

# Medicare Legislative and Regulatory Policy Update

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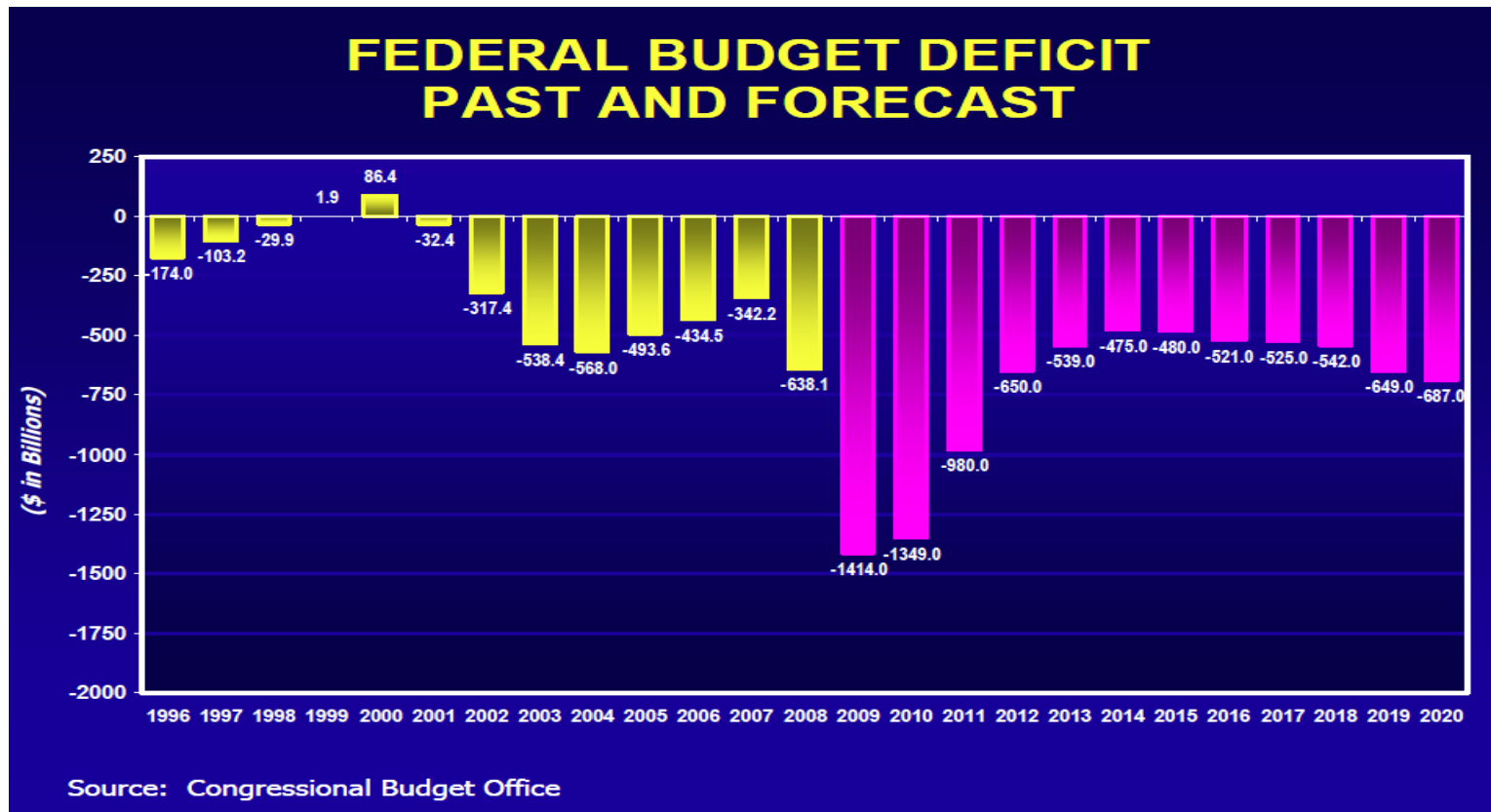
(With Thanks to John Hellow)

