



**WISCONSIN HOSPITAL  
ASSOCIATION**

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**REVISED  
SUMMARY OF THE FINAL  
FEDERAL FISCAL YEAR 2007  
MEDICARE HOSPITAL  
INPATIENT RULE**

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**October 2006**



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## **I. OVERVIEW**

On September 29, the Centers for Medicare and Medicaid Services (CMS) issued a rule titled, *Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates: Final Fiscal Year 2007 Wage Indices and Payment Rates After Application of Revised Occupational Mix Adjustment to Wage Index* on its Web site. CMS will subsequently publish the rule in the October 11, 2006 *Federal Register*. This is a revised summary of the Medicare Inpatient Prospective Payment System (IPPS) final rule for federal fiscal year (FFY) 2007 that includes these changes, which affect the wage indexes, standard rates, and outlier threshold.

CMS published the FFY 2007 IPPS final rule in the August 18, 2006 *Federal Register*. However, a court order required that CMS fully implement the occupational mix adjustment using new data (see the “Occupational Mix Adjustment Blended Wage Index” section below for a complete discussion). Because of this requirement, the wage indexes published in the August 18 final rule were tentative and did not include the occupational mix adjustment and CMS was unable to accurately calculate the outlier threshold, the outlier offset, and budget neutrality factors that are applied to the standardized amounts.

All changes are effective October 1, 2006 unless otherwise noted. Additional information regarding the IPPS is available on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS>.

- Note: text in italics is extracted from the August 18 *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 IPPS included payment restorations, while provisions of the DRA related to the IPPS mainly focus on the continued development of pay-for-performance initiatives.

## **III. STANDARDIZED AMOUNTS**

### **Marketbasket Update for FFY 2007**

*(Federal Register pages 48350 – 48351)*

Consistent with current law and based on the Office of the Actuary’s second quarter 2006 forecast of the FFY 2007 marketbasket increase, CMS’ 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.

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 will 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

Several provisions of the MMA and DRA continue to 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 (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%. The following table reports the final standard rates for FFY 2007 that CMS published on September 29 at <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp> - TopOfPage.

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)	\$3,397.52	\$1,476.97
Reduced Update (1.4 Percent)	\$3,331.80	\$1,448.40
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)	\$3,022.18	\$1,852.31
Reduced Update (1.4 Percent)	\$2,963.73	\$1,816.48
Capital Standard Federal Payment Rate		
National Capital Rate		\$427.03

## IV. REPORTING OF HOSPITAL QUALITY DATA

### Reporting Requirements to Receive the Full Marketbasket Update

*(Federal Register pages 48029 – 48045)*

**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 percentage points 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.”*

**CMS Final Rule:** *“... the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any “subsection (d) hospital” that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.”*

#### Program Expansion:

The DRA requires CMS to expand the quality reporting program. To receive the full update 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.

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

<b>Heart Attack (Acute Myocardial Infarction)</b>	<b>Heart Failure (HF)</b>	<b>Pneumonia (PNE)</b>	<b>Surgical Infection Prevention (SIP)</b>
Aspirin at arrival	Left ventricular function assessment	Initial antibiotic received within four hours of hospital arrival	Prophylactic antibiotic received within 1 hour prior to surgical incision
Aspirin prescribed at discharge	ACE-1 or ARBs for left ventricular systolic dysfunction	Oxygenation assessment	Prophylactic antibiotic discontinued within 24 hours
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			

**Pledge to Submit Data:**

Hospitals must pledge to submit data on the set of expanded quality measures (21 clinical quality measures), starting with discharges that occur in the third calendar quarter of 2006 (July through September discharges). Hospitals must have completed the “Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Notice of Participation” form to receive the full marketbasket update in FFY 2007. The form must have been signed by the hospital’s chief executive officer and received by the Quality Improvement Organization (QIO), by August 15.

**Data Submission:**

Hospitals will be required to submit data on the expanded set of 21 quality measures to the QIO Clinical Data Warehouse beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). The deadline for hospitals to submit these data for the third calendar quarter of 2006 is February 15, 2007.

CMS emphasizes that it is a hospital’s responsibility to ensure that its data are submitted successfully to the QIO Clinical Data Warehouse. To ensure that data submission problems are recognized and corrected early, CMS encourages hospitals to take advantage of the QualityNet Exchange Web site’s function that enables hospitals to run reports during test transmissions and after final transmission of data that indicate which records were successfully submitted, with and without errors, and/or which data were rejected by the warehouse.

**Chart Validation Requirements:**

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 samples for the 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, the hospital can appeal the results to its QIO.

Data Validation and Attestation:

For FFY 2007, CMS is requiring 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 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. 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.

CMS is proposing to include the survey as part of the hospital reporting initiative to receive a full marketbasket update for FFY 2008. More information on this survey is available on the CMS Web site at: <http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHCAHPSFactSheet200512.pdf>.

General:

For the first time, CMS will begin listing hospitals that met the current CMS requirements for quality data reporting and received their full payment update for FFY 2006 on <http://www.qualitynet.org/>. When available, QualityNet Exchange will display a list of those hospitals receiving their full update for FFY 2007. Additionally, CMS is considering how to inform those hospitals that do not receive their full annual payment update for FFY 2007.

