



June 1, 2005

AAMC Summary and Analysis

FISCAL YEAR 2006 MEDICARE INPATIENT PPS PROPOSED RULE: PROVISIONS OF INTEREST TO THE ACADEMIC MEDICAL COMMUNITY

On May 4, 2005, the Centers for Medicare & Medicaid Services (CMS) published its annual proposed rule containing changes to the Medicare hospital inpatient prospective payment system (PPS) and the PPS payment update for Federal fiscal year (FFY) 2006. See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule. 70 Fed. Reg. 23305. The proposed rule can be obtained by accessing the AAMC's issue brief on this topic at: <http://www.aamc.org/advocacy/library/teachhosp/hosp0056.htm>.

Comments on the proposed rule are due **June 24, 2005**.

Despite proposing an update of 3.2 percent, the financial impact analysis included in the proposed rule estimates that, in aggregate, average per case payments in FFY 2006 for all hospitals will increase by only 2.5 percent. The primary reason for a lower-than-market basket increase for hospitals is the expansion of the post-acute care transfer policy, which is responsible for an estimated payment decrease of 1.1 percent. With all changes, CMS estimates that **teaching hospitals with 100 or more residents will see an average per case increase of 2.1 percent**, compared to gains of 2.6 percent and 2.8 percent for other teaching and nonteaching hospitals, respectively.

I. INPATIENT PPS OPERATING RATE UPDATE

For FFY 2006, the proposed rule would implement the current law increase to the standardized payment amount for hospitals that submit performance data on 10 designated quality measures equal to the full market basket increase, currently estimated at 3.2 percent. Hospitals that do not submit quality data will receive an increase equal to the market basket increase minus 0.4 percentage points, or 2.8 percent.

Analysis--The actual update will reflect the most recent estimate of the market basket increase at the time the final rule is published in early August. As mentioned above, the average estimated actual increase in per case payments will be less than the market basket increase due to changes in the proposed rule that would reduce payments.

II. PROPOSALS AFFECTING BOTH DGME AND IME PAYMENTS

A. New Teaching Hospitals' Participation in Medicare GME Affiliated Groups (pages 23440-41)

Background

Under current regulations, existing teaching hospitals that meet specified criteria may enter into Medicare GME affiliation agreements by which they combine their respective resident caps and then redistribute them according to their agreement—with the proviso that the sum of the new caps cannot exceed the aggregate combined cap. Currently, 42 C.F.R. §413.79(e)(1)(iv) specifies that new teaching hospitals that are located in urban areas cannot be part of Medicare GME affiliated groups. New rural teaching hospitals may enter into these agreements but only if the rural hospital provides training for at least one-third of the FTE residents in all of the joint programs of the affiliated hospitals.

CMS states that its rationale for the new teaching hospital provision is to prevent “gaming” by current teaching hospitals that might encourage nonteaching hospitals to become teaching hospitals, receive a resident cap, and then enter into a GME affiliation agreement in which they would transfer many of their cap slots to the existing teaching hospital. A more flexible standard is provided for new rural teaching hospitals because rural hospitals may not have sufficient patient volume to support residency training programs.

Proposed Rule

The proposed rule would allow new urban teaching hospitals to enter into GME affiliation groups but only if there is a “positive adjustment” to its direct GME and/or IME cap; that is, the new teaching hospital’s revised cap pursuant to the affiliated agreement must be higher than its base year cap.

Analysis--While we appreciate that a positive action has been made, we continue to believe this policy is unnecessary. Hospitals do not decide to become teaching institutions and go through the rigors of the accreditation process without extensive thought and analysis. CMS has provided no evidence that so-called “gaming” has occurred. Even if such a concern existed, it could be addressed by time limiting the affiliation group exclusion for new urban teaching hospitals, for example, three or five years.

B. Resident Caps for Hospitals Changing Geographic Status (pages 23441-443, and 23433-434)

Background

Under the resident cap provisions, rural hospitals' resident caps equal 130 percent of their base year (generally 1996) resident counts and their resident caps are increased if the rural hospital starts a new residency program. These provisions do not apply to urban teaching hospitals.

