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HEALTH LAW
Update

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# The 2010 Inpatient Prospective Payment System Rule: No Stark Fireworks, But Still Plenty of Action

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In recent years, the Centers for Medicare & Medicaid Services ("CMS") has used the annual inpatient prospective payment system update, as well as other annual payment updates, as a vehicle to make significant regulatory changes, including changes to the Stark regulations. The final IPPS Rule for fiscal year 2010 (the "2010 IPPS Rule")[1] departs from this trend since it contains few regulatory changes. However, the 2010 IPPS Rule is still significant because it backs away from certain payment cuts previously proposed for 2010 and also contains important requirements for hospitals regarding payment, quality measures, and EMTALA, as well as provisions effecting payment changes for long-term acute care hospitals (LTCHs).

## Inpatient Payment Rates – Effective October 1, 2009

Under the 2010 IPPS Rule, payment rates to acute care hospitals will include a 2.1% increase over 2009 rates to account for inflation (commonly called the "market basket" update).[2] Hospitals that fail to report specified quality data will receive only a 0.1% 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 2010 IPPS Rule delays payment cuts associated with documentation and coding changes in the hospital payment system. In fiscal year 2008, CMS began a two year implementation of the Medicare severity-adjusted diagnosis related group (MS-DRG) system.[3] 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 eliminate what CMS estimated would be the effect of refinements in coding or classification changes to capture the new severity adjustments.

[1] 74 Fed. Reg. 43754 (Aug. 27, 2009).
[2] *See* 74 Fed. Reg. 43754, 44002 (Aug. 27, 2009). The market basket percentage change reflects the average change in the price of goods and services hospitals purchase in order to provide inpatient care. For a detailed description, see 74 Fed. Reg. 24080, 24153.
[3] 72 Fed. Reg. 47130, 47175.

In the *proposed* version of the 2010 IPPS Rule, CMS stated its need to implement a 1.9% reduction to offset the increased payments made due to improvements in coding under the MS-DRG system.[4] However, the final 2010 IPPS Rule does not implement this cut. Nonetheless, CMS has announced its intention to impose additional downward payment adjustments in 2011 and 2012 because of what CMS has determined to be an inadequate adjustment for 2008.

**Reporting Hospital Quality Data for Annual Payment Update**

In the 2010 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. CMS believes these new measures will assist in strengthening the relationship between payment and quality of healthcare services provided.[5]

The RHQDAPU initiative is an outgrowth of the Hospital Quality Initiative plan developed by CMS in consultation with hospital groups. After initial levels of participation proved to be disappointing under this voluntary program, Congress added a financial incentive tied to the ability of hospitals to receive the full market basket update each year.[6] Since the implementation of this financial incentive, participation has increased to ninety-nine percent and, of participating hospitals, ninety-seven percent received the full annual payment update last year. In addition, the RHQDAPU measure set has grown dramatically from a starter set of 10 measures in 2004 to the current set of 43 measures (not including the further expansion in the 2010 IPPS Rule).

In the 2010 IPPS Rule, CMS adds four new measures and program requirements for which hospitals are required to submit data under the RHQDAPU in 2010 in order to receive the full market basket update in 2011. Of the four measures added, two are part of the current Surgical Care Improvement Project (SCIP) measure set. The other two measures are designed by CMS to promote hospital participation in nursing-sensitive care and stroke care registries. CMS also retired one measure relating to beta-blockers based on changes in the American College of Cardiology/American Heart Association practice guidelines. Thus, after the 2010 IPPS Rule takes effect on October 1, 2009, the total number of quality measures will be 46.

The 2010 IPPS Rule also revises the RHQDAPU reconsideration process. CMS currently allows hospitals that will not be receiving the full market basket update an opportunity to submit to CMS a RHQDAPU reconsideration request. These hospitals may now submit a copy of all paper medical records they submitted to the CMS contractor each quarter for purposes of the validation, along with a copy of the reconsideration request form. CMS believes this new process will streamline reconsiderations and reduce the number of subsequent hospital appeals to the Provider Reimbursement Review Board (PRRB).

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[4] 74 Fed. Reg. 24080, 24096.
[5] *See* CMS "Fact Sheet - Medicare Adds Quality Measures for Reporting by Acute Care Hospitals for Inpatient Stays in FY 2010," July 31, 2009, available at http://www.cms.hhs.gov/apps/media/fact_sheets.asp.
[6] This was added by Congress in the Medicare Modernization Act of 2003.

## Hospital Acquired Conditions (HACs)

The 2010 IPPS Rule does not revise the list of hospital-acquired conditions (HACs) for 2010.[7] However, CMS takes the opportunity in the 2010 IPPS Rule to define more precisely the falls and trauma HAC category. In addition, CMS is planning to conduct joint evaluations with other governmental agencies of the program's impact.[8] CMS intends for these evaluations to assist with developing valuable information about the program's impact with respect to preventing HACs.

## Payments for Direct Graduate Medical Education (GME)

CMS clarifies the definition of a "new" medical residency training program.[9] Under the existing regulations, a new medical residency program is one that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995. According to CMS, some hospitals and Medicare contractors have misunderstood these regulations to mean that as long as the relevant accreditation body granted an "initial" accreditation or reaccredited a program as "new", the hospital may receive an FTE resident cap adjustment regardless of whether that program may have been accredited previously at another hospital.

