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CMS Publishes Proposed Policy and 2012 Payment Changes for Stays in Hospitals and Affordable Care Act Quality of Care Provisions

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On April 19, 2011, the Centers for Medicare & Medicaid Services (CMS) posted proposed updates to the Inpatient and Long-term Care Hospital Prospective Payment Systems for fiscal year 2012 (FY 2012). The proposed rule continues to implement various provisions of the Affordable Care Act (ACA), including Hospital Readmission Penalty programs and updates to the Value-based Purchasing program. CMS will consider comments received by June 20, 2011, and will respond to them in a final rule to be issued by August 1, 2011.

This white paper summarizes key provisions of the proposed rule. Hospitals are encouraged to review the entire rule, and to evaluate the impact of all of the proposed changes. The proposed rule will appear in the May 5, 2011, Federal Register and on the CMS website, www.cms.gov.

MS-DRG Documentation and Coding Adjustment

CMS proposes for FY 2012 a prospective reduction of 3.15 percent to the standardized amount to partially adjust for increases in the case mix index arising from the transition to Medicare Severity Diagnosis Related Groups (MS-DRGs). CMS acknowledges that Medicare statute requires an additional 0.75 percent reduction, but CMS does not propose a timeline for future implementation of this additional adjustment. In addition to the proposed 3.15 percent reduction, CMS proposes to maintain the 2.9 percent reduction finalized for FY 2011 to recoup overpayments made in FYs 2008 and 2009 as a result of documentation and coding improvements. CMS expects to remove this 2.9 percent recoupment adjustment beginning in FY 2013.

CMS also proposes a prospective reduction of 2.5 percent to hospital-specific rates used to determine payments to hospitals with Sole Community Hospital (SCH) and Medicare-dependent Hospital (MDH) status. Hospital-specific payments were reduced by 2.9 percent beginning in FY 2011. The cumulative effect of these two adjustments, beginning in FY 2012, would be a 5.4 percent reduction in hospital-specific payment rates.

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.

Hospital-Acquired Conditions (HACs)

For FY 2012, CMS proposes establishing a new HAC category: Contrast-Induced Acute Kidney Injury. Under the agency's proposal, hospital acquired contrast-induced acute kidney injuries would be identified on claims by ICD-9-CM diagnosis code 584.9 ("Acute kidney failure, unspecified"), plus one or more of the identified associated procedure codes (ICD-9-PCS codes 87.71 through 87.75 and ICD-9-PCS codes 88.40 through 88.67). 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 2009 discharges indicate an incidence of 38,324 for contrast-induced acute kidney injury. The incremental costs for these injuries are estimated at $2,654 per day.

CMS proposes adding five new ICD-9-CM diagnosis codes to existing HAC areas. The table that follows indicates the proposed additions.

HAC Category	ICD-9-CM Code	Code Descriptor
Deep Vein Thrombosis and Pulmonary Embolism (DVT/PE) Following Certain Orthopedic Procedures	415.13	Saddle embolus of pulmonary artery
Falls and Trauma	808.44	Multiple closed pelvic fractures without disruption of pelvic circle
Falls and Trauma	808.54	Multiple open pelvic fractures without disruption of pelvic circle
Surgical Site Infection (SSI) Following Certain Bariatric Procedures	539.01	Infection due to gastric band procedure
Surgical Site Infection (SSI) Following Certain Bariatric Procedures	539.81	Infection due to other bariatric procedure

In addition, CMS proposes changing the title of the "Electric Shock" subcategory of the Falls and Trauma HAC to "Other Injuries" to better describe the ICD-9-CM diagnosis codes captured in the subcategory.

Wage Index

OCCUPATIONAL MIX ADJUSTMENT

For FY 2012, CMS proposes, consistent with the methodology in FY 2011 and FY 2010, to use occupation mix data collected on the 2007-2008 Medicare Wage Index Occupational Mix Survey. CMS also proposes to continue to utilize the same methodology for calculating the occupational mix adjustment.

