Payment Matters®
Update on Medicare and Medicaid Payment Issues

April 28, 2011

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CMS Releases Proposed FFY 2012 IPPS Rule

By: Mark A. Stanley

CMS has released its proposed federal fiscal year (FFY) 2012 prospective payment system (PPS) rule for inpatient stays in acute care and long-term care hospitals (LTCHs). The rule projects a decrease in operating payments to acute care hospitals in the amount of $498 million dollars for FFY 2012, a 0.5% decrease in comparison with FFY 2011 payments. The proposed rule can be viewed here [PDF].

The proposed rule would:

- Add six new MS-DRGs, bringing the total to 751.
- Retool the administration of the quality reporting process under the Inpatient Quality Reporting (IQR) program by changing the deadlines for reporting quality data and tightening timelines for hospitals to submit records as part of the validation process.
  Retire 8 IQR measures for FY 2014, and add several measures between FY 2014 and 2015. The total IQR measure set would be increased to 73 and is detailed here.
- Distribute the remaining $250 million under Section 1109 of the Affordable Care Act (ACA), which established $400 million in payments to hospitals located in counties in the lowest quartile for per enrollee Medicare spending.
- Base the FFY 2012 low-volume payment adjustment (established by Section 3125 of the ACA) on MedPAR data.
- Allow the wage index imputed floor – which establishes that no urban hospital in a state may have a lower wage index than the state's rural area wage index – to sunset at the end of FFY 2011.
- Apply a 1.1% increase to IPPS rates to reflect CMS's error in calculating the rural floor budget neutrality adjustment, consistent with the holding of the D.C. Circuit Court in *Cape Cod Hospital v. Sebelius*, which we previously discussed here.

- Revise the calculation of pension costs for both wage index and cost reimbursement purposes. We previously discussed the concerns raised regarding CMS's treatment of pension costs here. The proposed rule would correct some of the more egregious errors in its treatment of pension costs, but still would not utilize GAAP in the calculation of pension expenses. For cost reimbursement purposes, CMS would still limit the amount of pension contributions that would be recognized. The limit would be 150% of the highest three year average contribution over the previous five years.
- Make four changes to the following existing MS-DRG classifications:
  - Excisional debridement: three new MS-DRGs would reduce payment for these procedures, in order to bring payment into line with CMS's view that they have significantly lower costs than other operating room procedures.
  - Autologous bone marrow transplant: two new MS-DRGs, one reflecting the procedure with complications or comorbidities (CC), and one reflecting the procedure without CC, would replace the existing MS-DRG 015.
  - Rechargeable dual array deep brain stimulation system: CMS would move the codes to MS-DRGs 023 – 024.
  - Thoracic aneurysm repair: two codes that either repair a thoracic aneurysm or place a stent (MS-DRGs 237 – 238) would be moved to the higher paying MS-DRGs 219-221.
- Add a new hospital-acquired condition category for acute renal failure after contrast administration.
- Apply the 3-day/1-day payment window (discussed in an interim final rule with comment released with the FFY 2011 IPPS rule) to both preadmission diagnostic and non-diagnostic services furnished by physician practices that are wholly owned or operated by the admitting hospital.
- Include all Medicare beneficiaries, including Medicare Advantage patients, in a hospital's count when determining the proportion of end stage renal disease (ESRD) patients. This count determines eligibility for the add-on payment to hospitals that treat a high proportion of ESRD beneficiaries.
- Exclude hospice patients from the calculation of a hospital's DSH adjustment.
- Not allow "routine services," such as room and board or nursing services, to be furnished under arrangements.
- Create a new quality reporting program for LTCHs.

- Determine the average length of stay for LTCH eligibility using data from both Medicare fee-for-service and managed care beneficiaries.
- Extend the moratorium on growth in bed numbers for LTCHs to facilities that were newly created under exceptions to the existing moratorium.

Ober|Kaler's Comments

Please watch for more in-depth articles on the proposed rule in coming *Payment Matters* editions. Comments to the final rule must be received no later than 5PM EDT on June 20, 2011.