American Hospital Association

Regulatory Advisory

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Medicare Inpatient PPS: The Final Rule for FY 2005

A Message to AHA Members:

The Centers for Medicare & Medicaid Services (CMS) published in the August 11 *Federal Register* the final rule implementing fiscal year (FY) 2005 changes to the Medicare hospital inpatient prospective payment system (PPS). The rule codifies a number of hospital provisions in the Medicare Modernization Act (MMA), revises inpatient operating and capital PPS payments, and finalizes a number of key policy changes, including those related to the hospital wage index, outlier payments, graduate medical education, and "hospital in a hospital" payments. The new provisions take effect October 1, 2004.

The final regulation adopts many of the AHA's recommendations to CMS' May 18 proposed rule. Our five comment letters on the regulation may be found at www.aha.org/aha/advocacy-grassroots/advocacy/jsp/commentletter.jsp?pyear=2004.

As mandated in the MMA, the final rule increases a hospital's FY 2005 payments by 3.3 percent – the full change in the hospital market basket – if the hospital submits data on 10 specific clinical measures of quality care. Hospitals that do not submit quality data would receive a reduced payment update to reflect market basket less 0.4 percentage points, or 2.9 percent. Nearly all eligible hospitals have volunteered to provide quality data and will receive the full 3.3 percent update. Given all the changes in the regulation, including additional funding from the MMA, the estimated average hospital payment increase will be 5.8 percent.

Other key provisions of the rule include:

- **Beginning October 1, CMS will adopt labor market areas that may substantially change your current wage index and thus your Medicare hospital payment.** At the urging of the AHA and others, the agency will implement protections for certain hospitals facing losses due to this provision. Specifically, CMS will adopt a blended wage index in 2005 for those hospitals that experience a decrease in their wage index solely because of the new labor market areas (but not due to any other reasons, such as a decline in the hospital's average hourly wage); will allow "urban" hospitals redesignated as "rural" to maintain the wage index where they are currently assigned for three years; will allow critical access hospitals (CAH) redesignated from "rural" to "urban" areas to seamlessly retain their special payment status through December 31, 2005; and will allow hospitals that applied for FY 2005 reclassification the opportunity to withdraw their application if the change does not benefit their wage index.

- **In a move strongly advocated by the AHA, CMS has lowered the outlier threshold to $25,800 for FY 2005.** This is a decline from the current FY 2004 threshold of approximately $31,000, and is significantly lower than CMS' proposed threshold of $35,085. This decline will help ensure that additional payments are available for the treatment of medically complex patients.

- **The rule modifies several policies affecting arrangements in which a long-term care hospital (LTCH) is located within another hospital**. While the AHA is pleased that CMS has deferred action on significant policy changes for one year, we remain concerned that appropriate, clear patient and facility criteria for LTCH care have not been identified. As requested by the AHA, the rule does not change the current guidelines regarding common ownership. However, in a disappointing move, CMS will proceed with its proposal to limit the number of patients that can be referred from a "host hospital" by imposing a downward payment adjustment for certain patients. This change unnecessarily and inappropriately interferes with clinical decision-making, and the ability to ensure patients receive the right care in the right place. The AHA will issue a separate *Regulatory Advisory* detailing the LTCH provisions.

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.

- ✓ Ask your chief financial officer to determine how changes to the inpatient PPS will affect your FY 2005 Medicare revenue. Specifically, calculate the financial impact of your new wage index (located in Table 2 beginning on page 49295 of the final rule). Identify whether your facility qualifies for special payment protections owing to the new labor market areas, and identify the impact of losing these protections in the future.

- ✓ Determine whether your hospital qualifies for reclassification based on the numerous changes made to the geographic reclassification policy and the new labor market areas. **Reclassification requests for FY 2006 are due to the Medicare Geographic Classification Review Board by September 1, 2004.**

- ✓ Determine if your hospital is one of the few that may still qualify to make changes to its final FY 2005 wage index. For example, certain hospitals may terminate or reactivate their reclassifications. Additionally, certain qualifying hospitals may notify CMS if they would like to waive their reclassification or redesignation in order to instead receive the out-migration adjustment. **These requests are due by September 10**.

- ✓ Share this advisory with your billing and medical records departments and clinical leadership to ensure they are aware of all policy changes impacting diagnosis related group coding. Ensure they are aware of items eligible to receive new technology add-on payments in FY 2005.

- ✓ If you are a CAH being re-designated to an "urban" area, initiate steps to obtain a "rural" designation by your state.

- ✓ If your hospital has a LTCH unit or satellite, please watch for the upcoming *Regulatory Advisory* detailing LTCH changes.

While the rule provides some important payment assistance to the nation's hospitals, we are becoming increasingly concerned about the effectiveness of the now 20-year old inpatient PPS. Yearly policy adjustments that redistribute payments among hospitals are "Band-aid" fixes to a progressively more broken payment system. The AHA will work with Congress and the administration to ensure 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 25, 2004

American Hospital Association

Regulatory Advisory

August 25, 2004

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Background

The Centers for Medicare & Medicaid Services (CMS) published in the August 11 *Federal Register* the final rule implementing fiscal year (FY) 2005 changes to the hospital inpatient prospective payment system (PPS).

The rule also implements many key hospital provisions of the Medicare Modernization Act (MMA), including a permanent equalization of the standardized amount, a lowering of the labor-related share to 62 percent of the standardized amount for hospitals in low wage areas, enhanced Medicare disproportionate share payments (DSH) for hospitals with fewer than 100 beds, and significant program improvements for critical access hospitals (CAHs). In addition, it revises inpatient PPS operating and capital payments and, for the first time, creates a link between the hospital payment update and submission of quality data.

