




Health Financial Systems User Meeting 2016

October 13-14, 2016
Denver, CO

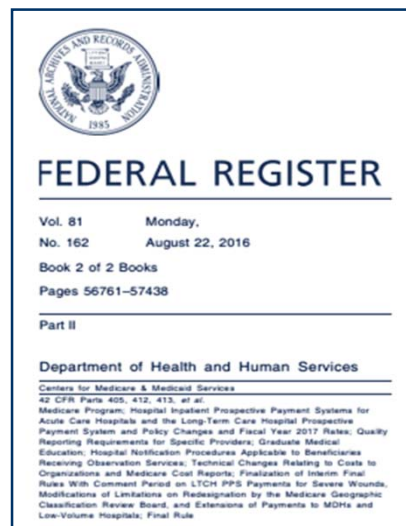
FY 2017 IPPS Legislative and Regulatory Update

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Basics IPPS Rates for FFYs 2016 and 2017

- A. FY16 Final Rule Issued on July 31, 2015 (print August 17, 2015)
- B. FY 17 Final Rule Issued August 2, 2016 (print August 22, 2016);
Correction Notice Issued on September 29, 2016 (print October 5, 2016)
- c. Highlights covered today:
 - 1. Inpatient payment update
 - 2. ATRA Adjustment/MACRA Restoration
 - 3. Two Midnight Payment Adjustment
 - 4. Hospital Dependent Adjustments
 - 5. Outlier Threshold
 - 6. Disproportionate Share (DSH) and UC-DSH
 - 7. Payment Consequences of Quality Metrics



Basics IPPS Rates for FFYs 2016 and 2017

| | FY 2016 IPPS Final Rule | FY 2017 IPPS Final Rule |
|--|----------------------------|-------------------------------|
| Market Basket | 2.4% | 2.7% |
| <u>ACA Reductions</u> | | |
| Market Basket | -0.2% | -0.75% |
| Productivity | -0.5% | -0.3% |
| Subtotal = Applicable Percentage Increase | 1.7% | 1.65% |
| ATRA Reduction (additive) | -0.8% | -1.5% |
| <u>TWO-MIDNIGHT ADJUSTMENT</u> | Continues | 0.8% (only 0.2% permanent) |
| <u>Total General Adjustment before Sequester</u> | 0.9% | 0.95% |

Note: This update does not include hospital-specific payment changes due to readmissions, value-based purchasing, hospital acquired conditions, meaningful use, etc.

Market Basket Updates

1. Latest market basket updates can be found on CMS website
2. CMS rebases the market basket and labor share every four years; last rebased for FY 2014 (next due FY 2018)
3. FY 2016 final rule uses an update of **2.4 percent**
4. FY 2017 update is **2.7 percent**
5. Quality reporting and meaningful use reductions to market basket rate will be discussed later.

ACA Productivity Cuts

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

| Fiscal Year | Cut |
|-------------|--------|
| 2012 | - 1.0% |
| 2013 | - 0.7% |
| 2014 | - 0.5% |
| 2015 | - 0.5% |
| 2016 | - 0.5% |
| 2017 | -0.3% |

Additional ACA-Mandated Reduction

- Market basket adjustment for FYs 2012 – 2019

| Fiscal Year | Cut |
|-------------|------|
| 2012 | .1% |
| 2013 | .1% |
| 2014 | .3% |
| 2015 | .2% |
| 2016 | .2% |
| 2017 | .75% |
| 2018 | .75% |
| 2019 | .75% |

- Similar, if not identical, market basket adjustments apply to long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospital services.

ATRA Recoupment and MACRA Restoration

A. ATRA imposes an aggregate estimated \$11 billion recoupment of asserted coding overpayments in FYs 2010-2012

1. Recoupment to take place over four years (FYs 2014 – 2017)
2. Secretary has discretion on timing and level of the recoupment
3. Adjustments are to be based on estimated discharges
4. CMS used a level 0.8% reduction per year, for FYs 2014 - 2016
5. CMS finalized a **-1.5% adjustment** to complete the recoupment in FY 2017.

B. MACRA Restoration

1. To generate savings to pay for the physician SGR fix, Congress prohibited CMS from restoring the aggregate ATRA adjustment to the IPPS rate in FY 2018.
2. Congress, anticipating a cumulative 3.2% ATRA adjustment through FY 2017 (4 X 0.8%), allows CMS to ramp up the IPPS rate by 0.5% per year between FYs 2018 and 2023 to restore part of the adjustment (3.0% total).
3. Unfortunately, CMS is now proposing an aggregate -3.9% ATRA adjustment, potentially leaving -0.9% permanent (3.9% - 3.0% = 0.9%).

