August 26, 2009

AAMC Summary and Analysis

FISCAL YEAR 2010 MEDICARE INPATIENT PPS FINAL RULE: PROVISIONS OF INTEREST TO THE ACADEMIC MEDICAL COMMUNITY

On July 31, 2009, the Centers for Medicare & Medicaid Services (CMS or the Agency) published its annual final rule containing changes to the Medicare hospital inpatient prospective payment system (IPPS) and the PPS payment update for Federal fiscal year (FFY) 2010. A display copy of the final rule is available at: http://www.federalregister.gov/OFRUpload/OFRData/2009-18663_PI.pdf. (Note that page numbers listed below correspond to pages in the display copy.) The rule is scheduled to be published in the *Federal Register* on August 27, 2009, and changes take effect for discharges on or after October 1, 2009.

The final rule and this Summary and Analysis may be found at: http://www.aamc.org/advocacy/teachhosp/inptpps/histreg/start.htm.

The final rule rescinds a previous regulation that would have eliminated the capital indirect medical education (IME) adjustment to payment rates for teaching hospitals effective for FY 2010. CMS states that in response to public comments and based on an updated analysis of hospital capital margins, the Agency decided that teaching hospitals will continue to receive the full capital IME adjustment in FFY 2010 and beyond. In the final rule, CMS also implemented a 2.1 percent market basket update and declined to finalize a corresponding 1.9 percentage point "documentation and coding" offset. The 2.1 percent update for inflation is lower than in prior years, which CMS states reflects the slowing rate of inflation. With all changes, CMS estimates that **teaching hospitals with 100 or more residents will see average *operating* per case payment increases of 1.7 percent**, compared to operating increases of 1.6 percent for other teaching and nonteaching hospitals. With all other changes, CMS estimates that **teaching hospitals with 100 or more residents will see average *capital* per case payment increases of 2.1 percent**, compared to capital increases of 1.9 percent and 1.8 percent for other teaching and nonteaching hospitals, respectively.

Highlights of the Final Rule Include:

- Maintaining the capital IME adjustment for FFY 2010 and beyond
- 2.1 percent market basket update, with *no* documentation and coding offset
- Decrease in the labor-related share from 69.7 percent to 68.8 percent
- 15.4 percent increase in the outlier payment threshold ($20,045 to $23,140)
- "Clarification" of the definition of a "new medical residency training program"
- Changes to the bed and day calculations used for IME and DSH payments
- Four new Hospital Compare quality measures
- Technical revisions to EMTALA waiver regulations

I. RESTORATION OF CAPITAL IPPS TEACHING ADJUSTMENT FOR FFY 2010 (pages 697-702)

Background

In CMS's FFY 2008 IPPS final rule with comment period, CMS announced the Agency's plans to eliminate the capital IME adjustment beginning with a 50 percent reduction in FFY 2009 and a complete elimination in FFY 2010 and beyond. The American Recovery and Reinvestment Act of 2009 (ARRA) directed CMS to rescind the 50 percent reduction to capital IME payments for FY 2009 but did not address the FFY 2010 elimination. In the IPPS FY 2010 proposed rule, CMS announced the Agency's intent to move forward with plans to eliminate the capital IME adjustment in its entirety for FY 2010 and thereafter.

Final Rule

The final rule restores the capital indirect medical education (IME) adjustment to payment rates for teaching hospitals effective for FFY 2010. CMS stated that based on (1) an updated analysis of hospital capital margins that indicates a decline in these margins compared to prior analyses, and (2) in response to public comments that unanimously opposed the elimination of the capital IME adjustment, the Agency decided that teaching hospitals will continue to receive the full capital IME adjustment in FFY 2010.

Analysis

The AAMC is extremely pleased that CMS considered the margin data that the AAMC and many of its members provided to the Agency and that CMS exercised its authority to restore the capital IME adjustment. AAMC President and CEO Darrell G. Kirch, M.D., also recently thanked the Obama administration for reversing this policy, stating that "we wholeheartedly commend the Obama administration for restoring Medicare's capital IME adjustment. This critical federal support—an estimated $380 million in the coming year and more than $5 billion over the next decade—will ensure that teaching hospitals can continue to train future doctors; care for very ill and uninsured patients; maintain vital standby services, such as emergency and trauma care; and provide highly specialized services to communities across the country."

II. IPPS PAYMENT RATE UPDATE

Final Rule

For FFY 2010, the final rule implements a full market-basket increase of 2.1 percent to the standardized payment amount for hospitals that comply with the requirements for reporting quality data. Hospitals that do not submit quality data will receive an increase equal to the market basket increase minus 2.0 percentage points, or 0.1 percent.

Analysis

The update of 2.1 percent reflects the most recent estimate of the market basket increase at the time the final rule was published. The average estimated actual change in per case payments will be less than the market basket increase due to budget neutrality requirements, but, as discussed in further detail below, the market basket will *not* be adjusted downward for a documentation and coding offset as originally proposed.