In addition, CMS also finalizes significant policy changes related to the hospital wage index – including substantial revisions to metropolitan statistical areas (MSAs), the implementation of an occupational mix adjustment, and changes to geographic reclassification. Other key policy changes impact acute-care diagnosis related group (DRG) and long-term care hospital DRG coding, classifications and weights; outlier payments; new technology payments; payments to hospitals for the direct and indirect costs of graduate medical education; the counting of hospital beds and patient days; and regulations governing hospitals within hospitals.

We are pleased that the final rule adopts a number of changes suggested by the AHA. Our five comment letters on the proposed rule are located at www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/comment/2003/cl030702inpatient.html.

The new regulations take effect October 1, 2004. The final rule is available at www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/register/arfedregister.html.

PPS Rate Update

The FY 2005 inpatient update, as dictated in the MMA, is equal to the full change in the hospital market basket – a measure of inflation in goods and services used by acute care hospitals – for those hospitals that submit data on 10 measures of quality care. The forecasted market basket rate for FY 2005 is 3.3 percent. Hospitals that do not submit quality data will receive an update of market basket minus 0.4 percentage points, or 2.9 percent. As of publication of the final rule,

approximately 95 percent of hospitals will qualify for the full Medicare payment update. (See section on **Reporting of Hospital Quality Data.**)

Beginning April 1, 2004, the MMA permanently raised the standardized amount for other urban and rural hospitals to the large urban rate (approximately a 1.6 percent increase). This provision also equalizes the Puerto Rico-specific urban and other area rates. All hospitals have been receiving a standardized amount based on the large urban rate since April 1, 2003 due to temporary provisions in the Consolidated Appropriations Resolution of 2003 and the Welfare Reform Bill of 2003.

The MMA also instructs CMS to adjust the proportion of the PPS base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative difference in labor costs among geographic areas. Beginning October 1, 2004, the MMA authorizes CMS to use 62 percent as the labor-related share for all hospitals that benefit – or those hospitals with a wage index less than 1.00. All other hospitals – or those with a wage index greater than 1.00 – will be held harmless from this provision and will maintain the current labor share of 71.1 percent.

The final operating standardized amounts for FY 2005 are as follows:

For Hospitals with an Area Wage Index Greater than 1.00
(71.1 Percent Labor Share/28.9 Percent Nonlabor Share)

Full Update (3.3 percent) (applicable for hospitals submitting quality data)		**Reduced Update (2.9 percent)** (applicable for hospitals not submitting quality data)	
Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
$3,238.73	$1,316.45	$3,226.19	$1,311.35

For Hospitals with an Area Wage Index Less than 1.00
(62 Percent Labor Share/38 Percent Nonlabor Share)

Full Update (3.3 percent) (applicable for hospitals submitting quality data)		**Reduced Update (2.9 percent)** (applicable for hospitals not submitting quality data)	
Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
$2,824.21	$1,730.97	$2,813.27	$1,724.27

For hospitals in Puerto Rico, the MMA mandates that the FY 2005 payment rate equal the sum of 25 percent of a Puerto Rico specific rate, which reflects the base year average costs per case of Puerto Rico hospitals, and 75 percent of the federal national rate. This is a change from a rate based on 37.5 percent of the local payment rates and 62.5 percent of the federal rate, which is in effect from April 1, 2004 through September 30, 2004.

Final Rates for Hospitals in Puerto Rico

	Wage Index is Greater than 1.00		Wage Index is Less than 1.00	
	Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
National	$3,238.73	$1,316.45	$2,824.21	$1,730.97
Puerto Rico	$1,555.07	$625.96	$1,352.24	$828.79

The capital standard federal payment rate for FY 2005 is $416.63 and $199.01 for hospitals in Puerto Rico.

Financial Impact on Hospitals

After taking into account all the changes in the final rule, CMS estimates the average per case increase from FY 2004 to FY 2005 is 5.8 percent for all hospitals – 5.7 percent for urban hospitals and 6.2 percent for rural hospitals. Detailed below is the financial impact for key groups of hospitals (for additional information regarding the financial impact by type of hospital refer to the impact analysis in Table I of the final rule on page 49758):

All Hospitals	5.8%
Urban Hospitals	5.7%
Large Urban	5.4%
Other Urban	6.1%
Rural Hospitals	6.2%

Reporting of Hospital Quality Data

The MMA stipulates that in order to receive a full Medicare inpatient update in FY 2005-FY 2007, inpatient PPS hospitals must submit data for 10 specific measures of care.[1] This provision does not apply to hospitals and hospital units excluded from the inpatient PPS (such as inpatient rehabilitation and psychiatric facilities, children's hospitals, and CAHs), nor does it apply to other payment systems, such as the outpatient PPS. In addition, by law, a hospital's participation (or failure to participate) will not affect its update in any subsequent fiscal year. As of publication of the final rule, 95 percent of hospitals will qualify for a full market basket update in FY 2005.

For more information on reporting hospital quality data for the 2005 update, please see the AHA's April 8 *Quality Advisory*, "The Quality Initiative: Full Medicare Inpatient Update Requirements and New Measures" at www.hospitalconnect.com/aha/key_issues/patient_safety/advocacy/040408qualityadvisory.html.

[1] These 10 measures are: *heart attack* – aspirin prescribed upon admission, aspirin prescribed upon discharge, beta blocker prescribed upon admission, beta blocker prescribed upon discharge, and ACE Inhibitor prescribed for left ventricular systolic dysfunction (LVSD); *heart failure* – assessment of left ventricular function and ACE inhibitor prescribed for LVSD; and *pneumonia* – antibiotic timing (prescribed within four hours), oxygenation assessment, and delivery of pneumonia vaccine.

