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CMS Issues FY 2008 Inpatient PPS Final Rule

Executive Summary

On August 22, 2007, the Centers for Medicare and Medicaid Services (CMS) published in the Federal Register a final rule to update the hospital inpatient prospective payment system (IPPS) for federal fiscal year (FY) 2008.

Most notably, CMS enacted major payment reforms by deciding to implement the Medical Severity DRG (MS-DRG) system that was discussed at length in the proposed rule published on May 3, 2007, characterizing the new system as a "modification of the current DRGs." In conjunction with the implementation of the new MS-DRG system, CMS is reducing the standardized amount by 2.4% in both FY 2008 and FY 2009, but despite this reduction to the standardized amount, CMS believes the increased coding accuracy resulting from the MS-DRG system will yield no significant payment changes in FY 2008.

Changes to DRG System

The new MS-DRG system greatly reduces the number of diagnosis codes that establish an individual as having "comorbidities and complications" (CCs), which translates into 40.34% of inpatients having a diagnosis that qualifies as a CC, down from 77.6% of patients with at least one CC based on the current list. Some of the reduction in CCs results from the removal of chronic conditions from the CC list if no acute manifestation is present. CMS will categorize the new CC severities into three levels or weights: Major Comorbidity or Complication (MCC), CC and non-CC. CMS evaluated the 311 base DRGs and created severity weights for some, but not all, of the base DRGs. After applying a case volume criteria, the end result is 745 DRGs for FY 2008, as nearly half of the 311 base DRGs did not split into three severity subgroups.

The proposed rule indicated that additional, permanent DRG reforms would take place by or for FY 2009. CMS stated in the final rule, however, that MS-DRGs may remain as the new DRG system permanently because it has yet to determine that any of the alternative DRG systems are better than the MS-DRG system and the MS-DRG system is publicly available.

To eliminate the projected effects of increased coding efficiency and case mix, CMS is reducing the standardized amount by 2.4% in FY 2008 and 2.4% in FY 2009. The American Hospital Association has estimated that this could contribute to a cut in hospital inpatient reimbursement of \$25 billion over the next five years; however, CMS stresses in the final rule that the reduction in the standardized amount will not lead to a reduction in overall inpatient reimbursement.

MS-LTC-DRG Reclassifications and Relative Weights for LTCHs for FY 2008

In concert with the development of MS DRGs described above, CMS will adopt MS-LTC-DRGs which correspond to the MS-DRGs. In addition, CMS will use the FY 2008 Grouper Version 25.0 to be effective for long-term care hospital discharges occurring on or after October 1, 2007 through September 30, 2008.

Hospital-acquired infections

CMS selected three conditions that, if present as a secondary diagnosis, will not yield any additional reimbursement, if the secondary diagnosis was not present on admission. They are Catheter-associated Urinary Tract Infections (ICD-9 Code 996.64), Pressure Ulcers (ICD-9 Codes 707.00-707.07, 707.09), and Mediastinitis following CABG (ICD-9 Code 519.2).

Add-On Payments for New Services and Technologies

For FY 2008, CMS will discontinue new technology add-on payments for GORE TAG (endovascular graft repair of the thoracic aorta), the Restore Rechargeable Implantable Neurostimulator, and the X STOP Interspinous Process Decompression System for failing to meet either the newness or cost threshold criterion.

Organ Transplant Programs - Limited Coverage Edit 17

CMS will add conforming Medicare Part A payment edits to the Medicare Code Editor, consistent with the requirements of the organ transplant regulation to ensure that Medicare covers only those organ transplants performed in Medicare-approved facilities. CMS is proposing to add the following procedure codes to the existing list of limited coverage procedures under Edit 17:

- 55.69, Other kidney transplantation;
- 52.80, Pancreatic transplant, not otherwise specified; and
- 5.282, Homotransplant of pancreas.

Devices that are Replaced Without Cost or Where Credit for a Replaced Device is Furnished to the Hospital

CMS will reduce the amount of Medicare IPPS payments when a full or partial credit towards a replacement device is made or the device is replaced without cost to the hospital or with full credit for the removed device. However, in recognition of the fact that, in many cases, the cost of the device is a relatively modest part of the IPPS payment, CMS is proposing to apply the policy *only* to those DRGs under IPPS where the implantation of the device determines the base DRG assignment *and* situations where the hospital received a credit equal to 50% or more of the cost of the device.

