

Medicare Update for Hospitals & Health Systems

Presented by
Tim Wolters, CPA
BKD, LLP

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Agenda

- FY2010 Inpatient PPS (IPPS) Proposed Rule
- Other regulatory issues
- American Recovery & Reinvestment Act of 2009 (Stimulus Bill)
- Health care reform issues

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FY2010 IPPS Proposed Rule

- 2.1% projected market basket update
- Reduced 1.9% for documentation & coding adjustment
- Outlier threshold up to \$24,240 (was \$20,045)
- Base rate, before wage index

	Operating	Capital	Total
FY09 Actual	\$5,128.41	\$424.17	\$5,552.58
FY10 Proposed	\$5,128.56	\$420.67	\$5,549.23

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FY2010 IPPS Proposed Rule

Discharges with	2007	2008
Major Complications	22%	27%
Other Complications	22%	22%
No Complications	56%	51%

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DATA & ANALYTICS

FY2010 IPPS Proposed Rule

- Documentation & Coding Adjustment (DCA)
 - ❖ CMS estimates 2.5% case mix growth in 2008
 - ❖ Currently estimate 2.3% in 2009
 - ❖ Because of 2007 legislation, CMS imposed 0.6% DCA in 2008 & additional 0.9% in 2009
 - ❖ Proposing additional 1.9% DCA for 2010
 - ❖ Estimates actual adjustment should be 8.5%
 - ❖ CMS believes additional 6.6% **cut** needed in future years to catch up for 2008/2009 "overpayments"

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DATA & ANALYTICS

FY2010 IPPS Proposed Rule

- Hospital-specific rates (HSRs)
 - ❖ CMS did not adjust sole community hospital (SCH) & Medicare-dependent hospital (MDH) HSRs for DCA in 2008 or 2009
 - ❖ Believes they have experienced similar case mix growth
 - ❖ Reducing 2010 HSRs by full 2.5%

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DATA & ANALYTICS

FY2010 IPPS Proposed Rule

- New cost report forms released in June?
- Implantable devices – new cost center
 - ❖ Report revenue codes 275 (Pacemaker), 276 (intraocular lens), 278 (other implants) & 624 (investigational devices)
 - ❖ Capture charges & costs
 - ❖ CAHs should evaluate as well

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FY2010 IPPS Proposed Rule

- No significant changes to hospital-acquired conditions
- Increasing quality reporting measures from 44 to 46
 - ❖ Retiring one
 - ❖ Combining two into one
 - ❖ Adding four new measures

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FY2010 IPPS Proposed Rule

- Wage index
 - ❖ Finalize transition of reclassification criteria requiring hospital's wage equal at least 88% (urban) & 86% (rural) of requested area's wage
 - ❖ Continue transition from national to state-specific budget neutrality for rural floor – applied 50%/50% for FY2010, 100% state specific in FY2011
 - ❖ New CBSAs for FY2010 – Cape Girardeau, MO; Manhattan, KS; Mankato, MN
 - ❖ Change labor share of standardized amount from 69.7% to 67.1% if wage index > 1.0
 - ✓ Will slightly reduce payments in high wage areas

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FY2010 IPPS Proposed Rule

- SCH & MDH budget neutrality
 - ❖ SCH base years – 1982, 1987, 1996, 2006
 - ❖ MDH base years – 1982, 1987, 2002
 - ❖ Inflated by market basket adjustment & budget neutrality
 - ❖ CMS imposing cumulative budget neutrality from 1993 forward for 1996, 2002 & 2006 base years
 - ❖ Reduces 2002 MDH rate by 1.74% starting October 1, 2009
 - ❖ Reduces 2006 SCH rate by 2.35% for FYs beginning on or after January 1, 2009
 - ❖ **Should be appealed!** (within 180 days of notice)

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DATA & ANALYTICS

FY2010 IPPS Proposed Rule

- Disproportionate share reimbursement
 - ❖ Changes for periods beginning October 1, 2009 or after
 - ❖ Include in disproportionate patient percent maternity patients admitted, regardless of whether occupied an inpatient bed yet
 - ❖ Medicaid patient days may be counted based on admission date, discharge date or service date
 - ✓ Request change 30 days before start of year
 - ❖ Exclude all observation days from count, regardless of whether patient was admitted
 - ✓ Also exclude beds from bed count

