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Arkansas HFMA

Annual Medicare Update

October 21, 2022

Healthcare

Agenda

- FFY 2023 IPPS and LTCH Final Rule Payment Updates
- Strategic Reimbursement Areas Update (Wage Index, S-10, Medicare DSH, Bad Debts, GME)
- CY 2023 OPPS Payment Updates
- Rural Emergency Hospital (REH)
- Discussion and Questions

FFY 2023 IPPS Final Rule Payment Update

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2023 IPPS Final Rule – Published August 1, 2022

/ Updates Market Basket Increase to 4.1% (Highest MB Increase in 25 Years) - Up from 3.1% in Proposed Rule due to cost inflation trends

- Anticipated overall increase of 2.6% for Urban hospitals and 2.4% for Rural hospitals, respectively

/ Maintains sunset of Medicare Dependent Hospital (MDH) status and reversion of Low Volume Adjustment (LVA) to 2010 restrictive criteria on October 1, 2022

/ Wage Index Changes

- 5% Annual decline made permanent – consistent with proposed rule
- Rural floor calculation changed to include 401 Rural hospitals without a separate MGCRB reclassification – **change from proposed rule**

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IPPS Rate update FY23

FFY 2023 **Proposed** Rule increased the IPPS payment rates by 3.2% for hospitals that fully adhere to Inpatient Quality Reporting (IQR) and are meaningful users

FFY 2023 **Final Rule** increases the IPPS payment rates by 4.3% for hospitals that fully adhere to Inpatient Quality Reporting (IQR) and are meaningful users

Overall payments are expected to increase by $2.6 billion in FFY 2023 for acute care hospitals

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IPPS Payment Rate Updates

How do we get to the 4.3% Increase?

4.1% Market Basket Update

Less 0.3% Productivity Adjustment

Plus 0.5 % Statutory Adjustment

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Outliers

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Outliers

- To qualify for outlier payments, a case would need to have costs greater than the sum of the PPS rate for
  - MS-DRG
  - IME
  - DSH payments
  - Uncompensated Care
  - New Technology add-on AND
  - The outlier threshold or fixed loss amount
- The outlier threshold is a dollar amount by which the costs of a case exceed payments

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Outliers

- In the proposed rule a modification to the methodology used to calculate payments on outlier cases to account for data impacted by COVID-19
- Final FFY 2022 Outlier Threshold $30,988
- Proposed FFY 2023 Outlier Threshold $43,214
- Proposed additional FFY 2023 alternative approach $58,798
- **Final FFY 2023 Outlier Threshold $38,859**
  - **Reduction of 10.61% from proposed rule, increase of 22.53% from FFY 2022**

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Low Volume and Medicare Dependent Hospital

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Low Volume Adjustment

- Criteria is reverting to 2010 methodology requiring:
  - 25 miles between nearest proximity hospital (was 15 miles in 2022)
  - Less than 200 Total Discharges (was 3,800 in 2022)
  - Application for payment is required to be received by the MAC by 10/1/22
  - Decrease in payments estimated at $437M

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Medicare Dependent Hospitals

MDH Program set to expire on 9/30/22 after multiple extensions in previous years

Applications for MDH providers to change to Sole Community Hospitals must be made by 10/1/22 and indicate that it is requested to coincide with the termination of MDH

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Medicare Dependent Hospital and Low-Volume Payment Adjustment

- Both will sunset (again) September 30, 2022
- *Rural Hospital Support Act* (H.R. 1887)(S. 4009)
  - Would make MDH and LVPA permanent
  - Would add an available base year for Sole Community Hospital (SCH) and MDH Hospital-Specific Rates
- *Assistance for Rural Community Hospitals Act of 2022* ("ARCH Act")(H.R.8747)
  - Would extend MDH and LVPA provisions for five years

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Long Term Care Hospitals (LTCH)

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2023 LTCH Final Rule Updates

- / LTCH standard payment rate increase 2.3%. Updates Market Basket Increase to 3.8% and projected decrease in high-cost outlier payments
- / CMS requested information on Inclusion of National Healthcare Safety Network (NHSN) associated C-diff infection in the LTCH QRP and overarching principles for Measuring Equity and Healthcare Quality Disparities across quality programs
- / Increase to LTCH PPS Payments by approximately $71 Million

