



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

May 2007

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Inpatient Prospective Payment System (PPS) for federal fiscal year (FFY) 2008. Additional information regarding the Inpatient PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS>.

CMS must receive comments on the proposal by 5 p.m. on June 12. CMS requests that comments reference the file code CMS-1533-P and the specific “issue identifier” that precedes the section on which you choose to comment. Each section of this summary provides the “issue identifier” that CMS request you reference in your comments.

Comments on the proposed rule can be:

Submitted electronically at:

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

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

-OR-

Regular Mail (an original and two copies):

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-P
P.O. Box 8011
Baltimore, MD 21244-1850

Express/Overnight Mail (an original and two copies):

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

-OR-

Hand-Delivered (an original and two copies):

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Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

OR

7500 Security Boulevard
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I. OVERVIEW

CMS published the proposed Medicare Inpatient Prospective Payment System (PPS) rule for federal fiscal year (FFY) 2008 in the May 3, 2007 *Federal Register*. Changes are effective October 1, 2007 unless otherwise noted.

Note: text in italics is extracted from the *Federal Register*.

II. THE MMA OF 2003 AND DRA OF 2005

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

III. STANDARDIZED AMOUNTS

Marketbasket Update

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

Federal Register pages 25133 – 25134

Consistent with current law, based on the Office of the Actuary’s first quarter 2007 forecast of the FFY 2008 marketbasket increase, CMS is estimating that the FFY 2008 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.

Although the proposal provides a full marketbasket update of 3.3% for FFY 2008, CMS is proposing a 2.4% “behavioral offset” reduction to the standardized amount for both FFY 2008 and FFY 2009. See the section “Behavioral Offset” below for a complete discussion of this issue.

Currently, children’s hospitals, cancer hospitals, and religious non-medical health care institutions (RNHCIs) are the remaining three types of hospitals to be reimbursed fully under reasonable costs. CMS is proposing to provide the FFY 2008 IPPS operating marketbasket percentage increase of 3.3% to update the target limits for children’s hospitals, cancer hospitals, and RNHCIs.

Behavioral Offset

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

Federal Register pages 24708 – 24711

Background: A provision in the Benefits Improvement and Protection Act (BIPA) of 2000, provides 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 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.”*

“We are considering proposing a 4.8 percent adjustment for FY 2008. However, we believe it would be appropriate to provide a transition because we would be making a significant adjustment to the standardized amounts.”

“Section 1886(d)(3)(A)(vi) of the Act further gives the Secretary authority to revisit adjustments to the standardized amounts for changes in coding or classification of discharges that were based on estimates in a future year. 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 for FY 2008 and FY 2009 for the FY 2010 and FY 2011 IPPS rules. As that time, if necessary, we may make a further adjustment to the standardized amounts to account for the difference between our projection and actual data.”

The proposed 4.8% “behavioral offset” reduction (to be applied over two-years at 2.4% per year) is 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 propose an adjustment for anticipated improvements in documentation and coding. The Maryland analysis in the proposed rule shows 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.

A complete discussion of the analysis of the experience of Maryland and the proposed “behavioral offset” is available on the *Federal Register* pages referenced above.

Operating and Capital Rates

There is no “issue identifier” supplied to submit a comment on this issue.
Federal Register pages 24846 – 24850

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.

In addition, CMS is also proposing two separate updates to the capital Federal rates for both FFYs 2008 and 2009. For FFY 2008, CMS is proposing a full capital update of 0.8% for rural hospitals and no capital update for urban hospitals. See the section “Capital Payments” below for a complete discussion of this topic area.

These changes are reflected in the following tables:

Standard Rate¹ for Hospitals with a Wage Index Greater Than 1.0 (69.7 Percent Labor Share and 30.3 Percent Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (3.3 Percent)	\$3,430.29	\$1,491.21
Reduced Update (1.3 Percent) ²	\$3,363.88	\$1,462.34

Standard Rate¹ for Hospitals with a Wage Index Less Than or Equal to 1.0 (62.0 Percent Labor Share and 38.0 Percent Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (3.3 Percent)	\$3,051.33	\$1,870.17
Reduced Update (1.3 Percent) ²	\$2,992.26	\$1,833.96

Capital Federal Rate¹	
Capital Federal Rate - Urban	\$413.87
Capital Federal Rate - Rural	\$417.26

Note 1: The rates shown in the tables above (both operating and capital) reflect the 2.4% reduction for the proposed "behavioral offset"

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

IV. DRG RECLASSIFICATIONS AND RELATIVE WEIGHTS

DRG Reclassifications

Refer to "DRG Reform and Proposed MS-DRGs" if you submit a comment on this issue.
Federal Register pages 24691 – 24712

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 Diagnosis Related Groups (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, MedPAC recommended that CMS refine the entire DRG system to take into account severity of illness. In the FFY 2007 final rule, CMS created 20 new DRGs and modified 32 other DRGs as a first step towards the recommended DRG refinement.