Proposed Rule

As a result of labor market definitional changes, some rural teaching hospitals are now considered urban. Under the proposed rule, these hospitals would retain their 130 percent cap determination, as well as any new program cap expansions that occurred while they were classified as rural.

Also, urban hospitals that received cap increases for rural training track programs may retain those increases even if the rural "track" has been re-designated as urban due to new labor market definitions.

The situation is different for an urban hospital that had applied and been approved to be reclassified as rural under section 1886(d)(8)(E) (codified at 42 C.F.R. §412.103) and then returns to being urban. First, according to CMS, urban hospitals that reclassify to rural under this section may receive the rural cap adjustments (130 percent and new program expansions), but only for their IME cap. This is because under the statute the reclassification affects only payments made under section 1886(d) of the Medicare statute. While IME payments are authorized under this section, DGME payments are authorized under section 1886(h). Consequently, CMS states that only the IME cap is affected by the change to rural status.

If the hospital subsequently rescinds its rural reclassification status and returns to being urban, CMS proposes that the hospital would forfeit any IME cap adjustment that it received during its rural status.

Analysis--CMS believes it is appropriate to allow rural hospitals that become urban due to labor market definitional changes to retain permanently any upward cap adjustments that occurred while they were considered rural because the labor market changes were not within their control. This is in contrast to those urban hospitals that voluntarily chose to change their status to rural under section 1886(d)(8)(E) and then return to urban status. CMS is concerned that some hospitals would seek rural status for a short period only to receive the upward cap adjustment. If this is the concern, it seems that urban teaching hospitals that reclassify to rural status for a significant period of time before returning to

urban status (for example, 3-5 years), should be permitted to retain any upward cap adjustments that occurred during the rural period.

We also will be examining the basis for CMS's determination that hospitals that reclassify to rural status under section 1886(d)(8)(E) are not eligible to receive DGME cap adjustments.

Note also that reclassifications pursuant to the Medicare geographic classification review board under section 1886(d)(1) or otherwise under section 1886(d)(8)(B) are effective only for wage index purposes and do not affect IME or DGME cap determinations.

III. OTHER CHANGES ASSOCIATED WITH DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS

A. DGME Initial Residency Period (IRP) Determinations For Specialties Requiring A General Clinical Training Year (pages 23438-440; 42 C.F.R. §413.79(a)(10))

Background

Initial residency periods (IRPs) are used to determine Medicare DGME payments. Residents are counted as 1.0 full time equivalents (FTEs) during the number of years required to achieve first board eligibility, known as the initial residency period (IRP), though no resident can be counted as a 1.0 FTE for more than five years. For any training beyond the IRP, residents are counted as 0.5 FTEs.

CMS historically held the position that the IRP for residents in specialties that require a general clinical training year (for example, radiology, anesthesiology, and dermatology,) is determined based on the specialty of the first residency program they enter, rather than the second year program, which reflects their intended specialty of training. Thus, a resident who enrolls in a preliminary year internal medicine program is assigned the internal medicine IRP of three years, even if that is not the resident's ultimate specialty choice.

In last year's FY 2005 IPPS final rule, CMS stated that effective for portions of cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a resident "simultaneously matched" for one year of training in a particular specialty residency program and for a subsequent period of training in a different specialty program, the resident's IRP will be determined based on the period of board eligibility associated with the second program.

Proposed Rule

The proposed rule broadens CMS's policy by allowing hospitals that can document that a resident matched to an advanced residency program beginning in the second year prior to the commencement of any training, the resident's IRP will be determined based on the advanced specialty, even if the resident had not matched for a clinical base year program.

Analysis--This proposal would broaden current CMS policy, which allows for only "simultaneous match" situations. However, we continue to believe that a much more straightforward--and administratively less burdensome--solution is that for residents whose first year of training is completed in a program that provides a general clinical year of training, an IRP should be assigned based on the specialty the resident enters in the second year of training, regardless of when the resident matches to the advanced specialty program.