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/>.

## V. COST OUTLIERS

*(Federal Register pages 48148 – 48152)*

**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. . . "

This proposal used the same methodology that was used for the FFY 2006 calculation of the outlier threshold.  
**CMS Final Rule:** ". . . we are establishing a final 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 \$24,485.”*

Based on comments from WHA and other state associations opposing the high outlier threshold, CMS in the final rule refined its outlier methodology. In doing so, CMS will account for the rate of change in the relationship between costs and charges, which would likely increase the precision of the outlier model.

Based on CMS’ refinements to the outlier methodology, the final \$24,485 outlier threshold for FFY 2007 represents an increase of 3.7% compared to the FFY 2006 threshold of \$23,600. FFY 2006 outlier payments are estimated to be 4.62% of total payments. Although this estimate is 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.

## **VI. WAGE INDEX**

### **Final FFY 2007 Wage Indexes**

On September 29, CMS published the final wage indexes including the occupational mix adjustment for FFY 2007 on the CMS Web site. The U.S. Court of Appeals decision in *Bellevue Hospital Center v. Leavitt*, ordered CMS to implement the full occupational mix adjustment (100%) beginning October 1. Please see the section “Occupational Mix Adjustment Blended Wage Index” below for a complete discussion of this issue. Information related to the final occupational mix-adjusted wage indexes and out-migration adjustments are provided on the CMS Web site at:

<http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage>.

Due to the delayed publication of the final wage index information, CMS implemented special rules for:

- reclassification withdrawals for FFY 2007; and
- reclassification requests for FFY 2008.

Please see the sections “Revised FFY 2007 Withdrawal Procedure for All Reclassifications” and “Reclassification Requests for FFY 2008” below for a complete discussion of these issues.

### **Occupational Mix Adjusted Wage Index**

*(Federal Register pages 48006 – 48019)*

**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 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. Therefore, 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. For those providers that did not submit occupational mix data, CMS applied a national occupational mix adjustment equivalent to 1.0000.

Last year, CMS issued a revised Occupational Mix Survey based on several public comments received. Some of the modifications included:

- allowing hospitals to report their own average hourly wage rather than using the Bureau of Labor and Statistics (BLS) data;
- extending the prospective survey period; and
- reducing the number of occupational categories but refining the subcategories for registered nurses.

The revised 2006 Occupational Mix Survey required providers to collect data for a six-month reporting period beginning January 1, 2006. The results of the revised survey were to be used in calculating the FFY 2008 wage index.

**CMS Proposal:** *“We . . . proposed to adjust 10 percent of the FY 2007 wage index by a factor reflecting occupational mix. However on April 3, 2006, in Bellevue Hosp Center v. Leavitt . . . the Court of Appeals for the Second Circuit (the Court) ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. The Court ordered CMS to “. . . immediately . . . collect data that are sufficiently robust to permit full application of the occupational mix adjustment.”*

Therefore, 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 was required to base the adjustment on more recent data, using the results from the revised 2006 Medicare Occupational Mix Survey. Because of the court order, CMS had strict time constraints to meet to implement the more recent occupational mix data by October 1. For that reason, CMS instructed providers to submit data for a **three-month** reporting period beginning January 1, 2006. This would allow sufficient time for hospitals, fiscal intermediaries, and CMS to collect, review, and correct the new data, and for CMS to perform required analyses and apply the new data in calculating the FFY 2007 occupational mix adjustment.

For the FFY 2007 wage index, hospitals that did not submit surveys will receive the average occupational mix adjustment for their labor market area. *“We believe this option would have the least impact on the wage index for other hospitals in the area and does not have the disadvantages of the other options . . .”* However, CMS will continue to evaluate different approaches for future years, including potentially penalizing non-responsive hospitals.

## **Occupational Mix Adjustment for FFY 2008**

*(Federal Register pages 48008 – 48009)*

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

CMS will allow hospitals an opportunity to revise both their first and second quarter 2006 occupational mix data for the FFY 2008 wage index. Further, CMS stated that it will notify hospitals early in the fall of 2006 regarding the revision/correction process for the FFY 2008 wage index for both the cost report wage data and the 2006 occupational mix survey data.

## **Hold Harmless—Urban Hospitals That Became Rural Under the New Labor Market Area Definitions**

([Federal Register pages 48005 – 48006](#))

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 “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. Applications for FFY 2008 geographic reclassifications were due to the MGCRB by September 1, 2006. Refer to the section “Reclassification Requests for FFY 2008” below for a complete discussion of this issue.

## **VII. WAGE INDEX RECLASSIFICATIONS**

As noted above in the section “Final FFY 2007 Wage Indexes,” CMS has implemented special rules for reclassification withdrawals and reclassification applications. CMS developed these special rules because the wage indexes published in the proposed rule were made obsolete by a U.S. Court of Appeals decision in *Bellevue Hospital Center v. Leavitt* that required CMS to implement the full occupational mix adjustment and a revised survey tool beginning October 1.

Described below are the special rules regarding reclassification withdrawals for FFY 2007 and reclassification applications for FFY 2008.