Two Midnight Policy and Payment Reduction

A. Original two-midnight policy FYs 2014 and 2015

1. CMS will generally consider hospital admissions spanning two midnights as appropriate for inpatient Part A payment
2. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity
3. CMS imposed a -0.2% payment reduction under the assumption the policy would increase claims inpatient stays

B. Modifications to the two-midnight policy CY 2016

1. CY 2016 outpatient PPS final rule
2. Stays less than two midnights may be appropriate for inpatient admission based on “the clinical judgement of the admitting physician and medical record support for that determination.”

C. Litigation Update

1. District Court orders CMS to publish explanation of assumption that inpatient stays would increase under policy and to consider comments in response thereto
2. As part of FY 2017 IPPS final rule CMS provides a permanent 0.2% adjustment and restores prior period adjustments by providing additional increase of 0.6% only in FY 2017, for an aggregate increase of 0.8% in FY 2017

Hospital-Dependent Adjustments for FY 2017

| FY 2017 | Hospital Submitted Quality Data and is a Meaningful EHR User | Hospital Submitted Quality Data and is NOT a Meaningful EHR User | Hospital did NOT Submit Quality Data and is a Meaningful EHR User | Hospital did NOT Submit Quality Data and is NOT a Meaningful EHR User |
|---|--|--|---|---|
| Market Basket Increase | 2.7 | 2.7 | 2.7 | 2.7 |
| Adjustment for Failure to Submit Quality Data | 0.0 | 0.0 | -0.675 | -0.675 |
| Adjustment for Failure to be a Meaningful EHR User | 0.0 | -2.025 | 0.0 | -2.025 |
| MFP Adjustment | -0.3 | -0.3 | -0.3 | -0.3 |
| Statutory Adjustment SSA section 1886(b)(3)(B)(xii) | -0.75 | -0.75 | -0.75 | -0.75 |
| Applicable % Increase Applied to Standardized Amounts | 1.65 | -0.375 | 0.975 | -1.05 |

Outlier Payment Adjustment

A. FY 2016

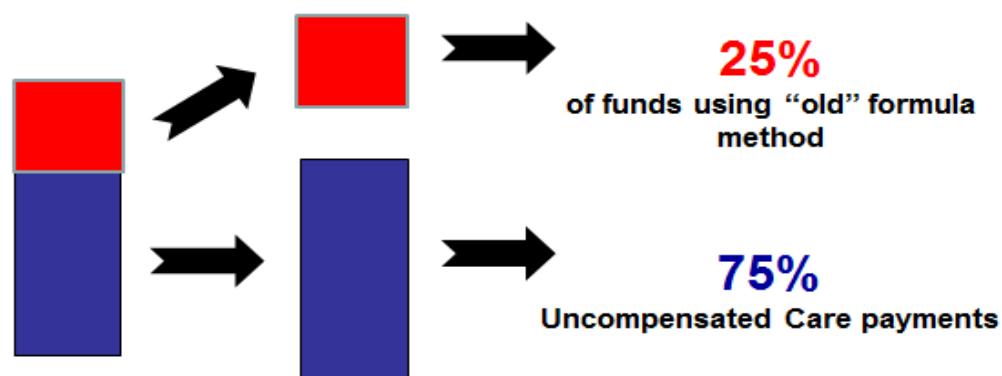
1. CMS proposed a \$24,485 threshold for FY 2016 (as compared to \$24,758 in FY 15 and \$21,748 in FY 14)
2. CMS finalized a much lower threshold of \$22,544 for FY 2016
3. Attributes change between the FY 2016 proposed and final rule to lower measured charge inflation from updated claims data
4. CMS indicates that actual outlier payments for FY 2013 equaled 4.86% of MS-DRG payments, and estimates that FY 2014 will equal 5.38% of MS-DRG payments (as compared to the 5.1% target and payment reduction). CMS now estimates FY 2015 outlier payments at 4.68% of MS-DRG payments.

B. FY 2017

1. CMS proposes a \$23,681 threshold for FY 2017, and finalizes a \$23,573 threshold (in Correction Notice).
2. CMS now estimates FY 2016 outlier payments at 5.3% of MS-DRG payments.

