Medicare Regulatory Update for Hospitals

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Acumen. Agility. Answers.

PRESENTERS

Peggi Ann Amstutz, Senior Manager | Moss Adams LLP

Peggi Ann has been in the health care industry since 1986. Her focus is providing leadership to projects, developing and presenting seminars from basic coding to compliance, as well as coding compliance audits. Peggi Ann has an extensive background in program and policy development, with a proven ability to interpret Federal and state rules and regulations in a compliant manner. She has hands-on experience in managing daily clinic operations, provider scheduling, ER coverage, EMR functionality, preparing and monitoring annual revenue and expense budgets, and planning and implementing quality improvement initiatives. She also possesses an excellent understanding of CMS reimbursement methodologies, compliance standards, and HIPAA. Peggi Ann is an AHIMA Approved ICD10-CM/PCS Trainer.

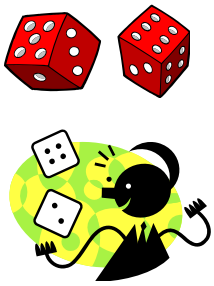
Susan Ruchin, Senior Manager | Moss Adams LLP

Susan has been in the health care industry for over 25 years, including 10 years working for a Medicare fiscal intermediary in the supervision and audit of large health care chain organizations. She also has six years of experience in hospital settings, where she was responsible for all phases of reimbursement, including Medicare cost report preparation and appeals with the Provider Reimbursement Review Board. She also prepares and reviews Medicare cost reports and provides audit support to hospitals, skilled nursing facilities, and federally qualified health clinics during Medicare and Medicaid audits.

TOPICS

- IPPS Updates, FFY 2014
- DSH/Uncompensated Care
- Inpatient Admissions
- Readmission Reduction Program
- Value-Based Purchasing Program
- Hospital Acquired Conditions
- OPPS proposed 2014

GOVERNMENT SHUTDOWN



DRG PAYMENT RATES: WAGE INDEX > 1.0000

	FFY 2014 Final (8/19/13 FR)	FFY 2013 Final (8/31/12 FR)
Labor-Related	$3,737.71	$3,679.95
Non-Labor	1,632.57	1,668.81
Capital	429.31	425.49
Total Payment Rate	$5,799.59	$5,774.25

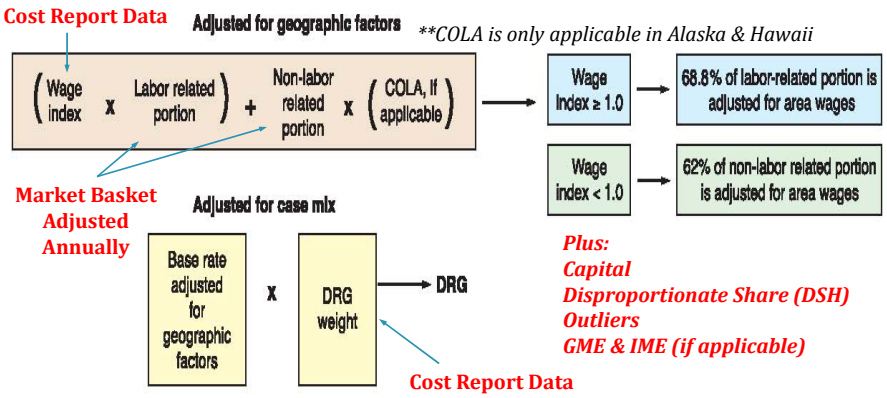
DRG PAYMENT RATES: WAGE INDEX <1.0000

	FFY 2014 Final (8/19/13 FR)	FFY 2013 Final (8/31/12 FR)
Labor-Related	$3,329.57	$3,316.23
Non-Labor	2,040.71	2,032.53
Capital	429.31	425.49
Total Payment Rate	$5,799.59	$5,774.25

LABOR/NON-LABOR DRG RATES: WAGE INDEX > 1.000

Description (for FFY 2014-Eff 10/01/13)	Labor	Non-Labor
FY2013 Base Rate	$4,176.63	$1,824.27
FY2014 Update Factor	1.017	1.017
FY2014 MS-DRG Recalibration & Wage Index Budget Neutrality Factor (BNF)	0.997936	0.997936
FY2014 Reclassification 'BNF'	0.990718	0.990718
FY2014 Outlier Factor	0.948995	0.948995
FY2014 Rural Demonstration 'BNF'	0.999415	0.999415
Adj to offset cost on Admission/Medical Review Criteria for Pt A IP svcs (new)	.998	.998
Cumulative Doc & Coding Adj	0.9403	0.9403
National Standardized Amount FY2013 DRG Payment Rate	$3,737.71	$1,632.57

ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM



NATIONAL AVERAGE CCRS*

Cost Center	WS C New CR Line #s	Revenue Codes	FY2014 Final (15) CCRs	FY2014 Final (19) CCRs
Routine Services	30	10x, 11x, 12x, 13x, 15x, 16x-19x	.514	.500
Intensive Care/ Coronary Care	31-35	20x, 21x	.442	.414
Drugs	64, 73	25x, 26x, 63x	.199	.193
Supplies & Equipment	71, 96, 97	270-274, 26x, 290-299, 624	*.335*	*.300*
Therapy Services	66-68	42x, 43x, 44x, 47x	.370	.356
Laboratory	60, 61, 70	30x, 31x, 74x, 75x, 86x	.143	.134
Operating Room	50, 51	36x, 71x, 72x	.238	.221
Cardiology	69	48x, 73x	*.145*	*.130*
Radiology	54-56	32x-35x, 40x, 61x	*.136*	*.171*
Emergency Room	91	45x	.226	.206
Blood & Blood Products	62, 63	38x, 39x	.371	.365
Other Services	75-77, 92	Pretty much all other rev codes	.389	.400
Labor & Delivery (only for 6 MS-DRGs)	52, 93	36x, 71x, 72x, 51x	.450	.424
Inhalation Therapy	65	41x, 46x	.189	.186
Anesthesia	53	37x	.109	.119
NEW: Implantables	72	275-278		.356
NEW: Cardiac Cath	59			.136
NEW: MRI	58			.090
NEW: CT Scans	57			.045

CT AND MRI COST CENTERS

- A coalition of imaging lobbying groups submitted concerns to CMS on breakout of MRI & CT cost centers
- Main concerns:
  - Inaccurate cost finding relating to capital costs (allocation v. direct costing)
  - Sensitivity to rate setting methods (IPPS v OPPS)
- Other areas of concern include charge structures and impact of Physician Fee Schedule

MS-DRG WEIGHT IMPACT (NEW CCRS)

(INCREASES)—*ILLUSTRATION FROM PROPOSED RULE*

MS-DRG	TYPE	DESCRIPTION	15 CCR WEIGHT	19 CCR WEIGHT	% INCREASE
227	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.2193	5.5714	6.70%
946	MED	REHABILITATION W/O CC/MCC	1.1295	1.2024	6.50%
849	MED	RADIOTHERAPY	1.3423	1.4258	6.20%
245	SURG	AICD GENERATOR PROCEDURES	4.4627	4.7320	6.00%
458	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	4.8794	5.1630	5.80%
223	SURG	CARD DEFIB IMPLANT W CARD CATH W AMI/HF/SHOCK W/O MCC	6.0956	6.4482	5.80%
225	SURG	CARD DEFIB IMPLANT W CARD CATH W/O AMI/HF/SHOCK W/O MCC	5.6298	5.9530	5.70%
484	SURG	MAJOR JOINT & LIMB REATT PROC OF UPPER EXTREMITY W/O CC/MCC	2.1211	2.2380	5.50%
455	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.9862	6.3133	5.50%
454	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	7.6399	8.0563	5.50%

MS-DRG WEIGHT IMPACT (NEW CCRS)

(REDUCTIONS)—*ILLUSTRATION FROM PROPOSED RULE*

MS-DRG	TYPE	DESCRIPTION	15 CCR WEIGHT	19 CCR WEIGHT	% DECREASE
90	MED	CONCUSSION W/O CC/MCC	0.7614	0.7013	-7.90%
84	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.9137	0.8516	-6.80%
87	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.7899	0.7369	-6.70%
965	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	1.0450	0.9800	-6.10%
185	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7281	0.6845	-6.00%
89	MED	CONCUSSION W CC	0.9959	0.9366	-6.00%
123	MED	NEUROLOGICAL EYE DISORDERS	0.7355	0.6920	-5.90%
343	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9880	0.9517	-5.70%
53	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.9355	0.8825	-5.70%
66	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARC W/O CC/MCC	0.8034	0.7579	-5.70%

