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Proposed Medicare hospital rules would help improve care quality

Proposal continues to tie annual update amount for many hospitals to participation in Inpatient Quality Reporting Program, supports efforts to lower health care costs

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that would update Medicare payment policies and rates for hospitals in Fiscal Year (FY) 2012. Proposals included in the rule would help support the Obama Administration's efforts to reform our health care delivery system by improving care quality and patient outcomes, addressing long-term health care cost growth, and supporting the goals of the recently announced Partnership for Patients.

"The proposals CMS is making today reflect an underlying premise that we can improve the quality of and access to care while at the same time slowing the growth in health care spending," said CMS Administrator Donald M. Berwick, M.D. "In fact, there is a growing body of evidence that improving care – focusing on the patient's needs, reducing unnecessary duplicate services, and avoiding costly mistakes and preventable healthcare acquired conditions – is key to reducing health care cost growth," he said.

The proposed rule would update payment policies and rates for acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), as well as hospitals paid under the Long Term Care Hospital Prospective Payment System (LTCH PPS). The proposed rule would also improve and expand the Hospital Inpatient Quality Reporting Program (IQR) with a greater focus on patient outcomes and experiences of care and establish the framework for a new quality reporting program that would apply to hospitals paid under the LTCH PPS.

Improving Patient Care

The proposed rule includes several quality improvement proposals that will support larger quality and patient safety efforts across the Department of Health and Human Services,

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including the Partnership for Patients. The Partnership for Patients is a new public-private partnership that will help improve the quality, safety and affordability of health care for Medicare, Medicaid and CHIP beneficiaries and, by extension, all Americans. One of the Partnership's goals is to decrease preventable complications during a transition from one care setting to another so that all hospital readmissions would be reduced by 20-percent by 2014 compared to 2010. Achieving this goal would mean more than 1.6 million additional patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Research by the Medicare Payment Advisory Commission (MedPAC) and others show that as many as 1 in 3 Medicare patients who leave the hospital will be readmitted within 30 days of discharge, and that a large portion of these readmissions can be avoided through well-coordinated, high-quality hospital care. To provide hospitals with an incentive to improve care coordination, the Affordable Care Act directs CMS to implement a Hospital Readmissions Reduction Program that will reduce payments beginning in FY 2013 to certain hospitals that have excess readmissions for certain selected conditions. Today's proposed rule proposes measures for rates of readmissions for three conditions -- acute myocardial infarction (or heart attack), heart failure, and pneumonia. CMS is also proposing a methodology that would be used to calculate excess readmission rates for the program. Additional conditions may be added in future rulemaking. The payment adjustments will apply to hospital payments in FY 2013, beginning with discharges on or after Oct. 1, 2012.

The proposed rule also includes proposals aimed at encouraging improvements in the quality of care in hospital inpatient settings, and makes proposals that would align the existing inpatient quality reporting program with a proposed new hospital value-based purchasing program required by the Affordable Care Act. The proposed rule also lays the groundwork for a quality reporting program under the LTCH PPS, by proposing the first measure set for reporting in FY 2013, for payment determination in FY 2014, and discusses specific quality considerations for hospitals providing acute-level care to patients requiring longer stays. To be paid under the LTCH PPS, a hospital must have an average length of stay for all patients it treats that exceeds 25 days.

Payment Updates

The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 420 LTCHs, would be effective for discharges occurring on or after Oct. 1, 2011. Under the proposed rule, CMS projects that Medicare operating payments to acute care hospitals for discharges occurring in FY 2012 would decrease by a projected \$498 million or 0.5 percent in FY 2012 relative to FY 2011. This includes a hospital update of 1.5 percent (based on a projected market basket update of 2.8, reduced by a productivity adjustment and an additional

0.1 percent), increased by 1.1 percent in response to litigation, as well as a documentation and coding adjustment of -3.15 percentage points to account for changes in documentation and coding following adoption of the Medicare severity DRGs that did not reflect actual increases in patients' severity of illness. Medicare payments to LTCHs in FY 2012 are projected to increase by \$95 million or 1.9 percent.

The Medicare law requires CMS to pay acute care hospitals (with a few exceptions that are specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. These payment systems establish prospectively set rates based on the patient's diagnosis and the severity of the patient's medical condition. Under the IPPS and the LTCH PPS, a hospital receives a single payment for the case based on the payment classification assigned at discharge. The law requires CMS to update the payment rates for both types of hospitals annually to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients, as well as for other factors.

The proposed rule can be downloaded from the *Federal Register* at:
www.ofr.gov/inspection.aspx.

CMS will accept public comments on the proposed rule until June 20, 2011, and will respond to them in a final rule to be issued by Aug. 1, 2011.

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