

Seventh Floor  
1501 M Street, NW  
Washington, DC 20005  
Phone: (202) 466-6550 | Fax: (202) 785-1756

## MEMORANDUM

**To:** Health Care Clients and Friends  
**From:** Powers Pyles Sutter & Verville, PC  
**Date:** August 28, 2008  
**Re:** Final Hospital Inpatient Prospective Payment System Rule for Federal Fiscal Year 2009

---

The following summarizes the final rule adopted by the Centers for Medicare and Medicaid Services (“CMS”) to update the acute-care hospital Inpatient Prospective Payment System (“IPPS”) for federal fiscal year (“FFY”) 2009. The rule was published in the August 19, 2008 Federal Register and takes effect on October 1, 2008. Due to the enactment of the Medicare Improvement for Patients and Providers Act of 2008 (Pub. L. 110-275) on July 25, 2008, certain payment rates, including the wage indices, are not yet available. CMS will publish them in a subsequent Federal Register. The electronic version of the rule is available online at <http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf>.

This memorandum addresses changes related to Medicare reimbursement rates and regulations. The August 19 rule also included changes to regulations interpreting the Stark law’s prohibitions on physician referrals. These changes are summarized in a separate memorandum available on the PPSV website.<sup>1</sup>

- **IPPS Update**

CMS is statutorily required to update hospital payments by the full market basket, which is 3.6% for FFY 2009, but is also required to reduce the standardized amount by -0.9% to adjust for changes in documentation and coding practices under the MS-DRG system. This -0.9% adjustment is in addition to the -0.6% adjustment applied in FFY 2008, for a cumulative

---

<sup>1</sup> <http://www.ppsv.com/assets/attachments/48.PDF>

reduction of -1.5% to the standardized amount in FFY 2009, or a total change of 2.1% (3.6% - 1.5% = 2.1%).

Although the standardized amount percentage update increase is finalized, certain offsets to the update, such as the outlier offset, could not be calculated at the time of publication of the final rule due to the enactment of Pub. L. 110-275. Accordingly, the standardized amounts in Table 1 of the final rule are tentative and will be republished.

- **Quality Initiatives**

- Under the “Reporting Hospital Quality Data for Annual Payment Update” or RHQDAPU program, hospitals must report on certain quality measures in order to receive the full annual Medicare payment update. Currently, hospital data is collected on 30 quality measures (listed at pp. 48,600-01), but CMS is using 42 quality measures (listed at pp. 48,609-10) for the 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 conditions and CC/MCC codes subject to the rule are listed at pages 48,490-91. CMS will pay for complications with the present on admission (POA) indicators “Y” (complication was present on admission) and “W” (provider affirmed, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred). CMS will not pay for complications with the POA indicator “N” (not present on admission) or the “U” indicator (medical record documentation is insufficient to determine whether the condition was present on admission).

- **Outlier Payments**

CMS did not finalize the outlier threshold because it does not have all the information to do so, due to the enactment of Pub. L. 110-275. The amount will be published at a later date.

- **Wage Data and Wage Index**

Pub. L. 110-275 extended Section 508 one-time wage index reclassifications, which now expire on September 30, 2009. CMS will implement the Section 508 extensions and issue the final FY 2009 wage index values (and other related tables) in a subsequent notice.

The national average hourly wage has increased 4.3% compared to FFY 2008, and the FFY 2009 national average hourly wage adjusted for occupational mix is \$32.2449. The FFY 2009 occupational mix adjustment is based on the same six-month 2006 occupational mix survey that was used to compute the FFY 2008 adjustment, with some minor updates. CMS put hospitals on notice that they may receive a payment penalty in FFY 2010 if they do not submit occupational mix survey data.

- **Rural Floor Budget Neutrality Adjustment**

For FFY 2009, CMS has finalized its proposal to convert to a statewide (from a nationwide) rural floor budget neutrality adjustment, but the adjustment will be phased in. In FFY 2009, hospitals will receive a blended wage index that reflects a 20% statewide adjustment and an 80% nationwide adjustment. In FFY 2010, the blend will be a 50% statewide and 50% nationwide adjustment. In FFY 2011, the rural floor budget neutrality adjustment will be an entirely statewide adjustment.

