MEDICARE REGULATORY UPDATE
Paula Archer, Director
Chris Clark, Partner

INDUSTRY TRENDS/UPDATE

// Current Environment
// PPACA Mandates and Updates
// IPPS Update
// Closing Comments and Questions
Public Exchange Enrollment Exceeds 7 Million

Bumpy Rollout Did Not Dampen Projections

Projected and Actual Enrollment in Qualified Health Plans

2014-2019

**Unchanged despite flawed rollout**

- 2014: 8.0M
- 2015: 13.5M
- 2016: 22.0M
- 2017: 24.5M
- 2018: 25.0M
- 2019: 25.0M

**Actual Enrollment**

**Projected Enrollment**

Reevaluating the Public Exchanges

“We had a very modest footprint in 2014. We do have a bias to increase that participation in 2015. [...] The size of the overall market is positive.”

Gail Boudreaux
EVP, UnitedHealth Group

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Observation #1: Affordable Premiums

Post-Subsidy Premiums Within Reach for Many

But Penalties Still Smaller than Cost of Coverage

**Weighted Average Monthly Premiums for Adult Individual Aged 27**

For Second Cheapest Silver Plan, by State, 2014, Pre and Post subsidy for Income of $30,000

<table>
<thead>
<tr>
<th>State</th>
<th>Before Subsidy</th>
<th>After Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tennessee</td>
<td>$154</td>
<td>$154</td>
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<tr>
<td>Florida</td>
<td>$206</td>
<td>$214</td>
</tr>
<tr>
<td>Mississippi</td>
<td>$214</td>
<td>$214</td>
</tr>
<tr>
<td>Alaska</td>
<td>$214</td>
<td>$214</td>
</tr>
</tbody>
</table>

**Penalties for Non-compliance**

- **Year**
  - 2014: $95 or 1% of income
  - 2015: $325 or 2% of income
  - 2016: $685 or 2.5% of income

**Annual Penalty**

Income: $30,000

- 2014: $100
- 2015: $600
- 2016: $750

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8/21/2014
Observation #2: Low Reimbursement

Trading Price for Volume on the Public Exchanges

Reimbursement Information Still Anecdotal, but Rates Not Generous

Anticipated Provider Reimbursement Rates for Exchange Plans

- Catholic Health Initiatives: Modest discounts from commercial rates
- WellPoint Inc.: Between Medicare and Medicaid rates
- Millers Medical Center: 20% below commercial rates
- Meyers Health: 50% above Medicare rates
- Tenet Healthcare: Up to 10% below commercial rates
- Morwether Hospital: 5% below commercial rates


Observation #3: Narrow Networks

Lower Prices through Narrower Networks

Monthly Health Insurance Premiums
Select California Exchange Plans, 2014

- Milken Project: $450
- Health Net: $222
- Anthem: $254
- Kaiser Permanente: $294

Prominent Health Systems Largely on the Sidelines

- Cedars-Sinai Health System, UCLA Health System each only participating in one exchange plan network

5M Individuals expected to be eligible for Covered California exchange, 2014
13 Insurers offering plans on Covered California exchange
36% Blue Shield of California network physicians in payer's exchange plans
80% California physicians, hospitals participating in at least one exchange plan

Failling Assumption #1: Robust Employer-Sponsored Coverage

Employer-Sponsored Coverage at a Crossroads

Employers Choosing Between Abdication, Activation

Spectrum of Options for Controlling Health Benefits Expense

“Abdication”

No Health Benefits

Pros:
- Total escape from cycle of rising premium costs

Cons:
- Fine for violating employer mandate
- Loss of important labor market differentiator

Defined Contribution/ Private Exchange

Pros:
- Health benefits still part of compensation package
- Predictable, controllable cost growth

Cons:
- Fundamental disruption in benefit design
- Employees may under-insure

Self-Funded Benefits

Pros:
- Full control over networks
- Exemption from minimum benefits requirements

Cons:
- Greater exposure to unexpected expenditures
- Complex network negotiations

Source: Health Care Advisory Board members and analysis.

