FY 2013 Inpatient PPS Final Rule Teleconference

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Link for Final Rule

- Published in *Federal Register* on August 31, 2012
- Available at http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf

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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
- Services Furnished Under Arrangements
- Outliers
- New Technology Add-On Payments
- Quality Payment Programs

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IPPS Payment Update

- CMS announced 2.3% update for hospital operating payments
  - Does *not* include L&D bed policy change
  - Does *not* include sequestration (-2%)

How did CMS get to 2.3 percent?

Policy	Proposed	Final
Market Basket Update	+3.0%	2.6%
Productivity Adjustment	-0.8%	-0.7%
ACA Required Adjustment	-0.1%	-0.1%
’08/’09 Prospective Doc & Coding	-1.9%	-1.9%
’10 Doc & Coding	-0.8%	**0.0%**
Removing ’12 Doc & Coding Recoupment	+2.9%	+2.9%
Outlier Adjustment*	-0.9%	**0.1%**
Readmissions Adjustment	-0.3%	-0.3%
Expiration of MDH Special Status	-0.1%	-0.2%
Expiration of Sec. 508 Reclassifications	-0.1%	-0.1%
Weighted Impact of SCH Update	-0.1%	-0.1%
Frontier Wage Index Floor	+0.1%	+0.1%
TOTAL	+0.9%	**+2.3%**

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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	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%~~	-1.9	+2.9%	+1.0%

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L&D Bed Policy

- CMS will now count ancillary labor & delivery beds in IME available bed count
- Drives down IRB ratio and IME payments
- CMS estimates $40 million cut to IME payments in FY 2013 (down from $170 in proposed rule)

See pages 53411 - 53413

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Some good news for new teaching hospitals…

- New teaching hospitals will 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)
- CMS also finalized apportionment plan when residents in new programs train in more than one hospital during the cap-building period

See pages 53416 - 53424

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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 final rule…

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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

See pages 53424 - 53434

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IPPS Final Rule re: § 5503 Slots

- CMS abandoned requirement to fill ½ of slots by 3rd year and all slots by 5th year
- Under final rule, awardee hospital must:
  - For expansions of existing programs, fill all slots by the fourth cost reporting period (any expansion-related slots not filled by the 4th CRP will be removed at the end of the 5th CRP)
  - For new programs, use all slots by 5th CRP or lose those slots hospital didn't fill
    - Note: hospital no longer loses all slots if all are not used

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IPPS Final Rule re: § 5503 Slots

Question: Can any Section 5503 slots be used for cap relief?

Answer: YES. 25% percent of any slots used in a given year may be for cap relief

- Be careful, though – still must meet 75% requirement and 3 year primary care average requirement *each* year hospital uses 5503 slots
- E.g., if hospital awarded 10 slots but only uses 2 in a given year, only 0.25 FTEs may be for cap relief that year

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§ 5506 Closed Hospital Slot Redistribution

- ACA requires redistribution of DGME & IME slots from hospitals that close
  - Geographic preference
  - Preference for taking over closed programs
- 1st 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
- 2nd Round = St. Vincent's (NY) – by end of 2012
- 3rd Round = Announcement in IPPS Final Rule

See pages 53434- 53448

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§ 5506 Closed Hospital Slot Redistribution – New Round (Due Oct. 29)

Provider Number	Provider Name	City & State	CBSA Code	Terminating Date	IME Cap	DGME Cap
120010	Hawaii Medical Center East	Honolulu, HI	26180	January 5, 2012	15.73	16.12
140301	Oak Forest Hospital	Oak Forest, IL	16974	August 31, 2011	0	2.03
360101	Huron Hospital	East Cleveland, OH	17460	October 3, 2011	50.06	50.92

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§ 5506 Guidance on CMS Website

- "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 Final Policy re: § 5506 Slots from Closed Hospitals

- Application time frame changed to 90 days (was 4 months)
- Revisions to ranking criteria
- Revisions to effective date determinations
- No changes to temporary cap program

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

Final 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, & hospital will use slots for nonprimary care/non-general surgery program or for cap relief

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

New Guidance on Definition of "Seamless" for RC #1 and #3:

