

REIMBURSEMENT UPDATE: COST REPORT CHANGES AND IPPS FINAL RULE

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Objectives

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- Highlight certain changes to Medicare Form 2552-10, Hospital Cost Report
- Summarize Hospital Medicare Inpatient Prospective Payment System final rule for 2012



Cost Report

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Form 2552-10

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- Quick Update on new 2552-10
 - Final Transmittal #1 issued 12/31/2010
 - Transmittal #2 issued 8/2011
 - Includes clarification and corrections to Transmittal #1
 - Effective for cost reporting periods beginning 5/1/2010 (fiscal year ending April 30, 2011)

Form 2552-10

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- Major changes include:
 - Obsolete lines, columns & worksheets eliminated
 - Inserted CMS-339 within S-2 (eliminates a separate filing document!)
 - Worksheet A now 200 lines
 - New cost centers (i.e. Cat Scan, MRI, Cardiac Cath., Rural Health Clinic, etc.)
 - HIT payment calculation and settlement

Form 2552-10

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REDESIGNATED WORKSHEETS

2552-96 Worksheet	Worksheet Description	2552-10 Worksheet
S	Settlement Summary	S, Parts I, II, III
S-2	Identification Data	S-2, Part I
	Reimbursement Questionnaire (CMS 339)	S-2, Part II
S-3, Part I	Statistical Data	S-3, Part I
S-3, Part II	Wage Data	S-3, Part II
S-3 Part III	Wage Index Summary	S-3, Part III
	Hospital Wage Related Costs (Exhibit 6, CMS 339)	S-3, Part IV
	Hospital Contract Labor and Benefit Cost	S-3, Part V
S-4	HHA Statistical Data	S-4
S-5	Renal Dialysis Statistical Data	S-5
S-6	Outpatient Rehab Statistical Data	S-6
S-7	Prospective Payment for SNF	S-7
S-8	RHC Statistical Data	S-8
S-9	Hospice Identification	S-9
S-10	Uncompensated Care Data	S-10
A	Trial Balance of Expenses	A
A-6	Reclassification of Expenses	A-6
A-7, Parts I - III	Analysis of Capital	A-7, Parts I - III
A-8	Adjustments to Expenses	A-8
A-8-1, Part A & B	Related Organizations and Home Office Costs & Interrelationships	A-8-1, Part A & B

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Form 2552-10

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2552-96 Worksheet	Worksheet Description	2552-10 Worksheet
A-8-3, Parts I - VII	Reasonable Cost For Therapy Services Furnished By Outside Suppliers	A-8-3, Parts I - VII
A-8-4	Reasonable Cost for Therapy Services Furnished By Outside Suppliers On Or After April 10, 1998	Eliminated
B, Part I	Cost Allocation - General Service Costs	B, Part I
B, Part II	Cost Allocation - Old Capital	NA
B, Part III	Cost Allocation - New Capital	B, Part II
B-1	Cost Allocation - Statistical Basis	B-1
C, Part I	Computation of Ratio of Costs to Charges	C
C, Part II	Calculation of Outpatient Service Cost to Charge Ratios Net of Reductions	Eliminated
C, Part III	Computation Of Total RPCH Inpatient Ancillary Cost And Inpatient RPCH Operating Cost	Eliminated
C, Part IV	Reasonable Cost Determination For Therapy Services Furnished By Outside Suppliers	Eliminated
C, Part V	Computation of Outpatient Cost Per Visit – Rural Primary Care Hospital	Eliminated
D, Part I	Apportionment of Inpatient Routine Service Capital Costs	D, Part I
D, Part II	Inpatient Ancillary Service Capital Costs	D, Part II
D, Part III	Inpatient Routine Service Other Pass Through Costs	D, Part III
D, Part IV	Inpatient/Outpatient Ancillary Service Other Pass Through Costs	D, Part IV
D, Parts V & VI	Inpatient/Outpatient Ancillary Service Other Pass Through Costs	D, Part V