### **Revised FFY 2007 Withdrawal Procedure for All Reclassifications**

([Federal Register pages 48020 – 48022](#))

Standard CMS procedure allows hospitals that have been approved for reclassification to withdraw their applications within 45 days of the publication of the IPPS proposed rule. This allows hospitals to choose the most advantageous wage index or labor market area. However, the reclassification withdrawal process was halted because the wage indexes published in the FFY 2007 proposed rule were obsolete.

CMS has published the final occupational mix adjusted wage indexes, reclassification assignments, and out-migration adjustments at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage>. Due to this delay, CMS will apply the following procedures for hospital reclassification withdrawals:

- ✓ For FFY 2007, upon release of the final wage indexes, CMS will make reclassification withdrawal determinations based on what CMS perceives would be most advantageous to the hospital, providing the hospital with the highest possible wage index. These decisions will apply to all reclassifications including:
  - MGCRB reclassifications;
  - Section 508 reclassifications (special one-time reclassifications);
  - Section 505 (out-migration adjustment); and
  - “Lugar” status.
- ✓ CMS acknowledges that hospitals may base withdrawal decisions on factors other than what would result in the highest wage index. Therefore, CMS will allow a hospital 30 days from publication of the final wage index data to appeal CMS’ interim decisions. Requests to reverse a decision or to choose another

reclassification for which hospitals are eligible are due by 5 p.m. on October 30, 2006 and must be made in writing to both CMS and the MGCRB at:

Centers for Medicare and Medicaid Services -AND- Medicare Geographic Classification Review Board  
Division of Acute Care 2520 Lord Baltimore Drive, Suite L  
C4-08-06 Baltimore, MD 21244-2670  
7500 Security Boulevard  
Baltimore, MD 21244  
Attention: Marianne Myers

- ✓ If a hospital fails to notify CMS that it is revising a determination within the 30-day deadline, the interim decision made by CMS on the hospital's behalf will be final for FFY 2007.
- ✓ Normally, when CMS approves a reclassification or withdrawal, it recalculates wage indexes for all providers to ensure budget-neutrality. However, CMS will not recalculate the final FFY 2007 wage indexes or standardized amounts based on hospital decisions that further revise decisions made by CMS on the hospitals' behalf.

**WHA urges hospitals to carefully review CMS' reclassification withdrawal determinations based on what CMS perceives would be most advantageous to the hospital.**

## **Reclassification Requests for FFY 2008**

*(Federal Register pages 48022 – 48023)*

**Applications for FFY 2008 reclassifications are due to MGCRB by September 1.** Individual hospitals or groups of hospitals (defined by counties) that meet specific proximity and wage criteria can apply to MGCRB to reclassify for another area's wage index. However, because the final FFY 2007 wage index data was unavailable at the application time, the three-year average hourly wage data necessary to complete the wage criteria section of the reclassification application was not available. Therefore, CMS will apply the following rules for FFY 2008 reclassification requests:

- ✓ Hospitals must submit reclassification applications for FFY 2008 by September 1, 2006. In the final rule, CMS states that because the three-year average hourly wage of hospitals for the FFY 2007 final rule will not be available by the September 1, 2006 deadline for submitting FFY 2008 geographic reclassification applications, CMS will allow hospitals to supplement incomplete reclassification applications when the final wage data is published.
- ✓ After publication of the FFY 2007 final wage indexes, hospitals will have 30 days to supplement their reclassification application with average hourly wage information for the wage criteria tests.
- ✓ Applications and other information regarding MGCRB reclassifications are available on the CMS Web site at <http://www.cms.hhs.gov/mgcrb> or by calling the MGCRB at (410) 786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670.

Supplements must be received by October 30, 2006. The supplement should include the official data for Attachment H in the MGCRB application; the three-year average hourly wage information necessary for FFY 2008 reclassification applications appears in Tables 2, 3A, and 3B of the rule (available at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1488-N.pdf>). The information also is available on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp> - TopOfPage by accessing the file titled, *Three Year MGCRB Reclassification Data for FY 2008 Applications*.

## Section 508 Reclassification Expiration

(Federal Register pages 48024 – 48025)

**Background:** Section 508 reclassifications are legislative wage index reclassifications provided by the MMA allowing select hospitals to reclassify for another area's wage index if specific criteria are 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, the proposed rule 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.

**Reclassification Withdrawal:** As discussed above, CMS has implemented special rules for reclassification withdrawals for FFY 2007. Please see the section "Revised FFY 2007 Withdrawal Procedure for All Reclassifications," for a complete discussion of this issue and the special rules for FFY 2007.

Below is how CMS will base reclassification withdrawal determinations for Section 508 hospitals:

### 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:

CMS will make reclassification withdrawal determinations for Section 508 hospitals that are approved by the MGCRB for individual reclassification, attempting to provide the most beneficial wage index for both halves of FFY 2007.

For the first half of FFY 2007, CMS will provide Section 508 hospitals with individual MGCRB reclassifications the higher of the:

- home wage index;
- Section 508 wage index; or
- MGCRB reclassification.

