MEDICARE REIMBURSEMENT UPDATE

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AGENDA

// Federal Fiscal Year 2016 Inpatient PPS Final Rule
// Other programs and developments
// 340B Update
FEDERAL FISCAL YEAR (FY) 2016 INPATIENT
PPS FINAL RULE

// Payment Rate Changes
// Wage Index Changes
// Disproportionate Share Hospital (DSH) Payment Changes
// Quality Provisions & Other Issues

For rule, tables & data files, go to:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html
PAYMENT RATE CHANGES
For Hospitals that submit quality data and are meaningful users.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Increase</td>
<td>2.4%</td>
</tr>
<tr>
<td>Less: Doc &amp; Coding Adjustment</td>
<td>(0.8)%</td>
</tr>
<tr>
<td>Less: Productivity Adjustment</td>
<td>(0.5)%</td>
</tr>
<tr>
<td>Less: ACA Required Cut</td>
<td>(0.2)%</td>
</tr>
<tr>
<td>Actual Rate Increase</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

PAYMENT RATE CHANGES

Factors that impact the Market Basket Rate-of-Increase:
- Failure to submit quality data (loses one quarter of MB)
- Failure to be a meaningful EHR user (loses one half of MB)
  - No quality data but MU, update is 0.3%
  - Not MU, but submits quality data, update is minus 0.3%
  - No quality data, not MU, update is minus 0.9%
DOCUMENTATION & CODING ADJUSTMENT

// Section 631 of American Taxpayer Relief Act
// Requires $11 billion be recovered from hospitals between 2014 & 2017 from MS-DRG transition in 2008
// CMS estimated 9.3% cut would recover all in 2014
// Instead, implemented 0.8% cut in 2014, cutting $1 billion
// An additional 0.8% cut in 2015, without removing prior year cut, cutting $2 billion
// Additional 0.8% cuts in 2016 & 2017 coming to recoup remaining $8 billion

DOCUMENTATION & CODING ADJUSTMENT

// CMS has not reduced hospital-specific rates for sole community hospitals (SCH) & Medicare-dependent hospitals (MDH) for the current year documentation & coding adjustment
PRODUCTIVITY ADJUSTMENT
// Starting 10/1/11, annual Medicare inflation adjustment is reduced by productivity adjustment “equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity”

<table>
<thead>
<tr>
<th>Date</th>
<th>Cut (vs. MB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/11</td>
<td>1.0% (vs. 3.0%)</td>
</tr>
<tr>
<td>10/1/12</td>
<td>0.7% (vs. 2.6%)</td>
</tr>
<tr>
<td>10/1/13</td>
<td>0.5% (vs. 2.5%)</td>
</tr>
<tr>
<td>10/1/14</td>
<td>0.5% (vs. 2.9%)</td>
</tr>
<tr>
<td>10/1/15</td>
<td>0.5% (vs. 2.4%)</td>
</tr>
</tbody>
</table>

ACA REQUIRED CUTS
//4/1/10 = 0.25% //10/1/14 = 0.2%
//10/1/10 = 0.25% //10/1/15 = 0.2%
//10/1/11 = 0.1% //10/1/16 = 0.75%
//10/1/12 = 0.1% //10/1/17 = 0.75%
//10/1/13 = 0.3% //10/1/18 = 0.75%
WAGE INDEX UPDATE

// CMS implemented the 2010 census labor market areas effective 10/1/14
// Housekeeping & dietary labor costs must be reported on wage survey
// New timeline for wage survey changes
// Occupational mix survey used was the data filed by 6/30/14. This one will also be used for FFY 2017.

OCCUPATIONAL MIX DATA

// Average Hourly Wages from the last survey
// National RN  $38.82
// National LPN and Surgical Tech $22.77
// National Nurse Aide, Orderly, Attendant  $15.96
// National Medical Assistant $18.01
// National Nurse Category $32.88
TRANSITION POLICIES

// Urban hospitals whose counties become rural can retain urban wage index for 3 years (FFY 2016 is the second of those 3 years), unless already receiving reclassification to a different area.

// In 2015 if the wage index with 2015 CBSAs would be lower than with 2014 CBSAs, a 50/50 blended wage index will be computed averaging 2014 and 2015 CBSAs. This is not applicable to the FFY 2016 wage index.

