



WISCONSIN HOSPITAL
ASSOCIATION

**SUMMARY OF THE PROPOSED
FFY 2010 MEDICARE
HOSPITAL INPATIENT RULE**

May 2009

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Inpatient Prospective Payment System (PPS) for federal fiscal year (FFY) 2010. Additional information regarding the Inpatient PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS>.

CMS must receive comments on the proposal by June 30 at 5 p.m. CMS requests that comments reference the file code CMS-1406-P.

Comments on the proposed rule can be submitted electronically at <http://www.regulations.gov>. Click on the "Submit Electronic Comments on CMS Regulations With an Open Comment Period" link. (Attachments should be in Microsoft® Word, WordPerfect, or Excel format.)

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I. OVERVIEW

CMS published the proposed Medicare Inpatient Prospective Payment System (IPPS) rule for FFY 2010 in the May 22, 2009 *Federal Register*. Changes are effective October 1, 2009, unless otherwise noted.

Note: Text in italics is extracted from the May 22, 2009 *Federal Register*.

Major Provisions of the Proposed Rule

Marketbasket Update: CMS is proposing a full marketbasket update of 2.1% for FFY 2010. This is the marketbasket update after CMS' proposed rebasing and revisions to price proxies.

Coding Reduction: For FFY 2010, CMS is proposing to apply a 1.9% reduction to the standard amount, based on its analysis of case-mix increases for claims paid in FFY 2008. CMS' analysis found that the increase in case mix due to coding improvements in FFY 2008 was 2.5%, compared to the 0.6% behavioral offset adjustment that was applied for that year.

Coding Reduction for Hospital-Specific Rates: CMS is proposing to reduce hospital-specific rates by 2.5 % (after application of the marketbasket) for FFY 2010, to adjust for case-mix increases that were due to documentation and coding improvements. Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs) paid at the hospital-specific rate are affected. CMS did not previously apply the 0.6% reduction to the FFY 2008 hospital-specific rates.

Quality Measures: Hospitals would be required to report data on 43 quality measures to receive a full marketbasket update in FFY 2010. For FFY 2011, CMS is proposing to add four new measures: two new chart-abstracted measures and two new structural measures.

Hospital-Acquired Conditions (HACs): CMS proposes no changes to the current list of HACs that will not be paid for FFY 2010.

Wage Index Labor Share: CMS has updated the data and revised the methodology used to calculate the marketbasket index and wage index labor share. As a result, the labor share for hospitals with a wage index over 1.0 will decrease from 69.7% to 67.1% in FFY 2010. The labor share for hospitals with a wage index less than 1.0 is set by law and will remain at 62%.

Wage Index Reclassifications: For FFY 2010 reclassification applications, CMS increased the comparison benchmarks to 86% for urban hospitals and group reclassifications and to 84% for rural hospitals. For FFY 2011 and subsequent years, the reclassification benchmarks will be set at 88% for urban hospitals and group reclassifications and 86% for rural hospitals.

Section 508 Reclassifications: Existing Section 508 wage index reclassifications will sunset in FFY 2010. CMS does not have the authority to extend Section 508 reclassifications beyond September 30, 2009, without legislation.

Occupational Mix Adjustment: For FFY 2010, CMS will use the revised 2007-2008 Medicare Wage Index Occupational Mix Survey, which required hospitals to submit data for July 1, 2007 through June 30, 2008, to compute an occupational mix adjustment.

Rural Floor and Imputed Floor Budget Neutrality: For FFY 2010, CMS will phase in the second year of transition to state-specific rural floor Budget Neutrality adjustments. Hospitals will receive a wage index reflecting 50% with the state level budget neutrality adjustment and 50% with the national budget neutrality adjustment. In FFY 2011, the rural floor budget neutrality adjustment will be 100% of the state level methodology.

IME for Capital: CMS is proposing to eliminate the Indirect Medical Education adjustment for capital in FFY 2010.

Labor and Delivery Patient Days for Disproportionate Share Hospital (DSH) Calculation: CMS is proposing to include patient days for maternity patients who were admitted as inpatients and receiving ancillary labor and delivery services at the time the inpatient routine census was taken in the disproportionate patient percentage (DPP) of the DSH calculation.

Medicaid Eligible Days for DSH Calculation: Recognizing that States report Medicaid days back to hospitals using different methodologies, CMS is proposing to allow hospitals to report Medicaid days for the numerator of the DPP based on one of three methodologies; date of admission, date of discharge, or dates of service.

Observation Beds: CMS is proposing to exclude inpatient observation bed days from both the DSH calculation and the Indirect Medical Education (IME) calculation. CMS believes that observation bed days should not be considered inpatient days for a beneficiary's spell of illness or for qualifying skilled nursing facility (SNF) benefits. In addition, CMS is proposing that hospitals report observation bed days for cost report periods beginning on or after October 1, 2009 so they can be deducted from the bed day count for DSH and IME payment adjustments.

II. LEGISLATIVE MANDATES

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; the Deficit Reduction Act of 2005 (DRA); the Transitional Medical Assistance; Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007; the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA); the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008; and the American Recovery and Reinvestment Act (ARRA) of 2009 each contain Medicare provisions that either currently affect program payment policy or will begin to affect payment policy in upcoming federal fiscal years. The majority of the MMA provisions regarding IPPS involve payment restorations, while provisions of the DRA focus on development of pay for performance and other initiatives. Where appropriate, legislative references are provided in the text below.

III. STANDARDIZED AMOUNTS/HOSPITAL-SPECIFIC RATES

Rebasing and Revision of the Marketbasket

Federal Register pages 24153 - 24161

Background: Every four years CMS rebases the marketbasket by updating the input price indexes and distribution of costs (weights) used in the calculation. The last update to the marketbasket was in FFY 2006, using FFY 2002 data as the base period for the construction of the weights.

CMS' Proposal: For FFY 2010, CMS is proposing to rebase the hospital marketbasket weights using 2006

Medicare Cost Report data. The marketbasket weights also require data from tables generated by the Bureau of Economic Analysis (BEA) and the Bureau of the Census. The most recent available BEA data are from 2002. In addition, CMS is proposing to revise several of the proxies used to measure input price changes, including those for blood and blood products and chemicals.

As a result of CMS' rebasing and proxy revisions, the proposed FFY 2010 marketbasket update is 2.1% compared to 2.3% prior to any changes. CMS indicates that the main cause for the decrease is the proposed change to the price proxy for chemicals. The new chemicals proxy gives less weight to petroleum products, which CMS states is more consistent with hospitals' chemical purchases.

The FFY 2010 marketbasket estimate in the proposed rule is based on the Office of the Actuary's first quarter 2009 forecast. Hospitals that do not submit qualifying quality data under Medicare's inpatient quality data reporting program would receive a 2.0 percentage point reduction to the marketbasket.

Offset for Coding Improvements

Federal Register pages 24092 - 24101

Background: In FFY 2008, CMS implemented new Medicare Severity Diagnosis Related Groups (MS-DRGs). CMS believed that the MS-DRGs, with their emphasis on patient severity, had the potential to generate payment increases not caused by changes in patient severity (referred to as "real" case mix change), but rather due to improved hospital documentation and coding of patient conditions. The Benefits Improvement and Protection Act (BIPA) of 2000 gave CMS authority to adjust the Medicare standard amount to eliminate the effects of coding or documentation improvements that do not reflect real changes in case mix.

CMS originally proposed a coding improvement adjustment ("Behavioral Offset") that would have reduced the standard amount by 4.8% over three years. Subsequently, the Transitional Medical Assistance, Abstinence Education, and Quality Initiative Programs Extension Act of 2007 reduced this adjustment to a 0.6% rate reduction in FFY 2008 and an additional 0.9% rate reduction in FFY 2009. The Bill also gave CMS authority to analyze FFY 2008 and 2009 claims to determine the actual impact of coding improvements in those years. If CMS determines that the actual impact of coding improvements differs from the reductions already taken, CMS can recoup overpayments for FFYs 2008 and 2009 and can prospectively adjust FFY 2010, 2011, and 2012 rates.

