

Update



# Regulatory

**Final Rule Summary**

**Medicare  
Inpatient Prospective  
Payment System  
Federal Fiscal Year  
2015**

**August 2014**

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## Overview and Resources

On August 4, the Centers for Medicare & Medicaid Services (CMS) released the federal fiscal year (FY) 2015 final payment rule for the Medicare inpatient prospective payment system (IPPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) inpatient payment rates and policies based on regulatory changes adopted by CMS and legislative changes previously adopted by Congress. Among other regular updates and policy changes, the rule includes policies that will:

- Change the Core-Based Statistical Area (CBSA) delineations for FY2015 and beyond, directly impacting the Medicare wage index and other factors used for payment purposes under the IPPS;
- Implement new payment penalties for non-compliance with the Electronic Health Record (EHR) incentive program; and
- Implement the first year of the Patient Protection Affordable Care Act (PPACA)-mandated Hospital-Acquired Condition (HAC) Reduction program and update the program rules for the Value-Based Purchasing (VBP) and the Readmissions Reduction programs.

Also of note, the rule requires hospitals to make charge data publicly available, responds to comments on steps towards establishing a new short-stay payment policy, and updates the PPACA-mandated Medicare Disproportionate Share Hospital (DSH) payment policies in a way that reduces the available DSH funding for hospitals. Outside of the IPPS directly, the rule would modify policies related to provider reimbursement appeals, update aspects of the EHR incentive program's quality reporting requirements, change the enforcement procedures for organ transplant centers, update/revise the reasonable compensation equivalent limits for services furnished by physicians to teaching hospitals excluded from the IPPS, update payment rates for hospitals excluded from the IPPS, update the quality reporting program for cancer hospitals, update the payment rates/policies for long-term care hospitals, and expand the allowable uses of Medicare Advantage risk adjustment data.

A brief summary of the major hospital IPPS sections of the final rule is provided below. Program changes adopted by CMS will be effective for discharges on or after October 1, 2014, unless otherwise noted.

A copy of the final rule *Federal Register* and other resources related to the IPPS are available on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>. An online version of the rule is available at <https://federalregister.gov/a/2014-18545>. Page numbers noted in this summary are from the preliminary “display” version of the final rule.

## IPPS Payment Rates

*Federal Register* pages 592-605 and 2276-2278

Incorporating the final updates and the effects of budget neutrality adjustments, the table below lists the full federal operating and capital rates for FY2015 compared to the rates currently in effect:

	Final FY2014	Final FY2015	Percent Change
Federal Operating Rate	\$5,370.28	\$5,431.22	+1.1 <i>(proposed at +0.58)</i>
Federal Capital Rate	\$429.31	\$434.26	+1.2 percent <i>(proposed at +0.86)</i>

The main driver of the rate changes from the proposed to final rule is the excessive budget neutrality factor applied to the proposed rates for Medicare Severity Diagnosis Related Group (MS-DRG) recalibration. CMS corrected the calculation of the DRG weights for FY2015 and, as anticipated, the budget neutrality impact to the rate was reduced for the final rule. Also, the operating rates shown reflect the full rates prior to any reductions for non-compliance under the inpatient quality reporting (IQR) program and EHR incentive program (see additional detail below).

The table below provides details and compares the final updates for the inpatient federal operating, hospital-specific, and federal capital rates for FY2015. Additional detail on other factors affecting the payment rates/rate updates is provided below:

	Federal Operating Rate (Percent)	Hospital- Specific Rates (Percent)	Federal Capital Rate (Percent)
Market Basket Update/Capital Input Price Index	+2.9 <i>(proposed at +2.7)</i>	+2.9 <i>(proposed at +2.7)</i>	+1.5 <i>(no change from proposed)</i>
PPACA-Mandated Reductions: 0.5 percent productivity reduction (proposed at 0.4 percent) and 0.2 percent pre-determined reduction (no change from proposed)	-0.7 <i>(proposed at -0.6)</i>	-0.7 <i>(proposed at -0.6)</i>	—
American Taxpayer Relief Act (ATRA)-Mandated <u>Retrospective Coding Adjustment Reduction</u>	-0.8 <i>(no change from proposed)</i>	—	—
<b><u>Rate Update (EXCLUDING BUDGET NEUTRALITY)</u></b>	<b>+1.4 <i>(proposed at +1.3)</i></b>	<b>+2.2 <i>(proposed at +2.1)</i></b>	<b>+1.5 <i>(no change from proposed)</i></b>

- Effect of the IQR and EHR Incentive Programs** (*Federal Register* pages 592-605 and 2276-2277): For the first time, the value of the market basket update for hospitals will be tied to participation in both the IQR and the EHR incentive programs. Currently, the value of the market basket update is only impacted by participation in the IQR program. Beginning FY2015, the IQR market basket penalty will shift from the traditional -2.0 percentage points to 25 percent of the full market basket and a new EHR market basket penalty of 25 percent of the full market basket will begin. The EHR market basket

penalty will increase to 50 percent of the market basket in FY2016 and 75 percent of the market basket in FY2017 while the IQR penalty will hold constant at 25 percent. As designed, by FY2017, the full market basket update will be at risk under these two programs before any PPACA, coding, or other reductions are applied to the market basket update/rate. This new penalty construct mandated by law will create four update scenarios for FY2015 and beyond. A CMS table that shows the various update scenarios for FY2015 is available on *Federal Register* page 600. CMS has not yet finalized the list of hospitals that will be penalized under the IQR and/or EHR incentive programs but plans to release a list of hospitals to be penalized prior to October 1. Generally, successful participation in both programs is based on data collection two years prior to the payment adjustment year.

