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Office of Media Affairs

MEDICARE FACT SHEET

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Proposed policy and payment changes for inpatient stays in acute care hospital inpatient and long-term care hospitals

OVERVIEW: On Apr. 19, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update Medicare payment policies and rates for inpatient stays in acute care hospitals under the Inpatient Prospective Payment System (IPPS) in Fiscal Year (FY) 2012. The proposed rule would also update payment policies and rates for hospitals paid under the Long-term Care Hospitals Prospective Payment System (LTCH PPS)

The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 420 LTCHs, would generally be effective for discharges occurring on or after Oct. 1, 2011. Under the proposed rule, CMS projects that Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2012 would decrease by a projected $498 million or 0.5 percent in FY 2012 relative to FY 2011. This reflects a proposed hospital update of 1.5 percent (based on a projected increase of 2.8 percent for inflation in hospital costs, reduced a multi-factor productivity adjustment of 1.2 percent and an additional 0.1 percent in accordance with the Affordable Care Act), increased by 1.1 percent in response to litigation, as well as a -3.15 percent documentation and coding adjustment. This documentation and coding adjustment is consistent with a statutory provision that requires CMS to adjust payments to remove the effect of increased aggregate payments due to changes in documentation and coding that did not reflect increases in patients' severity of illness after adoption of the MS-DRGs. Medicare payments to LTCHs in FY 2012 are projected to increase by $95 million or 1.9 percent.

This fact sheet discusses major provisions of the proposed rule other than the provisions in the proposed rule to continue strengthening Medicare's hospital quality initiatives and the proposed documentation and coding adjustment. These issues are addressed in a separate fact sheet which

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is available on the CMS Web page at:

www.cms.gov/apps/media/fact_sheets.asp.

BACKGROUND: By law, CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. The prospective payment systems establish prospectively set rates based on the patient's diagnosis and the severity of the patient's medical condition. Under the IPPS and the LTCH PPS, a hospital receives a single payment for the case based on the payment classification assigned at discharge. The Medicare law requires CMS to update the payment rates for both types of hospitals annually to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. The law exempts critical access hospitals (CAHs), children's hospitals, certain cancer hospitals, and certain other facilities from payment under the IPPS.

Until FY 2008, discharges from acute care hospitals were classified into one of 538 CMS-diagnosis-related groups (DRGs). In FY 2008, CMS replaced the 538 DRGs with 745 Medicare-severity DRGs (MS-DRGs) that provide higher payment for more severely ill or injured patients and lower payment for all other cases. Since FY 2008, CMS has modified these MS-DRGs through notice and comment rulemaking. For FY 2012, Medicare is proposing additional MS-DRGs which would bring the total to 751.

The LTCH PPS was implemented in FY 2003. Medicare payments under the LTCH PPS utilize the same DRG system as the IPPS, but payment weights associated with the LTCH patient classifications are calculated based on treatment costs at LTCHs. In conjunction with the IPPS, in FY 2008, the LTCH PPS adopted Medicare severity Long-Term Care DRGs (MS-LTC-DRGs).

PROPOSALS AFFECTING ACUTE CARE HOSPITALS

Proposals To Continue Implementing The Affordable Care Act:

- Proposals for hospital quality initiatives – The proposed rule addresses a number of proposals to improve the quality of care furnished by hospital. Specifically, CMS is proposing certain policies related to the Hospital Readmissions Reduction Program and the Hospital Value-Based Purchasing (HVBP) Program. More information about these proposals is included in a separate fact sheet on hospital quality initiatives also issued today.

- Payments for geographic variation (Section 1109 of the Affordable Care Act) - Section 1109 of the Affordable Care Act provides for additional payments for FY 2011 and 2012 totaling $400 million for qualifying hospitals that are in located in counties that rank within the lowest quartile of counties in the United States for spending per enrollee for benefits under Medicare part A and part B. In the FY 2011 IPPS Final Rule, CMS finalized a policy to distribute $150 million to qualifying hospitals for FY 2011 and $250 million for FY 2012 through an annual one-time payment made by the Medicare contractor. CMS is proposing to distribute the remaining $250 million under this provision to qualifying hospitals. The list of qualifying hospitals and their share of these payments can be found on the CMS website.

