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Health care legislative and regulatory update

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CMS Issues Final FY 2011 Medicare IPPS Update with Market Basket Increase of 2.35 Percent and A Negative Coding Adjustment of 2.9 Percent

The Centers for Medicare and Medicaid Services (CMS) have issued an interim final rule to update both the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2011. The 1,877-page document was placed on public display at the ***Federal Register*** office late on July 30, and is scheduled for publication on August 16. A copy of the notice is available on the ***Federal Register*** web site.

The market basket update for FY 2011 for hospitals paid under the IPPS is 2.6 percent. As required by the ***Deficit Reduction Act of 2005*** (DRA), hospitals that do not participate successfully in the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program will receive the market basket update less 2.0 percentage points, or 0.6 percent. The update amounts will be further reduced by 0.25 percentage points, as required by the ***Affordable Care Act*** (ACA). Therefore, the applicable percentage increase to the standardized amount for FY 2011 is 2.35 percent for hospitals that submit quality data in accordance with the RHQDAPU requirements and 0.35 percent for hospitals that do not submit quality data.

CMS will, as proposed reduce the IPPS standardized payment amounts by 2.9 percent to account for documentation and coding changes that the agency measured for FYs 2008 and 2009 that did not reflect increases in patient severity levels.

The market basket update for LTCHs for FY 2011 will be 2.5 percent. The market basket update is being reduced by 0.50 percentage points as required by the ACA. The FY 2011 LTCH standard Federal rate will also be adjusted by a negative 2.5 percentage points for documentation and coding practices for FY 2008 and 2009.

Others items being addressed include changes to capital payments, outlier thresholds, MS-DRGs, new medical technologies, area wage index values, and critical access hospitals (CAHs).

In addition, the rule is making changes affecting the: Medicare conditions of participation for hospitals relating to the types of practitioners who may provide rehabilitation services and respiratory care services; and determination of the effective date of provider agreements and supplier approvals under Medicare.

CMS is also setting forth provisions that offer psychiatric hospitals and hospitals with inpatient psychiatric programs increased flexibility in obtaining accreditation to participate in the Medicaid program. Psychiatric hospitals and hospitals with inpatient psychiatric programs will have the choice of undergoing a State survey or of obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS.

CMS is implementing a provision of the ***Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010*** relating to Medicare payments for outpatient services provided prior to a Medicare beneficiary's inpatient admission – the so called three-day payment window.

CMS says that payments under the IPPS to hospitals will decrease some $440 million while payments to LTCH will increase $22 million.

Comment

This is a long and complex rule providing information on more than just updates to the IPPS and LTCH PPS programs.

There appears to be a greater attempt of providing summaries of final actions the agency has taken with respect to its rulemaking. This is welcome inasmuch as it easier for the reader to comprehend CMS' positions. Nonetheless, there is still an abundance of history on the development of the issues. It would be helpful if CMS stated its decisions at the start of each section.

Other items

Outlier Threshold: CMS estimates that the total outlier payments in FY 2010 will be 4.7 percent of total payments under the IPPS. CMS is lowering the outlier threshold in FY 2011 to $23,075 to maintain projected outlier payments at 5.1 percent.

Partial Freeze to ICD-9-CM and ICD-10-CM/PCS Code Updates: The ICD-10 coding system will be implemented on October 1, 2013. CMS is considering whether to establish a partial freeze in the annual updates to both ICD-9-CM and ICD-10-CM/PCS code changes to alleviate concerns that any instructional or coding software programs would require frequent, significant updates. A final decision on whether to establish a partial freeze is expected to be announced at the September 2010 ICD-9-CM Coordination and Maintenance Committee meeting.

***New Medical Services and Technology*:** CMS is approving a new technology add-on payment for FY 2011 - the *Auto Laser Interstitial Thermal Therapy (AutoLITT™) System* (Monteris), which is a minimally invasive method for delivering a heat source to destroy a tumor or a portion of a tumor in a patient's brain using magnetic resonance imaging (MRI) guidance.

Graduate Medical Education (GME): CMS is clarifying that a physician who is not training in an approved medical residency program should bill for his/her services under the Part B Physician Fee Schedule and should not be included in the full-time equivalent (FTE) resident count for Indirect Graduate Medical Education (IME) and Direct GME purposes.

Additional Quality Measures: The final rule adds 12 measures to the RHQDAPU set, and retires one current measure – Mortality for selected surgical procedures (composite). However, only 10 of the new measures will be considered in determining a hospital's FY 2012 update. The remaining 2 measures to be reported in 2011 would be considered in determining the hospital's FY 2013 update.

Hospital Acquired Conditions (HACs): The final rule does not change the list of hospital-acquired conditions (HACs).

Additional Payments for Hospitals with Low per Enrollee Medicare Spending: The ACA provides for additional payments totaling $400 million to "qualifying hospitals" for FYs 2011 and 2012. A "qualifying

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hospital" is a "subsection (d) hospital" (a hospital paid under the IPPS methodology) that is located in a county that ranks, based upon its per enrollee Medicare spending under parts A and B, adjusted for age, sex, and race, within the lowest quartile of counties in the United States. CMS is finalizing the methodology and will distribute $150 million in FY 2011 to qualifying hospitals. In the final rule, CMS identified two additional eligible counties but did not identify any hospitals located in those counties.

Temporary Improvements to Low-Volume Hospital Adjustment: The ACA expands eligibility for the low-volume payment adjustment during FYs 2011 and 2012 to hospitals that are more than 15 miles from other hospitals (instead of the current statutory requirement of being more than 25 miles apart) and with less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A (instead of the current statutory requirement of 800 total discharges). The law requires the Secretary to create a sliding payment scale, ranging from a 25 percent adjustment for hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, Part A, to no payment adjustment for hospitals with 1,600 or greater discharges of individuals entitled to, or enrolled for, part A.

Protection for Hospitals in Frontier States: The ACA requires CMS to adopt a hospital wage index that is not less than 1.0000 for hospitals located in frontier states, beginning in FY 2011. Frontier states are defined in the law as states where at least 50 percent of the counties have a population density of less than six people per square mile. In the final rule, CMS is basing the frontier county and state determinations on the most recently available Annual Population Estimates from the U.S. Census. As a result, 51 IPPS hospitals in five states – Montana, Nevada, North Dakota, South Dakota, and Wyoming – will benefit from this provision in FY 2011.

Provisions Affecting Critical Access Hospitals (CAHs):

- **Reimbursement for Services of Certified Registered Nurse Anesthetists (CRNAs):** The final rule allows hospitals and CAHs that are geographically urban but have applied for and been granted rural status under a specific provision of the Medicare law to receive reimbursement for anesthesia and related care furnished by qualified CRNAs on reasonable cost basis, if the hospital or CAH meets all of the other statutory requirements for those reasonable cost payments.

- **Removal of the Annual Election Requirement on Maintaining Method II Payment:** The final rule provides that a CAH's election of the optional or "Method II" payment method for outpatient services remains in place until the CAH terminates it.

- **Clarification of Which Provider Taxes May Be Allowable Costs:** CMS regulations currently permit certain provider taxes to be treated as allowable costs if they are related to the reasonable and necessary cost of providing patient care and they are actually incurred. The final rule clarifies the extent to which these taxes may be allowable costs and states that Medicare contractors – that is, Medicare Administrative Contractors (MAC) or fiscal intermediaries (FIs) - will determine the extent to which provider taxes are allowable on a case-by-case basis, based on reasonable cost principles.

Other ACA provisions included in the IPPS/LTCH FY 2011 final rule:

- Adopting national budget neutrality in the calculation of the rural and imputed floors for the hospital wage index.

- Extending the Medicare Dependent Hospital (MDH) program through Oct. 1, 2012.

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- Implementing a technical correction to the payment methodology for critical access hospitals (CAHs) which elect the optional billing method allowing them to receive 101 percent (rather than 100 percent) of reasonable costs for outpatient facility services and ambulance services.

LTCH Outlier Threshold: CMS is projecting that the total estimated outlier payments in FY 2010 will be approximately 7.42 percent of total estimated LTCH PPS payments, 0.58 percentage points lower than the target rate of 8 percent. Even though FY 2010 payments are projected to be less than the 8 percent removed from the rates using current data, CMS is adopting a slight increase to the LTCH outlier threshold for FY 2011. CMS's payment models indicate the outlier threshold must be raised slightly to keep projected estimated LTCH outlier payments at 8 percent of total estimated payments under the LTCH PPS. The outlier threshold for FY 2011 will be $18,785.

