



WISCONSIN HOSPITAL ASSOCIATION, INC.

SUMMARY OF THE FINAL FFY 2005 MEDICARE HOSPITAL INPATIENT RULE

September 2004

WISCONSIN HOSPITAL ASSOCIATION
5721 Odana Road
Madison, WI 53719
(608) 274-1820
www.wha.org

TABLE OF CONTENTS

I.	Overview	1
II.	Standardized Amounts	1
III.	Cost Outliers	2
IV.	Wage Index	3
V.	Wage Index Reclassifications.....	4
VI.	Post-Acute Care Transfer Policy	6
VII.	Additional Payments for New Medical Technology	6
VIII.	Payment Adjustment for Low-Volume Hospitals	7
IX.	Disproportionate Share Hospital (DSH) Payments	7
X.	Graduate Medical Education	8
XI.	Redistribution of “Unused” Resident Slots	9
XII.	Additional Payments to Hospital With High Percentage of End-State Renal Disease (ESRD) Discharges.....	11
XIII.	Critical Access Hospitals (CAHs)	11
XIV.	Long-Term Care Hospitals	13

I. OVERVIEW

CMS published the final Medicare Inpatient Prospective Payment System (PPS) rule for federal fiscal year (FFY) 2005 in the August 11 *Federal Register*. A significant component of the final rule is the revision of the wage index, including revised wage index areas based on the 2000 U.S. Census and an adjustment to the wage index calculation to incorporate occupational mix data. The final rule also includes a full market basket update for hospitals that agree to submit quality data, implementation of payment improvements provided by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, and a methodology to redistribute unused resident slots. This document summarizes the provisions of the final inpatient PPS. Changes are effective October 1, 2004 unless otherwise noted.

II. STANDARDIZED AMOUNTS

Operating Rates: Several provisions of the MMA will affect the FFY 2005 standardized amounts. These provisions include the equalization of large urban and all other standardized amounts, a full or reduced marketbasket adjusted rate based on the reporting of quality data, and the reduction of the labor share to 62 percent for hospitals with a wage index of less than 1.0000. These changes are reflected in the following table:

Standard Rate for Hospitals with a Wage Index Greater than 1 (71.1 Percent Labor Share and 28.9 Percent Non-labor Share)		
	Labor-related	Non-labor related
Full Update (3.3%)	\$3,238.73	\$1,316.45
Reduced Update (2.9 %)	\$3,266.19	\$1,311.35
Standard Rate for Hospitals with a Wage Index Less than or Equal to 1 (62 Percent Labor Share and 38 Percent Non-labor Share)		
	Labor-related	Non-labor related
Full Update (3.3%)	\$2,824.21	\$1,730.97
Reduced Update (2.9%)	\$2,813.27	\$1,724.27

Capital Standard Federal Payment Rate	
National Capital Rate:	\$416.63

Equalization of Urban and Rural Standardized Amounts (*Federal Register* page 49077):

Before April 1, 2003 there were two standard rates: one for large urban areas (population over one million) and a lower rate for other urban areas and rural areas. Legislation was passed to temporarily increase the rate for other urban and rural areas by 1.6 percent to make it equal to the large urban rate. This provision was subsequently extended and then made permanent by the MMA.

Reporting of Hospital Quality Data for Annual Hospital Payment Update (*Federal Register* page 49078):

In prior updates to the inpatient PPS, CMS provided an update to the standard operating rates based on the latest estimate of the hospital marketbasket percentage or the marketbasket less a legislated reduction. The MMA provides a full marketbasket update for hospitals that submit quality data to CMS by established deadlines. Hospitals that fail to submit the necessary data or withdraw from the program will receive the marketbasket increase minus 0.4 percent.

Hospitals that join the program will be required to collect and report data on ten clinical measures. To receive the full marketbasket update for FFY 2005, hospitals must have completed the Reporting Hospital Quality Data for the Annual Payment Update program notice of participation form by August 1 and have met the following deadlines for data submissions:

- If the hospital began data submission for all ten measures effective with the first quarter 2004 discharges, then the hospital or their vendor must have begun data submission for some of the discharges for that quarter by July 1, 2004. Complete submissions must have been submitted and successfully accepted by August 1.
- If the hospital had submitted all ten measures for the fourth quarter 2003 discharges by the CMS deadline of May 15, 2004, the hospital or their vendor must have submitted the first quarter 2004 discharges by the regularly scheduled deadline of August 15.

Full instructions are available at: http://www.qnetexchange.org/public/hdc/docs/pdf/rhqdapu_checklist.pdf .

The law provides a full update factor for qualifying hospitals for three years (FFYs 2005-2007). Reductions to a non-participating hospital's rate will apply only to the fiscal year involved. If the hospital subsequently joins the program, the prior reduction will not be taken into account in computing the update for that fiscal year. The MMA restricts the application of this provision to hospitals paid under the inpatient PPS. Therefore, the provision does not apply to hospitals and hospital units excluded from the inpatient PPS nor to payments to hospitals under other systems such as the outpatient PPS. New hospitals will be held harmless, will receive a full market basket update, and are asked to submit quality data as soon as it becomes available.

