MEDICARE REIMBURSEMENT UPDATE

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Agenda

// Federal Fiscal Year 2015 Inpatient PPS Final Rule
// Protecting Access to Medicare Act of 2014
// Other developments & outlook
// 340B Update
Federal Fiscal Year (FY) 2015 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/FY2015-IPPS-Final-Rule-Home-Page.html
### Payment Rate Changes

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Increase</td>
<td>2.9%</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>1.4%</td>
</tr>
</tbody>
</table>

### PAYMENT RATE CHANGES

- Factors that impact the Market Basket Rate-of-Increase
  - Failure to submit quality data
  - Failure to be a meaningful EHR user
    - One-quarter of the Market Basket Update in FFY 2015
    - One-half of the Market Basket Update in FFY 2016
    - Three-fourths of the Market Basket Update in FFY 2017
  - Productivity adjustment (applies to all IPPS hospitals)
  - Statutory adjustment (applies to all IPPS hospitals)
  - Documentation and coding adjustment (applies to all IPPS hospitals)
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 continues to believe an additional prospective adjustment would be justified, calculated to be – 0.55%, but does not propose to make such an adjustment now (will wait until 2018?)
- CMS has not reduced hospital-specific rates for sole community hospitals (SCH) & Medicare-dependent hospitals (MDH) for documentation & coding
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>Productivity Cut</th>
<th>Market Basket Cut</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/11</td>
<td>1.0% (vs. 3.0%)</td>
<td>1.0%</td>
</tr>
<tr>
<td>10/1/12</td>
<td>0.7% (vs. 2.6%)</td>
<td>0.7%</td>
</tr>
<tr>
<td>10/1/13</td>
<td>0.5% (vs. 2.5%)</td>
<td>0.5%</td>
</tr>
<tr>
<td>10/1/14</td>
<td>0.5% (vs. 2.9%)</td>
<td>0.5%</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%
Impact of Medicare ACA Productivity Cuts, Fixed Cuts & Sequestration (Excludes DSH)

Impact of Quality Reporting and EHR Meaningful Use

<table>
<thead>
<tr>
<th>FFY 2015</th>
<th>Submit Quality Data &amp; Meets EHR MU</th>
<th>Submits Quality Data &amp; Does Not Meet EHR MU</th>
<th>Did Not Submit Quality Data &amp; Meets MU</th>
<th>Did Not Submit Quality Data &amp; Does Not Meet MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Rate-of-Increase</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Quality Data Adjustment</td>
<td>0.0</td>
<td>0.0</td>
<td>-0.725</td>
<td>-0.725</td>
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<tr>
<td>EHR Meaningful Use Adjustment</td>
<td>0.0</td>
<td>-0.725</td>
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<td>-0.725</td>
</tr>
<tr>
<td>Productivity Adjustment</td>
<td>-0.5</td>
<td>-0.5</td>
<td>-0.5</td>
<td>-0.5</td>
</tr>
<tr>
<td>ACA Required Adjustment</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
</tr>
<tr>
<td>Documentation &amp; Coding Adjustment</td>
<td>-0.8</td>
<td>-0.8</td>
<td>-0.8</td>
<td>-0.8</td>
</tr>
<tr>
<td>Operating Payment Rate Increase (Decrease)</td>
<td>1.4%</td>
<td>0.675%</td>
<td>0.675%</td>
<td>-0.05%</td>
</tr>
</tbody>
</table>
Wage Index Update

// CMS implementing 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 was due 6/30/14

TRANSITION POLICIES

// Urban hospitals whose counties become rural can retain urban wage index for 3 years, unless already receiving reclassification to a different area
// If 2015 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
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
- No grace period proposed for PPS hospitals

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

// October 6, 2014 – Deadline for hospitals to request revisions to wage data
  // MACs “must receive” requests and support by this date.
// December 8, 2014 – Deadline for MACs to tattle to State Hosp Asso on those that did not respond to MAC questions.
// December 16, 2014 – Deadline for MACs to complete wage index and occ mix reviews and transmit data.
// February 13, 2015 – Released of revised FY 2016 PUFs
// March 2, 2015 – Deadline for hospitals to submit requests for corrections
// April 8, 2015 - Deadline for MACs to transmit final data to CMS.
  // MACs must send written response to March 2nd requests
// April 15, 2015 – Deadline for hospitals to appeal MAC decisions to CMS
// June 1 – Deadline for Hospitals to submit corrections to final 2016 PUF

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>Hospitals to request revisions</td>
<td>11/21/13</td>
<td>10/6/14</td>
<td>Early August 2015</td>
</tr>
<tr>
<td>Contractors to complete desk reviews</td>
<td>1/29/14</td>
<td>12/16/14</td>
<td>Mid-October 2015</td>
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</tbody>
</table>
Urban to Rural Reclassification

