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CMS Releases Proposed FFY 2013 IPPS Rule

By: Mark A. Stanley

CMS has released its proposed federal fiscal year (FFY) 2013 prospective payment system (PPS) rule for inpatient stays in acute care and long-term care hospitals (LTCHs). The rule projects an increase in operating payments to acute care hospitals in the amount of $175 million dollars for FFY 2013 in comparison with FFY 2012 payments. The proposed rule can be viewed here [PDF].

The proposed rule would:

- Establish the Hospital Readmissions Reduction Program, as required by Section 3025 of the Affordable Care Act (ACA). The program would reduce payments (effective for discharges on or after October 1, 2012) to hospitals with an "excess readmission ratio." The term "excess readmission ratio" is a hospital-specific concept, which is based on CMS's projected readmission rates for a given hospital. The proposed rule would utilize three 30-day readmission measures – Acute Myocardial Infarction, Heart Failure, and Pneumonia – and compare each hospital's readmission ratio for those measures with the national average. Hospitals with an excessive rate of readmissions would have all Medicare payments reduced by a maximum of 1%. CMS proposes to use a minimum of three years' data to determine a provider's readmission ratio. In order to establish the readmission ratio for the current fiscal year, CMS will look back to a prior three year period, so a hospital with excess readmissions during the three year period of July 1, 2008 to June 30, 2011 would see adjustments to its FFY 2012 payments.
- Include labor and delivery beds in a provider's available bed count for purposes of calculating the disproportionate share hospital (DSH) and indirect graduate medical education adjustments.
- Postpone the limitations that were announced in the FFY 2012 IPPS Final Rule on circumstances under which a hospital may perform services "under

arrangement." The policy would now be effective for hospital cost reports beginning on or after October 1, 2013.

- Modify several provisions related to graduate medical education (GME) reimbursement. The rule would extend the timeframes for new programs to establish their full time equivalent (FTE) caps from 3 years to 5 years. The rule would also implement policies regarding the redistribution of FTE caps established under Section 5503 of the ACA.
- Apply the timely filing rules for claims submission to no-pay bills that providers submit for services furnished to Medicare managed care beneficiaries. The proposed rule states that the application of the timely filing rules is a "clarification" of existing policy. The rules affect payment for medical education and the DSH adjustment.
- End payment under the Medicare Dependent Hospitals (MDH) program, which expires at the end of FFY 2012. MDH payment will be based on the Federal rate under the IPPS beginning with FFY 2013.
- Apply the pre-ACA methodology to determine whether a hospital qualifies for the low-volume payment adjustment. Under the ACA methodology, hospitals qualify for the adjustment if they are more than 15 road miles from other IPPS hospitals and have fewer than 1600 Medicare discharges. Adjustments are calculated on a sliding scale based on the number of discharges, with a larger adjustment given to hospitals with fewer discharges. The rule would revert to the pre-ACA methodology, which limits the adjustment to hospitals that are more than 25 road miles from other IPPS hospitals and that have 200 or fewer total discharges (including non-Medicare discharges). The proposed rule would therefore significantly restrict the applicability of the adjustment.
- Establish the measures that would be used for quality reporting by long-term care hospitals (LTCHs) for FFYs 2015 and 2016. LTCHs that do not successfully participate in quality reporting would see payment reductions beginning in FFY 2014.
- Phase out several payment moratoria applicable to LTCHs that were established or extended by the ACA. Notably, CMS is proposing a one time 3.75% reduction of the standard Federal rate, to be phased in over three years. The reduction for FFY 2013 would be approximately 1.3%.

- Adopt a stand-alone market basket for LTCHs, based exclusively on data submitted by LTCHs.
- Implement a per-beneficiary spending measure under the Hospital Value-Based Purchasing Program (VBP). The measure would track all spending under Part A and Part B for a beneficiary, beginning 3 days prior to an inpatient admission and ending 30 days after discharge. The measure would be risk-adjusted based on a beneficiary's age and severity of illness.
- Establish outcome measures under the VBP Program to reward hospitals that avoid certain blood infections during inpatient hospital stays.
- Add measures to the hospital inpatient quality reporting program based on perinatal care and readmissions.
- Establish quality measure reporting programs for psychiatric hospitals and PPS-exempt cancer hospitals.
- Complete the documentation and coding adjustments for FFYs 2008 and 2009 as required by the TMA, Abstinence Education, and QI Programs Extension Act of 2007. The adjustment recaptured an estimated $6.9 billion increase in payments for FFYs 2008 and 2009 due to documentation and coding changes. For FFY 2013, providers will actually see a 0.2% net increase in payments, in sharp contrast to two successive years of adjustments. The increase results from CMS's restoration (beginning in FFY 2013) of the 2.9% recoupment adjustment that was applied to hospitals in each of FFY 2011 and FFY 2012.

Comments to the proposed rule must be received by CMS no later than 5:00 PM EDT on June 25, 2012.