May 18, 2010

AAMC Summary and Analysis

FISCAL YEAR 2011 MEDICARE HOSPITAL INPATIENT PPS PROPOSED RULE: PROVISIONS OF INTEREST TO THE ACADEMIC MEDICAL COMMUNITY

On April 19, 2010, the Centers for Medicare & Medicaid Services (CMS or the Agency) published its annual proposed rule containing changes to the Medicare hospital inpatient prospective payment system (IPPS) and the PPS payment update for Federal fiscal year (FFY) 2011 as a display copy. The proposed rule was then published in the Federal Register on May 4, 2010, at 75 Fed. Reg. 23852, http://edocket.access.gpo.gov/2010/pdf/2010-9163.pdf. If finalized, changes will take effect for discharges on or after October 1, 2010.

Comments on the proposed rule are due **June 18, 2010**.

Under the proposed rule, CMS proposes to update the IPPS market basket by 2.4 percent, but also to make a corresponding "documentation and coding" reduction of 2.9 percentage points. The agency believes this offset is necessary to remove one-half of what CMS believes to be the overpayments made to hospitals in FYs 2008 and 2009 due to changes in hospital coding practices that do not reflect increases in patients' severity of illness. This proposed coding adjustment will result in a negative overall update to hospital payment rates. CMS predicts that the net effect of the proposed rule would be to reduce operating and capital payments to acute care hospitals by $162 million in FY 2011.

Importantly, the proposed rule does *not* contain any provisions related to the recently-enacted Patient Protection and Affordable Care Act (PPACA, Pub. L. 111-148), including a 0.25 percentage point reduction to the FY 2011 update. Rather, CMS plans to issue separate regulations in the near future to implement provisions of the health reform legislation that affect inpatient hospitals.

Highlights of the Proposed Rule Include:

- 2.4 percent market basket update, with a -2.9 percent coding offset
- 4 percent increase in the outlier payment threshold
- Clarification of the definition of an "approved medical residency program"
- Three year plan for Quality Reporting Program (RHQDAPU)
- Proposed deadline of October 1, 2011, for ICD-9-CM and ICD-10 code updates

I. IPPS PAYMENT RATE UPDATE

Proposed Rule

For FFY 2011, the proposed rule would implement a full market-basket increase (currently estimated at 2.4 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 0.4 percent. An additional reduction of 0.25 percentage points is required by PPACA, but this reduction will be implemented through a separate proposed rule.

Analysis

The actual update will reflect the most recent estimate of the market basket increase at the time the final rule is published in early August. As mentioned above, the average estimated actual change in per case payments will be less than the market basket increase due to a documentation and coding offset and other budget neutrality requirements.

II. DOCUMENTATION AND CODING OFFSET (pages 23865 – 23876)

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 disproportionate share hospital (DSH) or indirect medical education (IME) payments).

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 were 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 percent 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 (P.L. 110-90) reduced the coding adjustment to -1.5% (-0.6% in FY 2008 and -0.9% in FY 2009).

Importantly, however, P.L. 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 indicated 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.

For the FY 2010 proposed rule, CMS estimated the documentation and coding increase in FY 2008 to be 2.5 percent. In the FY 2010 final rule, CMS confirmed its proposed rule analysis and conclusions but chose not to make any prospective or retrospective adjustments in FY 2010 for documentation and coding-related increases occurring in FY 2008. The final rule stated, "we believe that it would be more prudent to delay implementation of the documentation and coding adjustment to allow for a more complete analysis of FY 2009 claims data. If the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change, possibly lessen, the anticipated cumulative adjustments that we currently estimate we would have to make for FY 2008 and FY 2009 combined adjustment." CMS also indicated that the Agency would 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. During this phase-in, the agency also would address any difference between the documentation and coding-related case-mix increase in FY 2009 and the -0.9 percent prospective documentation and coding adjustment applied in FY 2009 under P. L. 110-90.

Proposed Rule

For the FY 2011 proposed rule, CMS performed the same analysis on FY 2009 claims data and used the same methodology as the Agency did on FY 2008 claims data for the FY 2010 proposed and final rules. Based on its analysis, CMS estimates that the documentation and coding increase in FY 2009 not reflective of real changes in case mix was 5.4 percent. Compared to the prospective adjustments of 0.6 and 0.9 percentage points made in FYs 2008 and 2009 respectively, for a cumulative prospective adjustment of 1.5 percentage points, the actual 5.4 percent increase in FY 2011 represents a gap of 3.9 percentage points. Thus, the proposed rule states that 3.9 percent of FY 2009 payments represent excess payments to be recovered – about $6.9 billion, with appropriate interest as required by law. Combined with the 1.9 percent in

excess FY 2008 payments (about $2.2 billion) stemming from a documentation and coding increase of 2.5 percentage points in FY 2008 compared to a 0.6 percentage point prospective adjustment, CMS reports that the total amount of excess payments to be recovered is 5.8 percent – or about $9.1 billion plus interest.

Pub. L. 110-90 requires CMS to recover the excess payments by the end of FY 2012. The FY 2011 proposed rule reduces the PPS standardized amounts by 2.9 percentage points in FY 2011 to recover about one-half of the excess payments. Because it is meant just to recoup excess payments, the adjustment to the standardized amounts is temporary. However, CMS anticipates removing the other half (2.9 percent) from the rates in FY 2012. These two steps in FY 2012, restoring the -2.9 percent adjustment made in FY 2011, and applying the remaining adjustment of approximately -2.9 percent, would effectively cancel each other out. The result would be an aggregate adjustment of approximately 0.0 percent (subject to the need to account for accumulated interest) in FY 2012.

