MEDICARE FFY 2017 PPS PROPOSED RULES OVERVIEW

2016 OHA Finance/PFS Webinar Series

May 10, 2016
Spring is Medicare PPS Proposed Rules Season

- Inpatient Hospital
- Long-Term Acute Care Hospital
- Inpatient Rehabilitation Facility
- Hospice Facility
- Skilled Nursing Facility
- Still to Come
  - Inpatient Psychiatric Facility
  - Home Health
  - Physician
MEDICARE INPATIENT ACUTE CARE HOSPITAL

Prospective Payment System Basics

• In Place Since FFY 1984
• Covers Inpatient Hospital Operating Expenditures
• Initially Used Diagnosis-Related Groups (DRGs)
  – Based on Similar, Weighted Charges for Conditions and Illnesses
  – Converted to Weighted Costs in 2007
• Expanded to Medicare Severity-Adjusted DRGs (MS-DRGs) in 2008
  – Severity Adjustment Based on Documented Complications & Co-Morbidities
MEDICARE INPATIENT ACUTE CARE HOSPITAL
Prospective Payment System Basics

• Base Payment = Standardized Amount (National Average Cost per Discharge) Updated Annually for Inflation (Market-Basket Estimate)

• Base Payment Multiplied by MS-DRG Relative Weight

• Largest Payment Adjustment from Area Wage Index
  – Area Wage Index Applied to “Labor Portion” of Base Rate

• Additional Adjustments for Outliers, Transfers, DSH, Medical Education & New Technology,

• Capital Expenditures Reimbursed Under Separate PPS

• Payments also Affected by Value-Based Purchasing, Hospital-Acquired Condition & “Unnecessary” Readmissions Programs
April 27 Federal Register; Comments Due June 17

2.8% IPPS Market Basket Inflation Estimate
- Minus 0.5 Percentage Points for Productivity
- Minus 1.5 Points for “Coding Creep”
- Minus 0.75 Points to Help Balance Federal Budget (ACA-Based)
- Plus 0.8 Points to Return “Two-Midnight Rule” Cuts
- Net Increase is 0.85%

After Other Adjustments for Budget Neutrality, Capital, “Excess” Readmissions, HAC, VPB, and DSH, CMS States Overall 2017 Inflationary Update = 0.7% ($539M)
- But is it?!
MEDICARE ANNUAL UPDATE IS UNDER SIEGE

Adjustments to 2017 IPPS Market-Basket Update

Behavioral Offset
Supplemental Reduction Factor
Value-Based Purchasing Pool Carve-Out
Productivity Offset
Meaningful Use Reduction for Non-Compliance
Readmissions Penalty
Quality Pay-for-Reporting Reduction for Non-Compliance
Healthcare-Acquired Conditions Penalty

Medicare Hospital Update Factor
MEDICARE ANNUAL UPDATE AT RISK TO FUND PERFORMANCE PROGRAMS

[Bar chart showing annual updates for Medicare annual update at risk to fund performance programs from 2013 to 2017.*]

Legend:
- Marketbasket
- Effective Market Basket
- Value Based Purchasing
- Readmissions Reduction
- Hospital Acquired Conditions
MEDICARE P-FOR-P PROGRAMS

...But do They Add up?

- 2015 GAO Report States Readmissions Reduction Policies Show Results, but
- VBP Shows Little Shift in Hospitals’ Quality Performance that Would Not Have Occurred Without the Program
- VBP-Eligible Hospitals Received <0.5% of Applicable Medicare Payments, Compared to 1.0% - 2.0% Cut to Annual Inflationary Update to Fund the Program
- Smaller VBP Hospitals Had Larger Negative Effects
MEDICARE P-FOR-P PROGRAMS

OHA 2017 Ohio VBP Forecast Shows Promise

- Ohio Hospitals Will Contribute 2% of Medicare Operating Payments to VBP in 2017
- OHA Predicts 72 Ohio Hospitals Will Gain More from VBP in 2017 Than They Contribute and Overall Ohio Return will be Positive

