

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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**Office of Media Affairs**

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## **MEDICARE FACT SHEET**

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### **PROPOSED FISCAL YEAR 2009 PAYMENT, POLICY CHANGES FOR INPATIENT STAYS IN GENERAL ACUTE CARE HOSPITALS**

#### **OVERVIEW:**

The Centers for Medicare & Medicaid Services (CMS) on April 14, 2008, issued a proposed rule that would change Medicare payment rates and policies for inpatient hospital services furnished by acute care hospitals to people with Medicare in fiscal year (FY) 2009. The changes would apply to more than 3,500 hospitals paid under the Inpatient Prospective Payment System (IPPS), effective for discharges on or after October 1, 2008 through September 30, 2009.

The proposed rule, which updates payments to hospitals, continues the transformation of the Medicare program to a prudent purchaser of services by proposing a number of payment policies that would help protect the solvency of the Medicare trust funds so that Medicare will be available to future beneficiaries. These proposals include making payments more accurate and strengthening incentives for hospitals to improve the quality of care they furnish to Medicare beneficiaries.

This Fact Sheet discusses the proposed changes to payment rates and policies for inpatient services in acute care hospitals in FY 2009, including physician-owned specialty hospitals, based on the Medicare Severity Diagnosis Related Groups (MS-DRGs) that began replacing the prior DRGs for discharges in FY 2008. It also proposes changes to the Medicare Severity Long-Term Care DRGs (MS-LTC-DRGs) which serve as the basis for payment for services to people with Medicare in long-term care hospitals (LTCHs) during rate year 2009.

Proposed improvements to the hospital quality initiatives are discussed in separate fact sheets also issued today, and are available on the CMS website at:

[www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp).

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**BACKGROUND:**

The Medicare law requires CMS to pay acute care hospitals for inpatient stays under an Inpatient Prospective Payment System (IPPS) that establishes prospectively set rates based on the patient's diagnosis. Until FY 2008, each case was categorized into a DRG that was assigned a payment weight based on the average resources used to treat Medicare patients in that DRG. In FY 2008, beginning for discharges on or after October 1, 2007, the 538 DRGs were replaced by 745 MS-DRGs that take into account not only the principal diagnosis, but also the severity of the patient's illness. The new payment categories provide for more accurate payments to hospitals by better recognizing patients' severity of illness or injury patients within inpatient hospital payment rates for a diagnosis. In addition, the new MS-DRGs, along with the hospital quality initiatives that have been implemented in recent years, give hospitals a financial incentive to more thoroughly assess and respond to a patient's medical needs at admission and throughout the inpatient stay.

Under the IPPS, the hospital receives a single payment rate for the case, based on the MS-DRG assigned at discharge. This payment is considered full payment for all costs incurred by the hospital in treating the patient, other than physician services which are paid separately to the physician under Medicare's Physician Fee Schedule.

The Medicare law requires CMS to adjust the payment to each hospital for an assigned MS-DRG, based on a number of factors including geographic wage differentials, the proportion of low-income patients treated by the hospital, and whether the hospital is a teaching hospital, receiving graduate medical education payments. Finally, the IPPS payment will be increased for cases in which the costs of treatment exceed the payment for the MS-DRG by a specified dollar threshold. This threshold is calculated annually at an amount that is projected to keep total outlier payments at no more than 5.1 percent of total payments under the IPPS.

**PROVISIONS INCLUDED IN THE PROPOSED RULE:**

**Proposed Payment Changes For FY 2009:**

Based on current data, CMS projects that the market basket update used to adjust hospital payments will be 3.0 percent. Under provisions of the Deficit Reduction Act of 2005, hospitals that have successfully reported the quality measures in FY 2008 will receive the full update in FY 2009. Hospitals that do not successfully report the quality measures will receive an update of 1.0 percent, which equals the full update less 2.0 percentage points.

In order to maintain budget neutrality as hospitals gain experience with the MS-DRGs, CMS must adjust payment rates to take into account changes in documentation and coding practices that do not reflect real changes in the types of patients and the severity of their illnesses that the hospital treats during inpatient stays. As required by Congress in the TMA, Abstinence Education, and QI Programs Extension Act of 2007, CMS will reduce the payment rates by -0.9 percent for FY 2009. This, along with all other proposed changes, is estimated to increase Medicare payments to acute care hospitals by nearly \$4.0 billion.

