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FY 2014 Inpatient PPS Proposed Rule Teleconference

May 15, 2013

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Association of
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Important Info on Proposed Rule

- In *Federal Register* on May 10 – available at http://www.gpo.gov/fdsys/pkg/FR-2013-05-10/pdf/2013-10234.pdf
- Comments due **June 25, 2013**

Save the Date:
Detailed call for quality/performance proposals on Thursday, May 23, 3-4PM Eastern

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Topics for Today's Teleconference

Topic	FR Pages
Payment Updates	27572-27573
Documentation & Coding	27502-27506
ACA DSH Calculations	27578-27592
GME Provisions	27636-27639
Revised MS-DRG Weights/New Cost Centers	27506-27509
Outliers	27766-27768
New Admissions and Medical Review Criteria	27644-27650
FY 2015 HAC Reduction	27622-27636
VBP	27606-27622
Readmissions Reduction	27593-27606
IQR	27677-27710

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FY 2014 IPPS Proposed Rule – Key Takeaways

1. FY 2014 payment update factor is 0.8%, but payment impact analysis shows aggregate payments decreasing 0.1 percent
2. Documentation and Coding- 0.8% reduction for ATRA Recoupment; 0.55% Prospective Adjustment Delayed
3. Two DSH Payments
   - 25% paid per discharge
   - Other 75% reduced and repurposed through new Uncompensated Care Payment
     - Interim payments, not through pricer
     - Not using S-10, but may in the future
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
8. Potential imaging reductions due to new cost centers

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- **Payment Updates/Documentation and Coding**
- ACA DSH Calculations
- GME Provisions
- Revised MS-DRG Weights/Cost Centers
- Outliers
- Medical Review
- Quality Provisions
  - FY2015 HAC Reduction
  - VBP, Readmissions Reduction, IQR

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FY 2014 Market Basket Update

- Market basket projected increase = 2.5 percent
  - Less 2 percent if hospital doesn't submit quality data
  - Less multi-factor productivity adjustment = 0.4 percent
  - Less an additional 0.3 percent (ACA)
  - Less 0.8 percent due to documentation and coding recoupment adjustment *(subject to comment)*
  - Less 0.2 percent offset for admission and medical review criteria *(subject to comment)*

FY2014 Payment Update: 0.8%

However, other factors may affect your payments

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Additional Factors Affecting Aggregate Payments – FY 2014

Policy	Impact
DSH Payment Modification	-0.9%
Readmissions	-0.2%
Higher SCH rate update	+0.1%
Expiration of MDH Special Status	-0.1%
Frontier Wage Index Floor	+0.1%
MS-DRG reweighting/Wage Index Changes	+0.1%
Impact from Additional Factors	-0.9%

Payment impact analysis shows aggregate amounts decreasing 0.1%

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Documentation & Coding

Two types of adjustments:

- **Retrospective**
  - Recoup overpayments that were already made as a result of documentation and coding improvements
  - ATRA requires $11B retrospective for FY2010- FY 2012 overpayments
- **Prospective**
  - Eliminate the effects of documentation and coding changes on future payments

Documentation & Coding Proposal

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

D & C – Prospective Adjustment

- If CMS were to apply an additional prospective, CMS agreed it would be **-0.55 percent**.

- **CMS asked for comments** regarding whether any portion of the proposed -0.8 percent recoupment adjustment should be reduced and instead applied to a prospective adjustment (to count toward the -0.55 CMS believes should be collected).

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DSH- ACA Sec. 3133

- Sec. 3133 of the ACA requires changes to the Disproportionate Share Hospital (DSH) payment formula and applies to all hospitals that are currently eligible for DSH payments

- Aggregate DSH payments will be reduced and repurposed.

New DSH Payment Overview

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

25% of DSH Payments ("Empirically Justified") will be paid the same way they have been paid.

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

This 75% (UCC payment pool) will be reduced as the uninsured population decreases (11.2% reduction to the 75% pool in FY 2014)

UCC payments will be periodic interim payments instead of through the pricer. This has implications for MA plans and Outliers.

