



**WISCONSIN HOSPITAL
ASSOCIATION**

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

August 2008

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I. OVERVIEW

CMS published the final Medicare Inpatient Prospective Payment System (IPPS) rule for federal fiscal year (FFY) 2009 in the August 19, 2008 *Federal Register*. Changes are effective October 1, 2008, unless otherwise noted.

Note: Text in italics is extracted from either the April 30, 2008 or the August 19, 2008 *Federal Registers*.

The final rule incorporates mandates contained in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which was enacted on July 15, 2008. Due to the timing of this legislation, CMS was unable to re-compute the FFY 2009 wage index values and rates in time for publication of the final rule. Therefore, **CMS has indicated that they will re-issue the final FFY 2009 wage index values and other related tables in a separate Federal Register notice.** This will affect wage index values, standardized amounts, Medicare-Severity Diagnosis Related Groups (MS-DRGs) relative weights, offsets, the outlier threshold, and budget neutrality adjustments.

Major Provisions of the Final Rule:

- **Marketbasket Update:** Even though CMS is providing a full marketbasket update of 3.6% for FFY 2009, the standard rate will only increase by 2.7% due to a legislatively mandated 0.9% reduction to account for anticipated coding improvements under the new MS-DRGs and adjustments for budget neutrality.

- **Quality Measures:** Hospitals will be required to report on 30 quality measures in order to receive the full marketbasket update in FFY 2009, compared to 27 measures in FFY 2008. In addition, for FFY 2010 payment determination, CMS will expand the number of required inpatient quality measures to 42. CMS had proposed an increase to 72 measures.

- **Hospital Acquired Conditions (HACs):** CMS in the proposed rule, solicited comments on nine additional HACs that could effect payment in FFY 2009. Based on comments received, CMS added only three conditions in the final rule, increasing the number of HACs from 8 to 11. Therefore, effective October 1, 2008, hospital claims with one of eleven selected hospital-acquired conditions may be reimbursed at a reduced MS-DRG level if the condition was acquired in the hospital.

- **Cost Report Changes:** CMS will revise the Medicare cost report to help improve the data CMS uses to determine DRG weights. In the final rule, CMS is adopting its proposal to split the current cost center for Medical Supplies Charged to Patients into one line for "Medical Supplies Charged to Patients" and another line for "Implantable Devices Charged to Patients." However, CMS rejected proposed criteria that would have established complex rules for determining the devices that could be reported on the new line. Instead, CMS accepted recommendations that the determination be done through use of existing revenue codes.

- **Section 508 Reclassifications:** Per MIPPA, Section 508 reclassifications, which were due to expire on September 30, 2008, will be extended through September 30, 2009.

- **Wage Index Reclassifications:** CMS has adopted its proposal to revise the average hourly wage (AHW) comparison criteria used in determining whether a hospital is eligible for reclassification to another geographic location. However, CMS will provide a two-year transition period for this revision, beginning with requests for FFY 2010. For FFY 2010, CMS will restrict geographic reclassifications by increasing the comparison benchmarks to 86% for urban hospitals and to 84% for rural hospitals. The group reclassifications test will increase from 85% to 86%. For reclassifications beginning in FFY 2011, the new average hourly wage comparison criteria will be fully phased-in, increasing the benchmarks to 88% for urban hospitals and to 86% for

rural hospitals. The group reclassification test will increase to 88%. These changes affect new reclassifications beginning with the FFY 2010 wage index and will not affect existing reclassifications.

- **Indirect Medical Education for Capital:** Last year, CMS adopted a policy to eliminate the capital teaching adjustment over a three-year period beginning October 1, 2007. In the final rule, CMS confirms that they will reduce the teaching adjustment by 50% in FFY 2009 and eliminate the teaching adjustment completely in FFY 2010.

- **Sole Community Hospitals (SCHs):** Per MIPPA, SCHs with cost reporting periods beginning on or after January 1, 2009 will be paid based on their FFY 2006 hospital specific rate if it yields the highest payment compared to using the Federal rate or to their hospital-specific rate based on 1982, 1987, or 1996 costs.

