Reimbursement Hot Topics

HFMA – MA/RI Chapter

June 12, 2018

Agenda

- FY 2019 Medicare IPPS Proposed Rules
- Wage Index
- DSH & Uncompensated Care Payments
- Cost Report Submissions
- EHR & Quality

FY 2019 Medicare Inpatient PPS Proposed Rules

FY 2019 Proposed IPPS Rules

- Issued on April 26, 2018
- Published in Federal Register on May 7, 2018
- Comments due to CMS by 5 p.m. June 25, 2018
- $4.1 billion increase in payments
  - Operating = $2.5 billion
  - Uncompensated Care Payments = $1.5 billion
  - Capital & Low Volume = $0.1 billion
- Total IPPS payment increase of 3.4%

FY 2019 Update Factors

- Base market basket adjustment = 2.8%
- Penalty for failure to submit quality data
  - 25% of market basket increase (2.8% x 25% = 0.7%)
  - 54 hospitals
- Penalty for failure to be meaningful user of EHR
  - 75% of market basket increase (2.8% x 75% = 2.1%)
  - 148 hospitals
- 43 hospitals received both penalties

FY 2019 Update Factors

- Productivity reduction = 0.8%
- ACA reduction = 0.75%
- Document and coding addition = 0.5%
  - Applies to FY 2018 - 2023

FY 2019 Update Factors

2019 Market Basket Increase	2.80%
Less: Productivity Adjustment	-0.80%
Less: ACA Reduction	-0.75%
2019 Net Market Basket Increase	1.25%
Less: Budget Neutrality Adjustments	-0.25%
Less: Documentation & Coding	0.50%
Net Market Basket Increase - Full Update	1.50%
Other Market Basket Increases:	
Not an EHR Meaningful User	-0.60%
Failed to Submit Quality Data	0.80%
No EHR & Failed to Submit Quality Data	-1.30%

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DRG and Outlier Changes

Full Update Standard Rates (Wage Index > 1.0)	Proposed FY 2019	Final FY 2018	Change	% Change
Labor (68.3%)	3,863.17	3,806.04	57.13	1.50%
Non-Labor (32.7%)	1,793.01	1,766.49	26.52	1.50%
Operating DRG	5,656.18	5,572.53	83.65	1.50%

Capital Rate	Proposed FY 2019	Final FY 2018	Change	% Change
Capital DRG	459.78	453.95	5.83	1.28%

Outliers	Proposed FY 2019	Final FY 2018	Change	% Change
Outlier Threshold	27,545	26,601	944	3.55%

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Multi-campus Hospitals

Main campus and remote location must have same status (SCH, RRC, MDH, Rural Reclassification)

- All campuses must meet qualifying criteria
- CMS assertions:
  - Single entity with one agreement
  - Administrative difficulties

Medicare Dependent Hospitals

- Program expired on Sept. 30, 2017
- Program reauthorized through Sept. 30, 2022
  - Bipartisan Budget Act of 2018
  - Retroactive to Oct. 1, 2017
  - Most MDH automatically reinstated
  - May need to reapply if, as of Oct. 1, 2017:
    - Classified as Sole Community Hospital, or
    - Cancelled rural classification

Low Volume Hospitals

- Program expired on Sept. 30, 2017
- Program reauthorized through Sept. 30, 2022
  - Bipartisan Budget Act of 2018
- FY 2018 rules are unchanged from FY 2017 rules
  - Qualifying criteria
    - Acute IPPS hospital
    - Fewer than 1,600 Medicare discharges
    - Greater than 15 road miles from nearest IPPS hospital
  - Payment adjustment: Sliding scale
    - 25% adjustment for 200 or fewer Medicare discharges
    - Decreases to 0% at 1,600 Medicare discharges

Low Volume Hospitals

- FY 2019 – FY 2022
  - Qualifying criteria
    - Acute IPPS hospital
    - Fewer than 3,800 total discharges
    - Greater than 15 road miles from nearest IPPS hospital
  - Payment adjustment: Sliding scale
    - 25% adjustment for 500 or fewer discharges
    - Decreases to 0% at 3,800 discharges
- FY 2023 and later
  - Reverts to rules in place from FY 2005 – FY 2010

