

April 28, 2008

## MEDICARE INPATIENT PPS: THE PROPOSED RULE FOR FISCAL YEAR 2009

### AT A GLANCE

#### **The Issue:**

On April 14, the Centers for Medicare & Medicaid Services (CMS) released its fiscal year (FY) 2009 proposed rule for the hospital inpatient prospective payment system (PPS). The proposed rule is available at <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp> and will be published in the April 30 *Federal Register*. Comments are due June 13. A final rule will be released by August 1, and changes will take effect October 1. This proposed rule affects inpatient PPS, long-term care and critical access hospitals. Major changes in the rule include:

**Operating Payment Update:** The rule proposes a market basket update of 3.0 percent for eligible hospitals that submit data on 30 quality measures. Eligible hospitals not submitting data would receive a 1.0 percent update.

**Quality Reporting:** The rule proposes to expand the number of quality measures required for public reporting to 72 in FY 2010. Some of the proposed measures have been endorsed by the National Quality Forum and adopted by the Hospital Quality Alliance, however, many have not. The AHA has been at the forefront of public reporting of hospital quality information and firmly believes that when linking payment to quality, all measures included should be endorsed by the National Quality Forum as appropriate national standards and adopted by the Hospital Quality Alliance as useful for public reporting on hospital quality of care.

**Diagnosis-related Groups (DRGs):** FY 2009 marks the end of the transition to the new Medicare-Severity DRG system. Beginning October 1, DRG weights will be fully adjusted for severity and calculated solely on cost-based relative weights. As mandated by Congress, the proposed rule includes a prospective 0.9 percent cut to the standardized amount to eliminate the effect of documentation and coding that CMS says do not reflect real changes in case mix.

**Wage Index:** CMS proposes changes to the method used to compute the hospital wage index and to make it more difficult to qualify for reclassification.

**Payment Cuts:** The rule would cut payments to hospitals by implementing a reduction to the indirect medical education adjustment to capital payments and by increasing the number of cases that would be paid under the post-acute care transfer policy when beneficiaries subsequently receive home health services.

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

- ✓ Share this advisory with your senior management team.
- ✓ Ask your chief financial officer to examine the potential impact of the proposed payment changes on your Medicare revenue for FYs 2008 and 2009.
- ✓ Watch for AHA's comments on the rule to use in making your own comments to CMS.

#### **Further Questions:**

If you have questions on the rule, contact Don May, vice president for policy, at (202) 626-2356 or [IPPSQuestions@aha.org](mailto:IPPSQuestions@aha.org). If you have trouble with this transmission, contact (202) 626-2973.

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## **BACKGROUND**

On April 14, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule for the fiscal year (FY) 2009 hospital inpatient prospective payment system (PPS). The proposed rule is available at <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp> and will be published in the April 30 *Federal Register*.

According to CMS' impact assessment, the overall changes would provide, on average, a 4.1 percent payment increase to hospitals. Urban hospitals would receive a 4.2 percent average increase, while rural hospitals would receive a 3.3 percent average increase. However, this is misleading because CMS assumes that all hospitals will alter their coding based on the diagnosis-related group (DRG) changes in a way that will increase payments by 1.8 percent without a commensurate increase in the severity of their patients. If this increase does not materialize, average payments to urban hospitals would only increase by 2.4 percent, while rural hospitals would experience an increase of 1.5 percent.

Comments are due June 13, and the final rule will be released by August 1. Changes will take effect October 1. A detailed summary of the proposed rule follows.

## **AT ISSUE**

### ***Operating PPS Rate Update***

The market basket is an input price index that measures price changes over a fixed period of time. To construct the market basket index, price proxies, such as the U.S. 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 2009 operating PPS payments is projected to be 3.0 percent. This also applies to the sole community hospital (SCH) and Medicare-dependent hospital (MDH) hospital-specific rates, as well as the rate-of-increase limits for children's hospitals and cancer hospitals.

As required by law, hospitals that do not report the 30 quality measures established in the 2008 outpatient PPS final rule will receive an update of the market basket minus 2.0 percentage points, or 1.0 percent for FY 2009. (See "Hospital Quality Reporting" for more information.)

Also 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 among geographic areas (known as the area wage index). For FY 2009, CMS proposes maintaining 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. CMS proposes leaving the labor-related share for Puerto Rico at 58.7 percent.

The proposed operating standardized amounts for 2009 are as follows:

**Area Wage Index Greater Than 1.0**

Full Update (3.0%)		Reduced Update (1.0%)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
\$3,553.98	\$1,544.98	\$3,484.97	\$1,514.98

**Area Wage Index Less Than 1.0**

Full Update (3.0%)		Reduced Update (1.0%)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
\$3,161.36	\$1,937.60	\$3,099.97	\$1,899.98

For Puerto Rico hospitals, the *Medicare Modernization Act* (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.

The proposed operating standardized amounts for Puerto Rico for 2009 are as follows:

**For Hospitals in Puerto Rico**

	Rates if wage index is greater than 1.0		Rates if wage index is less than or equal to 1.0	
	Labor-related	Non-labor-related	Labor-related	Non-labor-related
National	\$3,553.98	\$1,544.98	\$3,161.36	\$1,937.60
Puerto Rico	\$1,501.82	\$920.46	\$1,421.88	\$1,000.40

**Capital PPS Rate Update**

CMS is required to pay for a portion of the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for new facilities, renovations, expensive clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). This is done through a separate capital PPS, which is structured similarly to the operating PPS. Under the capital inpatient PPS, there is a standard federal payment rate that is adjusted by the DRG for each discharge, with additional payment adjustments for teaching hospitals, disproportionate share hospitals (DSH) and large urban hospitals.

The proposed capital standard federal payment rate for FY 2009 is \$421.29. Capital payments to hospitals in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the federal capital rate. The proposed FY 2009 capital rate for Puerto Rico is \$197.19.

In the FY 2008 final rule, CMS made two changes to the structure of payments under the capital PPS, claiming that payments under the capital PPS exceeded what is required for hospitals to provide inpatient services. First, the agency eliminated the 3.0 percent additional payment that had been provided to hospitals located in large urban areas. Second, the agency adopted a policy to phase out the indirect medical education (IME) adjustment to teaching hospitals over three years. In FY 2008, teaching hospitals would receive their full IME adjustment to capital payments; in FY 2009 they would receive half their adjustment; and in FY 2010 and beyond, the adjustment would be eliminated.