Based on current data, CMS is proposing to set the outlier threshold at \$21,025 in FY 2009, down from \$22,185 in FY 2008. This number may change in the final rule to reflect more recent information.

**Proposals Affecting Relative Weights Assigned To The MS-DRGs:**

In FY 2007, CMS began a three-year transition in the determination of DRG relative weights, moving to cost-based weights from weights based on charges. Beginning in FY 2009, the third year of the transition, CMS is proposing to base relative weights 100 percent on costs. CMS is also proposing to respond to industry concerns that the existing methodology for determining hospital cost-to-charge ratios does not take into account that hospitals may mark up lower cost supplies and devices at a higher rate than higher cost supplies and devices. In the proposed rule, we are proposing to add a cost center to the cost report to allow the costs and charges for relatively inexpensive medical supplies to be reported separately from the costs and charges of more expensive devices. The revised cost reporting form would be available for use by hospitals during FY 2009 and would ultimately affect the relative weights under the IPPS and Outpatient Prospective Payment System (OPPS).

**Proposed Changes To The MS-DRG Classifications:**

The proposed rule includes two proposed changes to the MS-DRG classification for FY 2009. First, CMS is proposing to subdivide current MS-DRG 245 (AICD Lead and Generator Procedures) and create a new MS-DRG to separate the implantation or replacement of the AICD leads from the implantation or replacement of the AICD pulse generators. The title for MS-DRG 245 would be revised to “AICD Generator Procedures” and include procedure codes 37.96, 37.98, and 00.54 that identify the implantation or replacement of AIC pulse generators. The proposed new MS-DRG would include procedure codes that identify the AICD leads (37.95, 37.97 and 00.52) and be titled “MS-DRG 265 AICD Lead Procedures.”

The proposed rule would insert the words “or severe sepsis” after “Septicemia” in the titles of the following MS-DRGs that became effective October 1, 2007 (FY 2008):

- MS-DRG 870 Septicemia with Mechanical Ventilation 96+ Hours
- MS-DRG 871 Septicemia without Mechanical Ventilation 96+ Hours with MCC
- MS-DRG 872 Septicemia without Mechanical Ventilation 96+ Hours without MCC

**Proposed Changes To The Post-Acute Transfer Policy:**

When the DRG classification was replaced by the MS-DRG classification in the FY 2008 IPPS final rule, CMS made conforming changes to the criteria for subjecting MS-DRGs to the post-acute transfer policy.

The FY 2009 IPPS proposed rule would apply the post-acute transfer policy to 273 MS-DRGs, the same number as were subject to the policy in the FY 2008 IPPS final rule. Of these, 24 MS-DRGs qualify as special pay post-acute transfer DRGs (approximately the same number as in FY 2008). These MS-DRGs, most of which are surgical MS-DRGs, tend to have higher costs during the first days of the stay. Under the general post-acute transfer policy, the transferring hospital will be paid 50 percent of the total IPPS payment plus the average per diem for the first day of the stay. For the special pay MS-DRGs, the transferring hospital will also receive 50 percent of the per diem amount for each subsequent day of the stay, up to the full MS-DRG payment amount.

The proposed rule would also apply the post-acute transfer policy to discharges to home under a written plan for the provision of home health services that begins within 7 days after the day of the discharge if the discharge from the hospital occurred prior to the geometric mean length of stay for one of the selected MS-DRGs. The current timeframe is 3 days.

**Proposals Relating To Add-on Payments For New Medical Services and Technology:**

In order for technology to qualify for an additional payment beyond the payment for the associated MS-DRG, the applicant must demonstrate that the medical service or technology:

- 1) is new – that is generally, that it has been available on the open market for no more than 2-3 years prior to the year for which the additional payment is sought;
- 2) meets a defined cost threshold (specifically, the lesser of 75 percent of the standardized amount or 75 percent of one standard deviation beyond the geometric mean charge for the DRG group); and
- 3) offers substantial clinical improvement over existing services or technologies for the Medicare patient population.

