

PUBLICATION

CMS Publishes Inpatient Prospective Payment System (IPPS) FY 2015 Proposed Rule [Ober|Kaler]

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On April 30, 2014, CMS posted its proposed changes and updates to the Medicare IPPS [PDF] that would apply beginning in fiscal year (FY) 2015. Comments are due by June 30, 2014. Below is a summary of the major changes to the proposed rule.

Acute Care Hospitals

- **Proposed Changes to Payment Rates under IPPS.** The proposed rule would increase IPPS operating payment rates by 1.3%.
- **Documentation and Coding Adjustment.** The proposed rule would adjust the rate by –0.8% to continue CMS's recoupment due to documentation and coding overpayments related to the transition to the MS-DRGs that started in FY 2008.
- **Updated Labor Market Areas.** CMS proposes to use the Office of Management and Budget's (OMB) most recent labor market area delineations in order to have a more accurate and up-to-date payment system that reflects population shifts and labor market conditions. CMS proposed transition periods to mitigate the negative impacts caused by the proposed adoption of the new OMB delineations.

Graduate Medical Education (GME) and Indirect Medical Education (IME)

- **Rural Teaching Hospitals.** The proposed rule would allow a hospital designated as urban by OMB during its cap-building period for a new program, to continue growing that program for the remainder of the cap-building period if the hospital was rural at the time it started training new residents in a new program. The hospital would receive a permanent cap adjustment for that new program effective for cost reporting periods beginning on or after October 1, 2014.
- **Participation of Redesignated Hospital in Rural Training Track.** CMS is proposing that when an urban hospital and a rural hospital are participating in a program separately accredited as a rural track program and the rural hospital is designated as urban as a result of implementing the new OMB labor market area delineations, the originally designated urban hospital will continue to be paid for the rural track throughout a two-year transition period. During the transition period, either the newly designated urban hospital must reclassify as rural under 42 C.F.R. § 412.103, or the originally designated urban hospital must find a new rural site to participate in the rural track for the originally designated urban hospital to receive payment under for the rural track after the two-year transition period terminates.
- **Change in the Effective Date of the FTE Cap, Rolling Average, and IRB Ratio Cap for New Programs.** The proposed rule would make these caps effective simultaneously. CMS proposes this would begin with the hospital's cost reporting period that precedes the start of the sixth program year of the first new program.

For a more in-depth discussion of the GME and IME proposed changes, please see Tom Coons' *Payment Matters* article entitled "Proposed 2015 IPPS Rule Contains Many Changes to GME and IME Rules."

Other Proposals

- **Hospital Price Transparency.** CMS proposes that hospitals either make public a list of their standard charges for items and services or make public their policies for allowing the public to view a list of these charges in response to an inquiry.
- **Hospital-Acquired Condition (HAC) Reduction Program.** Beginning FY 2015, the proposed rule would reduce Medicare IPPS payments by 1% for applicable hospitals in the top quartile for the rate of HACs.
- **Critical Access Hospitals (CAHs) Conditions of Participation.** If a CAH is redesignated as urban when OMB delineations take effect and the CAH was previously rural, the proposed rule will give the CAH two years from the effective date of the redesignation to reclassify as rural in order to retain its CAH status.
- **Requirements for Physician Certification of CAH Inpatient Services.** CMS proposes to allow physicians to complete certifications no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted.
- **Alternative Payment Approaches for Short Hospital Stays.** The proposed rule seeks public input on an alternative payment methodology for short stay inpatient cases that may also be treated on an outpatient basis. The proposed rule also seeks input on how to define short stays and what would be an appropriate payment.
- **Provider Reimbursement Appeals Regulations and Cost Reporting Requirements.** CMS proposes to amend the Provider Reimbursement Review Board (PRRB) appeals regulations to eliminate the provider dissatisfaction requirement that is currently a condition for PRRB jurisdiction. CMS proposes similar amendments for appeals to Medicare Administrative Contractor hearing officers. CMS also proposes to codify in the cost reporting regulations its “existing policy,” which requires a provider to include an appropriate claim for an item in the provider's cost report. CMS proposes that a provider's failure to include an appropriate claim for an item in its cost report will foreclose the provider from payment for that item in the notice of program reimbursement and in any decision or order issued by a reviewing entity in an administrative appeal filed by the provider.
- **Medicare Disproportionate Share Hospitals (DSH).** CMS proposes that, in calculating the uncompensated care costs portion of the DSH calculation, it will use the CMS Office of the Actuary's estimate of payments that would otherwise be made for Medicare DSH in FY 2015, adjusted by the change in the percentage of individuals that are uninsured as estimated by the CBO, and a statutory factor. CMS also proposes to adopt a process to identify hospitals that have merged so the data from all hospitals involved in the merger will be considered in determining the remaining provider's uncompensated care payment.

Long-Term Care Hospitals (LTCHs)

- **Proposed Changes to Payment Rates under LTCH PPS.** CMS proposes a 0.8% increase in LTCH PPS payment.
- **Statutory Upcoming Changes to Payment Rates under the LTCH PPS.** CMS seeks feedback in establishing the statutory framework for the application of patient criteria under the LTCH PPS implementation beginning in FY 2016.
- **Delay in Full Application of the 25% Patient Threshold.** The proposed rule would enact regulations consistent with the Pathway for SGR Reform Act of 2013 that imposes a four year moratorium on the full application of the 25% patient threshold rule for most LTCHs. This would be effective retroactively to the expiration of the previous statutory delay.
- **Moratoria on the Establishment of LTCHs and LTCH Satellite Facilities and on the Increase in Number of Beds in Existing LTCHs and Satellite Facilities.** CMS proposes to implement new

moratoria in the same manner as the exceptions to the original moratorium included in the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007.

- ***Expansion of the Interrupted Stay Policy and Termination of the 5% Readmissions Policy.*** CMS proposes to amend the applicable day thresholds under the “more than three days” category in the interrupted stay policy for all providers to 30 days. CMS also proposes to eliminate the “5 percent readmissions” policy.
- ***LTCH Area Wage Adjustment Updates.*** The proposed rule would update the LTCH PPS wage index and labor-related share. CMS proposes to revise LTCH PPS labor market areas based on the new OMB CBSA delineations. CMS also proposes budget neutral transition methodology consistent with the approach being proposed under the IPPS.