MS-DRGs impacted by this final rule are: MS-DRGs 1, 2, 23, 24, 25, 26, 27, 40, 41, 42, 129, 130, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 237, 238, 242, 243, 244, 258, 259, 461, 462, 466, 467, 468, 469, and 470 .

Changes to the Hospital Wage Index

Occupational Mix Adjustment

For FY 2008, the occupational mix adjustment factor will be calculated consistent with that used for FY 2007. The FY 2008 occupational mix adjustment factor will be based on survey data from the first half of 2006, and will be applied to 100% of the hospital wage index. CMS will provide proxy data for non-responsive providers and will eliminate aberrant data. CMS declined to impose a penalty on any provider in FY 2008 that failed to provide occupational mix survey data, indicating that any penalty would not be applied until FY 2010 when the results of the next occupational mix survey will take effect. Also, the next occupational mix survey will relate to the period from July 1, 2007 through June 30, 2008.

Aberrant Data in HWI

In the FY 2008 proposed rule, CMS believed there was aberrant data that resulted in 23 hospitals being removed from the wage index in the proposed rule. After further analysis for the final rule, CMS determined that the effect of the aberrant data was minimal and will have little impact on the hospital wage index.

The final FY 2008 wage index is calculated based on 3,568 hospitals. The resulting average hourly wage did not change for 3,032 hospitals, will increase for 327 hospitals and will decline for 209 hospitals.

Multicampus Providers

Under the provider-based rules, a single Medicare provider may have multiple campuses. In some cases, those campuses lie in different geographic areas. CMS pays those providers based on the geographic area in which the campus lies from which the patient was discharged. The hospital's wage data, however, is reported in the aggregate as data related to the geographic area in which the "main campus" is located. CMS will apportion a multicampus provider's wages and hours based on FTE staff by location if affected providers reported their status to CMS during the comment period for the proposed rule, and CMS is planning a revision to the cost report to allow multicampus providers to report FTEs directly in the cost report.

End of "Imputed Rural Floor"

CMS will discontinue the imputed rural floor adjustment to the wage index over a two year period in FY 2008 and FY 2009. The statutory rural floor adjustment will continue, as discussed below, but the imputed floor for states with no rural areas (or no rural hospitals) will be discontinued after FY 2008.

Labor-related share for the wage index for FY 2008

For FY 2008, CMS will continue to use a labor-related share of 69.7% for all discharges from hospitals with a wage index greater than 1.00, and 62% for all discharges from hospitals with a wage index equal to or less than 1.00.

Budget Neutrality Adjustments to the Wage Index

CMS is, for the most part, following its prior procedures in reflecting in the PPS standardized amount various budget neutrality adjustments. One notable exception from prior practice is the budget neutrality adjustment for the "rural floor" wage index adjustment. Historically, CMS has applied the rural floor budget neutrality adjustment to the standardized amount, but in FY 2008 CMS will apply the budget neutrality adjustment to the wage index instead. In addition, CMS also included a line item in the calculation of the FY 2008 standardized amount simply titled "Rural Floor Adjustment", which increases the standardized amount by a factor of 1.002214.

Hospital Quality Data Reporting

Reporting Hospital Quality Data for Annual Payment Update Program

The Deficit Reduction Act of 2005 (DRA) set out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The DRA revised the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. Specifically, the Act provides that the payment update for FY 2007 and each subsequent fiscal year will be reduced by two percentage points for any subsection (d) hospital that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

Any reduction in a hospital's payment update will only apply with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year. In the event that a hospital is denied the full market basket update, the hospital may submit a letter requesting that CMS reconsider their decision. If a hospital is dissatisfied with the result of the RHQDAPU program reconsideration, the hospital may file a claim under applicable regulations.

For the FY 2008 update, hospitals had to withdraw from the RHQDAPU program by August 15, 2007. If a hospital withdrew from the program, it will receive a two percentage point reduction in its payment update for FY 2008.

