



**WISCONSIN HOSPITAL
ASSOCIATION**

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

**Updated to Reflect Proposals by CMS to Implement
Provisions Contained in
The Affordable Care Act (ACA) of 2010**

June 2010

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Inpatient Prospective Payment System (PPS) for federal fiscal year (FFY) 2011 published by the Centers for Medicare and Medicaid Services (CMS) in the May 4, 2010 *Federal Register*. Subsequently, CMS released a supplemental proposed IPPS rule in the June 2, 2010 *Federal Register*, which contains provisions enacted under the final health care reform legislation – the Patient Protection and Affordable Care Act as modified by the Health Care and Education Affordability Reconciliation Act, known together as the Affordable Care Act (ACA) of 2010. Additional information regarding the Inpatient PPS is available on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS>.

CMS must receive comments on both proposed rules by June 18 at 5 p.m. CMS requests that comments reference the file code CMS-1498-P (May 4, 2010 *Federal Register*) or CMS-1498-P2 (June 2, 2010 *Federal Register*).

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

-OR-

Regular Mail (an original and two copies):

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1498-P (or CMS-1498-P2)
P.O. Box 8011
Baltimore, MD 21244-1850

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

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I. OVERVIEW

CMS published the proposed Medicare Inpatient Prospective Payment System (IPPS) rule for FFY 2011 in the May 4, 2010 *Federal Register*. Changes are effective October 1, 2010, unless otherwise noted.

On March 23, 2010, comprehensive federal health care reform--the Patient Protection and Affordable Care Act as modified by the Health Care and Education Affordability Reconciliation Act, known together as the Affordable Care Act (ACA) of 2010 was signed into law. Due to timing of the ACA, CMS was unable to include the ACA provisions in the proposed IPPS rule for FFY 2011, published in the May 4, 2010 *Federal Register*. CMS released a supplemental proposed IPPS rule for FFY 2011 in the June 2, 2010 *Federal Register*, which contains the ACA provisions that would affect IPPS payments in FFY 2011.

This summary is updated to include those ACA provisions by adding "CMS' Supplemental Proposed Rule Update" in the applicable areas. The ACA provisions will supersede the May 4, 2010 *Federal Register* provisions where applicable.

Provisions related to the ACA as published in the June 2, 2010 *Federal Register*:

(For more details on each of these provisions, refer to the applicable section within this document)

Marketbasket Update Factor: Effective October 1, 2010 through September 30, 2011 (FFY 2011), the marketbasket update of 2.4% will be reduced by 0.25 percentage points for inpatient hospitals.

Standardized Amounts (Operating and Capital): CMS is proposing to reduce the operating standardized amount from \$5,184.46 as published in the May 4, 2010 *Federal Register* to \$5,154.01 for FFY 2011, reflecting the marketbasket reduction of 0.25 and changes in budget neutrality. CMS is also proposing to increase the capital standardized amount from \$420.99 as published in the May 4, 2010 *Federal Register* to \$422.18 for FFY 2011, reflecting changes in budget neutrality.

Outlier Fixed-Loss Cost Threshold: CMS is proposing to increase the outlier fixed-loss cost threshold from \$23,970 as published in the May 4, 2010 *Federal Register* to \$24,165 for FFY 2011 to maintain outlier payments at 5.1% of total payments.

Rural Floor and Imputed Rural Floor Budget Neutrality: CMS is required to restore the rural floor and imputed rural floor budget neutrality adjustment to a national, rather than state-specific factor.

Medicare Wage Index Reclassification Thresholds: CMS is required to restore, for FFY 2011, the lower FFY 2008 Medicare hospital wage index reclassification thresholds used in 2008 to compare hospitals' average hourly wages (AHWs) for the purpose of determining wage index reclassifications.

"Frontier States" Medicare Wage Index Floor: Effective October 1, 2010 and thereafter for inpatient hospitals and January 1, 2011 and thereafter for outpatient hospitals and physicians, the Medicare wage index and Geographic Practice Cost Index (GPCI) is held to a floor of 1.0 in "frontier" states.

