



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE PROPOSED
FFY 2007 MEDICARE
HOSPITAL INPATIENT RULE**

May 2006

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Inpatient Prospective Payment System (PPS) for federal fiscal year (FFY) 2007. Additional information regarding the Inpatient PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS>.

CMS must receive comments on the proposal by 5 p.m. on June 12. CMS requests that comments reference the file code CMS-1488-P and the specific “issue identifier” that precedes the section on which you choose to comment. Each section of this summary provides the “issue identifier” that CMS requests you reference in your comments.

Comments on the proposed rule can be:

Submitted electronically at:

<http://www.cms.hhs.gov/eRulemaking>.

Click on the “Submit electronic comments on CMS regulations with an open comment period” link. (Attachments should be in Microsoft Word, WordPerfect, or Excel format.)

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I. OVERVIEW

CMS published the proposed Medicare Inpatient Prospective Payment System (PPS) rule for federal fiscal year (FFY) 2007 in the April 25, 2006 *Federal Register*. Changes are effective October 1, 2006 unless otherwise noted.

Note: Text in italics is extracted from the *Federal Register*

II. THE MMA OF 2003 AND DRA OF 2005

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and the Deficit Reduction Act of 2005 (DRA) contain a number of Medicare provisions that either currently affect program payment policy or will begin to affect Medicare payment policy in upcoming federal fiscal years. The majority of the MMA provisions applicable to the Inpatient PPS (IPPS) included payment restorations while provisions of the DRA related to the inpatient PPS mainly focused on the continued development of pay-for-performance initiatives. Where appropriate, both acts are referenced in the text below.

III. STANDARDIZED AMOUNTS

Marketbasket Update for FFY 2007

Refer to “Update Factors” if you submit a comment on this issue.

(*Federal Register* pages 24419 – 24420)

Consistent with current law, based on the Office of the Actuary’s first quarter 2006 forecast of the FFY 2007 marketbasket increase, CMS is estimating that the FFY 2007 update to the standardized amount will be 3.4% for hospitals in all areas, provided that hospitals submit quality data in accordance with the rules discussed in the “Reporting of Hospital Quality Data” section below.

Currently, children’s hospitals, cancer hospitals, and religious non-medical health care institutions (RNHCIs) are the remaining three types of hospitals still reimbursed fully under reasonable costs. CMS is proposing to provide the FFY 2007 IPPS operating marketbasket percentage increase of 3.4% to update the target limits for children’s hospitals, cancer hospitals, and RNHCIs.

Operating Rates

Refer to “Operating Payment Rates” if you submit a comment on this issue.

(*Federal Register* pages 24151 – 24153)

Several provisions of the MMA and DRA affect the FFY 2007 standardized amounts including a full marketbasket-adjusted rate for hospitals’ reporting of quality data as part of the CMS Hospital Quality Initiative and the continued use of a reduced labor share to 62% for hospitals with a wage index of less than 1.0. For FFY 2007, hospitals whose wage index is greater than 1.0 will continue to use a labor share of 69.7%.

These changes are reflected in the following table:

Standard Rate for Hospitals with a Wage Index Greater than 1		
(69.7 Percent Labor Share and 30.3 Percent Nonlabor Share)		
	Labor-related	Nonlabor-related
Full Update (3.4 Percent)	\$3,404.27	\$1,479.90
Reduced Update (1.4 Percent)	\$3,338.42	\$1,451.28
Standard Rate for Hospitals with a Wage Index Less than or Equal to 1		
(62 Percent Labor Share and 38 Percent Nonlabor Share)		
	Labor-related	Nonlabor-related
Full Update (3.4 Percent)	\$3,028.19	\$1,855.98
Reduced Update (1.4 Percent)	\$2,969.62	\$1,820.08
Capital Standard Federal Payment Rate		
National Capital Rate		\$424.42

IV. DRG RECALIBRATION AND CHANGES

(*Federal Register* pages 24004 – 24049)

For FFY 2007, CMS has proposed changes to the calculation of Diagnosis Related Group (DRG) weights that could result in a significant redistribution of Medicare inpatient hospital payments. In addition, in FFY 2008, CMS proposes to implement refined DRGs based on severity of illness classifications. Below is a brief summary and description of these proposals.

The DRG changes are summarized below and the proposed changes to specific DRG classifications can be found on the *Federal Register* pages referenced in the heading above.

Recalibration of DRG Weights

Refer to “DRG Weights” if you submit a comment on this issue.

(*Federal Register* pages 24044 – 24049)

CMS has proposed changes to the calculation of DRG weights that could result in a significant redistribution of Medicare inpatient hospital payments.

Currently, CMS calculates the DRG weights by aggregating charges for all hospitals paid under the PPS and determining the average charge by DRG. CMS is proposing to change the weight calculation to a methodology which groups hospital charges into ten categories and then applies national average cost-to-charge ratios to eliminate the effect of differential charge markups.

Background: The CMS revisions to the weights and DRG structure are prompted by a Medicare Payment Advisory Commission (MedPAC) report on physician-owned specialty hospitals that recommended a complete reworking of the DRG payment system. MedPAC concluded that differential charge markups cause a bias in the current charge-based DRG weights. MedPAC recommended that this problem be addressed by a complete overhaul of the DRG system that would include moving from charge-based to cost-based weights and implementation of severity-adjusted DRGs.

CMS agreed that it is appropriate to adjust the DRG relative weights to account for the differences in charge markups. However, CMS believes that MedPAC’s methodology, which developed costs using hospital-specific departmental cost-to-charge ratios (CCRs), would be administratively burdensome. In addition, MedPAC acknowledged that its method was too difficult to replicate on an annual basis and suggested that the weights be recalculated once every five years. CMS is concerned that this would delay the inclusion of costs for new technologies and devices in the DRG weights.

CMS Proposal: CMS proposes an alternative to MedPAC’s approach that is intended to achieve similar results in a more administratively feasible manner. This proposal, which CMS labels the Hospital Specific Relative Value cost center (HSRVcc) methodology, *“involves developing hospital-specific charge relative weights at the cost center level to remove the bias introduced by hospital characteristics (that is, teaching, Disproportionate Share Hospital, location, and size, among others) and then scaling the weights to costs using the national cost center charge ratios developed from the cost report data.”* The cost centers that CMS uses are comprised of eight ancillary cost groups, a routine cost category, and an intensive care cost category.

The CMS methodology begins by calculating relative charge weights by cost center at the hospital level. This was accomplished by dividing the cost center charges on each claim by the hospital’s average charge for the cost center. For example, the routine charges on each individual claim were divided by the average routine charge for the provider for all claims. These cost center relative charge values were then summed to develop the national average ratio by DRG and by cost center.

Next, CMS developed national CCRs for the ten cost centers using cost report data. Once the national average CCRs were computed, they were multiplied by the total charges for the matching cost centers in the claims file. The estimated costs were then summed to derive a total cost for all cases across the nation. The percentage that each cost center was contributing to the overall total costs was calculated by dividing the individual cost center cost by the total. For example, the total cost for routine days was divided by the total cost for all cases to arrive at 0.29, which indicated that routine costs were responsible for approximately 29% of total costs. The ten scaling factors sum to 1.0.