III. DOCUMENTATION AND CODING OFFSET (pages 93-113)

Background

Hospitals receive predetermined (prospective) specific rates for each Medicare discharge. To determine the payment, each discharge is assigned to a specific diagnosis-related group (DRG). Each DRG has a relative weight that increases as the case complexity increases. The per case payment equals the product of the relative weight and the standardized amount, adjusted by the hospital's wage index and increased by any relevant payment adjustments (such as DSH or IME).

In FY 2008, to better recognize severity of illness in Medicare hospital payment rates, CMS began a transition from 538 "CMS DRGs" to 746 "Medicare Severity DRGs" (MS-DRGs). For FY 2008, Medicare per case payments were based on a blend comprising 50% of the CMS DRG relative weight and 50% of the MS-DRG relative weight. In FY 2009, the payments are based on 100% of the MS-DRG weights

Under MS-DRGs, cases generally are assigned to one of three severity levels: cases with no complications or comorbidities (CCs); cases with a CC, or cases with a major CC (MCC). In general, an MS-DRG assignment for a case is based on diagnosis and procedure codes that the hospital includes on the Medicare claim submitted to CMS. Because MS-DRGs better reflect patient severity, there is an increased number of diagnosis and procedure codes that contribute to determining to which MS-DRG a case is assigned.

The MS-DRG relative weights for FY 2008 were calibrated with the intention that the change from CMS-DRGs to MS-DRGs would be budget neutral, with Medicare payments only increasing if there is an actual increase in the severity of patients treated. CMS was concerned, however, that payments might increase because of the incentives for hospitals to document and code their Medicare claims more accurately, which would result in more cases being assigned to higher weighted DRGs.

Consequently, when CMS finalized the MS-DRG policy in the FY 2008 inpatient final rule, the Agency included a 4.8% offset to the standardized amount to negate any payment increases that were not associated with real case mix increase. The offset was to be phased in over three years (-1.2% in FY 2008; -1.8% in FY 2009; and -1.8% in FY 2010). In the fall of 2007, Congress (PL 110-90) reduced the coding adjustment to -1.5% (-0.6% in FY 2008 and -0.9% in FY 2009).

Importantly, however, PL 110-90 gave CMS the authority to make "appropriate adjustments" to the extent that a retroactive analysis of actual claims data for FYs 2008 and 2009 indicate that coding changes did not comport with the legislated reductions. In other words, if in FY 2008 and FY 2009, coding changes resulted in payments that were more than the legislated offset, CMS is required to reduce the standardized amount for subsequent fiscal years to eliminate the effect of the coding changes. In addition, CMS is authorized to make a further reduction to the standardized amount to "recoup" payments made in FYs 2008 and FY 2009 due to coding changes. The recoupment adjustments may be made during FYs 2010, 2011 and 2012.

Final Rule

In the final rule, CMS decided **not** to implement the proposed regulation that would have reduced the update to the standardized amount for FY 2010 by 1.9 percentage points to account for documentation and coding adjustments. (This amount reflected CMS's estimate of the FY 2008 payment increase due to documentation and coding (2.5%) less the 0.6% reduction that was implemented in FY 2008 due to PL 110-90.) (See the AAMC Summary and Analysis of the FY 2010 inpatient proposed rule for a discussion of CMS's methodology for arriving at the documentation and coding increase of 2.5 percent).

Analysis

For the final rule, CMS was able to analyze more claims data (updated through March, 2009) and still believes that the effect of changes in documentation and coding for FY 2008 is 2.5 percent. The CMS actuaries also continue to estimate that the documentation and coding effect will be 2.3 percent for FY 2009, which exceeds the -0.9 percent adjustment that was applied to the FY 2009 standardized amount pursuant to current law. The cumulative estimated total impact for FYs 2008 and 2009 is 4.8 percent.

While acknowledging and defending these findings in the Agency's responses to comments, CMS stated in the final rule that the Agency believed it would be "more prudent" to delay implementation of any documentation and coding reduction to allow for a more complete analysis of all of FY 2009 claims data (*see* page 95). CMS states that "in future rulemaking we will consider applying a prospective adjustment based upon a complete analysis of FY 2008 and FY 2009 claims data over an extended time period, such as 5 years, beginning in FY 2011."

IV. CHANGES TO THE HOSPITAL WAGE INDEX AND LABOR-RELATED SHARE

Background

A portion of the standardized payment amount for each hospital is adjusted by the "wage index," which reflects relative differences in costs across geographic areas attributable to local labor markets. The portion of the standardized amount that is adjusted by the wage index is referred to as the "labor-related share."

For FFY 2010, the wage index values for each labor market area will be based on data submitted by hospitals for cost reporting periods that began in FFY 2006. Note that the wage data collected on FY 2006 cost reports include overhead costs for contract labor that were not collected on earlier cost reports. The wage index values will also reflect an occupational mix adjustment based on the FY 2007/2008 occupational mix survey. The intent of this adjustment is to ensure that the wage index reflects only geographic differences in the prices hospitals pay for labor and not differences in the mix of their employees (e.g., registered nurses versus licensed practical nurses). Like last year, CMS adjusted 100 percent of the wage index for occupational mix.