LTCH Adjustments: Extending for an additional two years the delay in application of certain payment adjustments for certain LTCHs and LTCH satellite facilities whose admissions from co-located or non co-located hospitals exceed a certain percent, and a moratorium on establishing new LTCHs and LTCH satellite facilities or increasing hospital beds in existing LTCHs and LTCH satellite facilities.

Clarification on Determining Provider/Supplier Agreement Effective Dates: CMS is clarifying that the effective date of a Medicare provider/supplier agreement with health care facilities that are subject to survey and certification is the date that the provider/supplier meets all Federal Medicare requirements, including the date CMS determines that it has met enrollment requirements. The date when all Federal requirements have been met may or may not be the date the survey was completed.

***Three-Day Payment Window*:** CMS says that the Medicare law requires hospitals to include diagnostic services and most admission-related non-diagnostic services provided in the hospital outpatient department on the day of admission or 3 calendar days prior to admission (one day for hospitals not paid under the IPPS) as part of the inpatient stay.

Congress recently clarified the situations in which these non-diagnostic services should be considered part of a beneficiary's inpatient stay. The clarification CMS says, which was included in the ***Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010*** ("Preservation of Access to Care Act"), "is consistent with how we understand hospitals have largely billed Medicare in the past." This provision was effective for services furnished on or after June 25, 2010. The comment period for this item closes on September 28, 2010.

Below is a section-by-section analysis of most items in the rule:

Documentation and Coding Adjustments

For FY 2008, CMS adopted MS-DRGs to more accurately account for patient resource consumption. This action increased the number of DRGs from 538 to 745. [There will be 746 DRGs in FY 2011.] CMS believes that the adoption of MS-DRGs encourages hospitals to improve their documentation and coding of patient diagnoses. CMS says it anticipated that hospitals would examine the MS-DRG MCC and CC code lists and then work with physicians and coders on documentation and coding practices so that coders could appropriately assign codes from the highest possible severity level. CMS' actuaries estimated, in FY 2008, that in order to maintain coding budget neutrality an adjustment of -4.8 percent to the national standardized amount was needed. CMS provided for phasing in this -4.8 percent adjustment over 3 years with coding adjustments of a negative 1.2 percent for FY 2008, a negative 1.8 percent for FY 2009, and a negative 1.8 percent for FY 2010.

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Congress via the ***Transitional Medical Assistance, Abstinence Education, and QI Programs Extension Act of 2007*** (TMA) required CMS to reduce its coding adjustments to a negative 0.6 percent for FY 2008 and a negative 0.9 percent for FY 2009. The TMA did not address CMS' third year (FY 2010) projected negative adjustment of 1.8 percent.

The amendment also requires CMS to adjust payment rates over FY 2010, FY 2011, and FY 2012 to "restore" budget neutrality if a retrospective review of claims data from FYs 2008 and 2009 found that changes in hospitals' documentation and coding practices were different from the amount of the adjustments specified in the TMA.

CMS did not make any adjustments in FY 2010. CMS now says that for FYs 2008 and 2009 coding and documentation increased 5.8 percent. For FY 2008 the retrospectively determined increase was 2.5 percent of which 0.6 was removed in setting the IPPS rates in FY 2008 by the TMA legislation leaving an underestimated value of 1.9 percent, and for FY 2009, coding increased by 5.4 percent of which 1.9 percent was removed by the TMA legislation (5.4 percent minus the statutory reductions of –(0.6 + 0.9) or -3.9 percent.

CMS is finalizing its proposal to make an adjustment of -2.9 percentage points for FY 2011 (or one-half of the total recoupment adjustment of 5.8 percent (1.9 + 3.9)) to begin recovering the excess payments for coding and documentation in FYs 2008 and 2009.

CMS also says that there is a remaining documentation and coding effect of a negative 3.9 percent that was paid in FY 2010. CMS notes that an additional cumulative adjustment of -3.9 percent is necessary to meet the requirements of TMA to make an adjustment to the average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments.

Although CMS says it has the authority to make the much larger reduction to the FY 2011 rates, CMS believes it is prudent to phase-in additional adjustments carefully over time

FY 2011 MS-DRG Documentation and Coding Adjustment

	Required Prospective Adjustment for FYs 2008-2009	Required Recoupment Adjustment for FYs 2008-2009	Total Adjustment	Recoupment Adjustment for FY 2011	Remaining Adjustment
Level of Adjustment	-3.9	-5.8	-9.7	-2.9	-6.8

Comment

CMS says that "a major advantage of making the -2.9 percent adjustment to the standardized amount in FY 2011 is that, because the required recoupment adjustment is not cumulative, we can anticipate removing the FY 2011 -2.9 percent adjustment from the rates in FY 2012, when it would also be necessary under current law to apply the remaining approximately -2.9 percent adjustment. These two steps in FY 2012, restoring the FY 2011 -2.9 percent adjustment and then 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, as discussed above) under section 7(b)(1)(B) of Pub. L. 110-90 in FY 2012."

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CMS' portrayal that next year's expected result would be to cancel itself out is quite misleading. Whether you take 5.8 percent in FY 2011 and zero percent in FY 2012, or 2.9 percent in each of FYs 2011 and 2012, you are reducing hospital payments by 5.8 percent.

Furthermore, CMS has not said how or when the additional 3.9 percent will be recaptured. The 3.9 percent represents the additional payments made in FY 2010 because CMS did not make any adjustments in the current year.

CMS has based its decision in great part on the Medicare Payment Advisory Commission's findings that CMS says support its conclusions.

In FY 2012, hospitals will become subject to the ACA's productivity adjustment factor. In the proposed hospital outpatient/ambulatory surgical center (ASC) proposed update for 2011. The ASC productivity factor is a negative 1.6 percent. If this is an indication of future productivity factors, more reductions may be ahead.

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Standardized Payment Rates

CMS says that it is increasing the FY 2011 amounts by a full market basket rate of 2.60 percent, reducing that amount by 0.25 percent as mandated by the ACA, reducing the standardized payment amounts further by an additional 2.9 percent documentation and coding factor. The rates will be as follows:

National Adjusted Operating Standardized Amounts
(68.8 Percent Labor Share/31.2 Percent Nonlabor if Wage Index Is Greater Than 1.0000)

Full Update (2.35 Percent)		Reduced Update (0.35 Percent)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
$3,552.91	**$1,611.20**	**$3,483.49**	**$1,579.72**

Rates Currently in Effect (April 1 – September 30, 2010)

Full Update		***Reduced Update***	
Labor-related	*Non-labor-related*	*Labor-related*	*Non-labor-related*
$3,587.24	*$1,626.78*	*$3,516.80*	*$1,594.84*

Rates in Effect October 1, 2009 – March 31, 2010

Full Update		***Reduced Update***	
Labor-related	*Non-labor-related*	*Labor-related*	*Non-labor-related*
$3,593.52	*$1,629.62*	*$3,523.13*	*$1,597.70*

National Adjusted Operating Standardized Amounts
(62 Percent Labor Share/38 Percent Nonlabor Share
if Wage Index Is Less Than or Equal To 1.0000)

Full Update (2.35 Percent)		Reduced Update (0.35 Percent)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
$3,201.75	**$1,962.36**	**$3,139.19**	**$1,924.02**

Rates Currently in Effect (April 1 – September 30, 2010)

Full Update		***Reduced Update***	
Labor-related	*Non-labor-related*	*Labor-related*	*Non-labor-related*
$3,232.69	*$1,981.33*	*$3,169.22*	*$1,942.42*

Rates in Effect October 1, 2009 – March 31, 2010

Full Update		***Reduced Update***	
Labor-related	*Non-labor-related*	*Labor-related*	*Non-labor-related*
$3,238.35	*$1,984.79*	*$3,174.91*	*$1,945.92*

Comment

The impact of the negative coding and documentation adjustment and market basket increases results in an overall standardized payment reduction for hospitals reporting quality information of $49.91 from the rates currently in effect and $59.03 from the rates that were effective October 1, 2009 for FY 2010.

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For hospitals not reporting quality the respective amounts are $48.43 and $57.62.

Changes for Inpatient Capital-Related Costs for FY 2011

CMS is increasing the capital payment amount by an update of 1.5 percent in determining the FY 2011 capital Federal rate for all hospitals. However, CMS is also reducing the update by -2.9 percent for coding and documentation changes. The FY 2011 capital rate will be **$420.01.** The FY 2010 rate was $429.26 (as corrected in the October 7, 2009 ***Federal Register***). And, the FY 2010 capital rate was recalculated further as a result of the ACA to $429.66.