- **Post-Acute Transfers to Home Health Services:** Based on comments from the industry, CMS rejected a proposal that would have extended the time period for when the post-acute transfer policy would apply to an acute care discharge to a home health care provider from three days to seven days.

- **Rural Floor and Imputed Floor Budget Neutrality:** CMS will change their policy as proposed and begin to apply the rural floor budget neutrality adjustment at the state level instead of the national level. This will decrease payments to those states that have the most hospitals receiving the rural floor wage index and increase payments to other states. CMS will implement this change over a three-year period. In FFY 2009, hospitals will receive a blended wage index of 20% of a wage index with the State level budget neutrality adjustment and 80% of a wage index with the national budget neutrality adjustment. For FFY 2010, the blended wage index will reflect a 50% State level adjustment and 50% national adjustment. In FFY 2011, the adjustment will be based entirely on 100% of the State level methodology

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 page 48681

Consistent with current law, CMS will provide a full marketbasket update of 3.6% 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 second quarter 2008 forecast. Hospitals that do not submit qualifying quality data would receive a 2.0 percentage point update factor reduction.

For FFY 2009, the budget neutrality adjustment is 0.999580 which will be applied to the national standardized amount.

Offset for Coding Improvements

Federal Register pages 48447 - 48450

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 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 hospital 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 three years. 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 established a policy that would apply the behavioral offset adjustment to hospital-specific rates, because Sole Community Hospitals (SCHs) and Medicare Dependent 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.

CMS’ Final Rule - Hospital-Specific Rates: In the final FFY 2009 rule, CMS asserts its belief that it does have the 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. In the FY 2009 IPPS proposed rule, we stated that 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 48778

For FFY 2009, hospitals with wage indexes greater than 1.0 will continue to use a labor share of 69.7% and hospitals with wage indexes less than or equal to 1.0 will receive a labor share of 62.0%. The 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. **The amounts shown are tentative due to MIPPA which was signed into law on July 15, 2008.**

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 (3.6 Percent)	\$3,571.82	\$1,552.74
Reduced Update (1.6 Percent) ²	\$3,502.87	\$1,522.76

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 (3.6 Percent)	\$3,177.23	\$1,947.33
Reduced Update (1.6 Percent) ²	\$3,115.89	\$1,909.74

Capital Federal Rate¹	
National Capital Rate	\$423.96

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

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

IV. MS-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

MS-DRG Patient Classifications

Federal Register pages 48443 - 48447

Background: 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 FFY 2008, CMS adopted MS-DRGs, which modified the basic logic of the prior DRG system by adding severity as a criteria. The MS-DRGs include three severity levels: 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 two-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' Final Rule: For FFY 2009, patients will be assigned to MS-DRGs with 100% MS-DRG weights.

Relative Weights

Federal Register pages 48450 - 48471

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.

CMS' Proposal—Relative Weight Calculation: In FFY 2009, CMS proposed “. . . 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 % based on costs.” The FFY 2009 relative weights will be computed using Version 26.0 MS-DRGs.

CMS' Final Rule—Relative Weight Calculation: For FFY 2009, CMS has adopted the above proposal as final.

Refining Medicare Cost Reports

Federal Register pages 48458 - 48471

Background: Concerns have been raised that the MS-DRG cost weights do not accurately reflect the costs of expensive medical devices. In an effort to improve the cost report information that CMS uses to determine DRG weights, state and national hospital associations have launched an educational campaign to 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 IPPS rule, stated its support for the associations' education initiative and issued Change Request 5928 on February 29, 2008, which informed fiscal intermediaries/Medicare Administrative Contractors (MACs) about it.

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

As a first step, CMS proposed 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 proposed that hospitals use the Outpatient PPS (OPPS) 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. Specifically, CMS proposed 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.”

CMS' Final Rule: For FFY 2009, CMS is adopting “. . . our proposed policy to split the current cost center for Medical Supplies Charged to Patients into one line for “Medical Supplies Charged to Patients” and another line for “Implantable Devices Charged to Patients.” However, when determining what should be reported in these respective cost centers, . . . we are instead adopting the commenters' recommendation that hospitals should use revenue codes established by the NUBC to determine what should be reported in the “Medical Supplies Charged to Patients” and the “Implantable Devices Charged to Patients” cost centers.”

