Reimbursement Update

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Agenda

- FY 2019 Medicare IPPS Final Rule
  - Payment Update
  - Wage Index
  - DSH & Uncompensated Care Payments
  - Cost Report Submissions
  - EHR & Quality
- CY 2019 Medicare OPPS Proposed Rules
  - Payment Update
  - Site Neutral
  - 340B Drugs

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FY 2019 Medicare Inpatient PPS Final Rules

FY 2019 Medicare IPPS Final Rules

- Issued on Aug. 2, 2018
  - Published in Federal Register Aug. 17, 2018
- Correction Notice published Sept. 28, 2018
  - Published in Federal Register on Oct. 3, 2018
- Effective Oct. 1, 2018 – Sept. 30, 2019

FY 2019 Medicare IPPS Final Rules

- $4.8 billion increase in payments
  - Operating = $3.3 billion
  - Uncompensated Care Payments = $1.5 billion
  - Capital, New Tech & Low Volume = $0.4 billion
- Total IPPS payment increase of 2.4%

FY 2019 Update Factors

2019 Market Basket Increase	2.90%
Less: Productivity Adjustment	-0.80%
Less: ACA Reduction	-0.75%
2019 Net Market Basket Increase	1.35%
Less: Budget Neutrality Adjustments	-0.53%
Add: Documentation & Coding	0.50%
Net Market Basket Increase - Full Update	1.32%

Negative Adjustments for Certain Hospitals

Not an EHR Meaningful User	-2.175%
Failure to Submit Quality Data	-0.725%
No EHR & Failure to Submit Quality Data	-2.900%

DRG and Outlier Changes

Full Update - Correction Notice Standard Rates (Wage Index > 1.0)	Final FY 2019	Final FY 2018	Change	% Change
Labor (68.3%)	3,856.27	3,806.04	50.23	1.32%
Non-Labor (32.7%)	1,789.81	1,766.49	23.32	1.32%
Operating DRG	5,646.08	5,572.53	73.55	1.32%

Capital Rate	Final FY 2019	Final FY 2018	Change	% Change
Capital DRG	459.41	453.95	5.46	1.20%

Outliers	Final FY 2019	Final FY 2018	Change	% Change
Outlier Threshold	25,743	26,601	-858	-3.23%

Multi-campus Hospitals

Main campus and remote location must have same status

- SCH, RRC, MDH, Rural Reclassification
- All campuses must meet qualifying criteria
- Applies to IPPS services only
- CMS assertions:
  - Single entity with one agreement
  - Administrative difficulties

Medicare Dependent Hospitals

- Program expired Sept. 30, 2017
- Program reauthorized through Sept. 30, 2022
  - Bipartisan Budget Act of 2018
  - Retroactive to Oct. 1, 2017
  - Most MDH automatically reinstated

Low Volume Hospitals

- Program expired Sept. 30, 2017
- Program reauthorized through Sept. 30, 2022
  - Bipartisan Budget Act of 2018
- FY 2018 rules were unchanged from prior rules

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

IPPS Excluded Hospitals

- Current
  - IPPS excluded hospitals cannot have excluded psychiatric or rehabilitation units
- Finalized
  - 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

Other Provisions

- Post Acute Transfers
  - Adds hospice discharges to transfer rules
    - Effective Oct. 1, 2018
    - Discharges status codes 50 and 51
    - $240 Million in FY 2019

Other Provisions

- Physician Admission Orders
  - Removes requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment
  - Documentation in medical record must support order for admission and coverage criteria

Wage Index

Highlights

- 3,283 hospitals included in wage index
- One new CBSA: 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 $42.955981146

Wage Index Factors

Area	Home State	Wage Index Factor - Rural Hospitals & Rural Floor			
		FY 2019 Final	FY 2018 Final	Change	% Change
Massachusetts	MA	1.3545	1.2430	0.1115	8.97%

Area	Home State	Wage Index Factor - Hospitals in Natural CBSA			
		FY 2019 Final	FY 2018 Final	Change	% Change
Barnstable, MA	MA	1.3545	1.3236	0.0309	2.33%
Boston, MA	MA	1.3545	1.3048	0.0497	3.81%
Providence	RI	1.0445	1.1445	(0.1000)	-8.74%

Area	Home State	Wage Index Factor - Reclassified Hospitals			
		FY 2019 Final	FY 2018 Final	Change	% Change
Boston, MA	RI	1.2200	1.2245	(0.0045)	-0.37%
Worcester, MA	RI	1.1322	1.1445	(0.0123)	-1.07%

Rural Floor

- 263 hospitals receive rural floor across country
- 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