As noted, Pub. L. 110-90 requires CMS to make prospective adjustments to correct the rates going forward to avoid making future excess payments. Through FY 2009, the cumulative increase in documentation and coding not reflective of real CMI increases is 5.4 percentage points, and the cumulative prospective adjustment made through FY 2009 is 1.5 percentage points, leaving 3.9 percentage points to be made in future prospective adjustments. In the proposed rule, CMS states that the law gives the Agency discretion concerning when to make these prospective adjustments – and no adjustment is proposed for FY 2011.

Analysis

CMS's data analysis concludes that there was no "real" case mix increases in FYs 2008 and 2009, and therefore the entire case mix change is due to documentation and coding. The AAMC is concerned that CMS's analytical framework fails to identify real case mix increases and thus overstates the impact of documentation and coding. The AAMC is working with other hospital associations to do in-depth data analyses that would help to identify real case mix changes.

III. PROPOSED CHANGES TO THE HOSPITAL WAGE INDEX (pages 23936 – 23956)

A. 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."

Proposed Rule

CMS is not proposing to make any changes to the labor-related share. The labor-related share will remain at 68.8 percent for hospitals with wage indices greater than 1.0. (The labor-related share for hospitals with wage indices less than 1.0 will remain at 62 percent, as required by the Medicare Modernization Act.)

B. Occupational Mix Adjustment

Background

The Benefits Improvement and Protection Act of 2000 (BIPA) mandates that the hospital wage index be adjusted to reflect the occupational mix of employees. 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). Pursuant to the statute, data on the occupational mix of employees for each hospital is to be collected every three years.

Proposed Rule

For FY 2011, the wage index values for each labor market area will be based on data submitted by hospitals for cost reporting periods that began in FY 2007. Note that the wage data collected on FY 2007 cost reports include overhead costs for contract labor. The wage index values will also reflect an occupational mix adjustment based on the 2007-2008 occupational mix survey, the most recent occupational mix survey. CMS proposes to adjust 100 percent of the wage index for occupational mix.

The response rate for the 2007-2008 occupational mix survey 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 2011 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.

The new 2010 occupational mix survey instrument was published in the *Federal Register* on January 15, 2010, and will be applied to the FY 2013 wage index. In response to comments, CMS will be using calendar year 2010 as the one-year collection period, instead of the July 1 through June 30. Hospitals will have a six-month period (until July 1, 2011) after the end of the survey reporting period to complete and submit their data to their Medicare fiscal intermediaries (FIs/MACs).

CMS expressed ongoing concern about the increasing number of hospitals that do not submit occupational mix data and the impact the declining response rate may have on area wage indices. The Agency has tried to address this issue in the past and has considered the application of a hospital-specific penalty to hospitals that fail to submit occupational mix survey data. However, CMS is not proposing to apply a penalty, but rather to require hospitals that do not submit

occupational mix data to provide an explanation for not complying with the submission requirements, beginning with the new 2010 occupational mix survey.

C. Wage Index Reform

(i) Acumen's Final Report on Analysis of the Wage Index Data and Methodology

Background

Section 106(b)(1) of the MIEA-TRHCA (Pub. L. 109-432) required MedPAC to submit to Congress, by June 30, 2007, a report that includes MedPAC's recommended alternative methodology to compute the wage index under the Medicare IPPS. The law also required that CMS include one or more proposals to revise the wage index adjustment, taking into account MedPAC's recommendations on the Medicare wage index classification system.

In the FY 2010 IPPS final rule, CMS noted that the Agency had contracted with Acumen LLC to study and report on the MedPAC report. The study resulted in a two-part final report. The first part analyzed the strengths and weaknesses of the data sources used to construct the MedPAC indexes compared to those used by CMS for the same purpose. The second focused on the methodology of wage index construction.

Acumen concluded that MedPAC's recommended methods for revising the wage index represent an improvement over the existing methods. For example, in the first part of its report, Acumen recommended the use of the Bureau of Labor Statistics (BLS) data used by MedPAC. With regard to the methodology used for wage construction, in the second part of its report, Acumen found that MedPAC's recommended method of improving upon the definition of the wage areas used in the wage index is also an improvement, in that it diminishes the size differences between adjacent areas.[1] However, this method does not guarantee an accurate representation of a hospital labor market and would not necessarily reduce hospitals' need to reclassify for a higher wage index. Acumen recommended further exploration of the labor market area definitions using a wage area framework based on hospital-specific characteristics, such as commuting time from hospitals to population centers, to construct a more accurate hospital wage index. Both reports are available at: http://www.acumenllc.com/reports/cms.

Proposed Rule

CMS is not proposing any changes at this time regarding reforming the wage index. However, the Agency is soliciting comments on the second part of Acumen's final report.

[1] MedPAC's method first blends Metropolitan Statistical Areas (MSA) and county-level wages and then implements a "smoothing" step that limits differences in wage index values between adjacent counties to no more than 10 percent.

(ii) Reclassification Policies and Budget Neutrality Adjustment for Rural and Imputed Floors

Background

In response to MedPAC's recommendations in its June 2007 Report to the Congress, CMS made two changes to the hospital wage index in the FY 2009 IPPS final rule. The rule tightened the criteria to qualify for reclassifications and replaced the national budget neutrality adjustment for the rural and imputed floor with a state level budget neutrality adjustment.

Specifically, the reclassification policies adopted as part of the FY 2009 IPPS final rule increased the minimum average hourly wage index of the area to which an urban hospital seeks reclassification from 84 percent to 88 percent and for rural hospitals, from 80 percent to 84 percent. The change was going to be implemented over a two-year transition period, from FY 2010 to FY 2011. However, Section 3137 as modified by Section 10317 of the PPACA (P.L. 111-148), restored the minimum average hourly wage to 84 percent for urban hospitals and 80 percent for rural hospitals, effective FY 2011. These changes will be addressed in a separate rulemaking, and these percentages would remain in effect until one year after the Secretary submits a required hospital wage index improvement plan. The report is due no later than December 1, 2011.

