

August 11, 2006

## MEDICARE INPATIENT PPS: THE FINAL RULE FOR FISCAL YEAR 2007

### AT A GLANCE

#### **The Issue:**

On August 1, the Centers for Medicare & Medicaid Services (CMS) released its final Medicare inpatient prospective payment system (PPS) rule for fiscal year (FY) 2007. However, many of the figures included in the rule are tentative estimates, as the wage index, which is used in many of the major calculations, has not been finalized. CMS will issue a second *Federal Register* notice with the final figures before the payment rates and policies take effect October 1.

As expected, CMS made major modifications to the DRG relative weights in FY 2007, including moving from charge-based to cost-based DRG weights. While CMS chose not to delay the DRG changes, it will phase in the changes over three years and has made significant methodological changes, as recommended by the AHA. CMS also moved forward with plans to increase the number of quality measures for which hospitals must submit data to receive their full payment update of 3.4 percent. In addition to the 10 previously required measures, hospitals must pledge, by August 15, to submit data on 11 additional measures for patients admitted on or after July 1, 2006.

The final rule will be published in the August 18 *Federal Register*. A display copy is currently available at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488f.pdf>.

#### **Our Take:**

While we continue to be concerned about the rule's implementation and impact, CMS has listened to our views and made important changes from its proposed rule. We are committed to working with CMS to ensure any needed changes are addressed in future years.

#### **What You Can Do:**

- ✓ Share this advisory with your senior management team.
- ✓ Ask your chief financial officer to examine the impact of the payment changes on your Medicare revenue for FY 2007.
- ✓ Submit by August 15 a "Notice of Participation" form, which can be found at <http://www.qualitynet.org> under "RHQDAPU participation forms."
- ✓ Watch for the final rates and impact analyses, which will be published by CMS before October 1.
- ✓ Sign up for a special call on the rule on Wednesday, August 16, at 1 p.m. Eastern (Noon CT, 11 a.m. MT, 10 a.m. PT). See the attachments for a faxback registration form.

#### **Further Questions:**

Contact Danielle Lloyd, AHA senior associate director of policy, at (202) 626-2340 or [dlloyd@aha.org](mailto:dlloyd@aha.org).



# *Regulatory* Advisory

August 11, 2006

## MEDICARE INPATIENT PPS: THE FINAL RULE FOR FISCAL YEAR 2007

### TABLE OF CONTENTS

#### **FINAL CHANGES**

Inpatient PPS Rate Update .....	p. 2
DRG Changes .....	p. 4
Changes to DRG Classifications and Coding .....	p. 5
Outlier Payments .....	p. 8
Wage Index .....	p. 9
Rural Hospitals .....	p. 13
Long-term Care Hospitals.....	p. 16
Emergency Medical Treatment and Active Labor Act (EMTALA) .....	p. 16
New Technology Payments.....	p. 17
Graduate Medical Education .....	p. 17
Excluded Hospital Market Basket.....	p. 18
Skilled-nursing Facility Bad Debt.....	p. 18
Overall Financial Impact of FY 2007 Proposals on Hospitals .....	p. 18
Health Care Infrastructure Improvement Program.....	p. 19

#### **OTHER FUTURE CONCEPTS**

Health Care Information Transparency Initiative.....	p. 19
Value-based Purchasing .....	p. 20
Hospital-acquired Infections .....	p. 20
Health Information Technology.....	p. 20

## **BACKGROUND**

On August 1, the Centers for Medicare & Medicaid Services (CMS) released its final rule for the fiscal year (FY) 2007 Medicare inpatient prospective payment system (PPS). The rule includes significant changes to the calculation of diagnosis-related group (DRG) relative weights, including the use of costs instead of charges and modifications to the classification system to better account for patient acuity. In addition, the rule updates the payment rates, outlier threshold, hospital wage index, quality reporting requirements and payments for indirect medical education, among other policies.

The policies and payment rates in this rule take effect October 1. **However, note that many of the figures included in the final rule and this advisory are *TENTATIVE* estimates, as the wage index, which is used in many of the major calculations, has not been finalized. CMS will publish a second notice with the final figures in the *Federal Register* before October 1.**

The display copy of the final rule is currently available at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488f.pdf>. The official copy will be published August 18 in the *Federal Register*.

## **AT ISSUE**

### **FINAL CHANGES**

#### ***Inpatient PPS Rate Update***

The market basket index measures price changes over a fixed period of time. To construct the market basket index, price proxies, such as the consumer price index, are used to estimate the price changes for a mix of goods and services purchased by hospitals. The rate increase in the hospital market basket for FY 2007 is projected to be 3.4 percent.

*The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)* provided an inpatient PPS update equal to the full market basket for hospitals submitting data on 10 specific clinical measures of quality for FYs 2005 – 2007. The *Deficit Reduction Act of 2005 (DRA)* instructed CMS to increase the number of clinical measures required. In response, in the final rule CMS added reporting requirements, beginning with patients discharged on or after July 1, 2006, for 11 new measures endorsed by the Hospital Quality Alliance. The AHA is pleased that CMS heeded the hospital field's concerns and will not require hospitals to retroactively collect data for the new measures back to January 1, 2006, as proposed.

Hospitals that report the current 10 measures, pledge by August 15 to report the full set of 21 measures and pass the validation process will receive a 3.4 percent update in their rates. Hospitals that do not submit the data will receive a payment update of

market basket minus 2.0 percentage points, or 1.4 percent. To inform CMS of your hospital's intent to comply with the final rule's reporting requirements, you must fill out and return a pledge form indicating that your hospital will report on all 21 measures. That form, which is available at <http://www.qualitynet.org> under "RHQDAPU participation forms," must be received by your state's quality improvement organization no later than August 15. (RHQDAPU is the Reporting Hospital Quality Data for the Annual Payment Update.) For more information, see the August 8 AHA Quality Advisory at <http://www.aha.org> under "What's New."

