Hospitals See Medicare Payments Increase Under Final Rule

General acute care hospitals were relieved to learn that under the Fiscal Year 2012 Inpatient Prospective Payment System (IPPS) Final Rule, they will see an increase in payments by 1% in fiscal year 2012 rather than the .5% decrease that CMS originally proposed. The 1% increase will result in an additional $1.13 billion in payments compared to fiscal year 2011. The one percent net increase was due to the adoption of a higher market basket of 3%, a lower multifactor productivity adjustment of 1% versus 1.2%, and a smaller coding adjustment of 2% rather than 3.15%.

The Final Rule also implements several quality initiatives. To the relief of many hospital administrators, CMS did not adopt its prior proposal to add contrast-induced acute kidney injury to the list of hospital-acquired conditions that are not eligible for Medicare payments. One of the quality initiatives required by the Affordable Care Act is the Hospital Readmission Reduction Program, which will reduce payments beginning in fiscal year 2013 to hospitals that have excess readmissions for certain conditions.

The goal of CMS is to decrease hospital readmissions by 20% by 2014. To that end, CMS has finalized the definition of readmission as "occurring when a patient is discharged from the applicable hospital and then is admitted to the same or another acute care hospital within a specified time period from the time of discharge from the index hospitalization." The specified time period is 30 days. The Final Rule sets out the methodology that CMS will use to calculate whether a hospital has excess readmission rates for three conditions: heart attack, heart failure, and pneumonia.

The Final Rule also brings changes for long term care hospitals (LTCHs). LTCHs will also see a 2.5% increase in Medicare payments for fiscal year 2012, which translates to about $126 million in total. The Affordable Care Act requires CMS to establish a new quality reporting program for hospitals paid under the LTCH PPS, and the Final Rule shapes the general structure of that program—known as the LTCH Quality Reporting Program. According to the Final Rule, CMS will begin collecting data on three 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. In fiscal year 2014, CMS will apply a 2% payment penalty to LTCHs that do not report quality data to it. Other hospitals will see their quality reporting requirements increase as well because the Final Rule expands the number of quality measures that hospitals must report under the Hospital Inpatient Quality Reporting Program to 76.