IV. OTHER CHANGES ASSOCIATED WITH INDIRECT MEDICAL EDUCATION (IME) PAYMENTS

A. IME Adjustment

While not addressed in the proposed rule, the IME adjustment will be reduced on October 1, 2005 from 5.8 percent (multiplier = 1.42) to 5.55 percent (multiplier = 1.37) pursuant to current law.

B. IME Resident Caps For Formerly Inpatient PPS-Excluded Hospitals

Background

PPS-excluded rehabilitation and psychiatric hospitals and PPS-excluded distinct-part units of acute care hospitals do not receive IME payments under the inpatient acute system payments because their payments are not determined by that payment system.¹ Consequently, they do not have an IME resident cap. However, these hospitals and units receive DGME payments and thus have a DGME resident cap.

According to the proposed rule, some PPS-excluded hospitals have failed to continue to qualify for a PPS-exclusion or purposely changed their status to be subject to the inpatient PPS. In these situations, these hospitals are now eligible to receive inpatient PPS IME payments, however, they do not have an IME resident limit.

¹ Until recently, these units and hospitals were paid on a cost-based system. However, they currently are paid based on the inpatient psychiatric facility PPS or inpatient rehabilitation facility (IRF) PPS. The psychiatric PPS has its own IME adjustment. CMS has recently proposed to include an IME adjustment as part of the IRF PPS (70 Fed. Reg. 30188 (May 25, 2005)).

Proposed Rule

Under the proposed rule, for PPS-excluded hospitals that subsequently become subject to the inpatient PPS, an IME cap will be established for them that will equal the resident count that was used to establish their DGME cap. The proposed rule is silent as to how a cap is determined for PPS

Analysis--The proposed rule does not discuss what happens to a hospital's IME cap when a PPS-excluded unit fails to continue to qualify for a PPS-exclusion, or purposely change their status such that it is subject to the acute care inpatient PPS. The situation for units seems analogous to hospitals, and thus it seems that CMS's proposal should also apply to units. Given that it is more likely that a PPS-excluded unit will lose its status (for example, pursuant to the 75 percent rule for PPS-excluded rehabilitation units), clarifying that the proposal also applies to converted PPS-excluded units is important.

V. POST-ACUTE CARE TRANSFER PAYMENT POLICY (pages 23411-58)

Background

Medicare patients who are sent from one acute care hospital to another are viewed as "transfers." The transferring hospital is paid a per diem rate based on the DRG payment and the number of days spent at the transferring hospital; the receiving hospital receives the full DRG payment.

In FFY 1999, in accordance with the BBA, CMS expanded its transfer policy such that hospitals that discharge patients associated with one of 10 specified DRGs to a post-acute care facility – such as rehabilitation hospitals and units, psychiatric hospitals and units, cancer, long-term care and children's hospitals, skilled nursing facilities, or are discharged home and receive home health services within three days after the date of discharge – would receive payments under the "post-acute care (PAC) transfer" policy. In subsequent years, CMS further expanded the post-acute care transfer policy, and as a result, a total of 30 DRGs were subject to the PAC transfer policy in FFY 2005.

Currently, to be included in the post-acute care transfer policy, DRGs must satisfy the following criteria for two of the most recent years:

- At least 14,000 post-acute care transfer cases;
- At least 10 percent of its post-acute care transfers occurring before the geometric mean length of stay;
- A geometric mean length of stay of at least 3 days; and
- If a DRG is not already included in the policy, a decline in its geometric mean length of stay during the most recent 5-year period of at least 7 percent.

Proposed Rule

CMS is proposing to expand--again--the post-acute care transfer policy. Although two options are discussed, the proposed rule states that CMS is “formally” proposing the second option. Option 1 would include all DRGs within the post-acute care transfer policy. Option 2 would expand the post-acute care transfer policy from 30 to 223 DRGs in FFY 2006.

Included in the transfer policy under option two are DRGs that meet the following criteria:

- The DRG has at least 2,000 discharges to post-acute care;
- It has at least 20 percent of its cases discharged to post-acute care;
- Out of the cases discharged to post-acute care, at least 10 percent occur before the geometric mean length of stay for the DRG;
- The DRG has a geometric mean length of stay of at least 3 days; and
- If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria above.

