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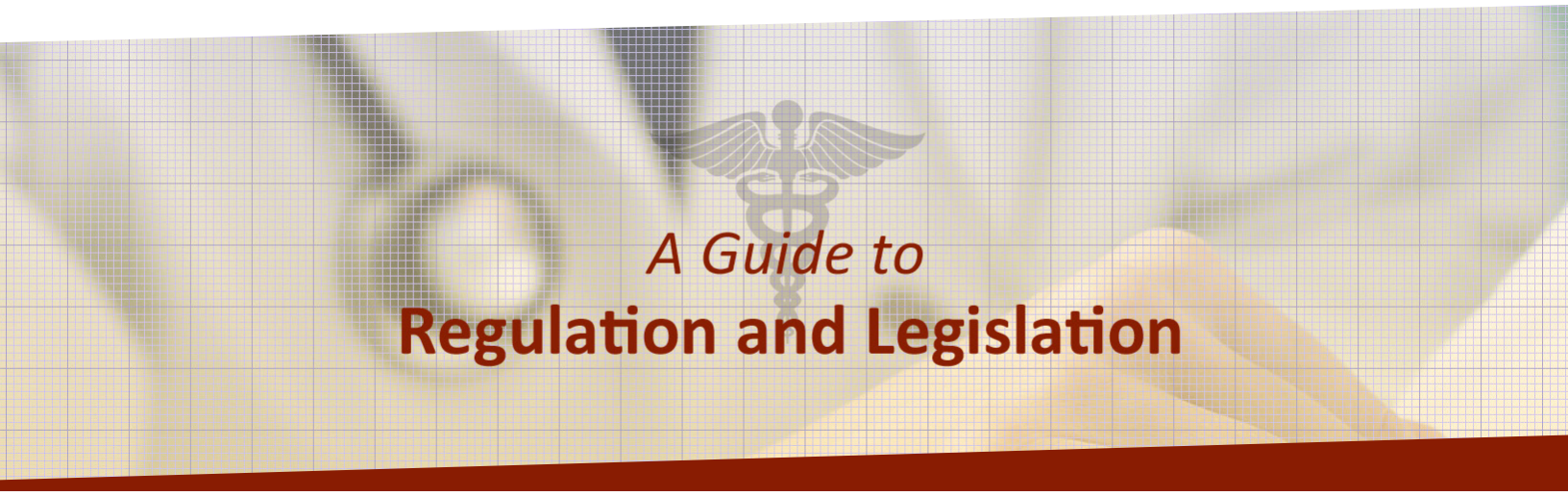

A Guide to
Regulation and Legislation

Regulatory Advisor

CMS Releases 2014 Proposed Rule for Inpatient Prospective Payment System (IP PPS)

On April 26, 2013, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update payment rates for approximately 3,400 acute care hospitals and about 440 long-term care acute hospitals (LTCHs) across the country. The proposed rule also continues to push the connection between quality, patient safety, and patient satisfaction to reimbursement.

The proposed rule outlines various provisions aimed at the continued implementation of the *Affordable Care Act* (ACA). One of the more anticipated changes is the proposed reductions in payments to disproportionate share hospitals (DSH) as a result of expected decreases in the percentage of uninsured patients.

Beginning January 1, 2014, the uninsured population will benefit from coverage through Medicaid expansion and the start of health insurance exchanges. The ACA mandates reductions in DSH payments under the premise that hospitals will no longer need these payments as a result of this expansion. The proposed rule outlines how these reductions will be handled. Below is a summary of the more critical information contained in the proposed rule. CMS is accepting comments on the proposed rule until June 25, 2013, and intends to respond to comments in the final IP PPS rule scheduled for release on August 1, 2013, (with an effective date of October 1, 2013). CliftonLarsonAllen (CLA) will continue to monitor CMS publications and release additional guidance as information becomes available.

Proposed payment rate changes to IP PPS

The rule proposes to increases payment rates for inpatient services by a net .8 percent, equating to an approximate $27 million increase in reimbursement. The .8 percent proposed increase is the net result after CMS applies the changes for market basket conditions and various provisions of the ACA, and recoups estimated overpayments due to coding and documentation as outlined in the *American Tax Relief Act of 2012* (ATRA):

- Hospital market basket increase 2.5%
- ACA mandated reduction to market basket increase: -.3%
- ACA mandated multi-factor productivity adjustment: -.4%
- ATRA coding and documentation recoupment: -.8%
- Offset cost of IP admissions and medical review criteria: -.2%

These offsets are discussed in more detail below.

