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IN THIS ISSUE

Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

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CMS Adopts IPPS and LTCH Payment Rates and Policies to Foster Quality-Based Improvements in Inpatient Care

By: John S. Linehan

On August 1, 2011, the Centers for Medicare & Medicaid Services (CMS) released a final rule updating Medicare payment policies and rates for general acute care hospitals and long-term care hospitals (LTCHs) for inpatient stays in fiscal year (FY) 2012. The rule is published in the August 18, 2011 Federal Register [PDF]. The rule also implements and builds upon certain statutory mandates set forth in the Affordable Care Act (ACA). Among other things, the rule establishes the Hospital Readmissions Reduction Program, broadens both the Hospital Inpatient Quality Reporting (IQR) Program and the Hospital Value-Based Purchasing (VBP) Program, and erects the framework for a new quality reporting program for LTCHs. The new regulations, which govern approximately 3,400 acute care hospitals and 420 LTCHs, will apply to discharges occurring on or after October 1, 2011, unless otherwise specified in the rule.

Payment Rate Updates

The payment rate updates concern acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), as well as hospitals paid under the Long Term Care Hospital Prospective Payment System (LTCH PPS).

According to CMS projections, Medicare operating payments to acute care hospitals for inpatient services will increase by $1.13 billion, or 1.1 percent, in FY 2012 over the previous year, due to a 1.0 percent increase in payment rates. Medicare payments to LTCHs will increase by $126 million, or 2.5 percent in FY 2012, based upon a 1.8 percent increase in payment rates. These numbers serve as welcome news for hospitals, who had previously expected lower payment amounts for general acute care hospitals (0.55 percent reduction) and LTCHs (1.9 percent increase). CMS departed from these earlier measures cited in the

proposed rule after receiving strong disapproval from hospital industry commentators, who foresee lower aggregate payments over the next decade as a result of health care reform. Addressing the upward adjustments, Jonathan Blum, the Deputy Administrator and Director for the Center for Medicare, explained that the "final policy strikes the appropriate balance between providing for a fair update to hospitals and ensuring careful stewardship of the Medicare Trust Fund."

Hospital Readmissions Reduction Program

In accordance with Section 3025 of the ACA, CMS finalized a Hospital Readmissions Reduction Program to encourage hospitals to reduce preventable readmissions and improve care coordination. Under this program, certain hospitals deemed to have excess readmissions for selected conditions will have their payments reduced beginning in FY 2013 for discharges on or after October 1, 2012. The final rule prescribes readmission measures and the methodology used to calculate excess readmission rates for three conditions: acute myocardial infarction, heart failure, and pneumonia. A "readmission" will be defined as occurring when a patient is discharged from an acute care hospital and is then readmitted to the same hospital or another acute care hospital within 30 days of the original discharge. Hospitals are charged with reporting the readmission information on the Hospital Compare website.

Changes to the Hospital Inpatient Quality Reporting (IQR) Program and the Hospital Value-Based Purchasing (VBP) Program

The final rule makes important changes in two related hospital programs involving inpatient quality reporting and value-based purchasing that are designed to reform Medicare by sharpening emphasis upon the quality — and not just the quantity — of health care services.

Established in 2004, Hospital Inpatient Quality Reporting (IQR) Program permits CMS to collect quality and patient experience data from acute care hospitals. Information is gathered on measures that relate to fundamental HHS priorities, including the achievement of reductions in preventable health care associated infections (HAIs), hospital-acquired conditions (HACs), and unnecessary

readmissions. The quality of care information is provided to consumers to facilitate informed health care decision-making and to encourage hospitals to make proactive improvements in inpatient care. Due to significant financial incentives, the vast majority of hospitals currently participate in the program.

The Hospital Value-Based Purchasing (VBP) Program — mandated by Section 3001 of the ACA and adopted by final rule published on April 29, 2011—authorizes value-based incentive payments to hospitals based upon their achievement and improvement on certain performance measures. With incentive payments scheduled for hospital discharges occurring after October 1, 2012, the Hospital VBP Program is modeled around the Hospital IQR Program's reporting infrastructure and incorporates selected IQR measures. CMS intends for the two programs to operate in tandem and is focused on aligning their reporting requirements to reduce hospitals' administrative burdens.

The final rule amends both programs by implementing the following reforms:

- The final rule introduces the "Medicare spending per beneficiary measure" that will be used in both the Hospital IQR and the Hospital VBP programs. The new measure, which will control payment determinations for FY 2014, will assess Part A and Part B beneficiary spending during a "Medicare spending per beneficiary episode" that spans from three days prior to a hospital admission through 30 days after patient discharge. The measure will reinforce the ultimate shared goal of the two programs — to encourage hospitals to uniformly improve the provision of care to Medicare beneficiaries in a more cost-efficient manner.
- For the Hospital IQR Program's FY 2014 measure set, CMS added one hospital acquired infection (HAI) measure and one structural measure. Also for FY 2014, CMS finalized the retirement of the antibiotics measure and three topped-out measures, and the suspension of data collection on four additional measures. For the program's FY 2015 measure set, CMS added three HAI measures as well as a Stroke measure and a Venous

Thromboembolism measure. In sum, the Hospital IQR Program's repertoire is increased to 76 measures for the FY 2015 payment determination. In addition, the final rule streamlines the IQR reporting process, making it less burdensome and more transparent for hospitals

LTCH Quality Reporting Program

Section 3004 of the ACA requires CMS to establish a new quality reporting program applicable to hospitals paid under the LTCH PPS. The final rule shapes the general structure of the LTCH Quality Reporting Program and authorizes CMS to begin collecting data on the following patient-safety quality measures in October 2012: (1) catheter-associated urinary tract infection; (2) central line catheter-associated bloodstream infections; and (3) new or worsening pressure ulcers. Beginning in FY 2014, CMS will apply a 2 percent payment penalty to LTCHs that fail to successfully report quality data to the Secretary.

Ober|Kaler's Comments

Although it offers a mixed assortment of reforms, the final rule was ultimately designed to ensure accurate reimbursement for inpatient services and to reinforce a "payment approach" aimed at incentivizing hospitals to reduce preventable errors in order to improve patient outcomes and mitigate long-term costs. According to CMS Administrator Donald M. Berwick, M.D., "this approach is part of a comprehensive strategy being implemented across Medicare's payment systems that is intended to reduce overall costs by improving how care is delivered." Because many of the programs and procedures set forth in the rule will continue to be implemented on a graduated basis, providers should remain cognizant of periodic updates and modifications. In the meantime, CMS welcomes comments as part of the deliberative rulemaking process.