Medicare Updates
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Hospital IPPS FY 2016 and Proposed FY 2017 Legislative and Regulatory Policy Update

FY 2016 and FY 2017 Final and Proposed IPPS Rules

A. FY16 Final Rule issued on July 31, 2015
   (print Aug. 17, 2015)
B. FY 17 Proposed Rule issued April 18, 2016
   (print April 27, 2016)
C. Highlights covered today:
   1. Inpatient payment update
   2. ATRA adjustment/MACRA restoration
   3. Two-midnight payment adjustment
   4. Hospital dependent adjustments
   5. Outlier threshold
   6. Disproportionate Share (DSH) and UC-DSH
   7. Payment consequences of quality metrics
Basic IPPS Rates for 2016 and Proposed for 2017

<table>
<thead>
<tr>
<th>FY 2016 Final IPPS Rule</th>
<th>FY 2017 Proposed IPPS Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket</td>
<td>2.4%</td>
</tr>
<tr>
<td>ACA Reduction</td>
<td>-0.2% 2.8%</td>
</tr>
<tr>
<td>Productivity</td>
<td>-0.5% 0.5%</td>
</tr>
<tr>
<td>Modified Applicable Percent Increase</td>
<td>1.5% 1.5%</td>
</tr>
<tr>
<td>ACA Reduction (additive)</td>
<td>-0.8% -1.5%</td>
</tr>
<tr>
<td>Two-Midnight Adjustment</td>
<td>continues 0.8% (and 0.2% permanent)</td>
</tr>
<tr>
<td>Total General Adjustment</td>
<td>0.9% 0.85%</td>
</tr>
</tbody>
</table>

Note: This update does not include hospital-specific payment changes due to readmissions, value-based purchasing, hospital-acquired conditions, meaningful use, etc.

Market Basket Updates

1. Latest market basket updates can be found on CMS website
2. CMS rebases the market basket and labor share every four years; last rebased for FY 2014
3. FY 2016 final rule uses an update of 2.4 percent
4. FY 2017 update currently projected to be 2.8 percent (subject to change in final rule)
5. Quality reporting and meaningful use reductions to market basket rate will be discussed later

ACA Productivity Cuts

1. Applies beginning in FY 2012
2. 10-year moving average of changes in annual non-farm productivity, as determined by the Secretary
3. Can result in a market basket increase of less than zero
4. Payments in a current year may be less than the prior year
5. Applies to other provider types

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Cut</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>-1%</td>
</tr>
<tr>
<td>2013</td>
<td>-0.7%</td>
</tr>
<tr>
<td>2014</td>
<td>-0.5%</td>
</tr>
<tr>
<td>2015</td>
<td>-0.5%</td>
</tr>
<tr>
<td>2016</td>
<td>-0.5%</td>
</tr>
<tr>
<td>2017</td>
<td>-0.5%</td>
</tr>
</tbody>
</table>

*subject to change
Additional ACA-Mandated Reduction

- Market basket adjustment for FYs 2012 – 2019
- Similar, if not identical, market basket adjustments apply for long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospital services

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Cut</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>1%</td>
</tr>
<tr>
<td>2013</td>
<td>1%</td>
</tr>
<tr>
<td>2014</td>
<td>3%</td>
</tr>
<tr>
<td>2015</td>
<td>2%</td>
</tr>
<tr>
<td>2016</td>
<td>2%</td>
</tr>
<tr>
<td>2017</td>
<td>5.5%</td>
</tr>
<tr>
<td>2018</td>
<td>7.5%</td>
</tr>
<tr>
<td>2019</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

ATRA Recoupment and MACRA Restoration

A. ATRA imposes an aggregate estimated $11 billion recoupment of asserted coding overpayments in FYs 2010 – 2012
   1. Recoupment to take place over four years (FYs 2014 – 2017)
   2. Secretary has discretion on timing and level of the recoupment
   3. Adjustments are to be based on estimated discharges
   4. CMS has used a level 0.8% reduction per year for FYs 2014 – 2016
   5. CMS proposes a -1.5% adjustment to complete the recoupment in FY 2017