Comparison of Factors and Adjustments: FY 2010 Capital Federal Rate And FY 2011 Capital Federal Rate

	FY 2010	FY 2011	Change	Change
Update Factor[1]	1.012	1.015	1.015	1.5
GAF/DRG Adjustment Factor[1]	0.9994	0.999	0.999	-0.1
Outlier Adjustment Factor[2]	0.9478	0.9404	0.9922	-0.78
Exceptions Adjustment Factor[2]	0.9998	0.9996	0.9998	-0.02
MS-DRG Documentation and Coding Adjustment Factor	0.9850[3]	0.9574[4]	0.9720[5]	-2.8
Capital Federal Rate[6]	$429. 56	**$420.01**	0.9778	-2.22

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2010 to FY 2011 resulting from the application of the 0.9990 GAF/DRG budget neutrality factor for FY 2011 is a net change of 0.9990.
[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2011 outlier adjustment factor is 0.9404/0.9478, or 0.9922.
[3] The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, and no additional reduction in FY 2010.
[4] The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, no additional reduction in FY 2010 and the -2.9 percent in FY 2011.
[5] The change is measured from the FY 2009 cumulative factor of 0.9850.
[6] Calculated using unrounded factors.

Outlier Payments

CMS has calculated a final outlier fixed-loss cost threshold for FY 2011 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus **$23,075.**

The current outlier fixed-loss cost threshold is $23,140.

Comment

CMS says it currently estimate that actual outlier payments for FY 2010 will be approximately 4.7 percent of actual total DRG payments, approximately 0.4 percentage points lower than the 5.1 percent projected in setting the outlier policies for FY 2010.

As has happened over the years, CMS has underestimated outlier payments. While CMS seems intent on correcting documentation and coding items, the agency has continued challenges identifying other errors in estimations or trying to make such corrections.

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Hospital-Specific Rates of Increase for Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs)

CMS says that hospitals (SCHs and MDHs) paid based in whole or in part on a hospital-specific rate use the same MS-DRG system as other hospitals, the agency believes they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness.

CMS says its best estimate, based on the most recently available data, is that a cumulative adjustment of -5.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments for these hospitals. Unlike the case of standardized amounts paid to IPPS hospitals, CMS has not made any previous adjustments to the hospital specific rates paid to SCHs and MDHs to account for documentation and coding changes. Therefore, the entire -5.4 percent adjustment remains to be implemented. Consequently, in order to maintain consistency as far as possible with the adjustments applied to IPPS hospitals, CMS is making an adjustment of -2.9 percent in FY 2011 to the hospital-specific rates paid to SCHs and MDHs.

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Changes to the Hospital Wage Index

1. Wage Index Study Requirements

a. MIEA-TRHCA

Section 106(b)(1) of the ***Medicare Improvements and Extension Act, the Tax Relief and Health Care Act of 2006*** (MIEA-TRHCA) required the Medicare Payment Advisory Commission (MedPAC) to submit to Congress, not later than June 30, 2007, a report on the Medicare wage index classification system. MedPAC has furnished its report. CMS is also required to make a report to Congress. To date the agency has not submitted any reports.

b. ACA

The ACA requires the Secretary to submit to Congress, not later than December 31, 2011, a report that includes a plan to reform the Medicare wage index applied under the Medicare IPPS.

2. Revision of the Reclassification Average Hourly Wage Comparison Criteria

For FY 2009, CMS, citing the MIEA-TRHCA, changed the criterion for the comparison of a hospital's average hourly wage to that of the area to which the hospital seeks reclassification to 88 percent for urban hospitals and 86 percent for rural hospitals. Previously, the amounts were 84 and 82 percent, respectively. The change was phased-in over two years.

ACA Section 3137(c) cancels this change. Specifically, section 3137(c) restores the average hourly wage standards that were in place for FY 2008 (that is, 84 percent for urban hospitals, 85 percent for group reclassifications, and 82 percent for rural hospitals) for applications for reclassification for FY 2011 and for each subsequent fiscal year until the first fiscal year beginning on or after the date that is one year after the Secretary submits a report to Congress on a plan for reforming the wage index.

CMS says "that section 3137(c) of the ACA does not provide for the revised average hourly wage standards to be applied retroactively, nor does it change the statutory deadline for applications for reclassification for FY 2011. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify 13 months prior to the start of the fiscal year for which reclassification is sought (generally by September 1). For reclassifications for the FY 2011 wage index, the deadline for applications was September 1, 2009."

Comment

CMS notes that 22 hospitals that applied for reclassification last September and failed to achieve reclassification status under CMS' higher thresholds will now be given reclassification status under the ACA revised thresholds. However CMS is not providing any opportunity for others to apply. CMS says it is bound by law. CMS says: "We believe that if the Congress had intended for hospitals to be afforded another opportunity to apply for reclassification for FY 2011 due to the revisions made by section 3137(c) of the ACA, the Congress also would have established such opportunity through a provision of the law."

3. Within-State Budget Neutrality Adjustment for the Rural and Imputed Floors

Section 4410 of the ***Balanced Budget Act of 1997*** (BBA) established a rural floor by requiring that the wage index for a hospital in an urban area of a State cannot be less than the area wage index determined for that

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State's rural area. In order to compensate for the increased wage indices of urban hospitals receiving the rural floor, a nationwide budget neutrality adjustment was applied to the wage index to account for the additional payment to these hospitals.

CMS began phasing-in over a 3-year period the transition from the national budget neutrality adjustment to one based on a State level budget neutrality adjustment. In FY 2009, hospitals received a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, the blended wage index reflects a 50 percent of the State level adjustment and 50 percent of the national adjustment. In FY 2011, the adjustment was to be completely transitioned to the State level methodology.

The ACA reverses CMS' actions. In accordance with the ACA, CMS is adopting a uniform, national budget neutrality adjustment for the rural and imputed floors, which, for FY 2011, is a factor of 0.996641. The wage indexes in the rule's Addendum reflects this policy.

Comment

CMS notes that the imputed floor is set to expire on September 30, 2011. CMS says it "is not reading the language of section 3141 of the ACA as altering this expiration date."

4. Floor for Area Wage Index for Hospitals in Frontier States

ACA section 10324(a) provides for establishing an adjustment to create a wage index floor of 1.0000 for all hospitals located in States determined to be Frontier States. The statute defines any State as a Frontier State if at least 50 percent of the State's counties are determined to be Frontier Counties. The statute defines such counties as those that have a population density of less than 6 persons per square mile.

All PPS hospitals located within that State will receive either the higher of its post-reclassification wage index rate, or a minimum value of 1.0000.

For FY 2011 IPPS wage index, the Frontier States are the following:

Frontier States under Section 10324(a)

State	Total Counties	Frontier Counties	Percent Frontier Counties
Montana	56	45	80%
Wyoming	23	17	74%
North Dakota	53	36	68%
Nevada	17	11	65%
South Dakota	66	34	52%

5. Core-Based Statistical Areas for the Hospital Wage Index

On December 1, 2009, OMB announced changes to the principal cities and, if applicable, titles of a number of CBSAs and Metropolitan Divisions (OMB Bulletin No. 10-2). The changes to the principal cities and titles are as follows:

- San Marcos, TX qualifies as a new principal city of the Austin-Round Rock, TX CBSA. The new title is Austin-Round Rock-San Marcos, TX CBSA.
- Delano, CA qualifies as a new principal city of the Bakersfield, CA CBSA. The new title: Bakersfield-Delano, CA CBSA.

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- Conroe, TX qualifies as a new principal city of the Houston-Sugar Land-Baytown, TX CBSA. The CBSA title is unchanged.
- North Port, FL qualifies as a new principal city of the Bradenton-Sarasota-Venice, FL CBSA. The new title is North Port-Bradenton-Sarasota, FL CBSA. The new code is CBSA 35840.
- Sanford, FL qualifies as a new principal city of the Orlando-Kissimmee, FL CBSA. The new title is Orlando-Kissimmee-Sanford, FL CBSA.
- Glendale, AZ qualifies as a new principal city of the Phoenix-Mesa-Scottsdale, AZ CBSA. The new title is Phoenix-Mesa-Glendale, AZ CBSA.
- Palm Desert, CA qualifies as a new principal city of the Riverside-San Bernardino-Ontario, CA CBSA. The CBSA title is unchanged.
- New Braunfels, TX qualifies as a new principal city of the San Antonio, TX CBSA. The new title is San Antonio-New Braunfels, TX CBSA.
- Auburn, WA qualifies as a new principal city of the Seattle-Tacoma-Bellevue, WA CBSA. The CBSA title is unchanged.

