Regulatory Advisory

AHA
Advancing Health in America

AHA's Regulatory Advisory, a service to AHA members, will be produced whenever there is a significant regulatory development that affects the job you do in your community. (Call 202-626-2298 if you do not receive all nine pages of this fax.)

Medicare Inpatient PPS: The Final Rule for FY 2004

A Message to AHA Members:

On August 1, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the final rule implementing fiscal year (FY) 2004 changes to the hospital inpatient prospective payment system (PPS). The rule revises inpatient PPS operating and capital payments, and finalizes changes to the diagnostic-related groups (DRGs), wage index, post-acute care transfer policy, outliers, new technologies, graduate medical education, payments to critical access hospitals, and other policies related to Medicare reimbursement for acute care hospitals. The new provisions take effect October 1, 2003.

The final regulation adopts a number of changes suggested by the AHA in response to CMS's May 19 notice of proposed rulemaking. Our July 2 comment letter and July 8 technical addendum are at www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/comment/2003/cl030702inpatient.html. Here are some highlights of the rule:

- **At the AHA's urging – and in response to your strong advocacy efforts – CMS lowered the outlier threshold to $31,000 for FY 2004.** This is a decline from the current FY 2003 threshold of $33,560, and is significantly lower than CMS's proposed threshold of $50,645. This move will help ensure that America's hospitals receive the full amount that is set aside to treat Medicare's sickest patients.

- **In a disappointing move, CMS expanded the post-acute care transfer provision to an additional 21 DRGs, resulting in an estimated $205 million a year payment cut to hospitals.** Beginning October 1, 29 DRGs will be subject to the post-acute care transfer provision – two of the original 10 DRGs no longer will qualify under new criteria adopted by CMS. The AHA maintains that this policy is not in the best interests of patients or caregivers, as it undermines the basic principals of the PPS and penalizes hospitals for providing the right care, at the right time, in the right place.

- As mandated by law, the rule will increase inpatient hospital payments for FY 2004 by 3.4 percent, which is the full change in the market basket – a measure of inflation in goods and services used by acute care hospitals. The AHA still is concerned, however, that Congress may adopt cuts to the inpatient update as part of the currently debated Medicare prescription drug bill legislation. **The AHA will strongly urge**

Congress to eliminate the House provision which would cut inpatient PPS payments by $12 billion over 10 years by providing an update of market basket minus 0.4 percentage points – a level less than inflation. Hospitals are unable to absorb further reductions in reimbursement if they are to maintain vital health care services needed by patients and the community.

The final rule also confirms that CMS will not adopt the Office of Management and Budget's revised definitions of Metropolitan Statistical Areas and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas for the FY 2004 wage index.

Final changes to the rule can be found at www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/register/arfedregister.html. After reviewing this advisory, check off the following items from your to-do-list:

- ✓ Share this advisory with your senior management team. Determine how changes to the inpatient PPS will affect your FY 2004 Medicare revenue.

- ✓ Share this advisory with your chief financial officer, and analyze what impact the expanded post-acute care transfer provision and the new outlier threshold would have on your projected Medicare payments.

- ✓ Share this advisory with your billing and medical records departments and clinical leadership to ensure they are aware of all aspects of this rule, especially the new payment provisions for the bone graft fusion devise InFUSE™.

- ✓ Ask your senators and representative to help eliminate cuts, as well as strengthen other hospital provisions in the Medicare prescription drug bill. Specifically, urge them to ask House and Senate conferees to:

    - **Eliminate** inpatient update reductions in the House bill.
    - **Restore** funding for Indirect Medical Education.
    - **Include the House** provision on the Medicaid DSH "cliff" and the **Senate** low-DSH provision.
    - **Protect** Senate language regarding niche providers.
    - **Maintain** important rural and other urban payment improvement provisions in both House and Senate bills

The AHA will continue to work with you to obtain adequate Medicare payment, so that your hospital and hospitals across the country have the resources needed to continue providing quality health care to America's communities.

