Hospital Improvements for Payment (HIP) Act of 2014

Section-by-Section

Sec. 101. Hospital Prospective Payment System

Subparagraph (a)(t)(1) – Findings

Provides background on the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS). Highlights one of the major differences between the IPPS and OPPS—the IPPS reimburses hospitals "add-on" payments for indirect medical education (IME) funds and disproportionate share hospital (DSH) costs. References audits of short hospital stays by the Recovery Audit Contractors (RACs). Provides a history and definition of the Centers for Medicare and Medicaid Services' (CMS) two-midnights standard.

Subparagraph (a)(t)(2) – Establishment of the hospital prospective payment system (HPPS)

Requires the Secretary to establish the HPPS by fiscal year (FY) 2020. The Secretary shall establish a base rate of payment for the HPPS through rulemaking. The base rate must be calculated by blending: (1) the base operating rate for short stays and an equivalent base operating rate for over night hospital outpatient services; and (2) data collected from hospitals. Requires the Secretary to aggregate all IME and DSH payments for short stays and build the aggregate amount into the HPPS base rate. Requires the Secretary to use unadjusted IPPS rates (excludes Puerto Rico, sole community hospitals (SCH), medicare-hospital dependent (MDH), *etc.*) in calculating the HPPS base rate. Requires the Secretary to subject all IPPS hospitals (including Puerto Rico, sole community, medicare-dependent, *etc.*) to the HPPS base rate without any further adjustments. Prohibits hospitals from receiving the ObamaCare low-volume add-on payment for HPPS discharges.

Subparagraph (a)(t)(3) – Establishment of weighting factor for different services

Requires the Secretary to establish weights to adjust the base payment for different services in the HPPS.

Subparagraph (a)(t)(4) – Application of area wage adjustment

Establishes a new wage index calculation for HPPS services. Requires the Secretary to use the pay localities for the Employer Cost Index published quarterly by the Bureau of Labor Statistics when calculating wage indices for HPPS services. Prohibits the Secretary from establishing any wage floors and from reclassifying any hospital to a different index. Requires the Secretary to transition the HPPS wage index from a hospital's current IPPS wage index to ensure that a hospital does not experience a variation of 10 percent (increase or decrease) in a wage index change in any given fiscal year. Requires the Secretary to publish an estimate of the HPPS wage index, per hospital, by October 1, 2018—one year prior to the implementation date.

Subparagraph (a)(t)(5) – Annual updating by a market basket increase factor
Requires the Secretary to apply an annual market basket update to the HPPS, beginning October 1, 2021. Requires the Secretary to apply adjustments to the annual market basked update for quality reporting and the meaningful use programs.

Subparagraph (a)(t)(6) – Application of hospital-specific payment adjustments
Requires the Secretary to adjust the HPPS for value-based purchasing, hospital-acquired conditions, readmissions and other hospital-specific adjustments as the Secretary determines appropriate.

Subparagraph (a)(t)(7) – Offsets
Requires the Secretary to make a one-time budget-neutral adjustment to the IPPS in order to reimburse hospital short stays under the HPPS. Requires the Secretary to make a one-time budget-neutral adjustment to the OPPS in order to reimburse outpatient overnight stays under the HPPS.

Subparagraph (a)(t)(8) – Treatment of outpatient short-term hospital stays as inpatient hospital services under Part A
Requires the Secretary to ensure overnight outpatient observation stays are reimbursed out of the Hospital Insurance trust fund once the HPPS is implemented. Clarifies that HPPS overnight outpatient observation will be subject to the Part A deductible and cost-sharing rules. Clarifies that outpatient overnight observation stays under the HPPS would count towards the 3-day stay requirement for qualifying for coverage in a skilled nursing facility.

Subparagraph (a)(t)(9) – Limitation
Prohibits administration and judicial review under section 101.

Subparagraph (a)(t)(10) – Definitions
Defines short-term hospital stays as: (1) having an actual length of stay less than 3 days; (2) classified to a MS-DRG that has a national average length of stay that is less than 3 days; and (3) is classified to a MS-DRG that is among the most highly ranked discharges that have been denied for reasons of medical necessity by RACs. Allows the Secretary to raise the 3-day threshold (for an individual and national average length of stay) if justified. Excludes MDH and SCH from the temporary inpatient short-term payment pool (described below). Defines overnight outpatient hospital services as an observation stay of more than 24 hours.

