

# VT-NH HFMA Annual Institute

## The Potential Impact of Healthcare Reform on the Revenue Cycle and Reimbursement

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# Agenda and Objectives

- Provide a summary of the key aspects of the Bill
- Highlight the areas of consideration for revenue and reimbursement implications
- Provide an update on any significant changes or amendments to the original Bill to date



# Healthcare Reform 2010

## **Patient Protection and Affordable Care Act**

**(PPACA)** signed into law in the United States by President Barack Obama  
- March 23, 2010

As amended by...

The Senate Manager's Amendment to the PPACA, adopted and amended to the PPACA legislation as **Title X**

The HCERA **Health Care & Education Reconciliation Act of 2010** -  
signed into law on March 30, 2010

The Reconciliation bill makes numerous modifications to the Patient Protection and Affordable Care Act.

# Healthcare Reform Overview

**Implementation over a period from enactment through 2020, with a concentration on the period 2010 - 2014**

## Key Provisions:

- Prohibits denial of coverage/claims based on pre-existing conditions
- Adds across-the-board coverage mandates\*
- Expands Medicaid eligibility
- Subsidizes insurance premiums
- Establishes health insurance exchanges
- Incentivizes businesses to provide health care benefits
- Reductions in Medicare reimbursement
- New demonstration projects and quality-based reimbursement programs

\* **Currently being contested in the courts**

# Impact On Uninsured

**According to Congressional Budget Office estimates, the number of uninsured people will drop from current levels by 32 million people. There will still be 23 million residents who will be uninsured in 2019 after the bill's provisions have taken effect. Among the individuals in this group will be:**

- Undocumented immigrants, estimated at almost one-third of the 23 million, will be ineligible for insurance subsidies and Medicaid.
- Those who do not enroll in Medicaid despite being eligible.
- Those who are not otherwise covered and opt to pay the annual penalty instead of purchasing insurance (cost/benefit). This will likely be mostly younger and single Americans.
- Those for whom insurance coverage would cost more than 8% of household income are exempt from paying the annual penalty.



# ...and the money comes from where?

- Cuts in Medicare reimbursement
- New Medicare taxes for high-income brackets
- New excise taxes
- Improved fairness in the Medicare Advantage program relative to traditional Medicare slowing the growth of Medicare provider payments
- Fees and taxes on medical devices, pharmaceutical companies, and health insurers
- Tax penalty for citizens who do not obtain health insurance (unless they are exempt due to low income or other reasons)
- Limitations on FSA contributions
- Modifications to the tax code

# Reimbursement & Revenue Cycle Implications

## Fraud and Abuse January 1, 2010

- “Enhanced” Civil Monetary Penalties:
  - \$15k/day for failure to grant timely access for OIG audits, investigations, or other functions.
  - \$50k/record or statement for knowingly making false statements or providing false records material to a false/fraudulent claim for services.
  - Effective for acts committed after January 1, 2010.
- Requires Medicare and Medicaid participating providers and suppliers to establish a compliance program as a condition of enrollment. Programs must contain certain core elements to be developed by HHS Secretary and the HHS Office of Inspector General (OIG) for each industry sector or category of provider or supplier.
  - Timeline to be determined
- January 24, 2011 update: Create screening process for providers and suppliers enrolling in Medicare, Medicaid and CHIP programs

# Reimbursement & Revenue Cycle Implications

## Price Transparency Continues Effective date TBD

“Each hospital operating within the United States shall 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 for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.”

- The effective date of this section was not specified in the law
- As of October 1, 2010, [www.HealthCare.gov](http://www.HealthCare.gov) is providing this information for over 4,400 plans offered by over 225 insurers for individuals and families in the private insurance marketplace – plans across all 50 states and Washington, DC.

# Reimbursement & Revenue Cycle Implications

## 340 B Program **Retroactive to 1/1/10**

**Expands eligibility for the 340(B) drug discount program to other entities. DSH payment adjustments were available only to hospitals paid under the Medicare Prospective Payment System (PPS) and hospitals excluded from the PPS have been historically unable to participate in the 340B program.**

- PPS-excluded children's hospitals and cancer hospitals will be able to participate if they would meet the DSH payment adjustment percentage of greater than 11.75 percent if they were otherwise a PPS hospital.
- CAHs are eligible to participate by virtue of having CAH status and meeting other program requirements. DSH percentage criterion not applicable.
- Sole Community Hospitals (SCHs) and Medicare designated Rural Referral Centers (RRCs) can now qualify if their Medicare DSH Payment Adjustment is 8%. Historically, the DSH payment adjustment had to be 11.75%.
- PPACA also introduces new methods for monitoring and enforcing compliance with 340B program rules.

