Hospital Finance 101

Medicare: Payment Methodologies, Focus on Value, and Focus on the Future

Kansas Hospital Association Critical Issues Summit for Hospital Boards

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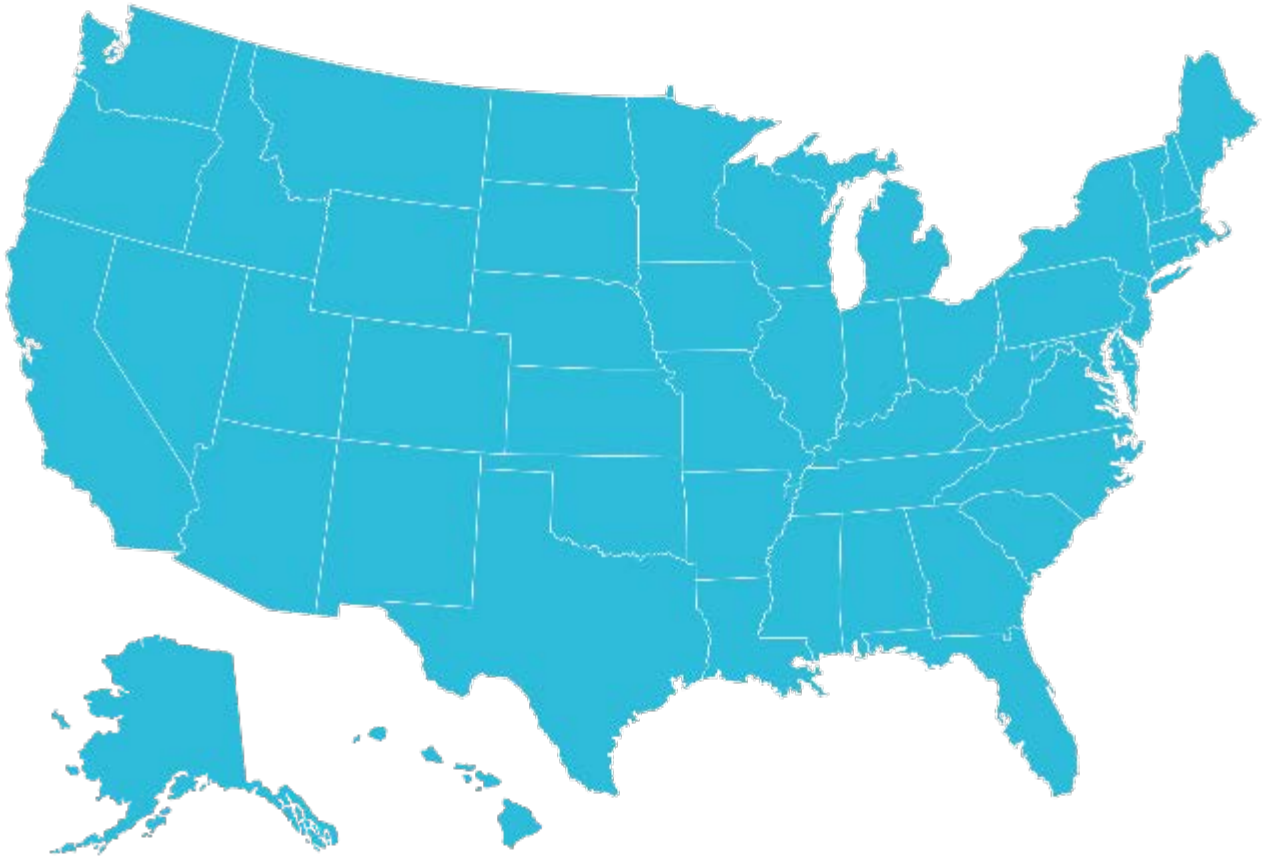
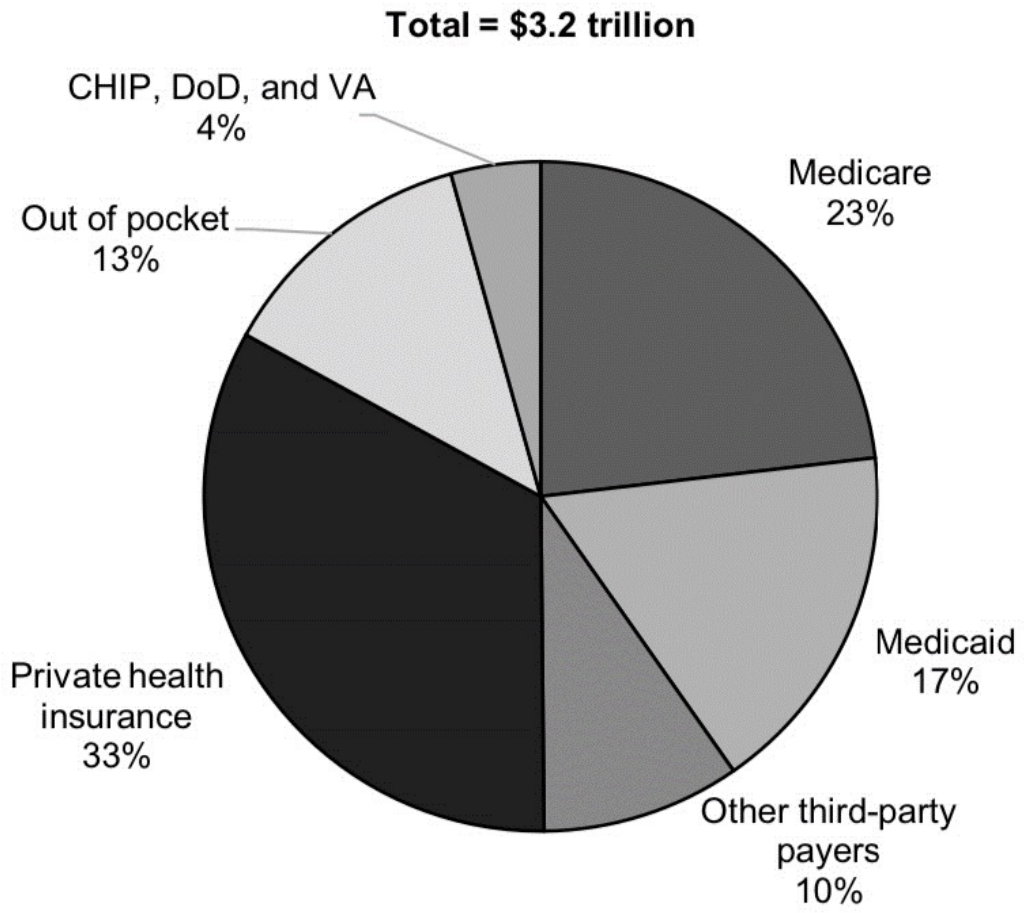
Health Care Expenditures

- National health expenditures
  - $3.8 trillion in 2019
    - $11,582 per person
  - Growing at average annual rate of 4.6 percent
  - 17.7 percent in 2019 of the Gross Domestic Product (GDP)
  - Projected to grow 19.7 percent by 2028



Medicare: Largest Single Purchaser of Personal Health Care in 2019



Source: MedPAC July 2021 Databook

Medicare – In The Beginning ...

- Established in 1965 as Health Insurance for the Aged (Title 18)

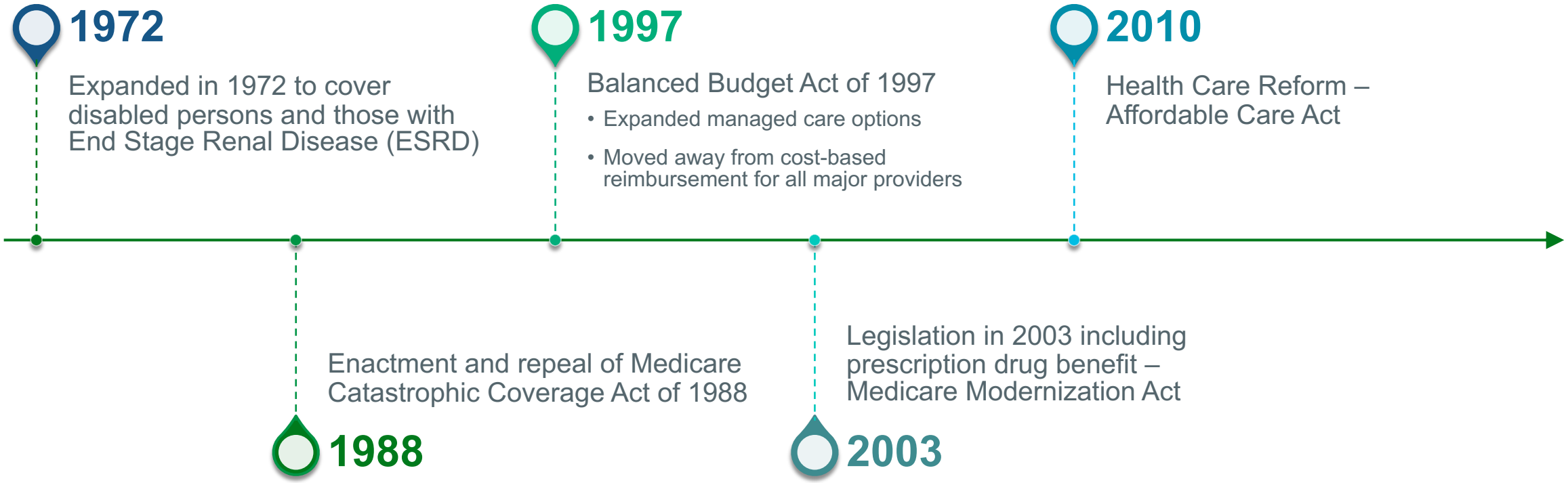
Part A: Hospital Insurance (Automatic Enrollment)

- Inpatient hospital services
- Skilled nursing facility services
- Some home health care

Part B: Supplemental Insurance (Voluntary Enrollment)

- Physician services
- Outpatient hospital services
- Independent laboratories

Major Legislative Changes



How Is Medicare Financed?

Part A

Hospital Insurance

- 1.45% payroll tax on both employer and employee

Part B

Supplemental Medical Insurance

- Beneficiary premium
- General revenues

Part C

Medicare Advantage

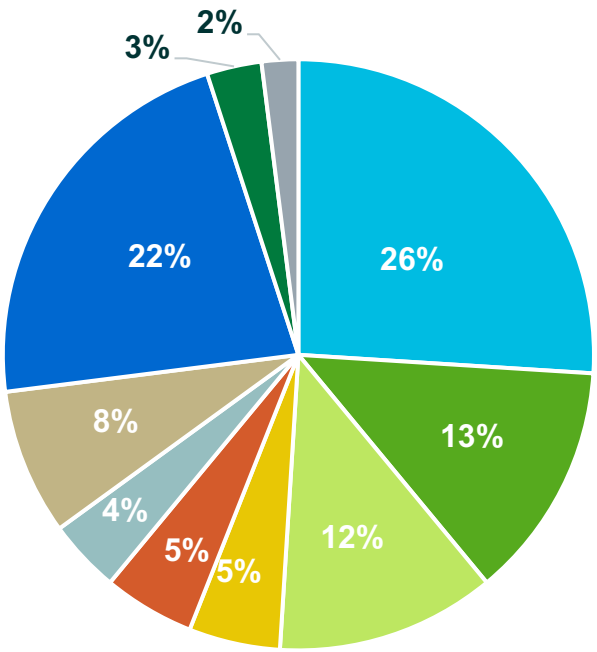
- Not separately financed

Part D

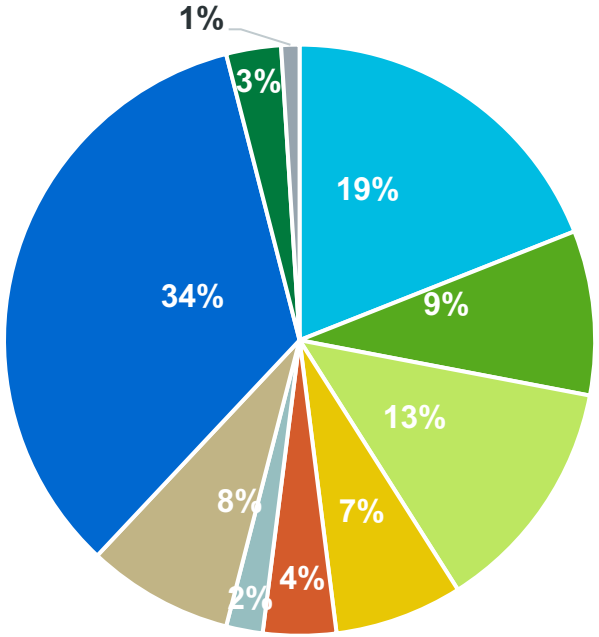
Prescription Drug Benefit

- Beneficiary premium – varies by geographic area
- General revenues

Medicare Benefit Payments by Type of Service, 2010 and 2019



Total Spending 2010 = $517 billion



Total Spending 2019 = $787 billion

- Inpatient services
- Physician payments
- Outpatient prescription drugs
- Outpatient services
- Skilled nursing facility
- Home health services
- Other services*
- Medicare Advantage
- Hospice
- DME