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Wage Index

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Quartile Adjustment

- "Low Wage Index Hospital Policy"
- 4 years FY 2019 to 2023
- Hospitals with wage index in lowest 25% quartile get ½ difference between wage index and quartile
  - FY 2023 final 25th quartile adjustment is 0.8427
  - The 2020 low wage index hospital policy and related **budget neutrality** are the subject of pending litigation
- Cases to watch *Bridgeport Hospital et al v. Becerra (D.D.C Mar. 2,2022)*

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Quartile Adjustment

- "Low Wage Index Hospital Policy"
- Argument of *Bridgeport Hospital et al v. Becerra* challenged the authority of CMS to adopt the low wage index policy
  - Courts agreed with plaintiffs, policy violates the statues since the benefiting hospital area paid a wage index that does not actually reflect their wage levels relative to the national average
  - ***Proposed rule:*** CMS proposed to continue the policy but asked for comments as to whether it should discontinue the policy it considering the Bridgeport decision.
  - ***Final rule:*** CMS made decision to continue the low wage index hospital policy.

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Rural Floor & Rural Wage Index

- **FFY 2023 Proposed**: Rural floor computed **without** redesignated hospitals under Section 412.103.
- **FFY 2023 Final: Rural** floor computed **with** redesignated hospitals under Section 412.103.
  - This reverts to the calculation prior to FY 20
- Case driving change: *Citrus HMA, LLC d/b/a Seven Rivers Regional Medical Center v. Becerra,* No. 1:20-cv-00707 (D.D.C)

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Rural Floor & Rural Wage Index

- What does *Citrus HMA, LLC d/b/a Seven Rivers Regional Medical Center v. Becerra,* No. 1:20-cv-00707 (D.D.C) argue?
  - Argument: Statute states the rural floor must equal the rural wage index
  - CMS response, statute give CMS discretion to calculate the rural floor and rural wage index separately
- Let's look at pre 2020 and post 2020 handling……

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Rural Floor & Rural Wage Index

Pre 2020	2020-2023
One Calculation	Separate Calculations
One calculation used for both Rural Floor = Rural Wage Index	Rural Wage Index = NATURAL rural plus RECLASSIFIED rural
Rural Wage Index = wage data for ALL RECLASSIFIED rural hospitals and NATURAL rural Hospitals	Rural Floor = NATURAL rural

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Rural Floor & Rural Wage Index

- Ruling: *Citrus HMA, LLC d/b/a Seven Rivers Regional Medical Center v. Becerra,* No. 1:20-cv-00707 (D.D.C)
  - Courts ruled on the side of the hospitals
    - "Nothing in the statutory text supports [CMS's] argument that the Secretary may calculate a rural wage index solely for purposes of determining the rural floor. Indeed, the statute does not speak to any rural wage index calculation whatsoever."[1]

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[1] *Source: Citrus HMA, LLC d/b/a Seven Rivers Regional Medical Center v. Becerra,* No. 1:20-cv-00707 (D.D.C) https://www.govinfo.gov/app/details/USCOURTS-dcd-1_20-cv-00707

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Rural Floor & Rural Wage Index

- CMS did appeal the decision and the case is still pending.
- In Proposed Rule, CMS asked for comments how the rural floor and rural wage index should be handled
- In Final Rule, CMS will finalize policy to calculate rural floor as it was done prior to FY 2020.
  - As of right now this will be done on prospective basis
  - 412.103 Hospitals can now be included in rural floor

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Cap on Wage Index Decrease

- Implemented in FFY 2020 Final Rule
- For FY 2023 and subsequent years, CMS finalized permanently adopting the 5% cap policy
- Under this policy, a hospital's wage index will not be less than 95% of its final wage index for the prior FY.
- CMS is paying for the cap by adjusting the budget neutrality computation within the standardized amount

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Other Wage Index Items

- Final occupational mix adjusted National average hourly wage $47.73
- 1,009 hospitals have MGCRB reclassification

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Worksheet S-10

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IPPS Final Rule & Transmittal 18

- Uncompensated care pool continues downward trend
- FFY2023 will use the average of FY18 & FY19 reports
- Merged hospitals and new hospitals
- Transmittal 18 (not finalized)
  - Adds second Worksheet S-10 (Hospital+Hospital Complex and Hospital Only)
  - Added new columns required for data submission

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What is Charity?