The 2010 IPPS Rule specifies that the accreditation must be truly "initial" as opposed to a reaccreditation of a program that existed previously at the same or another hospital. CMS will look at various supporting factors when determining whether a program is new, including whether the program director and teaching staff are new and whether there are new residents. In addition, CMS will consider whether a program in the same specialty previously existed at a hospital that closed and whether that program is part of the FTE caps of any existing hospital.

CMS also addresses the fact that flexibility in the submission of Medicare GME affiliation agreements is warranted due to an unanticipated need in situations where a hospital opens after July 1 and begins training residents for the first time prior to the following July. Therefore, pursuant to the 2010 IPPS Rule, a new hospital which begins training residents for the first time after July 1 is permitted to submit a Medicare GME affiliation agreement prior to the earlier of

[7] 74 Fed. Reg. 43754, 43784 (Aug. 27, 2009). With respect to HACs, a hospital will not receive additional payment for cases in which one of the selected HACs was not present on admission, and the case would be paid as though the secondary diagnosis were not present. For an example of how the HAC provision may affect an MS-DRG payment see http://www.cms.hhs.gov/hospitalacqcond/. In contrast, a Hospital will not receive any payment at all for a "never event", such as performing the wrong surgical procedure.

[8] *See* CMS "Fact Sheet - Medicare Adds Quality Measures for Reporting by Acute Care Hospitals for Inpatient Stays in FY 2010," July 31, 2009, available at http://www.cms.hhs.gov/apps/media/fact_sheets.asp. The agencies which may participate in the evaluation include Department of Health and Human Services, the Center for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Office of Public Health and Science.

[9] *See* 74 Fed. Reg. 43754, 43908. The definition of a "new" medical residency training program is important for purposes of determining the number of FTE residents a hospital may count for purposes of direct GME and IME payments. Pursuant to current CMS regulations, a "new" medical residency training program may make a hospital eligible to receive adjustments to its FTE resident cap.

the end of its cost reporting period or the end of the academic year in order to be able to participate in a Medicare GME affiliated group for the remainder of the academic year.[10]

**Outliers**

The 2010 IPPS Rule raises the outlier threshold to $23,140 in an attempt to limit outlier payments to 5.1 percent of total IPPS payments in FY 2010. CMS projects that 5.4 percent of the total IPPS payments will be paid as outliers in FY 2009.

**Emergency Medical Treatment and Labor Act (EMTALA) Waiver Policy**

CMS amends the EMTALA regulations with respect to waiver of EMTALA sanctions in an emergency period to ensure that these regulations are more consistent with Section 1135 of the Social Security Act.[11] The 2010 IPPS Rule clarifies that, when permissible under Section 1135, EMTALA sanctions are waived for an inappropriate transfer if certain conditions are met, including the transfer being necessitated by the circumstances of the declared emergency and the hospital ensuring it does not discriminate on the basis of the individual's payment or ability to pay.

**Long-Term Acute Care Hospitals**

In the 2010 IPPS Rule, CMS does not adopt its earlier proposal to adjust LTCH rates in 2010 by negative 1.3% (more specifically, CMS indicates that it is "delaying" its application), but rather provides for a 2.5% inflation update, which is expected to result, when compared to FY 2009, in $153 million in additional payments. The 2010 IPPS Rule also finalizes changes to the Medicare severity long-term care diagnosis related group classifications that are consistent with changes to the IPPS MS-DRGs, including the changes to the Medicare Code Editor (MCE) software and changes to the ICD-9-CM coding system. In addition, the 2010 IPPS Rule adopts an outlier threshold of $18,425 for LTCHs, which is lower than the outlier threshold for acute care.

The Final Rule also (1) modifies the start date of the three-year delay in the application of certain payment policies applicable to certain classifications of LTCHs and LTCH satellite facilities,[12] and (2) finalizes the three-year moratorium on the establishment of new LTCHs, LTCH satellite facilities, and increases in beds in existing LTCHs and LTCH satellite facilities, which became effective December 29, 2007 and is set to expire on December 28, 2010.

Finally, the 2010 IPPS Rule includes an *interim* final rule with comment period implementing provisions of the American Recovery and Reinvestment Act that further amended provisions

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[10] *Id.* at 44225; CMS "Fact Sheet – Payment and Policy Changes for Inpatient Stays in Acute Care and Long-Term Care Hospitals for FY 2010," July 31, 2009, available at http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

[11] This Section authorizes the Secretary to temporarily waive or modify the application of several Medicare, Medicaid, and Children's Health Insurance Program provisions of the Social Security Act, and their implementing regulations, in an emergency area during an emergency period. *See* 74 Fed. Reg. 43754, 43919.

[12] Whereas previously the three-year payment delay applied to all classifications of LTCHs, the delay now is applicable for "grandfathered" LTCH satellite facilities for cost reporting periods on or after July 1, 2007, for LTCHs and LTCH satellite facilities for cost reporting periods beginning on or after October 1, 2007, and for certain co-located LTCHs or satellite facilities as of December 29, 2007.

related to payments to LTCHs and LTCH satellite facilities and to increases in beds in existing LTCHs and LTCH satellite facilities. If enacted as currently drafted, the interim final rule will create an additional exception to the bed-increase moratorium in an existing LTCH or LTCH satellite facility if the hospital or facility is located in a certificate of need (CON) state and it obtained a CON for an increase in beds between April 1, 2005, and December 29, 2007. If you have any questions on this Health Law Update, please contact any of the attorneys in our Healthcare Practice Group listed below.

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