Health Care Reform Teleconference: Hospital-Related Provisions

Patient Protection and Affordable Care Act (as amended by the Health Care and Education Reconciliation Act of 2010)
Agenda for Today’s Call

Medicare DGME and IME Payments
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Other Hospital Provisions
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IRS, Program Integrity, Physician Sunshine Act, and HIPPA Admin. Simp.
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The Health Care Reform Laws

Patient Protection and Affordable Care Act (PPACA)
- Enacted March 23, 2010 [PL 111-148]

Health Care and Education Reconciliation Act (HCERA)
- “Side-Car Bill” that amended PPACA
- Enacted March 30, 2010 [PL 111-152]
FY 2011 Medicare Hospital Inpatient PPS Proposed Rule

Published on CMS web site on April 19
To be published in Federal Register on May 4
Comments due June 18

Note: No health reform regulations in IPPS proposed rule; those will be issued in a separate rule that will be published any time
MEDICARE DGME AND IME PAYMENTS
Resident Limit Redistribution Program (§5503)

Cap Reductions:

- 65% of slots unused for past 3 years
- Look back at last 3 settled or submitted cost reports
Resident Limit Redistribution Program (§5503), Cont.

Hospital Prioritization for Receiving Slots:

- 70% of slots:
  - In state with resident-to-population ratio in lowest quartile
- 30% of slots:
  - In state that is in top 10 in terms of population in HPSAs and rural hospitals

CMS also required to consider:

- Likelihood of using the slots within first 3 cost reporting periods beginning July 1, 2011
- Whether hospital has a rural training track program
Other issues:

- Max of 75 cap slots per hospital
- New slots effective July 1, 2011
- IME payment for redistributed slots = 5.5%
- 75% of slots must be used for primary care or general surgery for 5 years
Preserving Cap Slots from Closed Programs (§5506)

Permanently redistributes resident caps from hospitals that close

- Currently only temporary redistribution until residents complete training
- Applies to hospitals that close on or after March 23, 2008
Preserving Cap Slots from Closed Programs (§5506), Cont.

Priority for distribution?

- Same CBSA
- Contiguous CBSA
- Same state
- Same region
- General redistribution program criteria as last resort

No reopening of cost reports unless DGME / IME appeal pending as of March 23, 2010
Counting Resident Time in Nonhospital Sites (§5504)

Hospital may count time residents spend training in nonhospital sites if the hospital:

Currently: Incurs 90% of the sum of resident stipends & benefits & supervisory physician costs

Health Reform Bill: Incurs resident stipends & benefits while residents are at nonhospital sites

Effective Date: July 1, 2010
Counting Resident Time for Didactic and Research Activities (§5505)

Allows hospitals to count didactic time in hospital for IME payments

Allows hospital to count nonhospital didactic time for DGME payments

Allows counting of vacation, sick, and other “approved leave” in FTE count

Ratifies October 1, 2001, regulation that excludes research time for IME payments

Effective dates: vary
### Counting Resident Time for Didactic and Research Activities (§5505)

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### IME

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<td>NOT Research (Oct. 1, 2001+)</td>
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Note: Text in italics indicates language in health reform bill.

* The health reform bill clarifies that IME research time does not count after Oct. 1, 2001. It does not answer the question of whether IME research time counted prior to this date (the section states that it "shall not give rise to any inference as to how the law in effect prior to such date should be interpreted").
DGME/IME Provisions in FY 2011
IPPS Proposed Rule

Revise definition of “resident” from “enrolled” in an approved program to “formally accepted, enrolled, and participating in” an approved program

Electronic submission of GME affiliation agreements to CMS Central Office
OTHER HOSPITAL PROVISIONS
Hospital Payment Updates
(§§ 3401 of PPAC and 10319 and
1105 of HCERA)

Hospital update reductions (-$112.6b/10y)
Applies to inpatient and outpatient, rehab, and psych

2010/11: \( = \) Market basket increase (MB) minus 0.25
2012/13: \( = \) MB-productivity adjust.\(* \) -0.1
2014: \( = \) MB-productivity adjust. -0.3
2015/16: \( = \) MB-productivity adjust. -0.2
2017/18/19: \( = \) MB-productivity adjust. -0.75
2020 and beyond: \( = \) MB-productivity adjust.

