Medicare Regulatory Update
November 18, 2011
New Mexico HFMA Meeting

Cheryl Storey, CPA, Partner

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants
Acumen. Agility. Answers.

TODAY'S TOPICS

- Inpatient Related Issues
  - DRG Updates
  - Low Volume Adjustments
  - Low Per Capita Counties
  - Medicare Cost Per Beneficiary
  - Proposed Readmission Policies
- Cost Report Related Items
  - Disproportionate Share
  - Current Wage Index Issues
- 3 Day DRG Bundling Rule Changes
- OPPS Final Rule
- 2012 OIG Work Plan

DRG PAYMENT RATES – WAGE INDEX > 1.0000

SANTA FE

	FFY 2011 Final (8/16/10 FR)	FFY 2012 Final (8/18/11 FR)
Labor-Related	$3,552.91	$3,584.30
Non-Labor	1,611.20	1,625.44
Capital	420.01	421.42
Total Pmt Rate	$5,584.12	$5,631.16

68.8% Labor and 31.2% Non Labor

DRG PAYMENT RATES – WAGE INDEX <1.0000

ALBUQUERQUE, FARMINGTON, LAS CRUCES, RURAL NEW MEXICO

	FFY 2011 Final (8/16/10 FR)	FFY 2012 Final (8/18/11 FR)
Labor-Related	$3,201.75	$3,230.04
Non-Labor	1,962.36	1,979.70
Capital	420.01	421.42
Total Pmt Rate	$5,584.12	$5,631.16

62% Labor and 38% Non Labor

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	1.019	1.019
Adj for Restoring Rural Floor Budget Neutrality	1.011	1.011
FY2012 DRG Recalibration & Wage Index Budget Neutrality Factor (BNF)	0.99846	0.99846
FY2012 Reclassification 'BNF'	0.991493	0.991493
FY2012 Outlier Factor	0.948990	0.948990
FY 2012 Rural Demonstration 'BNF'	0.999487	0.999487
Documentation & Coding Adj,	0.9386	0.9386
FY2012 DRG Payment Rate	$3,584.30	$1,625.44

SOLE COMMUNITY HOSPITALS

- 4 update factors this fiscal year applied to 10/1/2010 SCH rate, for rate as of 10/1/2011
  - 1.0019 update factor
  - 0.997903 budget neutrality factor
  - 0.9528 documentation and coding adjustment
  - 1.009 rural floor budget neutrality factor
  - = 0.977587021 net adjustment factor or a *net decrease in the SCH rate of 2.241%*
- Note that CMS PUF file issued with the final 2012 IPPS rates has incorrect SCH rate for hospitals
- TOPs extended to SCH's regardless of number of beds for services through 12/31/2011
- 7.1% continued add-on for rural SCHs outpatient services paid under OPPS
  - Excludes separately payable drugs, biologicals, brachytherapy and devices

OUTLIERS

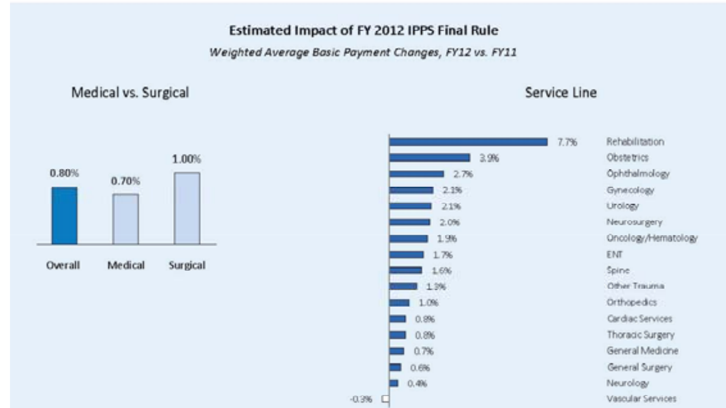
- Final outlier fixed loss cost threshold for FFY 2012 is $22,385
  - FFY 2011 was $23,075
- Outlier payments for 2012 are estimated to be 4.8% of total IPPS payments, but were 5.3% for 2009 and estimated at 4.7% for 2010