// Criteria for reclassification (42 CFR 412.103)

// Hospital is in a rural census tract, based on most recent Rural-Urban Commuting Area codes:

// Hospital is in an area designated by any law or regulation of the State as a rural area, or the hospital is designated rural by State law or regulation, OR

// Hospital would qualify as rural referral center or SCH if located in a rural area

RUCA Codes

// 2010 RUCA codes released in late 2013

// If a hospital previously elected rural status under 42 CFR 412.103, based on prior RUCA codes & is no longer rural based on 2010 RUCA codes, rural election is invalidated (unless hospital qualifies under one of remaining two criteria)
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 2015 Payment methodology remains the same as 2014

25% of Original DSH Payment + 75% Of Original DSH Payments \times \text{Change in Uninsured} \times \text{Uncomp Care Cost Ratio} = \text{Total New DSH Payment}

MEDICARE DSH PAYMENT CHANGES

Empirically Justified DSH – (Old DSH Methodology)

// Hospitals must meet the 15% threshold in order to qualify for these payments and the “Uncompensated Care” payments

// 340B Qualification

25% of Original DSH Pmt
**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

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
   - Actual amount paid may exceed or fall short

3. Hospital’s Uncompensated Care divided by the aggregate amount of Uncompensated Care for all hospitals eligible for payment.
   - Not using Worksheet S-10
   - Continue to be a proxy of Medicaid and SSI days
   - Medicaid Days from the 2012 cost reports
   - Most recently available SSI Days (FFY 2012)
   - 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)
MEDICARE DSH PAYMENTS

// BKD Thoughtware
// FFY 2014 versus FFY 2015 uncompensated care payments

Quality Provisions

// Value-based purchasing pool increases to 1.5% for FY15; 1.75% in FY16; 2.0% in FY17
// Maximum readmissions reduction increases to 3% for FY2015 & subsequent years
// Hospital-acquired conditions penalty of 1% for hospitals in lowest quartile of hospital-acquired conditions
// CMS estimates -0.3% impact on urban hospitals; -0.2% impact on rural hospitals
Indirect Medical Education Payments to SCHs

Sole community hospitals with teaching programs don’t get IME added to hospital-specific rate payments.

Arguably, IME is in base-year costs if SCH was a teaching hospital in base year.

CMS will start paying IME for Medicare Advantage patients to all SCHs, whether paid on federal rate or hospital-specific rate.

CMS estimates 50 hospitals will benefit, with $5 million aggregate payment increase.

Short Stays & 2-Midnight Policy

CMS seeks comments on developing payment policy for short-stay or low-cost inpatients, presumably for 1-day stays? Questions:

How to define short or low-cost stays

How to pay for short or low-cost stays

No change to 2-midnight policy, but offers the opportunity to identify additional exceptions to the policy

Continuing to withhold 0.2% to pay for policy
Charge Transparency

// ACA requires that each hospital “for each year establish (& update) & make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges”

// CMS “reminds” hospitals of obligation & provides “flexibility to determine how they make a list of their standard charges public”

// Charge information should be updated at least annually

Charge Transparency

// Hospitals should either make public a list of their standard charges (whether that be the charge master itself or in another form) or their policies for allowing the public to view a list of charges in response to an inquiry

// Hospitals should work with patients

  // To understand potential financial liability for hospital services they obtain

  // To be able to compare charges for similar services across hospitals
**OPPS Proposed Rule**

// Proposed rule issued on 7/3/14; published in the 7/14/14 Federal Register

// Proposed increase of 2.1% (2.7% less productivity adjustment of .4% and .2% cut required by ACA)

// ASC rates increase 1.2% (1.7% CPI increase less .5% productivity adjustment)

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**OPPS Proposed Rule**

// CMS proposes to begin collecting data on services in off campus provider-based departments by requiring Hospital and physicians to report a modifier

- Likely using this to set up mechanism to reduce payments and identify audit targets
- Also could be used as information for 340B compliance
OPPS Proposed Rule

Proposal to Package or include in payment for primary service for ancillary services assigned to APCs with a geometric mean cost of $100 or less

- Certain exceptions apply for drug administration; preventive services and Psychiatry
- CMS states that this will likely be updated and expanded in future years

SKILLED NURSING – MEDICARE UPDATE

// SNF PPS Final Rule – Medicare Payments
// Published in the August 5, 2014 Federal Register
   // Effective October 1, 2014
// Overall rate increase of 2.0% for FY 2015
   // Market basket 2.5%, less 0.5% productivity adjustment
       (ACA) = 2.0% net increase
SNF – MEDICARE UPDATE

