

## **CMS Releases Medicare IPPS Payment Rules for FFY 2012; Proposal Includes Rules to Establish the ACA's Inpatient Readmissions Payment Policy Effective FFY 2013 and New Policy Proposals for the FFY 2014 Inpatient VBP Program**

The Centers for Medicare and Medicaid Services (CMS) has released the federal fiscal year (FFY) 2012 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule updates inpatient payment rates and policies and implements provisions of the Affordable Care Act (ACA) of 2010.

In addition to updating inpatient payments for FFY 2012, the content-rich rule also includes proposals related to the ACA's Medicare inpatient readmissions payment policy, set for implementation beginning FFY 2013, and proposals related to the FFY 2014 Medicare inpatient value-based purchasing (VBP) program. The VBP proposals for FFY 2014 have been issued as the field awaits the final rule from CMS that will establish the initial FFY 2013 VBP program.

CMS Fact Sheets on the proposals are available on the CMS web site at: [http://www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp).

Comments on the proposed rule are due to CMS by Monday, June 20.

### **Highlights of the IPPS Proposed Rule**

#### ***IPPS Rate Updates for FFY 2012***

##### Federal Operating Rate

CMS' proposed rate updates, along with slight adjustments for budget neutrality, result in a federal inpatient operating rate of \$5,132.36 for FFY 2012 compared to \$5,164.11 for FFY 2011, a 0.6% decrease.

The proposed FFY 2012 operating rate would be updated as follows:

- *Plus 2.8%*: CMS is proposing to update the operating rate by a marketbasket of 2.8%.
- *Minus 1.2 percentage points*: Offsetting the marketbasket is an ACA-mandated productivity reduction of 1.2 percentage points.
- *Minus 0.1 percentage points*: Offsetting the marketbasket is an ACA-mandated pre-determined reduction of 0.1 percentage points.
- *Minus 3.15%*: CMS is proposing to continue its application of coding adjustments to inpatient rates, reducing the operating rate by a net 3.15%, to account for what CMS believes are increased inpatient payments to hospitals due to coding improvement. Unlike the coding adjustment reduction applied in FFY 2011, which was a retrospective or one-year

reduction only, the proposed FFY 2012 coding adjustment will be permanently built into the federal operating rate (i.e. the reductions will carry forward in future payment years).

- *Plus 1.1%:* CMS is proposing to increase the operating rate by 1.1% to account for the agency's inappropriate application of rural floor budget neutrality adjustments in past years, as decided in the case of Cape Cod Hospital vs. Sebelius.

#### Hospital-Specific Rates

CMS is proposing to update the hospital-specific rates for Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs) in a manner similar to the federal operating rate. The proposed FFY 2012 hospital-specific rates would be updated as follows:

- CMS is proposing to apply the same marketbasket update and ACA-mandated marketbasket reductions (*a full 2.8% marketbasket reduced by a 1.2% productivity adjustment and reduced by a 0.1% pre-determined factor*).
- *Minus 2.5%:* CMS is proposing to apply a prospective coding adjustment to the hospital-specific rates of 2.5% (rather than 3.15% as proposed for the operating rate). This coding adjustment is permanent and will carry forward in future payment years. The 2.9% coding adjustment applied to hospital-specific rates in FFY 2011 was also permanent and is carried forward.
- *Plus 0.9%:* CMS is proposing to increase hospital-specific rates by 0.9% (rather than 1.1% as proposed for the operating rate) to account for the inappropriate application of rural floor budget neutrality in past years. This increase is slightly less than that applied to the operating rate because CMS did not apply the rural floor budget neutrality adjustment to the hospital-specific rates in all years the adjustment was applied to the operating rate.

#### Federal Capital Rate

CMS' proposed rate updates, along with slight adjustments for budget neutrality, result in a federal inpatient capital rate of \$422.54 for FFY 2012 compared to \$420.01 for FFY 2011, a 0.6% increase.

CMS is proposing to update the capital rate by a marketbasket of 1.5%. Offsetting the update, CMS is proposing to apply a negative 1.0% coding adjustment to the capital rate. This coding adjustment is permanent and will carry forward in future payment years.

#### ***Details on the Coding Adjustment to the Federal Inpatient Operating Rate***

The need for a coding adjustment dates back to FFYs 2008 and 2009, when CMS transitioned to its new Medicare-Severity Diagnosis Related Groups (MS-DRGs). Under current law, in order to maintain the budget neutrality of the inpatient payment system, CMS has the authority to both retrospectively recoup for increases in inpatient payments during FFYs 2008 and 2009 that were due to coding improvement (rather than real case-mix changes) AND prospectively reduce inpatient payments to remove those coding improvement impacts from future payments.

