

**Date: August 19, 2008**

**Subject: Medicare Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates**

This document summarizes the fiscal year (FY) 2009 Medicare hospital inpatient prospective payment systems (IPPS) final rule. The Centers for Medicare and Medicaid Services (CMS) estimates a 3.6 percent increase in the national standardized amount, resulting in an increase of approximately \$4.749 billion in FY 2009 operating and capital payments.

CMS issued the proposed rule on its website on July 31, 2008, and expects to publish it in the Federal Register on August 19, 2008. It is available for download at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf>. These changes are applicable to discharges occurring on or after October 1, 2008 through September 31, 2009.

Highlights from the final rule are provided below.

### **Hospital Inpatient Payment Update**

- CMS projects a 3.6 percent increase in the national standardized amount, to \$5,124.56 (\$3,571.82 labor and \$1,552.74 non-labor), provided the hospital is in compliance with new quality reporting standards.<sup>1</sup>
  - CMS will not finalize the standardized amount, wage index tables, rates or impacts until later due to the effects of a provision in the recently passed Medicare Improvements and Patients and Providers Act of 2008 (Pub. L. 110-275) that relates to wage index reclassifications of certain hospitals.
  - This includes a 0.9% across-the-board reduction to payment rates to maintain budget neutrality by offsetting changes in coding practices under the Medicare severity diagnosis-related groups (MS-DRGs) that could shift the mix towards more costly patients. This is in addition to the -0.6 percent adjustment in FY 2008, yielding a combined effect of -1.5 percent.
- The market basket update to the IPPS rates would result in an approximate \$4.749 billion increase in FY 2009 operating and capital payments.

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<sup>1</sup> Hospitals that fail to report quality data will only receive an increase of 1.6%.

- CMS is establishing a high-cost outlier threshold of \$20,185, down from \$22,650 in FY2008.<sup>2</sup>

### **Refinement of the MS-DRG Relative Weight Calculation**

- CMS is finalizing the two-year transition to 100-percent MS-DRGs in FY 2009.
- CMS is finalizing its proposal to have its relative weights be 100-percent cost-based. This will complete a three-year transition from charge-based payment weights to cost-based weights.
- CMS is finalizing its proposal to address charge compression by modifying the cost report by splitting the current cost center for Medical Supplies and Equipment into one cost center for “Medical Supplies Charged to Patients,” and another line for “Implantable Devices Charged to Patients.”
  - The revised cost report may not be available until cost reporting periods starting after the Spring of 2009.
- CMS is adopting commenters’ recommendation that hospitals should use revenue codes established by the National Uniform Billing Committee (NUBC) to determine what should be reported in the two new cost centers.
  - Use of the existing NUBC definitions would not require that the implantable device remain in the patient when the patient is discharged.

### **Proposed Changes to Specific MS-DRG Classifications**

- *Pre-MDCs – Major Diagnostic Categories*
  - Artificial Heart Devices. CMS is finalizing its proposal to provide limited coverage of the previously-noncovered internal biventricular heart replacement system, provided that the recipient is participating in a clinical trial.
- *MDC 1 – Diseases and Disorders of the Nervous System*
  - Transferred Stroke Patients Receiving Tissue Plasminogen Activator (tPA). For FY 2009, CMS will not modify the MS-DRG system for the stroke patients receiving tPA in one facility prior to being transferred to another facility, due to the lack of information about the patients’ increased resource consumption.
    - However, CMS noted that the creation of ICD-9-CM code V45.88, (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility) in 2008 (and recognized in 2009), may provide the agency a better idea of how to classify these cases within the MS-DRG system.

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<sup>2</sup> Congress created a system to provide “outlier” payments (in addition to the prospective payments) to hospitals for cases whose costs far exceed the costs of typical cases within that DRG. To determine whether a case qualifies for outlier payments, CMS applies hospital-specific cost-to-charge ratios (CCRs) to the total covered charges for the case. These costs are then combined and compared with the outlier fixed-loss cost threshold.

