

**CMS-1498-F**

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<b>Issue</b>	<b>Page Number (from CMS 1498-F)</b>	<b>Synopsis</b>
Payments for Graduate Medical Education (GME)	50287 - 50298	<p><b><u>Payments for Graduate Medical Education (GME)</u></b> Medicare direct GME payments are calculated by multiplying the base-period per resident amount (PRA) by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex, and the hospital's Medicare share of total inpatient days. Hospitals may receive direct GME and IME payments for residents in "approved medical residency training programs."</p> <p>An "approved" medical residency program is a program that is accredited by either the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, the American Osteopathic Association (AOA), the Commission on Dental Accreditation (CODA) of the American Dental Association, and the Council on Podiatric Medicine Education (CPME) of the American Podiatric Medical Association, or leads toward board certification by the American Board of Medical Specialties (ABMS).</p> <p><b><u>Determining Whether an Individual is a Resident or a Physician - Clarification</u></b> In order to decide whether an individual is considered a resident or a physician for purposes of Medicare payment, the pertinent questions are whether the individual actually needs the training in</p>

		<p>order to meet board certification requirements in that specialty, and whether the individual is formally participating in an organized, standardized, structured course of study.</p> <p>Individuals who have already completed accredited residency programs in a particular specialty or subspecialty, and do not need to complete the additional training in order to meet board certification, should be treated and receive payment as physicians, not residents. The individual must also be formally accepted and enrolled in the training program and fully participating in that training. With regard to programs that are extended by a hospital for longer than the minimum accredited length for that specialty, individuals training in a program that extends beyond the actual accredited program length are not considered residents for IME and direct GME purposes because they are no longer training in an accredited program according to the ACGME.</p> <p>Individuals that act as chief residents after they have completed the accredited program and have satisfied the minimum requirements for board certification are no longer considered residents for IME and direct GME payment purposes.</p> <p>CMS is revising the definition of “resident” at §413.75(b) 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.” Similarly, CMS is changing 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</p>
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		<p>pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.” This change in the definitions of “resident” and “primary care resident” will be effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010.</p> <p>CHGME Payment Program: The definitions of a “resident” and “physician” are bounding on the program. This information should be disseminated to the CHGME FIs.</p>
Wage Index	50158 - 50177	<p><b><u>Wage Index Reform</u></b></p> <p>PL 109-432 required MedPAC to submit to Congress a report on the Medicare wage index classification system applied under the Medicare IPPS. Section 106(b) required the report to include any alternatives that MedPAC recommends to the method to compute the wage index under section 1886(d)(3)(E) of the Act.</p> <p>The first part of Acumen’s final report analyzed the strengths and weaknesses of the data sources used to construct the MedPAC and CMS indexes. Acumen suggested that MedPAC’s recommended methods for revising the wage index represented an improvement over the existing methods, and that the BLS data should be used so that the MedPAC approach can be implemented. The second part focuses on the methodology of wage index construction and covers issues related to the definition of wage areas and methods of adjusting for differences among neighboring wage areas, as well as reasons for differential impacts of shifting to a new index. Acumen recommended further exploration of labor market area definitions using a wage area framework based on hospital-specific characteristics, to construct a more accurate hospital wage index.</p>

**Core-Based Statistical Areas for the Hospital Wage Index - FINAL**

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. CMS defines hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003. CMS is providing that hospitals receive 100 percent of their wage index based upon the CBSA configurations.

**Occupational Mix Adjustment to the FY 2011 Wage Index - FINAL**

The purpose of the occupational mix adjustment is to control for the effect of hospital's employment choices on the wage index. For the FY 2011 hospital wage index, CMS used data from the revised 2007-2008 Medicare Wage Index Occupational Mix Survey. CMS based the FY 2011 wage index on wage data reported on the FY 2007 Medicare cost reports, salaries, hours, overhead salaries and overhead costs, wage-related costs, urban or rural labor market area, separate Puerto Rico-specific wage index and the "imputed" floor which was extended through FY 2011 to address a concern that hospitals in all-urban States were disadvantaged by the absence of rural hospitals to set a wage index floor in those States. CMS is applying the occupational mix adjustment to 100 percent of the FY 2011 wage index.

The FY 2010 wage index excludes direct and overhead salaries and hours for services not subject to the IPPS payment. The FY2011 wage index also excludes the salaries, hours, and wage-

related costs of hospital-based rural health clinics, and federally qualified health centers because Medicare pays for these costs outside of the IPPS

**Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications**

Hospitals must proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. Decisions on a hospital reclassification for purposes of the wage index are effective for 3 fiscal years. Applications for the FY 2012 reclassifications are due to the MGCRB by September 1, 2010. This is also the deadline for cancelling a previous wage index reclassification withdrawal or termination. Reclassifications are considered budget neutral actions, and therefore have no impact on total IPPS payments.

