Final policy and payment changes for inpatient stays in acute-care hospitals and long-term care hospitals in FY 2013

OVERVIEW: On August 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update Medicare payment policies and rates for inpatient stays in acute-care hospitals under the Inpatient Prospective Payment System (IPPS) and hospitals paid under the Long-Term Care Hospitals (LTCH) Prospective Payment System (PPS), in fiscal year (FY) 2013. The rule also finalizes the payment update that will be used to calculate FY 2013 target amounts for certain hospitals excluded from the IPPS, such as cancer and children’s hospitals, and religious nonmedical health care institutions.

The rule, which will apply to approximately 3,400 acute-care hospitals and approximately 440 LTCHs, will generally be effective for discharges occurring on or after October 1, 2012. Under the rule, payment rates for inpatient stays in general acute-care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program will be increased by 2.8 percent. Those that do not successfully participate in the IQR Program will receive an increase of 0.8 percent (i.e., a 2.0 percentage point reduction). CMS projects that the rate increase—together with other policies established in the rule, the expiration of certain statutory provisions that provided special temporary increases in payments to hospitals, and other changes to the IPPS payment policy—will increase payments by about $2 billion in FY 2013, or 2.3 percent.

Medicare payments to LTCHs in FY 2013 are projected to increase by approximately $92 million or 1.7 percent. Provisions affecting LTCHs are described in more detail below in this fact sheet.

This fact sheet discusses major payment provisions of the final rule. A separate fact sheet on policies relating to the provision of high-quality care is available on the CMS web page at:

www.cms.gov/apps/media/fact_sheets.asp.

BACKGROUND: By law, CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. These prospective payment systems set rates prospectively based on the patient’s diagnosis and
the severity of the patient’s medical condition. Under the IPPS and the LTCH PPS, a hospital receives a single payment for the case based on the payment classification assigned at discharge: “MS-DRGs” under the IPPS and “MS-LTC-DRGs” under the LTCH PPS. Medicare law requires CMS to update the payment rates for IPPS hospitals annually to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients—known as the hospital “market basket”—as well as for other factors. Critical Access Hospitals (CAHs), children’s hospitals, certain cancer hospitals, and certain other facilities do not receive payments under the IPPS.

Until FY 2008, discharges from acute-care hospitals were classified into one of 538 CMS-diagnosis-related groups (DRGs). In FY 2008, CMS replaced the 538 DRGs with 745 MS-DRGs that provide higher payments for more severely ill or injured patients and lower payments for all other cases. Since FY 2008, CMS has modified these MS-DRGs through notice and comment rulemaking, bringing the current total number of MS-DRGs to 751.

The LTCH PPS was implemented in FY 2003. Medicare payments under the LTCH PPS are based on the same DRG system as the IPPS, but payment weights associated with the LTCH patient classifications are calculated based on generally higher treatment costs at LTCHs. In conjunction with the IPPS, the LTCH PPS adopted MS-LTC-DRGs in FY 2008.

POLICIES AFFECTING ACUTE-CARE HOSPITALS

Changes to Payment Rates under IPPS: The rule will increase IPPS operating payment rates by 2.8 percent. This reflects an update of 2.6 percent for the hospital market basket adjusted by a multi-factor productivity adjustment of -0.7 percentage point and an additional -0.1 percentage point in accordance with the Affordable Care Act; this is increased by 1.0 percent for documentation and coding adjustments (more detail about these adjustments is included later in this fact sheet).

Policies to Continue Implementing the Affordable Care Act:

Hospital Readmissions Reduction Program: Section 1886(q) of the Social Security Act, as added by section 3025 of the Affordable Care Act, establishes the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to certain hospitals with excess readmissions, effective for discharges beginning on or after October 1, 2012.

In the FY 2012 IPPS/LTCH PPS final rule, CMS began implementation of the Readmissions Reduction Program and finalized the following policies:

• The use of three 30-day readmission measures—Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN), endorsed by the National Quality Forum for FY 2013 and FY 2014;

• The definition of “readmission” as generally referring to an admission to an acute-care hospital paid under the IPPS within 30 days of a discharge from the same or another acute-care hospital (subject to technical issues addressed in the rule);
The calculation of a hospital’s excess readmission ratio for AMI, HF and PN, which is a measure of a hospital’s readmission performance compared to the national average for the hospital’s set of patients with that applicable condition; and

A policy to use three years of discharge data and a minimum of 25 cases to calculate a hospital’s excess readmission ratio for each applicable condition. In FY 2013, the excess readmission ratio will be based on discharges occurring during the 3-year period of July 1, 2008 to June 30, 2011.

