

Hospital FY 2016 IPPS Legislative and Regulatory Policy Update

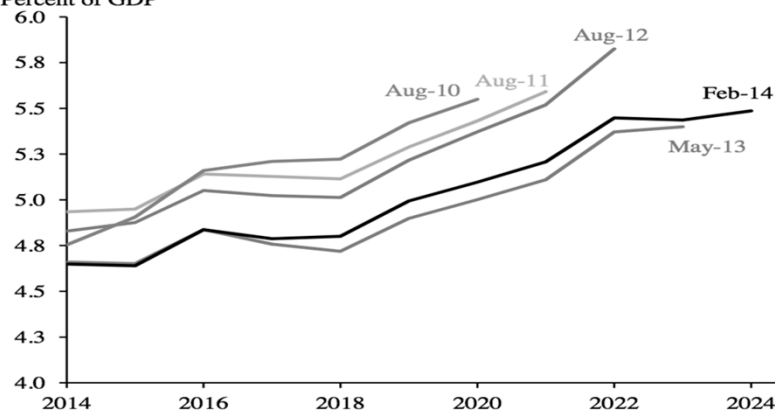
John Hellow
Hooper, Lundy and Bookman, PC



| Los Angeles | San Francisco | San Diego | Washington D.C. |

Economic Report of the President 2014

Recent CBO Projections of Medicare and Medicaid Outlays
Percent of GDP



Notes: Medicare outlays reflect spending net of offsetting receipts. Medicaid spending reflects Federal spending only.
Sources: Congressional Budget Office, Budget and Economic Outlook; CEA calculations.

Components of FY 2015 Inpatient Prospective Payment System (IPPS) Payment Changes

A. Market Basket

1. Latest market basket updates can be found on CMS website at http://www.cms.gov/MedicareProgramRatesStats/04_MarketBasketData.asp#TopOfPage
2. CMS rebases the market basket and labor share every four years; last rebased for FY 2014
3. FY 2015 final rule used an update of 2.9%
4. FY 2016 final rule uses an update of 2.4%
5. EHR adjustment changes from a 33 1/3 percent reduction to three-quarters of the applicable percentage increase in FY 2015 to 66 2/3 reduction to three-quarters of the applicable percentage increase in FY 2016

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Market Basket (cont.)

B. ACA Market Basket Adj. IPPS FYs 2012 – 2019

Fiscal Year	Market Basket - Adjustment
2012	.1%
2013	.1%
2014	.3%
2015	.2%
2016	.2%
2017	.75%
2018	.75%
2019	.75%

Similar if not identical market basket adjustments apply beginning in FY 2012 and thereafter for long term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospital services. There is no cut to the overall SNF market basket.

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Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

C. Productivity Adjustment

1. Applies beginning in FY 2012,
2. 10-year moving average of changes in annual non-farm productivity, as determined by the Secretary,
3. Negative adjustments of 1% for FY 2012, .3% in FY 2014, and .5% for FY 2015, and proposed .5% in FY 2016,
4. Can result in a market basket increase of less than zero,
5. Payments in a current year may be less than the prior year, and
6. Applies to other provider types.



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Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

D. Documentation and Coding Adjustments

1. Section 7(b)(1)(A) of Pub. L. 110-90
 - a. Make an adjustment to the average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments
 - b. Does not specify when CMS must apply the prospective adjustment, but merely requires CMS to make an “appropriate” adjustment
 - c. Full Adjustment completed in FY 2013, though phase-in resulted in unrecoverable overpayments in FYs 2010, 2011, and 2012
2. Section 7(b)(1)(B) of Pub. L. 110-90
 - a. Requires CMS to make an adjustment in FYs 2010, 2011, and/or 2012 for overpayments made in FYs 2008 and 2009
 - b. Determined a total recoupment of -5.8 percentage points. Adjustment completed in FY 2013

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Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

3. ATRA imposes an aggregate \$11 billion recoupment of asserted coding overpayments in FYs 2010-2012
 - a. Recoupment to take place over four years, FYs 2014 – 2017,
 - b. Secretary has discretion on timing and level of the recoupment over the period as it totals \$11 billion. She has chosen a level escalation of 0.8% per year in reductions to achieve the \$11 billion
 - c. MedPAC indicated hospitals needed a 3.25% net increase in IPPS payments for FY 2015, before sequestration
 - d. MedPAC projects Medicare margins for hospitals of -6% in FFY 2014, rising to -8% with sequestration
4. FY 2010 prospective adjustment. (-0.8 adj. proposed for FY 2013, not finalized). No adjustment is included in the FY 2016 IPPS Final Rule.