\(*\) Productivity adjustment estimate: 0.8% to 1.2%
IPPS Proposed Rule: Documentation and Coding Reduction

-2.9 % reduction to operating standardized amount recoup half of documentation and coding “overpayments” from 2008 and 2009

FY 2011 adjustment is “one time” and technically is put back into rates in FY 2012, but since other half of “overpayments” will be taken out in FY 2012, basically rates won’t change

CMS still needs to “reset” base rates as a result of documentation and coding increases in 2008/9 (3.9%) but will do this in future

National federal capital rate also will be reduced in FY 2011 by 2.9 percent; this is a permanent reduction
End Result: Change to FY 2011 IPPS Operating Standardized Amount

Update = Market Basket increase = 2.4 percent*

Update reduction due to D & C Adj. = -2.9% points

Update reduction due to health care reform

= -0.25% point for rest of FY 2010
= -0.25 % point for FY 2011

Result = -1.0 percent reduction in FY 2011 compared to FY 2010 standardized payment rate

* Update is 0.4 percent for hospitals that do not satisfy quality reporting requirements
Medicare DSH Payment Reductions (§3133 and §10316 and §1104 of HCERA))

Begin in 2014

10-year reduction = $22.1 billion

75 percent reduction to eliminate DSH payments “not empirically justified”

Additional “uncompensated care” payment available to hospitals based on:

- National uninsurance percent reduction plus additional adjustment
- Hospital-specific uncompensated care costs as a share of national uncompensated care costs
Impact of Medicare DSH Provision for a Hospital: 2014

Assumption:
National uninsurance rate falls by 2% between 2013 and 2014

Hospital receives:
(Medicare DSH Formula amount) * 25%
PLUS
(75% estimated aggregate national DSH payments) * (1 - 2% - 0.1%) * (Hospital-specific share of total uncompensated care)

(≈$5.25b) * (.979) = $5.14b *(hospital-specific share of total uncompensated care)
IPPS Proposed Rule: Medicare DSH

In response to a court case, CMS proposes to revise its data matching process for the SSI fraction of the Medicare DSH formula.
Medicaid DSH Reductions (§2551)

10-year reduction = $14 billion

Reductions in state DSH allotments for FYs 2014-2016 (bigger reductions in later years)

Secretary will establish methodology for reductions

Largest reductions on states with lowest percentages of uninsured individuals, or

Do not target DSH payments to hospitals with high volumes of Medicaid and uncompensated care
Payment Penalties for Readmissions (§3025 and 10309)

All base DRG payment amounts (excluding IME, DSH, outliers) in hospitals with excess readmissions are reduced by a factor determined by the level of “excess, preventable readmissions”

- Effective FY 2013
- Reduction is limited to 1% in 2013, 2% in 2014, and 3% in 2015 and beyond

Initially applied to heart attack, heart failure and pneumonia

- 30 day readmission window
- Excludes admissions unrelated to prior discharge

Expanded in 2015 to 4 additional conditions identified in MedPAC June 2007 report (COPD, CABG, PTCA, and “other vascular”)

10 year reduction = $7.1 billion
Payment Penalties for Readmissions (§3025 and 10309)

For ALL DRGs, payment will be reduced by:

Base DRG payment * adjustment factor (nlt 99% in FY 2013)

Adjustment factor =

1- (aggregate base DRG payments for excess readmissions for relevant DRGs/aggregate base DRG payments for all discharges for all DRGs)

“excess readmissions” determined by comparing actual risk-adjusted readmissions to “expected” risk-adjusted readmissions (as det. by the Secretary)
Readmissions, cont.

