



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE FINAL
FFY 2008 MEDICARE
HOSPITAL INPATIENT RULE**

August 2007

TABLE OF CONTENTS

I.	Overview	1
II.	Legislative Mandates	1
III.	Standardized Amounts	1
	-Marketbasket Update	1
	-Offset for Coding Improvements	1
	-Operating and Capital Rates	2
IV.	DRG Reclassifications and Relative Weights.....	3
	-DRG Reclassifications	3
	-Relative Weights.....	5
V.	Reporting of Hospital Quality Data.....	6
	-Reporting Requirements to Receive the Full Marketbasket Update	6
	-FFY 2008 Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program.....	6
	-FFY 2009 (and Beyond) RHQDAPU Program	9
	-Reporting Hospital-Acquired Conditions—Including Infections	10
VI.	Capital Payments	12
	-Capital Update Rate—FFY 2008 and FFY 2009	12
	-Capital Large Urban Add-On.....	12
	-Capital IME Elimination.....	13
VII.	Wage Index	13
	-Hold Harmless—Urban Hospitals That Became Rural Under the New Labor Market Area Definitions	13
	-Occupational Mix Adjustment	14
	-Application of Rural Floor Budget Neutrality	14
	-Imputed Rural Floor Adjustment	15
	-Worksheet S-3 Wage Data—Contract Labor for Indirect Patient Care Services.....	15
	-Multi-campus Hospital	16
	-Critical Access Hospital (CAH) Conversion to IPPS	16
VIII.	Wage Index Reclassifications	16
	-MGCRB Reclassifications	16
	-Out-Migration Adjustment.....	17
	-Section 508 Reclassifications	17
	-Other Hospital Reclassification Issues.....	18
IX.	Cost Outliers.....	18
X.	Graduate Medical Education	19
	-Indirect Medical Education Adjustment	19
	-Resident Time Spent in Non-Patient Care Activities.....	19
XI.	Additional Payments for New Technology.....	20
XII.	Rural Hospitals.....	21
	-Rural Referral Centers (RRCs)	21
	-Disproportionate Share Hospitals (DSH) Cap	21
XIII.	Other Issues	22
	-Value-Based Purchasing Plan for FFY 2009	22
	-Devices Replaced at No Cost or with Credit to Hospital.....	22
	-Hospital Emergency Services Under EMTALA	24
	-Emergency Room Disclosure	24
	-Disclosure of Physician Ownership in Hospitals	25

I. OVERVIEW

CMS published the final Medicare Inpatient Prospective Payment System (IPPS) rule for federal fiscal year (FFY) 2008 in the August 22, 2007 *Federal Register*. Changes are effective October 1, 2007, unless otherwise noted.

Note: Text in italics is extracted from the May 8, 2007 and August 22, 2007 *Federal Registers*.

II. LEGISLATIVE MANDATES

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 focused on the continued development of pay-for-performance and other initiatives. Where appropriate, both acts are referenced in the text below.

In addition, The Children's Health and Medicare Protection Act (CHAMP Act) of 2007, which has been passed by the U.S. House of Representatives, includes several Medicare provisions that would affect FFY 2008 Medicare payment policies. It is uncertain whether these proposals will be included in any final legislative package that must ultimately pass both chambers and be signed by the President. Relevant provisions are noted in the summary.

III. STANDARDIZED AMOUNTS

Marketbasket Update

Federal Register pages 47414 - 47415

Consistent with current law, based on the Office of the Actuary's second quarter 2007 forecast of the FFY 2008 marketbasket increase, the Centers for Medicare and Medicaid Services (CMS) update to the standardized amount will be 3.3% 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. Non-compliant hospitals will receive a 2% reduction to their update factor.

Although the final rule provides a full marketbasket update of 3.3% for FFY 2008, CMS will implement a 1.2% "behavioral offset" reduction to the standardized amount for FFY 2008 and a 1.8% behavioral offset reduction for both FFY 2009 and FFY 2010. See the "Behavioral Offset" section below for a complete discussion of this issue.

Even though CMS in the final rule provided a full marketbasket update for FFY 2008, the CHAMP Act of 2007 would reduce the IPPS marketbasket update by 0.25% for the period January 1, 2008 through September 30, 2008. It is uncertain whether this proposal will be included in any final legislative package that must ultimately pass both chambers and be signed by the President.

Offset for Coding Improvements

Federal Register pages 47175 - 47186

Background: The Benefits Improvement and Protection Act (BIPA) of 2000 gives CMS the authority to adjust the standardized amount to eliminate the effect of changes in coding or classification of discharges that do not

reflect real changes in case mix.

CMS is concerned that the proposed Medicare Severity-Diagnosis Related Groups (MS-DRGs) (see “DRG Reclassifications and Relative Weights” section below) will provide opportunities for hospitals to document and code information contained in the medical record in a way that may result in higher payments under the IPPS.

CMS Proposal: *“We believe that adoption of the MS-DRGs proposed in this proposed rule would create a risk of increased aggregate levels of payment as a result of increased documentation and coding . . . we are proposing to reduce the IPPS standardized amounts by 2.4 percent each year for FY 2008 and FY 2009.”*

The proposed 4.8% behavioral offset reduction (to be applied over two years at 2.4% per year) was based on an analysis of the experience in Maryland after adopting the All Patient Refined (APR) DRG system. CMS believes that the similarity between coding incentives under the APR DRGs in Maryland and the proposed MS-DRGs provides a basis to impose an adjustment for anticipated improvements in documentation and coding. The Maryland analysis in the proposed rule showed that hospitals improved coding and documentation in response to the adoption of APR DRGs. Subsequently, the reported case-mix index (CMI) increased at a greater rate than real CMI.

CMS Final Rule: *“We proposed to adjust the IPPS standardized amounts by -2.4 percent each year for FYs 2008 and 2009 for improvements in documentation and coding that will increase case-mix. As we are adopting the MS-DRGs over a 2-year transition period, we do not believe that the incentives to improve documentation and coding will be as strong in the first year as we previously estimated. Further . . . it can take several years for hospitals and physicians to adjust their documentation and coding practices in response to payment incentives. For these reasons, we believe the documentation and coding adjustment should be applied over a period of 3 rather than 2 years . . . We continue to believe that our analysis justifies a -4.8 percent adjustment for improvements in documentation and coding at this time. Therefore, we are applying an adjustment of -1.2 percent in this final rule with comment period to the IPPS standardized amounts for FY 2008 and based on current projections will apply adjustments of -1.8 percent each year to the IPPS standardized amounts for FYs 2009 and 2010.”*

“Consistent with the statute, we will compare the actual increase in case-mix due to documentation and coding to our projection once we have actual data to revise the Actuary’s estimate and the adjustment we make to the standardized amounts. With these adjustments occurring over 3 rather than 2 years, we will have information in 2009 as we prepare the IPPS rule for FY 2010 to reevaluate how the actual increase in case mix compares to our estimate. We may also have partial year information in 2008 to inform any proposal for FY 2009. Therefore, we will consider revising the planned adjustments for FY 2009 and FY 2010 if information in the Medicare billing data suggests that our projections are either too high or low compared to actual experience.”

Numerous comments on proposed rule held that the 4.8% reduction was based on a flawed analysis that overstated the potential impact of coding improvement. WHA and other industry groups stated that CMS should not implement a behavioral offset for anticipated case mix changes, and should instead wait until actual coding changes could be evaluated based on submitted claims data. The CMS final decision rejects this recommendation but could provide an opportunity to decrease the planned cuts in future years if the anticipated 4.8% increase in case mix due to coding improvements proves to be wrong.

Operating and Capital Rates

Federal Register pages 47420 - 47422

For FFY 2008, hospitals whose wage index is greater than 1.0 will continue to use a labor share of 69.7% and hospitals with a wage index less than or equal to 1.0 will receive a labor share of 62.0%. Standard amounts are shown in the following table for facilities receiving the full update and those receiving a reduced update due to

failure to submit quality data.

CMS Proposal: CMS proposed two separate updates to the capital federal rates for both FFYs 2008 and 2009. For FFY 2008, CMS had proposed a full capital update of 0.8% for rural hospitals and no capital update for urban hospitals.