The FY 2013 IPPS/LTCH PPS Rule finalizes a methodology to calculate the readmissions adjustment factor, which is the higher of a ratio of a hospital’s aggregate dollars for excess readmissions to their aggregate dollars for all discharges, or 0.99 (i.e., a 1.0 percent reduction) for FY 2013. CMS will apply the readmission adjustment factor to a hospital’s base operating DRG payment amount and estimates that the Hospital Readmissions Reduction Program will result in a 0.3 percent, or approximately $270 million decrease in overall payments to hospitals.

**Hospital Value-Based Purchasing (VBP) Program:** The final rule addresses operational details relating to payment rates to hospitals in FY 2013 (the first year that the VBP program’s payment implications will go into effect), as well as additional measures and policies that will affect value-based incentive payments for hospitals in FY 2015 and FY 2016.

For additional information about the Hospital VBP Program policies in this rule, please see the fact sheet on quality issues at: [www.cms.gov/apps/media/fact_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp).

**Documentation and Coding Adjustment:**

The final rule will complete all documentation and coding adjustments for FY 2008 and FY 2009 as required by the TMA, Abstinence Education, and QI Programs Extension Act of 2007.

Below is a summary of documentation and coding adjustments that will affect the FY 2013 IPPS update:

| Remaining FY 2008 and FY 2009 Prospective Documentation and Coding Adjustment | -1.9 percent |
| Restoration of One-Time 2012 Recoupment Adjustment | +2.9 percent |

**Total** | +1.0 percent*

*This total is higher than the +0.2 percent adjustment that was included in the proposed rule because CMS did not finalize its proposal to make a prospective documentation and coding adjustment to account for estimated overpayments in FY 2010.

**Other Changes in the IPPS/LTCH PPS Final Rule:**

**New Technology Add-On Payments For FY2013:** To remove barriers to access for costly new technologies that are not yet fully reflected in the current MS-DRG payment rates, the Medicare
law provides for temporary add-on payments for inpatient stays that involve the use of certain approved new technologies. CMS is approving new technology add-on payments for three applications, glucarpidase (Voraxaze®), fidaxomicin (DIFICID™), and the Zenith® Fenestrated Abdominal Aortic Aneurysm (AAA) Endovascular Graft.

Voraxaze® can be used to rapidly reduce toxic concentrations of methotrexate, a chemotherapy drug that can cause renal impairment in patients being treated for cancer. DIFICID™ is an oral medication used to treat Clostridium difficile-associated diarrhea (CDAD), a common hospital acquired illness that can result from treatment with antibiotics. The Zenith® Fenestrated AAA Endovascular Graft is an implantable device designed to treat patients who have an abdominal aortic aneurysm and are not candidates for treatment with open surgery or other grafts on the market because they have unique anatomical issues. Additionally, CMS is extending through FY 2013, the new technology add-on payment for the AutoLITT™, an MRI guided treatment for the removal of brain tumors.

Inclusion of Labor and Delivery Beds in the Available Bed Count for the Disproportionate Share Hospital (DSH) Adjustment and Indirect Medical Education (IME) Adjustment: CMS is finalizing inclusion of labor and delivery days in the count of available beds for purposes of both the Medicare DSH and IME adjustments. This change will align with the CMS policy, adopted in FY 2010, to include labor and delivery days in the patient day count for the Medicare DSH adjustment. CMS is also applying the timely filing requirements to the submission of no pay bills for purposes of calculating the DSH adjustment.

Postponement of “Services Under Arrangement” Requirements: In the FY 2012 IPPS/LTCH PPS final rule CMS finalized the policy that therapeutic and diagnostic services are the only services that may be furnished under arrangement outside of the hospital to Medicare beneficiaries. Routine services (that is, bed, board, and nursing and other related services) must be furnished by the hospital. Some hospitals have stated they need additional time to restructure existing arrangements and establish necessary operational protocols to comply with the policy. Therefore, CMS is postponing the effective date of the policy that limits “services under arrangement” to diagnostic and therapeutic services. This policy will now be effective for hospital cost reporting periods beginning on or after October 1, 2013.

Graduate Medical Education (GME): CMS is including several changes and clarifications of existing policy regarding GME in this rule. CMS is extending the timeframe for teaching hospitals that qualify to establish their caps for new programs from three years to five years. CMS is also making changes regarding the five-year period following the implementation of increases to hospitals’ full-time equivalent (FTE) resident caps under section 5503 of the Affordable Care Act. CMS is changing and clarifying existing policy related to the application of section 5506 of the Affordable Care Act, which preserves resident cap positions from closed hospitals. In addition, CMS is clarifying that timely filing rules for claims submission apply to no-pay claims submitted by hospitals to receive indirect medical education, direct medical education and nursing and allied health education payments for Medicare Advantage beneficiaries.

Additions to the list of Hospital Acquired Conditions (HACs): CMS is adding two categories of conditions to the list of HACs in FY 2013, Surgical Site Infection Following Cardiac
Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization.

