



American Hospital
Association

SPECIAL BULLETIN

Friday, August 1, 2008

Note: This is a five page Special Bulletin.

CMS Releases FY 2009 Inpatient PPS Rule

The Centers for Medicare & Medicaid Services (CMS) yesterday released the inpatient prospective payment system (IPPS) final rule for fiscal year (FY) 2009. The policies and payment rates included in this rule become effective October 1. Some of the rule's key provisions are outlined below.

CMS is still implementing certain provisions of the *Medicare Improvements for Patients and Providers Act of 2008*, which extended certain wage index reclassifications and affects the rule's budget neutrality adjustments. Therefore, CMS is only able to provide tentative FY 2009 wage index values for hospitals, as well as tentative standardized amounts, relative weights, and thresholds for outliers and new technology add-on payments. CMS indicated it will publish final figures in a subsequent rule, but before October 1, 2008.

Operating Payment Update: Hospitals that submit data on 30 quality measures will receive a 3.6% market-basket increase, while those hospitals not submitting data will receive a 1.6% update.

Quality Measure Reporting: To receive a full payment update in FY 2009, hospitals must report on two measures of surgical site infection prevention and one measure of 30-day mortality rates for pneumonia, in addition to continuing to report on the 27 measures required for FY 2008. The rule adds 13 new measures for reporting and retires one current measure for a total of 42 measures for hospitals to receive a full payment update in FY 2010. While AHA is pleased CMS reduced the number of new measures from 43 in its proposal to 13, we are disappointed that CMS chose only four measures adopted by the Hospital Quality Alliance.

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The new measures include:

- Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period;
- Heart failure 30-day readmission;
- Death among surgical patients with treatable serious complications;
- Iatrogenic pneumothorax;
- Postoperative wound dehiscence;
- Accidental puncture or laceration;
- Abdominal aortic aneurysm mortality rate;
- Hip fracture mortality rate;
- Mortality for selected surgical procedures (composite measure);
- Mortality for selected medical conditions (composite measure);
- Complication/patient safety for selected indicators (composite measure);
- Nursing sensitive measure: Failure to rescue;
- Participation in a systematic database for cardiac surgery.

CMS expects two new readmission measures for heart attack and pneumonia to be endorsed by the National Quality Forum this fall and will adopt them in the final outpatient PPS rule for IPPS implementation.

Reporting for Low-volume Hospitals: Beginning with January 2009 discharges, hospitals that have fewer than five heart attack, heart failure, pneumonia or surgical care patients in a calendar quarter are not required to submit data for those patients. Hospitals that have fewer than five HCAHPS-eligible patients in any month will not be required to submit HCAHPS surveys for that month. All hospitals must submit to CMS their total numbers of eligible patients for each condition and their sample sizes, if they choose to sample their patient populations for quality reporting.

Hospital-acquired Conditions: CMS is adding two hospital-acquired conditions to the previous list of eight conditions finalized in last year's rule for which it will no longer pay a higher diagnosis-related group (DRG) rate beginning in FY 2009 if they are not present on admission. The two new conditions are poor glycemic control associated with certain conditions and deep vein thrombosis/pulmonary embolism after certain orthopedic surgical procedures. In addition, CMS has expanded the surgical site infection condition to include infections occurring after certain orthopedic surgeries and bariatric surgery.

National Coverage Determination: CMS is initiating a national coverage determination process for three serious adverse events:

- Surgery on the wrong patient;
- Wrong surgery on the patient;
- Surgery on the wrong body part.

Capital Payment: CMS is moving forward with its plans to phase out the indirect medical education (IME) adjustment to capital payments by reducing payments by 50% in FY 2009 and then eliminating the IME adjustment in FY 2010. The AHA, along with 210 representatives and 51 senators, urged CMS not to proceed with these cuts.

