

HFS Medicare Cost Report Update

» For the ME HFMA December 2, 2010

By Becky Dolin, Health Financial Systems
888.216.6041

HFS Medicare Cost Report Update

▶ Objectives:

- Hospital Transmittal 21
- Hospital Transmittal 22
- Stimulus ACT - HIT
- 2552-10
- BCBSA ACA Summary
- Other Cost Report Form Changes
- Misc....

Hospital Transmittal 21

▶ T.21 is effective for FYE on or after 10/1/2009.

▶ FY PPS 2010 IPPS Final Rule

- ▶ Final Rule in the Aug 28, 2009, Federal Register
- ▶ Proposed Rule in the May 22, 2009, Federal Register

Hospital Transmittal 21

1. "Pickle Amendment" for Operating DSH was added to S-2 line 21.01, column 2. Automatic 35% DSH percentage on E part A line 4.03.
2. S-2 line 21.08 added for Method of accumulating the day count for Title XIX.

Hospital Transmittal 21

3. CAH, S-2 line 30.03 is N/A for "cost" reimbursed Ambulance (Report 85C - Cost based trips).
4. S-3 part I columns 5.01, 5.02, 6.01, 6.02, are N/A, for Observation Bed days Admitted and Not Admitted.
5. Inclusion of Labor and Delivery Room Days in DSH. Added S-3, Part I Line 29.

Hospital Transmittal 21

6. W/S A line 55.30 for Implantable Devices is effective for FY Begin 5/1/2009 and after (No longer "optional").
7. W/S A new cost centers for Cardiac Rehab (59.97), Hyperbaric Oxygen Therapy (59.98), and Lithotripsy 59.99, effective for FYE 10/1/2009 and after.

Hospital Transmittal 21

- 8. W/S E part A line 5.05 ESRD Rate change effective FYE 1/1/2009 and after. (\$401.43 for 2009 and \$405.45 for 2010).
- 9. W/S E part A line 4.01 (DSH), changed effective FY Begin 10/1/2009, to EXCLUDE Observation Bed Days, and INCLUDE Labor and Delivery Days (new line 29 on S-3).

Hospital Transmittal 21

- 10. W/S E-3 part I (Rehab), line 1.04, LIP calculation changed for discharges on or after 10/1/2009. Must split Payments on line 1.02, for before and after 10/1/2009. Lines 1.02, 1.04, 1.41, and 1.42 will have a subscripted column 1.01. Before 10/1/2009 the LIP Factor is 0.6229 and after 10/1/2009 it is 0.4613.

Hospital Transmittal 21

- 11. W/S L part I, line 5.01 changed same as E part A line 4.01 above, for Capital DSH.
- 12. W/S L part I, line 4.03, officially reinstated Capital IME reimbursed at 100%.

Hospital Transmittal 21

13. W/S M-3 (RHC/FQHC), line 14 calc revised to phase out 62.5% Limit, over 5 years - 2010 to 2014. 2009, 62.5% Limit; 2010-2011, 68.75%; 2012, 75%; 2013, 81.25%; 1/1/2014 and after, 100%.
14. W/S M-4 (RHC/FQHC Vaccine) revised for H1N1. Need to separately identify Medical Supplies, Total Injections, and Medicare Injections, for each service - Pneumococcal, Seasonal Influenza Only, H1N1 Only, and Influenza & H1N1 Combined. H1N1 vaccine changes are effective for services on or after 9/1/2009.

Hospital Transmittal 22

- ▶ Effective for Services on or after 1/1/2010.
- ▶ Final issued 9/13/2010.
- ▶ HFS approved 9/28/2010.
- ▶ Includes PPACA (Patient Protection and Affordable Care Act), now known as "ACA", changes

Hospital Transmittal 22

1. Extended TOPS to 12/31/2010 (Section 3121). Services on or after 1/1/2010 need to be accounted for (split charges and payments). Small Rural, and all SCH over 100 beds. S-2, Line 21.01 Column 2
2. MDH status extended to 10/1/2012 (was 10/1/2011). ACA Section 3124

Hospital Transmittal 22

3. Includes 23 New RUGs on W/S S-7.
4. E, Part A, Line 24.97 to capture additional hospital payment in accordance with the Health Care and Education Reconciliation Act (HCERA) of 2010.
5. CAH Lab services at "cost" extended to 6/30/2011. ACA Section 3122

Hospital Transmittal 22

6. 410A Demo extended to 2019, and opened for more potential participants (Now 20 States and some 30 Hospitals; only 10 currently in Demo). ACA Section 3123
7. Low Volume payment - up to 25%, to be paid providers with low volume (Total discharges less than 1600; for discharges on or after 10/1/2010 through 9/30/2012). ACA Section 3125
8. Clarifies CAH will still get 101% of "cost". ACA Section 3128

HITECH on the Cost Report

- ▶ Changes will be made to 2552-10 NOT 2552-96
- ▶ "incentive payments to eligible professionals(Eps) and eligible hospitals to promote the adoption and meaningful use of interoperable health information technologies and Electronic Health Records(EHR)"
- ▶ Eligible providers
 - Subsection (d) hospitals
 - Including MD Hospitals
 - Excluding PR Hospitals
 - Does not apply to excluded hospitals
 - Critical Access Hospitals

HITECH on the Cost Report

- ▶ Hospital must be “demonstrating meaningful use”
- ▶ Payments can begin for cost reporting periods beginning in FFY 2011 through cost reporting periods in FFY 2016.
- ▶ Failure to demonstrate meaningful use will result in penalties starting in cost reporting periods beginning in FFY2015.