Failling Assumption #2: Steady Public Payer Pricing Growth

Public Payer Reimbursement Already a Prime Target

Medicare Payment Cuts Becoming the Norm

ACA’s Medicare Fee-for-Service Payment Cuts

Reductions to Annual Payment Rate Increases

<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td>Savings</td>
<td>($540)</td>
<td>($148)</td>
<td>($218)</td>
<td>($320)</td>
<td>($420)</td>
<td>($530)</td>
<td>($640)</td>
<td>($750)</td>
<td>($860)</td>
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</table>

$415B in total fee-for-service cuts, 2013-2022

$260B Hospital payment rate cuts, 2013-2022

$56B Reduced Medicare and Medicaid DSH payments, 2013-2022

$151B Reduced Medicare payments due to sequestration and 2013 budget bill

Source: 1) Kaiser Family Foundation; 2) National Health Care at the Crossroads:

1. Includes hospital, skilled nursing facility, hospice, and home health
   services, including provider services.
2. Excludes inpatient hospital revenue

Note: ACA’s Medicare Fee-for-Service Payment Cuts: Reductions to Annual Payment Rate Increases

8/21/2014
Failing Assumption #3: Predictable Volume Channels

Volumes Still Soft Post-Downturn

Consumers Still Tightening their Belts

Households Postponing or Cancelling Medical Care

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2009</th>
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<tbody>
<tr>
<td></td>
<td>16%</td>
<td>20%</td>
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</table>

95%

Percentage of primary care physicians reporting that patients rationing or forgoing medications, treatments due to financial concerns.

Is it Cyclical...

“In 2009, despite the economic downturn, the number of prescription drugs dispensed rebounded to prerecession rates of growth.”

Health Affairs, 2011

...Or Is It An Enduring Trend?

“We have a very weak economy and it’s just a different environment for the elective parts of healthcare. This could go beyond the recession. Being a less aggressive consumer of healthcare is here to stay.”

Paul Ginsburg, Economist, Center for Studying Health System Change

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Tomorrow’s Growth All About Winning Share

Securing Preference from Purchasers, Physicians, Patients

Three Key Decision-Makers

Wholesale Purchasers (Payers, Employers)

Referring Providers

Consumers

System Growth

Source: Health Care Advisory Board interviews and analysis.
IPPS UPDATE

- Federal Fiscal Year 2015 Inpatient PPS Final Rule
- Protecting Access to Medicare Act of 2014

FEDERAL FISCAL YEAR (FY) 2015 INPATIENT PPS FINAL RULE

- Payment Rate Changes
- Wage Index Changes
- Disproportionate Share Hospital (DSH) Payment Changes
- Quality Provisions & Other Issues
PAYMENT RATE CHANGES

<table>
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<tr>
<th>Description</th>
<th>Percentage</th>
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<tr>
<td>Market Basket Increase</td>
<td>2.9%</td>
</tr>
<tr>
<td>Less: Documentation &amp; Coding Adjustment</td>
<td>(0.8)%</td>
</tr>
<tr>
<td>Less: Productivity Adjustment</td>
<td>(0.5)%</td>
</tr>
<tr>
<td>Less: ACA Required Cut</td>
<td>(0.2)%</td>
</tr>
<tr>
<td>Actual Rate Increase</td>
<td>1.4%</td>
</tr>
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</table>
PAYMENT RATE CHANGES

Factors that impact the Market Basket Rate-of-Increase

- Failure to submit quality data
- Failure to be a meaningful EHR user
  - One-quarter of the Market Basket Update in FFY 2015
  - One-half of the Market Basket Update in FFY 2016
  - Three-fourths of the Market Basket Update in FFY 2017

- Productivity adjustment (applies to all IPPS hospitals)
- Statutory adjustment (applies to all IPPS hospitals)
- Documentation and coding adjustment (applies to all IPPS hospitals)

DOCUMENTATION & CODING ADJUSTMENT

- -0.8% DCA reduction for FFY 2015
- Stems from MS-DRG transition in 2008
- Required to recoup $11 billion based upon American Tax Relief Act of 2012 (ATRA)
- CMS indicates a -9.3% DCA reduction would be necessary in FFY 2015 to fully recover the $11 billion required
- $8 billion remaining to be recouped in FFY 2016 (-0.8%) and FFY 2017 (-0.8%)
PRODUCTIVITY ADJUSTMENT

Starting 10/1/11, annual Medicare inflation adjustment is reduced by productivity adjustment “equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity”

- 10/1/11 cut = 1.0% (vs. 3.0% market basket)
- 10/1/12 cut = 0.7% (vs. 2.6% MB)
- 10/1/13 cut = 0.5% (vs. 2.5% MB)
- 10/1/14 cut = 0.5% (vs. 2.9% MB)