Given that the impact to teaching hospitals in phasing out the IME adjustment to capital payments is significant – a \$175.6 million reduction, CMS is providing the public with an additional opportunity to comment on this proposal. **The AHA remains opposed to this unnecessary cut and will urge CMS to rescind this provision in the final FY 2009 rule.**

### **Hospital Quality Reporting**

To be eligible for a full market basket update in FY 2009, CMS proposed in the 2008 inpatient PPS rule to add one outcome measure (pneumonia 30-day mortality) and four process measures to the set of 27 existing measures. Because several of the proposed measures did not receive timely endorsement from the National Quality Forum (NQF), CMS adopted only three measures in the 2008 outpatient PPS final rule for inpatient reporting, bringing the total number of measures to 30 for FY 2009. These three measures were:

- Cardiac surgery patients with controlled 6 AM postoperative serum glucose
- Surgery patients with appropriate hair removal
- Pneumonia 30-day mortality

In the current rule, CMS proposes that to be eligible for a full market basket update in FY 2009, hospitals submit quality data on all of the previously adopted measures and two new surgical care measures for discharges beginning in January 2008. For the new pneumonia mortality measure, as with the heart attack and heart failure mortality measures, CMS will calculate hospitals' mortality rates from claims data. Hospitals do not have to collect or submit any data for this measure. Hospitals also will have to meet the requirements of the previously established data validation process. More information on the data submission and validation process can be found on the QualityNet Web site, <http://www.qualitynet.org>.

In the proposed rule, CMS proposes to add 43 new measures for FY 2010. Appendix A to this advisory lists the current reporting measures and CMS' newly proposed measures. The proposed measures include:

- One surgical care measure
- Four nursing sensitive measures
- Three readmission measures
- Six venous thromboembolism (VTE) measures
- Five stroke measures

- Nine patient safety and quality indicators from the Agency for Healthcare Research and Quality (AHRQ)
- Fifteen cardiac surgery measures from the Society of Thoracic Surgeons registry

Most of these proposed measures have not been endorsed by the NQF and adopted by the Hospital Quality Alliance (HQA). **In our comments to CMS, the AHA will emphasize that any measures added to the pay-for-reporting program must first go through the rigorous, consensus-based assessment processes of both the NQF and the HQA.** Of the proposed measures, only the surgical care measure, the six VTE measures and three of the nine AHRQ measures have been adopted by the HQA. We do not believe that the other measures proposed by CMS are ready for reporting.

For the first time, CMS proposes to stagger the start dates for hospitals to begin reporting on the new measures and vary the data submission timelines. For example, CMS proposes that hospitals begin reporting on the surgical care, VTE and cardiac surgery measures on January 1, 2009; the nursing sensitive measures begin on April 1, 2009; the stroke measures on July 1, 2009; and the AHRQ measures on October 1, 2009. While data submission on all existing measures is due within four and a half months of the close of a calendar quarter, CMS proposes to vary the data submission timelines for some of the proposed measures. For instance, data for the AHRQ and cardiac surgery measures would be due within four months of the close of the calendar quarter. We believe that these proposals add unnecessary complexity into an already complicated reporting system. Furthermore, the proposed delayed start dates signal a red flag that many of these measures are not ready to be implemented for FY 2010 and should not be linked to the 2010 annual payment update.

CMS proposes to retire the pneumonia oxygenation assessment measure and no longer require hospitals to report on it. Almost all hospitals have been consistently performing at or near 100 percent on this measure, and CMS believes the benefits of reporting on this measure no longer outweigh the burden to hospitals of data collection.

In the proposed rule, CMS lists a wide range of additional measures and topics that it may consider for inclusion in FY 2011 or beyond. Most measures on this list have not been adopted by the HQA or endorsed by the NQF. For some of the listed topics of interest, measures do not exist.

In addition, CMS proposes to allow hospitals that have fewer than five heart attack, heart failure, pneumonia or surgical care patients in a calendar quarter to not submit quality measures data for those patients beginning in FY 2010. Hospitals that have fewer than five HCAHPS-eligible patients in any month will not be required to submit HCAHPS surveys for that month. The AHA supports this approach as a sensible way to reduce the reporting burden on hospitals with a very small number of cases; however, we believe hospitals should always be able to voluntarily report on quality measures if they wish.

### **Hospital-acquired Conditions**

In the inpatient PPS, potentially preventable complications in care, such as infections acquired in the hospital, can sometimes trigger higher payments – either as payment outliers or by assignment to a higher-paying complication or comorbidity (CC) or major CC (MCC) DRG. *The Deficit Reduction Act of 2005* (DRA) required CMS to identify by October 1, 2007 at least two preventable complications of care that could cause patients to be assigned to a higher-paying DRG. The statute required that the conditions be either high cost, high volume or both; result in the assignment of a case to a DRG that has a higher payment when the condition is present as a secondary diagnosis; and be reasonably preventable through the application of evidence-based guidelines. The DRA also mandated that for discharges occurring on or after October 1, 2008, the presence of one or more of these conditions would not lead to the patient being assigned to a higher paying DRG. That is, the case would be paid as though the secondary diagnosis was not present. Finally, the DRA required hospitals to submit the secondary diagnoses that are present on admission when reporting payment information for discharges on or after October 1, 2007.

In the FY 2008 inpatient PPS final rule, CMS adopted eight conditions for which it would no longer pay a higher DRG rate beginning in FY 2009 if the conditions occur while a patient is under the hospital's care. Those eight conditions are:

- Object left in during surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers
- Falls and trauma
- Catheter-associated urinary tract infections
- Vascular catheter-associated infections
- Surgical site infection – Mediastinitis after coronary artery bypass surgery

In the proposed rule, CMS makes two refinements to the hospital-acquired conditions adopted last year. The agency proposes to include an additional ICD-9 code (998.7) under the condition of object left in during surgery. Additionally, with the development of new ICD-9 codes to identify different stages of pressure ulcers, CMS plans to include only stage III and stage IV pressure ulcers under the new payment policy.

CMS also proposes to expand the list and include an additional nine conditions when the payment policy takes effect on October 1. The nine conditions are:

- Surgical site infections following elective procedures
- Legionnaires' disease
- Glycemic control
- Iatrogenic pneumothorax
- Delirium
- Ventilator-associated pneumonia
- Deep-vein thrombosis/pulmonary embolism
- Staphylococcus aureus septicemia
- Clostridium difficile-associated disease

Further, CMS discusses the public health concerns of Methicillin-resistant *staphylococcus aureus* (MRSA), but it proposes not to include MRSA as a hospital-acquired condition for payment purposes under the inpatient PPS.

