Introduction
The way today’s healthcare regulatory environment is impacting the world of Inpatient Reimbursement, one may feel as though their financial ground is shifting like sand. If a major portion of your inpatient revenue comes from Medicare reimbursement under the CMS Acute Care Inpatient Prospective Payment System (IPPS), this whitepaper will illustrate some key adjustments you are facing, with concrete examples based on real data. It is important to note that we have modified the names of providers in our examples to protect their integrity.

Changes to hospital reimbursement are driven by two major factors: Coding changes and Payment Logic changes. These changes are being pushed by multiple regulatory and legislative initiatives, including a deeper focus by CMS on quality and cost savings as well as the transition to ICD-10.

While accurate and complete ICD-10 coding will be paramount to financial success come October 1, 2015; under new legislation and regulation such as the Affordable Care Act (ACA) and associated updates, hospitals are now expected to engage in a number of activities designed to measure and compensate hospitals for performance. Specifically:

- Value Based Purchasing
- Quality Reporting
- Low Volume Adjustment
- Hospital Acquired Conditions
- Readmission Payments

We will discuss a few of these adjustments in the coming pages.
Background: Inpatient Coding & Grouping
Hospitals generally receive Medicare reimbursement on a per discharge or case basis for inpatient stays. Discharges are ultimately assigned to a Medicare Severity Diagnostic Related Group (MS-DRG) which translates similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay to a standard payment group. The principal diagnosis and up to 24 secondary diagnoses, including “comorbidities or complications” will determine the MS-DRG assignment for Medical stays. It is worth noting that as we shift from ICD-9 to ICD-10 diagnosis codes, greater specificity may lead to shifts in what is regarded as complications and comorbidities, so grouping under ICD-10 is expected to shift for many cases, and especially if there is a lack of specificity in the documentation.

For surgical stays, up to 25 procedures furnished during the stay may determine the MS-DRG assignment. Additionally, other factors may influence the MS-DRG assignment such as gender, age, or discharge disposition. As with diagnosis coding, shifts in MS-DRG grouping are expected under ICD-10 procedure coding.

In order to understand MS-DRG grouping logic, coders utilize a MS-DRG Grouper and the Medicare Code Editor, which assigns the MS-DRG based on factors described above. CMS also publishes an MS-DRG Definitions Manual which makes some of the software grouping logic more transparent.

Inpatient Prospective Payment
Inpatient Prospective Payment is based on this assigned MS-DRG which is weighted to affect payment. Each year in the Acute Inpatient Prospective Payment System Final Rule, CMS publishes Table 5, which lists the inpatient relative weight for each MS-DRG. Each acute care inpatient hospital in the United States receives a provider-specific payment based on that MS-DRG weight, national standard amounts, and adjustments for the specific provider. This complex formula takes many variables into consideration, adjusting the provider’s payment up or down.

In general, Medicare’s payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The two base rates are updated annually and are adjusted to reflect patient conditions, market conditions, and other factors recognized under Medicare’s payment system.

Because ICD-10 is an organization-wide issue, the work an organization needs to do to prepare and sustain itself once ICD-10 is implemented can be daunting. All organizations will need to change the way they currently do business under ICD-9 to be successful under ICD-10.
IPPS Provider-Specific Payment Logic¹

While IPPS logic is complex, below you will find an overview of the Acute IPPS from MedPAC; please note the footer in the graph noting exceptions.

Note: MS–DRG (Medicare severity diagnosis related group), LOS (length of stay), IPPS (inpatient prospective payment system). Capital payments are determined by a similar system.

* Transfer policy for cases discharged to post-acute care settings applies for cases in 275 selected MS–DRGs.

** Additional payment made for certain rural hospitals.

The additional aforementioned adjustments have increased the complexity of the core calculation and are better defined below:

### Operating MS-DRG Payment + Capital MS-DRG Payment + Pass Thru Payment + Low Volume Add-on Payment$^2$
- **Operating MS-DRG Payment**: Most of the payment is accounted for by the operating portion, which is quite complex impacted by many factors.
  
  Operating MS-DRG Payment = MAX((OSLS x OWI + OSNLS x OCOLA) x (1 + OIME + ODSH) x MS-DRGWT + UNCOMP_CARE_AMT, OHSP x MS-DRGWT)

- **Capital MS-DRG Payment**: The capital portion is usually the next largest portion. Each year, the hospital submits a cost report which is used to determine the cost-based capital portion of the total payment. Capital payments cover costs such as, depreciation, interest, rent, and property-related insurance and taxes.
  
