
SUMMARY OF THE PROPOSED FFY 2006 MEDICARE HOSPITAL INPATIENT RULE

May 2005



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) 2006. The proposed rule provides for a 60-day comment period. The Centers for Medicare and Medicaid Services (CMS) must receive comments by 5 p.m. on June 24.

CMS requests that comments reference the file code CMS-1500-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 & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011,
Baltimore, MD 21244-1850

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

Room 445-G
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Washington, DC 20201

OR

7500 Security Boulevard
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CMS is also accepting comments submitted electronically at:
to <http://www.cms.hhs.gov/regulations/ecomments> (attachments should be in Microsoft Word, WordPerfect, or Excel)

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I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the proposed Medicare Inpatient Prospective Payment System (PPS) rule for federal fiscal year (FFY) 2006 in the May 4, 2005 *Federal Register*. Changes are effective October 1, 2005 unless otherwise noted. Each section of this summary indicates its location in the Federal Register, and provides the “issue identifier” that CMS requests that you reference in your comments. Text in italics is extracted from the Federal Register.

II. STANDARDIZED AMOUNTS

Operating Rates: Several provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) will affect the FFY 2005 standardized amounts. These provisions include: a full or reduced marketbasket adjusted rate based on the reporting of quality data as part of the CMS Hospital Quality Initiative and the reduction of the labor share to 62% 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 (69.7 Percent Labor Share and 30.3 Percent Nonlabor Share)		
	Labor-related	Nonlabor-related
Full Update (3.2 Percent)	\$3,286.14	\$1,428.55
Reduced Update (2.8 Percent)	\$3,273.40	\$1,423.01
Standard Rate for Hospitals with a Wage Index Less than or Equal to 1 (62 Percent Labor Share and 38 Percent Nonlabor Share)		
	Labor-related	Nonlabor-related
Full Update (3.2 Percent)	\$2,923.11	\$1,791.58
Reduced Update (2.8 Percent)	\$2,911.78	\$1,784.63
Capital Standard Federal Payment Rate		
National Capital Rate		\$419.90

Reporting of Hospital Quality Data for Annual Hospital Payment Update

Refer to "Hospital Quality Data" if you submit a comment on this issue.

(Federal Register page 23424)

Background: The MMA provides a full marketbasket update of 3.2% for hospitals that submit data on ten quality measures data to CMS. This provision applies for three years (FFYs 2005-2007). Hospitals that fail to submit the necessary data or withdraw from the program will receive the marketbasket increase minus 0.4%. 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.

CMS Proposal: *For the first year, FY 2005, there were no chart-audit validation criteria in place. Based upon*

our experience from the FY 2005 submissions, and upon our requirement for reliable and valid data, we are proposing to place the following additional requirements on hospitals for the data for the FY 2006 payment update.

- *The hospital must have passed our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the third quarter data of calendar year 2004 in order to receive the full market basket update in FY 2006.....*
- *The hospital must have two consecutive quarters of publishable data. The information collected by CMS through this rule will be displayed for public viewing on the Internet. Prior to this display, hospitals are permitted to preview their information as we have it recorded. In our previous experience, a number of hospitals requested that this information not be displayed due to errors in the submitted data that were not of the sort that could be detected by the normal edit and consistency checks. We acquiesced to these requests in the public interest and because of our own desire to present correct data. However, we still believe that the hospital bears the responsibility of submitting correct data that can serve as valid and reliable information.*

The rule requires that the accuracy of hospital submitted data be validated through chart re-abstraction. A sample of five charts will be reabstracted by the Clinical Data Abstraction Center (CDAC) and compared to the hospital's submission. CMS will require an 80% agreement rate between the original submission and the re-abstraction. If a hospital disagrees with the abstraction results from the CDAC, the hospital can appeal the results to their Quality Improvement Organizations (QIO).

Audits and data validation are necessary to ensure that the data reported on the internet is reliable. However, we strongly oppose any attempt by CMS to link this validation process with the hospital update factor. CMS proposes to base the update on data from the third quarter of 2004. CMS audits of earlier periods in 2004 were often unreliable due to data problems and inconsistent definitions. These issues were not completely resolved by the third quarter of 2004. Hospitals should not suffer a payment reduction due to technical problems with the data submission and validation process.

Projected Hospital Marketbasket Increase

(Federal Register page 23384)

Background: The hospital update is based on a "marketbasket" factor that is intended to reflect the average change in the price of goods and services hospitals purchase in order to furnish inpatient care. To accomplish this, CMS selects wage and price proxies intended to reflect hospital costs. These proxies are primarily drawn from Producer Price Indexes (PPIs) and Consumer Price Indexes (CPIs). The price changes must be projected forward to estimate the increase for the subsequent year so that an appropriate marketbasket update can be determined in advance of payment. CMS projects a hospital marketbasket increase of 3.2% for FFY 2006.

The projected marketbasket increase provides an estimate of cost increases that is not reconciled to the actual increases for the proxies that are used. This is basic to the prospective nature of the PPS methodology. In some years the projection is higher than the actual and in others it is lower. Over the life of the PPS, the differences have balanced-out and the cumulative error is small. However, in recent years the projection has consistently been lower than the actual increase. The actual increase in FFY 2004 was 3.8% compared to a projected increase of 3.4%. In the proposed rule, CMS reports that, based on the most recent data, the FFY 2005 marketbasket increase is now estimated to be 4.1% compared to the estimated 3.3% increase that was projected for use in the update factor. We are very concerned that the methods that are being used to project the marketbasket increase are flawed and are failing to provide reliable results. Given a 4.1% cost increase for FFY 2005, a projected FFY 2006 increase of 3.2% does not seem consistent with evidence that inflation is increasing in the general economy. We will question the accuracy of the FFY 2006 marketbasket projection in our comments.

Rebasing and Revision of the Marketbasket

Refer to "Hospital Marketbasket" if you submit a comment on this issue.

(Federal Register page 23384)

Background: CMS periodically rebases the marketbasket by updating the costs and input price indexes used in the calculation. In addition, CMS may revise the marketbasket by changing the data sources or price proxies used in the input price index. The last update to the marketbasket was implemented in FFY 2003 with FFY 1997 data used as the base period for the construction of the marketbasket costs.