In this proposed rule, CMS reports the results of its analysis of case mix changes for FFY 2008. CMS found that total case mix growth from FFY 2007 to FFY 2008 was 1.9% (including both coding improvement and real case mix change). However, CMS' analysis concludes that the increase in case mix due to coding improvement was 2.5% and that real case mix actually declined by 0.6% from FFY 2007 to FFY 2008. CMS is, therefore, proposing an additional 1.9% Behavioral Offset adjustment to account for the difference between the 0.6% reduction that was applied to the FFY 2008 rates and the actual coding improvement increase of 2.5% based on FFY 2008 claims data.

While CMS is proposing to apply the additional 1.9% coding reduction prospectively to the FFY 2010 rates, CMS proposes to defer a retroactive adjustment to recoup the FFY 2008 overpayments. CMS also believes that an additional adjustment will be required for FFY 2009, but has deferred action until FFY 2009 claims data are available.

CMS' Proposal: For FFY 2010, CMS is proposing ". . . to change the average standardized amounts under Section 1886(d) of the Act in FFY 2010 by -1.9%, the difference between the changes in documentation and coding that do not reflect real changes in case mix for discharges occurring during FFY 2008 and the prospective adjustment applied Our actuaries currently estimate that this 1.9 percentage point increase resulted in an increase in aggregate payments of approximately \$2.2 billion requires an additional

adjustment for discharges occurring in FFYs 2010, 2011, and/or 2012 to offset the estimated amount of this increase in aggregate payments (including interest).”

“We are not proposing to make an adjustment to FFY 2010 to offset, in whole or in part, the estimated increase in aggregate payments for discharges occurring in FFY 2008, but intend to address this issue in future rulemaking for FFYs 2011 and 2012. That is, we will address recouping the additional expenditures that occurred in FFY 2008 as a result of the 1.9 percentage point difference between the actual changes in documentation and coding that do not reflect real changes in case mix, or 2.5%, and the -0.6% adjustment applied under Pub. L. 110-90 in FFY 2011 and/or FFY 2012, as required by law . . . we have the statutory authority to make this -1.9% recoupment adjustment entirely in FFY 2010, we are proposing to delay the adjustment until FFY 2011 and FFY 2012 because we do not have any data yet on the magnitude of the documentation and coding effect in FFY 2009.”

The industry does not believe that it is reasonable to assume that actual patient severity declined by 0.6% in one year as CMS reports. There is good reason to expect that patient severity (“real” case mix) has actually increased due to factors such as the aging of the population, migration of less complex cases to the outpatient setting, and increased use of new technologies in the inpatient setting.

Hospital-Specific Rates

In FFY 2008, CMS established a policy to apply the behavioral offset adjustment to hospital-specific rates, because SCHs and MDHs use the same MS-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 did not apply the 0.6% rate reduction in FFY 2008 or the 0.9% rate reduction in FFY 2009 to the hospital-specific rates paid to qualifying SCHs and MDHs. However, CMS held to its belief that it has the legal authority to make such an adjustment in future rulemakings.

CMS’ Proposal: For FFY 2010, CMS is proposing to apply the full 2.5% Behavioral Offset reduction to the hospital-specific rates for SCHs and MDHs.

“. . . we are proposing to use our authority under Section 1886(d)(5)(I)(i) of the Act to prospectively adjust the hospital-specific rates by -2.5%t in FFY 2010 to account for our estimated documentation and coding effect in FFY 2008 that does not reflect real changes in case mix. . . . This proposed -2.5% adjustment to the hospital-specific rates exceeds the proposed -1.9% adjustment to the national standardized amount under section 7(b)(1)(A) of Pub. L. 110-90 because, unlike the national standardized rates, the FFY 2008 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case mix resulting from the adoption of the MS-DRGs.”

Operating and Capital Rates

Federal Register page 24272

The standard amounts for FFY 2010 are shown in the following table for facilities receiving the full update and those receiving a reduced update for failure to submit adequate quality data. CMS is proposing to revise the wage index labor-related share from 69.7% to 67.1% in FFY 2010 for hospitals with a wage index over 1.0 (see “Wage Index Labor-Related Share” section).

| Standard¹ for Hospitals with a Wage Index Greater Than 1.0 (67.1% Labor Share and 32.9% Non-Labor Share) | | |
|---|---------------|-------------------|
| | Labor-related | Non Labor-related |
| Full Update (2.1%) | \$3,441.26 | \$1,687.30 |
| Reduced Update (0.1%) ² | \$3,373.85 | \$1,654.25 |

| Standard¹ for Hospitals with a Wage Index Less Than or Equal to 1.0 (62.0% Labor Share and 38.0% Non-Labor Share) | | |
|--|---------------|-------------------|
| | Labor-related | Non Labor-related |
| Full Update (2.1%) | \$3,179.71 | \$1,948.85 |
| Reduced Update (0.1%) ² | \$3,117.42 | \$1,910.68 |

| Capital Federal Rate¹ | |
|---|----------|
| National Capital Rate | \$420.67 |

Note 1: The rates shown in the tables above (both operating and capital) reflect the 1.9% reduction for the proposed “behavioral offset”

Note 2: The reduced update is applicable to hospitals that are not in compliance, or have withdrawn from the 2010 quality reporting

Budget Neutrality Adjustment Factors for Hospital-Specific Rates

Federal Register pages 24183 - 24185

Background: MDHs are paid the higher of the federal rate or a blend of 25% of the federal rate plus 75% of the hospital-specific rate (based on the higher of their 1982, 1987, or 2002 cost per discharge). SCHs are paid the higher of the federal rate or their hospital-specific rate (based on the highest of their 1982, 1987, 1996, or 2006 costs per discharge). Like acute care hospitals paid at the federal rate, Medicare payments for MDHs and SCHs are based on DRG weights. Since FFY 1994, CMS has calculated a budget neutrality factor adjustment that is applied to the standardized amount and to the hospital-specific rates to assure that estimated aggregate payments after the DRG changes are equal to estimated payments prior to the changes.

In implementing recent hospital-specific rate rebasing provisions for SCHs, CMS has directed its fiscal intermediaries to apply a cumulative budget neutrality adjustment factor to account for DRG changes back to FFY 1993, which was the original hospital-specific rate base year.

The DRA “. . . allows MDHs to use the hospital’s FFY 2002 costs per discharge for discharges occurring on or after October 1, 2006, if that results in a higher payment.” CMS issued Transmittal 1067 to implement this provision, but the instructions failed to include a cumulative budget neutrality adjustment factor to account for changes in the DRGs from FFY 1993 to 2002. Therefore, “. . . any MDH that has been paid based on its FFY 2002 hospital-specific rate since FFY 2007 was paid based on a hospital-specific rate that was computed inconsistent with CMS’ stated policy”

CMS' Proposal: For FFY 2010, CMS is providing clarification to its existing policy for applying the budget neutrality adjustment factor to hospital-specific rates. Effective “. . . for discharges beginning on or after October 1, 2009, we will include the cumulative budget neutrality adjustment factors for the DRG changes from FFYs 1993 through 2002 in addition to the cumulative budget neutrality adjustment factors for FFYs 2003 forward. The cumulative budget neutrality adjustment factor of 0.982557 is calculated as the product of the following budget neutrality adjustment factors to account for DRG changes from FFYs 1993 through 2002”

CMS estimates that in some cases, applying this cumulative budget neutrality adjustment to MDHs would lower the hospital-specific rate to a level where the federal rate would result in a higher payment.