A. Decrease to the Labor-Related Share (pages 380-407)

Final Rule

In the final rule, CMS decreased the labor-related share from 69.7 percent to 68.8 percent for hospitals with wage indices greater than 1.0. (The labor-related share for hospitals with wage indices less than or equal to 1.0 will remain at 62 percent, as required by the Medicare Modernization Act.) CMS explained that the decline is in part a result of more recent survey data that, for the first time, account for professional services obtained outside a hospital's local labor market. Previously, all professional fee expenses were considered to vary with the local labor market and were included in the labor-related share. CMS also attributed the decline to consolidation of administrative functions in home offices that are not in the same local labor market as individual hospitals.

This final decrease is, however, 1.7 percentage points less than the decrease from 69.7 percent to 67.1 percent the Agency initially published in the proposed rule, a change CMS attributed to a revised methodology for allocating home office costs. Instead of using provider counts (where each provider counts evenly) as the means for determining which home office costs will be apportioned to the labor-related share or deemed nonlabor related, CMS responded to commenters' suggestions and decided to weight providers by home office compensation costs as reported in Worksheet S-3, part II, line 11 of the Medicare cost report. This change resulted in a smaller reduction to the labor-related share.

Analysis

The finalized decrease has a negative impact on teaching hospitals that are in geographic areas with wage indices greater than 1.0. Nevertheless, the impact is less severe than if CMS had adopted the proposed decrease to 67.1 percent.

B. Solicitation of Comments Regarding Penalties for Failure to Submit Occupational Mix Data (pages 300-13)

Background

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires CMS to collect data every three years on the occupational mix of short-term acute care hospital employees for purposes of constructing an occupational mix adjustment to the wage

index. For the most recent FY 2007-2008 survey, the response rate was 89 percent, down from 90.7 percent for the 2006 survey and 93.8 percent for the 2003 survey. For purposes of calculating the FY 2010 wage index, hospitals that did not respond to the survey or submitted unusable data were assigned the average occupational mix adjustment for the labor market area.

Final Rule

In the final rule, CMS reiterated the Agency's concern about the increasing number of hospitals that fail to submit occupational mix data (or that submit unusable data) and the impact the declining response rate may have on area wage indices. Several comments suggested various types of possible penalties, and CMS indicated that the Agency will consider these comments and other possible punitive measures in developing a proposal for the FY 2011 IPPS proposed rule.

C. Continued Phase-In of Within-State Budget Neutrality for Rural and Imputed Floors (pages 292-96)

Background

The rural floor requires that an urban wage index may not be lower than the wage index for any rural hospital in that state, while the imputed floor sets a minimum wage index for states without rural areas or rural IPPS hospitals. In the FFY 2009 IPPS final rule, CMS adopted a policy to apply budget neutrality adjustments to the rural and imputed floors on a statewide, rather than national basis.

Final Rule

This final rule simply discusses the ongoing three-year phase-in of this policy. In FFY 2009, hospitals received a blended wage index that was 20 percent of a wage index with the State level adjustment and 80 percent of a wage index with the national adjustment. In FFY 2010, the blended wage index will reflect 50 percent of the State level adjustment and 50 percent of the national adjustment. In FFY 2011, the adjustment will reflect 100 percent of the State level adjustment.

V. OUTLIER PAYMENT THRESHOLD (pages 1027-51)

Background

Under the Medicare inpatient outlier policy, if the costs of a particular Medicare case exceed the relevant MS-DRG operating and capital payment (including any disproportionate share, IME, or new technology add-on payments) plus a fixed-loss cost threshold, determined by CMS, the hospital will receive an outlier payment. This payment equals 80 percent of the case's costs above the threshold calculation. The cost threshold is set at a level that is intended to result in outlier payments that are between 5 and 6 percent of total PPS expenditures. Outlier payments are budget-neutral. Therefore, the Agency reduces the inpatient standardized amount by 5.1

percent and estimates a cost threshold each year that will result in outlier payments that equal 5.1 percent.

Final Rule

Under the final rule, the fixed-loss cost threshold for FFY 2010 will be equal to a case's MS-DRG payment plus any IME and DSH payments, and any additional payments for new technologies, plus $23,140. This amount of $23,140 is up from $20,045 in FFY 2009 but is lower than the proposed rule's $24,240.

Analysis

The final outlier fixed-loss cost threshold is lower than the proposed threshold, because CMS did not adopt the proposed documentation and coding adjustments included in the proposed rule. The -3.4 percent cumulative adjustment included in the proposed rule reflected the -1.5 percent adjustment from FY 2008 and FY 2009 as well as a -1.9 percent proposed coding adjustment for FY 2010. Because CMS did not implement the proposed -1.9 percent coding adjustment for FY 2010, the FY 2010 national standardized amounts used to calculate the final outlier threshold reflect only the cumulative adjustment of -1.5 percent from FY 2008 and FY 2009. This smaller reduction to the standardized amount will, in and of itself, cause fewer cases to qualify for outlier payments. This requires that CMS lower the threshold included in the proposed rule to meet its target of 5.1 percent in total outlier payments.