CMS Proposal: *... we are proposing rebasing and revising the hospital operating and capital market baskets to be used in developing the FY 2006 update factor for the operating prospective payment rates ...*

The proposed hospital marketbasket would replace FFY 1997 Medicare cost report data with FFY 2002 data for the development of cost weights. The market basket weights also require data from tables created by the Bureau of Economic Analysis and the Bureau of the Census based on the Economic Census. The detailed 2002 tables are not yet available. Therefore, CMS is proposing to use the 1997 tables adjusted forward to FFY 2002 to correspond to the cost report data. CMS has also proposed a change in the proxy used for blood and blood product cost changes. Overall, the revisions to the marketbasket have only a minor effect on the update factor, and the projected FFY 2006 IPPS update is 3.2 using either the 1997-based or the 2002-based marketbasket weights.

CMS is also proposing to rebase and revise the excluded hospital marketbasket applying the same data sources as CMS used for the proposed hospital market basket. This results in a slight increase in the excluded hospital update from 3.3% using the 1997-based weights to 3.4% using the proposed 2002-based weights.

Revised Labor Share

Refer to "Labor-related Share" if you submit a comment on this issue.

(Federal Register page 23391)

Background: 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 determined using data from the hospital marketbasket calculation. The FFY 2005 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 otherwise would be made (i.e., the hospital has a wage index greater than 1.0000).

CMS Proposal: *... we are proposing to continue to calculate the labor-related share by adding the relative weights of the operating cost categories that are related to, influenced by, or vary with the local labor markets. These categories include wages and salaries, fringe benefits, professional fees, contract labor and labor-intensive services. Since we no longer believe that postage costs meet our definition of labor-related, we are excluding them from the labor-related share. Using this methodology, we calculated a labor-related share of 69.731.*

The proposed elimination of postal services decreases the labor share by 0.272%. The most significant factor in the change is a 3.049% decrease in the weight for "other labor-intensive services" from 7.277 to 4.228. This category includes costs for landscaping services, services to buildings, detective and protective services, repair services, laundry services, advertising, auto parking and repairs, physical fitness facilities, and other government enterprises.

We oppose the proposed decrease in the labor-related share of the PPS rate. In the inpatient PPS rule for FFY 2003, CMS examined the methodology used to determine the labor-related share. The CMS calculation of the labor-related share for FFY 2003 resulted in an increase from 71.06% to 72.495%. However, CMS did not implement the increase pending further research to determine whether a different methodology for determining

the labor-related share should be adopted. In the FFY 2006 proposed rule, CMS discusses continuing research on alternative methodologies for calculating the labor-related share. However, CMS states that the analysis has not yet produced sound enough evidence to propose a change and that they will continue to study the issue. It is clearly inequitable to decline to implement a labor-share increase pending an analysis of the methodology and then propose a labor-share decrease while that analysis is still not completed.

Frequency of Updates to the Marketbasket

(Federal Register page 23401)

Background: The MMA requires that CMS provide an explanation of the reasons for the current marketbasket revision intervals, and provide options for more frequent hospital marketbasket updates. CMS states that the decision to rebase and revise the index is largely data driven. The calculation depends on Medicare cost report data that is available on an annual basis and on Bureau of the Census data that are typically available only every five years. Therefore, CMS has rebased the marketbasket at approximately five-year intervals.

CMS Proposal: *First, we reviewed the frequency and availability of the data needed to produce the market basket. Second, we analyzed the impact on the market basket of determining the market basket weights under various frequencies..... We used the results from these areas of research to assist in our determination of a new rebasing frequency. Based on this analysis, we are proposing to rebase the hospital market basket every 4 years. This would mean the next rebasing would occur for the FY 2010 update.*

The last update to the marketbasket was implemented in FFY 2003. Under the CMS proposal for a four-year interval, the next update would be in FFY 2007. However, as described above, CMS proposes to update the marketbasket for FFY 2006. It is our position that there is no compelling reason for a FFY 2006 update. There is no new Census data available and CMS cites no immediate problem that must be addressed. Instead, CMS should adopt the four-year interval and implement the next update in FFY 2007. Moreover, this fits much better with the schedule for Census data releases. According to CMS, the next time that a full update of the required Census data will be available is FFY 2011. Therefore, it makes little sense to do marketbasket updates in FFY 2006 and FFY 2010 as proposed.

Update for Children's Hospitals and Cancer Hospitals

Refer to "Excluded Hospital Marketbasket" if you submit a comment on this issue.

(Federal Register page 23394)

Background: CMS calculates a distinct marketbasket that is used to update payments for all hospitals and units excluded from payment under the IPPS. A single excluded hospital operating market basket is calculated based on the cost structure of inpatient rehabilitation facilities (IRF), inpatient psychiatric facilities (IPF), long-term care hospitals (LTCH), children's hospitals, and cancer hospitals. CMS is considering development of a separate marketbasket for IRFs, IPFs, and LTCHs because these facilities are now paid through PPS methodologies. This will be addressed through subsequent proposed rules for these facilities. However, CMS believes that given the small number of children's and cancer hospitals and the limited Medicare cost report data for these facilities, it should not create a separate marketbasket specifically for these hospitals.

CMS Proposal: *... we are proposing to use the proposed FY 2002 IPPS operating market basket percentage increase to update the target amounts for children's and cancer hospitals reimbursed under sections 1886(b)(3)(A) and (b)(3)(E) of the Act...*

Children's hospitals and cancer hospitals are currently reimbursed using the excluded hospital marketbasket. CMS contends that the FFY 2002 cost weights for children's and cancer hospitals are closer to those used in the IPPS marketbasket than those used in the excluded hospital marketbasket. The IPPS marketbasket factor was lower than the excluded hospital factor in five of the last six years, and the proposed FFY 2006 IPPS marketbasket factor is 3.2% compared to 3.4% for the excluded hospital marketbasket.

There should be no change to the marketbasket for Children's and Cancer hospitals until after a decision is made on the development of a separate marketbasket for other exempt facilities. The data for Children's and Cancer hospitals are included in the current exempt hospital marketbasket and the updates for these hospitals should continue to be determined based on that marketbasket. If it is later decided to implement new marketbaskets for the IRFs, IPFs, and LTCHs, a proposal for the Children's and Cancer hospitals can be made at that time. Any such proposal should include a more detailed analysis of the cost structures of these hospitals.