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	0.525
Intensive Days	26-30	20x, 21x	0.453
Drugs	48, 56	25x, 26x, 63x	0.199
Supplies & Equipment	55, 66, 67	27x, 26x, 290-299	0.329
Therapy Services	50-52	42x, 43x, 44x, 47x	0.380
Laboratory	44, 45, 54	30x, 31x, 74x, 75x	0.146
Operating Room	37, 38	36x, 71x, 72x	0.251
Cardiology	53	48x, 73x	0.155
Radiology	41-43	28x, 32x-35x, 40x, 61x	0.140
Emergency Room	61	45x	0.236
Blood & Blood Products	46, 47	38x, 39x	0.402
Other Services	58-60, 62	Pretty much all other rev codes	0.402
Labor & Delivery (only for 6 MS-DRGs)	39, 63	36x, 71x, 72x, 51x	0.454
Inhalation Therapy	49	41x, 46x	0.191
Anesthesia	40	37x	0.116

PAYMENT INCREASES FOR MOST SERVICE LINES IN FFY 2012

By our calculations, we estimate that the changes outlined in the FY 2012 IPPS Final Rule will lead to hospital payments that are higher in FY 2012 compared to FY 2011, painting a very different picture from the overall negative payment update originally proposed. As with any year, the impact will vary across service lines, with reimbursement for services such as obstetrics, urology and neurosurgery expected to post modest year-over-year gains, while only vascular services are expected to see a decline in payments relative to FY 2011 rates. Surgical MS-DRGs fare slightly better 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



© 2011 The Advisory Board Company

Source: CMS, Advisory Board analysis

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

MS-DRG	Description	FY2011 Weight	FY 2012 Final Weights	% Different
65	Intracranial hemorrhage or cerebral infarction w CC	1.1667	1.1485	-1.56%
190	Chronic obstructive pulmonary disease w MCC	1.1924	1.1684	-2.01
191	Chronic obstructive pulmonary disease w CC	0.9735	0.9628	-1.10
192	Chronic obstructive pulmonary disease w/o CC/MCC	0.7220	0.7081	-1.93
193	Simple pneumonia & pleurisy w MCC	1.4796	1.4948	1.03
194	Simple pneumonia & pleurisy w CC	1.0152	1.0026	-1.24
247	Perc cardiovascular proc w drug-eluting stent w/o MCC	1.9691	1.9828	0.70
287	Circulatory disorders except AMI, w card cath w/o MCC	1.0879	1.0743	-1.25
291	Heart failure & shock w MCC	1.4943	1.5010	0.45
292	Heart failure & shock w CC	1.0302	1.0214	-0.85
293	Heart failure & shock w/o CC/MCC	0.6853	0.6756	-1.42
309	Cardiac arrhythmia & conduction disorders W CC	0.8387	0.8155	-2.77
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5709	0.5068	-1.77

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

MS-DRG	Description	FY2011 Weight	FY 2012 Final Weights	% Different
312	Syncope & collapse	0.7172	0.7139	-0.46%
313	Chest pain	0.5499	0.5434	-1.18
378	GI hemorrhage w CC	1.0274	1.0238	-0.35
392	Esophagitis, gastroent & misc digest disorders w/o MCC	0.7173	0.7241	3.46
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.1039	2.0866	-0.82
603	Cellulitis w/o MCC	0.8377	0.8444	0.80
641	Nutritional & misc metabolic disorders w/o MCC	0.6916	0.6988	1.04
682	Renal failure w MCC	1.6407	1.6410	0.02
683	Renal failure w CC	1.0243	1.0183	-0.59
690	Kidney & urinary tract infections w/o MCC	0.7864	0.7870	0.08
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	1.9074	1.9090	0.08
872	Septicemia or severe sepsis w/o MV 96+ hours w/o MCC	1.1545	1.1339	-1.78

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:
  - Add-on also available to SCHs and MDHs
- If you haven’t yet submitted your request for FFY 2012, it’s not too late

