



**WISCONSIN HOSPITAL  
ASSOCIATION**

**SUMMARY OF THE FINAL  
FFY 2011 MEDICARE  
HOSPITAL INPATIENT RULE**

**August 2010**

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## I. OVERVIEW

CMS published the final Medicare Inpatient Prospective Payment System (IPPS) rule for FFY 2011, which contains payment updates and policy changes, including provisions mandated by the Affordable Care Act (ACA) of 2010, in the August 16, 2010 *Federal Register*. Changes are effective October 1, 2010, unless otherwise noted.

In this *Federal Register*, CMS is also issuing an interim final rule with comment period to implement a provision of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 relating to Medicare payments for outpatient services provided prior to a Medicare beneficiary's inpatient admission. Comments on the interim final rule with comment period (CMS-1498-IFC) must be received no later than 5 p.m. EST on September 28, 2010.

**Note:** Text in italics is extracted from the May 4, 2010, June 2, 2010, or August 16, 2010 *Federal Register*.

### **Major Provisions of the Final Rule**

**Marketbasket Update:** CMS will provide a marketbasket update of 2.35 percent for FFY 2011, which reflects a full marketbasket update of 2.60 percent minus 0.25 percentage points as mandated by the ACA.

**Coding Adjustment to IPPS Payment Rates:** Despite strong opposition by the hospital field, CMS has adopted its proposal to recapture 5.8% of the increase in IPPS payments during FFYs 2008 and 2009. CMS contends that this 5.8% increase can be attributed to improved hospital coding and classification of patients, resulting from the implementation of Medicare-Severity Diagnosis Related Groups (MS-DRGs) rather than real case-mix changes due to patient characteristics and treatment patterns.

CMS will reduce both the FFY 2011 and the FFY 2012 standard payment amount by 2.9% to achieve the 5.8% recoupment. These reductions will also apply to the hospital-specific rates for Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs). The FFY 2011 2.9% coding adjustment will more than offset the 2.35% marketbasket update to IPPS payments rates, causing hospitals to experience a decrease in their overall Medicare IPPS payments from FFY 2010 to FFY 2011.

**Quality Measures Used for the Hospital Pay-for-Reporting Program:** To receive a full marketbasket update under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program in FFY 2011 (FFY 2011 payment determinations), hospitals will be required to successfully report data on 46 quality measures, (including HCAHPS, which CMS counts as one measure). Hospitals that do not successfully submit quality data will be subject to a 2.0 percentage point reduction to their IPPS marketbasket update – the reduction factor has not changed.

Finalizing its proposal to select RHQDAPU measures for three consecutive payment years rather than one payment year in a given rulemaking cycle, CMS has adopted RHQDAPU measures for FFY 2012 through 2014 payment determinations.

**Outlier Threshold:** CMS will decrease the outlier threshold by 0.3% from \$23,140 in FFY 2010 to \$23,075 in FFY 2011 in order to maintain estimated outlier payments at 5.1% of total payments under the IPPS.

**Consideration of Costs of Provider Taxes as Allowable Costs:** Despite strong opposition from the hospital field, CMS is moving forward with a clarification for determining which provider taxes assessed by states may be considered allowable reasonable costs and paid under Medicare. The clarification, which could affect Medicare reimbursement to Critical Access Hospitals (CAHs) as well as other providers that are paid on the basis of their incurred reasonable costs, will require Medicare fiscal intermediaries to determine if the provider taxes are

allowable on a case-by-case basis, based on reasonable cost principles.

**Low-Cost County Adjustment:** For FFY 2011, CMS has adopted as final its proposal to distribute \$150 million in 2011 and \$250 million in FFY 2012 to IPPS hospitals (including Sole Community Hospitals and Medicare Dependent Hospitals) located in counties within the lowest national quartile for total Medicare Part A and Part B spending per enrollee.

**Low-Volume Hospital Adjustment:** Per the ACA, CMS is required to implement a temporary change to its policy regarding the low volume hospital adjustment (for FFYs 2011 and 2012) that would allow more hospitals to qualify for the adjustment. CMS has modified its policy (as mandated) and is implementing a continuous sliding scale methodology that will provide payment adjustments for hospitals with less than 1,600 Medicare discharges. *Hospitals must apply for this adjustment by September 1, 2010.*

**Wage Index Reclassifications:** CMS is required, under the ACA, to restore the less restrictive, FFY 2008 Medicare hospital wage index reclassification thresholds for comparing hospitals' average hourly wages when reviewing wage index reclassification requests.

**Rural Floor/Imputed Floor Budget Neutrality Adjustment:** Effective FFY 2011, CMS is required by the ACA to restore the budget-neutrality adjustment for the rural and imputed floor to the national, rather than the state-specific, basis through a uniform, national adjustment to the area wage index.

**Medicare Dependent Hospitals (MDHs):** Per the ACA, CMS is extending the MDH program one additional year, through September 30, 2012.

**Wage Index Floor for Certain States:** Beginning in FFY 2011, the ACA establishes a Medicare hospital wage index floor of 1.0 for hospitals located in states determined to be "frontier states." The ACA defines any state as a frontier state if at least 50 percent of the state's counties are determined to be frontier counties. The ACA defines a frontier county as counties that have a population density less than 6 persons per square mile.

**CAHs—Election of the Optional Payment Method for Payment of Outpatient Services:** CMS is adopting its proposal to permit CAHs that elect to be paid for outpatient services under the "optional method" to be paid under the option on a continuous basis.

**Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and CAHs:** CMS is adopting its proposal to modify current rules to allow hospitals and CAHs that have successfully reclassified from urban status to rural status to be eligible for payment on reasonable cost for anesthesia and related care furnished by qualified non-physician anesthetists.

**Modifications to the 3-Day Payment Window – "72-Hour Rule (Interim Final Rule with Comment Period):"** As required by the Preservation of Access to Care Act, CMS has clarified the Medicare payment policy regarding how hospitals may bill for outpatient non-diagnostic services related to an inpatient admission (other than ambulance and maintenance renal dialysis services) provided on the day of admission or during the 3 days (72 hours) prior to the admission. Effective for services furnished on or after June 25, 2010, such services must be bundled for payment. Outpatient non-diagnostic services that are unrelated to the hospital inpatient stay should be billed separately under Medicare Part B; hospitals will be required to attest to the fact that the services were unrelated. The law does not change the billing of diagnostic services during this period.

## II. LEGISLATIVE MANDATES

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; the Deficit Reduction Act (DRA) of 2005; the Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006; the Transitional Medical Assistance; Abstinence Education, and Qualifying Individuals Programs Extension Act (TMA) of 2007; the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007; the Medicare Improvements for Patients and Providers Act of 2008; the American Recovery and Reinvestment Act of 2009; the Affordable Care Act (ACA) of 2010, and the Preservation of Access to Care Act of 2010, each contain Medicare provisions that either currently affect program payment policy or will begin to affect payment policy in upcoming federal fiscal years. Where appropriate, legislative references are provided in the text below.

## III. STANDARDIZED AMOUNTS/HOSPITAL-SPECIFIC RATES

### Marketbasket Update

*Federal Register* page 50352

**CMS' Final Rule:** For FFY 2011, CMS will provide a marketbasket update of 2.35 percent, which reflects a full marketbasket update of 2.60 percent minus 0.25 percentage points as mandated by the ACA. This marketbasket estimate is based on IHS Global Insight, Inc.'s second quarter 2010 forecast. Hospitals that do not submit qualifying quality data will receive a 2.0 percentage point reduction to this marketbasket, yielding a net 0.35 percent update.

For FFY 2011, the labor-related amount will remain at 68.8% for hospitals with wage indexes over 1.0 and 62% for hospitals with wage indexes equal to or less than 1.0.

### Offset for Coding Improvements

*Federal Register* pages 50057 - 50073

**Background:** In FFY 2008, CMS adopted the Medicare-Severity Diagnosis Related Groups (MS-DRGs) to better recognize severity of illness in Medicare IPPS payments. MS-DRGs substantially changed the structure of the Medicare DRGs by revising the list of diagnosis codes that are designated as complications and comorbidities and adding new DRGs for major complications and comorbidities. CMS believed that the MS-DRGs had the potential to generate increases in aggregate payments that would not be caused directly by increases in actual patient severity of illness (referred to as "real" case-mix change), but rather would be due to improved hospital documentation and coding.

CMS has the authority, under the Benefits Improvement and Protection Act (BIPA) of 2000, to adjust the IPPS standardized amount to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case mix.

In its final FFY 2008 IPPS rule, CMS announced a prospective 4.8% coding adjustment, to be phased-in over three years, to neutralize for anticipated case-mix increases due to changes in documentation and coding. The TMA mandated that CMS reduce its prospective coding adjustments to 0.6% in FFY 2008 and 0.9% in FFY 2009 (a total prospective adjustment of 1.5%), but the law authorized CMS to revisit the issue and recapture any additional coding-related overpayments made during those years — in addition to any further prospective adjustments. The retrospective recoupments were to be made during FFYs 2010, 2011, and 2012. In its final FFY 2010 rule, CMS postponed a proposed 1.9% coding adjustment, stating that a full analysis of the FFY 2009

case-mix changes could not be completed to determine the magnitude of the documentation and coding effect.

### **Retrospective Coding Adjustment**

**CMS' Proposal:** CMS proposed to reduce the FFY 2011 standard amount by 2.9% to recapture half of the “excess” payments made during FFYs 2008 and 2009 for case-mix increases due to coding improvements. According to CMS’ analysis of claims data, IPPS payments increased 2.5% in FFY 2008 and 5.4% in FFY 2009 as a result of coding improvements. Because the IPPS rates were already prospectively reduced by 0.6% in FFY 2008 and 1.5% in FFY 2009 (0.6% plus an additional 0.9%) for anticipated coding improvements, CMS stated that the remaining overpayment for the two years is equivalent to 5.8% of one year’s payments. The basis of CMS’ calculation is shown below:

	<b>FFY 2008</b>	<b>FFY 2009</b>	<b>Total</b>
IPPS payment increase resulting from coding improvement (compared to FFY 2007)	2.5%	5.4%	
Reduction already applied to rate	<u>0.6%</u>	<u>1.5%</u>	
Residual “overpayment”	1.9%	3.9%	5.8%

CMS proposed to recoup the total 5.8% over the next two years by reducing the IPPS standard payment amount by 2.9% in both FFYs 2011 and 2012. CMS stated that *“the recoupment or repayment adjustment to the standardized amounts . . . is not cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FFY 2008 expenditures and FFY 2009 expenditures.”*

**CMS' Final Rule:** Despite strong opposition and numerous comments from the industry, CMS is adopting their proposal as final without modification and will *“...make an adjustment to the standardized amount of -2.9 percent, representing approximately half of the aggregate recoupment adjustment required... for FY 2011.”*

CMS rejected comments from the industry and did not acknowledge a letter signed by 242 members of the U.S. House of Representatives and 52 U.S. Senators arguing that the methodology for the offset was flawed. CMS also rejected an AHA analysis that supported a much lower adjustment for changes due to coding and documentation. The industry pointed out that the CMS analysis goes against reason because it implies a decline in real case-mix. The general conclusion was that the CMS analysis does not fulfill the legislative mandate—it does not differentiate between case-mix increases due to changes in coding behavior and case-mix changes that reflect real changes in patient characteristics and treatment patterns. CMS’ analysis ignored factors such as changes in patient severity (due to aging of the population, increased public health problems such as obesity levels, etc.) and changes in treatment patterns (due to the introduction of new technologies, more widespread use of existing complex procedures, increased use of outpatient surgeries, etc.).

