

HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

It's Payment Update Season Again: CMS Issues Hospital Inpatient Payment Final Rule for Fiscal Year 2012

September 20, 2011

On August 18, 2011, the Centers for Medicare and Medicaid Services ("CMS") published in the Federal Register the final rule for the fiscal year 2012 hospital inpatient prospective payment system update (the "2012 IPPS Rule"). The 2012 IPPS Rule includes payment updates for both acute care hospitals and long-term care hospitals ("LTCHs"), as well as an assortment of guidelines and clarifications. Almost all of the provisions of the 2012 IPPS Rule go into effect on October 1, 2011. Although it is not feasible to address every issue in the 2012 IPPS Rule, this *Health Law Update* describes some of the rule's significant provisions.

IPPS Payment Rate

Under the 2012 IPPS Rule, payment rates to acute care hospitals are projected to increase by an estimated \$1.13 billion in fiscal year 2012, a 1.1 percent increase over the previous year. This net change takes into account documentation and coding adjustments, market basket (i.e. inflation) adjustments and a productivity adjustment. Hospitals that fail to submit required quality data to CMS will have their payment rates reduced by two percentage points.

Under Arrangements

The 2012 IPPS Rule modifies the way that CMS pays for certain services that hospitals provide "under arrangements" with another entity. CMS explains that it has made the change out of concern that some "under arrangements" relationships between IPPS hospitals (such as acute care hospitals) and non-IPPS hospitals (such as LTCHs, rehabilitation hospitals or psychiatric hospitals) have resulted in hospitals receiving inappropriate payments. For example, if a rehabilitation hospital required intensive care unit ("ICU") services for a patient but could not provide the services, the patient might be moved to an acute care hospital that could furnish the ICU services. In some of these situations the hospitals would not technically transfer the patient, but, rather, the rehabilitation hospital would continue to treat the patient as its patient who is simply receiving some services from the acute care hospital "under arrangements." CMS believes this sort of arrangement could result in excessive Medicare payments. To address the issue, CMS states in the 2012 IPPS Rule that it will no longer pay hospitals for routine services (other than therapeutic and diagnostic services) provided by another entity unless those services are provided *in the hospital*. In other words, if a hospital wants to have another entity provide routine services (such as bed, board, nursing and other related services) under arrangements, then those services will have to be provided *inside* the hospital. Only therapeutic and diagnostic services can be provided by another entity under arrangements outside the hospital. CMS states that it will change certain provisions of the Provider Reimbursement Manual to reflect this change.

CMS recognizes that co-located hospitals, or “hospitals within hospitals” (“HwHs”), are permitted under existing regulations to contract with one another to provide basic services such as food, housekeeping, maintenance, etc. CMS states that, in spite of its new general policy, it will continue to permit these arrangements for HwHs.

Three-Day Window

The so-called three-day payment window policy limits Medicare payments for certain services provided shortly before a hospital admission. Under this policy, all outpatient non-diagnostic services provided by a hospital (or an entity wholly-owned or operated by the hospital) on the date of a Medicare beneficiary’s admission, or during the three days immediately preceding the date of admission, are normally deemed to be related to the admission and must be billed with the inpatient stay. In other words, if a patient receives outpatient non-diagnostic care at an acute care hospital on Monday and returns to the hospital on Wednesday and is admitted, the hospital will not be able to separately bill for the Monday outpatient care. The only exception to this policy is if the prior outpatient service is not “clinically associated” with the later inpatient service. This three-day payment window applies to other types of hospitals as well, such as psychiatric hospitals and LTCHs, but for those types of hospitals the payment window is one day rather than three days. In the 2012 IPPS Rule, CMS confirms that the payment window policy applies not only to hospitals but also to the technical component of physician clinic visits if the physician practice is owned or operated by the hospital. The 2012 IPPS Rule does not address whether the payment window policy applies to billing for the *professional* component of services rendered by hospital-owned physician practices, since that issue is to be addressed in the Medicare Physician Fee Schedule. CMS also does not provide a clear definition of “clinically associated” services in the 2012 IPPS Rule, but does note that services could be clinically associated even if they do not have identical ICD-9-CM principal diagnosis codes.