<table>
<thead>
<tr>
<th>Year</th>
<th>Contribution</th>
<th>Ohio Return</th>
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<tbody>
<tr>
<td>FFY 2014</td>
<td>1.25%</td>
<td>104%</td>
</tr>
<tr>
<td>FFY 2015</td>
<td>1.50%</td>
<td>102%</td>
</tr>
<tr>
<td>FFY 2016</td>
<td>1.75%</td>
<td>103%</td>
</tr>
<tr>
<td>FFY 2017</td>
<td>2.0%</td>
<td>103%</td>
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FFY 2017 MEDICARE PPS PROPOSED RULES

Medicare Disproportionate Share Hospital (DSH) Program

• ACA Split DSH Payments Into Two Pools:
  – Total 2017 DSH Payment Base Calculated from 2014 Payment Increased for Inflation, Utilization & Case Mix
  – 25% of 2017 Total DSH Base Paid on Old Formula (Traditional Pool)
  – 75% of 2017 Base Adjusted by Uninsured Factor (DSH Pool)

• CMS Proposes Cutting 75% DSH Pool by $400M
  – Based on CBO Estimate that Uninsured Will Drop to 10%

• Total Medicare DSH Estimated to Drop by $135 - $150M
  – Note that Final Rule will Likely Differ

• CMS Still not Adopting the S-10 Worksheet;
  – Proposing a 3-Year Phase-in of FFY 2014 S-10 Data, Beginning in FFY 2018
Concerns About Proposed Use of S-10 Data

- CMS “Desires” to Use Line 23, (Cost of Charity Care) and Line 29 (Bad Debt Costs)
- Links to EHR Incentive Program
- Congressional Consideration of Linking NFP Status to Ratio of Charity Care to Net Patient Service Revenues
- Increased Public Scrutiny
- Concerns about Comparability and Completeness!!!
High-Cost Outliers
• Threshold Increased 5% to $23,581

Wage Index (Proposed)
• Ohio Ranges From .8193 (Rural) to .9543 (Columbus)
• Labor-Related Portion of Base Rate for CBSA’s with Indexes Below 1.0 Stays at 62%
• Changes to Policies and Timelines for Reclassification

Hospital-Acquired Conditions
• Maintains the 1% Payment Reductions for Top Quartile
• Updates Scoring Methodology & Patient Safety Indicator

Readmissions Reduction Program
• Maximum Payment Penalty for 3%
• CABG Measure Added
• No Adjustment for Sociodemographic Outliers
Value-Based Purchasing
• Increases the Funding Percentage to 2%
• Adds Future Measures (2021 & 2022) for Heart Attack and Heart Failure; Updates Measure for Pneumonia & CABG

Inpatient Quality Reporting
• Updates Reportable Measures
• Changes 2019 Program to Better Align Electronic Clinical Quality Measures (eCQMs) with EHR Incentives
• Updates Inpatient Psychiatric Facility Quality Reporting Program and PPS-Exempt Cancer Hospital Quality Reporting Program
FFY 2017 MEDICARE PPS PROPOSED RULES

Medicare Outpatient Observation Notice (MOON)

• Effective August 2016 (Implementation Date?)
• Covers ALL Medicare Beneficiaries Who Are in Outpatient Observation Status for More than 24 Hours
• Hospital Must Clearly Explains Financial and Coverage Implications of Observation Status
• Requires Formal, Standardized Notice & Oral Overview Between 24 and 36 Hours after Start of Observation Services
• Requires Formal Notice of Receipt
• Additional Details, MOON Format, Policies and Procedures Will be Laid Out in a Separate Proposed Rule Due Later This Spring
FFY 2017 MEDICARE PPS PROPOSED RULES

OHA Overview of IPPS Proposed Rule Available

Medicare Inpatient Prospective Payment System

April 25, 2016

Payment Rule Brief — PROPOSED RULE
Program Year: FY2017

Overview and Resources

On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2017 proposed payment rules for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) Inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, this proposed rule includes:

• The final rate reduction amount (2.8%) for the Coding Offset adjustment, as mandated by the American Taxpayer Relief Act of 2012 (ATRA);

• Updates to the case mix methodology for the Value-Based Purchasing (VBP) and Hospital Acquired Condition (HAC) programs;

• Updates to the payment penalties for non-compliance with the Electronic Health Record (EHR) Incentive Programs;

• Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies, as mandated in the Affordable Care Act of 2010 (ACA); and

• Implementation of a notification process for Medicare patients placed in observation for at least 24 hours.

