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Tomorrow's Doctors, Tomorrow's Cures

FY 2014 IPPS Final Rule Teleconference

Learn
Serve
Lead

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Important Info on the Final Rule

- Posted in the *Federal Register* on August 19- available at http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf
- The AAMC Comments on the FY 2014 IPPS proposed rule can be found here https://www.aamc.org/download/346874/data/aamccommentsonippsfy2014proposedrule.pdf
- Additional information on AAMC IPPS webinar presentations can be found here www.aamc.org/hospitalpaymentandquality

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FY 2014 IPPS Final Rule – Key Takeaways

1. FY 2014 payment update factor is 0.7%, but payment impact analysis shows aggregate payments increasing 0.5% percent
2. Documentation and Coding- 0.8% reduction for ATRA Recoupment
3. Two DSH Payments
   - 25% paid per discharge
   - Other 75% reduced and repurposed through new Uncompensated Care Payment
     - UC Pool Increased
     - Per discharge payments through PRICER
4. GME – Addition of Labor & Delivery Beds to DGME

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FY 2014 IPPS Proposed Rule – Key Takeaways Continued

5. New Admission and Medical Review Policies- made budget neutral by 0.2% reduction in rates
6. Hospital-Acquired Conditions Penalty for 2015
   - 1% reduction impacts all payments (including IME,DSH)
7. Increased risk in Value Based Purchasing and Readmissions Reduction Program

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Topics for Today's Teleconference

- Payment Updates/Documentation and Coding
- ACA DSH Calculations
- GME Provisions
- Revised MS-DRG Weights/Cost Centers
- Outliers
- Part B Inpatient Rebilling
- Two Midnights
- Quality Provisions
  - FY2015 HAC Reduction
  - VBP, Readmissions Reduction, IQR

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FY 2014 Market Basket Update

- Market basket increase = 2.5 percent
  - Less multi-factor productivity adjustment = 0.5 percent
  - Less a 0.3 percentage point ACA Adjustment
  - Less 0.8 percent documentation and coding recoupment adjustment
  - Less 0.2 percent offset for admission and medical review criteria

FY 2014 Payment Update: 0.7%

However, other factors may affect your payments

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Additional Factors Affecting Aggregate Payments – FY 2014

Policy	Impact
DSH Payment Modification	-0.4%
Readmissions	-0.2%
Higher SCH rate update	+0.1%
Outlier Payments at 5.1% in FY 2014	+0.3%
Expiration of MDH Special Status	-0.2%
Frontier Wage Index Floor	+0.1%
MS-DRG reweighting/Wage Index Changes	+0.1%
Impact from Additional Factors	-0.2%

Aggregate payments to increase 0.5%

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Impact by Major Hospital Category

Hospital Type	All Final Rule Changes
All Hospitals	0.5%
Large Urban	1.0%
Other Urban	0.2%
Rural	-1.6%
Major Teaching	1.4%

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Documentation & Coding Cut

- CMS finalized the proposed -0.8 percent recoupment adjustment to the standardized amount.
  - ATRA requires the full adjustment ($11B) to be completed by FY 2017. CMS' adjustment would begin phasing this in slowly.
  - CMS estimates the -0.8 percent for FY 2014 will recover almost $1B.

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New DSH Payments Under ACA Sec. 3133

DSH payments will be split into 2 separate payments: "Empirically Justified" and the "Uncompensated Care Payment"

25% of DSH Payments will be paid the same way they have been paid.

75% of DSH payments will be used toward the uncompensated care (UC) payment.

This 75% (UC payment pool) will be reduced as the uninsured population decreases

(5.7% reduction to the 75% pool in FY 2014)

UC payments will be made on a per discharge basis through the IPPS PRICER program

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The New "Uncompensated Care Payment"

Factor 1	Factor 2	Factor 3
• 75% of what otherwise would have been paid as Medicare DSH Payments	• Reduces the 75% to reflect changes in the percentage of people under age 65 who are newly insured due to ACA Implementation.	• Represents a hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals (expressed as a %)

Product of Factors 1 and 2 = Total UC Pool

UC Pool multiplied by Factor 3 = Your UC Payment

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How to Figure Out Your UC Payment

The UC Payment Pool = 75% x $12.772 = $9.579 B

3.5% higher than proposed rule!