HLB

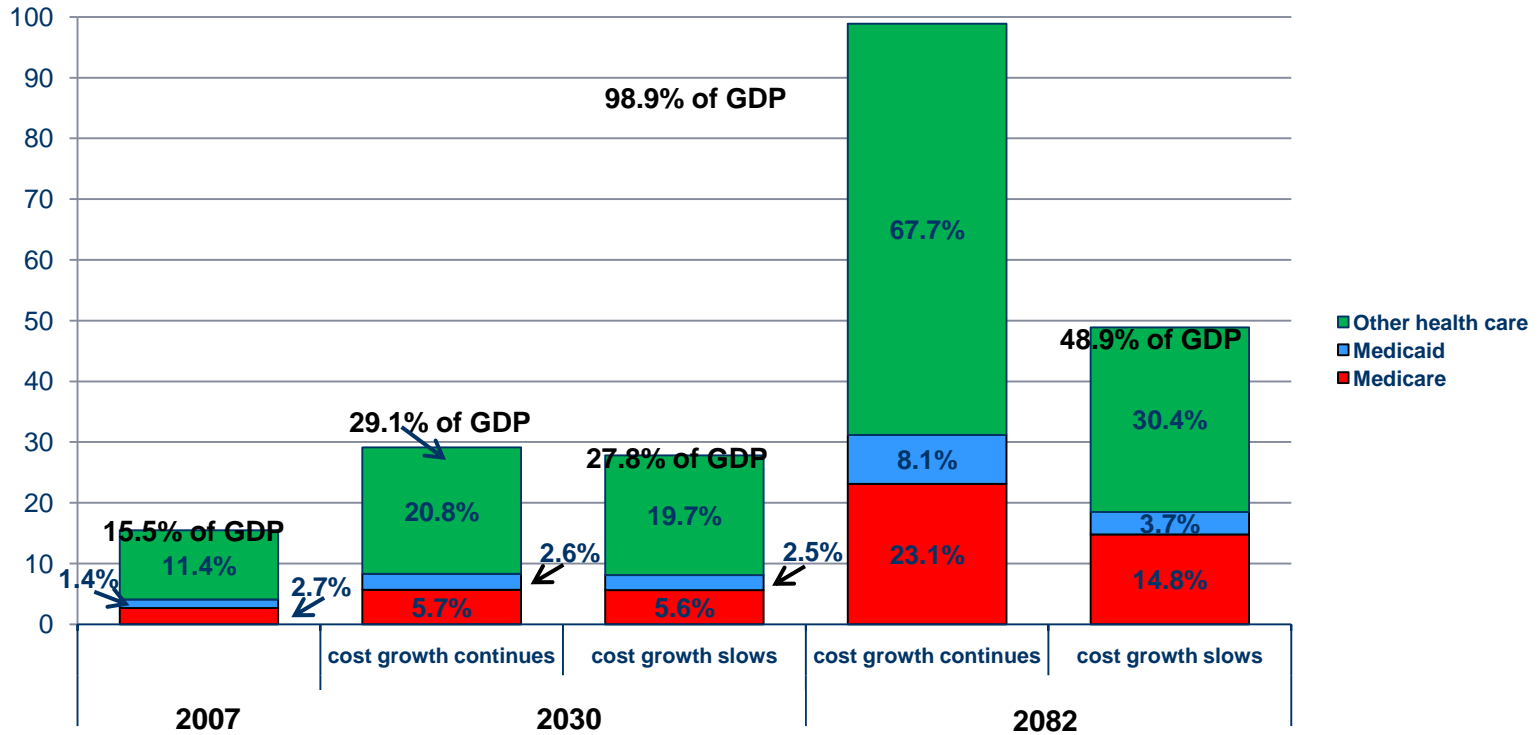
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HEALTH CARE LAWYERS

