Disclaimer

All information provided is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the particular situation.
Objectives:

1) Understand new regulations included in the Medicare Inpatient PPS FY 13 Final Rule effective October 1, 2012.
2) Update on healthcare reform and implications to Medicare reimbursement
3) Update on FY 14 Wage Index review timeline and related opportunities
4) Overview of other reimbursement related topics
FY 2013 Inpatient PPS Final Rule
FY 2013 IPPS Final Rule

• Published in Federal Register on August 31

• CMS FY 2013 Final Rule Home Page -
## FY 2013 Operating Base Rate

<table>
<thead>
<tr>
<th></th>
<th>FY 2012 Final</th>
<th>FY 2013 Final</th>
<th>Change from FY 12 to FY 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Adjusted Operating Standardized Amount (Full Update)</td>
<td>$5,209.74</td>
<td>$5,348.76</td>
<td>$139.02</td>
</tr>
</tbody>
</table>
**FY 13 Labor Adjusted Portion of Base Rate**

National Adjusted Operating Standardized Amounts
(62 Percent Labor Share/38 Percent Nonlabor Share
if Wage Index Is Less Than or Equal To 1.0000)

<table>
<thead>
<tr>
<th>Full Update (With Quality Reporting)</th>
<th>Reduced Update (W/O Quality Reporting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Amt</td>
<td>Reduced Update (W/O Quality Reporting)</td>
</tr>
<tr>
<td>Non-Labor Amt</td>
<td></td>
</tr>
<tr>
<td>$3,316.23</td>
<td>$3,251.08</td>
</tr>
<tr>
<td>$2,032.53</td>
<td>$1,992.59</td>
</tr>
</tbody>
</table>
FY 2013 Operating Base Rate

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Update</td>
<td>2.6%</td>
</tr>
<tr>
<td>Market Basket Adjustment (PPACA)</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Productivity Adjustment (PPACA)</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Documentation and Coding Effect</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.8%</strong></td>
</tr>
</tbody>
</table>

(-1.9% from 08/09 & +2.9% cumulative one time effect in FY 12)  

* CMS had included a 2.3% increase in FY 13 proposed rule. FY 13 final rule includes a 2.8% increase
## FY 2013 Capital Base Rate

<table>
<thead>
<tr>
<th></th>
<th>FY 2012 Final</th>
<th>FY 2013 Final</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Standard Federal Payment Rate</td>
<td>$421.42</td>
<td>$425.49</td>
<td>$4.07</td>
</tr>
</tbody>
</table>
FY 2013 Wage Index

- FY 2013 wage index is based on wage data from cost reporting periods beginning in Federal Fiscal Year 2009 (3,447 hospitals included)
- Wage index also reflects Occupational Mix Survey submitted on July 1, 2011
## FY 2013 Wage Index – South Carolina

<table>
<thead>
<tr>
<th>Area Wage Index</th>
<th>FY 2012 Final</th>
<th>FY 2013 Final</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenville-Mauldin-Easley, SC</td>
<td>0.9330</td>
<td>0.9474</td>
<td>1.50%</td>
</tr>
<tr>
<td>Spartanburg, SC</td>
<td>0.9059</td>
<td>0.8985</td>
<td>-0.80%</td>
</tr>
<tr>
<td>Anderson, SC</td>
<td>0.8566</td>
<td>0.8913</td>
<td>4.10%</td>
</tr>
<tr>
<td>Charleston-North Charleston-Summerville, SC</td>
<td>0.8933</td>
<td>0.8690</td>
<td>-2.70%</td>
</tr>
<tr>
<td>Columbia, SC</td>
<td>0.8756</td>
<td>0.8554</td>
<td>-2.3%</td>
</tr>
<tr>
<td>Myrtle Beach-North Myrtle Beach-Conway, SC</td>
<td>0.8532</td>
<td>0.8535</td>
<td>0.00%</td>
</tr>
<tr>
<td>Sumter, SC</td>
<td>0.8241</td>
<td>0.8287</td>
<td>0.60%</td>
</tr>
<tr>
<td>Rural South Carolina</td>
<td>0.8241</td>
<td>0.8287</td>
<td>0.60%</td>
</tr>
<tr>
<td>Florence, SC</td>
<td>0.8349</td>
<td>0.8287</td>
<td>-0.70%</td>
</tr>
</tbody>
</table>
FY 2013 Wage Index Tables

