

# Washington Bulletin

Health care legislative and regulatory update

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## CMS Issues Proposed FY 2012 Medicare IPPS Update; More Changes for Documentation and Coding; Tables Now Online Only

The Centers for Medicare and Medicaid Services (CMS) have issued a proposed rule to update both the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2012. The 1,032 page document was placed on public display at the *Federal Register* office late on April 19<sup>th</sup>, and is scheduled for publication on May 5<sup>th</sup>. The rule provides a 60-day comment period ending June 20<sup>th</sup>.

For FY 2012, CMS will no longer provide the myriad of tables in the published version. Tables will now be available only on the CMS web site via the internet.

A copy of the notice is available on the *Federal Register* web site at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-05/pdf/2011-9644.pdf>.

The tables are located on CMS' web site at [http://www.cms.hhs.gov/AcuteInpatientPPS/01\\_overview.asp](http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp). Click on the link on the left side of the screen titled, "FY 2012 IPPS Proposed Rule Home Page" or "Acute Inpatient – Files for Download".

The LTCH PPS tables are available at <http://www.cms.gov/LongTermCareHospitalPPS/LTCHPPSRN/list.asp> under the list item for Regulation Number CMS-1518-P.

CMS projects that Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2012 would decrease by a projected \$498 million or 0.5 percent in FY 2012 relative to FY 2011. This reflects a proposed hospital update of 1.5 percent (based on a projected market basket increase of 2.8 percent for inflation in hospital costs, reduced by a multi-factor productivity adjustment of 1.2 percent and an additional 0.1 percent in accordance with the *Affordable Care Act* (ACA)), increased by 1.1 percent in response to litigation with respect to the area wage index, as well as a -3.15 percent documentation and coding adjustment that occurred in FY 2010. CMS says this documentation and coding adjustment is consistent with a statutory provision that requires CMS to adjust payments to remove the effect of increased aggregate payments due to changes in documentation and coding that did not reflect increases in patients' severity of illness after adoption of the MS-DRGs.

As required by the *Deficit Reduction Act of 2005* (DRA), hospitals that do not participate successfully in the Hospital Quality Data reporting requirements would receive the market basket update less 2.0 percentage points, or -0.5 percent.

The market basket update for LTCHs for FY 2011 will be 2.8 percent. CMS says Medicare payments to LTCHs would increase by \$95 million or 1.9 percent.

## CMS Highlights

CMS notes that the proposed rule would impact approximately 3,400 acute care hospitals and approximately 420 LTCHs. CMS has identified a number of issues it considers pertinent to the rulemaking. These include:

***Proposals for hospital quality initiatives*** – The proposed rule addresses a number of proposals to improve the quality of care furnished by hospital. Specifically, CMS is proposing certain policies related to the Hospital Readmissions Reduction Program and the Hospital Value-Based Purchasing (HVBP) Program.

***Restoring to the Standardized Amount Prior Rural Floor Budget Neutrality Adjustments*** – CMS is proposing to apply a +1.1 percent adjustment to IPPS standardized rates in recognition of a decision in the case, *Cape Cod Hospital vs. Sebelius*. The case involved how budget neutrality was calculated for the area wage index rural floor, and on January 14, 2011, the D.C. Circuit Court ruled against the Secretary.

***Imputed Floor*** – In FY 2005, CMS adopted an “imputed” floor policy establishing for three years a wage index floor for those states that did not have rural hospitals and later extended the “imputed” floor through FY 2011. CMS is not proposing to extend the imputed floor. In accordance with CMS regulations, it will sunset at the end of FY 2011 (September 30, 2011).

***Payments for geographic variation (Section 1109 of the Affordable Care Act)*** – Section 1109 of the ACA provides for additional payments for FY 2011 and 2012 totaling \$400 million for qualifying hospitals that are in located in counties that rank within the lowest quartile of counties in the United States for spending per enrollee for benefits under Medicare Parts A and B. In the FY 2011 IPPS Final Rule, CMS finalized a policy to distribute \$150 million to qualifying hospitals for FY 2011 and \$250 million for FY 2012 through an annual one-time payment made by the Medicare contractor. CMS is proposing to distribute the remaining \$250 million under this provision to qualifying hospitals. The list of qualifying hospitals and their share of these payments can be found on the CMS website.

***Low-volume hospital payment adjustment*** – Sections 3125 and 10314 of the ACA amended the low-volume hospital payment adjustment by allowing hospitals, for FYs 2011 and 2012, to qualify for the adjustment if they are located more than 15 (rather than 25) miles from another hospital and have less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Medicare Part A (as opposed to 800 total discharges) in the fiscal year. In the FY 2011 IPPS Rule, CMS used FY 2009 MedPAR data (the most current data then available) to determine the FY 2011 low-volume payment adjustment. CMS is proposing to base the FY 2012 low-volume payment adjustment on FY 2010 MedPAR data, the most recent data currently available.

***Pension Costs for Medicare Wage Index*** – As a result of amendments made by the Pension Protection Act of 2006 to the Employee Retirement and Income Security Act (ERISA) of 1974, CMS is proposing to revise how hospitals report pension contributions for the purpose of the Medicare wage index. CMS is proposing to use a rolling three-year average of the annual funds that the hospital contributed to its pension plan in determining the Medicare wage index. CMS says the three-year average controls for potential large annual fluctuations in a hospital’s allowable pension cost.

***Proposed Changes to MS-DRG Classifications*** – CMS is proposing the following four changes to the MS-DRG classifications:

- Excisional debridement – The current classification of excisional debridement as an operating room procedure results in a classification of these stays to a surgical MS-DRG. However, CMS believes these cases use significantly fewer resources than other surgical cases in their MS-DRG assignment, resulting in payment approximately 40 percent in excess of costs. CMS is therefore proposing to remove these cases from their current MS-DRG and assign them to three new MS-DRGs that would still be classified as operating room procedures but would provide for “more accurate, and lower, payment.”
- Autologous bone marrow transplant – Autologous bone marrow transplants are currently assigned to MS-DRG 015, with no severity adjustment. CMS is proposing to create two new MS-DRGs, one for autologous bone marrow transplants with complications or comorbidities (CC), and one for these transplants in the absence of any CC.
- Rechargeable dual array deep brain stimulation system – CMS is proposing to move the codes for rechargeable dual array deep brain stimulation to MS-DRGs 023–024 (Craniotomy with Major device implant/acute complex CNS PDX).
- Thoracic aneurysm repair – CMS is proposing to move two codes that either repair a thoracic aneurysm or place a stent from MS-DRG 237–238 (Major cardiovascular procedures with major CC (MCC) or thoracic aortic aneurysm repair and without MCC to the higher paying MS-DRGs 219–221 (Cardiac valve and other major cardiothoracic procedure without cardiac catheterization with MCC or CC, and without CC).

***Other Technical Proposals Included in the IPPS Proposed Rule*** –

- Payment for Hospital Acquired Conditions – CMS is proposing to add one category of conditions to the list of hospital-acquired conditions (HACs). The proposed HAC is Acute Renal Failure after Contrast Administration (also known as contrast-induced acute kidney injury, or CI-AKI0), which is an abrupt deterioration in renal function that can be associated with the use of iodinated contrast medium.
- Three Day/One Day Payment Window – CMS proposes to clarify that the 3-day/1-day payment window applies to both preadmission diagnostic and non-diagnostic services furnished to a patient at physician’s practices that are wholly owned or wholly operated by the admitting hospital, and to address the payment window policy as it impacts physician billing in the 2012 Medicare physician fee schedule proposed rule.
- Clarification of Add-on Payment to Hospitals Treating Patients with End-Stage Renal Disease – Medicare regulations provide for an add-on payment to IPPS hospitals that provide inpatient dialysis treatment to a high proportion of beneficiaries with end-stage renal disease (ESRD) whose stays do not fall under certain MS-DRGs that account for the high cost of dialysis. CMS is proposing to clarify that discharges of all patients entitled to Medicare Part A, including Medicare Advantage patients, should be included in determining whether the hospital qualifies for the add-on payment.