*Applications For Add-on Payments In FY 2009:* The proposed rule discusses the following applications for new technology add-on payments in FY 2009:

The CardioWest™ temporary Total Artificial Heart system (CardioWest™ TAH-t) — a technology used as a bridge-to-heart transplant device for transplant-eligible patients dying from end stage biventricular failure. The technology was approved by the Food and

- 1) Drug Administration (FDA) on October 15, 2004. CMS had previously issued a national non-coverage determination for the technology, but has now proposed to extend coverage to this technology when used in an FDA-approved clinical study. A final coverage decision is expected around May 1, 2008. CMS has also proposed to assign cases involving this technology to a higher-paying MS-DRG; the applicant maintains that it would continue to meet the cost threshold for purposes of new technology add-on payment even if were reassigned to a higher-paying MS-DRG.
- 2) The Zephyr® EBV — a technology intended to treat patients with emphysema by reducing volume in the diseased, hyperinflated portion of the emphysematous lung. The manufacturer expects FDA approval by August 2008.
- 3) The TherOx Downstream® System — a technology which the applicant claims will reduce the size of acute myocardial infarctions (AMIs) by supplying the affected heart muscle with blood that has been super-saturated with oxygen (SSO2) and thus preserve heart function. The TherOx Downstream® System is expecting FDA approval by June 2008.
- 4) Oxiplex® — an absorbable gel that is applied to exposed tissues after certain spinal surgical procedures which the applicant claims will reduce post-operative pain. Oxiplex® is expecting FDA approval by June 2008.

*Deadline For FDA Approval For Technology Considered For Add-on Payments:* The proposed rule would set July 1 of each year as the deadline by which new technology applicants must receive FDA approval/clearance to allow CMS enough time to fully consider all of the new technology add-on criteria for each application in time for publication of the annual IPPS final rule and to maintain predictability in the IPPS for the coming fiscal year.

### **Wage Index and Data**

*Proposed FY 2009 Wage Index Update:* The FY 2009 proposed national average hourly wage (AHW) is \$32.2252, an increase of 4.2 percent over the FY 2008 figure, based on data for hospital cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005. For FY 2009, 106 labor market areas have AHWs that are greater than or equal to the national AHW, and 329 are below.

*Occupational Mix Adjustment:* The proposed occupational mix adjustment for FY 2009 will be based on the same 6-month 2006 Occupational Mix Survey that was used to compute the FY 2008 adjustment, but the data for FY 2009 have been updated to include revised 1st quarter data for 21 providers and revised 2nd quarter data for 22 providers. CMS also added 1st quarter data for 19 providers who submitted data during the original 1st quarter submission period but had no

relevant data to report prior to the FY 2009 wage index, and 2nd quarter data for 4 providers who submitted occupational mix data during the original 2nd quarter submission period but had no relevant data to report prior to FY 2009. This brings the total providers having occupational mix survey data for the proposed FY 2009 wage index to 3,364.

For FY 2009, CMS is again allowing hospitals to use full-time equivalent (FTE) or discharge data for the allocation of multicampus hospital's wage data among the different labor market areas where its campuses are located. The Medicare cost report will be updated in spring 2008 to provide for the reporting of FTE data by campus for multicampus hospitals. Since the data from cost reporting periods that begin in FY 2008 will not be used in calculating the wage index until FY 2012, a multicampus hospital will still have the option, through FY 2011, to use either FTE or discharge data for allocating wage data among its campuses.

*Rural Floor and Imputed Floor Budget Neutrality:* CMS is required to give urban hospitals within a state a wage index that is no less than the applicable rural wage index in that state. However, this adjustment must be made in a budget neutral manner. CMS is proposing to make such budget neutrality adjustments on a state-wide basis, rather than on a national basis, beginning with the FY 2009 wage index.

CMS is also proposing to extend the imputed floor through FY 2011. Like the rural floor, the imputed rural floor is applied at the state level. For this reason, CMS is also proposing to apply the imputed floor budget neutrality adjustment to the wage index on a state-wide basis, rather than on a national basis.

### **Geographic Reclassification**

*Average Hourly Wage Comparison For Individual Reclassification:* CMS is proposing to change the average hourly wage (AHW) comparison criteria that an individual hospital must meet in order for the Medicare Geographic Classification Review Board (MGCRB) to approve a geographic reclassification application. Specifically, CMS is proposing that an urban hospital seeking reclassification have an AHW that is at least 88 percent of the AHW for the area to which it seeks reclassification rather than 84 percent as is currently required. CMS is also proposing to increase the percentage for rural hospitals seeking individual reclassification to 86 percent from 82 percent of the AHW in the desired labor market area. Finally, CMS is proposing to reevaluate these standards when there are significant changes to labor market definitions in order to allow CMS to consider the effects of periodic changes in labor market boundaries, and provide a regular timeline for updating and validating the reclassification criteria.

