Arkansas HFMA October 19, 2018: CMS Final Rules & the Ever Changing Landscape of Healthcare

Today’s topics

1. FFY2019 Medicare Inpatient PPS Final Rule
2. Medicare Uncompensated care DSH payments & Worksheet S-10 reporting
3. 2019 OPPS Proposed Rules & 340B program
4. Changes in the Healthcare Landscape
Meet today’s speakers

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FFY2019 IPPS
Program updates

- Rate Adjustments
- Capital Related Costs
- Rural Reimbursement
- Wage Index
- Value-Based Purchasing
- DSH & Uncompensated Care

Final changes to MS-DRG classifications & weights

Section II

**Documentation & Coding Adjustments**

- 0.5% rate increase for 2019, 2nd year of increases after years of significant decreases
- 0.5% rate increases scheduled to occur in 2020-2023
- Lost 3.7% and most will be made back is 3.2% with the 0.5% annual increases

**Various Refinements & Recalibrations To MS-DRG Weights**

**Voluminous Discussion On Clinical & New Technology Issues**
Final Changes Wage Index

Final National Average Hourly Wage $42.96
- 2.14% increase from the prior year (proposed was 2.12%)
- 52 hospitals excluded due to aberrant data
- Hospitals that converted to CAH on or after 1/26/18 were excluded

National Budget Neutrality Adjustment Factor 0.993142

Imputed rural floor will expire 9/30/18 (New Jersey-10, Delaware-3 & Rhode Island-9)

FFY 2019 1st Year To Use The 2016 OMS
- OMS proxy to hospitals that did not submit
- 95% response rate
- MACs asking non-responders to submit for FFY 2020 & 2021

Occupational Mix Survey

<table>
<thead>
<tr>
<th>Category</th>
<th>Average</th>
<th>Percentage of Hours to Total Nursing</th>
<th>Percentage of Hours to Total Nursing Prior OMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>$41.66</td>
<td>70.9%</td>
<td>71.5%</td>
</tr>
<tr>
<td>LPN</td>
<td>$24.74</td>
<td>6.6%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Nurse Aide</td>
<td>$16.97</td>
<td>18.9%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Med Assistant</td>
<td>$18.13</td>
<td>3.6%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Nursing</td>
<td>$35.04</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

42.1% Nursing vs. 57.9% All Other
# National Wage Index

<table>
<thead>
<tr>
<th>Wage Index – categories as a percent of total salary - National</th>
<th>Unadjusted average hourly wage increase</th>
<th>Part A Physician</th>
<th>Wage related costs</th>
<th>Patient care under contract</th>
<th>Administrative &amp; General under contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>2.6%</td>
<td>1.6%</td>
<td>28.2%</td>
<td>3.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>2018</td>
<td>2.4%</td>
<td>1.7%</td>
<td>28.7%</td>
<td>3.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>2017</td>
<td>2.5%</td>
<td>1.7%</td>
<td>28.9%</td>
<td>2.9%</td>
<td>1.3%</td>
</tr>
<tr>
<td>2016</td>
<td>2.2%</td>
<td>1.7%</td>
<td>29.1%</td>
<td>2.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>2015</td>
<td>2.1%</td>
<td>1.7%</td>
<td>28.7%</td>
<td>2.8%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

# NATIONAL AVERAGES (PER JAN 2018 PUF)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PERCENTAGE OF SALARIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement</td>
<td>6.5%</td>
</tr>
<tr>
<td>Retirement related fees</td>
<td>0.2%</td>
</tr>
<tr>
<td>Health/dental/prescription</td>
<td>12.9%</td>
</tr>
<tr>
<td>Worker's compensation</td>
<td>0.9%</td>
</tr>
<tr>
<td>FICA/Medicare taxes</td>
<td>6.7%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>0.2%</td>
</tr>
<tr>
<td>Tuition reimbursement</td>
<td>0.3%</td>
</tr>
<tr>
<td>Remaining categories (life insurance, deferred comp, day care, etc.)</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Final Changes Wage Index

Section III

No changes to frontier policy – 50 hospitals receive 1.0000 wage index

Final labor share - 68.3% if above 1.00 and 62% is below 1.00

Other wage related costs (WS S-3, Part II, In 18/25)
- Clarification on criteria to report data on this line
  - (1% of adjusted salaries, IRS recognized benefit & taxed to employee)
- Only 8 hospitals reported data on line 18 properly - out of 80
- Will no longer be considered, effective for FFY 2020

Final Changes Wage Index

Section III

Reclassifications

Reiterates 4/21/16 change to allow Section 412.103 hospitals to seek a MGCRB reclassification

- 412.103 redesignated hospitals are excluded from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area (page 885)
- 881 hospitals with MGCRB reclassification status in FFY 2019 - down from 906 in FFY 2018
- Continue to have 45 days from publication of proposed rule making to withdraw request
- FFY 2020 reclassifications were due 9/4/18
  - New online filing requirements
Final Changes Wage Index

Reclassifications
- Previously, reclassifications under 412.103 in order to be treated as rural in the wage index for next FFY, hospital must file at least 70 days prior to the second Monday in June of the current FFY and application be approved by CMS RO. - 906
- FFY 2019 Change – now 60 days prior to when proposed rules become public is the “lock in date” – no specified date.

