Medicare Regulatory Update - July 2011

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TODAY'S TOPICS

- DRG Updates
- Low Volume Adjustments
- Low Per Capita Counties
- Medicare Cost Per Beneficiary
- Proposed Re-admisssion policies
- Disproportionate Share
- Occupational Mix and Current Wage Index Issues
- Medical Education
- Physician Supervision
- OPPS
- EHR Implementation (Stage 2 Delay)
- Wage Index Reform

DRG PAYMENT RATES – WAGE INDEX > 1.0000

	FFY 2011 Final (8/16/10 FR)	FFY 2012 Proposed (5/5/11 FR)
Labor-Related	$3,552.91	$3,531.06
Non-Labor	1,611.20	1,601.30
Capital	420.01	422.54
Total Pmt Rate	$5,584.12	$5,554.90

Decrease of $29.22 or .52% from prior year.

DRG PAYMENT RATES – WAGE INDEX <1.0000

	FFY 2011 Final (8/16/10 FR)	FFY 2012 Proposed (5/5/11 FR)
Labor-Related	$3,201.75	$3,182.06
Non-Labor	1,962.36	1,950.30
Capital	420.01	422.54
Total Pmt Rate	$5,584.12	$5,554.90

LABOR / NON-LABOR DRG RATES – WI > 1.000

Description (for FFY 2012-Eff 10/1/11)	Labor	Non-Labor
FY2011 Base Rate	$3,947.65	$1,790.21
FY2012 Update Factor	1.015	1.015
Proposed Adj for Restoring Rural Floor Budget Neutrality	1.011	1.011
FY2012 DRG Recalibration & Wage Index Budget Neutrality Factor (BNF)	0.998532	0.998532
FY2012 Reclassification 'BNF'	0.991528	0.991528
FY2012 Outlier Factor	0.949000	0.949000
FY 2012 Rural Demonstration 'BNF'	0.999479	0.999479
Proposed Documentation & Coding Adj,	0.9282	0.9282
Proposed FY2012 DRG Payment Rate	$3,531.06	$1,601.30

PROPOSED IPPS UPDATE FACTORS – FFY 9/30

	2011	2012	2013	2014	2015	2016
Market Basket	2.4%	2.8%	2.9%	3.0%	2.9%	2.9%
ACA Reduction - MB	-0.25%	-0.1%	-0.1%	-0.3%	-0.2%	-0.2%
ACA Reduction - Productivity	N/A	-1.2%	-1.2%	-1.1%	-1.0%	-1.0%
Subtotal	2.15%	1.5%	1.6%	1.6%	1.7%	1.7%
MS-DRG Adj						
'08-09 Recoupment	-2.9%	0.0 (net)	2.9%	N/A	N/A	N/A
Prospective Reduction	N/A	-3.15%	-0.75%	N/A	N/A	N/A
Cape Cod Decision		1.1%				
Net Update	-0.9%	-0.55%	3.75%	1.6%	1.7%	1.7%

SOLE COMMUNITY HOSPITALS

- -0.24% update to SCH rate
  - Check CMS PUF file for new rate
- TOPs extended to SCH's regardless of number of beds for services through 12/31/2011
  - Proposed 2012 OPPS Rule – TOPs expires on 12/31/11
- 7.1% continued add-on for rural SCHs outpatient services paid under OPPS
  - Excludes separately payable drugs, biologicals, brachytherapy and devices

OUTLIERS

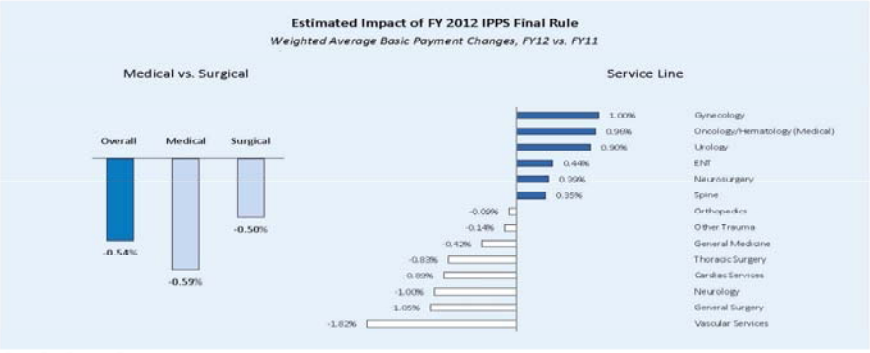
- Proposed FFY 2012 is $23,375, final outlier threshold for FFY 2011 was $23,075
- Outlier payments are to be 5.1% of total IPPS payments, but were 5.3% for 2009 and estimated at 4.7% for 2010

NATIONAL AVERAGE RCCS (FROM 2009 CR DATA)

Cost Center	WS C CR Line #s	Revenue Codes	Cost Charge Ratio
Routine Days	25	10x, 11x, 12x, 13x, 15x, 16x-19x	0.514
Intensive Days	26-30	20x, 21x	0.448
Drugs	48, 56	25x, 26x, 63x	0.199
Supplies & Equipment	55, 66, 67	27x, 26x, 290-299	0.331
Therapy Services	50-52	42x, 43x, 44x, 47x	0.381
Laboratory	44, 45, 54	30x, 31x, 74x, 75x	0.145
Operating Room	37, 38	36x, 71x, 72x	0.251
Cardiology	53	48x, 73x	0.154
Radiology	41-43	28x, 32x-35x, 40x, 61x	0.140
Emergency Room	61	45x	0.239
Blood & Blood Products	46, 47	38x, 39x	0.408
Other Services	58-60, 62	Pretty much all other rev codes	0.395
Labor & Delivery (only for 6 MS-DRGs)	39, 63	36x, 71x, 72x, 51x	0.470
Inhalation Therapy	49	41x, 46x	0.192
Anesthesia	40	37x	0.117

MODERATE CUTS PROPOSED FOR KEY SERVICES IN 2012

By our calculations, we estimate that the changes outline in the FY 2012 Proposed Rule will lead to hospital payments that are marginally down in FY 2012 compared to FY 2011, exacerbation an already difficult financial environment for hospitals. As with any year, the impact will vary across service lines, with reimbursement for gynecology, medical oncology and urology services expected to post modest year-over-year gains, while payment for vascular services, general surgery and neurology expected to decline. Medical MS_DRGs fare slightly worse than their surgical counterparts when examining overall payment changes. However, the overall impact of these rate changes at a given facility will depend greatly upon the mix of services performed.



