



# VCU Medical Center

## Office of Health Innovation

### Proposed Rule: Fiscal Year 2014 Hospital Inpatient and Long-Term Care Prospective Payment System

**Description:** This proposed rule would make payment and policy changes under the Medicare inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals as well as for certain hospitals and hospital units excluded from the IPPS. In addition, it would make payment and policy changes for inpatient hospital services provided by long-term care hospitals (LTCHs) under the long-term care hospital prospective payment system (LTCH PPS). It also would make policy changes to programs associated with Medicare IPPS hospitals, IPPS-excluded hospitals, and LTCHs.

These proposed changes would be applicable to discharges occurring on or after October 1, 2013, unless otherwise specified in this proposed rule.

### Background

Section 1886(g) of the Social Security Act, which sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A, requires that, instead of paying for capital-related costs of inpatient hospital services on a reasonable cost basis, the Secretary use a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge.

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. If the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of certain low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment varies based on the outcome of the statutory calculations.

If the hospital is approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of residents to beds. Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act. The amount of payment for direct GME costs for a cost

reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

Section 1886(d)(1)(B) of the Social Security Act specifies that certain hospitals and hospital units are excluded from the IPPS. These hospitals and units are:

- Rehabilitation hospitals and units;
- Long-term care hospitals (LTCHs);
- Psychiatric hospitals and units;
- Children's hospitals;
- Cancer hospitals; and
- Religious nonmedical health care institutions.

**Financial Impact of Proposed Rule on Payments**

Policy	Average Impact on Payments
Market basket update	+ 2.5%
Productivity Cut	- 0.4%
Additional cut mandated in PPACA	- 0.3%
Documentation and coding cut for FYs 2010-2012 mandated by ATRA	- 0.8%
Offset for proposed changes to admission and medical review criteria for hospital inpatient services	- 0.2%
<i>Total</i>	<i>+ 0.8%</i>

**Major Provisions**

**Medicare DSH Adjustment**

Currently, Medicare DSHs qualify for a DSH payment adjustment under a statutory formula that considers their Medicare utilization due to beneficiaries who also receive Supplemental Security Income benefits and their Medicaid utilization. Section 1886(r) of the Social Security Act, as added by section 3313 of the Affordable Care Act, requires that, for “fiscal year 2014 and each subsequent fiscal year,” “subsection (d) hospitals” that would otherwise receive a “disproportionate share payment... made under subsection (d)(5)(F)” will receive two separate payments:

1. 25 percent of the amount they previously would have received under subsection (d)(5)(F) for DSH (“the empirically justified amount”), and
2. An additional payment for the DSH hospital’s proportion of uncompensated care, determined as the product of three factors. These three factors are:
  - a. **Factor 1:** 75 percent of the payments that would otherwise be made;
  - b. **Factor 2:** 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured (minus 0.1 percentage points for FY 2014, and minus 0.2 percentage points for FY 2015 through FY 2017); and

- c. **Factor 3:** A hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals expressed as a percentage.

### **Calculating Proportion of Uncompensated Care**

**Factor 1:** The difference between CMS estimates of: (1) the amount that would have been paid in Medicare DSH payments for FY 2014 and subsequent years, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY 2014 and subsequent years, which takes into account the requirement to reduce Medicare DSH payments by 75 percent.

The data are based on the December 2012 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2013 IPPS/LTCH PPS final rule IPPS Impact file, published in conjunction with the publication of the FY 2013 IPPS/LTCH PPS final rule. For the July 2013 estimate, CMS anticipates that the data will be based on the March 2013 update of the Medicare Hospital Cost Report data and this proposed rule's IPPS Impact file, published in conjunction with this proposed rule. For purposes of this proposed rule, CMS is using the February 2013 Medicare DSH estimates to calculate Factor 1 and to model the proposed impact of this provision.

**Factor 2:** Section 1886(r)(2)(B) of the Act establishes, as Factor 2 in the uncompensated care payment formula, the percent change in uninsurance, based on a comparison of the percent of individuals under 65 without insurance in 2013 to the percent of such individuals without insurance in the most recent period for which CMS has data, minus 0.1 percentage points for FY 2014 and 0.2 percentage points for each of FYs 2015, 2016, and 2017.

Section 1886(r)(2)(B)(i)(I) of the Act further indicates that the percent of individuals under 65 without insurance in 2013 must be the percent of such individuals "who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment)."

**Factor 3:** Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and subsection (d) Puerto Rico hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY 2014 and subsequent years.

