

# FY 2014 IPPS Update

Mel Bowens  
Lorri Frewert

Fall 2013

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## August 19, 2013, Federal Register

**FY**

Effective: For discharges occurring on or after Oct. 1, 2013

CMS Clarifications and New Policy

Implements provisions of the Patient Protection and Affordable Care Act of 2010 (ACA)

Includes:

- Updates of IPPS, LTCH, Excluded Hospital Payment Rates
- GME and IME Payments
- DSH Payments
- Hospital Value-Based Purchasing Program
- Hospital Readmissions Reduction Program
- Other Payment Adjustments

**2014**

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## Hospital Payment Update

### FY 2014 Update to Standard Rate

**2014**

- Acute Care Hospital update: 1.7 percent net increase
  - If hospital does not submit Quality Data, update: -2.0 percent
  - Puerto Rico-specific Hospital update: 1.7 percent net increase
- LTCH update: 1.7 percent net increase
- LTCH One-Time Prospective Adjustment of 0.98374 (Year 2)
  - Reflects difference between estimated LTCH TEFRA and LTCH PPS payments for 2003.
  - Three-year phase-in (FYs 2013, 2014, 2015)

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## MS-DRG Documentation and Coding Adjustments

### Moved from DRG to MS-DRG classification effective 10/1/2007

**2014**

- FY 2008 IPPS Final Rule
  - Adaption of MS-DRG has potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness.
  - Initially proposed 4.8% reduction to standardization amount phased in over three years
  - By Law documentation and coding adjustment reduced to -0.6 percent in FY 2008 and 0.9 in FY 2009
- CMS began restoring the adjustment in FY 2010
  - -2.9% in FY 2010 and 2011
  - -1.9% in FY 2013
- CMS increased FY 2013 standard rate by 2.9 %, effectively removed FY 2012 -2.9 % one-time reduction
- CMS will phase in the ATRA \$11 billion recoupment, beginning with a -0.8% recoupment adjustment to the standardized amount in FY 2014.

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## Labor and Delivery Beds in IME and DSH

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### Effective for Cost Reporting Periods beg. on or after Oct. 1, 2009

- Labor and delivery room days methodology for Medicare DSH calculation not used in apportionment.
- Days included in DPP as inpatient days once the patient has been admitted.
- If patient did not occupy a bed prior to routine census, day not included in determination of available beds

### Effective for Cost Reporting Periods beg. on or after Oct. 1, 2012

- Labor and delivery room days methodology for Medicare DSH calculation not used in apportionment.
- Days included in DPP as inpatient days once patient has been admitted.
- **Labor and delivery room days included in determination of available beds.**

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## Labor and Delivery Room Beds in IME and DSH

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Effective FY 2013, regulations at 42 CFR 412.105(b)(4) revised to remove Labor and Delivery Room days from excluded beds

Labor and delivery room days included in count of available beds.

If patient not admitted, related day(s) not included in DSH or available beds.

If beds furnish service payable under IPPS, beds included in bed count. Includes:

- Maternity suite
- Ancillary labor and delivery room beds

Medicare cost report (T4) has a carve-out of outpatient labor and delivery room days.

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## Labor and Delivery Room Days in GME Patient Load

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Effective for cost reporting periods beginning on or after Oct. 1, 2013, inpatient labor and delivery room days, including those in ancillary areas, will be included in the calculation of GME patient load.

- Will not affect routine inpatient services paid on cost basis.
- Will not affect Nursing and Allied Health Payment determination.
- Will apply to hospitals seeking SCH status on or after Oct. 1, 2013
- Will apply to hospitals whose SCH status is being reviewed by MAC or CMS.

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### Required Cost Report Changes

- Worksheet S-3, Part I
- Worksheet E-4

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## Graduate Medical Education

**FY**

### Approved Training Programs at CAHs

ACA, Section 5504, Counting Resident Time in Non-Provider Settings

For GME: Effective for cost reporting periods beginning on or after July 1, 2010

For IME: Effective for discharges occurring on or after July 1, 2010

Allows teaching hospitals to claim time resident spends in non-provider setting if hospital incurs costs of salaries and fringe benefits of resident while at the *non-provider site*.

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## Graduate Medical Education

**FY**

### Approved Training Programs at CAHs

Prior to effective date of ACA, Section 5504, CMS used “non-hospital” and “non-provider” terms interchangeably.

CAH is not a “hospital,” but CAH is a “provider.”

Therefore a CAH is not non-provider setting.