“Hospitals must continue to report ICD-9-CM codes and charges with an appropriate UB revenue code consistent with NUBC requirements. When reporting the appropriate revenue codes for services, hospitals should choose the most precise revenue code, or subcode if appropriate.”

“. . .the policy that we are finalizing in this final rule does not include a cost threshold to determine whether items should be reported as a medical device or a medical supply.” CMS continues to be concerned that a cost threshold may affect pricing practices of device manufacturers where prices of certain devices could be inflated to ensure that item met the threshold to be classified as a device.

V. REPORTING OF HOSPITAL QUALITY DATA

The IPPS FFY 2009 final rule includes major changes to hospital quality reporting requirements, including an expansion of the number of reportable quality measures for FFY 2010 and subsequent years.

Currently, hospitals must report 27 quality measures to receive the full marketbasket update. CMS plans to add three new measures in FFY 2009 and 13 more for FFY 2010. CMS had proposed an additional 43 measures for FFY 2010.

Reporting Requirements to Receive the Full Marketbasket Update

Federal Register pages 48597 - 48628

Background: The MMA authorized a quality data reporting program that required hospitals to submit quality data to CMS for three years (FFYs 2005-2007) to receive a full IPPS payment update. Participating hospitals were required to submit data on a set of ten core quality measures and those data were required to meet certain validation requirements. Hospitals that withdrew from the program or failed to submit valid data received a reduced 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 or failure to comply with the quality reporting program was increased to a reduction of 2.0 percentage points. The FFY 2007 rule also included procedural changes 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 27 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 it would adopt new quality measures a year in advance and notify the industry 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 NQF. However, 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 requiring hospitals to report Hospital Consumer Assessment of

Healthcare Providers and Systems (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 shows the quality measures for FFY 2009, adopted as final in the CY 2008 OPPS rule (the new 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, 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' Final Rule—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 proposed to “. . . 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.”

CMS’ Final Rule—Attestation: For FFY 2009, CMS has adopted the above proposal as final.

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’ 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 proposed to “. . . 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.

CMS’ Final Rule—Appeals: For FFY 2009, has adopted the above proposal as final.

FFY 2010 RHQDAPU Program

CMS’ Proposal—Update of Current Measures: For FFY 2010, CMS proposed “. . . 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’ Final Rule—Update of Current Measures: For FFY 2010 payment determination, “. . . CMS will retire the *Pneumonia Oxygenation measure*. Hospitals will no longer be required to submit data on this measure beginning with January 1, 2009.”

For FFY 2010, CMS will calculate the AMI and Pneumonia measures using the updated timing intervals starting with discharges on or after January 1, 2009.

CMS’ Proposal—Program Expansion: For FFY 2010, CMS proposed “. . . 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*.”

CMS’ Final Rule—Program Expansion: CMS has adopted 13 of the 43 measures and retired the pneumonia oxygenation measure for FFY 2010. Therefore, the total quality measures to be reported are 42 for FFY 2010. Those measures adopted for FFY 2010 are highlighted in the chart below.

FFY 2010 Proposed and Adopted RHQDAPU Measures
 (highlighted measures are endorsed by the NQF and have been adopted)

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.

CMS stated, “To the extent that the proposed measures have not already been endorsed by a consensus building entity such as the NQF, we anticipated that they would be endorsed prior to the time that we issued this final rule. . . . We stated that we intended to finalize the FY 2010 RHQDAPU program measure set for the FY 2010 payment determination in this final rule, contingent upon the endorsement status of the proposed measures.

However, we stated that, if a measure had not received NQF endorsement by the time we issued this final rule, we intended to adopt that measure for the RHQDAPU program measure set in the CY 2009 OPPS/ASC final rule . . . if the measure received endorsement prior to the time we issued the CY 2009 OPPS/ASC final rule. . . .”

