American Hospital Association

SPECIAL BULLETIN

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CMS RELEASES RULE ON REFORM PROVISIONS AFFECTING INPATIENT AND LONG-TERM CARE HOSPITAL PAYMENTS FOR FY 2011

The Centers for Medicare & Medicaid Services (CMS) Friday issued a second proposed rule affecting fiscal year (FY) 2011 inpatient and long-term care hospital prospective payment system (PPS) payments. This additional rule addresses provisions included in the *Patient Protection and Affordable Care Act* (PPACA) that affect FY 2011 payments. Comments on the proposed rule, available at http://www.cms.gov/AcuteInpatientPPS/IPPS2010/list.asp, will be accepted until June 21. A final rule will be released by August 1, and the policies and payment rates will generally take effect October 1.

Compared to FY 2010, FY 2011 payments will decrease by 0.9 percent on average, or $820 million total. We are extremely disappointed with the proposed level of payment for FY 2011, most of which is due to the coding offset CMS previously proposed. We are conducting a detailed and thorough analysis of CMS' proposals in this rule, as well as its proposal and methodology for determining the coding offset, and are committed to helping ensure that hospitals receive an appropriate update for FY 2011.

Based on our preliminary read, a summary of the key provisions of the second proposed inpatient PPS rule follows.

Operating Payment Update: The rule includes a mandated 0.25 percentage point cut to the FY 2011 market basket update of 2.4 percent. The resulting market basket update for FY 2011 will be 2.15 percent. The rule also implements a mandated 0.25 percentage point cut to FY 2010 inpatient PPS payments, which will be applied retrospective to April 1.

Protections for Frontier States: The rule implements, for FY 2011 and beyond, a wage index floor of 1.0 for Medicare inpatient and outpatient PPS payments to hospitals in frontier states and a geographic practice expense index floor of 1.0 for Medicare payments to physicians in frontier states. Frontier states are those states where at least 50 percent of counties have fewer than six people per square mile; under the provision, Alaska and Hawaii are not eligible for the floors.

CMS used Census Bureau data to propose the following states as eligible: Montana; Nevada; North Dakota; South Dakota; and Wyoming. However, wage indices and geographic practice expense indices in Nevada already are above 1.0. The agency clarifies that all hospitals geographically located in the state, regardless of reclassification status, will benefit from the floor. This new policy is expected to increase payments to hospitals in eligible states by approximately $48 million in FY 2011.

Area Wage Index: The rule makes several changes to the hospital area wage index mandated by the PPACA. Specifically, the rule:

- Decreases the thresholds necessary for a hospital to reclassify to another wage area, setting them at the levels that were in effect in FY 2008. This change will remain in effect through FY 2013. An urban hospital would need to have an average hourly wage (AHW) that is 84 percent (down from 88 percent) of the area to which it wants to reclassify. A rural hospital would need an AHW that is 82 percent (down from 86 percent). Rural and urban county groups of hospitals would need to have an AHW that is 85 percent (down from 88 percent) of the area to which they want to reclassify. CMS has identified 18 additional hospitals that will qualify for reclassification for FY 2011; five additional hospitals that had previously qualified for reclassification to their secondary requested area also will now qualify for their primary area for FY 2011.
- Applies the rural floor budget-neutrality adjustment on a national basis, rather than at the state level.

Payments to Qualifying Hospitals in "Low-cost" Counties: The rule implements a PPACA provision that provides $400 million total in FY 2011 and 2012 to hospitals in counties that rank in the lowest quartile of Medicare per-beneficiary spending, adjusted by age, sex and race. CMS proposes to obtain age, sex and race data from their "Denominator" file, which contains demographic and enrollment characteristics on all Medicare beneficiaries.

