Medicare IPPS FY 2009 Final Rule

The Centers for Medicare & Medicaid Services (CMS) on July 31 released its Fiscal Year (FY) 2009 inpatient prospective payment system (IPPS) final rule, which partially addresses concerns voiced by hospitals nationwide during the public comment period. The Final Rule pare the proposed increase of 43 new quality measures hospitals must report to receive a full market basket update in 2010. Instead, CMS removed one current measure related to pneumonia and added 13 more; however, only four of those have been adopted by the Hospital Quality Alliance (HQA). Hospitals must report on 42 measures, up from 30 this year, to receive the 3.6% full market basket update in FY 2010.

The full update for FY 2009 is 3.6%. Hospitals that submitted data on 30 quality measures during the past year will receive that market-basket increase, while those hospitals not submitting data will receive a 1.6% update. The rule also finalizes CMS’ proposed wage index changes, but implementation will be phased-in. Specifically, CMS will:

- Increase the threshold necessary for both individual and group area wage index reclassifications with a two-year transition.
- Apply the rural floor budget-neutrality adjustment at the state level, rather than to the standardized amount, with a three-year transition.
- Extend the imputed rural floor provision for those states that do not have rural areas for an additional three years through FY 2011.

The rule also adds two more healthcare-acquired conditions for which it will no longer pay a higher DRG rate beginning in FY 2009 if present on admission, expands one condition adopted in last year’s rule and finalizes CMS’ proposals related to cutting capital indirect medical education payments. The Arkansas Hospital Association will send members more details on the Final Rule later this week.

The final rule will be published in the August 18 Federal Register; a display copy is available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf.

Arkansas Health Summit Scheduled

The Arkansas Hospital Association is serving as a co-sponsor for the 2nd Arkansas Health Summit. The purpose of the meeting is to educate legislators, declared candidates and interested stakeholders about leading public health issues. The Arkansas Health Summit will be held Wednesday, August 20 at Next Level Events, 1400 West Markham in Little Rock. The meeting will begin at 9:30 a.m. and conclude at 3:30 p.m.

The discussion will center on public policy issues in healthcare and serves as a preview of issues coming before the 87th Arkansas General Assembly. Dr. Joe Thompson, Arkansas Surgeon...
General, will moderate the discussions, as well as provide an overview of the current state of healthcare in Arkansas. Other topics include: Arkansas 2020 Study; the Economic Benefits of a Strong Medicaid Program; Looming Challenges in Medicaid; Statewide Trauma System; Tobacco Settlement Update; E-Prescribing; and Fighting Childhood Obesity. Other co-sponsor organizations are the Arkansas House and Senate Committees on Public Health, Welfare and Labor, the Arkansas Center for Health Improvement, the Arkansas Foundation for Medical Care, the Arkansas Medical Society and the University of Arkansas for Medical Sciences College of Public Health. Contact Bo Ryall at (501) 224-7878 or boryall@arkhospitals.org for registration information.

**Hospital Reports Book Sale Scam**

Saint Mary’s Regional Medical Center in Russellville has asked the Arkansas Hospital Association to help notify other hospitals about a scam which victimized the hospital. The medical center’s Employee Activities Committee recently scheduled two book fairs with an individual from Oklahoma named Vickie Robinson, with A+ Plus Books, as a fund raiser for a program that helps people in need.

The hospital’s rebate was to be 30% of total sales, with a $300 bonus at each sale. However, according to Saint Mary’s, Robinson left town immediately after the book fair without providing any information about how the sale went, how much the hospital could expect in the form of a rebate or when to expect payment. She apparently failed to pay the local temporary employment agency that she used for set up and tear down her sales displays, too.

Hospital officials have left repeated phone messages on Robinson’s phone and have written several letters, but have not heard back from her. Saint Mary’s has since filed a complaint with the Oklahoma and Arkansas Attorneys General offices.

**Legal Note: Poliner Case Reversed**

The *Poliner v. Texas Health Systems* case generated a great deal of attention and was harshly criticized for its potential to chill the peer review process. In *Poliner*, a federal district court in Texas found that a hospital and several physicians were not entitled to immunity under the Health Care Quality Improvement Act (HCQIA), for summarily suspending a cardiologist, Dr. Lawrence Poliner.

Dr. Poliner convinced the jury that Presbyterian Hospital of Dallas and three of its physicians were liable for defamation and was awarded $366 million in compensatory and punitive damages, although this amount later was reduced to $22.5 million. However, after a lengthy appeals process, on July 23, 2008, hospital and physician leaders across the country breathed a sigh of relief when the Fifth Circuit Court of Appeals reversed the *Poliner* decision.

Dr. Poliner had alleged that the suspension was based upon hostility toward him and the participating physicians’ anti-competitive motives. Among other issues discussed in the lengthy opinion, the Court “roundly rejected the argument that [subjective bias or bad faith motives] overcome HCQIA immunity.” The Court also found that the peer review action at issue in the case satisfied the procedural requirements of the HCQIA. Holding that the hospital and its physicians enjoyed immunity under the HCQIA, the Court found that Dr. Poliner was not entitled to money damages and entered judgment for the defendants.
AHA Endorses S. 3300

The American Hospital Association sent a letter last week expressing support for legislation introduced by Sen. Charles Grassley (R-IA) that would benefit rural hospitals and ban self-referral to new physician-owned hospitals. The Rural Hospital Assistance Act of 2008 (S. 3300) would benefit hospitals that are too large to be critical access hospitals but too small to be financially viable in the inpatient prospective payment system by exempting Medicare dependent-hospitals from the wage-adjusted payment rate and improving the low-volume adjustment so that hospitals with 800-1500 discharges can get as much as a 25% increase in their payments on a sliding scale.