For the second half of FFY 2007, CMS will provide Section 508 hospitals with individual MGCRB reclassifications the higher of the:

- home wage index; or
- MGCRB reclassification.

In no case could such a hospital receive its home wage index for the first half of the year and its MGCRB reclassification for the second half, or vice versa.

### Group MGCRB Reclassification:

CMS will make reclassification withdrawal determinations for Section 508 hospitals that are approved by the MGCRB for group reclassification by applying the decision that was made by the group on the MGCRB group application. In the application, the group either:

- withdrew from its MGCRB group reclassification for the first half of FFY 2007 and will only receive a second half FFY 2007 MGCRB group reclassification; or
- the group will receive the MGCRB group reclassification for the entire year and the Section 508 hospital withdraws from its Section 508 reclassification for the first half of the FFY 2007 unless

the group informs CMS differently after publication of the final occupational mix adjusted wage indexes.

Groups that include a Section 508 hospital will be able to make decisions as a group, separately for the first and second half of FFY 2007. Thus, the group may decide to withdraw its group reclassification that would be applicable only for the second half of FFY 2007.

In no case could a group whose Section 508 hospital chose to waive its 508 reclassification (and therefore accept the MGCRB group reclassification for the first half of FFY 2007) withdraw its MGCRB group reclassification for the first half of FFY 2007, but not the second (or vice versa).

#### 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.

**WHA urges hospitals to carefully review CMS' reclassification withdrawal determinations based on what CMS perceives would be most advantageous to the hospital.**

### **Lugar Reclassifications**

*(Federal Register pages 48023 – 48024)*

**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 Core-based Statistical Area (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:** As discussed above, CMS has implemented special rules for reclassification withdrawals for FFY 2007. Please see the section “Revised FFY 2007 Withdrawal Procedure for All Reclassifications,” for a complete discussion of this issue and the special rules for FFY 2007.

**WHA urges hospitals to carefully review CMS' reclassification withdrawal determinations based on what CMS perceives would be most advantageous to the hospital.**

### **Out-Migration Adjustment**

*(Federal Register page 48026)*

**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. As discussed above, CMS has implemented special rules for reclassification withdrawals for FFY 2007. Please see the section “Revised FFY 2007 Withdrawal Procedure for All Reclassifications,” for a complete discussion of this issue and the special rules for FFY 2007.

**WHA urges hospitals to carefully review CMS’ reclassification withdrawal determinations based on what CMS perceives would be most advantageous to the hospital.**

## **Other Hospital Reclassification Issues**

*(Federal Register pages 48067 – 48072)*

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

- **multi-campus hospital reclassifications**—eliminating the ability of an 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;
- **reclassifications for a single hospital MSA surrounded by rural counties**—addressing, but not adopting any of the identified concerns of an urban hospital’s ineligibility for reclassification to a higher wage index area (individual or county group) under the existing regulations; and
- **special adjustment for group reclassification denied on the basis of incomplete CSA listing**—adjusting the wage index of a hospital group that failed to reclassify based on incomplete the Office of Management and Budget (OMB) guidance for FFY 2007.

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

## **VIII. DRG RECALIBRATION AND CHANGES**

*(Federal Register pages 47879 – 47939)*

CMS will revise the calculation of DRG weights and add 20 new DRGs for FFY 2007. However, CMS has substantially modified its new weight calculation methodology from the original proposal and will phase in the revisions over a three-year transition period. As a result, the extreme losses that some hospitals would have experienced under the original CMS proposal will be significantly reduced.

The DRG changes are described in a subsequent section of this summary 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**

*(Federal Register pages 47882 – 47898)*

**Background:** Currently, CMS calculates the DRG weights by aggregating charges for all hospitals paid under the PPS and determining the average charge by DRG. An analysis by the Medicare Payment Advisory Commission (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.

**CMS Proposal:** CMS proposed an alternative to MedPAC’s approach that was 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.

WHA, the American Hospital Association, and other groups had recommended that CMS delay implementation of the revised weight calculations for one year, providing time for CMS to correct errors and methodological flaws and to allow for a thorough evaluation and validation of the proposed methodology.

**CMS Final Rule:** *“In order to reduce the bias in weights and make more appropriate payments under the IPPS, we believe it is necessary to initiate the transition to a cost-based relative weight methodology in FY 2007. However, we have considered the commenters’ requests to further review the HSRV methodology. Therefore, in this final rule, we are not adopting our proposal to standardize charges using the HSRV methodology. However, we are adopting our proposal to reduce charges to estimated costs prior to setting DRG weights. We will undertake further analysis of the HSRV methodology during the next year. Based on this analysis, we will consider proposing further changes to adopt the HSRV methodology for FY 2008.”*

The CMS final rule applies the same basic methodology currently used by CMS to calculate charge-based weights. However, the new methodology converts the charges to estimated costs by using national average cost-to-charge ratios and determines weights based on the estimated average cost for each DRG. National average CCRs were calculated for 13 cost centers. The original proposal calculated costs using ten centers. In the final rule, CMS responded to comments by expanding the number by creating separate cost centers for anesthesia, labor and delivery, and inhalation therapy. The cost centers and national average CCRs are shown below:

Cost Center	Cost to Charge Ratio
Routine Days	0.56
Intensive Days	0.50
Anesthesia	0.16
Cardiology	0.21
Drugs	0.21
Inhalation Therapy	0.20
Laboratory	0.19
Labor & Delivery	0.46
Operating Room	0.32
Other Services	0.38
Radiology	0.19
Supplies & Equipment	0.34
Therapy Services	0.44

In FFY 2007, CMS will begin a three-year transition period by blending 33% of the DRG weights calculated using the cost-based methodology and 67% calculated using the existing charge-based weight methodology. The revised weight calculation combined with the three-year transition period minimize the redistributive effects of the weight revisions in FFY 2007.

