



WISCONSIN HOSPITAL ASSOCIATION, INC.

SUMMARY OF THE FINAL FFY 2004 MEDICARE HOSPITAL INPATIENT RULE

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This document provides an overview of the Medicare final rule for the Inpatient Prospective Payment System (PPS) for federal fiscal year (FFY) 2004. The rule is available at www.wha.org/financeanddata/. Questions about this rule or this summary should be addressed to George Quinn or Brian Potter, at (608) 274-1820 or at gquinn@wha.org or bpotter@wha.org.

OVERVIEW

Although the final FFY 2004 Medicare inpatient rule provides a full market basket update and there are no payment reductions scheduled under current law, it includes several administrative changes that could result in decreased reimbursement. These include expansion of the post-acute transfer policy and changes to medical education policies. The final rule does not address several proposed changes to the rules for counting days and beds for Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments. The Centers for Medicare and Medicaid Services (CMS) plan to issue a separate final rule on these proposals, including changes to policies regarding unoccupied beds, dual-eligible days, and Medicare + Choice days.

STANDARD RATES

Operating Rates: The FFY 2004 final Inpatient PPS operating standardized amounts are:

		2003	2003	2004	% Change	%Change
		October- March	April- September	Final	From October 2003	From April 2003
Large Urban	Labor-related	\$3,022.60	\$3,022.31	\$3,146.06	4.1%	4.1%
	Non labor-related	\$1,228.60	\$1,228.48	\$1,278.78	4.1%	4.1%
Rural/Other Urban	Labor-related	\$2,974.75	\$3,022.31	\$3,096.25	4.1%	2.4%
	Non labor-related	\$1,209.15	\$1,228.48	\$1,258.54	4.1%	2.4%

Note: CMS has indicated that the labor-related rates reported on Table 1A of the August 1 *Federal Register* are incorrect. The correct rates (shown above) can be found on page 45479 of the *Federal Register*.

Labor-related proportion of standardized amounts: 71.1%

Non labor-related proportion of standardized amounts: 28.9%

These amounts reflect the latest estimated market basket update of 3.4% as mandated by current law. The actual increase over FFY 2003 rates published in the 2003 final rule is 4.1%. However, hospitals in rural and other urban areas received a temporary 1.6% increase to their operating rates from April 1, 2003 to September 30, 2003 and will see only a 2.4% increase compared to that rate. WHA and AHA continue to advocate for congressional action to extend the 1.6% increase in the standardized rate for rural and other urban area hospitals.

Capital Rates: For 2004, the final capital rate is an increase of 2.1% over the final FFY 2003 rate. The change in the capital standardized amount is as follows:

▪ Capital Rate:	<u>FFY 2003</u> \$406.93	<u>FFY 2004</u> \$415.47	<u>Change</u> 2.1%
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COST OUTLIERS

The inpatient final rule provides a 2004 cost outlier threshold equal to the PPS rate for the Diagnosis Related Group (DRG) plus \$31,000. This is a decrease from the 2003 threshold of \$33,560. However, the 2004 threshold is based on the major revisions to the outlier payment policy that CMS published in the June 9 *Federal Register*.

CMS will update the cost-to-charge ratios (CCRs) used in the outlier calculation beginning October 1, 2004. CCRs will be derived from tentative settled cost reports instead of final cost reports, decreasing the CCR lag time from a range of about three to five years to a range of one to two years. In addition, CMS will apply an alternative CCR adjustment to a limited number of hospitals that “appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios.” Beginning August 8, 2003, if recent charge data indicate that a hospital’s charges have been increasing at “an excessive rate,” CMS will direct the fiscal intermediary to change the hospital’s CCR to reflect the high charge increases evidenced by the later data. CMS Program Memorandum A-03-058 provided the following criteria to identify these hospitals:

- hospitals with federal fiscal year (FFY) 2003 outlier payments of at least 10% of total operating plus outlier payments;
- outlier payments relative to total operating payments increased by at least 20% from FFY 2001 to FFY 2002 or from FFY 2002 to FFY 2003, and;
- average charges per case increased by at least 15% from both FFY 2000 to FFY 2001 and FFY 2001 to FFY 2002.

