American Hospital Association

FY 2011 Inpatient Rule – Supplement

FALL 2010

*The **August** issue of the **Small or Rural Update** covered legislative and regulatory issues, including a brief look at the Centers for Medicare & Medicaid Services (CMS) inpatient prospective payment system (IPPS) final rule for fiscal year (FY) 2011. This edition of **Update** examines in detail the rule's impact on small or rural hospitals, including critical access hospitals (CAH). The IPPS rule implements a number of provisions in the Patient Protection and Affordable Care Act (ACA), which are highlighted for the first time in **Update**. The IPPS final rule takes effect October 1; a copy of the rule may be found at http://edocket.access.gpo.gov/2010/2010-19092.htm. The AHA's 30-page IPPS Regulatory Advisory may be found at Medicare Inpatient and Long-term Care PPS: The Final Rule for Fiscal Year 2011.*

Major provisions of the final rule are highlighted below.

PAYMENT UPDATE AND ADJUSTMENTS

Operating Payment Update – The rule includes a mandated marketbasket update of 2.6%, as well as a 0.25 percentage point reduction to the FY 2011 marketbasket mandated by the ACA. Thus, the marketbasket update for those hospitals that publicly report data on 45 quality measures is 2.35%. Hospitals not submitting data will receive a 0.35% update.

The final standardized amounts for FY 2011 are as follows:

Area Wage Index Greater Than 1.0			
Full Update (2.35%)		**Reduced Update (0.35%)**	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
$3,522.91	$1,611.20	$3,483.49	$1,579.62

Area Wage Index Less Than 1.0			
Full Update (2.35%)		**Reduced Update (0.35%)**	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
$3,201.75	$1,962.36	$3,139.19	$1,924.02

Capital Payment Update – CMS also will apply a 2.9% documentation and coding adjustment to the capital federal rate on a prospective basis, which will permanently remove these increased payments from the system. When coupled with the capital input price index update of 1.5%, hospitals will see their capital payments decrease by an average of 0.5%, or $21 million total, in FY 2011 compared to FY 2010.

Documentation and Coding Offset – Ignoring concerns expressed by America's hospitals and a bipartisan majority of both houses of Congress – and two independent studies that show CMS' methodology was flawed – the final rule included a 2.9% cut – $3.7 billion for FY 2011 – to recoup half of the payments made in FYs 2008 and 2009 that CMS claims were due to implementation of Medicare Severity Diagnosis-related Groups (MS-DRGs) that the agency says do not reflect real changes in case-mix. Although CMS has the authority to apply a prospective cut to permanently remove the remaining increased payments from the system, the agency stated that it will not do so at this time. Unlike in previous IPPS rules, CMS will apply the coding offset to sole community hospitals, Medicare-dependent hospitals (MDHs) and Puerto Rico hospitals.

The AHA strongly voiced its concerns about payment cuts that CMS attributed to documentation and coding offsets. In combination with other policy changes, this cut will result in hospitals actually being paid less in FY 2011 than in FY 2010. The AHA is extremely disappointed with the level of payment for FY 2011. The market basket update for FY 2011 already is lower than in other years – a 2.35% update compared to 3.6% for FY 2009.

Hospital Wage Index – The area wage index adjusts payments to reflect differences in labor costs across geographic areas. The final rule bases the FY 2011 wage index on data from hospitals' FY 2007 cost reports. According to CMS, the national average hourly wage increased 4.3% compared to the FY 2010 index. As a result, a number of hospitals may see their wage index decline relative to last year because, even though their wages rose, they did not rise as quickly as those at other hospitals.

Individual and Group Reclassifications: Many hospitals apply each year to the Medicare Geographic Classification Review Board for reclassification to another area to receive a higher area wage index. CMS had not evaluated or recalibrated the average hourly wage (AHW) criteria for geographic reclassification since they were established in FY 1993. As part of its effort to implement wage index changes in the FY 2009 rule-making period, CMS reevaluated these criteria. Based on these new data, for FY 2010 reclassifications, CMS increased the thresholds necessary for a hospital to reclassify to another wage area.

