CMS Releases Final Rule on the FY 2014 Inpatient Prospective Payment System

August 2, 2013 – Late this afternoon, the Centers for Medicare and Medicaid Services (CMS) publicly released its annual Inpatient Prospective Payment System (IPPS) Final Rule. AdvaMed will provide a comprehensive summary in the near future. CMS estimates that the proposed rule will increase average FY 2014 IPPS operating payment rates for hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program (IQR) by 0.7 percent. This rate increase for operating costs, together with capital payments, will increase Medicare’s payments to acute care hospitals by approximately $632 million in FY 2014. Some of the major items of interest in the final rule are summarized below:

CMS’ Final IPPS Rule for FY 2014 will result in an increase in the average operating payment per discharge for all hospitals by approximately 0.7 percent. The update includes the following specific adjustments:

- a projected +2.5 percent reflecting changes in the hospital market basket;
- an adjustment of -0.5 percent for productivity increases;
- an adjustment of -0.3 percent to the market basket as required by the health care reform law of 2010;
- a -0.8 adjustment for documentation and coding changes, the first of 4 years of adjustments as required by the American Taxpayer Relief Act of 2013; and
- a -0.2 adjustment for inpatient and medical review criteria.

CMS’s impact analysis of the final rule shows that when these and all other changes such as the hospital readmissions reduction program and changes to Medicare DSH policy are taken into account Medicare payments for IPPS operating costs will increase by 0.5 percent.

Charge Compression—Beginning in FY 2014, CMS will move forward with calculating the MS-DRG relative weights using 19 cost-to-charge ratios (CCRs), creating distinct new CCRs from hospital cost report data for implantable devices, MRIs, CT scans, and cardiac catheterization.

DSH Payment Adjustments—Medicare disproportionate share hospitals (DSH) qualify for a payment adjustment under a statutory formula that considers their share of low income patients. The health care reform law modified the Medicare DSH methodology beginning in FY 2014. DSH hospitals will receive 25 percent of the amount they previously would have received under the current formula and the remaining 75 percent will be adjusted to reflect the percentage of individuals that are uninsured. The proposed rule implements these statutory changes and CMS will be making these new uncompensated care payments through the claims
processing system, as commenters recommended, instead of biweekly payments. CMS estimates that its impact on operating costs in FY 2014 will be -0.4 percent.

**Rebasing and Revision of the Hospital Market Baskets for Acute Care Hospitals**—CMS will be rebasing and revising the acute care hospital operating and capital market baskets used to update the IPPS rates using FY 2010 as the base year. CMS will also recalculate the labor-related share using the proposed FY 2010-based hospital market basket, adopting a labor-related share of 69.6 percent for discharges occurring on or after October 1, 2013.

**New Technology Add-on Payments:**

CMS finalized the following changes for New Technology Add-on Payments for FY 2014:

- CMS will discontinue new technology add-on payments for the AutoLITT™ for FY 2014.
- CMS will continue new technology add-on payments for Glucarpidase (Trade Brand Voraxaze® for FY 2014.
- CMS will continue new technology add-on payments for DIFICID™ for FY 2014.
- CMS will continue new technology add-on payments for Zenith® F. Graft technology for FY 2014.

CMS considered five applications for New Technology Add-on Payments in FY 2014. Two of the five technologies for which CMS received applications for new technology add-on payments (the Responsive Neurostimulator System and the MitraClip System, did not receive FDA approval by the July 1 deadline, and therefore were not eligible for further consideration for add-on payments. CMS approved the following three applications for add-on payments for FY 2014:

- Kcentra™, a replacement therapy for fresh frozen plasma (FFP) for specified patients with an acquired coagulation factor deficiency due to warfarin and who are experiencing a severe bleed.
- Argus® II System, an active implantable medical device that is intended to provide electrical stimulation of the retina to induce visual perception in patients who are profoundly blind due to retinitis pigmentosa (RP).
- Zilver® PTX® Drug Eluting Peripheral Stent is intended for use in the treatment of peripheral artery disease (PAD) of the above-the-knee femoropopliteal arteries (superficial femoral arteries).

**New Hospital-Acquired Condition (HAC) Reduction Program**—

- Beginning in FY 2015, hospitals that rank among the lowest-performing 25 percent with regard to hospital-acquired conditions will be penalized 1% of what they would otherwise be paid under the IPPS.
- In the final rule, CMS establishes measures, a risk adjustment methodology, and modifications to the scoring methodology to implement the FY 2015 payment adjustment under the HAC Reduction Program.
  - In response to public comments, CMS is modifying the scoring scheme and will begin at the minimum value for each measure rather than the 75th percentile, as originally proposed. The finalized methodology will assess the top quartile of applicable hospitals for HACs based on the Total HAC Score. However, based on comments received
requesting that CMS give greater weight to Domain 2 (CDC NHSN) measures, CMS is finalizing a different weight for each Domain than originally proposed.

