CMS Issues Rulemakings on Inpatient Prospective Payment System, National Provider Identifier Number

Last week, CMS issued the Proposed Fiscal Year 2013 Inpatient Prospective Payment System Update and, separately, issued a final rule regarding the use of National Provider Identifiers. These rulemakings contain few surprises, but reflect CMS's continuing implementation of payment and program integrity elements of the Patient Protection and Affordable Care Act of 2010 (ACA)—while both CMS and the country at large await the Supreme Court's decision on the ACA's constitutionality, expected in June.

Proposed FY 2013 IPPS Update

On April 26, 2012, CMS issued the proposed FY 2013 update to the Inpatient Prospective Payment System (IPPS). The update continues Medicare's movement toward tying payment to performance.

Beginning in FY 2013, Medicare payments to acute hospitals will increase by approximately 0.9% while payments to long-term acute care (LTAC) hospitals will increase by approximately 1.9%. FY 2013 also will see CMS's introduction of incentive payments established under the Value-Based Payment (VBP) Program under the ACA. Payment increases can be increased to 2.3% or decreased to 0.3% depending on a hospital's performance under the Hospital Inpatient Quality Reporting Program (HIQRP). The HIQRP requires hospitals to report data on 72 specific quality measures. A further 0.3% payment decrease is possible under the Hospital Readmissions Reduction Program if a hospital experiences a high readmission rate for heart attack, heart failure, or pneumonia.

The April 26 proposed rule anticipates addition of several care and outcome measures to the VBP Program for FY 2014, including a measure for reducing central line-associated bloodstream infections. The proposed rule also looks ahead to including a Medicare spending per beneficiary efficiency measure in FY 2015. The first measurement period for that measure, which would assess Medicare Part A and Part B payments for services provided to a beneficiary during the period three days prior to inpatient admission through thirty days after discharge, would run from May 1, 2013 through December 31, 2013. Adoption of this measure would move even standard fee-for-service hospitals toward an accountable model.

The display copy of the proposed update is available here. The update will be published in the Federal Register on May 11, 2012. CMS will accept comments on the proposed rule until June 25, 2012, with a final rule to be issued by August 1, 2012.

Final Rule Regarding NPIs

April 27, 2012 the Federal Register published a final rule issued by CMS implementing program integrity provisions of the ACA.

The final rule, which is effective on June 26, 2012, makes some adjustments to an interim final rule that was effective July 6, 2010 and requires all providers and suppliers of Medicare and Medicaid services to obtain a National Provider Identifier (NPI). While new providers were required to have NPIs listed in their provider agreements beginning July 6, 2010, under the final rule, providers and suppliers previously enrolled must add their NPIs to their enrollment records through Form CMS-855 or the online Provider Enrollment, Chain, and Ownership System (PECOS).

The rule also requires that all claims for Part B services must include the NPI of the billing provider or supplier and of any other provider or supplier identified on the claim form, which, in the case of claims for

imaging or clinical laboratory services, DMEPOS, and home health services, includes the ordering or certifying physician (or, in the case of imaging, lab services, and DMEPOS, other eligible practitioner). Significantly, the ordering or certifying physician must be enrolled in the Medicare program or have a valid Medicare opt-out on record in PECOS in order for the Part B claim to be paid. CMS estimates that claims that cannot be submitted or will be denied will total approximately $1.59 billion over ten years. The estimate is based on reductions in the use of DMEPOS, imaging, clinical laboratory, and home health care services attributable to patients whose physicians do not have NPIs.

CMS Revalidation Process

The NPI final rule is a reminder of program integrity provisions enacted in the ACA that will increase administrative burdens on—and create the risk for missteps by—providers and suppliers. Also pursuant to the ACA, Medicare Administrative Contractors (MACs) are now sending revalidation notices to all providers and suppliers that enrolled in the Medicare program before March 25, 2011. MACs will send a revalidation notice to each such provider and supplier by May 25, 2015. Upon receipt of the notice, a provider or supplier must submit a revalidation application within sixty days. MACs will screen providers and suppliers under the ACA's program integrity rules, according to the new categories of risk designation: limited, moderate, and high.

Providers and suppliers reenrolling must take care to complete the revised enrollment application forms. The revised forms require more detailed disclosure of ownership information, including ownership information for physician-owned hospitals. Particular information is required for individuals or entities holding an ownership interest of 5% or more, including the classification of each organizational owner (*e.g.*, medical provider or supplier, management services company, holding company, investment firm, financial institution, or consulting firm), and biographical information regarding each officer and director.

Providers or suppliers that fail to reenroll within sixty days of receiving a revalidation notice are subject to deactivation of billing privileges. In a conference call (the transcript is here), CMS committed that MACs will send revalidation notices (a sample is here) in distinctly colored envelopes, and providers and suppliers can consult CMS's Provider Supplier Enrollment Revalidation page, which maintains a list of providers and suppliers to which MACs have sent notices.

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If you have any questions regarding these rules or implementation of other areas of health reform, please see our Health Reform Resource Center or contact your regular Ropes & Gray lawyer.