For portions of cost reporting periods occurring on or after Oct. 1, 2013, hospital may not claim the time residents train at a CAH or CAH-based entity for IME or GME.

CAH may incur the cost of training at the CAH site and receive 101 percent of cost reimbursement.

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## Graduate Medical Education

**FY**

### Expiration of Freeze for Per Resident Amounts (PRAs) Exceeding National Average

BBRA of 1999 established floor and ceiling for hospital-specific PRAs

- Floor = 70 percent of locality adjusted national PRA
- Ceiling = 140 percent of locality adjusted national PRA

MMA froze annual updates for hospitals with PRAs exceeding the ceiling for FYs 2004 through 2013

Annual update freeze expires for cost reporting periods beginning on or after Oct. 1, 2013

Full CPI-U update applies to all GME PRAs

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## Disproportionate Share Hospital

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Medicare Part C Days

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FY 2014 Final Rule reaffirms that Medicare Part C days are counted in the Medicare fraction of DSH.

Medicaid Days + Medicare with SSI Days = DPP

Total Days

Total Medicare Days

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**Rule**



## Disproportionate Share Hospital

**FY**

ACA, Section 3133

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- Effective for discharges on or after Oct. 1, 2013
- Expands DSH to more hospitals, because expanded Medicaid programs under ACA
- Gradually reduces DSH payments to each eligible hospital, as uninsured population decreases, due to ACA

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## Disproportionate Share Hospital

**FY**

ACA, Section 3133

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- Empirically Justified Amount - 25% of estimated Medicare DSH payments, based on current DSH methodology
- Uncompensated Care Amount - 75% of estimated Medicare DSH payments – based on three factors
  - Factor 1 – estimation of 75 % of global DSH payment
  - Factor 2 – reduction based on estimated decrease in uninsured
  - Factor 3 – individual hospital's proportion of uncompensated care to all DSH hospitals' uncompensated care

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Operating IPPS only, does not affect Capital PPS DSH

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## Disproportionate Share Hospital

**FY**

ACA, Section 3133

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Uncompensated Care Payments Based on Estimates of:

- Total national Medicare DSH payments
- Change in national uninsured rates
- Each hospital's share of uncompensated care
- National pool of hospital uncompensated care

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## Disproportionate Share Hospital

**FY**

ACA, Section 3133

Applies to:

- Puerto Rico hospitals
- SCHs paid on federal rate

Does not apply to:

- Maryland hospitals
- SCHs paid on hospital-specific rate
- Hospitals participating in the Rural Community Demonstration

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## Disproportionate Share Hospital

**FY**

ACA, Section 3133

Factor 1 for FY 2014: \$9.2579 billion per final rule

75% of the aggregate amount of DSH payments hospitals would receive under section 1886(d)(5)(F) of the Act

July 2013 estimates, based on the March 2013 Medicare cost report data

Excludes payment data on:

- Maryland hospitals,
- Puerto Rico hospitals,
- SCHs paid on hospital-specific rates
- Hospitals participating in Rural Community Demonstration

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## Disproportionate Share Hospital

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ACA, Section 3133

Factor 2 for FY 2014: 0.943 per final rule

For FYs 2014 through 2017

1 minus the percent change in the percent of individuals under the age of 65 who are uninsured in 2013

- Less 0.1 percentage in FY 2014
- Less 0.2 percentage points in FYs 2015 through 2017

Based on estimates of Insured Share of Nonelderly Population Including all Residents (March 20, 2010, letter from Director of Congressional Budget Office to the Speaker of the House)

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## Disproportionate Share Hospital

**FY**

ACA, Section 3133

Factor 3: Hospital-Specific Data on Uncompensated Care

Not using Worksheet S-10 at this time, as this is a relatively new worksheet and there are concerns regarding consistency and accuracy of reporting.

FY 2014:

Hospital utilization of insured low-income patients considered a reasonable proxy for the treatment costs of uninsured patients.

- Inpatient days of Medicaid patients from March 2013 update to the Provider Specific File for the 2011 cost report, Worksheet S-3 (2552-96), Worksheet S-2 (2552-10), plus
- Inpatient days of Medicare SSI patients for the 2011 cost report.