- CMS will calculate a Total HAC Score for each hospital by using the hospital’s performance score on each measure within a domain to determine a score for each domain, then multiplying each domain score by the following weights: Domain 1-(AHRQ PSI-90), 35 percent; and Domain 2-(CDC NHSN Measures), 65 percent; and combining the weighted domain scores to determine the Total HAC Score.

**Hospital Inpatient Quality Reporting (IQR) Program—**

- For FY 2015 CMS is finalizing its proposal to reduce the number of records used for HAI validation from 48 to 36 patient charts for individual hospitals annually.
- CMS is finalizing adopting five new claims-based measures for FY 2016 and subsequent years: (1) the Hospital 30-day, all-cause risk-standardized rate of readmission following acute ischemic stroke measure; (2) the Hospital 30-Day, all-cause risk-standardized rate of mortality following an admission for acute ischemic stroke; (3) Hospital Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Acute Myocardial Infarction (AMI) Measure; (4) Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization Measure (NQF #1891); and Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization Measure (NQF #1893).
- For the FY 2016 payment determination and subsequent years, CMS will validate two additional chart abstracted HAI measures: MRSA bacteremia, and C. difficile.
- CMS is finalizing the removal of six chart-abstracted measures and one structural measure beginning with the FY 2016 payment determination (See chart p.1144)
- CMS states that IMM-1 (Immunization for Pneumonia) in the Hospital IQR Program cannot be implemented in its current state and therefore will suspending data collection for IMM-1 from the Hospital IQR Program beginning with the FY 2016 payment determination until further notice.
- A complete list of previously adopted Hospital IQR measures and the new quality measures finalized in the final rule for FY 2016 payment determinations and beyond appear on pages 1240 – 1243 (This list does not include suspended/removed measures).

**Hospital Readmissions Reduction Program—**

- The maximum payment reduction for hospitals with a high number of readmissions will increase from one percent today to two percent of payment amounts in FY 2014.
- CMS is finalizing its proposed change to the three existing readmissions measures endorsed by the National Qualify Forum (NQF)—heart attack, heart failure, and pneumonia--to address unplanned readmissions that occur after a planned readmission but within 30 days of the patient’s initial index discharge, without modification.
- CMS is finalizing its proposal, without modification, to use the revised versions of the heart attack, heart failure, and pneumonia to calculate the payment adjustments for the Hospital Readmissions Reduction Program in FY 2014.
- CMS is finalizing its proposal to add two new readmission measures in FY 2015--readmissions for hip/knee arthroplasty and chronic obstructive pulmonary disease.

**Hospital Value-Based Purchasing (VBP)—CMS includes in the final rule several changes to HVBP:**
FY 2014—For FY 2014, CMS estimates the applicable percent reduction to base operating DRG payment amounts will be 1.25 percent and the total estimated amount available for value-based purchasing incentive payments will be approximately $1.1 billion (p. 521). (A complete list of the finalized measures for the FY 2014 Hospital VBP Program is found on p. 523.)

FY 2015—A complete list of the finalized measures for the FY 2015 Hospital VBP Program is found on p. 722-723.

FY 2016—
- CMS finalized its proposal to remove from the FY 2016 Hospital VBP Program (1) AMI-8a: Primary PCI Received within 90 Minutes of Hospital Arrival; (2) HF-1: Discharge Instructions; (3) PN-3b: Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital; and (4) SCIP-Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.
- A complete list of re-adopted and proposed Clinical Process of Care measures for the FY 2016 Hospital VBP is found on p. 753-754.
- **Efficiency Measure**—CMS is considering including additional measures in the Efficiency Domain for future years of both the Hospital Quality Reporting Program and the Hospital VBP Program. This would be done through future rulemaking.
- CMS finalized its proposal to adopt new quality measurement domains based on the CMS National Quality Strategy for the FY 2017 Hospital VBP Program as proposed. CMS intends to propose more details about this policy in future rulemaking.
- CMS finalized a policy under which it will consider, upon a hospital’s request and after its review, providing an exception from a Hospital VBP Program year hospitals affected by natural disasters or other extraordinary circumstances.

**PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program**—CMS finalized its program policy that PPS-exempt cancer hospitals (PCHs) submit data on one additional measure beginning with FY 2015 and 12 additional measures beginning with FY 2016, for a total of 18 measures (5 previously adopted plus 13 new measures) (See tables on pages 1865-1866 for complete list).
- This includes the following measure: NQF #0753, Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure.

A copy of the 2,225 page final rule is available [here](#).

It will appear in the August 19, 2013 *Federal Register*.

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