



# Georgia HFMA - Workshop October 2011

Medicare Update

PPS 2012



# Medicare PPS 2012

## In The Beginning

- Established 1965 as Health Insurance for the aged(Title 18)
- Part A Hospital Insurance(Mandatory)
  - Inpatient hospital services
  - skilled nursing
  - Some home health
- Part B: Supplemental Insurance(Voluntary)
  - Physician services
  - Outpatient hospital services
  - Independent Laboratories



# Medicare PPS 2012

## Major Legislative Changes

- Expanded in 1972 to cover disabled persons and those with ESRD.
- DRG were established in 1984. Prior reimbursement was cost based.
- Balanced Budget Act of 1997  
Expanded managed care options  
Moved away from remaining cost based reimbursement(Still some exceptions)
- Balanced Budget Act of 2003 added prescription drugs
- Health Care Reform of 2010(Obama Care)



# Medicare PPS 2012

## How is Medicare Financed

- Part A: 1.45 % payroll tax on both employer and employee
- Part B: beneficiary premium, general revenue, interest on investments
- Part C(Medicare Advantage): general revenues
- Part D(Prescription Drugs):beneficiary premium, general revenues
- Source of Eligibility
  - Elderly 85%
  - Disabled 14%
  - ESRD 1%



# Medicare PPS 2012

## Beneficiary Benefit Periods

- Hospital benefit period

60 day basic, 30 day co-insurance, 60 days lifetime reserve

Basic and co-insurance periods restart when patient has been out of the hospital or SNF for 60 consecutive days.

No limit on number of benefit periods

Reserve days are used for hospital stays beyond 90 days. Entitled to only 60 reserve days(lifetime)

- Inpatient Hospital deductible: \$1,132

Copay days 61-90 \$283

Copay after day 90 \$566

- Part B: \$162 deductible and 20% of services after deductible



# Medicare PPS 2012

## How does Medicare Pay Providers

- Prospective Payment System
- Fee Schedule
- Cost-Based
- Per Diems
- Outliers
- Case Rates
- Short Stay Payments
- Transfer Payment Discounts



# Medicare PPS 2012

## Common Components

- Base Rate(Labor and Non-Labor)
- Classification System
- Patient Adjustment
  - Intensity of service
  - Excessive case cost(outlier)
  - Partial treatment
- Facility Adjustment
  - Wage Index
  - Urban versus rural setting
  - Medical Education
  - Disproportionate number of low income patients



# Medicare PPS 2012

## Updating the Components

- Annual proposed and final rules(comment period)
- Market basket or inflation update(traditionally 2.5%)
- Wage indexes recalculated based on updated hospital salary
- Relative weights are updated based on more current data(Cost Report and patient detail)
- Operating cost and capital cost
- Graduate Medical Education
- Disproportionate Share Adjustment
- Full market basket update only available if quality indicators are submitted to QIO.



# Medicare PPS 2012

## Components Continued

- Wage Index measures relative level of hourly wages in a labor market to national average
- Wage index is applied to the labor component of the federal rate.
- Relative weights reflect the resources used in furnishing a particular services to patients within a group, compared to the average patient.
- Case mix reflects the types of patients treated by a provider compared to the national mix of patients.(1.0 is average)



# Medicare PPS 2012

## Fee Schedule Reimbursement

- Virtually the same as prospective payments, but certain services have traditionally been identified as being paid under a fee schedule.
- Just as with PPS, the fee schedule is adjusted for provider characteristics and patient characteristics.(levels of care)
- Who receives fee schedule reimbursement
  - Physicians
  - Hospital(Outpatient Therapy)
  - Ambulance Services
  - Laboratories



# Medicare PPS 2012

## Cost Based Reimbursement

- Initially all provider payments were based on allowable costs.
- Retrospective cost based reimbursement created the need for a cost report to settle payments. The Cost Report was basically a tax return for Hospitals.
- In many cases cost was capped with top level limits. This methodology is still in place for many Medicare payments.
- The cost were frequently related to base year(first) trended forward.