For each DRG, the cost center weights are multiplied by these scaling factors (that is, the routine day weight is multiplied by the routine day scaling factor, the intensive care unit weight is multiplied by the intensive care unit scaling factor, and so on). After the weights are adjusted by the scaling factor, they are summed by DRG to create one final weight for each DRG. According to CMS, this process removed the effects of differential markups within cost centers. The cost center scaling factors are shown below.

Cost Center	Weighting Factor
Routine Days	0.2881
Intensive Days	0.1919
Therapeutic Services	0.0384
Supplies & Equipment	0.1150
Operating Room	0.0812
Other Services	0.0639
Laboratory	0.0670
Radiology	0.0427
Cardiology	0.0241
Drugs	0.0877

The most significant effect of the CMS proposal would be a payment shift from surgical DRGs to medical DRGs. Under the proposal, the average weight for medical DRGs would increase by 6.0%, with weights for 86% of medical DRGs increasing. Surgical DRGs would experience a 5.7% average weight decrease, with weights for 42% of surgical DRGs declining. The largest decrease would be for surgical cases in Major Diagnostic Category 5 (Diseases and Disorders of the Circulatory System), where weights for 87% of the DRGs would decrease and the average weight would decrease by 16%.

Refinement of DRGs Based on Severity of Illness

Refer to “DRGs: Severity of Illness” if you submit a comment on this issue.

(*Federal Register* pages 24011 – 24030)

CMS considers the implementation of new weights to be the first step in a planned major overhaul of the DRG system. In FFY 2008, CMS proposes to replace the current 526 DRGs with 861 severity-adjusted DRGs. The severity-adjusted system will subdivide DRGs to allow for recognition of the higher costs incurred by the more severely ill patients within DRGs.

Background: Currently, DRG assignments are based on the reporting of International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis and procedure codes. The DRG system is composed of a base DRG that describes the reason for hospital admission and a subdivision of the base DRG based on other patient attributes that affect the care of the patient including age and the presence of complications or comorbidities. In Version 23.0 of the CMS DRG system, there are 526 total DRGs.

In the FFY 2006 final rule, CMS stated that it would consider revising the current DRG system to better reflect severity of illness among patients. To that end, CMS contracted with 3M Health Information Systems to analyze use of a revised DRG system modeled on the All Patient Refined (APR) DRGs. The APR DRG system subdivides the DRGs by adding four severity of illness subclasses to each DRG. The underlying clinical principle of APR DRGs is that the severity of illness of a patient is highly dependent on the patient’s underlying problem and that patients with high severity of illness are usually characterized by multiple serious diseases or illnesses. Therefore, patients with multiple comorbid conditions involving multiple organ systems are assigned to the higher severity of illness subclasses. The four severity of illness subclasses under the APR DRG system are numbered sequentially from 1 to 4, with 1 indicating minor severity and 4 representing extreme severity of illness. The APR DRG system is comprised of 1,258 DRGs.

CMS Proposal: CMS is proposing FFY 2008 implementation of “consolidated severity-adjusted DRGs.” The DRGs would be based on a consolidated version of the APR DRGs that reduces the number of DRGs from 1,258 under the APR DRGs to 861 consolidated severity-adjusted DRGs. DRGs were consolidated to combine DRGs with low Medicare volumes and DRGs with clinical similarities that had similar average charges.

CMS notes that in addition to changing the way claims are grouped, severity DRGs introduce other issues requiring additional analysis, including possible increases in reported case mix and changes to the outlier threshold.

CMS makes it clear that it considers the proposed DRGs to be an initial plan that may be refined. CMS is interested in public comments on whether there are alternative DRG systems that could result in better recognition of severity than the consolidated severity-adjusted DRGs and that “it is possible that the public comment process will present compelling evidence that there are potential alternatives to the consolidated severity-adjusted DRG system for us to consider that could more effectively recognize severity of illness.”

CMS estimates that the implementation of consolidated severity-adjusted DRGs will in some instances offset the impact of the proposed new weighting methodology. For example, CMS estimates that rural hospitals will experience a 2.7% payment increase due to the change in weights and a 3.1% decrease due to the change in DRGs resulting in a combined 0.4% decrease. Payments to major teaching hospitals would decrease by 1.1% due to the weights and increase by 0.5% due to the DRGs for a net 0.5% decrease. The CMS impacts are available on *Federal Register* pages 24025 – 24026.

V. REPORTING OF HOSPITAL QUALITY DATA

Reporting Requirements to Receive the Full Marketbasket Update

Refer to “Hospital Quality Data” if you submit a comment on this issue.

(*Federal Register* pages 24091 – 24095)

Background: The MMA required hospitals to begin submitting data on quality measures to CMS. This provision applied for three years (FFYs 2005-2007). Hospitals that failed to submit the data on a set of ten quality measures as well as meet validation requirements, or withdrew from the program received the marketbasket increase minus 0.4% for FFYs 2005 and 2006. The DRA has extended and expanded this program, increasing the penalty for not submitting data and expanding the set of quality measures.

CMS Proposal: *“We are proposing to amend our regulations at §412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for hospitals that do not comply with requirements for reporting quality data as provided for under section 5001(a) of Pub L.109-171. We are also revising the RHQDAPU program’s procedures to reflect our experience with this program and to implement section 5001(a) of Pub. L. 109-171, including the new requirement for reporting of an expanded set of quality measures.”*

Program Expansion:

The DRA requires CMS to expand the quality reporting program. For FFY 2007, hospitals are required to continue to collect data for all ten “starter set” quality measures used for FFYs 2005 and 2006 as well as report on 11 new quality measures (21 clinical quality measures total), including a new category for surgical infection prevention. According to CMS, the expanded quality measures are the Hospital Quality Alliance-released measures that the 2005 Institute of Medicine of the National Academy of Sciences report recommended CMS use as expanded “starter set” measures.

To receive the full marketbasket update for FFY 2007, hospitals also will be required to complete and return a written form on which they pledge to submit data on the set of expanded quality measures (anticipated 21 clinical quality measures), starting with discharges that occur in calendar year (CY) 2006.

Hospitals will be required to submit data retroactively on the expanded measures to the Quality Improvement Organization (QIO) Clinical Warehouse beginning with discharges that occur in the first calendar quarter of 2006 (January-March discharges). The deadline for hospitals to submit their data for first quarter 2006 is August 15, 2006. Hospitals may withdraw from the revised quality reporting program at any time up to August 1, 2006. If a hospital withdraws from the program, it will receive a 2% reduction in its payment update.

To participate in the hospital reporting initiative and receive a full marketbasket update for FFY 2007, hospitals must follow a number of steps. These steps are available in detail on the *Federal Register* pages referenced in the heading above and on the “Reporting Hospital Quality Data for Annual Payment Update Reference Checklist” section of the QualityNet Exchange Web site at <http://qnetexchange.org/public/>.

