



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE PROPOSED
FFY 2009 MEDICARE
HOSPITAL INPATIENT RULE**

May 2008

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) 2009. 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 13. CMS requests that comments reference the file code CMS-1390-P.

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-

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Department of Health and Human Services
Attention: CMS-1390-P
P.O. Box 8011
Baltimore, MD 21244-1850

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I. OVERVIEW

CMS published the proposed Medicare Inpatient Prospective Payment System (IPPS) rule for federal fiscal year (FFY) 2009 in the April 30, 2008 *Federal Register*. Changes are effective October 1, 2008, unless otherwise noted.

Note: Text in italics is extracted from the April 30, 2008 *Federal Register*.

Major Provisions of the Proposed Rule Include:

- **Marketbasket factor:** CMS is proposing a full marketbasket, update of 3.0% for FFY 2009. In addition, CMS will apply a 0.9% reduction to account for anticipated coding improvements under the new Medicare-Severity Diagnosis-Related Groups (MS-DRGs) and adjustments for budget neutrality.
- **Standard Amount - Operating:** CMS is proposing to increase the operating standard amount from \$4,990.60 in FFY 2008 to \$5,098.96 in FFY 2009.
- **Standard Amount – Capital:** CMS is proposing to decrease the capital standard amount from \$426.14 in FFY 2008 to \$421.29 in FFY 2009.
- **Quality Measures:** Hospitals will be required to report 30 measures in order to receive the full marketbasket update in FFY 2009, compared to 27 measures in FFY 2008. In addition, CMS has proposed to expand the requirements to include 72 inpatient quality measures by FFY 2010.
- **Hospital Acquired Conditions:** Effective October 1, 2008, hospital claims with one of eight selected hospital-acquired conditions may be reimbursed at a reduced Diagnosis Related Group (DRG) level if the condition was not present on admission. CMS is soliciting comments on nine additional conditions that could effect payments in FFY 2009.
- **Wage Index Reclassifications:** CMS is proposing to revise the average hourly wage (AHW) comparison criteria used in determining whether a hospital is eligible for reclassification to another geographic location. Current criteria require an urban hospital to demonstrate that its average hourly wage is at least 84 % of the average hourly wage of hospitals in the area to which it seeks redesignation. Rural hospitals AHW must be at least 82 % of the area. CMS is proposing to restrict reclassifications by increasing this to 88 % for urban hospitals and to 86 % for rural hospitals. The test for group reclassifications would increase from 85 to 88 %. CMS' proposal would affect new reclassifications beginning with the FFY 2010 wage index and would not affect existing reclassifications.
- **Indirect Medical Education for Capital:** CMS in the FFY 2008 final rule adopted a policy to eliminate the capital teaching adjustment over a three-year period beginning October 1, 2007. CMS maintained the current adjustment in FFY 2008, and will reduce the teaching adjustment by 50% in FFY 2009, and eliminate the teaching adjustment completely in FFY 2010.
- **Indirect Medical Education (IME):** For FFY 2009, the proposed rule would hold the operating IME adjustment at 5.5 % as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
- **Outliers:** CMS proposes to decrease the outlier threshold from \$22,185 in FFY 2008 to \$21,025 in FFY 2009.
- **Post-Acute Transfers to Home Health Services:** CMS proposes to extend the timeframe for when the post-acute transfer policy would apply to an acute care discharge to a home health care provider. The current timeframe applies to transfers within three days; the proposed timeframe would apply to transfers within seven days of the discharge from the hospital.
- **Rural Floor and Imputed Floor Budget Neutrality:** For FFY 2009, CMS proposes to apply the rural floor budget neutrality adjustment at the State level, which would redistribute payments within the State rather than across all other providers within the Nation.

II. LEGISLATIVE MANDATES

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA); the Deficit Reduction Act of 2005 (DRA); the Transitional Medical Assistance (TMA); Abstinence Education, and Qualifying Individuals (QI) Programs Extension Act of 2007; and the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA), each contain 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 affecting IPPS involve payment restorations, while provisions of the DRA related to the IPPS focus on development of pay-for-performance and other initiatives. Where appropriate, legislative references are provided in the text below.

III. STANDARDIZED AMOUNTS

Marketbasket Update

Federal Register pages 23921 - 23922

Consistent with current law, the Centers for Medicare and Medicaid Services (CMS) proposes a full marketbasket update of 3.0 % to the standardized amount for all IPPS hospitals that submit quality data in accordance with the rules discussed in the "Reporting of Hospital Quality Data" section below. The FFY 2009 marketbasket estimate is based on the Office of the Actuary's first quarter 2008 forecast. Hospitals that do not submit qualifying quality data will receive a 2.0 percentage point reduction to their update factor.

Although the proposed rule would provide a full marketbasket update of 3.0% for FFY 2009, CMS will apply a "behavioral offset" reduction of 0.9% to the standardized amount for FFY 2009. See the "Offset for Coding Improvements" section below for a complete discussion of this issue.

Offset for Coding Improvements

Federal Register pages 23540 - 23542

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, in the FFY 2008 IPPS final rule, indicated that the adoption of the Medicare Severity-Diagnosis Related Groups (MS-DRGs) (see "MS-DRG Classifications and Relative Weights" section below) had the potential to generate increases in aggregate payments that would not be caused directly by increases in actual patient severity of illness, but rather would be due to improved documentation and coding. As a result, in the FFY 2008 final rule, CMS implemented a "behavioral offset" adjustment that would reduce the standardized amount over a three year period. Since then, the TMA, Abstinence Education, and QI Programs Extension Act of 2007 reduced the "behavioral offset" adjustments to half of what CMS had originally adopted in the FFY 2008 final rule; establishing a 0.6% rate reduction in FFY 2008; a 0.9% rate reduction in FFY 2009; and allowing CMS to make additional adjustments to offset the estimated amount of the increase or decrease in aggregate payments from prior years in FFYs 2010, 2011, and 2012.

"Behavioral Offset" Adjustment – Hospital-Specific Rates: In the FFY 2008 final rule CMS had also established a policy that would apply the behavioral offset adjustment to hospital-specific rates, because Sole Community Hospitals (SCHs) and Medicare Dependant Hospitals (MDHs) use the same DRG system as all other IPPS hospitals. However, this policy was later rescinded, in the November 27, 2007 *Federal Register*, based on concerns over CMS' authority to make such changes to hospital-specific rates under BIPA. In this proposed FFY 2009 rule, CMS asserts its belief that it does have legal authority to make such an adjustment and that, "In

light of this authority, for the FY 2010 rulemaking, we plan to examine our FY 2008 claims data for hospitals paid based on the hospital-specific rate. If we find evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 hospital-specific rates . . .”

Operating and Capital Rates

Federal Register page 23723

For FFY 2009, hospitals with wage indexes greater than 1.0 would continue to use a labor share of 69.7% and hospitals with wage indexes less than or equal to 1.0 would 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 adequate quality data.