“ . . . the measures which have not yet received NQF endorsement, and that we intend to adopt for the FY 2010 RHQDAPU program measure set in the CY 2009 OPPS/ASC final rule . . . if the measures receive endorsement from a national consensus-based entity such as NQF. . . .” are as follows:

- Readmission Measures (Medicare Patients)
 - AMI 30-Day Risk Standardized Readmission Measure (Medicare patients); and
 - Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)

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

- *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 begin implementing this requirement with discharges on or after January 1, 2009.”

CMS’ Final Rule—RHQDAPU Program Procedures: For FFY 2010, CMS has adopted the above proposal with the exception of HCAHPS.

*“Even though data on applicable measures will not be due until 4.5 months after the end of the preceding quarter, hospitals must submit their aggregate population and sample size counts **no later than 4 months** after the end of the preceding quarter (the exact dates will be posted on the QualityNet Web site).” CMS “. . . will provide hospitals with these Medicare claims counts and submitted patient level data counts on the QualityNet Web site approximately 2 weeks before the quarterly submission deadline.”*

“The data submission deadline for hospitals to submit patient level data for the 26 SCIP, AMI, HF, PN measures for 1st calendar quarter of 2009 discharges will be August 15, 2009.”

“The data submission deadline for hospitals to submit aggregate population and sample size count data for SCIP, AMI, HF, PN for 1st calendar quarter of 2009 discharges will be August 1, 2009.”

“The following RHQDAPU program measures will be calculated using **Medicare claims** with no additional data submitted by hospitals:”

Topic	Quality Measure
Mortality Measures (Medicare Patients)	<ul style="list-style-type: none"> • MORT-30-AMI Acute Myocardial Infarction 30-day mortality Medicare patients • MORT-30-HF Heart Failure 30-day mortality Medicare patients • MORT-30-PN Pneumonia 30-day mortality Medicare patients
Readmission Measure (Medicare Patients)	<ul style="list-style-type: none"> • Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSI), Inpatient Quality Indicators (IQI) and Composite Measures	<ul style="list-style-type: none"> • Death among surgical patients with treatable serious complications • Iatrogenic pneumothorax, adult • Postoperative wound dehiscence • Accidental puncture or laceration • Abdominal aortic aneurysm (AAA) mortality rate (with or without volume) • Hip fracture mortality rate • Mortality for selected surgical procedures (composite) • Complication/patient safety for selected indicators (composite) • Mortality for selected medical conditions (composite)
Nursing Sensitive	<ul style="list-style-type: none"> • Failure to Rescue (Medicare claims only)

CMS’ Proposal—Chart Validation: For FFY 2010, CMS proposed “. . . 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 in 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’ Final Rule—Chart Validation: For FFY 2010, CMS has adopted the above proposal as final without modification.

CMS’ Proposal—Withdrawal from RHQDAPU: For FFY 2010, CMS proposed “. . . 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.”

CMS’ Final Rule—Withdrawal from RHQDAPU: For FFY 2010, CMS has adopted the above proposal as final.

FFY 2011 (and subsequent years) RHQDAPU Program

CMS' Proposal—Program Expansion: CMS sought 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 48611 - 48613.

CMS' Final Rule—Program Expansion: For FFY 2011 and subsequent years, CMS did not adopt any of the proposed additional 59 measures, but stated they are developing cancer care measures for future implementation. CMS also indicated that it is their “. . . *practice to utilize the most current science and the guidance of technical experts in the respective fields when selecting measures for inclusion in the program.*”

Reporting Hospital-Acquired Conditions (HACs)—Including Infections

Federal Register pages 48471 - 48488

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 a 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 the HAC payment provisions only apply to IPSS hospitals.

CMS' Proposal—List of HACs: For FFY 2009, CMS considered nine additional HACs that could be subject to the HAC payment provision.