IV. MS-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

MS-DRG Patient Classifications

Federal Register pages 24089 - 24092

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 criterion. The MS-DRGs include three severity levels: complications and comorbidities (CC), major CC, and non-CC. According to CMS' analysis, this provides a more accurate match between the costs of providing patient care and payments for that care. In FFY 2009, there are 746 MS-DRGs.

Relative Weights

Federal Register pages 24101 - 24104

Background: Before FFY 2007, CMS calculated DRG weights by aggregating charges by DRG for all IPPS hospitals and determining an average charge per DRG. In its March 2005 report to Congress, MedPAC recommended calculating DRG weights using average costs rather than average charges. In FFY 2007, CMS implemented and phased in a cost-based DRG relative weight methodology. In FFY 2009, the final year of the transition, MS-DRG relative weights are calculated 100% based on hospital costs.

There continues to be significant concern regarding the issue of charge compression in CMS' cost-based weighting methodology—the practice of applying a higher percentage charge markup over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. As a result, cost-based weights undervalue high-cost items and overvalue low-cost items if a single cost-to-charge ratio (CCR) is applied to items of widely varying costs in the same cost center. To address the concern, CMS contracted with RTI International and RAND Corporation to study the effects of charge compression and the cost weighting methodology.

RTI's study demonstrated that charge compression exists in several CCRs, most notably in the Medical Supplies and Equipment CCR. RTI suggested a number of recommendations for CMS to mitigate the effects of charge compression, including regression-based estimates of CCRs for certain cost centers and adding new cost centers to the Medicare cost report, such as a “Devices, Implant and Prosthetics” line and a “CT Scanning and MRI” subscribed line. In another study covering both the inpatient and outpatient PPSs, RTI endorsed short-term regression-based CCRs, concluding that more refined and accurate accounting data are the preferred long-term solution. RAND's findings suggested that regression-based adjustments to the CCRs do not significantly improve payment accuracy.

Based on these studies, CMS has decided not to adopt regression-based CCRs for the calculation of the FFY 2010 IPPS relative weights, but to refine the Medicare Cost Reports. In FFY 2009, CMS began making cost report changes and proposed modifications to one cost center for “Medical Supplies Charged to Patients” and one cost center for “Implantable Devices Charged to Patients.” CMS plans to release the actual changes to the cost reporting form, the cost reporting software, and the cost reporting instructions in June 2009. CMS indicates that cost report data with two distinct CCRs, one for medical supplies and one for devices, will first be available for use in the calculation of FFY 2013 IPPS relative weights.

CMS’ Proposal—Relative Weight Calculation: CMS is not proposing any changes to the relative weight calculation in FFY 2010.

V. REPORTING HOSPITAL QUALITY DATA

Federal Register pages 24165 - 24181

Currently, hospitals must report valid data on 43 quality measures in order to receive a full marketbasket update. CMS proposes to add four new measures to the list for the FFY 2011 payment year.

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 percentage points for FFYs 2005 and 2006).

The DRA extended and expanded this program, giving CMS greater authority to choose and require quality reporting measures. 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). For the FFY 2009 payment year, CMS increased the number of required measures to 30 and continued to apply a 2.0 percentage point reduction for non-compliance or withdrawal from the program.

FFY 2010 Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program

Program Expansion

CMS announces new quality measures one year in advance and notifies hospitals to give them time to prepare for reporting changes. In the final FFY 2009 IPPS rule, CMS adopted 15 new measures and two additional measures were pending approval. The two measures were later endorsed by NQF and adopted by CMS. In addition, CMS retired two measures during 2009:

- AMI-6 Beta Blocker at Arrival; and
- PN-1 Oxygenation Assessment.

The addition of these 15 measures, minus two retired measures, brings the total number of core quality measures to 43 for FFY 2010 payment determinations.

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 <https://www.qualitynet.org/>.

RHQDAPU Quality Measures for FFY 2010
(Retired Measures for FFY 2010 are Highlighted in the Chart)

| Heart Attack (Acute Myocardial Infarction) | Heart Failure (HF) | Pneumonia (PNE) | Surgical Care Improvement Project (SCIP) | Mortality Measures (Medicare patients) | Patients' Experience of Care | Readmission Measures | AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQI) and Composite Measures ⁴ | Cardiac Surgery Measures ⁵ | Nursing Sensitive |
|--|---|--|--|---|------------------------------|--|---|--|---|
| AMI-1 Aspirin at arrival | HF-1 Discharge instructions | PN-2 Pneumococcal vaccination status | SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision | MORT-30-AMI: Acute Myocardial Infarction 30-day mortality (Medicare patients) | HCAHPS patient survey | READ-30-PN: Pneumonia 30-day Risk Standardized Readmission Measure | PSI 4: Death among surgical patients with treatable serious complications | Participation in a Systematic Database for Cardiac Surgery | PSI 4: Death among surgical patients with treatable serious complications /Failure to Rescue (Medicare claims only) |
| AMI-2 Aspirin prescribed at discharge | HF-2 Left ventricular function assessment | PN-3b Blood culture performed before first antibiotic received in hospital | SCIP-3 Prophylactic antibiotic discontinued within 24 hours after surgery end time | MORT-30-HF: Heart Failure 30-day mortality (Medicare patients) | | READ-30-AMI: Heart Attack 30-day Risk Standardized Readmission Measure | PSI 6: Iatrogenic pneumothorax, adult | | |
| AMI-3 ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction | HF-3 ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction | PN-4 Adult smoking cessation advice/counseling | SCIP-VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients | MORT-30-PN: Pneumonia 30-day mortality (Medicare patients) | | READ-30-HF: Heart Failure 30-day Risk Standardized Readmission Measure | PSI 14: Postoperative wound dehiscence | | |
| AMI-4 Adult smoking cessation advice/counseling | HF-4 Adult smoking cessation advice/counseling | PN-5c Initial antibiotic received within 4 hours of hospital arrival | SCIP-VTE 2: VTE prophylaxis within 24 hours pre/post surgery | | | | PSI 15: Accidental puncture or laceration | | |
| AMI-5 Beta blocker prescribed at discharge | | PN-6 Appropriate initial antibiotic selection | SCIP-Infection 2: Prophylactic antibiotic selection for surgical patients | | | | IQI 11: Abdominal aortic aneurysm mortality rate (with or without volume) | | |
| AMI-6 Beta blocker at arrival (Retired April 1, 2009) | | PN-7 Influenza vaccination status | SCIP-Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose | | | | IQI 19: Hip fracture mortality rate | | |
| AMI-7a Thrombolytic agent received within 30 minutes of hospital arrival | | PN-1 Oxygenation assessment (Retired on January 1, 2009) | SCIP-Infection 6: Surgery Patients with Appropriate Hair Removal | | | | Mortality for selected medical conditions | | |
| AMI-8a Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival | | | SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period | | | | Mortality for selected surgical conditions | | |
| | | | | | | | Complications/patient safety for selected indicators | | |

Withdrawal from RHQDAPU

The deadline for withdrawal from the program for FFY 2010 is August 15, 2009. If a hospital withdraws, it will receive a 2.0 percentage point reduction in its FFY 2010 annual payment update.

Chart Validation Requirements

CMS will continue, until further notice, to require that hospitals meet the chart validation requirements implemented in the FFY 2006 IPPS rule, including the 80% reliability standard. In the FFY 2009 final rule, CMS adopted additional chart validation requirements that apply to the Surgical Care Improvement Program (SCIP) measures (SCIP-VTE 1, SCIP-VTE 2, and SCIP Infection 2). Hospitals are required to attest to the completeness and accuracy of their data, including volume, on a quarterly basis.

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

In the FFY 2009 final rule, CMS adopted a provision that would defer the requirement for hospitals to separately attest to the accuracy and completeness of their submitted data because the burden placed on hospitals to report paper attestation forms on a quarterly basis. CMS expects that hospitals will submit quality data that are accurate to the best of their knowledge and ability.