The Pool is Reduced by the Percentage Insured = $9.579 x 0.943 = $ 9.033 B

9.9 % higher than proposed rule amount!

UC Payment = $9.033 B x [(Your Hospital Medicaid Days + Medicare SSI Days) ÷ (Medicaid Days + Medicare SSI Days for All DSH Eligible Hospitals)] = YOUR UC PAYMENT

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Why the UC Pool Increased

- The Final Rule estimates for Factor 1 (the total UC pool) use more recent data, and correct an error that the AAMC and other commenters pointed out, by including an estimate of the impact of the Medicaid expansion.
- CMS also accepted a suggestion to normalize CBO estimates for Factor 2, which are for calendar years, to correspond with the appropriate fiscal year.

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Per Discharge UC Payments

- CMS did NOT finalize the proposal to make UC payments periodic interim payments.
- Instead, the final rule makes interim uncompensated care payments on a per discharge basis through the IPPS PRICER.
- CMS took into account comments from the AAMC and other hospital associations that MA plans would end up underpaying hospitals if CMS finalized the proposal to make UC care payments periodic interim payments.

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Per Discharge UC Payments

- The estimated per-discharge amount is the same for every discharge in a particular hospital
- It is based on the amount of the uncompensated care payment that CMS calculates for a hospital for a fiscal year divided by the number of discharges (or claims) in the most recently available 3 fiscal years of the Medicare claims dataset.
- For FY 2014 payments, CMS uses the avg. number of claims from the most recent 3 yrs. of MedPAR claims data, FYs ‘10,‘11,‘12

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Cost Settlement: UC Payment

The only aspect of the hospital's total uncompensated care DSH payment that the agency proposes to cost settle is whether or not a hospital was eligible for it at all.

Therefore, cost report settlement would **not** include reconciliation of the values of Factors 1, 2, or 3 that were established in the final rule.

Utilization Reconciliation

- CMS finalized that the **UC payment will be paid on the basis of the federal fiscal year** because that is how they are determined.
- CMS will reconcile that amount (not the total UC payment to the hospital which will remain the same, but how much is paid out per discharge) **based on the hospital's actual utilization in the cost reporting period that begins in the respective federal fiscal year**.

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Looking ahead…

- CMS only plans to use the proxy for determining uncompensated care (Medicaid days + Medicare SSI days) temporarily.
- CMS is not proposing to use S-10 data in this proposed rule due to data deficiencies.
- CMS will likely propose to use S-10 data to determine uncompensated care costs in the future.
- Please get in touch if you have questions about S-10 reporting.

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IPPS Graduate Medical Education (GME) Provisions

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Labor & Delivery Days

- CMS finalized the proposal to include labor and delivery days as inpatient days in the Medicare utilization calculation.
  - L & D days will be considered inpatient days for purposes of determining Medicare share for DGME payments.
  - CMS estimates this change will result in a $19 M reduction in hospital payments for FY 2014.

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FTE Residents at CAHs

- CMS clarifies that **a CAH is a provider**, and therefore, CMS finalizes the proposal that **a hospital may not claim the time FTE residents are training at a CAH for IME and/or DGME purposes.**
  - Currently, teaching hospitals can count time that residents rotate to CAHs if the teaching hospital incurs the costs of stipends and benefits of the residents and the resident spends his/her time on patient care activities.
  - Teaching hospitals will no longer be able to count time residents spend training at CAHs.

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PRA Ceiling Freeze

- CMS provides notice that the "freeze" for per resident amounts (PRAs) that exceed the ceiling expires in FY 2014, as required by statute.