CMS' Final Rule—List of HACs: For FFY 2009, CMS is adopting three of the nine proposed conditions that will be subject to the HAC payment provision. They are listed in the table below:

Hospital Acquired Conditions

(the highlighted conditions are the current and adopted conditions for FFY 2009)

Current HACs	Proposed FFY 2009 HACs	New HACs for FFY 2009
Mediastinitis after CABG/Surgical Site Infection	Surgical Site Infections	Surgical Site Infections/ Orthopedic/Total Knee, Bariatric Surgery
Foreign object retained after surgery	Deep Vein Thrombosis/Pulmonary Embolism	Deep Vein Thrombosis/Pulmonary Embolism
Air embolism	Glycemic Control	Glycemic Control
Blood incompatibility	Legionnaires' Disease	
Stage III and IV pressure ulcers	Iatrogenic Pneumothorax	
Falls and trauma: fracture, dislocation, intracranial injury, crush	Delirium	
Catheter associated(Urinary Tract Infections) UTI	Ventilator-associated Pneumonia	
Vascular catheter associated infection	Staphylococcus Aureus Septicemia	
	Clostridium Difficile-associated Disease	

CMS has indicated that the other conditions, which were proposed but not adopted, could be considered for future years.

CMS Proposal—Payment for HACs: For FFY 2009, CMS proposed “. . . 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.”

CMS Final Rule—Payment for HACs: For FFY 2009, CMS is “. . . finalizing our proposal to pay for both the POA “Y” and “W” options.” CMS will not pay for the POA “N” or “U” indicator option.”

VI. CAPITAL PAYMENTS

Capital Update Rate

Federal Register pages 48769 - 48771

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’ Final Rule: In FFY 2009, CMS will continue to provide a capital update for both urban and rural hospitals. The final update factor for FFY 2009 is 0.9 percent based on “. . . a projected 1.4 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 48673 - 48681

Background: CMS has provided a teaching adjustment to capital payments to cover the costs of Indirect Medical Education (IME). The current capital IME adjustment was determined using 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 proposed 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’ Final Rule: For FFY 2009, CMS is adopting the above proposal as final without modification.

VII. WAGE INDEX

Occupational Mix Adjustment

Federal Register pages 48575 - 48581

Background: CMS was required to include an occupational mix adjustment as part of its calculation of the wage index beginning in FFY 2005. 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’ Final Rule: For FFY 2009, CMS will continue 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 48570 - 48574

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 the 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 applied was achieved by adjusting the national 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 proposed “. . . 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.

CMS’ Final Rule: For FFY 2009, CMS has adopted the above proposal with some modification.

“We have decided to phase in, over a 3-year period, the transition from the national budget neutrality adjustment to the State level budget neutrality adjustment. In FY 2009, hospitals will receive a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, the blended wage index will reflect 50 percent of the State level adjustment and 50 percent of the national adjustment. In FY 2011, the adjustment will be completely transitioned to the State level methodology.”

Imputed Rural Floor Adjustment

Federal Register pages 48570 - 48574

Background: Currently, two states have no rural areas and one state has no IPPS hospitals located in rural 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 proposed “. . . to extend the imputed floor for 3 additional years, through FY 2011” In addition, CMS proposed 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 believed that both of these adjustments should be applied in the same manner.

CMS’ Final Rule: For FFY 2009, CMS is adopting the above proposal to extend the imputed floor for three additional years without modification. In addition, “Beginning with the FY 2009 wage index in this final rule, we are also applying budget neutrality for the imputed floor in the same manner that we apply budget neutrality for the rural floor.”

Critical Access Hospital (CAH) Conversion to IPPS

Federal Register pages 48572 - 48573

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' Final Rule: For FFY 2009, CMS believes applying a state level rural floor budget-neutrality adjustment (see "Application of the Rural Floor Budget Neutrality" section above) to the wage index will address this issue.

Multi-Campus Hospitals

Federal Register page 48582

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 began using full-time equivalents (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 will require the reporting of FTE data by campus.

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

MGCRB Reclassifications

Federal Register pages 48568 - 48570

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 proposed 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 proposed “. . . 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% for rural hospitals).”