CMS estimates that the national average hourly wage for the entire nurse category is $30.4425. Hospitals with a nurse average hourly wage below this national average will have an occupational adjustment greater than 1.0. Hospitals with a nurse average hourly wage above this national average will have an occupational adjustment less than 1.0.

CMS notes in the rule that the 2010 Medicare Wage Index Occupational Mix Survey that will be used to collect data for the FY 2013 wage index is available on the CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage and through Fiscal Intermediaries and Medicare Administrative Contractors (FIs/MACs). Effective with the introduction of the 2010 survey, hospitals that do not submit a completed survey by the July 1, 2011, deadline are required to provide an explanation as to why they are not complying. Based on findings, CMS maintains the right to alter the agency's approach in future years, including penalizing noncompliant hospitals.

PENSION COST REPORTING FOR THE HOSPITAL WAGE INDEX

Historically, CMS has required that defined benefit pension costs reported for the purpose of the wage index reflect actuarial accrued liability and normal cost. However, the Pension Protection Act (PPA) of 2006 amended the Employee Retirement Income Security Act (ERISA) of 1974 such that there is no longer a standard actuarial basis used by all plans for determining pension costs. To account for these changes and to ensure a consistent approach to reporting pension costs across all hospitals,

for FY 2012 CMS proposes using a three-year average of the hospital's actual cash contributions deposited to a hospital's defined benefit pension plan. CMS proposes to use, for the purpose of calculating three-year average contributions, data from the fiscal year on which the wage index is based as well as the prior and subsequent year. For example, in FY 2013 the wage index will be based on FY 2009 data. As such, under the proposed methodology, reported pension costs should reflect hospital contributions to the pension plan in FY 2008, FY 2009, and FY 2010. CMS is accepting comments related to this proposal.

OUT-MIGRATION ADJUSTMENT

In the FY 2012 proposed rule, CMS clarifies agency policy regarding waiver of a hospital's Lugar status in order for a hospital to receive an out-migration adjustment. Specifically, CMS proposes that a hospital that waives its Lugar status in order to receive an out-migration adjustment has waived its deemed urban status and is considered rural for all purposes under the Inpatient Prospective Payment System (IPPS). Previously, there was some confusion as to whether a hospital waiving Lugar status to accept an out-migration adjustment was waiving urban designation for all purposes, or just for purposes of the wage index. CMS also proposes that a hospital that waives its Lugar-deemed urban status agrees to be treated as rural for the duration of the three-year out-migration eligibility period, unless the hospital explicitly rejects the out-migration adjustment by notifying CMS in writing within 45 days from the publication of the proposed rule.

Hospitals that are reclassified that wish to receive their out-migration adjustment instead must terminate their reclassification. If they do not terminate their reclassification, they will be deemed as waiving their out-migration adjustment.

IMPUTED RURAL FLOOR

Beginning in FY 2005, and in each subsequent year, CMS imputed a rural wage index floor for states that did not have rural areas or hospitals located in rural areas. Historically, three states – New Jersey, Rhode Island and Massachusetts – were impacted by this policy. The original policy was to endure for three years, but CMS twice extended it. The current extension is set to expire at the end of FY 2011. CMS has not proposed extending the policy for FY 2012, but is seeking comments on whether to do so.Hospitals that are reclassified that wish to receive their out-migration adjustment instead must terminate their reclassification. If they do not terminate their reclassification, they will be deemed as waiving their out-migration adjustment.

CMS Clarification of the Three-Day/One-Day IPPS Payment Window

In the FY 2011 IPPS rule, CMS clarified the three-day payment window policy (one day for hospitals exempt from the IPPS), which requires hospitals to include, in the claim for an inpatient stay, charges for certain outpatient services and admission-related non-diagnostic services furnished within three days prior to an inpatient admission. CMS now proposes to further clarify that the three-day payment window applies to both preadmission diagnostic and non-diagnostic services furnished to a patient at a physician practice that is wholly owned or operated by the admitting hospital. CMS is seeking comments on this additional proposal.