Program changes would be effective for discharges on or after October 1, 2016 unless otherwise noted.

A copy of the proposed rule Federal Register (FR) and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/Medicare/Fee-for-Service-Payment/InpatientPps/FY2017-IPPS-Proposed-Rule-Home-Page.html. Comments on all aspects of the proposed rule are due to CMS by June 17 and can be submitted electronically at http://www.regulations.gov for using the website’s search feature to search for file code “1020-FI”.

An online version of the rule is available at https://federalregister.gov/2016-09410. Page numbers noted in this summary are from the Online Copy of the proposed rule.

A brief summary of the major hospital IPPS sections of the proposed rule is provided below.

By the Numbers

IN THIS ISSUE

• CMS Releases Multiple Proposed Payment System Rules
• OHA Whitepaper on Proposed Medicaid Waiver Available
• BWC Updates Outpatient Hospital, ASC Fee Schedules
• OHA Finance Committee Considering Medicaid EAPG OPPS and Rebased IPPS Impact Models; 3M Extends Discounted EAPG Pricing
• Final 30-Day Window for SFY 2015 Cost Report Corrections Starts April 30
• West Virginia Medicaid Out of Money?!?
• CMS Issues Final Rule for Medicaid, CHIP Managed Care Plans
• ODM/DataGen Medicare Comprehensive Care for Joint Replacement Demo Webinar Available

CMS Releases Multiple Proposed Payment System Rules

The Centers for Medicare & Medicaid Services this month released its annual rush of proposed rules to support many of its provider prospective payment systems. The proposals cover federal fiscal year 2017 and mostly go into effect Oct. 1.

OHA will hold a membership webinar on the proposed Medicare rules May 10. Watch for additional information and webinar links the week of May 2. Read more.
LTCH PPS Basics

- In Place Since FFY 2003
- Covers Facilities with Average Length of Stay Greater than 25 Days
- Uses Severity-Adjusted Long-Term Care DRGs, with LTCH-Specific DRG Weights
- Base Payment = Standardized Federal Rate per Discharge; Base Rate Includes Operating and Capital Costs
- Employs IPPS Area Wage Index; Labor-Related Portion = 62% of Base
- Additional Up and Down Adjustments for High-Cost, Short-Stay, and Very Short-Stay Outliers; Interruption of Stay
- No Medical Education or DSH
- Requires LTCH Quality Data Reporting
MEDICARE LONG-TERM ACUTE CARE HOSPITAL

**LTCH PPS Basics**

- **2013 Federal Law Requires “Site-Neutral,” IPPS-Based, Payments** (= Lesser of MS-DRG or LTCH Cost) Unless:
  - LTCH is for Some Diagnosis Other than Psych or Rehab
  - LTCH Stay Immediately Follows Acute-Care Hospital (ACH) Discharge, **and**
  - ACH Stay Included at Least Three Days in ICU/CCU, **or**
  - ACH Stay Included Mechanical Ventilation for 96 Hours or More

- **FFY 2017 is Second Year of Two-Year Phase in for Site-Neutral Payments at 50/50 Blend**
- **Other LTCH Discharges Paid at “Standard (Old) Rate”**
FFY 2017 MEDICARE PPS PROPOSED RULES
Medicare Long-Term Acute Care Hospital

