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CMS Issue Alert

Significant Aspects of CMS Fiscal Year 2009 Acute Care Inpatient Hospital Proposed Rule

David J. Oakley, 518.431.6705
William Connelly, 202.585.6552

On April 14, 2008, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2009 acute care hospital inpatient prospective payment system (IPPS) proposed rule (CMS-1390-P). This proposed rule is scheduled to be published in the April 30, 2008, *Federal Register*. CMS proposes significant policies regarding hospital quality data reporting, the payment adjustment for hospital-acquired conditions, cost-based payment weights, Medicare-Severity Diagnosis-Related Groups (MS-DRGs), and the hospital wage index adjustment. CMS estimates that the policies proposed will result in an increase in aggregate IPPS payments of nearly $4 billion over estimated payments for FY 2008.

The proposed changes would be effective October 1, 2008. CMS is seeking public comments on its proposals for 60 days. Comments must be submitted no later than June 13, 2008. Below is an analysis of key elements of the FY 2009 IPPS proposed rule.

- **Update to Standardized Amount**. CMS proposes a standardized amount of $5,098.96 for FY 2009. The standardized amount is the base-per-discharge payment amount under the IPPS. The standardized amount CMS proposes reflects a 3.0 percent market-basket update (which is a measure of the increase in the costs of hospital goods and services), a -0.9 percent "documentation and coding" adjustment to account for changes in hospital coding behavior due to the new MS-

NEWSLETTER EDITORS

Helen Pfister
Partner
hpfister@manatt.com
212.830.7277

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DRG system that CMS adopted in FY 2008, and a number of budget neutrality adjustments. Overall, the proposed FY 2009 standardized amount is an increase of 2.7 percent over the standardized amount for FY 2008.

- **Update of the Outlier Threshold**. To qualify for high-cost outlier payment under the IPPS, the estimated cost of a case must be greater than the sum of the adjusted federal prospective payment amount and a "fixed-loss amount." CMS proposes a fixed-loss amount of $21,025 for FY 2009. This is a slightly lower amount than the fixed-loss amount of $22,185 that CMS set for FY 2008. CMS does not propose to change its methodology for calculating the fixed-loss amount.

- **Completion of Transition to Cost-Based Weights and MS-DRGs**. In FY 2007, CMS adopted a new methodology for calculating payment weights for DRGs, which was based on estimated costs of cases instead of the charges hospitals bill for cases. For FYs 2007 and 2008, hospitals were paid based on a blend of cost-based and charge-based weights. CMS proposes to complete this transition in FY 2009 so that hospitals will be paid entirely based on cost-based weights. In addition, when CMS adopted MS-DRGs in FY 2008, CMS paid hospitals based on a blend of the new MS-DRGs and the old DRGs. CMS proposes to pay hospitals solely based on MS-DRGs in FY 2009.

- **Addition of New Measures Under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program**. Under the RHQDAPU program, a hospital is subject to a 2-percentage-point decrease in its market-basket update if it fails to report data on quality measures selected by CMS. CMS selects new quality measures one year in advance—thus the quality measures CMS selects in the FY 2009 IPPS final rule will affect payments beginning in FY 2010. Currently the RHQDAPU program includes 30 measures. CMS proposes to add 43 new quality measures and delete 1 measure for payments beginning in FY 2010. This would bring the total number of measures to 72. CMS would delete the existing Pneumonia Oxygenation Assessment measure and add the following categories of new measures:

    - 1 Surgical Care Improvement Project measure;
    - 4 nursing-sensitive measures;
    - 3 readmission measures;
    - 6 venous thromboembolism measures;
    - 5 stroke measures;

- 9 Patient Safety Indicators and Inpatient Quality Indicators developed by the Agency for Healthcare Research and Quality; and
- 15 cardiac surgery measures derived from The Society of Thoracic Surgeons' National Cardiac Database.

- **Payment Adjustment for Hospital-Acquired Conditions**. Beginning in FY 2009, CMS will no longer pay extra for cases that involve certain hospital-acquired secondary conditions that could reasonably have been prevented through the application of evidence-based guidelines. In the FY 2008 IPPS final rule, CMS selected 8 conditions to be subject to this payment adjustment, although the payment adjustment was not to be implemented until FY 2009. CMS now requests public comment on whether the following 9 conditions (in addition to the 8 conditions selected in the FY 2008 final rule) should be subject to the payment adjustment for hospital-acquired conditions:

  - Surgical-site infections following elective surgeries;
  - Legionnaires' disease;
  - Glycemic control;
  - Iatrogenic pneumothorax;
  - Delirium;
  - Ventilator-associated pneumonia;
  - Deep vein thrombosis/pulmonary embolism;
  - Staphylococcus aureus septicemia; and
  - Clostridium difficile-associated disease.