*Average Hourly Wage Comparison For County Group Reclassification:* The current AHW comparison criterion for county group reclassification is 85 percent, meaning that in order to

reclassify, all hospitals in a county must have an aggregate AHW that is at least 85 percent of the labor market area to which they seek reclassification. CMS is proposing to set the standard for county group reclassification, which is currently 1 percent higher than the standard for individual hospital reclassification, at 88 percent, the same percentage required for individual reclassification.

*Section 508 Reclassifications:* The proposed rule notifies hospitals that per the Medicare, Medicaid and SCHIP Extension Act all Section 508 reclassifications, as well as special exception providers' wage indexes, will expire on September 30, 2008. These providers will revert back to their home area wage index, plus any applicable out-migration adjustment or current/prior reclassification.

**Emergency Medical Treatment And Labor Act (EMTALA) Requirements:**

CMS is proposing to delete the requirement in the EMTALA regulations that hospitals maintain a list of on-call physicians because the provider agreement regulations already contain a provision addressing this issue. CMS is also proposing to amend its regulations to allow hospitals to comply with the on-call list requirement by participating in a formal community call plan as specified in the preamble to the proposed rule.

CMS is proposing to clarify that a participating hospital with specialized capabilities cannot refuse to accept the appropriate transfer of an individual who had been admitted as an inpatient at another hospital, but remained unstable and needs specialized care only available at the hospital with specialized capabilities, so long as the hospital with specialized capabilities has the capacity to treat the individual. We are also requesting comment on applying EMTALA to a participating hospital with specialized capabilities when a transferred emergency patient, who was stable after admission and prior to transfer, becomes unstable.

**Rural Community Hospital Demonstration Program:**

The proposed rule discusses the implementation of a provision in the Medicare law requiring the Secretary of Health and Human Services to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Currently, 9 hospitals in 7 States are participating, but CMS is currently soliciting up to 6 additional hospitals to participate in the demonstration. CMS estimates the additional payment to be made for 15 hospitals for FY 2009 would be \$32,011,849. CMS is proposing to offset this increase in the budget neutrality adjustment that will be applied across all IPPS payments nationwide.

**Proposed Revisions To The Physician Self-Referral Rules and Hospital Conditions of Participation:**

The physician self-referral rules prohibit physicians from making referrals for eleven types of designated health services (DHSs) furnished in facilities in which the physician or an immediate family member of a physician has an ownership interest or compensation arrangement, and prohibits the entity from billing Medicare or any other entity for services that were referred in violation of the ban. The proposed rule would:

- Modify the physician self-referral “stand in the shoes” provisions in the definition of indirect compensation arrangement to: (1) accommodate certain financial transactions made between physicians and academic medical centers or integrated healthcare delivery systems; and (2) require a DHS entity to stand in the shoes of an organization in which it has a 100% 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 such DHS (the “period of disallowance”) where a financial relationship between the physician and the entity failed to satisfy the requirements of an exception to the prohibition on physician self-referral.
- Solicit public comment on gainsharing arrangements and physician-owned implant companies about the extent to which these arrangements pose a risk for program abuse.

In addition, CMS is soliciting public comments on a mandatory “Disclosure of Financial Relationships Report” (DFRR) in the proposed rule to collect information about financial relationships between hospitals and physicians. The proposed rule would also expand an existing hospital condition of participation to require disclosure to patients of hospital ownership interests held by physicians and their relatives. The expanded condition of participation will allow patients to make more informed treatment decisions.

**MEDICARE ADVANTAGE ENCOUNTER DATA:**

Finally, CMS is proposing to amend the current Medicare Advantage regulation on risk adjustment data to allow CMS to collect from MA organizations encounter-level data for services provided to their enrollees. Collecting encounter data could inform CMS’ MA risk adjustment models.

Comments on the proposed rule will be accepted through June 13. CMS will respond to comments in a final rule to be issued on or before August 1, 2008.

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