




Medicare Administrative Contractor
Audit & Reimbursement Update

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Audit Discussion Topics

- MAC Update
- Audit & Reimbursement Update
- Accessing Redesign PS&R Reports Using CMS IACS System
- SSI Update
- FY 2012 Wage Index Review
- Maine Crossover Bad Debts
- Quick Hits
- Question & Answers




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MAC Update



Medicare FFS Contracting Reform

•Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) signed into law by President Bush December 8, 2003

•The MMA enables the Centers for Medicare & Medicaid Services (CMS) to make significant changes to the Medicare FFS program's administrative structure

•Goal: make contracting dynamic, competitive, performance-based and generate savings to the Trust Fund



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Original Jurisdictions and the procurement

• Jurisdictions and the procurement schedule for the new contractors were announced by CMS on 2/22/05

- CMS plans to award a total of 23 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)
 - 4 Specialty MACs (home health and hospice providers)



Medicare Administrative Contractor (MAC)

MAC Requirements:

- Statement of Work spells out what the contract is required to perform
- Additional work outside the SOW requires contract modification
- All direction to the MAC contractor from CMS must come through the CMS Project Officer
- The CMS Project Officer will work directly with the MAC's identified point of contact



Implementing the Changes

Last group of RFPs were issued August 31, 2007

All cutovers complete by July 2009

The Law required all existing contracts to be completed by Sept 2011

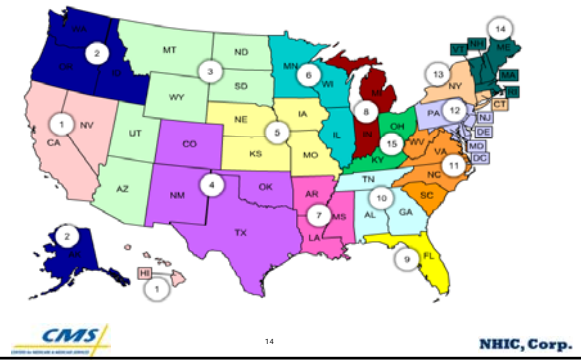
Original schedule allowed for a 2 years slippage



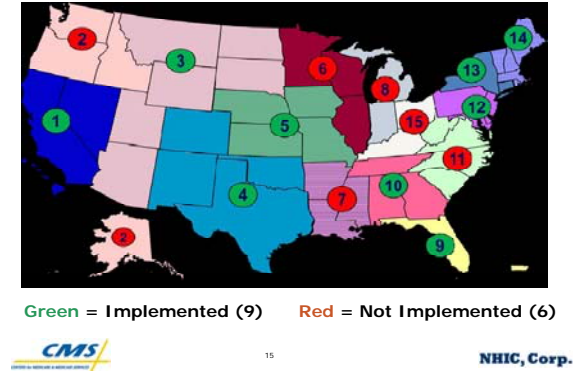
Medicare's A/B MAC Jurisdictions

| Jurisdiction # | States Included in Jurisdiction |
|----------------|---|
| 11 | North Carolina, South Carolina, Virginia and West Virginia - awarded to Palmetto on January 7, 2009. |
| 12 | Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania - awarded to Highmark on October 24, 2007 |
| 13 | Connecticut and New York - awarded to NGS on March 18, 2008 |
| 14 | Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont -awarded to NHIC on November 19, 2008 |
| 15 | Kentucky and Ohio - awarded to Highmark on January 7, 2009, Protested and awarded to Cigna October 29, 2010. |

Jurisdictions for A/B MACs



Current Implementation Status of the A/B MACs



Proposed Future MAC Awards
(Round 2 Procurements)

CMS intends to pursue the following three strategies through the A/B MAC Round II procurements:

- CMS will consolidate the present 15 A/B MAC jurisdictions into ten (10) A/B MAC jurisdictions, in a phased process that will take several years to complete.
- CMS will implement an award limit for the A/B MAC contracts, to be included in all A/B MAC solicitations beginning with the consolidated A/B MAC Jurisdiction 2/Jurisdiction 3.



Proposed Future MAC Awards (cont)

- CMS will implement changes in the A/B MAC statement of work to augment and enhance the role of the contractor medical directors, including a requirement that each A/B MAC contract be supported by at least one full-time, fully-dedicated medical director.



Proposed Timing of Future MAC Awards

- Over the next several years, CMS will consolidate the ten (10) A/B MAC workloads, comprising 5 pairings, to form five consolidated A/B MAC contracts. The approximate timing for each consolidation will be outlined on the next slide, although the exact timing of consolidation actions may be adjusted based on program considerations (contractual status, schedule, etc.).

