 1-888-734-6433
  - EHR Webpage - <http://www.cms.gov/EHRIncentivePrograms/>
  - Regional Office Contacts: [http://www.cms.gov/EHRIncentivePrograms/Downloads/Regional\\_Point\\_Of\\_Contacts\\_10-12-10.pdf](http://www.cms.gov/EHRIncentivePrograms/Downloads/Regional_Point_Of_Contacts_10-12-10.pdf)




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**PS&R Redesign Update**

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### PS&R Redesign Issue-Negative Charges

- A problem has occurred in the claims processing system where non-covered charges have been duplicated in certain situations.
- In these situations the duplicated non-covered charges are reported in the covered charge field as a negative amounts on the paid claim. The paid claims with the negative covered charge amounts were subsequently sent to the PS&R.
- The issue affects outpatient claims processed and paid after April 1, 2010 with a "51MUE" denial code.
- As a result, some outpatient charges may be understated or shown as negative amounts on PS&R reports. The problem primarily affects hospital outpatient reports.
- Initial reprocessing of these claims did not fix the issue.
- Impacting cost report settlements




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### Cost Report Extensions

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### Cost Report Extensions

- The CMS Office of Financial Management and the Division of Cost Reporting are working on the rolling extensions for the 2552-10 cost reports.
- All providers with full 12 month or greater cost reporting which begin on or after May 1, 2010 (and end on or after April 30, 2011) must file on the 2552-10 subject to the schedule.




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### Cost Report Extensions

- Cost Report Extensions
- 2552-10

FYE	Due	Now Due	Extension
4/30/2011	9/30/2011	11/30/2011	60 days
5/31/2011	10/31/2011	11/30/2011	30 days
6/30/2011	11/30/2011	1/31/2012	60 days
7/31/2011	12/31/2011	1/31/2012	30 days
8/31/2011	1/31/2012	2/29/2012	30 days
9/30/2011	2/29/2012	3/31/2012	30 days
10/31/2011	3/31/2012	3/31/2012	none




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### New MAC Jurisdictions

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### Implementing the Changes

- Jurisdictions and the procurement schedule for the new contractors were announced by CMS on 2/22/05
- CMS plans to award a total of 19 MACs through competitive bidding
  - 15 Primary A/B MACs servicing the majority of all provider types (both Part A and Part B)
  - 4 Specialty MACs (durable medical equipment suppliers)




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### Implementing the Changes (cont.)

- Several MAC jurisdictions are being protested.
- They include MAC J6; (Wisconsin, Illinois, and Minnesota) J6 was originally awarded to Noridian.
- No timetable has been developed for a final decision.
- Once a final decision is made there will be a transition schedule.
- The transition schedules will be between 6 and 12 months.
- Super MAC Concept has been proposed by CMS. Under this proposal J5 and J6 would be combined.




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### Medicare Cost Reporting Issues 8/30/11

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### AGENDA

- Medicare Cost Report Holds
- MSP Audits
- Electronic documentation
- Crosswalk for Settlement
- Medicare Bad Debts
- Reporting Meaningful Use & EHR Costs




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### Medicare Cost Reports

#### Medicare Cost Reports on Hold

- Hold for PS&R
- Hold for SSI
- Hold for some Outlier Providers




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### Cost Reports on Hold

- PS&R – Effect CAH
- Once they are released we will send out adjustment reports including the updated PS&R adjustments.
- NGS will settle based on the PS&R  
However the split of ancillary charges is important and the PS&R does not always match the total charges of the provider.
- Review your crosswalk when the adjustments are received.




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### MSP Audits

- CMS has instructed NGS to do a certain amount of MSP Audits each year.
- Issues determining selection:  
Random selection.  
Hospital has not been selected in the past.  
Medicare Claims history – i.e. failed to develop MSP claim properly.  
Dollars at Risk.




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### MSP Audit

When Medicare is the secondary Payer.

- Must first submit the claim to the primary payer.
- After primary pays for services, Medicare secondary benefits may be for services as prescribed in the MSP Manual Pub. 100-05, chapter 1 section 10.8.




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### MSP Audit

Contact the hospital

- Auditor will call and obtain name & number of the person to contact.
- Auditor will give a brief overview.
- Initial notification letter will be mailed.
- Sample is selected
- Bill review consists of inpatient, outpatient and subunits.




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### MSP Audits

MSP audit procedure:

- Sample is sent to the provider.
- Provider has 30 days from the account selection letter to return the information.
- Auditor will review the information and schedule an onsite visit.




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### **MSP Audit CMS Questionnaire**

Auditor will review the hospital's questionnaire to ensure it is compliant with CMS guidelines. Providers are not required to us the CMS Admission Questionnaire but must collect at least as much information as CMS requires.



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### **MSP Audit**

#### **On Site Visit**

- Conduct Entrance Conference
- Determine if the hospital has established policies for billing other payers
- Interview billing and admitting staff
- Inform the hospital of any follow up.



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### **MSP Audit**

#### **Prepare a Review Report**

- Auditor will send a review report within 30 days of the on site visit.
- Indicate follow up activity needed.

#### **Prepare a Cover Letter**

- Submitted after the completion of the review.
- Sent to the provider and CMS
- A response date will be given.



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### MSP Audit

Follow up:

- Follow up will occur every 30 days until the appropriate corrective action is taken or completed.
- If continued problems after 3 months, report problem to the CMS MSP Coordinator.
- Notify the provider in writing when the MSP review is closed.




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### Electronic documentation

The NGS Audit Department is going to a paperless audit system.

- Would appreciate electronic submission of documentation.
- However make sure PHI is encrypted and password protected.
- Send the password in a separate email.




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### Crosswalk for Settlement

- CMS wants us to use the PS&R UB codes to identify Medicare Charges by ancillary cost center.
- This is the starting point for our staff. We have software that groups the UB codes to each ancillary department.




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### Crosswalk to Settlement

- Our software does not have the ability to factor Medicare Charges based on the as filed numbers.
- It is important to provide a crosswalk between the cost and charges on the trial balance and the UB codes on the PS&R.




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### Medicare Bad Debts

- CMS continue to pursue the must bill policy.
- When an account is at a collection agency it cannot be deemed worthless because there is still the likelihood of recovery. When it is returned from the collection agency is when it is deemed worthless.




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### Reporting Meaningful Use & EHR Costs

- The HITECH review will be included with the current cost report process.
- CMS needs to revise audit instructions to address additional data elements including total discharges and charity care amounts reported on the cost report




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### Reporting Meaningful Use & EHR Costs

- CAH depreciation – under the act - CAHs will be able to implement a “first year expensing” for approved capital purchases of electronic healthcare technology. Audit concerns is that there is a risk a provider may expense the asset and then later capitalize the asset.
- As with the review of charity care, capital costs for CAHs will have to be audited.




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### Reporting Meaningful Use & EHR Costs

- If any of the information does not appear reasonable, a limited review may be needed to verify the data.
- Examples –  
 Inpatient part A days compared to PS&R – data does not appear reasonable.  
 Charity Care – compare to prior years or other information. If a reasonable amount cannot be found , a zero may be used.




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### Questions?




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