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CMS Proposes Changes to Medicare Inpatient Prospective Payment System for Fiscal Year 2013

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The Centers for Medicare & Medicaid Services (CMS) has posted a more than 1,300-page proposed rule that would update Medicare's Inpatient Prospective Payment System for fiscal year 2013. Parties affected by the proposed changes are encouraged to review the document with counsel in order to assess the impact of the updates and to prepare comments for submission to CMS.

The Centers for Medicare and Medicaid Services (CMS) posted a proposed rule on April 24, 2012, that would update Medicare's Inpatient Prospective Payment System (IPPS) for fiscal year 2013. The proposal would update and modify a variety of payment factors and policies, including the Medicare Severity-Diagnosis Related Groups (MS-DRGs), wage index, value-based purchasing and readmission programs, graduate medical education payments and a variety of rules impacting long-term care hospitals (LTCHs). The proposed rule is available on the agency's website, at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Proposed-Rule-Home-Page.html, and will appear in the *Federal Register* on May 11, 2012. Comments on the proposed rule are due June 25, 2012.

This *White Paper* summarizes some of the more significant changes in the proposed rule. However, the rule spans more than 1,300 pages, not including the many tables that accompany the IPPS update. Interested persons are encouraged to review the entire rule or consult with their regular McDermott attorney or any of the individuals listed below for a more complete assessment of the proposed changes.

PAYMENT UPDATE

CMS proposes to reduce the FY 2012 standardized amount, $5,902.11, by 9.8 percent for a proposed FY 2013 standardized amount of $5,325.62. This reduction reflects a positive change of 2.1 percent in the market basket as well as reductions to account for increases in the case mix index arising from the transition to MS-DRGs and various budget neutrality adjustments. CMS's proposals with regard to adjustments for increases in the case mix index arising from the transition to MS-DRGs are described in further detail below.

For FY 2013, CMS proposes a prospective reduction of 1.9 percent to the standardized amount to complete adjustments for increases in the case mix index arising from the transition to MS-DRGs. In addition to the proposed 1.9 percent reduction, CMS proposes a 0.8 percent reduction to recoup overpayments made in FY 2010 as a result of documentation and coding improvements. CMS also proposes to remove the 2.9 percent recoupment adjustment applied for FY 2013. The net impact of proposed FY 2013 documentation and coding adjustments would be an increase in 0.2 percent (-1.9 percent minus 0.8 percent plus 2.9 percent).

For hospital-specific rates used to determine payments to hospitals with Sole Community Hospital (SCH) and Medicare-Dependent Hospital (MDHs) status, CMS proposes a prospective reduction of 0.5 percent. Hospital-specific payments were reduced by 2.9 percent beginning in FY 2011 and by an additional 2.0 percent beginning in FY 2012. The cumulative effect of these three adjustments, beginning in FY 2013, would be a 5.4 percent reduction in hospital-specific payment rates. CMS also proposes a 0.8 percent reduction to recoup overpayments made in FY 2010 as a result of documentation and coding improvements. The net impact to hospital-specific rates of proposed FY 2013 documentation and coding adjustments is a reduction of 1.3 percent (-0.5 percent minus 0.8 percent).

A prospective reduction of 2.6 percent was applied to the Puerto Rico-specific rate in FY 2011. No further reductions are proposed for hospitals in Puerto Rico.

QUALITY PROGRAMS

HOSPITAL-ACQUIRED CONDITIONS (HACS)

For FY 2013, CMS proposes establishing two new HAC categories: (1) Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) and (2) Iatrogenic Pneumothorax with Venous Catheterization.

Under the agency's proposal, SSI following CIED would be identified on claims by either ICD-9-CM diagnosis code 996.61 (Infection and inflammatory reaction due to cardiac device, implant and graft) or 998.59 (Other postoperative infection), plus one

or more of the identified associated procedure codes (ICD-9-PCS codes 00.50-00.54, 37.80-37.83, 37.85-37.87, 37.94, 37.96, 37.98, 37.74-37.77, 37.79 and 37.89). Statute requires that a condition be "high cost, high volume, or both" to be included in the HAC program. As defined and measured by CMS, FY 2011 discharges indicate an incidence of 859 for SSI following CIED. Of these 859 discharges, 276 cases did not include 996.61 or 998.59 as present on admission. These cases had an average cost of $72,485. In contrast, the 583 cases in which 996.61 or 998.59 was present on admission had an average cost of $41,999.

