MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

WA/AK HFMA Fall Conference

9/22/2016

Medicare Regulatory Update for Hospitals

The material appearing in this presentation is for informational purposes only and should not be construed as advice of any kind, including, without limitation, legal, accounting, or investment advice. This information is not intended to create, and receipt does not constitute, a legal relationship, including, but not limited to, an accountant-client relationship. Although this information may have been prepared by professionals, they should not be used as a substitute for professional services. If legal, accounting, investment, or other professional advice is required, the services of a professional should be sought.

Topics

- Wage Index Deadlines
- IPPS Final Updates for FFY 2017 (8-22-2016)
- DSH/Uncompensated Care
- Medical Education
- Readmission Policies
- Value-Based Purchasing Program
- OPPS Proposed Updates for CY 2017 (7-6-2016)
- MPFS Proposed Updates for CY 2017 (7-7-2016)
- 2016 OIG Work Plan Considerations

Wage Index Deadlines

- PUF FY 2018 wage index file released 5/16/16
  - FY 2014 W/S S-3 wage data files
  - 2013 Occupational Mix data
- 9/2/16 – deadline (not postmarked) for hospitals to request revisions to wage index and occupational mix data
- 11/4/16 – deadline for MACs to notify State hospital associations of hospitals that did not respond to wage index queries
  - Member hospitals failure to respond to MAC inquiries can result in lowering of area's wage index value
- 11/15/16 – deadline for MACs to complete all desk reviews of submitted revisions
- 1/30/17 – release of revised FY 2018 wage index PUF files on CMS web site

Wage Index – Geo Reclassifications

- Geographic reclassifications for wage index purposes were due 9/01/16 (first working day of September)
  - Deadline for canceling a previous wage index reclassification withdrawal or termination
  - Effective for FFY beginning on 10/01/17
  - 817 hospitals in reclass status for FY 2017 (10/01/16 - 9/30/17)
    - 57 hospitals reclassified to rural areas
- CMS requests MGCRB reclassification applications now be submitted electronically to *wageindex@cms.hhs.gov*
- MGCRB instructions are to still send in paper copies; "delivery to CMS does not constitute delivery to MGCRB"

Occupational Mix Adjustments

Final national average hourly wages

(how does your hospital compare?)

Occupational mix nursing subcategory	Average hourly wage
National RN	$38.834
National LPN & Surgical Tech	$22.738
National Nurse Aide, Orderly, & Attendant	$15.954
National Medical Assistant	$18.048
National Average Nurse Category	$32.859
Nursing as % of total employees	42.60%

Wage Index Fast Facts

- 407 urban CBSAs
- 47 rural CBSAs
  - Delaware, New Jersey and Rhode Island all urban
    - Imputed rural floor extended 1 year, thru 9/30/17
    - CMS exploring potential wage index reforms
- Out-migration adjustment
  - Increase to hospital's wage index value based on commuting patterns from 2010 Census
  - Wage index tables indicate applicable hospital's out-migration adjustment
  - 293 hospitals receive out-migration adjustment
- Next Occupational Mix Survey – July 2017

Wage Index - Pension Changes

- FY 2017 and later wage indices require revised reporting of average defined benefit pension costs
  - Eventually, *most* filed cost reports will have correct data
- Formerly pension costs reported on 3 year rolling average of the WI base year (i.e. FY 2012, **2013**, 2014)
- CMS revised the 3 year average to include base year + prior 2 years (i.e. FY 2011, 2012, **2013**)
- For the upcoming wage index reviews with responses due September 2, 2016 (for FFY 2018), pension costs to be based on 3 year average of years 2012, 2013, 2014 (September and December year ends) or 2013, 2014, 2015 (March and June year ends)

Wage Index – Overhead Cost Treatment

- CMS is soliciting feedback on proposed changes to WKS S-3, IV
- Proposed changes include new methods of allocating wage related costs to excluded areas
- CMS also interested in feedback on treatment of Home Office costs added to WKS S-3, II Line 14
- If Home Office allocations include services beyond A&G costs, must be assigned to corresponding line on S-3, II