- Low-volume hospital payment adjustment (Section 3125 as amended by Section 10314 of the Affordable Care Act) - Sections 3125 and 10314 of the Affordable Care Act amended the low-volume hospital payment adjustment by allowing hospitals, for FYs 2011 and 2012, to qualify for the adjustment if they are located more than 15 (rather than 25) miles from another hospital and have less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Medicare part A (as opposed to 800 total discharges) in the fiscal year. In the FY 2011 IPPS Rule, CMS used FY 2009 MedPAR data (the most current data then available) to determine the FY 2011 low-volume payment adjustment. CMS is proposing to base the FY 2012 low-volume payment adjustment on FY 2010 MedPAR data, the most recent data currently available.

Issues Relating To The Hospital Wage Index:

- Imputed Floor: Under the Balanced Budget Act of 1997, the wage index for a hospital in an urban area of a state cannot be less than the area wage index determined for the state's rural area. This policy is budget neutral and the Affordable Care Act, established that CMS would determine budget neutrality on a national basis—redistributing payments from rural hospitals and urban hospitals that don't receive the rural floor to hospitals that do receive the rural floor. In FY 2005, CMS adopted an "imputed" floor policy establishing for three years a wage index floor for those states that did not have rural hospitals and later extended the "imputed" floor through FY 2011. CMS is not proposing to extend the imputed floor. In accordance with CMS regulations, it will sunset at the end of FY 2011 (Sept. 30, 2011).

- Restoring to the Standardized Amount Prior Rural Floor Budget Neutrality Adjustments. CMS is proposing to apply a +1.1 percent adjustment to IPPS rates in recognition of a decision in the case, Cape Cod Hospital vs. Sebelius. The case involved how budget

neutrality was calculated for the rural floor, and on Jan. 14, 2011, the D.C. Circuit Court ruled against the Secretary.

- Pension Costs for Medicare Wage Index – As a result of amendments made by the Pension Protection Act of 2006 to the Employee Retirement and Income Security Act (ERISA) of 1974, CMS is proposing to revise how hospitals report pension contributions for the purpose of the Medicare wage index. CMS is proposing to use a rolling three-year average of the annual funds that the hospital contributed to its pension plan in determining the Medicare wage index. The three-year average controls for potential large annual fluctuations in a hospital's allowable pension cost. In a related proposal described below, CMS is also proposing to change its policy for reporting the maximum annual allowable pension costs on Medicare cost reports for purposes of cost finding.

Proposed Changes To MS-DRG Classifications: CMS is proposing the following four changes to the MS-DRG classifications:

- Excisional debridement - The current classification of excisional debridement as an operating room procedure results in a classification of these stays to a surgical MS-DRG. However, CMS believes these cases use significantly fewer resources than other surgical cases in their MS-DRG assignment, resulting in payment approximately 40 percent in excess of costs. CMS is therefore proposing to remove these cases from their current MS-DRG and assign them to three new MS-DRGs that would still be classified as operating room procedures but would provide for more accurate, and lower, payment.

- Autologous bone marrow transplant – Autologous bone marrow transplants are currently assigned to MS-DRG 015, with no severity adjustment. CMS is proposing to create two new MS-DRGs, one for autologous bone marrow transplants with complications or comorbidities (CC), and one for these transplants in the absence of any CC.

- Rechargeable dual array deep brain stimulation system – CMS is proposing to move the codes for rechargeable dual array deep brain stimulation to MS-DRGs 023 – 024 (Craniotomy with Major device implant/acute complex CNS PDX). Similar devices are already in this set of MS-DRGs.

- Thoracic aneurysm repair – CMS is proposing to move two codes that either repair a thoracic aneurysm or place a stent from MS-DRG 237 – 238 (Major cardiovascular procedures with major CC (MCC) or thoracic aortic aneurysm repair and without MCC

to the higher paying MS-DRGs 219 – 221 (Cardiac valve and other major cardiothoracic procedure without cardiac catheterization with MCC or CC, and without CC).

Applications For New Technology Add-On Payments For 2012: To remove barriers to access for costly new technologies that are not yet fully reflected in the current MS-DRG payment rates, the Medicare law provides for temporary add-on payments for inpatient stays that involve the use of certain approved new technologies. Applicants for new technology add-on payments must meet three general criteria in order to receive these add-on payments:

1. The technology must be new (less than 2-3 years old), typically based on its Food and Drug Administration (FDA) approval or clearance date
2. The technology must be high cost relative to other cases in the relevant MS-DRG(s); and
3. The technology must offer substantial clinical improvement over what is currently available for the Medicare patient population.

