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Medicare/Medicaid Payment Update

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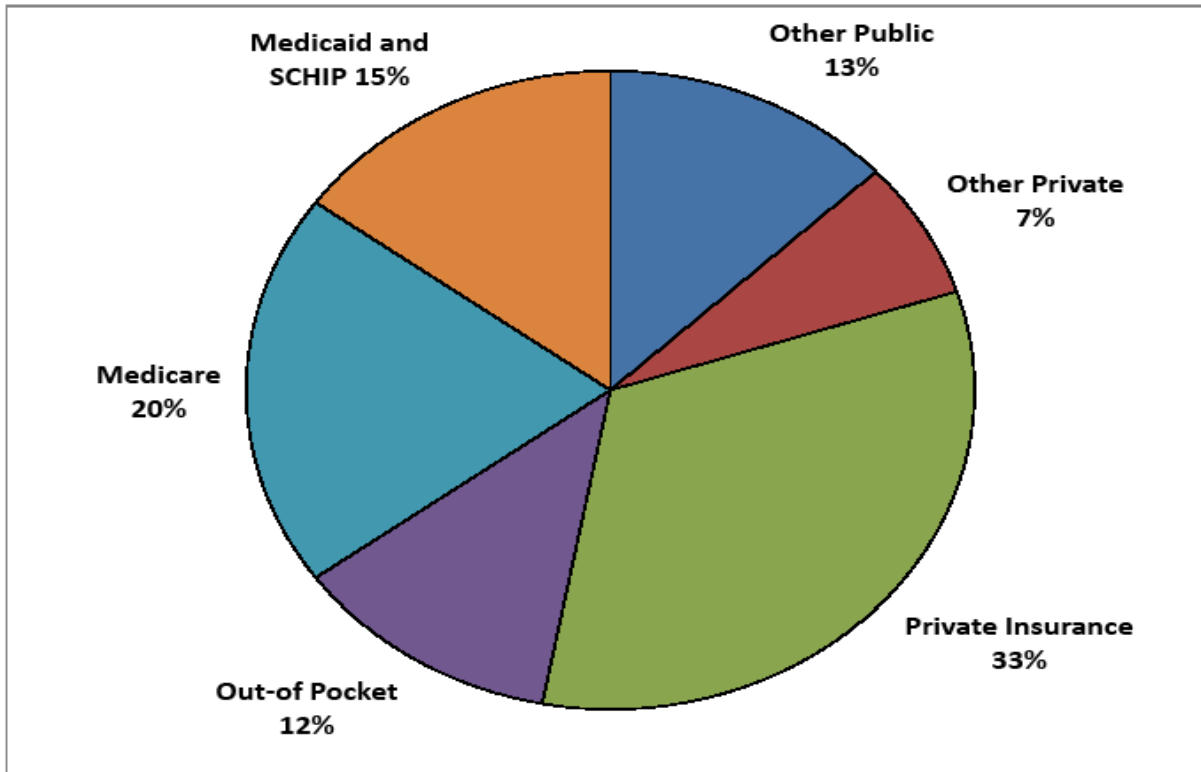
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Today's Discussion

- National Health Care Expenditures
- Estimated Impact of Health Care Reform
- Overview of Select Provisions of Health Care Reform
- Miscellaneous Medicare Updates
 - Cost Report Changes
 - Pension Expense for Wage Index Reviews