OUTLIERS: FIXED LOSS THRESHOLD

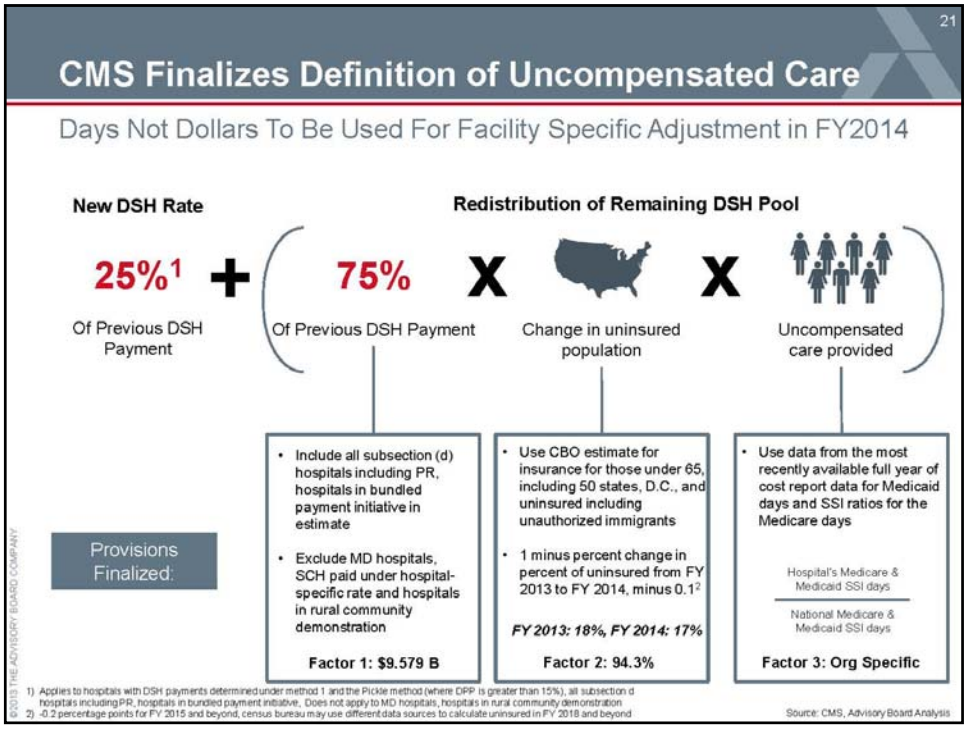
- Final outlier threshold for FFY 2014 is $21,748 while the proposed threshold was $24,140 (FFY 2013 outlier threshold was $21,821)
- Slight decrease from the 2013 threshold
- (Proposed Rule) CMS attributed increase in outlier level due to the decrease in DSH payments

DSH/UNCOMPENSATED CARE

- As of 10/1/2013, DSH payments reduced to 25% of current
- Remaining dollars, 75% of Medicare DSH, used for additional payments based on uncompensated care
  - Remaining dollars reduced by a % to account for uninsured individuals becoming insured
- Thus, total DSH $ + Uncompensated Care $ in FFY 2014 expected to be less than total DSH dollars in FFY 2013

DSH/UNCOMPENSATED CARE

- 75% of DSH dollars = $9.579 billion (Factor 1). Increase from proposed of $9.2535 billion
- CMS posted table in final rule with each hospital's factors
  - Factor 1 dollars using July 2013 Office of the Actuary's Medicare DSH calculations



DSH/UNCOMPENSATED CARE

- CMS states the FFY 2013 uninsured population under age 65, including unauthorized immigrants, is 18%
  - FFY 2013 uninsured % to be baseline for FFY 2014 – 2017
- FFY 2014 uninsured estimated to be 17%
  - Factor 2 formula:
    - 1 – [(0.17 - 0.18)/0.18] = 1 – 0.056 = 0.944 (94.4%)
    - 0.944 (94.4 %) – 0.001 (0.1 percentage points) = 0.943 (94.3%)
  - Factor 2 to be adjusted in FFY 2015 based upon CBO estimates of uninsured population and reduced by 0.2 percentage points rather than 0.1 percentage points

DSH/UNCOMPENSATED CARE

- Factor 3 was supposed to be based on WS S-10 uncompensated care costs
- CMS concerned about S-10 accuracy
  - Hospitals with high cost-to-charge ratios reap benefits in uncompensated care DSH payments over more "efficiently performing hospitals"
  - CMS may adopt revised methodology for S-10 in future years
- Factor 3 ratio based on 2010/2011 Medicare cost reports (HCRIS) and FFY 2011 SSI database

DSH/UNCOMPENSATED CARE

- Factor 3 topic for discussion
  - Doesn't allow for uncompensated care on outpatients
  - Large # of uncompensated care occurs in Emergency
  - Hardest hit to be smaller hospitals relying on DSH safety net dollars
  - Hospitals with greater than average Medicare utilization may be more negatively impacted than hospitals with below-average Medicare utilization
  - Hospitals must be proactive in educating and enrolling beneficiaries into SSI where eligible

DSH/UNCOMPENSATED CARE

- As of 10/1/2013, DSH will continue to be paid on a claim by claim basis
- Uncompensated care payments to be made on per discharge basis
- Change from proposed rule as result of public comments on potential cash flow issues