Update for Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHS)

Refer to "Sole Community Hospitals and Medicare Dependent Hospitals" if you submit a comment on this issue.

(Federal Register page 23426)

Background: Sole Community Hospitals (SCHs) are paid based on the higher of the Federal rate applicable to the hospital or the SCH's updated hospital-specific rate. Medicare dependent hospitals (MDHs) are paid based on the Federal rate or, if higher, the Federal rate plus 50% of the difference between the Federal rate and the updated hospital-specific rate.

CMS is required to ensure that aggregate payments to hospitals under section 1886(d) of the Act are projected to neither increase nor decrease as a result of the annual updates to the DRG classifications and weighting factors and for the updated wage indices. This is done by determining a budget neutrality factor that is applied to the hospital update factor. The budget neutrality adjustment is applied to all hospitals paid under section 1886(d) of the Act, including those that are paid based on a hospital-specific rate. Thus, the budget neutrality factor applies to SCHs and MDHs. Recently, concerns were raised that hospitals whose reimbursement is based on a hospital-specific rate should not be subject to the wage index component of the budget neutrality adjustment.

CMS Proposal: *We are proposing to remove the wage index component from the budget neutrality adjustment applied to the hospital-specific rate for hospitals paid under section 1886(d) of the Act. The DRG reclassification and recalibration factor component of the budget neutrality adjustment would still apply to these hospitals, as payments to SCHs and MDHs are based on DRGs and affect total Medicare payments to hospitals under section 1886(d) of the Act.*

CMS proposes to continue to apply the DRG reclassification and recalibration component of the budget neutrality adjustment to SCHs and MDHs. CMS reports that the proposed DRG reclassification and recalibration budget neutrality factor for the hospital-specific rates is 0.999003. In contrast, the combined budget neutrality factor for DRG reclassification and recalibration plus the wage index component is equal to 1.002494. Therefore, the proposal would result in a lower hospital-specific rate update for SCHs and MDHs in FFY 2006 because the estimated wage index neutrality factor is positive for that year. The impact will vary from year to year depending on wage index changes.

III. COST OUTLIERS

Cost Outlier Threshold

Refer to "Operating Payment Rates" if you submit a comment on this issue.

(Federal Register page 23469)

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% 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 make

outlier reimbursement equal 5.1% of total payments.

CMS Proposal: ... we are proposing to establish a fixed-loss cost outlier threshold for FY 2006 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus \$26,675.

The proposed \$26,675 threshold for FFY 2006 represents an increase of 3.4% compared to the FFY 2005 threshold of \$25,800. This does not appear to be extreme compared to the change in the IPPS standard rate from FFY 2005 to FFY 2006. However, CMS estimates that actual FFY 2004 outlier payments were 3.5% of total payments and that projected FFY 2005 outlier payments are approximately 4.4% of total payments. Given the shortfall in the prior two years compared to the 5.1% target for outlier payments, we are concerned that the proposed 3.4% threshold increase will result in another year of underpayments. The AHA has indicated that they will be analyzing the threshold calculation and we will address this issue in our comments.

IV. WAGE INDEX

(Federal Register page 23367)

Core-Based Statistical Areas

Refer to "CBSAs" if you submit a comment on this issue.

(Federal Register page 23367)

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." 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.

In FFY 2005, CMS implemented revised wage areas based on Core-Based Statistical Areas (CBSAs) defined using data from the 2000 Census. This change had a significant redistributive impact with many areas experiencing substantial increases or decreases in their wage adjustment. As a result, CMS provided a one-year transition for hospitals that were harmed by the redefinition of wage index areas. Hospitals that would have received a higher wage index under the prior geographic area definitions were provided a blended wage index combining 50% of the wage index based on the new definitions and 50% based on the old definitions.

CMS Proposal: ... we are proposing that hospitals receive 100 percent of their wage index based upon the new CBSA configurations beginning in FY 2006. Specifically, we will determine for each hospital a new wage index employing wage index data from FY 2002 hospital cost reports and using the CBSA labor market definitions.

The attached impact analysis for your hospital includes the wage indexes posted by CMS on May 6. These wage indexes were based on preliminary data. CMS may still make revisions to the wage indexes to correct data errors made by the fiscal intermediaries or by CMS and the final wage indexes could change.

Occupational Mix Adjustment

Refer to "Occupational Mix Adjustment" if you submit a comment on this issue.

(Federal Register page 23368)

Background: The law provides for the collection of data on occupational mix every three years and a new survey could be issued in FFY 2007. CMS is currently reviewing options for revising the occupational mix survey and data collection process. Any proposed changes to the occupational mix survey would be published in a Federal Register notice.

CMS Proposal: *For the FY 2006 wage index, we are proposing to use the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics (BLS) data that we used for the FY 2005 wage index.. For the proposed FY 2006 wage index, we are proposing to use the same methodology that we used to calculate the occupational mix adjustment to the FY 2005 wage index.*

CMS has not changed the calculation of the occupational mix adjustment and has only made minor changes to the data. Therefore, the proposed FFY 2006 adjustments do not differ materially from those applied to the FFY 2005 wage indexes.

Occupational Mix Blended Wage Index

Refer to "Blended Wage Index" if you submit a comment on this issue.

(Federal Register page 23375)

Background: CMS was required to include an occupational mix adjustment as part of the calculation of the wage index beginning in FFY 2005. The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. CMS explains that hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and other employees for the purpose of providing care to their patients. According to CMS, the varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor. The occupational mix factor is intended to neutralize the effect of employee mix, resulting in a decreased wage adjustment for hospitals with higher skill mixes and an increased adjustment for those with lower mixes.

In FFY 2005, CMS calculated wage indexes using 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 was moving cautiously due primarily to data issues. CMS did not establish a phase-in schedule for the adjustment. Instead, the application of the occupational mix adjustment will be determined in each inpatient rule update.