Of the 786 counties in the lowest quartile of adjusted Medicare per-beneficiary spending, 276 counties include a PPS hospital. Each of the 415 PPS hospitals in these qualifying counties will receive funding in an amount that is proportional to the FY 2009 Medicare inpatient hospital operating payments made to the individual hospital as a percentage of the FY 2009 Medicare inpatient hospital operating payments made to all hospitals receiving the funding. CMS proposes to distribute $150 million of the $400 million in FY 2011 and the remaining $250 million in FY 2012. The agency also proposes to distribute payments through the individual hospital's Medicare contractor through an annual one-time payment during each of FYs 2011 and 2012. These payments will not be cost-settled.

A list of the hospitals qualifying for these payments, as well as the "weighting factor" that determines the amount of payment they will receive, can be found in Table 3 on page 68 of the display copy of the proposed rule.

Payment Adjustment for Low-volume Hospitals: The rule improves the low-volume adjustment for FYs 2011 and 2012. For these years, a low-volume hospital will be defined as one that is more than 15 road miles from another comparable hospital and has up to 1,600 discharges of individuals entitled to, or enrolled in, Part A. Under the statute, CMS must provide these hospitals with an add-on payment in an amount determined using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with Medicare discharges below 200, to no adjustment for hospitals with 1,600 or more Medicare discharges. The agency proposes to use the following adjustments:

Medicare discharges	Payment add-on percentage
1-200	25.0000
201-300	23.3333
301-400	21.6667
401-500	20.0000
501-600	18.3333
601-700	16.6667
701-800	15.0000
801-900	13.3333
901-1000	11.6667
1001-1100	10.0000
1101-1200	8.3333
1201-1300	6.6667
1301-1400	5.0000
1401-1500	3.3333
1501-1599	1.6667
1600 or more	0

To qualify for the low-volume adjustment, a hospital must provide to its fiscal intermediary or Medicare Administrative Contractor sufficient evidence to document that it meets the discharge and distance criteria.

Critical Access Hospital (CAH) Payments: The rule ensures CAHs will be paid 101 percent of reasonable costs for all outpatient services they provide, regardless of the billing method elected. In FY 2010, CMS set outpatient service reimbursement for CAHs electing Method 2 at 100 percent of cost instead of at 101 percent of cost. The provision in this rule is retroactive, meaning CAHs will continuously receive the 101 percent reimbursement, despite CMS' previous policy.

Rural Community Hospital (RCH) Demonstration: The rule extends the RCH demonstration for five additional years, through December 31, 2014. It also increases the maximum number of participating hospitals from 15 to 30 and expands the eligible sites from rural areas in 10 states to those in 20 states with low population densities. For hospitals currently in the demonstration, the inpatient payment amount will be re-based.

Medicare-dependent Hospital (MDH) Extension: The rule extends the MDH program for one year, through September 30, 2012.

Long-term Care Hospital (LTCH) PPS

The proposed rule adds the mandated 0.5 percentage point cut to the FY 2011 market basket update of 2.4 percent. The modified market basket update for FY 2011 will be 1.9 percent. This revised market basket is offset by a coding cut of 2.5 percent, which results in a 0.59 percent reduction to the proposed FY 2011 LTCH standard rate, $39,560.16. CMS estimates that, with the added 0.5 percent cut, FY 2011 Medicare payments to LTCHs will increase by approximately $13 million, taking into account the -0.59 percent update and increased payments for high-cost outlier and short-stay outlier cases. The proposed rule also implements a mandated 0.25 percentage point cut to LTCH payments for the second half of FY 2010, effective for discharges occurring between April 1 and September 30, 2010.

In addition, the rule extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2007*. Specifically, it extends through December 29, 2012 the hold on implementing the rate year 2008 short-stay outlier cut and a one-time reduction to adjust for the budget-neutral implementation of the LTCH PPS. The current moratorium on new LTCH beds and facilities, with exceptions, also will be extended through the same date. The postponement of full implementation of the LTCH "25% Rule" also is extended for two years, with LTCHs in the meantime being held to either a 50 or 75 percent threshold, depending on their type and location.

Next Steps

Comments on the rule, available at http://www.cms.gov/AcuteInpatientPPS/IPPS2010/list.asp, will be accepted until June 21. The final rule will be published by August 1, and the policies and payment rates will take effect October 1.