- Sole hospital in labor market
  - Beginning in 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

- Eliminate 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

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% = $12.3 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	Final FY 2019	Final FY 2018	Final FY 2017
Estimated National DSH Payments (Billions)	$16.339	$15.553	$14.397
Less: 25% Empirical DSH Payments (Billions)	(4.085)	(3.888)	(3.599)
Factor 1: Uncompensated Care Pool (Billions)	12.254	11.665	10.797
Factor 2: Reduction in Uninsured	32.49%	41.99%	44.64%
Net Uncompensated Care Pool (Billions)	8.272	6.767	5.977
Factor 3: Sample Hospital % of UC Care	0.037%	0.037%	0.037%
Hospital Uncompensated Care Payment (Millions)	$3.068	$2.510	$2.217

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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
    - Updated factors to be published Oct. 3, 2018
  - 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

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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

Cost Report Submissions

Cost Report Acceptance Requirements

- Cost reports filed on or after Oct. 1, 2018
- Requirements to submit with 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 by home office, 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

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

EHR & Quality

EHR & Quality Presentation

Very helpful CMS presentation and webinar:

https://www.qualityreportingcenter.com/event/fy-2019-ipps-ltch-pps-final-rule-overview-of-ecqm-reporting-and-promoting-interoperability-programs/

EHR: Meaningful Use

- Rebranded as Promoting Interoperability Program
- Changes
  - Move from threshold based scoring to performance based
  - Reduce number of measures to 6 in 4 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

Meaningful Measures Initiative

- Identify high-priority areas for quality measurement and improvement
- Increase measure alignment across CMS programs
- Reduce provider burden

Hospital Acquired Conditions

- Hospitals in worst quartile receive 1% reduction to base DRG and add-on payments
- Changes
  - Equal weight to all measures
  - Remove domains

Hospital Readmissions

- 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

- 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 14 measures in IQR and HAC programs
    - Removal of Safety Domain was not finalized
    - Revise domain weights at 25% each
      - Clinical Outcomes, Efficiency & Cost Reduction, Person & Community Engagement, and Safety
    - Must score in 3 of 4 domains to receive Total Performance Score

CY 2019 Medicare Outpatient PPS Proposed Rules

CY 2019 OPPS Proposed Rules

- Issued on July 25, 2018
- Published in Federal Register on July 31, 2018
- Final Rule expected Nov. 2, 2018
- Effective Jan. 1, 2019 – Dec. 31, 2019
- $90 million increase in payments
- Total OPPS payment decrease of 0.1%

Proposed Market Basket

	OPPS	ASC
2019 Market Basket Increase	2.80%	2.80%
Less: Productivity Adjustment	-0.80%	-0.80%
Less: ACA Reduction	-0.75%	0.00%
2019 Net Market Basket Increase	1.25%	2.00%
Budget Neutrality Adjustments	-0.09%	0.03%
Net Market Basket Increase - Full Update	1.16%	2.03%
Negative Adjustments for Certain Hospitals		
Failure to Submit Quality Data	-2.00%	

Proposed Conversion Factor Update

	OPPS	ASC
FY 2018 Conversion Factor (With Quality)	78.636	45.575
FY 2019 Conversion Factor (With Quality)	79.546	46.500
Change in Conversion Factor	0.910	0.925
Change %	1.16%	2.03%
FY 2019 Conversion Factor (No Quality)	77.973	45.575

Site Neutral (CY 2018)

- Off-campus provider based department (OCPBD)
  - Excepted (grandfathered) OCPBD services:
    - Furnished and billed at OCPBD prior to Nov. 2, 2015
  - Non-excepted OCPBD services
    - New locations after Nov. 2, 2015
    - Paid at 40% of Medicare outpatient PPS rate
  - Does not apply to services:
    - Provided in dedicated emergency department
    - Furnished within a hospital department within 250 yards of a remote location of the hospital

Site Neutral Proposals

- All OCPBDs will be paid at site neutral rate
  - Excepted and non-excepted
  - 40% of Medicare outpatient PPS rate
  - Payment decrease of $760 million
- Expansion of services at excepted OCPBDs will be paid at site neutral rates
  - New clinical families since November 2, 2015

340B Drugs

- CY 2018
  - OPPS payment for 340B drugs reduced to Average Sales Price (ASP) minus 22.5%
  - Previously paid at ASP plus 6%
  - Reduction does not apply to non-excepted OCPBDs
- CY 2019 Proposed
  - Expands reduction to non-excepted OCPBDs
  - Excludes sole community hospitals, children's hospitals and PPS exempt cancer hospital

Questions?

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