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Tomorrow's Doctors, Tomorrow's Cures

FY 2013 Inpatient PPS Proposed Rule Teleconference

Learn
Serve
Lead

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Important Info on Proposed Rule

- In *Federal Register* on May 11 – available at http://www.gpo.gov/fdsys/pkg/FR-2012-05-11/pdf/2012-9985.pdf
- Comments due **June 25, 2012**

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Topics for Today's Teleconference

- Market Basket Update
- Documentation & Coding Update
- GME-Related Proposals
  - Counting L&D bed days for IME
  - Building a cap as a new teaching hospital
  - 5503 Unused Resident Slot Redistribution
  - 5506 Slot Redistribution from Closed Hospitals
  - Shadow claims & billing
- Wage Index Reports
- Services Furnished Under Arrangements
- Quality Payment Programs
- New Technology Add-On Payments
- Outliers

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IPPS Payment Update

- CMS estimates 0.9% update for hospital operating payments
  - Does *not* include L&D bed proposal that cuts IME
  - Does *not* include sequestration (-2%)

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FY 2013 Market Basket Update

- Market basket projected increase = 3.0 percent
- Less 2 percent if hospital doesn't submit quality data
- Less multi-factor productivity adjustment = 0.8 percent
- Less an additional 0.1 percent (ACA)
- Less 1.9 percent due to perceived documentation and coding impacts (related to FYs 2008 and 2009)
- Less 0.8 percent due to perceived documentation and coding impacts (related to FY 2010)
- Plus 2.9 percent restored that was taken out for documentation and coding in FY 2012

How did CMS get to 0.9 percent?

Policy	Impact
Market Basket Update	+3.0%
Productivity Adjustment	-0.8%
ACA Required Adjustment	-0.1%
’08/’09 Prospective Doc & Coding	-1.9%
’10 Doc & Coding	-0.8%
Removing ’12 Doc & Coding Recoupment	+2.9%
Outlier Adjustment*	-0.9%
Readmissions Adjustment	-0.3%
Expiration of MDH Special Status	-0.1%
Expiration of Sec. 508 Reclassifications	-0.1%
Weighted Impact of SCH Update	-0.1%
Frontier Wage Index Floor	+0.1%
TOTAL	+0.9%

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Documentation & Coding Adjustment

History:

- Transition to MS-DRGs - FY 2008
- CMS projected increase in average case-mix index (CMI), especially in initial years, b/c of improved medical record documentation & more complete and accurate coding
- CMI changes of this nature increase payments to hospitals, but do not reflect the type of real increases in the severity of cases that require additional hospital resources

Documentation & Coding Adjustment

	Remaining prospective adjustment for FYs 2008-2009	Prospective adjustment for FY 2010	Proposed prospective adjustment for FY 2013	Removal of onetime recoupment adjustment in FY 2013	Combined proposed documentation & coding adjustment for FY 2013
Level of Adjustments…….	-1.9%	-0.8%	-2.7% (= -1.9 -0.8)	+2.9%	+0.2%

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L&D Bed Proposal

- CMS would now count ancillary labor & delivery beds in IME available bed count
- Will drive down IRB ratio and IME payments
- CMS estimates $170 million cut to IME payments in FY 2013

Some good news for new teaching hospitals…

- New teaching hospitals would have 5 year window (instead of 3 year window) to build DGME and IME caps
  - Effective only prospectively though (for hospitals that begin training residents on or after 10/1/12)
- Also proposal for apportionment plan when residents in new programs train in more than one hospital during the cap-building period

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Proposal for Apportionment Plan for New Teaching Hospitals

If residents in new program ("Hospital A") rotate to other hospitals during 5-year window, to calculate cap for Hospital A:

- (1) Look at 5th year – ask: which is highest PGY year FTE count, if you add time spent in all hospitals?
- (2) Multiply that number of FTEs by minimum accredited length of program
- (3) Determine % of time residents in that program spent in Hospital A *over 5 years*
- (4) Multiply #2 by #3

Detailed examples set out in proposed rule…

Unused Resident Limit Redistribution Program (§ 5503)

- 65% of FTE slots unused over 3 years redistributed to other hospitals
- Statute required redistribution to certain states
  - Lowest resident-to-population ratios
  - Highest proportion of population in HPSAs
  - Rural hospitals
- Awardees announced in August 2011
- For 5 years, awardees must:
  - Use 75% of additional slots for primary care or general surgery
  - Maintain 3-year primary care average

IPPS Proposals re: § 5503 Slots

Hospital that was awarded slots would have to:

- Use half of its awarded slots w/in at least one of the first 3 cost reporting periods of the 5 year evaluation period
- Use *all* awarded slots in the final cost reporting period of evaluation period

IF HOSPITAL DOES NOT MEET BOTH REQUIREMENTS, WOULD LOSE ENTIRE AWARD.