Multicampus Hospitals
- Each location must meet certain criteria to qualify together (SCH, MDH, RRC, etc..)

Single Hospital MSA
- Single hospital MSA now only needs to provide final Table from previous year to support they are only CCN listed in 3 year average, beginning with applications due 9/1/19 for FFY 2021
Changes to MS-DRGs Subject to Post-acute Care Transfer & MS-DRG Special Payment Policies

**CAR-T**
Propose assigning CAR-T therapy procedure codes to MS-DRG 016 (proposed revised title: Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy)

**Kidney & Urinary Tract**
Propose deleting MS-DRG 685 (Admit for Renal Dialysis) & reassign diagnosis codes from MS-DRG 685 to MS-DRGs 698, 699, & 700 (Other Kidney & Urinary Tract Diagnoses with MCC, with CC, & without CC/MCC, respectively)

**Pregnancy & Childbirth**
Propose deleting 10 MS-DRGs (MS-DRGs 765, 766, 774, 775, 777, 778, 780, 781, & 782) & create 18 new MS-DRGs relating to Pregnancy, Childbirth & the Puerperium (MS-DRGs 783-788, 794, 796, 798, 805, 806, 807, 817, 818, & 831-833)

**Neuro**
Propose assigning two additional diagnosis codes to MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator)

**Bowel**
Propose reassigning 12 ICD-10-PCS procedure codes from MS-DRGs 329, 330 & 331 (Major Small & Large Bowel Procedures with MCC, with CC, & without CC/MCC, respectively) to MS-DRGs 344, 345, & 346 (Minor Small & Large Bowel Procedures with MCC, with CC, & without CC/MCC, respectively)

**Sepsis**
Propose reassigning ICD-10-CM diagnosis codes R65.10 & R65.11 from MS-DRGs 870, 871, & 872 (Septicemia or Severe Sepsis with & without Mechanical Ventilation >96 Hours with & without MCC, respectively) to MS-DRG 864 (proposed revised title: Fever & Inflammatory Conditions)

**Not Included**
MS-DRGs 329, 330, 331, 344, 345, and 336 will not be included in the updated analysis of the postacute care transfer policy.
Section IV — Other Decisions & Final Changes to the IPPS for Operating Systems

Proposed Implementation of Changes Required by Section 53109 of the Bipartisan Budget Act of 2018

- Effective October 1, 2018, if a discharge is assigned to one of the MS-DRGs subject to the post-acute care transfer policy & the individual is transferred to hospice care by a hospice program, the discharge would be subject to payment as a transfer case.

Inpatient Rate update FFY19

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Market basket rate of increase</td>
<td>2.90%</td>
<td>2.90%</td>
<td>2.90%</td>
<td>2.90%</td>
</tr>
<tr>
<td>Adjustment if no quality data submitted</td>
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<td></td>
<td>-0.725%</td>
<td>-0.725%</td>
</tr>
<tr>
<td>Adjustment if not meaningful use</td>
<td></td>
<td>-2.175%</td>
<td>-2.175%</td>
<td></td>
</tr>
<tr>
<td>MFP adjustment</td>
<td>-0.80%</td>
<td>-0.80%</td>
<td>-0.80%</td>
<td>-0.80%</td>
</tr>
<tr>
<td>Section 1886(b)(3)(B)(xii) adjustment</td>
<td>-0.75%</td>
<td>-0.75%</td>
<td>-0.75%</td>
<td>-0.75%</td>
</tr>
<tr>
<td>Proposed change to standardized amount</td>
<td>1.35%</td>
<td>-0.825%</td>
<td>0.625%</td>
<td>-1.55%</td>
</tr>
<tr>
<td>D&amp;C adjustment</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total with D&amp;C</td>
<td>1.85%</td>
<td>-0.325%</td>
<td>1.125%</td>
<td>-1.05%</td>
</tr>
</tbody>
</table>
Rural Referral Center (RRC)

New RRC for CRP beginning on or after 10/1/18 if rural & under 275 beds:
- CMI of 1.6612 (previously 1.6635) national-all urban value or the median CMI value for urban hospitals for the census region

Discharges same 5,000 or median of region
- Median of each region exceeds the 5,000 national standard; therefore, 5,000 is the minimum criterion for all hospitals except osteopathic hospitals (3,000 discharges)

Low Volume Adjustment

Hospitals must submit written request to MAC by September 1, 2018
  - Mileage – more than 15 miles from nearest “like” hospital
  - Discharges – based on total discharges less than 3,800

Percentage increase determined using:
- Continuous, linear sliding scale
- ≤ 500 discharges – Additional 25% payment adjustment
- > 500 - < 3,800 discharges – Additional payment adjustment is calculated using formula = [(95/330) - x (# of total discharges/13,200)]
- > 3,800 discharges – 0% additional payment adjustment
- Discharges are not payor specific
Indirect Medical Education

Same multiplier of 1.35 proposed
• Estimate continues to yield an increase of 5.5% for every 10% increase in the hospital’s resident to bed ratio

Medicare Dependent Hospitals & Sole Community Hospitals

Extends MDH status from 2018 - 2022
• Existing MDH classification as of 9/30/17, no need to reapply for MDH classification.