URBAN TO RURAL RECLASSIFICATION

// Hospitals becoming urban may benefit from reclassification to retain rural status

// Retain sole community hospital (SCH) status

// Retain Medicare-dependent hospital (MDH) status

// Retain critical access hospital (CAH) status

// Two year grace period proposed for CAHs to reclassify back to rural status. We are more than halfway through the grace period now.
CONTRACT HOUSEKEEPING & DIETARY

// CMS concerned about hospitals not reporting contract housekeeping or dietary costs (due to not having hours identified)

// CMS believes this overstates hospital’s average hourly wage & has instructed contractors to estimate housekeeping & dietary costs if hospitals do not report them

WAGE INDEX TIMELINE

// September 2, 2015 – Deadline for hospitals to request revisions to wage data. Defined benefit plan revisions deadline 10/15/15

// November 4, 2015 – Deadline for MACs to tattle to State Hosp Asso on those that did not respond to MAC questions.

// November 13, 2015 – Deadline for MACs to complete wage index desk reviews and transmit data to CMS.

// January 29, 2016 – Release of revised FY 2017 PUFs

// February 16, 2016 – Deadline for hospitals to submit requests for corrections to the PUF data

// March 24, 2016 - Deadline for MACs to transmit final data to CMS.

    // MACs must send written response to hospital regarding Feb requests

// April 5, 2016 – Deadline for hospitals to appeal MAC decisions to CMS
ACCELERATION OF WAGE SURVEY TIMELINE

<table>
<thead>
<tr>
<th>Deadline</th>
<th>FFY 2015</th>
<th>FFY 2016</th>
<th>FFY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS to publish preliminary public use file</td>
<td>9/13/13</td>
<td>5/23/14</td>
<td>5/15/15</td>
</tr>
<tr>
<td>Hospitals to request revisions</td>
<td>11/21/13</td>
<td>10/6/14</td>
<td>9/2/15</td>
</tr>
<tr>
<td>Contractors to complete desk reviews</td>
<td>1/29/14</td>
<td>12/16/14</td>
<td>11/13/15</td>
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</tbody>
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MEDICARE DSH PAYMENT CHANGES

// ACA changed DSH formula, effective 10/1/13

Two payments calculated for a DSH hospital

Traditional DSH payments continue to be computed but only paid at 25% (now called the "Empirically Justified" DSH payment)

A second payment will be based on three factors & is referred to as the "Uncompensated Care" DSH payment
MEDICARE DSH PAYMENT CHANGES

// Uncompensated Care DSH three factors:
// Factor 1 – Difference between 100% of DSH payment that would have been paid out if the law had not been changed & the 25% that will be paid out
// Factor 2 – 1 minus the % change in uninsured individuals based on CBO’s estimate
// Factor 3 – Proportion of uncompensated care for hospital compared to all hospitals who receive DSH, using Medicaid days & SSI days

// Factor 3 is based on each hospital’s share of total uncompensated care costs across all IPPS hospitals that received DSH payments

MEDICARE DSH PAYMENT CHANGES

// Proposed 2016 Payment methodology remains the same as 2014 and 2015

25% of Original DSH Payment + 75% Of Original DSH Payments × Change in Uninsured × Uncomp Care Cost Ratio = Total New DSH Payment
MEDICARE DSH PAYMENT CHANGES

Uncompensated Care DSH

// Distribution of the 75% pool based on 3 Factors

1. DSH Payments that would have been made, after 25% reduction
   • FFY 2014 = $9.593 Billion
   • FFY 2015 = $10.038 Billion
   • FFY 2016 = $10.003 Billion

2. Decrease pool by the change in the uninsured population
   • CBO estimate from 16% in 2014 to 13.75% in 2015
   • FFY 2014 = $9.044 Billion
   • FFY 2015 = $7.648 Billion
   • FFY 2016 = $6.406 Billion

3. Hospital's Uncompensated Care divided by the aggregate amount of Uncompensated Care for all hospitals eligible for payment.
   • Still not using Worksheet S-10
   • Continue to be a proxy of Medicaid and SSI days
   • Medicaid Days from the 2012 cost reports, again (same as last year)
   • Most recently available SSI Days (FFY 2013)
   • Review Supplemental DSH Data File
     • [http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.htm](http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.htm)
QUALITY PROVISIONS

- Value-based purchasing pool was 1.5% for FY15. Increases to 1.75% in FY16; 2.0% in FY17
- Maximum readmissions reduction increased to 3% for FY2015 & subsequent years
- Hospital-acquired conditions penalty of 1% for hospitals in lowest quartile of hospital-acquired conditions

INPATIENT QUALITY REPORTING (IQR) PROGRAM

- In the final rules 7 new measures were added
  - FY18, three new claims-based measures and one structural measure
  - FY19, three new claims-based measures
  - FY18, 9 measures will be removed
- Leaves 64 measures for FY17 and beyond
VALUE BASED PURCHASING PROGRAM

// Will be adding 2 new measures in FY18
  // New measures include a 3-item Care Transition Measure
// Will be removing 2 measures in FY18.
// VBP incentive payments will total $1.499 Billion for FY16
  // Reduction percentage used to create pool increases from 1.5% in FY15 to 1.75% in FY16.