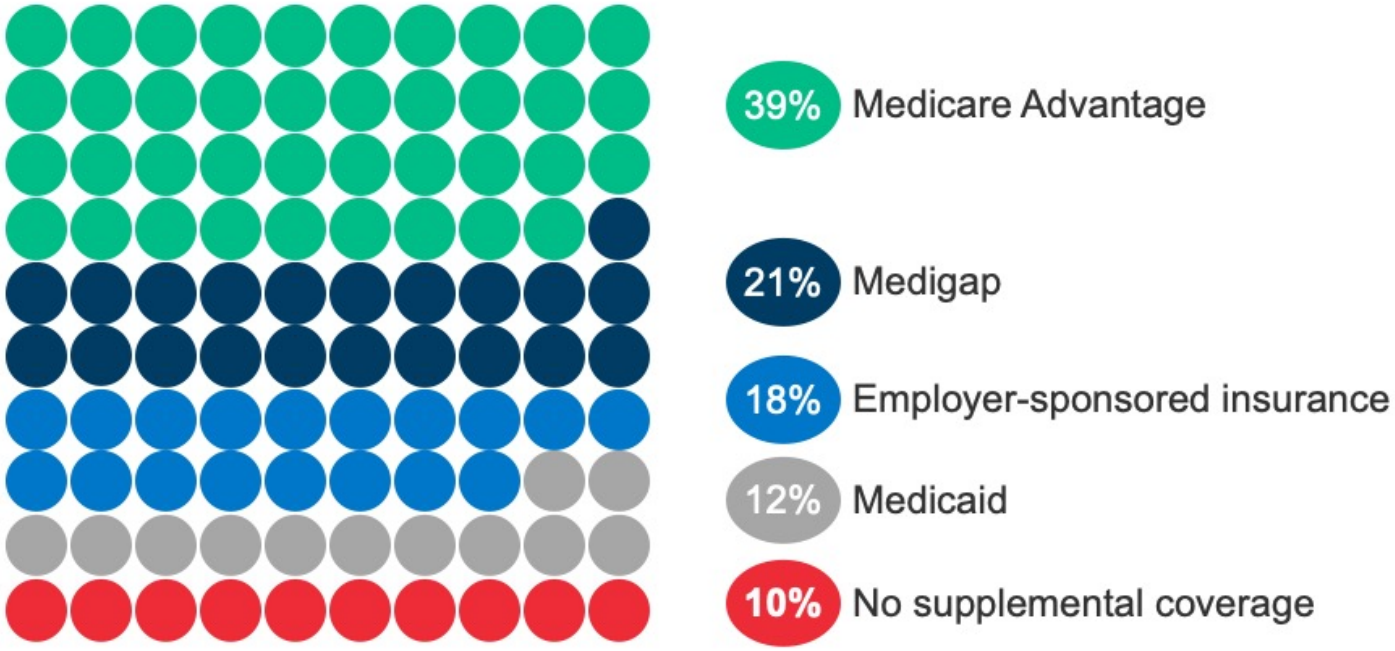
Source: MedPAC July 2021 Databook

Part A: Beneficiary Benefit Periods

- Hospital Benefit period:
  - 60 days basic, 30 days co-insurance, 60 days lifetime reserve
  - Basic and co-insurance periods restart when patient has been out of the hospital or skilled nursing facility for 60 consecutive days
  - No limit on number of benefit periods
  - Reserve days are used for hospital stays beyond 90 days
    - Entitled to only 60 reserve days (lifetime)

Distribution of Supplemental Coverage Among Beneficiaries

In 2018, 9 In 10 Medicare Beneficiaries Either Had Traditional Medicare With Supplemental Coverage (51%) Or Were Enrolled In Medicare Advantage (39%)



NOTE: Total excludes beneficiaries with Part A only or Part B only for most of the year (n=4.7 million) or Medicare as a Secondary Payer (n=1.7 million).
SOURCE: KFF analysis of CMS Medicare Current Beneficiary Survey, 2018 Survey File.

Hospitals in Kansas

Metropolitan Statistical Areas (MSAs)

- ✓ Kansas City
- ✓ Lawrence
- ✓ Manhattan
- ✓ Topeka
- ✓ Wichita

Rural

- ✓ Statewide Rural
- ✓ Sole Community Hospitals (16)
- ✓ Medicare Dependent Hospitals (10)
- ✓ Rural Referral Center (4)
- ✓ Critical Access Hospitals (82)

Sole Community Hospitals

Eligibility

- Urban hospitals – must be located more than 35 miles from other hospitals
- Rural hospitals – several alternative criteria based on distance to like hospitals, inpatient bed capacity, patient share, travel time, and weather conditions

Reimbursement

- Paid the higher of their trended 1982, 1987, 1996, or 2006 Hospital Specific Rate or the federal inpatient operating amount
- Receive a 7.1% add-on to outpatient payments
- May also qualify for other payment adjustments such as a Low Volume Hospital payment adjustment

Medicare Dependent Hospitals

Eligibility:

- Hospital located in a rural area
- Hospital has 100 or fewer beds
- At least 60% of the hospital's acute inpatient days or discharges are attributable to Medicare Part A beneficiaries

Reimbursement:

- Paid the higher of the federal rate or a 25/75% blend of the federal rate and the Hospital Specific Rate for inpatient services

How Does Medicare Pay Providers?

- Cost-Based Reimbursement
- Fee Schedule
- Prospective Payment System (PPS)

Cost-Based Reimbursement

Cost-Based Reimbursement

- Initially all provider payments were based on allowable costs
  - “Retrospective” cost-based reimbursement created the need for a cost report to settle payments
- Frequently subject to a limit
- Frequently related to a base-year cost trended forward

Cost-Based Reimbursement

- Not all costs are allowable under Medicare
  - Examples of unallowable costs:


Patient telephones


Patient TV


Advertising


Lobbying


Costs in excess of established limits

Cost-Based Reimbursement

- Medicare reimburses costs based on Medicare utilization
  - Various methods to allocate costs
    - Square footage
    - Time studies
    - Gross salaries
    - Patient days
    - Full-time equivalents (FTEs)
    - Pounds of laundry
- Provider receives interim payments based on prior year data
- Final costs calculated from cost report
- Final settlement

Which Payments are Cost-Based?

Critical Access Hospitals

Hospitals

Direct (Graduate) Medical Education

Rural Health Clinics

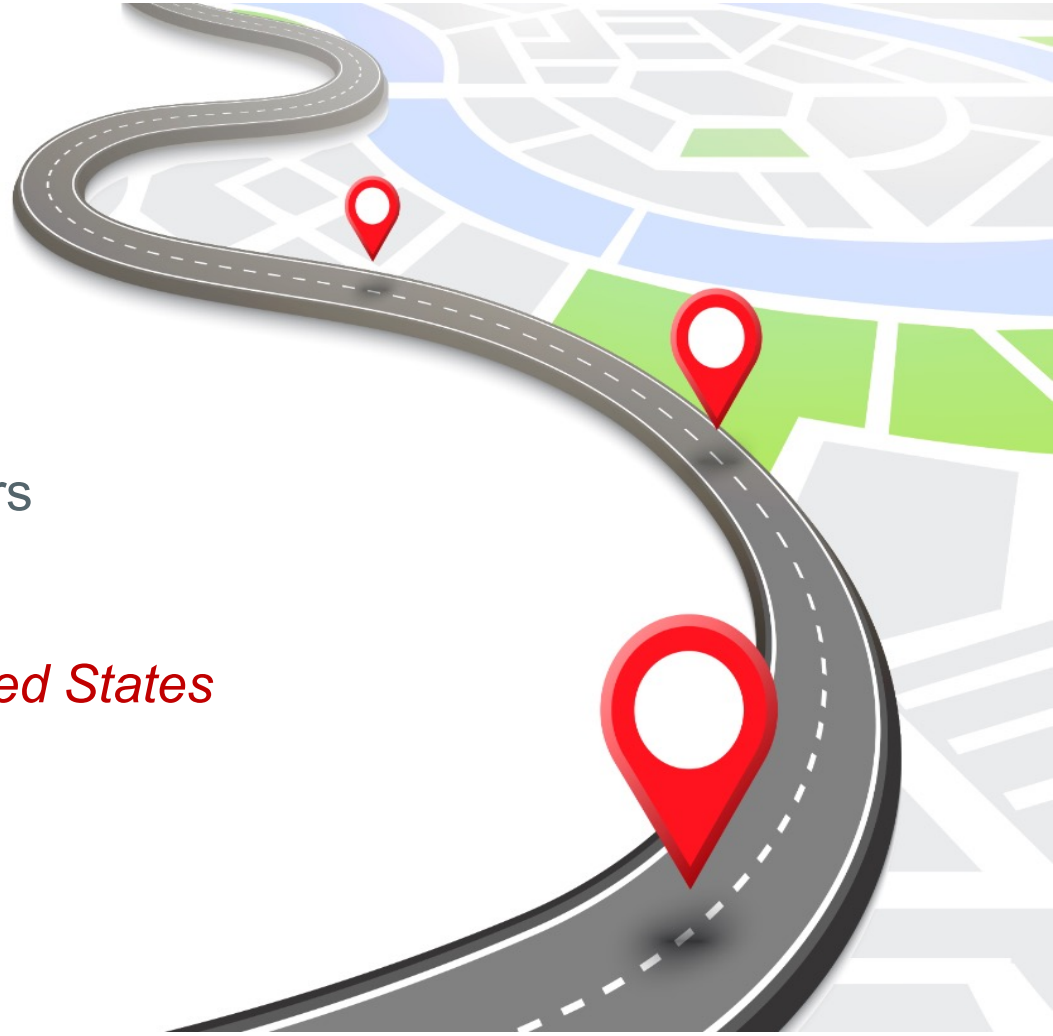
Sole Community Hospitals

Higher of PPS or
trended base year costs

Critical Access Hospitals

Critical Access Hospitals – Eligibility

- Located in a federal or state defined rural area
- More than 35 road miles from a similar hospital (15 miles in certain conditions)
- Provides 24-hour emergency services
- No more than 25 beds
- Annual average length-of-stay of no more than 96 hours



Note: *Kansas has the most CAHs of any state in the United States*

Critical Access Hospitals – Reimbursement

Entirely based on 101% of allowable costs, with no limits

- Inpatient acute and swing bed
- Outpatient services
- Ambulance services absent another near-by service

All other services based on prospective payment system or fee schedule

- Rehab
- Psych
- Home health
- Skilled nursing facility

Fee Schedule Reimbursement

Fee Schedule Reimbursement

Pre-determined rates for units of service

Fee schedule is adjusted for provider characteristics and location

Who Receives “Fee Schedule” Reimbursement?