Revision of the Labor-Related Share for the Hospital Wage Index (*Federal Register* page 49082):

The wage index adjustment is only applied to a portion of the PPS standard rate. This labor-related share is based on an estimate of the national average proportion of hospital operating costs that vary with the local labor market. The FFY 2004 labor-related share is 71.066 percent. The MMA requires that, effective FFY 2005, CMS apply a labor share of 62 percent to the standard rate unless this would result in lower payments than otherwise would be made (i.e., the hospital has a wage index greater than 1.0000).

III. COST OUTLIERS

Background: CMS provides payments for outlier cases involving extraordinarily high costs when compared to average cases in the same Diagnosis Related Group (DRG). To qualify as a cost outlier, a hospital's cost for the case must exceed the payment rate for the DRG plus a specified amount called the fixed loss threshold. The outlier payment is equal to 80 percent of the difference between the hospital's cost for the stay and the threshold amount. The threshold is adjusted every year based on CMS' projections of total outlier payments, in order to make outlier reimbursement equal 5.1 percent of total payments. CMS estimates that actual FFY 2003 outlier payments were 5.7 percent of total payments and that projected FFY 2004 outlier payments are approximately 4.4 percent of total payments.

Costs for the outlier calculation are based on the reported charges for a case multiplied by the hospital's cost to charge ratio (CCR). Before FFY 2004, the ratio was based on data from the most recent final settled cost report for each hospital. These data were from a period that was three to five years before the payment period. As a result, hospitals that implemented extremely high charge increases received inflated outlier payments. In FFY 2004, CMS began to update the CCRs using tentatively settled cost reports instead of finalized cost reports, cutting the lag time in determining the CCR to between one and two years. In addition, beginning August 8, 2003, a policy was implemented to revise the CCR if recent charge data indicated that a hospital's charges were "increasing at an excessive rate."

CMS Final FFY 2005 Rule: The outlier threshold is reduced from \$31,000 in FFY 2004 to \$25,800 in FFY 2005. This will make it easier for complex, high-cost cases to qualify for outlier payments. CMS had proposed a \$35,085 threshold, but, based on comments submitted by the hospital industry, acknowledged that this threshold reflected inaccurate charge increase assumptions.

IV. WAGE INDEX

Background: The law requires that the PPS standard rate be adjusted “for area differences in hospital wage levels by a factor [established by the Secretary of Health and Human Services] reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” Currently, CMS defines hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB) using data from the 1990 Census. The data used to calculate the relative wages for each area are updated annually based on information submitted by the hospitals. The law requires that this update and any other adjustments to the wage index be made in a budget-neutral manner that ensures that aggregate payments to hospitals are not affected by the changes.

CMS Final FFY 2005 Rule: The final rule incorporates significant wage index revisions due to data updates, revised wage area definitions and an occupational mix adjustment.

Redefinition of Geographic Areas (*Federal Register* page 49026):

CMS currently defines geographic areas using Metropolitan Statistical Areas or New England County Metropolitan Areas based on the 1990 Census. Last summer, OMB released new definitions based on the 2000 Census. The OMB defines Core-Based Statistical Areas (CBSAs) as geographic entities with at least one core of 10,000 or more population. Within these CBSAs are two subcategories: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas. MSAs will still be the basic unit for defining wage areas. MSAs are defined as urban areas with populations of 50,000 or more, which is the same definition that was used to derive MSAs based on the 1990 Census data. Micropolitan Statistical Areas are defined as urban areas of greater than 10,000, but less than 50,000 population. CMS is not establishing separate wage indexes for Micropolitan Areas; these areas will be included in the statewide rural areas. Some additional points of note with regard to the new geographic areas are:

- The boundaries of many MSAs change based on the 2000 Census data and several new MSAs are created due to population changes from 1990 to 2000.
- The “metropolitan division” is a new designation that did not exist under the prior definitions. Metropolitan divisions are defined as a county or group of counties within a MSA that has a population of at least 2.5 million and its own urban core. Metropolitan divisions will be treated as distinct wage areas.
- CMS will provide a one-year transition for hospitals that are harmed by the redefinition of wage index areas. Hospitals that would have received a higher wage index under the prior geographic area definitions will receive a blend of 50 percent of the wage index based on the new definitions and 50 percent based on the old definitions. The transition will be implemented in a budget-neutral manner, decreasing the standard rate by 0.18 percent.
- Urban hospitals that become rural under the new geographic definitions will maintain their assignment to the urban area where they are currently classified for a three-year transition period.
- CMS has established policies that will allow Sole Community Hospitals (SCHs), Rural Referral Centers (RRCs) and Critical Access Hospitals (CAHs) to retain their status, if the county they are located in is redesignated from rural to urban.
 - RRCs will be allowed to keep their status under an existing policy that grandfathered these

facilities in the past.

- SCHs and CAHs are instructed to apply for rural designation based on an existing regulation in Section 412.103 that allows a hospital in an urban area to be reclassified as rural. This regulation allows reclassification if the hospital is located in a rural census tract; is located in an area designated by any law or regulation of the State in which it is located as a rural area or is designated as a rural hospital by the State law or regulations; or if the hospital would qualify as an RRC or SCH if it was located in a rural area. CMS is amending this regulation to make the same criteria applicable to CAHs.

