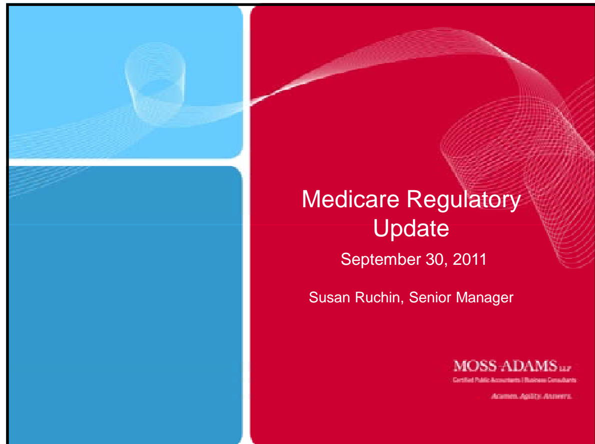

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TODAY'S TOPICS

- MS-DRG Updates
- Low Volume Adjustments
- Low Per Capita Counties
- Medicare Cost Per Beneficiary - 2014
- Readmissions - 2013
- Disproportionate Share
- Uncompensated Care
- Occupational Mix
- Physician Supervision
- Three Day Bundling Rule Changes
- Outpatient PPS
- EHR Implementation (Stage 2 Delay)

DRG PAYMENT RATES – WAGE INDEX > 1.0000

	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

	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 MS-DRG RATES WITH WAGE INDEX > 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

IPPS UPDATE FACTORS – FFY 9/30

	2011	Final 2012	Proposed 2013	Proposed 2014	Proposed 2015	Proposed 2016
Market Basket (MB)	2.4%	3.0%	3.0%	3.0%	3.0%	3.0%
ACA MB Adjustments	-0.25%	-0.1%	-0.1%	-0.3%	-0.2%	-0.2%
ACA Reduction - Productivity	N/A	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%
MS-DRG Adj						
'08-09 Recoupment	-2.9%	0.0%	2.9%	N/A	N/A	N/A
Prospective Reduction	N/A	-2.0%	-1.9%	N/A	N/A	N/A
Cape Cod Decision of 1.1% and other adj		1.2%				
Net Update	-0.9%	1.1%	2.9%	1.7%	1.8%	1.8%

One Plausible Scenario

SOLE COMMUNITY HOSPITALS

- .9% update to SCH rate
  - Check CMS PUF file for new rate
- TOPs extended to SCH's regardless of number of beds for services through 12/31/2011
  - Proposed 2012 OPPS Rule – TOPs expires on 12/31/11
- 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 RATIO COST TO CHARGE – 2009 COST REPORTS

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.

Estimated Impact of FY 2012 IPPS Final Rule
Weighted Average Basic Payment Changes, FY12 vs. FY11

Medical vs. Surgical
Overall
Medical
Surgical

Service Line

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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 and are to include:
    - Medicare FFS and Medicare Advantage discharges
    - Discharges for eligible Part A patients who exhausted inpatient benefits or stay not covered by Medicare
  - Add-on also available to SCHs and MDHs

LOW VOLUME ADJUSTMENT

- Max of 25% “add-on” to standardized amount
- Hospitals must submit application for FFY 2012 by 9/1/11 (even if applied for FFY 2011)
  - Hope all eligible applications were submitted!
- Published % based on 12/2010 update of FY 10 MedPAR data

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 s/h received their 2011 payments by now
    - Means you know who you are!
  - Payments are 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
  - We can send your estimated 2012 pmt amount to you if you'd like

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**

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

HOSPITAL READMISSION REDUCTION PROGRAM - 2013

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

HOSPITAL READMISSION REDUCTION PROGRAM - 2013

- Risk Adjustment to level the playing field
- Using 3 years of data to calculate excess re-admission ratios
  - o 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

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

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

DISPROPORTIONATE SHARE

- Hospital specific SSI data file
  - Will share "certain detailed SSI fraction data used to calculate the hospital's SSI fraction as long as hospital has a valid data use agreement with CMS and submits a request for such data"
  - More detail about the data located at:
    - www.cms.gov/PrivProtectedData/07_DSHRateData.asp

DISPROPORTIONATE SHARE

Timeline to Calculate FY 2011 SSI Fractions

CR using FY 2011 SSI Ratios	Deadline for Timely Filing of Claims	MedPAR Data File Used	SSI Entitlement File	CR Normally Accepted	CR Final Settlement	SSI Fraction Available
CR beginning Oct 1, 2010 thru Sept 30, 2011	Sept 2012	Dec 2012 update of FY 2011 MedPAR	Dec 2012 update of FY 2011 SSI eligibility	Generally; between Mar 2012 and Feb 2013	Generally; between Mar 2013 and Feb 2014	Spring 2013