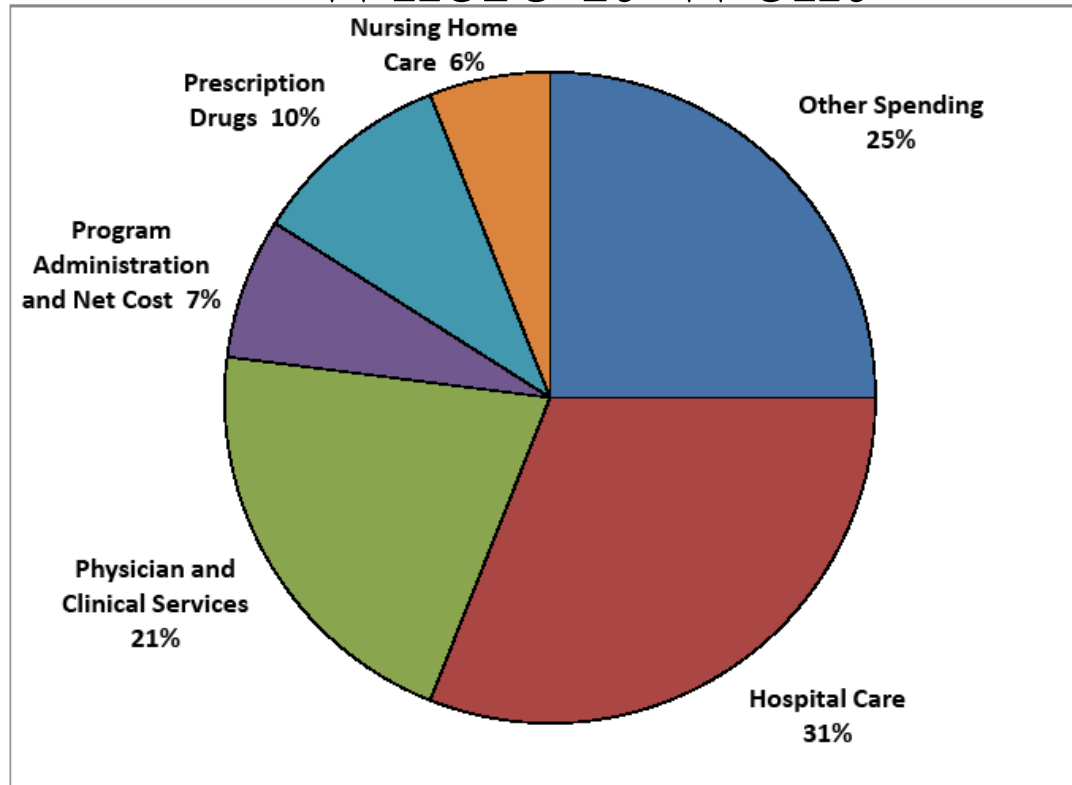
National Health Care Expenditures 2008: Where it Came From



SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.



National Health Care Expenditures 2008: Where it Went



NOTE: Other Spending includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, other personal health care, research and structures and equipment.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.



National Healthcare Expenditures Status and Outlook

- According to the Congressional Budget Office (CBO), the U.S. spent more than 16% of its GDP on health care in 2009, an amount that has steadily increased due to the excess in spending for health care over the growth in GDP:

Amount by Which Spending Exceeded Growth in GDP (%)				
Time Frame	Medicare	Medicaid	All Other	Total
1975-1990	2.9	3.2	2.3	2.6
1990-2007	1.7	0.8	1.3	1.4
1975-2007	2.3	1.9	1.8	1.9