In addition, CMS proposed “. . . to adjust the 85% criterion for both urban and rural county group reclassifications to be equal to the proposed 88% standard for urban reclassifications”

CMS’ Final Rule: For FFY 2009, “. . . we are adopting . . . the policy to adjust the reclassification average hourly wage standard, comparing a reclassifying hospital’s (or county hospital group’s) average hourly wage relative to the average hourly wage of the area to which it seeks reclassification. However, we will be phasing in the adjustment over two years. For the first transitional year, FY 2010, the average hourly wage standards will be changed to 86 percent for urban and group reclassifications and to 84 percent for rural hospitals. In the second year, FY 2011, the average hourly wage standards will be changed to 88 percent for urban and group reclassifications and to 86 percent for rural hospitals”

This change only affects new reclassifications beginning in FFY 2010, it does 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/MGCRB/02_instructions_and_applications.asp#TopOfPage.

Out-Migration Adjustment

Federal Register pages 48589 - 48590

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 period ends, or it may qualify and receive a different out-migration adjustment. CMS designates new qualifying counties each year.

Before FFY 2008, CMS used the pre-reclassified wage index when calculating the out-migration adjustment. 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 proposed to continue to calculate the out-migration adjustment based on the post-reclassified wage indexes.

CMS' Final Rule: For FFY 2009, CMS is adopting the above proposal as final without modification.

Section 508 Reclassifications

Federal Register pages 48588 - 48589

Background: Section 508 of the MMA states that a qualifying hospital may appeal its wage index classification 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.

CMS' Final Rule: Per the enactment of MIPPA on July 15, Section 508 reclassifications have been extended through September 30, 2009.

Lugar Reclassifications

Federal Register pages 48586 - 48588

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 proposed to increase the rural MGCRB reclassification threshold to 86%.

CMS' Final Rule: For FFY 2009, CMS is adopting the proposed policy with modification that would adjust the reclassification average hourly wage standard over two years. More specifically, the hospital must ". . . demonstrate that its average hourly wage is equal to at least 84 percent (in FY 2010) and 86 percent (beginning in FY 2010) of the average hourly wage of hospitals in the area to which it seeks redesignation . . ."

Wage Index Study

Federal Register pages 48563 - 48568

Background: 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 by June 30, 2007 on the Medicare wage index reclassification system under the Medicare IPPS. Within that report, MedPAC was to include any recommended alternatives to the wage index methodology that could be included in the FFY 2009 proposed rule.

MedPAC's proposal (or proposals) considered 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 Statistics (BLS) 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.

MedPAC's June 2007 Report to Congress did address most of the nine points mentioned above. 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. Congressional action would be needed to switch from cost report data to BLS data. Acumen discussed their analysis plan at CMS' May 20, 2008 Special Open Door Forum on wage index reform. The full transcript of the forum discussions is available at http://www.cms.hhs.gov/OpendoorForums/05_ODF_SpecialODF.asp. In addition, Acumen will post their analysis plan on their Web site subsequent to the publication of the final rule at <http://www.acumen.com>.

CMS' Final Rule: For FFY 2009, CMS is "...neither proposing nor finalizing any changes in response to the specific MedPAC recommendations." CMS states that Acumen has not yet completed all of its research and analysis and they have not fully analyzed the MedPAC recommendations.

"We plan to include our assessment of the MedPAC recommendations, along with any additional recommendations for further reforming the wage index, in the FY 2010 IPPS proposed rule."

VIII. COST OUTLIERS

Federal Register pages 48762 - 48766

Background: CMS provides payments for outlier cases; those involving extraordinarily high costs when compared to average cases in the same DRG. To qualify as an 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 proposed 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."

CMS' Final Rule: For FFY 2009, CMS has calculated a **tentative** outlier 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 \$20,185. With this threshold, we project that outlier payments will equal 5.1 percent of total IPPS payments.”

IX. GRADUATE MEDICAL EDUCATION

Indirect Medical Education Adjustment

Federal Register pages 48636 - 48637

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 restored the multiplier back to the FFY 2003 level of 1.35 for FFY 2008 and thereafter.

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.”

X. ADDITIONAL PAYMENTS FOR NEW TECHNOLOGY

Federal Register pages 48552 - 48563

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 considered four applications for new technology add-on payments:

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

CMS' Final Rule: For FFY 2009, CMS will provide a new technology add-on payment for CardioWest™ Temporary Artificial Heart System.