Low-Cost County Add-On: Beginning in FFY 2011, the ACA provides \$400 million over two years to IPPS hospitals (including Sole Community Hospitals and Medicare Dependent Hospitals) located in counties within the lowest quartile of total Medicare Part A and Part B spending per enrollee nationwide. CMS is proposing to distribute \$150 million in FFY 2011 and \$250 million in FFY 2012.

Critical Access Hospital (CAH) Outpatient Services: CMS is required to reimburse CAHs that elect the "optional method" of payment for outpatient services at 101% of reasonable costs for facility services. In addition, CMS must reimburse for ambulance services furnished by a CAH at 101% of reasonable costs if the CAH is the only provider of ambulance services within a 35-mile radius.

Medicare Dependent Hospitals (MDHs): CMS is required to extend the MDH program one additional year

through September 30, 2012.

Low-Volume Hospital Adjustment: CMS is required to implement a temporary change for FFY's 2011 and 2012 that would allow more hospitals to qualify for a low-volume payment adjustment. An IPPS hospital can apply for the adjustment if it is more than 15 road miles from another subsection (d) hospital and has less than 1,600 discharges for individuals entitled to, or enrolled for benefits under Part A (including Medicare Advantage) during the fiscal year.

Major Provisions of the Proposed Rule as Published in the May 4, 2010 *Federal Register*:

Coding Reduction: For FFY 2011, CMS proposes to reduce the standard amount by 2.9% to adjust for case-mix increases resulting from coding improvements. CMS states that a 5.8% reduction is required to recoup a 1.9% overpayment in FFY 2008 plus a 3.9% overpayment in FFY 2009. CMS proposes to take half of the reduction (2.9%) in FFY 2011 and half in FFY 2012.

Coding Improvement Offset for Hospital-Specific Rates: CMS proposes to reduce the FFY 2011 hospital-specific rates for Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs) by 2.9% to account for case-mix increases in 2008 and 2009 due to documentation and coding improvements.

Quality Measures: Hospitals are required to report data on 45 quality measures. These include 41 quality measures from FFY 2010 and four new measures—two new chart-abstracted measures and two new structural measures—to receive a full marketbasket update in FFY 2011.

Hospital-Acquired Conditions (HACs): CMS proposes to continue using the current ten HAC categories for FFY 2011, with one modification of adding five new International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes as complications and comorbidities to the current HAC Blood Incompatibility category.

Calculation of the Disproportionate Share Hospital (DSH) Payment Adjustment: CMS proposes to change the data matching process used to calculate the Supplemental Security Income (SSI) fraction of the Medicare DSH payment adjustment. CMS is proposing to calculate the DSH adjustment using SSI eligibility data and Medicare Provider Analysis and Review (MedPAR) claims data that are updated 15 months after the end of the federal fiscal year.

Graduate Medical Education (GME): CMS is proposing a clarification to its GME policy, stating that individuals should be billed as physicians under the Physician Fee Schedule if they have already successfully completed at least one residency program and continue their training but are not in an approved medical residency training program. In this proposed rule, CMS clarifies that such an individual's time should not be included in the full-time equivalent (FTE) count for IME and direct GME purposes.

Critical Access Hospital (CAH) Provider Taxes: CMS proposes a clarification to the provider tax policy as it relates to CAHs, which will require Medicare fiscal intermediaries to determine if the provider taxes are allowable on a case-by-case basis, based on reasonable cost principles.

CAH Optional Method Election for Payment of Outpatient Services: CMS is proposing 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 proposes to modify current rules to allow hospitals and CAHs that have successfully reclassified from urban to rural status to be eligible for payment of reasonable cost for anesthesia and related care furnished by qualified non-physician anesthetists.

Capital Indirect Medical Education (IME): CMS has not proposed any changes to capital IME for FFY 2011.

Provisions Contained in the ACA and NOT Included in this Proposed Rule:

Medicare Wage Index Reform: By December 31, 2011, the HHS Secretary must report to Congress with recommendations for comprehensive reform of the Medicare wage index system. The plan is required to take into account the 2007 Medicare Payment Advisory Commission (MedPAC) wage index report, including the proposed use of Bureau of Labor Statistics (BLS) data and the recommended redefinition of wage areas.