The changes to titles resulting from changes to the order of principal cities based on population are as follows:

- Rockville, MD replaces Frederick, MD as the second most populous principal city in the Bethesda-Frederick-Rockville, MD Metropolitan Division. The new title is Bethesda-Rockville-Frederick, MD Metropolitan Division.
- Rock Hill, SC replaces Concord, NC as the third most populous principal city in the Charlotte-Gastonia-Concord, NC-SC CBSA. The new title is Charlotte-Gastonia-Rock Hill, NC-SC CBSA.
- Joliet, IL replaces Naperville, IL as the second most populous principal city in the Chicago-Naperville-Joliet, IL Metropolitan Division. The new title is Chicago-Joliet-Naperville, IL Metropolitan Division.
- Crestview, FL replaces Fort Walton Beach, FL as the most populous principal city in the Fort Walton Beach-Crestview-Destin, FL CBSA. The new title is Crestview-Fort Walton Beach-Destin, FL CBSA. The new code is 18880.
- Hillsboro, OR replaces Beaverton, OR as the third most populous principal city in the Portland-Vancouver-Beaverton, OR-WA CBSA. The new title is Portland-Vancouver-Hillsboro, OR-WA CBSA.
- Steubenville, OH replaces Weirton, WV as the most populous principal city in the Weirton-Steubenville, WV-OH CBSA. The new title is Steubenville-Weirton, OH-WV CBSA. The new CBSA code is 44600.

6. Occupational Mix Adjustment to the FY 2011 Wage Index

CMS used data collected on a revised 2007-2008 Medicare Wage Index Occupational Mix Survey to compute the occupational mix adjustment for FY 2011.

The FY 2011 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$36.073112086
National LPN and Surgical Technician	$20.866432497
National Nurse Aide, Orderly, and Attendant	$14.619357374
National Medical Assistant	$16.479254498
National Nurse Category	$30.473796690

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the FY 2011 wage index results in a national average hourly wage of **$34.9664.**

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The wage index values for FY 2011 are included in the rule's addenda – Tables 4A, 4B, 4C, and 4F – reflect/include the occupational mix adjustment.

Tables 3A and 3B list the 3-year average hourly wage for each labor market area before the redesignation of hospitals based on FYs 2009, 2010, and 2011 cost reporting periods.

CMS notes that a new 2010 survey (Form CMS-10079 (2010)) will provide for the collection of hospital-specific wages and hours data for calendar year 2010 (that is, payroll periods ending between January 1, 2010 and December 31, 2010) and will be applied beginning with the FY 2013 wage index.

7. FY 2011 Medicare Geographic Classification Review Board (MGCRB) Reclassifications

CMS notes that the MGCRB had completed its review of FY 2011 reclassification requests. Based on such reviews, there are 285 hospitals approved for wage index reclassifications for FY 2011. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2011, hospitals reclassified during FY 2009 or FY 2010 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications. There were 247 hospitals approved for wage index reclassifications in FY 2009 and 251 hospitals approved for wage index reclassifications in FY 2010. CMS says there are 823 hospitals reclassified for FY 2011. [CMS's numbers for each year do not add to 823]

Applications for FY 2012 reclassifications are due to the MGCRB by September 1, 2010 (the first working day of September 2010). Applications and other information about MGCRB reclassifications may be obtained via the CMS Internet web site at: http://cms.hhs.gov/MGCRB/02_instructions_and_applications.asp, or by calling the MGCRB at (410)786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670.

8. Redesignations of Hospitals under Section 1886(d)(8)(B) of the Social Security Act

Section 1886(d)(8)(B) of the Social Security Act requires CMS to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria are met.

Hospitals located in these counties have been known as "Lugar" hospitals and the counties themselves are often referred to as "Lugar" counties. CMS has provided a table in the preamble of the final rule listing the FY 2011 rural counties containing the hospitals designated as urban.

Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MGCRB, they are subject to the rural reclassification rules and are subject to the proximity criteria and payment thresholds that apply to rural hospitals.

Hospitals not located in a Lugar county seeking reclassification to the urban area where the Lugar hospitals have been redesignated are not permitted to measure to the Lugar county to demonstrate proximity (no more than 15 miles for an urban hospital, and no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or SCHs) in order to be reclassified to such urban area. These hospitals must measure to the urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural area requirement.

9. Reclassifications under Medicare Modernization Act (MMA) "Section 508 Hospitals"

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Section 124 of the ***Medicare Improvements for Patients and Providers Act of 2008,*** (MIPPA) extended the hospital reclassifications provisions of so-called section 508 hospitals and certain special exceptions through September 30, 2009 (FY 2009). The ACA extends the provision till September 30, 2010.

CMS says because the latest extension of these provisions expires on September 30, 2010, and will not be applicable in FY 2011 it is not making any changes related to these provisions in this final rule.

Comment

Legislation is pending that would extend the section 508 provision. However, it has still not been passed by the Senate.

10. FY 2011 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

Beginning with FY 2005, CMS established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the "out-migration" adjustment).

These adjustments are effective for each county for a period of 3 fiscal years. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2010.

Hospitals receiving this wage index adjustment are not eligible for reclassification unless they waive the out-migration adjustment.

Table 4J in the Addendum to the rule lists the proposed out-migration wage index adjustments for FY 2011

Other Decisions and Changes to the IPPS for Operating Costs and GME Costs

1. Reporting of Hospital Quality Data for Annual Hospital Payment Update (RHQDAPU)

FY 2012

The payment determination, that is, whether or not a hospital receives a full market basket rate of increase or one subject to a 2.0 percent reduction from market basket, is based on the successful reporting by a hospital of the RHQDAPU program measure set.

CMS is adopting its proposal to retire the Mortality for Selected Surgical Procedures Composite from the RHQDAPU program measure set for the FY 2011 payment determination and for subsequent payment determinations because the measure is not considered suitable for purposes of comparative reporting by the measure developer.

For the FY 2012 payment determination, CMS is adopting 2 additional Patient Safety Indicators developed by the AHRQ. They are: PSI-11: Post-Operative Respiratory Failure and PSI-12: Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT).

CMS is adopting as RHQDAPU measures for the FY 2012 payment determination 8 (of 10) current Hospital Acquired Conditions (HACs). These measures are:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility

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

CMS notes it will calculate these rates using Medicare Part A fee for service claims, and it intends to publicly report these measures on Hospital Compare starting in the fall of 2010 after an appropriate preview period.

Therefore, CMS is adopting as final to retain 45 existing measures from the FY 2011 RHQDAPU payment determinations for the FY 2012 payment determination, and is adding the 10 claims-based measures above (2 AHRQ surgical outcome measures, and 8 HAC measures) for a total of 55 measures.

The RHQDAPU measure set for the FY 2012 payment determination is listed below:

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination
Acute Myocardial Infarction (AMI)	
	●AMI-1 Aspirin at arrival
	●AMI-2 Aspirin prescribed at discharge
	●AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	●AMI-4 Adult smoking cessation advice/counseling
	●AMI-5 Beta blocker prescribed at discharge
	●AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	●AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF)	
	●HF-1 Discharge instructions
	●HF-2 Left ventricular function assessment
	●HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	●HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	●PN-2 Pneumococcal vaccination status
	●PN-3b Blood culture performed before first antibiotic received in hospital
	●PN-4 Adult smoking cessation advice/counseling
	●PN-5c Timing of receipt of initial antibiotic following hospital arrival
	●PN-6 Appropriate initial antibiotic selection
	●PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	●SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	●SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	●SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	●SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	●SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	●SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	●SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
	●SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	●SCIP-Infection-10: Perioperative Temperature Management
	●SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period

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Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination
Mortality Measures (Medicare Patients)	
	●MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	●MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	●MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	●HCAHPS patient survey
Readmission Measure (Medicare Patients)	
	●READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	●READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	●READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and	
Composite Measures	
	●PSI 06: Iatrogenic pneumothorax, adult
	●PSI 11: Post Operative Respiratory Failure *
	●PSI 12: Post Operative PE or DVT *
	●PSI 14: Postoperative wound dehiscence
	●PSI 15: Accidental puncture or laceration
	●IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	● IQI 19: Hip fracture mortality rate
	●Complication/patient safety for selected indicators (composite)
	●Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	●Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	●Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	●Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	●Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Hospital Acquired Conditions	
	● Foreign Object Retained After Surgery *
	● Air Embolism *
	● Blood Incompatibility *
	● Pressure Ulcer Stages III & IV *
	● Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)*
	● Vascular Catheter-Associated Infection*
	● Catheter-Associated Urinary Tract Infection (UTI)*
	● Manifestations of Poor Glycemic Control*

* New for FY 2012 payment determinations

New Measures for the FY 2013 Payment Determination

In addition to retaining the 55 FY 2012 measures above, CMS is adding one new chart-abstracted measure for the FY 2013 payment determination - AMI-statin at discharge.