Occupational Mix Adjustment (*Federal Register* page 49034):

CMS is required to include an occupational mix adjustment as part of the calculation of the FFY 2005 wage index. For FFY 2005 CMS calculated wage indexes using a blend of 10 percent of the wage data adjusted for occupational mix and 90 percent of the data unadjusted for occupational mix. CMS indicates that it is moving cautiously due, primarily, to data issues, including the short timeframe that hospitals had for collecting their occupational mix survey data and the lack of baseline data for CMS to use in developing a desk review program to ensure the accuracy of the occupational mix survey data. CMS is not proposing a phase-in of the occupational mix adjustment beyond FFY 2005. Instead, the application of the occupational mix adjustment beyond FFY 2005 will be determined and discussed in subsequent inpatient rule updates.

V. WAGE INDEX RECLASSIFICATIONS

Background: Hospitals are able to request a reclassification to another wage area if they meet specified criteria, including proximity requirements and wage level comparisons. These requests are made to the Medicare Geographic Classification Review Board (MGCRB). If the request is granted, the hospital is paid based on the wage index of the requested area for a three-year period. Currently, a rural or other urban hospital may also request a one-year reclassification to a large urban area for the standard amount. If granted, the hospital would be assigned to that area for the use of the PPS rate and other reimbursement purposes. In addition to these reclassifications granted by the MGCRB, certain hospitals were granted special, one-time appeals under Section 508 of the MMA. These reclassifications were effective for three years beginning April 1, 2004.

CMS Final FFY 2005 Rule: CMS includes several wage index reclassification/adjustment provisions in the final rule. In addition to the reclassifications discussed above, CMS has reclassified additional rural hospitals under the existing Lugar criteria due to the new CBSA definitions and has calculated add-on adjustments to recognize the out-migration of residents in certain counties who work in other wage index areas (per Section 505 of the MMA).

Reclassification Criteria (*Federal Register* page 49053):

CMS has revised the regulations such that, to qualify for reclassification, the hospital's three-year average hourly wage must be at least 106 percent (in the case of a hospital located in a rural area) or at least 108 percent (in the case of a hospital located in an urban area) of the average hourly wage of all other hospitals in the area in which the hospital is located – **excluding the hospital's own data**. This will make it easier for hospitals to qualify for reclassification. The new regulations are effective for reclassifications for FFY 2006 and thereafter.

Application of CBSAs to Reclassified Hospitals (*Federal Register* page 49053):

Wage index reclassifications are granted for a three-year period. Therefore, many hospitals have a continuing reclassification to a wage area defined under the existing MSAs based on 1990 Census data. In addition, applications to MGCRB for FFY 2005 reclassifications and the applications for Section 508 reclassifications were determined based on those MSAs. CMS has assigned hospitals that received these reclassifications to the new CBSA wage areas. CMS instructs hospitals with reclassifications to check the wage index for the area to

which they are reclassified. If the reclassification is no longer beneficial, a hospital must withdraw its reclassification request within 30 days of the publication of the final rule, making the deadline September 11.

Some MSAs are divided into two or more CBSAs under the new definitions. If a hospital was reclassified to one of these MSAs, CMS has assigned it to the new CBSA that includes the county that is closest to the hospital. Hospitals that reclassified under Section 508 of the MMA will automatically receive the higher of the wage indexes if the CBSA is split. Reclassified hospitals that have been assigned to a new CBSA are reported on Tables 9A2 and 9B of the Addendum to the final rule (*Federal Register* page 49704).

Lugar Reclassifications (*Federal Register* page 49056):

The law requires that CMS automatically reassign any hospital located in a rural county adjacent to one or more urban areas if the county meets specified commuting criteria known as “Lugar criteria.” CMS has used the new CBSA definitions and 2000 Census data to assign reclassifications to hospitals in counties that meet these criteria. Hospitals that qualify for an automatic Lugar reclassification might have also requested a reclassification under the MGCRB or Section 508 criteria, in which case the requested reclassification overrides the Lugar reclassification. Hospitals that qualify for both are instructed to compare their wage index under the MGCRB/Section 508 reclassification to the wage index under the Lugar reclassification. Hospitals must withdraw their MGCRB/Section 508 reclassification requests within 30 days of publication of the final rule (September 11) if they prefer to receive the Lugar assignment. Counties that meet the Lugar criteria are reported in the *Federal Register* on page 49057.

Wage Index Adjustment for Commuting Patterns (Out-migration) (*Federal Register* page 49061):

Section 505 of the MMA requires that CMS develop an alternative adjustment to the wage index based on the commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index. Qualifying hospitals receive an adjustment to their wage index based on the percentage of county residents that commute to the other area. The adjustment is added to the wage index for the area that the hospital is located in and is to be effective for three years beginning October 1, 2004. If a hospital in one of these counties does not have an existing reclassification, it will automatically receive the adjustment. Hospitals cannot receive an adjustment under this provision if they already receive a reclassification. Therefore, if a hospital has an existing reclassification (MGCRB, Section 508 or Lugar), that hospital must withdraw its reclassification by September 11 (30 days after publication of the final rule) in order to receive the out-migration adjustment instead. Hospitals eligible for this adjustment are reported on Table 4J of the final rule (*Federal Register* page 49580).