**Redesignation and Reclassification of Hospitals under Section 1886(D)(8)(B) of the Act**

Effective beginning FY 2005, CMS uses OMB's 2000 CBSA standards and the Census 2000 data to identify counties in which hospitals receive the wage index of the urban area. These hospitals are known as "Lugar" hospitals. Lugar hospitals are treated like reclassified hospitals for purposes of determining their applicable wage index and receive the reclassified wage index for the urban area to which they have been redesignated. The hospital must be no more than 35 miles from the area to which it seeks reclassification. A Lugar hospital must also demonstrate that its average hourly wage is equal to at least 84 percent and 86 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

		<p><b><u>FY 2011 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees</u></b></p> <p>Beginning in FY 2005, CMS established a process to make adjustments to the hospital wage index based on the commuting patterns of hospital employees (“out-migration” adjustment). Adjustments to the wage index are effective for 3 years. A county that qualifies in any given year may no longer qualify after the 3-year period. For the FY 2011 wage index, CMS is calculating 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.</p> <p>CHGME Payment Program: The yearly updated wage index is used in the determination of payments.</p>
<p>Labor-Market Share for the Proposed FY 2011 Wage Index</p>	<p>50179</p>	<p><b><u>Labor-Related Share for the FY 2011 Wage Index - FINAL</u></b></p> <p>Section 1886(d)(3)(E) of the Act directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related. The labor-related share is used to determine the proportion of the national IPPS base payment rate to which the area wage index is applied. CMS will not make any further changes to the national average proportion; therefore, CMS will continue to use a labor-related share of 68.8 percent for discharges occurring on or after October 1, 2010. For all IPPS hospitals whose wage indices are less than 1.0000, CMS is applying the wage index to a labor-related share of 62 percent of the national standardized amount. For all IPPS hospitals whose wage indices are greater than 1.0000, CMS is applying the wage index to a labor-related share of 68.8 percent of the national</p>

		<p>standardized amount. This does not apply for CHGME. For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. CMS will continue to use a labor-related share for the Puerto Rico-specific standardized amounts of 62 or 62.1 percent, depending on which results in higher payment for hospitals, for discharges occurring on or after October 1, 2010.</p> <p>CHGME Payment Program: The program used the labor share and the non labor share computed by CMS in the determination of DME and IME payments.</p>
Case-Mix Index (CMI)	50237	<p><b><u>Case-Mix Index – FINAL</u></b>  Section 412.96(c)(1) provides that CMS establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. National median CMI value and regional value for FY 2011 are based on discharges occurring during FY 2009 and include bills posted to CMS' records through March 2010.</p> <p>CHGME Payment Program: The program uses the CMS methodology in computing the severity of illness index (CMI).</p>
Indirect Medical Education (IME) Adjustment	50275	<p><b><u>Indirect Medical Education (IME)</u></b>  Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The IME adjustment to the MS-DRG payment is based in part on the applicable IME</p>

		<p>adjustment factor. The IME adjustment factor is calculated by using a hospital's ratio of residents to beds and a formula multiplier. For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35. Accordingly, for discharges occurring during FY 2011, the formula multiplier is 1.35. CMS estimates that application of this formula multiplier for the FY 2011 IME adjustment 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.</p> <p>CHGME Payment Program: The program uses the same IME adjustment factor for the computation of the indirect medical education (IME) payments.</p>
<p>Fraction of the Medicare DSH Calculation/Payments for Direct Graduate Medical Education (GME) Costs</p>	<p>50275 - 50276</p>	<p><b><u>Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)</u></b></p> <p>One method for qualifying for the DSH payment adjustment is based on a complex statutory formula under which the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP). A hospital's DPP is the sum of the Supplemental Security Income (SSI) fraction, and the "Medicaid fraction." The SSI fraction, or the "Medicare" fraction, is computed by dividing the number of the hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A and SSI benefits by the hospital's total number of patient days furnished to patients entitled to benefit under Medicare Part A. The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's</p>

		<p>total number of inpatient days in the same period.</p> <p>CHGME Payment Program: No effect.</p>
<p>Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2011</p>	<p>50067 - 50074, 50161, 50356 - 50433</p>	<p><b><u>Prospective Payment Rates for Hospital Inpatient Operating Costs - FINAL</u></b>  The basic methodology for determining prospective payment rates for hospital inpatient operating costs for acute care hospitals is set forth at §412.64. For FY 2011, the update to the average standardized amount is 2.4 percent for hospitals in all areas. The estimated market basket increase of 2.4 percent is based on IHS Global Insight, Inc.'s 2010 first quarter forecast of the hospital market basket increase. The update to the Puerto Rico-specific standardized amount is 2.4 percent.</p> <p>CHGME Payment Program: No effect.</p> <p><b><u>Reclassified Hospitals –Budget Neutrality Adjustment</u></b>  Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.</p> <p><b><u>Rural Floor and Imputed Floor Budget Neutrality Adjustment - FINAL</u></b>  In FY 2011 the adjustment will be completely transitioned to the State-level methodology, such that the wage index will be determined by applying 100 percent of the State-level budget neutrality adjustment. The rural floor budget neutrality adjustment is applied to the wage index and not the standardized amount. To determine each State's rural or imputed floor budget neutrality adjustment, CMS compared each State's total simulated payments with and without the rural or imputed floor</p>

applied. These State-level rural and imputed floor budget neutrality factors were then applied to the wage indices to produce a State-level rural and imputed floor budget neutral wage index, which was used in determining the FY 2011 wage indices. CMS is adopting a uniform, national budget neutrality adjustment for the rural and imputed floors for FY 2011 which is a factor of 0.996641.