Sincerely,

Rick Pollack
Executive Vice President

August 20, 2003

Regulatory Advisory

AHA
Advancing Health in America

August 20, 2003

Medicare Inpatient PPS: The Final Rule for FY 2004

Background

On August 1, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the final rule implementing fiscal year (FY) 2004 changes to the hospital inpatient prospective payment system (PPS). The rule revises inpatient PPS operating and capital payments, and finalizes changes to the diagnostic-related groups (DRGs), long-term care DRGs and relative weights, wage index, post-acute care transfer policy, outliers, new technologies, graduate medical education, the counting of hospital beds and patient days, payments to critical access hospitals (CAHs), and other policies related to Medicare reimbursement for hospitals. The new regulations take effect October 1, 2003.

The final regulation adopts a number of changes suggested by the AHA in response to CMS's May 19 notice of proposed rulemaking. Our July 2 comment letter and July 8 technical addendum are at www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/comment/2003/cl030702inpatient.html.

PPS Rate Update

Under current law, the FY 2004 inpatient update equals the full change in the hospital market basket – a measure of inflation in goods and services used by acute care hospitals. The forecasted market basket for FY 2004 is 3.4 percent, down slightly from the 3.5 percent forecast in the proposed rule.

The final operating standardized amounts are:

National	**Large Urban**	**Other Urban & Rural**
Labor-Related	$3,146.06*	$3,096.25*
Non-Labor Related	$1,278.78	$1,258.54
Puerto Rico		
Labor-Related	$1,510.12	$1,486.22
Non-Labor Related	$607.86	$598.24

*** Note that the numbers in Table 1A on page 45488 of the August 1, 2003 *Federal Register* are incorrect. The correct rates can be found on page 45479. CMS indicated on a Hospital Open Door Forum call that it will publish a correction notice in the *Federal Register* confirming the correct rates that are listed above.**

The final capital standard federal payment rate for FY 2003 is $415.47, and $203.15 for Puerto Rico.

Also beginning October 1, hospitals located in other urban and rural areas no longer will receive

the large urban standardized amount. Congress adopted this provision for inpatient discharges only from April 1-September 30. However, both the House and Senate versions of the Prescription Drug Bill call for equalizing the standardized amount for rural and small urban hospitals immediately beginning in FY 2004. The AHA will continue to strongly advocate for inclusion of this provision in a final package.

After taking into account all changes in the final rule, the estimated average per case increase from FY 2003 to FY 2004 is 1.8 percent for all hospitals – 1.2 percent for urban hospitals and 5.8 percent for rural hospitals. For a more detailed look at the financial impact on types of hospitals please refer to the impact analysis in Table I of the final rule (page 45661).

Outliers

In a move strongly advocated by the AHA, CMS lowered the outlier threshold to $31,000 for FY 2004. This is a decline from the current FY 2003 threshold of $33,560, and is significantly lower than CMS's proposed threshold of $50,645. The lowering of the threshold will help ensure that America's hospitals receive the full amount that is set aside to treat Medicare's sickest patients.

Outlier payments are made only if the DRG payment, plus indirect medical education (IME) and disproportionate share hospital (DSH) payments, plus any payments for new technologies, plus some threshold (set annually by CMS) is exceeded. Created by Congress to limit hospitals' financial risk while ensuring that elderly patients with especially serious illnesses receive appropriate care, outlier payments are a critical and necessary component of any PPS. CMS's proposed outlier threshold of over $50,000 – an increase of over 50 percent from the 2003 level – would have made it extremely difficult for hospitals to qualify for these payments, and would have put them at greater risk when treating high cost cases.

In its July 8 technical addendum, the AHA argued that the threshold should be lowered to $30,930, a number derived from an extensive data analysis that calculated the most valid 2004 threshold given policy changes adopted in a final outlier regulation published on June 9, 2003. This outlier regulation significantly changed outlier payments, including adopting the use of more recent data for determining a hospital's cost-to-charge ratio, eliminating the use of the statewide average ratio floor and reconciling outlier payments for certain hospitals. The AHA argued that the threshold amount must be lowered in response to the new provisions on outlier payments.

Transfer Payment Policy

Although strongly opposed by the AHA, CMS expanded the post-acute care transfer policy to an additional 21 DRGs, resulting in an estimated $205 million a year cut to hospitals.

Since 1999, the post-acute care transfer policy has applied to 10 DRGs. Based on CMS's newly adopted criteria (below), two of the original 10 DRGs no longer will qualify, resulting in 29 DRGs subject to the post-acute care transfer policy in FY 2004 and beyond. The AHA believes that this policy undermines the basic principles of the PPS and penalizes hospitals for providing the right care, at the right time, in the right place.

