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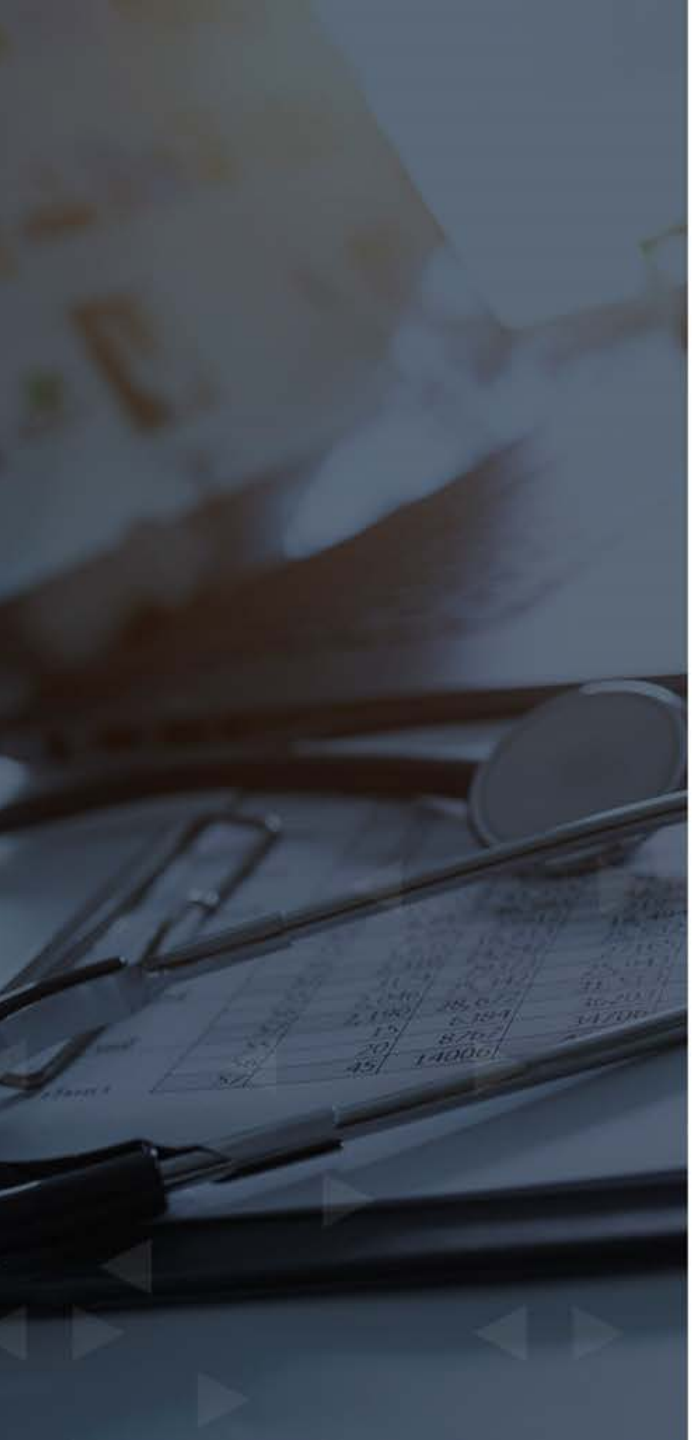

Proposed FFY 2019 IPPS Rules

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Highlights

- Overall Medicare Update
- Wage Index Changes
- Uncompensated Care / Worksheet S-10
- Low Volume Changes / MDH
- IME / GME
- HRRP, VBP, HAC
- Other Items

Overall Medicare Update

Inpatient Rate Update FY2019

FFY 2019	W/quality & meaningful use	W/quality W/O meaningful use	W/O quality W/ meaningful use	W/O quality & meaningful use
Market basket rate of increase	2.80%	2.80%	2.80%	2.80%
Adjustment if no quality data submitted			-0.70%	-0.70%
Adjustment if not meaningful use		-2.10%		-2.10%
MFP adjustment	-0.80%	-0.80%	-0.80%	-0.80%
Section 1886(b)(3)(B)(xii) adjustment	-0.75%	-0.75%	-0.75%	-0.75%
Proposed change to standardized amount	1.25%	-0.85%	0.55%	-1.55%