- **Sole Community Hospital (“SCH”) Rates**

Pub. L. 110-275 requires that, for costs periods beginning on or after January 1, 2009, SCHs will be paid based on the rate that results in the greatest aggregate payment using either the federal rate or the hospital-specific rate based on the SCH’s 1982, 1987, 1996 or 2006 costs per discharge.

- **Geographic Reclassification Criteria**

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 current percentage is 84%; for rural hospitals the percentage is 82%; and for county-wide reclassification requests, the percentage is 85%. For redesignations effective in FFY 2010, CMS increased the AHW standards to 86%, 84%, and 86%, respectively. For redesignations effective in FFY 2011, the average hourly wage standards will be increased to 88%, 86%, and 88%, respectively. Geographic reclassification applications for FFY 2010 are due September 2, 2008.

- **Transfer Payment Policy**

The Medicare transfer payment policy applies to patients discharged to their home who receive home health services within three days of discharge. CMS proposed to extend this timeframe to seven days. Citing almost uniform opposition to the proposal, CMS decided not to move forward with the proposal. CMS has stated, however, that it will monitor transfers and may still address the issue in subsequent rulemaking.

- **IME**

The indirect graduate medical education (“IME”) adjustment factor will remain at 1.35% for FFY 2009. CMS estimates that the use of this multiple will result in an increase in IME payment of 5.5% for every approximately 10% increase in a hospital’s resident-to-bed ratio.

- **IME Capital Payments**

Beginning October 1, 2008, capital IME payments will be 50% of the amount calculated under the current formula. The capital IME payment will be completely phased out in FFY 2010.

- **EMTALA**

CMS proposed to amend the Emergency Medical Treatment and Labor Act (“EMTALA”) 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, CMS proposed that, if a hospital admits a patient with an emergency medical condition, but the hospital later determines that the unstable patient needs the specialized capabilities of another hospital, EMTALA obligations would be extended to that second hospital, assuming it had the capacity to treat the patient. This expansion of EMTALA was not finalized. The final rule states instead that if a patient with an emergency medical condition presents to a hospital emergency department and is admitted, the second hospital with specialized capabilities to treat the patient does *not* have an EMTALA obligation to accept the patient. CMS stated, however, that if the patient is not admitted to the first hospital, EMTALA requires the second hospital with the specialized capabilities to accept the transfer, provided it has the capacity to do so.

CMS did, however, finalize its proposal 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 agree to share on-call responsibilities for either a certain time period or for certain services.

- **Cost Reporting Changes**

CMS finalized the establishment of separate cost centers for medical supplies (“Medical Supplies Charged to Patients”) and implantable devices (“Implantable Devices Charged to Patients”). This change is designed to mitigate “charge compression,” which is the practice of applying a higher percentage markup to lower cost items and services and a lower percentage markup to higher cost items and services. When determining what supplies and devices should be reported in these respective cost centers, CMS adopted recommendations from commenters that hospitals simply use existing revenue codes as established by the National Uniform Billing Committee.

- **Hospital Ownership Disclosure Requirements**

Currently, CMS requires that physician-owned hospitals (other than publically traded hospitals) give patients written notice at the beginning of the patient’s inpatient stay or outpatient visit that (1) a hospital is physician-owned, and that (2) the list of physician-owners is available upon request. The Medicare regulations do not currently contain a timeframe for furnishing the list following a patient request. The final rule requires that the list of physician-owners be

furnished at the time of the request and expands the patient disclosure requirement to include situations where an immediate family member of a physician has an ownership interest in the hospital. The final rule also makes an exception for physician-owned hospitals that do not have at least one referring physician.

Furthermore, CMS added a requirement that that hospitals mandate that all physicians on the medical staff, as a condition of continued medical staff membership or admitting privileges, disclose in writing to all patients whom they refer any ownership or investment interest in the hospital held by the physician or an immediate family member. This written disclosure must be made at the time of referral.

\* \* \* \*

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