# Reimbursement & Revenue Cycle Implications

## Market Basket Update Beginning FY 2010

- Reduces annual market basket updates for most providers, including inpatient and outpatient hospital services, long-term care hospitals, inpatient rehab facilities, and psychiatric hospitals/units.
- For hospital providers, after the regular update is calculated (including the productivity adjustment when it becomes applicable in FFY 2012), it will be reduced further by:
  - 0.25 percentage point for fiscal years 2010 and 2011
  - 0.1 percentage point for each of fiscal years 2012 and 2013
  - 0.3 percentage point for fiscal year 2014
  - 0.2 percentage point for each of fiscal years 2015 and 2016
  - 0.75 percentage point for each of fiscal years 2017 – 2019
- **Inpatient hospital services are effected for discharges on or after April 1, 2010. Outpatient services are impacted for services on or after January 1, 2010.**

# Reimbursement & Revenue Cycle Implications

## Medicare Wage Index **FY 2010 and beyond**

- Retroactively extended **Section 508** hospital wage index reclassifications through FY 2010 \*
- **Budget neutrality** - applied on a national basis in the calculation of the Medicare hospital wage index floor effective 10/1/2010
- 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

\* further extensions contained in other bills not yet acted upon

# Reimbursement & Revenue Cycle Implications

## Temporary High Risk Pool June 21, 2010

### Temporary high-risk pool for adults with pre-existing conditions

- May be operated through contracts with states or non-profit entities
- To qualify for coverage:
  - applicants must have a pre-existing health condition and have been uninsured for at least the past six months
  - No age requirement
  - Premiums set under the pool as if for a standard population
  - Premiums to vary only by age, geographic area, family composition
  - Limited out-of-pocket spending : \$5,950 for individuals and \$11,900 for families, excluding premiums

# Reimbursement & Revenue Cycle Implications

## GME/IME - Resident Time July 1, 2010

### Counting Resident Time in Non-Provider Setting

- Prior: A hospital could count time that residents spent in non-provider sites, if the resident was involved in direct patient care activity and the provider incurred 90% of the sum of resident stipend & benefit costs and the supervising physician costs.
- As of July 1, 2010: Hospital can count all time if the provider incurs the resident stipend and benefit costs while the resident is at the non-provider location.
- Eliminates the need for extensive agreements and recordkeeping in most situations.
- Provision to be implemented without reopening hospital cost reports, unless a proper appeal on IME or DGME payments is pending on 03/23/2010.

# Reimbursement & Revenue Cycle Implications

## GME/IME - Resident Time July 1, 2010

### Non-Provider and Didactic Activities

- Non-provider setting must be primarily engaged in furnishing patient care, meaning a setting in which the primary activity is the care and treatment of patients.
- All resident time in an approved program for non-direct patient care activities (didactic and scholarly activities) may be counted.
- Research activities that are not associated with treatment or diagnosis may not be counted.

### Other Activities

- Research, vacation, sick leave and other approved leave which does not extend the program's duration for the individual
- The counting rules may not be applied to open settled cost reports unless there is a jurisdictionally proper appeal pending as of 03/23/2010.

# Reimbursement & Revenue Cycle Implications Coverage Changes – New Plans September 23, 2010

- Children will be permitted to remain on their parents' insurance plan until their 26th birthday. Includes children that no longer live with their parents, are not a dependent on a parent's tax return, are no longer a student, or are married.
  
- Prohibits individual and group health plans from:
  - placing **lifetime** limits on the dollar value of coverage
  - rescinding coverage/dropping policyholders when they get sick, except in cases of fraud
  - denying children coverage based on pre-existing medical conditions

# Reimbursement & Revenue Cycle Implications

## Coverage Changes – New Plans September 23, 2010

- Insurers' abilities to apply **annual** spending caps will be restricted, and completely prohibited by 2014.
- Plans to provide, at a minimum, coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

# Grandfathered Plans

- All health insurance policies in effect on or before March 23rd, 2010 will be initially grandfathered (exempt) from most of the PPACA requirements. Plans issued between March 23rd and Sept 22nd, 2010 will not have all benefits included now, but they must be brought into future compliance.
- **Any significant changes made to a grandfathered policy, (i.e. increasing the deductible, increasing out of pocket maximums) will result in the loss of grandfathered status.**

# Grandfathered Plans

## **Reforms with which grandfathered health plans must comply for plan years beginning on or after September 23, 2010 are:**

- Prohibition on lifetime limits on essential health benefits.
- Prohibition on health plan rescissions.
- Requirement to extend dependent coverage to children until the individual is 26 years old. Prior to 2014, a child may enroll for dependent coverage on a grandfathered plan only if such individual is not eligible for employment-based health benefits.