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E. Hospital Dependent Adjustments Imposed for Failing to Implement EHR and Quality Data (QD) Reporting

FY 2016	QD + EHR	QD – EHR	EHR – QD	- QD – EHR
Market Basket Rate-of-Increase	1.7%	1.7%	1.7%	1.7%
Adjustment for Failure to Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.6	-0.6
Adjustment Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-1.2	0.0	-1.2
Applicable Percentage Increase Applied to Standardized Amount	1.7%	0.5%	1.1%	-0.1

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Budget Policy on Admission and Medical Review Criteria (Two-Midnight Rule)

F. Two-Midnight IPPS Payment Reduction Adjustment


1. Effective October 1, 2013
2. Stay less than “two midnights” is generally considered appropriate for an outpatient stay
3. Greater than “two midnights” is appropriate for an inpatient stay
4. Permanent adjustment of -0.2% made to IPPS Rates
5. Guidance: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf>
6. Certification Requirements modified in CY 2015 OPPS final rule;
7. CMS proposes extraordinary circumstance at physician’s reasonable discretion for shorter than two midnights stay in CY 2016 OPPS proposed rule.

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Mandated Adjustments to IPPS Update for FY 2015 and Possible FY 2016 Based on CMS and Congressional Budget Office’s (CBO) February 2014 Baseline

	FY 2014 Final IPPS Rule	FY 2015 Final IPPS Rule	FY 2016 Final IPPS Rule
Market Basket	2.5%	2.9%	2.4%
<u>ACA Reductions</u>			
Market Basket	-0.3%	-0.2%	-0.2%
Productivity	-0.3%	-0.5%	-0.5%
Subtotal = Applicable Percentage Increase	1.9%	2.2%	1.7%
<u>MS-DRG DCI Adjustments</u>			
ATRA Reduction (additive)	-0.8%	-0.8%	-0.8%
<u>TWO-MIDNIGHT ADJUSTMENT</u>	-0.2%	continues	continues
<u>Total General Adjustment before Sequester</u>	0.9%	1.2%	0.9%

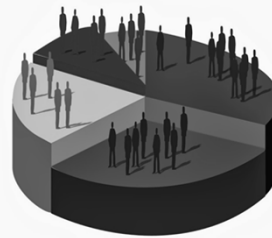
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 <h2 data-bbox="529 296 1138 394">Disproportionate Share Hospital (DSH) Payment Improvement?</h2> <p data-bbox="529 436 948 468">G. Implementation of ACA § 3133</p> <ol data-bbox="542 480 1198 842" style="list-style-type: none"> 1. Statute appears as new 42 U.S.C. § 1395ww(r) 2. CMS adds new 42 C.F.R. § 412.106(f)-(h) effective with discharges on and after 10/1/13 3. Affected Hospitals – <ol style="list-style-type: none"> a. 2440 Hospitals, including Puerto Rico b. Excluding Maryland and CAHs c. Sole Community Hospitals – consider all DSH when assessing eligibility for a hospital specific rate 	<p data-bbox="1230 852 1263 877">11</p>
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<h2 data-bbox="475 1167 1084 1266">Disproportionate Share Hospital Payment Improvement?</h2> <ol data-bbox="391 1304 1162 1780" style="list-style-type: none"> 4. Purpose – Reduce traditional DSH payments by 75% and redistribute portion of 75% pool to reflect relative hospital cost of uncompensated care <ol style="list-style-type: none"> a. \$500 million savings in year 1, b. 0.4% IPPS Operating Payments Reduction 5. Payments from pool subject to three factors: <ol style="list-style-type: none"> a. One – Determine pool at 75% of estimated traditional DSH, b. Two – Reduce pool by improvement in insured rates c. Three – Distribute pool based on ratio of an individual hospital's Medicaid and SSI days to all DSH hospitals Medicaid and SSI days 	<p data-bbox="1230 1724 1263 1749">12</p>
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Factor One – Estimate DSH