# Underpinnings of Accountable Care Act

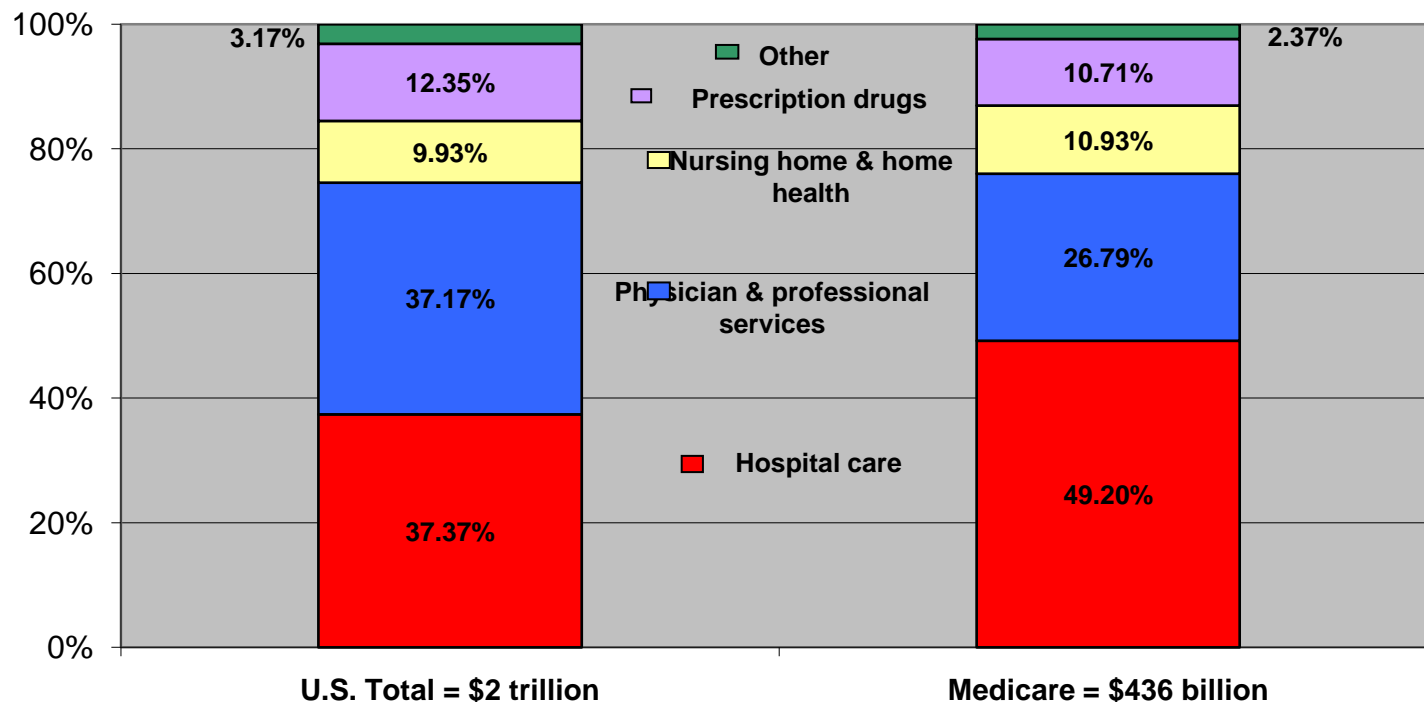


# Projected Spending as a Portion of GDP



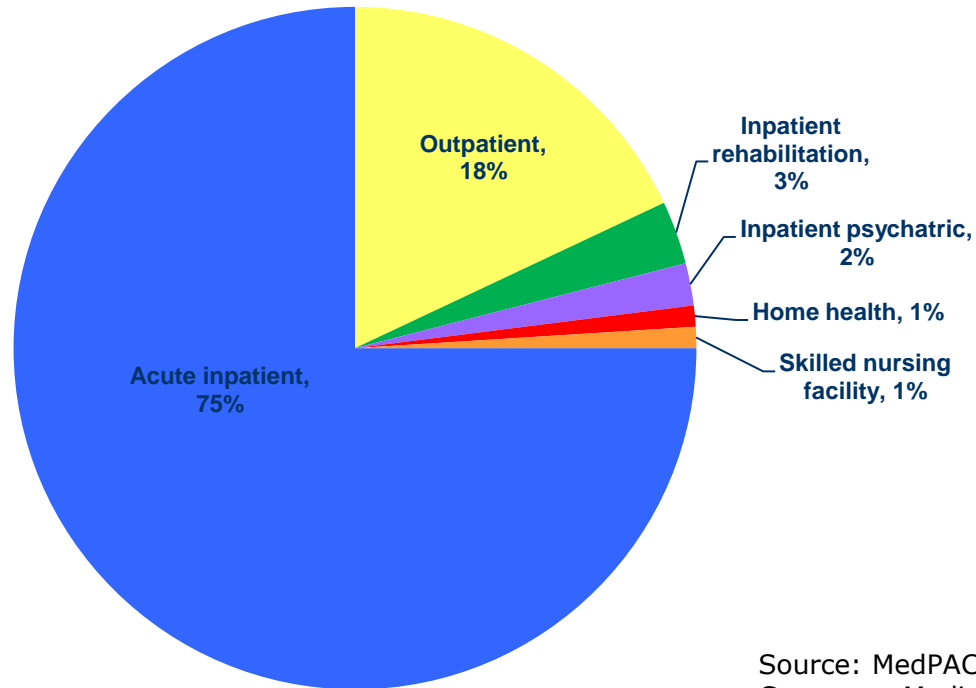
Source: CBO, "The Long-Term Outlook for Health Care Spending," November 2007. Accessed online at [www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf](http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf)