FY 2019 New Technology Add-on

- Discontinued
  - EDWARDS INTUITY Elite Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
  - GORE EXCLUDER Iliac Branch Endoprosthesis (IBE)
  - Praxbind Idarucizumab
  - Vistogard (Uridine Triacetate)

FY 2019 New Technology Add-on

- Continued
  - Defitelio (Defibrotide): Maximum payment will remain at $75,900
  - Ustekinumab (Stelara): Maximum payment for a case involving Stelara would remain at $2,400 for FY 2019
  - Bezlotoxumab (ZINPLAVA): Maximum new technology add-on payment amount for a case involving the use of ZINPLAVA is $1,900

IPPS Excluded Hospitals

- Current
  - IPPS Excluded hospitals cannot have excluded psychiatric or rehabilitation units
- Proposed
  - IPPS Excluded hospitals may have excluded psychiatric or rehabilitation units
  - Excluded unit may not be the same type as hospital
  - Effective for cost reports beginning on or after Oct. 1, 2019

Public Posting of Charges

- Hospitals required to post list of standard charges on the internet
  - Machine-readable format
  - Update annually, or more often as appropriate
  - Could be full chargemaster or similar listing
- Effective Jan. 1, 2019
- CMS seeks input on what is a “standard charge”

Other Provisions

- Post Acute Transfers
  - Adds hospice discharges to transfer rules on Oct. 1, 2018
    - Discharges status codes 50 and 51
- Physician Orders: Removed requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment

Long Term Care Hospitals

- Overall payments decrease by $5 million
  - Rates: Increase of $6 million
  - Site Neutral Cases: Decrease of $11 million
- Elimination of 25% rule
- Base rate increase of 1.15%
  - 0.90% reduction due to elimination of 25% rule
- Federal standard rate of $41,482.98
  - FY 2018 = $41,415.11

Wage Index
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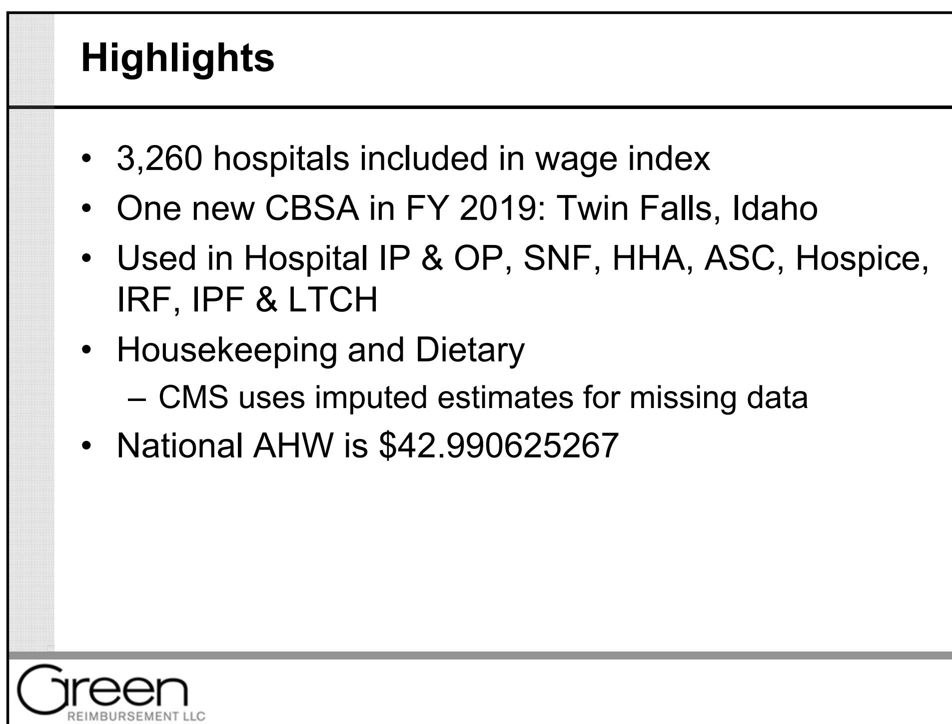
Highlights
• 3,260 hospitals included in wage index
• One new CBSA in FY 2019: Twin Falls, Idaho
• Used in Hospital IP & OP, SNF, HHA, ASC, Hospice, IRF, IPF & LTCH
• Housekeeping and Dietary
– CMS uses imputed estimates for missing data
• National AHW is $42.990625267
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Wage Index Factors