Wage Index – Urban to Rural Reclasses

- Hospital in urban area can apply for rural status for payment purposes separate from reclassification thru MGCRB
  - Can be effective no later than 60 days after receipt of application
  - Can apply at any time w/effective date of date application filed
- CMS is setting a "Lock In" date for list of hospitals reclassed from urban to rural status for rate-setting purposes
- "Lock In" date is Second Monday in June each year
  - If hospital wants its data reflected in next FFY (10/1) wage index and budget neutrality calculations, must file application no later than 70 days prior to 2nd Monday and application must be approved
- "Locking In" allows more transparency in IPPS, Wage Index and BNFs

DRG Payment Rates (Quality Data/MU MET)

WAGE INDEX > 1.0000

	FFY 2017 Final (8/22/16 FR)	FFY 2016 Final (8/17/15 FR)
Labor-Related	$3,839.57	$3,804.40
Non-Labor	1,677.06	1,661.69
Capital	446.81	438.65
Total Payment Rate	$5,963.44	$5,904.74

WAGE INDEX <= 1.0000

	FFY 2017 Final (8/22/16 FR)	FFY 2016 Final (8/17/15 FR)
Labor-Related	$3,420.31	$3,388.98
Non-Labor	2,096.32	2,077.11
Capital	446.81	438.65
Total Payment Rate	$5,963.44	$5,904.74

Labor/Non-Labor DRG Rates: Wage Index > 1.0000

Description (for FFY 2017-Final for 10/01/16)	Labor	Non-Labor
FY2016 Base Rate, after removing PY Reduction Factors	$4,394.09	$1,919.26
FY2017 Net Market Basket Update Factor *SEE NEXT SLIDE*	1.0165	1.0165
FY2017 MS-DRG Recalibration Budget Neutrality Factor (BNF) (-.092%)	0.999079	0.999079
FY2017 Wage Index Budget Neutrality Factor (BNF) (-.02%)	1.000209	1.000209
FY2017 Reclassification 'BNF' (-1.12%)	0.988224	0.988224
FY2017 Operating Outlier Factor (-5.1%)	0.948999	0.948999
Cumulative FY2008 thru FY 2017 Doc & Coding Recoupment Adjustment (-8.82%)	0.9118	0.9118
FY 2016 New Labor Market Wage Index Transition 'BNF'	0.999994	0.999994
FY2017 2-Midnight Rule One Time Add Back (.60%)	1.006	1.006
National Standardized Amount FY2017 DRG Payment Rate (-12.70% from FY16 Base Rate)	$3,839.57	$1,677.06

FINAL FFY 2017 Update

FFY 2017	Quality Data Submitted and Meaningful User	Quality Data Submitted / NOT a Meaningful User	Quality Data NOT Submitted / Meets Meaningful Use	Quality Data NOT Submitted / NOT a Meaningful User
MB "Rate of Increase"	2.70%	2.70%	2.70%	2.70%
Failure to submit Quality Data	0.00	0.00	-0.675	-0.675
Failure to meet Meaningful Use	0.00	-2.025	0.00	-2.025
MFP Adjustment	-0.30	-0.30	-0.30	-0.30
ACA Reduction	-0.75	-0.75	-0.75	-0.75
Net Percent Increase/Decrease	***1.65%***	***-0.375%***	***0.975%***	***-1.05%***

2-Midnight Rule

- CMS revising its position on the -.20% reduction to IP payments
- *Shands Jacksonville Medical Center, Inc. v. Burwell* – court decision remanded -.20% reduction back to the Secretary
- Deemed a procedural error – Avoids a court decision allowing providers to seek settlement
- Example of CMS' ability to "correct" payments prospectively
- QIO reviews still in effect – medical record must support determination for IP admission
  - QIO reviews were paused as of 5/4/16 – expected to last 60-90 days
  - Claims rejected since October 2015 will be reviewed

