Legislative & Regulatory Update for Rural PPS Hospitals
Session C02, June 18, 2013
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Agenda

• Federal Fiscal Year (FFY) 2014 Inpatient PPS Proposed Rule (comments due 6/25/13)
  – Regulations.gov, search for “0938-AR53”
• CMS Proposed Disproportionate Share Hospital (DSH) Formula
• Other Regulatory & Legislative Issues
**Proposed Payment Update**

<table>
<thead>
<tr>
<th>Category</th>
<th>Change</th>
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<tbody>
<tr>
<td>Market Basket Update</td>
<td>2.5%</td>
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<tr>
<td>Productivity/ACA* Cut</td>
<td>(0.7)</td>
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<tr>
<td>Documentation &amp; Coding Cut</td>
<td>(0.8)</td>
</tr>
<tr>
<td>Pay for Inpatient Criteria Change</td>
<td>(0.2)</td>
</tr>
<tr>
<td>DSH Payment Change</td>
<td>(0.9)</td>
</tr>
<tr>
<td><strong>Net Change</strong></td>
<td>(0.1)%</td>
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*Patient Protection and Affordable Care Act (ACA) of 2010, HR 3590 & HR 4872

**ACA Productivity Cuts**

- Starting 10/1/11, annual Medicare inflation adjustment is reduced by productivity adjustment “equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity”
  - 10/1/11 cut = 1.0% (vs. 3.0% market basket)
  - 10/1/12 cut = 0.7% (vs. 2.6% MB)
  - Proposed 10/1/13 cut = 0.4% (vs. 2.5% MB)
Other Fixed ACA Cuts

- 4/1/10 = 0.25%
- 10/1/10 = 0.25%
- 10/1/11 = 0.1%
- 10/1/12 = 0.1%
- 10/1/13 = 0.3%
- 10/1/14 = 0.2%
- 10/1/15 = 0.2%
- 10/1/16 = 0.75%
- 10/1/17 = 0.75%
- 10/1/18 = 0.75%

Productivity cuts have no sunset date & have cumulative impact on hospitals

Example, household budget:
- Salary, after taxes = $30,000
- Salary grows 2% per year
- Expenses = $29,000
- Expenses grow 3% per year
- $1,000 “margin” in Year 1
- What happens by Year 10?
### Cumulative Impact of ACA Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>Income</th>
<th>Expenses</th>
<th>Margin</th>
<th>Cumulative</th>
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<td>Year 1</td>
<td>$30,000</td>
<td>$29,000</td>
<td>$1,000</td>
<td>$1,000</td>
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<td>Year 4</td>
<td>31,836</td>
<td>31,689</td>
<td>147</td>
<td>2,323</td>
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<td>Year 7</td>
<td>33,785</td>
<td>34,628</td>
<td>(843)</td>
<td>817</td>
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<td>Year 10</td>
<td>35,853</td>
<td>37,838</td>
<td>(1,986)</td>
<td>(3,961)</td>
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#### Cumulative Impact of ACA Cuts

- Costs (+3%)
- Pmts (+2%)
Documentation & Coding

- Section 631 of American Taxpayer Relief Act
  - Requires $11 billion be recovered from hospitals between 2014 & 2017
  - CMS estimates 9.3% cut would recover all in 2014
  - Instead, proposes 0.8% cut in 2014
  - Presumably, 1.6% in 2015, 2.4% in 2016 and 3.2% in 2017?

- CMS proposes no additional cut to hospital-specific rates for sole community hospitals (SCH) & Medicare-dependent hospitals (MDH)

Change in Inpatient Criteria

- Current rules: Medicare Benefit Policy Manual, Chapter 1, Section 10 – “Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. . . . Admissions of particular patients are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.”
Change in Inpatient Criteria

• CMS proposes presumption “that inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 “midnights”) in the hospital receiving medically necessary services.”
  – Contractors would disregard 2-midnight presumption for hospitals “systematically delaying the provision of care to surpass the 2-midnight timeframe.”