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DATA & ANALYTICS

FY2010 IPPS Proposed Rule

- New medical residency programs
 - ❖ Clarifies that new program is one that “receives initial accreditation for the first time, as opposed to reaccreditation of a program that existed previously at the same or another hospital”
 - ❖ Cannot rely on characterization of program by relevant accrediting body
- Capital indirect medical education
 - ❖ Paid at 100% through September 30, 2009 (per Stimulus Bill) & 0% thereafter

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DATA & ANALYTICS

FY2010 IPPS Proposed Rule

- CAHs paid 101% of cost for lab tests July 1, 2009 & after, even if patient is not at CAH when the specimen is collected, if
 - ❖ Patient receives outpatient services at CAH on the same day **or**
 - ❖ Specimen is collected by a CAH employee
- SNF consolidated billing rules unchanged

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CONSTRUCTION

2010 IPPS Proposed Rule

- Lab outpatient definition, continued
 - ❖ CMS has instructed FIs/MACs to implement July 1, 2009 (Change Request 6395)
 - ❖ CMS will consider comments received
 - ❖ CMS will develop billing modifiers to identify claims paid under this provision & issue related guidance

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CONSTRUCTION

2010 IPPS Proposed Rule

- CAH-specific provider-based rule provisions
 - ❖ Apply provider-based rules to offsite CAH labs
 - ❖ Should provider-based rules apply to ambulances for which CAHs get cost reimbursement?
 - ✓ CMS requests comments

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CONSTRUCTION

2010 IPPS Proposed Rule

- MMA 03 increased CAH reimbursement 1%
- CMS identified apparent drafting error & is revising regulations accordingly
 - ❖ Providers electing “optional” or “Method II” outpatient reimbursement lose the 1% add on for CAH outpatient facility reimbursement
 - ❖ Specifies no effective date for this change

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FY2010 IPPS Proposed Rule

- Impact – CMS estimates 0.5% reduction for all PPS hospitals
 - ❖ 0.4% reduction for urban hospitals
 - ❖ 1.3% reduction for rural hospitals
- Documentation & coding adjustment may have even greater impact in future years
- Comments due June 30, 2009

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FY2010 SNF PPS Proposed Rule

- 2.1% market basket update effective October 1, 2009
- Offset by 3.3% reduction due to higher percent of residents scoring in new RUG categories effective January 1, 2006 (30% in new categories; expected only 19%)
- Proposing new RUG system for FY2011, increasing from 53 to 66 categories
- Proposing to eliminate short-form MDS for swing-bed PPS hospitals effective October 1, 2010

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FY2010 Rehab PPS Proposed Rule

- Proposing 2.4% market basket increase
- Updating outlier threshold to increase outlier payments from 2.8% to 3.0% of total payments
- Decrease in rural add-on – rural facilities to see 0.7% increase; urbans see 2.8% increase
- Requiring completion of patient assessment instrument for Medicare Advantage patients effective October 1, 2009

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FY2010 Psych PPS Final Rule

- 2.1% market basket update July 1, 2009
- Outlier threshold increases, reducing outlier payments
- Mentions potential one-time adjustment (*i.e.*, documentation & coding) but no specific proposal this year
- Retains existing adjustments – rural, teaching, variable per diem, age, MS-DRG, comorbidity, etc.

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Outpatient 2009 PPS Final Rule

- 3.6% payment update
 - ❖ 1.6% if not reporting quality data
- Four new quality measures for 2009 for imaging efficiency (11 total)
- “Clarifies” physician supervision requirements – particularly troublesome for off-site oncology & cardiac rehab services

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Home Health 2009 PPS Final Rule

- 2.9% market basket update
 - ❖ 0.9% if not reporting quality data
- Mostly offset by 2.75% case-mix offset
 - ❖ Similar reductions to come in 2010 & 2011
- Outlier fixed dollar loss ratio remains .89
 - ❖ CMS estimates 8.1%; should be 5.0%
 - ❖ CMS to review high outlier locations