While CMS will accept new technology applications that have not yet received FDA approval or clearance, all applicants must receive FDA approval or clearance by July 1, 2011 in order to be considered "new."

For FY 2012, CMS has received applications for add-on payments for the following three technologies:

- Implantable Hemodynamic Monitor System (IHMS) (CardioMEMS, Inc) - The IHMS is comprised of an implantable sensor/monitor placed in the distal pulmonary artery that measures multiple pulmonary artery pressure parameters and transmits this data to a secure website.

- AxiaLIF 2-Level System (TranS1®, Inc) - AxiaLIF 2-Level System (AxiaLIF 2L+) is an implantable spinal fixation system that facilitates the spinal fusion of the anterior S1 and L4 lumbars of the spine ("anterior fusion") using a pre-sacral approach that provides access to the lumbar through a small incision rather than open surgery.

- PerfectCLEAN with Micrillon (UMF Corporation) - PerfectCLEAN with Micrillon (PerfectCLEAN) is a cleaning textile product (or cleaning mat/wipe) with chlorine bound to the surface of the fiber that the applicant states is capable of trapping, removing, and killing or inactivating more than 99.99% of bacteria on hard surfaces.

Other Technical Proposals Included In The IPPS Proposed Rule:

- Payment for Hospital Acquired Conditions – In the FY 2012 proposed rule, CMS is proposing to add one category of conditions to the list of hospital-acquired conditions (HACs) in FY 2012 for purposes of the HACs payment policy. This policy prevents hospitals from being paid at an enhanced rate for treating a beneficiary if the sole reason for the higher payment is the occurrence, during the beneficiary's hospital stay, of one of conditions on the HACs list. The proposed HAC is Acute Renal Failure after Contrast Administration (also known as contrast-induced acute kidney injury, or CI-AKI0), which is an abrupt deterioration in renal function that can be associated with the use of iodinated contrast medium. More information about these proposals is included in a separate fact sheet on hospital quality initiatives also issued today.

- Three Day/One Day Payment Window - The FY 2011 IPPS final rule contained an interim final rule with comment wherein CMS clarified that the 3-Day/1-Day Payment Window policy, which requires hospitals to include charges for certain outpatient services and admission-related non-diagnostic services furnished within three days (or one day for non subsection (d) hospitals) prior to an inpatient admission into the claim for the inpatient stay. In the IPPS FY 2012 NPRM, CMS explains that the agency has received comments on the interim final rule with comment and will respond to those comments, as well as any comments received on the additional proposals related to the 3-day/1-day payment window contained in the IPPS FY 2012 NPRM, in the IPPS FY 2012 final rule. This IPPS FY 2012 NPRM proposes to clarify that the 3-day/1-day payment window applies to both preadmission diagnostic and non-diagnostic services furnished to a patient at physician's practices that are wholly owned or wholly operated by the admitting hospital, and to address the payment window policy as it impacts physician billing in the FY 2012 Medicare physician fee schedule proposed rule.

- Clarification of Add-on Payment to Hospitals Treating Patients with End-Stage Renal Disease - Medicare regulations provide for an add-on payment to IPPS hospitals that provide inpatient dialysis treatment to a high proportion of beneficiaries with end-stage renal disease (ESRD) whose stays do not fall under certain MS-DRGs that account for the high cost of dialysis. CMS is proposing to clarify that discharges of all patients entitled to Medicare Part A, including Medicare Advantage patients, should be included in determining whether the hospital qualifies for the add-on payment.

- Excluding Hospice Discharges from the Disproportionate Share Hospital Adjustment and Indirect Medical Education (IME) Adjustment – Medicare beneficiaries who elect to receive hospice care, can receive inpatient hospice care in a hospital under certain circumstances, such as hospitalization for pain control and symptom management and

respite care needed to provide temporary relief to family members or other caretakers. CMS is proposing to exclude from the Medicare DSH adjustment patient days and bed days for inpatient hospice services because these patients are not receiving acute care services generally payable under the IPPS, but rather are receiving a hospice benefit. For the same reasons, CMS is proposing to exclude such bed days from the calculation of available bed days for the indirect medical education adjustment.