Appeals

A hospital has the right to submit a written request for reconsideration if it has been denied the full marketbasket update based on CMS' decision that the hospital did not meet the RHQDAPU requirements. The rules for reconsideration are posted on the QualityNet Web site. The deadline for reconsideration for FFY 2010 payment determinations is November 1, 2009. 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).

FFY 2011 RHQDAPU Program

CMS' Proposal—Program Expansion: For FFY 2011 payment determinations, CMS is proposing “. . . to retain 41 of the measures we adopted for the FFY 2010 payment determination . . . harmonize an AHRQ measure and a Nursing Sensitive measure by combining these measures into a single measure entitled *Death Among Surgical Inpatients with Serious, Treatable Complications*. Finally, we are proposing to add four measures (two SCIP Infection measures and two structural measures) to the RHQDAPU program measure set.” This would result in 46 quality measures for a hospital's FFY 2011 payment determination.

The four new proposed measures are:

- Chart-Abstracted Measures
 - SCIP-Infection 9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2; and
 - SCIP-Infection 10: Perioperative Temperature Management.
- Structural Measures
 - Participation in a Systematic Clinical Database Registry for Stroke Care; and
 - Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.

CMS' Proposal—RHQDAPU Program Procedures: For FFY 2011, CMS is proposing “. . . that the following procedures will apply to hospitals participating in the RHQDAPU program . . . for the most part, the same as the procedures that apply to the FFY 2010 payment determination.”

The proposed modifications are:

- “. . . that any hospital that receives a new CCN on or after October 15, 2009 . . . that wishes to participate in the RHQDAPU program and has not otherwise submitted a Notice of Participation form using that CCN must submit a completed Notice of Participation form no later than 180 days from the date identified as the “open date” on the approved CMS Online System Certification and Reporting (OSCAR) system;
- . . . that hospitals having an open date (as noted on the approved CMS OSCAR system) before October 15, 2009 that did not participate in the RHQDAPU program in FFY 2010 but that wish to participate in the RHQDAPU program for the FFY 2011 payment determination must submit a completed Notice of Participation form to CMS on or before December 31, 2009;
- . . . that hospitals report the information needed to calculate the three proposed structural measures directly onto the QualityNet Web site on a quarterly basis starting with 1st calendar quarter 2010. The quarterly submission deadline for reporting these measures will be 4½ months following the last date in the quarter covered by the data report.

The collection of new chart-abstracted measures for FFY 2011 payment determination would begin with 1st calendar quarter 2010 discharges, for which the submission deadline would be August 15, 2010.”

The following RHQDAPU program claims-based measures will be calculated using Medicare claims for FFY 2011 payment determinations:

| Topic | Quality Measures |
|--|--|
| Mortality Measures (Medicare Patients) | |
| | * 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 Measures (Medicare Patients) | |
| | * READ-30-HF Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients) |
| | * READ-30-AMI Acute Myocardial Infarction (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients) |
| | * READ-30-PN Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients) |
| AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures | |
| | * PSI 06: Iatrogenic pneumothorax, adult |
| | * PSI 14: Postoperative wound dehiscence |
| | * PSI 15: Accidental puncture or laceration |
| | * IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume) |
| | * IQI 19: Hip fracture mortality rate |
| | * Mortality for selected surgical procedures (composite) |
| | * Complications/patient safety for selected indicators (composite) |
| | * Mortality for selected medical procedures (composite) |
| AHRQ Patient Safety Indicator 4 (PSI) and Nursing Sensitive Care | |
| | * Death among surgical inpatients with serious, treatable complications |

“For the FFY 2011 payment determination, CMS will use three years of discharges from July 1, 2006 through June 30, 2009 for the 30-day mortality and 30-day readmission measures. For the AHRQ PSI, IQI and Composite measures (including the AHRQ PSI and Nursing Sensitive Care measure, Death Among Surgical Inpatients with Serious, Treatable Complications), we will use one year of claims from July 1, 2008 through June 30, 2009 to calculate these measures.”

CMS’ Proposal—Chart Validation: For FFY 2011, CMS is proposing to use the existing requirements from prior years with some modification.

CMS is proposing the following modification:

- “Beginning with CDAC requests for second calendar quarter 2009 paper medical records, the CDAC will request paper copies of the randomly selected medical charts from each hospital via certified mail, and the hospital will have 45 days from the date of the request (as documented on the request letter) to submit the requested records to the CDAC.
 - If the hospital does not comply within 30 days, the CDAC will send a second certified letter to the hospital, reminding the hospital that it must return paper copies of the requested medical records within 45 calendar days following the date of the initial CDAC medical record request. If the hospital still does not comply, then the CDAC will assign a ‘zero’ score to each data element in each missing record.”

In addition, for the FFY 2011 payment update, CMS is proposing to validate fourth quarter 2008 through third quarter 2009 discharge data, except “SCIP–Cardiovascular-2 will be validated using data from 2nd and 3rd calendar quarter 2009 discharges.”

HCAHPS Requirements

Hospitals must continuously collect and submit HCAHPS data in accordance with the current HCAHPS Quality Assurance Guidelines and the quarterly data submission deadlines, which are both available at www.hcahpsonline.org. “. . . any hospital that has five or fewer HCAHPS-eligible discharges in any month is no longer required to submit HCAHPS surveys for that month, although the hospital may voluntarily choose to submit these data. However, the hospital must still submit its total number of HCAHPS-eligible cases for that month as part of its quarterly HCAHPS data submission.”

CMS’ Proposal—HCAHPS Requirements: CMS is proposing “. . . for the FFY 2011 payment determination, the RHQDAPU program HCAHPS requirements we adopted for FFY 2010 would continue to apply.”

Withdrawal from RHQDAPU

CMS’ Proposal—Withdrawal from RHQDAPU: For FFY 2011, CMS is proposing to “. . . accept RHQDAPU program withdrawal forms for the FFY 2011 payment determination from hospitals until August 15, 2010.” If a hospital withdraws, it will receive a 2.0 percentage point reduction in its FFY 2011 annual payment update.

FFY 2012 RHQDAPU Program

CMS’ Proposal—Program Expansion: CMS is seeking comments on an additional 69 quality measures that are being considered for inclusion in the RHQDAPU program in FFY 2012 or in subsequent years. For a list of the measures, refer to *Federal Register* pages 24172 – 24173.

CMS’ Proposal—Chart Validation: CMS is proposing to modify the RHQDAPU program validation methodology, beginning with the FFY 2012 payment determination.

“Specifically, we propose to do the following:

- Randomly select on an annual basis 800 participating hospitals that submitted chart-abstracted data for at least 100 discharges combined in the measure topics to be validated. To determine whether a hospital meets this ‘100 chart threshold,’ we will look to the discharge data submitted by the hospital during the calendar year three years prior to the fiscal year of the relevant payment determination.
 - We will announce the topic areas that apply for the FFY 2012 payment determination at a later date, and we plan to select the first 800 hospitals in July 2010. We will select hospitals for the FFY 2012 validation if they meet the 100-chart threshold during CY 2009.

- *Randomly validate for each of the 800 selected hospitals a stratified sample each quarter of the validation period. Each quarterly sample will include 12 cases, with at least one but no more than three cases per topic for which chart-abstracted data was submitted by the hospital.*

For the FFY 2012 payment determination, we will validate 1st calendar quarter 2010 through 3rd calendar quarter 2010 discharge data.”

In addition, for FFY 2012, CMS is proposing to decrease the validation score from 80% to 75% per quarter to pass validation.