CMS proposes to identify Iatrogenic Pneumothorax with Venous Catheterization on claims by ICD-9-CM diagnosis code 512.1 (Iatrogenic pneumothorax), plus the associated ICD-9-PCS procedure code 38.93 (Venous catheterization NEC). As defined and measured by CMS, FY 2011 discharges indicate an incidence of 4,467 for iatrogenic pneumothorax with venous catheterization. Of these 4,467 discharges, 3,855 cases did not include 512.1 as present on admission. These cases had an average cost of $41,102. In contrast, the 612 cases in which 512.1 was present on admission had an average cost of $26,693.

CMS also proposes adding two new ICD-9-CM diagnosis codes—999.32 (Bloodstream infection due to central venous catheter) and 999.33 (Local infection due to central venous catheter)—to the HAC Category Vascular Catheter-Associated Infection.

HOSPITAL READMISSION REDUCTION PROGRAM (HRRP)

CMS discusses further the Hospital Readmission Reduction Program required under the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), and proposes a final program framework and key program elements that will apply beginning in FY 2013, including readmission adjustment factor, readmission measures, ratios and other methodologies, and public reporting. The HRRP reduces payments to hospitals to account for excess admissions for acute myocardial infarction, pneumonia and heart failure.

In the rule, CMS proposes to define the "base operating DRG payment amount" as the wage-adjusted DRG operating payment amount plus any additional payments made related to new technology. CMS proposes to further define "base operating DRG payment amount" by proposing that this amount is equal to the applicable, wage-adjusted standardized amount, multiplied by the applicable DRG weight. As indicated, the proposed definition excludes any additional payments that may be related to programs such as, but not limited to, disproportionate share, medical education and outliers. With regard to hospitals paid on the basis of their hospital-specific rate, the definition of "base operating DRG payment amount" excludes any payments the hospital receives as a result of its hospital-specific rate. The "base operating DRG payment amount" is the foundation for determining the payment adjustment that will be applied to payments to account for excess readmissions.

CMS proposes to define the readmission adjustment factor as the higher of (a) 1.0 minus the ratio of aggregate payments for excess readmissions to aggregate payments for all discharges or (b) the "floor adjustment factor." For FY 2013, the statutorily set floor is 0.99. The floor adjustment factor sets the maximum payment reduction at 1.0 percent for FY 2013. For FYs 2014 and for 2015 and beyond, the maximum payment reductions are 2.0 percent and 3.0 percent respectively. To determine aggregate payments for excess readmissions, CMS proposes summing the product of the base operating DRG payments and the excess readmission ratio for each clinical condition. CMS proposes to define aggregate payments for all discharges as the sum of all base operating DRG payments.

Based on the statute, CMS proposes for FY 2013 to define "applicable hospital" as all hospitals paid under the IPPS as well as certain Maryland hospitals that are currently excluded from the IPPS. Insofar as the statute allows CMS to exempt Maryland hospitals from the program if certain criteria are met, CMS is seeking comments regarding whether Maryland hospitals should be exempted from the HRRP.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

For FY 2013 and FY 2014, CMS did not propose any changes to the hospital IQR program. For FY 2015, CMS is proposing to remove 17 measures and to add four new measures for a total of 59 measures. Of the 17 measures proposed for removal, 16 are claims-based measures and one is a chart-abstracted measure. The four measures proposed for addition in FY 2015 include total hip/knee arthroplasty readmission rate, total hip arthroplasty complication rate, hospital-wide readmission rate, and elective delivery prior to 39 weeks gestation. For FY 2016, CMS proposes to add one measure, Safe Surgery Checklist, for a total of 60 measures.

VALUE-BASED PURCHASING (VBP) PROGRAM

FY 2013 marks the first year of the Hospital Value-Based Purchasing (VBP) Program. As such, CMS proposes to begin reducing the base operating DRG payment amount by 1.0 percent beginning January 2013 to fund the VBP incentive payment pool. In addition, CMS also proposes to begin applying value-based incentive payments at that time. In future program years, all VBP adjustments—both reductions to base operating DRG payment amounts and value-based incentive payments — will be applied at the start of the federal fiscal year. In the proposed rule, CMS describes in detail methods for calculating reductions to base operating DRG amounts as well as proposed methods for calculating incentive payments.

In the proposed rule, CMS also makes proposals regarding FY 2015 and FY 2016 VBP program years. Most notably, for FY 2015, CMS proposes to adopt the Medicare Spending per Beneficiary measure, which examines all Medicare Part A and Part B spending for an index admission beginning three days prior to the admission through 30 days post discharge. The Medicare Spending per Beneficiary measure would comprise the Efficiency domain, which is also proposed for FY 2015. For FY 2016, CMS proposes to reclassify measure domains into six categories: (1) Clinical Care, (2) Person- and Caregiver-Centered Experience and Outcomes, (3) Safety, (4) Efficiency and Cost Reduction, (5) Care Coordination and (6) Community/Population Health. CMS is seeking specific comments on appropriate weights.