# Personal Healthcare Spending by Service Type, 2008



Source: Aaron Catlin, Cathy Cowan, Micah Hartman, Stephen Heffler the National Health Expenditure Accounts Team, "National Health Spending In 2006: A Year of Change For Prescription Drugs," *Health Affairs*, vol. 27, no. 1 (January/February 2008), pp. 14-29.

# Medicare Payments to Institutional Providers in FY 2006



Source: MedPAC, Report to the Congress: Medicare Payment Policy, March 2008

# Commonwealth Fund Report

## June 23, 2010

Exhibit ES-1. Overall Ranking

Country Rankings	
	1.00-2.33
	2.34-4.66
	4.67-7.00



	AUS	CAN	GER	NETH	NZ	UK	US
<b>OVERALL RANKING (2010)</b>	3	6	4	1	5	2	7
<b>Quality Care</b>	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
<b>Access</b>	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
<b>Efficiency</b>	2	6	5	3	4	1	7
<b>Equity</b>	4	5	3	1	6	2	7
<b>Long, Healthy, Productive Lives</b>	1	2	3	4	5	6	7
<b>Health Expenditures/Capita, 2007</b>	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: \* Estimate. Expenditures shown in \$US PPP (purchasing power parity).  
 Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

# Deficit Reduction

- A. In BBA 1997 budget was balanced on the backs of hospitals
- B. Medicare is the balancing item in the federal budget
- C. Hospitals are the largest Medicare expense, followed by physicians
- D. Expect further cuts to specialty physicians and outpatient expenses
- E. Expect further inpatient cuts around 2015

# Overview of Recent Developments

- I. Patient Protection & Accountable Care Act of (ACA), enacted March 23, 2010 (see HLB booklet posted on website:
  - <http://www.health-law.com/publications/reform/201003HealthcareReform.pdf>)
- II. Health Care & Education Reconciliation Act of 2010 (HCERA) (ACA fix legislation)
- III. FY 2011 IPPS Final Rule (August 15, 2010)
- IV. American Jobs and Closing Tax Loopholes Act of 2010, H.R. 4213
- V. Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, enacted June 25, 2010

# Changes Affecting Medicare Payments to Acute Care Hospitals

## I. Payment Changes

### A. Acute Hospital Inpatient Proposed Payment Change FY 2011

1. Overall IPPS operating rate change of – 0.55%
2. Estimate operating payment change of -0.4%
3. Difference is correction of outlier underpayment
4. Estimate total payment change, including capital of -0.5%

## IPPS RATE CHANGE FY 2011 (cont.)

➤ Market Basket	2.6%
➤ ACA adjustment	(0.25%)
➤ Doc. and coding adj.	(2.9%)
➤ Total	(0.55%)

## DOC AND CODING ADJUSTMENT

- CMS projected CMI would increase due to MS-DRGs beginning in FY 2007
- Estimated need adjustment of -4.8% to be budget neutral
- FY 2008 Final Rule phased this in over 3 years: -1.2% in FY 2008, -1.8% in FY 2009, and -1.8% in FY 2010
- Congress reduces FY 2008 and 2009 adjustments to -0.6% and -0.9% (cumulative -1.5%) and CMS implements

## DOC AND CODING ADJUSTMENT

- Extensions Act of 2007 requires CMS to recoup for FYs 2008-09 excess mix change over “real” case mix increased during FYs 2010-2012
- 2 types of adjustments
  - ❖ Recapture “overpayments” made in FYs 2008 and 2009
  - ❖ Reduce IPPS rates to eliminate affect of excess case mix change

## DOC AND CODING ADJUSTMENT

- CMS chooses not to make adjustment for FY 2010
- Notes large adjustments likely would be large in FYs 2011 and 2012