- Determined by the Office of the Actuary,
- The aggregate amount of DSH payments that would be made to all hospitals, minus
- The amount paid on account of subsection 1395ww(r)(1), 25% of empirically justified DSH payments,
- The Factor 1 amount for FFY 2015 is \$10.037 billions compared to \$9.593 billion for FY 2014, and for FY 2016 is finalized at \$10.058 billion
- Actuary assumed new populations will use inpatient hospital services at only 50% of the rate of traditional Medicaid populations.



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Factor Two – Reduction of Pool to Account For Growth of Insured Population

A. For FFYs 2014 – 17, the pool of funds is multiplied by 1 minus

1. The percentage change in the uninsured under age 65, between 2013 (as determined by Secretary based on March 2010 estimates from CBO), which was 18%,
2. The FY 2016 uninsured rate (also from CBO, but normalized by CMS), is 11.5% and
3. Minus .1% for 2014 and .2% for 2015-17 equals:
 - a. For FY 2015 that formula results in a factor applied to the pool of 76.19% as compared to 94.3% in FY 2014, and
 - b. For FY 2015 this would equal a pool amount of \$7.6476 billion, as compared to \$9.046 billion for FFY 2014
 - c. For the FY 2016 that formula results in a factor applied to the pool of 63.69%, and a pool of \$6.406 billion.

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Factor Two (cont.)



B. FY 2018 and after the pool of funds is multiplied by 1 minus

1. The percentage change in the uninsured between 2013 (as determined by Secretary and certified by the actuary), and
2. The current year uninsured rate (as determined above), and
3. Minus .2 percent for 2018 and thereafter.



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Factor Two (cont.)

C. Issues With the Calculation - FYs 2018 and thereafter

- a. Estimates now include all age groups including 65+
- b. Do not require reliance on CBO data
- c. What data sources will CMS use to capture this information?
- d. Need to insure undocumented are adequately covered in the data



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Estimated CMS Uncompensated Care Reduction Percentage

Based on February 2014 CBO Report on the Effects of the Affordable Care Act on Health Insurance Coverage as of 1-20-2014

FFY 2017 Model	2017
Prior Calendar Year	2016
Months in FFY	3
Uninsured Percentage per May 13 and February 2014 CBO Report	11%
Calendar Year Beginning in FFY	2017
Months in FFY	9
Uninsured Percentage per May 13 and February 2014 CBO Report	11%
Uninsured Percentage for FFY	11%
Uninsured Percentage per CBO Report Prior to ACA passage	18%
% Reduction in Uninsured	-38.89%
Additional Adjustment	-0.20%
% Reduction in Pool	-39.09%
Estimated Factor 2	60.9%

Note: Calculation based on methodology described in the Final 2014 IPPS Regulation

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Factor Three – Distributing Uncompensated Care Funds to Providers

A. Under FFY 2014 Final Rule distribution of the fund each year is made by establishing a quotient for each DSH eligible hospital that equals

1. Hospital prior period Medicaid and SSI days
 - a. Medicaid data from W/S S-2 in the March 2013 update of the Provider-specific File
 - b. FY 2011 SSI ratios
2. Total Medicaid and SSI days for all DSH-eligible hospitals using aggregated same data
3. Secretary has elected to use alternate data that is a better proxy than cost of treating the uninsured from existing W/S S-10 data

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Factor Three – Distributing Uncompensated Care Funds to Providers (cont.)