# Medicare PPS 2012 Cost Based Payments

- Hospitals – Direct Medical Education
- Sole Community Hospitals(Higher of PPS or trended base year costs)
- Critical Access Hospitals
- Rural Health Clinics
- New Hospitals (Capital)



# Medicare PPS 2012

## Prospective Payment System

- Hospital Inpatient Operating Cost(DRG)
- Hospital Inpatient Capital Cost(DRG)
- Hospital Outpatient (OPPS or APC)
- Skilled Nursing Facility(RUG Rates) (Per Diems)
- Home Health(Case Rates)
- Inpatient Rehabilitation(DRG)
- Inpatient Psychiatric(Per Diems)
- Long Term Acute Care (Case Rate)



# Medicare PPS 2012

## Hospital Inpatient Base Rate

• Operating: Labor (Wage Adjusted)	\$3,066.92
• Operating: Non Labor	\$1,979.70
• Operating: DSH	\$1,189.13
• Operating: IME	\$304.48
• Capital: National Adjusted	\$421.42
• Capital: DSH	\$35.90
• Capital: IME	<u>\$19.82</u>
Total Base Rate	\$7,017.37
DRG 469 Weight	<u>3.44</u>
Gross Payment	\$24,139.76



# Medicare PPS 2012

## Hospital Inpatient – Core Issues

- Standard operating amount multiplied by wage index
- Wage index is extremely complicated and can be effected by:
  - Core Statistical Business Area(CBSA)
  - Annual geographic reclassification
  - Rural floors
  - Special one time reclassifications
  - Two different labor shares(Less than 1.0 and above 1.0)
  - Occupational mix adjustment
  - Wage areas were redefined in 2005(Atlanta large CBSA)
  - Adjustments for hospitals in rural areas bordering urban areas with commuting patterns to urban areas



## Medicare PPS 2012

# DRG Assignment-Weights-Case Mix

- Principle diagnosis(Levels of care)
- (1)Simple procedures or w/o
- (2)Co morbidities and/or complications(cc)
- (3)Major complications
- Cost Based weights verse charge based weights



# Medicare PPS 2012

## Inpatient Operating PPS-Other

- Indirect Medical Education – Payment adjustment reflecting indirect cost of patient care associated with operating approved graduate medical education.
- Disproportionate Share Hospital – Payment adjustment intended to partially offset losses from uncompensated care.(Medicaid and SSI component)
- Cost Outlier – Payment for high cost cases based on charge threshold multiplied by hospital cost to charge ratio
- Transfer Policy – Reduced payments for short stay patients transferred to other acute hospitals and transfers to post acute settings.



# Medicare PPS 2012

## Inpatient Operating – Other Concepts

- New Technology payments
- Bad Debt Pass Thru payments
- ESRD add-on payments
- Direct Medical Education
- Dual eligible cross over payments to Medicaid
- National Disaster Medical System
- Acts of God or nature
- Local Federal governmental programs(Black Lung)
- Section 1011 payments
- Three(3) day window
- Reporting quality indicators



# Medicare PPS 2012 Final Rules

- Market Basket increase 3.0%
- Productivity adjustment -1.9%
- Prospective documentation and coding adjustment - 2.0%. (Added Back)
- Affordable Care Act Reduction -0.1%
- Final analysis is an average of 1.1% increase.
- Provisions related to Affordable Care Act:
  - Hospital Quality Adjustment
  - Inpatient Quality Reporting Measure Act
  - Payments for Hospitals in counties with lowest per ben. Spending
  - Low volume hospital payment adjustment



# Medicare PPS 2012 Final Rules

- Hospital Wage Index Provisions
  - Cape Cod Adjustment decision( 1.1% increase) rural floor
  - Pension cost will move to a 3 year rolling average
  - Imputed floor(for states with no rural hospitals)
- MS-DRG classifications
  - Excision debridement-new DRG classification(less money)
  - Autologous Bone Marrow transplants-add severity adjustment
  - Brain stimulation system – Moving to 023 and 024
  - Thoracic aneurysm repair-too higher paying DRG's.
- New Technology Add On payments – no new applications were accepted.