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Source: CMS, Advisory Board analysis

HIGH VOLUME (> 100,000 DISCHARGES) MS-DRGs

MS-DRG	Description	FY2011 Weight	FY 2012 Proposed Weights	% Different
65	Intracranial hemorrhage or cerebral infarction w CC	1.1667	1.1490	-1.52
190	Chronic obstructive pulmonary disease w MCC	1.1924	1.1730	-1.63
191	Chronic obstructive pulmonary disease w CC	0.9735	0.9656	-0.81
192	Chronic obstructive pulmonary disease w/o CC/MCC	0.7220	0.7101	-1.65
193	Simple pneumonia & pleurisy w MCC	1.4796	1.4981	1.25
194	Simple pneumonia & pleurisy w CC	1.0152	1.0079	-0.72
247	Perc cardiovascular proc w drug-eluting stent w/o MCC	1.9691	1.9763	0.37
287	Circulatory disorders except AMI, w card cath w/o MCC	1.0879	1.0699	-1.65
291	Heart failure & shock w MCC	1.4943	1.4978	0.23
292	Heart failure & shock w CC	1.0302	1.0208	-0.91
293	Heart failure & shock w/o CC/MCC	0.6853	0.6752	-1.47
309	Cardiac arrhythmia & conduction disorders W CC	0.8387	0.8136	-2.40
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5709	0.5594	-2.01

HIGH-VOLUME (> 100,000 DISCHARGES) MS-DRGS

MS-DRG	Description	FY2011 Weight	FY 2012 Proposed Weights	% Different
312	Syncope & collapse	0.7172	0.7096	-1.06
313	Chest pain	0.5499	0.5405	-1.07
378	GI hemorrhage w CC	1.0274	1.0261	-0.13
392	Esophagitis, gastroent & misc digest disorders w/o MCC	0.7173	0.7280	1.49
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.1039	2.0943	-0.46
603	Cellulitis w/o MCC	0.8377	0.8517	1.67
641	Nutritional & misc metabolic disorders w/o MCC	0.6916	0.6962	0.67
682	Renal failure w MCC	1.6407	1.6373	-0.21
683	Renal failure w CC	1.0243	1.0209	-0.33
690	Kidney & urinary tract infections w/o MCC	0.7864	0.7926	0.79
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	1.9074	1.9095	0.11
872	Septicemia or severe sepsis w/o MV 96+ hours w/o MCC	1.1545	1.1401	-1.25

LOW VOLUME ADJUSTMENT

- Temporary changes effective only for FFY 2011 and 2012
  - Mileage changed from 25 to 15 road miles
  - Maximum Medicare discharges changed to 800 from 1600 and are to include:
    - Medicare FFS and Medicare Advantage discharges
    - Discharges for eligible Part A patients who exhausted inpatient benefits or stay not covered by Medicare
  - Add-on also available to SCHs and MDHs

LOW VOLUME ADJUSTMENT

- Max of 25% "add-on" to standardized amount
- Hospitals must submit application for FFY 2012 by 9/1/11 (even if applied for FFY 2011)
- Published % based on 12/2010 update of FY 10 MedPAR data

CMS Certification Number (CCN)	Medicare Discharges	Proposed FY 2012 Low-Volume Payment Adjustment (Percentage Add-on)	Eligible?
380001	953	11.5536%	yes
380005	692	16.2143%	no
380021	1,261	6.0536%	no
380022	1,550	0.8929%	no
380029	905	12.4107%	yes
380033	651	16.9464%	no
380037	894	12.6071%	no
380038	1,460	2.5000%	no
380040	949	11.6250%	yes
380052	1,380	3.9286%	yes
380056	489	19.8393%	yes
380082	1,451	2.6607%	no

LOW PER CAPITA COUNTIES

- Section 1109 eligible hospitals
  - FFY 2011 and 2012 only, excluding CAHs
- Counties ranking in lowest quartile of expenditures per enrollee, 5 yr average:
  - Source of spending from MedPAR, Standard Analytic File and National Claims History File
  - Divided by # of beneficiaries enrolled within the county
- Payment is ratio of IPPS payments to aggregate of all qualifying hospitals
  - Includes operating DRGs, Outliers, DSH, IME

LOW PER CAPITA COUNTIES

- $150 million distributed in FFY 2011
  - Payments not yet made for this FFY
  - Expected to be made in September
  - Payment to be made thru single Medicare contractor to all eligible hospitals in USA
  - Not to be reported in cost report
- $250 million to be distributed in FFY 2012

ELIGIBLE NORTHWEST HOSPITALS

Provider Number	Provider Name	Payment Weight Factor	Estimated Pmt – Yr 1	Estimated Pmt – Yr 2
380001	MID-COLUMBIA MEDICAL CENTER	0.00075	$112,774	$187,957
380004	PROVIDENCE ST VINCENT MEDICAL CENTER	0.00662	992,410	1,654,017
380007	LEGACY EMANUEL HOSPITAL	0.00335	502,248	837,079
380009	OHSU HOSPITAL AND CLINICS	0.01205	1,807,261	3,012,101
380014	GOOD SAMARITAN REGIONAL MEDICAL CTR	0.00295	442,584	737,640
380017	LEGACY GOOD SAMARITAN HOSPITAL	0.00445	667,501	1,112,502
380021	TUALITY COMMUNITY HOSPITAL	0.00132	198,687	331,145
380025	LEGACY MT HOOD MEDICAL CENTER	0.00110	165,519	275,865
380029	SILVERTON HOSPITAL	0.00040	59,639	99,399
380038	WILLAMETTE FALLS HOSPITAL	0.00059	88,810	148,017
380040	ST CHARLES MEDICAL CENTER - REDMOND	0.00097	145,792	242,986
380047	ST CHARLES MEDICAL CENTER - BEND	0.00549	823,556	1,372,594