DISPROPORTIONATE SHARE

- Future Medicare DSH reduction to 25% of current level
  - By 2014, about 75% reduction to DSH pmts
  - 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

WORKSHEET S-10 UNCOMPENSATED CARE

- CMS 2552-10 cost report forms – required reporting of uncompensated care costs for hospital organization
  - NEW for Critical Access Hospitals
  - Work closely with preparer to ensure all information on worksheet is prepared accurately
  - Complex reporting requirements with uncompensated care for dates of service during fiscal year not write off date

OCCUPATIONAL MIX – FOR 2012 WAGE INDICES

- CMS data on National AHW of occupational mix categories, as used in FFY 2012 rule
- From 2007/2008 survey

Occ Mix Nsg Category	Avg Hourly Wage
RN Mgmt	Not included
RN Staff	$36.075785685
LPN/Surg Tech	$20.860811964
Nurse Aides, Orderlies, Attendants	$14.619464256
Med Assistants	$16.443954736
National Rate - Entire Nursing Category	$30.463606009

OCCUPATIONAL MIX – 2010 SURVEY

- Survey impacts average hourly rates – the higher the RN wages to total nursing wages, the greater negative impact on hospital's avg hourly rate
- Purpose is to control for hospital's choices of employment categories to provide nursing care
- Will be used in FFY 2013 wage index
- Estimated completion time was 480 hours!

OCCUPATIONAL MIX – 2010 SURVEY

- Unaudited data to be 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

- The survey:
  - Includes FT, PT, directly hired and contract personnel
  - Includes employees allocated from the home office, if applicable
  - 'Should' mirror job codes reported by hospitals on Worksheet S-3 Part II of the Medicare cost report
  - Excludes compensation and overhead relating to areas excluded under IPPS (i.e. psych, rehab, SNF, etc.)
  - Excludes physician Part B and interns and residents

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

OCCUPATIONAL MIX SURVEY – IMPACT

State	AHW (unadjusted)	AHW (adjusted for Occ. Mix)	$ Change	Impact
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 – GEO RECLASSIFICATIONS

- Geographic reclassifications for wage index purposes were due 9/1/11
  - Effective for FFY 2013 (10/1/12 – 9/30/13)
  - 659 hospitals in reclass status for FFY 2012 (10/1/11 - 9/30/12)
  - Section 508 reclassifications expire on 9/30/11

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
  - Likely to be part of this fall'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

CMS DEFINITIONS – SUPERVISION IN HOSPITAL OPPS SETTING

- Direct Supervision
  - Physician or non-physician practitioner must be present in off-campus provider-based dept. but doesn't have to be present during procedure
    - Supervision level in on campus hospital outpatient departments was "historically assumed"
    - "Assumed" does not mean no supervision necessary
  - CMS deems direct supervision to be "default level"
  - CMS will evaluate if more appropriate level (general or personal) s/apply to specific services
    - Evaluation done at request of stakeholder or CMS

OTHER SUPERVISION LEVELS

- General Supervision
  - Applies to non-surgical extended duration services
    - Direct supervision required during initiation period, followed by general supervision for duration of service
- Personal Supervision
  - Physician physically present in room when service is performed

NON-PHYSICIAN SUPERVISION

- Nonphysician practitioners may directly supervise outpatient therapeutic services
  - If service is one they can perform w/in their State scope of practice and hospital-granted privileges
  - Cannot supervise pulmonary and cardiac rehab services
    - Only MD and DO can supervise

PHYSICIAN SUPERVISION – CAH/SCH/RURAL

- CMS will <u>not</u> enforce supervision requirements for outpatient therapeutic services in CAHs for CY 2011
  - SCH/Rural hospitals under 100 beds also exempt from supervision requirements
- *Extended non-enforcement thru CY 2012*

BUNDLING OF PAYMENTS

- Services provided to outpatients who later are admitted as an inpatient: Three Day Window
- One day window applies to:
  - Psych and rehab hospitals and units
  - LTC hospitals
  - Children's hospitals
  - Cancer hospitals

BUNDLED PAYMENTS

- Include diagnostic, clinical diagnostic lab tests or other services related to the admission furnished by the hospital (or by an entity that is wholly owned OR operated by a hospital).

