



WISCONSIN HOSPITAL
ASSOCIATION

**SUMMARY OF THE PROPOSED
FFY 2005 MEDICARE
HOSPITAL INPATIENT RULE**

June 2004

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Inpatient Prospective Payment System (PPS) for federal fiscal year (FFY) 2005. The proposed rule (available at http://www.wha.org/financeAndData/pps_inpatient.aspx) provides for a 60-day comment period. The Centers for Medicare and Medicaid Services (CMS) must receive comments by 5 p.m. on July 12.

CMS requests that comments reference the file code CMS-1428-P and the specific “issue identifier” that precedes the section on which you choose to comment. One original and three copies can be delivered to:

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
P.O. Box 8010
Baltimore, MD 21244-1850

Alternatively, comments (an original and three copies) may be hand-delivered to CMS at:

Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

OR

Room C5-14-03
Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

CMS is also accepting comments submitted electronically at:

<http://www.accessdata.fda.gov/scripts/oc/dockets/commentdocket.cfm?AGENCY=CMS>

OR

<http://www.regulations.gov>.

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I. OVERVIEW

CMS published the proposed Medicare Inpatient PPS rule for FFY 2005 in the May 18 *Federal Register*. The proposal includes significant changes including a full marketbasket rate 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 proposed methodology to redistribute unused resident slots. It also proposes significant wage index revisions, 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.

II. STANDARD RATES

Operating Rates: Several provisions of the MMA will affect the FFY 2005 standardized rates. These provisions include the equalization of urban and rural standardized rates, a full or reduced marketbasket adjusted rate based on the reporting of quality data, and the reduction of the labor share to 62% for hospitals with a wage index of less than or equal to one. 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%)	\$3,243.10	\$1,318.22
Reduced Update (2.9 %)	\$3,230.55	\$1,313.12
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%)	\$2,828.02	\$1,733.30
Reduced Update (2.9%)	\$2,817.08	\$1,726.59

	<u>FFY 2004</u>	<u>FFY 2005</u>	<u>Change</u>
Capital Rate:	\$413.83	\$416.59	0.7%

Equalization of Urban and Rural Standardized Amounts (*Federal Register* page 28277)

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% 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 28277)

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%.

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 complete the Reporting Hospital Quality Data for the Annual Payment Update program notice of participation form by August 1 and meet the following deadlines for data submissions:

- If the hospital begins 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 be successfully accepted by August 1.
- If the hospital has submitted all ten measures for the fourth quarter 2003 discharges by the CMS deadline of May 15, 2004, the hospital or their vendor must submit 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.

Proposed Revision of the Labor-Related Share for the Hospital Wage Index (*Federal Register* page 28271)
The wage index adjustment is only applied to a portion of the PPS standard rate. The "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%. The MMA requires that, effective FFY 2005, CMS apply a labor share of 62% to the standard rate unless this would result in lower payments than would otherwise be made (i.e., the hospital has a wage index greater than 1.0).

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 a 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% 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 to try to make outlier reimbursement equal 5.1% of total payments. CMS estimates that actual FFY 2003 outlier payments were 5.7% of total payments and that projected FFY 2004 outlier payments are approximately 4.4% 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 from 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 CCRs using tentative settled cost reports instead of finalized cost reports, cutting the lag time in determining the CCR to a range of one to 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 are "increasing at an excessive rate."

CMS Proposal (*Federal Register* page 28375): CMS is proposing to increase the fixed loss threshold from \$31,000 in FFY 2004 to \$35,085 in FFY 2005. In calculating the FFY 2005 outlier threshold, CMS estimated

the outlier payments using charges from FFY 2003 inflated by the average annual rate of change in charges per case derived from the period FFY 2001 to FFY 2003. CMS notes that this rate of increase is from the period before the revised CCR policies were established when some hospitals were increasing charges at a rapid rate to increase outlier payments. CMS admits that this may result in the proposed outlier threshold for FFY 2005 being too high.

CMS is soliciting comments on the data used to update charges for purposes of determining the threshold and on alternatives that would lead to results that are more accurate. An American Hospital Association (AHA) workgroup is analyzing the proposed rule. An alternative outlier threshold calculation will be one of the areas that is addressed.