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Empirically Justified DSH Payments

- Empirically Justified" DSH payments (the 25% of current DSH payments that stays the same)

- CMS would implement this provision simply by revising its claims payment methodologies to adjust the interim claim payments to equal 25% of what otherwise would have been paid.

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 UCC Pool

UCC Pool multiplied by Factor 3 = Your UCC Payment

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CMS Estimates for the UCC Payment

- For purposes of the proposed rule, CMS' **estimate for DSH payments for FY 2014** is **$12.338 billion** (this is the pool we are starting with).

- CMS proposes to use the CBO estimate from March 20, 2010, which is **18 percent, as the baseline estimate of the uninsurance percentage for 2013.**

- CMS proposes to use the CBO estimate from Feb. 5, 2013, which is **16 percent as the uninsurance percentage for 2014.**

The UCC Payment formulas…

Factor 1
(the Pool)

- Factor 1 = 75% of the estimate for Medicare DSH Payments for FY 2014=
- **.75 x $12.338 Billion = 9.2535 Billion**

Factor 2
(The Pool Reduced by the % Insured)

- Factor 2 = 1- |[(0.16- 0.18) ÷ 0.18]|= 1- 0.111= 0.889 = 88.9%
- 0.889 (88.9 percent) – 0.001 (0.1 percentage points required to be subtracted by the statute) = **0.888 (88.8%)**
- **Therefore, the amount available for uncompensated care payments for FY14 = 0.888 x $9.2535 billion = $8.217 billion**

Factor 3
(Your UCC Payment)

- Each hospital's UCC payment = **[(Your Hospital Medicaid Days + SSI Days) ÷ (Medicaid Days + SSI Days for All DSH Eligible Hospitals)] x $8.217 billion**

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How to Figure Out Your UCC Payment

The UCC Payment Pool= 75% x $12.338 = $9.2535 B

The Pool is Reduced by the Percentage Insured = $9.2535 x 88.8% = $8.217 B

UCC Payment = $8.217 B x [(Your Hospital Medicaid Days + SSI Days) ÷ (Medicaid Days + SSI Days for All DSH Eligible Hospitals)] = YOUR UCC PAYMENT

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Pricer Issue

- MA plans may end up underpaying hospitals if the DSH policy is implemented as proposed.
  - CMS pricer will only report the immediate DSH payment and not the interim UCC payment
  - MA plans are often contracted to pay hospitals based on the amounts reported in the pricer.
- AAMC plans to comment and we would welcome your input.

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Cost Settlement: Empirically Justified DSH Payments

- Final eligibility for Medicare DSH payments and the final amount of these empirically justified payments for eligible hospitals **will be determined at the time of cost report settlement**.

Cost Settlement: UCC Payment

The only aspect of the uncompensated care DSH payment that the agency proposes to 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.

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Factor 3/Eligibility Tables

- CMS is posting proposed tables listing Factor 3 for the hospitals that it estimates would receive Medicare DSH payments for FY 2014 on the CMS Website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatient PPS/dsh.html

- CMS proposes that hospitals have **60 days** from the date of display of the IPPS proposed rule (**i.e. until June 25**) to review these tables and notify CMS in writing of a change in a hospital's PPS hospital status (for example a hospital closed or converted to a CAH).

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CMS Request for Comments

CMS asks for comments on whether a hospital's final uncompensated care payments should be based on Factor 3 numerators and denominators that are estimated using more recent cost report data (and associated inputs) at the time of cost report settlement.

AAMC would also like your input on this issue.

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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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Questions?

- Payment Updates
- Documentation and Coding
- DSH

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- **GME Provisions**
- Revised MS-DRG Weights/Cost Centers
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GME – Labor & Delivery Days

- CMS proposes to include labor and delivery days as inpatient days in the Medicare utilization calculation.
  - L & D days would be considered inpatient days for purposes of determining Medicare share for DGME payments.
  - CMS estimates this change would decrease DGME payments by $15 M for FY 2014

GME- FTE Residents at CAHs

- CMS clarifies that **a CAH is a provider**, and therefore, CMS proposes that **a hospital may not claim the time FTE residents are training at a CAH for IME and/or DGME.**
  - Under ACA Sec. 5504(a) a hospital's ability to count residents not training in the hospital is now limited to non-provider settings.
  - A CAH may still incur the costs of training the FTE residents for the time that the FTE residents rotate to the CAH, and receive payment based on 101 percent of its Medicare reasonable costs (the CAH reimbursement rate).