- Clarifying "Under Arrangements" Requirements – The Medicare law permits hospitals to provide certain diagnostic or therapeutic services to inpatient under arrangements with an outside entity. In these cases, the hospital bills Medicare for the stay under the IPPS, and pays the outside entity for its services out of the hospital's Part A payment. CMS is proposing that hospitals may not furnish "routine services", such as room and board and nursing services, at a separate location under arrangements with another entity. Under the proposal, if routine services are provided in the hospital to its inpatient, those services would be considered as being provided by the hospital. However, if these services are provided outside the hospital, the services would be considered as being provided under arrangement, and not by the hospital. Only therapeutic and diagnostic services could be provided under arrangement.

- Clarifying Payment Policy for Replacement of Recalled Devices – CMS reduces payment under both the IPPS and the Outpatient Prospective Payment System (OPPS) for replacing an implanted device that has been recalled if the hospital receives a credit from the device manufacturer of 50 percent or more of the device cost. CMS is proposing to clarify that, as in the OPPS "partial credit" policy, the relevant device cost is the cost of the replacement device, not the cost of the original device.

- Modifying Payment Policy for Ambulances Operated by Critical Access Hospitals – CMS is proposing to modify its regulations that allow payment for ambulance services furnished by a CAH or by an entity owned and operated by the CAH based on 101 percent of reasonable costs rather than the ambulance fee schedule to conform with language in the Medicare law and also to make provision of reasonable cost payment to an entity owned and operated by a CAH that is further than 35 miles from the CAH, if it is the closest provider or supplier of ambulance services to the CAH.

- Pension Costs for Medicare Cost Finding – As indicated previously, CMS is proposing revisions to our rules for determining pension costs for Medicare cost-finding and wage index purposes. With respect to Medicare cost-finding, CMS is proposing to allow the hospital to report on its cost report what the hospital contributed to its pension fund for that year with a cap of 150 percent of the highest average contributions during three consecutive cost reporting periods within the five most recent cost reporting periods.

- CMS is also proposing to allow hospitals with contributions in excess of the proposed limit to submit documentation demonstrating that all or a portion of the "excess" costs are reasonable and necessary for a particular cost reporting period. In addition, CMS is also proposing that current period contributions in excess of the limit that are not considered reasonable for the current cost reporting period under the proposed review process would be carried forward and included in future period(s) as the applicable limit will allow.

- Inpatient Quality Reporting (IQR) Program – The proposed rule would add measures to be reported for purposes of the IQR (formerly called the Reporting Hospital Quality Data for Annual Payment Update or RHQDAPU) for the FY 2013 and FY 2014 updates. More information about these proposals is included in a separate fact sheet on hospital quality initiatives also issued today.

PROPOSALS AFFECTING LONG-TERM CARE HOSPITALS

New quality reporting program for LTCHs: CMS is proposing to implement a new quality reporting program for LTCHs in FY2012, as required by the Affordable Care Act. More information about this proposal is included in the fact sheet on hospital quality initiatives.

Clarifying Average Length Of Stay Requirements: LTCHs are defined generally as hospitals that have an average length of stay (ALOS) greater than 25 days. CMS is proposing to clarify two existing policies related to the calculation of ALOS. First, the agency is proposing to clarify that both traditional Medicare fee-for-service program stays and beneficiary days paid for under Medicare Advantage are included in the determination of whether an LTCH meets the greater than 25 days ALOS requirement. Second, in cases involving a change of ownership of an LTCH, CMS is also proposing to clarify CMS policy regarding the evaluation of whether an LTCH (either an LTCH under-formation or an existing LTCH) meets the greater than 25 days ALOS requirement when an LTCH changes ownership.

Proposed extension of the moratorium on growth in bed numbers to LTCHs developed under exceptions to the moratorium enactment under the MMSEA. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) imposed a moratorium on the establishment or classification of new LTCHs and LTCH satellite facilities and on increasing the number of beds in existing LTCHs subject to specific exceptions. The Affordable Care Act extended both moratoria an additional two-year period. CMS is proposing to extend the application of the moratorium on bed increases to those LTCHs and LTCH satellite facilities, newly established under the applicable MMSEA moratorium exceptions, to be consistent with the application of the moratorium on bed increases that applies to existing LTCHs and LTCH satellite facilities.

The proposed rule can be downloaded from the *Federal Register* at:

www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

CMS will accept comments on the proposed rule until June 20, 2011, and will respond to them in a final rule to be issued by Aug. 1, 2011.

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