- **Retrospective Coding Adjustment** (*Federal Register* pages 95-108): CMS is adopting its proposal to apply a retrospective coding adjustment of -0.8 percent to the federal operating rate in FY2015. This rate reduction was authorized as part of the ATRA and requires inpatient payments to be reduced by \$11 billion (or -9.3 percent) over a four-year period. To meet the ATRA requirements, CMS applied a -0.8 percent coding adjustment for FY2014 and is expected to apply similar reductions in FYs 2016 and 2017. Because retrospective coding adjustments are one-time adjustments that are not permanently built into the rates, CMS will eventually adjust the federal operating rate upward through a positive adjustment (equivalent to the negative adjustments applied, anticipated to be +3.2 percent) once the \$11 billion is fully recouped. The positive adjustment to “reset” the rates is anticipated in FY2018. CMS considered, but did not propose/adopt, any additional documentation and coding adjustments beyond the adjustment mandated by the ATRA.
- **Two-Midnight Rule Reduction** (no *Federal Register* page reference): For FY2014, CMS applied a -0.2 percent reduction to the federal operating, hospital-specific, and federal capital rates to maintain program budget neutrality related to the implementation of the new two-midnight policy (see additional policy details below). CMS did not propose and is not adopting any changes to this policy for FY2015 and the -0.2 percent reduction will remain in the rate unless/until CMS actively makes a change to this policy.
- **Effect of Sequestration** (no *Federal Register* page reference): While the final rule does not specifically address the 2.0 percent sequester reductions to all Medicare payments authorized by Congress and currently in effect through FY2024, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and EHR incentives are also affected by the sequester reductions. Payments from Medicare Advantage plans should not be automatically impacted by sequester.

## **Wage Index**

*Federal Register* pages 427-586

CMS is adopting several changes that will affect the wage index and wage index-related policies for FY2015 and beyond. Of most significance, CMS is adopting its proposal to update the CBSA

delineations, the labor markets that define a hospital's Medicare wage index. CMS did not propose and is not adopting any major changes to the standard calculation of Medicare hospital wage indexes, the rural floor budget neutrality policy, the imputed rural floor methodology, the current Medicare Geographic Classification Review Board (MGCRB) administrative reclassification rules, or the cost-of-living adjustments applicable to hospitals in Alaska and Hawaii. The CBSA changes and other notable wage index-related items are detailed below:

- **CBSA Delineation Changes** (*Federal Register* pages 428-472): CMS' changes to the CBSA delineations will have a direct impact on the Medicare wage index and other factors used for payment purposes under the IPPS. CMS last updated the CBSA delineations in FY2005 (based on the 2000 Census). The CBSA changes adopted for FY2015 (based on the 2010 Census) are not as substantial as those made in FY2005 in terms of changes in the geographic make-up of the labor market areas. However, under the new delineations there will be:
  - newly created CBSAs;
  - urban counties that become rural;
  - rural counties that become urban; and
  - existing CBSAs that split apart or incorporate additional counties.

The new delineations will also have an effect on:

- hospital reclassifications under the MGCRB;
- the treatment of hospitals with Lugar status;
- hospitals that reclassify as rural; and
- the applicability of the out-migration adjustment.

The CBSA changes will have both positive and negative impacts on IPPS payments to hospitals. To mitigate negative impacts, CMS is adopting its proposal to apply a one-year transitional wage index for any hospital that experiences a wage index decrease (post-reclassified value) due solely to the new CBSA delineations (estimated to be about 620 hospitals). The transition value will be for FY2015 only, using FY2015 wage data, with 50 percent based on the current CBSA delineations and 50 percent based on the new CBSA delineations (the out-migration adjustment will apply after the 50/50 blend is calculated). The transitional wage index will expire for FY2016. At that point, the wage index values will be fully based on the new CBSA delineations. In very limited circumstances (urban to rural change that affects geographic location or Lugar status), CMS is adopting its proposal to apply a three-year transition to the new wage index.

Hospitals should be sure to understand their hospital-specific wage index value and wage index circumstance for FY2015 and beyond, especially hospitals receiving a transitional wage index, those with MGCRB reclassifications, hospitals that lose rural/urban status, and those that have a change in Lugar status. In reviewing the wage index, hospitals should utilize FY2014 and FY2015 wage index information in the IPPS Impact Files and wage index tables 2, 4A/4B (home CBSA values), 4C (reclassified values), 4J (out-migration adjustments), and 9A/9C (reclassified hospitals and CBSAs). These tables are

available on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>.