ELIGIBLE NORTHWEST HOSPITALS

Provider Number	Provider Name	Payment Weight Factor	Estimated Pmt – Yr 1	Estimated Pmt – Yr 2
380050	SKY LAKES MEDICAL CENTER, INC	0.00229	343,397	572,329
380051	SALEM HOSPITAL	0.00559	839,013	1,398,355
380052	HOLY ROSARY MEDICAL CENTER	0.00098	146,661	244,435
380056	SANTIAM MEMORIAL HOSPITAL	0.00021	31,196	51,994
380060	ADVENTIST MEDICAL CENTER	0.00204	306,000	510,000
380061	PROVIDENCE PORTLAND MEDICAL CENTER	0.00545	817,677	1,362,795
380082	PROVIDENCE MILWAUKIE HOSPITAL	0.00060	89,656	149,427
380089	LEGACY MERIDIAN PARK HOSPITAL	0.00209	314,230	523,717
380091	KAISER SUNNYSIDE MEDICAL CENTER	0.00010	14,547	24,246

ELIGIBLE NORTHWEST HOSPITALS

Provider Number	Provider Name	Payment Weight Factor	Estimated Pmt – Yr 1	Estimated Pmt – Yr 2
500002	PROVIDENCE ST MARY MEDICAL CENTER	0.00161	241,338	402,230
500012	YAKIMA REGIONAL MEDICAL AND CARDIAC CENTER	0.00337	505,056	841,760
500016	CENTRAL WASHINGTON HOSPITAL	0.00491	737,200	1,228,666
500024	PROVIDENCE ST PETER HOSPITAL	0.00821	1,230,758	2,051,264
500036	YAKIMA VALLEY MEMORIAL HOSPITAL	0.00475	712,764	1,187,940
500037	TOPPENISH COMMUNITY HOSPITAL	0.00029	43,778	72,963
500049	WALLA WALLA GENERAL HOSPITAL	0.00057	85,825	143,042
500050	S W WASHINGTON MEDICAL CENTER	0.00704	1,056,067	1,760,111
500072	OLYMPIC MEDICAL CENTER	0.00213	319,752	532,919
500139	CAPITAL MEDICAL CENTER	0.00172	258,226	430,377
500148	WENATCHEE VALLEY HOSPITAL	0.00023	33,752	56,253
500150	LEGACY SALMON CREEK HOSPITAL	0.00270	404,698	674,497

MEDICARE SPENDING PER BENEFICIARY

- Proposed new claim-based measure for 2014
  - Using discharges between 5/15/12 thru 2/14/13
- Based on episode running 3 days prior to I/P PPS admission thru 90 days post discharge
  - Reinforce need to reduce adverse outcomes, incl readmissions
  - Encourage delivery of coordinated care
  - CMS seeking comments on alternative 30 days post discharge
    - Thought 30 days insufficient emphasis on longer term care transitions and care coordination

MEDICARE SPENDING PER BENEFICIARY

- Propose to include all Part A and B payments
- Transfers, readmissions and additional admissions to be included in episode of care
- Calculation to exclude -
  - Episodes for benes not enrolled in both Part A and B
  - Benes enrolled in MA plan during period
  - Benes that die during period
  - Benes covered under Railroad Retirement Board
  - Episodes where Medicare is secondary

MEDICARE SPENDING PER BENEFICIARY

- Per bene spending to be calculated for ***each hospital*** by compiling all beneficiary pmts for the period
  - Divided by the total # of bene episodes for the hospital
- CMS proposing to include per bene spending in hospital's FFY 2014 VBP measure set

DEFINITION OF "RE-ADMISSION"

- 30 days from date of discharge from index hospital
- 3 risk-standardized re-admission measures
  - Acute Myocardial Infarction (AMI)
  - Heart Failure
  - Pneumonia
- Exclusions from re-admission measure
  - PTCA or CABG
    - Typically scheduled re-admissions for patients with AMI
  - Transfers

DEFINITION OF "RE-ADMISSION"

- Count to include re-admissions for all causes, except excluded (previous slide)
- Using 3 years of data to calculate excess re-admission ratios
  - FFY 2013 – w/b using discharges from 7/1/08 thru 6/30/11
- Only hospitals w/25+ discharges for each of 3 proposed conditions to be included in "*Hospital Compare*"
  - Fewer cases not reliable to gauge hospital performance

EXCESS RE-ADMISSION RATIO

- Using risk-standardized ratio of the 3 measures
  - Ratio is "risk adjusted re-admission based on actual" to "risk adjusted expected re-admissions"
  - Hospital performing better than average would have ratio below 1.000
- Ratio is risk adjusted for the 3 measures only
  - Hospital w/higher than average raw admission rate caring for very sick patients may have ratio below 1.000
  - Hospital w/low unadjusted re-admission rate caring for very low risk population may have ratio over 1.000

DISPROPORTIONATE SHARE

- Reminder: Labor days counted in DSH if patient has been admitted to hospital as an inpatient
  - Fiscal Intermediary/MAC s/b making adjustments in cost reports to add back labor days to DSH calculation before finalization
- Cost Report forms changed to report labor room days on separate line of S-3, Part I

DISPROPORTIONATE SHARE

- Exclusion of hospice beds/days
  - Inpatient respite care
    - Limited to 5 consecutive days
  - General inpatient care
    - Patient receives care for pain control or acute/chronic symptom not feasible in other setting
  - Hospice not paid under IPPS
  - Exclude hospice days from DSH calculation
  - Also exclude hospice days from bed count days
    - Helps IME calculation

