Medicare Payment Cut Analysis – November 2013 Update

-Version 1, November 2013-

Analysis Description

The Medicare Payment Cut Analysis – November 2013 Update is intended for advocacy purposes and to support your understanding of how existing Medicare provider payment cuts would be exacerbated by additional cuts that Congress may consider to achieve Medicare payment policy and/or long-term deficit reduction goals. The analysis has been updated from a prior version (released in February 2013) to reflect additional provider payment cuts under consideration by Congress.

The existing payment cuts analyzed consist of:

- selected cuts authorized by the Affordable Care Act (ACA) of 2010;
- the effect of the 2.0% across-the-board reduction to payments authorized by the Budget Control Act (BCA) of 2011 (sequestration);
- the reduction in bad debt payments authorized by the Middle Class Tax Relief and Job Creation Act of 2012;
- inpatient coding adjustment reductions and outpatient payment cuts for radiosurgery services authorized by the American Taxpayer Relief Act (ATRA) of 2012; and
- regulatory coding adjustments implemented by the Centers for Medicare and Medicaid Services (CMS).

The payment cuts analyzed that Congress may consider consist of outpatient payment changes, graduate medical education cuts, bad debt payment cuts, and cuts to rural programs, among others. These potential options are consistent with recommendations put forward by the Simpson-Bowles Commission in December 2010, a provision of U.S. House bill H.R. 3630 approved by the House in December 2011, recommendations included in the Congressional Budget Office's (CBO's) deficit reduction report published in November of 2012, and policy options put forward by the Medicare Payment Advisory Commission (MedPAC) in June 2013 and the Office of the Inspector General (OIG) in August 2013.

The analysis includes a report with a bar chart that shows the year-by-year dollar impacts of the existing payment cuts and additional cuts under consideration. A data table with 10-year summary values is also provided. The dollar impacts for the "Cuts under Consideration" are 10-year impacts that graphed for a 9-year period beginning 2014, the first possible year of implementation.

In addition, the analysis includes a data point that evaluates the existing legislative and regulatory Medicare fee-for-service (FFS) payment cuts as a percent of total Medicare FFS revenue. This estimate helps put into context the level of payment cuts being absorbed by hospitals and health systems over the next 10-years.

This value is calculated by first estimating and aggregating Medicare FFS revenue over a 10-year period (2013-2022) without the effect of existing legislative or regulatory payment cuts. Then, the estimated impact of the existing legislative and regulatory payment cuts (shown on the left side of the report) over the same 10-year period are aggregated and divided by the aggregate revenue calculated in the first step. The result is a 10-year summary value of the existing legislative and regulatory Medicare FFS payment cuts as a percent of total Medicare FFS revenue. This number does not include any of the additional cuts under consideration (shown on the right side of the report).

This analysis projects impacts on Medicare FFS revenues for the following care settings (where applicable):

- Inpatient hospital;
- Outpatient hospital;
- Inpatient Rehabilitation Facility (IRF) -- hospital-based and free-standing;
- Inpatient Psychiatric Facility (IPF) -- hospital-based and free-standing;
- Skilled Nursing Facility (SNF) --hospital-based;
- Home Health (HH) -- hospital-based; and
- Long-Term Care Hospital (LTCH) -- free-standing.

This analysis evaluates Medicare FFS payments only. It does NOT reflect any estimated payment changes for Medicare Advantage patients nor does it show potential changes in revenues from non-Medicare payers, such as the potential positive revenue impacts, beginning in 2014, of expanded health insurance coverage under the ACA. Also, all components related to facility operations are held constant for each cut analyzed (e.g. volume, case-mix, etc.) in order to measure the impact of policy changes only.

Dollar impacts shown in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods. Dollar impacts have been rounded to the nearest hundred dollars; hence, totals may not sum and dollar amounts less than $50 will appear as zeros due to rounding.

Data Sources and Methods Used to Calculate Impacts

The following describes the data sources and methods used to calculate the payment impacts:

Existing Legislative Medicare Cuts Analyzed:

- ACA Cuts: The impact shown reflects the ACA-authorized hospital/health system Medicare payment cuts and include: update factor cuts (all provider settings); payment cuts and changes related to the mandatory quality-based payment reforms of value-based purchasing (VBP), the readmissions reduction program, and the hospital-acquired conditions (HAC) payment policy (inpatient hospitals); and Medicare Disproportionate Share Hospital (DSH) payment cuts (inpatient hospitals) The impact shown does not capture ACA update factor cuts implemented prior to 2013 that carry forward additional negative impacts in the budget window analyzed.