- **Labor-related Share** (*Federal Register* pages 580-586): The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FY2015, CMS is adopting its proposal to continue applying a labor-related share of 69.6 percent for hospitals with a wage index greater than 1.0. By law, the labor-related share for hospitals with a wage index less than 1.0 will remain at 62 percent.
- **FY2016 Wage Index Reclassification Applications** (*Federal Register* pages 533-535): Applications for FY2016 wage index reclassifications are due to the MGCRB by September 2, 2014. Reclassification requests for FY2016 will be based on the new CBSA delineations. Applications and other information regarding MGCRB reclassifications are available on the CMS Web site at <http://www.cms.gov/MGCRB/>.
- **New Occupational Mix Survey for FY2016** (*Federal Register* pages 490-491): CMS is required to include an occupational mix adjustment in its calculation of the hospital wage index. This adjustment is intended to neutralize the effect of employee mix, resulting in a decreased wage index for hospitals with higher skill mixes and an increased wage index for hospitals with lower skill mixes. As required by law, CMS must perform a new measurement of occupational mix for the FY2016 wage indexes. Hospitals were required to submit their new occupational mix surveys to their Medicare Administrative Contractors (MACs) by July 1, 2014. The new survey collects hospital-specific wage and hourly data for calendar year (CY) 2013 (the current data is from CY2010). The survey tool is available on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/WAGE-INDEX-OCCUPATIONAL-MIX-SURVEY2013.pdf>.
- **New Wage Index Development Timetable for FY2016 and Beyond** (*Federal Register* pages 570-580): Each year, CMS takes on a three-part process to refine unaudited wage and occupational mix data to develop the upcoming year's Medicare wage index. This process is critical for hospitals to ensure accurate data is considered by CMS. CMS is adopting its proposal to revise the wage index development timetable for FY2016 and beyond to improve the data review process. Of most significance, CMS is moving the first data review period back by four months (from September back to May). This change will allow hospitals more time to review and make corrections to their data and additional time for MACs to validate the data. The FY2016 wage index development timeline is available on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2016-WI-Time-Table-Final.pdf>.

## **Quality-Based Payment Adjustments**

*Federal Register* pages 722-1049

For FY2015, based on previously established and newly adopted program rules, IPPS payments to hospitals will be adjusted for historic quality performance under the VBP program, Readmissions Reduction program, and, for the first time, the HAC Reduction program. The following provides detail on the FY2015 programs and payment adjustment factors (future program year program changes are addressed at the end of this document):

- VBP Adjustment** (*Federal Register* pages 824-832): The FY2015 program will evaluate hospital quality data in four areas: process of care, patient experience of care, patient outcomes, and efficiency (for 19 measures, up from three domains and 17 measures in the current year). By law, the VBP program must be budget neutral and the FY2015 program will be funded through a 1.5 percent reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at \$1.4 billion). The FY2014 program is currently being funded through a 1.25 percent reduction in IPPS payments. Because the program is budget neutral, hospitals have an opportunity to earn back some, all, or more than the 1.5 percent reduction in payments used to fund the program. While the data applicable to the FY2015 program is still being finalized, CMS has calculated and published proxy factors based on current year program performance. Hospitals should use extreme caution in reviewing these factors as they do not consider hospital performance on the new outcomes and efficiency measures for FY2015, the new weighting scheme used to calculate the VBP adjustment (more emphasis on outcomes/efficiency), and CMS does not calculate proxy factors for hospitals that may be part of the VBP program under changes that have expanded eligibility. The proxy factors published with the final rule are available in Table 16A on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>. It is anticipated that CMS will make actual FY2015 adjustment factors available prior to October 1 via an updated Table 16. Additional detail and information on the VBP program is available on CMS' QualityNet Web site at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublicpercent2FPagepercent2FQnetTier2&cid=1228772039937>.
- Readmissions Adjustment** (*Federal Register* pages 722-756 and 788-821): The FY2015 program will increase the number of readmissions condition areas evaluated from three to five. In addition to the current acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN) measures, this year's program will evaluate readmissions for patients admitted for chronic obstructive pulmonary disease (COPD) and elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). CMS is moving forward with its proposal to add a slight refinement to the algorithm adopted last year to better account for planned/unplanned readmissions. This policy will slightly increase the nationwide readmissions rates for HF, PN, and THA/TKA. Unlike the VBP program, the Readmissions Reduction program is not budget neutral. Hospitals can either maintain full payment levels or be subject to a hospital-specific payment penalty of up to 3.0 percent (up from 2.0 percent in the current year). This capped reduction amount will remain at 3.0 percent for future program years. As a result of the measure expansion along with the higher capped reduction amount, CMS estimates that the FY2015 program will cut about \$424 million from IPPS payments (up from about \$227 million in the current year). While the data applicable to the FY2015 program is still being finalized, CMS has calculated and published proxy adjustment factors. Unlike the VBP proxy factors, the readmissions factors take into consideration performance on all program measures and the appropriate measurement timeframes. As a result, the proxy factors provide a very good assessment of relative performance and potential exposure. The factors published with the final rule are available in Table 15A on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service->

[Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html). It is anticipated that CMS will make actual FY2015 adjustment factors available prior to October 1 via an updated Table 15. Additional detail and information on the Readmissions Reduction program is available on CMS' QualityNet Web site at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublicpercent2FPagepercent2FQnetTier2&cid=1228772412458>.