Medicare GME-Redistribution of Unused Residency Slots: Effective July 1, 2011, 65% of the currently unused hospital resident training slots will be redistributed to hospitals based on a priority order, with all residency increases occurring by March 23, 2012.

Counting of Resident Time for IME and DGME: Allows hospitals to include in the determination of its full-time equivalency (FTE) count for Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) purposes, resident training in non-hospital settings if the hospital incurs the costs of the stipends and fringe benefits for the resident, time spent by a resident in non-patient care activities such as didactic conferences and seminars, vacation, sick leave and other approved resident leave time, and resident research activities not associated with patient care.

Hospital Reporting of Charges: Effective October 1, 2010, hospitals must publicize a list of standard charges for items and services provided by the hospital, including charges related to DRG.

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; and the Patient Protection and Affordable Care Act as modified by the Health Care and Education Affordability Reconciliation Act, known together as the Affordable Care Act (ACA) 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 24063

June 2, 2010 *Federal Register* pages 30922 - 30923

CMS' Supplemental Proposed Rule Update: CMS is required by the ACA to reduce the full marketbasket update of 2.4% by 0.25 percentage points, yielding a proposed marketbasket update of 2.15 for FFY 2011.

The FFY 2011 marketbasket estimate is “based on IHS Global Insight, Inc.’s 2010 first quarter forecast, with historical data through the 2009 fourth quarter.” Hospitals that do not submit qualifying quality data would receive a 2.0 percentage point update factor reduction.

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

Offset for Coding Improvements

Federal Register pages 23865 - 23874

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 the final IPPS rule for FFY 2008, CMS announced a 4.8% coding adjustment, to be phased in over three years, to neutralize for case-mix increases due to changes in documentation and coding. TMA reduced the prospective coding adjustments to 0.6% in FFY 2008 and to 0.9% in FFY 2009, but authorized CMS to recoup any additional overpayments made during those years that were due to coding improvements—in addition to correcting the adjustment on a prospective basis. The retrospective recoupments are 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.

CMS’ Proposal—Retrospective Coding Adjustment: CMS proposes to reduce the FFY 2011 standard amount by 2.9% to recoup payments for case-mix increases resulting from coding improvements. According to the CMS analysis of claims data, IPPS payments increased 2.5% in FFY 2008 and 5.4% in FFY 2009 as a result of coding improvement compared to FFY 2007. Because the IPPS rates were 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 is proposing that an additional 5.8% reduction is required to recoup 1.9% for FFY 2008 and 3.9% for FFY 2009 as shown on the following table.

	FFY 2008	FFY 2009	Total
Increase resulting from coding improvement	2.5%	5.4%	
Reduction already applied to rate	<u>0.6%</u>	<u>1.5%</u>	
Proposed additional reduction	1.9%	3.9%	5.8%

CMS is proposing 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 states 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’ Proposal—Prospective Coding Adjustment: In addition to the retrospective adjustments for FFY 2008 and 2009, CMS is authorized to adjust the IPPS standardized amounts for subsequent fiscal years to eliminate the full effect of the documentation and coding changes on future payments.

Based on the same analysis of 2008 and 2009 claims data, CMS estimates that the annual (recurring) increase in IPPS payments due to coding improvement is 5.4%. 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% [0.6% plus 0.9%]) on a go-forward basis to permanently realign payments to the baseline FFY 2007 coding level.

CMS proposes to forestall the implementation of a prospective coding adjustment 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.”*

Association’s Position: In our comments on the FFY 2010 proposal, we pointed out numerous conceptual and technical flaws in the CMS calculations. The FFY 2011 proposal relies on the same flawed methodology. Our general conclusion in FFY 2010 was the CMS analysis did not fulfill the legislative mandate—it did 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.). The CMS calculation for FFY 2011 again fails to take any of these factors into account—instead attributing all change to coding improvement.

Hospital-Specific Rates

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—Hospital Specific Rates: 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 the 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 is proposing 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.”

Operating and Capital Rates

June 2, 2010

Federal Register page 30983

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.