# Medicare PPS 2012 Final Rules

- Other Provisions:
  - Payment for Hospital Acquired Conditions
  - Three Day/One Day payment windows
  - Clarification of add-on payment for treating ESRD patients
  - Excluding Hospice discharges from DSH and IME adjustments
  - Changes to under arrangement agreements
  - Clarifying payment policy for replacement of recalled devices
  - Modifying payment policy for ambulances operated by CAH
  - Pension costs for Medicare cost findings
  - Finalizing redistribution of GME
  - Expediting Medical Records request



# Medicare PPS 2012 Final Rules

- Operating amounts if wage index is greater than 1.0
  - Labor \$3,584.30 / Current - \$3,552.91
  - Non Labor \$1,625.44 / Current - \$1,611.20
- Operating amounts if wage index is less than or equal 1.0
  - Labor \$3,230.04 / Current - \$3,201.75
  - Non Labor \$1,979.70 / Current - \$1,962.36
- Outlier Threshold
  - New \$23,375
  - Current \$23,075
  - Actual outlier payments in 2010 was 4.7% of total DRG payments



# Medicare PPS 2012 Final Rules

- Changes to Inpatient Capital Related cost for 2012:
  - CMS will increase the capital payment amount by an update of 1.5%.
  - CMS is also reducing the update by 2% for coding and documentation changes.
  - The final FY 2012 capital is \$421.24 verse the current \$420.01.
- Wage Index changes
  - Pension Cost Changes
  - Occupational will be based on the 2007-2008 Survey.
  - 208 Hospitals were reclassified based on Geo Review Board
  - Reclassed hospitals under Section 1886 Social Security Act
  - Section 508 reclassifications
  - Adjustments based on Commuting patterns of Hospital employees



# Medicare PPS 2012

## Final Rules

- New Claims based measure for 2014 (Medicare spending per beneficiary)
  - Length of the Medicare spending per beneficiary episode.
  - Medicare payments included in the spending per beneficiary episode.
  - Adjusting the Medicare payments included in spending per beneficiary episode
  - Calculating a Hospitals Medicare spending per beneficiary amount
  - Calculating a Hospital Medicare spending per beneficiary ratio
- Indirect Medical Education adjustment
  - The IME multiplier will be 1.35.
- Changes to MS-DRG Post Acute Transfer DRG Policy
  - 275 DRG's (new – 570,571,572)



# Medicare PPS 2012

## Hospital Outpatient PPS

- In August 2000, outpatient moved from cost based reimbursement to DRG type system called Ambulatory Payment Classification (APC) groups.
- The rate is a conversion factor that has capital and wage index component multiplied by APC individual weight.
- Unlike Inpatient DRG, outpatient claims can have multiple APC per encounter.
- No payment for IME or DSH.
- Payment for Cost Outlier, extremely difficult to achieve.
- Transition payments for certain hospitals.
- Co insurance on 20 year transition to 20% of payments.



# Medicare PPS 2012 Proposed OPPS

- Effective date 01/01/2012.
- Market Basket 2.8% increase.
- Mandated 1.3% point reduction on the market basket.
- Reduction of 1.5% for those hospitals not reporting the 15 quality indicators.
- Conversion Factor amount would be \$69.42 for 2012
- Conversion Factor amount currently \$68.87
- Conversion Factor multiplied by GAF.
- Estimated increase for All hospitals is 1.1%.
- CMS proposed to add 10 new quality measures for 2014.