DISPROPORTIONATE SHARE

- Hospital specific SSI data file
  - Will share "certain detailed SSI fraction data used to calculate the hospital's SSI fraction as long as hospital has a valid data use agreement with CMS and submits a request for such data"
  - More detail about the data located at:
    - www.cms.gov/PrivProtectedData/07_DSHRateData.asp

DISPROPORTIONATE SHARE

Timeline to Calculate FY 2011 SSI Fractions

CR using FY 2011 SSI Ratios	Deadline for Timely Filing of Claims	MedPAR Data File Used	SSI Entitlement File	CR Normally Accepted	CR Final Settlement	SSI Fraction Available
CR beginning Oct 1, 2010 thru Sept 30, 2011	Sept 2012	Dec 2012 update of FY 2011 MedPAR	Dec 2012 update of FY 2011 SSI eligibility	Generally; between Mar 2012 and Feb 2013	Generally; between Mar 2013 and Feb 2014	Spring 2013

DISPROPORTIONATE SHARE

- Future Medicare DSH reduction to 25% of current level
  - By 2014, about 75% reduction to DSH pmts
  - Mitigated by add-on for uncompensated care at hospital level via cost report WS S-10
    - If not previously DSH hospital, would not qualify for uncompensated care add-on

OCCUPATIONAL MIX – FOR 2012 WAGE INDICES

- CMS data on National AHW of occupational mix categories, as used in FFY 2012 rule
- From 2007/2008 survey

Occ Mix Nsg Category	Avg Hourly Wage
RN Mgmt	Not included
RN Staff	$36.04943
LPN/Surg Tech	$20.85054
Nurse Aides, Orderlies, Attendants	$14.61140
Med Assistants	$16.45837
National Rate - Entire Nursing Category	$30.44254

OCCUPATIONAL MIX – 2010 SURVEY

- Survey impacts average hourly rates – the higher the RN wages to total nursing wages, the greater negative impact on hospital's avg hourly rate
- Purpose is to control for hospital's choices of employment categories to provide nursing care
- Will be used in FFY 2013 wage index
- Estimated completion time – 480 hours!

OCCUPATIONAL MIX – 2010 SURVEY

- Unaudited data to be released Oct 2011, with 2009 wage index data and correction process
- CMS publishes wage index calculator with occupational mix adjustment
  - Can see impact to your own hospital
  - See p. 25872 of 5/5/11 Federal Register
  - Excel file available on CMS website

OCCUPATIONAL MIX – 2010 SURVEY

- The survey:
  - Includes FT, PT, directly hired and contract personnel
  - Includes employees allocated from the home office, if applicable
  - 'Should' mirror job codes reported by hospitals on Worksheet S-3 Part II of the Medicare cost report
  - Excludes compensation and overhead relating to areas excluded under IPPS (i.e. psych, rehab, SNF, etc.)
  - Excludes physician Part B and interns and residents

OCCUPATIONAL MIX – 2010 SURVEY

- **Cost centers included in Survey**
  - Line 14 – Nursing Administration
  - Line 25 –Routine Care
  - Line 26 – ICU
  - Line 27 – CCU
  - Line 28 – Burn ICU
  - Line 29 – Surgical ICU
  - Line 30 – Other Special Care Unit
  - Line 33 – Nursery
  - Line 37 – Operating Room
  - Line 38 – Recovery Room
  - Line 39 – Delivery Room
  - Line 53 – EKG
  - Line 57 – Renal Dialysis
  - Line 58 – ASC
  - Line 59 – Other Ancillary
  - Line 60 – Clinics**
  - Line 61 – Emergency Room
  - Line 62 – Observation Room

OCCUPATIONAL MIX SURVEY – IMPACT

State	AHW (unadjusted)	AHW (adjusted for Occ. Mix)	$ Change	Impact
Oregon	$40.79	$40.04	$(.75)	Negative
Washington	$40.34	$39.90	(.44)	Negative
California**	$47.41	$46.73	(.68)	Negative
New York	$42.32	$42.98	.66	Positive
Florida	$33.79	$33.85	.06	Positive
Texas	$33.76	$33.88	.12	Positive

**California has mandatory staffing requirements

WAGE INDEX COMPARISONS – OREGON

Locale (CBSA#)	Hospitals in CBSA	AHW FFY2012	Wage Index	Reclassified Wage Index
National Avg.	3,504	$36.14	1.0000	1.0000
Bend (13460)	2	$40.77	1.1212	1.1212
Corvallis (18700)	1	$39.02	1.0729	1.0368
Eugene (21660)	3	$41.67	1.1458	1.1333
Medford (32780)	3	$37.21	1.0277	1.0277
Portland/OR (38900)	16 (2 in WA)	$40.52	1.1143	1.1143
Portland/WA (38900)	2	$40.52	1.1143	1.1143
Salem (41420)	3	$40.58	1.1160	1.1042
Rural Oregon	7	$37.13	1.0277	1.0277

WAGE INDEX – GEO RECLASSIFICATIONS

- Geographic reclassifications for wage index purposes will be due 9/1/11 *(first working day of September)*
  - Effective for FFY beginning on 10/1/2012
  - 823 hospitals in reclass status for FY 2011 (10/1/10 - 9/30/11)
  - 857 hospitals in reclass status for FY 2011 (10/1/10 - 9/30/11)
  - Section 508 reclassifications expire on 9/30/11

WAGE INDEX – PENSION COSTS

- PRM 1, Section 2142 revised
- Interim measure – CMS JSM issued 11/2009 w/instructions and spreadsheet
- Proposed rule revising policy
  - No longer using actuary computations to determine maximum
  - Must be funded to be reportable
  - Cash basis
- Separate methodologies for
  - Cost finding
  - Wage index purposes

PENSION COSTS

- For wage index purposes
  - Pension costs allowed equal to average cash contributions over 3 year period
    - E.g. FY 2013 wage index based on MC CR periods during 2009 and should reflect average pension costs for 2008, 2009 and 2010
  - Above methodology to be used beginning with FFY 2013 PPS update
  - Likely to be part of this fall's wage index inquiries from your FI/MAC