Incentive Payment Calculation for Eligible Hospitals

H
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- ▶ Product of:
 - An initial amount
 - X
 - The Medicare share
 - X
 - A transition factor applicable to the payment year
- ▶ Interim payments will be based on previous years cost reporting data
- ▶ Final payments will be determined at the time of settlement

Incentive Payment Calculation for Eligible Hospitals

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- Initial Amount = Sum of “base amount” and a “discharge related amount”
- Base Amount = \$2,000,000
- Discharge related amount
 - First through 1,149th discharge = \$0
 - 1,150th through 23,000th discharge, \$200
 - For any discharge greater than 23,000th, \$0
- Minimum initial amount = \$2,000,000
- Maximum initial amount = \$6,370,000

Incentive Payment Calculation for Eligible Hospitals

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Medicare Share

- Medicare days use definition similar to DGME patient load
 - Total Medicare inpatient days plus Medicare Part C days
- Divided by total days computed as:
 - The total number of inpatient-bed-days with respect to the hospital multiplied by the ratio of
 - Total hospital charges excluding charges attributed to charity care divided by the total hospital charges.

	Initial Amount				
Base Amount					\$2,000,000
	Total Discharges less 1,500		Net Discharges Times \$200		
	5,820	1,500	4,320		
Discharge Amount					\$ 864,000
Initial Amount					\$2,864,000
	Medicare Share				
	Part A	Part C	Total		
Medicare Days	36,092	1,000	37,092		
Total Days					121,466
Total Charges	Charity Care	Numerator	Denominator	Ratio	
33,619,705	600,000	33,019,705	33,619,705	0.982153	
Adjusted Total Days					119,288
Medicare Share					31.09%
Potential Incentive Payment					\$ 890,544

Incentive Payment Calculation for Eligible Hospitals

Transition Factor

Fiscal Year	Fiscal Year that Eligible Hospital First Receives the Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.00	-----	-----	-----	-----
2012	0.75	1.00	-----	-----	-----
2013	0.50	0.75	1.00	-----	-----
2014	0.25	0.50	0.75	0.75	-----
2015	-----	0.25	0.50	0.50	0.50
2016	-----	-----	0.25	0.25	0.25

expenditures.

Hospital Incentive Payment Adjustments Effective in 2015 and subsequent years

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- ▶ Adjustment to IPPS market basket updates for hospitals that are not meaningful HER users for payment years beginning in 2015 and each subsequent FY.
 - Reduction of 33.3% for FY 2015
 - Reduction of 66.6% for FY 2016
 - Reduction of 100% for FY 2017 and subsequent
- Reductions apply only with respect to the FY involved and do not otherwise apply to subsequent FYs

Potential Cost Reporting Issues

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- ▶ Incentive payment issues
 - Review of total discharges
 - Hospital vs. sub provider charges
 - Reporting of charity care
 - MA days and shadow billing
- ▶ Penalty payment issues
 - Similar to current quality reporting payment reductions

Incentive Payments for Critical Access Hospitals (CAHs)

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- ▶ CAH must qualify as a meaningful EHR user
- ▶ Reasonable costs for the purchase of certified EHR technology
 - The reasonable acquisition costs, excluding any depreciation and interest expense associated with the acquisition, incurred for the purchase of depreciable assets such as computers and associated hardware and software, necessary to administer certified EHR technology.

Incentive Payment Calculation for Eligible CAHs

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▶ Product of:

The reasonable costs incurred for the purchase of certified HER technology in a cost reporting period plus any similarly incurred costs from the previous cost reporting period to the extent that they have not been fully depreciated.

$$\begin{matrix} \times \\ \text{The Medicare share} \end{matrix}$$

Incentive Payment Calculation for Eligible CAHs

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▶ Medicare Share

- Medicare days use definition similar to DGME patient load
 - Total Medicare inpatient days plus Medicare Part C days
- Divided by total days computed as:
 - The total number of inpatient-bed-days with respect to the hospital divided by
 - Total hospital charges excluding charges attributed to charity care divided by the total hospital charges.
- Plus 20% points - Not to exceed 100%

Incentive Payment Calculation for Eligible CAHs

H
I
T
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C
H

▶ May be made in a cost reporting period that begins during a payment year after FY 2010 but before FY 2016

▶ In no case will be made to more than 4 consecutive payment years

▶ Incentive payments are made in lieu of 101% cost reimbursement

◦ Depreciation and interest must not be allowed in payment year and all subsequent payment years

Incentive Payment Calculation for Eligible CAHs

- H. "Prompt interim payment"
- I.
 - o CAH must qualify as meaningful EHR user
 - o CAH submits the necessary documentation to support the computation of the incentive payment
 - o MAC reviews documentation and determines interim amount
- T.
- E. Subject to reconciliation on Medicare cost report
- C.
- H.

CAH Incentive Payment Adjustments Effective in 2015 and subsequent years

- H.
- I.
 - o Adjustment to 101% reasonable cost reimbursement for CAHs that are not meaningful HER users for payment years beginning in 2015 and each subsequent FY.
 - o Reduction to 100.66% for FY 2015
 - o Reduction to 100.33% for FY 2016
 - o Reduction to 100% for FY 2017 and subsequent
 - o "Significant hardship" provision for up to 5 years
- T.
- E.
- C.
- H.

Potential Cost Reporting Issues

- H. Similar to hospital issues
- I.
 - o Determination of HIT costs in current and potentially previous cost reporting period
- T. HIT costs reimbursed as incentive cannot be claimed as depreciation in future years
- E. "Prompt" payment
- C.
- H.

Draft 2552-10

- ▶ The 2nd Draft 2552-10 was published in the April 30, 2010 Federal Register, with a 30 day comment period, to June 1, 2010.
- ▶ HFS' commented but CMS asked that we not share these comments yet.
- ▶ The new "2552-10" is effective for FY Begin 5/1/2010.
- ▶ More Title XIX specificity is expected.
- ▶ HFS may add its own Title 19 screen/questions, if necessary.