By law, CMS must adjust the proportion of the standardized amount that is attributable to wages and wage-related costs (known as the labor-related share) by a factor that reflects the relative difference in labor costs across geographic areas (known as the wage index). For FY 2007, CMS maintained a labor-related share of 62 percent for those hospitals with wage indices less than 1.0, and 69.7 percent for those hospitals with wage indices greater than 1.0. The labor-related share for Puerto Rico will remain 58.7 percent.

The **TENTATIVE** operating standardized amounts for 2007 are as follows:

#### Area Wage Index Greater Than 1.0

Full Update (3.4%)		Reduced Update (1.4%)	
Labor-Related	Non-labor-Related	Labor-Related	Non-labor-Related
\$3,400.13	\$1,478.20	\$3,334.36	\$1,449.51

#### Area Wage Index Less Than 1.0

Full Update (3.4%)		Reduced Update (1.4%)	
Labor-Related	Non-labor-Related	Labor-Related	Non-labor-Related
\$3,024.51	\$1,853.72	\$2,966.00	\$1,817.87

For Puerto Rico hospitals, the MMA mandated that the payment per discharge equal the sum of 25 percent of a Puerto Rico-specific rate, which reflects the base year average costs per case of Puerto Rico hospitals, and 75 percent of the federal national rate.

#### For Hospitals in Puerto Rico

	Rates if Wage Index is Greater than 1.0		Rates if Wage Index is Less than 1.0	
	Labor-Related	Non-labor-Related	Labor-Related	Non-labor-Related
National	\$3,400.13	\$1,478.10	\$3,024.51	\$1,853.72
Puerto Rico	\$1,436.25	\$880.28	\$1,359.80	\$956.72

The **TENTATIVE** capital standard federal payment rate for FY 2007 is \$427.38, compared to \$420.65 in FY 2006. For Puerto Rico, the FY 2007 rate is \$203.13, compared to \$201.93 in FY 2006.

### **DRG Changes**

The FY 2007 DRG changes are noteworthy, but more modest than the sweeping changes CMS proposed. They will significantly redistribute payments among the DRGs and hospitals once fully implemented. Most of the cardiac DRG weights will decrease, while many medical DRG weights will increase.

CMS proposed two major changes for FY 2007: use of Hospital-specific Relative Values (HSRVs) and a modified version of cost-based weights instead of weights based on charges. CMS also proposed refining the DRGs to account for patient acuity through a new Consolidated Severity-Adjusted (CS) DRG system, to be implemented by FY 2008.

These proposals resulted from CMS' review and consideration of four major recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its March 2005 specialty hospital report:

- Use HSRVs to calculate DRG weights.
- Refine DRGs to more fully capture patient severity of illness (MedPAC modeled this recommendation using All-Patient Refined DRGs (APR) DRGs).
- Calculate DRG relative weights using hospital- and department-specific costs.
- Use DRG-specific offsets to fund the outlier pool, instead of making a uniform reduction in payment across all cases.

However, the final rule limits the changes to a simpler cost-based weighting methodology and more modest alterations to the DRG classification system, similar to last year's cardiac DRG changes. Over the next year, CMS will continue to research additional refinements, which will likely include the use of HSRVs and CS-DRGs, in consultation with the hospital field.

In brief, the new CMS methodology involves the following basic steps, which will:

- group charges for each discharge into 13 cost center categories established by CMS, including routine days, intensive days, drugs, supplies and equipment, therapy services, inhalation therapy, operating room, labor and delivery, anesthesia, cardiology, laboratory, radiology and other services, which were not separated out in the proposed rule;
- standardize charges, as currently is done, for each of the 13 cost centers for each discharge;
- reduce standardized charges to costs using 13 national cost-to-charge ratios (CCRs) for each DRG;
- sum the total costs across cost centers to create a "cost" for each DRG;

- divide the total costs by the total discharges for that DRG, as currently is done with charges; and
- create the index and final DRG weights by dividing by the national average standardized cost per DRG by the national average standardized cost for all DRGs, as currently is done with charges.

Based on input from the AHA and others, CMS also changed the calculation of the national CCRs to include charge-weighting rather than hospital-weighting. This means that a large hospital will contribute more to the calculation than a small hospital. Also, CMS will remove the data for hospitals whose CCRs are more than three standard deviations from the mean, rather than a cutoff of 1.96. The more stringent trimpoint in the proposed rule resulted in the inappropriate removal of data from a large number of high-volume hospitals from the calculation.

While CMS will not delay the DRG changes, it will phase in the changes over three-years, as recommended by the AHA. During FY 2007, 33 percent of the DRG weight will be based on the new methodology while 67 percent of the weight will be based on the old methodology.

Rather than implement the substantial changes to the DRG classification system discussed in the proposed rule, CMS created 20 new DRGs and modified others within 13 clinical areas. CMS also announced that it will engage a contractor and work with the hospital field to further refine the DRGs for implementation in FY 2008. More details on these changes are included below in the “Changes to DRG Classifications and Coding” section of this advisory.

The AHA is in the process of analyzing CMS’ changes to determine the impact, appropriateness and validity of the new cost-based weighting methodology and the new and modified DRGs. Over the next year, the AHA also will work with CMS to determine what additional refinements are appropriate and necessary and help identify implementation issues, reasonable timing and interactions with other components of the inpatient PPS.

### ***Changes to DRG Classifications and Coding***

To improve the system’s recognition of severity of illness, CMS created 20 new DRGs (eight surgical and 12 medical) in 13 different clinical areas. The new DRGs were created through a combination of approaches, including subdividing existing DRGs on the basis of diagnosis codes, specific surgical procedures and selecting cases with specific diagnosis and/or procedure codes and assigning them to a new DRG. CMS also modified 32 DRGs to better capture differences in severity.

For FY 2007, CMS will make the following changes to the DRG classification system.

Nervous System Infection except Viral Meningitis. Prior to FY 2007, all nervous system infections except viral meningitis were assigned to DRG 20. To better account for severity, separate DRGs have been created to distinguish bacterial infection and

tuberculosis from other infections of the nervous system. DRG 20 will be deleted and replaced by DRG 560 (Bacterial and tuberculosis infections of nervous system) and DRG 561 (Non-bacterial infections of nervous system except viral meningitis).

