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Centers for Medicare & Medicaid Services
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# FACT SHEET

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Contact: CMS Media Relations
(202) 690-6145 or press@cms.hhs.gov

**FISCAL YEAR 2015 PROPOSED POLICY AND PAYMENT CHANGES FOR INPATIENT STAYS IN ACUTE-CARE HOSPITALS AND LONG-TERM CARE HOSPITALS**

**OVERVIEW**: On April 30, 2014 the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update fiscal year (FY) 2015 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS).

The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 435 LTCHs, would generally be effective for discharges occurring on or after October 1, 2014. Under the proposed rule, the operating payment rates for inpatient stays in general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users would be increased by 1.3 percent. (The market basket update is projected to be 2.7 percent for FY 2015, but is reduced as described in detail below.) Beginning with FY 2015, those hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data will be subject to a one-fourth reduction of the market basket update (previously these hospitals received a 2 percentage point reduction). Also, the law requires that the update for any hospital that is not a meaningful EHR user will be reduced by one-quarter of the market basket update in FY 2015, one-half of the market basket update in FY 2016, and three-fourths of the market basket update in FY 2017 and later years. Total IPPS payments (capital and operating payments) are projected to decrease by $241 million. Medicare payment rates to LTCHs in FY 2015 are projected to increase by approximately 0.8 percent as compared to FY 2014 Medicare payments.

**BACKGROUND**. CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. Under these two payment systems, CMS generally sets payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. A hospital receives a single payment for the case based on the payment classification – MS-DRGs under the IPPS and MS-LTC-DRGs under the LTCH PPS – assigned at discharge.

Under Medicare law, CMS is required to update payment rates for IPPS hospitals annually, and to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. This is known as the hospital "market basket." LTCHs are paid according to a separate market basket based on LTCH-specific goods and services.

**CHANGES IN POLICIES AFFECTING ACUTE-CARE HOSPITALS**

***Proposed Changes to Payment Rates under IPPS***. The proposed rule would increase IPPS operating payment rates by 1.3 percent. This reflects the projected hospital market basket update of 2.7 percent adjusted by -0.4 percentage points for multi-factor productivity and an additional adjustment of -0.2 percentage point in accordance with the Affordable Care Act; like last year, the rate is further decreased by 0.8 percent for a proposed documentation and coding recoupment adjustment required by the American Taxpayer Relief Act of 2012. CMS projects that the rate increase, together with reductions under the Hospital Readmissions Reduction Program, the Hospital Acquired Condition Reduction Program, Medicare disproportionate share hospitals changes, the expiration of certain statutory provisions that provided special temporary increases in payments to hospitals, and other proposed changes to IPPS payment policies would decrease IPPS operating payments by approximately 0.8 percent. CMS projects that total Medicare spending on inpatient hospital services will decrease by about $241 million in FY 2015.

***Documentation and Coding Adjustment***. Section 631 of the American Taxpayer Relief Act of 2012 requires CMS to recover $11 billion by 2017 to fully recoup documentation and coding overpayments related to the transition to the MS-DRGs that began in FY 2008. For FY 2015, CMS proposes to continue the approach begun in FY 2014 by making another -0.8 percent adjustment to continue the recovery process. A positive adjustment will be made to remove these one-time recoupment adjustments once the recovery is complete.

***Updated Labor Market Areas.*** In order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions, we are proposing to use the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

In order to mitigate potential negative payment impacts due to the proposed adoption of the new OMB delineations, we are proposing transition periods. We are proposing that hospitals currently located in an urban county that would become rural under the new OMB delineations would be assigned the urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. The rule also proposes a one-year transition for all hospitals that would experience a decrease in their actual payment wage index exclusively due to the proposed implementation of the new OMB delineations.

***Low-Volume Hospitals.*** Section 105 of the Protecting Access to Medicare Act of 2014 extended the temporary changes to the low-volume hospital payment adjustment for an additional year (through March 31, 2015). In the FY 2015 IPPS/LTCH proposed rule, we are proposing conforming changes to the regulations.

***Medicare Dependent Hospitals.*** Section 106 of the Protecting Access to Medicare Act of 2014 extended the Medicare Dependent Hospital program for an additional year (through March 31, 2015). In the FY 2015 IPPS/LTCH proposed rule, we are proposing conforming changes to the regulations.