- Write-offs of patient responsibility that align with the Financial Assistance Policy (FAP)
  - Charity (application-based and presumptive)
  - Uninsured discounts
  - Medicaid non-covered charges
  - Anything else that is part of your FAP (exhausted benefits, non-contracted payers, etc.)

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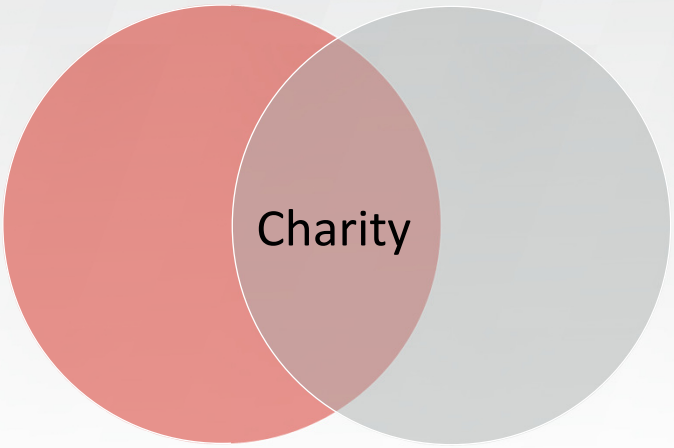
S-10 Charity vs. 990 Schedule H

What's the difference?



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Recent S-10 Audit Trends

- Error and extrapolation of items not explicitly part of the FAP
- Charity and bad debt reconciliation to the financials
- LOTS of questions
- Significant variances in audit methodologies between MACs and subcontractors

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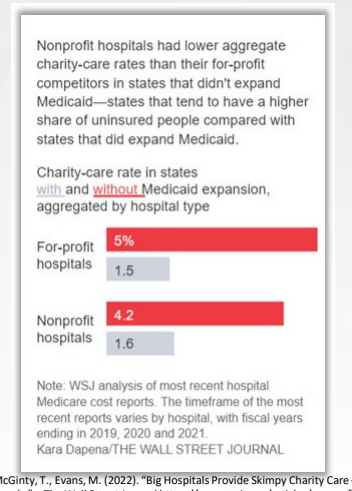
Worksheet S-10: Big Picture

- "Big Hospitals Provide Skimpy Charity Care – Despite Billions in Tax Breaks" – The Wall Street Journal
- State Medicaid Waivers
- How do we maximize uncompensated care reimbursement?



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Source: Mathews, A., McGinty, T., Evans, M. (2022). "Big Hospitals Provide Skimpy Charity Care – Despite Billions in Tax Breaks" – The Wall Street Journal https://www.wsj.com/articles/nonprofit-hospitals-vs-for-profit-charity-care-spending-11657936777

Recommendations

Policy and Procedures
- FAP Review
- Questionnaire
- Interviews

Historical Reporting & Data analysis
- Audit Adjustments
- Trending

Peer Comparisons
- IRS Form 990
- Insured Charity
- Cost-to-Charge Ratios

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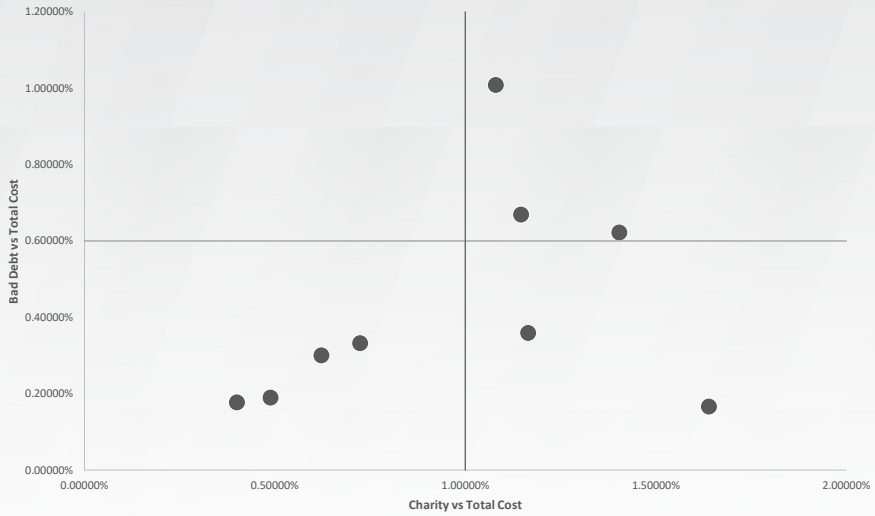
Peer Comparison