Seizure and Headache. Seizures and headaches are grouped together under DRGs 24, 25 and 26. DRG 24 (Seizure & headache age >17 with complications and comorbidities (CC)) and DRG 25 (Seizure & headache age >17 without CC) will be deleted and replaced by three new DRGs:

- DRG 562 (Seizure age > 17 with CC)
- DRG 563 (Seizure age > 17 without CC)
- DRG 564 (Headaches age >17)

Respiratory System Diagnosis with Ventilator Support. Medical patients treated with mechanical ventilation for respiratory failure are grouped to DRG 475 (Respiratory system diagnosis with ventilator support). DRG 475 will be deleted and replaced with DRGs 565 and 566, depending on whether the patient is on ventilator support for 96 hours or more to recognize differences in severity and utilization of resources.

Major Esophageal Disorders and Major Gastrointestinal and Peritoneal Infections. CMS will create two new DRGs to recognize higher levels of severity and higher average charges for patients with these conditions: DRGs 571 (Major esophageal disorders) and 572 (Major gastrointestinal disorders and peritoneal infections). These cases were previously spread across eight different DRGs (174, 175, 182, 183, 184, 188, 189 and 190).

Major Gastrointestinal Diagnosis. A list of higher-severity diagnosis codes will be identified as “Major Gastrointestinal Diagnoses.” DRGs 148 (Major small & large bowel procedures with CC) and 154 (Stomach, esophageal & duodenal procedures age > 17 w CC) will be deleted, and four new DRGs based on the presence or absence of a Major Gastrointestinal Diagnosis (567, 568, 569 and 570) will be added.

Major Bladder Procedures. Major bladder procedures were found to have a higher level of severity than cases with other types of bladder procedures in DRGs 303, 304, 305, 308 and 309. DRG 573 (Major bladder procedures) will be created to recognize the higher severity level and greater use of resources. In addition, three DRGs will be renamed as follows:

- DRG 303 (Kidney and Ureter Procedures for Neoplasm)
- DRG 304 (Kidney and Ureter Procedures for Non-Neoplasm With CC)
- DRG 305 (Kidney and Ureter Procedures for Non-Neoplasm Without CC)

Major Hematological and Immunological Disorders. DRG 574 (Major hematologic/immunologic diagnoses except sickle cell crisis and coagulation disorders), will be created to recognize the higher level of severity of major hematological and immunological diagnoses. These conditions are more resource intensive than other

conditions assigned to the DRGs where they are currently grouped (395, 396, 398 and 399).

Operating Room (O.R.) Procedures for Patients with Infectious and Parasitic Diseases. DRG 415 (O.R. procedure for infectious and parasitic diseases) will be deleted and divided into two new DRGs:

- DRG 578 (Infectious and Parasitic Diseases with O.R. Procedure)
- DRG 579 (Postoperative or Post-traumatic Infection with O.R. Procedure)

Severe Sepsis. DRG 416 (Septicemia age > 17) will be deleted and the cases split into two new DRGs (575 and 576) based on whether the patient is on mechanical ventilation for 96 hours or more. Note, CMS is not creating new DRGs for medical or surgical severe sepsis.

Heart Transplants or Implant of Heart Assist System. DRG 103 will be revised to include patients who have both the replacement of an external heart-assist system (code 37.63) and the explantation of that system (code 37.64) prior to the hospital discharge. This change recognizes the higher costs associated with patients who have a longer length of stay and are discharged alive with their native heart. DRG 103 will continue to include cases in which a heart transplant occurs during the same hospitalization.

Pancreas Transplant. On July 1, 1999, CMS specified that pancreas transplants were covered only when performed simultaneously with or after a Medicare covered kidney transplant. CMS has issued a final National Coverage Determination that a pancreas transplant alone is reasonable and necessary under limited circumstances for patients with Type I diabetes. DRG 513 (Pancreas Transplant) will be modified to remove the requirement that patients also have kidney disease as a principal or secondary diagnosis.

Dual Array Implantable Neurostimulator for Deep Brain Stimulation. Full-system dual array neurostimulator cases will be moved from DRGs 1 (Craniotomy age > 17 with CC) and 2 (Craniotomy age > 17 without CC) to DRG 543 to more accurately recognize the higher resources associated with this technology. The DRG title for DRG 543 is changing to "Craniotomy with major device implant or acute complex CNS principal diagnosis."

Carotid Artery Stents. Effective October 1, 2004, new ICD-9-CM procedure codes were created for percutaneous angioplasty or atherectomy of precerebral vessels (code 00.61) and percutaneous insertion of carotid artery stents (code 00.63). Code 00.61 was assigned to four MDCs and seven DRGs. Code 00.63 is used in combination with code 00.61. The most common DRGs for these procedures were 533 (Extracranial procedures with CC) and 534 (Extracranial procedure without CC). These cases will be moved to new DRG 583 (Carotid artery stent procedure). Both codes 00.61 and 00.63 must be reported in order for cases to be assigned to this DRG. Coverage of the

carotid artery stent procedure is limited to patients at risk for a stroke due to narrowing or stenosis of the carotid artery. As such, diagnosis code 433.10 (Occlusion and stenosis of carotid artery without mention of cerebral infarction) should be used to identify the site of the procedure in the carotid artery.

CRT-D Defibrillators. CMS will add code 37.74 (Insertion or replacement of epicardial lead [Electrode] into atrium) to the DRG logic so that all types of defibrillator device and lead combinations would be included in the following DRGs:

- DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheter)
- DRG 535 (Cardiac Defibrillator Implant with Cardiac Catheter with AMI/Heart Failure/Shock)
- DRG 536 (Cardiac Defibrillator Implant with Cardiac Catheter without AMI/Heart Failure/Shock)

This correction was made to align with the coding advice change to assign code 37.74 in conjunction with implantation of CRT-D defibrillators.