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 Proposal: The rule proposes wage index revisions that would result in swings in Medicare payments and a positive change for most Wisconsin hospitals. The revisions include:

- the update of the hospital data used to calculate the wage index from 2000 to 2001 data;
- implementation of 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 following chart summarizes the changes in the wage index caused by each of these factors.

Core-Based Statistical Areas (CBSA)	FFY 2004 Wage Index	Change due to Data Update	Change due to Wage Area Redefinition	Change due to Occupational Mix	Estimated FFY 2005 Wage Index
Wisconsin Rural	0.9304	0.0200	(0.0006)	(0.0001)	0.9497
Appleton, WI	0.9304	0.0200	(0.0006)	(0.0001)	0.9497
Duluth, MN-WI	1.0171	0.0191	(0.0016)	(0.0007)	1.0340
Eau Claire, WI	0.9304	0.0200	(0.0006)	(0.0001)	0.9497
Fond du Lac, WI	0.9304	0.0200	0.0400	(0.0035)	0.9869
Green Bay, WI	0.9518	0.0074	0.0005	(0.0009)	0.9588
Janesville, WI	0.9304	0.0285	-	0.0014	0.9603
La Crosse, WI-MN (WI Hospitals)	0.9304	0.0200	(0.0006)	(0.0001)	0.9497
Lake County-Kenosha County, IL-WI	1.0892	(0.0034)	(0.0509)	0.0005	1.0354
Madison, WI	1.0264	0.0138	(0.0089)	(0.0011)	1.0301
Milwaukee-Waukesha-West Allis, WI	0.9988	0.0094	-	0.0003	1.0085
Minneapolis-St. Paul-Bloomington, MN-WI	1.1001	0.0081	(0.0009)	(0.0019)	1.1054
Oshkosh-Neenah, WI	0.9304	0.0200	(0.0006)	(0.0001)	0.9497
Racine, WI	0.9304	0.0200	(0.0006)	(0.0001)	0.9497
Sheboygan, WI	0.9304	0.0200	(0.0006)	(0.0001)	0.9497
Wausau, WI	0.9783	(0.0207)	0.0473	0.0058	1.0106

Note: The estimated FFY 2005 wage indexes are calculated using more recent data than used by CMS in the proposed rule.

* MSA = Metropolitan Statistical Area

Redefinition of Geographic Areas (*Federal Register* page 28249)

CMS currently defines geographic areas using Metropolitan Statistical Areas (MSAs) or New England County Metropolitan Areas based on the 1990 Census. OMB released new definitions last summer based on the 2000 Census. The OMB definitions replace MSAs with Core-Based Statistical Areas (CBSAs). CMS is not required to update the definitions for wage index areas, but has proposed to adapt the new OMB definitions as follows:

- Under the proposal, MSAs would still be the basic unit for defining wage areas. MSAs are defined as urban areas with populations of 50,000 or more. This is the same definition that was used to derive MSAs based on the 1990 Census data. However, 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.
- Metropolitan divisions would be treated as distinct wage areas. 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.
- OMB also defined micropolitan statistical areas as urban areas with populations greater than 10,000 but less than 50,000. CMS does **not** propose to treat micropolitan statistical areas as separate wage areas. Instead, they would be included as part of the statewide rural area. Hospitals that were urban under the old definitions and are rural under this proposal would be assigned to their former MSA for a three-year transition period.

The redefinition of geographic areas can cause significant wage index changes for the areas that are modified. In addition, many individual providers can experience extreme revenue increases or decreases when they are removed from their current area and reassigned to another area. This does not significantly impact Wisconsin providers.

Some hospitals with special rural status, such as Sole Community Hospitals (SCHs), Rural Referral Centers (RRCs), Medicare Dependent Hospitals, or Critical Access Hospitals (CAHs) would be reclassified from rural to urban under the new geographic definitions. CMS does not address this issue in the proposed rule. We will seek a “grandfather” provision to protect these hospitals.

Occupational Mix Adjustment (*Federal Register* page 28252)

CMS is required to include an occupational mix adjustment as part of the calculation of the FFY 2005 wage index. However, CMS is proposing to base the FFY 2005 wage index on a blend of 10% of the wage data adjusted for occupational mix and 90% 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 would be determined and discussed in subsequent inpatient rule updates.