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OSHA & AHA

TriCare OPSS Final Rule

- Implementing May 1, 2009
- Excludes CAHs, specialty hospitals
- Five year transition on emergency/clinic visits
 - ❖ Still estimate 23% cut in reimbursement
- 7.1% sole community hospital add-on
- Hold harmless payments as well
- Transitional payments for high-volume hospitals (over \$1.5 million in payments)
 - ❖ Four years – 20%, 15%, 10%, 5% add-ons

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OSHA & AHA

Change Request 6329 (March 6, 2009)

- Between July 6 - November 30, 2009, PPS hospitals receiving DSH must submit no-pay bills to Medicare contractor for Medicare Advantage patients discharged between October 1, 2005 - September 30, 2006
- Also affects rehab facilities receiving LIP
- Already applies to teaching hospitals & hospitals with nursing/allied health programs
- Will affect SSI percent used for disproportionate share & rehab LIP payments

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OSHA & AHA

Medicare Bad Debts

- May 2, 2008 CMS memorandum
- Contractors to disallow bad debts if not returned from collection agency
- Settlements issued after May 2, 2008

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Recovery Audit Contractors

- Nationwide implementation planned during 2009
- RACs receive percentage of recoveries
- Should perform risk assessment
- Monitor at www.cms.hhs.gov/RAC/

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Stimulus Bill - EHR Funding

- \$2 billion to Office of the National Coordinator of Health Information Technology (ONCHIT) to implement Health Information Technology for Economic & Clinical Health Act (HITECH) for electronic health records (EHR)
 - ❖ 53 pages of details in bill

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Stimulus Bill - EHR Funding

- Certified EHR technology
 - ❖ “. . . a qualified electronic health record . . . certified . . . as meeting standards . . . applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).”

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Stimulus Bill - EHR Funding

- Meaningful EHR user
 - ❖ Uses certified EHR technology in meaningful manner, determined by Secretary
 - ❖ Connected in manner to provide for meaningful exchange of information to improve quality/care coordination
 - ❖ Using EHR to report clinical quality & other measures required by Secretary

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Stimulus Bill - EHR Funding

- Health Information & Management Systems Society (HIMSS) EMR Adoption Model
 - ❖ Eight stages, 0 – 7
 - ❖ First quarter 2009, 92.6% of hospitals at Stages 0 – 3
 - ❖ 41 hospitals at Stage 6
 - ❖ 15 hospitals at Stage 7

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Stimulus Bill - EHR Funding

- Certification Commission for Healthcare Information Technology (CCHIT)
 - ❖ Mission is “accelerating the adoption of robust, interoperable health information technology by creating a credible, efficient certification process.”
- Websites
 - ❖ www.himssanalytics.org
 - ❖ www.cchit.org
 - ❖ www.hhs.gov/healthit/

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Stimulus Bill - EHR Funding

- Reporting clinical quality & other measures

“The Secretary shall seek to improve the use of EHR and health care quality **over time** by requiring **more stringent** measures of meaningful use selected under this paragraph”

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Stimulus Bill - EHR Funding

- PPS hospitals
 - ❖ Base amount = \$2 million
 - ❖ Discharge amount = \$200/discharge, discharges 1,150 - 23,000
 - ❖ Sum of amounts x Medicare percent = gross annual amount
 - ❖ Gross annual amount x transition factor = actual payment

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Stimulus Bill - EHR Funding

- Medicare percent
 - ❖ Numerator - Part A days + Part C days
 - ✓ Part C days documented based on no-pay bills?
 - ❖ Denominator - Total days x (charges net of charity ÷ total charges)
 - ✓ CMS to decide what constitutes charity care?

