CMS issues proposed payment rules for inpatient hospital and long-term care hospital prospective payment system for 2015 fiscal year

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On April 30, 2014, the Centers for Medicare & Medicaid Services (CMS) issued the inpatient prospective payment system (IPPS) proposed rule for the 2015 fiscal year (FY) with updates and other payment-related changes for inpatient hospital services and long-term care hospital (LTCH) services. The proposed rule would generally be effective for discharges occurring on or after October 1, 2014.

Inpatient Hospital PPS Proposed Rule for FY 2015

CMS projects that the proposed changes to IPPS payment policies would decrease IPPS operating payment rates by approximately 0.8 percent, which is $241 million in savings in FY 2015. The proposed rule includes a number of changes that implement and revise programs introduced by the Affordable Care Act, such as changes to the disproportionate share hospital (DSH) adjustment, hospital-acquired conditions and value-based purchasing methodologies.

In addition to updating and establishing standards for payment for Medicare-covered inpatient services, the FY 2015 IPPS rule:

- Includes an initial market basket update of 2.7 percent for those hospitals that participate in the Hospital Inpatient Quality Reporting (IQR) Program and were meaningful users of electronic health records (EHR).
- Increases IPPS operating payment rates by 1.3 percent, which reflects the FY 2015 market basket update of 2.7 percent decreased to 1.3 percent by other reductions, including a 0.4 percent update for a productivity adjustment; a 0.2 percent update for cuts under the Patient Protection and Affordable Care Act; and a negative 0.8 percent documentation and coding adjustment.
- Proposes that hospitals that do not submit the required quality data would lose a quarter of the market basket update, and hospitals that are not meaningful EHR users would be subject to another quarter reduction of the market basket update.
- Proposes a 75 percent reduction in Medicare DSH payments by 2019. The reduction functions in two parts: providers will be paid 25 percent of the previously-calculated total DSH amount; the other 75 percent will be put in a pot that will decrease year-over-year in proportion to the decrease in the total uninsured population; in any given year, this pot will be re-distributed to DSH-eligible hospitals based on each hospital's proportion of the total amount of uncompensated care it renders.
- Increases the maximum payment reduction from 2 percent of payment amounts to 3 percent of payment amounts for the Hospital Readmissions Reduction Program.
- Proposes to assess hospitals' readmissions penalties using five readmissions measures endorsed by the National Quality Forum: heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease and hip/knee arthroplasty.
- Proposes that hospitals scoring in the top quartile for the rate of hospital-acquired conditions will have their Medicare inpatient payments reduced by 1 percent.
- Increases the reduction to base operating DRG amounts to 1.5 percent for the Hospital Value-Based Purchasing Program.

- Asks for public input on an alternative payment methodology for short-stay inpatient cases that may also be treated on an outpatient basis, including how to define short stays.
- Reminds stakeholders of the existing process for requesting additional exceptions to the two-midnight benchmark.
- Reinforces that hospitals are obligated to support price transparency for patients and the public and can do so by disclosing charges for their services online or in response to a request; describes how hospitals can comply with statutory requirements to disclose charges for their services online or in response to a request.
- Proposes the use of the most recent labor market area delineations based on the 2010 Census and issued by the Office of Management and Budget (OMB) to maintain a more accurate up-to-date payment system that reflects the reality of population shifts and labor market conditions.
- Proposes to allow a hospital that was “rural” at the time the hospital started training residents in a new program but is redesignated by the OMB as “urban” during the hospital’s cap-building period for that program, to continue growing that program for the remainder of the cap-building period and receive a permanent cap adjustment for that new program effective for cost reporting periods beginning on or after October 1, 2014.
- Proposes that critical access hospitals (CAHs) affected by the OMB redesignations, that are now located in "urban" areas instead of "rural" areas, be given two years from the date the redesignation becomes effective to reclassify as rural and thereby retain their CAH status.
- Proposes to allow the physician certification requirement that must be met for inpatient CAH services to be payable under Part A to be completed no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted.
- To conform regulations to the statutory requirements of the Provider Reimbursement Review Board (PRRB) appeals based on untimely determinations of the Medicare Administrative Contractor (MAC), the FY 2015 IPPS rule proposes to amend the regulations to eliminate the provider dissatisfaction requirement as a condition for PRRB jurisdiction over such appeals.
- Proposes a similar amendment to the regulations for appeals to MAC hearing officers to maintain consistency between the regulations for MAC and PRRB appeals (see previous bullet point).

Long-Term Care Hospital PPS Proposed Rule for FY 2015

CMS projects that under the proposed rule, LTCH PPS payments would increase by 0.8 percent (about $44 million), which reflects the market basket update of 2.7 percent decreased to 0.8 percent after other required reductions, including: 0.4 percentage point and an additional adjustment of 0.2 percentage point in accordance with the Affordable Care Act; the one-time budget neutrality adjustment to standard federal rate of approximately 1.3 percent under the last year of a three-year phase-in; and projected decrease in estimated high-cost outlier payments as compared to FY 2014. In addition to updating and establishing standards for payment for Medicare-covered LTCH services, below are some of the other key provisions pertaining to LTCHs:

- Since the Pathway for SGR Reform Act of 2013 establishes a new framework for the application of patient criteria under the LTCH PPS for implementation beginning with FY 2016, the proposed rule describes the statutory framework for the application of patient criteria and asks for stakeholder feedback on implementation in advance of the FY 2016 regulatory cycle.
- Proposes expansion of the interrupted stay policy threshold (which results in bundled LTCH payments if a patient is discharged from an LTCH, admitted to an IPPS hospital, an inpatient rehabilitation facility or a skilled nursing facility, and then directly readmitted to the LTCH within a provider-specific day threshold) for all providers to 30 days, which would be consistent with the 30 day window for hospitals that is applied under the HRRP and IQR programs.
- Proposes elimination of the "5 percent readmissions” policy under which readmissions from co-located providers in excess of 5 percent are paid a single LTCH payment rather than two payments (one for both the admission and readmission).
- Implements statutory provisions in the Pathway for SGR Reform Act of 2013 and the Protecting Access to Medicare Act of 2014, including reinstating moratoria on full implementation of the 25 percent threshold payment adjustment and on the

development of new LTCHs and LTCH satellite facilities and additional LTCH beds.

- Revises measures for the LTCH Quality Reporting Program by proposing the following three new quality measures for the FY 2018 payment determination and subsequent years: Ventilator-Associated Event Outcome Measure; Functional Status Quality Measure: Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function; and Functional Outcome Measure: Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support.

Finally, comments on the proposed rule are due by June 30, 2014, and a final rule is due on August 1, 2014. For more information, see the CMS Fact Sheet accompanying the release of the proposed rule on the payment-related components.

Authors