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2552-96 Worksheet	Worksheet Description	2552-10 Worksheet
D-2	Apportionment Of Cost Of Services Rendered By Interns And Residents	D-2
D-4	Inpatient Ancillary Service Cost Apportionment	D-3
D-6, Parts III & IV	Computation of Organ Acquisition Costs and Charges	D-4
D-9	Teaching Physicians Reasonable Compensation Equivalent Computation	D-5
E, Part A	Inpatient Hospital Services Under PPS	E, Part A
E, Part B	Medical and Other Health Services	E, Part B
E, Part C	Outpatient Ambulatory Surgical Center	Eliminated
E, Part D	Outpatient Radiology Services	Eliminated
E, Part E	Other Outpatient Diagnostic Procedures	Eliminated
E-1	Analysis of Payments	E-1
E-2	Swing Beds	E-2
E-3, Part I	Medicare Reimbursement Settlement under TEFRA, IRF, PPS, LTAC PPS and IPF PPS	
	Medicare Reimbursement Settlement under TEFRA	E-3, Part I
	Medicare Reimbursement Settlement under IPF PPS	E-3, Part II
	Medicare Reimbursement Settlement under IRF PPS	E-3, Part III
	Medicare Reimbursement Settlement under LTAC PPS	E-3, Part IV
E-3, Part II	Medicare Part A Services - Cost Reimbursement	E-3, Part V
E-3, Part III	Title V of Title XIX Services or Title XXIII SNF PPS	E-3, Part VI
	Title V and XIX SNF Reimbursement	E-3, Part VII

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2552-96 Worksheet	Worksheet Description	2552-10 Worksheet
E-3, Part IV	Direct Graduate Medical Education (GME) & ESRD Outpatient Direct Medical Education Costs	E-4
L	Calculation of Capital Payment	L
H	Home Health Agency Costs	H
H-1	Compensation Analysis - Salaries & Wages	Eliminated
H-2	Compensation Analysis - Employee Benefits	Eliminated
H-3	Compensation Analysis - Contracted/Purchased Services	Eliminated
H-4, Part I & II	Cost Allocation & Statistics	H-1, Parts I & II
H-5, Part I & II	Allocation to HHA Cost Centers & Statistics	H-2, Parts I & II
H-6	Apportionment of Patient Service Costs [HHA]	H-3
H-7	Calculation of HHA Reimbursement Settlement	H-4
H-8	Analysis of Payments	H-5

Red – New Forms

Green – Eliminated Forms

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Form 2552-10

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- Approved Extension
 - One Time Only
 - Due to extra time to get Transmittal #2 out and implemented
 - Short periods beginning on or after 5/1/2010 but ending before 4/30/2011 must file and settle using the 2552-96

Form 2552-10

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- All providers with full 12 months or greater cost reporting periods that began on or after May 1, 2010 (and ended on or after April 30, 2011), will file on Form CMS-2552-10, subject to the following filing extension schedule:

FYE	Due	Now Due	Extension
4/30/2011	9/30/2011	11/30/2011	60 days
5/31/2011	10/31/2011	11/30/2011	30 days
6/30/2011	11/30/2011	1/31/2012	60 days
7/31/2011	12/31/2011	1/31/2012	30 days
8/31/2011	1/31/2012	2/29/2012	30 days
9/30/2011	2/29/2012	3/31/2012	30 days
10/31/2011	3/31/2012	3/31/2012	NONE



Poll Question

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HIT Settlement

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- HIT Settlement for EHR Incentive program
 - Providers must have registered to be eligible
 - Must be designated a “Meaningful user” of certified EHR technology
 - Hospitals have been designated as such in 2011, but may also do so in 2012 and 2013 to be eligible for the full incentive payment
 - Different calculations for IPPS Hospitals and CAH designated Hospitals

HIT Settlement

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- Starts with Worksheet S-2:
 - Line 167 – Are you a meaningful user?
 - Line 168 – If a CAH and meaningful user, cost incurred for HIT assets
 - Costs incurred in the current cost reporting period
 - Line 169 – If a meaningful user and not a CAH, enter Transition Factor:

	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>
<u>2011</u>	1.0				
<u>2012</u>	.75	1.0			
<u>2013</u>	.50	.75	1.0		
<u>2014</u>	.25	.50	.75	.75	
<u>2015</u>		.25	.50	.50	.50
<u>2016</u>			.25	.25	.25

HIT Settlement

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- Worksheet A-7, Part I, Line 7
 - If S-2, Line 167 is yes, then enter amount for certified HIT assets acquired.
 - Information only, not used in calculations

- Worksheet E-1, Part II (New Form)
 - Calculation of HIT incentive payment settlement
 - If not meaningful user in FY 2011, then no settlement
 - Data from FY 2011 cost report used in FFY2012 preliminary payment
 - Preliminary payment based on most recent filed cost report at the time of calculation.
 - Final settlement data taken from the cost reporting period beginning in the payment year. (Must be a 12 month cost report)
 - Days and Discharges from S-3, Part I
 - Hospital charges from W/S C (net of professional charges)
 - Charity Care charges from S-10, Col. 3, Ln 20
 - For CAH only, cost of HIT assets from S-2, line 168.



Poll Question

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HIT Settlement

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- Line 8 then states to calculate the HIT payment
 - Cost report software will calculate
 - Rather cumbersome formula
 - Line 30 - Enter the HIT payment received
 - Line 31 – adjustments, if any
 - Line 32 – Balance due Program/Provider
-
- Reminder – beginning in FY 2011, must include the HIT settlement in your estimated third party settlement amounts.

HIT Settlement

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12-10 CMS FORM-2552-10 4090 (Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	PROVIDER NO.:	PERIOD:	WORKSHEET E-1, PART II
	_____	FROM _____	
	COMPONENT NO.:	TO _____	

Check applicable box:	<input type="checkbox"/> Hospital	<input type="checkbox"/> CAH
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HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 sum of lines 14		1
2	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		2
3	Medicare HMO days from Wkst S-3, Part I, column 6. sum of lines 2		3
4	Total inpatient bed days from S-3, Part I column 8 sum of lines 1, 8-12		4
5	Total hospital charges from Wkst C, Part I, column 8 line 200		5
6	Total hospital charity care charges from Wkst S-10, column 3 line 20		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 167		7
8	Calculation of the HIT incentive payment (see instructions)		8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s).		30
31	Other Adjustments (specify)		31
32	Balance due provider (line 8 minus line 30 ± line 31)		32

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Worksheet S-10

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- Worksheet S-10 Uncompensated and Indigent Care Data
 - Now required for CAH's (due to use in HIT settlement!)
 - Calculates difference between net revenue and cost for Medicaid, Charity, Bad Debt, SCHIP and other state or local programs
 - Computes the cost of providing Uncompensated and Indigent care by using an overall CCR

Worksheet S-10

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12-10		FORM CMS-2552-10		4090 (Cont.)	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-10	
Uncompensated and indigent care cost computation					
1	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)				1
Medicaid (see instructions for each line)					
2	Net revenue from Medicaid				2
3	Did you receive DSH or supplemental payments from Medicaid?				3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?				4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid				5
6	Medicaid charges				6
7	Medicaid cost (line 1 times line 6)				7
8	Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)				8
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9	Net revenue from stand-alone SCHIP				9
10	Stand-alone SCHIP charges				10
11	Stand-alone SCHIP cost (line 1 times line 10)				11
12	Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)				12
Other state or local government indigent care program (see instructions for each line)					
13	Net revenue from state or local indigent care program(not included on lines 2, 5 or 9)				13
14	Charges for patients covered under state or local indigent care program(not included in lines 6 or 10)				14
15	State or local indigent care program cost (line 1 times line 14)				15
16	Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)				16
Uncompensated care (see instructions for each line)					
17	Private grants, donations, or endowment income restricted to funding charity care				17
18	Government grants, appropriations or transfers for support of hospital operations				18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility				20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)				21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)				23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire facility (see instructions)				26
27	Medicare bad debts for §1886(d) hospitals from Worksheets E, Part A and E, Part B, or for CAHs from Worksheet E-3, Part V				27
28	Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)				28
29	Cost of non-Medicare bad debt expense (line 28 times line 19)				29
30	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