• Federal Register tables related to wage index:
  – Table 2 – case mix index, wage index, and AHW details for every PPS provider
  – Table 3A – current and 3-year AHW for each urban CBSA
  – Table 3B – current and 3-year AHW for each rural CBSA
  – Table 4A – wage index for each urban CBSA
  – Table 4B – wage index for each rural CBSA
  – Table 4C – reclassified wage index by CBSA
  – Table 4D – states receiving Frontier State floor wage index and urban areas receiving statewide rural floor
  – Table 4E – urban CBSAs and constituent counties
  – Table 4J – out-migration adjustments by provider
  – Table 9A – reclassified hospitals
  – Table 9C – hospitals redesignated as rural

Note: Tables are consistent from year to year
## Rural Floor Impact By State

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Hospitals</th>
<th># of Hospitals Receiving Rural Floor</th>
<th>Percent Change in Payments</th>
<th>Difference (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>96</td>
<td>3</td>
<td>-0.4</td>
<td>($8.2)</td>
</tr>
<tr>
<td>Georgia</td>
<td>108</td>
<td>0</td>
<td>-0.4</td>
<td>($12.7)</td>
</tr>
<tr>
<td>North Carolina</td>
<td>88</td>
<td>0</td>
<td>-0.4</td>
<td>($16.4)</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>61</td>
<td>60</td>
<td>5.7</td>
<td>$188</td>
</tr>
<tr>
<td>South Carolina</td>
<td>56</td>
<td>5</td>
<td>-0.3</td>
<td>($5.9)</td>
</tr>
<tr>
<td>Virginia</td>
<td>79</td>
<td>1</td>
<td>-0.4</td>
<td>($10.1)</td>
</tr>
</tbody>
</table>
FY 2013 IPPS Final Rule

• Geographic Reclassification
  – 193 hospitals approved for reclassification for FY 13-15
    • 663 hospitals in reclassification status for FY 13
  – Section 508 reclassifications and certain special exceptions have not been extended for FY 13

  – Typically, September 1st annually is the deadline for geographic reclass applications.
  – FY 14 reclassification applications were due in Sept 2012.
    http://cms.hhs.gov/MGCRB/02_instructions_and_applications.asp
FY 2013 IPPS Final Rule

• Low Volume Payment Adjustment
  – Adjustment has existed since 2005, but previous regulations made it nearly impossible for hospitals to qualify
  – For Federal FY 2011 and 2012 PPACA loosened the two qualification requirements:
    • First, a hospital has to be located at least 15 road miles from another acute PPS hospital instead of the previous requirement of at least 25 miles
    • Second, a hospital must have less than 1,600 Medicare-eligible discharges
  – Beginning Federal FY 13 relaxed requirements expired
    • Only hospitals with less than 200 total discharges can qualify for the additional payment
    • 600 hospitals qualified in FY 12, approximate $318m reduction in FY 13
**FY 2013 IPPS Final Rule**

- **Rural Referral Center Eligibility Criteria**
  - Case Mix requirement per FY 13 IPPS final rule:

<table>
<thead>
<tr>
<th>Region</th>
<th>Case-Mix Index Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New England (CT, ME, MA, NH, RI, VT)</td>
<td>1.3237</td>
</tr>
<tr>
<td>2. Middle Atlantic (PA, NJ, NY)</td>
<td>1.3745</td>
</tr>
<tr>
<td>3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)</td>
<td>1.4589</td>
</tr>
<tr>
<td>4. East North Central (IL, IN, MI, OH, WI)</td>
<td>1.4620</td>
</tr>
<tr>
<td>5. East South Central (AL, KY, MS, TN)</td>
<td>1.3996</td>
</tr>
<tr>
<td>6. West North Central (IA, KS, MN, MO, NE, ND, SD)</td>
<td>1.4456</td>
</tr>
<tr>
<td>7. West South Central (AR, LA, OK, TX)</td>
<td>1.5689</td>
</tr>
<tr>
<td>8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)</td>
<td>1.6277</td>
</tr>
<tr>
<td>9. Pacific (AK, CA, HI, OR, WA)</td>
<td>1.5169</td>
</tr>
</tbody>
</table>
• Medicare Dependent Status Expiration 10/1/12
  – MDH’s that were previously Sole Community Hospitals could have obtained one time abbreviated conversion back to Sole Community status if still meeting criteria for SCH. Had to of filed request by 9/1/12
  – Currently 213 MDH’s
  – Estimated $183 million decrease in payments
• **Sole Community Hospital**
  
  – Effective 10/1/12 if a hospital was incorrectly designated as SCH and notifies CMS of error, SCH may be terminated effective 30 days from CMS date of determination.
  