DSH and UC-DSH Payment Policy

- ACA changed Medicare DSH payments starting in FY 2014
 - Statute appears as new 42 U.S.C. § 1395ww(r)
 - CMS adds new 42 C.F.R. § 412.106(f)-(h) effective with discharges on and after 10/1/13



- Total Uncompensated Care fund pool reduced as uninsured rate declines; hospital share of fund pool based on the relative uncompensated care each DSH Hospital provides relative to all DSH hospitals, but CMS uses a proxy for uncompensated care costs.

UC – DSH Basics

- Affected Hospitals
 - 2440 Hospitals, including Puerto Rico
 - Excluding Maryland and CAHs
 - Sole Community Hospitals – consider all DSH when assessing eligibility for a hospital specific rate
- Total Uncompensated Care payments subject to three factors:
 - **One** – Estimate 75% of traditional DSH payments and reduce traditional DSH payments to hospitals by that amount
 - **Two** – Establish Uncompensated Care DSH Fund by taking 75% of Estimated traditional DSH payments reduced by improvement in insured rates + an additional statutory factor (0.2 percentage points for FYs16 and 17)
 - **Three** – Distribute Uncompensated Care DSH Fund based on the ratio of each hospital's 3 year average of Medicaid and SSI days to all DSH hospitals' Medicaid and SSI days using at least through FY 2017. CMS is investigating an alternate proxy and a transition to uncompensated care costs from W/S S-10 before FY 2021.

UC- DSH Factor One Calculation

- A. Initial size of the 75 percent aggregate uncompensated care payments
- B. Difference between CMS estimates of
 - 1. The amount of DSH payments that would be made to all hospitals in the absence of the ACA payment provision; and
 - 2. The amount of the empirically justified Medicare DSH payments actually made in that year
- C. 75 percent of DSH payments that would be made to all hospitals in the absence of the ACA payment provision.
- D. Set *prospectively*
- E. FY 2016 Factor One amount is \$10.058 billion
 - 1. \$10.037 billion in FY 2015
 - 2. \$9.579 billion in FY 2014
- F. Final FY 2017 Factor One amount is \$10.797 billion, proposed was \$10.671 billion.

Factor Two Calculation for Final FY 2016

- A. Change in the percentage of uninsured from 2013 baseline of 18%
- B. Congressional Budget Office (CBO) data
 - 1. March 2015 estimate of the effects of the ACA on health insurance coverage – estimate of individuals under the age of 65 with insurance in CY 2015 is 87 percent (rate of uninsurance is 13%)
 - 2. Estimate of individuals under the age of 65 with insurance in CY 2016 is 89 percent (rate of uninsurance is 11 percent)
 - 3. These figures are then weighted to determine the rate of uninsurance for FY 2016
 - 4. Percent change from 2013 uninsurance rate minus an additional statutory factor (0.2 percentage points or .002)
 - 5. FY 2016 Factor two is equal to 0.6369
- C. As a result, CMS retained 63.69 percent – or \$6.406 billion – of the original aggregate uncompensated care payments (75-percent) in FY 2016
- D. This amounts to a reduction of approximately \$1.2 billion in Medicare DSH payments in FY 2016 compared to FY 2015