- **HAC Adjustment** (*Federal Register* pages 976-1036): The FY2015 program will evaluate hospital performance on three measures: Patient Safety Indicator (PSI)-90 – a composite of eight individual HAC measures, Central Line-Associated Bloodstream Infection (CLABSI), and Catheter-Associated Urinary Tract Infection (CAUTI). Similar to the Readmissions Reduction program, the HAC Reduction program is not budget neutral. By law, hospitals with a Total HAC Score – as calculated under the adopted policies – that fall within the top quartile (the worst performing quartile) for all eligible hospitals will be subject to a 1.0 percent reduction in IPPS payments. CMS estimates that the FY2015 program will cut about \$369 million from IPPS payments. Because the 1.0 percent reduction factor is not scheduled to increase in future years, the IPPS cut should remain around \$350-\$400 million each year going forward. Because data applicable to the FY2015 program is still being finalized, CMS did not publish a table/list of hospitals that could potentially be subject to the program penalty for FY2015 (in contrast, CMS did publish a list of hospitals estimated to be penalized with the proposed rule). It is anticipated that CMS will make available a list of hospitals actually penalized under the program prior to October 1 via Table 17 on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>. Additional detail and information on the HAC Reduction program is available on CMS' QualityNet Web site at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublicpercent2FPagepercent2FQnetTier2&cid=1228774189166>.

