Are You Expecting Increased Payments this Year?

After reading all of the reimbursement changes included in the final rule it is hard to imagine hospitals increasing payments by 4.7%

By:

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As October 1st approaches many providers that participate in the Medicare Inpatient Prospective Payment System (IPPS) are wondering what the impact of the Federal Fiscal Year (FFY) 2009 changes will be for their facility. The financial impact will vary by facility but the overall impact is estimated to be a 4.7% increase with urban hospitals increasing an estimated 4.8%.

The Centers for Medicare and Medicaid Services (CMS) published the Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates in the August 19, 2008 Federal Register. On July 15, 2008, the Medicare Improvements for Patients and Provider Act of 2008 (MIPPA) was passed. This Act affects the wage index values and rates included in the FFY 2009 final rule.

The timing of this Act, did not allow CMS adequate time to recalculate all of the wage index values and rates before the final rule was published on August 19, 2008. Therefore the final rule contains tentative wage index

values and rates. CMS has indicated that the final wage index values and rates will be published in a separate Federal Register notice.

Market Basket Update

The FFY 2009 final rule includes a market basket update of 3.6% that is an increase from the proposed market basket increase of 3.0%. **Hospitals that have not submitted quality data under the "Reporting of Hospital Quality Data for Annual Hospital Payment Update" (RHQDAPU) program will receive a 2% reduction.** Under the RHQDAPU program hospitals had to report 27 quality measures in FFY2008 to receive a full market basket update in FFY 2009. CMS has added 3 new quality measures for reporting in FFY 2009 and has added an additional 13 new quality measures for reporting in FFY 2010.

The market basket update for all hospitals will be reduced by 0.9% as required by the Medicare "TMA, Abstinence Education, and QI Programs Extension Act of 2007". This reduction is a behavioral offset adjustment which is being applied to compensate for hospitals improved documentation and coding under the Medicare Severity-Diagnostic Related Groups (MS-DRG). In FFY 2008 the behavioral offset was a reduction of 0.6% so over the two years the cumulative reduction is 1.5%.

DRG Relative Weights

In the FFY 2008 final rule CMS introduced the MS-DRG system that takes into account a patient's severity of illness when assigning a DRG. The MS-DRGs were introduced with a two-year transition to lessen the shifts in payments. In FFY 2008 DRG relative weights were calculated using 50% of the CMS DRG relative weight and 50% of the MS-DRG relative weight. Beginning in FFY 2009 DRG relative weights are based on 100% of the MS-DRG weights.

In addition to the full transition to MS-DRG relative weights, FFY 2009 is also the third year of a transition to 100% cost based weights. The idea of calculating the relative weights based on cost instead of the traditional charge methodology was initially introduced in FFY 2007 with a three-year transition. The idea of using cost based weights derived from Medicare cost report data has raised a number of concerns. In an effort to improve the accuracy of the data used to calculate the cost based weights CMS has

announced they will be revising the cost report. CMS intends to split out the Medical Supplies Charged to Patients cost center into one line for "Medical Supplies Charged to Patients" and a second line for "Implantable Devices Charged to Patients". The determination of what should be reported in the respective cost centers is to be based on the assigned UB revenue code. The change in the cost report is not expected to take place until cost reporting periods beginning after the Spring of 2009. Since there is a three year lag in the use of cost report data this change will not affect the calculation of the IPPS relative weights until FFY 2012 or FFY 2013.

Hospital Acquired Conditions

As of October 1, 2008 hospitals may also be financially impacted by the eleven Hospital Acquired Conditions (HACs) identified by CMS in the FFY 2009 final rule. If a patient acquires one of the identified conditions during a hospital stay CMS will not pay the higher DRG resulting from the hospital acquired condition. In other words CMS will calculate the DRG payment as if the diagnosis of the hospital acquired condition was not present. Although hospitals began reporting present on admission (POA) indicators in FFY 2007 it is extremely important that hospitals reinforce the importance of properly reporting all conditions that are POA to prevent reductions in payments.

Post Acute Transfer Policy

The post-acute transfer policy affects 270 DRGs in FFY 2009 that is a slight decrease from FFY 2008 which had 273 DRGs. In the proposed FFY 2009 rule CMS had included a change to the Home Health criteria. The proposed change expanded the Home Health criteria from receiving home health services within three days of discharge to receiving home health services within seven days of discharge. This proposal was not adopted in the FFY 2009 final rule although CMS did state they will continue to review this data.

Indirect Medical Education

A hospitals Indirect Medical Education (IME) adjustment to the DRG payment is calculated using a hospital's ratio of residents to beds and a formula multiplier. The formula multiplier for FFY 2009 will remain at 1.35.

As stated in the FFY 2008 final rule the capital IME adjustment will be phased-out over three years. In FFY 2009, the second year of this phase-out, the capital IME payments will be reduced by 50%. In FFY 2010 the capital IME payments will be eliminated.

Wage Index and Rural Floor

MIPPA that was enacted in July 2008 extends the Section 508 reclasses through the end of FFY 2009.

In the FFY 2009 proposed rule CMS proposed to apply a state-level rural floor budget neutrality adjustment to the wage index instead of the current policy of applying the rural floor budget neutrality adjustment to the wage index nationally.

The effect of applying the rural floor budget neutrality adjustment at the state-level versus nationally is that states that do not have any hospitals that receive the rural floor will not have a negative budget neutrality adjustment applied to their wage indices. On the flip side, a state that has hospitals that receive the rural floor will have a negative budget neutrality adjustment applied to their wage indices to achieve budget neutrality within the state. The final rule for FFY 2009 includes a three-year transition from the national budget neutrality adjustment to the state-level rural floor budget neutrality adjustment. In the first year of the transition, FFY 2009, hospitals will have a blended wage index that is calculated using 80% of a wage index with the national budget neutrality adjustment and 20% of a wage index with the state-level rural floor budget neutrality adjustment.

In FFY 2010 the blend will be 50% national budget neutrality adjustment and 50% state-level rural floor budget neutrality adjustment. The state-level budget neutrality adjustment will be applied 100% in FFY 2011.

Conclusion

As you can see there are a number of initiatives that are in their final transition year while other initiatives are just beginning in FFY 2009. After reading all of the reimbursement changes included in the final rule it is hard to imagine hospitals increasing payments by 4.7%; but this is obviously

only an estimate and will vary based on a number of factors including case-mix, location, and teaching status.

The above summary only touches on the reimbursement changes included in the FFY 2009 final rule.

The entire final rule can be accessed using the following link: http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf.

To help you sort through the final rule and how it's likely to impact your facility, contact BESLER Consulting.