National Average CCRs

Cost Center	WS C CR Line #s	Revenue Codes	FY2016 FINAL CCRs	FY2017 FINAL CCRs
Routine Services	30	10x, 11x, 12x, 13x, 14x, 15x, 16x-19x	.480	.457
Intensive Care/ Coronary Care	31-35	20x, 21x	.393	.375
Drugs	64, 73	25x, 26x, 63x	.191	.194
Supplies & Equipment	71, 96, 97	270-274, 277, 279, 290-299, 621-623	.297	.297
Implantables	72	275, 276, 278, 624	.337	.331
Therapy Services	66-68	42x, 43x, 44x, 47x	.332	.321
Inhalation Therapy	65	41x, 46x	.177	.170
Operating Room	50, 51	36x, 71x	.199	.191
Labor & Delivery (only for 8 MS-DRGs)	52	72x	.404	.410
Anesthesia	53	37x	.106	.089
Cardiology	69	48x, except 481, 73x	.118	.112
Cardiac Cath	59	481	.124	.118
Laboratory	60, 61, 70	30x, 31x, 74x, 75x, 86x	.125	.120
Radiology	54-56	28x, 32x, 331-335, 339, 342-344, 40x	.159	.153
CT Scans	57	35x	.041	.038
MRI	58	61x	.085	.079
Emergency Room	91	45x	.183	.171
Blood & Blood Products	62, 63	38x, 39x	.336	.323
Other Services	74-76, 88-90, 92.01, 93-95	Pretty much all other rev codes	.368	.365