To offset the cost of the provisions, the bill would ban self-referral to new physician-owned hospitals. It also would create a prospective ban on physician self-referral to hospitals in which a physician has an ownership interest. The AHA letter of support can be found online at http://www.aha.org/aha/letter/2008/080728-let-pollack-grassley.pdf.

Hospital Bond Bill Now Law

President Bush on July 30 signed legislation allowing Federal Home Loan Banks to issue letters of credit on hospital and other tax-exempt bonds. The provision was included in the Housing and Economic Recovery Act (H.R. 3221) to help communities raise funds for healthcare facilities and other infrastructure improvements. It is effective immediately and sunsets on December 31, 2010.

CMS Extends Patient Data Deadline

The Centers for Medicare & Medicaid Services has extended to August 15 the deadline for submitting Initial Patient Population and Sampling data for first-quarter 2008 discharges (January through March). Hospitals participating in the inpatient quality reporting initiative must submit the data by 11:59 p.m. on that date. The data was originally due August 1.

The AHA Calendar

August 2008

6 Top Seven Mistakes Hospitals Make in Designing Physician Compensation Structures – Webinar #V7608
7-8 Arkansas Society for Healthcare Marketing & Public Relations (ASHM&PR) 2008 Summer Conference, Crowne Plaza, Little Rock
12 Medicare Conditions of Participation and Joint Commission Standards: Crosswalk to Continuous Compliance – Three-part Audioconference Series: Part 1
12 New Models for Hospital-Physician Partnership – Webinar AZ081208
13 Facility Investment: Getting Past Stop – Webinar VA081308
13 AHA Mid-Management Certificate Series: Financial Skills for Managers, Crowne Plaza, Little Rock
Final Thoughts by Paul Cunningham

If you’re wondering what has happened to CMS’ Medicare Recovery Audit Contractors, the RACs, then join the club. The latest update is that there is little to report. Throughout the early months of this year CMS was abuzz with talk of its new contractor for bird-dogging Medicare claims and payments. After making quite a stir about what was about to descend upon the nation’s hospitals, the official word about RACs has seemingly moved underground. Not that there’s anything wrong with that, but it’s beginning to make folks who want time to prepare nervous.

Rewind a few frames and you’ll recall that RACs are new private organizations which contract with CMS to review Medicare claims. Their primary goals are to detect and correct past improper Medicare payments and to provide information to CMS and its Medicare claims-processing contractors aimed at helping protect the Medicare Trust Fund by preventing future improper payments and lowering the Medicare Fee-For-Service payment error rate.

The RAC demonstration program began in March 2005 and ran three years, ending last March. It was initially conducted in New York, California and Florida, before CMS eventually expanded the jurisdictions to providers in Arizona and South Carolina, too. The apparent success of the demonstration led Congress to include in the Tax Relief and Health Care Act of 2006 provisions for the RAC program become permanent and to be expanded to all 50 states by January 2010.

By 2007, CMS was dancing as fast as it could and accelerating that timetable with intentions for the RACs to begin reviewing inpatient and outpatient hospital claims in all 50 states by March 2008 to coincide with the final month of the demonstration. Plans were made. CMS quickly divided the country into four RAC regions and last October issued a request for proposals from interested organizations wanting the business. The final step was to name a contractor for each of the four RAC regions. January of 2008 was the hard target date. Except, the timetable later slipped to March, then May, then June. Since the June date faded into the past, there’s been nothing. Zilch. Na-da. Nyet. We now understand that the RACs won’t be named until sometime in September.

Exactly which of the competing groups will become RACs must be the most closely guarded secret since the mystery surrounding whatever it was that Billie Joe McAllister and his girlfriend threw off the Tallahatchie Bridge and why on earth he later jumped off of it. Odd as it seems, nobody is talking and nothing is seeping out. We knew more about many of the CIA’s past government secrets before they were officially declassified a year ago than we know about the RAC contractors, and those had a valid reason for being “need to know.” Go figure.

The embedded good news could be that the delay will push back the dates for starting the RAC reviews, at least for a while, but don’t depend on it. Fortunately, Arkansas hospitals are situated about as well as possible. RAC reviews aren’t scheduled to begin here until next January at the earliest. But, many Arkansas hospitals had hoped to use the extra time to learn more about the region’s RAC and the review process from the experience of others in the region that were to have gone online in March and October of this year. Unless CMS delays its planned phased-in rollout, there may no longer be much of an opportunity to learn from those lessons.

Rest assured that the RAC program isn’t going away and chances are it won’t be significantly delayed. CMS reported last month that the three-year RAC demonstration resulted in pinpointing more than $1.03 billion in Medicare improper payments and returning $693.6 million to the Medicare Trust Fund. In Congress’ eyes that’s like finding needed money forgotten away in the pocket of an old pair of jeans. It makes the prospects for legislation to put a one-year moratorium on nationwide RAC reviews (H.R. 4105) even slimmer than before.

CMS said in its report that it still intends to implement the permanent RAC program gradually. Obviously, that won’t be quite so deliberately as before. The agency also indicated that the new RACs are expected to sponsor outreach efforts in every state before issuing overpayment notices and medical record requests. However, key dates in the report concerning the award of national RAC contracts and the beginning of provider outreach are both tagged “TBD,” or to be determined. Tick-tock………..