- This means that starting Oct. 1, 2013, the usual full CPI-U updates would apply to all PRAs for DGME payment purposes.

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Sec. 5506 Slot Redistribution Closure Notice

Closed Hospital	Notice Date	App. Due	DGME Cap	IME Cap
Cooper Green Memorial Hospital (Norristown, PA)	8/2/13	10/31/13	26.24	29.65
Sacred Heart Hospital (Chicago, IL)	8/2/13	10/31/13	1.40	4.00

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MS-DRG Weights/Costs Centers

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Finalized Reweighting of MS-DRGs

- Revise Weights of MS-DRGs by including new Cost-to-Charge Ratios (CCRs)
  - Finalized moving from 15 to 19 CCRs to incorporate new cost centers
  - Estimated using data from FY 2011 Cost Reports and FY 2012 admission claims
- New Cost Centers
  - Implantable Devices (added 5/1/2009)
  - Cardiac Catheterization (added 5/1/2010)
  - MRI and CT Scans (added 5/1/2010)
- Budget Neutral
  - Pricing fluctuations across MS-DRGs
- Similar proposal for OPPS

Questions?

Outliers

Outlier Threshold

- CMS finalized proposed methodological changes
- Changes to methodology for setting the outlier threshold:
  - Determine the charge inflation factor using a 1-year period of the most recent charge data
  - Adjust the CCRs by comparing the % change in the national average case-weighted operating CCR and capital CCR from Dec. 2011 to those from Dec. 2012
- Final FY 2014 outlier threshold of $21,748
  - Change from proposed rule: DSH uncompensated care payments will be included in determining the outlier threshold and in calculating outlier payments

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New Technology Add-On Payments

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New Technology Add-On

Update on FY 2013 New Technologies

New Tech	Approved for FY 2014?	Max Add-On per Case
AutoLITT™ System	☒	N/A
Voraxaze®	☑	$45,000
DIFICID™	☑	$868
Zenith® F. Graft	☑	$8,171.50

FY 2014 Applications for New Tech Add-On

New Tech	Approved for FY 2014?	Max Add-on per Case
Kcentra™	☑	$1,587.50
Argus® II Retinal Prosthesis System	☑	$72,028.75
RNS® System	☒	N/A
Zilver® PTX®	☑	$1,705.25
MitraClip® System	☒	N/A

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Patient Status and the 2-Midnight Rule

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CMS Actions re: Patient Status

- CY 2013 OPPS: solicited and summarized public comments on potential policy changes
- March 13, 2013: ALJ ruling on Part B billing following denial of Part A claim
- March 13, 2013: CMS issued NPRM "Medicare Program; Part B Inpatient Billing in Hospitals" to propose permanent policy
- CY 2014 IPPS: included proposals (now final policies) to clarify the requirements for Part A payment and admission and medical review criteria for hospital inpatient services
  - Sept. 5, 2013 guidance on Hospital Inpatient Admission Order and Certification

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ALJ Ruling, March 13, 2013

- Ruling expanded the class of payable services but applies only when the inpatient admission is disapproved as not reasonable and necessary by a Medicare review contractor
- Current policy continues to apply in all other circumstances, such as when a beneficiary exhausts Part A benefits
- Policies apply as long as denial was made:
  - While ruling in effect
  - Prior to effective date of ruling but for which timeframe to file appeal has not expired
  - Prior to effective date of ruling if appeal pending
- Ruling effective until final OPPS effective

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Part B Re-Billing

- CMS finalized proposals from the "Part B Inpatient Billing" proposed rule in the IPPS Final Rule
- Revision to Part B inpatient payment policy:
  - For claims to which ALJ ruling does not apply, if Part A claim denied as not reasonable and necessary, CMS will allow payment for all services that would have been reasonable and necessary if beneficiary has been treated as a hospital outpatient, except services specifically requiring an outpatient status
- If Part A claim rejected, filing for a Part B inpatient claim must be within 1 year of date of service