GME – 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.

GME- Sec. 5506 Closure Notice

- CMS used the proposed rule to notify the public of the closure 4/9/12 of **Peninsula Hospital Center** in Far Rockaway NY, and to initiate the fourth round ("**Round 4**") of the section 5506 application and selection process.
- Hospitals that wish to apply for Peninsula Hospital Center's slots have to make sure that their applications are **received** by the **CMS Central Office** no later than **July 25, 2013**.
- CMS encourages applicants to notify it by email (ACA5506application@cms.hhs.gov) indicating that a hard copy of the application has been mailed.

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Peninsula Hospital Center Closure

Provider # 330002

CBSA Code 35644

Closure Date 4/9/12

IME Cap (including Sec. 422 Adjustment= 28.32

DGME Cap including Sec. 422 Adjustment = 36.34

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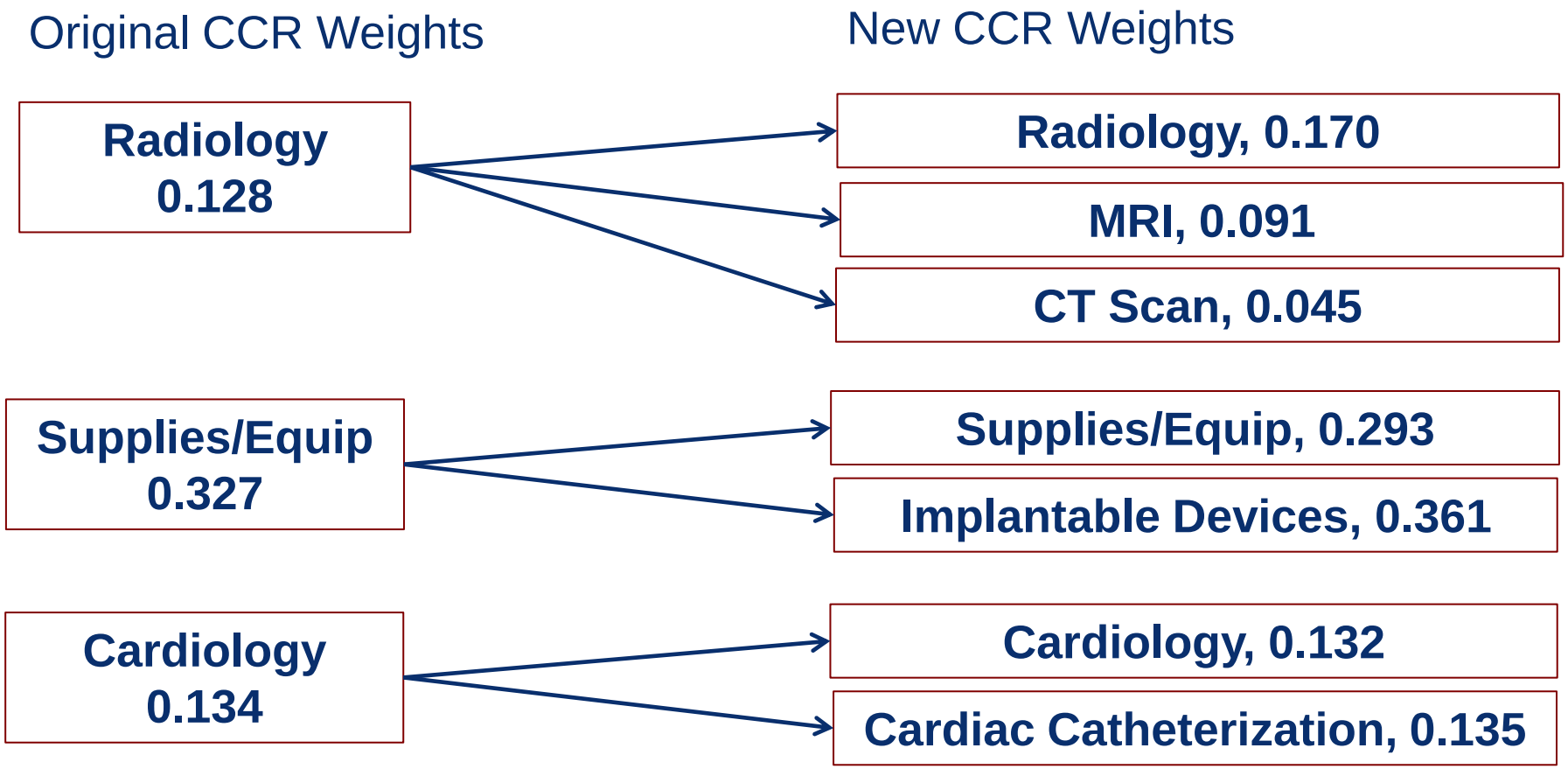
Reweighting MS-DRGs