CMS is seeking comments on reasons why specific conditions should not be selected as one of the initial conditions, in particular, the degree to which these conditions are not reasonably preventable through the application of evidence-based guidelines. **The AHA is concerned that most of the selected conditions are not always preventable. Even when appropriate precautions are taken, some patients, particularly high-risk individuals, may still develop the conditions on the list. We will share these concerns with CMS and urge members to do the same.**

The payment changes for hospital-acquired conditions will apply only when the selected conditions are the only CCs or MCCs present on a claim. Under this policy, CMS would not make higher payments for the selected conditions if they are coded as not present on admission or if the medical record documentation is insufficient to determine whether the condition was present on admission. CMS believes not paying a higher payment amount when the medical record documentation is insufficient will foster better medical record documentation. However, the AHA contends that this is a misguided policy, particularly as hospitals gain experience with the new present on admission coding requirement. We will urge CMS to allow hospitals to gain experience with present on admission coding for several years before determining any payment policies for cases with documentation that is insufficient to determine whether a condition is present on admission.

CMS recognizes there may be some exceptional circumstances, such as a patient's death, for which the hospital may not have the ability to fully determine whether a condition is present on admission. In these situations, the agency proposes that the hospital will still receive the higher payment amount for that patient, even if the medical record documentation is insufficient. CMS is seeking comments on what circumstances should be included on this list.

### **Value-based Purchasing**

The DRA mandated that CMS develop a plan to implement value-based purchasing for hospitals under the Medicare program. CMS submitted its plan to Congress on November 21, 2007. In the proposed rule, CMS outlines its development of the plan and discusses the plan's components. For more information on the plan, see the AHA's December 5, 2007 Quality Advisory at <http://www.aha.org>.

Implementation of value-based purchasing requires action by Congress. CMS intends to test the potential impact of its value-based purchasing plan by conducting a simulation of hospitals' performance under the program and assessing the performance scores and the financial impact of the proposal. CMS is seeking comments as to whether and how the results of this testing should be made public.

### **Wage Index**

The area wage index adjusts payments to reflect the differences in labor costs across geographic areas. The final rule will base the FY 2009 wage index on data from hospitals' FY 2005 cost reports. According to CMS, the national average hourly wage increased 4.2 percent compared to the FY 2007 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 those at other hospitals. We recommend that you verify that the wage data used for your hospital is accurate. It can be found on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp> or in the Addendum to the proposed rule.

MedPAC Recommendations. In the *Tax Relief and Health Care Act of 2006*, Congress required the Medicare Payment Advisory Commission (MedPAC) to develop a report by June 2007 with recommendations and alternatives to improve the area wage index. Additionally, the act required CMS to consider MedPAC's recommendations and propose changes to the wage index in the FY 2009 proposed rule. While CMS is still reviewing MedPAC's recommendations and using an external contractor to analyze their impact, the agency is proposing other changes to address some concerns with the wage index. Results of CMS' research of the MedPAC recommendations and other proposals to address the wage index will be published in the FY 2009 final rule or a subsequent *Federal Register* notice.

Individual and Group Reclassifications. Many hospitals apply each year to the Medicare Geographic Classification Review Board (MGCRB) for reclassification to another area to receive a higher area wage index. CMS' current criteria for reclassification require an urban hospital to demonstrate that its average hourly wage is at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation and at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located. For rural hospitals, the thresholds are 82 percent and 106 percent, respectively.

CMS developed the methodology for these criteria in its FY 1993 inpatient PPS final rule by calculating one standard deviation above (108 percent) and below (84 percent) the national average hourly wage. In the FY 2000 inpatient PPS final rule, the wage comparison criteria for rural hospitals seeking individual hospital reclassifications were reduced to 82 percent and 106 percent to compensate for the historic economic underperformance of rural hospitals.

CMS has not evaluated or recalibrated the average hourly wage criteria for geographic reclassification since they were established in FY 1993. As part of its effort to propose wage index changes, CMS re-evaluated the average hourly wage criteria for geographic reclassification using the 1993 methodology and wage data for FYs 2006, 2007 and 2008. Based on this new data, CMS is proposing to change the criteria for FY 2010 and after so that an urban hospital would need to have an average hourly wage that is 88 percent (up from 84 percent) of the area to which they want to reclassify. A rural

hospital would need an average hourly wage that is 86 percent (up from 82 percent) of the area to which it wants to reclassify.

CMS also is proposing to re-evaluate and recalibrate the criteria when there are significant changes in geographic boundaries (including changes due to each decennial census).

Hospitals also can apply for reclassification as a “group” when all hospitals in a county have an average hourly wage that is at least 85 percent of the area to which they want to reclassify. CMS proposes to increase the 85 percent criteria to 88 percent so that the group standard is comparable to that of individual hospitals. CMS is not proposing to differentiate between hospitals in rural or urban counties for purposes of group reclassification, and all groups would be subject to the 88 percent threshold.

CMS estimates that approximately 15 percent of hospitals with individual reclassifications and approximately 9 percent of hospitals with group reclassifications in 2007 and 2008 would not have qualified for reclassification under its new proposed criteria. **The new criteria would only apply to new reclassifications beginning in FY 2010.** Any hospitals or county group in the midst of a three-year reclassification in FY 2010 would not be affected by the proposed change until they reapply for reclassification. The proposed effective date for these changes would be September 1 – the deadline for hospitals to submit applications for reclassification for the FY 2010 wage index.

Budget Neutrality Related to the Rural Floor. *The Balanced Budget Act of 1997* (BBA) established the rural floor by requiring that the wage index for a hospital in an urban area of a state cannot be less than the area wage index determined for that state’s rural area. Additionally, CMS in 2006 temporarily adopted an “imputed” rural floor measure by establishing a wage index floor for those states that did not have rural hospitals. Both the rural floor and the imputed rural floor are funded through a nationwide budget neutrality adjustment. In the FY 2009 proposed wage index, 266 hospitals in 27 states would benefit from the rural floor. An additional 26 hospitals in New Jersey would receive the imputed rural floor.

For FY 2009, CMS proposes to apply a statewide (rather than a nationwide) rural floor budget neutrality adjustment to the wage index. Therefore, states with no hospitals receiving a rural floor wage index no longer would have a negative budget neutrality adjustment applied to their rates. Conversely, hospitals within each state with hospitals receiving a rural floor would fund the higher payments for those hospitals. The budget neutrality adjustment for the imputed floor also would be applied at a state level for those states with no rural areas.

The imputed floor is a temporary three-year provision CMS created in 2006. The agency proposes to extend the imputed rural floor through 2011.

### **Documentation and Coding Adjustment for DRG Changes**

CMS proposes to complete its two-year transition to Medicare-Severity DRGs (MS-DRGs) and its three-year transition from charge-based DRG weights to cost-based weights. Beginning in FY 2009, the relative weights will be based on 100 percent cost weights using the MS-DRGs.