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Medicare DSH

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IPPS Final Rule & Transmittal 18

- Waiver days: Final rule kicks the can down the road
  - Will revisit in future rulemaking
  - Proposed rule was to ***include*** 1115 demonstrations that meet the following:
    - Provide premium assistance for Essential Health Benefits (EHB) that cover at least 90% of cost for health insurance
    - Patients are "Regarded as" eligible for medical assistance under title XIX
  - Proposes to ***exclude***:
    - **Uncompensated Care Pools** - Fail to provide inpatient hospital insurance benefits directly to beneficiaries
    - **Family Planning** – Benefits not comparable to Medicaid coverage
  - Would have been effective for discharges on or after October 1, 2022
  - Big Deal – particularly in TX, TN, CA, MA, NM, KS, FL

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IPPS Final Rule & Transmittal 18

- Transmittal 18
  - Required fields should be attainable
  - Possible missing fields
    - Mother's information
    - Multiple eligibility segments
- Exhibit for each S-2 Field
  - Results in patients being on multiple lists

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Recent Medicare DSH Legislative Trends

- Several DSH related Protest Items remain
- Medicaid Fraction
  - Include dual-eligible Part C days in numerator
  - Include Medicaid patients with exhausted Medicare days in numerator
- SSI Fraction
  - Exclude Part C days (Allina decision)
  - Protest to include “non-paid but entitled” SSI days in numerator

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Medicare Bad Debts

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Recent Medicare Bad Debt Audit Trends

- Agency returned accounts
  - Vouching
- Crossover accounts
  - "Must bill" continues
  - Write-off to bad debt/implicit price concession GL
- Charity/Indigent
  - Asset and income test with extensive documentation

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IPPS Final Rule & Transmittal 18

- IPPS Final Rule: Nothing to report
- Transmittal 18
  - Additional fields required:
    - A/R write-off date
    - Agency sent and returned date
    - Collection effort ceased date
    - Medicaid remittance date
    - Current year payments received
    - Others

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Graduate Medical Education

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Graduate Medical Education (GME) Proposals

- Section E – For Discharges occurring during FY 2023 the formula multiplier is 1.35 (Estimated to increase IPPS payment by 5.5% for every 10% increase in IRB (Resident-to-bed ratio).
- Section F - Modifies the policy for applying the GME FTE cap for certain situations when hospital's weighted FTE count is greater than its FTE cap (Milton S. Hershey Medical Center, et al. vs Becerra)
- Section F - Allow urban and rural hospitals that participate in the same RTP to enter into a RTP Medicare GME affiliation agreement, effective for 7/1/203

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GME Cap Modification (Fellows)

- Tied to resolution of Milton S. Hershey Medical Center, et al. vs Becerra and the weighting factor of residents that are beyond their Initial Residency Period
- Applied prospectively for all teaching hospitals as well as retrospectively for certain providers and cost years
- Effective for cost reporting periods beginning on or after October 1, 2022
- Applicable to hospital's where the unweighted number of FTE residents exceeds the FTE cap, and the number of weighted FTE residents also exceeds the cap
- Proposal to adjust the total weighted FTE resident counts (Primary Care and Other) to make the total weighted FTE count equal to the FTE cap

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Direct Graduate Medical Education (GME)

- Changes coming to Worksheet E-4, Line 9
- This rule is established retroactively to October 1,2001
  - Hospitals with open or "re-openable" cost reports can take advantage
- CMS did note that the new rule is NOT a basis for reopening a CMS or contractor determination
  - Even though retro, CMS will not open closed cost reports

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Rural Track Medicare GME Affiliation Agreement

