

# FY 2012 Inpatient PPS Proposed Rule Teleconference

May 26, 2011

**Lori Mihalich-Levin, J.D.**  
[lmlevin@aamc.org](mailto:lmlevin@aamc.org)

**Karen Fisher, J.D.**  
[kfisher@aamc.org](mailto:kfisher@aamc.org)

**Jennifer Faerberg**  
[jfaerberg@aamc.org](mailto:jfaerberg@aamc.org)

**Jane Eilbacher**  
[jeilbacher@aamc.org](mailto:jeilbacher@aamc.org)



Tomorrow's Doctors, Tomorrow's Cures

---

Learn

---

Serve

---

Lead



Association of  
American Medical Colleges

# Inpatient PPS Proposed Rule

- Published in *Federal Register* on May 5, 2011 at page 25788.
- Available at:  
[http://www.access.gpo.gov/su\\_docs/fedreg/a110505c.html](http://www.access.gpo.gov/su_docs/fedreg/a110505c.html) under “Centers for Medicare & Medicaid Services”.

**Comments are due June 20, 2011**

# Topics for Today's Teleconference

- IME & DSH Payments – Exclusion of Hospice Days
- Market Basket Update
- Documentation & Coding Adjustment
- Outlier Payments
- VBP Program
- Readmissions
- Wage Index & Pension Issue
- Clarification Regarding Additional ESRD Payments
- New Technology Add-On Payments
- Policy Clarification on Recalled Devices
- 3-day Window

# Only Change Relating to IME Payments: Exclude Hospice Days

CMS proposes to:

- Exclude inpatient hospice days from bed day count for IME calculation
- Also, exclude inpatient hospice bed days and patient days from DSH calculation

See pages 25942 – 25944.

# FY 2012 Market Basket Update

Market basket projected increase = 2.8 percent

- Less 2 percent if hospital doesn't submit quality data
- Less multi-factor productivity adjustment = 1.2 percent
- Less an additional 0.1 percent
- Less 3.15 percent due to perceived documentation and coding impacts
- Increase 1.1 percent in response to a decision in the case of *Cape Cod Hospital v. Sebelius* (but remains under appeal)

Aggregate "update" = - 0.55%

Bottom line: Medicare operating payments would decrease by a projected \$498 million, or 0.5 percent, in FY 2012 compared to FY 2011

See pages 25948 – 25951.

# Documentation & Coding Adjustment

When the transition to MS-DRGs began in FY 2008, CMS projected that the average case-mix index (CMI) would increase, especially in the initial years, due to improved medical record documentation as well as more complete and accurate coding. CMI changes of this nature increase payments to hospitals, but they do not reflect the type of real increases in the severity of cases that require additional hospital resources.

CMS must “recoup” overpayments made in FYs 2008 and 2009 and must make a prospective adjustment to base rate to avoid overpayments in future years

See pages 25966 – 25968.

# Documentation & Coding Adjustment, Cont.

Recoup “overpayments”:

FY 2008 = 2.5% - 0.6% = 1.9%

FY 2009 = 5.4% - 1.5% = 3.9%

Total = 5.8%

FY 2011: Recoup 2.9%

Proposed FY 2012: Put back in FY 2008 2.9% but take out other half (2.9%) of recoupment; net result is no change to payments in FY 2012 due to recoupment

The 2.9% FY 2012 recoupment should be added back into standardized amount in FY 2013

# Documentation & Coding Adjustment, Cont.

## Make Prospective Adjustment

Prospective adjustment to account for FY  
2008-2009 changes = 5.4% less legislative  
adjustments of 1.5% = 3.9%

FY 2011: No prospective adjustment

Proposed FY 2012: 3.15% prospective adjustment

Remaining prospective adjustment = 0.75%

# FY 2012 Documentation and Coding Adjustment

	Required Prospective Adjustment for FYs 2008-2009	Remaining Required Recoupment Adjustment for FYs 2008-2009	Total Remaining Adjustment	Proposed Prospective Adjustment for FY 2012	Proposed Recoupment Adjustment to FY 2012 Payments	Remaining Prospective Adjustment If proposals are Finalized
Level of Adjustments	-3.9%	-2.9%	-6.8%	-3.15%	-2.9%	-0.75%

# Outlier Payments

Goal: Spend 5.1% of Total IPPS Payments for Outlier Payments

FY 2011 Outlier Threshold = \$23,075

FY 2012 Proposed Outlier Threshold = \$23,375

% increase = 1.3%

Note, estimated FY 2011 Outlier Payments = 4.9% and FY 2010 Outlier Payments = 4.7%

# VBP Final Rule - Key Points

- Domain weighting
  - 70% process measures
  - 30% HCAHPS
- Measures
  - Process measures reduced to 12 (topped out status)
  - All AHRQ individual PSI measures removed
  - HACs and mortality measures finalized
- HCAHPS
  - Changed from percentile to percentage scoring
  - Benchmark = mean of top decile
- Threshold and benchmarks for all measures released

# Medicare Spending per Beneficiary\*

- Proposed for IQR and VBP simultaneously
- Determining Spending Amount
  - Based on episodes of care 3 days prior to admission through 90 days post discharge
  - Includes part A and B services
  - Will be adjusted based on age and severity of illness (SOI)
  - Utilize standardized rates
  - Excludes IME and DSH

**\*Proposed in FY 2012 IPPS Rule**

See pages 25926 – 25928.