The second important change that CMS made in the FY 2009 IPPS final rule was to apply the rural and imputed rural floor budget neutrality adjustments to the wage index at the state rather than the national level. The rural floor provision requires CMS to give urban hospitals within a state, a wage index that is no less than the applicable rural wage index in that state. Similarly, the imputed rural floor provision is intended to protect hospitals in states that have no rural hospitals and therefore no rural floor. Prior to the FY 2009 IPPS final rule, payments to hospitals to which a rural or imputed rural floor applies were subsidized through the application of a national budget neutrality adjustment to the standardized amount, which in effect lowers payments to hospitals nationwide. Under the FY 2009 final rule, the budget neutrality adjustment would be applied at the state level, so that the increase in payments to hospitals that receive the rural or imputed rural floor in a state would be subsidized by a decrease in payments for the hospitals in that state only. This change was to be implemented over a three-year period from FY 2009 to FY 2011. However, Section 3141 of PPACA reinstated the pre-FY 2009 IPPS rule policy so that, effective FY 2011, CMS would apply a national budget neutrality adjustment for the rural and imputed floor. CMS will address this reinstatement in a future rulemaking.

Proposed Rule

CMS will be addressing the PPACA changes related to the reclassification policies and the budget neutrality adjustment for the rural and imputed floor in separate rulemaking documents.

IV. OUTLIER PAYMENT THRESHOLD (pages 24067 – 24070)

Background

If the costs of a particular Medicare case exceed the relevant MS-DRG operating and capital payment (including any DSH, indirect medical education (IME), or new technology add-on payments) plus a fixed-loss cost threshold, the hospital will receive an outlier payment. This payment equals 80 percent of the case's costs above the threshold calculation.

Outlier payments are funded through a 5.1 percent reduction in the PPS standardized payment amount. Consequently, CMS sets the outlier cost threshold at a level the Agency believes will result in outlier payments that equal 5.1 percent of total DRG payments.

Proposed Rule

The proposed rule would increase the fixed-loss cost threshold for outlier payments to be equal to a case's MS-DRG payment plus any IME and DSH payments, and any additional payments for new technologies, plus $23,970, up from $23,140 in FY 2010. The threshold would be applicable for both operating and capital outlier payments.

Analysis

According to CMS's estimates, a $23,970 outlier threshold would result in total outlier payments of 5.1 percent of total DRG payments. CMS estimates that outlier payments represented 5.4 percent of total DRG payments in FY 2009, 0.3 percentage points higher than the 5.1 percent target. For FY 2010, the Agency estimates that outlier payments were 4.7 percent of total DRG payments, approximately 0.4 percentage points lower than the 5.1 percent target. CMS does not make retroactive adjustments to outlier payments to ensure that they meet the 5.1 percent target. However, because CMS believes it will pay out the full 5.1 percent of outlier payments in FY 201l, when computing the estimated payment impact of the proposed rule, CMS assumes hospitals, in aggregate, will receive 0.4 percentage points more (5.1 minus 4.7) in overall payments than they did in FY 2010.

V. PROPOSALS AFFECTING BOTH DGME AND IME PAYMENTS

A. Clarification of the Definition of "Approved Medical Residency Program" (pages 24007 – 24009)

Background

Teaching hospitals receive direct graduate medical education (DGME) and indirect graduate medical education (IME) payments for residents in "approved medical residency training programs" up to a hospital-specific resident limit (the hospital's "cap"). Hospitals do not receive DGME and IME payments for physicians who are not part of approved medical residency programs; rather, these physicians, if appropriately licensed and meet all applicable Medicare requirements, bill for their services under Medicare Part B.

Proposed Rule

The proposed rule would clarify the term "approved medical residency program" and revise the regulatory definitions of "resident" and "primary care resident" (at 42 C.F.R. § 413.75(b)). The regulatory definition of "approved medical residency program" (which CMS does not propose to change), is a program that meets *one* of the following criteria: (1) is approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the American Dental Association (ADA), or the American Podiatric Medical Association (APMA); (2) "may count towards certification of the participant in a specialty or subspecialty" listed in the American Medical Association's (AMA's) Directory of Graduate Medical Education Programs or the American Board of Medical Specialties' (ABMS's) Annual Report and Reference Handbook; (3) is approved by the ACGME as a fellowship program in geriatric medicine; or (4) is a program that would be accredited but for requirements relating to induced abortions. Thus, in general, an approved program is one that is accredited by a national organization or that leads to board certification.

The regulations currently define a "resident" as "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" and a "primary care resident" as "a resident who is enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice." In the proposed rule, CMS states that under these definitions, hospitals have expressed confusion regarding whom to include in a hospital's DGME and IME FTE count.

CMS proposes to revise the definitions of "resident" and "primary care resident" for cost reporting periods beginning on or after October 1, 2010, to change the phrases "who participates in" and "who is enrolled in" to "who is formally accepted, enrolled, and participating in" an approved medical residency program. CMS states that the agency will focus on two factors in determining whether an individual is a resident whose time may be counted for DGME and IME payments: (1) whether the individual "actually <u>needs</u> the training in order to meet board certification requirements in <u>that</u> specialty; <u>and</u>" (emphasis in original) whether the individual "is formally participating in an organized, standardized, structured course of study." In short, training that is not done under the auspices of a national accrediting body and for which there is no existing board certification examination may not be counted for DGME or IME purposes.

