POWERS
PYLES
SUTTER &
VERVILLE PC

ATTORNEYS AT LAW

7th Floor
1501 M Street, NW
Washington, DC 20005
Phone: (202) 466-6550 Fax: (202) 785-1756

MEMORANDUM

To: Health Care Clients and Friends

From: Powers Pyles Sutter & Verville PC

Date: August 20, 2010

Re: Final Rule on Medicare Hospital Inpatient Prospective Payment System (IPPS) for Federal Fiscal Year (FFY) 2011

The Centers for Medicare & Medicaid Services ("CMS") has issued the final rule for the FY 2011 acute care hospital inpatient prospective payment system ("IPPS"). This final rule incorporates comments solicited from the proposed rule published on May 4, 2010 and a supplementary rule adopting changes mandated by the Patient Protection and Affordable Care Act ("PPACA"), Pub. Law No. 111-148, published on June 2, 2010. The final rule becomes effective on October 1, 2010 with the exception of the three-day bundling provision, which is issued as an interim final rule. Comments are requested on the three-day bundling provision by September 28, 2010. The final rule is available online at http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf and was published in the Federal Register on August 16, 2010. 75 Fed. Reg. 50,042.

Table I in the final rule (which begins on page 50650 of the Federal Register) demonstrates the impact of all the final changes included in the rule on Medicare hospitals. Overall, hospitals are expected to experience a 0.4 percent decline in payments from FY 2010 due to the IPPS changes.

Among the IPPS changes addressed in the final rule are the following:

- Market Basket Changes

CMS set the market basket update at 2.6 percent. However, PPACA imposed a .25% reduction to the market basket update beginning with discharges on or after April 1, 2010. Hospitals are also subject to a documentation and coding reduction of 2.9 percent. The final standardized amounts for operating IPPS payments are:

Table 1A. – National Adjusted Operating Standardized Amounts, Labor/Nonlabor **(if Wage Index is Greater Than 1)**

Full Update	
Labor-related	**Nonlabor-related**
$3,552.91	$1,611.20

Table 1B. – National Adjusted Operating Standardized Amounts, Labor/Nonlabor **(if Wage Index is Less Than or Equal to 1)**

Full Update	
Labor-related	**Nonlabor-related**
$3,201.75	$1,962.36

Hospitals that do not properly report quality data under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program are subject to an additional two percent reduction.

The capital standard federal payment rate is $420.01 (**Table 1D).**

- Quality Measures Program (RHQDAPU)

The hospital quality measures that CMS established for the FFY 2011 update under the RHQDAPU program are listed at 50187 of the Federal Register and reflect CMS's decision not to score the AHRQ Mortality for Selected Measures Composite. For the FFY 2012 update, CMS is proposing the measures listed at 50198 of the Federal Register, and for FFY 2013, CMS is proposing the measures listed at 50208 of the Federal Register.

- Outlier

CMS finalized an outlier threshold of $23,075.

- Wage Data, Wage Index and Labor-Related Share

For geographic reclassifications, PPACA restored the average hourly wage ("AHW") standards that were in effect for FY 2008 (84% for urban hospitals, 85% for group reclassifications, and 82% for rural hospitals) for reclassification applications for FY 2011 and subsequent years (until the Secretary submits the wage index reform plan to Congress). Based on the revised AHW standards, CMS changed the reclassification decisions for 22 hospitals by allowing the reclassification or changing the reclassification to the area that the hospital had primarily requested.

In the FY 2009 IPPS rule, CMS adopted a statewide budget neutrality adjustment for the rural and imputed floors. PPACA requires a uniform, national budget neutrality adjustment, starting with the FY 2011 wage index, which CMS adopted.

Effective with FY 2011, PPACA requires that PPS hospitals located in "Frontier States" have a wage index of at least 1.0. A Frontier State is a state where at least 50 percent of its counties have a population density less than 6 persons per square mile. CMS determined that the following states are

Frontier States: Montana, Wyoming, North Dakota, Nevada, and South Dakota. CMS finalized the Frontier State policy without modification in the final rule.

Additionally, the FY 2011 occupational mix adjusted national average hourly wage is $34.9664. The occupational mix adjustment will be based on the 2007-2008 occupational mix survey, which collected information from July 1, 2007 – June 30, 2008.

- Hospital Acquired Conditions (HACs)

The final rule invalidates the ICD-9-CM code 999.6 for blood incompatibility HACs and establishes five new HAC categories listed below:

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

- Three-Day Bundling Rule

The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L. 111–192) amended the definition of nondiagnostic services for purposes of the three-day bundling rule and imposed limitations on reopening on the basis of the former definition. The August 16 rule includes an interim final rule to implement the statutory changes.

