



# Payment Rule Summary

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## Medicare Inpatient Prospective Payment System

Federal Fiscal Year 2012

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Final Rule

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# Overview

On August 18, 2011, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2012 final payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule updates inpatient payment rates and policies and implements provisions of the Patient Protection and Affordable Care Act (PPACA) of 2010.

In addition to updating inpatient payment rules for FFY 2012, CMS is adopting rules to establish the basis for the PPACA's Medicare inpatient readmissions payment policy, set for implementation beginning FFY 2013, and rules related to the FFY 2014 (second year) Medicare hospital inpatient value-based purchasing (VBP) Program. Complete program policies for the first year VBP Program (FFY 2013 program), and several program policies for the FFY 2014 program have already been adopted by CMS.

A copy of the final rule *Federal Register* and other resources related to the IPPS are available on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/FR2012/>.

An online version of the final rule *Federal Register* is available at <http://federalregister.gov/a/2011-19719>.

Program changes are effective for discharges on or after October 1, 2011 unless otherwise noted. Complete details of the final rule are provided below. Quoted text in italics is from the May 5 *Federal Register*.

## Inpatient Payment Rates

The following table lists the federal operating and capital rates for FFY 2012 compared to the rates currently in effect. Additional detail on the factors updating these rates and hospital-specific rates is provided below.

	Final FFY 2011	Final FFY 2012	Percent Change
<b>Federal Operating Rate</b>	<b>\$5,164.11</b>	<b>\$5,209.74</b>	<b>+0.9%</b>
<b>Federal Capital Rate</b>	<b>\$420.01</b>	<b>\$421.42</b>	<b>+0.3%</b>

### Updates to the Federal Operating Rate

*Federal Register* pages 51,785-51,797

**CMS's Final Rule:** CMS adopted rate updates, along with slight adjustments for budget neutrality, resulting in a federal inpatient operating rate of \$5,209.74 for FFY 2012 compared to \$5,164.11 for FFY 2011, a 0.9% increase.

CMS-proposed updates would have resulted in a rate decrease of 0.6%. The change in the rate from the proposed to final rule reflects an increased market basket value, a reduced productivity adjustment, and CMS decision to reduce the value of the coding reduction for FFY 2012.

The final FFY 2012 operating rate will be updated as follows:

- *Plus 3.0% (proposed at 2.8%):* CMS will update the operating rate by a market basket of 3.0%.

- *Minus 1.0 percentage points (proposed at minus 1.2 percentage points):* Offsetting the market basket is a PPACA-mandated productivity reduction of 1.0 percentage points.
- *Minus 0.1 percentage points (no change from proposed to final):* Offsetting the market basket is a PPACA-mandated pre-determined reduction of 0.1 percentage points.
- *Minus 2.0% (proposed at minus 3.15%):* CMS will continue its application of coding adjustments to inpatient rates, reducing the operating rate by 2.0%, to account for what CMS believes are increased inpatient payments to hospitals due to coding improvement (see “Details of the Coding Adjustment” below). CMS had proposed a 3.15% adjustment, but reduced the proposed value in an attempt to mitigate the effects of significant downward adjustments on hospital payments. The FFY 2012 coding adjustment will be permanently built into the federal operating rate (i.e. the reductions will carry forward into future payment years).
- *Plus 1.1% (no change from proposed to final):* CMS will increase the operating rate by 1.1% to account for the agency’s inappropriate application of rural floor budget neutrality adjustments in past years, as decided in the case of Cape Cod Hospital vs. Sebelius.

### Updates to the Hospital-Specific Rates

*Federal Register pages 51,798-51,799*

**CMS’s Final Rule:** CMS will update the hospital-specific rates for Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs) in a manner similar to the federal operating rate. The FFY 2012 hospital-specific rates will be updated as follows:

- CMS will apply the same market basket update and PPACA-mandated market basket reductions (a full 3.0% market basket reduced by a 1.0 percentage point productivity adjustment and reduced by a 0.1 percentage point pre-determined factor).
- *Minus 2.0% (proposed at minus 2.5%):* CMS will apply a 2.0% prospective coding adjustment to the hospital-specific rates. CMS had proposed a 2.5% adjustment, but reduced the proposed value stating that they believe coding adjustments made to the hospital-specific rates should be as similar as possible to the adjustments applied to the federal operating rate. This coding adjustment is permanent and will carry forward into future payment years. The 2.9% coding adjustment applied to hospital-specific rates in FFY 2011 was also permanent and is being carried forward.
- *Plus 0.9% (no change from proposed to final):* CMS will increase hospital-specific rates by 0.9% (rather than 1.1% as adopted for the federal operating rate) to account for the inappropriate application of rural floor budget neutrality in past years. This increase is slightly less than that applied to the federal rate because CMS did not apply the rural floor budget neutrality adjustment to the hospital-specific rates in all years the adjustment was applied to the operating rate.

### Updates to the Federal Capital Rate

*Federal Register pages 51,799-51,806*

**CMS’s Final Rule:** CMS’s adopted rate updates, along with adjustments for budget neutrality, result in a federal inpatient capital rate of \$421.42 for FFY 2012 compared to \$420.01 for FFY 2011, a 0.3% increase.

CMS is adopting its proposal to update the capital rate by a market basket of 1.5%. Offsetting the update, CMS is adopting its proposal to apply a negative 1.0% coding adjustment to the capital rate. This coding adjustment

is permanent and will carry forward into future payment years. The capital rate is also decreased by 0.2% due to an increase in the capital outlier budget neutrality factor.

**Coding Adjustments for FFY 2012**

*Federal Register pages 51,489-51,501*

**Background:** The need for coding adjustments dates back to FFYs 2008 and 2009, when CMS transitioned to its new Medicare-Severity Diagnosis Related Groups (MS-DRGs). CMS believed that the MS-DRGs had the potential to generate increases in aggregate payments that would not be caused directly by increases in actual patient severity of illness (referred to as “real” case-mix change), but rather would be due to improved hospital documentation and coding.

In order to maintain the budget neutrality of the IPPS, CMS has the authority to both retrospectively recoup for increases in inpatient payments during FFYs 2008 and 2009 that were due to coding improvement (rather than real case-mix changes) AND prospectively reduce inpatient payments to offset the impact of coding improvement on a go-forward basis to permanently realign payments to the baseline FFY 2007 coding level.

Prospective adjustments are applied permanently to the base payment rate by CMS and carried forward through future payment years. Retroactive adjustments are one-time adjustments that are factored back into rates the following payment year.

**CMS’s Final Rule:** Details of prior coding adjustments and the adjustments CMS is adopting for the federal operating rate, hospital-specific rates, and federal capital rate for FFY 2012 are provided in the table below. As shown, an additional 1.9% adjustment to the federal operating rate and 0.5% adjustment to the hospital-specific rates will be required in future rulemaking. CMS suggests in the final rule that these additional adjustments could be applied to next year’s payment rates.