B. Application Issues – Prior Year Data DSH Eligible

1. Interim payments are calculated per discharge based on three-year rolling avg. Discharges applied to fixed predetermined payment for DSH eligible hospitals to derive amount;
2. Interim payments reconciled to predetermined payment;
3. DSH eligibility will be finally determined based on cost report reconciliation, either keep or lose predetermined amount. But no changes to amount;

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CMS Publication of Uncompensated Care Payments in IPPS Proposed and Final Rule



010038	1724	1056	2780	0.000075879	"\$483,438.87"	1098	\$440.42	1638	\$295.08	YES
010039	41917	6856	48773	0.001331240	"\$8,481,569.82"	9812	\$864.44	14683	\$577.66	YES
010040	12346	3493	15839	0.000432319	"\$2,754,384.28"	3335	\$825.82	4994	\$551.54	YES
010044	239	158	397	0.000010836	"\$69,037.85"	209	\$329.80	353	\$195.57	YES
010045	499	520	1019	0.000027813	"\$177,202.95"	461	\$384.39	699	\$253.51	YES
010046	3102	2588	5690	0.000155306	"\$989,484.60"	2076	\$476.63	3059	\$323.50	YES
010047	363	224	587	0.000016022	"\$102,078.64"	286	\$356.92	417	\$244.79	YES

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Factor Three – Distributing Uncompensated Care Funds to Providers

C. Prior Data Indicates Not DSH Eligible

1. Prior period data indicates not DSH eligible
2. Numerator for payment of uncompensated care still calculated
3. No interim payments
4. No payments unless current year cost report reconciliation establishes DSH eligibility
5. If DSH eligible, lump sum payment calculated when cost report settled



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Factor Three – Distributing Uncompensated Care Funds to Providers (cont.)

D. New Providers

New hospitals are allowed to qualify and receive payment based on current period data, on cost report finalization, no interim payments



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Factor Three – Distributing Uncompensated Care Funds to Providers (cont.)



E. Merged Hospitals

1. FY 2014 - Merged hospitals use only surviving Provider Number hospital data, no merger of multiple DSH hospital data
2. FY 2015 -
 - a. Data merged and hospitals can check special table in proposed rule for inclusion and accuracy and comment for corrections
 - b. Hospitals that merge after a final rule is issued treated as new hospitals in that year

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Factor Three – Distributing Uncompensated Care Funds to Providers (cont.)

F. Corrections and Appeals

1. Subsection (d) status is subject to correction if information submitted within 60 days of listing in proposed rule
2. For FY 2015 corrections may be requested until before October 1
3. No appeals of payment determinations
4. DSH status determined at cost report settlement, no appeals of DSH status for uncompensated care payments

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CMS Ultimately Will Move to W/S S-10 Uncompensated Care Cost Data To Calculate Payment

1. CMS Strong Inclination to Use W/S S-10 data

- A. First new W/S S-10s used in FY 2011 and have not been audited per 12/31/2012 HCRIS data
- B. Many errors obvious in filed S-10 data that strongly suggests data is unreliable as a basis to determine relative share of uncompensated care costs
 - 1. Many hospitals did not report S-10 data at all, about 5%
 - 2. 14% had no total bad debt data, but 90% of that group reported Medicare bad debt data
 - 3. Some had a CCR of 1, many had CCRs above .6, a few had more gross charges on S-10 than on C



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W/S S-10 Data Problems

2. Definitional problems

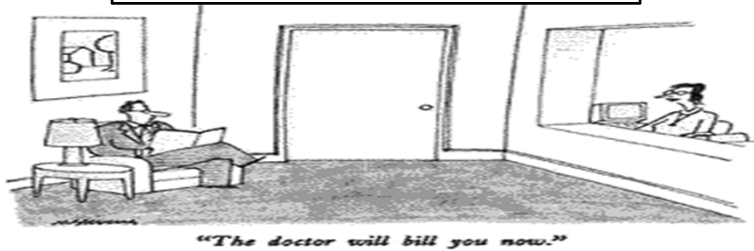
- a. Uninsured vs. Charity – Non means tested uninsured discounts likely not included in charity
- b. Charity must be determined during the cost reporting period
- c. Medicaid and other indigent program non-covered charges – must be addressed in charity policy or excluded
- d. Non-Medicaid gov't indigent care program patients likely should be excluded, but unclear
- e. Bad debt timing - written off or expected to be written off on balances owed by patients delivered during the cost reporting period. Accrual based account for bad debt should govern

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W/S S-10 Data Problems (cont.)