CMS Proposal: *For FY 2006, we are again proposing to adjust 10 percent of the wage index factor for occupational mix. In computing the occupational mix adjustment for the proposed FY 2006 wage index, we used the occupational mix survey data that we collected for the FY 2005 wage index While we considered adjusting 100 percent of the wage index by the occupational mix, we did not believe it was appropriate to use first-year survey data to make such a large adjustment. As hospitals gain additional experience with the occupational mix survey, and as we develop more information upon which to audit the data we receive, we expect to increase the portion of the wage index that is adjusted.*

CMS found that the proposed wage index values for 30% of rural areas and 54% of urban areas would decrease as a result of the adjustment. CMS states that: *Although these results show that rural hospitals would gain the most from an occupational mix adjustment to the wage index, their gains may not be as great as might have been expected. Further, it might not have been anticipated that almost one-third of rural hospitals would actually fare worse under the adjustment.* This is another reason why CMS is not increasing the occupancy mix blend percentage.

Wage Index Calculation

Refer to "Wage Data" if you submit a comment on this issue.

(Federal Register page 23372)

Background: The wage index is calculated using data reported by hospitals in the Medicare cost report. The wage data includes salaries and hours, certain contract labor costs and hours, and fringe benefit costs including pensions and other deferred compensation costs.

CMS Proposal: *Due to recent questions and concerns we received regarding inconsistent reporting and over reporting of pension and other deferred compensation plan costs, as a result of an ongoing Office of Inspector General review, we are clarifying in this proposed rule that hospitals must comply with the PRM, Part I, sections*

2140, 2141, and 2142 and related Medicare program instructions for developing pension and other deferred compensation plan costs as wage related costs for the wage index.

Beginning with the FY 2007 wage index, CMS will require that the fiscal intermediaries ensure that pension, post-retirement health benefits, and other deferred compensation plan costs for the wage index are developed according to Provider Reimbursement Manual (PRM) instructions. **Hospitals should be prepared for more intensive review in this area.**

Urban Hospitals Redesignated as Rural

Refer to "Hospital Redesignations and Reclassifications" if you submit a comment on this issue.
(*Federal Register* page 23376)

Background: Under Section 1886(d)(8) an urban hospital can apply for redesignation as a rural hospital. If it meets the criteria, the hospital will be treated as a rural hospital for all purposes of payment under the Medicare IPPS. Currently, when an urban hospital is redesignated as a rural hospital, its wage index data is excluded from the wage index calculation for the area where the urban hospital is geographically located and is included in the rural hospital wage index calculation.

CMS Proposal: *We are persuaded that there is a need to modify our policy when hospital redesignations occur under section 1886(d)(8)(E) of the Act. ... the rule would be that the wage data of the urban hospital reclassifying into the rural area is included in the rural area's wage index, if including the urban hospital's data increases the wage index of the rural area. Otherwise, the wage data is excluded. Similarly, we are proposing to apply to these cases the rule that currently applies when urban hospitals reclassify under the MGCRB process. Thus, the wage data for an urban hospital reclassifying under section 1886(d)(8)(E) of the Act is always included in the wage index of the urban area where the hospital is located, and can also be included in the wage index of the rural area to which it is reclassifying (if doing so increases the rural area's wage index).*

V. WAGE INDEX RECLASSIFICATIONS

Refer to: "Geographic Reclassifications" if you submit a comment on these issues.
(*Federal Register* page 23436)

Goldsmith Modification Criterion for Urban Hospitals Seeking Reclassification as Rural

(*Federal Register* page 23437)

Background: Urban hospitals can apply for rural designation based on specified criteria. One of the criteria allows redesignation if the hospital is located in a rural census tract that is part of an urban area. This is determined using the most recent version of the "Goldsmith Modification" as determined by the Office of Rural Health Policy. The Office of Rural Health Policy has developed an updated version of the Goldsmith Modification called Rural-Urban Commuting Areas (RUCAs). RUCAs use urbanization, population density, and daily commuting data to identify rural census tracts in all metropolitan counties.

CMS Proposal: *We are proposing to update the Medicare regulations at §412.103(a)(1) to incorporate this change in the identification of rural census tracts. We are also proposing to update the website and the agency location at which the RUCA codes are accessible.*

Multi-campus Hospitals

(*Federal Register* page 23436)

Background: The Medicare State Operations Manual provides that merged hospitals operating as a single institution must submit a combined cost report using a single provider identification number. This provision

applies even if the hospitals are in different wage index areas. As a result, the wage index data for the merged facility is reported for the entire entity on a single cost report. In order to apply for a reclassification, a hospital must provide data from the CMS hospital wage survey for an average hourly wage comparison. Currently, it is not possible for a facility that is part of a multi-campus hospital with a single cost report to supply wage data in support of a reclassification application for the individual hospital campus.

CMS Proposal: *... for FY 2007 and subsequent year reclassifications, we are proposing to allow a campus of a multicampus hospital system that wishes to seek geographic reclassification to another labor market area to report campus-specific wage data using a supplemental Form S-3 (CMS' manual version of Worksheet S-3) for purposes of the wage data comparison.*

For FY 2006 reclassification applications, we are proposing to allow a campus of a multicampus hospital system to use the average hourly wage data submitted for the entire multicampus hospital system as its appropriate wage data under §412.232(d)(2). We are establishing this special rule for FY 2006 reclassifications because the deadline for submitting an application to the MGCRB was September 1, 2004, and there no longer is an opportunity to provide a Supplemental Form S-3 that allocates the wage data by individual hospital campus. This special rule will be applied only to an individual campus of a multicampus hospital system that made an application for reclassification for FY 2006 and that otherwise meets all of the reclassification criteria.

Out-migration Adjustment

Refer to “Out-Migration Adjustment” if you submit a comment on this issue.

(Federal Register page 23381)

Background: Section 505 of the MMA provided 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. CMS will designate qualifying counties each year. After a qualifying county’s three-year period ends, the county might receive a new out-migration adjustment for another three-year period. The adjustments for a qualifying county are not recalculated during the three-year period, and all counties that had an adjustment in FFY 2005 receive the same adjustment in FFY 2006.

CMS Proposal: *Hospitals that received the adjustment in FY 2005 will be eligible to retain that same adjustment for FY 2006 and FY 2007. For hospitals in newly qualified counties, adjustments to the wage index would be effective for 3 years, beginning with discharges occurring on or after October 1, 2005.*

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 received a reclassification. Therefore, if a hospital has an existing reclassification (MGCRB, Section 508, or Lugar), that hospital must withdraw its reclassification within 45 days of the publication of this proposed rule to receive the out-migration adjustment instead. If your facility is eligible for the outmigration adjustment, it will appear on the attached impact analysis in the section for 2006 Wage Index.

