CliftonLarsonAllen

A Guide to
Regulation and Legislation

Regulatory Advisor

CMS Releases 2014 Final Rule for Inpatient Prospective Payment System

On August 2, 2013, the Centers for Medicare and Medicaid Services (CMS) issued the final 2014 Inpatient Prospective Payment System (IP PPS) Rule that updates payment rates for approximately 3,400 acute care hospitals and about 440 long-term care acute hospitals (LTCHs) across the country. The rule continues to push the connection between quality, patient safety, and patient satisfaction to reimbursement.

In the final rule, CMS includes various provisions aimed at the continued implementation of the *Affordable Care Act* (ACA). One of the more anticipated changes is the final formula for reductions in payments to disproportionate share hospitals (DSH) due to anticipated decreases in the percentage of uninsured patients. Beginning January 1, 2014, the uninsured population will benefit from expansion of 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 final rule outlines how these reductions will be handled. Below is a summary of the more critical information contained in the final rule.

Payment rate changes to IP PPS

The rule increases payment rates for inpatient services by a net .7 percent. Once all adjustments in the final rule are considered, CMS estimates a net increase of .5 percent in operating payments compared to 2013. The .7 percent payment rate increase is the net result after CMS applies the changes for market basket conditions, various provisions

of the ACA, and recoups estimated overpayments due to coding and documentation as outlined in the *American Taxpayer Relief Act of 2012* (ATRA):

Hospital market basket increase	2.5%
ACA mandated reduction to market basket increase	-.5%
ACA mandated multi-factor productivity adjustment	-.3%
ATRA coding and documentation recoupment	-.8%
Offset cost of IP admissions and medical review criteria	-.2%
Total net payment rate increase	.7%

These offsets are discussed in more detail below.

ACA adjustments

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 efficiency in health care delivery by using this offset throughout all of CMS annual payment updates. These provisions have been in effect since the inception of the ACA in March 2010. For federal fiscal year 2014 (FFY 2014) the final productivity offset reduction to the market basket increase is .5 percent.

ATRA adjustments

The ATRA was passed into law on January 1, 2013, to avoid the fiscal cliff, 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 the MS-DRG payment system, which began in 2008.

CMS has estimated that approximately $11 billion may be recouped, and the .8 percent reduction is 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. While reductions in payment rates are never positive, the silver lining for providers — if CMS holds true to its "similar adjustment" reference — is the reductions will be similar over the four-year recoupment period.

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's final rule states that a hospital inpatient stay spanning two midnights will be required for payment under Medicare Part A. Under current policy, the decision to admit a patient as an inpatient may 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 change 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 settled on a .2 percent reduction in the annual payment rate update to offset this impact.

CMS also indicated 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." In addition, CMS included revised guidance stating hospital stays of less than two midnights should automatically be considered outpatient services unless there is clear physician documentation indicating an expectation of a two midnight stay or longer.

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 or after October 1, 2013, CMS will use a revised formula for DSH payments that will pay hospitals 25 percent of the payment they would have normally received. CMS refers to the 25 percent payment as the "empirically justified payment." The remaining 75 percent will be reduced to reflect the change in the uninsured population. This "additional uncompensated care payment" will be based on each hospital's 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 .1 percent for 2014.

Formula guiding additional DSH payments

Each hospital's additional DSH payment will be the product of three factors. The three factors and example calculations are outlined in the final rule as follows:

- Factor one: The CMS Office of Actuary estimated total DSH payments for all hospitals, less 25 percent that will be distributed as "empirically justified" payments. According to CMS's July 2013 estimates, the total estimated DSH payments for 2014 equate to approximately $12.772 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	$12,772,000,000
Less: 75 percent reduction (DSH pool withheld to be used as factor one)	(9,579,000,000)
Empirically justified DSH payments FFY 2014 for all hospitals	$3,193,000,000
Remaining DSH amount for factor one	**$9,579,000,000**