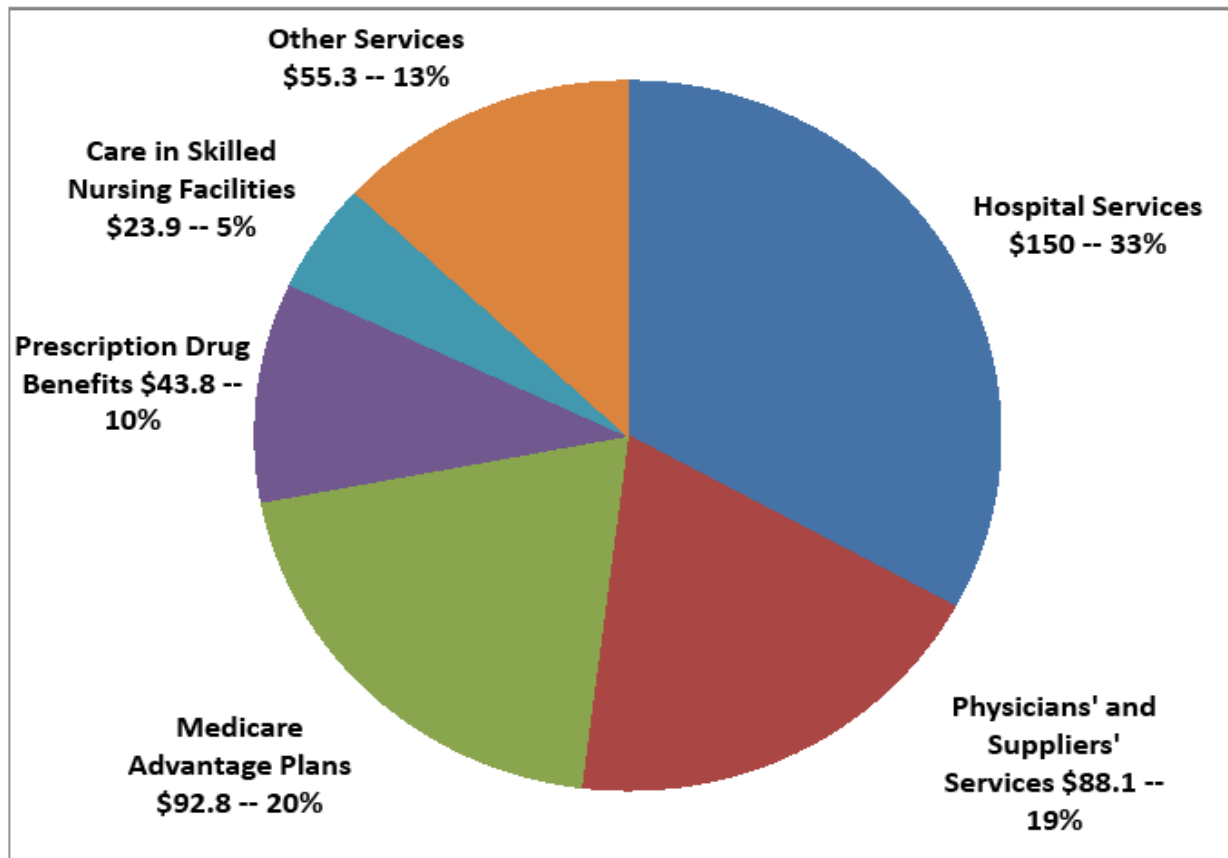


National Healthcare Expenditures Status and Outlook

- In 2009 the CBO projected that health care spending would be 31% of GDP in 2035 and 46% of GDP in 2080.
- Medicare spending, without the effects of reform legislation, was projected to grow at an average annual rate of 6.8%.
- In 2009 the Medicare trustees projected that the Hospital Insurance (HI) Trust Fund would be insolvent by 2017.



Medicare Spending by Type of Service 2008



SOURCE: Congressional Budget Office



Medicare: Change in Net Assets, 2009

Medicare Data for Calendar Year 2009				
	HI or Part A	Part B	Part D	Total
Assets at end of 2008 (billions)	\$321.3	\$59.4	\$0.9	\$381.6
Total Income	\$225.4	\$221.9	\$60.9	\$508.2
Payroll taxes	190.9	-	-	190.9
Interest	15.3	3.0	0.0	18.3
Taxation of benefits	12.4	-	-	12.4
Premium	2.9	56.0	6.3	65.2
General revenue	1.9	162.8	47.1	211.7
Transfers from States	-	-	7.6	7.6
Other	2.1	0.1	-	2.2
Total Expenditures	\$242.5	\$205.7	\$60.8	\$509.0
Benefits	239.3	202.6	60.5	502.3
Hospital	133.9	30.5	-	164.4
Skilled nursing facility	26.3	-	-	26.3
Home health care	7.3	11.4	-	18.6
Physician services	-	62.5	-	62.5
Private Health plans (Part c)	59.4	53.4	-	112.7
Prescription drugs	-	-	60.5	60.5
Other	12.5	44.9	-	57.4
Administrative expenses	\$3.2	\$3.1	\$0.3	\$6.7
Net changes in assets	-\$17.1	\$61.2	\$0.1	-\$0.7
Assets at end of 2009	\$304.2	\$75.5	\$1.1	\$380.8
Enrollment (millions)				
Aged	38.3	36.0	n/a	38.7
Disable	7.6	6.8	n/a	7.6
Total	46.0	42.8	33.4	46.3
Average benefit per enrollee	\$5,205	\$4,728	\$1,810	\$11,743