Group Reclassifications

(Federal Register page 23437)

Background: The regulations allow all hospitals in a county to file a group application for wage index reclassification if they meet specified criteria. One of the criteria requires that the county must be in the same Combined Statistical Area (CSA) under the definitions announced by the OMB on June 6, 2003, **or** in the same Consolidated Metropolitan Statistical Area (CMSA) under the standards published by the OMB on March 30, 1990, as the urban area to which they seek redesignation. The alternative use of the CSA or the CMSA was adopted in FFY 2005, when the wage area definitions were revised. This allowed hospitals in counties that

qualified under the old definitions to continue to qualify in future years even if the new definitions no longer supported their reclassification.

CMS Proposal: ... we are proposing to delete §412.234(a)(3)(ii) to remove reference to the CMSA eligibility criterion. Beginning with FY 2006, we are proposing to require that hospitals must be located in counties that are in the same Combined Statistical Area (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation to qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

VI. POST-ACUTE CARE TRANSFER POLICY

Refer to "Post-acute Care Transfers" if you submit a comment on this issue.

(Federal Register page 23411)

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 established criteria for determining the DRGs that should be included and extended in the policy to cover 29 DRGs in FFY 2004. In FFY 2005, CMS found that no additional DRGs met the criteria. However, CMS revised the list of DRGs to adjust for one post-acute transfer DRG current that was split into two new DRGs, resulting in 30 DRGs subject to the policy.

CMS Proposal: As a result of our analysis, we considered two options for revising the current criteria. Option 1 is to include all DRGs within the postacute care transfer policy. ... Option 2 would expand the application of the postacute care transfer policy to 223 DRGs that have both a relatively high volume and a relatively high proportion of postacute care utilization. In this proposed rule, we are formally proposing Option 2 as presented above. However, we invite comments on both of these options.....

In the proposed rule, CMS says [T]he purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases. The proposal results in expansion of the policy to many DRGs where there is no evidence that hospitals are changing behavior to take advantage of the payment system.

The attached analysis includes an estimate of the impact of the proposed postacute transfer policy under Option 2.

We strongly oppose the expansion of the post-acute transfer policy. In this proposal, CMS makes substantial revisions to the DRG selection criteria with little justification or evidence. The revised criteria do not address specific changes in hospital behavior that might indicate an attempt to take advantage of the payment system. Moreover, they would not result in more equitable payments. For all practical purposes, such an extensive expansion of the post-acute transfer policy acts as an across-the-board reduction in Medicare payments. As a result, hospitals would be penalized for providing efficient care in the setting that is most appropriate for the patient.

VII. ADDITIONAL PAYMENTS FOR NEW MEDICAL TECHNOLOGY

Refer to "New Technology Applications" if you submit a comment on this issue.
(*Federal Register* page 23353)

Background: Current law provides additional payments for new medical services and technologies that meet specified criteria. The MMA eliminated the budget neutrality provision for payments for a new medical service or technology. Therefore, 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. An approved new technology is eligible for additional payments for two to three years. However, CMS has consistently eliminated the payments after two years.

CMS Proposal: CMS proposes to continue reimbursement for one technology that is currently eligible for new technology payment. In addition, three technologies are under review and may be approved for payment in FFY 2006.

- CMS proposes to continue payment for the Kinetra® implantable neurostimulator.
- CMS proposes to discontinue payments for: INFUSE™ Bone Morphogenetic Proteins, and the In Sync® defibrillator system.
- CMS proposes to deny payments for: INFUSE™ Bone Graft for tibia fractures, the Aquadex™ System 100 Fluid Removal System, the Safe-Cross® Radio Frequency Total Occlusion Crossing System, and the Wingspan™ Stent System with Gateway™ PTA Balloon Catheter.
- CMS continues to review approval for: the CHARTITE™ Artificial Disc, Endovascular Graft Repair of the Thoracic Aorta (GORE TAG), the Trident® Ceramic Acetabular System for total hip replacements, and the Restore™ Rechargeable Implantable Neurostimulator.

VIII. Graduate Medical Education

(*Federal Register* page 23432) – Indirect GME
(*Federal Register* page 23438) – Direct GME

Indirect Medical Education (IME) Adjustment

Refer to "IME Adjustment" if you submit a comment on this issue.
(*Federal Register* page 23432)

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 during FFY 2005, the formula multiplier is 1.42 (equivalent to a 5.8% adjustment).
- For discharges occurring during FFY 2006, the formula multiplier is 1.37 (equivalent to a 5.55% adjustment).

IME for Exempt Hospitals Converting to IPPS Hospitals

(*Federal Register* page 23432)

Background: The Balanced Budget Act of 1997 (BBA) established a limit on the number of residents that a hospital may count for direct GME and IME based on the hospital's resident count for its most recent cost

reporting period ending on or before December 31, 1996. At that time, the fiscal intermediaries did not determine IME resident counts for hospitals that were excluded from the IPPS (that is, psychiatric hospitals, rehabilitation hospitals, children's hospitals, cancer hospitals, and long term care hospitals) because these hospitals did not receive any IME payment adjustments. Only the FTE resident data related to direct GME payments were relevant for these excluded hospitals and, therefore, only those data were collected. Therefore, if an exempt hospital converts to IPPS, there is no data available to determine the IME cap.

CMS Proposal: *We are clarifying and proposing to adopt into regulations our existing policy that, in such a situation, the fiscal intermediary would determine an IME FTE cap for the hospital, applicable beginning with the hospital's payments under the IPPS, based on the FTE count of residents during the cost reporting period(s) used to determine the hospital's direct GME FTE cap.*

Rural Hospitals that Became Urban Due to the New Wage Area Definitions (Federal Register page 23442)

Background: Rural hospitals receive a 130% adjustment to their IME resident cap. An urban hospital that reclassifies as rural is provided with this 130% increase and its IME cap may be adjusted for any new programs under rules that apply to hospitals located in rural areas. In FFY 2005, CMS adopted new wage index areas. As a result, a number of hospitals that previously were classified as rural are now located in urban areas.