- Intractable Epilepsy with Video Electroencephalogram (vEEG). CMS is finalizing its proposal to not refine MS-DRG 101 (Seizures without MCC) by subdividing cases with a primary diagnosis of intractable epilepsy (codes 345.01 through 345.91) when vEEG (code 89.19) is also performed into a separate MS-DRG.
  - In 2007, CMS performed an analysis using Medicare Provider Analysis and Review File (MedPAR) data, and found that the data do not support the creation of a new subdivision for MS-DRG 101 for cases with intractable epilepsy and vEEG, nor does the data support moving those cases from MS-DRG 101 to MS-DRG 100 (Seizures with MCC).
- *MDC 5 – Diseases and Disorders of the Circulatory System*
  - Automatic Implantable Cardioverter-Defibrillators (AICD) Lead and Generator Procedures. CMS is finalizing its proposals to revise the title of MS-DRG 245 to read “AICD Generator Procedures,” which includes procedure codes 37.96, 37.98, 00.54, and to create a new MS-DRG 265 (AICD Lead Procedures) to include procedure codes 37.95, 37.97 and 00.52.
  - Left Atrial Appendage Device. CMS is not modifying MS-DRG 250 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI with MCC), 251 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI without MCC), or ICD-9-CM procedure code 37.90 (Insertion of left atrial appendage device) for FY 2009.
    - CMS received no comments on its proposal to modify MS-DRG 250, 251, or ICD-9-CM code 37.90.
- *MDC 8 – Diseases and Disorders of the Musculoskeletal System and Connective Tissue*
  - Hip and Knee Replacements and Revisions. CMS is finalizing its proposals to not make any revisions to the joint procedure MS-DRGs, nor change the MCC/CC classifications or the MS-DRG reassignments for ICD-9-CM procedure codes 00.73 (Revision of hip replacement, acetabular liner and/or femoral head only), 00.83 (Revision of knee replacement, patellar component), and 00.84 (Revision of knee replacement, tibial insert (liner)).
    - The American Association of Hip and Knee Surgeons (AAHKS) had requested that CMS enact multiple modifications of the lower joint procedure MS-DRGs. Due to the recent implementation of the MS-DRG system, CMS did not have the opportunity to review data for AAKHS’ requests under the new MS-DRGs. However, it did analyze the impact of these recommendations using cases prior to the implementation of MS-DRGs. Each major suggestion was examined; CMS found that its data and clinical analysis did not support making these changes.
- *MDC 18 – Infections and Parasitic Diseases (Systemic or Unspecified Sites)*
  - Severe Sepsis. CMS is finalizing its proposal to revise the titles of the following three MS-DRGs to include the term “severe sepsis,” to better assist in the recognition and identification of this disease, which could lead to better clinical outcomes and quality improvement efforts:

- 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)

The titles of MS-DRGs 870, 871, and 872 will be revised to read as follows:

- MS-DRG 870 (Septicemia or Severe Sepsis with Mechanical Ventilation 96+ Hours)
- MS-DRG 871 (Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours with MCC)
- MS-DRG 872 (Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours without MCC)

Additionally, a commenter requested that CMS modify the title for MS-DRG 853 (Infectious and Parasitic Diseases with O.R. Procedure with MCC) to include the term “severe sepsis and other.” However, CMS is not making any change to the title for MS-DRG 853.

- CMS noted that the MS-DRG titles generally do not reflect all of the diagnoses or conditions that may have a significant concentration of patients within that particular MS-DRG.
- *MDC 21 – Injuries, Poisonings and Toxic Effects of Drugs*
  - Traumatic Compartment Syndrome. CMS is finalizing its proposal to add traumatic compartment syndrome ICD-9-CM diagnosis codes 958.90 through 958.99 to MS-DRGs 963 (Other Multiple Significant Trauma with MCC) and MS-DRG 965 (Other Multiple Significant Trauma without CC/MCC) in MDC 24 (Multiple Significant Trauma).
    - ICD-9-CM codes 958.90 through 958.99 are added to the list of principal diagnosis of significant trauma.
    - ICD-9-CM code 958.91 is added to the list of significant trauma of upper limb
    - ICD-9-CM code 958.92 is added to the list of significant trauma of lower limb.
    - ICD-9-CM code 958.93 is added to the list of significant abdominal trauma.

