

RMA
Healthcare Lending Forum
October 2011
Reimbursement Update

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Medicare IPPS Reimbursement

2

- The market basket update is **1.9%** for hospitals in compliance with quality reporting. (**MB – 3.00% less ACA 1.1%**)
- Hospitals that do not comply with the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) will be penalized 2.0%
- CMS continues retroactive coding adjustment payment recoupments of -2.9% as the last year by law (should be added back in 2013)
- **FY 2012 prospective coding improvement adjustment of -2.0%**
- The FY 2012 capital rate increased by **0.34%**

Medicare IPPS Reimbursement

3

- Coding improvement, budget neutrality and other adjustments applied to 2012 rate

National Standard Rates				
	2011	2012	2012 Update	2011 Update
Case Mix Greater than 1.0				
Labor Rate	\$3,552.91	\$3,584.30	0.88%	-0.94%
Non-Labor Rate	1,611.20	1,625.44	0.88%	-1.13%
Total	\$5,164.11	\$5,209.74	0.88%	-1.10%
Capital Rate	\$420.01	\$421.42	0.34%	-2.22%

* Labor Share of **68.8%** for hospitals with wage index greater than 1.0 for both 2011 & 2012, **62.0%** if less than 1.0

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Medicare IPPS Reimbursement

4

Area Wage Index (AWI)

- The 2007 – 2008 occupational mix survey will continue to be used to adjust the 2012 wage index
- For FY 2013, a revised survey tool has been developed and will be used to collect 2010 wage and hours data

Rural Floor Budget Neutrality

- In FY 2012, the ACA required CMS to restore the national rural floor budget neutrality adjustment rather than using the state specific amount
 - Significant positive impact for Massachusetts in FY 2012
 - Rural floor for Massachusetts is based upon Nantucket Cottage Hospital, the only rural hospital within the state. This new rural floor for Massachusetts will create an increase of close to \$275 million dollars in Medicare reimbursements over FY 2011

Medicare IPPS Reimbursement

Sample of Local area AWI:

COUNTY/WAGE AREA	2012		2011 FINAL		Change in Rate
	AWI	RATE	AWI	RATE	
Boston-Quincy, MA	1.3530	\$6,475.00	1.2263	\$5,968.13	8.49%
Cambridge, MA	1.3530	\$6,475.00	1.1237	\$5,603.60	15.55%
Springfield, MA	1.3530	\$6,475.00	1.0342	\$5,285.62	22.50%
Fall River/New Bedford, MA	1.3530	\$6,475.00	1.0698	\$5,412.10	19.64%
Providence, RI	1.0618	\$5,431.25	1.0698	\$5,412.10	0.35%

COUNTY/WAGE AREA	2012 AWI
Hartford / Norwich / New London, CT	1.2048
Burlington, VT	1.0307
Manchester / Nashua / Rockingham County, NH	1.0875
Portland, ME	.9600
Puerto Rico	.3912
Santa Cruz, CA	1.6996

Long-Term Care Hospital (LTCH) PPS Inpatient Rehabilitation Facility (IRF) PPS

6

- PPS full market basket update of **1.8%**
(Based on RPL market basket of 2.9% reduced by ACA of 1.1%)
- Added a wage index budget neutrality adjustment of -.225%
- Standard Federal Base Rates:

Major Provisions	FY 2011 Final Rule	FY 2012 Final Rule	% Change
Net Market Basket Update	2.00%	1.80%	-0.20%
LTCH Standard Federal Rate	\$ 39,600	\$ 40,222	1.57%
IRF Conversion Factor	\$ 13,860	\$ 14.076	1.56%

Long-Term Care Hospital (LTCH) PPS Inpatient Rehabilitation Facility (IRF) PPS

7

- Area Wage Index (AWI)
 - Pre-budget-neutrality, reclassification and rural floor IPPS wage index values
 - Labor Component – 70.199% down from 75.271%
- The LTCH 25th Percentile Rule
 - LTCH Hospitals within Hospitals (HwHs) or LTCH satellites that admit more than 25% of their Medicare cases from their host hospital, or LTCHs admitting 25% of Medicare cases from one hospital, receive an adjusted payment rate, which is the lesser of:
 - LTCH PPS amount
 - IPPS amount
- **Continued Moratorium until 12/29/12 on The 25th Percentile Rule, Short Stay Outliers, New LTCHs, LTCH Satellites and Increase in LTCH Beds**