# Medicare PPS 2012

## Proposed OPSS

- Proposed measurements include surgical site infections, diabetes measures, and cardiovascular disease measures.
- Supervision policy for outpatient therapeutic services.
- Recalibration of APC weights (clinic visits, weights are lower for 183 and higher for 189 APC's)
- Expansion of packaging and bundling of APC's.
- Proposed composite APC for cardiac resynchronization therapy with defibrillator.
- Wage Index – 60% of rate is wage related.
- Wage Index – CMS considering using a modified version of the IPPS wage index to address rural floor issues



# Medicare PPS 2012

## Proposed OPPS

- Projected targets for outlier payments continue at 1% of total OPPS payments.
- Outlier target threshold would be \$2,100, this is \$75 increase from PPS 2011.
- Per Law, hold harmless payments are due to expire 01/01/2012, for rural and sole community hospitals.
- CMS proposed to increase payments for sole community hospitals by 7.1%.
- CMS proposed to increase payments for 11 cancer hospitals
- CMS proposed no changes to the conversion factor for transitional pass through payments



# Medicare PPS 2012

## Proposed OPPS

- CMS will continue to observe the distribution of high level ER visit for Providers
- Partial Hospitalization payment will continue to decrease based on four payment codes(Previously one).
- Changes for payments related to CT(abdomen and Pelvis)
- Continued decrease of the beneficiary coinsurance (22.1% of total payments)
- Changes to the Value Based Purchasing program.
- Quality reporting requirements through Electronic Health Records.



# Medicare PPS 2012

## Medicare Advantage

- Revamped in 1997(Medicare Part C) and changed in 2003 to Medicare Advantage.
- Types of plans included:
  - Health Management Organization
  - Preferred Provider Organization
  - Provider Sponsored Organization
  - Private Fee For Services
  - Medical Savings Accounts
    - Originally based on average fee for service costs in a county.
    - 2003 significantly increased managed care rates to Insurance companies.
    - Hospitals and physicians negotiate rates insurance companies



# Medicare PPS 2012

## Skilled Nursing Facilities PPS

- Payments based on per diems with the following components(nursing, therapy).
- Payment groups(like DRG) are called resource utilization groups(RUG) totaling 44.
- Classifications are based on a tool called a minimum data set.
- RUG categories can change during the course of a patient stay.
- No payment for DSH, IME or cost outliers
- Wage index is based on hospital inpatient wage index.
- Capital included in rate
- FY 2012 , Case Mix will be recalibrated to align payments with costs.



# Medicare PPS 2012

## Home Health PPS

- The Federal Rate is called the national 60-day episode of care rate. Capital is included in rate.
- The Wage index is based on the hospital inpatient wage index and the location of the patient not the agency.
- Payment groups are called resource groups.
- Resource use is measured for clinical severity, functional status, and service utilization.
- There are 80 resource groups.
- No payment for DSH or IME.
- There are three episode adjustments (low utilization, high cost outlier, partial episodes)



## Medicare PPS 2012

# Hospital Inpatient Rehabilitation PPS

- The Federal Rate is called a standard payment amount per discharge.
- The Wage index is based on the hospital inpatient wage index.
- Payment groups are case mix groups(21). Further breakdowns are based on measuring motor and cognitive scores, age and co morbidities resulting in 290 categories.
- No IME payments
- Cost outliers and DSH are available.
- Partial payments for patients transferred to other modes of care.



## Medicare PPS 2012

### Hospital Inpatient Psychiatric PPS

- The Federal rate is the base rate per diem.
- The wage index is based on the hospital inpatient wage index.
- Payments groups are DRG's.
- Teaching adjustment(IME) is available if residents used on unit.
- No DSH but cost outlier available.
- Patient level adjustments include weighting days, age adjustment, and co morbidities.



# Medicare PPS 2012

## Fee Schedule Reimbursement

- Physicians
  - Paid based on a conversion factor
  - Relative Value Units (Service intensity, practice expense, and malpractice cost)
  - Geographic practice cost indices
  - Annual updates called “Sustainable Growth Rate”
- Hospital Outpatient Rehabilitation Therapy Services
- Ambulance Services
- Physician extenders w/ discounts 10%
- Add on payment for underserved areas based on zip code



# Medicare PPS 2012

## Direct Medical Education

- Per Resident payment amount intended to reimburse for resident salary, supervising physician salary, and overhead costs.
- Payment based on hospital specific base year costs trended forward consumer price index .
- Upper and lower limits to the wage adjusted national per resident amount.
- Final resident amounts are applied to the hospital resident count.