	Federal Operating Rate		Hospital-Specific Rates	Federal Capital Rate
	<b><i>Prospective</i></b> Coding Adjustment Details	<b><i>Retrospective</i></b> Coding Adjustment Details *	<b><i>Prospective</i></b> Coding Adjustment Details	<b><i>Prospective</i></b> Coding Adjustment Details
Total Coding Impact Estimated by CMS	5.4%	5.8%	5.4%	5.4%
Coding Adjustment Reduction(s) Previously Applied	-1.5%	-2.9%	-2.9%	-4.4%
Remaining Coding Adjustment Reduction Required	3.9%	2.9%	2.5%	1.0%
<b><i>Final FFY 2012 Coding Adjustment Reductions</i></b>	<b><i>-2.0%</i></b> (proposed at -3.15%)	<b><i>-2.9%</i></b>	<b><i>-2.0%</i></b> (proposed at -2.5%)	<b><i>-1.0%</i></b>
<b><i>Remaining Coding Adjustment to be Applied (Likely to be Applied in FFY 2013)</i></b>	<b><i>-1.9%</i></b>	<b><i>0.0%</i></b>	<b><i>-0.5%</i></b>	<b><i>0.0%</i></b>

\* Because retrospective adjustments are one-time reductions, the net impact of backing out the FFY 2011 adjustment and then applying the FFY 2012 adjustment is zero. By law, FFY 2012 is the last year CMS is permitted to implement retrospective coding adjustments.

# Hospital Wage Index and Wage Index Reclassifications

## Wage Index Reform

*Federal Register* page 51,601

**Background:** The PPACA mandates that the Health and Human Services (HHS) Secretary recommend comprehensive reform of the Medicare wage index system to Congress by December 31, 2011. The plan is required to take into account the 2007 Medicare Payment Advisory Commission (MedPAC) wage index report, including the proposed use of Bureau of Labor Statistics (BLS) data and the recommended redefinition of wage areas.

**CMS's Final Rule:** CMS did not address the Report to Congress in the proposed rule other than to request comments to be considered as part of the Secretary's Report on ways to redefine the geographic reclassification requirements to more accurately define labor markets. CMS did not address the comments it received on this issue in the final rule.

## Wage Index and Labor-Related Share for FFY 2012

*Federal Register* pages 51,591-51,593, pages 51,604-51,605, and page 51,823

**Background:** The labor-related portion of the IPPS federal operating payment rate is adjusted for differences in area wage levels using a wage index. The wage index is calculated and assigned to hospitals by labor market area. CMS uses Core-Based Statistical Areas (CBSAs) to define labor-market areas under the IPPS. The federal capital rate is adjusted by the geographic adjustment factor (wage index to the 0.6848 power).

**CMS's Final Rule:** As noted in the proposed rule, the wage data for the FFY 2012 wage index are from Worksheet S-3, Parts II and III of the Medicare cost report for cost reporting periods beginning on or after October 1, 2007, and before October 1, 2008.

The PPACA requires CMS to apply a national budget neutrality factor to the wage indexes to account for the rural floor and imputed rural floor wage index policies. The FFY 2012 rural floor budget neutrality factor will reduce wage indexes by -0.9%.

CMS will continue to apply the wage index to a labor-related share of 62% for hospitals with a wage index of less than 1.0; 68.8% for hospitals with a wage index of greater than 1.0.

A complete list of the wage indexes for FFY 2012 is available on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/FR2012/>.

## Occupational Mix Adjustment for FFY 2012 and New Survey Requirements for FFY 2013

### Adjustments

*Federal Register* pages 51,582-51,586

**Background:** CMS is required to include an occupational mix adjustment in its calculation of the hospital wage index. The occupational mix adjustment is intended to neutralize the effect of employee mix, resulting in a decreased wage index for hospitals with higher skill mixes and an increased wage index for hospitals with lower skill mixes.

Data on occupational mix are collected every three years via a survey instrument. The hospital wage index is currently adjusted using data collected on the 2007-2008 Medicare Wage Index Occupational Mix Survey. Data

from this survey reflect wage and hour data for a one-year reporting period from July 1, 2007 through June 30, 2008.

**CMS's Proposal:** *“For the FY 2012 hospital wage index, we are proposing to again use occupational mix data collected on the 2007-2008 Medicare Wage Index Occupational Mix Survey to compute the occupational mix adjustment for FY 2012.”*

**CMS's Final Rule:** CMS is adopting its proposal as final.

The FFY 2012 occupational mix adjusted national average hourly wage (AHW) is \$36.2481.

As required by law, CMS has developed a revised survey tool to collect new occupational mix data for adjustment of the FFY 2013 wage index. The new 2010 survey will collect hospital-specific wage and hour data from January 1, 2010 through December 31, 2010.

The new survey, approved by the Office of Management and Budget (OMB) on February 26, 2010, is available on the CMS Web site at <http://www.cms.gov/AcuteInpatientPPS/WIFN/>. Hospitals were required to submit the 2010 survey to their Fiscal Intermediaries (FIs)/Medicare Administrative (MACs) by July 1, 2011.

Hospitals that do not complete the 2010 survey are required to submit an explanation for not complying with the submission requirements. FIs/MACs are instructed to gather this information as a part of the FFY 2013 wage index desk review process.

### *MGCRB Reclassification Applications for FFY 2013*

*Federal Register* page 51,596 and pages 51,600-51,601

**Background:** Individual hospitals or groups of hospitals (defined by counties) can apply to the Medicare Geographic Classification Review Board (MGCRB or “Board”) for reclassification to another area for wage index purposes. Hospitals seeking reclassification must meet specific proximity and wage level criteria. Currently, over 800 hospitals have been approved for Board reclassifications.

**CMS's Final Rule:** Applications for FFY 2013 reclassifications are due to the MGCRB by September 1, 2011. Applications and other information regarding MGCRB reclassifications are available on the CMS Web site at <http://www.cms.gov/MGCRB/>.

In the final rule, CMS is modifying the average hourly wage (AHW) criterion for hospitals in single hospital Core-Based Statistical Areas (CBSAs). Currently, for a hospital to qualify for a geographic reclassification to a higher wage index area it must demonstrate its own AHW is higher than the AHW of the other hospitals in their CBSA (108% for urban hospitals and 106% for rural hospitals). Beginning with FFY 2013 reclassification requests, CMS is waiving this AHW criterion for hospitals in single hospital CBSAs.

### *Changes for Hospitals Waiving “Lugar” Reclassification for the Out-Migration Adjustment*

*Federal Register* pages 51,597-51,600

**Background:** Current law requires that, for wage index purposes, CMS automatically reassign any hospital located in a rural county that is adjacent to one or more urban areas (CBSAs) to that CBSA if the county meets specified commuting criteria. These reclassifications are known as “Lugar” reclassifications. In addition to receiving the urban area wage index, hospitals with Lugar reclassifications are also deemed as urban for other payment purposes under the IPPS, including for Disproportionate Share Hospital (DSH) payment.

**CMS's Proposal:** CMS proposed a clarification and procedural change for instances where a hospital waives its Lugar reclassification in order to receive an out-migration adjustment to their rural wage index.