Retroactive adjustments are applied as one-time adjustments that are added back into the rate in the next payment year. Prospective adjustments are applied by CMS as permanent adjustments to the base payment rate and are carried forward in future payment years.

CMS has made some prospective adjustments in anticipation of coding improvements (-0.6% in FFY 2008 and another -0.9% in FFY 2009), but those adjustments did not fully cover the full impact of coding improvements (according to CMS).

For FFY 2012, CMS is proposing to apply a net coding adjustment of minus 3.15% to the operating rate. Below describes how CMS arrived at this amount.

#### Retrospective Coding Adjustment for FFY 2012

CMS calculates that over those two years, there was additional coding improvement of 5.8% that needs to be recouped. To achieve the 5.8% recoupment, CMS reduced the operating rate by 2.9% in FFY 2011 and is proposing another 2.9% reduction in FFY 2012. Because the retrospective adjustments are one-time reductions, there is no year-to-year change in the operating rate due to the application of this adjustment. By law, FFY 2012 is the final year that CMS can implement retrospective coding adjustments.

#### Prospective Coding Adjustment for FFY 2012

CMS has determined that an additional prospective coding adjustment of 3.9% (above the 1.5% total already implemented in previous years) is needed to fully account for coding improvements in order to maintain the budget neutrality of the IPPS. CMS is proposing to apply a prospective coding adjustment of 3.15% to the operating rate. CMS notes that an additional 0.75% adjustment will be required in future rulemaking, but did not propose a timeline for this adjustment.

### ***Hospital Inpatient Quality Reporting (IQR) Program***

As adopted in the FFY 2011 IPPS final rule, CMS is confirming that hospitals must report on 55 quality measures for FFY 2012 and 57 quality measures for FFY 2013 in order to successfully participate in the Hospital IQR program. Hospitals that do not successfully participate in the IQR program are subject to a 2.0 percentage point reduction to the IPPS marketbasket update for the applicable year—the reduction factor has not changed.

CMS is proposing refinements to the IQR program for FFYs 2014 and 2015. These refinements not only update the IQR program, but also put in place measures that CMS may incorporate into the Medicare inpatient VBP program, established by the ACA. CMS is proposing the following changes to the quality reporting requirements under the IQR program:

- For FFY 2014 payment determinations, CMS is proposing to retire 8 chart-abstracted measures and add 2 healthcare-associated infection (HAI) measures, 1 claims-based measure (Medicare spending per beneficiary – see additional detail in VBP section below), and 1 structural measure, for a total of 56 measures.
- For FFY 2015 payment determinations, CMS is proposing to add 3 HAI measures and 14 chart-abstracted measures, for a total of 73 measures.

CMS is also proposing several modifications to the IQR program data submission deadlines and validation procedures.

### ***HAC Payment Policy***

For FFY 2012, CMS is proposing to add one new HAC category, contrast-induced acute kidney injury, to the twelve HAC categories currently not recognized for Medicare IPPS payments. CMS is also proposing to expand the HAC diagnoses list by adding five new, International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM), diagnosis codes to three current HAC categories.

### ***Hospital Wage Index***

#### Allowable Pension Costs for the Wage Index

CMS is proposing to revise its policy for determining allowable pension costs used to calculate the hospital wage index. This proposed revision will allow hospitals to report pension costs on Worksheet S-3 equal to the average actual cash contributions deposited to a hospital's/system's defined benefit pension plan over a 3-year period. CMS states that it is proposing this change to enhance the stability of the wage index. The 3-year average would be centered on the base cost reporting year for the wage index, i.e. the cost report year plus the year immediately prior and an estimate for the year immediately after.

For cost settlement purposes, CMS will maintain its current requirement that pension costs must be funded to be reportable, and will require all hospitals to report actual pension contributions funded during the reporting period, on a cash basis.

#### Section 508 Reclassifications

Section 508 wage index reclassifications are set to expire at the end of FFY 2011. CMS does not have the authority to extend these reclassifications beyond FFY 2011 without legislative action.

#### Clarification for Hospitals Waiving "Lugar" Reclassification for the Out-Migration Adjustment

CMS clarifies in the proposed rule that a hospital, in waiving its Lugar reclassification in order to receive an out-migration adjustment, has waived its deemed urban status and will be treated as rural for all payment purposes under IPPS, including Disproportionate Share Hospital (DSH) payments. CMS also proposes that a hospital that rejects its Lugar reclassification will maintain their rural status and out-migration adjustment for the 3-year eligibility period without needing to annually notify CMS.

#### Occupational Mix Survey

CMS collects data every three years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program. This data is used to adjust the hospital wage index. A new survey is required for FFY 2013. Hospitals must submit the completed survey tool to their (FI)/Medicare Administrative Contractor (MAC) by July 1, 2011.