In addition, CMS also stated in the FFY 2007 final rule that it planned to look at several alternatives for DRG refinement to better reflect severity of illness among patients for FFY 2008. On September 1, 2006, CMS contracted with RAND Health to analyze alternative systems that could classify discharges into severity-adjusted DRGs. The following severity-adjusted DRG systems are currently being evaluated by RAND:

- CMS DRGs modified for AP-DRG Logic (CMS+AP-DRGs)
- Consolidated Severity-Adjusted DRGs (CS DRGs)
- Refined DRGs (HSC-DRGs)
- All-Payer Severity DRGs with Medicare modifications (MM-APS-DRGs)
- Solucient Refined DRGs (Sol-DRGs)

RAND issued an interim report in March 2007 with some preliminary findings and will continue to evaluate the alternative DRG systems with expected completion 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.”

The proposed Medicare Severity DRGs (MS-DRGs) would 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 proposed MS-DRGs also reflect a complete renumbering of the DRG codes. CMS also indicates that the final RAND report could still influence future changes in the Medicare DRGs.

As part of CMS’ analysis and development of the MS-DRGs, it also performed a review of the list of secondary diagnoses that are designated as CCs for severity. That review led to a significant reduction to the number of secondary diagnoses that qualify as CCs – from 3,326 to 2,583.

CMS is soliciting comments on how best to refer to both the current and proposed DRGs in order to avoid confusion. CMS is also soliciting comments on RAND’s preliminary analysis of the alternative severity-adjusted DRG systems.

Relative Weights

Refer to “DRGs: Relative Weight Calculations” if you submit a comment on this issue.

Federal Register pages 24712 – 24716

Background: Prior to 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 final 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. Since costs are not reported by DRG, the methodology that CMS adopted for calculating cost-based weights converts charges to costs using national average cost-to-charge ratios (CCRs). National average CCRs were calculated 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.”

While proposing to continue with the same costing methodology for DRG weights in FFY 2008 CMS is considering ways to improve its DRG cost calculations. In August 2006, CMS contracted with RTI to assess the differences in relative weights calculated using the current 13 CCRs vs. alternative methods. RTI has recommended expanding from the 13 CCRs to 19 CCRs as a short-term improvement by:

- “Disaggregating ‘Emergency Room’ and ‘Blood and Blood Products’ from the “Other Services’ cost center;
- Establishing regression-based estimates as a temporary or permanent method for disaggregating the Medical Supplies, Drugs, and Radiology cost centers; and
- Reclassifying intermediate care charges from the intensive care unit cost center to the routine cost center.”

Meanwhile, RAND is conducting its own analysis of the Hospital-specific relative value cost center (HSRVcc) costing methodology, which was originally proposed for FFY 2007 and withdrawn by CMS in the final rule. The results of the RAND study are due September 2007.

CMS is soliciting comments on expanding to 19 CCRs and whether this expansion should be adopted for FFY 2008 in the absence of a detailed analysis of how DRG relative weights would change if this expansion were to be adopted in conjunction with the proposed MS-DRGs and an HSRVcc costing methodology.

CMS is also soliciting comments on “potential changes to cost reporting instructions to improve consistency between how charges are reported on cost reports and in the Medicare claims.” This was another area cited by RTI as having potential for short-term improvement to the DRG relative weights.

V. REPORTING OF HOSPITAL QUALITY DATA

Reporting Requirements to Receive the Full Marketbasket Update

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

Federal Register pages 24802 – 24809

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 for their data to 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 final rule, the penalty for withdrawal from the program or failure to comply with its requirements was increased to 2.0%; some procedural changes were effected; and the set of quality measures was expanded to a total of twenty-one.

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

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 is 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 who 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 & 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

Program Expansion:

In response to requests from the public for notice as far in advance as possible of any further expansions, the CY 2007 OPSS final rule adopted six additional quality measures for the FFY 2008 RHQDAPU program. One of these, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey, was first implemented separately from the quality reporting program requirements in the FFY 2007 IPSS 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, which is detailed below, data on the new quality measures must be reported for discharges occurring on or after January 1, 2007.

Validation and Attestation:

CMS will continue until further notice to require that hospitals meet the chart validation requirements first implemented in the FFY 2006 IPSS final rule, including the reliability standard of 80%. 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. Also until further notice, 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 website.