Standard Rate¹ for Hospitals with a Wage Index Greater Than 1.0 (68.8 Percent Labor Share and 31.2 Percent Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (2.15 Percent)	\$3,545.96	\$1,608.05
Reduced Update (0.15 Percent) ²	\$3,476.53	\$1,576.57
Standard Rate¹ for Hospitals with a Wage Index Less Than or Equal to 1.0 (62.0 Percent Labor Share and 38.0 Percent Non-Labor Share)		
	Labor-related	Non-Labor-related
Full Update (2.15 Percent)	\$3,195.49	\$1,958.52
Reduced Update (0.15 Percent) ²	\$3,132.92	\$1,920.18
Capital Federal Rate¹		
National Capital Rate		\$422.18

Note 1: The rates shown in the tables above (both operating and capital) reflect the 2.9% reduction for the proposed coding and documentation improvement adjustment and the marketbasket reduction of 0.25 percentage points as required by ACA.

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 23876 - 23880

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 rule over three years. 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 over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. As a result, 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 RTI International 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 adding a "Devices, Implants, and Prosthetics" line under "Medical Supplies Charged to Patients," and a "CT Scanning and MRI" subscripted line 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.

Based on these studies, CMS decided not to adopt regression-based CCRs for its calculation of the IPPS relative weights, but to refine 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—Relative Weight Calculation: CMS is not proposing any changes in the relative weight calculation for FFY 2011. However, CMS is proposing 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."

Changes to the ICD-9-CM Coding System

Federal Register pages 23910 - 23914

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 instead of a single update on October 1 of each 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.

Even though 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.

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, *"commenters 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.”

CMS’ Proposal—Code Freeze: In this proposed rule, CMS is soliciting 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 specifically would like feedback on the following:

- *“Having the last regular, annual update to both ICD-9-CM and ICD-10 be made on October 1, 2011; or*
- *“On October 1, 2012, there would be only limited code updates to both the ICD-9-CM and ICD-10 coding systems to capture new technologies and diseases; or*
- *“On October 1, 2013, there would be only limited code updates to ICD-10 to capture new technologies and diagnoses.”*
- *“Any other issues raised would be considered for implementation in ICD-10 on October 1, 2014. . . .”*

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’ Proposal—Additional Processing 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.”*

V. REPORTING HOSPITAL QUALITY DATA

Federal Register pages 23956 - 23997

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 were required to meet certain validation requirements. Hospitals that withdrew from the program or failed to submit valid data received a reduced marketbasket increase (-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 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 is *“proposing 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.”*

FFY 2011 Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program

Program Expansion

For FFY 2011 payment determinations, CMS will retain 41 of the FFY 2010 quality measures, harmonize two measures, retire one measure (mortality for selected surgical conditions), and add the following four new 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 45.

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
(The Retired Measure for FFY 2011 is 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 ⁴	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 one 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 (ARB) for left ventricular systolic dysfunction	HF-3 ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARB) 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 four 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 6 a.m. post operative 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 one or two	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 ⁵	AHRQ 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 RHOAPU

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

Chart Validation Requirements

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

HCAHPS Requirements

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

Program Procedures

Hospitals are required to submit RHOAPU program data starting with the first day of the quarter following the date when the hospital registers to participate in the program. To meet this requirement, CMS considers the registration date to be the date that the hospital submits a completed Notice of Participation form. Hospitals must submit complete data for each quality measure that requires chart abstraction. Specifically, hospitals are required to submit a random sample or complete population of cases for each of the topics covered by the quality measures.

The submission of patient level data that require chart abstraction is 4½ months following the last discharge date in the calendar quarter. The submission of aggregate population and sample size count data for the measures requiring chart abstraction is four months following the last discharge date in the calendar quarter. CMS will post the quarterly submission deadline schedule on the QualityNet Web site.

New Hospitals

New hospitals are required to register for the RHOAPU program and begin collecting and reporting data immediately. A new hospital receiving a provider number on or after October 1 of the year is required to report

RHQDAPU data beginning with the first day of the quarter following the date the hospital registers to participate in the RHQDAPU program. CMS strongly recommends that new hospitals participate in an HCAHPS dry run prior to the collection of HCAHPS data to meet RHQDAPU program requirements. For a schedule of upcoming dry runs, refer to <http://www.hcahpsonline.org>.