  – Hospitals still required to monitor SCH designation and notify the MAC of any changes that would impact qualifying for designation, such as:
    
    • Opening of new hospital
    • New road between itself and like provider
    • Increase in number of beds to more than 50
    • Change in geographic reclassification
    • Changes in travel time between itself and like provider
  
  – Not required to monitor patient origin data if hospital qualified under this criteria. However if hospital determines original patient origin data was incorrect, hospital must notify CMS.
FY 2013 IPPS Final Rule

• Sole Community Hospital (continued)

– Clarified that retroactive loss of Sole Community Status would end 30 days from provider notification to CMS
– If hospital does not notify of changes listed above that would impact SCH designation, CMS will cancel status effective with date which hospital no longer met criteria (clarified subject to reopening criteria)
– Documentation/coding adjustment of minus .5% to the hospital specific rate
FY 2013 IPPS Final Rule

- Timely filing of no pay (Medicare Advantage) bills. Hospitals to comply with same timely filing requirement as Medicare Part A. (See federal regulation 42 CFR 424.44)
  - IME/GME and Nursing /Allied Health
  - Medicare Advantage days for Medicare DSH purposes
FY 2013 IPPS Final Rule

• Labor delivery beds
  – Inclusion for determining DSH and IME payments for cost report periods beginning on/after 10/1/12
    • DSH
      – No impact on calculation
      – Could benefit hospitals that previously did not minimum bed count criteria to qualify for DSH

• IME
  – Increase in available beds would result in decrease in resident to bed ratio, consequently decreasing IME payments to teaching hospitals
FY 2013 IPPS Final Rule

• Hospital services provided under arrangement clarification effective for cost report periods beginning on or after October 1, 2013
  – Routine services must be provided by hospital
  – Only therapeutic and diagnostic items and services may be furnished under arrangement outside of the hospital

• New resident programs beginning on or after 10/1/12 will have Resident CAP and Per Resident Amount established based on first 5 years rather than 3 years. (Provider community had expressed concern that 3 years was not sufficient to grow into residency program to determine caps and number of residents)
Federal Fiscal Year 2014 Wage Index Review
FFY 2014 Wage Index Timeline (Estimated)

• **October 2012** – Release of Preliminary FY 2013 wage index and occupational mix public use files (PUF).

• **December 10, 2012** – Deadline for Hospitals to request revisions to their Worksheet S-3 Wage Data and OMS.

• **February 2013** – Deadline for FIs/MACs to complete all desk reviews.

• **February 2013** – Deadline for FIs/MACs to notify state hospital associations regarding hospitals that fail to respond to issues raised during the desk reviews.

• **February 2013** – Release of revised FY 2014 wage index and occupational mix PUF.
• **March 2013** – Deadline for hospitals to submit requests (including supporting documentation) for: 1) corrections to errors in the February PUFs due to CMS or FI/MAC mishandling of the wage index data, or 2) revisions of desk review adjustments to their wage index data as included in the February PUFs (and to provide documentation to support the request).

• **April/May 2013** – Approximate date proposed rule will be published (45 day withdrawal deadline for hospitals applying for geographic reclassification).
FY 2014 Wage Index Timeline (Cont.)

• **April 2013** – Deadline for hospitals to appeal FI/MAC determinations and request CMS’ intervention in cases where the hospital disagrees with the FI’s/MAC’s determination. The request must included all correspondence between the hospital and FI/MAC that document the hospital’s attempt to resolve the dispute earlier in the process.

• **May 2013** – Release of final FY 2014 wage index and occupational mix data PUFs on CMS Web page.

• **June 2013** – Deadline for hospitals to submit correction requests to both CMS and their FI/MAC to correct errors due to CMS or FI/MAC mishandling of the final wage and occupational mix data.
FY 2014 Wage Index Timeline (Cont.)

- **August 2013** – Approximate date for publication of the FY 2014 final rule; wage index includes final wage index corrections.
- **October 2013** – Effective date of FY 2014 Wage Index.
Areas you can have an impact!

