REIMBURSEMENT UPDATE: THE GOOD, THE BAD AND THE UNKNOWN

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TODAY'S AGENDA

- HFMA Pricing Transparency Task Force
  David Kennedy
- RAC Report to Congress FY 2012
- Protecting Access to Medicare Act of 2014
- Medicare DSH FY 2014
- Hospital Acquired Conditions Reduction Program FY 2015
  Ellen Donahue
- MedPAC's 2014 Report to Congress
  Connie Ouellette

HFMA PRICING TRANSPARENCY TASK FORCE

- The HFMA's report was developed in light of the increasing number of healthcare recipients who require "meaningful and transparent" pricing information.
- The media is critical of the healthcare industry as a result of this issue. Articles in newspapers and magazines (such as a 2013 article in Time) dispense significant criticism towards the hospital chargemaster based on how it impacts the cost to uninsured or underinsured patients.
- The HFMA's approach to pricing transparency was more comprehensive and addressed the issue from the perspective of various stakeholders. The Task Force consisted of individuals representing providers, payers, patients, and the FTC.

WHAT THE TASK FORCE DID

The multi-disciplined group performed the following:

- Agreed on definition of terms
- Developed guiding principles for price transparency
- Recommended price transparency frameworks for different care purchaser groups
- Identified transparency-related policy considerations
- Charted the way to achievement of a more transparent healthcare pricing system

Charge, Cost, and Price

The report defines each component separately to add clarification to the issue of pricing itself. Price is derived differently depending on the underlying reimbursement arrangement.

- Charge – The dollar amount a provider sets for services rendered before negotiating any discounts.
- Cost – Varies by the part incurring the expense – patient, provider, insurer, or employer.
- Price – The total amount a provider expects to be paid by payers and patients for healthcare services.

  "While there has been a historical relationship between charges and prices for healthcare services, that relationship has become less relevant as new payment models have emerged."

  By defining each separately, the taskforce sought to eliminate confusion associated with the debate.

PRICING TRANSPARENCY AS DEFINED BY THE TASK FORCE

Readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

PRICE TRANSPARENCY FRAMEWORKS

- Insured patients – Insurance health plans should be responsible and provide:
  - The total estimated price of the service
  - An indication of in network vs. out of network
  - An estimate of out-of-pocket payments
- Uninsured and Out of Network Patients – The provider should be the principal source and provide
  - The total estimated price of the service with and without complications
  - Pre-service price estimates
  - The services included in the estimate
- Employers – Should continue to use and expand transparency tools that assist their employees in identifying higher-value providers.
- Referring clinicians – Should help a patient make informed decisions about treatment plans that best fit the individual's situation. Should also recognize the needs of price sensitive patients.

HFMA'S GUIDING PRINCIPLES FOR PRICE TRANSPARENCY

Principal 1. Price transparency should empower patients to make meaningful price comparisons prior to receiving care.

Principal 2. Any form of price transparency should be easy to use and easy to communicate to stakeholders.

Principal 3. Price information should be paired with other information that defines the value of the services for the care purchaser.

Principal 4. Should provide patients with the information they need to understand the total price of their care and what is included in that price.

Principal 5. Requires the commitment and active participation of all stakeholders

POTENTIAL IMPACT OF TRANSPARENCY

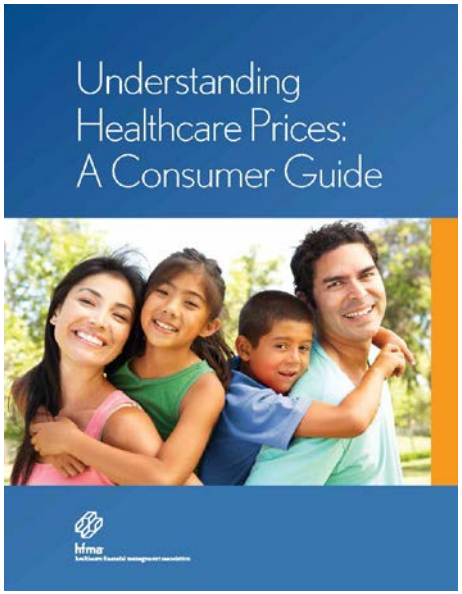
- Transparency of negotiated rates may lead to price inflation associated with the business to business market place. Taskforce recommends focus on out-of-pocket payments within the privately insured market to avoid pricing wars.