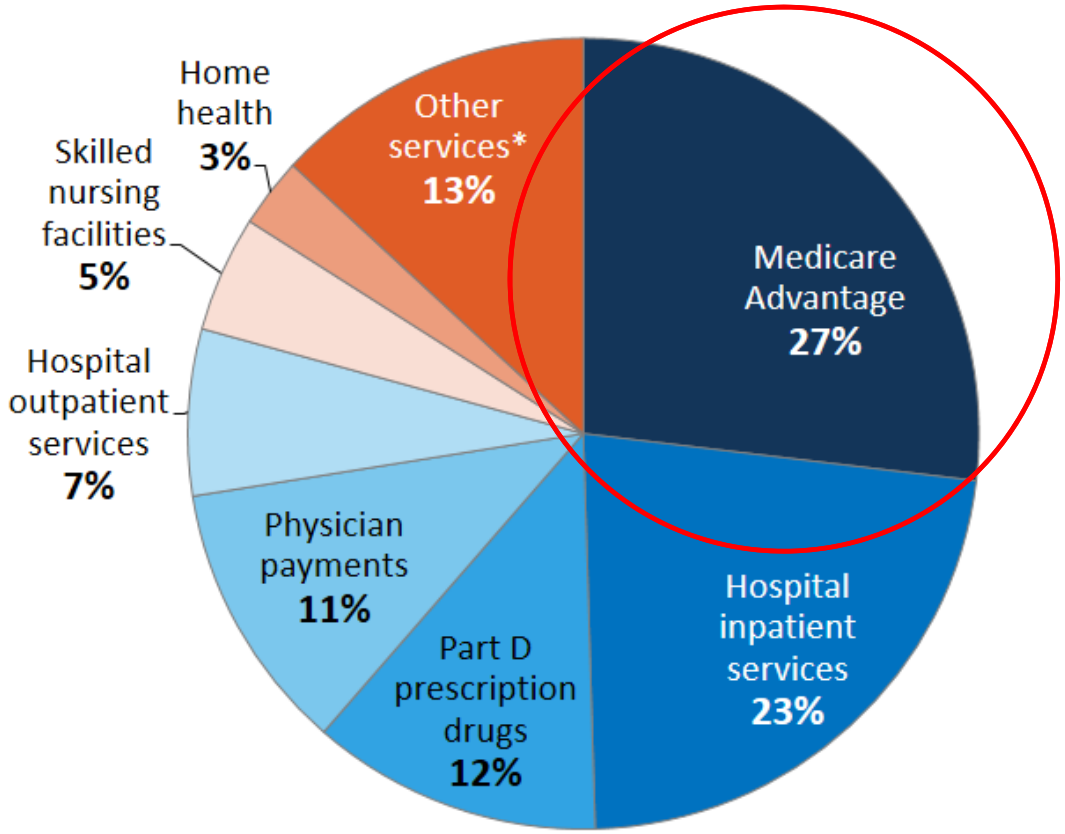
20 most costly inpatient conditions

Diagnosis	$ in Billions*
Septicemia	$ 23.66
Osteoarthritis	$ 16.52
Live birth	$ 13.29
Complication of device, implant or graft	$ 12.43
Acute myocardial infarction	$ 12.09
Congestive heart failure	$ 10.22
Spondylosis, intervertebral disc disorders, other back problems	$ 10.20
Pneumonia	$ 9.50
Coronary atherosclerosis	$ 9.00
Acute cerebrovascular disease	$ 8.84
Cardiac dysrhythmias	$ 7.18
Respiratory failure, insufficiency, arrest (adult)	$ 7.08
Complications of surgical procedures or medical care	$ 6.08
Rehabilitation care, fitting of prostheses, and adjustment of devices	$ 5.37
Mood disorders	$ 5.25
Chronic obstructive pulmonary disease and bronchiectasis	$ 5.18
Heart valve disorders	$ 5.15
Diabetes mellitus with complications	$ 5.14
Fracture of neck of femur	$ 4.86
Biliary tract disease	$ 4.72

*Actual hospital cost – not reimbursement (Excludes Pro Fees)

Figure 2

Medicare Benefit Payments by Type of Service, 2015



Total Medicare Benefit Payments, 2015: $632 billion

NOTE: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.
SOURCE: Congressional Budget Office, 2016 Medicare Baseline (March 2016).

THE HENRY J. KAISER FAMILY FOUNDATION

Outliers: Fixed Loss Threshold

- Proposed outlier threshold for FFY 2017 was $23,681
- **Final** outlier threshold for FFY 2017 is $23,570
  - Expected total outlier payments $4,479,256,519 ($4.45B)
- FFY 2016 outlier threshold was $22,544
  - CMS estimates threshold to result in outlier payments = 5.1% of total operating DRG payments
  - Capital outliers to represent 6.26% of Federal capital payments

Capital Costs

- Update factor for FY 2017 capital costs is .90%
- Capital costs about 10% of total payments
- Real case mix projected to increase 0.5%
- Total increase in case mix projected to increase 0.5%
- 0% adjustment for reclassification/recalibration
- Net adjustment for case mix change expected at 0.0% (difference between real case mix increase and total increase in case mix)

Sole Community Hospitals (SCH)

- SCH rate update
  - +2.7% full rate of increase
  - -.675% for hospitals meaningful users but not submit quality data
  - -2.025% for hospitals not meaningful users but submits quality data
  - -0.3% MFP adjustment
  - -0.75% Statutory adjustment (ACA)
  - -0.999079 MS-DRG reclassification and recalibration budget neutrality factor
- 7.1% continued add-on for rural SCHs outpatient services paid under OPPS

Low Volume Adjustment

- Part of SGR fix – MACRA or Medicare Access and CHIP Reauthorization Act of 2015
- Extended through 9/30/17
- CMS Change Request: CR 9197/MM9197
- Application were due 9/1/16
- Criteria:
  - More than 15 road miles from another PPS hospital
  - Less than 1600 Medicare discharges
  - Table 14 lists all hospitals 1600 < discharges
- Need to confirm distance in order to qualify

DSH/Uncompensated Care

- No change to eligibility requirements for DSH or uncompensated care for FFY 2017
- Maryland, hospitals in Rural Community Hospital Demonstration Program ineligible for DSH
  - 14 hospitals in demonstration program, 10 to participate thru end of FY 2016, 4 to continue participating thru 12/31/16
  - Once demonstration program ends, hospitals eligible to participate
- FFY 2017 gross DSH payments estimated at $14.397B in the final rule compared to $13.732B in FFY 2016
- 25% of DSH = $3.599 billion
- Factor 1 – uncompensated care = $10.797 billion

DSH/Uncompensated Care

- CBO states the *CY* 2017 uninsured population under age 65, including unauthorized immigrants, is 10%
  - Insured nonelderly population at 90%
- *CY* 2016 uninsured population at 11%/insured at 89%
- % of individuals w/o insurance for *FFY* 2017 = 10.25%, down from 11.5% in FFY 2016
- Factor 2 formula:
  - 1 – [(0.1025 - 0.18)/0.18] = 1 – 0.4444 = 0.5555 (55.56%)
  - 0.5555 (55.56%) – 0.002 (0.2 percentage points for FY 2017) = 0.5536 (55.36%)
  - Factor 2 = 55.36%
- Factor 1 after Factor 2 formula = $5.977B
  - ($10.797B x 55.36%)