Standard¹ for Hospitals with a Wage Index Greater Than 1.0 (69.7 % Labor Share and 30.3% Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (3.0 Percent)	\$3,553.98	\$1,544.98
Reduced Update (1.0 Percent) ²	\$3,484.97	\$1,514.98

Standard¹ for Hospitals with a Wage Index Less Than or Equal to 1.0 (62.0 % Labor Share and 38.0 % Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (3.0 Percent)	\$3,161.36	\$1,937.60
Reduced Update (1.0 Percent) ²	\$3,099.97	\$1,899.98

Capital Federal Rate¹	
National Capital Rate	\$421.29

Note 1: The rates shown in the tables above (both operating and capital) reflect the 0.9% reduction for the proposed “behavioral

Note 2: The reduced update is applicable to hospitals that are not in compliance, or have withdrawn from the FFY 2009 quality reporting

IV. MS-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

MS-DRG Patient Classifications

Federal Register pages 23537 - 23589

Background: DRG assignments are based on the reporting of International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis and procedure codes. 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.

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 final rule, CMS created 20 new DRGs and modified 32 other DRGs as a first step toward the recommended DRG refinement.

In FFY 2008, CMS adopted MS-DRGs which modified the basic logic of the prior DRG system by adding an additional severity level. As a result, the MS-DRGs include three subgroups: major complications and comorbidities (MCC), complications and comorbidities (CC), and non-CC. 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. In FFY 2008, there were 745 MS-DRGs.

To help mitigate large shifts in payment, CMS provided for a 2-year transition to MS-DRGS. In the first year, FFY 2008, an overall MS-DRG weight was determined by applying 50 % of the old DRG relative weight and 50% of the new MS-DRG relative weight.

CMS Proposal: For FFY 2009, patients will be assigned to MS-DRGs and the weights will be 100 % MS-DRGs.

Relative Weights

Federal Register pages 23542 - 23589

Background: Before FFY 2007, CMS calculated DRG weights by aggregating charges by DRG for all PPS hospitals and determining an average charge per 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 weights. In FFY 2008, the transition was continued by blending 67% cost-based and 33% charge-based weights.

The methodology that CMS adopted for calculating cost-based weights converts charges to costs using national average cost-to-charge ratios (CCRs) for 15 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 – Relative Weight Calculation: In FY 2009, CMS is proposing “. . . to fully implement the cost-based DRG relative weights . . . which is the third year in the 3-year transition period to calculate the relative weights at 100 %t based on costs.” The FFY 2009, relative weights will be computed using Version 26.0 MS-DRGs.

Refining Medicare Cost Reports

Federal Register pages 23544 - 23547

Background: Concerns have been raised that the DRG weights do not accurately reflect the cost of expensive medical devices. In an effort to help improve the cost report information CMS uses to determine DRG weights, state and national hospital associations have launched an educational campaign, to help promote the use of cost center groupings that are consistent with the way charges are grouped in the Medicare Provider Analysis and Review (MedPAR) file. CMS, in the FFY 2008 final rule, stated their support for the education initiative of the industry and issued Change Request 5928 on February 29, 2008, which informed fiscal intermediaries/MACs of the hospital associations' initiative to promote more consistent reporting on cost reports.

CMS Proposal – Refining Medicare Cost Reports: For FFY 2009, CMS is proposing “. . .to begin making cost report changes geared to improving the accuracy of the IPPS and OPSS relative weights.”

As a first step, CMS is proposing to “. . . focus at this time on the CCR for Medical Supplies and Equipment because RTI found that the largest impact on the relative weights could result from correcting charge compression for devices and implants.” RTI’s study concluded that cost ratios for devices and implants would average 17 points higher than the ratios for other medical supplies.

“. . . we are proposing to modify the cost report to have one cost center for Medical Supplies Charged to Patients and one cost center for Implantable Devices Charged to Patients. We are proposing to instruct hospitals to report only devices that meet the four criteria . . .(specifically including that the device is implantable and remains in the patient at discharge) in the cost center for Implantable Devices Charged to Patients. All other devices and non-chargeable supplies would be reported in the Medical Supplies cost center.”

CMS is proposing that hospitals use the Outpatient PPS (OPSS) criteria used to define a device for pass-through payment, with some modification, to determine what should be reported in the Medical Supplies cost center versus the Medical Devices cost center. More specifically, CMS is proposing to “. . . instruct hospitals to report only implantable devices that remain in the patient at discharge in the cost center for devices. All other devices and non-routine supplies which are separately chargeable would be reported in the medical supplies cost center.”

In lieu of, or in conjunction with, the criteria CMS has proposed for determining what should be reported in the cost center for Implantable Devices and Medical Supplies, CMS is also considering alternative approaches. One of the approaches under consideration would distinguish between high-cost and low-cost items based on a cost threshold. The option of using a cost-threshold would help address charge compression; however, it may not eliminate all charge compression from the device cost center if the cost-threshold does not accurately capture differential markup policies for an individual hospital.

Even though CMS is only focusing on two areas as a first step, CMS welcomes comments on other areas within the Medicare cost report that would help improve CCRs.

For more details on the OPSS criteria with modifications refer to the *Federal Register* pages referenced in the heading above.

V. REPORTING OF HOSPITAL QUALITY DATA

Reporting Requirements to Receive the Full Marketbasket Update

Federal Register pages 23642 - 23661

Background: The MMA authorized a quality data reporting program that required hospitals to submit quality data to CMS for three years (FFYs 2005-2007) in order to receive a full IPPS payment update. Participating hospitals were required to submit data on a set of ten core quality measures and that data must meet certain validation requirements. Hospitals that withdrew from the program or failed to submit valid data received a reduced marketbasket increase (minus 0.4 percentage points 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 quality reporting program or failure to comply with its requirements was increased to a reduction of 2.0 percentage points. Also in FFY 2007, some procedural changes were implemented and the set of core quality measures was expanded to 21.

CMS continues to expand the set of core quality measures that hospitals are required to report, based on endorsements from the National Quality Forum (NQF). In FFY 2008, CMS increased the number to 28 and continued to apply a 2.0 percentage point reduction for non-compliance or withdrawal from the program.

FFY 2009 Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program

Program Expansion:

CMS stated in the FFY 2008 final rule that they would adopt and notify the industry of new quality measures a year in advance, to allow hospitals time to prepare for the changes related to the RHQDAPU program. At the time of publication for the FFY 2008 final rule, some of the proposed quality measures for that FFY were not yet endorsed by the NQF. However, the NQF had endorsed two of the FFY 2008 IPPS proposed quality measures in time for the calendar year (CY) 2008 Outpatient PPS final rule; therefore, CMS adopted these two additional quality measures as part of the FFY 2009 RHQDAPU program. The addition of these two measures brings the total number of core quality measures to 30 for FFY 2009.

In addition to the core measures, CMS is also requiring hospitals to report HCAHPS data as part of RHQDAPU, effective July 2007. CMS has also begun calculating mortality measures for heart attack and heart failure patients.

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>.