In addition, CMS will establish a new process to recalculate outlier payments when the cost report corresponding with the outlier cases is settled, using the actual CCR. This settlement will only apply to hospitals identified as having disproportionately high growth in charges and high outlier payments. Hospitals identified by the above criteria and given an alternative CCR for discharges occurring on or after August 8, 2003, will be subject to reconciliation of outlier payments at the time of the cost report final settlement if:

- the actual operating or capital CCRs are found to be plus or minus ten percentage points from the CCRs used during that time period to make outlier payments, and
- total outlier payments in that cost reporting period exceed \$500,000.

The same two criteria will be applied to all hospitals in FFY 2004 to identify hospitals that will be subject to the settlement process. When a reconciliation is required, payments will be adjusted to account for the time value of any underpayments or overpayments.

WAGE INDEX

Wage Index Revisions: Hospital wage indexes for FFY 2004 are based on 2000 wage survey data. The final rule addresses the following wage index revisions:

- The wage index calculation excludes data for services not subject to the PPS. The 2000 cost report was modified to separately report wages and hours for rural health clinics and federally qualified health centers and CMS has removed these clinics from the FFY 2004 wage index calculation.
- CMS has implemented its proposed exclusion of data for hospitals that are subject to the PPS in the year that wage data are collected, but subsequently convert to Critical Access Hospital (CAH) status. According to CMS, this has “minimal” redistributive impact, with a majority of labor markets experiencing a 0.3% wage index decrease and with 48 areas receiving a wage index increase.

- The wage index is calculated using “paid hours.” Based on substantial disagreement in the comments that were submitted, CMS rejected proposals to exclude military duty, jury duty, and paid lunch hours from the FFY 2005 wage index calculation. CMS intends to revisit these proposals in the future as part of a more comprehensive assessment of the use of paid hours.

Below is a table of the final FFY 2003 and the final FFY 2004 wage indexes.

	FINAL FY 2003 <u>WAGE INDEX</u>	FINAL FY 2004 <u>WAGE INDEX</u>	PERCENT CHANGE IN <u>WAGE INDEX</u>
WISCONSIN - RURAL	0.9162	0.9266	1.1%
APPLETON-OSHKOSH-NEENAH	0.9162	0.9266	1.1%
DULUTH-SUPERIOR, MN-WI	1.0368	1.0130	-2.3%
EAU CLAIRE	0.9162	0.9266	1.1%
GREEN BAY	0.9668	0.9479	-2.0%
JANESVILLE-BELOIT	0.9849	0.9266	-5.9%
KENOSHA	0.9686	0.9721	0.4%
LA CROSSE, WI-MN	0.9400	0.9266	-1.4%
MADISON	1.0467	1.0222	-2.3%
MILWAUKEE-WAUKESHA	0.9893	0.9947	0.5%
MINNEAPOLIS-ST PAUL, MN-WI	1.0903	1.0957	0.5%
RACINE	0.9334	0.9266	-0.7%
SHEBOYGAN	0.9162	0.9266	1.1%
WAUSAU	0.9782	0.9744	-0.4%

Wage Index Development Timetable: Due to the growing number of revisions requested by hospitals after the release of the preliminary wage data public use file, CMS is modifying the hospital wage index development timetable. Currently, the preliminary wage data are released for hospital corrections in early January and hospitals have 30 days to request corrections. Under the new timetable, hospitals will receive the data four months earlier, in mid-September. Hospitals will then have 45 days to request corrections (in response to comments, CMS increased the review period from 30 days to 45 days). Fiscal intermediary desk reviews would be conducted after hospital corrections. CMS believes this will make the desk reviews more effective and provide for more accurate wage index calculations in the proposed rule.

Metropolitan Statistical Areas: The Office of Management and Budget (OMB) released revisions to the definitions of Metropolitan Statistical Areas (MSAs) on June 6. The new definitions are based on 2000 U.S. Census data and will include two types of Core Based Statistical Areas (CBSAs): MSAs, which contain populations of 50,000 or more, and Micropolitan Statistical Areas, which contain populations of 10,000 to 49,000. CMS will consider the possible use of these new definitions for FFY 2005 at the earliest. In the final rule, CMS indicated that the decision on use of the new definitions will be published as notice with a comment period.