WAGE INDEX

The proposed update is more noteworthy for what is not included than for what is proposed. While CMS proposes typical updates to the wage index to reflect labor cost and other data derived from more recent cost reports, the agency does not propose any major policy changes to how the wage index is calculated, the occupational mix adjustment, the out-migration adjustment, reclassification rules or other factors that adjust a hospital's payment to reflect labor cost experience. Perhaps most noteworthy, the agency proposes no major changes to the manner in which the wage index is calculated consistent with a report sent by the Secretary of the Department of Health and Human Services, Kathleen Sebelius, to Congress on April 11, 2012, that provided a series of recommendations for how the hospital wage index could be overhauled. Many of the proposed changes included in that report would require legislative action, but some could be implemented at the agency's discretion. CMS is not seeking to implement any of those changes at this time.

Moreover, the agency was surprisingly silent on a wage index matter that has divided the hospital community: the budget neutrality adjustments arising from the Rural Floor. Under current rules, no urban area within a state can have a wage index that is lower than the rural portions of that same state. Changes made consistent with this rule are implemented in a budget-neutral fashion. In 2008, CMS changed the manner for attaining budget neutrality by specifying that budget neutrality would be achieved on a state-specific level (in other words, increases to the wage index within a state resulting from the Rural Floor would be offset by corresponding payment decreases within that same state). The Affordable Care Act undid that change, and required the agency to return to achieving budget neutrality by making adjustments across all hospitals. In recent months, a number of state hospital associations and individual hospitals and systems have urged the President of the United States, Secretary Sebelius and CMS to further modify its Rural Floor budget neutrality policy to address what these organizations perceive as a windfall for hospitals in Massachusetts, which this year will see payments increase by $182 million (5.5 percent) solely as a result of this change. Every other state except California and New Hampshire will see aggregate payments decline as a result of this policy. CMS discusses this issue in the proposed rule, but proposes no change to this policy.

CMS did, however, propose to revise the manner in which it calculates the imputed Rural Floor for states that have no rural areas. Hospitals in Rhode Island would be affected by this policy.

QUALITY PROGRAMS

Hospitals that are reclassified or wish to seek reclassification should be mindful of two important dates:

- Hospitals that are reclassified for fiscal year 2013 are permitted to withdraw their applications within 45 days of the publication of this proposed rule in the Federal Register. Presuming CMS publishes the rule in the Federal Register on May 11, 2012, as anticipated, hospitals wishing to withdraw their applications would need to notify the Medicare Geographic Classification Review Board (MGCRB) by no later than June 25, 2012.

- Hospitals wishing to seek reclassification for fiscal years 2014 through 2016 need to submit a request for reclassification to the MGCRB by September 4, 2012.

SOLE COMMUNITY HOSPITALS

Hospitals that are a certain distance from another "like" hospital may be designated as Sole Community Hospitals (SCHs) and receive enhanced inpatient and outpatient reimbursement. A hospital that qualifies for SCH status maintains that classification without the need for reapproval unless there is a change in the circumstances under which the classification was approved. Medicare regulations require an SCH to notify its fiscal intermediary or Medicare Administrative Contractor (MAC) if certain changes affecting eligibility occur.

CMS is now proposing a minor change to these regulations to address situations where an SCH no longer meets the requirements to be classified as an SCH not because of a "change," but rather because the hospital never met the requirements to be classified as an SCH in the first instance, and was incorrectly classified as an SCH. Under this proposed change, if a hospital did not ever qualify to be an SCH, CMS could revoke the hospital's SCH status retroactively provided the revocation action is initiated within three years of the determination. If the determination was procured by fraud, there is no time constraint, and CMS can seek to revoke the SCH status going back to the initial determination regardless of when it was made. CMS proposes to be able to take this action regardless of whether the hospital had knowledge that it did not meet the qualification criteria.

EXPIRING PROGRAMS AND PROVISIONS

The proposed rule discusses a number of changes that will occur as a result of expiring statutory authority. For example, a hospital can qualify as a Medicare-Dependent Small Rural Hospital (MDH) and for enhanced payments if, among other things, a majority of its inpatient patients are Medicare beneficiaries. Under current law, the authority for this program and its attendant benefits expire October 1, 2012. CMS reminds hospitals that this program is expiring and revises its regulations accordingly, but also proposes a change that may ease the transition for some hospitals with MDH status.