The following table describes the quality measures proposed for FFY 2007 (highlighted measures are the expanded measures):

Heart Attack (Acute Myocardial Infarction)	Heart Failure (HF)	Pneumonia (PNE)	Surgical Infection Prevention (SIP)
Aspirin at arrival	Left ventricular function assessment	Initial antibiotic received within 4 hours of hospital arrival	Prophylactic antibiotic received within 1 hour prior to surgical incision Prophylactic antibiotic discontinued within 24 hours
Aspirin prescribed at discharge	ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction	Oxygenation assessment	
ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction	Discharge instructions	Pneumococcal vaccination status	
Beta blocker at arrival	Adult smoking cessation advice/counseling	Blood culture performed before first antibiotic received in hospital	
Beta blocker prescribed at discharge		Adult smoking cessation advice/counseling	
Thrombolytic agent received within 30 minutes of hospital arrival		Appropriate initial antibiotic selection	
Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival		Influenza vaccination (collected but not publicly reported – subject to change)	
Adult smoking cessation advice/counseling			

Revised Program Procedures:

- CMS will continue to require that hospitals meet chart validation requirements implemented in the FFY 2006 IPPS final rule. The rule requires that the accuracy of hospital-submitted data be validated through chart re-abstraction. For FFY 2006, CMS reviews five charts and requires an 80% agreement rate between the original submission and the re-abstraction. For FFY 2007, in an attempt to improve accuracy in the validation process, CMS will combine the samples for first quarter, second quarter, and third quarter (15 cases) into a single sample to determine whether the 80% reliability level is met. Hospital data must be deemed valid to receive the full update for FFY 2007. As was the case for FFY 2006, if a hospital disagrees with the abstraction results from the Clinical Data Abstraction Center (CDAC), the hospital can appeal the results to its QIO.

- For FFY 2007, CMS is also proposing that hospitals attest to the completeness and accuracy of the data submitted to the QIO Clinical Warehouse. To meet this requirement, for each quarter, hospitals will have to sign off on the volume of the data submitted. CMS will provide additional information to explain the data completeness requirement and as well as a form to be completed on the QualityNet Exchange Web site.

Patient Survey Implementation:

- CMS will implement the Hospital Consumer Assessment of Healthcare Providers and Systems® (HCAHPS®) patient survey in October 2006. However, CMS does not anticipate including the survey as part of the quality reporting program. The survey is designed to measure patients’ perspectives on hospital care including communications with doctors, communications with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information. More information on this survey can be found on the CMS Web site at:

<http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHCAHPSFactSheet200512.pdf>.

VI. CONTINUED DEVELOPMENT OF QUALITY AND “PAY FOR PERFORMANCE” INITIATIVES

Value-Based Purchasing

Refer to “Value-Based Purchasing” if you submit a comment on this issue.
(*Federal Register* pages 24095 – 24100)

The DRA requires CMS to develop a plan to implement hospital value-based purchasing beginning with FFY 2009. CMS' and Congress' initial steps toward hospital value-based purchasing include the Premier Hospital Quality Incentive Demonstration and the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program (discussed in detail above).

In the proposed rule, CMS is seeking public comment on the implementation of hospital value-based purchasing, as required by the DRA, beginning with FFY 2009. According to law, CMS is required to develop a plan to implement hospital value-based purchasing beginning with FFY 2009. The plan must consider the following issues:

- the ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings;
- the reporting, collection, and validation of quality data;
- the structure of payment adjustments, including the determination of thresholds of improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the payments; and
- the disclosure of information on hospital performance.

In the proposed rule, CMS discusses its activities to date on the above issues and solicits comments on outstanding policy questions. A complete discussion of CMS' steps toward value-based purchasing can be found on the *Federal Register* pages referenced in the heading above.

Hospital-Acquired Infections

Refer to "Value-Based Purchasing" if you submit a comment on this issue.
(*Federal Register* page 24100)

Medicare's IPPS encourages hospitals to treat patients efficiently. However, complications such as infections acquired in the hospital can trigger higher payments in the form of outlier payments and higher DRG payment based on the presence of a complication or comorbidity (CC).

The DRA requires CMS to identify, by October 1, 2007, at least two conditions that:

- are high cost, high volume, or both;
- result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and
- could reasonably have been prevented through the application of evidence-based guidelines.

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions (based on criteria above) was not present on admission. That is, the case would be paid as though the secondary diagnosis was not present.

Additionally, the DRA requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

CMS is seeking comments about which conditions and which evidence-based guidelines should be selected.

Health Information Technology

Refer to “Value-Based Purchasing” if you submit a comment on this issue.

(*Federal Register* pages 24100 – 24101)

In the proposed rule, CMS discusses the mixed signals about the potential of health information technology (HIT) to reduce costs. Although the Bush Administration supports the adoption of HIT, it considers it the normal cost of doing business. Payments under the IPPS do not vary depending on the adoption and use of HIT; however, CMS states that hospitals that leverage HIT to provide better quality services may more efficiently reap the reward of any resulting cost savings, improved processes, and outcomes of care.

In the proposed rule, CMS considers the role of interoperable HIT systems in increasing the quality of hospital services while avoiding unnecessary costs. CMS is seeking comments on the following:

- statutory authority to encourage the adoption and use of HIT;
- the appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the IPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care; and
- the promotion of the use of effective HIT through hospital conditions of participation, perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary of Health and Human Services.

Health Care Information Transparency Initiative

Refer to: “Transparency of Health Care Information” if you submit a comment on these issues.

(*Federal Register* pages 24120 – 24121)

Concerned that health care costs are growing at an unsustainable rate, CMS is seeking comment on ways to encourage transparency in health care quality and pricing, whether through CMS’ leadership on voluntary initiatives or through regulatory requirements. CMS is also seeking comment on its statutory authority to impose such requirements.

According to CMS, because patients have limited information about the quality and actual costs of care, there is little incentive or means to carefully shop for providers offering the best value. Thus, providers of care are not subject to the competitive pressures that exist in other markets for offering quality services at the best possible price.

CMS has provided three options to foster comments on possible options to promote the aims of transparency of quality and pricing information and how this can ultimately be used to slow the growth in health care costs:

- *“First, we could publish a list of hospital charges either for every region of the country or for selected regions of the country. In addition, we could publish the rates that Medicare actually pays to a particular hospital for every DRG or for selected DRGs that could be adjusted to take into account the hospital’s labor market area, teaching hospital status, and DSH status. Some might argue that publishing these payment rates does not provide meaningful information to consumers because Medicare payment rates are not set by the market, but rather by a statutory payment formula. In addition, providing information on hospital payments only does not disclose the true cost of an episode of care because it would not take into account the cost of physician services, laboratory tests, and other procedures that go along with hospital charges. On the other hand, Medicare payment rates may provide a helpful benchmark, especially for uninsured individuals, to determine whether the charges they see on a hospital bill bear any relationship to what third-party fee-for-service payors pay to the hospital.”*