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Stimulus Bill - EHR Funding

- PPS hospital transition factors

1 st Eligible→	2011-2013	2014	2015
Year 1	1.00	0.75	0.50
Year 2	0.75	0.50	0.25
Year 3	0.50	0.25	0
Year 4	0.25	0	0

- No payment if first year eligible is after 2015

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Sample PPS Payment

- Assumptions
 - ❖ 20,000 total patient days
 - ❖ 9,000 Medicare Part A patient days
 - ❖ 1,000 Medicare Part C patient days
 - ❖ 5,000 total discharges
 - ❖ 3% charity care

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Sample PPS Payment

▪ Base Amount	\$2,000,000
▪ Discharge Amount (\$200 x 3,851)	<u>770,200</u>
▪ Subtotal	2,770,200
▪ Medicare % – 10,000/(20,000 x 97%)	x 51.5%
▪ First Year Payment	<u>\$1,427,938</u>
▪ Total Payment over Four Years	<u>\$3,569,845</u>

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Stimulus Bill - EHR Funding

- Critical access hospitals
 - ❖ CMS to define specifics in regulations
 - ❖ First eligible for special funding for cost reporting periods beginning in 2011
 - ❖ Paid depreciable costs in year incurred x {Medicare percent (same as PPS) + 20%}
 - ❖ Payment limited to 100% of depreciable costs

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Stimulus Bill - EHR Funding

- Critical access hospitals
 - ❖ Book value as of 2011 to be paid in 2011 for prior costs
 - ❖ Payment for up to four eligible years, but no payment after 2015
 - ❖ Other allowable costs paid through cost report

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Stimulus Bill - EHR Funding

- Physicians & other professionals
 - ❖ 75% add-on to fee schedule payments for up to five years
 - ❖ Excludes services with hospital as service site
 - ❖ 10% bonus if in HPSA
 - ❖ No payment if first adopting after 2014

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Stimulus Bill - EHR Funding

- Physicians & other professionals
 - ❖ Aggregate payment (excluding 10% HPSA bonus) based on year first eligible =
 - ✓ 2011-2012 - \$44,000
 - ✓ 2013 - \$39,000
 - ✓ 2014 - \$24,000
 - ✓ 2015 - \$0

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Stimulus Bill - EHR Funding

- Rural health clinics (RHCs) & federally qualified health centers (FQHCs) can be paid EHR costs through Medicaid
- Must provide 30% of services to needy individuals—Medicaid, charity or sliding fee scale patients

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Stimulus Bill - EHR Funding

- RHCs & FQHCs paid no more than \$25,000 in first year (no later than 2016) & \$10,000 per year thereafter, for up to five years
- Pediatricians with 20% medical assistance volume eligible for 2/3 of amounts
- Eligible professionals must forego Medicare EHR payments to receive Medicaid payments

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Stimulus Bill - EHR Funding

- Children's hospitals or **acute-care hospitals** with at least 10% Medicaid volume also can receive Medicaid payment (may include CAHs?)
 - ❖ Computed same as Medicare gross payment over four years, if Medicare percent was 100%
 - ❖ Total above times Medicaid percent
 - ❖ Payment spread over at least three years

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Stimulus Bill - EHR Funding

- Penalties start in 2015 for nonusing PPS hospitals, CAHs or professionals
- Hardship exception available for up to five years
- Secretary to issue study by June 30, 2010 on whether EHR funding should be made available to other providers—SNFs, home health agencies, etc.

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EHR Readiness

- Major HIT modules
 - ❖ Patient management
 - ❖ Clinical
 - ❖ Ancillary
 - ❖ Financial
 - ❖ Patient accounting
 - ❖ Data management & analysis
 - ❖ System integration

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EHR Readiness

- Why an EHR now?
 - ❖ More informed decisions
 - ❖ Improved quality of care
 - ❖ Improved compliance
 - ❖ Improved ability to manage PPS & managed care contracts
 - ❖ Compliance with federal EHR initiatives
 - ❖ Enhanced reimbursement

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EHR Readiness

- Managing the process
 - ❖ Control the process
 - ❖ Control the vendors
 - ❖ Control the "squeaky wheel" (MD or department head)
 - ❖ Maximize the return on your IT investment

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EHR Readiness

▪ Key questions

- ❖ How do I manage such a large project?
- ❖ Can our current systems & technology support an EHR?
- ❖ What exactly do I want a new HIT / EHR system to do?
- ❖ How do I manage the selection process?
- ❖ How can I be sure my new HIT / EHR investment is implemented properly?