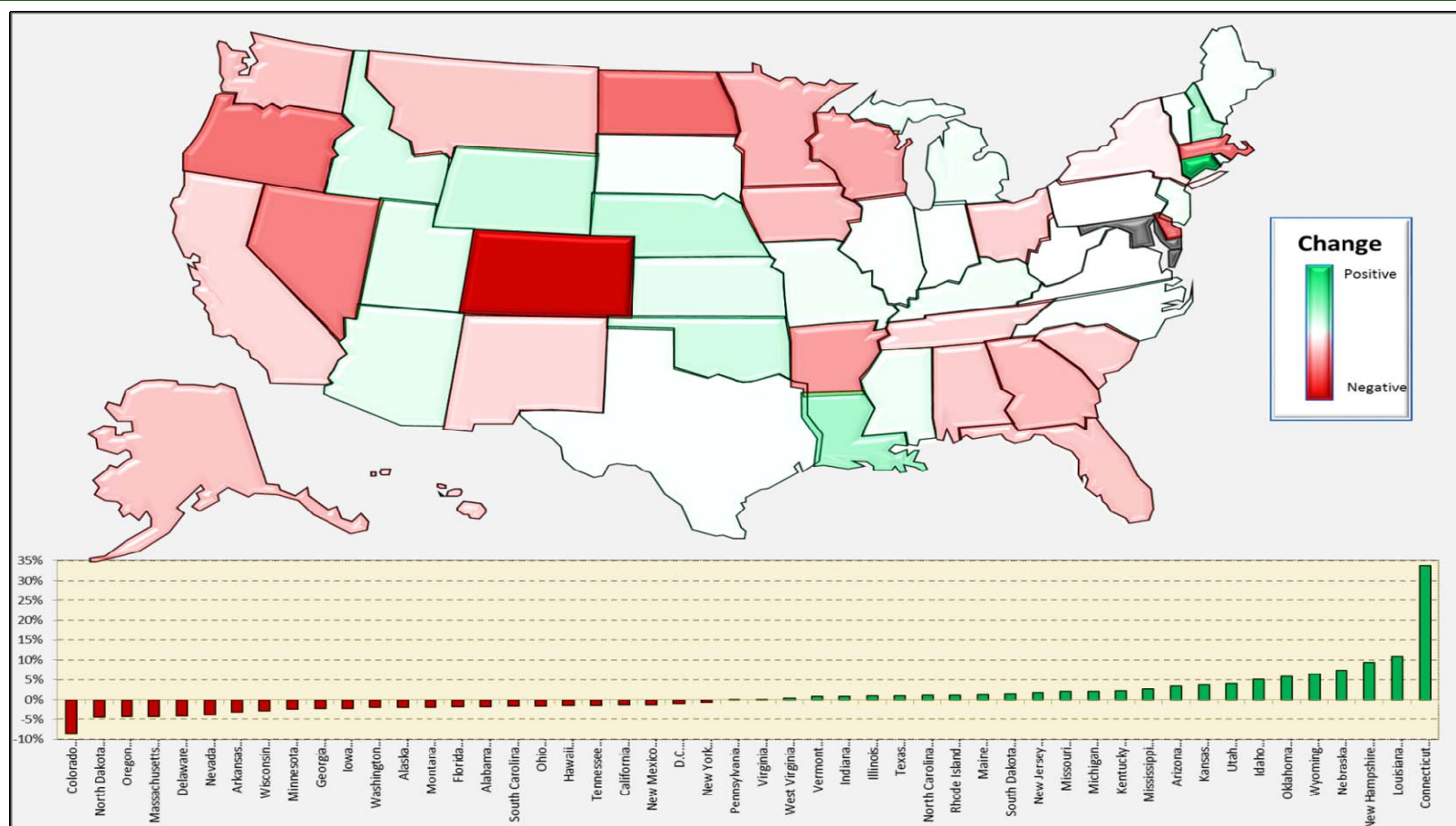
Factor Two Calculation for FY 2017

- A. Change in the percentage of uninsured from 2013 baseline of 18%
- B. Congressional Budget Office (CBO) data
 - 1. Estimate of individuals under the age of 65 with insurance in CY 2016 is 89 percent (un-insurance rate of 11 percent)
 - 2. Estimate of individuals under the age of 65 with insurance in CY 2017 is 90 percent (un-insurance rate of 10 percent)
 - 3. These figures are then weighted to determine the un-insurance rate for FY 2017
 - 4. Percent change from 2013 un-insurance rate minus an additional statutory factor (0.2 percentage points or .002)
 - 5. Proposed FY 2017 Factor Two is equal to 0.5536
- C. As a result, CMS retains 55.36 percent – or \$5.977 billion – of the original aggregate uncompensated care payments (75-percent) in FY 2017
- D. This amounts to a reduction of approximately \$400 million in Medicare DSH payments in FY 2017 compared to FY 2016

Factor Three Calculation for FYs 2016 and 2017

- A. Premised on Hospitals' uncompensated care costs
- B. Allocates Factor Two pool based on relative uncompensated care costs
- C. Proportion of each hospital's measure to aggregate hospitals' total measure for all DSH eligible hospitals:
 - 1. CMS continues to use inpatient days of Medicaid beneficiaries plus inpatient days of Medicare supplemental security income (Medicare SSI) beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides
 - 2. For FY 2016 CMS used March 2015 update of the 2011/2012 Medicare cost reports for the Medicaid days and the FY 2013 SSI ratios for the Medicare SSI days
 - 3. For FY 2017 CMS is using a 3 year average for Medicaid and Medicare with SSI days (Puerto Rico hospitals would receive a proxy for this factor) from March 2016 update for FYs 2011-13 (but is not annualizing partial periods) and the FY 2014 SSI ratios for the Medicare SSI days
 - 4. CMS has published on its website, a table listing Factor Three for all IPPS hospitals it estimates would receive uncompensated care payments