Long-Term Care Hospital (LTCH) PPS Inpatient Rehabilitation Facility (IRF) PPS

8

IRF Coverage and Payment Requirements

- Require as an admission criterion that the patient can actively participate in an intensive rehabilitation program
- Require that an interdisciplinary team meet weekly to review a patient's progress and to make any modifications necessary to the patient's overall plan of care
- Require a pre-admission screening and a post-admission evaluation (within 24 hours), approved by a physician to document the status of the patient after admission to the IRF and require the comparison of this to the pre-admission documentation – at least three face to face visits by trained rehab physicians
- **Establishment of a Pay-for-Reporting Program**
 - Beginning CY 2014 CMS will be implementing a requirement for LTCHs and IRFs to report quality measurements (three initial measures for LTCHs and two for IRFs)

Psychiatric Hospital PPS

9

- Rate year 2012 updated in final rule to a fiscal year beginning July 1, 2011 and ending September 30, 2012 (**15 months**) to align the rate update with the annual update of the patient classification system that is used to set the rate
- Market basket update of **2.95%** (based on RPL market basket of 3.2% reduced by ACA of .25%)
- Area Wage Index is based on the pre-reclassification and pre-rural floor wage indexes by CBSA with a labor component of 70.317% down from 75.400% in 2011

Psychiatric Hospital PPS

10

□ Federal Per Diem Base Rates

	Per Diem	% Change
FY 2010	651.76	2.19%
FY 2011	665.71	2.14%
FY 2012	685.01	2.90%

- CMS will continue to use the same patient and facility level adjustment factors for RY 2012 as in RY 2011
 - Patient age
 - DRG adjustment factor
 - Comorbidities adjustment factor
 - Teaching adjustment
 - Rural location
 - Emergency room
 - Variable per diem

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Proposed Outpatient PPS

11

- Market basket update of **1.5%** (MB 2.8% reduced by ACA of 1.3%)
- Proposed **-.73%** budget neutrality adjustment for exempt hospital payment increases (cancer hospitals)

National Standard Conversion Factor			
Rate Year	Standard Conversion Factor	\$ Change	% Change
CY 2011	\$69.42	\$0.54	0.78%
CY 2011	\$68.88	\$1.64	2.38%
CY 2010	\$67.24	\$1.18	1.79%
CY 2009	\$66.06	\$2.36	3.71%
CY 2008	\$63.69	\$2.23	3.62%

- *Reduction in conversion factor of 2% for hospitals, failing to meet requirements of “HOPQ DRP”*
- **AWI as proposed based on inpatient index without adjustment**

Proposed Outpatient PPS

- ❑ For 2012, CMS has proposed that all hold-harmless TOPS paid to rural hospitals and Sole Community Hospitals (SCHs) with 100 or fewer beds that were extended in FY 2011 will expire on January 1, 2012
- ❑ In CY 2011, CMS adopted a policy to calculate partial hospitalization rates for CMHCs based solely on CMHC data and a hospital based rate based only on hospital based data.
 - ❑ CMS’ proposal fully implements the two-year transition for calculating the relative payment weights for CMHCs

Group Title	CY 2012 Proposed Per Diem Rate	CY 2011 Final Per Diem Rate	(\$) Change	(%) Change
Level I Partial Hospitalization (3 services) for CMHCs	\$94.38	\$129.64	\$(35.26)	-27%
Level II Partial Hospitalization (4+ services) for CMHCs	\$109.67	\$164.43	\$(54.76)	-33%
Level I Partial Hospitalization (3 services) for PHPs	\$156.69	\$204.89	\$(48.20)	-24%
Level II Partial Hospitalization (4+ services) for PHPs	\$183.27	\$238.33	\$(55.06)	-23%



Proposed Outpatient PPS

13

- CMS proposed to establish a **federal advisory APC panel**, as an independent review process that would allow for an assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services
- CMS is proposing to charge the Panel with **recommending a supervision level** (general, direct, or personal) to ensure an appropriate level of quality and safety for delivery of a given service, as defined by a CPT code

President's Plan for Economic Growth and Deficit Reduction

14

- **Reduce Medicare coverage of patient bad debts from 70% to 25%**
- Better align IME payments with cost through a **10% reduction in IME add-on payments**
- Reduce enhanced payments to rural healthcare providers
 - Eliminate add-on payments for low population areas
 - Eliminate 101% reimbursement for CAH – back to 100%
- Eliminate payment updates for certain post-acute care providers (IRF, LTCH) until payments are aligned with cost
- **Equalize payments for certain conditions treated in IRFs and SNFs**
- **Restore the 75% rule for IRFs from the current 60% threshold**