CMS Final Rule: “. . .we are not finalizing the proposed zero percent update for urban hospitals, which would have resulted in separate capital Federal rates for FY 2008 rural and urban hospitals. Therefore, we are establishing an update of 0.9 percent in determining the FY 2008 capital Federal rate for all hospitals.” See the “Capital Payments” section below for a complete discussion of this topic area.

These changes are reflected in the following table:

Standard¹ for Hospitals with a Wage Index Greater Than (69.7 Percent Labor Share and 30.3 Percent Non-Labor Share)			
		Labor-	Non-Labor-
Full Update (3.3		\$3,459.66	\$1,503.98
Reduced Update (1.3	²	\$3,392.68	\$1,474.86

Standard¹ for Hospitals with a Wage Index Less Than or Equal to (62.0 Percent Labor Share and 38.0 Percent Non-Labor Share)			
		Labor-	Non-Labor-
Full Update (3.3		\$3,077.46	\$1,886.18
Reduced Update (1.3	²	\$3,017.87	\$1,849.67

Capital Federal¹	
National Capital	\$423.34

Note 1: The rates shown in the tables above (both operating and capital) reflect the 1.2% reduction for the proposed “behavioral

Note 2: The reduced update is applicable to hospitals that are not in compliance, or have withdrawn from the 2008 quality reporting

IV. DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

DRG Classifications

Federal Register pages 47141 - 47188

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 current CMS DRGs are derived based upon the principal diagnosis (25 Major Diagnostic Categories or MDCs), up to eight additional diagnoses, up to six procedures performed during the stay, and in some cases, other patient characteristics. There are 538 possible assignments under the 2007 CMS DRGs.

In its March 2005 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that CMS refine the entire DRG system to take into account severity of illness. In the FFY 2007 rule, CMS created 20 new DRGs and modified 32 other DRGs as a first step toward the recommended DRG refinement.

In addition, CMS contracted with RAND Health to analyze alternative systems that could classify discharges into severity-adjusted DRGs. RAND is currently evaluating the following severity-adjusted DRG systems:

- CMS DRGs modified for All Patient (AP)-DRG Logic (CMS+AP-DRGs)
- Consolidated Severity-Adjusted DRGs (CS DRGs)
- Refined Health Systems Consultants DRGs (HSC-DRGs)
- All-Patient Severity DRGs with Medicare Modifications (MM-APS-DRGs)
- Solucient Refined DRGs (Sol-DRGs)

RAND issued an interim report in March 2007 with preliminary findings and is expected to complete its evaluation of the alternative DRG systems by September 1, 2007. The interim report can be accessed at the CMS Web site at <http://www.cms.hhs.gov/Reports/downloads/Wynn0307.pdf>.

CMS Proposal: “. . . we are proposing to adopt MS-DRGs beginning with FY 2008. The MS-DRGs are the result of modifications to the CMS DRGs to better account for severity. While we are proposing to implement the MS-DRGs on October 1, 2007, we believe that the MS-DRGs should be evaluated by RAND. We have instructed RAND to evaluate the proposed MS-DRGs using the same criteria that it is applying to the other DRG systems.”

CMS Final Rule: “. . . we believe it is appropriate at this time to adopt the MS-DRG system for Medicare in FY 2008. We believe the MS-DRGs represent an improvement over the current CMS DRGs. While there will be an opportunity for the public to comment on RAND’s findings, we expect to permanently adopt the MS-DRGs for the IPPS. . . . Changes in payments from MS-DRGs will be mitigated in any single year by adopting them over a 2-year transition period.”

The MS-DRGs will increase the number of DRGs from 538 to 745. The current CMS DRGs include 115 DRGs that split based upon the presence or absence of a complication or comorbidity (CC). CCs are conditions that require increased resource use and, therefore, receive higher payment. The MS-DRGs retain the basic logic of the current system, but add an additional severity level by designating certain diagnoses as major CCs, which would have the highest weight. As a result, the proposed MS-DRGs include 152 DRGs that divide into three subgroups: Major CC, CC, and non-CC and another 106 DRGs that divide into two severity-level subgroups. According to CMS’ analysis, this provides a more accurate match between cost and payments and will increase average payments to urban hospitals and to teaching hospitals that tend to treat more severely ill patients. The MS-DRGs also reflect a complete renumbering of the DRG codes.

Industry comments responding to the proposed rule urged a four-year transition to mitigate the impact on hospitals that will see significant revenue decreases under the MS-DRGs, and to provide time for hospitals to adapt to the new system. In response, CMS will provide a two-year phase-in through the calculation of the relative weights. For FFY 2008, the 50% of the relative weight for each MS-DRG will be based on the relative weight calculated using the current DRG and 50% will be based on the MS-DRG relative weight. In FFY 2009, the relative weights will be based entirely on the MS-DRG relative weight. The calculation of the blended weights is described in the “Relative Weights” section of this summary.

The final RAND report on alternative DRG systems is due in September. However, CMS asked RAND to

compare the MS-DRGs to the other alternatives for the final rule. RAND found that the MS-DRGs are better than the current DRGs at explaining variations in costs, but have lower explanatory power than other systems analyzed. However, CMS believes that the MS-DRGs have other advantages that make it the optimal choice for implementation. While the other alternatives would entirely replace the current DRG methodology, the MS-DRGs begin with the CMS DRGs and modify them to better account for severity; and unlike the other systems, the MS-DRGs are available in the public domain. As a result, CMS believes that system implementation problems and costs will be minimized.

In the proposed rule, CMS indicated that the RAND report could still influence future changes in the Medicare DRGs and did not preclude implementation of the MS-DRGs in FFY 2008 followed by an entirely different DRG system in FFY 2009. In the final rule, CMS responded to comments by withdrawing this scenario, stating that it will “permanently adopt” the MS-DRGs. WHA had commented that hospitals and intermediaries should not be subjected to the burdens, expenses, and disruptions that would be result from multiple major revisions of the Medicare DRG system.

During the analysis and development of the MS-DRGs, CMS reviewed the list of secondary diagnoses that are designated as CCs for DRG assignment. That review led to a complete reconfiguration of the list of CC codes for use with the MS-DRGs; removing 423 codes from the list of CCs, adding others, and designating some codes as major CCs. There are 3,326 codes on the CC list for the current FFY 2007 Medicare DRGs. The FFY 2008 MS-DRGs will have 3,343 codes that count as CCs and another 1,584 codes designated as major CCs.

The 423 codes that were deleted from the CC list for FFY 2008 include several diagnoses that could have a major impact on payments. The FFY 2007 Medicare DRGs include many non-specific and chronic condition diagnoses on the CC list. Under the MS-DRGs, non-specific codes are not classified as CCs or major CCs if more specific codes are available that provide more information about patient severity of illness. In addition, codes for chronic diseases without a significant acute manifestation will not count as either CCs or major CCs. The non-specific and chronic condition codes comprise a material portion of the cases assigned to DRGs with CCs in FFY 2007. The new CMS policy will require that hospitals review current coding and documentation practices to ensure that appropriate reimbursement is received under the MS-DRGs.

Relative Weights

Federal Register pages 47188 - 47200

Background: Before FFY 2007, CMS calculated the DRG weights by aggregating charges for all PPS hospitals and determining an average charge by DRG. In its March 2005 report to Congress, MedPAC concluded that differential charge markups cause a bias in the charge-based DRG weights. MedPAC recommended that DRG weights be based on average costs rather than average charges. CMS implemented a cost-based relative weight methodology in the FFY 2007 rule, to be phased in over three years. For the first year of the transition, DRG weights were calculated based on a blend of 33% cost-based and 67% charge-based. The methodology that CMS adopted for calculating cost-based weights converts charges to costs using national average cost-to-charge ratios (CCRs) for 13 cost centers.

The change from a charge-based DRG weight calculation to a cost-based methodology increased reimbursement for less complex cases and for medical cases, which tended to benefit smaller hospitals and rural hospitals.

CMS Proposal: “ . . . we are proposing to continue the 3-year transition from charge-based to cost-based relative weights. The proposed relative weights for FY 2008 will be 2/3 cost-based and 1/3 charge-based ”

CMS did not change the proposed continuation of the transition to cost-based weights in the final rule. However, this transition is now combined with a transition to the MS-DRGs through modification of the relative weights.