Attestation

In the FFY 2010 final rule, CMS adopted a provision that would require hospitals to electronically attest to the accuracy and completeness of their submitted data once a year. CMS expects that hospitals will submit quality data that are accurate to the best of their knowledge and ability.

Appeals

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

FFY 2012 RHQDAPU Program

CMS' Proposal—Program Expansion: For FFY 2012, CMS proposes to “*retain 45 of the FFY 2011 measures.*”

In addition, CMS is proposing “*to add 10 claims-based measures to the RHQDAPU program measure set for the FFY 2012 payment determination*” 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' Proposal—Submission of All-Patient Volume Data: “*We are proposing 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 will use the all-patient volume data elements submitted by hospitals to group the data by MS-DRG category. However, CMS invites comments on an alternative approach that allows hospitals to submit their all-patient data based upon specific ICD-9-CM codes related to the MS-DRGs.

CMS’ Proposal—RHQDAPU Program Procedures: For FFY 2012 and subsequent years, CMS is proposing the following modifications:

- *“. . . 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’ Proposal—HCAHPS Requirements: CMS is proposing *“ that the FFY 2012 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from April 1, 2010 through December 31, 2010.”*

CMS’ Proposal—Submission of Data: For FFY 2012 CMS is proposing *“that hospitals must submit data for five calendar year discharge quarters as follows: 4Q CY 2009, 1Q CY 2010 (AMI, HF and PN only), 2Q CY 2010, 3Q CY 2010 and 4Q CY 2010.”*

“For the FFY 2012 payment determination, CMS would use up to three years of discharges prior to January 1, 2011 (as appropriate for the measure), to calculate the 30-day mortality and 30-day readmission measures AHRQ PSI, IQI and Composite measures (including the AHRQ PSI and Nursing Sensitive Care measure, Death among surgical inpatients with serious, treatable complications), and the proposed new HAC Measures.”

CMS’ Proposal—Chart Validation: For FFY 2012, 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.”

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

FFY 2013 RHQDAPU Program

CMS’ Proposal—Program Expansion: “*We are proposing 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 is proposing to add:

- One new chart-abstracted measure:
 - AMI-statin at discharge
(This measure is not NQF-endorsed.)
- Two new Healthcare Acquired Infection (HAI) measures:
 - Central Line Associated Blood Stream Infection (NQF #0139); and
 - Surgical Site Infection (NQF #0299).
(These proposed HAI measures are NQF-endorsed.)

CMS states, “*Collection of these measures would begin with January 1, 2011 discharges for the FFY 2013 payment determination.*”

CMS is also proposing that “*hospitals choose **one** of the following four proposed measure topics:*

- “*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’ Proposal—RHQDAPU Program Procedures: For FFY 2013, CMS is proposing “*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 FFY 2013 payment*

determination, we will look at whether the hospital properly submitted data for quality measure data for the four calendar year quarters of CY 2011.

“Thus, for the FFY 2013 payment determination, we will validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011.

“This proposed synchronization will give us a more complete picture of the quality of care provided by a hospital during a given time period, thus enabling us to link that quality of care to the applicable RHQDAPU payment determination.”

CMS’ Proposal—Submission of Data: For FFY 2013, CMS is proposing “that hospitals must submit data for four consecutive calendar year discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011.”

CMS’ Proposal—Chart Validation: For FFY 2013, CMS is proposing “to adopt the same validation requirements that we 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’ Proposal—HCAHPS Requirements: CMS is proposing “that the FFY 2013 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from January 1, 2011 through December 31, 2011.”

FFY 2014 RHQDAPU Program

CMS’ Proposal—Program Expansion: “We are proposing 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 is proposing to “add the following 4 new chart-abstracted measures to the RHQDAPU program measure set:

- ED [Emergency Department]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);
- Global Flu Immunization; and
- Global Pneumonia Immunization.

CMS’ Proposal—Chart Validation: For FFY 2014, 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 is also considering “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’ Proposal—HCAHPS Requirements: CMS is proposing “that the FFY 2014 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from January 1, 2012 through December 31, 2012.”