**Frontier State Floor Adjustment - FINAL**

CMS is implementing that all PPS hospitals located within a State that qualifies as a Frontier State (Montana, Wyoming, North Dakota, Nevada, or South Dakota) will receive either the higher of its post-reclassification wage index rate, or a wage index with a minimum value of 1.00. The Frontier State adjustment will not be subject to budget neutrality.

CHGME Payment Program: No effect.

**Case-Mix Budget Neutrality Adjustment - FINAL**

**1) Adjustment to the FY 2011 IPPS Standardized Amount**

Beginning in FY 2008, CMS adopted the MS-DRG patient classification system for the IPPS to better recognize patients' severity of illness in Medicare payment rates. In the FY 2008 final rule, CMS established prospective documentation and coding adjustments to maintain budget neutrality by adjusting the national standardized amounts to eliminate the effect of changes in documentation and coding that do not reflect real change in case-mix. Between FY 2008 and FY 2009, the total change exceeded the cumulative prospective adjustments by 5.8 percentage points. This increase resulted in an increase in aggregate payments of approximately \$6.9 billion. Therefore, an

aggregate adjustment of -5.8 percent in FYs 2011 and 2012 is necessary to offset the estimated amount of the cumulative increase in aggregate payments in FYs 2008 and 2009. Therefore, CMS is making an adjustment to the standardized amount of -2.9 percent for FY 2011.

**2) Adjustment to the FY 2011 Puerto Rico Standardized Amount**

Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. For FY 2011, CMS is making an adjustment of -2.6 percent to Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount.

CHGME Payment Program: the program uses the CMS methodology for computing the CMI.

**Outlier Payments**

To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount. The marginal cost factor for FY 2011 is 80 percent, which is the same marginal cost factor used since FY1995.

**FY 2011 Outlier Fixed-Loss Cost Threshold - FINAL**

For FY 2011, CMS will continue to use the same methodology used for FY 2009 to calculate the outlier threshold. CMS is

		<p>applying an adjustment factor to the CCRs to account for cost and charge inflation.</p> <p><b><u>Adjustments for Area Wage Levels and Cost-of-Living - FINAL</u></b></p> <p><b>1)Adjustment for Area Wage Levels</b>  Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that CMS make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located.</p> <p><b>2)Adjustment for Cost-of-Living in Alaska and Hawaii</b>  For FY 2011, CMS is adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor. These factors were obtained from the U.S. Office of Personnel Management and are the same factors currently in use under the IPPS for FY 2010.</p> <p>CHGME Payment Program: This policy is not applicable to the program</p>
Electronic Submission of Affiliation Agreements	50298 - 50299	<p><b><u>Electronic Submission of Affiliation Agreements - FINAL</u></b>  Under authority of section 1886(h)(4)(H)(ii) of the Act, the Secretary issued regulations to allow institutions that are members of the same Medicare GME affiliated group to elect to apply their direct GME and IME FTE resident caps based on the aggregate cap of all hospitals that are part of a Medicare GME</p>

		<p>affiliated group. To date, CMS has only accepted signed hard copies of Medicare GME affiliation agreements that are received through the mail. <u>CMS is changing the policy allowing electronic submission of the affiliation agreement that is required to be sent to the CMS Central Office.</u> This would not affect the authority of the fiscal intermediary or MAC to continue to specify its requirements for submission for hospitals in its servicing area. Electronic affiliation agreement would need to be submitted either as a scanned copy or a Printer-Friendly Display version of that hard copy agreement which will enable CMS to ensure that the agreements are signed and dated as required. Allowing an electronic submission of the affiliation agreement to the CMS Central Office would assist in more effectively tracking the groups of hospitals that affiliate as well as the numbers of FTE cap slots that are being transferred within those groups. An electronic submission process would minimize the paperwork burden for hospitals. CMS is in the process of developing an electronic submission system for Medicare GME affiliation agreements. If a system is developed that is ready to receive electronic affiliation agreements by July 1, 2011, CMS will notify teaching hospitals by May 2011.</p> <p>CHGME Payment Program: This policy is applicable to the program. The program should disseminate this information emphasizing the projected effective date.</p>
Capital-Related Costs	50353	<p><b><u>Capital-Related Costs</u></b></p> <p>A new hospital is a hospital that has operated for less than two years. The following are not considered new hospitals: 1) a hospital that builds new or replacement facilities at the same or another location, 2) a hospital that closes and subsequently</p>

		<p>reopens, 3) a hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years, and 4) a hospital that changes its status from a hospital that is excluded from the IPPS to a hospital that is subject to the capital IPPS. For cost reporting periods beginning on or after October 1, 2002, a new hospital is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive full prospective payment based on 100 percent of the Federal rate.</p> <p>Hospitals located in Puerto Rico are paid a blend of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal rate.</p> <p>CHGME Payment Program: This policy is not applicable for CHGME .</p>
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