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TOP MEDICARE REIMBURSEMENT OPPORTUNITIES POST COVID-19

Illinois Health and Hospital Association | May 17, 2022

Introductions

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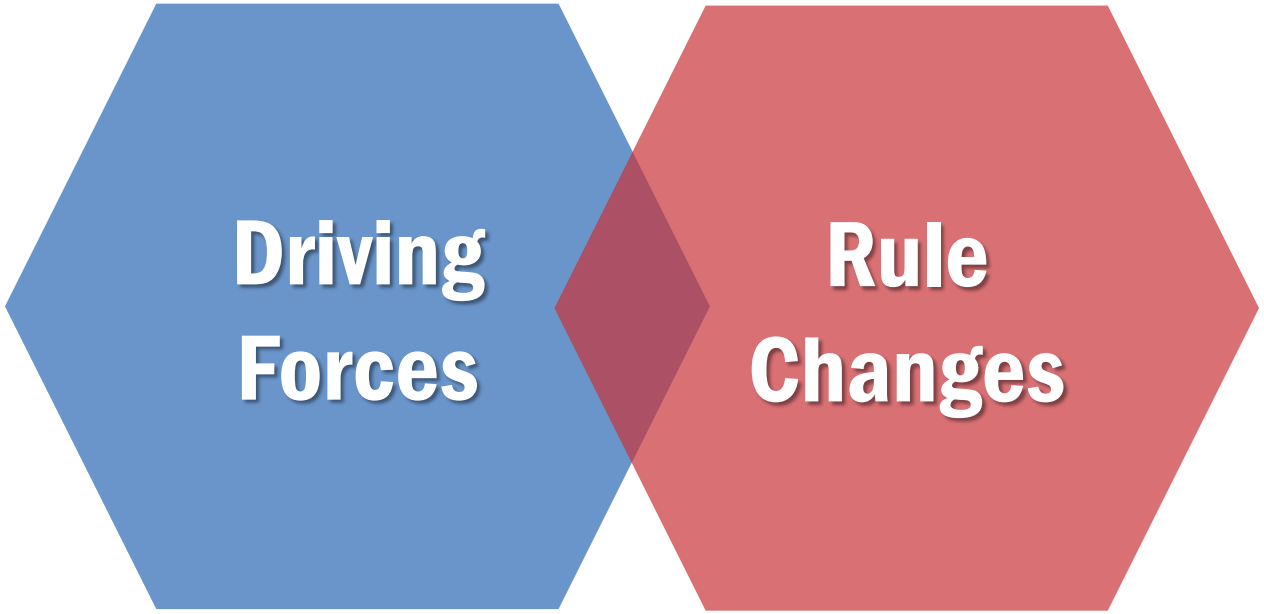
Where is Medicare Reimbursement Heading?



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COVID Impacts – What Do We Know?

CLINICAL OUTCOMES & QUALITY MEASURES ARE CHANGING

- Hospital-Acquired Infections
- Acuity
- Readmission Rates
- Length of Stay
- Spending per Beneficiary
- Visitor Restrictions
- Etc.

COST OF CARE IS CHANGING

- Labor Cost Demands
- PPE Surge
- Infection Control
- Capacity Constraints
- Length of Stay
- Drug Prices
- Post-Acute Alternatives
- Delayed or Deferred Care

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COVID Impacts: What Do We Know?

- Impact for every provider is different
  - GEOGRAPHIC
  - DURATION & TIMING
  - POPULATION SPREAD
  - ACUITY
- Payment systems (including CMS) must adapt

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Some Key Reimbursement Factors in Play

DRG Weights & Market Basket Update	Wage Index Factors & MGCRB Reclassifications	Value/Quality Factors	IME & GME Reimbursement
Volume Decline Adjustments	CAH/RHC Cost-Based Reimbursement	Reimbursable Bad Debts	Medicaid DSH Payments
Telehealth	Uncompensated Care Pool Factors	DSH Percentages & 340B Eligibility	Post-Acute Care Reimbursement

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COVID's Impact on the Wage Index

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Cost Report Year-Ends

FEDERAL YEAR 2023	FEDERAL YEAR 2024
Beginning during FY 2019	*Beginning during FY 2020*
9.30.19	9.30.20—COVID 6+ months
12.31.19	12.31.20—COVID 9+ months
3.31.20—limited COVID	3.31.21—COVID all year
6.30.20—COVID 3+ months	6.30.21—COVID all year

