BETTER BENEFITS – MORE CHOICES

Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!

CMS ANNOUNCES FY 2005 PAYMENT INCREASES AND POLICY CHANGES TO IMPROVE QUALITY AND ACCESS FOR ACUTE CARE HOSPITALS

- The Centers for Medicare & Medicaid Services (CMS) yesterday issued a final rule that will **increase payments to acute care hospitals for inpatient services** in fiscal year 2005, **offer additional financial relief to rural hospitals**, and for the first time in the history of Medicare, **create a link between quality services to Medicare beneficiaries and payment for those services**.

  - The final rule implements major payment and policy changes for acute care hospitals required by the Medicare Prescription Drug Improvements and Modernization Act of 2003 (MMA) signed into law on December 8, 2003.

- CMS projects that:

  - ✓ The combined impact of the inflation update and other proposed changes will yield an **average 5.7 percent increase in payments for urban hospitals** in fiscal year 2005;
  - ✓ **Rural hospitals will see an average increase of 6.2 percent**;
  - ✓ In FY 2005, **Medicare payments to approximately 3,900 acute care hospitals under the inpatient prospective payment system (IPPS) are projected to be $105 billion**, up from a projected $100 billion in fiscal year 2004.

- Among other things, the rule provides:

  - ✓ a full market basket update for hospitals that report on the quality of their care;
  - ✓ it reduces the impact of labor rates on the wage index for hospitals with relatively low labor costs, thus increasing significantly the payment rates for most rural hospitals;
  - ✓ it provides additional payments for hospitals in remote areas to reflect the higher costs associated with having a low volume of total discharges;
  - ✓ and it increases payments for important new medical technologies.

- As required by the MMA, **hospitals reporting specified quality data will receive an inflation update equal to the hospital market basket percentage increase of 3.3 percent**.

- ✧ Hospitals that do not report this information will receive the market basket percentage increase less 0.4 percentage points, or a 2.9 percent increase.

❖ The market basket percentage increase refers to the projected rate of inflation for goods and services used by hospitals in caring for Medicare beneficiaries.

- ✧ This is the **first time that hospital payment rate increases have been related to performance**, in this case by providing incentives for making quality of care information available to patients and health professionals.
- ✧ The overwhelming **majority of acute care hospitals will be eligible to get the full update for 2005**.

❖ The final rule addresses the impact of the new Metropolitan Statistical Area (MSA) definitions on hospital geographic classification.

❖ The MSAs, which were developed by the Office of Management and Budget on the basis of 2000 Census data, will replace the currently used Metropolitan Statistical Areas and New England County Metropolitan Areas, which reflect 1990 data.

- ✧ As a result of these changes, a number of **hospitals, currently located in rural areas, will benefit from being classified into areas with higher payment rates**.

❖ For hospitals that will experience a decrease in their wage indices, CMS has decided to provide for a phase-in of the new MSAs over a two-year period.

- ✧ Hospitals that will experience an increase as a result of the new MSAs will receive the **full benefit of the new labor markets in FY 2005**.
- ✧ In addition, hospitals that had been reclassified by the Medicare Geographic Classification Review Board will continue to be paid according to their reclassification.
- ✧ Those hospitals that had applied for reclassification in 2005 will be permitted to withdraw their applications if reclassification will no longer be to their advantage.
- ✧ Hospitals that had previously been reclassified to an adjoining MSA that has been split under the new MSA definitions will be reclassified to the new MSA nearest them.
- ✧ In addition, for hospitals in areas that have been **redesignated from urban to rural** as a result of the labor market area changes, **CMS is providing a three-year period during which those hospitals will continue to be paid as urban hospitals**.

❖ The MSA changes also have an impact on hospitals that are entitled to automatic geographic reclassification because they are located in rural counties whose workforces tend to commute to adjacent urban areas. The number of such counties is increasing from 28 to 97 under the final rule.

❖ The final rule also **implements a number of provisions in the MMA designed to help critical access hospitals (CAHs) as they serve rural beneficiaries**.

- ✧ For example, these hospitals can now designate up to **25 beds as either acute care beds** or beds that may be used for either acute or post-acute care (called swing beds).
- ✧ Now CAHs can also **set aside units of up to ten beds** each to be used exclusively for inpatient rehabilitation and psychiatric services.
- ✧ These units, which would not count toward the CAH's 25-bed maximum, will be paid as if they were distinct parts of acute care hospitals, and will have to meet the same standards as units in acute care hospitals.
- ✧ In addition, payment for both inpatient and outpatient services rendered by critical access hospitals **has been increased from 100 percent to 101 percent of reasonable costs**.
- ✧ Finally, CAHs that are in a county that is now classified as urban will be permitted to retain their CAH status for two years.

❖ The rule also implements Section 406 of the MMA, which **requires CMS to make an additional payment to low-volume acute care hospitals that are located more than 25 road miles from another acute care hospital**: payments will be based on their additional incremental costs.

❖ Based on an analysis of the most recent data, CMS has determined that **costs per case do not increase for a hospital until the total number of discharges per year falls to 200 or fewer**. Therefore, CMS is setting 200 total discharges per year as the threshold number for eligibility for the low-volume payments. CMS will use the number of discharges from a previous fiscal year in determining whether a hospital qualifies for the adjustment. This will make it possible for hospitals to know in advance whether they will be receiving adjustment.