This final rule implements this provision and sets the thresholds 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 AHW that is 84% of the AHW of the area to which it wants to reclassify. A rural hospital would need an AHW that is 82%. Rural and urban county groups of hospitals would need to have an AHW that is 85% of the AHW of the area to which they want to reclassify. As a result, 22 additional hospitals qualify for reclassification to their primary area for FY 2011.

Budget Neutrality Related to the Rural Floor: *The Balanced Budget Act of 1997* established the rural floor by requiring that the wage index for a hospital in an urban area of a state cannot be less than the area wage index determined for that state's rural area. In addition, in 2006, CMS temporarily adopted an "imputed" rural floor measure by establishing a wage index floor for those states that did not have rural hospitals. Both the rural floor and the imputed rural floor have been funded through a

nationwide budget-neutrality adjustment. In FY 2009, CMS began applying a statewide (rather than a nationwide) rural floor and imputed rural floor budget-neutrality adjustment to the wage index, with a three-year transition; thus, in FY 2011, this new policy would have been fully phased in. However, as mandated by the ACA, in this final rule, CMS modifies its existing policy so that the rural floor budget-neutrality adjustment is once again applied on a national basis, rather than at the state level.

Section 508 Reclassifications: Under the ACA, wage index reclassifications under Section 508, will expire after September 30. Therefore, CMS does not include these reclassifications in the final rule. However, the *Veterans', Seniors', and Children's Health Technical Corrections Act of 2010*, which passed the House on August 20, 2010, but not the Senate, would extend Section 508 reclassifications through September 30, 2011.

Protections for Frontier States – The rule implements, for FY 2011 and beyond, a wage index floor of 1.0 for Medicare IPPS payments to hospitals in frontier states. Frontier states are those where at least 50% of counties have fewer than six people per square mile; however, under the provision Alaska and Hawaii are not eligible for the floors. CMS used Census Bureau data to identify as eligible Montana, Nevada, North Dakota, South Dakota and Wyoming. However, wage 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 inpatient payments to PPS hospitals in eligible states by approximately $48 million in FY 2011.

72-hour Rule (Three-day Payment Window) – CMS modifies Medicare's policy for payment of outpatient non-diagnostic services provided on either the day of or during the three days prior to a Medicare beneficiary's inpatient admission – generally known as the "72-hour rule" or the "three-day payment window." For PPS hospitals, for outpatient services furnished on or after June 25, 2010, all non-diagnostic services (other than ambulance and maintenance renal dialysis services) provided by the hospital on the first, second and third calendar days preceding the date of a beneficiary's inpatient admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless the hospital attests that the non-diagnostic service is unrelated to the hospital stay.

CMS is making similar changes for non-PPS hospitals such as rehabilitation or psychiatric, but only for services provided on the date of admission and on the first calendar day preceding the date of admission. *CAHs ARE EXEMPT FROM THIS POLICY.* CMS states that it intends to establish a process for hospitals to attest that a non-diagnostic service is unrelated to the hospital stay, which will involve a condition code, modifier or other indicator on the claim. As part of the process, hospitals would be required to maintain documentation in the beneficiary's medical record to support their claim.

Outliers – The final rule decreases the outlier fixed-loss threshold from its current level of $23,140 to $23,075.

Payment Adjustment for Low-volume Hospitals – Since FY 2005, the IPPS has included a payment add-on to account for the higher costs per discharge for low-volume hospitals. This rule, as mandated by the ACA, 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 ACA, CMS must provide these hospitals with an add-on payment in an amount

determined using a continuous linear sliding scale ranging from 25% for low-volume hospitals with Medicare discharges below 200, to no adjustment for hospitals with 1,600 or more Medicare discharges. The formula for such an adjustment (only applicable to hospitals with 200 or greater discharges – those with fewer than 200 discharges automatically receive an adjustment of 25%) is: Add-on percentage = (4/14) – (Medicare discharges/5600).