### **Prospective Coding Adjustment**

**CMS' Final Rule:** In addition to the retrospective adjustments for coding improvements in FFY 2008 and 2009, CMS is authorized to adjust the IPPS standardized amounts prospectively to neutralize the remaining effect of the documentation and coding changes on future payments.

Based on the same analysis, CMS estimates that the annual (recurring) increase in IPPS payments due to coding improvement is 5.4% (the total increase from FFY 2007 to FFY 2009). To restore budget neutrality, CMS states that it would need to reduce the standard amount by an additional 3.9% (5.4% minus 1.5%) on a go-forward basis to permanently realign payments to the baseline FFY 2007 coding level.

CMS is not implementing a prospective coding adjustment at this time, because it would cause too great of a disruption to Medicare IPPS payments in one year. CMS indicates that *“this proposal would require us to apply the -3.9 percent adjustment in future payment years, which may be applied all at once in a single year or phased in over more than one year.”*

### **Hospital-Specific Rates**

**Background:** CMS initially exempted the hospital-specific rates paid to SCHs and MDHs from the coding adjustment, and did not apply the 0.6% rate reduction in FFY 2008 or the 0.9% rate reduction in FFY 2009 to those rates. In its final FFY 2010 rule, CMS proposed, but never adopted, a 2.5% rate reduction to hospital-specific rates for coding improvement. At that time, CMS indicated that it had the authority to apply such an adjustment using its special “exceptions and adjustment” authority, as deemed appropriate by the HHS Secretary, *“because SCHs and MDHs use the same MS-DRG system as all other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients’ severity of illness. Therefore, we believe they should be equally subject to a prospective budget neutrality adjustment that we are applying for adoption of the MS-DRGs to all other hospitals. We believe the documentation and coding estimates for all subsection (d) hospitals should be the same.”*

**CMS’ Proposal:** Based on the same claims analysis, CMS asserts that SCHs and MDHs paid at the hospital-specific rate should be subject to a prospective rate reduction of 5.4% in order to eliminate the full effect of coding and documentation changes on future payments. CMS states, *“Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital-specific rates paid to SCHs and MDHs to account for documentation and coding changes. Therefore, the entire -5.4 percent adjustment remains to be implemented.”*

For FFY 2011, CMS proposed a prospective *“adjustment of -2.9 percent in FFY 2011 to the hospital-specific rates paid to SCHs and MDHs . . . . This proposal is consistent with our proposed adjustment for IPPS hospitals in two ways. First, as in the case of the IPPS adjustment, we are not proposing to implement the entire adjustment that is warranted by our data (in this case, 5.4 percent) in one year. Second, we are maintaining consistency by proposing the same numerical level of adjustment for both groups of hospitals in FFY 2011. . . . Although the proposed adjustment for SCHs and MDHs is cumulative and prospective, as opposed to the noncumulative recoupment adjustment we are proposing for other IPPS hospitals, we believe that proposing equal numerical adjustments in this first year is the most appropriate means to maintain such consistency and equity at this time.”*

**CMS’ Final Rule:** CMS has adopted its proposal as final *“...to apply an adjustment of -2.9 percent ... to the hospital-specific rates paid to SCHs and MDHs. This adjustment is prospective in nature.”*

### **Operating and Capital Rates**

*Federal Register* pages 50432 and 50440

The standard amounts for FFY 2011 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. These rates reflect the marketbasket update reduction of 0.25 percentage points as required by the ACA.

<b>Standard Rate<sup>1</sup> for Hospitals with a Wage Index Greater Than 1.0</b> (68.8 Percent Labor Share and 31.2 Percent Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (2.35 Percent)	\$3,552.91	\$1,611.20
Reduced Update (0.35 Percent) <sup>2</sup>	\$3,483.49	\$1,579.72
<b>Standard Rate<sup>1</sup> for Hospitals with a Wage Index Less Than or Equal to 1.0</b> (62.0 Percent Labor Share and 38.0 Percent Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (2.35 Percent)	\$3,201.75	\$1,962.36
Reduced Update (0.35 Percent) <sup>2</sup>	\$3,139.19	\$1,924.02
<b>Capital Federal Rate<sup>1</sup></b>		
National Capital Rate		\$420.01

Note 1: The rates shown in the tables above (both operating and capital) reflect the 2.9% reduction for the coding and documentation improvement adjustment.

Note 2: The reduced update is applicable to hospitals that are not in compliance, or have withdrawn from the FFY 2011 quality reporting program.

## IV. MS-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

### Relative Weights

*Federal Register* pages 50073 - 50080

**Background:** Before FFY 2007, CMS calculated Diagnosis Related Group (DRG) weights by aggregating charges by DRG for all IPPS hospitals and determining an average charge per DRG. In FFY 2007, CMS began to phase-in a cost-based relative weight methodology. Since FFY 2009, MS-DRG relative weights have been calculated 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 to lower cost items and services and a lower percentage charge markup to higher cost items and services. As a result, the cost-based weights might 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 Research Triangle International (RTI) and RAND Corporation to study the effects of charge compression and the new 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 estimating regression-based CCRs for certain cost centers and adding new cost centers to the Medicare cost report, such as "Devices, Implants, and Prosthetics" under "Medical Supplies Charged to Patients," and "CT Scanning and MRI" under "Radiology-Diagnostics." 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. However, RAND's finding suggested that regression-based adjustments to the CCRs do not significantly improve payment accuracy.

CMS decided not to adopt regression-based CCRs for its calculation of the IPPS relative weights, but rather to refine the Medicare cost reports. In doing so, in the final FFY 2009 rule CMS modified the Medicare cost report to include one cost center for "Medical Supplies Charged to Patients" and one cost center for "Implantable

Devices Charged to Patients.”

**CMS’ Proposal:** CMS did not propose any changes in the relative weight calculation for FFY 2011. However, CMS did propose to “*create new standard cost centers for CT scanning, MRI, and cardiac catheterization . . .*”

*“If we decide to finalize these proposed new cost centers, the upcoming Federal Register notice that will finalize Form CMS-2552-10 will provide more information regarding the addition of these proposed new standard cost centers for CT scans, MRI, and cardiac catheterization, including the instructions for completing these cost centers on the new cost report.”*

**CMS’ Final Rule:** CMS in the final rule is “*...establishing standard cost centers for CT scanning, MRI services, and cardiac catheterization in hospital cost reports for cost report periods beginning on or after May 1, 2010.*”

*In addition, CMS urges “...all hospitals to properly report their costs and charges for MRI, CT scans, and all other services so that, in several years’ time, we will have reliable data from all hospitals on which to base a decision as to whether to incorporate additional CCRs into the relative weight calculation.”*

CMS plans “*... to issue the final hospital cost report Form CMS-2552-10 later this summer.*”

## **Changes to the ICD-9-CM Coding System**

*Federal Register pages 50101 - 50128*

**Background:** The International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) is a coding system used for the reporting of valid diagnoses and procedures performed on a patient. In 1985, the ICD-9-CM Coordination and Maintenance Committee was developed with a charge of maintaining and updating the ICD-9-CM system. This committee encourages feedback from the community by providing public meetings for discussion of education and coding changes. The committee is required by law to update the ICD-9-CM codes twice a year to improve the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. The code titles are published in the proposed and final IPPS rules each year, but are not subject to comment at that time.

On October 1, 2013, the ICD-9-CM will be replaced by the ICD-10-CM coding system for hospital inpatient services. In addition, the ICD-10-Procedure Coding System (PCS) for inpatient hospital procedure coding will be implemented. In January 2009, the final ICD-10-CM and ICD-10-PCS rules were published, which included a discussion of the need for a partial or total freeze in the annual updates to the ICD-9-CM, ICD-10-CM, and ICD-10-PCS codes. CMS states, “*commenter’s stated that this freeze of code updates would allow for instructional and/or coding software programs to be designed and purchased early, without concern than an upgrade would take place immediately before the compliance date, necessitating additional updates and purchases.*”

### **Code Freeze**

**CMS’ Proposal:** In its proposed rule, CMS solicited additional input on the freeze of ICD-9-CM code updates, especially with regard to the new requirements placed on hospitals for meaningful use of electronic health records. CMS would like to explore whether a freeze is necessary to assist with the adoption of health information technology.

CMS believes there is a “*need to provide the provider, payer, and vendor community time to prepare for the implementation of ICD-10 and the accompanying system and product updates.*”

**CMS' Final Rule:** *“A final decision on whether or not there will be a partial code freeze will be announced at the September 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee.”*

CMS believes *“...that this advance notice of a partial freeze provides the health care industry ample time to request last major code updates to ICD-9-CM and ICD-10, which could be discussed at the September 15-16, 2010 and the March 2011 ICD-9-CM Coordination and Maintenance Committee meeting. Codes discussed at these two meetings would be considered for the final major code updates on October 1, 2011.”*

CMS seeks further input on the following:

- Last regular code updates to ICD-9-CM and ICD-10 on October 1, 2011 ;
- Only add codes for new technologies and diseases on October 1, 2012 and 2013; and
- Next regular update to ICD-10 to occur again on October 1, 2014.

### **Additional Processing Codes**

**CMS' Proposal:** Although hospitals can process up to 25 diagnosis and procedure codes on an electronic inpatient claim, CMS' inpatient claims database can only accept the first nine diagnoses and six procedure codes reported. As a result, valuable information reported by a hospital is lost by not processing the additional codes.

Beginning on January 1, 2011, *“CMS will be able to process up to 25 diagnosis codes and 25 procedure codes when received on the 5010 format. . . . We recognize the value of the additional information provided by this coded data for multiple uses such as for payment, quality measures, outcome analysis, and other important uses.”*

**CMS' Final Rule:** CMS is adopting its proposal as final without modification.

## **V. REPORTING HOSPITAL QUALITY DATA**

*Federal Register* pages 50180 - 50235

**Background:** The MMA authorized and mandated 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 needed to meet certain validation requirements. Hospitals that withdrew from the program or failed to submit valid data received a reduced marketbasket factor (-0.4 percentage points for FFYs 2005 and 2006).

DRA extended and expanded this program, giving CMS greater authority. In the final FFY 2007 IPPS rule, the penalty for withdrawal from or failure to comply with, the quality reporting program was increased to a marketbasket reduction of 2.0 percentage points. 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); CMS changes/adds/deletes measures as part of its rule making process. Currently, CMS adopts new quality measures a year in advance in order to give hospitals time to prepare.

**CMS' Proposal:** CMS believes that a different approach is needed to provide hospitals with ample time for planning and compliance with future quality reporting requirements. Specifically CMS proposed *“... an expansion to the RHQDAPU program that will take place over three payment years, and are proposing to add measures not only for the FFY 2012 payment determination, but also for the FFY 2013 and FFY 2014 payment determinations.”*

**CMS' Final Rule:** CMS is adopting its proposal as final without modification.

## **FFY 2011 Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program (from the final FFY 2010 IPPS rule)**

### **Required Measures**

For FFY 2011 payment determinations, CMS retained 41 of the FFY 2010 quality measures, merged two measures, retired one measure (mortality for selected surgical conditions), and added the following four measures:

- 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

The total number of core quality measures for FFY 2011 payment determinations is 46 – this includes the reporting of HCAHPS, which CMS counts as one measure.