B. MACRA Restoration
   1. To generate a saving to pay for the physician SGR fix, Congress prohibited CMS from restoring the aggregate ATRA adjustment to the IPPS rate in FY 2018.
   2. Congress, anticipating a 3.2% ATRA adjustment, only allows CMS to ramp up the IPPS rate by 0.5% per year between 2018 and 2023 to restore part of the adjustment.
   3. Unfortunately, CMS is now proposing an aggregate -3.9% ATRA adjustment, potentially leaving -0.9% permanent.
Two-Midnight Policy and Payment Reduction

A. Original two-midnight policy FYs 2014 and 2015

1. CMS will generally consider hospital admissions spanning two midnights as appropriate for inpatient Part A payment
2. In contrast, hospital stays of fewer than two midnights will generally be considered outpatient cases, regardless of clinical severity
3. CMS imposed a -0.2% payment reduction under the assumption the policy will increase claims inpatient stays

B. Modifications to the two-midnight policy CY 2016

1. CY 2016 outpatient PPS final rule
2. Stays of fewer than two midnights may be appropriate for inpatient admission based on “the clinical judgement of the admitting physician and medical record support for that determination.”

C. Litigation update

1. District Court orders CMS to publish explanation of assumption that inpatient stays would increase under policy and to consider comments in response thereto;
2. As part of FY 2017 IPPS proposed CMS, CMS proposes to withdraw - 0.2% adjustment and restore prior period adjustments by providing additional increase of 0.8% in FY 2017, 0.2% of which would become permanent.

Hospital-Dependent Adjustments Proposed for FY 2017

<table>
<thead>
<tr>
<th>FY 2017</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital Submitted Quality Data and is a Meaningful EHR User</td>
<td>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</td>
</tr>
<tr>
<td></td>
<td>Market Basket Rate of Increase</td>
<td>-2.8</td>
</tr>
<tr>
<td></td>
<td>Adjustment for Failure to Submit Quality Data</td>
<td>-0.0</td>
</tr>
<tr>
<td></td>
<td>Adjustment for Failure to be a Meaningful EHR User</td>
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</tr>
<tr>
<td></td>
<td>MFP Adjustment</td>
<td>-0.1</td>
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<tr>
<td></td>
<td>Inpatient Adjustment (Section 1860(d)(3)(F)(iii))</td>
<td>-0.75</td>
</tr>
<tr>
<td></td>
<td>Proposed Applicable Percentage Increase Applied to Inpatient</td>
<td>1.05</td>
</tr>
</tbody>
</table>
Outlier Payment Adjustment

A. FY 2016
1. CMS proposed a $24,485 threshold for FY 2016 (as compared to $24,758 in FY 2015 and $21,748 in FY 2014)
2. CMS finalized a much lower threshold of $22,544 for FY 2016
3. Attributes change between the FY 2016 proposed and final rule to lower measured charge inflation from updated claims data
4. CMS indicates that actual outlier payments for FY 2013 equaled 4.86% of MS-DRG payments, and estimates that FY 2014 will equal 5.38% of MS-DRG payments (as compared to the 5.1% target and payment reduction). CMS now estimates FY 2015 outlier payments at 4.68% of MS-DRG payments

Outlier Payment Adjustment (cont.)

B. FY 2017
1. CMS proposes a $23,681 threshold for FY 2017
2. With updated claims data, we expect the actual threshold for FY 2017 to be set about 5% lower than the proposed
3. CMS now estimates FY 2016 outlier payments at 5.3% of MS-DRG payments

DSH and UC-DSH Payment Policy

- ACA changed Medicare DSH payments starting in FY 2014
  - Statute appears as new 42 U.S.C. § 1395ww(r)
  - CMS adds new 42 C.F.R. § 412.106(f)-(h) effective with discharges on and after 10/1/13
  - 25% of funds using "old" formula method
  - 75% uncompensated care payments

- Total uncompensated care payments reduced as uninsured declines; payments based on uncompensated care each DSH hospital provides
UC – DSH Basics

- Affected Hospitals
  - 2,440 hospitals, including Puerto Rico
  - Excluding Maryland and CAHs
  - Sole Community Hospitals – consider all DSH when assessing eligibility for a hospital specific rate

UC – DSH Basics (cont.)