LOW VOLUME ADJUSTMENT

Provider #	Medicare Discharges	2012 Percent Add-On	Hospital Name	2011 Percent Add-On
320003	875	**12.9464%**	**ALTA VISTA REGIONAL HOSPITAL**	12.3929%
320011	821	**13.9107%**	**ESPANOLA HOSPITAL**	15.2321%
320013	1,007	**10.5893%**	**HOLY CROSS HOSPITAL A DIV OF TAOS HEALTH SYSTEMS**	11.0714%
320014	924	**12.0714%**	**MIMBRES MEMORIAL HOSPITAL**	10.5000%
320016	1,156	**7.9286%**	**GILA REGIONAL MEDICAL CENTER**	7.6250%
320017	1,307	**5.2321%**	**LOVELACE WOMEN'S HOSPITAL**	5.7500%
320022	1,571	**0.5179%**	**PLAINS REGIONAL MEDICAL CENTER CLOVIS**	0.5536%
320030	462	**20.3214%**	**ARTESIA GENERAL HOSPITAL**	21.3750%
320033	438	**20.7500%**	**LOS ALAMOS MEDICAL CENTER**	20.3393%
320037	292	**23.3571%**	**CIBOLA GENERAL HOSPITAL**	23.9286%
320038	1,043	**9.9464%**	**REHOBOTH MCKINLEY CHRISTIAN HEALTH SER**	9.4286%
320057	51	**25.0000%**	**SANTA FE PHS INDIAN HOSPITAL**	25.0000%
320058	57	**25.0000%**	**MESCALERO PHS INDIAN HOSPITAL**	25.0000%
320059	740	**15.3571%**	**NORTHERN NAVAJO MEDICAL CENTER**	14.7857%
320060	131	**25.0000%**	**ZUNI INDIAN HOSPITAL**	25.0000%
320061	809	**14.1250%**	**GALLUP INDIAN MEDICAL CENTER**	16.4107%
320062	191	**25.0000%**	**CROWNPOINT PHS INDIAN HOSPITAL**	25.0000%
320065	1,033	**10.1250%**	**LEA REGIONAL HOSPITAL**	9.5000%
320067	114	**25.0000%**	**GUADALUPE COUNTY HOSPITAL**	25.0000%
320069	484	**19.9286%**		18.5714%
320070	104	**25.0000%**	**ACOMA CANONCITO LAGUNA PHS HOSPITAL**	25.0000%
320074	1,255	**6.1607%**	**LOVELACE WESTSIDE HOSPITAL**	5.3214%
320084	622	**17.4643%**	**ROOSEVELT GENERAL HOSPITAL**	18.5893%
320086	724	**15.6429%**	**ROSWELL REGIONAL HOSPITAL**	17.4286%
320087	99	**25.0000%**	**PHYSICIANS MEDICAL CENTER OF SANTA FE**	25.0000%

But only if located more than 15 miles from another hospital

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
  - Hospitals have received their 2011 payments
    - Means you know who you are!
  - Payments 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
  - Amounts for New Mexico hospitals on next slides

SECTION 1109 - ELIGIBLE STATES

State	Number of Eligible Hospitals	Percentage of payment	2012 Pmt Amount by State
Alabama	4	0.66%	$1,646,792
Arizona	5	1.10%	2,740,251
Arkansas	6	2.02%	5,037,797
California	6	1.45%	3,617,959
Colorado	3	0.19%	483,518
Georgia	11	4.45%	11,115,856
Hawaii	14	3.77%	9,431,902
Idaho	11	2.61%	6,522,154
Illinois	6	1.16%	2,889,700
Indiana	12	2.00%	4,989,310
Iowa	20	8.32%	20,807,837
Kansas	4	0.45%	1,131,255
Kentucky	2	0.12%	306,477
Maine	4	0.83%	2,074,628
Michigan	8	1.13%	2,820,700
Minnesota	13	2.66%	6,656,957
Mississippi	4	0.85%	2,114,397
Missouri	11	4.85%	12,117,105
Montana	9	2.52%	6,291,384
Nebraska	4	1.02%	2,538,996

SECTION 1109 - ELIGIBLE STATES

State	Number of Eligible Hospitals	Percentage of payment	2012 Pmt Amount by State
New Mexico	22	4.13%	10,324,104
New York	50	11.55%	28,862,740
North Carolina	7	0.72%	1,801,463
North Dakota	5	2.35%	5,876,908
Ohio	2	0.14%	341,390
Oklahoma	1	0.27%	664,727
Oregon	21	5.96%	14,890,643
Pennsylvania	13	4.15%	10,368,416
South Carolina	1	0.61%	1,518,439
South Dakota	19	3.79%	9,476,923
Texas	3	0.32%	794,069
Utah	11	0.49%	1,224,641
Vermont	2	0.24%	599,169
Virginia	31	10.36%	25,912,110
Washington	12	3.76%	9,408,585
West Virginia	2	0.05%	134,577
Wisconsin	40	8.33%	20,819,351
Wyoming	3	0.66%	1,646,770
Total	**402**	**100.00%**	**$250,000,000**