  Data Source(s)/Method(s):

  - Update Factor Cuts (all provider settings): Medicare payment data is from:
    - Inpatient hospital: CMS' federal fiscal year (FFY) 2013 IPPS final rule Impact File;
    - Outpatient hospital: CMS' CY 2013 OPPS proposed rule Impact File;
    - IRF: CMS' FFY 2013 IRF PPS final rule Impact File;
    - IPF: Medicare cost report data (latest of 2009 or 2010);

- SNF: Medicare cost report data (latest of 2008, 2009, or 2010) – reflects revenue based on payments using Resource Utilization Groups (RUGs)-III patient classification system and therefore, does not account for payment changes due to the implementation of RUGs-IV in FFY 2011;
- LTCH: CMS' FFY 2012 LTCH PPS final rule Impact File; and
- HH: Medicare cost report data (latest of 2008, 2009, or 2010) – reflects revenue based on payments using the Home Health Resource Group (HHRG) weights applied in 2008, 2009, or 2010 and therefore, does not account for the HHRG weight changes and subsequent payment changes implemented in CY 2012.

  The impact is calculated by estimating baseline revenue at the full projected marketbasket value as provided by CMS (calculated by Global Insight, Inc. for the fourth quarter of 2011). The baseline is then compared to estimated revenue at the ACA-reduced marketbasket value.

o VBP (inpatient hospital): The VBP adjustment factor applicable under the inpatient hospital VBP program and subsequent impact is based on final VBP data issued by CMS in December 2013. Quality performance is held constant in this analysis and payment impacts are based on performance for this point in time (the FFY 2013 VBP Program for eligible hospitals). Payment impacts are inflated each year by the marketbasket factor and corresponding increase in the VBP carve-out factor (the amount of inpatient payments at risk under program).

  Updated FFY 2013 VBP adjustment factors from March 2013 and adjustment factors for FFY 2014 are not considered in this analysis.

o Readmissions Reduction Program (inpatient hospital): The readmissions adjustment factor applicable under the Readmissions Reduction Program and subsequent impact is based on final readmissions data from CMS' FFY 2013 IPPS final rule impact file and subsequent correction notice. Quality performance is held constant in this analysis and payment impacts are based on performance for this point in time (the FFY 2013 Readmissions Reduction Program for eligible hospitals). Payment impacts are carried forward into future years by allocating the CBO's originally estimated national impact of the payment change to each hospital based on current performance.

  Updated FFY 2013 Readmissions adjustment factors from March 2013 and adjustment factors for FFY 2014 are not considered in this analysis.

  HAC Payment Policy (inpatient hospital): *The HAC impacts included in this analysis were developed prior to CMS adopting policies for how the actual program will function. As a result, the measures analyzed and methods used in this analysis are not the actual measures/methods adopted by CMS in the FFY 2014 IPPS final rule. Actual impacts due to this policy will differ from those provided in this analysis.*

  HAC data is from the FFY 2011 Medicare inpatient claims file (MedPAR). Payment impacts are based on program policies as originally outlined in the ACA and Medicare payment data provided by CMS in the FFY 2013 IPPS final rule Impact File. Quality performance is held constant in this analysis and payment impacts are based on performance for this point in time. Payment impacts are inflated each year by the marketbasket factor.

  Medicare DSH Payment Changes (inpatient hospital): *The DSH impacts included in this analysis were developed prior to CMS adopting policies for how the actual ACA mandated DSH payment changes will be applied. As a result, the data and methods used in this analysis do not match the*

data and methods adopted by CMS in the FFY 2014 IPPS final rule. Actual impacts due to this policy will differ from those provided in this analysis.

Medicare payment data is from CMS' FFY 2013 IPPS final rule Impact File. This provision was analyzed by allocating CBO's originally estimated national impact of the payment change to each hospital's current share of the Medicare DSH program. While this payment change will begin in 2014, CBO's national estimates begin in 2015.

- Sequestration Cuts (all provider settings): The impact shown reflects the BCA-authorized 2.0% sequester reduction on total Medicare payments for a 9-year period (2013-2021–the two-month delay in sequestration cuts legislated under the ATRA is accounted for in this analysis).

  Data Source(s)/Method(s): Inpatient, Outpatient, IRF, and LTCH impacts are based on Medicare payment data provided by CMS in the FFY 2013 payment rule Impact Files. IPF, SNF, HH, Critical Access Hospitals (CAH), cancer hospital, and children's hospital impacts are based on Medicare payments reported on the Medicare cost report (latest of 2008, 2009, or 2010). The impact is calculated by applying a 2.0% reduction to estimated revenues in each applicable care setting. CMS has not released guidance on how sequestration will be implemented. The 2.0% adjustment is applied to all Medicare lines of payment, including those outside of the PPS rate and not shown in this analysis, i.e., Direct Graduate Medical Education. Payments to Medicare Advantage plans will also be reduced, but the potential effect on providers will depend on the terms of each individual contract.

