

## GENERAL MEMO 10-02

August 2, 2002

**TO: Packet Recipient**

**FROM: George Quinn, Vice President, Finance  
Brian Potter, Director of Finance and Information Services**

**SUBJECT: FY 2003 Inpatient PPS Final Rule: Overview and Summary**

The Centers for Medicare & Medicaid Services (CMS) issued their final rule regarding the FY 2003 Hospital Inpatient Prospective Payment System (PPS). This memo provides a brief overview and summary of major changes to the PPS.

The rule provides an inpatient rate update of 2.95 percent, up from 2.75 percent in the proposed rule. By law, the update for 2003 must be market basket less 0.55 percentage points. The revised estimate of the market basket is 3.5 percent (rather than 3.3 percent).

- Note that even with a 2.95 percent update, after accounting for legislative and regulatory changes, as well as technical adjustments to ensure budget neutrality, the average overall increase in per case payments for hospitals will be only 0.4 percent.

In general, the rule does not address EMTALA provisions, which will be published in a separate document in the future. CMS received over 600 comment letters on EMTALA provisions and, given the short timeframe, indicated that it was unable to adequately reflect on suggested changes prior to August 1.

### Changes From the Proposed Rule

**Transfer Policy.** The post-acute care transfer policy will NOT be expanded to additional DRGs in FY 2003. The expansion of this policy would have cut hospital payments by between \$15 million and \$32 million for Wisconsin hospitals in FY 2003 alone. WHA strongly opposed this policy, and is pleased with Secretary Thompson's decision not to expand it to either an additional 13 DRGs or to all DRGs. This is the right decision, as it will help assure that patients will receive the right care at the right time in the right setting.

**Outlier Threshold.** CMS will raise the outlier threshold by 60 percent, from \$21,025 in FY 2002 to \$33,560 in FY 2003 (a slight increase from the \$33,450 threshold in the proposed rule). WHA advocated that the threshold amount be lowered, and argued that CMS' proposed methodology was flawed. In the final rule, CMS changed its methodology and based the threshold on increases in *charge* inflation (rather than cost inflation). This excessive increase in the outlier threshold will make it more difficult for hospitals to recover the costs associated with treating the most seriously ill patients.

**Labor-related share.** The labor-related share, or that portion of the PPS standardized amount that is adjusted by a hospital's area wage index, will remain at 71.1 percent. CMS had proposed increasing this amount to 72.5 percent, which would result in redistributing funds from rural hospitals to urban hospitals. As WHA recommended, CMS will further analyze its methodology (which will be later proposed and open to public comment) before making any refinements to the labor-related share.

**Counting Beds.** CMS will NOT change the way it counts beds for the purposes of IME and DSH payments. CMS had proposed to decrease a hospital's total number of beds reported on its cost report if its annual occupancy rate was below 35 percent. This policy would have resulted in a reduction in hospital payments on a national level of \$143 million in FY 2003.

**Sole Community Hospitals (SCHs).** The final rule allows hospitals to maintain SCH status even if there is another limited-service short-term acute care hospital within a 35-mile limit, as long as the total inpatient days provided by the limited-service hospital do not exceed 8 percent of the total inpatient days provided by the SCH. This is a change from the proposed rule, which allowed the services provided by the two hospitals to overlap by no more than 3 percent. This provision will allow hospitals greater flexibility in obtaining and maintaining SCH status.

**Drug-Eluting Stents.** The rule creates two new DRGs (DRG 526 & 527), which will be activated on or after April 1, 2003, to pay for drug eluting stents. Payment will not be made until FDA approves the new stents, and if FDA approval occurs prior to April 1, the drug eluting stents will be paid using the current assignment of DRG 517 (note that drug-eluting stents remain mapped to the over reimbursed DRG).

**New Technology.** The rule approves the sepsis drug Xigris™ for new technology add-on payments in FY 2003 and FY 2004.

CMS estimates that these add-on payments will total \$74.8 million nationally in FY 2003.

## **Changes Consistent with the Proposed Rule**

**Wage Index.** CMS is moving forward with its proposal to remove 100 percent of the salary costs associated with teaching physicians, residents, and CRNAs from the FY 2003 wage index, rather than continuing with a five-year transition to exclude these salary costs which was agreed to in 1998. The proposed change will cause a more rapid redistribution of funds from teaching hospitals to rural hospitals.

**Market Basket Index.** CMS will update the base year of the market basket to 1997 from 1992. In addition, CMS will add a separate component to account for blood prices and will adopt a hospital-specific (rather than general economy) wage measure.

**CRNAs.** The final rule increases the threshold for procedures requiring anesthesia from 500 to 800, which will allow for additional rural hospitals to qualify for pass-through payments for non-physician anesthetists.

**MDS.** CMS has eliminated the requirement for CAHs to complete a lengthy patient assessment form for skilled nursing facility patients (often called the Minimum Data Set), an initiative strongly pushed by the American Hospital Association.