PENSION COSTS

- For cost finding purposes calculation
  - Actual costs incurred
  - Funding appropriate basis to measure expense
  - Limit on current period liability equal to
    - 150% of 3 consecutive reporting periods
    - Limit deemed appropriate so as to not reflect excessive or advance funding in a particular year
    - Exceptions to limit if funding requirements imposed by 3rd party, i.e., ERISA, statute or collective bargaining
  - Costs in excess of limit allowed if hospital submits documentation
  - Effective for CR period beginning on/after 10/1/11

RURAL FLOOR DISCUSSION

- CMS considering policy to address situations where wage index adjustments, such as rural floor, result in significant fluctuations to the wage index values
- One option proposed is to not apply rural floor in OPPS where rural floor is set by a small number of hospitals, resulting in rural floor benefiting all hospitals in the State
- Other option is to apply within a State, a rural budget neutrality to OPPS wage index as was done for both IPPS and OPPS wage indices beginning in FFY 2009

WAGE INDEX SCHEDULES IN 2552-10

Worksheet S-3, Parts II-V, Wage index

- New Part IV replaces CMS 339, Exhibit 6
  - Flows to Lines 17 and 18 of Part II
  - Since part of Cost Report, benefit detail by type to be part of ECR file
- New S-3 Part V for Contract Labor and Benefit Cost. Not clear if this is line 11 of Part II.

WAGE INDEX SCHEDULES IN 2552-10

- CMS Instructions for S-3 Paid Hours
  - Do not include hours related to bonus pay
  - Include hours for severance pay
  - If hours cannot be determined, pay cannot be included
  - Include hours for paid lunch time
  - Exclude call hours – *except* for "workers" who are contracted solely for purpose of providing services on-call
    - On-call workers salary and call hours to be reported

WAGE INDEX SCHEDULES IN 2552-10

Worksheet S-3, Part V

- Limited instructions for reporting by hospital complex and applicable subproviders and units
  - Column 1 to report contract labor by hospital "unit"
  - Column 2 to report benefit costs by hospital "unit"
- Instructions are:

  "*Identify the contract labor costs and benefit costs for each component on the applicable line.*"
- Unknown if any flow through or if duplicative of costs reported elsewhere

MEDICAL EDUCATION

- 90% rule eliminated as of July 1, 2010
- CMS eliminating definition of "all or substantially all of the costs for training in nonhospital setting"
  - Effective for cost report periods beginning on/after July 1, 2007 and before July 1, 2010!
- Count of nonpatient care time can be applied to prior years for "pending, jurisdictionally proper appeals" *as of March 23, 2010*

MEDICAL EDUCATION

- ACA requires hospitals to maintain records of resident time in nonprovider settings and compare to base year
  - Proposed "base year" CR periods beginning on/after July 1, 2009 and before June 30, 2010
  - Expect rotation schedules to provide data
- Possible amendment to cost report forms
  - Used to id barriers to training in nonprovider sites
  - Did not see change in cost report forms – maybe separate survey?

MEDICAL EDUCATION

- If more than one hospital incurs residency training costs in non-hospital setting
  - Each hospital counts proportional share of training time
  - Allocated per written agreement
  - Ensure 100% of resident costs are paid
  - Lump sum payment arrangements may not be sufficient to prove all resident salary/benefit costs paid

REDISTRIBUTION OF FTEs

- Rural hospitals under 250 beds exempt from reduction
- Reduction w/b 65% of difference between count and cap
  - Affected hospitals should already have been notified of reduction to their cap
- 70% of slots to hospitals in States w/resident-to-population ratios in lowest quartile
- Changes effective July 1, 2011

REDISTRIBUTION OF FTEs

- Determinations *were* to be made by May 1, 2011
  - CMS *still* working on determinations and notifications
    - For hospitals that applied for add'l FTEs
    - To be effective 7/1/11, but hospitals don't yet know if they get an increase
  - Hospitals that received increases to their cap in prior redistribution w/be exempt from removal of excess FTEs

REDISTRIBUTIONS OF FTEs

- 13 States eligible for increased FTEs
  - Montana, Idaho, Alaska, Wyoming, Nevada, North/South Dakota, Mississippi, Florida, Puerto Rico, Indiana, Arizona, Georgia
- Oregon is 14th on the list; Colorado 15th; Washington 19th; California 23rd; Hawaii 33rd
- 2011 OPPS rule discussed exception if slots not fully redistributed
  - As determinations not completed, unknown whether excess FTEs available for redistribution

NEW MEDICAL EDUCATION PROGRAMS

- Urban/rural hospitals not yet teaching hospitals
  - Currently serve as rotating site for another hospital's existing program
  - Not preempted from later getting new cap under §413.79(e) for starting new program
    - Has been interpreted vary narrowly – we've had discussions w/CMS Central Office and legal counsel on FTE caps
    - Before proceeding further, recommend discussion with CMS CO

CMS DEFINITIONS – SUPERVISION IN HOSPITAL OPPS SETTING

- Direct Supervision
  - Physician or non-physician practitioner must be present in off-campus provider-based dept. but doesn't have to be present during procedure
    - Supervision level assumed by CMS met when provided in department on-campus
  - CMS deems direct supervision to be "default level"
  - CMS will evaluate if more appropriate level (general or personal) s/apply to specific services
    - Evaluation done at request of stakeholder or CMS

OTHER SUPERVISION LEVELS

- General Supervision
  - Applies to non-surgical extended duration services
    - Direct supervision required during initiation period, followed by general supervision for duration of service
- Personal Supervision
  - Physician physically present in room when service is performed

NON-PHYSICIAN SUPERVISION

- Nonphysician practitioners may directly supervise outpatient therapeutic services
  - If service is one they can perform w/in their State scope of practice and hospital-granted privileges
  - Cannot supervise pulmonary and cardiac rehab services
    - Only MD and DO can supervise

PHYSICIAN SUPERVISION - CAH

- CMS will <u>not</u> enforce supervision requirements for outpatient therapeutic services in CAHs for CY 2011
  - SCH/Rural hospitals under 100 beds also exempt from supervision requirements
- Extended non-enforcement thru CY 2012