V. WAGE INDEX RECLASSIFICATIONS

Background: Hospitals are able to request to be reclassified 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. 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 the normal 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 proposal: CMS included several wage index reclassification provisions in the proposed rule. In addition to the normal reclassifications, CMS has reclassified hospitals located in certain rural counties under the “Lugar criteria” and has proposed a methodology to implement an MMA provision that requires an adjustment to recognize out-migration of county residents who work in other wage index areas. The rule also includes a number of proposals that would modify the reclassification rules in specified situations.

Application of CBSAs to Reclassified Hospitals (*Federal Register* page 28263)

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 45 days of the publication of the proposed rule making July 2 the deadline.

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 disagree with this assignment are instructed to submit a comment to the proposed rule indicating the basis for the objection. Changes to assignments will be included in the final rule. Reclassified hospitals are reported on Table 9A of the proposed rule beginning on *Federal Register* page 28752.

Lugar Reclassifications (*Federal Register* page 28263):

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 the criteria. Hospitals that qualify for a Lugar reclassification might also have received a reclassification under the MGCRB criteria. Hospitals that qualify for both are instructed to compare the wage index for the MGCRB reclassification to the wage index under the Lugar reclassification. Hospitals are instructed to withdraw their MGCRB reclassifications by July 2 if they are lower and the hospital wants to receive the Lugar assignment instead. Counties that meet the Lugar criteria are reported in the *Federal Register* on page 28264.

These requirements for withdrawal of existing reclassifications seem unnecessary and unfair. It requires that the hospital give up the certain benefit of the existing reclassification for the uncertain benefit of a proposal. It is possible that CMS could modify the new reclassification rules or that data corrections could change the adjustment such that the hospital no longer benefits. WHA will be discussing this issue with AHA and will try to resolve the issue with CMS. However, hospitals with reclassification options should still determine the best alternative and be prepared to withdraw an existing reclassification, if required.

Alternative Reclassification for Commuting Patterns (*Federal Register* page 28266):

The MMA requires that CMS develop an alternative adjustment to the wage index based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index. Qualifying hospitals would receive an adjustment to their wage index based on the percentage of county residents who commute to the other area. CMS has proposed a methodology to implement this provision. The proposed adjustment would be added to the wage index for the area that the hospital is located in and would be effective for three years beginning October 1, 2004. If a hospital in one of these counties does not have an existing reclassification, it would automatically receive the adjustment. Hospitals cannot receive an adjustment under this provision plus another reclassification. Therefore, if a hospital has an existing reclassification, CMS will require that the hospital withdraw that reclassification by July 2 to receive the adjustment instead. Hospitals eligible for this adjustment are reported on Table 4J of the proposed rule beginning on *Federal Register* page 28631.

Elimination of Standard Rate Reclassifications (*Federal Register* page 28288):

In the past, hospitals could request a reclassification for the standard rate. Under the standard rate reclassification, a rural or small urban hospital could qualify to be paid the higher large urban rate. CMS proposes to eliminate the process for applying for a standard rate reclassification because the MMA has equalized the rates. CMS states that its longstanding policy, as reflected in the regulations, is to allow standard rate reclassification only to areas with a higher standard rate. 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 CMS proposal would eliminate this possibility.

Group Appeals That Were Denied Due to Standard Amount Criteria (*Federal Register* page 28288)

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 standard amounts. Due to the equalization of the rates, CMS has determined that these criteria are no longer appropriate. Therefore, under the proposal, any hospital that was part of a group appeal for the FFY 2004 or FFY 2005 wage index that was denied because it failed to meet the standard amount criteria could receive the reclassification that was requested in that appeal.

Rural Referral Center (RRC) Reclassification Criteria (*Federal Register* page 28289)

Medicare law and regulations provide RRCs advantageous reclassification rules. 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 standard criterion requiring that the hospital's AHW must meet a threshold percentage of the AHW of the hospitals located in the area to which the hospital seeks reclassification. This threshold is 84% for hospitals located in urban areas and 82% for hospitals located in rural areas. It is possible for an RRC to be located in an urban area and CMS has decided that it is appropriate for all RRCs to be treated the same. Therefore, CMS is proposing that all RRCs, regardless of urban or rural location, be required to meet the lower 82% threshold.