Analysis--Although CMS believes that Option 1 would provide consistent treatment of all DRGs, the Agency did not formally propose this option because a significant number of DRGs have lengths of stay less than 3 days and thus would essentially receive the full DRG payment in the first two days of the stay.

CMS is formally proposing Option 2. The Agency believes that this proposed change would expand the application of the post-acute care transfer policy to DRGs that have both a relatively high volume and a relatively high proportion of post-acute care utilization. According to CMS, this option would result in \$880 million less in Medicare program payments to hospitals, the equivalent of a 1.1 percent decrease in payments.

We believe that CMS should not implement an expansion of the post-acute care transfer policy. Such a policy penalizes hospitals that ensure that Medicare patients receive care in the most appropriate setting. Moreover, it undercuts the fundamental principle of the PPS, which is that some cases will cost more than the DRG payment, while others will cost less, but on average, the overall payments should be adequate. It also is important to recognize that to the extent there still are cost reductions associated with discharging patients to post-acute care facilities (a debatable presumption given the current low average lengths of stay), such reductions will be reflected in lower DRG case weights during the DRG recalibration process.

VI. OUTLIER PAYMENT THRESHOLD (pages 23469-470)

Background

If the costs of a particular Medicare case exceed the relevant DRG operating and capital payment (including any DSH, indirect medical education (IME), or new technology add-on payments) plus a fixed-loss cost threshold, the hospital will receive an outlier payment. This payment equals 80 percent of the case's costs above the threshold calculation.

Proposed Rule

The proposed rule would increase the fixed-loss cost threshold for outlier payments to be equal to a case's DRG payment plus any IME and DSH payments, and any additional payments for new technologies, plus \$26,675. The threshold would be applicable for both operating and capital outlier payments. In FFY 2005, the threshold was the DRG payment plus any IME and DSH payments, plus new technology payments, plus \$25,800.

Analysis--the FFY 2006 proposed cost threshold is 3.4 percent higher than the level in FFY 2005. Outlier payments are funded through a 5.1 percent reduction in the PPS standardized payment amount. Consequently, CMS sets the outlier cost threshold at a level that it believes will result in outlier payments that equal 5.1 percent of total DRG payments. However, CMS estimates that outlier payments represented only 3.5 percent of total DRG payments in FFY 2004. Further, CMS believes that outlier payments for FFY 2005 will be approximately 4.4 percent of actual total DRG payments, 0.7 percentage point lower than the 5.1 percent projected in setting the FFY 2005 outlier threshold. Because outlier payments were less than the 5.1 percent reduction to the standardized amount, the result is less total Medicare payments to hospitals.

Given that in the past two years, the threshold was seemingly set too high since it resulted in total outlier payments that were less than 5.1 percent of operating payments, it is unclear whether the threshold should be further increased or potentially decreased, for the upcoming year.

VII. REPORTING OF HOSPITAL QUALITY DATA (pages 23424-426)

Background

Pursuant to the MMA, a hospital's inpatient PPS payment update is now linked with its submission of quality data. For FFYs 2005 through 2007, hospitals will receive a full market basket update if they submit their data for ten quality indicators in Heart Attack (Acute Myocardial Infarction), Heart Failure and Pneumonia. If a hospital does not submit quality data then its percentage increase will be reduced by 0.4 percentage points.

The quality data collected is published on the Hospital Compare Website at www.hospitalcompare.hhs.gov.

The process for reporting data under the “Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU)” program can be found on the Qnet Exchange Web site at <http://www.qnetexchange.org>

For FFY 2005 hospitals submitted their first and second quarter quality data by August 1, 2004.

Proposed Rule

For FFY 2006, CMS is proposing that hospitals submit their data on a rolling basis, which would mean each quarter. A complete schedule for data submission can be found on the Qnet Exchange.