Subparagraph (a)(t)(11) – Unified hospital payment system study
Requires the Secretary to submit a report to Congress on a prototype design to further blend payments for outpatient and inpatient services in order to transition to one unified HPPS.

Subparagraph (b)(u)(1) – Alternate payment rate for inpatient short-term hospital stays
Creates an alternate payment rate for inpatient short stays for fiscal years 2016 through 2019—until the HPPS is available.

Subparagraph (b)(u)(2) – Payment rate for inpatient short-term hospital discharges based on short-term payment pool for fiscal years 2016 through 2019
Requires the Secretary to create a payment pool to reimburse short-term hospital discharges. The payment pool will equal no less than [X] and no more than [Y] percent. The payment pool will reduce total payments for short-term hospital stays by [Z] percent. The intent of this subparagraph is to ensure the total cost/savings of the HIP Act is budget neutral.

Subparagraph (b)(u)(3) – No impact on dGME payments
Ensures the reduced payment rates for short-term hospital stays under the temporary payment pool do not adversely effect dGME payment calculations.

Subparagraph (b)(u)(4) – Dual submission of claims; cross-walk of ICD-10 codes and CPT codes and HCPCS codes; crosswalk of DRGs and APCs
Requires hospitals to submit information necessary to process claims for such a stay as an inpatient hospital discharge and an outpatient hospital service for fiscal year 2016. Allows RACs to audit short-term hospital stays to ensure hospitals have submitted information for both inpatient and outpatient purposes. Requires the Secretary to reimburse all hospital short-term stays in fiscal year 2016 as inpatient discharges. Requires the Secretary to publish a crosswalk linking the relevant ICD-10 codes to CPT and HCPCS codes for short-term hospital discharges by October 1, 2015. Further, requires the Secretary to complete a crosswalk for all discharges by October 1, 2017. Requires the Secretary to complete a crosswalk between DRGs and APCs one year after the ICD-CPT-HCPCS crosswalks are completed.

Subparagraph (c)(1) – 6-month extension of RAC audit moratorium
Extends the previously regulated and legislated RAC audit moratorium regarding the enforcement of CMS' two-midnights standard.

Subparagraph (c)(2) – Further extension of moratorium to inpatient short-term hospital discharges through transition
Prohibits RAC audits of short-term hospital stays until the HPPS is available.

Subparagraph (d) – Funding
Allocates resources from the Medicare trust funds for no more than 4 direct hire FTEs for the implementation of sections 101 and 102.

Sec. 102. Per Diem Rate for Short Lengths of Stay
Requires the Secretary to establish a new payment for discharges with unusually short lengths of stay (LOS). Requires the Secretary to compute the base operating DRG at 80 percent for each DRG. Further, requires the Secretary to derive a per diem payment rate based off-of the 80 percent rate. When applying the per diem payment, the Secretary shall reimburse the first two days in any discharge at a higher rate than other days within the discharge. Requires the Secretary to refer to the existing post-acute care transfer policy when determining whether an individual discharge will qualify for the per diem reimbursement. This policy would begin on October 1, 2015.

Sec. 103. Repeal of the Two-Midnights Payment Reduction
Repeals the 0.2 percent ($220 million per year) reduction that CMS implemented in its fiscal year 2014 IPPS final rule with the two-midnights standard. Requires the Secretary to make a prospective adjustment to payments beginning October 1, 2015.

Sec. 104. Monitoring Performance of the RAC Program
Subparagraph (a) – Findings on the lack of public availability of statistics regarding the RAC program
Refers to the May 20, 2014 Ways and Means Health Subcommittee hearing when Congressional Members heard mixed messages about the statistics surrounding the amount of payment denial versus the number of denials overturned on appeal.

Subparagraph (b) – Establishment of a RAC Compare website
Requires the Secretary to publicly report metrics on the total number of claims paid, the number of claims denied and the number of denied claims that are overturned at the third or fourth level of appeal. The Secretary must publicly report this for each RAC contractor, no later than October 1, 2015.

Subparagraph (c) – CMS payment system defined
Requires the Secretary to publicly report RAC data on each Medicare payment system.

Sec. 105. Improvements to the RAC Program
Subparagraph (a) – Maximum look-back period of 3 years for RAC audit and recovery activities
Reduces the current statutory look-period for RAC audits from 4 years to 3 years.

Subparagraph (b) –Period for discussion
Requires RAC auditors to make a 30-day discussion period available to providers and suppliers prior to issuing a full or partial payment denial.