DSH/UNCOMPENSATED CARE

- DSH will continue to be trued-up and final settled with the cost report
- CMS proposing to adopt similar system of interim eligibility and payment determination w/final cost report for uncompensated care payments
- If hospital did not qualify for DSH but found to be eligible and vice versa, CMS to adjust DSH / uncompensated care payments at cost report settlement

UNCOMPENSATED CARE

- As historical data used to determine interim payments, CMS to develop reconciliation process
  - FI/MAC to make final determination on eligibility
- Reconciliation process based on Factor 1, 2 and 3 values finalized prospectively for FFY
  - Uncompensated care trued up by comparing per discharge payment to total uncompensated care payment as published by CMS in the Final IPPS rule
  - Reconciliation also done if hospital status changes from eligible/ineligible and vice versa when cost report is settled

UNCOMPENSATED CARE

- CMS not re-estimating Factors 1, 2 and 3 in reconciliation process
  - CMS recognizes total uncompensated care payments [on back end] could be more or less than total payments as published in each Final IPPS rule
  - Believes "inherent use" of estimates similar to manner used to estimate outlier payments
- CMS requested comments on whether Factor 3 should be part of reconciliation

DSH UNCOMPENSATED CARE – PAGE 1

FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act- Medicare DSH-Supplemental Data

Updated September 30, 2013 to reflect changes in Correction Notice and Interim Final Rule with Comment

PROV	Name	Medicaid Days	SSI Days	Insured Low Income Days	Factor 3	Total Uncomp Care Payment Amount	Projected to Receive DSH for FY 2014
500001	NORTHWEST HOSPITAL	2,395	935	3,330	0.000091409	826,919	Y
500002	PROVIDENCE ST MARY MEDICAL CENTER	2,828	372	3,200	0.000087840	794,637	Y
500003	SKAGIT VALLEY HOSPITAL	7,280	949	8,229	0.000225887	2,043,458	Y
500005	VIRGINIA MASON MEDICAL CENTER	4,120	1,688	5,808	0.000159430	N/A	N
500007	ISLAND HOSPITAL	1,321	104	1,425	0.000039116	N/A	N
500008	UNIVERSITY OF WASHINGTON MEDICAL CT	33,246	2,843	36,089	0.000990646	8,961,764	Y
500011	HIGHLINE MEDICAL CENTER	6,271	1,702	7,973	0.000218860	1,979,887	Y
500012	YAKIMA REGIONAL MEDICAL AND CARDIAC	4,132	1,813	5,945	0.000163191	1,476,286	Y
500014	PROVIDENCE REGIONAL MEDICAL CENTER	22,643	2,710	25,353	0.000695942	6,295,758	Y
500015	AUBURN REGIONAL MEDICAL CENTER	6,242	884	7,126	0.000195609	1,769,557	Y
500016	CENTRAL WASHINGTON HOSPITAL	8,549	1,219	9,768	0.000268133	2,425,629	Y
500019	PROVIDENCE CENTRALIA HOSPITAL	4,147	650	4,797	0.000131678	1,191,210	SCH
500021	SAINT CLARE HOSPITAL	5,158	1,724	6,882	0.000188912	1,708,966	Y
500024	PROVIDENCE ST PETER HOSPITAL	16,184	2,533	18,717	0.000513783	4,647,880	Y
500025	SWEDISH MEDICAL CENTER/CHERRY HILL	3,249	1,456	4,705	0.000129153	1,168,364	Y
500026	SWEDISH EDMONDS HOSPITAL	7,698	1,845	9,543	0.000261956	2,369,756	Y
500027	SWEDISH MEDICAL CENTER	44,971	4,029	49,000	0.001345055	12,167,876	Y
500030	ST JOSEPH MEDICAL CENTER	14,550	1,778	16,328	0.000448205	4,054,634	SCH