- Total Uncompensated Care payments subject to three factors:
  - Determine aggregate Uncompensated Care payments at 75% of estimated traditional DSH
  - Reduce aggregate Uncompensated Care payments by improvement in insured rates + an additional statutory factor (0.2 percentage points for FYs 2016 and 2017)
  - Distribute Uncompensated Care payments based on ratio of an individual hospital’s Medicaid and SSI days to all DSH hospitals Medicaid and SSI days at least through FY 2017 and proposed three-year blended transition to use of hospital uncompensated care costs from W/S S-10 and the prior ratio beginning in FY 2018

UC – DSH Factor One Calculation

Factor One

A. Initial size of the 75% aggregate uncompensated care payments
B. Difference between CMS estimates of
   1. The amount of DSH payments that would be made to all hospitals in the absence of the ACA payment provision; and
   2. The amount of the empirically justified Medicare DSH payments actually made in that year
C. 75% of DSH payments that would be made to all hospitals in the absence of the ACA payment provision
D. Set prospectively
E. FY 2016 Factor One amount is $10.058 billion
   1. $10.037 billion in FY 2015
   2. $9.579 billion in FY 2014
F. Proposed FY 2017 Factor One amount is $10.671 billion
Factor Two Calculation for Final FY 2016

A. Change in the percentage of uninsured from 2013 baseline of 18%

B. Congressional Budget Office (CBO) data
   1. March 2015 estimate of the effects of the ACA on health insurance coverage – estimate of individuals under the age of 65 with insurance in CY 2015 is 87% (rate of uninsurance is 13%)
   2. Estimate of individuals under the age of 65 with insurance in CY 2016 is 89% (rate of uninsurance is 11 percent)
   3. These figures are then weighted to determine the rate of uninsurance for FY 2016
   4. Percent change from 2013 uninsurance rate minus an additional statutory factor (0.2 percentage points or .002)
   5. FY 2016 Factor Two is equal to 0.6369

Factor Two Calculation for Final FY 2016 (cont.)

C. As a result, CMS retains 63.69% – or $6.406 billion – of the original aggregate uncompensated care payments (75%) in FY 2016

D. This amounts to a reduction of approximately $1.2 billion in Medicare DSH payments in FY 2016 compared to FY 2015

Factor Two Calculation for Proposed FY 2017

A. Change in the percentage of uninsured from 2013 baseline of 18%

B. Congressional Budget Office (CBO) data
   1. Estimate of individuals under the age of 65 with insurance in CY 2016 is 89% (rate of uninsurance is 11%)
   2. Estimate of individuals under the age of 65 with insurance in CY 2017 is 90% (rate of uninsurance is 10%)
   3. These figures are then weighted to determine the rate of uninsurance for FY 2017
   4. Percent change from 2013 uninsurance rate minus an additional statutory factor (0.2 percentage points or .002)
   5. Proposed FY 2017 Factor Two is equal to 0.5674
Factor Two Calculation for Proposed FY 2017 (cont.)

C. As a result, CMS retains 56.74% – or $6.054 billion – of the original aggregate uncompensated care payments (75%) in FY 2017.

D. This amounts to a reduction of approximately $350 million in Medicare DSH payments in FY 2017 compared to FY 2016.

Factor Three Calculation for FYs 2016 and 2017

A. Premised on hospitals’ uncompensated care costs

B. Allocates Factor Two pool based on relative uncompensated care costs

C. Proportion of each hospital’s measure to aggregate hospitals’ total measure for all DSH eligible hospitals:
   1. CMS continues to use inpatient days of Medicaid beneficiaries plus inpatient days of Medicare supplemental security income (Medicare SSI) beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides.