# Medicare Spending per Beneficiary (cont'd.)

- Hospital specific score = ratio of hospital score compared to median across all hospitals
- Performance period
  - May 15, 2012 – February 14, 2013
- Singular measure contained in new Efficiency domain
- Scored similar to other measures (based on achievement and improvement)

# Readmissions Payment Policy

- All base DRG payment amounts (excluding IME, DSH, outliers) in hospitals with excess readmissions are reduced by a factor determined by the level of “excess, preventable readmissions”
  - Effective FY 2013
  - Reduction is limited to 1% in 2013, 2% in 2014, and 3% in 2015 and beyond
  - Initially applied to heart attack, heart failure and pneumonia
- Expands in 2015 to 4 additional conditions identified in MedPAC June 2007 report (COPD, CABG, PTCA, and “other vascular”)

# Readmissions - IPPS

- FY 2013
  - AMI, HF, PN
  - NQF-endorsed measures
  - Readmission timeframe = 30 days
  - **No modifications for “unrelated” readmissions**
  - Performance period – July 1, 2008 – June 30, 2011
- Excess readmission ratio
  - Numerator = actual adjusted readmissions
  - Denominator = expected readmissions

See pages 25928 – 25937.

# Issues Relating to Hospital Wage Index

- “Imputed floor” for states without rural hospitals sunsets at end of FY 2011
  - CMS is **NOT** proposing to extend the imputed floor
- ACA requires Secretary to submit to Congress by 12/31/11 a plan to reform the wage index
  - Upcoming listening session regarding Acumen’s concept
- No changes to occupational mix methodology
  - But hospitals not completing 2010 occupational mix survey, due 7/1/11, must submit explanation for not submitting data
- No change to labor-related share of 68.8 percent (for hospitals with wage index > 1)

See pages 25870 – 25890.

# Issues Relating to Hospital Wage Index – Pension Costs

- Beginning with FY 2013, CMS proposes to include in wage index:
  - **Rolling 3-year average of actual cash contributions hospital contributed to pension plan**

See pages 25875 -25876.

*Note: New proposal for reporting pension costs for Medicare cost finding purposes: contribution to pension fund in that year with cap of 150% of highest average during 3 consecutive cost reporting periods in 5 most recent cost reporting periods. Effective for cost reporting periods beginning 10/1/11.*

See pages 25951 – 25953.

# Additional Payments to Hospitals with High Percentage of ESRD Discharges - Clarification

- Hospitals providing dialysis during inpatient stay to  $\geq 10\%$  of Medicare discharges receive additional payments
- Proposal to clarify that “Medicare discharges” means all beneficiaries entitled to Part A –
  - Fee-for-service beneficiaries
  - Benefits exhausted
  - Stay not covered by Medicare
  - Medicare Advantage enrollees

See page 25951.

# Add-On Payments for New Technologies

- Update on FY 2011 New Technologies
  - AutoLITT System will continue to receive new technologies add-on in FY 2012
- FY 2012 Applicants for New Technologies Add-On
  - AxiaLIF 2L+ System
  - Champion HF Monitoring System
  - PerfectCLEAN with Micrillon

See pages 25858 – 25870.

# Recalled Device Policy Clarification

- FY 2012 IPPS Proposal: clarify recalled device policy to state it applies where “the hospital received a credit equal to 50 percent or more of the cost of the replacement device”
- CMS Rationale:
  - Discrepancy between IPPS and OPPS recalled device policies
    - CY 2008 OPPS final rule specified that the credit must be 50 percent or greater of replacement device whereas FY 2008 IPPS final rule did not specify whether it was 50 percent of original device or replacement device

See page 25849.

# 3-Day Payment Window

New proposal:

- 3-day window applies to preadmission diagnostic & nondiagnostic services furnished at physician practices wholly owned or wholly operated by admitting hospital.

CMS will address:

- Comments on this proposal *and* comments on Aug. 2010 interim final rule in FY 2012 IPPS final rule
- Policy's impact on physician billing in FY 2012 physician fee schedule proposed rule

Note: reminder to use condition code 51 to attest to nondiagnostic *unrelated* services.

See pages 25960 – 25961.

Questions?