Subparagraph (c) – Limits on ADRs
Directs the Secretary to establish limits on the number of documentation requests made of providers and suppliers that varies by Medicare payment system. Requires the Secretary to vary the limit for individual providers and suppliers to reflect a lower limit for low denial rates and a higher limit for high denial rates.

Subparagraph (d) – Preventing duplicative audits
Requires all Medicare contractors who perform pre- and post-payment reviews to enter active audits into the RAC data warehouse.

Sec. 106. Retrospective Hospital Solutions to Address Problems in the Medicare Appeals Process
Subparagraph (a) – Findings
References the Obama Administration's suspension on hearing Medicare appeals at the Administrative Law Judge (ALJ) level. Notes the current estimate of over 800,000 Medicare claims in the ALJ backlog. Highlights the discrepancies in the Obama Administration's appeals settlement offer.

Subparagraph (b) – Voluntary settlement process for medical MS-DRGs
Directs the Secretary to establish an alternative voluntary settlement process allowing hospitals to settle claims in exchange for waiving all future appeal rights. This voluntary settlement process would only be applicable to those discharges in which providers have filed a request for an ALJ hearing on or prior to the enactment of this section. All applicable cases that are identified by a hospital would be reimbursed at a settlement rate that is empirically derived through the rulemaking process. Requires the Secretary to articulate the details of the voluntary settlement process within 60 days of enactment. Further, within 90 days of enactment, the Secretary is required to provide notification of a settlement offer to any hospital indicating it would like to participate in the settlement process. Each hospital will have 60 days to accept any settlement offer. Each hospital may accept or deny a settlement offer on an individual discharge. Once a claim has been settled, it is no longer eligible for any administrative or judicial review and the Secretary is prohibited from any further audit of the claim, except in case of suspected fraud or misrepresentation of facts.

Subparagraph (c) – Rebilling option for surgical MS-DRGs
Requires the Secretary to establish a voluntary rebilling process for surgical discharges that are in the ALJ appeals backlog. Would allow hospitals to rebill going back to dates of service of July 1, 2007. Requires the Secretary to make rebilling available within 60 days of the date of enactment. Hospitals would be able to choose the rebilling option on a per discharge basis. RAC contingency fees collected on the initial denial would be held harmless. All beneficiary cost-sharing would also be held harmless upon rebilling.

Sec. 107. Retrospective Non-Hospital Solutions to Address Problems in the Medicare Appeals Process
Subparagraph (I) – Expediting decisions on part B claims to reduce ALJ backlog
Requires the Secretary to allow for extrapolation through a statistically valid sample for part B services currently in the ALJ backlog within 60 days of enactment.

Subparagraph (J) – Authorizing voluntary settlement process for part B claims
Allows the Secretary to establish a voluntary settlement process for those part B claims that are currently in the ALJ backlog. Directs the Secretary to model the part B settlement process from the hospital settlement process in section 106.

Sec. 108. Prospective Solutions to Address Problems in the Medicare Appeals Process
Subparagraph (a) – Data collection requirements
Requires the Secretary to publish data on Medicare Administrative Contracts (MACs), Qualified Independent Contractors (QICs), ALJs and the Departmental Appeals Board (DAB) regarding reviews of appeals.

Subparagraph (b) – Comprehensive electronic system for managing appeals
Requires the Secretary to implement an electronic system for managing appeals by July 1, 2015. The system shall: (1) contain basic information, such as total allowed charges for all appeals; (2) allow for extraction information by individual Medicare payment system; and (3) allow providers and suppliers to electronically file clinical documentation.

Subparagraph (c) – Posting of information on pending appeals and determinations
Requires the Secretary to publicly post data on appeals within 6 months of enactment. Requires that all information be updated at least bi-annually. Requires the Secretary to report on the total number of claims and total charges being appealed by individual Medicare payment system. Specifically, directs the Secretary to separate rates of durable medical equipment from prosthetics, orthotics and supplies. Further requires the Secretary to report the most frequent reason for appeals (by provider/supplier type), number of requests overturned on appeal and the number of cases that had a hearing at the ALJ level.

Subparagraph (d) – Treatment of certain documentation created by orthotists and prosthetists
Requires, within 90 days of enactment, the Secretary to make public the elements needed for documentation when evaluating the need for a lower limb prosthetic device.