- If hospital closes July 1 – Dec 31, applicant must demonstrate slots vacated by displaced residents will be filled by following July 1
- If hospital closes Jan 1 – June 30, applicant must demonstrate slots vacated by displaced residents will be filled by *second* academic year following hospital closure

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

Effective Dates of Redistributed Slots

Effective Date	Ranking Criteria
Date of Hospital Closure	RC #2 RC # 1 and #3 if no temporary cap adjustment for any displaced residents
Day after Graduation Date of Displaced Resident(s)	RC # 1 and #3 if hospital receives temporary cap adjustment for displaced residents
Later* of Date Slots Actually Filled *or* July 1 after Resident Graduation	RC #4 – 7 RC #8 if used to start or expand a nonprimary care or nongeneral surgery program
***Later* of Date of Award *or* July 1 after Resident Graduation**	RC #8 if used for cap relief

*** Slots in this category will be held by contractor in "pending" status until hospital provides documentation that it filled the additional positions through a match/recruitment process**

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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

See pages 53409 - 53411

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Services Furnished Under Arrangements

- In FY 2012 final rule, CMS limited "under arrangement" services to therapeutic and diagnostic services
  - "Routine services" (bed, board, nursing) must be furnished by the hospital
- Hospitals still pursuing compliance
- CMS postponed effective date to CRP beginning on or after October 1, 2013

See pages 53453 - 53454

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Outlier Payments

- For FY 2013, target for total outlier payments continues to be set at 5.1% of total operating DRG payments
  - In the proposed rule, CMS said outliers were 6.0% of actual DRG payments in FY 2012, creating a -0.9% impact for FY 2013
  - CMS corrected the FY 2012 projections to be **5.0%, creating a 0.1% increase for FY 2013**
- CMS finalizes the outlier fixed-loss cost threshold to be $21,821 for FY 2013

See pages 53691 - 53698

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New Technology Add-On

- Update on FY 2012 New Technologies:
  - **AutoLITT System:** CMS considers AutoLITT to be new for FY 2013 and will continue making new technology payments
- FY 2013 Applicants for New Tech. Add-On:

New Tech Applicant	Proposed	Finalized	Max Add-On per Case
Glaucarpidase (Trade Brand Voraxaze®)	☑	☑	$45,000
DIFICID™ (Fidaxomicin) Tablets	☑	☑	$868
Zilver® PTX® Drug Eluting Stent	☑	☒	Not yet received FDA approval; not eligible
Zenith® Fenestrated Abdominal Aortic Aneurysm Endovascular Graft	☑	☑	$8,171.50

See pages 53343 - 53365

New Technology Add-On (cont.)

Under current policy, new technology payments are limited to new technologies associated with an ICD-9 procedure code

- Commenters noted the issue of this policy related to coding of oral therapies
- CMS agrees that the statute does not preclude new technology payments for oral medications that have no inpatient procedure
- **Revising policy in final rule to allow use of NDCs as alternative code set to identify oral medications where no inpatient procedure is associated**

See page 53354

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Inpatient Quality Reporting (IQR)

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17 Measures Finalized for Removal

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

See pages 53506 - 53509

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New Measures Finalized for FYs 2015 and 2016

FY 2015

- 3-item care transition tool
- Hip and Knee complication rate
- Hip and Knee readmission rate
- Hospital-wide 30-Day All Cause Readmission Rate
- Elective Delivery prior to 39 weeks

FY 2016

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

See pages 53510 - 53534

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3-item Care Transition Tool Finalized

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

See pages 53513 - 53516

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New Questions for HCAHPS Finalized

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
- Data collection starting January 2013

See pages 53513 - 53516

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Hospital-wide Readmission (HWR) Measure Finalized

- Measure was endorsed by the NQF (#1789)
- Unplanned, all cause readmissions for eligible conditions within 30 days following hospital 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
- One year lag until data is posted on Hospital Compare

See pages 53521 - 53528

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Total Hip and Knee Readmission and Complication Rates Finalized

- 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

See pages 535139- 53521

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CLABSI & CAUTI Expansion

- NQF previously recommended expansion of CLABSI and CAUTI measures to cover non-ICU locations in hospitals and in other care settings
- At this time, CMS will require hospitals to submit measure data on ICU locations only for the IQR program. (For VBP, CMS will finalize requirements for hospitals to collect CLABSI in non-ICU locations starting in 2014.)