- **Excluding Hospice Discharges from the Disproportionate Share Hospital Adjustment and Indirect Medical Education (IME) Adjustment** – Medicare beneficiaries who elect to receive hospice care, can receive inpatient hospice care in a hospital under certain circumstances, such as hospitalization for pain control and symptom management and respite care needed to provide temporary relief to family members or other caretakers. CMS is proposing to exclude from the Medicare DSH adjustment patient days and bed days for inpatient hospice services because these patients are not receiving acute care services generally payable under the IPPS, but rather are receiving a hospice benefit. For the same reasons, CMS is proposing to exclude such bed days from the calculation of available bed days for the indirect medical education adjustment.
- **Clarifying “Under Arrangements” Requirements** – The Medicare law permits hospitals to provide certain diagnostic or therapeutic services to inpatients under arrangements with an outside entity. In these cases, the hospital bills Medicare for the stay under the IPPS, and pays the outside entity for its services out of the hospital’s Part A payment. CMS is proposing that hospitals may not furnish “routine services”, such as room and board and nursing services, at a separate location under arrangements with another entity. Under the proposal, if routine services are provided in the hospital to its inpatient, those services would be considered as being provided by the hospital. However, if these services are provided outside the hospital, the services would be considered as being provided under arrangement, and not by the hospital. Only therapeutic and diagnostic services could be provided under arrangement.
- **Clarifying Payment Policy for Replacement of Recalled Devices** – CMS reduces payment under both the IPPS and the Outpatient Prospective Payment System (OPPS) for replacing an implanted device that has been recalled if the hospital receives a credit from the device manufacturer of 50 percent or more of the device cost. CMS is proposing to clarify that, as in the OPPS “partial credit” policy, the relevant device cost is the cost of the replacement device, not the cost of the original device.
- **Modifying Payment Policy for Ambulances Operated by Critical Access Hospitals** – CMS is proposing to modify its regulations that allow payment for ambulance services furnished by a CAH or by an entity owned and operated by the CAH based on 101 percent of reasonable costs rather than the ambulance fee schedule to conform with language in the Medicare law and also to make provision of reasonable cost payment to an entity owned and operated by a CAH that is further than 35 miles from the CAH, if it is the closest provider or supplier of ambulance services to the CAH.
- **Pension Costs for Medicare Cost Finding** – As indicated previously, CMS is proposing revisions to its rules for determining pension costs for Medicare cost-finding and wage index purposes. With respect to Medicare cost-finding, CMS is proposing to allow the hospital to report on its cost report what the hospital contributed to its pension fund for that year with a cap of 150 percent of the highest average contributions during three consecutive cost reporting periods within the five most recent cost reporting periods.

CMS is also proposing to allow hospitals with contributions in excess of the proposed limit to submit documentation demonstrating that all or a portion of the “excess” costs are reasonable and necessary for a particular cost reporting period. In addition, CMS is also proposing that current period

contributions in excess of the limit that are not considered reasonable for the current cost reporting period under the proposed review process would be carried forward and included in future period(s) as the applicable limit will allow.

- Inpatient Quality Reporting (IQR) Program – The proposed rule would add measures to be reported for purposes of the IQR (formerly called the Reporting Hospital Quality Data for Annual Payment Update or RHQDAPU) for the FY 2013 and FY 2014 updates.

### Comment

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

There is still a considerable amount of boiler plate language and repetition, especially in the LTCH sections that can add to readership confusion.

Many issues do have a summary paragraph of actions CMS is proposing, but not all.

### Other items

**Outlier Threshold:** CMS is proposing to set the FY 2012 outlier threshold at \$23,375. The current amount is \$23,075.

**New Medical Services and Technology:** For FY 2012, CMS has received applications for add-on payments for the following three technologies. So far, none have been approved.

- Implantable Hemodynamic Monitor System (IHMS) (CardioMEMS, Inc) – The IHMS is comprised of an implantable sensor/monitor placed in the distal pulmonary artery that measures multiple pulmonary artery pressure parameters and transmits this data to a secure website.
- AxiaLIF 2-Level System (Trans1®, Inc) – AxiaLIF 2-Level System (AxiaLIF 2L+) is an implantable spinal fixation system that facilitates the spinal fusion of the anterior S1 and L4 lumbar of the spine (“anterior fusion”) using a pre-sacral approach that provides access to the lumbar through a small incision rather than open surgery.
- PerfectCLEAN with Micrillon (UMF Corporation) – PerfectCLEAN with Micrillon (PerfectCLEAN) is a cleaning textile product (or cleaning mat/wipe) with chlorine bound to the surface of the fiber that the applicant states is capable of trapping, removing, and killing or inactivating more than 99.99% of bacteria on hard surfaces.

### ACA Requirements

In this proposed rule, CMS is proposing to implement the following provisions (or portions of the following provisions) of the Affordable Care Act that are applicable to the IPPS and LTCH PPS for FY 2012:

- Section 3001 which provides for establishment of a hospital value-based purchasing program and applicable measures for value-based incentive payments with respect to discharges occurring during FY 2013.
- Section 3004 which provides for the submission of quality data for LTCHs in order to receive the full annual update to the payment rates and the establishment of quality data measures.

- Section 3025 which provides for a hospital readmissions reduction program and related quality data reporting measures.
- Section 3124 which provides for extension of the Medicare-dependent, small rural hospital (MDH) program through FY 2012.
- Section 3401 which provides for the incorporation of productivity improvements into the market basket updates for IPPS hospitals and LTCHs.

In addition, CMS is proposing to continue in FY 2012 to implement the following provisions, which were initiated in FY 2011:

- Section 10324 which provided for a wage adjustment for hospitals located in frontier States.
- Sections 3401 and 10319 and section 1105 which revise certain market basket update percentages for IPPS and LTCH PPS payment rates for FY 2012.
- Sections 3125 and 10314 which provides for temporary percentage increases in payment adjustments to low-volume hospitals for discharges occurring in FY 2012.
- Section 1109 which provides for additional payments in FY 2012 for qualifying hospitals in the lowest quartile of per capita Medicare spending.
- Extending the Medicare Dependent Hospital (MDH) program through Oct. 1, 2012.

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

### **Standardized Payment Rates**

CMS says that it is increasing the FY 2012 amounts by a full market basket rate estimated at 2.80 percent, reducing that amount by multifactor productivity adjustment of 1.2 percentage points and less 0.1 percentage points, as required by the ACA.  $(2.80-1.20-0.1=1.5)$

For FY 2012, CMS is proposing to continue to use a labor-related share of 68.8 percent for discharges occurring on or after October 1, 2011. Consistent with section 1886(d)(3)(E) of the Act, CMS is applying the wage index to a labor-related share of 62 percent for all IPPS hospitals whose wage index values are less than or equal to 1.0000.

CMS is also making additional adjustments for documentation and coding changes that are not reflected as changes in patient severity (see discussion below).

CMS is also proposing an adjustment related to the budget neutral calculation that increased payments to certain urban areas that had wage indexes less than the statewide rural amounts. The adjustment is part of a court settlement. However, CMS notes that the proposed adjustment of +1.1 percent is still subject to ongoing court review (see below).

The rates would be as follows:

**National Adjusted Operating Standardized Amounts**

**(68.8 Percent Labor Share/31.2 Percent Nonlabor if Wage Index Is Greater Than 1.0000)**

Full Update (1.50 percent)		Reduced Update (-0.50 percent)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
\$3,531.06	\$1,601.30	\$3,461.48	\$1,569.75

*Rates Currently in Effect*

<i>Full Update</i>		<i>Reduced Update</i>	
<i>Labor-related</i>	<i>Non-labor-related</i>	<i>Labor-related</i>	<i>Non-labor-related</i>
\$3,552.91	\$1,611.20	\$3,483.49	\$1,579.72

**National Adjusted Operating Standardized Amounts**

**(62 Percent Labor Share/38 Percent Nonlabor Share**

**if Wage Index Is Less Than or Equal To 1.0000)**

Full Update (1.50 percent)		Reduced Update (-0.50 percent)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
\$3,182.06	\$1,950.30	\$3,119.36	\$1,911.87

*Rates Currently in Effect*

<i>Full Update</i>		<i>Reduced Update</i>	
<i>Labor-related</i>	<i>Non-labor-related</i>	<i>Labor-related</i>	<i>Non-labor-related</i>
\$3,201.75	\$1,962.36	\$3,139.19	\$1,924.02

**Proposed Adjustment in Light of Court Decision in Cape Cod v. Sebelius**

CMS is proposing a 1.1 percent adjustment to the standardized amount in recognition of the decision of Cape Cod v. Sebelius (630 F.3d 203 (D.C. Cir. 2011)). However, CMS emphasizes that remand proceedings in that case are not complete and this proposal reflects the timing of the development of this proposed rule and not a

final decision as to how the remand will proceed. In *Cape Cod*, the plaintiff hospitals challenged the rural floor budget neutrality adjustments for FY 2007 and FY 2008. In its opinion, the D.C. Circuit Court found that section 4410 of the *Balanced Budget Act of 1997* (BBA), which authorized both the rural floor and rural floor budget neutrality, would not permit CMS to ignore prior year errors in calculating rural floor budget neutrality adjustments. The case has now been remanded to CMS for further proceedings consistent with the D.C. Circuit Court's opinion.

### **Proposed Case-Mix Budget Neutrality Adjustment – Documentation and Coding**

#### ***FYs 2008 and 2009***

CMS notes that the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009 exceeded the -0.6 and -0.9 percent prospective documentation and coding adjustment it applied previously by 1.9 percentage points in FY 2008 and 3.9 percentage points in FY 2009. In total, this change exceeded the cumulative prospective adjustments by 5.8 percentage points.

CMS made an adjustment in FY 2011 to the standardized amount of -2.9 percent, representing half of the aggregate adjustment.