CMS finalized the criteria it used to select which DRGs will be included in the post-acute care transfer policy expansion:

1. The DRG must have at least 14,000 cases of post-acute care transfers;
2. The DRG must have at least 10 percent of its post-acute care transfers occurring before

the mean length of stay for the DRG;
3. The DRG must have a length of stay of at least three days; and
4. The DRG must have at least a 7 percent decrease in length of stay over the past five years (1998 – 2003).

In order to improve the year-to-year stability of DRGs subject to the policy, CMS added a requirement in the final rule that these four criteria must be met over the two most recent years for which data are available. After applying these new criteria and correcting programming errors that allowed inpatient-exempt units to be included in the analysis, CMS made a number of changes from its proposed rule. Specifically:

- Two of the original 10 DRGs subject to the provision no longer qualify and have been removed – DRG 263 and 264 (Skin Graft and/or Debridement).
- Two of the proposed 19 DRGs in the May 19 notice of proposed rulemaking would no longer qualify and have been removed – DRG 243 (Medical Back Problems) and 462 (Rehabilitation).
- Four additional DRGs now qualify and have been added – DRG 88 (Chronic Obstructive Pulmonary Disease), DRG 127 (Heart Failure and Shock), DRG 294 (Diabetes Age >35); DRG 395 (Red Blood Cell Disorders, Age >17). Note that these four DRGs are new and were not included in the May 19 proposed rule.

Beginning October 1, the 29 DRGs subject to the transfer policy are:

DRG	DESCRIPTION
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT
24	SEIZURE & HEADACHE AGE >17 W CC
25	SEIZURE & HEADACHE AGE >17 W/O CC
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE
127	HEART FAILURE & SHOCK
130	PERIPHERAL VASCULAR DISORDERS W CC
131	PERIPHERAL VASCULAR DISORDERS W/O CC
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC
236	FRACTURES OF HIP & PELVIS
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY
277	CELLULITIS AGE >17 W CC
278	CELLULITIS AGE >17 W/O CC
294	DIABETES AGE >35
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC
395	RED BLOOD CELL DISORDERS AGE >17
429	ORGANIC DISTURBANCES & MENTAL RETARDATION
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS
483	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK

The agency will review and update this list periodically to assess whether additional DRGs should be added or whether existing DRGs should be removed.

Finally, CMS also changed its general transfer policy – in addition to its post-acute care transfer policy. It has adopted the proposal to expand the current transfer policy to include all patients that are discharged under code "07 – Left Against Medical Advice (LAMA)." Thus, if a patient leaves a hospital in LAMA status and is later readmitted to a second hospital on the same day for the same condition, the discharge will be counted as a transfer unless the transferring hospital can demonstrate that the patient's treatment was completed when the patient left the hospital. Fiscal intermediaries will be responsible for notifying the transferring hospital that a same-day admission has occurred, and the hospital will need to submit an adjustment claim for the patient or present documentation that the patient's care was completed before discharge.

Exclusion of CAH Wage Data

Beginning in FY 2004, CMS will exclude from the wage index calculation the wages and hours for all hospitals currently designated as critical access hospitals (CAHs).

The wage index adjusts DRG payments to reflect the difference in labor costs across geographic areas. In its proposed rule, the agency requested public comments on whether wage data from CAHs should be excluded from the wage index. Historically, the wage index has included wage data for all facilities that were inpatient PPS hospitals during the cost reporting period used in calculating the wage index – even if these facilities were subsequently converted to CAH status. The AHA's comment letter said that we would support the removal of CAHs from the wage index, but were concerned about the immediate financial impact this might have on all hospitals in FY 2004. We recommended that CMS examine the impact of removing CAH wage data and make this analysis available for notice and public comment before making any changes.

In the final rule, CMS analyzed the impact of removing CAHs from the 2004 wage index and found that the wage data for CAHs, in general, are significantly different from other short-term hospitals, and that removing CAHs from the wage index would have a minimal redistributive effect on Medicare payment to hospitals – with only 10 areas experiencing a decrease in their wage index values of greater than 0.30 percent.

Other Wage Index Changes

The final rule will base the FY 2004 wage index on data from hospital cost reporting periods beginning on or after October 1, 1999 and before September 30, 2000 (FY 2000 cost reports), just as the FY 2003 wage index was based on FY 1999 data.