- Revise Weights of MS-DRGs by including new Cost-to-Charge Ratios (CCRs)
  - Propose 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

How New Weights Work



Application: MRI services would be worth less, because the MRI specific weight (0.091) is less than the original combined Radiology weight (0.128).

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Reweighting Questions

- Is the data for the new cost centers correct?
  - Any concerns about the accuracy or completeness of data for FY 2011 cost report?
  - Are capital expenditures for MRI and CT Scans depreciated in general overhead instead of cost center?
- What is the impact to individual hospitals? To Teaching Hospitals as a cohort?
  - AAMC conducting analysis to answer these questions
- Imaging decreases could eventually affect OPPS services and Physician Fee Schedule Services

MS-DRGs with Largest Variation

Top 10 Decreases

MS-DRG	Title	% Change
90	Concussion without CC/MCC	-7.90%
84	Traumatic Stupor & Coma, Coma >1 Hour without CC/MCC	-6.80%
87	Traumatic Stupor & Coma, Coma <1 Hour without CC/MCC	-6.70%
965	Other Multiple Significant Trauma without CC/MCC	-6.10%
185	Major Chest Trauma without CC/MCC	-6.00%
89	Concussion with CC	-6.00%
123	Neurological Eye Disorder	-5.90%
343	Appendectomy without Complicated Principal Diagnosis without CC/MCC	-5.70%
53	Spinal Disorders & Injuries without CC/MCC	-5.70%
66	Intracranial Hemorrhage or Cerebral Infarction without CC/MCC	-5.70%

Top 10 Increases

MS-DRG	Title	% Change
454	Combined Anterior/Posterior Spinal Fusion with CC	5.50%
455	Combined Anterior/Posterior Spinal Fusion Without CC/MCC	5.50%
484	Major Joint & Limb Reattachment Procedure of Upper Extremity without CC/MCC	5.50%
225	Cardiac Defibr Implant w/ Cardiac Catheterization w/o AMI/HF/Shock w/o MCC	5.70%
223	Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/HF/Shock without MCC	5.80%
458	Spinal Fusion Except Cervical with Spinal Curve/Malignant/Infection OR 9+ Fusion without CC/MCC	5.80%
245	AICD Generator Procedures	6.00%
849	Radiotherapy	6.20%
946	Rehabilitation without CC/MCC	6.50%
227	Cardiac Defibrillator Implant w/o Cardiac Catheterization w/o MCC	6.70%

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Outlier Payments

- For FY 2014, target for total outlier payments continues to be set at 5.1% of total operating DRG payments
  - Current estimate is that actual outlier payments for FY 2012 were 5.47% of actual total MS-DRG payments
  - Currently estimates that actual FY 2013 outlier payments will be 5.17% of actual total MS-DRG payments

Outlier Threshold

- Proposed 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
- Proposed FY 2014 outlier threshold of $24,140

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
  - Kcentra™
  - Argus® II Retinal Prosthesis System
  - RNS® System
  - Zilver® PTX®
  - MitraClip® System

