# Legislative and Regulatory Update

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February 18, 2016

Florida Hospital Association
Mission to Care. Vision to Lead.

# State Issues

Florida Hospital Association

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# Legislative Session: Key Issues

- Balance billing
- Certificate of need
- Ambulatory surgical centers
- Transparency
- EAPGs and 340B

# Observation Services: Florida

- Effective July 2015
- Revises section 395.301, Florida Statutes
  - *If a licensed facility places a patient on observation status rather than inpatient status, observation services shall be documented in the patient's discharge papers. The patient or the patient's proxy shall be notified of observation services through discharge papers, which may include brochures, signage, or other forms of communication for this purpose.*

# Federal Issues

# Observation Services: Federal

- Notice of Observation Treatment and Implication for Care Eligibility Act
- Required patient notice as of August 2016

# Observation Services

- Applies to Medicare patients whose hospital stay lasts more than 24 hours
  - Must be notified of financial consequences of *their* patient status
  - Notification must be made by discharge or within 36 hours, whichever is sooner
  - Requires written notice of status, reasons for the status, outline of cost sharing and SNF implications
  - Must be in appropriate languages and signed by the patient or designee

# CY2016 OPPS: 2MN Changes

- Keeps in place two midnight presumption, benchmark – stays expected to cross at least two midnights payable as inpatient claims
- Maintains exceptions for inpatient-only list; national exception list (only current exception = newly initiated mechanical ventilation)

# CY2016 OPPS: 2MN Changes

- Stays that are expected to cross less than two midnights may be payable as inpatient claims "based on the clinical judgment of the admitting physician and medical record support for that determination"
  - Judgment should be based on complex medical factors such as patient history and comorbidities, severity of signs and symptoms, current medical needs, and risk of an adverse event
    - MUST BE DOCUMENTED IN THE RECORD

# CY2016 OPPS: 2 MN Changes

*. . . We would like to clarify that our proposed modification to the current exceptions process does not define inpatient hospital admissions with expected lengths of stay less than 2 midnights as rare and unusual. Rather it modifies our current "rare and unusual" exceptions policy to allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark . . .*

*Source 11/13/15 FR, page 70545*

# CY2016 OPPS: Medical Review Changes

- Beginning Oct. 1, 2015, Quality Improvement Organizations (QIOs) will conduct reviews of short inpatient stays
  - Will review sample of post-payment claims
  - Priority review area: Inpatient admissions after minor surgical procedures or other treatments that do not span at least overnight
  - Minor surgical procedures should continue to be billed as outpatient

# Quality-Based Payment Reform

- Value-based purchasing
  - Transitions hospitals from P4R to P4P
  - Program self-funded by hospital “contributions”
  - Budget-neutral, redistributive
  - Hospital performance for each measure is compared to national performance standards
    - Current domains:
      - Clinical process of care
      - Patient experience of care (HCAPHS)
      - Outcomes
      - Efficiency

# Quality-Based Payment Reform

- Readmissions reduction program
  - Hospitals with higher than expected risk-adjusted readmission rates for 30-days post-discharge receive reduced Medicare payment for every discharge
  - Admissions are categorized as either an index admission or a potential readmission
  - Important to use expanded list of discharge status codes for claims

# Quality-Based Payment Reform

- Hospital-acquired conditions reduction program
  - Results in 1.0% reduction in IPPS payments for hospitals with highest total HAC scores
    - Worst quartile
    - Reduction applies to all Medicare patients and is applied to total payment, not Medicare base rate

# Comprehensive Care for Joint Replacement (CJR)

- Program runs from April 2016 through December 2020
- Includes every hospital located in 67 MSAs except those participating in bundled payment initiative involving lower extremity joint replacements

# CJR Demo

- Claims
  - 90-day episode triggered by MS-DRGs 469 and 470
  - All SNF, HH, LTCH, IRF and hospice claims are included
  - Inpatient readmission claims excluded by DRG
  - Professional, OPD, DME claims excluded by DX code
    - Professional claims during a readmission will be excluded by DX code not by acute readmission DRG
- Separate bundles by DRG and hip fracture

# CJR Demo

- Payments
  - Fee-for-service payments continue
  - No downside risk in Year 1
    - Responsibility for repayment begins in Year 2
- Retrospective, two-sided risk model with hospitals bearing financial responsibility
  - After a performance year, actual episode spending compared to the episode target
  - Gainsharing allowed

# Analysis of Comprehensive Care of Joint Replacement (CJR) Episodes
## Sample Hospital
### Located in a Mandatory Metropolitan Statistical Area (MSA)