The Key is Assessment
Assessment / Opportunities

• **Wage Index Assessment Process**
  – Providers have the opportunity to request corrections to their wage data.
    • October 2012 – CMS to release preliminary FY 2014 Wage Index PUF files.
    • December 10, 2012 – Deadline for hospitals to request revisions to their wage survey or Occupation Mix Survey.
  – Focus review on paid hours first – review pay categories and mapping on the cost report.
  – Verify documentation can be made available quickly for FI audit review.
  – Compare current PUF file to prior year final PUF file – analyze any research significant variances.
  – Use review techniques and checklist for upcoming cost report period.
Assessment / Opportunities

• **Wage Index Assessment Process (Cont.)**
  – Meet with HR and Payroll Managers to confirm all hours and benefits are being properly recorded.
  – Convert all hours reported to be based on Payroll data not General Ledger data (assuming they are different).
  – Review all re-classes to ensure all salary re-classes are needed and recorded correctly as well as recording the associated hours.
  – Review all pension cost/distributions reported and adjust any of these wage related costs reported to the new methodology provided by CMS.
  – Due to the complexity in determining the adjusted payroll hours and determining allowable pension expense – you may wish to consider having an external review of your Wage Index.
The following paid hours should be included in the payroll file for wage index reporting:

- Regular Hours (including paid lunch hours)
- Overtime Hours
- Paid Holiday
- Vacation and Sick Leave hours
- Paid Time-Off hours
- Hours associated with severance pay
- Jury Duty
- Bereavement

Remember to reclass applicable hours for each A-6 reclass that effects salary.
Hours Related to Paid Salaries

- The following hours should be **removed** in the payroll file for wage index reporting:
  - On Call Hours (report hours for workers who are contracted solely for the purpose of being on call on appropriate contract labor line)
  - Differential OT hours that are recorded (i.e. if an employee works 1 hour, but the time is recorded at 1.5, then .5 hours should be removed)
  - Bonus Hours
  - Shift Differential Hours
  - Buy/Sell back PTO
  - Buy/Sell back Vacation
  - Hours related to capitalized salaries
  - Leave of Absence (unpaid)
Hours Related to Paid Salaries

• The following hours should be **removed** in the payroll file for wage index reporting (cont.):
  – Family Medical Leave (unpaid)
  – Disability (unpaid)
  – Baylor Plan; employees work 36 hours, but get paid for 40 hours- remove 4 hour difference (potential future appeal item)
  – Seasonal Plan; employees work certain months of the year, but get paid for 52 weeks – remove the time not actually employed
  – Severance hours; General rule: if severance is booked as a “salary” expense then included hours. If severance is booked as a non-salary expense than do not include hours
  – Holiday Pay for nurses who work a paid holiday. They could be paid regular pay + holiday pay + overtime; make sure that hours are not being double counted
Contract Labor

• Potential Areas for Contract Labor
  – Patient Care Contract Labor (Line 11)
  – Physician Part A Contract Labor (Line 13)
  – A&G Contract Labor (Line 28)
  – Housekeeping Contract Labor (Line 33)
  – Dietary Contract Labor (Line 35)
Contract Labor

• Line 11 - Contract Labor (Patient Care)
  – Line is used to report paid services under contract rather than by employees for direct patient care and management services
  – Examples of common contract labor are Nurses, PT, OT, RT, ST, Sleep Clinic, Infection Control, MRI, Cath Lab, Lithotripsy, Pharmacy, Per fusionists and Lab.
  – Do not include costs applicable to excluded units reported on line 9 and 10.
Contract Labor

• Line 13 – Physician Part A Contract Labor
  – Line used to report contract labor for Part A Physician services (Excluding teaching) to the extent that hours can be accurately determined.
  – Do not include the costs for Part A Physicians services from the home office allocation and/or related organizations (to be reported on Line 15).
  – Do not include any contracted interns and residents (to be reported on Line 7.01)
  – Do not include any costs applicable to excluded units if reported on line 9 and 10.
Contract Labor

• Line 28 - Administrative & General under contract
  – Line used to report contract labor costs that a hospital incurs in carrying out its administrative and/or general management functions.
  – These expenses must be reported on Worksheet A, line 5 and any subscripts.
  – Generally this area can have the highest AHW.
  – These items normally also will draw a lot of scrutiny from the Fiscal Intermediary so it is critical to have all the data needed to support your amounts reported.
  – Examples of the types of contract labor reported on Line 28:
    • Legal; Tax Preparation; Cost Report Preparation; Purchasing Services; Information and Data Processing services; and Audit
Physician Part A Services

• **Line 4 and 4.01 – Physician Part A salaries and Hours**
  – used to report physician Part A salaries included in Line 1.
  – Do not include fringe benefits on this line.