CMS also proposed adopting two new HAI measures that are currently being collected by CDC via the National Healthcare Safety Network (NHSN). These measures are: (1) Central Line Associated Blood Stream Infection (CLABSI) (NQF #0139) and (2) Surgical Site Infection (SSI) (NQF #0299).

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CMS is finalizing the CLABSI measure for the FY 2013 payment determination. Collection for the CLABSI measure will begin with January 1, 2011 discharges. However, while CMS is finalizing the SSI measure, it will be used for the FY 2014 payment determination with collection to begin with January 1, 2012 discharges.

New Measures for the FY 2014 Payment Determination

CMS will add the following 4 new chart-abstracted measures to the RHQDAPU program measure set for the FY 2014 payment determination: (1) ED [Emergency Department] Throughput – Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497); (2) ED Throughput - Median time from emergency department arrival to ED departure for admitted patients (NQF #0495); (3) Global Flu Immunization; and (4) Global Pneumonia Immunization.

CMS will retire the PN-2 and PN-7 measures for the FY 2014 and subsequent payment determinations, which will be replaced by the two global measures for influenza and pneumococcal vaccination beginning with January 1, 2012 discharges.

Comment

Quality measures are growing and becoming a central issue in hospital payments. CMS devotes some 50 pages on the "*Synchronization of RHQDAPU Program Data Submission and Validation Quarters with Quarters Used to Make Payment Determinations."* This is an area that hospitals need to review in-depth to insure their data submissions are acceptable.

2. Payment for Transfers of Cases from Medicare Participating Acute Care Hospitals to Nonparticipating Hospitals and CAHs (§412.4)

CMS is adding a new paragraph (b)(3) to §412.4 to specify that an acute care hospital "transfer case" includes a transfer to an acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program, and a new paragraph (b)(4) to state that an acute care hospital "transfer" also includes a transfer to a CAH.

Hospitals must use patient discharge status code "66" (Discharged/Transferred to a Critical Access Hospital) on IPPS claims to identify transfers to CAHs. For transfers to nonparticipating acute care hospitals, hospitals must continue to use patient status code "02" (Discharged/Transferred to a Short-Term General Hospital for Inpatient Care) on IPPS claims.

3. Medicare-Dependent, Small Rural Hospitals (MDHs): Change to Criteria (§412.108)

CMS is adopting its proposing to revise the Medicare-dependency criterion at §412.108(a)(1)(iii) of the regulations to replace the term "receiving" with the phrase "entitled to". As a result, CMS will include in the count of Medicare inpatient days or discharges all days or discharges attributable to individuals entitled to the Medicare Part A insurance benefit, including individuals who have exhausted their Medicare Part A inpatient hospital coverage benefit, as well as individuals enrolled in Medicare Advantage plans and section 1876 cost contracts, that is, health maintenance organizations (HMOs) and competitive medical plans (CMPs).

Extension of the MDH Program

Section 3124 of the ACA extended the MDH program from the end of FY 2011 (that is, for discharges occurring before October 1, 2011) to the end of FY 2012 (that is, for discharges occurring before October 1, 2012).

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4. Rural Referral Centers (RRCs)

A rural hospital with less than 275 beds may be classified as an RRC if—

● The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

● The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

CMS is requiring that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, they must have a CMI value for FY 2009 that is at least—

● 1.5136; or

● The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in regulation Section 413.75) calculated by CMS for the census region in which the hospital is located.

The median CMI values by region are set forth below:

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

A hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, must also have as the number of discharges for its cost reporting period that began during FY 2008 a figure that is at least—

● 5,000 (3,000 for an osteopathic hospital); or
● The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census regional discharge numbers are greater than 5,000.

5. Payment Adjustment for Low-Volume Hospitals (§412.101)

Sections 3125 and 10314 of the ACA Section revised the distance requirement for FYs 2011 and 2012 from "25 road miles" to "15 road miles" such that a low-volume hospital is required to be only more than 15 road miles,

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rather than more than 25 road miles, from another subsection (d) hospital for purposes of qualifying for the low-volume payment adjustment.

Sections 3125(3)(B) and 10314(1) of the ACA revised the discharge requirement for FYs 2011 and 2012 to less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Medicare Part A during a fiscal year. The discharge requirement to qualify as a low-volume is currently a hospital with less than 800 total discharges annually, which includes discharges of both Medicare and non-Medicare patients.

CMS proposed, and is adopting its linear scale formula, that the payment adjustment would be as determined below:

Medicare Discharge Range	**Payment Adjustment (Percent Add-On)**
1 - 200	25.0000
201 - 301	23.3333
301 -400	21.6667
401 - 500	20.0000
501 - 600	18.3333
601 -700	16.6667
701 - 800	15.0000
801 - 900	13.3333
901 - 1000	11.6667
1001 - 1100	10.0000
1101 - 1200	8.3333
1201 - 1300	6.6667
1301 - 1400	5.0000
1401 - 1500	3.3333
1501 - 1599	1.6667
1600 or more	0.0000

For qualifying hospitals with fewer than 1,600 Medicare discharges but more than 200 Medicare discharges, the low-volume add-on payment is calculated by subtracting from 25 percent the proportion of payments associated with the Medicare discharges in excess of 200. That proportion is calculated by multiplying the Medicare discharges in excess of 200 by a fraction that is equal to the maximum available add-on payment (25 percent) divided by a number represented by the range of Medicare discharges for which this policy applies (1,600 minus 200, or 1,400).

In other words, for qualifying hospitals with fewer than 1,600 Medicare discharges but more than 200 Medicare discharges, the add-on payment is calculated using the following formula:

Low volume add-on payment = 0.25 – [(0.25/1400)*(Number of Medicare discharges – 200)] = (4/14) – (Medicare discharges/5600).

CMS has provided a chart in the rule's preamble that lists the hospitals with fewer than 1,600 Medicare discharges based on the March 2010 update of the FY 2009 MedPAR files. Eligibility for the low-volume payment adjustment for FY 2011 and FY 2012 is also dependent upon meeting mileage criteria, which CMS has not performed. Hospitals still need to notify the MACs/FIs by September 1, 2010 using a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion.

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6. Indirect Medical Education (IME) Adjustment

CMS notes that for discharges occurring during FY 2011, the IME formula multiplier is 1.35, and will result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

7. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs): Supplemental Security Income (SSI) Fraction (§412.106)

CMS is adopting the use of three databases in a revised match process for FY 2011 and subsequent fiscal years in determining the SSI fraction for determining a hospital's DSH.

The first database is the SSI eligibility data file, which contains a unique social security number (SSN) for every SSI record and would include as many as 10 different historical Title II numbers for the records related to one individual. CMS will use 10 as the maximum number of Title II numbers for a beneficiary because that is likewise the maximum number of Health Insurance Claims Account Number (HICANs) that can be attributed to any one individual in the Medicare Enrollment Database (EDB). However, CMS notes that as a practical matter, the greatest number of historical HICANs associated with any beneficiary appears to be 7. The SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI benefits.

The second relevant database, the Medicare EDB, contains a SSN for virtually every record in the EDB. Furthermore, the EDB has the capacity to hold up to 10 historical HICANs for a specific Medicare enrollee. (It is important to note that, of the more than 100 million records in the EDB, less than 0.07 percent (that is, fewer than 7 of every 10,000 records) relate to individuals for whom the EDB does not include a SSN for the person. The EDB might not include a SSN for an individual if, for example, the person lives in another country but is entitled to Medicare benefits through his or her spouse.)

The third relevant database is a revised match process is the MedPAR file. Hospitals submit claims to Medicare for inpatient services provided to Medicare beneficiaries. These claims are eventually accumulated in the MedPAR database. It is important to note that the MedPAR database does not contain SSNs. The MedPAR database contains one HICAN number for each and every record of services provided to a Medicare beneficiary who was admitted to a Medicare-certified hospital or skilled nursing facility. This database allows CMS to calculate the number of Medicare inpatient hospital days, which CMS will use in determining each hospital's DSH SSI fraction.