**Estimated Calendar Year (CY) 2014 CJR Performance**

| | DRG 469 | | DRG 470 | | |
|---|---|---|---|---|---|
| | Without Hip Fracture Episodes | Hip Fracture Episodes | Without Hip Fracture Episodes | Hip Fracture Episodes | Total |
| Hospital Average CYs 2012-2014 Baseline @ CY 2014 Dollars (adjusted to reflect national weights) | $42,797 | $60,699 | $25,235 | $45,539 | |
| Regional Average CYs 2012-2014 Baseline @ CY 2014 Dollars (adjusted to reflect national weights) | $38,909 | $55,185 | $22,943 | $41,402 | |
| Blended Average (2/3 Hospital, 1/3 Regional)[+] | $38,909 | $55,185 | $24,471 | $44,160 | |
| Estimated CY 2014 Target Price (Blended Average *.97) | $37,742 | $53,529 | $23,737 | $42,835 | |
| CY 2014 Hospital Volume [++] | | | 26 | 24 | |
| CY 2014 Hospital Average Episode Payment | $0 | $45,283 | $24,508 | $45,720 | |
| CY 2014 Total Hospital Episode Payments | | | $637,208 | $1,097,280 | $1,825,054 |
| CY 2014 Total Estimated Target Price | | | $617,162 | $1,028,040 | $1,752,260 |
| CY 2014 Hospital Performance | | $16,492 | -$20,046 | -$69,240 | -$72,794 |
| % Gain/(Loss) | | 18.2% | -3.1% | -6.3% | -4.0% |

# Analysis of Medicare Comprehensive Care for Joint Replacement (CJR) Episodes
## Sample Hospital
### Located in a Mandatory Metropolitan Statistical Area (MSA)

**DRG 470: Major Joint Replacement or Reattachment of Lower Extremity w/o MCC Without Hip Fracture (26 total episodes)**

| | | Sample Hospital | | | | South Atlantic | | | |
|---|---|---|---|---|---|---|---|---|---|
| MS - DRG Description | # of CY 2014 Episodes * | 26 | | | | 68,842 | | | |
| | Average CY 2014 Total Payment | $24,508 | | | | $23,476 | | | |
| | Episode Component/Service Type | Average Number of Claims per Episode | Average Payment Per Claim | Average Payment per Episode | % of Average Episode Payment | Average Number of Claims per Episode | Average Payment Per Claim | Average Payment per Episode | % of Average Episode Payment |
| 470 - Major Joint Replacement or Reattachment of Lower Extremity w/o MCC (Without Hip Fracture) | Anchor Admission | 1.0 | $15,071 | $15,071 | 61% | 1.0 | $14,558 | $14,558 | 62% |
| | Acute Transfer | 0.0 | $0 | $0 | 0% | 0.0 | $12,178 | $5 | 0% |
| | Readmission | 0.1 | $6,963 | $464 | 2% | 0.1 | $8,108 | $710 | 3% |
| | Inpatient Rehabilitation | 0.1 | $11,971 | $1,596 | 7% | 0.0 | $13,476 | $556 | 2% |
| | Home Health | 0.8 | $3,112 | $2,489 | 10% | 0.8 | $3,045 | $2,360 | 10% |
| | SNF | 0.5 | $5,341 | $2,849 | 12% | 0.6 | $5,963 | $3,457 | 15% |
| | Long-Term Care Hospital | 0.0 | $0 | $0 | 0% | 0.0 | $32,432 | $26 | 0% |
| | Inpatient Psychiatric | 0.0 | $0 | $0 | 0% | 0.0 | $7,515 | $12 | 0% |
| | Hospice | 0.0 | $0 | $0 | 0% | 0.0 | $2,756 | $2 | 0% |
| | Physician Office | 7.8 | $147 | $1,147 | 5% | 2.6 | $360 | $946 | 4% |
| | Durable Medical Equipment | 1.0 | $143 | $143 | 1% | 1.0 | $143 | $147 | 1% |
| | Outpatient | 1.2 | $623 | $748 | 3% | 2.2 | $314 | $698 | 3% |

# Provider-Based Site Neutral Policy

- Revision to payment policy under recent legislation (Section 603 – BBA 2015)
  - If not billing Medicare 11/2/15, will see payment at physician office rate, ASC rate or lab fee schedule rate as of January 1, 2017
  - Working to redefine grandfathered
    - Changes in ownership
    - Relocation
    - Definition of dedicated emergency department
    - Under development
  - How to bill after December 31, 2016

# Provider-Based Site Neutral Policy

- Letter to Energy & Commerce Committee
  - Focus on MedPAC recommendations
    - OPD/Physician payment equalization for E/M services
    - OPD/Physician payment equalization for targeted services (66 APCs)
    - OPD/ASC payment equalization for targeted services (12 APCs)
    - Florida impact - $1.26B over ten years

# 60-Day Overpayments Rule

- Final rule published in February 12 *Federal Register*
- Report and return overpayments to Medicare within 60 days of identification
  - Identified when the person has or should have through the exercise of *reasonable diligence*, determined that an overpayment was received and quantified the amount of the overpayment
- Failure to do so could lead to liability under the Federal False Claims Act

# 60-Day Overpayments Rule

- Proposed 10-year lookback period reduced to six years
- Reasonable diligence
  - Proactive compliance to monitor claims
  - Reactive investigations after receiving credible information about a potential overpayment
  - At most, six months from receipt of credible information, except in extraordinary circumstances
- Not retroactive; effective March 14, 2016

# President's FY2017 Budget

- Reduce CAH reimbursement from 101 percent of reasonable costs to 100 percent
- Reduce bad debt reimbursement to all providers to 25 percent over three years
- Modify/reduce payment for IME
- Reduce payment for post-acute care providers
- Move threshold for inpatient rehab facilities from 60 percent to 75 percent
- Code present on arrival rather than present on admission

# And It Doesn't End There….

- Discharge planning NPRM
- DME prior authorization final rule
- DOJ/Yates memo
  - Investigating and prosecuting individuals involved in alleged corporate wrongdoing

# Questions??

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