•What is the possible impact on Maine Providers?



Consolidated MACS

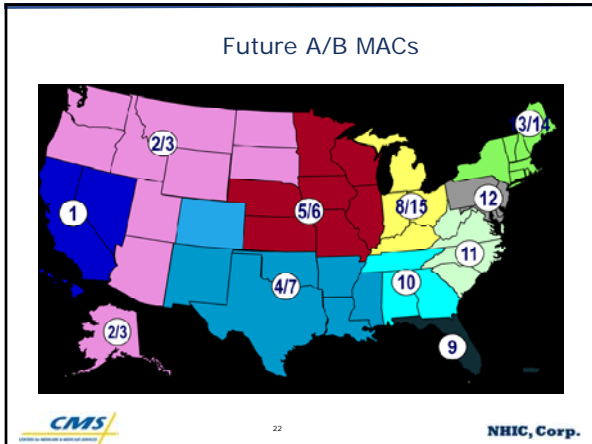
- o **A/B MAC Jurisdictions 2 and 3** (Alaska, Washington, Oregon, Idaho, North Dakota, South Dakota, Montana, Wyoming, Utah, and Arizona)
- o **A/B MAC Jurisdictions 4 and 7** (Louisiana, Arkansas, Mississippi, Texas, Oklahoma, Colorado, and New Mexico)
- o **A/B MAC Jurisdictions 5 and 6** (Minnesota, Wisconsin, Illinois, Kansas, Nebraska, Iowa, and Missouri)
- o **A/B MAC Jurisdictions 8 and 15** (Kentucky, Ohio, Michigan, and Indiana)
- o **A/B MAC Jurisdictions 13 and 14 (New York, Connecticut, Massachusetts, Rhode Island, Vermont, Maine, and New Hampshire)**

Medicare's A/B MAC not consolidating

| Jurisdiction # | States Included in Jurisdiction |
|----------------|---|
| 1 | <i>American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands</i> |
| 9 | <i>Florida, Puerto Rico, and U.S. Virgin Islands</i> |
| 10 | <i>Alabama, Georgia, and Tennessee</i> |
| 11 | <i>North Carolina, South Carolina, Virginia and West Virginia</i> |
| 12 | <i>Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania</i> |

The Consolidated A/B MAC Jurisdictions, Their Predecessor Jurisdictions, Their Relative Size, and Their Approximate Solicitation Release Dates.

| New Jurisdiction Designation | Former Jurisdiction Designation(s) | Percentage of National Part A & Part B Workload | Estimated Solicitation Release Date for Next Round of MAC Procurements |
|------------------------------|------------------------------------|---|--|
| E | 1 | 8.8% | January 2012 |
| F | 2 & 3 | 6.0% | September 2010 |
| G | 5 & 6 | 12.4% | September 2011 |
| H | 4 & 7 | 13.1% | October 2010 |
| I | 8 & 15 | 11.4% | July 2014 |
| J | 10 | 7.2% | January 2013 |
| K | 13 & 14 8.2% & 4.1% | 12.3% | March 2012 |
| L | 12 | 10.8% | March 2012 |
| M | 11 | 9.8% | May 2014 |
| N | 9 | 8.2% | September 2012 |



Medicare Contracting Reform

- Information concerning contract reform can be found on the CMS web site at:

<http://www.cms.gov/MedicareContractingReform>

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Upcoming A&R Changes

- A&R will be less reliant on the Acceptance and Reimbursement Hub in Syracuse New York
- A majority of the A&R work will be done locally (South Portland, Maine and Manchester, New Hampshire)
- Besides working with local A&R associates, the changes should be transparent to the provider community.



General Reimbursement and Cost Report Questions

The following individuals in J14 are primary contacts for cost report and reimbursement related issues:

Primary Contact

Kelley Cook
Medicare A&R Lead
Tel: (207) 253-3307
Fax: (502) 423-2059
Kelley.Cook@WellPoint.com

Secondary Contact

Justin Clark
Medicare A&R Lead
Tel: (603) 222-7532
Tel: (978) 777-3244
Fax: (502) 423-2059
Justin.Clark@Wellpoint.com



Cost Report Submissions

- Cost report submissions should be addressed to the **Cost Report Processing Unit** to ensure timely processing