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 2011**  
**(Retired Measures for FFY 2011 are Highlighted in the Chart)**

Heart Attack (Acute Myocardial Infarction)	Heart Failure (HF)	Pneumonia (PNE)	Surgical Care Improvement Project (SCIP)	AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQI) and Composite Measures <sup>4</sup>	Mortality Measures (Medicare patients)	Readmission Measures
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	PSI 6: Iatrogenic pneumothorax, adult	MORT-30-AMI: Acute Myocardial Infarction 30-day mortality (Medicare patients)	READ-30-PN: Pneumonia 30-day risk standardized readmission measure
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	PSI 14: Postoperative wound dehiscence	MORT-30-HF: Heart Failure 30-day mortality (Medicare patients)	READ-30-AMI: Heart Attack 30-day risk standardized readmission measure
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	PSI-15: Accidental puncture or laceration	MORT-30-PN: Pneumonia 30-day mortality (Medicare patients)	READ-30-HF: Heart Failure 30-day risk standardized readmission measure
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	IQI 11: Abdominal aortic aneurysm mortality rate (with or without volume)		
AMI-5 Beta blocker prescribed at discharge		PN-6 Appropriate initial antibiotic selection	SCIP-Infection 2: Prophylactic antibiotic selection for surgical patients	IQI 19: Hip fracture mortality rate		
AMI-7a Thrombolytic agent received within 30 minutes of hospital arrival		PN-7 Influenza vaccination status	SCIP-Infection 4: Cardiac surgery patients with controlled 6am postoperative serum glucose	Mortality for selected medical conditions		
AMI-8a Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival				SCIP-Infection 6: Surgery patients with appropriate hair removal	Mortality for selected surgical conditions	
				SCIP-Infection 9: Postoperative urinary catheter removal on post operative day 1 or 2	Complications/patient safety for selected indicators	
				SCIP-Infection 10: Perioperative temperature management		
			SCIP-Cardiovascular-2: Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period			

## RHQDAPU Quality Measures for FFY 2011

(Continued)

Patients' Experience of Care	Cardiac Surgery Measures <sup>5</sup>	AHQR PSI and Nursing Sensitive Care	Stroke Care	Nursing Sensitive Care
HCAHPS patient survey	Participation in a systematic database for cardiac surgery	PSI 4: Death among surgical patients with treatable serious complications /Failure to Rescue (Medicare claims only)	Participation in a systematic clinical database registry for stroke care	Participation in a systematic clinical database registry for nursing sensitive care

### **Withdrawal from RHQDAPU**

The deadline for withdrawal from the program for FFY 2011 was August 15, 2010. If a hospital withdraws, it will receive a 2.0 percentage point reduction to its FFY 2011 annual payment update.

### **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 concerning the FFY 2011 payment determinations is November 1, 2010. 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).

### **Submission of Data**

For FY 2011 payment determination, CMS will look at discharge data submitted by hospitals from 4th quarter 2008 through 3rd quarter 2009 for the AMI, HF, and PN chart-abstracted RHQDAPU program measures, 1st quarter 2010 for the newly added SCIP infection measures, April 2008 through March 2009 for HCAHPS, and January 1, 2010 through June 30, 2010 data for the structural measures.

## **FFY 2012 RHQDAPU Program**

### **Required Measures**

**CMS' Proposal:** For FFY 2012 payment determinations, CMS proposed to retain 45 of the FFY 2011 measures and add 10 claims-based measures to the RHQDAPU program measure set as follows:

- Two Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators:
  - PSI-11: Post Operative Respiratory Failure; and
  - PSI-12: Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)  
(These proposed AHRQ measures have been endorsed by NQF.)
- Eight Hospital-Acquired Condition (HAC) Measures:
  - Foreign Object Retained After Surgery;
  - Air Embolism;

- Blood Incompatibility;
- Pressure Ulcer Stages III & IV;
- Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing, Injury, Burn, Electric Shock);
- Vascular Catheter-Associated Infection;
- Catheter-Associated Urinary Tract Infection (UTI); and
- Manifestations of Poor Glycemic Control

CMS states, “*These proposed measures would be calculated using up to three years’ of Medicare claims for discharges prior to January 1, 2011.*”

**CMS’ Final Rule:** CMS is adopting its proposal as final without modification.

#### **Submission of All-Patient Volume Data**

**CMS’ Proposal:** CMS proposed “... *that hospitals begin submitting as data on measures selected for the RHQDAPU program the **all-patient data elements**. . . . Hospitals would begin reporting these data once annually beginning with January 1, 2011 discharges by submitting the all-patient data elements needed to calculate MS-DRG volume to QualityNet...*”

*“CMS currently displays volume data for 70 MS-DRGs, 55 of which relate to RHQDAPU program measures on the Hospital Compare Web site. However, the volume data currently shown on Hospital Compare is based on Medicare claims only. Although we do not consider volume alone to be a quality measure unless volume has been determined to be an indicator of quality, we believe that to the extent all-patient volume data are related to the measures, as they provide context for the quality measures in the inpatient hospital setting, and may assist Hospital Compare users in understanding the measure calculations.”*

**CMS’ Final Rule:** In response to public comments, CMS *did not* adopt its proposal to collect the all-patient data elements, but plans to look into more efficient ways to collect the data in the future.

#### **RHQDAPU Program Procedures**

**CMS’ Proposal:** For FFY 2012 and subsequent years, CMS proposed “. . . *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 the new CCN must submit a completed Notice of Participation form no later than 180 days from the date identified as the open date (that is, the Medicare acceptance date) on the approved CMS Online System Certification and Reporting (OSCAR) system to participate in the RHQDAPU program for FFY 2012 and future years.*”

**CMS’ Final Rule:** CMS is adopting its proposal as final without modification.

#### **Submission of Data**

**CMS’ Proposal:** CMS proposed that, for FFY 2012 payment determinations, hospitals submit data for five calendar year discharge quarters: 4<sup>th</sup> Q CY 2009 through 4<sup>th</sup> Q 2010 for the AMI, HF, and PN chart-abstracted RHQDAPU program measures; 1st quarter 2010 through 4<sup>th</sup> Q 2010 for the newly added SCIP infection measures; April 1, 2010 through December 31, 2010 for HCAHPS; and January 1, 2011 through June 30, 2011 for the structural measures.

**CMS’ Final Rule:** CMS is adopting its proposal as final without modification.

### **Chart Validation**

**CMS' Final Rule:** For FFY 2012 payment determinations, CMS will use the chart validation requirements that were adopted in the FFY 2010 IPPS final rule which are:

- *“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-case 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. For example, if the 100-case threshold applied for the FFY 2011 payment determination (which it will not), the applicable measure topics would be AMI, HF, PN, and SCIP, and we would choose 800 hospitals that submitted discharge data for at least 100 cases combined in these topics during calendar year 2008.*
- *“Validate for each of the 800 hospitals a randomly selected stratified sample for 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 . . . . Under the validation methodology, once the CDAC contractor receives the charts, it will re-abstract the same data submitted by the hospitals and calculate the percentage of matching RHQDAPU program measure numerators and denominators for each measure within each chart submitted by the hospital.*
- *“. . . we will 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.*
- *“Use the upper bound of a one-tailed 95 percent confidence interval to estimate the validation score; and*
- *“Require all RHQDAPU program participating hospitals selected for validation to attain at least a 75 percent validation score per quarter to pass the validation requirement.”*

### **Attestation**

**CMS' Proposal:** For FFY 2012 payment determinations, CMS proposed *“to require hospitals to electronically acknowledge their data accuracy and completeness once between July 1, 2010 and August 15, 2010. . .”*

**CMS' Final Rule:** CMS is requiring hospitals to attest electronically to their data accuracy and completeness, but they are changing the dates to once between July 1, 2011 and August 15, 2011.

## **FFY 2013 RHQDAPU Program**

### **Required Measures**

**CMS' Proposal:** CMS proposed *“... to retain all of the proposed measures for the FFY 2012 RHQDAPU payment determination, if finalized, for the FFY 2013 payment determination.”* In addition, for FFY 2013 payment determinations, CMS proposed to add three new measures. CMS states, *“Collection of these measures would begin with January 1, 2011 discharges for the FFY 2013 payment determination.”*

CMS also proposed that hospitals choose **one** of the following four proposed measure topics for submission of quality data to a registry:

- Implantable Cardioverter Defibrillator (ICD) Complications;
- Cardiac Surgery;
- Stroke; or
- Nursing-Sensitive Care.

*“We are proposing that hospitals begin submitting data to the qualified registry of its choosing for discharges on or after January 1, 2011.”*

**CMS’ Final Rule:** CMS is finalizing its proposal to retain the 55 quality measures from FFY 2012 for payment determination in FFY 2013. In addition, they are accepting the following two new quality measures for FFY 2013 payment determination:

- One new chart-abstracted measure:
  - AMI-statin at discharge (NQF #0639)  
(This measure is NQF-endorsed.)
- One new Healthcare Acquired Infection (HAI) measures:
  - Central Line Associated Blood Stream Infection (NQF #0139)  
(This measure is NQF-endorsed.)

Collection of these new measures will begin with January 1, 2011 discharges.

CMS is *not* adopting its proposal to add four registry based measures to the RHQDAPU program. However, the Electronic Health Record Incentive Program final rule published in the July 28, 2010 *Federal Register*, includes; emergency department, stroke and venous thrombolysis electronic measures as part of the Clinical Quality Measures required for electronic reporting for meaningful use of EHR.

### **Synchronization of RHQDAPU Program Data Submission and Validation Quarters with Quarters Used To Make Payment Determinations**

**CMS’ Proposal:** *“Starting with the FY 2013 payment determination, we proposed to determine whether the hospital meets the data submission requirement for quality measure data by looking at whether the hospital properly submitted data on the applicable measures during the same quarterly discharge periods. Specifically, the quarterly discharge periods that will apply to a particular payment determination will be the four quarters that occur within a calendar year. In other words, beginning with the FY 2013 payment determination, we will look at whether the hospital properly submitted data for HCAHPS, CDC NHSN, chart-abstracted measures, and structural measure quality measure data during the four calendar year quarters of FY 2011. With respect to our requirement that hospital data be successfully validated in order for the hospital to earn the full payment update for a given fiscal year, we also proposed, beginning with the FY 2013 payment determination, to validate four discharge quarters, but the quarters will be the 4th calendar quarter of the year that occurs 2 years before the payment determination and the first 3 calendar quarters of the following calendar year. Thus, for the FY 2013 payment determination, we will validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011. We believe this is appropriate given the time required for the validation abstraction and appeal process.”*

**CMS’ Final Rule:** CMS is adopting its proposal as final without modification. CMS will post a table outlining the discharge quarters that will be used to make each fiscal year payment determination no later than September 15th annually on the QualityNet Web site (<http://www.QualityNet.org>).