Policy on Admission and Medical Review Criteria

- CMS finalizes its proposal to clarify requirements for orders of inpatient admissions by adding new §412.3
  - Patient must be formally admitted as inpatient by order of a physician or other qualified practitioner who had admitting privileges and who is responsible for patient's inpatient care
  - Order must be present in medical record and supported by admission and progress notes
  - May not delegate the order to another individual who is not responsible for the care, not state-authorized to admit patients, or has not been granted admitting privileges
  - Orders must authenticated promptly, and verbal orders to be used infrequently
  - CMS does not finalize any new documentation requirements and current regulations at §424.11 continue in force
- Medical documentation must support physician's orders and certification
- No presumptive weight is given to order or certification alone

Sept. 5 Guidance

- CMS issued guidance, "Hospital Inpatient Admission Order and Certification" (available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-09-05-13.pdf)
- Order for inpatient admission must be done by practitioner a) licensed by the State to admit; b) granted hospital privileges; and c) knowledgeable about patient's case
  - Guidance clarifies that residents can admit
  - Admitting order may be documented by indiv. who does not possess qualification above (ex. PAs, residents, RNs)
  - Qualified "ordering practitioner" must be identified in the order, and ordering practitioner must authenticate prior to discharge

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2-Midnight Rule

- Beneficiaries expected to remain in hospital for care surpassing 2-midnights after initiation of care: generally considered appropriate for inpatient admission and payment
- If stay less than 2-midnights, inpatient services generally will be considered inappropriate unless:
  - Clear documentation in medical record supporting physician's order AND
  - Expectation that beneficiary would require care over more than 2-midnights OR
  - Beneficiary receives procedure on inpatient-only list

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2-Midnights: When does it begin?

- Permitted to count time spent receiving services—even prior to admission:
  - If beneficiary spent 1-midnight in outpatient observation status or in routine recovery following outpatient surgery, 2-midnight benchmark is met if physician expects beneficiary to require an additional midnight in the hospital
  - Beneficiary who has unexpected recovery during medically necessary stay should not be converted to outpatient because at time inpatient order was written 2-midnight expectation was reasonable
- CMS distinguishes between 2-midnight benchmark (above) and 2-midnight presumption (guidance for review contractors)

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Additional Provisions

- Exclusion from 2-Midnights
  - Procedures on OPPS inpatient-only list are always appropriately inpatient, regardless of actual time spent in hospital, so they are excluded from 2-midnight benchmark
- Transfers and 2-Midnights
  - Guidance will be drafted for manual instructions.

Medical Review Policy: Payment Impact

- In the proposed rule, CMS actuaries estimated that the medical review proposal would increase IPPS expenditures by $220 million
  - FY 2009 to 2011 data on extended outpatient encounters and short inpatient stays estimated a net shift of 40,000 encounters to the inpatient setting
- CMS proposed to use authority under section 1886(d)(5)(I)(i) of the Act to offset the estimated payment increase
- Finalized proposal to reduce standardized amount by 0.2 percent

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Questions?

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Hospital Acquired Condition (HAC) Reduction Program

Background on HAC Reduction Program

- HAC Reduction program will start FY 2015 and is required by law: Section 3008 of the ACA requires Secretary to implement a HAC payment adjustment
- Hospitals in the worst performance quartile of HACs will face 1 percent reduction in all payments (including IME and DSH)
- This HAC program is in addition to the HAC Non-Payment Program
- HAC reductions will be applied after adjustments for the VBP and the readmissions programs

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Impact on Teaching Hospitals

- **As finalized, teaching hospitals will be disproportionately affected by the HAC Reduction Program in two significant ways:**
  - According to CMS, almost half (48.6%) of all teaching hospitals will be penalized. This is a slight decrease from the proposed rule, where 56.7% were estimated to be penalized
  - Institutions that are penalized will see their total payments reduced, including add-ons (IME and DSH). This is different from the Readmissions and VBP Programs, where the penalty only applies to base DRG payments. CMS will discuss the methodology for applying the penalty in the FY 2015 IPPS proposed rule