RHQDAPU Quality Measures for FFY 2009

The following table sets forth the quality measures for FFY 2009, which were adopted as final in the CY 2008 OPSS rule (the expanded measures are highlighted):

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	Pneumonia 30-day mortality (Medicare 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	SCIP-Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose		
Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival		Influenza vaccination (collected but not publicly reported – subject to change)	SCIP Infection 6: Surgery Patients with Appropriate Hair Removal		
Adult smoking cessation advice/counseling					

Withdrawal from RHQDAPU

The deadline for withdrawal from the program for FFY 2009 is August 15, 2008. If a hospital withdraws from the program, it will receive a 2.0 percentage point reduction in its FFY 2009 annual payment update.

Chart Validation Requirements

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. Due to time constraints, in FFY 2008, CMS exempted; Surgical Care Improvement Program (SCIP) measures (SCIP-VTE 1, SCIP-VTE 2, and SCIP Infection 2), from the validation requirements. Hospitals are required to attest to the completeness and accuracy of their data, including volume, on a quarterly basis.

CMS Proposal – Chart Validation Requirements: For FFY 2009, the chart validation requirements for the RHQDAPU program will apply to the following:

- *“The 21-measure expanded set will be validated using 4th quarter CY 2006 (4Q06) through 3rd quarter CY 2007 (3Q07) discharges;*
- *SCIP VTE-1, VTE-2, and SCIP Infection 2 will be validated using 2nd quarter CY 2007 and 3rd quarter CY 2007 discharges;*
- *SCIP Infection 4 and SCIP Infection 6 must be submitted starting with 1st quarter CY 2008 discharges but will not be validated;*
- *HCAHPS data must continuously be submitted and will be reviewed...; and.*
- *AMI, HF, and PN 30-day mortality measures will be calculated....”*

New Hospitals

Currently, new hospitals are required to register for the RHQDAPU program and begin collecting and reporting data immediately. A new hospital receiving a provider number on or after October 1 of the year is 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 strongly recommends that new hospitals participate in an HCAHPS dry run, prior to the collection of HCAHPS data to meet RHQDAPU program requirements. For a schedule of upcoming dry runs, refer to <http://www.hcahpsonline.org>.

Attestation:

Beginning in FFY 2008, CMS started to require that “. . . hospitals attest each quarter to the completeness and accuracy of their data, including the volume of data, submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks.”

CMS Proposal - Attestation: For FFY 2009, CMS is proposing “. . . defer the requirement for FY 2009 for hospitals to separately attest to the accuracy and completeness of their submitted data due to the burden placed on hospitals to report paper attestation forms on a quarterly basis. We continue to expect that hospitals will submit quality data that are accurate to the best of their knowledge and ability.”

Appeals:

A hospital has the right to submit a written request for reconsideration if it has been denied the full marketbasket update based on CMS’s decision that the hospital did not meet the RHQDAPU requirements. The rules for reconsideration are posted on the *QualityNet* Web site. If a request for reconsideration does not yield a favorable result, the hospital may appeal further by filing a claim under 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board appeal).

CMS Proposal – Appeals: For FFY 2009, CMS is proposing “. . . continue the current RHQDAPU program reconsideration and appeal procedures finalized in the FY 2008 IPPS final rule.” The deadline for submitting a request for reconsideration for the FFY 2009 payment determination is November 1, 2008. In addition, CMS is proposing the same procedural rules for FFY 2009 as finalized in the FFY 2008 IPPS final rule.

FFY 2010 RHQDAPU Program

CMS Proposal – Update of Current Measures: For FFY 2010, CMS is proposing “. . . to require continued submission of data on 26 of the 30 existing AMI, Heart Failure, Pneumonia, HCAHPS, and SCIP measures adopted for FY 2009. . . . In addition, we are proposing to remove the Pneumonia Oxygenation Assessment measure from the RHQDAPU program measure set. We are proposing to discontinue requiring hospitals to submit data on the Pneumonia Oxygenation Assessment measure, effective with discharges beginning January 1, 2009.”

“The specifications for two of the existing measures have been updated by the NQF, effective May 2007, with respect to the applicable timing interval. . . . Because the NQF is now endorsing different timing intervals with respect to these measures, we are proposing to also update these measures for the purposes of the FY 2010 RHQDAPU program. The updated measures are as follows:

- *AMI – Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI); and*
- *Pneumonia – Timing of receipt of initial antibiotic following hospital arrival*

We note that the technical specifications for these measures will not change, and hospitals will continue to submit the same data they currently submit. However, beginning with discharges on or after January 1, 2009, CMS will calculate the measure using the updated timing intervals.”

CMS Proposal - Program Expansion: For FFY 2010, CMS is proposing “. . . to add the following 43 measures for the FY 2010 payment determination: a SCIP measure that we proposed last year; 4 nursing sensitive measures; 3 readmission measures; 6 Venous Thromboembolism measures; 5 stroke measures; 9 AHRQ measures; and 15 cardiac surgery measures.” The new measures for FFY 2010 are as follows:

FFY 2010 Proposed RHQDAPU Measures
 (highlighted measures are endorsed by the NQF)

Nursing Sensitive Measures ¹	Readmission Measures	Surgical Care Improvement Project (SCIP) ²	Venous Thromboembolism Measures ²	Stroke Measures ³	AHRQ Patient Safety Measures/Inpatient Quality Indicators (IQI) ⁴	Cardiac Surgery Measures ⁵
Failure to Rescue	Pneumonia 30-day Risk Standardized Readmission Measure	SCIP Cardiovascular 2 - Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period	VTE-1: VTE Prophylaxis	STK-1 DVT Prophylaxis	Patient Safety Indicator (PSI) 4-Death among surgical patients with treatable serious complications	Participation in a Systematic Database for Cardiac Surgery
Pressure Ulcer Prevalence and Incidence by Severity	Heart Attack 30-day Risk Standardized Readmission Measure		VTE-2: VTE Prophylaxis in the ICU	STK-2 Discharged on Antithrombotic Therapy	PSI 6-Iatrogenic pneumothorax, adult	Pre-Operative Beta Blockade
Patient Falls Prevalence	Heart Failure 30-day Risk Standardized Readmission Measure		VTE-4: Patients with overlap in anticoagulation therapy	Stk-3 Patients with Atrial Fibrillation Receiving Anticoagulation Therapy	PSI 14-Postoperative wound dehiscence	Prolonged Intubation
Patient Falls with Injury			VTE-5/6: Patients with UFH dosages who have platelet count monitoring adjustment of medication per protocol or nomogram	Stk05 Antithrombotic Medication by End of Hospital Day Two	PSI-15 Accidental puncture or laceration	Deep Sternal Wound Infection Rate
			VTE-7: Discharges instructs to address: follow-up monitoring, compliance, dietary restrictions and adverse drug reactions/interactions	Stk-7 Dysphasia Screening	IQI 4 and 11- Abdominal aortic aneurysm mortality rate (with or without volume)	Stroke/CVA
			VTE-8: Incidence of preventable VTE		IQI 19-Hip fracture mortality rate	Post-Operative Renal Insufficiency
					IQI Mortality for selected medical conditions	Surgical Reexploration
					IQI Mortality for selected surgical conditions	Anti-Platelet Medication at Discharge
					IQI Complications/patient safety for selected indicators	Beta Blockade Therapy at Discharge
						Anti-Lipid Treatment at Discharge
						Risk-Adjusted Operative Mortality for CABG
						Risk-Adjusted Operative Mortality for Aortic Valve Replacement
						Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair
						Risk-Adjusted Mortality for Mitral Valve Replacement and CABG Surgery
						Risk-Adjusted Mortality for Aortic Valve Replacement and CABG Surgery

¹ Effective with discharges beginning April 1, 2009.