*“ . . . beginning with FY 2012, we are proposing that an eligible hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status and, thus, is rural for all purposes under the IPPS, including being considered rural for the DSH payment adjustment . . . ”*

*“In addition, we are proposing to make a minor procedural change that would allow a Lugar hospital that qualifies for and accepts the out-migration adjustment (through written notification to CMS within 45 days from the publication of the proposed rule) to automatically waive its urban status for the 3-year period for which its out-migration adjustment is effective.”*

**CMS's Final Rule:** CMS is adopting its proposal as final.

A list of rural counties containing hospitals with Lugar reclassifications is available on *Federal Register* pages 51,597-51,598.

### *Expiration of Section 508 Reclassifications in FFY 2012*

*Federal Register* page 51,599

**Background:** The Medicare Modernization Act (MMA) of 2003 allowed certain hospitals (about 100) to receive wage index reclassifications they otherwise would not have been eligible to receive under the traditional MGCRB wage index reclassification rules. Reclassifications under “Section 508” of the MMA, originally set to expire after a 3-year period, have been legislatively extended several times. Most recently, the Medicare and Medicaid Extender Act of 2011 extended Section 508 reclassifications through the end of FFY 2011.

**CMS's Final Rule:** Section 508 wage index reclassifications are set to expire at the end of FFY 2011. CMS does not have the authority to extend these reclassifications beyond FFY 2011 without legislative action.

### *Expiration of the Imputed Rural Floor Wage Index in FFY 2012*

*Federal Register* pages 51,593-51,594

**Background:** In FFY 2005, CMS adopted an imputed rural floor measure for three years to address concerns that hospitals in all-urban states were disadvantaged by the absence of rural areas, because there is no floor for their wage index. In FFY 2009, CMS extended the use of an imputed rural floor for three additional years, through FFY 2011. New Jersey is the only state that benefits from this policy.

**CMS's Proposal:** *“ . . . we are not proposing to extend the imputed floor policy.”*

**CMS's Final Rule:** CMS is not adopting its proposal to eliminate the imputed rural floor policy. Instead, CMS will extend this policy for two additional years, through FFY 2013.

### *Cost-of-Living Adjustment (COLA) for FFY 2012*

*Federal Register* pages 51,797-51,798

**Background:** Current law allows the HHS Secretary to make an adjustment to take into account the unique high-cost circumstances of hospitals located in Alaska and Hawaii. To account for these circumstances, the IPPS provides a COLA adjustment to payments for hospitals located in Alaska and Hawaii based upon the city,

county, or area in which the hospital is located. The COLA adjustment is made by multiplying the nonlabor-related portion of the federal operating rate by the applicable COLA factor.

CMS currently uses the most recent updated COLA factors obtained from the U.S. Office of Personnel Management (OPM) Web site at <http://www.opm.gov/oca/cola/rates.asp>.

**CMS's Proposal:** “. . . for FY 2012, we are proposing to continue to use the same COLA factors (published by OPM) that we used to adjust payments in FY 2011 (which are based on OPMs 2009 COLA factors) . . .”

**CMS's Final Rule:** CMS is adopting its proposal as final. A list of the FFY 2012 COLA factors is available on *Federal Register* page 51,798.

## Additions to Inpatient Rates and Payments

### DSH and Indirect Medical Education (IME) Payments

*Federal Register* pages 51,681-51,683

**Background:** CMS believes that only patient days that directly determine the allowable costs of inpatient hospital care payable under the IPPS should be included for the purposes of determining DSH and IME payments. In FFY 2005, CMS adopted a policy to exclude observation and swing-bed days from the patient day counts to account for this position. Currently, hospice days are included in the patient day count for the purposes of DSH payments and the bed day count for the purposes of both DSH payments and IME payments.

**CMS's Proposal:** “. . . we are proposing to exclude inpatient hospice days from the patient day count . . . for DSH and the bed day count . . . for IME and . . . for DSH.”

**CMS's Final Rule:** CMS is adopting its proposal as final.

CMS is adopting its proposal to exclude inpatient hospice days from the DSH and IME payment calculations because the agency does not consider these days acute care services generally payable under the IPPS. CMS believes the policy change will impact DSH payments in only limited situations (both positive and negative) and may increase IME payments to teaching hospitals depending on the extent to which these hospitals were providing inpatient hospice services to hospice patients.

### Low-Volume Adjustment

*Federal Register* pages 51,677-51,680

**Background:** The MMA authorized the low-volume adjustment to account for the higher costs per discharge for low-volume hospitals. The law defined a low-volume hospital as a subsection (d) hospital that is located more than 25 road miles from another subsection (d) hospital and has less than 800 total discharges during the fiscal year. Beginning in FFY 2005, CMS provided an additional payment adjustment of 25% for hospitals determined to be low-volume hospitals. The methodology CMS employed resulted in only a very small number of qualifying hospitals.

For FFYs 2011 and 2012, the PPACA temporarily modified the criteria for low-volume hospitals to make it easier for hospitals to qualify for the adjustment; lessening the distance criteria to 15 miles and increasing the discharge criteria to 1,600. The PPACA also temporarily modified the payment adjustment methodology, providing higher payment adjustments to hospitals with fewer discharges.

Hospitals eligible for the low-volume adjustment based on the discharge criteria are identified by CMS using Medicare discharge data from the Medicare Provider Analysis and Review (MedPAR) file. For the FFY 2011 adjustment, CMS used FFY 2009 discharge data to identify eligible hospitals.

Hospitals that believe they meet both the distance and discharge criteria must apply in writing to their FI/MAC to obtain the low-volume adjustment.

**CMS's Proposal:** *“ . . . we are proposing that, for FY 2012, qualifying low-volume hospitals and their payment adjustment would be determined using Medicare discharge data from the most recent update of the FY 2010 MedPAR file . . . ”*

*“ . . . we are proposing that, for FY 2012, a hospital make its request for low-volume hospital status in writing to its fiscal intermediary or MAC by September 1, 2011 . . . ”*

For qualifying hospitals that miss the September 1 deadline, CMS proposed to apply the applicable low-volume adjustment within 30 days of the FI/MAC's low-volume status determination.

While CMS proposed a September 1 deadline for hospitals seeking the adjustment for the first time, for hospitals that qualified for the adjustment in FFY 2011 and continue to meet both the discharge and distance criteria, CMS proposed to require that these hospitals verify, in writing, to the FI/MAC by September 30, 2011 that they continue to meet the distance criteria.

**CMS's Final Rule:** CMS is adopting its proposals as final.

A list of hospitals potentially eligible for the payment adjustment based on the volume criteria and the amount of the adjustment is available in Table 14 on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/FR2012/>. As required by law, hospitals must also meet distance criterion to be eligible for the adjustment. The table does not address the distance criterion.

The PPACA-mandated changes to the low-volume hospital adjustment criteria for FFYs 2011 and 2012 that allowed more hospitals to qualify for the adjustment and modified the amount of the adjustment will expire after FFY 2012 without legislative action.