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## Disproportionate Share Hospital

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ACA, Section 3133

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### Uncompensated Care Payments

- Paid on a per discharge basis for interim, settled on cost report
- Will be included in the SCH comparison of payments between the federal rate and hospital-specific payments for interim rate and final settlement purposes
- If hospital eligible for empirically justified DSH payments, will receive uncompensated care payments in the interim.
- If hospital ineligible for empirically justified DSH payments, will not receive uncompensated care payments in the interim.
- When cost report settled, uncompensated care payments will be made or recouped based on eligibility for empirically justified DSH.
- No administrative or judicial review

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## Disproportionate Share Hospital

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Uncompensated Care Payments for hospitals with cost reporting periods not concurrent with the Federal fiscal year:

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- Uncompensated care payments (paid on a per discharge basis for interim payment purposes) will be reconciled on the cost report based on:
  - The proportion of the Federal fiscal year(s) occurring in the cost reporting period, and
  - the amounts CMS computes as uncompensated care for each Federal fiscal year
- If hospital is eligible for empirically justified DSH payments in the cost reporting period that begins in the Federal fiscal year, it is eligible to receive uncompensated care payment for the entire Federal fiscal year.
- If hospital is ineligible for empirically justified DSH payments in the cost reporting period that begins in the Federal fiscal year, it is ineligible to receive uncompensated care payments for the entire Federal fiscal year.

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## Disproportionate Share Hospital

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### Example of Uncompensated Care Payment Reconciliation

Facts:

- Provider has cost reporting period ending December 31, 2013
- Provider's uncompensated care payment for FFY 2014 is \$1,000,000
- Provider's uncompensated care payment for FFY 2015 is \$1,500,000

For cost reporting period ending 12/31/13, provider will receive uncompensated care payments of \$250,000 for FFY 2014

3 months of FFY 2014 (10/01/13 to 12/31/13)  
12 months in cost reporting period, times \$1,000,000

Final determination of eligibility for FFY 2014 uncompensated care payments is based on FYE 12/31/14 cost report.

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## Disproportionate Share Hospital

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### Example of Uncompensated Care Payment Reconciliation, continued

Facts:

- Provider has cost reporting period ending December 31, 2014
- Provider's uncompensated care payment for FFY 2014 is \$1,000,000
- Provider's uncompensated care payment for FFY 2015 is \$1,500,000

For cost reporting period ending 12/31/14, provider will receive uncompensated care payments of:

\$750,000 for FFY 2014 (9 months/12 months times \$1,000,000), plus  
\$375,000 for FFY 2015 (3 months/12 months times \$1,500,000)  
\$1,125,000 total uncompensated care payments for FYE 12/31/14

- Final determination of eligibility for FFY 2014 uncompensated care payments is based on FYE 12/31/14 cost report DSH eligibility.
- Final determination of eligibility for FFY 2015 uncompensated care payments is based on FYE 12/31/15 cost report eligibility.

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## Value-Based Purchasing

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### Overview

- Effective for discharges occurring on or after Oct. 1, 2012
- Funded through payment reduction to base operating DRG payments
  - FY 2013: 1.00 percent
  - FY 2014: 1.25 percent
  - FY 2015: 1.5 percent
  - FY 2016: 1.75 percent
  - FY 2017 and subsequent: 2.0 percent
- Redistributed to IPPS hospitals based on their performance
  - As compared to other hospitals
  - As compared to the hospital's own prior performance

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## Value-Based Purchasing

**FY**

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### Who Participates in VBP?

- All “subsection (d) hospitals”
- Exempt or excluded hospitals
  - IPPS-excluded hospitals
  - Hospitals subject to payment reduction under IQR
  - Hospitals cited for health or safety deficiencies
  - Maryland hospitals for FY 2014, based on exemption request
  - Hospitals without minimum number of measures or cases

**NOTE:** Hospitals need to have at least 4 quality measures to participate and at least 10 cases per measure and 100 HCAHPS surveys.

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## Value-Based Purchasing

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### The Score

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- Multiple-Domain Performance Scoring Model
  - Clinical Process of Care domain - 45% (13 clinical measures)
  - Patient Experience of Care domain – 30% (8 dimensions of HCAHPS scores)
  - Mortality Outcomes Measures – 25% (3 mortality outcomes measures)
- Points for both achievement and improvement
  - The hospital's **achievement** based on national measures and
  - The hospital's **improvement** as against the hospital's own baseline performance
- The *higher* of its achievement score or its improvement score during the performance period will be used in calculating a hospital's total performance score.