CMS believes that adopting the MS-DRGs will lead to coding and classification changes that will increase aggregate hospital payments without a corresponding increase in actual patient severity of illness. As a result, CMS in the FY 2008 inpatient PPS final rule established a prospective documentation and coding adjustment of negative 1.2 percent for FY 2008, negative 1.8 percent for FY 2009 and negative 1.8 percent for FY 2010. Congress, in P.L. 110-90, lowered this prospective adjustment to negative 0.6 percent in FY 2008 and negative 0.9 percent in FY 2009. In the proposed rule, CMS indicates that it will apply the mandated documentation and coding adjustment of negative 0.9 percent to the FY 2009 inpatient PPS national standardized amount.

Last November, CMS reversed its earlier decision to apply the documentation and coding adjustment to SCHs and MDHs. While CMS stated its belief that the adjustment should apply to these facilities, it expressed a concern that applying the adjustment to hospital-specific rates was not consistent with the plain meaning of the statute, which only mentions adjusting “the standardized amount” and does not mention adjusting hospital-specific rates. Thus, for FY 2008, the documentation and coding adjustment was not applied to SCHs or MDHs. For FY 2009, CMS proposes to continue this policy and not apply the negative 0.9 percent adjustment to SCHs or MDHs.

In addition, CMS proposes not to apply the negative 0.9 percent adjustment to that portion of the Puerto Rico-specific standardized amount (25 percent of the total Puerto Rico - specific rate) in FY 2009. CMS now believes after examining the statute further that the documentation and coding adjustment applies to the *national* standardized amounts but not the Puerto Rico-specific standardized amount. CMS plans to issue a *Federal Register* notice to correct the error in the Puerto Rico-specific standardized amount for FY 2008 retroactive to October 1, 2007.

CMS indicates, however, that it continues to have concerns about implementation of the documentation and coding adjustment. The agency believes that it should be applied to the hospital-specific rates; thus, payments to SCHs, MDHs and Puerto Rico hospitals should be lowered. In the proposed rule, CMS asserts that it has the authority to do this using its special exceptions and adjustment authority, which authorizes the agency to provide “for such other exceptions and adjustments to [inpatient PPS] payment amounts... as the Secretary deems appropriate.” While not proposing to decrease payments to these three types of hospitals at this time, CMS states that if it finds evidence of significant increases in case-mix for patients treated in these facilities it would consider applying a cumulative documentation and coding adjustment to the FY 2010 hospital-specific rates.

### **Refinement of the MS-DRG Relative Weight Calculation**

For FY 2009, CMS does not propose any changes to the methodology used in FY 2008 for calculating cost-based MS-DRG relative weights. In FY 2009, CMS proposes to complete the three-year transition to cost-based weights, moving from a blend of cost- and charge-based weights in FY 2008 to full implementation. However, as discussed below, CMS does propose changes to the cost report to improve the accuracy of cost-based weights.

CMS continues working to respond to concerns about potential bias in the weights due to “charge compression” – applying a higher percentage charge markup over costs to lower cost items and services, and a lower percentage charge markup over cost to higher cost items and services. This potentially leads to undervaluing high cost items and overvaluing low cost items in the calculation of cost-based weights. Research indicates that this occurs most often in the area of medical supplies.

In response to public comments and research concluding that more precise cost reporting is the best way to minimize charge compression and improve the accuracy of cost-based weights, CMS is proposing changes to the cost report. Specifically, CMS proposes to add one cost center to the cost report to separate the costs and charges for relatively inexpensive medical supplies from those of more expensive devices (such as pacemakers and other implantable devices). These changes would affect the inpatient PPS and outpatient PPS relative weights and by extension, the ambulatory surgery center rates.

CMS proposes to use a modified version of the criteria for a medical device to be eligible for pass-through payment under the outpatient PPS plus a requirement that the device be implanted and remain in the patient as the criteria for what to report in the cost center for devices. All other devices and non-chargeable supplies would be reported on the “Medical Supplies” line. CMS is soliciting comments on other criteria such as using a cost threshold or dividing up supplies based on the markup policies of the individual hospital.

CMS expects the proposed revision of the cost report to be issued after the publication of this inpatient PPS proposed rule. The revised cost report would be available for cost reporting periods beginning on or after October 1. These changes would affect the relative weights beginning in FY 2012.

In order to improve the match between the costs and charges included on the cost report and the charges in the MedPAR file, CMS is recommending that certain revenue codes be used for items reported in these two different cost centers. In general, if an item is reported as an implantable device on the cost report, the associated charges should be recorded in the MedPAR file with either revenue codes 0275 (Pacemaker), 0276 (Intraocular Lens) or 0278 (Other Implants). CMS also is soliciting comments on how existing revenue codes or additional revenue codes could best be used in conjunction with the revised cost centers on the cost report.

### ***Changes to DRG Classifications***

Artificial Heart Devices. CMS proposes to remove procedure code 37.52 (Implantation of internal biventricular heart replacement system) from MS-DRG 215 (Other Heart Assist System Implant) and assign it to MS-DRG 001 (Heart Transplant or Implant of Heart Assist System With Major Comorbidity or Complication) and MS-DRG 002 (Heart Transplant or Implant of Heart Assist System Without Major Comorbidity or Complication). Artificial hearts currently are not covered under the Medicare program. On February 1, CMS published a proposed coverage decision memorandum for artificial hearts when performed under the auspices of a Food and Drug Administration (FDA)-approved clinical study. CMS expects to make a final decision on or about May 1. Should the national coverage determination be approved, CMS also is proposing to remove procedure code 37.52 from the Medical Code Editor (MCE) "Non-Covered Procedure" edit and assign it to the "Limited Coverage" edit. The proposed edit includes the requirement that ICD-9-CM diagnosis code V70.7 (Examination of participant in clinical trial) also be present on the claim.

Automatic Implantable Cardioverter-Defibrillators (AICD) Lead and Generator Procedures. CMS proposes to subdivide current MS-DRG 245 to better recognize the differences in resource utilization between implantation or replacement of the AICD leads and AICD pulse generators. CMS proposes to revise the title for MS-DRG 245 "AICD Generator Procedures" and include procedure codes capturing the implantation or replacement of AIC pulse generators (codes 37.96, 37.98, and 00.54). The proposed new MS-DRG 265 would be titled "AICD Lead Procedures" and would include procedure codes that identify the implantation or replacement of AICD leads (codes 37.95, 37.97 and 00.52).

Severe Sepsis. CMS proposes to incorporate the term "or severe sepsis" after "Septicemia" into the titles of the following MS-DRGs that became effective October 1, 2007 (FY 2008):

- MS-DRG 870 (Septicemia With Mechanical Ventilation 96+ Hours)
- MS-DRG 871 (Septicemia Without Mechanical Ventilation 96+ Hours With MCC)
- MS-DRG 872 (Septicemia Without Mechanical Ventilation 96+ Hours Without MCC)

The change is proposed to better assist in the recognition and identification of severe sepsis, which would lead to better clinical outcomes and quality improvement efforts. Both severe sepsis (code 995.92) and septic shock (code 785.52) currently are already assigned to these three MS-DRGs.