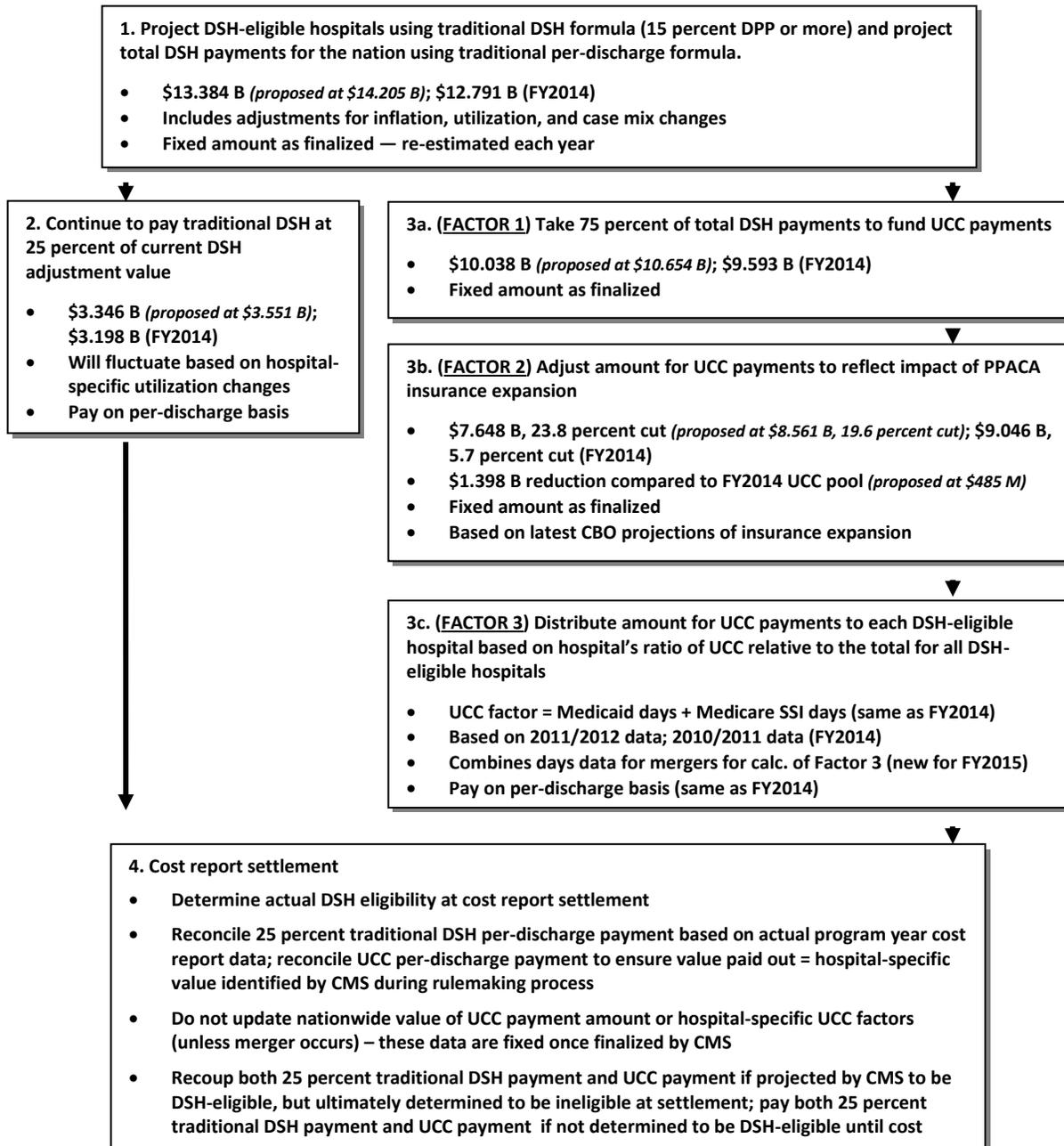
## **DSH Payments**

*Federal Register* pages 638-714

The PPACA requires the implementation of new Medicare DSH payment policies that reduce and redistribute DSH funding when compared to the traditional DSH payment methodology. Under the law, 25 percent of estimated DSH funding under the traditional formula will continue to be paid to each DSH-eligible hospital under that formula. The remaining 75 percent is reduced to reflect the impact of insurance expansion under the PPACA and is then redistributed to hospitals as a new and separate uncompensated care (UCC) payment based on each hospital's ratio of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FY2015** (*Federal Register* pages 653-714): CMS did not propose or adopt any major changes to the DSH payment policies for FY2015 when compared to the current year program. The following schematic describes the new DSH payment methodology mandated by the PPACA along with how the program will change from FY2014 to FY2015 with a specific focus on three key payment methodology

factors: Factor 1 (program funding), Factor 2 (program reductions), and Factor 3 (hospital-specific UCC factor/payments):



As identified in the schematic above, DSH dollars available to hospitals under the PPACA's payment formula will see a notable decline from FY2014 and from what CMS had identified in the proposed rule. The decline is the result of two specific factors: updated traditional DSH dollar projections from CMS and new insurance expansion estimates from the Congressional Budget Office (CBO). While traditional DSH dollars that drive the payment methodology increase by \$593 million from FY2014, that is less than the \$1.4 billion increase projected by CMS in the proposed rule (box 1). According

to CMS, the change in the traditional DSH dollar estimate is due to lower than projected inpatient hospital spending. In addition, as a result of the mandated payment reduction policies tied to updated insurance expansion estimates from the CBO, DSH dollars available for distribution from the UCC pool will decrease by \$1.398 billion when compared to the current year pool (box 3b). Based on CBO projections issued during the proposed rule, CMS had projected a \$485 million decrease. This UCC pool is expected to see additional reductions in the coming years as insurance coverage rates are expected to increase.

- **Eligibility for FY2015 DSH Payments** (*Federal Register* pages 646-656): Based on analysis of the most recent cost report and claims data available, CMS is projecting that 2,399 hospitals will be eligible for DSH payments in FY2015. This projection is significant because under the DSH payment policies, hospitals identified as DSH-eligible will be paid as such during FY2015. CMS has made a file available on its Web site that includes DSH eligibility status. The file also includes the UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file (Table 18) is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>.
- **Impact of the New CBSA Delineations on DSH Payments** (*Federal Register* pages 472-474): Under the new CBSA delineations, a hospital's DSH payments may be impacted by the loss of urban status. If DSH payment will be impacted by the loss of urban status, CMS is adopting its proposal to provide a two-year transition from the urban DSH payment amount to the new DSH payment amount based on the rural status.
- **Future Use of Data from Cost Report Worksheet S-10 for Determining Factor 3** (*Federal Register* pages 681-688): As identified last year, CMS again indicates its desire to eventually determine the UCC payment factor (Factor 3) using UCC data from Worksheet S-10 of the Medicare cost report. CMS used the low-income patient days proxy for Factor 3 in FY2014 and is adopting its proposal to do so again for FY2015 due to concerns regarding data variability and lack of reporting experience with this relatively new cost report Worksheet. In the final rule, CMS again states its commitment to making the necessary revisions and clarifications to the S-10 instructions to ensure accurate and consistent reporting across hospitals.

## **GME Payments**

*Federal Register* pages 627-637 and 1050-1185

CMS did not propose and is not adopting any major changes to the Indirect Medical Education (IME) and direct GME payment policies for FY2015. Instead, CMS is adopting program tweaks to:

- Account for the loss of rural status due to the new CBSA delineations as it relates to full-time equivalent (FTE) resident counts/caps for formerly rural hospitals with a new teaching program and for urban hospitals that have established residency training programs with an integrated rural track in a formerly rural area;

- Align the effective dates of the FTE resident and Intern-and Resident-to-Bed Ratio (IRB) ratio caps for new teaching program; and
- Update the review and award process for the PPACA-mandated policies that allow hospitals to add new residency slots due to hospital closures.

In addition, CMS is adopting its proposal to begin paying the Medicare Part C (Medicare Advantage) IME add-on amount to Sole Community Hospitals (SCHs) paid at the hospital-specific rate. Currently, CMS only pays this add-on amount to non-special status teaching hospitals and SCHs paid at the federal rate. For FY2015, the IME adjustment factor will remain at 1.35.

### **Updates to the MS-DRGs**

*Federal Register* pages 93-427 and 586-592

Each year, CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes adopted for the DRGs for FY2015 will increase the number payable DRGs from 749 to 751. Overall, while some DRG weights will shift significantly from FY2014 to FY2015, when compared to the current weights, over 80 percent of the DRG weights will change by less than +/-5 percent. Related to the general updates to the DRGs, CMS is adopting its proposal to update the list of DRGs subject to the post-acute care transfer policy, adding five DRGs and eliminating one. The post-acute transfer DRG changes are listed on *Federal Register* pages 591-592. The full list of FY2015 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>. For comparison purposes, the current year (FY2014) DRGs are available in Table 5 on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html>.