Hip and Knee Replacements. For FY 2006, new codes were created to differentiate between new and revised hip and knee replacements. More specific codes also were created to identify the joint components replaced. After publication of the FY 2006 inpatient PPS final rule, a number of commenters advised CMS that the logic for DRG 471 (Bilateral or multiple major joint procedures of lower extremity) included knee and hip procedures that are not bilateral or do not involve multiple major joints. CMS agreed that the new and revised joint procedure codes should not be assigned to DRG 471 unless they include bilateral and multiple joints. Therefore, CMS will remove a series of codes from DRG 471 that do not capture bilateral and multiple joint revisions or replacements and assign them to DRG 545.

Spinal Disc Replacement Device. CMS did not consider it appropriate at this time to revise the DRG for the CHARITE™ Lumbar Artificial Disc because of a recent decision to limit coverage for surgical procedures involving this device. Medicare charge data shows a very small number of cases involving patients under 60 years of age undergoing this procedure. CMS believes it is appropriate to base the decision on charge data for the population for which the procedure is covered.

Medicare Code Editor Changes. A number of edits that were discussed at the March 2006 ICD-9-CM Coordination and Maintenance meeting, but were approved too late to be included in the proposed rule, will be added to the newborn-diagnoses edits for new diagnosis codes. Updates consistent with ICD-9-CM code changes will be made to several edits.

### **Outlier Payments**

CMS calculates that it spent 3.96 percent of total payments on outliers in FY 2005 and estimates that it will spend 4.62 percent in FY 2006, even though 5.1 percent was set aside in both years. CMS will continue to estimate the one-year average annualized

rate-of-change in charges per case this year using data from the first and second quarters of FY 2005, compared to the first and second quarters of FY 2006. However, unlike last year, CMS will use a combination of the change in costs per discharge from the cost reports, market basket and the charge inflation just described to project forward the cost-to-charge ratios gathered from the March 2006 provider-specific file. Cases will qualify for outlier payments in FY 2007 if their costs exceed the PPS rate for the DRG – including indirect medical education, disproportionate share hospital (DSH) and new technology payments – in addition to the **TENTATIVE** fixed-loss threshold of \$24,475. This is \$1,055 lower than the \$25,530 proposed and likely will result in Medicare outlier spending closer to the 5.1 percent of funds set aside. We are pleased that CMS has altered its methodology for calculating the fixed-loss threshold, which we have urged for a number of years.

### **Wage Index**

The wage index adjusts payments to reflect the differences in labor costs across geographic areas. The final FY 2007 wage index is based on data from hospitals' FY 2003 cost reports. **However, the final wage index tables were not included in this publication, but instead will be published before October 1 in a second *Federal Register* notice.**

In the proposed rule, CMS estimated that the national average hourly wage will increase 5.7 percent compared to the FY 2006 index. As a result, a number of hospitals may see their wage index decline relative to last year because even though their wages rose, they did not rise as quickly as at other hospitals. The AHA recommends that you verify that your hospital's wage data is accurate once it is released on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp>.

Occupational Mix. *The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* required CMS to collect data every three years on the occupational mix of employees at hospitals subject to the inpatient PPS in order to construct an adjustment to the wage index to control for the effect of employment choices – such as greater use of registered nurses versus licensed practical nurses or certified nurse aides – rather than geographic differences in the costs of labor.

CMS stated in the proposed rule that it would again limit the occupational mix adjustment to 10 percent because of concerns regarding the validity of the data and the potential financial impact on hospitals. However, as a result of the federal appellate court decision in *Bellevue Hospital Center v. Leavitt*, CMS is required to collect new data and implement the occupational mix adjustment in full by October 1. Thus, CMS required hospitals to submit data from January 1 through March 31 by June 1. CMS also is requiring hospitals to submit by August 31 data from April 1 through June 30. The first three-months of data will be used to adjust the FY 2007 wage index, while the full six-months of data will be used for FYs 2008 and 2009. Details on the survey currently underway are in the May 22 occupational mix advisory, which can be found on the AHA Web site at [http://www.aha.org/aha/key\\_issues/ipps/ipps\\_occmixresources.html](http://www.aha.org/aha/key_issues/ipps/ipps_occmixresources.html).

As suggested by the AHA, CMS did not alter the ongoing survey, thus preventing hospitals from having to alter the data for the first three months of 2006. In addition, CMS will allow hospitals that did not submit data by the June 1 deadline to submit the first calendar quarter data by August 31 for use in FYs 2008 and 2009. CMS also will allow hospitals that did submit data earlier this year to make corrections during the audit process this fall for the FY 2008 adjustment.

In the proposed rule, CMS requested comments for dealing with hospitals that did not submit data on time. In the past, the agency has substituted the national average, or 1.0, meaning that the hospital received no adjustment based on its occupational mix. However, CMS offered three different options for the upcoming adjustment:

1. assign the hospital the average occupational mix factor for its labor market area;
2. assign the hospital the lowest occupational mix adjustment factor for its labor market area; or
3. assign the hospital the average occupational mix factor for similar hospitals based on factors such as geographic location, bed size, teaching versus non-teaching status and case mix.

CMS selected the first option for FY 2007. This will minimize the negative effect of non-responsive hospitals on other hospitals in the area. However, CMS reserves the right to penalize non-responsive hospitals in the future. To avoid such negative data substitutions, it is critical that hospitals meet the August 31 deadline.

The calculation will remain essentially the same as was used for the FYs 2005 and 2006 adjustments. However, rather than use Bureau of Labor Statistics data to determine the national average hourly wage, CMS will use the wage data collected directly on the survey instrument. In addition, CMS will use the percent of nursing wages as compared to total wages, rather than the percent of nursing hours as compared to total nursing hours, to determine what portion of a hospital's wages will be adjusted. The wages attributable to the "all other employees" category are not adjusted.

In future rulemaking, CMS will consider whether refinements need to be made to the employee definitions or cost centers added to the collection.