Occupational Mix: CMS indicated that the occupational mix survey is currently under review. CMS is required to begin collecting occupational mix data by September 30, 2003, and to apply this information in the calculation of the federal year 2005 wage index. CMS released a proposed survey in April that would be used to collect calendar year 2002 data from hospitals. A final notice will be published in the *Federal Register* with a 30-day comment period. This notice will contain revisions to the occupational mix survey form and a timetable for submission. CMS still intends to use the data in the 2005 wage index.

Wage Index Reclassifications: Requests for FFY 2005 reclassifications will be due September 2. While CMS intends to consider use of the revised CBSA definitions for use in 2005, CMS instructs hospitals to submit reclassification applications based on the current MSAs. CMS will consider the implications of the new CBSA definitions on reclassifications in the FFY 2005 proposed rule.

Wage index reclassifications are determined based on the wage index data for the three most recently available years. Currently, hospitals are prohibited from correcting the data used in the reclassification calculations because the deadline for wage index data correction has already passed for all the years in question. The final rule provides a limited exception that allows corrections for urban hospitals that are in an MSA that receives the rural floor. CMS determined that these hospitals had no incentive to correct their data at the time that the wage index calculations were done and should be able to request corrections for purposes of reclassification. The exception will apply only to cost report periods beginning before FFY 2000, which was the first year that the three-year calculation was used.

NEW TECHNOLOGY ADD-ON

Payment for New Technologies: CMS has established an add-on to the DRG payment to cover a portion of the cost of new technologies during the two-year period before charge data for the technologies are incorporated into the DRG weights. To qualify, a technology must be new, the service must provide verifiable improvement in the treatment or diagnosis of beneficiaries; and the mean standardized charge for treatment using the new technology must be at least one standard deviation above the mean standardized charge for treating the same case without the new technology.

CMS approved one new technology for payment in 2003—Xigris®—and will continue the add-on payment for this technology in FFY 2004. CMS approved one application for new technology designation for FFY 2004: the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device. This device is used to promote bone growth for patients undergoing spinal fusions and the add-on payment will be limited to cases using this technology for anterior lumbar fusions assigned to DRGs 497 or 498. New technology payments are limited to 50% of the average cost of the device or 50% of cost in excess of the DRG payment. Therefore, the maximum payment for InFUSE™ will be \$8,900.

In recognition of the fact that few applications were filed this year, CMS is proposing to reduce the qualifying threshold from one standard deviation to 75% of one standard deviation above the mean standardized charge. The new threshold will be applied to applications for payment in 2005.

POST-ACUTE TRANSFERS

Under current regulations, cases in ten specified DRGs are paid as transfers if discharged to post-acute care. CMS selected the ten DRGs because of their high volumes of discharges to post-acute care and a disproportionate use of post-acute care. A transfer is paid a per diem rate not to exceed the full DRG amount. Patients are considered to be discharged to post-acute care if they enter a skilled nursing facility, receive home health agency services within three days of discharge from the acute facility; or hospitals or hospital units that are exempt from inpatient PPS reimbursement (psychiatric and rehabilitation hospitals and units; children's hospitals, long-term care hospitals, and cancer hospitals). Patients transferred to swing beds are exempted from this policy.

CMS has statutory authority to expand the policy to apply to other DRGs. CMS proposed an expansion for 2003, but did not make the changes due to concerns and issues that were raised during the comment period. Subsequently, the Medicare Payment Advisory Commission recommended an expansion of the transfer DRGs in its March 2003 Report to Congress.

For FFY 2004, CMS established the following criteria for choosing additional DRGs for the post-acute transfer policy: at least 14,000 post-acute transfer cases, at least 10% of the DRGs post-acute care transfers occur before reaching the DRG geometric mean length of stay, a 7% decline in the DRGs length of stay since 1998, and the DRG must have at least a three-day geometric mean length of stay. The criteria were applied to both the current TEN DRGs and the potential new DRGs. Based on these criteria, two of the current ten DRGs, DRG 263 and 264, no longer qualify and will be removed from the list for 2004. However, there are 21 additional DRGs that meet these criteria and will be added to the list for a total of 29 DRGs that will be subject to the post-acute transfer policy in 2004.