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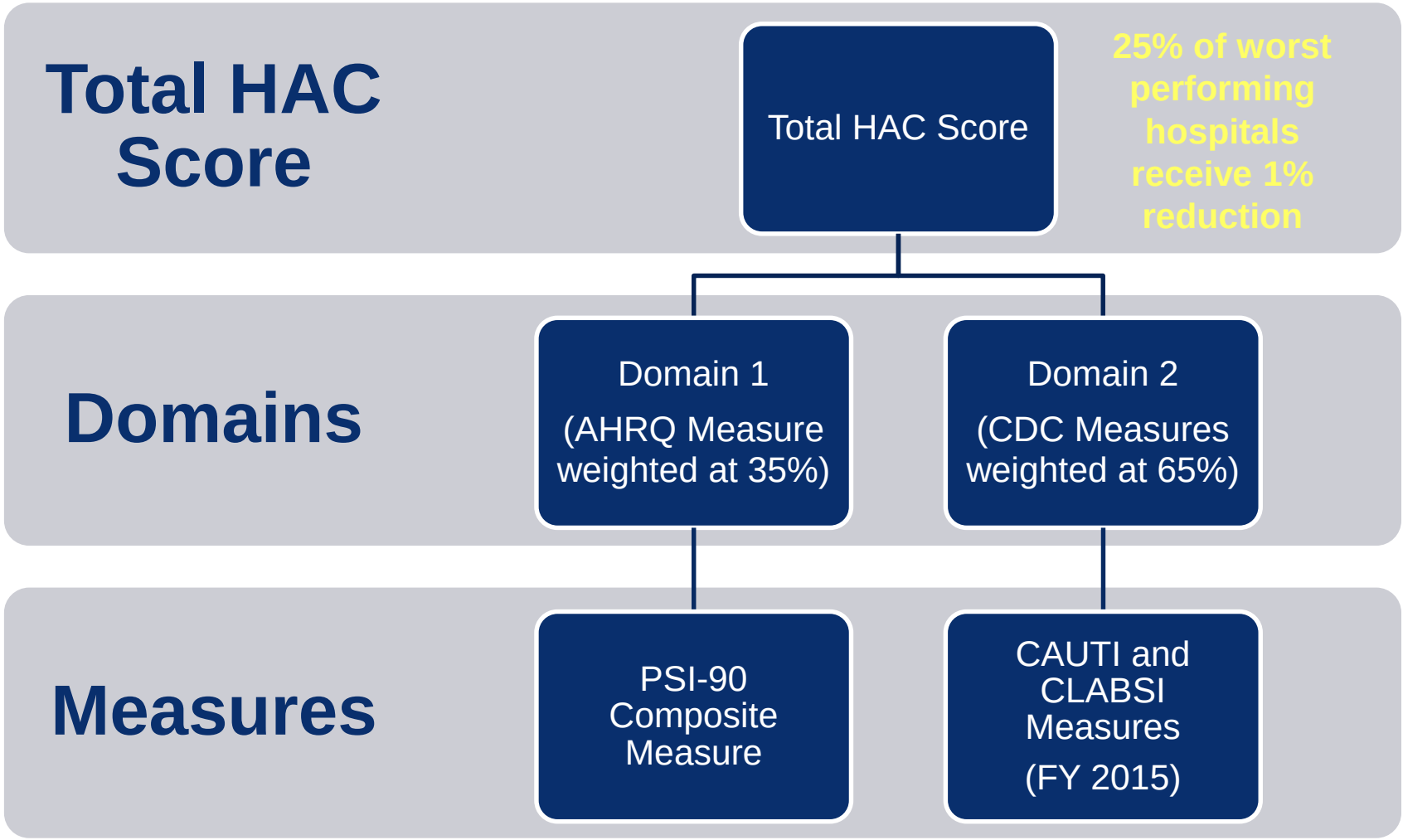
HAC Reduction Program Framework



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HAC Domains and Measures

Domain 1
(AHRQ Measure)

Weighted 35%

AHRQ PSI-90 Composite

This measure consists of:

PSI-3: pressure Ulcer

PSI-6: Iatrogenic pneumothorax

PSI-7: central venous catheter-related blood stream infection rate.