OUTPATIENT PPS CONVERSION RATES

- Final 2011 Conversion Factor of $68.267
- Proposed 2012 Conversion Factor of $69.420
- Proposed 2012 Conversion Factor of $68.052 *if failed to report quality measures*

PROPOSED OUTPATIENT PPS

- Current 2011 outlier threshold of $2,025
  - When costs of service exceed 1.75 x APC payment
  - Payment is 50% of amount exceeding 1.75 x APC
  - Outliers are to represent 1% of total OPPS pmts
- Proposed 2012 outlier threshold is $2,100

PROPOSED OUTPATIENT PPS

- Currently, drugs with mean daily cost of $70 packaged with APC payment
  - Threshold increased to $80 mean daily cost
  - Implies more drugs likely to be packaged
- Proposed decrease in separately payable drugs w/o pass-through status from ASP+5% to ASP+4%
- Drug payments going down
  - CMS leaving possibility in final rules to reduce pmts further

DRUGS IN PHYSICIAN FEE SCHEDULE

- Proposed 2012 drug pmt for physicians to change from ASP +6% to ASP +4%
  - Reduction in drug pmts to physicians may mean hospitals doing more injections/infusions if physicians can't afford to do in office
  - Happened previously with chemo services

OUTPATIENT PPS – SERVICE LINE

CY 2010 Hospital Outpatient Data	
Procedure Category	**% of Total Services**
Cardiovascular	75.50%
Chest	0.00%
Ear	0.20%
Endocrine	0.10%
Eye	1.70%
Gastrointestinal	5.70%
Genitourinary	2.70%
Hemic & Lymphatic	0.30%
Maternity	0.00%
Musculoskeletal	3.80%
Nervous System	2.80%
Radiology	0.10%
Respiratory	1.00%
Skin	6.20%
Total	100.00%

PROPOSED 2012 OUTPATIENT PPS

Visit Level	Clinic Visit APC Cost	Type A ED APC Cost	Type B ED Visit Cost
Level 1 – 99201/11, 99281, G0380	$50	$52	$41
Level 2 – 99202/12, 99282, G0381	$75	$89	$59
Level 3 – 99203/13, 99283, G0382	$105	$142	$94
Level 4 – 99204/14, 99284, G0383	$138	$229	$141
Level 5 – 99205/15, 99285, G0384	$178	$340	$271

PROPOSED 2012 OUTPATIENT PPS

- Implantable devices cost center (in cost report)
  - Cost center available on/after 4/30/10 YE cost reports
    - Only 437 hospitals out of 3,500 used this cost center
    - CMS determined not sufficient data to establish separate RCC for implantable devices in 2012 OPPS rule
  - To be reassessed in CY 2013 OPPS Rules
- Be sure to use the CMS designated lines whenever possible for future pmt calculations
  - Cardiac cath, MRI, and CT

OUTPATIENT PPS – NO CHANGE FROM P/Y

- No Cost/Full Credit and Partial Credit Devices
  - "FB" modifier used for devices with cost or full credit
  - "FC" modifier used for devices furnished with partial credit
  - Hospital reports token device charge of $1.01
- Modifiers reduce payment for device-dependent APCs by portion of APC payment "attributable to device costs"
  - In place since 2007
- Bene co-pay based on reduced APC payment amount

OUTPATIENT PPS – NO CHANGE FROM P/Y

- Device upgrade when full/partial credit received for device replaced
  - Device charge billed is *difference* between usual charge for new device and usual charge for replaced device
  - As of 2008, includes devices where 50% or more partial credit received and billed with "FC" modifier
  - OPPS payment reduced 100% of device offset for no cost/full credit cases
  - OPPS payment reduced by 50% of device offset for partial credit cases

MEANINGFUL USE

- Meaningful Use requirements:
  - Use a *certified EHR in a meaningful way*
  - Use an EHR that can *exchange information with other systems electronically*
  - Submit reports to CMS that include *performance measures proving meaningful use*
- Meaningful Use occurs in three stages (so far):
  - Stage 1:Data capture and reporting/sharing
  - Stage 2: Use of Health IT for Quality Improvement at the point of care & exchange
  - Stage 3: Improved Outcomes – Quality, Safety & Efficiency

Stage 1 commenced in FFY2011

MEANINGFUL USE – STAGE 2 DELAY

- HIT Policy Committee voted June 8, 2011 to recommend a 1-year delay in Stage 2 Meaningful Use requirements
- Vote included not only issue of timing but also some of the specific requirements incorporated into Stage 2
- While this allows for breathing room for implemented providers, those in the process of 'implementing' should not delay any longer than necessary

STAGE OF MEANINGFUL USE REQUIREMENTS

Implementation Year	Payment Year 2011	Payment Year 2012	Payment Year 2013	Payment Year 2014	Payment Year 2015
2011	Stage 1	Stage 1	Stage 2**	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1^^	Stage 3
2015					Stage 3

** Delay will only directly affect EPs and EHs that qualified for the incentives in 2011

^^ 2014 implementation creates greatest leap in implementation from Stages 1 to 3.