In order to implement the statutory requirements for this factor of the uncompensated care payment formula, CMS must determine the following:

1. The definition of uncompensated care, or in other words, the specific items that are to be included in the numerator (the estimated uncompensated care amount for an *individual hospital*) and denominator (the estimated uncompensated care amount for *all hospitals* estimated to receive DSH payments in the applicable FY).
2. The data source(s) for the estimated uncompensated care amount.
  - a. **Worksheet S- 10:** For purposes of selecting an appropriate data source for this possible definition of uncompensated care costs, CMS reviewed the literature and available data sources and determined that the Medicare cost report Worksheet S-10 could potentially provide the most complete data for Medicare hospitals. However, Worksheet S-10 is a relatively new data source that has been used for specific payment purposes only in relatively restricted ways.
    - i. Concerns about the standardization and completeness of the Worksheet S-10 data could be more acute for data collected in the first year of the Worksheet's use. Because of these concerns, CMS is not proposing to define of uncompensated care in a way that would require use of the Worksheet S-10 data.
    - ii. CMS expects reporting on Worksheet S-10 to improve over time, particularly in the area of charity care which is already being used and audited for payment determinations related to the electronic health record incentive program, and will continue to monitor these data. Accordingly, CMS may proceed with a proposal to use data on the Worksheet S-10 to determine uncompensated care costs in the future, once hospitals are submitting accurate and consistent data through this reporting mechanism.
  - b. **Utilization of insured low-income patients:** CMS believes it would be appropriate to use data elements that have been historically publicly available, subject to audit, and used for payment purposes (or that the public understands will be used for payment purposes) as alternative data for the first year or years of implementation. Accordingly, CMS proposes to use the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively to determine Factor 3.
    - i. CMS believes that the data in the Medicare cost report (and data that are used to update the SSI ratios in the cost report) are acceptable for use as a source for this alternative data because they include data for all Medicare hospitals. Specifically, it contains information regarding Medicaid days (i.e., the numerator of the Medicaid fraction). The SSI ratios can be found in Worksheet E, Part A and hospitals' SSI ratios are reported by CMS on the Medicare DSH website, by Federal fiscal year, and include a hospital's Medicare SSI days.
    - ii. The SSI ratios for a Federal fiscal year are the data that would ultimately be used in Worksheet E, Part A to determine a hospital's Medicare DSH adjustment for that fiscal year.
3. The timing and manner of computing the quotient for each hospital estimated to receive DSH payments.

- a. CMS proposes to use data from the most recently available cost report for the Medicaid days and the most recently available SSI ratios (that is, latest available SSI ratios before the beginning of the Federal fiscal year) for the Medicare-SSI days.

Thus for FY 2014, the denominator for Factor 3 would reflect the estimated Medicaid and Medicare SSI patient days based on data from the 2010/2011 Medicare cost report (including the most recently available data that may be used to update the SSI ratios) for all hospitals that CMS estimates would receive an empirically justified DSH payment in FY 2014. The numerator of Factor 3 would be the estimated Medicaid and Medicare SSI patient days for the individual hospital based on its most recent 2010/2011 Medicare cost report data (including the most recently available data that may be used to update the SSI ratios).

### **Changes to MS-DRG Classifications and Recalibrations of Relative Weights**

Section 631 of the American Taxpayer Relief Act (ATRA) requires the Secretary to make a recoupment adjustment to the standardized amount of Medicare payments to acute care hospitals to account for changes in Medicare severity diagnosis-related group (MS-DRG) documentation and coding that do not reflect real changes in case-mix, totaling \$11 billion over a 4-year period of FYs 2014, 2015, 2016, and 2017.

CMS actuaries estimate that a -9.3 percent adjustment to the standardized amount would be necessary if CMS were to fully recover the \$11 billion recoupment required by section 631 of the ATRA in FY 2014. As part of an effort to phase in rate adjustments over more than one year, this rule proposes a -0.8 percent recoupment adjustment to the standardized amount in FY 2014. CMS is not proposing any future adjustments at this time but notes that if recoupment adjustments of approximately -0.8 percent are implemented in FYs 2014, 2015, 2016, and 2017, it is estimated that the entire \$11 billion will be recovered by the end of the statutory 4-year timeline. Because these are recoupment cuts, they would be restored in FY 2018 through a one-time increase of 3.2 percent in inpatient PPS payments.

Beginning in FY 2014, CMS proposes to calculate the MS-DRG relative weights using 19 CCRs (up from 15 in FY 2013), creating distinct CCRs from cost report data for implantable devices, MRIs, CT scans, and cardiac catheterization.