// SNF PPS Final Rule – Medicare Payments
// Wage index update
  // Adopts most recent OMB statistical area delineations
  // Changes in certain facilities’ urban or rural status
  // One-year transition with blended SNF PPS wage index for FY 2015

SNF – MEDICARE UPDATE

// Medicare bad debt reductions - reminder
// Middle Class Tax Relief & Job Creation Act of 2012. For CR periods beginning during FFY 2013
  // Reduce from 70% to 65% (non dual-eligibles)
  // Reduce (phased) from 100% to 65% (dual-eligibles)
    // FFY 2013: 88%
    // FFY 2014: 76%
    // FFY 2015: 65%
// FYE 12/31/14 providers currently at 65% (non-duals) and 76% (duals)
  // Net bad debts also subject to 2% sequestration
SNF – MEDICARE UPDATE

Future of SNFs
Accountable Care Organizations/Bundled Payment
   Where do SNFs fit in?
   Reduced hospital readmissions
   Opportunity for good operators (efficient, good outcomes, effective compliance programs, lower hospital readmissions, etc.)
Consolidation
   Similar to hospitals and other provider types

WE COMPETE AGAINST EACH OTHER...OR DO WE?

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>ALOS-1st Quartile</th>
<th>Median</th>
<th>3rd Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding SNF</td>
<td>26.87</td>
<td>32.81</td>
<td>41.67</td>
</tr>
<tr>
<td>PPS SNF/Swing bed</td>
<td>8.76</td>
<td>10.52</td>
<td>12.81</td>
</tr>
<tr>
<td>CAH SNF/Swing bed</td>
<td>8.99</td>
<td>10.85</td>
<td>13.37</td>
</tr>
</tbody>
</table>

Source: BKD proprietary databases of free-standing SNFs, PPS Hospitals & Critical access hospitals
Rehab/Psych/Ambulance

// Rehabilitation Rates
- Increase of 2.2% (2.9% MBI less .5 productivity and .2 ACA cut)
- Revises list for diagnosis codes that presumptively meet the “60 percent rule”
- Delays changes to the presumptive compliance method finalized for FFY 14 to 10/1/15

Rehab/Psych/Ambulance

// Inpatient Psychiatric PPS rate change
- Increase of 2.1% (2.9% MBI less .5 productivity and .3 ACA cut)

// Ambulance Inflation Factor for FFY 2015 is 1.4%
Protecting Access to Medicare Act

// Physician Fee Schedule
// Rural Extenders
// ICD-10 Delay
// 2-Midnight Rule Enforcement
// Computed Tomography (CT) Payment Penalty
// Outpatient Lab Payment Study
// Financing

Physician Fee Schedule

// Extends current fee schedule through 3/31/15, avoiding 24% cut on 4/1/14
// House & Senate have crafted permanent fee schedule fix, but can’t decide on financing
  // Further negotiations likely delayed until after November elections, or after new Congress seated in January?
Rural Extenders

// Low-volume hospital payment add-on extended one year to 3/31/15
// 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 9/1/14) that they continue to qualify based on location
  // No other IPPS hospitals within 15 miles

Rural Extenders

// Medicare-dependent hospital classification extended one year to 3/31/15
  // CMS automatically extended status for existing MDHs
  // Special rules for MDHs that had reverted to urban or SCH status
// To apply for SCH status effective 4/1/15, must apply by 3/1/15 & request 4/1/15 effective date
ICD-10 Delay

“The Secretary of Health & Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets . . .”

CMS has announced that 10/1/15 will be the new implementation date

HFMA survey prior to delay showed 90% of hospitals with 600+ beds were very or extremely confident of ICD-10 readiness

58% of hospitals under 100 beds were very or extremely confident of ICD-10 readiness

2-Midnight Rule Enforcement

Delay in enforcement of 2-midnight policy for six months through 3/31/15

No post-payment patient status reviews with admission dates between 10/1/13-3/31/15, absent evidence of systematic gaming or abuse

May still be reviewed for reasonable & necessary services, accurate coding & documentation, etc.
CT Payment Penalty

// Applies to outpatient CT scans paid under outpatient PPS or physician fee schedule
// If CT equipment standards not met, Medicare payments reduced 5% in 2016; 15% thereafter

CT Equipment Standards

// Patient record captures post exam dose information in standardized electronic format
// Dose check feature alerts operator to avoid excessive radiation
// Automatic exposure control tailored to specific body regions
// Pre-loaded reference adult & pediatric protocols
Outpatient Lab Payment Study