Draft 2552-10

- ▶ The primary reason for the 2552-10, was to clean up the "2552-96".
- ▶ The term "Intermediary" is replaced with "Contractor", throughout the Forms and Instructions.
- ▶ Obsolete lines/columns/worksheets, were deleted, and the forms renumbered.
- ▶ "Standard" Subscripts eliminated.

Draft 2552-10

- ▶ Worksheet S
 - Will also have the FI/Contractor info, and this will become part of the ECR file.
 - Will have Line for the IPF and IRF Subprovider (2 and 3) and RHC and FQHC (10 and 11).
 - Will have a new column 4 for settlement for HIT payments.

Draft 2552-10

- ▶ Worksheet S-2
 - New lines for IPF and IRF (4 and 5).
 - S-2 lines 24 and 25 are new for T.19 "paid" and "eligible" days of S-3). This should be for DSH, but there were no instructions for the use of these new lines, 10, and 11).
 - S-2 now has a column for the "Type" of provider (col. 4, instead of the old lines 19.00 and 20.00).

Draft 2552-10

- ▶ S-2 part II is new for the 339 Exhibit I - no more separate hard copy Exhibit I. This will now be part of the ECR file. Exhibits 2-5 are still hard copy.
- ▶ S-2 reorganized to group info (e.g. CAH all in one section, lines 105-109; PPS all in one section, lines 45, 47, etc.).

Draft 2552-10

- ▶ S-2 now has a column for each component CBSA (col. 3). Previously, only three places (SNF old line 28.02, col. 4; 21.03, col. 5 for Hospital; and S-4 line 20 for HHA), input the CBSA code.
- ▶ All SNF info will be on S-7.

Draft 2552-10

- ▶ Worksheet S-3
 - S-3, parts I, II, III, new column 1 added for W/S A line reference.
 - S-3 part I, new line for LTCH non covered days (line 33) was added (was only instructional in '96, as col. 4.01).
 - S-3 part I revised to add column "4" for CAH hours (was only instructional in '96 as col. 2.01).
 - S-3 parts II and III revised to remove 339 references (old col. 6 deleted).

Draft 2552-10

- ▶ New S-3 part IV for old 339 wage related costs for Core services (benefits). This is the detail (lines 24 and 25) for Part II, lines 17 and 18. Part IV flows to lines 17 and 18 of part II.
- ▶ New S-3 part V for Contract Labor and Benefit Cost. Not clear if this is line 11 of Part II.
- ▶ All Organ Acquisition are now "standard lines", (e.g. Intestine, Islet).

Draft 2552-10

- ▶ Worksheet S-4
 - S-4 lines 21-38, columns 5 and 6 were removed (SCIC). N/A for 1/1/2008 and after.
 - S-4 MSA is gone (died 1/1/2006), and only CBSA are now reported in column 1, lines 19 and 20.
 - HFS added CBSA Look Up Table under TOOLS.

Draft 2552-10

- ▶ Worksheet S-7.
 - S-7 now includes all SNF info.
 - New line 58 on S-7, asks for CBSA at beginning and end of FY, to identify changes in status.
 - S-7 columns for split of days before and after 10/1 removed, as not used since 2003. All days reported in columns 2 or 3.
 - New 23 RUGs will be added.

Draft 2552-10

- ▶ S-8, for RHC/FQHC, deleted lines 10 and 11 from the 1st draft (old lines 9 and 10), for Physician info, as it is considered PHI data, and should not be in the cost report for Freedom of Information.
- ▶ S-10 was virtually totally redesigned. Charity Care more detailed. Line 20 is the critical line. CAH now MUST complete S-10.
 - Line 31 calculation revised to remove line 23, as it was included twice.

Draft 2552-10

- ▶ W/S A
 - Renumbered 1-200.
 - Line 30 now Adults & Peds (old line 25).
 - Line 42 added for Other Subprovider.
 - Line 50 now begins Ancillary (old line 37).
 - Lines 57-59 new for CT Scan, MRI, and Cardiac Cath, respectively.
 - Line 72 new for Implantable Devices (added in Transmittal 20 as line 55.30).

Draft 2552-10

- ▶ Worksheet A, cont.d.
 - Outpatient now begins on Line 88 (RHC and FQHC are now on lines 88 and 89.00).
 - Line 90 moved to line 3 (Other Capital).
 - Other Reimbursable now begins at Line 94
 - Special Purpose now begins at Line 105
 - Non Reimbursable now begins at Line 190
 - Total line is now line 200 is (old line 101).

Draft 2552-10

- ▶ W/S A lines skipped in each category for future use (e.g. 24-29, 47-49, etc.).
- ▶ IPF and IRF; RHC and FQHC; as well as all Organ Acquisition, now "standard lines".
- ▶ OLD Capital reference eliminated. Now JUST Capital cost center lines 1 and 2.00.

Draft 2552-10

- ▶ A-7 eliminated "old" capital (Part I) and renumbered new form as Parts I, II, and III - no part IV.
- ▶ A-7 part I, line 7, new for HIT.
- ▶ W/S A-8 mostly the same - only eliminated obsolete references to A-8-3 and A-8-4, as now only A-8-3 (old A-8-4) remains for Therapy adjustments (CAH).

Draft 2552-10

- ▶ A-8 line 32 new for CAH HIT adjustment.
- ▶ Worksheet B and B-1.
 - W/S A lines 1-24 used to equate to B and B-1, lines/columns 1-24 for Overheads. Now line 3 is dropped, so B, B-1 skip line/column 3 (1, 2, 4, 5).
 - "Old Capital" was eliminated (as was the term "new"), so B part II was removed and old B part III is now Part II. All references are just "Capital".