- Factor two: This factor will identify the estimated change in uninsured from 2013 to 2014. The data used for the 2013 base year comes from the 2010 Congressional Budget Office (CBO) report that estimated the uninsured population in 2013 at 18 percent. To arrive at the estimate for 2014, CMS will use updated calendar year 2013 and calendar year 2014 uninsured estimates from May and July 2013, respectively. These two calendar year estimates will be pro-rated to arrive at a FFY 2014 estimate of uninsured. The change from the base period of 2013 compared to the estimated FFY 2014 rate of uninsured will be used to arrive at the reduction amount applied to the 75 percent DSH pool, plus an additional reduction of .1 percent. The following table illustrates this calculation:

Factor Two: Estimated Change in Uninsured Population	
Variable Description	Percent
Estimated percent of uninsured for 2013 (March 2010 CBO estimate)	18
Estimated percent of uninsured for FFY 2014 (weighted CY 2013 and 2014 estimate from CBO)	17
CBO estimated percent change in uninsured	-5.6
Additional reduction per ACA	-0.1
Total change in uninsured plus additional ACA reduction	**-5.7**

- Factor three: The final factor used in the calculation will reflect the 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. Due to concerns of accuracy in the data, CMS has opted to use the utilization of insured patients defined by Medicaid days, plus the inpatient days of Medicare SSI patients to determine factor three. This data will come from the most recent Medicare cost reports available from the time period of 2010 – 2011. As a result, each hospital's specific uncompensated care ratio will be provided by CMS.

  Any additional DSH adjustment a hospital receives will be the product of all three factors. Due to the variables involved in the calculation, the impact on a per hospital basis will vary.

  In the proposed rule, CMS indicated the uncompensated care payments would be made "periodically" but did not define what this meant. Due to significant concerns about cash flow issues expressed during the comment period, the final rule concludes that DSH payments to eligible hospitals (both empirical and uncompensated care payments) will be paid on a per discharge basis, with settlement based on the final cost report.

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

- Applicable:
  a. Subsection (d) Puerto Rico hospitals receiving DSH payments
  b. Sole community hospitals
  c. Hospitals participating in the bundled payments for care initiative
- Not applicable:
  a. Maryland waiver hospitals
  b. Hospitals participating in the Rural Community Hospital Demonstration

Part B inpatient billing for denied Part A inpatient services

CMS noted an increasing number of Part A inpatient claims being denied as part of recovery audit contractor (RAC) and other payment review initiatives. The denials claimed the admissions were not reasonable and necessary. Hospitals were appealing these decisions to the Medicare Appeals Council (MAC) or Administrative Law Judges (ALJ), who would support the not reasonable

and necessary conclusion on the admission, but ordered payment for services as if they were rendered as an outpatient or "observation level" of care. These decisions effectively required Medicare to issue a payment for all Part B services that would have been reimbursable had the patient originally been treated as an outpatient rather than an inpatient.

These MAC and ALJ decisions were in direct contradiction of CMS's long-standing policies on such payment, and as a result, in March 2013, CMS issued a proposed rule and CMS ruling that established a standard process for handling these types of claims. The ruling was effective immediately until CMS finalized its position.

CMS is finalizing its proposal to allow payment for Part B inpatient services to a hospital if it is determined, after the beneficiary is discharged, that the inpatient admission was not reasonable and necessary and the patient should have been treated as an outpatient. In order to receive payment, the patient must be enrolled in Part B Medicare, and the claim must be filed within one calendar year after the date of service, except for the following conditions:

1. The Part A inpatient claim was one in which the original CMS ruling from March 2013 applied; or
2. The part A inpatient claim has a date of admission before October 1, 2013, and is denied after September 30, 2013, on the grounds the medical care was reasonable and necessary but the inpatient admission was not.

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 final framework for implementing a 1 percent penalty for hospitals that rank in the lowest quartile of HAC performance beginning on October 1, 2014.