Graduate Medical Education

INDIRECT MEDICAL EDUCATION ADJUSTMENT FACTOR

Hospitals with approved graduate medical education programs receive an additional indirect medical education (IME) payment to reflect the higher patient-care costs of teaching hospitals relative to nonteaching hospitals. For discharges occurring in FY 2012, CMS proposes that the formula multiplier would be 1.35. CMS estimates that application of this formula multiplier for the FY 2012 IME adjustment will result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

EXCLUSION OF HOSPICE BED DAYS FROM IME ADJUSTMENT

CMS also proposes to remove hospice stays from the IME calculation. Medicare beneficiaries who receive hospice care can receive inpatient hospice care in a hospital for pain control, symptom management, and respite care needed to provide temporary relief to family or other care givers. Because these patients are not receiving acute care services generally payable under IPPS, but rather are receiving a hospice benefit, CMS proposes to exclude bed days associated with hospice patients receiving inpatient hospice services in an inpatient hospital setting from the calculation of available bed days for the IME adjustment. CMS proposes to amend its cost reporting instructions accordingly. CMS states that the exclusion of bed days associated with hospice patients from the available bed count for IME would reduce the available beds, increase the resident-to-bed ratio, and consequently, may increase IME payments to teaching hospitals, depending on the extent to which these hospitals were providing inpatient hospice services to hospice patients.

Restriction of "Under Arrangement" Hospital Payment to Only Therapeutic and Diagnostic Services and not Routine Services

Medicare permits hospitals to provide certain diagnostic or therapeutic services to hospital inpatients "under arrangements" with an outside entity. In cases where the diagnostic or therapeutic services are provided under these outside arrangements, the hospital may bill Medicare for the stay under IPPS, and pay the outside provider for its services from the hospital's Part a Medicare payment. CMS is proposing that hospitals may not furnish "routine services" – e.g., room, board and nursing services – through another entity. If those services are provided in the hospital to its hospital inpatients, those services would be considered as being provided by the hospital. Under the proposal, however, if these routine services were provided outside the hospital, the services would be considered as being provided "under arrangement," and not by the hospital.

Hospital Inpatient Quality Reporting (IQR) Program

CMS does not recommend any changes to the Hospital IQR program for FYs 2012 and 2013, but does proposes several changes that would be effective in FYs 2014 and 2015.

FY 2014

Beginning with FY 2014, CMS proposes to add four measures and retire eight.

Proposed Retired Measures

Seven of the eight measures CMS proposes to retire are considered "topped out" – performance is uniformly high nationwide, with little variability among hospitals.

- AMI-1 Aspirin at arrival
- AMI-3 ACEI/ARB for left ventricular systolic dysfunction
- AMI-4 Adult smoking cessation advice/counseling
- AMI-5 Beta-blocker prescribed at discharge
- HF-4 Adult smoking cessation advice/counseling
- PN-4 Adult smoking cessation advice/counseling
- SCIP INF-6 Appropriate Hair Removal

CMS proposes to retire an eighth measure that addresses timing of receipt of initial antibiotic following hospital arrival for pneumonia patients, because the agency believes it may result in inappropriate antibiotic use.

- PN-5c Timing of receipt of initial antibiotic following hospital arrival

Proposed New Measures

In total, CMS proposes to add four measures to the FY 2014 Hospital IQR program: two healthcare-associated infection (HAI) measures, one claims-based measure, and one web-based structural measure.

- Central Line Insertion Practices (CLIP) Percentage (HAI)
- Catheter Associated Urinary Tract Infection (CAUTI) (HAI)
- Medicare Spending per Beneficiary (claims-based measure)
- Participation in a Systematic Clinical Database Registry for General Surgery (structural measure)

A detailed discussion of each measure, including measure specifications and reporting periods, can be found in the proposed rule.

Medicare Spending Per Beneficiary Measure

With respect to the claims-based measure noted above, Medicare Spending per Beneficiary, CMS also proposes a method to calculate this new cost-efficiency measure. To calculate spending per beneficiary, CMS proposes to evaluate Medicare Part a and Part B spending for a beneficiary episode.

- **Beneficiary episode** – CMS proposes to define a beneficiary episode as three days prior to an inpatient hospital admission (the index admission) through 90 days post hospital discharge. CMS considered but did not propose a 30-day post discharge timeframe.