Draft 2552-10

- ▶ W/S B-1 is to allow additions to accumulated cost stats (previously, only reductions were allowed). ECR Spec change.
- ▶ More B-1 "automatic stats" expected to be allowed in the ECR file (e.g. Gross Salary, Gross Charges, etc.). Currently, only accumulated cost is an "automatic stat".
- ▶ ECR may add "repeat stat" identifier (e.g. square feet).

Draft 2552-10

- ▶ W/S B-2 added new "standard" lines for Aranesp drug carve out (from W/S S-5, same as EPO). Thus, drug "cost" must be in line 74 or 94 (old 57 or 64), so B-2 carve out applies to correct cost.
- ▶ W/S C part I, new lines added for Special Purpose Cost centers (99-117).
- ▶ W/S C part II was to be eliminated, but CMS added back after comments.
- ▶ W/S C parts III, IV, and V, eliminated.

Draft 2552-10

- ▶ D worksheets, Parts I, II, III, and IV, for Pass Through Costs, eliminated "old" capital, so new forms have fewer columns - basically renumbered, and no material changes.
- ▶ D part III eliminated CRNA (old col. 1), and added Allied Health and All Other - col. 2 and 3. 2552-96 added these via Instruction (subscripts col. 2.01, 2.02).

Draft 2552-10

- ▶ W/S D part IV revised to display Allied Health and All Other columns (added via Instruction in '96 - subscripted col. 2.01, 2.02).
- ▶ D part IV has new column 6 to display Total Outpatient Cost.
- ▶ D part IV columns renumbered, but essentially the same as 2552-96.

Draft 2552-10

- ▶ D part VI eliminated for Vaccine.
- ▶ D part V, new column 4, is now for Vaccine charges (services not subject to Ded. & Coins.).
- ▶ D part V columns 2 and 3 are like the old columns 5.01 and 5.02.
- ▶ If charges need to be split as of January 1st, then column 2 is subscripted as 2.01 - e.g. for TOPS, as it was extended by ACA section 3121.

Draft 2552-10

- ▶ D-1 part III for SNF, eliminated per diem calc for T.19, in 1st Draft, and is now back.
- ▶ D-1 part IV, line 87 in 2nd Draft, will reflect Post Stepdown Adjustments (PSA), if entered on B-2 for line 92, Observation Beds. This was actually clarified in Transmittal 20 of the 2552-96 (HFS ver. 20.0.118.0). The problem is that you do NOT see this as it is done behind the scenes.

Draft 2552-10

- ▶ W/S D-3 (old W/S D-4) added Nursery line – line 43 (for T.19).
- ▶ New W/S D-4 (old D-6), added Form for Islet Transplant. Also, new “standard” lines on W/S A for Pancreas, Intestinal, and Islet (lines 109, 110, 111), as well as “check boxes” on new W/S D-4, for Kidney, Heart, Liver, Lung, Pancreas, Intestinal, and Islet.

Draft 2552-10

- ▶ Worksheet E Part A
 - IME and DSH were expected to be moved to separate (new) worksheet, versus E part A. 2nd Draft/Final did NOT do this.
 - W/S E part A line 4, Bed Days Available (old line 3), was to be moved to S-3, as this is used for all “bed size” calculations. 2nd Draft/Final did NOT do this.
 - No more “splits” of payments on E part A.
 - IME adjustment “factor”– no change (1.35).

Draft 2552-10

- ▶ DSH – no more reduction factor.
- ▶ If allowable DSH percentage changes during FY, then subscribing will be needed (generally no change).
- ▶ “Pickle” providers automatically use 35% for DSH (S-2 line 22, column 2 = Y).
- ▶ Section 422 add on I&R FTE, old W/S E-3 part VI, was incorporated into E part A (see lines 23-29), and new W/S E-4.

Draft 2552-10

- ▶ Worksheet E part B
 - Line 1.02 payments must be split for TOPS, if FY overlaps 1/1/2010 or 12/31/2010.
 - W/S E part B moved I&R and Teaching Phys. “cost” out of LCC (Transmittal 18 retroactive change).
 - New lines 22 and 23 (old line 2 and 4), moved I&R and Teaching Physician “cost” out of the LCC calc as there were no comparable “charges”.

Draft 2552-10

- ▶ E part B, cont.d
 - New lines 90-94 for Outlier Reconciliation (added in T.20).
- ▶ New E-1 part II for HIT (Health Information Technology) payments. Must be identified separately and paid out of the Stimulus Bill (HR 1), as these payments are NOT Part A or Part B, Medicare Trust Funds.

Draft 2552-10

- ▶ Old E-3 part I, II, III was revised for each component (CAH, IPF, IRF, LTCH, etc.), so there is a new settlement page for each.
- ▶ New E-3 part I = TEFRA.
- ▶ New E-3 part II = IPF.
- ▶ New E-3 part III = IRF.
- ▶ New E-3 part IV = LTCH.
- ▶ New E-3 part V = CAH.

Draft 2552-10

- ▶ New E-3 part VI = SNF (Medicare).
- ▶ New E-3 part VII = Title 5 or 19.
- ▶ New E-4 = IME/GME (old E-3 part IV and VI).

Draft 2552-10

- ▶ Worksheet E-4 is old E-3 part IV for GME, plus old E-3 part VI for I&R redistribution.
 - **Note** that E-4 line 2 is similar to the old E-3 part VI, line 2 - **BUT** E-4 line 2 is the actual reduction (i.e. 25 FTE), whereas old E-3 part VI was the reduced, or resultant FTE (i.e. $33-25=8$). The old would input 8, and the new will input 25.

Draft 2552-10

- ▶ Old E-3 part VI (redistribution of IME and GME FTE - Section 422), was eliminated, and now part of new W/S E-4 for GME and 422 FTE, as well as E part A for IME.
- ▶ W/S G lines 27 and 28 new for HIT assets and depreciation, respectively.