Traumatic Compartment Syndrome. Five ICD-9-CM diagnosis codes were implemented October 1, 2006 to identify traumatic compartment syndrome of various sites (codes 958.90, 958.91, 958.92, 958.93 and 958.99). Cases with one of these diagnosis codes as the principal diagnosis and no operating room procedure currently are assigned to either MS-DRG 922 (Other Injury, Poisoning and Toxic Effect Diagnosis With MCC) or MS-DRG 923 (Other Injury, Poisoning and Toxic Effect Diagnosis Without MCC) in Major Diagnostic Code (MDC) 21.

In the FY 2008 inpatient PPS final rule, CMS inadvertently omitted these traumatic compartment syndrome codes – 958.90 through 958.99 – from the multiple trauma MS-DRGs 963 (Other Multiple Significant Trauma With MCC), MS-DRG 964 (Other Multiple Significant Trauma With CC), and MS-DRG 965 (Other Multiple Significant Trauma Without CC/MCC) in MDC 24 (Multiple Significant Trauma). Cases are assigned to MDC 24 based on the principal diagnosis of trauma and at least two significant trauma diagnosis codes (either as principal or secondary diagnoses) from different body site categories.

For FY 2009, CMS proposes to add traumatic compartment syndrome codes 958.90 through 958.99 to MS-DRGs 963 and MS-DRG 965 in MDC 24. Under this proposal, these codes would be added to the list of principal diagnosis of significant trauma. In addition, code 958.91 would be added to the list of significant trauma of upper limb; code 958.92 would be added to the list of significant trauma of lower limb; and code 958.93 would be added to the list of significant abdominal trauma.

MCE Changes. CMS proposes to make the following changes to the MCE edits:

- List of unacceptable principal diagnoses in MCE – CMS proposes to remove code V62.84 (Suicidal ideation) from the MCE list of Unacceptable Principal Diagnoses.
- Diagnoses allowed for males only edit – CMS proposes to add the following four codes located in the ICD-9-CM Chapter Diseases of Male Genital Organs:
  - 603.0 Encysted hydrocele
  - 603.1 Infected hydrocele
  - 603.8 Other specified types of hydrocele
  - 603.9 Hydrocele
- Limited coverage edit – CMS proposes to remove procedure code 37.52 (Implantation of internal biventricular heart replacement system) from the MCE "non-covered procedure" edit and to assign it to the "limited coverage" edit. In addition, this edit will require both ICD-9-CM diagnosis code V70.7 (Examination of participant in clinical trial) and procedure code 37.52 on the same claim to comply with the proposed coverage policy.

Surgical Hierarchies. CMS proposes to revise the surgical hierarchy for MDC 5 (Diseases and Disorders of the Circulatory System) by placing MS-DRG 245 (AICD Generator Procedures) above proposed new MS-DRG 265 (AICD Lead Procedures).

CC Exclusion List. CMS proposes limited revisions to the CC Exclusions List to take into account the changes that will be made in the ICD-9-CM diagnosis coding system effective October 1. The agency's changes are in accordance with the principles established when the CC exclusions list was created in 1987.

Review of Procedure Codes in MS-DRGs 981. MS-DRGs 981 through 983, 984 through 986 and 987 through 989 (formerly CMS DRGs 468, 476, and 477, respectively) are reserved for those cases in which none of the operating room procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases – those not occurring with sufficient frequency to represent a

distinct, recognizable clinical group. Each year, CMS reviews cases assigned to these DRGs to determine whether it would be appropriate to change the procedures assigned among these DRGs. CMS is not proposing to change the procedures assigned among these DRGs.

### ***Post-acute Care Transfers***

Since FY1999, certain Medicare patients discharged to a post-acute care setting – including rehabilitation hospitals and units, long-term care hospitals and units, cancer hospitals, psychiatric hospitals, children’s hospitals and skilled nursing facilities – or discharged within three days to home health services, are defined as transfer cases and are paid a daily (per diem) rate, rather than a fixed DRG amount, up to the full PPS rate.

CMS proposes to expand this provision to patients receiving home health care services within seven days of discharge. The agency suggests that a three-day timeframe creates an incentive for providers to delay the provision of necessary care beyond the window so that hospitals will receive the full DRG payment amount. **The AHA opposes this unreasonable and unjustified expansion of the post-acute care transfer policy, which is estimated to result in reduced payments to hospitals of \$50 million in FY 2009 and \$330 million over five years.**

### ***Outlier Payments***

According to the proposed rule, cases would qualify for outlier payments in FY 2009 if their costs exceed the inpatient PPS rate for the DRG, including IME, DSH and new technology payments, plus a the fixed-loss threshold of \$21,025. This is down from \$22,185 in FY 2008. For FY 2008, CMS estimates that it only will pay out 4.8 percent of the 5.1 percent of payments withheld for outlier cases. The decrease in the outlier threshold should make it easier for hospitals to qualify for outlier payments and help ensure that the total funds withheld for outlier cases in FY 2009 are returned to hospitals in outlier payments.

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

The inpatient PPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies. 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 the lesser of either 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation above mean charges for the DRG involved.

CMS received four applications for new technology add-on payments for FY 2009 and invites public comment on whether these technologies should qualify:

- CardioWest™ Temporary Total Artificial Heart System – a device used as a bridge to heart transplant patients with end-stage biventricular failure.

- Emphasys Medical Zephyr® Endobronchial Valve – a technology to treat patients with emphysema by reducing hyperinflation in the diseased portion of the lung.
- Oxiplex® – an absorbable, viscoelastic gel that is surgically implanted during operations to relieve pressure on the spinal cord and nerves resulting in less inflammation and pain.
- TherOx Downstream® System – a technology that uses SuperSaturatedOxygen Therapy (SSO2) to limit myocardial necrosis by minimizing microvascular damage in heart attack patients.

The agency also proposes to set July 1 of each year as the deadline by which new technology add-on payment applications must receive FDA approval. Applications that have not received FDA approval by July 1 would not be considered in the final rule, even if they were summarized in the corresponding inpatient PPS proposed rule.

### **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 criteria – a minimum case-mix index and number of discharges – and one of three additional criteria relating to specialty composition of medical staff, source of inpatients or referral volume. The proposed rule would update the alternative criteria for RRC designation in FY 2009 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 (1.4285), 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).