Elimination of Standard Rate Reclassifications (*Federal Register* page 49103):

In the past, hospitals could request a reclassification for the standardized amount. The final rule eliminates the process for applying for a standardized amount reclassification because the MMA has equalized the rates. Even with no difference in rates, a hospital that reclassifies might still benefit from other payment advantages applied to large urban areas, such as higher Disproportionate Share Hospital payments and an increase to capital rates. The final rule eliminates this possibility.

Group Appeals That Were Denied Due to Standard Amount Criteria (*Federal Register* page 49104):

The existing reclassification rules allow all hospitals in a county to file a group appeal for wage index reclassification if they meet specified criteria. These include criteria based on the standardized amounts. Due to the equalization of the standardized amounts, CMS has determined that these criteria are no longer appropriate. Therefore, the final rule states that any hospital that was part of a group appeal for the FFY 2004 or FFY 2005 wage index and was denied because it failed to meet the standard amount criteria may receive the reclassification that was requested in that appeal.

Rural Referral Center (RRC) Reclassification Criteria (*Federal Register* page 49105):

Medicare law and regulations provide more advantageous reclassification rules to RRCs. They are exempt from the requirement that the hospital’s average hourly wage (AHW) meet a threshold percentage in relation to the

AHW of the area in which the hospital is located. However, they are **not** exempt from another reclassification criterion that requires the hospital's AHW to meet a threshold percentage of the AHW of the hospitals located in the area to which the hospital seeks reclassification. This threshold is 84 percent for hospitals located in urban areas and 82 percent for hospitals located in rural areas. Since it is possible for an RRC to be located in an urban area, CMS has decided that it is appropriate for all RRCs to be treated the same. Therefore, the final rule states that all RRCs, regardless of urban or rural location, are required to meet the lower 82 percent threshold for reclassification.

Reclassification for Sole Community Hospitals in Low Density States (*Federal Register* page 49106):

CMS has decided to provide a special reclassification for SCHs in low-density states. The MMA provided a special, one-time wage index reclassification for SCHs in states with fewer than 10 people per square mile (Alaska, Montana, North Dakota, South Dakota and Wyoming). However, some SCHs in those states did not meet all of the required criteria for that reclassification. CMS says it is "concerned that these hospitals could now be placed at a serious disadvantage in comparison to other SCHs in their States and regions." Therefore, the final rule provides special protection to SCHs in the five low-density states, allowing them to adopt the wage index of another geographic area within their state for 3 years. Those SCHs that qualify for this special reclassification need to have applied to CMS during the comment period for the proposed rule. These wage index assignments become effective for FFY 2005 through FFY 2007 and will not be available thereafter.

States without a Rural Area (*Federal Register* page 49109):

CMS has established a proxy wage index floor for hospitals in all-urban states (Massachusetts, New Jersey and Rhode Island) as a substitute for the rural floor that applies in other states. A minimum wage index has been calculated for each of these states based on the ratio of lowest to highest wage indexes in the state.

VI. POST-ACUTE CARE TRANSFER POLICY

Background: When a patient is transferred from one acute care facility to another acute care facility, the transferring hospital receives a per diem payment with total payment limited to the full Diagnostic Related Group (DRG) amount that would have been made if the patient were discharged without being transferred. Beginning in FFY 1999, the transfer policy was expanded to cover patients discharged to a post-acute care setting. Initially, this policy applied to cases assigned to one of ten DRGs that had high volumes of cases discharged to post-acute care. The law gave CMS authority to expand the number of DRGs for FFY 2001 and subsequent years.

CMS Final FFY 2005 Rule (*Federal Register* page 49070):

CMS established criteria for determining the DRGs that should be included and extended the policy to cover 29 DRGs in FFY 2004. In the FFY 2005 final rule, CMS found that no additional DRGs met the current criteria. However, CMS is revising the list of DRGs included in the post-acute care transfer policy to take into account that one DRG current subject to the post-acute transfer policy has split into two new DRGs. Therefore, cases that were previously assigned to DRG 483: Tracheostomy will now fall into either DRG 541: Tracheostomy with Major Operating Room Procedure or DRG 542: Tracheostomy without Major Operating Room Procedure. Both of these new DRGs will be included in the post-acute transfer policy.

VII. ADDITIONAL PAYMENTS FOR NEW MEDICAL TECHNOLOGY

Background: Current law provides additional payments for new medical services and technologies that meet specified criteria. The adjustment is required to be budget-neutral, and one percent of total estimated operating prospective payments were carved out of the standard PPS rate for these payments.

CMS Final FFY 2005 Rule (*Federal Register* page 49084):

The final rule incorporates the MMA requirement that CMS lower the threshold criteria for technologies to be designated for the additional payment. The MMA also eliminates the budget neutrality provision for payments for a new medical service or technology. Therefore, under the FFY 2005 final rule, CMS no longer includes the impact of additional payments for new medical services and technologies in the budget neutrality factor that is applied to the standard rate.