The revised weights have the same general effect as those in the proposed rule: on average, they increase the payments for medical cases and decrease the payments for surgical cases. However, the CMS final rule will greatly reduce the redistributive effects of the FFY 2007 weight revisions compared to the original proposal. CMS estimated that the proposed revisions would increase the average weight for medical DRGs by 7.3% and reduce the weights for surgical DRGs by 6.9%. CMS estimates that the final weights, after blending for transition, will increase the average medical DRG weight by 0.9% and decrease the average surgical DRG weight by 1.2%.

Over the next several months, CMS intends to conduct an analysis aimed at developing more accurate systems of cost-based weights that better reflect the relative costs of the services provided under the IPPS. The analysis will include further evaluation of the HSRV methodology. CMS states that it will “. . . *plan to fully involve appropriate stakeholders in future analysis of this issue to the extent feasible.*” CMS intends to describe its analysis and any potential proposed changes as part of the IPPS proposed rule for FFY 2008.

## Refinement of DRGs Based on Severity of Illness

*(Federal Register pages 47898 – 47914)*

**Background:** 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 the 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 one to four, with one indicating minor severity and four representing extreme severity of illness. The APR DRG system is comprised of 1,258 DRGs.

**CMS Final Rule:** *“The commenters have brought some important issues to our attention that we believe should be carefully considered before we adopt the CS DRGs. We will consider these issues if we were to make further modifications to the CS DRGs and propose adopting them for FY 2008. However, as we indicate elsewhere in this final rule, we have engaged a contractor to assist us with completing an evaluation of alternative DRG systems that may better recognize severity than the current CMS DRGs and meet other criteria that would make them suitable to adopt for purposes of payment under the IPPS. We expect to complete this evaluation of alternative DRG systems quickly this fall as part of moving forward on adopting a revised DRG system that better recognizes severity in the IPPS rulemaking for FY 2008. It is possible that some of the alternatives that we evaluate for better recognizing severity in the DRGs will be based on the current CMS DRGs.”*

In FFY 2007, CMS will take what it considers an interim step toward refined DRGs by creating 20 new DRGs and by modifying 32 other DRGs to improve recognition of severity within the existing DRG system. The new DRGs are shown below:

DRG	DRG Description
560	Bacterial & Tuberculosis Infections of Nervous System
561	Non-Bacterial Infections of Nervous System Except Viral Meningitis
562	Seizure Age > 17 with CC
563	Seizure Age > 17 without CC
564	Headaches Age >17
565	Respiratory System Diagnosis with Ventilator Support 96+ Hours
566	Respiratory System Diagnosis with Ventilator Support < 96 Hours
567	Stomach, Esophageal & Duodenal Procedures Age > 17 with Complication/Comorbidity with Major Gastrointestinal Diagnosis
568	Stomach, Esophageal & Duodenal Procedures Age > 17 with Complication/Comorbidity without Major Gastrointestinal Diagnosis
569	Major Small & Large Bowel Procedures with CC with Major Gastrointestinal Diagnosis
570	Major Small & Large Bowel Procedures with CC without Major Gastrointestinal Diagnosis
571	Major Esophageal Disorders
572	Major Gastrointestinal Disorders and Peritoneal Infections
573	Major Bladder Procedures
574	Major Hematologic/Immunologic Diagnoses Except Sickle Cell Crisis and Coagulation Disorders
575	Septicemia with Mechanical Ventilation 96 + Hours Age >17
576	Septicemia without Mechanical Ventilation 96 + Hours Age >17
577	Carotid Artery Stent Procedure
578	Infectious and Parasitic Diseases with O.R. Procedure
579	Postoperative or Post-traumatic Infection with O.R. Procedure

CMS indicates that it plans to look at several alternatives for DRG changes in FFY 2008. In the final rule CMS states: *“As suggested by the commenters, much research has already been completed on alternative DRG systems. We believe it is likely that at least one of these systems (or potentially a system that we develop ourselves based on our own prior research) will be suitable to achieve our goal of improvements in payment accuracy by FY 2008. We are currently in the process of engaging a research contractor to evaluate the 3M Severity of Illness DRG products along with the other DRG severity systems that have come to our attention during the comment process.”*

## IX. RURAL HOSPITALS

### Medicare Dependent Hospitals

*(Federal Register pages 48062 – 48063)*

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 final rule addresses a number of MDH payment methodology enhancements provided by the DRA. Those 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%; and
- exemption from the 12% DSH adjustment limit that applies to rural hospitals.