Pub. L. 111-192 states that: nondiagnostic services provided by a hospital (or entity wholly owned or operated by the hospital) on the date of an inpatient admission are considered part of the inpatient stay, and nondiagnostic services furnished by the hospital or related entity in the three days prior to admission are related to the inpatient stay "unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission."[1] (For non-IPPS hospitals, the nondiagnostic services are considered a part of the admission if rendered within the day of the patient's admission or the day preceding admission.) Ambulance and maintenance dialysis services are exempted. Congress also amended the Medicare statute to state that CMS may not reopen or pay a claim that unbundles nondiagnostic

[1] Pub. L. 111-192, § 102(a) (amending 42 U.S.C. § 1395ww(a)(4)).

services, as newly defined, if a Part A claim was previously submitted and a Part B claim was not submitted prior to enactment of the legislation.[2]

The preamble states that CMS will establish a process for hospitals to attest that nondiagnostic services are unrelated to the hospital claim by using a condition code, modifier, or some other indicator on the outpatient claim. Hospitals are required to maintain documentation in the medical record to support their claim that the outpatient services were unrelated. CMS also amended the bundling regulation to incorporated the changes to the definition of nondiagnostic services required by Pub. L. 111-192. Comments on this provision are due September 28, 2010.

- Payments to Hospitals in Counties with Low Medicare Spending

For FY 2011 and 2012, PPACA provides an additional IPPS payment to hospitals that are located in counties in the bottom quartile of counties with the lowest risk-adjusted spending per Medicare enrollee. The total amount of payment available over the two-year period is $400 million. CMS is proposing to distribute $150 million in FY 2011 and $250 million in FY 2012. The final rule addresses CMS' methodology for determining the bottom quartile of counties with the lowest Medicare spending, including development of a risk adjustment model and calculation of county level spending.

Payments would be distributed to qualifying hospitals through an annual one-time payment during each of FY 2011 and FY 2012. The amount of payment will be based on the proportion of each qualifying hospital's IPPS operating payments for FY 2009 relative to the total IPPS operating payments to all qualifying hospitals in FY 2009. A list of qualifying hospitals, along with each hospital's weighting factor, is included in the final rule.

- Transfer Policy

The final rule expands the current transfer policy which reduces payments to a hospital when it transfers a patient to another Medicare-participating hospital. The expansion of this rule means that a transferring hospital will be subject to reduced payments even when it sends a patient to a non-participating acute care hospital or critical access hospital.

- Disproportionate Share Hospital (DSH) Payments

To implement Bayside Medical Center v. Leavitt, 545 F.Supp.2d 20, as amended 587 F.Supp.2d 37, 44 (D.D.C. 2008), CMS is correcting its process for determining the SSI fraction of the DSH calculation. Specifically, CMS will:

  - include stale records and forced pay records in the SSI eligibility data files;
  - use social security numbers and multiple databases in the match process;
  - determine the SSI fraction approximately 15 months after the end of the FFY to capture more recent Medicare claims and SSI eligibility data; and

[2] Id. at § 102(c).

- exclude a record from the data matching process if it can find a health insurance claim number (HICAN) in the MedPAR file that is not located in the Medicare Enrollment Database.

CMS also noted that, pursuant to Ruling No. CMS-1498-R, it will adopt the above procedures for determining the SSI fraction for any pending appeals on the Baystate issue. (That Ruling also states that, in addition to amending the SSI fraction for the Baystate issue, CMS will include L&D days in either the Medicaid or SSI fraction (whichever is applicable) regardless of whether the patient previously occupied an inpatient bed; for non-covered Medicare days, CMS will include the days in the SSI fraction, even if the appeal requested the inclusion of those days in the Medicaid fraction.)

- IME

The IME adjustment factor remains at 1.35 percent.

- Medical Residency Programs

CMS finalized the definition of the term "resident" for purposes of the DGME and IME resident counts to mean an "intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board." The rule also modifies the definition of "primary care resident" to mean a "resident who is formally accepted, enrolled, and participating in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice."

CMS also provided guidance about how to determine whether certain individuals are residents or physicians for purposes of DGME and IME payments. When a physician trains in an unaccredited program, or finishes an accredited program but stays for additional training, a hospital must determine whether the individual is a resident or a physician by asking the following:

1. Does the individual actually need the training in order to meet board certification requirements in that specialty; and
2. Is the individual formally participating in an organized, standardized, structured course of study?

If both answers are "yes," then the physician is in an approved program and is a resident for purposes of DGME and IME payments. Otherwise, the individual is considered a physician whose services are payable under Medicare Part B.

- DGME & IME Affiliation Agreements

CMS will accept electronic DGME and IME affiliation agreements, but is not requiring fiscal intermediaries or MACs to accept electronic agreements.

- ICD-9 and ICD-10 Coding System Freeze

To assist in the transition to the ICD-10 coding system scheduled for October 1, 2013, CMS solicited comments in the proposed rule regarding the feasibility of making the last regular annual update to both the ICD-9 and ICD-10 coding systems on October 1, 2011, except for updates for new technology and new diseases. Regular updates to the ICD-10 coding system would begin on October 1, 2014. Based on the comments submitted in response to the proposed rule, CMS plans to consider a partial freeze of the ICD-9 codes. It will make a final decision on the partial code freeze at the September 15-16 ICD-9-CM Coordination and Maintenance Committee meeting.

- Effective Date of Provider Agreements and Supplier Approvals

The final rule adopts changes to state that the effective date of a provider or supplier agreement may not be earlier than the date in which all federal requirements have been satisfied.

* * * * *

If you have any questions, please call Susan Philp, Barbara Williams, Ron Connelly or the attorney with whom you normally work at (202) 466-6550.