Standard Mail

NHIC, Corp.
C/O National Government Services, Inc.
Cost Report Processing Unit
P.O. Box 4900
Syracuse, NY 13221-4900

Overnight Mail (USPS Express Mail)
Mail received Prior to 12/3/2010

NHIC, Corp.
C/O National Government Services, Inc.
Cost Report Processing Unit
400 S. Salina Street
Syracuse, NY 13202

Please refer to slide 35 regarding the overnight address subsequent to 12/3/2010

- *Early submissions may alleviate potential payment interruptions*



Primary Reasons for Rejecting a Cost Report

Cost Report

- Certification page does not include an original signature
- An outdated version of the cost report software was used
- The electronic file contains a Level I error

Free Software

- An outdated version of the CMS free software was used
- Cost report was submitted using the CMS free software, however a manual completion of the cost report was not submitted



Primary Reasons for Rejecting a Cost Report
(Cont.)

CMS 339

- Form CMS 339 was not submitted
 - Form CMS 339 that was submitted does not contain an original signature
 - An outdated version of the Form CMS 339 was used. The current version is Version 6, which is available as a download from the CMS Web site (www.cms.hhs.gov).
- Note: The 339 has been incorporated into the 2552-10 cost report and will be required to be completed within the cost report for fiscal years *beginning* 5/1/10



Primary Reasons for Rejecting a Cost Report
(Cont.)

CD / Disk

- Did not receive a CD / diskette containing the ECR and the Print Image files
- CD / Diskette that was submitted does not contain the ECR and/or the Print Image files



A Rejected Cost Report

- Cost reports are reviewed completely to identify all problems or issues that would cause the cost report to be rejected
- Notification of the rejection will be sent to the provider and will outline the reasons for rejection
- Payments are suspended upon the rejection of the cost report and are not released until the refiled cost report is accepted
- Note: Cost reports are reviewed under the FIFO method (first in, first out) to ensure compliance with Medicare requirements (30 days to accept from time of receipt)



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Grace Period

- A one-time grace period is identified for cost reports that are filed prior to the due date
- Receipt date of cost report is compared to the due date to determine the applicable grace period
- Provider will be given the grace period plus one day to resubmit the cost report prior to a payment suspension
- Grace period does not impact the determination of whether or not the cost report is acceptable



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Submission of Electronic Data

It is preferred that documentation supporting cost report assertions be submitted electronically.

- Listings (I.E. DSH, Bad Debt, etc) should be formatted in Excel
- Contracts and supporting documents can be submitted in either a PDF or word format.

Electronic data submitted on a CD or emailed should be password protected.



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In the Future...

- A&R is exploring a secure Portal to allow the transmission of information electronically.
- Consulting with CMS regarding Secured Websites maintained by the provider and whether not it is appropriate to transmit PHI or PII over this type of connection.
- Goal is to be 100% Paperless!!!



Audit & Reimbursement Correspondence

Correspondence and all other information to Audit and Reimbursement should be mailed to:

Standard Mail

NHIC, Corp
 C/O National Government Services, Inc.
 Attn: Medicare Audit & Reimbursement
 P.O. Box 4900
 Syracuse, NY 13221-4900

Overnight Mail (USPS Express Mail) (Received Prior to 12/03/2010)

NHIC, Corp
 C/O National Government Services, Inc.
 Attn: Medicare Audit & Reimbursement
 400 S. Salina Street
 Syracuse, NY 13202



Audit & Reimbursement Cost Report or Correspondence (Post 12/3/2010)

The Syracuse Office is moving to a new location at the Close of Business December 3, 2010. All overnight packages scheduled for arrival after December 3, 2010 should be addressed to the following:

Overnight Mail (USPS Express Mail) (Received post 12/03/2010)

NHIC, Corp
 C/O National Government Services, Inc.
 Attn: (Cost Report Processing Unit or Medicare Audit & Reimbursement) Suite 100
 5000 Brittonfield Parkway
 East Syracuse, NY 13057



Cost Report Appeal Correspondence

All cost report appeals and supporting documentation should be mailed to the following address

Standard Mail

NHIC, Corp
C/O National Government Services, Inc.
Attn: Ms. Rhonda Utter
MP: INA102-AF42
P.O. Box 7191
Indianapolis, IN 46207-7191

Overnight Mail (USPS Express Mail)

NHIC, Corp
C/O National Government Services, Inc.
Attn: Ms. Rhonda Utter
8115-8125 Knue Road
Indianapolis, IN 46207-7191
Tel: (317) 841-4626