CMS Final Rule: “Although we received strong general support for adopting the MS-DRGs, we do believe that

some transition is warranted to mitigate the magnitude of potential changes in payment to hospitals that could occur in one year. Furthermore, we agree with MedPAC that a two-year transition period that coincides with the remainder of the transition period for implementing cost-based weights is appropriate. By having these changes occur simultaneously over the same transition period, we can avoid having large changes in payment that would occur with sequential implementation. Further, we can also accomplish all of the payment reforms according to the same schedule. Accordingly, we are implementing a 2-year transition to MS-DRGs. For FY 2008, the first year of the transition, 50 percent of the relative weight for each MS-DRG will be based on the CMS DRG relative weight and 50 percent will be based on the MS-DRG relative weight. In FY 2009, the relative weights will be based entirely on the MS-DRG relative weight.”

The blended relative weights for FFY 2008 are computed by combining four sets of weights. Both cost-based and charge-based weights were calculated using the Version 24.0 GROUPER (the DRGs in effect for FFY 2007). These were then combined using two-thirds of the cost-based weights and one-third of the charge-based weights. Similarly, cost-based and charged-based weights were calculated using the Version 25.0 GROUPER (MS-DRGs) and also blended using two-thirds of the cost-based weights and one-third charge-based weights. Finally, the blended Version 24 and Version 25 weights were combined using a 50/50 blend. This was done by grouping all cases to the Version 24 DRG and assigning the Version 24 relative weight to each case. Cases were then assigned to the Version 25 DRG and the average Version 24 relative weight was calculated for each Version 25 DRG. 50% of this weight was then combined with 50% of the Version 25 weight for each DRG.

CMS is still considering changes to the weight calculations for future years. A report by RTI International suggested a regression-based adjustment as a temporary or permanent method for disaggregating the Medical Supplies, Drugs, and Radiology cost centers which CMS is evaluating. CMS has also solicited recommendations on methods for making an adjustment for differences in nursing intensity across DRGs that are not reflected by the current weight calculations. In addition, RAND is analyzing the hospital-specific relative value cost center (HSRVcc) costing methodology, which was originally proposed for FFY 2007 and withdrawn by CMS in the FFY 2007 final rule.

V. REPORTING OF HOSPITAL QUALITY DATA

Reporting Requirements to Receive the Full Marketbasket Update

Federal Register pages 47345 - 47367

Background: The MMA required hospitals to begin submitting data on quality measures to CMS. This provision applied for three years (FFYs 2005-2007). Participating hospitals were required to submit data on a set of ten quality measures and their data must meet certain validation requirements. Hospitals that withdrew from the program or failed to submit valid data received the marketbasket increase minus 0.4% for FFYs 2005 and 2006.

The DRA extended and expanded this program, giving CMS greater authority. In the FFY 2007 IPPS rule, the penalty for withdrawal from the program or failure to comply with its requirements was increased to 2.0%; some procedural changes were affected; and the set of quality measures was expanded to a total of 21.

2008 Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program

Program Expansion:

In response to requests from the public for notice as far in advance as possible of any further expansions, the calendar year (CY) 2007 Outpatient Prospective Payment System (OPPS) rule adopted six additional quality measures for the FFY 2008 RHQDAPU program. One of these, the HCAHPS patient survey, was first implemented separately from the quality reporting program requirements in the FFY 2007 IPPS rule, and is now

being included as part of the quality reporting program (see “HCAHPS” section below). With the exceptions of the mortality measures, which are calculated from Part A and Part B claims data and for which no additional reporting is required, and HCAHPS, data on the new quality measures must be reported for discharges occurring on or after January 1, 2007. CMS will require continuous submission of HCAHPS data beginning with July 2007 discharges in accordance with the HCAHPS Quality Assurance Guidelines, Version 2.0, located at <http://www.hcahpsonline.org>.

Hospitals must follow a number of steps to satisfy the RHQDAPU requirements and qualify for the full marketbasket update. 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 deadline for withdrawal from the program for FFY 2008 was August 15, 2007. This is also the deadline for submission of the revised “Reporting Hospital Quality Data for Annual Payment Update Notice of Participation” form for hospitals that do wish to participate. Below is a listing of important dates regarding the FFY 2008 RHQDAPU program.

Date	Description
January 1, 2007	Data for all measures (except mortality and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) must be reported for discharges occurring on or after this date.
July 1, 2007	HCAHPS data must be reported continuously for discharges occurring on or after this date.
July 13, 2007	Submission of HCAHPS dry run data.
August 15, 2007	Submission of RHQDAPU Notice of Participation.
August 15, 2007	Withdrawal from RHQDAPU program.
November 1, 2007	Written request for appeal of CMS determination of non-compliance.

Validation and Attestation:

CMS will continue until further notice to require that hospitals meet the chart validation requirements first implemented in the FFY 2006 IPPS rule, including the 80% reliability standard. However, due to time constraints, the three new Surgical Care Improvement Program (SCIP) measures (SCIP-VTE 1, SCIP-VTE 2, and SCIP Infection 2) are exempted from the validation requirement for FFY 2008. Hospitals will be required to attest to the completeness and accuracy of their data, including volume, on a quarterly basis. CMS will provide additional information as well as the required form on the QualityNet Exchange Web site.

Appeals:

A hospital has the right to make a written request for reconsideration if it is denied the full marketbasket update due to CMS’s decision that the hospital did not meet the RHQDAPU requirements. The deadline for such a request for FFY 2008 is November 1, 2007. Additional procedural rules will be posted on the QualityNet Exchange Web site. If a request for reconsideration does not result in the hospital’s favor, the hospital may appeal further by filing a claim under 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board appeal).

HCAHPS:

The following table sets forth the quality measures for FFY 2008, adopted as final in the CY 2007 OPSS rule (highlighted measures are the expanded measures):

Heart Attack Myocardial	Heart Failure	Pneumonia	Surgical Improvement (SCIP); known as Infection (SIP)	Mortality (Medicare)	Patients Experience of
Aspirin at	Left ventricular assessmen	Initial antibiotic within four hours of hospital arrival	Prophylactic received within 1 prior to surgical	Acute Infarction 30-day (Medicare)	HCAHPS surve
Aspirin prescribed at	ACE inhibitor (ACE-I) Angiotensin Receptor (ARBs) for left systolic	Oxygenation	Prophylactic discontinued within hour	Heart Failure 30-mortality patients	
ACE inhibitor (ACE-I) Angiotensin Receptor (ARBs) for left systolic	Discharge	Pneumococcal statu	SCIP-VTE 1: thromboembolism prophylaxis ordered surgery		
Beta blocker at	Adult smoking advice/counselin	Blood culture before first received in	SCIP-VTE 2: prophylaxis within hours pre/post		
Beta blocker prescribed discharg		Adult smoking advice/counselin	SCIP Infection Prophylactic selection for patient		
Thrombolytic agent within 30 minutes of arriva		Appropriate antibiotic			
Percutaneous Intervention (PCI) within 120 minutes of arriva		Influenza (collected but not reported—subject change			
Adult smoking advice/counselin					

CMS Proposal—RHQDAPU Notice of Participation: *“In [an] effort to alleviate the burden associated with submitting this form annually, we are proposing that a hospital that submits this form will be considered an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS.”*

CMS Final Rule: For FFY 2008, CMS has adopted the above proposal without change.

CMS Proposal—Shared Medicare Provider Numbers: *“Currently, hospitals that share the same Medicare Provider Number (MPN) must combine data collection and submission across their multiple campuses (for both clinical measures and for HCAHPS). These measures are then publicly reported as if they apply to a single hospital. . . . For FY 2008 and subsequent years, we are proposing to require hospitals to begin to report the name and address of each hospital that shares the same MPN.”*

“This information will be gathered through the RHQDAPU program Notice of Participation form, which hospitals will submit to their QIOs by August 15, 2007. To increase transparency in public reporting and improve the usefulness of Hospital Compare, CMS plans to note on the Web site where publicly reported measures combine results from two or more hospitals.”

CMS Final Rule: For FFY 2008, CMS has adopted the above proposal without change.

CMS Proposal—New Hospitals: Currently, new hospitals are required to register for the RHQDAPU program and to begin collecting and reporting data immediately.