# Acute Hospital Inpatient Proposed Payment Change FY 2011 (cont.)

- c) Comparison of CMS vs. Industry Measures of Doc. And Coding Adjustment

	Applied Adjustment	CMS Est. D&C	CMS Excess	Industry D&C	Industry Excess
2008	-0.6%	2.5%	1.9%	0.7%	0.1%
2009	-1.5%	5.4%	3.9%	2.3%	0.8%
Total	-1.5%*	7.9%	5.8%	3.0%	0.9%

\*-0.9 percent incremental adjustment was applied to the 2009 rate for a total of 1.5 percent including the -0.6 percent adj. in 2008 carried forward

## DOC AND CODING ADJUSTMENT

- Recovering FY 2008 and 2009 overpayments
  - ❖ 1.9% excess in FY 2008 and 3.9% in FY 2009
  - ❖ \$9.1 billion (plus interest), about 5.8%
  - ❖ CMS reduces IPPS rates by 2.9% in FY 2011, which will flow through to 2012 to recover excess payments, and then be restored

## DOC AND CODING ADJUSTMENT

- Reducing rates to remove cumulative impact of “excess” CMI
  - ❖ Through FY 2009 would require 3.9% reduction (5.4% excess CMI – 1.6% previously accounted for)
  - ❖ CMS makes no adjustment for FY 2011

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

### B. Market Basket Adj. IPPS FYs 2012 – 2019

Fiscal Year	Market Basket - Adjustment
2012	.1%
2013	.1%
2014	.3%
2015	.2%
2016	.2%
2017	.75%
2018	.75%
2019	.75%

Similar if not identical market basket adjustments apply beginning in FY 2012 and thereafter for long term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospital services. There is no cut to the overall SNF market basket.

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

### c. Productivity Adjustment

1. Applies Beginning in FY 2012,
2. 10-year moving average of changes in the annual non-farm productivity, as determined by the Secretary,
3. Can result in a market basket increase of less than zero,
4. Payments in a current year may be less than the prior year, and
5. Applies to other provider types.

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- D. Medicare DSH Reductions – Reduced to 25% of current level + add'l amount calculated as product of three factors:
1. Aggregate amount of payments by which total DSH payments have been reduced;
  2. FYs 2014 through 2017, a factor of 1 minus the percentage change from 2013 in the number of uninsured individuals under age 65 minus 0.1 percentage points (for 2014) and minus 0.2 percentage points (for 2015, 2016 and 2017); and for fiscal years 2018 and 2019, a factor of 1 minus the percentage change of uninsured individuals minus 0.2 percentage points;

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

3. A factor equal to the percent, for each hospital, that represents the quotient of (i) the amount of uncompensated care for such hospital, as estimated by the Secretary for a period chosen by the Secretary, and (ii) the aggregate amount of uncompensated care for all Medicare DSH hospitals.
4. For FY 2014:  
(25% current level) +  
(Aggregate DSH payment reduction) x  
(1 - % change in number of uninsured under 65 - 0.1%) x  
(Hospital's amount of uncompensated care / Aggregate amount of uncompensated care for all DSH hospitals)

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

### E. DSH Changes CMS Ruling 1498-R

1. CMS agrees to recalculate SSI percentage based on new matching method;
2. CMS agrees to include dual eligible with exhausted Part A in DSH in Medicare but not Medicaid fraction;
3. CMS concedes inclusion of L&D days in DSH calculation; and
4. Attempts to divest PRRB jurisdiction until DSH recalculated.

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- F. Hospital Value-Based Purchasing –ACA § 3001
  - 1. Applies to Discharges on and after 10/1/2012;
  - 2. Funded through base operating DRG reductions, 1 percent in 2013, 1.25 percent in 2014, 1.5 percent in 2015, 1.75 percent in 2016 and 2 percent thereafter;

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- F. Hospital Value-Based Purchasing –ACA § 3001
  - 3. Incentive measures include ACI, HF, pneumonia, certain surgeries and infections and spending per beneficiary;
  - 4. Incentives distributed by performance score and vary continuously based on score;
  - 5. Certain hospitals excluded – non EHR users beginning 2015, cited for immediate jeopardy, or too few measures or cases.