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Maine Part A Mailing Medicare Payments

Payment location information for Maine, MA, RI and HHA Part A providers changed on August 30, 2010. A check and a letter of explanation for determined overpayments and / or voluntary refunds should be mailed to the following lockbox address:

Regular Mail

NHIC, Corp.
P.O. Box 809086
Chicago, IL 60680-9086

Overnight Mail

US Bank Lockbox
P.O. Box 809086
5300 South Cicero Ave.
Chicago, IL 60638

The information can also be found on the NHIC Website at:

www.medicarenhic.com/PA/PartA_AR_AuditReimbursement.shtml



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Specific Payment Questions

Questions pertaining to payment issues such as the status, receipt or application of a payment should be directed to Customer Care:

Part A (877) 757 7783

RHHI (866)289-0423



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Accessing Redesign PS&R Reports Using CMS IACS System



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Accessing Redesign PS&R Reports Using CMS IACS System

Enroll Now

CMS has notified the contractor that many providers have still not enrolled




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Accessing Redesign PS&R Reports Using CMS IACS System

- CMS initiated a total redesign of the PS&R system which is now complete.
- New system is a Web-based system with on-line request capability (i.e. providers register with CMS-IACS system to order own reports)
 - Two report formats (PDF and CSV)
 - On-line retrieval
 - Enhanced security
 - Faster turnaround times
 - Reports includes more claim data (i.e., 'real-time' system) versus legacy PS&R where contractor loaded monthly paid history.



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Accessing Redesign PS&R Reports Using
CMS IACS System

- Providers and FI/MAC's are directed to a CMS web site for additional information regarding the redesigned PS&R system at www.cms.hhs.gov/psrr/
- CMS link above includes all pertinent information on new IACS system, including:
 - Registration Tips
 - Link to IACS Log-In screen
 - PS&R Users Manual
- First impacted cost reports are FYE 1/31/09.
- Cost Report FYEs prior to 1/31/09 will be settled on old (legacy) PS&R System. (Note – previous claim history was not 'moved' to new system.)



Accessing Redesign PS&R Reports
Using CMS IACS System (cont)

- CMS allowed providers to Register in IACS system on a phased-in basis based on FYE (starting with FYE 1/31/09 providers).
- Since October 1, 2009, all FYE providers allowed to Register in new system.
- Providers need to be signed up in IACS in time to get the PS&R for cost report filing purposes. CMS has indicated that they will not be instructing the contractor to send out PS&R reports for cost reporting periods ending on or after 09/30/2010.





Accessing Redesign PS&R Reports
Using CMS IACS System (cont)

- With IACS Registration Process, Providers can make decisions on who is going to be the Security Official, User Group Administrator & End Users.
- Once Provider's primary Security Official is registered, then additional users (at provider) can be registered. (Note-consultants cannot be Registered as a Provider)
- Do you know who your Security Official?



**Accessing Redesign PS&R Reports
Using CMS IACS System (cont)**



- If having access problems, call the EUSS Helpdesk early in morning (they open at 7am): 866-484-8049, or email them at EUSSupport@cgi.com
- CMS has previously instructed the contractor to email PS&R reports to providers that have not enrolled in IACS for cost report filing purpose and not financial reporting purposes.


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**Accessing Redesign PS&R Reports
Using CMS IACS System**

Important IACS links:

- **Educational Article on new PS&R process:** <http://www.cms.gov/ContractorLearningResources/downloads/JA6519.pdf>
- **IACS portal link for Registering and changing passwords:** <https://applications.cms.hhs.gov/warning.html>
- **IACS link for entering PS&R web page to order PS&R reports (once you're registered):** <https://psr-ui.cms.hhs.gov/psr-ui/>




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**Accessing Redesign PS&R Reports
Using CMS IACS System**

Questions regarding PS&R (legacy and new Redesign system) can be directed to:

David Garland
Sr. Reimbursement Specialist
Tel: (207)-253-3312
Email: david.garland@wellpoint.com

Or, questions can be emailed to following shared mailbox:
PSR@wellpoint.com


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SSI Update




SSI – Billing Requirements for Medicare Advantage

- **Change Request 6821 was released on May 5, 2010 outlining the requirements for Hospital Attestation and Billing of Fiscal Year 2007 and 2008 Informational Only Inpatient Claims for Medicare Advantage Beneficiaries.**
- **Attestations required to be submitted by September 15, 2010.**
- **Contractor submitted results to CMS on September 29, 2010.**
- **77 % of the required Hospital Providers in J14 attested. (81% of Maine Providers Responded)**