Documentation & Coding Adjustment

- Documentation & Coding Adjustments
  - Initially recouping $11B over 4-years (2014-2017)
    - Originally 3.9% reduction over period (only 3% paid back)
  - 0.5% rate increase for 2019, 2nd year of increases after years of significant decreases
  - 0.5% rate increases scheduled to occur in 2020-2023

Proposed changes to standardized amounts	1.25%
D&C Adjustment	0.50%
Total Update Proposed	1.75%

Capital Proposed Update

COMPARISON OF FACTORS & ADJUSTMENTS:
FY18 CAPITAL FEDERAL RATE & FY19 PROPOSED CAPITAL FEDERAL RATE

	FY18	Proposed FY19	Proposed Change	Proposed Percent Change
Update Factor	1.0130	1.012	1.012	1.20
GAF/DRG Adjustment Factor	0.9987	0.9997	0.9997	-0.03
Outlier Adjustment Factor	0.9483	0.9494	1.0012	0.12
Capital Federal Rate	$453.95	$459.78	1.0128	1.28[3]

Wage Index Changes

Section III — Proposed changes Wage Index

- Proposed national average hourly wage $42.95
  - 2.12% increase over the prior year
  - Appeals pending typically drive final increase higher
  - 80 hospitals excluded due to aberrant data
- South Carolina average hourly wage $35.07 and median of $36.09
  - AHW’s range from $24.27 to $39.92

South Carolina Proposed AWI's

- Proposed Wage Indices Beginning 10/1/18
  - Charleston 0.8804 Compared to 0.8853 in 2017 (6 Natural, 1 LUGAR, 1 MGCRB)
  - Columbia 0.8371 Compared to 0.8323 in 2017 (4 Natural, 1 LUGAR, 1 MGCRB)
  - Florence 0.8056 Compared to 0.8109 in 2017 (4 Natural, 1 LUGAR)
  - Greenville 0.8875 Compared to 0.9148 in 2017 (8 Natural, 4 MGCRB)
  - Hilton Head 0.8067 Compared to 0.8034 in 2017 (1 Natural)
  - Myrtle Beach 0.8336 Compared to 0.8232 in 2017 (3 Natural)
  - Rural 0.8056 Compared to 0.8043 in 2017 (6 Natural, 2 412.103 Elections)
  - Spartanburg 0.8423 Compared to 0.8463 in 2017 (1 Natural)
  - Sumter 0.8056 Compared to 0.8043 in 2017 (1 LUGAR)

Sumter and Florence are at the SC Rural Floor. AWI's would have been 0.6989 and 0.7725, respectively, without rural floor.

SC Hospitals also get included in Charlotte, Augusta and Savannah

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Section III — Proposed changes Wage Index

- National budget neutrality adjustment factor 0.994733
  - Imputed rural floor set to expire 9/30/18 (New Jersey, Delaware & Rhode Island).
- Hospitals that convert to CAH on or after 1/26/18 excluded for FFY19 wage index
- 1st year to use the 2016 OMS with proxy applied to hospitals that did not submit-94% response rate

Section III — Proposed changes Wage Index

- Proposed labor share - 68.3% if above 1.00
  - See Section IV
- Other wage related costs (WS S-3, Part II, ln 18)
  - Clarification on criteria to report data on this line (1% of adjusted salaries, IRS recognized benefit & taxed to employee)
  - Only 8 hospitals reported data on line 18 properly-out of 80
  - Proposed to no longer be considered - effective for FFY20

Section III — Proposed changes Wage Index

- Reclassifications
  - Reiterates 4/21/16 change to allow Section 412.103 hospitals to seek a MGCRB reclassification – RRC Election is Often Utilized By Larger Facilities
    - Some Facilities Elect Rural for Certain Benefits (i.e. SCH, MDH, RRC, 340B Thresholds, IME, etc.)
    - After Rural Election Can Potentially Have Wage Index MGCRB Reclassification
    - Specific Timing Situations Must Be Considered
    - 5 SC Hospitals Have Utilized This Option – 3 RRC & 2 SCH

Section III — Proposed changes Wage Index

- Reclassifications
  - 412.103 redesignated hospitals are excluded from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area (page 723)
  - 941 hospitals with MGCRB reclassification status in FFY19 -- up from 906 in FFY18
  - Continue to have 45 days from publication of proposed rule making to withdraw request
  - FFY20 reclassifications will be due 9/4/18
    - Further data & MGCRB information to be available mid-July