- *“A second option would be for the Secretary to use his authority to establish conditions of participation for hospitals to propose a rule that relates to charges for uninsured patients. For example, the conditions of participation could include a requirement that hospitals post their prices and/or post their policies regarding discounts or other assistance for uninsured patients.”*
- *“Yet another alternative to posting Medicare DRG payment rates would be to make publicly available the total Medicare payments for an episode of care. For example, one of the most common inpatient hospital procedures under the Medicare program (based on total dollars spent) is hip replacement surgery. Under this proposal, we could make publicly available the expected total payment for an episode of care for hip replacement surgery, including the inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute care services such as services provided in an IRF, SNF, or LTCH. We are currently assessing methods for making such information available and are seeking comments on how to do so as quickly and effectively as possible.”*

Electronic Medical Records

Refer to: “Hospital Quality Data” if you submit a comment on this issue.
(*Federal Register* page 24095)

In the FFY 2006 IPPS final rule, CMS encouraged hospitals to take steps toward the adoption of electronic medical records (EMRs) that will allow for reporting of clinical quality data from the EMRs directly to CMS. In the FFY 2007 proposed rule, CMS is encouraging hospitals that are developing systems to conform them to both industry standards and, when developed, the Federal Health Architecture Data standards, to ensure that the data necessary for quality measures are captured. CMS is seeking comments on the requirements and options for EMRs.

VII. WAGE INDEX

Core-Based Statistical Areas

Refer to “CBSAs” if you submit a comment on this issue.
(*Federal Register* pages 24074 – 24075)

Background: In FFY 2005, CMS implemented revised wage areas based on Core-Based Statistical Areas (CBSAs) defined using data from the 2000 Census. This change had a significant redistributive impact, with many areas experiencing substantial increases or decreases in their wage adjustment. As a result, CMS provided a one-year transition for hospitals that were harmed by the redefinition of wage index areas. Hospitals that would have received a higher wage index under the prior geographic area definitions were provided a blended wage index combining 50% of the wage index based on the new definitions and 50% based on the old definitions. For FFY 2006, this transition expired and hospitals received 100% of their wage index based upon the CBSA configurations.

CMS Proposal: “. . . as we did beginning in FY 2006, for FY 2007 we are proposing to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, we will determine for each hospital a proposed wage index for FY 2007 employing wage index data from FY 2003 hospital cost reports and using the CBSA labor market definitions.”

A recent U.S. Court of Appeals decision in *Bellevue Hospital Center v. Leavitt*, which challenged the FFY 2005 implementation of the CBSA definitions, upheld CMS’ authority to implement these revised wage index area definitions. Therefore, three New Jersey counties included in the New York City wage area under the CBSA configurations will continue to be included in the New York City wage index area. In that same decision, CMS was ordered to implement the full occupational mix adjustment (100%) beginning October 1. Please see the section “100% Implementation—Occupational Mix Adjustment” below for a complete discussion of this issue.

Hold Harmless—Urban Hospitals that became Rural Under the New Labor Market Area Definitions

Refer to “CBSAs” if you submit a comment on this issue.
(*Federal Register* pages 24074 – 24075)

Urban hospitals that became rural under the revised labor market area definitions developed from the 2000 Census were assigned the wage index of the urban area in which they were located under the previous labor market area definitions for a three-year period (FFY 2005-FFY 2007).

FFY 2007 is the final year of the “hold-harmless” for these hospitals. Beginning in FFY 2008, these hospitals will receive the statewide rural wage index. These hospitals are eligible to apply for a reclassification to another wage area by the Medicare Geographic Classification Review Board (MGCRB) and are considered rural for reclassification purposes.

100% Implementation—Occupational Mix Adjustment

Refer to “Occupational Mix Adjustment” if you submit a comment on this issue.
(*Federal Register* pages 24075 – 24077)

Background: CMS was required to include an occupational mix adjustment as part of the calculation of the wage index beginning in FFY 2005. The purpose of the occupational mix adjustment is to control for the effect of hospitals’ employment choices on the wage index. CMS explains that hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and other employees for the purpose of providing care to their patients. According to CMS, the varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor. The occupational mix factor is intended to neutralize the effect of employee mix, resulting in a decreased wage adjustment for hospitals with higher skill mixes and an increased adjustment for those with lower mixes. The law provides for the collection of data on occupational mix every three years.

In FFY 2005 and FFY 2006, CMS calculated wage indexes using a blend of 10% of the wage data adjusted for occupational mix and 90% of the data unadjusted for occupational mix.

New Occupational Mix Requirements: CMS’ intent in the FFY 2007 proposed rule was to use the same data as previous years and apply the same methodology for the occupational mix adjustment. However, due to a recent U.S. Court of Appeals decision in *Bellevue Hospital Center v. Leavitt*, CMS has been ordered to implement the full occupational mix adjustment, using more recent data beginning October 1, 2006. On April 21, CMS issued a memorandum announcing the new occupational mix requirements that would supersede the current proposal under the FFY 2007 proposed rule. CMS is required to base the adjustment on more recent data, using the results from the revised 2006 Medicare Occupational Mix Survey. **Hospitals will be required to submit new occupational mix data on June 1 to their Fiscal Intermediary (FI).**

CMS had planned to use the revised 2006 Medicare Occupational Mix Survey in calculating the federal fiscal year (FFY) 2008 wage index. Originally, CMS required providers to complete the 2006 Occupational Mix Survey for a six-month reporting period beginning January 1, 2006. However, due to time constraints based on the Court of Appeals decision, CMS is now requiring providers to submit data for a three-month reporting period beginning January 1, 2006. The results of the new 2006 Occupational Mix Survey for January through March 2006 will be used in the FFY 2007 wage index calculation.

CMS had originally requested the submission of all January through June data by July 31, 2006; however, due to the changes in reporting for FFY 2007, CMS is extending the submission deadline for April through June data to August 31, 2006.

The results of the full six-month data collection period beginning January 1, 2006 will be used to establish the

FFY 2008 occupational mix adjustment.

Within the next few weeks, CMS will publish a separate notice in the *Federal Register* announcing the occupational mix adjustment methodology and the procedures for hospitals whose reclassification may be impacted by this change.

VIII. WAGE INDEX RECLASSIFICATIONS

Standard CMS procedure allows hospitals that have been approved for reclassification to withdraw their applications within 45 days of the publication of the proposed rule. However, due to the recent U.S. Court of Appeals decision in *Bellevue Hospital Center v. Leavitt* (discussed above), CMS has been ordered to implement the full occupational mix adjustment (100%) beginning October 1.

This decision will alter the wage indexes as published in the proposed rule, which are based on a 10% occupational mix adjustment and the original survey data. Because the wage indexes published in the proposed rule are incorrect, hospitals do not have accurate data upon which to base a reclassification withdrawal on. WHA and the American Hospital Association are attempting to address this issue with CMS.

MGCRB Reclassifications

Refer to: “Hospital Redesignations and Reclassifications” if you submit a comment on these issues. (*Federal Register* pages 24082 – 24083)

Background: Individual hospitals or groups of hospitals (defined by counties) can apply to MGCRB to reclassify for another areas wage index. Hospitals seeking reclassification must meet specific proximity and wage criteria. Applications for FFY 2008 reclassifications are due to MGCRB by September 1, 2006.