² Effective with discharges beginning January 1, 2009.

³ Effective with discharges beginning July 1, 2009.

⁴ The AHRQ Patient Safety Indicators and Inpatient Quality Indicators, are claims-based outcome measures. These measures will be calculated using all-payer claims data that hospitals currently collect with respect to each patient discharge.

⁵ Begin submitting data by July 1, 2009, on a quarterly basis to the STS data registry or CMS for 1st quarter calendar year 2009 discharges.

“To the extent that the proposed measures have not already been endorsed by a consensus building entity such as the NQF, we anticipate that they will be endorsed prior to the time that we issue the FY 2009 IPPS final rule. We intend to finalize the FY 2010 RHQDAPU program measure set in the FY 2009 IPPS final rule, contingent on the endorsement status of the proposed measures. However, to the extent that a measure has not received NQF endorsement by the time we issue the FY 2009 IPPS final rule, we intend to finalize that measure . . . in the CY 2009 OPPS/ASC final rule . . .”

CMS Proposal – RHQDAPU Program Procedures: For FFY 2010, CMS is proposing “. . . to continue requiring the FY 2009 RHQDAPU program procedures for FY 2010 for hospitals participating in the RHQDAPU program, with the following modifications:

- *Notice of Participation – New subsection (d) hospitals and existing hospitals that wish to participate in RHQDAPU for the first time must complete a revised ‘Reporting Hospital Quality Data for Annual Payment Update Notice of Participation’ that includes the name and address of each hospital that shares the same CCN.*
- *Data Submission – In order to reduce the burden on the hospital that treat a low number of patients who are covered by the submission requirements, we are proposing the following:”*
 - *A hospital that has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter for the following categories will not be required to submit patient level data for that category for the quarter. However, the hospital must still submit its aggregate population and sample size counts for the category to CMS for that quarter.*
 - *AMI;*
 - *HCAHPS;*
 - *HF;*
 - *PN; and*
 - *SCIP*

“We are proposing to be implementing this requirement with discharges on or after January 1, 2009.”

CMS Proposal - Chart Validation: For FFY 2010, CMS is proposing “. . . the following chart validation requirements to reflect the proposed 72-measure set:”

- The 21 measures from the FFY 2009 RHQDAPU program measure set will be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges; and
- The SCIP Infection 4 and Infection 6 will be validated using data from 2nd and 3rd quarter CY 2008 discharges.

“In addition, we are proposing to include the following three measures in the FY 2010 RHQDAPU program validation process that are included the FY 2009 RHQDAPU program measure set but have been updated or deleted for the FY 2010 measure set:

- *Pneumonia antibiotic prophylaxis timing within 4 hours will be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.*
- *Percutaneous Coronary Intervention (PCI) Timing within 120 minutes will be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.*
- *Pneumonia Oxygenation Assessment will be validated using data from 4th quarter through 3rd quarter 2008 discharges.”*

CMS Proposal – Withdrawal from RHQDAPU: For FFY 2010, CMS is proposing “. . . to accept RHQDAPU program withdrawal forms for FY 2010 from hospitals through August 15, 2009. If a hospital withdraws from the program for FY 2010, it will receive a 2.0 percentage point reduction in its FY 2010 annual payment update.”

FFY 2011 (and subsequent years) RHQDAPU Program

CMS Proposal – Program Expansion: CMS is seeking comments on an additional 59 quality measures that could be selected for inclusion in the RHQDAPU program in FFY 2011 or in subsequent years. For a list of the measures refer to the *Federal Register* pages 23651 - 23653.

This Association will be commenting on the IPPS Quality Proposals and we encourage hospitals to also give specific examples related infrastructure needs to collect these additional measures. We welcome any comments from hospital to be incorporated into our comment letter.

Reporting Hospital-Acquired Conditions (HACs) - Including Infections

Federal Register pages 23547 - 23562

Background: Complications such as infections acquired in the hospital can trigger higher payments in the form of outlier payments and/or assignments to a higher severity DRG. The DRA required 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.

In the FFY 2008 final rule, CMS selected eight conditions that met these criteria. For discharges occurring on or after October 1, 2008 (FFY 2009), CMS will not include these diagnoses in the DRG assignment if the condition was not present on admission (POA) (i.e. hospital-acquired). This could 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 of HACs from time to time, as long as the list contains at least two conditions.

Currently, there are five POA indicator reporting options that hospitals should use: “Y”, “N”, “W”, “U”, and “1”. For more details on the POA indicators visit the CMS Web site at http://www.cms.hhs.gov/HospitalAcqCond/Downloads/poa_fact_sheet.pdf. The POA reporting requirements and hospital-acquired conditions (HAC) payment provisions only apply to IPPS hospitals.

CMS Proposal – List of HACs: For FFY 2009, CMS is considering nine additional HACs that could be subject to the HAC payment provision. Those under consideration for FFY 2009 are:

- Surgical Site Infections
- Legionnaires’ Disease
- Glycemic Control
- Iatrogenic Pneumothorax
- Delirium
- Ventilator-Associated Pneumonia
- Deep Vein Thrombosis / Pulmonary Embolism
- Staphylococcus aureus Septicemia
- Clostridium Difficile-Associated Disease

CMS is seeking comments on all of these conditions.

CMS Proposal – Payment for HACs: For FFY 2010, CMS is proposing “. . . to pay the CC/MCC MS-DRGs only for those HACs coded as “Y” and “W” indicators. The “Y” option indicates that the condition was present on admission. The “W” indicator affirms that the provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred.”

CMS believes “. . . that this approach will encourage better documentation and promote the public health goals of POA reporting by providing more accurate data about the occurrence of HACs in the Medicare population.”

VI. CAPITAL PAYMENTS

Capital Update Rate

Federal Register pages 23716 - 23717

Background: Reimbursement for IPPS 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: In FFY 2009, CMS will continue to provide a capital update for both urban and rural hospitals. *“The proposed update factor for FY 2009 . . . is 0.7 percent based on the best data available at this time. The proposed update factor under that framework is based on a projected 1.2 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a –0.5 percent adjustment for the FY 2007 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent.”*

In addition, CMS will apply a 0.9% behavioral offset reduction to the FFY 2009 federal capital payment rates 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 0.9% coding reduction, see the “Offset for Coding Improvements” section above.