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 initially proposed two equally weighted domains consisting of multiple measures that hospitals would receive performance scores on. However, in the final rule, the domains are weighted at 35 percent and 65 percent. Domain one will be comprised of patient safety measures and will carry the 35 percent weight. (This domain was the "alternative" domain in the proposed rule). Domain one will be a composite of eight measures:

1. Pressure ulcer rate
2. Iatrogenic pneumothorax rate
3. Central venous catheter-related blood stream infection
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). The initial HAI's to be included are:

1. Central line-associated blood stream infection
2. Catheter-associated urinary tract infection

In FFY 2016 and FFY 2017, CMS proposes that HAIs included in domain two 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 final scoring methodology is less complex than what was originally proposed. Each measure within each domain would receive points based on the decile ranking. The points from all the measures would be added together to arrive at the total domain score. The total domain scores would then be weighted 35/65 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 will use the Agency for Health Care Research and Quality data for domain one scores from the

24-month time period of July 1, 2011, through June 30, 2013. For domain two measures, CMS will use data from a 24-month period from calendar years 2012 and 2013.

CMS finalized a process for providing hospitals with their specific confidential reports through the current Hospital IQR program wherein each hospital will be given the opportunity to review and correct its specific data. In addition, CMS will 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 Washington, DC, 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

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.

CMS also finalized the baseline and performance periods for the FFY 2016 efficiency measures as follows:

- Baseline period: January 1, 2012, through December 31, 2012
- Performance period: January 1, 2014, through December 31, 2014

For information purposes, CMS included the "achievement" and "benchmark" thresholds for efficiency measures for the time period of January 1, 2012, through December 31, 2012. These spending levels, along with refined definitions of each are as follows:

- Achievement threshold (spending level: $18,412)— Defined as the median (50th percentile) of hospital performance during the performance period with respect to a fiscal year (January 1, 2012, through December 31, 2012).
- Benchmark threshold (spending level: $15,311) — Defined as the arithmetic mean of the top decile of hospital performance during the performance period with respect to a fiscal year (January 1, 2012, through December 31, 2012).

The efficiency measure will be initially 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, along with the domains finalized for FFY 2014, FFY 2015, and FFY 2016.

Final 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 announced the final performance and baseline periods for the VBP program for FFY 2016 through 2019, as

reflected in the corresponding table. The important thing for hospitals to note is that performance on measures within these domains will impact payments for five or six years into the future.

CMS discusses incorporating a ratio of Part B inpatient claims billed as a result of finalizing the rule allowing hospitals to re-bill certain inpatient claims that are denied as part of a RAC audit. CMS is considering developing such a ratio and would include it as a component of the efficiency domain.

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. Additional domains, reclassifying 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.

FFY 2016 VBP Program

Domain	Baseline Period	Performance Period
Clinical process of care	1/1/12 – 12/31/12	1/1/14 – 12/31/14
Patient experience of care	1/1/12 – 12/31/12	1/1/14 – 12/31/14
Efficiency	1/1/12 – 12/31/12	1/1/14 – 12/31/14
Outcomes		
Mortality	10/1/11 – 6/30/11	10/1/12 – 6/30/14
AHRQ PSI composite	10/15/10 – 6/30/11	10/15/12 – 6/30/14

FFY 2017 VBP Program

Domain	Baseline Period	Performance Period
Outcomes		
Mortality	10/1/10 – 6/30/12	10/1/13 – 6/30/15
AHRQ PSI composite	10/1/10 – 6/30/12	10/1/13 – 6/30/15

FFY 2018 VBP Program

Domain	Baseline Period	Performance Period
Outcomes		
Mortality	10/1/09 – 6/30/12	10/1/13 – 6/30/16
AHRQ PSI composite	7/1/10 – 6/30/12	7/1/14 – 6/30/16

FFY 2019 VBP Program

Domain	Baseline Period	Performance Period
Outcomes		
Mortality	7/1/09 – 6/30/12	7/1/14 – 6/30/17
AHRQ PSI composite	7/1/10 – 6/30/12	7/1/15 – 6/30/14

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 adding any new conditions for the program and will continue with the current conditions of acute myocardial infarction (AMI), heart failure (HF) and pneumonia (PN). The primary change for FFY 2014 is incorporation of the CMS Planned Readmission Algorithm Version 2.1 to identify planned readmissions. CMS will 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 patients initial index discharge. According to CMS, this change has minimal impact on the index admissions and included the following table to illustrate the impact.