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Historical Trend
National Average Hourly Wage

FEDERAL YEAR	INCREASE FROM PRIOR YEAR
2009	4.3%
2010	4.0%
2011	4.3%
2012	3.7%
2013	3.4%
2014	2.4%
2015	2.3%
2016	2.5%

FEDERAL YEAR	INCREASE FROM PRIOR YEAR
2017	2.2%
2018	2.2%
2019	2.1%
2020	2.9%
2021	2.4%
2022	2.7%
2023	2.8% +
2024	**??**

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FFY 2024 National COVID Impacts

WAGE INDEX ANTICIPATED SWINGS	FFY 2023 (1/28/22 PUF)	FFY 2024 (AS-FILED)
Adjusted rate	2.78% increase	3.75% increase
Patient care contract labor (as a percentage of salaries)	3.06%	3.97%
Unadjusted salary average rate (total salaries divided by total hours)	3.25% increase	4.07% increase
Physician Part A & downtime (salaried & contracted Part A as a percentage of total salaries)	1.38%	1.62%

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What are the Trends in Illinois?

FY 2022 VS. PROPOSED FY 2023 VS. AS-FILED FY 2024

CBSA	FY 2022 WAGE INDEX	FFY 2023 WAGE INDEX	FFY 2024 AS-FILED INCREASE (DECREASE)*
Bloomington	0.9258	0.9247	(4.90%)
Carbondale-Marion	0.8433 rural	0.8477 rural	8.90%
Champaign	0.8781	0.8998	0.00%**
Chicago	1.0326	1.0472	6.70%
Danville	0.9523	0.9499	0.30%
Davenport-Moline IA/IL	0.8433 rural	0.8477 rural	6.00%
Decatur	0.8467	0.8825	12.60%

* NEED OVER 4% INCREASE JUST TO KEEP EVEN
** HCRIS DATA NOT UPDATED

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What are the Trends in Illinois?

FY 2022 VS. PROPOSED FY 2023 VS. AS-FILED FY 2024

CBSA	FY 2022 WAGE INDEX	FFY 2023 WAGE INDEX	FFY 2024 AS-FILED INCREASE (DECREASE)*
Elgin	1.0164	1.0226	0.30%
Kankakee	0.8837	0.9122	10.20%
Lake County IL/WI	1.0504	0.9965	8.30%
Peoria	0.8493	0.8545	0.20%
Rockford	0.9933	0.9653	(1.40%)
Rural Illinois	0.8433	0.8477	(1.40%)
Springfield	0.9020	0.8591	10.70%
St. Louis MO/IL	0.9422	0.9351	2.80%

* Need over 4% increase just to keep pace

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Wage Index Impact in Illinois

CHANGES OF 0.01 TO THE WAGE INDEX IMPACT BY CBSA

CBSA	TRADITIONAL MEDICARE	ESTIMATE WITH MEDICARE ADVANTAGE
Bloomington	$0.6 million	$0.8 million
Carbondale-Marion	$0.9 million	$1.1 million
Champaign	$1.2 million	$2.2 million
Chicago	$32.1 million	$43.4 million
Danville	$0.1 million	$0.2 million
Davenport-Moline IA/IL	$1.5 million	$2.2 million
Decatur	$1.0 million	$1.2 million

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Wage Index Impact in Illinois

CHANGES OF 0.01 TO THE WAGE INDEX IMPACT BY CBSA

CBSA	TRADITIONAL MEDICARE	ESTIMATE WITH MEDICARE ADVANTAGE
Elgin	$2.2 million	$2.9 million
Kankakee	$0.9 million	$1.1 million
Lake County IL/WI	$2.6 million	$3.0 million
Peoria	$1.6 million	$2.4 million
Rockford	$1.6 million	$2.3 million
Rural Illinois	$2.1 million	$2.5 million
St. Louis MO/IL	$13.6 million	$22.5 million

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Reclassified Wage Index

- Reclassified hospitals data included in geographic area where hospital is located & reclassified
  - Wage index is still highly important to keep meeting criteria to reclass &
  - If reclassified area is within 0.01 of the CBSA where reclassed, the reclassified hospitals get the full wage index. Example opportunities

CBSA	WAGE INDEX	RECLASSIFIED WAGE INDEX
Kankakee	0.9122	0.8987
Elgin	1.0226	1.0049
Chicago	1.0472	1.0299
Rockford	0.9653	0.9406
Danville	0.9499	0.9334

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Will the Proposed Rules Help?