Draft 2552-10

- ▶ W/S H series for HHA, eliminated old H-1, H-2, and H-3 and renumbered them as below:
- ▶ New H-1 part I (old H-4 part I).
- ▶ New H-1 part II (old H-4 part II).
- ▶ New H-2 part I (old H-5 part I).
- ▶ New H-2 part II old H-5 part II).
- ▶ New H-3 (old H-6).
- ▶ New H-4 (old H-7).
- ▶ New H-5 (old H-8).

Draft 2552-10

- ▶ The I, J, K, L, L-1, and M worksheets are virtually the same as in the 2552-96.
- ▶ One exception is that Worksheet L eliminated Part II (hold harmless), and renumbered so old Part III is Part II, and old Part IV is now Part III.

Draft 2552-10

- ▶ The instructions for the calculation of line 37 on W/S E-4, page 40-213 (the old line 12 on E-3 part IV), for inpatient cost, now includes the SNF, W/S D-1 line 74 "cost", as well as the E-3 part VI, line 4 "cost" (RUG payments and pass through costs). This is a change from the 2552-96, in including the SNF "cost".

Draft 2552-10

- ▶ The instructions for the calculation of line 6 on W/S L part I, page 40-273, include the Outlier payments on line 2. The 2552-96 did NOT. This change should be noted.

ACA Summary

Section	Title	Description	Effective Date	Notes
3001	Incentive Value Based Purchasing Program	Hospitals that meet or exceed the established standards will be paid an incentive. The incentive will be calculated as the base operating DRG payments times an incentive payment percentage. The incentive payment percentage is calculated using the individual hospital scores and will be calculated to distribute the funds made available. Available funds will be determined by applying a reduction to the base operating DRGs as follows: - FY 2013 1% - FY 2014 1.25% - FY 2015 1.5% - FY 2016 1.75% - FY 2017 and subsequent 2% For MDHs and SCNs the base DRG amount would exclude the additional "cost" payments.	Program that apply for payments for discharges on or after 10/1/2012	Applies to subsection (2) hospitals. Considerations will begin "no later than 2 years after the date of enactment" for CAHS.
3004	Quality Reporting for LTCH, IRF and Hospice	Imposes penalties for failure to report required quality data: - LTCH for rate year 2014 and subsequent 2% decrease to annual update - IRF for rate year 2014 and subsequent 2% decrease to annual update - Hospice for rate year 2014 and subsequent 2% decrease to annual update.	See description	THIS COULD RESULT IN A NEGATIVE UPDATE.
3005	Quality Reporting for FFS-Exempt Cancer Hospitals	Will require establishing quality measures and reporting outcomes, but no penalty for failure. Requires "Plan"	Fiscal year 2014 and subsequent	
3006	Plans for a value-based purchasing program for SNF and risk	Adjustment to hospital payments for hospital acquired conditions	Report to Congress not later than 10/1/2011	
3008	Adjustment to hospital payments for hospital acquired conditions	Applies to subsection (2) hospitals. Applicable hospitals: - Top quartile of hospitals in nation for hospital acquired conditions in an applicable period to be defined by the Secretary. - Risk Adjusted Payments equal to 80% of the amount that would otherwise apply. Does not apply if they have a similar program.	Discharges occurring during FY 2010 and subsequent	

ACA Summary				
Section	Title	Description	Effective Date	Notes
3025	Hospital Readmissions Reduction Program	Subsection (b) and (3)(B) hospitals will have payments determined by a ratio of the ratio of: - The aggregate payments for excess readmissions - The aggregate payments for all discharges With a floor of: - 0.99 for FY 2013 - 0.98 for FY 2014 - 0.97 for FY 2015 and subsequent	Payment for discharges occurring during a fiscal year beginning on or after October 1, 2012.	
Amended by 10312	Extension of certain payment rules for LTCH services and of monitoring on the establishments of certain hospitals and facilities			Extends the three-year moratorium on the LTCH payment adjustment to 4 years. The amendment extends the moratorium to 5 years.
3121	Extension of Outpatient HED Harmonization Provision	Continues TOPs (total hospital payments) for small rural hospitals and BCRs and will provide TOPs payments for all BCRs (those over 100 beds) for 1/1/2010 through 12/31/2010.	Continues TOPs through 1/1/2011 and provides for large BCRs 1/1/2010 through 12/31/2010.	Cost Report impact will be included in FY 2011 and FY 2012-13. Addressed in FY 2011 IPPS Final Rule published on the August 16, 2010. Exhibit B (table).
3122	Extension of Medicare Reasonable Cost Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Medically Needy Patients in Certain Rural Areas	Extends the small rural clinical lab exception program to include BCRs.	During the one-year period beginning on July 1, 2010.	Cost Report impact will be included in FY 2012 and FY 2013-15. Addressed in FY 2011 IPPS Final Rule published on the August 16, 2010. Exhibit B (table).
Amended by 10313	Extension of the Rural Community Hospital Demonstration Program	<ul style="list-style-type: none"> Extends the demonstration program by one year (3 years in total). (Amended to 3 years and 18 months in total) Expands the number of States that can participate to 20 (from 15) Increases the number of hospitals that can participate to 20 (from 15) Currently participating providers automatically extended one year (amended to 5 years unless they opt out) 		Has new cost report change but more FIMACs may need to be provided and possibly trained on the program and cost report impact. Addressed in FY 2011 IPPS Final Rule published on the August 16, 2010. Exhibit B (table).
3124	Extension of the MCH Program	Extends (through October 1, 2012) and allows MCHs to continue to decline reclassification for that period.		Cost Report impact will be included in FY 2012 and FY 2013-15. Addressed in FY 2011 IPPS Final Rule published on the August 16, 2010. Exhibit B (table).