DSH/Uncompensated Care

- Factor 3 is hospital-specific value
- Computed using:
  - FY2011, 2012 and 2013 cost report data
  - FY2012, 2013 and 2014 SSI Ratios
  - UCC Factor = $\frac{\text{(Medicaid Days + Medicare SSI Days)}_{hospital}}{\text{(Medicaid Days + Medicare SSI Days)}_{nation}}$
- 2,432 hospitals projected to receive DSH and UC in FY 2017, per listing in DSH Supplemental File, not including SCH facilities

Uncompensated Care Info

FY 2017 IPPS FINAL Rule - Medicare DSH - Supplemental Data					
State	**Total Uncompensated Care for All Hospitals - 10/1/2016 - 9/30/2017**	**Average Payment Per Claim**	**% Uncompensated Care $ to Total $**	**Change in Total Uncompensated Care from FFY 2016**	**% Change in Total from FFY 2016**
Alaska	$ 8,816,411	$ 1,510.76	0.15%	$ (271,141)	-2.98%
Arizona	107,724,259	1,409.93	1.80%	(1,965,538)	-1.79%
California	750,297,289	2,839.44	12.53%	(39,487,367)	-5.00%
Colorado	56,803,580	1,045.50	0.95%	(1,054,773)	-1.82%
Florida	65,622,711	1,401.50	1.10%	(11,720,743)	-15.15%
Hawaii	13,997,945	890.24	0.23%	(1,163,215)	-7.67%
Idaho	16,855,994	842.00	0.28%	839,158	5.24%
Nevada	44,043,136	755.00	0.74%	(758,341)	-1.69%
New Mexico	33,924,261	1,277.79	0.57%	(2,527,215)	-6.93%
New York	645,531,628	1,671.14	10.78%	(51,530,895)	-7.39%
Oregon	47,461,748	759.97	0.79%	(2,458,853)	-4.93%
Texas	495,377,783	1,221.95	8.27%	(42,448,256)	-7.89%
Washington (excl Group Health)	94,340,166	618.78	1.58%	(6,412,426)	-6.36%
Total All States	$ 5,988,807,865	$ 1,285.51	100.00%	$ (416,977,523)	-6.51%
	Total $ Nationwide	**Average per claim**			

CMS Backed Off on use of Worksheet S-10

- CMS instead to institute additional QC and data improvement measures before moving forward with S-10
  - Expect modifications to S-10 form
  - Substantive cost report revisions not realistic for FY 2018
- After revisions to S-10, CMS to provide time for hospitals to adjust reporting data based on revised instructions
  - CMS states 3-4 year lag between ratesetting year and cost report data used by CMS to develop rates
- CMS expects CR periods beginning in FY 2017 be first cost reports using revised S-10 forms
  - Data available for uncompensated care calculations with FY 2021

Medical Education

- Following info is reiteration of prior Federal Register issuances:
  - Labor/delivery beds counted with total beds for IME
  - Labor/delivery days in calculation of Medicare utilization for GME reimbursement
    - Dilutes Medicare % to total patient days
    - Effective for cost report periods beginning on/after 10/1/2013
  - Sole Community Hospitals now paid operating IME on Medicare managed care claims