The Agency rejected comments from the AAMC and other hospital associations recommending a modification to the methodology for determining the outlier fixed-loss cost threshold. The AAMC had recommended that CMS use a methodology for determining the adjustment factor to the cost-to-charge ratio (CCR) that uses a recent historical industry-wide average rate of change, rather than utilizing the relationship between actual costs and the hospital market basket and assuming that the rate of change is constant over time. This methodology would also be similar to the methodology used to develop the charge inflation factor. In response, CMS stated that the Agency's own methodology is more accurate and stable, because it takes into account the costs per discharge and the market basket percentage increase when determining a cost adjustment factor.

The Agency also rejected the recommendation that CMS project CCRs over different periods of time, based on variations in hospital fiscal year ends. The AAMC and other hospital associations urged CMS to make this change, because it would take into account the different hospital fiscal year ends and would utilize their most current CCR as it becomes available. The Agency stated that it is possible that some of the CCRs in the March Provider Specific File (PSF), the most recently available data at the time of the final rule, will be used in FY 2009 for actual outlier payments, while other CCRs may be one year old. According to CMS, applying a one-year adjustment to the CCRs should account for the variations in hospital fiscal year ends.

CMS accepted a recommendation by the AAMC and other hospital associations regarding the elimination of charges for organ acquisition costs and Medicare Advantage claims from the claims data that CMS uses for the outlier threshold determination. An analysis by Vaida Health

Data Consultants shows that CMS had included these costs even though they are paid separately from the IPPS system. Although the managed care claims and organ acquisition costs affect the outlier payments in opposite ways, the net effect is an overestimation of the fixed-loss amount. Removing these costs leads to a decrease in the outlier threshold. The Agency accepted the recommendation but did not provide an estimate showing the effect of removing the managed care claims and organ acquisition costs from the data used for the outlier fixed-loss threshold determination.

VI. PROPOSALS AFFECTING BOTH DGME AND IME PAYMENTS

A. "Clarification" of the Definition of New Medical Residency Training Program (pages 613-48)

Background

Teaching hospitals are subject to a cap on the number of residents that may be counted for direct graduate medical education (DGME) and indirect graduate medical education (IME) payments. In general, this cap is based on the number of full time equivalent (FTE) residents the hospital has claimed in its most recent cost reporting period ending on or before December 31, 1996. New teaching hospitals are given three years to establish residency programs, after which a resident cap is determined based on the resident counts in those programs.

Final Rule

In the final rule, CMS finalized the Agency's "clarified" definition of "new medical residency training program" (at 42 C.F.R. § 413.79(l)) when a new teaching hospital is attempting to establish its resident cap. The regulations define "new medical residency training program" as one "that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." Following this definition, many hospitals relied solely on accreditation of a new program by the appropriate accrediting body for purposes of determining whether the program's residents could be included in the resident cap. CMS now states that the Agency will look beyond accreditation to factors that include but are not limited to: (1) whether the program director is new; (2) whether the teaching staff is new; (3) whether there are new residents; (4) the relationship between hospitals (for example, common ownership or a shared medical school or teaching relationship); (5) the degree to which the hospital with the original program continues to operate its own program in the same specialty; (6) whether the program has been relocated from a hospital that closed; (7) if the program had been relocated from a closed hospital, whether the program was part of the closed hospital's FTE cap determination; and (8) whether the program is part of any existing hospital's FTE cap determination. Factors listed here as (6) through (8) (CMS does not number the factors) were new in the final rule.

Analysis

Even through responses to comments in the final rule, CMS does not specify precisely what combination of factors will contribute to a program's failure to be deemed a "new medical residency training program." Although CMS has now "clarified" that the Agency will look

beyond what type of accreditation the program has received, the only certainty the rule provides is that decisions about whether programs are "new" will be made on a case-by-case basis.

B. Submission Deadline Flexibility for New Hospitals Joining GME Affiliated Groups (pages 648-57)

Background

Under current regulations, existing teaching hospitals that meet specified criteria may enter into Medicare GME affiliation agreements, under which they may combine their respective resident caps and redistribute them according to their agreement. The sum of the new caps under the affiliation agreement may not, however, exceed the aggregate combined cap.

Final Rule

CMS finalized the Agency's proposal to increase flexibility in submission deadlines for new hospitals joining Medicare GME affiliated groups. Current regulations require each hospital in a GME affiliated group to submit its Medicare GME affiliation agreement to its intermediary or MAC and the CMS Central Office no later than July 1 of the residency program year during which the agreement would be in effect. This deadline precludes new hospitals opening after July 1 from immediately entering into GME affiliation agreements. CMS's new policy permits a new hospital that opens after July 1 of a given year to submit a GME affiliation agreement at any time prior to the end of its first cost reporting period to participate in an existing affiliated group. Under the new policy, the agreement may begin no earlier than the date the affiliation agreement is submitted to CMS, and hospitals already participating in the affiliated group must submit an amended agreement no later than June 30 of the year the revised agreement will be in effect.

