



DIXON HUGHES PLLC

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CMS ISSUES FY 2008 HOSPITAL INPATIENT PROPOSED RULE

NOTE: The following information reflects corrections published by CMS on May 15, 2007.

Drawing swift and vigorous criticism, the Centers for Medicare & Medicaid Services published its FY 2008 hospital inpatient PPS proposed rule on April 13, 2007. The American Hospital Association expressed reservations almost immediately, and followed up with an April 27 release that claims the proposed rule would result in payment cuts of \$25 billion to hospitals over the next five years. Other industry groups joined the AHA in a letter on May 3 strongly urging CMS to reconsider certain provisions of the proposed rule.

The rule was included in the May 3 Federal Register, and public comments will be accepted until June 12. Comments can be submitted electronically.

Key provisions of the proposed rule include the following:

- **Adoption of Severity-Adjusted DRG System**—CMS has proposed the adoption of Medicare-Severity DRGs (MS-DRGs), replacing the current 538 DRGs with 745 new DRGs in an effort to better recognize the severity of illness in Medicare patients and the related cost of treatment.

Although revamping the DRG system is budget neutral, CMS has determined it will be necessary to reduce IPPS payments by 2.4% in each of the next two years, to account for expected increases in payments due to improvements in hospital documentation and coding that do not reflect any true increase in the severity of patient illness.

The proposed 4.8% cumulative decrease for behavioral offset has drawn significant criticism from the AHA and other industry groups. However, it brings to light the importance of hospitals examining their documentation and coding processes to ensure that severity of illness is properly reflected in their patient claims.

As part of its FY 2007 IPPS Final Rule, CMS commissioned RAND Corporation to analyze five separate DRG products. CMS has now asked RAND to also include the new MS-DRGs in its final analysis. CMS states it will not make a decision as to which DRG system to adopt permanently until RAND issues its final report, which is due by September 1, 2007. Because of the expected timing of the FY 2008 final rule relative to RAND publishing this final report, it is entirely possible that any DRG system implemented for FY 2008 could be significantly modified or even replaced in FY 2009.

CMS has made available online a crosswalk between the current DRGs and the proposed MS-DRGs.

• **Continuation of Transition to Cost-based DRG Weights**—CMS has proposed to continue its transition started in FY 2007 to calculate DRG weights based on hospital costs as opposed to hospital charges. For FY 2008, two-thirds of the calculation will be cost-based, and one-third charge-based under the proposed rules. However, CMS acknowledges that analysis performed by RTI International on behalf of CMS has indicated that the cost-based system currently being phased in has certain shortcomings, and CMS has left the door open to modify the process in its FY 2008 final rule.

Reductions in IPPS Capital Payments for Urban Hospitals—CMS has proposed to not increase the capital payment rate in FY 2008 and 2009 for urban hospitals, as opposed to applying the .8% increase that would have resulted under their previous methodology. Rural hospitals will receive the .8% increase in FY 2008, and will continue receiving updates in future years. Both urban and rural rates will be decreased by 2.4% to reflect the expected behavioral offset.

In addition, CMS has proposed eliminating the 3% add-on to the capital payment for large-urban hospitals (hospitals located in CBSAs with greater than 1 million population).

CMS points to the “consistent and significant positive margin” of urban hospitals as justification for these proposed changes to capital payments.

• **Wage Index**—Several proposals specifically relate to the wage index:

—Wage index calculations for FY 2008 and FY 2009 will take into account the combined six months of Occupation Mix Survey data collected in 2006.

—The next Occupation Mix Survey is proposed to be applied to the FY 2010 wage index process, and will cover the time period July 1, 2007 through June 30, 2008. This next survey will include certain minor changes to the process completed in 2006. CMS published their proposed rule for the next Occupational Mix Survey in the February 2, 2007 Federal Register, and the final rule is expected by July 1, 2007.

—Contract services for management, A&G, housekeeping and dietary will be included in the wage index calculation for FY 2008. Although this data has been collected since FY 2004, there has never been any determination on how or even if this data would be used. CMS encourages feedback on whether any other “indirect patient care” cost centers should be included in the wage index process in the future.

—The list of hospitals eligible for an out-migration adjustment increasing their wage index was updated. Hospitals that have been redesignated or reclassified are not eligible to also receive an out-migration adjustment, and these hospitals are deemed to have waived the out-migration adjustment unless they notify CMS within 45 days of publication of the proposed rule that they elect the out-migration adjustment instead of

their redesignated or reclassified wage index. Hospitals currently redesignated or reclassified for FY 2008 that are also eligible for out-migration should analyze which treatment is preferable.

—As in prior years, hospitals reclassified by the MGCRB for FY 2008 have 45 days from the publication date of the proposed rule to request a withdrawal of their application if they desire. Hospitals currently reclassified for FY 2008 should verify that reclassification is in their best interest by examining the appropriate wage index tables in the proposed rule.