Proposed effective date change for rural reclassification, SCH status & MDH status for the payment adjustment to be the date that the MAC receives the completed application
Section IV

**Readmission**
- Applicable period for FY 2019 – FY2021
- Six readmission measures in the HRRP deemed appropriately included
- The adjustment factor ranges between 1.0 (no reduction) and .9700 (largest reduction)
- Claim data is based on MedPar files from July 1, 2014, through June 30, 2017

**Value-based Purchasing**
- FFY19 removes 3 measures for the Hospital VBP Program
- FFY21 remove one safety measure
- Published in Table 16

**Hospital-Acquired Conditions**
- 1% payment reduction if you rank in the top 25% quartile of all applicable hospitals
- Actual measures are unchanged FY19.
- Remove CMS PSI 90 & NHSN HAI removed from hospital IQR & VBP, & adopted by HAC starting FY20
- Removing domains & adopting an Equal Measure Weights beginning FY20
- Evaluating eCQMs (electronic clinical quality measures) & seeking comments on potential measures

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Section IV — IME/GME

**Affiliation agreement change**
- "Urban teaching hospitals that qualify for an adjustment to its FTE cap & receive an adjustment that is a decrease to the urban hospital’s FTE cap, only if the decrease results from a Medicare GME affiliated group consisting solely of two or more new urban teaching hospitals that qualify to receive adjustments to their FTE cap is under 413.79 (e)(1). Due date for affiliation agreement is July 1, 2019.
- Goal is to provide a change in caps to existing hospitals in order to train hospitals in a new teaching hospital
- This previously was disallowed & viewed to be “gaming” the system establishing hospital caps
- Must be consistent with the intent of the Medicare GME affiliation agreement; to promote the cross-training of residents at participating hospitals & not to provide an unfair advantage of one hospital at the expense of another hospital
Rural demonstration project

- 16 Previously Participating Hospitals & 13 Newly Participating Hospitals
- Newly Participating Hospitals - effective for first cost report beginning on or after October 1, 2017
- Budget neutrality methodology similar to previous years
- FFY19 budget neutrality will include cost estimates for FFY18, FFY19, & reconciliation of FFY11-13 finalized cost reports

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FY18 Estimated Costs</td>
<td>31,070,880</td>
</tr>
<tr>
<td>FY19 Estimated Costs</td>
<td>70,929,313</td>
</tr>
<tr>
<td>FY11 Actual to Estimate Recon</td>
<td>(29,971,829)</td>
</tr>
<tr>
<td>FY12 Actual to Estimate Recon</td>
<td>(8,500,373)</td>
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<tr>
<td>FY13 Actual to Estimate Recon</td>
<td>(5,398,382)</td>
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<tr>
<td></td>
<td>58,129,609</td>
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</table>

Final revision of hospital inpatient admission orders documentation requirements under Medicare Part A

Removing language stating that the written inpatient admission (physician) order to be present in the medical record, in order to receive Medicare Part A payment

No changes to the 2-Midnight payment policy
### Section V

**CMS PROPOSED FY19 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE**

<table>
<thead>
<tr>
<th>Factor</th>
<th>FFY18</th>
<th>FFY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Input Price Index*</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Intensity</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td><strong>Case-Mix Adjustment Factors:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real Across DRG Change</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Projected Case-Mix Change</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Effect of FY17 Reclassification &amp; Recalibration</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Forecast Error Correction</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Proposed Update</strong></td>
<td>1.4</td>
<td></td>
</tr>
</tbody>
</table>

*The capital input price index represents the proposed 2014-based CIPI.

### COMPARISON OF FACTORS & ADJUSTMENTS:

<table>
<thead>
<tr>
<th>Factor</th>
<th>FFY18</th>
<th>FFY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Factor</td>
<td>1.0130</td>
<td>1.0140</td>
</tr>
<tr>
<td>GAF/DRG Adjustment Factor</td>
<td>0.9987</td>
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<tr>
<td>Outlier Adjustment Factor</td>
<td>0.9483</td>
<td>0.9494</td>
</tr>
<tr>
<td>Capital Federal Rate</td>
<td>$453.95</td>
<td>$459.72</td>
</tr>
</tbody>
</table>
Final changes to hospitals excluded from IPPS

Children’s hospitals, 11 cancer hospitals & hospitals located outside the 50 States, the District of Columbia, & Puerto Rico (that is, hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands & American Samoa)

- Cost subject to rate-of-increase ceiling
- FY19 rates were rebased to use 2014 as the base year to calculate the increase
- 2.9% increase (market basket estimate)

Extended Neoplastic Disease Hospitals

- Extended Neoplastic Disease Hospitals
  - LTCHs that are not subject to LTCH PPS
- Get same 2.9% (market basket) increase as other hospitals excluded from PPS

Final Changes to Regulations Governing Satellite Facilities

- A Satellite facility is defined as part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital
- CMS believe there is no compelling policy rationale for treating satellite facilities and HWH differently on the issue of separateness and control because there is not meaningful distinction between these types of facilities
- Effective 10/1/2018, IPPS-excluded satellite facilities, co-located with another IPPS-excluded Hospital will not have to adhere to the separateness and control rules
Section VI

Hospital-Within-Hospital (HwH)