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Worksheet S-10

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■ Medicaid

■ Line 2 = Net Revenue from Medicaid

- Includes payments from Medicaid Managed Care Programs
- DSH and other supplemental payments reported here if not separately identifiable
 - DSH and supplemental payments reported net of provider taxes or assessments
- Net of all professional fees

- Line 3 – enter yes if you expect to receive DSH or supplemental payments
- Line 4 – If line 3 is yes, does line 2 include DSH and supplement payments (yes or no)
- Line 5 – if line 4 is yes, skip; if line 4 is no enter DSH and supplemental payment amounts
- Line 6 = Gross Medicaid charges (should relate to the amount reported in line 2)

Worksheet S-10

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- SCHIP
 - Lines 9 through 12 similar to Medicaid

- Other State of Local Indigent Care Program

- Line 17 – Enter non-government gifts, grants, endowment income for charity care
- Line 18 – Enter grants, appropriations or transfers from government agencies for support of hospital operations.
 - Line 18 = Net Revenue received from the HSN program

Worksheet S-10

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- Charity Care – defined as
 - Patient qualifies under hospital charity care policy
 - Hospital demonstrates patient unable to pay
 - Excludes courtesy discounts
 - Excludes discounts to patients who failed to qualify for charity care

- Line 20 – used in the HIT settlement calculation
 - Includes uninsured and insured patients (two columns)
 - Col 1 = charges for full and partial charity care write offs
 - Col 2 = deductible and/or coinsurance payment from a government or private insurer given as a charity care write off
 - Includes MA HSN Program
 - Payments and charges can be associated with specific patients and documented in the patient accounting system
 - Line 20 = Gross Charges associated HSN

- Line 22 = any partial payments received from patients approved for partial charity care

Worksheet S-10

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- Line 26 – Total bad debts written off (or expected to be written off) for the facility (bad debt expense)
 - Includes Medicare bad debts
 - Excludes bad debts that were the obligation of private insurer rather than the patient (e.g. denials)
- Line 27 – enter *Reimbursable* Medicare bad debts
- Line 31 – Sum of cost of all unreimbursed and uncompensated care.

Worksheet A-7

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- Worksheet A-7
 - Part I – Roll forward schedule of fixed assets
 - See line 7 – Hit assets
 - Includes column for fully depreciated assets
 - Part II – Reconciles amounts on W/S A, Col. 2, lines 1 & 2
 - Includes all directly assigned interest, etc.
 - Part III – Reconciles to W/S A, col. 7, lines 1 & 2
 - Used to calculate the reclassification from Line 3 to Lines 1 & 2
 - Col. 7, Line 3 will equal zero

Worksheet A-7

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4090 (Cont.)

FORM CMS-2552-10

12-10

RECONCILIATION OF CAPITAL COSTS CENTERS

PROVIDER NO.:

PERIOD:
FROM _____
TO _____

WORKSHEET A-7,
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Purchases	Donation	Total				
	1	2	3	4	5	6	7	
1 Land								1
2 Land Improvements								2
3 Buildings and Fixtures								3
4 Building Improvements								4
5 Fixed Equipment								5
6 Movable Equipment								6
7 HIT-designated Assets								7
8 Subtotal (sum of lines 1-7)								8
9 Reconciling Items								9
10 Total (line 7 minus line 9)								10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)
	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)		
	9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
3 Total (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)
	1	2	3	4	5	6	7	8
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
3 Total (sum of lines 1-2)				1.000000				3

Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)
	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)		
	9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
3 Total (sum of lines 1-2)								3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

FORM CMS-2552-10 (12/2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 4090)

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Summary of IPPS Final Rule

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Medicare Inpatient Prospective Payment System Update