### **Rebasing and Revision of the Hospital Market Baskets for Acute Care Hospitals**

CMS proposes to rebase and revise the acute care hospital operating and capital market baskets used to update IPPS payment rates. For both market baskets, CMS proposes to update the base year cost weights from a FY 2006 base year to a FY 2010 base year (currently at 2.5 percent under the IPPS).

- FY 2014 Market Basket Update
  - o Market basket projected increase = 2.5 percent
  - o Less 2 percent if hospital doesn't submit quality data
  - o Less multi-factor productivity adjustment = 0.4 percent
  - o 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)

CMS proposes to update the labor-related share under the IPPS for FY 2014 based on the proposed FY 2010-based IPPS market basket, which would result in a labor-related share of 69.6 percent (compared to the FY 2013 labor-related share of 68.8) or 62 percent, depending on which results in higher payments to the hospital.

CMS proposes to use the FY 2010-based market basket in developing the FY 2014 update factor for the operating and capital prospective payment rates and the FY 2014 update factor for the excluded hospital rate-of-increase limits. The proposed FY 2010-based IPPS capital input price index update (as measured by percentage increase) for FY 2014 is currently forecasted to be 1.2 percent, 0.2 percentage points lower than the update based on the FY 2006-based capital input price index.

#### **Additional Factors Affecting Aggregate Payments**

<b>Policy</b>	<b>Impact</b>
DSH Payment Modification	-0.9%
Readmissions	-.02%
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%
<b>Impact from Additional Factors</b>	<b>-.09%</b>

#### **Hospital Readmissions Reduction Program**

Section 1886(q) of the Act, as added by section 3025 of the Affordable Care Act and amended by section 10309 of the Affordable Care Act, establishes the “Hospital Readmissions Reduction Program” effective for discharges from an “applicable hospital” beginning on or after October 1, 2012, under which payments to those hospitals under section 1886(d) of the Act will be reduced to account for certain excess readmissions.

The Hospital Readmissions Reduction Program requires a reduction to a hospital’s base operating DRG payment to account for excess readmissions of selected applicable conditions. These conditions are acute myocardial infarction, heart failure, and pneumonia. For FY 2014, CMS proposes additional exclusions to the three existing readmission measures (that is, the excess readmission ratio) that account for planned readmissions, as well as additional readmission measures to be used in the payment determination for FY 2015.

CMS proposes that the readmissions payment adjustment factors for FY 2014 can be no more than a 2 percent reduction (there is a 1 percent cap in FY 2013), consistent with the statute. CMS proposes a change in the methodology used to calculate the readmissions payment adjustment factors to make it more consistent with the calculation of the excess readmission ratio. CMS estimates that the reduction

to a hospital's base operating DRG payment amount to account for excess readmissions of selected applicable conditions under this program will result in a reduction of approximately -\$175 million, in payments to hospitals for FY 2014.

### **Hospital-Acquired Condition Reduction Program**

Section 1886(p) of the Social Security Act, as added by section 3008 of the Affordable Care Act, establishes an adjustment to hospital payments for hospital-acquired conditions (HACs), or a Hospital-Acquired Condition (HAC) Reduction Program, under which payments to applicable hospitals are adjusted to provide an incentive to reduce hospital-acquired conditions, effective for discharges beginning on October 1, 2014. In this proposed rule, CMS proposes measures, scoring, and risk adjustment methodology to implement the FY 2015 payment adjustment under the HAC Reduction Program.

For hospitals performing in lowest quartile of HACs, the amount of payment will be reduced by 1% of the amount of payment that would otherwise apply to such discharges. These 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.

### **Hospital Inpatient Quality Reporting (IQR) Program**

Under section 1886(b)(3)(B)(viii) of the Social Security Act, hospitals are required to report data on measures selected by the Secretary for the Hospital IQR Program in order to receive the full annual percentage increase. In past rules, CMS established measures for reporting and the process for submittal and validation of the data.

In this proposed rule, CMS proposes to make several changes to: (1) the measure set, including the removal of some measures, the refinement of some measures, and the adoption of several new measures; (2) the administrative processes; and (3) the validation methodologies. CMS estimates that the combination of these proposed will reduce burden hours by 700,000 hours annually.

- For the FY 2016 payment determination, CMS proposes to remove seven chart-abstracted measures and one structural measure.
- CMS proposes to adopt five new claims-based measures for the FY 2016 payment determination and subsequent years.
- CMS proposes, for the FY 2016 payment determination and subsequent years, to validate two additional chart-abstracted HAI measures: MRSA *bacteremia*, and *C. difficile*.
- CMS proposes to reduce the number of records used for HAI validation from 48 records per year to 36 records per year beginning with the FY 2015 payment determination.
- CMS proposes to allow hospitals to submit patient charts for purposes of validation either in paper form or by means of electronic transmission.

