BALCH & BINGHAM LLP
Alabama • Georgia • Mississippi • Washington, D.C.

HEALTHCARE BULLETIN

May 14, 2009

CMS PROPOSES UPDATES TO PROSPECTIVE PAYMENT SYSTEMS AND OCCUPATIONAL MIX ADJUSTMENT TO PROPOSED WAGE INDEX FOR FY 2010

Recently, the Centers for Medicare & Medicaid Services ("CMS") released proposed rules updating five of the Medicare prospective payment systems for Fiscal Year ("FY") 2010, including the Hospital Inpatient Prospective Payment System ("IPPS").

Proposed Changes to IPPS

Proposed Update

On May 1, 2009, CMS released its proposed IPPS rule, scheduled to be published in the *Federal Register* on May 22, 2009. Public comments regarding the proposed IPPS rule for FY 2010 are due by June 30, 2009. The proposed rule increases acute care hospital rates for FY 2010 by 2.1%, but reduces the update by 1.9% to remove increases in aggregate payments due to changes in coding practices that do not reflect increased severity of patients' illnesses.

It is estimated the proposed IPPS rule will result in a $979 million decrease in operating and capital payments to acute care hospitals. CMS anticipates that over 3,500 acute care hospitals, accounting for approximately 58% of all Medicare-participating hospitals, will be affected by the updated payment rates that are applicable to services provided on or after October 1, 2009.

Key proposals contained in the proposed IPPS rule include:

- Increasing the outlier threshold to $24,240;
- Decreasing the labor-related share from 69.7% to 67.1%;
- Reassigning patients receiving hip or knee joint replacements who contract infections requiring inpatient hospitalization to higher paying MS-DRGs;

- Adding new services to the list of "new technologies" that qualify for additional payment;

- Changing Medicare disproportionate share hospital ("DSH") adjustment policies related to labor and delivery patient days, observation beds and inpatient days, and aggregating inpatient days, allowing DSHs to accumulate days based on either the date of admission, the date of discharge or the date of service;

- Amending the Emergency Medical Treatment and Labor Act ("EMTALA") regulations relating to waiver of EMTALA sanctions during an emergency period; and

- Updating the applicable regulations to reflect the American Recovery and Reinvestment Act of 2009 requirement that the full capital indirect medical education adjustment be paid in FY 2009.

Quality Data Reporting Requirements

In an attempt to strengthen the relationship between payment and quality of service, CMS seeks to expand the quality measures hospitals must report in order to receive the full market basket update in FY 2011. The proposed rule adds four new measures and program requirements for which hospitals must submit data under the Reporting Hospital Quality Data for Annual Payment Update ("RHQDAPU"), including two extensions to existing Surgical Care Improvement Project measures requiring removal of a urinary catheter on postoperative day one or two and perioperative temperature management for surgery patients, and participation in systematic clinical database registries for nursing sensitive care and stroke care. CMS also proposes to retire the acute myocardial infarction measure requiring administration of beta-blockers on arrival.

Proposed Occupational Mix Adjustment for FY 2010 Wage Index

In the IPPS rule, CMS released its proposed occupational mix adjustment to the FY 2010 Wage Index. Occupational mix data is collected every three (3) years for employees for each short-term, acute care hospital participating in the Medicare program so that CMS may construct an occupational mix adjustment to the wage index. Occupational mix data collected on a revised 2007-2008 Medicare Wage Index Occupational Mix Survey was used to compute the proposed occupational mix adjustment for FY 2010.

Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the proposed FY 2010 wage index. In computing the proposed FY 2010 wage index, if a hospital did not respond to the occupational mix survey or if CMS found the hospital's submitted data too erroneous to include in the wage index, CMS assigned the hospital the average occupational mix adjustment for the labor market area.

The proposed FY 2010 occupational mix adjusted national average hourly wage is $33.4935. The national occupational mix nursing subcategory calculations are as follows: $36.0677 for RNs; $20.9089 for LPNs and surgical technicians; $14.6102 for nurse aides,

orderlies, and attendants; $16.3583 for medical assistants; and $30.4847 for the national nurse category.