In the proposed rule, CMS also elaborates that to be considered a resident, an individual must be (1) formally accepted and enrolled in the training program; and (2) fully participating in that training (unless there is a documented arrangement for the resident to work part time). CMS explains that formal acceptance should include an application process and an enrollment process, which would include letters or other official notifications from the hospital or program sponsor about the resident's acceptance into the program. CMS also expects the resident to have an employment contract with the institution(s) sponsoring the program and/or the institution(s) where the resident is training.

Analysis

The AAMC does not believe that CMS's clarification represents a significant change to the Agency's method of distinguishing between residents and billing physicians. We encourage you to consider and communicate with us regarding: (1) how this proposal affects how you have viewed the Chief Residents in your program; (2) how this clarification compares with how you currently capture residents within your IRIS reporting; (3) whether there are physician training programs that do not lead to certification by a "medical specialty board" but that you believe legitimately should be considered to meet the definition of "resident"; (4) whether you anticipate any programmatic, documentation, or credentialing issues as a result of this clarification.

We also note that it is not clear from the proposed rule whether CMS intended to eliminate the use of Line 70 of Worksheet B-1 of the Medicare hospital cost report, which currently allows hospitals to enter the costs of interns and residents not in approved teaching programs. In the proposed rule CMS described residents whose time may be claimed for DGME and IME payments as well as physicians who may bill the Medicare program, but the Agency did not appear to contemplate the third category of residents whose time may not be claimed and who also may not bill. The AAMC will ask CMS to verify that the Agency did not intend to eliminate the use of Line 70 of Worksheet B-1.

The AAMC encourages you to provide us with any other comments and insights you may have on the effects of this proposed clarified definition on your institution.

B. Permitting Electronic Submission of GME Affiliation Agreements (pages 24009 – 24010)

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.

Proposed Rule

CMS proposes to increase flexibility in the method by which hospitals submit their Medicare GME affiliation agreements to CMS. Current regulations require each hospital in a GME affiliated group to submit its Medicare GME affiliation agreement to its intermediary or Medicare Administrative Contractor (MAC) and the CMS Central Office no later than July 1 of the residency program year during which the agreement would be in effect. Until now, CMS has only accepted signed hard copies of the Medicare GME affiliation agreements that have been received through the mail. Facsimile (FAX) and electronic submissions have not been permitted.

CMS's proposal permits a hospital to submit affiliation agreements to the CMS Central Office electronically. The agency is proposing an electronic submission process that would consist of either an e-mail mailbox or a Web site where hospitals could submit their affiliation agreements.

Agreements would be required to be received by the electronic system by 11:59 p.m. on July 1 of each academic year, and agreements would have to be submitted as a scanned or PDF version of the signed and dated hard copy agreement.

Analysis

The proposed rule would allow hospitals to avoid the postage and paperwork burdens associated with mailing affiliation agreements to CMS. The AAMC supports this proposal and will recommend that CMS provide hospitals with an electronic receipt for each electronically submitted agreement, so that hospitals may have documentation that they completed the submission requirements. We also encourage you to share with us any concerns you may have about this proposal.

VI. CHANGES AFFECTING THE MEDICARE DISPROPORTIONATE SHARE (DSH) ADJUSTMENT (pages 24002 – 24007)

Background

In response to the court decision in *Baystate Medical Center v. Leavitt*, CMS proposes to revise its data matching process for the SSI fraction of the Medicare DSH adjustment formula. The District Court concluded: (1) that the SSI eligibility data CMS used failed to include stale and forced pay SSI records; (2) that CMS's use of only a single Title II number and one Health Insurance Claims Account Number (HICAN) was faulty; and (3) that the match process used did not appropriately account for retroactive SSI eligibility determinations and lifting of payment suspensions.

Proposed Process for Matching Medicare and SSI Eligibility Data

A. Inclusion of Stale Records and Forced Pay Records in the SSI Eligibility Data Files

All SSI payment records are now, and will continue to be, included in the data files provided by the Social Security Administration (SSA). This includes payments that were automated or manual or were for an individual whose record was active or stale.

B. Use of SSNs in the Revised Match Process

Databases Used:

The SSI eligibility data file contains a unique SSN for every SSI record and will include up to 10 different Title II numbers for the records related to one individual. The Medicare Enrollment Database (EDB) contains a SSN for virtually every record in the EDB and can hold up to 10 historical HICANs for a specific Medicare enrollee. The MedPAR file contains Medicare hospital inpatient claims provided to Medicare beneficiaries and includes one HICAN number for each and every record of services provided to a Medicare beneficiary admitted to a Medicare-certified hospital or skilled nursing facility. It does not contain SSNs.

Revised Match: 4-Step Process:

1. CMS's proposed revised match process would use the Medicare EDB, which includes SSNs as well as all of an individual's HICANs.

2. CMS proposes to compare the complete list of Title II numbers from the SSI eligibility data file (up to 10 Title II numbers for any one individual) to the list of HICANs generated through Step 1. Any Title II numbers not already identified in Step 1 will be compared to any and all HICANs in MedPAR.

3. CMS will further ensure consistency among the HICANs in the EDB, the Title II numbers, and the HICANs in the MedPAR file by converting the Beneficiary Identification Code (BIC) identifiers to the identifiers indicated on inpatient claims in the MedPAR file. CMS also proposes to attempt to match beneficiaries' HICANs in the MedPAR file for those SSI-eligible beneficiaries receiving Medicare benefits based on their own account but whose records have not already been matched.

4. CMS would calculate the SSI fraction in the same manner as it has done in the past.

C. Timing of the Match

CMS notes that section 6404 of PPACA requires the submission of hospital inpatient claims no later than 1 year after the date of service or by September 30, 2012, for claims with a September 30, 2011, service date. For FY 2011 and subsequent years, CMS proposes 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 versus the 6 months under current practice. CMS believes use of claims data that are updated 15 months after the close of the Federal fiscal year would provide it with the best available data. CMS expects to publish the FY 2011 SSI fractions around March 2013, which would be used to settle cost reports for reporting periods beginning during FY 2011. CMS would also continue using each hospital's latest available SSI fraction to determine IPPS interim payments.