• **Why are Physician Part A salaries and hours important?**
  – Physician Part A time is allowable and does not have to be removed.
  – These individuals usually have higher AHW. Normally greater than $100 per hour. (This is a good way to test to see if the dollars and hours are reasonable on your Wage Index Survey.)
Physician Part A Services

• Common Findings:
  – Understatement of Physician Part A time
  – Physician salaries and Fees reported incorrectly

• Ways to improve Physician Part A data collection:
  – Time studies should be completed on a periodic basis each year to support Part B (Hands-On Patient Care), Part A (Administration) and Part A (Teaching).
  – Physician contracts should identify Part A time.
  – Salaries and Fees need to be separated.
  – Keep all Physician contracts because they will be needed as supporting documentation.
Wage Related Cost – Core Benefits

• Wage Related Costs: need to be allocated between core areas (acute areas) and excluded areas.
  – Includes:
    • 401(k) Employer Contributions
    • Tax Sheltered Annuity (TSA) Employer contribution
    • Qualified and Non-Qualified Pension Plan Cost
    • Prior Year Service Cost
    • 401(k)/TSA Plan Administration Fees
    • Legal/Accounting/Management Fees – Pension Plan
    • Employee Managed Care Program Administration Fees
    • Health Insurance (Purchased or Self-Funded)
    • Prescription Drug Plan, Dental, Hearing & Vision Plans
    • Life Insurance (If employee is owner or beneficiary)
    • Accident Insurance (If employee is owner or beneficiary)
Wage Related Cost – Core Benefits

- Wage Related Costs (core) cont.
  - Disability Insurance (If employee is owner or beneficiary)
  - Long-Term Care Insurance (If employee is owner or beneficiary)
  - Worker’s Compensation Insurance
  - Retiree Health Care Costs (only current year)
  - FICA – Employers Portion Only
  - Medicare Taxes - Employers Portion Only
  - Unemployment Insurance
  - State or Federal Unemployment Taxes
  - Executive Deferred Compensation
  - Day Care Cost and Allowances
  - Tuition Reimbursement
Other Wage Related Costs (less common)

- Line 18 - Other Wage Related Costs
  - Cafeteria Subsidy
  - Parking Lot Subsidy (most likely to meet the 1% Test)
  - Licensing fees for Nurses, Techs, etc.
  - Transportation Subsidy
  - Employee Wellness and fitness center program
  - Salaried Physician Malpractice insurance
  - Employee Service Awards and Banquets

- Must meet the “1% Test”
  - Each wage related costs other than core must exceed 1% of total salaries from worksheet S-3, Part III, Line 3, Column 4.

- Other wage related costs must also be allocated between allowable and excluded areas.
Pension Cost
Wage Index – Pension Costs

• Changes for reporting of pension costs
  – Included in FY 2012 IPPS final rule
  – Treatment for cost finding is different than for wage survey
  – Treatment for wage survey:
    • “…the pension cost to be included in the wage index equals a hospital’s average cash contributions deposited to its defined benefit pension plan over a 3-year period, or number of years that the hospital has sponsored a defined benefit plan if less than 3 years.”
    • “Any reversion or other withdrawal of assets from the pension fund or trust is treated as a negative contribution for purposes of measuring the 3-year average.”
Changes for reporting of pension costs

Treatment for wage survey (cont.):

• “The 3-year average is centered on the base cost reporting period for the wage index. For example, the FY 2013 wage index will be based on Medicare cost reporting periods beginning during FFY 2009 and will reflect the average pension contributions made in hospitals’ cost reporting periods beginning during FFYs 2008, 2009, and 2010.”

• Hospitals may “determine a “prefunding balance” based on pension contributions made but not reflected in the wage index during certain prior periods.”
Wage Index – Pension Costs

• Changes for reporting of pension costs
  – Treatment for wage survey (cont.):
    • This prefunding balance is “equal to (A) minus (B), where (A) is the sum of cash contributions made during a period of consecutive provider cost reporting periods commencing no earlier than October 1, 2002 (the cost reporting period applicable for the FY 2007 wage index), and ending with the cost reporting period applicable for the FY 2012 wage index, and (B) is the sum of pension costs actually reflected in the wage index for the same cost reporting periods.”
    • “The transition policy permits a hospital to include 1/10th of the prefunding balance in the wage index pension cost each year commencing with the FY 2013 wage index and ending with the FY 2022 wage index, that is, in 10 equal prefunding installments.”
    • The reporting can become very complicated if the entity has a home office or multiple hospitals under one entity
Wage Index – Pension Costs

• FY 14 Pension Wage Index Cost

  • Defined Benefit Pension wage index data needs to be submitted to Palmetto GBA by 12/10/12.
  • Worksheets and guidance available on CMS website.
    • [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2014-Wage-Index-Pension-Cost-Guidelines.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2014-Wage-Index-Pension-Cost-Guidelines.html)
Why Review Wage Data?