Reclassification for Sole Community Hospitals in Low Density States (*Federal Register* page 28289)

CMS has decided to provide a special reclassification for SCHs in low-density states. This would apply in Alaska, Montana, North Dakota, South Dakota, and Wyoming. The MMA provided a special one-time reclassification that included a reclassification for SCHs in low density states. 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 would now be placed at a serious disadvantage in comparison to other SCHs in their States and regions." Therefore, CMS proposes to allow any SCH in the five low-density states a reclassification to any area in their state. We believe that many other hospitals are also placed at a serious competitive disadvantage when neighboring hospitals are able to reclassify; we will comment on this issue.

Dominant Hospitals (*Federal Register* page 28290)

CMS has requested comments on potential special reclassification criteria for dominant hospitals and hospitals in single-hospital MSAs. CMS defines a “dominant hospital” as a hospital that pays a substantial portion of all wages paid by hospitals within its MSA, such that its data dominate the wage index calculation. CMS has acknowledged the validity of comments indicating that it is virtually impossible for a dominant hospital to qualify for a reclassification because of the requirement that its own AHW would need to be at least 108% of the AHW for the MSA (including the dominant hospital’s data) for an urban hospital or 106% of the AHW for the MSA for a rural hospital.

CMS is considering revised criteria for dominant hospitals that would compare their AHW to the AHW of the other hospitals in the MSA, excluding their own wage data. CMS suggests that a hospital that pays at least 40% of the wages in the MSA should be considered dominant. CMS invites comments and says it is considering adopting this policy in the final rule. CMS also invites comments on whether this criteria change should be extended to all hospitals.

CMS notes that the problem is even worse for hospitals in a single-hospital MSA and it is impossible for these facilities to reclassify under the current methodology. However, CMS believes that the problem may be solved because many of these hospitals will qualify for an adjustment using the new reclassification methodology based on percentage of county residents who commute to another area. CMS invites comments on other means of revising the reclassification criteria for single-hospital MSAs or other measures to address this issue.

States without a Rural Area (*Federal Register* page 28291)

CMS is requesting comments on the need for a special adjustment for all-urban states. The law specifies that the wage index for an urban area cannot be less than the wage index applicable to rural hospitals in the state. This is referred to as the “rural floor.” CMS specifies that two states, New Jersey and Rhode Island, have no rural areas. However, Table 4B of the proposed rule also reports Massachusetts as having no rural counties. It has been suggested that hospitals in these states are disadvantaged by the absence of a rural floor. CMS requests comments on a proposal to impute a wage index floor for these states based on the relationship of the rural floor in other states to the other wage indexes in those states. CMS notes that any wage index change would be budget-neutral, reducing payments for all other areas.

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 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 Proposal (*Federal Register* page 28271): CMS established criteria for determining the DRGs that should be included and extended the policy to cover 29 DRGs in FFY 2004. In the 2005 proposed rule, CMS found that no additional DRGs met the current criteria. However, CMS has proposed alternative criteria that would increase the number of DRGs to 31. The proposed rule replaces DRG 483: Tracheostomy with two DRGs—DRG 541: Tracheostomy with Major Operating Room Procedure and DRG 542: Tracheostomy without Major Operating Room Procedure. DRG 483 was included in the transfer policy. Neither of the new DRGs meets the existing criteria to be covered by the policy. However, CMS believes that they should be included because they pertain to the same cases as were assigned to DRG 483. Therefore, CMS added new criteria that would cover these DRGs. DRG 430: Psychoses, also meets the new criteria and CMS proposes to apply the policy to it as well.

WHA believes the CMS proposal arbitrarily changes the established criteria to justify CMS' pre-determined result. In addition, if CMS believes that the splitting of a DRG on the list justifies including the two new DRGs, CMS should propose a change to cover that exact situation. CMS should not make up new criteria to force those two DRGs onto the list and then use the new criteria to add new and unrelated DRGs (like DRG 430) to the policy.

VII. ADDITIONAL PAYMENTS FOR NEW MEDICAL TECHNOLOGY

Current law provides additional payment for new medical services and technologies that meet specified criteria. The adjustment is required to be budget-neutral, and 1% of total estimated operating prospective payments was "carved out" of the standard PPS rate for these payments. The MMA requires 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 proposed rule, CMS would no longer include the impact of additional payments for new medical services and technologies in the budget neutrality factor that is applied to the standard rate.

CMS approved InFUSE™ for add-on payments effective for FFY 2004 and will continue to pay this add-on in FFY 2005. However, CMS is proposing to reduce the amount of the add-on. CMS states that payment for an interbody fusion device is bundled in the current maximum add-on for InFUSE and the device no longer qualifies as a new technology. The proposal would reduce the add-on payment to account for no longer paying for the device.