The median case-mix index values and number of discharges are listed in the chart below, but will be updated in the FY 2009 final rule based on the latest available cost reports:

<b>Region</b>	<b>Median Case-mix Index Value</b>	<b>Number of Discharges</b>
1. New England (CT, ME, MA, NH, RI, VT)	1.2515	8,158
2. Middle Atlantic (PA, NJ, NY)	1.2691	10,443
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3589	10,344
4. East North Central (IL, IN, MI, OH, WI)	1.3572	8,900
5. East South Central (AL, KY, MS, TN)	1.3040	7,401
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.3557	7,988
7. West South Central (AR, LA, OK, TX)	1.4405	5,816
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.4692	9,919
9. Pacific (AK, CA, HI, OR, WA)	1.3872	8,600

Rural Community Hospital Demonstration Program. Section 410 of the MMA requires 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. CAHs are not eligible for this program. To participate, a rural community hospital must be located in one of the following states: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah or Wyoming. As in the past four inpatient rules, CMS proposes to implement this program in a budget-neutral manner by offsetting inpatient PPS payments to all hospitals by an estimated \$32 million to account for the additional spending by the participating hospitals.

### ***Volume Decrease Adjustment for SCHs and MDHs: Updated Data Sources***

An SCH or MDH may apply for special payments if it experiences a decrease of five percent or more in the total number of inpatient discharges that was 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.

In the FY 2007 inpatient PPS rule, CMS finalized its policy to update the data sources and methodology used to determine the core staffing factors used for calculating the volume adjustment. An SCH or MDH could use one of two data sources – the AHA Annual Survey or the Occupational Mix Survey. Hospitals no longer could use the HAS/Monitrend Databook that dated back to 1989. However, CMS failed to publish the data for use by hospitals in applying for this adjustment.

CMS now has finished processing the 2006 Occupational Mix Survey as well as the 2006 AHA Annual Survey data and published it in the proposed rule. In doing so, the agency revised its methodology and employed several statistical measures to remove the extreme values which may impact the mean. CMS is seeking input on this revised methodology.

*[Note: If a hospital chooses to use the AHA Annual Survey data, the survey includes nursing staff from hospitals’ distinct part units.]*

### ***Hospital Readmissions***

While not proposing any changes related to hospital readmissions at this time, CMS is requesting public comment on three approaches that would give hospitals an incentive to reduce what the agency claims are avoidable readmissions. According to a 2005 MedPAC report, approximately 18 percent of Medicare patients discharged from hospitals are readmitted to hospitals within 30 days, costing approximately \$15 billion. MedPAC suggests that many of these 2 million readmissions are potentially avoidable. In fact, at its April meeting, MedPAC commissioners recommended that Congress require CMS to report readmission rates to hospitals and the general public and to reduce payments to hospitals with relatively high readmission rates.

CMS states that readmissions are financially rewarding to hospitals under the current inpatient PPS because they generate an additional DRG payment. The agency is interested in applying incentives to encourage the reduction of avoidable readmissions. The three approaches discussed include:

- A direct adjustment to the hospital DRG payment for avoidable readmissions.
- An adjustment to hospital DRG payments through a performance-based methodology.
- Public reporting of readmission rates.

The first two provisions adjust provider payment and would require congressional changes to the Medicare program.

### ***Hospitals and Hospital Units Excluded from the Inpatient PPS***

Only cancer hospitals, children's hospitals and religious non-medical health care institutions remain subject to the historical TEFRA rate-of-increase limits. Inpatient psychiatric, inpatient rehabilitation and long-term care hospitals (LTCH) now are fully subject to their respective PPSs. CMS is proposing that the percentage increase in the rate-of-increase limits would be the proposed percentage increase in the FY 2009 inpatient PPS operating market basket, which is estimated to be 3.0 percent.

### ***Long-term Care Hospital Provisions***

Just as it did for inpatient hospitals, CMS proposes to fully implement the revised payment categories for long-term care hospitals (LTCH) – the MS-LTC-DRGs. The rule also includes CMS' proposal to reweight the LTC-DRGs for FY 2009 in a budget-neutral manner. This is a welcome departure from CMS' recent pattern of using the annual reweighting of the LTCH payment categories to implement a coding cut.

In this proposed rule, CMS also proposes to modify a Medicare criterion for state-owned hospital-within-hospital LTCHs that are co-located on the campus of a state-owned hospital. These co-located LTCHs would be allowed to keep their Medicare certification, even if state law does not allow the LTCH to maintain a separate governing board, as otherwise required by Medicare.

The annual rate update for LTCHs will be released soon in the LTCH PPS final rule. Further LTCH regulatory activity is expected to implement LTCH provisions enacted by Congress in December 2007. These provisions include several new facility criteria for LTCHs and a three-year moratorium on new and expanded LTCHs.

### ***Physician Self-referral Provisions***

"Stand in the Shoes" Policy. In the proposed rule, CMS revisits the "stand in the shoes" policy and regulations issued in Phase III of its Stark regulations. In the Phase III regulations, certain contracts between a provider of designated health services (DHS) and a physician practice or group practice were treated as arrangements directly with the physicians, members, employees or independent contractors of that practice, with these physicians "standing in the shoes" of their physician organizations. As a result, the regulatory exception related to indirect compensation arrangements was no longer

applicable and some existing arrangements were required to meet a different exception in order to be permissible under the physician self-referral statute.

CMS' decision to revisit the "stand in the shoes" policy and regulations was motivated by expressed concerns about their scope and impact, particularly as applied to compensation arrangements involving "mission support payments" and similar payments. Such payments are intended to support the overall mission of an academic medical center or maintain operations of an integrated delivery system and usually are not tied to specific items or services provided to the physician or group practice. They likely do not satisfy the fair market value requirement that is a typical component of most existing exceptions to the physician self-referral regulations. As a result, while support payment arrangements, to be permissible, were required under the Phase III regulations to satisfy a direct compensation arrangement exception, there was no applicable exception available.

*For Physicians:* In the proposed inpatient PPS rule, CMS suggests two alternative approaches for revision. Under the first approach, a physician would be deemed not to stand in the shoes of the physician organization if the physician's compensation arrangement with his or her physician organization satisfies the requirements of any of the current exceptions for bona fide employment relationships, personal services arrangements or fair market value compensation. CMS cautions that, under this approach, arrangements between DHS entities and physician organizations whose physicians do not stand in their shoes may still create indirect compensation arrangements that would need to satisfy the regulatory requirements for the indirect compensation arrangements exception.