CMS will be utilizing Clinical Data Abstraction Contractors (CDAC) to validate the quality data submitted to the Clinical Data Warehouse. CDAC will reabstract data that was submitted to the Data Warehouse by the hospitals and randomly sample five (5) charts. They will determine the percent agreement at the element level between the data originally submitted and the data reabstracted by the CDAC. In order to be eligible for the market basket update in FFY 2006 and 2007, a hospital must achieve an 80 percent agreement between the two data sets. Appropriate confidence intervals will be used to determine the 80 percent reliability. However, since this is a new process for CMS, they are soliciting comments on their validation approach including the sampling and confidence intervals methodology.

In addition to passing validation, CMS is proposing that a hospital must have data reported for all 10 quality measures for two quarters in order to receive their update. Therefore hospitals must have data displayed on the Compare website for the March 2005 and September 2005 postings in order to be eligible for the FFY 2006 update.

As more hospitals start to use EMR systems, CMS is exploring ways that hospitals can submit quality data from their EMR systems directly to a CMS data repository rather than sending a raw data file. CMS is exploring the requirements for such a data transfer and is soliciting comments on how this might best be done.

VIII. PAYMENTS FOR NEW TECHNOLOGIES (pages 23353-67)

Background

Pursuant to a provision in BIPA, in a September 7, 2001 final rule (66 Fed. Reg. 46902), CMS established a methodology that would provide additional payments to hospitals for new technologies that they use that are not yet reflected in the DRG payment system. In

order to qualify for the additional payments the new service must meet three criteria under the DRG system:

- The medical service or technology is considered “new” until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration – usually 2 to 3 years beginning with FDA approval.
- It must be inadequately paid under the DRG system. The adequacy of payment is established based on a threshold for each DRG (a list of qualifying thresholds by DRG can be found in Table 10 of the Addendum).
- It must represent an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

The additional payment is based on the hospital’s cost for the new medical service or technology. Medicare pays the lesser of a) 50 percent of the difference between the cost of the case with the new technology and the DRG payment, or b) 50 percent of the cost of the new technology.

Payments for new services and technology were initially subject to a budget-neutrality factor. However, the law was subsequently amended and add-on payments from FFY 2005 forward are no longer budget-neutral.

In FFY 2005, hospitals could receive additional payments for three new technologies.

Proposed Rule

Pursuant to its evaluation, CMS proposes to discontinue add-on payments for two technologies that had received payments in FFY 2005-- and continue them for one. In addition, the proposed rule discussed its evaluation of eight new technology applications that the Agency received. The eight applications for FY 2006 include two applications for products that were denied new technology add-on payments for FY 2005. As a result of its evaluations, CMS is proposing to deny add-on payments for five of the eight technologies. For two technologies, CMS will make a decision in the FFY 2006 final rule, and for one device, CMS is not making a decision at this time.

Below are the technologies that were discussed in the proposed rule:

1. INFUSE™ (Bone Morphogenetic Proteins (BMPs) for Spinal Fusions)

In the FY 2004 IPPS final rule, CMS approved INFUSE™ for add-on payments, effective for FY 2004. In the FY 2005 final rule, CMS continued add-on payments for FY 2005. Because the cost of this technology is now reflected in the DRG weights, it is no longer considered “new” and CMS is proposing to discontinue new technology add-on payments for FY 2006. In addition, since CMS used the same policies in making new

technology payment for OP-1 Putty, the agency is proposing to discontinue new technology add-on payment for OP-1 Putty as well for FY 2006.

2. InSync® Defibrillator System (Cardiac Resynchronization Therapy with Defibrillation (CRT-D))

CRT-Ds were available upon initial FDA approval in May 2002 and considered to be new from this date. As a result, for FY 2006, the CRT-D will be beyond the two- to three-year period during which a technology can be considered new. Therefore, CMS is proposing to discontinue add-on payments for CRT-D for FY 2006.

3. Kinetra® Implantable Neurostimulator for Deep Brain Stimulation

This technology received FDA approval on December 16, 2003, and remains within the two- to three-year period during which the neurostimulator can be considered new. Therefore, CMS is proposing to continue add-on payments for Kinetra® Implantable Neurostimulator for deep brain stimulation for FY 2006.

4. INFUSE™ Bone Graft (Bone Morphogenetic Proteins (BMPs) for Tibia Fractures)

Since the costs of these products are already reflected in the relevant DRGs, they are no longer considered new and CMS is proposing to deny new technology add-on payment.