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Policy Proposal on Admission and Medical Review Criteria

- CMS proposes 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
- Medical documentation must support physician's orders and certification
- No presumptive weight is given to order or certification alone

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Policy Proposal on Admission and Medical Review Criteria

- Proposal to establish guidelines for inpatient admissions for both physicians and Medicare review contractors.
- Contractors would:
  - Presume that the inpatient admission is reasonable and necessary for a beneficiary who requires more than one Medicare utilization day (encounter that crosses “2 midnights”) in the hospital and for procedures on the inpatient only list
  - Presume services spanning less than “2 midnights” should have been provided on an outpatient basis, absent clear physician documentation as to why inpatient care was necessary
- CMS proposes that the starting point for calculating the time would be when the patient is moved from any outpatient area to a bed in the hospital
- Physician must document expectation patient will meet 2-midnight threshold, CMS proposes exceptions for death and transfers

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Medical Review Policy: Payment Impact

- CMS actuaries have estimated that the medical review proposal will 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 proposes to use authority under section 1886(d)(5)(I)(i) of the Act to offset the estimated payment increase
- Proposing to reduce standardized amount by 0.2 percent

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Questions?

- GME Provisions
- MS-DRG Reweighting
- Outliers
- Admissions and Medical Review

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Hospital Acquired Condition (HAC) Reduction Program

Background

Starting FY 2015

- Section 3008 of the ACA requires Secretary to implement a HAC payment adjustment
- Hospitals performing in lowest quartile of HACs will face 1 percent reduction in all payments (including IME, DSH)
- HAC reductions will be applied after adjustments for the VBP and the readmissions programs
- This HAC program is in addition to the HAC Non-Payment Program

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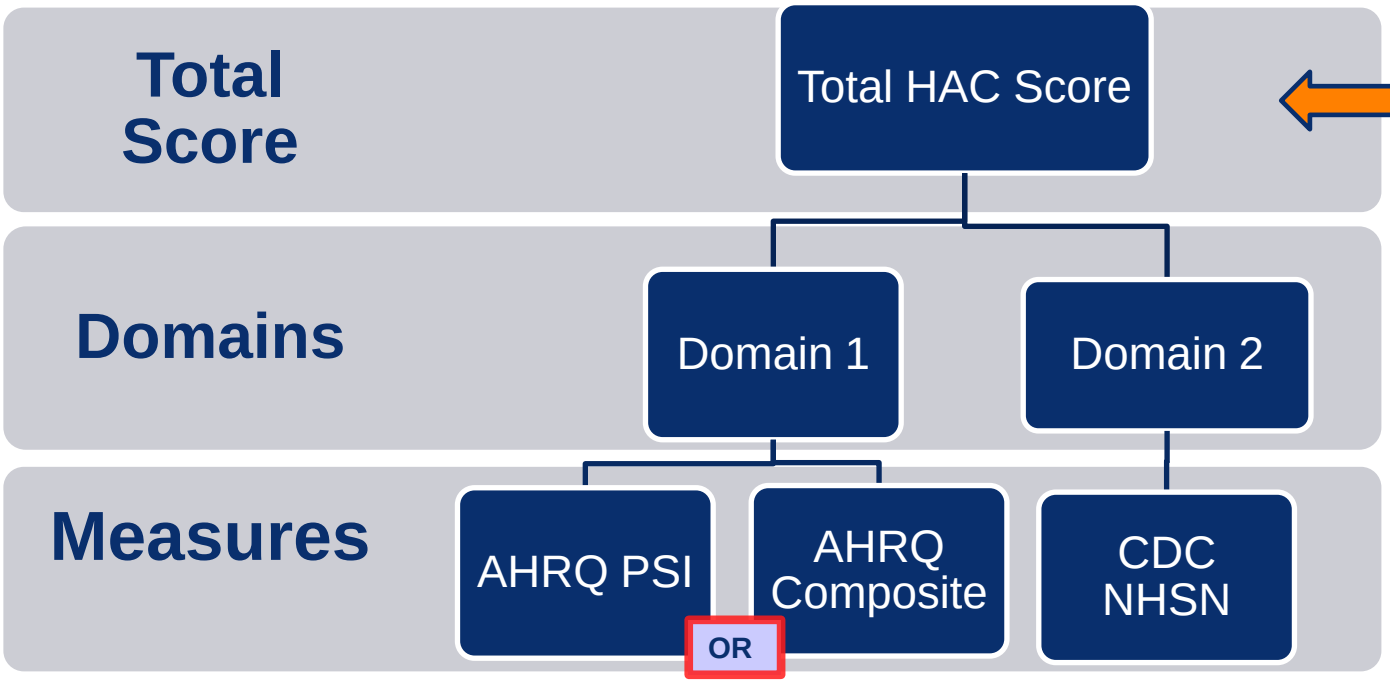
HAC Reduction Program Framework