Appeals:

In the case of a hospital’s being denied the full marketbasket update due to CMS’s decision that the hospital did not meet the RHQDAPU requirements, the hospital has the right to make a written request for reconsideration. The deadline for such a request for FFY 2008 will be November 1, 2007. Additional procedural rules will be posted on the QualityNet Exchange website. 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:

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 www.hcahponline.org. The CY 2007

OPPS rule required HCAHPS-eligible hospitals to participate in the March 2007 dry run of the HCAHPS survey, if they have not already participated in a previous dry run. Hospitals must submit HCAHPS dry run data to the QIO Clinical Warehouse by July 13, 2007. Hospitals and survey vendors will be required to participate in a quality oversight process. Until July 2007 this will be for informational purposes only, to provide feedback to the hospitals and survey vendors. Beginning in July 2007, CMS may request timely corrections and corresponding documentation of any problems found through this process, and may declare a hospital deficient in its reporting obligations if the hospital fails to do so.

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

Heart Attack (Acute Myocardial Infarction)	Heart Failure (HF)	Pneumonia (PNE)	Surgical Care Improvement Project (SCIP) (previously known as Surgical Infection Prevention (SIP))	Mortality Measures (Medicare patients)	Patients' Experience of Care
Aspirin at arrival	Left ventricular function assessment	Initial antibiotic received within 4 hours of hospital arrival	Prophylactic antibiotic received within 1 hour prior to surgical incision	Acute Myocardial Infarction 30-day mortality (Medicare patients)	HCAHPS patient survey
Aspirin prescribed at discharge	ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction	Oxygenation assessment	Prophylactic antibiotic discontinued within 24 hours	Heart Failure 30-day mortality (Medicare patients)	
ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction	Discharge instructions	Pneumococcal vaccination status	SCIP-VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients		
Beta blocker at arrival	Adult smoking cessation advice/counseling	Blood culture performed before first antibiotic received in hospital	SCIP-VTE 2: VTE prophylaxis within 24 hours pre/post surgery		
Beta blocker prescribed at discharge		Adult smoking cessation advice/counseling	SCIP Infection 2: Prophylactic antibiotic selection for surgical patients		
Thrombolytic agent received within 30 minutes of hospital arrival		Appropriate initial antibiotic selection			

Heart Attack (Acute Myocardial Infarction)	Heart Failure (HF)	Pneumonia (PNE)	Surgical Care Improvement Project (SCIP) (previously known as Surgical Infection Prevention (SIP))	Mortality Measures (Medicare patients)	Patients' Experience of Care
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					

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

“We believe that some new hospitals have found it difficult to start reporting RHQDAPU measures immediately after signing up to participate in the RHQDAPU program.”

“Therefore . . . we are proposing that the fiscal intermediary would continue to provide information on the new hospital to the QIO in the state in which the hospital is located as soon as possible so that the QIO could enter the provider information into its PRS and follow through with ensuring provider participation with the requirements for quality data reporting.”

“However, 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.”

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 final rule. Any measure that has not been endorsed by that time will not be finalized in that rule.”

Additionally, CMS has published the following list of possible measures and sets for potential inclusion in the RHQDAPU program for FFY 2009 and beyond, and is soliciting comments regarding them, especially concerning the following questions:

- Are there any critical gaps or missing measures/sets?
- Which of these should be included for FFY 2009 and/or subsequent years?
- What challenges are posed by these measures/sets for data collection and reporting, and how could these be addressed?

Possible Measures and Measure Sets for FY 2009 and Subsequent Years

Measures	Clinical Condition
Intensive Care Unit (ICU) Critical Care Measures	
Stress Ulcer Disease Prophylaxis	ICU/Critical Care
Urinary Catheter-Associated Urinary Tract Infection For Intensive Care Unit (ICU) Patients	ICU/Critical Care
Readmission Measures	
Readmission Heart Failure (HF) Within 30 Days Rate - Medicare Only (CMS Methodology)	Efficiency/HF
Readmission (same hospital) Acute Myocardial Infarction (AMI) Within 30 Days Rate	Efficiency/AMI
Readmission (same hospital) PNE Within 30 Days Rate	Efficiency/PNE
Readmission Within 30 Days Of Surgery - Medicare Only (SCIP Global-2)	Surgical Care
NQF -- Nursing Sensitive Condition Set (Outcomes Measures Only)	
Failure To Rescue - Nursing Sensitive Measure	Patient Centered
Pressure Ulcer Prevalence - Nursing Sensitive Measure	Patient Centered
Patient Falls Prevalence - Nursing Sensitive Measure	Patient Centered