The only modification CMS is making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if CMS finds a HICAN in the MedPAR file that it is not able to locate in the EDB, which CMS says is an extremely unlikely situation.

8. Payments for Direct Graduate Medical Education (GME) (§§413.75 and 413.79)

CMS proposed to clarify that individuals participating in a specialized course of training created by a senior physician, and not under the auspices of a national accrediting body, and for which there is no explicit existing board certification examination, should not be counted for IME and direct GME purposes. Such individuals should be treated as physicians, and their services should be billed to Medicare for payment as physicians' services.

If an individual has already successfully completed at least one residency program and has met the requirements to be board eligible in a specialty (regardless of whether the individual has passed the board examination for that specialty), and is engaged in subsequent training that will not provide additional knowledge or skills that

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could be applied for board certification in a subspecialty, the individual should be treated and bill for services provided as a physician.

CMS also proposed to revise the definition of "resident" at §413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board."

CMS is adopting as final, with some modification, its proposed revisions. Specifically, CMS is clarifying that individuals participating in a specialized course of training created by a senior physician, and not under the auspices of a national accrediting body, and for which there is no explicit existing board certification examination, may not be counted for IME and direct GME payment purposes. Such individuals should be treated as physicians (assuming full licensure) and their services billed to Medicare for payment as physicians' services. If an individual has already successfully completed at least one residency program and has met the generally applicable requirements to be board eligible in a specialty (regardless of whether the individual has passed the board examination for that specialty), and is engaged in subsequent training that will not provide additional knowledge or skills that could be applied for board certification in another different subspecialty, the individual will be treated and bill for services provided as a physician (assuming full licensure). CMS is making a technical change to the definition of "approved medical residency program" under §415.152 relating to payment for physician services in teaching settings. CMS also is revising the definition of "resident" at §413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board."

CMS is making a conforming change to the definition of "primary care resident" to mean "a resident who is formally accepted, enrolled, and participating in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice." These changes in the definitions of "resident" and "primary care resident" are effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010.

Essentially, a resident for IME and direct GME purposes is an individual who, in accordance with CMS' revised definition of "resident" at §413.75(b), is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. The program would be an "approved program" if it is either accredited by one of the four recognized accrediting bodies, or if not accredited, the individual who is formally accepted, enrolled, and participating in the program actually needs the training in order to meet the established minimum standards for board certification requirements in that specialty.

With regard to chief residencies, effective for cost reporting periods beginning on or after October 1, 2010, CMS is changing its policy to provide that individuals that act as chief residents after they have completed the accredited program and have satisfied minimum requirements for board certification are not considered residents for IME and direct GME payment purposes. With regard to programs that are extended by a hospital for longer than the minimum accredited length for that specialty, effective for cost reporting periods beginning on or after October 1, 2010, CMS is changing its policy to provide that such training is not part of an approved program. That is, individuals training in a program that extends beyond the actual accredited program length are not considered residents for IME and direct GME purposes because they are no longer training in an accredited program according to the ACGME.

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9. Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and CAHs

Under existing regulations, neither CAHs/hospitals that have reclassified from urban to rural under the regulations at §412.103 nor CAHs/hospitals located in Lugar counties are eligible to receive pass-through payments for anesthesia services and related care furnished by qualified nonphysician anesthetists.

CMS is adopting as proposed its provision to revise §412.113(c)(2)(i)(A) to state that effective for cost reporting periods beginning on or after October 1, 2010, CAHs and hospitals that have reclassified pursuant to section 1886(d)(8)(E) of the Act and §412.103 of the regulations are also rural for purposes of section 1886(d) of the Act and, therefore, are eligible to be paid based on reasonable cost for anesthesia services and related care furnished by a qualified nonphysician anesthetist.

10. Additional Payments for Qualifying Hospitals with Lowest Per Enrollee Medicare Spending

ACA Section 1109 provides $400 million for FYs 2011 and 2012 for supplemental payments to qualifying hospitals located in counties that rank within the lowest quartile of counties in the United States for spending for benefits under Medicare Part A and Part B.

CMS will distribute $150 million for FY 2011 and $250 million for FY 2012.

CMS says there are 786 counties that rank in the lowest quartile of counties with regards to adjusted Medicare Part A and Part B spending per enrollee. Of those 786 eligible counties, there are only 273 counties in which qualifying hospitals are located.

Using Medicare provider numbers, CMS has identified 416 IPPS hospitals that are currently located in those eligible counties and received IPPS operating payments in FY 2009. CMS has set out the final list of eligible counties in the rule's preamble Table 1. In addition, CMS has set out the final list of qualifying hospitals, location, and payment weighting factors in the rule's preamble Table 2. Finally, CMS has set out the payments under section 1109 by State for FY 2011 the rule's preamble Table 3.

The table's begin on page 902 and extend through page 931.

11. Rural Community Hospital Demonstration Program

Section 410A (a) of the ***Medicare Prescription Drug, Improvement, and Modernization Act of 2003*** (MMA), required the Secretary to establish a demonstration program to test the feasibility and advisability of establishing "rural community hospitals" to furnish covered inpatient hospital services to Medicare beneficiaries. The demonstration pays rural community hospitals for such services under cost based methodology for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries.

CMS is finalizing a budget neutral adjustment that would incorporate the following 4 components: (1) the estimated costs that would be incurred in FY 2011 for the 10 currently participating hospitals as a result of the demonstration's continuation in FY 2011; (2) the estimated cost incurred in FY 2010 for the 7 "originally participating hospitals" that were not accounted for in the FY 2010 IPPS final rule but that now must be accounted for as a result of the demonstration being continued by the ACA's 5-year extension for such hospitals; (3) the estimated FY 2011 demonstration costs associated with the participation of up to 20 new hospitals; and (4) a factor by which the cost of the demonstration program in 2007, as indicated by settled cost reports beginning in FY 2007, exceeded the amount that was identified in the FY IPPS 2007 final rule as the budget neutrality offset for FY 2007.

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CMS says the estimated amount for this adjustment is $70,483,384.

12. Interim Final Rule with Comment Period: Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted As Inpatients: 3-Day Payment Window

The Section 102 of the ***Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010*** pertains to Medicare's policy for payment of outpatient services provided on either the day of or during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) prior to a Medicare beneficiary's inpatient admission. This policy is generally known as the "3-day payment window". Section 102 is effective for services furnished on or after the date of enactment, June 25, 2010.

CMS says that for outpatient services furnished on or after June 25, 2010, all non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and, therefore, must be billed with the inpatient stay. Also, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for non subsection (d) hospitals) preceding the date of a beneficiary's admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, *unless* the hospital attests to certain non-diagnostic services as unrelated to the hospital claim (that is, the preadmission services are clinically distinct or independent from the reason for the beneficiary's admission).

CMS notes further, that section 102(c) of Pub. L. 111-192 also prohibits Medicare from reopening a claim, adjusting a claim, or making payments pursuant to any request for payment under Title XVIII, submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital), for services (as described under section 102(c)(2) of Pub. L. 111-192) for purposes of treating, as unrelated to a patient's inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's inpatient admission.

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Changes for Hospitals Excluded from the IPPS

1. Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages

For cancer and children's hospitals and RNHCIs, the FY 2011 rate-of increase percentage that is applied to the FY 2010 target amounts in order to determine the FY 2011 target amount is 2.6 percent.

2. Critical Access Hospitals (CAHs)

Under section 1834(g)(2) of the Act (the optional method), a CAH submits bills for both the facility and the professional services to its Medicare fiscal intermediary or its Medicare Part A/B MAC. If a CAH chooses this optional method for outpatient services, the physician or other practitioner must reassign his or her billing rights to the CAH to bill the Medicare program for those services. In accordance with section 1834(g)(2) of the Act, under this optional method, the CAH receives reasonable cost payment for its facility costs and, with respect to the professional services, 115 percent of the amount otherwise paid for professional services under Medicare.

CMS is revising §413.70(b)(3)(i) to specify, under paragraphs (A)(*1*) and (A)(*2*), that for CAH cost reporting periods beginning on or after October 1, 2010, once a CAH elects the optional method, including an election made for its most recent cost reporting period beginning prior to October 1, 2010, its election will remain in place until it is terminated. That is, CAHs would no longer be required to make an annual election in order to continue to be paid under the optional method in a subsequent year.