Section III — Proposed changes Wage Index

- Previously, reclassifications under 412.103 in order to be treated as rural in the wage index for next FFY, hospital must file at least 70 days prior to the second Monday in June of the current FFY and application be approved by CMS RO.
- FFY19 Change – now 60 days prior to when proposed rules become public is the “lock in date” – no specified date.
- May 30, 2018 – deadline for hospitals to dispute data corrections made by CMS

Section III — Proposed changes Wage Index other

- Multicampus hospitals – each location must meet certain criteria to qualify (SCH,MDH,RRC, etc..)
- Single hospital MSA now only needs to provide final Table from previous year to support they are only CCN listed in 3 year average, beginning with applications due 9/1/19 for FFY21
- Out-migration-735 New Table 4

Section IV — RRC

- New RRC for CRP beginning on or after 10/1/18 if rural & under 275 beds:
  - CMI of 1.66185 (previously 1.6635) national-all urban value or the median CMI value for urban hospitals for the census region (page 805)
  - CMI – SC Region – 1.5486
- Discharges same 5,000 or median of region (page 559)
  - Median of each region exceeds the 5,000 national standard; therefore, 5,000 is the minimum criterion for all hospitals except osteopathic hospitals (3,000 discharges)

Uncompensated Care & Worksheet S-10

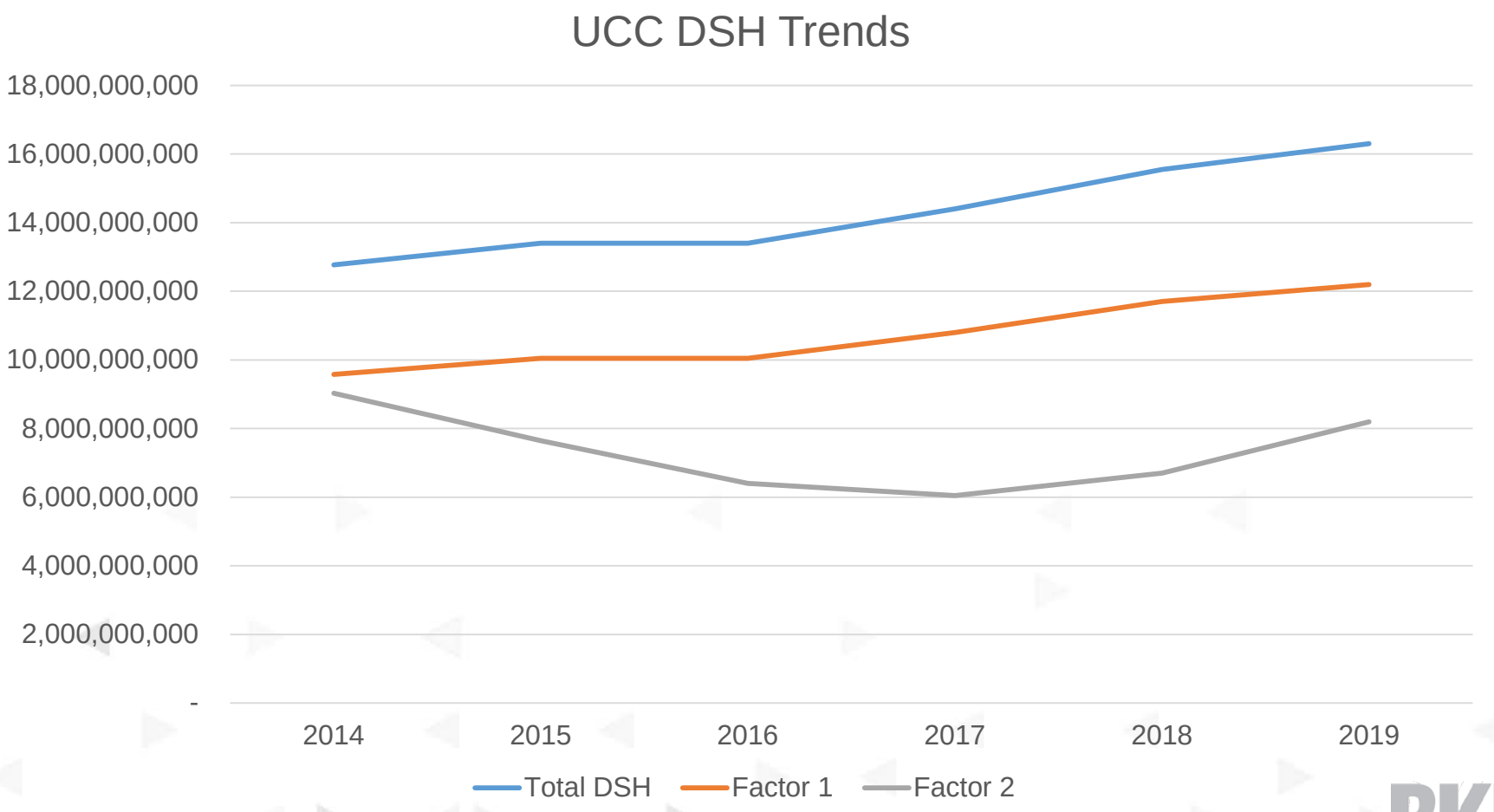
Section IV — DSH – Uncompensated Care Payments