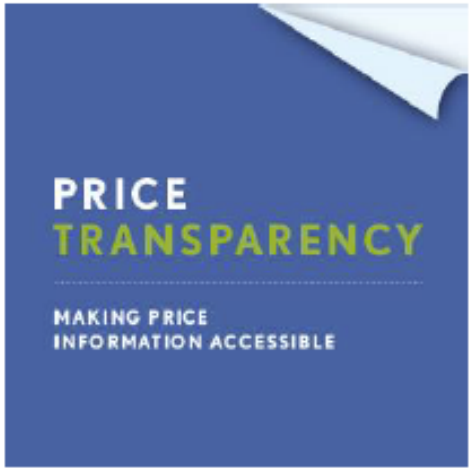
- May lead to lower prices based on the effect of "reference"(1) pricing. However, a provider may raise prices elsewhere to offset the impact of meeting reference prices.

- The goal of price transparency is to make the healthcare system more efficient, encouraging providers to focus on maximizing the efficiency of their operations and reducing their internal cost structure so they can better compete on price.

(1) Reference pricing sets a limit on the amount that an employer with a self funded plan will pay for healthcare services purchased by its employers.

HFMA RESOURCES AVAILABLE





hfma.org/transparency

RAC
Report to Congress
FY 2012

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RECOVERY AUDIT PROGRAM

Medicare FFS

- Part A, Part B and DME

Medicare Part C

- Notice issued April 4, 2013 seeking contractors

Medicare Part D

- Initial review focused on excluded prescribers and pharmacies

Medicaid

- Medicaid RACs-At-A-Glance (Phase II) website for State status

LEVEL OF ACTIVITY

Claims reviewed by Fiscal Year	FY 2010	FY 2011	FY 2012
	91,878	887,291	1,272,297

TYPES OF AUDITS – FY 2012

Corrections by Review Type				
Review Type	**No. of Claims**	**% of Claims**	**Amount Corrected**	**% of $**
Automated	859,706	68.6%	$ 226,047,161	9.4%
Complex	375,732	30.0%	2,151,913,710	89.6%
Semi-Automated	2,158	0.2%	4,923,318	0.2%
Unknown	15,301	1.2%	17,837,959	0.7%
Total	**1,252,897**	**100.0%**	**$ 2,400,722,147**	**100.0%**

MEDICARE FFS

Most common reasons for improper payment:

- Medically unnecessary
- Incorrectly coded services
- Supporting documentation does not support services ordered

AMOUNTS RETURNED TO MEDICARE TRUST FUNDS

(in millions)

	FY 2012	FY 2011
Overpayments Collected	$ 2,291.40	$ 797.40
Underpayments Restored	(109.40)	(141.90)
Amount Over-turned on Appeal	(21.30)	(37.90)
Recovery Auditor Contingency Fees	(142.30)	(81.90)
CMS Administration Costs	(85.80)	(47.50)
Amount Returned to Medicare Trust Funds	**$ 1,932.60**	**$ 488.20**

COLLECTIONS AND UNDERPAYMENTS BY STATE

	FY 2012	FY 2011	FY 2010
		Maine	
Collected	$10,041,282	$2,575,241	$85,580
Restored	2,962,822	1,836,524	100,288
Total Corrected - Maine	**$13,004,105**	**$4,411,765**	**$185,868**
		New Hampshire	
Collected	$4,406,659	$844,617	$73,690
Restored	1,855,742	574,160	41,568
Total Corrected - New Hampshire	**$6,262,401**	**$1,418,777**	**$115,258**
		Vermont	
Collected	$3,345,195	$887,282	$15,793
Restored	1,028,479	749,554	55,164
Total Corrected - Vermont	**4,373,674**	**1,636,836**	**70,957**
		Total – All States	
Collected	$2,291,350,056	$797,447,027	$75,435,474
Restored	109,372,091	141,918,042	16,889,918
Total Corrected - All States	**$2,400,722,147**	**$939,365,069**	**$92,325,392**

Protecting Access to Medicare Act of 2014

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DOC FIX

Prevents 24% cut in reimbursement to doctors

- 0.5% increase through 12/31/2014
- 0% update from 1/1 to 4/1/2015

Extends for 1 year

- Therapy cap exception process
- Ambulance pass-on payments
- Low Volume adjustment
- Medicare-Dependent Hospital program

MORE DOC FIX

Other Extensions

- Two-midnight rule auditing program for 6 months
    - And…RACs may not conduct patient status reviews for inpatient claims with dates of admission 10/1/2013 through 3/31/2015 (exception)
- The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets

MORE DOC FIX

- Medicaid DSH
  - Delays reductions in payments to DSH hospitals by one year to 2017
  - Makes additional reductions for years through 2024