## **FY 2009 Applications for New Technology Add-On Payments**

- CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH-t). CMS approves the TAH-t for FY 2009 new technology add-on payment. The manufacturer submitted data to support its estimated operating cost per case involving the TAH-t procedure of \$106,000. Accordingly, CMS is finalizing a maximum add-on payment of \$53,000 for cases that involve the technology.

- Emphasys Medical Zephyr® Endobronchial Valve (Zephyr® EBV). CMS does not approve the Zephyr® EBV for FY 2009 new technology add-on payment. It did not meet the newness criterion, as it was not yet FDA approved.
- Oxiplex®. CMS does not approve Oxiplex® for FY 2009 new technology add-on payment. It did not meet the newness criterion, as it was not yet FDA approved.
- TherOx Downstream® System. CMS does not approve the TherOx Downstream® System for FY 2009 new technology add-on payment. It did not meet the newness criterion, as it was not yet FDA approved.

### **Regulatory Change – Proposed Add-On Payments for New Services and Technologies**

- CMS is finalizing its proposal to establish July 1 of each year as the deadline by which IPPS new medical service or technology add-on payment applications must receive FDA approval to be fully evaluated in the applicable IPPS final rule each year.

### **Reporting of Hospital Quality Data for Annual Payment Update (RHQDAPU)**

- As is the case since FY 2007, CMS will reduce the hospitals' annual payment update by 2.0 percentage points for any qualifying hospital that does not submit certain quality data in FY 2010.
- CMS is proposing to increase the RHQDAPU program measures from 30 measures for FY 2009 to a total of 72 measures for FY 2010.
- CMS is seeking public comments on proposed additional quality measures for the RHQDAPU program, which will provide hospitals a greater awareness of the quality of care they provide, and provide actionable information for consumers to make more informed decisions about their health care providers and treatments.
  - CMS is proposing to add the following 43 measures for the FY 2010 payment determination:
    - Surgical Care Improvement Project (SCIP) Cardiovascular 2, Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period. CMS is adopting this measure. Hospitals will be required to submit data on the SCIP Cardiovascular 2 measure for discharges occurring on after January 1, 2009. The initial data submission deadline for this measure will be August 15, 2009.
    - Four nursing sensitive measures. CMS is adopting one nursing sensitive measure, Failure to Rescue, for the FY 2010 payment determination. It will not adopt the other three measures.
    - Three readmission measures. CMS is only finalizing the Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients); it intends to adopt the acute myocardial infarction and pneumonia readmission measures for the FY 2010 payment determination in the CY 2009 OPPTS/ASC final rule with comment

- period, contingent upon endorsement from a national consensus-based entity such as the NQF.
- Six venous thromboembolism measures. CMS is not adopting these proposed measures, because they would require submission of chart-abstracted data for which current submission mechanisms will not be available for use for the FY 2010 payment determination. CMS intends to propose these measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination. In addition, CMS intends to explore whether data needed to calculate these measures could be submitted using electronic health records.
  - Five stroke measures. CMS will not be implementing stroke measures, because they have not yet received endorsement from a consensus-building entity. CMS intends to propose the stroke measure set during the FY 2010 IPPS rulemaking process for inclusion in the FY 2011 RHQDAPU program measure set.
  - Nine Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) and Inpatient Quality Indicators (IQIs). CMS will adopt the nine AHRQ measures, but will initially calculate them based on existing Medicare claims data. CMS will use the same Medicare claims data set that it uses to calculate the 30-day heart failure, readmission measure, as well as the three mortality measures.
  - Fifteen cardiac surgery measures. CMS is only adopting one of the cardiac surgery measures: Participation in a Systematic Database for Cardiac Surgery. CMS is not finalizing the other 14 process and outcome measures that it proposed to collect from the Society of Thoracic Surgeons (STS) due to hospitals' concern about the perceived requirement to participate specifically in the STS registry, and because CMS has not yet established the infrastructure to collect these measures directly from hospitals.
- For FY 2010, CMS is finalizing its proposal to require continued submission of data on 26 of the 30 existing acute myocardial infarction, heart failure, pneumonia, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and SCIP measures adopted for FY 2009.
    - The three outcome measures do not require hospitals to submit data.
    - CMS is finalizing its proposal to remove the Pneumonia Oxygenation Assessment measure, as compliance is almost 100 percent and CMS believes the burden to hospitals to abstract and report these data outweighs the benefit. Hospitals will no longer be required to submit data on this measure beginning with January 1, 2009 discharges.
  - CMS is finalizing its proposal to update the following timing measures to conform to the National Quality Forum's (NQF) new endorsements:
    - Acute Myocardial Infarction (AMI) – Timing of Receipt of Primary Percutaneous Coronary Intervention (from within 120 minutes to 90 minutes of hospital arrival), and

- Pneumonia – Timing of receipt of initial antibiotic following hospital arrival (from within four hours to six hours of hospital arrival).