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CMS Ruling 1498

- **CMS issued a ruling on April 28, 2010 impacting all open cost reports claiming DSH reimbursement as well as qualifying cost report appeals**



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Disproportionate Patient Percentage (DPP)

Applies to the following three issues:

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 patients Part A inpatient hospital benefits were exhausted
3. Appeals of the exclusion from the DPP of labor/delivery room inpatient days



Highlights

- The PRRB and other Medicare administrative tribunals lack jurisdiction over provider appeals for all three issues
- Tribunals are required to remand each qualifying appeals to the Medicare contractors
- To limit future appeals, CMS-1498-R also applies to any qualifying hospital reporting period not yet finally settled [open cost reports]
- No cost report can be reopened to apply this ruling



Highlights (cont)

- The XIX fraction cannot be revised to include non-covered or exhausted XVIII entitled days
- All open, jurisdictionally valid appeals will be remanded back to the MAC rendering all current appeals for the applicable issues moot
- Unitary relief will be given to all properly pending appeals using the revised data match regardless of the number of issues appealed



History

Up to 10/1/04

SSI % = Entitled to SSI & covered, entitled XVIII Pt A (+ Pt C enrolled)
Total Entitled covered XVIII Pt A (+ Pt C enrolled)

XIX % = Eligible for XIX & not entitled to XVIII Pt A
Total Provider days

Starting 10/1/2004 (FFY 2005) – term covered removed

SSI % = Entitled to SSI & Entitled to XVIII Pt A (+ Pt C enrolled) [include non-covered, exhausted, MSP] Total Entitled XVIII Pt A (+ Pt C enrolled)

XIX % = Eligible for XIX & not entitled to XVIII Pt A
Total Provider days

- Individuals must be enrolled in either XVIII Part A or Part C and a claim must have been submitted to count a day
- Once an Individual is entitled, entitlement never changes regardless if covered, exhausted or dual-eligible
- Dual Eligible is not addressed by the ruling but by definition would be included in the SSI %



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Appeals of the data matching process used in calculation the SSI fraction

• Baystate recalculated the SSI fraction for 1993 through 1996 using a data match updated to compare SSNs as well as HIC numbers and Title II numbers.

• The final IPPS rule published on August 16, 2010 for FFY 2011 calls for the Baystate method for cost reports beginning 10/1/2010 and forward as well as for cost reporting periods covered under the Ruling.



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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 patients Part A inpatient hospital benefits were exhausted

- For cost reports with discharges before 10/1/04, Contractors will resolve appeals by including the revised SSI percentage which includes days entitled to Medicare Part A days even if the stay was not covered or the benefits were exhausted in both the numerator and denominator of the SSI fraction
- The appeal/open cost report request is valid regardless of which fraction was requested but the days must only be added back to the SSI fraction



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Appeals of the exclusion from the DPP of labor/delivery room inpatient days

•Applies to cost reports beginning before 10/1/09 (FFY 2010)

•Inpatient Labor and Delivery room days will be included in either the SSI or XIX fraction as applicable regardless of the type of bed occupied prior to the census taking hour

•CMS will include L&D days who are also XVIII Part A eligible in the revised SSI data match and calculation

History Note:

- Prior to 12/91 – L&D were included if admitted at the census taking hour
- August 2003 final rule changed handling to only counting days where the patient occupied a routine bed prior to the ancillary L&D bed before the census taking hour
- FFY 2010 IPPS rule (BOA 10/1/09) changed again to include L&D inpatient days if admitted as an inpatient regardless of what type of bed was occupied



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Implementation of CMS-1498-R
One of two procedures will be used:

The Standard [Default] Implementation Procedure:

- The tribunal will determine if jurisdictional and procedural requirements are met
 - Each claim [issue] will be remanded to the MAC to recalculate DSH payment
- If the tribunal determines jurisdictional and procedural requirements are not met
 - The tribunal will issue a statement why the issue is not subject to the Ruling and will process the claim through normal processes
 - Providers may challenge the determination that an issue is not subject to the Ruling. Challenges will be reviewed under normal appeal procedures.