- Factor 1 - 75% of the amount of Medicare DSH payments that would have otherwise been paid under the original DSH method
  - Adjusted FFY18 - $11,700,000,000
  - Adjusted FFY19 - $12,200,000,000
- Factor 2 - Uninsured population
  - Utilizing CMS's Office of the Actuary (OACT) estimates to determine the change in the uninsured population which is consistent with FFY18

Section IV — DSH – Uncompensated Care Payments

- Factor 2 – OACT estimate for uninsured rate
  - FFY18 – 9.1%
  - FFY19 – 9.6%
- Factor 2: Adjustment factor applied to the uncompensated care amount
  - FFY18 – 58.01%
  - FFY19 – 67.51% (weighted)
- Factor 2 – Uncompensated care pool
  - FFY18 – $6.7 billion ($6,766,695,164)
  - FFY19 – $8.2 billion ($8,250,415,972)

UCC DSH Trending



Section IV — DSH – Uncompensated Care Payments

- Factor 3
  - Proposed rule includes S-10 updated in HCRIS through February 15, 2018
  - Will use HCRIS data updated through May 31, 2018 for the final rule
  - S-10 data changed for FY14 & FY15 for **roughly 50%** of the hospitals eligible to receive Medicare DSH payments
  - Expect changes in Factor 3 in Final Rule

Section IV — DSH – Uncompensated Care Payments

- Hospital's uncompensated care as a percentage of the total uncompensated care for all eligible hospitals
  - Step 1: Low-income insured days proxy based on FY13 cost report Medicaid days & the FY16 SSI ratios
  - Step 2: FY14 Worksheet S-10 charity care & bad debt expense data
  - Step 3: FY15 Worksheet S-10 charity care & bad debt expense data
  - Step 4: Average of the values computed in Steps 1, 2, & 3 to determine the hospital specific Factor 3
  - FY20 would be the first year using three years of S-10 data to allocate uncompensated care payments, based on FY14, FY15 & FY16
  - When reviewing FY16 S-10 information for FY20, it is possible the 3 year averaging will be eliminated

Section IV — DSH – Uncompensated Care Payments

- Key takeaways
  - Factor 1 & Factor 2 methodology is consistent with FFY 2018
  - Factor 3 is consistent & includes one more year of S-10 information & one less year of Medicaid days/SSI%
  - Maintain auditable documentation for charity care & bad debt amounts
  - Comply with Worksheet S-10, 2552-10 Transmittal 11
  - Cost report periods beginning on or after October 1, 2016, write-offs are based on date of write-off (no longer date of service)
  - No indication of Medicare audit time line or review process

Regulation Updates S-10

Medicare

Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10

Department of Health and Human Services (DHHS)

Centers for Medicare and Medicaid Services (CMS)

Transmittal 10 — **Date: November 18, 2016**

Medicare

Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 11 — **Date: September 29, 2017**

Updates to Medicare's Cost Report Worksheet S-10 to Capture Uncompensated Care Data

MLN Matters Number: SE17031
Related Change Request (CR) Number: N/A
Article Release Date: September 29, 2017
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Key Changes in Instructions