Capital IME Elimination

Federal Register pages 23678 - 23680

Background: CMS has provided a capital payment teaching adjustment to eligible providers for the costs of Indirect Medical Education (IME). The current capital IME adjustment was determined by an empirical analysis, as reported in the 1991 capital rule. Based on recommendations from MedPAC, CMS adopted a policy to phase out the capital IME adjustment over three years, beginning in FFY 2008. As a result, CMS maintained the current capital IME adjustment in FFY 2008 to help mitigate abrupt changes in payment policy, but proposed to reduce capital IME payments by half for FFY 2009.

CMS Proposal: For FFY 2009, CMS is proposing to continue the phase-out of the capital IME payments. *“During the second year of the transition, FY 2009, the formula for determining the amount of the teaching adjustment was revised so that adjustment amounts will be half of the amounts provided under the current formula. For FY 2010 and after, hospitals will no longer receive an adjustment for teaching activity under the capital IPPS.”*

CMS concludes that *“. . . the record of relatively high and persistent positive margins for teaching hospitals under the capital IPPS indicated that the teaching adjustment is unnecessary, and that it was therefore appropriate to exercise our discretion under the capital IPPS to eliminate this adjustment.”*

CMS is providing an additional opportunity for comments on this policy change. **This Association will strongly object to this change and urges hospitals to submit comments as well.**

VII. WAGE INDEX

Wage Index Study

Federal Register pages 23617 - 23619

Background: “. . . as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” The regulations allow hospitals to request reclassification to another area, if they can prove that their wage levels are more similar to an adjacent area. The regulations (based on legal statute) also provide for reclassifications and adjustments to reflect employee commuting patterns and out-migration.

The Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA) required MedPAC to submit a report to Congress no later than June 30, 2007 on the Medicare wage index reclassification system applied under the Medicare IPPS. Within that report MedPAC was to include any alternatives that they would recommend to the wage index methodology that could be included in the FFY 2009 proposed rule.

MedPAC’s proposal (or proposals) must consider each of the following nine points:

- 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.

MedPACs’ June 2007 Report to Congress did address most of the nine points mentioned above. For more details on MedPAC’s recommendations reference the *Federal Register* pages shown above. A copy of the June 2007 Report to Congress is available at http://www.medpac.gov/documents/Jun07_EntireReport.pdf .

In February 2008, CMS awarded a Task Order to Acumen, LLC to help assist the Agency with meeting its requirements under MIEA-TRHCA. Acumen’s main responsibilities are to:

- conduct a detailed impact analysis that compares the effects of MedPAC’s wage and hospital compensation indexes with the CMS wage index; and
- assist CMS in developing a proposal (or proposals) that addresses the nine points for consideration.

Acumen is to determine whether differences between the two types of wage data (CMS’ cost report and occupational mix data versus BLS data) produce significant differences in wage index values between labor markets. CMS will present the results of Acumen’s findings in the FFY 2009 final rule or in a special *Federal Register* notice issued after the final rule is published. Congressional action would be needed to switch from cost

report data to BLS data.

Occupational Mix Adjustment

Federal Register pages 23624 - 23629

Background: CMS was required to include an occupational mix adjustment as part of its calculation of the wage index beginning in FFY 2005. The purpose of the occupational mix adjustment is to neutralize the effects of hospitals' employment choices (skill mix) 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.

Data on occupational mix are collected every three years, via a survey instrument. The current survey covers the six-month period from January 2006 through June 2006. The results of the 2006 Occupational Mix Survey were applied to the FFY 2008 wage index calculation.

CMS Proposal: For FFY 2009, CMS is proposing “. . . to use the entire 6-month 2006 survey data to calculate the occupational mix adjustment . . .”

Based on comments received last year, CMS has issued a revised 2007-2008 occupational mix survey that will be applied beginning with the FFY 2010 wage index. The revised 2007-2008 survey will collect hospitals' wage and hours data for a one-year prospective reporting period from July 1, 2007, through June 30, 2008 and will: eliminate the registered nurse subcategories; refine the definitions of some occupational categories; and include additional cost centers that typically provide nursing services.

Application of Rural Floor Budget Neutrality

Federal Register pages 23620 - 23623

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”). As is the case with most adjustments under IPPS, the increases that result from application of the rural floor must be applied in a budget neutral manner. Between FFY 1998 and FFY 2008, the rural floor budget neutrality adjustment was achieved by adjusting the standardized amounts. In FFY 2008, CMS began applying the rural floor budget neutrality adjustment to the wage indexes rather than to the standardized amount.

CMS Proposal: For FFY 2009 CMS is proposing “. . . to apply a State level rural floor budget neutrality adjustment to the wage index. . . . States that have no hospitals receiving a rural floor wage index would no longer have a negative budget neutrality adjustment applied to their wage indices. Conversely, hospitals in States with hospitals receiving a rural floor would have their wage indices downwardly adjusted to achieve budget neutrality within the State. All hospitals within each State would, in effect, be responsible for funding the rural floor adjustment applicable within that specific State.

Imputed Rural Floor Adjustment

Federal Register pages 23620 - 23623

Background: Currently, two states have no rural areas and one state with a rural area has no IPPS hospitals located in those areas. In FFY 2005, CMS adopted a three-year “imputed floor” measure to address concerns that hospitals in these all-urban states were disadvantaged by the absence of rural areas, because there is no floor for

their wage index. In FFY 2008, CMS extended the imputed floor for one additional year but allowed for it to expire in FFY 2009.

CMS Proposal: For FFY 2009, CMS is proposing “. . . to extend the imputed floor for 3 additional years, through FY 2011 . . .” In addition, CMS is proposing to apply the imputed floor budget neutrality adjustment at the State level to wage indexes in the same manner as the rural floor budget neutrality adjustment. CMS believes that both of these adjustments should be applied in the same manner.

Critical Access Hospital (CAH) Conversion to IPPS

Federal Register pages 23622 – 23623

Background: Currently, a CAH’s Medicare payment is based on 101% of reasonable costs. Generally, CAH Medicare payments are greater than Medicare IPPS payments because a CAH is guaranteed to recover its costs, while under the IPPS, it is not. CMS is aware of a number of CAHs that may be considering converting from CAH status back to IPPS, even though they continue to be CAH-eligible. CMS believes that these types of conversions would not benefit the CAH-eligible hospitals directly, but would benefit the urban hospitals in the state by increasing the rural floor.

CMS Proposal: For FFY 2009, CMS has proposed to address this issue by applying a State level rural floor budget neutrality adjustment (See “Application of the Rural Floor Budget Neutrality” section above) to the wage index.

Multi-campus Hospitals

Federal Register pages 23629 - 23630

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. 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.

In FFY 2008, CMS implemented the use of FTEs or Medicare discharge data to allocate salaries and hours to the campuses of multi-campus hospitals that are located in different labor markets. CMS will continue to use this method until revisions are made to Worksheet S-3 of the Medicare cost report that would require the reporting of FTE data by campus.