New Hospital Labor Markets. In June 2004, the Office of Management and Budget released revised standards defining Metropolitan Statistical Areas (MSAs), including its new definitions of Core-based Statistical Areas. Consequently, CMS adopted changes to its labor market definitions in the FY 2005 rule. As a result, a small number of hospitals classified as urban in FY 2004 were reclassified as rural in FY 2005. Because reclassification would have resulted in a significant decline in these hospitals' wage indices, CMS implemented a three-year transition period (FYs 2005 – 2007). In the final rule, CMS extended the hold-harmless period for these hospitals for one more year. While these hospitals will continue to be paid based on their previous MSA assignments, they will be considered rural for all other purposes and no longer will be

eligible for adjustments such as the large urban add-on to the capital rates. Beginning in FY 2008, these hospitals will receive their statewide rural wage index. However, they are eligible to apply for reclassification.

Out-migration Adjustment. Section 505 of the MMA provided hospitals in lower-wage areas with a wage-index adjustment if a significant number of hospital workers commute to higher-wage areas nearby. This adjustment, which is effective for three years, is based on the percentage of out-migration of hospital employees and the differences in wage indices between or among the areas. By law, the provision is not budget neutral and does not affect payments for other hospitals. Also, under changes prescribed by the MMA, hospitals that receive this adjustment are not eligible for geographic reclassification. Table 4J, found at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp> or in the Addendum to the final rule, tentatively lists the eligible hospitals and out-migration adjustments. However, once the final data are available, CMS will re-evaluate which counties are newly eligible for the out-migration adjustment based on the full implementation of the occupational mix adjustment. The FY 2007 final tables will be published before October 1 in a second *Federal Register* notice.

Section 508 Reclassifications. Section 508 of the MMA provided \$900 million over three years for a one-time geographic reclassification opportunity, which expires March 31, 2007. Because the 508 reclassifications expire mid-year, CMS has made special provisions for accepting or denying partial-year reclassifications for FY 2007.

In FY 2006, CMS stated that individual hospitals reclassified under Section 508 will be allowed to request regular reclassification for the portion of the three-year period that the hospital is not receiving Section 508 funding, or to turn down the Section 508 reclassification for the first half of FY 2007 and receive regular individual reclassification for the full three years.

CMS also stated that Section 508 hospitals that would like to be part of a group reclassification could reject their 508 reclassification for the first half of FY 2007 and join a group for the full three-year period. Hospitals also could elect to maintain Section 508 reclassification while the rest of the group gets their "home wage index" for the first half of the year. The entire group then could reclassify together for the rest of the three-year period.

In the final rule, CMS clarified that "home wage index" means that hospitals could receive the wage index they otherwise would have, absent the group reclassification. For some hospitals, this might literally be the wage index for the area in which they are located. For others, this may be an individual reclassification to another area.

Section 508 and other reclassifications can be found in Tables 9A and 9B at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp>, or in the Addendum to the proposed rule. However, note that the final FY 2007 tables will be published before October 1 in a second *Federal Register* notice.

Geographic Reclassifications. Hospitals typically have 45 days from the publication of the proposed rule to accept or deny their geographic reclassifications. However, this year the wage-related information on which hospitals normally base that decision was not available within that timeframe. Thus, CMS waived the 45-day deadline for FY 2007 and instructed the Medicare Geographic Classification Review Board (MGCRB) not to act on any withdrawal requests since hospitals making such requests were doing so based on incorrect information. Instead, CMS will actively choose the most favorable wage index for each hospital, including Section 505, Section 508 and other reclassifications, such as Lugar status.

Note that the geographic reclassification tables published in the final rule are tentative. CMS will publish before October 1 a second *Federal Register* notice with the final tables. **Hospitals will be given 30 days from the publication of the geographic reclassification and wage-index tables to reverse CMS' decision. Hospitals that wish to withdraw a reclassification must notify CMS and the MGCRB in writing by 5 p.m. EDT on the 30th day after the publication of the final tables, at:**

Centers for Medicare & Medicaid Services  
Attn: Marianne Myers  
Division of Acute Care  
C4-08-06  
7500 Security Boulevard  
Baltimore, MD 21244

AND

Medicare Geographic Classification Review Board  
2520 Lord Baltimore Drive, Suite L  
Baltimore, MD 21244-2670.

If a hospital wishes to definitively choose a reclassification or terminate a reclassification without viewing the final occupational mix-adjusted wage tables, it must notify CMS and the MGCRB by 5 p.m. EDT on August 15 at the addresses above. A hospital that, for instance, would like to maintain urban status, regardless of whether the wage index is higher in the rural area, would use this option. Otherwise, CMS will choose the option it believes will result in the highest wage index for the hospital.

For FY 2008 geographic reclassification applications, hospitals will need to comply with the September 1 deadline. However, hospitals can supplement their applications with the final FY 2007 occupational mix-adjusted average hourly wage data, provided they do so within 30 days of the publication of the files on the CMS Web site. Hospitals also can request the cancellation of a withdrawal or termination and reinstate an application within this time frame if they notify CMS and the MGCRB in writing at the addresses above. Applications and other information can be found on the CMS Web site at <http://www.cms.hhs.gov/mgcrb>.

## ***Rural Hospitals***

Low-volume Hospitals. Section 406 of the MMA created a payment adjustment under the inpatient PPS to account for low-volume hospitals' higher costs per case. The law defined eligible hospitals as those with fewer than 800 total discharges during the year located more than 25 miles from another facility – including Medicare and non-Medicare patients. The law further specified that the payment adjustment may not be greater than 25 percent based on a formula developed by CMS that takes into account the standardized cost per case, the number of hospital discharges and the incremental costs for these discharges.

The final rule maintained a 25 percent increase in payments to hospitals with fewer than 200 discharges. For those hospitals with 200 to 800 discharges, CMS will not provide an adjustment. CMS noted that only two hospitals in the country are expected to qualify under the discharge and location criteria for FY 2007.

Medicare Dependent Hospitals. The final rule implemented a provision in the DRA that not only reauthorized the Medicare Dependent Hospital (MDH) program, but also added FY 2002 as an allowable base year. MDHs will be paid 75 percent of the difference between the PPS payments and the hospital-specific rate, rather than 50 percent. MDHs also will no longer be subject to the 12 percent DSH cap.

