

Cardiovascular Intervention Payments Relatively Stable

SUMMARY

Boston Scientific is pleased to provide you with the following update on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule (PR) for inpatient payment rates to hospitals for Fiscal Year (FY) 2009 as posted April 14, 2008 at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-P.pdf> . Proposed payment rates and policy changes will also be published in the Federal Register on April 30, 2008. The final version of the policies and payments will become known around the first of August, and become effective October 1, 2008.

In general, proposed payments for interventional cardiology, peripheral interventions and cardiac rhythm management (CRM) procedures fall within expected ranges and would remain relatively stable. Overall, the net effect of the proposed changes would be a 4.1% increase in payment for inpatient hospital services in FY2009. It should be noted that the changes in the proposed inpatient hospital payment rates are primarily a function of the continued movement to cost-based weights, changes in the distribution of cases among the Medicare Severity MS-DRGs (MS-DRGs) established for FY2008, and a proposed 3% market basket update.

The PR builds on policies initiated over the past two years to improve payment accuracy and quality. Specifically, FY2009 will be the final year of a three-year transition to cost-based weighting for procedures, meaning that all procedure payments will be calculated based on costs as opposed to reported charges. In addition, Medicare is proposing to significantly expand the list of hospital-acquired conditions (HACs) for which it will not pay higher rates and the list of quality measures that hospitals would be required to report on in FY2009 in order to receive the full payment amount for inpatient services in FY2010.

While the payment level changes differ between the MS-DRGs, the average percentage changes proposed for select MS-DRGs typically associated with various segments of percutaneous cardiovascular interventions are as follows: (See Table 1 at the end of this document for select cardiovascular FY2009 MS-DRG proposed payment changes.)

- Interventional Cardiology (IC): Increase 1%
- Peripheral Interventions (PI): Increase 2%

The weighted average financial impact to CRM and select electrophysiology (EP) MS-DRGs should be neutral to positive:

- Weighted average ICD and CRT-D system implants proposed to increase 3%
- ICD pulse generator replacements proposed to increase 30%
- Weighted average Pacemaker and CRT-P system implant proposed to increase 2%
- Weighted average Pacemaker revision and replacement proposed to increase 13%
- Weighted average cardiac ablation proposed to decrease 1%

For more information on proposed changes impacting CRM procedures, please refer to the following web link: <http://www.bostonscientific.com/templatedata/imports/HTML/CRM/Reimbursement/news.html> .

PROPOSED CHANGES TO THE MS-DRG PAYMENT SYSTEM

CMS Continues to Link Quality of Care and Payment

According to CMS Acting Administrator, Kerry Weems, "CMS is taking aggressive actions to ensure that beneficiaries get safe, high quality, and efficient care from their health care providers, and the actions we

are announcing today build on our efforts. The reforms we are proposing in this Rule should lead to greater value for Medicare beneficiaries and the Medicare program.”¹

The proposed payment policy changes are in two primary areas:

1. Determining payments based on costs
 - For FY2009 and beyond, Medicare will determine inpatient hospital payments based on a 100% “cost-based” calculation (this is the 3rd year of a three-year transition).
 - CMS invited public comment but is reserving its final decision on hospital-specific relative values (HSRV) for FY2009 until they receive additional information and recommendations from RAND, one of the groups engaged to assist CMS with its assessment of HSRV options. It is possible that CMS could implement HSRVs in FY2009 by including them in the Final Rule for FY2009 inpatient hospital payment if they determine that the RAND report is conclusive.
2. Expanding the links between quality and payment
 - CMS is proposing to expand the list of hospital acquired conditions for which it will no longer pay a higher rate to include serious reportable adverse events (“never events”) such as surgery on the wrong body part, death/disability associated with use of contaminated drugs, device or biologics, death/disability associated with use of device other than as intended and death/disability associated with intravascular air embolism.
 - CMS is also proposing to add 43 new measures to the list of quality measures for which hospitals have to report data in order to receive a full payment update in FY2010, bringing the total number of required measures to 73. Examples of suggested new measures include measures related to hospital readmissions, nursing care, venous thromboembolism, stroke, and cardiac surgery.

CMS has proposed additional modifications that would have a substantive impact on many hospitals:

- The implementation of a 0.6% reduction in rates for FY2009 to eliminate the effect of improved coding and documentation resulting from the shift to MS-DRGs (this reduction would be in addition to a 0.9% reduction implemented in FY2008, for a total reduction of 1.5%).
- The introduction of a new cost center specifically for certain implantable devices from the hospital that would represent the first step towards fixing the issue of charge compression for high cost devices. For the first time, implantable devices would be able to be assigned to a different cost category than lower-priced medical supplies. Medicare would utilize a different cost-to-charge ratio for items in this cost category to better address charge compression.
- In its proposal, CMS defines implantable devices that would be able to be assigned to the new cost category as implants that remain in a patient’s body upon discharge. Based on previous analyses, we estimate that the change would result in a 4% to 5% increase in payments for DES procedures over time.

WHAT DO PROPOSED CHANGES MEAN FOR HOSPITALS?

Overall, the net impact of the proposed changes for hospitals would be positive (4.1% increase). However, it must be noted that the increase would be reduced by 2% for hospitals that did not report quality data in FY2008. Finally, as can be seen below, there would be some variation in the payment impact depending upon the characteristics of the hospital:

- Urban Hospitals: 4.2% increase
- Large Urban Hospitals: 4.4% increase
- Rural Hospitals: 3.3% increase

¹ United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. *CMS Proposes to Expand Quality Program for Hospital Inpatient Services in FY2009*. Press Release April 14, 2008.