ACA Summary				
Section	Title	Description	Effective Date	Notes
Amended by 10314	Temporary requirements to the Medicare Inpatient Hospital Payment Adjustment for Low Volume Hospitals	For two years the low volume payment adjustments is revised to: - Change outlier requirements from 25 read miles to 15 read miles - Change outlier count from 100 discharges to 1500 discharges (amended to 1000) - Requires CMS to develop a sliding scale adjustment for number of discharges from 20% to 200 to <= for over 1300 (amended to 1600).	For discharges occurring in FY 2011 and 2012.	Currently the one-month adjustment is calculated off the full report. Addressed in FY 2011 IPPS Final Rule published on the August 16, 2010. Exhibit B (table).
3128	Technical Correction Related to CAH Services	Reimburses CAHs for 101% of facility costs	As if included in MFRA	This corrects the technical error that was identified in the FY 2010 Final Rule. This provision eliminates the otherwise required cost reporting change. Addressed in FY 2011 IPPS Final Rule published on the August 16, 2010. Exhibit B (table).
Amended by 10315	Payment adjustments for home health agencies	<p>Will require the re-basing of the HHA PPS payment rates to account for:</p> <ul style="list-style-type: none"> changes in the number of visits in an episode the use rate of services in an episode level of intensity of services provided in an episode the average costs of providing care per episode <p>The move to the new base HHA PPS payments will be phased in over a 4-year period and be fully implemented in 2016 (Amended to 2017).</p> <p>This provision will also change the HHA outlier calculations by:</p> <ul style="list-style-type: none"> Changing the projected pool of funds available to look outlier payments to 10% of the payments Applying through Legislation a 10% cap on the total amount of outlier payments an HHA can receive to 10% of its total payments for years beginning in 2011. 	For 2013 and subsequent years (Amended to 2016)	

ACA Summary				
Section	Title	Description	Effective Date	Notes
3132	Hospice Care Payment Reform	The Secretary shall collect additional data and information appropriate to revise payments for hospice care. Information shall include: - Charges and payments - Number of days of hospice care provided to individuals enrolled in Part A - For each type of service - Number of days of hospice care - The cost of the type of service - The amount of payment for type of service - Charitable contributions and other revenue to the hospice - Number of hospice visits - Type of practitioner providing the visit - The length of the visit This data can be collected on cost reports claims or other means.	Data collection will begin no later than 1/1/2011.	Significant cost reporting revisions may be required.
Amended by 10316 and 1104 of Reconciliation	Improvements to Medicare DSH Payments	<p>Not earlier than 10/1/2012 the Secretary shall implement changes to the hospice payment methodology based on the analysis of the data reported above. Payment methodology must be budget neutral in relation to the previous methodology.</p> <p>Medicare DSH payments will be adjusted to 20% of the otherwise expeditiously settled amounts.</p> <p>The reduction in the legacy DSH payments will be used to fund additional payments to hospitals based on the product of three factors:</p> <ul style="list-style-type: none"> The difference payments that would have been made under DSH and the payments made at the 20% level. A reduction factor based on the percentage change of individuals under the age of 65 who are uninsured. An individual payment adjustment based on the quotient of the amount of uncompensated care provided by the individual hospital and aggregate uncompensated care for all applicable hospitals. 	FY 2015 and subsequent (amended to 2014)	This will create significant cost reporting changes and data collection for FY 2013 and beyond.

ACA Summary				
Section	Title	Description	Effective Date	Notes
3137	Hospital Wage Index Improvement	Not later than 12/31/2011 CMS must submit a report to Congress to describe a plan to reform the hospital wage index system.	Discharges occurring on or after 10/1/2010	Addressed in FY 2011 IPPS Final Rule published in the August 16, 2010, Federal Register .
3141	Application of Budget Neutrality on a National Basis in the Calculation of the Rural Foot	Requires the budget neutrality adjustment to a national basis. Beginning in FY 2009 CMS began moving to a budget adjustment.	Effective for cost reporting periods beginning on or after 10/1/2011, the otherwise applicable resident level shall be reduced by 50% of the difference between the otherwise applicable limit and a reference resident level.	Addressed in CY 2010 OPPS Proposed Rule published in the August 9, 2010, Federal Register .
5503	Distribution of Additional Residency Positions	Effective for cost reporting periods beginning on or after 10/1/2011, the otherwise applicable resident limit for each qualifying hospital. No hospital may receive more than 75 additional FTEs.	Effective for cost reporting periods beginning on or after 10/20/10	Addressed in CY 2010 OPPS Proposed Rule published in the August 3, 2010, Federal Register .
5504	Counting of Resident Time in Non-prospector Settings	IME - all the time spent by a resident shall be counted without regard to the setting if a hospital incurs the costs of the education and fringe benefits of the resident. In addition, more than one hospital may share the costs. IME - Similar to IME but effective for discharges occurring on or after 7/1/2010.	Effective for cost reporting periods beginning on or after 7/1/2010	Addressed in CY 2010 OPPS Proposed Rule published in the August 3, 2010, Federal Register .

ACA Summary				
Section	Title	Description	Effective Date	Notes
5505	Limit on Counting Residency Time for Didactic and Scholarship Activities and Other Activities	IME - Didactic and research time associated with research time not associated with a particular patient shall be included in FTE count. Effective for cost reporting periods beginning on or after 7/1/2009, vacation time shall be counted toward the allowable FTE calculation effective for cost reporting periods beginning on or after 11/1/2009. IME - Didactic and research time (including research time not associated with a particular patient) shall be included in FTE count. Effective for cost reporting periods beginning on or after 10/1/2009, vacation time shall be counted toward the allowable FTE calculation effective for cost reporting periods beginning on or after 11/1/2009.	See description	Addressed in CY 2010 OPPS Proposed Rule published in the August 3, 2010, Federal Register .
5506	Preservation of Resident Cap Positions From Closed Hospitals			Addressed in CY 2010 OPPS Proposed Rule published in the August 3, 2010, Federal Register .
5104	Staff Reporting of Experiences	Facilities shall separately report expenditures for wages and benefits for direct care staff (including but not limited to registered nurses, licensed professional nurses, certified nurse assistants and other medical and therapy staff). The Secretary in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home care reports, shall redesign such reports to meet the requirements not later than 1 year after enactment.	For cost reporting periods beginning on or after the date that is 2 years after the date of enactment.	Also addressed in 2009TCU 10436, issued 09-28-10, which results in future cost reporting changes.