§ 5506 Closed Hospital Slot Redistribution

- ACA requires redistribution of DGME & IME slots from hospitals that close
  - Geographic preference
  - Preference for taking over closed programs
- First round of slots awarded 1/30/12
  - Came from 14 hospitals that closed 3/23/08 through 8/3/10
  - 662 IME slots redistributed to 57 hospitals
  - 695 DGME slots redistributed to 62 hospitals
- Next round = St. Vincent's (NY) – by end of 2012
- Future announcements coming…

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§ 5506 New Guidance Posted

- "Miscellaneous Guidelines Regarding the Section 5506 Application Process" posted on CMS website April, 2012
- Advice regarding application, including re:
  - What contact info to list
  - Redact social security numbers
  - Where to send application
  - Types of supporting documentation
  - How many applications to complete
  - Psych/rehab residents

IPPS Proposals re: § 5506 Slots from Closed Hospitals

- Application time frame proposed to be 60 days instead of 4 months
- Revisions to final ranking criterion
- Revisions to effective date determinations
- Requesting comments on whether there should still be a temporary cap adjustment for displaced residents, given the permanent program

IPPS Proposals re: § 5506 Slots from Closed Hospitals, Cont.

Proposed Ranking Criteria

(1) Seamlessly assumes entire program (= ≥ 90% of residents)

(2) Received slots from closed hospital under affiliated group & training same # as under affiliation

(3) Seamlessly assumes displaced residents-not entire program

(4) Not (1) – (3) and new or expanded geriatrics program

(5) Not (1) – (3), in HPSA, use all slots for new or expanded primary care or general surgery program

(6) Not (1) – (3), not in HPSA, and use all slots for new or expanded primary care or general surgery program

(7) Purpose not described above, but application is for primary care or general surgery & hospital is applying for slots under RC #8

(8) Purpose not described above

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IPPS Proposals re: § 5506 Slots from Closed Hospitals, Cont.

Effective Date Proposals

- Guiding premise: ensure no duplication

Effective Date	Ranking Criteria
Date of Hospital Closure	RC #2 RC #1 & #3 if no temporary cap adjustment for any displaced residents
Cost Reporting Period Following Date of Closure	RC # 1 & #3 if hospital receives temporary cap adjustment for displaced residents
Date of Award	RC #4 – 8 if: •*Any displaced residents graduated before award date* •No temporary cap slots were given for displaced residents
July 1 after Resident Graduation	RC # 4 – 8 if displaced residents still training after award date

Note: Text in italics indicates proposed change from current method of calculating effective date.

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Shadow-claims and deadlines

- For MA patients, CMS “clarifies” that timely filing rules apply to no-pay / “shadow” claims
- Applies for IME, DGME, nursing/allied health, and DSH payments

Newest Wage Index Report

- "Plan to Reform the Medicare Hospital Wage Index"
  - Secretary submitted to Congress on April 11, 2012
  - Commuting based wage index (CBWI) concept
    - Based on number of hospital workers commuting from home to work to define labor market
- No policy changes yet…

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Services Furnished Under Arrangements

- In FY 2012 final rule, CMS limited "under arrangement" services to therapeutic and diagnostic services
- Hospitals still pursuing compliance
- CMS proposes postponing effective date to CRP beginning on or after October 1, 2013

Inpatient Quality Reporting (IQR)

Measures Proposed for Removal Starting in FY 2015

- 8 AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs)
- All Hospital Acquired Condition (HACs)
- 1 Surgical Care Improvement Project (SCIP) Measure
  - Surgery patients with VTE prophylaxis ordered

Proposed New Measures

FY 2015

- 3-item care transition tool
- Hip and Knee complication rate
- Hip and Knee readmission rate
- Hospital-wide All Cause Readmission Rate
- Elective Delivery prior to 39 weeks

FY 2016

- Safe Surgical Checklist (structural)
  - Attestation April 1- May 15

3-item Care Transition Tool

Care Transition Questions:
During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. ○ Strongly disagree ○ Disagree ○ Agree ○ Strongly Agree
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. ○ Strongly disagree ○ Disagree ○ Agree ○ Strongly Agree
When I left the hospital, I clearly understood the purpose for taking each of my medications. ○ Strongly disagree ○ Disagree ○ Agree ○ Strongly Agree ○ I was not given any medication when I left the hospital

- Embedded in HCAHPS
- NQF endorsed
- Developed by Eric Coleman/University of Colorado
- Beginning with January 2013 discharges

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Proposed New Questions for HCAHPS

Two Additional Questions:
During this hospital stay, were you admitted to this hospital through the Emergency Room? ○ Yes ○ No
In general, how would you rate your overall mental or emotional health? ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