Physicians

Hospital – Outpatient Therapy Services

Uses the Physician Fee Schedule

Hospital – Diagnostic and Screening Mammography

Uses the Physician Fee Schedule

Laboratories

Ambulance Services

Physicians

Physician Fee Schedule – Reimbursement

- Fee established for each service
  - Starts with a Federal Rate called the Conversion Factor: $34.8931 in CY2021
- Relative Value Units (RVUs) for 3 components
  - Work – service intensity
  - Practice Expense (separate facility/non-facility values)
  - Malpractice Expense
- Geographic Practice Cost Indices (GPCIs) for same 3 components

Physician Fee Schedule

- The general formula for calculating the Medicare fee schedule amount for a given service in a particular fee schedule area can be expressed as:
  - **Payment** = [(RVU work x GPCI work) + (RVU practice expense x GPCI practice expense) + (RVU malpractice x GPCI malpractice)] x CF

HCPCS Code 99203 -- Office/Outpatient Visit, New Patient

	Nonfacility Setting	Facility Setting
Conversion Factor	$34.8931	$34.8931
Work RVU	1.60	1.60
Work GPCI	1.000	1.000
Practice Expense RVU	1.51	0.67
Practice Expense GPCI	0.939	0.939
Malpractice RVU	0.15	0.15
Malpractice GPCI	1.435	1.435
Work weight	1.60	1.60
Practice Expense weight	1.42	0.63
Malpractice weight	0.22	0.22
Total weight	3.23	2.44
Total payment	$112.81	$85.29

Prospective Payment Systems (PPS)

Programs/Providers Paid Under PPS

Hospital Inpatient Operating	*Hospital Inpatient Capital*	*Hospital Outpatient*
Inpatient Rehabilitation	*Inpatient Psychiatric*	*Home Health*
Skilled Nursing Facilities	*Long-term Acute Hospital*	*End-stage Renal Disease Facilities/Providers*

PPS Reimbursement – Common Components

Base Rate

- Unadjusted national payment rate

Facility Adjustments

- Differences in area wages
- Urban versus rural setting
- Medical education
- Disproportionate number of low-income patients

Patient Adjustments

- Intensity of services
- Excessive case costs
- Partial treatment

PPS Reimbursement – Updating the Components

- Annual proposed and final rules
  - Regulatory changes from the Centers for Medicare & Medicaid Services (CMS)
- Market basket update
  - Measures inflation
  - Used to provide annual update to base rate
- Wage indexes recalculated based on updated hospital salaries
- Relative weights are updated based on more current data
- Other changes to “improve” payment policy

Why is the Wage Index So Important?

Measures relative level of hourly wages in a labor market to national average

- Sample Wage Indexes:
  - **Location A** 1.0469
  - **Location B** 0.8698

Applied to the labor component of the federal rate

- Labor component: portion of total operating costs attributable to salaries and benefits
- Ranges from 50% to nearly 80%

Circularity of the wage index

Relative Weights and Case Mix

Relative Weight

Reflects the resources used in furnishing a particular service to patients within a group, compared to the "average" patient

Case Mix

Reflects the types of patients treated by a provider compared to the national mix of patients

Inpatient Operating PPS

Inpatient Operating PPS – The Core Issues

- As of 2004 – One federal rate for all hospitals
  - In past years, separate rates for Large Urban (in an area with more than 1 million population), Other Urban, and Rural hospitals
  - Standardized Amount: $6,121.71 (FY2022)
  - Exception for hospitals not participating in quality initiative (2% reduction)
- As Wage Index method now complicated by legislative and regulatory actions
  - Annual geographic reclassification
  - Rural floor
  - Two different labor shares
  - Adjustment for hospitals in rural areas bordering an urban area with commuting patterns to the urban area
  - Occupational mix adjustment

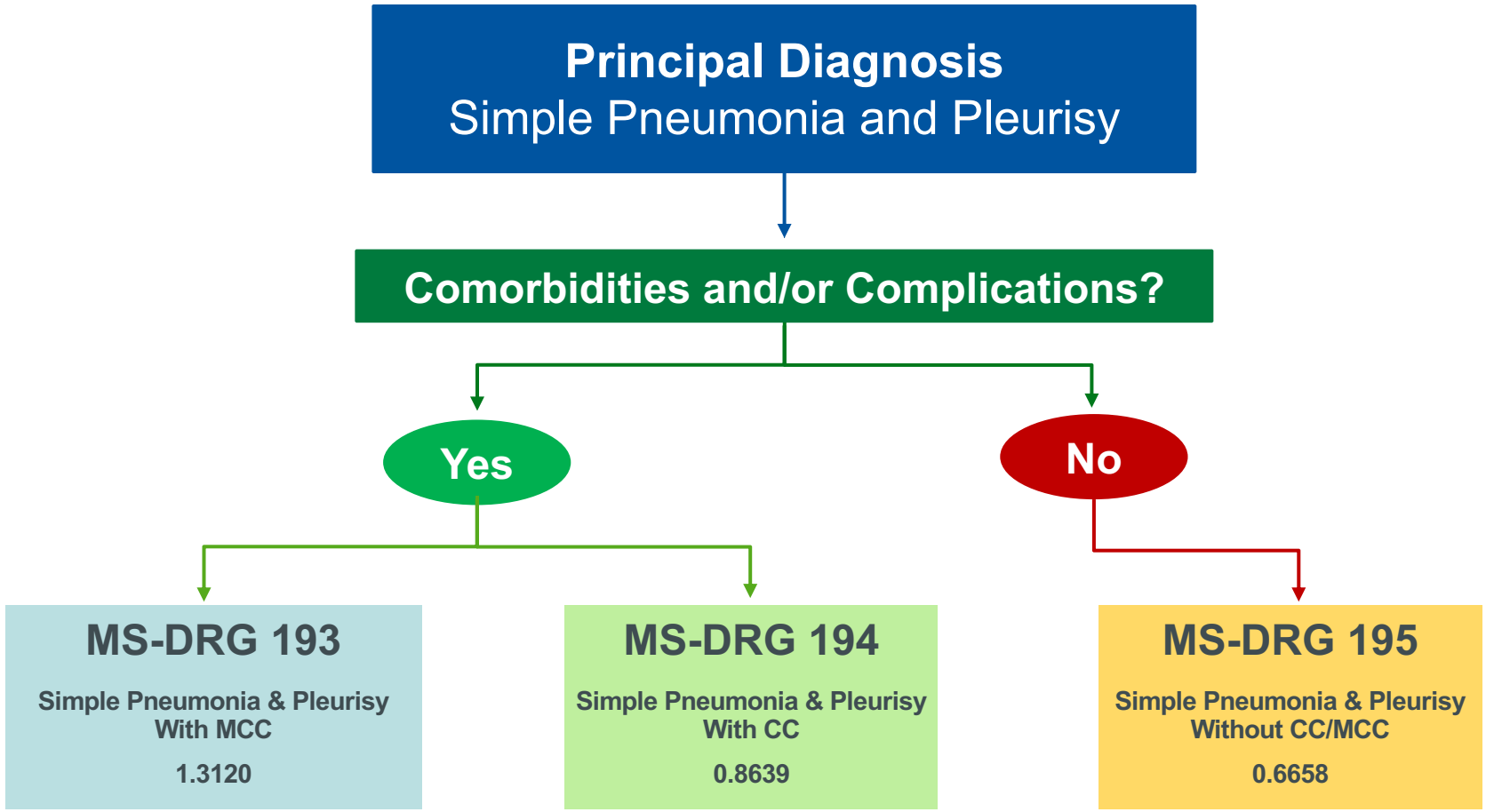
Example – Wage-Adjusted Federal Rate for Hospital Inpatient Operating PPS Based on FY2022 Final Rule

	Location A	Location B
Federal Share	$6,121.71	$6,121.71
Labor Share	67.6%	62.0%
Labor Share of Rate	$4,138.28	$3,795.46
Wage Index	1.0469	0.8698
Adjusted Labor Share	$4,332.36	$3,301.29
Non-Labor Share	$1,983.43	$2,326.25
Wage-Adjusted Rate	$6,315.80	$5,627.54

Medicare-Severity DRGs (MS-DRGs)

- New classification system developed by CMS in 2007 for inpatient services
  - Severity-adjusted DRGs
  - Allows for higher payments for more complicated cases
  - Designates certain secondary diagnoses as major complications or comorbidities
  - Base DRGs split by –
    - A major complication or comorbidity (MCC)
    - A complication or comorbidity (CC)
    - No complication or comorbidity
  - Expanded number of DRGs – from pairs to triplets

MS-DRG Assignment FY2022



Continuation of Example – DRG Relative Weights Applied to Wage-Adjusted Rates Based on FY2022 Final Rule

	Location A	Location B
Wage-Adjusted Rate	$6,315.80	$5,627.54
MS-DRG 509 – Arthroscopy Weight	1.6865	1.6865
Payment	$10,651.60	$9,490.85

Hospital Inpatient Operating PPS – Other Critical Issues

- **Cost Outliers:** Additional payment for high-cost cases
- **Transfer Policy:** Reduced payments for short stay patients
  - Transferred to acute hospitals and for certain patients transferred to post-acute care settings
- **Indirect Medical Education (IME):** Adjustment reflecting indirect costs of patient care associated with operating approved graduate medical education program:
  - Based on the ratio of interns and residents to hospital beds (IRB)
    - Other programs use ADC
- **Disproportionate Share Hospital (DSH):** Adjustment intended to partially offset losses from uncompensated care
  - Based on a hospital's share of Medicaid patients and Medicare SSI patients (called the DSH percent)
    - Hospitals must have at least 15% DSH to qualify.
    - The adjustment is capped for rural hospitals less than 500 beds, urban hospitals less than 100 beds, and sole community providers.

Hospital Inpatient Capital PPS

Hospital Inpatient Capital PPS – The Core Issues

As of 2002 – one federal rate for all but new hospitals

- Called the Federal Rate: $472.60 per discharge in FY2022
- New hospitals receive 85% of costs for 2 years
- From 1992 to 2001, there was a transition from cost-based to PPS

The geographic adjustment factor (GAF) is based on the hospital wage index

- GAF = Wage Index.[6848]
- 0.9582 = 0.9396.[6848]

DRGs are the same as for inpatient operating PPS

Hospital Inpatient Capital PPS – Other Critical Issues

- Indirect Medical Education (IME) – same concept as inpatient operating:
  - However, based on the ratio of interns and residents to average daily census
  - Adjustment formula for capital is different from operating, and produces lower add-ons

Hospital Outpatient PPS

Hospital Outpatient PPS – The Core Issues

August 2000 – cost-based prior; now one federal rate for all hospitals

- Called the Conversion Factor
  - Final rule CY2022: $84.177 per procedure
- Capital included in Conversion Factor

The wage index is the same as hospital inpatient

- Applied to 60% of the Conversion Factor

Payment groups are APCs – Ambulatory Payment Classification groups

Hospital Outpatient PPS – Determination of an APC

APC 5311 **Weight: 9.5855**

Level 1 Lower GI Procedures

HCPCS	Short Descriptor
44385	Endoscopy of bowel pouch
44386	Endoscopy bowel pouch/biop
44388	Colonoscopy thru stoma spx
44390	Colonoscopy for foreign body
44408	Colonoscopy w/decompression
45300	Proctosigmoidoscopy dx
45330	Diagnostic sigmoidoscopy
45331	Sigmoidoscopy and biopsy
45333	Sigmoidoscopy & polypectomy
45335	Sigmoidoscopy w/submuc inj
45337	Sigmoidoscopy & decompress
45341	Sigmoidoscopy w/ultrasound
45378	Diagnostic colonoscopy
45399	Unlisted procedure colon

HCPCS	Short Descriptor
45520	Treatment of rectal prolapse
45900	Reduction of rectal prolapse
45999	Rectum surgery procedure
46050	Incision of anal abscess
46221	Ligation of hemorrhoid(s)
46500	Injection into hemorrhoid(s)
46608	Anoscopy remove for body
46611	Anoscopy
46942	Treatment of anal fissure
46999	Anus surgery procedure
C9725	Place endorectal app
G0104	Ca screen;flexi sigmoidscope
G0105	Colorectal scrn; hi risk ind
G0121	Colon ca scrn not hi rsk ind

Hospital Outpatient PPS – Other Critical Issues

- **Medical education/disproportionate volume of low-income patients:** No additional payments
- **Cost Outlier Payments:** Same concept as inpatient operating
- **Special Payment Rules:**
  - New technologies
  - Transitional pass-through payments for new drugs and medical devices for 2 to 3 years
- **Co-insurance:** Transitioning to beneficiary co-payments at 20% of APC payments