Beginning with discharges on or after January 1, 2009, CMS will calculate the measures using the updated timing intervals.

- After considering the comments received, CMS has decided not to adopt a separate subregulatory process to implement measure updates made to existing measures by consensus-building entities. CMS will continue to update technical specifications for each of the measures in the Specifications Manual.
  - Substantive changes to existing measures will be made through the rulemaking process.
- CMS sought comment on a list of 59 measures and four measure sets from which additional quality measures could be selected for inclusion in the RHQDAPU program in 2011 and subsequent years. The list includes the following:
  - Chronic Pulmonary Obstructive Disease Measures
  - Two Complications of Vascular Surgery
  - Inpatient Diabetes Care Measures
  - Two Healthcare Associated Infections
  - Three Timeliness of Emergency Care Measures, including Timeliness
  - Two SCIP Measures
  - Complication Measures (Medicare patients)
  - Three Healthcare Acquired Conditions
  - Five Hospital Inpatient Cancer Care Measures
  - 24 Serious Reportable Events in Healthcare (“Never Events”)
  - Average Length of Stay Coupled with Global Readmission Measure
  - 13 Preventable Hospital-Acquired Conditions (HACs)

CMS received comments that supported the adoption of the following quality measures and measure sets from the above list:

- Surgical resection includes at least 12 nodes (Hospital Inpatient Cancer Care Measures),
- Care coordination measures, and
- Additional glycemic control measures.

### **Medicare Hospital Value-Based Purchasing (VBP)**

- The Medicare Hospital VBP Plan builds on the foundation of Medicare’s current RHQDAPU program.

- If authorized by Congress, the VBP Plan would replace the current quality reporting program with a new program that would include both public reporting and financial incentives to drive improvements in clinical quality, patient-centeredness, and efficiency.
- CMS is seeking public comments on how to take full advantage of the new information generated through plan development.
  - CMS received 65 comments regarding the VBP Plan; the commenters agreed that testing will provide valuable information for understanding the range of performance results under the Hospital VBP Plan, and it could provide a useful planning tool for individual hospitals. CMS categorized the comments into eight themes:
    1. What testing results should be posted,
    2. Where testing results should be posted,
    3. At what level testing results should be posted,
    4. Sharing results with individual hospitals,
    5. Application of Incentives,
    6. Sensitivity to hospital burden,
    7. Convening a Technical Advisory Panel, and
    8. Nursing-specific issues.

### **Payments to Medicare Advantage Organizations: Collection of Risk Adjustment Data**

- Given the increased importance of the accuracy of CMS' risk adjustment methodology, CMS is finalizing its proposal to collect data from Medicare Advantage (MA) organizations regarding each item and service provided to an MA plan enrollee.
  - CMS will use the encounter data for the following uses:
    - Calculating risk factors,
    - Updating risk adjustment models,
    - Calculating Medicare DSH percentages,
    - Conducting quality review and improvement activities, and
    - For Medicare coverage purposes.

### **Application of Incentives to Reduce Avoidable Readmissions to Hospitals**

- Medicare spends \$15 billion each year on hospital readmissions. According to a Medicare Payment Advisory Commission (MedPAC) analysis, \$12 billion in spending were found to be potentially avoidable.
- CMS is presenting for public comment three approaches to applying incentives to reduce avoidable readmissions for public comment:

1. Direct adjustment to hospital DRG payments for avoidable readmissions (would likely require new statutory authority),
2. Adjustments to hospital DRG payments through a performance-based payment methodology (may require new statutory authority), and
3. Public reporting of readmission rates.

CMS indicated that it appreciated all of the public comments it received in response to the solicitation, and will take them into consideration in future rulemaking efforts.