FY 2008 Quality Measures

There are now twenty-seven quality measures, which includes six new FY 2008 measures. Hospitals are required to report the twenty-seven measures for the FY 2008 payment determination. The most recent six measured that were adopted for the FY 2008 update include:

1. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey;
2. SCIP-VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patient;
3. SCIP-VTE 2: Prophylactic antibiotic selection for surgical patients;
4. SCIP Infection 2: Prophylactic antibiotic selection for surgical patients;
5. Acute Myocardial Infarction 30-day mortality Medicare patients;
6. Heart Failure 30-day mortality Medicare patients.

Rural Referral Centers

One of the criteria under which a hospital may qualify as a RRC is to have 275 or more beds available for use. If a rural hospital does not meet the bed size requirement, it may still qualify as an RRC if the hospital meets (i) both a predetermined minimum case mix index (CMI) and minimum number of discharges; and (ii) at least one of three optional criteria relating to medical staff, source of inpatients, and referral volume. The CMI threshold currently requires hospitals to have a CMI that is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally. And the current minimum discharge requirement for RRCs with less than 275 beds is 5,000 per year, or if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located.

CMS is amending the CMI requirement for rural hospitals with fewer than 275 beds that are seeking to qualify for initial RRC status on or after October 1, 2007 by requiring such hospitals to have a CMI value for FY 2006 that is at least:

- 1.4049; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs) by region.

In addition to meeting other necessary requirements, hospitals seeking to qualify for initial RRC status on or after October 1, 2007 must have as the number of discharges for its FY 2004 cost reporting period at least:

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located.

Finally, if an urban hospital that received a rural status elects to return to urban status, it will lose its RRC designation effective the day it returns to its urban hospital status.

IME/GME Orientation Time, Vacation, and Sick Leave

Resident Orientation Time for IME and GME purposes

CMS is adopting as final its proposed policy to *continue* counting time spent by residents in orientation activities *in the hospital complex* for GME and IME purposes. Effective for cost reporting periods beginning on or after October 1, 2007, however, CMS is revising its policy so that time spent by residents in orientation activities occurring *in a non-hospital site* where patient care is routinely provided may be included in FTE counts, provided the hospital complies

with all other CMS requirements related to inclusion of such non-hospital resident time. Further, CMS is defining “orientation activities” in 42 C.F.R. § 413.75(b) to mean “activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program.” In addition, CMS is finalizing the definition of “patient care activities” found in § 413.75(b) and used in the determination of whether time is counted towards FTE totals as “the care and treatment of particular patients, including services for which a physician or other practitioner may bill, *and orientation activities...*”

CMS also notes that not all resident orientation activities may be counted. Rather, only orientation activities that are a necessary prerequisite for residents as they commence (or continue) their training program and are required as a term of employment would be considered allowable orientation activities. CMS states that “In orientation sessions, much of the information being imparted to the residents is essential knowledge for the residents in order to furnish patient care services in a particular hospital facility or approved program” and that “the information furnished during orientation is not [didactic] information that merely enhances the resident’s patient care delivery knowledge and skills during the residency program.” As such, CMS believes that “[allowable] orientation activities would occur either at the beginning of a particular specialty program, or when a resident goes to another facility for training.”

Resident Vacation or Sick Leave for IME and Direct GME

Importantly for FY 2008, CMS opted to ***not*** finalize its proposed rule that time spent by residents on vacation or sick leave would be excluded from the determination of what constitutes an FTE resident for IME and GME payment purposes. Although CMS is seeking comments with respect to how to implement this policy and a future change in this area seems likely, for FY 2008 time spent by residents on vacation or sick leave will continue to be included in the resident count process for GME and IME purposes.

CMS further clarifies that the delay in its policy change related to sick leave and vacations does not alter the current policy on extended leave. CMS reiterates its current policy that that residents who are on extended leave that prolongs the total time that the resident must spend in the program beyond its normal duration are not counted while out on leave. When the resident is fulfilling the time extension, however, the resident can be counted in the FTE count, under the resident count rules.

IME Adjustment Factor

For FY 2008, CMS is changing the IME formula multiplier to 1.35 (from 1.32 for FY 2007). CMS estimates that the FY 2008 formula multiplier will result in an increase of 5.5% in IME payment to a hospital for every approximate 10% increase in the hospital’s resident-to-bed ratio. This is not an estimate of the increase in reimbursement from 2007 to 2008, but it is the estimate of the IME adjustment fact on the hospital’s IME payments.