5. Aquadex TM System 100 Fluid Removal System (System 100)

CMS is proposing to deny this application, because this technology does not meet the newness criterion.

6. CHARITE™ Artificial Disc (CHARITE™)

CMS is continuing to evaluate whether CHARITE™ represents a substantial clinical improvement over existing technology for certain patient populations. The agency will make a final determination on whether to approve new technology add-on payments for CHARITE™ for FY 2006 in its final rule. If approved for add-on payments, the device would be reimbursed up to half of the costs for the device. Because the manufacturer has stated that the cost for the CHARITE™ Artificial Disc would be \$11,500, the maximum add-on payment for the device would be \$5,750.

7. Endovascular Graft Repair of the Thoracic Aorta (GORE TAG)

GORE TAG has received FDA approval on March 23, 2005. As a result, CMS has not been able to conduct a complete analysis of cost and substantial clinical improvement data before publishing this proposal. The agency will make its decision on whether to

approve GORE TAG for new technology add-on payments in the FY 2006 final rule. In addition, should this technology be approved for new technology add-on payments, CMS would extend add-on payments to any substantially similar technology that also receives FDA approval prior to publication of the FY 2006 final rule.

8. Restore® Rechargeable Implantable Neurostimulator

This product has not yet received FDA approval and CMS is not making a decision regarding the Restore® application at this time.

9. Safe-Cross® Radio Frequency Total Occlusion Crossing System (Safe-Cross®)

CMS is proposing to deny this application, because it does not appear to represent a substantial clinical improvement over existing technologies.

10. Trident® Ceramic Acetabular System

Since Trident® became available on the market in April 2003, charges reflecting the cost of the device may have been included in the data used to calculate the DRG weights in FY 2005 and the proposed DRG weights for FY 2006. Therefore, the technology may no longer be considered new for the purposes of new technology add-on payments and CMS is proposing to deny add-on payments for this device.

11. Wingspan™ Stent System with Gateway™ PTA Balloon Catheter

Wingspan™ does not have FDA approval or Medicare coverage, and CMS is proposing to deny the new technology add-on payment for this device.

The AAMC has been following this issue closely. We seek any input you may have regarding CMS' process for identifying and paying for new technologies.

IX. PROPOSED CHANGES TO THE HOSPITAL WAGE INDEX (pages 31431-38)

A portion of the standardized payment amount for each hospital is adjusted by the “wage index,” which reflects relative differences in costs across geographic areas that are due to local labor markets. The portion of the standardized amount that is adjusted is referred to as the “labor related share.”

For FFY 2006, the wage index values for each labor market area will be based on 2002 cost report data. The wage index values also will reflect an occupational mix adjustment. The intent of this adjustment is to ensure that the wage index reflects only geographic differences in the prices hospitals pay for labor and not differences in the mix of their

employees (i.e., registered nurses versus licensed practical nurses). Like last year--the first year an occupational mix adjustment was included--CMS proposes to adjust only 10 percent of the wage index for occupational mix.

A. PROPOSED DECREASE TO THE LABOR-RELATED SHARE (pages 23391-394)

Background

CMS defines labor-related share as “the national average proportion of operating costs that are related to, influenced by, or vary with local labor markets. We believe that the operating cost categories that are related to, influenced by, or vary with local labor markets are wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services” (page 23391).

Currently, for hospitals with wage indices above 1.0, the labor related share that is adjusted by the wage index is 71.1 percent. The labor share for hospitals with wage indices less than 1.0, is 62 percent, as dictated by the Medicare Modernization Act (MMA).

Proposed Rule

CMS proposes to decrease the labor related share from 71.1 percent to 69.7 percent. Because of the MMA mandate, the labor share for hospitals with wage indices below 1.0 will remain at 62 percent.

Analysis--CMS’s proposal is based on analyses using more recent data (2002 versus 1997), as well as a decision to remove postage-related costs from the labor share determination. CMS’s proposal would have a negative impact for many teaching hospitals because they are in geographic areas with wage indices greater than one.