Original Post-Acute Transfer DRGs Remaining in

DRG	DRG TITLE
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE
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
429	ORGANIC DISTURBANCES & MENTAL RETARDATION
483	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK DX OSES

New Post-Acute Transfer DRGs Beginning in FFY

DRG	DRG TITLE
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS
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
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
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
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS

Transfer cases are paid a per diem rate for each day of the stay, not to exceed the full DRG payment. The first day is paid at twice the per diem amount and subsequent days at the per diem rate. Most post-acute transfers are paid under this methodology. However, an alternative payment is provided for DRGs with high initial costs, which pays 50% of the full DRG amount plus the per diem rate for the first day of the stay and 50% of the per diem for the remaining days. This alternative payment is provided for DRGs 209, 210, and 211. It will not apply to any of the DRGs that are added in 2004.

TRANSFERS TO ANOTHER ACUTE CARE HOSPITAL

Under current law, a patient transferred from one inpatient PPS hospital to another is paid a per diem rate instead of the case payment rate. However, an exception is made if a patient discharges himself or herself without seeking any medical opinion and is billed as “left against medical advice” (LAMA). Under current regulation, anyone coded as LAMA is treated as a discharge and the hospital will receive the full case payment amount.

CMS is concerned that hospitals are abusing this policy by incorrectly coding transfer cases as LAMA. A review by the Health and Human Services Office of Inspector General found instances where physicians were participating in the decision process when patients left to go to another inpatient PPS hospital, but the hospital submitted the claim as LAMA. CMS is proposing to end this practice by changing the transfer definition. CMS will revise this policy to include as transfers all patients who are admitted to another inpatient PPS hospital on the same day that the patient is discharged. An exception will be made if the transferring hospital could provide documentation that the patient received full treatment at the time of discharge.

CMS recognizes that hospitals cannot always know if a patient has gone to another hospital. Therefore, the fiscal intermediary will be required to notify the hospital of those patients and request that the hospital submit an adjustment claim. At that point, the hospital could present documentation showing that the patient’s care was completed before discharge and the transfer policy would not be applied.

COUNTING BEDS AND DAYS FOR DSH AND IME

The final rule does not address several proposed changes to the rules for counting days and beds for IME and DSH payments. CMS is still reviewing the comments that were submitted on these issues and intends to publish a separate final rule on these proposals:

- revising the policy for determining available bed days for IME and DSH purposes by requiring that the beds in a unit that was occupied for an Inpatient PPS level of care during the three preceding months would be counted unless they could not be made available for patient occupancy within 24 hours;
- revising the DSH methodology to include days for dual-eligible patients who have exhausted their Medicare Part A coverage in the Medicaid fraction of the DSH calculation and;
- clarifying the status of Medicare +Choice patient days in the DSH calculation by specifying that they should not be included in the Medicare count and that any dual-eligible patient days that qualify may be included in the Medicaid day count.

OBSERVATION BEDS AND SWING BEDS FOR DSH AND IME

Under current policy, bed days attributable to beds used for observation or for swing beds are excluded from the counts of available bed days and patient days. This policy is based on regulations that state: “[t]he number of patient days includes only those days attributable to areas of the hospital that are subject to the Prospective Payment

System and excludes all others.” Recently, the CMS policy was challenged in court because the regulations do not specifically exclude swing beds or observation beds. Therefore, CMS has revised the regulations to explicitly state that observation bed and swing bed days are excluded from the counts of both available beds and patient days.

CMS also proposed a new exception to this policy that would allow observation bed days to be counted if the patient is ultimately admitted. CMS will make a final determination on this proposal in a later rule.

LABOR, DELIVERY, RECOVERY, AND POSTPARTUM BEDS AND DAYS

In general, CMS’ policy requires that an inpatient day be counted for an admitted patient who is in an ancillary department at the census-taking hour. A specific policy for maternity inpatients in the labor/delivery room at midnight states that these patients will not be included in the census of inpatient routine care if the patient has not occupied an inpatient routine bed at some time since admission. Therefore, a Medicaid patient who is in the labor room at the census and has not yet occupied a routine bed should not be included in the day count for the DSH calculation.

CMS has found that hospitals are increasingly redesigning their maternity areas from separate postpartum and labor/delivery areas to single labor, delivery, recovery, and postpartum (LDRP) rooms. CMS has clarified its policy regarding these rooms to require that hospitals apportion the patient’s stay between the time in the LDRP rooms when the patient is receiving ancillary services (labor/delivery) as opposed to routine services (recovery and postpartum). Only the routine portion of the stay would be included in total and Medicaid days. CMS will allow hospitals to determine for each individual patient in a LDRP room the amount of time spent in labor/delivery and the amount of time spent receiving routine care or, alternatively, the hospital could calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care during a typical month, and apply it to the rest of the year.