For more information on quality-related provisions in this rule, please see www.cms.gov/apps/media/fact_sheets.asp.

**Expiring Provisions:**

**Medicare-Dependent Hospital (MDH) Program:** Under current law, the MDH program will expire at the end of FY 2012, that is, for discharges occurring after September 30, 2012. Accordingly, beginning in FY 2013, hospitals that are currently paid under the MDH program will instead be paid based on the Federal rate as are other IPPS hospitals (unless they can also qualify as sole community hospital).

**Low-Volume Hospital Payment Adjustment:** Prior to 2011, a low-volume hospital had to be at least 25 miles from the nearest hospital and have less than 800 total discharges. For FY 2011 and FY 2012, sections 3125 and 10314 of the Affordable Care Act defined a low-volume hospital as being more than 15 road miles from other IPPS hospitals and having fewer than 1,600 Medicare discharges. Payment adjustments were made on a sliding scale with a higher adjustment for hospitals with fewer discharges and a lower adjustment for hospitals with higher discharges.

Effective for FY 2013 and forward, the low-volume hospital definition and payment adjustment methodology will return to the pre-2011 definition and payment adjustment methodology. Hospitals that qualify for the low-volume hospital adjustment will receive a 25 percent adjustment rather than an adjustment based on a sliding scale.

**Policies Affecting Long-Term Care Hospitals**

**Changes to Payment Rates under the LTCH PPS:** CMS projects that LTCH PPS payments will increase by 1.7 percent, or approximately $92 million, in FY 2013. This estimated increase is attributable to several factors, including the update of 1.8 percent (based on a market basket update of 2.6 percent reduced by a multi-factor productivity adjustment of 0.7 percentage point and an additional 0.1 percentage point reduction in accordance with the Affordable Care Act); the “one-time” budget neutrality adjustment of approximately -1.3 percent (the first year of a 3 year phased-in adjustment) to the FY 2013 standard Federal rate (which is not applicable to payments for discharges occurring on or before December 28, 2012); and, projected increases in estimated high cost outliers and decreases in short-stay outlier (SSO) payments due to a change in the SSO payment methodology effective for discharges occurring on or after December 29, 2012.

**Expiration of Moratoria Established Under the Medicare Statute:** In the Medicare, Medicaid and SCHIP Extension Act of 2007, Congress imposed a three-year moratorium on the effective date of certain LTCH PPS payment policies. At the same time, Congress imposed a three-year moratorium on the development of new LTCHs and LTCH satellites and on increases in the number of LTCH beds in existing LTCHs and LTCH satellite facilities, unless an exception applied. The payment policies subject to the moratorium included:
• Inclusion of the “IPPS comparable per diem amount” option for very short stay cases in the short-stay outlier (SSO) payment formula;
• Implementation of the “25 percent threshold” payment adjustment; and
• Application of a one-time prospective budget neutrality adjustment to the standard Federal rate.

The Affordable Care Act extended the moratoria for two more years, with the moratoria expiring at various times during CY 2012.

With the expiration of the moratoria, CMS will apply the “IPPS-comparable per diem amount” option to payment determinations made under the SSO policy for discharges with a certain length of stay beginning on and after December 29, 2012.

However, the rule includes an extension of the moratorium on the implementation of the “25 percent threshold” payment policy that is generally effective for cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013. For certain LTCHs and LTCH satellites with cost-reporting periods beginning on or after July 1, 2012 and before October 1, 2012, we are also providing a supplemental moratorium effective for discharges occurring on or after October 1, 2012 and through the end of the cost reporting period. This extension is being finalized as proposed in light of CMS’s ongoing research which may result in LTCH payment policies that could eliminate the need for the 25 percent rule.

CMS is also applying a one-time prospective adjustment to the standard Federal rate so any significant difference between the data used in the original computations for budget neutrality for FY 2003 and more recent data is not perpetuated in the Prospective Payment System in future years. The rule establishes a permanent 3.75 percent payment reduction to the standard Federal rate to be phased in over three years. The adjustment for FY 2013 is approximately -1.3 percent. The adjustment will not apply to payments for discharges occurring on or before December 28, 2012, consistent with the statute.

**Development of the Long-Term Care Hospital-Specific Market Basket:** CMS is adopting a stand-alone LTCH-specific market basket based solely on LTCHs’ Medicare cost report data that specifically reflect the cost structures of LTCHs. This market basket will replace the Rehabilitation, Psychiatric, and Long-Term Care Hospital (RPL) market basket used under the LTCH PPS prior to FY 2013.

The final IPPS/LTCH PPS rule can be downloaded from the Federal Register at:


It will appear in the August 31, 2012 *Federal Register*, and will take effect October 1, 2012.

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