Area	Home State	Wage Index Factor - Rural Hospitals & Rural Floor			
		FY 2019 Proposed	FY 2018 Final	Change	% Change
Massachusetts	MA	1.2249	1.2424	(0.0175)	-1.41%

Area	Home State	Wage Index Factor - Hospitals in Natural CBSA			
		FY 2019 Proposed	FY 2018 Final	Change	% Change
Barnstable, MA	MA	1.3126	1.3229	(0.0103)	-0.78%
Boston, MA	MA	1.2740	1.3042	(0.0302)	-2.32%
Providence	RI	1.0444	1.1438	(0.0994)	-8.69%

Area	Home State	Wage Index Factor - Reclassified Hospitals			
		FY 2019 Proposed	FY 2018 Final	Change	% Change
Boston, MA	RI	1.2214	1.2238	(0.0024)	-0.20%
Worcester, MA	RI	1.0978	1.1438	(0.0460)	-4.02%

Outmigration Adjustment Counties

County	State	Outmigration Adjustment			
		FY 2019 Proposed	FY 2018 Final	Change	% Change
Barnstable	MA	0.0084	0.0084	0.0000	0.00%
Bristol	MA	0.0120	0.0047	0.0073	155.32%
Middlesex	MA	0.0211	0.0082	0.0129	157.32%

Rural Floor

- Imputed Rural Floor:
  - Applies to states with no rural areas
  - Delaware, New Jersey and Rhode Island
  - Expires Sept. 30, 2018
- Frontier Floor
  - Applies to 5 frontier states: Montana, Nevada, North Dakota, South Dakota & Wyoming
  - Wage index set at 1.0000

Reclassifications

- 337 new reclassifications for FY 2019
- 941 total hospitals reclassified in FY 2019
- FY 2020 geographic reclassification applications
  - FY 2020 applications are due on Sept. 4, 2018
  - FY 2020 cancellations are also due on Sept. 4, 2018

Reclassifications

- Sole hospital in labor market
  - Proposal for FY 2021
    - Provide Table 2 from the latest IPPS final rules to provide sole hospital status
  - Current rules
    - Certify with CMS Regional Office or MAC
- Multi-campus hospital remote location
  - Remote locations are eligible for individual and county group reclassifications

FY 2020 Data and Timeline

- Cost report periods beginning during FY 2016
  - Oct. 1, 2015 to Sept. 30, 2016

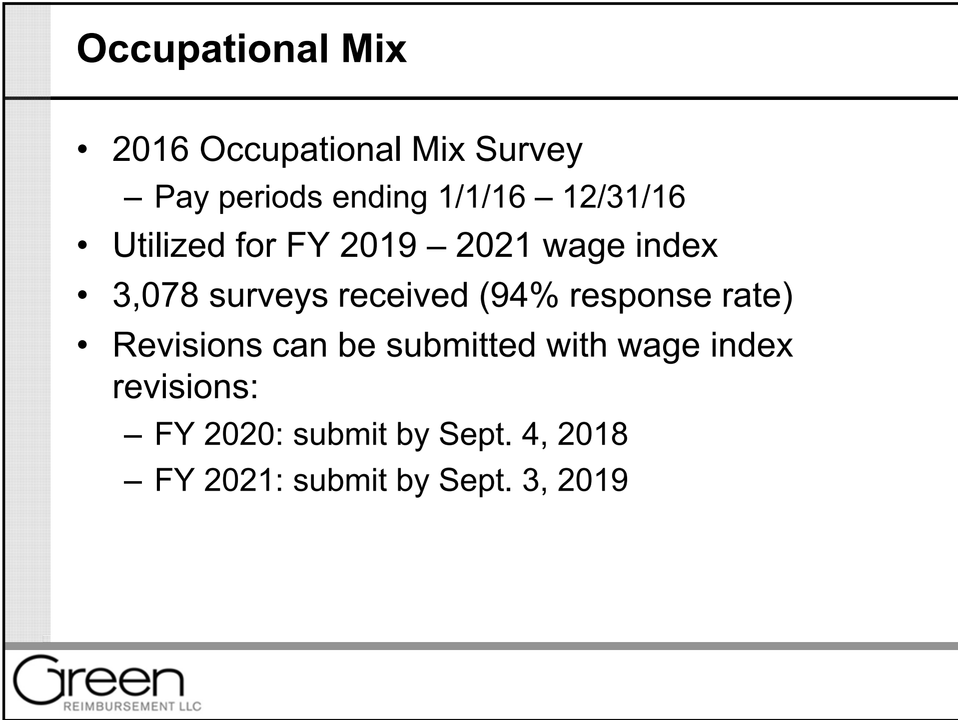
Date	Deadline
5/19/2018	Public Use Files Released (S-3 and Occ. Mix)
9/4/2018	Revision Request received by MAC
11/16/2018	MAC Desk Review Completion
1/31/2019	Revised Public Use Files Released
2/15/2019	Deadline for Error Correction & Revisions
3/22/2019	MAC Corrections & Revisions
4/4/2019	Request CMS Intervention
4/30/2019	Proposed Rule Public Use Files Released
5/30/2019	Request Correction of Errors