- **Proposed** 5% cap on decrease
- That is still a large decrease!
- How can it help?
  - Evaluation of rural status

EXAMPLE:

Wage index FY 2022	0.9800
Times	95%
Capped Wage index	0.9310

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Where are the Opportunities in Illinois?

- Key areas of the wage index indicate that while several hospitals are reclassifying, their base wage index data is lower than national benchmarks
- Key areas for today's presentation
  - Salaries & hours
  - Physicians
  - Contract labor
  - Wage related costs, specifically health insurance
- Changes to FY 2024 data likely due September 1 or 2, 2022

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Salaries & Hours

SALARIES

- Accrual basis = financials
- COVID/Labor shortage
  - Identify bonus
  - Identify special salary payments

HOURS

- Paid basis
- Exempt = 2,080 hours
- Review pay codes
- COVID
  - Evaluate termination
  - Evaluate furlough
  - Make sure new codes are not doubling up on hours worked

Total salaries/total hours
Worksheet S-3, Part II line 1

Per HCRIS, hospitals with less than 4% increase:
Chicago: 29 out of 54 hospitals
Rest of IL: 42 out of 85 hospitals

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Physicians Part A vs. B

DEFINITION

- Part A physician time is non-patient care time performing services for hospital including provider-based clinics such as
  - Medical directors
  - Committee meetings
  - Overall department management/improvement projects
  - Other hospital administrative duties

WHY IT MATTERS?

- Omission of Part A time has a significant impact on the wage index due to high average hourly wage of physicians
- Part A salaried & contracted/total salaries, *i.e.*, Worksheet S-3, Part II, line 4 & line 13 divided by total salaries
  - National average 1.6%
  - Academic medical centers should be closer to 3.0%

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Illinois Hospitals vs. Benchmark

PHYSICIANS PART A SALARIED & CONTRACTED AS % OF SALARIES	CHICAGO	REST OF ILLINOIS
0.00%	9	12
0.01 – 1.60%	27	59
1.61 – 3.00%	12	9
> 3.00%	6	5

Small % at or above the expected 1.6% overall national benchmark
More than six academic medical centers in Illinois that should be > 3.0%

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Physician Part A/Part B Recordkeeping

Physician Contract or Employment Agreement Terms for Services To Be Provided Will Dictate:

- If a time study is required
- Carefully review the wording & of course, make sure a contract or employment agreement exits
- Total hours cannot be imputed

Time Study Frequency

- Best practice: two week time study completed quarterly
- MAC can accept (per FFY 2021 IPPS final rules): two week time study completed semiannually
- See next slide for PHE exceptions

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Physician Part A/Part B Recordkeeping

MAC Interpretation of Physician Data in Overhead Cost Centers

- Guidance per CMS
- Impact to salaried physicians vs. contracted physicians

Physician Time Studies During the COVID Pandemic Options

- One week time study every six months
- Time studies completed in the cost report period prior to 1/27/20
- Time studies from the same period in CY 2019

Opportunities FY 2024 & Beyond

PHYSICIANS

- Gather contracts & employment agreements
  - Evaluate need for addendums
  - Watch wording
- Automate time study recordkeeping
  - Tracking time is both a compliance & a reimbursement issue

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Contract Labor

KEY CONSIDERATIONS

- Only the labor component dollars & hours may be included.
- Only contract labor in these categories may be included:
  - Patient care
  - Management & administrative of routine/ancillary area
  - Administrative & general (A&G)
  - Dietary
  - Housekeeping

WHY IT MATTERS?

- Omission of contract labor has a significant impact on the wage index due to higher average hourly wage of most contracted services
- Statistics
  - Patient care under contract FFY 2024 expected close to 4% of total salaries
  - A&G under contract historically 1.5% of total salaries

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Illinois Hospitals vs. Benchmark

PATIENT CARE CONTRACT LABOR AS A % OF TOTAL SALARIES	CHICAGO	REST OF ILLINOIS
0.00 – 4.00%	29	48
> 4.00%	25	37

A&G CONTRACT LABOR AS A % OF TOTAL SALARIES	CHICAGO	REST OF ILLINOIS
0.00%	7	7
0.01 – 1.50%	26	47
> 1.50%	21	31

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Where are the Opportunities in Illinois?