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- G. Payment Adjustment for HACS – ACA § 3008
  1. Discharges on and after 10/1/2014 – hospitals in top quartile of risk adjusted HAC measure receive only 99% of total PPS payments;
  2. Public disclosure of HACs in such hospitals;
  3. Report by 1/1/2012 about extending to other provider types

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

### H. Hospital Readmissions Reduction Program

1. Fiscal years commencing and after 10/1/2012;
2. Conditions subject to measure are high value or high volume as selected by Secretary;
3. Adjustment factor is the greater of: (a) 1 minus the ratio of payments for excess aggregate readmissions and aggregate payments for all discharges, or (b) a floor adjustment of .99 for FY 2013, .98 for 2014, or .97 for FY 2015 and thereafter;
4. Applies to base operating DRG.

# Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

## I. Hospital Wage Index Improvement –

### ACA §§ 3137 and 3141

1. Section 508 reclassifications extended to 9/30/2010;
2. Criteria used to determine geographic reclassifications must revert to the criteria that were in effect as of September 30, 2008, until 1 year after wage index reform report submitted by HHS;
  - a) Geographic Reclass window closed before more lenient criteria restored
  - b) CMS should reopen window only for newly qualified

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- I. Hospital Wage Index Improvement –  
ACA §§ 3137 and 3141
  3. Effective for discharges occurring on or after October 1, 2010, the wage index for hospitals located in “frontier states” shall not be lower than 1; and
  4. Budget neutrality calculated on national basis.
  5. Montana, Wyoming, North Dakota, Nevada, South Dakota

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- J. Low Expenditure Hospital Incentives – ACA Managers Amendment
  1. \$400 million aggregate for FYs 2011 and 2012
  2. Applies to hospitals in counties with lowest quartile of expenditures per enrollee;
  3. Qualifying hospital receives portion of funds = to ratio of IPPS payments to aggregate of all qualifying hospital payments
  4. Humboldt, Modoc, Placer, Yolo

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- K. MDH Program extended through 10/1/2012, ACA § 3124
- L. Temporary Improvements Low Volume Hospital, ACA § 3125
  1. Within 15 versus 25 miles from nearest hospital,
  2. Less than 1600 discharges, previously 800 discharges,
  3. Percentage increase in payments from 25% to 0% based on decreasing scale from 200 to 1600 discharges,
  4. Dispute with proposed rule using steps of 100 beds versus continuous scale, and
  5. Under proposed rule hospital with 201 to 300 Medicare discharges = add-on of 23.33 %, and with 301 to 400 discharges = 21.66 %

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

### M. Refinement of DRG Weights Calculations

1. CMS proposes three new costs centers MRI, CT and Cardiac Cath;
2. Use square footage to allocate equipment;
3. Square footage an unreliable measure for high cap cost centers;
4. Many hospitals do not maintain ability to reclassify equipment costs;  
and
5. CMS and Congress will use data to adversely impact payment

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- N. Proposed FY 2011 Operating Outlier Threshold
  1. CMS proposes \$24,165
  2. Industry proposes \$23,280
  3. CMS seems to be targeting only 4.9% of DRG payments, contrary to statute
  4. CMS has underpaid from 2004-2009 – see next slide

# Proposed FY 2011 Operating Outlier Threshold (cont.)

IPPS Outlier Payments FFY 2004-2010

Federal Fiscal Year	Outlier Percentage			Percent Pmt Shortfall from 5.1% (1)	Payment Shortfall in Billions \$ (1)
	CMS Modeled and Estimated	FAH Calculation of Actual Payments Provided in Comments	Variance		
2004	3.50%	3.40%	0.10%	1.70%	\$ .40
2005	4.10%	3.80%	0.30%	1.30%	1.10
2006	4.50%	4.40%	0.10%	0.70%	0.65
2007	4.64%	4.30%	0.34%	0.80%	0.70
2008	4.80%	4.57%	0.23%	0.53%	0.47
2009	5.30%	4.86%	0.44%	0.24%	0.22
2010 Projected (2)	4.70%	4.76%	-0.06%	0.34%	<u>0.31</u>
Total					<u>\$ 4.85</u>

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- o. Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program
  1. Retirement of Measures
    - a) Retire Agent for Health Research and Quality (AHRQ) composite surgical mortality measure,
    - b) Measure developer does not support the use of this measure for public reporting and comparison across hospitals,
    - c) Measure was neither NQF-endorsed nor HQA approved

## Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program (cont.)

2. Individual and Composite Measures – CMS has been requested to avoid duplicate reporting of measures;
3. EHR – CMS should focus efforts on requiring EHR vendor certification that incorporates quality measure data that can be directly transmitted to CMS data warehouse

## Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program (cont.)