### ***Outlier Payments***

CMS is proposing to increase the outlier threshold by 1.3%, from \$23,075 in FFY 2011 to \$23,375 in FFY 2012. This threshold increase would reduce the number of cases eligible for outlier payments.

### ***DSH and Indirect Medical Education (IME) Payment Adjustments***

CMS is proposing to modify its DSH and IME payment adjustments to exclude inpatient hospice services. CMS is proposing to exclude inpatient hospice days from the patient day count for DSH purposes and the bed day count for DSH and IME purposes.

CMS notes in the proposed rule that the proposed policy change would impact DSH payments in only limited situations (both positive and negative) and may increase IME payments to teaching hospitals depending on the extent to which these hospitals were providing inpatient hospice services to hospice patients.

### ***Low-Volume Hospital Adjustment***

CMS is proposing to update the data used to determine which hospitals meet the volume criteria for the low-volume hospital adjustment from FFY 2009 to FFY 2010 Medicare discharge data. The new data may change the hospitals eligible for the adjustment. As required by law, hospitals must also meet distance criterion to be eligible for the adjustment.

The ACA-mandated changes to the low-volume hospital adjustment criteria for FFYs 2011 and 2012 that allowed more hospitals to qualify for the adjustment and modified the amount of the adjustment will expire after FFY 2012 without legislative action.

### ***Low-Cost County Add-On***

CMS has amended the list of hospitals eligible for the low-cost county add-on from 416 hospitals to 405 hospitals. This add-on payment established by the ACA provides \$400 million over two years (\$150 million in FFY 2011 and \$250 million in FFY 2012) to IPPS hospitals (including SCHs and MDHs, but excluding CAHs) located in counties within the lowest national quartile for total, risk-adjusted, Medicare Part A and Part B spending per enrollee. The updated list excludes 11 hospitals identified by CMS as non-subsection (d) hospitals. This modification will change each qualifying hospitals' payment weighting factors published in the FFY 2011 IPPS final rule. CMS has yet to distribute the \$150 million allotted for FFY 2011—the agency has until the end of the FFY to do so.

CMS notes that it intends to make payments to qualifying hospitals through a one-time annual payment made by one Medicare contractor who would pay all of the qualifying hospitals directly. The low-cost county add-on payments will expire after FFY 2012 without legislative action.

### ***MDH Program***

The ACA extends the MDH program through FFY 2012. The MDH program and special payment methodology for hospitals designated as MDHs will expire after FFY 2012 without legislative action.

### ***Critical Access Hospital (CAH) Payment for Ambulance Services***

In order to align CMS regulation with statute, CMS is proposing to revise its regulations for payments to CAHs for ambulance services. Effective October 1, 2011, payment for ambulance services provided by a CAH or by a CAH-owned and operated entity would be 101% of reasonable costs if the CAH or the entity is the only provider of ambulance services located within a 35-mile drive of the CAH. If there is another provider of ambulance services within the 35-mile drive of the CAH, payments will be made under the ambulance fee schedule.

Effective for cost reporting periods beginning on or after October 1, 2011, CMS proposes if there is no provider of ambulance services within a 35-mile drive of the CAH, but there is a CAH-owned and operated entity that is more than a 35-mile drive from the CAH, the CAH-owned and operated entity would be paid at 101% of reasonable cost as long as that entity is the closest provider of ambulance services to the CAH. If it is not the closest provider, the CAH-owned entity would be reimbursed under the ambulance fee schedule.

### ***Allowable Pension Costs***

Currently, certain pension costs may be allowable for cost-based reimbursement under Medicare. CMS is proposing a change to the methodology for calculating the maximum annual allowable pension costs to 150% of three consecutive reporting periods out of the five most recent reporting periods. CMS states that the limit has been proposed to ensure that reported pension costs are reasonable. If adopted, this proposal would be effective for cost reporting periods beginning on or after October 1, 2011.

## **Highlights of the Proposed Hospital Readmissions Reduction Program for FFY 2013**

Included as part of the IPPS proposed rule are several proposals that put in place the framework for the Medicare hospital inpatient readmissions payment policy established by the ACA. This program, dubbed the Hospital Readmissions Reduction Program in the proposed rule, is designed to reduce Medicare inpatient payments for acute care hospitals with higher than expected risk-adjusted readmission rates related to certain conditions. The program will begin October 1, 2012 (FFY 2013). Medicare payment reductions under this program will be capped at 1.0% in FFY 2013. The capped reduction amount will increase over time. CAHs are not subject to this program.