SOURCE: 2010 Annual Report of the Medicare Trustees



Estimated Operations of HI Trust Fund, 2009-2019, including Reform Impact

Table II .E.1 – Estimated Operations of the HI Trust Fund under Intermediate Assumptions, Calendar Years 2009-2019
(Dollar amounts in billions)

Calendar Year	Total Income ¹	Total expenditures	Change in fund	Fund at year end	Ratio of assets to expenditures ²
2009³	225.4	242.5	-17.1	304.2	132
2010	217.6	249.3	-31.7	272.5	122
2011	241.5	259.3	-17.8	254.7	105
2012	254.4	271.2	-16.8	237.9	94
2013	277.0	282.5	-5.5	232.4	84
2014	297.2	296.0	1.2	233.6	79
2015	315.9	305.0	10.8	244.4	77
2016	336.6	321.2	15.4	259.8	76
2017	357.2	338.2	19.0	278.8	77
2018	377.9	357.9	20.0	298.8	78
2019	397.9	379.7	18.2	317.0	79

¹ Includes interest income.

² Ratio of assets in the fund at the beginning of the year to expenditures during the year.

³ Figures for 2009 represent actual experience

SOURCE: 2010 Annual Report of the Medicare Trustees

NOTE: Total do not necessarily equal the sums of rounded components



Impact of Healthcare Reform on the HI Trust Fund (2010 Medicare Trustees Report)

- These latest estimates, which include assumptions related to savings provisions in the Patient Protection and Affordable Care Act (“ACA”) show the HI Trust Fund depleting by 2029, or 12 years later than last year’s estimates.
- Savings are estimated at > \$400 Billion in 2010 -2019 mostly attributable to:
 - Productivity adjustments to provider payment updates (\$162 Billion)
 - Reduced payments to Medicare Advantage Plans (\$86 Billion)
 - Increased payroll taxes on high income workers (\$63 Billion)



Impact of Healthcare Reform according to CMS Office of the Actuary

Estimated Federal Costs (+) or Savings (-) under Selected Provisions Of the Patient Protection and Affordable Care Act as Enacted and Amended

Provisions	Fiscal Year										Total 2010-19
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Total	\$9.2	-\$0.7	-\$12.6	-\$22.3	\$16.8	\$57.9	\$63.1	\$54.2	\$47.2	\$38.5	\$251.3
Coverage	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicare	1.2	-4.7	-14.9	-26.3	-68.8	-60.3	-75.2	-92.1	-108.2	-125.7	-575.1
Medicaid/CHIP	-0.9	-0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost Trend	-	-	-	-	-0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
CLASS program	-	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-37.8
Immediate reforms	5.6	3.2	1.2	-	-	-	-	-	-	-	10.0



Selected Key Cost Containment Strategies in the ACA (Per CMS)

Cost Containment Strategy	Key Provisions	2010-2011 Cost Savings	Ten-Year Cost Savings
Improve the quality of Care	Reduce hospital readmissions	—	\$8.2 Billion
Improve the quality of Care	Reduce Hospital Acquired Conditions (HAC)	—	\$3.2 Billion
Improve the quality of Care	Bundling payments for ESRD	—	\$1.7 Billion
Improve the quality of Care	Improve Physician Quality Reporting	—	\$1.9 Billion



Selected Key Cost Containment Strategies in the ACA (Per CMS)

Cost Containment Strategy	Key Provisions	2010-2011 Cost Savings	Ten-Year Cost Savings
Reform Delivery System	Promotes Accountable Care Organizations	—	\$4.9 Billion
Reform Delivery System	Establishes Independent Advisory Board	—	\$23.7 Billion