FFY 2013 RHQDAPU Program

CMS’ Proposal—Chart Validation: *“Beginning with the FFY 2013 payment determination, we propose validating data submitted by hospitals during the four quarters that make up the fiscal year that occurs two years prior to the year that applies to the payment determination.”*

In addition, CMS is proposing the following:

- *“. . . that the CDAC contractor will, each quarter that applies to the validation, ask each of the 800 selected hospitals to submit 12 randomly selected medical charts from which data was abstracted and submitted by the hospital to the QIO Clinical Warehouse.*
- *. . . to continue the following timeline with respect to CDAC contractor requests for paper medical records for the purpose of validating RHQDAPU program data. Beginning with CDAC requests for second calendar quarter 2009 paper medical records, the CDAC will request paper copies of the randomly selected medical charts from each hospital via certified mail, and the hospital will have 45 days from the date of the request (as documented on the request letter) to submit the requested records to the CDAC.*
- *To use the . . . scoring approach . . . as recommended in the CMS Hospital Value-Based Purchasing Report to Congress . . .*
- *. . . to continue using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes.”*

Reporting Hospital-Acquired Conditions—Including Infections

Federal Register pages 24104 - 24106

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. 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 final FFY 2008 IPPS rule, CMS selected eight conditions that met these criteria. For discharges occurring on or after October 1, 2008 (FFY 2009), CMS does not include these diagnoses in the MS-DRG assignment if the condition was not present on admission (POA) (hospital-acquired). This could result in a lower Medicare 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. In FFY 2009, CMS expanded the list to include four new conditions that would be subject to the HAC payment provision.

Currently, there are five POA indicator reporting options: “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 Medicare MS-DRG Grouper will recognize HAC conditions if the POA indicator is Y or W. HAC conditions with an N or U indicator will not be considered in the MS-DRG assignment. The POA reporting requirements and the HAC payment provisions only apply to IPPS hospitals.

CMS’ Proposal: For FFY 2010, CMS is “. . . *not proposing to add or remove categories of HACs . . .*” However, CMS continues to seek input from the public about refinements to the current HAC list.

Hospital Acquired Conditions for FFY 2010

| | |
|--|---|
| Surgical Site Infection (Mediastinitis after CABG, Bariatric Surgery, Orthopedic Procedures) | Catheter-Associated Urinary Tract Infection (UTI) |
| Foreign Object Retained After Surgery | Vascular Catheter Associated Infection |
| Air Embolism | Blood Incompatibility |
| Stage III and IV Pressure Ulcers | Deep Vein Thrombosis/Pulmonary Embolism |
| Falls and Trauma (Fractures, Dislocations, Intracranial Injuries, Crush Injuries, Burns, Electric Shock) | Manifestations of Poor Glycemic Control |

VI. CAPITAL PAYMENTS

Capital Update Rate

Federal Register pages 24252 - 24254

Background: Reimbursement for IPPS capital-related costs is based on a national capital rate that is updated annually based on the capital input price index (CIPI). Similar to the operating rate marketbasket, CIPI is rebased and revised every four years using Medicare cost report data. The last CIPI update was implemented in FFY 2006, using FFY 2002 data.

CMS’ Proposal: For FFY 2010, CMS is proposing to rebase the CIPI cost weights using 2006 Medicare Cost Report data. CMS is also revising its methodology to calculate depreciation and interest costs. These revisions cause the CIPI to decrease compared to the current methodology. The proposed FFY 2010 CIPI update is 1.2% compared to 1.5% prior to revision. CMS indicates that the primary reasons for the decrease are the change to the proxy used to measure building and fixed equipment cost and a change in the assumed expected life of debt instruments.

CMS will apply a 1.9% behavioral offset reduction to the FFY 2010 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 1.9% coding reduction, see the “Offset for Coding Improvements” section.

Capital IME Elimination

Federal Register page 24197

Background: The teaching adjustment to capital payments was intended to cover the costs of IME. Based on recommendations from MedPAC, CMS adopted a policy to phase out the capital IME adjustment over three years, beginning in FFY 2008. Subsequently, the ARRA directed the Secretary of Health and Human Services

(HHS) to reverse the second year's phase-in of a 50% reduction to the capital IPPS teaching adjustment for FFY 2009.

CMS' Proposal: For FFY 2010, CMS is proposing to eliminate capital IME payments entirely.

VII. WAGE INDEX

Wage Index Labor-Related Share

Federal Register pages 24159 - 24161

Background: The wage index adjustment is applied to the labor-related portion of the PPS standard rate. The labor-related share is an estimate of the average proportion of hospital operating costs that are subject to local labor market changes. The labor-related share is calculated using data from the hospital marketbasket. The law directs CMS to determine a labor-related share that reflects the “*proportion . . . of hospitals' costs which are attributable to wages and wage-related costs.*” The law sets the labor share for hospitals with a wage index less than 1.0 at 62%. Currently, the labor-related share for hospitals with a wage index over 1.0 is 69.7%. CMS has the authority to adjust the labor-related share portion for hospitals with a wage index over 1.0 as deemed necessary.

CMS' Proposal: For FFY 2010, CMS is proposing to update the data used to calculate the marketbasket and wage index labor share. To meet statutory requirements, CMS is proposing to use the “. . . *cost category weights from the proposed FFY 2006-based IPPS market basket, we calculated a labor-related share of 67.062%, approximately three percentage points lower than the current labor-related share of 69.731 Accordingly, we are proposing to implement a labor-related share of 67.1% for discharges occurring on or after October 1, 2009. We note that Section 403 of Pub. L. 108-173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62% as the labor-related share unless this employment would result in lower payments than would otherwise be made.*”

The decrease in the labor share is caused by a CMS' proposed for professional fees. Professional fees for accounting and auditing services, engineering services, legal services, management and consulting services, and home office costs are included as labor-related costs in the determination of the labor share. CMS proposes to revise the calculation in FFY 2010 to differentiate between professional services purchased in the local labor market (which CMS would classify as labor costs) and professional fees purchased outside of the market (which would be included as non-labor costs). CMS conducted a survey and is relying on responses from 108 hospitals to estimate the proportion of professional fees that are purchased within local labor markets.

Professional fees represented 5.5% of total costs in the FFY 2009 marketbasket; this increased to 9.4% of costs in the 2010 data. If CMS were to continue using the existing marketbasket methodology, the labor share would increase from 69.7% in FFY 2009 to 72.8% in FFY 2010. However, CMS estimates that 3.6% of costs (rather than 9.4%) are for professional services purchased within local labor markets, decreasing the proposed FFY 2010 labor share to 67.1%.

CMS does not provide the data necessary to verify its allocation of the professional fees and the validity of estimates based on such a small number of hospitals is questionable. Even if CMS' calculations are accurate, the industry opposes this proposed change to the treatment of professional fees. We believe that CMS' assumption that fees paid to professionals outside of a hospital's labor market are not labor-related, is invalid. Professional services, no matter where from, are substitutes for hospital employed staff and should be included as labor costs.

Occupational Mix Adjustment

Federal Register pages 24140 - 24148

Background: CMS has been required to include an occupational mix adjustment as part of its calculation of the wage index since FFY 2005. The occupational mix adjustment is intended to neutralize for 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. CMS issued a revised 2007-2008 Medicare Occupational Mix Survey for hospitals to collect wage and hours data for the one-year prospective reporting period, July 1, 2007 through June 30, 2008.

CMS' Proposal: For FFY 2010, CMS is proposing to use “. . . *the occupational mix data collected on a revised 2007-2008 Medicare Wage Index Occupational Mix Survey (the 2007-2008 survey) to compute the proposed occupational mix adjustment for FFY 2010.*” At this time, CMS has not adopted a penalty for hospitals that fail to submit occupational mix data, but is seeking input from the public for future rulemaking.

