CMS Issues Final Rule on Inpatient Payments

Hospitals will begin measuring readmission rates for acute MI, heart failure, and pneumonia.

BY JANE ANDERSON

The Center for Medicare and Medicaid Services' final rule to update Medicare's inpatient prospective payment system rates for hospitals beginning Oct. 1 will increase overall payments to hospitals by 1.1%, but also will begin implementing policies that ultimately will cut hospital reimbursement if patients are readmitted too quickly.

Hospitals are ramping up quality improvement initiatives that they hope will decrease readmission rates by October 2012, when those pay cuts will start to take effect.

"We see preventable readmissions, but we also see a whole large group of nonpreventable readmissions," said Dr. Lauren Doctoroff, a hospitalist at Beth Israel Deaconess Medical Center, Boston. "What the payment system is trying to do is measure all-cause readmissions, and this makes most hospitalists nervous."

The final Medicare Inpatient Prospective Payment System rule estimates that total payments to acute care hospitals for inpatient services occurring in fiscal year 2012 (which begins Oct. 1) will increase by about $1.1 billion to total approximately $100 billion. Each year, the rule spells out recalculated payments for individual codes, leading to a mixed bag of increases and decreases for specific procedures.

This year, the CMS rule also expanded the Hospital Inpatient Quality Reporting Program, with a greater focus on patient outcomes and experiences. The agency added a reporting measure involving the rates of methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia, along with reporting measures for stroke and venous thromboembolism.

However, the agency said that it is not adopting its prior proposal to add contrast-induced acute kidney injury to the list of hospital-acquired conditions that are not eligible for Medicare payments. In an interview, Dr. Doctoroff welcomed that news, saying "it's a condition that's hard to prevent."

But for hospitals, the most important provisions in the new rule are those asking them to begin measuring readmission rates for three conditions (acute myocardial infarction, heart failure, and pneumonia) in preparation for Medicare to begin cutting reimbursement for "excessive" all-cause readmission rates. The rule also outlines a methodology to calculate those excessive readmission rates.

The CMS defines readmission as "occurring when a patient is discharged from the applicable hospital and then is admitted to the same or another acute care hospital within a specified time period from the time of discharge from the index hospitalization."

The CMS has set 30 days as the time period it will use to determine if a patient was readmitted unnecessarily. Beginning in 2012, it will begin cutting overall payments for hospitals that have numbers the agency deems excessive.

"As many as one in three Medicare patients who leave the hospital will be readmitted within 30 days of discharge," the agency said in a statement. "A large portion of these readmissions can be avoided through well-coordinated, high-quality hospital care."

The American College of Cardiology has advocated use of registries to report on performance measures, however no registries were included in the final rule. ■

Nuts and Bolts of the Final Rule

The CMS's final rule to update Medicare's inpatient prospective payment system rates includes the following:

- ► Reporting measures for the rates of MRSA bacteremia, stroke, and venous thromboembolism.
- ► No adoption of its prior proposal to add contrast-induced acute kidney injury to the list of hospital-acquired conditions that are not eligible for Medicare payments.
- ► A directive that hospitals should begin measuring readmission rates for three conditions (acute MI, heart failure, and pneumonia) in preparation for Medicare to begin cutting reimbursement for "excessive" all-cause readmission rates.
- ► Methodology to calculate those excessive readmission rates.
- ► More than 20 new procedure codes, including codes for atherectomy and for endovascular and transapical heart valve procedures.
- ► A Medicare spending-per-beneficiary measure to assess Part A and Part B beneficiary spending from 3 days before a hospital admission through 30 days after a patient is discharged, in an effort to encourage hospitals to provide high-quality care to Medicare beneficiaries at a lower cost.

Federal Agencies Set Stage For Health Exchanges

FROM A TELECONFERENCE SPONSORED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal officials are laying the groundwork for the launch of state-based health insurance exchanges in 2014, handing out millions of dollars in grants to states, designing tools to determine eligibility to buy insurance, and proposing details on how the refundable premium tax credits will work.

The U.S. Department of Health and Human Services announced during the teleconference that it is awarding $185 million in "establishment" grants to 13 states and the District of Columbia to help them build their insurance exchanges.

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These grants follow planning grants that were awarded last year by HHS. More than half of the states have already taken some action to begin building their exchanges, according to the department.

HHS, along with the Treasury Department, also issued three proposed rules that are aimed at creating a system that's easy for consumers and small businesses to navigate.

The first proposal, issued by HHS, outlines the standards and processes for consumers to enroll in a health plan and to seek financial assistance. It also explains the standards for small employers to participate in the exchange.

Another proposal from HHS attempts to simplify the process for determining eligibility in Medicaid and the Children's Health Insurance Program and to coordinate these processes with the insurance exchanges, so that individuals can move from Medicaid to another health plan without losing coverage.

Finally, the Treasury Department issued a proposed regulation that explains how individuals and families can receive premium tax credits for purchasing insurance. Under the Affordable Care Act, taxpayers with incomes between 100% and 400% of the federal poverty level will be eligible for premium tax credits if they purchase insurance through the exchange for themselves or a family member. The tax credits are paid in advance to the health plan to reduce the individual's monthly premium.

–Mary Ellen Schneider

Smoking Bans, Taxes Could Trim $2 Billion in Health Costs

FROM THE AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

Enacting comprehensive state laws that ban smoking in workplaces and restaurants as well as raising the cigarette tax by $1 per pack across the country could bring in billions in revenue for cash-strapped states, while also saving nearly 2 million lives.

The ACS CAN released two reports that examined the public health benefits and economic savings from strengthening state antitobacco policies. In one report, researchers from the University of Illinois at Chicago looked at what would happen if the 27 states without comprehensive smoke-free laws were to enact such laws. In the second report, the same researchers considered the impact if all 50 states and the District of Columbia were to adopt a $1 per pack increase in the cigarette excise tax.

"The bottom line is that strong tobacco control policies are a win-win for state legislators, for the states themselves, and [for] their constituents," said John R. Seffrin, Ph.D., CEO of ACS CAN.

Currently, 23 states and the District of Columbia have enacted comprehensive laws that ban smoking in all bars, restaurants, and workplaces. The remaining 27 states have either less-comprehensive laws or no laws at all. But when the researchers considered the impact if these 27 states were to adopt comprehensive smoking bans, they found that more than 1 million adults would quit smoking, nearly 400,000 children would never start, and smoking-related deaths would fall by 624,000.

On the economic side, those 27 states would see a savings of about $316 million from lung cancer treatment, $875 million from heart attack and stroke treatment, and $128 million from smoking-related pregnancy treatment. And the researchers estimated that Medicaid programs in those 27 states would save a collective $42 million.

The report on tobacco taxes found similar public health and financial gains if a $1 per pack tax increase were enacted around the country. Such a tax would result in 1.4 million adults quitting smoking, 1.69 million children never starting to smoke, and 1.32 million fewer people dying from smoking-related causes. States also could benefit from both decreases in Medicaid spending and increased revenue. The report estimated that the tax would cut Medicaid spending by about $146 million across the states, and would bring in $8.62 billion in new state revenue.

–Mary Ellen Schneider