Selected Key Cost Containment Strategies in the ACA (Per CMS)

Cost Containment Strategy	Key Provisions	2010-2011 Cost Savings	Ten-Year Cost Savings
Appropriately price services; modernize financing systems	End overpayments to Advantage Plans	\$5.3. Billion	\$145 Billion
Appropriately price services; modernize financing systems	Productivity and market basket updates	\$1.4 Billion	\$205 Billion
Appropriately price services; modernize financing systems	Revise payments for advanced imaging services	\$.01 Billion	\$2.0 Billion
Appropriately price services; modernize financing systems	Expand DME competitive bidding	\$0.5 Billion	\$17 Billion



Selected Key Cost Containment Strategies in the ACA (Per CMS)

Cost Containment Strategy	Key Provisions	2010-2011 Cost Savings	Ten-Year Cost Savings
Fight Fraud, Waste & Abuse	Various, including expanding RACs, requiring face encounters with physicians before receiving certain services and requiring greater data matching capabilities	\$0.4 Billion	\$4.9 Billion



Impact of the ACA; Additional Notes from the Medicare Trustees

- The Trustees note that their estimates pertaining to the improvements in the HI Trust Fund Balance depend in part on the long range feasibility of lower increases in Medicare payment rates to most healthcare providers, as mandated by the ACA.
 - Annual increases in payments to be reduced by the estimated growth in multifactor productivity (about 1.1%)
 - Over time, unless providers can reduce their cost per service, the prices paid by Medicare will fall below costs
 - Congress would then most likely override the payment update reductions



Impact of the ACA; Additional Notes from the Medicare Trustees

- Per the Trustees: “Actual future costs for Medicare are likely to exceed those shown by the current law projections...” and “there is a strong likelihood that without very substantial and transformational changes in health care practices, payment rates would become inadequate in the long range.”
- Transformations in the way healthcare is delivered and in the way that is financed are necessary. ACA includes initiatives in that direction.

Overview of Select Provisions of Health Care Reform: Improving Quality

- Hospital Readmissions (For PPS hospitals): Beginning in FY 2012 payments to hospitals under the IPPS would be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.
 - Based on conditions currently endorsed by the National Quality Forum
 - Secretary can expand the policy to additional conditions in future years
- Community Based Transitions Program: Five year program providing funding to hospitals and community based entities furnishing “evidence based care transition services” to Medicare beneficiaries with high risk of readmission.



Overview of Select Provisions of Health Care Reform: Improving Quality

- Various funding for development of quality measures and reporting including the development of an initial set of measures for adults who are Medicaid eligible.
- Hospital Acquired Conditions (HAC): Prohibits Federal payments to States for Medicaid services related to HACs.
 - Effective July 1, 2011
 - Consistent with HACs under Medicare but not limited to conditions acquired in hospitals
 - Take into account differences between the Medicare and Medicaid programs



Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- Establishes Center for Medicare and Medicaid Innovation within CMS to develop, test, and expand innovative payment and delivery arrangements to improve quality and reduce cost of care.
 - Models that improve patient care without increasing spending can be expanded nationally
 - Scope includes Medicaid and CHIP programs

Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- Creates a 15-member Independent Payment Advisory Board tasked with presenting Congress with proposals to reduce excess cost growth and improve quality of care.
 - 6-year terms appointed by the President with Senate advice & consent
 - Proposals begin in 2014
- In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes alternative measures that achieves the same level of savings.



Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- Community Living Assistance Services and Support (CLASS) Program: Establishes a voluntary, self-funded public long-term care insurance program, for the purchase of community living assistance services by individuals with functional limitations.
 - Develop an actuarially sound benefit plan ensuring solvency for 75 years; no taxpayer funding
 - Five year vesting period for eligibility of benefits
 - Benefit triggers based on functional limitations
 - Cash benefit not less than \$50/day



Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- Community First Choice Option: Establishes an optional Medicaid benefit through which States could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care required in a hospital, nursing facility or intermediate care facility for the mentally retarded.



Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- Incentives for States to Offer Home and Community Based Services (HCBS): Creates financial incentives to States to shift Medicaid beneficiaries out of nursing homes into HCBS. Increases the federal match to States that rebalance their spending between HCBS and nursing homes.



Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- State Option to Provide Health Homes for Enrollees with Chronic Conditions:
 - Medicaid State Plan Option
 - Enrollees must have at least two chronic conditions, or one and at risk of another, or one serious and persistent mental health condition
 - Provider, team of health care professionals or health team designated as “health home” meeting standards to be established
 - Designated health home provides comprehensive care management, care coordination, follow-up care, referral to support services and other community based care
 - Team required to report to State on quality measures



Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- Health Homes (cont).
 - States must develop payment mechanism, track avoidable hospital readmissions and a plan for producing savings from improved chronic care coordination and management
 - Provides enhanced Federal match of 90% for 2 years for States that take this option

Overview of Select Provisions of Health Care Reform: Reforming Delivery System

- Accountable Care Organizations (ACOs): Encourages the establishment of ACOs or groups of health care providers by rewarding those that take responsibility for the costs and quality of care received by their assigned Medicare beneficiaries.
 - Those meeting quality of care targets and cost reductions rewarded with a share of the savings they generate for the program
 - Not later than January 1, 2012
 - Preference may be given to those who have similar arrangements with other payers

Overview of Select Provisions of Health Care Reform: Pricing Services

- Implements market basket update reductions for inpatient and outpatient hospital for FFY 2010 through 2019 from between .25 and .75 percent.
- Implements a “productivity adjustment” to the update factor beginning in FFY 2012.
- Establishes hospital value based purchasing in FFY 2013
 - Funding for value based incentives paid for through further reducing Medicare IPPS payments

Overview of Select Provisions of Health Care Reform: Fight Fraud, Waste & Abuse

- Enhances provider screening and enrollment requirements under Medicare, Medicaid, and CHIP.
- Requires known overpayments to be reported the later of 60 days after identification or date any corresponding cost report is due.
- Entities enrolled in Medicare and Medicaid must submit performance statistics on the number of fraud referrals, overpayments recovered, and return on investment.



Overview of Select Provisions of Health Care Reform: Fight Fraud, Waste & Abuse

- Reduces the maximum period for Medicare claims submission to not more than 12 months.
- Increases federal sentencing guidelines for healthcare frauds. Changes the intent requirement under the Anti-Kickback statute.
- Expands RACs to Medicaid and Medicare Parts C and D.

Common Themes of the ACA

- Quality & Innovation
 - Emphasis on chronic conditions
 - Community based services
- Coordination & Collaboration of Care
 - Bundling
- Accountability (scrutiny)

IME/GME Provisions in the ACA

- **Training in Non-Provider Settings:** Generally all time can be counted if hospital incurs the costs of resident's salaries and benefits. Eliminates need for written agreement except if multiple providers share the cost. Must still be documented on rotation schedules.
- **Didactic Conferences & Seminars:** For cost reporting periods beginning after 7/1/09 didactic time in non-provider settings can be counted for GME as long as that setting is engaged in furnishing patient care. For IME, didactic activities can be counted for time spent in the hospital.



IME/GME Provisions in the ACA

- Vacation, Sick or Other Approved Leave: Effective January 1, 1983 all time spent on vacation, sick leave or other approved leave is counted as part of the FTE count for both IME and GME as long as the leave doesn't prolong the total time the resident is participating in the approved program. Cost reports can not be reopened for this provision.

IME/GME Provisions in the ACA

- Redistribution of resident FTE slots: Based on the highest last three cost reporting years prior to March 23, 2010 compared to the hospital's historic limit or cap. If the highest year falls below the cap, then the limit will be reduced by 65% of the difference and the unused FTEs redistributed to other hospitals.