Factor Three Calculation for FYs 2016 and 2017 (cont.)

2. For FY 2016, CMS uses March 2015 update of the 2011/2012 Medicare cost reports for the Medicaid days and the FY 2013 SSI ratios for the Medicare SSI days.

3. For proposed FY 2017, CMS indicates it will use three-year average for Medicaid and Medicare with SSI days (Puerto Rico hospitals would receive a proxy for this factor) from March 2015 update and the FY 2014 SSI ratios for the Medicare SSI days.

4. CMS has published on its website, a table listing Factor Three for all IPPS hospitals it estimates would receive uncompensated care payments.
Proposed FY 2018 Factor Three Methodology – Moving to W/S S-10

A. CMS proposes to begin using W/S S-10 data in FY 2018, as a transition to full use of such data by FY 2020

1. For FY 2018, CMS would calculate Factor Three based on an average of Factor Three calculated using low-income insured days (proxy data) determined using Medicaid days from FY 2012 and FY 2013 cost reports and FY 2014 and FY 2015 SSI ratios, and Factor Three calculated using uncompensated care data based on FY 2014 Worksheet S-10

2. For FY 2019, CMS would calculate Factor Three based on an average of Factor Three calculated using low-income insured days (proxy data) determined using Medicaid days from the FY 2013 cost report and the FY 2015 SSI ratios, and Factor Three calculated using uncompensated care data based Worksheet S-10 from FYs 2014 and 2015 cost reports

3. For FY 2020, CMS would calculate Factor Three using uncompensated care data based on Worksheet S-10 data from FYs 2014, 2015 and 2016 cost reports

4. After 2020, CMS would advance the three-year time period by one year to determine the cost reports used

5. Data is still unaudited and CMS has only proposed one concrete edit of the data, a double trim of hospital CCRs that exceed by three standard deviations the mean CCR, and the assignment of a statewide average CCR to such hospitals. 27 hospitals would be subject to the as-proposed trims
B. For FY 2018, the computation of the average for each hospital would work in the following way:

1. Step 1: Calculate Factor Three using the low-income insured days proxy based on FY 2012 cost report data and the FY 2014 SSI ratio;
2. Step 2: Calculate Factor Three using the insured low-income days proxy based on FY 2013 cost report data and the FY 2015 SSI ratio;
3. Step 3: Calculate Factor Three based on the FY 2014 Worksheet S-10 data; and
4. Step 4: Average the Factor Three values that are computed in Steps 1, 2, and 3; that is, adding the Factor Three values from FY 2012, FY 2013 and FY 2014 for each hospital, and dividing that amount by the number of cost reporting periods with data to compute an average Factor Three.

C. Definition of “uncompensated care” for FY 2018 and after:

1. “Uncompensated care” is defined as the amount on line 30 of W/S S-10 and combines the cost of charity care with the cost of non-Medicare bad debt
2. Cost of charity care is the cost of initial obligation of patients approved for charity care (line 21) less partial payment by patients approved for charity care (line 22)
3. Cost of non-Medicare bad debt expense is a cost-to-charge ratio (line 1) times non-Medicare or non-reimbursable bad debt expense (line 28)
Proposed FY 2018 Factor Three Methodology – Moving to W/S S-10 (cont.)

4. CMS proposes to exclude Medicaid shortfalls reported on Worksheet S-10 from the definition of uncompensated care for purposes of calculating Factor Three.

5. CMS would also exclude discounts for the uninsured that are not means tested, even though the statute in question, ACA section 3133, applies to the uncompensated care costs of the uninsured and does not refer to charity care.

Proposed FY 2018 Factor Three Methodology – Moving to W/S S-10 (cont.)

D. Timing of reporting charity care and non-Medicare bad debt:

1. CMS intends to revise the current Worksheet S-10 cost report instructions for line 20 concerning the timing of reporting charity care, such that charity care will be reported based on date of write-off, and not based on date of service.