In order for hospitals to receive the full market basket update in FY 2006 and FY 2007, CMS has adopted a validation process to confirm data submitted by hospitals. Specifically, 80 percent of the data elements submitted by a hospital on a sample of its records need to match the data elements abstracted by a CMS contractor hired to check its validity. For the annual payment update, the validation process will be restricted to the 10 measures, rather than applying to all measures submitted by a facility. Hospitals that fail this validation process will be able to appeal to their local Quality Improvement Organization to review the validation results.

The AHA remains concerned that hospitals may be penalized for unintentional errors in processing the data. We will continue to work with CMS and its contractors to help identify, communicate and correct problems that may arise in the data abstraction process.

Wage Index

The final rule adopts a number of significant changes to the hospital wage index, which adjusts DRG payments to reflect the differences in labor costs across geographic areas. These changes include the use of more recent wage data, the adoption of revised MSAs, the implementation of an occupational mix adjustment, an adjustment for the out-migration of hospital employees and significant changes to the rules surrounding geographic reclassifications, which may result in a substantial increase or decrease in your Medicare payments.

Updated Wage Data. The FY 2005 wage index will be based on wage data from hospital cost reporting periods October 1, 2000 to September 30, 2001 (FY 2001 cost reports), just as the FY 2004 wage index was based on FY 2000 data.

New Hospital Labor Markets. Beginning October 1, CMS will re-draw the lines of labor market areas to incorporate new 2000 census data. The AHA is pleased that CMS has chosen to adopt a number of transitional provisions to help mitigate some of the significant losses that would have been faced by many hospitals.

The wage index is calculated and assigned to hospitals based on the labor market area in which the hospital is located. In a budget neutral system, any changes to labor market areas will create a significant redistribution of Medicare payments. Beginning FY 2005, CMS will adopt, as proposed, the Office of Management and Budget's (OMB) new definitions of labor market areas based on 2000 census data. These new definitions include the creation of new "Core Based Statistical Areas" (CBSA), defined as "a geographic entity associated with at least one core of 10,000 or more residents, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." The new standards establish two categories of CBSAs:

- Metropolitan Statistical Areas (with populations of 50,000 or more people); and
- Micropolitan Statistical Areas (with populations from 10,000 to 49,999 people).

Currently, CMS defines hospital labor market areas for the purposes of the wage index based on Metropolitan Statistical Areas (MSA), Primary MSAs (PMSA) and New England County Metropolitan Areas (NECMA), which are typically deemed "urban," and combines all of the counties in a state outside these areas together to calculate a statewide rural wage index. CMS' new labor market areas create 49 new MSAs – which include the absorption of NECMAs as well as a significant reconfiguration of existing MSAs.

As supported by the AHA and others, CMS will not adopt the OMB definition of Micropolitan Statistical Areas for use in the Medicare payment system. Rather, hospitals located in these areas will remain part of the statewide rural area for purposes of inpatient PPS. Adopting this "third" labor area would have added another layer of complexity to an already complicated payment system. It would have dramatically altered a number of hospitals' wage indexes (62 percent of rural hospitals would experience a decrease in their wage index), and it would have potentially threatened the special payment status of a number of hospitals now deemed "rural" that could have be viewed as "urban" under the Micropolitan definition.

Given all the changes in labor market areas, as described above, CMS is implementing the following transitional policies:

- For hospitals that experience a decrease in their wage index solely because of the new labor market areas (but not due to any other reasons, such as a decline in a hospital's average hourly wage), CMS will implement for FY 2005 only a blended wage index consisting of 50 percent of the wage index value using the new MSAs and 50 percent of the wage index using the old MSAs. Specifically, CMS will take 50 percent of the wage index reflecting the MSA labor market definitions employed in FY 2004, and 50 percent of the wage index reflecting the new CBSA definitions. This blended transition will be budget neutral, such that the wage indexes of some hospitals will decline to limit the losses of those hospitals harmed by the census changes. Hospitals can find their FY 2005 hospital-specific blended wage index in Table 2 (beginning on page 49295) of the final rule.

- As a result of adopting these changes, a number of hospitals currently classified as "urban" would become "rural" in FY 2005. Moving from an MSA to the rural statewide average generally results in a significant decline in these hospitals' wage indexes. As supported by the AHA, CMS will allow current "urban" hospitals that would be re-designated as "rural" due to the new labor market areas to maintain the wage index of the MSA where they are currently assigned for three years. These hospitals, however, will no longer be considered by CMS as "urban." They will not be eligible, for example, for a large urban add-on under the capital PPS. The agency, however, will provide these hospitals with a three-year transition for their DSH adjustment. Specifically, in the first year, the hospital will receive an additional payment that equals two-thirds of the difference between the urban DSH payments and the rural DSH payments. In the second year, hospitals will receive one-third of the difference between the urban and rural DSH payments. Beginning in 2008, hospitals re-designated from urban to rural would receive their statewide rural wage index, although they are eligible to apply for reclassification both during the transition period as well as in subsequent years.

- CAHs re-designated to "urban" areas will retain their current CAH status, as requested by the AHA, through December 31, 2005, allowing time to obtain a state designation as "rural." Specifically, CAHs that in FY 2004 were located in a county that was not part of a MSA but as of FY 2005 were included as part of a MSA would be considered to meet the rural location requirement and, therefore, could continue participating without interruption as a CAH as the hospital obtains a rural designation from the state. This grandfathering provision is valid through December 31, 2005.

- In a move urged by the AHA, the agency will allow hospitals until September 10 to either terminate their reclassifications or redesignations, or reactivate a hospital's reclassification or redesignation if a hospital withdrew this reclassification or redesignation within 45 days of the May 18 proposed rule.

