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They're Back: Behavioral Offsets Spoil a Perfectly Good Market Basket Update (And Other Highlights of the 2011 Inpatient Prospective Payment System Rule)

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The Centers for Medicare & Medicaid Services ("CMS") recently published the annual inpatient prospective payment system update for fiscal year 2011 (the "2011 IPPS Rule")[1]. This rule contains several measures required by the recent health reform legislation and also implements certain payment cuts previously proposed but avoided in 2010. In addition, the 2011 IPPS Rule contains important requirements for hospitals regarding payment, quality measures, and the three-day payment rule, as well as provisions effecting payment changes for long-term acute care hospitals ("LTCH"s). We reported on the three-day payment rule in earlier issues of *Health Law Update*[2], so in this update, we'll provide just a few additional developments on the rule.

Inpatient Payment Rates – Effective October 1, 2010

Under the 2011 IPPS Rule, payment rates to acute care hospitals will include a 2.6% increase over 2010 rates to account for inflation (commonly called the "market basket" update) reduced by 0.25% as required by the Health Reform Act, effectively setting the market basket increase at 2.35%. (However, the implementation of the behavioral offsets discussed below will erase this increase.)[3] Hospitals that fail to report specified quality data will receive only a 0.35% increase (since failure to report quality measures under the Reporting Hospital Quality Data for Annual Payment Update ("RHQDAPU") program results in a 2.0% decrease in payments to those hospitals).

Additionally, the 2011 IPPS Rule implements payment cuts associated with documentation and coding changes in the hospital payment system that were proposed but not implemented in 2010. In fiscal year 2008, CMS began a two year implementation of the Medicare severity-

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[1] 75 Fed. Reg. 50041 (Aug. 16, 2010).
[2] *See* "The 'Very Near Future' Is Closer Than You Think: CMS Publishes Interim Final Rule Implementing The 3-Day Payment Window Legislation," Aug. 6, 2010 and "Battening Down the 3-Day Payment Window Hatch: CMS Addresses New Statutory Provision," July 30, 2010, both available at http://www.bassberry.com/communicationscenter/newsletters/.
[3] *See* 75 Fed. Reg. 50041, 50352 (Aug. 16, 2010). The market basket percentage change reflects the average change in the price of goods and services hospitals purchase in order to provide inpatient care.

adjusted diagnosis related group ("MS-DRG") system.[4] This change represented a refinement to the then-existing diagnosis related group ("DRG") system by allowing coding for the severity of an illness as well as for the general diagnosis and therefore providing increased payment for increased care received. The implementation of this MS-DRG system included payment reductions for hospitals in 2008 and 2009 as a "behavioral offset" to neutralize the payment increases that CMS estimated would be the effect of refinements in coding or classification changes to capture the new severity adjustments.

In the proposed IPPS for 2010, CMS stated its intent to fix the offset at a 1.9% reduction.[5] However, in the final 2010 IPPS Rule, CMS did not implement this cut but instead announced its intention to impose additional downward payment adjustments in 2011 and 2012 because of what CMS determined to be an inadequate adjustment for 2008.[6] Now the 2011 IPPS Rule implements this adjustment by decreasing payments by 2.9%.[7] In addition, CMS notes that this reduction is only half of the full recoupment of the 5.8% needed to offset the calculations of excess payments in 2008 and 2009.[8]

With the market basket increase of 2.35% and the documentation and coding reduction of 2.9%, acute hospital payments under the 2011 IPPS Rule will experience an overall 0.4% reduction from the rates for similar services in 2010.

Reporting Hospital Quality Data for Annual Payment Update

In the 2011 IPPS Rule, CMS expands the hospital quality measurements under the RHQDAPU program that hospitals are required to report in order to receive the full market basket update. The RHQDAPU initiative is an outgrowth of the Hospital Quality Initiative plan developed by CMS in consultation with hospital groups, and Congress added a financial incentive tied to the ability of hospitals to receive the full market basket update each year.[9] The RHQDAPU measure set has grown dramatically from a starter set of 10 measures in 2004 to the current set of 46 measures (not including the further expansion in the 2011 IPPS Rule).

The 2011 IPPS Rule adds 10 new measures about which hospitals are required to submit data under the RHQDAPU in 2011 to receive the full market basket update in 2012.[10] In addition, CMS retires one measure related to mortality for selected surgical procedures.[11] CMS also names two additional measures which will not be required to be reported until 2012.[12] Of the ten measures added, two are part of the current Surgical Care Improvement Project ("SCIP") measure set.[13] The other eight measures are designed by CMS to address hospital acquired

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[4] 72 Fed. Reg. 47130, 47175.
[5] 74 Fed. Reg. 24080, 24096.
[6] 74 Fed. Reg. 43754, 43768 (Aug. 27, 2009).
[7] 75 Fed. Reg. 50041, 50071 (Aug. 16, 2010).
[8] *Id.* at 50063 (Aug. 16, 2010).
[9] This was added by Congress in the Medicare Modernization Act of 2003.
[10] 75 Fed. Reg. 50041, 50197 (Aug. 16, 2010).
[11] *Id.* at 50186.
[12] *Id.* at 50200.
[13] *Id.* at 50197. These measures are post-operative respiratory failure and post-operative pulmonary embolism or deep vein thrombosis.

conditions.[14] Thus, after the 2011 IPPS Rule takes effect on October 1, 2010, the total number of quality measures to be reported to receive a full market basket update in 2012 will be 55.