Analysis

The final rule allows new hospitals to enter into affiliated groups in their first year of operation. This new policy applies only to new *hospitals* with new Medicare provider agreements (not to new residency training programs at already-existing hospitals) and only permits the joining of existing GME affiliated groups (not the formation of new affiliated groups). CMS also confirmed in the final rule that this new policy does not change the current restriction that a new urban teaching hospital may only enter into a GME affiliated group if the new hospital's revised cap pursuant to the affiliation agreement is higher than its base year cap (*see* 42 C.F.R. § 413.79(e)(1)(iv)).

VII. OTHER PROPOSAL AFFECTING INDIRECT MEDICAL EDUCATION PAYMENTS: REMOVAL OF OBSERVATION BED DAYS FROM THE INTERN AND RESIDENT-TO-BED (IRB) RATIO (pages 597-611)

Background

A hospital's ratio of full-time equivalent (FTE) interns and residents-to-beds (the "intern and resident-to-bed ratio" or "IRB ratio") is a key component in determining a teaching hospital's

IME payment level. The number of beds in the IRB ratio is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. Currently, hospitals are instructed to include observation bed days in this count for patients who ultimately are admitted as inpatients.

Final Rule

CMS adopted without modification the Agency's proposal to exclude all observation beds from the available bed count used to determine the IRB ratio for IME payment purposes. Under the new policy, no observation bed days will be included, regardless of whether patients ultimately are admitted for inpatient care. CMS stated that the cost report will be changed to accommodate this policy change.

Analysis

Because a decrease in the number of beds results in an increase in the IRB ratio, CMS predicts that its proposal to exclude observation bed days from the IME bed count will result in an increase of approximately $7 million in IME payments to teaching hospitals. However, while not addressed in the rule, given the current requirement that the IRB ratio used for payment not be greater than the ratio in the previous year, it seems that any increase in payments will not occur until 2011.

CMS also adopted a corresponding exclusion of observation bed days from the DSH payment calculation (see Section VIII.C. below), which the Agency states will, in the aggregate, off-set any IME payment increases resulting from this change in policy.

VIII. CHANGES AFFECTING THE DISPROPORTIONATE SHARE (DSH) ADJUSTMENT

Background

Under the Social Security Act, hospitals that serve a disproportionate number of low-income patients may qualify for a Medicare disproportionate share hospital (DSH) adjustment. Under the most common method for qualifying for the DSH adjustment, a hospital's DSH payments are based in part on the level of the hospital's disproportionate patient percentage (DPP). The DPP is the sum of what is referred to as the "Medicare fraction" (the number of inpatient days furnished to patients entitled both to Medicare Part A and SSI benefits divided by the total number of inpatient days furnished to patients entitled to Medicare Part A benefits) and the "Medicaid fraction" (the number of inpatient days furnished to patients eligible for Medicaid but not entitled to benefits under Medicare Part A, divided by the total number of inpatient days).

A. Inclusion of Labor and Delivery (L&D) Days in the DSH Calculation (pages 573-84)

Final Rule

CMS finalized the Agency's proposal to include labor and delivery (L&D) bed days in the Medicare DSH calculation, even when a patient does not occupy a routine bed prior to occupying an ancillary L&D bed. Under the current regulations, a patient in the labor and delivery room at the census-taking hour does not count in the numerator or denominator of the Medicaid fraction, unless the patient first occupied a routine inpatient bed. Under the new policy, all L&D days will be included, as long as the patient was admitted to the hospital as an inpatient at some point during the stay. The new policy does apply to labor and delivery patients who are not admitted to the hospital as inpatients (e.g. false labor).

Analysis

This finalized policy change is quite narrow, as the only additional L&D days that would be counted in the Medicaid fraction would be in circumstances when an inpatient day *follows* the use of an ancillary L&D bed. The effect of this change will vary by hospital, depending on the proportion of the hospital's additional L&D days that are attributable to Medicaid-eligible patients. In response to a comment, CMS confirmed that the Agency will provide cost reporting instructions in the future to reflect the revised policy.

B. Allowing Alternative Methods of Aggregating Days in the Numerator of the Medicaid Fraction (pages 585-97)

Final Rule

CMS adopted its proposal to offer hospitals additional options regarding the methodology used to report days in the numerator of the DPP Medicaid fraction. The Agency states that its current policy requires hospitals to report Medicaid inpatient days in the cost reporting period in which a patient is discharged, but the Agency acknowledges that hospitals currently may be using other methods. CMS notes that the variation may stem from differences in State Medicaid agency requirements for how to report Medicaid-eligible days. Under the final rule, hospitals may now report Medicaid inpatient days in the cost reporting period in which the patient was discharged *or* admitted *or* based on dates of service. In deciding to change its methodology, a hospital must notify CMS of an intent to change methods, retain the same method for the entire cost reporting year, and avoid "double counting" when making any change.