- **Medicare payments included** – CMS proposes to include all Medicare Part a and B payments made for services provided to the beneficiary during the episode when calculating spending. The proposed payments would exclude episodes where at any time during the episode the beneficiary is not enrolled in both Medicare Part a and B. Also excluded will be episodes where the beneficiary expires, enrolls in Medicare Advantage, is covered by the Railroad Retirement Board, or where Medicare is a secondary payer.

- **Adjustments to Medicare payments** – CMS proposes to adjust the Medicare spending per beneficiary measure for age and severity of illness. Adjustment for severity of illness would be based on the hierarchical condition categories (HCCs) for the period 90 days prior to the episode and based on the MS-DRG during the index admission. Patients not enrolled in Medicare for the 90 days prior to the episode would be excluded as episodes. Payments would also be adjusted to exclude geographic payment rate differences as well as the differential spending that results from hospital-specific payments, disproportionate share payment adjustments and indirect medical education payments.

- **Calculation** – CMS proposes to calculate the hospital's Medicare spending per beneficiary episode by aggregating adjusted Medicare Part a and B payments and dividing by the total number of beneficiary episodes for that hospital. For inclusion in the FY 2015 Hospital Inpatient VBP program, CMS proposes to calculate a hospital's Medicare spending per beneficiary episode ratio as the hospital's Medicare spending per beneficiary episode amount divided by the median Medicare spending per beneficiary episode amount across all hospitals.

- **Data** – CMS proposes that the measure will be calculated using claims data for discharges occurring between May 15, 2012, and February 14, 2013.

FY 2015

CMS proposes to add 17 new measures beginning in FY 2015.

Proposed New Measures

Of the 17 new measures, three are healthcare-associated infection (HAI) measures and 14 are chart-abstracted measures from the stroke and VTE measure sets.

- Methicillin-resistant staphylococcus aureus (MRSA) bactremia

- Clostridium difficile (c. difficile)
- Healthcare personnel influenza vaccination
- STK-1 Venous thromboembolism (VTE) prophylaxis for patients with ischemic or hemorrhagic stroke
- STK-2 Ischemic stroke patients discharged on antithrombotic therapy
- STK-3 Anticoagulation therapy for atrial fibrillation/flutter
- STK-4 Thrombolytic therapy for acute ischemic stroke patients
- STK-5 Antithrombotic therapy by the end of hospital day two
- STK-6 Discharge on statin medication
- STK-8 Stroke education
- STK-10 Assessed for rehabilitation services
- VTE-1 Venous thromboembolism prophylaxis
- VTE-2 Intensive care unit venous thromboembolism prophylaxis
- VTE-3 Venous thromboembolism patients with anticoagulation overlap therapy
- VTE-4 Venous thromboembolism patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol
- VTE-5 Venous thromboembolism discharge instructions
- VTE-6 Incidence of potentially preventable venous thromboembolism

MEASURES BEYOND FY 2015

CMS proposes 68 specific measures for consideration for future years of the Hospital IQR program, including a measure of average length of stay and 30-day readmission measures for patients with chronic obstructive pulmonary diseases and patients undergoing coronary artery bypass graft (CABG). a complete list of the measures proposed for future consideration can be found in the proposed rule. CMS requests comments on these proposed measures, as well as suggestions for additional measures.

FORM, MANNER, AND TIMING OF IQR REPORTING

For FY 2012, CMS proposes significant changes to hospital reporting for participation in the Hospital IQR program. For example, CMS would reduce from four months to three months following the last discharge date in the calendar quarter the aggregate population and sampling deadline. CMS would also advance by one week the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data submission deadline. Additional deadline changes are also proposed.

Additionally, CMS is proposing changes to the methods in which data for certain Hospital IQR program measures are reported. For example, CMS proposes that hospitals submit data for healthcare-associated infection measures via the Centers for Disease Control's National Health Safety Network beginning with the FY 2014 Hospital IQR program.

CMS also proposes chart validation requirements for chart-abstracted measures. The agency's validation proposals increase the number of medical records that must be abstracted to validate hospital performance on these measures.