“...three out of four applicants had not yet received FDA approval of their technologies (Emphasys Medical Zephyr® Endobronchial Valve, Oxiplex®, and the TherOx Downstream® System). . . ” “Therefore, those three applications are not eligible for consideration for FY 2009 new technology add-on payments because they do not meet the newness criterion . . . ”

XI. RURAL HOSPITALS

Rural Referral Centers (RRCs)

Federal Register pages 48635 - 48636

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 geographic reclassification requirement.

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 proposed 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.”*

For FFY 2009, CMS suggested that for a hospital to qualify “. . . for initial RCC status for cost reporting periods beginning on or after October 1, 2008 it 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”*

CMS’ Final Rule—Additional Criteria: For FFY 2009, CMS updated the proposed rule such 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—

- 1.4270; 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 final median CMI values by region are shown in the following table:

Region	Case-Mix Index Value
New England (CT, ME, MA, NH, RI, VT)	1.2532
Middle Atlantic (PA, NJ, NY)	1.2661
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3588
East North Central (IL, IN, MI, OH, WI)	1.3579
East South Central (AL, KY, MS, TN)	1.3051
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.3571
West South Central (AR, LA, OK, TX)	1.4208
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.4669
Pacific (AK, CA, HI, OR, WA)	1.3945

In addition, for FFY 2009, CMS has adopted the proposed discharge criteria, with modifications to the number of discharges required. The final median numbers of discharges for urban hospitals by census region are as follows:

Region	Discharges
New England (CT, ME, MA, NH, RI, VT)	8,158
Middle Atlantic (PA, NJ, NY)	10,659
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,982
East North Central (IL, IN, MI, OH, WI)	9,290
East South Central (AL, KY, MS, TN)	7,927
West North Central (IA, KS, MN, MO, NE, ND, SD)	8,206
West South Central (AR, LA, OK, TX)	6,589
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,738
Pacific (AK, CA, HI, OR, WA)	8,620

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

Federal Register pages 48630 - 48635

Background: SCHs and MDHs 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% hospital-specific and 25% 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 an SCH or MDH for 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, an 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 proposed 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.”

In addition, CMS proposed 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.”

CMS 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.”

CMS' Final Rule—Calculating Core Staffing Factors: For FFY 2009, CMS is adopting their “. . . proposal to calculate the staff adjustment for the SCH and MDH low volume adjustment using the 2006 Occupational Mix Survey data. . . . ”

For FFY 2009, CMS is finalizing their “. . . methodology to calculate the average nursing hours per patient day using AHA Annual Survey data and the Medicare Cost Report. . . . ”

Rebasing of Payments to SCHs

Federal Register pages 48629 - 48630

Background: Currently, SCHs are paid the higher of the Federal rate or their hospital specific rate (based on their 1982, 1987, or 1996 costs per discharge).

CMS' Final Rule: MIPPA, which was enacted into law on July 15, 2008, changed the rebasing provisions for payments to SCHs. Therefore “. . . effective with cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on the rate that results in the greatest aggregate payment using either the Federal rate or their hospital-specific rate based on their 1982, 1987, 1996, or 2006 costs per discharge.”

XII. OTHER ISSUES

Post-Acute Transfers to Home Health Services

Federal Register pages 48592 - 48597

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 FFY 2009, CMS proposed to “. . . extend the timeframe to within 7 days of discharge to home under a written plan for the provision of home health services.”

CMS' Final Rule: For FFY 2009, “. . . we are not proceeding with finalizing this proposal.” CMS will continue “. . . to monitor the current policy to see if there are trends of delays in the initiation of home health services, whether such delays are "legitimate" or not.”

Value-Based Purchasing Plan

Federal Register pages 48628 - 48629

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 the FFY 2009 proposed rule, CMS discussed the next steps for testing and refining its VBP proposal, but did 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' Final Rule: CMS will take all comments received on this issue into consideration as they undertake further testing and refinements to the Hospital VBP Plan.