## **Grandfathered group health plans will be required to comply with the following reforms:**

- Restriction on annual limits, as determined by the Secretary, on essential health benefits provided by group health plans, for plan years beginning on or after September 23, 2010.
- Prohibition on coverage exclusions for pre-existing health conditions. For most enrollees (adults), this provision will become effective for plan years beginning on or after January 1, 2014. However, for children under age 19, this provision will become effective for plan years beginning on or after September 23, 2010.

# Reimbursement & Revenue Cycle Implications

## Medicaid October 1, 2010

- Require **Medicaid** coverage for tobacco cessation services for pregnant women.
- Mandates that state **Medicaid** programs, "effective for claims filed on or after Oct. 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative [NCCI] administered by the Secretary [or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment] and such other methodologies of that Initiative [or such other national correct coding methodologies] as the Secretary identifies. ..."

# Reimbursement & Revenue Cycle Implications

## Medicaid Hospital Acquired Conditions (HACs) July 1, 2011

- PPACA prohibits **Medicaid** payment for any care provided for **HACs** as identified in the regulations. The regulations must ensure that the prohibition of payment for HACs will not result in a loss of access to care or services for Medicaid beneficiaries.
  - In carrying out this section, the Secretary shall apply to State Medicaid plans the regulations promulgated pursuant to Medicare relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program.
- Proposed Rule published 2/17/11
  - Programs required to use Medicare HACs as a minimum, but authorizes States to use broader categories of “Provider Preventable Conditions” (PPCs).

# Reimbursement & Revenue Cycle Implications

## Medicare GME Cost Reporting Periods after July 1, 2011

- Redistribution of **unused residency training positions** as a way to encourage increased training and increase the number of Graduate Medical Education (GME) training positions. 65% of slots have gone unused in the last 3 years.
  - Redistribute currently unused slots, with priorities given to primary care and general surgery (75%) and to states with the lowest resident physician-to-population ratios.
    - 70% of slots: States with resident-to-population ratio in lowest quartile
    - 30% of slots: States that are in top 10 in terms of population in HPSAs and rural hospitals
- If a hospital's reference resident level is less than its otherwise applicable resident limit or full-time equivalent (FTE) cap, the FTE cap will be reduced by 65 percent of the difference between the FTE cap and reference resident level.
  - Does not apply to rural hospitals with fewer than 250 beds or a hospital that was part of the voluntary residency reduction plan, if the hospital demonstrates it has a plan to fill the unused positions within two years of enactment (i.e. March 23, 2012).

# Reimbursement & Revenue Cycle Implications

## Medicare GME Cost Reporting Periods after July 1, 2011

- Reference resident level – look back at last 3 settled or submitted cost reports: highest number of residents
- Hospitals can apply to increase their FTE cap:
  - Qualified hospitals may request up to 75 new FTE slots
  - Hospitals receiving an increase in their FTE cap will be paid for these additional slots beginning on or after July 1, 2011
  - Application for unused resident slots is due by 12/1/2010
- CMS also required to consider:
  - Probability of using the slots within first 3 cost reporting periods beginning July 1, 2011
  - Whether hospital has a rural training track program

# Reimbursement & Revenue Cycle Implications

## Teaching Health Centers/GME Fiscal Year 2011

- Establish Teaching Health Centers (THCs), defined as community-based, ambulatory patient care centers that that will be eligible for GME payments for primary care residency programs starting in FFY 2011.
  - FQHCs
  - Community mental health centers
  - Rural Health Clinics (RHCs)
  - Indian health centers
  - family planning programs
- Authorizes award grants to THCs to establish newly accredited or expanded primary care residency training programs.
- Grant term not more than 3 years, with a maximum of \$500k

# Reimbursement & Revenue Cycle Implications Urban Medicare-Dependent Hospital By December 23, 2010

- Health and Human Services shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services.
  - Analysis of the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under the Medicare system; and
  - Whether payments to Medicare-dependent, small rural hospitals should be applied to urban Medicare-dependent hospitals.