3. Converting Charges to Costs

- a. Problem particularly acute with bad debt
- b. Hospitals may be grossing up charges to address copayment shortfalls – should a hospital be allowed to claim a cost for a copayment that exceeds the actual copayment obligation? If the answer is yes, how do you standardize how that cost will be measured?



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Changes Affecting Medicare Payments to Acute Care Hospitals

H. Hospital Value-Based Purchasing – ACA § 3001

1. ACA Requirements
 - a. Applies to discharges on and after 10/1/2012;
 - b. Funded through base operating DRG reductions, 1 percent in FY 2013, 1.25 percent in FY 2014, **1.5 percent in FY 2015**, 1.75 percent in FY 2016 and 2 percent for FY 2017 and thereafter;
 - c. Incentive measures include AMI, HF, pneumonia, certain surgeries, patient experience of care (i.e., HCAHPS survey), health care acquired infections, and spending per beneficiary;
 - d. Incentives distributed by performance score and vary on score;
 - e. Certain hospitals excluded – cited for immediate jeopardy, or too few measures or cases; and
 - f. New measure must be posted on Hospital Compare website one year prior to implementation

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Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

I. Hospital Readmissions Reduction Program

1. ACA Provisions
 - a. Fiscal years commencing on and after 10/1/2012;
 - b. Conditions subject to measure are high value or high volume as selected by Secretary
 - c. Law compares risk adjusted actual and expected readmissions;
 - d. Secretary can exclude unrelated readmissions (such as planned readmissions or transfer to another applicable hospital)
 - e. Adjustment factor is the greater of: (a) 1 minus the ratio of payments for excess aggregate readmissions for a condition to the aggregate payments for total hospital discharges (not expected readmissions for such) admissions, or (b) a floor adjustment of .99 for FY 2013, .98 for 2014, or .97 for FY 2016 and thereafter;
 - f. Applies to base operating DRG

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Readmission Reductions (cont.)

2. FY 2015 and 2016 Final Rule
 - a. Covered Conditions - acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD) and total hip arthroplasty (THA)/total knee arthroplasty (TKA),
 - b. Adds coronary artery bypass graft surgery for FY 2017 and refinement of 30-day all cause PN readmissions,
 - c. Payment adjustment will be calculated from MedPAR discharge data from July 1, 2010 through June 30, 2013,
 - d. Many comments on risk adjustment for socioeconomic circumstances. IMPACT Act requires ASPE to study and issue recommendations. Also two year trial study by NQF

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Hospital Readmissions Reduction Program and VBP Payment Adjustment Formula

Definition of the base operating DRG payment amount:

1. Excludes Indirect Medical Education (IME), DSH, outliers, low-volume adjustment, and additional payments made due to status as an Sole Community Hospital (SCH), but
2. Includes new technology payments, and will be
3. Adjusted to account for transfer cases
4. $((\text{Labor Share} * \text{Wage Index}) + (\text{Non Labor Share} * \text{COLA}) * \text{DRG Weight}) + \text{New Technology Add On Payment}) * (\text{Adjustment Factor}-1)$

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Data From Hospital Readmission Reduction Program – Three Year Phase-In