- ED question to account for ED admission data element no longer being collected
- Plan to use data for patient-mix adjustment
- Unclear how patient reported evaluation of mental health will be used for adjustment - need further clarification
- Proposed data collection starting January 2013

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Hospital-wide Readmission (HWR) Measure

- Unplanned, all cause readmissions for eligible conditions within 30 days of discharge
- Similar to previous readmission measures with some improvements
  - Exclusions for some planned readmissions
  - Exclusions for certain admissions – eg. medical treatment of cancer
- Measure calculation based on one year of data
- NQF endorsement expected Summer of 2012

Total Hip and Knee Readmission and Complication Rates

- Measure structure similar to previous readmission measures
  - Readmission rates based on 30 days post discharge
  - Complication rates based on 90 days post discharge
  - Includes exclusions for planned readmissions

Future Expansion of CLABSI/CAUTI?

- NQF recommended expansion of CLABSI and CAUTI measures to cover non-ICU locations in hospitals and in other care settings
- Currently, CMS requires hospitals to submit information only for the ICU setting.
- CMS intends to expand data collection on non-ICU patients at a future date

CMS seeks feedback on the feasibility and timing of expanding data collection. Is this doable?

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Changes to Validation Process

- Reduce number of hospitals that must submit data for validation from 800 to 400
- CMS also proposes two separate validation approaches
  - Chart-abstracted measures
  - HAI measures (CAUTI, CLABSI, and SSI)
- HAI validation approach similar to process finalized previously for CLABSI

Alignment with National Quality Strategy – Proposed FY 2016

CMS proposes to align measure selection for IQR with National Quality Strategy (NQS)

NQS domains are:

- Clinical quality
- Care coordination
- Patient safety
- Patient and caregiver experience of care
- Population/community health
- Efficiency

CMS seeks feedback on the appropriateness of these domains for the IQR program

Value-Based Purchasing

Base DRG Definition

- For the VBP Program, CMS defines “base operating DRG payment amount” as the wage-adjusted DRG operating payment, plus any applicable technology add on payment.
  - Provision of new technology is considered a treatment decision
- Per statute definition DRG amount excludes adjustments for IME, DSH, low-volume hospitals and outliers

Is it appropriate to include tech payments in definition?

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Distribution of Incentive Payments

- Incentive pool funded by reduction of base DRG payment by 1% starting with FY 2013 and increasing to 2% by 2017
- CMS proposes to process the DRG reduction and incentive payment adjustment simultaneously in the claims processing system starting in January 2013
- All FY2013 claims prior to January will be re-processed
- FY 2014 reduction/payment would be applied beginning in October

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Review, Corrections, and Appeal Process

- CMS has proposed a confidential review and corrections process for VBP claims-based measure rates and scores
- Process would be modeled after IQR process
- 30 days to review reports (available on QualityNet)
- Hospitals can submit a correction to CMS – if rejected then can submit an appeal through QualityNet
- Only calculation of rates/scores can be appealed

Measures for FYs 2015 & 2016

FY 2015

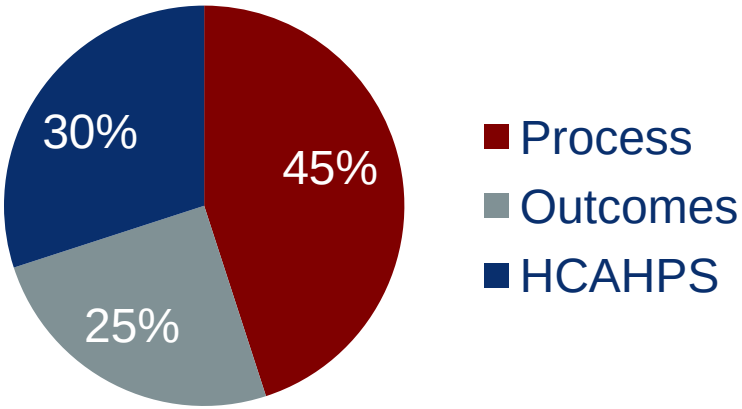
- Maintain 2014 measures
- Statin prescribed at discharge (*process*)
- AHRQ Patient Safety Composite (*outcome*)
- CLABSI (*outcome*)
- Medicare Spending Per Beneficiary (*efficiency*)