Applications and other information regarding MGCRB reclassifications will be available beginning in mid-July on the CMS Web site at: <http://www.cms.hhs.gov/mgcrb/>.

Reclassification Withdrawal: Hospitals that have been approved for FFY 2007 MGCRB reclassifications are permitted to withdraw their applications within 45 days of the publication of the proposed rule.

Section 508 Reclassification Expiration

Refer to: “Hospital Redesignations and Reclassifications” if you submit a comment on these issues. (*Federal Register* pages 24085 – 24087)

Background: Section 508 reclassifications are legislative wage index reclassifications provided by the MMA allowing select hospitals to reclassify for another areas wage index if specific criteria were met. These reclassifications are applicable to discharges occurring during the three-year period beginning April 1, 2004, and ending March 31, 2007.

Because Section 508 reclassifications expire mid-fiscal year 2007, CMS has established rules for these hospitals to retain their Section 508 reclassification through its expiration on March 31, 2007, and reclassify through the MGCRB or retain another wage index adjustment for the second half of FFY 2007. Below are the rules established by CMS in preparation of Section 508 expirations.

No MGCRB Reclassification:

Hospitals with no reclassification (individual or group) for FFY 2007 will be subject to their home wage index area upon expiration of their section 508 reclassification.

Individual MGCRB Reclassification:

Section 508 hospitals that are approved by the MGCRB for reclassification have 45 days from the date of the

publication of the proposed rule to cancel their MGCRB reclassification. The following table expresses the options for Section 508 hospitals that have been approved by the MGCRB for reclassification for FFY 2007 and wish to exercise that reclassification.

	October 1, 2006 - March 31, 2007 (first half FFY 2007) Reclassification	April 1, 2007 - September 30, 2007 (second half FFY 2007) Reclassification	FFY 2008 Reclassification	FFY 2009 Reclassification
Section 508 Hospital's Action:				
Cancels MGCRB - first half of FFY 2007	Section 508	MGCRB	MGCRB	MGCRB
Cancels MGCRB - entire FFY 2007	Section 508	Home Wage Index	Home Wage Index	Home Wage Index
Does not Cancel MGCRB	MGCRB	MGCRB	MGCRB	MGCRB

Group MGCRB Reclassification:

Hospital groups that include a Section 508 hospital(s) were also permitted to submit reclassification applications to MGCRB by the September 1, 2005 deadline. For a group reclassification that contained a section 508 hospital to be approved, either of the following conditions needed to be met:

- the Section 508 hospital that is part of the group waived its Section 508 reclassification for the first half of FFY 2007. In such a case the following would apply:

	October 1, 2006 - March 31, 2007 (first half FFY 2007) Reclassification	April 1, 2007 - September 30, 2007 (second half FFY 2007) Reclassification	FFY 2008 Reclassification	FFY 2009 Reclassification
Section 508 Hospital(s)	MGCRB Group	MGCRB Group	MGCRB Group	MGCRB Group
Remainder of Group	MGCRB Group	MGCRB Group	MGCRB Group	MGCRB Group

-OR-

- each member of the group agreed, in writing, at the time the application was submitted September 1, 2005, that they cancelled the group reclassification if granted for the first six months of FFY 2007. In such a case the following would apply:

	October 1, 2006 - March 31, 2007 (first half FFY 2007) Reclassification	April 1, 2007 - September 30, 2007 (second half FFY 2007) Reclassification	FFY 2008 Reclassification	FFY 2009 Reclassification
Section 508 Hospital(s)	Section 508	MGCRB Group	MGCRB Group	MGCRB Group
Remainder of Group	MGCRB Group or Pre- Existing Reclassification (if applicable)	MGCRB Group	MGCRB Group	MGCRB Group

No action is needed by MGCRB group applicants that contain a Section 508 hospital. All group declarations were made during the application period. However, the group may cancel the April 1, 2007 through September 30, 2009 group reclassification within 45 days of publication of the proposed rule.

Out-Migration Adjustment:

Section 508 hospitals that are not approved by MGCRB for reclassification for the second half of FFY 2007 will be eligible for the out-migration adjustment. No action is needed by the provider to receive the add-on to the wage index.

Lugar Reclassifications

Refer to: “Hospital Redesignations and Reclassifications” if you submit a comment on these issues.
(*Federal Register* pages 24083 – 24085)

Background: The law requires that CMS automatically reassign any hospital located in a rural county adjacent to one or more urban areas if the county meets specified commuting criteria known as “Lugar criteria.” CMS has used the new CBSA definitions and 2000 Census data to assign reclassifications to hospitals in counties that meet these criteria. Hospitals that qualify for an automatic Lugar reclassification might have also requested a reclassification under the MGCRB or Section 508 criteria, in which case the requested reclassification overrides the Lugar reclassification. Hospitals that qualify for both are instructed to compare their wage index under the MGCRB/Section 508 reclassification to the wage index under the Lugar reclassification.

Reclassification Withdrawal: Hospitals must withdraw their MGCRB/Section 508 reclassification requests within 45 days of publication of the proposed rule if they prefer to receive the Lugar assignment.

Out-Migration Adjustment

Refer to: “Hospital Redesignations and Reclassifications” if you submit a comment on these issues.
(*Federal Register* pages 24087 – 24088)

Background: Section 505 of the MMA requires that CMS develop an alternative adjustment to the wage index based on the commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index. Qualifying hospitals receive an adjustment to their wage index based on the percentage of county residents that commute to the other area. The adjustment is added to the wage index for the area that the hospital is located in and is to be effective for three years. The adjustments for a qualifying county are not recalculated during the three-year period, and all counties that had an adjustment in FFY 2005 receive the same adjustment in both FFY 2006 and FFY 2007. CMS will designate qualifying counties each year.

FFY 2007 is the final year for qualifying counties originally designated to receive the out-migration adjustment. According to CMS, after a qualifying county’s three-year period ends, the county might receive a new out-migration adjustment for another three-year period.

Reclassification Withdrawal: If a hospital in one of these counties does not have an existing reclassification, it will automatically receive the adjustment. Hospitals cannot receive an adjustment under this provision if they already received a reclassification. Therefore, if a hospital has an existing reclassification (MGCRB, Section 508, or “Lugar criteria”), that hospital must withdraw its reclassification within 45 days of the publication of this proposed rule to receive the out-migration adjustment instead.

Other Hospital Reclassification Issues

Refer to: “Geographic Reclassification” if you submit a comment on these issues.
(*Federal Register* pages 24109 – 24110)

The proposed rule addresses a handful of other specific and unique hospital reclassification issues. These include:

- **multi-campus hospital reclassifications**—eliminating the ability of a individual campus to use the average hourly wage data of the entire multi-campus hospital system to seek geographic reclassification to the labor market area in which the other campus is located (permitted after the labor-market area changes of FFY 2005).