Add-On Payments

Acute care hospitals may receive additional payments for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over other available technologies and services and that it would be inadequately paid under the regular payment rate. In the 2012 IPPS Rule, CMS discontinues add-on payments for several technologies that it no longer deems “new” and declines requests to provide add-on payments for two additional new technologies. The agency opts to continue making add-on payments for certain laser interstitial thermal energy technology used on brain tumors.

Excluding Inpatient Hospice Days From DSH And IME Calculations

Acute care hospitals that treat a disproportionately high percentage of low-income patients may receive a percentage add-on payment applied to their base payment rate from Medicare. This add-on payment is known as the disproportionate share hospital (“DSH”) adjustment. In addition, hospitals that are approved teaching hospitals receive a percentage add-on payment known as the indirect medical education (“IME”) adjustment. The DSH adjustments may vary according to a complex formula involving the number of beds and the number of days that certain patients receive inpatient care. Similarly, the IME percentage payment varies depending on the ratio of residents to beds at a hospital. In recognition of the fact that care provided for hospice patients at hospitals differs from other types of care, the 2012 IPPS Rule excludes inpatient hospice days from the patient day count under DSH and from the bed day count under both DSH and IME.

Readmission Reduction Program

The 2012 IPPS Rule, in accordance with Section 3025 of the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act ("PPACA"), finalizes a Hospital Readmissions Reduction Program ("HRRP") to incentivize hospitals to improve patient care coordination and reduce preventable hospital readmissions. Under the HRRP, hospitals that are deemed to have excessive readmissions for acute myocardial infarction, heart failure and pneumonia will have their payments reduced beginning in fiscal year 2013 for discharges that occur on or after October 1, 2012. Additional conditions are expected to be added to the initial list of conditions for which the HRRP tracks readmissions. A readmission will be deemed to have occurred if a patient is discharged from an acute care hospital and is then readmitted to the same or another acute care hospital within 30 days of the initial discharge. Hospitals will be required to report readmissions via the [Hospital Compare website](#), which is the website also used for the Value-Based Purchasing Program.

Global Per Admission Spending Performance Measure

CMS also adopts, in the 2012 IPPS Rule, a global per-admission spending performance measure that will be used in the Hospital Inpatient Quality Reporting Program and also in the Hospital Value-Based Purchasing Program. The new measure will assess Part A and Part B beneficiary spending during a period that begins three days prior to a hospital admission and ends 30 days after discharge. The 30-day limitation is shorter and more provider-friendly than the proposed rule, which included a 90-day post-discharge period. This measure will affect payments beginning in October 2013.

Inpatient Quality Reporting

The 2012 IPPS Rule implements several changes to the Hospital Inpatient Quality Reporting Program, including retirement of certain quality measures, suspension of data collection for certain measures, addition of healthcare-associated infection measures, and addition of new quality measures. Specifically, four measures are to be retired beginning with discharges on or after January 1, 2012, including measures related to certain smoking cessation counseling and the timing of initial antibiotic doses. CMS has also suspended data collection effective with January 1, 2012 discharges for (1) aspirin upon arrival, (2) ACEI/ARB for left ventricular systolic dysfunction, (3) beta-blocker prescription at discharge, and (4) appropriate hair removal. Four new healthcare-associated infection measures are to be implemented in 2014 and 2015, including catheter-associated urinary tract infection, influenza vaccination of healthcare personnel, MRSA bacteremia, and C. difficile standardized infection ratio. CMS has added a quality measure for participation in a registry for general surgery for fiscal year 2014 and has added a series of stroke and venous thromboembolism measures to become effective in fiscal year 2015.

