



Payment Rule

Summary

Proposed Rule

Medicare

Inpatient Prospective Payment
System

Federal Fiscal Year 2012

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Overview

On May 5, 2011, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2012 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule updates inpatient payment rates and policies and implements provisions of the Affordable Care Act (ACA) of 2010.

In addition to updating inpatient payments for FFY 2012, the rule also includes proposals related to the ACA's Medicare inpatient readmissions payment policy, set for implementation beginning FFY 2013, and proposals related to the FFY 2014 Medicare inpatient hospital value-based purchasing (VBP) program.

A copy of the proposed rule *Federal Register* and other resources related to the IPPS are available on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/IPPS2012/>.

An online version of the proposed rule *Federal Register* is available at http://www.federalregister.gov/articles/2011/05/05/2011-9644/medicare-program-proposed-changes-to-the-hospital-inpatient-prospective-payment-systems-for-acute#table_of_contents.

Comments on the proposed rule are due to CMS by Monday, June 20. Instructions for submitting comments are available on the last page of this summary. Proposed program changes, if adopted, would be effective for discharges on or after October 1, 2011 unless otherwise noted.

Complete details of the proposed rule are provided below. Text in italics is from the May 5 *Federal Register*.

Inpatient Payment Rates

The following table lists the proposed 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	Proposed FFY 2012	Percent Change
Federal Operating Rate	\$5,164.11	\$5,132.36	-0.6%
Federal Capital Rate	\$420.01	\$422.54	+0.6%

Updates to the Federal Operating Rate

Federal Register pages 26,018-26,027

CMS' Proposal: CMS' proposed rate updates, along with slight adjustments for budget neutrality, result in a federal inpatient operating rate of \$5,132.36 for FFY 2012 compared to \$5,164.11 for FFY 2011, a 0.6% decrease.

The proposed FFY 2012 operating rate would be updated as follows:

- *Plus 2.8%:* CMS is proposing to update the operating rate by a marketbasket of 2.8%.

- *Minus 1.2 percentage points:* Offsetting the marketbasket is an ACA-mandated productivity reduction of 1.2 percentage points.
- *Minus 0.1 percentage points:* Offsetting the marketbasket is an ACA-mandated pre-determined reduction of 0.1 percentage points.
- *Minus 3.15%:* CMS is proposing to continue its application of coding adjustments to inpatient rates, reducing the operating rate by a net 3.15%, to account for what CMS believes are increased inpatient payments to hospitals due to coding improvement (see “Coding Adjustments for FFY 2012” below). Unlike the coding adjustment reduction applied in FFY 2011, which was a retrospective or one-year reduction only, the proposed FFY 2012 coding adjustment will be permanently built into the federal operating rate (i.e. the reductions will carry forward in future payment years).
- *Plus 1.1%:* CMS is proposing to 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 26,029-26,030

CMS’ Proposal: CMS is proposing to 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 proposed FFY 2012 hospital-specific rates would be updated as follows:

- CMS is proposing to apply the same marketbasket update and ACA-mandated marketbasket reductions (a full 2.8% marketbasket reduced by a productivity adjustment of 1.2 percentage points and a pre-determined factor of 0.1 percentage points).
- *Minus 2.5%:* CMS is proposing to apply a prospective coding adjustment to the hospital-specific rates of 2.5% (rather than 3.15% as proposed for the operating rate). This coding adjustment is permanent and will carry forward in future payment years. The 2.9% coding adjustment applied to hospital-specific rates in FFY 2011 was also permanent and is carried forward (see “Coding Adjustments for FFY 2012” below).
- *Plus 0.9%:* CMS is proposing to increase hospital-specific rates by 0.9% (rather than 1.1% as proposed for the 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 operating rate because CMS did not apply the rural floor budget neutrality adjustment to the hospital-specific rates in all of the same years.