### Outlier Payments

*Federal Register* pages 51,792-51,796

**Background:** CMS provides payments for outlier cases—those involving extraordinarily high costs when compared to average cases in the same DRG. To qualify as an outlier, a hospital's cost for the case must exceed the payment rate for the DRG plus a specified amount called the fixed-loss threshold. The outlier payment is equal to 80% of the difference between the hospital's cost for the stay and the threshold amount. The threshold is adjusted every year based on CMS's projections for total outlier payments to ensure that total outlier payments equal 5.1% of total IPPS payments. The fixed-loss threshold is currently \$23,075.

**CMS's Proposal:** *“For FY 2012, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments is greater than the prospective payment rate for the MS-DRG plus the proposed fixed-loss amount of \$23,375.”*

**CMS's Final Rule:** To maintain total outlier payment under the IPPS at 5.1% of total IPPS payments, CMS is adopting an outlier fixed-loss threshold of \$22,385 for FFY 2012. The reduced threshold from 2011 (a 3.0% reduction) will increase the number of cases eligible for outlier payments.

### Low-Cost County Add-On

*Federal Register* pages 51,685-51,689

**Background:** The PPACA provides new Medicare funding of \$400 million over two years to be allocated to IPPS hospitals (including SCHs and MDHs, but excluding Critical Access Hospitals (CAHs)) located in counties within the lowest national quartile for total, risk-adjusted, Medicare Part A and Part B spending per enrollee.

Under a methodology developed by CMS last year, 416 hospitals were identified and assigned a payment factor for the distribution of this funding (\$150 million in FFY 2011 and \$250 million in FFY 2012). Distribution of this funding will occur through one-time payments (one in FFY 2011 and one in FFY 2012). The FFY 2011 payment to qualifying hospitals was made in mid-July. CMS anticipates making the FFY 2012 payment at the end of 2011 or early 2012. CMS is making these payments through a one-time annual payment made by one Medicare contractor (rather than individual FIs/MACs) that pays all of the qualifying hospitals directly.

**CMS's Final Rule:** In the final rule, CMS builds on its efforts in the proposed rule to refine the list of hospitals eligible for the low-cost county add-on. The updated list of hospitals (about 400) eligible for the payment adjustment for each year and the payment adjustment factors are available on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/FR2012/>.

Qualifying hospitals will not be required to report these additional payments on their Medicare cost report as originally requested by CMS. The low-cost county add-on payments will expire after FFY 2012 without legislative action.

## Updates to the MS-DRGs

*Federal Register* pages 51,485-51,581

**Background:** Each year, CMS updates the MS-DRG classifications and relative weights. These updates are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

**CMS's Proposal:** “. . . for FY 2012 we are proposing to delete one MS-DRG and create two new MS-DRGs for a net gain of one MS-DRG. If this proposal is adopted, we would have a total of 751 MS-DRG groupings.”

**CMS's Final Rule:** CMS is adopting its proposal as final.

To develop the MS-DRG weights for FFY 2012, CMS used FFY 2010 Medicare claims data and FFY 2009 Medicare cost report data. Table 5, a table of the final FFY 2012 MS-DRGs and weights, is available online at <https://www.cms.gov/AcuteInpatientPPS/FR2012/>.

Related to the updates to the MS-DRGs, the final rule also addresses:

- changes to specific MS-DRG classifications;
- additions and deletions from the complication or comorbidity (CC) Exclusion list that modifies which diagnoses are recognized as valid CCs;
- new services and technologies that will be eligible for add-on payments;
- changes to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and

- a discussion of the ICD-10-CM and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) that will be implemented for FFY 2014.

Additional detail regarding these updates is available on *Federal Register* listed above.

## Updates to the Hospital Inpatient Quality Reporting (IQR) Program

*Federal Register* pages 51,605-51,653

**Background:** The MMA authorized the HHS Secretary to develop a quality data pay-for-reporting program for hospitals paid under the IPPS. Subsequent legislation has substantially expanded this program, now known as the Hospital IQR Program. Hospitals that fail to successfully participate in the IQR Program receive reduced payments through a reduction of 2.0 percentage points to the hospital marketbasket update. CMS makes these payment determinations each year.

Quality data is currently collected on an array of quality measures related to heart attack, heart failure, pneumonia, surgical care, Agency for Healthcare Research and Quality (AHRQ) indicators, mortality, readmissions, hospital-acquired conditions (HACs), participation in systematic clinical database registries for various topics, and patient satisfaction. Some of this data is reported by hospitals to CMS and some is calculated using information from Medicare claims data.

Quality data collected under the IQR Program is made available to the public on the Hospital Compare Web site at <http://www.hospitalcompare.hhs.gov/>. A subset of the measures collected under the IQR Program will be used going forward by CMS to implement two mandatory delivery system reforms for hospitals mandated by the PPACA; the Hospital VBP Program and the Hospital Readmissions Reduction Program. These programs will affect IPPS payments beginning FFY 2013.

Each year, CMS updates the IQR measures and policies. Currently, CMS has adopted measures for the IQR Program through FFY 2014.

As adopted in the FFY 2011 IPPS final rule, for FFY 2012 payment determinations, hospitals were required to successfully report on a total of 55 quality measures. For FFY 2013 payment determinations, hospitals are currently reporting on a total of 57 quality measures. For FFY 2014 payment determinations CMS adopted rules that would have required hospitals to report on a total of 60 quality measures. A complete list of the IQR Program measures for FFYs 2012 and 2013 payment determinations is available on *Federal Register* pages 50,198-50,199 and pages 50,208-50,209 of the FFY 2011 IPPS final rule at <http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf>.

**CMS's Final Rule:** CMS is adopting refinements to the IQR Program for FFYs 2014 and 2015. These refinements not only update the IQR Program, but also remove and/or put in place measures for use under the Hospital VBP Program. As proposed, going forward, CMS will simultaneously specify measures for adoption into the IQR Program and use under the Hospital VBP Program when CMS will use the measures under both programs.

The adopted refinements also take steps to eventually align the IQR Program measures with the hospital quality measures adopted under the Electronic Health Record (EHR) Incentive Program. The EHR Incentive Program, authorized by the American Recovery and Reinvestment Act (ARRA) provides incentive payments to hospitals and doctors that successfully adopt and use EHR systems under rules established by CMS. EHR-based quality reporting is a specific requirement of this program.

## FFY 2014 Payment Determinations

Federal Register pages 51,609-51,629

**CMS's Proposal:** “. . . we are proposing to retire 8 measures from the measure set for the FY 2014 payment determination that was finalized in the FY 2011 IPPS/LTCH PPS final rule, and we are proposing to add 4 measures to the measure set for the FY 2014 payment determination: 2 HAI measures collected through the NHSN, 1 claims-based measure (Medicare Spending Per Beneficiary), and 1 structural measure, for a total of 56 measures for the FY 2014 Hospital IQR payment determination.”

**CMS's Final Rule:** CMS is adopting its proposal as final with some modifications. Specifically, rather than adopting its proposal to retire 8 chart-abstracted measures, CMS will retire 4 of these measures and suspend collection on the other 4 measures. In addition, CMS is not adopting its proposal to add a healthcare-associated infection (HAI) measure, Central Line Insertion Practice Adherence Percentage (CLIP), to the IQR Program.