Comparison of Original Measures Finalized in FFY 2013 Relative to Proposed Revised Measures in FFY 2014

Description	AMI		PN		HF	
	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%

For FFY 2015 CMS will 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)

CMS selected COPD for inclusion in the readmissions reduction program because this condition is a leading cause for hospital readmissions and ranked fourth among the top seven most costly avoidable readmissions in a study conducted by MedPAC

in 2007. In addition, CMS noted wide variation in readmissions for patients with COPD and suggested opportunities exist for improving care. In 2008, patients aged 65 and older reflected a median readmission rate of 22 percent with a range of 18.33 percent to 25.03 percent across over 4,500 hospitals.

CMS believes selecting THA and TKA for the readmissions reduction program is appropriate because these conditions are both high volume and high cost. Medicare is the single largest payer for these procedures in the United States, covering approximately two-thirds of all THA and TKA procedures performed in the country. The aggregate cost to Medicare for these procedures is projected to increase from 2005 to 2015 by 340 percent for TKA (to $17.4 billion) and by 450 percent for TKA (to $40.8 billion). The 30-day readmissions rate from 2008 to 2010 was at 5.7 percent and varied across over 3,500 hospitals from 3.2 percent to 9.9 percent. CMS believes focusing on these procedures can be of significant benefit to the Medicare program.

Proposed payment adjustment for low-volume hospitals

The ACA and ATRA adjusted the criteria for qualification to receive additional payments from Medicare for low-volume hospitals. 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 that was in effect from FFY 2005 through FFY 2010, which are as follows:

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. Hospitals must submit their request for low-volume adjustment to its fiscal intermediary or MAC by September 1, 2013, in order for the payment adjustment to be applied by October 1, 2013. If the hospital's request is received after September 1, 2013, the request (if approved) will become effective within 30 days of the date of the fiscal intermediaries' or MAC's determination of qualification.

Medicare dependent small rural hospital (MDH) program

The combination of the ACA and ATRA extended the MDH program to the end of FFY 2013. In the final 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 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 become effective on October 1, 2013, immediately after MDH status expires
3. If an MDH misses the August 31, 2013, application deadline, CMS indicates if it is 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 finalized its position 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. This change becomes effective in the Medicare utilization calculation for cost reporting periods beginning on or after October 1, 2013. CMS acknowledged this policy will reduce direct GME payments, but believes the ratio is more accurate.

Hospitals classified as sole community hospitals (SCH) should also take note of this change, as inclusion of these days may impact designation as an SCH in the future. CMS utilizes inpatient days to compare eligibility for the SCH designation. If a nearby hospital's inpatient days are greater than 8 percent of an SCH applying hospital's total inpatient days, the nearby hospital is considered to be a "like hospital" and SCH designation would be denied. Including these days may change SCH eligibility for a hospital applying for such designation after October 1, 2013, as well as potentially impacting hospitals that currently have the SCH designation.

Payment for residents training in residency programs at Critical Access Hospitals

CMS finalized its position 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. The OMB revisions include new core-based statistical areas (CBSAs), urban counties that have become rural counties, rural counties that became urban, and existing CBSAs that have been split apart. These changes impact reimbursement for a significant number of hospitals, and CMS believes additional detailed analysis is warranted before incorporating these changes into the final FFY 2014 rule.

Due to the timing of the OMB announcement, the amount of detailed analysis CMS believes is necessary, and the release date of the final 2014 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, cardiac catheterization, and high-cost imaging services like MRIs and CT scans. These were created to avoid charge compression by combining lower-cost and higher-cost procedures. CMS evaluated these cost centers as part of establishing the relative value weights used in MS-DRG weighting. Beginning in FFY 2014, CMS is implementing 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 will be expanding several EHR incentive programs with the hospital IQR program policies, and expanding the submission period for electronic submission of various clinical quality measures. CMS believes this will reduce the burden of quality reporting on eligible hospitals and CAHs.

Hospitals participating in the IQR program will have the option of electronically submitting one quarter's data for 16 quality measures from four different measure sets. 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.

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