HOSPITAL-ACQUIRED CONDITION PROGRAM

// Still a 1% reduction to hospitals in the bottom quartile of performance
// CMS adding an extraordinary circumstance exception policy
  // For hospitals experiencing a significant disaster or other extraordinary circumstance beyond their control.
INDIRECT MEDICAL EDUCATION PAYMENTS

// No changes to the IME formula or payments

SHORT STAYS & 2-MIDNIGHT POLICY

// CMS addresses the 2-midnight policy in the 2016 OPPS/ASC proposed rules.

// QIOs will oversee most of the patient status audits, RAC only high denial rate hospitals.

// Adding a case by case exception rules, will need to document the following:

// Severity of the signs and symptoms of the patient

// Medical predictability of an adverse event

// Need for diagnostic studies that more appropriately OP services
Pathway to SGR Reform Act of 2013 directed CMS make changes in LTCH PPS

There are now 2 different rates for LTCH care, the patient’s clinical criteria controls the payment. You get either

// The LTCH PPS standard Federal rate, or

// A new LTCH PPS site neutral payment rate generally comparable to the IPPS payment rate.

To be paid at the higher LTCH standard rate the patient discharged must:

// Not have a psych or rehab principal diagnosis

// Be preceded by an acute care discharge, with

// Either 3 ICU days during the acute stay or 96-hours of vent services during the LTCH stay

// Two-year transition with the site neutral payments paid on 50/50 blend.

// Begins 10/1/15
LTCH PPS – MAJOR CHANGES AHEAD

// CMS projects LTCH payments will decrease by 4.6%, primarily due to the site neutral rules
// LTCH standard rates increased 1.7% for LTCH submitting quality data
// Impact will depend greatly on the make up of the patients coming to the LTCH

OPPS PROPOSED RULE

// Proposed rule issued on 7/1/15; published in the 7/8/14 Federal Register
// Proposed decrease of 0.1% (2.7% less productivity adjustment of .6% and .2% cut required by ACA and a 2.0% reduction for excess packaged payment for lab tests)
OPPS PROPOSED RULE
Overpayment for Packaged Lab
// CMS reports it overestimated the shift in CY 2014 spending for newly packaged labs into the OPPS rates
// Now they propose a 2% cut to account for the $1 billion inflation in OPPS spending

OPPS PROPOSED RULE
APC re-organized
// Proposing to restructure, reorganize and consolidate many APCs
// Less APCs in 9 clinical groups
// Comprehensive APCs (C-APCs), implemented in CY 2015 will grow from 25 to 34
// Original 25 were mainly implant procedures
// New C-APC will include surgical and one observation
OPPS PROPOSED RULE
Packaging

// Additional ancillary services will be packaged
// Some drugs used in surgical procedures
// Lab gets a packaging status indicator which will make it easier to bill for lab tests provided without other related services

SKILLED NURSING FACILITY

// SNF PPS Final Rule – Medicare Payments
// Published in the August 4, 2015 Federal Register
  // Effective October 1, 2015
// Overall rate increase of 1.2% for FY 2016
  // Market basket 2.3%, less 0.5% productivity adjustment (ACA) and 0.6% forecast error = 1.2% net increase
// Additional 2% reduction for failing to submit quality data
SKILLED NURSING FACILITY

// SNF PPS Final Rule – Quality Measures Finalized
// 2% withhold of all SNF PPS payments
// Can earn back some of the withhold by improving rehospitalization rates
// 3 quality measures added to comply with the IMPACT Act

LONG-TERM CARE, NEW CoPs

// Comment period extended 30 days to 10/14/15
// First substantial changes since 1991
    // CMS notes nursing home populations are much different now than in 1991
// CMS anticipates implementation will take more than 12-months from final rule
Requires a facility-wide assessment to ensure adequate resources available to care for residents.

A “competency” requirement to determine if sufficient and appropriately skilled staff is available.

Extensive, enhanced requirements for food and nutrition considering resident assessments.

Several new requirements related to behavioral health, use of psychotropic and other drugs.

