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Medicare payment rule to promote improved inpatient care

Proposed rule would strengthen tie between payment and quality improvement

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that would update Medicare payment policies and rates for inpatient stays to general acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and long-term care hospitals (LTCHs) paid under the LTCH Prospective Payment System (PPS). This proposed rule would is a continuation of our efforts to promote improvements in hospital care that will lead to better patient outcomes while slowing the long-term health care cost growth.

"The proposed rule would implement key elements of the Affordable Care Act's value-based purchasing program as well as the hospital readmissions reduction program. It also establishes the groundwork for extending Medicare's quality reporting programs beyond general acute care hospitals to other types of facilities," said CMS Acting Administrator Marilyn Tavenner. "It is part of a comprehensive strategy to use Medicare's payment systems to foster better care and better value in all settings, thereby reducing overall Medicare spending."

CMS is projecting that payment rates to general acute care hospitals will increase by 2.3 percent in FY 2013. The 2.3 percent is a net update after inflation, improvements in productivity, a statutory adjustment factor, and adjustments for hospital documentation and coding changes. CMS projects that the rate increase, together with other policies in the proposed rule and projected utilization of inpatient services, would increase Medicare's operating payments to acute care hospitals by approximately 0.9 percent in FY 2013. After taking into account the expiration of certain statutory provisions that provided special temporary increases in payments to hospitals, and other proposed changes to IPPS payment policies, CMS projects that total Medicare spending on inpatient hospital services will increase by about $175 million in FY 2013.

CMS projects that LTCH payments will increase by approximately $100 million or 1.9 percent in FY 2013 under the proposed rule. CMS is proposing an annual update to LTCH payment

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rates of 2.1 percent. As explained further below, in addition to this update for inflation (adjusted as required by the statute), the 2.1 percent update to LTCH payment rates will be reduced by approximately 1.3 percent to 0.8 percent for the "one-time" budget neutrality adjustment for discharges on or after December 29, 2012.

Improving Patient Care

The proposed rule would strengthen the Hospital Value-Based Purchasing Program (VBP Program) to further Medicare's transformation from a system that rewards volume of service to one that rewards efficient, high-quality care. This program, which was required by the Affordable Care Act, will adjust hospital payments beginning in FY 2013 and annually thereafter based on how well they perform or improve their performance on a set of quality measures.

Specifically, CMS is proposing to add the Medicare spending per beneficiary measure to the Hospital VBP Program, which would affect payments beginning in FY 2015. This measure would include all Part A and Part B payments (after removing differences attributable to geographic payment adjustments and other payment factors) from three days prior to an inpatient hospital admission through 30 days post discharge with certain exclusions. The proposed measure would be risk-adjusted for the beneficiary's age and severity of illness.

The proposed rule also includes a new outcome measure that rewards hospitals for avoiding certain kinds of life-threatening blood infections that can develop during inpatient hospital stays. This measure, the central line-associated bloodstream infection measure, supports ongoing work by CMS and other hospital safety leaders to reduce healthcare-associated infections through the Partnership for Patients initiative.

The proposed rule would also strengthen the inpatient quality reporting program (IQR). Specifically, CMS is proposing to include measures for perinatal care and readmissions, including overall readmissions and readmissions relating to hip and knee replacement procedures, and for the use of surgery checklists designed to reduce errors. CMS is also proposing to add a new survey measure to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures to assess the quality of patients' care transitions.

To provide hospitals with an incentive to reduce hospital readmissions and improve care coordination, the Affordable Care Act required CMS to implement a Hospital Readmissions Reduction Program that will reduce payments beginning in FY 2013 (that is, for discharges on or after October 1, 2012) to certain hospitals that have excess readmissions for three selected conditions: heart attack, heart failure and pneumonia. Today's rule proposes a methodology and the payment adjustment factors to account for excess readmissions for these three conditions.

The proposed rule also builds on CMS' quality reporting initiatives by proposing the measures that will be used for LTCHs for the FY 2015 and FY 2016 payment determinations and establishing programs and quality measure reporting for psychiatric hospitals that are paid under the Inpatient Psychiatric Facility Prospective Payment System and PPS-exempt cancer hospitals. Additional reporting requirements are also proposed for the ambulatory surgical center quality reporting program.

Documentation and Coding

The proposed rule would 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, while continuing to ensure that the new coding system introduced in 2008 is budget neutral. The net effect of all proposed documentation and coding adjustments is projected to result in an aggregate rate increase of 0.2 percent.

Expiration of Medicare, Medicaid, and SCHIP Extension Act Moratorium

In the Medicare, Medicaid, and SCHIP Extension Act of 2007, Congress imposed a three-year moratorium that prevented CMS from implementing certain payment policies affecting LTCHs. At the same time, the law imposed a moratorium on establishing new LTCHs and LTCH satellite facilities and on increasing the number of patient beds in existing LTCHs, unless an exception applied. The moratorium was extended for two years in the Affordable Care Act of 2010. The moratorium will, therefore, expire at various times in 2012.

In this rule, CMS is proposing:

- A one-year extension of the existing moratorium on the "25 percent threshold" policy, pending results of an on-going research initiative to re-define the role of LTCHs in the Medicare program.
- To apply an approximate 1.3 percent reduction (first year of a proposed three-year phase-in) for a one-time prospective budget neutrality adjustment. The proposed reduction would not apply to discharges occurring on or before December 28, 2012, because the law prohibits its application before that date. The budget neutrality adjustment reduces the update from 2.1 percent to 0.8 percent.
- To reduce Medicare payments for very short stay cases in LTCHs to the IPPS comparable per diem amount payment option for discharges occurring on or after December 29, 2012. The law prohibits application of this policy prior to that date.

The legislative moratorium on new LTCHs and satellite facilities will expire at the end of 2012.

CMS will accept comments on the proposed rule until June 25, 2012, and will respond to all comments in a final rule to be issued by August 1, 2012. The proposed rule can be downloaded from the *Federal Register* at:

http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

The proposed rule will appear in the May 11, 2012 *Federal Register*.

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