- Effective with cost reporting periods beginning on/after 10/1/19 an IPPS excluded hospital would be permitted to have an excluded psychiatric &/or rehabilitation unit as long as CoPs are met
- An IPPS-excluded hospital may not have the IPPS-excluded unit of the same kind (an IRF may not have an IRF unit)
- Note the effective date of 10/1/19 is utilized to allow sufficient time to get the units operating without unnecessary administrative issues & delays
- Clarified that for cost reporting periods beginning on or after 10/1/19, the Medicare inpatient days from patients treated in an IPPS-excluded unit will not be included in the Medicare average length of stay calculations
- As LTCH patient with a principal diagnosis relating to a psychiatric or rehabilitation diagnosis must be paid under a site neutral rate, & as those LTCH patients days are not counted toward a facility's average length of stay calculation, excluding psychiatric and rehabilitation unit days from the calculations of an LTCH's average length of stay is the most appropriate policy

Critical access hospitals

- Section focuses on the FCHIP Demonstration Project in which 10 CAH's were selected to participate in Montana, Nevada & North Dakota
- Any reduction to CAH payments in order to recoup excess costs under the demonstration will not begin until CY 2020

Policy will have no impact for any national payment system for FFY19.
Final changes to the LTCH PPS for 2019

No final changes to existing methodology to determine the DRG relative weights.

Final modifications to the application of the site neutral payment rate
- Will continue blended payment for two years
- Blended payment is 50% of the site neutral payment and 50% of the LTCH PPS payment rate
- The IPPS portion of the site neutral payment will be reduced by 4.6% vs. the 4.7% proposed

Final changes to LTCH PPS payment rates

<table>
<thead>
<tr>
<th>FFY 2019</th>
<th>W/quality</th>
<th>W/O quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market basket rate of increase</td>
<td>2.90%</td>
<td>2.90%</td>
</tr>
<tr>
<td>Adjustment if no quality data submitted</td>
<td>-2.00%</td>
<td>-2.00%</td>
</tr>
<tr>
<td>MFP adjustment</td>
<td>-0.80%</td>
<td>-0.80%</td>
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<tr>
<td>ACA adjustment</td>
<td>-0.75%</td>
<td>-0.75%</td>
</tr>
<tr>
<td>Proposed change to standardized amount</td>
<td>1.35%</td>
<td>-0.65%</td>
</tr>
</tbody>
</table>
Section VII

Elimination of the “25-Percent threshold policy”

- Originally established in the FY 2005 final rule for LTCH HwHs & satellites
- Will include a temporary, one-time payment factor of 0.990884

Section VIII

Quality data reporting requirements for specific providers & suppliers

- CMS is focusing on commitment to using a smaller set of more meaningful measures, focusing on patient-centered outcome measures & taking into account opportunities to reduce paperwork & reporting burden on providers
- Overhaul of the Meaningful Use Program to focus on interoperability
- Hospital Inpatient Quality Reporting (IQR) Program
  - Removal of 39 measures
    - Removal of 21 measures to avoid duplication/overlap
    - Removal of 18 measures that have “topped out”, are irrelevant, or no longer worth burden of data collection
  - Changes for reporting of electronic clinical quality measures (eCQMs)
    - For the calendar year 2019 reporting period/FY 2021 payment determination, require that hospitals submit one, self-selected calendar quarter of discharge data for 4 eCQMs in the Hospital IQR Program measure set, which is a continuation of the same reporting requirements previously adopted for the calendar year 2018 reporting period/FY 2020 payment determination
    - Require use of the 2015 Edition of certified electronic health record technology (CEHRT) for eCQMs
Section VIII

Quality data reporting requirements for specific providers & suppliers

• Adoption of one additional factor for evaluating measures for removal from the program: “The cost associated with a measure outweighs the benefit of its continued use in the program”

• PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
  o Reporting of 1 new measure:
    • Claims based hospital 30-day unplanned readmission outcome measure beginning with CY 2019 reporting period
  o Removal of 4 measures:
    • Oncology: Radiation Dose Limits to Normal Tissues;
    • Oncology: Medical and Radiation – Pain Intensity Quantified;
    • Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients; and
    • Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
  o Adoption of one additional factor for evaluating measures for removal from the program: “The costs associated with a measure outweigh the benefit of its continued use in the program”

• Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
  o Removal of 3 measures that have significant operational reporting challenges or are duplicative of other measures:
    • National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bactereemia Outcome Measure (NQF #1716) (beginning with the FY20 LTCH QRP)
    • National Healthcare Safety Network (NHSN) Ventilator Associated Event (VAE) Outcome Measure (beginning with the FY20 LTCH QRP)
    • Percent of Residents or Patients Who Were Assessed & Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) (beginning with the FY21 LTCH QRP)
  o Update on methods by which LTCHs are notified of non-compliance with the LTCH QRP
  o Adoption of one additional factor for evaluating measures for removal from the program: “The costs associated with a measure outweigh the benefit of its continued use in the program”
Section VIII