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Implementation of CMS-1498-R

The Alternative Implementation Procedure

- Due to the substantial number of case, single hospital appeals may submit written request to the tribunal to remand each and every specific claim to the MAC for the determination of jurisdictional and procedural review
- The above also applies to Group cases if one request is submitted for ALL providers in the group at the same time and none of the providers raise objection
- If the MAC finds the case valid, the MAC will recalculate the DSH Payment



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The Alternative Implementation Procedure

- If the MAC finds the case invalid, the MAC will issue a brief statement as to why
- If found invalid, upon written request by the provider to the tribunal, the case can then be process under normal appeal procedures
- Providers may challenge the determination that an issue is not subject to the Ruling.



Provider Responsibilities under the Alternative Method

- To invoke the alternative method, the provider must submit written request to the tribunal AND the MAC
- Jurisdictional documents must be promptly submitted to the MAC only





Provider Responsibilities under the Alternative Method
(cont.)

- Once the request is received by the tribunal, the tribunal will issue a remand order to the MAC
- The MAC may ask for additional documentation to implement the order. For Example, the MAC may need additional information to determine if the L&D room day is to be included in the SSI% or the XIX percentage. The Provider is to comply with all requests.





Mixed Appeals where some claims are , but other claims are not, subject to the Ruling

- Under this rule, only claims [issues] subject to this ruling will be remanded
- All other issues will continue to be processed under normal appeal rules

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Implementation by CMS and MACs

- SSI Data match will be revised by CMS to include non-covered (MSP), exhausted and applicable Labor Room days
- CMS will calculate a revised SSI % for the MAC to use to recalculate DSH payment
- MAC will include applicable Labor and Delivery days in the XIX fraction [numerator and denominator]

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Implementation by CMS and MACs (Cont.)

- MAC will process the appeal
- MAC will issue a revised NPR with administrative and judicial review rights
- MAC will implement CMS-1498-R with all applicable open cost reports

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Labor and Delivery Room Review

The MAC will:

- Obtain information from hospital to determine whether some or all of the days at issue are to be included in the SSI or XIX fraction
- The MAC will determine which days should be included in the XIX fraction (not eligible for XVIII Pt A) and recalculate the XIX fraction
- If the L&D days are entitled to Medicare Part A, CMS will include them in the revised data match
- Once both the SSI% and XIX fraction are revised, the MAC will recalculate the DSH payment and issue the NPR and payment



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Resolution

- SSI % are expected sometime in the first quarter of 2011 (Calendar Year)
- All audit/review work will continue to be completed. However, an NPR will not be issued until the contractor is instructed to do so by CMS. Memo adjustment recognizing this problem will be included in all 15 day letters.



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Website Address for SSI Updates

Acute IPPS:

http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage

IRF:

http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage

LTCH:

http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp



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FY 2012 Wage Index




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Objectives

- Affected Cost Reports
- CMS Timeline for FY 2012 WI Reviews
- Contract Labor
- Miscellaneous




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Acronyms Used in Slides

CMS – Centers for Medicare & Medicaid Services
MAC – Medicare Administrative Contractor
OMS – Occupational Mix Survey
PUF – Public Use Files
WI – Wage Index



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Cost Reports Affected

- Affects cost reporting periods beginning on or after 10/1/2007 through 9/30/2008 (FY 2008 Wage Data)
- If a hospital has more than one cost report that begins during this time frame, we only conduct a wage review on one of the periods
 - Select the longest period
 - If more than one period is the same length, select the latest period (ended most recently)



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Cost Reports Affected

- Includes short-term acute care hospitals paid under Inpatient PPS
- Excludes hospitals designated as Critical Access Hospitals (CAH), even if the hospital was paid under IPPS during the FY 2008 wage data period



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CMS Timeline for WI Reviews

October 4th, 2010

- CMS released the 2 preliminary FY 2012 wage index files
 - 1st file is for unaudited W/S S-3 wage data file (FY 2008 wage data)
 - 2nd file is for 2007-2008 OMS data
- Hospitals were notified that the preliminary files are available and that the deadline to request revisions must be received by the intermediary before or on December 6th, 2010.



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CMS Timeline for WI Reviews

December 6th, 2010

- **Deadline for hospitals to submit request revisions to their W/S S-3 data and OMS. Email submissions to Douglas.Fong@wellpoint.com are preferred.**
- **Address for hard copy submissions:**
Douglas Fong
Mailstop: NH0104-E010
NHIC, Corp.
c/o National Government Services
P.O. Box 4900
Syracuse, NY 13221-4900
**For Overnight
Please refer to
Slide 34 & 35**
- **Providers are encouraged to inform the contractor via email indicating there are "NO" revision request.**



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CMS Timeline for WI Reviews

December 6th, 2010 (cont.)