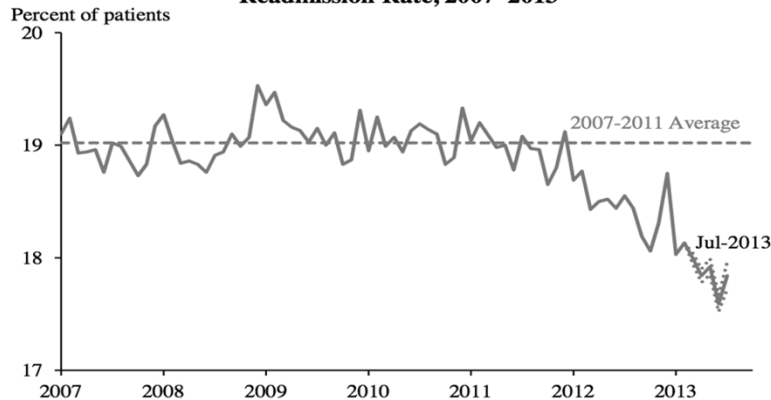
Year penalty applied			
(Penalties: percentage reductions in payments for all Medicare admissions in the year)	FY 2013	FY 2014	FY 2015
Performance (measurement) period	June 2008-July 2011	June 2009-July 2012	June 2010-July 2013
Diagnoses of initial hospitalization	Heart attack Heart failure Pneumonia	Heart attack Heart failure Pneumonia	Heart attack Heart failure Pneumonia COPD Hip or knee replacement
Maximum rate of penalty	1%	2%	3%
Average hospital payment adjustment (among penalized and non-penalized hospitals)	-0.27%	-0.25%	-0.49%
Average hospital penalty (among penalized hospitals only)	-0.42%	-0.38%	-0.63%
Percent of hospitals penalized	64%	66%	78%
Percent of hospitals at maximum penalty	8%	0.6%	1.2%
CMS estimate of total penalties	\$290 million	\$227 million	\$428 million

NOTES: Penalties are applied to each hospital in the fiscal year shown, based on its performance during a preceding 3-year measurement period, also shown. Analysis excludes hospitals not subject to HRRP, such as Maryland hospitals and other hospitals not paid under the Medicare Hospital Inpatient Prospective Payment System, such as psychiatric hospitals. COPD: Chronic obstructive pulmonary disease. FY: fiscal year.
SOURCE: Kaiser Family Foundation analysis of CMS Final Rules and Impact files for the Hospital Inpatient Prospective Payment System.

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Economic Report of the President 2014

Medicare 30-Day, All-Condition Hospital Readmission Rate, 2007–2013



Notes: Recent months are based on preliminary data. The dotted blue lines depict the range in which the final estimates are likely to fall.
Source: Centers for Medicare and Medicaid Services, Office of Information Products and Data Analytics.

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Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

J. HAC Reduction Program Payment Adjustment – ACA§3008

1. Discharges on and after 10/1/2014 – hospitals in top quartile of risk adjusted HAC measure receive only 99% of total PPS payments;
2. For FY 2015 Measure data:
 - a. 24-month period from July 1, 2011 to June 30, 2013 for AHQR measures
 - b. Calendar years 2012 and 2013 for CDC HAI measures
3. Adjustment is applied after VBP and HRRP adjustments;
4. Public disclosure of HACs in such hospitals;
5. No measure changes in FY 2015 Rule, but the weights of the Domains for groups of measures will change over time

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HAC Reduction Program (cont.)

4. Summary of Measures for FYs 2015 – 17 Courtesy of Health Policy Alternatives

Final HAC Reduction Program Measures			
	FY 2015	FY 2016	FY 2017
Domain 1: AHRQ Patient Safety Indicators			
PSI-90 (PSI-90 is a composite of eight PSI measures: PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax), PSI-7 (Central venous catheter related blood stream infections rate), PSI-8 (Postoperative hip fracture rate), PSI-12 (postoperative VE or DVT rate), PSI-13 (Postoperative sepsis rate), PSI-14 (Wound dehiscence rate), and PSI-15 (accidental puncture or Laceration)).	X	X	X
Domain 2: CDC HAI Measures			
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X
Surgical Site Infection (SSI):		X	X
◦ SSI Following Colon Surgery			
◦ SSI Following Abdominal Hysterectomy			
Methicillin-resistant Staphylococcus aureus (MRSA)			X
Clostridium difficile			X

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HAC Reduction Program (cont.)