Of the ten applications for new technology status for FFY 2005, five were rejected and five are still under review including: InFUSE for use in tibia fractures, the InSync® Defibrillator System, Kinetra®, the TandemHeart™ Percutaneous Left Ventricular Assist System, and the Aquadex™ System 100 Fluid Removal System (System 100). If approved, payment for these technologies could be included in the final rule.

One technology will lose its eligibility for an add-on payment in 2005: Xigris®, which became eligible for additional payments in FFY 2003. Early in FFY 2005, Xigris will be beyond the two-year to three-year period during which a technology can be considered new. Therefore, CMS is proposing that Xigris will not continue to receive new technology add-on payments in FFY 2005.

VIII. PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS

Background: The MMA established an adjustment for "low-volume hospitals" effective October 1, 2004. It defines low-volume hospitals as having fewer than 800 discharges per year for all payers and specifies that each such hospital must be located more than 25 road miles from another hospital. The maximum adjustment that any hospital could receive is 25%.

CMS Proposal (*Federal Register* page 28286): 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. CMS found no evidence of higher incremental costs for hospitals with more than 500 discharges. Therefore, CMS provides an adjustment of zero for hospitals with 501 to 799 discharges.

For hospitals with 500 or fewer discharges, CMS has proposed to calculate an adjustment based on the following formula: low volume adjustment = $1.25 - (0.0005 * \text{the number of discharges})$. Discharges would be based on total inpatient acute discharges in the latest submitted cost report. To qualify, a hospital would be required to submit data to the fiscal intermediary demonstrating that it meets the 25-mile criteria.

IX. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

Background: The DSH adjustment provides additional payment for 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 that are furnished to 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 number of total hospital inpatient days. Hospitals whose DSH patient percentage exceeds 15% are eligible for a DSH payment adjustment.

The MMA establishes higher DSH payments for rural hospitals and for urban hospitals with fewer than 100 beds (*Federal Register* page 28285). Before the MMA, these hospitals received payments based on a less generous formula and their DSH adjustment was capped at 5.25%. The MMA increases the cap to 12%. The cap for Sole Community Hospitals is also increased from 10% to 12%. RRCs are not capped, but can benefit from the more generous DSH formula provided by the MMA.

X. GRADUATE MEDICAL EDUCATION

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 28283)

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% 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% 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% adjustment).
- For discharges occurring during FFY 2005, the formula multiplier is 1.42 (equivalent to a 5.8% adjustment).

Direct Medical Education (*Federal Register* 28313)

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

Initial Residency Period for DME Payment (*Federal Register* 28310)

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 direct GME payment a hospital will receive for residents who switch specialties.

There are programs, including anesthesiology, dermatology, psychiatry, and radiology, that require a year of generalized clinical training to be used as a prerequisite for the subsequent training in the particular specialty. This first year of generalized residency training is commonly known as the "clinical base year." The clinical base year requirement is often fulfilled by completing either a preliminary year in internal medicine or a transitional year program. Typically, a medical student who wants to train to become a specialist is "matched" to both the

clinical base year program and the residency training specialty program at the same time. Under CMS' current policy, these residents are "labeled" with the initial residency period associated with internal medicine (three years) even though the resident may seek board certification in a specialty such as anesthesiology which requires a minimum of four years of training to become board eligible. As a result, this resident would be weighted at 0.5 full-time equivalents (FTEs) in the fourth year of training for purposes of direct GME payment.

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 must allow for differentiation of 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.

CMS is proposing that if a hospital can document that a particular resident matches simultaneously for a first year of training in a clinical base year in one medical specialty and for additional years of training in a different specialty program, the resident's initial residency period would be based on the period of board eligibility associated with the specialty program in which the resident matches for the subsequent years of training and not on the period of board eligibility associated with the clinical base year program, for purposes of DME payment. CMS requests comments on how to establish the initial residency period in cases where a preliminary year is completed but there is no simultaneous match.

Exception to Initial Residency Period for Geriatric Residency Programs (*Federal Register* 28312)

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 in 1998. As a result, the initial residency period, and full direct GME 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 program requires a resident to complete two years or more of training to initially become board eligible in the geriatric specialty. CMS proposes to implement this requirement effective for cost-reporting periods beginning on or after October 1, 2003.