CMS is proposing to complete the recoupment adjustment by implementing the remaining -2.9 percent adjustment. "Because these adjustments will, in effect, balance out, there will be no year-to-year change in the standardized amount due to this recoupment adjustment. As this adjustment will complete the required recoupment for overpayments due to documentation and coding effects on discharges occurring in FYs 2008 and 2009, we [CMS] anticipate removing the effect of this adjustment by adding 2.9 percent to the standardized amount in FY 2013."

#### ***FY 2010***

After accounting for the -0.6 percent and the -0.9 percent documentation and coding adjustments in FYs 2008 and 2009, CMS said it found a remaining documentation and coding effect of 3.9 percent for FY 2010. Therefore, an additional cumulative adjustment of -3.9 percent would be necessary to meet the statutory requirements to make an adjustment to the average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments.

Therefore, CMS is proposing a -3.15 percent prospective adjustment to the standardized amount to partially eliminate the full effect of the documentation and coding changes on future payments. This proposal recognizes that an additional adjustment of -0.75 percent (3.9 minus 3.15) will be required in future rulemaking.

#### ***Applicability to Hospital-Specific Rates***

CMS has indicated that because sole community hospitals (SCHs) and Medicare dependent hospitals (MDHs) use the same DRG system as all other hospitals, the agency believes they should be equally subject to the documentation and coding budget neutrality adjustment that are being applied for adoption of the MS-DRGs to all other hospitals.

CMS is proposing a -2.5 percent payment adjustment to the hospital-specific rate.

**Outlier Payments**

CMS says its current estimate, using available FY 2010 claims data, is that actual outlier payments for FY 2010 were approximately 4.7 percent of actual total DRG payments, – 0.4 percent less than assumed.

CMS currently estimates that actual outlier payments for FY 2011 will be approximately 4.9 percent of actual total DRG payments, approximately 0.2 percentage points lower than the 5.1 percent projected amount when setting the outlier policies for FY 2011.

CMS is proposing an outlier fixed-loss cost threshold for FY 2012 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus \$23,375.

The FY 2011 threshold is \$23,075.

**Comment**

Once again, as has happened over the years, CMS has underestimated outlier payments. While CMS seems intent on correcting documentation and coding items, the agency never seems to identify other errors in estimations or tries to make such corrections.

Since CMS is paying less than the 5.1 percent set aside for outliers, one must question why the threshold for FY 2012 would be higher than the current amount.

**Rural Community Hospital Demonstration Program Adjustment**

For FY 2012, CMS is proposing an adjustment to the national IPPS rates for payments to be made under the rural community hospital demonstration program of \$52,642,213. FY 2012, CMS has computed a proposed budget neutrality factor of 0.999479.

CMS provides the following table to show how it has arrived at its proposed FY 2012 standardized amounts.

**Comparison of FY 2011 Standardized Amounts to the Proposed FY 2012 Standardized Amount with Full and Reduced Update**

	<b>Full Update (1.5 percent); Wage index is greater than 1.0000</b>	<b>Full Update (1.5 percent); Wage index is less than or equal to 1.0000</b>	<b>Reduced Update (-0.5 percent); Wage index is greater than 1.0000</b>	<b>Reduced Update (-0.5 percent); Wage index is less than or equal to 1.0000</b>
FY 2011 Base Rate, after removing geographic reclassification	Labor: \$3,947.65 Nonlabor:	Labor: \$3,557.48 Nonlabor:	Labor: \$3,947.65 Nonlabor:	Labor: \$3,557.48 Nonlabor:

	<b>Full Update (1.5 percent); Wage index is greater than 1.0000</b>	<b>Full Update (1.5 percent); Wage index is less than or equal to 1.0000</b>	<b>Reduced Update (-0.5 percent); Wage index is greater than 1.0000</b>	<b>Reduced Update (-0.5 percent); Wage index is less than or equal to 1.0000</b>
budget neutrality, demonstration budget neutrality, cumulative FY 2008 and FY 2009 documentation and coding adjustment, FY 2011 documentation and coding recoupment, and outlier offset (based on the labor- related share percentage for FY 2011)	\$1,790.21	\$2,180.39	\$1,790.21	\$2,180.39
Proposed FY 2012 Update Factor	1.015	1.015	0.995	0.995
Proposed Adjustment for Restoring Rural Floor Budget Neutrality	1.011	1.011	1.011	1.011
Proposed FY 2012 DRG Recalibration and Wage Index Budget Neutrality Factor	0.998532	0.998532	0.998532	0.998532
Proposed FY 2012 Reclassification Budget Neutrality Factor	0.991528	0.991528	0.991528	0.991528
Proposed FY 2012	0.999479	0.999479	0.999479	0.999479

	<b>Full Update (1.5 percent); Wage index is greater than 1.0000</b>	<b>Full Update (1.5 percent); Wage index is less than or equal to 1.0000</b>	<b>Reduced Update (-0.5 percent); Wage index is greater than 1.0000</b>	<b>Reduced Update (-0.5 percent); Wage index is less than or equal to 1.0000</b>
Rural Demonstration Budget Neutrality Factor				
Proposed FY 2012 Outlier Factor	0.949	0.949	0.949	0.949
Proposed documentation and coding adjustments required under sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110-90	0.9282	0.9282	0.9282	0.9282
<b>Proposed Rate for FY 2012</b>	<b>Labor: \$3,531.06  Nonlabor: \$1,601.30</b>	<b>Labor: \$3,182.06  Nonlabor: \$1,950.30</b>	<b>Labor: \$3,461.48  Nonlabor: \$1,569.75</b>	<b>Labor: \$3,119.36  Nonlabor: \$1,911.87</b>

**Changes for Inpatient Capital-Related Costs for FY 2012**

CMS would increase the capital payment amount by an update of 1.5 percent in determining the FY 2012 capital Federal rate for all hospitals. However, CMS is also reducing the update by -2.9 percent for coding and documentation changes. The FY 2012 capital rate would be **\$422.54**. The current rate is \$420.01.

**Comparison of Factors and Adjustments:**

**FY 2011 Capital Federal Rate**

and

**Proposed FY 2012 Capital Federal Rate**

	<b>FY 2011</b>	<b>Proposed FY 2012</b>	<b>Change</b>	<b>Percent Change</b>
Update Factor <sup>1</sup>	1.015	1.015	1.0150	1.50
GAF/DRG Adjustment Factor <sup>1</sup>	0.999	1.005	1.0005	0.05
Outlier Adjustment Factor <sup>2</sup>	0.9404	0.9406	1.0002	0.02
Exceptions Adjustment Factor <sup>3</sup>	0.9996	1.000	1.0004	0.04
MS-DRG Documentation and Coding Adjustment Factor	0.9574 <sup>4</sup>	0.9479 <sup>5</sup>	0.9901 <sup>6</sup>	-0.99
Capital Federal Rate <sup>7</sup>	\$420.01	<b>\$422.54</b>	1.0060	0.60

1. The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2011 to FY 2012 resulting from the application of the 1.0005 GAF/DRG budget neutrality factor for FY 2012 is a net change of 1.0005.
2. The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2012 outlier adjustment factor is 0.9406/0.9404, or 1.0002.
3. There are no longer any hospitals eligible to receive special exception adjustments in FY 2012, but since the exceptions payment adjustment is not cumulative, we are restoring the 0.9996 special exceptions adjustment applied to the FY 2011 capital rate.
4. The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, no additional reduction in FY 2010, and the -2.9 percent in FY 2011.
5. The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, no additional reduction in FY 2010, the -2.9 percent in FY 2011, and the proposed -1.0 percent in FY 2012.
6. The change is measured from the FY 2011 cumulative factor of 0.9574.
7. Sum of percent change may not sum due to rounding.

## Changes to the Hospital Area Wage Index

### *Proposed Occupational Mix Adjustment to the FY 2012 Wage Index*

For the FY 2012 hospital wage index, CMS is proposing to again use occupational mix data collected on the 2007-2008 Medicare Wage Index Occupational Mix Survey to compute the occupational mix adjustment for FY 2012.

The proposed FY 2012 national average hourly wages for each occupational mix nursing subcategory are as follows:

<b>Occupational Mix Nursing Subcategory</b>	<b>Average Hourly Wage</b>
National RN	36.04943
National LPN and Surgical Technician	20.85054
National Nurse Aide, Orderly, and Attendant	14.6114
National Medical Assistant	16.45837
<i>National Nurse Category</i>	<b>30.44254</b>

Hospitals with a nurse category average hourly wage of greater than the national nurse category average hourly wage receive an occupational mix adjustment factor of less than 1.0. Hospitals with a nurse category average hourly wage of less than the national nurse category average hourly wage receive an occupational mix adjustment factor of greater than 1.0.

### *New 2010 Occupational Mix Survey for the FY 2013 Wage Index*

A new 2010 survey (Form CMS-10079 (2010)) provides for the collection of hospital-specific wages and hours data for calendar year 2010 (that is, payroll periods ending between January 1, 2010 and December 31, 2010) and will be applied beginning with the FY 2013 wage index. The 2010 survey was adopted in the **Federal Register** on January 15, 2010 and approved by OMB on February 26, 2010 (OMB control number 0938-0907).

