MEDICARE PAYMENT UPDATE
PROPOSED CHANGES AND
UPDATES FROM HFMA ANI
AGENDA

- IPPS Updates
- OPPS Updates
- Two-Midnight Rule
- Medicare Physician Fee Schedule Update
- FQHC – Prospective Payment Draft Cost Report
- NH/VT Tax Issues
- Hospital Quality Star Ratings
### 2016 IPPS Final Rule – Update Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
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<tr>
<td>Update factor</td>
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<td>Documentation &amp; Coding Adjustment</td>
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<td>Update for operating payments</td>
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- ¼ reduction in market basket update for hospitals not submitting quality data
- ½ reduction in market basket update for hospital not meaningful user of EHR
EHR INCENTIVE PROGRAMS & QUALITY REPORTING

• Pertains to eligible hospitals and Critical Access Hospitals

• Electronic reporting of Clinical Quality Measures (CQM) for EHR incentive programs

• Align the CQM reporting period for electronic reporting for both EHR programs and the Hospital IQR program

• Options will be specified for the Editions of certified EHR technology providers may use
2016 OPPS PROPOSED RULE – UPDATE FACTORS

• OPPS update factors will be the same as the Final IPPS update factors

PLUS

• Adjustment of -2.0% is being proposed to redress excess lab packaged payment. $1 billion in lab test payments were projected to be packaged in CY 2014 but continued to be paid separately.

• Documentation and coding adjustment does not apply

• This will bring the OPPS update factor to -0.3%.

• 7.1% increase for Sole Community Hospital APC payments remains
TWO-MIDNIGHT RULE

PROBLEM - Inpatient vs. Outpatient Payment

• Medically necessary inpatient stay vs. extended outpatient observation services
• Observation stays don’t count towards 3-day stay for SNF admit
• Higher copays for outpatient stays

ORIGINAL SOLUTION – Two-midnight rule beginning October 1, 2013

• Generally inpatient if practitioner expected stay to cross two midnights
• Generally inpatient payment not appropriate for stay that does not cross two midnights
MORE ON TWO-MIDNIGHTS

RESOLUTION process

• Involved extensive stakeholder input
• Feedback of “probe and educate process” from MACs
• Balance multiple goals
  • Respecting judgment of physicians
  • Supporting high quality care for beneficiaries
  • Providing clear guidelines, and
  • Incentivizing efficient care
MORE ON TWO-MIDNIGHTS

OPPS PROPOSED RULE SOLUTION

• Less than two midnights:
  • Inpatient admission would be payable on a case-by-case basis (Documentation must support admission)
  • Expectation that rarely would an admission be required for a stay that does not span at least one overnight
• No change for two-midnight benchmark:

  Stays expected to be two midnights or longer, the services are generally appropriate for inpatient payment (Stay may be less than two midnights if expectation was that stay would be longer)
EDUCATING & ENFORCING TWO MIDNIGHT RULE

CMS will use Quality Improvement Organizations (QIOs) rather than MACs or RAC auditors to conduct first line medical reviews

- QIOs have history of collaborating with stakeholders to ensure high quality care for beneficiaries
- QIO reviews will focus on educating doctors and hospitals

RAC issues:

- Reviews will be on “offenders”
- “Look-back period” for patient status reviews will be changed to 6 months
- Limits placed on additional documentation requests
- Complex reviews must be completed within 30 days
- 30 hold period before RAC adjustment can be sent to MAC for adjustment
MEDICARE PHYSICIAN FEE SCHEDULE

SUSTAINABLE GROWTH RATE IS GONE

• First PFS proposed rule to be issued since the repeal of the SGR
• Across the board 0.5% increase in all payments
• The proposed rule begins to lay the groundwork for Merit-Based Incentive Payment System (MIPS) which is required by legislation beginning with 2019 payments
• Rule focuses on better care, smarter spending and healthier people
**MEDICARE PFS KEY PROVISIONS**

- Focus on patient-centered care
- Implementation of statutory adjustment to payments based on mis-valued codes
- Updates to Physician Quality Reporting System (PQRS)
- Updates to Physician VBPM (Value-Based Payment Modifier) program
- Medicare Electronic Health Record (EHR) Incentive program
- Medicare Shared Saving Program (MSSP), and
- The Physician Compare site.
MIPS HIGHLIGHTS

Requirements for MIPS:

1. Develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards for a performance period for a year.

2. Using the methodology, provide for a composite performance score for each eligible professional for each performance period, and

3. Use the composite performance score of the MIPS eligible professional for a performance period of a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) to the professional for the year.

- Focus on quality, resource use, clinical practice improvement activities and meaningful use of an electronic health record system.

- MIPS consolidates the PQRS, EHR/meaningful use, and the VBP modifier;

- Sunsets the individual penalties associated with those programs; and

- Adds an additional category for clinical practice improvement activities.
FQHC – COST REPORTING CHANGES

• FQHC – Prospective payment for cost reporting periods beginning on or after October 1, 2014, therefore, cost reports periods ending September 30, 2015 will be changing.

• More information is being required to allow CMS to calculate cost by visit.