Certification of Medicare Dependent Hospitals and Sole Community Hospitals. The proposed rule included a provision that would have required an approved MDH or Sole Community Hospital (SCH) to notify the appropriate CMS Regional Office of any change affecting its classification status. It previously had been the fiscal intermediaries' (FI) responsibility to evaluate a hospital's continuing qualification for MDH or SCH status. CMS proposed this change after becoming aware of situations in which providers continued as MDHs or SCHs even though they no longer met the requirements.

Many commenters, including the AHA, argued that hospitals should not be held accountable for reporting occurrences of which they might not be aware or that lie outside their control. Regardless, CMS finalized this policy with some modifications. CMS agreed that hospitals should not have to report on circumstances that are difficult to track, such as competitors' market share. It also specified which types of changes should be tracked:

- For SCHs:
  - distance between it and another like-hospital;
  - demographic classification status (urban/rural);
  - number of beds; and
  - travel time between itself and a like-hospital.
  
- For MDHs:
  - geographic classification status (urban/rural); and
  - whether the number of beds is greater than 100.

CMS expects hospitals to self-disclose such material changes in circumstances to their FIs, rather than the regional office as originally proposed, or face a retroactive cancellation of their designation back to the occurrence of the event once an FI discovers their ineligibility. If the event occurred more than three years prior, the cancellation of the designation would apply to cost reports subject to the three-year reopening period. In addition, CMS clarified that the retroactive cancellation also would apply to hospitals that were aware of changes in circumstances not listed above, but did not notify their FI. If the change is not on the list above, and the provider was unaware, then the hospital will be notified that its status will be revoked 30 days after the regional office discovers the change in circumstance. If the hospital becomes aware of a change that is not on the list and notifies the FI, then the cancellation would be effective as of the day the FI was notified.

Drop in Volume at MDHs and SCHs. An MDH or SCH may apply for special payments if it experiences a decrease of 5 percent or more in the total number of inpatient discharges that were out of its control from one cost-reporting period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. CMS believes that only “core staff and services” should be covered by these special payments. To date, CMS has used the AHA’s *HAS/Monitrend Data Book* to compare the hospital’s staffing to other similar hospitals in the area. However, the *Data Book* has not been updated since 1989. Thus, CMS proposed using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for the hospital in question and local peer hospitals.

The AHA is pleased that CMS modified the proposed policy in the final rule. For all open adjustment requests, hospitals may choose between the 1989 Monitrend data, occupational mix data or *AHA Annual Survey* data. Beginning with adjustment requests for decreases experienced in 2007, hospitals may choose between the occupational mix data and *AHA Annual Survey* data.

If a hospital chooses to use the *AHA Annual Survey* data, then the survey includes nursing staff from the hospitals’ distinct part units. Thus CMS will remove those hospitals with skilled-nursing facilities from the data set and include the number of days from the other distinct part units in the patient day count.

CMS also reiterated that it will use registered nurses, licensed practical nurses and certified nurse aides in response to commenters who asserted that nurse aides should not be included in the calculation.

Critical Access Hospitals. The final rule made only one immaterial technical correction related to Critical Access Hospitals. CMS declined to address the AHA’s concerns with the interpretative guidelines issued in November 2005 regarding relocation. However, CMS noted that it is actively considering the issue.

New Rural Referral Centers. If a hospital wants to become a Rural Referral Center (RRC), but does not have 275 or more beds, it must meet two mandatory alternative criteria and one of three additional criteria (relating to specialty composition of medical staff, source of inpatients or referral volume). The final rule updated the alternative criteria for RRC designation in FY 2007 to include:

- a case-mix index that is at least equal to either the median case-mix index for urban hospitals in its census region (excluding hospitals with approved teaching programs) or the national median case-mix index (1.3132), whichever is lower; or
- at least 5,000 discharges per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located (at least 3,000 for osteopathic hospitals).

No region has a discharge value of less than 5,000, thus 5,000 discharges is the minimum criterion for all hospitals. The median case-mix index values are listed in the chart below:

<b>Region</b>	<b>Median Case-Mix Index Value</b>
1. New England (CT, ME, MA, NH, RI, VT)	1.2313
2. Middle Atlantic (PA, NJ, NY)	1.2619
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3252
4. East North Central (IL, IN, MI, OH, WI)	1.3118
5. East South Central (AL, KY, MS, TN)	1.2926
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2344
7. West South Central (AR, LA, OK, TX)	1.3872
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3877
9. Pacific (AK, CA, HI, OR, WA)	1.3366

In addition, CMS clarified that when an osteopathic hospital first applies for RRC status, the agency will use the cost-reporting period that began during the same fiscal year the regional median discharges were calculated to determine the hospital's number of discharges. The regulations currently state that CMS will use the discharges during the hospital's most recently completed cost report, which may differ from the fiscal year on which the national median discharges were based.

Rural Community Hospital Demonstration Program. Section 410 of the MMA required CMS to conduct a demonstration program in rural areas under which qualifying hospitals with fewer than 51 beds will receive cost-based reimbursement rather than PPS payment for inpatient acute care and swing-bed services for a five-year period. CMS is implementing this program in a budget neutral manner by reducing inpatient PPS payments to all hospitals by \$9.2 million to account for the additional spending by the nine hospitals participating in the demonstration.

### **Long-term Care Hospitals (LTCH)**

The final rule reweighted the LTCH-DRG relative weights for FY 2007 payments. CMS estimates the non-budget neutral reweighting will reduce aggregate LTCH payments by 1.3 percent. The new FY 2007 LTCH-DRGs are in Table 11 of the rule.

CMS also finalized changes to the methodology used to calculate the LTCH CCRs that are used for reconciling high-cost and short-stay outlier payments. Under the final rule, CMS may use a statewide CCR if it is unable to determine an accurate CCR for an individual LTCH. In addition, the LTCH CCR ceiling will be based on inpatient PPS CCR data to account for the small number and uneven geographic distribution of LTCHs. The CCR ceiling for FY 2007 will be 1.321.

The final rule authorized LTCH hospitals-within-hospitals and satellites that are grandfathered to maintain this status if they alter their square footage or reduce their number of beds.

CMS also stated that it will finalize its refinement of the inpatient PPS DRGs before it proceeds with recommending changes to the current LTCH-DRG patient classification system.