Diagnosis-related Groups (DRGs): FY 2009 marks the end of the transition to the new Medicare-Severity DRG system. Beginning October 1, 2008, the Medicare-Severity DRGs and the cost-based relative weights will be fully phased in. As mandated by Congress, the final rule includes a prospective 0.9% cut to the standardized amount to eliminate the effect of coding and classification changes – the so-called “behavioral offset” – that CMS says do not reflect real changes in case mix.

Area Wage Index: CMS finalized its proposed wage index changes, but will be phasing in their implementation. Specifically, CMS will:

- Increase the threshold necessary for both individual and group area wage index reclassifications with a two-year transition.
- Apply the rural floor budget-neutrality adjustment at the state level, rather than to the standardized amount, with a three-year transition.
- Extend the imputed rural floor provision for those states that do not have rural areas for an additional three years through FY 2011.

Cost Report Changes: To address charge compression when setting Medicare-Severity DRG relative weights, CMS is splitting the current cost center for “Medical Supplies Charged to Patients” into one line for “Medical Supplies Charged to Patients” and another line for “Implantable Devices Charged to Patients.” However, CMS has revised its proposal of assigning devices to cost centers based on AHA’s recommendation to use revenue center codes, which is less burdensome on hospitals.

Outliers: CMS tentatively lowered the outlier fixed-loss threshold from its current level of \$22,185 to \$20,185 (pending new budget neutrality changes for extension of Sec. 508 area wage index reclassification).

Disclosure Regarding Physician Ownership: A “physician-owned hospital” must disclose to all patients whether it is physician-owned and, if so, the names of its physician owners. This disclosure requirement will extend to hospitals in which a physician’s immediate family member holds an ownership or investment interest, even if the physician does not. The hospital must also require all members of its medical staff to agree, as a condition of their continued medical staff membership or admitting privileges, to disclose any ownership or investment interest in the hospital held by the physician or an immediate family member in writing at the time of the referral to all patients they refer to the hospital.

Physician Self-referral Provisions:

- **Stand in the Shoes Provisions** – CMS finalized only one of its proposed revisions to the physician “stand in the shoes” provisions. Only physicians who have an ownership or investment interest in a physician organization will “stand in the shoes” of that physician organization for purposes of analyzing the financial arrangement under the physician self-referral law. Physicians without the ability or right to receive financial benefits, such as distribution of profits, dividends, sale proceeds or similar returns on investment, are not required to “stand in the shoes” of their physician organizations. CMS also clarified that the physician “stand in the shoes” provisions do not apply to an arrangement that satisfies the exception in the physician self-referral law for Academic Medical Centers. CMS chose not to finalize the “stand in the shoes” provisions related to the designated health services entity side of the financial arrangement (e.g., collapsing a hospital and its medical foundation for purposes of analyzing the financial arrangements under the self-referral law).
- **Disclosure of Financial Relationships Report (DFRR):** CMS finalized its proposed collection of information on hospital financial relationships with physicians, to include no more than 500 hospitals. It will be a one-time collection effort and CMS is not adopting a regular reporting or disclosure process at this time. The agency adjusted its estimate of burden upwards for the second time based on public comment, from 33 hours to 100 hours for each hospital. CMS must obtain clearance from the Office of Management and Budget before the DFRR can be sent to hospitals; that process includes a public notice and comment period. CMS indicated that the number of hospitals receiving the DFRR may be reduced depending on public comment during the clearance process.

EMTALA: CMS did not finalize its proposal to require a hospital with specialized capabilities to accept the transfer of certain hospital inpatients under EMTALA. Instead, CMS stated that “if an individual with an unstable emergency medical condition is admitted, the EMTALA obligation has ended for the admitting hospital and even if the individual’s emergency medical condition remains unstabilized and the individual requires special services only available at another hospital, the hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual.”

CMS finalized its proposal to allow hospitals to meet their on-call list obligation through participation in a “community-call plan.” These plans must be formal among the participating hospitals and include specified elements, and each hospital participating must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control.

The final rule will be published in the August 18 *Federal Register*; a display copy is available at

<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf>.

Look for an AHA Regulatory Advisory containing a more detailed analysis in the coming weeks.