CMS Rulings:

CMS prepared a Ruling addressing CMS's process for matching Medicare and SSI eligibility data and calculating hospitals' SSI fractions that required the Medicare administrative appeals tribunal to remand each qualifying appeal to the appropriate Medicare contractor. On remand, for a provider with a cost report that is not a final settled report, CMS and the contractor will recalculate the provider's DSH payment adjustment and make any payment owing, by applying the provisions of the Ruling, on the data matching process issue (and two other DSH issues, as applicable).

For hospitals for which this issue is of particular concern, please see pages 24002 – 24007 of the proposed rule.

VII. HOSPITAL ACQUIRED CONDITIONS (HACs) (pages 23880 – 23898)

Background

Since October 1, 2008, an inpatient hospital discharge is not assigned to a higher paying MS-DRG if a selected HAC was not present on admission (POA). That is, the case will be paid as though the secondary diagnosis was not present. The selected HACs are among those that CMS determines (1) are high cost, high volume or both, (2) would result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (3) could reasonably have been prevented through the application of evidence based guidelines.

The current list of HAC categories is as follows:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III and IV
- Falls and Trauma
- Catheter-Associated UTI
- Vascular Catheter-Associated Infection
- Poor Glycemic Control
- Surgical Site Infection, Mediastinitis Following Coronary Artery Bypass Surgery (CABG)
- Surgical Site Infection following Certain Orthopedic Procedures
- Surgical Site Infection following Bariatric Surgery for Obesity
- Pulmonary Embolism & DVT (Orthopedic)

Proposed Rule

For FY 2011, CMS is not proposing any additions or deletions to the current list of HACs nor any changes to the POA reporting or payment requirements. Rather, CMS proposes only one refinement, to replace ICD-9-CM code 999.6 (ABO blood incompatibility reaction) with a new ICD-9-CM subcategory of five codes.

CMS also uses the proposed rule to discuss some of the findings of an ongoing evaluation of the HAC-POA policies being conducted by Research Triangle Incorporated (RTI). In the final rule, CMS intends to update its summary of these analyses with additional data that have become available.

VIII. REPORTING HOSPITAL QUALITY DATA FOR ANNUAL HOSPITAL PAYMENT UPDATE (RHQDAPU) (pages 23956 – 23997)

Background

Under the hospital quality reporting program, hospitals must submit data on selected quality performance measures to receive their full market basket update. The penalty for not reporting the full set of quality measures is a reduction in the payment update by 2 percentage points. For

the FY 2011 payment determination, there are 45 required measures: 27-chart-abstracted measures; 15 claims-based measures; three structural measures; and HCAHPS, the Patient Experience of Care Survey.

Proposed Rule

Historically, CMS has proposed a set of measures for inclusion in the payment determination for the next fiscal year. For the first time, CMS proposed measures for the next three years (FY 2012 - FY 2014), providing a road map for hospitals as to what to expect in the upcoming years. CMS clarifies, however, that the Agency may not finalize all of the measures for the out years in this rulemaking.

FY 2011

For the FY 2011 payment update, CMS proposes to retire one measure from the original list of 46 measures finalized in the FY 2009 final rule. The AHRQ composite measure, Mortality for Selected Surgical Procedures, is proposed for retirement, because it did not obtain NQF endorsement and was not recommended for comparative reporting. Therefore, the FY 2011 payment update will be calculated based on the remaining 45 measures.

FY 2012

CMS proposes to add 10 additional measures for the FY 2012 payment determination, bringing the total to 55 measures. The proposed measures are two AHRQ patient safety indicators (PSI) and eight Hospital Acquired Conditions (HACs). All of the proposed measures are claims-based and will be calculated based on three years of Medicare FFS claims. The proposed measures are as follows:

- PSI11 – Post-operative Respiratory Failure
- PSI12 – Post-operative DVT/PE
- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma
- Vascular Catheter-Associated Infection
- Catheter-associated urinary tract infection
- Manifestations of Poor Glycemic Control

CMS also proposes to require hospitals to submit all-patient volume data on 55 MS-DRGs that relate to the RHQDAPU condition areas, beginning with January 1, 2011 discharges. The volume data submitted by hospitals would replace what is currently reported on the Hospital Compare website, which is based on Medicare claims only. Hospitals would be required to submit claims data, including all of the information needed to group the claims by MS-DRG, and CMS would do the grouping. CMS has proposed that the claims data be submitted through the

existing data collection mechanism for the quality measures; however, CMS is inviting public comment on alternative methods for data submission.

FY 2013

In addition to the 55 proposed measures for FY 2012, CMS proposes to add three measures for the FY 2013 payment determination in addition to requiring hospitals to select a registry topic area (ICD complications, Stroke, Nursing Sensitive, or Cardiac Surgery) and report on the quality measures associated with the topic through a qualified registry. Depending on the topic chosen, the number of measures a hospital would report could range from 1-15 additional measures.

The three measures proposed include two hospital acquired infection measures to be reported to the CDC's National Healthcare Safety Network (NHSN) instead of directly to CMS. Collection of these measures would begin with January 1, 2011, discharges.

The proposed measures for FY 2013 are as follows:

- AMI Statin at Discharge

Hospital Acquired Infections
- Surgical Site Infection
- Central Line Associated Blood Stream Infection

Registry topics
- ICD Complications – one measure through the American College of Cardiology – National Cardiovascular Data Registry (ACC-NCDR)
- Stroke – eight measures through certified registries
- Nursing Sensitive Care – eight measures through certified registries
- Cardiac Surgery – 15 measures through the Society for Thoracic Surgeons Registry (STS)

For a list of the specific measures associated with each registry, please see pages 23971 – 23974 of the proposed rule.