# Medicare PPS 2012

## Cost Based Hospitals

- Sole Community Hospitals (25 miles from another hospital)  
Some instances mileage can be greater than 35 miles.
- Critical Access Hospital(mileage limit, less than 25 beds, rural, 24 hour emergency services, low length of stays)
- Rural Health Clinics(underserved areas)



## Medicare PPS 2012

# End Stage Renal Disease Services

- Maintenance dialysis treatments for end stage patients
- Facility must be approved for outpatient services
- Composite rate moving to PPS on 01/01/2011.
- Inpatient add-on for certain hospitals serving over 10% patients with ESRD.



# Medicare PPS 2012

## Hospice Care

- Per diem rates for different setting(routine home care, continuous home care, inpatient respite care, general inpatient care)
- Wage index based on hospital wage index with adjustments
- Overall cap on benefit per year
- Physician declaration of end of life care.
- Hospice Wage Index will increase 2.5% for FY 2012.



# Medicare PPS 2012 Health Care Reform

- 2010 – Market basket reductions, start year 1
- 2011 – Insurance exchanges and new residency slots for primary care and general surgery
- 2012 – Value based purchasing, wage index reform proposal, bundling and demonstration projects
- 2013 – Readmission penalties, Medicaid payment expansion for primary care
- 2014 and beyond – Medicaid expansion to 133% FPL, individual mandates, DSH cuts for Medicaid and Medicare, POA payment hits, quality payment reductions, other Medicare cuts.



# Medicare PPS 2012 Health Care Reform

- Medicaid and State added responsibility
- SCHIP stream lined enrollment
- Medicaid expansion by 40%
- Medical home options
- Electronic Health Record monies for Medicare and Medicaid
- RAC and MIP audit acceleration
- Grants for trauma hospitals
- State run insurance exchanges
- Accountability of care organization



# Medicare PPS 2012

## Health Care Reform

- Health Insurance companies most adhere to medical loss ratios of 85%.
- Community needs assessment expanded (Form 990's) Keeping tax exempt status.
- Uncompensated care tracked on the Cost Report. (DSH payment and Electronic record funding)
- Funding for Health Care Reform (Medicare cuts, Medicare advantage cuts, Industry fees, Individual mandate fines, Medicare taxes, Cadillac health plan taxes, employer opt out fees)
- At least 10 new regulatory agencies will be formed.
- Expansion of power of HHS/FDA/IRS/Department of Labor



# Medicare PPS 2012 Health Care Reform

- Pre-existing conditions will be limited from denying health care coverage to individuals.
- Medicare overpayment policy will be enforced to 60 days of knowledge.
- Physician owned hospital and ancillary service stricter rules
- Will all not for profit hospitals eventually pay income taxes?
- New rules on charging uninsured patients for services.
- Start of value based purchasing based on quality measures.



# Medicare PPS 2012 Health Care Reform

- Medicare prescription drug coverage expansion(Part D).
- Expansion of Medicare coverage of preventive care for beneficiaries.
- Expansion of Public Health and well care centers(FQHC).
- Funding for certain health care workforce positions.
- Coverage of dependents up to the age of 26 in a house hold
- Coverage of individuals who could not acquire health insurance over a six month period.



# Medicare PPS 2012 Other Observations

- Health Care Reform cuts
- Debt Ceiling automatic cuts if Task force cannot come to common ground agreements(Defense and entitlements)
- MAC stance on Cost Report submissions( Amending and Re-openings)
- Medicaid Integrity Audits (cross over's audits)



# Medicare PPS 2012 Georgia Fall HFMA

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