CMS Proposal: For FFY 2009, CMS will continue to allow hospitals the option of allocating their wage and hours for the FY 2009 wage index based on either FTEs or discharge data.

VIII. WAGE INDEX RECLASSIFICATIONS

MGCRB Reclassifications

Federal Register pages 23619 - 23620

Background: Individual hospitals or groups of hospitals (defined by counties) can apply to the Medicare Geographic Classification Review Board (MGCRB) to reclassify to another area for wage index purposes. Hospitals seeking reclassification must meet specific proximity and wage level criteria. CMS’ current average

hourly wage (AHW) comparison criterion for individual hospitals, is based on FFY 1993 wage index data and requires a hospital to demonstrate that its average hourly wage is:

- at least 108 % (for urban hospitals) or 106 % (for rural hospitals) of the average hourly wage of hospitals in the area in which the hospital is located; and
- at least 84 % (for urban hospitals) or 82 % (for rural hospitals) of the average hourly wage of hospitals in the area to which it seeks redesignation.

The average hourly wage standard for county group reclassifications has always been equivalent for both urban and rural county groups; 1% higher than the 84 % urban area individual reclassification standard (i.e. 85%).

In consideration of the MIEA-TRHCA requirements to review the reclassification system and in response to MedPAC's findings that more than one-third of hospitals currently receive a higher wage index due to geographic reclassifications or other wage index exceptions, CMS is proposing to implement some regulatory changes to the reclassification system.

CMS Proposal: Based on the use of more recent data used to compute the FFYs 2006, 2007, and 2008 wage indexes, for FFY 2009, CMS is proposing “. . . to change the criterion for the comparison of a hospital's average hourly wage to that of the area to which the hospital seeks reclassification to 88 percent for urban hospitals and 86 percent for rural hospitals for new reclassifications beginning with the FY 2010 wage index. . . .” CMS notes “. . . that the proposed changes in the reclassification criteria apply only to new reclassifications beginning with the FY 2010 wage index.” “The criterion for the comparison of a hospital's average hourly wage to that of its geographic area would be unchanged (108% for urban hospitals and 106 percent for rural hospitals).”

In addition, CMS is proposing “. . . to adjust the 85%t criterion for both urban and rural county group reclassifications to be equal to the proposed 88% standard for urban reclassifications . . .” CMS does “. . . not believe it would be appropriate to have a group reclassification standard lower than the individual reclassification standards, thus potentially creating a situation where all of the hospitals in a county could reclassify. . . .”

This proposal would not affect existing reclassifications.

Reclassification Withdrawal: Hospitals that had been approved for FFY 2009 MGCRB reclassifications are permitted to withdraw their applications within 45 days of the publication of the proposed rule.

Applications for FFY 2010 reclassifications are due to MGCRB by September 2, 2008. Applications and other information regarding MGCRB reclassifications are available on the CMS Web site at <http://www.cms.hhs.gov/providers/prrb/mginfo.asp>.

Out-Migration Adjustment

Federal Register page 23636

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 one county and work in a different county with a higher wage index. Hospitals in 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 adjustment. 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 three-year ends, or it may qualify and receive a different out-migration adjustment. CMS designates new qualifying counties each year.

Prior to FFY 2008, CMS used the pre-reclassified wage index when calculating the out-migration adjustments. For the FFY 2008 wage index, CMS began using the post-reclassified wage indexes when determining the out-migration adjustment.

CMS Proposal: For FFY 2009, CMS is proposing to continue to calculate the out-migration adjustment based on the post-reclassified wage indexes.

“Consistent with our FY 2005, 2006, 2007, and 2008 IPPS final rules, we are proposing that hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act will be deemed to have chosen to retain their redesignation or reclassification. . . .redesignated/reclassified hospitals would be deemed to have waived the out-migration adjustment unless CMS is otherwise notified.”

Section 508 Reclassifications

No *Federal Register* pages are available on this issue.

Background: Section 508 of the MMA states that a qualifying hospital may appeal its 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 through September 30, 2007. The Medicare, Medicaid, SCHIP Extension Act of 2007 extended the Section 508 reclassifications through September 30, 2008.

Beginning October 1, 2008 (FFY 2009), all providers currently receiving a Section 508 reclassification will revert to their home area wage index, plus any applicable out-migration adjustment or reclassification.

Lugar Reclassifications

Federal Register pages 23634 - 23636

Background: Current 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.” Hospitals that qualify for an automatic Lugar reclassification may have also requested a reclassification under the MGCRB criteria, in which case, the requested reclassification overrides the Lugar reclassification. Lugar hospitals, being located in rural areas, are subject to the rural MGCRB reclassification criteria.

Hospitals that qualify for both a Lugar and a MGCRB reclassification 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.

CMS Proposal: For FFY 2009, CMS is proposing to increase the rural MGCRB reclassification threshold to 86%.

IX. COST OUTLIERS

Federal Register pages 23710 - 23712

Background: CMS provides payments for outlier cases; those 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 for total outlier payments in order to ensure that total outlier payments equal 5.1 % of total IPPS payments.

CMS Proposal: For FFY 2009, CMS is proposing a fixed-loss cost threshold “. . . equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus \$21,025.”

The proposed \$21,025 outlier threshold for FFY 2009 represents a decrease of 5.2 % compared to the FFY 2008 threshold of \$22,185. “*Better recognition of severity of illnesses 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 need to decrease the fixed-loss outlier threshold so that more cases qualify for outlier payments.*”

X. Graduate Medical Education

Indirect Medical Education Adjustment

Federal Register pages 23666 - 23667

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 FFYs 2005 and 2006 to 1.42 and 1.37 respectively. However, in FFY 2007, the MMA called for a decrease in the multiplier to 1.32, then restores the multiplier back to the FFY 2003 level of 1.35 for FFY 2008 and thereafter.

Therefore, the multiplier will remain at 1.35 for FFY 2009. CMS estimates “. . . that application of this formula multiplier for FY 2009 IME adjustment will result in an increase in IME payment of 5.5% for every approximately 10% increase in the hospital's resident-to-bed ratio.”

XI. Additional Payments for New Technology

Federal Register pages 23608 - 23617

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 did not approve any applications for new technology add-on payments for FFY 2008.

CMS Proposal: For FFY 2009, CMS is considering four applications for new technology add-on payments:

- CardioWest™ Temporary Artificial Heart System
- Emphasys Medical Zephyr® Endobronchial Valve
- Oxiplex®
- TherOx Downstream® System

Any applications set forth in the proposed rule that do not receive FDA approval by July 1, will not be considered in the IPPS final rule.

XII. RURAL HOSPITALS

Rural Referral Centers (RRCs)

Federal Register pages 23665 - 23666

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% or 108% 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 exempt from the requirement that its average hourly wage exceed 106% or 108% of the average hourly wage of the labor market area where the hospital is located for the purpose of geographic reclassification.