CONTRACT LABOR

- **Gather contracts**
- **Gather hours**
  - Invoice
  - Contact vendor = BE PERSISTENT
- **Think beyond just the traditional nursing & therapy**
- **Focus on these categories**
  - Patient care
  - Management & administrative
  - A&G

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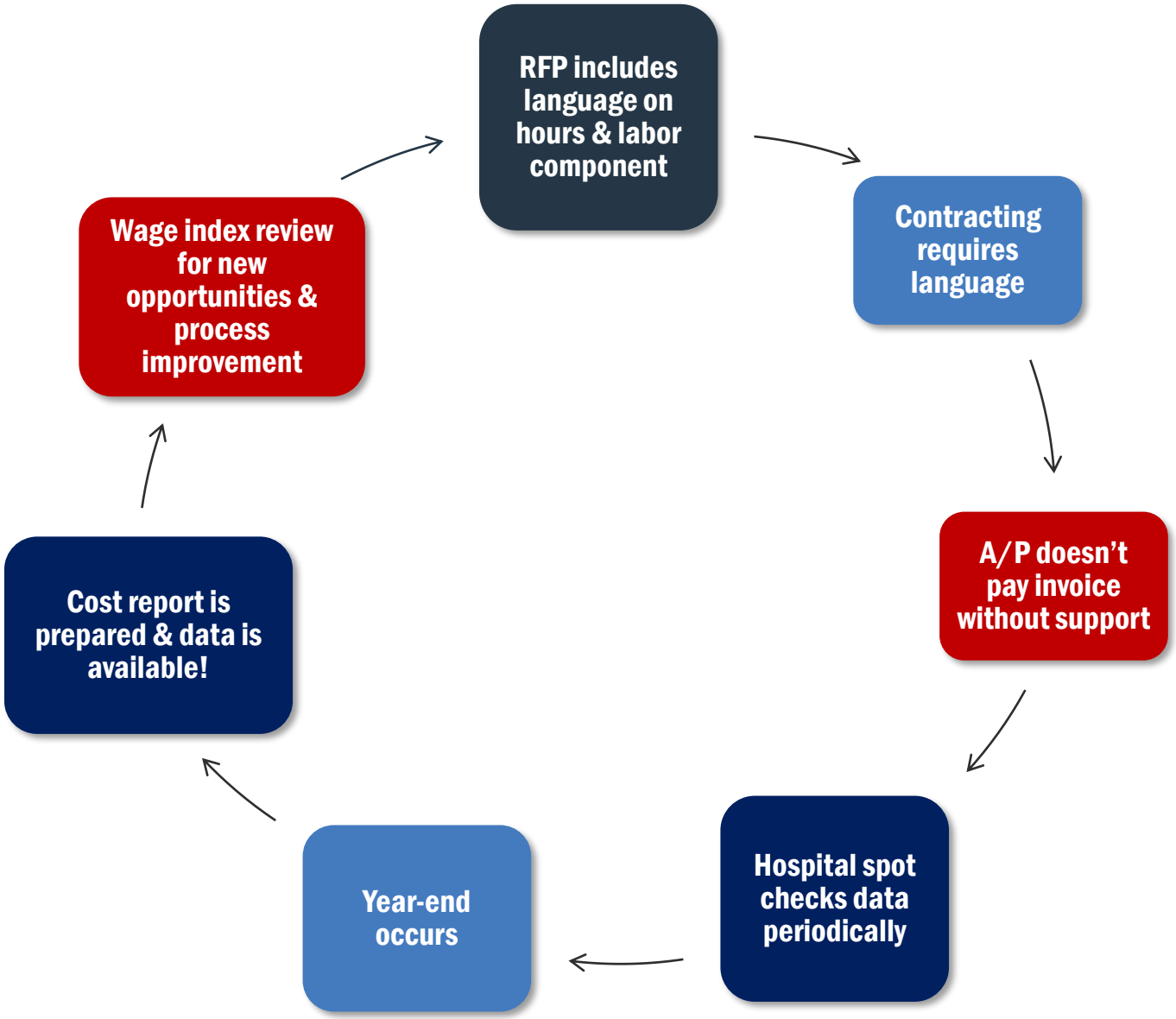
Example of Best Practice