“ . . . for a new hospital that receives a provider number on or after October 1st of each year (beginning with October 1, 2007), we are proposing that the hospital would be required to report RHQDAPU data beginning with the first day of the quarter following the date the hospital registers to participate in the RHQDAPU program.”

CMS Final Rule: CMS has adopted the above proposal without change.

FFY 2009 (and Beyond) RHQDAPU Program

CMS Proposal—Program Expansion: *“We are proposing to add 1 outcome measure and 4 process measures to the existing 27 measure set to establish a new set of 32 quality measures to be used for the FY 2009 annual payment determination. We plan to adopt these measures a year in advance in order to provide additional time for hospitals to prepare for changes related to the RHQDAPU program.”*

“We are proposing to add the following quality measures for the FY 2009 RHQDAPU program.”

- *Pneumonia: 30-day Mortality (Medicare patients)*
- *SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose*
- *SCIP Infection 6: Surgery Patients with Appropriate Hair Removal*
- *SCIP Infection 7: Colorectal Patients with Immediate Postoperative Normothermia*
- *SCIP Cardiovascular 2: Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period”*

“The proposed measures have been put forth by the HQA for inclusion in its public reporting set, contingent on endorsement by the NQF. (In the case of SCIP Infection 7, the HQA recently withdrew its previous support unless the measure receives NQF endorsement.) We anticipate that the NQF will endorse these measures prior to the publication of the FY 2008 IPPS rule. Any measure that has not been endorsed by that time will not be finalized in that rule.”

CMS Final Rule: The proposed SCIP measures have yet to be endorsed by the NQF. Therefore, *“We are adopting as final the Pneumonia 30-day Mortality measure we proposed. We intend to add SCIP Infection 4, SCIP Infection 6 and SCIP Cardiovascular-2 to the FY 2009 RHQDAPU measurement set (effective with CY 2008 discharges) in the CY 2008 OPSS final rule which is scheduled for publication in November 2007 if these measures have received NQF endorsement. . . . If SCIP Cardiovascular-2 receives NQF endorsement, we intend to add it for purposes of the FY 2009 RHQDAPU program in the CY 2008 OPSS final rule.”*

CMS Proposal—Data Submission and Validation: *“For the additional SCIP measures that we are proposing to add through this rule (SCIP Infection 4, 6, and 7 and SCIP-Card-2), hospitals will be required to submit data to the QIO Clinical Warehouse starting with discharges that occur in CY 2008. We are proposing that the deadline for hospitals to submit this data for [the] first calendar quarter of 2008 would be August 15, 2008. Data must be submitted for each subsequent quarter by 4.5 months after the end of the quarter. . . . Hospitals may report data on these measures for discharges prior to CY 2008 discharges, if they so choose.*

“For the proposed Pneumonia 30-day Mortality measure, we are proposing to use claims data that are already being collected for index hospitalizations to calculate the mortality rates. As is the case with the other 30-day mortality (outcome) measures already associated with the RHQDAPU program (AMI, HF), hospitals need not submit additional data. Claims data submitted to CMS for index hospitalizations occurring from July 2006 through June 2007 (3Q06 through 2Q07) will be used to calculate the Pneumonia 30-day mortality rate that will be used for FY 2009 annual payment determination.”

All chart validation requirements already in effect will continue to apply. *“We will modify the validation requirement to pool the quarterly validation estimates for 4th quarter CY 2006 through 3rd quarter 2007 discharges.”*

CMS Final Rule: CMS has adopted the above proposal.

Reporting Hospital-Acquired Conditions—Including Infections

Federal Register pages 47200 - 47218

Background: Complications such as infections acquired in the hospital can trigger higher payments in the form of outlier payments and/or higher DRG payments due to the presence of a CC. The DRA requires CMS to identify, by October 1, 2007 (FFY 2008), at least two secondary diagnoses 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 (FFY 2009), hospitals will not receive additional payment for cases where one of the selected conditions was not present on admission. For these cases, the diagnosis code for the condition will be eliminated and the case will be reassigned to a DRG. This will result in lower payment if the condition is the only complication or comorbidity on the claim. The law states that CMS can revise the list from time to time, as long as the list contains at least two conditions. Additionally, the DRA requires hospitals to report the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

CMS Proposal: CMS worked with public health and infectious disease experts from the Centers for Disease Control and Prevention (CDC) to identify a list of hospital-acquired conditions, including infections, that could potentially meet the criteria mandated by the DRA provision. CMS listed 13 hospital-acquired conditions in the proposed rule and solicited comments on which should be selected for implementation.

The American Hospital Association and WHA recommended three conditions representing serious preventable events identified by CMS—object left in during surgery, air embolism and blood incompatibility—as appropriate conditions for potential implementation. The other conditions on the CMS list are not always preventable or involve problems in determining whether the condition was present on admission. CMS rejected this suggestion in the final rule and selected eight conditions for implementation and three additional conditions for further consideration.

CMS Final Rule: *“Below is the list of conditions that we are selecting in this FY 2008 final rule. These conditions will be made subject to the provision beginning on October 1, 2008 (FY 2009).”*

- *Serious Preventable Event—Object Left in During Surgery*
- *Serious Preventable Event—Air Embolism*
- *Serious Preventable Event—Blood incompatibility*
- *Catheter-Associated Urinary Tract Infections*
- *Pressure Ulcers (Decubitus Ulcers)*
- *Vascular Catheter-Associated Infection*
- *Surgical Site Infection—Mediastinitis After Coronary Artery Bypass Graft (CABG) Surgery*
- *Hospital-Acquired Injuries—Fractures, Dislocations, Intracranial Injury, Crushing Injury, Burn, and Other Unspecified Effects of External Causes*

We will also propose the following conditions for consideration in the FY 2009 IPPS proposed rule. We will work diligently to address issues surrounding these conditions and propose to select these conditions in the FY 2009 IPPS final rule.

- *Ventilator Associated Pneumonia (VAP)*
- *Staphylococcus Aureus Septicemia*
- *Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE)*”

CMS acknowledged that there are problems that must be addressed prior to implementation of payment reductions for some of these conditions. For example:

- Selected conditions must be reasonably preventable through the application of evidence-based guidelines, but CMS has not identified specific prevention guidelines for the hospital-acquired injuries. CMS states that it will work with the Centers for Disease Control and Prevention to identify research that will assist hospitals in following the appropriate steps to prevent these conditions from occurring after admission.
- CMS selected pressure ulcers but acknowledges the need for further specificity in the ICD-9-CM codes to help distinguish early from late stage pressure ulcers prior to implementation of an adjustment for this condition on October 1, 2008.
- CMS is still considering comments that identified specific clinical situations where a vascular catheter-associated infection would not be considered preventable and says that it could provide for exceptions when the policy is implemented.

Implementation of the payment adjustment will require that hospitals begin submitting a Present on Admission (POA) indicator with each secondary condition. The statute requires the Secretary of Health and Human Services to begin collecting this information as of October 1, 2007. CMS issued instructions on the POA in Change Request No. 5499 released on May 11, 2007 which specifies that:

“This instruction will require hospitals to begin reporting the POA code on claims with discharges beginning on or after October 1, 2007. Although hospitals must report the POA code on the claim, the information will not be used by claims processing systems until January 1, 2008. Beginning with claims with discharges on or after January 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will continue to process. However, hospitals will be provided with a remark code on their remittance advice advising them that they did not correctly submit the POA code on the claim. Beginning April 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will be returned to the hospital for correct submission of POA information. Direct data entry (DDE) screens cannot be updated to include a space for entering POA information until January 1, 2008. Therefore, hospitals that submit claims via DDE will be unable to submit the POA indicator on October 1, 2007. These hospitals must begin submitting the POA indicator on January 1, 2008.”

Specific instructions on how to select the correct POA indicator for a diagnosis code are now included in the ICD-9-CM *Official Guidelines for Coding and Reporting*, which can be found at <http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm>

VI. CAPITAL PAYMENTS

Despite comments from WHA and other state associations strongly objecting to any capital related reductions, CMS in the final rule modified the proposed provisions but will still implement capital reductions. CMS' final provisions are discussed below.