- **Outlier Threshold**—CMS has proposed reducing the outlier threshold for FY 2008 to \$22,940, compared to the FY 2007 threshold of \$24,485. CMS believes the new MS-DRGs will increase payments for severe cases that were previously paid as outliers, resulting in the need to decrease the threshold.
- **Payment for Replacement Devices**—CMS has proposed reducing payments to hospitals for certain replacement devices that were obtained by the hospital at a reduced cost or with full credit for the removed device. CMS has provided a list of specific DRGs subject to the policy.
- **Required Disclosure for Physician Ownership in Hospitals**—CMS has proposed requiring specific disclosures to patients for hospitals with physician ownership, and for physicians referring patients to hospitals where the physician has an ownership interest.
- **Hospital-Acquired Conditions**—In response to a requirement included in the Deficit Reduction Act of 2005, CMS has proposed a list of six conditions that will not result in additional payment unless the condition was present upon admission. Although these conditions have been identified by CMS in this proposed rule, payment adjustments will not take place until discharges on or after October 1, 2008.
- **Reporting of Hospital Quality Data**—CMS has proposed adding five quality measures in FY 2009, bring the total to 32, required for hospitals to qualify for a full market basket rate increase.
- **Medicare Cost Report**—Although there are no specific related proposals, it is interesting to note that CMS mentions they “recently began doing a comprehensive review of the Medicare cost report and plan to make updates that will consider its many uses.” This review ties in to RTI’s analysis of cost-based DRG weights, which noted that certain shortcomings in the current cost-based system are directly related to problems with cost report data, both in the format of the cost report and in inconsistencies between hospitals.

A Quick Look at What the New DRGs Could Mean to You

Although every hospital should consider taking meaningful steps in the coming months to get their arms around the potential impact of new DRGs, one source is available right now, at no cost, to provide a quick estimation of what might be in store. When CMS issues its proposed

and final rules each year, it also publishes an impact file with a wide range of data for every PPS hospital. This Excel file can be downloaded from the CMS website.

Included in the impact file for the FY 2008 proposed rule is each hospital's transfer adjusted case mix index under the current DRG system for all Medicare claims in the December 2006 MedPAR data file, and what the transfer adjusted case mix index would be for the same claims under the proposed MS-DRGs. The current CMI is in column AA, while the MS-DRGs CMI can be found in column AD.

For more detailed information on what to do about the new DRGs, read [The New DRGs—What's a Hospital to Do?](#)

FY 2008 Proposed Rule – By the Numbers

	FY 2007 Final	FY 2008 Proposed
Labor-related standardized operating amount (wage index > 1, full update)	\$3,397.52	\$3,430.41
Nonlabor-related standardized operating amount (wage index > 1, full update)	1,476.97	1,491.27
Labor-related standardized operating amount (wage index <= 1, full update)	3,022.18	3,051.44
Nonlabor-related standardized operating amount (wage index <= 1, full update)	1,852.31	1,870.24
Capital standard federal rate – urban	427.03	413.73
Capital standard federal rate – rural	427.03	417.12

Rules for Inpatient Psych and Rehab also Published

In addition to the proposed rule for hospital inpatient PPS, CMS has also recently published its final inpatient psych payment rates for RY 2008, and its proposed rule for inpatient rehab for FY 2008. The inpatient psych payment rates were published in the May 4 Federal Register and are effective July 1, 2007. The inpatient rehab proposed rule was published in the May 8 Federal Register and is effective October 1, 2007. Comments will be received by CMS until July 2. Comments can be submitted electronically [here](#).

CMS did not open up for public comment the changes to inpatient psych, on the grounds that there were no significant changes in policy, but merely updates to rates using previously accepted methodologies. Last year CMS indicated that it intended to collect several years of psych PPS data before it would attempt to develop any significant changes in methodology.

The proposed rule for inpatient rehab continues the phase-in to a 75 percent compliance threshold (“75 Percent Rule”). This requirement when fully phased in will necessitate at least 75 percent of the patient population of an inpatient rehab facility to have one of thirteen specific medical conditions. Under the phase-in period currently in progress, a 60 percent threshold applies for cost reporting periods beginning between July 1, 2006 and June 30, 2007. The compliance threshold increases to 65 percent for cost reporting periods beginning between July 1, 2007 and June 30, 2008. For cost reporting periods beginning on or after July 1, 2008, the compliance percentage is 75 percent.

A provision of the 75 Percent Rule currently in place allows rehab providers to possibly use patient comorbidities in determining compliance with the required medical conditions. However, this specific provision expires for cost report periods beginning after July 1, 2008, and CMS is seeking comments and research to support extending this provision or possibly making it a permanent part of inpatient rehab policy.

Wage Index – Big Changes on the Way?

A provision of last December’s Tax Relief and Health Care Act of 2006 may have kicked off a series of events that could eventually lead to a complete overhaul of how the wage index is calculated and applied. In the act, Congress instructs the Medicare Payment Advisory Commission (MedPAC) to provide recommendations for alternatives to the current wage index process. Congress also instructs CMS to take MedPAC’s recommendations under advisement and present one or more recommendations related to the wage index in the FY 2009 proposed rule.

MedPAC has indicated they will include their wage index recommendations in their annual report to Congress in June 2007. However, a discussion draft from MedPAC’s staff indicates what direction MedPAC may be headed. Rather than basing the wage index off data collected by individual hospitals, the draft suggests utilizing Bureau of Labor Statistics data that is already collected and is developed from a broader labor pool. MedPAC’s staff claims the end results of their draft process include less volatility from year to year, smaller differences between geographic regions, smaller range between highest and lowest wage index, and a reduction in data collection burden on individual hospitals. One additional result from this system is that the option of geographic reclassifications would most likely be eliminated, a factor that certain hospitals are sure to not like.

Although the specifics of MedPAC’s draft are likely to change before final recommendations are presented, and any significant changes in the wage index process are over a year away from

implementation if not longer, this issue is worth keeping an eye on in order to anticipate significant changes down the road.

Questions? Contact David Hall at 919.484.0630 or dhall@dixon-hughes.com.

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