Application of Rural Floor Budget Neutrality

Federal Register pages 24242 - 24243

Background: Current law provides that the wage index applicable to any hospital that is located in an urban area of a state may not be less than the wage index applicable to hospitals located in rural areas of that state (“the rural floor”). As is the case with most IPPS adjustments, the increases that result from application of the rural floor must be applied in a budget-neutral manner. Between FFY 1998 and FFY 2008, the rural floor budget neutrality adjustment was implemented by adjusting the national standardized amounts. In FFY 2009, CMS adopted a provision that would apply state-specific rural floor budget neutrality adjustments to the wage indexes rather than to the standardized amount. CMS provided a three-year phase-in for this policy. In FFY 2009, hospitals received a blended wage index that reflects 20% with the state-specific rural floor budget neutrality adjustment and 80% of the national budget neutrality adjustment. In FFY 2010, the blended wage index will reflect 50% of the state level adjustment and 50% of the national adjustment. In FFY 2011, the adjustment will be 100% state-specific.

Hospitals in states with hospitals receiving a rural floor would have their wage indices downwardly adjusted to achieve budget neutrality within the state.

CMS' Proposal: For FFY 2010, CMS will continue “. . . *the second year of the three-year transition to apply rural floor budget neutrality adjustment at the state level. In FFY 2010, hospitals would receive a blended wage index that is 50% of a wage index with the state level rural and imputed floor budget neutrality adjustment and 50% of a wage index with the national budget neutrality adjustment.*”

Imputed Rural Floor Adjustment

Federal Register pages 24242 - 24243

Background: Currently, there are two states with no rural areas and one state with no IPPS hospitals located in a rural area. In FFY 2005, CMS adopted a three-year “imputed floor” adjustment methodology to address concerns that hospitals in these all-urban states were disadvantaged because there is no floor for their wage index. In FFY 2009, CMS extended the imputed floor for three additional years, through FFY 2011.

Beginning in FFY 2009, CMS began to apply the imputed floor budget neutrality adjustment at the state level in the same manner as the rural floor budget neutrality adjustment.

CMS' Proposal: For FFY 2010, CMS will continue “. . . *the second year of the three-year transition to apply rural floor budget neutrality adjustment at the state level. In FFY 2010, hospitals would receive a blended wage index that is 50% of a wage index with the state level rural and imputed floor budget neutrality adjustment and 50% of a wage index with the national budget neutrality adjustment.*”

Multi-Campus Hospitals

Federal Register page 24145

Background: A multi-campus hospital is a single, integrated institution that has one provider number and submits total wages and hours for each of its campuses on a single cost report. In FFY 2005, when CMS revised the wage areas to be based on Core-based Statistical Areas (CBSAs), it caused some multi-campus hospitals to be located in more than one CBSA. The wage data for these multi-campus hospitals were assigned to the labor market 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.

Beginning 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 full-time equivalent data by campus.

CMS' Proposal: For FFY 2010, CMS is proposing to allow “. . . *hospitals to use FTE or discharge data for the allocation of a multi-campus hospital's wage data among the different labor market areas where its campuses are located.*”

CMS updated the Medicare cost report in May 2008 to allow for the reporting of FTE data by campus for multi-campus hospitals. However, this data will not be used in calculating the wage index until FFY 2012, therefore, “. . . *a multicampus hospital will still have the option, through the FFY 2011 wage index, to use either FTE or discharge data for allocating wage data among its campuses . . .*”

MGCRB Reclassifications

Federal Register page 24149

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.

In consideration of the Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006 (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 implemented some regulatory changes to its reclassification policy. In the final FFY 2009 IPPS rule, CMS adopted the following changes to the average hourly wage (AHW) comparison criterion for hospitals over a two-year transition period, beginning with reclassifications for FFY 2010. For FFY 2010, a hospital had to demonstrate that its AHW was:

- at least 108% (for urban hospitals), or 106% (for rural hospitals) of the AHW of hospitals in

- the area in which the hospital is located; and
- at least 86% (for urban hospitals or group reclassifications), or 84% (for rural hospitals) of the AHW of hospitals in the area to which it seeks redesignation.

CMS' Proposal: For FFY 2011 reclassifications, the final year of the transition, CMS is proposing that a hospital demonstrate that its AHW is:

- at least 88% (for urban hospitals or group reclassifications), or 86% (for rural hospitals) of the AHW of hospitals in the area to which it seeks redesignation.

Reclassification Withdrawal: Hospitals that had been approved for FFY 2010 MGCRB reclassifications are permitted to withdraw their applications within 45 days of the publication of the proposed rule.

Applications for FFY 2011 reclassifications are due to MGCRB by September 1, 2009. 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 24151 - 24152

Background: Section 505 of MMA required CMS to develop an adjustment to the wage index to reflect the commuting patterns of hospital employees who work in a county with a higher wage index than where they reside.

Hospitals located in qualifying counties receive an out-migration adjustment added to their wage index for a three-year period, unless the hospital requests to waive the adjustment. A county cannot lose its out-migration adjustment during the three-year period and will receive the same adjustment for those three years. However, a county that qualifies in any given three-year period may not 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 subsequent years CMS calculates the out-migration adjustment using the post-reclassified wage indexes.

CMS' Proposal: For FFY 2010, CMS is “. . . *proposing to calculate the out-migration adjustment using the same formula described in the FFY 2005 IPPS final rule . . . with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment.*”

Section 508 Reclassifications

Federal Register page 24151

Background: Section 508 of 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, and SCHIP Extension Act of 2007 extended the Section 508 reclassifications through September 30, 2008. Subsequently, MIPPA extended Section 508 reclassifications another year through September 30, 2009.

CMS' Proposal: Existing Section 508 reclassifications will expire on September 30, 2009. CMS does not have the authority to extend Section 508 reclassifications without legislation.

“Lugar” Reclassifications

Federal Register pages 24149 - 24151

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.

The MGCRB reclassifications threshold for rural hospitals that applied for reclassification in FFY 2010 is 84%.

Wage Index Study

Federal Register page 24138

Background: 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 future rulemaking.

MedPAC’s proposal 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 Metropolitan Statistical Areas 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 *Report* 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) addressing 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's Final Report, Part 1 is now available at <http://www.acumenllc.com/reports/cms>.

CMS' Proposal: For FFY 2010, CMS is not proposing any additional changes to the hospital wage index for acute care hospitals, since the Acumen study is not yet complete.

VIII. MEDICARE DSH CALCULATION

Medicare makes an additional payment to hospitals that serve a disproportionate number of low-income patients. To qualify for the Medicare DSH adjustment the hospital must:

1. Be located in an urban area, have 100 beds or more, and more than 30% of its net inpatient care revenue is derived from state and local government payments for care furnished to low income patients; or
2. Calculate its DSH patient percentage (DPP) using the complex statutory formula illustrated below:

$$\text{DSH Patient Percentage} = \frac{(\text{Medicare SSI Days})}{\text{Total Medicare Days}} + \frac{\text{Medicaid(Non-Medicare Days)}}{\text{Total Patient Days}}$$

The second method is the most common method used by hospitals to qualify for DSH payments. The first part of the computation includes patient days for patients who were entitled to Medicare Part A and Supplemental Security Income (SSI). This number is divided by the total number of Medicare Part A days. The second part of the computation includes patient days for patients who were eligible for Medicaid, not including any days in the first computation, divided by total patient days. Hospitals whose DPP exceeds 15% are eligible for a DSH payment adjustment.

Labor and Delivery Patient Days for DSH Calculation

Federal Register pages 24187 - 24188

Background: “. . . under the current policy, days associated with labor and delivery services furnished to patients who did not occupy a routine bed prior to occupying an ancillary labor and delivery bed before census-taking hour are not included as inpatient days for purposes of the DSH calculation.”

CMS' Proposal: Effective for cost reporting periods beginning on or after October 1, 2009, CMS is proposing to allow hospitals to include “. . . patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, regardless of whether the patient occupied a routine bed prior . . . ” to receiving the ancillary services. CMS is not proposing any policy changes on patient days for labor and delivery patients who are **not** admitted, such as false labor, as these patients would be considered outpatients and would not be included in the count.