Capital Update Rate—FFY 2008 and FFY 2009

Federal Register pages 47424 - 47433

Background: Reimbursement for capital-related costs was implemented in FFY 1992. Over a ten-year period, payments for capital were transitioned from a reasonable cost-based methodology to a prospective methodology. Beginning in FFY 2002, all hospitals were paid based on 100% of the capital federal rate. The capital federal rate is updated based on changes in a capital input price index (CIPI) and several other policy adjustment factors. Since the inception of the capital IPPS, urban and rural hospitals have received the same update to the capital federal rate.

CMS Proposal: *“We believe that the data on inpatient hospital Medicare capital margins . . . provide sufficient evidence that some adjustment of the updates under the capital IPPS is warranted at this time. In light of the significant disparities in the margin performances of different classes of hospitals, we do not believe that an adjustment to the updates for FYs 2008 and 2009 should apply equally to all hospitals. . .”*

“ . . . for FYs 2008 and 2009, we are proposing that the update to the capital standard Federal rate for urban hospitals will be 0.0 percent . . .”

“ . . . we are also proposing to give rural hospitals the full 0.8 percent update determined by the update framework in FY 2008. We anticipate that we will provide the full update to rural hospitals in FY 2009 as well, once we have determined what the update would be under the update framework.”

CMS Final Rule: In FFY 2008, CMS will continue to provide a capital update for both urban and rural hospitals. The urban and rural *“ . . . update factor for FY 2008 is 0.9 percent, based on the best data available at this time. That update factor is derived from a projected 1.3 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a -0.4 percent adjustment for the FY 2005 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent.”*

CMS states that they agree *“ . . . with MedPAC that our proposal for a differential update for urban and rural hospitals during FYs 2008 and 2009 is not entirely consistent with this direction of policy for the capital and operating IPPSs. As MedPAC noted, eliminating the large urban add-on would complete the process of equalizing the base rates of urban and rural hospitals, but our proposal for differential updates would then reintroduce separate base rates.”*

In addition, CMS will apply a 1.2% reduction to federal capital payment rates in FFY 2008 to account for changes in coding or classification of discharges that do not reflect real changes in case-mix in light of the adoption of the MS-DRGs. For a complete discussion of the 1.2% coding reduction, see the “Behavioral Offset” section above.

Capital Large Urban Add-On

Federal Register pages 47392 - 47401

Background: Since the inception of the capital IPPS in FFY 1992, CMS has provided a 3.0% add-on to the capital federal rate for hospitals that are located in “large urban” areas.

CMS Proposal: “. . . we are proposing to discontinue the 3.0 percent additional payment that has been provided to hospitals located in large urban areas. The consistent and significant positive margin of hospitals located in urban areas is strong evidence that it is not necessary to continue this adjustment . . . effective for discharges on or after October 1, 2007. . . .”

CMS Final Rule: In FFY 2008, CMS will eliminate the 3.0% adjustment provided to large urban hospitals under the capital IPPS. CMS rationalizes this action as consistent with the statutory precedent toward equalizing the base rates of urban and rural hospitals.

Capital IME Elimination

Federal Register pages 47392 - 47401

Background: Under the capital IPPS, CMS has provided a teaching adjustment to eligible providers for Indirect Medical Education (IME). The current IME adjustment applied to capital payments was determined by an empirical analysis as reported in the 1991 capital rule. However, under the law, CMS has “*broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs.*”

CMS Proposal: Even though CMS proposed no changes to the IME adjustment for capital payments in FFY 2008, CMS did invite comments on eliminating the IME adjustment paid under the capital IPPS, due to sustained positive margins over the years.

CMS Final Rule: Based on recommendations from MedPAC, CMS will phase out the IME adjustment for capital payments over a three-year period beginning in FFY 2008. CMS will maintain the current IME adjustment under the capital IPPS in FFY 2008, reduce the teaching adjustment by 50% in FFY 2009, and eliminate the IME adjustment completely in FFY 2010.

“We believe that the record of relatively high and persistent positive margins for teaching hospitals under the capital IPPS indicates that the current teaching adjustment is unnecessary, and that it is therefore appropriate to exercise our discretion under the capital IPPS to eliminate this adjustment.”

CMS is adopting this final policy in this final rule with a comment period—due to the significance of this change and the effect it will have on the structure of payments under the capital IPPS, CMS will provide the public with an opportunity for further comment. CMS will only accept comments on the IME adjustment related to capital payments no later than 5 p.m. on November 20, 2007. No further comments will be accepted at this time.

WHA will strongly object to this change and urges hospitals to submit comments as well. If you choose to comment on this specific issue refer to the “Capital IPPS Payment Adjustments” identifier in your comment letter. For details on where to submit your comments refer to page 47130 of the *Federal Register*.

VII. WAGE INDEX

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

Federal Register page 48165

Background: Urban hospitals that became rural under the revised CBSA labor market area definitions were held harmless and re-designated back to the urban area in which they were located under the previous labor market area definitions for a three-year period (FFY 2005 through FFY 2007).

Beginning in FFY 2008, these hospitals will receive their state's rural wage index or, if applicable, a reclassified wage index under a Medicare Geographic Classification Review Board (MGCRB) reclassification or a reclassification under the "Lugar" criteria. These hospitals are considered rural for reclassification purposes.

Occupational Mix Adjustment

Federal Register pages 47309 - 47315

Background: The purpose of the occupational mix adjustment is to neutralize 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.

CMS was required to include an occupational mix adjustment as part of the calculation of the wage index beginning in FFY 2005. The data for this adjustment are collected through a survey instrument. The latest survey covered the period of January through June 2006. The results of the 2006 Occupational Mix Survey for January through March 2006 (three-month reporting period) were used in the FFY 2007 wage index calculation.

CMS Proposal: *"We are proposing to use the 6-month 2006 survey data to calculate the occupational mix adjustment for the FY 2008 wage index. We used the 1st quarter of 2006 survey data in the FY 2007 wage index. . ."*

"In addition, if a hospital submitted survey data for either the 1st quarter or 2nd quarter, but not for both quarters, we are proposing to use the data the hospital submitted for one quarter to calculate the hospital's FY 2008 occupational mix adjustment factor."

CMS Final Rule: For FFY 2008, CMS has adopted the proposed provisions as final.

CMS is required to collect occupational mix data every three years. In response to suggestions from commenters, CMS has modified the occupational mix survey. *"The revised 2007-2008 occupational mix survey will provide for the collection of hospital-specific wages and hours data for a one-year prospective reporting period from July 1, 2007, through June 30, 2008, additional clarifications to the survey instructions, the elimination of the registered nurse subcategories, some refinements to the definitions of the occupational categories, and the inclusion of additional cost centers that typically provide nursing services. The revised 2007-2008 Medicare occupational mix survey will be applied beginning with the FY 2010 wage index."*

In the FFY 2008 proposed rule, CMS solicited comments and suggestions for a hospital-specific penalty for hospitals that do not submit occupational mix survey. In the final rule, CMS notes that any penalty for non-compliant hospitals would apply to subsequent years, not the FFY 2008 wage index.

Application of Rural Floor Budget Neutrality

Federal Register pages 47325 - 47330

Background: Current law provides that the area wage index applicable to any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas of that state ("the rural floor"). Since FFY 1998, the rural floor budget neutrality has been implemented by adjusting the standardized amounts.

CMS Proposal: “. . . we are proposing a prospective change to how budget neutrality is applied to implement the rural floor for FY 2008 and subsequent years.”

“. . . we are proposing to implement the rural floor budget neutrality requirement by applying a uniform budget neutrality adjustment to all hospital wage indices . . . our proposed change would apply the budget neutrality adjustment to the wage index, and not to the standardized amount. In previous years, we applied a budget neutrality adjustment to the standardized amount to ensure that payments remained constant to payments that would have occurred in the absence of the rural floor requirement. . . .”

CMS Final Rule: For FFY 2008, CMS has adopted the above proposal.

Imputed Rural Floor Adjustment

Federal Register pages 47321 - 47324

Background: CMS provides that the area wage index applicable to any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas of that state (“the rural floor”). Currently, there are two states that have no rural areas and one state that has rural areas but no IPPS hospitals located in the rural areas of the state. In FFY 2005, CMS temporarily adopted a three-year “imputed floor” measure to address concerns by some individuals that hospitals in all urban states were disadvantaged by the absence of rural areas, because there is no floor within the state. Therefore, FFY 2007 was to be the last year of this provision unless CMS made additional changes to the policy.