Resident Training in Non-Hospital Settings (*Federal Register* 28315)

Under the proposed rule, 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. The 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. CMS believes that the written agreement has become burdensome for the fiscal intermediaries to enforce and that they should instead focus on whether the hospital is actually incurring all of the costs. Therefore, CMS proposes to replace the written agreement requirement with a requirement that the hospital pay for the non-hospital training on a concurrent basis.

CMS proposes that, if a hospital is counting resident training in a non-hospital setting for DME and IME purposes in any month of its cost-reporting period, the hospital must make payment by the end of the following month to cover all or substantially all of the costs of training in that setting attributable to the preceding month. If a hospital does not pay for all or substantially all of the costs of the program in the non-hospital setting by the end of the following month, the hospital could not count those FTE residents in the month that 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 direct GME 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% 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 no more than 25 additional FTEs.

CMS Proposal (*Federal Register* 28292): The CMS proposal would implement the MMA provision by reducing the resident cap 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* 28293)

CMS proposes that if a hospital’s resident level were less than the hospital’s resident cap in the “reference period”, the hospital’s resident cap would be permanently reduced by 75% 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 and its resident level for that period is 80 FTEs, CMS would reduce the hospital’s resident cap by 15 FTEs (75% of 20 FTEs). The reduced cap would be effective beginning with portions of cost-reporting periods occurring on or after July 1, 2005.

The “reference period” for determining the hospitals 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 yet been settled as of April 30, 2004, the “as-submitted” cost report would 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 be submitted to the fiscal intermediary on or before June 14, 2004. See Program Transmittal 87 for details on the request process, which is available online at www.cms.hhs.gov/manuals/pm_trans/R87OTN.pdf.

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 must also be 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 caps for one hospital are temporarily reduced and these otherwise "excess" FTE slots are transferred for use by other hospitals. Therefore, CMS would take into account the revised caps under the affiliation agreement for both the hospitals that are in the group. CMS proposes that hospitals that are affiliated "as of July 1, 2003" will mean 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. CMS intends to use a hospital's cap as revised by the July 1, 2003 Medicare GME affiliation agreement in determining possible reductions to its resident cap.

In addition, the MMA states that there will be no redistribution of reductions in residency positions attributable to voluntary reduction programs approved as of October 31, 2003. CMS proposes to apply this provision to any hospital that was participating in the demonstration during the hospital's most recent cost-reporting period ending on or before September 30, 2002. For purposes of determining possible reductions to the FTE resident caps, CMS would compare the higher of the hospital's base number of residents, and the resident level in the hospital's most recent cost-reporting period ending on or before September 30, 2002, to the hospital's resident cap. If a hospital withdrew from participation in the demonstration project before its most recent cost-reporting period ending on or before September 30, 2002, CMS is proposing that the hospital would be subject to the procedures applicable to all other hospitals for determining possible reductions to the resident caps.

Criteria for Determining Hospitals That Will Receive Increases in Resident Caps (*Federal Register* 28299)

The MMA established general criteria for the redistribution of resident slots. CMS has proposed a detailed methodology with several priority listings that would be used in determining which hospitals qualify and in what order they would receive the additional resident slots. The proposed rule includes an evaluation form that hospitals would complete and submit as part of its application. Applications would be due by December 1, 2004. Hospitals that receive the slots would be given an increased resident cap for portions of cost-reporting periods occurring on or after July 1, 2005.

The MMA specifies that CMS take into account the demonstrated likelihood that the hospital would be able to fill the positions within the first three cost-reporting periods beginning on or after July 1, 2005. Therefore, a hospital must first document that it meets one following criteria:

- it plans to establish a new residency program;
- it intends to expand current programs;
- it is already training a number of residents that exceeds the cap; or
- it is at risk of losing accreditation of a program as a result of an insufficient number of residents.

The proposed methodology establishes a priority list based on MMA requirements. Slots would be distributed to hospitals in the following order:

- rural hospitals with the only specialty training program in the state;
- rural hospitals;
- hospitals located in "small" urban areas (population of less than 1,000,000) with the only specialty program in the state;
- hospitals located in small urban areas; and

- hospitals that meet none of the statutory priority criteria.