VIII. PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS

Background: The MMA provides for a payment adjustment for low-volume hospitals effective October 1, 2004. This payment adjustment is intended to compensate for the higher cost per case in lower volume hospitals, which are defined as hospitals having fewer than 800 discharges per year (for all payers). The MMA specifies that each such hospital must be located more than 25 road miles from another hospital. The maximum adjustment that any hospital may receive is a 25 percent add-on to the standardized amount.

CMS Final FFY 2005 Rule (*Federal Register* page 49099):

The MMA defines low volume as fewer than 800 discharges; however, CMS states that the MMA also requires that CMS base the adjustment on the empirical relationship of low volume to higher costs. Based upon their own analysis, CMS found no evidence of higher incremental costs for hospitals with more than 200 discharges; however, they acknowledge that the empirical evidence was not overwhelming and will re-examine this issue next year.

For FFY 2005, hospitals having fewer than 200 discharges per year that are located more than 25 miles from the next nearest hospital will receive the full 25 percent adjustment for each Medicare discharge. The number of discharges will be based on **total** inpatient acute discharges from the latest submitted cost report. Qualifying low volume hospitals must submit data to their fiscal intermediary demonstrating that they meet the 25-mile criteria.

IX. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

Background: The DSH adjustment provides additional payments to hospitals that treat a high percentage of low-income patients. The adjustment is based on the hospital's DSH patient percentage, which is the sum of the number of patient days for patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits, divided by the total number of Medicare Part A patient days; plus the days for patients who were eligible for Medicaid divided by the total number of hospital inpatient days. Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment.

CMS Final FFY 2005 Rule (*Federal Register* page 49090):

The MMA calls for higher DSH payments for rural hospitals with less than 500 beds and urban hospitals with less than 100 beds. Before the MMA, these hospitals received payments based on a less generous DSH adjustment formula and their DSH adjustment was capped at 5.25 percent. The MMA increases the cap to 12 percent and provides for the same DSH adjustment formula as is used for large rural and large urban hospitals. The cap for SCHs has also been raised from 10 percent to 12 percent. RRCs are not capped, but benefit from the change in DSH formula.

Available Bed Days (*Federal Register* page 49092):

In the final FFY 2005 rule, CMS makes a final determination on proposed revisions to its policies for counting beds and days for DSH and Indirect Medical Education (IME) payments. These proposals were issued in the

FFY 2004 inpatient PPS proposed rule that was published in the May 19, 2003 *Federal Register*. CMS postponed its final determination on these proposals until this final FFY 2005 rule. All of the following policies are effective for discharges occurring on or after October 1, 2004:

- Beds in a unit that was not occupied to provide an inpatient PPS level of care during the three preceding months are excluded from the available bed day count. If any of the beds in a unit or ward were used to provide an inpatient PPS level of care at any time during the preceding three-month period, all of the beds in that unit or ward will be counted for purposes of determining available bed days during the current month. In addition, bed days for any bed within a unit that would otherwise be considered occupied are excluded from the available bed day count if that bed has remained unavailable for 30 consecutive days or if that bed is used to provide outpatient observation services or swing bed skilled nursing care.
- Observation and swing bed days are excluded from the counts of both available bed days and patient days unless the patient receiving outpatient observations services in a bed that is generally used to provide hospital inpatient acute care services is ultimately admitted, in which case the beds and days associated with the observation services should be included in those counts.
- The days associated with dual-eligible beneficiaries are included in the Medicare fraction of the DSH formula, whether or not the beneficiary has exhausted Medicare Part A hospital coverage. If the patient is entitled to Medicare Part A and Supplemental Security Income (SSI), the patient days will be included in both the numerator and the denominator of the Medicare fraction.

X. GRADUATE MEDICAL EDUCATION (GME)

Background: Direct Medical Education (DME) payments are based on a hospital's allowable per resident amount (PRA), the number of residents it trains, and its Medicare patient share. Indirect Medical Education (IME) payments are based on the ratio of the hospital's residents to the number of hospital beds.

Indirect Medical Education (IME) Adjustment (*Federal Register* page 49088):

The IME adjustment factor is calculated using a hospital's ratio of residents to beds and a formula multiplier, which is represented as "c" in the equation: $c \times [(1 + \text{ratio of residents to beds})^{\text{raised to the power of } 0.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10 percent increase in the resident-to-bed ratio. Before enactment of the MMA, the formula multiplier was set at 1.35 for discharges occurring during FFY 2003 and thereafter, which equates to a 5.5 percent adjustment. The MMA modified the formula as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47 (equivalent to a 6.0 percent adjustment).
- For discharges occurring during FFY 2005, the formula multiplier is 1.42 (equivalent to a 5.8 percent adjustment).

Direct Medical Education (*Federal Register* 49111):

The MMA extends the ceiling on the PRA and eliminates the update for hospitals over 140 percent of the national average PRA for the period FFY 2004 through FFY 2013.