FY 2014

In addition to the proposed measures for FY 2013, CMS proposes to add four chart-abstracted measures for the FY 2014 payment determination. Two of the measures address emergency department throughput and two measures address all patient immunizations. The proposed measures are as follows:

Emergency Department (ED) Throughput
- Admit Decision Time to ED Departure Time for Admitted Patients
- Median Time from ED Arrival to ED Departure for Admitted Patients

Immunization

- Global Flu Immunization
- Global Pneumonia Immunization

The global immunization measures are pending NQF endorsement. If the measures are endorsed and finalized in the RHQDAPU program, the current Influenza and Pneumonia vaccine measures would likely be retired.

Measure Retirement

In order to be sensitive to the burden placed on hospitals for reporting quality measures, CMS is considering the retirement of one or more chart-abstracted measures, which are the most burdensome for hospitals to collect. Eleven measures are proposed for potential retirement and seven of the eleven measures are proposed due to their topped out performance and lack of variation amongst hospitals. CMS is soliciting comments on the option to retire one or more measures from the following list:

- AMI – Aspirin at Arrival
- AMI – ACE/ARB for Left Ventricular Systolic Dysfunction
- AMI – Smoking Cessation Advice/Counseling
- AMI – Beta Blocker Prescribed at Discharge
- HF – Smoking Cessation Advice/Counseling
- PN - Smoking Cessation Advice/Counseling
- SCIP – Surgery Patients with Appropriate Hair Removal
- HF – Discharge Instructions
- PN – Blood Culture Performed Before First Antibiotic Received in Hospital
- SCIP – Prophylactic Antibiotic Selection for Surgical Patients
- SCIP – Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

Data Submission Synchronization

Beginning with the FY 2013 payment determination, CMS proposes to synchronize the timing of reporting for various measures, so that all measures will be required to be reported for the four calendar quarters of calendar year 2011. Currently, different reporting periods apply to different measures. CMS also proposes that data validation will be required for four consecutive calendar quarters beginning with the fourth quarter of the calendar year that occurs two years before the payment determination. Therefore, for the FY 2013 payment determination, validation will be required for the data reported for the fourth calendar quarter of calendar year 2010 through the third quarter of calendar year 2011.

Among several reasons provided for proposing this change, CMS indicates that the change will assist the Agency in implementing the Value Based Purchasing provision required under the Patient Protection and Affordable Care Act (PPACA).

Validation

For the FY 2012 RHQDAPU payment determination, CMS proposes no changes to the chart validation requirements that were adopted for the FY 2011 payment determination. These requirements involve validating records for an annual sample of 800 hospitals among those that submitted chart-abstracted data for at least 100 discharges combined for all topics.

Beginning with FY 2013, CMS proposes to continue the same validation process with four changes. First, a targeting criterion will be added. All hospitals that fail the validation process in a given year will be selected for validation again in the following year.

Second, CMS proposes to eliminate the 100 discharge minimum beginning with the validation sample for the FY 2013 payment determination, which will be selected in January 2011. The sample will be chosen from among all hospitals that successfully submitted at least one RHQDAPU case for the third calendar quarter two years prior to the validation year.

Third, for hospitals chosen to be part of the validation sample, CMS proposes to modify the methodology for sampling discharges in cases where hospitals have fewer than 3 cases in a topic area in a quarter. When this occurs, more cases will be chosen from other topic areas to ensure that 12 cases are reviewed per quarter.

Finally, CMS proposes to adjust the timing of data validation to be consistent with the proposed synchronization of RHQDAPU data discussed earlier. The data proposed to be validated for the FY 2013 payment determination are data from the fourth quarter of calendar year 2010 through the third quarter of calendar year 2011.

Analysis

The AAMC is pleased that CMS has provided hospitals a road map for including new measures into the RHQDAPU program over the next three fiscal years. However, the AAMC is concerned with the number and types of measures being proposed. If all of the proposed measures are approved, hospitals could be reporting up to 74 measures, of which 49 could be chart-abstracted depending on what registry topic is chosen. This is unduly burdensome for hospitals.

Several of the proposed measures expand the types of data submission mechanisms required in the RHQDAPU program to include reporting to the CDC as well as reporting to registries. These data sources vary in their ability to collect and report reliable and valid data and therefore cause concern with their inclusion in public reporting.

The AAMC is specifically concerned about the inclusion of the hospital acquired infection measures through the CDC's National Healthcare Safety Network. Monitoring and tracking the incidence of infections is central to patient safety and quality improvement. Most academic medical centers have infection control personnel supporting sophisticated mechanisms to identify infections and report the appropriate data. However, because this sophistication is not necessarily available in all hospitals, we are concerned that academic medical centers will be better at identifying infections and therefore be at a disadvantage when the data is reported for

comparative purposes. In addition, while many of our member institutions already report to the NHSN, the process can be labor intensive and onerous.

Similarly, the AAMC is concerned about the inclusion of the HACs in the reporting program with no information on how the rates will be calculated, the risk-adjustment methodology, or the plan for public reporting.

Last, there are concerns with the inclusion of the ED throughput measures. Historically, these are measures in which teaching hospitals fare disproportionately worse than other hospitals largely because of the structure of the institution and the patient population being served. While these measures are important to track internally, there is concern regarding the public reporting of these data.

The AAMC welcomes your comments and observations on the concerns listed above and on any additional concerns you may have about CMS's proposals.