Updates to the Federal Capital Rate

Federal Register pages 26,030-26,036

CMS’ Proposal: CMS’ proposed rate updates, along with slight adjustments for budget neutrality, result in a federal inpatient capital rate of \$422.54 for FFY 2012 compared to \$420.01 for FFY 2011, a 0.6% increase.

CMS is proposing to update the capital rate by a marketbasket of 1.5%. Offsetting the update, CMS is proposing to apply a negative 1.0% coding adjustment to the capital rate. This coding adjustment is permanent and will carry forward in future payment years (see “Coding Adjustments for FFY 2012” below).

Coding Adjustments for FFY 2012

Federal Register pages 25,801-25,808

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’ Proposal: Details of prior coding adjustments and the adjustments CMS is proposing to the federal operating rate, hospital-specific rates, and federal capital rate for FFY 2012 are provided in the table below. As shown, an additional 0.75% adjustment to the federal operating rate will be required in future rulemaking; CMS did not propose a timeline for this adjustment.

	Federal Operating Rate		Hospital-Specific Rates	Federal Capital Rate
	<u>Prospective</u> Coding Adjustment Details	<u>Retrospective</u> Coding Adjustment Details *	<u>Prospective</u> Coding Adjustment Details	<u>Prospective</u> 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%
Proposed FFY 2012 Coding Adjustment Reduction	-3.15%	-2.9%	-2.5%	-1.0%
Remaining Coding Adjustment (if FFY 2012 Proposal is Adopted)	0.75%	0.0%	0.0%	0.0%

* 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 25,887

Background: The ACA 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' Proposal: CMS does 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.

Wage Index and Labor-Related Share for FFY 2012

Federal Register pages 25,876-25,880 and pages 25,889-25,890

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' Proposal: *"The wage data for the proposed FY 2012 wage index were obtained 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."*

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 proposed wage indexes for FFY 2012 is available on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/IPPS2012/>.

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

Federal Register pages 25,870-25,874

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' 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.”*

The proposed FFY 2012 occupational mix adjusted national average hourly wage (AHW) is \$36.1406.

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 are required to submit the 2010 survey to their fiscal intermediaries by July 1, 2011.

CMS is also requiring, for any hospital that does not complete the 2010 survey, an explanation for not complying with the submission requirements. Fiscal Intermediaries (FIs)/Medicare Administrative (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 25,881

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' Proposal: 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/>. Applications for FFY 2013 reclassifications are expected to be posted to this site beginning in mid-July.

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

Federal Register pages 25,885-25,886

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' Proposal: CMS is proposing 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.”

A list of rural counties containing hospitals with Lugar reclassifications is available on *Federal Register* pages 25,883-25,885.

Expiration of Section 508 Reclassifications in FFY 2012

Federal Register page 25,885

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’ Proposal: 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 25,878-25,879

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’ Proposal: “. . . we are not proposing to extend the imputed floor policy.”

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

Federal Register pages 26,027-26,028

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’ 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) . . .”

A list of the proposed COLA factors is available on *Federal Register* page 26,028.

Additions to Inpatient Rates and Payments

DSH and Indirect Medical Education (IME) Payments

Federal Register pages 25,942-25,944

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' 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 states that they are proposing to exclude inpatient hospice days from the DSH and IME payment calculations because they do not consider these days acute care services generally payable under the IPPS.

CMS notes in the proposed rule that the policy change would 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 25,939-25,941

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 ACA 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 ACA also temporarily modified the payment adjustment methodology, providing higher payment adjustments to hospitals with fewer discharges.

The ACA-mandated changes to the low-volume hospital adjustment criteria for FFYs 2011 and 2012 will expire after FFY 2012 without legislative action.

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' 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 is proposing to apply the applicable low-volume adjustment within 30 days of the FI/MAC’s low-volume status determination.

For hospitals that qualified for the low-volume adjustment in FFY 2011 and continue to meet both the discharge and distance criteria, CMS is proposing to require that these hospitals verify, in writing, to the FI/MAC by September 30, 2011 that they continue to meet the distance criteria.