Initial Residency Period for DME Payment (*Federal Register* 49169):

While a resident is in the initial residency period the resident is weighted at 1.00. When a resident is no longer in the initial residency period the resident is weighted at 0.5. The initial residency period is determined as of the time the resident enters the initial or first residency training program and is based on the period of board

eligibility associated with that medical specialty. This can cause limitations on the amount of DME payment a hospital will receive for residents who switch specialties.

The Conference Report that accompanied the MMA required that “the initial residency period for any residency for which the ACGME [Accreditation Council on Graduate Medical Education] requires a preliminary or general clinical year of training is to be determined in the resident’s second year of training.” CMS is concerned that implementation of this requirement allows for a differentiation between those residents who simultaneously matched in a specialty program before their first year of training; those residents who did not match simultaneously, but participated in a clinical base year and then continued on to train in a different specialty; and those residents who simply switched specialties in their second year.

The FFY 2005 final rule implements a simultaneous match policy, effective October 1, 2004. 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 the specialty program in which the resident intends to seek board certification, the resident’s initial residency period will be based 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.

Exception to Initial Residency Period for Geriatric Residency Programs (*Federal Register* 49174):

In 1998, The American Board of Internal Medicine and the American Board of Family Physicians reduced the minimum number of years of formal training required for residents to become board eligible in geriatrics from two years to one year. As a result, the initial residency period and full DME funding for residents in geriatric training programs is limited to one year. However, many hospitals continue to run geriatric residency or fellowship programs of at least two years in length. The MMA requires that CMS provide an exception to the initial residency policy in cases where the hospital program requires a resident to complete two years or more of training to initially become board eligible in the geriatric specialty. The FFY 2005 final rule implements this policy, effective cost-reporting periods beginning **on or after October 1, 2003**.

Resident Training in Non-Hospital Settings (*Federal Register* 49176):

Under existing rules, a hospital may count residents training in non-hospital settings if the residents spend their time in patient care and the hospital incurs all of the costs of the program. Current CMS policy requires that there be a written agreement stating that the hospital will incur all, or substantially all, of the costs for the training program at the non-hospital site. The FFY 2005 final rule allows hospitals to qualify for DME payments under this scenario if they meet at least one of two criteria: (1) there is a written agreement between the hospital and the non-hospital setting that the hospital will incur all or substantially all of the costs of training in the non-hospital setting; or (2) the hospital pays the costs associated with the training program in the non-hospital setting by the end of the third month following a month in which the training occurred.

XI. REDISTRIBUTION OF “UNUSED” RESIDENT SLOTS

Background: The Balanced Budget Act (BBA) of 1997 established a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for DME and IME purposes. The cap is based on the number of residents that each hospital trained in its most recent cost-reporting period ending on or before December 31, 1996. The MMA provided for reductions in the resident caps for certain hospitals and a redistribution of the resident slots resulting from the reductions to other hospitals. A hospital’s resident cap will be reduced if the number of residents who are training during a specified cost-reporting period is below the cap for that period. The reduction will equal 75 percent of the difference between the hospital’s otherwise applicable resident cap and its actual resident level. Rural hospitals with less than 250 acute care inpatient beds are exempt from the reduction.

The MMA provides that CMS shall increase the resident caps for certain hospitals for portions of cost-reporting periods occurring on or after July 1, 2005, by an aggregate number that does not exceed the estimated overall

reduction in resident caps. In determining which hospitals receive increases, CMS is required to establish a priority order to distribute resident slots first to programs in hospitals located in rural areas; second, to urban hospitals that are not in large urban areas; and third, to other hospitals operating a training program in a state where there is no other training program for a particular specialty. CMS must also take into account the demonstrated likelihood of the hospital filling the additional positions within the first three cost-reporting periods beginning on or after July 1, 2005. No hospital may receive an increase in its FTE resident cap of more than 25 additional FTEs.

CMS Final FFY 2005 Rule (*Federal Register* 49112):

The final rule implements the MMA provision by reducing the resident caps for hospitals that have unused resident slots and establishing a methodology to redistribute unused resident slots to other hospitals based on priorities determined by a point system.

Hospitals Subject to the FTE Resident Cap Reduction (*Federal Register* 49113):

If a hospital's resident level is less than the hospital's resident cap in the reference period, the hospital's resident cap will be permanently reduced by 75 percent of the difference between the actual resident level and the resident cap. For example, if a hospital's resident cap for the reference period is 100 full time equivalents (FTEs) and its actual resident level for that period is 80 FTEs, CMS would reduce the hospital's resident cap by 15 FTEs (75 percent of 20 FTEs). The reduced caps will be effective beginning with portions of cost-reporting periods occurring on or after July 1, 2005.

The reference period for determining a hospital's resident level is specified in the MMA as the most recent cost-reporting period ending on or before September 30, 2002. If a hospital's cost report for the most recent cost-reporting period ending on or before September 30, 2002 has not been settled as of April 30, 2004, the "as-submitted" cost report will be used to determine any reduction in the FTE resident cap, subject to audit by the fiscal intermediary.