ELIGIBLE NEW MEXICO HOSPITALS

Provider Number	Provider Name	Payment Weight Factor	Estimated Pmt – Yr 1	Estimated Pmt – Yr 2
320001	UNIVERSITY OF NEW MEXICO HOSPITAL	0.0073135	$ 1,097,020	$ 1,828,367
320002	ST VINCENT HOSPITAL	0.0039254	588,814	981,357
320003	ALTA VISTA REGIONAL HOSPITAL	0.0006679	100,184	166,973
320004	GERALD CHAMPION REGIONAL MEDICAL CENTE	0.0017363	260,440	434,066
320009	LOVELACE MEDICAL CENTER	0.0027085	406,269	677,116
320011	ESPANOLA HOSPITAL	0.0005877	88,153	146,921
320013	HOLY CROSS HOSPITAL A DIV OF TAOS HEALTH SYSTEMS	0.0008756	131,347	218,912
320014	MIMBRES MEMORIAL HOSPITAL	0.0006373	95,591	159,319
320016	GILA REGIONAL MEDICAL CENTER	0.0008741	131,108	218,514
320017	LOVELACE WOMEN'S HOSPITAL	0.0006248	93,721	156,202
320018	MEMORIAL MEDICAL CENTER INC	0.0039763	596,452	994,087
320021	PRESBYTERIAN HOSPITAL	0.0096837	1,452,552	2,420,919

ELIGIBLE NEW MEXICO HOSPITALS

Provider Number	Provider Name	Payment Weight Factor	Estimated Pmt – Yr 1	Estimated Pmt – Yr 2
320033	LOS ALAMOS MEDICAL CENTER	0.0005814	$ 87,214	$ 145,356
320037	CIBOLA GENERAL HOSPITAL	0.0002130	31,957	53,261
320057	SANTA FE PHS INDIAN HOSPITAL	0.0000571	8,559	14,265
320058	MESCALERO PHS INDIAN HOSPITAL	0.0000233	3,501	5,835
320067	GUADALUPE COUNTY HOSPITAL	0.0001464	21,963	36,605
320070	ACOMA CANONCITO LAQUNA PHS HOSPITAL	0.0001000	14,993	24,988
320074	LOVELACE WESTSIDE HOSPITAL	0.0004772	71,587	119,311
320083	HEART HOSPITAL OF NEW MEXICO	0.0024960	374,395	623,992
320085	MOUNTAIN VIEW REGIONAL MEDICAL CENTER	0.0034824	522,360	870,601
320087	PHYSICIANS MEDICAL CENTER OF SANTA FE LLC	0.0001086	16,283	27,138

MEDICARE SPENDING PER BENEFICIARY

- New claim-based measure for 2014
  - Using discharges between 5/15/12 thru 2/14/13
- Measure will be tied to the Hospital Inpatient Quality Reporting (IQR) for 2014 payment determinations
- Based on episode spanning 3 days prior to hospitalization through 30 days post discharge (significantly different than proposed rule of 90 days)

MEDICARE SPENDING PER BENEFICIARY

- Will include all Part A and B payments excluding statistical outliers
- Public use file will be provided to hospitals for use in determining historical spending
- Measure will adjust for beneficiary age and severity of illness by applying a condition category for the preceding 90 days prior the episode.

MEDICARE SPENDING PER BENEFICIARY

- CMS will adjust for payment differences such as wage index, geographic cost differences, IME and DSH
- Per bene spending to be calculated for ***each hospital*** by compiling all beneficiary pmts for the period
  - o Divided by the total # of bene episodes for the hospital

MEDICARE SPENDING PER BENEFICIARY

- CMS excluding from payment calculation -
  - Payments when beneficiary is not enrolled in both Medicare Part A and B, including enrollment in a Medicare Advantage plan or dies
  - If beneficiary is covered by the Railroad Retirement Board
  - Medicare is a secondary payer.
  - Episodes where beneficiary is not enrolled in both Medicare Part A and Medicare Part B for the 90 days prior to the episode

HOSPITAL READMISSION REDUCTION PROGRAM - 2013

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

HOSPITAL READMISSION REDUCTION PROGRAM - 2013

- Count to include readmissions for all causes, except excluded (previous slide)
- Risk Adjustment to level the playing field
- Using 3 years of data to calculate excess re-admission ratios
  - FFY 2013 – will be using discharges from 7/1/08 thru 6/30/11
- Only hospitals w/25+ discharges for each of the 3 conditions to be included in "*Hospital Compare*"

EXCESS READMISSION RATIO

- Using risk-standardized ratio of the 3 measures
  - Ratio is "risk adjusted readmission based on actual" to "risk adjusted expected readmissions"
  - 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 readmission rate caring for very low risk population may have ratio over 1.000

