



# The NOTEBOOK

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## CMS Proposes Medicare IPPS Rules for FFY 2014

On April 26, CMS released its federal fiscal year (FFY) 2014 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). Among other regular updates and policy changes, the expansive rule includes proposals that would:

- Allow a 0.8% net rate change for FFY 2014;
- Provide new guidance on determining inpatient and outpatient status; and
- Update and put in place new policies for the ACA-mandated Value-Based Purchasing (VBP) Program, Readmissions Reduction Program, and Hospital-Acquired Condition (HAC) Reduction Program.

Under the proposal, the Federal Operating Rate increases 0.5% for FFY 2014, to \$5,376, while the Federal Capital Rate goes from \$425.49 in FFY 2013 to \$432.04, a 1.5% jump. Details for the inpatient operating, hospital-specific, and federal capital rates for FFY 2014 are:

	Federal Operating and Hospital-Specific Rates	Federal Capital Rate
Marketbasket (MB) Update/Capital Input Price Index	<b>+2.5%</b>	<b>+0.9%</b>
ACA-Mandated Productivity MB Reduction	<b>-0.4%</b>	—
ACA-Mandated Pre-Determined MB Reduction	<b>-0.3%</b>	—
American Taxpayer Relief Act (ATRA)-Mandated <u>Retrospective</u> Coding Adjustment Reduction	<b>-0.8%</b>	—
Inpatient Admission Guidance Offset	<b>-0.2%</b>	<b>-0.2%</b>
<b><i>Net Rate Change (EXCLUDING BUDGET NEUTRALITY)</i></b>	<b>+0.8%</b>	<b>+0.7%</b>

Other major highlights of the proposed rule involve:

**A Retrospective Coding Adjustment of -0.8% for FFY 2014** to offset a portion of the cost associated with the latest temporary Medicare physician payment fix. The 2% sequestration applied to Medicare claims will continue in effect for FFY 2014 unless Congress intervenes.

**Wage Index and Labor-Related Share for FFY 2014** are minimally affected. There are no major changes to the calculation of Medicare hospital wage indexes, the rural floor budget neutrality policy, the imputed rural floor methodology, or the current administrative reclassification rules. But, the proposal would update the labor-related share value for hospitals with a wage index of greater than 1.0 to 69.6% for FFY 2014, a slight increase over the current labor share of 68%. By law, the labor-related share for hospitals with a wage index of less than 1.0 will remain at 62%.

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**A VBP Adjustment for FFY 2014** is proposed to account for historic quality performance under the VBP Program. The FFY 2014 program will evaluate quality of care data for (1) process of care; (2) patient experience of care; and (3) patient outcomes. By law, the VBP Program must be budget neutral and the FFY 2014 program will be funded through a 1.25% reduction in IPPS payments (estimated at \$1.1 billion) for hospitals that meet the program eligibility criteria.

**A Readmissions Adjustment for FFY 2014** would alter the calculation to establish excess hospital readmission rates related to heart attack, heart failure, and pneumonia patients. Unlike the VBP Program, the Readmissions Reduction Program is not budget neutral. Hospitals can either maintain full payment levels or be subject to a hospital-specific payment penalty of up to 2.0% (up from 1.0% in the current year). This capped reduction amount will increase to 3.0% next year.

**Guidance on Determining Inpatient and Outpatient Status** is included to specify in regulation that a patient qualifies for payment as an inpatient pursuant only to an order for inpatient admission by a physician or other qualified practitioner. The proposal also addresses when hospital inpatient admissions are determined reasonable and necessary for payment. For review purposes, the presumption would be that hospital services spanning less than two midnights should have been provided on an outpatient basis, unless there is clear documentation in the medical record supporting the physician's order. CMS estimates that the proposal would increase inpatient payments by about \$220 million, thus is proposing to use its "exceptions and adjustment authority" to apply a -0.2% reduction to the federal operating and hospital-specific rates.

A copy of the full proposed rule and related resources are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Proposed-Rule-Home-Page.html>. Comments on all aspects of the proposed rule are due to CMS by Tuesday, June 25 and may be submitted electronically at <http://www.regulations.gov>.



## **ADH Seeks Hospital Discharge Submittal Revisions**

The Arkansas Department of Health is revising its Hospital Discharge Data System Inpatient & Emergency Department Data Submittal Guides. A Public Hearing on the proposed revisions is set for May 30, 2013 from 9:30-10:30 a.m. at the Arkansas Department of Health, 4815 W. Markham Street, Little Rock, Room 2508. Plans are to have the finalized data submittal guides out by the end of October 2013 if not sooner, but the first submission under these guidelines will not be until the 4<sup>th</sup> quarter of 2014.