To qualify for the low-volume adjustment, a hospital must provide to its fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) sufficient evidence to document that it meets the discharge and distance criteria. CMS estimates that this provision will increase payments to almost 600 hospitals by $380 million in FY 2011 and $450 million in FY 2012. In addition, it estimates that there will be an increase of $50 million in FY 2013 for hospital stays at the end of FY 2012 that are paid in FY 2013.

REPORTING HOSPITAL QUALITY DATA

CMS finalized several new measures for the Reporting Hospital Quality Data for the Annual Payment Update program. These new measures expand the data reporting requirements from 45 measures in FY 2011 to 60 measures in FY 2014. In addition, CMS will require hospitals to use additional mechanisms for the submission of data in certain instances. CMS did **not** finalize two proposals – collection of all-payer volume data and mandatory reporting into a clinical registry database.

POST-ACUTE CARE TRANSFER POLICY

Since FY 1999, certain Medicare patients discharged to a post-acute care setting or discharged within three days to home health services, are defined as transfer cases, which are paid based on a daily (per diem) rate, rather than a fixed DRG amount, up to the full PPS rate. The current transfer policy applies to patients who are transferred between IPPS hospitals.

In its final rule CMS will expand the post-acute care transfer policy as it relates to transfers to non-IPPS hospitals. The final rule expands the policy so that it also applies to transfers between IPPS hospitals and hospitals that would otherwise be eligible to be paid under the IPPS, but that do not have an agreement to participate in the Medicare program, and also to transfers between IPPS hospitals and CAHs.

CRITICAL ACCESS HOSPITALS

CAH Provider Taxes and Allowable Costs – CMS "clarified" its policy concerning when provider taxes are considered allowable costs under Medicare. Medicare contractors will determine the allowability of provider taxes on a case-by- case basis, based on reasonable cost principles, and will determine if a reduction of the allowable tax expenses is necessary to account for payments providers receive that are associated with the assessed tax. The AHA strongly opposes CMS' plan to revise a policy that permits certain provider taxes to be treated as allowable costs for CAHs. The proposal is too vague for CMS to solicit comment on, and therefore, may finalize an unspecified revision.

Method 2 Payment – Effective for cost-reporting periods beginning on or after October 1, 2010, once a CAH has elected to receive payments under "the optional method" (also known as "Method 2"), the election will remain in place until it is terminated. CAHs will no longer have to re-elect the optional method annually. If a CAH is being paid under the optional method and wishes to terminate

that election, it must submit a request in writing to its FI or MAC at least 30 days prior to the start of the next cost-reporting period.

101% of Reasonable Costs for Outpatient Services – The rule ensures CAHs will be paid 101% 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% of cost instead of at 101% of cost. The provision in this rule is retroactive, meaning CAHs will continuously receive the 101% reimbursement, despite CMS' previous policy.

Payments for Certified Registered Nurse Anesthetist (CRNA) Services

Certain hospitals located in rural areas are eligible for reasonable-cost based reimbursement for CRNA services. Under the existing regulations, neither hospitals that have reclassified from urban to rural, nor hospitals that are located in "Lugar" counties, are eligible to receive this cost-based reimbursement. (Lugar counties are certain counties that are rural, but adjacent to one or more urban areas, and are treated as being located in the urban area.) However, effective for cost-reporting periods beginning on or after October 1, 2010, CMS will make hospitals (including CAHs) that have reclassified from urban to rural eligible for CRNA cost-based reimbursement. CMS will not make hospitals (or CAHs) that are located in Lugar counties eligible for CRNA cost-based reimbursement.

Medicare-dependent Hospitals

Currently, under the regulations, for a hospital to qualify as an MDH, at least 60% of its inpatient days or discharges must be attributable to individuals "receiving" Medicare Part A benefits. Thus, the MDH regulations do not allow hospitals to count Medicare beneficiaries who have exhausted their Medicare Part A inpatient benefits towards the 60% threshold. However, the *Social Security Act* states that at least 60% of an MDH's inpatient days or discharges must be attributable to individuals "entitled to" Medicare Part A benefits.