DAYS ASSOCIATED WITH LIMITED BENEFIT 1115 WAIVER POPULATIONS

Some states have received a Social Security Act Section 1115 waiver extending medical benefits to populations that would not otherwise be eligible for Medicaid under the state plan. Current CMS policy allows hospitals to include the patient days of all populations that receive benefits under a Section 1115 waiver in the DSH calculation.

CMS has found that some states have instituted Section 1115 waiver programs with limited benefit packages that do not cover inpatient care. CMS provides examples of programs that provide only a family planning benefit or are limited to only outpatient prescription drug coverage. CMS believes that the DSH calculation should not include as Medicaid days those patient days attributable to limited benefit Section 1115 waiver populations. Therefore, CMS is revising the regulations to clarify that hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved state plan or through a Section 1115 demonstration would not be counted in the calculation of Medicaid days.

GRADUATE MEDICAL EDUCATION

RESIDENTS IN NON-HOSPITAL SETTINGS

Graduate Medical Education (GME) includes both Direct Medical Education (DME), the direct costs associated with the operation and administration of a GME program, and IME, which recognizes the higher costs associated with the operation and administration of a GME program. Hospitals can count residents that train at a non-hospital site for GME payments if the hospital incurs all or substantially all of the costs for the training program.

In the proposed rule, CMS noted instances where dental schools are shifting program costs from the school to teaching hospitals. In these cases, the hospital begins to assume the costs of the training program, and, in turn, is able to increase its resident count. According to CMS, because dental residents are excluded from resident caps, hospitals are receiving significant GME payments while incurring much less increase in actual costs. CMS believes that inappropriate resident counts and cost shifting are not limited to dental programs and is proposing a policy change for all residents in non-hospital settings.

CMS believes that Congress intended the provision allowing hospitals to count residents in non-hospital sites to apply when hospitals rotate residents from the hospital to the non-hospital settings, and not to situations in which non-hospital sites transfer the costs of an existing program to the hospital. In addition, CMS cites the “longstanding Medicare policy” stating that education costs should not be redistributed to the Medicare program if the community has previously undertaken these costs.

Therefore, CMS is revising the regulations to require that a hospital must continuously incur direct GME costs of residents training in a particular program since the date the residents first began training at that site, for the hospital to count the full-time equivalent (FTE) residents. For administrative convenience, CMS will require each teaching hospital and its fiscal intermediary to determine which entity had been incurring the training costs at least since January 1, 1999. If a non-hospital entity, such as a school of medicine or dentistry, had incurred the costs of training the residents any time on or after January 1, 1999 and a hospital subsequently begins to incur direct GME costs of training those FTE residents, the hospital would not qualify to count those FTE residents for purposes of DME and IME payments. While CMS would not require that intermediaries examine periods before January 1, 1999, if the fiscal intermediaries determine that there was a redistribution of costs before January 1, 1999, a disallowance of DME and IME payments would be made.

CMS is implementing a prospective effective date of October 1, 2003, for purposes of payment. That is, for direct GME, effective for portions of cost reporting periods beginning with October 1, 2003, and for IME, effective for discharges occurring on or after October 1, 2003, 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, for the hospital to count the FTE residents. A fiscal intermediary that determines that a redistribution of costs has taken place for a particular hospital prior to October 1, 2003, may disallow FTEs beginning with October 1, 2003. For example, if a fiscal intermediary determines that a redistribution of costs has occurred that affected ten FTEs for direct GME and IME during the hospital’s cost report ending in the fiscal year ending in 1999, the fiscal intermediary would take disallowances for those ten FTEs, but not until October 1, 2003, for purposes of direct GME and IME payment.

In the final rule, CMS also agreed to “grandfather” residents who begin training before October 1, 2003. Under this policy, a resident who began training on or before October 1, 2003 may continue to be counted by a hospital for purposes of direct GME and IME payments until the resident has completed training in that program, or until three years after the date the resident began training in that program, whichever comes first. The grandfather policy will only apply to specific residents. Hospitals will be required to identify those residents, by social security number, to their fiscal intermediary and specify the length of time the hospital will be counting these FTE residents for direct GME and IME payment purposes.

