CMS Issues Hospital Payment Proposed Rule for 2010 – Affecting 3,500 Acute Care Hospitals

May 11, 2009

HEALTHCARE ALERT - MAY 11, 2009

written by Thomas Barker, Maia M. Larsson

On May 1, 2009 the Centers for Medicare & Medicaid Services (CMS, or the Agency) issued a proposed rule (.pdf) for the FY2010 Medicare hospital inpatient prospective payment systems (IPPS). The regulation proposes revisions to policies and payment rates for general acute care hospitals paid under the Medicare hospital IPPS and also inpatient stays in long-term care hospitals (LTCHs) under the LTCH Prospective Payment System (LTCH PPS). The proposed rule would also implement certain provisions made by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110-275) and the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. 111-5).

The IPPS proposed rule would apply to approximately 3,500 acute care hospitals and 400 LTCHs in the United States, and would be effective for most discharges on or after October 1, 2009. The Agency invites public comments on its proposals, and requires the comments be received by CMS electronically or by regular mail no later than 5pm on June 30, 2009. The final rule must, by statute, be published by August 1, 2009. The following Alert summarizes key components of the proposed rule.

Market Basket Update

A key proposal in the FY2010 IPPS proposed rule is to establish the update to the acute care hospital standardized amount for FY 2010 at 2.1 percent, which CMS then proposes to reduce by a documentation and coding adjustment of 1.9 percent. CMS is similarly proposing to update long-term care hospital rates by 2.4 percent for inflation minus a documentation and coding adjustment of 1.8 percentage points.

In 2007, CMS implemented refined diagnosis-related groups (DRGs) called Medicare Severity Diagnosis-Related Groups (MS-DRGs) that were far more precise than the DRGs used before 2007. At the time, however, CMS expressed concern that hospitals would respond to the more precise DRGs by enhancing their coding practices and placing patients in higher-acuity DRGs. To avoid this, CMS proposed a coding adjustment. Congress, however, issued a moratorium on CMS to block it from implementing such a coding adjustment. Pub. L. No. 110-90 §7(b)(1)(A). That moratorium on implementing the coding adjustment expires on October 1, 2009, and CMS is now proposing to move forward with the coding adjustment.

In a CMS press release issued in conjunction with the proposed rule on May 1, 2009, the Agency noted that the Medicare Actuary estimated a 2.5% increase in spending due to additional documentation and coding in FY 2008, and estimates an

increase of 2.3% for FY 2009. CMS's proposed 1.9 % coding adjustment for FY 2010 is intended to prevent the FY 2008 increase in spending from being carried forward. The Agency welcomes comments on its coding and documentation proposals.

Electronic Health Records (EHRs) and Meaningful Use

CMS makes clear that the provisions in this proposed rule "do not implicate or implement any HITECH statutory provisions." These HITECH (which stands for the "Health Information Technology for Economic and Clinical Health" Act) provisions that were part of ARRA – most significantly, those related to "meaningful use" — will be implemented in a future rulemaking.

In the proposed rule, CMS reiterates its interest in the reporting of quality measures using EHRs and stated that it will "continue to encourage hospitals to adopt and use EHRs that conform to industry standards."[1] The Agency is currently working with the Office of National Coordinator (ONC) for Health Information Technology (HIT) to harmonize standards for EHR data in several areas, which are scheduled to be finalized in late 2009. CMS states that it expects to move forward with testing its technical ability to accept data from EHRs as early as July 1, 2010. CMS is also intending to select several EHR vendors and hospitals to help in this process of developing and testing EHR clinical quality data submission, as explained further in the proposed rule. The test measures that will be used in this IT testing are currently not required under CMS's voluntary Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, CMS notes, and as such, will not be used in RHQDAPU program payment decisions.

Currently, CMS's RHQDAPU program includes a set of 43 quality measures. By statute, hospitals not participating in this program receive a reduction of 2.0% in their annual payments. Social Security Act, § 1886(b)(3)(B)(viii)(I). CMS notes in the proposed rule that there are important areas of "overlap and synergy" between the RHQDAPU program and the HITECH Act, and states its belief that the ARRA financial incentives will encourage the adoption and use of certified EHRs for reporting under the RHQDAPU program.

Linking Payment to Quality Measures

In the proposed rule, CMS states its goal to "promot[e] accurate payment for inpatient services to Medicare beneficiaries" by "strengthen[ing] the relationship between payment and quality of service, by expanding the quality measures that hospitals must report in order to receive the full market basket update in fiscal year 2011."[2] The proposed rule would add four new measures to the RHQDAPU program, retire one measure for Acute Myocardial Infarction (AMI), and add new program requirements for current measures. Hospitals would need to submit required data and comply with the new requirements to receive the full market basket update in FY 2011. CMS is also proposing a new program requirement whereby CMS would annually select 800 hospitals on a random basis and validate 12 medical records quarterly for each of the hospitals.

CMS is not proposing any changes for FY2010 to the list of hospital-acquired conditions (HACs), which currently includes 10 categories of "reasonably preventable" conditions, but welcomes comments on the issue. CMS is planning to conduct, together with the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Office of Public Health and Science (OPHS) an evaluation of the impact of the HAC program.

Emergency Medical Treatment and Labor Act
(EMTALA) Waiver Policy

The Agency proposes to amend the EMTALA regulations at 42 C.F.R. § 489.24(a)(2) with respect to the waiver of EMTALA sanctions in an area in which the Secretary of Health and Human Services has declared a public health emergency under section 1135 of the Social Security Act during the period of the emergency so that the regulations conform more closely to the underlying statutory language. Specifically, the proposed rule proposes to clarify that CMS will waive EMTALA sanctions for an inappropriate transfer "only if the inappropriate transfer arises out of the circumstances of the" public health emergency. In addition, CMS proposes to limit the waiver of sanctions for both an inappropriate transfer and redirection or relocation of an individual for a medical screening examination to another hospital. Under the proposed rule, CMS would only waive sanctions if the hospital seeking the waiver does not discriminate on the basis of an individual's source of payment or ability to pay. Thus, a hospital in an emergency area that transferred a patient solely based on ability to pay — regardless of the fact that the hospital was located in an area in which a public health emergency was declared — would still be subject to sanctions under EMTALA. CMS also proposes revising the regulations to clarify that a waiver of EMTALA sanctions may be applied to one or more hospitals, or just to a portion of a hospital, in the emergency area for a portion or all of the emergency period, and that the Secretary is authorized to apply such a waiver, as necessary.

---

1. Medicare IPPS Proposed Rule for FY2010 (May 1, 2009), at 384.

2. CMS Fact Sheet, Proposals to Improve Quality of Care in Inpatient Stays in Acute Care Hospitals in FY2010, available at http://www.cms.hhs.gov/apps/media/fact_sheets.asp.