VI. HOSPITAL-ACQUIRED CONDITIONS

Reporting HACs—Including Infections

Federal Register pages 23880 - 23883

Background: Complications such as infections acquired in the hospital can trigger higher payments in the form of outlier payments and/or assignments to a higher severity DRG. DRA required CMS to identify, by October 1, 2007 (FFY 2008), at least two secondary diagnoses that:

- are high-cost, high-volume, or both;
- result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and
- could reasonably have been prevented through the application of evidence-based guidelines.

In 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. Hence, 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.

CMS’ Proposal—HAC Categories: For FFY 2011, CMS is not proposing any changes to its current list of HACs conditions.

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

Even though CMS is proposing no change to the current HAC categories CMS is proposing 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’ Proposal—POA Reporting: CMS is proposing 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.*”

Research Triangle Incorporated HAC Evaluation

Federal Register pages 23883 - 23898

Background: Currently, only IPPS hospitals are required to submit on Medicare claims the POA indicator data for all diagnosis codes. In September 2009, Research Triangle Incorporated (RTI) was awarded a contract to evaluate the impact of the HAC-POA provisions on:

- incidence of selected conditions;
- effects on Medicare payments;
- impacts on coding accuracy;
- unintended consequences; and
- infection and event rates.

RTI’s preliminary analysis focused on:

- POA indicator reporting across Medicare discharges;
- POA indicator reporting of current HACs;
- Frequency of discharges and POA indicator reporting on current HACs;
- Circumstances when application of HAC provisions do not result in MS-DRG reassignment;
- Coding change for HAC-associated secondary diagnosis for current HACs; and
- Candidates for future HAC conditions.

Based on RTI's analysis, a majority of secondary diagnoses (83.5%) were reported with a POA indicator of "Y," meaning condition is present on admission. Using MedPAR claims data from October 2008 through June 2009, RTI estimated a total net savings of \$16.4 million under the current HAC policy. The highest savings was generated from three HAC conditions: Falls and Trauma; Orthopedic PE/DVT; and Pressure Ulcer Stages III & IV.

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. . . ."*

VII. CAPITAL PAYMENTS

Capital Rate Update

Federal Register pages 24012 - 24016

Background: Reimbursement for IPPS capital-related costs is based on a national capital rate that is updated annually based on the capital input price index (CIPI).

June 2, 2010 *Federal Register* page 30979

CMS' Supplemental Proposed Rule Update: CMS is proposing to increase the capital rate update from \$420.99 as published in the May 4, 2010 *Federal Register* to \$422.18 in order to reflect the budget neutrality impact of changes required by the ACA.

This includes *"a -2.9 percent adjustment . . . to account for the cumulative effect of changes in documentation and coding under the MS-DRGs that do not correspond to changes in real increases in patients' severity of illness."*

For a complete discussion of the coding adjustment, see the "Offset for Coding Improvements" section.

VIII. WAGE INDEX

Occupational Mix Adjustment

Federal Register pages 23938 - 23947

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' Proposal: For the FFY 2011 occupational mix adjustment, CMS is proposing to continue to use the occupational mix data collected on the revised 2007-2008 *Medicare Occupational Mix Survey*. “*The proposed FFY 2011 occupational mix adjusted national average hourly wage is \$34.9124.*”

CMS' Proposal—New 2010 Occupational Mix Survey: 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 pages 23937 - 23938

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.

June 2, 2010 *Federal Register* page 30920

CMS' Supplemental Proposed Rule Update: Beginning FFY 2011, CMS is required by the ACA, to restore the rural floor and imputed rural floor budget neutrality adjustment to a uniform, national adjustment rather than a state-specific adjustment to the wage index. CMS proposes a budget neutrality adjustment of 0.995425 to all wage indexes.

Imputed Rural Floor Adjustment

Federal Register pages 23937 - 23938

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.

June 2, 2010 *Federal Register* page 30920

CMS' Supplemental Proposed Rule Update: Beginning FFY 2011, CMS is required by the ACA, to restore the rural floor and imputed rural floor budget neutrality adjustment to a uniform, national adjustment rather than a state-specific adjustment to the wage index. CMS proposes a budget neutrality adjustment of 0.995425 to all wage indexes.

“Frontier States” Wage Index Floor

June 2, 2010 *Federal Register* page 30920

CMS' Supplemental Proposed Rule Update: The ACA establishes a wage index floor of 1.0000 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.