President's Plan for Economic Growth and Deficit Reduction

15

- **Apply readmission penalties to SNFs (up to 3% adjustment)**
- Align Medicare drug payment policies with Medicaid policies for low income beneficiaries
- **Update pricing for advanced imaging services and require prior authorization**
- Reduce Medicaid provider tax thresholds, thereby reducing **Federal Medicaid matching payments** (FFP / FMAP)
- Increase Medicare Part B deductible (\$25)
- Establish a co-payment for home healthcare services (\$100 per episode)
- **Create a Part B surcharge to encourage more efficient healthcare choices**

MassHealth - Acute Care

16

- FY 2012 rates increased 2.69% from 2011 (effective 10/1/11)
- **Inpatient – Standard Payment Amount per Discharge (“SPAD”)**
 - Hospital specific all inclusive per discharge payment
 - MassHealth inflation and Case mix adjusted statewide average payment
 - Hospital specific malpractice and organ acquisition expenses
 - Capital cost allowance
 - **Direct medical education was eliminated in 2010**
 - **Reduced the 10% add-on to 5% for hospitals with >63% governmental and free care GPSR**
 - **Reduces SPAD by 2.20% for hospitals with high readmission rates**
 - Recognizes 101% of CAH cost

MassHealth - Acute Care

17

- Statewide SPAD (Inpatient):

Rate Year	Rate	% Change
RY 2012	\$ 8,108.80	2.69%
RY 2011	\$ 7,896.01	6.47%
RY 2010	\$ 7,416.16	(13.24%)

- **Outpatient – Payment Amount Per Episode (PAPE)**

- Outpatient case mix trending is being changed to use actual active hospital-specific case mix instead of multiple years' trending
- FY 2012 PAPE is a blend of 2011 PAPE and preliminary rate year 2012 PAPE
- Rate reductions limited to 10%
- Additional add-on of 20% for CAH

MassHealth - Acute Care

18

- Statewide PAPE (Outpatient):

Year	Rate	% Change
FY 2012	\$ 168.40	3.84%
FY 2011	\$ 162.17	1.82%
FY 2010	\$ 159.27	(4.03%)

- P4P payments will be less than budgeted
 - FY 2008 budget was \$20 million – paid \$20 million
 - FY 2009 budget was \$58 million – expected payment \$41 million
 - FY 2010 budget was \$100 million – expected payment in 2012 of \$66 - \$75 million (originally expected in 2011)
 - FY 2011 budget was \$75 million
 - FY 2012 budget is \$75 million

MassHealth – Non-Acute

19

- **Inpatient**
 - Hospital specific all inclusive per diem rate
 - Rate year 2011 & 2012 based on base year 2003
 - **Inflation proxy for 2011 & 2012 is 10.918% (1.2% per year)**
 - AD rate supplementary per diem factor is at **64%**, down from **75%** in 2011
- **Outpatient**
 - Payment based on Hospital-specific Outpatient “CCR” applied to the Hospital’s usual and customary charge on file with DHCFP as of **July 1, 2011** for RY 2012
 - Payment for lab and dental services based on DHCFP fee schedules
 - The FY 2012 outpatient RCC will remain consistent with the previous 7 years (based on the original base year conversion hold harmless legislation)
 - **Speculation on what DHCFP is considering for new system**
 - New base year?
 - PPS?

MassHealth – Non-Acute

20

- Average Rate Increase:
 - Inpatient
 - RY 2009 1.35%
 - RY 2010 .51%
 - RY 2011 & 12 .00%

 - Outpatient ???

Massachusetts Health Safety Net (Formerly UC Pool)

21

- **Prospective based funding for uncompensated care based on historical claims (2 month lag)**
- Eligibility –services/patients are eligible for reimbursement from the HSN
 - Medically necessary services
 - Services to Low Income Patients
 - Medical Hardship Services
 - Emergency/Urgent Care Bad Debt
- Payments & Funding
 - Hospitals pay into the HSN Trust Fund- **Uniform Assessment**
 - Commercial payors (non-governmental payors) pay into the HSN Trust Fund-**Payer Surcharge**
 - State Budget Appropriation
 - Intergovernmental transfers (IGT)

Massachusetts Health Safety Net

22

HSN Sources and Uses

(\$ In Millions)

	<u>FY 11</u>	<u>FY12 (Est.)</u>
SOURCES		
Hospital Assessment	\$160.0	\$160.0
Surcharge Payers	160.0	160.0
General Fund Contributions	30.0	30.0
Intergovernmental Transfer	70.0	70.0
Prior Year Surpluses	-	-
Total Sources	<u>\$420.0</u>	<u>\$420.0</u>
USES		
CHC Funding (including est. dental)	58.0	62.0
Admin & Other	6.0	6.0
Hospital Funding	441.0	482.0
Total Uses	<u>\$505.0</u>	<u>\$550.0</u>
Shortfall (estimated)	<u>\$85.0</u>	<u>\$130.0</u>