ELECTRONIC HEALTH RECORD (EHR)

The Hospital IQR program and the EHR Incentive program include overlapping measures. To the extent that the Health Information Technology for Economic and Clinical Health (HITECH) Act requires CMS to reduce redundancy across programs, CMS is considering options to eliminate this overlap. Specifically, the agency is seeking comments on selecting a date, such as calendar year (CY) 2015, after which chart-abstracted data would be required to be reported via EHR-based reporting only. CMS seeks comments on this proposal.

Hospital Value-Based Purchasing (VBP) Program

For the FY 2014 Hospital Inpatient VBP program, CMS proposes to adopt the Medicare Spending per Beneficiary (see above) that is proposed as a Hospital IQR program measure for FY 2013. Scoring of this measure would follow the scoring proposed for

the process of care measures proposed in CMS's January 7, 2011, Hospital VBP program proposed rule. a hospital would receive both an achievement score and an improvement score based on the hospital's performance relative to the performance of all hospitals in the program. The maximum points earned for the measure would be 10 with a hospital's performance on the measure determined by the higher of their achievement or improvement scores. This measure, if finalized as part of the FY 2014 VBP program, would create a third – "Efficiency" – domain in the Hospital VBP program. Introduction of a third domain will require CMS to propose new domain weights for the VBP program in FY 2014. CMS plans to address domain weights in the CY 2012 Hospital Outpatient Prospective Payment System proposed rule. CMS seeks comments on its proposal to adopt this measure for the FY 2014 Hospital VBP program and to establish an Efficiency domain.

Like its proposal for the Medicare Spending Per Beneficiary Measure, CMS proposes to incorporate concurrently additional measures for adoption into the Hospital Inpatient VBP program and adoption into the Hospital IQR program.

Hospital Readmission Reduction Program

CMS introduces the Hospital Readmission Reduction program required under the Affordable Care Act, and proposes a program framework and key program elements that will apply beginning in FY 2013, including applicable conditions, readmission measures, ratios and other methodologies, and public reporting.

APPLICABLE CONDITIONS AND MEASURES

CMS proposes to select acute myocardial infarction (AMI), heart failure, and pneumonia as the applicable conditions for the Hospital Readmissions Reduction program in FY 2013. To measure hospital readmissions, CMS proposes to adopt as part of the Hospital Readmissions Reduction program the three National Quality Forum (NQF)-endorsed, hospital risk-standardized readmission measures that are currently included in the Hospital IQR Program:

- AMI 30-day Risk Standardized Readmission Measure
- Heart Failure 30-day Risk Standardized Readmission Measure
- Pneumonia 30-day Risk Standardized Readmission Measure

CMS proposes to adopt these measures without modifications to their NQF-endorsed methodology. Complete measure specifications are posted online at http://www.QualityNet.org. CMS seeks public comment on the selection and adoption of these measures.

EXCESS READMISSION RATIO

The ACA requires CMS to develop a risk-adjusted Excess Readmissions Ratio that will be used to determine payment adjustments under the Hospital Readmissions Reduction program. CMS proposes to use the risk-standardized ratio (RSR) that is calculated for the proposed NQF-endorsed readmissions measures as the Excess Readmission Ratio. Under the Hospital IQR program, the RSR is multiplied by a national raw rate of readmission to calculate the risk-standardized readmission rate (RSRR). Under the proposed Hospital Readmissions Reduction program, the RSR will not be multiplied by the national raw rate of readmission.

The RSR compares risk-adjusted actual readmissions to risk-adjusted expected readmissions and is a measure of the relative performance of a hospital. Hospitals that perform better than average for a hospital with similar patients will have a ratio that is less than one. Hospitals that perform worse than average for a hospital with similar patients will have a ratio that is greater than one. Hospitals with a ratio greater than one are considered to have excess readmissions. CMS seeks comments on the use of the RSR as the Excess Readmission Ratio required under the ACA.

MEASUREMENT PERIOD

Under the Hospital IQR program, hospital performance on readmission measures is measured based on three years of data. For the FY 2013 Hospital Readmissions Reduction program, CMS proposes to use three years of data for discharges from July 1, 2008, through June 30, 2011. CMS seeks public comments on an appropriate data period for measuring readmissions.