WAGE INDEX – CURRENT MANDATE

…The Act requires Secretary to adjust standardized amounts for area differences in hospital wage levels by a factor (established by the Secretary), reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level

WAGE INDEX REFORM

- The Affordable Care Act (ACA) mandates the Secretary recommend comprehensive reform of the Medicare wage index system to Congress by December 31, 2011
- Establish new system to -
  - Use BLS or other data
  - Minimize wage index adjustments between/within MSAs and rural areas
  - Minimize volatility
  - Account for impact on implementation to providers
  - Provide transition

WAGE INDEX REFORM

Timeline & studies performed

2007	MedPAC issues wage index reform recommendations to CMS
2009-10	Acumen contracted by CMS to provide wage index reform recommendations
2011	Institute Of Medicine (IOM) panel submits recommendations on wage index reform to CMS

WAGE INDEX REFORM STUDIES

- MedPAC and IOM recommend defining a wage index to allow index values to vary at county level within wage areas by "blending" a county-level index with an MSA-level index
  - Includes "smoothing" initial values to limit differences
  - BLS wage survey data to be used instead of hospital-reported costs currently used to calculate the wage indices
- Acumen recommends using commuting data to create hospital-specific wage index based on geographic areas hospital hires its workers

MedPAC & IOM PROPOSED WI METHODOLOGY

- Use Bureau of Labor Statistic data
- Include hospital and non-hospital data
- 10% maximum cliff (smoothing)
- Eliminate geographic reclassifications
  - MedPAC and IOM believe blending and smoothing techniques would reduce need for reclassification
- Include Critical Access Hospitals in labor data

CURRENT WAGE INDEX SYSTEM v. MedPAC PROPOSAL

Current wage index system:

- Single data source (Medicare CR) sorted based on Census/OMB designated CBSAs (statewide rural areas reconciled to cost reports). Wages, fringes and hours are consistent.
- Available for review in the Public Use File (PUF)
- Full year historical hospital data 100% reviewed by FI/MACs
- Providers are required to submit data on an annual basis

MedPAC proposal:

- Sample data (two payroll periods May and November)
- Compensation may exclude fringe benefits and physician compensation
- Participation by employers is voluntary and confidential
- BLS may secretly impute data for non-responsive employers, CMS would not know

MedPAC PROPOSAL CONCERNS

- BLS data is reduced to a simple average hourly wage, excluding fringe benefits
- BLS distortion caused by mixing part time/full time employees (part time x 2,080)
- Would include areas of the county where 7.5 hour workday is standard rather than 8.0
- Possible Manipulation of Data -
  - Under current wage index, would be deemed fraud or abuse and unlawful
  - Under MedPAC proposal, may be incentives for low cost employers to not own SNFs, physician offices, etc.

MedPAC PROPOSAL CONCERNS

- BLS does not pick up salaried physician Part A services
- BLS does not pick up contract physician Part A services (required by law in California)
- BLS reports agency nursing and other contract services in the county where agency is located rather county the hospital is located

ACUMEN'S WAGE INDEX ASSESSMENT

- Under current wage index system, geographically distant hospitals having different labor costs often receive same wage index value as they are located within the same broad CBSA or county
- As many as 1/3 of IPPS hospitals seek reclassification or an exception to increase hospital's wage index value

ACUMEN'S WAGE INDEX ASSESSMENT

- Acumen recommends further exploration of labor market definitions using a wage area framework based on hospital-specific characteristics, such as the commuting times from hospitals to population centers, to construct a more accurate hospital wage index**

**May affect rural hospitals that currently benefit more from existing reclassifications and exceptions

ACUMEN'S WAGE INDEX ASSESSMENT

- Fulcrum in Acumen's concept is commuting data
- Discussion to potentially use 2000 Census Transportation Planning Package data on all workers commuting between Census tracts
- Explore alternative option of directly collecting data from hospitals on distribution of hospital's employees' residences by ZIP code

COMMUTING BASED WAGE INDEX

Hospital	Workers by Hospital	Workers by Zip Code					
		A	B	C	D	E	F
1 (located in B)	75	20	45	8	2	0	0
2 (located in C)	310	20	80	120	50	30	10
3 (located in F)	150	0	3	7	20	40	80
Total Workers	535	40	128	135	72	70	90

Steps to calculate the commuting based wage index:
1) Calculate average wages in workers' commuting area
2) Estimate the wage level for each hospital (the numerator of the CBWI)
3) Compute the national wage (the denominator of the CBWI)**

**This is a function of the current wage index calculation

ACUMEN PROPOSAL CONCERNS

- Would Census data, which updates every 10 years, be accurate and relevant?
- If hospital employee data was required, what is anticipated burden on the provider?

AHA'S RESPONSE TO ACUMEN'S STUDY

- "Acumen's concept is well thought and intriguing [but] it is presented as a theory only"
- "The main concerns are gaps in a full data analysis that shows the manner and extent to which hospital wage indices would change under this concept"
- "For example, if this concept were to substantially lower the wage indices of safety-net hospitals or isolated rural hospitals, it could potentially affect Medicare beneficiaries' access to care"

WAGE INDEX COMPARISONS

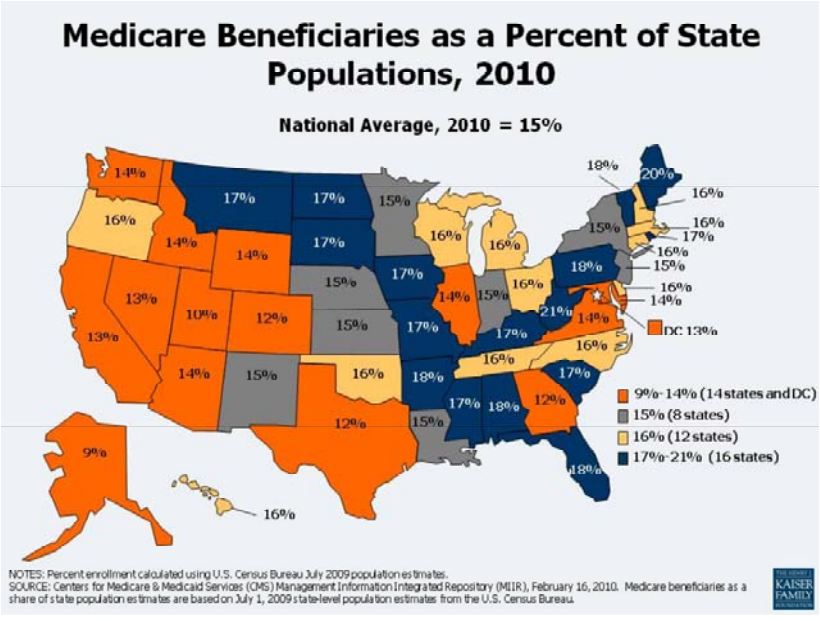
	Current WI System	Acumen, LLC	MedPAC	Institute of Medicine
Labor Market Definitions	CBSA	ZIP Codes	Counties	CBSA
Cost Finding	Medicare Cost Report (S-3 part II)	Blended Methodology	Bureau of Labor Statistics (BLS)	Bureau of Labor Statistics (BLS)
Equity	Geographic Reclass/Lugar	Commuting Based Wage Index (CBWI)	Blending-Smoothing	Blending-Smoothing w/CBWI
Biggest Impact (+/-)	Varies	Unknown	Unknown	Unknown

