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Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

CMS Releases Final IPPS Rules for FY 2011 and Interim Final Rule on Three-Day Window

By: Carel T. Hedlund and Lisa D. Stevenson

On July 30, 2010, CMS posted its final rule [PDF] and updates to the Medicare Inpatient Patient Prospective Payment System (IPPS) and the Long Term Care Hospital (LTCH) Prospective Payment System that will apply beginning in federal fiscal year 2011. Future issues of Payment Matters will discuss some of these provisions in greater depth. For now, the highlights of the final rule include provisions to:

- Update acute care hospital rates by 2.35 percent for hospitals that successfully report quality measures in fiscal year 2010, but then reduce the 2.6 percent market basket increase for inflation update by 0.25 percent, as required by the Affordable care Act, and apply a "documentation and coding" adjustment of -2.9 percent. The net result is a decrease of 0.4 percent in IPPS payments.
- Update LTCH rates by 2.5 percent for inflation, but reduce the inflation update by 0.5 percentage point as required by the Affordable Care Act and apply a -2.5 percent documentation and coding adjustment, for a net increase in payments to LTCHs of 0.5 percent.
- Add 12 new quality measures for which hospitals must submit data under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, and retire one, the Mortality for selected surgical procedures.
- Update the rate-of-increase limits for children's and cancer hospitals.
- Revise the 2011 wage index for acute care hospitals as required by the Affordable Care Act, including providing a wage index of not less than 1.0 for hospitals in five "frontier" states and using a national budget neutrality adjustment for rural and imputed floors.
- Continue to use the revised matching process it adopted after the *Baystate* decision (see "Hopeful News for Providers on DSH/SSI Issue," *Payment Matters*, 11/25/08) to calculate hospitals' Supplemental Security Income (SSI)

fractions for Disproportionate Share Hospital (DSH) adjustments for fiscal year 2011 and subsequent fiscal years.

- Clarify that only CMS, rather than state survey agencies or national accreditation organizations, determines whether healthcare facilities have satisfied the requirements for participation in the Medicare program.
- Amend Medicare enrollment regulations to provide that a provider or supplier agreement cannot be effective earlier than the latest date on which all applicable federal requirements are determined by CMS to be met, including enrollment requirements.

In the same document CMS also issued an interim final rule with comment period to implement a change to the three-day payment window rule. Previously under the three-day payment window rule, a hospital was required to bill as part of an inpatient stay all outpatient diagnostic services and those non-diagnostic therapeutic services that were related to the inpatient admission provided during a three day payment window. CMS had previously defined "related" to be an exact 5-digit diagnosis code match between the inpatient admission and the outpatient therapeutic services. The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act, signed into law on June 25, 2005, adopts a new definition for "other services related to the admission" that must also be billed as part of the inpatient stay (see "The DRG Window Becomes a DRG Wall," *Payment Matters*, 7/1/10). Under the new definition, effective for services provided on or after June 25, 2010, hospitals should bill as part of the inpatient stay *all* nondiagnostic services provided on the day of admission as well as those in the three days prior to admission, unless they can demonstrate that the services are unrelated to the admission. According to CMS, it will issue instructions specifying how hospitals can meet this requirement. Comments on the interim final rule are due by September 28, 2010.