CMS Proposal: “In the FY 2008 IPPS proposed rule, we proposed to discontinue the imputed floor policy after the FY 2007 wage index.”

CMS Final Rule: “. . . in light of public comments, we believe it appropriate to transition the expiration of the imputed rural floor over a 2-year period. We will continue the imputed rural floor for FY 2008, but allow it to expire in FY 2009. Thus beginning in FY 2009, only States with both rural areas and hospitals located in such areas. . . would benefit from the rural floor, as required by Congress.”

Worksheet S-3 Wage Data—Contract Labor for Indirect Patient Care Services

Federal Register pages 47315 - 47317

Background: CMS has continuously discussed the inclusion of contract labor cost in calculating the wage index as the role of contract labor increases in meeting special personnel needs of hospitals. For FFY 2004, CMS revised the Medicare cost report to provide for the collection of cost and hours data on Worksheet S-3, part II for:

- Contract Management and Administrative Services (Line 9.03);
- Contract Administrative & General (A&G) Services (Line 22.01);
- Contract Housekeeping Services (Line 26.01); and
- Contract Dietary Services (Line 27.01).

CMS Proposal: “Public commenters have expressed interest in including in the wage index the costs and hours for contract management, A&G housekeeping, and dietary services. We also believe that including a more comprehensive measure of area differences in the cost of labor will improve the accuracy of the wage index. For these reasons, we are proposing to include these contract services in the wage index, beginning with FY 2008.”

CMS Final Rule: For FFY 2008, CMS will include the proposed contracted services in the wage index

calculation.

Multi-campus Hospitals

Federal Register pages 47317 - 47319

Background: A multi-campus hospital is a single integrated institution that has one provider number and submits a single cost report that combines the entire institution's total wages and hours for each of its campuses, which is included in the calculation of the wage index for that labor market area. However, in FFY 2005, CMS implemented revised wage areas based on Core-based Statistical Areas (CBSAs), which caused some multi-campus hospitals to be located in more than one CBSA rather than in a single labor market area.

As a result of the new CBSAs, multi-campus hospitals were still required to report wage data in the labor market area of the hospital campus associated with the provider number, even though some of the hospital's staff were working at different campuses in more than one labor market area.

CMS Proposal: CMS proposed to allocate a multi-campus hospital's wages and hours across the different labor market areas where its campuses are located (currently three nationwide) based on Full Time Equivalent (FTE) staff for FFY 2008 and beyond.

CMS Final Rule: “. . . as our final policy, and as reflected in the FY 2008 wage index in this final rule with comment period, we are using FTEs or Medicare discharge data to allocate salaries and hours to the campuses of multicampus hospitals that are located in different labor markets. We will continue the policy of using annually reported FTEs or Medicare discharges to allocate wage data by campus until revisions are made to Worksheet S-3 of the Medicare cost report to require reporting FTE data by campus, and until such data in the cost report can be used to calculate the wage index, at which time the wage data of a multicampus hospital will be allocated among its campuses based only on reported FTE counts by campus.”

Critical Access Hospital (CAH) Conversion to IPPS

Federal Register pages 47324 – 47325

Background: Currently, a CAH's Medicare payment is based on 101% of reasonable costs. Generally, CAH Medicare payments are greater than payments Medicare would make if the same hospitals were paid under the IPPS. In addition, a CAH is guaranteed to recover its costs, while under the IPPS, it is not. However, CMS is aware of a few CAHs that are considering converting from CAH status back to IPPS, even though they continue to still be CAH-eligible.

CMS Proposal: In the FFY 2008 proposed rule, CMS discussed the conversion of the two specific CAHs to an IPPS and has concerns that the hospitals may be converting solely to take advantage of the rural floor provisions for the other hospitals in the state, but not for any reasons that are intrinsic to the two specific hospitals.

CMS Final Rule: “While we have proposed no policy pertaining to this issue at this time, we will consider all of these comments as we develop the FY 2009 IPPS proposed rule.”

VIII. WAGE INDEX RECLASSIFICATIONS

MGCRB Reclassifications

Federal Register pages 47332 - 47333

Background: Individual hospitals or groups of hospitals (defined by counties) can apply to the MGCRB to reclassify for another area's wage index. Hospitals seeking reclassification must meet specific proximity and

wage criteria.

Reclassification Withdrawal: Hospitals that had been approved for FFY 2008 MGCRB reclassifications were permitted to withdraw their applications within 45 days of the publication of the proposed rule, or by June, 18, 2007.

Applications for FFY 2009 reclassifications are due to MGCRB by September 4, 2007. Applications and other information regarding MGCRB reclassifications are available on the CMS Web site at <http://www.cms.hhs.gov/providers/prrb/mgcinfo.asp>.

Out-Migration Adjustment

Federal Register pages 47339 - 47341

Background: Section 505 of the MMA required CMS to 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 counties receive an adjustment to their wage index based on the percentage of county residents who commute to the other area.

Hospitals located in qualifying counties will have the out-migration adjustment added to their wage index for a three-year period unless a hospital requests to waive the application of the adjustment (see “Reclassification Application/Withdrawal” below). A county cannot lose its out-migration adjustment during the three-year period and counties will receive the same adjustment for those three years. However, a county that qualifies in any given three-year period may no longer qualify after the end of the period, or it may qualify but receive a different out-migration adjustment. CMS designates qualifying counties each year.

Currently, CMS uses the pre-reclassified wage index when calculating out-migration adjustments.

CMS Proposal: *“To date, we have used pre-reclassified wage indices when determining the out-migration adjustment. We have reconsidered our policy in this proposed rule and are proposing to calculate the out-migration adjustment using the post-reclassified wage index. We are proposing to use the same formula described in the FY 2005 rule . . . , with the addition of now using the post-reclassified wage indices, to calculate the out-migration adjustment.”*

CMS Final Rule: For FFY 2008, CMS has adopted the above proposal without change.

Section 508 Reclassifications

Federal Register page 47338

Background: Section 508 of the MMA states that a qualifying hospital could appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the state in which the hospital is located. Reclassifications under this provision were applicable to discharges occurring during the three-year period beginning April 1, 2004 and ending March 31, 2007. Section 106(a) of the Tax Relief and Health Care Act of 2006 extended Section 508 reclassifications for six months to September 30, 2007.

CMS Proposal: *“Because the section 508 provision will expire on September 30, 2007, and will not be applicable in FY 2008, in this proposed rule, we are not making any proposals related to the provision.”*

CMS Final Rule: *“By law, the section 508 reclassifications will expire on September 30, 2007. Therefore, the basis for providing this hospital with a special wage index will end with the expiration of section 508 on September 30, 2007.”*

However, The CHAMP Act of 2007 would extend the Section 508 reclassifications for two years, until

September 30, 2009. It is uncertain whether this proposal will be included in any final legislative package that must ultimately pass both chambers and be signed by the President.

Other Hospital Reclassification Issues

Federal Register pages 47333 -47338

CMS Proposal: The proposed rule addressed other specific and unique hospital reclassification issues, including:

- clarification of the policy for reinstating reclassifications (canceling a previous withdrawal or termination);
- procedural information regarding “fallback” reclassifications in cases where a hospital has an existing reclassification and then applies to the MGCRB to a second area and is approved, and has a choice between two reclassifications and its home area wage index for the following fiscal year;
- geographic reclassification issues for multi-campus hospitals regarding the proposal for allocation of a multi-campus hospital’s wages and hours across the different labor market areas where its campuses are located (currently three nationwide) based on FTE staff for FFY 2008 and beyond, and;
- changes to New England deemed counties.

CMS Final Rule: For FFY 2008, CMS has adopted the proposed wage index issues as final. A complete discussion of these issues can be found on the *Federal Register* pages referenced in the heading above.