The survey is available on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage> and through the fiscal intermediaries/MACs. Hospitals are required to submit their completed 2010 surveys to their fiscal intermediaries/MACs by July 1, 2011.

### ***Index Values***

The proposed wage index values for FY 2012 (except those for hospitals receiving wage index adjustments under section 1886(d)(13) of the Act) are included in Tables 4A, 4B, 4C, and 4F, which are listed in section VI of the Addendum to this proposed rule and available via the Internet, include the proposed occupational mix adjustment.

### ***FY 2012 Medicare Geographic Classification Review Board (MGCRB) Reclassifications***

CMS notes that the MGCRB had completed its review of FY 2012 reclassification requests. Based on such reviews, there are 280 hospitals approved for wage index reclassifications for FY 2012. Because MGCRB wage index reclassifications are effective for 3 years hospitals reclassified during FY 2010 or FY 2011 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications. There were 283 hospitals approved for wage index reclassifications in FY 2010 and 294 hospitals approved for wage index reclassifications in FY 2011. CMS says there are 857 hospitals reclassified for FY 2012.

Applications for FY 2013 reclassifications are due to the MGCRB by September 1, 2011 (the first working day of September 2011). Applications and other information about MGCRB reclassifications may be obtained via the CMS Internet web site at: [http://cms.hhs.gov/MGCRB/02\\_instructions\\_and\\_applications.asp](http://cms.hhs.gov/MGCRB/02_instructions_and_applications.asp), or by calling the MGCRB at (410)786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670.

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

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

Hospitals located in these counties have been known as “Lugar” hospitals and the counties themselves are often referred to as “Lugar” counties. CMS has provided a table in the preamble of the proposed rule listing the FY 2012 rural counties containing the hospitals designated as urban.

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

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

### ***Reclassifications under Medicare Modernization Act (MMA) “Section 508 Hospitals”***

The most recent extension of the MMA section 508 provision was included in section 102 of the ***Medicare and Medicaid Extender Act***, which extends, through FY 2011, section 508 reclassifications as well as certain

special exceptions. The latest extension of these provisions expires on September 30, 2011, and will no longer be applicable effective with FY 2012.

### ***FY 2012 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees***

Beginning with FY 2005, CMS established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the "out-migration" adjustment). These adjustments are effective for each county for a period of 3 fiscal years.

For the proposed FY 2012 wage index, CMS is proposing to calculate the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule, with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment.

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

Table 4J in the Addendum to the rule lists the proposed out-migration wage index adjustments for FY 2012.

### **Other Decisions and Changes to the IPPS for Operating Costs**

#### ***Reporting of Hospital Quality Data for FY 2012***

The payment determination, that is, whether or not a hospital receives a full market basket rate of increase or one subject to a 2.0 percent reduction from market basket, is based on the successful reporting by a hospital of the Hospital Inpatient Quality Reporting (IQR) Program (formerly referred to as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program). CMS says that 99 percent of hospitals submit required data and 97 percent receive the full market basket update.

CMS is proposing to implement a Hospital Value-Based Purchasing (VBP) Program under section 1886(o) of the Act. On January 7, 2011, CMS issued a proposed rule to implement the Hospital VBP. CMS notes that the Hospital IQR Program is intertwined with the Hospital VBP Program because the measures and reporting infrastructure for both programs will overlap.

In summary, CMS is proposing to retire 8 measures from the measure set for the FY 2014 payment determination that was finalized in the FY 2011 IPPS/LTCH PPS final rule, and is proposing to add 4 measures to the measure set for the FY 2014 payment determination: 2 HAI measures collected through the NHSN, 1 claims-based measure (Medicare Spending Per Beneficiary), and 1 structural measure, for a total of 56 measures (see discussion that follows).

#### ***Retirement of Hospital IQR Program Measures***

CMS says based on its own analysis, the agency has concluded that the following measures are "topped out" and for this reason, CMS has proposed not to include them in the FY 2013 Hospital VBP Program measure set.

- AMI-1 Aspirin at arrival
- AMI-3 ACEI/ARB for left ventricular systolic dysfunction

- AMI-4 Adult smoking cessation advice/counseling
- AMI-5 Beta-blocker prescribed at discharge
- HF-4 Adult smoking cessation advice/counseling
- PN-4 Adult smoking cessation advice/counseling
- SCIP INF-6 Appropriate Hair Removal

In addition, CMS proposed to not include an eighth measure in the FY 2013 Hospital VBP Program measure set because the agency believes that inclusion of this measure would result in the unintended consequence of inappropriate antibiotic use. This measure is PN-5c Timing of receipt of initial antibiotic following hospital arrival.

CMS is proposing to retire these eight measures from the Hospital IQR measure set for FY 2014 and subsequent years, and that hospitals would no longer be required to submit data on these measures starting with January 1, 2012 discharges.

#### ***Proposed Measures for the FY 2014 and FY 2015 Hospital IQR Payment Determinations***

CMS previously finalized 60 measures for the FY 2014 Hospital IQR Program measure set. However, as noted above, CMS is proposing to retire 8 measures from the FY 2014 measure set. CMS is proposing to retain the remaining 52 of the 60 quality measures finalized in the FY 2011 IPPS/LTCH PPS final rule for the FY 2014 payment determination.

In this proposed rule, CMS is proposing to adopt two additional HAI measures for the FY 2014 Hospital IQR measure set. These proposed measures were developed by the CDC and are currently collected by the CDC via the NHSN. These measures are: (1) Central Line Bundle Compliance (NQF #0298) (referred to by the CDC and in this proposed rule as Central Line Insertion Practices, or CLIP); and (2) Catheter Associated Urinary Tract Infection (CAUTI) (NQF #138).

#### ***Proposed New Claims-Based Measure***

CMS is also proposing to add new claim-based measure to the Hospital IQR Program measure set for the FY 2014 payment determination: Medicare Spending per Beneficiary.

CMS is proposing that this Medicare spending per beneficiary measure would be calculated using claims data for hospital discharges occurring between May 15, 2012 and February 14, 2013.

In order to calculate the Medicare spending per beneficiary for each hospital, CMS believes that it would be necessary to determine: (1) the timeframe, or length of the “spending per beneficiary episode” during which Medicare payments would be aggregated; (2) the types of Medicare payments to be aggregated over this timeframe; and (3) how to adjust or standardize these payments across hospitals (for example, risk adjustment).

- **Length of the Medicare Spending per Beneficiary Episode**

CMS is proposing an episode that runs from three days prior to an inpatient PPS hospital admission (the index admission) through 90 days post hospital discharge. CMS is proposing to include the time period 90

days post hospital discharge in order to emphasize the importance of care transitions and care coordination in improving patient care. CMS says it believes inclusion of this time period surrounding the hospital admission would reinforce the need to reduce adverse outcomes, including readmissions. Encouraging delivery of coordinated care in an efficient manner is an important goal which can best be achieved through inclusion of Medicare payments made outside the timeframe of the hospital inpatient stay.

- **Medicare Payments Included in the Spending per Beneficiary Episode**

In order to calculate the Medicare spending per beneficiary, CMS says it is necessary to define the Medicare payments included in the spending per beneficiary episode. Subject to certain adjustments, CMS is proposing to include all Medicare Part A and Part B payments made for services provided to the beneficiary during the episode, including payments made by beneficiaries that the agency can determine using claims data, such as Part B deductibles and coinsurance amounts.

CMS is also proposing that transfers, readmissions, and additional admissions that began during the 90-day post discharge window of an index admission would be included in the episode used for calculating the measure.

CMS would exclude from the Medicare spending per beneficiary calculation episodes where at any time during the episode the beneficiary is not enrolled in both Medicare Part A and Medicare Part B, including if the beneficiary is enrolled in a Medicare Advantage plan at any time during the episode or becomes deceased.

- **Adjusting the Medicare Payments Included in the Spending per Beneficiary Episode**

CMS is proposing to adjust the proposed Medicare spending per beneficiary measure for age and severity of illness. CMS would adjust for severity of illness based on the hierarchical condition categories (HCCs) for the period 90 days prior to the episode and based on the MS-DRG during the index admission.

CMS is not proposing to adjust the Medicare spending per beneficiary for sex and race, consistent with the understanding of NQF's position strongly discouraging adjusting measures based on these factors.

In addition, CMS is proposing to exclude geographic payment rate differences (for example, based on the wage index and geographic practice cost index) in order to standardize the spending per beneficiary.

- **Calculating a Hospital's Medicare Spending per Beneficiary Amount**

For each subsection (d) hospital participating in the Hospital IQR Program, CMS would add together all the adjusted Medicare Part A and Part B payments, as defined above, included in all the Medicare spending per beneficiary episodes, as defined above, for that hospital. CMS would then divide this sum by the total number of Medicare Spending per Beneficiary episodes for that hospital. The resulting amount would constitute the hospital's Medicare spending per beneficiary amount for the period.