Patient Falls With Injury - Nursing Sensitive Measure	Patient Centered
Cancer (Inpatient) Measures	
Patients With Early Stage Breast Cancer Who Have Evaluation Of The Axilla	Cancer - Breast
College Of American Pathologists Breast Cancer Protocol	Cancer - Breast
Surgical Resection Includes At Least 12 Nodes (ACOS-02)	Cancer - Colon
College Of American Pathologists Colon And Rectum Protocol	Cancer - Colon
Completeness Of Pathologic Reporting (CCO-04)	Cancer - Colon
Leapfrog Leaps, Identified by IOM and Deficit Reduction Act	
Use Of Computerized Physician Order Entry (CPOE) Systems	Patient Safety
Use of Intensivists in ICUs/ ICU Physician Staffing (IPS)	Patient Safety
Evidence-Based Hospital Referrals	Patient Safety

Measure Sets (Individual Measures Not Specified)	Clinical Condition
Sets Under Active Review by National Quality Forum (NQF)	
Healthcare-Associated Infection measures – under consideration by the NQF National Voluntary Consensus Standards for Reporting of Healthcare-Associated Infections Data Project	Patient Safety
Readmission Rates by Condition – under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project	Efficiency
Average Length of Stay (ALOS) by Condition – under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project	Efficiency
AHRQ Quality Indicators, including Patient Safety Indicators - under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project	Patient Safety, Various Conditions
Measure Sets/Practices Previously Endorsed by NQF	
Safe Practices for Better Healthcare	Patient Safety
Serious Reportable Events in Healthcare (“Never Events”)	Patient Safety
Other Hospital Measure Sets	
Hospital Emergency Department Measures	Various
Vascular Surgery Complications (for Carotid Endarterectomy, Lower Extremity Bypass, Open Surgery Abdominal Aortic Aneurysm Repair, Endovascular Abdominal Aortic Aneurysm Repair)	Surgical Care

CMS Proposal – Data Submission & 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, with the following modifications:

- *“We will modify the validation requirement to pool the quarterly validation estimates for 4th quarter CY 2006 through 3rd quarter 2007 discharges.*
- *We will also expand the list of validated measures in the FY 2009 update to add SCIP Infection-2, SCIP VTE-1, and SCIP VTE-2 starting with 4th quarter CY 2006 discharges.*
- *We will also drop the current two-step process to determine if the hospital is submitting valid data.*
- *We propose for the FY 2009 update to pool validation estimates covering the 4 quarters (4th quarter CY 2006 discharges through 3rd quarter 2007 discharges) in a similar manner to the current 3 quarter pooled confidence interval.”*

CMS Solicitation of Public Comments – Retirement or Replacement of Measures: CMS expects that the measures in use will evolve over time, and is authorized by the Act to modify the set as deemed appropriate.

“CMS recognizes the need to develop a process related to the retirement and/or replacement of measures that comprise the RHQDAPU program measure set. In this proposed rule, we solicit public comment and suggestions concerning the criteria and mechanism for a process that would identify and, where appropriate, retire or replace measures that comprise the RHQDAPU program measure set.”

Reporting Hospital-Acquired Conditions – Including Infections

Refer to “DRGs: Hospital-Acquired Conditions” if you submit a comment on this issue.

Federal Register pages 24716 – 24726

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 complication or comorbidity (CC). The DRA requires CMS to identify, by October 1, 2007 (FFY 2008), at least two CC 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. That is, the case would be paid as though the secondary diagnosis was not present. 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.

In the FFY 2007 IPPS rulemaking process, CMS sought comments on determining which hospital-acquired conditions should be subject to reporting. In addition, 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, as required by the DRA provision.

The following table represents CMS' proposed selection of hospital-acquired conditions as possible candidates to satisfy the DRA provision. According to CMS' selection method, the conditions at the top of the following list best meet the statutory selection criteria, while the conditions lower on the list may meet the selection criteria but could present a particular challenge (that is, they may be preventable only in some circumstances, but not in others) and therefore, the first conditions listed should receive the highest consideration of selection among the initial group of hospital-acquired conditions.