Quality data reporting requirements for specific providers & suppliers

- Changes to the Medicare & Medicaid EHR Incentive Programs (Promoting Interoperability Programs)
  - CY19, reiteration that all eligible hospitals & CAHs under the Medicare & Medicaid EHR Incentive Programs are required to use the 2015 Edition of CEHRT
  - EHR reporting periods in 2019 & 2020 for new & returning participants attesting to CMS or their State Medicaid agency would be a minimum of any continuous 90-day period within each of the calendar years 2019 & 2020
  - eCOMs for eligible hospitals & CAHs
    - Reporting period is one, self-selected calendar quarter of CY19 data, reporting on at least four self-selected eCOMs from the set of 16
    - Submission period for the Medicare Promoting Operability Program is the two-months following the close of the calendar year 2019, ending February 29, 2020
    - Removal of eight of the 16 eCOMs which is consistent with CMS’ commitment to producing a smaller set of more meaningful measures & in alignment with the Hospital IQR Program, beginning with the 2020 reporting period
  - Overhaul of the Medicare & Medicaid EHR Incentive Programs (Meaningful Use program) change name to “Promoting Interoperability
    - Performance based scoring methodology – smaller set of objectives
    - Two new measures related to e-prescribing of opioids
    - Removal of certain measures that do not emphasize interoperability

Medicare cost reporting

- Changes to Supporting Documentation Requirements (periods beginning on/after 10/1/18)
  - Removing reference to Reimbursement Questionnaire
  - Detail reports with required columns of patient data will have to be included with the initial cost report submission or it will be rejected
    - Charity Care & Uninsured Discounts for S-10
    - Bad debts (Exhibit 2)
    - DSH: Can still file amended cost reports within 12 months to add additional days, but new detail must be submitted again
  - No longer going to be adopted in Final Rule: IRIS data will be required to contain the same total counts of IME/GME FTEs as what is on the cost report
  - Change from proposed: All cost reports that claim home office costs must have a Home Office (HO) Cost Statement on file with the MAC, but now the responsibility to submit it to the MAC lies with the HO
    - There just has to be something on file that covers a portion of the provider’s cost report, if the HO has a different fiscal year end
Section X

✓ On January 1, 2019 guidelines will be updated to require hospitals to make available a list of their current standard charges in a machine readable format via the Internet that is updated at least annually

✓ CMS asks multiple questions regarding how this will work as well as other potential ways to help patients navigate pricing
  - Definition of “standard charges”?
  - How should CMS enforce pricing transparency?
  - Many others related to what information hospitals could potentially be required to provide to patients prior to receiving services
  - CMS is also looking at these related to Medigap coverage

Section XI

Final revisions - physician certification & recertification of claims

42 CFR 424.11(c)
- Current last sentence requires physicians to make a statement as to where in the Medical Records supporting documentation of claim can be found
- This rule has been used to deny claims if a statement with the specific location is not included even if location is obvious

Changes to 424.11(c) proposed
- Delete last sentence requiring the statement specifying the location of the documentation
- Move 2nd sentence to paragraph (b)
  - Indicates cert/recert does not need to contain info contained elsewhere in provider records
**Request for info: promoting interoperability & elect HC info exchange**

**Hospitals must use EHR tech certified in 2015 edition**

Draft of Trusted Exchange Framework & Common Agreement released in January 2018 contains four goals:

- Professional Care Providers have access to patient info across continuum
- Patients can find all their health info across continuum
- All needed groups can find info on population groups
- Health IT community has access to Application Programming Interface

**Draft of TEF finalized after public comment**

**CMS considering changes to Hospital COPs requiring electronic transfer of info to other providers**

- Goes farther than the proposed rules to implement the IMPACT Act

---

**Section IV — DSH Uncompensated Care**

**Factor 1**

75% of the amount of Medicare DSH payments that would have otherwise been paid under the original DSH method

- Adjusted FFY18 - $11,700,000,000
- Adjusted FFY19 - $12,200,000,000

**Factor 2 Uninsured population**

Utilizing CMS’s Office of the Actuary (OACT) estimates to determine the change in the uninsured population which is consistent with FFY18
DSH Uncompensated Care (UC) Payments

Factor 2
OACT Estimate for Uninsured Rate

- 2018 Final Rule
  - CY 2017 – 8.3%
  - CY 2018 – 8.1%
- 2019 Final Rule
  - CY 2018 – 9.1%
  - CY 2019 – 9.6%

Factor 2
Adjustment Factor Applied To The UC Amount

- FFY18 – 58.01%
- FFY19 – 67.51%

FACTOR 2 - TOTAL DSH PAYMENTS

- 2017: $5,977
- 2018: $6,767
- 2019: $8,273
DSH – Uncompensated Care Payments

Factor 3
- Includes S-10 updated in HCRIS through June 30, 2018
- S-10 data changed for FY14 & FY15 for roughly half of the hospitals eligible to receive Medicare DSH payments
- Methodology is consistent with previous year but includes one more year of S-10 information & one less year of Medicaid days/SSI%

---

DSH – Uncompensated Care Payments

Hospital’s uncompensated care as a percentage of the total uncompensated care for all eligible hospitals
- Step 1: Low-income insured days proxy based on FY13 cost report Medicaid days & the FY16 SSI ratios
- Step 2: FY14 Worksheet S-10 charity care & bad debt expense data
- Step 3: FY15 Worksheet S-10 charity care & bad debt expense data
- Step 4: Average of the values computed in Steps 1, 2, & 3 to determine the hospital specific Factor 3
- FY2020 would be the first year using three years of S-10 data to allocate uncompensated care payments, based on FY14, FY15 & FY16
- When reviewing FY16 S-10 information for FY2020, it is possible the 3 year averaging will be eliminated
**DSH – Uncompensated Care Payments**