- **urban group hospital reclassifications**—specifically addressing the Combined Statistical Area (CSA) standard that precludes urban county group reclassifications between three Metropolitan Divisions within one CBSA in Florida;
- **the effect of the change of ownership on urban county group reclassifications**—clarifying reclassification eligibility rules for newly constructed hospitals and hospitals that do not accept assignment of the previous owner’s provider agreement; and
- **reclassifications for a single hospital MSA surrounded by rural counties**—addressing concerns of an urban hospitals ineligibility for reclassification to a higher wage index area (individual or county group) under the existing regulations.

A complete discussion of these reclassification issues can be found on the *Federal Register* pages referenced in the heading above.

IX. COST OUTLIERS

Refer to “Operating Payment Rates” if you submit a comment on this issue.
(*Federal Register* pages 24149 – 24151)

Background: CMS provides payments for outlier cases involving extraordinarily high costs when compared to average cases in the same DRG. To qualify as a cost outlier, a hospital’s cost for the case must exceed the payment rate for the DRG plus a specified amount called the fixed-loss threshold. The outlier payment is equal to 80% of the difference between the hospital’s cost for the stay and the threshold amount. The threshold is adjusted every year based on CMS’ projections of total outlier payments to make outlier reimbursement equal 5.1% of total payments.

CMS Proposal: “. . . we are proposing to establish an outlier fixed-loss cost threshold for FY 2007 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus \$25,530. . . . we are proposing to use the same methodology used for FY 2006 (70 FR 47493) to calculate the outlier threshold.”

The proposed \$25,530 threshold for FFY 2007 represents an increase of 8.2% compared to the FFY 2006 threshold of \$23,600. The higher proposed threshold is due to the national average cost-to-charge ratios declining by approximately 1%; whereas, hospital charges have steadily increased at a rate of 7% to 8% for each of the past two years. Based on CMS’ current estimates actual FFY 2005 outlier payments were 4.1% of total payments and FFY 2006 outlier payments are estimated to be 4.71% of total payments. Even though both estimates are below the 5.1% outlier payment target, CMS indicated that the Medicare data used for the FFY 2007 projections show increased charge inflations; therefore, an increase in the FFY 2007 outlier threshold is needed. CMS has indicated that the outlier threshold could potentially change in the final rule due to updated data.

X. RURAL HOSPITALS

Medicare Dependent Hospitals

Refer to “Payments to MDHs” if you submit a comment on this issue.
(*Federal Register* pages 24104 – 24105)

Medicare Dependent Hospitals (MDHs) receive special Medicare payment status under the IPPS. To qualify, a hospital must meet specific criteria. Currently, MDHs are paid based on the federal rate or, if higher, the 50-50 blend of the federal rate and the updated hospital-specific rate based on FFY 1982 or FFY 1987 costs per discharge. In addition, MDHs are capped at 12% under the Disproportionate Share Hospital (DSH) calculation. By law, MDH special payment status was scheduled to expire September 30, 2006.

The proposed rule addresses a number of MDH payment methodology enhancements provided by the DRA. The

MDH program enhancements include:

- extension of the program through October 1, 2011 (five years);
- increase to payments by providing an option to use 2002 as the base year for determining the hospital-specific rate;
- increase to the hospital-specific portion of the rate from 50% to 75%;
- exemption from the 12% DSH adjustment limit that applies to rural hospitals.

Volume Decrease Adjustment for SCHs and MDHs

Refer to “SCH/MDH Volume Decrease Adjustment” if you submit a comment on this issue.
(*Federal Register* pages 24101 – 24104)

Background: CMS is required to make a payment adjustment to Sole Community Hospitals (SCHs) and MDHs that experience a decrease of more than 5% in their total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the facility’s control. These adjustments were designed to compensate a SCH or MDH for the fixed costs it incurs in the year following the reduction in discharges, which it may be unable to reduce. Such costs include the maintenance of necessary core staff and services. However, because not all staff costs can be considered fixed, the SCH or MDH must demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. CMS examines nursing staff in particular. If an SCH or MDH has an excess number of nursing staff, the cost of maintaining those staff members is deducted from the total volume decrease adjustment.

Currently, FIs obtain average nurse staffing data from the American Hospital Association’s HAS/Monitrend Data Book to determine the volume decrease adjustment. Because the most recent version of the HAS/Monitrend Data Book was published in 1989 and is no longer updated, hospitals expressed concern that the data in the publication are too outdated for current use for determining the volume decrease adjustment.

CMS Proposal: “. . . we are proposing an alternative method for determining an SCH’s or MDH’s target number of core staff using data from the Medicare cost report and the occupational mix survey. . . . beginning with requests for adjustments for FY 2008.”

The former and proposed methodologies used to determine the volume decrease adjustment are discussed in detail in the proposed rule on the *Federal Register* pages referenced in the heading above. CMS is seeking comments on this proposal.

SCH/MDH Changes in Qualification Status

Refer to “SCH/MDH Changes in Qualification Status” if you submit a comment on this issue.
(*Federal Register* page 24104)

Background: Under current regulations, once a facility has been designated as an SCH or MDH, the classification remains in effect without need for re-approval unless there is a change in the hospital's circumstances. Currently, regulations do not contain an explicit requirement that a SCH or MDH report to CMS a change in circumstances that would affect its status. In the case of MDHs, the FI is required to evaluate on an ongoing basis whether a hospital continues to qualify for MDH status. CMS has become aware of several hospitals that have maintained SCH or MDH status after the original circumstances that led to the respective classification change.

CMS Proposal: *“We are proposing . . . to require an SCH or MDH to report to its appropriate CMS Regional Office when the circumstances under which the hospital was approved for SCH or MDH status have changed. . . . If an SCH or MDH no longer meets these criteria, the CMS Regional Office will issue a letter canceling the classification within 30 days of its determination. If the circumstances affecting a hospital's SCH or MDH classification change and the hospital does not disclose the information to the CMS Regional Office, CMS will cancel the hospital's SCH or MDH designation effective on the earliest discernable date on which the fiscal intermediary can determine that the hospital no longer met the criteria for classification. For MDHs, this reporting requirement is in addition to the fiscal intermediary's ongoing evaluations of whether a hospital continues to qualify for MDH status as set out in our existing regulations at §412.108(b)(5).”*

Rural Referral Centers

Refer to “Rural Referral Centers” if you submit a comment on this issue.
(*Federal Register* pages 24105– 24107)

Background: Rural referral centers receive special Medicare payment status under the IPPS. To qualify, a hospital must meet specific criteria. Advantages of rural referral center status include:

- exemption from the 12% cap on DSH payments that is applicable to other rural hospitals
- special treatment under the geographic reclassification rules including:
 - exemption from the proximity criteria
 - exemption from the requirement that a hospital’s average hourly wage must exceed 106% of the average hourly wage of the labor market area where the hospital is located

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use. Alternatively, a hospital can qualify as a rural referral center by meeting two mandatory prerequisites: a minimum case-mix index (CMI) and a minimum number of discharges, and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if:

The hospital’s CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

The hospital’s number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year).

CMS establishes the updated national and regional CMI values and discharges in each year’s proposed rule for purposes of determining rural referral center status.