However, CMS is also making some technical revisions to the proposed language of §413.70(b)(3)(i)(A)(*2*) in order to state more clearly that if a CAH did not elect the optional method in its most recent preceding cost reporting period and chooses to be paid under the optional method for a cost reporting period beginning on or after October 1, 2010, it must submit a request in writing to the fiscal intermediary or MAC at least 30 days prior to the start of the cost reporting period for which the election is to be effective. If a CAH wishes to terminate its optional method election, it must submit its termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the start of the next cost reporting period. CAHs will have until December 1, 2010, to terminate their prior year election if they have cost reporting periods beginning in October 2010 or November 2010, had elected the optional method in 2009, and wish to terminate that election in 2010. The termination will be effective for the entire FY 2011 cost reporting period.

3. Changes in Payments to CAHs Made by the ACA

ACA section 3128 (a) requires that effective for cost reporting periods beginning on or after January 1, 2004, CAHs that are paid under the optional method will be paid based on 101 percent of reasonable costs for outpatient facility services and all CAHs will be paid based on 101 percent of reasonable cost for ambulance services.

4. Costs of Provider Taxes as Allowable Costs for CAHs

CMS is clarifying the policy set forth in sections 2122.1 and 2122.2 of the Provider Reimbursement Manual (PRM) to reflect concerns when certain provider taxes may be allowable costs under the Medicare program. CMS will modify the PRM to clarify that Medicare contractors will determine the allowability of provider taxes on a case-by-case basis, based on reasonable cost principles, and will determine if a reduction of the allowable tax expenses is proper to account for payments providers receive that are associated with the assessed tax.

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Changes to Medicare Severity DRG (MS-DRG) Classifications and Relative Weights

The rule's table 5 contains the MS-DRG relative weighting factors.

Charge Compression

The issue of charge compression regarding DRG weights is still a concern. To help remedy the issue, CMS says it plans to issue a revised hospital cost report Form CMS-2552-10, later this summer.

CMS is establishing standard cost centers for CT scanning and MRI services in hospital cost reports for cost report periods beginning on or after May 1, 2010. CMS is also adding a standard cost center to the cost report for cardiac catheterization.

Present on Admission Indicator Reporting

On or after January 1, 2011, hospitals are required to begin reporting POA indicators using the 5010 electronic transmittal standards format. The 5010 format removes the need to report a POA indicator of "1" for codes that are exempt from POA reporting. The POA indicator of "1" is currently being used because of reporting restrictions from the use of the 4010 electronic transmittal standards format.

Preventable Hospital-Acquired Conditions (HACs), Including Infections

In the FY 2011 IPPS/LTCH PPS proposed rule, CMS did not propose to add or remove categories of HACs, nor did it propose any changes to previously established policies.

CMS is adopting its proposal to add five new ICD-9-CM diagnosis codes to replace existing ICD-9-CM code 999.6 (ABO incompatibility reaction) for FY 2011. ICD-9-CM code 999.6 is currently the only code identified under the Blood Incompatibility HAC category. CMS will delete code 999.6 and form a new subcategory of 999.6 to identify new diagnoses relating to ABO incompatibility reaction due to transfusion of blood or blood products as follows:

ICD-9-CM Code	Code Descriptor	Proposed CC/MCC Designation
999.60	ABO incompatibility reaction, unspecified	CC
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC
999.62	ABO incompatibility with acute hemolytic transfusion reaction	CC
999.63	ABO incompatibility with delayed hemolytic transfusion reaction	CC
999.69	Other ABO incompatibility reaction	CC

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As final policy for FY 2011, the following conditions will continue to be subject to the HAC payment provision:

HAC	CC/MCC (ICD-9-CM Code)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63.(CC) 999.69.(CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infections	
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, 81.85

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HAC	CC/MCC (ICD-9-CM Code)
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis*– 278.01 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (CC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

Changes to Specific MS-DRG Classifications

1. Pre-Major Diagnostic Categories (MDCs)

a. Postsurgical Hypoinsulinemia (MS-DRG 008 (Simultaneous Pancreas/Kidney Transplant)

CMS is adopting as final without modification its proposals to add diagnosis code 251.3 to the list of acceptable principal diagnoses in MS-DRG 008 and, as a conforming change, to add diagnosis code 251.3 to the list of acceptable principal or secondary diagnoses in MS-DRG 010.

b. Bone Marrow Transplants

CMS is finalizing its proposal to delete MS-DRG 009, and to create two new MS-DRGs: MS-DRG 014 (Allogeneic Bone Marrow Transplant) and MS-DRG 015 (Autologous Bone Marrow Transplant). New MS-DRG 014 will include cases reported with one of the following ICD-9-CM procedure codes: 41.02; 41.03; 41.05; 41.06; or 41.08. New MS-DRG 015 will include cases reported with one of the following ICD-9-CM procedure codes: 41.00; 41.01; 41.04; 41.07; or 41.09.

2. MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period)

a. Discharges/Transfers of Neonates to a Designated Cancer Center or Children's Hospital

CMS is adopting as final for FY 2011 that all newborn cases assigned to MS-DRGs 790 through 795 and identified with discharge status 05 be reassigned to MS-DRG 789 for transferred neonates.

b. Vaccinations of Newborns

CMS is adopting its proposal to remove code V64.05 from MS-DRG 794 and to add it to the only secondary diagnosis list for MS-DRG 795.

3. Medicare Code Editor (MCE) Changes

a. Unacceptable Principal Diagnosis Edit:

CMS will not, as proposed, include code 536.3 on the list of unacceptable principal diagnoses in the MCE.

b. Open Biopsy Check

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CMS will delete the entire Open Biopsy Check edit from the MCE, which means removing 63 codes from the edit.

c. Noncovered Procedure Edit

CMS will add procedure code 251.3 code 251.3 (Postsurgical hypoinsulinemia) to the MCE in the list of acceptable principal or secondary codes associated with procedure codes 52.80 (Pancreatic transplant, not otherwise specified) and 52.82 (Homotransplant of pancreas).

4. Surgical Hierarchies

CMS is revising the surgical hierarchy for Pre-MDCs and MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders) to reflect the resource intensiveness of the MS-DRGs, as follows:

In Pre-MDCs, CMS is reordering new MS-DRG 014 (Allogeneic Bone Marrow Transplant) above MS-DRG 007 (Lung Transplant); and new MS-DRG 015 (Autologous Bone Marrow Transplant) above MS-DRG 010 (Pancreas Transplant).
In MDC 10, CMS is reordering MS-DRG 614 (Adrenal and Pituitary Procedures With CC/MCC) and MS-DRG 615 (Adrenal and Pituitary Procedures Without CC/MCC) above MS-DRG 625 (Thyroid, Parathyroid and Thyroglossal Procedures With MCC).

5. Complications and Comorbidity Exclusions List

Change to the Severity Level for Acute Renal Failure, Unspecified Diagnosis Code

CMS will change the severity level for diagnosis code 584.9 from a MCC to a CC for FY 2011.

Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List, respectively, which are effective for discharges occurring on or after October 1, 2010, are not being published in the rule's Addendum because of the length of the two tables. Instead, CMS is making them available through the Internet on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS.

To assist readers in identifying the changes to the MCC and CC lists that occurred as a result of updates to the ICD-9-CM codes, as described in Tables 6A, 6C, and 6E of the Addendum to this final rule, CMS is providing the following summaries of those MCC and CC changes.

Summary of Additions to the MS-DRG MCC List

Code	Description
488.01	Influenza due to identified avian influenza virus with pneumonia
488.11	Influenza due to identified novel H1N1 influenza virus with pneumonia

Summary of Deletions from the MS-DRG MCC List

Code	Description
584.9	Acute renal failure, unspecified

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Summary of Additions to the MS-DRG CC List

Code	Description
278.03	Obesity hypoventilation syndrome
488.02	Influenza due to identified avian influenza virus with other respiratory manifestations
488.09	Influenza due to identified avian influenza virus with other manifestations
584.9	Acute kidney failure, unspecified
780.33	Post traumatic seizures
786.30	Hemoptysis, unspecified
786.31	Acute idiopathic pulmonary hemorrhage in infants [AIPHI]
786.39	Other hemoptysis
999.60	ABO incompatibility reaction, unspecified
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.62	ABO incompatibility with acute hemolytic transfusion reaction
999.63	ABO incompatibility with delayed hemolytic transfusion reaction
999.69	Other ABO incompatibility reaction
999.70	Rh incompatibility reaction, unspecified
999.71	Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.72	Rh incompatibility with acute hemolytic transfusion reaction
999.73	Rh incompatibility with delayed hemolytic transfusion reaction
999.74	Other Rh incompatibility reaction
999.75	Non-ABO incompatibility reaction, unspecified
999.76	Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.77	Non-ABO incompatibility with acute hemolytic transfusion reaction
999.78	Non-ABO incompatibility with delayed hemolytic transfusion reaction
999.79	Other non-ABO incompatibility reaction
999.83	Hemolytic transfusion reaction, incompatibility unspecified
999.84	Acute hemolytic transfusion reaction, incompatibility unspecified
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified
V85.41	Body Mass Index 40.0-44.9, adult
V85.42	Body Mass Index 45.0-49.9, adult
V85.43	Body Mass Index 50.0-59.9, adult
V85.44	Body Mass Index 60.0-69.9, adult
V85.45	Body Mass Index 70 and over, adult

Summary of Deletions from the MS-DRG CC List

Code	Description
786.3	Hemoptysis
999.6	ABO incompatibility reaction
999.7	Rh incompatibility reaction
V85.4	Body Mass Index 40 and over, adult

6. Changes to the ICD-9-CM Coding System, Including Discussion of the Replacement of the ICD-9-CM Coding System with the ICD-10-CM and ICD-10-PCS Systems in FY 2014

a. ICD-9-CM Coding System

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 rule's Addendum.