### **Chart Validation**

**CMS' Proposal:** For FFY 2013, CMS proposed to adopt the same validation selection requirements that it adopted for the FFY 2012 payment determination with the following modifications:

- “. . . validate the data submitted by a hospital if the hospital failed the previous year’s RHQDAPU program validation;
- “. . . discontinue the 100 case minimum threshold for selection in the RHQDAPU 800 hospital random sample;
- “. . . modify the quarterly stratified sample selection by reallocating sample cases when a hospital has submitted fewer than three cases in a topic within a quarter;
- “. . . validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011 in accordance with our proposed synchronization of RHQDAPU data . . . .”

**CMS' Final Rule:** CMS is adopting its proposal as final without modification.

## **FFY 2014 RHQDAPU Program**

### **Required Measures**

**CMS' Proposal:** CMS proposed “... to retain all of the measures adopted for the FFY 2013 payment determination for the FFY 2014 payment determination. Collection of data for these measures would begin with January 1, 2012 discharges.” In addition, for FFY 2014 CMS proposed to add four new chart-abstracted measures.

**CMS' Final Rule:** For FFY 2014 payment determination, CMS is retiring two FFY 2013 measures:

- PN-2: Pneumococcal vaccinations status; and
- PN-7: Influenza vaccination status.

These measures will be replaced with two global immunization measures:

- Global Flu Immunization; and
- Global Pneumonia Immunization.

CMS will retain all other FFY 2013 measures. In addition, they are adopting two emergency department (ED) throughput measures:

- ED Throughput – Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497);
- ED Throughput - Median time from emergency department arrival to ED departure for admitted patients (NQF #0495);

CMS is also adopting an HAI measure for the FFY 2014 payment determination that was originally proposed for FFY 2013:

- Surgical Site Infection (NQF #0299)

### **Chart Validation**

**CMS' Proposal:** For FFY 2014 payment determinations, CMS is “considering adding two strata to the current RHQDAPU program validation sample of SCIP, AMI, HF, and PN cases. We are considering selecting 2 additional validation samples of 3 cases per selected hospital per quarter.”

CMS also considered “requiring hospitals to sign a written form explicitly granting CMS access to their patient level data submitted for the proposed Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure.”

**CMS' Final Rule:** CMS did *not* finalize its proposal on chart validation.

## VI. HOSPITAL-ACQUIRED CONDITIONS

*Federal Register* pages 50080 - 50101

**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 its FFY 2008 final 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 DRG assignment if the condition was not present on admission (POA). 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 two additional categories that would be subject to the HAC payment provision.

Currently, there are five POA indicator reporting options that hospitals should use as indicated below:

Indicator	Descriptor
Y	Indicates that the condition was present on admission.
W	Affirms that the hospital has determined that, based on data and clinical judgement, it is not possible to document when the onset of the condition occurred.
N	Indicates that the condition was not present on admission.
U	Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
1	Signifies exemption from POA reporting.

For more details on the POA indicators, visit the CMS Web site at:  
[http://www.cms.hhs.gov/HospitalAcqCond/Downloads/poa\\_fact\\_sheet.pdf](http://www.cms.hhs.gov/HospitalAcqCond/Downloads/poa_fact_sheet.pdf).

### HAC Categories

**CMS' Proposal:** For FFY 2011, CMS did not propose any changes to its current list of HACs. CMS did propose the “*adoption of the five ICD-9-CM diagnosis codes as CCs that . . . if finalized, would be added to the current HAC Blood Incompatibility category.*”

**CMS' Final Rule:** CMS is adopting, as final, its proposal “*...to make code 999.6 an invalid code and to add codes 999.60, 999.61, 999.62, 999.63, and 999.69 as CCs to the HAC blood incompatibility category...*”

### Hospital Acquired Conditions for FFY 2011

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

#### **POA Reporting**

**CMS' Proposal:** CMS proposed to replace the current 4010 format used for POA reporting with the 5010 format, beginning January 1, 2011. *“The 5010 format removes the need to report a POA indicator of ‘1’ for codes that are exempt from POA reporting. The POA indicator of ‘1’ is being used because of reporting restrictions from the use of the 4010 format. Therefore, hospitals that begin reporting with the 5010 format on and after January 1, 2011, will no longer report a POA indicator of ‘1’ for POA exempt codes. The POA field will instead be left blank for codes exempt from POA reporting. We are planning to issue CMS instructions on this reporting change.”*

**CMS' Final Rule:** For FFY 2011, CMS is adopting their proposal as final with no modification.

#### **RTI Evaluation**

**CMS' Proposal:** CMS believes that *“the RTI analysis . . . does not provide additional information that would require us to change our previous determinations regarding either current HACs . . . or previously considered candidate HACs in the FFY 2008 IPPS final rule . . . and FFY 2009 IPPS final rule. . . . Accordingly, we are not proposing to add or remove categories of HACs at this time. . . .”*

**CMS' Final Rule:** CMS is adopting their proposal as final with no modification.

## **VII. WAGE INDEX**

### **Occupational Mix Adjustment**

*Federal Register* pages 50162 - 50164

**Background:** CMS was required to include an occupational mix adjustment in its calculation of the wage index beginning in FFY 2005. The occupational mix adjustment 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. CMS issued a revised *2007-2008 Medicare Occupational Mix Survey* that required hospitals to collect wage and hours data for a one year prospective reporting period from July 1, 2007 through June 30, 2008. Currently, hospitals that do not submit occupational mix data are not penalized and are assigned the hospital average occupational mix adjustment for the labor market area or the national occupational mix adjustment of 1.0.

**CMS' Final Rule:** For the FFY 2011 occupational mix adjustment, CMS will continue to use the occupational mix data collected on the revised 2007-2008 Medicare Occupational Mix Survey. *“The FY 2011 occupational mix adjusted national average hourly wage is \$34.9664.”*

### **New 2010 Occupational Mix Survey**

**CMS' Final Rule:** For FFY 2013, a revised survey tool has been developed to collect new occupational mix data. *“The new 2010 survey . . . will provide for the collection of hospital-specific wages and hours data for calendar year 2010 (that is, payroll periods ending between January 1, 2010 and December 31, 2010) and will be applied beginning with the FFY 2013 wage index.”*

The new survey, approved by OMB on February 26, 2010, is available on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage>. Hospitals are required to submit the 2010 survey to their fiscal intermediaries by July 1, 2011.

In addition, beginning with the new 2010 occupational mix survey, CMS *“will require hospitals that do not submit occupational mix data to provide an explanation for not complying with the submission requirements. We will instruct fiscal intermediaries/MACs to gather this information as part of the FFY 2013 wage index desk review process.”*

## **Rural Floor Budget Neutrality**

*Federal Register* page 50160

**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 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 achieved by adjusting the national standardized amounts. In FFY 2009, CMS adopted a provision to apply a separate state-specific rural floor budget neutrality adjustment to the wage index rather than to the standardized amount. CMS provided a three-year phase-in period for this policy, beginning in FFY 2009.

**CMS' Final Rule:** For FFY 2011, CMS is required by the ACA, to restore the budget neutrality adjustment for the rural floor and imputed rural floor to a uniform, national adjustment to the wage index, rather than a state-specific. To implement this requirement, CMS applied a budget neutrality adjustment of 0.996641 to all wage indexes.

## **Imputed Rural Floor Adjustment**

*Federal Register* page 50160

**Background:** Currently, there are two states that have no rural areas and one state that has no IPPS hospitals located in rural areas. In FFY 2005, CMS adopted an “imputed floor” measure for three years 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 2009, CMS extended the use of an imputed floor for three additional years, through FFY 2011.

In addition, beginning in FFY 2009, CMS applied 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' Final Rule:** For FFY 2011, CMS is required by the ACA, to restore the budget neutrality adjustment for the rural floor and imputed rural floor to a uniform, national adjustment to the wage index, rather than a state-specific. To implement this requirement, CMS applied a budget neutrality adjustment of 0.996641 to all wage indexes. The ACA does not extend the imputed rural floor adjustment beyond September 30, 2011.

## **Wage Index Floor for Frontier States**

*Federal Register* pages 50160 - 50161

**Background:** CMS is required by the ACA, to establish a wage index floor of 1.00 for all hospitals located in "frontier States." A frontier State is defined as any State where at least half of its counties have a population density of less than 6 persons per square mile. Based on this definition, CMS has determined that Montana, Nevada, North Dakota, South Dakota, and Wyoming qualify as Frontier States. Because the Frontier Floor is not subject to budget neutrality, CMS interprets the law such that the wage index floor is compared to the final wage index value, after reclassifications, adjustments, and budget neutrality. Only hospitals that are geographically located in a Frontier State qualify for the floor, hospitals that reclassify into these states are ineligible.

**CMS' Final Rule:** For FFY 2011, CMS is implementing the Frontier State floor adjustment using the criteria described above.

## **Multi-Campus Hospitals**

*Federal Register* page 50168

**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 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.

Beginning in FFY 2008, CMS allowed hospitals to use 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' Final Rule:** For FFY 2011, CMS will continue allowing "*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.*"

Beginning in FFY 2012, CMS will be able to obtain this information from the Medicare cost report, which was updated to allow for the reporting of FTE data by campus for multi-campus hospitals.

## **MGCRB Reclassifications**

*Federal Register* pages 50171 - 50173

**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 legislative 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 the reclassification system. In FFY 2009, CMS adopted changes to the average hourly wage (AHW) comparison criterion for hospitals over a two-year period, beginning with reclassifications for FFY 2010.

**CMS' Final Rule:** As required by the ACA, CMS will restore, for FFY 2011, the less restrictive, FFY 2008 Medicare hospital wage index reclassification thresholds used to compare hospitals' AHWs for the purpose of determining wage index reclassifications. A hospital has to demonstrate that its AHW is:

- at least 84% (for urban hospitals), or 85% (for group reclassifications), or 82% (for rural hospitals) of the AHW of hospitals in the area to which it seeks redesignation.

Hospitals must apply for a reclassification 13 months before the start of a new fiscal year; therefore, applications for a FFY 2011 reclassification were due by September 1, 2009. The law did not change the statutory deadline for the FFY 2011 application for reclassification. Therefore, CMS did not allow hospitals to file new reclassification applications for FFY 2011. CMS did review the applications that were filed before the September 1, 2009 deadline, and concluded that an additional 22 hospitals would qualify for a reclassification for FFY 2011 based on the new thresholds.

**Reclassification Withdrawal:** Hospitals that had been approved for FFY 2011 MGCRB reclassifications are permitted to withdraw their applications within 45 days of the publication of the proposed rule.

Applications for FFY 2012 reclassifications are due to MGCRB by September 1, 2010. 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](http://www.cms.hhs.gov/MGCRB/02_instructions_and_applications.asp#TopOfPage).

## **Out-Migration Adjustment**

*Federal Register* pages 50176 - 50177

**Background:** Section 505 of the MMA required CMS to develop an 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. Once the three year period ends for a qualifying county, it may or may not re-qualify for a new adjustment. CMS designates new qualifying counties each year.

Prior to FFY 2008, CMS used the pre-reclassified wage index to calculate the out-migration adjustment. In

subsequent years CMS calculates the out-migration adjustment using the post-reclassified wage indexes. Adjustments under this provision are not subject to budget neutrality.