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EHR Readiness

▪ Step one: Support the process

- ❖ Process must be supported by management:
 - ✓ IT steering committee – blend business planning, budgeting & IT strategic planning
 - ✓ Project team(s) – utilize project management tools and processes

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EHR Readiness

▪ Step two: EHR readiness assessment

- ❖ ARRA reimbursement analysis
- ❖ Technical & IT infrastructure inventory
- ❖ Security compliance (HIPAA) & control assessment
- ❖ Current systems capabilities assessment
- ❖ Development of EHR project charter

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EHR Readiness

- Step three: EHR needs assessment
 - ❖ Understand the current state of EHR/HIT options
 - ❖ Define your specific needs, requirements & expectations for EHR/HIT
 - ❖ Develop a request for proposal (RFP) or request for information (RFI)

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EHR Readiness

- Step four: System selection
 - ❖ Follow structured evaluation & selection process using needs driven metrics
 - ❖ Perform due diligence analysis of top two vendors or suites of vendors
 - ❖ Understand total cost of ownership (TCO)
 - ❖ Perform implementation planning
 - ❖ Assess, negotiate & execute contracts

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EHR Readiness

- Step five: Implementation management
 - ❖ Utilize structured project management tools
 - ❖ Manage the project
 - ✓ Vendors
 - ✓ Internal staff
 - ✓ External staff
 - ❖ Control changes
 - ❖ Transition to ongoing vendor & system management

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Stimulus Bill - Other Funding

- Agency for Healthcare Research & Quality - \$1.1 billion for comparative effectiveness research
 - ❖ Research to compare two or more medical treatments & services addressing particular medical conditions
- Bank-qualified tax-exempt bond limit increased from \$10 million to \$30 million in 2009 & 2010
 - ❖ Borrower is considered issuer so many more issues will qualify

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Stimulus Bill - Other Funding

- 6.2% increase in federal Medicaid match
- Additional increase for states based on increase in unemployment rate
- Applies from October 1, 2008 - December 31, 2010
- \$86.6 billion

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2010 Administration Budget

- Where it's going
 - ❖ \$630 billion reserve fund over 10 years as "down payment" on health care reform
 - ❖ \$330 billion for "additional expected Medicare physician payments"
 - ❖ \$9 billion for "nurse home visitation program"

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2010 Administration Budget

- Where it comes from
 - ❖ \$177 billion from establishing competitive bidding for Medicare Advantage
 - ❖ \$37 billion from home health payment cuts
 - ❖ \$2 billion from “private sector enhancements to ensure Medicare pays accurately” - RACs?

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2010 Administration Budget

- Where it comes from
 - ❖ \$18 billion from bundling Medicare payments covering hospital & post-acute settings
 - ✓ Services during 30 days following hospitalization
 - ❖ \$12 billion from creating hospital quality incentive payments
 - ❖ \$8 billion from reducing hospital readmission rates for Medicare patients
 - ✓ 18% readmitted within 30 days

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Senate Finance Committee Plans

- Value-based program
 - ❖ Funds withheld from hospitals, redistributed based on quality results – 2% in 2013, increasing to 5% in 2016 & beyond
 - ❖ No incentive below 26th percentile, full incentive above 75th percentile, sliding-scale in between
- Hospital readmissions
 - ❖ Starting in 2013, hospitals with readmission rates above 75th percentile would see 20% withhold of payments for readmissions within 30 days

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Senate Finance Committee Plans

- Bundling policy
 - ❖ IPPS payments & post-acute services within 30 days of discharge bundled into one payment
 - ❖ Post-acute services include home health, skilled nursing, inpatient rehabilitation & long-term care hospital services
 - ❖ Effective October 2014 for top 20% of admission categories; October 2016 for next 30%; full implementation October 2018

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Senate Finance Committee Plans

- Teaching hospitals
 - ❖ 80% of unused residency slots included in pool for redistribution
 - ❖ Rural hospitals under 250 beds exempt
 - ❖ 75% of new slots allocated to primary care or general surgery residency training for at least five years

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Final Takeaways

- Monitor payments under MS-DRGs
- Monitor quality of services
- Prepare to track revenues & costs for implantable devices
- Ensure no-pay bills are being submitted
- Evaluate EHR readiness
- Communicate with legislators

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Questions?

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Contact Information

Tim Wolters

twolters@bkd.com

BKD National Health Care Group

417.865.8701

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