Occupational Mix. Beginning October 1, CMS will implement a blended wage index that incorporates a 10 percent adjustment to reflect the occupational mix of hospital employees. Specifically, a hospital's wage index will consist of 10 percent of an average hourly wage adjusted for occupational mix, and 90 percent of an average hourly wage unadjusted for occupational mix.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 requires CMS to construct an occupational mix adjustment to the wage index beginning in FY 2005. The intent of the adjustment is to control for the effect of hospitals' employment choices – such as the use of registered nurses versus licensed practical nurses or the employment of physicians – rather than geographic differences in the costs of labor on the wage index. CAHs are excluded from this adjustment because they are paid their reasonable costs rather than a prospective payment.

CMS developed the occupational mix adjustment based on survey data received from approximately 90 percent of hospitals. In the final rule, CMS applied the national occupational mix (or 1.00) to those hospitals that did not submit wage data so as not to penalize other hospitals in the labor market area. The agency says that it will not be administering another survey for the FY 2006 wage index, but that it may do so for FY 2007. The final rule states that any future survey would follow a 60-day notice period and would be based on a full year of hospital data.

Under the new adjustment, CMS indicates that over one-third of rural areas and more than one-half of urban areas will see a decrease in their wage index. In our comment letter, the AHA expressed concern about the accuracy and completeness of the data used to create the adjustment, and supported a blended wage index to dampen the financial impact on hospitals.

The Out-Migration of Hospital Employees. Section 505 of the MMA provides hospitals in lower wage areas an increase in their wage index if a significant number of hospital workers commute from the lower wage area to higher wage areas nearby. This adjustment is not budget neutral, so payment increases to qualifying hospitals do not result in corresponding decreases to other hospitals. CMS has used journey-to-work data compiled by the U.S. Census Bureau to implement the provision. By law, CMS is to set the threshold of hospital workers in a county that must be commuting to a higher wage area(s) in order for the hospitals in the county to receive the adjustment, but this threshold must not be less than 10 percent.

In the final rule, as proposed, CMS has adopted the minimum commuting threshold of 10 percent, and has determined that any difference – i.e., any amount greater than zero – between the wage index that applies to the county and the higher wage index areas is sufficient to qualify for the adjustment. The adjustment to the wage index is effective for FY 2005 through FY 2007. The AHA is pleased that CMS has adopted the minimum thresholds possible regarding the commuting patterns of hospital employees thus allowing the greatest number of hospitals to qualify for the adjustment.

CMS has identified 230 counties and 415 hospitals that qualify for the out-migration adjustment (identified by Table 4J on page 49580). However, by law, hospitals that receive this adjustment are not eligible for geographic reclassification. The rule indicates that 181 of these hospitals have been reclassified, and that CMS assumes that these hospitals will not wish to receive the out-migration adjustment**. Hospitals have until September 10 (or 30 days from the August 11 publication of the final rule) to notify CMS if they would like to waive their reclassification or redesignation in order to instead receive the out-migration adjustment**.

Geographic Reclassification. In general, a hospital may reclassify from one labor market area to another if it meets certain threshold requirements. One requirement is that a hospital's average hourly wage (AHW) be at least 108 percent (for urban hospitals) or 106 percent (for rural hospitals) of the AHW of hospitals in its area. In the proposed rule, CMS acknowledged that this requirement might disadvantage "dominant hospitals," or those hospitals that pay a substantial proportion of all the wages paid by all hospitals located in the hospital's geographic area. This is because the current formula includes the reclassifying hospital's own AHW in the denominator of the equation, thus making it more difficult to demonstrate that its wage costs are disproportionately high when compared to its neighbors.

In the final rule, CMS has made a significant change to the rules associated with reclassification. Beginning October 1, the agency has revised the wage comparison formula for all hospitals such that in order to qualify for reclassification, the reclassifying hospital's AHW must be at least 106/108 percent of the AHW of all other hospitals in the area in which the hospital is located. This change may make it possible for a number of new hospitals to qualify for reclassification.

Reclassification requests for FY 2006 are due to the Medicare Geographic Classification Review Board by September 1. The AHA is concerned that hospitals will have difficulty determining whether their AHW meets the new qualifications given that CMS has not provided hospitals the data and information necessary to calculate the AHW of all other hospitals in the labor market area. **We recommend that all hospitals that are on the cusp of the 106/108 rule apply for reclassification, and allow CMS to calculate whether they meet the new criteria.**

Additionally, and as strongly advocated by the AHA, CMS will allow hospitals until September 10 to either terminate their reclassifications, or reactivate a hospital's reclassification if a hospital withdrew this reclassification within 45 days of the May 18 proposed rule.

Finally, the rule adopts other key changes to the regulations governing reclassifications and redesignations below:

- Standardized Amount: Given that the MMA has equalized the standardized amount by raising the rate for rural and other urban areas to the large urban area rate, CMS has eliminated standardized amount reclassifications beginning October 1. However, given that some hospitals who were part of an urban county group reclassification are now unable to reclassify because of this change, yet other hospitals in the group are able to reclassify, CMS will allow hospitals meeting certain criteria to be assigned the wage index of the area identified in their FY 2004 or FY 2005 urban county group

reclassification application.[2] **Qualifying hospitals have until September 10 to notify CMS that they meet the criteria for this change to their wage index.**

- Reclassification of Urban RRCs: The rule equalizes the threshold that rural referral centers (RRC) located in both rural and urban areas must meet in order to reclassify. Previously, a rural referral center located in urban areas could only reclassify if its three-year AHW was at least 84 percent of the AHW of the hospitals located in the area to which the RRC sought reclassification. Rural RRCs had to meet a threshold of 82 percent. Beginning October 1, both rural and urban RRCs will have to meet the 82 percent threshold to reclassify.