CMS Proposal: *“We are proposing that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, rural hospitals with fewer than 275 beds must have a CMI value for FY 2005 that is at least—*

- 1.3365; or
- *The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in §412.105) calculated by CMS for the census region in which the hospital is located.”*

The proposed median CMI values by region are:

Region	Case-Mix Index Value
New England (CT, ME, MA, NH, RI, VT)	1.2678
Middle Atlantic (PA, NJ, NY)	1.2701
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.1781
East North Central (IL, IN, MI, OH, WI)	1.3156
East South Central (AL, KY, MS, TN)	1.2009
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2856
West South Central (AR, LA, OK, TX)	1.2445
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3024
Pacific (AK, CA, HI, OR, WA)	1.3620

“we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, must have as the number of discharges for its cost reporting period that began during FY 2003 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

Region	Discharges
New England (CT, ME, MA, NH, RI, VT)	7,360
Middle Atlantic (PA, NJ, NY)	10,170
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,117
East North Central (IL, IN, MI, OH, WI)	8,983
East South Central (AL, KY, MS, TN)	7,427
West North Central (IA, KS, MN, MO, NE, ND, SD)	7,346
West South Central (AR, LA, OK, TX)	7,060
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,832
Pacific (AK, CA, HI, OR, WA)	7,680

“We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.”

XI. Additional Payments for New Technology

Refer to “New Technology” if you submit a comment on this issue.

(Federal Register pages 24068 – 24074)

Background: Current law provides additional payments for new medical services and technologies that meet specified criteria. An approved new technology is eligible for additional payments for two to three years. However, CMS has consistently eliminated the payments after two years.

CMS Proposal: CMS proposes to continue reimbursement for two technologies that are currently eligible for new technology payment. One technology currently eligible for new technology payment has been discontinued. In addition, three technologies are under review and may be approved for payment in FFY 2007.

CMS proposes to continue payment for:

- Endovascular Graft Repair of the Thoracic Aorta
- Restore® Rechargeable Implantable Neurostimulator

CMS proposes to discontinue payment for:

- Kinetra® Implantable Neurostimulator for Deep Brain Stimulation

CMS continues to review approval for:

- C-Port® Distal Anastomosis System
- NovoSeven® for Intracerebral Hemorrhage
- X STOP Interspinous Process Decompression System

XII. Graduate Medical Education

Indirect Medical Education Adjustment

Refer to “IME Adjustment” if you submit a comment on this issue.

(Federal Register page 24107)

Background: Indirect Medical Education (IME) payments attempt to recognize the higher costs associated with the operation and administration of a Graduate Medical Education (GME) program. The IME adjustment factor is calculated using a hospital’s ratio of residents to beds and a formula multiplier, which is represented as “c” in the equation: $c \times [(1 + \text{ratio of residents to beds}) \text{ raised to the power of } 0.405 - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10% increase in the resident-to-bed ratio.

Before enactment of the MMA, the formula multiplier was set at 1.35 for discharges occurring during FFY 2003 and thereafter, which equates to a 5.5% adjustment. The MMA modified the formula, increasing the multiplier for FFY 2005 and FFY 2006 to 1.42 and 1.37 respectively. The law schedules a decrease in the multiplier for FFY 2007 and restores the multiplier to the FFY 2003 level of 1.35 for FFY 2008 and thereafter.

CMS Proposal: *“In this proposed rule, we are specifying that for any discharges occurring during FY 2007, the formula multiplier is 1.32. We estimate that application of the mandated formula multiplier for FY 2007 will result in an increase of 5.38 percent in IME payment for every approximately 10-percent increase in the resident-to-bed ratio from FY 2006 to FY 2007”*

Direct Medical Education

Refer to “GME Payments” if you submit a comment on this issue.

(Federal Register page 24111)

Direct Medical Education (DME) attempts to recognize the direct costs associated with the operation and administration of a GME program. Medicare pays teaching hospitals for the direct costs of GME based on a hospital-specific base period per resident amount (PRA). For most hospitals, the base year is FFY 1984. PRAs are updated annually for inflation and are subject to established floors and ceilings. In addition, hospitals that were training non-primary care residents in FFYs 1994 and 1995 have a separate non-primary care PRA because there was no update for inflation applied to the PRA for non-primary care residents in those years.

Determination of Weighted Average PRAs for Merged Teaching Hospitals

Refer to “GME: PRA for Merged Hospitals” if you submit a comment on this issue.

(Federal Register pages 24111 – 24113)

Background: Currently, when two or more teaching hospitals merge, CMS determines a weighted PRA for the surviving merged hospital using direct GME costs and resident data from the base year cost report for each hospital involved in the merger. CMS determined this policy to be equitable because it is based on the relative costs and sizes of the GME training programs in the respective facilities and minimized gaming by eliminating the incentive to choose the surviving hospital based in part on the hospitals’ relative PRAs.

Because the current methodology for calculating the weighted average PRA for a merged teaching hospital is based solely on data from the PRA base year (which is usually prior to the years during which the PRAs were not adjusted for inflation to reflect non-primary care residents), this methodology does not take into account that the merged hospitals may currently have more than one PRA. Additionally, base year data (usually FFY 1984 data)

used by CMS and the FIs in calculating the weighted average of the PRAs for merged hospitals are now often over 20 years old and have become administratively burdensome to obtain.

CMS Proposal: *“Effective for cost reporting periods beginning on or after October 1, 2006, rather than use direct GME count of residents and PRA from hospitals' base year cost reports, we are proposing to simplify and revise the weighted average PRA methodology for determining a merged teaching hospital's PRA by using FTE resident data and PRA data from the most recently settled cost reports of the merging hospitals. It is less administratively burdensome to use these data, since these data are more recent and, therefore, more accessible. In addition, these data would reflect both a primary care and obstetrics and gynecology PRA and, if applicable, a nonprimary care resident PRA.”*

The details of the proposal for calculating the weighted average PRA for a merged teaching hospital is discussed in detail on the *Federal Register* pages referenced in the heading above.

Determination of PRAs for New Teaching Hospitals

Refer to “GME: PRA for New Teaching Hospitals” if you submit a comment on this issue.
(*Federal Register* page 24113)

Background: A new teaching hospital's PRA (a hospital that did not participate in Medicare or have any approved medical residency training programs during the base period - FFY 1984) is established by using the lower of its hospital-specific PRA based on the actual allowable direct GME costs and full-time equivalent (FTE) residents during a base period or the updated weighted mean value of PRAs of other teaching hospitals in the same geographic area.

Existing regulations specify that the PRA is to be determined by using the cost and resident data from the first cost reporting period during which residents are training in the first month of the cost reporting period. New teaching hospitals that begin training residents but do not have residents on duty during the first month of the first cost reporting period in which training occurs are paid on a reasonable cost basis for any GME costs incurred. The intent of this policy for new teaching hospitals is to make a more accurate determination of a PRA.