- Occupational Mix Adjustment. By law, CMS is required to collect occupational mix data from all inpatient PPS hospitals by September 30, 2003, for incorporation into the FY 2005 wage index. On April 4, 2003, the agency published a notice of intent to collect 2002 data from hospitals, and provided an opportunity to comment on a proposed survey tool (AHA's detailed comment letter of June 3, 2003 on the proposed survey can be found on www.aha.org). Unfortunately, CMS again failed to publish a detailed proposed methodology illustrating how the occupational mix index would be calculated and how it would be used to adjust the overall wage index. The agency said it plans to publish a separate final notice of intent in the *Federal Register*, with a 30-day comment period. This notice would include revisions to the survey as well as a detailed timetable. The inpatient final rule also states that the methodology to calculate the occupational mix index and an explanation as to how it will be used to adjust the overall wage index will not be finalized until publication of the FY 2005 inpatient rule.

- Metropolitan Statistical Areas. On June 6, 2003, the Office of Management and Budget issued a bulletin announcing revised definitions of Metropolitan Statistical Areas, as well as new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. These definitions recognize 49 new Metropolitan Areas, 575 new Micropolitan Areas and extensively revise the composition of many of the existing Metropolitan Areas. CMS confirms in the August 1 inpatient PPS final rule that the soonest these new definitions would be used is for the FY 2005 wage index. The agency also said it would broadly review and assess the new definitions, and engage in notice and comment rulemaking prior to adopting any changes. According to CMS, hospitals considering geographic reclassification in FY 2005 should continue to submit applications based on the current metropolitan statistical areas to the Medicare Geographic Classification Review Board (MCGRB) by September 2, 2003.

- Timetable for Updating the Wage Index. Beginning with the FY 2005 wage index, CMS will adopt a new timeline to gather and review wage data. The most significant modification to the timeline presented in the proposed rule – and in response to the AHA's concerns – is that CMS will allow hospitals a full 45-day period, rather than the shortened 30-day period, to review and submit corrected data. Although instructions and a detailed timeline will be released in an upcoming Program Memorandum, a summary of the general wage index development process can be found on page 45404 of the final rule.

- Removal of Wage Cost for RHCs and FQHCs. The rule finalizes the proposal to remove non-physician Part B salaries, hours and wage-related costs associated with Rural Health Clinics (RHC) and Federal Qualified Health Centers (FQHC) in calculating the FY 004 hospital wage index. This change will refine the wage index by excluding costs Medicare already pays for outside of the inpatient PPS.

- Paid Hours. In a move supported by the AHA, CMS will not exclude paid lunch hours, military leave or jury duty hours from calculation of the wage index. The AHA and others questioned whether exclusion of this data would result in a more accurate wage index, and expressed concern that additional data collection effort for providers would outweigh any benefits achieved.

Add-on Payments for New Technology

Two items will receive new technology add-on payments in FY 2004: 1) Xigris® to treat severe sepsis, and 2) InFUSE™ a bone graft fusion device approved for use in single-level, anterior lumbar spinal fusions. Approximately $15 million (down from $75 million in FY 2003) has been carved out of the FY 2004 inpatient base rate to fund add-on payments for these qualifying technologies.

The agency also adopted as final a proposal making it easier for drugs, biologicals and devices to qualify for new technology add-on payments, beginning in FY 005. Specifically, CMS will lower the high-cost threshold from one standard deviation to 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned. These technologies, however, still would need to meet CMS's other eligibility requirements to ensure that the item is "new" and provides a "significant clinical improvement" over existing technologies in the diagnosis or treatment of patients.

CAH Outpatient Clinical Diagnostic Laboratory Tests

Although the AHA strongly opposed it, CMS has adopted clarifying language that patients must be "physically present in a critical access hospital," rather than solely an outpatient of a CAH, when a laboratory specimen is collected in order for the hospital to receive cost-based reimbursement for the lab service. If the patient is not "physically present," the CAH will receive Medicare reimbursement for the lab service based on the laboratory fee schedule. The agencies policies were unclear as to how Medicare would pay for laboratory services that a CAH furnished to beneficiaries who are outpatients of the CAH, but whose labs were drawn in other settings (such as rural health clinics, skilled nursing facilities or a patient's home). The AHA argued that CMS's proposed revision was not a clarification of current policy, but rather an implicit change contrary to the spirit of the creation of the CAH program, and that it would threaten the financial stability of the CAHs. CMS disagreed and finalized its "physically present" criteria effective October 1.