IX. PAYMENTS FOR NEW TECHNOLOGIES (pages 23923 – 23936)

Background

Pursuant to BIPA, CMS established a methodology in a September 7, 2001 final rule (66 Fed. Reg. 46902) that would provide additional payments to hospitals for new technologies that they use and that are not yet reflected in the DRG payment system. To qualify for the additional payments, the new service or technology must meet three criteria under the DRG system:

- Be considered "new" until such time as data are available to fully reflect the cost of the technology in the MS-DRG weights through recalibration – usually 2 to 3 years beginning with FDA approval;
- Be more costly than existing technologies. The cost criterion is established based on a threshold for each MS-DRG (a list of qualifying thresholds by MS-DRG can be found in Table 10 of the Addendum); and
- Demonstrate a substantial clinical improvement over existing services or technologies.

In the FY 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 FY 2006 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. In the FY 2010 IPPS final rule, CMS included a third factor that the Agency would consider when determining whether a new technology is substantially similar to an existing technology: (3) whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population.

If the cost of the discharge (determined by applying cost-to-charge ratios) exceeds the full MS-DRG payment (including payments for IME and DSH, but excluding outlier payments),

Medicare makes an add-on payment equal to the lesser of (a) 50 percent of the difference between the cost of the case with the new technology and the DRG payment, or (b) 50 percent of the cost of the new technology. Payments for new services and technology were initially subject to a budget-neutrality factor. However, the law was subsequently amended, and add-on payments from FFY 2005 forward are no longer budget-neutral.

In the FY 2010 final rule, CMS approved Spiration® IBV® Valve System for new technology add-on payment. The Agency finalized an add-on payment of $3,437.50.

In the FY 2009 final rule, CMS approved CardioWest Temporary Total Artificial Heart System (CardioWest TAH-t) for new technology add-on payment. The Agency finalized a payment of $53,000 for this technology.

Proposed Rule

CMS is proposing to continue new technology add-on payments for cases involving Spiration® IBV® Valve System and CardioWest Temporary Total Artificial Heart System (CardioWest TAH-t) in FY 2011, with a maximum add-on payment of $3,437.50 and $53,000 respectively. The Agency seeks public comment regarding whether there is new evidence that demonstrates that the TAH-t continues to be effective and whether it should still be considered to be a substantial clinical improvement for FY 2011.

The agency is seeking comments on the following five applications for new technology add-on payments:

1. Auto Laser Interstitial Thermal Therapy (AutoLITT™) System

This device received FDA approval in May 2009 and was introduced to the market in December 2009, which is when CMS believes the newness criterion begins. CMS invites public comment to determine whether this device meets the newness criterion. The agency is concerned that AutoLITT™ may be substantially similar to the device listed as its predicate device (Visual-ase), which was approved by the FDA in 2006. The applicant maintains that AutoLITT™ can be distinguished from the Visual-ase by its mechanism of action (that is, side-firing laser versus elliptical firing).

CMS also seeks public comment with regard to whether AutoLITT™ meets the cost criterion. According to the applicant's estimation, the device's total average standardized charge per case ($96,397) exceeds the threshold amount for each individual MS-DRGs (MS-DRGs 25, 26 and 27) to which the technology would map. Finally, because this technology has been used for the treatment of only a few patients, the Agency requests additional clinical data and public comment to determine whether AutoLITT™ meets the substantial clinical improvement criterion.

2. LipiScan™ Coronary Imaging System

This application was submitted for FY 2010 but was denied, because it did not meet the substantial clinical improvement criterion at that time. For FY 2011, the applicant, InfraReDx presented additional information that it did not present when it submitted the application in FY 2010. InfraReDx believes that this information demonstrates the device can provide many benefits including detection of a medical condition that is not currently detectable, helping to make a diagnosis that better affects the management of the patient, and prevention of coronary events (for more information on the evidence provided by InfraReDx, see pages 23932-33).

This technology received FDA approval for a new indication on April 25, 2008. LipiScan™ would still be considered new in FY 2011, because a device meets the newness criterion if it is new for more than 6 months into the third year after it received FDA approval.

While the applicant estimated a total case-weighted average standardized charge per case of $59,727, CMS estimated it to be $54,154. CMS seeks public comment on whether the LipiScan™ represents a substantial clinical improvement in the Medicare population and whether it meets the newness criterion and the cost criterion.

3. LipiScan™ Coronary Imaging System with Intravascular Ultrasound (IVUS)

This technology uses Intravascular near infrared spectroscopy (INIRS) combined with intravascular ultrasound (IVUS) during an invasive coronary angiography to determine the chemical composition of coronary plaques.

Although this device is not currently approved by the FDA, the manufacturer anticipates that FDA approval will be granted in the second quarter of 2010. Because IVUS has been used for over 20 years, according to CMS, it would not qualify as a new technology on its own. However, the Agency seeks comments on whether LipiScan IVUS, as a combined technology, should be considered substantially similar to each individual technology as of the date that each separate technology received FDA approval (or the date that each technology became available on the market, if either technology was not available on the market until a date after FDA approval).

The applicant calculated a total case-weighted average standardized charge per case of $68,190. CMS's methodology however, estimated a $62,617 total case-weighted average standardized charge per case. According to the Agency, "it appears that LipiScan™ IVUS would meet the cost criterion."

With regard to the substantial clinical improvement criterion, the applicant asserts that this technology provides the same benefits as LipiScan™ as well as the benefits of IVUS. Specifically, the applicant maintains that LipiScanTM IVUS is superior to perfusion imaging and coronary angiography because those procedures only provide information about the lumen, but not the wall of the vessel. The applicant asserts that LipiScanTM IVUS affects the management of the patient by improving the safety and efficacy of stenting.