- Only exception if services do not pertain to the inpatient admission; hospital must attest that specific non-diagnostic services are unrelated to inpatient claim – condition code 51

BUNDLED PAYMENTS – PROPOSED PHYSICIAN FEE SCHEDULE RULE FOR CY 2012

- When a hospital wholly owned or operated physician practice furnishes preadmission diagnostic and nondiagnostic services that are clinically related to inpatient admission, clinic would be paid at lower facility rate which excludes:
  - Overhead, Staff, equipment and supplies performed in the physician office.

OUTPATIENT PPS CONVERSION RATES

- Final 2011 Conversion Factor of $68.267
- Proposed 2012 Conversion Factor of $69.420
- Proposed 2012 Conversion Factor of $68.052 *if failed to report quality measures*
- Overall proposed payment update increase is 0.9%

PROPOSED OUTPATIENT PPS

- Current 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
- Proposed 2012 outlier threshold is $2,100

CY 2012 CANCER HOSPITAL PMT ADJUST

Provider Number	Name	% Increase, w/o TOPs and Outlier Pmts
050146	City of Hope Helford Clinical Research Hosp	10.10%
050660	USC Kenneth Norris Jr Cancer Hospital	15.70%
100079	University of Miami Hospital & Clinic	27.60%
100271	H Lee Moffitt Cancer Center & RI	21.60%
220162	Dana-Farber Cancer Institute	54.40%
330154	Memorial Hospital for Cancer/Allied Dis	39.40%
330354	Roswell Park Cancer Institute	24.30%
360242	James Cancer Hospital & Solove RI	30.10%
390196	Hospital of the Fox Chase Cancer Center	15.30%
450076	U of Texas M.D. Anderson Cancer Center	61.80%
500138	Seattle Cancer Care Alliance	43.70%

OUTPUTPATIENT 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%

PROPOSED 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

PROPOSED 2012 OUTPATIENT PPS

- Implantable devices cost center (in cost report)
  - Cost center available on/after 4/30/10 YE cost reports
    - Only 437 hospitals out of 3,500 used this cost center
    - CMS determined not sufficient data to establish separate RCC for implantable devices in 2012 OPPS rule
  - To be reassessed in CY 2013 OPPS Rules
- Be sure to use the CMS designated lines whenever possible for future pmt calculations
  - Cardiac cath, MRI, and CT

MEANINGFUL USE

- Meaningful Use requirements:
  - Use a *certified EHR in a meaningful way*
  - Use an EHR that can *exchange information with other systems electronically*
  - Submit reports to CMS that include *performance measures proving meaningful use*
- Meaningful Use occurs in three stages (so far):
  - Stage 1:Data capture and reporting/sharing
  - Stage 2: Use of Health IT for Quality Improvement at the point of care & exchange
  - Stage 3: Improved Outcomes – Quality, Safety & Efficiency

Stage 1 commenced in FFY2011

MEANINGFUL USE – STAGE 2 DELAY

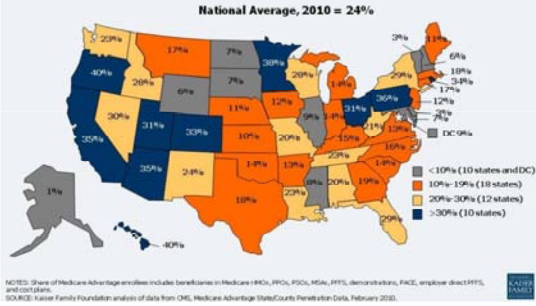
- HIT Policy Committee voted June 8, 2011 to recommend a 1-year delay in Stage 2 Meaningful Use requirements
- Vote included not only issue of timing but also some of the specific requirements incorporated into Stage 2
- While this allows for breathing room for implemented providers, those in the process of 'implementing' should not delay any longer than necessary

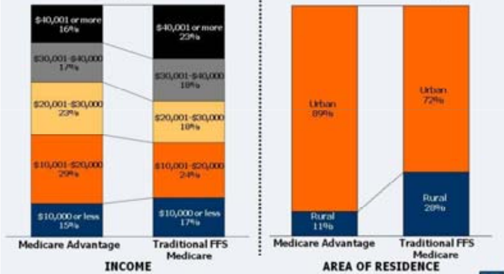
STAGE OF MEANINGFUL USE REQUIREMENTS

Implementation Year	Payment Year 2011	Payment Year 2012	Payment Year 2013	Payment Year 2014	Payment Year 2015
2011	Stage 1	Stage 1	Stage 2**	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1^^	Stage 3
2015					Stage 3

** Delay will only directly affect EPs and EHs that qualified for the incentives in 2011

^^ 2014 implementation creates greatest leap in implementation from Stages 1 to 3.





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