- SCHs in Low Population Density States: The rule implements a temporary special provision that allows sole community hospitals (SCH) in low-density states (defined as fewer than 10 people per square mile, currently AK, MT, ND, SD and WY) to adopt the wage index of another geographic area within its state for three years from FY 2005-FY 2007.

- Dominant Hospitals and Hospitals in Single-Hospital MSAs: The rule does not adopt any specific changes to address the reclassification concerns of hospitals that supply the majority of hospital labor in a wage area and thus find it difficult to meet the 108/106 percent test. However, CMS' adoption of a revised formula that removes a hospital's own wages in determining whether the hospital meets 108/106 percent test should assist dominant hospitals in qualifying for reclassification (see above). Similarly, hospitals that are the only hospital in an MSA may qualify for an increase in their wage index under the out-migration adjustment (discussed above).

- All-Urban States: Beginning October 1, CMS will create an "imputed rural floor" for two all-urban states (NJ and RI), as well as a third state (MA) that has a rural area but where no hospitals are classified as rural.[3] The floor will be calculated by comparing the average ratio of the lowest-to-highest wage indexes of the three all-urban states to the ratio of the lowest-to-highest wage index of each of the three states individually. For each state, CMS would base the imputed floor on the higher of these two ratios. Any hospital in these three states with a wage index less than the imputed rural floor would be raised to the imputed rural floor, thus providing these hospitals – in a budget neutral manner – with higher Medicare reimbursement for a limited time period of three years (FY 2005–FY 2007). After this time, CMS will determine whether to make additional changes to the policy or to eliminate it.

[2] The criteria are as follows: 1) the hospital was part of an urban county group reclassification application for FY 2004 or FY 2005 that failed solely on the basis of the standardized amount criterion; 2) at least one-third of the hospitals that had been parties to the urban county group reclassification application have subsequently been reclassified for FY 2005 either through the regular reclassification process or the special one-time wage index appeal process under section 508 of the MMA; and 3) the hospital can demonstrate that the hospitals that have since reclassified to another area have a wage index at least 10 percent higher than the wage index of the MSA where the hospital is located.

[3] Puerto-Rico, which is all-urban, is excluded.

Outliers

In a move strongly advocated by the AHA, CMS has lowered the outlier threshold to $25,800 for FY 2005. This is a decline from the current FY 2004 threshold of approximately $31,000, and is significantly lower than CMS' proposed threshold of $35,085. This change will help ensure that additional payments are available for the treatment of medically complex patients. Outlier payments are made only if the DRG payment, plus indirect medical education, DSH and any new technologies payments exceed a threshold set annually by CMS.

In our comment letter, the AHA argued that CMS' proposed methodology for calculating the FY 2005 outlier threshold was flawed because it did not take into account substantial changes to the outlier payment policy made in June 2003, including the adoption of more recent data for determining a hospital's cost-to-charge ratio, the elimination of the statewide average ratio floor and the reconciliation of outlier payments for certain hospitals. The AHA argued that the threshold amount must be lowered in response to the new provisions on outlier payments. In addition, we were concerned about any increase in the threshold, given that CMS estimated that outlier payment would be significantly underpaid in FY 2004.[4]

For FY 2005, CMS will change the methodology it uses to estimate the outlier threshold. Rather than calculating the outlier threshold based on the two-year average annual rate of change in charges per case from FY 2001 to FY 2002 and FY 2002 to FY 2003, the agency will estimate the annual rate of change in charges per case from the first six months of FY 2003 to the first six months of FY 2004. The use of this more recent data results in a lower estimate of charge growth, and thus a lower outlier threshold. CMS notes, however, that it is adopting this methodology only for FY 2005 because of the "special circumstances surrounding the revisions to the outlier payment methodology," and may consider other methodologies in the future.

Transfer Payment Policy

As advocated by the AHA, CMS will <u>not</u> adopt its proposed "alternative criteria," for determining which DRGs would be subject to the post-acute care transfer policy. This proposal would have expanded the policy from 29 DRGs to 31 DRGs and would have reduced hospital Medicare payments by an estimated $25 million in FY 2005.

Medicare patients in certain DRGs discharged to a post-acute care setting – including rehabilitation hospitals and units, long-term care hospitals and units, cancer hospitals, psychiatric hospitals, children's hospitals, and skilled nursing facilities – or discharged within three days to home health services, are defined as transfer cases when their acute care length of stay is at least one day less than the national average. These cases are paid a daily (per diem) rate, rather than a fixed DRG amount, up to the full PPS rate. Thus, if a patient has a shorter than average inpatient stay, even by just one day, the hospital is paid less than the full DRG rate.

For FY 2004, CMS adopted four criteria that a DRG must meet in order for it to be added to the post-acute care transfer policy. For FY 2005, the agency proposed alternative criteria that would be applied if a DRG did not satisfy the FY 2004 criteria. The AHA opposed this alternative

[4] In the final rule, CMS estimates that actual outlier payments for FY 2004 will be approximately 3.5 percent of actual total DRG payments – or 1.6 percentage points lower than the 5.1 percent withheld from hospitals to fund outlier payments.

criteria, and expressed concern that CMS was adopting it solely to recapture those cases currently in DRG 483 (Tracheostomy with Mechanical Ventilation). CMS had proposed to split DRG 483 and move its cases into two new DRGs 542 and 543. These new DRGs, however, would no longer meet the criteria necessary to qualify for the transfer policy. In adopting alternative criteria, however, not only would tracheostomy cases be included in the post-acute care transfer provision but also cases under DRG 430 (Psychoses).