Medicaid Eligible Days for DSH Calculation

Federal Register pages 24188 - 24189

Background: *“Under the existing Medicare DSH payment adjustment policy, a hospital is required to report its Medicaid inpatient days (that is, the “numerator” of the Medicaid fraction) in the cost reporting period in which the patient was discharged.”* In many cases, hospitals have been reporting days based on the method used by their respective state agency, which include date of discharge, date of admission, date of Medicaid payment, and dates of service. This is contrary to current policy and has led to an inconsistent reporting of patient days.

CMS’ Proposal: Effective for cost reporting periods on or after October 1, 2009, CMS is proposing to allow hospitals to count Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP based on one of methodologies: date of admission, date of discharge, or date of service. If a hospital chooses to change from its current methodology it must notify CMS, in writing, at least 30 days before the beginning of the cost reporting period for which the change applies.

Observation Beds

Federal Register pages 24189 - 24191

Background: Current regulations *“ . . . specify that observation days are to be excluded from the counts of both available beds and patient days, unless a patient who receives outpatient observation services is ultimately admitted for acute inpatient care, in which case the bed days and patient days would be included in both counts.”*

CMS’ Proposal: Effective for cost reporting periods on or after October 1, 2009, CMS is proposing that the patient days incurred while observation services are furnished **not** be included in the calculation of the DPP regardless of whether the patient is later admitted. CMS believes observation days should not be considered as inpatient days. In addition, CMS is proposing that *“ . . . hospitals would be required to report their total observation bed days so that the total observation days can be deducted from the bed day count for IME and DSH payment adjustment purposes.”*

IX. COST OUTLIERS

Federal Register pages 24245 - 24248

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 to ensure that total outlier payments equal 5.1% of total IPPS payments.

CMS’ Proposal: For FFY 2010, CMS is *“ . . . proposing an 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 \$24,240.”*

The proposal increases the outlier threshold from \$20,045 in FFY 2009 to \$24,240 in FFY 2010. Thresholds are set each year to target 5.1% of estimated total payments to outlier payments. CMS reports that 4.8% of total payments were actually made for outliers in FFY 2008. Currently, CMS estimates that outlier payments will represent 5.4% of total FFY 2009 payments. CMS uses the FFY 2009 estimate to justify the higher threshold in

FFY 2010, arguing that the projected over payment in FFY 2009 requires an increase in the FFY 2010 threshold to avoid additional overpayments in FFY 2010.

X. GRADUATE MEDICAL EDUCATION

Direct Graduate Medical Education (DME)

Direct Medical Education (DME) attempts to recognize the direct costs associated with the operation and administration of a GME program. Medicare pays teaching hospitals for the direct costs of GME based on a hospital-specific base period per resident amount (PRA). For most hospitals, the base year is FFY 1984. PRAs are updated annually for inflation and there is a limit on the number of FTE residents a hospital may include in its resident count for calculating direct GME payments.

New Medical Residency Training Program

Federal Register pages 24191 - 24192

Background: CMS' regulations allow for adjustments to the FTE resident caps for hospitals with newly established medical residency training programs on or after January 1, 1995. “. . . if a hospital had no allopathic or osteopathic residents in the base year, the hospital may receive an adjustment to its FTE resident cap . . . if it establishes one or more new medical residency training programs, but only for new programs established within 3 academic years after residents begin training in the first program.” There has been some misinterpretation of the definition of “new” as it relates to a medical residency training program. Some hospitals have interpreted the regulation to mean that “. . . as long as the relevant accrediting body . . . grants an ‘initial’ accreditation or reaccredits a program as ‘new’ the hospital may receive an FTE cap adjustment for that program . . .” even if the program had been previously accredited at another hospital.

CMS' Proposal: In the FFY 2010, CMS is clarifying its policy “. . . that a new medical residency program is one that receives initial accreditation for the first time, as opposed to a reaccreditation of a program that existed previously at the same or another hospital.”

Participation of New Teaching Hospitals in Medicare GME Affiliation Group

Federal Register pages 24192 - 24193

Background: Hospitals that belong to the same Medicare GME-affiliated group are allowed to “. . . apply their direct GME and IME FTE resident caps on an aggregate basis, and to temporarily adjust each hospital's caps to reflect the rotation of residents among affiliated hospitals during an academic year.” The regulations require each hospital in a Medicare GME-affiliated group to submit a Medicare GME affiliation agreement to the fiscal intermediary (FI) or Medicare Administration Contractor (MAC) assigned to the hospital and send a copy to CMS' Central Office by July 1 of the residency program year during which the Medicare GME affiliation is in effect.

CMS' Proposal: For FFY 2010, CMS is proposing “. . . that a hospital that is new after July 1 and that begins training residents for the first time prior to the following July 1 would be permitted to receive a temporary adjustment to its FTE resident caps to reflect its participation in an existing Medicare GME affiliated group” The new hospital must submit a Medicare GME affiliation agreement, specifying the effective period of the agreement, prior to the end of the first cost reporting period during which the hospital begins training residents.

CMS is also “. . . proposing that each of the other hospitals participating in the Medicare GME affiliated group

with the new hospital would be required to submit an amended Medicare GME affiliation agreement that reflects the participation of the new hospital . . . no later than June 30 of the residency program year. . . .”

Indirect Medical Education (IME) Adjustment

Federal Register pages 24186 - 24187

Background: IME payments are intended to recognize the higher costs associated with the operation and administration of a 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. Currently, observation bed days are included in the number of available inpatient beds used for purposes of calculating a hospital’s IME adjustment.

Before MMA, the formula multiplier was set at 1.35 for discharges occurring during FFY 2003 and thereafter, which equates to a 5.5% adjustment. MMA modified the formula, increasing the multiplier for FFYs 2005 and 2006 to 1.42 and 1.37, respectively. However, in FFY 2007, 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 2010. CMS estimates “. . . *that application of this formula multiplier for the FFY 2010 IME adjustment will result in an increase in IPPS payment of 5.5% for every approximately 10% increase in the hospital’s resident-to-bed ratio.*”

Observation Bed Days

CMS’ Proposal: CMS is proposing for cost reporting periods on or after October 1, 2009, that the patient days incurred while observation services are furnished **not** be included in the calculation of the IME adjustment, regardless of whether the patient is later admitted. CMS considers observation days an outpatient visit rather than an inpatient day. In addition, CMS is proposing that “. . . *hospitals would be required to report their total observation bed days so that the total observation days can be deducted from the bed day count for IME and DSH payment adjustment purposes.*”

XI. ADDITIONAL PAYMENTS FOR NEW TECHNOLOGY

Federal Register pages 24127 - 24137

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.

For FFY 2009, CMS only approved CardioWest™ Temporary Artificial Heart (TAH) system for a new technology add-on payment.

CMS’ Proposal: For FFY 2010, CMS is proposing “*to continue new technology add-on payments for cases involving the TAH . . . with a maximum add-on payment of \$53,000.*”

In addition, CMS is considering five applications for new technology add-on payments in FFY 2010:

- the AutoLITT™ System;
- the CLOLAR® (clofarabine) Injection;
- the LipiScan™ Coronary Imaging System;

- the Spiration® IBV® Valve System; and
- the TherOx Downstream® System.