ACA adjustments

The ACA contains mandatory reductions to annual market basket increases and applies productivity factor adjustments to ensure health care providers are keeping pace with productivity changes in other industries. These provisions have been in effect since the inception of the ACA in March 2010. For federal fiscal year 2014 (FFY 2014) the scheduled reduction to the market basket increase is .3 percent.

The ACA mandated the use of the 10-year moving average of the "private non-farm business multifactor productivity" indicator to also reduce annual market basket increases. This reduction is intended to encourage improvements in health care delivery efficiency by using this offset throughout all of CMS annual payment updates.

American Tax Relief Act of 2012 adjustments

To avoid the "fiscal cliff" on January 1, 2013, the ATRA was passed into law, and it included several health care related provisions. Among these provisions was a one-year deferral of reductions in physician reimbursement through the sustainable growth rate (SGR) formula. In order to accomplish this deferral, Congress authorized CMS to continue to recoup estimated increases in reimbursement as a result of the transition to Medicare Severity Diagnosis Related Group (MS-DRG) payment system, which began in 2008. CMS has estimated that approximately $11 billion may be recouped, and is proposing a .8 percent reduction as an initial step to recovery for FFY 2014. CMS expects to make similar adjustments in FFY 2015, 2016, and 2017 to fully recover the $11 billion.

Inpatient admission and medical review criteria

CMS has expressed concerns about the increasing length of stay for Medicare beneficiaries in hospital outpatient setting as "observation bed" patients. In the 2013 final outpatient payment rule, CMS noted the rate of beneficiaries staying in observation status for 48 hours or more has increased from 3 percent in 2006 to 8 percent in 2011.

This increase is believed to be correlated to a significant number of one-day-length of stays being denied in recovery audit contractors (RAC) audits, and because of billing regulations, providers could not re-bill for these services. Providers have been asking CMS to provide clarity around admissions criteria to improve their understanding of Medicare's policies for what constitutes an appropriate inpatient admission.

CMS states in its proposed rule that a hospital inpatient stay spanning two midnights will be appropriate for payment under Medicare Part A and those inpatient stays spanning less will be inappropriate. Under current policy, CMS states that the decision to admit a patient as an inpatient be made within 24 to 48 hours of observation care and that expectation of an overnight stay may be a factor in the decision to admit.

CMS actuaries estimated the impact of this proposal would increase reimbursement by approximately $220 million as a result of an expected "net increase in inpatient encounters." In order to ensure this policy remains budget-neutral, CMS is proposing a .2 percent reduction in the annual payment rate update to offset this impact.

Included in the proposed rule is extensive discussion to indicate the "two-midnight stay" criteria is not the only requirement that must be met in order to receive payment under Medicare Part A. CMS emphasizes that "…physicians would be required to clearly and completely document the clinical facts supporting the inpatient hospital admission."

Medicare DSH

Section 3133 of the ACA outlines a methodology for calculating Medicare DSH payments that are intended to reflect the change in the percentage of individuals under age 65 who are uninsured as a result of coverage expansion beginning January 1, 2014.

Beginning with discharges on October 1, 2013, eligible hospitals will have their DSH payments reduced to 25 percent of the payment they would have normally received under current formulas. CMS refers to this payment as the "empirically justified payment." The remaining 75 percent

will be reduced to reflect the change in the percentage of individuals who are uninsured and under age 65, then redistributed to hospitals in the form of an additional DSH payment. This payment will be based on each hospitals' amount of uncompensated care for a specific period relative to the total uncompensated care by all hospitals during that same period. Prior to distribution, the DSH pool amount will be further reduced by an ACA-mandated additional .1 percent for 2014.