• Directly impacts reimbursement
• Generally, the last schedule completed and often not much effort is put into its completion
• Rules change from filing to actual use
• Increasingly complex schedule (even more with the new Medicare form 2552-10)
• Worksheet S-3 is reviewed closely by CMS, the FI/MACs, the OIG, MedPac and Congress
Wage Index Changes Being Discussed for the Future
Future Proposed Changes

• Congress is currently looking at alternatives for reporting of wage costs and determining future payments.
  – Hospitals have complained that the current system often does not reflect the true labor costs for individual hospitals, particularly ones on the periphery of the markets.
  – Since the nation health care force is not restricted within a single labor market area, the fixed CBSA boundary system may not accurately define any particular hospital’s available labor pool.
Future Proposed Changes

• The Affordable Care Act required that the Secretary of Health and Human Services submit to Congress a plan that comprehensively reforms the wage index applied to the Medicare hospital IPPS.

• HHS Recommends using commuting data to establish a labor market area and wage index value for each hospital (as opposed to labor market areas) as a way to reform the Medicare wage index system.
Future Proposed Changes

• Commuting Based Wage Index (CBWI) addresses the goals of broad-based Medicare Wage Index Reform.
  – “CBWI is based on actual employment patterns of hospitals and would reduce large wage index differences between nearby hospitals and more accurately reflect the true labor market forces of individual hospitals.” - Kathleen Sebelius – The Secretary of Health and Human Services

• The 66 page report issued April 2012 discusses 5 issues to consider in moving forward with implementation.
  – Available and accurate commuting data
  – Potential for hospitals to change hiring patterns in response to change in the wage index
  – Portability to other Medicare payment systems
  – The need for exceptions
  – Transition
Future Proposed Changes

• The CBWI would use smaller, more discrete labor market areas and only incorporate wage data from hospitals that actually employ workers in that area.
  – The result would be a wage index specific to an individual hospital based upon the labor markets from which that hospital hires its workers.

• The CBWI could accomplish the major goals of moving towards a wage index system that yields greater accuracy and less distortion – in particular, one focused on eliminating large differences (currently known as “Cliffs” - differences in nearby hospitals in different CBSA’s).
• The CBWI uses data on the number of hospital workers commuting from home to work to define a hospital’s labor market.

• The Calculation:
  – Once the hiring proportions by area and area wage levels are determined, the numerator of the CBWI, which is the hospitals benchmark wage level, is calculated as the weighted average of these two elements. The denominator is the national average wage level. This calculation results in a hospital-specific value, which reflects wage levels in the areas from which a hospital hires.
Future Proposed Changes

• Advantages:

1. Since the CBWI accounts for specific differences in hospitals’ geographic hiring patterns (using smaller areas than the current CBSA), it would yield wage index values that more closely correlate to actual labor costs.

2. Concerns about CBWI leading to hospitals altering hiring patterns and distorting labor markets do not appear to be worse than under the current system and could be managed with minimum policy adjustments.

3. The CBWI will help to eliminate (“Cliffs”) sharp differences in a hospital’s wage index just because the nearby hospital is in a different or adjacent CBSA.
• Disadvantages:
  1. Where CBWI to be adopted, a more up to date reporting system for collecting commuting data from hospitals would have to be established so that the wage index calculations would accurately reflect the commuting patterns of the hospital employees.
  2. Exceptions to the current wage index would need to be reviewed and may not be applicable under the new CBWI system. For example hospitals that geographically re-class could be impacted.
  3. If CBWI were adopted in a budget neutral manner (as the current system) then payments for some providers would increase and others would decrease.
  4. Implementation of CBWI may require both statutory and regulatory changes.
Future Proposed Changes

• The “Take” around DC:
  