	Proposed Hospital - Acquired Condition	Coding - Unique Code?	Burden - high cost and/or high volume?	Prevention guidelines?	CC?	Considerations?
1	Catheter associated urinary tract infections	Yes	Yes	Yes	Yes	Minimal - additional infection codes
2	Pressure ulcers (Decubitus ulcers)	Yes	Yes	Yes	Yes	No
3	Serious preventable event - object left in surgery	Yes	Yes - high cost in specific circumstances	Yes	Yes	No
4	Serious preventable event - air embolism	Yes	Yes - high cost in specific circumstances	Yes	Yes	No
5	Serious preventable event - blood incompatibility	Yes	Yes - high cost in specific circumstances	Yes	Yes	No
6	Staphylococcus aureus septicemia	Yes - multiple codes reported	Yes	Yes	Yes	Multiple codes
7	Ventilator associated pneumonia (VAP)/ Pneumonia	No VAP code, multiple pneumonia codes	Yes	Yes	No - no unique codes	Preventability issues. VAPs - identification issues
8	Vascular catheter associated infections	No	Yes	Yes	Yes - but code is too broad	Preventability issues
9	Clostridium difficile-associated disease (CDAD)	Yes	Yes	No	Yes	Preventability issues
10	Methicillin-resistant staphylococcus aureus (MRSA)	Yes	Yes	Yes	No	Preventability issues

	Proposed Hospital - Acquired Condition	Coding - Unique Code?	Burden - high cost and/or high volume?	Prevention guidelines?	CC?	Considerations?
11	Surgical site infections	No	Yes	Yes	Yes - but code is too broad	Cannot identify
12	Serious preventable event - wrong surgery	Yes	Yes - high cost in specific circumstances	Yes	No	Not a CC
13	Falls	No - not for all types of falls	Yes - high cost in specific circumstances	No - for all types of falls	No	Cannot identify

In this proposed rule, CMS is seeking comments on:

- how many and which conditions should be selected for implementation on October 1, 2008, along with justifications for these selections;
- whether or not the conditions are ranked appropriately;
- clinical, coding, and prevention issues that may affect the conditions selected; and
- compelling public health reasons for including conditions that are not at the top of our list.

VI. CAPITAL PAYMENTS

Capital Federal Rate – FFY 2008 and FFY 2009

Refer to “Capital IPPS” if you submit a comment on this issue.

Federal Register pages 24818 – 24823

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.”

“As a result of the proposed 0.8 percent update for rural hospitals, the proposed 0.0 percent update for urban hospitals, the proposed 2.4 percent reduction to account for upcoding (for all hospitals), . . . we are proposing to establish a capital Federal rate for rural hospitals of \$417.26 for FY 2008, and we are proposing to establish a capital Federal rate for urban hospitals of \$413.87 for FY 2008.”

After application of the 2.4% behavioral offset and reductions for budget neutrality, the FFY 2008 capital Federal rates, for both urban and rural hospitals, are lower than the capital Federal rate in FFY 2007. For a complete discussion of the 2.4% coding reduction, see the section “Behavioral Offset” above.

Capital Large Urban Add-On

Refer to “Capital IPPS” if you submit a comment on this issue.

Federal Register pages 24818 – 24823

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. . . ”*

“When the payment adjustments were instituted at the inception of the program, the initial standard Federal payment rate was adjusted in a budget-neutral fashion to account for the expenditures that would be required by these adjustments. . . . in light of the excessive capital IPPS payments over the period of FYs 1996 through 2004, we believe that it is appropriate for the program to realize savings from this proposal.”

Capital IME and DSH Adjustments – Potential Elimination

Refer to “Capital IPPS” if you submit a comment on this issue.

Federal Register pages 24818 – 24823

Under the law, CMS has “*broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs.*” In the proposed rule, CMS considers and seeking comment on eliminating the special payment adjustments provided under the capital IPPS.

Based on CMS’ analysis of capital IPPS margins in the proposed rule, CMS is considering further reductions to certain classes of hospitals that have sustained positive margins. These reductions could be focused on the payment adjustments received by teaching hospitals and disproportionate share hospitals. Because these adjustments are not required by law, CMS is considering proposals that would reduce or eliminate the IME and DSH capital adjustments. CMS is also determining whether these potential changes to the capital IPPS should be made in a budget neutral manner, or should instead result in savings to the Medicare program.

VII. WAGE INDEX

Core-Based Statistical Areas

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

Federal Register pages 24776 – 24777

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

CMS Proposal: “Consistent with the FY 2005, FY 2006, and FY 2007 IPPS final rules, for FY 2008 we are proposing to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we will determine a wage index for FY 2008 employing wage index data from FY 2004 hospital cost reports and using the CBSA labor market definitions.”

On December 18, 2006, OMB announced the inclusion of two new CBSAs and the revision of designations for six areas (OMB Bulletin No. 07-01). Details on the new or modified CBSAs is available on the *Federal Register* pages referenced above and on the OMB Web site at <http://www.whitehouse.gov/OMB>. These changes will be effective October 1, 2007.