Similar to VBP:



However:

- **Different methodology to assign points**
- **Worse performance = more points**
- **Most hospitals receive zero points for each measure**
- **No improvement points**
- **No incentive payments**

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Measures and Domains FY 2015

Domain 1
(6 AHRQ PSI Measures)

- PSI-3: Pressure Ulcer
- PSI-5: Foreign Object left in body
- PSI-6: Iatrogenic pneumothorax
- PSI-10: Postoperative physiologic and metabolic derangement rate
- PSI-12: Postoperative PE/DVT rate
- PSI-15: Accidental puncture

OR

Domain 1
(AHRQ Composite)

- PSI-90: Composite measure (includes different selection of PSIs)

Domain 2
CDC NHSN Measures

- CLABSI
- CAUTI

- ***2016***
- Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)

- ***2017***
- MRSA
- C. Diff

- **FFS claims based data**
- **24 month data period**
- **Measures adverse events across hospitals**
- **Risk adjusted at patient level**

- **Chart abstracted data**
- **Reported Quarterly**
- **Measures adverse events at unit level**
- **Risk adjusted at hospital level and patient care unit level**

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Proposed Measure Scoring

- Hospitals only receive points if measure performance is in lowest quartile
  - EXCEPTION: Any incidence of PSI-5 (foreign object left in body) = automatic 10 points.
- Hospitals in lowest quartile: measures scored on sliding scale between 1 and 10 points

CMS Estimates Teaching Hospitals will be Disproportionately Affected

CMS Analysis of Total HAC Scores under Proposed Rule, by type of hospital				
Hospital Type	Number of Hospitals In Analysis	Number of Hospitals in Worst Performing Quartile (Total = 858)	Percent of Hospital Type	Percent of Hospitals in Worst Performing Quartile
Urban	2461	731	29.7%	85.2%
Rural	964	127	13.2%	14.8%
Teaching	270	153	56.7%	17.8%
Nonteaching	3037	691	22.8%	80.5%

Calculation is based on CMS data, which has not been verified

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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 proposes a VBP disaster waiver (similar concept in IQR)
- This is the first year of outcomes measures

Measures Proposed for Removal Starting FY 2016

- Primary PCI received within 90 minutes of arrival
- Blood cultures performed in ED prior to Initial Antibiotic
- Heart failure discharge instructions
- For full list of measures in the VBP program, please see the VBP proposed rule

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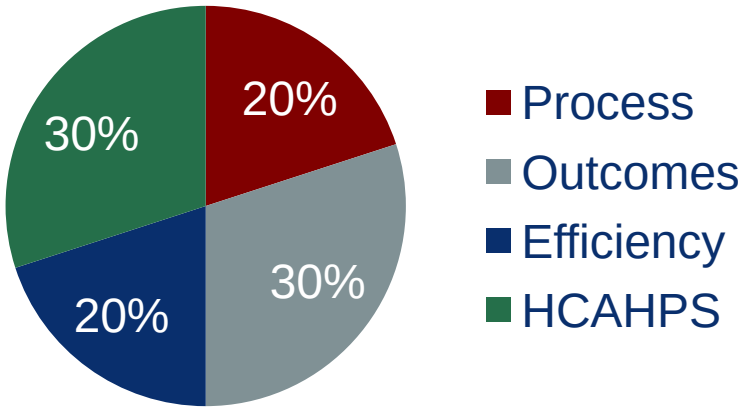
Proposed Additional Measures Starting FY 2016