A list of hospitals that meet the low-volume adjustment discharge criteria is available on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/IPPS2012/>.

Outlier Payments

Federal Register pages 26,024-26,026

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

CMS’ 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.”*

The proposed threshold increase of 1.3% would reduce the number of cases eligible for outlier payments in FFY 2012 compared to FFY 2011.

Low-Cost County Add-On

Federal Register pages 25,945-25,948

Background: The ACA 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). CMS has yet to distribute the \$150 million allotted for FFY 2011—the agency has until the end of the FFY to do so.

CMS’ Proposal: *“ . . . we are proposing to revise our list of qualifying hospitals and their payment weighting factors finalized in the FY 2011 IPPS/LTCH PPS final rule to exclude these 11 providers.”*

CMS is proposing to remove 11 hospitals from the original list because CMS has determined that they do not meet the statutory definition of a qualifying hospital for the add-on. This modification will change each qualifying hospitals’ payment weighting factors published in the FFY 2011 IPPS final rule. The revised qualifying hospital list and payment weighting factors are available on the CMS Web site at <https://www.cms.gov/AcuteInpatientPPS/IPPS2012/>.

Modifying the approach for distributing this funding developed last year, CMS states in the proposed rule that they intend to make payments through a one-time annual payment made by one Medicare contractor (rather than individual FIs/MACs). CMS will be notifying qualifying hospitals in writing as to how this process will work. Qualifying hospitals would 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 25,797-25,870

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' 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.”

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 proposed FFY 2012 MS-DRGs and weights is available online at <https://www.cms.gov/AcuteInpatientPPS/IPPS2012/>.

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

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

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

Updates to the Hospital Inpatient Quality Reporting (IQR) Program

Federal Register pages 25,890-25,926

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 ACA; 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.

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. A complete list of the IQR Program measures for FFY 2012 and FFY 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 available at <http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf>.

CMS' Proposal: CMS is proposing 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. CMS is proposing to simultaneously specify additional measures for the Hospital VBP program and adoption into the IQR Program where it is appropriate for measures to be used under both programs.

The proposed refinements would also take steps to eventually align the IQR Program with the quality measures adopted for use by hospitals under the Electronic Health Record (HER) 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 25,892-25,901

CMS' 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 is proposing to retire the following measures from the IQR Program for FFY 2014 payment determinations:

- 8 chart-abstracted measures:
 - AMI-1: Aspirin at arrival
 - AMI-3: ACEI/ARB for left ventricular systolic dysfunction
 - AMI-4: Adult smoking cessation advice/counseling
 - AMI-5: Beta-blocker prescribed at discharge
 - HF-4: Adult smoking cessation advice/counseling
 - PN-4: Adult smoking cessation advice/counseling
 - PN-5c: Timing of receipt of initial antibiotic use

- SCIP INF-6 Appropriate Hair Removal

CMS is proposing that hospitals would no longer be required to submit data on these measures beginning January 1, 2012. CMS is proposing to retire all measures, except PN-5c, 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 will retire this measure from the IQR Program for this reason.

CMS is proposing to add the following measures to the IQR Program for FFY 2014 payment determinations:

- 2 Center for Disease Control and Prevention (CDC)/National Healthcare Safety Network (NHSN)-based Healthcare-Associated Infection (HAI) measures:
 - Central Line Insertion Practice Adherence Percentage (CLIP)
 - Catheter Associated Urinary Tract Infection (CAUTI)

CMS is proposing that hospitals would begin submitting data on these measures beginning with events that occur on or after January 1, 2012.

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

CMS is proposing to 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

CMS is proposing that annual data submission for this proposed structural measure via a Web-based collection tool would begin in July 2012 with respect to the time period January 1, 2012, through June 30, 2012.

A complete list of the proposed IQR Program measures for FFY 2014 payment determinations is available on *Federal Register* pages 25,899-25,901.