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

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

Federal Register pages 24776 – 24777

Background: Urban hospitals that became rural under the revised CBSA labor market area definitions were held harmless and redesignated 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

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

Federal Register pages 24777 – 24782

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

CMS was required to include an occupational mix adjustment as part of the calculation of the wage index beginning in FFY 2005. 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 FFY 2007, due to the U.S. Court of Appeals decision in *Bellevue Hospital Center v. Leavitt*, the occupational mix adjustment was required to be implemented at 100%, using more recent survey data. 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.

For the FFY 2007 wage index, hospitals that did not respond to the occupational mix survey, or submitted erroneous data, were assigned the average occupational mix adjustment for the labor market area. For areas where no hospital submitted occupational mix data, the national occupational mix factor of 1.0000 was applied. CMS has indicated that they may apply a different approach in future years, including potentially penalizing non-responsive hospitals.

CMS Proposal – FFY 2008 Adjustment: *“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 to comply with a court decision in Bellevue Hosp. Center v. Leavitt. . .”*

CMS Proposal – Data Submission: *“For the FY 2008 wage index, we are proposing to handle the data for hospitals that did not respond to the occupational mix survey (neither the 1st quarter nor 2nd quarter data) in the same manner as . . . 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.”

“Lastly, if a hospital submitted a survey(s), but that survey data could not be used because we determined it to be aberrant, we also assigned the hospital the average occupational mix adjustment for its labor market area.”

CMS is required to collect occupational mix data every three years. As discussed above, CMS is currently using occupational mix survey data collected in 2006 to adjust the FFY 2007 and FFY 2008 wage index. On February 2, 2007, CMS published proposed revisions to the occupational mix survey, seeking comments on potential improvements to the survey. The final notice is expected to be published in the *Federal Register* by July 1, 2007. CMS states in the proposed rule that it has modified the occupational mix survey for 2007-2008 based on comments received. The results of this survey will be applied to the FFY 2010 wage index.

Application of Rural Floor Budget Neutrality

Refer to “Wage Index” if you submit a comment on this issue.
Federal Register pages 24787 – 24792

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 . . .”

“For FY 2008, we are proposing to use FY 2006 discharge data and FY 2008 wage indices to simulate IPPS payments without the rural floor. We would compare these simulated payments to simulated payments using the same data with a rural floor.”

Expiration of the Imputed Rural Floor

Refer to “Imputed Floor” if you submit a comment on this issue.

Federal Register page 24786

Background: As described above, current law provides a “rural floor” wage index. There are two States that have no rural areas (New Jersey and Rhode Island) and one State that has rural areas but no IPPS hospitals located in the rural areas of the State (Massachusetts). In the FFY 2005 IPPS final rule, CMS adopted an “imputed” floor measure to address the concern that hospitals in all-urban States were disadvantaged by the absence of rural areas, because there is no floor within the State. This imputed floor measure was limited to FFYs 2005, 2006, and 2007.

CMS Proposal: *“We are proposing to discontinue the imputed floor policy after the FY 2007 wage index. After further considering the issue, we do not believe that it is necessary to have an “imputed” rural floor in States that have no rural areas or no rural hospitals.”*

“. . . when a rural IPPS hospital opens in a State that has rural areas, but no wage data are available to calculate a rural wage index, we are proposing to apply a wage index to that hospital using the same methodology that we currently use for home health and other post-acute care providers in rural Massachusetts (71 FR 65906). That is, we would use the un-weighted average of the wage indices from all CBSAs that are contiguous to the rural counties of the State. (We define contiguous as sharing a border.)”

“. . . if a State has rural areas, and a hospital is reclassified as rural . . . then there would be no need to apply the above policy. The reclassified hospital would set the rural floor, and the wage data of the newly opened rural hospitals would be included in the calculation of the wage index of the rural area only once their wage data correlated with the survey year used to establish the wage index (4 years after wage data are reported).”

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

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

Federal Register page 24782

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 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.”

Other Wage Index Issues

See topic in the *Federal Register* pages referenced below for the appropriate issue identifier.

Federal Register pages 24776 – 24793

The proposed rule addresses two other specific and unique wage index issues. These include:

- 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
- potentially precluding a special arrangement in the case of two Critical Access Hospitals (CAHs) considering converting from CAH status back to IPPS even though they continue to still be CAH eligible. In these cases, CMS is concerned that the hospitals may be converting solely in order 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.

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

VIII. WAGE INDEX RECLASSIFICATIONS

MGCRB Reclassifications

Refer to: “MGCRB” if you submit a comment on this issue.

Federal Register pages 24793 – 24794

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.