2. This is consistent with charity write-offs that hospitals report in accordance with GAAP.

3. Hospitals currently report non-Medicare bad debt without regard when the services were provided.

4. The current instructions specify that charity care provided (not necessarily written off) during the period should be recorded on line 20 (See CMS Pub. 15-2, Chapter 40, Section 4012).

California DSH Breakout

Estimated Impacts of OBRA Proposals Related to Distribution of the DSH Uncompensated Care Pool

<table>
<thead>
<tr>
<th>Methodology</th>
<th>FY 2015 DSH Pool - Prior to Proposals</th>
<th>FY 2015 DSH Pool - After Proposals</th>
<th>Impact ($M)</th>
<th>Impact (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2016 DSH Pool Current Cost Distribution</td>
<td>$1,564,020,000</td>
<td>$1,564,020,000</td>
<td>$0</td>
<td>0.00%</td>
</tr>
<tr>
<td>FY 2016 DSH Pool Current Cost Distribution - 1% Increase</td>
<td>$1,564,020,000</td>
<td>$1,564,020,000</td>
<td>$0</td>
<td>0.00%</td>
</tr>
<tr>
<td>FY 2016 DSH Pool Current Cost Distribution - 2% Increase</td>
<td>$1,564,020,000</td>
<td>$1,564,020,000</td>
<td>$0</td>
<td>0.00%</td>
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<tr>
<td>FY 2016 DSH Pool Current Cost Distribution - 3% Increase</td>
<td>$1,564,020,000</td>
<td>$1,564,020,000</td>
<td>$0</td>
<td>0.00%</td>
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</table>

*California DSH Breakout is based on the distribution methodology used in the prior year. The table reflects the impact of the proposed changes on the distribution to DSH hospitals.
Problems with the Reliable Use of W/S S-10

• Many errors obvious in filed S-10 data that strongly suggest data is unreliable as a basis to determine relative share of uncompensated care costs
  o Many hospitals did not report S-10 data at all, about 5%
  o 14% had no total bad debt data, but 90% of that group reported Medicare bad debt data
  o Some had a CCR of 1, many had CCRs above 6, a few had more gross charges on S-10 than on C

Problems with the Reliable Use of W/S S-10 (cont.)

• Definitional problems
  o Uninsured vs. charity – non-means tested uninsured discounts, or discounted care that is not charity care likely not included in charity
  o Charity must be determined during the cost reporting period
  o Medicaid and indigent programs’ non-covered charges must be addressed in charity policy or excluded
  o Non-Medicaid government indigent care program patients likely should be excluded

Problems with the Reliable Use of W/S S-10 (cont.)

• Converting charges to costs
  o Problem particularly acute with bad debt
  o Hospitals may be grossing up charges to address copayment shortfalls – should a hospital be allowed to claim a cost for a copayment that exceeds the actual copayment obligation? If the answer is yes, how do you standardize how that cost will be measured?
Payment Formula for Value-Based Purchasing and Readmissions

What is the “base operating DRG amount” subject to reduction?

- No changes to the penalty formula in FY 2016 or 2017
- Excludes Indirect Medical Education (IME), DSH, outliers, low-volume adjustment, and additional payments made due to status as a Sole Community Hospital (SCH), but
- Includes new technology payments, and will be,
- Adjusted to account for transfer cases, and then equals,
- \[ \text{((Labor Share} \times \text{Wage Index}) + (\text{Non Labor Share} \times \text{COLA}) \times \text{DRG Weight}) + \text{New Technology Add On Payment}) \times (\text{Adjustment Factor-1}) \]

Hospital Value-Based Purchasing Program

- ACA-mandated; applies to discharges on and after 10/1/2012
- Funded through base operating DRG reductions: 1% in FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016 and 2% for FY 2017 and thereafter
- Budget neutral – all funds withheld are redistributed as incentive payments to applicable hospitals
- The available pool for FY 2016 was estimated to be $1.5 billion and increases to $1.7 billion for FY 2017

Hospital Value-Based Purchasing Program (cont.)