Other Updates: Medicare Cost Report Changes

- Form 2552-96 Transmittal 21: For FY '10 filing new line 55.30 for high cost implantable devices charged to patients. Low cost devices should not be included (still line 55)
 - Generally includes items associated with revenue codes 275, 276, 278 and 624

Other Updates: Medicare Cost Report Changes: New 2552-10

- Draft Form 2552-10 published in July 2, 2009; to be effective FYB 2/1/2010.
- Primarily to remove obsolete worksheets and generally “clean-up” the 2552-96.
 - Forms renumbered
 - Instructions updated

Other Updates: Medicare Cost Report Changes: New 2552-10

- S-2 Changed to incorporate Exhibit 1 of 339 (now part of ECR file). No more separate hard copy Exhibit 1.
- S-2 questions organized to group info by type.
- New S-3 Part IV for old 339 wage related cost detail (Formerly Exhibit 6).
- New S-3 Part V for Contract Labor and Benefit Cost.

Other Updates: Medicare Cost Report Changes: New 2552-10

- S-10 Hospital Uncompensated and Indigent Care Data completely revised:
 - Medpac endorses the proposed revision and notes “current form and instructions have produced unreliable data.”
 - AHA, after reviewing the draft, asked for more revisions
 - Requires input on total initial payment obligation of patients who are given a full or partial discount based on the hospital’s charity care criteria (measured at full charges), for care delivered during the cost reporting period for the entire facility



Other Updates: Medicare Cost Report Changes: New 2552-10

- W/S A line numbers renumbered lines 1-200
 - Old Capital lines 1 & 2 removed
 - W/S A line 30 now Adults & Peds (old line 25)
 - W/S A line 50 now begins Ancillary (old line 37)
 - W/S A line 90 now begins Outpatient (old line 60)
 - W/S A line 94 now begins Other Reimbursable (old line 64)
 - W/S A line 105 now begins Special Purpose (old line 83)
 - W/S A line 190 now begins Non Reimbursable (old Line 96)
 - W/S Line 200 is Total (old line 101)



Other Updates: Medicare Cost Report Changes: New 2552-10

- W/S A new ancillary cost centers for CT, MRI and Cardiac Cath.
- W/S C line numbers renumbered to match W/S A.
- D Part VI for vaccines eliminated; added column on D Part V.
- D-4 renamed D-3, D-6 (transplant) now D-4.



Pension Adjustments in Wage Index Reviews

- For Medicare Cost Reporting purposes wage related costs must meet the “reasonable cost” provisions of Medicare.
 - For ERISA (Employee Retirement Income Security Act of 1974) covered plans, Medicare requires that hospitals provide “valuation interest rate”, “actuarial accrued liability”, and “normal cost” data.
- The Pension Protection Act (PPA) of 2006 made certain amendments to ERISA where the minimum and tax deductible contributions are no longer determined using these elements.



Pension Adjustments in Wage Index Reviews

- CMS developed a spreadsheet for its contractors to use to determine pension costs for purposes of the cost report wage index after the effective date of the PPA.
- Spreadsheet completed using the IRS Form 5500 (first two tabs)
 - Available for download on CMS or Medicare Administrative Contractor (MAC) website

MAC Pension Cost Audit

Approach for the Wage Index

- Spreadsheet consists of 5 years of data which allows for reconciliation of prior period differences between:
 - Pension costs determined in accordance with the PRM
 - Amounts funded
 - Pension costs reported for wage index purposes and if applicable, any amount of funding in excess of the pension cost which can be carried forward and applied towards the funding of costs in subsequent periods



Defining Pension Costs and Plan Types

Two separate types of pension plans which can have many subsets:

- Deferred Benefit Retirement Plan:
 - Cash Balance Plan
- Defined Contribution Retirement Plan:
 - Profit Sharing Plan
 - Money Purchase Pension Plan
 - Stock Bonus Plan
 - Employee Stock Ownership Plan (ESOP)
 - Target Benefit Plan
 - Cash or Deferred Arrangement (401(k) Plan)
 - 403(b)