In the final rule, CMS adopts a policy of grandfathering, for a period of two years, any cases that were previously included within a DRG that has split, when the split DRG qualified for inclusion in the post-acute care transfer policy for both of the previous two years. This means that tracheostomy cases (DRGs 542 and 543) will still be subject to the transfer provision, but that psychoses cases, that do not meet the original criteria, will not be subject to the transfer policy for FY 2005. CMS states that the grandfathering provision is an interim measure, and suggests that it may revisit the treatment of trachesotomy cases after the grandfathering period.

Beginning October 1, the 30 DRGs listed below will be subject to the post-acute care transfer policy:

DRGs subject to the Post-Acute Care Transfer Provision

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
541	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK W/ MAJOR OR PROC (Formally DRG 483)
542	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK W/O MAJOR OR PROC (formally DRG 483)

Graduate Medical Education

The rule finalizes a number of significant and complex changes to direct graduate medical education (DGME) and indirect medical education (IME) payments to hospitals.

Initial Residency Period. Currently, a number of residency programs, such as anesthesiology and radiology, require a year of generalized clinical training in internal medicine as a prerequisite to subsequent training in their chosen specialty. CMS policy, however, has been to base DGME payments on the resident's first year of training, without factoring in the specialty in which the resident ultimately seeks board certification. The problem, for example, is that an anesthesiologist doing a base year of generalized clinical training would be labeled with a three-year training period – which is the time required to be board eligible in internal medicine – rather than the four years it takes to be board eligible in anesthesiology. And the result is that the teaching hospital receives only half of the DGME reimbursement for the fourth year of that resident's training.

The AHA argued that CMS' current policy violates the statute, does not reflect congressional intent, and results in inequitable payments to teaching hospitals for residents training in certain specialties. **As the AHA requested, CMS has addressed the "preliminary year" issue in the final rule, and will allow hospitals to receive full payment for the full training period for those specialties in which residents first complete a preliminary year of generalized training**.

Effective October 1, if a hospital can document that a particular resident matches simultaneously for a first year of training in a clinical base year, and for a second year of training in a specialty program for which the resident intends to seek board certification, then CMS will base the resident's initial residency period on the specific specialty program for the subsequent year(s) of training in which the resident matches and not on the clinical base year program.

Unused Residency Slots. The final rule implements Section 422 of the MMA, and establishes a process for determining whether, and by what amount, a hospital's resident cap will be reduced, and specifies the application process for hospitals seeking to increase their resident caps and the criteria CMS will use to determine which hospitals receive cap increases. Any reductions, or increases, in a hospital's residency count could impact a hospital's Medicare IME and DGME payments.

- Reduction in Residency Slots: By law, if a hospital's resident cap is more than its resident count, then its hospital cap will be reduced by 75 percent of the difference between its cap and its actual resident count. These "excess" residency slots would be redistributed to hospitals that demonstrate a need to have their caps increased. The reduction takes effect for cost reporting periods starting July 1, 2005, although rural hospitals with less than 250 beds are exempt from any reduction. According to the final rule, CMS will use the urban or rural designation that will be in effect on July 1, 2005 (and thus the revised MSAs) to determine whether a hospital is exempt from this reduction.

  An estimate of whether and by how much a hospital's residency cap would be reduced will be made by May 1, 2005. In the proposed rule, CMS indicated that it would "estimate" the reduction if the applicable cost report determination was under appeal as of May 1, 2005. In the final rule, CMS reversed this decision, and will now use the latest available cost report or audit data at the time they make their final determinations regarding resident limit reductions.

The AHA is concerned about CMS making reductions to a hospital's cap based on cost reporting data that may change, as the hospital's resident count may increase upon appeal.

- Increase in Residency Slots: The MMA sets forth several requirements for distributing the additional slots to qualifying hospitals. By law, one criterion that CMS must take into account is the "demonstrated likelihood" of the hospital filling the new positions within the first three cost reporting periods. In the rule, CMS defines "demonstrated likelihood" as hospitals starting a new residency program on or after July 1, 2005, expanding a current residency program, or having a resident count that exceeds their current cap.

  In addition, the law requires that excess residency slots be redistributed first to rural hospitals, then to hospitals not located in large urban areas, then to other hospitals in a state where there is no other training program for a particular specialty, and finally to hospitals located in large urban areas. But under any redistribution, not more than 25 additional residency positions will be given to any one hospital. In the final rule, CMS adopts procedures for distributing slots among the six priority categories in the event that the "demand" for additional cap slots exceeds "supply" (the first being hospitals located in rural area that have the only specialty program in the state), using an elaborate scoring system within each priority category. Any increases in residency positions under this provision, however, will be paid at a national average DGME payment amount and a reduced IME payment amount.

  In general, those hospitals that are interested in increasing their Medicare residency cap need to submit an application to CMS, along with a CMS Evaluation Form, available on page 49163 of the rule, by December 1, 2004.

Residents Training in Non-Hospital Settings. Under certain conditions, hospitals have been allowed to count towards hospital DGME and IME payments the time residents spent training in sites that are not part of the hospital. Currently hospitals may receive Medicare DGME and IME payments if residents spend their time in patient care activities and there is a written agreement between the hospital and the non-provider entity stating that the hospital will incur all or substantially all of the training program at that site. Beginning in FY 2005, CMS will give hospitals the option of not having a written agreement between hospital and non-hospital sites where residency training occurs.

The AHA is pleased that final rule modifies the "written agreement" requirement for hospitals that have residents training in non-hospital settings.

If a hospital chooses to not have a written agreement, CMS had proposed that hospitals must compensate the non-hospital site for GME costs on a monthly basis. The AHA and others felt that this requirement was overly burdensome. In the final rule, CMS slightly relaxed this requirement, and beginning October 1, will allow hospitals to compensate the non-hospital site by the end of the third month following a month in which the training in the non-hospital site occurred.