Hospital-Acquired Conditions (HACs)

CMS adds two new ICD-9 codes, i.e., falls and trauma, to the HAC category, two new codes to the category of surgical site infection following certain bariatric procedures, and one new code to the category of deep vein thrombosis and pulmonary embolism following certain orthopedic procedures. However, CMS did not follow through on its proposal to add a new HAC for contrast-induced acute kidney injury.

Long Term Care Hospitals (LTCHs)

CMS makes several changes to the payment rate and related measures for LTCHs in accordance with Section 3004 of PPACA. For fiscal year 2012, LTCH payments will increase by a net of 2.5 percent. However, the 2012 IPPS Rule also implements a pay-for-reporting program applicable to LTCHs that will begin in October 2012. The 2012 IPPS Rule sets out the general structure of the program and authorizes CMS to begin collecting data on the quality measures in 2012. For LTCHs that fail to report the quality

measures, including catheter-associated urinary tract infections, central line catheter-associated bloodstream infections and new or worsening pressure ulcers, a 2.0 percent payment penalty will be imposed beginning in fiscal year 2014 for discharges occurring on or after October 1, 2013.

As indicated by CMS, the above-discussed changes are part of CMS' "comprehensive strategy being implemented across Medicare's payment systems that is intended to reduce overall costs by improving how care is delivered."¹ If you have any questions regarding this *Health Law Update*, please contact any of the attorneys in our Healthcare Practice Group below.

Bass, Berry & Sims Healthcare Attorneys**Philip F. Berg**

(615) 742-7908

pberg@bassberry.com**Lauren Gaffney**

(615) 742-7824

lgaffney@bassberry.com**Angela Humphreys**

(615) 742-7852

ahumphreys@bassberry.com**Claire F. Miley**

(615) 742-7847

cmiley@bassberry.com**Brian D. Roark**

(615) 742-7753

broark@bassberry.com**Leigh Walton**

(615) 742-6201

lwalton@bassberry.com**Krista T. Cooper**

(615) 742-7734

kcooper@bassberry.com**Pooneh Ghiassi**

(615) 742-7782

pghiassi@bassberry.com**J. James Jenkins, Jr.,
Chair**

(615) 742-6236

jjenkins@bassberry.com**T. Scott Noonan**

(615) 742-6273

snoonan@bassberry.com**Catherine J.B. Sloan**

(615) 742-7789

csloan@bassberry.com**Elizabeth S. Warren**

(615) 742-7719

ewarren@bassberry.com**Meredith Edwards**

(615) 742-7823

medwards@bassberry.com**Anna Grizzle**

(615) 742-7732

agrizzle@bassberry.com**Seth A. Killingbeck**

(615) 742-7707

skillingbeck@bassberry.com**Shannon Pinkston**

(615) 742-7727

spinkston@bassberry.com**Danielle M. Sloane**

(615) 742-7763

dsloane@bassberry.com**Douglas M. Wolford**

(615) 742-7917

dwolford@bassberry.com**Mary Beth Fortugno**

(615) 742-7739

mfortugno@bassberry.com**Elisa E. Harris**

(615) 742-6553

eharris@bassberry.com**Daniel R. Kuninsky**

(615) 742-7837

dkuninsky@bassberry.com**Cynthia Y. Reisz**

(615) 742-6283

creisz@bassberry.com**Nesrin Garan Tift**

(615) 742-7903

ntift@bassberry.com

The materials contained herein have been abridged from the statutory sources and should not be construed or relied upon for legal advice. Readers are urged to consult legal counsel concerning particular situations and specific legal questions.

To ensure compliance with requirements imposed by the IRS, we inform you that this message is not intended to be used, and cannot be used, by the addressee or any other person for the purpose of avoiding penalties that may be imposed under the Internal Revenue Code.

¹ CMS Administrator Donald M. Berwick, M.D.; CMS Press Release, August 1, 2011.