Example – APC Payment for Hospital Outpatient PPS Based on FY2022 Final Rule

	Location A	Location B
Conversion Factor	$84.177	$84.177
Labor Share	60%	60%
Labor Share Rate	$50.51	$50.51
Wage Index	1.0469	0.8698
Adjusted Labor Share	$52.89	$43.93
Non-Labor Share	$33.67	$33.67
Wage-Adjusted Rate	$86.56	$77.60
APC 5312 Weight	12.5814	12.5814
APC 5312 Payment	$ 1,089.05	$976.32

Comparison of Medicare Prospective Payment Systems

Provider Component	Hospital Inpatient Operating	Hospital Inpatient Capital	Hospital Outpatient	Skilled Nursing	Home Health	Inpatient Rehabilitation	Long-Term Acute*	Inpatient Psych
Federal Rate	Standard Amount	Federal Rate per Discharge	Conversion Factor per Procedure	Federal Rate per Diem	National 30-Day Episode Rate	Standard Amount per Discharge	Standard Amount per Discharge	Per Diem Base Rate
Rate Year	Oct. – Sept.	Oct. – Sept.	Jan. – Dec.	Oct. – Sept.	Jan. – Dec.	Oct. – Sept.	Oct. – Sept.	Oct. – Sept.
Area Salary Adjustment/ Labor Share	Wage Index 67.6% or 62%	Geographic Adjustment Factor	Wage Index 60%	Wage Index w/o Reclassifications 70.4%	Wage Index w/o Reclassifications 76.1%	Wage Index w/o Reclassifications 72.9%	Wage Index w/o Reclassifications 67.9%	Wage Index w/o Reclassifications 77.2%
Urban/Rural Adjustment	None	None	Temporary Hold Harmless for Small Rurals (7.1% Add-On for SCH)	Urban and Rural Rates	Temporary 3% Rural Add-On	14.9% Rural Add-On	None	17% Rural Add-On
Medical Education	IME Adjustments	IME Adjustments	None	None	None	Teaching Variable	None	Teaching Variable
Disproportionate Volume of Low-Income Patients	DSH Adjustment	DSH Adjustment	None	None	None	Low-Income Patient Adjustment	None	None
Intensity of Services	MS-DRGs	MS-DRGs	APCs	Patient-Driven Payment Model, Case Mix Groups (CMGs)	Patient-Driven Groupings Model	CMGs w/Comorbitities	Medicare Severity Long-Term Care DRGs	MS-DRGs w/Day Weights and Comorbidities
Excessive Costs	Cost Outliers	Cost Outliers	Cost Outliers	None	Cost Outliers	Cost Outliers	Cost Outliers	Cost Outliers; ECT, Increase in Day 1 Per Diem for Hospitals w/ED
Partial Treatment	Short Stay Transfers	Short Stay Transfers	None	None	Partial Episodes, Low Utilization	Short Stay CMGs	Short Stay Outliers, Interruption of Stay	Interrupted Stay

***Note: Services provided to patients not meeting LTCH criteria under the IMPACT Act are paid under IPPS.**

Updated September 2021

Moving from Volume to Value

Quality-Based Payment Reform: Hospitals Paid Under Inpatient PPS

- Value-based purchasing program
- Readmissions reduction program
- Hospital-acquired conditions reduction program

Value-Based Purchasing

What's at Stake under VBP?

- Transitions hospitals from P4R to P4P under Medicare
  - Program is self-funded by hospital "contributions"
    - 1.0 percent reduction in FY2013
    - Reduction increased by 0.25 percent each year
    - 2.0 percent reduction for FY2017 and beyond
  - Budget-neutral
    - Redistributive
    - Best performers win, others break even or lose
    - VBP payments are netted against contributions

Current Quality Domains – Each Represents 25% of Total Score

FY2022 Hospital VBP Program Measures

Domain	Measure ID	Measure Name
Clinical Outcomes	MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
	MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate
	MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate
	MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate
	MORT-30-CABG	Coronary Artery Bypass Graft Surgery 30-Day Mortality
	COMP-HIP-KNEE	Elective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate
Person and Community Engagement*	HCAHPS	Communication with Nurses
		Communication with Doctors
		Responsiveness of Hospital Staff
		Communication about Medicines
		Cleanliness and Quietness of Hospital Environment
		Discharge Information
		Care Transitions
		Overall Rating of Hospital
Safety*	CLABSI	Central Line-Associated Bloodstream Infection
	CAUTI	Catheter-Associated Urinary Tract Infection
	CDI	*Clostridium difficile* Infection
	MRSA	Methicillin-Resistant *Staphylococcus aureus* Bacteremia
	SSI	Surgical Site Infection: • Colon Surgery • Abdominal Hysterectomy
Efficiency and Cost Reduction*	MSPB	Medicare Spending per Beneficiary

*These domains have been suppressed for FY 2022.

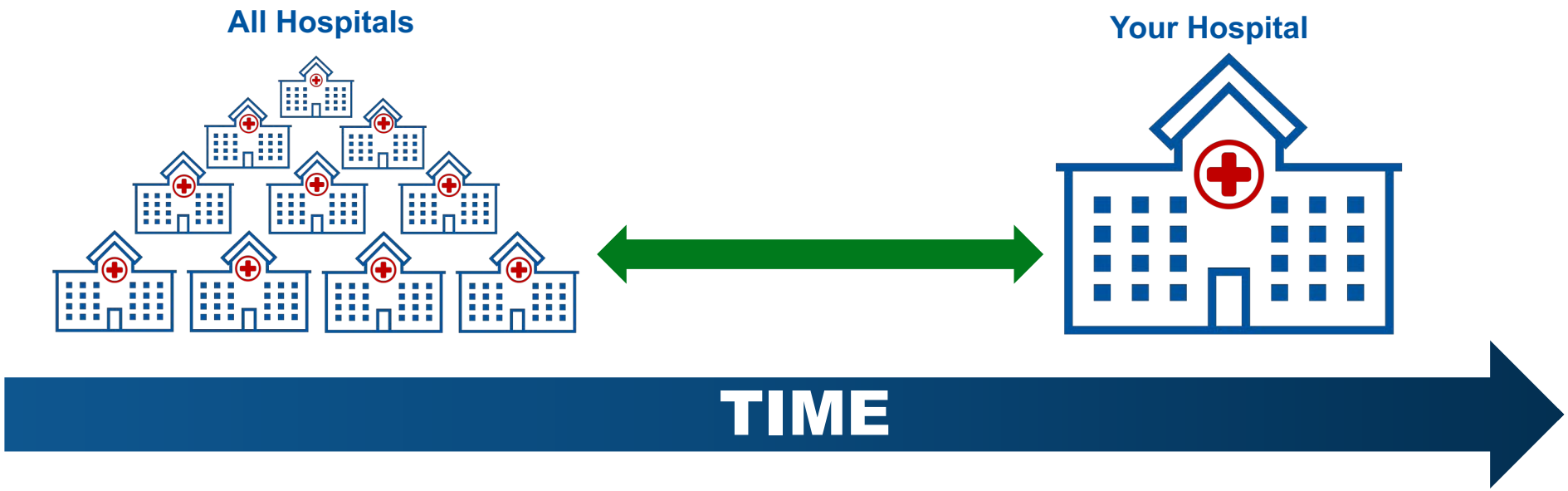
VBP National Performance Standards

- National Benchmarks
  - Highest achievement levels
  - Average performance score for the top 10% of all hospitals
- National Thresholds
  - Minimum achievement levels
  - Median performance score for all hospitals
- Established from baseline period data
- Vary by measure

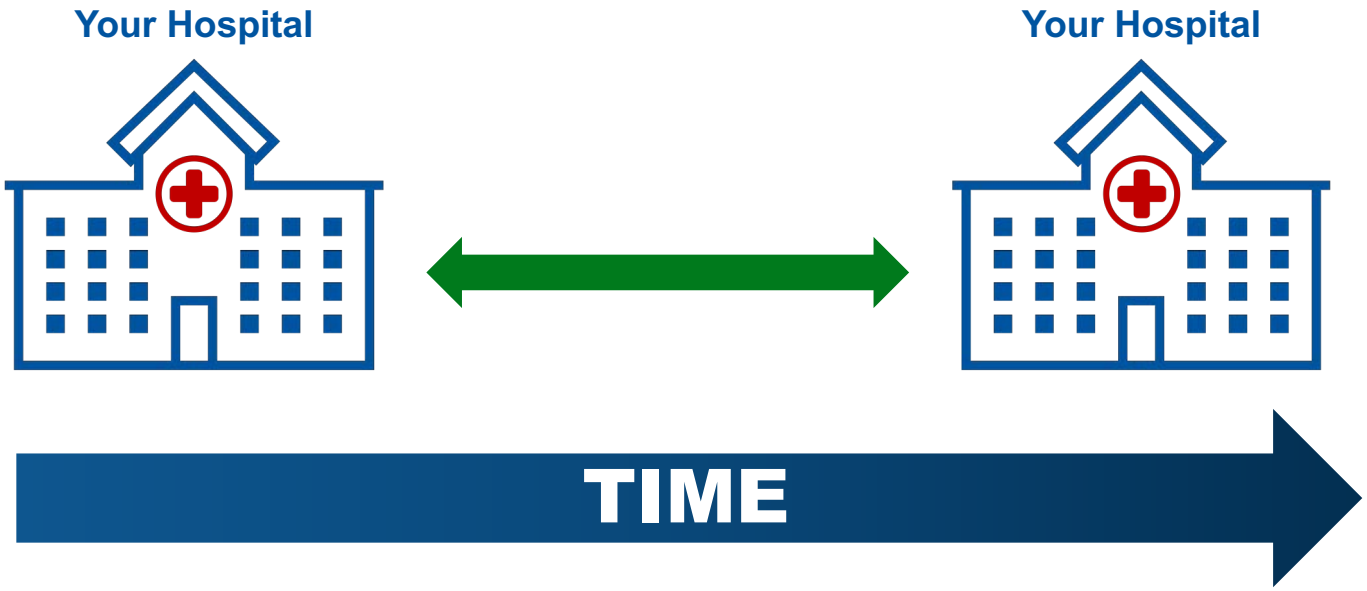
VBP Scoring Methodology

- Hospital performance for each measure is compared to national performance standards
- Points are awarded for:
  - Achieving high quality goals
  - Improving towards high quality goals
- Maximum = 10 points/measure
  - Score based on either achievement or improvement, not both
- Points scored for each measure are used to calculate domain scores
- Domain scores are weighted to calculate a Total Performance Score

Achievement Points



Improvement Points



Efficiency Domain

- Medicare spending per beneficiary
  - The MSPB measure evaluates hospitals' efficiency relative to the efficiency of the "median" hospital
  - Includes all Part A and Part B payments from three days prior to admission through 30 days post-discharge
  - Risk-adjusted for age and severity of illness
  - Payments are standardized to remove geographic and other payment adjustment factors