The LTCH changes in this rule follow the 7.1 percent reduction to the LTCH PPS for RY 2007, which began on July 1.

### **Emergency Medical Treatment and Active Labor Act (EMTALA)**

In the final rule, CMS finalized two proposed changes to the EMTALA regulations based on recommendations from the EMTALA Technical Advisory Group (TAG). First, a qualified medical person other than a physician will be allowed to certify false labor if it is within their scope of practice according to medical staff bylaws and state laws. The AHA supported this change, as it will improve access to care and flexibility in staffing.

Second, hospitals with specialized capabilities must accept appropriate transfers under EMTALA even if they do not have an emergency department (ED), so long as they have the capacity to treat the patient. The AHA urged CMS to provide clarification of its definition of “specialized capability.” We asked CMS to treat physician-owned, limited-service hospitals as hospitals “with specialized capabilities,” but cautioned that change is unlikely to result in improved access for patients to the specialty care they need because these facilities often do not have the capability to handle emergencies. We also proposed other requirements to address the patient care issues presented by those hospitals. However, CMS deferred making any further changes, commenting that the TAG may consider further recommendations.

The AHA continues to be concerned about CMS' failure to address the issue of continuity of care for patients of physician-owned, limited-service hospitals who experience complications and are transferred to or instructed to go to the local community hospital's ED without the provision of critical information for the ED

physicians. The AHA will continue working with the TAG and CMS to achieve improved guidance.

### ***New Technology Payments***

New technology add-on payments are not subject to budget neutrality and, therefore, do not reduce payments for all other inpatient services. To gain approval for such payments, a technology must be considered new, be inadequately paid otherwise and represent a substantial clinical improvement over previously available technologies. The cost threshold for new technologies to qualify for add-on payments is either 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation for the DRG involved, whichever is less.

For FY 2007, CMS retained two of the three existing approved technologies for add-on payments and approved one of the three new applications it considered.

Re-evaluation of FY 2006 Approvals. CMS discontinued the new technology add-on payment for Kinetra® Implantable Neurostimulator, which was approved by the Food and Drug Administration on December 16, 2003, because it is no longer considered new. However, CMS will continue add-on payments for GORE TAG and Restore®.

New FY 2007 Applications. CMS considered three new technologies for add-on payments: C-Port® Distal Anastomosis System, X STOP® Interspinous Process Decompression System and NovoSeven® for Intracerebral Hemorrhage. However, it only approved X STOP® Interspinous Process Decompression System for FY 2007. The maximum add-on payment for procedures that involve X STOP will be \$4,400, or half of its estimated cost.

### ***Graduate Medical Education***

The final rule makes a number of changes to direct graduate medical education (DGME) and indirect medical education (IME) payments.

IME Adjustment. As required by section 502 of the MMA, CMS reduced the IME payment adjustment multiplier from 1.35 to 1.32. This will reduce the adjustment from a 5.55 percent increase in payments for every 10 percent increase in a hospital's resident-to-bed ratio to 5.35 percent.

Exclusion of Didactic Training. CMS finalized a proposal requiring resident training occurring at non-hospital sites to be related to patient care in order for that time to count for DGME payment purposes. Similarly, training both at non-hospital sites and on the hospital's campus must be related to patient care to count for IME payment. However, CMS refined how it intended to implement this provision. Rather than disallowing all time spent in didactic activities – such as educational conferences, journal clubs and seminars – CMS expects hospitals to exclude only entire days spent on such activities. While the AHA disagrees with this policy, the change CMS made will make compliance easier.

The final rule also contains several more minor technical changes relating to documentation requirements, GME aggregation agreements and determination of per-resident amounts when teaching hospitals merge.

### ***Excluded Hospital Market Basket <sup>1</sup>***

The excluded hospital market basket previously applied to rehabilitation, psychiatric, long-term care, cancer and children's hospitals, as well as religious non-medical health care institutions. However, CMS recently created separate prospective payment systems for three of these provider types – rehabilitation, psychiatric and long-term care hospitals – resulting in the “RPL” market basket index. This index, used to update the PPS-based portion of payments for the three provider types, is updated through other rulemaking. At the same time, CMS decided to use the inpatient PPS hospital market basket to update the rate-of-increase limits for cancer hospitals, religious non-medical health care institutions and children's hospitals. Accordingly, CMS will update payments for these providers by 3.4 percent for FY 2007.

However, CMS must continue to maintain the excluded market basket, as it is used to determine the annual update to the reasonable cost-based portion of payments for inpatient psychiatric facilities, which are transitioning from a full cost-based reimbursement system subject to rate of increase limits (TEFRA) to a full PPS. For FY 2007, CMS estimates the excluded market basket at 3.4 percent.

### ***Skilled-nursing Facility (SNF) Bad Debt***

Currently, SNFs are reimbursed for 100 percent of bad debt, or uncollectible coinsurance, from Medicare beneficiaries. Per the DRA, beginning in FY 2006, SNFs will be reimbursed for only 70 percent of their Medicare bad debt. However, 100 percent of bad debt will continue to be covered for full-benefit dual-eligible beneficiaries. CMS clarified that by “full-benefit dual-eligible individuals” it means beneficiaries who are “entitled to benefits under Part A of Medicare and is determined eligible by the state for medical assistance under title XIX.” Ascertaining the beneficiary’s coverage under Part C or D of Medicare is not necessary.

### ***Overall Financial Impact of FY 2007 Proposals on Hospitals***

According to CMS’ impact assessment, the overall changes would provide, on average, a 3.5 percent payment increase to hospitals. Urban hospitals would receive a 3.4 percent average increase, while rural hospitals would receive a 3.7 percent average increase. CMS estimates that the total impact of these changes for FY 2007 operating payments will result in a \$3.4 billion increase over FY 2006.