CMS Proposal: *We are clarifying in this proposed rule our policy that hospitals that became urban in FY 2005 due to the new labor market areas would nevertheless be permitted to retain the adjustments they received for new programs as long as they were rural at the time they received them ...*

Hospitals that Withdraw Rural Reclassification (Federal Register page 23433)

Background: An urban hospital that reclassifies as rural can voluntarily withdraw its election and return to urban status. CMS is concerned that urban hospitals might reclassify to rural areas for a short period of time solely as a means of receiving an increase to their IME caps and then return to urban status.

CMS Proposal: *We are proposing that, effective with discharges occurring on or after October 1, 2005, hospitals that rescind their section 1886(d)(8)(E) reclassifications and return to being urban would not be eligible for permanent increases in their IME caps. Rather, any adjustments the hospitals received to their IME caps due to their rural status would be forfeited upon returning to urban status.....*

Initial Residency Period for DME Payment (Federal Register page 23438)

Background: 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 (IRP) 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 FFY 2005 final rule implemented a "simultaneous match policy." Under this policy, if a hospital can document that a particular resident matches simultaneously for a first year of training in a clinical base year, and for a second year of training in a different specialty program, 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.

The intent of the simultaneous match policy is to identify the specialty associated with the program in which the

resident will initially train and seek board certification. When a medical student in their final year of medical school matches into an advanced program for the second program year, but fails to match in a clinical base year, and obtains a preliminary year position outside the match process, they do not qualify under this policy. However, CMS acknowledges that it is still possible to identify the specialty associated with the program in which the resident is ultimately expected to train and seek board certification in these circumstances.

CMS Proposal: ... we are proposing to revise §413.79(a)(10) to state that, when a hospital can document that a resident matched in an advanced residency training program beginning in the second residency year prior to commencement of any residency training, the resident's IRP will be determined based on the period of board eligibility for the specialty associated with the advanced program, without regard to the fact that the resident had not matched for a clinical base year training program.

CMS notes that this change would not result in a policy to determine the IRP for all residents who must complete a clinical base year during the second residency training year based on the specialty associated with that second residency training year. It is CMS policy that a resident's IRP would not change if the resident, after initially entering a training program in one specialty, changes programs to train in another medical specialty.

New Teaching Hospitals' Participation in Medicare GME Affiliated Groups *(Federal Register page 23440)*

Background: Regulations provide an adjustment to the resident caps of hospitals that begin training residents in new medical residency training programs. Currently, these hospitals are not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate resident cap. CMS established this policy to avoid any incentive for hospitals with existing residency programs to affiliate with new teaching hospitals simply as a means of receiving an upward adjustment to their cap under an affiliation agreement. CMS acknowledges comments that, while these rules were meant to prevent gaming on the part of existing teaching hospitals, they also preclude affiliations that are designed to facilitate additional training at new teaching hospitals.

CMS Proposal: We are proposing to revise §413.79(e)(1)(iv) so that new urban teaching hospitals that qualify for an adjustment under §413.79(e)(1) may enter into a Medicare GME affiliation agreement under certain circumstances. Specifically, a new urban teaching hospital that qualifies for an adjustment to its FTE caps for a newly approved program may enter into a Medicare GME affiliation agreement, but only if the resulting adjustments to its direct GME and IME caps are "positive adjustments." "Positive adjustment" means, for the purpose of this policy, that there is an increase in the new teaching hospital's caps as a result of the affiliation agreement.

IX. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

Refer to "DSH Adjustment Data" if you submit a comment on this issue.
(Federal Register page 23434)

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% are eligible for a DSH payment adjustment. Section 951 of the MMA requires that CMS furnish the data necessary for hospitals to compute the number of patient days used in calculating the disproportionate patient percentages.

The numerator of the Medicare fraction is the number of days for patients who were entitled to both Medicare Part A and SSI benefits. CMS matches Medicare Part A entitlement information against a data file from the

Social Security Administration (SSA) to determine the number of Medicare SSI days for each hospital during the fiscal year. Currently, a hospital can obtain a file containing data for these patients only if it has an appeal pending on a DSH payment issue. Once determined eligible to receive the data, the hospital is required to sign a data use agreement with CMS to ensure that the data are appropriately used and protected, and pay a fee. In addition, a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. However, the hospital must accept the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year.

CMS Proposal: *We are interpreting section 951 to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the Medicare and Medicaid fractions. With respect to both the Medicare and Medicaid fractions, we also are interpreting section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the CMS' records, and in the case of the Medicaid fraction, against the State Medicaid agency's records.*

Beginning with cost reporting periods that include December 8, 2004, CMS will furnish a file containing data for a hospital's patients eligible for both SSI and Medicare at the hospital's request. The file will contain a summary of the services furnished to a Medicare beneficiary, SSI eligibility information; and Medicare enrollment data. This is the same data that CMS uses to calculate the Medicare fraction. Because CMS is required by the MMA to furnish this information, it will no longer charge hospitals for the data. CMS intends to make the information available for either the federal fiscal year or for the hospital's cost reporting period. This will enable the hospital to calculate and verify its Medicare fraction, and also to decide if it prefers to have the fraction determined on the basis of its cost reporting year rather than the Federal fiscal year. CMS will publish the details for the implementation of this proposal in a future Federal Register document.

The numerator of the Medicaid fraction includes hospital inpatient days that are furnished to patients who were eligible for Medicaid but were not entitled to benefits under Medicare Part A. Current regulations make hospitals responsible for proving Medicaid eligibility for each Medicaid patient day and verifying with the State that the patients were eligible for Medicaid on the claimed days. CMS ask the regional offices to report on the availability of this information to hospitals. According to CMS, *[T]he information we received suggested that, in the vast majority of cases, there are established procedures for hospitals or their authorized representatives to obtain the information needed for hospitals to meet their obligation under §412.106(b)(4)(iii) and to calculate their Medicaid fraction.* CMS interprets the MMA requirement to encompass both Medicare and Medicaid data used in the DSH calculation. However, CMS states that they believe hospitals are best situated to provide and verify Medicaid eligibility information and that the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction.