Formula guiding additional DSH payments

Each hospital's additional DSH payment will be the product of three factors, which are outlined with example calculations in the proposed rule as follows:

- Factor one: The CMS Office of Actuary estimated total DSH payments for all hospitals, minus the 25 percent that will be distributed as "empirically justified" payments. According to CMS, the total estimated DSH payments for 2014 equate to approximately $12.3 billion. Factor one would be determined as follows:

Factor One: Pool for Additional DSH Payments	
Variable Description	*DSH Pool*
CMS Office of Actuary estimated 2014 DSH payments	$12,338,000,000
Less: 75 percent reduction (DSH pool withheld to be used as Factor One	(9,253,500,000)
Empirically justified DSH payments FFY 2014 for all hospitals	$3,084,500,000
Remaining DSH amount for factor one	**$9,253,500,000**

- Factor two: This factor will identify the change in uninsured from a baseline time period to 2013, which will represent the most recently available estimate prior to coverage expansion. The data will be calculated using the Congressional Budget Office (CBO) estimate of uninsured population from 2010 of 18 percent as the baseline, compared to their most recent estimate from February 2013 of 16 percent. The following table illustrates:

Factor Two: Estimated Change in Uninsured Population	
Variable Description	*Percent*
CBO estimated percent of uninsured 2010	18
CBO estimated percent of uninsured 2013	16
CBO estimated percent change in uninsured	-11.1
Additional reduction per ACA	-.01
Total change in uninsured plus additional ACA reduction	**-11.2**

- Factor three: The final factor used in the calculation will reflect a hospital's specific portion of uncompensated care as a percent of uncompensated care provided by all hospitals. CMS discusses various data points that could be used in this calculation, including the data reported on Worksheet S-10 of the Medicare Cost Reports. The most recently available data for uncompensated care reported in the Medicare reports would be from those reports filed on or after May 1, 2010, which represents the initial year of this data being collected as a result of the electronic health record incentive program. Due to concerns of accuracy in the data, CMS proposed to use the utilization of insured patients defined by Medicaid days, plus the inpatient days of Medicare SSI patients to determine factor 3. This data will come from the most recently available Medicare cost reports which are from the time period of 2010/2011. As a result, each hospital's specific uncompensated care ratio will be provided by CMS.

The additional DSH adjustment a hospital receives (if any) will be the product of all three factors. Due to the variables involved in the calculation, the impact per hospital will vary.

CMS explains the above modification to DSH payments will affect only the operating portion of the payment, and does not affect the DSH capital payments. In addition, CMS points out that this change will depend on hospital classifications:

- Applicable:
  - Subsection (d) Puerto Rico hospital's receiving DSH payments
  - Sole community hospitals
  - Hospitals participating in the bundled payments for care initiative
- Not Applicable:
  - Maryland waiver hospitals
  - Hospitals participating in the Rural Community Hospital Demonstration

Hospital acquired conditions (HACs) reduction program

Section 3008 of the ACA requires CMS to establish a process for assessing financial penalties to hospitals that reflect poor performance in HACs. CMS outlines the proposed framework for implementing a 1 percent penalty for hospitals that rank in the lowest quartile of HAC performance beginning in FFY 2015.

CMS states the 1 percent HAC penalty will be determined after the application of any payment adjustment under

the Hospital Readmissions Reduction Program, and the adjustment made under the Hospital Value-Based Purchasing Program.

CMS proposes that hospitals would receive performance scores on two equally weighted domains, each with multiple measures. CMS is seeking input on two options for domain one. Domain two will remain the same regardless of which domain one option becomes final.

One option for domain one consists of six measures reflecting patient safety indicator (PSIs) measures developed by the Agency for Health Care Research and Quality (AHRQ). The specific PSIs for domain one are proposed as follows:

1. Pressure ulcer rate
2. Volume of foreign object left in the body
3. Iatrogenic pneumothorax rate
4. Postoperative physiologic and metabolic derangement rate
5. Postoperative pulmonary embolism or deep vein thrombosis rate
6. Accidental puncture and laceration rate

The alternative domain one includes a complications and patient safety for selected conditions composite consisting of eight measures:

1. Pressure ulcer rate
2. Iatrogenic pneumothorax rate
3. Central venous catheter-related bloodstream infection rate
4. Postoperative hip fracture rate
5. Postoperative pulmonary embolism or deep vein thrombosis rate
6. Postoperative sepsis rate
7. Wound dehiscence rate
8. Accidental puncture and laceration rate

Domain two will consist initially of two health care-associated infection (HAI) measures developed and collected via the Center for Disease Control's (CDC) National Health Safety Network (NHSN) regardless of which domain one option is selected. The initial HAIs to be included are:

1. Central line-associated bloodstream infection
2. Catheter-associated urinary tract infection

In FFY 2016 and FFY 2017, the HAIs included in domain two will be expanded to include the following measures:

1. Surgical site infection following colon surgery (FFY 2016 and subsequent years)
2. Surgical site infection following abdominal hysterectomy (FFY 2016 and subsequent years)
3. Methicillin-resistant staphylococcus aureus (MRSA) bacteremia (FFY 2017 and subsequent years)
4. Clostridium difficile (FFY 2017 and subsequent years)

Many of the above measures have been reported on by hospitals through the Hospital Inpatient Quality Reporting (IQR) system, and some will be included in value-based purchasing reimbursement calculations as well. The selection of these types of measures across all payment initiatives demonstrates how CMS will combine payment reform activities to form a common set of measures over time.

CMS's proposed scoring methodology is complex and each measure within each domain would receive a risk-adjusted score. The total domain score would be calculated from the individual measure's scores in each domain, and the domains would then be equally weighted to arrive at the hospital's total HAC score. Hospitals with total HAC scores in the highest quartile will be subject to the 1 percent penalty reduction in reimbursement.

For FFY 2015, CMS is proposing to use AHRQ data for domain one scores from the 24-month time period of July 1, 2011, through June 30, 2013. For domain two measures, CMS proposes using data from a 24-month period from calendar years 2012 and 2013.

CMS has proposed a process for providing hospitals with their specific confidential reports through the current hospital IQR program, wherein each hospital will be provided the opportunity to review and correct its specific data. In addition, CMS proposes to post the data to the Hospital Compare website so it is available to the public. The information posted to the website will include:

1. Hospital's scores with respect to each measure
2. Hospital's domain specific scores
3. Hospital's total HAC score

The HAC payment reduction program will apply to all subsection (d) hospitals operating in one of 50 states or the District of Columbia, and as such would include Indian Health Service hospitals and hospitals located in the state of Maryland, unless specifically exempted by the Secretary of Health and Human Services.

The following hospitals would be specifically excluded from the HAC payment reduction program because they are not considered subsection (d) hospitals:

- Long-term care acute hospitals
- Cancer hospitals
- Children's hospitals
- Independent rehab facilities
- Inpatient psychiatric facilities
- Critical access hospitals

Hospital value-based purchasing (VBP)

In accordance with the evolution of the VBP program, CMS is increasing the payment reduction from 1 percent used in 2013 to 1.25 percent in 2014. The VBP program remains budget neutral, and CMS estimates there will be approximately $1.1 billion available for performance-based incentive payments in 2014.

For FFY 2014, CMS has adopted the same 12 clinical processes of care and HCAPS measures used in the FFY 2013 VBP program and added one additional clinical process of care measure and a new outcomes domain (that includes three mortality outcomes measures). The additional measures are as follows:

1. Clinical processes of care measure:
   a. HAI postoperative urinary catheter removal on postoperative day one or two
2. Outcomes domain — mortality outcomes measures:
   a. Acute myocardial infarction (AMI) 30-day mortality rate
   b. Heart failure (HF) 30-day mortality rate
   c. Pneumonia (PN) 30-day mortality rate

CMS also outlines the final VBP measures for FFY 2015 and proposed measures for FFY 2016 along with performance standards for FFYs 2017, 2018, and 2019, and is seeking comments on all of the proposed measures and performance standards.

Beginning in FFY 2015, CMS will begin to incorporate efficiency measures into the VBP calculation. These will be based on total Medicare Part A and Part B spending per beneficiary, including the periods of one to three days prior to admission, during the inpatient stay, and up to 30 days after discharge from the hospital setting. For information purposes, CMS included the "achievement" and "benchmark" thresholds for the efficiency measure for the time period of May 1, 2011, through December 31, 2011. These spending levels, along with proposed refined definitions of each, are as follows:

- Achievement threshold (spending level: $18,079) — Defined as the median (50th percentile) of hospital performance during the performance period with respect to a fiscal year
- Benchmark threshold (spending level of $14,985) — Defined as the arithmetic mean of the top decile of hospital performance during the performance period with respect to a fiscal year

The efficiency measure will be added in FFY 2015 and will increase in importance in FFY 2016 as the proposed weight for this domain increases. The table below reflects the FFY 2013 domains and weighting, the domains finalized for FFY 2014 and FFY 2015, and what is currently proposed for FFY 2016.

