

CMS Proposes Prospective Payment System Update Rules for Inpatient and Long Term Care Hospitals

On Friday, April 26, the Centers for Medicare and Medicaid Services (CMS) issued a crucial payment system rule that proposes updated rates and regulatory policies for inpatient hospitals (including inpatient psychiatric facilities) and for long term care hospitals. The Proposed Rule incorporates update factors for FY 2014 rates effective October 1, 2013 and sets forth new proposed policies and policy revisions with respect to patient quality, including hospital acquired condition and readmission reduction programs, and admission and medical review criteria.

In general, Cozen O'Connor believes the Proposed Rule represents a fair starting point for Inpatient Prospective Payment System (IPPS) hospitals for FY 2014 and offers stakeholders an important opportunity to provide comments that CMS specifically suggests could help shape final policy.

OVERVIEW OF KEY COMPONENTS

Proposed Rates for FY 2014

- The Proposed Rule increases IPPS rates by 0.8 percent in FY 2014. The +0.8 percent update is the product of a +2.5 percent market basket update, reduced by the Affordable Care Act (ACA) mandated productivity adjustment (-0.4 percent), additional ACA adjustments (-0.3 percent), documentation and coding reductions for FY 2010, '11 and '12 per the American Taxpayer Relief Act of 2012 (-0.8 percent), and an offset for proposed changes to admission and medical review criteria for IPPS services (-0.2 percent). The Proposed Rule for Long Term Care Hospitals (LTCHs) would increase LTCH PPS rates by 1.1 percent¹.

Other Rate-Related Proposals – Documentation and Coding Offsets

- The American Taxpayer Relief Act of 2012 (ATRA) requires CMS to reduce future rates over the next four years to offset \$11 billion in increased payments from prior years. For FY 2014, CMS is proposing a -0.8 percent recoupment adjustment as the first step in complying with the law.

Other Rate-Related Proposals – Medicare Disproportionate Share Hospitals (DSH)

- DSH payments will be reduced under the Proposed Rule to 25 percent of what Medicare would pay under the current policy; the remaining 75 percent will be adjusted for decreases in the rate of uninsured individuals nationally and distributed to hospitals that receive DSH payments based on each hospital's share of uncompensated care relative to all Medicare DSH hospitals. The Proposed Rule seeks comments on how additional DSH payments will be distributed.

Other Rate-Related Proposals – Direct Graduate Medical Education (DGME)

- The Proposed Rule suggests it will revise the current GME policy addressing inpatient labor and delivery days in the inpatient Medicare utilization calculation. CMS also proposes, for portions of cost reporting periods beginning on or after October 1, 2013, that a hospital may not claim Full Time Equivalent (FTE) residents training at a Critical Access Hospital (CAH) for Indirect Medical Education or DGME purposes. But if the CAH itself incurs the costs of training the FTE residents when these residents rotate to the CAH, then the CAH may receive payment based on 101 percent of those Medicare reasonable costs.

Admission and Medical Review Criteria for IPPS Services

- The Proposed Rule clarifies CMS's policy on how its contractors will review IPPS admissions for payment purposes. Under the proposal, CMS asserts that hospital admissions "spanning at least two midnights" would presumptively qualify as appropriate for payment under Part A. Conversely, hospital inpatient



Colin T. Roskey

Member

croskey@cozen.com
Phone (215) 665-4100
Fax (215) 665-2013

Related Practice Areas

Industry Sectors

- Health Care & Life Sciences

admissions spanning less than two midnights would presumptively be inappropriate for payment under Part A. According to CMS, the proposed policy is intended to “address longstanding concerns from hospitals that they need more guidance on when a patient is appropriately treated and paid by Medicare as an inpatient.” Importantly, CMS believes that the greater accuracy associated with the proposed guidance will cause payments to be reduced by \$220 million, a policy proposal some hospital organizations find concerning, even while other stakeholders remain concerned that the guidance may interfere with an individual physician’s medical judgment.