FFY 2015 Payment Determinations

Federal Register pages 25,901-25,910

CMS’ 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 is proposing to add the following measures to the IQR Program for 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)

If adopted, the addition of these chart-abstracted measures would eventually align the IQR Program with the quality measures adopted by CMS for use by hospitals under the EHR Incentive Program. Currently, almost all measures between the two programs differ. However, as proposed, these measures would 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 proposed IQR Program measures for FFY 2015 payment determinations is available on *Federal Register* pages 25,908-25,910.

Updates to the IQR Program Participation Policies

Federal Register pages 25,914-25,925

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' Proposal: CMS is proposing several 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 proposed changes is available on *Federal Register* pages listed above.

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

Federal Register pages 25,925-25,926

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 the IQR Program. As described above, CMS, in this rule, is proposing to adopt the remainder of the EHR Incentive Program measures for the IQR Program beginning with FFY 2015 payment determinations. However, as proposed, 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' Proposal: CMS is seeking comment on how to better align the quality reporting requirements of the IQR and EHR Incentive programs. Specifically, CMS states in the proposed rule that they anticipate 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 is seeking 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.

Possible New Measures and Topics for Future Years

Federal Register pages 25,911-25,914

CMS' Proposal: CMS is seeking comment on the expansion of the IQR Program. CMS lists 68 quality measures under 15 topic areas for which it is considering expanding the IQR Program. 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 25,912-25,914.

Updates to the Hospital VBP Program for FFY 2014

Federal Register pages 25,926-25,928

Background: Included in the IPPS proposed rule are proposals related to the FFY 2014 (second year) inpatient hospital VBP Program established by the ACA. CMS has adopted program rules for the initial program year, the FFY 2013 VBP Program. Using measures reported under the IQR Program, the VBP Program will redistribute Medicare inpatient fee-for-service (FFS) payments to hospitals based on quality performance beginning October 1, 2012 (FFY 2013). CAHs are not subject to this program.

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

CMS' Proposal: “. . . for the FY 2014 Hospital Inpatient VBP Program, we are proposing to adopt a Medicare spending per beneficiary measure.”

As described in the “Updates to the Hospital IQR Program” section above, CMS is also proposing to adopt this claims-based measure for the IQR Program for FFY 2014 payment determinations.

CMS' proposals related to this efficiency measure are closely related to the VBP policies and scoring methodologies adopted by CMS 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 proposing the following related to the Medicare spending per beneficiary measure:

- CMS would incorporate this measure score into the FFY 2014 VBP Program as part of a new, efficiency domain. If adopted, the FFY 2014 VBP Program would 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. CMS did not propose a weight for the efficiency domain but will do so in future rulemaking.

- CMS is proposing 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 proposing to evaluate Medicare spending per beneficiary for each hospital using an episode of care that runs from three days prior to an inpatient hospital admission (index admission) through 90 days post hospital discharge.
 - CMS would include all Medicare Part A and Part B payments made for services provided to the beneficiary during the proposed 90-day episode to calculate this measure. Transfers, readmissions, and additional admissions that began during the 90-day post discharge window of an index admission would be included in the episode used for calculating the measure.
 - CMS would 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 cause by hospital-specific rates, IME, and DSH. CMS is not proposing to adjust this measure for sex and race.
- To calculate a hospital's Medicare spending per beneficiary amount for the proposed periods, CMS is proposing 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.
- For the purposes of calculating a VBP score, CMS is proposing to translate the spending amount into a Medicare spending per beneficiary ratio. CMS is proposing to calculate this ratio as the hospital's Medicare spending per beneficiary amount (as described above) divided by the median Medicare spending per beneficiary amount across all hospitals nationwide. A hospital's ratio would be compared to the national benchmark ratio and national achievement threshold ratio to calculate a VBP score for this measure. Hospitals could earn up to 10 achievement points and up to 9 improvement points for the proposed efficiency measure. A final score would be the higher of the two scores.
- CMS is proposing to set the national benchmark at the mean of the lowest decile of Medicare spending per beneficiary ratios during the performance period and the national achievement threshold at the median Medicare spending per beneficiary ratio across all hospitals during the performance period.
- CMS is proposing to calculate the efficiency domain score as follows: total points earned on the Medicare spending per beneficiary measure divided by 10, multiplied by 100%.