• Direct cost, visits, medical visits and mental health visits by practitioner:

  Physician, Physician services under arrangement, Physician Assistant, Nurse Practitioner, Visiting Registered Nurse, Visiting Licensed Practical Nurse, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker
CALCULATION OF COST PER VISIT

<table>
<thead>
<tr>
<th>Positions</th>
<th>From What A, col. 7, line</th>
<th>Direct Cost by Practitioner</th>
<th>Total Medical &amp; Mental Health Visits by Practitioner</th>
<th>Other Direct Care Costs (see instructions)</th>
<th>General Service Cost (see instructions)</th>
<th>Total Costs by Practitioner</th>
<th>Average Cost Per Visit by Practitioner</th>
<th>Medical Visits by Practitioner</th>
<th>Mental Health Visits by Practitioner</th>
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**PART II - CALCULATION OF ALLOWABLE DIRECT GRADUATE MEDICAL EDUCATION COSTS**

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<th>Allowable GME Costs</th>
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FQHC – COST REPORTING CHANGES (CONT.)

- Contract labor costs by practitioner
- FTEs – Staff and Contract by practitioner
- More questions on W/S S-2 – includes CMS Form 339
- Medicare advantage supplemental payments (for information only)
- Statement of Revenues and Expenses
<table>
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<td>F-1</td>
<td>Statement of Revenues &amp; Expenses</td>
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NH / VT TAX ISSUES

NGS update - No change in process

- NH – holding settlements
- VT – workaround continued to be used
OVERALL HOSPITAL QUALITY STAR RATINGS

• An addition to the Hospital Compare website

• Hospital Compare:
  • Information about hospital quality to help patients make informed decisions & encourage quality care improvements
  • Info on more than 100 quality measures on more than 4,000 hospitals
  • Aims to summarize info in a useful & interpretable way for patients and consumers
    • The hospital’s star rating will be a summary of performance of certain measures on Hospital Compare
    • Overall Hospital Quality Star Ratings (OHQSR) methodology will not replace individual measure scores
MEASURES NOT INCLUDED IN OHQSR

1. Suspended, retired, or delayed measures
2. Measures not yet publicly reported on Hospital Compare
3. Measures with fewer than 100 hospitals reporting
4. Structural measures without evidence of association with improved outcomes, and
5. Non-directional measures
HOSPITAL REPORTS

- Hospitals will have the opportunity to review the methodology as well as their star rating during a dry run period.

- Hospitals will be provided with:
  1. Hospital-Specific Report with group summary scores, hospital summary scores, hospital star rating
  2. HSR User Guide with detailed explanation for interpretation of HSF

- HSR, HSR User Guide and the methodology report will be available at the Quality Net Secure Portal.

- If implemented OHQSR results will appear on the Hospital Compare site beginning next year.

GAIN CONTROL
Common themes from keynote speakers
Outlook for Medicare and Medicaid
Accountable Care Organizations And Consumer Driven Healthcare
New Technology
External Competitors
KEYNOTE PRESENTATION THEMES:

GAIN CONTROL

MAKING IT HAPPEN

Turning GOOD IDEAS Into GREAT RESULTS

Peter Sheahan
KEYNOTE PRESENTATION THEMES:

Dan Heath:

How to Change Things When Change is Hard
“Positive deviants, bright spots”
KEYNOTE PRESENTATION THEMES:

Ian Morrison:

*Healthcare 2025: Building the Future*

“Driven by demands for care transformation, the healthcare industry is realigning at an unprecedented pace.”
KEYNOTE PRESENTATION THEMES:

Peter Sheahan:

*Leadership in a Rapidly Changing World*

“People who get good with a hammer tend to think everything that presents itself is a nail.”
OUTLOOK FOR MEDICARE AND MEDICAID

Medicare and Medicaid Shares Projected to Grow Under Current Law:

• 2015 Medicaid population comparable to population of France, bigger than Walmart by $50+ billion

• Medicaid expansion significant: (Oregon enrollment 1,000,000, an increase of 69% over pre-ACA levels.)

• By 2050, the 65 & Over Population Will More Than Double, and the 85 & Over Population Will More Than Triple
OUTLOOK FOR MEDICARE AND MEDICAID (CONT.)

CMS Goals For Medicare

- 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018.

- Target 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018.

Sylvia Burwell, CMS Administrator, Jan. 26, 2015, New England Journal of Medicine
ACCOUNTABLE CARE AND CONSUMER DRIVEN HEALTHCARE

U.S. Healthcare Spending per Capita Has Risen at Historically Low Rates in Recent Years

Average annual growth rate of health spending per capita for 1970s - 1990s;
Annual change in actual health spending 2000 - 2013 and projected 2014 - 2023

ACCOUNTABLE CARE AND CONSUMER DRIVEN HEALTHCARE (CONT.)

Both drive demand for healthcare transformation and realignment.

“Creating Sustainable Revenue Through Accountable Care.” – Charles E. Saunders M.D.
NEW TECHNOLOGY – IAN MORRISON

Clinical technology
• Personalized medicine, new drugs, new treatments
• Shift to ambulatory, less invasive, new modalities

Health IT
• From electronic health records to advanced health information infrastructure
• Rise of personal devices as key platform for healthcare delivery and coordination
NEW TECHNOLOGY
“Taking analytics to the next level.” – Graham Hughes

• Technology exists to better understand the individual consumer. (Zulily, Target, Social Media.)

• Move from rigid “Data Warehouse” structure to “Data Lake” concept. Eliminates need for upfront time to source data and reduces labor intensive aspect.

• Utilize parallel technology already in use by every other industry.

• Improve population health management
EXTERNAL COMPETITORS

• Catalyst for disruptive change in industries that are inflexible

• Speculation that outside organizations threaten the current state of health care

• William Shrank MD MDHS – Chief Scientific Officer, CVS Health

Working with health systems

• New ideas for traditional pharmacy care

• Integrate with health care continuum

• Cognitive computing to leverage data for better care
INTERESTED IN MORE?

We are always available for your questions

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