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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

**42 CFR Parts 412, 413, 415, et al.
Medicare Program; Hospital Inpatient
Prospective Payment Systems for Acute
Care Hospitals and the Long Term Care
Hospital Prospective Payment System
Changes and FY2011 Rates; Provider
Agreements and Supplier Approvals; and
Hospital Conditions of Participation for
Rehabilitation and Respiratory Care
Services; Medicaid Program: Accreditation
for Providers of Inpatient Psychiatric
Services; Final Rule**

no data available for FY 2007 or FY 2008.

We refer readers to the RTI detailed report for all the conditions in each fiscal year (FY 2007 through FY 2009) as described above at the following Web site: <http://www.rti.org/reports/cms/>.

g. RTI Analysis of Estimated Net Savings for Current HACs

RTI estimated the net savings generated by the HAC payment policy based on 12 months of MedPAR claims from October 2008 through September 2009.

(1) Net Savings Estimation Methodology

The payment impact of a HAC is the difference between the IPPS payment amount under the initially assigned MS-DRG and the amount under the reassigned MS-DRG. The amount for the reassigned MS-DRG appears on the MedPAR files. To construct this, RTI modeled the IPPS payments for each MS-DRG following the same approach that we use to model the impact of IPPS annual rule changes. Specifically, RTI replicated the payment computations carried out in the IPPS PRICER program using payment factors for IPPS providers as identified in various CMS downloaded files. The files used are as follows:

- Version 26 of the Medicare Severity GROUPER software (applicable to discharges between October 1, 2008 and September 30, 2009). IPPS MedPAR claims were run through this file to obtain needed HAC-POA output variables.

- The FY 2009 MS-DRG payment weight file. This file includes the weights, geometric mean length of stay (GLOS), and the postacute transfer payment indicators.

- CMS standardized operating and capital rates. Tables 1A through 1C, as downloaded from the Web site at: <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009>, include the full update and reduced update amounts, as well as the information needed to compute the blended amount for providers located in Puerto Rico.

- The IPPS impact files for FY 2009, also as downloaded from the Web site at: <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/>. This file includes the wage index and geographic adjustment factors, plus the provider type variable to identify providers qualifying for alternative hospital-specific amounts and their respective HSP rates.

- The IPPS impact files for FY 2010, as downloaded from the Web site at: <http://www.cms.hhs.gov/AcuteInpatientPPS/10FR/>. This file includes indirect

medical education (IME) and disproportionate share (DSH) percent adjustments that were in effect as of March 2009.

- CMS historical provider-specific files (PSF). This includes the indicator to identify providers subject to the full or reduced standardized rates and the applicable operating and capital cost-to-charge ratios. A SAS version was downloaded from the Web site at: http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp.

There were 50 providers with discharges in the final HAC analysis file that did not appear in the FY 2009 impact file, of which 11 also did not appear in the FY 2010 impact file. For these providers, we identified the geographic CBSA from the historical PSF and assigned the wage index using values from Tables 4A and 4C as downloaded from the Web site at: <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/>. For providers in the FY 2010 file but not the FY 2009 file, we used IME and DSH rates from FY 2010. The 11 providers in neither impact file were identified as non-IME and non-DSH providers in the historical PSF file.

The steps for estimating the HAC payment impact are as follows:

Step 1: Rerun the Medicare Severity Groupers on all records in the analysis file. This is needed to obtain information on actual HAC-related MS-DRG reassignments in the file, and to identify the CCs and MCCs that contribute to each MS-DRG assignment.

Step 2: Model the base payment and outlier amounts associated with the initial MS-DRG if the HAC were excluded using the computations laid out in the CMS file "Outlier Example FY 2007 new.xls," as downloaded from the Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage, and modified to accommodate FY 2009 factors.

Step 3: Model the base payment and outlier amounts associated with the final MS-DRG where the HAC was excluded using the computations laid out in the CMS file "Outlier Example FY 2007 new.xls," as downloaded from the Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage and modified to accommodate FY 2009 factors.

Step 4: Compute MS-DRG base savings as the difference between the nonoutlier payments for the initial and final MS-DRGs. Compute outlier amounts as the difference in outlier amounts due under the initial and final reassigned MS-DRG. Compute net savings due to HAC reassignment as the

sum of base savings plus outlier amounts.