# Reimbursement & Revenue Cycle Implications Urban Medicare-Dependent Hospital By December 23, 2010

“Urban Medicare-Dependent Hospital” definition:

- Does not receive any additional Medicare payment or adjustment under:
  - IME
  - DSH
  - RRC
  - CAH

And

- More than 60 percent of its inpatient days or discharges during 2 of the 3 most recently settled cost reports were attributable to inpatients entitled to Part A.

# Reimbursement & Revenue Cycle Implications

## New RAC Provisions By December 31, 2010

- CMS is required to enter into contracts with RACs to review **Medicare** Parts C and D.
- Every state will be required to contract with at least one RAC for its **Medicaid** program. As with the Medicare program, the Medicaid RACs will be responsible for identifying underpayments and overpayments for services payable under state programs.
  - Paid on a contingency fee basis with a set fee for the identification of underpayments.
  - “Adequate process” for entities to appeal adverse determinations made by the Medicaid RACs (current Medicaid appeals process may not meet standards).
  - Medicaid RACs must coordinate with state and federal law enforcement, including the Department of Justice and the FBI.

# Reimbursement & Revenue Cycle Implications

## New RAC Provisions By December 31, 2010

- The **Medicaid** RAC program is in addition to and not in lieu of the Medicaid Integrity Contractors (MICs)
- Important distinctions:
  - Medicaid RACs will contract with individual states, while the MICs contract directly with the federal government through HHS.
  - MICs are not paid on a contingency fee basis and, thus, do not have the same incentives to identify overpayments.
  - Currently remain two distinct programs , increasing the potential of an audit for Medicaid providers.

# Reimbursement & Revenue Cycle Implications

## New RAC Provisions By December 31, 2010

### Implementation date modified

- CMS letter containing preliminary guidance sent to State Medicaid Directors October 1, 2010.
  - Expectation that States implement program by April 1, 2011
  
- Informational Bulletin issued by CMS February 1, 2010
  - States not required to implement RAC programs by 4/1/11
  - New implementation date to be published in the Final Rule (to be published later in 2011)

# Reimbursement & Revenue Cycle Implications

## New Medicare Coverage/Reimbursement January 1, 2011

- Provides a 10% **Medicare** physician bonus payment under the Primary Care Incentive Payment Program (PCIP) for **primary care services** and provides a 10% Medicare bonus payment under the Surgical Incentive Payment Program (HSIP) to **general surgeons** practicing in Health Professional Shortage Areas (HPSAs)
  - Response to anticipated demand for primary care services
  - PCIP now open to all primary care providers (not just those in a HPSA)
  - January 1, 2011 through December 31, 2015
  
- MedLearn Matters MM7060, Change Request 7060:
  - Payments will be made quarterly
  - Prior “Special HPSA Remittance” will now be the “Special Incentive Remittance”
  - PCPs eligible for both PCIP and HPSA payment if services provided in a HPSA
  - Defines criteria for Primary Care Practitioner (including certain NPPs)

# Reimbursement & Revenue Cycle Implications

## New Medicare Coverage/Reimbursement January 1, 2011

- Eliminates cost-sharing for Medicare-covered **preventive services** recommended (rated A or B) by the U.S. Preventive Services Task Force and waives the Medicare deductible for colorectal cancer screening.
- Provide Medicare beneficiaries access to a **comprehensive health risk assessment** and creation of a personalized prevention plan. (Health risk assessment model developed within 18 months following enactment).
- Provide incentives to Medicare and Medicaid beneficiaries to complete **behavior modification programs**. (Effective January 1, 2011 or when program criteria is developed, whichever is first).

# Reimbursement & Revenue Cycle Implications

## Medicare Advantage January 1, 2011

- Prohibit **Medicare Advantage (MA)** plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Rates for 2011 frozen at 2010 levels. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas.
- FY 2012, restructure payments to MA plans by setting payments to be partially based on traditional Medicare fee-for-service (FFS) costs.
- County-based quartiles to be established based on cost of traditional Medicare.
- Quartile benchmarks will be inverse to level of quartile: higher multiplier for quartiles with lower FFS costs and lower multiplier for areas with high FFS costs.

# Reimbursement & Revenue Cycle Implications

## ACOs January 1, 2012

- Allow providers organized as **Accountable Care Organizations (ACOs)** that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- To qualify as an ACO, organizations must agree (in a 3-year contract with the Secretary) to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. If an ACO achieves a minimum level of savings, the ACO will receive a share of the savings.
- Clinical integration and financial incentives may lead to higher quality and more efficient care through ACOs.