PSI-8: hip fracture rate

PSI-12: postoperative PE/DVT rate

PSI-13: sepsis rate

PSI-14: wound dehiscence rate

PSI-15: accidental puncture

Domain 2
(CDC Measures)

Weighted 65%

2015 (2 measures):
CAUTI
CLABSI

2016 (1 additional measure):
Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)

2017 (2 additional measures):
MRSA
C Diff

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HAC Measure Scoring for FY 2015

- Points will be assigned according to a hospital's performance on three measures (PSI-90 Composite, CLABSI, and CAUTI)
- The performance range for each of the measures will be divided into 10 deciles. All hospitals will receive between 1 and 10 points for each measure
- Higher score equals worse performance
- A hospital's total HAC score is calculated by:
  - Multiplying the Agency for Healthcare Research and Quality (AHRQ)'s PSI-90 Composite measure (Domain 1) score by 35 percent and the average of the two Centers for Disease Control (CDC) measure (Domain 2) scores by 65 percent
  - Summing the two weighted domain scores to determine the total HAC score
- If a hospital only reports measure(s) in one domain, that domain score will be used for the total HAC score
- The total HAC score will be used to determine the top quartile of affected hospitals

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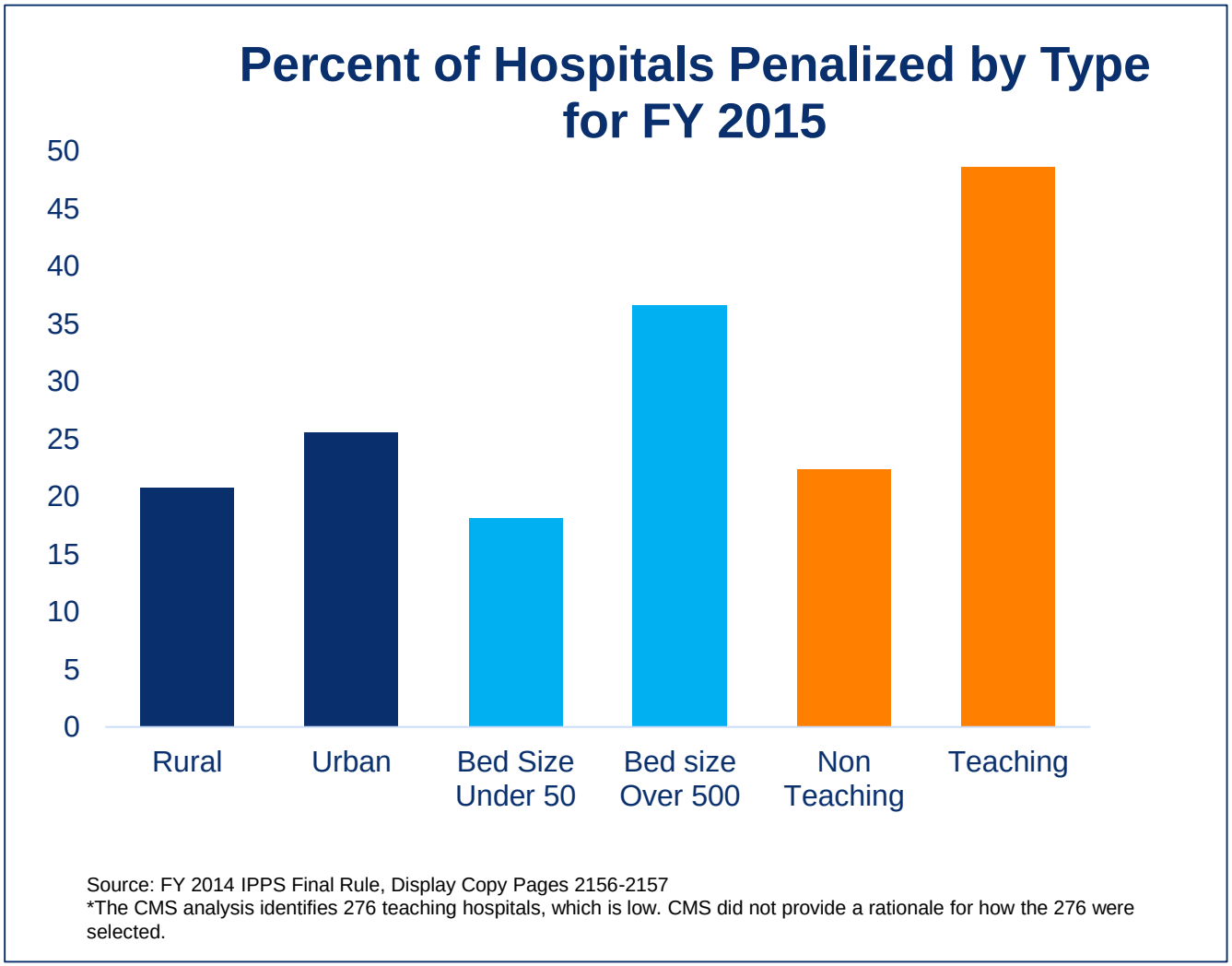
Which Hospitals Will Be Affected Under the HAC Reduction Program?



