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## CMS Releases Final IPPS Rule for FY 2009

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Principals

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Leslie Demaree Goldsmith

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CMS recently posted its final changes and updates to the Medicare Inpatient Patient Prospective Payment System (IPPS) that apply beginning in fiscal year (FY) 2009 at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf>.

The final rule:

- Establishes that the market basket update used to adjust hospital payments will be:
  - 3.6 percent for hospitals that successfully report quality measures in FY 2008; and
  - 1.6 percent for hospitals that do not successfully report the quality measures in FY 2008.
- Adds 13 (out of 43 proposed) new quality reporting measures and retires one existing measure, which are tied to hospitals receiving the full market basket update.
- Reduces payment rates by 0.9 percent in order to maintain budget neutrality and comply with the TMA, Abstinence Education, and QI Programs Extension Act of 2007.
- Reduces the outlier threshold to \$20,185.
- Bases MS-DRG relative weights 100% on costs beginning in FY 2009. In response to cost-to-charge concerns regarding the relatively high mark-up rate for lower cost supplies and devices, the rule adds a cost center to the cost report to allow separate reporting of costs and charges for relatively inexpensive medical supplies versus more expensive devices. The revised cost reporting will ultimately affect the relative weights under the IPPS and outpatient PPS.
- Subdivides current MS-DRG 245 (AICD Lead and Generator Procedures), creates a new MS-DRG 265 entitled "MS-DRG AICD

S. Craig Holden	Lead Procedures” and renames MS-DRG 245 “MS-DRG AICD Generator Procedures.”
Julie E. Kass	
Paul W. Kim (Counsel)	<ul style="list-style-type: none"> <li>● Revises the titles for MS-DRGs 870, 871 and 872 to include severe sepsis, in addition to septicemia.</li> </ul>
Robert E. Mazer	<ul style="list-style-type: none"> <li>● Applies the post-acute transfer policy to 273 MS-DRGs. Of these, 24 MS-DRGs qualify as special post-acute transfer DRGs.</li> </ul>
Christine M. Morse	<ul style="list-style-type: none"> <li>● Does not finalize the proposed expansion of the post-acute transfer policy to discharges to home under a written plan for the provision of home health services that begins within seven days (up from the current timeframe of three days).</li> </ul>
Laurence B. Russell	
Susan A. Turner	<ul style="list-style-type: none"> <li>● Establishes a July 1 deadline for FDA approval before CMS will consider new medical services and technology for add-on payments.</li> </ul>
<b>Associates</b>	
Kristin C. Cilento	<ul style="list-style-type: none"> <li>● Increases the occupational mix adjusted national average hourly wage (AHW) to \$32.2449.</li> </ul>
Joshua J. Freemire	<ul style="list-style-type: none"> <li>● Continues to allow multi-campus hospitals the option to use either full-time equivalent or discharge data for allocating wage data among their campuses.</li> </ul>
Donna J. Senft	
Mark A. Stanley	<ul style="list-style-type: none"> <li>● Establishes that, beginning with FY 2009, CMS will transition to applying budget neutrality adjustments with respect to the rural floor and the imputed rural floor on a state-wide basis, rather than on a national basis. The mix of state-wide budget neutrality adjustments in the wage index will be 20% in FY 2009, 50% in FY 2010, and 100% in FY 2011. The rule also extends the imputed floor through FY 2011.</li> </ul>
Emily H. Wein	<ul style="list-style-type: none"> <li>● Increase the AHW comparison criteria for geographic reclassification to the following percentages: <ul style="list-style-type: none"> <li>○ 86 percent of the desired labor market area for individual urban hospitals (to be increased to 88 percent in FY 2010)</li> <li>○ 84 percent of the desired labor market area for individual rural hospitals (to be increased to 86 percent in FY 2010)</li> <li>○ 86 percent of the desired labor market area for county group hospitals (to be increased to 88 percent in FY 2010).</li> </ul> </li> <li>● Allows hospitals to comply with on-call list requirement in the provider agreement regulations by participating in a formal community call plan.</li> <li>● Declines to finalize the proposed rule that would have expanded application of EMTALA to include transfer to a participating hospital with specialized capabilities of a patient who, though stable after admission and prior to transfer, subsequently becomes unstable.</li> <li>● Expand the rural community hospital demonstration program mandated by the Medicare law to include four additional hospitals at an aggregate cost to CMS of \$22,790,388 for all of the participating hospitals. The costs are to be offset in the budget neutrality adjustment applied across all IPPS payments.</li> <li>● Revises the definitions of “physician” and “physician organization” under the self-referral rules.</li> <li>● Clarifies the period of time for which physicians are prohibited from referring Medicare patients to an entity for DHS and for which the DHS entity is prohibited from billing, where an exception does not apply.</li> </ul>

- Expands hospital conditions of participation to require disclosure to patients of hospital ownership interests held by physicians and their relatives.
- Allows CMS to collect from Medicare Advantage organizations encounter-level data for services provided to enrollees. This data will be used by CMS to calculate risk scores, update risk adjustment models, calculate Medicare DSH percentages, determine whether Medicare day limits have been exhausted, and for quality review purposes.
- Adds three (out of a proposed list of nine) categories of conditions to the eight existing conditions on the list of hospital-acquired conditions that will not lead to increased Medicare payment.

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