CMS also notes that under this approach, all physician owners and investors would continue to stand in the shoes of their physician organizations. CMS, however, is concerned that considering all physician owners and investors as such might be overly inclusive, citing the instance of a physician owner of a captive or "friendly" professional corporation in a state that prohibits the corporate practice of medicine who has no right to the distribution of profits. CMS is considering whether these and similarly situated physicians should have to stand in the shoes of their physician organizations when their ownership interest is nominal and their compensation arrangement with their physician organization satisfies the requirements for the bona fide employment relationships, personal services arrangements or fair market value compensation exceptions and specifically requests comments on this issue.

CMS also is requesting comments on whether it should consider an alternative approach under which only owners of a physician organization would stand in the shoes of that physician organization. In this case, a non-owner or non-investor physician would not stand in the shoes of the physician organization even if the physician's compensation arrangement with the physician organization does not satisfy the requirements for the bona fide employment relationships, personal services arrangements or fair market value compensation exceptions. In conjunction with this approach, CMS is interested in hearing whether and under what circumstances the

stand in the shoes provisions should apply to a physician organization that has no physician owners.

While CMS offers no proposed regulatory text, its alternative approach would leave the Phase III provisions as promulgated and CMS would instead, using its general authority to create exceptions, create a new one specific to “nonabusive arrangement that warrant protection not otherwise available under any existing exceptions” with conditions necessary to protect against program and patient abuse. CMS requests that comments specifically identify the types of compensation arrangements that should be permitted, including whether an exception should be limited to “mission support” payments; whether other types of payments or compensation arrangements should be eligible; the types of parties that should be permitted to use the exception; and the conditions that should apply to such an exception to ensure that an arrangement poses no risk of program or patient abuse.

In addition, CMS requests comments about other approaches to consider, including whether any changes to the existing “stand in the shoes” provisions are needed at all.

*For DHS Entities:* CMS also proposes once again, with some modifications, its previous “stand in the shoes” provisions related to the DHS entity side of the financial arrangement. These provisions were part of the 2008 physician fee schedule final rule published in the *Federal Register*, but never finalized. Comments suggested that the proposal was unclear and potentially overly broad. Under the proposal, an entity that provides DHS would be deemed to stand in the shoes of an organization in which it has a 100 percent ownership interest and would be considered to have the same compensation arrangements with the same parties and on the same terms as the organization that it owns. CMS requests comments on whether, and if so, what amount of, ownership less than 100 percent should trigger applications of the entity “stand in the shoes” provisions. CMS also requests comments on whether a DHS entity that “controls” an organization should be deemed to stand in the shoes of that organization. CMS would define “control” of an organization as having the power, directly or indirectly, significantly to influence or direct the actions or policies of that organization, and CMS requests comments about what level of control should trigger the application of the “stand in the shoes” provisions.

Gainsharing. While not putting forth a specific proposal, CMS also requests comments on whether it should establish an exception specific for gainsharing arrangements and, if so, what safeguards should be included in the exception.

Period of Disallowance. In addition, CMS requests comments on various proposals related to calculating the “period of disallowance” (i.e., the time period for which a physician could not refer patients for DHS to an entity and for which the entity could not bill Medicare where a financial relationship between the referring physician and the DHS entity failed to satisfy the requirements of an exception to the general self-referral prohibition).

### ***Disclosure Regarding Physician Ownership and Coverage***

In the FY 2008 inpatient PPS final rule, CMS revised the Medicare provider agreement regulations to require a physician-owned hospital to disclose to all patients whether it is physician-owned and, if so, the names of its physician owners. In the FY 2009 inpatient PPS proposed rule, this disclosure requirement would extend to hospitals in which an immediate family member of a physician holds an ownership or investment interest even if the physician does not. CMS believes that this change is necessary to create consistency between the disclosure requirements and the physician self-referral statute and regulations. A potential conflict of interest occurs not only in instances where a physician has a financial relationship, but also where the physician's immediate family member has a similar interest.

However, CMS proposes to exempt physician-owned hospitals from making the ownership/investment disclosure if the hospital has:

- No physician owners who refer patients to the hospital; and
- No referring physicians who have an immediate family member with an ownership or investment interest in the hospital.

In this circumstance, the hospital must attest in writing that it meets these conditions and maintain the attestation in its files for governmental oversight.

CMS also proposes to clarify that the physician-owned hospital must provide a list of owners at time the patient, or someone on behalf of the patient, makes the request.

In addition, CMS proposes to add a new disclosure requirement that a hospital require all members of its medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing any ownership or investment interest in the hospital held by the physician or the physician's immediate family member to all patients who they refer to the hospital. Again, the disclosure would be made at the time of the referral. This is similar to a requirement CMS proposed, but did not adopt, in the FY 2008 inpatient PPS rule.

CMS also is requesting public comments on whether hospitals, including CAHs, should educate patients about the availability of information on physician ownership (e.g., posting information in the admissions office or including it in a patient brochure).

The proposed rule would permit CMS to enforce these disclosure requirements by terminating the hospital's provider agreement. CMS also would be permitted to terminate the hospital's provider agreement when the hospital fails to disclose that it does not have a physician on-site 24-hours a day, seven days per week.

CMS states that no corresponding change to the medical staff bylaws condition of participation (CoP) is proposed. CMS believes that the disclosure requirements would be difficult to enforce as a CoP because the mandated notification generally is given outside the hospital's premises. However, CMS requests comments about whether the proposed disclosure requirements would be better effectuated through changes in the hospital and CAH CoP regulations.

### ***Financial Relationship between Hospitals and Physicians***

In the proposed rule, CMS reissues its proposal for a Disclosure of Financial Relationships Reporting (DFRR) system. The DFRR is designed to collect information about the ownership and investment interests and compensation arrangements between hospitals and physicians. CMS withdrew a previous request for Office of Management and Budget clearance on a proposed data collection form in light of criticism and questions from the AHA and others about the agency's authority under current regulation.

CMS' reissued proposal is not significantly different from what it previously put forth, except that the agency has revised its estimate of the burden of completing the data collection form. CMS' new estimate of burden is an average of 31 hours to complete, but the agency specifically seeks further comments on the accuracy of the time and burden estimates.

As outlined in the reissued proposal, CMS expects to send the DFRR form to 500 hospitals, a sample size that CMS has determined to be a significant percentage of the total number of Medicare-participating hospitals. CMS contends that this data collection effort is consistent with its statutory and regulatory authority and that the specific information to be collected is necessary to provide the agency with sufficient information to:

- Determine compliance with the physician self-referral requirements; and
- Assist in any future rulemaking concerning the physician self-referral reporting and other requirements.

CMS proposes that the DFRR be completed, certified by the appropriate hospital officer and returned within 60 days of the date that appears on the cover letter or e-mail transmission of the form. CMS proposes not to invoke its authority to impose civil monetary penalties for failure to timely submit the requested information. Rather, the agency will work with entities to ensure compliance with the reporting requirements.