Requires establishment of a quality improvement program (by March, 2013) under public health service act to help hospitals improve readmission rates through PSOs

Hospitals also required to report on overall readmissions rates; data will be publicly released
Wage Index Provisions

Requires the Secretary to report to Congress by 12/31/2011 with a plan, developed with stakeholder consultation, to comprehensively reform the Medicare inpatient hospital wage index system taking into account the goals set forth in the June 2007 MedPAC.

Applies budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor effective 10/1/2010.

Extends Sec. 508 hospital wage index reclassifications through FY 2011.
IPPS Proposed Rule: Outlier Payments

CMS estimates FY 2010 outlier payments = 4.7%

Despite this, CMS still plans to increase outlier payment threshold, from $23,140 in FY 2010 to $23,970 in FY 2011
Price Transparency (§1001; §2718 of PHS)

Requires each hospital to establish (and update) and make public a list of the hospital’s “standard charges for items and services provided by the hospital, including for diagnosis-related groups”
HOSPITAL QUALITY PROVISIONS
Value Based Purchasing

Budget neutral

Starting FY 2013 – base DRG payment reduced by 1% to fund incentive pool
  • IME, DSH, outliers excluded from base payment
  • Reduction increases by .25 percentage points per year to 2% in 2017 and beyond

Payments will be based on both attainment and improvement (whichever is higher)

Score used to determine payment based on composite of measure groups

Initial measures will be subset of current measures in Pay for Reporting program
  • 2014 include efficiency and outcome measures (i.e. Medicare spending per beneficiary)
  • Readmission measures not included
Hospital Acquired Conditions

Effective FY 2015

Secretary to calculate Hospital Acquired Conditions (HAC) rate by hospital (risk-adjusted)

Base DRG payment reduced by 1% for hospitals scoring in top quartile (as compared to national average)
  • IME, DSH, outliers excluded from base payment

Possible expansion to other facilities (e.g. hospital outpatient departments)
Potential Dollars at Risk for Quality Provisions (% reduction in DRG payments)

**Potential to have 6% of base DRG payments at risk by 2017**

- **VBP**
  - Begin FY 2013
  - 1-2% reduction (phased in over 4 years)
  - Opportunity to recoup full amount and more

- **Readmissions**
  - Begin FY 2013
  - 1-3% reduction (phased in over 3 years)

- **Hospital Acquired Conditions**
  - Begin FY 2015
  - 1% reduction
Additional Quality Provisions

Medicaid Health Care Acquired Conditions
• States to implement program similar to current Medicare HAC program

Quality Reporting for LTCH, Rehab and Hospice Programs
• Implements pay for reporting program effective 2014

Medicaid Quality Reporting
IPPS Proposed Rule Quality Reporting - RHQDAPU

2012
• 2 AHRQ PSIs
  • Post-op DVT/PE
  • Post-op Respiratory Failure
• 8 Hospital Acquired Conditions (HAC)

2013
• Central Line Blood Stream Infection
• Surgical Site Infection
• AMI – Statin at discharge
• Registry measures based on topic area

2014
• 2 ED throughput measures
• 2 Global immunization measures (Flu, PN)
New Requirement for Quality Reporting

Submission of patient level volume data for specific MS-DRGs
All-payor data
Submit annually
REQUIREMENTS FOR 501(C)(3) HOSPITALS
501(c)(3) Hospitals and the IRS

Amends the tax code

Requirements apply to 501 (c)(3) hospitals

If organization operates more than 1 hospital, applies to each facility
  • Any facility not meeting the requirements won’t be a (c)(3)
Who’s Covered?