Limits on binding arbitration agreements, prohibited as condition of admission.

Limits residents to no more than 2 in a bedroom.

Requires available private, in-room toilet facilities.

And others.
REHAB & PSYCH FINAL RULES

// Rehabilitation Rates - Increase of 1.7% (2.4% MBI less 0.2% ACA cut and a 0.5% productivity cut)

// Psych Rates - Increase of 1.5% (2.4% MBI less 0.2% ACA cut, a 0.5% productivity cut and a 0.2% cut due to the update of the outlier threshold)

RURAL EXTENDERS

// Low-volume hospital payment add-on extended one year to 9/30/17 by Medicare Access and CHIP Reauthorization Act of 2015

// Hospitals must have fewer than 1,600 Medicare & Medicare Advantage discharges

  // 25% add-on for 200 or fewer discharges; decreasing to 0% for 1,600 or more discharges

// Eligible hospitals must notify Medicare contractor annually (by September1) that they continue to qualify based on location

// No other IPPS hospitals within 15 miles
RURAL EXTENDERS

// Medicare-dependent hospital classification extended 9/30/17

// CMS automatically extended status for most existing MDHs, effective to 4/1/15.
// Special rules for MDHs that had reverted to urban or SCH status
// These hospitals do not automatically get reinstated as MDH, they must apply
// Even if approved, it will not be retroactive to 4/1/15

ICD-10 IMPLEMENTATION

“End of the Rainbow” or “Something Wicked This Way Comes”

// ICD-10 went live October 1, 2015
// No updates to ICD-10 until 10/1/2016
// ICD-9 no longer valid on or after 10/1/2015. Claims filed with ICD-9 after 9/30/2015 will be rejected.
MEDICAID DSH CUTS

// Medicaid DSH is a $12 billion per year federal program

// Original Medicaid DSH cuts under Affordable Care Act, 2014-2020 = $18.1 billion

// Revised Medicaid DSH cuts under current law, 2018-2024 = $43.0 billion

// CMS does not want to provide relief to states that don’t expand Medicaid

// MedPAC report on uncomp care due Feb 2016

OTHER REGULATORY ISSUES

// DOJ intends to hold individuals accountable for corporate fraud and misconduct

// Development of a unified payment system for post-acute care

// Mandated report due June 30, 2016

// Common patient assessment tool for SNF, HHA, IRF, LTCH

// CMS to collect common assessment data beginning 2018 and recommend an approach for PAC PPS after collecting data for 2 years
NOTICE ACT

// Enacted August 6, 2015 and effective August 6, 2016
// Applies to all hospital, including CAH, IRF, IPF and LTACH
// Must provide written and verbal notice to observation patients and get signed acknowledgement
// Notice must be given after 24 hours but within 36 hours

NOTICE ACT

// Notification must include
   // Reasons why the patient is classified as OP
   // Implications of such a classification
      // Financial ramifications
      // Eligibility for other services
HRSA’S 340B MEGA GUIDANCE

// Federal Register published rules 8/28/15
// Officially called 340B Drug Pricing Program Omnibus Guidance
// Comment period open until 10/27/15
// There are significant changes and clarifications

340B MEGA GUIDANCE

// Extends the prohibition on use of group purchasing organizations
  // Except as a last resort (document, document, document)
// Definition of “eligible patient” clarified
  // Child sites must be on 340B register to be covered. This is a critical compliance element
  // Staff privileges not enough, physician must be employed (or contracted) such that the covered entity may bill for services
### 340B MEGA GUIDANCE

// Definition of “eligible patient” clarified – continued

// Inpatients are not an “eligible patient”. This now includes the ER, observation or other OP services done prior to admission.

// Covered entities can make different decisions on traditional Medicaid and Medicaid Managed Care related to Medicaid discounts.

// Contract pharmacy dispensations (to both traditional and Managed Care Medicaid) will be excluded from the 340B program unless a well-documented plan is in place to avoid duplicate discounts.

### 340B MEGA GUIDANCE

// Notes the expectation of annual independent audits

// Expects auditable data kept for at least 5 years

340B COALITION CONFERENCE TAKEAWAYS

Be prepared – have policies and procedures for all compliance areas.

Compliance is the entity’s responsibility. Do not rely on the software to do that.

Patient eligibility includes maintaining auditable records and maintaining patient responsibility.

Understand how you prevent duplicate discounts.

Have methods in place to prevent diversion and perform self-audits to ensure they are effective.

Questions?

Contact Information

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