MSPB – Who's In

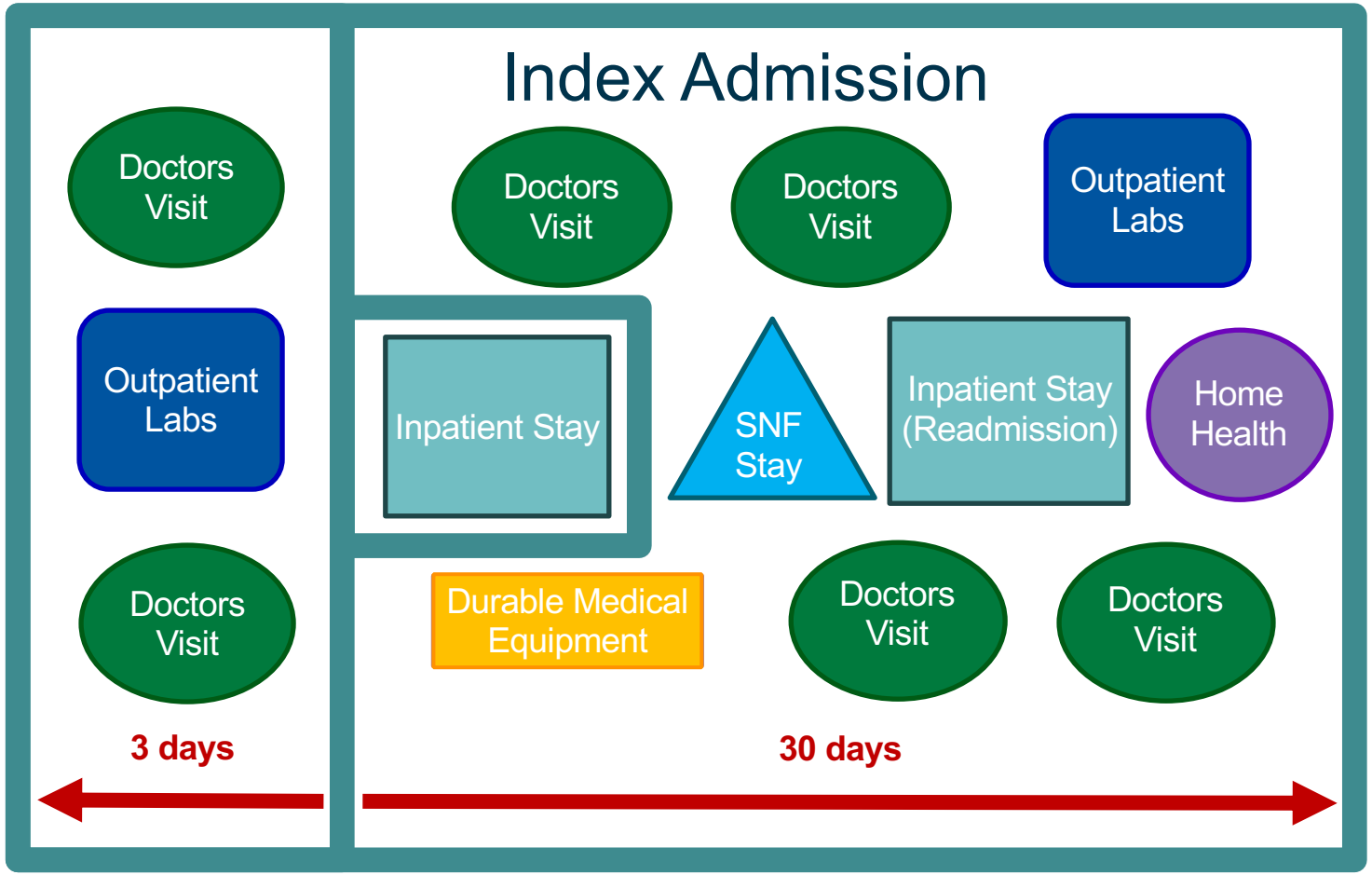
Included

- Beneficiaries enrolled in both Part A & B for at least 90 days prior to an index admission
- Must be discharged from a short-term acute hospital within the performance period

Excluded

- Medicare advantage enrollees
- Beneficiaries who die during the episode
- If Medicare is not the primary payer
- Beneficiary covered by the railroad retirement board

MSPB – What's In



Efficiency Measure: 1 – 3 Days Prior to Index Hospital Admission, Sample Hospital

Claim Type	Percent of Spending (Hospital)	Percent of Spending (State)	Percent of Spending (Nation)
Home Health Agency	0.09	0.09	0.06
Hospice	0.01	0.00	0.00
Inpatient	0.03	0.03	0.03
Outpatient	0.17	0.33	0.70
Skilled Nursing Facility	0.00	0.01	0.01
Durable Medical Equipment	0.03	0.04	0.04
Carrier	2.99	2.75	2.70

Efficiency Measure: During Index Hospital Admission, Sample Hospital

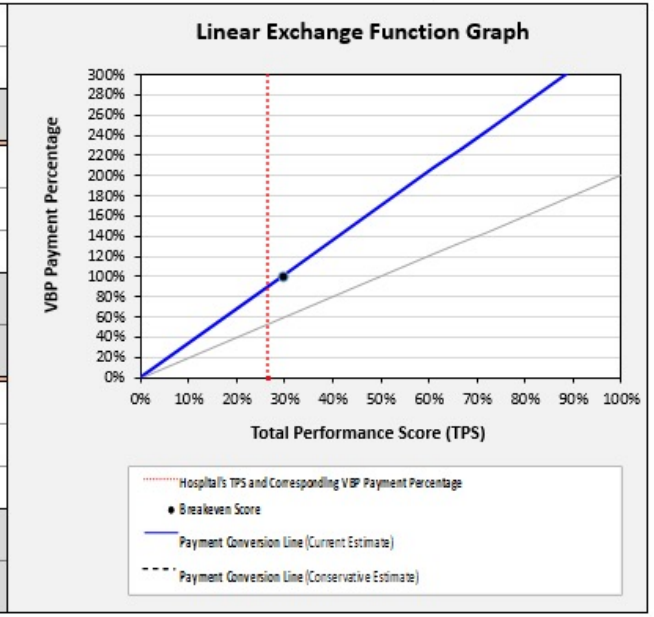
Claim Type	Percent of Spending (Hospital)	Percent of Spending (State)	Percent of Spending (Nation)
Home Health Agency	0.00	0.00	0.00
Hospice	0.00	0.00	0.00
Inpatient	48.04	44.58	46.84
Outpatient	0.00	0.00	0.00
Skilled Nursing Facility	0.00	0.00	0.00
Durable Medical Equipment	0.08	0.09	0.09
Carrier	8.08	7.78	7.14

Efficiency Measure: 1 – 30 Days After Discharge from Index Hospital, Sample Hospital

Claim Type	Percent of Spending (Hospital)	Percent of Spending (State)	Percent of Spending (Nation)
Home Health Agency	5.33	4.73	3.81
Hospice	0.91	0.84	0.69
Inpatient	10.81	13.41	13.20
Outpatient	2.78	3.06	3.95
Skilled Nursing Facility	13.62	15.42	14.91
Durable Medical Equipment	0.30	0.42	0.41
Carrier	6.71	6.43	5.42

Value Based Purchasing (VBP) Score, Impact, and Trend Estimates, Sample Hospital

			Unweighted Domain Score	Original Domain Weight	Proportionally Reweighted Domain Weight *	Weighted Score (Unweighted Domain Score X Reweighted Domain Weight)
VBP Score Estimates	A	Person and Community Engagement Domain	26.0%	25.0%	25.0%	6.5%
	B	Clinical Outcomes Domain	58.0%	25.0%	25.0%	14.5%
	C	Safety Domain	22.0%	25.0%	25.0%	5.5%
	D	Efficiency and Cost Reduction Domain	0.0%	25.0%	25.0%	0.0%
	E	***Total VBP Performance Score (TPS)*** *(Sum of weighted scores)*				***26.5%***
VBP Contribution Amount	F	Estimated Total IPPS Operating Payments	$53,857,200			
	G	VBP Contribution Percentage	2.0%			
	H	**Program Contribution (F X G)**	**$1,077,100**			
VBP Program Impact (Current Estimate)	I	Linear Payout Function Factor *(slope of solid line in chart - based on U.S. distribution of hospital TPS)*	3.4008			
	J	VBP Payment Percentage (E X I)	90.1%			
	K	VBP Payment (H X J)	$970,700			
	L	***Net Gain/Loss (K - H)***	($106,400)			
	M	***Estimated Payment Adjustment Factor [1+ ((G X J) - G)]***	***0.9980***			
VBP Program Impact (Conservative Estimate) **	N	Linear Payout Function Factor *(slope of dashed line in chart set at 2.0)*	2.00			
	O	VBP Payment Percentage (E X N)	53.0%			
	P	VBP Payment (H X O)	$570,900			
	Q	***Net Gain/Loss (P - H)***	($506,200)			
	R	***Estimated Payment Adjustment Factor [1+ ((G X O) - G)]***	***0.9906***			



Source: DataGen, 2021

Readmissions

Readmissions Reduction Program

- Beginning in FY2013, hospitals with higher-than-expected, risk-adjusted readmissions rates for 30-days post-discharge will receive reduced Medicare payments for every discharge.
- Includes readmissions for ALL causes.
- Maximum payment reduction for individual facilities: 1.0% in FY2013, increasing to 3.0% in FY2015 and thereafter
  - Uses Medicare fee-for-service base operating DRG payment
    - Excludes add-ons such as indirect medical education and disproportionate share.
- Minimum case size varies by condition

Reductions Reduction Program

- **What is HRRP?**
  - HRRP is a Medicare value-based purchasing program that reduces payments to hospitals with excess readmission.
  - Under HRRP, CMS encourages hospitals to improve communication and care coordination to better engage patients and caregivers in post-discharge planning.

- **Which readmission measures are included?**
  - AMI (acute myocardial infarction)
  - COPD (chronic obstructive pulmonary disease)
  - HF (heart failure)
  - Pneumonia
  - CABG (coronary artery bypass graft surgery
  - THA/TKA (total hip and/or total knee arthroplasty

Defining Readmissions

Key Terms

Index Admission

The first admission for a patient within a specific time period. Readmission clock starts counting at day of discharge.

Readmission

An admission to any acute care hospital, for any acute care reason, that occurs within 30 days of a previous discharge.

Readmissions

Includes

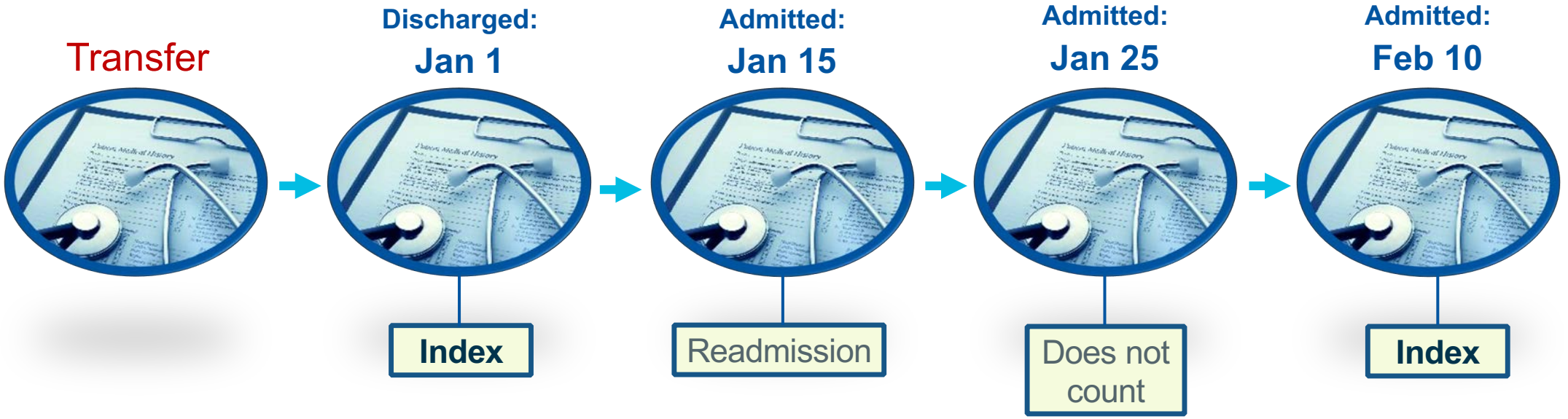
- Medicare fee-for-service patients, at least 65 years of age, with a principal diagnosis identified by CMS for the program
- 12 full months of enrollment in Parts A and B prior to the index admission
- Medicare Part A at the time of the index admission
- One full month of enrollment in Parts A and B post-discharge (fee-for-service)

Readmissions

Excludes

- Incomplete Medicare enrollment data
- Under age 65
- Length of stay greater than one year
- Discharged against medical advice
- In-hospital deaths
- Transfers out
- Same day readmissions for the same condition to the same hospital

Example


Transfer
Discharged:
Jan 1
Admitted:
Jan 15
Admitted:
Jan 25
Admitted:
Feb 10
Index
Readmission
Does not count
Index

Hospital-Acquired Conditions (HAC) Reduction Program

HAC Reduction Program Overview

- ACA-mandated
- First payment adjustment began October 1, 2014
  - Most hospitals are eligible for the program (3366 of 3468, 97%)
- Bottom quartile of hospitals will always receive a penalty
- Payment penalty held constant at 1.0% unlike RRP/VBP
  - Applies to total payment amount