Multi-Campus Hospitals

Federal Register page 23944

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' Proposal: 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 23947 - 23949

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.

June 2, 2010 *Federal Register* pages 30919 - 30920

CMS' Supplemental Proposed Rule Update: CMS is required to restore, for FFY 2011, the lower FFY 2008 Medicare hospital wage index reclassification thresholds used to compare hospitals' AHWs for the purpose of determining wage index reclassifications. A hospital must 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 re-designation.

Hospitals must apply for a reclassification 13 months prior to the start of the fiscal year; applications for a FFY 2011 reclassification were due by September 1, 2009. The ACA did not change the statutory deadline for the FFY 2011 reclassification applications. CMS will not allow hospitals to file new reclassification applications for FFY 2011, but CMS has reviewed applications filed by September 1, 2009 and determined that an additional 23 hospitals qualify for a reclassification in 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 (by June 18, 2010) 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.

Out-Migration Adjustment

Federal Register page 23953

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 proposes to *“calculate the out-migration adjustment using the same formula described in the FFY 2005 IPPS final rule . . . with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment.”*

Section 508 Reclassifications

Federal Register pages 23952 - 23953

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 PPACA and HCEARA of 2010 extended Section 508 reclassifications to September 30, 2010.

CMS' Proposal: For FFY 2011, the Section 508 reclassifications will sunset. CMS does not have the authority to extend Section 508 reclassifications without legislation.

“Lugar” Reclassifications

Federal Register pages 23949 - 23952

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 (by June 18, 2010) of publication of the proposed rule if they prefer to receive the Lugar assignment.

Wage Index Study

Federal Register pages 23936 - 23937

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.

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 in the proposed rule 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.*"

CMS' Proposal: For FFY 2011, CMS is "*not proposing any additional changes regarding reforming the wage index.*"

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.

IX. MEDICARE DSH CALCULATION

Federal Register pages 24002 - 24007

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."*

CMS' Proposal: For FFY 2011, CMS is proposing 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 is proposing 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 is proposing 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 is proposing 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’ Proposal—Timing of the Match: For FFY 2011, CMS is proposing 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 is also considering 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.”

X. COST OUTLIERS

Federal Register pages 24068 - 24070

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.

June 2, 2010 *Federal Register* page 30975

CMS' Supplemental Proposed Rule Update: CMS is proposing to increase the outlier fixed-loss cost threshold from \$23,970 as published in the May 4, 2010 *Federal Register* to \$24,165 for FFY 2011 to reflect the changes in expected outlier payments resulting from implementation of ACA provisions. Increasing the threshold will maintain outlier payments at 5.1% of total payments.

XI. 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 24007 - 24009

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 is proposing 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 is clarifying that such an individual's time should not be included in the FTE count for IME and DGME purposes. CMS is also proposing 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.’*
- *“the definition of ‘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 would be effective for cost report periods beginning on or after October 1, 2010.

Medicare GME Affiliation Groups

Federal Register pages 24009 - 24010

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 is proposing *“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.”*

Indirect Medical Education Adjustment

Federal Register pages 24001 - 24002

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.

Health Care Reform Update: The ACA of 2010 require the redistribution of 65% of the currently unused hospital resident training slots effective July 1, 2011 with all residency increases occurring by March 23, 2012. The law also improves how hospitals can count resident time for DGME and IME purposes. These changes are not addressed in the proposed rule, but will be corrected as part of future rulemaking

XII. ADDITIONAL PAYMENTS FOR NEW TECHNOLOGY

Federal Register pages 23923 - 23936

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.

In FFY 2010, CMS continued add-on payments for CardioWest™ Temporary Artificial Heart (TAH) system at a maximum of \$53,000.

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

In addition, CMS is considering 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.