Source: FY 2014 IPPS Final Rule, Display Copy Pages 2156-2157
*The CMS analysis identifies 276 teaching hospitals, which is low. CMS did not provide a rationale for how the 276 were selected.

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Value Based Purchasing (VBP) Program

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Updates to VBP Program for FY 2014

- Reduction in base DRGs increased from 1% to 1.25% to fund incentive pool
- CMS finalized a VBP disaster waiver (similar concept in IQR)
- This is the first year of the outcomes domain (mortality measures for heart attack, heart failure and pneumonia)

Measures Finalized for Removal Starting FY 2016

- AMI-8A: Primary PCI received within 90 minutes of arrival
- PN-3b: Blood cultures performed in ED prior to Initial Antibiotic
- HF-1: Heart failure discharge instructions

Two measures were finalized for removal, but were not originally proposed for removal:

- SCIP-Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.
- SCIP-Inf-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

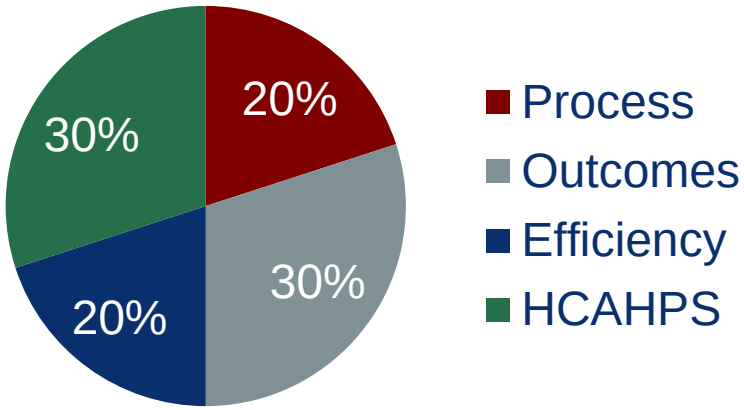
Four Additional Measures Finalized Starting FY 2016

- IMM-2: Influenza Immunization
- CAUTI
- SSI (colon and hysterectomy)
- CLABSI readopted for FY 2016 (NQF has not yet endorsed a reliability adjustment)