CMS proposes to allow hospitals the option of reporting the measures in four measure sets electronically in CY 2014 for the FY 2016 payment determination.

## **Hospital Value-Based Purchasing (VBP) Program**

Section 1886(o) of the Social Security Act requires the Secretary to establish a Hospital Value-Based Purchasing (VBP) Program under which value-based incentive payments are made in a fiscal year to hospitals meeting performance standards established for a performance period for such fiscal year. In this proposed rule, CMS outlines payment details for the FY 2014 Hospital VBP Program.

Under the program, hospitals would have 1.25 percent of their Medicare payments withheld, and the resulting \$1.1 billion in incentive payments will be distributed to the hospitals that deliver the best quality of care based on clinical process of care measures and patient satisfaction scores.

In addition, CMS proposes numerous policies for the FY 2016 Hospital VBP Program, including measures, performance standards, and performance and baseline periods. CMS also proposes a disaster/extraordinary circumstances waiver process, domain reclassification and weighting based on CMS' National Quality Strategy for the FY 2017 Hospital VBP Program, and certain measures, performance and baseline periods, and performance standards for the FY 2017 through FY 2019 Programs.

## **Counting of Inpatient Days for Medicare Payment or Eligibility Purposes**

The calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive.

For hospitals that receive direct graduate medical education funding, CMS proposes that patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, will be included in the Medicare utilization calculation effective for cost reporting periods beginning on or after October 1, 2013.

CMS projects that the proposal to include labor and delivery days as inpatient days in the Medicare utilization calculation would result in a savings of approximately \$15 million for FY 2014.

## **Outlier Payments**

For FY 2014, the target for total outlier payments continues to be set at 5.1% of total operating DRG payments. The current estimate is that actual outlier payments for FY 2012 were 5.47% of actual total MS-DRG payments. CMS estimates that actual FY 2013 outlier payments will be 5.17% of actual total MS-DRG payments. For FY 2014, CMS proposes an outlier threshold of \$24,140.

## **Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A**

CMS proposes to clarify and specify in the regulations that an individual becomes an inpatient of a hospital, including a critical access hospital, pursuant to an order for inpatient admission by a physician or other qualified practitioner and, therefore, the order is required for payment of hospital inpatient services under Medicare Part A. A Physician or qualified practitioner 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. Medical documentation must support physician's orders and certification.

CMS proposes to establish guidelines for inpatient admissions for both physicians and Medicare review contractors. Under the proposed rule, 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. The proposed rule emphasizes that 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.

CMS actuaries estimate that this proposal would increase IPPS expenditures by approximately \$220 million due to an expected net increase in inpatient encounters. CMS proposes to offset the additional IPPS expenditures under this proposal by reducing the standardized amount, the hospital-specific amount, and the Puerto Rico-specific standardized amount by 0.2 percent. CMS also proposes to apply that 0.2 percent reduction to the capital Federal rates.

#### **Long-Term Care Hospital PPS Standard Federal Rate**

CMS's proposals would increase LTCH payments by 1.1 percent in FY 2014 compared to FY 2013. The rule contains a market basket update of 1.8 percent, which includes a 2.5 percent market basket adjustment, less 0.4 percent for productivity, less an additional 0.3 percent, as mandated by the Affordable Care Act.

The rule also includes a proposed adjustment factor of 0.98734 for the second year of the 3-year phase-in of the permanent one-time adjustment to the standard Federal rate. In addition, under the LTCH Quality Reporting (LTCHQR) Program, the proposed annual update to the standard Federal rate will be reduced by 2 percentage points for LTCHs that fail to submit data for FY 2014 on specific measures under section 3004 of the Affordable Care Act. CMS estimates that these proposed changes would result in an increase in estimated payments from FY 2013 of approximately \$62 million (or 1.1 percent).

#### **Medicare Conditions of Participation for Critical Access Hospitals**

CMS proposes to revise the conditions of participation (CoPs) for hospitals relating to the administration of vaccines by nursing staff as well as the CoPs for critical access hospitals relating to the provision of acute care inpatient services. These rural providers must furnish emergency care and acute-care inpatient services on-site and cannot only function as a nursing home/skilled nursing facility.

#### **ICD-9 and ICD-10 Code Sets**

Starting October 1, 2013, there will only be limited code updates to both ICD-9 and ICD-10 code sets to capture new technology and diseases. Starting October 1, 2014, when ICD-10 goes live, there will only be limited code updates to ICD-10, and on October 1, 2015, regular updates to ICD-10 will begin.