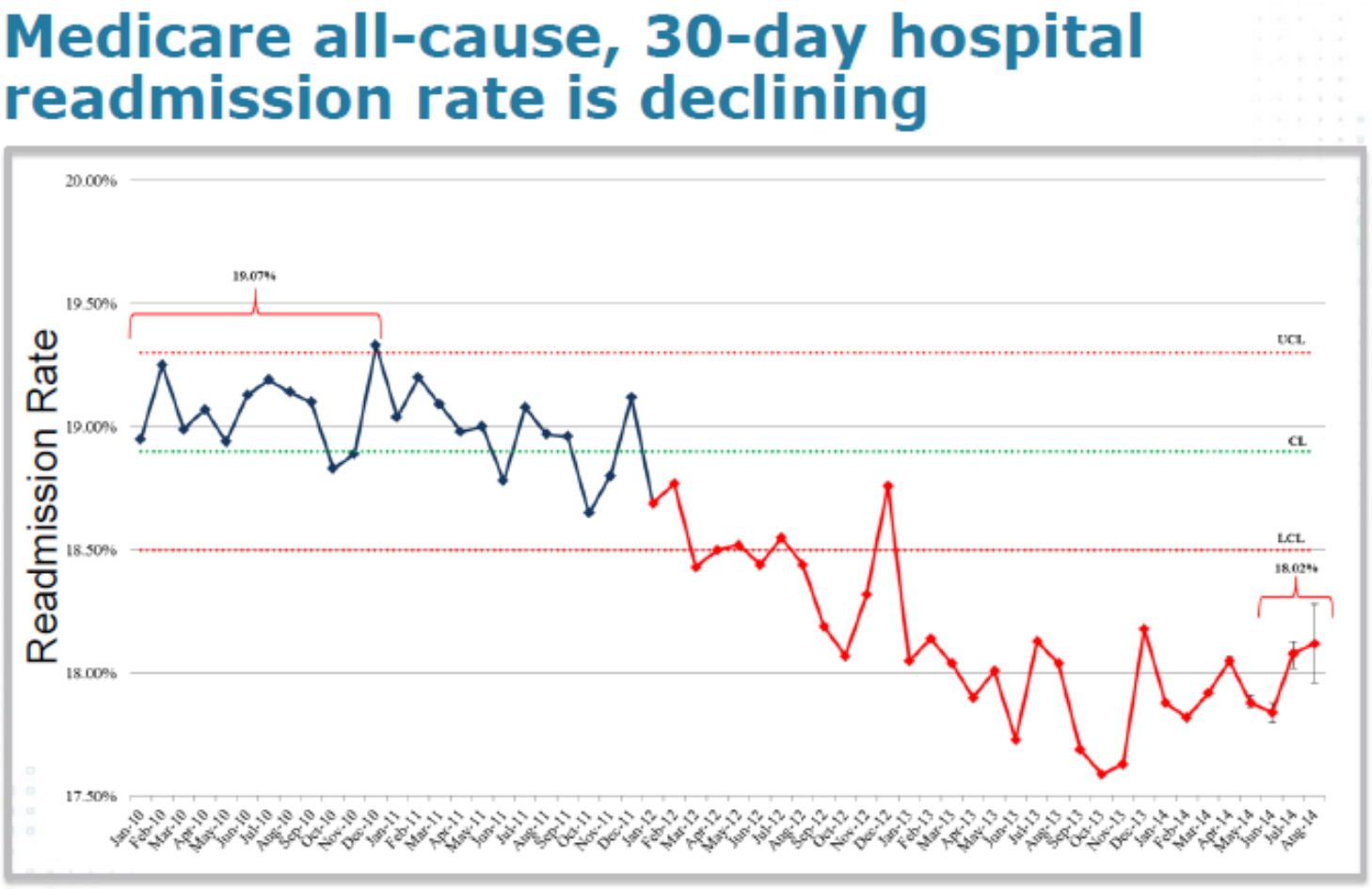
Hospital Readmission Reduction Program (HRRP)

- Policy changes included in FY2017 Final rule:
  - Clarify public reporting of excess readmission ratios to be posted to *Hospital Compare* website
  - Proposed methodology to include CABG application condition to readmit payment adjustment

Readmissions – Calculation

- Aggregate is sum for each applicable condition
  - Used MedPAR data w/discharges on/after 7/1/2012 and no later than 6/30/2015
  - Use updated MedPAR for each Fed fiscal year, updated 6 mos. after end of fiscal year
- MedPAR files available for purchase, $3,655 at:
  - www.cms.hhs.gov/LimitedDataSets/
- CMS to use excess readmission ratios from claims for period of 7/1/2012 – 6/30/2015

Readmission Rates Over Time



Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. April 2014 – August 2014 readmissions rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.