Qualification Criteria for RRC Status: To qualify for RRC status, a hospital must meet the following criteria:

- 275 or more beds available for use; or
- Rural hospitals that do not meet the bed size requirement need to meet two mandatory prerequisites:
 - *“The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and*
 - *The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year . . .)”*

CMS Proposal - Additional Criteria: For FFY 2009, CMS is proposing that “. . . if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2008, they must have a CMI value for FY 2007 that is at least—

- 1.4285; or
- *The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs . . .) calculated by CMS for the census region in which the hospital is located.”*

The proposed median CMI values by region are shown in the table below:

Region	Case-Mix Index Value
New England (CT, ME, MA, NH, RI, VT)	1.2515
Middle Atlantic (PA, NJ, NY)	1.2691
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3589
East North Central (IL, IN, MI, OH, WI)	1.3572
East South Central (AL, KY, MS, TN)	1.3040
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.3557
West South Central (AR, LA, OK, TX)	1.4405
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.4692
Pacific (AK, CA, HI, OR, WA)	1.3872

For FFY 2009, CMS suggests that if a hospital is to qualify “. . . for initial RCC status for cost reporting periods beginning on or after October 1, 2008, must have as the number of discharges for its cost reporting period that began during FY 2006 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located . . .”

The proposed median number of discharges for urban hospitals by region are shown in the table below:

Region	Discharges
New England (CT, ME, MA, NH, RI, VT)	8,158
Middle Atlantic (PA, NJ, NY)	10,443
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,344
East North Central (IL, IN, MI, OH, WI)	8,900
East South Central (AL, KY, MS, TN)	7,401
West North Central (IA, KS, MN, MO, NE, ND, SD)	7,988
West South Central (AR, LA, OK, TX)	5,816
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,919
Pacific (AK, CA, HI, OR, WA)	8,600

Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs): Volume Decrease Adjustment

Federal Register pages 23661 - 23665

Background: SCHs and MDHs may receive special payment protections under the IPPS. These providers are eligible to receive hospital-specific payment rates, if that rate exceeds their adjusted federal standard payment amount. SCHs may receive a full hospital-specific payment rate, while MDHs may receive a blended rate consisting of 75 percent hospital-specific and 25 percent federal amounts. SCHs and MDHs receive an adjustment to their hospital-specific payment rates if they experience a decrease of more than 5% in the total number of inpatient discharges from one cost reporting period to another. The circumstances leading to this decline must have been beyond the facility’s control. This volume adjustment is designed to compensate a SCH or MDH for the fixed costs, including the maintenance of necessary core staff and services. However, not all staff costs can be considered fixed costs.

The SCH or MDH must use a standardized formula to demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. The process for determining the amount of the volume decrease adjustment can be found in Section 2810.1 of the Provider Reimbursement Manual. For adjustment requests for decreases in discharges beginning with FFY 2007, a SCH or MDH could opt to use either the AHA Annual Survey or the Occupational Mix Survey.

CMS Proposal – Calculating Core Staffing Factors: For FFY 2009, CMS is proposing to “. . . modify our methodology for calculating the average nursing hours per patient day using the FY 2006 Occupational Mix Survey data and the FY 2006 Medicare Cost Report. . . . For each provider in the pool, we would calculate the number of nursing hours by adding the number of registered nurses, licensed practical nurses, and nursing aide hours reported on the Occupational Mix Survey. We would divide the result of this calculation by the total number of patient days reported on line 12 of Worksheet S-3, Part 1, Column 6 of the Medicare Cost Report. This includes patient days in the general acute care area and the intensive care unit area. The result is the number of nursing hours per patient day.”

For FFY 2009, CMS also recommends a “. . . different method to remove outliers in the data. First, we would calculate the difference between the observations in the 75th percentile and the 25th percentile...the inter-quartile range. We would remove observations that are greater than the 75th percentile plus 1.5 times the inter-quartile range and less than the 25th percentile minus 1.5 times the inter-quartile range.”

In addition, CMS is also proposing to “. . . refine our methodology to calculate the core staffing factors using the AHA Annual Survey data as well. . . . we would merge the AHA Annual Survey Data with the corresponding Medicare Cost report. . . . We would multiply the number of nurse, licensed practical nurse, and nursing aide FTEs reported on the AHA Annual Survey by 2,080 hours to derive the number of nursing hours per year. . . . We would then divide this number by the total number of patient days reported on line 12 on Worksheet S-3, Part 1, Column 6 of the Medicare cost report.”

They would also remove the outliers from the AHA Annual Survey in the same way as for the Occupational Wage Mix Survey, described above.

“After removing the outlier, we would group the hospitals by bed size and census area to calculate the average number of nursing hours per patient day for each category.”

XIII. OTHER ISSUES

Post-Acute Transfers to Home Health Services

Federal Register pages 23639 - 23642

Background: When a patient is transferred from one acute care facility to another acute care facility, the transferring hospital receives a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient were discharged without being transferred. Beginning in FFY 1999, the transfer policy was expanded to cover patients discharged to a post-acute care setting. With respect to home health services, the rule established a three-day timeframe within which services must begin (after patient discharge) for the case to be subject to post-acute care transfer rules. In FFY 2006, CMS expanded the list of post-acute eligible DRGs to 182 based on the following criteria:

- The DRG must have a mean length of stay of at least three days.
- The DRG must have at least 2,050 post-acute care transfer cases.
- At least 5.5% of the cases in the DRG are discharged prior to the geometric mean length of stay

for the DRG.

- If the DRG is one of a paired set of DRGs based on a presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria.

With the adoption of MS-DRGs, CMS increased the total number of DRGs from 538 to 745; which increased the number of post-acute care transfer DRGs to 273.

CMS Proposal: In FY 2009, CMS is proposing to “. . . extend the timeframe to within 7 days of discharge to home under a written plan for the provision of home health services.”

CMS is not proposing any additional MS-DRGs for inclusion in the post-acute care transfer policy in FY 2009. However, since some MS-DRGs are being revised, CMS plans to evaluate the revised and new MS-DRGs to determine if they will meet the post-acute transfer criteria. The MS-DRGs being evaluated are 001, 002, 215, 245, 901 through 909, 913 through 923, 955 through 959, and 963 through 965.

Value-Based Purchasing Plan

Federal Register pages 23660 - 23661

Section 5001(b) of the DRA authorized CMS to develop a plan for Value-Based Purchasing (VBP) under the Medicare inpatient PPS. CMS has developed a plan which has been presented to Congress for approval and authorization. Although the DRA authorized the development of a VBP program, additional legislation is required to establish and implement the VBP program.

In this FFY 2009 proposed rule, CMS discusses the next steps for testing and refining its VBP proposal, but does not propose any implementation steps. The VBP plan will be tested using the data from the RHQDAPU program to generate performance scores and financial impacts under the scenarios laid out in CMS' Report to Congress (available on the CMS Web site.) CMS will use the results from these tests to analyze and refine its VBP proposal.

Two issues that CMS highlights as priorities for refinement are:

- How to handle hospital data with small sample sizes; and
- Developing a scoring methodology for outcomes measures.