**GRADUATE MEDICAL EDUCATION (GME)**

***Rural Teaching Hospitals***. Under existing regulations, a rural teaching hospital receives a permanent cap adjustment any time it starts training residents in a brand new program. We are proposing to allow a hospital that was rural at the time it started training residents in a new program(s) and is redesignated by the Office of Management and Budget (OMB) as urban during its cap-building period for that program(s), to continue growing that program(s) for the remainder of the cap-building period and receive a permanent cap adjustment for that new program(s) effective for cost reporting periods beginning on or after October 1, 2014.

***Participation of Redesignated Hospital in Rural Training Track***. We are proposing that when an urban hospital and a rural hospital are participating in a program that is separately accredited as a rural track program (in which the residents rotate for more than one-half of the duration of the program to a rural hospital(s) and/or rural nonprovider setting(s)) and the rural hospital is redesignated as urban due to implementation of new OMB labor market area delineations, the "original" urban hospital will continue to be paid for the rural track during a two-year transition period. During this period either the redesignated newly urban hospital must reclassify back to rural under § 412.103 or the "original" urban hospital must find a new geographically rural site to participate as the rural site for purposes of the rural track in order for the "original" urban hospital to be paid for the rural track after the two-year transition period ends.

***Change in the Effective Date of the FTE Cap, Rolling Average, and IRB Ratio Cap for New Programs.*** New teaching hospitals currently have a "5-year window" to establish new residency programs, before the full-time equivalent (FTE) resident caps take effect. FTE residents in new programs are also exempt from the application of the 3-year rolling average and the IME intern-and-resident-to-bed (IRB) ratio cap, based on the length of the particular new program. We are proposing to simplify and streamline the timing of these policies by making the FTE resident caps, rolling average, and IRB ratio cap effective simultaneously, beginning with the applicable hospital's cost reporting period that precedes the start of the 6th program year of the first new program.

**OTHER PROPOSALS**

***Hospital Price Transparency.*** The Affordable Care Act contains a provision that is consistent with our effort to improve the transparency of hospital charges. It requires that each hospital establish and make public a list of its standard charges for items and services. In this proposed rule, we are reminding hospitals of their obligation to comply with the statutory requirements. Our guidelines for implementing the provision are that hospitals either make public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry. We encourage hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals.

***Hospital-Acquired Condition Reduction Program***. Section 3008 of the ACA established the Hospital Acquired Condition (HAC) Reduction Program. Beginning in FY 2015, the applicable hospitals in the top quartile for the rate of HACs (i.e., those with the poorest performance) will have their Medicare IPPS payments reduced by 1 percent.

***Other Affordable Care Act Quality-Related Provisions.*** The proposed rule would update the measures and financial incentives in the Hospital Value-Based Purchasing (VBP) and Readmissions Reduction programs. It would also revise measures for the Hospital Inpatient Quality Reporting, Long-Term Care Hospital (LTCH) Quality Reporting and PPS-Exempt Cancer Hospital Quality Reporting Programs.

For more information on these and other proposed quality-related provisions, please see the quality fact sheet at: http://www.cms.gov/apps/media/fact_sheets.asp.

***Critical Access Hospitals (CAHs) Conditions of Participation***. In light of the recent OMB redesignations, some CAHs that were previously located in rural areas may now be located in urban areas. CMS is proposing that affected CAHs be given two years from the date the redesignation becomes effective to reclassify as rural and thereby retain their CAH status.

***Requirements for Physician Certification of Critical Access Hospital Inpatient Services***. Current law requires that for inpatient critical access hospital services to be payable under Part A, a physician must certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the critical access hospital. Regulations adopted in FY 2014 require CAHs to complete the physician certification prior to discharge. In order to reduce the administrative burden on CAHs, provide greater flexibility in meeting the statutory physician certification requirement, and make the requirement more consistent with the CAH Conditions of Participation that allow for staffing by midlevel practitioners (who cannot sign the certification by law), we are proposing to allow the physician certification be completed no later than 1 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 notes that some members of the hospital community have expressed support for the general concept of an alternative payment methodology under the Medicare program for short inpatient hospital stays. CMS is soliciting comments on such a payment methodology, specifically how it might be designed. The proposed rule asks for public input on an alternative payment methodology for short stay inpatient cases that also may be treated on an outpatient basis, including how to define short stays and what an appropriate payment would be.