# Reimbursement & Revenue Cycle Implications

## ACOs January 1, 2012

- To participate in incentives, an ACO must:
  - Develop a mechanism for shared governance and a formal legal structure;
  - Be accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries assigned to it;
  - Create clinical and administrative systems promoting evidence-based medicine and patient-centeredness.
- Providers who participate in an ACO will continue to receive payment under the regular Medicare fee-for-service program, but will also be eligible to receive incentive payments for shared savings if the ACO meets established quality performance standards.
- In structuring an ACO, providers must be cognizant to avoid violations under the Anti-Kickback Statute, Stark law, corporate practice of medicine prohibitions, antitrust restrictions, and other laws.

# Reimbursement & Revenue Cycle Implications

## Enhanced Data Collection March 23, 2012

- Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.
- Also requires collection of access and treatment data for people with disabilities. Requires the Secretary to analyze the data to monitor trends in disparities.

# Reimbursement & Revenue Cycle Implications

## Value-Based Purchasing October 1, 2012

- Establish a hospital value-based purchasing program (VBP) for Medicare, under which value-based incentive payments would be made to hospitals that meet specified performance standards.
- Budget neutral: Total amount of payments available = total amount of reduced payments to hospitals.
- In FFY 2013, payments would be tied to hospital performance on quality measures related to common conditions, including, at a minimum, the following conditions: acute myocardial infarction, heart failure, pneumonia, surgeries, and health care-associated infections.

# Reimbursement & Revenue Cycle Implications

## Value-Based Purchasing October 1, 2012

- Starting FY 2013 – **overall 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 forward
- Payments will be based on the higher of attainment or improvement
- Score used to determine payment will be based on a composite of measure groups
  - Initially will be subset of measures in current Pay for Reporting program
  - 2014: include efficiency and outcome measures (i.e. Medicare spending per beneficiary)
  - Readmission measures not included

# Reimbursement & Revenue Cycle Implications

## Market Basket Update Fiscal Year 2013

- Beginning in FFY 2013, applies a productivity adjustment to the market basket updates for inpatient and outpatient hospitals, inpatient rehabilitation facilities, long term care hospital services and skilled nursing facilities and hospice
  - Inpatient psychiatric hospitals: July 1, 2011
  - Home health: FFY 2015
  - Applies a productivity adjustment to CPI updates for specified Part B items and services (various dates)
- The productivity adjustment is the 10-year moving average of changes in annual economy-wide private non-farm business, multi-factor productivity (as projected for the 10-year period ending with the applicable year, fiscal year, cost reporting period, or other annual period). **The productivity adjustments may cause a negative update and may result in payment rates for a year being less than the payment rates for the preceding year.**

# Reimbursement & Revenue Cycle Implications

## Medicare Readmissions **Fiscal Year 2013**

### Payment Penalties for Excessive Readmissions

- **All base DRG payment amounts** (excluding IME, DSH, outliers) in acute care hospitals with higher than expected risk-adjusted readmission rates will be reduced by a factor determined by the level of “excess, preventable readmissions”
- Excess readmissions are readmissions over an established minimum for the respective conditions for a specified period
- Payment reduction is limited to a “floor” of 1% in 2013, 2% in 2014, and 3% in 2015 and beyond
- 30 day readmission window
- Excludes admissions unrelated to prior discharge
- Initially applied to heart attack, heart failure, and pneumonia
- Expanded in 2015 to 4 additional conditions (COPD, CABG, PTCA, and other vascular)
- 10 year reduction = \$7.1 billion

# Reimbursement & Revenue Cycle Implications

## Medicare Readmissions Fiscal Year 2013

### Formula

- For affected providers, payment for all DRGs will be reduced by:
  - Base DRG payment \* Adjustment Factor (99% floor in FY 2013)
- Adjustment Factor = the greater of the formula or the “floor”  
Formula = [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 determined by the Secretary)

# Reimbursement & Revenue Cycle Implications

## Medicare Readmissions **Fiscal Year 2013**

- There shall be no administrative or judicial review of certain calculations and measures under this initiative.
- The payment adjustment for Sole Community and Medicare-Dependent, small rural hospitals will only be applied to the federal portion of the Medicare payment rate. CAHs are not included in the readmissions payment penalty policy.
- Requires establishment of a quality improvement program prior to FFY 2013 to help hospitals improve readmission rates.
- Hospital readmission rate data to be publicly released.