CMS is asking for public comments on “. . . how to take full advantage of the new information generated through this testing and further Plan development.” **This Association will take this opportunity to also comment that this plan, and any other proposed VBP plan, should not generate any program savings.**

Hospital Emergency Services Under EMTALA

Federal Register pages 23668 - 23673

Background: Medicare participating hospitals and CAHs are required to adequately treat and stabilize all individuals who may present themselves at a 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 FFY2008 final rule, CMS revised the sanction waiver provision regulations to state: “. . . *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.*”

CMS Proposal: For FFY 2009, CMS is proposing to provide clarification to ensure an individual the protections intended by the EMTALA statute, “. . . *especially section 1867(g) of the Act (obligating a hospital with specialized capabilities to accept an appropriately transferred individual if it has the capacity to treat that individual), we believe it is appropriate to propose to clarify that section 1867(g) of the Act continues to apply so as to protect even an individual who has been admitted as an inpatient to the admitting hospital who has not been stable since becoming an inpatient.*” CMS believes that this clarification is necessary to ensure that EMTALA protections are continued for individuals who are not otherwise protected by the hospital CoPs.

CMS Proposal – EMTALA Physician On-Call Requirements: For FFY 2009, CMS is proposing to delete the provision related to maintaining a list of on-call physicians from the current language, replacing it with: “. . . *An on-call list of physicians on its medical staff available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under §489.24 in accordance with the resources available to the hospital . . .*” CMS believes that these proposed changes will make regulations consistent with the statutory basis for maintaining an on-call list.

In addition, CMS is proposing a “. . . *community call*” to be a formal on-call plan that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both . . .” CMS believes this will provide additional flexibility to hospitals offering on-call services and also improve access to specialty physician services for individuals in an emergency department. For more details on what to include in a community plan refer to the *Federal Register* pages referenced in the section heading above.

Emergency Room Disclosure

Federal Register pages 23683 - 23685

Background: CMS believes that hospitals should be required to disclose information concerning whether a physician is available on the premises 24 hours per day, 7 days per week to patients at the time of inpatient admission or outpatient registration. In the FFY 2008 final rule, CMS adopted this as policy to require 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.

CMS Proposal: For FFY 2009, CMS is proposing “. . . *to terminate the provider agreement of any hospital or CAH that fails to comply with the requirements.*”

Disclosure of Physician Ownership in Hospitals

Federal Register pages 23683 - 23685

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 is the transparency of investment information.

As a result, CMS in the FFY 2008 final rule, revised their regulations to require that a hospital disclose to all patients whether it is physician-owned and, if so the names of its physician owners.

CMS Proposal: For FFY 2009, CMS is proposing further clarification to “. . . revise the language in §489.3 to define a “physician-owned hospital” as a participating hospital in which a physician, or an immediate family member of a physician (as defined at §411.351), has an ownership or investment interest in the hospital.”

Since some physician-owned hospitals have no physician, owners who refer patients to the hospital it would be an unnecessary burden to require them to disclose to all patients that it is a physician-owned. Therefore, CMS is proposing to revise the language to read; “. . . §489.20(v) new language to provide for an exception to the disclosure requirements for a physician-owned hospital (as defined at §489.3) that does not have any physician owners who refer patients to the hospital (and that has no referring physicians (as defined at §411.351) who have an immediate family member with an ownership or investment interest in the hospital), provided that the hospital attests, in writing, to that effect and maintains such attestation in its files for review by State and Federal surveyors or other government officials.”

Furthermore, CMS is proposing “. . . to require a hospital to require all physicians who are members of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients who they refer to the hospital any ownership or investment interest in the hospital held by themselves or by an immediate family member.”

Physician Self-Referrals

Federal Register pages 23685 - 23693

Stand in the Shoes:

The physician self-referral law prohibits a physician from making referrals for certain designated health services (DHS) payable under Medicare to an entity in which the physician (or an immediate family member) has a financial relationship. CMS published a final rule in the *Federal Register* on September 5, 2007, entitled “Medicare Program; Physicians’ Referrals to Health Care Entities with Which They Have Financial Relationships (Phase III).” This Phase III final rule includes provisions for applying the rules that describe direct and indirect compensation arrangements in §411.354. In order to determine what the compensation arrangements are, the referring physician “stands in the shoes” of one of the following:

- another physician who employs the referring physician;
- his or her wholly owned professional corporation;
- a physician practice that employs or contracts with the referring physician or in which the physician has an ownership interest; or
- a group practice of which the referring physician is a member or independent contractor.

The referring physician has the same compensation arrangements as the physician organization in whose shoes he/she stands. Currently, all physicians stand in the shoes of their physician organizations, regardless of the nature of the compensation they receive.

CMS Proposal – Stand in the Shoes: For FFY 2009, CMS is proposing two alternatives to address concerns of Academic Medical Centers and integrated tax-exempt health care delivery systems with the “stand in the shoes” issues described within this rule. “For the first proposal, we propose revising §411.354(c)(2)(iv) to provide that a physician would be deemed not to stand in the shoes of his or physician organization if the compensation arrangement between the physician organization and the physician satisfies the requirements of the exception in §411.357(c) (for bona fide employment relationships), the exception in §411.357(d) (for personal service arrangements), or the exception in §411.357(l) (for fair market value compensation).”

“Our alternative proposal is to make no revisions to the Phase III “stand in the shoes” provisions in §§411.354(c)(1)(ii), (c)(2)(iv), and (c)(3) and, to the extent necessary to protect non-abusive arrangements, promulgate a separate exception using our authority under section 1877(b)(4) of the Act to create exceptions for arrangements that do not pose a risk of program or patient abuse. . . . Specifically, we are considering establishing a new exception . . . for compensation arrangements between DHS entities and the physician organizations and physicians for ‘mission support’ payments...how we should define those payments . . . and what criteria such an exception should include to protect against program or patient abuse.”

Period of Disallowance:

The “period of disallowance” is the time period for which the physician can’t refer patients for designated health services to an entity and for which the entity could not bill Medicare when a financial relationship between a referring physician and an entity failed to satisfy the requirements of an exception to the general prohibition on self-referral.

CMS Proposal – Period of Disallowance: In response to commenters’ questions, CMS is proposing to define the period of disallowance for FFY 2009. *“ . . . we are proposing to amend §411.353(c) to provide that, where the reason(s) a financial relationship does not meet any applicable exception is not related to compensation . . . the period of disallowance would begin on the date the arrangement first was out of compliance and end no later than the date the arrangement was brought into compliance . . . ”*

“We are also proposing that, where the reason a financial relationship does not meet any applicable exception is related to the payment or receipt of excess compensation . . .the period of disallowance would begin on the date the arrangement first was out of compliance and end no later than the date the excess compensation . . .was returned by the party receiving it . . .”

“Our proposal would also prescribe a period of disallowance where the reason a financial relationship does not meet any applicable exception is related to the payment or receipt of compensation that is insufficient to satisfy the requirements of an exception . . .the period of disallowance would begin on the date the arrangement first was out of compliance and end no later than the date the shortfall was paid to the party to which it was owed . . .”