CMS provides the following example. It is determined that the costs of training residents at a non-hospital site were incurred by a university from 1990 through 1999 and subsequently redistributed to the hospital. The program includes five FTEs that began training in a two-year orthodontics program in a dental school on July 1, 2003, and another five residents that began their training in the same program on July 1, 2004. The five FTEs who began training on July 1, 2003, are grand fathered and would not be disallowed as of October 1, 2003. The hospital may continue to count these five FTEs through June 30, 2005, when they finish the two-year orthodontics program. However, the five FTEs that began training on July 1, 2004 are not grand fathered and beginning July 1, 2004 of the hospital’s December 31, 2004 cost report, the fiscal intermediary will disallow IME and direct GME payment associated with these five FTE slots.

CMS specifies that the redistribution of costs would **not** apply and there would be no disallowance in the case of a new program that is established at a non-hospital site. It is also permissible under the proposal to count FTE residents where the hospital incurs the cost of FTE residents that are added to an existing program at a non-hospital site. However, to count residents in a non-hospital setting, a hospital is required to incur “all or substantially all of the costs of the program” in that setting. Therefore, a hospital would be required to assume financial responsibility for the full complement of residents training in a non-hospital site, but would only be able to count the additional FTE residents who were added to the existing program.

The policy will **not** apply if one hospital had incurred the direct GME costs of training residents in a particular program in a non-hospital site and then another hospital consecutively incurs the costs. The second hospital would be eligible to receive direct GME and IME payments for training the FTE residents from the point in time where it began to incur the direct GME costs because the costs were incurred previously by a hospital, and not the community or a university.

RURAL TRACK PROGRAMS

CMS established rural track provisions to encourage the training of physicians in rural areas. An urban hospital that establishes a separately accredited approved medical residency program in a rural area or has a program with an integrated rural track receives an adjustment to its FTE cap. CMS has defined a rural track as a program in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital. The program must be separately accredited as a rural track residency program by the Accreditation Council of Graduate Medical Education (ACGME). Current policy requires that time spent training in a rural setting must constitute at least two-thirds of the duration of the program.

CMS has found that in certain circumstances ACGME will accredit a rural track program where less than two-thirds of the time is spent in rural areas. Therefore, CMS is revising the regulations so that rural track residents must train in a rural setting for at least one-half of the time. This revised policy will be effective for cost reporting periods beginning on or after October 1, 2003.

CMS is also revising the regulations to bring them in line with current policy regarding the treatment of rural track residents in the three-year rolling average for GME payment. Under this policy, when an urban hospital with an existing FTE cap establishes a new program with a rural track or expands an existing rural track program, the FTE residents in that program are included in the hospital’s rolling average FTE resident count immediately.

TECHNICAL CHANGE RELATING TO AFFILIATED GROUPS

Current regulations allow hospitals to institute an affiliation agreement electing to apply the FTE resident limit on an aggregate basis. CMS has found that there is confusion because the term “affiliation” is used in other contexts. Therefore, CMS is revising the regulations to read “Medicare GME affiliation agreement” and “Medicare GME affiliated group” to clarify that there must be an agreement specifically related to GME payment.

NURSING AND ALLIED HEALTH EDUCATION

PROGRAMS OPERATED BY WHOLLY OWNED SUBSIDIARY EDUCATIONAL INSTITUTIONS

Medicare currently pays providers for approved nursing and allied health education (NAHE) programs on a reasonable cost basis. According to current regulations, to be identified as a provider-operated NAHE program, the provider must directly incur the training costs, have direct control of the curriculum and administration of the program, employ the teaching staff, and provide and control the classroom training and clinical instruction.

The rules include a provision allowing a hospital to establish its own educational institution to meet accrediting standards, if the educational institution is wholly within the provider's control and ownership and the provider continues to incur the costs of both classroom and clinical training. CMS states that simply transferring the operation of NAHE programs to educational institutions entirely under the control of the hospital does not necessarily mean that the programs continue to meet the provider-operated criteria. To remain provider-operated, the hospital must have direct control of the program, the hospital itself must employ the teaching staff, it must have direct control of the program curriculum, and it must meet all other requirements for receiving pass-through payments.