To rank hospitals within each of the priority categories, CMS proposes to compute a score for each hospital based on ten evaluation criteria. These include high Medicare utilization, geriatrics programs, rural track programs, location in a health personnel shortage area, and points for a number of other factors.

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, payment for the new residents would be phased in over three years.

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

Background: Additional Medicare payments are provided to a hospital for inpatient dialysis provided to Medicare beneficiaries with ESRD if the hospital's ESRD Medicare beneficiary discharges are 10% or more of its total Medicare discharges. The special payment was intended to ameliorate those circumstances in which the concentration of ESRD beneficiaries receiving inpatient dialysis is such that the hospital could not offset the entire expense with revenue from other less costly cases.

CMS Proposal: CMS has been informed that some hospitals may be counting all discharges of ESRD Medicare beneficiaries toward determining the 10% factor rather than counting only those discharges where the ESRD beneficiary received inpatient dialysis. Therefore, CMS is proposing to revise 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 an inpatient hospital stay are to be counted. This proposed change would be applied prospectively, effective for cost-reporting periods beginning on or after October 1, 2004.

XIII. CRITICAL ACCESS HOSPITALS

In the proposed rule (*Federal Register* page 28327), CMS is revising regulations to reflect a number of MMA provisions affecting CAHs including:

- Effective for cost-reporting periods beginning on or after January 1, 2004, payment for inpatient, outpatient, and skilled nursing facility (SNF) services furnished by a CAH would equal 101% of the reasonable cost of providing these services.
- The MMA eliminates the requirement that all practitioners furnishing outpatient services must assign billing rights to the CAH for the CAH to elect outpatient payment for professional services at 115% of the physician fee schedule.
- 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.
- Effective for payments made on or after July 1, 2004, inpatient services furnished by CAHs would be eligible for Periodic Interim Payment (PIP). CMS is proposing that CAHs applying for and receiving PIP would operate under current Medicare rules for other providers currently receiving PIP.
- Effective January 1, 2004, any currently participating CAH, or applicant for CAH approval, would be

allowed to maintain up to 25 inpatient beds. If swing bed approval has been granted, all 25 beds could be used interchangeably for acute care or swing bed services.

- Effective for the cost-reporting periods beginning on or after October 1, 2004, CAHs would be permitted to establish distinct part rehabilitation and psychiatric units of up to ten beds each. The beds in the distinct part units would not count against the 25-bed limit and admissions, and lengths of stay in distinct part unit beds would not be used in determining the facility-wide average length stay for purposes of the 96-hour limitation on the average length of inpatient stay. Medicare payment for inpatient services provided in the distinct part unit will be made under the applicable existing payment methodology for IRFs and IPFs.
- 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.

In addition to the MMA provisions, the proposal also discusses payment for clinical laboratory services. Currently, payment to a CAH for clinical diagnostic laboratory tests for outpatients is 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 specimens are collected. Otherwise, payment for these tests is made on a fee schedule basis. In the proposed rule, CMS did not propose any changes to current regulations applicable to clinical diagnostic laboratory testing.

XIV. LONG-TERM CARE HOSPITALS

CMS is proposing a provision regarding payments for inpatient care to providers that change classification status during a patient stay. 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, patients admitted while the hospital is an acute care hospital and discharged after the LTCH status is granted are paid for with two separate bills.

CMS proposes to make one payment covering the total stay (days before and after status was 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. CMS considered, but rejected, using the transfer policy for these patients—this would have paid the acute portion of the stay on a per diem basis as a transfer and the full LTCH payment. CMS holds that the long length of stay for these patients mean that CMS would still be overpaying. The one payment covering the total stay using the LTCH PPS policy would 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.

XV. SPECIAL CIRCUMSTANCES OF HOSPITALS FACING HIGH MALPRACTICE INSURANCE RATE INCREASES

CMS has received comments about the effects of rapidly escalating malpractice insurance premiums on hospital financial performance and continued access for Medicare beneficiaries to high quality inpatient hospital services.

CMS acknowledges malpractice insurance premiums have increased at a high rate in some areas of the country during the last few years, but states that it has no evidence that malpractice premiums have created issues of access to inpatient hospital services for Medicare beneficiaries. Therefore, CMS is inviting comments on the effect of increases in malpractice insurance premiums on hospitals participating in the Medicare program and whether increasing malpractice costs may pose access problems for Medicare beneficiaries.