- Current law requires caps on the number of FTE residents per hospital
- Current Regulations allow GME affiliation agreements to share or redistribute cap slots to accommodate actual rotations
- Current Regulations do not allow GME affiliation agreements for RTPs
- Finalized Proposal to allow an urban and a rural hospital participating in the same RTP to enter an "RTP Medicare GME affiliation agreement" effective July 1, 2023

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CY 2023 Outpatient PPS Update

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CY 2023 OPPS & ASC Proposed Rule

PUBLICATION DATE
JULY 15, 2022

COMMENT PERIOD ENDED
SEPTEMBER 13, 2022

- Comments were due September 13, 2022
- Supplemental tables/files located at: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-p

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OPPS Update

Payment Rate = 2.7% Increase

- IP Market Basket = 3.1%
- Multifactor Productivity = (.4%)

Total Estimated OPPS Payments = $86.2 Billion

- $6.2 Billion Increase Compared to CY 2022

Continue 2% Reduction for Quality Reporting Failure

Proposing for CY 2023 rate-setting to utilize most recent claims data from CY 2021, however utilize CY 2019 cost report data due to PHE impacts in CY 2020

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ASC Payment Update

- CYs 2019 – 2023 – Utilize Hospital Market Basket Update
- 2.7% Increase for CY 2023
  - 3.1% - Market Basket
  - (.4%) - ACA mandated multifactor productivity adjustment
- Estimated Total Payments = $5.4 Billion
  - Increase of $130 Million from CY 2022
- 2% reduction factor for ASCs that fail to meet quality reporting requirements
- Adding 1 procedure (lymph node biopsy or excision) to CPL

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OPPS Inpatient Only (IPO) List

/ CY 2022 OPPS final rule halted elimination of IPO and returned most services removed in CY 2021

/ For CY 2023 proposing to remove 10 services that meet 5 existing criteria from removal from the IPO list

CPT 16036 Escharotomy	CPT 22632 Arthrodesis
CPT 21141 Reconstruction midface	CPT 21142 Reconstruction midface
CPT 21143 Reconstruction midface	CPT 21194 Reconstruction of mandibular rami
CPT 21196 Reconstruction of mandibular rami	CPT 21347 Open treatment of nasomaxillary complex fracture
CPT 21366 Open treatment of complicated fracture	CPT 21422 Open treatment of palatal or maxillary fracture

/ Add 8 services to the IPO list that were created by the AMA CPT Editorial Panel for CY 2023

CPT codes 157X1, 228XX, 49X06, 49X10, 49X11, 49X12, 49X13, and 49X14

/ See Table 46 for full list and descriptions

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OPPS Mental Health via Telehealth

Mental Health Services – proposing mental health services furnished to patients in their homes would be covered by OPPS

- In person service within 6 months prior to initial remote service and 12 months thereafter
- Clinical staff must be physically located in hospital when providing service

TABLE 48: PROPOSED SI, APC ASSIGNMENT AND GEOMETRIC MEAN COST FOR HCPCS CODE CXX78-CXX80

HCPCS Code	Short Descriptor	Proposed SI	Proposed Proxy Service	PFS Facility Rate	Proposed APC	APC GMC
CXX78	HOPD mntl hlt, 15-29 min	S	96159	$19.52	5821	$30.48
CXX79	HOPD mntl hlt, 30-60 min	S	95158	$56.56	5822	$77.67
CXX80	HOPD mntl hlt, ea addl	N	N/A	N/A	N/A	N/A

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OPPS Other

- Partial Hospitalization – propose to calculate at per diem cost consistent with existing methodology, but will utilize cost data from CY 2019
- N95 Respirators
  - Payment Adjustment – bi-weekly reconciled on the cost report
  - Cost Report periods beginning on/after 1/1/23 separate worksheet

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Medicare Payments for 340B Drugs

- Prior to 2018 Medicare paid ASP plus 6% for most drugs
- Effective CY 2018 CMS reduced payment for 340B drugs to ASP minus 22.5%
  - *American Hospital Association v. Becerra*
    - Supreme Court ruled reduced payment violates Medicare statute
    - CMS continues cuts in CY 2023 OPPS Proposed Rule but expectation is all payments will return to ASP plus 6% in Final Rule
    - CMS seeking comments on how to address prior years 2018-2022