# Reimbursement & Revenue Cycle Implications

## Medicare and Medicaid Payments January 1, 2013

- Establish a national **Medicare pilot program** to develop and evaluate paying a **bundled payment** for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge.
- In essence, an expansion of the current CMS Acute Care Episodes (ACE) demonstration project although current project includes only acute-care services related to cardiac and orthopedic surgical services.
- Secretary to select eight conditions to be included in the pilot. Likely will include acute, chronic, surgical and medical.

# Reimbursement & Revenue Cycle Implications

## Medicare and Medicaid Payments January 1, 2013

- Increase **Medicaid payments** in fee-for-service and managed care for **primary care services** provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates.

# Reimbursement & Revenue Cycle Implications

## Medicaid Expansion January 1, 2014

- Expand **Medicaid** to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law, undocumented immigrants are not eligible for Medicaid).
- All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits.
- States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014.

# Reimbursement & Revenue Cycle Implications

## Medicaid Expansion January 1, 2014

- To finance the coverage for the newly eligible individuals, states will receive:
  - ✓ 100% federal funding (FMAP) for 2014 through 2016
  - ✓ 95% federal financing in 2017
  - ✓ 94% federal financing in 2018
  - ✓ 93% federal financing in 2019
  - ✓ 90% federal financing for 2020 and subsequent years.

# Reimbursement & Revenue Cycle Implications

## General Coverage January 1, 2014

- Insurers are prohibited from discriminating against or charging higher rates for any individuals based on pre-existing medical conditions. (For children under age 19, this provision became effective for plan years beginning on or after September 23, 2010.)
- Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age, geographic area, family composition, and tobacco use in the individual and the small group market and the Exchanges.

# Reimbursement & Revenue Cycle Implications

## General Coverage January 1, 2014

- Insurers are prohibited from establishing annual spending caps. Prior to January 2014, plans may only impose annual limits on coverage, as determined by the Secretary.
- Set a maximum of \$2000 annual deductible for a plan covering a single individual or \$4000 annual deductible for any other plan. These limits can be increased under rules set in the Bill.
- Limit any waiting periods for coverage for group plans to 90 days. Applies waiting period restriction to all grandfathered plans effective for plan years beginning on or after 1/01/2014.

# Reimbursement & Revenue Cycle Implications

## “Mandated” Coverage January 1, 2014

- **Individual Mandate:** Requires U.S. citizens and legal residents who are not covered by employer-based or governmental plans to obtain acceptable health insurance coverage.
- Those **without coverage pay a tax penalty** of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income as of 2016. The “greater of” penalty will be phased-in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016, for the flat fee, or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.
- **Exemptions** will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual’s income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples).

# Reimbursement & Revenue Cycle Implications

## Benefits Package January 1, 2014

- Create an **essential health benefits package** that provides a comprehensive set of services, limits annual cost-sharing to the current law Health Saving Account (HSA) limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Secretary to define and annually update the benefit package through a transparent and public process.
- Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges (except grandfathered individual and employer-sponsored plans) to offer at least the essential health benefits package.

# Reimbursement & Revenue Cycle Implications

## Medicaid DSH Fiscal Years 2014 - 2020

- Reduce aggregate **Medicaid DSH** allotments by \$.5 billion in 2014, \$.6 billion in 2015, \$.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, and \$5.6 billion in 2019, and \$4 billion in 2020.
- Adjusts for reductions to the number of uninsured individuals
- Perspective: \$11.65 billion federal DSH allotment in FFY 2010
- HHS will establish methodology for reductions:
  - Largest reductions on states with lowest percentages of uninsured individuals, or
  - States that do not target DSH payments to hospitals with high volumes of Medicaid and uncompensated care (non including bad debt)
- New FY 2012 Budget proposal to base DSH allotments for 2021 on States' actual 2020 DSH allotments

# Reimbursement & Revenue Cycle Implications

## Medicare DSH Fiscal Year 2014

- Reduces **Medicare** Disproportionate Share Hospital (DSH) payments to 25 percent of the amount that otherwise would be made beginning in FFY 2014
- 10 year reduction of ~ \$20B
- Provides an additional payment to reflect uncompensated care costs, based on a formula that takes into account:
  - the aggregate difference in payments to all hospitals attributable to the reduction in DSH payments under PPACA
  - the reduction in uninsured individuals in a year (relative to 2013)
  - each hospital's relative % share of uncompensated care, as provided by all hospitals

# Reimbursement & Revenue Cycle Implications

## Medicare DSH Fiscal Year 2014

**Additional payment:** In addition to the revised 25% payment made to eligible hospitals for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such hospitals an additional amount equal to the product of the following factors:

- **Factor one** - A factor equal to the difference between:
  - (i) the aggregate amount of payments that *would have been* made to DSH hospitals if this new section did not apply for such fiscal year; and
  - (ii) the aggregate amount of DSH payments that *will be* made to hospitals for such fiscal year

**Interpretation:** total national \$ difference between old and new DSH payment calculations

# Reimbursement & Revenue Cycle Implications

## Medicare DSH **Fiscal Year 2014**

- **Factor two:** For each of fiscal years 2014 – 2019, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured minus .1 (2014) or .2 (2015-2019), as determined by comparing the percent of such individuals:
  - Under 65 who are uninsured in 2013 (as calculated); minus
  - Individuals under 65 who are uninsured in the most recent period for which data is available.

For 2018 and subsequent years, the factor shall be:

- Individuals\* who are uninsured in 2013; minus
- Individuals who are uninsured in the most recent period for which data is available.

**Interpretation:** Downward adjustment to the additional payment amount based on drop in uninsured population plus an additional artificial adjustment.

**\*PPACA does not specifically define “individuals for the purpose of this calculation as being those under the age of 65**

# Reimbursement & Revenue Cycle Implications

## Medicare DSH Fiscal Year 2014

**Factor three** - A factor equal to the percent, for each hospital, that represents the quotient of:

- (i) the amount of uncompensated care for the hospital (for a period selected and estimated by the Secretary) and
- ii) the aggregate amount of uncompensated care for all hospitals that receive a payment for such period (as estimated)

Interpretation: hospital-specific % of total national uncompensated care.

# Reimbursement & Revenue Cycle Implications

## Medicare DSH Fiscal Year 2014

### 2014 Example

- Assumption: National uninsured rate falls 2% between 2012 and 2013
- Hospital receives:

(Current Medicare DSH formula amount) \*25%

plus

(75% of estimated aggregate national DSH payments) x (1-2% -0.1%) x (hospital-specific % of total uncompensated care)

(~\$5.25b) x (.979) = \$5.14b x (hospital-specific % of total uncompensated care)

# Reimbursement & Revenue Cycle Implications

## Medicare DSH Fiscal Year 2014

- Limitations on review - There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:
  - Any estimate of the Secretary for purposes of determining the factors
  - Any period selected by the Secretary for such purposes
- To what extent will expanded coverage offset reduction in DSH reimbursement?
- Uncompensated care reporting could be critical.

# Reimbursement & Revenue Cycle Implications

## Medicare HACs **Fiscal Year 2015**

- Reduces Medicare base DRG payments to impacted hospitals by 1 percent, beginning in FFY 2015.
  - IME, DSH, outliers excluded from base payment
- **Affected hospitals are those in the “top quartile...relative to the national average, of hospital acquired conditions during the applicable period.”**
- Secretary to calculate HAC rate.
- Requires the Secretary of Health to submit a report to Congress by 1/1/12 on potentially expanding this policy to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.
- Prior to FY2015, the hospitals shall receive confidential reports with respect to their HAC conditions.

# Reimbursement & Revenue Cycle Implications

## Total Base DRG Reductions Fiscal Years 2013 - 2017

### Total Potential Base DRG Rate Reductions: 6% by 2017

- Readmissions
  - FFY 2013
  - Limited to 1-3% reduction with three year phase-in (3% beyond 2015)
- Value-Based Purchasing
  - FFY 2013
  - 1-2%, four year phase-in
  - Potential to recoup
- HACs
  - FFY 2015
  - 1%



# Reimbursement & Revenue Cycle Implications Medicare Preventative Care Co-Pays **By 2018**

- All existing health insurance plans, including grandfathered plans, must cover approved preventive care and checkups without co-payment.

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

Section 9007(a) of the PPACA amended Section 501 of the IRC by adding a new Section 501(r) which outlines the additional requirements.

- **A hospital organization to which this subsection applies shall not be treated as described in subsection (c) (3) unless the organization:**
  - meets the community health needs assessment requirements
  - meets the financial assistance policy requirements
  - meets the requirements on charges
  - meets the billing and collection requirement

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

### Community Health Needs Assessment (CHNA) Requirements

- Must conduct community health needs assessment in either of the 2 tax years immediately preceding the current tax year (i.e. assessment at least every 3 years), 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

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

### Financial Assistance Policy Requirement

- Written policy which includes:
  1. eligibility criteria for financial assistance, and whether such assistance includes free or discounted care
  2. the basis for calculating amounts charged to patients
  3. the method for applying for financial assistance
  4. in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies
  5. measures to widely publicize the policy within the community to be served by the organization

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

### Financial Assistance Policy Requirement *(continued)*:

- Written policy relating to emergency medical care requiring the organization to provide, without discrimination, care for emergency medical conditions (defined by EMTALA) to individuals regardless of their eligibility under the financial assistance policy.