Step 5: Adjust the model to incorporate short-stay transfer payment adjustments.

Step 6: Adjust the model to incorporate hospital-specific payments for qualifying rural providers receiving the hospital-specific payment rates.

It is important to mention that using the methods described above, the MS-DRG and outlier payments amounts that are modeled for the final assigned MS-DRG do not always match the DRG price and outlier amounts that appear in the MedPAR record. There are several reasons for this. Some discrepancies are caused by using single wage index, IME and DSH factors for the full period covered by the discharges, when in practice these payment factors can be adjusted for individual providers during the course of the fiscal year. In addition, RTI's approach disregards any Part A coinsurance amounts owed by individual beneficiaries with greater than sixty covered days in a spell of illness. Five percent of all HAC discharges showed at least some Part A coinsurance amount due from the beneficiary, although less than two percent of reassigned discharges (55 cases in the analysis file) showed Part A coinsurance amounts due. Any Part A coinsurance payments would reduce the actual savings incurred by the Medicare program.

There are also a number of less common special IPPS payment situations that are not factored into RTI's modeling. These could include new technology add-on payments, payments for blood clotting factors, reductions for replacement medical devices, adjustments to the capital rate for new providers, and adjustments to the capital rate for certain classes of providers who are subject to a minimum payment level relative to capital cost.

(2) Net Savings Estimate

Chart F below summarizes the estimated net savings of current HACs based on MedPAR claims from October 2008 through September 2009, based on the methodology described above. Column A shows the number of discharges where a MS-DRG reassignment for each HAC category occurred. For example, there were 12 discharges with an Air Embolism that resulted in an actual MS-DRG reassignment. Column B shows the total net savings caused by MS-DRG reassignments for each HAC category. Continuing with the example of Air Embolism, the chart shows that the 12 discharges with an MS-DRG reassignment resulted in a total net

savings of \$148,394. Column C shows the net savings per discharge for each HAC category. For the Air Embolism

HAC category, the net savings per discharge is \$12,366.
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**CHART F.—ESTIMATED NET SAVINGS OF CURRENT HACs
OCTOBER 2008 THROUGH SEPTEMBER 2009**

Selected HAC	Number of Discharges That Change MS-DRG Due to HAC (Column A)	Net Savings (In Dollars) (Column B)	Net Savings Per Discharge (In Dollars) (Column C)
1. Foreign Object Retained After Surgery	42	\$153,046	\$3,644
2. Air Embolism	12	\$148,394	\$12,366
3. Blood Incompatibility	0	\$0	\$0
4. Pressure Ulcer Stages III & IV	384	\$2,156,113	\$5,615
5. Falls and Trauma	1,577	\$8,093,391	\$5,132
a. Fracture	1,355	\$6,979,013	\$5,151
b. Dislocation	4	\$16,506	\$4,127
c. Intracranial Injury	226	\$1,150,807	\$5,092
d. Crushing Injury	0	\$0	\$0
e. Burn	6	\$21,639	\$3,607
f. Shock	1	\$12,749	\$12,749
6. Catheter-Associated UTI	223	\$642,003	\$2,879
7. Vascular Catheter-Associated Infection	26	\$85,254	\$3,279
8. Poor Glycemic Control	116	\$611,428	\$5,271
9a. SSI Mediastinitis CABG	6	\$57,676	\$9,613
9b. SSI Orthopedic	5	\$43,958	\$8,792
9c. SSI Bariatric	1	\$2,381	\$2,381
10. Pulmonary Embolism & DVT Orthopedic	1,024	\$6,919,410	\$6,757
Total ¹	3,416	\$18,779,932 ²	\$5,522

¹ Discharges can appear in more than one row. The total figure is not adjusted for the 60 discharges with more than one HAC that appear as secondary diagnoses (15 of these resulted in MS-DRG reassignment).

² Total net savings is adjusted by -\$133,122 for 15 claims that have multiple HACs.

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through September 2009.

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As shown in Chart F above, the total net savings calculated for the 12-month period from October 2008 through September 2009 was roughly \$18.78 million. The three HACs with the largest number of discharges resulting in MS-DRG reassignment, Falls and Trauma, Orthopedic PE/DVT, and Pressure Ulcer Stages III & IV, generated \$17.17 million of net savings for the 12 month period. Estimated net savings for the 12-month period associated with the Falls and Trauma category were \$8.09 million. Estimated net savings associated with Orthopedic PE/DVT for the 12-month period were \$6.92 million. Estimated net savings for the 12-month period associated with Pressure Ulcer Stages III & IV were \$2.16 million.