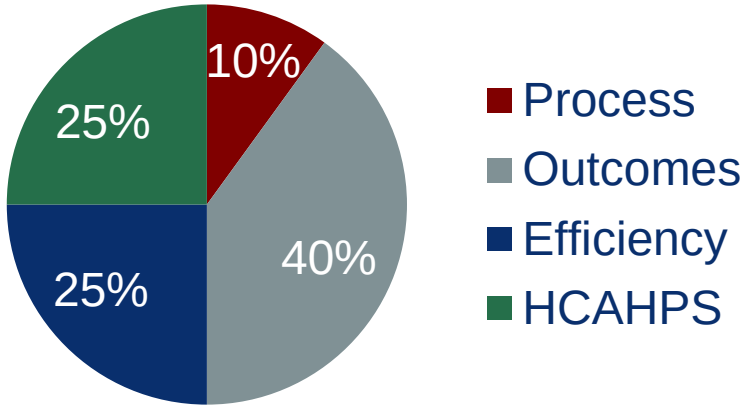
Also: Baseline periods, performance periods, and performance standards were finalized (*Federal Register*, Pages 50692-50699)

Finalized VBP Domains for FY 2016

Finalized Domain Weighting FY 2015



Finalized Domain Weighting FY 2016



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Readmissions Reduction Program

Finalized Changes to Readmissions Program

- Maximum penalty increased to 2%
- Incorporation of planned readmissions algorithm (Version 2.1)
  - Applied to AMI, HF, and PN measure starting FY 2014
- CMS will not count unplanned readmissions that follow a planned readmission if it is within 30 days of the initial index admission
- New Measures for FY 2015:
  - COPD
  - Elective THA/TKA

Inpatient Quality Reporting (IQR) Program

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Measures Removed/Suspended for FY 2016

Finalized Measures for Removal in FY 2016
PN-3b: Blood culture performed in the emergency department prior to first antibiotic received in hospital
HF-1: Discharge planning
Participation in Stroke Registry
AMI-2: Aspirin prescribed at discharge
AMI-10: Statin prescribed at discharge
HF-3: ACEI or ARB for LVSD
SCIP-Inf-10: Surgery patients with perioperative temperature

Measures Suspended:

IMM-1 (Immunization for pneumonia was originally proposed for removal but is now suspended), AMI- 1, AMI-3, AMI-5, SCIP Inf-6

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Refinements to Existing Measures

- The planned readmission algorithm for HF, AMI, PN, THA/TKA, and hospital-wide readmissions will be added starting January 2013.
- Expansion of CLABSI and CAUTI to select non-ICU locations will be deferred one year (start date is now January 1, 2015)
- SCIP Inf-4 will be updated to incorporate NQF changes
- The MSBP measure will include Railroad Retirement Board (RRB) beneficiaries

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CMS Finalized 5 Additional Claims Based Measures for FY 2016

- 30-day risk standardized COPD readmissions
- 30- day risk standardized COPD mortality
- 30- day risk standardized stroke mortality
- 30- day risk standardized stroke readmission
- AMI payment per episode of care

Requirements for Voluntary Electronic Submission of IQR Measures in CY 2014

Finalized data submission requirements:

- **Electronic Reporting**
  - Up to four of the following measure sets may be electronically reported: stroke, VTE, perinatal care, emergency department
  - Measure set must be reported for one quarter to receive IQR credit; for simultaneous MU credit, must be reported for Q1, Q2, or Q3 and meet all other program requirements
  - Must report all measures in the set
    - Exception: STK-1 does not need to be reported for IQR because the e-specifications have not been created
  - Data will be publicly reported if it is "accurate enough"
- **Chart Abstraction**
  - All chart abstracted measures not reported electronically must be reported via chart abstraction (except STK-1 if stroke measure set reported electronically)
  - Must be done for all 4 quarters

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Questions?

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