The major revisions to the Inpatient Submittal Guide include:

- Wording and formatting changes to allow for ICD-10 coding when it goes into effect;
- Source of Payment coding changed to the Public Health Data Standards Consortium typology;
- Data record formats changed to provide additional field length for the patient name and address;
- Data record formats changed to provide additional field length (9 to10) for Health Plan ID to accommodate CMS requirements; and
- Data record formats changed to provide additional fields for diagnosis codes, procedure codes and external cause of injury codes.

The major revisions to the Emergency Department Submittal Guide include:

- Wording and formatting changes to allow for ICD-10 coding when it goes into effect;
- Source of Payment coding changed to the Public Health Data Standards Consortium typology;
- Data record formats changed to provide additional field length for the patient name and address; and

- Data record formats changed to provide additional field length (9 to 10) for Health Plan ID to accommodate CMS requirements.

A copy of the proposed revisions can be found at [www.healthy.arkansas.gov](http://www.healthy.arkansas.gov) under Proposed Rules and Regulations.



## **AHA Offers Medicare 101 Session May 15**

Understanding the basics of how Medicare works can be essential for many types of hospital employees. Too often, it's easy to assume that all hospital executives and managers know even as much as the formula for calculating hospital Medicare payments, but that is not the case. To assist in helping them learn more, the Arkansas Hospital Association is sponsoring a Wednesday, May 15 workshop, "Medicare 101: A Comprehensive Review of Medicare Provider Reimbursement Systems and Methodologies." The program will be held at the Crowne Plaza in Little Rock.

Florida Hospital Association vice president of financial services Kathy Reep will facilitate the workshop. She will provide an understanding of the fundamentals of various Medicare facility reimbursement methodologies, including those based on cost, prospective payment systems and fee schedules. In addition, each attendee will receive a 150-page reference manual *Medicare 101: An Overview of Medicare Payment Systems*, a valuable tool on provider payment rules and reimbursement formulae in every facility-based Medicare program area.

Suggested participants are CEOs; COOs; CNOs; hospital staff involved in finance, compliance, patient relations, public relations and communications, government relations, and health information management; as well as Joint Commission coordinators; and state agency directors and surveyors. A copy of the program agenda and registration form is located at <http://www.arkhospitals.org/events>.



## **Arkansas Infant and Child Death Review Program Activated**

Act 1818 of 2005 requires a death review to be performed in all cases of unexpected deaths of infants/children under 18 years of age. An unexpected death is defined as "a death involving a child who has not been in the care of a licensed physician for treatment of an illness that is the cause of death; a clinical diagnosis of death due to Sudden Infant Death Syndrome; or a death due to an unknown cause." The review is required to help reduce the incidence of injury and death to infants and children.

The Arkansas Infant and Child Death Review program is administered by Arkansas Children's Hospital and the University of Arkansas for Medical Sciences with support that originates at the Arkansas Department of Health. The program's purpose is to improve the response to infant and child fatalities, provide accurate information on how and why Arkansas children are dying, and ultimately reduce the number of preventable infant and child deaths by establishing an effective review and standardized data collection system for all unexpected infant and child deaths.

Dr. Pamela Tabor, DNP-Forensics, is the program director. She notified the Arkansas Hospital Association last week that her program has begun notifying Arkansas hospital health information management directors of their purpose and that they will request medical records of a child who dies from an unexpected death. She noted that multi-disciplinary teams from local communities will collect, review, analyze and understand child, family and community factors that led to a child's death.

Dr. Tabor noted that the program is not punitive or fault-finding, but meant to offer preventive and intervention efforts. The goals of the program are to:

- Assure an accurate inventory of infant/child deaths by age, location, cause, manner and circumstances.
- Support timely, accurate, and thorough infant and child death investigation through training and use of Sudden Unexplained Infant Death Investigation practice and protocols.
- Improve communication and networking between local and state agencies involved in infant/child deaths.
- Enable multi-disciplinary and multi-agency collaboration, cooperation, and communication at federal, state and local levels regarding infant/child deaths.
- Improve the recognition of unexplained infant and child deaths through analysis of patterns and trends.
- Enhance the public awareness of infant and child death through examination of issues that affect health, safety, and prevention.
- Identify system-based barriers to infant/child health and safety, that, when removed, will ultimately reduce the number of unexpected infant/child deaths.
- Utilize the findings of infant and child death review teams to recommend policy, organizational, and community prevention initiatives.
- Utilize retrievable statistics related to birth and death data to identify trends and support prevention and research efforts.