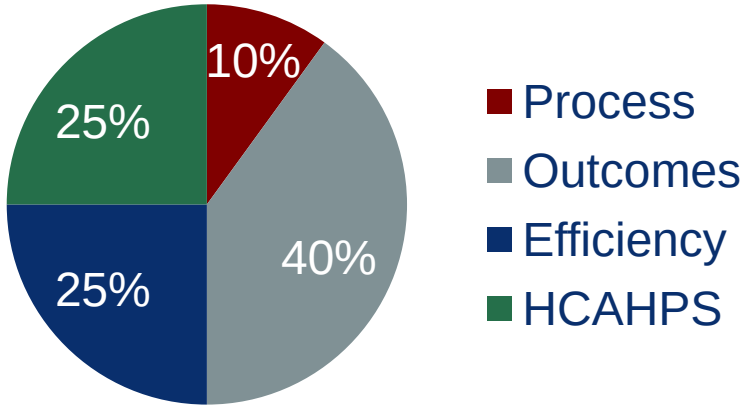
- Influenza Immunization
- CAUTI
- SSI (colon and hysterectomy)
- CLABSI readopted for FY 2016 (NQF still reviewing reliability adjustment)

Proposed VBP Domains for FYs 2016

Finalized Domain Weighting FY 2015



Proposed Domain Weighting FY 2016



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Readmissions Reduction Program

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
- As proposed, CMS will not count unplanned readmissions that follow a planned readmission if it is within 30 days of the initial index admission
- New Measures:
  - COPD
  - Elective THA/TKA

Inpatient Quality Reporting (IQR) Program

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Removal/Suspension of Measures For FY 2016

Measure	CMS Reasons for Proposed Removal
PN-3b: Blood culture performed in the emergency department prior to first antibiotic received in hospital.	No longer NQF endorsed, MAP recommended removal; MAP believes it is topped out, and there is inadequate link to patient outcomes.
HF-1: Discharge planning.	No longer NQF endorsed, MAP recommended removal, challenges in validating efficacy.
IMM-1: Immunization for pneumonia	Cannot feasibly implement the measure to incorporate new Advisory Committee on Immunization Practices guidelines on pneumococcal vaccination
Participation in Stroke Registry	Stroke measure set more meaningful
AMI–2: Aspirin prescribed at discharge	Either recommended for removal by MAP or "topped out"
AMI–10: Statin prescribed at discharge	Either recommended for removal by MAP or "topped out"
HF–3: ACEI or ARB for LVSD	Either recommended for removal by MAP or "topped out"
SCIP-Inf–10: Surgery Patients with perioperative temperature	Either recommended for removal by MAP or "topped out"

Continued suspension:

AMI-1, AMI-3, AMI-5, SCIP Inf-6

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Proposed Refinements to Existing Measures for FYs 2015 and 2016

- Adding planned readmission algorithm for HF, AMI, PN, THA/TKA, and hospital-wide readmissions
- Expansion of CLABSI and CAUTI to select non-ICU locations
- Updates to SCIP Inf-4 to incorporate NQF changes
- Update to MSBP to include Railroad Retirement Board (RRB) beneficiaries

Proposed Addition of 5 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

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New Voluntary Proposal to Align IQR and Meaningful Use

Proposed data submission requirements:

- Hospitals have the ability to electronically report 16 measures across four measure sets (STK, VTE, ED, and PCI)
- Hospitals must electronically report at least one quarter of CY 2014 quality measure data for each measure in the four measure sets
- Must use MU reporting process for submitting quality measures finalized in stage 2
- Data that is electronically reported will not be publicly displayed for CY 2014.

Questions?

Follow Up FY 2014 IPPS Quality Webinar

- Thursday, May 23 from 3:00 to 4:00 EST
- Registration details forthcoming
  - Posted on events page: https://www.aamc.org/initiatives/patientcare/events/

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