Massachusetts Health Safety Net

23

- ❑ Inpatient Payment Rates based on Medicare reimbursement methodologies
- ❑ Outpatient Payment Rates based on an average charge per visit using paid free care claims processed through November 2, 2010 and applying the Medicare Payment on Account Factor (PAF) with an additional 25% adjustment for DSH and non-teaching hospitals
- ❑ Emergency/urgent care bad debt payment rate excludes the 25% add-on
- ❑ Dental services paid based on DHCFP fee schedule
- ❑ Physician services paid based on Medicare fee schedule
- ❑ Prescribed drugs paid according to MassHealth coverage rules
- ❑ DSH Hospitals will receive at least 85% of allowable cost

Rhode Island (RI)

24

- Received global waiver (Global Consumer Choice Compact) in 2009 and has been monitoring and tracking efforts to:
 - ▣ *Rebalance the LTC services and support systems by increasing home and community based services while decreasing the reliance on the institutional care*
- RI hospitals operating margin at 0.3% in comparison to New England's average of 3.3% and the national average of 4.6%

Connecticut (CT) and Vermont (VT)

25

Connecticut

- Reduced UC and DSH funding by \$83M
- Imposed a 5.5% tax on hospitals (H.B. 6380)
- Medicaid payments at 70% of cost

Vermont

- New “Green Mountain Care Board”
 - Set the direction of a single payor healthcare system
 - Oversee every aspect of healthcare in VT
 - Set rates for drug manufacturers
 - Determine appropriate rates for Medicaid
 - Work with hospital to establish healthcare budget
 - Revamp existing system of hospital budget approval by the state

New Hampshire (NH)

26

- Hospitals are reimbursed, on average, just over 50% of cost of treating Medicaid patients
- DSH program challenges
 - The Medicaid DSH program began in 1991
 - The DSH program has been funded with hospital assessments known as the “Medicaid Enhancement Tax” (MET)
 - Used to generate FFP while returning the tax to hospitals
 - FY 2012 / 2013 budget eliminates the return of the MET (5.5% of NPSR)
 - NH hospitals indicate they will pay more in MET than they received in Medicaid reimbursement

Maine (ME)

27

MaineCare

- Converting to a PPS reimbursement system from discounted cost reimbursement
 - DRG – (FY 2011) effective 7/1/11
 - APC – planned to be effective 7/1/12
- DRG payment based on three components:
 - Statewide direct care rate
 - Hospital specific capital rate
 - Hospital specific medical education rate
- Outstanding hospital cost report settlements from 2007 through 2011
- MMIS conversion issues in FY 2011
 - Hospital overpaid (DRG payments and PIP)

Skilled Nursing Facilities

28

Medicare

- The FY 2012 update factor is **1.7%** including the budget neutrality factor. The FY 2011 update factor was also 1.7%
- The FY 2012 Wage Index will be applied to **68.693%** of the Federal Rate. The labor portion was 69.311% in FY2011
- **FY 2012 - use of MDS 3.0 and RUGs IV mandated**
- Parity adjustment for unanticipated increase in case-mix due to documentation of Group Therapies on MDS 3.0. **Downward adjustment of 26% in nursing CMI of therapy RUGS.** No adjustment to other non-therapy RUGs
- **Parity adjustment results in overall reduction of 11.1% or \$4.5 billion in payments**

Skilled Nursing Facilities

29

Medicare

- **Overall reduction of approximately 10.9% or \$3.87B (increase in market basket offsets parity adjustment)**
- Overall, the rate changes will range from decreases of **10.4%** to **16.9%** in MA, depending on geographic location, and will result in a decrease of **14.4%** in RI
- **Massachusetts rural wage index increases from 1.1769 to 1.3962** due to inclusion of non-CAH hospital in rural area for 2012. Rural SNF's will see a rate **increase of approx. 12.3%**

Skilled Nursing Facilities

30

MassHealth

- **No changes for standard rate components for FY 2012, similar to FY 2009 through FY 2011. (Fourth year of no increase)**
- User fee on non-Medicare patient days continues in 2012. Assessment is \$18.41 per day, \$18.41 per day payment included in MassHealth reimbursement
 - Previous assessment was \$18.41 per day with payment of \$15.47 per day (variance of \$2.94/day)
 - Benefit of **\$2.94 per day** effective September 1, 2011
- One time add on of \$.26/day, making a total increase of **\$3.20 per day**
- Payments for P4P continue...authorized to be \$2.8M for FY 2012
 - \$5M budgeted and paid in FY 2010, nothing budgeted nor paid for in FY 2011
- **Bed hold policy reinstated - \$80.10 per day**