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## Value-Based Purchasing

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### FY 2014

In addition to the existing 12 Clinical Process of Care Measures and the HCAHPS measure, CMS adopted the following measures for FY 2014:

2014

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- Clinical Process of Care Measure: SCIP-INF-9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
- 3 mortality outcome measures:
  - Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
  - Heart Failure (HF) 30-Day Mortality Rate
  - Pneumonia (PN) 30-Day Mortality rate

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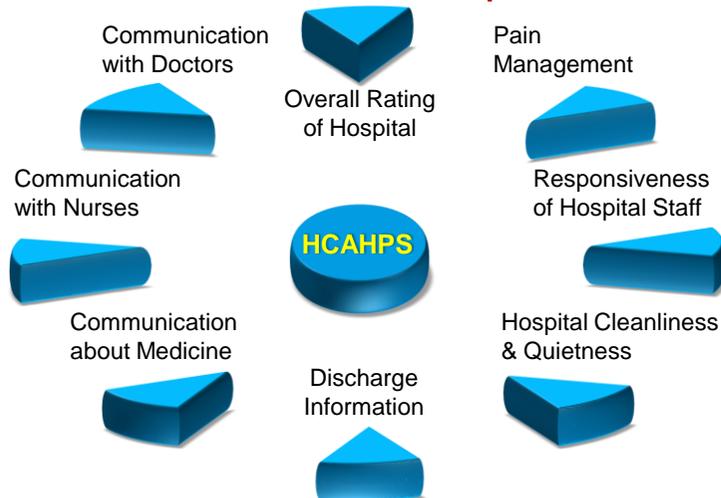
## Value-Based Purchasing

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### HCAHPS 8 Dimensions of Patient Experience of Care

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## Value-Based Purchasing

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### VBP Program Weighting

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VBP Program Weighting (Fiscal Year)				
Domain	2013	2014	2015	2016
Clinical process of care	70%	45%	20%	10%
Patient experience of care	30%	30%	30%	25%
Outcomes		25%	30%	40%
Efficiency			20%	25%

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## Value-Based Purchasing

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### The Payment

- Adjustment to base operating DRG per discharge payment, which does not include:
  - Payment reductions under Hospital Readmission Reduction Program
  - IME payments
  - DSH payments
  - Outlier payments
- Reduction and value-based incentive payment applied to each discharge.
- New field added to PS&R IPPS report for VBP.
- Medicare cost report ( Worksheet E, Part A) modified for VBP (T-4).

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## Hospital Readmission Reduction Program

**FY**

- ACA, Sections 3025, 1039
- Effective for discharges on or after Oct. 1, 2012.
- Hospital payments will be reduced for certain excess readmissions:
  - Acute Myocardial Infarction (AMI)
  - Heart Failure (HF)
  - Pneumonia (PN)
- Readmission: Discharge from hospital, admitted to same or different hospital within 30 days.

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## Hospital Readmission Reduction Program

**FY**

### Effect on Payments

Adjustment to base operating DRG per discharge payment, which does not include:

- Low volume adjustments
- IME payments
- DSH payments
- Outlier payments
- New field added to PS&R IPPS report for HRRP.
- Medicare cost report ( Worksheet E, Part A) modified for HRRP (T-4).

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## Hospital Readmission Reduction Program

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### Planned Readmissions

Certain readmissions are scheduled as follow-up care within 30 days of discharge.

CMS developed an expanded Planned Readmission Algorithm to identify planned readmissions across readmissions measures.

- If first readmission is planned, will not count as readmission.
- Subsequent unplanned readmissions after planned readmission will not count if they fall within 30 days of discharge.

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## Medicare-Dependent Hospitals

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### Expiration of MDH Program

MDH Program expired Sept 30, 2012 (ACA, Section 3124)

MDH Program extended through Sept. 30, 2013 (American Taxpayer Relief Act of 2012, Section 606)

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If hospital with MDH status applied for SCH status at least 30 days prior to the expiration, SCH status could begin with the date after expiration (Oct. 1, 2013)

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## Payment Adjustment for Low Volume Hospitals

**FY**

### ACA Sections 3125 and 10314

- Modified Definition of low volume hospital for FY 2011 and 2012
  - Located more than 15 miles from another IPPS hospital , and
  - Has less than 1,600 Medicare discharges (including Medicare Part C)
- Payment based on:
  - 200 or less discharges – 25%
  - More than 200 and fewer than 1,600 discharges - sliding scale
  - More than 1,600 discharges - -0-

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ACA extension expired at the end of FY 2013

- The road mileage qualifying criterion reverts to 25 miles from the nearest subsection (d) hospital.
- The discharge qualifying criterion reverts to no more than 200 total (Medicare and non-Medicare) discharges.
- The payment adjustment will be an additional 25 percent for discharges occurring during the fiscal year.

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