DSH: Effect of Three-Year Averaging of Factor Three vs. FY 2016 Single Year



FY 2017 IPPS Proposed Rule Methodology for FY 2018 Factor Three: Moving to W/S S-10

- A. As part of the FY 2017 IPPS proposed rule, CMS proposed to begin using W/S S-10 data in FY 2018, as the first step in a transition to full use of such data by FY 2020.
1. For FY 2018, CMS would calculate Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from FY 2012 and FY 2013 cost reports and FY 2014 and FY 2015 SSI ratios, and Factor 3 calculated using uncompensated care data based on FY 2014 Worksheet S-10.
 2. For FY 2019, CMS would calculate Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from the FY 2013 cost report and the FY 2015 SSI ratios, and Factor 3 calculated using uncompensated care data based Worksheet S-10 from the FYs 2014 and 2015 cost reports.
 3. For FY 2020, CMS would calculate Factor 3 using uncompensated care data based on Worksheet S-10 data from FYs 2014, 2015 and 2016 cost reports.
 4. After 2020, CMS would advance the 3-year time period by 1 year to determine the cost reports used.
 5. Data is still unaudited and CMS proposed only one concrete edit of the data, a double trim of hospital CCRs that exceed by 3 standard deviations the mean CCR, and the assignment of a statewide average CCR to such hospitals. 27 hospitals would have been subject to these trims.

FY 2017 IPPS Proposed Rule Methodology for FY 2018 Factor Three: Moving to W/S S-10, cont'd

B. FY 2017 IPPS Final Rule – CMS Abandons Proposed Rule W/S S-10 Transition in FY 2018

1. A strong majority of the hospital industry opposed the W/S S-10 transition
 - The data is unaudited
 - Hospitals reported data inconsistently
 - W/S instructions are ambiguous
2. CMS committed to moving to W/S S-10 data before FY 2021
3. CMS committed to developing a better proxy before W/S S-10 implementation and may do so in FY 2018 rulemaking
4. CMS indicates a future rulemaking will implement modifications to W/S S-10
5. Another Administration may move to W/S S-10 more quickly than expected

FY 2017 Final Rule UC-DSH Changes

C. Timing of reporting charity care and non-Medicare bad debt:

1. CMS revises Worksheet S-10 cost report instructions for Line 20 concerning the timing of reporting charity care, such that charity care will be reported based on date of write-off, and not based on date of service (See CMS Pub. 15-2, Chapter 40, Section 4012)
2. This is consistent with charity write-offs that hospitals report in accordance with GAAP
3. Hospitals currently report non-Medicare bad debt without regard when the services were provided
4. CMS advised contractors to allow W/S S-10 amendments to the FY 2014 reported data to accommodate this change and other corrections hospitals may offer, so long as received by Sept. 20, 2016

Example: California DSH Breakout

Estimated Impacts of CMS' Proposals Related to Distribution of the DSH Uncompensated Care Pool

| | Est. UCC Revenue | Est. Total Revenue | Impact (\$) | Impact (%) |
|---|------------------|--------------------|-----------------------|---------------|
| FFY 2017 Calculation Maintained at Single Year of Data (Current) | \$767,106,300 | \$10,887,038,200 | | |
| FFY 2017 Calculation Based on Proposed Three Year Data Average | \$756,857,200 | \$10,876,832,300 | (\$10,205,900) | -0.09% |

- CMS is proposing to utilize Medicaid Days from FFY 2011, 2012, and 2013 Medicare Cost Reports; and Medicare SSI Days from FFYs 2012, 2013, and 2014 in the calculation of the FFY 2017 DSH UCC distribution factors. As FFY 2014 Medicare SSI Days are not yet available, the proposed rule uses FFY 2013 as a proxy. The "Single Year" calculation is based a sum of FFY 2013 Medicaid Days and FFY 2013 Medicare SSI Days.