IX. COST OUTLIERS

Federal Register pages 47416 - 47420

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: *“For FY 2008, we are proposing to use the same methodology used for FY 2007 (71 FR 48148 through 484151) to calculate the outlier threshold . . . we are proposing an outlier fixed-loss cost threshold for FY 2008 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus \$23,015. With this threshold, we are projecting that outlier payments will equal 5.1 percent of total IPPS payments.”*

In addition, due to the proposed MS-DRG system, CMS believed that *“better recognition of severity of illness with the MS-DRGs means that non-outlier payments will compensate hospitals for the higher costs of some cases that previously received outlier payments. As cases are paid more accurately, in order to meet the 5.1 percent target, we would need to decrease the fixed-loss outlier threshold so that more cases qualify for outlier payments.”*

CMS Final Rule: CMS is implementing *“. . . a blend of CMS- and MS-DRG weights for FFY 2008. Therefore, the current threshold is based on cases that are grouped and paid using blended MS-DRG weights . . . for FY*

2008, we are using the same methodology we proposed to calculate the outlier threshold. Using the most recent data available, we calculated . . . an outlier fixed-loss cost threshold for FY 2008 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus \$22,635. With this threshold, we project that outlier payments will equal 5.1 percent of total IPPS payments.”

The final \$22,635 outlier threshold for FFY 2008 represents a decrease of 7.6% compared to the FFY 2007 threshold of \$24,485. FFY 2007 outlier payments are now estimated to be 4.6% of total payments, while those for FFY 2006 are now estimated at 4.65%. CMS’ policy precludes a retroactive adjustment to ensure that total outlier payments amount to the targeted 5.1% of total DRG payments.

X. Graduate Medical Education

Indirect Medical Education Adjustment

Federal Register page 47373

Background: 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. However, the law provided a decrease in the multiplier for FFY 2007 to 1.32 and then restores the multiplier to the FFY 2003 level of 1.35 for FFY 2008 and thereafter.

Resident Time Spent in Non-Patient Care Activities

Federal Register pages 47373 - 47383

Background: In the FFY 2007 IPPS rule, CMS clarified its policy with respect to the time that residents spend in non-patient care activities as part of approved residency programs, amending regulations to state, “*In order to be counted, a resident must be spending time in patient care activities . . .*” Based on this clarification, CMS has received numerous questions regarding whether FTE resident time spent on vacation or sick leave, or in orientation activities, should be counted for purposes of IME payment. Historically, time spent by residents on vacation or sick leave and in initial orientation activities has been included in the FTE resident count for IME and direct GME.

CMS Proposal—Vacation and Sick Leave Time: “. . . we are proposing, for cost reporting periods beginning on or after October, 1, 2007, for direct GME and IME, that time spent by residents on vacation or sick leave would not be included in the determination of what constitutes an FTE resident (or would be removed from both the numerator and denominator of the FTE count) for both IME and direct GME payment purposes.”

CMS Final Rule: For FFY 2008, CMS stated that “*Despite our continued belief that vacation, sick leave, and other approved leave is neither a patient care nor a non-patient care activity, we acknowledge the significant concerns raised by the commenters regarding the administrative burdens associated with the implementation of the proposed policy. Therefore, we will not be finalizing the proposed policy to remove vacation and sick leave from the FTE calculation at this time.*”

CMS will continue to consider ways to implement the proposed policy, or something similar to it, but in a more

administratively feasible manner.

CMS Proposal—Orientation Activities: “. . . we are proposing to continue to count time spent by residents in orientation activities for both IME and direct GME payment purposes.”

“We are proposing . . . to add a definition of the term “orientation activities,” to mean “activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program.”

CMS Final Rule: For FFY 2008, “. . . the current policy on orientation activities occurring in the hospital complex will continue to be effective for IME and direct GME payment purposes, and a new policy with respect to orientation occurring in certain nonhospital settings. . . will be effective for cost reporting periods beginning on or after October 1, 2007.” . . . “Time spent by residents in orientation activities occurring in nonhospital settings such as physicians offices or clinics where patient care is routinely provided and a hospital is permitted to count the time spent by residents . . . may be counted only for cost reporting periods beginning on or after October 1, 2007.”

XI. Additional Payments for New Technology

Federal Register pages 47299 - 47308

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 proposed to discontinue reimbursement for the three technologies that are currently eligible for new technology payment. In addition, one technology is under review and may be approved for payment in FFY 2008.

CMS proposed to discontinue payment for:

- Endovascular Graft Repair of the Thoracic Aorta (eligibility expired);
- Restore® Rechargeable Implantable Neurostimulator (eligibility expired); and
- X STOP Interspinous Process Decompression System (still eligible with respect to the time limit, but no longer meets the cost-threshold criterion under the proposed MS-DRG system).

CMS continues to review approval for:

- Wingspan® Stent System with Gateway™ PTA Balloon Catheter.

CMS Final Rule: For FFY 2008, CMS will discontinue the add-on payment for the three technologies that are currently eligible for new technology payment. With respect to the Wingspan® Stent System, CMS states that “. . . there is not sufficient data to demonstrate that Wingspan® patients have better outcomes . . . we are not approving the Wingspan® for new technology add-on payments for FY 2008.” Therefore, CMS will provide no additional payments for new technology in FFY 2008.

A complete discussion of this provision is available on the *Federal Register* pages referenced above.

XII. RURAL HOSPITALS

Rural Referral Centers (RRCs)

Federal Register pages 47368 - 47373

Background: RRCs receive special Medicare payment status under the IPPS. Advantages of RRC status include:

- exemption from the 12% cap on DSH payments that is applicable to other rural hospitals; and
- 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.

A hospital may voluntarily cancel its rural status, in which case it will lose its RRC designation, and will lose the above-mentioned exemptions. However, it will continue to be exempted from the requirement that its average hourly wage exceed 106% of that of its labor market area for the purpose of geographic reclassification.

CMS Proposal—Canceling RRC Status: “. . . to address concerns that some IPPS hospitals are acquiring rural status solely to benefit from reclassification rules applying to hospitals that were once RRCs and then canceling that rural status within a short period of time, such as a few months, we are proposing to require IPPS hospitals to retain acquired rural status for at least one 12-month cost reporting period. If the hospital chooses to cancel its rural reclassification, the effective date of that cancellation would occur both after at least one 12-month cost reporting period and at the start of the next Federal fiscal year.”

“. . . for example, if a hospital with a cost reporting period from July 1, 2008, to June 30, 2009, becomes rural on May 30, 2008, its acquired rural status . . . would remain in effect from May 30, 2008, through at least September 30, 2009 (that is, the date it acquired rural status through the end of the fiscal year containing a full cost reporting period). We believe this policy is reasonable, given that acquired rural status for IPPS hospitals should be a considered decision for hospitals that truly wish to be considered as rural, and not purely as a mechanism for reclassifying.”

CMS Final Rule: For FFY 2008, CMS has adopted the above proposal without change.

Qualification Criteria for RRC Status: To qualify for RRC status, a hospital must meet several specific criteria. These criteria are based on hospital-specific characteristics, and regional/national case-mix index values and discharges. The criteria for FFY 2008, along with other information regarding qualification for RRC status, are available on the *Federal Register* pages referenced in the heading above.

Disproportionate Share Hospitals (DSH) Cap

No *Federal Register* pages are available for this topic.

Background: CMS provides Medicare DSH payments under the IPPS to acute hospitals that serve a patient population that includes 15% or more low-income Medicare and Medicaid patients. Specifically, if hospitals are eligible based on their patient population percentage, CMS caps the DSH adjustment for urban hospitals with 100 or fewer beds and rural hospitals with fewer than 500 beds at 12%, excluding hospitals classified as RRCs or Medicare Dependent Hospitals (MDH).

However, The CHAMP Act of 2007 would increase the DSH adjustment cap for urban hospitals with 100 or fewer beds and rural hospitals with fewer than 500 beds to 16% in 2008 and to 18% in 2009. It is uncertain

whether this proposal will be included in any final legislative package that must ultimately pass both chambers and be signed by the President.

XIII. OTHER ISSUES

Value-Based Purchasing Plan for FFY 2009

Federal Register pages 47367 - 47368

Section 5001(b) of the DRA requires CMS to develop a plan to implement a value-based purchasing (VBP) program applicable for payments under the Medicare IPPS beginning with FFY 2009. The law specifies that CMS must consult with relevant affected parties and review the experience of relevant demonstration projects while considering 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 value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments; and
- the disclosure of information on hospital performance.