Final and Proposed Domains and Domain Weights FFY 2013 – FFY 2016

Domain	*FFY 2013 Final*	*FFY 2014 Final*	*FFY 2015 Final*	*FFY 2016 Proposed*
Clinical process of care	70%	45%	20%	10%
Patient experience	30%	30%	30%	25%
Outcome measures	–	25%	30%	40%
Efficiency care measures	–	–	20%	25%

CMS also included the finalized performance standards (achievement and benchmark thresholds) for the outcome measures for FFY 2016 as well as the proposed performance standards measures for FFY 2016 for the clinical process of care, patient experience, outcome measures, and efficiency of care domains. They are seeking comments on the performance standards.

In addition to refining the measures and performance standards within the measures, CMS outlines how domains and the weighting of those domains will change as they are modified. One of the proposed changes may include reclassifying current measures and domains to be in alignment with the National Quality Strategy (NQS) domains outlined in the ACA. In that case, measures currently grouped under one domain would move to another. For example, under current CMS domains, certain measures reflected as outcomes measures would be reflected as safety measures under the NQS structure. If adopted, CMS is proposing changing domain names and weighting to reflect and align with the NQS structure. The proposed domains and domain weighting structure for FFY 2017 is summarized in the following table.

Proposed Domains and Domain Weights for FFY 2017 Hospital VBP Program	
Domain	*Weight*
Safety	15%
Clinical care Clinical care – outcomes: 25% Clinical care – process: 10%	35%
Patient and caregiver centered experience of care/care coordination	25%

The VBP program will continue to evolve and change over the next several years. This evolution will undoubtedly create a shifting environment for hospitals in terms of qualifying for a VBP incentive payment or being assessed a VBP penalty. The additional domains, potential reclassification of measures, and weighting changes means there is a risk of qualifying for an incentive payment in one year and not qualifying in a subsequent year with the same performance.

Proposed changes to Hospital Readmissions Reduction Program (HRRP)

The HRRP began in FFY 2013 with a maximum payment reduction of 1 percent. In accordance with the ACA, the maximum reduction will increase to 2 percent in FFY 2014.

For FFY 2014, CMS is not proposing any new conditions for the program and will continue with the current conditions (AMI, HF, and PN). The primary change for FFY 2014 is incorporation of the CMS Planned Readmission Algorithm Version 2.1 to identify planned readmissions. CMS proposes to update the readmission measures for the above three conditions to account for planned readmissions and not count unplanned readmissions that follow planned readmissions within 30 days of the patient's initial index discharge. According to CMS, this change has minimal impact on the index admissions, and included the following table to illustrate the impact:

For FFY 2015, CMS is proposing to increase the number of conditions from AMI, HF, and PN to include the following additional conditions:

1. Patients admitted for acute exacerbation of chronic obstructive pulmonary disease (COPD)
2. Patients admitted for total hip arthroplasty (THA) and total knee arthroplasty (TKA)

Proposed payment adjustment for low-volume hospitals

The ACA and ATRA adjusted the criteria for qualification to receive additional payments from Medicare for those hospitals considered to have low-volume. The original ACA adjustment criteria expired on September 30, 2012, only to be extended by the ATRA through September 30, 2013. Absent additional action by Congress, CMS does not have authority to extend the low-volume adjustment program beyond FFY 2013.

To qualify for low-volume adjustment in FFY 2014, hospitals will have to meet the original criteria in effect from FFY 2005 through FFY 2010, which requires hospitals to:

1. Be a subsection (d) hospital
2. Be more than 25 road miles from another subsection (d) hospital
3. Have less than 200 discharges, including Medicare and non-Medicare discharges, during the fiscal year

Hospitals qualifying under these criteria will receive a payment adjustment of an additional 25 percent for each discharge during the fiscal year.