1. Clarification of definition of charity care, includes uninsured discounts (according to hospital's FAP)
2. Medicare and non-Medicare bad debts must be net of recoveries
3. Addition of line 27.01, to separate Medicare and non-Medicare bad debts
4. Modification calculation of costs on insured charity care charges not subject to CCR
5. Non-covered services beyond length of stay limit subject to CCR
6. Application of CCR to non-Medicare bad debts
7. Non-reimbursed Medicare bad debts (ded/coins) non subject to CCR

Change in Factor 3

PROV	Hospital Name	2019 -F3	2018 -F3	Change	% Change
420007	Spartanburg Regional Medical Center	0.001797632	0.001160247	0.000637385	54.9%
420078	GHS Greenville Memorial Hospital	0.002634629	0.002192589	0.000442040	20.2%
420079	Trident Regional Medical Center	0.000823075	0.000518414	0.000304661	58.8%
420048	Kershaw Health	0.000410675	0.000205297	0.000205378	100.0%
420065	St. Francis Xavier Bon Secours	0.000561514	0.000357062	0.000204452	57.3%

PROV	Hospital Name	2019 -F3	2018 -F3	Change	% Change
420106	Palmetto Health Baptist Parkridge	0.000159318	0.000197755	-0.000038437	-19.4%
420091	Carolinas Hospital System	0.000346659	0.000412131	-0.000065472	-15.9%
420004	Medical University of SC	0.002267075	0.002340192	-0.000073117	-3.1%
420086	Palmetto Baptist	0.000614475	0.000736803	-0.000122328	-16.6%
420018	Palmetto Richland	0.001700904	0.002055988	-0.000355084	-17.3%

Changes in South Carolina

PROV	Hospital Name	Factor 3	Proposed 2019	Final 2018	Change
420007	Spartanburg Regional Medical Center	0.001797632	14,831,212	7,851,038	6,980,174
420078	GHS Greenville Memorial Hospital	0.002634629	21,736,785	14,836,581	6,900,204
420079	Trident Regional Medical Center	0.000823075	6,790,711	3,507,950	3,282,761
420004	Medical University of SC	0.002267075	18,704,312	15,835,366	2,868,946
420027	ANMED Health	0.000865662	7,142,072	4,706,047	2,436,025
420065	St. Francis Xavier Bon Secours	0.000561514	4,632,724	2,416,130	2,216,594
420073	Lexington Medical Center	0.001079169	8,903,593	6,829,788	2,073,805
420048	Kershaw Health	0.000410675	3,388,240	1,389,182	1,999,058
420085	Grand Strand Regional Medical Center	0.000550984	4,545,847	2,775,549	1,770,298
420051	McLeod Regional Medical Center	0.001154751	9,527,176	7,766,095	1,761,081
420002	Piedmont Medical Center	0.000632449	5,217,967	3,471,524	1,746,443

- No decreases noted over the prior year.

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Low Volume Changes / MDH

Section IV — Low Volume adjustment

- Hospitals must submit written request to MAC by September 1, 2018
  - Criteria for FFY19 based on proposed changes made by the Bipartisan Budget Act of 2018 for FYs 19 - 22.
    - Mileage – more than 15 miles from nearest “like” hospital
    - Discharges – based on total discharges less than 3,800

Section IV — Low Volume adjustment

- Percentage increase determined using:
  - Continuous, linear sliding scale
  - ≤ 500 discharges – Additional 25% payment adjustment
  - > 500 - < 3,800 discharges – Additional payment adjustment is calculated using formula = [(95/330) x (# of total discharges/13,200)] ***error in formula***
  - Actual Formula – B < 3,800 = 0.25 – (B – 500)/ (3800-500)x0.25
  - > 3,800 discharges – 0% additional payment adjustment
  - Discharges are not payor specific

Section IV — MDH and SCH programs

- Extends MDH status from 2018 - 2022
  - Existing MDH classification as of 9/30/17
  - No need to reapply for MDH classification
- Proposed effective date change for rural reclassification, SCH status and MDH status for the payment adjustment to be the date that CMS receives the complete SCH application

IME / GME

Section IV — IME

- Same multiplier of 1.35 proposed
  - Estimate continues to yield an increase of 5.5% for every 10% increase in the hospital's resident to bed ratio