XIII. RURAL ISSUES

Rural Referral Centers (RRCs)

Federal Register pages 23999 - 24001

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’ Proposal: For FFY 2011, CMS is proposing that *“if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, they must have a CMI value for FFY 2009 that is at least:*

- *“1.5127; or*
- *“The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located.”*

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

Region	Case-Mix Index Value
New England (CT, ME, MA, NH, RI, VT)	1.3010
Middle Atlantic (PA, NJ, NY)	1.3590
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4559
East North Central (IL, IN, MI, OH, WI)	1.4262
East South Central (AL, KY, MS, TN)	1.3776
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4404
West South Central (AR, LA, OK, TX)	1.5181
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6004
Pacific (AK, CA, HI, OR, WA)	1.4826

In addition, for FFY 2011, CMS is proposing that *“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 proposed median numbers of discharges for urban hospitals by census region are as follows:

Region	Discharges
New England (CT, ME, MA, NH, RI, VT)	7,701
Middle Atlantic (PA, NJ, NY)	11,346
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,905
East North Central (IL, IN, MI, OH, WI)	9,329
East South Central (AL, KY, MS, TN)	5,902
West North Central (IA, KS, MN, MO, NE, ND, SD)	8,091
West South Central (AR, LA, OK, TX)	6,264
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,346
Pacific (AK, CA, HI, OR, WA)	8,464

Change to Criteria for Medicare Dependent Hospitals

Federal Register page 23999

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.

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. . . .”

June 2, 2010 *Federal Register* pages 30925 - 30926

CMS' Supplemental Proposed Rule Update: CMS is required to extend the MDH program one additional year through September 30, 2012.

Certified Registered Nurse Anesthetist (CRNA) Services

Federal Register pages 24010 - 24011

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 is proposing 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 nonphysician 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 nonphysician anesthetists.”

XIV. CRITICAL ACCESS HOSPITALS

CAH Optional Payment Method

Federal Register pages 24017 - 24018

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.

CMS' Proposal: To prevent CAHs that miss the 30-day deadline from losing the optional method, CMS is *“proposing 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 before the 30-day deadline.

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.

June 2, 2010 Federal Register page 30965

CMS' Supplemental Proposed Rule Update: 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 is proposing 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.”*

Provider Taxes as Allowable Costs for CAHs

Federal Register pages 24018 - 24019

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.”

XV. OTHER ISSUES

Electronic Health Records (EHRs)

Federal Register page 23996

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’ Proposal: For FFY 2011, *“the provisions in this proposed 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 24016 - 24017

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 is “proposing 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 is proposing a 2.4% marketbasket update.

Payment for Acute Care Transfers

Federal Register pages 23997 - 23998

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 is proposing 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.”

Medicare Conditions of Participation (COPs)

Federal Register pages 24050 - 24051

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 is proposing to “clarify the types of practitioners who are allowed to order rehabilitation services.” Specifically, CMS is “proposing 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 is proposing “*changes to the existing requirements for ordering of respiratory care services . . .*”

CMS is proposing 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.*”

XVI. OTHER ACA PROVISIONS

Low-Cost County Add-On

June 2, 2010 *Federal Register* pages 30926 - 30960

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’ Supplemental Proposed Rule Update: CMS is proposing to distribute \$150 million in FFY 2011 and \$250 million in FFY 2012 based on the proposed methodology mentioned below. Based on CMS’ proposal 415 hospitals nationally would receive an allocation of the \$150 million in FFY 2011

CMS’ Proposed Methodology for Medicare Part A and B Spending

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.*”

CMS’ Proposed Age, Sex, and Race Model

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...”

Proposed Distribution of Funds

CMS is proposing 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.

Low-Volume Hospital Adjustment

June 2, 2010 *Federal Register* pages 30923 – 30925

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' Supplemental Proposed Rule Update: Per requirements of the ACA, CMS is required to revise its current regulations in order to allow more hospitals to qualify for a low-volume payment adjustment in FFY's 2011 and 2012. 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. The proposed payment adjustments are as follows:

Medicare Discharge Range	Payment Adjustment (Percent Add-On)
1 - 200	25.0000
201 - 300	23.3333
301 - 400	21.6667
401 - 500	20.0000
501 - 600	18.3333
601 - 7 00	16.6667
701 - 800	15.0000
801 - 900	13.3333
900 - 1000	11.6667
1001 - 1100	10.0000
1101 - 1200	8.3333
1201 - 1300	6.6667
1301 - 1400	5.0000
1401 - 1500	3.3333
1501 - 1599	1.6667
1600 or more	0.0000

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.”

XVII. ACRONYMS

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