• Proposed Rule Out April 27; Comments Due June 16
• FFY 2017 LTCH Payment Update
  – Standard-Rate Discharges
    • 2.7% Updated (2013 Data) LTCH Market-Basket Estimate
    • Minus 0.5 Percentage Points for Productivity
    • Minus 0.75 Points to Help Balance Federal Budget (ACA-Based)
    • Net Increase is 1.45%; CMS Estimates 0.3% Payment Increase for Standard Rate Discharges
  – Site-Neutral Discharges
    • = 45% of All LTCH Discharges in 2017
    • Additional Site Neutral Payment Cut (Over 2016) = $367M
  – Overall 2017 LTCH PPS Payments Decrease 6.9%
**FFY 2017 MEDICARE PPS PROPOSED RULES**

Medicare Long-Term Acute Care Hospital

- **Other**
  - LTCH Outliers + Federal Rate = Fixed Loss Amount
  - LTCH 2017 Fixed-Loss Outlier Estimates
    - Standard = $22,728 (way up from $16,423 in 2016)
    - Site-Neutral = IPPS Fixed-Loss Amount ($23,681)
  - 25% Rule
    - Reduces Payments to “Co-Located” LTCHs if More Than 25% of Discharges Come From “Host” Hospital
      - Rural LTCHs Have More Lenient 50% Rule; “MSA-Dominant” LTCHs Will be Set Between 25% & 50%
      - Prior Hospital High-Cost Outliers Counted Differently
      - Site Neutral Cases Included in Count; MA Cases Not
      - “Grandfathered” LTCHs Exempt
Other

- LTCH Quality Reporting Program
  - Pay for Reporting Penalties Apply (2% in 2017)
  - Four New Reporting Measures Proposed
    - Medicare Spending per Beneficiary, Discharge to Community & Post-Discharge Readmissions Proposed for 2018; Drug Regimen Review for 2020
  - Separate Proposed Rule Offers Limited Relief from Site-Neutral Payment Policy for Co-Located, Rural LTCHs Delivering Wound Care
  - Specific Limits on Covered Services, LTACs and Patient Eligibility Timelines, and UB-04 Coding Apply
MEDICARE INPATIENT REHABILITATION FACILITY

IRF PPS Basics

• In Place Since CY 2002
• Covers Facilities That Meet Detailed Requirements for Patient Screening and Coordinated & Specialized Rehab Multidisciplinary Staffing
  – Also Requires that a Majority of Patients Have Diagnoses Within 13 Specified Rehabilitation-Related Conditions
• Employs Rehab Impairment Categories to Assign Patients into Case Mix Groups (CMGs), Adjusted for Diagnosis, Age & Comorbidities
  – Separate, Unadjusted CMGs for Short Stays, and Patients who Expire During Stay
MEDICARE INPATIENT REHABILITATION FACILITY

IRF PPS Basics

- Base Payment = IRF Conversion Factor (Federal Base Rate)
- Base Rate Multiplied by CMG Relative Weight
  - Includes Operating and Capital Costs
- Uses IPPS Area Wage Index, Labor Portion = 71% of Base Payment
- Additional Payment Adjustments for High-Cost Outliers; Transfers, & Interrupted Stays
- Facility-Specific Payments also Adjusted for High Number of Low-Income Patients, Rural Status & Medical Education
- Requires IRF Quality Data Reporting
FFY 2017 MEDICARE PPS PROPOSED RULES
Medicare Inpatient Rehabilitation Facility

• Proposed Rule in FR April 25; Comments Due June 20
• FFY 2017 LTCH Proposed Payment Update
  – 2.7% Update (2013 Data) IRF Market-Basket Estimate
  – Minus 0.5 Percentage Points for Productivity
  – Minus 0.75 Points to Help Balance Federal Budget (ACA-Based)
  – Plus 0.2% to Account for Changes in Outlier Threshold
  – Net Inflationary Update is 1.65%; CMS Estimates 1.6% Payment Increase Over 2016 ($125M)
  – Facilities that Don’t Submit Quality Data Get 2.0% Cut to Update
• No Changes Proposed to IRF Facility-Level Adjustments
  – CMS States it is Still Examining Data; Update at Final Rule (?)
• Several Changes to IRF Quality Reporting Program
  – New Measures Proposed for 2018 & 2020
MEDICARE SKILLED NURSING FACILITY