Change in Inpatient Criteria

• CMS also proposes “that hospital services spanning less than 2 midnights should have been provided on an outpatient basis, unless there is clear documentation in the medical record supporting the physician’s order and expectation that the beneficiary would require care spanning more than 2 midnights or the beneficiary is receiving a service or procedure designated by CMS as inpatient-only.”
  – Transfers & deaths could still qualify as inpatients if stay is less than 2 days
Change in Inpatient Criteria

- CMS actuary estimates
  - 400,000 encounters would shift from outpatient to inpatient
  - 360,000 encounters would shift from inpatient to outpatient
  - Net additional expenditures of $220 million

- CMS proposing 0.2% cut to inpatient payment rates to pay for added expenditures

MS-DRG Weight Calculation

- Proposing to move from 15 cost centers to 19 – new cost centers are:
  - Implantable devices
  - Cardiac catheterization
  - MRI
  - CT scan

- Impact is budget neutral overall, but CMS estimates rural hospitals will see 0.5% cut on average
MS-DRG Weight Calculation

- “Change in DRG Weights with 19 Cost Centers” spreadsheet can be used to estimate your impact
  - Input your claims by DRG in Column N
  - Column O shows the “normal” recalibration impact between 2013 and 2014
  - Column P shows the additional impact of the 4 new cost centers
  - Column Q shows the total impact
  - Multiply by your average DRG payment for the financial impact to your hospital

Wage Index Issues

- Proposing not to implement 2010 census changes until FFY 2015
- List 2 shows all metropolitan areas & counties
- List 6 shows metropolitan areas by state
  - Evaluate your area now to see if changes may impact payments: SCH status, wage index, etc.
  - Even if your county didn’t change, see if nearby counties did
Wage Index Issues

- Occupational mix survey for calendar year 2013 will be due July 1, 2014
- Proposing to increase labor-share of DRG payment from 68.8% to 69.6% for areas with wage index > 1.0
  - Labor share remains 62% if wage index < 1.0
- Proposing to continue rural floor budget neutrality policy, spreading impact across all states rather than within states
  - Selected impacts on next slide

Rural Floor Winners & Losers

<table>
<thead>
<tr>
<th>Winners</th>
<th>Losers</th>
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</thead>
<tbody>
<tr>
<td>Massachusetts +5.6%</td>
<td>DE, IL, NY -0.6%</td>
</tr>
<tr>
<td>Connecticut +4.9%</td>
<td>13 States &amp; DC -0.5%</td>
</tr>
<tr>
<td>Alaska +3.3%</td>
<td>14 States -0.4%</td>
</tr>
<tr>
<td>Nevada +1.6%</td>
<td>7 States -0.3%</td>
</tr>
<tr>
<td>California +0.9%</td>
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</tr>
<tr>
<td>New Hampshire +0.8%</td>
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</tr>
<tr>
<td>Rhode Island +0.5%</td>
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</tr>
<tr>
<td>New Jersey +0.4%</td>
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Quality Initiatives


- Value-Based Purchasing

- Readmissions Reduction

- Hospital-Acquired Conditions

Value-Based Purchasing

- Starting 10/1/12, 1% of Medicare inpatient reimbursement is withheld for a value-based purchasing pool

- Increases 0.25% annually to 2% by 10/1/16

- Earned back with favorable quality outcomes, based on achieving certain performance levels or improving performance

- Withhold based on federal base rate, not hospital-specific rate “add-on”, DSH, etc.
Value-Based Purchasing Scoring

<table>
<thead>
<tr>
<th></th>
<th>FFY 2013</th>
<th>FFY 2014</th>
<th>FFY 2015</th>
<th>FFY 2016*</th>
<th>FFY 2017*</th>
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<tbody>
<tr>
<td>Process</td>
<td>70%</td>
<td>45%</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
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<tr>
<td>HCAHPS</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>25%</td>
<td>25%</td>
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<tr>
<td>Outcomes</td>
<td>25%</td>
<td>30%</td>
<td>40%</td>
<td>25%</td>
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<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
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<tr>
<td>Safety</td>
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<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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</table>

*Proposed, subject to change

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Readmissions Reduction

- Effective 10/1/12, up to 1% of inpatient reimbursement withheld from hospitals with higher than expected readmission rates
- Effective 10/1/13, up to 2% withheld
- Effective 10/1/14 & thereafter, up to 3% withheld
- CMS determines “expected” risk-adjusted readmission rates for each hospital
- Withhold based on federal base rate, not hospital-specific rate “add-on”, DSH, etc.
Readmissions Reduction

- Currently based on readmissions for heart attack, heart failure & pneumonia
- For FFY 2015, CMS proposes adding
  - Acute exacerbation of cardiopulmonary disease
  - Elective total hip or total knee arthroplasty
- CMS also proposes to broaden the exclusion for planned readmissions & to exclude unplanned readmissions that follow planned readmissions

Hospital-Acquired Conditions

- Effective 10/1/14, 1% of inpatient reimbursement withheld annually from hospitals in bottom 25% of hospitals based on level of hospital-acquired conditions
- CMS proposes two alternative sets of measures using AHRQ Patient Safety Indicators, as well as CDC infection measures
- Initial reporting period proposed to be July 1, 2011 through June 30, 2013
CMS Proposed DSH Formula

