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Final FY 2014 Inpatient and SNF Payment Rules

CMS Issues FY 2014 Inpatient Payment Rule

Rule Improves Value and Quality Focus in Hospital Payments

On August 2, CMS issued a final rule updating fiscal year (FY) 2014 Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs). The rule improves value and quality in hospital care and provides clarification about when a patient should be admitted to the hospital and responds to recent concerns about extended Medicare beneficiary stays in the hospital outpatient department.

The final FY 2014 Hospital Inpatient Prospective Payment System (IPPS) rule increases overall hospital payments (capital and operating) by \$1.2 billion. The rule also moves forward with health care delivery system reforms made possible by the Affordable Care Act. These include a new program aimed at improving safety in hospitals and refining the Hospital Readmissions Reduction program.

FY 2014 Payment Update

The final rule would increase IPPS operating rates by 0.7 percent after accounting for inflation and other adjustments required by the law. This increase reflects a temporary reduction of 0.8 percent to implement the American Taxpayer Relief Act's requirement to recoup overpayments from prior years as a result of a new patient classification system that better recognizes patient severity of illness. CMS is also making an additional 0.2 percent reduction to offset projected spending increases associated with changes to admission and medical review criteria for inpatient services. CMS projects that LTCH PPS payments would increase by 1.3 percent, or approximately \$72 million, in FY 2014.

Key FY 2014 Payment and Quality Changes

New Hospital-Acquired Condition (HAC) Reduction Program

As part of a new HAC Reduction program created by the Affordable Care Act, beginning in FY 2015 hospitals that are in the lowest quartile for medical errors or serious infections that patients contract while in the hospital will be paid 99 percent of what they otherwise would have been paid under the IPPS. This rule finalizes the criteria to rank hospitals with a high rate of hospital-acquired conditions.

Readmissions Reduction Program

In October 2012, Medicare began encouraging hospitals with excess 30-day readmissions to lower 30-day readmission rates for heart attack, heart failure, and pneumonia patients by reducing a portion of the hospital's payments by up to one percent, depending on their performance on key readmissions measures. As required by law, the FY 2014 IPPS rule increases the maximum reduction of payments to up to two percent. It adds hip and knee surgery and chronic obstructive pulmonary disease to the list of conditions used to determine the reduction, effective in FY 2015. CMS has increased the number and types of planned readmissions that no longer count against a hospital's readmission rate.

Admission and Medical Review Criteria for Inpatient Services

The final rule provides greater clarity regarding when inpatient hospital admissions are generally appropriate for Medicare Part A payment. The new rules are intended to address concerns about Medicare beneficiaries having long stays in the hospital as outpatients and improve program integrity.

Under the rule, if a physician expects a beneficiary's surgical procedure, diagnostic test or other treatment to require a stay in the hospital lasting at least two midnights, and admits the beneficiary to the hospital based on that expectation, it is presumed to be appropriate that the hospital receive Medicare Part A payment. The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status, but permits the physician to consider all time a patient has already spent in the hospital as an outpatient receiving observation services, or in the emergency department, operating room, or other treatment area in guiding their two-midnight expectation.

The rule also finalizes the provision in a March 2013 proposed rule that set the timeframe in which to bill Medicare Part B for hospital inpatient services inappropriately billed under Part A at one year from the date of service. This portion of the rule makes clear that its terms apply to admissions with dates of service on or after October 1, 2013.

Medicare Disproportionate Share Hospitals (DSH)

The Affordable Care Act directs CMS to revise the methodology used to recalculate the additional amount Medicare pays hospitals that serve a disproportionate share of low-income patients. Under the new rules, part of those payments will be distributed to hospitals based on an estimate of how much uncompensated care they provide relative to other hospitals. The final rule determines the total amount of money available as uncompensated care payments based on a federal fiscal year determination of the uninsured.

Other changes

The August rule also finalizes a number of payment policies as proposed, among them rebasing the hospital market basket and the method to recover documentation and coding. The final rule also will allow the LTCH 25-percent patient threshold payment adjustment policy moratorium to expire.