**Section IV**

<table>
<thead>
<tr>
<th>DSH - Uncompensated Care Payments</th>
<th>PERCENT OF PAYMENTS TO TOTAL</th>
<th>PERCENT CHANGE 2017 - 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>504,002,486 $</td>
<td>730,655,269 $</td>
</tr>
<tr>
<td>Florida</td>
<td>461,705,386 $</td>
<td>593,966,674 $</td>
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<tr>
<td>Indiana</td>
<td>119,846,739 $</td>
<td>162,407,980 $</td>
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<tr>
<td>Missouri</td>
<td>198,599,035 $</td>
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<td>Louisiana</td>
<td>123,417,859 $</td>
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<tr>
<td>Tennessee</td>
<td>145,389,834 $</td>
<td>165,194,320 $</td>
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<tr>
<td>Alabama</td>
<td>150,959,130 $</td>
<td>123,218,629 $</td>
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<tr>
<td>Mississippi</td>
<td>63,761,125 $</td>
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<tr>
<td>Kansas</td>
<td>31,572,649 $</td>
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<td>Oklahoma</td>
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<tr>
<td>Illinois</td>
<td>245,596,163 $</td>
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<tr>
<td>Arizona</td>
<td>51,759,743 $</td>
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<tr>
<td>District of Columbia</td>
<td>30,838,445 $</td>
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<tr>
<td>Arizona</td>
<td>107,365,946 $</td>
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<td>Wisconsin</td>
<td>98,229,231 $</td>
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<td>Washington</td>
<td>94,664,595 $</td>
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<tr>
<td>Connecticut</td>
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<td>67,429,607 $</td>
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<tr>
<td>Minnesota</td>
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<td>Michigan</td>
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<tr>
<td>New York</td>
<td>649,128,996 $</td>
<td>615,133,330 $</td>
</tr>
</tbody>
</table>

**Section IV — DSH – Uncompensated Care Payments**

**Key takeaways**

- **FY19** will require a Charity detail listing with submission of the cost report
- No timeline for amending FY16 S10 information
- MAC audits to begin fall of 2018
- Possible that the UC DSH Payment increased from FY18, but could be losing ground
- Expect trend to carry forward in FY2020
Section IV — DSH – Uncompensated Care Payments

S-10 Planning Opportunities

- Evaluate non-reimbursable cost centers
- Charge Master Pricing
- Charity Policy Thresholds
- Compare Bad Debt detail to Financials
- Add “non-Traditional” Medicare bad debt amounts to the Bad Debt line 26
- Update FY16 S-10 amounts when filing cost report amendments
- Evaluate Self-pay adjustments (including Amounts Generally Billed) especially in FY17
- Review criteria used to capture amounts reported on S10

Audit Request Items

- Hospitals given 3 weeks to submit requested information
- Details regarding charity care policies
- Specific information on report query process
- Detail listings by patient and revenue charge code for charity and bad debt lines
- Crosswalk of all transaction/adjustment codes
- Reconcile bad debt general ledger expense to detail listing of bad debt write-offs
OPPS proposed rule CY 2019

- Maintain OPPS drug reduction for certain 340B organizations and expand to include reductions at non-excepted off-campus provider based locations.
- Additionally, payment rate reductions proposed for clinic visits at off-campus provider-based departments to 40% of OPPS rate (regardless of grandfathered status)
- Expands 40% of OPPS rate payment to service lines added at grandfathered off-campus provider based locations

Other Issues

- Homeland Security to add rule that will likely push millions of immigrant families off the Medicaid roles
- Court ruling opens up possibility of corrected errors in old base rates, such as per resident amounts, hospital specific rates (Saint Francis decision from D.C. Circuit Court)
- S-10 audits have begun, request lists from MAC appear to be the same, so probably dictated by CMS. They are asking for a lot of data
- CMS heading toward all electronic filing? Cost Reports, MGCRB, PRRB…
340B Program Update

On August 28, 2015, HRSA released 340B Omnibus Guidance (Mega Guidance)

On January 30, 2017, the White House Office of Management & Budget withdrew the final Mega Guidance

OPPS Final Rule 340B Reduction for Status Indicator K drugs effective January 1, 2018

H.R 4392 introduced to reverse OPPS Final Rule on November 20, 2017. AHA files lawsuit to block OPPS Final Rule

Pause Act introduced on December 21, 2017 in House

Energy and Commerce Committee releases Review of the 340B Drug Pricing Program on January 10, 2018

HELP Act introduced on January 17, 2018 in Senate
Energy & commerce review

- HRSA should have regulatory authority to administer & oversee 340B
  - Improve program integrity
  - Program requirements
  - Monitor & track use
  - Ensure low-income & uninsured directly benefit from 340B
- HRSA requires additional resources
- Independent audit requirements
- Reduce duplicate discounts paid for under Medicaid managed care
- HRSA should work toward ensuring that it audits covered entities & manufacturers at the same rate
- Intent of the 340B program
- 340B transparency
  - Ceiling prices
  - Disclose annual savings &/or revenue
- Monitor charity care provided by covered entities
- Reassess whether DSH is an appropriate measure for program eligibility or base on outpatient population metric