  Capital MS-DRG Payment = CSFR x MS-DRGWT x GAF x CCOLA x (1 + CIME + CDSH)

- **Pass Thru Payment**: Some hospitals qualify for a per diem pass through adjustment for a qualified inpatient stay, which is a fairly simple formula:
  
  Pass Thru Payment = Pass_thru_amt x Length of Stay

- **Low Volume Add-on Payment**: CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. Qualified hospitals are assigned a low volume adjustment factor, which is factored into the Medicare Expected Payment with the following formula for Years 2011 to 2015:
  
  Low_Volume Add-on Payment = (Operating MS-DRG Payment - (OSLS x OWI + OSNLS x OCOLA) x (Readm_AF + VBP_AF - 2) x MS-DRGWT + Capital MS-DRG Payment) x Low_VLM

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$^2$ 42 CFR parts § 412.110-412.120
Select Payment Adjustments Under IPPS

Value Based Purchasing
Per MedPAC publication October 2014, the value-based incentive purchasing program was implemented in fiscal year 2013. In this incentive program for 2015, CMS will redistribute a pool of dollars, equal to 1.5 percent, to hospitals based on their overall performance on a set of quality measures. The size of the value-based purchasing redistribution pool will increase by 0.25 percentage points each year, reaching a maximum of 2 percent of DRG payments for fiscal year 2017.

The Fiscal Year 2015 Hospital Value-Based Purchasing (VBP) Program adjusts hospitals’ payments based on their performance on four domains that reflect hospital quality, each weighted as shown:
• Clinical Process of Care (20%),
• Patient Experience of Care (30%),
• Outcome (30%) and;
• Efficiency (20%).

The public is invited to review VBP data on the Hospital Compare website; for FY 2015, the Total Performance Scores range from 6.6 to 92.9, which can cause a very large variance in reimbursement. The Performance Score is translated to a variable called the “Value Based Purchasing Adjustment Factor”, and is applied to the base MS-DRG operating payment, so overall payment impact depends on the hospital’s case mix.

For example, consider reimbursement for MS-DRG 292. Notice there are a few ‘winner’ and ‘loser’ providers when applying this variable compared to the National Unadjusted Medicare Expected Payment. Below, you will find that the adjustment isn’t generally making a significant change to the reimbursement, but can cause a negative payment shift.
As an alternative look consider the impact on a low weight and a high weight MS-DRG as noted below at a Community Medical Center; since the adjustment is based on the relative weight of the MS-DRG, the impact varies by stay.³

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3. Citations for this section:
- 3001(a)(1) of the Affordable Care Act
- 42 CFR parts §412.160-§412.167
- Section IV.I. of the 2015 IPPS final rule.
- Tables 16A and 16B of the Final Rule (and correction notice) provides the proxy and actual adjustment factors
Quality Reporting & Meaningful Use

Hospitals are now required to report information about quality of patient care for a designated set of measures and submit evidence that they are engaged in “meaningful use” of electronic health record systems. Payment is adjusted on every MS-DRG payment across the board for every hospital in the country.

You can see this reflected in the Operating payment, where the Operating Standard Labor Share and Operating Standard Non-Labor share used in the calculation is higher or lower depending on compliance with the program.

Operating MS-DRG Payment = \[ \text{MAX}((\text{OSLS} \times \text{OWI} + \text{OSNLS} \times \text{OCOLA}) \times (1 + \text{OIME} + \text{ODSH}) \times \text{MS-DRGWT} + \text{UNCOMP\_CARE\_AMT}, \text{OHSP} \times \text{MS-DRGWT}) \]

<table>
<thead>
<tr>
<th>Did Hospital Submit Quality Data?</th>
<th>Is Hospital Meaningful E.H.R. User?</th>
<th>Payment Adjustment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
<td>2.200%</td>
</tr>
<tr>
<td>NO</td>
<td>YES</td>
<td>1.475%</td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
<td>1.475%</td>
</tr>
<tr>
<td>NO</td>
<td>NO</td>
<td>.750%</td>
</tr>
</tbody>
</table>

The example below based on CMS IPPS pricer data, shows the National Unadjusted Payment Medicare Expected Payment for a common MS-DRG.

The hospital reporting program provides CMS with data to help consumers make more informed decisions about their healthcare, giving hospitals a financial incentive to report the quality of their services. Additional information regarding quality measures can be found at: www.hospitalcompare.hhs.gov.