4. 10 New Measures Proposed for 2012
  - a) 2 Patient Safety Indicators (PSI)
    - 1) Post Op Resp Failure
    - 2) Post Op Pulm Emb and Deep Vein Thrombosis (limited NQF endorsement)
  - b) 8 Claims Base HAC Measures

# Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program (cont.)

## 5. Registry Reporting

- a) CMS is proposing that hospitals report select quality measures to certain registries
  - 1) Society of Thoracic Surgeons (STS) as cardiac surgery registry,
  - 2) American College of Cardiology (ACC) for cardioverter defibrillator complications

# Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program (cont.)

## 5. Registry Reporting (cont.)

### b) Industry Opposition

- 1) Lack of quality control at registries and no data validation requirements for registries,
- 2) Sanctioned monopolies
- 3) Burden on hospitals to abstract data,
- 4) CMS should focus on deriving data from EHR, and
- 5) Data record layout not available for comment.

### c) CMS does not finalize

## Changes Affecting Medicare Payments to Acute Care Hospitals (cont.)

- P. Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and CAHs
  1. CMS recognizes CAHs and urban hospitals reclassified to rural under 1886(d)(8)(E)
  2. Allows reasonable cost reimbursement for CNRAs
  3. Effective October 1, 2010

## Changes Affecting Medicare Payments to Long Term Care Hospitals

- A. Market Basket Increase of 2.4% Offset by 2.5 % Documentation and Coding Adjustment
- B. LTCH Reimbursement Changes Go to Federal Fiscal Year Cycle Instead of Rate Year Cycle

# Changes in CoPs Hospital Rehabilitation and Respiratory Therapy

## A. Rehab Services

1. Can be ordered by all licensed practitioners if,
2. Privileges authorized by medical staff
3. In accordance with hospital policies and state law
4. Ordering practitioner responsible for care of patient

## B. Respiratory Care Services

1. NP and PAs included in licensed practitioners
2. Same as Rehab above
3. No requirement that MD countersign orders

## Effective Dates for Provider Agreements and Supplier Approvals

- A. Survey/accreditation decision must show prospective provider or supplier complies with all of the applicable health and safety standards; and
- B. *All other Federal requirements* related to participation in the Medicare program have been met;
- C. Federal requirement not defined
- D. No survey of new facility until surveyor has notice from the Medicare contractor that enrollment application has been reviewed and approved;

## Effective Dates for Provider Agreements and Supplier Approvals

- E. Providers and suppliers at risk of unidentified and unknown federal requirements;
- F. Effective date of provider agreement is not earlier than the latest of the dates on which each applicable Federal requirement is met; and
- G. Can never be earlier than the date on which the enrollment requirements are met, as determined by CMS.

# Quality Reporting for Other Providers

- A. Quality reporting for LTCHs, Inpatient Rehabilitation Hospitals, Hospices (ACA§ 3004);
  - 1. Quality measures development with required reporting
  - 2. Reduction of payment methodology by 2.0% for failure to report starting FY 2014
- B. Quality reporting for PPS-exempt cancer hospitals (ACA § 3005) starts FY 2014;
- C. Value-Based Purchasing for SNFs, HHAs, ASCs (ACA § 3006) - Report to Congress by January 1, 2011.

# System Redesign Initiatives Under ACA

- Establishes a CMS Innovations Center by 2011
  - A. Develop patient centered payment models
  - B. Encourage evidence based, coordinated care for Medicare, Medicaid, CHIP
  - C. Rapid piloting/testing of new payment programs
  - D. Medicare Shared Savings Program (ACOs)

# System Redesign Initiatives Under ACA (cont.)

- E. National Pilot Program on Payment Bundling
- F. Independence at Home Demonstration
- G. Hospital Readmissions Reduction Program
- H. Community Based Care Transitions Program
- I. Extension of Gain-Sharing Demonstration

## System Redesign Initiatives Under ACA (cont.)

- J. Trauma Centers creation
- K. Women's Health provisions
- L. Coordinated care for chronic conditions
- M. Increased payments to primary care physicians in shortage areas for 5 years, 10% bonus for PCPs and general surgeons
- N. Medicaid physician rates 100% of adjusted Medicare rates in 2013 and 2014

# QUESTIONS