340B pause act

- Introduced in House in late December with bi-partisan support
- 2 year moratorium on new DSH covered entities entering 340B
- 2 year moratorium on new child sites for current DSH covered entities
- Significant data reporting requirements
  - DSH, Cancer Hospitals & Children’s Hospitals
  - All other covered entities are exempt from new reporting requirements
  - Would begin within 14 months of the enactment of the bill
  - Provides authority for HHS
- Government official contract
- OIG & GAO reporting for DSH, Cancer Hospitals & Children’s Hospitals
- No change to patient definition
- Does not apply to all covered entity types
Help act

- Introduced in the Senate on January 17, 2018 by Dr. Bill Cassidy
- Increase transparency and strengthen reporting requirements to prevent abuse and ensure 340B savings are used to lower drug costs
- Hold hospitals accountable for passing 340B savings from drugs to patients
- Prohibit new enrollments in 340B for at least 2 years
- Require the HHS Secretary to issue new reporting requirements for current program covered entities
- Critical Access Hospitals, Rural Referral Centers, Sole Community Hospitals, Grantees, PPS-exempt Children’s and Cancer Hospitals would be excluded from enrollment restrictions and new reporting requirements
- In recent years, government watchdogs like the GAO, HHS, OIG and MedPAC have identified transparency concerns and loopholes in the 340B program that enable hospitals to take advantage of Medicare and Medicaid reimbursement rates and divert resources away from the patients the program is intended to help.
- “The 340B program is an important resource for hospitals serving low-income areas,” said Dr. Cassidy. “But too often the program’s discounts are used to pad hospitals’ bottom lines instead of helping disadvantaged patients afford their treatments. This bill will increase transparency and accountability and help ensure these discounts reach patients.”

OPPS final rule CY 2018

- On November 1, 2017, CMS released a Final Rule that reduces payment to certain 340B hospitals for separately payable Part B drugs without pass-through status (Status Indicator K) by nearly 30%
  - Prior to January 1, 2018, these drugs are reimbursed at Average Sales Price + 6%. Effective January 1, 2018, the Final Rule reduces the payment rate to Average Sales Price minus 22.5%
  - The payment reduction will apply to 340B hospitals that are designated by Medicare as DSH, RRC or Urban SCH
  - The payment reduction will not impact 340B hospitals that are designated by Medicare as CAH, Rural SCH, children’s hospital and PPS-exempt cancer hospitals
- For CY 2018, Non-excepted off-campus provider based locations were not subject to the nearly 30% reduction
# OPPS final rule CY 2018

<table>
<thead>
<tr>
<th>Hospital Type (CMS Designation)</th>
<th>Status Indicator G Drugs (Pass-through)</th>
<th>Status Indicator K Drugs (Separately Payable)</th>
<th>Vaccine (Status Indicator F, L or M)</th>
<th>Status Indicator N (Packaged Drug)</th>
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<tbody>
<tr>
<td>Critical Access Hospital</td>
<td>TB, Optional</td>
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<td>Maryland Waiver Hospital</td>
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<td>Non-Excepted Off-Campus</td>
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<tr>
<td>Paid under OPPS, Excepted from the 340B Payment Adjustment for 2018</td>
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<tr>
<td>Children's Hospital</td>
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<tr>
<td>PPS-Exempt Cancer Hospital</td>
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<td>N/A</td>
<td>TB or JG, Optional</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Paid under the OPPS, Subject to the 340B Payment Adjustment</td>
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<tr>
<td>Rural Sole Community Hospital</td>
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<td>Disproportionate Share Hospital</td>
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<td>Medicare Dependent Hospital</td>
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<td>Rural Referral Center</td>
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<tr>
<td>Non-Rural Sole Community Hospital</td>
<td>TB</td>
<td>JG</td>
<td>N/A</td>
<td>TB or JG, Optional</td>
</tr>
</tbody>
</table>
**1 Transition from FFS to Value**

- Obama's ACA focused on two key items:
  - **Access** to care which remains politically problematic
  - **Delivery** of care which is making steady progress

- Centers for Medicare and Medicaid Innovation (CMMI)
  - ACO
  - Bundled Payments
  - MACRA

- Despite political uncertainty, CMS presses forward with transitioning from volume to **value** (code word for **RISK**)

---

**Payment Reform Discussion**

1. **Payment Reform Landscape**
2. **Bundle Basics**
3. **Strategic Considerations**
Where are we today?

Q&A with Dr. Patrick Conway: “I do believe we need more outcome oriented measures”

MH: To what extent did the Trump administration taking over and the future of the Innovation Center drive the decision?

Conway: I worked on value-based care in Republican and Democratic administrations. I believe the Innovation Center and the work on value-based care will continue. It’s driven in both the public and private sectors. Private insurers are driving value-based care models like accountable care organizations and bundled payments.