DSH UNCOMPENSATED CARE – PAGE 2

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PROV	Name	Medicaid Days	SSI Days	Insured Low Income Days	Factor 3	Total Uncomp Care Payment Amount	Projected to Receive DSH for FY 2014
500031	GRAYS HARBOR COMMUNITY HOSPITAL	5,111	745	5,856	0.000160748	1,454,185	SCH
500033	SAMARITAN HOSPITAL	3,630	263	3,893	0.000106863	966,725	Y
500036	YAKIMA VALLEY MEMORIAL HOSPITAL	19,865	1,413	21,278	0.000584083	5,283,838	Y
500037	TOPPENISH COMMUNITY HOSPITAL	3,025	248	3,273	0.000089844	812,764	Y
500039	HARRISON MEDICAL CENTER	11,331	1,777	13,108	0.000359816	3,255,031	Y
500041	PEACHEALTH ST JOHN MEDICAL CENTER	10,347	1,465	11,812	0.000324241	2,933,203	Y
500044	DEACONESS MEDICAL CENTER	18,996	1,698	20,694	0.000568052	5,138,817	Y
500049	WALLA WALLA GENERAL HOSPITAL	1,312	140	1,452	0.000039858	360,566	Y
500050	PEACEHEALTH SOUTHWEST MEDICAL CENTE	10,594	4,252	14,846	0.000407524	3,686,618	Y
500051	OVERLAKE HOSPITAL MEDICAL CENTER	4,341	1,230	5,571	0.000152924	N/A	N
500052	GROUP HEALTH CENTRAL HOSPITAL	-	5	5	0.000000137	1,242	Y
500053	KENNEWICK GENERAL HOSPITAL	6,767	487	7,254	0.000199123	1,801,342	Y
500054	PROVIDENCE SACRED HEART MEDICAL CEN	43,175	3,535	46,710	0.001282194	11,599,214	Y
500058	KADLEC REGIONAL MEDICAL CENTER	16,542	1,475	18,017	0.000494568	4,474,053	Y
500060	CASCADE VALLEY HOSPITAL	1,066	114	1,180	0.000032391	293,022	Y
500064	HARBORVIEW MEDICAL CENTER	30,562	4,964	35,526	0.000975192	8,821,958	Y
500072	OLYMPIC MEDICAL CENTER	2,884	340	3,224	0.000088499	800,597	SCH
500077	PROVIDENCE HOLY FAMILY HOSPITAL	7,646	1,453	9,099	0.000249768	2,259,500	Y

DSH UNCOMPENSATED CARE – PAGE 3

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PROV	Name	Medicaid Days	SSI Days	Insured Low Income Days	Factor 3	Total Uncomp Care Payment Amount	Projected to Receive DSH for FY 2014
500079	GOOD SAMARITAN HOSPITAL & REHAB CEN	9,167	1,616	10,783	0.000295994	2,677,678	Y
500084	VALLEY GENERAL HOSPITAL	705	98	803	0.000022042	199,404	Y
500088	VALLEY MEDICAL CENTER	19,734	2,634	22,368	0.000614004	5,554,511	Y
500108	ST JOSEPH MEDICAL CENTER	21,237	4,522	25,759	0.000707087	6,396,578	Y
500119	VALLEY HOSPITAL & MEDICAL CENTER	3,765	608	4,373	0.000120039	1,085,921	Y
500124	EVERGREEN HOSPITAL MEDICAL CENTER	9,274	1,027	10,301	0.000282763	2,557,985	Y
500129	TACOMA GENERAL ALLENMORE HOSPITAL	31,206	2,681	33,887	0.000930201	8,414,955	Y
500139	CAPITAL MEDICAL CENTER	2,598	299	2,897	0.000079523	719,395	Y
500141	ST FRANCIS COMMUNITY HOSPITAL	7,027	1,318	8,345	0.000229071	2,072,264	Y
500148	WENATCHEE VALLEY HOSPITAL	309	21	330	0.000009059	N/A	N
500150	LEGACY SALMON CREEK MEDICAL CENTER	13,978	1,161	15,139	0.000415567	3,759,377	Y
500151	ST ANTHONY HOSPITAL	1,780	451	2,231	0.000061241	N/A	N

TWEAKS TO FY 2014

- AHA letter to CMS voicing concerns regarding the timing of the settlements
- Proposed changes to procedural cost reporting related to DSH Uncompensated Care (UC DSH)
- Include Indian Health Hospitals to Factor 1 & 3
- Responses due November 29
- Retroactive to October 1, 2013

REMINDER: MEDICARE BAD DEBT

	Allowable Bad Debts for Cost Reports Beginning During -			
Provider Type	**FFY 2012**	**CR Periods Beginning 10/1/2012**	**CR Periods Beginning 10/1/2013**	**FFY 2015 (10/1/2014) and After**
Hospitals	70%	65%	65%	65%
SNFs, Non Dual Eligibles	70%	65%	65%	65%
Swing-Bed Hospitals, Non Dual Eligibles	100%	65%	65%	65%
SNFs & Swing-Bed Hospitals, Dual Eligibles	100%	88%	76%	65%
CAHs	100%	88%	76%	65%
ESRDs	100%	88%	76%	65%
CMHCs	100%	88%	76%	65%
FQHCs/RHCs	100%	88%	76%	65%
Cost Based HMOs	100%	88%	76%	65%
Health Care Pre-Payment Plans	100%	88%	76%	65%
Competitive Medical Health Plans	100%	88%	76%	65%