COST REPORT RELATED ITEMS

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
  - Only use this line if your labor/delivery costs are reported in the ancillary section on Line 52 (old cost report line 39)

DISPROPORTIONATE SHARE

- Exclusion of hospice beds/days
  - Inpatient respite care and general inpatient care
  - Hospice not paid under IPPS
  - Exclude hospice days from DSH calculation
  - Cost report forms will be updated to incorporate
  - Effective for reporting periods beginning on or after October 1, 2011
  - Also exclude hospice days from bed count days
    - Helps IME calculation

2552-10 DISPROPORTIONATE SHARE

- Future Medicare DSH reduction to 25% of current level
  - DSH payment amounts phasing down to 25% over several years
  - 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 – 2010 SURVEY

- Unaudited data 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. 51594 of 8/18/11 Federal Register
  - Excel file available on CMS website

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

FFY 2012 OCCUPATIONAL MIX SURVEY – IMPACT

State	AHW (unadjusted)	AHW (adjusted for Occ. Mix)	$ Change	Impact
New Mexico	$34.25	$34.62	$.37	Positive
Arizona	$37.36	$37.15	(.21)	Negative
Nevada	$42.10	$41.24	(.86)	Negative
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 – PENSION COSTS

- PRM 1, Section 2142 revised for reporting defined qualified benefit pension costs
- Interim measure – CMS JSM issued 11/2009 w/instructions and spreadsheet
- Revised 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 – DEFINED BENEFIT

- For wage index purposes
  - Pension costs allowed equal to average cash contributions over 3 year period
    - 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
  - Should be part of this winter's wage index inquiries from your FI/MAC

PENSION COSTS – DEFINED BENEFIT

- 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*

WAGE INDEX SCHEDULES IN 2552-10

- Worksheet S-3, Parts II-V, Wage index
  - New Part IV replaces CMS 339, Exhibit 6
  - Since part of Cost Report, benefit detail by type to be part of ECR file
  - Flows to Lines 17 and 18 of Part II
    - Is in error since these lines are only for allowable hospital cost center wage index costs
    - Will need to report benefit costs by type for hospital only
      - CR Vendor has notified CMS of issue, but may not be corrected in first round of reports filed on new forms
  - New S-3 Part V for Contract Labor and Benefit Cost

MEDICAL EDUCATION IN 2552-10

- ACA requires hospitals to maintain records of resident time in nonprovider settings and compare to base year
  - "Base year" CR periods beginning on/after July 1, 2009 and before June 30, 2010
  - Rotation schedules should provide data
- Information to be reported on S-2
  - For cost reports ended April 30, 2011 and after
  - Used to id barriers to training in nonprovider sites

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

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

NAVIGATING CHANGES TO THE 3-DAY DRG BUNDLING RULE

CURRENT 3 DAY WINDOW

- Services provided to outpatients who later admitted as an inpatient within 3 days of inpatient admission (not 72 hours) required to be bundled on inpatient claim
  - Example - patient admitted Wednesday
    - Outpatient services provided Sunday, Monday, Tuesday (within 3 days) are bundled on the inpatient claim
    - Services provided on day of admission (Wednesday) also bundled

CURRENT 3 DAY WINDOW

- For hospitals not a "subsection (d) hospital" (psych, rehab, LTCH, children's, cancer), bundling required for services provided 1 day prior to admission
  - Published in 9/1/1995 Federal Register (60 FR 45840)
  - Day refers to entire day preceding admission, not 24 hours
- Critical Access Hospitals exempt from bundling rules as services are cost based
- FQHC/RHC services also excluded from bundling due to payment at all inclusive rate

CURRENT 3 DAY WINDOW

- Diagnostic services always bundled
- For non-diagnostic preadmission services, ICD-9 codes no longer required to be exact match
  - But be "clinically associated" w/inpatient admission
  - Outpatient CPT-4 codes are converted to ICD-9 codes on I/P claim
  - May affect MS-DRG assignment
- Non-related services still billed as outpatient
- Again, still excluding maintenance dialysis and ambulance services

3 DAY WINDOW CLARIFICATION

- Applies to pre-admission services furnished by the hospital (or <u>by an entity that is wholly owned OR operated by a hospital</u>)
  - Includes entities that are treated as free-standing by the hospital
- 42 CFR §412.2(c)(5) and 42 CFR §413.40(c)
- Hospital is sole operator of entity if:
  - Hospital has exclusive responsibility for conducting/overseeing entity's routine operations
    - Does not need to have policymaking authority

