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Medicare payment rule promotes improved inpatient care

Final rule strengthens tie between payment and quality improvement, and will lead to lower costs

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule that will update Medicare payment policies and rates for hospitals in fiscal year (FY) 2012. The final rule, which will affect Medicare payments to general acute care hospitals and long-term care hospitals for inpatient stays, supports efforts to promote ongoing improvements in hospital care that will lead to better patient outcomes while addressing long-term health care cost growth.

"The final rule continues a payment approach that encourages hospitals to adopt practices that reduce errors and prevent patients from acquiring new illnesses or injuries during a hospital stay," said CMS Administrator Donald M. Berwick, M.D. "This approach is part of a comprehensive strategy being implemented across Medicare's payment systems that is intended to reduce overall costs by improving how care is delivered."

The final rule updates 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 final rule also strengthens the Hospital Inpatient Quality Reporting (IQR) Program by placing greater emphasis on preventing health care-associated infections in general acute care hospitals, and establishes the framework for a new quality reporting program that will apply to hospitals paid under the LTCH PPS.

CMS projects that total Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2012 will increase by $1.13 billion, or 1.1 percent, in FY 2012 compared with FY 2011, due to a 1.0 percent increase in payment rates together with other policies adopted in the final rule. Medicare payments to LTCHs in FY 2012 are projected to increase by $126 million or 2.5 percent in FY 2012 relative to FY 2011, due to a 1.8 percent increase in payment rates together with other policies adopted in the final rule.

Improving Patient Care

To provide hospitals with an incentive to reduce preventable hospital readmissions and improve care coordination, the Affordable Care Act requires CMS to implement a Hospital Readmissions Reduction Program that will reduce payments beginning in FY 2013 – for discharges on or after Oct. 1, 2012 - to certain hospitals that have excess readmissions for certain selected conditions. Today's final rule finalizes readmissions measures for three conditions -- acute myocardial infarction (or heart attack), heart failure, and pneumonia – as well as the methodology that will be used to calculate excess readmission rates for these conditions.

The final rule also adopts a Medicare spending per beneficiary measure for both the Hospital IQR Program and the new Hospital Inpatient Value-Based Purchasing (VBP) program required by the Affordable Care Act. The new measure will assess Part A and Part B beneficiary spending during a period of time that spans from three days prior to a hospital admission through 30 days after the patient is discharged. The goal is to encourage hospitals to provide high quality care to Medicare beneficiaries at a lower cost and to promote greater efficiencies across care settings and throughout the entire U.S. health care system.

The final rule also lays the groundwork for a quality reporting program under the LTCH PPS, by establishing the first measure set for reporting beginning October 1, 2012.

Payment Rate Updates

The final rule, which will apply to approximately 3,400 acute care hospitals and 420 LTCHs, will be effective for discharges occurring on or after Oct. 1, 2011, unless otherwise specified in the rule. The final rule will increase payments to general acute care hospitals under the IPPS by 1.1 percent, compared with a 0.55 percent reduction in the proposed rule, and will increase payments to LTCHs by 2.5 percent, compared with 1.9 percent in the proposed rule. For certain hospitals excluded from the IPPS (such as, cancer and children's hospitals and religious nonmedical health care institutions)

"CMS has developed its update policy in response to many comments expressing concerns about our original proposal," said Deputy Administer and Director for the Center for Medicare, Jonathan Blum. "We believe that our final policy strikes the appropriate balance between providing a fair update to hospitals and ensuring careful stewardship of the Medicare Trust Fund."

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 final rule can be downloaded from the *Federal Register* at:
http://www.ofr.gov/OFRUpload/OFRData/2011-19719_PI.pdf or
http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

It will appear in the Aug. 18, 2011 *Federal Register*.

For additional information please see the CMS Fact sheets issued today **(8/1)** go here:
CMS Fact Sheet Link: http://www.cms.hhs.gov/apps/media/fact_sheets.asp