SEQUESTRATION

- Cuts in Medicare payments to providers and insurance plans are limited to 2% each year or $11 billion in 2013 (majority is acute care)
- Timing and reconciliation through cost report with sequestration effective April 1, 2013

HOSPITAL READMISSION REDUCTION PROGRAM (HRRP)

- Effective for discharges on/after 10/1/2012
- Adjustment made to base DRG payment
- Adjustment not made to hospitals' SCH payment rates
- HRRP Adjustment reconciling line item in cost report for all impacted facilities (E Pt A, Line 70.94)
- 3 risk-standardized readmission measures
  - Acute Myocardial Infarction (AMI)
  - Heart Failure (HF)
  - Pneumonia (PN)

READMISSIONS

- Readmission measures to be expanded in FFY 2015 to:
  - Acute exacerbation of COPD
  - Elective total hip (THA) and total knee arthroplasty (TKA)
  - CMS stated not feasible to add readmission measures for:
    - CABG
    - PCI
    - Other vascular conditions
    - As procedures are either decreasing or done in outpatient departments

INPATIENT ADMISSION

- New benchmark for medical review
  - To address concerns about Medicare beneficiaries having long stays in the hospital as outpatients
  - Physician order of inpatient admission
  - Measured by crossing 2 midnights of care (requiring more than 1 Medicare day)
  - Permits the physician to consider all time a patient has already spent in the hospital as an OP observation, emergency services ,etc. in guiding the two midnight expectation

INPATIENT ADMISSION

- If less than 2 midnights, CMS maintains services should be on outpatient basis
  - Unless medical record documentation clearly supports inpatient
  - Or inpatient only type services were provided
- Impact to SNF qualifying stay with a required 3 day stay from a physician order of IP admission in a hospital
- FAQs issued based on the August, 2013 CMS conference call regarding this topic

INPATIENT ADMISSION . . . . . .

- Physician Order and Physician Certification
  - Under this final rule—in addition to services designated as inpatient-only—surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician

  (1) expects the beneficiary to require a stay that crosses at least two midnights and

  (2) admits the beneficiary to the hospital based upon that expectation.

INPATIENT ADMISSION . . . . . .

- Who is the 'physician'?
  - The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care and current condition.
  - The admission decision (order) cannot be delegated to an individual who does not have this authority in his or her own right.

AND……

- To improve clarity regarding the relationship between the order and the physician certification, CMS amended the regulations governing the physician certification, **specifying that the certification begins with the order** for inpatient admission.
- For each inpatient admission, the certification must be completed, signed and documented in the medical record **prior to discharge** (except for outlier extended stay cases, which require earlier certification and recertification).
- In the final rule, CMS specified that inpatient rehabilitation facilities must also continue adhering to their existing admission requirements in the regulations.

SPECIFY IN THE ORDER

- The specificity requirements outlined in the FY 2014 IPPS Final Rule are most clearly met by the inclusion of the term "inpatient" in the admission order, as illustrated above. However, in the event that explicit identification of the admission as "inpatient" is not specified, the admission order may still be consistent with 42 CFR 412.3 provided that the intent to admit as an inpatient is clear. Orders that specify admission to an inpatient unit (e.g., "Admit to 7W", "Admit to ICU"), admission for a service that is typically provided on an inpatient basis ("Admit to Medicine"), or admission under the care of an admitting practitioner ("Admit to Dr. Smith"), and orders that do not specify beyond the word "Admit," **will be considered to specify admission to an inpatient status** provided that this interpretation is consistent with the remainder of the medical record.

IMPACT OF HOSPITAL ACQUIRED CONDITIONS

- CMS classifies HACs into 11 categories including
  - Foreign Object Retained After Surgery
  - Air Embolism
  - Blood Incompatibility
  - Stage III and IV Pressure Ulcers
  - ***Falls and Trauma***
  - Catheter-Associated Urinary Tract Infection (UTI)
  - Surgical Site Infection Following Certain Orthopedic Procedures

HAC REIMBURSEMENT DIFFERENTIAL

DRG: **315 Other circulatory system diagnoses w CC**
MDC: **5 Diseases and Disorders of the Circulatory System**

DRG Weight:	0.9527
AMLOS:	4
GMLOS:	3.1
Hospital Wage Index:	1.2282

MCO/HMO Amt:	$7,509.53
Total Oper Amt:	$7,013.72
Total Capital Amt:	$502.93
Pass Thru Amt:	$0.00
New Tech Amt:	$0.00
DRG Reimb:	$7,509.53

Falls from bed due to negligence, fractures hip requiring open reduction in the OR (No reimbursement difference from Principal Dx.)