To conform to the *Social Security Act*, effective October 1, 2010, CMS will change the regulations to read "entitled to," instead of "receiving." This will allow hospitals to count Medicare beneficiaries who have exhausted their Medicare Part A inpatient benefits, as well as those enrolled in Medicare Advantage and section 1876 cost contracts, towards the 60% threshold. CMS estimates that this proposal could allow 48 more IPPS hospitals to qualify as MDHs, which would increase Medicare payments by $3.6 million in FY 2011. In addition, the rule extends the MDH program for one year, through September 30, 2012, increasing payments to hospitals by $110 million in FY 2012.

CRITERIA FOR PURPOSES OF DETERMINING RURAL REFERRAL CENTER (RFC) STATUS

If a hospital wants to become an RRC, but does not have 275 or more beds, it must meet two mandatory criteria – a minimum case-mix index and a minimum number of discharges – and one of three additional criteria relating to specialty composition of medical staff, source of inpatients or referral volume. The final rule updates the alternative criteria for RRC designation in FY 2011 to include:

- A case-mix index that is at least equal to either the median case-mix index for urban hospitals in its census region (excluding hospitals with approved teaching programs) or the median case-mix index for urban hospitals nationally (1.5136), whichever is lower; or

- At least 5,000 discharges per year (at least 3,000 for osteopathic hospitals) or, if fewer, the median number of discharges for urban hospitals in its census region.

Payments to Qualifying Hospitals in "Low-cost" Counties – The rule implements an ACA provision that provides $400 million total in FYs 2011 and 2012 to hospitals in counties that rank in the lowest quartile of Medicare per-beneficiary spending, adjusted by age, sex and race. The agency obtained age, sex and race data from its "denominator" file, which contains demographic and enrollment characteristics on all Medicare beneficiaries. In the proposed rule, CMS made a number of technical errors in determining the specific counties, and the hospitals within them, that are in the lowest quartile of adjusted Medicare per-beneficiary spending. CMS remedied these issues in the final rule. Specifically, the agency:

- Identified two additional PPS hospitals that are located in qualifying counties;
- Removed one PPS hospital from the list of qualifying hospitals because it did not have any FY 2009 Medicare inpatient hospital operating payments;

Removed two counties that do not contain PPS hospitals from the list of qualifying counties

RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM

The Medicare Modernization Act of 2003 required CMS to conduct a demonstration program in rural areas under which up to 15 qualifying hospitals with fewer than 51 beds could receive cost based reimbursement rather than PPS payment for inpatient acute-care and swing-bed services for a five-year period. CAHs are not eligible for this program.

Although the RCH demonstration was scheduled to end in 2009, the ACA extended it 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 as determined by the Secretary. For this demonstration, hospitals must be located in one of the 20 least densely populated states: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, or Wyoming.

Hospitals selected for participation in the demonstration will receive payment for inpatient services, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules:

- For discharges occurring in the first cost reporting period on or after the implementation of the program, their reasonable costs for covered inpatient services;
- For discharges occurring during the second or subsequent cost reporting period, the lesser of their reasonable costs or a target amount. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the IPPS update factor (as defined in Section 1886(b)(3)(B)) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount increased by the IPPS update factor for that particular cost reporting period.

For hospitals currently in the demonstration, the inpatient payment amount will be rebased.

Each rural community hospital that wants to participate in the demonstration must submit an application. *Applications will be considered timely if received on or before 5:00 p.m., October 14, 2010.* For further information, contact Sid Mazumdar at (410) 786-6673 or siddhartha.mazumdar@cms.hhs.gov.

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January 30 — February 2, 2011
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Accountable Care Organizations (ACOs)
Want to learn more about accountable care organizations (ACOs)? Plan to participate in our October 5 webcast featuring a discussion on ACOs with input from Dr. Steven Hester, CMO of Norton Healthcare in Louisville. We also will provide a federal update. AHA's Town Hall Interactive webcasts occur at 4 p.m. ET.

To register or to view the webcast, go to www.aha.org/townhall

Visit the Section for Small or Rural Hospitals Web site at http://www.aha.org/smallrural

For more information, contact John Supplitt, senior director, Section for Small or Rural Hospitals, at (312) 422-3306 or jsupplitt@aha.org.