- Other details
  - New measures and modifications are addressed in a different CHA program following this one
  - CMS is proposing to change the exclusion from VBP for hospitals cited for immediate jeopardy. CMS would increase from two to three the number of surveys for which a hospital must be cited for immediate jeopardy before its exclusion from the VBP Program. A hospital must be cited on Form CMS-2567, Statement of Deficiencies and Plan of Correction, for immediate jeopardy on at least three surveys during the performance period in order to meet the standard for exclusion from the VBP Program.
Hospital Readmissions Reduction Program (HRRP)

- ACA-mandated and assesses penalties on hospitals for having “excess” readmission rates when compared to expected rates
- Maximum penalty topped out at 3.0% of Medicare base operating payments in FY 2015, and remains at 3.0% in FY 2016 and thereafter
- CHA addresses substantive changes to measures in a subsequent session
- Congress is considering legislation to require CMS to consider socioeconomic demographic data in the risk adjustment

Hospital Readmissions Reduction Program (cont.)

Data from HRRP – Three-Year Phase-In

<table>
<thead>
<tr>
<th>Year</th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average readmission rate (per 1,000 admissions)</td>
<td>Heart attack</td>
<td>Heart attack</td>
<td>Heart attack</td>
</tr>
<tr>
<td>Average hospital rate (per 1,000 admissions)</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Percent of hospitals penalized</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Average penalty (per hospital)</td>
<td>$30,000</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

Economic Report of the President 2014

Medicare 30-Day, All-Cause Hospital Readmission Rate, 2007–2013

Note: Data are monthly hospital performance data. The United States has operated in a deficit in each of the last 10 years, with the nation’s debt exceeding $17 trillion in 2013.
HAC Reduction Program

A. Hospital-Acquired Condition Reduction Program (HACRP) is an ACA-mandated program that imposes a 1% reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates.

B. Therefore, for discharges on and after Oct. 1, 2014, hospitals in the top quartile of risk-adjusted HAC measures receive only 99% of total PPS payments.

C. Adjustment is applied after VBP and HRRP adjustments.

D. CHA will cover changes to the HAC measures in a subsequent session.

Impact of Medicare Access and CHIP Reauthorization Act on Inpatient PPS


The 60-Day Report and Return Final Rule for Medicare Parts A and B: Analysis and Practical Considerations
Disclaimer

The views expressed in these slides and in the seminar presentation are the personal views of the author and do not represent the formal positions of Hooper, Lundy & Bookman, P.C., any other individual attorneys at that firm, or any of its clients.

Topics Covered

• Identification of overpayments and “reasonable diligence” during investigations
• The six-month “benchmark” to complete investigations of potential overpayments and make refunds to Medicare
• The six-year lookback period and the CMS position on using underpayments to offset identified overpayments

Topics Covered (cont.)

• The requirement to be “proactive” with compliance activities
• Cost report issues
• Report and return mechanics
• Waiver of liability, reopening, and appeals
• Implication of Stark self-disclosures
• Open questions for Medicaid overpayments
Final Rule – Major Takeaways

• Final Rule is a mixed bag for providers – provides guidance to mitigate risk, but perpetuates uncertainty by relying on several vague terms
• The overpayment refund buck stops with providers – even if they did not cause the overpayment
• Need to operationalize the overpayment investigation and refund process – now more guidance
• “Throwaway” sentences in Preamble important

Final Rule for Medicare Part A/B Overpayments

• Published in Federal Register on February 12, 2016 (81 Fed. Reg. 3564)
• Effective March 14, 2016
  ○ Statutory obligations effective March 23, 2010
  ○ Reports and returns made before March 14, 2016 require “good faith” compliance with statute
• Applies only to Medicare Parts A and B
• Less than one page of new regulations
• 29 pages of explanations

