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**MEMORANDUM**

To: Health Care Clients and Friends  
From: Powers, Pyles, Sutter & Verville, PC  
Date: April 21, 2008  
Re: Proposed Changes to Medicare Hospital Inpatient Prospective Payment System (IPPS) for Federal Fiscal Year (FFY) 2009

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The following is a brief outline of the changes to the acute-care hospital IPPS proposed by the Centers for Medicare and Medicaid Services (CMS) for FFY 2009. The proposed rule will be published in the Federal Register on April 30, but is currently available on-line at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-P.pdf>. This memorandum does not address CMS proposals regarding the Stark law exceptions that were included in the IPPS proposed rule. PPSV will be sending a memorandum on these proposals, as well as a related case-law development, in the near future. Among the IPPS changes proposed by CMS are the following:

- IPPS Update
  - Beginning October 1, 2008, payments will be based 100% on cost-based MS-DRGs. CMS is statutorily required to update hospital payments by the full market basket, which CMS projects to be 3.0% for FFY 2009. CMS is statutorily required to offset the payment increase by -0.9% to adjust for changes in documentation and coding practices under the MS-DRGs. (This adjustment is in addition to the -0.6% adjustment applied in FFY08, for a cumulative adjustment of -1.5%.) Hospitals that did not submit quarterly data on quality indicators in FFY 2008 are subject to a reduction of 2.0%. CMS is required to make a retrospective evaluation of claims data, and if it determines that the

amount of its coding payment adjustments for FFYs 2008 and 2009 was inaccurate, it is required to adjust payments (either positively or negatively) in FFYs 2010 through 2012.

- Quality Initiatives

- Currently, hospitals submit data on 30 quality measures (listed at pp. 425-26 of the online version) to receive the full payment update. CMS is proposing that hospitals report on 72 quality measures (listed at pp. 440-43) in order to receive the full payment update for federal fiscal year 2010.
- The payment provisions regarding certain hospital-acquired conditions (i.e., no payment for complications arising from certain conditions acquired in the hospital) go into effect on October 1, 2008. The current conditions subject to the rule were announced last year and are listed at pages 105-107. CMS is proposing refinements to the “foreign object retained after surgery” and “pressure ulcers” conditions. CMS is also considering adding additional conditions effective October 1, 2008. These are: surgical site infections following certain elective surgeries, Legionnaires’ Disease, extreme glucose derangement, iatrogenic pneumothorax, delirium, deep vein thrombosis/pulmonary embolism, *staphylococcus aureus* septicemia, and *clostridium difficile*-associated disease. CMS will pay for present on admission (POA) indicators “Y” (complication was present on admission) and “W” (not possible to document when the onset of the condition occurred), but states that it is leaving open the possibility of not paying when indicator “W” is used. CMS will pay for the POA indicator “N” (not present on admission) or the “U” indicator (medical record documentation is insufficient to determine whether the condition was POA). However, CMS is considering whether payment should be made for the “U” indicator in certain circumstances, such as death, transfer, or when a patient leaves against medical advice.
- CMS also summarized its November 2007 report to Congress on value-based purchasing or VBP. CMS suggests that the VBP program contain some of the following elements:
  - A “Performance Assessment Model” that would be used to score a hospital’s performance on different measures, and these scores would generate a “Total Performance Score.”
  - A way to convert the Total Performance Score into an incentive payment.

CMS suggests a reduction of hospitals’ DRG payments by two to five percent. (CMS stated that the reduction could be to the base operating payment or other payments). A hospital could then earn back a percentage or all of the DRG payment based on the hospital’s performance on a set of measures (the Performance Assessment Model) during a 12-month period. CMS would establish at least three performance “domains” (e.g., clinical quality, patient-centered care and efficiency) and establish quality measures for each domain. The hospital’s score for each measure would be the greater of either an “attainment score” or an “improvement score.” An attainment score would be calculated by comparing the hospital’s performance with national thresholds and benchmarks, and an improvement score would be calculated by comparing the hospital’s current

performance with its performance from the year before. The Total Performance Score would be calculated by combining the scores for all domains. Further Congressional action is needed before any VBP program could be adopted.