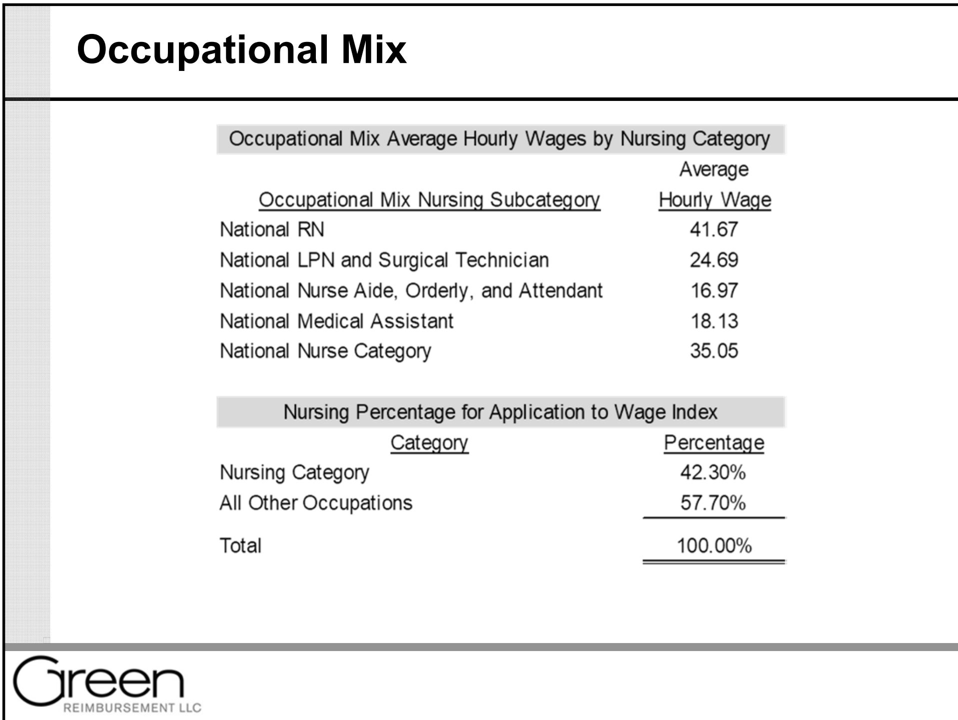
Noncore Wage Related Costs

- Criteria to claim from FY 2018 final rules
  - Not on list of 23 Core wage related costs
  - Cost is greater than 1% of total salaries, net of excluded salaries
    - Cost / (Sum of S-3, Part III, Lines 3 & 4)
  - Defined as fringe benefit by IRS
  - Reported on W-2 or 1099 as taxable income
  - Not furnished for convenience of provider
  - Not excludable from income (Working Condition Fringe)

Noncore Wage Related Costs

- Proposal to exclude Noncore Wage Related Costs
  - Beginning in FY 2020
  - CMS assertions
    - Compromises accuracy of wage index
    - Not a relative measure of labor costs
    - Not a concrete list of what is included
    - Simplify paperwork burden
    - CMS states only 8 hospitals have reported noncore WRC data correctly





Occupational Mix Average Hourly Wages by Nursing Category

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	41.67
National LPN and Surgical Technician	24.69
National Nurse Aide, Orderly, and Attendant	16.97
National Medical Assistant	18.13
National Nurse Category	35.05

Nursing Percentage for Application to Wage Index

Category	Percentage
Nursing Category	42.30%
All Other Occupations	57.70%
Total	100.00%

Wage Index: Future

- CMS has requested guidance for regulatory and policy changes for the wage index
- Welcoming analysis regarding CMS' authority
- Where is CMS going with this?