ACA REQUIRED CUTS

- 4/1/10 = 0.25%
- 10/1/10 = 0.25%
- 10/1/11 = 0.1%
- 10/1/12 = 0.1%
- 10/1/13 = 0.3%
- 10/1/14 = 0.2%
- 10/1/15 = 0.2%
- 10/1/16 = 0.75%
- 10/1/17 = 0.75%
- 10/1/18 = 0.75%
Impact of Medicare ACA Productivity Cuts, Fixed Cuts & Sequestration (Excludes DSH)

IMPACT OF QUALITY REPORTING AND EHR MEANINGFUL USE

<table>
<thead>
<tr>
<th>FFY 2015</th>
<th>Submit Quality Data &amp; Meets EHR MU</th>
<th>Submits Quality Data &amp; Does Not Meet EHR MU</th>
<th>Did Not Submit Quality Data &amp; Meets MU</th>
<th>Did Not Submit Quality Data &amp; Does Not Meet MU</th>
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<tbody>
<tr>
<td>Market Basket Rate-of-Increase</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
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<tr>
<td>Quality Data Adjustment</td>
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<td>-0.725</td>
<td>-0.725</td>
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<tr>
<td>EHR Meaningful Use Adjustment</td>
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<td>0.0</td>
<td>-0.725</td>
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<tr>
<td>Productivity Adjustment</td>
<td>-0.5</td>
<td>-0.5</td>
<td>-0.5</td>
<td>-0.5</td>
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<tr>
<td>ACA Required Adjustment</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
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<tr>
<td>Documentation &amp; Coding Adjustment</td>
<td>-0.8</td>
<td>-0.8</td>
<td>-0.8</td>
<td>-0.8</td>
</tr>
<tr>
<td>Operating Payment Rate Increase (Decrease)</td>
<td>1.4%</td>
<td>0.675%</td>
<td>0.675%</td>
<td>-0.05%</td>
</tr>
</tbody>
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WAGE INDEX UPDATE

- CMS proposes implementing 2010 census labor market areas effective 10/1/14
- Housekeeping & dietary labor costs must be reported on wage survey
- New timeline for wage survey changes

TRANSITION POLICIES

- Urban hospitals whose counties become rural can retain urban wage index for 3 years, unless already receiving reclassification to a different area
- If 2015 wage index with 2015 CBSAs would be lower than with 2014 CBSAs, a 50/50 blended wage index will be computed averaging 2014 and 2015 CBSAs
- CAHs that are located in an urban area as a result of the change will have a two-year transition period. During the transition period, the affected CAH must reclassify as rural to retain CAH status.
CONTRACT HOUSEKEEPING & DIETARY

CMS concerned about hospitals not reporting contract housekeeping or dietary costs (due to not having hours identified)

CMS believes this overstates hospital's average hourly wage & has instructed contractors to estimate housekeeping & dietary costs if hospitals do not report them

WAGE SURVEY TIMELINE

<table>
<thead>
<tr>
<th>Deadline</th>
<th>FFY 2015</th>
<th>FFY 2016</th>
<th>FFY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals to request revisions</td>
<td>11/21/13</td>
<td>10/6/14</td>
<td>Early August 2015</td>
</tr>
<tr>
<td>Contractors to complete desk reviews</td>
<td>1/29/14</td>
<td>12/16/14</td>
<td>Mid-October 2015</td>
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</table>
MEDICARE DSH PAYMENT CHANGES

ACA changed DSH formula, effective 10/1/13

Two payments calculated for a DSH hospital

Traditional DSH payments continue to be computed but only paid at 25% (now called the “Empirically Justified” DSH payment)

A second payment will be based on three factors & is referred to as the “Uncompensated Care” DSH payment

Uncompensated Care DSH three factors:

Factor 1 – Difference between 100% of DSH payment that would have been paid out if the law had not been changed & the 25% that will be paid out

Factor 2 – 1 minus the % change in uninsured individuals based on CBO’s estimate

Factor 3 – Proportion of uncompensated care for hospital compared to all hospitals who receive DSH, using Medicaid days & SSI days

Factor 3 is based on each hospital’s share of total uncompensated care costs across all IPPS hospitals that received DSH payments
MEDICARE DSH PAYMENT CHANGES

Final 2015 Payment methodology remains the same as 2014

25% of Original DSH Payment + 75% of Original DSH Payments × Change in Uninsured × Uncomp Care Cost Ratio = Total New DSH Payment