- **MAC must receive the requests and supporting documentation by this date. All supporting data must be included in submission**
- **MACs have just over 9 weeks to complete the reviews**



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CMS Timeline for WI Reviews

February 9th, 2011

- **MACs must have all desk reviews completed, including OMS revisions**

February 14th, 2011

- **MACs must notify state hospital associations regarding hospitals that did not respond to issues reviewed during the WI reviews**



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CMS Timeline for WI Reviews

February 21st, 2011

- CMS will release the revised Public Use Files (PUFs) on their website
- CMS will also make available a file that includes each urban and rural area's average hourly wages for FY 2011 (Final) and FY 2012 (Preliminary)



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CMS Timeline for WI Reviews

March 7th, 2011

- **Deadline for hospitals to submit requests (including supporting documentation) for one of the following**
 - Corrections to errors in the February PUFs due to CMS or MAC mishandling, or
 - Revisions of desk review adjustments to their wage data included in the February PUFs
- **MACs must receive requests AND supporting documentation by this date**
- **NO NEW requests for WI or OMS revisions will be accepted**



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CMS Timeline for WI Reviews

April/May 2011

- Hospital IPPS Proposed Rule will be published and will include revised wage index data per the February PUF (may or may not include "second round" revisions)

April 13th, 2011

- MACs must also send written (email) notifications to hospitals addressing how the revisions received by March 7, 2011 were addressed



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CMS Timeline for WI Reviews

April 20th, 2011

- Deadline for hospitals to appeal MAC determinations and request that CMS intervene
- Requests must be submitted to CMS with a copy to MAC
- Request must include all correspondence between hospital and MAC to document the hospital's attempt to resolve the dispute



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CMS Timeline for WI Reviews

Late April 2011

- Notice from CMS to MAC that the final FY 2012 WI PUFs will be released on May 6, 2011 and that hospitals will have until June 6, 2011 to request corrections
- MACs then forward this notice to hospitals that they service

May 6th, 2011

- Release of final FY 2012 WI & OMS PUFs on CMS Website



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CMS Timeline for WI Reviews

June 6th, 2011

- Deadline for hospitals to submit correction requests to both CMS & MAC
- Data that was incorrect per the October or February PUFs, but no correction request was filed, will not be changed at this point in the process
- MAC must review each request and determine if the request qualifies for correction



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CMS Timeline for WI Reviews

August 1st, 2011

- Approximate release of the Hospital IPPS FY 2012 Final Rule, which includes Final Wage Index Corrections

October 1st, 2011

- Effective date of FY 2012 Wage Index



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Contract Labor

- If Contract Labor (various lines of W/S S-3, part II) has exceeded thresholds and sampling will be used, a listing of all costs and hours for each W/S S-3, Part II, line under review will need to be obtained from providers
- CMS has been adamant over the past few years that we obtain "source" documents to verify contract labor, not "supporting" documents
 - Source – Contracts and/or invoices
 - Supporting – Spreadsheets or other analysis compiled by the provider



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Miscellaneous

- A representation letter must be submitted to allow us to correspond with any consultants during the process
 - Signed by appropriate hospital representative
 - On hospital letterhead
- Update contact information should be submitted for provider contact and email addresses to ensure we are corresponding with the appropriate staff member
- Original submissions are addressed to Douglas Fong but all subsequent questions/correspondence should go to the auditor assigned the wage index review
- A team of 6 Auditors will be completing the reviews for J14.




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Maine Crossover Bad Debts
Background

- January 20, 2005 - State of Maine brought a new claims processing system on line. The State has been unable to produce an approved "No Pay" remittance advice that properly identifies QMB (Qualified Medicare Beneficiary) claims.
- A "No Pay" remittance advice is required per PRM II § 310 – Criteria for Allowable Bad Debt – "The provider must be able to establish that reasonable collection efforts were made."
- Must Bill Policy - In order to fulfill the requirement that a provider make a "reasonable" collection effort with respect to the deductibles and co-insurance amounts owed by dual-eligible patients, CMS' bad debt policy requires the provider to bill the patient or entity legally responsible (the State) for the patient's bill before the provider can be reimbursed for uncollectible amounts.


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Solution

- CMS has entered into an agreement with the State of Maine as a workaround with the following criteria:
 - The state will provide a crossover bad list to NHIC for hospital in the state by FYE.
 - The list must separately identify QMB claims which are not allowable bad debts.
 - The list must be signed and certified by a state official.
 - Prior to 1/20/05, hospitals are required to supply the data.