Proposals Related to Quality Improvement

New Hospital Acquired Condition (HAC) Reduction Program

- The Proposed Rule asserts that, pursuant to the ACA, beginning in 2015, hospitals in the top quartile of HAC rates will receive a 1 percent reduction in Medicare payments. The Proposed Rule establishes program eligibility requirements and the basics of the payment adjustment methodology. For FY 2015, CMS is proposing to measure HACs using measures that are either calculated based on claims or are part of the Inpatient Quality Reporting (IQR) Program, divided into two domains that include patient safety indicator measures developed by the Agency for Healthcare Research and Quality in Domain 1, and two health care-associated infection measures developed by the Centers for Disease Control and Prevention National Health Safety Network: Central Line Blood Stream Infection and Catheter-Associated Urinary Tract Infection in Domain 2. The Proposed Rule says it welcomes comment on this proposal, and suggests it would consider patient risk factors, such as age, gender and comorbidities in an attempt to avoid unfairly penalizing hospitals that serve a large proportion of sicker patients.

Value Based Purchasing Program

- The Proposed Rule, again in response to an ACA mandate, suggests it will fund the FY 2014 Value Based Purchasing Program (VBP) by reducing the base operating DRG payment amounts to participating hospitals by 1.25 percent. Since the VBP is budget neutral, CMS estimates that total amount available for performance-based incentive payments for FY 2014 would be approximately \$1.1 billion

Hospital Readmission Reduction Program

- The Readmissions Reduction Program, which began on October 1, 2012, will see its maximum payment reduction increase to 2 percent of payment amounts in 2014, per the ACA. In addition to assessing hospitals’ readmission penalties under three measures endorsed by the National Quality Forum: heart attack, heart failure and pneumonia, CMS proposes a revised methodology to take into account planned readmissions in FY 2014, and proposes to add two new readmission penalties beginning in FY 2015: readmissions for hip/knee arthroplasty and chronic obstructive pulmonary disease.

Quality Reporting Programs

- The Hospital IQR program has a near perfect (99 percent) participation rate, and measures reported under it are published on the Hospital Compare website. The Proposed Rule would update the measures for FY 2014 and subsequent years and align the reporting requirements with the Electronic Health Record Incentive Program policies.

Long Term Care Hospital Issues

- 25 Percent Rule – The Proposed Rule for the first time asserts that CMS will enforce the so-called “25 percent” rule, which requires LTCHs that admit more than 25 percent of their patients from a single acute care hospital to be paid the lower IPPS rate for those cases. A statutory moratorium was in place from December 2007 to December 2012, and CMS further expanded the enforcement moratorium in subsequent

Atlanta • Charlotte • Cherry Hill • Chicago • Dallas • Denver • Harrisburg • Houston • London • Los Angeles • Miami • New York
Philadelphia • San Diego • Seattle • Toronto • Washington, D.C. • West Conshohocken • West Palm Beach • Wilkes-Barre • Wilmington

rulemakings, but for FY 2014, CMS is proposing to let the 25 percent rule go into effect.

- Chronically Ill/Medically Complex Criteria – CMS is soliciting feedback on initial findings on criteria to identify patients that are chronically critically ill and medically complex, a patient classification the CMS asserts is the “most appropriate core population” for LTCH care and for full payment under the LTCH PPS. Although the findings are not yet complete, the Proposed Rule publishes the current version and specifically solicits comments on their approach, with the stated expectation of proposing such changes to the LTCH PPS for FY 2015.

To be considered timely, comments are due by 5:00 p.m. on June 25, 2013. As is the usual case, the final rule will be published on or about August 1, 2013 and the policies and payment rate will take effect October 1. The regulation will be published in the Federal Register on May 10 and is available on the CMS website.

If you are interested in discussing any of the payment or regulatory issues in the Proposed Rule and/or submitting comments to the Proposed Rule, please contact Colin Roskey at 215-665-4100 or croskey@cozen.com or any other member of our Health Law Department or Cozen O’Connor Public Strategies.

[1] None of the rates proposed include the impact of budget sequestration, which in general equals a -2.0 percent reduction on all payments to Medicare providers, which became effective on April 1, 2013.

Atlanta • Charlotte • Cherry Hill • Chicago • Dallas • Denver • Harrisburg • Houston • London • Los Angeles • Miami • New York
Philadelphia • San Diego • Seattle • Toronto • Washington, D.C. • West Conshohocken • West Palm Beach • Wilkes-Barre • Wilmington