### Volume Decrease Adjustment for SCHs and MDHs

*(Federal Register pages 48056 – 48060)*

**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 an 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, fiscal intermediaries (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 in 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.”*

**CMS Final Rule:** *“After consideration of the public comments received, we are finalizing a policy to allow SCHs and MDHs the option of using the results of (1) the occupational mix survey, (2) the AHA Annual survey, or (3) the HAS/Monitrend Databook for purposes of determining the amount of the volume decrease adjustment for any open adjustment requests.”*

*“Beginning with adjustment requests for decreases in discharges occurring beginning with 2007, the amount of the volume decrease adjustment will be based on either the AHA Annual Survey or the occupational mix survey results. Therefore a SCH or MDH that has experienced a decrease in discharges in 2007 as compared to 2006*

*will no longer be permitted to use the HAS/Monitrend Databook results to calculate the amount of the volume decrease adjustment.”*

The former and final methodologies used to determine the volume decrease adjustment are discussed in detail in the final rule on the *Federal Register* pages referenced in the heading above.

## **SCH/MDH Changes in Qualification Status**

*(Federal Register pages 48060 – 48062)*

**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 an 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).”*

**CMS Final Rule:** *“After consideration of the public comments received, we are finalizing a change to the regulations to specify that SCHs and MDHs will be required to report to the fiscal intermediary specific changes it becomes aware of that would affect the criteria under which it was eligible for such designation.”*

*“For an SCH, the changes are as follows: distance between it and another like hospital, its geographic classification status (urban/rural), the number of beds if the SCH was eligible under §412.92(a)(1)(ii), and the travel time between itself and a like-provider.”*

*“An MDH will be required to report if there is a change to the number of beds in the facility that increase the bed count to more than 100 and/or if its geographic classification changed from rural to urban.”*

## **Rural Referral Centers**

*(Federal Register pages 48063 – 48065)*

**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; and
  - 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, at least 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 final rule for purposes of determining rural referral center status.

**CMS Final Rule:** *“Based on the latest data available (FY 2005 bills received through March 2006), 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—*

- 1.3132; or
- *The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in §412.105(f)) calculated by CMS for the census region in which the hospital is located.”*

The finalized median CMI values by region are:

Region	Case-Mix Index Value
New England (CT, ME, MA, NH, RI, VT)	1.2313
Middle Atlantic (PA, NJ, NY)	1.2619
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3252
East North Central (IL, IN, MI, OH, WI)	1.3118
East South Central (AL, KY, MS, TN)	1.2926
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2344
West South Central (AR, LA, OK, TX)	1.3872
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3877
Pacific (AK, CA, HI, OR, WA)	1.3366

*“. . . 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:*

Region	Discharges
New England (CT, ME, MA, NH, RI, VT)	7,366
Middle Atlantic (PA, NJ, NY)	10,307
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,546
East North Central (IL, IN, MI, OH, WI)	9,200
East South Central (AL, KY, MS, TN)	7,519
West North Central (IA, KS, MN, MO, NE, ND, SD)	7,441
West South Central (AR, LA, OK, TX)	7,239
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	10,419
Pacific (AK, CA, HI, OR, WA)	7,965

*“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.”*

The final rule also clarifies that the cost reporting period to be used to determine the number of discharges of a hospital applying for initial rural referral center status will be the same as the cost reporting period used to develop the regional medians. Therefore, for FFY 2007, because CMS uses the FFY 2003 data for developing the regional medians, CMS will also use these data for determining the hospital’s own discharges.

## **X. Additional Payments for New Technology**

*(Federal Register pages 47994 – 48005)*

**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 Final Rule:** CMS will continue reimbursement for two technologies that are currently eligible for new technology add-on payments. One technology currently eligible for new technology payment has been discontinued. In addition, one of the three technologies under review during the proposed rule is approved for add-on payment in FFY 2007.

Add-On Continued for FFY 2007:	Endovascular Graft Repair of the Thoracic Aorta
	Restore® Rechargeable Implantable Neurostimulator
Add-On Discontinued for FFY 2007:	Kinetra® Implantable Neurostimulator for Deep Brain Stimulation
Newly Approved for FFY 2007:	X STOP Interspinous Process Decompression System
Denied for FFY 2007:	C-Port® Distal Anastomosis System
Withdrew Application:	NovoSeven® for Intracerebral Hemorrhage

## XI. Graduate Medical Education

### Indirect Medical Education Adjustment

*(Federal Register pages 48065 – 48066)*

**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 Final Rule:** The mandated formula multiplier for FFY 2007 is 1.32 and will result in an increase of 5.35% in IME payment for every approximately 10% increase in the resident-to-bed ratio.