As proposed, CMS is retiring the following measures from the IQR Program beginning with FFY 2014 payment determinations:

- 4 chart-abstracted measures (retired):
  - AMI-4: Adult smoking cessation advice/counseling
  - HF-4: Adult smoking cessation advice/counseling
  - PN-4: Adult smoking cessation advice/counseling
  - PN-5c: Timing of receipt of initial antibiotic use

As proposed, hospitals will no longer be required to submit data on these measures beginning with January 1, 2012 discharges.

Modifying its proposal to retire an additional 4 chart-abstracted measures from the IQR Program, CMS will instead suspend data collection on the following measures beginning with FFY 2014 payment determinations:

- 4 chart-abstracted measures (suspended):
  - AMI-1: Aspirin at arrival
  - AMI-3: ACEI/ARB for left ventricular systolic dysfunction
  - AMI-5: Beta-blocker prescribed at discharge
  - SCIP INF-6 Appropriate Hair Removal

Hospitals will no longer be required to submit data on these measures beginning with January 1, 2012 discharges. If CMS determines that adherence to the practices associated with these measures declines, the agency will provide 3-months notice before again collecting data on these measures.

CMS is retiring/suspending collection of these measures because performance nationwide is uniformly high and CMS has not adopted these measures for the purposes of the Hospital VBP Program. Hence, these measures are no longer needed for the IQR Program. For PN-5c, CMS did not adopt this measure for the Hospital VBP Program due to concern over the unintended consequences of inappropriate antibiotic use. CMS is retiring this measure from the IQR Program for this reason.

As proposed, CMS will add the following measures to the IQR Program beginning with FFY 2014 payment determinations:

- 1 Center for Disease Control and Prevention (CDC)/National Healthcare Safety Network (NHSN)-based HAI measure:

- Catheter Associated Urinary Tract Infection (CAUTI)

As proposed, hospitals must begin submitting data on this measure beginning with events that occur on or after January 1, 2012.

As noted above, citing commenter concerns over its effectiveness and appropriateness, CMS is not adopting its proposal to add a second HAI measure, CLIP, to the IQR Program.

- 1 Claims-based measure:
  - Medicare spending per beneficiary

As proposed, CMS will calculate this measure using claims data for hospital discharges occurring between May 15, 2012 and February 14, 2013. Additional detail regarding this measure is provided in the “Updates to the Hospital VBP Program for FFY 2014” section below.

- 1 Web-based structural measure
  - Participation in a Systematic Clinical Database Registry for General Surgery

The annual data submission for this structural measure via a Web-based collection tool will occur between April 1, 2013 and May 15, 2013 with respect to the time period January 1, 2012, through December 31, 2012.

A complete list of the 55 adopted IQR Program measures for FFY 2014 payment determinations is available on *Federal Register* pages 51,628-51,629.

### FFY 2015 Payment Determinations

*Federal Register* pages 51,629-51,637

**CMS’s Proposal:** “. . . we are proposing to retain all of the FY 2014 measures (56 measures if all of the measures are finalized), to adopt 3 HAI measures, and 14 chart-abstracted measures for a total of 73 measures for the FY 2015 payment determination.”

**CMS’s Final Rule:** CMS is adopting its proposal as final.

As proposed, CMS will retain the measures that will be used for FFY 2014 payment determinations and add the following measures to the IQR Program beginning with FFY 2015 payment determinations:

- 3 CDC/NHSN-based HAI measures:
  - Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia
  - C. Difficile SIR
  - Healthcare Personnel (HCP) Influenza Vaccination (NQF # 0431)
- 14 Chart-abstracted measures for stroke and venous thromboembolism (VTE):
  - STK-1: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke (NQF #0434)
  - STK-2: Ischemic stroke patients discharged on antithrombotic therapy (NQF #0435)
  - STK-3: Anticoagulation therapy for atrial fibrillation/flutter (NQF #0436)
  - STK-4: Thrombolytic Therapy for Acute ischemic stroke patients (NQF #0437)
  - STK-5: Antithrombotic therapy by the end of hospital day two (NQF #0438)
  - STK-6: Discharged on statin medication (NQF #0439)

- STK-8: Stroke education (NQF #0440)
- STK-10: Assessed for rehabilitation services (NQF #0441)
- VTE-1: Venous thromboembolism prophylaxis (NQF #0371)
- VTE-2: Intensive care unit venous thromboembolism prophylaxis (NQF #0372)
- VTE-3: Venous thromboembolism patients with anticoagulation overlap therapy (NQF #0371)
- VTE-4: Venous thromboembolism patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol (NQF #0371)
- VTE-5: Venous thromboembolism discharge instructions (NQF #0371)
- VTE-6: Incidence of potentially-preventable venous thromboembolism (NQF #0371)

The addition of these chart-abstracted measures will eventually align the IQR Program measures with the hospital quality measures adopted under the EHR Incentive Program. Currently, almost all measures between the two programs differ. However, as adopted, these measures will exist as two sets of measures; chart-abstracted for the IQR Program and electronically specified for the EHR Incentive Program.

A complete list of the 72 adopted IQR Program measures for FFY 2015 payment determinations is available on *Federal Register* pages 51,636-51,637.

#### *Updates to the IQR Program Participation Policies*

*Federal Register* pages 51,639-51,652

**Background:** Hospitals must follow a number of steps to satisfy the IQR Program requirements and qualify for the full marketbasket update. These steps are continuously updated by CMS and available in detail on the QualityNet Exchange Web site at <https://www.qualitynet.org/>.

**CMS's Final Rule:** CMS is adopting several proposed changes to the IQR Program data submission deadlines and procedures, chart validation requirements and methods, and other IQR-related procedures and processes. Complete detail on these adopted changes is available on *Federal Register* pages listed above.

#### *Alignment of Quality Reporting Between the IQR Program and EHR Incentive Program*

*Federal Register* pages 51,652-51,653

**Background:** Currently, there is very little alignment between the quality measures collected from hospitals under the IQR Program and the newly-established EHR Incentive Program. The EHR Incentive Program requires the submission of 15 quality measures, 2 of which were previously selected for use under the IQR Program. As described above, CMS, in this rule, is adopting the remainder of the EHR Incentive Program measures for the IQR Program beginning with FFY 2015 payment determinations. However, even with the alignment of measures, participation in the IQR Program requires manual chart abstraction while participation in the EHR Incentive Program requires EHR-based reporting.

**CMS's Final Rule:** In the final rule, CMS responds to a handful of comments related to how CMS can better align the quality reporting requirements of the IQR and EHR Incentive programs. In the proposed rule, CMS stated that they anticipate, at some point in the future, using a single set of quality measures for both programs, most of which would be electronically specified (CMS notes exceptions for survey measures, claims-based measures, etc). CMS specifically sought comment on an approach of selecting a date, such as calendar year 2015, after which chart-abstracted data would no longer be used for the IQR Program. Under this approach, EHR-based reporting would be required to successfully participate in the IQR Program. CMS states in the final rule that they anticipate most hospitals will have the capability to report quality measures electronically by 2015 because payment penalties associated with the EHR Incentive Program are phased in

beginning in that year. CMS anticipates developing policies in the future related to the alignment of the quality reporting requirements of the IQR and EHR Incentive programs.