- Bad Debt Payment Cuts (all provider settings): The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012-authorized reduction to Medicare payments for reimbursable bad debts for all provider settings to 65%.

  Data Source(s)/Method(s): Medicare bad debt payment data is from the Medicare cost report (latest of 2008, 2009, or 2010) for the following settings: Inpatient, Outpatient, IRF, IPF, SNF, LTCH, and HH. The impact shown reflects the reduction in Medicare payment, beginning 2013, for reimbursable bad debts for all provider settings from 70% to 65%. Payments to CAHs will phase-down from the full amount to 65% (88%, 76%, 65%).

- Coding Adjustment Cuts (inpatient hospital) and Radiosurgery Payment Cut (outpatient hospital): The impact shown reflects the ATRA of 2012-authorized retrospective (one-time) coding adjustment cuts totaling around $11.0 billion that CMS must implement over a 4-year period (FFY 2014-2017). If applicable, the impact of the ATRA provision that reduces the outpatient payment amount for certain stereotactic radiosurgery services beginning April 1, 2013 and thereafter is also shown.

  Data Source(s)/Method(s): Coding adjustment impacts are based on Medicare inpatient hospital payment data provided by CMS in the FFY 2013 IPPS final rule Impact File. The impact is calculated by estimating baseline revenue at the full projected marketbasket value as provided by CMS (calculated by Global Insight, Inc. for the second quarter of 2012). The baseline is then compared to estimated revenue after applying the coding adjustments.

  If applicable, the outpatient radiosurgery impacts are based Medicare outpatient data from the 2011 outpatient claims data file for the Healthcare Common Procedure Coding System (HCPCS) codes affected by this payment change (codes 77371 and G0173). The estimated impact is calculated by setting the payment amount for stereotactic radiosurgery services defined by HCPCS code 77371 to the lesser payment amount for stereotactic radiosurgery services defined by HCPCS code G0173. Rural hospitals, Rural Referral Centers (RRCs), and Sole Community Hospitals (SCHs) are exempt from this policy and are identified using payment data provided by CMS in the FFY 2013 IPPS final rule Impact File. Impacts shown for exempt cancer hospitals do not take into consideration the potential applicability of outpatient hold

harmless payments. Due to data limitations, impacts for flat rate hospital potentially subject to this cut are not shown in this analysis.

Existing Regulatory Medicare Cuts Analyzed:

- Coding Adjustment Cuts: The impact shown reflects the CMS-imposed prospective (permanent) coding adjustment cuts of 1.9% in (0.5% for hospitals paid at the hospital-specific rate) in 2013 (inpatient hospitals) and, if applicable, 1.32% in 2013 (HH providers). The impact shown does not capture CMS coding adjustment cuts implemented prior to 2013 that carry forward additional negative impacts in the budget window analyzed.

  Data Source(s)/Method(s): Medicare inpatient hospital payment data provided by CMS in the FFY 2013 IPPS final rule Impact File. If applicable, impacts for HH providers are based on Medicare revenues reported on the Medicare cost report (latest of 2008, 2009, or 2010). The impact is calculated by estimating baseline revenue at the full projected marketbasket value as provided by CMS (calculated by Global Insight, Inc. for the fourth quarter of 2011). The baseline is then compared to estimated revenue after applying the coding adjustments.

Additional Medicare Cuts Under Consideration Analyzed:

- OPD/Physician Payment Equalization-E/M Services (source: H.R. 3630): The impact shown reflects the U.S. House-approved policy to cap payment to hospitals for outpatient (OPD) evaluation and management (E/M) services at the payment level provided to physicians in non-hospital based freestanding offices under the Medicare physician fee schedule (PFS).

  Data Source(s)/Method(s): Medicare outpatient data is from the 2010 outpatient claims data file for the services that would be affected by this payment change (service codes 99201 through 99215). The new payment amounts are from the 2011 PFS. The impact is estimated by taking the difference between traditional OPD rates from 2011 and the newly defined payment levels for these services. This estimated changed in the national rates is then applied to hospital payments across these particular APCs to calculate dollar impacts.