An organization which operates a facility that is licensed, registered, or recognized as a hospital and

Any organization for which provision of hospital care is a principle function or purpose constituting the basis of its (c)(3) exemption
Needs Assessment

Must conduct community health needs assessment in either of the 2 tax years immediately preceding the current tax year

AND

Adopt an implementation strategy to meet the needs identified

Assessment requires input from people who represent broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health
Financial assistance—must include:

- Eligibility criteria; whether assistance includes free or discounted care
- Basis for calculating amounts charged to patients
- Method for applying financial assistance
- If no separate billing and collections policy, actions that may be taken in event of non-payment
- Measures to widely publicize the policy
Policies That are Required: 2

Emergency medical care

• Organization must provide, without discrimination, care for emergency medical conditions (defined by EMTALA) to individuals regardless of their eligibility under the financial assistance policy.

• Requirements are met if limit amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance to not more than lowest amounts charged to individuals who have insurance coverage AND prohibit use of gross charges.
Additional Requirement

Must not engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for financial assistance

Regulations and guidance are coming
Effective Dates

Financial assistance and emergency medical care policies: taxable years beginning after date of enactment

Community health needs assessment: taxable years beginning 2 years after date of enactment
Penalties and Reviews

$50,000 penalty for failure to comply

At least every 3 years: Secretary of the Treasury to review the community benefit activities of each hospital to which this section applies
IRS and HHS Report

Report on levels of charity care to Congress with respect to private tax-exempt, taxable, and government-owned hospitals:

- Levels of charity care provided
- Bad debt expenses
- Unreimbursed costs for services provided with respect to means-tested government programs
- Unreimbursed costs provided with respect to non-means tested government programs
- For private tax-exempt hospitals: costs for community benefit activities
PROGRAM INTEGRITY AND PHYSICIAN SUNSHINE ACT
First, Medicaid and CHIP

In 6 months: procedures for provider screening

• Level of screening depending on risk of fraud, waste and abuse
• Includes licensure check
• May include: criminal background check, fingerprinting, unscheduled and unannounced site visits (including pre-enrollment), and database checks
• 2 years after enactment applies to current providers
• No screening, no enrollment
More Medicaid and CHIP

Enhanced oversight for new providers

- Procedures to provide for provisional enrollment period of 30 days to 1 year, during which provider is subject to prepayment review and payment caps

Temporary moratorium on enrollment of new providers can be imposed if necessary to prevent or combat fraud, waste or abuse
Program Integrity

By 12/31/10: RAC expansion to Medicare Parts C and D; Medicaid

Compliance programs required for enrollment in Medicare, Medicaid, or CHIP.

• Must contain “core elements”

Medicare self-disclosure protocol for actual or potential violations of Stark law within 6 months
Where’s the Data?

Integrated Data Repository

At a minimum claims and payment data from:

• Medicare (A, B, C, D) and Medicaid
• CHIP
• VA health-related programs
• DoD health-related programs
• Federal old age, survivors, and disability benefits
• Indian Health Service
Even More Data for OIG/DOJ

HHS OIG and DOJ to have access to claims and payment data from HHS and contractors for Medicare, Medicaid, and CHIP
Overpayments

After reconciliation, Medicare and Medicaid overpayments to be returned within later of: 60 days from discovery or date next cost report due

• Written notification of reason for overpayment
• Failure to do so = obligation = FCA violation
Suspension Before Conviction

Can suspend Medicare and Medicaid payments pending investigation of a credible allegation of fraud

• Consult with OIG to make determination
Money for Fighting Fraud

2011: $105m
2012: $65m
2013-14: $40m
2015-16: $30m
2017-2020: $10m
Enhanced penalties may be triggered by:

- Failure to grant timely access upon reasonable request by OIG for audits, investigations, evaluations, or other statutory functions: $15,000 per day penalty

- If knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services: $50,000 for each record or statement
There’s More: NPDB and HHS

HHS to report information to National Practitioner Data Bank (NPDB) on final adverse actions (except those with no findings of liability) related to health care fraud and abuse.
Stark Exception Change