Outliers

The 2011 IPPS Rule reduces the outlier threshold to $23,075 in an attempt to set outlier payments at 5.1% of total IPPS payments in FY 2011.[15]

Three-Day Payment Window

As discussed in our previous issues of *Health Law Update*, CMS has included in the 2011 IPPS Rule an interim final provision implementing statutory changes to Medicare's policy for the payment of hospital services within the so-called "3-day payment window."[16] This rule is effective for admissions on or after June 25, 2010. During a Hospital Open Door Forum held by CMS on August 26, 2010, hospitals expressed concerns that the Medicare claims processing systems may not allow hospitals to accurately reflect the correct dates of service of the ICD-9-CM procedure codes provided during the three calendar days immediately preceding the admission date on the inpatient claim. Essentially, the hospitals expressed concerns that they would have to change the dates of service for the procedure codes to the admission date, and thereby arguably falsify the dates of service, in order to comply with the three-day payment rule. On September 10, 2010, CMS responded by issuing a message to hospital providers via the National Institutes of Health listserv.[17] In this message, CMS confirms that it has verified that the Medicare claims processing system does allow the ICD-9-CM procedure code dates for non-diagnostic services provided up to three calendar days prior to the admission date on the inpatient claim. Therefore, hospitals are able to bill correctly for admission-related outpatient non-diagnostic services (that is, bundle the services on the inpatient hospital claim) without modifying dates on the inpatient claim. If providers encounter systems difficulties, CMS advises that such providers should contact their local contractor, CMS Regional Office, or CMS Central Office, accordingly.

Long-Term Acute Care Hospitals

CMS will adjust LTCH rates in 2011 by providing for a 2.5% inflation update coupled with a negative 2.5% adjustment to account for an increase in case mix resulting from changes in documentation and coding. In addition, LTCH payment rates will be subject to a 0.5% reduction as mandated by the Health Reform Act. Therefore, CMS estimates LTCHs will experience an approximate 0.5% increase in federal payments compared to the 2010 rate year. In addition, the 2011 IPPS Rule adopts an outlier threshold of $18,785 for LTCHs, which

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[14] *Id.* at 50199. These measures involve foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcers stage III and IV, falls and trauma, vascular catheter-associated infection, catheter-associated urinary tract infection, and manifestations of poor glycemic control.

[15] *Id.* at 50430.

[16] On June 25, 2010, Congress passed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Fund Act of 2010 (the "Act") which includes a provision clarifying how Medicare pays for services provided by hospitals on an outpatient basis on either the day of or during the three days prior to an inpatient admission. Pub. Law. 111-192, § 102(a)(1). In the Act, a "hospital" includes any entity wholly owned or wholly operated by the hospital.

[17] Available at: https://list.nih.gov/cgi-bin/wa.exe?A2=ind1009&L=OP-PPS-L&F=&S=&P=1792

represents an increase from 2010. In the 2011 IPPS Rule, CMS announces that LTCH policies will now be revised based on fiscal years, rather than on a rate year basis.[18]

Beyond the rates, the 2011 IPPS implements several provisions related to LTCHs stemming from the health reform law. These health reform changes include two year extensions of statutory provisions that: 1) offer some LTCHs and LTCH satellite facilities an exemption from payment adjustments for LTCHs whose admissions from co-located or non-co-located hospitals exceed a certain threshold (known as the 25% rule); 2) continue the moratorium on establishing new LTCHs and LTCH satellite facilities or expanding bed capacity in existing facilities; 3) apply an adjustment for short stay outlier discharges; and 4) continue a one-time adjustment of the federal LTCH payment rate.[19]

DSH Payment Updates and SSI Fraction Calculation

There are two methods for determining whether a hospital qualifies to receive the Medicare disproportionate share hospital ("DSH") payment adjustment. The most common method is based on a complex statutory formula under which the amount of the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (the "DPP").

CMS' calculation of the DPP was challenged in *Baystate Medical Center v. Levitt* on the basis that CMS' procedures for calculating the Supplemental Security Income ("SSI") did not use the "best available data."[20] The *Baystate* court upheld this assertion and required CMS to implement procedural changes in its calculation of the SSI. In the 2011 IPPS Rule, CMS implements the following three key changes to the calculation of DSH payments, all of which impact the process for calculating hospitals' SSI fractions for FY2011 and subsequent years:

- First, CMS now will use all SSI payment records, including "stale" records and forced pay records, for purposes of calculating the DPP;
- Second, CMS will revise its process for identifying individuals who qualify for both Medicare Part A and SSI by using social security numbers; and
- Finally, CMS will use more updated data for calculating the SSI fractions to further limit the time lag between the close of a hospital's cost reporting period and the date that CMS receives SSI eligibility information.

The 2011 IPPS Rule also discusses CMS Ruling 1498-R, which states that the new data matching process adopted in the 2011 IPPS Rule applies to properly pending appeals and open cost reports for cost reporting periods beginning prior to October 1, 2010. The administrator, Provider Reimbursement Review Board ("PRRB"), fiscal intermediary hearing officer or the CMS

[18] 75 Fed. Reg. 50041, 50050 (Aug. 16, 2010).
[19] These provisions were initially passed in the Medicare, Medicaid, and SCHIP Extension Act of 2007.
[20] 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d, 37, 44 (D.D.C. 2008). In the *Baystate* case, the hospital challenged CMS' calculation of the SSI fractions used for its Medicare DSH payments for fiscal years 1993 through 1996. The Court overruled as arbitrary and capricious the CMS Administrator's finding that CMS relied on the best data available in calculating the SSI fraction. For additional information on how healthcare reform affects DSH payments, *see* "The Dish on DSH: Reductions to Medicare and Medicaid Disproportionate Share (DSH) Payments," May 10, 2010, available at http://www.bassberry.com/healthreformimpact/.

reviewing official is required to remand each qualifying appeal to the appropriate Medicare administrative contractor and then explain how CMS and the contractor will recalculate the DSH payment adjustment.

If you have any questions on this issue of *Health Law Update*, please contact any of the attorneys in our Healthcare Practice Group listed below.

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