| CCR Methodology | Transition Year | Factor 3 Data Mix | Est. UCC Revenue | Est. Total Revenue | Impact (\$) vs Current Proxy Distribution | Impact (%) |
|---|-----------------|-------------------|------------------|--------------------|---|---------------|
| FFY 2014 S-10 Using Current CCR Calculation | 1st | 2 Proxy, 1 S-10 | \$617,744,600 | \$10,738,030,000 | (\$149,008,200) | -1.37% |
| | 2nd | 1 Proxy, 2 S-10 | \$481,605,900 | \$10,602,186,500 | (\$284,851,700) | -2.62% |
| | 3rd | 3 S-10 | \$338,855,700 | \$10,459,760,400 | (\$427,277,800) | -3.92% |
| FFY 2014 S-10 After Applying Proposed Double-Trim Methodology to Hospital CCR | 1st | 2 Proxy, 1 S-10 | \$598,473,100 | \$10,718,741,300 | (\$168,296,900) | -1.55% |
| | 2nd | 1 Proxy, 2 S-10 | \$443,062,800 | \$10,563,609,200 | (\$323,429,000) | -2.97% |
| | 3rd | 3 S-10 | \$281,041,000 | \$10,401,892,400 | (\$485,145,800) | -4.46% |

Problems with the Reliable Use of W/S S-10

- Many errors obvious in filed S-10 data that strongly suggest data is unreliable as a basis to determine relative share of uncompensated care costs
 - Many hospitals did not report S-10 data at all, about 5%
 - 14% had no total bad debt data, but 90% of that group reported Medicare bad debt data
 - Some had a CCR of 1, many had CCRs above .6, a few had more gross charges on S-10 than on C
 - Some reported unreimbursed costs of Medicaid as uncompensated care.
- Definitional problems
 - Uninsured vs. Charity – non-means tested uninsured discounts, or discounted care that is not charity care likely not included in charity
 - Charity must be determined during the cost reporting period
 - Medicaid and indigent programs' non-covered charges must be addressed in charity policy or excluded
- Converting charges to cost
 - Problem particularly acute with bad debt
 - 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?

Payment Formula for Value Based Purchasing and Readmissions

What is the “base operating DRG amount” subject to reduction?

- No changes to the penalty formula in FY 2016 or 2017
- Excludes Indirect Medical Education (IME), DSH, outliers, low-volume adjustment, and additional payments made due to status as an Sole Community Hospital (SCH), but
- Includes new technology payments, and will be,
- Adjusted to account for transfer cases, and then equals,
- $((\text{Labor Share} * \text{Wage Index}) + (\text{Non Labor Share} * \text{COLA}) * \text{DRG Weight}) + \text{New Technology Add On Payment}) * (\text{Adjustment Factor}-1)$

Hospital Value-Based Purchasing Program

- ACA-mandated; applies to discharges on and after 10/1/2012
- 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**
- Budget neutral – all funds withheld are redistributed as incentive payments to applicable hospitals
- The available pool for FY 2016 was estimated to be \$1.5 billion and increases to \$1.7 billion for FY 2017
- Other details
 - CMS increases from two to three the number of surveys for which a hospital must be cited for immediate jeopardy before its exclusion from the VBP Program. A hospital must be cited on Form CMS-2567, Statement of Deficiencies and Plan of Correction, for immediate jeopardy on at least three surveys during the performance period in order to meet the standard for exclusion from the VBP Program.

Hospital Readmissions Reduction Program (HRRP)

- ACA-mandated and assesses penalties on hospitals for having “excess” readmission rates when compared to expected rates
- Maximum penalty topped out at 3.0 percent of Medicare base operating payments in FY 2015, and **remains at 3.0 percent in FY 2016 and thereafter**
- Congress is considering legislation to require CMS to consider socio economic demographic data in the risk adjustment.