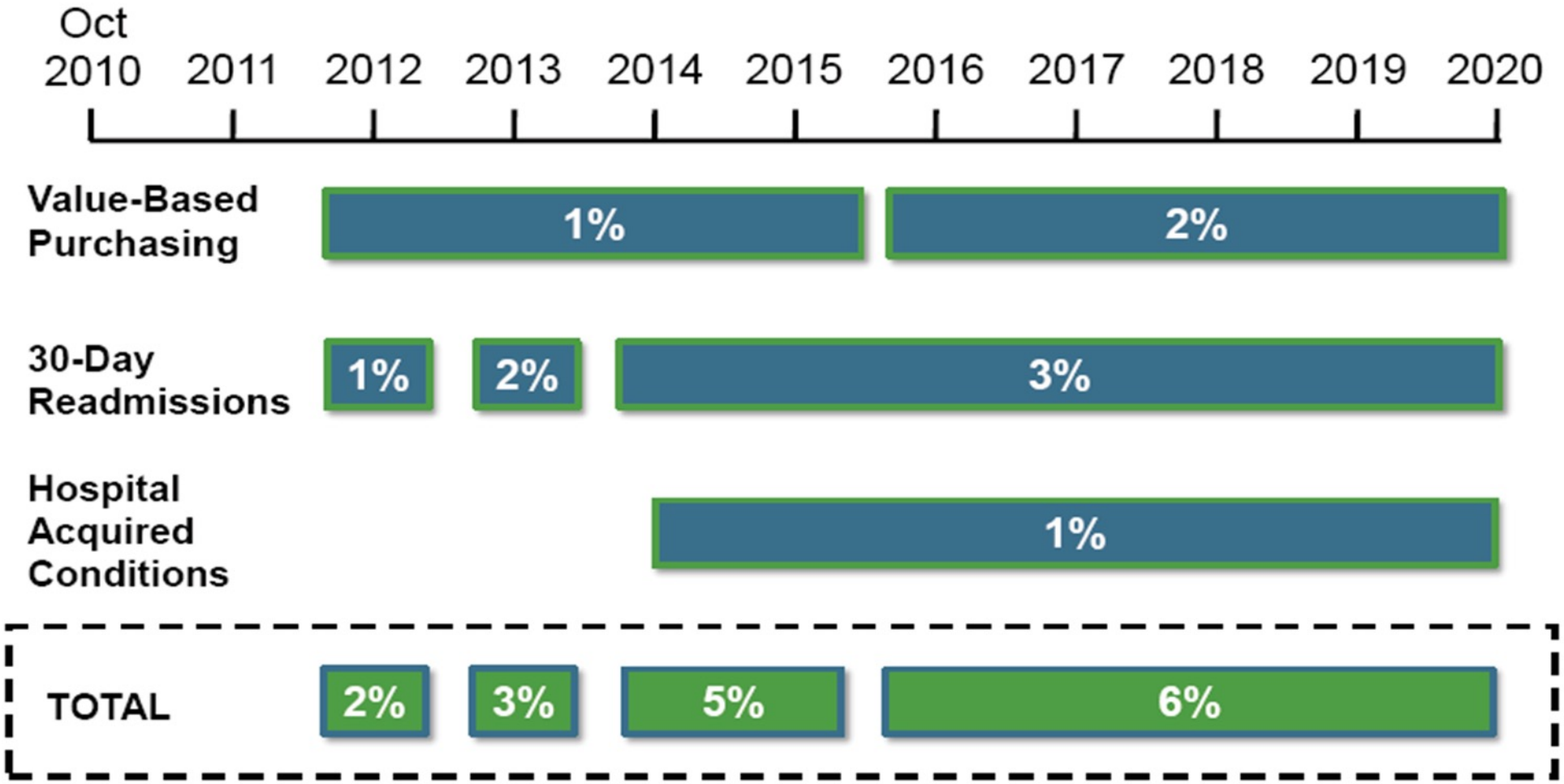
HAC Reduction Program Measures

Measure	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Recalibrated PSI-90 Composite: Patient Safety for Selected Indicators	X	X	X					
Recalibrated PSI-90 Composite: Patient Safety and Adverse Events Composite				X	X	X	X	X
CLABSI	X	X	X	X	X	X	X	X
CAUTI	X	X	X	X	X	X	X	X
SSI (colon and hysterectomy)		X	X	X	X	X	X	X
MRSA bacteremia			X	X	X	X	X	X
Clostridium difficile Infection			X	X	X	X	X	X

Source: QualityNet

Paying for Value – Summary

Hospital Reimbursement at Risk



In Summary

- This is not just collection/reporting program
- Payment levels are at stake
- Complexity from use of multiple data sources
- Hospitals are competing against each other
- Not isolated to Medicare
- Historical data will continue to drive these programs
  - Paid today for how you performed yesterday
- Performance is public information
- Program targets move with national performance
  - Hospitals must keep pace with the pack
- MedPAC proposal to establish single Hospital Value Incentive Program

The Future of the Medicare Trust Fund

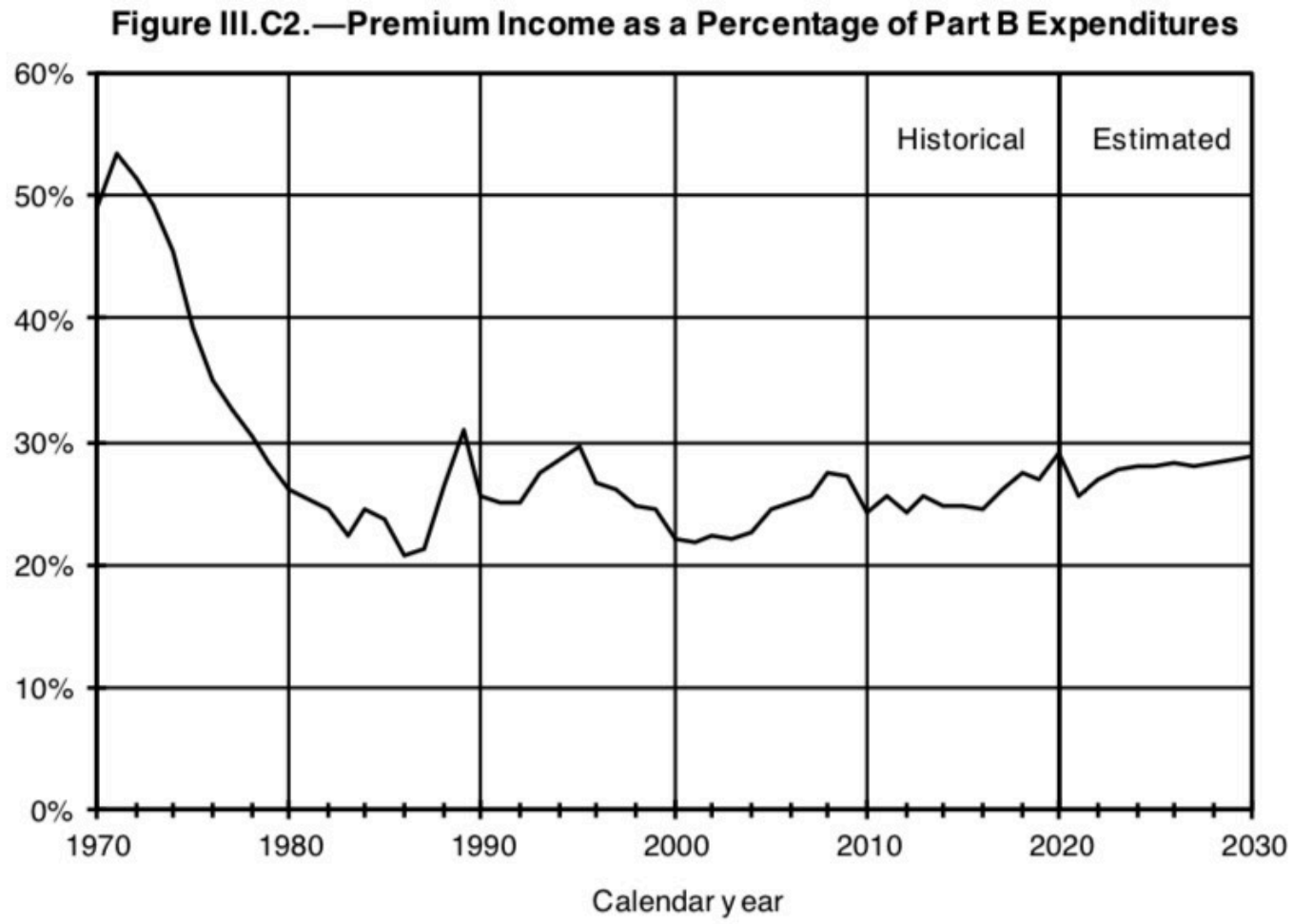
Forecast

The Supplemental Medical Insurance Trust Fund (Part B)

SMI Solvency Projections 2021

- Adequately financed over the next decade and beyond
  - Premiums paid by enrollees plus government funding
  - Reset annually
    - Does not require Congressional approval
- Part B costs have averaged annual growth rate of 8.5 percent over the last five years
  - Compared to GDP growth of 2.8 percent
  - Growth expected to average 7.2 percent over next five years (GDP = 5.3 percent)
- Higher spending results in increased general revenue funding and higher beneficiary premiums

Part B: Premium to Expense



Source: 2021 Medicare Trustees

Proposals Impacting Providers

Outpatient Site Neutral

- Non-grandfathered off-campus
- On campus clinics

340B Drug Program

- Modify payment rate
- User fee
- Revise distribution methodology

Reduce bad debt reimbursement from 65% to 25%

Reduce payment to critical access hospitals

- From 101% of cost to 100% of cost

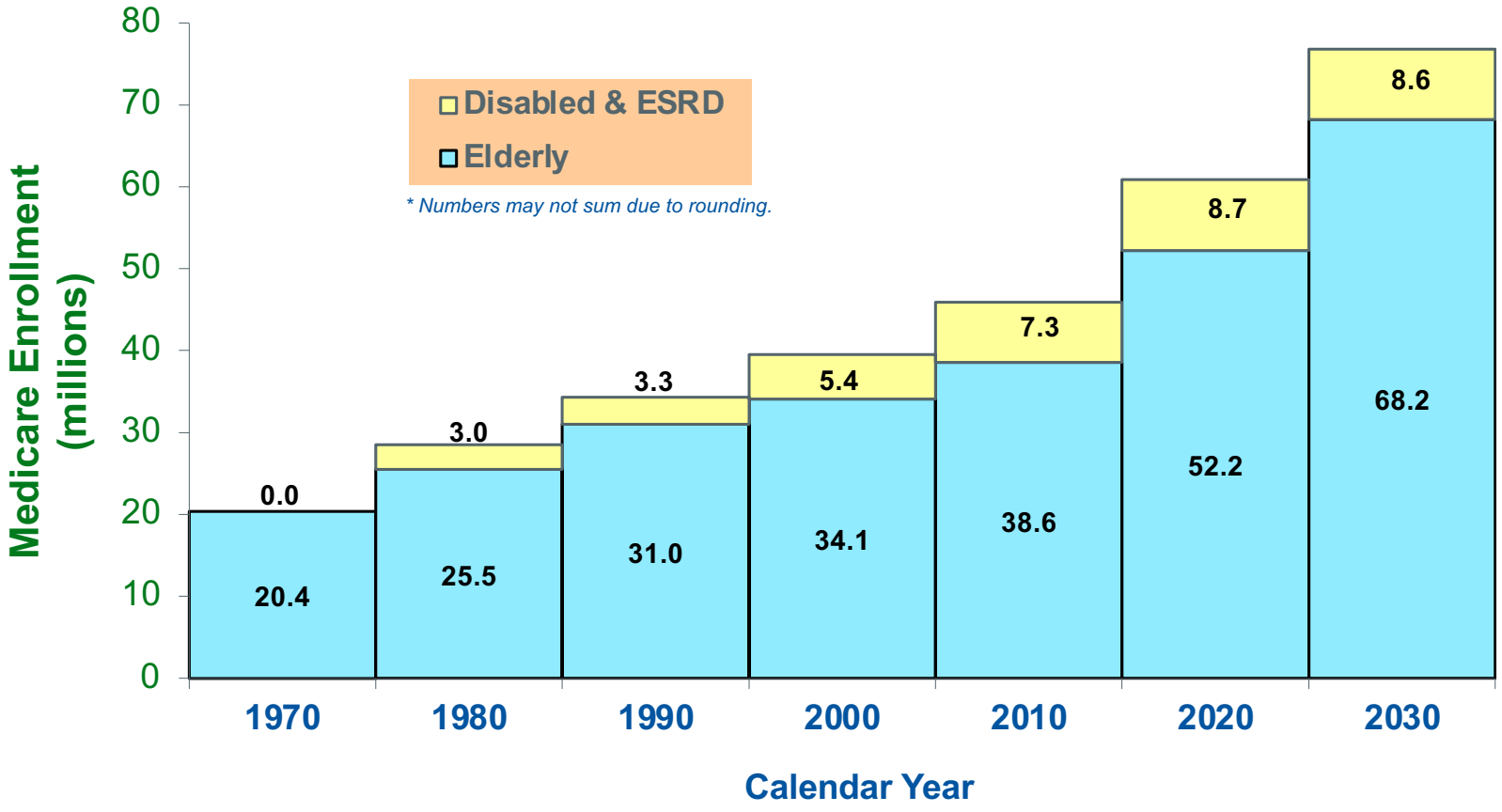
Forecast
The Hospital Insurance Trust Fund (Part A)