CMS will not recoup pass-through payments from hospitals that transferred the operation of NAHE programs to educational institutions under the hospital's control and ownership before October 1, 2003. In addition, these hospitals will continue to receive pass-through payments. Hospitals that choose to restructure programs to be operated by a wholly-owned subsidiary educational institution on or after October 1, 2003 would not be eligible for pass-through payments unless the hospital meets all of the requirements.

CONTINUING EDUCATION FOR NURSING AND ALLIED HEALTH

CMS has revised the regulations to clearly differentiate between provider-operated continuing education programs that CMS considers normal hospital operating costs covered by the PPS rate, and approved NAHE programs that are eligible for pass-through payments. CMS is amending the regulations to state that activities treated as normal operating costs include "Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty." These types of programs will not be paid as pass-throughs.

Pass-through payments will be provided only to programs that qualify an individual to be employed in a specialty in which the individual could not have been employed before completing a particular education program. CMS will use "industry norms" as the standard to determine whether participation in a program enables an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. Industry norm will be defined to mean that more than 50% of hospitals in a random, statistically valid sample require the completion of a particular training program before an individual may be employed in a specialty. CMS provides the following as examples of application of this criterion:

- Participants in a provider-operated nursing diploma program could not practice as nurses without that training. Therefore, the nursing program may be eligible for pass-through payment.
- A nurse residency program is a postgraduate program that typically lasts one year and trains nurses to care for patients who require complex services. CMS states that these programs do **not** qualify the nurse to be employed in a new specialty and are not eligible for pass-through payment.
- A one-year pharmacy practice residency is typically required before a hospital will hire an individual to fill a position that requires direct work with hospital patients. CMS considers this the industry norm for practice in the "specialty" of hospital pharmacy. Therefore, these programs may be eligible for pass-through payment.
- Pharmacists may also go on to participate in a second year of specialized residency in a focused area of pharmacy practice such as oncology or cardiology. CMS has determined that it is NOT currently the industry norm to require completion of these programs before beginning work in these specialties. Therefore, these programs are not eligible for pass-through payment. This could change if it later becomes the industry norm to require this training.

- It is the industry norm for hospitals to employ only board-certified chaplains and to require completion of approximately 1,600 hours of Clinical Pastoral Education (CPE) before an individual can begin employment as a hospital chaplain. Therefore, a hospital that operates a CPE program may be eligible for pass-through payment.

To receive pass-through payment, an eligible program must meet all other criteria including: the program must be accredited by a national approving body; and the provider must directly incur the training costs, have direct control of the curriculum and administration of the program, employ the teaching staff, and provide and control the classroom training and clinical instruction.

CRITICAL ACCESS HOSPITALS

CAHs receive payment at a reasonable cost for outpatient services. However, payments for outpatient clinical diagnostic laboratory tests are made on a reasonable cost basis only if the test is done for an individual who is an outpatient of the CAH at the time the specimens are collected. An outpatient is defined as a person who has not been admitted as an inpatient but is registered on hospital records as an outpatient and receives services (rather than supplies alone) directly from the hospital. Clinical tests for those who are not patients of the CAH are based on the fee schedule that applies to independent laboratories.

Questions have been raised about payment when the employees of a CAH collect specimens at a setting outside of the CAH. CMS is revising the regulations to state that a CAH will receive payment for clinical diagnostic laboratory tests based on reasonable cost only if the individuals for whom the tests are made are outpatients of the CAH and are physically present in the CAH at the time the specimens are collected. Payments for anyone not meeting the proposed criteria will be based on the fee schedule.

HOSPITAL UNITS EXCLUDED FROM THE INPATIENT PPS

Psychiatric Excluded Hospitals or Units: The FFY 2004 market basket update is 3.4% for exempt units. Each year CMS sets payment limitations for new excluded hospital or hospital units. Rehabilitation and long-term care hospitals or units are now subject to PPS and new facilities are paid 100% of the federal prospective rate. Payments for psychiatric hospitals or units are based on 110% of the national median target amount updated by the market basket. The FFY 2004 labor-related rate is \$7,294 and the non-labor rate is \$2,899 for new psychiatric facilities.

CMS states that it is in the process of developing a proposed rule that will establish a per diem PPS for inpatient psychiatric facilities, but does not provide a timetable in the final rule.