CMS will propose domain weighting, additional measures, and other FFY 2014 proposals related to the VBP Program in the CY 2012 hospital outpatient PPS proposed rule. This rule is typically published in July/August of each year.

Establishment of the Hospital Readmissions Reduction Program for FFY 2013

Federal Register pages 25,928-25,937

Background: Included in the IPPS proposed rule are several proposals that put in place the framework for the Medicare hospital inpatient readmissions payment policy established by the ACA. This program, dubbed the Hospital Readmissions Reduction Program, is designed to reduce Medicare inpatient 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' Proposal: CMS is proposing policies to begin implementation of this program. CMS indicates its plans to implement the requirements of the readmissions payment policy over the next two IPPS rulemaking cycles.

The following reflect the major provisions of the program proposed by CMS:

- CMS is proposing to use readmission rates currently included in the IQR Program and collected from Medicare FFS claims data, for 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).
- CMS is proposing to use 3 years of data (discharges from July 1, 2008 through June 30, 2011) to calculate readmission rates. The 3-year period coincides with how the proposed measures are currently calculated and displayed under the IQR Program.
- CMS is proposing to define a readmission as a second admission to another acute care hospital within 30-days of the discharge from the index hospital (the initial hospitalization hospital). This definition coincides with how the proposed measures are currently evaluated under the IQR Program.
- CMS is not proposing any additional exclusions nor any additional risk adjustment in determining the readmission rates for the proposed measures beyond the exclusions and risk adjustment currently applied to these measures under the IQR Program. The ACA requires CMS to exclude readmissions that are unrelated to the initial discharge and to apply a risk adjustment to the measures.
- CMS is proposing to exclude from the program, readmission measures with fewer than 25 discharges. This policy comports 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 subject to the ACA's readmission payment policy, CMS is proposing a methodology that would 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 would be an "Excess Readmission Ratio." If a hospital performs worse than average, the ratio would be greater than 1.0 and the hospital would be subject to a payment penalty.
- The ACA requires hospitals, or a State, or an appropriate entity on behalf of hospitals to submit to the Secretary the information necessary to calculate "all patient" readmission rates. CMS is seeking comment on how to implement this requirement.

Rural Hospital Inpatient Payment and Policy Issues

Expiration of MDH Status in FFY 2013

Federal Register page 25,944

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 are attributable to individuals receiving Medicare Part A benefits.

CMS' Proposal: CMS is not proposing changes to the MDH program. However, unlike other special rural provider types, the MDH program is set by law and requires legislation to continue. The ACA 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 25,937-25,939

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' Proposal: As it does each year, CMS is proposing to update the minimum CMI and discharge values required for hospitals seeking RRC status that do not meet the 275 bed criteria. The proposed FFY 2012 minimum values by region are available on *Federal Register* pages 25,938-25,939.

Payments to CAHs for Ambulance Services

Federal Register pages 25,968-25,971

Background: The ACA 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' Proposal: CMS is proposing to revise its current policy to clarify instances of when providers or suppliers of ambulance services would be paid at 101% reasonable costs and when they would be paid under the ambulance fee-schedule.

CMS states that it is proposing 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 CMS' proposed policy changes are available on *Federal Register* pages 25,970-25,971. These changes, if adopted, would 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 25,810-25,816

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

CMS is proposing to identify this new HAC with diagnosis code 584.9 in combination with one or more of 33 associated procedure codes listed on *Federal Register* page 25,813. The addition of contrast-induced acute kidney injury to the list of HACs would increase the number of HAC categories subject to the MS-DRG policy to 11.