PROPORTION OF HOSPITALS IN THE WORST PERFORMING QUANTILE (>75TH PERCENTILE) OF THE TOTAL HAC SCORE BY HOSPITAL CHARACTERISTIC AND BY SIMULATION WITH THE 35/65 WEIGHTING SCHEME

Hospital characteristics		Simulation with the 35/65 weighting scheme in worst performing quartile	
Characteristic	Number of hospitals Percent	Number of hospitals Percent	
Bed Size:			
<50	656 19.6	119 18.1	
50–99	680 20.4	181 26.6	
100–199	893 26.7	204 22.8	
200–299	512 15.3	133 26.0	
300–399	268 8.0	71 26.5	
400–499	125 3.7	37 29.6	
500+	205 6.1	75 36.6	
Teaching Status:			
Teaching	276 8.3	134 48.6	
NonTeaching	3,063 91.7	686 22.4	
Ownership:			
Non-Profit	2,026 60.7	511 25.2	
Government	558 16.7	148 26.5	
For-Profit	755 22.6	161 21.3	
Urbanicity:			
Urban	2,493 72.1	639 25.6	
Rural	965 27.9	201 20.8	
Disproportionate Share Percentage:			
Non-DSH	749 21.9	145 19.4	
DSH Quartile 1	658 19.3	149 22.6	
DSH Quartile 2	665 19.5	150 22.6	

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GME/IME Changes in the FY 2015 Final Rule – Urban and Rural Changes

- A. The Final rule provides a transition period for rural hospitals re-designated as urban, and for rural training track (RTT) programs:**
1. If a hospital was rural when it received a letter of accreditation and/or had begun training in a new program, *prior to re-designation as urban* by OMB it can continue to launch and grow the program and still receive a permanent cap adjustment; and,
 2. If an urban and a rural teaching hospital are participating in a RTT program but the rural hospital is re-designated as urban, the original urban hospital continues to be paid for the rural track for a transition period through the end of the second residency training year after the date of implementation of the re-designation

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GME/IME Changes in the FY 2015 Final Rule – Urban and Rural Changes

- B. To continue to be paid for the rural track beyond the transition one of two options are available:**
1. Either the former rural hospital (now urban) is reclassified as rural; or
 2. The urban hospital identifies a new rural hospital for the RTT program
- C. Due to the volume of applications and administrative burden, the final rule eliminates “cap relief” under Section 5506 awards of GME slots from closed hospitals; and**
- D. The Final rule also clarifies that the payment rules which apply to teaching hospitals for training in non-provider settings also apply to FQHCs and RHCs**

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Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

K. FY 2016 Operating Outlier Threshold

1. CMS proposes \$24,485 for FY 2016, as compared to \$24,758 in FY 2015 and \$21,748 in FY 2014;
2. CMS settled on a much lower threshold of \$22,544 for FY 2016;
3. Attributes change to between the FY 2016 proposed and final rule to lower measured charge inflation from updated claims data;
4. CMS indicates that actual outlier payments for FY 2013 equaled 4.86 % of MS-DRG payments, and for FY 2014 estimates that outlier payments will equal 5.38% of MS-DRG payments, as compared to the 5.1% target and payment reduction. CMS is projecting FY 2015 outlier payments at 4.65% of MS-DRG payments.