We've got over 80% of payments tied to quality and value in some way in Blue Cross North Carolina and now it's taking it to the next step of really scaling these ACO models and bundled payments across the state.
### MSSP ACOs

<table>
<thead>
<tr>
<th>MSSP ACOs</th>
<th>Episode Models (Bundles)</th>
<th>Primary Care Transition</th>
<th>Medicaid and CHIP</th>
<th>Acceleration Models</th>
<th>Speed Adoption of Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pioneer Model</td>
<td>ACE Demonstration</td>
<td>Advanced Primary Care Initiative</td>
<td>Reduce Avoidable Hospitalizations</td>
<td>State Innovation Models</td>
<td>Beneficiary Engagement Model</td>
</tr>
<tr>
<td>MSSP Tracks 1,2,3</td>
<td>BPCI Model 1, 2, 3, 4</td>
<td>Comprehensive Primary Care Initiative</td>
<td>Financial Alignment Incentive for Medicare and Medicaid</td>
<td>Frontier Community Health Integration</td>
<td>Community-Based Care Transitions</td>
</tr>
<tr>
<td>ACO Next Generation</td>
<td>Oncology Care Model</td>
<td>Accountable Care Model</td>
<td>Strong Start for Mothers and Newborns</td>
<td>Health Care Innovation Rounds</td>
<td>Health Care Action and Learning Network</td>
</tr>
<tr>
<td>Track 1+</td>
<td>CPC+</td>
<td>Medicaid Prevention of Chronic Diseases</td>
<td>Health Plan Innovation Initiative</td>
<td>Innovative Advisors Program</td>
<td></td>
</tr>
</tbody>
</table>

### State Innovation Models

- Pioneer Model ACE Demonstration
- MSSP Tracks 1,2,3
- ACO Next Generation
- Track 1+

### Other Models

- BPCI Model 1, 2, 3, 4
- Comprehensive Primary Care Initiative
- Financial Alignment Incentive for Medicare and Medicaid
- Frontier Community Health Integration
- Community-Based Care Transitions
- Accountable Care Model
- Strong Start for Mothers and Newborns
- Health Care Innovation Rounds
- Health Care Action and Learning Network
- CPC+
- Medicaid Prevention of Chronic Diseases
- Health Plan Innovation Initiative
- Innovative Advisors Program

### Colorado Statewide Innovation Initiative

- Reduce Avoidable Hospitalizations
- State Innovation Models
- Community-Based Care Transitions
- Accountable Care Model
- Strong Start for Mothers and Newborns
- Health Care Innovation Rounds
- Health Care Action and Learning Network
- CPC+
- Medicaid Prevention of Chronic Diseases
- Health Plan Innovation Initiative
- Innovative Advisors Program
2006 heart surgery with a 90-day warranty

“ProvenCare” model for coronary artery bypass surgery bundled best practices, patient engagement, preoperative, inpatient and postoperative care (rehospitalizations) within 90 days into a packaged fixed price.

2008 ACE Demonstration (Acute Care Episode)

CMS develops new project for bundling payment on certain cardiovascular and orthopedic procedures. Bundle includes hospital and physician charges with an automatic 1%-6% discount. Medicare beneficiaries could receive $250- $1,175 in incentives for receiving procedures in participating hospitals.
2013- current bundle payments for care improvement (BPCI)

### Bundled Payment Models

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode</td>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs post-acute period</td>
<td>Post acute only for selected DRGs</td>
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<tr>
<td>Services included in the bundle</td>
<td>All Part A and B services (hospital, physician, LTC, HHA, SNF, DME, Part B drugs, etc.) and readmissions</td>
<td>All Part A and B services (hospital, physician, LTC, HHA, SNF, DME, Part B drugs, etc.)</td>
<td>All Part A and B services (hospital, physician) and readmissions</td>
</tr>
<tr>
<td>Payment</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
</tr>
</tbody>
</table>

### BPCI Results

- The majority of clinical episodes under Model 2 had relative declines in total Medicare payments.
- Lower use of institutional post-acute care led to reduced Medicare payments under Model 2.
- Few indications that BPCI affected quality.
- Beneficiary surveys indicated BPCI did not negatively impact patient satisfaction.
2 2016 comprehensive care for joint replacement (CJR)

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Department of Health and Human Services

75 MGAs

2 2018 BPCI advanced

The Model Timeline for BPCI Advanced is as follows:

- Request for Application: March 2018
- Application Due: May 2018
- CMS Reviews Applications: June 2018
- CMS Selects Participants: July 2018
- Participants Start: October 2018
- Second Cohort: April 2019

Everyone needs a trusted advisor. Who’s yours?
2 Bundle Basics

- Hospitals are financially at risk for entire episode
  - Anchor stay
  - 90 days post acute
- IP & OP clinical episodes that trigger bundles
- Target pricing
- Inclusion & exclusion criteria
- Windsorization at the patient level
- Stop loss/stop gain at the clinical grouper level
- Retrospective reconciliation
- Waivers
- Gainsharing

3 Strategic Considerations & Analytics

- Timing
- Volume
- Governance & Oversight
  - Finance, Operations, Physicians, Quality, IT, Nursing, Legal
- Clinically Integrated Network
- Physician Alignment
- Internal Cost Reduction & Gainsharing
- Change Management and Culture
- Financial Analysis of Risk
- Compliance, Stark, Anti-Trust
- Data Analytics Capabilities
Questions?

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