### Possible New Measures and Topics for Future Years

*Federal Register* pages 51,637-51,639

**CMS's Final Rule:** In the final rule, CMS lists 68 quality measures under 15 topic areas for which it is considering expanding the IQR Program. In the proposed rule, CMS solicited comment on the expansion of the IQR Program and specifically these measures. CMS states that they are seeking to limit the number of chart-abstracted measures in order to facilitate the eventual transition to EHR-based reporting. A complete list of the measures under consideration by CMS for IQR expansion is available on *Federal Register* pages 51,637-51,638.

## Updates to the Hospital VBP Program for FFY 2014

*Federal Register* pages 51,653-51,660

**Background:** Included as part of the IPPS final rule are several policies related to the FFY 2014 (second year) hospital inpatient VBP Program established by the PPACA. Complete program policies for the first year VBP Program (FFY 2013 program), and several program policies for the FFY 2014 program have already been adopted by CMS. Using measures reported under the IQR Program, the VBP Program will redistribute inpatient FFS payments to hospitals based on quality performance beginning October 1, 2012 (FFY 2013). CAHs are not subject to this program.

The PPACA requires CMS to adopt, for the VBP Program, measures of efficiency, including measures of Medicare spending per beneficiary, as early as FFY 2014.

**CMS's Final Rule:** CMS is moving forward with its proposal to adopt a Medicare spending per beneficiary measure for use under the Hospital IQR Program (see "Hospital IQR Program" above) and FFY 2014 VBP Program.

CMS's policies and scoring methodologies adopted for the efficiency measure are closely related to the VBP policies and scoring methodologies adopted for the process of care and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measures that will be used for the FFY 2013 VBP Program. The VBP final rule for the FFY 2013 program is available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf>.

CMS is adopting the following related to this measure:

- As proposed, CMS will incorporate the Medicare spending per beneficiary measure score into the FFY 2014 VBP Program as part of a new, "efficiency," domain. With the addition of this domain, the FFY 2014 Program will have a total of four domains; process of care, patient experience of care, outcomes, and efficiency. Under VBP, each domain is given a specific weight in order to calculate a Total Performance Score. In the calendar year 2012 Outpatient PPS proposed rule released in July, CMS proposed to set the weight of the efficiency domain at 20%. CMS proposed to set the other domain weights for the FFY 2014 VBP Program as follows: clinical process of care: 20% (set at 70% for the FFY 2013 program), patient experience of care: 30% (set at 30% for the FFY 2013 program), and patient outcomes: 30% (new domain for FFY 2014 program).

- A VBP score for the efficiency measure will be calculated for each hospital based on its performance on the measure during two specific time periods. These time periods are defined by CMS as a “baseline period” and a “performance period.” As proposed, CMS is adopting a 9-month baseline period of hospital discharges occurring between May 15, 2010 through February 14, 2011 and a 9-month performance period of hospital discharges occurring between May 15, 2012 and February 14, 2013.
- CMS is adopting its proposal that the Medicare spending per beneficiary measure be a claims-based measure.
- Modifying its proposal, CMS will evaluate Medicare spending per beneficiary for each hospital using an episode that runs from three days prior to an inpatient hospital admission (index admission) through 30 days post-hospital discharge. CMS had originally proposed to evaluate this measure using data for 90 days post-hospital discharge.
  - CMS is adopting its proposal to include all Medicare Part A and Part B payments made for services provided to the beneficiary during the proposed 30-day episode to calculate this measure. This spending will be attributed to the hospital at which the index admission occurred. As proposed, transfers to sub-acute providers, readmissions, and additional admissions that begin during the 30-day post discharge window of the index admission will be included in the calculation of this measure. Altering its proposal slightly, CMS will not include statistical outliers in this spending amount. Also, in a change from the proposed rule, an acute care hospital to acute care hospital transfer will not generate a new episode.
  - As proposed, CMS will adjust Medicare payments included in the spending per beneficiary episode to account for age and severity of illness and exclude geographic payment rate differences (wage index and geographic practice cost index) and the portion of inpatient payments related to payment differentials caused by hospital-specific rates, IME, and DSH.
- To calculate a hospital’s Medicare spending per beneficiary amount, CMS is adopting its proposal to divide the sum of all adjusted Medicare Part A and Part B payments included in all of the Medicare spending per beneficiary episodes by the total number of Medicare spending per beneficiary episodes for the hospital. Based on comments from the hospital field related to transparency, CMS will make a public use file available so that hospitals can determine their own historical spending amounts.
- For the purpose of scoring hospital performance under the FFY 2014 VBP Program, CMS will use a hospital’s per beneficiary amount to calculate a Medicare spending per beneficiary ratio. As proposed, CMS will calculate this ratio as a hospital’s individual Medicare spending per beneficiary amount divided by the median Medicare spending per beneficiary amount across all hospitals.
- Once a hospital’s Medicare spending per beneficiary ratio is calculated, the ratio will be compared to the national benchmark ratio (1.0, as proposed) and national achievement threshold ratio (the mean of the lowest decile of Medicare spending during the performance period, as proposed) to calculate a VBP score for the measure. Hospitals can earn up to 10 achievement points and up to 9 improvement points for the efficiency measure using the following formulas (final VBP score for the measure will be based on the higher of a hospital’s achievement or improvement score):
  - Achievement points for the efficiency measure will be calculated as follows:
    - If a hospital’s Medicare spending per beneficiary ratio is–
      - At or below the national benchmark, the hospital will receive the maximum of 10 achievement points;

- Above the national achievement threshold , the hospital will receive achievement points;
  - Between the national benchmark and achievement threshold, the hospital will receive between 1 and 9 achievement points according to the following formula:  $[9 * ((national\ achievement\ threshold - Hospital's\ performance\ period\ Medicare\ spending\ per\ beneficiary\ ratio) / (national\ achievement\ threshold - national\ benchmark))] + 0.50$
- Improvement points for the efficiency measure will be calculated as follows:
  - If a hospital's Medicare spending per beneficiary ratio is-
    - At or above its baseline period ratio, the hospital will receive 0 improvement points;
    - Below its baseline period ratio, the hospital will receive between 0 and 9 improvement points according to the following formula:  $[10 * ((hospital\ baseline\ period\ Medicare\ spending\ per\ beneficiary\ ratio - hospital\ performance\ period\ Medicare\ spending\ per\ beneficiary\ ratio) / (hospital\ baseline\ period\ Medicare\ spending\ per\ beneficiary\ ratio - national\ benchmark))] - 0.50$
- As proposed, CMS will calculate the efficiency domain score as follows: total points earned on the Medicare spending per beneficiary measure divided by 10, multiplied by 100%.