INDUSTRY CONCLUSIONS

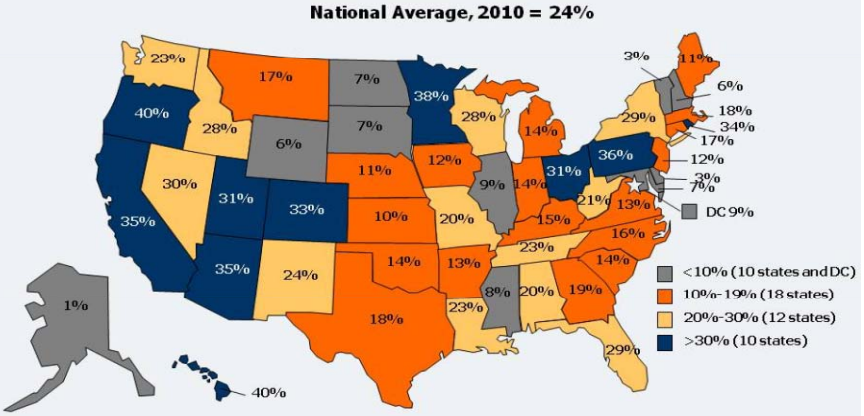
- When/if CMS implements changes to wage index, important to implement hold-harmless or transitional provisions
  - Wage index changes could likely redistribute large amounts of funds and hold-harmless or transitional provisions necessary to allow hospitals to fully prepare for and adjust to the new system
- Wage index itself needs to be as accurate as possible by ensuring both hospitals and Medicare able to use consistent definitions, methodologies, rules and interpretations for acquisition and application of wage data
- Hospitals must be able to examine and verify data used to construct the index
  - Wage index has a significant impact on payment hospitals receive under IPPS and OPPS

PROVIDER FOLLOW-UP & WHAT 'YOU' CAN DO

- Before any replacement of current wage index can be considered, impact on providers must be analyzed
  - Specifically safety net providers, hospitals serving populations with limited access to services, and providers heavily dependent on Medicare payments
- Hospitals anticipating significant reimbursement impacts (+ / -) arising from wage index changes should consider discussing these issues with congressional representatives and healthcare lobbying groups

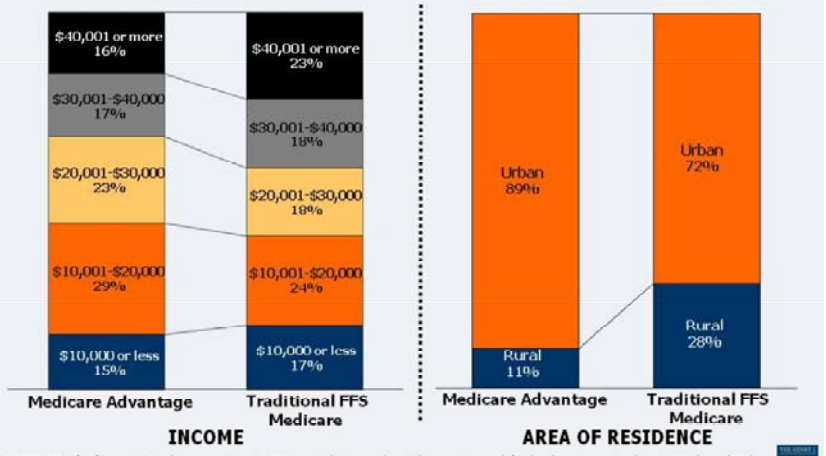


Medicare Advantage Enrollees as a Percent of Medicare Beneficiaries, by State, 2010



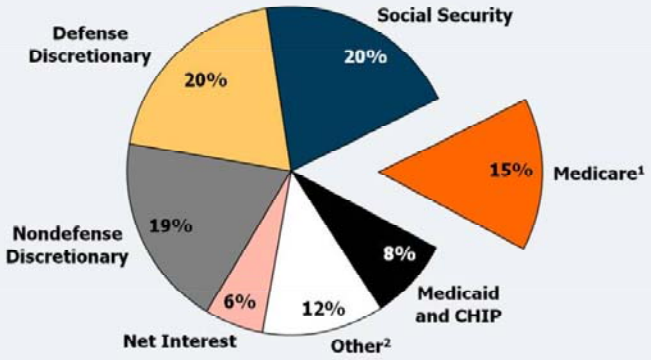
NOTES: Share of Medicare Advantage enrollees includes beneficiaries in Medicare HMOs, PPOs, PSOs, MSAs, PFFS, demonstrations, PACE, employer direct PFFS, and cost plans.
SOURCE: Kaiser Family Foundation analysis of data from CMS, Medicare Advantage State/County Penetration Data, February 2010.

Characteristics of Beneficiaries in Medicare Advantage and Traditional Fee-for-Service Medicare, by Income and Area of Residence, 2008



NOTES: FFS is fee-for-service. Numbers may not sum to 100 percent due to rounding. Urban counties are defined as those in a metropolitan statistical area (MSA); all other counties are classified as rural.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Medicare Spending as a Percent of Total Federal Spending, Fiscal Year 2010



Total Federal Spending, FY2010 = $3.5 Trillion

NOTES: FY is fiscal year. ¹Amount for Medicare includes offsetting premium receipts. ²Other category includes disaster costs and negative outlays for Troubled Asset Relief Program.
SOURCE: Office of Management and Budget, FY2011 Budget, Summary Tables; February 2010.

QUESTIONS??

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