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REH (CY 23 OPPS Proposed)

/ **Provider Enrollment** – Outlines enrollment requirements. Must comply with 42 CFR part 424, subpart P

/ **Physician Self Referral Update** – Addresses physician ownership, referral and compensation

/ **Quality Reporting** – Initial requirements and requesting input

/ **Payment Policy** – Outlines payment policy for REH services eligible for payment at OPPS + 5% and monthly facility amounts

Other Rural

CAH CoP - CMS clarifying definition of primary roads in relation to CAH mileage requirement

- Numbered Federal Highway
- Numbered State Highway with two or more lanes each way
- Requesting feedback if should consider Federal Highways as two lane each way
- Proposing a centralized data driven review, would review all hospitals within 50 miles of CAH during each review of eligibility and then 3 yr cycle

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RHC Grandfathered rate setting

(Proposed CY 23 Physician Fee Schedule)

Clarifies a full 12-month cost report in 2020 be utilized

If a 12-month cost report not available for 2020, utilize first full 12-month cost report after 12/31/2020 to set grandfathered rate

- Newer RHC' s in process at 12/31/2020
- Rate would be adjusted beginning with MEI in year following their 12-month base period

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Rural Emergency Hospital

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REH Overview

- An eligible facility is a CAH or subsection (d) with <=50 beds as of December 27, 2020, located in a county (or equivalent) in a rural area or treated as rural through redesignation (1,716 potentially eligible)
- Payment process begins January 1, 2023
- Summary other requirements include (but not limited to) the following:
  - Provide Emergency Department Services & Observation Care
  - Annual patient average of 24 hours or less (individual patients may be kept over 24 hours when necessary)
  - Cannot Provide IP services (Distinct SNF exception)
  - Transfer agreement with a Level I or Level II trauma center
  - Other Conditions of Participation

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REH Payment Policy

- For REH payment purposes, REH services are covered outpatient services that would typically be paid under OPPS in an OPPS hospital
  - Utilize existing OPPS payment policies
  - REH payment equal to OPPS plus 5%
  - Utilize OPPS claims processing system, logic to include REH flag
  - Additional 5% not subject to patient copayment
- Additional Monthly amount = $268,294 ($3,219,524 annual)

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REH CoP: Emergency Services and Staffing

- Emergency Department services available 24/7
- Physician, Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist on-call and immediately available by phone and onsite within specified timeframes
- RN, Clinical Nurse Specialist, or LPN on duty whenever one or more patients are receiving care
- Meet emergency needs of patients in community served
- Emergency services under direction of qualified member of medical staff and integrated with other REH departments
- Basic lab services available 24/7, similar to CAH CoPs
- Emergency services integrated with other departments of REH

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REH CoP: Optional Services

- May provide additional outpatient services
  - + Low-risk labor and delivery
  - + Outpatient surgeries
- May provide outpatient behavioral health treatment services
- May establish SNF unit, but must be distinct unit
  - + Separately licensed and certified
  - + SNF regulations and CoPs apply (42 CFR 483)
- May be originating site for telemedicine
  - + Agreements required with distant sites
- Discharge planning required, even though no inpatient services

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REH Enrollment

- Enrollment as a REH remains in effect until REH elects to withdraw or Secretary determines the facility does not meet the requirements
- Enrollment authority of CMS applies for REH

  - 855A with supporting documentation
  - Completion of any applicable state surveys
  - Reporting changes to REH enrollment information
  - Revalidation
- Application fee not applicable since change of information

  - Less timely process
  - REHs proposed as low enrollment screening risk (similar to hospitals)

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REH Example Considerations

Post Acute strategy and discharge planning

Alignment of SNF or other CAH Swing Beds in system

Practices in system, potential alignment with REH for PB reimbursement

Utilization of previous IP space, expand OP services?

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Evaluate the #'s

- / Evaluate proposed revenue and expense changes
- / Analyze the projected differential in current Outpatient reimbursement vs Outpatient payment under REH
- / Impact without 340B
- / Potential volume shift to other providers within system
- / New or expansion of services

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Questions?

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Thank you!

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