  CMS also asks for comments with respect to when a condition should be considered to be hospital-acquired. CMS program guidance currently requires hospitals to submit a "present on admission" (POA) indicator on their claims for payment. CMS proposes that a discharge would not be subject to the payment adjustment for hospital-acquired conditions?that is, CMS would pay extra for a secondary condition?if the POA indicator shows that the secondary condition was present on admission or that the hospital has determined that it was not possible to document when the onset of the condition occurred. CMS would not pay extra for the secondary condition when the POA indicator shows that the secondary condition was not present on admission or that the medical record was insufficient to determine whether the condition was present on admission. CMS

requests comments on "exceptional circumstances," such as the patient leaving the hospital against medical advice, that would justify paying extra for a secondary condition when the medical record is insufficient to determine whether the condition was present on admission. We note that hospitals should work with their coders to ensure that the POA indicator is properly reported on all claims, especially now that there will be payment consequences.

- **Modification of the Hospital Wage Index System**. CMS applies a wage index adjustment to IPPS payments to account for geographic differences in wage levels. Recent analysis by CMS and the Medicare Payment Advisory Commission has suggested that the existing IPPS wage index system does not accurately reflect geographic wage levels. Under the Medicare Improvements and Extension Act of 2006, CMS was required to include in the FY 2009 IPPS proposed rule one or more proposals for revising the hospital wage index system. In this proposed rule, CMS emphasizes that its analysis of the existing system is not complete, so the agency is not yet proposing an overhaul of the current system.

  CMS, however, proposes two significant changes to the current wage index system. First, CMS proposes to adjust for "rural floor" and "imputed rural floor" budget neutrality on a state-by-state basis. Under CMS's "rural floor" policy (which is mandated by statute), an urban hospital may not receive a lower wage index adjustment than a rural hospital located in the same state. Similarly, the "imputed rural floor" policy (which is a discretionary policy) establishes a wage index floor for states with no hospitals located in rural areas.

  These provisions increase payments to hospitals paid on the basis of a wage index floor because, in the absence of a floor, these hospitals would be paid based on a wage index lower than the floor. CMS annually makes a budget neutrality adjustment to hospital payment rates so that aggregate payments under the IPPS do not increase because of these wage index floors. Currently CMS ensures budget neutrality by decreasing payments to all hospitals nationally. In this proposed rule, however, CMS proposes to apply the budget neutrality adjustment on a state-by-state basis. Payments to all

hospitals in a state would be decreased by the amount hospitals in that state benefit from wage index floor provisions. CMS believes that it is more equitable for hospitals in each state to fund the wage index floor for hospitals located in their state. This policy proposal also addresses CMS's concern that hospitals in one particular state are gaming the rural floor provision.

Second, CMS would make it more difficult for a hospital to reclassify to another geographic area for purposes of the hospital wage index adjustment. Under the IPPS, a hospital may apply to be treated as if it is located in a different geographical area for purposes of the hospital wage index adjustment. Under current policy the hospital must demonstrate, among other things, that its wages are at least 84 percent (82 percent for rural hospitals) of the average hourly wage of hospitals in the area to which the hospital seeks to reclassify. CMS proposes to raise this threshold to 88 percent (86 percent for rural hospitals). In addition, CMS proposes to raise the threshold for urban and rural "county group" reclassifications from 85 percent to 88 percent. Although these may appear to be small changes, CMS estimates that 15.3 percent of individual hospitals and 9.1 percent of "county groups" that are currently reclassified would not be able to meet the new standards. CMS, however, would apply these higher standards only to new applications for geographic reclassification. Hospitals that are already reclassified will continue to be reclassified for the remainder of the 3-year term of their reclassification.