MEDICARE DSH PAYMENT CHANGES

Empirically Justified DSH – (Old DSH Methodology)
Hospitals must meet the 15% threshold in order to qualify for these payments and the “Uncompensated Care” payments
340B Qualification

25% of Original DSH Pmt
MEDICARE DSH PAYMENT CHANGES

Uncompensated Care DSH

Distribution of the 75% pool based on 3 Factors

1. DSH Payments that would have been made, after 25% reduction
   • FFY 2014 = $9.593 Billion
   • FFY 2015 = $10.038 Billion

2. Decrease pool by the change in the uninsured population
   • CBO estimate from 16% in 2014 to 13.75% in 2015
   • FFY 2014 = $9.044 Billion
   • FFY 2015 = $7.648 Billion
   • Actual amount paid may exceed or fall short

3. Hospital’s Uncompensated Care divided by the aggregate amount of Uncompensated Care for all hospitals eligible for payment.
   • Not using Worksheet S-10
   • Continue to be a proxy of Medicaid and SSI days
   • Medicaid Days from the 2012 cost reports
   • Most recently available SSI Days (FFY 2012)
   • Review Supplemental DSH Data File
   • http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html
**MEDICARE DSH PAYMENTS**

- Estimated Impact
  - FFY 2014 versus FFY 2015 uncompensated care payments

**QUALITY PROVISIONS**

- Value-based purchasing pool increases to 1.5% for FY2015
- Maximum readmissions reduction increases to 3% for FY2015 & subsequent years
- Hospital-acquired conditions penalty of 1% for hospitals in lowest quartile of hospital-acquired conditions
  - CMS estimates -0.3% impact on urban hospitals; -0.2% impact on rural hospitals
In addition to Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia (PN) – CMS finalized the expansion of the readmission measures to include:

- Acute Exacerbation of COPD,
- Total Hip Arthroplasty (THA) and;
- Total Knee Arthroplasty (TKA)

Focus on Health-Care Associated Infections (HAIs) – Examples: urinary tract infections, surgical site and bloodstream infections. Need patient surveillance and infection control

HHS states that 1 in every 20 inpatients receive an infection related to hospital care. To see the national action plan, go to www.health.gov/hai/prevent_hai.asp

Discharge planning, discharge instructions – be clear, concise

Maintain data on high-risk patients with chronic conditions, nursing home patients, patients requiring palliative care

Post-discharge follow-up appointments and communication with PCP that can manage the medications and chronic conditions (ulcers, diabetes, COPD, etc.)

Reduce hospital falls and trauma – hospital acquired conditions
HOSPITAL ACQUIRED CONDITIONS

- Foreign Object Retained after Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages II & IV
- Falls and Trauma (fractures, dislocations)
- Catheter-Associated Urinary Tract Infection
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control (ketoacidosis, coma)
- Surgical Site Infection (CABG following AMI)
- Surgical Site Infection following Ortho Procedures (spine, neck, shoulder)
- Surgical Site Infection following Bariatric Surgery

HOSPITAL ACQUIRED CONDITIONS, CONTINUED

- Surgical Site Infection following Cardiac Implantable Electronic Device
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Ortho Procedures (Knee/Hip Replacements)
- Iatrogenic Pneumothorax with Venous Catheterization (accidental lung puncture)

www.cms.gov/HospitalAcqCond on the CMS Website

- Present on Admission documentation is critical. Monitor documentation and coding of secondary conditions and Present on Admission (POA) indicators (N-No)
SHORT STAYS & 2-MIDNIGHT POLICY

CMS sought comments on developing payment policy for short-stay or low-cost inpatients, presumably for 1-day stays? Questions:

// How to define short or low-cost stays
// How to pay for short or low-cost stays
// No change to 2-midnight policy, but offered the opportunity to identify additional exceptions to the policy

SHORT STAYS & 2-MIDNIGHT POLICY

Mitigate risks that usually start in the Emergency Department (ED) or Inpatient Surgery

• Utilize Utilization Review (UR) in the ED
• Integrate CDI program into the ED
• UR reviews all daily inpatient surgery schedules to catch any outpatient surgeries scheduled inappropriately as inpatient
• Train surgery schedulers to review surgery CPT code, research and notify UR if problems
• Get physician advisor or Chief Medical Officer involved as needed for peer-to-peer education, training
• Assess the current UR processes, UR Plan and UR physician members and determine if needed assistance and intervention is being obtained
SHORT STAYS & 2-MIDNIGHT POLICY, CONTINUED