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

### Limitation on Charges Requirement

1. Limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy to not more than the amounts generally billed to individuals who have insurance covering such care, and
2. Prohibits the use of gross charges (???)

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

### Gross Charges Prohibition Clarification

- 990 Schedule H IRS Instructions:
  - Permits the use hospital gross charges as the baseline upon which rates for financial assistance patients can be established
  - Amounts actually billed to these patients must be discounted to ensure patients are billed charges in accordance with Section 501(r)
  - Requires hospital to state whether it has charged any of its patients an amount equal to gross charges
  - Does this prohibit hospitals from billing any patient gross charges?

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

- Technical Explanation Of The Revenue Provisions Of The “Reconciliation Act Of 2010,” As Amended, In Combination With The “Patient Protection And Affordable Care Act” \*
  - *“It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.”*

\* Joint Committee on Taxation

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

### Billing and Collection Requirement

- Hospital does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy.

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

- \$50,000 penalty for failure to comply.
- These new requirements, except for the CHNA requirements, apply to taxable years beginning after March 23, 2010.
- The requirements regarding CHNA become effective for taxable years after March 23, 2012.

# Section 9007 PPACA

## Section 501(c)3 Tax Years after 3/23/10

- IRS Reporting Delay to complete implementation of changes and forms relative to the additional requirements for charitable hospitals under PPACA.
  - Hospitals (only) may not file Forms 990 before July 1, 2011.
  - Automatic 3-month filing extension for hospitals with tax year filing due dates before August 15, 2011.
  - No need to file Form 8868 (*Application for Extension of Time to File an Exempt Organization Return*).

# Reimbursement & Revenue Cycle Implications Begin the Discussion Now

- How will expanded coverage impact your operations (i.e. Patient Access, insurance verification, PFS resource allocation)?
- How will you meet the continuing trend towards more plans with higher out-of-pocket costs (i.e. shoring up POS collections)?
- How will key revenue cycle departments need to be integrated as a result of potential new delivery structures and reimbursement models (i.e. ACOs, bundled payments, VBP)?
- Are you ready for the increased data demands that will be required to effectively manage and report on patient quality and clinical information related to reimbursement?

# Reimbursement & Revenue Cycle Implications Begin the Discussion Now

- Reducing “fraud and abuse” is a major basis for funding healthcare reform. RAC expansion to Medicaid is the tip of the iceberg. Do you have adequate resources/technology to assess potential liability, respond to audits, and track results?
- How would your hospital fare today with regard to the expansion of HAC payment reductions to Medicaid and the potential for additional Medicare payment reductions for HACs? What about reimbursement reductions relative to readmissions?
- Hospitals will need to better understand their costs, as compared to reimbursement. New programs will reward those that can delivery high quality at lower costs. Effective and efficient ACOs may eat into your patient population if you are not prepared.

# Reimbursement & Revenue Cycle Implications Begin the Discussion Now

- Does an ACO make sense for your hospital? Working closely with the medical community now to evaluate the potential and develop a collaborative structure is critical.
- Are your accounting and patient accounting systems adequate to help you function in an ACO environment?
- How will your hospital respond to the increased demand for services as a greater percentage of the population gains coverage? Consider how to partner with other providers (i.e. doctors, FQHCs, local clinics) to deliver care.

# Reimbursement & Revenue Cycle Implications Begin the Discussion Now

- Can your facility afford to absorb the Medicare payment reductions that are here/coming without taking advantage of the new programs offering incentive payments?
- Non-federal payers are already considering reimbursement methodologies (and penalties) similar to those in PPACA (i.e. bundled payments, HAC denials, gainsharing, etc.). This is bigger than just Medicare and Medicaid.
- Make sure you meet the new 501(c)3 requirements! Is your Community Health Needs Assessment adequate?

# Reimbursement & Revenue Cycle Implications

## Then again...

- Will reform survive or be repealed?
  - Watch the elections
- Is the timetable reasonable or will it move?
  - Already seeing some delays
- What will the implementing regulations look like?
  - Watch them closely



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