X. CRITICAL ACCESS HOSPITALS

Refer to "Critical Access Hospitals" if you submit a comment on this issue.
(Federal Register page 23450)

CAHs as Necessary Providers *(Federal Register page 23451)*

Background: 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. CMS notes that the regulations are limited to CAHs that were necessary providers as of January 1, 2006, and does not address the situation where the CAH is no longer the same facility due to relocation, cessation of business, or a substitute facility. Currently, CMS Regional Offices make the decision for continued certification following relocation of a certified facility on a

case-by-case basis.

In the case of a CAH constructing a new facility in a different location, CMS believes it is necessary to determine if the facility is:

- a replacement of an existing facility in essentially the same location,
- a relocation of the facility in a new location, or
- a cessation of business at one location and establishment of new business at another location.

CMS Proposal: ... we are proposing to revise §485.610 of the regulations by adding a new paragraph (d) to incorporate this proposal. Specifically, the proposed new paragraph (d) would specify that a CAH may maintain its necessary provider certification provided for under §485.610(c) if the new facility meets the requirements for either a replacement facility that is constructed within 250 yards of the current building or contiguous to the current CAH on land owned by the CAH prior to December 8, 2003; or as a relocated CAH if, at the relocated site, the CAH provides essentially (75 percent) the same services to the same service area with essentially the same staff. The CAH that plans to relocate must provide documentation demonstrating that its plans to rebuild in the relocated area were undertaken prior to December 8, 2003. We are also proposing that if a CAH that has a necessary provider certification from the State places a new facility in service on or after January 1, 2006, and does not meet either the requirements for a replacement facility or a relocated facility, as specified in the regulations, the action will be considered a cessation of business.

According to the CMS proposed rule, construction of a new building is considered to be a replacement if:

- Construction was undertaken within 250 yards of the current building;
- The new building is constructed on land that is contiguous to the current CAH, and that land was owned by the CAH prior to enactment of Pub. L. 108-173 (December 8, 2003), and the CAH is operating under a State-issued necessary provider waiver;

Construction of a new building is to be considered a relocation if the building is:

- within the same service area;
- serving the same population;
- providing essentially the same services (75 percent of the range of services are maintained in the new location); and
- with the same staff (at least 75 percent of the same staff).

Once it has been determined that constructing a new CAH facility will be considered a replacement or a relocation, the next step is to determine if the CAH has necessary provider designation and, if so, whether it can maintain this designation after relocating. CMS is proposing to use the specified relocation criteria as the initial step for determining whether to continue necessary provider status for CAHs that have relocated. When a CAH is determined to have relocated, it may continue to operate under its necessary provider designation (which exempts it from the distance criterion) only if the following conditions are met:

1. The relocated CAH has submitted an application to the State agency for relocation prior to January 1, 2006 and the following items are included in the application:
 - A demonstration that the CAH will meet the same State criteria for the necessary provider designation that were established when the waiver was originally issued;
 - Assurance that, after the relocation, the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff;
 - Assurance that the CAH will remain in compliance with all of the CoPs in the new locations; and
 - Proof that construction plans were “under development” prior to the effective date of Pub. L. 108-173 (December 8, 2003).
2. In the application, the CAH demonstrates that the replacement will facilitate the access to care and improve the delivery of services to Medicare beneficiaries.

This proposal would severely restrict the ability of CAHs designated as necessary providers to replace their existing facilities. We are particularly concerned by the requirement that plans must have been undertaken prior

to December 8, 2003. In addition, the other criteria would unnecessarily curtail service changes that are intended to benefit the community.

Continued Participation by CAHs in Lugar Counties (*Federal Register* page 23451)

Background: The criteria for designation as a CAH require that a Hospital be located in a rural area or be treated as being located in a rural area. A CAH must meet any one of the following three requirements:

- A CAH must not be located in an MSA and not be reclassified by CMS or the MGCRB as urban for purposes of the standardized payment amount, nor be a member of a group of hospitals reclassified to an urban area;
- If a CAH does not meet the first criterion, if located in an MSA, a CAH will be treated as rural if it has reclassified under 42CFR412.103; or
- If a CAH cannot meet either of the first two criteria and is located in a revised labor market area (CBSA) under the standards announced by OMB on June 6, 2003 and adopted by CMS effective October 1, 2004, it has until September 30, 2006 to meet one of the other classification requirements without losing its CAH status.

The law also requires that CMS automatically reassign any hospital located in a rural county adjacent to an urban area if the county meets specified commuting criteria known as “Lugar criteria.” In FFY 2005, CMS applied the new CBSA definitions and 2000 Census data to assign reclassifications to hospitals in counties that meet these criteria. As a result, CAHs located in newly designated “Lugar counties” were reclassified to urban areas and could no longer meet the rural location requirement for CAH designation.

CMS Proposal: ... *we are proposing to make changes to §485.610(b) of the regulations that would permit CAHs located in a county that, in FY 2004, was not part of a Lugar county, but as of FY 2005 was included in such a county as a result of the new labor market area definitions, to maintain their CAH status until September 30, 2006.*

According to CMS, this change would permit CAHs in newly designated Lugar counties to continue participating in Medicare as a CAH until September 30, 2006, allowing CAHs a reasonable opportunity to seek reclassification as rural facilities under current regulation. The list of rural counties that are redesignated as urban under these criteria can be found on pages 23379 through 23381 of the *Federal Register*. CAHs in these counties must apply for reclassification as rural by September 30, 2006.

XI. OTHER

Long-Term Care Hospitals

Refer to “LTC-DRGs” if you submit a comment on this issue.
(*Federal Register* page 23338)

Proposed LTC-DRG Reclassifications and Relative Weights for LTCHs for FY 2006

(*Federal Register* page 23339)

The patient classification system utilized under the long-term care hospital (LTCH) PPS is based on the diagnosis-related groups (DRGs) used under the Inpatient PPS. Therefore, the annual update of the long-term care diagnosis-related group (LTC-DRG) classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the DRGs used under the Inpatient PPS. CMS is proposing to

update the FFY 2006 LTC-DRG relative weights using the December 2004 update of the FFY 2004 Medicare Provider Analysis and Review (MedPAR) file.

CMS has also identified 172 low-volume LTC-DRGs (fewer than 25 LTCH cases), grouped them into quintiles, and is proposing to assign the same relative weights and average length of stay to each low-volume LTC-DRG within the quintile.