## Establishment of the Hospital Readmissions Reduction Program for FFY 2013

*Federal Register* pages 51,660-51,676

Included in the IPPS final rule are several policies that put in place the framework for the Medicare hospital inpatient readmissions payment policy established by the PPACA. This program, dubbed the Hospital Readmissions Reduction Program, is designed to reduce Medicare inpatient fee-for-service (FFS) payments to hospitals with higher than expected risk-adjusted readmission rates related to certain conditions. The program will begin October 1, 2012 (FFY 2013). Medicare payment reductions under this program will be capped at 1.0% in FFY 2013. The capped reduction amount will increase over time. CAHs are not subject to this program.

CMS plans to implement additional requirements of the readmissions payment policy in next year's IPPS rulemaking cycle. The following reflect the major policies of the program adopted by CMS:

- CMS adopted its proposal to use the following measures, currently included in the Hospital IQR Program and collected from Medicare FFS claims data, for use under the FFY 2013 program:
  - Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure (NQF# 0505);
  - Heart Failure 30-day Risk Standardized Readmission Measure (NQF#0330 ); and
  - Pneumonia 30-day Risk Standardized Readmission Measure (NQF#0506).
- As proposed, CMS will use 3 years of data as the period to calculate readmission rates to be used under the program (discharges from July 1, 2008 through June 30, 2011 for FFY 2013). The 3-year period coincides with how the adopted measures are currently calculated and displayed on the Hospital Compare Web site.
- As proposed, CMS will define a readmission as a second admission to the same or another acute care hospital within 30-days of the discharge from the index hospital (the initial hospitalization hospital).

This definition coincides with how the measures are currently evaluated under the IQR Program. An index hospitalization, the admission from which 30 days is reviewed for possible readmissions, will exclude in-hospital deaths, patients not enrolled in Medicare FFS for at least 30 days post-discharge, patients discharged against medical advice, and patients under the age of 65.

- As proposed, CMS will not adopt any additional exclusions nor any additional risk adjustment in determining the readmission rates for the measures beyond the exclusions and risk adjustment currently applied to these measures under the IQR Program. The PPACA requires CMS to exclude readmissions that are unrelated to the initial discharge and to apply a risk adjustment to the measures.
- CMS is adopting its proposal to exclude from the program, readmission measures with fewer than 25 discharges. This policy compares with the discharge threshold CMS currently uses for displaying readmission rates for these measures on the Hospital Compare Web site.
- To determine which hospitals have higher than expected risk-adjusted readmission rates and will be subject to the PPACA's readmission payment policy, CMS is adopting its proposed methodology that will compare a hospital's risk-adjusted readmission rate to the unadjusted/raw US average rate (both currently reported on the Hospital Compare Web site). The result of this calculation will be an "Excess Readmission Ratio." If a hospital performs worse than average, the ratio will be greater than 1.0 and the hospital will be subject to a payment penalty.

## Rural Hospital Inpatient Payment and Policy Issues

### Expiration of MDH Status in FFY 2013

*Federal Register* page 51,683

**Background:** Rural hospitals that meet certain criteria can be classified as a MDH under the IPPS. This special rural status allows inpatient payments to be based on the higher of the federal rate or a blended federal/hospital-specific rate.

To obtain MDH status, a rural hospital must not have status as a SCH and have no more than 100 beds with at least 60% of its inpatient days or discharges attributable to individuals receiving Medicare Part A benefits.

**CMS's Final Rule:** Unlike other special rural provider types, the MDH program is set by law and requires legislation to continue. The PPACA extended the MDH program through FFY 2012. The MDH program will expire after FFY 2012 without legislative action.

### Updates to Minimum Criteria for Hospitals Seeking Rural Referral Center (RRC) Status

*Federal Register* pages 51,676-51,677

**Background:** Rural hospitals that meet certain criteria can be classified as a RRC under the IPPS. This special rural status allows:

- exemption from the 12% cap on DSH payments that is applicable to other rural hospitals; and
- special treatment under the geographic reclassification rules including:
  - exemption from the proximity criteria; and
  - exemption from the requirement that a hospital's AHW must exceed 106% or 108% of the AHW of the labor market area where the hospital is located.

A hospital may voluntarily cancel its RRC status, in which case it will lose the DSH cap exemption. However, it will continue to be exempt from the geographic reclassification requirement.

To obtain RRC status, a rural hospital must have 275 or more beds available for use. As an alternative, a rural hospital can obtain RRC status if it meets certain minimum case-mix index (CMI) and discharge criteria and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume).

**CMS's Final Rule:** As it does each year, CMS is updating the minimum CMI and discharge values required for hospitals seeking RRC status that do not meet the 275 bed criteria. The FFY 2012 minimum values by region are available on *Federal Register* page 51,677.

### Payments to CAHs for Ambulance Services

*Federal Register* pages 51,729-51,732

**Background:** The PPACA increased payment for ambulance services furnished by a qualifying CAH or entity owned and operated by a CAH from reasonable costs to 101% of reasonable costs effective for cost reporting periods beginning on or after January 1, 2004.

Current regulations state that payment for ambulance services at 101% of reasonable costs require the CAH or the entity furnishing the service to be the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

Providers or suppliers of ambulance services that do not qualify for cost-based reimbursement are paid under the ambulance fee-schedule.

**CMS's Final Rule:** CMS is adopting its proposal to revise its current policy and clarify instances of when a CAH-owned and operated entity will be paid at 101% of reasonable costs and when they will be paid under the ambulance fee-schedule.

CMS put forward these policy changes because:

- there is conflict between the statutory language and current regulations; the statute does not address instances where there is another provider or supplier of ambulance services within a 35-mile drive of the CAH-owned and operated entity while the regulation does; and
- the statutory language does not address situations where the entity that is owned and operated by the CAH is located more than a 35-mile drive from the CAH.

A series of diagrams that clarify the adopted policy changes are available on *Federal Register* pages 51,730-51,731. These changes will be effective for cost reporting periods beginning on or after October 1, 2011.

# Other Inpatient Payment and Policy Issues

## Updates to the HAC MS-DRG Payment Policy

*Federal Register* pages 51,504-51,522

**Background:** Complications such as infections acquired in the hospital can trigger higher payments in the form of case assignments to a higher severity MS-DRG and/or outlier payments. As required by the Deficit Reduction Act (DRA) of 2005, CMS implemented a HAC payment policy beginning October 1, 2008 (FFY 2009), that no longer assigns cases to a higher paying MS-DRG when certain conditions are not present on admission (POA) and, therefore, considered hospital-acquired.

Currently, there are 10 HAC categories subject to the HAC MS-DRG payment policy. CMS has the authority to revise the list of HACs subject to this payment policy.

**CMS's Proposal:** *"For FY 2012, we are proposing . . . the creation of a new HAC category for Contrast-Induced Acute Kidney Injury . . ."*

**CMS's Final Rule:** Citing data integrity issues, CMS is not adopting its proposal to add a new HAC category, contrast-induced acute kidney injury, to the 10 HAC categories currently not recognized for Medicare IPPS payments.