Section IV — IME/GME

- Affiliation agreement change
  - “Urban teaching hospitals that qualify for an adjustment to its FTE cap & receive an adjustment that is a decrease to the urban hospital’s FTE cap, only if the decrease results from a Medicare GME affiliated group consisting solely of two or more new urban teaching hospitals that qualify to receive adjustments to their FTE cap is under 413.79 (e)(1). Due date for affiliation agreement is July 1, 2019.
  - Goal is to provide a change in caps to existing hospitals in order to train hospitals in a new teaching hospital
  - This previously was disallowed & viewed to be “gaming” the system establishing hospital caps
  - Must be consistent with the intent of the Medicare GME affiliation agreement; to promote the cross-training of residents at participating hospitals & not to provide an unfair advantage of one hospital at the expense of another hospital

HRRP, VBP, HAC

Section IV — Readmission

- Applicable period for FY19 – FY21
- Six readmission measures in the HRRP deemed appropriately included
- The adjustment factor ranges between 1.0 (no reduction) and 0.9700 (largest reduction)
- Claim data is based on MedPar files from July 1, 2014, through June 30, 2017

Section IV — Value based purchasing

- Proposed removing 10 measures for the Hospital VBP Program
  - FY21 proposed to remove 8 measures (including entire Safety Domain)
  - FY22 & FY23 proposed to remove 1 additional measure each year
- Proposed removing the three out of four condition-specific payment measures & proposed to weigh the remaining 3 domains effective FY21 (50/25/25)
- Published in Table 16

Section IV — Hospital-acquired conditions

- 1% payment reduction if you rank in the top 25% quartile of all applicable hospitals
- Actual measures are unchanged. Collection, validation, & reporting of measures may change depending on proposed changes to the Hospital IQR program.
- Proposing to remove domains & assign equal weighting to each measure applicable to the hospital
- Seeking comments on potential of additional measures, including eCQMs (electronic clinical quality measures)

Other Items

Section X — Requirement for hospitals to post their charges to the internet

- CMS is looking for comments on a variety of issues related to pricing transparency
  - On January 1, 2019 guidelines will be updated to require hospitals to make available a list of their current standard charges in a machine readable format via the Internet that is updated at least annually
  - CMS asks multiple questions regarding how this will work as well as other potential ways to help patients navigate pricing
    - Definition of “standard charges”?
    - How should CMS enforce pricing transparency?
    - Many others related to what information hospitals could potentially be required to provide to patients prior to receiving services
    - CMS is also looking at these related to Medigap coverage

Section IX — Medicare cost reporting & provider requirements

- Changes to Supporting Documentation Requirements (periods beginning on/after 10/1/18)
  - Removing reference to Reimbursement Questionnaire
  - Detail reports with required columns of patient data will have to be included with the initial cost report submission or it will be rejected
    - Charity Care & Uninsured Discounts for S-10
    - Bad debts (Exhibit 2)
    - DSH
      - Can still file amended cost reports within 12 months to add additional days, but new detail must be submitted again

Section IX — Medicare cost reporting & provider requirements

- Changes to Supporting Documentation Requirements (cont)
  - IRIS data will be required to contain the same total counts of IME/GME FTEs as what is on the cost report
  - All cost reports that claim home office costs but don’t include a Home Office Cost Statement with the submission packet will be rejected
    - Some PPS providers didn’t think it was required

Section XII — Request for info: promoting interoperability & elect HC info exchange

- Hospitals must use EHR tech certified in 2015 edition
- Draft of Trusted Exchange Framework & Common Agreement released in January 2018 contains four goals:
  - Professional Care Providers have access to patient info across continuum
  - Patients can find all their health info across continuum
  - All needed groups can find info on population groups
  - Health IT community has access to Application Programming Interface
- Draft of TEF finalized after public comment
- CMS considering changes to Hospital COPs requiring electronic transfer of info to other providers
  - Goes farther than the proposed rules to implement the IMPACT Act

Section IV — Proposed revision of Hospital Inpatient admission Orders documentation requirements under Medicare Part A

- Proposing to remove language stating that the written inpatient admission (physician) order to be present in the medical record, in order to receive Medicare Part A payment
- No proposed changes to the 2-Midnight payment policy
- Proposed discharges to hospice care will also qualify as postacute care transfer and be subject to payment adjustments

Thank You!

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