  – “CMS acknowledges that implementing a new system would require statutory change. It is a politically thorny issue that will be very difficult for Congress to embrace and advance, and as such, it is probably not going anywhere in the short term.” Eric Zimmerman – partner with McDermott, Will & Emery in Washington

  – Major concern is the availability and collection of the needed data to change to a new system.
Healthcare Reform & Related FY 13 IPPS Guidance
Medicare DSH Payment Revisions

- Beginning in FY 2014 aggregate Medicare DSH payments will be reduced
  - Hospitals will be paid 25% of what they would have been paid under current DSH regulations
  - Hospitals will receive an additional payment amount based on each hospital’s amount of uncompensated care compared to aggregate amounts
  - Total amount available for this additional payment will be reduced as the uninsured population decreases
Impact From Healthcare Reform

- CBO projected aggregate decreases:
  - FY 14 – $3.6 billion (25.4%)
  - FY 15 – $4.0 billion (26.5%)
  - FY 16 – $5.0 billion (31.1%)
  - FY 17 – $4.4 billion (25.7%)
  - FY 18 – $5.1 billion (27.9%)
Impact From Healthcare Reform

• Medicaid DSH Payment Reductions
  – Beginning in FY 2014 aggregate Medicaid DSH payments will be reduced
    • CMS will determine specific reductions by state
      – Largest reductions will be applied to states that have the lowest percentage of uninsured or states that do not target DSH payments to hospitals with high Medicaid utilization or uncompensated care
      – Smallest reductions will be applied to states with low DSH
Impact From Healthcare Reform

- Aggregate reductions:
  - FY 14 – $500 million (5.1%)
  - FY 15 – $600 million (5.9%)
  - FY 16 – $600 million (5.8%)
  - FY 17 – $1.8 billion (17.1%)
  - FY 18 – $5.0 billion (46.7%)
  - FY 19 – $5.6 billion (50.9%)
Impact From Healthcare Reform

- **Hospital Value-Based Purchasing Program**
  - Program was mandated by Congress in the Deficit Reduction Act of 2005
  - Was to be implemented by October 1, 2008
  - CMS notified Congress that the legislation did not provide for them to implement the program
  - Final rule issued April 29, 2011, additional clarifications included in FY 12 IPPS final rule and CY 2012 OPPS final rule
  - **Effective FY 2013**
Impact From Healthcare Reform

- **Hospital Value-Based Purchasing Program**
  - Initial reductions to base operating DRG rate:
    - FY 13 – 1.00% (approx $963m available)
    - FY 14 – 1.25%
    - FY 15 – 1.50%
    - FY 16 – 1.75%
    - FY 17 and after – 2.00%
  - Hospitals will initially be scored in two domains
    - Clinical process of care – 12 clinical measures (70% of total score)
      - Patient experience of care – HCAHPS survey (30%)
    - Estimated VBP adjustment factors by hospital were reflected in table 16 of FY 13 final rule
Impact From Healthcare Reform

• Hospital Value-Based Purchasing Program
  – Hospital performance from 7/1/11-3/31/12 will be compared to performance measured from 7/1/09-3/31/10.
  – Hospital is scored on both achievement compared to others and on improvement compared to its own baseline
  – Actual hospital summary report and adjustment factors provided to hospitals 11/1/12 on qualitynet website.
    • 30 day period for hospitals to review and request any corrections to CMS. Can file an appeal if continue to disagree after receiving determination from CMS.
  – Claim adjustments will begin on 1/1/13 for any claims after that point.
  – CMS will re-process any claims from 10/1/12 – 12/31/12
Impact From Healthcare Reform

- Hospital Value-Based Purchasing Program (cont.)
  - The FY 2013 Actual Percentage Payment Summary Report posted for each hospital on 11/1/12 contains the following information:
    - Scores and Value-Based Payment Summary
    - Total Performance Score (TPS)
    - Clinical Process of Care Domain Score
    - Patient Experience of Care Domain Score
    - Value-Based Percentage Payment
    - Clinical Process of Care numerators, denominators, and rates for the baseline and performance periods
    - Clinical Process of Care benchmarks, thresholds, improvement points, achievement points, measure scores, and condition/procedure scores
    - Patient Experience of Care baseline rates, performance rates, floor values, benchmarks, thresholds, improvement points, achievement points, dimension scores, base score, and consistency score
Impact From Healthcare Reform

• Hospital Value-Based Purchasing Program (cont.)