**CMS' Proposal:** For FFY 2011, CMS proposed 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.*”

**CMS' Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification.

## **Section 508 Reclassifications**

*Federal Register* page 50176

**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. Several subsequent pieces of legislation have extended the sunset date for Section 508 reclassifications. Most recently, the ACA of 2010 extended Section 508 reclassifications to September 30, 2010.

**CMS' Final Rule:** For FFY 2011, the Section 508 wage index reclassifications will sunset. CMS does not have the authority to extend Section 508 wage index reclassifications without legislation.

## **“Lugar” Reclassifications**

*Federal Register* page 50176

**Background:** Current law requires that, for wage index purposes, 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. Because they are located in rural areas, Lugar hospitals 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.

## **Wage Index Study**

*Federal Register* pages 50157 - 50159

**Background:** The Medicare Improvements and Extension Act—Tax Relief and Health Care Act (MIEA-TRHCA) required MedPAC to submit a report to Congress by June 30, 2007 on the Medicare IPPS wage index system. Within that report, MedPAC was to include any recommended alternatives to the wage index methodology that could be included in future rulemaking. MedPAC’s June 2007 *Report to Congress* is available at [http://www.medpac.gov/documents/Jun07\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun07_EntireReport.pdf).

In its report, MedPAC recommended that Congress should repeal the existing hospital wage index statute

including reclassifications and exceptions, and give the HHS Secretary authority to establish a new wage index system. The Commission further recommended that wage indexes be based on wage data from BLS and the Census Bureau rather than solely on wage data reported by hospitals. Other recommendations were offered to minimize variation in the wage index across county borders and distinguish between the effects of skill mix differences and wage differences.

The Secretary, taking into account MedPAC's recommendations, was required by the MIEA-TRHCA to include in the FFY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment. The Secretary was required to consider each of the following:

- problems associated with the definition of labor markets for the wage index adjustment;
- the modification or elimination of geographic reclassifications and other adjustments;
- the use of 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.

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's Final Reports (Part 1 and Part 2) are available at <http://www.acumenllc.com/reports/cms>. CMS notes that Acumen in its first report concluded *"that MedPAC's recommended methods for revising the wage index represented an improvement over the existing methods, and that the BLS data should be used so that the MedPAC approach can be implemented."*

Further, CMS points out that Acumen's second report *"suggested that MedPAC's method does not guarantee an accurate representation of a hospital labor market and would not necessarily eliminate or reduce hospitals' desire to reclassify for a higher wage index. Acumen recommended further exploration of labor market area definitions using a wage area framework based on hospital-specific characteristics, such as commuting times from hospitals to population centers, to construct a more accurate hospital wage index. Acumen suggested that such an approach offers the greatest potential for replacing or greatly reducing the need for hospital reclassifications and exceptions."*

***Health Care Reform Update: The ACA mandates that the Secretary recommend comprehensive reform of the Medicare wage index system to Congress by December 31, 2011. The plan is required to take into account the 2007 MedPAC wage index report, including the proposed use of BLS data and the recommended redefinition of wage areas.***

## VIII. MEDICARE DSH CALCULATION

*Federal Register* pages 50275 - 50286

Hospitals that serve a disproportionate number of low-income patients can be eligible for additional Medicare payments, if they qualify as a Disproportionate Share Hospital (DSH). There are two methods by which hospitals can qualify. To qualify, a 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 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 ratio is the percentage of total inpatient days attributable to patients eligible for both Medicare Part A (including Medicare Advantage (MA) and Supplemental Security Income (SSI) divided by total Medicare Part A (including MA) days. The second ratio is the percentage of 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.

CMS calculates the SSI percentage for each acute care hospital paid under IPPS. The data used to derive this percentage come from the Medicare Provider Analysis and Review (MedPAR) data file and SSI eligibility records. CMS matches the MedPAR data and SSI records using Health Insurance Claims Account Numbers (HICAN) (included in the MedPAR file) and Title II numbers (included in the SSI records) to produce the number of Medicare SSI days. This process has come under scrutiny as it only uses one HICAN and one Title II number to create a match and derive Medicare SSI days. A beneficiary may receive SSI and Medicare Part A benefits under more than one Title II number and HICAN over a period of time. The current match process also does not account for retroactive eligibility determinations and payment suspensions.

Currently, the CMS data match uses MedPAR files that were updated six months after the end of the FFY; however, this timeframe may not capture all of a provider's Medicare inpatient claims. Providers have no incentive to wait until the end of an FFY to submit a fee-for-service claim but do have an incentive to submit a claim closer to a patient's discharge date. This is not true for MA claims because they are paid by the MA plans.

CMS does require that "*all IPPS hospitals that do not qualify for IME payments, direct GME payments, or nursing and allied health payments are required to submit informational-only claims for all MA inpatients . . . included in the SSI fraction.*"

### Data Matching

**CMS' Proposal:** For FFY 2011, CMS proposed a new data match approach for determining SSI eligibility. In *Baystate Medical Center v. Leavitt*, the district court concluded that CMS' current matching process did not use the "best available data" to match Medicare patient day information with SSI eligibility data. In implementing the *Baystate* decision, CMS recalculated the plaintiff's SSI fractions and DSH payments using a revised data matching process that comports with the district court's decision. CMS proposed to adopt the same revised data matching process for calculating hospitals' DSH SSI fractions for FFY 2011 and subsequent fiscal years. In doing so, CMS proposed to use the following three databases to accumulate the data in the revised match process:

- 1) the SSI eligibility data file which includes up to ten different Title II numbers associated with a unique social security number (SSN);

- 2) the Medicare Enrollment Database (EDB) which contains the records of all individuals who have ever been enrolled in Medicare, an SSN for each record, and the HICAN associated with the record; and
- 3) the MedPAR file, which contains a HICAN for each inpatient claim.

Furthermore, CMS proposed to utilize a four-step process using the “*three databases in a revised match process for FFY 2011 and subsequent fiscal years:*”

- “**Step 1** -- Use SSNs to find any and all relevant HICANs. Using the SSI eligibility data file provided by SSA, we are proposing to compare the individual SSNs in that file to the SSNs contained in the Medicare EDB. Each matched SSN would then be “crosswalked” (within the EDB) to find any and all HICANs associated with the individual’s SSN. The resulting HICANs would then be matched against those HICANs contained in the MedPAR claims data file. . . .
- “**Step 2** -- In order to provide further assurance that all of the Title II numbers and HICANs for SSI-eligible individuals have been identified, next we are proposing to compare the complete list of Title II numbers from the SSI data file (up to 10 Title II numbers for any one individual) to the list of HICANs generated through Step 1 above. If the SSI data file includes any Title II numbers that were not already identified in Step 1, the Title II number will be included in our revised match process and compared to any and all HICANs in MedPAR. . . .
- “**Step 3** -- This third step should ensure consistency between the HICANs from Step 1 and the Title II numbers from Step 2 by “equating” (or converting) the BIC identifiers to the identifiers that are on the inpatient claim that is included in the MedPAR file. In addition, we are proposing that, for any SSI-eligible beneficiary who is receiving Medicare benefits based on his or her own account but whose records have not been matched already, we will attempt to match the beneficiary’s HICAN in the MedPAR file. . . .
- “**Step 4** -- Calculate the SSI fraction. We are not proposing any changes with respect to the final step in determining the SSI fraction.”

**CMS’ Final Rule:** For FY 2011 and beyond, CMS is adopting their proposal as final with some modification. “*The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay.*”

### **Timing of the Data Match**

**CMS’ Proposal:** For FFY 2011, CMS proposed to use “*SSI eligibility data files compiled by SSA and MedPAR claims information that are updated 15 months after the close of each Federal fiscal year. This proposal would more closely align the timing of the match process with the timing of our requirements . . . for the timely submission of claims.*”

CMS also considered changes to “*the timing of data match process to ensure . . . a hospital’s MA claims are included in the revised matching process. . . .*”

“*The proposed timing of the data match for the SSI fractions, effective for FFY 2011, would result in FFY 2011 SSI fractions being published around March 2013 and would generally coincide with the final settlement of cost reports for cost reporting periods beginning in FFY 2011.*”

**CMS’ Final Rule:** For FFY 2011, CMS is “*. . . finalizing our proposal to conduct the data matching process and calculate SSI fractions approximately 15 months after the end of the Federal fiscal year to ensure we have*

*captured all of the inpatient claims and to capture as many retroactive SSI entitlement determinations as possible.”*

## **IX. COST OUTLIERS**

*Federal Register* pages 50426 - 50431

**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’ Final Rule:** For FFY 2011, CMS will provide a “...*final 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 \$23,075.*” This will result in a decrease from the FFY 2010 outlier fixed-loss threshold of \$23,140 in order to maintain outlier payments at 5.1 percent of total payments under the IPPS in FFY 2011.

## **X. GRADUATE MEDICAL EDUCATION**

### **Direct Medical Education**

Direct Medical Education (DME) payments 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.

### **Residents in an Approved Residency Program**

*Federal Register* pages 50287 - 50290

**Background:** Hospitals can only receive a Direct Graduate Medical Education (DGME) or Indirect Medical Education (IME) payment if the residents are in an “approved medical residency training program.” The law defines an approved medical residency training program as “*a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.*”

An “approved medical residency program” must meet one of the following criteria:

- *“Is approved by one of the national organizations listed in §415.152. . . .;*
- *“May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:*
  - *“The Directory of Graduate Medical Education Programs published by the American Medical Association; or*

- *“The Annual Report and Reference Handbook published by the American Board of Medical Specialties.*
- *“Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine; or*
- *“Is a program that would be accredited except for the accrediting agency’s reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.”*

CMS states that a resident means *“an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board . . . . an approved program is one that is accredited by one of the listed national organizations, or one that may count towards board certification.”*

**CMS’ Proposal:** For FFY 2011, CMS proposed a clarification to the existing GME policy, stating that individual practitioners should bill for payment as physicians under the Physician Fee Schedule if they have already successfully completed at least one residency program in which they meet the requirements to be board eligible and continue their training, but are not in an approved medical residency training program. CMS also clarified that such an individual’s time should not be included in the FTE count for IME and DGME purposes. CMS proposed to revise the definition of ‘resident’ and ‘primary care resident’ to include that an individual must be “formally accepted, enrolled, and participating in an approved medical residency program to become certified by the appropriate specialty board.”

**CMS’ Final Rule:** For FFY 2011, CMS is adopting their proposal as final with some modification. *“Specifically, we are clarifying that individuals participating in a specialized course of training created by a senior physician, and not under the auspices of a national accrediting body, and for which there is no explicit existing board certification examination, may NOT be counted for IME and direct GME payment purposes. Such individuals should be treated as physicians (assuming full licensure) and their services billed to Medicare for payment as physicians’ services.”*

*“If an individual has already successfully completed at least one residency program and has met the generally applicable requirements to be board eligible in a specialty (regardless of whether the individual has passed the board examination for that specialty), and is engaged in subsequent training that will not provide additional knowledge or skills that could be applied for board certification in another different subspecialty, the individual will be treated and bill for services provided as a physician (assuming full licensure).”*

CMS has adopted their proposal to revise the definition of:

- *“...“resident” to mean “an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.”*
- *“...“primary care resident” to mean “a resident who is formally accepted, enrolled, and participating in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.”*

*“These changes in the definitions of “resident” and “primary care resident” are effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010.”*

*“With regard to chief residencies, effective for cost reporting periods beginning on or after October 1, 2010, we are changing our policy to provide that individuals that act as chief residents after they have completed the accredited program and have satisfied minimum requirements for board certification are not considered residents for IME and direct GME payment purposes.”*

Furthermore, “...individuals training in a program that extends beyond the actual accredited program length are not considered residents for IME and direct GME purposes because they are no longer training in an accredited program according to the ACGME.”