Recommendations for compliance with 2-Midnight Policy

• Certification Form – great, but not necessary
• UR in the ER – perform admission criteria and communicate with ED physicians prior to patient status order being placed
• Hospitalist or Attending – see the patient as soon as possible/less than 2 hours from referral time to admission or change from observation to admission
• Consider a dedicated observation unit – UR or CM closely monitor patients that exceed 24 hours
• Physician champion is crucial

ICD-10 DELAY

• “The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets . . .”
• CMS has announced that 10/1/15 will be the new implementation date
• HFMA survey prior to delay showed 90% of hospitals with 600+ beds were very or extremely confident of ICD-10 readiness
• 58% of hospitals under 100 beds were very or extremely confident of ICD-10 readiness
2-MIDNIGHT RULE ENFORCEMENT

Delay in enforcement of 2-midnight policy for 6 months, through 3/31/15
- No post-payment patient status reviews with admission dates between 10/1/13-3/31/15, absent evidence of systematic gaming or abuse
- May still be reviewed for reasonable & necessary services, accurate coding & documentation, etc.

CHARGE TRANSPARENCY

ACA requires that each hospital “for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges”

CMS “reminds” hospitals of obligation and provides “flexibility to determine how they make a list of their standard charges public”

Charge information should be updated at least annually
CHARGE TRANSPARENCY

Hospitals should either make public a list of their standard charges (whether that be the chargemaster itself or in another form) or their policies for allowing the public to view a list of charges in response to an inquiry.

Hospitals should work with patients to understand potential financial liability for hospital services they obtain and to be able to compare charges for similar services across hospitals.

PROTECTING ACCESS TO MEDICARE ACT

- Physician Fee Schedule
- Rural Extenders
- ICD-10 Delay
- 2-Midnight Rule Enforcement
- Computed Tomography (CT) Payment Penalty
- Outpatient Lab Payment Study
- Financing
PHYSICIAN FEE SCHEDULE

- Extends current fee schedule through 3/31/15, avoiding 24% cut on 4/1/14
- House & Senate have crafted permanent fee schedule fix, but can’t decide on financing
  - Further negotiations likely delayed until after November elections, or after new Congress seated in January?

RURAL EXTENDERS

- Low-volume hospital payment add-on extended 1 year, to 3/31/15
- Hospitals must have fewer than 1,600 Medicare & Medicare Advantage discharges
  - 25% add-on for 200 or fewer discharges; decreasing to 0% for 1,600 or more discharges
- No other IPPS hospitals within 15 miles
- Eligible hospitals must notify Medicare contractor annually (by 9/1/14) that they continue to qualify based on location
RURAL EXTENDERS

- Medicare-dependent hospital classification extended 1 year, to 3/31/15
- CMS automatically extended status for existing MDHs
- Special rules for MDHs that had reverted to urban or SCH status
- To apply for SCH status effective 4/1/15, must apply by 3/1/15 & request 4/1/15 effective date

CT PAYMENT PENALTY

- Applies to outpatient CT scans paid under outpatient PPS or physician fee schedule
- If CT equipment standards not met, Medicare payments reduced 5% in 2016; 15% thereafter
CT EQUIPMENT STANDARDS

- Patient record captures post exam dose information in standardized electronic format
- Dose check feature alerts operator to avoid excessive radiation
- Automatic exposure control tailored to specific body regions
- Pre-loaded reference adult & pediatric protocols

OUTPATIENT LAB PAYMENT STUDY

- CMS to conduct study of lab payments beginning 1/1/16 & every 3 years thereafter
- For labs where a majority of their revenues are from Medicare
- Study to include Medicare & Medicaid managed care plans & all private payors
- Will be used to set Medicare payment rates effective 1/1/17
- Will not apply to new advanced diagnostic tests & certain other new tests
MEDICAID DSH CUTS

ACA requires federal DSH payments to states be cut as coverage expands; cuts =
- FFY 2014 - $500 million
- FFY 2015 - $600 million
- FFY 2016 - $600 million
- FFY 2017 - $1.8 billion
- FFY 2018 - $5 billion
- FFY 2019 - $5.6 billion
- FFY 2020 - $4 billion

CMS acknowledges state that expand Medicaid may have a lower share of uninsured in the future, & thus more Medicaid DSH cuts