Provider-Based Status

Refer to “Provider-Based Entities” if you submit a comment on this issue.

(Federal Register page 23443)

Limits on the Scope of the Provider-Based Regulations: Facilities for Which Provider-Based Determinations Will Not Be Made

(Federal Register page 23443)

Background: Providers operating in the Medicare program, referred to as “main providers,” can functioned as a single entity while owning and operating multiple provider-based departments, locations, and facilities that are treated as part of the main provider for Medicare purposes. The designation of provider-based status can result in additional Medicare payments for services furnished at the provider-based facility. In regulation, CMS lists specific types of facilities and organizations for which determinations of provider-based status *will not* be made because the determination would not affect Medicare payment.

CMS Proposal: *... we are proposing to revise §413.65(a)(1)(ii) to add rural health clinics with hospitals having 50 or more beds to the listing of the types of facilities for which a provider-based status determination will not be made. We believe this proposed revision to §413.65(a)(1)(ii) is appropriate because all rural health clinics affiliated with hospitals having 50 or more beds are paid on the same basis as rural health clinics not affiliated with any hospital, and the scope of Medicare Part B benefits and beneficiary liability for Medicare Part B deductible and coinsurance amounts would be the same, regardless of whether the rural health clinic was found to be provider-based or freestanding.*

Location Requirement for Off-Campus Facilities: Application to Certain Neonatal Intensive Care Units

(Federal Register page 23444)

Background: Criteria have been established to determine if facilities located off the main provider campus are sufficiently integrated with the main provider to justify provider-based designation. These requirements specify that a facility or organization not located on the main campus of the potential main provider can qualify for provider-based status only if it is located within a 35-mile radius of the campus of the main provider, or is able to meet other specified criteria.

CMS has been advised that, in some cases, the location requirements in current regulations may impede the delivery of intensive care services to newborn infants in areas where there is no nearby children's hospital with a neonatal intensive care unit (NICU). In some cases, a children’s hospital participating in the Medicare program staffs and operates an offsite NICU located in space leased from another hospital. In rural areas, provider-based status for these units may be difficult to obtain based on the current provider-based location requirements. CMS is soliciting comments on this issue to determine the extent of the problem and potential solutions.

Definition of a Hospital in Connection with Specialty Hospitals

Refer to “Specialty Hospitals” if you submit a comment on this issue,

(Federal Register page 23447)

The MMA imposed an 18-month moratorium (through June 8, 2005) on physician referrals to new specialty

hospitals in which the physician has an ownership interest. In addition it required that CMS to study physician-owned cardiac, surgery, and orthopedic specialty hospitals. CMS has determined that some entities that describe themselves as surgical or orthopedic specialty hospitals may be primarily engaged in furnishing services to outpatients, and thus might not meet the definition of a hospital. CMS states that if it were determined that a specialty hospital operating under an existing Medicare provider agreement is not, or is no longer, primarily engaged in treating inpatients, the hospital is subject to having its provider agreement terminated.

The conditions of participation for hospitals specify that, in order to be a Medicare-participating hospital, an institution must, among other things, be primarily engaged in furnishing services to inpatients. An institution that applies for a Medicare provider agreement as a hospital but is unable to meet this requirement will have its application denied. In addition, institutions that have a Medicare hospital provider agreement but are no longer primarily engaging in furnishing services to inpatients are subject to having their provider agreements terminated. The issue has arisen in the context of MMA provisions regarding specialty hospitals. In this context, specialty hospitals are defined as hospitals that are primarily or exclusively engaged in the care and treatment of: patients with a cardiac condition; patients with an orthopedic condition; or patients receiving a surgical procedure.

MedPAC Recommendations on Physician-Owned Specialty Hospitals

Refer to “MedPAC” Recommendations” if you submit a comment on this issue.

(Federal Register page 23454)

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. CMS is required by law to respond to MedPAC’s Inpatient PPS recommendations. In this proposed rule, CMS responds to MedPAC’s recommendations including the establishment of a quality incentive payment policy, and the issue of Physician-owned specialty hospitals.

In regard to Physician-owned specialty hospitals, CMS discusses a number of issues related to MedPAC’s recommendations that the Secretary should improve payment accuracy in the hospital inpatient PPS by:

- Refining the current DRGs to more fully capture differences in severity of illness among patients
- Basing the DRG relative weights on the estimated cost of providing care rather than on charges
- Basing the weights on the national average of hospitals' relative values in each DRG

CMS, in an attempt to reduce the advantages of selection of desirable patients within DRGs by specialty hospitals responds to MedPAC’s recommendation by stating that they expect to make changes to the DRGs to better reflect the severity of illness. CMS discusses the options of:

- a comprehensive and systematic review of the complications and comorbidities (CC) list for the FFY 2007 Inpatient PPS proposed rule,
- a selective review of the specific DRGs, such as cardiac, orthopedic, and surgical DRGs, that are alleged to be overpaid and that create incentives for physicians to form specialty hospitals, and
- the use of alternative DRG systems such as the all patient refined diagnosis related groups (APR-DRGs) in place of Medicare’s current DRG system. The APR-DRGs have a greater number of DRGs, potentially relating payment rates more closely to patient resource needs.

CMS further notes that they are concerned about their ability to account for the effect of changes in coding behavior on payment if there were a significant expansion to the number of DRGs, and that any large change to the DRG patient classifications could have substantial effects across all hospitals. Therefore, CMS believes they must thoroughly analyze these options before making any proposal.

Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

Refer to “Blood Clotting Factor” if you submit a comment on this issue.

(Federal Register page 23453)

Background: Currently, CMS makes payments for blood clotting factors furnished to inpatients at 95 percent of average wholesale price (AWP). The MMA required that Medicare Part B drugs not paid on a cost or prospective basis be paid at 106 percent of average sales price (ASP) and provided for payment of a furnishing fee for blood clotting factor, effective January 1, 2005.

CMS Proposal: ... *we are proposing to revise §§412.2(f)(8) and 412.115(b) of the regulations governing the IPPS to specify that, for discharges occurring on or after October 1, 2005, the additional payment for the blood clotting factor administered to hemophilia inpatients is made based on the average sales price methodology specified in Subpart K of 42 CFR Part 414 and the furnishing fee specified in §410.63.*