- Outlier
  - CMS proposes an outlier threshold of \$ 21,025.
- Wage Data and Wage Index
  - The national average hourly wage is \$32.2252, but may change with modifications to hospital wage indices before the final rule.
  - The occupational mix adjustment will be based on the same six-month 2006 occupational mix survey that was used to compute the FFY 2008 adjustment, with some minor updates. CMS is reserving the right to apply a payment penalty in FFY 2010 to hospitals that did not respond to the 2007-08 occupational mix survey.
  - Section 508 one-time wage index reclassifications expire on September 30, 2008 (although it is possible that they may be extended, as they have in the past).
- Rural Floor Budget Neutrality Adjustment
  - CMS is statutorily required to apply the rural wage index to urban hospitals if the rural wage index in a state is higher than the urban wage index (commonly known as the “rural floor”) and is required to apply the adjustment in a budget neutral manner. In FFY 2008, CMS made the budget neutrality adjustment to wage indices nationwide. For FFY 2009, CMS proposes a state-wide budget neutrality adjustment to wage indices. Stated differently, if no hospitals in a state receive a rural floor adjustment, no budget neutrality adjustment would apply in that state; but if hospitals in a state receive a rural floor adjustment, there would be a state-wide budget neutrality adjustment to offset the impact of the rural floor adjustment. (It is questionable whether CMS has the authority to apply the budget neutrality adjustment in this manner because the statute provides that the budget neutrality adjustment has to be made to hospitals that don’t benefit from the rural floor.)
- Geographic Reclassification Criteria
  - Currently, a hospital that seeks to be reclassified to another area must show that its average hourly wage (AHW) is at least a certain percentage of the AHW in the area to which it seeks to be reclassified. For urban hospitals, the percentage is 84%; for rural hospitals, the percentage is 82%; and for county-wide reclassification requests, the percentage is 85%. CMS proposes to increase these percentages to 88%, 86% and 88%, respectively.

- Transfer Payment Policy
  - Currently, the Medicare transfer payment policy applies to patients discharged to their home within three days of discharge. CMS proposes to extend the timeframe to seven days. The number of MS-DRGs subject to the transfer policy will remain the same (273), although CMS is evaluating whether new and revised MS-DRGs should be subject to the policy.
- IME
  - The IME adjustment factor remains at 1.35%.
- Capital Payments
  - CMS proposes to phase-in the elimination of the IME adjustment to capital payments, with a 50% reduction starting October 1, 2008 and no IME capital payments starting October 1, 2009. It first proposed to do so last year, but is still accepting comments on this proposal.
- EMTALA
  - CMS proposes to amend the regulations to state that a hospital’s EMTALA obligations are not affected by the fact that a patient was previously admitted to another hospital. Specifically, if a patient in an emergency condition is admitted to a hospital, but that hospital later determines that the unstable patient needs the specialized capabilities of another hospital, that second hospital still has obligations under EMTALA to stabilize or treat the patient, assuming the second hospital has the capacity to treat the patient.
  - CMS proposes to allow hospitals to fulfill their obligations to maintain a list of on-call physicians by participating in a community call plan. In a community call plan, hospitals would schedule to be the on-call facility for certain periods.
- Cost Reporting Changes
  - In order to mitigate charge compression that results from including medical devices in the “Medical Supplies Charged to Patients” cost center, CMS is proposing to add a new cost center to the cost report: Implantable Devices Charged to Patients. The criteria for including a device in this cost center are the same as for a pass-through payment under the outpatient prospective payment system (42 C.F.R. § 419.66(b)), with the additional requirement that the device remain in the patient (i.e., implantable devices). Only devices for which a separate charge is customarily made are recorded in this cost center. CMS is also recommending that certain revenue codes be used for items reported in the “Medical Supplies Charged to Patients” cost center and the “Implantable Devices Charged to Patients” cost center. CMS expects that this revision to the cost report (as

well as other modifications) will be available to hospitals for cost reporting periods beginning on or after October 1, 2008.

- Disclosure Requirements

- Currently, CMS requires that physician-owned hospitals give patients written notice at the beginning of the patient’s inpatient stay or outpatient visit that a hospital is physician-owned and that the list of physician-owners is available upon request. CMS proposes to amend this rule to also require disclosure when an immediate family member of the physician has an ownership interest and to make an exception when no physician-owners (which includes physician family members with ownership interests) refer to the hospital. Currently, a list of physician owners must be furnished to the patient if requested, but there is no timeframe for furnishing the list. CMS proposes to require that the list be provided at the time the patient requests it. CMS also proposes that hospitals require all physicians on the medical staff, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients who they refer to the hospital, at the time of referral, any ownership or investment interest in the hospital held by themselves or an immediate family member. Lastly, CMS proposes to permit termination from the Medicare program for failure to comply with these provisions. Physician ownership does not include ownership in publicly traded securities or mutual funds.
- Hospitals are also currently required to furnish a patient written notice if a physician is not available 24 hours per day, 7 days per week. CMS proposes to permit termination from the Medicare program for failure to comply with this provision.

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If you have any questions, please call Barbara Straub Williams at (202) 872-6733 or the attorney with whom you usually work.