Available Beds and Patient Days

The rule finalizes changes in the counting of available beds and patient days used in the calculation of IME and DSH payments. In general, beds and patient days that are counted for IME and DSH payments are limited to those that would be directly included in determining the allowable costs of inpatient hospital care payable under the inpatient PPS of the Medicare cost report.

- Dual-Eligible Patient Days. The final rule *does not change* how dual-eligible patients who have exhausted their Medicare coverage are counted for DSH payments. CMS proposed excluding these patients from the Medicare fraction and counting them in the Medicaid fraction of the DSH patient percentage. The AHA opposed CMS's proposed change, arguing that it is inconsistent with statutory intent, would place new regulatory and administrative burdens on hospitals, and likely would result in a reduction in DSH payments. CMS said it is still reviewing comments on this issue and will address it in a separate document.

- Unoccupied Beds. The final rule *does not change* the current method of counting unoccupied beds. CMS proposed determining bed availability based on whether the unit was used to provide patient care at any time during the preceding three months. The agency still is reviewing the numerous comments it received, and said that it will address the comments in a separate document.

- Non-acute Care Beds. CMS adopted the proposal to exclude beds and patient days attributable to non-acute care units or wards (such as psychiatric and rehabilitation units, bassinets in the newborn nursery, and custodial care beds) from the calculation of IME and DSH payments.

- Observation and Swing Beds. The final rule adopts CMS's proposed policy to exclude observation beds and swing-beds from the counts of available beds and patient days. However, CMS deferred final action on how to deal with observation bed days of patients who are later admitted to the hospital, because the agency is still in the process of reviewing comments on the issue.

- Labor, Delivery and Postpartum (LDP) Beds. The rule adopts as final CMS's policy that hospitals must apportion the days and costs of a patient stay between the labor/delivery ancillary cost centers and the routine adults and pediatrics cost centers, based on the percentage of time during the entire stay associated with these various services.

- Demonstration Project Days. The final rule adopts CMS's proposal to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in calculating a hospital's DSH patient percentage.

- Medicare+Choice (M+C) Days. CMS also deferred finalizing provisions related to counting M+C days for purposes of the IME and DSH adjustments, and announced that it will address comments related to this policy in a separate document.

Nursing and Allied Health Education Activities

In the final rule, CMS significantly changed the policy governing payments to hospitals for provider-operated nursing and allied health education programs. In the past, Medicare excluded these costs from the inpatient PPS, and paid separately its share of reasonable costs associated with approved educational activities. CMS clarified in the final rule what constitutes an approved educational activity, and adopted, with modification, the proposal to distinguish between continuing educational activities and approved educational programs. Under the rule, continuing educational activities are not eligible for reasonable cost reimbursement.

In a significant positive change from the proposed rule – and argued by AHA in its comment letter – clinical pastoral education (CPE) programs and pharmacy residency programs will receive cost-based reimbursement under certain circumstances. Specifically, hospitals may receive cost-based reimbursement for CPE hours that are *not* prerequisites for *any* academic degree, *and* are provided to students in order to obtain board certification in hospital chaplaincy. Additionally, pharmacy practice residency training programs (but not specialized pharmacy residencies) that are accredited, under direct operation by a provider, and lead to certification that is a requirement for employment would be eligible for cost-based reimbursement. Both provisions are based on the "industry norm," and what is currently required for an individual to practice *and* begin employment in a specialty.

Counting of Residents

Against the AHA's recommendation, the agency adopted proposed changes in how it will count residents that spend time training in non-hospital sites. Currently, hospitals may count, for the purposes of Medicare IME and GME payments, the time residents spend training in non-hospital sites if certain conditions are met, including the requirement that hospitals incur all or substantially all of the costs of training at the non-hospital site. Under the final rule, CMS also will require that a hospital must have been continuously incurring direct GME costs of residents training in a particular program since the date the residents first began training in the program in order for the hospital to count the resident toward IME and GME payments. However, in response to AHA's concerns, CMS said these changes will be implemented prospectively, beginning in FY 2004. And, it will grandfather particular residents who began training in a program on or before October 1, 2003 so that they may finish their training.