Clarifying Pension Costs and Plan Types To Reduce Audit Exposure

- Defined Benefit (DB) Retirement Plans and Defined Contribution (DC) Retirement Plans differ and need to be recognized, segregated, and communicated to the MAC or their subcontractor.
- DC plans do not require an actuarial report and costs are allowable to the extent that such costs are actually incurred by the provider (i.e. THE MATCH).
 - No actuarial report means no Schedule SB (Actuarial Information) on Form 5500
 - No Schedule SB means CMS spreadsheet should not be used in determining allowable DC plan costs



Clarifying Pension Costs and Plan Types To Reduce Audit Exposure

- DB plans do require an actuarial report because current funding (contributions) is determined based on future accumulated benefit obligations using measurements such as employee's age, years of service and compensation.
 - DB plans are designed to provide benefits for employees or their beneficiaries to be paid upon retirement, or over a period of years after retirement
 - Actuarial data is used to generate Schedule SB of the Form 5500 and must include the minimum funding (contribution) specifying the normal cost, the actuarial accrued liability, the actuarial and market value of assets and the unfunded actuarial liability or surplus assets



Clarifying Pension Costs and Plan Types To Reduce Audit Exposure

- Providers must understand all pension plans of their organization and the associated costs booked for the year reported on the cost report and subsequently audited by the MAC.
 - Obtain all Form 5500s from the Human Resources Department
 - Identify pension costs on the books by plan which match the individual Form 5500s
 - Prepare schedule for MAC so they understand all plans of the provider and the separate costs pertaining to the plans
 - Complete CMS spreadsheet for DB plan costs and make the appropriate cost report adjustment – submit with the Wage Index portion of the cost report submission along with the breakdown of the provider’s various pension plans and related expenses



Clarifying Pension Costs and Plan Types To Reduce Audit Exposure

- MAC Audit Adjustments
 - Apples to apples comparison does not appear to be occurring in audit process
 - Providers must ensure that the MAC or its subcontractor understands all plans and the related costs on the books to avoid an overstated adjustment



Clarifying Pension Costs and Plan Types To Reduce Audit Exposure

- MAC Audit Adjustments (continued)
 - Example:
 - Hospital has DB and DC plans and books costs to one single general ledger account
 - MAC ask for Form 5500 and posts actuarial data to CMS spreadsheet (Remember, this is DB plan only)
 - MAC arrives at allowable pension costs using spreadsheet and compares to (1) general ledger account which includes DB and DC plans' expenses and adjusts difference
 - Result is overstated decrease in allowable pension costs and negative impact on wage index for related CBSA



Final Audit Results and Effect

- Substantial negative MAC adjustments to pension costs will affect future wage index amounts and have an effect on the calculated reimbursement amounts to Maryland non-acute care hospital providers.
- Communicate with the MAC or their subcontractor during their wage index audit to ensure they understand the provider's individual pension plans and related costs.
- Communicate with the MAC or their subcontractor so they understand the booked (DB plan) costs they should be comparing the allowable pension costs to based the completed CMS spreadsheet.

Maryland Wage Indices

Cored Based Statistical Area (CBSA)	CBSA Description	FFY 9/30/05	FFY 9/30/06	FFY 9/30/07	FFY 9/30/08	FFY 9/30/09	FFY 9/30/10	FFY 9/30/11
12580	Baltimore-Towson	.9892	.9882	.9922	1.0031	.9982	1.0148	1.0153
13644	Bethesda-Frederick-Gaithersburg	1.0935	1.1459	1.0848	1.1017	1.1009	1.0789	1.0363
19060	Cumberland	*.9925	*.9357	*.8881	*.8912	*.8790	*.9246	*.9258
25180	Hagerstown	.9744	.9518	.9314	.9256	.9268	.9246	.9457
41540	Salisbury	*.9225	*.9357	*.8881	*.8912	.9189	*.9246	*.9258
47894	Washington-Arlington-Alexandria	1.1026	1.0928	1.0977	1.0676	1.0685	1.0718	1.0528
48864	Cecil County	1.1095	1.0516	1.0570	1.0667	1.0639	1.0760	1.0723
99021	Rural	.9225	.9357	.8881	.8912	.8790	.9246	.9258

*Limited to Rural wage index



Questions?

For a copy of this presentation, please go to
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Thank you!