## **Medicare GME Affiliation Groups**

*Federal Register* pages 50298 - 50299

**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 hard copy of their Medicare GME affiliation agreement to CMS’ 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. Currently, CMS does not accept facsimile and other electronic submissions of the Medicare GME affiliation agreements.

**CMS’ Proposal:** For FFY 2011, CMS proposed “an electronic submission process that would consist of either an e-mail mailbox or a Web site where hospitals would submit their Medicare GME affiliation agreements to the CMS Central Office. As part of this process, a copy of the Medicare GME affiliation agreement would need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are proposing that the electronic affiliation agreement would need to be submitted either as a scanned copy or a Printer-Friendly Display (PDF) version of that hard copy agreement.”

**CMS’ Final Rule:** For FFY 2011, CMS is adopting their proposal as final with no modification. CMS is “... currently in the process of developing the electronic submission system for Medicare GME affiliation agreements. If a system is developed that is ready to receive affiliation agreements for the academic year beginning July 1, 2011, we will notify teaching hospitals by May 2011 of the electronic submission process in order to allow ample time for the preparation and electronic submission of affiliation agreements before the July 1, 2011 deadline.”

In the meantime, CMS “...will continue to accept hard copies of affiliation agreements even if the electronic submission system is in operation for the academic year beginning July 1, 2011.”

## **Indirect Medical Education Adjustment**

*Federal Register* pages 50275

**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. For FFY 2011, CMS will maintain the formula multiplier at 1.35, which equates to a 5.5% adjustment.

## **XI. ADDITIONAL PAYMENTS FOR NEW TECHNOLOGY**

*Federal Register* pages 50137 - 50157

**Background:** Current law provides additional payments for new medical services and technologies that meet specified criteria. The medical service or technology must (1) be new, (2) be costly in a DRG that is considered to be insufficient, and (3) demonstrate a substantial clinical advance over current practices. An approved new technology is eligible for additional payments until Medicare data becomes available for the cost to be fully recognized in the MS-DRG weights, which usually occurs between two and three years. CMS has consistently eliminated the new technology payments after two years.

These additional payments are based on the cost to hospitals for the new service or technology. If the cost per discharge exceeds the full DRG payment, the hospital will receive an add-on payment. This payment will equal either 50% of the estimated costs of the new technology or 50% of the difference between the full DRG payment and the estimated cost of the discharge, whichever is lower. The payment must be less than the full MS-DRG payment plus 50% of the estimated costs of the new technology unless the discharge receives an outlier payment.

**CMS' Proposal:** For FFY 2011, CMS proposed to “*continue new technology add-on payments for cases involving TAH-t . . . with a maximum add-on payment of \$53,000.*”

In addition, CMS considered three applications for new technology add-on payments in FFY 2011:

- the AutoLITT™ System;
- the LipiScan™ Coronary Imaging System; and
- the LipiScan™ Coronary Imaging System with Intravascular Ultrasound.

**CMS' Final Rule:** For FFY 2011, CMS will “*continue new technology add-on payments for cases involving TAH-t . . . with a maximum add-on payment of \$53,000.*”

In addition, for FFY 2011 “*...after consideration of the clinical evidence received, we are approving the AutoLITT™ for a new technology add-on payment*” of \$5,300. “*Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with a procedure code of 17.61 in combination with a primary diagnosis codes that begins with a prefix of 191.*”

## **XII. RURAL ISSUES**

### **Rural Referral Centers (RRCs)**

*Federal Register* pages 50236 - 50238

**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 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:

- Have 275 or more beds available for use; or
- 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’ Final Rule:** For FFY 2011, *“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, 2010, they must have a CMI value for FFY 2009 that is at least:*

- *“1.5136; 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:

<b>Region</b>	<b>Case-Mix Index Value</b>
New England (CT, ME, MA, NH, RI, VT)	1.2993
Middle Atlantic (PA, NJ, NY)	1.3582
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4567
East North Central (IL, IN, MI, OH, WI)	1.4251
East South Central (AL, KY, MS, TN)	1.3771
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4407
West South Central (AR, LA, OK, TX)	1.5240
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6204
Pacific (AK, CA, HI, OR, WA)	1.4861

In addition, for FFY 2011, *“a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, must have, as the number of discharges for its cost reporting period that began during FFY 2008, 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 final median numbers of discharges for urban hospitals by census region are as follows:

<b>Region</b>	<b>Discharges</b>
New England (CT, ME, MA, NH, RI, VT)	7,713
Middle Atlantic (PA, NJ, NY)	11,346
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	11,393
East North Central (IL, IN, MI, OH, WI)	9,232
East South Central (AL, KY, MS, TN)	7,016
West North Central (IA, KS, MN, MO, NE, ND, SD)	8,159
West South Central (AR, LA, OK, TX)	7,081
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,282
Pacific (AK, CA, HI, OR, WA)	8,622

## **Change to Criteria for Medicare Dependent Hospitals**

*Federal Register* page 50286 - 50287

**Background:** An MDH is a hospital located in a rural area that is not considered a sole community hospital (SCH) and has no more than 100 beds with at least 60% of its inpatient days or discharges are attributable to individuals receiving Medicare Part A benefits. Currently, Medicare beneficiaries who have exhausted their Medicare Part A inpatient benefits are not included in the calculation of the Medicare inpatients.

Unlike other rural provider types, the MDH program is set by law, therefore requires legislation to continue its existence. The MDH program was due to sunset on September 30, 2011.

**CMS' Proposal:** For FFY 2011, CMS is proposing *“to revise the Medicare-dependency criterion . . . to replace the term ‘receiving’ with the phrase ‘entitled to.’ As a result, we would include in the count of Medicare inpatient days or discharges all days or discharges attributable to individuals entitled to the Medicare Part A insurance benefit, including individuals who have exhausted their Medicare Part A inpatient hospital coverage benefit, as well as individuals enrolled in Medicare Advantage plans. . . .”*

**CMS' Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification. *“... the final policy change will be effective beginning October 1, 2010, at which time all Medicare days or discharges of patients entitled to Medicare Part A will be counted as Medicare days or discharges, affecting the determination of MDH status for hospitals from October 1, 2010 forward.”*

In addition, as mandated by the ACA, CMS is required to extend the MDH program on additional year through September 30, 2012.

## **Certified Registered Nurse Anesthetist (CRNA) Services**

*Federal Register* pages 50299 - 50303

**Background:** DRA provided that a hospital or CAH that provides anesthesia services and related care by qualified hospital-based non-physician anesthetists, including CRNAs can receive pass-through payments on a reasonable cost basis. To qualify for reasonable cost-based payment for anesthesia and related services provided by qualified non-physician anesthetists, a rural hospital or CAH cannot exceed an annual limit of 800 surgical procedures requiring anesthesia. Currently, hospitals or CAHs that have been reclassified from urban to rural or are located in a Lugar county are not eligible to receive pass-through payments for anesthesia services and related care.

**CMS' Proposal:** Effective for cost reporting periods beginning on or after October 1, 2010, CMS proposed that CAHs and hospitals that have reclassified from urban to rural *“are eligible to be paid based on reasonable cost for anesthesia services and related care furnished by a qualified non-physician anesthetist.”* However, *“we are not proposing to change our regulations to permit Lugar facilities to be paid based on reasonable cost for anesthesia services and related care furnished by qualified non-physician anesthetists.”*

**CMS' Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification.

## **XIII. CRITICAL ACCESS HOSPITALS**

### **CAH Optional Payment Method**

**Background:** Under the optional payment method, CAHs may elect to bill the Medicare fiscal intermediary or MAC for both facility services and professional services to its outpatients. In doing so, the physician or other practitioner must reassign his or her billing rights to the CAH for the CAH to bill for the Medicare services.

Before FFY 2010, payment under this optional method was:

- for facility services, the lesser of 80% or 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.

In the final FFY 2010 IPPS rule, CMS adopted a change to how CAHs were paid under the optional method, reducing reimbursement from 101% to 100% of reasonable costs for cost reporting periods beginning on or after October 1, 2009. CMS stated that the MMA legislative language establishing the optional method did not specify payment at 101% of cost.

Current regulations require a CAH being paid under the optional method to submit an election to their fiscal intermediary no less than 30 days before the start of the cost reporting period for which they wish to receive the optional method. This must be done on an annual basis.

### **30 Day Deadline**

**CMS' Proposal:** To prevent CAHs that miss the 30-day deadline from losing the optional method, CMS proposed "... *to amend the regulations . . . to state that, effective for CAH cost reporting periods beginning on or after October 1, 2010, if a CAH has elected the optional method for its most recent cost reporting period beginning prior to October 1, 2010 or chooses to elect the optional method for its upcoming cost reporting period, that election will remain in place until it is terminated.*" To terminate payment of the optional method, CAHs will have to submit a termination request to the fiscal intermediary or MAC at least 30-days prior to the start of the next cost reporting period.

CAHs that are paid under the standard method and wish to change to the optional method will need to submit an election in writing at least 30 days prior to the cost reporting period for which the election is effective.

**CMS' Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification.

### **Optional Method Payment**

**CMS' Proposal:** Per the ACA, CMS is required to reimburse CAHs that elect the optional method of payment for outpatient services at 101% of reasonable costs for facility services, not 100% as interpreted by CMS in the 2010 inpatient rule.

In addition, CMS must reimburse for ambulance services furnished by a CAH at 101% of reasonable costs if the CAH is the only provider or supplier of ambulance services within a 35-mile radius of such a CAH.

CMS proposed that both of the above changes be effective for cost reporting periods beginning on or after January 1, 2004. CMS notes "... *that we do not believe these proposals will result in additional payments to CAHs for prior periods because we believe in fact that CMS has paid CAHs for these services at 101 percent of reasonable costs during these prior periods.*"

**CMS' Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification.

## **Provider Taxes as Allowable Costs for CAHs**

*Federal Register* pages 50362 - 50364

**Background:** Medicare permits certain taxes assessed on a provider to be allowable costs. To be considered allowable costs, these taxes must be related to the care of Medicare patients and must be incurred by the provider. To help providers determine which taxes are allowable costs, CMS has issued instructions in the Provider Reimbursement Manual (PRM). Recently, CMS has become aware that there is still some uncertainty among providers about how to determine if a tax is an allowable cost.

The PRM (Section 2122), which lists the unallowable taxes was last updated in 1979 and does not reflect the variety of provider taxes currently imposed by states. However, CMS is also concerned that even if a tax is directly “related to the care of Medicare beneficiaries” providers may not incur the entire amount of the tax and therefore should not include the total assessed amount as allowable.

**CMS’ Proposal:** CMS clarifies that “*Medicare contractors will determine the allowability of provider taxes on a case-by-case basis, based on reasonable cost principles, and will determine if a reduction of the allowable tax expenses is proper to account for payments providers receive that are associated with the assessed tax.*”

*“. . . this policy clarification could impact certain providers that are paid on the basis of their incurred reasonable costs, such as CAHs.”*

**CMS’ Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification.

## **XIV. OTHER ISSUES**

### **Electronic Health Records (EHRs)**

*Federal Register* page 50231 - 50233

**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. CMS continues to urge hospitals to adopt and use EHRs that are defined by the Office of the National Coordinator for Health Information Technology.