PAYMENT RATE CHANGES

- Physician payment for professional component at free-standing location physician clinic will be at same rate as physician payment rate for provider-based clinics
  - Reduced physician payment avoids duplicate payment for facility services (technical component) since facility component bundled on I/P claim
  - Incident-to (nurse-only) billing issues

PAYMENT RATE CHANGES

- New Medicare HCPCS modifier “PD” established
  - Signifies professional service s/b paid at provider-based rate (SOS differential)
  - Modifier appended to HCPCS code for applicable **pre-admission** services provided
  - Modifier available for use as of 1/1/2012, but CMS is delaying implementation until 7/1/2012
- CMS will no longer separately pay the TC bundled services
  - Charges for TC services in free-standing clinic bundled on inpatient claim

CLAIMS PROCESSING ISSUES

- Hospital will need to ensure “wholly owned or operated entities” are informed of inpatient admissions
- Hospitals and physician clinics will need to be more closely aligned
  - Outsourced billing vendors will need to be brought into the fold

PAYMENT RATE CHANGES

- CMS will modify regulation defining sites of service (SOS) to add SOS for entity "wholly owned or operated by a hospital"
- CMS provides examples in 2012 Final Physician Fee Schedule Rule issued 11/1/2011
  - To be published in 11/28/2011 Federal Register
  - Similar to examples published in 2/11/98 Federal Register

HOSPITAL OWNED/OPERATED

- 42 CFR §412.2(c)(5) and 42 CFR §413.40(c)
  - CMS indicates that physician practices and other entities self-designate whether owned or operated by a hospital during Medicare enrollment process
    - Check your CMS form 855B
    - Hospitals, check your CMS form 855A
    - Check state corporate practice of medicine (CPM) law and Articles of Organization – CMS may have been carefully avoiding referencing professional medical aspects of the practice

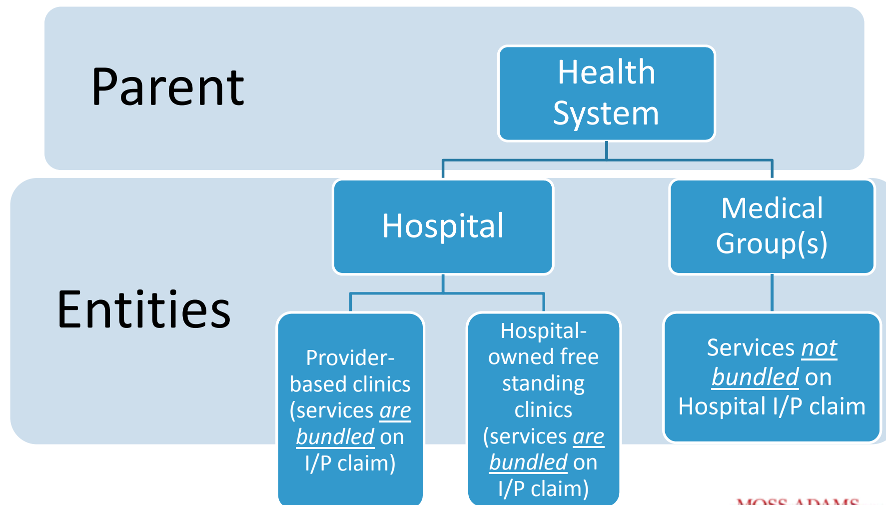
WHAT ENTITIES ARE INCLUDED?

- CMS believes most hospitals' wholly owned entities are already provider based, but many wholly owned entities are billed as free-standing
  - Physicians practicing in these locations billed with POS 11 (physician office) rather than POS 22 (outpatient hospital) – physician claims not reduced by site of service differential
    - These locations are impacted unless redesigned

WHAT PHYSICIAN PRACTICES/ENTITIES SHOULD *NOT* BE INCLUDED?