Applications for FFY 2009 reclassifications are due to MGCRB by September 4, 2007. Applications and other information regarding MGCRB reclassifications will be available beginning in mid-July on the CMS Web site at: <http://www.cms.hhs.gov/providers/prrb/mgcinfo.asp>. HANYS will send information to members after CMS’ data release regarding potential reclassification opportunities for individual hospitals.

Reclassification Withdrawal: Hospitals that have been approved for FFY 2008 MGCRB reclassifications are permitted to withdraw their applications within 45 days of the publication of the proposed rule.

Lugar Reclassifications

There is no “issue identifier” supplied to submit a comment on this issue.

Federal Register pages 24796 – 24797

Background: The law requires that CMS automatically reassign any hospital located in a rural county adjacent to one or more urban areas if the county meets specified commuting criteria known as “Lugar criteria.” CMS has used the new CBSA definitions and 2000 Census data to assign reclassifications to hospitals in counties that meet these criteria.

Reclassification Withdrawal: Hospitals that qualify for an automatic Lugar reclassification might have also

requested a reclassification under the MGCRB 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 reclassification to the wage index under the Lugar reclassification. Hospitals must withdraw their MGCRB reclassification requests within 45 days of publication of the proposed rule if they prefer to receive the Lugar assignment.

Out-Migration Adjustment

Refer to: “Out-Migration Adjustment” if you submit a comment on this issue.

Federal Register pages 24798 – 24799

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 that 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.

Reclassification Application/Withdrawal: If a hospital in an eligible county 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, or “Lugar criteria”), that hospital must withdraw its reclassification within 45 days of the publication of this proposed rule to receive the out-migration adjustment instead.

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 final rule (69 FR 49064), with the addition of now using the post-reclassified wage indices, to calculate the out-migration adjustment.”*

Hospitals eligible for the out-migration adjustment are listed on table 4J, pages 24952 – 24960 of the *Federal Register*.

Section 508 Reclassifications

Refer to: “508 Reclassifications” if you submit a comment on this issue.

Federal Register page 24798

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 3-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.”*

Other Hospital Reclassification Issues

See topic in the *Federal Register* pages referenced below for the appropriate issue identifier.
Federal Register pages 24793 – 24799

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

- 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.

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

IX. COST OUTLIERS

There is no “issue identifier” supplied to submit a comment on this issue.
Federal Register pages 24836 – 24838

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.”

The proposed \$23,015 threshold for FFY 2008 represents a decrease of 6.0% compared to the FFY 2007 threshold of \$24,485. The lower proposed threshold is due to several factors. First, the *actual* national average cost-to-charge ratio (as calculated by CMS from hospitals’ cost reports) has declined by approximately 1.3%. Second, CMS, in response to public comments, further reduced the CCRs by applying an adjustment factor to reflect the *projected* differential increase between costs and charges (charges have been increasing at a greater percentage rate than costs).

Finally, with adoption of the proposed new MS-DRG system, CMS believes 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 currently estimates that actual FFY 2006 outlier payments were 4.50% of total actual DRG payments. Outlier payments for FFY 2007 are estimated at 4.9% of total DRG payments. CMS states that, consistent with ongoing policy, retroactive adjustments will not be made to outlier payments for the purpose of ensuring that they amount to the target 5.1% of total DRG payments.

X. Graduate Medical Education

Indirect Medical Education Adjustment

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

Federal Register pages 24812 – 24813

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 scheduled a decrease in the multiplier for FFY 2007 and restores the multiplier to the FFY 2003 level of 1.35 for FFY 2008 and thereafter.

CMS Proposal: *“In this proposed rule, we are specifying that, for any discharges occurring during FY 2008, the statutorily mandated formula multiplier is 1.35. . . . We estimate that application of the mandated formula multiplier for FY 2008 will result in an increase of 5.5 percent in IME payment for every approximately 10-percent increase in the resident-to-bed ratio.”*

Resident Time Spent in Non-Patient Care Activities

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

Federal Register pages 24812 – 24815

Background: In the FFY 2007 IPPS final rule, CMS clarified their 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 is not proposing to change the current policy with respect to time spent by residents on maternity leave or

other approved sick leave of extended duration. In these instances, FTE time spent by such residents is counted during the training time they spend to make up for their absence.

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.””