Freeze in Direct GME Per Resident Amount. The rule codifies a MMA provision that freezes the DGME per resident amount for hospitals above 140 percent of the national average from FY 2004 through FY 2013.

IME Adjustment. As part of part of the MMA, the rule decreases the IME payment adjustment from a level of 6.0 percent for the last six months of FY 2004 to 5.8 percent in FY 2005. This level of 5.8 percent, however, is higher than the 5.5 percent adjustment that would have been in effect without the adoption of the MMA.

Add-on Payments for New Technology

Two items will receive new technology add-on payments in FY 2005:

- Kenetra®, an implantable neruostimulator to treat patients with essential tremor and Parkinson's disease; and
- InSync® Defibrillator System, a cardiac resynchronization therapy with defibrillation (CRT-D) for patients with congestive heart failure and ventricular arrhythmias.

In addition, InFUSE™, a bone graft fusion device approved for use in single-level, anterior lumbar spinal fusions, will continue to receive add-on payments.

Inpatient payments will not be reduced to finance these new technologies. Previously, payments for new technologies were done on a budget neutral basis such that increased funding for the technology was offset by decreased funding for all other inpatient services. Beginning in FY 2005, the MMA provides new money for add-on payments under the inpatient PPS. In addition, the MMA lowers the cost threshold for new technologies to qualify for new technology payments to the lesser of 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation for the DRG involved.

Available Beds and Patient Days

The rule finalizes changes suggested in the FY 2004 proposed rule (August 1, 2003 *Federal Register*) regarding the counting of available beds and patient days used in calculating IME and DSH payments. For IME, a lower number of beds result in a higher resident-to-bed ratio, and thus a higher IME payment. To qualify for DSH, hospitals must meet a disproportionate patient percentage threshold which is the sum of two fractions: the "Medicare fraction," calculated as the number of patient days attributable to patients eligible for both Medicare Part A and SSI benefits divided by total Medicare days, and the "Medicaid fraction," calculated as the number of patient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits divided by total patient days. A higher DSH payment is available for urban hospitals with more than 100 beds and rural hospitals with more than 500 beds.

Unoccupied Beds. The final rule revises the current method of counting unoccupied beds. Beginning October 1, beds located in a unit that provides inpatient care at any time during the preceding three months will count as available bed days. In addition, CMS clarifies that beds in individual rooms within units that would otherwise be considered occupied and available, but that are actually unavailable due to renovations, will be excluded from the available bed count if the bed remains unavailable for 30 consecutive days.

Observation and Swing-Beds. The FY 2004 final rule clarified that observation beds and swing-beds should be excluded from the counts of both available beds and patient days. CMS had deferred final action, however, on how to treat observation bed days of patients who are later admitted to the hospital. Beginning October 1, if a patient received outpatient observation services in a bed that is generally used to provide hospital inpatient acute care services and is ultimately admitted, then the beds and days associated with the observation services are to be counted in the IME and DSH formulas.

Dual-Eligible Patient Days. The FY 2005 final rule changes how dual-eligible patients who have exhausted their Medicare coverage are counted for DSH payments. Last year, CMS had proposed to include dual-eligible beneficiaries who have exhausted their Medicare Part A hospital coverage in the *Medicaid* fraction. The AHA opposed this 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. In the FY 2005 final rule, we are pleased that CMS has determined that the days associated with dual-eligible beneficiaries should be included in the *Medicare* fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage. If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction of the DSH calculation.

Medicare Advantage (previously Medicare+Choice) Days. Last year, CMS proposed to include those days associated with Medicare Advantage beneficiaries in the *Medicaid* fraction for purposes of calculating the DSH patient percentage. The agency has amended its proposal and, beginning October 1, as with dual-eligible patient days, CMS will include days associated with Medicare Advantage beneficiaries in the *Medicare* fraction of the DSH calculation.

Low-Volume Hospital Adjustment

The final rule will provide a 25 percent increase in Medicare per-case payments for those hospitals with less than 200 total discharges a year. CMS had proposed to provide a sliding scale adjustment for hospitals with less than 500 total discharges, and Congress allows for a payment adjustment for hospitals with less than 800 discharges. Section 406 of the MMA provides additional payment under the inpatient PPS to account for the higher costs per discharge of low-volume hospitals. By law, the increase in payment is to be determined based on "an empirical relationship between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental cost (if any) that are associated with such discharges." In the final rule, CMS states that they could find no empirical relationship between costs and discharges at a level of more than 200 discharges. The AHA is disappointed that CMS will limit increased payments to such a small number of hospitals, thus denying many needy – and deserving – hospitals of a congressionally mandated payment adjustment.

Critical Access Hospitals

The rule details and finalizes a number of CAH improvements contained in the MMA:

Payment Amount. Beginning January 1, 2004, Medicare payment for CAH inpatient, outpatient and skilled nursing facility services has been increased to 101 percent (from 100 percent) of the reasonable cost of the CAH service.

"Method 2" Billing. CAHs may bill for hospital outpatient services in one of two ways: the *standard option* pays outpatient facility services at 101 percent of the CAH's reasonable costs of providing the outpatient service, with other professional services paid under the physician fee schedule directly to the physician by the carrier; or the *method 2 option* pays outpatient facility services at 101 percent of cost and 115 percent of the physician fee schedule for professional services with payments directly to the CAH by the fiscal intermediary.

Previously, in order for hospitals to elect the method 2 option, all practitioners furnishing services to outpatients of a CAH needed to agree to reassign to the CAH their rights to bill the Medicare program for those services. The MMA now allows CAHs to elect the optional payment method even if all practitioners do not reassign their billing rights to the CAH. The 15 percent increase in payment, however, is not then available for professional services for which billing rights are not reassigned. The final rule details this change.