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Wage-Related Costs

Health insurance is typically the largest component of the benefits

The national average for health insurance expense (health plus prescription drugs) per FTE is $9,677

Example of opportunity

Chicago Average health insurance per FTE = $8,414

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Self-Insured Health Insurance: Domestic Portion

If an unrelated TPA is used:

- Support tied to general ledger or claims paid report
  - Systems watch the allocation
- Payments supported by TPA reports & evidence of payment
- Market rate support
  - Top three to five commercial insurance plans
  - Payments/charges overall commercial vs. domestic plans

If related party TPA or not using TPA

- Charges times cost to charge ratios

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What Else Should You Evaluate?

MGCRB benefit & ability to reclassify may have altered

- Forecast for future periods
- Evaluate all CBSA options

Impact of seeking rural designation may have altered

- Evaluate prior forecasts

Don’t forget that the counties comprising a CBSA may change

- Monitor OMB
- Watch out for FFY 2025 IPPS proposed rules
- Change in the definition of a CBSA further out on the horizon most likely

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Academic Medical Centers

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Reminder of PHE Waivers in Place

- Holding hospitals harmless from reductions in IME payments due to increases in bed counts as a result of COVID
- Holding teaching rehab & psychiatric hospitals harmless for increases in patients
- Adjustments for time spent by residents at another hospital or at alternative locations during PHE

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Graduate Medical Education (GME) 2023 IPPS Proposals

- Section E – For discharges occurring during FY 2023 the formula multiplier is 1.35 (Estimated to increase IPPS payment by 5.5% for every 10% increase in IRB (Resident-to-bed ratio)).
- Section F – Modifies the policy for applying the GME FTE cap for certain situations when hospital's weighted FTE count is greater than its FTE cap (Milton S. Hershey Medical Center, et al. vs. Becerra)
- Section F – Allow urban & rural hospitals that participate in the same RTP to enter into a RTP Medicare GME affiliation agreement, effective for 7/1/203
- Section G – Propose to continue to reimburse for Chimeric Antigen Receptor T-cell (CAR-T) treatment stays through MS-DRG with differential reimbursement if product (drug) was part of a clinical trial.

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GME Cap Modification (Fellows)

- Tied to resolution of Milton S. Hershey Medical Center, et al. vs. Becerra & the weighting factor of residents that are beyond their IRP
- Applied prospectively for all teaching hospitals as well as retrospectively for certain providers & cost years
- Effective for cost reporting periods beginning on or after October 1, 2022
- Applicable to hospitals where the unweighted number of FTE residents exceeds the FTE cap, & the number of weighted FTE residents also exceeds the cap
- Proposal to adjust the total weighted FTE resident counts (Primary Care & Other) to make the total weighted FTE count equal to the FTE cap

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GME Cap Modification (Fellows)

- **ILLINOIS ESTIMATED IMPACTS**
  - Five academic medical centers anticipated to receive in excess of $1M of additional GME reimbursement annually
  - Eight additional providers anticipated to receive in excess of approximately $200K of additional GME reimbursement annually
  - Over $12M anticipated annual impact for IL hospitals

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Relevant & Prospective Regulatory Changes

- **SECTION 412.103 HOSPITALS**
  - New program expansion
  - IME cap increase 130%
  - Rural election with no GME cap increase
  - Capital DSH eligibility
- **CONSOLIDATED APPROPRIATIONS ACT OF 2020 “CAP RELIEF”**
  - Section 126 – 1000 GME slots for distribution over five years starting in FY 2023
  - Section 127 – “Expansion” of rural training potential
  - Section 131 – Resets low PRAs & FTE counts

Common Themes – Regulatory

- Current frenzy to take *advantage* of the increase in caps (Section 126)
- Various levels of understanding about existing or new regulations
- Short/compressed timetables for regulatory relief (Sections 126 & 131)
  - Section 126 (1000 new residency slots)
    - Application - 3/31/22
    - Notification - 1/31/23
    - Resident start date – 7/1/23
  - Section 131 (PRA & FTE reset)
    - Application – 7/1/22
    - Establish new program(s) within five years of 12/27/20