- Cardiac Specialty Hospitals: 1.8% increase
- Non-Teaching Hospitals: 4.0% increase
- Teaching Hospitals: 4.2% increase

PROPOSED CHANGES IN INTERVENTIONAL CARDIOLOGY AND PERIPHERAL VASCULAR PROCEDURE PAYMENT INCLUDE:

- **Drug-eluting stent** MS-DRG 246 would increase by 11% (\$1,655) and the payment amount for MS-DRG 247 would be reduced by 8% (\$951). The weighted average payment for drug-eluting stent (DES) MS-DRGs, based on case mix, would decrease by 4-5%.
- Payment for the two **bare metal stent MS-DRGs** would be decreased by 2.5-3% over FY2008 (weighted average).
- Payment for **carotid artery stenting** would increase 1.6% over FY2008 on average (weighted).

DRAFTING AND SENDING PUBLIC COMMENTS

Boston Scientific will continue to analyze the FY2009 Proposed Rule for inpatient hospital payment, and we look forward to addressing CMS' proposed changes through the public comment process.

Whether you or your institution agrees or disagrees with the proposed changes, you should determine whether you want to participate in the public comment process. Providing detailed comments to CMS regarding the impact of these changes to both your hospital and your patients may make a difference in the final payment policy for hospital inpatient services for FY2009 and beyond.

Comments must be submitted to CMS no later than 5 p.m. on Friday, June 13, 2008.

When commenting to CMS, be sure to reference the file code CMS-1390-P to submit comments on this proposed rule. Comments can be submitted electronically at <http://www.regulations.gov>, via regular or Express/overnight mail or delivered by hand or courier to either CMS' Washington, DC or Baltimore, MD offices. For address information, please refer to pages 3-5 of the display copy of the PR, which can be found at the following link: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-P.pdf>.

Please allow enough time for comments to be received by CMS before the close of the comment period.

COMMENTS/QUESTIONS

If you have questions or would like additional information from Boston Scientific, contact:

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If you would like to receive reimbursement updates, please register on our website, www.bostonscientific.com/login.

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CMS CONTINUES TO LINK QUALITY OF CARE AND PAYMENT IN THE FY2009 HOSPITAL INPATIENT PROPOSED RULE

Table 1: Summary of Proposed FY2009 MS-DRG Inpatient Hospital Payment Rates for Select Cardiovascular Procedures

Procedure	2008 MS-DRG	MS-DRG Descriptor	FY2008 Urban Payment (final)	PR2009 Urban Payment	\$ Variance 2008 vs. 2009(Proposed)	% Variance 2008 vs. 2009 (Proposed)
Interventional Cardiology						
DES	246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	\$15,733	\$17,388	\$1,655	10.52%
	247	Perc cardiovasc proc w drug-eluting stent w/o MCC	\$11,513	\$10,562	(\$951)	(8.26%)
BMS	248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	\$13,639	\$15,493	\$1,854	13.59%
	249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	\$9,817	\$9,052	(\$765)	(7.79%)
ICD	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	\$43,460	\$47,798	\$4,338	9.98%
	223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	\$37,272	\$34,797	(\$2,475)	(6.64%)
	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	\$39,639	\$44,033	\$4,394	11.09%
	225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	\$34,102	\$32,637	(\$1,465)	(4.30%)
PTCA	250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	\$13,471	\$16,518	\$3,047	22.62%
	251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	\$9,468	\$8,845	(\$623)	(6.58%)
Diagnostic Cath (may include IVUS)	286	Circulatory disorders except AMI, w card cath w MCC	\$9,028	\$10,900	\$1,872	20.74%
	287	Circulatory disorders except AMI, w card cath w/o MCC	\$6,182	\$5,644	(\$538)	(8.70%)

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Procedure	2008 MS-DRG	MS-DRG Descriptor	FY2008 Urban Payment (Final)	PR2009 Urban Payment	\$ Variance 2008 vs. 2009(Proposed)	% Variance 2008 vs. 2009 (Proposed)
Peripheral Interventions						
Carotid Stenting	034	Carotid artery stent procedure w MCC	\$13,779	\$17,765	\$3,986	28.93%
	035	Carotid artery stent procedure w CC	\$10,289	\$11,183	\$894	8.69%
	036	Carotid artery stent procedure w/o CC/MCC	\$9,196	\$8,670	(\$526)	(5.72%)
PTA, Atherectomy, Peripheral Stenting, Thrombectomy	252	Other vascular procedures w MCC	\$14,930	\$16,299	\$1,369	9.17%
	253	Other vascular procedures w CC	\$12,207	\$12,472	\$265	2.17%
	254	Other vascular procedures w/o CC/MCC	\$9,092	\$8,548	(\$544)	(5.98%)
Biliary Stenting	435	Malignancy of hepatobiliary system or pancreas w MCC	\$8,483	\$9,449	\$966	11.39%
	436	Malignancy of hepatobiliary system or pancreas w CC	\$6,991	\$6,565	(\$426)	(6.09%)
	444	Disorders of the biliary tract w MCC	\$7,445	\$8,600	\$1,155	15.51%
	445	Disorders of the biliary tract w CC	\$5,975	\$5,727	(\$248)	(4.15%)
	446	Disorders of the biliary tract w/o CC/MCC	\$4,616	\$3,988	(\$628)	(13.59%)

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