On-Call Providers. The final rule codifies the MMA provision that expands Medicare cost reimbursement of on-call emergency department providers to include physician assistants, nurse practitioners and clinical nurse specialists beginning January 1, 2005. CMS clarifies in a technical change that all practitioners who have on-call responsibilities should have training or experience in emergency care.

Periodic Interim Payments (PIP). CMS has clarified that beginning on or after July 1, 2004 (not cost reporting periods on or after July 1, 2004) eligible CAHs will be able to receive Medicare payments made on a periodic interim basis. These facilities must elect this payment option from their fiscal intermediary. The AHA is concerned, however, that fiscal intermediaries have been given great flexibility in determining whether the facility meets the requirements to receive PIP. We will monitor this situation to ensure that CAHs have equal access to PIP payments.

Bed Limit. Previously, a CAH could use only 15 of its 25 beds to provide acute inpatient care (the remaining beds were granted swing-bed approval for skilled nursing care). Beginning January 1, 2004, the law allows CAHs to operate up to 25 acute care beds at one time.

Distinct Part Unit. Previously, CAHs were not allowed to operate distinct part units, preventing many hospitals from converting to CAH status. The law was modified to allow CAHs to operate psychiatric or rehabilitation units of no more than 10 beds each. In the rule, CMS clarifies and adopts the MMA provision, effective October 1, 2005.

CAHs as a "Necessary Provider." In the rule, CMS finalizes the MMA provision that terminates a state's authority to designate a CAH as a necessary provider of health care beginning January 1, 2006. Currently, the governor in each state may certify a hospital as a "necessary provider," which allows that hospital to become a CAH even if it fails to meet the distance requirement of being more than 35 miles away from a hospital or another CAH. In the rule, CMS clarifies that hospitals must be fully converted to CAH status prior to January 1, 2006

in order to be grandfathered as a CAH and as a necessary provider in its state's rural health plan. Receiving a state designation by January 1, 2006 is not sufficient; the hospital must have fully converted to CAH status.

CAH Lab Payments. Although strongly opposed by the AHA, CMS has reiterated its clarifying language from the FY 2004 rule 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 AHA continues to object to this policy, and will urge both CMS and Congress to reconsider so that all outpatient clinical diagnostic laboratory services provided by a CAH are paid on a reasonable cost basis.

ESRD Discharges

Although opposed by the AHA, CMS has revised its policies to reduce the number of hospitals with a high percentage of end-stage renal disease (ESRD) discharges that qualify for a Medicare payment adjustment. Currently, CMS provides additional Medicare payments to hospitals if their ESRD Medicare beneficiary discharges are 10 percent or more of their total Medicare discharges. Beginning October 1, the agency will only count ESRD Medicare beneficiaries who received a *dialysis treatment during the inpatient hospital stay* toward qualifying for this adjustment, rather than all ESRD discharges.

New Rural Referral Centers

The final rule updates the qualifying criteria for new RRC designation if the hospital does not meet the bed size criterion of 275 or more beds. To qualify for RRC status in FY 2005, a hospital must have at least 5,000 discharges and a case-mix index that is at least 1.3550, or a case mix value that is greater than the median case-mix value for urban hospitals in its census region. Because all regions have proposed median case-mix values that are less than 1.3550, please refer to the chart provided in the rule on page 49086 of the *Federal Register* for specific details.

Changes to DRG Classifications and Weights

Given that the MMA requires updating ICD-9-CM codes twice a year instead of the current process of annual updates on October 1 of each year, the AHA is extremely pleased that CMS has finalized its proposal that the mid-year updates in April will include only those codes that are critical to tracking new technologies potentially eligible for add-on payments. This policy will lessen the additional burden of this MMA requirement.

Other key changes to DRGs for FY 2005 include:

- Restructuring and re-titling several DRGs to reflect expanded coverage of heart assist systems such as ventricular assist devices or left ventricular assist devices as destination or permanent therapy for end-stage heart failure patients who are <u>not</u> candidates for heart transplantation.
- Adding pacemaker device and lead procedure code combinations for DRG 115 and 116.
- Moving the procedure code for 360-degree spinal fusion through a single incision from DRG 496 to DRG 498.
- Adding combination codes, including heart failure, to the list of major problems under DRG 387 and 389.

- Modifying the burn DRGs 504-509 to recognize the impact of long-term mechanical ventilation for these patients.
- Deleting DRG 483, and splitting cases into proposed new DRGs 541 and 542 on the basis of the performance of a major operating room procedure.

PPS-Exempt Hospitals and Units

Psychiatric Hospitals. New psychiatric hospitals or units, defined as those that first received payment after October 1, 1997, are subject to the following FY 2005 cap:

	Labor-Related Share	Nonlabor-Related Share
Psychiatric	$7,535	$2,995

A final rule for the psychiatric hospital and unit PPS is expected in late 2004.

Long-Term Care Hospitals. The rule modifies several policies affecting arrangements in which a long-term care hospital (LTCH) is located within another hospital. While the AHA is pleased that CMS has deferred action on significant policy changes for one year, we remain concerned that appropriate, clear patient and facility criteria for LTCH care have not been identified. As requested by the AHA, the rule does not change the current guidelines regarding common ownership. However, in a disappointing move, CMS will proceed with its proposal to limit the number of patients that can be referred from a "host hospital" by imposing a downward payment adjustment for certain patients. This change unnecessarily and inappropriately interferes with clinical decision-making, and the ability to ensure patients receive the right care in the right place. The AHA will issue a separate *Regulatory Advisory* detailing the LTCH provisions.