- Medical office building where hospital is merely a landlord
- Owned by the hospital parent, other health system (non-hospital) affiliate
  - CMS deems these to be owned by a "third party" (personal communication, September 29, 2011)
- Joint Ventures – so long as not wholly-operated or provider-based

HEALTH SYSTEM EXAMPLE



GLOBAL SURGERY ISSUES

- Global surgeries have period of 0, 10 or 90 days
  - Medicare payment includes preop visits, intra-op visits, complications following surgery, post op visits, postsurgical pain mgmt, supplies, and misc other services such as suture/staple removal
  - Time frame for 3-day payment window and global surgical package may overlap

GLOBAL SURGERY ISSUES

- If surgical procedure done within 3-day window
  - Practice (aka "technical" or "facility") expense should be included on Hospital's Part A claim form
  - Practice will apply the new HCPCS modifier
  - Medicare pays practice for the professional component at the facility rate, same that a provider-based clinic would receive

GLOBAL SURGERY ISSUES

- If surgical procedure done outside 3-day window
  - Guess what! 3-day window policy would not apply!
  - CMS does not deem it appropriate to unbundle post op services
  - Services not part of global surgical procedure still subject to potential 3-day window

ISSUES TO DEAL WITH

- What does CMS deem as "clinically related" to an inpatient admission?
  - CMS said sticking with "exact match" would be "too narrow" (76 F.R. at 51707, 8/18/2011)
  - CMS leaving it up to hospitals to determine "clinically related"
    - Case by case basis
  - CMS expects hospitals to document in beneficiary's medical record to support non-diagnostic services that are *not* "clinically related" in order to bill as outpatient
    - Hospital attestation process

REQUIRED HOSPITAL ATTESTATION

- CMS established process for hospitals to *attest* that non-diagnostic services are unrelated to the hospital admission
  - Issued in Change Request (CR) #7142
  - Implementation date of 4/4/2011, for dates of service 4/1/11 and after

REQUIRED HOSPITAL ATTESTATION

- If O/P services not related to admission, hospital attests when submitting O/P claim
  - o Hospital adds Condition Code 51 - Attestation of Unrelated Outpatient Non-diagnostic services
    - May have required retroactive adjustments by hospital for services provided after 6/25/10, if claim rejected by Medicare
    - Documentation to be maintained in beneficiary's medical record to support claim
  - o Subject to subsequent CMS review
  - o How do you do this if outpatient facility is free-standing clinic?
    - Services are billed on CMS 1500 claim form

ISSUES TO DEAL WITH

- CMS believes full adoption of EMR will facilitate coordination and tracking of patients
- Should you convert your clinics to provider-based status?
  - o Opportunity to revisit provider-based status vs freestanding for various services
  - o Immediate review of impact on revenue and operations required

ISSUES TO DEAL WITH

- Does the new rule require re-evaluation of these objections?
  - Physician PC payments are going to be reduced if "clinically associated" with inpatient admission.
    - Does not apply to all physician services – outpatient only services are not impacted
    - If CMS seeks to extract revenues from these settings, no reason not to offset through legal, legitimate system redesign by converting to provider-based status
  - Flexibility and independence of freestanding practices further eroded

COST REPORT ADJUSTMENTS – BUNDLED SERVICES

- CMS expects hospitals to make Worksheet A-8-1 to bring in the "costs" of the technical component of services bundled on the inpatient claim
  - Applies to costs in the free-standing clinic setting
  - Hospitals to "accumulate" costs incurred and report as related organization costs
  - Since charges for technical component on inpatient claim, need to match cost of service
    - Allows for "proper matching" of costs and charges for future rate setting

OPPS AND OIG WORKPLAN

OUTPATIENT PPS CONVERSION RATES

- Final 2011 Conversion Factor of $68.267
- Final 2012 Conversion Factor is $70.016
- Final 2012 Conversion Factor of $68.616 *if failed to report quality measures*

- Overall final payment update increase is 1.9%

FINAL OUTPATIENT PPS

- 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
- Final 2012 outlier threshold is $1,900
  - Outlier payment continues to be 50% of amount exceeding 1.75 time APC payment

FINAL OUTPATIENT PPS

- Drugs with mean daily cost of $75 packaged with APC payment
  - Threshold for 2011 was $70 of mean daily cost
- Decrease in separately payable drugs without pass-thru status changes from ASP+5% to ASP+4%, with exceptions
  - Dx radiopharmaceuticals, contrast agents, implantable biologicals are packaged and paid separately on if have pass-thru status

NO-COST RADIOPHARMACEUTICALS

- Modifier FB applied to nuclear medicine exam code when radiopharmaceutical is provided at no cost
  - Radiopharmaceutical is reported with token charge of $1.00
- CMS requesting input if policy should also be applied to contrast agents

DRUGS IN PHYSICIAN FEE SCHEDULE

- Drugs with pass-thru status paid at ASP + 6%
- 19 drugs have pass-thru status expiring on 12/31/11
  - See Table 33 for list of 2012 pass-thru drugs
- Final 2012 drug pmt to physicians to change from 106% of ASP to 103% of AMP
  - Potential 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%