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- Proposed rule issued May 2011
- Final Rule issued August 18, 2011
- Final rule reduced proposed cut for changes in documentation and coding from 3.15% to 2.0%, representing \$1.2 billion in payments in FY 2012 nationally
- Overall, proposed rule decreased payments 0.55% but final rule increased payments by 1.1%
- Final rule addresses rural floor budget neutrality adjustment, quality reporting (quality measures, hospital acquired conditions and readmissions), value based purchasing, changes to wage index, outliers, other payment issues

Medicare Inpatient Prospective Payment System Update

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- Establish basis for ACA's Medicare inpatient readmissions payment policy effective FY 2013
- Establishing rules related to hospital inpatient value-based purchasing program effective FY 2014
- Final rule can be found at either site:
 - ▣ <https://www.cms.gov/AcuteInpatientPPS/FR2012/>
 - ▣ <http://federalregister.gov/a/2011-19719>

Medicare Inpatient Prospective Payment System Update

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	Final FY 2011 Rate	Final FY 2012 Rate	Percentage Change
Federal Operating Rate	\$5,164.11	\$5,209.74	0.9%
Federal Capital Rate	\$420.01	\$421.42	0.3%

- Federal Operating rate:
 - ▣ Market basket update is 3.0%
 - ▣ Less 1.0% ACA-mandated productivity reduction
 - ▣ Less 0.1% ACA-mandated pre-determined reduction
 - ▣ Less 2.0% coding reduction to offset perceived coding improvements
 - ▣ Plus 1.1% to account for CMS' inappropriate application of rural floor budget neutrality adjustments ("Cape Cod Hospital vs. Sebelius" case)
 - ▣ Additionally, an additional 2.0% reduction is possible if not participating in IQR

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Medicare Inpatient Prospective Payment System Update

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- Hospital-specific rates for SCH's and MDH's:
 - Market basket update is 3.0%
 - Less 1.0% ACA-mandated productivity reduction
 - Less 0.1% ACA-mandated pre-determined reduction
 - Less 2.0% coding reduction to offset perceived coding improvements
 - Plus 0.9% to account for CMS' inappropriate application of rural floor budget neutrality adjustments

Medicare Inpatient Prospective Payment System Update

32

- Capital rate:
 - Market basket update is 1.5%
 - Less 1.0% coding reduction to offset perceived coding improvements
 - Less 0.2% due to an increase in the capital outlier budget neutrality factor

Medicare Inpatient Prospective Payment System Update

33

- Coding adjustments

	Federal Operating Rate	Hospital-Specific rate	Federal Capital Rate
	Retrospective Coding Adjustment	Prospective Coding adjustment	Prospective Coding adjustment
Total Coding Impact estimated by CMS	5.4%	5.8%	5.4%
Coding adjustment reductions previously applied	-1.5%	-2.9%	-4.4%
Remaining coding adjustment reduction required	3.9%	2.9%	1.0%
Final FFY2012 coding adjustment reduction	-2.0%	-2.9%	-1.0%
Remaining coding adjustment reduction to be applied (FFY 2013)	1.9%	0.0%	0.0%

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Rural Floor Budget Neutrality Adjustment

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Rural Floor Budget Neutrality

- In FY 2009, CMS began a 3 year transition to shift from a national to a state level budget neutrality adjustment
- FY 2010 represented the second year of the 3 year transition with 50% national and 50% state budget neutrality
 - Once completed, all hospitals in each state would have been responsible for funding the rural floor within the state
- In FY 2011, the ACA required CMS to restore the national rural floor budget neutrality adjustment rather than state specific
 - Significant positive impact for Massachusetts in future years
 - Rural floor for Massachusetts expected to exceed 1.30

Inpatient Quality Reporting

35

- For FFY 2012 payment determinations, hospitals reported on 55 quality measures
- For FFY 2013 payment determinations, hospitals reporting on 57 quality measures
- For FFY 2014 payment determinations, hospitals will report on 60 quality measures
- Final rule makes continued refinements to align the IQR with the EHR Incentive Program