XI. Additional Payments for New Technology

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

Federal Register pages 24771 – 24776

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

CMS Proposal: CMS proposes to 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 proposes to discontinue payment for:

- Endovascular Graft Repair of the Thoracic Aorta (eligibility expired)
- Restore® Rechargeable Implantable Neurostimulator (eligibility expired)
- 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

XII. RURAL HOSPITALS

Rural Referral Centers

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

Federal Register pages 24810 – 24812

Background: Rural referral centers receive special Medicare payment status under the IPPS. Advantages of rural referral center 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 therefore 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 Proposal – 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. These criteria and other information regarding qualification for RRC status are available on the *Federal Register* pages referenced in the heading above.

XIII. FUTURE REFINEMENTS TO THE IPPS

Value-Based Purchasing Plan – Development

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

Federal Register pages 24809 – 24810

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 final plan for implementing 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 final plan. Information regarding the “Listening Sessions” is available on CMS’ Web site at <http://www.cms.hhs.gov/Center/Hospital.asp>.

CMS states 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) which will provide the foundation for, and be incorporated into the new Medicare Hospital VBP program.

Revision of the Wage Index Adjustment – FFY 2009 Proposed Rule

There is no “issue identifier” supplied to submit a comment on this issue.

Federal Register page 24802

Section 106(b)(1) of the Tax Relief and Health Care Act of 2006 requires MedPAC to review the current Medicare wage index classification system and recommend alternatives to the method of computing the wage index. MedPAC is required to submit a report to Congress on their findings by June 30, 2007.

In addition, the law requires CMS, taking into account MedPAC’s recommendations, to include one or more proposals to revise the wage index adjustment applied to the IPPS in the FFY 2009 IPPS proposed rule. The law requires the proposal (or proposals) to consider the following:

- problems associated with the definition of labor markets for the wage index adjustment;
- the modification or elimination of geographic reclassifications and other adjustments;
- the use of Bureau of Labor of Statistics data or other data or methodologies to calculate relative

wages for each geographic area;

- minimizing variations in wage index adjustments between and within MSAs and statewide rural areas;
- the feasibility of applying all components of CMS' proposal to other settings;
- methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality;
- the effect that the implementation of the proposal would have on health care providers on each region of the country;
- methods for implementing the proposal(s) including methods to phase in such implementations; and
- issues relating to occupational mix such as staffing practices and any evidence on quality of care and patient safety including any recommendation for alternative calculations to the occupational mix.

To date, MedPAC has presented its preliminary findings regarding this issue. More detailed information, a formal report, and recommendations are expected in the coming months.

Electronic Medical Records – Solicitation of Comments

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

Federal Register page 24809

CMS intends to begin to create specifications for a system that will allow for reporting of clinical quality data from the EMRs directly to a CMS data repository, replacing the current system which requires the transfer of the raw data into an XML file. CMS has been encouraging hospitals to begin development of such systems themselves, and to ensure that they conform to the as-yet-undeveloped Federal Health Architecture Data standards. CMS believes that ideally, such systems will enable high-level performance on the measures by providing point-of-care decision support. CMS welcomes further comments on this issue.

XIV. OTHER ISSUES

Devices Replaced at No Cost or with Credit to Hospital

Refer to “Replaced Devices” if you submit a comment on this issue.

Federal Register pages 24742 – 24746

Background: In the FFY 2007 IPPS final 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 final 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.
- Condition Code 50 – Product Replacement for Known Recall of a Product. The manufacturer or the FDA 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 is seeking comment on both the proposed 20 percent credit “threshold” and also on the best approach to making the payment adjustment. In addition, CMS is seeking comment on what types of documentation hospitals should provide to the FI or MAC.

CMS has listed the CMS DRGs (and proposed MS-DRG) that would be subject to this proposed policy on *Federal Register* pages 24744 – 24745.

Hospital Emergency Services Under EMTALA

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

Federal Register pages 24815 – 24816

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.

CMS Proposal: CMS is proposing to amend its regulations to ensure that they are in keeping with the law:

“ . . . we are proposing to make two changes to paragraph (a)(2) of §489.24. First, we would 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. We also are proposing to revise by adding a second sentence to paragraph (a)(2) 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 (such as pandemic influenza). . . .”

“This proposed change would clarify that, in the case of public health emergencies involving pandemic infectious diseases, the waiver of EMTALA sanctions is not limited to 72 hours, but will remain in effect until the termination of the applicable declaration of a public health emergency”

Disclosure of Physician Ownership in Hospitals

Refer to “Physician Ownership in Hospitals” if you submit a comment on this issue.

Federal Register pages 24816 – 24817

Background: The Deficit Reduction Act of 2005 (DRA) 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 proposes to define any Medicare participating hospital as “physician owned” if the hospital has a physician or group of physicians as owners or investors. CMS is soliciting 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 is proposing to require 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 is also proposing 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. . . .”*