DRG: **981 Extensive O.R. procedure unrelated to principal diagnosis w MCC**
MDC: **5 Diseases and Disorders of the Circulatory System**

DRG Weight:	5.027
AMLOS:	13.7
GMLOS:	10.5
Hospital Wage Index:	1.2282

MCO/HMO Amt:	$39,624.67
Total Oper Amt:	$37,008.46
Total Capital Amt:	$2,653.77
Pass Thru Amt:	$0.00
New Tech Amt:	$0.00
DRG Reimb:	$39,624.67

Patient presents with hip fracture requiring open reduction and pleural effusion/Post PMI syndrome.

OUTPATIENT PPS CONVERSION RATES

- Final 2013 Conversion Factor of $71.313
- Proposed 2014 Conversion Factor of $72.728, an increase of 1.8%
- Proposed 2014 Conversion Factor of $71.273 if failed to report quality measures

PROPOSED OUTPATIENT PPS

- Current 2013 outlier threshold of $2,025 (was proposed at $2,400)
  - 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 2014 outlier threshold is $2,775

CHANGE IN COST W/NEW CR FORMS

CT, MRI, Cath Costs Down Significantly As A Result of Proposal

Percentage Change in Estimated Cost for APCs Significantly Affected by Use of the New Standard Cost Center CCRs

Increasing

0276	Level I Digestive Radiology	15.2%
0378	Level II Pulmonary Imaging	15.2%
0396	Bone Imaging	15.5%
0390	Level I Endocrine Imaging	15.8%
0395	GI Tract Imaging	16.2%
0402	Level II Nervous System Imaging	16.2%
0398	Level I Cardiac Imaging	16.3%
0262	Plain Film of Teeth	16.9%
0377	Level II Cardiac Imaging	17.0%
0267	Level III Diagnostic and Screening Ultrasound	17.2%
0406	Level I Tumor/Infection Imaging	17.4%
0403	Level I Nervous System Imaging	18.9%
0266	Level II Diagnostic and Screening Ultrasound	25.1%
0265	Level I Diagnostic and Screening Ultrasound	29.9%
8004	Ultrasound Composite	30.2%

Decreasing

0282	Miscellaneous CT	-38.1%
0332	Computed Tomography w/o Contrast	-34.0%
8005	CT and CTA w/o Contrast Composite	-33.9%
0331	Combined AbdoPelvic CT w/o Contrast	-32.9%
8006	CT and CTA w/Contrast Composite	-29.0%
0334	Combined Abdomen and Pelvis CT w/Contrast	-28.8%
0662	CT Angiography	-27.0%
0283	Computed Tomography w/Contrast	-27.0%
0333	Computed Tomography w/o Contrast followed by Contrast	-26.3%
0383	Cardiac Computed Tomographic Imaging	-24.8%
8008	MRI and MRA w/Contrast Composite	-18.9%
8007	MRI and MRA w/o Contrast Composite	-18.5%
0080	Diagnostic Cardiac Catheterization	-8.7%

Source: CMS; Advisory Board analysis

OPPS PAYMENT FOR HOSPITAL VISITS

- CMS eliminating OPPS payment for the 20 CPT codes for clinic and Type A/B Emergency departments
- Replacing 20 codes with only 3 Level II HCPCS codes
- CMS has given up on developing E&M guidelines for facility services
- Reduced # of codes for payment eases admin burden, “while maintaining…ability to calculate accurate payment rates under OPPS.”

OPPS PAYMENT FOR HOSPITAL VISITS

- No distinction for new and established patient visits for facility payment
- Clinics - newly created APC 0634
  - HCPCS II codes GXXXC, previously CPT 99201-99205, 99212-99215
- Type A ED - newly created APC 0635
  - HCPCS II code GXXXA, previously 99281-99285
- Type B ED - newly created APC 0636
  - HCPCS II Code GXXXB, previously G0380-G0384

OPPS PAYMENT FOR HOSPITAL VISITS

- Payment rates not provided for clinic and ED visits in proposed rule
- CMS requesting input on proposal
- Requesting comments on additional levels of payment or if special high/low complexity cases should be recognized

PACKAGED CODES

- Proposed for CY2014 certain laboratory services will be packaged with the APC payment.
- Lab services will be packaged if:
  - *Provided on the same date of service as the primary service, and*
  - *Ordered by the same practitioner who ordered the primary service*
- See Addendum P of OPPS Rule for list of codes

