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CMS Publishes Inpatient Prospective Payment System (IPPS) FY 2010 Proposed Rule

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On May 1, 2009, CMS posted its proposed changes and updates to the Medicare Inpatient Patient Prospective Payment System (IPPS) that would apply beginning in fiscal year (FY) 2010. (See **federalregister.gov/OFRUpload/OFRData/2009-10458_PI.pdf**) Comments are due by June 30, 2009. The proposed rule:

- Projects that the market basket update used to adjust hospital payments will be:
  - 2.1 percent for hospitals that successfully report quality measures in FY 2009; and
  - 0.1 percent for hospitals that do not successfully report the quality measures in FY 2009.

  The projected increases would be almost entirely offset by CMS's 1.9 percent documentation and coding adjustment, which is intended to reduce overpayments that would otherwise occur as a result of the transition to the new MS-DRG system.
- Would raise the outlier threshold to $24,240.
- Would reduce the labor related share from 69.7 percent to 67.1 percent.
- Would reassign certain orthopedic procedures to higher paying MS-DRGs.
- Would continue the phase-in of changes in budget neutrality adjustments to the rural and imputed floors. In FY 2009, CMS began phasing out the national budget neutrality adjustment to the rural and imputed floors, and phasing in a state-based budget neutrality adjustment. For FY 2010, CMS proposes to increase the contribution of the state level adjustment to 50 percent (the FY 2009 budget neutrality adjustment was 80 percent national, and 20 percent state-based).
- Pursuant to the FY 2009 Final Rule, would increase the average hourly wage comparison criteria for geographic reclassification to the following percentages:
  - 86 percent of the desired labor market area for individual urban

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hospitals;

  - 86 percent of the desired labor market area for individual rural hospitals; and
  - 84 percent of the desired labor market area for county group hospitals.

- Discusses several examples of new technology that may qualify for add-on payments beginning in FY 2010.
- Would change the Disproportionate Share Hospital (DSH) adjustment by:
  - Including Labor and Delivery patient days in the Medicare fraction of the DSH calculation;
  - Excluding observation days from all components of the DSH calculation; and
  - Allowing providers to determine the number of days in the numerator of the Medicaid fraction on the basis of (1) date of discharge, (2) date of admission, or (3) dates of service.
- Would "clarify" the definition of a new medical residency program for GME purposes by limiting that term to only programs that receive initial accreditation for the first time.
- Would amend the Emergency Medical Treatment and Labor Act (EMTALA) regulations regarding the waiver of EMTALA sanctions in an emergency area during an emergency period. Under the proposed rule, a waiver of EMTALA sanctions could be issued for a portion of an emergency area or emergency period. The proposed rule would limit waivers of EMTALA sanctions to only those hospitals that, when making a potentially inappropriate transfer or redirection of an individual, do not discriminate on the basis of the individual's source of payment or ability to pay.
- Would allow Critical Access Hospitals (CAHs) to receive reasonable cost-based payments for laboratory services when the patient is not present in a CAH at the time that the laboratory specimen is collected.
- Delays a planned phase-out of the indirect medical education (IME) capital adjustment. Pursuant to the American Recovery and Reinvestment Act of 2009 (ARRA), hospitals will receive the full capital IME adjustment for 2009. CMS is soliciting public comments with respect to its implementation of the ARRA provision.
- Would modify the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative by:
  - Adding four new measures for which hospitals must submit data under RHQDAPU;
  - Requiring providers that CMS determines to have failed to meet RHQDAPU validation requirements to submit additional documentation with their reconsideration requests;
  - Establishing that hospitals must submit a RHQDAPU participation form within 180 days of receiving a new CMS Certification Number; and
  - Increasing the number of records randomly validated by CMS under the RHQDAPU program from 5 to 12 per quarter.