Overpayment

• “Any funds a person has received or retained under Title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.”
• Includes overpayments not caused by provider, such a MAC edit problem paying for non-covered services
• No offset for underpayments
Examples

- Medicare payments for non-covered services
- Medicare payments in excess of the allowable amount for an identified covered service
- Errors and non-reimbursable expenditures in cost reports
- Duplicate payments
- Receipt of Medicare primary payment when another payer had the primary responsibility for payment
- Insufficient documentation
- Lack of medical necessity

Deadline For Reporting and Returning

Later of:

- 60 days after the date on which the overpayment was “identified”
- Date “any corresponding cost report is due”

Suspension of Deadline

Deadline is suspended if:

- OIG acknowledges receipt of submission to the OIG Self-Disclosure Protocol (SDP) or, CMS acknowledges receipt of submission to the Self-Referral Disclosure Protocol (SRDP), until settled, disclosing party withdraws, disclosing party removed from Protocol
- If withdraw or are terminated from SDP or SRDP have balance of 60 days to report and return identified overpayment
- Disclosures to DOJ or Medicaid Fraud Control Units (MFCU) do not suspend the deadline
- Person requests a repayment plan until request rejected or person fails to comply with plan (suspends return, but not report, deadline)
- Also worth noting – credit balances and probe samples
Identified an Overpayment

• “A person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.”

• Overpayment is identified “if the person fails to exercise reasonable diligence and the person in fact received an overpayment.”

• Note overpayment in Final Rule not identified until quantified or should have been quantified with reasonable diligence.

Reasonable Diligence

• “ ‘Reasonable diligence’ includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayment and investigation conducted in good faith in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.”

• “We believe that compliance with the statutory obligation to report and return received overpayments requires both proactive and reactive compliance.”

Proactive Compliance

• “We advise those providers and suppliers (that do not have active compliance programs) to undertake such efforts to ensure they fulfill their obligations under section 1128J(d) of the Act.”

• “We believe that undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier’s Medicare claims would expose a provider or supplier to liability under the identified standard articulated in this rule…”
Proactive Compliance (cont.)

Raises troubling questions:

• Standard is unreasonably vague in light of risk of possible CMPs, program exclusion, and FCA liability
• Unclear what a provider must do to comply
• If a provider does not, but arguably could have, discovered an overpayment by being “proactive” has the provider identified the overpayment?
• If so, when does the 60-day deadline commence?
• Will this lead to challenges to the adequacy of providers’ compliance efforts?

Credible Information

• “Information that supports a reasonable belief that an overpayment may have been received.”
• Appears to endorse examples from proposed rule
   - Hotline complaint that qualifies as credible information (i.e., not all hotline complaints)
   - Provider reviews records and learns it incorrectly coded services resulting in increased reimbursement

Credible Information (cont.)

• Provider learns patient death occurred prior to the service date on a claim submitted for payment
• Internal audit reveals overpayments
• Informed by a government agency of an audit that discovered a potential overpayment
• Provider experiences significant increase in Medicare revenue for no apparent reason
• Adds, learning that profits from a practice were unusually high in relation to hours worked or relative value units (RVUs)
Credible Information (cont.)

• Increase in Medicare revenue could be credible information of overpayment
• Rejects comment that a lab or other provider that does not order tests or services must investigate when Medicare volume goes up
• What does the lab investigate under these circumstances?

Liability

• Liability arises only if there is actually an overpayment
• Failure to exercise reasonable diligence does not create liability unless there is an overpayment
• Risky to rely on non-existence of overpayment and ignore credible information of potential overpayment

Six Month Guideline

• Reasonable diligence demonstrated “through the timely, good faith investigation of credible information”
• At most six months from receipt of the credible information “except in extraordinary circumstances”
• Total of eight months, six months to investigate, 60 days to report and return, but must act with reasonable speed
Extraordinary Circumstances

- Fact specific, appears narrow
- Unusually complex investigations that provider reasonably anticipates will require more than six months to investigate
- Example is Stark violation reported under the SRDP
- Other examples include natural disasters or state of emergency
- Perhaps investigation requiring review of numerous medical records?