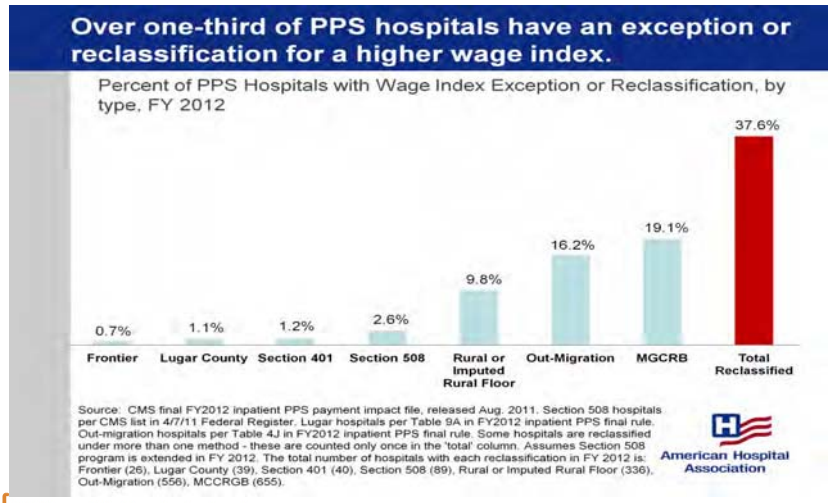
CMS RULING 1455-R AKA PART B BILLING

- CMS Ruling 1455-R only applies to denials of Part A hospital inpatient claims when the inpatient admission was determined to be not reasonable and necessary by a Medicare review contractor (provided payment was not made under the waiver of liability provision (Section 1879 of the Act), and repayment of any Part A overpayment was not waived (Section 1870 of the Act)).
- In this situation, under the Ruling, you may submit a Part B inpatient claim for all Part B services that would have been payable to you had the beneficiary originally been treated as an a hospital outpatient rather than admitted as an a hospital inpatient, except when those services specifically require an outpatient status (for example, outpatient visits, emergency department visits, and observation services).
- For details – see CR 8277 or MLM8277

WAGE INDEX – GEO RECLASSIFICATIONS

- Geographic reclassifications for wage index purposes were due 9/03/2013 (first working day of September)
  - Effective for FFY beginning on 10/01/2014
  - 679 hospitals in reclass status for FY 2014 (10/01/13 - 9/30/14)
    - Was 773 hospitals in proposed rule

WAGE INDEX RECLASSIFICATIONS FROM AMERICAN HOSPITAL ASSOCIATION



ACA SECTION 3141 (NATIONAL RURAL FLOOR)

- Known on the beltway as the "Bay State Boondoggle"
- Previously rural floor set at State level with only New Jersey benefiting
- As of 10/1/13, MA and CA greatly benefit from National Rural Floor
- Impact of change shown on next slide
- May 2013 legislation introduced (R) to repeal National Rural Floor – still pending
  - *Medicare Hospital Wage Index Equity Act of 2013*

REIMBURSEMENT IMPACT

State	# of Hospitals	# of Hospitals receiving Rural / Imputed Floor	% Change in Pmts Due to Rural Floor	Difference (in Millions)	Benefit (Loss) Per Hospital
Massachusetts	61	60	550%	167.60	$ 2,793,333
California	309	182	100%	94.10	$ 517,033
Connecticut	32	19	420%	65.40	$ 3,442,105
New Jersey	64	25	40%	13.80	$ 552,000
Nevada	24	19	170%	11.20	$ 589,474
New Hampshire	13	9	190%	8.60	$ 955,556
Alaska	6	4	330%	4.70	$ 1,175,000
Rhode Island	11	4	50%	1.70	$ 425,000
Colorado	46	6	10%	1.30	$ 216,667
Wyoming	11	-	-20%	(0.20)	$ (18,182)
Montana	12	4	-10%	(0.40)	$ (33,333)
North Dakota	6	1	-30%	(0.80)	$ (133,333)
Hawaii	14	-	-40%	(1.20)	$ (85,714)
Idaho	14	-	-40%	(1.20)	$ (85,714)
New Mexico	25	-	-30%	(1.50)	$ (60,000)
Utah	32	-	-30%	(1.50)	$ (46,875)
Washington	49	5	-10%	(2.40)	$ (48,980)
Washington, DC	7	-	-60%	(2.60)	$ (371,429)
Oregon	33	-	-50%	(4.50)	$ (136,364)
Arizona	57	7	-30%	(5.30)	$ (92,982)
Florida	168	7	-40%	(29.70)	$ (176,786)
Texas	324	3	-50%	(32.20)	$ (99,383)
New York	166	-	-60%	(47.70)	$ (287,349)

CONCLUSION

- With the expansion of cost centers on the Medicare cost report and the sensitivity to rate setting, accurate/homogenous cost reporting is key
- Uncompensated care reporting is the new hot button and providers must be proactive in this process
- Wage Index reform is nearing and will continue to be a contested issue as labor markets & costing are refined.

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THANK YOU
QUESTIONS?

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