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Wage Index

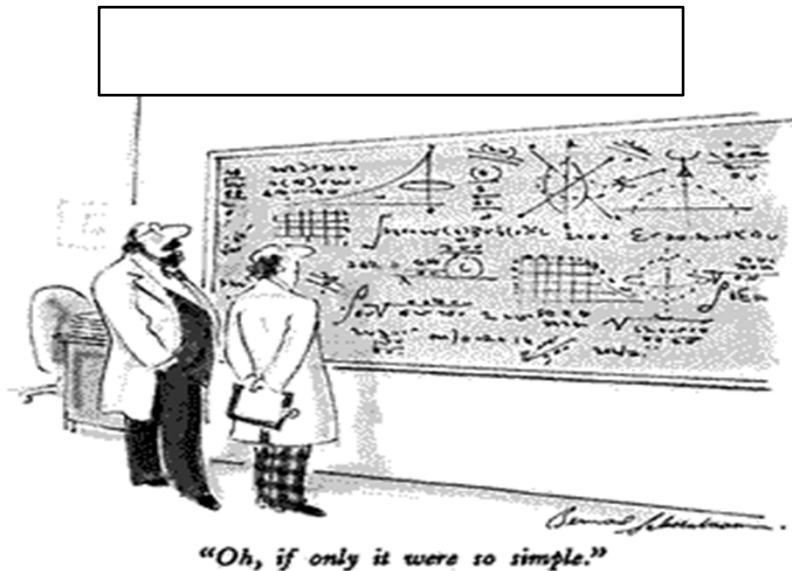
- New CBSAs adopted in FY 2015 based on 2010 census data
 - Expiration of Transitional Wage Indexes for FY 2016
 - Second year of Three-Year Hold Harmless for FY 2016 for Hospitals that went Urban to Rural
- New Out Migration Commuting Data for FY 2016
- Issues with application of rural floor in the Pricer for FY 2015
- FY 2016 MGCRB Reclassification: Hospitals should carefully review the decision issued by the MGCRB
- NRPM 2016 Wage Index Reclassification Tables
- Wage Index Timeline for FY 2017

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Proposed Elimination of Simplified Cost Allocation Method

- A. CMS proposes to eliminate the method asserting only 9 CAHs and 23 hospitals use it to prepare cost reports
- B. CMS asserts elimination necessary to:
 - 1) ensure payment accuracy, dependent in using dollar value as an allocation statistic for moveable equipment, CT, MRI and Radiology cost centers; and
 - 2) Hospital accounting systems are more sophisticated and can handle added complexity
- C. Actually about 1700 hospitals use the simplified method and most of those would struggle to use standard cost report allocation statistics

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MS-DRG Refinement

- A. CMS expresses concern with hospital use of non-standard cost center lines in preparing cost reports
- B. Use of non-standard lines is causing a mismatch in cost calculations for APCs
- C. CMS will continue to consider input on the 5 new CCRs, but is going ahead with using those 5 as part of the 19 revenue code categories used to calculate ancillary weights for FY 2016.

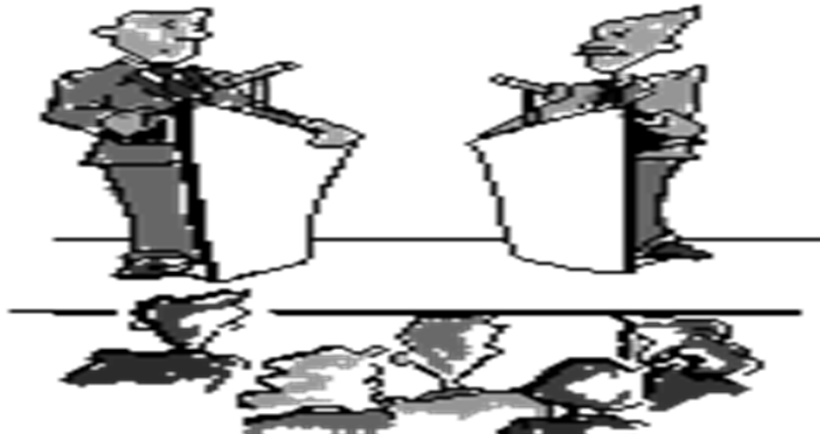
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Impact of SGR Pay-Fors on IPPS H.R. 2 Medicare Access and CHIP Reauthorization Act (MACRA) Proposed

- 1. Extends Low Volume Hospitals and MDH Programs until October 1, 2017 (Secs. 204 and 205);
- 2. Phases in FY 2018 IPPS 3.2% Increase over 6 Years at .5% per year, instead of all in FY 2018 (Sec. 414); and
- 3. Extends Two-Midnight Rule Probe and Educate until Sept. 31, 2015 (Sec. 521)

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Questions?



Thank you!

John Hellow
Hooper, Lundy and Bookman, PC
(310) 551-8155
jhellow@Health-Law.com