### Direct Medical Education

*(Federal Register pages 48072 – 48094)*

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

*(Federal Register pages 48073 – 48076)*

**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 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.”*

**CMS Final Rule:** *“Although we initially proposed to determine a single PRA for the merged hospital, after considering this comment, we are convinced that it is appropriate to determine two PRAs for a merged teaching hospital.”*

*“Although we do not believe the determination of a single PRA for a merged hospital would necessarily result in “inaccurate reimbursement,” we do recognize the commenter’s point that the application of a single PRA for a merged hospital would be inconsistent with the application of two PRAs for most other teaching hospitals (typically, a lower one for residents in nonprimary care specialties), and could produce some unintended incentives.”*

*“Specifically, we recognize that the two PRAs have the continuing effect of discouraging shifts from primary care and obstetrics and gynecology programs to nonprimary care programs. Therefore, we are revising the steps for calculating the weighted average PRAs for a merged teaching hospital.”*

The details of the proposed and finalized rules for calculating the weighted average PRA for a merged teaching hospital are discussed in detail on the *Federal Register* pages referenced in the heading above.

## **Determination of PRAs for New Teaching Hospitals**

*(Federal Register pages 48076 – 48077)*

**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.”*

**CMS Final Rule:** CMS has adopted the above proposal as final with no revisions.

## Requirements for Counting and Appropriate Documentation of FTE Residents

*(Federal Register pages 48077 – 48080)*

The final rule reiterates CMS' clarifications to the current policy for proper documentation of FTEs. In the proposed rule, CMS stated 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, as well as CMS' responses to comments raised during the comment period are addressed in detail on the *Federal Register* pages referenced in the heading above.

## Resident Time Spent in Non-Patient Care Activities

*(Federal Register pages 48080 – 48094)*

**Background:** In the proposed rule, CMS did not propose to expand or change the current policy for FTE resident counts relating to non-patient care. CMS has stated, “*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.*”

**CMS Final Rule:** “. . . *we are finalizing the clarification of our policy that only time spent in patient care activities may be counted for IME purposes in the hospital complex and for direct GME and IME purposes in nonhospital sites.*”

“*We are amending §413.75(b) to add a definition of the term “patient care activities” which means, “the care and treatment of particular patients, including services for which a physician or other practitioner may bill.” In addition, we are amending the IME regulations at §412.105(f)(1)(iii) to add a paragraph (C) to state that “In order to be counted, a resident must be spending time in patient care activities, as defined in §413.75(b).” We are also making conforming changes to the regulations text at §412.105(f)(1)(iii)(C), and §413.78(c)(1), (d)(1), and (e)(1) for residency training in nonhospital settings.*”

“*Lastly for cost reporting periods beginning on or after October 1, 2006, we are implementing a “one workday” approach to documentation of residents' time, where, if a resident's workday consists entirely of scheduled nonpatient care activities, that workday must be identified as nonpatient care time and must be subtracted from the allowable FTE count (for IME, if the training occurred in the hospital complex, and for both IME and direct GME, if the training occurred in a nonhospital site).*”

The finalized “one workday” approach to document resident time in non-patient care activities provides an improvement from the proposed rule. The clarification from the proposed rule would have required the documentation and exclusion of any time linked to non-patient care activities from the allowable FTE count (for IME if the training occurred within the hospital complex, and for both IME and direct GME if the training occurred in a non-hospital site).

## XII. OTHER

## Grandfathering of Hospitals-Within-Hospitals and Satellite Facilities

*(Federal Register pages 48106 – 48115)*

**Background:** Hospitals-within-hospitals (HwHs) are defined as hospitals that occupy 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 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.”

**CMS Final Rule:** “. . . in this final rule, for cost reporting periods beginning on or after October 1, 2006, we are revising the regulations in §§412.22(f)(3)(applicable to HwHs), 412.22(h)(4) (applicable to satellites of IPPS-excluded hospitals), and 412.25(e)(4) (applicable to satellites of IPPS-excluded units) to allow these facilities to increase or decrease the square footage of the facility or to decrease the number of beds in the facility without affecting the facility’s grandfathered status.”

“Under the final rule, such changes could be undertaken for any reason and would not be limited to situations involving changes in Federal, State, or local laws or catastrophic events. Such changes also would not be limited to cases in which a facility must be relocated.”

“. . . we continue to believe that an increase in the number of beds, which could have a much more significant impact on the level of payments to the facility under the Medicare programs, is a change to the facility that should be a basis for terminating its grandfathered status.”

## Proxy for the Hospital Marketbasket

*(Federal Register page 48029)*

**Background:** 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 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; and
- 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. CMS sought comment on the continued use of the BLS ECI data in light of the BLS change to the NAICS-based ECI.

**CMS Final Rule:** *“As the SIC-based ECIs no longer exist, we will therefore adopt the proposed policy of using the BLS NAICS-based ECIs to replace the SIC-based ECIs as price proxies in the market basket.”*

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

*(Federal Register pages 48094 – 48095)*

**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.”*

**CMS Final Rule:** CMS has adopted the above proposal as final with no revisions.

## **Payment for Blood Clotting Factor Administered to Hemophilia Inpatients**

*(Federal Register page 48165)*

**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 Final Rule:** *“In . . . this final rule, we are providing that 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.”*

## **XIII. CONTINUED DEVELOPMENT OF QUALITY AND “PAY-FOR-PERFORMANCE” INITIATIVES**

### **Value-Based Purchasing**

*(Federal Register pages 48045 – 48051)*

**Background:** The DRA requires CMS to develop a plan to implement hospital value-based purchasing beginning FFY 2009. CMS’ and Congress’ initial steps toward hospital value-based purchasing include the Premier Hospital Quality Incentive Demonstration and the RHQDAPU program (discussed in detail above). In the proposed rule, CMS sought comment on the implementation of hospital value-based purchasing.