Analysis

During the May 6, 2009, Hospital Open Door Forum teleconference, CMS stated that a hospital must notify the Agency if it intends to use a methodology other than date of discharge for reporting Medicaid-eligible days. The proposed rule and proposed regulation, however, indicated that the hospital must notify CMS if seeking to make a "change" to its methodology, while acknowledging that hospitals currently may be using other methods of counting Medicaid-

eligible days other than date of discharge. In response to comments, CMS clarified in the final rule that if a hospital is not changing the methodology it uses, it is not required to notify the fiscal intermediary or Medicare Administrative Contractor (MAC). In the absence of notification, however, CMS instructs the fiscal intermediary or MAC to presume the hospital is using a date of discharge methodology and to "act accordingly to ensure that Medicaid patient days are not 'double counted' in the numerator of the Medicaid fraction." Hospitals that currently use a methodology other than date of discharge should, therefore, communicate with their contractor to avoid this presumption.

C. Removing Observation Bed Days from the DSH Calculation (pages 597-611)

Final Rule

As with the IRB calculation discussed in Section VII above, CMS finalized its proposal to exclude all observation beds and patient days from the DSH calculation. Currently, hospitals are instructed to include observation bed days in this count for patients who ultimately are admitted as inpatients. Under the new policy, no observation bed days will be included, regardless of whether patients ultimately are admitted for inpatient care. CMS stated that the cost report will be changed to accommodate this policy change.

Analysis

CMS states that some hospitals will gain from this proposal and others will lose, depending on how the exclusion of observation patient days affects the hospital's overall DPP. At the same time, however, CMS indicates (without explaining why) that this proposal would have an aggregate negative effect on DSH hospitals, as the Agency predicts that this policy change will result in a reduction in DSH payments by $10 million for FY 2010.

IX. REBASING THE HOSPITAL MARKET BASKETS (pages 354-80)

Background

The "basket" in the phrase "market basket" refers to the mix of goods and services hospitals purchase to furnish inpatient care. Each type of good and service (e.g. employee wages) is given a "weight" such that the total of all of the weights in the market basket equals 100 percent. The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchase in order to furnish inpatient care. CMS is required to rebase the hospital market baskets every four years.

Proposed Rule

CMS finalized its proposal to rebase and revise the hospital operating and capital market baskets used as the basis for setting the standardized payment update. Among other changes, CMS updated the market baskets to reflect FFY 2006, rather than 2002, cost data.

Analysis

Having updated and accurate hospital market baskets is important because of their role in determining the update to the DRG standardized payment rate.

X. HOSPITAL ACQUIRED CONDITIONS (pages 136-48)

Background

To focus on the problem of hospital-acquired infections, the Deficit Reduction Act (DRA) required the Secretary to identify at least two conditions that: are high cost, high volume, or both; result in a higher weight DRG assignment when the condition is present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence-based guidelines.

Effective October 1, 2008, any claim submitted that included one of the selected conditions, and for which the condition was not documented as being present on admission (POA), and is the only complication or comorbidity (CC) or major complication or comorbidity (MCC) listed, is no longer reimbursed at the rate of the higher paying DRG. In other words, claims are now paid as if the complication did not occur.

The current list of Hospital Acquired Condition (HAC) categories is as follows:

- Foreign object retained during surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers
- Falls and Trauma
- Catheter Associated Urinary Tract Infection
- Vascular Catheter Associated Infection
- Surgical site infection – Mediastinitis after Coronary Artery Bypass Graft (CABG)
- Surgical Site Infections Following Certain Orthopedic Procedures
- Surgical Site Infections Following Bariatric Surgery for Obesity
- Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hypersmolar Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hypersmolarity
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic surgeries, specifically hip and knee replacements surgeries.

Final Rule

For FFY 2010, CMS finalized the Agency's proposal not to add or delete any conditions to the current list of HACs nor make any changes to POA reporting or payment. CMS finalized one refinement to the current "falls and trauma" category to include the following diagnosis codes:

- 813.46 Torus fracture of ulna
- 813.47 Torus fracture of radius and ulna

CMS will be conducting an evaluation of the impact of the HAC program through a joint agreement with the Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare Research and Quality (AHRQ). The evaluation will be based on early program data and will focus on the selection and maintenance of the HAC categories and the reporting of POA data. As a result of comments received from the proposal rule, CMS will be looking at including unintended consequences, adherence to evidence based guidelines as part of the scope of the project, as well as providing for public input and review.

XI. REPORTING HOSPITAL QUALITY DATA FOR ANNUAL HOSPITAL PAYMENT UPDATE (RHQDAPU) (pages 420-551)

Background

Under the hospital quality reporting program, hospitals must submit data on selected quality performance measures to receive their full market basket update. As stated above, the penalty for not reporting the full set of quality measures is a reduction in the payment update by 2 percentage points. For the FFY 2010 payment determination, there are 44 required measures: 26-chart-abstracted measures; 16 claims-based measures; one structural measure; and HCAHPS, the Patient Experience of Care Survey.