---

<sup>1</sup> Excluded hospitals and units include inpatient rehabilitation and psychiatric hospitals and units, long-term care hospitals, children’s hospitals, cancer hospitals and religious non-medical health care institutions. The PPS for inpatient rehabilitation facilities (IRFs) was effective January 1, 2002; the long-term care hospital (LTCH) PPS went into effect October 1, 2002; and the inpatient psychiatric facility (IPF) PPS was effective January 1, 2005. The remaining excluded hospitals are paid under the reasonable-cost system, subject to the rate-of-increase limits.

### **Health Care Infrastructure Improvement Program**

Section 1016 of the MMA established the Health Care Infrastructure Improvement Program, which provides certain hospitals engaged in cancer research loans to cover the costs of some capital projects. In this rule, CMS finalized the proposed loan qualifying criteria, selection criteria and terms of the loans without modification. In addition, CMS finalized the proposed conditions for loan forgiveness with only minor changes.

## **OTHER FUTURE CONCEPTS**

### **Health Care Information Transparency Initiative**

In the proposed rule, the Department of Health and Human Services announced its intent to launch a major health information transparency initiative in 2006 and solicited comments on options for increasing the transparency of quality and pricing information, including:

- publishing a list of hospital charges, either for every region of the country or for selected regions of the country;
- publishing the rates that Medicare actually pays to a particular hospital for every DRG, or for selected DRGs, that could be adjusted to take into account the hospital's labor market area, teaching hospital status and DSH status;
- establishing conditions of participation for hospitals that relate to posting of prices and/or the posting their policies regarding discounts or other assistance for uninsured patients; and
- posting total Medicare payments for an episode of care. Under this proposal, CMS could include the costs for an inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist) and payments for post-acute care services such as those provided in an inpatient rehabilitation facility, SNF or LTCH for a certain service (such as hip replacement).

On June 1, CMS published on its Web site the national average Medicare payment to hospitals for 30 common conditions and elective procedures. In addition, CMS included, by county, the range of payments made to hospitals in those areas along with the number of patients each hospital treated for specific conditions.

In the final rule, CMS did not finalize any of its proposed policies, but instead summarized the comments it received on these and other possible options to promote the aims of transparency of quality and pricing information. CMS acknowledged the complexities involved in presenting pricing information in an accurate and useful manner to the public, and stated that it plans to move forward with making pricing information available for other providers and practitioners.

### **Value-based Purchasing**

The DRA required CMS to develop a plan to implement hospital value-based purchasing (pay-for-performance) beginning in FY 2009. The plan must consider the following issues:

- measurement development – the ongoing development, selection and modification process for measures of quality and efficiency in hospital inpatient settings;
- data infrastructure and refinement – reporting, collecting and validating of quality data;
- incentives – the structure of payment adjustments, including the determination of thresholds for quality improvements that would substantiate a payment adjustment, the size of such payments and the sources of funding for the payments; and
- public reporting – disclosure of information on hospital performance.

While CMS sought input on each of these issues in the proposed rule and summarized the resulting input from the field in the final rule, it did not make any policy changes related to value-based purchasing in the final rule. The agency indicated that it will be hosting public listening sessions in 2007 for additional public input on this initiative.

### **Hospital-acquired Infections**

The DRA requires CMS to identify by October 1, 2007 at least two conditions – mainly complications or comorbidities – that result in a higher DRG payment rate and are reasonably preventable. For discharges occurring on or after October 1, 2008, hospitals would not receive additional payment for cases in which the selected conditions were not present on admission. That is, the case would be paid as though the secondary diagnosis were not present. The DRA also requires hospitals to submit secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

In the final rule, CMS summarized the comments it received from the field about which conditions and which evidence-based guidelines should be selected. However, it did not adopt any conditions or place any new requirements on hospitals. CMS indicated that it will soon select the conditions it proposes for implementation and will seek formal public comment during the FY 2008 proposed rule-making cycle.

### **Health Information Technology**

The final rule summarizes comments received on CMS' statutory authority to encourage the adoption and use of health information technology (IT), the inclusion of health IT in a value-based purchasing program and the inclusion of health IT requirements in Medicare's conditions of participation. The agency did not make IT use a Medicare condition of participation, but may revisit the issue in future rulemaking. CMS will continue taking steps to facilitate use of electronic health records for reporting of hospital quality data.

## **NEXT STEPS**

Given the major changes included in this year's rule, the AHA encourages hospital leaders to estimate the impact of the provisions on their facilities based on the tentative numbers included in the final rule. However, members also should watch for a second advisory once the final wage tables, standardized amount, DRG weights and outlier threshold are published sometime before October 1. The final wage data will be posted on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp> and the final impact file will be posted to <http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp>.

In order to receive a full payment update, hospitals should also submit by August 15 a "Notice of Participation" indicating that they will continue to submit data on the original 10 quality measures, as well as the 11 new measures. The form is available at <http://www.qualitynet.org> under "RHQDAPU participation forms."

The AHA has set up a conference call Wednesday, August 16, at 1 p.m. Eastern (Noon CT, 11 a.m. MT, 10 a.m. PT) for member hospitals to discuss the inpatient rule. Details are on the attached sheet. Please be sure to fax back the attached form to register for the call so we can ensure there will be enough phone lines.



**American Hospital  
Association**

## **Fax Back Form**

### **AHA Conference Call IPPS FINAL RULE**

*Dial-In Number: 1-866-710-0179  
Security Code: 4491*

To help us plan an appropriate number of lines for the call, please return this form if you are interested in participating.

- Wednesday, August 16<sup>th</sup> at 1 pm Eastern (Noon CT, 11 am MT, 10 am PT)**

.....

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

City, State \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Please return this form via fax to  
Elisa Arespachoga at (312) 422-4590**



**American Hospital  
Association**

**AHA Conference Call  
IPPS FINAL RULE**

August 16, 2006

**CONFERENCE CALL FOLLOW-UP**

1. Request for additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Questions or comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Evaluation:				Strongly		Strongly
				Agree		Disagree
A. The information provided on the call was useful.	5	4	3	2	1	
B. My questions were addressed on the call.	5	4	3	2	1	
C. There was ample time on the call to ask questions or make comments.	5	4	3	2	1	

-----  
Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Please return this form via fax to  
Elisa Arespachoga at (312) 422-4590**