- **Calculating a Hospital’s Medicare Spending per Beneficiary Ratio**

CMS is proposing to calculate a hospital’s Medicare spending per beneficiary ratio as the hospital’s Medicare spending per beneficiary amount divided by the median Medicare spending per beneficiary amount across all hospitals.

CMS is proposing to adopt this proposed measure for the Hospital VBP Program FY 2014 measure set.

***Proposed New Web-Based Structural Measure***

CMS is proposing to include a new structural measure, Participation in a Systematic Clinical Database Registry for General Surgery, in the Hospital IQR Program beginning with the FY 2014 payment determination. The Participation in a Systematic Clinical Database Registry for General Surgery measure would require each hospital that participates in Hospital IQR Program to indicate whether it is participating in a Systematic Clinical Database Registry for General Surgery and, if so, to identify the registry.

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

***Proposed Hospital IQR Program Quality Measures for the FY 2015 Payment Determination***

CMS is proposing to retain all of the proposed measures for the FY 2014 payment determination, if finalized, for the FY 2015 payment determination.

***Proposed New Hospital IQR Program Measures for the FY 2015 Payment Determination***

For the FY 2015 payment determination, CMS is proposing to adopt three additional HAI measures that are currently collected by CDC via the NHSN. These measures are: (1) Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia measure; (2) C. Difficile SIR; and (3) Healthcare Personnel (HCP) Influenza Vaccination.

***Proposed New Chart-Abstracted Measures for the FY 2015 Payment Determination***

CMS is proposing to adopt two sets of chart-abstracted measures for the FY 2015 payment determination: the Stroke and Venous Thromboembolism (VTE) measure sets. CMS says that all of these proposed measures have either previously been proposed for the Hospital IQR Program, or have been listed as being under consideration for future adoption into the program.

The table below lists and describes each of these proposed measures.

<b>8 Proposed Stroke Measures</b>	
STK-1: Venous Thromboembolism (VTE) Prophylaxis for patients with	Percent of patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end

<b>8 Proposed Stroke Measures</b>	
ischemic or hemorrhagic stroke (NQF #0434)	of hospital day two.
STK-2: Ischemic stroke patients discharged on antithrombotic therapy. (NQF #0435)	Percent of patients with an ischemic stroke prescribed antithrombotic therapy at discharge.
STK-3: Anticoagulation therapy for atrial fibrillation/flutter. (NQF #0436)	Percent of patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy.
STK-4: Thrombolytic Therapy for Acute ischemic stroke patients. (NQF #0437)	Percent of acute ischemic stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV t-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.
STK-5: Antithrombotic therapy by the end of hospital day two. (NQF #0438)	Percent of patients with ischemic stroke who receive antithrombotic therapy by the end of hospital day two.
STK-6: Discharged on statin medication. (NQF #0439)	Percent of ischemic stroke patients with LDL $\geq$ 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication.
STK-8: Stroke education. (NQF #0440)	Percent of patients with ischemic or hemorrhagic stroke or their caregivers who were given education or educational materials during the hospital stay addressing all of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency.
STK-10: Assessed for rehabilitation services. (NQF #0441)	Percent of patients with an ischemic stroke or hemorrhagic stroke who were assessed for rehabilitation services.

CMS is proposing to adopt for the FY 2015 Hospital IQR measure set 6 VTE measures which are aimed at preventing the incidence of potentially preventable VTE. These 6 measures are listed and described below.

<b>6 Proposed Venous Thromboembolism (VTE) Measures</b>	
VTE-1: Venous thromboembolism prophylaxis (NQF #0371)	Percent of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
VTE-2: Intensive care unit venous thromboembolism prophylaxis (NQF #0372)	Percent of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).
VTE-3: Venous thromboembolism patients with anticoagulation overlap therapy (NQF #0371)	Percent of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) = 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.
VTE-4: Venous thromboembolism patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol (NQF #0371)	Percent of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.
VTE-5: Venous thromboembolism discharge instructions (NQF #0371)	Percent of patients diagnosed with confirmed VTE that are discharged to home, to home with home health or home hospice on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.
VTE-6: Incidence of potentially-preventable venous Thromboembolism (NQF #0371)	Percent of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.

In summary, for the FY 2015 payment determination, CMS is proposing to retain all of the FY 2014 measures (56 measures if all of the measures are finalized), to adopt 3 HAI measures, and 14 chart-abstracted measures for a total of 73 measures for the FY 2015 payment determination. The measures proposed for the Hospital IQR Program for the FY 2015 payment determinations are set forth below.

Topic	Proposed Hospital IQR Program Measures for FY 2015 Payment Determination
Acute Myocardial Infarction (AMI)	
	<ul style="list-style-type: none"> <li>● AMI-2 Aspirin prescribed at discharge</li> </ul>
	<ul style="list-style-type: none"> <li>● AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival</li> </ul>
	<ul style="list-style-type: none"> <li>● AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)</li> </ul>
	<ul style="list-style-type: none"> <li>● AMI-10 Statin Prescribed at Discharge</li> </ul>
Heart Failure (HF)	
	<ul style="list-style-type: none"> <li>● HF-1 Discharge instructions</li> </ul>
	<ul style="list-style-type: none"> <li>● HF-2 Left ventricular function assessment</li> </ul>
	<ul style="list-style-type: none"> <li>● HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction</li> </ul>
Stroke Measure Set	
	<ul style="list-style-type: none"> <li>● STK-1 VTE prophylaxis**</li> </ul>
	<ul style="list-style-type: none"> <li>● STK-2 Antithrombotic therapy for ischemic stroke**</li> </ul>
	<ul style="list-style-type: none"> <li>● STK-3 Anticoagulation therapy for Afib/flutter**</li> </ul>
	<ul style="list-style-type: none"> <li>● STK-4 Thrombolytic therapy for acute ischemic stroke**</li> </ul>
	<ul style="list-style-type: none"> <li>● STK-5 Antithrombotic therapy by the end of hospital day 2**</li> </ul>
	<ul style="list-style-type: none"> <li>● STK-6 Discharged on Statin**</li> </ul>
	<ul style="list-style-type: none"> <li>● STK-8 Stroke education**</li> </ul>
	<ul style="list-style-type: none"> <li>● STK-10 Assessed for rehab**</li> </ul>

Topic	Proposed Hospital IQR Program Measures for FY 2015 Payment Determination
VTE Measure Set	
	<ul style="list-style-type: none"> <li>● VTE-1 VTE prophylaxis**</li> </ul>
	<ul style="list-style-type: none"> <li>● VTE-2 ICU VTE prophylaxis**</li> </ul>
	<ul style="list-style-type: none"> <li>● VTE-3 VTE patients with anticoagulation overlap therapy**</li> </ul>
	<ul style="list-style-type: none"> <li>● VTE-4 Patients receiving un-fractionated Heparin with doses/labs monitored by protocol**</li> </ul>
	<ul style="list-style-type: none"> <li>● VTE-5 VTE discharge instructions**</li> </ul>
	<ul style="list-style-type: none"> <li>● VTE-6 Incidence of potentially preventable VTE**</li> </ul>
Pneumonia (PN)	
	<ul style="list-style-type: none"> <li>● PN-3b Blood culture performed before first antibiotic received in hospital</li> </ul>
	<ul style="list-style-type: none"> <li>● PN-6 Appropriate initial antibiotic selection</li> </ul>
Surgical Care Improvement Project (SCIP)	
	<ul style="list-style-type: none"> <li>● SCIP INF-1: Prophylactic antibiotic received within 1 hour prior to surgical incision</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP INF-2: Prophylactic antibiotic selection for surgical</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP INF-3: Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP INF-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP INF-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2 with surgery being day zero</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP INF-10: Surgery patients with Perioperative Temperature Management</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP INF-VTE-1: Surgery patients with recommended Venous thromboembolism (VTE) prophylaxis ordered</li> </ul>
	<ul style="list-style-type: none"> <li>● SCIP INF-VTE-2: Surgery patients who received appropriate VTE prophylaxis</li> </ul>