FY 2016

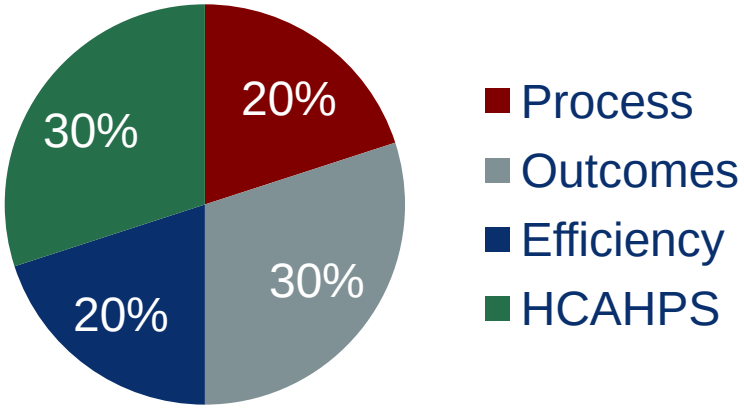
- No measures have been proposed for FY 2016 at this time

VBP Domains for FYs 2014-15

Domain Weighting FY 2014



Domain Weighting FY 2015



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VBP FY 2015 Performance Periods

Federal Register, Pg 28084:

Domain	Baseline period	Performance period
Clinical Process of Care	January 1, 2011–December 31, 2011	January 1, 2013–December 31, 2013.
• AMI–10*	• April 1, 2011–December 31, 2011	• April 1, 2013–December 31, 2013.
Patient Experience of Care	January 1, 2011–December 31, 2011	January 1, 2013–December 31, 2013.
Outcome:		
• Mortality	• October 1, 2010–June 30, 2011	• October 1, 2012–June 30, 2013.
• AHRQ	• October 15, 2010–June 30, 2011	• October 15, 2012–June 30, 2013.
• CLABSI	• January 26, 2011–December 31, 2011	• January 26, 2013–December 31, 2013.
Efficiency:		
• Medicare Spending Per Beneficiary-1	• May 1, 2011–December 31, 2011	• May 1, 2013–December 31, 2013.

*As discussed further above, we are proposing a separate performance period for the AMI–10 measure. The proposed 12-month performance period specified above would apply to all other clinical process of care measures.

Hospital Acquired Conditions (HACs)

HAC Requirements

Per the Deficit Reduction Act (DRA), CMS has been required to select at least two conditions that are:

- high cost, high volume, or both
- are assigned to a higher paying MS–DRG when present as a secondary diagnosis
- Could reasonably have been prevented through the application of evidence-based guidelines

New Conditions Proposed for FY2013

- Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) Procedures and
- Pneumothorax with Venous Catheterization

Do these conditions meet the criteria? Are these measures preventable by evidence-based guidelines?

Readmissions Payment Reduction Program

Primary Concern:

Lack of Adjustment for SES Factors

CMS Distribution of Hospitals Readmission Adjustment Factor by DSH Patient Percentage

DISTRIBUTION OF HOSPITALS READMISSION ADJUSTMENT FACTOR BY DSH PATIENT PERCENTAGE (DPP)

Decile	Number of hospitals	Payment adjustment of less than −1 percent	−1 Percent floor adjustment	No readmission adjustment factor
Lowest DPP	339	156	38	145
Second	339	164	57	118
Third	339	168	44	127
Fourth	339	170	48	121
Fifth	339	182	42	115
Sixth	339	171	43	125
Seventh	339	187	44	108
Eighth	339	182	43	114
Ninth	339	179	58	102
Highest DPP	342	185	61	96
Total	3,393	1,744	478	1,171

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- Must adjust for SES via DSH or proxy – preferably dual-eligible %
- Adjustment for top DSH hospitals
- AAMC data analysis shows natural cut point at 7th percentile for DPP
- Want to avoid unintended consequences and establish incentives not to treat vulnerable patient populations

Base DRG Definition

- CMS proposes the "base operating DRG payment amount" as the wage-adjusted DRG operating payment, plus any applicable technology add on payment.
  - Provision of new technology is considered a treatment decision
- Per statute definition DRG amount excludes adjustments for IME, DSH, low-volume hospitals and outliers

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New Technology Add-On

- Update on FY 2012 New Technologies
  - AutoLITT System: CMS is not proposing to continue making new tech add-on payments for FY 2013
- FY 2013 Applicants for New Technologies Add-On
  - Glaucarpidase (Trade Brand Voraxaze®)
  - DIFICID™ (Fidaxomicin) Tablets
  - Zilver® PTX® Drug Eluting Stent
  - Zenith® Fenestrated Abdominal Aortic Aneurysm Endovascular Graft

Outlier Payments

- For FY 2013, target for total outlier payments continues to be set at 5.1% of total operating DRG payments
  - Outliers were 6.0% of actual DRG payments in FY 2012, creating a -0.9% impact for FY 2013
- CMS proposes the outlier fixed-loss cost threshold to be $27,425 for FY 2013
- Caveat: The published numbers are incorrect; CMS inadvertently switched the capital and operating CCR adjustment factors. Correction notice coming soon.

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