Example quality measures include but not limited to:
- Acute Myocardial Infarction
- Heart Failure
- Pneumonia
- Surgical Care Improvement Project
- Children’s Asthma Care
- Venous Thromboembolism
- Stroke and
- Emergency Department

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4. Citations for this section:
- 42 CFR part §412
- Addendum II.A. of the 2015 IPPS final rule.
- Tables 1A and 1B of the Final Rule (and correction notice) provide the standardized amounts
When applying different adjustment variables in the calculation, reimbursement is impacted by a few hundred dollars. If extrapolated for the entire year, it can become a significant impact for an organization.
Low Volume Adjustment

CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. To qualify, the hospital must be more than 15 miles from the nearest subsection (d) hospital and have fewer than 1600 Medicare discharges. The Low Volume Adjustment is an added payment that is provided beyond the operating and capital and pass-through payments, and it is calculated as follows for years 2011 to 2015:

\[
\text{Low Volume Add-on Payment} = (\text{Operating MS-DRG Payment} - (\text{OSLS x OWI} + \text{OSNLS x OCOLA}) \times (\text{Readm_AF + VBP_AF - 2}) \times \text{MS-DRGWT + Capital MS-DRG Payment}) \times \text{Low VLM}
\]

Below we examine reimbursement for MS-DRG 865, which has a national unadjusted payment rate in 2015 of $8,886.16. The table below shows the Medicare Expected Payment for a sampling of facilities for DRG 865 calculated for February 2015.

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Total MS-DRG payment</th>
<th>Low Volume Add-On Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nevada Rural Hospital</td>
<td>$15,158.48</td>
<td>$3,031.70</td>
</tr>
<tr>
<td>Texas County Hospital</td>
<td>$25,988.31</td>
<td>$5,197.66</td>
</tr>
</tbody>
</table>

Please take note that beginning April 1, 2015 of FY15, low volume adjustments will apply when total discharges (including Medicare) are 200 or less and at least 25 miles from the nearest hospital.

5. Citations for this section:
- Sections 3125 and 10314 of the Affordable Care Act
- 42 CFR part §412.101
- Section IV.I. of the 2015 IPPS final rule.
- CMS Inpatient Prospective Payment System Fact Sheet
- Table 14 of the Final Rule (and correction notice) lists hospitals that are potentially eligible for this adjustment
Outlier Payments

While outlier payments are not a newer IPPS payment adjustment factor, for purposes of this whitepaper, it is important to mention, specifically with the industry transitioning to ICD-10.

Hospitals that encounter extremely costly cases may be eligible for an additional outlier payment. Additional payments are provided when the estimated operating and capital costs for a case exceed a specified threshold. According to IPPS FR FY 2015, “For FY 2015, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments (including the new estimated uncompensated care payment) is greater than the prospective payment rate for the MS-DRG plus the fixed-loss amount of $24,758.” This is up considerably from previous years and will have an impact for some facilities.

Proper and complete documentation ensures that hospitals receive due compensation, but abuse of the outlier concept can place organizations at risk for audit and recovery.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Fixed-Loss Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$23,075</td>
</tr>
<tr>
<td>2012</td>
<td>$22,385</td>
</tr>
<tr>
<td>2013</td>
<td>$21,821</td>
</tr>
<tr>
<td>2014</td>
<td>$21,748</td>
</tr>
<tr>
<td>2015</td>
<td>$24,758</td>
</tr>
</tbody>
</table>

6. Citations for this section:
- Predates the Affordable Care Act
- 42 CFR parts § 412.80-412.86
- CMS Page: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html
To illustrate outlier logic, consider the following Medicare Expected Payment for an Alabama hospital in February 2015, for MS-DRG 249:

<table>
<thead>
<tr>
<th>Stay Information (LOS)</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Charges</td>
<td>$0.00</td>
<td>$10,000.00</td>
<td>$84,539.00</td>
</tr>
<tr>
<td>MS-DRG Information</td>
<td>PERC CARDIOVASC PROC W/ NON-DRUG ELUTING STENT W/O MCC (MS-DRG 249)</td>
<td>PERC CARDIOVASC PROC W/ NON-DRUG ELUTING STENT W/O MCC (MS-DRG 249)</td>
<td>PERC CARDIOVASC PROC W/ NON-DRUG ELUTING STENT W/O MCC (MS-DRG 249)</td>
</tr>
<tr>
<td>NDC Code and Description</td>
<td>Circulatory System(OS), Type: SURG</td>
<td>Circulatory System(OS), Type: SURG</td>
<td>Circulatory System(OS), Type: SURG</td>
</tr>
<tr>
<td>Relative Weight</td>
<td>1.8808</td>
<td>1.8808</td>
<td>1.8245</td>
</tr>
<tr>
<td>Medicare Expected Base Payment</td>
<td>$10,390.50</td>
<td>$10,390.50</td>
<td>$10,346.64</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Analyses</th>
<th>Eligible for Outlier Payment?</th>
<th>Outlier Payment Increase</th>
<th>Outlier Operating Room</th>
<th>Outlier Capital Portion</th>
<th>Medicare Expected Base Payment</th>
<th>Outlier Payment Increase</th>
<th>Total Medicare Expected Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>$2,881.81</td>
<td>$2,473.56</td>
<td>$456.26</td>
<td>$13,406.59</td>
<td>$7,264.19</td>
<td>$17,670.83</td>
</tr>
</tbody>
</table>