If a hospital expanded an existing residency training program and the expansion was not reflected in the cost report ending on or before September 30, 2002, it may request the substitution of the cost report that includes July 1, 2003. CMS states that an "expansion of an existing program" simply means that the hospital's total number of unweighted allopathic and osteopathic FTE residents training in existing programs in a cost-reporting period up to and including the hospital's cost report that includes July 1, 2003 is greater than the resident level in the hospital's most recent settled cost report. The request must have been submitted to the fiscal intermediary on or before June 14, 2004. A hospital may also request an adjustment to include residents in newly approved programs. If a hospital's new program was accredited by the appropriate accrediting body before January 1, 2002, but was not in operation during the hospital's reference period, the hospital may request that the reference resident level be increased to include the number of residents for which a new program was accredited at a hospital. This request also must have been submitted to the fiscal intermediary by June 14, 2004.

The MMA requires that CMS consider whether a hospital is a member of a Medicare GME affiliated group as of July 1, 2003 in determining whether a hospital's FTE resident cap should be reduced. Under an affiliation agreement, the resident cap(s) for one or more hospitals are temporarily reduced and these otherwise "excess" FTE slots are transferred to other hospitals in the group. The FFY 2005 final rule states that "hospitals that are affiliated as of July 1, 2003" means hospitals that have in effect a Medicare GME affiliation agreement for the program year July 1, 2003 through June 30, 2004 and have submitted a Medicare GME affiliation agreement by July 1, 2003 to their fiscal intermediaries with a copy to CMS. Once those hospitals that are affiliated have been identified, the comparison between the FTE resident cap and the reference period count will be conducted first at the affiliated group level and, if the group's aggregate FTE resident count is equal to or exceeds the aggregate resident cap, no reductions will be made to any of the individual hospitals' resident caps. Likewise, these hospitals will be treated as a group in instances where the FTE resident count of the group falls below the aggregate FTE resident cap.

Criteria for Determining Hospitals That Will Receive Increases in Resident Caps (*Federal Register* 49132): The MMA established general criteria for the redistribution of unused resident slots. The FFY 2005 final rule implements the MMA provision by establishing a methodology to redistribute unused resident slots based on priorities determined by a point system. The *Federal Register* (pages 49163 through 49168) includes an evaluation form that hospitals must complete and submit as part of their application to receive these slots. Applications are due by December 1. This application requires the hospital to demonstrate the likelihood that it will be able to fill the additional positions within the first three cost-reporting periods beginning on or after July 1, 2005. The application also requires the hospital to report its priority level category and to identify how many of fifteen evaluation criteria apply (for purposes of assigning points). Hospitals that receive the slots will be given an increased resident cap for portions of cost-reporting periods occurring on or after July 1, 2005. In no case will any hospital receive an FTE cap increase of more than 25 additional slots as a result of the redistribution.

The priority categories that will be used to distribute unused slots to hospitals are (in order):

- rural hospitals with the only specialty training program in the state (for the program requested);
- rural hospitals;
- hospitals located in an other than large urban area with the only specialty program in the state (for the program requested);
- hospitals with the only specialty training program in the state (for the program requested); and
- hospitals that meet none of the statutory priority criteria.

The MMA requires that DME medical payments for the residents attributed to the redistributed slots be calculated using the locality-adjusted national average PRA instead of the hospital's own PRA. The MMA also requires that IME payments for these residents be made at a reduced level using a multiplier of 0.66. In addition, CMS has determined that hospitals that add residents are subject to the rolling average calculation and to the cap on resident to bed ratios. As a result, payments for the new residents will be phased-in over three years.

XII. ADDITIONAL PAYMENTS TO HOSPITALS WITH HIGH PERCENTAGE OF END-STAGE RENAL DISEASE (ESRD) DISCHARGES

Background: Medicare makes additional payments to hospitals that provide inpatient dialysis services to Medicare beneficiaries with ESRD, if the hospital's ESRD Medicare beneficiary discharges are 10 percent or more of its total Medicare discharges. This special payment was intended to ameliorate those circumstances in which the concentration of ESRD beneficiaries receiving inpatient dialysis is such that the hospital can not offset the entire expense with revenue from other, less costly cases.

CMS Final FFY 2005 Rule (*Federal Register* page 49087):

CMS has been informed that some hospitals may be counting all discharges of ESRD Medicare beneficiaries toward determining the 10 percent factor, rather than counting only those discharges where the ESRD beneficiary received inpatient dialysis during their stay. Therefore, the final rule revises the regulations to make it clear that, in determining a hospital's eligibility for the additional Medicare payment, only discharges involving ESRD Medicare beneficiaries who have received a dialysis treatment during their inpatient hospital stay are to be counted.

XIII. CRITICAL ACCESS HOSPITALS

Background: The Critical Access Hospital Program was created by Congress in the Balanced Budget Act of 1997. The purpose of the program is to support small, limited-service hospitals that are located in rural areas. In

order to be designated as a CAH, a hospital must be located in a rural area, provide 24-hour emergency services, have an average length-of-stay of less than 96 hours, and be located more than 35 miles from another hospital (15 miles in areas with mountainous terrain or only secondary roads). The mileage requirement may be waived if the hospital is certified by its State as being a “necessary provider” of healthcare services to the area. CAHs are exempt from the inpatient and outpatient PPS; Medicare pays CAHs for these services based on current allowable costs. CMS has revised the regulations to reflect a number of MMA provisions affecting CAHs including:

Payment Amounts (*Federal Register* page 49214):

Effective for cost-reporting periods beginning on or after January 1, 2004, Medicare payments to CAHs for inpatient, outpatient and skilled nursing facility services will equal 101 percent of the reasonable costs of providing these services.