However, as proposed, CMS will expand the current HAC payment policy by adding five new, International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM), diagnosis codes to three existing HAC categories.

The following represent the new diagnosis codes that will be added to the existing HACs.

- Falls and Trauma:
  - 808.44: Multiple closed pelvic fractures without disruption of pelvic circle (CC)
  - 808.54: Multiple open pelvic fractures without disruption of pelvic circle (MCC)
  
- Surgical Site Infections Following Bariatric Surgery:
  - 539.01: Infection due to gastric band procedure (CC)
  - 539.81: Infection due to other bariatric procedure (CC)
  
- Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
  - 415.13: Saddle embolus of pulmonary artery (MCC)

A complete list of the current HAC categories and the diagnosis codes that identify the conditions is available on *Federal Register* pages 51,511-51,512.

## Updates to the MS-DRGs Subject to the Post-Acute Care Transfer Payment Policy

*Federal Register* pages 51,709-51-711

**Background:** When a patient is transferred from an acute care facility to a post-acute care setting, the transferring hospital receives a per diem payment, with a total payment capped at the full MS-DRG amount. For MS-DRGs subject to the post-acute care transfer policy that CMS deems to be high cost, CMS applies a special payment methodology so that the transferring hospital receives 50% of the full MS-DRG payment plus a per diem payment, with total payment capped at the full MS-DRG amount. Each year, CMS, using established criteria, reviews the list of MS-DRGs subject to the post-acute care transfer policy.

**CMS's Final Rule:** As proposed, CMS is updating the list of MS-DRGs subject to the post-acute care transfer policy. CMS is:

- Adding the following eight MS-DRGs to the policy:
  - 023: Cranio w Major Dev Impl/Acute Complex CNS PDX w MCC or Chemo Implant
  - 024: Cranio w Major Dev Impl/Acute Complex CNS PDX w/o MCC
  - 216: Cardiac Valve & Oth Maj Cardiothoracic Proc w Card Cath w MCC
  - 217: Cardiac Valve & Oth Maj Cardiothoracic Proc w Card Cath w CC
  - 218: Cardiac Valve & Oth Maj Cardiothoracic Proc w Card Cath w/o CC/MCC
  - 570: Skin Debridement w MCC
  - 571: Skin Debridement w CC
  - 572: Skin Debridement w/o CC/MCC
  
- Removing the following three MS-DRGs from the policy:
  - 228: Other Cardiothoracic Procedures w MCC
  - 229: Other Cardiothoracic Procedures w CC
  - 230: Other Cardiothoracic Procedures w/o CC/MCC

CMS is not adopting its proposal to remove the following two MS-DRGs from the policy:

- 640: Misc Disorders of Nutrition, Metabolism, Fluids/Electrolytes w MCC
- 641: Misc Disorders of Nutrition, Metabolism, Fluids/Electrolytes w/o MCC

As proposed, CMS will apply the special payment methodology to MS-DRGs 216, 217, and 218.

### *Updates to the "3-Day Payment Window" or "72-Hour Rule"*

*Federal Register* pages 51,705-51,709

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

Under the modifications made to the 72-hour rule, all outpatient non-diagnostic services provided by the hospital on the date of the inpatient admission or during the 3-days immediately preceding the date of the inpatient admission are deemed related to the admission and must be billed with the inpatient stay unless the hospital attests to specific non-diagnostic services as being unrelated to the hospital claim. Prior to the legislative change, hospitals were allowed to bill or, in some cases, re-bill Medicare Part B for these non-diagnostic services.

**CMS's Final Rule:** On October 29, 2010, CMS issued a Transmittal (Transmittal 796) denoting how hospitals could attest to non-diagnostic services as being unrelated and therefore billed separately as an outpatient service. As it did in the proposed rule, CMS reiterates the requirements in the final rule.

As of April 1, 2011, if a hospital wishes to attest to non-diagnostic services as being unrelated to the hospital claim, the hospital must add condition code 51 on claims for separately billed outpatient non-diagnostic services furnished on or after June 25, 2010. If a hospital attests to non-diagnostic services as being unrelated to the inpatient admission, the hospital must maintain documentation in the beneficiary's medical record to support the claim.

As it did in the proposed rule, CMS clarifies in the final rule that the 72-hour rule policy applies to physician practices that are wholly owned or wholly operated by the admitting hospital.

### *Changes to the Maximum Annual Allowable Pension Costs for Purposes of the Wage Index and Cost-Based Reimbursement*

*Federal Register* pages 51,586-51,591 and 51,693-51,697

**Background:** CMS includes hospital pension costs in calculating the wage index. Also, certain pension costs may be allowable for cost-based reimbursement under Medicare if the costs are related to the reasonable and necessary cost of providing patient care and represent costs actually incurred.

Currently, CMS relies on actuarial computations to determine maximum annual allowable pension costs for purposes of the wage index. Under current rules, these computations must be performed in accordance with the Employee Retirement Income Security Act (ERISA) of 1974 and the maximum allowable pension costs must be funded in order to be allowable. Under changes to ERISA made by the Pension Protection Act (PPA) of 2006, there is no longer a standard actuarial basis used by all plans to determine maximum pension costs.

**CMS's Final Rule:** CMS is adopting, with slight modifications, its proposals to revise the policies for determining maximum allowable pension costs for the purposes of computing the hospital wage index and for cost-based reimbursement. CMS is adopting these changes while maintaining current requirements that pension costs must be funded to be reportable, and will require all hospitals to report actual pension contributions funded during the reporting period, on a cash basis.

- For determining the *maximum allowable pension costs for the purposes of the wage index*—CMS is adopting its proposal to include pension costs, in the wage index, equal to the average actual cash contributions deposited to a hospital's defined benefit pension plan by the hospital and/or the hospital system over a 3-year period.

As proposed, CMS will center the 3-year average on the base cost reporting year for the wage index. As this policy is effective for the FFY 2013 wage index, this wage index will reflect average contributions made during FFYs 2008, 2009, and 2010.

In response to concerns over prefunded pension plans, CMS is enhancing its proposal and will allow certain prefunded amounts to be reported as pension costs in future periods. This will allow hospitals to include funding that may have exceeded the amounts reportable for the FFY 2007 through FFY 2012 wage indexes. The transition policy permits hospitals to include 1/10<sup>th</sup> of the prefunding balance in the wage index pension cost each year beginning with the FFY 2013 wage index and ending with the FFY 2022 wage index, in 10 equal prefunding installments.

CMS believes that this policy is necessary to ensure uniformity among all hospitals, regardless of their tax status or Employee Retirement Income Security Act (ERISA) coverage and the use of a 3-year average will reduce the volatility that can occur due to timing of contributions.

- For determining the *maximum allowable pension costs for the purposes of cost-based reimbursement*—CMS is adopting its proposal to limit the current period liability equal to 150% of the three consecutive reporting periods out of the five most recent reporting which produce the highest average.

This policy is effective for cost reporting periods beginning on or after October 1, 2011. CMS believes the limit will ensure that reported pension costs are reasonable for the purposes of cost-based reimbursement.