To date, CMS has created an internal hospital pay-for-performance workgroup that is charged with preparing a set of design options, narrowing the set of design options to prepare a draft plan, and preparing the plan for implementing value-based purchasing (VBP) that will be provided to Congress. The workgroup is organized into four subgroups to address each of the required planning issues:

- measures;
- data collection and validation;
- incentive structure; and
- public reporting.

In addition, CMS has hosted two “Listening Sessions” to solicit comments from relevant affected parties on outstanding design questions associated with development of the plan. Information regarding the “Listening Sessions” is available on CMS’ Web site at <http://www.cms.hhs.gov/Center/Hospital.asp>.

CMS stated in the proposed rule that, although the DRA authorized development of a VBP program, additional legislation will be required to establish and implement the VBP program. As described in CMS’ draft plan, CMS will rely on the current RHQDAPU program (see “Reporting of Hospital Quality Data” section above) to provide the foundation for, and be incorporated into the new Medicare hospital VBP program.

Devices Replaced at No Cost or with Credit to Hospital

Federal Register pages 47246 - 47251

Background: In the FFY 2007 IPPS rule, CMS addressed the topic of payment for devices that are replaced at no cost or where credit for a replaced device is furnished to the hospital. CMS believes that Medicare should not

pay the hospital for the full cost of the replacement if the hospital is receiving a partial or full credit, due either to a recall or to service during the warranty period. In this case, CMS states that the cost of the device was incurred at the time of initial implantation, and Medicare should retain the credit that is being provided to the hospital. In the CY 2007 OPSS rule, CMS adopted a policy that requires a reduced payment to a hospital or ambulatory surgical center when a device is provided at no cost.

CMS Proposal: *“We are proposing to reduce the amount of the Medicare IPPS payment when a full or partial credit towards a replacement device is made or the device is replaced without cost to the hospital or with full credit for the removed device.”*

“We . . . believe that it is appropriate to limit application of the policy only to those DRGs where implantation of the device determines the DRG assignment.”

“. . . we are proposing to apply the policy . . . where the hospital received a credit equal to 20 percent or more of the cost of the device. We believe a credit that is equal to or more than this percentage is substantial, and Medicare should not pay for the full cost of these replacement devices because hospitals have received significant savings from the manufacturer for its replacement costs.”

“We are proposing to require the hospital to provide invoices or other information indicating the cost of the device and the amount of credit it received.”

Transmittal 741, issued on November 4, 2005, required hospitals, beginning in April of 2006, to report the following codes on any claim for IPPS services that includes a replacement device or product for which they received full or partial credit:

- Condition Code 49—Product Replacement within Product Lifecycle. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly; and
- Condition Code 50—Product Replacement for Known Recall of a Product. The manufacturer or the Food and Drug Administration has identified the product for recall and therefore replacement.

For a device provided to the hospital without cost, the fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) would subtract the cost of the device from the DRG payment. For a device for which the hospital received a full or partial credit, the FI or MAC would subtract the amount credited from the DRG payment.

CMS Final Rule: CMS adopted as final this policy as proposed, with the following alterations:

“We agree with the commenters who suggested that the proposed threshold should be raised from 20 percent to 50 percent or greater of the cost of the device. The commenters have raised valid issues about potential administrative burden and delays that could occur. . . . Therefore . . . we are applying the policy in situations where the hospital received a credit equal to 50 percent or more of the cost of the device.”

Regarding the submission of invoices, *“Our fiscal intermediaries (or MAC if applicable) are in the best position to evaluate and determine matters regarding the adequacy of documentation to determine Medicare payment. . . . we are not requiring any specific documentation to determine whether the percentage credit will apply. Invoices or the documentation (including those suggested in the public comments) would be at the discretion of the fiscal intermediary or MAC.”*

Additionally, in submitting claims under this policy, hospitals will have the option of either:

- “. . . (1) submitting the claims immediately without condition code 49 and a claim adjustment with condition code 49 at a later date once the credit determination is made, or
- “(2) holding the claim until a determination is made on the level of the credit.”

Should hospitals choose option 1, CMS notes that the rules for submitting adjustment claims apply, and can be found at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> .

CMS will issue specific claims processing instructions to Medicare contractors and hospitals on implementing this policy.

CMS has listed the MS-DRGs that will be subject to this policy on *Federal Register* pages 47250 -47251.

Hospital Emergency Services Under EMTALA

Federal Register pages 47384 - 47385

Background: Medicare participating hospitals and CAHs are required to adequately treat and stabilize all individuals who may present themselves at the facility’s emergency room, regardless of ability to pay or type of program coverage. This requirement is in the Emergency Medical Treatment and Labor Act (EMTALA). This law states that if a patient presents with an emergency condition, a hospital is obligated to provide the necessary stabilizing treatment or provide appropriate transfer to another facility where stabilization can occur. There is an exception to the EMTALA requirements for hospital emergency departments in areas that have been declared an emergency or disaster area during a time of emergency. Sanctions under EMTALA for inappropriate transfer of emergency patients are waived in such instances. EMTALA has also been amended to include a similar waiver of sanctions for the transfer of emergency patients in the case of a public health emergency that involves a pandemic infectious disease.

In the final rule, CMS revises the regulations to implement the sanction waiver provision. For FFY 2008, CMS states that “. . . we are adopting as final, without modification, the proposed revision . . . to specify that the sanctions that do not apply are those for either the inappropriate transfer of an individual who has not been stabilized, or those for the direction or relocation of an individual to receive medical screening at an alternate location and to add a second sentence . . . to state that a waiver of these sanctions for EMTALA violations is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that if a public health emergency involves a pandemic infectious disease . . . , the duration of the waiver will be determined in accordance with section 1135(e) of the Act as it applies to public health emergencies.”

Emergency Room Disclosure

Federal Register pages 47385 47387

CMS believes that “. . .hospitals should be required to disclose to patients at the time of inpatient admission or registration for an outpatient service information concerning whether a physician is available on the premises 24 hours per day, 7 days per week.” In the FFY 2008 proposed rule, CMS proposed to add a new provision that would require hospitals to furnish all patients a notice at the beginning of their hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, seven days per week, and to describe how the hospital will meet the medical needs of any patient who develops an emergency medical condition, at a time when no physician is present in the hospital.

CMS Final Rule: For FFY 2008, CMS is “. . .requiring hospitals and CAHs that do not have a physician on-site 24 hours per day, 7 days per week to disclose this information to patients, along with information about how they would handle an emergency when no physician is on-site. We are not making any changes to the hospital or

CAH CoPs in this final rule with comment period. The current hospital and CAH CoPs do not include a requirement for a physician to be on site at all times”.

Disclosure of Physician Ownership in Hospitals

Federal Register pages 47385 - 47387

Background: The Deficit Reduction Act of 2005 requires CMS to develop a plan to address several issues with respect to physicians’ investments in specialty hospitals. One issue to be addressed is the transparency of investment information.

CMS Proposal: CMS proposed to define any Medicare participating hospital as “physician owned” if the hospital has a physician or group of physicians as owners or investors. CMS solicited comments on “. . . whether, for purposes of the ownership disclosure requirements only, the definition of ‘physician-owned hospital’ should exclude certain physician ownership or investment interests based on the nature of the interest or the relative size of the interest, or the entity’s assets. . . .”

CMS proposed requiring that a hospital give patients written notice that it is physician-owned and make the list of physician owners available to patients upon request. CMS also proposed that physician-owned hospitals require all physician owners who are also members of that facility’s medical staff to disclose their ownership interest, in writing, to all patients being referred to the hospital. *“Patient disclosure would be required at the time a physician makes a referral. . . . In order to enforce these proposed requirements, we are proposing to amend §489.12 to deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital. In addition, we are proposing to amend §489.53 to permit CMS to terminate a provider agreement with a physician-owned hospital if the hospital fails to comply with the requirements. . . .”*

CMS Final Rule: For FFY 2008, *“After consideration of the public comments we received, we are revising the proposed changes to 489.3 by adding a provision to except from the definition of a “physician-owned hospital” those hospitals in which the physician ownership is limited to holding publicly traded securities or mutual funds . . .”* *“We are redesignating proposed paragraph (u)(1) of 489.20 as paragraph (u) and revising it to specify that the hospital should furnish a list of physician owners to patients at the beginning of their hospital stay or outpatient visit.”*