DATA SOURCES AND ALL-PATIENT DATA

CMS proposes to use Medicare inpatient claims data for Medicare Fee-for-Service patients only for measuring hospital performance on hospital readmissions across the three conditions. These are the same data used to calculate hospital performance under the Hospital IQR program.

To risk-adjust hospital performance, CMS proposes to use data from the patient's hospitalization as well as from Medicare inpatient and outpatient claims from 12 months prior to gathering information regarding patient risk factors. If data from the prior 12 months is not available, CMS proposes to use data only from the hospitalization. CMS seeks public comment on these proposals.

The ACA requires CMS to calculate readmission rates for "all" patients. CMS does not propose policies to implement this requirement at this time, but seeks comments and suggestions on how this might be accomplished.

MINIMUM NUMBER OF DISCHARGES

The minimum number of discharges required for each condition for public reporting of readmission performance under the Hospital IQR program is 25. CMS proposes to use this same threshold of 25 discharges for each condition for the Hospital Readmissions Reduction program. CMS seeks public comments on the appropriate minimum number of discharges to consider for the readmission measures.

PUBLIC REPORTING OF HOSPITAL-SPECIFIC READMISSION RATES

To publicly report data on the readmission rates calculated for the Hospital Readmissions Reduction program, CMS proposes to use a similar process to the one used to publicly report data from the Hospital IQR program on the Hospital Compare website (http://www.hospitalcompare.hhs.gov/).

FY 2013 IPPS PROPOSED RULE

CMS will discuss and finalize in the FY 2013 IPPS rulemaking cycle outstanding provisions related to the Hospital Readmission Reduction program, including the following:

- Base operating DRG payment amount
- Adjustment factor
- Aggregate payments for excess readmissions
- Applicable hospital

Payment Adjustment for Low-Volume Hospitals

The Medicare Modernization Act established a supplemental payment adjustment for hospitals with a relatively low volume, effective beginning FY 2005. The original benefit applied to hospitals located more than 25 road miles from another subsection (d) hospital and that have less than 800 discharges during a fiscal year.

The Affordable Care Act temporarily (for FY 2011 through FY 2012 only) broadened the eligibility criteria to include hospitals within 15 miles (instead of 25) and 1,600 discharges (instead of 800).

In this proposed rule, CMS is proposing that, for FY 2012, qualifying low-volume hospitals and their payment adjustment would be determined using Medicare discharge data from the most recent update of the FY 2010 MedPAR file, i.e., the December 2010 update.

The proposed rule includes a list of hospitals with fewer than 1,600 discharges. In order to receive a low-volume hospital adjustment payment, a hospital must notify and provide documentation to its fiscal intermediary or MAC that it meets the mileage criterion.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH)

CMS proposes to exclude patient days associated with hospice patients receiving inpatient hospice services in an inpatient hospital from the Medicare and Medicaid fractions of the disproportionate patient percentage (DPP) calculation. Likewise, these inpatient hospice stays are excluded from calculations of available bed days. Medicare beneficiaries who receive hospice care can receive inpatient hospice care in a hospital for pain control, symptom management, and respite care needed to provide temporary relief to family or other care givers. Because these patients are receiving a hospice benefit, CMS proposes to exclude these patient days and bed days from the DPP calculation and the DSH payment adjustment. It is important to note, however, that acute care services provided to a hospice patient to treat a condition unrelated to the patient's hospice plan of care (e.g., a broken bone) are not excluded from the DPP calculation or the DSH payment adjustment.

For more information or if you have questions on the proposed updates to the Inpatient and Long-term Care Hospital Prospective Payment Systems, please contact your regular McDermott lawyer or:

For more information, please contact your regular McDermott lawyer, or:

Peter R. Leone: +1 617 535 4058 pleone@mwe.com

Jessica M. Roth: +1 202 756 8169 jmroth@mwe.com

Eric Zimmerman: +1 202 756 8148 ezimmerman@mwe.com

For more information about McDermott Will & Emery visit www.mwe.com