SNF PPS Basics

• In Place Since July 1998
• Requires Qualifying Inpatient Hospital Discharge for Related Conditions Within 30 Days of SNF Admission
• Employs Resident Assessments to Assign Patients into Resource-Utilizations Groups (RUGS), Categorized by the Need for Therapy Services & the Level of Nursing Care
• Base Payment = Federal Per Diem Rate Components for Nursing, Therapy Services, and Non-Therapy Services or Independent Living Capability
  – Distinct Component Rates for Urban vs. Rural SNFs
  – Patient- Appropriate Base Rates Multiplied Nursing or Therapy RUG Relative Weights
  – Includes All Costs
• Applies IPPS Area Wage Index to 69% of Federal Rate
• Services are Highly Consolidated (Bundled)
• Requires SNF Quality Data Reporting
FFY 2017 MEDICARE PPS PROPOSED RULES
Medicare Skilled Nursing Facility PPS

- Proposed Rule out April 21; Comments Due June 20
- FFY 2017 SNF-PPS Proposed Payment Update
  - 2.6% Update SNF Market-Basket Estimate
  - Minus 0.5 Percentage Points for Productivity
  - Net Inflationary Update is 2.1%; CMS Estimates 2.1% Payment Increase Over 2016 ($800M)
  - Facilities That Don’t Submit Quality Data Get 2.0% Cut to Update
- Three Claims-Based SNF Quality Measures to Start in 2018, One Assessment Measure Scheduled for 2020
  - SNF Program Will be Run Similar to Hospital Quality Program
- SNF Value-Based Purchasing Program to Start in 2019
  - Start with Preventable Readmissions
  - Other Performance Standards Proposed for Discussion
Hospice Benefit Basics

• Not a PPS, but Employs Many of the Same Characteristics
• Each Day of Care Classified Into One of Four Levels
  – Routine Home Care (RHC), Continuous Home Care (CHC), Inpatient Respite Care (IRC) & General Inpatient Care (GIC)
  – Majority of Hospice Payments are Made at RHC Level
  – Limited “Service-Intensity Add-on” Available for End-of-Life Care
• Base Payment = Federal Per Diem for Each Care Level (Except SIA)
• IPPS Area Wage Index Applied to 69% of Base for RHC & CHC & 54% of Base for IRC & GIC
• Hospice Benefit Has Annual Caps on Total Days of Inpatient Care and Average Payment per Beneficiary
FFY 2017 MEDICARE PPS PROPOSED RULES

Hospice Benefit

• Proposed Rule out April 21; Comments Due June 16
• CMS Realigned Annual Hospice Updates to FFY Basis
  – Will Cause some Partial-Year Calculations of Benefit Caps
• FFY 2017 SNF-PPS Proposed Payment Update
  – Employs 2.8% IPPS Market Basket
  – Minus 0.5 Percentage Points for Productivity
  – Minus 0.3% to Help Balance Federal Budget
  – Net Inflationary Update is 2% Increase Over 2016 ($330M)
  – Facilities That Don’t Submit Quality Data Get 2% Cut to Update
• Hospice Annual Per Beneficiary Cap = $28,377; Inpatient Days Cap Remains at 20% of Total Patient Care Days
• New Quality Measures and Revised “Hospice Items Set” Data Collection Tool Proposed
• First CHAPS Survey Due in 2019 Covering 2017 Data
FFY 2017 MEDICARE PPS PROPOSED RULES

Additional Resources

- CMS All-Programs Webpage
  - https://www.cms.gov/Medicare/Medicare.html

- OHA’s Monthly *By the Numbers* Bulletin

- OHA / HANYS Medicare Rules Reviews & Fiscal Impact Analyses

- **Medicare 101 & Medicare Cost Reporting Fundamentals**
  - Two-Day Session Presented by OHA & FHA
  - Scheduled July 28 & 29, 2016 in Columbus
  - Attend One Day or Both
  - Registration Materials out Later this Month
OHA collaborates with member hospitals and health systems to ensure a healthy Ohio

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