Medicare dependent small rural hospital (MDH) program

The combination of the ACA and ATRA extended the MDH program to the end of FFY 2013 from the initially scheduled date of conclusion at the end of FFY 2011. In the proposed rule, CMS points out that the MDH program has been authorized by legislation to continue through FFY 2013, and therefore CMS does not have authority

Comparison of Original Measures Finalized in FFY 2013 Relative to Proposed Revised Measures in FFY 2014						
	AMI		HF		PN	
Description	*Proposed Revised Measure*	*Original Measure*	*Proposed Revised Measure*	*Original Measure*	*Proposed Revised Measure*	*Original Measure*
Number of admissions	501,765	501,765	957,854	957,854	1,195,967	1,195,967
Number of unplanned admissions	91,360	96,302	170,396	177,480	276,748	294,260
Readmission rate	18.2%	19.2%	17.8%	18.5%	23.1%	24.6%
Number of planned readmissions	12,811	7,869	7,084	–	17,512	–
Planned readmission rate	2.6%	1.6%	0.7%	0.0%	1.5%	0.0%
Percent of readmissions that are planned	12.3%	7.6%	4.0%	0.0%	6.0%	0.0%

to extend it. As a result, those hospitals qualifying for reimbursement under the MDH program will revert to being reimbursed at the federal rate for FFY 2014, as the MDH program will be discontinued.

CMS noted in the FFY 2013 rule, regulations were modified to allow MDHs to apply for sole community hospital (SCH) designation, and these regulations remain intact for FFY 2014. As a result, those hospitals that re-applied for MDH status can apply for SCH designation. In order to do this, the hospitals must do the following:

1. Apply for SCH status at least 30 days prior to the end of the MDH program, which is August 31, 2013
2. State that, if approved for SCH status, it will make it effective on October 1, 2013, immediately after MDH status expires
3. If an MDH misses the August 31, 2013, application deadline, CMS indicates if approved for SCH status it will become effective 30 days after the date of CMS's written notification of approval

Maternity patients included in census

CMS is proposing that patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time inpatient routine census is taken, will be included in the Medicare utilization calculation. CMS acknowledged this policy will reduce direct GME payments, but believes the ratio is more accurate when included.

Direct graduate medical education

CMS also proposes that for the portion of cost reporting periods beginning on or after October 1, 2013, a hospital may not claim full-time equivalent residents training in a critical access hospital (CAH) in its count for either indirect medical education (IME) or graduate medical education (GME) reimbursement. CMS states that if the CAH incurs the cost of training the resident, it may claim those training costs in its cost report and receive reimbursement at 101 percent of costs. However, the CAH is not allowed to claim costs for resident training for any costs incurred when the resident is not at the CAH.

Wage index statistical area designation

CMS is required by Medicare law to adjust the labor-related portion of the standardized payment amount for geographical differences in wage levels. To accomplish this, CMS utilizes the Office of Management and Budget (OMB) delineations of statistical areas to define the geographic areas used in determining these wage levels.

At the end of February 2013, OMB announced revisions to the statistical areas based on the 2010 Census. CMS would normally update the labor-related portion in the standardized payment based on this update, however, due to the timing of the announcement and the release date of the proposed and final IP PPS rules, CMS intends to adjust these statistical area definitions in the FFY 2015 rule.

MS-DRG relative weight refinement

In the FFY 2009 and 2011 final rules, CMS created new cost centers for certain high-cost implantable devices and high-cost imaging services of MRI, CT scans, and cardiac catheterization. These cost centers were created to avoid charge compression by combining lower cost and higher cost procedures. CMS has evaluated implementing these cost centers as part of establishing the relative value weights used in MS-DRG weighting. Beginning in FFY 2014, CMS proposes to implement these new cost centers, which will increase the number of cost-to-charge ratios used in arriving at relative value weights from 15 to 19.

Proposed changes to hospital inpatient quality reporting (IQR) program and electronic health record (EHR) incentive

As part of elevating the use of EHRs, CMS is proposing to expand several EHR incentive program policies with the hospital IQR program policies, and expand the period for electronic submission of various clinical quality measures. CMS believes this change would reduce the burden of quality reporting on eligible hospitals and CAHs.

Hospitals participating in the IQR program have the option of submitting one quarter's data for 16 quality measures from four different measure sets in electronic format. Hospitals that choose to not submit electronically would be required to submit a full years worth of quality data through chart-abstraction.

CMS notes that hospitals that choose to submit electronically will satisfy the requirements for both the clinical quality measures component of EHR incentive program, as well as the reporting requirements for the hospital IQR program.

Conclusion

The health care industry is in the midst of turbulent times, and the regulations are rapidly changing. Access to accurate information is the first step to positioning your organization for future success. The CLA Regulatory Advisor will keep you informed as new legislation is enacted.

Contacts

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