***Provider Reimbursement Appeals Regulations and Cost Reporting Requirements:*** CMS is proposing to amend the Provider Reimbursement Review Board (PRRB) appeals regulations to eliminate the provider dissatisfaction requirement as a condition for PRRB jurisdiction. We are proposing similar amendments for appeals to Medicare Administrative Contractor hearing officers. We are also proposing to codify in the cost reporting regulations our existing policy requiring providers to include an appropriate claim for an item in its cost report. We additionally propose that providers' failure to include an appropriate claim for an item in its cost report will result in foreclosure of payment 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)***. In accordance with the Affordable Care Act, beginning in FY 2014, hospitals receive 25 percent of the amount they previously would have received under the former statutory formula for Medicare DSH. The remainder, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH, will be adjusted for decreases in the rate of uninsured individuals and distributed to hospitals that receive DSH payments based on each hospital's share of uncompensated care costs relative to all hospitals that receive DSH payments. In the FY 2015 rule, we propose to 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 to determine the amount available for uncompensated care payments. Additionally, we are proposing to adopt a process to identify hospitals that have merged such that data from all hospitals involved in the merger may be taken into consideration for purposes of determining the remaining provider's uncompensated care payment.

**PROPOSALS AFFECTING LONG-TERM CARE HOSPITALS**

***Proposed Changes to Payment Rates under LTCH PPS.*** CMS projects that LTCH PPS payments would increase by 0.8 percent, or approximately $44 million, based on the proposed payment rates for FY 2015. This estimated increase is attributable to several factors, including the proposed update of 2.1 percent (based on a market basket update of 2.7 percent adjusted by a multi-factor productivity adjustment of -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.

***Statutory Upcoming Changes to Payment Rates under the LTCH PPS***. 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. CMS describes the statutory framework and asks for stakeholder feedback on implementation in advance of the FY 2016 regulatory cycle.

***Delay in Full Application of the 25 Percent Patient Threshold***. Under the 25-percent patient threshold policy, if an LTCH admits more than 25 percent of its patients from a single acute care hospital, Medicare will make payments at a rate comparable to IPPS hospitals for those patients above the 25-percent threshold. The Pathway for SGR Reform Act of 2013 imposed a four year moratorium on the full application of the 25 percent patient threshold rule for most LTCHs, effective retroactive to the expiration of the previous statutory delay. Certain "grandfathered" LTCHs are now permanently exempted from the policy by law.

***Moratoria on the Establishment of LTCHs and LTCH Satellite Facilities and on the Increase in Number of Beds in Existing LTCHs and Satellite Facilities***. The Pathway for SGR Reform Act of 2013 as amended by the Protecting Access to Medicare Act of 2014 imposed moratoria on new LTCHs, LTCH satellites, and an increase in beds in existing LTCHs and satellites from April 1, 2014 to September 30, 2017. There are three exceptions to the moratorium on new LTCHs and satellites (but not on the increase in beds) that are analogous to the original moratorium included in the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. CMS is proposing to implement the new moratoria in the same manner as the exceptions to the original moratoria that were included in MMSEA.

***Expansion of the Interrupted Stay Policy and Termination of the 5 Percent Readmissions Policy***: The interrupted stay policy, which was implemented at the start of the LTCH PPS, results in bundled LTCH payments if a patient is discharged from an LTCH, admitted to an IPPS hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF), and then directly readmitted to the LTCH within a provider-specific day threshold. CMS is proposing to amend the applicable day thresholds under the "more than three days" category of the interrupted stay policy for all providers to 30 days, which would be consistent with the 30 day window for hospitals that is applied under the Hospital Readmissions Reductions Program and the Hospital Inpatient Quality Reporting program. Simultaneously, CMS is proposing to eliminate 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). CMS data indicates that the majority of such cases would be captured by this proposed payment adjustment under the interrupted stay policy. We also believe that the new statutory revisions to the LTCH PPS, which will be implemented for FY 2016 (establishing clinical criteria for standard LTCH PPS payment) will further obviate the need for the 5 percent policy.

***LTCH Area Wage Adjustment Updates.*** For FY 2015, consistent with our historical approach, we are proposing to update the LTCH PPS wage index and labor-related share based on the best available data. We are also proposing to adopt revisions to the LTCH PPS labor market areas based on the new OMB CBSA delineations developed from the 2010 census data, and are proposing a budget neutral transition methodology consistent with the approach being proposed under the IPPS.

The proposed rule will publish soon in the Federal Register and can be downloaded from the Federal Register at http://ofr.gov/inspection.aspx.

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