Who Must Receive Credible Information

- CMS rejects comment that a senior official in the organization must receive the credible information to give rise to reasonable diligence obligation
- “Organizations are responsible for the activities of their employees agents at all levels.”
- So, when does six months begin?
- Perhaps emphasize to employees importance of promptly reporting overpayments internally

60-Day Period

60-day period begins:

- If provider receives credible information that an overpayment may exist, and exercises reasonable diligence to determine if there is an overpayment, 60-day period begins when reasonable diligence completed, BUT
- If provider receives credible information that an overpayment may exist, and fails to exercise reasonable diligence to determine if there is an overpayment, the 60-day period begins when provider received the credible information
Quantification

• Identification includes quantifying the amount of the overpayment
• 60 days does not begin until overpayment is quantified or should have been quantified upon exercise of reasonable diligence
• CMS declined to adopt a minimum materiality threshold
• Limited references to beneficiaries

Medicare Enrollment

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• Enrollment Revalidation
• Proposed Medicare Enrollment Regulations
Revalidation

- Suppliers and providers must revalidate enrollment information
  - Every three years for DMEPOS suppliers
  - Every five years for all others
- Deadlines posted at: data.CMS.gov/revalidation, generally six months in advance
- MAC generally will notify provider/supplier about two to three months before deadline
- Due dates not yet established listed as “TBD”
- DME/POS suppliers deadlines not posted, will be contacted by NSC

Revalidation (cont.)

- Revalidate all active practice locations
- Revalidate all current reassignments
- Can submit through PECOS or the appropriate CMS-855 form
- Failure to submit revalidation timely:
  - Possible hold on Medicare payments
  - Deactivation of Medicare billing privileges
  - May have to submit complete new enrollment application, not retroactive
  - So, submit early, but within six months of deadline to avoid problems

Medicare and Medicaid Enrollment (Proposed Rule)

- 81 Fed. Reg. 10720 (March 1, 2016)
- Implements sections of the Affordable Care Act that require certain disclosures of applicants and providers
- Proposes changes to regulations in 42 C.F.R. Parts 405, 424, 455, and 457
Required Disclosures

• Requires certain Medicare, Medicaid and CHIP providers and suppliers to disclose if a provider or supplier has any current or previous direct or indirect affiliation with a provider or supplier that:
  - Has uncollected debt;
  - Has been or is subject to a payment suspension under a federal health care program;
  - Has been excluded from Medicare, Medicaid, or CHIP;
  - Has had its Medicare, Medicaid, or CHIP billing privileges denied or revoked
• Permits Secretary to deny enrollment based on an affiliation that Secretary determines poses an undue risk of fraud, waste or abuse.

Re-Enrollment Bar

• Provides CMS with the authority to increase the maximum reenrollment bar from three years to ten years
• Allows CMS to add three more years to the re-enrollment bar if the provider attempts to re-enroll in Medicare under a different name, numerical identifier, or business identity
• Imposes a maximum 20-year re-enrollment bar if the provider or supplier is being revoked from Medicare for the second time

Enrollment Denial/Revocation

Provides CMS with the authority to revoke/deny Medicare enrollment if:
• CMS determines that the provider/supplier is currently revoked under a different name, numerical identifier or business identity and the applicable re-enrollment bar period has not expired;
• The provider/supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements;
• The provider/supplier has an existing debt that CMS refers to the Department of Treasury.
Enrollment Denial/Revocation (cont.)

• Provides CMS with the authority to revoke/deny a provider’s or supplier’s Medicare enrollment if:
  o The provider/supplier is currently terminated or suspended (or otherwise barred) from participation in a particular state Medicaid program or other federal healthcare program; or
  o The provider/supplier’s license is currently revoked or suspended in a state other than the state in which the provider/supplier is enrolling.