Disproportionate Share & Uncompensated Care Payments

Medicare DSH Payments

Total payment is the sum of the following:

- Historical DSH payment methodology
  - Reduced by 75%
- Uncompensated Care Payment
  - Factor 1: 75% of historical DSH payments
    - $16.3 billion in total DSH x 75% = $12.2 billion
  - Factor 2: Reduction in uninsured population
    - 32.49% reduction for FY 2019 (41.99% in FY 2018)
  - Factor 3: Hospital allocation percentage
    - Ratio of hospital data to national data

Uncompensated Care Payment

Uncompensated Care Payment Calculation

	Proposed FY 2019	Final FY 2018	Final FY 2017
Estimated National DSH Payments (Billions)	$16.295	$15.553	$14.397
Less: 25% Empirical DSH Payments (Billions)	(4.074)	(3.888)	(3.599)
Factor 1: Uncompensated Care Pool (Billions)	12.221	11.665	10.797
Factor 2: Reduction in Uninsured	32.49%	41.99%	44.64%
Net Uncompensated Care Pool (Billions)	8.250	6.767	5.977
Factor 3: Sample Hospital % of UC Care	0.037%	0.037%	0.037%
Hospital Uncompensated Care Payment (Millions)	$3.060	$2.510	$2.217

Uncompensated Care Payment: Factor 3

- Hospital allocation percentage
  - FY 2019 is a blend of
    - FY 2013 Medicaid days and FY 2016 SSI days
    - FY 2014 Worksheet S-10 Uncompensated Care Cost
    - FY 2015 Worksheet S-10 Uncompensated Care Cost
  - FY 2020 and beyond
    - 3-year average of Worksheet S-10 cost data
      - FY 2020 based on FY 2014, 2015 & 2016 S-10 data
      - Medicaid and SSI days will no longer be used
    - CMS is considering replacing 3-year blend with data for one year (FY 2020 would use FY 2016 data)

Uncompensated Care Cost: Guidance

- Worksheet S-10 Uncompensated Care Costs
  - Includes charity care
  - Includes bad debts
  - Excludes unreimbursed Medicaid shortfalls
- Transmittal 11
  - Revises Worksheet S-10
  - Released Sept. 29, 2017
  - Effective for cost reports beginning on or after Oct. 1, 2013

Worksheet S-10: Transmittal 11

- Applies to IPPS and Critical Access Hospitals
- Changes to Worksheet S-10 - Charity Care
  - Charity care definition includes uninsured discounts
  - Adjustments may be full or partial discounts
  - Adjustments must conform to policies
  - Report deductibles and coinsurance for insured
    - Not subject to Cost to Charge Ratio (CCR)
  - Include entire facility, except physicians

Worksheet S-10: Transmittal 11

Changes to Worksheet S-10 - Charity Care

- Charges & Payments
  - Cost reports beginning before Oct. 1, 2016
    - Charges and payments based on service dates in cost report year
    - Record full charges for uninsured patients (Column 1)
  - Cost reports beginning on or after Oct. 1, 2016
    - Adjustments and payments incurred in cost report year
    - Report charges patient is not responsible for paying

Worksheet S-10: Transmittal 11

Changes to Worksheet S-10 - Bad Debts

- Include write-offs in cost report period, regardless of service dates
- Bad debts write-offs must follow policies
- Bad debts must be net of recoveries
- Non-Medicare bad debts are subject to CCR
- Non-reimbursable Medicare bad debts are not subject to CCR
- Include entire facility, except physicians

Worksheet S-10: Prospective Actions

- Continue to monitor guidance
- Prepare and submit revised S-10 data
- Update policies and procedures
- Educate patient registration and patient accounting
- Monitor write-offs and test for policy adherence
- Develop new reports to appropriately capture charity care and bad debt adjustments