❖ The final rule **approves two technologies for add-on payments**.

- ✓ **implantable neurostimulator for deep brain stimulation**, which is used to treat patients with essential tremor and Parkinson's disease.
- ✓ a device that provides **cardiac resynchronization therapy with defibrillation**. It provides significant benefits in treating congestive heart failure and ventricular arrhythmias that could result in sudden death.

❖ In addition, the final rule continues new technology payments in FY 2005 for a technology which, when placed at a spinal fusion site, promotes bone growth, offering a less invasive alternative to a traditional bone graft. This technology was first approved for new technology payments for FY 2004.

❖ We are also implementing procedures outlined in the new Medicare law to **increase early opportunities for public input**, especially on the issue of whether a technology provides a substantial clinical improvement over existing treatments.

❖ In the final rule, CMS is also adopting several changes to the diagnosis related groups (DRGs) that serve as the basis for payment under the IPPS. The rule

creates a new DRG for certain craniotomy procedures that involve the implantation of a chemotherapeutic agent. This DRG also includes cases in which the principal diagnosis is an acute complex central nervous system diagnosis.

- Based on a review of claims data, CMS is **increasing payment to hospitals for treating burn patients who have respiratory failure and require the long-term use of mechanical ventilation**.

- In addition, CMS is **reassigning heart assist devices**, including left ventricular assist devices or LVADs, to the DRG for heart transplants, which will increase the payment for these devices.

  - These devices were **originally approved only as a "bridge" therapy to keep a patient alive** while awaiting a heart transplant, but are **now approved as a "destination" therapy** for patients requiring permanent mechanical cardiac support, but for whom a transplant is not anticipated.
  - This DRG will now be called **"Heart Transplant or Implant of Heart Assist System."** This will have the effect of increasing payment for the heart assist system, but is not expected to reduce payments for transplants.

- Additional changes to the DRGs include splitting the DRG for tracheostomy into two new DRGs, to allow for a higher payment when an additional surgical procedure is performed with the tracheostomy, and removing a spinal fusion procedure requiring only a single incision from the DRG for spinal fusions requiring two incisions, resulting in a higher payment for the latter procedures.

- The final rule adopts two changes affecting hospitals that receive graduate medical education payments.

  - First, it **implements section 422 of the MMA**, which redistributes unused residency slots among teaching hospitals to better reflect changes in the location of residency training. Hospitals located in rural areas are given first priority.
  - Second, it **allows a hospital to receive full payment for up to four years of specialty training when a resident matches simultaneously to a generalized, preliminary year of training and a subsequent specialty training program**.
  - The final rule also modifies the requirement that a hospital have a written agreement with a non-hospital site if the hospital wants to count the time a resident spends in the non-hospital site in its indirect medical education and graduate medical education full time equivalent count by permitting the hospital to satisfy this requirement by paying the costs associated with the training program in the non-hospital setting by the end of the third month following a month in which the training in the non-hospital setting occurred.

- The rule modifies several policies affecting arrangements in which a long-term care hospital is located within another hospital. The final rule reflects substantial changes from the proposed rule on hospitals-within hospitals issued earlier this year, based on many comments on the proposed rule. The changes **assure**

continued adequate payment for high-quality LTCH services, especially for the "outlier" patients that LTCHs were primarily intended to serve, while imposing gradual, reasonable limits on payment of a second large payment for patients who do not reach outlier status at the host. CMS has not adopted a proposal to prohibit common ownership of a hospital-within-hospital and its host, but the two hospitals must have separate administrations.

- In addition, the rule **does not adopt the proposed 25 percent limit on the number of patients of the long-term care hospital that can be referred from the host hospital**.

- Instead, the rule **continues to provide for full LTCH payment for all truly long-stay host hospital patients** (i.e., "outlier" patients in the host inpatient setting), and it **provides a slow transition to reasonable limits on paying twice** – once in the host setting and again in the LTCH setting – for patients that generally have received only a single payment to the host hospitals.

  - Consequently, Medicare will continue to pay the host hospital for all patients admitted to a "hospital-within-hospital" LTCH, but will gradually impose a reasonable limit on the total additional payments for patients at the hospital-within-hospital LTCH who did not reach outlier status at the host hospital.
  - The limits, which are phased in over four years for existing LTCHs and certain LTCH hospitals within hospitals under development that meet specified criteria, vary depending on the extent to which the long-term care hospital has sources of admission other than the host hospital. During this gradual transition, Medicare will conduct further research to determine whether the criteria for LTCHs and their admissions should be further revised.

- The final rule sets the **outlier threshold at $25,800 for FY 2005**, down from $31,000 in FY 2004 and from the proposed threshold for FY 2005 of $35,085.

- The rule establishes a **five-year demonstration project required by the MMA to test the feasibility and advisability of establishing a separate payment system for inpatient services provided by rural community hospitals**. The MMA requires that the demonstration include up to 15 hospitals in rural areas of states with low population densities. Participating hospitals will be paid on a reasonable cost basis for the first year of the demonstration. Thereafter, the hospitals will be paid at the lesser of reasonable costs or a target amount.

- The rule also **includes proposed changes to the long-term care hospital DRGs**, which are based on the inpatient DRGs.

- The **final rule will be published in the August 11 *Federal Register***, and will become effective for hospital discharges on or after October 1, 2004.

Note: For more information, visit the CMS Website at www.cms.hhs.gov.