X. REBASING THE HOSPITAL MARKET BASKETS (pages 23384--411)

Proposed Rule

CMS proposes to rebase and revise the hospital market basket used as the basis for setting the standardized payment update. The “basket” in the phrase “market basket” refers to the mix of goods and services hospitals purchase to furnish inpatient care. Each type of goods and services, for example employee wages, are given a “weight” such that the total of all of the weights in the market basket equals 100 percent. The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchase in order to furnish inpatient care.

Among other changes, CMS proposes to update the market basket so that it reflects FFY 2002, rather than 1997 cost data.

Analysis--Having an updated and accurate hospital market basket is important because of its role in determining the update to the DRG standardized payment rate.

XI. CHANGES RELATED TO PROVIDER-BASED STATUS (pages 23443-446)

To bill under the outpatient prospective payment system, the facility where the beneficiary receives services must qualify as provider-based. Over the past few years, CMS has issued several rules that provide details on the requirements for qualifying as provider-based. In the proposed rule, CMS proposes several primarily technical changes to the provider-based rules, and asks for comments related to the effect of the current rule on certain neonatal intensive care units (NICUs) that are located in rural areas.

One of the proposed changes is that rural health clinics affiliated with hospitals having 50 or more beds will be included among the facilities for which a provider-based status determination will not be made. The reason behind this change is that these clinics are paid the same amount, regardless of whether they are hospital-based.

CMS has been contacted about a possible problem created by the provider-based rules that affects some neonatal intensive care units (NICUs) located in rural areas. Some children's hospitals that participate in the Medicare program establish off-site NICUs that they operate and staff but which are located in space leased from other hospitals. This arrangement provides infants in rural communities with ready access to the specialized care offered by NICUs. However, these off-site NICUs would not be able to qualify for provider-based status under the current rules. CMS is trying to better understand this issue. In particular CMS wants to learn whether this is, in fact, a problem and, if so, where it is occurring. CMS has asked for comments on four possible solutions to the NICU problem, as follows:

1. An exception to the location requirements for NICUs located in community hospitals that are more than 35 miles from the children's hospital that is the potential main provider.
2. A change in the regulations to allow off-campus NICUs that meet other provider-based requirements to qualify as provider-based for purposes of payment under Medicaid, even though those facilities would not qualify under Medicare.
3. A change in the individual state's Medicaid plans to provide enhanced financial incentives for community hospitals to establish NICUs, possibly in collaboration with children's hospitals.
4. Establishing children's hospitals that meet that meet the requirements for being hospitals-within hospitals.

The proposed rule stated that other potential solutions also are welcome.

XII. SPECIALTY HOSPITALS (page 23447)

The proposed rule clarifies that specialty hospitals do not qualify under the statutory definition of “hospital” if they are not engaged primarily in furnishing services to hospital inpatients.

It has come to CMS’s attention that certain “specialty” hospitals may not meet the statutory definition because they are engaged in furnishing services primarily to outpatients. While not making any specific proposals, the discussion in the proposed rule indicates that CMS will be looking at these institutions in this context to determine whether they should be considered “hospitals” for Medicare purposes.

XIII. OTHER TOPICS IN THE PROPOSED RULE THAT MAY BE OF INTEREST TO AAMC MEMBERS:

- DRG Changes (pages 23312-23338)
- Obtaining SSI and Medicaid Data for calculating the disproportionate share (DSH) adjustment (pages 23434-36)
- Long Term Care-DRG Reclassifications (pages 23338-53)

XIV. SUMMARY

This year’s proposed rule has a number of important proposed changes that could have a significant impact on teaching hospitals’ Medicare payments.

If you have any questions regarding the proposed rule or this summary, or additional issues of which we should be aware, please contact Ivy Baer, ibaer@aamc.org, 202-828-0490 (provider-based issues), Jennifer Faerberg, jfaerberg@aamc.org (quality data submission issues), Diana Mayes, dmayes@aamc.org (new technology payments), or Karen Fisher, kfisher@aamc.org (GME and all other issues). Any of these staff members may also be reached by calling 202-828-0490.