Final Rule

CMS finalized the addition of four new measures (two chart-abstracted and two structural measures), to the quality reporting program which are required for the FY 2011 payment determination. The measures are as follows:

- SCIP-Infection-9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
- SCIP-Infection-10 Perioperative Temperature Management
- Participation in a Systematic Clinical Database Registry for Stroke Care
- Participation in a Systematic Clinical Database Registry for Nursing Care

Data submission for the two proposed SCIP measures will begin with first calendar quarter discharges for 2010. For the two structural measures, hospitals will indicate through a web-based tool on Quality Net Exchange whether or not they participate in this type of registry, just as they must for the Cardiac Surgery Registry measure required for FY 2010. The proposed rule would have required hospitals to report on their registry participation on a quarterly basis; however, CMS modified the requirement in the final rule so hospitals will only report on an annual basis.

The rule also finalized the retirement of the AMI-6 Beta blocker at arrival measure, which was removed from the RHQDAPU program in December 2008 because of a change in science. In addition, CMS finalized the Agency's plans to harmonize the two "Failure to Rescue" measures

included in the Nursing Sensitive measure set and the AHRQ Patient Safety Indicator set. These measures will, however, still be reported separately on the Hospital Compare website.

Possible Measures for FFY 2012

CMS included in the final rule a list of possible measures to be evaluated for inclusion in the FY 2012 payment determination. This is not an all-inclusive list but provides some insight into CMS's interests moving forward. The measures are in the broad areas of Emergency Department Throughput, Stroke, Venous Thromboembolism (VTE), Cardiac Surgery, Acute Myocardial Infarction (AMI), Percutaneous Coronary Intervention (PCI), Outcomes, Nursing Sensitive, and Hospital Acquired Infections.

Validation Process

The validation process for the FY 2011 payment determination will not change. However, CMS will be implementing a new validation process for the RHQDAPU program for FY 2012. The new process is similar to what was included in the proposed Value Based Purchasing Report sent to Congress in November 2007.

Under the new process, CMS will randomly select 800 hospitals on an annual basis to participate in the validation program. The selected hospitals will be asked to submit 12 cases per quarter in the selected topic areas for validation. For FY 2012, CMS will validate three quarters of data (first calendar quarter 2010 through third calendar quarter 2010 discharges) with the intention of validating four quarters of data (fourth calendar quarter 2010 through third quarter 2011 discharges) for FY 2013 and subsequent years.

A validation score would be calculated for each quarter and then the three quarters would be pooled to calculate a single validation score. Each hospital would need a score of 75 percent or higher to pass validation. This is a decrease from the current 80 percent threshold. CMS did acknowledge that after evaluating the results of the validation program in the first year, the Agency may need to make adjustments in subsequent years. It is also important to note that the results of the validation for the selected hospitals will have no impact on the hospitals that were not selected for validation.

Data Accuracy and Completeness Acknowledgement

For FFY 2011 payment determination and future years, CMS finalized the requirement that hospitals submit an electronic acknowledgement that the data submitted is complete and accurate to the best of their knowledge. Hospitals will be required to complete the acknowledgement through the same web-based tool used to report on the structural measures between January 1, 2010 and August 15, 2010.

Public Reporting with Multiple CMS Certification Numbers (CCNs)

Currently, hospitals that share the same CCN must combine the data collection and submission process across the multiple campuses and report a single score as though the multiple campuses

belong to a single hospital. CMS estimates that 5 to 10 percent of hospitals fall in this category. To provide more transparency, CMS will now be indicating on the Hospital Compare website where multiple hospitals are sharing a CCN number and therefore are reporting combined data across more than just one hospital.

Reporting Quality Data through Electronic Health Records

In conjunction with the requirements for Health Information Technology (HIT) through the American Recovery and Reinvestment Act (ARRA), the final rule reiterates the steps CMS is taking toward the reporting of quality data through electronic health records (EHR).

CMS is currently working with the Healthcare Information Technology Standards Panel (HITSP) to develop standards for the reporting of three measure sets through EHR data submission, including emergency department throughput, stroke, and venous thromboembolism. It is expected that the standards for these measure sets will be finalized and available for review and testing by late 2009. A testing and review process will be put in place for vendors and hospitals as early as July 2010. A *Federal Register* notice will be published seeking comments on the process for testing and the selection of hospitals and vendors to participate in the testing. Any hospital interested in self-nominating for participation in the testing process can submit a letter of interest by December 31, 2009 to:

RHQDAPU Program IT Testing Nomination
Centers for Medicare and Medicaid Services
Office of Clinical Standards and Quality
Quality Measurement and Health Assessment Group
7500 Security Boulevard
Mail Stop S3-02-01
Baltimore, MD 21244-8532

Analysis

The Health Information Technology for Economic and Clinical Health (HITECH) Act included in the ARRA provides financial incentives for hospitals and physicians to implement and maintain EHR systems. The law states that in order to receive the incentive, the hospital or physician must be a “meaningful user.” While a specific definition of “meaningful user” is still being determined, the law states that a meaningful user must be able to report on quality measures to CMS utilizing an EHR. Since many COTH-member hospitals have already implemented, to some degree, an electronic health record system, we continue to welcome your insights on the key issues you have seen or envision as problematic for reporting quality measures specifically in teaching hospitals.