Home Health

31

Medicare Proposal

- Proposed rule major provisions for 2012
 - ▣ Market basket of 1.5% compared to 1.1% in 2011
 - ▣ **Proposed increase of coding adjustment reduction to 5.06% compared to 3.79% in 2011**
 - ▣ **Proposed standardized payment rate of \$2,112.37 (3.6% decrease)**
 - ▣ Proposed to continue to apply 3% rural add on

MassHealth

- Home Health rates same as 2008 – No increase

Hospice

32

Medicare

- 2012 hospice rates increased by market basket of **3.0%**
- 7-year phase out of BNAF to Hospice wage index
 - Budget Neutrality Adjustment Factor Reduction
 - 10% in FY 2010, 15% in FY 2011-2016 and 100% phased out in FY 2016
- Hospice rate history

Description	FY 2010	FY 2011	FY 2012
Routine home care	\$142.91	\$146.82	\$151.03
Continuous care	\$834.10	\$856.12	\$881.46
Inpatient respite	\$147.83	\$159.65	\$156.22
Inpatient care	\$635.74	\$652.27	\$671.84
Effective rate change	2.1%	2.6%	2.7%
Hospice Cap	\$23,875	\$24,528	TBD

Ambulatory Surgical Centers

33

Proposed Medicare Payment Rates

- Align ASC rates with OPPS rate & minimize the impact of financial incentives on decision about treatment settings
- Proposed 2012 ASC conversion factor of **\$42.33** which is up from \$41.93 in CY 2011, A **0.95% increase** (MB of 2.3% less 1.4% reduction required by the ACA)
 - ▣ OPPS conversion factor is \$69.42, a .78% increase
- CY 2012 proposes new requirements to quality reporting with seven claim-based quality measures to be reported

Physicians

34

Medicare Proposed Rule CY 2012

- Continuation of the provisions of the “Medicare Improvements for Patients and Providers Act of 2008” (MIPPA) (H.R. 6331) regarding bonus payments
 - Bonuses to physicians who e-prescribe
 - +1% in 2012
 - +0.5% in 2013
 - Bonus payment threshold achieved by reporting e-prescribing codes just 25 times for both 2012 and 2013
- Provides a .5% incentive bonus for participating in the Physician Quality Reporting System (PQRS) for 2012
 - CY 2011 final rule reduced the PQRS threshold from **80% to 50%** reporting for individual measures as well as the lowering of group practice thresholds so more group practices could qualify

Physicians

35

- If physicians and eligible professionals do not e-prescribe, they will receive penalties
 - -1.0% in 2012
 - -1.5% in 2013
 - -2.0% in 2014 and beyond
- Payment reduction related to the assumed service delivery efficiencies associated with multiple therapy and imaging services
 - 50% payment reduction for a second imaging (CT, ultrasound, MRI) service provided on the same day to the same patient
 - For CY 2012, the 50% reduction is proposed to be applicable to both the technical component **AND the professional component**
 - According to the impact statement that accompanies the rule, this would reduce payments to the affected services by about \$100 million a year

Physicians

MEDICARE PHYSICIAN FEE CONVERSION FACTOR			
	<u>CY 2010</u> <i>Effective 1/10; 6/10</i>	<u>CY 2011</u> <i>Effective 1/11</i>	<u>CY 2012 proposed</u> <i>Effective 1/12</i>
Conversion Factor	\$36.08/\$36.87	\$34.01	\$23.96
Actual Change	- .03%	-7.76%	TBD
SGR Proposed	-21.50%	-26.11%	-29.50%

- Sustainable growth rate (SGR) was established in the BBA of 1997
- Over a decade, short-term fixes, mainly deferrals of the application of the SGR, have been voted by Congress
- \$300B in debt has accumulated through deferrals of addressing the SGR
- Over 100 U.S. Representatives have submitted requests to the Joint Select Committee on deficit reduction to repeal SGR



Physicians

37

- Repeal of the SGR Formula must be paid for by reduction in other programs:
 - Reduce hospital updates to **1%**
 - Reduce dialysis and hospice updates to **1%**
 - **Rebase home care pricing and no update in 2012**
 - No update for IRF and LTCH
 - Reduce ASC update to **0.5%**
 - Pay hospital outpatient E&M visits at physician fee schedule amounts
 - Reduce clinical lab services by **10%**
 - Rebase SNF reimbursement
 - **Apply readmission policy to SNFs, HH, LTCHs and IRFs**
 - Reduce hospice rates by **6%**