New DSH Formula

- CMS has surprised most with their proposal for computing the new DSH payments
- Creates big winners and losers
- But is it in line with the Affordable Care Act and legislative intent?
- Significant errors exist in data, many hospitals show no Medicaid days but are large DSH hospitals
New DSH Formula

- The Affordable Care Act set forth a new DSH formula beginning in FY2014
- 25% of DSH payment continues to be based on current methodology
- Remaining 75% is based on product of 3 factors

\[
\text{Total New DSH Payment} = \left( \frac{25}{100} \times \text{DSH Payment} \right) + \left( \frac{75}{100} \times \text{DSH Payment} \times \text{Change in Uninsured Care Costs} \right)
\]

- Proposed rule confirms reduction in DSH payments to many hospitals
- Worksheet S-10 from the cost report **will not** be used in FFY 14 to gather data, could be used in future years
- Only subsection(d) hospitals, those who qualify for DSH, will qualify for the “add-on” payment under the new method
New DSH Formula

- FY2014 Proposed Rule throws a curve ball
- Medicaid & Medicare SSI days used as a proxy for Uncompensated Care Costs
- SSI Enrollment remains a driving force for future DSH payments

Why did CMS ignore cost of uninsured?

- Varying definitions of uncompensated care
- Lack of clarity on days definition
- Lack of consistent reporting (CMS-2552-10 Form S-10)
New DSH Formula

• Two payments will be calculated for a DSH hospital

• The traditional DSH payments will continue to be computed but only paid at 25% (called the empirically justified Medicare DSH payment)

• A second payment will be based on three factors & is referred to as the “uncompensated care payment”

New DSH Formula

• Three factors:
  – Factor 1 – Difference between 100% of DSH payment that would have been paid out if the law had not been changed & the 25% that will be paid out – estimated for the proposed rule at $9.25 billion
  – Factor 2 – For FFY2014, 1 minus the % change in uninsured individuals from 2013 – proposed to use 88.8% based on CBO’s estimate
  – Factor 3 – Proportion of uncompensated care for hospital compared to all hospitals who receive DSH, using Medicaid days & SSI days
New DSH Formula

- Factor 3 is based on each hospital’s share of total uncompensated care costs across all PPS hospitals that received DSH payments
  - So the numerator is all PPS hospitals, but denominator is just DSH hospitals

### New DSH Formula

<table>
<thead>
<tr>
<th></th>
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<td>23114</td>
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<td>HARTSelle MEDICAL CENTER</td>
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<td>MARSHALL MEDICAL CENTER NORTH</td>
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<td>00011</td>
<td>ST VINCENT’S EAST</td>
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<td>HEBBLY BAPTIST MEDICAL CENTER</td>
<td>8134</td>
<td>1815</td>
<td>9949</td>
<td>0.027728%</td>
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FY 2014 IPPS Proposed Rule: Implementation of Section 3133 of the Affordable Care Act- Medicare DSH- Supplemental Data
New DSH Formula

Example FFY 2014 Proposed Rule: 2014 Estimated Payment

<table>
<thead>
<tr>
<th>FY 2011 DSH Payment</th>
<th>$5,000,000.00</th>
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<tbody>
<tr>
<td>25% Historical DSH</td>
<td>$1,250,000.00</td>
</tr>
<tr>
<td>Factor 1: (Constant)</td>
<td>$9,253,500.00</td>
</tr>
<tr>
<td>Factor 2: (Constant)</td>
<td>88.8%</td>
</tr>
<tr>
<td>Factor 3: (From CMS Table)</td>
<td>0.0345624%</td>
</tr>
<tr>
<td>Uncompensated Care Payment</td>
<td>$2,840,000.00</td>
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<tr>
<td>Estimated Total FY 2014 DSH Payment</td>
<td>$4,090,000.00</td>
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<tr>
<td>Reimbursement Comparison</td>
<td>($910,000.00)</td>
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Data table on CMS website should be reviewed by all hospitals – notify CMS if data is in error

CMS is using as-filed 2012 cost reports; this is problematic because of the Medicare Part C issue

Worksheet S-10 could be used in the future so it is important to complete it accurately

Proposed formula will punish states that do not expand Medicaid if methodology is used in the future
New DSH Formula

• The uncompensated care component of the payment will be paid on an interim basis, not per discharge

• A final settlement of the empirically justified & uncompensated care payments will be made on the cost report

• DSH scrubs will continue to be important for hospitals not only for the original computation (which now pays at 25%) but also for computing the uncompensated care payment which uses the same days

New DSH Formula

• BKD has developed a calculator at: http://www.bkd.com/industries/health-care/hospitals/dsh-reimbursement-database.htm

• CMS will get pounded with comments – Stay tuned for changes in the final rule!!
How will CMS DSH changes impact PPS hospital eligibility for 340B?