CMS expresses concern that in the LipiScanTM IVUS application, the applicant has generally repeated the statements made regarding use of LipiScanTM alone and has not provided information that indicates that combined use of LipiScanTM plus IVUS offers additional clinical benefit. CMS notes that most of the studies that were presented in an effort to support that LipiScanTM by itself as a substantial clinical improvement were also included to support the LipiScanTM IVUS application. The applicant did not present any published peer-reviewed journal articles that were specifically related to the clinical merits of the combined LipiScanTM IVUS device.

CMS seeks public comment on whether the LipiScanTM IVUS represents a substantial clinical improvement over existing technologies as well as public comments on what is the appropriate comparison for LipiScanTM IVUS.

X. PROPOSALS AFFECTING THE ICD-9-CM, ICD-10-CM AND ICD-10-PCS CODING SYSTEMS (pages 23910 – 23914)

A. ICD-9-CM Coding System

Coding changes are announced in Tables 6A through 6F in the Addendum to the proposed rule. The ICD-9-CM code changes that have been approved will become effective October 1, 2010. The new ICD-9-CM codes are listed, along with their MS-DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to the proposed rule. CMS solicits comments on the proposed classification of the new codes, which are shown in Tables 6A and 6B of the Addendum to this proposed rule.

B. Code Freeze

Background

On January 16, 2009, the Department of Health and Human Services (HHS) published a final rule that would replace the current ICD-9 codes set used to report health care diagnoses and procedures on health care transaction claims with a new version, known as ICD-10. The ICD-10 coding system includes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding, as well as the Official ICD-10-CM and ICM-10-PCS Guidelines for Coding and Reporting. The implementation of the new coding system would begin on October 1, 2013.

Proposed Rule

CMS is soliciting public comment on the approach for updating ICD-9-CM and ICD-10-CM/PCS codes prior to the statutorily required deadline for ICD-10 implementation on October 1, 2013. In the rule, CMS proposes the last regular, annual update to both ICD-9-CM and ICD-10 be made on October 1, 2011, with limited annual code updates to both systems October 1, 2012 and 2013. Under the proposal, regular annual updates would resume October 1, 2014. Public comments providing approaches were initially received at the September 16-17, 2009,

ICD-9-CM Coordination and Maintenance Committee meeting. Comments ranged from support for a complete freeze for both coding systems to recommendations that both coding systems continue to be updated annually prior to ICD-10 implementation.

In the proposed rule, CMS also seeks comment on whether a coding update freeze is needed to help hospitals with the adoption of health information technology (HIT), in light of the requirements for the meaningful use of electronic health records.

C. Processing of 25 Diagnosis Codes and 25 Procedure Codes on Hospital Inpatient Claims

Background

CMS has received repeated requests from the hospital community to process all 25 diagnosis codes and 25 procedure codes submitted on electronic hospital inpatient claims. Hospitals can submit up to 25 diagnoses and 25 procedures; however, CMS's current system limitations allow for the processing of only the first 9 diagnoses and 6 procedures. While CMS accepts all 25 diagnoses and 25 procedures submitted on the claims, CMS does not process all of the codes because of these system limitations.

Proposed Rule

In the proposal, CMS notes that much valuable information is lost by not processing the additional diagnosis and procedure codes reported by hospitals. CMS indicates plans to complete the expansion of the Agency's internal system capability in order to process up to 25 diagnoses and 25 procedures on hospital inpatient claims as part of the HIPPA ASC X12 Technical Reports Type 3, Version 005010 (Version 5010) standards system update. CMS indicates that the Agency will be able to process up to 25 diagnosis and 25 procedure codes beginning January 1, 2011.

XI. PAYMENT FOR TRANSFER OF CASES TO NONPARTICIPATING HOSPITALS AND CAHS (pages 23997 – 23998)

Background

Under Medicare's acute care transfer policy, when a patient is transferred and his or her length of stay is less than the geometric mean length of stay for the particular MS-DRG, the transferring hospital is paid 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 had the patient been discharged without being transferred. The receiving hospital that ultimately discharges the patient receives the full MS-DRG payment, regardless of the length of the patient's stay. This policy currently only applies, however, when the patient is readmitted on the same day to another hospital that is (1) paid under the IPPS, or (2) excluded from the IPPS because of participation in a statewide cost control program (*i.e.* Maryland). The policy currently does not apply to transfers to acute care hospitals that would otherwise be eligible to be paid under the IPPS but do not have an agreement to participate in the Medicare program or to transfers to critical access hospitals (CAHs).

Proposed Rule

CMS proposes to extend application of payment adjustments under the transfer policy to include a transfer of a case from an IPPS hospital to (1) a nonparticipating acute care hospital that would otherwise be eligible for payment under the IPPS, and (2) to a critical access hospital. CMS states that the Agency's goal is to avoid creating a financial incentive for an IPPS hospital to transfer cases to one type of provider over another and to align its transfer policy with the principle that a hospital's payment should be commensurate with the resources it expends for the case.

CMS notes that hospitals will be required to use the following codes on IPPS claims for transfer cases to these facilities:

- For transfers to CAHs, patient discharge status code "66" (Discharged/Transferred to a Critical Access Hospital); and
- For transfers to nonparticipating acute care hospitals, patient status code "02" (Discharged/Transferred to a Short-Term General Hospital for Inpatient Care).

XII. OTHER TOPICS IN THE PROPOSED RULE THAT MAY BE OF INTEREST TO AAMC MEMBERS

- Proposed Changes to the Long-Term Care Hospital PPS for FY 2011 (pages 24019 – 24047)
- Proposed Changes Affecting Critical Access Hospitals (pages 24017 – 24019)
- Geographic Reclassification Criteria (pages 23947 – 23953)
- CRNA Services Furnished in Rural Hospitals and CAHs (pages 24010 – 24011)

If you have any questions regarding the proposed rule or this summary, or additional issues of which we should be aware, please contact Karen Fisher kfisher@aamc.org (general issues), 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.