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Current Status

- A majority of the 2005 Cost reports have been reviewed.
- All Critical Access Hospital cost reports have been reviewed and an NPR has been issued.
- PPS Hospitals claiming DSH reimbursement have been placed back on hold due to the 1498 Ruling.
- The 2006 Listings are being tested. A settlement plan will be developed with a focus on CAH providers.
- All Maine Bad Debt reviews that have been placed on hold due to the SSI problem will be settled in Fiscal Year End order.





Quick Hits



Electronic Health Record (EHR) Incentive Payments

- 2 types of hospitals are eligible for Health Information Technology for Economics and Clinical Health Act (HITECH Act) payments, Subsection (d) Hospitals, which are acute care hospitals located in the fifty States and District of Columbia, and Critical Access Hospitals (CAHs)
- May receive incentive payments for up to four years, beginning in federal fiscal year 2011 (starting October 1, 2010), provided they meet the requirements for demonstrating meaningful use of EHR
- The initial payment will be calculated based on the data reported on the hospital's latest submitted cost report
- Initial Payments are expected in the Spring of 2011.
- The "New" cost report, CMS 2552-10, will include specific fields related to the EHR payments. In addition, Worksheet S-10 will need to be revised to capture charity care appropriately.



Freedom of Information Request (FOIA)

Please use the contact information below for all FOIA requests:

Address: NHIC, Corp.
Attn: Freedom of Information Act
43 Landry Street
Biddeford, ME 04005



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Electronic Workpapers

• Audit & Reimbursement is currently transitioning to an electronic audit file system called TeamMate. The system will allow Audit & Reimbursement to move into a paperless environment. Any desk review or audits started in Option Year 2 will utilize this system.

• Auditors will be requesting all documentation (listings in particular) be submitted in electronic format in the future. Much more information will be disseminated electronically via email.

• A system called SecureZip is currently being used by the audit staff to send encrypted information via email. Instructions on downloading free software are attached to the emails containing PHI. (Passwords are sent separately.)



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Types of Evidence

As Medicare Auditors we are responsible for collecting sufficient and competent evidential data as a basis for drawing conclusions about the Medicare cost report.

Categories of evidence include:

• Physical Evidence

This is obtained from direct observation or inspection of property, equipment, inventory, cash, activities, or events.

• Documentary Evidence

This type of evidence is the most commonly used and referred to by an auditor. It is created information such as letters, contracts, accounting records, invoices, checks, interns' and residents' rotation schedules, etc.



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Types of Evidence (cont.)

• **Analytical Evidence.**

This is developed by the auditor through calculations, analysis, comparisons, and reasoning. It can be used to test the provider's calculations, account breakdowns, statistics, and allocations.

• **Testimonial Evidence**



This is the least reliable type of evidence. It is obtained from others, both inside and outside the provider's organization, through responses to inquiries and interviews. (By itself, this category of evidence is unacceptable for Medicare purposes.)


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PHI - PII



Transmitting Protected Health Information (PHI)/Protected Individual Information (PII)

- PHI/PII examples include but are not limited to:
 - Name
 - Social security Number
 - Birth date
 - Address
 - Health Insurance Number
 - Medical History
 - Medical claim Information
 - Provider/Facility Information
 - IRIS Information


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Protecting PHI - PII



- CMS does not allow the transmittal of PHI /PII over the Internet unless the information is password protected and encrypted
 - If the information cannot be protected and encrypted, it is acceptable to transmit PHI information through the mail or over a fax machine
- We encourage you to submit as much supporting documentation as possible in electronic format (on diskette or CD)
- The CD / File should be password protected


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Option Year 2 Audits

Audits:



- NHIC will be performing 11 in-house audits and 10 field audits during Option Year 2 (November 14, 2010 through November 13, 2011). Audit staff will be contacting selected facilities within the next several months.
 - 3 - Maine
 - 11 - Massachusetts
 - 2 - New Hampshire
 - 3 - Vermont
 - 2 - Rhode Island
- Rules and time frames are the same for both in house and field audits


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MSP Audits



MSP Audits:

- 32 MSP Audits have been selected for review.
 - 8 - Maine
 - 13 - Massachusetts
 - 4 - New Hampshire
 - 4 - Vermont
 - 3 - Rhode Island
- Reviews are expected to be completed throughout Option Year 2 (November 14, 2010 through November 13, 2011)


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Questions..... and thank you




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Other Contacts

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