The mean net savings per discharge calculated for the 12-month period from October 2008 through September 2009 was roughly \$5,522. The HAC categories of Air Embolism; SSI, Mediastinitis, Following Coronary Artery Bypass Graft (CABG); and SSI Following Certain Orthopedic Procedures had the highest net savings per discharge, but represented a small proportion of total net savings because the number of discharges that resulted in MS-DRG reassignment for these HACs was low. With the exception of Blood Incompatibility, where no savings occurred because no discharges resulted in MS-DRG reassignment, SSI Following Bariatric Surgery for Obesity and Catheter-Associated UTI had the lowest net savings per discharge.

We refer readers to the RTI detailed report available at the following Web site: <http://www.rti.org/reports/cms/>.

As mentioned previously, an extremely small number of cases in the 12-month period of FY 2009 analyzed by RTI had multiple HACs during the same stay. In reviewing our 9.3 million claims, RTI found 60 cases where two HACs were reported on the same admission as noted in section II.F.3. d. of this preamble. Of these 60 claims, 15 resulted in MS-DRG reassignment. Chart G below summarizes these cases. There were 15 cases that had two HACs not POA that resulted in an MS-DRG reassignment. Of these, 5 discharges involved Pressure Ulcer Stages III & IV and Falls and Trauma and 4 discharges involved Orthopedic PE/DVT and Falls and Trauma.

**CHART G.--CLAIMS WITH MORE THAN ONE HAC SECONDARY DIAGNOSIS WHERE MS-DRG REASSIGNMENT OCCURRED
OCTOBER 2008 THROUGH SEPTEMBER 2009**

Selected HAC	4. Pressure Ulcer Stages III & IV - MCC	5. Falls and Trauma - MCC & CC	6. Catheter-Associated UTI - CC
3. Blood Incompatibility - CC		1	
5. Falls and Trauma - MCC & CC	5		
6. Catheter-Associated Urinary Tract Infection (UTI) - CC	1	1	
7. Vascular Catheter-Associated Infection - CC		1	1
10. Pulmonary Embolism & DVT Orthopedic - MCC	1	4	
Total	7	7	1

As we discuss in section II.F.1.b. of this preamble, implementation of this policy is part of an array of Medicare VBP tools that we are using to promote increased quality and efficiency of care. We again point out that a decrease over time in the number of discharges where these conditions are not POA is a desired consequence. We recognize that estimated net savings should likely decline as the number of such discharges decline. However, we believe that the sentinel effect resulting from CMS identifying these conditions is critical. (We refer readers to section IV.A. of this preamble for a discussion of the inclusion of the incidence of these conditions in the RHQDAPU program.) It is our intention to continue to monitor trends associated with the frequency of these HACs and the estimated net payment impact through

RTI's program evaluation and possibly beyond.

h. Previously Considered Candidate HACs—RTI Analysis of Frequency of Discharges and POA Indicator Reporting

RTI evaluated the frequency of conditions previously considered, but not adopted as HACs in prior rulemaking, that were reported as secondary diagnoses (across all 9.3 million discharges) as well as the POA indicator assignments for these conditions. Chart H below indicates that the three previously considered candidate conditions most frequently reported as a secondary diagnosis were: (1) Clostridium Difficile-Associated Disease (CDAD), which demonstrated the highest frequency, with a total of 85,096 secondary diagnoses codes being reported for that condition, of which

28,844 reported a POA indicator of "N"; (2) Staphylococcus aureus Septicemia, with a total of 22,433 secondary diagnoses codes being reported for that condition, with 5,004 of those reporting a POA indicator of "N"; and (3) Iatrogenic Pneumothorax, with a total of 20,673 secondary diagnoses codes being reported for that condition, with 17,602 of those reporting a POA indicator of "N." As these three conditions had the most significant impact for reporting a POA indicator of "N," it is reasonable to believe that these same three conditions would have the greatest number of potential MS-DRG reassignments. The frequency of discharges for the previously considered HACs that could lead to potential changes in MS-DRG assignment is discussed in the next section. We take this opportunity to remind readers that because more than