CMS requests comments on the proposed DFRR collection instrument as well as the data collection process, including whether:

- The correct type and amount of information is collected on the proposed form.
- Data collection should be recurring, and if so, whether it should be annual or some other periodic basis.
- The DFRR should be completed by all hospitals and, if so, whether reporting should be staggered over multiple years, requiring only a certain number of hospitals to report each year.
- Hospitals, after completing an initial report, should have to send in yearly updates and report only changed information.

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

CMS proposes a number of changes to the EMTALA regulations, most of which derive from recommendations made by the recently disbanded EMTALA Technical Advisory Group (TAG).

CMS proposes to revise EMTALA to require that when an individual covered by EMTALA is admitted as an inpatient and remains unstabilized with an emergency medical condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual, assuming that the transfer of the individual is an appropriate transfer and the participating hospital with specialized capabilities has the capacity to treat the individual. This proposal stems from a controversial TAG recommendation which, while it passed by a slim majority, was opposed by most of the hospital and physician TAG representatives.

CMS proposes that, as part of the obligation to have an on-call list, hospitals may choose to participate in a shared plan or community call plan, to provide on-call coverage for an area. A community call plan must be a formal plan among the participating hospitals and include, at a minimum, the following elements:

- A clear delineation of on-call coverage responsibilities, i.e., when each hospital participating in the plan is responsible for on-call coverage.
- A definition of the specific geographic area to which the plan applies.
- The signature of an appropriate representative of each hospital participating in the plan.
- An assurance that any local and regional emergency medical services system protocol formally includes information on community on-call arrangements.
- An analysis by all the participating hospitals of the specialty on-call needs of the community for which the plan is effective.
- A statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.
- An annual reassessment of the community call plan by the participating hospitals.

Additionally, each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control.

CMS also proposes to move the regulation discussing the obligation of a hospital to maintain an on-call list from the EMTALA regulations to the hospital provider agreement regulations. Finally, CMS proposes to make technical corrections regarding the nonapplicability of EMTALA provisions in an emergency area during an emergency period.

## **NEXT STEPS**

### **Comments**

Given the major changes included in this year's rule, the AHA encourages members to submit their own comments to CMS outlining how the changes will affect their facility.

Watch for more information from the AHA that may assist you in preparing your organization's comment letter.

All comments are due to CMS by June 13 and may be submitted electronically at: <http://www.cms.hhs.gov/eRulemaking>. Follow the instructions for "Comment or Submission" and enter the file code CMS-1390-P to submit comments on this proposed rule.

You also may submit written comments (an original and two copies) to CMS.

Via regular mail

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS –1390 – P  
P.O. Box 8011  
Baltimore, MD 21244-1850

Via overnight or express mail

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS –1390 – P  
Mailstop: C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

## Appendix A: List of Current and Proposed Reporting Measures

Current Measures	
Condition	Measure
Acute Myocardial Infarction (AMI)/Heart attack	Aspirin at arrival
	Aspirin at discharge
	Beta-blocker at arrival
	Beta-blocker at discharge
	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction (LVSD)
	Smoking cessation advice/counseling
	Thrombolytic medication received within 30 minutes of arrival
	Percutaneous Coronary Intervention (PCI) received within 90 minutes of arrival
	30-day mortality rate
Heart Failure	Left ventricular systolic function evaluation
	ACE inhibitor or ARB for LVSD
	Discharge instructions received
	Smoking cessation advice/counseling
	30-day mortality rate
Pneumonia	Initial antibiotic(s) received within six hours of arrival
	Oxygenation assessment
	Pneumococcal vaccination
	Blood culture performed prior to administration of first antibiotic(s)
	Smoking cessation advice/counseling
	Received most appropriate antibiotic
	Influenza vaccination
	30-day mortality rate
Surgical Care Improvement	Prophylactic antibiotic(s) one hour before incision
	Prophylactic antibiotic(s) stopped within 24 hours after surgery
	Selection of antibiotic given to surgical patients
	Prophylaxis to prevent venous thromboembolism ordered
	Prophylaxis to prevent venous thromboembolism received
	Appropriate hair removal
	Cardiac surgery patients with controlled 6AM postoperative serum glucose
Patient Experience of Care	HCAHPS survey results on patient interaction with doctors, nurses, and hospital staff; cleanliness of the organization; pain control; communication about medicines; and discharge information

**Measures Proposed by CMS in the FY 2009 Inpatient PPS Proposed Rule**

<b>Condition</b>	<b>Measure</b>
Surgical Care Improvement	Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period
Readmission	Heart attack 30-day risk standardized readmission measure
	Heart failure 30-day risk standardized readmission measure
	Pneumonia 30-day risk standardized readmission measure
Stroke	Deep vein thrombosis prophylaxis
	Discharged on antithrombotic therapy
	Patients with atrial fibrillation receiving anticoagulation therapy
	Antithrombotic medication by end of hospital day two
	Dysphasia screening
Venous Thromboembolic (VTE) Care	VTE prophylaxis
	VTE prophylaxis in the ICU
	Patients with overlap in anticoagulation therapy
	Patients with unfractionated heparin dosages who have platelet count monitoring and adjustment of medication per protocol or nomogram
	Discharge instructions to address: follow-up monitoring, compliance, dietary restrictions, and adverse drug reactions/interactions
	Incidence of preventable VTE
AHRQ Patient Safety Indicators	Death among surgical patients with treatable serious complications
	Iatrogenic pneumothorax, adult
	Postoperative wound dehiscence
	Accidental puncture or laceration
AHRQ Inpatient Quality Indicators (IQI)	Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	Hip fracture mortality rate
AHRQ IQI Composite Measures	Mortality for selected surgical procedures (composite)
	Complication/patient safety for selected indicators (composite)
	Mortality for selected medical conditions (composite)
Nursing Sensitive Measures	Failure to rescue
	Pressure ulcer prevalence and incidence by severity
	Patient falls prevalence
	Patient falls with injury
Cardiac Surgery Measures	Participation in a systematic database for cardiac surgery
	Pre-operative beta blockade
	Prolonged intubation
	Deep sternal wound infection rate
	Stroke/ cerebral vascular accident
	Postoperative renal insufficiency
	Surgical re-exploration
	Anti-platelet medication at discharge
	Beta blockade therapy at discharge
	Anti-lipid treatment at discharge
	Risk-adjusted operative mortality for CABG
	Risk-adjusted operative mortality for aortic valve replacement
	Risk-adjusted operative mortality for mitral valve replacement/repair
	Risk-adjusted operative mortality for mitral valve replacement and CABG surgery
	Risk-adjusted operative mortality for aortic valve replacement and CABG surgery