Topic	Proposed Hospital IQR Program Measures for FY 2015 Payment Determination
	within 24 hours pre/post surgery
Mortality Measures (Medicare Patients)	
	<ul style="list-style-type: none"> <li>● Acute Myocardial Infarction 30-day mortality rate</li> </ul>
	<ul style="list-style-type: none"> <li>● Heart Failure (HF) 30-day mortality rate</li> </ul>
	<ul style="list-style-type: none"> <li>● Pneumonia (PN) 30-day mortality rate</li> </ul>
Patients' Experience of Care	
	<ul style="list-style-type: none"> <li>● HCAHPS patient survey</li> </ul>
Readmission Measure (Medicare Patients)	
	<ul style="list-style-type: none"> <li>● Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure</li> </ul>
	<ul style="list-style-type: none"> <li>● Heart Failure 30-Day Risk Standardized Readmission Measure</li> </ul>
	<ul style="list-style-type: none"> <li>● Pneumonia 30-Day Risk Standardized Readmission Measure</li> </ul>
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	<ul style="list-style-type: none"> <li>● PSI 06: Iatrogenic pneumothorax, adult</li> </ul>
	<ul style="list-style-type: none"> <li>● PSI 11: Post Operative Respiratory Failure *</li> </ul>
	<ul style="list-style-type: none"> <li>● PSI 12: Post Operative PE or DVT *</li> </ul>
	<ul style="list-style-type: none"> <li>● PSI 14: Postoperative wound dehiscence</li> </ul>
	<ul style="list-style-type: none"> <li>● PSI 15: Accidental puncture or laceration</li> </ul>
	<ul style="list-style-type: none"> <li>● IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)</li> </ul>
	<ul style="list-style-type: none"> <li>● IQI 19: Hip fracture mortality rate</li> </ul>
	<ul style="list-style-type: none"> <li>● Complication/patient safety for selected indicators (composite)</li> </ul>
	<ul style="list-style-type: none"> <li>● Mortality for selected medical conditions (composite)</li> </ul>
AHRQ PSI and Nursing Sensitive Care	
	<ul style="list-style-type: none"> <li>● PSI-4 Death among surgical inpatients with serious, treatable complications</li> </ul>

Topic	Proposed Hospital IQR Program Measures for FY 2015 Payment Determination
Structural Measures	
	<ul style="list-style-type: none"> <li>● Participation in a Systematic Database for Cardiac Surgery</li> </ul>
	<ul style="list-style-type: none"> <li>● Participation in a Systematic Clinical Database Registry for Stroke Care</li> </ul>
	<ul style="list-style-type: none"> <li>● Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care</li> </ul>
	<ul style="list-style-type: none"> <li>● Participation in a Systematic Clinical Database Registry for General Surgery*</li> </ul>
Healthcare-Associated Infection Measures	
	<ul style="list-style-type: none"> <li>● Central Line Associated Bloodstream Infection</li> </ul>
	<ul style="list-style-type: none"> <li>● Surgical Site Infection</li> </ul>
	<ul style="list-style-type: none"> <li>● Central Line Insertion Practice Percentage*</li> </ul>
	<ul style="list-style-type: none"> <li>● Catheter-Associated Urinary Tract Infection*</li> </ul>
	<ul style="list-style-type: none"> <li>● MRSA Bacteremia**</li> </ul>
	<ul style="list-style-type: none"> <li>● Clostridium Difficile (C.Diff)**</li> </ul>
	<ul style="list-style-type: none"> <li>● Healthcare Personnel Influenza Vaccination**</li> </ul>
Hospital Acquired Conditions	
	<ul style="list-style-type: none"> <li>● Foreign Object Retained After Surgery</li> </ul>
	<ul style="list-style-type: none"> <li>● Air Embolism</li> </ul>
	<ul style="list-style-type: none"> <li>● Blood Incompatibility</li> </ul>
	<ul style="list-style-type: none"> <li>● Pressure Ulcer Stages III &amp; IV</li> </ul>
	<ul style="list-style-type: none"> <li>● Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)</li> </ul>
	<ul style="list-style-type: none"> <li>● Vascular Catheter-Associated Infection</li> </ul>
	<ul style="list-style-type: none"> <li>● Catheter-Associated Urinary Tract Infection (UTI)</li> </ul>
	<ul style="list-style-type: none"> <li>● Manifestations of Poor Glycemic Control</li> </ul>

Topic	Proposed Hospital IQR Program Measures for FY 2015 Payment Determination
Emergency Department Throughput Measures	
	<ul style="list-style-type: none"> <li>● ED-1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital</li> </ul>
	<ul style="list-style-type: none"> <li>● ED-2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status</li> </ul>
Prevention: Global Immunization Measures	
	<ul style="list-style-type: none"> <li>● Immunization for Influenza</li> </ul>
	<ul style="list-style-type: none"> <li>● Immunization for Pneumonia</li> </ul>
Cost Efficiency	
	<ul style="list-style-type: none"> <li>● Medicare Spending per Beneficiary*</li> </ul>

\* New proposed quality measures for the FY 2014 payment determination

\*\* New Proposed quality measures for FY 2015 payment determination

***Form, Manner, and Timing of Quality Data Submission***

The data submission requirements, Specifications Manual, and submission deadlines are posted on the QualityNet Web site at: <http://www.QualityNet.org/>. CMS requires that hospitals submit data in accordance with the specifications for the appropriate discharge periods. Hospitals submit quality data through the secure portion of the QualityNet Web site (formerly known as QualityNet Exchange) (<https://www.QualityNet.org>). CMS says this Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements for security of protected health information.

The proposed Hospital IQR Program procedural requirements are, for the most part, the same as the procedures adopted in the FY 2011 IPPS/LTCH PPS final rule for the Hospital IQR Program. Hospitals must comply with the following procedural requirements to participate:

- Register with QualityNet, before participating hospitals initially begin reporting data, regardless of the method used for submitting data.
- Identify a QualityNet Administrator who follows the registration process located on the QualityNet Web site (<http://www.QualityNet.org>).
- Complete a Notice of Participation. New subsection (d) hospitals and existing hospitals that wish to participate in the Hospital IQR Program for the first time must complete an online Notice of Participation (formerly known as “Reporting Hospital Quality Data for Annual Payment Update Notice of Participation,” also referred to as IPledge) that includes the name and address of each hospital campus that shares the same CMS Certification Number (CCN). CMS will revise the Notice of

Participation periodically as needed and provide appropriate notification of any revisions to hospitals and QIOs through the routine Hospital IQR Program communication channels, which include memo and email notification and QualityNet Web site articles and postings.

- Any hospital that receives a new CCN on or after October 15, 2009 (including new subsection (d) hospitals and hospitals that have merged) that wishes to participate in the Hospital IQR Program and has not otherwise submitted a Notice of Participation using the new CCN must submit a completed Notice of Participation no later than 180 days from the date identified as the open date (that is, the Medicare acceptance date) on the approved CMS Online System Certification and Reporting (OSCAR) system to participate in the Hospital IQR Program. CMS is proposing regulation text to codify this requirement.
- CMS will accept Hospital IQR Program withdrawal forms for the FY 2013 payment determination from hospitals any time from October 1, 2011 until August 15, 2012.

### ***Proposed Data Submission Requirements for Chart-Abstracted Measures***

CMS is proposing to reduce the quarterly submission deadline for chart-abstracted quality measures from 4 ½ months to 104 days.

CMS is proposing to change the aggregate population and sampling deadline from 4 months to 3 months to align with the corresponding proposal to change the data submission deadline from 135 to 104 days

### **Comment**

CMS spends a considerable amount of time and effort discussing data submissions, times, compliance and related issues. Those involved in these activities are referred to the proposed rule for details and guidance.

### **Hospital Value-Based Purchasing (VBP) Program**

The ACA directs the Secretary to begin making value-based incentive payments under the Hospital Inpatient VBP Program to hospitals for discharges occurring on or after October 1, 2012. These incentive payments will be funded for FY 2013 through a reduction to the FY 2013 base operating MS-DRG payment for each discharge of 1.0 percent.

CMS reiterates a number of the VBP program it proposed in its January 7<sup>th</sup> rulemaking.

CMS is proposing to incorporate the Medicare spending per beneficiary measure score into the FY 2014 Hospital Inpatient VBP Program as part of a new domain: The “Efficiency” domain.

### **Comment**

However, like CMS’ January VBP rule, this proposal does not shed any additional information about hospital numbers and values with respect to scoring.

## **Hospital Readmissions Reduction Program**

ACA Section 3025 as amended by section 10309 establishes a “Readmission Reduction Program” effective for discharges from an “applicable hospital” beginning on or after October 1, 2012.

In this year’s IPPS rulemaking, CMS address: (i) those aspects of the program that relate to the conditions and readmissions to which the program will apply for the first program year beginning October 1, 2012; (ii) the readmission measures and related methodology used for those measures, as well as the calculation of the readmission rates; and (iii) public reporting of the readmission data. Specific information regarding the payment adjustment will be proposed in next year’s IPPS/LTCH PPS proposed rule.

CMS is addressing the following provisions:

- Selection of applicable conditions;
- Definition of “readmission;”
- Measures for the applicable conditions chosen for readmission;
- Methodology for calculating the Excess Readmission Ratio;
- Public reporting of the readmission data; and
- Definition of “applicable period.”

In the FY 2013 IPPS/LTCH proposed rule, CMS says it plans to address the following provisions:

- Base operating DRG payment amount, including policies for SCHs and MDHs;
- Adjustment factor (both the ratio and floor adjustment factor);
- Aggregate payments for excess readmissions;
- Applicable hospital; and
- The calculation of the excess readmission ratio that will then be used, in part, to calculate the readmission payment adjustment factor and the application of the readmission payment adjustment factor to inpatient hospital payments.