"In addition, we are proposing to add five new ICD-9-CM diagnosis codes and to revise the title of the "Electric Shock" subcategory in the Falls and Trauma HAC category."

The following represent the proposed new diagnosis codes proposed to 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 25,815-25,816.

Updates to the MS-DRGs Subject to the Post-Acute Care Transfer Payment Policy
Federal Register pages 25,961-25,964

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' Proposal: CMS is proposing to update the list of MS-DRGs subject to the post-acute care transfer policy. CMS is proposing to:

- Add the following seven 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
 - 570: Skin Debridement w MCC
 - 571: Skin Debridement w CC
 - 572: Skin Debridement w/o CC/MCC
- Remove the following five MS-DRGs from the policy:
 - 229: Other Cardiothoracic Procedures w CC
 - 229: Other Cardiothoracic Procedures w CC
 - 230: Other Cardiothoracic Procedures w/o CC/MCC
 - 640: Misc Disorders of Nutrition, Metabolism, Fluids/Electrolytes w MCC
 - 641: Misc Disorders of Nutrition, Metabolism, Fluids/Electrolytes w/o MCC

CMS is proposing to apply the special payment methodology to MS-DRGs 216 and 217.

Updates to the “3-Day Payment Window” or “72-Hour Rule”

Federal Register pages 25,960-25,961

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’ Proposal: 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. CMS reiterates the requirements in the proposed rule.

“As of April 1, 2011, a hospital must add condition code 51 on claims for separately billed outpatient non-diagnostic services furnished on or after June 25, 2010 . . . if the hospital wishes to attest to non-diagnostic services as being unrelated to the hospital claim.”

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.

CMS also clarifies 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 25,874-25,876 and 25,951-25,953

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’ Proposal: CMS is proposing to revise its policy for determining maximum allowable pension costs for the purposes of computing the hospital wage index and cost-based reimbursement. CMS will maintain its current requirement 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:

- “. . . we are proposing to include, in the wage index, pension costs 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.”

If adopted, this proposal would be effective beginning with the FFY 2013 update. CMS is proposing that the 3-year average would be centered on the base cost reporting year for the wage index. As proposed, the FFY 2013 wage index, which will be based on Medicare cost reporting periods beginning during FFY 2009, would reflect average contributions made during FFYs 2008, 2009, and 2010. CMS states in the proposal that the use of cash contributions as a measure of the costs incurred is necessary to ensure uniformity among all hospitals, regardless of their tax status or ERISA coverage. CMS further notes that it is proposing to use a 3-year average to reduce the volatility that can occur due to timing of contributions.

- For determining the maximum allowable pension costs for the purposes cost-based reimbursement:
 - “. . . we are proposing a limit on the current period liability equal to 150 percent of the three consecutive reporting periods out of the [five most] recent reporting which produce the highest average.”

If adopted, this proposal would be effective for cost reporting periods beginning on or after October 1, 2011. CMS states that the limit has been proposed to ensure that reported pension costs are reasonable.

Submission of Comments

Federal Register page 25,788

Comments on the proposed must be submitted by Monday, June 20 at 5 p.m. CMS requests that comments reference the file code CMS-1518-P.

Comments can be submitted electronically at <http://www.regulations.gov>. Follow the instructions for “Comment or Submission” and enter the file code CMS-1518-P to submit comments on this proposed rule.

-OR-

Regular Mail (an original and two copies):

Centers for Medicare and Medicaid Services
 Department of Health and Human Services
 Attention: CMS-1518-P
 P.O. Box 8011
 Baltimore, MD 21244-1850

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

Centers for Medicare and Medicaid Services
 Department of Health and Human Services
 Attention: CMS-1518-P
 Mail Stop C4-26-05
 7500 Security Boulevard
 Baltimore, MD 21244-1850

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Hand-Delivered (an original and two copies):

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 Note: Call (410) 786-7195 to schedule the delivery if you use the Baltimore address.