When applying three (3) different total charge amounts; the threshold is met on the AVERAGE case for this facility.
Our Solutions
Wolters Kluwer understands the challenges that small and large healthcare providers, payers and vendors face and has solutions to support your successful implementation of ICD-10.

With over forty years of health care regulatory coverage, we provide advanced primary source content and expert tools—updated in real time—to ensure the integrity of your program, revenue, and audit documentation. We provide your coding, billing, reimbursement, and HIM teams the tools they need to work effectively, whether it’s a simple coding tool with integrated medical necessity information, support for claims processing rules and edits, a provider-specific Medicare-compliant reimbursement resource, or critical audit analysis tools.

Confidently manage audit, risk, and drive compliance with our customized, scalable SaaS solutions created and supported by experts in healthcare audit, risk, compliance and reimbursement.

And finally, ensure accurate procedure documentation with our award-winning computer-assisted coding solution.

Risk Management
ICD-10 Impact Analysis
Of the many competing initiatives vying for providers’ time, money and attention, ICD-10 carries the largest risk to the financial health of a hospital. All reimbursement schemes for hospital inpatient procedures currently based on ICD-9 will be directly affected by the ICD-10 transition.

New Health Analytics and Wolters Kluwer have collaborated to develop the ICD-10 Payment Impact Analysis solution to help providers understand and gain insight on how ICD-10 payment will impact the organization’s bottom line. Leveraging existing state and commercial databases, the revenue impact is determined by MDC, MS-DRG and major service line to give organizations an online view of their claims data for a recent period of time translated into ICD-10 with Medicare expected payment data applied.

Information Systems & Data Sets
Data Sets
Healthcare organizations, providers, consultants, life science companies, payers and software vendors struggle to understand and keep up-to-date with complex Medicare expected payment information. Analyzing published CMS information, which can be confusing, incomplete and difficult to aggregate into consistent format, is a major burden that eats through staff time. And, once they have the data in hand, they still have to calculate provider-specific or location-specific rates.

Medicare Payment System Data Files, powered by New Health Analytics, are accurate, consistent and versioned provider-specific data sets packaged “to go”—for reporting, analysis and to populate your software and IT systems with the essential data for projecting financial outcomes and strategic planning. Available data files include: Inpatient PPS, Outpatient PPS, Ambulatory Surgical Center Fee Schedule, Physician Fee Schedule, Clinical Laboratory Diagnostic Fee Schedule, Durable Medical Equipment Fee Schedule, and Long Term Care Hospital PPS.
Health Language Enterprise Terminology Management Platform

The Health Language Enterprise Terminology Management Platform provides providers, payers and vendors with the software, content, and consulting solutions that map, translate, update, and manage standard and enhanced clinical terminologies on an enterprise scale—enabling the information liquidity required to support some of healthcare’s toughest challenges, such as meaningful use compliance, ICD-10 conversion, population health management, analytics, ACOs, and semantic interoperability among systems.

To ensure ICD-10 readiness, healthcare organizations are encouraged to leverage Health Language solutions and expertise to support the key aspects of transition planning: protecting the revenue cycle, ensuring a clinically complete translation, preparing for post ICD-10 updates, and optimizing clinical workflow.

Policy and Procedure Revisions

ComplyTrack Document & Policy Manager

Part of your Clinical Documentation Improvement and Education Program will include revising and introducing new policy documents for staff members. Use the ComplyTrack Document & Policy Manager to provide staff with an easy-to-access location for policies and version tracking with a streamlined revision and approval process. It can even be integrated with links to primary source regulations within any of our research products, such as the Coding Suite.