The Future of Medicare Part A

- Financing challenges:
  - Aging of the U.S. population (baby boomers)
    - **Averages over 2% per year**
  - Declining ratio of workers to beneficiaries
  - Decline in available staff of working age, including physicians
    - Increases competition and salary expense
  - Increasing health care costs (new technologies, new drugs, etc.)
    - **Growth in volume and intensity of services**
    - **Averages 2.6% per year**

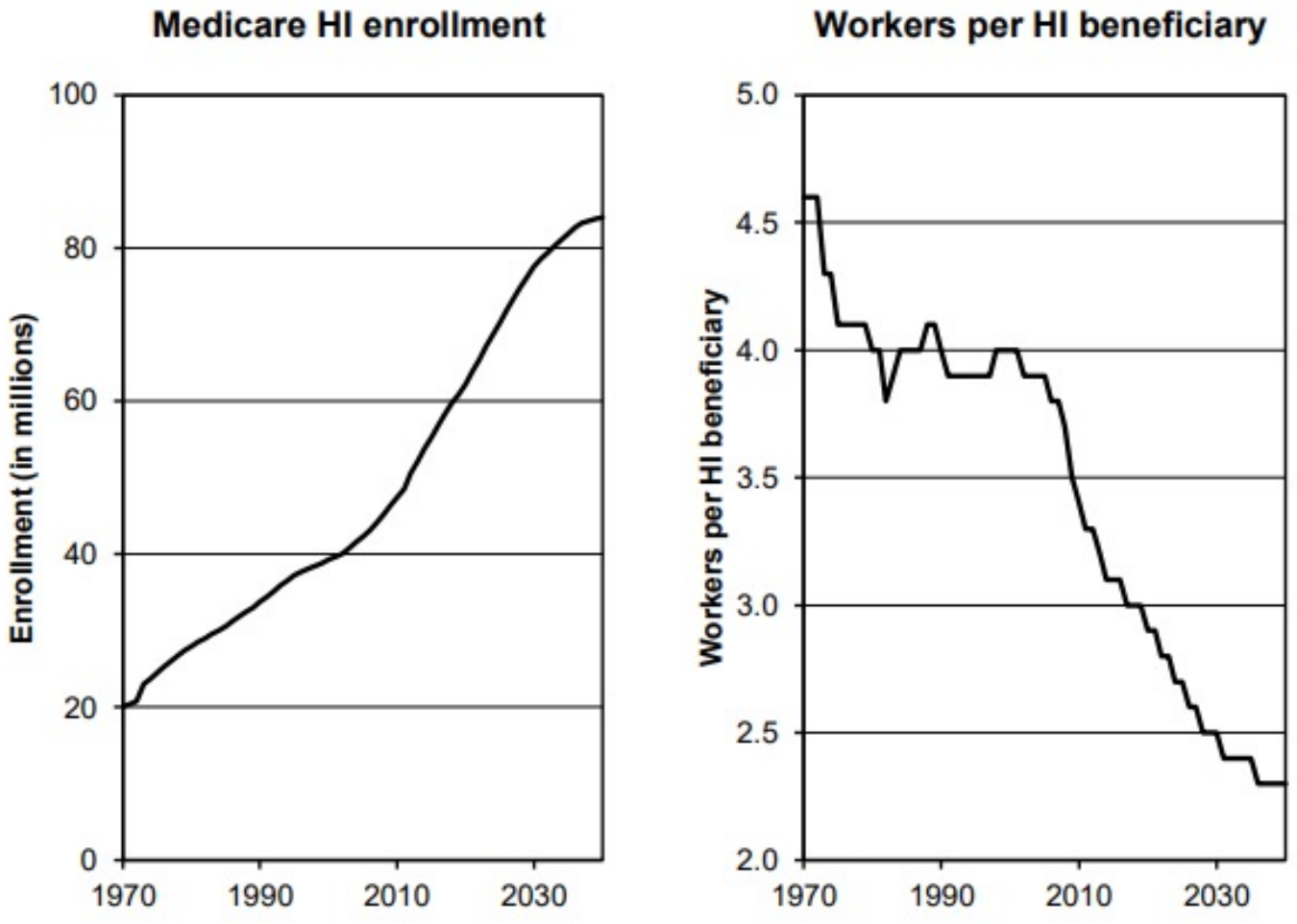
Aging of the Baby-Boomers

The number of people Medicare serves will nearly double by 2030.



Source: CMS, Office of the Actuary

Workers per Beneficiary

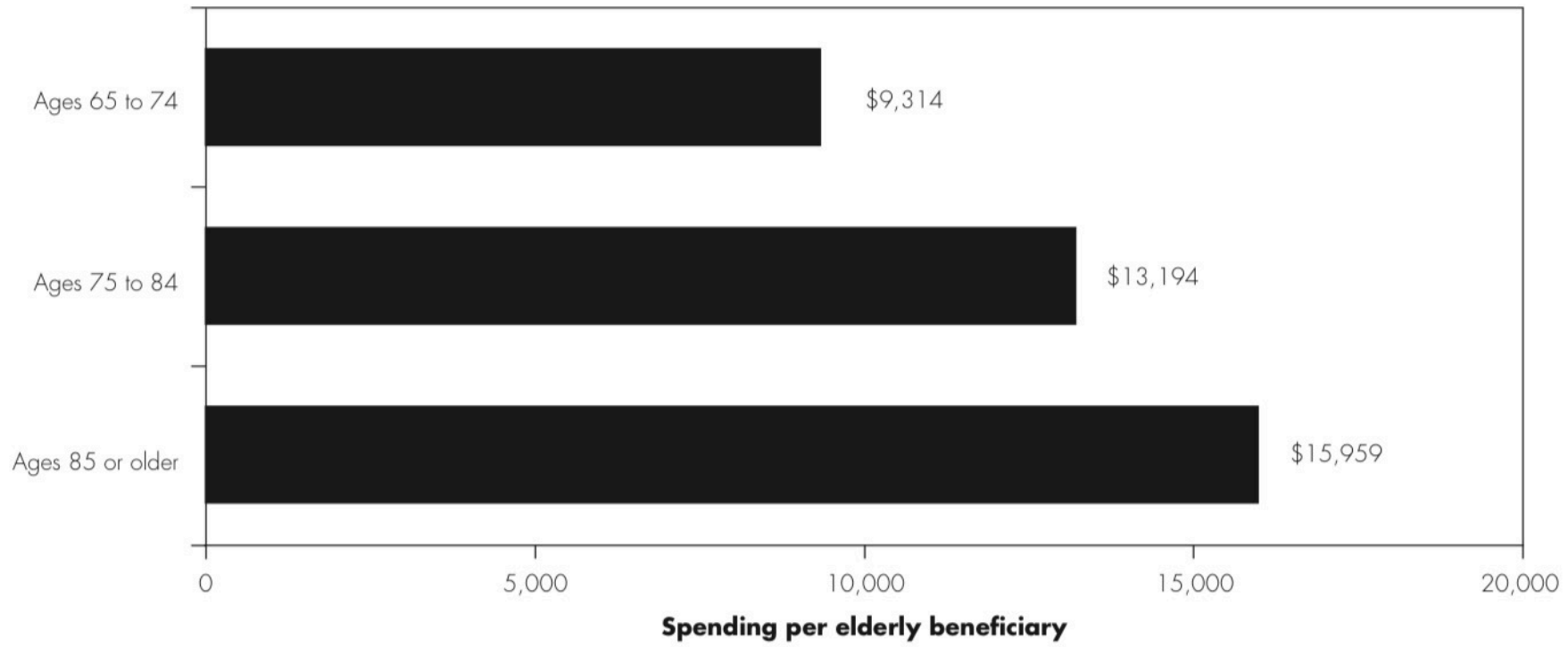


Source: MedPAC July 2021 DataBook

Spending Varies with Age

FIGURE 1–5

Spending per elderly beneficiary varied by age, 2017



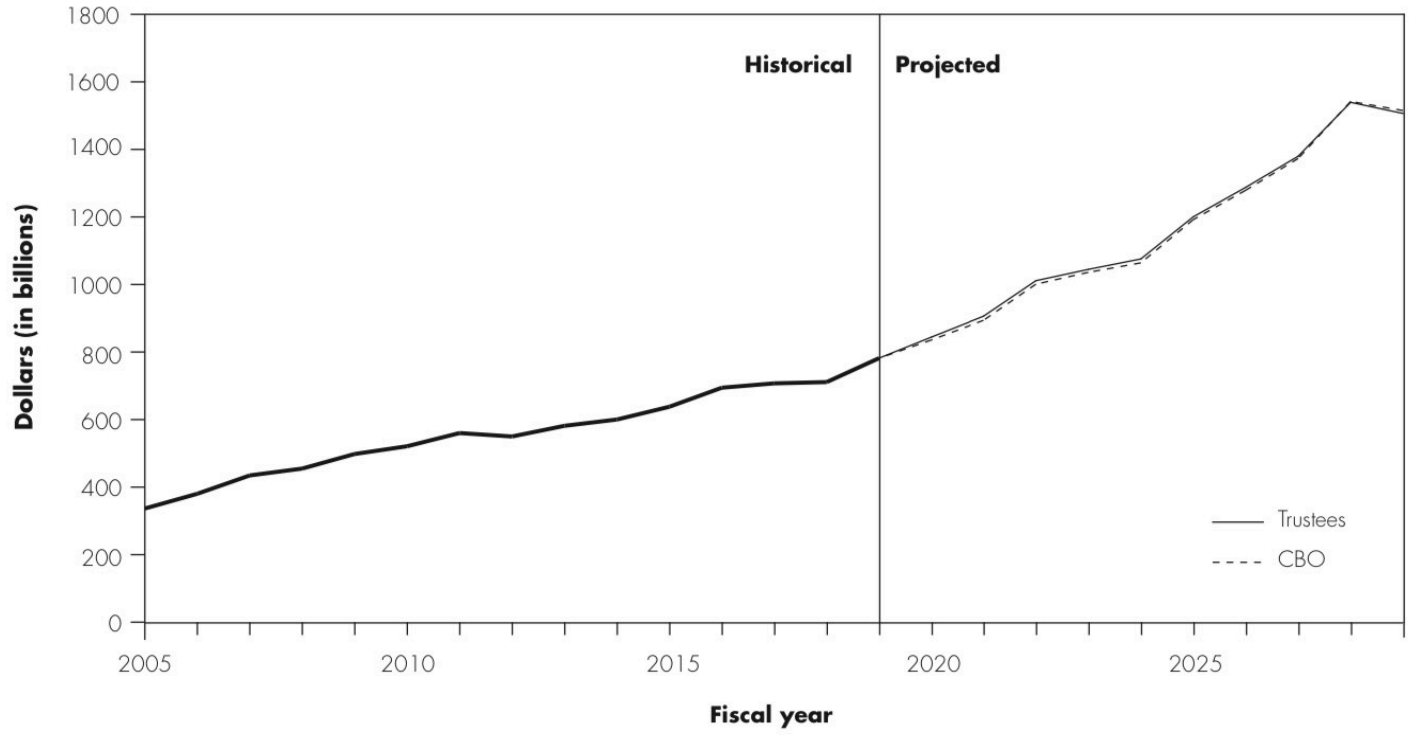
Note: Includes beneficiaries in traditional Medicare and Medicare Advantage dwelling in the community and in institutions. Spending per beneficiary for non-elderly enrollees (who are eligible for Medicare due to end-stage renal disease or disability) was $15,879 (not shown above).