  – Link for details on “How to Read Your FY 2013 Actual Payment Summary Report
  • https://www.qualitynet.org/dcs/ContentServer?c=Page&page
    name=QnetPublic%2FPage%2FQnetTier3&cid=1228772237202
Impact From Healthcare Reform

• Hospital Value-Based Purchasing Program (cont.)
  – Value Based Incentive Adjustment Payments

  • VBP > 1% reduction applied to the base-operating DRG payment amount, hospital will receive a higher payment amount for each Medicare discharge

  • VBP = 1% reduction applied to the base-operating DRG payment amount; hospital will receive the same payment amount for each Medicare discharge

  • VBP < 1% reduction applied to the base-operating DRG payment amount, hospital will receive a lower payment amount for each Medicare discharge
• Hospital Readmissions Reduction Program
  – Effective beginning FY 2013
    • Based on claims data from July 1, 2008 to June 30, 2011
  – Three conditions to be used:
    • Acute Myocardial Infarction [AMI] 30-day Risk Standardized Readmission Measure (NQF # 0505)
    • Heart Failure [HF] 30-day Risk Standardized Readmission Measure (NQF # 0330)
    • Pneumonia [PN] 30-day Risk Standardized Readmission Measure (NQF # 0506)
  – Readmission adjustment factors by hospital are reflected in table 15 of FY 13 final rule
• Hospital Readmissions Reduction Program
  – Initial reductions to base operating DRG rate is the higher of a ratio of the hospital’s aggregate dollars for excess readmissions to their aggregate dollars for all discharges or a % reduction based on the Fiscal Year, which is listed below:
    • FY 13 – 1.00%
    • FY 14 – 2.00%
    • FY 15 and after – 3.00%
  – FY 2013, estimated total savings of .3% decrease or approx. $280M
  – FY 13 IPPS clarification of base operating DRG to exclude IME, DSH and Outliers (operating DRG is transfer adjusted) however is wage adjusted and does include payments for new technology add on
Impact From Healthcare Reform

• Hospital Readmissions Reduction Program (cont’d)
  – The QualityNet reports that are to be used for the Readmission calculation were delivered in the hospitals’ secure QualityNet account on June 20, 2012.
  – The data was to be on a discharge-level detail for the report.
  – There was a similar review timeline as other QualityNet accounts, which was 30 days to review and submit corrections for their excess readmission ratios.
  – Cost Report forms to be revised for FY 13 to separate operating DRG by period, and also lines to include readmission adjustment factor and payments. PS&R’s to also be modified.
Impact From Healthcare Reform

• Payment Adjustments for Hospital Acquired Conditions (HACs)
  – Two new HACs for FY 2013:
    • Surgical Site Infection following Cardiac Implantable Electronic Device Procedures
    • Iatrogenic Pneumothorax with Venous Catherization
  – Less than $1M in projected savings for these two new conditions.
  – Total Estimated Savings of $24M.
Medicare Bad Debts
Medicare Bad Debt Reimbursement Changes

- Hospital (IP/OP), Psych and Rehab, & Regular SNF Bad Debts
  - Currently subject to 30% reduction in reimbursement (70% reimbursement)
  - Beginning in FY 2013, subject to 35% reduction in reimbursement (65% reimbursement)

- CAH's, SNF Crossovers, RHCs & Other Entities
  - Currently, not subject to 30% reduction (100% reimbursement)
  - Following to occur over next three years
    - FY 2013 subject to 12% reduction in reimbursement (88% reimbursement)
    - FY 2014 subject to 24% reduction in reimbursement (76% reimbursement)
    - FY 2015 subject to 35% reduction in reimbursement (65% reimbursement)
Medicare Bad Debts

• Medicare Bad Debt (Continued)
  – Recent PRRB case in providers favor
    • Case Number 08-1404 released July 18, 2012 (Doctors Hospital, Columbus OH vs BCBS CGS Administrators)
      – Further strengthens provider’s case that the PRM 15-1 312 does not provide documentation requirements for the proof of indigency (provider unable to provide application for all patients in sample, but had supporting notes and documents supporting hospital made the determination consistent with their policy)

      – In the PRRB conclusion, emphasized that 2 of the 4 guidelines in section 312 use the verb “must” versus “should”.
        » Provider must determine indigency, not the patient
        » Provider must determine no other source other than patient responsible for the bill

  – Provider’s should consider PRRB appeal options for disallowance of indigent/charity Medicare bad debts
Questions
or Comments?
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