Application of Special Professional Service Payment Adjustment (*Federal Register* page 49214):

The Social Security Act provides for two methods of payment for outpatient CAH services. Under this law, a CAH is to be paid under a reasonable cost method unless it elects payment under an optional method, also known as Method II. In this case, the CAH submits bills for both facility and professional services to the fiscal intermediary and Medicare makes payments for the facility services at the same level that would apply under the reasonable cost method (set at 101 percent for cost reporting periods beginning on or after January 1, 2004), but services of professionals to outpatients are paid at 115 percent of the amount that would have otherwise been paid under the physician fee schedule. The MMA amends the law by specifying that CMS may not require, as a condition for a CAH to make an election of Method II, that each physician or other practitioner providing professional services in the CAH must assign billing rights to the CAH. However, the optional payment method does not apply to those physicians and practitioners who have not assigned such billing rights.

The final rule states that a CAH may elect to be paid under Method II for outpatient services in any cost-reporting period beginning on or after July 1, 2004. The rule also states that such an election must be made at least 30 days prior to the start of the cost-reporting period for which the election is made and that the provision applies to all services furnished to outpatients during that cost-reporting period by a physician or other practitioner who has assigned his/her billing rights for those services to the CAH.

Coverage of Costs for Certain Emergency Room On-Call Providers (*Federal Register* page 49215):

Effective January 1, 2005, reimbursement to CAHs for on-call emergency room providers is expanded beyond physicians to include physician assistants, nurse practitioners, and clinical nurse specialists for the costs associated with covered Medicare services.

Authorization of Periodic Interim Payments (PIP) (*Federal Register* page 49215):

As per the MMA, effective for payments made on or after July 1, 2004, inpatient services furnished by CAHs will be eligible for PIP. CMS states that the final rule does allow for PIP to be made to CAHs prior to the completion of a full 12-month cost report, so long as the hospital can provide sufficient information in order for its fiscal intermediary to be satisfied that the PIP will result in accurate payments.

Revision of Bed Limits (*Federal Register* page 49217):

Prior to the enactment of the MMA, CAHs were restricted to 15 acute care beds, and a total of 25 beds if the CAH had been granted swing bed approval. The number of beds used at any time for acute inpatient care could not exceed 15 beds. Effective January 1, 2004, any currently participating CAH, or applicant for CAH approval, will be allowed to maintain up to 25 inpatient beds. If swing bed approval has been granted, all 25 beds can be used interchangeably for acute care or swing bed services.

Authority to Establish Distinct Part Units (*Federal Register* page 49217):

Effective for cost-reporting periods beginning on or after October 1, 2004, CAHs will be permitted to establish distinct part rehabilitation and psychiatric units of up to ten beds each. The beds in the distinct part units will not count against the 25-bed limit. Admissions and lengths of stay in distinct part unit beds will not be used in

determining the facility-wide average length stay for purposes of the 96-hour limitation on the average inpatient length of stay. Medicare payments for inpatient services provided in distinct part units will be made under the applicable existing payment methodology for inpatient rehab facilities and inpatient psychiatric facilities.

Waiver Authority for Designation as a Necessary Provider (*Federal Register* page 49220):

Effective January 1, 2006, the MMA eliminates the authority of states to waive distance criteria for CAH status if a hospital is designated as a necessary provider. This provision includes a grandfathering provision that allows a CAH designated as a necessary provider in its state's rural health plan before the effective date to be permitted to maintain its necessary provider designation.

Payment for Clinical Diagnostic Laboratory Tests (*Federal Register* page 49220):

Currently, payments to a CAH for outpatient clinical diagnostic laboratory tests are made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH and are physically present at the CAH at the time the specimens are collected. Otherwise, payments for these tests are made on a fee schedule basis. CMS reaffirms this policy in the final FFY 2005 rule.

XIV. LONG-TERM CARE HOSPITALS

Background: Long-term care hospitals (LTCHs) are required to begin operation as another type of facility, generally as acute care hospitals. After five months, they may qualify as an LTCH by demonstrating an average length of stay in excess of 25 days. Currently, Medicare patients that are admitted while the hospital is an acute care hospital and discharged after the LTCH status is granted are paid under two separate methodologies.

CMS Final FFY 2005 Rule (*Federal Register* page 49075):

The final rule requires CMS to make one payment covering the total stay (days before and after a change in status has been granted) using the LTCH PPS. CMS argues that the current policy with two payments is a holdover from the period before the LTCH PPS and is no longer appropriate. According to CMS, with the LTCH PPS in effect the current policy represents double payment. This one payment policy will only apply to new LTCHs. However, CMS says it could be a model for other situations, such as an acute care hospital that becomes an exempt rehabilitation hospital.