Technical Correction to Medicare DSH Regulation

CMS is making a technical correction to the Disproportionate Share Hospital (DSH) regulations to incorporate the policy adopted in the FY 2005 IPPS final rule to include Medicare Advantage Days in the Medicare Fraction of the DSH calculation.

EMTALA

CMS is adopting two changes to EMTALA to accommodate new statutory requirements for hospitals and critical access hospitals during national disasters and pandemics. Currently, a hospital is required to perform a medical screening

examination for an individual who comes to the hospital and requests examination or treatment of an emergency medical condition. If the individual has an emergency medical condition, the hospital is obligated to stabilize the individual or arrange for the individual to be appropriately transferred to another medical facility. There are two specific changes that affect EMTALA in emergency areas during an emergency period:

1. sanctions will not apply for inappropriate transfer of an individual who has not yet been stabilized or for the direction or relocation of an individual to receive medical screening at an alternate location so long as the hospital is situated in an emergency area during either a national disaster declared by the President of the United States pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or a public health emergency declared by the Secretary of Health and Human Services.
1. waiver of sanctions for EMTALA violations will be limited to seventy-two (72) hours beginning upon the implementation of a hospital disaster protocol for national emergencies, except that in the event of a pandemic infectious disease outbreak, waiver of sanctions for violations shall be determined by the Secretary in accordance with the Social Security Act.

Physician Ownership in Specialty Hospitals and Patient Safety Measures

CMS will require that hospitals disclose to patients in writing if they are physician-owned, and if so, also disclose the names of any physicians who have an ownership or investment interest upon the request of the patient. Physicians will be exempt from this disclosure requirement if their ownership is limited to the holding of publicly traded securities or mutual funds. In order to enforce the disclosure requirements, CMS is amending the provider agreement regulations to permit CMS to deny a provider agreement to a hospital that does not have the patient notification procedures in place and to terminate the provider agreements of physician-owned hospitals if the hospital fails to comply with the new requirements.

CMS is also adopting a new patient safety measure that will require all hospitals, including critical access hospitals (CAHs), to disclose to patients at the time of admission if a physician is not available on the premises at all times. The notice must describe how the hospital or CAH will meet the medical needs of any patient who needs emergent care when no physician is present in the hospital.

Capital PPS

Using its historical policy, CMS calculated a 0.9% increase to the capital PPS standard federal rate. CMS observed, however, that hospitals have experienced "sustained significant positive margins" in Medicare capital cost reimbursement over the past several years. Consequently, CMS will reduce Medicare spending for capital PPS by eliminating for FY 2008 and beyond the 3% add-on payment for large urban hospitals and by instituting a three year elimination of the add-on payments for IME and DSH. Specifically, CMS will not change the amount of IME and DSH add-on payments in FY 2008 but will reduce the add-on payments by 50% in FY 2009 and eliminate them entirely in FY 2010. CMS is accepting comments on the elimination of the add-on payments for IME and DSH and will readdress the issue in the FY 2009 notices of rulemaking for IPPS.

Payments to Existing and New Excluded Hospitals and Hospital Units

Payment for children's hospitals and cancer hospitals that are excluded from IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience.

For existing psychiatric hospitals and units (IPFs) that are paid under the blend

methodology, the applicable percentage increase to update the target amount for the reasonable cost-based portion of the PPS payment will be 3.3% in FY 2008.

CMS is adopting a total cost-to-charge ratio (CCR) ceiling of 1.284 under the LTCH PPS, effective October 1, 2007. Additionally, the LTCH PPS statewide average total CCRs for urban and rural hospitals that are effective October 1, 2007 are set forth in Table 8c of the final rule.

Services Furnished to Beneficiaries in Custody of Penal Authorities

Medicare regulations prohibit payments for services provided to individuals who are in custody of penal authorities unless state or local law requires the individuals to repay the cost of the services they receive while in custody and the state or local authority bills the individuals for those services and pursues collections against them. The final rule defines "custody" as individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, under medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention or confined partially or completely by any penal rule.

If you would like additional information on any of the topics contained in the IPPS 2008 Final Rule, please contact your regular Hall Render Attorney or

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