For additional information, please contact Dr. Tabor at (501) 364-3389 or [pdtabor@uams.edu](mailto:pdtabor@uams.edu), or the program coordinator, Martin Maize, at [momaize@uams.edu](mailto:momaize@uams.edu).



## **Groups Join to Support Strong Start Campaign**

The American Hospital Association (AHA) and six other organizations that support the delivery of maternity care on May 1 issued a joint statement of support for the Strong Start Initiative, a national public-private partnership to eliminate non-medically indicated elective deliveries before 39 weeks gestation. The statement encourages all hospitals to have a documented plan or policy to reduce or eliminate early elective deliveries (EED). It also suggests posting the policy to the hospital's website and voluntarily reporting early elective delivery data to a Hospital Engagement Network (HEN).

In addition to AHA, signers include the American Academy of Family Physicians; American Academy of Pediatrics; American College of Nurse Midwives; American College of Obstetricians and Gynecologists; Association of Women's Health, Obstetric and Neonatal Nurses; and March of Dimes.

The AHA board of trustees last year adopted a formal position supporting policies to eliminate early-term, non-medically necessary deliveries, which research has shown can increase health complications for babies. AHA and its Health Research & Educational Trust affiliate are working with the Strong Start initiative to reduce early elective deliveries at hospitals through the Centers for Medicare & Medicaid Services' Partnership for Patients campaign.

AHA HEN hospitals may always report their EED data and continue to share their hard stop policies by sending them to Pamela Brown, Arkansas Hospital Association vice president for quality and patient safety, [pbrown@arkhospitals.org](mailto:pbrown@arkhospitals.org). You may also call Pam if you have questions about setting up an EED hard stop policy. See <http://www.aha.org/about/membership/constituency/mch/index.shtml> to read the statement.

## Newsnotes About Arkansas Folks

**Marcella (Marcy) L. Doderer**, FACHE, vice president and administrator of Children's Hospital (ACH) of San Antonio, has been named president and CEO of Arkansas Children's Hospital in Little Rock, effective July 15. Doderer will succeed **Dr. Jonathan Bates** who retires June 30 after 20 years as president and CEO of ACH, the state's only pediatric medical center. Doderer, a native of Little Rock, has 20 years of healthcare management experience in a variety of hospital settings in San Antonio, Dallas and Paris, Texas.

**Greg Stubblefield** has been named vice president of clinical services for Baptist Health in Little Rock. His new position includes system responsibilities for radiology, laboratory and continuous improvement objectives for Baptist Health's emergency departments. Stubblefield joined Baptist Health in 2002 as an administrative resident. Following his residency, he served as assistant vice president and night administrator. He was promoted to vice president and administrator of Baptist Health Medical Center – Arkadelphia in 2007.

**John Bowen** has been named assistant vice president and administrator of Baptist Health Medical Center – Arkadelphia. Before joining Baptist Health as assistant vice president and night administrator, Bowen served as system strategic planning manager for Christus Spohn Health System in Corpus Christi, Texas.

**John Tucker**, FACHE, administrator and CEO of Atmore (AL) Community Hospital, has been named CEO of Dallas County Medical Center in Fordyce, effective June 3. Tucker was previously CEO of the Fordyce facility from 2006-2008, when he accepted a similar position at Five Rivers Medical Center in Pocahontas. In 2008, he was named the AHA's C. E. Melville Young Administrator of the Year.

**William R. Bowes** has been named CFO of the University of Arkansas for Medical Sciences, succeeding Melody Goodhand who left the position in 2012 for a similar position in Tennessee. Of Bowes' 32 years in higher-education finance, he most recently was CFO for the Connecticut Colleges and State Universities Board of Regents for Higher Education. Prior to that position, he spent 16 years in various leadership roles at the University System of Georgia.

**Richard Boone**, CFO of Sparks Health System in Fort Smith, has been promoted to oversee the operations/finance division of Health Management Associates Inc. Southern and Western groups, parent company of Sparks. He will oversee 26 hospitals in seven states that are part of the Florida-based company, including Sparks and Summit Medical Center in Van Buren. A search is ongoing for his replacement.