XII. RURAL HOSPITALS

Rural Referral Centers (RRCs)

Federal Register pages 24185 - 24186

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

- exemption from the 12% cap on DSH payments that is applicable to other rural hospitals;
- special treatment under the geographic reclassification rules including:
 - exemption from the proximity criteria; and
 - exemption from the requirement that a hospital’s average hourly wage must exceed 106% 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 2010, CMS is proposing that “. . . if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2009, they must have a CMI value for FFY 2008 that is at least:

- 1.4667; or
- *The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs . . .) calculated by CMS for the census region in which the hospital is located.”*

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

| Region | Case-Mix Index Value |
|---|----------------------|
| New England (CT, ME, MA, NH, RI, VT) | 1.2609 |
| Middle Atlantic (PA, NJ, NY) | 1.2993 |
| South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) | 1.4159 |
| East North Central (IL, IN, MI, OH, WI) | 1.4013 |
| East South Central (AL, KY, MS, TN) | 1.3377 |
| West North Central (IA, KS, MN, MO, NE, ND, SD) | 1.4010 |
| West South Central (AR, LA, OK, TX) | 1.4667 |
| Mountain (AZ, CO, ID, MT, NV, NM, UT, WY) | 1.5233 |
| Pacific (AK, CA, HI, OR, WA) | 1.4390 |

In addition, for FFY 2010, CMS is proposing that for a hospital to qualify “. . . for initial RCC status for cost reporting periods beginning on or after October 1, 2009 it must have as the number of discharges for its cost reporting period that began during FFY 2007 a figure that is at least:

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

The proposed median numbers of discharges for urban hospitals by census region are as follows:

| Region | Discharges |
|---|------------|
| New England (CT, ME, MA, NH, RI, VT) | 8,329 |
| Middle Atlantic (PA, NJ, NY) | 10,655 |
| South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) | 10,038 |
| East North Central (IL, IN, MI, OH, WI) | 9,262 |
| East South Central (AL, KY, MS, TN) | 6,311 |
| West North Central (IA, KS, MN, MO, NE, ND, SD) | 8,764 |
| West South Central (AR, LA, OK, TX) | 6,222 |
| Mountain (AZ, CO, ID, MT, NV, NM, UT, WY) | 10,452 |
| Pacific (AK, CA, HI, OR, WA) | 8,763 |

XIII. CRITICAL ACCESS HOSPITALS

Payment for Clinical Diagnostic Laboratory Tests Furnished by CAHs

Federal Register pages 24202 - 24203

Background: Currently, payments to CAHs for clinical diagnostic laboratory services are made at 101% of reasonable cost “. . . only if the individuals [for whom the tests are performed] are outpatients of the CAH . . . and are physically present in the CAH, at the time the specimens are collected.” Tests performed for individuals who are not physically present at the time when the specimen is collected are paid based on the Clinical Laboratory Fee Schedule (CLFS).

CMS’ Proposal: For FFY 2010, CMS is proposing changes to the current regulations. “. . . effective for services furnished on or after July 1, 2009, individuals are no longer required to be physically present in the CAH at the time the specimen is collected in order for the CAH to receive payment based on reasonable cost for furnishing outpatient clinical diagnostic laboratory tests.” To be considered an outpatient of the CAH, CMS proposes that “. . . the individual must either have received outpatient services in the CAH on the same day the specimen is collected or the specimen must be collected by an employee of the CAH.” In addition, CMS is proposing to establish a modifier to assist in the tracking of payments for laboratory services made to CAHs under this provision.

CAH Optional Payment Method

Federal Register pages 24203 - 24204

Background: CAHs are paid based on one of two methods:

- the standard method of 101% of their allowable costs; or

- the optional method that CAHs may elect to bill the Medicare fiscal intermediary or MAC for both facility services and professional services to its outpatients. Payment under this optional method would be:
 - for facility services, the lesser of 80% of 101% of the reasonable costs or 101% of the outpatient CAH services less applicable Part B deductible and coinsurance amounts; and
 - for professional services, 115% of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule.

CMS' Proposal: CMS believes that legislative language establishing the optional method does not specify payment at 101% of cost. Therefore, for FFY 2010, CMS is proposing that “. . . CAHs that elect the optional method will receive payment based on reasonable cost for outpatient facility services. The proposed change would not affect payment for the professional component . . .” Under this proposal, CAHs electing the optional method would be reimbursed at 100% of their reasonable costs for outpatient services, instead of 101%.

CAH-Based Clinical Diagnostic Laboratory Facilities

Federal Register pages 24204 - 24205

Background: Facilities that only provide clinical diagnostic laboratory services are currently exempt from provider-based determinations because such facilities are typically paid under the CLFS whether the laboratory is freestanding or provider-based. CMS notes that a clinical diagnostic laboratory operated as part of a CAH, generates higher Medicare payments (paid at 101% of reasonable cost) than one operating as a freestanding facility and, therefore, provider-based rules should apply.

CMS' Proposal: For FFY 2010, CMS is proposing that clinical diagnostic laboratories that operate as part of a CAH must meet applicable provider-based requirements if the CAH wishes to receive payments at 10% of reasonable cost for services provided at that facility.

CAH-Based Ambulance Services

Federal Register pages 24205 - 24206

Background: Existing regulation provides that “. . . ambulance services are paid at reasonable cost if the services are furnished by a CAH or by an entity owned and operated by a CAH, but only if the CAH or entity is the only supplier or provider of ambulance service within a 35-mile drive of the CAH or entity.”

CMS' Proposal: For FFY 2010, CMS is seeking input regarding whether an ambulance service that is owned and operated by a CAH, and is eligible to receive reasonable cost-based payment, should be required to meet the provider-based status rules.” Since CAH ambulance services are paid at a higher Medicare payment level by virtue of being owned and operated by a CAH, CMS believes it can be argued that ambulance providers owned and operated by a CAH should be required to meet the provider-based status requirements.

XIV. OTHER ISSUES

Electronic Health Records (EHRs)

Federal Register pages 24181 - 24183

Background: Beginning in FFY 2006, CMS encouraged hospitals to adopt EHRs so that they could report clinical quality data electronically to a CMS data repository. In FFY 2008, CMS decided to continue participating in the American Health Information Community (which is now replaced by the National eHealth Collaborative) to explore ways through which EHR could improve the speed and efficiency in data collection and quality reporting.

Currently, CMS is working with the Office of the National Coordinator for Health Information Technology on EHR standards development, toward enabling EHR-based submission of emergency department “throughput” measures, stroke measures, and venous thromboembolism measures. Interoperable standards regarding these three measures are scheduled to be developed and finalized by October 2009. CMS plans to begin testing these measures as early as July 1, 2010.

CMS intends to select several EHR vendors and hospitals to develop and test EHR clinical quality data submission. Before starting testing EHR-based data submission, CMS will publish a separate *Federal Register* notice seeking public comments on the process to select EHR vendors/hospitals and the methodology to be used for EHR-based data submissions.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted on February 17, 2009, was part of ARRA, which authorized payment incentives under Medicare for the adoption and use of certified EHR technology beginning in FFY 2011. Hospitals are eligible for these payment incentives if they meet the following three requirements:

- meaningful use of certified EHR technology;
- electronic exchange of health information; and
- reporting on measures using certified EHR technology.

The Act requires the HHS Secretary to select measures, including clinical quality measures, for reporting to be eligible for the EHR incentive payments and to give preference to those clinical quality measures included in the RHQDAPU program.

CMS’ Proposal: For FFY 2010, CMS is not including any proposals to implement the HITECH Act payment incentive for adoption and use of certified EHR technology. Those provisions will be implemented in a future rulemaking.

Hospital Emergency Services Under EMTALA

Federal Register pages 24193 - 24195

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 appropriately transfer the patient 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 “. . . *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 2010, CMS is proposing to revise the regulatory language to state “. . . *that EMTALA sanctions for an inappropriate transfer may be waived only if the inappropriate transfer arises out of the circumstances of the emergency.*” In addition, CMS is also proposing further clarification by stating “*the sanctions waived for both an inappropriate transfer and the redirection or relocation of an individual to receive a medical screening examination at an alternate location are only applicable if the hospital does not discriminate on the basis of an individual’s source of payment or ability to pay.*”