Cost Report Submissions

Cost Report Acceptance Requirements

- Cost reports filed on or after Oct. 1, 2018
- Requirements to submit with cost report:
  - Medical Education: IRIS data files that match FTE amounts reported on cost report
  - Medicare Bad Debts: Medicare bad debt logs, in proper format, that match amounts on cost report
  - Home Office Costs: Home Office Cost Statement must be submitted with cost report, if applicable.
    - CMS reiterated Home Office Cost Statements are required to be completed

Cost Report Acceptance Requirements

- Requirements to submit with cost report:
  - Medicare DSH & Uncompensated Care
    - Medicaid day log that matches Medicaid days on cost report
    - Charity and uninsured discounts reported on Worksheet S-10 must be supported by a detailed listing containing:
      - Name, dates of service, insurer (if applicable), discount provided
    - No discussion of support for facility bad debts reported on Worksheet S-10

Medicare Cost Report e-Filing: MCReF

- System Login: https://mcref.cms.gov
- Electronic transmission of cost report package
  - Available May 1, 2018
  - Open to all Part A providers
  - Submit cost report files and support
    - System will test validity of files, software updates, provider numbers, etc.
  - One submission per day
    - Can request rejection of erroneous submission
  - Timely filing if received by 11:59 p.m. ET on due date

Medicare Cost Report e-Filing: MCReF

- System Login: https://mcref.cms.gov
- Electronic transmission of cost report package
  - Secure portal, can transmit PHI / PII
  - Accessible by your EIDM PS&R Security Official (SO) and Backup Security Official (BSO)
    - Delegate access to MCReF role by end of May 2018
- July 2, 2018, CMS-approved submission method:
  - Electronic through MCReF
  - Physical delivery via mail or hand-delivery

Electronic Cost Report Signature

- Cost reports ending on or after Dec. 31, 2017
- Requirements for electronic signature
  - Must be signed by Administrator or CFO
  - Must place on signature line and may be:
    - Any format of original signature or
    - Entered into cost report software
  - Electronic signature checkbox must be marked
- May upload scan of signed certification page to MCReF

Electronic Cost Report Signature

MCR Version	Provider Type	e-Signature Capable?
2552-10	Hospital	Yes
2540-10	SNF	Yes
265-11	ESRD	Yes
224-14	FQHC	Yes
1728-94	HHA	Yes
216-94	OPO/Histolab	Yes
1984-14	Hospice	Yes
222-92	RHC	No - Ink Signature Required
2088-92	CMHC	No - Ink Signature Required
287-05	Home Office	No - Ink Signature Required

EHR & Quality

EHR: Meaningful Use

- Rebranded as Promoting Interoperability Program
- Proposed changes
  - Move from threshold based scoring to performance
  - Reduced number of measures to 6 in four categories
    - e-Prescribing, Health Information Exchange, Provider to Patient Exchange and Public Health and Clinical Data Exchange
  - Measurement period is any continuous 90-day period in CY 2019 and 2020
  - Will use 2015 edition of CEHRT

Hospital Acquired Conditions

- Hospitals in worst quartile receive 1% reduction to base DRG and add-on payments
- Proposed change
  - Equal weight to all six measures
  - Remove Domains

Hospital Readmissions

- Proposed FY 2019 factors published in Table 15
- Maximum reduction to payments is 3%
- FY 2019 Revisions
  - Based on discharges from July 1, 2014, to June 30, 2017
  - Codify dual-eligible criteria implemented in FY 2018

Value Based Purchasing

- Proposed FY 2019 factors are published in Table 16
- Budget neutral: Funded through reduction in base operating MS-DRG payments
  - 2.00% reduction
- Incentive payments based on hospital performance
  - $1.9 billion available for distribution

Value Based Purchasing

- Changes to Domains and Measures
  - None for FY 2019 & FY 2020
  - Significant changes for FY 2021 and beyond
    - Removal of 10 measures in IQR and HAC programs
    - Removal of Safety Domain
    - Revise domain weights
      - Clinical Outcomes = 50%
      - Efficiency & Cost Reduction = 25%
      - Person & Community Engagement = 25%
    - Must score in all 3 domains to receive Total Performance Score

Questions?

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