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CMS Publishes FY 2015 Final IPPS Rule [Ober|Kaler]

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On August 4, 2014, CMS posted its final changes and updates to the Medicare Inpatient Prospective Payment System (IPPS) that apply for fiscal year (FY) 2015, effective October 1, 2014. Below are some of the highlights of the final rule, which is scheduled to be published in the Federal Register on August 22, 2014.

Acute Care Hospitals

- ***Changes to Payment Rates under IPPS.*** The final rule increases IPPS operating payment rates by 1.4%. This change reflects, among other adjustments, a 0.8% reduction to recoup documentation and coding overpayments related to the transition to the MS-DRGS.
- ***Updated Labor Market Areas.*** CMS will use the Office of Management and Budget's (OMB's) most recent labor market area delineations based on 2010 Census data. For hospitals that would have experienced a decrease in their wage indices exclusively due to the use of the new OMB delineations, CMS adopted a one-year transition period during FY 2015 that will be based on a 50/50 blend of the former wage index and the new wage index. The new wage index will take full effect in FY 2016. Further, for hospitals located in an urban county that became rural under the new OMB delineations, CMS provided a three-year transition.

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

- ***Rural Teaching Hospitals.*** The final rule allows a hospital redesignated as urban as a result of the implementation of the new OMB delineations to receive a permanent cap adjustment for a new program if it received a letter of accreditation for the new program, and/or started training residents in the new program, prior to being redesignated as urban. This is effective for cost reporting periods beginning on or after October 1, 2014.
- ***Participation of Redesignated Hospital in Rural Training Track.*** CMS finalized its proposed changes to the participation of redesignated hospitals in rural training track programs, giving rural hospitals redesignated as urban two years in which to seek reclassification as rural.
- ***Change in the Effective Date of the FTE Cap, Rolling Average, and IRB Ratio Cap for New Programs.*** The final rule makes these caps effective beginning with the applicable hospital's cost reporting period that coincides with or follows the start of the 6th program year after the first new program started.

Other Finalized Changes

- ***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 final rule gives 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 finalized its proposal to allow physicians to complete certifications (except admission orders) no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted.
- ***Provider Reimbursement Appeals Regulations and Cost Reporting Requirements.*** CMS finalized its proposal to amend the Provider Reimbursement Review Board (PRRB) appeals regulations to eliminate the provider dissatisfaction requirement that is currently a condition for PRRB jurisdiction in cases in which the Medicare contractor failed to issue an NPR within 12 months. CMS, however, did not adopt its other proposed changes to the cost report and PRRB jurisdiction rules.
- ***Medicare Disproportionate Share Hospitals (DSH).*** CMS will distribute $7.64 billion in uncompensated care payments, a decrease from the $8.56 billion estimate in the proposed rule. CMS adopted 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. *CMS is providing hospitals 30 days from the date the final rule is displayed to submit corrections to its list of mergers.*

Long-Term Care Hospitals (LTCHs)

- ***Final Changes to Payment Rates under LTCH PPS.*** CMS finalized a 1.1% increase in LTCH PPS payment.
- ***Delay in Full Application of the 25% Patient Threshold.*** The final rule implements the Pathway for SGR Reform Act of 2013 provision that imposes a four year moratorium on the full application of the 25% patient threshold rule for most LTCHs.
- ***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 final rule also implements the Pathway for SGR Reform Act of 2013 provision, as amended by the Protecting Access to Medicare Act of 2014, that imposed moratoria on new LTCHs and LTCH satellites, and on an increase in beds in those hospitals or satellites, until September 30, 2017. CMS will continue to apply exceptions to moratoria on new LTCHs and satellite units (but not on bed increases) analogous to 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 eliminated the “5 percent readmissions” policy. CMS did not adopt its proposed revisions to the interrupted stay policy.
- ***LTCH Area Wage Adjustment Updates.*** CMS updated the LTCH PPS wage index and labor-related share. CMS will revise LTCH PPS labor market areas based on the new OMB delineations. CMS will use a budget neutral transition methodology consistent with the approach finalized in the IPPS.