Common Themes - General

- Most large facilities are training more than their caps
  - ”Unfunded” resident positions
- Many program operations are different/changed since establishment of caps in 1996
- Significant Increase in the Section 412.103 Hospitals
- Recognition of the non-financial benefits of teaching programs
- Diverse stakeholders within most health systems
  - Financial & operational vs. medical education
  - Recognize the need for health system strategy vs. academic medical center strategy
- Funding is based on inpatient only (no IME or GME adjustment for outpatient)

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RTP Medicare GME Affiliation Agreement

- Current law requires caps on the number of FTE residents per hospital
- Current regulations allow GME affiliation agreements to share or redistribute cap slots to accommodate actual rotations
- Current regulations do not allow GME affiliation agreements for RTPs
- Proposal to allow an urban & a rural hospital participating in the same RTP to enter an "RTP Medicare GME affiliation agreement" effective July 1, 2023

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Medicare CAR-T Inpatient Reimbursement

- Hospital inpatient reimbursement is based on Ms-drg 018 adjusted for wage index, new technology add-on payments (total payment of $365k vs. $374k in PY)
- Ntap Includes (Tecartus & Abecma)
- Proposed rule uses FY 2021 Medpar data to establish payments (skipped FY 2020) & now includes much larger sample of products reducing outlier amounts
- Proposed rule increases clinical trial treatments for inpatients (total payment of $62k vs. $53k in PY)

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Where was CMS Headed with Organs?

- **PROPOSED FFY 2022 IPPS RULES**
  - Limit organ acquisition costs
  - No longer count deceased donor organs procured at hospitals

35% livers & lungs

36% kidneys

38% hearts

41% pancreas

48% of intestines

- **FINAL FFY 2022 IPPS RULES**
  - Tabled for future rulemaking

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Reminders – Cost report software revisions for organ reimbursement

- Medicare Advantage usable organs
  - No separate subscripted line, however the instructions have been updated to include Medicare Advantage beneficiary organ count to be included in Medicare usable organs
- CAR-T reporting
  - Providers are to enter information on Worksheet A line 76 subscripted along with the statistics until line 78 is established for CAR-T reimbursement. MAC will then move all information to line 78 during the desk review/audit

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Capital Payments

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Capital Exception Payment

- If more than $5M in capital expenditures beyond the hospital's control (net)
- Request to regional office within 180 days after extraordinary circumstance (PHE?)
- 85% of Medicare's Share for hospitals other than SCH who receive 100% of Medicare's share
- Difference between calculated portion & PPS capital reimbursement

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Other Impacts

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Miscellaneous Items to Anticipate

- Additional data reporting required under hospital & CAH conditions of participation
  - Pandemic monitoring & response data
- Increased reimbursement for hospitals sourcing U.S. manufactured PPE – proposals discussed
  - Potential cost reporting methods & bi-weekly passthrough payments
  - Potential add-on claim payment
  - Requesting information for policy development

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How Can Providers Respond?

HEIGHTENED FOCUS ON ACCURATELY REPORTING COST REPORT & QUALITY DATA

- Wage index drivers – contract labor, physician time studies, pay codes, etc.
- Patient statistics may drive payment variables (DSH, LVA, etc.)
- **It is often unknown how current data may be used in the future** – volume decline adjustment considerations, base rates, etc.

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Did COVID Change Your Eligibility?

LOW VOLUME ADJUSTMENT

- FFY 2022 criteria unchanged
  - Fewer than 3,600 discharges
  - 15 miles apart from like hospital
- What impact has COVID had on volume?

NOTE: Without additional legislation, FFY 2023 criteria reverts to fewer than 200 discharges

VOLUME DECLINE

- Sole community hospital/Medicare dependent hospital (MDH currently slated to expire in FFY 2023)
- 5% or greater drop in discharges beyond hospital's control
- What impact has COVID had on volume?

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How Can Providers Respond?

REVIEW POTENTIAL CMS DESIGNATIONS

- Volume fluctuations may drive eligibility criteria (SCH, MDH (if extended), RRC (CMI impact), etc.)
- Competitor changes may drive eligibility criteria
- Wage index changes may alter impact of designation as rural or MGCRB options
- New option for small PPS & CAH hospitals—rural emergency hospital status

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Thank You!

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