Recently finalized were the electronic specifications and interoperability standards for emergency department “throughput” measures, stroke measures, and venous thromboembolism measures. CMS plans to begin accepting data from EHRs on these measures as early as summer 2011.

The Health Information Technology for Economic and Clinical Health (HITECH) Act enacted on February 17, 2009, as part of ARRA, 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.

HITECH 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' Final Rule:** For FFY 2011, *“the provisions in this ...rule do not implicate or implement any HITECH statutory provisions. Those provisions are the subject of separate rulemaking . . .”*

## **Hospitals Excluded from IPPS**

*Federal Register* pages 50359

**Background:** Hospitals and hospital units not subject to inpatient hospital payments under IPPS are paid based on reasonable costs, subject to a rate-of-increase ceiling. Excluded hospitals or hospital units have a per discharge limit (target amount) that is based on the hospital's base year costs, and updated annually by a rate-of-increase percentage. This updated target amount was then multiplied by total Medicare discharges for that year, creating a ceiling for total inpatient operating costs.

Currently, only cancer and children's hospitals are excluded from IPPS and are subject to the rate-of-increase ceiling. In FFY 2006, CMS began using the percentage increase in IPPS operating marketbasket as the rate-of-increase percentage to update these target amounts for excluded providers.

**CMS' Proposal:** For FFY 2011, CMS proposed *“... that the rate-of-increase percentage to be applied to the target amount for cancer and children's hospitals and RNHCIs (religious nonmedical health care institution) would be the proposed FFY 2011 percentage increase in the IPPS operating market basket.”* For FFY 2011, CMS proposed a 2.4% marketbasket update.

**CMS' Final Rule:** For FFY 2011, CMS will provide a *“...percentage increase in the rate-of-increase limits for cancer and children's hospitals and RNHCIs would be the percentage increase in the FY 2011 IPPS operating market basket, the FY 2011 rate-of-increase percentage that is applied to the FY 2010 target amounts in order to calculate the final FY 2011 target amounts for cancer and children's hospitals and RNHCIs is 2.6 percent.”*

## **Payment for Acute Care Transfers**

*Federal Register* pages 50235 - 50236

**Background:** An acute care discharge occurs when a patient is either released from the hospital or dies in the hospital. Sometimes, a discharge is considered to be a transfer for payment purposes. To minimize incentive for hospitals to transfer or discharge patients early in a stay, CMS developed an IPPS transfer policy that would reimburse the transferring hospital *“based on a graduated per diem rate for each day of the stay, not to exceed the full MS-DRG payment that would have been made if the patient had been discharged without being transferred.”*

Under this policy, the hospital that receives and ultimately discharges the patient will be reimbursed the full MS-DRG payment no matter how long the patient stays at the receiving hospital.

Currently, the acute care transfer policy applies if:

- the transferred patient is readmitted, for an issue related to the initial hospital visit, on the same day to a hospital paid under the IPPS; or
- the receiving hospital is excluded from IPPS payments due to participation in a statewide cost control program.

CMS states, “*The acute care transfer policy also does not currently apply to IPPS acute care hospital transfers to CAHs.*”

**CMS’ Proposal:** For FFY 2011, CMS proposed to change their acute care transfer policy to “*specify that an acute care hospital “transfer case” includes a transfer to an acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program, and . . . that an acute care hospital “transfer” also includes a transfer to a CAH.*”

**CMS’ Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification.

## **Medicare Conditions of Participation (COPs)**

*Federal Register* pages 50405 - 50407

**Background:** Currently, federal standards allow hospital rehabilitation services to be ordered by any practitioner who has authority by the medical staff to order the service. Many states have their own regulations which limit the type of practitioners who can order rehabilitation services to physicians, nurse practitioners (NPs), and physician assistants (PAs).

The current standards for ordering hospital respiratory services are more stringent. Doctors are allowed to designate the task of ordering these services to NPs and PAs, but must still co-sign all orders given.

**CMS’ Proposal:** For FFY 2011, CMS proposed to “*clarify the types of practitioners who are allowed to order rehabilitation services.*” Specifically, CMS proposed “*. . . to limit those types of individuals to qualified, licensed practitioners who are responsible for the care of the patient and who are acting within the scope of practice under State law. We also are proposing that these practitioners would need to be authorized to order rehabilitation services by the hospital’s medical staff, in accordance with both hospital policies and procedures and State laws.*”

In addition, CMS proposed “*changes to the existing requirements for ordering of respiratory care services . . .*”

CMS proposed to allow licensed practitioners, in addition to physicians, to order respiratory care services “*as long as such privileges are authorized by the medical staff and are in accordance with both hospital policies and procedures and State laws.*”

**CMS’ Final Rule:** For FFY 2011, CMS is adopting their proposal as final without modification.

## **XV. OTHER ACA PROVISIONS**

### **Low Cost County Adjustment**

*Federal Register* pages 50303 - 50341

**Background:** Beginning in FFY 2011, the ACA legislation provides new Medicare funding of \$400 million over two years—to be allocated to hospitals located in counties within the lowest quartile of total Medicare Part A and Part B spending per enrollee nationwide adjusted for age, sex, and race. According to the legislation, the funds must be distributed to subsection (d) hospitals that are located in the counties in the lowest quartile. Subsection (d) hospitals are those hospitals that are paid under the IPPS including SCHs, and MDHs. CAHs,

inpatient psychiatric facilities, inpatient rehabilitation facilities, children's hospitals, cancer hospitals, and long-term care hospitals do not qualify.

**CMS' Proposal:** CMS proposed to distribute \$150 million in FFY 2011 and \$250 million in FFY 2012 based on the proposed methodology mentioned below.

### **Methodology for Medicare Part A and B Spending**

**CMS' Proposal:** The county cost comparison is based on total Medicare Part A and Part B spending per beneficiary. This includes hospitals, nursing homes, physicians, home care, and all other services and suppliers. CMS calculated Medicare Part A and Part B county level spending for each county in the 50 States and the District of Columbia using a method similar to the one used to establish county level fee-for-service rate for MA payments. *“Using a 5 year average of each county's actual spending (from 2002 to 2006), CMS's Office of the Actuary calculated an average geographic adjuster (AGA), which reflects the county's expenditure relative to the national expenditure.” “The AGA was then applied to the 2009 United States Per Capita Cost estimate (USPCC), which is the national average cost per Medicare beneficiary, to determine 2009 Medicare Part A and Part B spending for each county.”*

### **Age, Sex, and Race Model**

**CMS' Proposal:** CMS' proposed risk adjustment model uses 2006 data for beneficiary characteristics and 2007 data for Medicare Part A and Part B spending. CMS' proposed methodology to determine the Medicare Part A and Part B spending per enrollee by county adjusted for age, sex, and race is similar to the way that CMS calculates the risk adjustment models for Medicare Advantage (MA) rate setting. Unlike the MA risk adjustment model, the ACA requires only three risk adjustment factors; age, sex, and race and does not adjust for other factors such as patient severity or cost of living. CMS is proposing to use the Five Percent Standard Analytic Denominator file (a standard 5 percent sample from the 2007 denominator file) to estimate the three risk adjustment factors. CMS considered two methods to adjust for race in county spending using the enrollment database:

1. categorize race by White, Black, Hispanic, and Other (which includes Asian/Pacific Islander, American Indian/Alaska Native, and all others); or
2. categorize race by White, Black, and Other (which includes same as other above plus Hispanics).

CMS found minimal difference in county ranking using the two methods under consideration, and is proposing to use the White, Black, Hispanic, and Other method to develop an adjustment for Medicare spending based on race.

CMS applied the results of the age, sex, and race model to each *“...individual in the county enrolled in Medicare Part A and/or Part B, summing the resulting risk scores and dividing by the number of beneficiaries by county enrolled in Medicare Part A and/or Part B. The county level Medicare Part A and or Part B spending was adjusted by dividing the county level Medicare Part A and/or Part B spending by the county level average risk score. The resulting spending distribution was then sorted lowest to highest dollars, the 786 counties in the lowest quartile of spending (that is, lowest adjusted spending per enrollee) were determined to be eligible counties...”*

**CMS' Final Rule:** For FFY 2011, CMS has adopted their proposals as final without modification. *“...finalizing, without change, our proposed methodology to calculate our Medicare Part A and Part B county spending per enrollee, which uses 5 years' worth of Medicare spending data from 2002 to 2006 to calculate the AGA and adjusts for age, sex, and race.”*

In addition, based on comments received, CMS published “...*the final unadjusted county rates, the age-sex-race adjustments applied to the county rates, and the county rates adjusted for age-sex-race for the eligible counties that are included in this final rule on the CMS Web site at <http://www.cms.gov/AcuteInpatientPPS/IPPS2011/list.asp#TopOfPage>.*”

### **Proposed Distribution of Funds**

**CMS’ Proposal:** CMS proposed to distribute the funds to hospitals in the qualifying counties based on the ratio of the individual qualifying hospital’s FFY 2009 IPPS operating hospital payments to the sum of total FFY 2009 IPPS operating hospital payments made to all qualifying hospitals. CMS proposes to distribute funds to hospitals as annual one-time payments to be made during each of FY 2011 and FY 2012, rather than distribute at the time of cost report settlement for those applicable years. However, exact timing of the payments is not specified.

In addition, CMS also proposed “... *that qualifying hospitals report these additional payments on their Medicare hospital cost report corresponding to the appropriate cost reporting period that the hospitals receive the payments. The Medicare hospital cost report, Form 2552, has an "Other adjustment" line on Worksheet E, Part A, that can used by hospitals to report the payments received...*”

**CMS’ Final Rule:** For FFY 2011, CMS is adopting their proposals as final without modification. “*The funding will not be reconciled through the Medicare cost report because payments will be distributed through a one-time payment made in FY 2011 and a one-time payment made in FY 2012 to the qualifying hospitals by the Medicare contractor. Rather, hospitals will report the payments received under this provision for tracking purposes.*”

## **Low-Volume Hospital Adjustment**

*Federal Register pages 50238 - 50275*

**Background:** Beginning in FFY 2005, CMS provided a special payment adjustment to account for the higher costs per discharge for low-volume hospitals. A low-volume hospital was defined as a subsection (d) hospital that is located more than 25 road miles from another subsection (d) hospital and has less than 800 total discharges during the fiscal year. CMS added its analysis and interpretation such that only those qualifying low-volume hospitals with less than 200 discharges received an additional payment adjustment of 25 percent. The current statute limits the payment adjustment to no more than 25 percent “...*because the statute requires that the adjustment be empirically based to provide relief to low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges.*”

**CMS’ Proposal:** CMS is revising the provision for FFYs 2011 and 2012 such that “... *a hospital qualifies as a low volume hospital if it is “more than 15 road miles from another subsection (d) hospital and has less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year (including Medicare Advantage enrollees).*” In addition, CMS is proposing a scaled approach that would provide a 25 percent payment adjustment for hospitals with 200 or fewer Medicare discharges and scale down in increments of 100 discharges to 1.6667 percent for hospitals with 1,501 to 1,599 Medicare discharges.