For your Medical Policy Documents, you can work concurrently in the ICD-10 Explorer and Document & Policy Manager to translate your policies from ICD-9 to ICD-10, and include links to automatically updated manuals, LCDs, and coding/payment tools within your subscription.

Coding Suite

With the ever-increasing pace of health care regulatory change that includes the ongoing adoption of ICD-10, it’s harder than ever for coding and reimbursement professionals to ensure proper code assignment up front. In order to minimize claim denials and secure your bottom line, you need quick, easy access to the comprehensive information and tools that are necessary for effective revenue cycle management.

Our Coding Suite, designed specifically for health care professionals, combines expert legal and regulatory information, web-enabled research, and the specialized content of the CCH Medicare & Medicaid Guide to offer the most robust coding, reimbursement, and compliance solution available today. Search on multiple terms simultaneously or utilize automatic alerts to inform you of new documents containing your targeted search terms. Name your stored searches after the related internal policy to prompt you to review new information and to point you to any necessary updates.
Coding

ProVation MD – Structured Reporting and Coding Software
ProVation MD is the only dedicated structured reporting and coding solution that provides clinically relevant, intuitive software that ensures hyper-accurate procedure documentation. Covering 11 medical specialties, including Cardiology, Gastroenterology and Orthopedics, ProVation MD allows physicians to efficiently capture robust detail from even the most complex procedures, and then automatically generates clear, complete procedure notes and appropriate reimbursement codes—quickly, easily and without dictation. By automatically applying the reimbursement codes and disseminating critical procedural information, ProVation MD ensures appropriate payment, reduces costs and streamlines quality reporting while improving clinical communication and care coordination.

Coding Plus
A companion to ProVation MD, Coding Plus provides coding, coverage, payment information and guidance for surgical coders, enabling them to confirm the accuracy of reimbursement, utilize primary source material to confirm accurate code selection, confirm medical necessity for both local and national coverage determinations, assess code edits prior to claim submission (national correct coding initiatives or NCCI), and keep up to date on ever-changing Medicare rules and guidelines.

ICD-10 Resource Center
Built for health care providers and payers who need intense focus on ICD-10, the ICD-10 Resource Center is a complete, easy-to-use solution for coding staff across the organization.

ICD-10-CM Electronic Codebook
Get to know the new ICD-10 diagnosis system with this comprehensive, up-to-date codebook that connects ICD-10 coding to Medicare rules, with:
- Comprehensive with guidelines and indexes;
- Easy to navigate tabular pages; and
- Additional Wolters Kluwer coding, coverage, reimbursement and compliance content and tools.

ICD-10-PCS Electronic Codebook
Master the new ICD-10 procedure coding system with this comprehensive, up-to-date codebook that connects to MS-DRG coding resources and Medicare rules, with:
- Easy to use tables that demystify procedure code assignment;
- Comprehensive guidelines, index, and reference manual; and
- Connection to companion MS-DRG/ICD-10 Coding Manual.

ICD-10 Explorer
Search for and compare ICD-9 and ICD-10 clinical terminology and related codes using GEMs in one simple tool!
- Interactive interface provides simple, user-friendly approach for training, translation and professional coding.
- Simultaneously search in both I-9 and I-10 for direct comparison.
- Instantly map any code using GEMs forward & backward mapping and CMS reimbursement mapping.
- Connect instantly to related documents, coding instructions and guidelines.

ICD-10 Regulatory Resources, Data and Archives
Find all the resources necessary within the solution, including coding, coverage, payment and regulatory compliance resources for ICD-10 such as:
- Download Center, CMS notifications and training materials;
- HHS regulatory requirements for ICD-10;
- Payer contractors related to ICD-10; and
- CMS Manuals and policies related to ICD-10.
Conclusion
While this whitepaper only covered a few of the IPPS adjustment factors as a result of the ACA, there are many others factors that impact inpatient reimbursement. Healthcare reimbursement challenges are only going to become inherently difficult as the industry approaches the onset of ICD-10. Specifically, providers should understand and prepare for the MS-DRG shifts in payment due to the coding changes, but most importantly, the need for complete and accurate documentation. Organizations not properly documenting will miss out on reimbursement of which they are entitled. Being cognizant of any potential financial risk will be vital to a facilities success under ICD-10.

About Wolters Kluwer
Wolters Kluwer is a market-leading global information services company. Professionals in the areas of legal, business, tax, accounting, finance, audit, risk, compliance, and healthcare rely on Wolters Kluwer’s leading, information-enabled tools and solutions to manage their business efficiently, deliver results to their clients, and succeed in an ever more dynamic world.