XII. PAYMENTS FOR NEW TECHNOLOGIES (pages 219-81)

Background

Pursuant to a provision in the Benefits Improvement and Protection Act of 2000, in the September 7, 2001 final rule (66 Fed. Reg. 46902), CMS established a methodology that would provide additional payments to hospitals for new technologies that they use that are not yet reflected in the MS-DRG payment system. To qualify for the additional payments, the new service or technology must meet thresholds related to "new," "significant improvement" over the current service, and "inadequate payment" under the MS-DRG system. (See the AAMC Summary and Analysis of the proposed rule for a more complete discussion of these criteria.)

In addition, in the FFY 2006 IPPS final rule, CMS established certain conditions that would allow new technology add-on payments for the new use of an existing technology. Specifically, the new use of the existing technology cannot be substantially similar to the use of the existing technology. The final rule included two factors to consider in determining whether the two technologies are "substantially similar": (1) whether the product uses the same or a similar mechanism of action to achieve a therapeutic outcome; and (2) whether the product is assigned to the same or a different MS-DRG.

The additional payments are not subject to budget neutrality restrictions. Thus, funding for the new technology need not be offset by decreased funding for all other inpatient services. The cost threshold for new technologies to qualify for add-on payments is the lesser of 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation above mean charges for the MS-DRG involved.

Final Rule

Of the five applications included in the proposed rule, three (the AutoLITT™ System, CLOLAR® (clofarabine) Injection, and TherOx Downstream® System) withdrew their applications. CMS did not approve add-on payments for LipiScan™ Coronary Imaging System, because, according to the Agency, it did not meet the substantial clinical improvement criterion. CMS approved add-on payments of $3,437.50 for Spiration® IBV® Valve System.

The Agency finalized its proposal to add a third criterion for determining whether the new use of an existing technology is substantially similar to the use of the existing technology. Thus, if an existing technology is used for the treatment of a different type of disease or different patient population, the new indication would not be considered substantially similar to a previous indication and would consequently become eligible for the new technology add-on payment. The AAMC supported this proposal in its comment letter.

XIII. PROPOSED CHANGES TO EMTALA WAIVER REGULATIONS (pages 657-72)

Background

The Emergency Medical Treatment and Labor Act (EMTALA), also commonly referred to as the patient "anti-dumping" statute, imposes certain obligations on Medicare-participating hospitals regarding the examination and treatment of individuals who come to a hospital emergency department for examination or treatment of a medical condition. EMTALA also permits the temporary waiver of several of the Act's requirements in emergency areas during emergency periods. In the FFY 2008 and FFY 2009 final rules, CMS revised the regulations implementing EMTALA to incorporate changes to the waiver of sanctions provisions made by the Pandemic and All-Hazards Preparedness Act.

Final Rule

CMS adopted the three proposed amendments to the EMTALA regulations. The goal of the final regulations is to make them more consistent with the EMTALA statute by: (1) permitting waiver of EMTALA sanctions for inappropriate transfer and relocation only if the hospital does not discriminate based on the source of an individual's payment or ability to pay; (2) permitting the Secretary to apply a waiver of EMTALA sanctions only to a portion of an emergency area or to a portion of an emergency period; and (3) requiring that the "inappropriate transfer" arise out of the circumstances that gave rise to the emergency.

Analysis

In response to comments that certain proposed regulatory language lacked clarity, CMS revised the language in the final rule. To clarify that an individual's emergency medical condition need not be a direct result of the public health emergency for sanctions to be waived, CMS revised the regulatory text of 42 CFR § 489.24(a)(2)(i)(A) to state: "The transfer is necessitated by the circumstances of the declared emergency area during the emergency period."

XIV. CHANGES TO GOVERNANCE AND CONTROL CRITERIA FOR SATELLITE FACILITIES OF HOSPITALS (pages 706-16)

Background

A satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in a building located on the same campus as buildings used by another hospital. Satellite facilities meeting certain regulatory requirements are exempt from the inpatient prospective payment system.

Final Rule

To eliminate an inadvertent inconsistency in governance and control criteria in two sections of the regulations, CMS finalized the Agency's proposal to add a separate governing body

requirement to the satellite facility regulations. This will ensure that a satellite facility is not merely a unit of the acute care hospital with which it is co-located, but rather is organizationally and functionally separate from the hospital. Under the final regulations, the satellite facility may not be under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located. The final rule includes a grandfathering provision that imposes the new requirement only on satellite facilities established in cost reporting periods beginning on or after October 1, 2009.

XV. OTHER TOPICS IN THE FINAL RULE THAT MAY BE OF INTEREST TO AAMC MEMBERS

- Changes to the Long-Term Care Hospital PPS for RY 2010 (pages 768-872)
- Changes Affecting Critical Access Hospitals (pages 717-47)
- Geographic Reclassification Criteria (pages 333-36)

If you have any questions regarding the final rule or this summary, or additional issues of which we should be aware, please contact Jennifer Faerberg, jfaerberg@aamc.org (quality issues), Diana Mayes, dmayes@aamc.org (new technology and outlier payments), or Lori Mihalich-Levin, lmlevin@aamc.org (GME and all other issues). Any of these staff members may also be reached by calling 202-828-0490.