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b. Partial Freeze to ICD-9-CM and ICD-10-CM/PCS Code Updates

The ICD-10 coding system will be implemented on October 1, 2013. A final decision on whether or not there will be a partial code freeze will be announced September 15-16, 2010

c. Claims

For claims submitted on the 5010 format beginning January 1, 2011, CMS will increase the capacity to process diagnosis and procedure codes on hospital inpatient claims from the current 9 diagnoses and 6 procedures up to 25 diagnoses and 25 procedures.

8. Add-On Payments for New Services and Technologies

CMS is continuing new technology add-on payments for cases involving the Spiration® IBV® in FY 2011, with a maximum add-on payment of $3,437.50.

CMS will continue new technology add-on payments for cases involving the TAH-t in FY 2011 with a maximum add-on payment of $53,000.

CMS will add a new technology add-on payment to cases involving the AutoLITT™ in MS-DRGs 25, 26, and 27. Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with a procedure code of 17.61 in combination with a primary diagnosis codes that begins with a prefix of 191. The maximum add-on payment for a case involving the AutoLITT™ is $5,300.

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Effective Date of Provider Agreements and Supplier Approvals

CMS proposed to amend §489.13 and make a technical amendment to §489.1 in order to clarify its policy. Specifically, to make it clearer that it is only CMS that determines whether health care facilities have satisfied the requirements for participation in the Medicare program, not State survey agencies or national accreditation organizations.

CMS also proposed to add language to §489.13(a) in order to clarify that surveys of non-accredited facilities may be conducted not only by State survey agencies, but also by CMS staff or contractors, as appropriate.

CMS proposed to revise §489.13(b) to make explicit that the effective date of a provider agreement or supplier approval may not be earlier than the latest of the dates on which each applicable Federal requirement is determined to be met. CMS also proposed to state explicitly that "Federal requirements" include, but are not limited to, the enrollment requirements established in 42 CFR Part 424, Subpart P, that have been determined by CMS to have been met. In addition, CMS proposed to revise §489.13(b) to include language concerning accredited facilities, to assure that accredited and non-accredited facilities are treated in the same manner.

CMS is adopting as final its proposed revisions of §489.13(a), (b), and (c), removal of existing §489.13(d), and technical amendments to §489.1, with some modifications and technical corrections.

Medicare Hospital Conditions of Participation Affecting Rehabilitation Services and Respiratory Care Services

CMS proposed to revise §482.56 to clarify the types of practitioners that are allowed to order rehabilitation services

CMS is adopting as final without modification, its proposals to revise §482.56 and §482.57 to clarify the types of practitioners who are allowed to order rehabilitation services and respiratory care services, respectively in accordance with both hospital policies and procedures and State laws; and to provide that all orders for these services be documented in accordance with existing requirements at §482.24.

Changes to the Accreditation Requirements for Medicaid Providers of Inpatient Psychiatric Services for Individuals under Age 21

CMS proposed to remove the requirement that psychiatric hospitals and hospitals with inpatient psychiatric programs providing inpatient psychiatric services to individuals under age 21 obtain accreditation from The Joint Commission in order to provide these services under the Medicaid program.

CMS is adopting as final, without modification, its proposed revision of §440.160(b)(1) and §441.151(a)(2)(i) by removing the requirement for accreditation by The Joint Commission of psychiatric hospitals and hospitals with inpatient psychiatric programs. Under the final regulations, psychiatric hospitals will have the choice of undergoing a State survey to determine whether the hospital meets the requirements to participate in Medicare as a psychiatric hospital, under 42 CFR 482.60 or obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS.

Likewise, hospitals with inpatient psychiatric programs will have the choice of undergoing a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 CFR Part 482 or obtaining accreditation by a national accrediting organization whose hospital accrediting program has been approved by CMS.

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Changes to the MS-LTC-DRGs for FY 2011

Nonetheless, CMS is modifying and revising the MS-Long-Term Care Hospital (LTC)-DRG classifications effective October 1, 2010, through September 30, 2011 (FY 2011) consistent with the changes to specific IPPS MS-DRG classifications.

Table 11 in the rule's Addendum lists the MS-LTC-DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in determining short stay outlier (SSO) payments for FY 2011. The FY 2011 MS-LTC-DRG relative weights in Table 11 reflect both the normalization factor of 1.10382 and the budget neutrality factor of 0.988124.

The FY 2011 market basket estimate for the LTCH PPS is 2.5 percent minus 0.5 percent as mandated by the ACA, or 2.0 percent.

For FY 2011, CMS is establishing an update to the LTCH PPS standard Federal rate of -0.49 percent, based on the market basket update for FY 2011 of 2.0 percent and an adjustment of -2.5 percent to account for the increase in case-mix in the prior periods that resulted from changes in documentation and coding practices rather than increases in patient severity of illness.((That is, applying a factor of 0.9951 in determining the LTCH PPS standard Federal rate for FY 2011, calculated as 1.020 x 1 divided by 1.025 = 0.9951 or -0.49 percent).

The standardized Federal rate for FY 2011 is $39,599.95.

The labor-related share was proposed at 75.407. It will be **75.271** percent.

The FY 2011 LTCH wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas) in the Addendum.

The fixed-loss outlier amount for FY 2011 is $18,785.

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Final Comment

Below is an analysis that compares the current MS-DRG (FY 2010) weights to those for FY 2011 for all MS-DRGs having 100,000 or more discharges.

MS-DRG	Description	FY 2010 Weight	FY Final 2011 Weights	Percent Difference
65	Intracranial hemorrhage or cerebral infarction w CC	1.1580	1.1667	0.75
190	Chronic obstructive pulmonary disease w MCC	1.2076	1.1924	-1.26
191	Chronic obstructive pulmonary disease w CC	0.9622	0.9735	1.17
192	Chronic obstructive pulmonary disease w/o CC/MCC	0.7175	0.7220	0.63
193	Simple pneumonia & pleurisy w MCC	1.4378	1.4796	2.91
194	Simple pneumonia & pleurisy w CC	0.9976	1.0152	1.76
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121	1.9691	2.98
287	Circulatory disorders except AMI, w card cath w/o MCC	1.0321	1.0879	5.41
291	Heart failure & shock w MCC	1.4609	1.4943	2.29
292	Heart failure & shock w CC	0.9740	1.0302	5.77
293	Heart failure & shock w/o CC/MCC	0.6940	0.6853	-1.25
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5710	0.5709	-0.02
312	Syncope & collapse	0.7215	0.7172	-0.60
313	Chest pain	0.5404	0.5499	1.76
378	G.I. hemorrhage w CC	0.9873	1.0274	4.06
392	Esophagitis, gastroent & misc digest disorders w/o MCC	0.6621	0.7173	8.34
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613	2.1039	2.07
603	Cellulitis w/o MCC	0.8178	0.8377	2.43
641	Nutritional & misc metabolic disorders w/o MCC	0.6843	0.6916	1.07
682	Renal Failure w MCC	1.6422	1.6407	-0.09
683	Renal Failure w CC	1.0523	1.0243	-2.66
690	Kidney & urinary tract infections w/o MCC	0.7708	0.7864	2.02
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	1.8437	1.9074	3.46

These 23 MS-DRGs account for approximately 35.0 percent of the nearly 11 million MS-DRG discharges.

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