CRITICAL CARE SERVICES

- CPT manual indicates certain ancillary services are included in critical care (99291 – 99292) for physician billing
  - Cardiac output measurements
  - Chest x-rays
  - Pulse oximetry
  - Blood gases
  - NG tube placement
  - Transcutaneous pacing
  - Ventilator management

CRITICAL CARE SERVICES

- CMS continue packaging previous ancillary services for 2012
- Hospitals s/continue to report codes for these services
- If services are reported with critical care codes (99291 - 99292), payment for ancillary service to be paid in critical care rate
- If billed w/o critical care codes, ancillary service may be paid separately

FINAL 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

FINAL 2012 OUTPATIENT PPS

- Implantable devices cost center (in cost report)
  - Cost center available on/after 4/30/10 YE cost reports
    - CMS determined not sufficient data to establish separate RCC for implantable devices in 2012 OPPS rule
    - 3 year lag in availability of cost report data in given year used to set payment rates
  - To be reassessed in CY 2013 OPPS Rules

FINAL 2012 OUTPATIENT PPS

- Be sure to use the CMS designated lines whenever possible for future pmt calculations
  - Cardiac Cath
  - MRI
  - Cat Scan
  - Hyperbaric Oxygen Therapy
  - Cardiac Rehabilitation
  - Lithotripsy

SECTION 1011 PROGRAM

- Section 1011 provides reimbursement to eligible providers for emergency services that are rendered to:
  - Undocumented aliens
  - Aliens paroled in US port of entry for purpose of receiving eligible services
  - Mexican citizens permitted to enter US on laser visa

SECTION 1011 PROGRAM

- Highmark Medicare Services (Highmark Medicare Services) is the national contractor for Section 1011
  - Providers must enroll in program to be eligilble
  - Section 1011 allows an additional **10 percent reimbursement on approved outpatient emergency services**
  - https://www.highmarkmedicareservices.com/section1011/

SECTION 1011 PROGRAM

- Section 1011 obligation begins and ends when the EMTALA obligation begins and ends
- Eligible providers are:
  - Medicare participating hospitals,
  - Physicians (Medicare participation not required)
  - State licensed ambulance providers
  - Indian Health Services and
  - Critical Access Hospitals
- Section 1011 generally uses Medicare payment rules to calculate reimbursement

NEW MEXICO HAS NOT EXHAUSTED THEIR FUNDS

- According to the Highmark web site as of August 26, 2011, 21 states have exhausted their funds:
  - Alabama, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Mississippi, Nebraska, New Jersey, Nevada, North Carolina, Oklahoma, Tennessee, Texas, Utah, Virginia, Washington
- Funds remaining, selected states (FY 2011, 1st Qtr)
  - Arizona, $42.3 million
  - California, $15.75 million
  - New Mexico, $1.73 million

WHAT'S ON THE OIG'S 2012 WORK PLAN?

- Hospital I/P Outlier Payments – trends and characteristics
- Evaluation of acute care transfers to I/P hospice
  - Is there a financial or common ownership relationship between hospital and hospice?
- Accuracy of hospitals' occupational mix data used to calculate wage indices
  - Impact on Medicare of inaccurate data

WHAT'S ON THE OIG'S 2012 WORK PLAN?

- Review of nonphysician outpatient services provided to patients prior to admission
  - 3 day bundling rule?
- Observation services during O/P visits
  - OIG believes improper use of obs subjects benes to higher co-pays
- Evaluate appropriateness of admissions to rehab facilities
  - Review level of therapy provided

WHAT'S ON THE OIG'S 2012 WORK PLAN?

- Do CAHs meet designation criteria and C of P?
  - Profile CAHs in size, services and distance from other hospitals
  - Examine numbers and types of patients treated
  - 25 beds or less?
  - Located in rural area, furnishing 24-hour emergency care

WHAT'S ON THE OIG'S 2012 WORK PLAN?

- Physicians
  - Place of service errors
  - Billing of "incident to" services
    - 2009 OIG report found physicians billing more than 24 hours of service in a day and that ½ the services are not performed by a physician
    - Unqualified nonphysicians performed 21% of "incident to" services
  - Impact of physicians opting out of Medicare
    - Are these physician submitting claims to Medicare?
    - Impact on benes as physicians allowed to enter into private contracts with Medicare beneficiaries

QUESTIONS??

Cheryl Storey (503) 478-2132
cheryl.storey@mossadams.com