## The AHA Calendar

### May 2013

- 7        Leading Through Influence: Success Strategies that Get Results! *Governance Administrative Professionals Webinar Series* – Webinar TX0513
- 7        The Chargemaster and New Cardiovascular Coding and Payment – Webinar T2836
- 7        The Arkansas Quitline Experience: Free Webinar for Medical, Dental and Behavioral Health Professionals
- 8-10   AAHE Annual Meeting, Holiday Inn Airport Conference Center, Little Rock
- 8-10   SAHPMM 2013 Annual Meeting, Crowne Plaza, Little Rock
- 9        Evidence-Based Practice in Nursing – Making it Contagious – Webinar T2838

*Information on all AHA educational programs and activities is available at [www.arkhospitals.org/events](http://www.arkhospitals.org/events).*

## Final Thoughts by Paul Cunningham

Sometimes, no matter how good you are, it's just not good enough. Sometimes, it's necessary to take the extra step to get others to not only hear the noise of what's being said, but also to take notice and actually listen. Country music super-group Alabama said as much in the lyrics of their hit *If You're Gonna Play in Texas*.

The song, a sort of tip-of-the-hat to the legendary Bob Wills and the Texas Playboys who more or less created the type of music called Texas Swing, starts, "If you're gonna play in Texas, you gotta have a fiddle in the band." Regardless of how good the sound and the lead guitar riffs might be, they don't do justice to tunes that garner a particular affection from Texas audiences like *Louisiana Man*, *Cotton-Eyed Joe!*, and *Faded Love*. Forget the fiddle and nobody listens.

There's a lesson in Alabama's tune that hospitals in Arkansas and every other state should take to heart as we approach the next phase of budget talks that will take place in Congress over the coming summer months and into the fall. If the past few years are any sort of indicator, then it seems like Congress and CMS have no limit on expectations for hospitals to do it all when it comes to making sacrifices for Medicare. Other payer groups aren't far behind.

Much to nobody's surprise, hospitals are doing it all, so far. They're operating more efficiently, improving quality, engaging in the newest forms of value based purchasing programs, adapting to innovative payment methodologies and dealing with all sorts of external audits and other outrageous and outdated rules that govern their every move. At the same time, they continue to serve their communities around the clock, in good times and bad. What's more, they are doing it quite well and with a minimum of complaining. But, are they being too quiet, in essence forgetting the fiddle that could draw attention to their good works and their limitations?

The late Darrell Royal, the former University of Texas football coach had a favorite expression, "Dance with who brung ya." In sports lingo, that little quip means to go with the players and plays that result in wins. Sounds to me like the powers-that-be over Medicare have the same philosophy about penciling in hospitals on their dance cards to be the go-to guys for absorbing billions upon billions of dollars in payment reductions time and again.

America's hospitals have had about as much fun at Medicare's annual ball as they can stand, to a point where they likely empathize more each year with actress/dancer Ginger Rogers, who "did everything Fred Astaire did, but backwards and in high heels." You might even add "until their feet are bleeding." It is time for Medicare to be paired with other partners to find sizeable savings.

That's the message attendees at the American Hospital Association's Annual Meeting heard last week in Washington, DC and the one they should be communicating loud and clear to members of Congress throughout the budget/deficit reduction talks.

Originally written-in for \$155 billion in future Medicare/Medicaid spending cuts over a 10-year period under the Affordable Care Act, total hospital reductions now approach \$250 billion. More than \$14 billion came in January as part of the American Taxpayer Relief Act. To make matters worse, the potential for more health insurance coverage under the law, which started three years ago in the vicinity of 50 million people, currently hovers around 30 million. Arkansas hospitals will bear about \$2.4 billion of the future reductions, a heavy lift for a small, rural state. That's one reason why getting legislative approval last month for the state's private option plan to expand coverage to 250,000 low income Arkansans was so incredibly crucial.

Unfortunately, there could be more to come. Every proposal for the 2014 federal budget now lining up at the start gate includes billions of dollars more in hospital spending reductions. That's true, too, of the recently revised Bowles-Simpson debt reduction plan. As another country music icon, George Jones, the Possum, who died a week ago, once sang, "The Race Is On."

Because it really is necessary on occasion to take the extra step to get others not only to hear what's being said, but also to take notice and actually listen, hospitals need to be relentless with this primal message to Congress over the summer: Reject more arbitrary cuts to Medicare and Medicaid and spend time finding better alternatives for deficit reduction. The implications for hospitals if the annual ritual of cuts continues can be best summed up in another homespun remark from Coach Royal, "All the white meat is gone. There's nothin' but necks on the platter."