See pages 53531- 53536

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Validation Process Changes Finalized

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

See pages 535151- 53552

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Value-Based Purchasing (VBP)

Base DRG Definition Finalized

- 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

See pages 53571

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 finalized its proposal that the DRG reduction and incentive payment adjustment be simultaneously processed 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

See pages 53567 - 53568

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Review, Corrections, and Appeal Process

- CMS has finalized 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

See pages 53578 - 53582

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Measures Finalized for FYs 2015 & 2016

FY 2015

- Maintain 2014 measures
- AHRQ Patient Safety Composite (*outcome*)
- CLABSI (*outcome*)
- Medicare Spending Per Beneficiary (*efficiency*)

Not adopted: Statin prescribed at discharge

FY 2016

- No additional measures were added for FY 2016

See pages 53582- 53592

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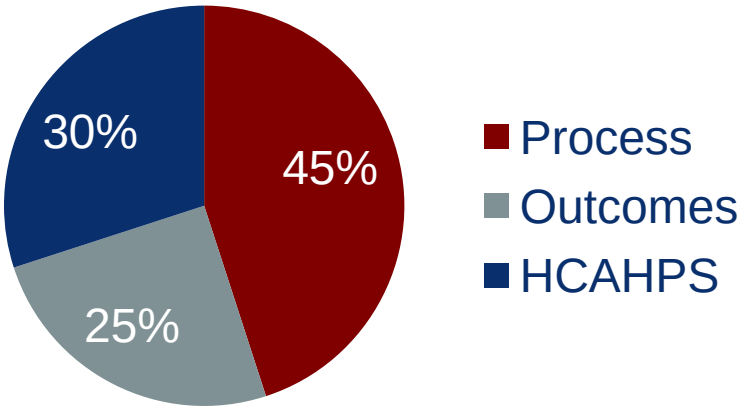
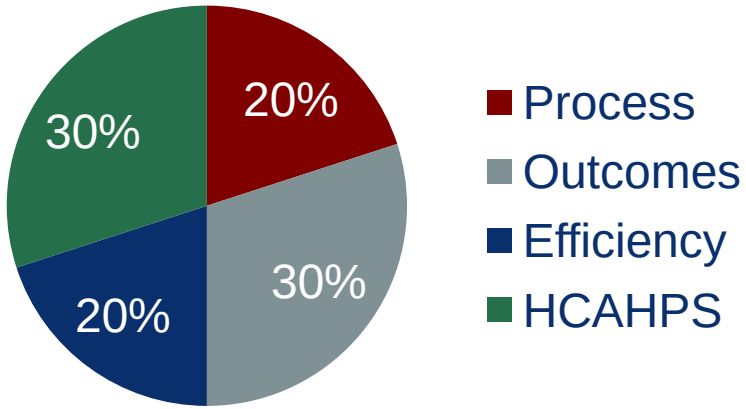
VBP Domains for FYs 2014-15

Domain Weighting FY 2014



Domain Weighting FY 2015



See pages 53605 – 53608

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VBP FY 2015 & 2016 Performance Periods

FY 2015

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

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VBP FY 2015 & 2016 Performance Periods, Cont

FY 2016

Measure	Baseline period	Performance period
Mortality	October 1, 2010 – June 30, 2011	October 1, 2012 – June 30, 2014
AHRQ PSI	October 15, 2010 – June 30, 2011	October 15, 2012 – June 30, 2014

See pages 53598

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

See pages 53286 - 53293

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New Conditions Finalized for FY2013

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

See pages 53286 - 53293

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Readmissions Payment Reduction Program

Consideration of SES factors

- AAMC conducted a data analysis of SES and its impact on readmissions. As a result, the AAMC developed a recommendation and advocated for an SES adjustment based on dual-eligible % as a proxy or DSH share
- CMS did not include an SES adjustment in the final rule, but has pledged to monitor the impact of the readmissions program on providers of vulnerable populations
- The AAMC is exploring a legislative approach

Base DRG Definition Finalized

- 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

See pages 53382 - 53384

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