Medicare DSH
FY 2014

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DSH PAYMENTS - 10/1/2013

- Two Payments
  - 25% - Empirically Justified
    - Same as “old” calculation
  - 75% - Uncompensated Care
    - Pool based on what would have been paid – reduced for the changes in the percentage of individuals that are insured
    - Pool allocated based on “the aggregate amount of uncompensated care for all subsection (d) hospitals”

25% EMPIRICALLY JUSTIFIED

DSH Calculation	P =	SSI% + (Medicaid patient days / Total patient days)	
	Urban >100	Urban >100	Urban >100
DSH %age	15% - 20.2%	> 20.3%	30% State
Calculation	(P-15)(.65) + 2.5	(P-20.2)(.825) + 5.88	35%
P =	18.00	29.15	35.00
Reduced by	(15.00)	(20.20)	-
	3.00	8.95	35.00
Multiplied by	0.65	0.825	
	1.95	7.384	
Plus	2.50	5.88	
DSH Adjustment	**4.45**	**12.00**	**35.00**

- Hospitals that aren't large urban will use large urban formula for DSH payments capped at 12%, rural referral centers aren't capped
- As of 10/1/06 MDHs are not capped

75% - UNCOMPENSATED CARE POOL

- FFY 2014 Uncompensated Care Pool amount available:
  - $9,046,380,143
  - Allocation to each hospital based on factor of the Hospital's Medicaid days plus SSI days divided by the 36,429,747 (total IPPS hospitals Medicaid and SSI days for FFY 2014)
  - Calculated to a per claim amount and paid through claims processing

UNCOMPENSATED CARE POOL - EXAMPLE

Southeast Alabama Medical Center - 010001	
Medicaid Days	16,388
SSI Days	5,700
Insured Low Income Days	22,088
Total Days - Denominator	**36,429,747**
Factor	0.000606318
Pool Available	**$9,046,380,143**
Total Uncompensated Care Payment Amount	$5,484,980
Claims Average	7,872
Estimated per Claim Amount	**$ 696.77**

Hospital Acquired Conditions **Reduction Program** FY 2015

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HAC REDUCTION PROGRAM

- Mandated by ACA
  - Reduce payments by 1% for hospitals that rank among the lowest-performing 25% with regard to HACs
    - Does not apply to hospitals excluded from IPPS – CAHs, IRFs, IPFs
    - Does apply to Sole Community Hospitals
  - Reduction will be applied after adjustments have been made for VBP and Readmission Reduction programs
  - Reduction also applies to IME and DSH payments

MEASURES & DOMAINS

- Three Measures – Two Domains
  - Domain 1 – weighted 35%
    - Patient Safety Indicators (PSI) PSI 90
  - Domain 2 – weighted 65%
    - Central Line Associated Bloodstream Infections
    - Catheter Associated Urinary Tract Infections

TOTAL HAC REDUCTION SCORE

- Each measure given a score
  - If more than one measure per domain scores are averaged to get domain score
- Domain weighting factor is applied
- Weighted Domain scores are added to get Total HAC Score
- Total HAC Scores are ranked to identify lowest-performing 25% that will be penalized

MedPAC's 2014 Report to Congress

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MEDPAC'S 2014 REPORT TO CONGRESS

- Required by law to review Medicare payment policies annually
- 2015 FFS Payment Update Recommendations
  - Hospitals:
    - Differences in payment rates between OP depts and physician offices for selected APCs – reduce or eliminate
    - For payment of non-chronically critically ill (CCI) cases of LTCHs, set payment rate equal to those of acute care hospitals
      - Redistribute savings to create additional IP outlier payments for CCI cases for IPPS hospitals
      - Phase in over 3 years
    - 3.25% payment increase of IP and OP

MEDPAC'S 2014 REPORT TO CONGRESS (CONT'D)

2015 FFS Payment Update Recommendations

Physicians

- Replace SGR system with 10-yr path of statutory fee schedule updates, with higher update to primary care than specialists (Oct 2011)
  - Also increase shared savings opportunity for physicians and health professionals who join or lead 2-sided risk ACOs
- Work and practice expense values based on cohort of efficient practices
- Reduce RVUs for overprices fee schedule services; budget neutral

ASC, OP Dialysis, IRF, LTCH

- No payment increases

MEDPAC'S 2014 REPORT TO CONGRESS (CONT'D)

2015 FFS Payment Update Recommendations

SNF

- No market basket update
- PPS rebasing, with an initial 4% reduction and subsequent reductions
- Adjustments for high risk-adjusted rates of rehospitalization during stays and including after discharge

HHA

- Also a reduction for hospital readmissions

Hospice

- No payment update
- Higher payment per day at beginning of episode and higher payment for costs associated with patient death

QUESTIONS?

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