### **Outlier Payments**

*Federal Register* pages 2150-2182

To maintain total outlier payments at 5.1 percent of total IPPS payments, CMS is establishing an outlier threshold of \$24,758 for FY2015 (proposed at \$25,799). The new threshold amount represents a +13.8 percent increase compared to the current threshold of \$21,748. CMS cites an increase in hospital charges as the reason for the threshold increase.

### **HAC MS-DRG Payment Policy**

*Federal Register* pages 115-130

CMS did not propose or adopt any expansion to the categories/conditions under the current HAC MS-DRG payment policy and will continue to recognize 11 HAC categories. As has been the case in prior years, when any of these conditions are not present on admission (POA), the diagnosis will not be recognized in the assignment of a case to a MS-DRG. Additional detail on the HAC MS-DRG payment policy is available on CMS' Web site at

[http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired\\_Conditions.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html).

## **Updates to the IQR Program and Electronic Reporting Under the Program**

*Federal Register* pages 1443-1781

As previously adopted for FY2015 payment determinations under the IQR program, hospitals were required to report on a total of 59 quality measures. IPPS payment is linked to successful participation in IQR program. Importantly, the traditional payment penalty structure for non-compliance with the IQR program will change for FY2015 due to the addition of a payment penalty for non-compliance with the EHR incentive program (see “Effect of the IQR and EHR Incentive Programs” section above).

A table that lists the 59 measures CMS collected for FY2015 payment determinations is available on *Federal Register* pages 50784-50785 of the FY2014 IPPS final rule (<https://federalregister.gov/a/2013-18956>). A table that lists the 57 measures CMS is currently collecting for FY2016 payment determinations is available on *Federal Register* pages 50805-50807 of the same final rule.

CMS used the FY2015 rulemaking process to put forward IQR program changes for FY2017 payment determinations and beyond. CMS focused its program updates in two main areas: increased measurement of outcomes and efficiency and expansion of the voluntary electronic reporting for the clinical quality measures with the movement toward electronic reporting for all. The following describes the major IQR program updates:

- **New Outcomes and Efficiency Measures** (*Federal Register* pages 1498-1600): Last year, for FY2016 payment determinations, CMS added an episode of care payment measure for AMI patients and a readmissions/mortality measure for COPD patients. CMS is continuing its effort to move the focus of the IQR program towards the collection of outcomes and efficiency measures. Among the adopted measure additions and deletions, CMS is adopting its proposals to add the following claims-based outcomes/efficiency measures for FY2017 payment determinations:
  - Readmissions rate for coronary artery bypass graft (CABG) patients;
  - Mortality rate for CABG patients;
  - Episode of care payment for PN patients; and
  - Episode of care payment for HF patients.
- **Electronic Reporting of Clinical Quality Measures** (*Federal Register* pages 1630-1645): Last year, for FY2016 payment determinations, CMS established policies allowing hospitals to voluntarily report clinical quality measures electronically to satisfy a portion of the IQR program requirements. Establishment of this policy essentially created two IQR program participation tracks: the traditional chart-abstraction track and the electronic clinical quality measure (eCQM) track. For FY2017 payment determinations (data collection during CY 2015), CMS is adopting its proposal to increase, from 16 to 28, the number of eCQMs available for voluntary reporting. Hospitals participating in this track will be required to report performance on 16 of the 28

available measures for FY2017 payment determinations. To encourage participation in the eCQM track, CMS will require hospitals to submit only one quarter's worth of data from any of the first three quarters of CY2015. Successful participation in the voluntary option will satisfy the quality reporting requirements for both the IQR and EHR incentive programs. CMS believes that EHR-based collection of quality data will streamline the various federal quality data reporting programs. In the final rule, CMS states that it intends to propose mandatory eCQM reporting under the IQR program beginning with FY2018 payment determinations (data collection during CY2016).

CMS' adopted quality reporting policies not only to update the IQR program and work towards alignment between the IQR and EHR incentive programs, but also remove and/or potentially put in place measures for future use under the VBP program, Readmissions Reduction program, and HAC Reduction program.

A table that lists the measures CMS will collect for FY2017 payment determinations is available on *Federal Register* pages 1622-1630. The table identifies the new/expanded measures for FY2017 payment determinations, which measures are eCQMs, and which measures are voluntary for electronic reporting. Details on the IQR program data submission deadlines and procedures, chart validation requirements and methods, and other IQR-related procedures and processes are available on *Federal Register* pages 1645-1781.

## **Two-Midnight Policy**

*Federal Register* pages 1205-1212

For FY2014, CMS established a time-based, two-midnight benchmark for determining the appropriateness of treatment and payment on an inpatient basis versus treatment and payment on an outpatient basis. This policy was established in response to concerns about appropriate inpatient hospital admission decisions and recent increases in denials of short-stay inpatient claims by federal claims review contractors, such as Recovery Audit Contractors (RACs). As of this writing, legislative action by Congress has delayed full enforcement of this policy.