Whole hospital and rural provider exception

• By 9/23/2011 only hospitals with physician ownership and investment and Medicare agreement in operation as of 12/31/10 and that meet other requirements, qualify for exception

• Limits operating rooms, procedure rooms, and beds to # licensed as of date of enactment of bill

• Annual report to secretary identifying all owners and investors and nature and extent of ownership/investment

• Must disclosure to: patients, on public website, and in advertising
Other requirements

Cannot condition physician ownership or investment either directly or indirectly on physician owner/investor making or influencing referrals

 Aggregate value of ownership or investment limited to percentage on 3/21/10

Disclosure to patients if physician will not be available on premises during all hours in which hospital is providing services to patients
Anti-Kickback Statute and False Claims Act (FCA)

For anti-kickback law, no need to have actual knowledge or specific intent to commit a violation

FCA:

Not considered an “original source” if:

• Allegations publicly disclosed in Federal criminal, civil, or administrative hearing in which the Government is party, or congressional, GAO, or other Federal report, etc., or news media
Original Source

To be an original source:

• Prior to public disclosure voluntary disclosed information to government on which allegation is based OR

• Has knowledge that is independent of and adds materially to publicly disclosed allegations AND

• Has voluntarily provided information to the Government before filing an action
Physician Payment and Ownership Sunshine Provisions [§6002]

Requires annual reporting of payments, other transfers of value to physicians and teaching hospitals from manufacturers of drugs, devices, biological, or medical supplies for which payment is available under Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP)

Also requires reporting of physician ownership or investment interests in such manufacturers

Reporting begins March 31, 2013

Secretary to post reports on public Web site
Physician Payment and Ownership Sunshine Provisions

Excludes payments of less than $10 unless annual aggregate to a recipient exceeds $100

Requires description of the nature of the payment

- consulting fees;
- compensation for services other than consulting;
- honoraria;
- gift;
- entertainment;
- food;
- travel (including the specified destinations);
Physician Payment and Ownership Sunshine Provisions

- education;
- research;
- charitable contribution;
- royalty or license;
- current or prospective ownership or investment interest;
- direct compensation for serving as faculty or a speaker for a medical education program;
- grant; or
- any other nature of the payment or other transfer of value (as defined by the Secretary).
Definition of physician:

- Allopaths
- Osteopaths
- Dentists
- Podiatrists
- Optometrists
- Chiropractors
Sunshine Act Penalties

Penalties:

- For failure to report in timely manner: $1,000-$10,000 per payment, NTE $150,000
- Knowing failure to report: $10,000-$100,000 for each payment, NTE $1m
CHANGES TO HIPAA ADMIN SIMPLIFICATION
Admin Simplification (§1104)

To “reduce the clerical burden on patients, health care providers, and health plans”

For financial and administrative transactions

Calls for single set of “operating rules”: necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications

• To extent feasible and appropriate, allow determination of individuals’ eligibility and financial responsibility at point of care

• Transparent claims and denial management process
Timing of Admin Simplification

By 7/1/11: operating rules for eligibility for a health plan and health claims status transactions; effective by 1/1/13; may allow for use of machine readable ID card

By 7/1/12: adopt rules for EFT and health care payment and remittance; effective by 1/1/14

By 7/1/14: rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, premium payments and referral certification and authorization; effective by 1/1/16
Upcoming Calls

**Topic:** GME (includes redistribution of unused Medicare resident cap slots; counting didactic and other time in hospital and non-hospital settings; permanently distributing cap slots from closed hospitals)

**Date:** May 3, 2-3:30pm EDT

**Topic:** Quality Provisions (includes quality reporting and performance-based payments for hospitals and physicians)

**Date:** May 10, 2-3:30pm EDT
Upcoming Calls (Cont.)

**Topic:** Workforce, Title VII, Public Health, and Disparities  
**Date:** May 12, 2-3:30pm EDT

**Topic:** Demonstration Projects and the CMS Innovation Center  
**Date:** May 13, 2-3:30pm EDT