It has come to the attention of CMS that new teaching hospitals could continue to be reimbursed for direct GME costs on a reasonable cost basis beyond the first cost reporting period during which residents begin training at the hospital as long as no residents are on duty at the new teaching hospital in the first month of the subsequent cost reporting period(s). CMS notes that this situation is rare and is occurring “*either through happenstance or by purposeful gaming of the policy.*”

CMS Proposal: *“ . . . we are proposing . . . to provide that we will make a PRA determination even where residents are not on duty in the first month of a cost reporting period but where residents began training at the hospital in the prior cost reporting period. Effective for cost reporting periods beginning on or after October 1, 2006, if a new teaching hospital begins training residents in a cost reporting period beginning on or after October 1, 2006, and no residents are on duty during the first month of that period, the fiscal intermediary establishes a PRA for the hospital using: (1) the cost and resident data from the cost reporting period immediately following the one for which GME training at the hospital was first reported (that is, the base period); or (2) the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. We note that, as with existing policy, the proposed base year need not be a full cost reporting year. Even where that cost reporting period may be a short (less than 12 months) cost reporting period, we believe an appropriate PRA will be determined since the number of FTEs will be commensurate with the costs incurred in this short cost reporting period.”*

Requirements for Counting and Appropriate Documentation of FTE Residents

Refer to “FTE Resident Count and Documentation” if you submit a comment on this issue.
(*Federal Register* pages 24113 – 24114)

CMS is not expanding or making any changes to the current policy for proper documentation of FTEs. In the proposed rule, CMS states that “. . . *proper documentation on where and when a FTE resident is training during a cost reporting period is essential in order for the hospital to receive direct GME and IME payments based on the proper number of FTE resident(s). Inaccurate, incomplete, or inappropriate documentation will lead to Medicare disallowing certain FTE residents from being counted for purposes of direct GME and IME payments.*”

A complete discussion clarifying the existing regulations concerning proper counting and documentation of FTEs is discussed in detail on the *Federal Register* pages referenced in the heading above.

Resident Time Spent in Non-Patient Care Activities

Refer to “FTE Resident Count and Documentation” if you submit a comment on this issue.
(*Federal Register* pages 24114 – 24115)

CMS is not expanding or making any changes to the current policy for FTE resident counts relating to non-patient care. In the proposed rule, CMS states that “*We have most recently received questions as to whether the time residents spend in nonhospital sites in didactic activities such as journal clubs or classroom lectures may be included in determining the allowable FTE resident counts. To respond to these inquiries and to resolve any confusion, we are clarifying our policy concerning the counting of time spent in nonpatient care activities for the purpose of direct GME and IME payments in both hospital and nonhospital settings. With respect to training in nonhospital settings, the time that residents spend in nonpatient care activities as part of an approved program, including didactic activities, cannot be included in a hospital’s direct GME or IME FTE resident count. This longstanding policy is based on the statutory requirements for counting FTE residents training in nonhospital sites.*”

A complete discussion clarifying the existing regulations concerning proper FTE resident counts relating to non-patient care is discussed in detail on the federal register pages referenced in the heading above.

XIII. OTHER

Grandfathering of Hospitals-Within-Hospitals and Satellite Facilities

Refer to “Hospitals-Within-Hospitals” if you submit a comment on this issue.
(*Federal Register* pages 24124 – 24126)

A hospital-within-a-hospital (HwH) is defined as a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital. To be paid outside of the IPPS as an excluded hospital, an HwH is required to create operational and organizational “separateness” between the HwH and the host hospital with which it is co-located.

Certain HwHs are exempt from compliance with the “separateness and control” criteria governing the relationships with their host hospitals. However, regulations require that the grandfathered entity make no change in either its square footage or number of beds in order to retain its grandfathered status.

CMS Proposal: “. . . *we are proposing a corresponding change to the HwH grandfathering provision at §412.22(f)(3) that would allow for increases or decreases in square footage, or decreases in the number of beds of the HwH that are needed for specific circumstances beyond the control of the facility. We are specifying that increases or decreases in square footage or decreases in the number of beds that are required because of the relocation of a facility to permit construction or renovation necessary for compliance with Federal, State, or*

local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.”

“ . . . we are proposing revisions to the regulations at §412.22(f) for grandfathered HwHs and at §§412.22(h) and 412.25(e)(5) for grandfathered satellites of hospitals and satellites of hospital units, respectively, to allow these entities to decrease their square footage or number of beds, or both, without jeopardizing their grandfathered status.”

Proxy for the Hospital Marketbasket

Refer to “Hospital Marketbasket Proxy” if you submit a comment on this issue.

(Federal Register page 24091)

The hospital update is based on a marketbasket factor that is intended to reflect the average change in the price of goods and services hospitals purchase to furnish inpatient care. To accomplish this, CMS selects wage and price proxies intended to reflect hospital costs. CMS projects a hospital marketbasket increase of 3.4% for FFY 2007. To estimate the marketbasket factor for a given year, CMS primarily uses the Bureau of Labor Statistics (BLS) data as price proxies, which are grouped in one of the three BLS categories:

- Producer Price Indexes
- Consumer Price Indexes
- Employment Cost Indexes (ECIs)

Beginning with the publication of March 2006 data, the BLS' ECI will use a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SIC), which will no longer exist. CMS has consistently used the ECI as the data source for wages and salaries and other price proxies in the IPPS marketbasket and is seeking comment on the continued use of the BLS ECI data in light of the BLS change to the NAICS-based ECI.

Payment for the Costs of Nursing and Allied Health Education Activities—Clarification

Refer to: “Nursing and Allied Health Education Activities” if you submit a comment on these issues.

(Federal Register page 24116)

Background: In the FFY 2004 IPPS final rule, CMS revised the regulations to clarify the difference between provider-operated and continuing education programs. The revised regulations state that, effective October 1, 2003, programs in which employees participate that do not lead to the ability to practice and begin employment in a nursing or allied health specialty are considered by CMS to be part of the hospitals' normal operating costs and payment for these costs is included in the per discharge payment amount for hospitals subject to the IPPS.

CMS Proposal: *“ . . . we are proposing to make a technical change to §413.85(h)(3) to make it applicable to both employees and trainees. This proposed technical change would clarify that the educational activities in which employees or trainees participate, but that do not lead to the ability to practice and begin employment in a nursing or allied health specialty, are treated as normal operating costs. We note that we are not proposing to expand or make any changes to the current payment policy for nursing and allied health education activities; rather, we are merely proposing to clarify the language of the existing regulations.”*

Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

Refer to “Blood Clotting Factor Payment Rate” if you submit a comment on this issue.

(Federal Register pages 24136 – 24137)

Background: Prior to October 1, 2005, payments for blood clotting factors furnished to inpatients were made at 95% of average wholesale price (AWP). CMS amended the regulations, therefore, payments for blood clotting factor administered to hospital inpatients beginning on or after October 1, 2005 would be made using the Medicare Part B payment amounts for blood clotting factor as determined under Subpart K of 48 CFR Part 414 and for the furnished fee as determined under §410.63.

CMS Proposal: “ . . . we are proposing that the fiscal intermediaries continue to make payment amounts for blood clotting factor administered to hemophilia inpatients using the Medicare Part B payment amounts determined under Subpart K of 42 CFR Part 414 and that payment amounts for the furnishing fee for the blood clotting factor be calculated at 3 digits, currently at \$0.146 per I.U. of blood clotting factor.”