CMS is proposing a change to the SCH qualification process to benefit any hospital with MDH status that also meets the qualification criteria for SCH status. SCH's status is generally effective 30 days after CMS's written notification of approval. Hospitals that presently have MDH status, but could qualify for SCH status may be reluctant to apply for SCH classification status well before the expiration of their MDH status because they would prefer to maintain their MDH status for as long as possible. However, if those hospitals were to wait to apply for SCH classification status after expiration of their MDH status, they could experience a financial hardship if there were a delay in the approval for SCH classification status. As such, CMS is proposing that, for any MDH that applies for SCH classification status at least 30 days prior to the expiration of the MDH program (October 1, 2012) and requests that SCH classification status be effective with the expiration of the MDH program provision, the effective date of the hospital's classification as an SCH would be the day following the expiration date of the MDH program provision (i.e., October 1, 2012).

CMS also makes clear that changes made by the Affordable Care Act expanding eligibility for enhanced payments for hospitals with a relatively low number of discharges will also expire October 1, 2012. The Medicare Modernization Act of 2003 created a payment supplement for rural hospitals with fewer than 800 discharges that also are at least 25 miles from another hospital. The Affordable Care Act eased the eligibility criteria and revised the payment methodology for two years by raising the discharge bar to 1,600 discharges, and lowering the distance requirement to 15 miles, among other things. The statutory authority for those lower eligibility thresholds expires October 1, 2012. CMS announces that it will revert to the eligibility standards and payment adjustment methodology that were in place prior to fiscal year 2011. For a hospital to qualify for low-volume hospital payment adjustments for FY 2013, it must make its request in writing to its fiscal intermediary or MAC by September 1, 2012. If a hospital requests the status after September 1, 2012, it will be effective prospectively within 30 days of the date of the fiscal intermediary's or MAC's low-volume status determination.

GRADUATE MEDICAL EDUCATION

Under the IPPS, an additional payment amount is made to hospitals that have residents in an approved graduate medical education (GME) program. Under current rules, if a hospital begins training residents in a new residency program, the hospital's resident cap is established during the third year of the first new program, for all new residency training programs established during that three-year period. CMS is now proposing that a new teaching hospital will have five years, instead of the current three, in which to establish and grow new programs. At the end of the fifth year of the first new program in which the new teaching hospital participates, the new teaching hospital's resident caps would be determined, and set permanently, effective with the beginning of the sixth program year.

BEDS

CMS is proposing a change to its rules to include labor and delivery bed days in the count of a hospital's total number of beds. This change could affect Disproportionate Share Hospital and Indirect Medical Education payment adjustments, as well as other programs that hinge on a hospital's bed count (e.g., MDH status and outpatient prospective payment system hold harmless payments).

SERVICES FURNISHED UNDER ARRANGEMENTS

In 2011, CMS implemented changes limiting the circumstances under which a hospital may furnish services to Medicare beneficiaries "under arrangement." Under the revised policy, therapeutic and diagnostic services are the only services that may be furnished to Medicare beneficiaries under arrangements outside of the hospital. "Routine services" (that is, bed, board, and nursing and other related services) must be furnished by the hospital. If routine services are furnished outside of the hospital, the services are considered to be furnished "under arrangement" and not by the hospital in violation of the rule. CMS is now proposing to postpone the effective date of this requirement to cost reporting periods beginning on or after October 1, 2013, to give hospitals additional time to comply with this change.

LONG-TERM CARE HOSPITALS (LTCHS)

Legislation enacted in 2007, and since extended most recently by the Affordable Care Act, blocked CMS from expanding policies restricting the number of patients LTCHs can admit from nearby general acute care hospitals before incurring payment penalties (commonly referred to as "the 25 percent rule") and from applying a short-stay outlier payment adjustment. That same legislation also imposed a temporary moratorium on establishment and enrollment of new LTCHs or satellites, and on any increase in beds at existing facilities. Each of these legislative provisions was set to expire at various times in 2012.

CMS is now proposing to further delay implementation of the 25 percent payment adjustment threshold for an additional year, such that it would become effective with cost reporting periods beginning on or after October 1, 2013. CMS is not proposing a similar delay with respect to the short-stay outlier adjustment or development moratorium.

For more information regarding the Centers for Medicare & Medicaid Services' proposed rule updating Medicare's Inpatient Prospective Payment System, please contact your regular McDermott lawyer or:

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