- **New Technology Add-On Payment**. Under the IPPS, CMS selects certain new services and technologies for an IPPS add-on payment. To qualify for new technology add-on payment, a technology or service must be new, meet a cost threshold, and represent an advance that substantially improves the diagnosis or treatment of Medicare beneficiaries over existing technologies. In each annual IPPS proposed rule, CMS requests comments on applications for new technology add-on payment. In this one CMS requests comment on the following four applications:

    - Cardio-West™ Temporary Total Artificial Heart System;
    - Emphasys Medical Zephyr® Endobronchial Valve;
    - Oxiplex® viscoelastic gel; and

  - TherOx Downstream® SuperSaturatedOxygen Therapy System.

- **Postacute Care Transfer Payment Policy**. CMS would expand its postacute care transfer payment policy with respect to transfers to a home with a written plan for provision of home health services in order to reach home health services that begin within 7 days after the patient's discharge from the hospital. Under the postacute transfer payment policy, CMS pays a hospital a reduced amount if a patient with a qualifying diagnosis is discharged to certain postacute settings. In most cases this policy applies when a patient is discharged from a hospital directly to a rehabilitation hospital, long-term care hospital, or skilled nursing facility. In the context of home health services, a case is subject to the postacute transfer payment policy when a patient is discharged to his or her home, the patient is under a written plan of care for the provision of home health services from a home health agency, and those services begin within 3 days after the date of discharge. CMS proposes to change this 3-day threshold to a 7-day threshold.

- **Other IPPS Payment Policies**. This proposed rule also addresses the following IPPS payment policies:

  - CMS proposes:

    - Modifying the hospital cost report to better capture the costs of implantable devices. CMS intends to use this information to calculate more accurate payment weights for MS-DRGs that involve these devices.
    - Making a number of changes to MS-DRG assignments.
    - Extending its "imputed rural floor" policy, which was due to expire at the end of FY 2009, through FY 2011.

  - CMS also discusses how best to approach the events on the National Quality Forum's list of Serious Reportable Adverse Events (also known as "never events"). It notes that it is exploring a wide range of approaches, including payment adjustments, coverage policy, conditions of participation, and Quality Improvement Organization retrospective review.

- **Other Issues**. CMS also proposes several policies and requests comments on other issues that are not directly

related to payment under the IPPS.

- CMS proposes to amend the physician self-referral (or "Stark") provisions as follows:
    - Modify the Stark "stand in the shoes" provisions to accommodate certain financial transactions made between physicians and academic medical centers or integrated healthcare delivery systems and require a designated health service (DHS) entity to stand in the shoes of an organization in which it has a 100 percent ownership interest.
    - Revise the definitions of "physician" and "physician organization."
    - Clarify the period of time for which a physician would be prohibited from referring Medicare patients to an entity for DHS and for which the DHS entity would be prohibited from billing for DHS if a financial relationship between the physician and the entity fails to meet a Stark exception.
- CMS continues to expand its efforts to evaluate physician ownership of hospitals.
    - CMS would:
        - Require a sample of 500 hospitals to submit a Disclosure of Financial Relationships Report to collect information about financial relationships between hospitals and physicians.
        - Expand an existing hospital condition of participation to require disclosure to patients of hospital ownership interests held by physicians and their relatives.
    - CMS also requests public comment regarding program integrity concerns with respect to hospital-physician gainsharing arrangements and physician-owned implant companies.
- CMS proposes to collect from Medicare Advantage (MA) organizations encounter-level data for services provided to their enrollees. The agency

states that these data could inform CMS's MA risk-adjustment models.

Click **here** for the version of this proposed rule that is currently on display at the Office of the Federal Register.

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FOR ADDITIONAL INFORMATION ON THIS ISSUE, CONTACT:

David J. Oakley Mr. Oakley is one of the leading health insurance and HMO lawyers in New York. Over the past 25 years he has been involved in nearly every aspect of health insurance in New York, particularly at the legislative and regulatory levels. He has represented many of the largest health plans in their New York operations, especially with regard to HMO licensure, premium rates and underwriting, and all aspects of managed care.

William Connelly Mr. Connelly's practice focuses on federal healthcare programs -- including Medicare managed care, Medicare Part D, and compliance with the federal anti-kickback statute. He also has experience with state regulation of pharmacies and health plan contracting. Mr. Connelly came to Manatt after spending four years with the Centers for Medicare & Medicaid Services Division of the Office of the General Counsel of the U.S. Department of Health & Human Services, where he was lead attorney for the Medicare hospital inpatient prospective payment system.

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