CMS is proposing policies to begin implementation of this program. CMS indicates it plans to implement the requirements of the readmissions payment policy over the next two IPPS rulemaking cycles. The following reflect the major provisions proposed by CMS:

- CMS is proposing to use the following measures, currently included in the Hospital IQR program and collected from Medicare fee-for-service claims data, for use under the FFY 2013 program:
  - Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure (NQF# 0505);
  - Heart Failure 30-day Risk Standardized Readmission Measure (NQF#0330 ); and
  - Pneumonia 30-day Risk Standardized Readmission Measure (NQF#0506).
- CMS is proposing to use 3 years of data (discharges from July 1, 2008 through June 30, 2011) as the period to calculate readmission rates to be used under the program.
- CMS is proposing to define a readmission as a hospital admission 30 days from the date of discharge from the index hospital (the initial hospitalization hospital).
- CMS is not proposing any additional exclusions in determining the number of readmissions for the proposed measures or any additional risk adjustment to the proposed measures beyond the exclusions and risk adjustment currently applied to the measures.
- CMS is proposing to exclude from the program, readmission measures with fewer than 25 discharges.
- CMS is proposing a methodology that would compare the hospital's risk-adjusted readmission rate to the unadjusted/raw US average rate (both currently reported at Hospital Compare) as the calculation of the Observed to Expected (O/E) Ratio. If a hospital performs worse than average, the ratio would be greater than 1.0 and the hospital would be subject to a payment penalty.

## **Highlights of the New Policy Proposals for the FFY 2014 Inpatient VBP Program**

Included as part of the IPPS proposed rule are several proposals related to the FFY 2014 (second year) hospital inpatient VBP program established by the ACA. The VBP proposals for FFY 2014 have been issued as the field awaits the final rule from CMS that will establish the initial FFY 2013 VBP program. Using measures reported under the IQR program, the VBP program will redistribute inpatient payments to hospitals based on quality performance beginning October 1, 2012 (FFY 2013). CAHs are not subject to this program.

The ACA requires CMS to adopt, for the VBP program, measures of efficiency, including measures of Medicare spending per beneficiary, as early as FFY 2014. CMS is proposing to

adopt a Medicare spending per beneficiary measure for use under the Hospital IQR program (see “Hospital IQR Program” above) and FFY 2014 VBP program. CMS is proposing the following related to this measure:

- CMS is proposing the Medicare spending per beneficiary measure be a claims-based measure.
- For the VBP program, CMS is proposing a baseline period of hospital discharges occurring between May 15, 2010 through February 14, 2011 and a performance period of hospital discharges occurring between May 15, 2012 and February 14, 2013.
- CMS is proposing to evaluate Medicare spending per beneficiary for each hospital using an episode that runs from three days prior to an inpatient hospital admission (index admission) through 90 days post hospital discharge.
  - CMS would include all Medicare Part A and Part B payments made for services provided to the beneficiary during the proposed 90-day episode to calculate this measure. Transfers, readmissions, and additional admissions that began during the 90-day post discharge window of an index admission would be included in the episode used for calculating the measure.
  - CMS would adjust Medicare payments included in the spending per beneficiary episode to account for age and severity of illness and exclude geographic payment rate differences (wage index and geographic practice cost index) and the portion of inpatient payments related to payment differentials cause by hospital-specific rates, IME, and DSH.
- To calculate a hospital’s Medicare spending per beneficiary amount, CMS is proposing to divide the sum of all adjusted Medicare Part A and Part B payments included in all of the Medicare spending per beneficiary episodes by the total number of Medicare spending per beneficiary episodes for the hospital.
- CMS is proposing to incorporate this measure into the VBP program similar to how CMS has proposed to calculate scores for the clinical process of care and outcomes measures under the proposed FFY 2013 VBP program. Hospitals would earn between 1 and 10 points for the measure and the final score for the measure would be based on the higher of a hospital’s achievement or improvement score.
- CMS would incorporate the Medicare spending per beneficiary measure score into the FFY 2014 VBP program as part of a new, “efficiency,” domain. If adopted, the FFY 2014 program would have a total of four domains; process of care, patient experience of care, outcomes, and efficiency. Under VBP, each domain is given a specific weight in order to calculate a total performance score. CMS did not propose a weight for the efficiency domain.
- CMS notes that it will propose domain weighting, additional measures, and other FFY 2014 proposals related to the VBP program in the CY 2012 hospital outpatient PPS proposed rule. This rule is typically published in July/August of each year.

The FFY 2012 IPPS proposed rule will be published in the May 5, 2011 *Federal Register*. A display copy of the proposed rule and other resources are available on the CMS Web site at: <https://www.cms.gov/AcuteInpatientPPS/IPPS2012/list.asp#TopOfPage>.