Value-Based Purchasing Program

- Budget Neutral
- FY 2017 estimated VBP payments = $1.7B
  - Based on 12/2015 update of MedPAR file
  - CMS to publish Table 16B in October with final VBP data
- CMS considering future adoption of a scoring methodology to produce a composite "value" score assessing overall quality and efficiency measure performance.
  - Specific value measures developed and then incorporated into the IQR and VBP programs through the measure development process; or
  - Using VBP Program scoring methodology to either compare scores on specific quality and cost measures; or by comparing quality and efficiency domain scores.

Looking Ahead: Proposed Measures for Future Years

VBP Measures for Future Years

Domain	Description	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Safety		**25%**	**TBD**	**TBD**	**TBD**	TBD
CAUTI	Catheter-Associated Urinary Tract Infection	●	●	●	●	●
CLABSI	Central line associated blood stream infection	●	●	●	●	●
C. Diff	Clostridium Difficile Infection Rate	●	●	●	●	●
MRSA	Methicillin Resistant Staph. Aureas Infection Rate	●	●	●	●	●
PSI-90	Complication/Patient Safety for Selected Indicators (Composite)	●	●	●	●	●
SSI - Colon	Colon Surgical Site Infections	●	●	●	●	●
SSI – Abdo Hyst	Abdominal Hysterectomy Surgical Site Infections	●	●	●	●	●
PC-01	Elective Delivery Prior to 39 Weeks	●	●	●	●	●
Clinical Care		**25%**	**TBD**	**TBD**	**TBD**	TBD
MORT-30-AMI	Acute myocardial infarction 30-day mortality rate	●	●	●	●	●
MORT-30-HF	Heart failure 30-day mortality rate	●	●	●	●	●
MORT-30-PN	Pneumonia 30-day mortality rate	●	●	●	●	●
MORT-30-CABG	CABG 30-Day Mortality					●[1]
THA/TKA Complication	Hip and Knee Arthroplasty Complication Rate	-	●	●	●	●
COPD	Chronic obstructive pulmonary disease 30-day mortality rate	-	-	-	●	●
Person and Community Engagement[1]		**25%**	**TBD**	**TBD**	**TBD**	TBD
HCAHPS	Patient Satisfaction Measures	●	●	●	●	●
Efficiency and Cost Reduction		**25%**	**TBD**	**TBD**	**TBD**	**TBD**
MSPB_1	Medicare Spending Per Beneficiary	●	●	●	●	●
AMI 30-Day Episodic Payment	AMI Hospital level, 30-Day payment for Episode of Care				●[1]	●[1]
HF 30-Day Episodic Payment	HF Hospital-level, 30-Day payment for Episode of Care				●[1]	●[1]

1. Domain name change proposed in FY 2017 IPPS proposed rule; would be effective FY 2019.
2. Comprised of: Communication with nurses, Communication with doctors, Responsiveness of hospital staff, Pain management, Communication about medicines, Cleanliness and quietness of hospital environment, Discharge information, Overall rating of hospital, CTM-3

Source: CMS; Advisory Board interviews and analysis.

Hospital Outpatient Prospective Payment System (OPPS) Update

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

Outpatient PPS Conversion Rates

- Final 2016 Conversion Factor of $73.725
- Proposed 2017 Conversion Factor of $74.909
- Proposed 2017 Conversion Factor of $73.411 if failed to report quality measures
- Proposed pass-thru spending for drugs, biologicals, devices of ~ $148.3 million, up from proposed 2016 spending of $136.8 million

Proposed Outpatient PPS

- Current CY 2016 outlier threshold of $3,250
- 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 CY 2017 outlier threshold is $3,825

Headline Update Doesn't Include Site-Neutral Impact

As Proposed, a 'Readmissions-Sized' Reduction to HOPPS Payment

1.55%

Proposed increase in rates for hospital outpatient provider departments

Includes:

- Market basket update (+2.8%)
- Multi-factor productivity adjustment (-0.5%)
- ACA market basket reduction (-0.75%)

$671M

Proposed increase in hospital outpatient payments in CY 2017[1]

Includes:

- HOPD[2] payments
- Outlier payments
- Pass-through payments
- Wage adjustments

Does not Include:

- Site-neutral reduction in payments of around $500M

$171M

Net change in Medicare spending on hospital outpatient services from CY 2016 to CY 2017, if all changes finalized as proposed

Includes:

- Net savings for CMS of $330M includes $500M reduction to HOPPS spending, combined with a $170M uptick in MPFS spending as a result of site-neutral proposal.
- *CBO[3] estimates of section 603 to save CMS $9.3B over 10 years*

1) Estimate does consider potential changes in case mix.
2) Hospital outpatient department. .
3) Congressional Budget Office.