Hospital Readmissions Reduction Program

Data from HRRP – 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 |

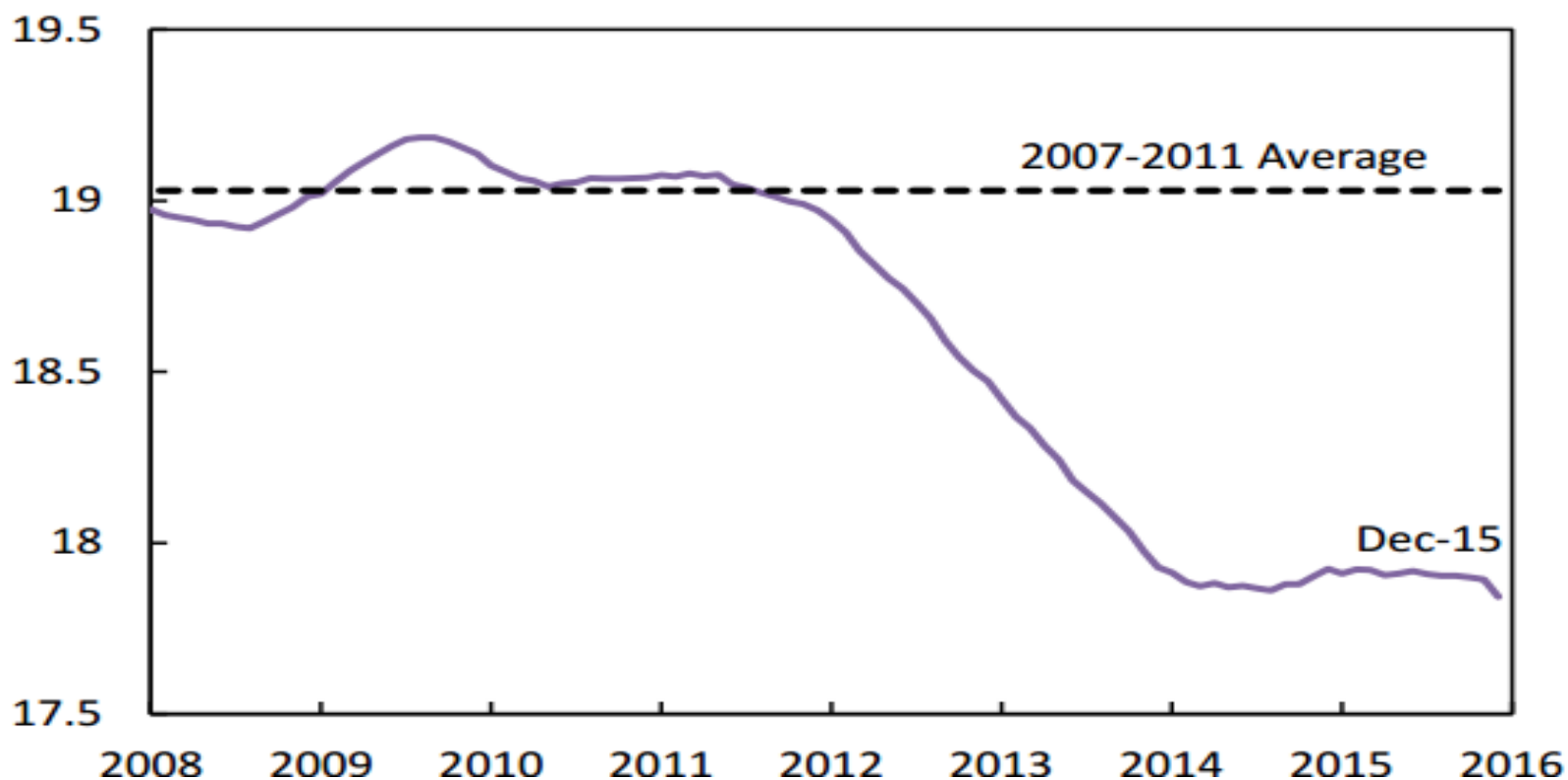
NOTES: Penalties are applied to each hospital in the fiscal year shown, based on its performance during a preceding 3-year measurement period, also shown. Analysis excludes hospitals not subject to HRRP, such as Maryland hospitals and other hospitals not paid under the Medicare Hospital Inpatient Prospective 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.

Hospital Readmissions Reduction Program Economic Report of the President 2014

Medicare 30-Day, All-Condition Hospital Readmission Rate

Percent, 12-month moving average



HAC Reduction Program

- A. Hospital-Acquired Condition Reduction Program (HACRP) is an ACA-mandated program that imposes a **1 percent** reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates
- B. Therefore, for discharges on and after Oct. 1, 2014, hospitals in top quartile of risk adjusted HAC measures receive only 99% of total PPS payments
- C. Adjustment is applied after VBP and HRRP adjustments

Impact of Medicare Access and CHIP Reauthorization Act on Inpatient PPS

Extends enhanced low volume hospital payments and the Medicare-dependent Hospital program until October 1, 2017.

Questions



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