For FY2015, CMS did not propose or adopt any major changes to the two-midnight policy. In response to comments asking for improvements to the policy, CMS noted that they plan to evaluate the results of the "probe and educate" process and issue additional sub-regulatory guidance to claim review contractors, if necessary, to ensure consistent application of the policy. The probe and educate reviews being completed by MACs are designed to review a sample of claims to determine appropriate admissions and provide hospital-specific education to correct improper admissions/payments.

The following items included in the proposed/final rule are also related to the two-midnight policy:

- **Short-Stay Payment Policy Development** (*Federal Register* pages 1205-1209): Citing support for the development of a short-stay payment policy, CMS sought comments on how to design a new payment methodology for short-stay inpatient cases (i.e., medically necessary inpatient stays that span less than two-midnights). Specifically, CMS asked how to define the length of a short-stay, how to design the payment methodology, and

how to rationalize payment between the inpatient and outpatient settings. Below is the comment and CMS' response from the final rule:

Comment: *“Many commenters indicated that any short-stay policy should adhere to certain general principles, specifically citing some or all of the following: a short-stay policy should provide more appropriate and adequate payment for medically necessary inpatient services that span less than 2 midnights – payment should be higher than the outpatient PPS rate for the service, but should not exceed the full IPPS payment; a short-stay policy should not apply to those procedures on the “inpatient only” list; a short-stay policy should be budget neutral; hospitals should be eligible for all add-on payments they would otherwise receive (for example, DSH and IME), either in full or on a pro rata basis; beneficiaries requiring short inpatient hospital stays paid under a short-stay policy should be considered inpatients and cost-sharing obligations should be calculated under Medicare Part A; a short-stay policy should be developed in a way that would not increase administrative burden for hospitals, physicians, or other medical providers; and CMS should provide clear and consistent guidance and allow adequate time for hospitals to implement the short-stay policy prior to its effective date.*

*Other commenters indicated that CMS could or should consider approaches such as a per diem approach modeled after the existing transfer policy, creating separate MS-DRG weights for short-stay cases and nonshort-stay cases, or allowing the full MS-DRG payment on an interim basis while the issue is studied further.*

*Some commenters also stated that the MS-DRG system is predicated on the understanding that there will be a diversity of treatment patterns and individual patient circumstances for any given clinical condition, and that this diversity balances out – high-intensity cases are balanced by low-intensity cases. These commenters contended that creating a new category of “short stays” and paying for them differentially undermines the MS-DRG system.*

*Many commenters stated that additional research and collaboration were needed before a formal short-stay policy proposal could be made. MedPAC indicated that it intended to explore alternative short-stay policies in its upcoming work cycle.*

*Almost all commenters provided their comments on Medicare payment for short hospital stays in the context of broader comments on the current 2-midnight policy.”*

CMS Response: *“We thank commenters for the many comments submitted on this issue, and we will take these into account in any potential future rulemaking. Although there was no consensus among the commenters, we look forward to continuing to actively work with stakeholders to address the complex question of how to further improve payment policy for short inpatient hospital stays.”*

- **Exceptions to the Two-Midnight Policy** (*Federal Register* pages 1209-1212): Under the current two-midnight policy, there are some exceptions applied to the two-midnight benchmark. For example, procedures listed on the outpatient prospective payment systems (OPPS) “Inpatient Only” list are exempt from the two-midnight policy. Since implementation of the policy, CMS has put in place additional exceptions. CMS believes that there could be other limited exception circumstances that could apply and is asking for comments to suggest exceptions by emailing [SuggestedExceptions@cms.hhs.gov](mailto:SuggestedExceptions@cms.hhs.gov).

## **Public Reporting of Hospital Charges**

*Federal Register* pages 1203-1205

The PPACA includes a provision requiring hospitals to make public a list of the standard charges for items and services provided by the hospital, including a list of charges for services by MS-DRG. Until now, CMS has not issued guidance on the implementation of this PPACA requirement. CMS used the IPPS rulemaking process to “remind” hospitals of their obligation to comply with this provision and is providing flexibility as to how hospitals should make their charges public. CMS states that hospitals should either make public a list of their standard charges (whether that be the charge master itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry. CMS does not provide a deadline for compliance, but sets the expectation that hospitals should update the information at least annually, or more often as appropriate.

## **Expiration of the More Inclusive Low-Volume Adjustment Criteria**

*Federal Register* pages 613-627

Legislative action by Congress over the past several years has mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. Absent additional legislation, beginning mid-FY2015 (April 1, 2015), the low-volume adjustment criteria will revert to the more restrictive requirements previously in effect (25-mile/800 discharge criteria and 25 percent payment adjustment). This change will reduce the number of hospitals eligible for the adjustment from about 600 to 6. Hospitals that qualified for the low-volume adjustment in FY2014 do not need to reapply to receive the adjustment for the partial fiscal year. Instead, hospitals only need to notify their MAC in writing that the 15-mile distance criterion continues to be met. Hospitals newly seeking the adjustment must make a request in writing to their MAC by September 1, 2014, in order to achieve the adjustment beginning October 1. Hospitals that request the status after September 1 and qualify will be eligible for the adjustment effective prospectively within 30 days of the MACs determination.