The rule's changes to Medicare quality incentive programs will reduce providers' reporting burden in both the Electronic Health Record (EHR) Incentive Program and the Hospital Inpatient Quality Reporting (IQR) Program. It finalizes new measures for the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing program, and quality reporting programs for LTCHs, PPS-Exempt Cancer Hospitals, and Inpatient Psychiatric Facilities.

For more information on these and other payment and quality of care provisions in the FY 2014 IPPS/LTCH rule:

[Final IPPS/LTCH PPS Rule](#)
[Payment and Quality Fact Sheet](#)

This rule is scheduled to be published in the Federal Register on August 19, 2013.

CMS Finalizes Fiscal Year 2014 Payment and Policy Changes for Medicare Skilled Nursing Facilities

On July 31, 2013, CMS issued a final rule (CMS-1446-F) outlining fiscal year (FY) 2014 Medicare payment rates for skilled nursing facilities (SNFs). The major provisions of the final rule are summarized below.

Changes to payment rates under the SNF Prospective Payment System (PPS) for FY 2014

Based on the changes contained within this final rule, CMS estimates that aggregate payments to SNFs will increase by \$470 million, or 1.3 percent, for FY 2014 relative to payments in FY 2013. This estimated increase is attributable to the 2.3 percent market basket increase, reduced by the 0.5 percentage point forecast error correction (explained below) and further reduced by the 0.5 percentage point multifactor productivity adjustment required by law.

The FY 2014 SNF PPS payment rates and policies will be effective on October 1, 2013.

Revise and rebase the market basket

The Medicare statute requires CMS to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. CMS has developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. The SNF market basket index is a factor used to update the SNF PPS payments on an annual basis. CMS is rebasing and revising the SNF

market basket for FY 2014 and subsequent years to reflect more recent data. The current SNF market basket reflects data from FY 2004 and CMS is updating the SNF market basket using data from FY 2010. In addition, CMS will make changes to the components of the SNF market basket index by adding five new cost categories and dividing the existing Nonmedical Professional Fees cost category into two separate categories, labor-related and non labor-related Nonmedical Professional Fees (for a total of 29 cost categories), and revising several price proxies, including the price proxy for the Wages and Salaries and Employee Benefit cost component.

Reporting of distinct therapy days

To ensure accuracy in case-mix assignment and payment, CMS is adding an item to the Minimum Data Set (MDS) to record the number of distinct calendar days of therapy provided by all the rehabilitation disciplines to a beneficiary over the seven-day look-back period. CMS is clarifying that the qualifying condition for the Medium Rehab (RM) Category requires five distinct calendar days of therapy. Similarly, CMS is clarifying that the qualifying condition for the Low Rehab (RL) Category requires three distinct calendar days. Currently, the number of days for each therapy discipline reported on the MDS is summed without regard to the number of separate and unique days per week during which the patient receives therapy services across all rehabilitation disciplines. This results in some residents qualifying inappropriately for an RM or RL Resource Utilization Group (RUG). The addition to the MDS ensures SNFs are paid accurately for the therapy services they provide to their residents.

Forecast error correction

A forecast error correction is applied when the difference between the actual and projected market basket percentage change for a given year (the most recent available FY for which there is final data) exceeds the 0.5 percentage point threshold. While CMS normally reports the forecast error to one significant digit, such reporting makes it difficult to determine if the threshold has been exceeded in those instances where the difference between the projected and actual market basket percentage change rounds to 0.5 percentage point. Therefore, only in those instances where the difference between the projected and actual market basket percentage change rounds to 0.5 percentage point at one significant digit, CMS will report the difference to the second significant digit to determine if the threshold has been exceeded. The most recent available FY for which there is final data is FY 2012. For FY 2012, the projected market basket percentage change exceeded the actual market basket percentage change by 0.51 percentage point. As the projected market basket percentage change exceeded the actual market basket percentage change by an amount greater than the 0.5 percentage point threshold, the FY 2014 market basket update will include a downward adjustment of 0.5 percentage point.

A link to the final rule, which will be published in the *Federal Register* on August 6, 2013, is available at:

<https://www.federalregister.gov/public-inspection>.

For further information, please visit the [SNF PPS webpage](#).

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