Sec. 109. Hospital Assessment Data
Subparagraph (a)(j) – Assessment requirements for inpatient hospitals, pps-exempt cancer hospitals and critical access hospitals
Requires the Secretary to collect standardized assessment data from hospitals, beginning October 1, 2018. Hospitals would be required to report the following: medical conditions and co-morbidities, functional status, cognitive function, living situation and access to family caregivers at home.

Subparagraph (b) – Payment consequences under the applicable reporting provisions
Requires the Secretary to apply a 2 percent payment reduction to any hospital that fails to report standardized patient assessment data.

Sec. 110. Cost Information on Hospital Payments*
Subparagraph (a) – Reporting of certain hospital payment data
Requires hospitals to report data on the actual amounts collected from uninsured and insured patients for the 50 most common DRGs. Requires the Secretary to publicly report such data.

Subparagraph (b) – Inclusion of information on charity care furnished by hospitals in MedPACs annual report
Requires MedPAC to annually include the percentage of charity care as a proportion of total care furnished by inpatient acute and critical access hospitals.

*This section was introduced by Senators Coburn and McCaskil (S. 2005).

Sec. 201. (Johnson) Repeal of ObamaCare Moratorium on Physician-Owned Hospitals
By repealing the ObamaCare moratorium on physicians-owned hospitals, the section would allow full building and bed expansion of physician-owned hospitals.

Sec. 202. (Brady) Repeal of ObamaCare Bay-State Boondoggle
Repeals the state-specific budget neutrality clause when implementing the Medicare hospital wage index and makes the hospital wage index budget neutral on a national basis, beginning October 1, 2015.

Sec. 203. (Ryan) Expanding the Available of Medicare Data
Broadens access to Medicare data for qualified entities.

Sec. 204. (Nunes) Ambulatory Surgical Center Parity
Allows Ambulatory Surgical Centers (ASCs) to be represented on CMS' APC panel.

Sec. 205 (Roskam) DISARM
Focuses on using Medicare reimbursement to incentivize investments in antibiotic drugs.

Sec. 206 (Buchanan) Hand Sanitation Demonstration
Recruits hospitals to participate in a voluntary demonstration to test processes for improving hand sanitation compliance. Requires a national hand sanitation quality measure(s) that would be publicly reported and used in hospital value-based purchasing.

Sec. 207 (Smith) Physician Supervision
Extends the House-passed non-enforcement instruction for direct supervision for critical access hospitals for an additional year.

Sec. 208 (Smith) CAH 96 Hours
Repeals the statutory condition of payment requiring CAHs to provide an average length of stay that is at least 96 hours in duration.

Sec. 209 (Schock) MEND
Includes a technical fix that allows nursing programs to continue to receive hospital pass-through payments regardless of the program's accreditation status with the hospital.

Sec. 210 (Schock) Puerto Rico Electronic Health Records
Includes a technical fix that would allow hospitals in Puerto Rico to participate in the meaningful use program.

Sec. 211 (Jenkins) Pass-Through Payments for Anesthesiologists
Establishes parity between anesthesiologists and certified registered nurse anesthetists (cRNAs) by allowing anesthesiologists to receive pass-through payments in the same fashion cRNAs receive pass-through payments.

Sec. 212 (Black) Documentation by Non-Physician Providers
Provides parity by allowing nurse practitioners, physician assistants, clinical nurse specialists and midwives to meet the documentation requirements for ordering a hospital stay.

Sec. 213 (Black) Comprehensive Bundling
Establishes a comprehensive, voluntary bundled payment program.

Sec. 214 (Black) Restoration of Tennessee's Medicaid DSH Funding
Allows for Tennessee to receive disproportionate share hospital (DSH) money through its special waiver status.

Sec. 215 (Reed) Ensuring Accurate Reimbursement for Bladder Cancer
Requires the Secretary to reimburse separately those services that use contrast separately for those services that do not.

Sec. 216 (Young) NOTICE
Requires hospitals to notify beneficiaries, who are in observation, that they may not qualify for coverage of skilled nursing facility services.

Sec. 217 (Renacci) Readmissions Equity
Directs the Secretary to make adjustments to the hospital readmission measures that take into account socio-economic factors.

Sec. 218 (Camp) PPS-Exempt Cancer Hospitals
Allows those hospitals that meet the specified criteria to receive pps-exempt cancer status.

Sec. 219 (Camp) Protecting Hospitals During a CMS Contractor Change
Holds hospitals harmless, above a threshold of 25 percent, during a transition for Medicare Administrative Contractor (MAC) functions when the new MAC questions payment determinations made by the previous MAC.