ACA Summary				
Section	Title	Description	Effective Date	Notes
Reconciliation Att Section 1109	Payment for Qualifying Hospitals	Provides an additional payment for "qualifying hospitals" in FY 2011 and 2012. - Provides \$400,000,000 for FY 2011 and 2012. - Payment amount - amount available will be distributed based on proportion of each qualifying payment under 1005(d) to the qualifying hospital to total payments under the section for all qualifying hospitals. - A qualifying hospital is a subsection (b) hospital that is located in a county that ranks, based upon its ranking in age, sex, and race adjusted spending for benefits under parts A and B per enrollee, within the lowest quartile of such counties in the US.	FY 2011 and FY 2012	Will need implementing Regulations and cost reporting changes. Addressed in FY 2011 IPPS Final Rule published in the August 16, 2010, Federal Register .

SNF 2540-96, Transmittal 17

- ▶ T.17 issued 12/16/2009.
- ▶ T.17 effective FYE on or after 10/1/2009.
- ▶ Primary change was addition of columns for H1N1 vaccine on I-4.

SNF 2540-96, Transmittal 18

- ▶ CMS issued Transmittal 18 for the SNF, which will add 23 new RUGs, on 9/8/2010.
- ▶ HFS was approved 10/12/2010.
- ▶ The effective date is FYE on or after 10/1/2010. The old 45 RUGs are used for services prior to 10/1/2010, and the old plus new 23 RUGs, are used for services on or after 10/1/2010.
- ▶ T.18 also removed the "Simplified SNF" option (S-2 lines 50-52, B part III, and B-1 part II).

HHA Transmittal 14/15

- ▶ HHA, 1728-94, Transmittal 14 issued 1/28/2010.
- ▶ HFS was approved 3/12/2010.
- ▶ Primary change was H1N1 vaccines (W/S RF-4), and phase out of 62.5% limit on clinic costs (W/S RF-3 line 14).
- ▶ HHA Transmittal 15 issued 2/22/2010, and was "clean up" of T.14, with no new policy changes.
- ▶ HFS current version is 15.2.121.1.

ESRD, 265-94, Transmittal 9

- ▶ ESRD T.9 is current Transmittal.
- ▶ HFS approved 2/24/2006.
- ▶ HFS version 9.13.121.0.
- ▶ No material changes for some time, but CMS must address Arenesp soon, so a new Transmittal (or Form Set) is expected.
- ▶ ESRD is to go "PPS" effective for services on or after 1/1/2011. A new cost report is expected.

Hospice, 1984-99

- ▶ CMS Transmittal 7.
- ▶ HFS approved 11/2/2006.
- ▶ HFS current version 7.9.121.0.
- ▶ New Hospice form set expected soon, due to PPACA Section 3132.
- ▶ 1984-10??

HCRIS

- ▶ CMS has issued a new HCRIS (HDT file) for the 222-92, RHC/FQHC.
- ▶ New HCRIS effective for FYE 3/31/2010 and after.
- ▶ The New HCRIS will be an "export all", or all the data in a cost report, versus selected data in the usual HDT file (similar to ESRD and Hospice).
- ▶ "All" format is expected for 2552-10

Wage Index

- ▶ CMS changed the format of the PUF (Public Use File).
- ▶ HFS modified our Wage Index Verification to account for these changes.
- ▶ Current version is 3.00.
- ▶ PPACA section 3137 requires the HHS Secretary to submit to Congress by 12/31/2011, a report to reform wage index.

MACs

By
Health Financial Systems
November 2010

Figure 1: Current A/B MAC Jurisdictions



Part A/B MACs

1	CA, NV, HI	Palmetto, GBA
2	Protest of Contract Award AK, ID, OR, WA	NHIC Noridian
3	AZ, MT, ND, SD, UT, WY	Noridian
4	CO, NM, OK, TX	TrailBlazer
5	IA, KS, MO, NE	WPS

Part A/B MACs

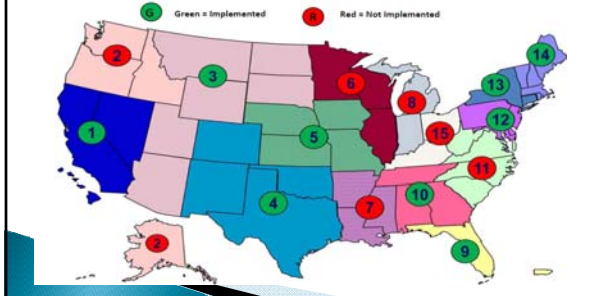
6	Protest of Contract Award IL, WI MN	Noridian National Government Services Noridian
7	Protest of Contract Award AR LA, MS	Pinnacle Arkansas Blue Cross TriSpan
8	Protest of Contract Award IN, MI	National Government Services National Government Services
9	FL, PR	First Coast Service Options
10	AL, GA, TN	Cahaba

Part A/B MACs

11	SC, NC VA, WV	Palmetto National Government Services
12	DC, DE, MD, NJ, PA	Highmark
13	CT, NY	National Government Services
14	MA, ME, NH, RI, VT	NHIC National Government Services
15	Protest of Contract Award KY, OH	Highmark