Source: CMS; Advisory Board analysis.

Packaged Lab Services

- CY 2017 – CMS to discontinue unrelated lab test exception
  - Means separate payment eliminated for lab tests billed with “L1” modifier
- CMS believes unrelated lab tests not really that much different from most other packaged lab tests
- Impact would increase payment for advanced diagnostic lab tests, while ultimately expanding packaging for lab services

Prospective Outpatient Payment Info

CY 2017 OPPS PROPOSED Rule: Total APC Payments by State				
State	**Estimated CY 2017 OPPS Payments (including Outliers)**	**Estimated CY 2016 OPPS Payments (including Outliers)**	**$ Change**	**% Change**
01 - Alaska	$ 887,973,189	$ 875,410,017	$12,563,172	1.44%
03 - Arizona	816,130,766	808,603,716	7,527,050	0.93%
05 – California	4,141,754,305	4,069,291,883	72,462,422	1.78%
06 - Colorado	628,106,406	609,064,357	19,042,049	3.13%
07 - Florida	801,021,994	790,771,560	10,250,434	1.30%
12 - Hawaii	121,136,224	117,145,469	3,990,755	3.41%
13 - Idaho	275,487,970	273,929,983	1,557,987	0.57%
29 - Nevada	249,264,951	244,525,189	4,739,762	1.94%
32 - New Mexico	259,771,898	255,263,734	4,508,164	1.77%
33 - New York	2,468,035,437	2,449,367,836	18,667,601	0.76%
38 - Oregon	497,546,833	488,070,728	9,476,106	1.94%
45 - Texas	2,637,105,324	2,585,550,852	51,554,472	1.99%
50 - Washington	1,138,708,070	1,125,019,608	13,688,462	1.22%
Total All States	$49,538,053,085	$48,734,370,757	$803,682,329	1.65%

Clinic and Emergency Visits

Level	Type A ED	Type B ED	Clinic
1 – 99281, G0380, G0463	$61.78	$87.42	$105.31
2 – 99282, G0381, G0463	$111.85	$78.91	$105.31
3 – 99283, G0382, G0463	$202.40	$127.08	$105.31
4 – 99284, G0383, G0463	$335.52	$177.91	$105.31
5 – 99285, G0384, G0463	$492.72	$370.75	$105.31

Medicare Physician Fee Schedule (MPFS)

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

MPFS Proposed Rule

- Creation of the “Diabetes Prevention Program” an Innovation Center pre-diabetes lifestyle intervention beginning in 2018
- Expansion of eligible tele-health services
- Begin gathering data on the activities and resources involved in global surgical procedures
- Major changes to provider and supplier requirements for Medicare Part C
- Improving data transparency
- Revising the methodology used to calculate geographic practice cost indices

2016 OIG Work Plan Considerations

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

2016 OIG Work Plan Highlights - Hospitals

- **RECONCILIATIONS OF OUTLIER PAYMENTS:**
  - We will review Medicare outlier payments to hospitals to determine whether CMS performed necessary reconciliations in a timely manner to enable Medicare contractors to perform final settlement of the hospitals' associated cost reports.
- **MEDICARE OVERSIGHT OF PROVIDER-BASED STATUS:**
  - We will determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to oversee provider-based billing. We will also determine the extent to which provider-based facilities meet requirements described in 42 CFR Sec. 413.65 and CMS Transmittal A-03-030 .
- **DUPLICATE GRADUATE MEDICAL EDUCATION PAYMENTS:**
  - We will review provider data from CMS's Intern and Resident Information System (IRIS) to determine whether hospitals received duplicate or excessive graduate medical education (GME) payments.

Questions?

Paul Holden
(503) 478-2108
paul.holden@mossadams.com

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants