BETTER BENEFITS – MORE CHOICES

Proposed FY 2005 Payment Increases and Policy Changes for Acute Care Hospitals

On Tuesday, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would increase payments to acute care hospitals for inpatient services in fiscal year 2005. It would also offer additional financial relief to rural hospitals, and for the first time in the history of Medicare, create a direct link between the quality of services to Medicare beneficiaries and payment for those services. The proposed rule would implement major payment and policy changes for acute care hospitals required by the comprehensive Medicare modernization legislation 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 4.7 percent increase in payments for urban hospitals in fiscal year 2005, while rural hospitals will see an average increase of 6.0 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.

Market Basket Update:

As required by the Medicare Modernization Act of 2003 (MMA), hospitals reporting specified quality data will receive an inflation update equal to the hospital market basket percentage increase, currently estimated at 3.3 percent. Hospitals that do not report this information will receive the market basket percentage increase less 0.4 percentage points, or an estimated 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 giving information to patients and health professionals related to quality of care.

Low-Volume Hospitals:

The proposed rule would also implement 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. CMS has proposed that this adjustment will be paid to eligible hospitals with 500 or fewer discharges in a year, because the available evidence shows lower volumes are associated with increases in costs per case below this level of discharges. CMS is proposing to use the number of discharges from a previous fiscal year both in determining whether a hospital qualifies for the adjustment and in determining the amount of the adjustment to make it possible for hospitals to know in advance whether they will be receiving adjustments and how much.

Geographic Reclassification:

The proposed rule implements the new Core Based Statistical Areas (CBSAs). The CBSAs, 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. Overall, the impact of the CBSAs is expected to be relatively small, although a number of hospitals, currently located in rural areas, are expected to benefit from being classified into areas with higher payment rates.

The CBSAs will 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 proposed rule.

Critical Access Hospitals:

The MMA contained a number of provisions to help critical access hospitals (CAHs) serve rural beneficiaries. The proposed rule implements these provisions. For example, these hospitals can now designate up to 25 beds that may be used for either acute or post-acute care, and can 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. 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.

Diagnosis Related Groups (DRGs):

CMS is also proposing several changes to the diagnosis related groups (DRGs) that serve as the basis for payment under the IPPS. CMS is proposing to increase payment to hospitals for treating burn patients who have respiratory failure and require the long-term use of mechanical ventilation. In addition, CMS is proposing to reassign heart assist devices, including left ventricular assist devices or LVADs, to the DRG for heart transplants. 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.

Graduate Medical Education:

The proposed rule includes several important changes that would affect reimbursements to teaching hospitals for direct and indirect medical education costs. CMS is proposing to implement a provision of the MMA that redistributes unused residency slots among teaching hospitals for purposes of calculating both direct and indirect graduate medical education payments. The additional slots will be allocated first to rural hospitals, then to hospitals in other than large urban areas, and then to hospitals using the slots to train residents in a program that is the only program in that specialty in the state. Hospitals that have in the past been training fewer residents than their GME resident cap would have their caps reduced.

The proposed rule also discusses, and invites public comment on, a possible change in how CMS pays a hospital for residents pursuing specialty residencies. The proposal discusses allowing the hospital to receive full payment for the duration of specialty residencies when a resident matches simultaneously to a generalized, preliminary year of training and a subsequent specialty training program. The proposed rule also would eliminate 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 IME and direct GME FTE count.

Outlier Threshold:

The proposed rule sets the outlier threshold at $35,085, up from $31,000 in FY 2004. CMS is specifically soliciting comments, including data, from hospitals that will help determine whether this is an appropriate level. Note: this provision makes it harder for hospitals to qualify for outlier payments. There needs to be additional discussion of payment equity issues if the author wants to include this provision as "good news" about the Medicare program.

Rural Community Hospital Demonstration Program:

The proposed rule establishes a five-year demonstration project 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. Hospitals that meet the criteria as a rural community hospital and are located in one of the 10 lowest population density states can submit an application to CMS to participate in the demonstration.

Hospitals-within-hospitals:

The proposed rule would modify several policies affecting arrangements in which a hospital that is excluded from payment under the IPPS is located within an IPPS hospital. Under the proposed rule, the two hospitals could not be under common ownership, and no more than 25 percent of the IPPS-excluded hospital's admissions could be from the host hospital. The proposed rule also includes proposed changes to the long-term care hospital DRGs, which are based on the inpatient DRGs.

The proposed rule will be published in the May 18 *Federal Register*. Comments will be accepted until July 12, 2004, and a final rule will be published later in the year.