Hospital Emergency Services Under EMTALA

Federal Register pages 48654 - 48667

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. The Emergency Medical Treatment and Labor Act (EMTALA) 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 FFY 2008 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 proposed 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 believed that this clarification was necessary to ensure that EMTALA protections are continued for individuals who are not otherwise protected by the hospital Conditions of Participation.

CMS’ Final Rule: For FFY 2009, CMS is “. . . *clarifying our policy on the EMTALA obligation of a hospital with specialized capabilities, by stating that if an individual presents to the admitting hospital that has a dedicated emergency department, is provided an appropriate medical screening examination, and is found to have an emergency medical condition, and is admitted as an inpatient in good faith for stabilizing treatment of an emergency medical condition, then the admitting hospital has met its EMTALA obligation to that individual, even if the individual remains unstable.*”

In addition, “. . . *we believe it is appropriate to finalize a policy to state that if an individual with an unstable emergency medical condition is admitted, the EMTALA obligation has ended for the admitting hospital and even if the individual’s emergency medical condition remains unstabilized and the individual requires special services only available at another hospital, the hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual.*”

CMS’ Proposal—EMTALA Physician On-call Requirements: For FFY 2009, CMS proposed 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 believed that these proposed changes would make regulations consistent with the statutory basis for maintaining an on-call list.

In addition, CMS proposed 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 believed that this would 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.

CMS’ Final Rule—EMTALA Physician On-call Requirements: For FFY 2009, CMS has finalized the regulation text to read, “*An on-call list of physicians who are on the hospital’s medical staff, or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal*

community call plan in accordance with §489.24(j)(2)(iii) 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.”

In addition, CMS is finalizing the community call regulation as proposed, with the deletion of one requirement under paragraph (E) of the proposed §489.24(j)(2)(iii); *“Evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective.”*

Emergency Room Disclosure

Federal Register pages 48686 - 48688

Background: CMS believes that hospitals should be required to disclose information concerning whether a physician is available on the premises 24 hours per day/seven 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/seven days per week to disclose this information to patients, along with information about how they would handle an emergency when no physician is onsite.

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

CMS’ Final Rule: For FFY 2009, CMS is adopting the above proposal as final without modification.

Disclosure of Physician Ownership in Hospitals

Federal Register pages 48686 - 48688

Background: The DRA 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.

In the FFY 2008 final rule, CMS revised its 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 proposed 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 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 proposed *“. . . 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.”*

CMS’ Final Rule: For FFY 2009, CMS is adopting the above proposal as final without modification.

Physician Self-Referrals

Federal Register pages 48688 - 48705

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 proposed 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 her 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.”

CMS’ Final Rule—Stand in the Shoes: For FFY 2009, CMS is finalizing “. . . revisions to the physician “stand in shoes” provisions to deem a physician who has ownership or investment interest in a physician organization to stand in the shoes of that physician organization. Physicians with only a titular ownership interest (that is, physicians without the ability or right to receive the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment) are not required to stand in the shoes of their physician organizations.”

“In addition, we are permitting nonowner physicians (and titular owners) to stand in the shoes of their physician organizations and we are also clarifying that the physician “stand in the shoes” provisions in §411.354(c) do not apply to an arrangement that satisfies the requirements of the exception in §411.355(e) for AMCs.”

“We are not finalizing our proposal regarding compensation arrangements between physician organizations and AMC components for the provision of services required to satisfy the AMC’s obligations under the Medicare GME rules in 42 CFR Part 413, Subpart F.”

At this time, CMS is not finalizing their proposed DHS entity “stand in shoes” provisions.

Period of Disallowance

The “period of disallowance” is the time period for which the physician cannot refer patients for designated health services to an entity and for which the entity can 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 proposed to define the period of disallowance for FFY 2009. *“ . . . we are proposing to amend §411.353(c) to provide that, where the reasons(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”

CMS’ Final Rule—Period of Disallowance: For FFY 2009, CMS is adopting *“ . . . the period of disallowance proposals, without modification in substance.”*

“ . . . we are revising the proposed text for language for §411.353(c) to provide that the period of disallowance ends no later than the date on which all excess compensation is returned to the party that paid it, or the date on which all additional required compensation is paid to the party to which it is owed.”