Source: MedPAC July 2021 DataBook

Spending Projections

FIGURE 1–2

Medicare Trustees and CBO project Medicare spending to nearly double over the next decade

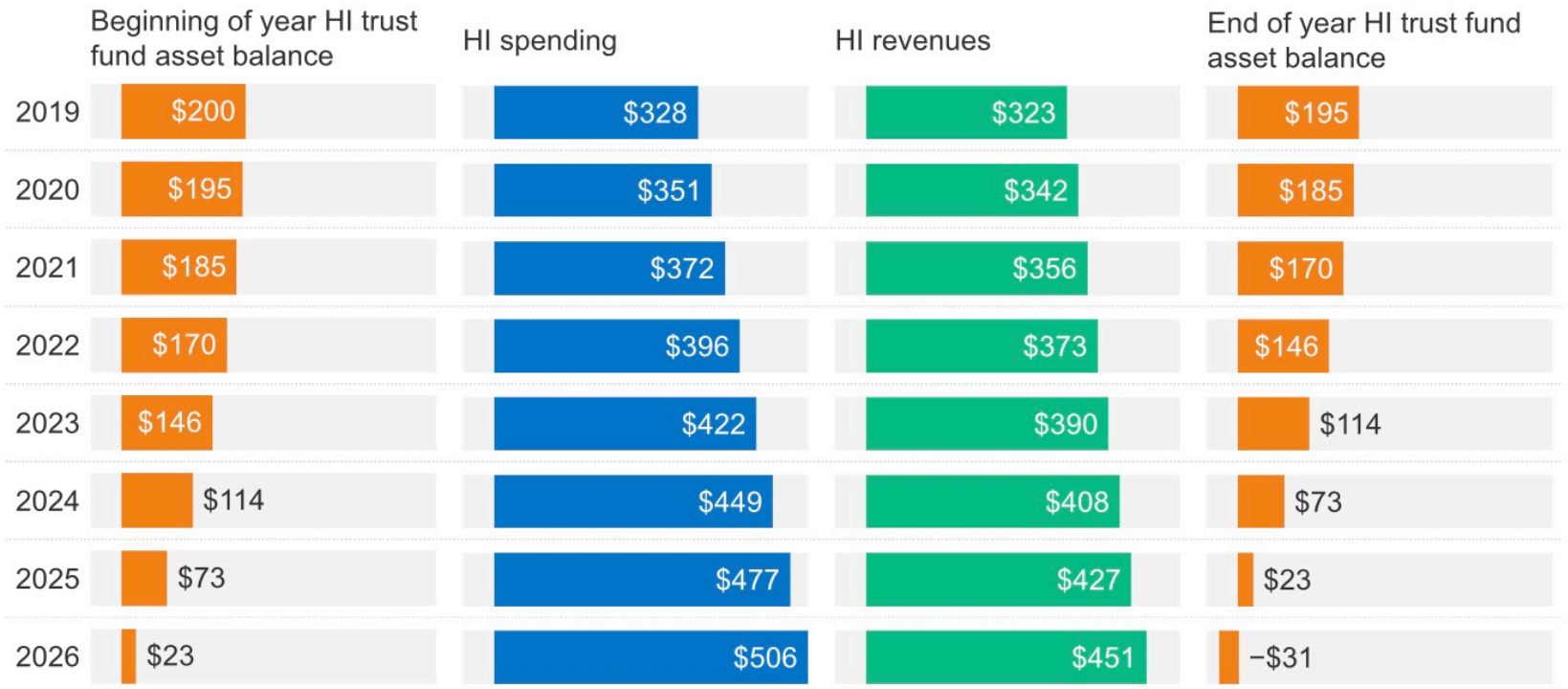


Note: CBO (Congressional Budget Office). Figure shows spending per fiscal year (as opposed to calendar year). The potential effects of the coronavirus pandemic are not reflected in these projections. At the time these projections were developed, a statutorily required sequestration was scheduled to increase in size in 2029 (growing from the current 2 percent reduction to benefit payments to a 4 percent reduction for the period from April 1, 2029, through September 30,

Source: MedPAC July 2021 DataBook

Current Status

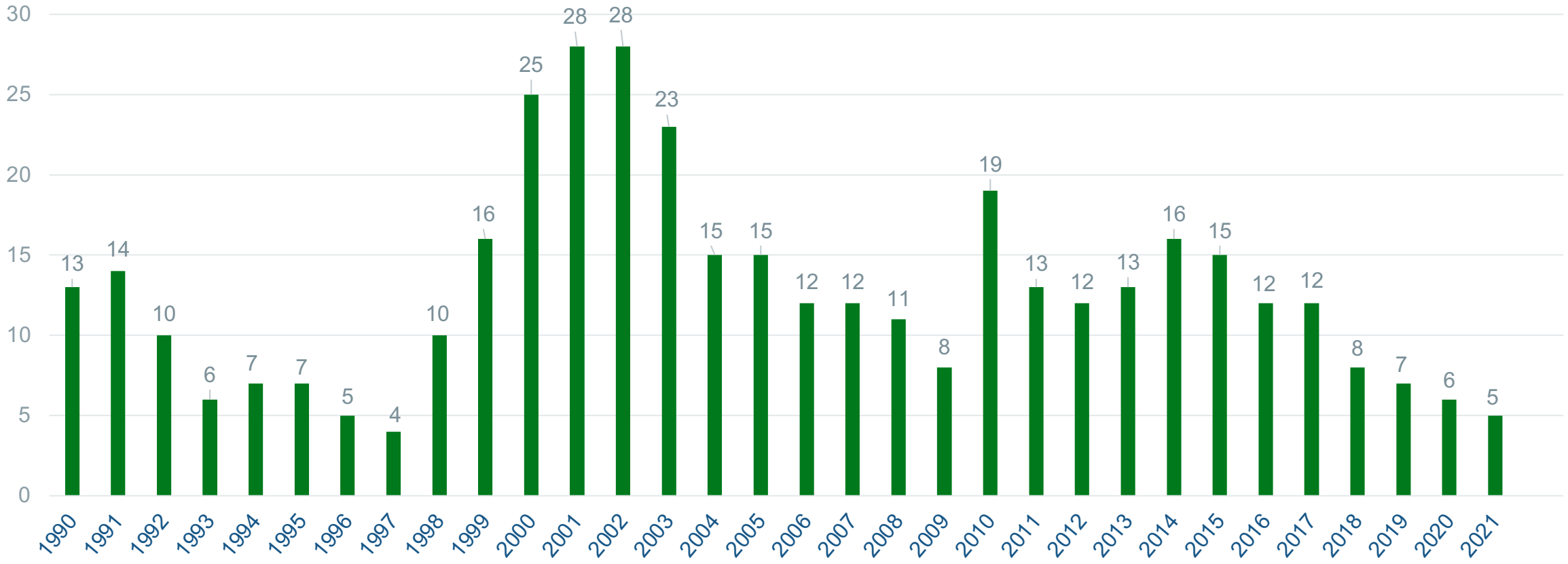
Assets in the Medicare Hospital Insurance Trust Fund are Gradually Being Depleted



NOTE: HI is Hospital Insurance. Amounts in billions.
SOURCE: KFF analysis of data from the 2020 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, April 2020.
• PNG

KFF

Insolvency: The Past & the Future



2021 Trustee's Report

- *The projected trust fund depletion date is 2026, the same as estimated in last year's report.*
- *HI income is projected to be lower than last year's estimates due to lower payroll taxes.*
- *HI expenditures are projected to be lower than last year's estimates because of lower projected provider payment updates and certain methodological improvements….*

Exhausted?

- If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues.
  - ✓ These revenues would be inadequate to fully cover costs.
  - ✓ Beneficiary access to health care services would rapidly be curtailed.

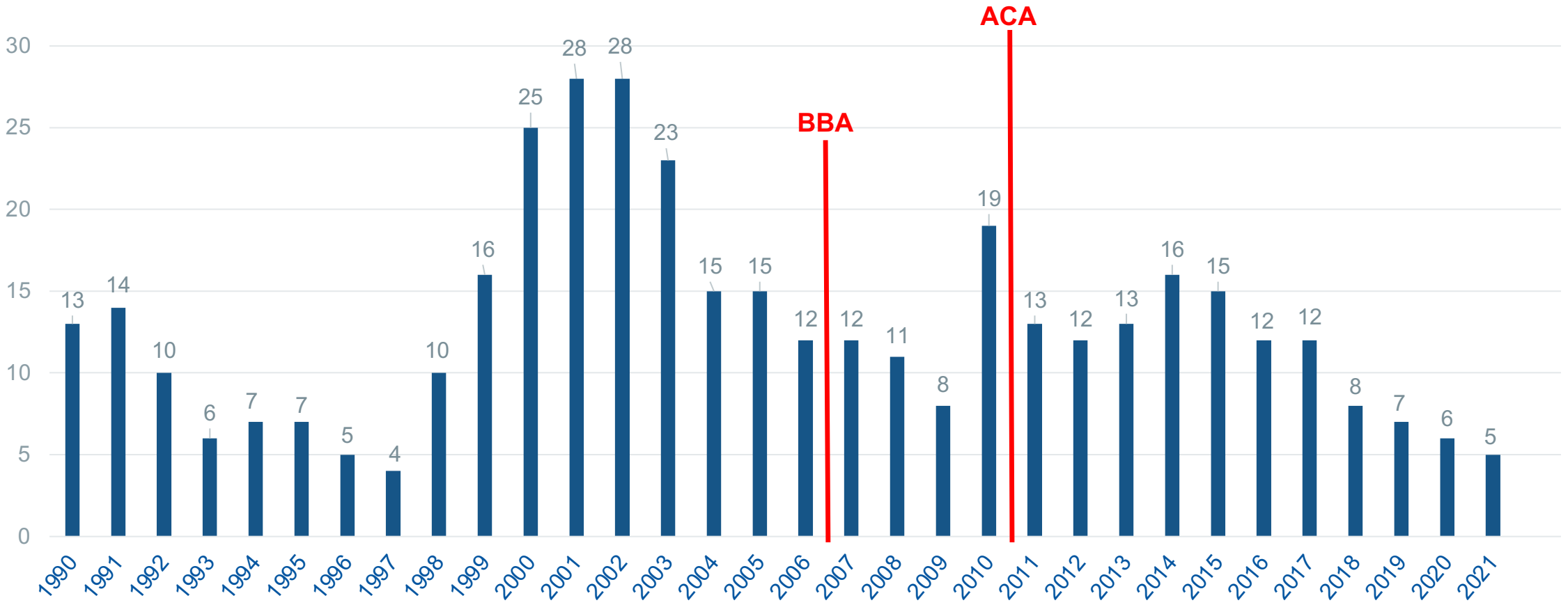
- For the HI trust fund to remain solvent through the 75-year projection period:
  1. The standard 2.90 percent payroll tax could be immediately increased by the amount of the actual deficit to 3.81 percent; ***or***
  2. Expenditures could be reduced immediately by 19 percent.

Source: Annual MedicareTrustees Report

Insolvency

- Solvent today due to surpluses from prior years
  - Already spending more than collected
- Projection (2021) to maintain solvency for another 25 years
  - Increase payroll tax from 2.9% to 3.7%
  - Decrease Part A spending by $70 billion (18%)

Insolvency: Past Responses



Proposals Impacting Providers

Medical Education
- Move GME and IME to national pool

Remove Disproportionate Share from IPPS
- Index to inflation

Reduce Bad Debt Reimbursement from 65% to 25%

Post-Acute Care
- Reduce payments for post-acute care services
- Unified post-acute care payment system
- Shifting more payment for home health from Part A to Part B

Critical Access Hospitals
- Eliminate program
- Reduce payment from 101% of cost to 100% of cost
- Reduce swing bed program reimbursement

Eliminate Sole Community Hospital Program

Medicare Advantage

- **MedPAC**
  - Impact of MA plans on federal spending:
    - Part of 2021 – 2022 workplan
    - Issue of plan profits
    - Need to revise MA payment methodology

Questions?

Thank you!

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