**CMS Final Rule:** By law, CMS must implement a value-based purchasing program by FFY 2009. CMS noted in the final rule that this was the first opportunity for the public to be involved in this planning process and that CMS will host public listening sessions in 2007 to receive public input on drafts of the plan. CMS encourages participation in these listening sessions as it prepares its value-based purchasing program plan as required by the DRA.

The final rule mainly addresses comments provided on the topics of measure development and refinement, data infrastructure, incentive methodology, and public reporting and their relation to value-based purchasing. CMS stated that it will “. . . use the comments provided on this topic to “. . . inform our design of the plan for Medicare hospital value-based purchasing . . . ”

The final rule reiterates CMS’ position on funding for value-based purchasing incentives, stating that CMS does not “. . . believe that providing additional aggregate funding to finance performance-based incentives is either supportable or necessary.”

A complete discussion of the comments, responses, and CMS’ current and future steps toward value-based purchasing can be found on the *Federal Register* pages referenced in the heading above.

### **Hospital-Acquired Infections**

*(Federal Register pages 48051 – 48053)*

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

The DRA requires CMS:

- to identify, by October 1, 2007, at least two preventable hospital acquired infections conditions;
- require hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007; and
- for discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected preventable hospital-acquired infection conditions was not present on admission; that is, the case would be paid as though the secondary diagnosis was not present.

In the proposed rule, CMS sought comment on which conditions and which evidence-based guidelines should be selected.

**CMS Final Rule:** The final rule addresses comments received by CMS, and CMS stated that it will “. . . carefully consider their views as we move toward implementing this section. CMS will be working closely with our colleagues at the Centers for Disease Control and Prevention over the coming months to select appropriate conditions to propose for implementation. We anticipate that the next opportunity for formal public comment will be the FY 2008 IPPS proposed rule-making . . .”

A complete discussion of the comments and responses regarding hospital-acquired infections can be found on the *Federal Register* pages referenced in the heading above.

## **Health Information Technology**

*(Federal Register pages 48053 – 48055)*

**Background:** In the proposed rule, CMS discussed 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 sought comments on HIT adoption and the promotion of the use of effective HIT through hospital conditions of participation.

**CMS Final Rule:** “. . . we are not adopting at this time our proposal to require adoption of certified, interoperable HIT as a Medicare CoP. Rather, we are reserving judgment on the imposition of such a requirement and will continue to research the feasibility of doing so. We may revisit this issue in the FY 2008 IPPS proposed rule or in another rulemaking proceeding.”

The final rule reiterates CMS’ position on direct government funding for HIT, restating the Bush Administration’s position as stated in the President’s 2007 Budget, “. . . the Administration supports the adoption of [HIT] as a normal cost of doing business to ensure patients receive high quality care.”

Additionally, based on comments submitted, the final rule addresses three main topic areas in promoting the effective use of HIT including value-based purchasing, the e-prescribing rule, and infrastructure and interoperability standards.

A complete discussion of the comments and responses regarding HIT can be found on the *Federal Register* pages referenced in the heading above.

## **Health Care Information Transparency Initiative**

*(Federal Register pages 48100 – 48103)*

**Background:** Concerned that health care costs are growing at an unsustainable rate, CMS sought comments on ways to encourage transparency in health care quality and pricing, whether through CMS’ leadership on voluntary initiatives or through regulatory requirements. CMS also sought comments 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, CMS believes providers of care are not subject to the competitive pressures that exist in other markets for offering quality services at the best possible price.

In the proposed rule, CMS sought 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.

**CMS Final Rule:** The final rule does not adopt any of the price transparency initiatives identified in the proposed rule. The final rule simply addresses the transparency issue by responding to comments from the field that focused on the following concepts:

- features of transparency;
- types of pricing information;
- leadership/stakeholder participation;
- Medicare conditions of participation;
- limited effectiveness of transparency efforts to address uninsured and safety net providers;
- physician-identifiable Medicare claims data;
- concerns regarding the June 1, 2006 posting of payment information on the 30 common elective procedures by DRG; and
- the link between value-based purchasing and making the health care system more transparent.

A complete discussion of the comments and responses regarding the health care information transparency initiative can be found on the *Federal Register* pages referenced in the heading above.

## **Electronic Medical Records**

*(Federal Register page 48045)*

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 EMRs directly to CMS. In the FFY 2007 proposed rule, CMS encouraged 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. In the proposed rule, CMS once again sought comments on the requirements and options for EMRs.

In the final rule, CMS considered public comments and stated that it will continue to pursue the adoption of EMRs for the reporting of hospital quality data, taking all comments submitted under consideration as it moves forward. Comments published in the final rule focused on cost implications, implementation timeframe, CMS' statutory authority, and the CMS' development of partnerships with affected parties to ensure successful development.