// CMS to conduct study of lab payments beginning 1/1/16 & every three years thereafter
// For labs where a majority of their revenues are from Medicare
// Study to include Medicare & Medicaid managed care plans & all private payors
// Will be used to set Medicare payment rates effective 1/1/17
// Will not apply to new advanced diagnostic tests & certain other new tests

Financing PAMA

// 2% sequestration cut for federal fiscal year 2024 (10/1/23-9/30/24) changed to 4% cut for first six months (10/1/23-3/31/24) & 0% thereafter
// $4.4 billion reduction in Medicaid disproportionate share (DSH) payments in federal fiscal year 2024
Medicaid DSH Cuts

// Medicaid DSH is a $12 billion federal program
// Original Medicaid DSH cuts under Affordable Care Act, 2014-2020 = $18.1 billion
// Revised Medicaid DSH cuts under current law, 2017-2024 = $35.1 billion
// Doesn’t appear CMS will provide relief to states that don’t expand Medicaid

Arkansas Medicaid Regulatory Changes

// Removal of 24 day eligibility cap
// Effectively end outpatient crossover claims
  // Effective 7/1/2015
Arkansas Trauma System Financial Survey

Commissioned by Arkansas Hospital Association
Purpose was to provide information on the total cost of trauma and to consider whether the current funding methodology is appropriate.
First comprehensive study of the cost of hospital trauma care across the Arkansas State Trauma System

Hospital Trauma Financial Impact in a State-Wide Trauma System - Conclusion
In total, Arkansas trauma centers that participated in the survey lost $6,638,295 from providing trauma services, while caring for more than 75% of the state’s trauma cases.
Trauma care is a critical service, and it must be funded adequately for the Arkansas State Trauma System to continue to provide the highest level of care to injured patients throughout the state.
Basing trauma grants on factors other than designation level, such as those most directly linked to costs, patient mix or ISS scores, may result in better matching of state funds received with costs incurred.
Other Regulatory Issues

// Site Neutral or Provider based payment concerns
// Concerns being raised on Observation usage & three day qualifying stay of skilled nursing coverage/CMS demonstration study
// Hackbarth, MedPAC Chairman called the three-day stay rule for SNF stays “archaic” and urged Congress to eliminate the rule.

THOUGHTS ON THE CURRENT LEGISLATIVE ENVIRONMENT

// Yes, it’s toxic
// So what else is new?
// Not likely to change anytime soon
// Crises management
// Job preservation over problem resolution
APPROPRIATIONS

// Not before the “lame-duck” session in late November or early December
// Thus a stop-gap measure will be necessary
  // Another “continuing resolution”
  // Will probably be for 90 days
  // Enacted at the last minute on September 30
// Important because the Medicare contractors get funded this way

IMPACT ACT OF 2014

// Mandates use of common assessment instrument for all post-acute provider
// Has strong bipartisan & bicameral support
// Was up for vote in the House in early August
  // But was pulled before a vote was taken
  // The bill has a small cost attached to it
  // Thus, the bill needs a “pay-for”
// Will be back, but probably as part of a bigger bill
SGR FIX

// Current fix runs until 3/31/15
// Thus, chances of action in this Congress are very slim
  // Senate Finance Democrats still hold out hope
  // No one else does
// Action will obviously be necessary in Q1 of 2015
  // But that might be just another temporary adjustment

WAGE INDEX REFORM

// Not happening in the foreseeable future, if at all
// Industry cannot agree on a common strategy
// Any solution would be highly redistributitional
  // Thus, controversial
  // Congress won’t touch it
Hospitals & 340B

// Hospital eligibility
// Audit activity
// Upcoming proposed regulations

Hospital 340B Eligibility

// Must be governmental hospital, or have agreement with local government to care for indigent patients, AND one of the following
   // Have traditional DSH payment percent of at least 11.75%; OR
   // Be sole community hospital or referral center with DSH payment percent of at least 8%; OR
   // Be critical access hospital
   // Cancer hospitals & children's hospitals also qualify
**Audit Activity**

// HRSA began conducting audits in 2012
// Manufacturers may also conduct audits

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**Compliance Issues**

// DSH hospitals must not obtain outpatient drugs through group purchasing organization
// SCH, RRC or CAH must meet certain requirements related to orphan drugs
// 340B discounts only available for eligible hospital outpatients
// Medicaid outpatients are ineligible if state is claiming drug rebates on these outpatients
// Oversight of contract pharmacy operations
Upcoming Proposed Regulations?

// HRSA ability to issue regs challenged in court
// Were expected to clarify
  // Hospital eligibility criteria
  // Eligibility of off-site facilities, including eligibility of each service provided at an off-site facility
  // Definition of eligible patient
  // Compliance requirements for contract pharmacy arrangements

Questions?

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