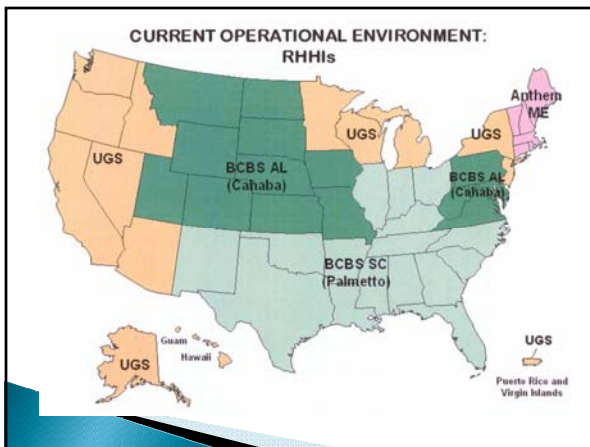
MAC Implementation Status

Figure 2: Current Implementation Status of the A/B MACs



6 Protested Areas

- ▶ CMS fully intends to implement MACs 6, 8 and 15 by the end of 2011.
- ▶ 11 has been awarded since the map was made – green now.
- ▶ See Round II for information on MACs 2 and 7.....



HHH and Hospice MACs

6	Delayed AK, AZ, CA, HI, ID, MI, MN, NV, NJ, NY, OR, PR, WI, WA	Noridian
11	AL, AR, FL, GA, IL, IN, KY, LA, MS, NC, NM, OH, OK, SC, TN, TX	Palmetto/National Government Services
14	CT, MA, ME, NH, RI, VT	NHIC/National Government Services
15	Delayed CO, DE, DC, IA, KS, MD, MO, MT, NE, ND, PA, SD, UT, VA, WV, WY	Highmark Cahaba?

Transition Areas

- ▶ MACs beginning to receive WPS files. J1 has been transitioned. J7 is in transition.
- ▶ RHCs to start going to MACs (previously went Riverbend – Tennessee)

Not That Anyone is Counting....

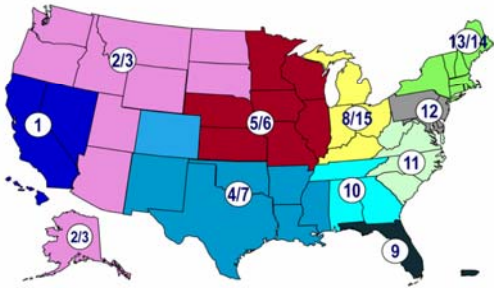
- ▶ Current MAC Count
 - Awarded Protested
 - HFS 8 3
 - KPMG 2 2

Round II – The Rules Change

- ▶ CMS will consolidate the present 15 A/B MAC jurisdictions into 10 A/B MAC jurisdictions.
- ▶ CMS will implement an award limit for the A/B MAC contracts(26% of workload?).
- ▶ CMS will enhance the Statement of Work to include the requirement that each MAC employ at least one full-time, fully dedicated medical director.
- ▶

Round II Consolidations

Figure 4: Jurisdictional Boundaries After Second Phase of Consolidation (Approx 2016)



Combined Areas

- ▶ A/B MAC Jurisdictions 2 and 3(AK, WA, OR, ID, MT, ND, SD, WY, UT and AZ)
- ▶ A/B MAC Jurisdictions 4 and 7(LA, AR, MS, TX, OK, CO, NM)
- ▶ A/B MAC Jurisdictions 5 and 6(MN, WI, IL, KS, NE, IA, MO)
- ▶ A/B MAC Jurisdictions 8 and 15(KY, OH, MI, IN)
- ▶ A/B MAC Jurisdictions 13 and 14(NY, CT, MA, RI, VT, ME, NH)

Round II Timelines

New Jurisdiction Designation	Former Jurisdiction Designation(s)	Percentage of National Part A & Part B Workload	Estimated Solicitation Release Date for Next Round of MAC Procurements
E	1	8.8%	January 2012
F	2 & 3	6.0%	August 2010
G	5 & 6	12.4%	September 2011
H	4 & 7	13.1%	October 2010
I	8 & 15	11.4%	July 2014
J	10	7.2%	January 2013
K	13 & 14	12.3%	March 2012
L	12	10.8%	March 2012
M	11	9.8%	May 2014
N	9	8.2%	September 2012



HFS Software Development

Health Financial Systems



HFS Software Development Supported O/S

- ▶ Windows 7
- ▶ Windows Vista
- ▶ Windows XP with pack 3
- ▶ Windows Server 2003/2008



HFS Software Development Systems Status

- ▶ All Cost Report systems 32-bit
- ▶ Hospital 2552-10 in Development stage
- ▶ SNF 2540-10 Development
- ▶ IRIS - New Version Released
- ▶ HCRIS Product - Release in 2011



HFS Software Development Significant System Changes

- New Spreadsheet Used for screens
- Registry Issues - User area only now.
- Encryption Program Improvement

Recent Feature Enhancements

- | | |
|---|---|
| ▶ Mgmt Reports -
New Level of
Criteria | ▶ AAI - Multiple
Imports
Accommodated |
| ▶ PS&R - Reads new
CMS extract
Format, New Export
Option | ▶ .pdf available for all
reports. |
| ▶ Auditor - Impact
Report New format | ▶ New Look Up
format available in
Batch Data
Extractor |



HFS Software Development Hospital 2552-10

- ▶ Speed improvement
- ▶ Eliminate file corruption
- ▶ New worksheet printout look
- ▶ Introducing file sharing?
- ▶ Introducing quick calculations
- ▶ Adding adjustments from cells
- ▶ Fully 32/64-bit compatible



HFS Software Development Coming Soon.....New Website

- ▶ Completely redesigned
- ▶ Customer Portal
- ▶ New Support/Help Features
- ▶ Web Training

Sources

- ▶ The maps used in this presentation are from CMS .
- ▶ The ACA table and some of the HITECH information is from a presentation by Blue Cross Blue Shield Association.