Budget Neutrality Adjustment and Geographic Reclassification Requirements Adjustments

CMS provided updates on the status of transitions for two FY 2009 final rules' regulatory revisions related to the wage index. In FY 2009, CMS adopted a policy of applying a budget neutrality adjustment to the rural and imputed floors within a state rather than on a national basis. For FY 2010, the blended wage index will reflect 50% of the state level adjustment and 50% of the national adjustment. In FY 2011, the adjustment will be fully transitioned and reflect 100% of the state level adjustment.

Also in the FY 2009 final rule, CMS adopted a policy of adjusting the average hourly wage standard for geographic reclassification. For reclassification applications for FY 2010, the average hourly wage standards were set at 86% for urban hospitals and group reclassifications, and 84% for rural hospitals. For applications for FY 2011 reclassification and subsequent fiscal years, the average hourly wage standards will be 88% for urban and group reclassifications and 86% for rural hospitals.

Proposed Changes to LTCH PPS, SNF PPS and IRF PPS

CMS also proposes an update to Long-Term Care Hospital Prospective Payment System ("LTCH PPS") rates of 2.4%, less an adjustment of 1.8% for FY 2010 to account for coding practices that do not reflect increases in the severity of patients' illnesses. CMS proposes to continue using the FY 2002-based rehabilitation, psychiatric, long term care ("RPL") hospital market basket to update the LTCH PPS for rate year 2010.

In a separate proposed rule, published in the *Federal Register* on May 12, 2009, CMS proposes a 3.3% reduction in payments under the Skilled Nursing Facilities Prospective Payment System ("SNF PPS") by recalibrating the case-mix indexes ("CMIs") to correct a January 2006 adjustment to the CMIs, resulting in over a $1 billion decrease. This reduction is offset by a proposed 2.1% increase in payments to SNFs based on market basket increases, totaling approximately $660 million. If finalized, the SNF PPS rule would reduce payments to SNFs by nearly $390 million for FY 2010. All public comments regarding the proposed SNF PPS rule must be submitted to CMS by June 30, 2009.

Similarly, in a proposed rule published in the May 6, 2009, edition of the *Federal Register*, CMS updates elements of the Inpatient Rehabilitation Facilities Prospective Payment System ("IRF PPS"), including average length-of-stay values to better reflect the current cost of care in IRFs. CMS anticipates the total aggregate payments to IRFs in FY 2010 will not be affected. The updated payment rates would be effective for discharges occurring on or after October 1, 2009. Public comments regarding the proposed IRF PPS rule must be submitted to CMS by June 29, 2009.

Proposals for Critical Access Hospitals

Included with proposals regarding hospitals exempt from IPPS, CMS has proposed one regulatory revision and solicited comments on another as a result of its recognition that critical access hospital ("CAH")-owned clinical laboratories and ambulance services are paid a higher rate by Medicare than free-standing clinical laboratories and ambulance services. CMS proposes that clinical laboratories owned and operated by a CAH must meet provider-based

rules in order to receive cost-based payment from Medicare and has solicited comments as to whether an ambulance service owned and operated by a CAH must meet the provider-based rules in order to receive cost-based payments.

Confusingly, CMS has also proposed what appears to be a less restrictive method for CAHs to provide clinical laboratory services and receive cost-based payment. The proposal is to allow CAHs to receive cost-based payment for outpatient clinical diagnostic laboratory tests furnished to an individual if the individual is an outpatient of the CAH and is receiving outpatient services in the CAH on the day the specimen is collected OR if an employee of the CAH collects the specimen (even if the individual is not on the premises when the specimen is drawn). This proposal anticipates that the CAH must and will meet the provider-based criteria.

***

Should you have any questions, please do not hesitate to contact one of our healthcare attorneys at the offices below.

H E A L T H C A R E C O N T A C T S

BIRMINGHAM, AL

Matthew A. Aiken
205.226.3425
maiken@balch.com

Colin H. Luke
205.226.8729
cluke@balch.com

Jack B. Levy
205.226.8750
jlevy@balch.com

MONTGOMERY, AL

Dorman Walker
334.269.3138
dwalker@balch.com

ATLANTA, GA

Richard D. Sanders
404.261.6020
rsanders@balch.com

Philip M. Sprinkle, II
404.261.6020
psprinkle@balch.com

GULFPORT, MS

H. Rodger Wilder
228.214.0412
rwilder@balch.com

JACKSON, MS

Dinetia Newman
601.965.8169
dnewman@balch.com