## **Expiration of MDH Status**

*Federal Register* pages 714-722

Legislative action by Congress over the past several years has extended the Medicare-Dependent Hospital (MDH) program through mid-FY2015 (March 31, 2015). Absent legislation to extend the program, MDH status and the associated IPPS payment benefits will expire April 1. MDHs losing their status that can achieve SCH status must apply in writing to their MAC. If the request is made 30 days prior to the expiration of MDH status (March 1, 2015), SCH status will be effective immediately after the MDH expiration. Approved requests made after March 1, will be effective 30 days after the date of CMS approval.

## **RRC Status**

*Federal Register* pages 607-613

Hospitals that meet certain criteria can be classified as Rural Referral Centers (RRCs). This special status allows exemption from the 12 percent cap on traditional DSH payments and special treatment under the geographic reclassification rules. Each year, CMS updates the minimum case mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The FY2015 minimum case mix and discharge values by region are available on *Federal Register* pages 610-613.

## **CAH Payment Policies**

*Federal Register* pages 1271-1286

- **CBSA Delineation Changes** (*Federal Register* pages 1272-1278): Critical Access Hospital (CAH) status may be at risk for CAHs that lose rural status under the new CBSA delineations. CMS is adopting its proposal to allow a two-year grace period for CAHs to retain their current status, providing an opportunity to achieve rural status under a reclassification or other mechanism. CMS states in the final rule that it plans to post a list of CAHs anticipated to lose rural status to the CMS Web site. CMS did not provide a location or timeline for such posting.
- **96-Hour Rule** (*Federal Register* pages 1278-1286): Inpatient payment for CAHs requires that a physician certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Prior to FY2014, this physician certification was required no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted. For FY2014, in implementing the two-midnight policy, CMS changed the certification policy to require the certification be completed, signed, and documented in the medical record prior to discharge. To provide CAHs with more flexibility, CMS is adopting its proposal to revert back to the pre-FY2014 standard. That is, all certification requirements must be completed, signed, and documented in the medical record no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted.

## **Quality-Based Payment Policies – FYs 2016 and Beyond**

For FYs 2016 and beyond, CMS used the FY2015 rulemaking process to put in place new quality-based payment policies and measures for the VBP program, Readmissions Reduction program, and HAC Reduction program. The following provides a brief description of the proposed/adopted policies by program:

**VBP Program – FYs 2017-2020** (*Federal Register* pages 833-976): CMS has already adopted VBP program rules through FY2016 and has put in place some program policies for FYs 2016 and beyond. CMS used the FY2015 rulemaking process to adopt program updates/changes for FYs 2017-2020. These adopted changes include:

- Measure additions/deletions for FYs 2017 and 2019 (the adopted changes will continue the shift of the program's focus from process to patient outcomes/safety)

- measures – CMS suggests that future program expansion will include efficiency measures targeted at select conditions);
- New data collection time periods (baseline/performance periods) for the FY2017-2020 program years (some periods were previously adopted and some are newly adopted);
  - National performance standards for a subset of the FY2017, 2019, and 2020 program measures (performance standards for other program measures, including the FY2018 program measures, will be put forward in future rulemaking);
  - New measure weighting formulas for FY2017 used for calculating each hospital's VBP Total Performance Score (TPS) and resulting payment adjustment (the adopted weighting formula will continue the shift toward putting a greater emphasis on patient outcomes, safety, and efficiency); and
  - Updates to the minimum measure/case counts and domain scores hospitals must need in order to be included in the program.

CMS is also adopting its proposal to allow for retroactive updates to the national performance standards if there are major changes in a measure's specifications. Currently CMS holds the standards constant.

Details and CMS tables on the newly adopted measures, collection time periods, performance standards, and measure weighting are available on the *Federal Register* pages listed above. Additional detail and information on the VBP program is available on CMS' QualityNet Web site at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublicpercent2FPPagepercent2FQnetTier2&cid=1228772039937>.

**Readmissions Reduction Program – FYs 2016 and 2017** (*Federal Register* pages 757-785): CMS will not add any additional readmissions measures to the FY2016 program. For the FY2017 program, CMS is adopting its proposal to add a new measure – readmissions for patients admitted with CABG. CMS did not propose and is not adopting any changes to the payment adjustment factor calculation. The maximum adjustment applicable for FY2015 and beyond is -3.0 percent (0.9700 adjustment factor). Additional detail and information on the Readmissions Reduction program is available on CMS' QualityNet Web site at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublicpercent2FPPagepercent2FQnetTier2&cid=1228772412458>.

**HAC Reduction Program – FYs 2016 and 2017** (*Federal Register* pages 1036-1049): Last year, CMS adopted policies to add one surgical site infection (SSI) measure to the FY2016 program and two additional measures for the FY2017 program to evaluate Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia and *Clostridium difficile* (C. difficile) infection. CMS is not proposing any additional measure expansion. For FY2016, CMS is adopting its proposal to shift the domain weighting scheme used to calculate a hospital's Total HAC Score for determining penalty applicability. CMS will decrease the Domain 1 weight (PSI-90 composite measure) to 25 percent (from 35 percent) and increase the Domain 2 weight (all other program measures) to 75 percent (from 65 percent). Additional detail and information on the HAC Reduction program is available on CMS' QualityNet Web site at

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166>.