- PPS hospitals are eligible for DSH under Public Health Service Act Section 340B(a)(4)(L)(ii) if they have "a disproportionate share adjustment percentage (as determined under section 1886(d)(5)(F) of the Social Security Act) greater than 11.75 percent"

- 1886(d)(5)(F) was modified by ACA to include the new DSH calculation CMS is proposing to implement

Rural referral centers & sole community hospitals have alternative 340B qualification criteria, requiring 8% DSH adjustment percentage

- However, they are subject to orphan drug exclusion for 340B drugs
Other Regulatory & Legislative Issues

Medicaid DSH Cuts

- ACA requires federal DSH payments to states be cut as coverage expands; cuts =
  - Federal FY 2014 - $500 million
  - Federal FY 2015 - $600 million
  - Federal FY 2016 - $600 million
  - Federal FY 2017 - $1.8 billion
  - Federal FY 2018 - $5 billion
  - Federal FY 2019 - $5.6 billion
  - Federal FY 2020 - $4 billion
Medicaid DSH Cuts

• CMS methodology to cut individual states must consider 5 factors:
  – Smaller reduction on “low DSH States”
  – Larger reduction on states with lowest % of uninsured using most recent data
  – Larger reduction on states that don’t target DSH to hospitals with high Medicaid utilization
  – Larger reduction on states that don’t target DSH to hospitals with high uncompensated care
  – Consider whether state’s DSH allotment included in BN calculation for expansion at 7/31/09

Medicaid DSH Cuts

• CMS published proposed rule 5/15/13
  – Comments due 7/12/13

• Proposed methodology cuts 1.2% ($6.2 million) from 17 low DSH states: AK, AZ, DE, HI, ID, IA, MN, MT, NE, NM, ND, OK, OR, SD, UT, WI, WY – range of 0.5% to 2.3%

• Remaining states have range of 1.9% to 7.1%, average cut of 4.4%
Medicaid DSH Cuts

- CMS acknowledges states that expand Medicaid may have lower share of uninsured in the future, & thus more Medicaid DSH cuts
  - “Given the statutory reductions in the funding for Medicaid DSH in the Affordable Care Act, we intend to account for the different circumstances among states in the formula in future rulemaking.”

Sequestration

- Required by Budget Control Act of 2011, after Congress & White House failed to agree on deficit reduction measures
- 2% cut in all Medicare payments, effective for services on or after April 1, 2013
- Based on net Medicare payment, not counting deductible/coinsurance
- Theoretically reinstated in 2022
### Impact of Sequestration

![Graph showing the impact of sequestration over time with lines for costs and payments.]

### American Taxpayer Relief Act of 2012

- Requires $11 billion documentation & coding adjustment starting 10/1/13
- Extended low-volume payment add-on through September 30, 2013, for hospitals with fewer than 1,600 Medicare discharges
- Extended Medicare-dependent hospital program through September 30, 2013
  - CMS automatically reinstated MDHs with no change in status
  - Special rules for MDHs that had reverted to urban or SCH status
Other Rural Hospital Extenders

- Medicare outpatient cost-based lab program expired June 30, 2012
- Medicare outpatient hold harmless program expired December 31, 2012
  - December 2012 CMS report (required by February 2012 legislation) implied hospitals earning hold harmless may be inefficient
  - CMS notes they’ve changed from geometric median to mean costs for outpatient rates; this $3 million may “decrease the need” for $104 million in hold harmless payments

Deficit Reduction Talks

- Debate continues, with debt extension rapidly approaching
- Additional cuts are possible, such as
  - Reducing ability of states to fund Medicaid programs with provider taxes
  - Additional Medicare documentation & coding cuts
  - Cutting payments for provider-based clinics
  - Cutting payments for Medicare bad debts
TRICARE Inpatient Payments

- TRICARE statute requires payments to hospitals to follow Medicare rules “to the extent practicable”
- TRICARE uses DRG system for most hospitals
- Historically paid SCHs based on % of charges
- 7/5/11 proposed rule would transition SCH rates down to DRG rates with small add-on
- Rule has still not been finalized

Questions?
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