Value Based Purchasing

36

- ACA mandated a VBP program to redistribute payments to hospitals meeting IQR measures beginning 10/1/12
- Final rule adopts a Medicare spending per beneficiary measure for use under the IQR and 2014 VBP program
- Adds a fourth domain, efficiency, to three existing domains, process of care, patient experience of care, and outcomes
- Medicare spending per beneficiary measured from 3 days prior to admission to 30 days post discharge, including all Part A and B payments
- Individual hospital's Medicare spending per beneficiary calculated in proportion to national median
- Resulting ratio applied as a weighted factor with other domains to obtain total scoring

Hospital Readmissions Reduction Program

37

- Mandated by ACA and designed to reduce FFS payments to hospitals with higher than expected readmissions rates for certain conditions
- Begins 10/1/12
- Capped at 1.0% in FY 2013, increasing over time
- Using specific measures from IQR program from 2008-2011 related to Acute Myocardial Infarction, Heart Failure, Pneumonia
- Need at least 25 total discharges by area to be included in program
- Compared to unadjusted raw US averages
- Data from the Hospital Compare website
- Excesses will be measured at greater than 1.0 and penalties will then apply

Changes to Wage Index

38

- Wage index reform – ACA requires HHS to recommend reform to the Wage index system by December 31, 2011
- Proposed IPPS FY 2012 rule does not address this mandate other than to solicit comments and not addressed in Final Rule
- FY 2012 rural floor budget neutrality factor reduces wage index by 0.9%
- Labor-related share is 62% if wage index less than 1.0 and 68.8% if greater than 1.0

Changes to Wage Index

39

Area Wage Index (AWI)

- The 2007-08 Occupational Mix Survey will continue to be used to adjust the 2012 wage index
- The FY 2012 occupational mix adjusted national average hourly wage is \$36.2481 vs. \$34.9664 in 2011
- For FY 2013, a revised survey tool has been developed and will be used to collect 2010 wage and hours data
 - Hospitals were required to submit the 2010 survey by July 1, 2011

Outliers

40

- Maintain total outlier payments under IPPS at 5.1%, an outlier fixed-loss threshold of \$22,385 for FFY 2012, a 3% reduction from 2011, which will increase number of eligible cases
- Outlier cases are paid 80% of the difference between estimated cost and the outlier threshold.

Other Payment Issues

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- Now excluding inpatient hospice days from the patient day count for DSH and the bed day count for IME and DSH
 - Limited impact on DSH
 - May increase payments for IME
- Low volume adjustments to be based on Medicare discharges from FY2010 MedPAR file
 - Filings due 9/1/11
- Low cost county add-on – 400 hospitals – FY 2012 is final year



Poll Question

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Other Payment Issues

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- Added one new net MS-DRG category for total of 751 DRG's
 - Based on 2010 claims data and 2009 cost report data
- Medicare Dependent Hospitals (< 100 beds and >60% Medicare A days or discharges) status expiring after FY2012 unless Congress extends
- CAH ambulance services policy clarifications as to when payments are made at 101% of costs or fee schedule
- Updates to DRGs subject to the post-acute care transfer payment policy
- Update to 3-day payment window (72-hour rule) – reiterates process to attest to unrelated non-diagnostic outpatient services to inpatient admission

Other Payment Issues

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- Maximum allowable annual pension costs for wage index or cost reimbursement
 - Pension costs must be funded to be allowable
 - All hospitals must report actual pension contributions funded on a cash basis
- For wage index for FY2013, costs equal to average actual cash contributions made to DB plan over three year period for 2008, 2009, 2010
- Certain pre-funded amounts from FY2007 through 2012 can be included in 2013 through 2022 wage index calculations in 1/10 increments
- For cost reimbursement – allowable maximum limited to 150% of the three consecutive reporting periods out of the five most recent reporting which produce the highest average
 - Effective for CRP beginning on or after 10/1/11

ANY QUESTIONS?



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Thank you!

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