### ***Proposed Applicable Conditions for the FY 2013 Hospital Readmission Reduction Program***

CMS is proposing to include three conditions – Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure (NQF# 0505); Heart Failure 30-day Risk Standardized Readmission Measure (NQF#0330); and Pneumonia 30-day Risk Standardized Readmission Measure (NQF#0506) – as “applicable conditions” for the Hospital Readmissions Reduction Program for FY 2013.

Under the three NQF-endorsed risk-standardized readmission measures, transfers to other acute care facilities are excluded from each of the readmission measures.

For the FY 2013 Hospital Readmissions Reduction Program, CMS is proposing to use 3 years of data for discharges from July 1, 2008 through June 30, 2011 as the applicable period upon which to calculate excess readmission ratios for each of the three proposed measures.

CMS is proposing to use the risk-standardized ratio calculated for the NQF-endorsed measures for AMI, HF, and PN as the “excess readmission ratio.”

If a hospital performs better than an average hospital that admitted similar patients (that is, patients with the same risk factors for readmission such as age and comorbidities), the ratio will be less than one. If a hospital performs worse than average, the ratio will be greater than one. Hospitals with a ratio greater than one have excess readmissions relative to average quality hospitals with similar types of patients.

### **Rural Referral Centers (RRCs)**

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

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

CMS is requiring that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2011, they must have a CMI value for FY 2010 that is at least—

- 1.5292; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in regulation Section 413.75) calculated by CMS for the census region in which the hospital is located.

The median CMI values by region are set forth below:

<b>Region</b>	<b>Case-Mix Index Value</b>
1. New England (CT, ME, MA, NH, RI, VT)	1.3247
2. Middle Atlantic (PA, NJ, NY)	1.3723
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4579
4. East North Central (IL, IN, MI, OH, WI)	1.4624
5. East South Central (AL, KY, MS, TN)	1.4001
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4419
7. West South Central (AR, LA, OK, TX)	1.5689
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6292

9. Pacific (AK, CA, HI, OR, WA)

1.5151

A hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2011, must also have as the number of discharges for its cost reporting period that began during FY 2009 a figure that is at least—

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

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

### **Indirect Medical Education (IME) Adjustment**

CMS notes that for discharges occurring during FY 2012, the IME formula multiplier is 1.35, and will result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

### **Extension of the MDH Program**

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

### **Proposed Changes to MS-DRGs Subject to the Postacute Care Transfer Policy**

CMS is proposing to update the list of MS-DRGs that are subject to the postacute care transfer policy to include the proposed new MS-DRGs 570, 571, and 572 for FY 2012. (These MS-DRGs are reflected in Table 5, which is listed the Addendum to this proposed rule and available via the Internet.

### **Proposed Changes for Hospitals Excluded from the IPPS**

CMS is proposing that the FY 2012 rate-of-increase percentage to be applied to the target amount for cancer and children's hospitals and RNHCI's be the estimated FY 2012 percentage increase in the IPPS operating market basket, estimated to be 2.8 percent.

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

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

### **Present on Admission (POA) Indicator Reporting**

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

## Proposed Additions and Revisions to the Hospital-Acquired Conditions (HACs), Including Infections

### *Contrast-Induced Acute Kidney Injury*

CMS is proposing to add contrast-induced kidney injury to the list of HACs. Contrast-induced acute kidney injury is a significant complication of the use of iodinated contrast media and accounts for a large number of cases of hospital-acquired acute kidney injury cases.

CMS is proposing to identify contrast-induced acute kidney injury with diagnosis code 584.9 in combination with one or more of the following associated procedure codes.

- 88.40 (Arteriography using contrast material, unspecified site)
- 88.41 (Arteriography of cerebral arteries)
- 88.42 (Aortography)
- 88.43 (Arteriography of pulmonary arteries)
- 88.44 (Arteriography of other intrathoracic vessels)
- 88.45 (Arteriography of renal arteries)
- 88.46 (Arteriography of placenta)
- 88.47 (Arteriography of other intra-abdominal arteries)
- 88.48 (Arteriography of femoral and other lower extremity arteries)
- 88.49 (Arteriography of other specified sites)
- 88.50 (Angiocardiology, not otherwise specified)
- 88.51 (Angiocardiology of venae cavae)
- 88.52 (Angiocardiology of right heart structures)
- 88.53 (Angiocardiology of left heart structures)
- 88.54 (Combined right and left heart angiocardiology)
- 88.55 (Coronary arteriography using a single catheter)
- 88.56 (Coronary arteriography using two catheters)
- 88.57 (Other and unspecified coronary arteriography)
- 88.58 (Negative-contrast cardiac roentgenography)
- 88.59 (Intra-operative coronary fluorescence vascular angiography)
- 88.60 (Phlebography using contrast material, unspecified site)
- 88.61 (Phlebography of veins of head and neck using contrast material)
- 88.62 (Phlebography of pulmonary veins using contrast material)
- 88.63 (Phlebography of other intrathoracic veins using contrast material)
- 88.64 (Phlebography of the portal venous system using contrast material)
- 88.65 (Phlebography of other intra-abdominal veins using contrast material)
- 88.66 (Phlebography of femoral and other lower extremity veins using contrast material)
- 88.67 (Phlebography of other specified sites using contrast material)
- 87.71 (C.A.T. of kidney)
- 87.72 (Other nephrotomogram)
- 87.73 (Intravenous pyelogram)

- 87.74 (Retrograde pyelogram)
- 87.75 (Percutaneous pyelogram)

***New Diagnosis Codes Proposed to be Added to Existing HACs***

CMS is proposing to add two new codes for the Falls and Trauma HAC category, two new codes for the Surgical Site Infection (SSI) following Certain Bariatric Procedures HAC category, and one new code for the Deep Vein Thrombosis and Pulmonary Embolism (DVT/PE) following Certain Orthopedic Procedures HAC category.

Shown in the table below are these five new diagnosis codes with their corresponding descriptions and their proposed CC/MCC designations.

ICD-9-CM Code	Code Descriptor	Proposed CC/MCC Designation
539.01	Infection due to gastric band procedure	CC
539.81	Infection due to other bariatric procedure	CC
415.13	Saddle embolus of pulmonary artery	MCC
808.44	Multiple closed pelvic fractures without disruption of pelvic circle	CC
808.54	Multiple open pelvic fractures without disruption of pelvic circle	MCC

***Revision to HAC Subcategory Title***

CMS is proposing to change the title of this HAC subcategory from “Electric Shock” to “Other Injuries” because it includes a variety of injury codes.

***Conclusion***

The following table lists the current HAC categories and the ICD-9-CM codes that identify the conditions and have been finalized through FY 2011. For FY 2012, CMS is proposing that these conditions continue to be subject to the HAC payment provision, along with the creation of a new HAC category for Contrast-Induced Acute Kidney Injury, and in addition, the five new ICD-9-CM diagnosis codes and to revise the title of the “Electric Shock” subcategory in the Falls and Trauma HAC category.

HAC	CC/MCC (ICD-9-CM Code)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma:  - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Electric Shock	Codes within these ranges on the CC/MCC list:  800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC)  Also excludes the following from acting as a C/MCC:  112.2 (CC)

HAC	CC/MCC (ICD-9-CM Code)
	590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infections	
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08 81.23-81.24

HAC	CC/MCC (ICD-9-CM Code)
	81.31-81.38 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis – 278.01 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (CC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

**Proposed Changes to Specific MS-DRG Classifications**

***Autologous Bone Marrow Transplant***

CMS is proposing to delete MS-DRG 015 and create two new MS-DRGs:

- Proposed MS-DRG 016 (Autologous Bone Marrow Transplant with MCC/CC); and
- Proposed MS-DRG 017 (Autologous Bone Marrow Transplant without MCC/CC).

***Rechargeable Dual Array Deep Brain Stimulation System***

CMS is proposing to assign rechargeable dual array systems for deep brain stimulation cases identified by reporting both procedure codes 02.93 and 86.98 to MS-DRGs 023 and 024 for FY 2012.

***Aneurysm Repair Procedure Codes***

CMS is proposing to move procedure codes 38.45 and 39.73 from MS-DRGs 237 and 238 and to add these codes to MS-DRGs 216, 217, 218, 219, 220, and 221.

To conform to this proposed change, CMS is also proposing to change the title of MS-DRG 237 (Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair) by removing the terms “or

Thoracic Aortic Aneurysm Repair.” Therefore, the new proposed title of MS-DRG 237 would be “Major Cardiovascular Procedures with MCC.”

***MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast): Excisional Debridement of Wound, Infection, or Burn***

CMS is proposing to remove excisional debridements (procedure code 86.22) from their current MS-DRG assignments within MS-DRGs 573 through 578 for skin grafts and assign them to new excisional debridement MS-DRGs. CMS is proposing to maintain MS-DRGs 573 through 578 for skin grafts. The following list describes the proposed new and revised MS-DRG titles:

Proposed new MS-DRGs based on procedure code 86.22:

- Proposed MS-DRG 570 (Skin Debridement with MCC)
- Proposed MS-DRG 571 (Skin debridement with CC)
- Proposed MS-DRG 572 (Skin Debridement without CC/MCC)
- Proposed Revised MS-DRGs based on codes currently assigned to MS-DRGs 573 through 578, excluding procedure code 86.22:
- Proposed revised MS-DRG 573 (Skin Graft for Skin Ulcer or Cellulitis with MCC)
- Proposed revised MS-DRG 574 (Skin Graft for Skin Ulcer or Cellulitis with CC)
- Proposed revised MS-DRG 575 (Skin Graft for Skin Ulcer or Cellulitis without CC/MCC)
- Proposed revised MS-DRG 576 (Skin Graft Except for Skin Ulcer or Cellulitis with MCC)
- Proposed revised MS-DRG 577 (Skin Graft except for Skin Ulcer or Cellulitis with CC)
- Proposed revised MS-DRG 578 (Skin Graft Except for Skin Ulcer or Cellulitis without CC/MCC)

***Nutritional and Metabolic Diseases: Update of MS-DRG Titles***

CMS is proposing to change the titles of DRGs 640-642 as follows:

MS-DRG 640 (Miscellaneous Disorders of Nutrition, Metabolism, and Fluids and Electrolytes with MCC); MS-DRG 641 (Miscellaneous Disorders of Nutrition, Metabolism, and Fluids and Electrolytes without MCC); and MS-DRG 642 (Inborn and Other Disorders of Metabolism).

***Sleeve Gastrectomy Procedure for Morbid Obesity***

CMS is proposing to add a procedure code or codes identifying sleeve gastrectomy to MS-DRGs 619 through 621 for FY 2012.

***Discharge Status Code 66 (Discharged/Transferred to Critical Assess Hospital (CAH))***

CMS is proposing to add discharge status code 66 to the MS-DRG GROUPER logic for MS-DRG 789.

### ***Surgical Hierarchies***

In Pre-MDCs, CMS is proposing to reorder proposed new MS-DRG 016 (Autologous Bone Marrow Transplant with CC/MCC) and proposed new MS-DRG 017 (Autologous Bone Marrow Transplant without CC/MCC) above MS-DRG 010 (Pancreas Transplant).

#### **Comment**

CMS is proposing a number of changes involving Surgical Hierarchies, the Complications or Comorbidity (CC) Exclusions List and procedure code revisions. For more information on these changes, please refer to the proposed rule and the tables on this subject.

There are many coding changes taking place that need review by hospital personnel that are conversant in this area.

### **Add-On Payments for New Services and Technologies**

#### ***Spiration® IBV® Valve System***

As of March 12, 2012, the Spiration® IBV® will have been on the market for 3 years, and is therefore no longer considered “new” as of March 12, 2012. Because the 3-year anniversary date of the Spiration® IBV®’s entry onto the market will occur in the first half of the fiscal year CMS is proposing to discontinue its new technology add-on payment for FY 2012.

#### ***CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH-t)***

With regard to the newness criterion for the TAH-t CMS considers the beginning of the newness period for the device to have commenced from the Medicare NCD date of May 1, 2008; it is no longer considered new as of May 11, 2011. Because the 3-year anniversary date of the TAH-t will occur prior to the start of FY 2012, CMS is proposing to discontinue the new technology add-on payment for the TAH-t in FY 2012.

#### ***Auto Laser Interstitial Thermal Therapy (AutoLITT™) System***

The device will be considered “new” until December 2012. Because the 3-year anniversary date for the AutoLITT™ will occur after FY 2012, CMS is proposing to continue to make new technology add-on payments for the AutoLITT™ in FY 2012.

### **Changes to the MS-LTC-DRGs for FY 2012**

The FY 2011 market basket estimate for the LTCH PPS is 2.8 percent. Like the IPPS proposed rates, the proposed LTCH rates would be reduced by a productivity factor of 1.2 percent and an ACA reduction of 0.1 percent. The net update would be 1.5 percent.

The standardized Federal rate for FY 2012 would be **\$40,082.61** versus the current rate of \$39,599.95.

CMS is proposing to establish a fixed-loss outlier amount of **\$19,270** for FY 2012. The current amount is \$18,785

The proposed MS-LTC-DRGs for FY 2012 presented in this proposed rule are the same as the proposed MS-DRGs that would be used under the IPPS for FY 2012. Table 11, available via the Internet, lists the proposed MS-LTC-DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in determining short stay outliers (SSO) payments under §412.529) for FY 2012.

The labor-related share that CMS is proposing to use for LTCH PPS in FY 2012 would be **70.344** percent. The current labor-related share is 75.271 percent.

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

### ***Proposed Quality Reporting for LTCHs***

ACA Section 3004(a) authorizes an additional quality reporting program for LTCHs for rate year 2014 and each subsequent rate year.

CMS is proposing that, for the FY 2014 payment determination, LTCHs submit data on three quality measures: (1) Urinary Catheter-Associated Urinary Tract Infections (CAUTI); (2) Central Line Catheter-Associated Blood Stream Infection (CLABSI); and (3) Pressure Ulcers that are New or Have Worsened.

### ***Clarifying Average Length Of Stay Requirements***

LTCHs are defined generally as hospitals that have an average length of stay (ALOS) greater than 25 days. CMS is proposing to clarify two existing policies related to the calculation of ALOS. First, the agency is proposing to clarify that both traditional Medicare fee-for-service program stays and beneficiary days paid for under Medicare Advantage are included in the determination of whether an LTCH meets the greater than 25 days ALOS requirement. Second, in cases involving a change of ownership of an LTCH, CMS is also proposing to clarify CMS policy regarding the evaluation of whether an LTCH (either an LTCH under-formation or an existing LTCH) meets the greater than 25 days ALOS requirement when an LTCH changes ownership.

### ***Proposed extension of the moratorium on growth in bed numbers to LTCHs developed under exceptions to the moratorium enactment under the MMSEA***

The ***Medicare, Medicaid, and SCHIP Extension Act of 2007*** (MMSEA) imposed a moratorium on the establishment or classification of new LTCHs and LTCH satellite facilities and on increasing the number of beds in existing LTCHs subject to specific exceptions. The ACA extended both moratoria an additional two-year period. CMS is proposing to extend the application of the moratorium on bed increases to those LTCHs and LTCH satellite facilities, newly established under the applicable MMSEA moratorium exceptions, to be consistent with the application of the moratorium on bed increases that applies to existing LTCHs and LTCH satellite facilities.

### **Final Comment**

Below is an analysis that compares the current MS-DRG (FY 2011) weights to those being proposed for FY 2012 for all MS-DRGs having 100,000 or more discharges.

MS-DRG	Description	FY 2011 Weight	FY Proposed 2012 Weights	Percent Difference
65	Intracranial hemorrhage or cerebral infarction w CC	1.1667	1.1490	-1.52
190	Chronic obstructive pulmonary disease w MCC	1.1924	1.1730	-1.63
191	Chronic obstructive pulmonary disease w CC	0.9735	0.9656	-0.81
192	Chronic obstructive pulmonary disease w/o CC/MCC	0.7220	0.7101	-1.65
193	Simple pneumonia & pleurisy w MCC	1.4796	1.4981	1.25
194	Simple pneumonia & pleurisy w CC	1.0152	1.0079	-0.72
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9691	1.9763	0.37
287	Circulatory disorders except AMI, w card cath w/o MCC	1.0879	1.0699	-1.65
291	Heart failure & shock w MCC	1.4943	1.4978	0.23
292	Heart failure & shock w CC	1.0302	1.0208	-0.91
293	Heart failure & shock w/o CC/MCC	0.6853	0.6752	-1.47
309	Cardiac arrhythmia & conduction disorders W CC	0.8387	0.8136	-2.40
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5709	0.5594	-2.01
312	Syncope & collapse	0.7172	0.7096	-1.06
313	Chest pain	0.5499	0.5405	-1.07
378	G.I. hemorrhage w CC	1.0274	1.0261	-0.13
392	Esophagitis, gastroent & misc digest disorders w/o MCC	0.7173	0.7280	1.49
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.1039	2.0943	-0.46

MS-DRG	Description	FY 2011 Weight	FY Proposed 2012 Weights	Percent Difference
603	Cellulitis w/o MCC	0.8377	0.8517	1.67
641	Nutritional & misc metabolic disorders w/o MCC	0.6916	0.6962	0.67
682	Renal Failure w MCC	1.6407	1.6373	-0.21
683	Renal Failure w CC	1.0243	1.0209	-0.33
690	Kidney & urinary tract infections w/o MCC	0.7864	0.7926	0.79
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	1.9074	1.9095	0.11
872	Septicemia or severe sepsis w/o MV 96+ hours w/o MCC	1.1545	1.1401	-1.25

These MS-DRGs account for approximately 35.0 percent of the nearly 11 million MS-DRG discharges. Of the 25 values, only 8 are increasing.

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