For FFYs 2011 and 2012 “... *to qualify, a hospital must provide to its FI or MAC sufficient evidence to document that it meets the number of Medicare discharges and distance requirements. The FI or MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment and, if so, the add-on percentage.*”

CMS “... *will continue to pay hospitals with fewer than 200 discharges a payment adjustment amount equal to an additional 25 percent.*” In addition, CMS is “... *proposing to clarify that a hospital must continue to qualify*

*as a low-volume hospital in order to receive the payment adjustment in that year; that is, it is not based on a one-time qualification.”*

### **Methodology**

**CMS’ Final Rule:** For FFY 2011, CMS is adopting their proposal as final with some modification. Specifically, based on comments received, CMS is modifying their “continuous linear sliding scale” approach so there will be “...less fluctuation in the payment amount in situations in which the number of discharges varied slightly in both years” Therefore, “for qualifying hospitals with fewer than 1,600 Medicare discharges but more than 200 Medicare discharges, the low-volume add-on payment is calculated by subtracting from 25 percent the proportion of payments associated with the Medicare discharges in excess of 200. That proportion is calculated by multiplying the Medicare discharges in excess of 200 by a fraction that is equal to the maximum available add-on payment (25 percent) divided by a number represented by the range of Medicare discharges for which this policy applies (1,600 minus 200, or 1,400).” In other words, the add-on payment is calculated using the following formula:

- “Low volume add-on payment =  $0.25 - [(0.25/1400) * (\text{Number of Medicare discharges} - 200)] = (4/14) - (\text{Medicare discharges}/5600)$ .”

*“Low-volume hospitals with 200 or fewer Medicare discharges will receive a low-volume adjustment of an additional 25 percent for each discharge . . .”*

### **Discharge Requirements**

**CMS’ Final Rule:** For FFY 2011, CMS will determine eligible hospitals and the low-volume adjustment based on the most recent data available using Medicare discharges from the 2009 MedPAR data files (March 2010 update). For FFY 2012, CMS plans to use Medicare claims data for FFY 2010. Starting FFY 2013 the low-volume hospital payment adjustment and qualifying criteria implemented in FY 2005 will resume.

CMS is also “revising the regulations to specify ... that “Medicare discharges” means a discharge of inpatients entitled to Medicare Part A, including discharges associated with individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare and also discharges of individuals enrolled in a MA organization under Medicare Part C.”

CMS includes a listing of the hospitals eligible to receive the low-volume adjustment for FFY 2011 based on fewer than 1,600 Medicare discharges, on pages 50242-50274 of the *Federal Register*. However, this list does **NOT** reflect whether or not a hospital meets the mileage criterion that is also required.

### **Distance Requirements**

**CMS’ Final Rule:** Hospitals are only eligible to receive the low-volume adjustment if they have fewer than 1,600 Medicare discharges and are located more than 15 miles from any other IPPS hospital.

### **Documentation Requirements**

**CMS’ Final Rule:** A hospital must notify and provide documentation to its fiscal intermediary (FI) or MAC that it meets the mileage criterion. “The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals is acceptable.” For FFY 2011, hospitals requesting for low-volume status should make its request in writing to their FI or MAC by September 1, 2010. “The fiscal intermediary or MAC will refer to the hospital’s Medicare discharge data

determined by CMS ... to determine whether or not the hospital meets the discharge criterion, and the amount of the payment adjustment, once it is determined that both the mileage and discharge criteria are met.”

“For FY 2012, a hospital that qualified for the low-volume adjustment in FY 2011 may continue to receive the add-on payment, without reapplying, if it continues to meet the Medicare discharge criterion based on the latest available MedPAR data. However, the hospital must verify in writing to its fiscal intermediary or MAC that it continues to be more than 15 miles from any other IPPS hospital.”

## **XVI. LEGISLATIVE CHANGES TO THE “3-DAY PAYMENT WINDOW” (72-HOUR RULE)**

*As required by the Preservation of Access to Care Act of 2010, CMS has clarified the Medicare payment policy regarding the “3-day payment window.” CMS issued the clarification as an interim final rule with comment period. Comments on the mandated changes to the 72-hour rule are due no later than 5 p.m. EST on September 28, 2010. CMS requests that comments reference the file code CMS-1498-IFC. Details for submitting comments can be found on page 50042 of the Federal Register.*

**Background:** The Preservation of Access to Care Act of 2010 included provisions that have modified the Medicare payment policy regarding how hospitals may bill for outpatient non-diagnostic services related to an inpatient admission (other than ambulance and maintenance renal dialysis services) provided on the day of admission or during the 3-days (72 hours) prior to the admission. This policy is generally known as the “3-day payment window” or “72-hour rule.”

Prior to enactment of the new law, for non-diagnostic services provided in outpatient departments within the 3-day payment window, hospitals were allowed to bill Medicare Part B for the services in cases where there was not an exact match (for all 5 digits if applicable) between the primary ICD-9-CM diagnosis codes of the non-diagnostic services and that of the inpatient stay. Diagnostic services provided in outpatient departments within the 3-day payment window were to be billed (bundled) by a hospital with the services associated with the inpatient stay.

Prior to the legislative change, in many cases, hospitals were bundling their non-diagnostic services provided within the 3-day payment window with their claims for inpatient services. In other instances, hospitals were billing, or in some cases, rebilling Medicare Part B these non-diagnostic services. The new law requires CMS to implement modifications to Medicare payment policy related to non-diagnostic services. The law does not change how diagnostic services are treated.

Part A services provided by home health agencies, skilled nursing facilities, hospice, outpatient maintenance dialysis, and ambulance are excluded from the 3-day payment window. CAHs are also excluded from this policy. Hospital and hospital units that are excluded from the IPPS are subject to a one-day payment window.

**CMS’ Interim Final Rule:** “In accordance with section 102 of Public Law 111–192, for outpatient services furnished on or after June 25, 2010, all non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary’s inpatient admission are deemed related to the admission and, therefore, must be billed with the inpatient stay.”

“In addition, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary’s

*admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless the hospital attests to certain non-diagnostic services as unrelated to the hospital claim (that is, the preadmission services are clinically distinct or independent from the reason for the beneficiary's admission)."*

*"Outpatient non-diagnostic services provided during the applicable payment window that are unrelated to the admission, and are covered by Medicare Part B, should be separately billed to Medicare Part B."*

CMS intends to establish a process for hospitals to attest to non-diagnostic services as being unrelated to the hospital claim when a hospital submits an outpatient claim. As part of the process, hospitals would be required to maintain documentation in the beneficiary's medical record to support their claim that the outpatient non-diagnostic services are unrelated to the beneficiary's inpatient admission. Separately billed outpatient preadmission services may be subject CMS review.

In addition, legislation prohibits Medicare from reopening a claim and adjusting a claim that was not submitted prior to June 25, 2010 for the sole purpose of un-bundling services.

CMS provides the following example related to the provision that prohibits Medicare from reopening a claim.

*"For example, if a beneficiary presented with chest pain at the emergency department of a subsection (d) hospital on June 1, 2010, was retained for observation until admitted as an inpatient on June 3, 2010 (with a principal diagnosis of myocardial infarction), was released from the hospital on June 7, 2010, and the hospital billed Medicare Part A on June 10, 2010, for the beneficiary's entire stay (bundling all of the outpatient charges and procedures on the inpatient stay bill), Medicare will make no payment to the hospital for any Part A adjustment claims submitted on or after June 25, 2010, to remove unrelated outpatient non-diagnostic services, nor for any new Part B claims submitted on or after June 25, 2010, to separately bill Medicare for unrelated outpatient non-diagnostic services, that the hospital had previously included on its June 10, 2010 bill for services furnished to the beneficiary."*

## XVIII. ACRONYMS

<b>Acronyms</b>	
<b>AHRQ</b>	Agency for Healthcare Research and Quality
<b>ARRA</b>	American Recovery and Reinvestment Act of 2009
<b>BIPA</b>	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits, Improvement and Protection Act of 2000
<b>BLS</b>	Bureau of Labor Statistics
<b>CAH</b>	Critical Access Hospital
<b>CBSAs</b>	Core-based Statistical Areas
<b>CC</b>	Complication or comorbidity
<b>CIPI</b>	Capital input price index
<b>CMI</b>	Case-mix index
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CoP</b>	Condition of Participation
<b>CPI</b>	Consumer Price Index
<b>CRNA</b>	Certified Registered Nurse Anesthetist
<b>DPP</b>	Disproportionate patient percentage
<b>DRA</b>	Deficit Reduction Act of 2005
<b>DRG</b>	Diagnosis related group
<b>DSH</b>	Disproportionate share hospital
<b>EDB</b>	Enrollment Database
<b>EHR</b>	Electronic health record
<b>FFY</b>	Federal fiscal year
<b>FI</b>	Fiscal Intermediary
<b>FTE</b>	Full-time equivalent
<b>GME</b>	Graduate medical education
<b>HAI</b>	Hospital-acquired infection
<b>HACs</b>	Hospital-acquired conditions
<b>HCAHPS</b>	Hospital Consumer Assessment of Healthcare Providers and Systems
<b>HCEARA</b>	Health Care and Education Affordability Reconciliation Act
<b>HICAN</b>	Health Insurance Claims Account Number
<b>HIT</b>	Health information technology
<b>HITECH</b>	Health information technology for Economic and Clinical Health
<b>ICD-9-CM</b>	International Classification of Diseases, Ninth Revision, Clinical Modification
<b>ICD-10-CM</b>	International Classification of Diseases, Tenth Revision, Clinical Modification
<b>ICD-10-PCS</b>	International Classification of Diseases, Tenth Revision, Procedure Coding System
<b>IME</b>	Indirect medical education
<b>IPPS</b>	Inpatient prospective payment system
<b>MA</b>	Medicare Advantage
<b>MAC</b>	Medicare Administrative Contractor
<b>MCC</b>	Major complication or comorbidity
<b>MDH</b>	Medicare-dependent, small rural hospital
<b>MedPAC</b>	Medicare Payment Advisory Commission
<b>MedPAR</b>	Medicare Provider Analysis and Review
<b>MGCRB</b>	Medicare Geographic Classification Review Board
<b>MIEA-TRHCA</b>	Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006
<b>MIPPA</b>	Medicare Improvements for Patients and Providers Act of 2008
<b>MMA</b>	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
<b>MMSEA</b>	Medicare, Medicaid, and SCHIP Extension Act of 2007
<b>MS-DRG</b>	Medicare severity diagnosis-related group
<b>NQF</b>	National Quality Forum
<b>OSCAR</b>	Online System Certification and Reporting
<b>POA</b>	Present on admission
<b>PPACA</b>	Patient Protection and Affordable Care Act
<b>PRM</b>	Provider Reimbursement Manual
<b>PSI</b>	Patient Safety Indicator
<b>RHQDAPU</b>	Reporting hospital quality data for annual payment update
<b>RRC</b>	Rural Referral Center
<b>RTI</b>	Research Triangle Institute, International
<b>SCH</b>	Sole Community Hospital
<b>SSI</b>	Supplemental Security Income
<b>SSN</b>	Social Security number
<b>TEFRA</b>	Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248
<b>TMA</b>	Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007