- OPD/Physician Payment Equalization-Targeted Services (source: MedPAC policy option): The impact shown reflects a MedPAC policy option to cap payment to hospitals for certain outpatient services (66 APCs) at the payment level provided to physicians in non-hospital based freestanding offices under the Medicare PFS.

  Data Source(s)/Method(s): Medicare outpatient data is from the 2011 Standard Analytic File (SAF) for the services that would be affected by this payment change. The new payment levels are estimated by calculating a weighted average payment amount for each of the MedPAC-identified APCs using service-level payment rates and factors from the 2013 PFS and national outpatient volumes from the claims data. The impact is estimated by taking the difference between traditional OPD rates for 2013 and the newly calculated payment levels for these services. This estimated change in the national rates is then applied to hospital payments across these particular APCs to calculate dollar impacts.

  Under the MedPAC policy, rates for individual APCs are estimated to both decrease and increase. In limited circumstances, hospital-specific results may yield positive impacts. Nationwide, the policy results in a reduction in payment under the OPPS.

- OPD/ASC Payment Equalization-Targeted Services (source: MedPAC policy option): The impact shown reflects a MedPAC policy option to cap payment to hospitals for certain outpatient ambulatory surgical services (12 APCs) at the payment level provided to Ambulatory Surgical Centers (ASCs) under the ASC payment system.

  Data Source(s)/Method(s): Medicare outpatient data is from the 2011 outpatient claims data file for the services that would be affected by this payment change. The new payment levels are estimated by calculating a weighted average payment amount for each of the MedPAC-identified APCs using service-level payment rates from the 2013 ASC payment system and PFS and national outpatient volumes from the claims data. The impact is estimated by taking the difference between traditional OPD rates for 2013 and the newly calculated payment levels for these services. This estimated changed in the national rates is then applied to hospital payments across these particular APCs to calculate dollar impacts.

- IME Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to cut inpatient Indirect Medical Education (IME) payments in half by reducing the IME reimbursement percentage of 5.47% to 2.2%.

  Data Source(s)/Method(s): IME payment data is from the Medicare cost report (latest of 2008, 2009, or 2010). The impact is calculated by estimating the difference between estimated IME payments at current levels and estimated IME payments at the reduced value.

- DGME Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to limit teaching hospital's Direct Medical Education (DGME) reimbursement to 120% of the national average salary paid to residents in 2010, updated annually thereafter.

  Data Source(s)/Method(s): DGME impacts are based on payments under current law using the hospital-specific Per-Resident Amounts as reported in the Medicare cost report (latest of 2008, 2009, or 2010) compared to estimated payments that limit DGME payments to 120% of the national average salary paid to residents in 2010, updated annually thereafter.

- Bad Debt Payment Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to eliminate payment for reimbursable bad debts for all provider settings.

  Data Source(s)/Method(s): Medicare bad debt payments reported on the Medicare cost report (latest of 2008, 2009, or 2010) for the following settings: Inpatient, Outpatient, IRF, IPF, SNF, LTCH, and HH. The impact reflects the complete phase-out of these payments when compared to payment at current levels.

- SCH Program Elimination (source: Congressional Budget Office): The impact shown reflects the recommendation to eliminate special inpatient payment status for sole community hospitals (SCHs).

  Data Source(s)/Method(s): Impacts for SCHs are based on Medicare inpatient payments at the current hospital-specific rate compared to federal rate payments using Medicare inpatient hospital payment data provided by CMS in the FFY 2013 IPPS final rule Impact File.

- CAH Payment Cuts (source: OIG policy option): The impact shown reflects an Office of the Inspector General (OIG) policy option to eliminate and replace Medicare reasonable cost-based payment to certain Critical Access Hospitals (CAHs) targeted by the OIG with payment under the Inpatient and Outpatient Prospective Payment Systems. Specifically, the OIG policy would target hospitals that achieved CAH status under special exceptions but do not meet the statutory location criteria.

  Data Source(s)/Method(s): Inpatient impacts are calculated using a combination of Medicare cost reports (2011 or 2012 in most cases); payment rates and factors from the FFY 2014 IPPS; and FFY inpatient claims

data from the FFY 2011 Medicare Provider Analysis and Review (MedPAR) file. Outpatient impacts are based on Medicare cost report data (2011 or 2012 in most cases). The impacts do include the potential reduction such a policy would have on payment for swing bed services.

Based on the data and methods used in this analysis, payment for inpatient services for several CAHs is estimated to increase compared to current CAH payment levels (outpatient payments can only decrease based on the methodology used in this analysis). As a result, in limited circumstances, hospital-specific results may yield positive impacts. Nationwide, the policy results in a reduction in payment for CAHs.