

## AAMC Summary and Analysis

### **FEDERAL FISCAL YEAR 2003 MEDICARE INPATIENT PPS FINAL RULE: PROVISIONS OF INTEREST TO THE ACADEMIC MEDICAL COMMUNITY**

On August 1, 2002, the Centers for Medicare and Medicaid Services (CMS) published in the Federal Register the final rule containing changes to the Medicare hospital inpatient prospective payment system (PPS) and the PPS payment update for Federal fiscal year (FFY) 2003. See *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates*. 67 Fed. Reg. 49982. This rule finalizes changes contained in a May 4 proposed rule (67 Fed. Reg. 31404).

The final rule can be obtained by accessing the AAMC's issue brief on this topic at: <http://www.aamc.org/advocacy/library/teachosp/hosp0043.htm>

Among other items, the final rule includes discussion on the update factor for the inpatient PPS base payment rate, outlier payments, post-acute care transfers, the wage index, and payments for new technologies. Of particular importance to the academic medical community is the discussion and changes related to Medicare direct graduate medical education (DGME) payments and the indirect medical education (IME) payment adjustment.

#### **I. PPS Payment Rate Update (page 50121)**

Unless modifying legislation is passed this year, for FFY 2003 the update to the inpatient standardized payment rate will be 2.95 percent. This update reflects the requirement in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) that the Medicare payment update equal the increase in the hospital market basket less 0.55 percentage points. The final rule estimate of the market basket increase was 3.5 percent.

*Analysis*—It is important to remember that the payment update does not necessarily mean that hospitals' overall inpatient payments will increase by that amount; in fact, they usually do not. This is because a number of other items in the final rule, including issues related to the wage index and outlier payments, also affect providers' payments. For this year in particular, the average per case payment increase for FFY 2003 will be less than the update because CMS estimates that per case outlier payments will be significantly less in FFY 2003 than in FFY 2002 (see below). As a result, CMS estimates that per case payments for all hospitals will rise, on average, only 0.4 percent in 2003. Medicare per case payments for teaching hospitals with 100 or more residents are expected to *decline* by 1.4 percent, compared to increases of 0.5 percent and 1.3 percent for other teaching and nonteaching hospitals, respectively. In addition to the outlier payment reductions, the decline in major teaching hospital payments is due to the scheduled FFY 2003 decrease in the IME adjustment from 6.5 percent to 5.5 percent.

The AAMC, along with other associations, is seeking legislation to increase the FFY 2003 update and maintain the IME adjustment at current levels. Two bills have been introduced, H.R. 1556 and S. 839, that would set the payment update equal to the full market basket

increase and maintain the IME adjustment at current levels. An additional Senate bill, S. 2447, addresses maintaining the IME payment level.

## **II. PROPOSALS AFFECTING BOTH DGME AND IME PAYMENTS**

### **A. Resident Limit Affiliation Agreements (pages 50069--77)**

#### Background

The Balanced Budget Act of 1997 (BBA) mandated that, in general, for purposes of IME and DGME reimbursement, a hospital's number of allopathic and osteopathic residents may not exceed the number reported on the hospital's most recent cost report that ended on or before December 31, 1996 (42 U.S.C. 1395ww(h)(4)(F)). Dental and podiatry residents are excluded from the resident limit provision.

The BBA permitted CMS to establish a system by which hospitals could elect to apply their resident limits on an aggregate basis. Briefly, hospitals that qualify may execute an "affiliation" agreement that would set forth an aggregate limit (the sum of the individual hospital limits) as well as the individual hospital resident limits agreed upon by the parties during the term of the agreement. For example, if Hospital A and Hospital B each had resident limits of 100, their aggregate limit would be 200. In the agreement for a particular academic year, they might specify that Hospital A would agree to a resident limit of 90 so that Hospital B could have a limit of 110. According to CMS, one of the reasons for establishing a resident limit affiliation agreement mechanism is to permit flexibility in complying with the resident limits for hospitals that have shared resident rotations.

#### Final Rule

The final rule adds two new regulatory sections: 42 C.F.R. §413.86(b) would set forth a definition of "affiliated agreement" and 413.86(g)(7) would add additional requirements for hospitals that enter into affiliation agreements.

Under 413.86(b), an affiliated agreement is defined as:

"a written, signed, and dated agreement by responsible representatives of each respective hospital in an affiliated group, as defined in this section, that specifies-

- (1) The term of the agreement (which, at a minimum is one year), beginning on July 1 of a year;
- (2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the affiliation;
- (3) The total adjustment to each hospital's FTE caps in each year that the affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;
- (4) *The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the affiliated group for each year the affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and*
- (5) The names of the participating hospitals and their Medicare provider numbers.

Section 413.86(g)(7) is expanded to include:

(i) Each hospital in the affiliated group must submit the affiliation agreement, as defined under paragraph (b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the affiliation agreement will be in effect.

*(ii) Each hospital in the affiliated group must have a shared rotational arrangement, as defined in paragraph (b) of this section, with at least one other hospital within the affiliated group, and all of the hospitals within the affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.*

(iii) The net effect of the adjustments (positive or negative) on the affiliated hospitals' aggregate FTE cap for each affiliation agreement must not exceed zero.

(iv) If the affiliation agreement terminates for any reason, the FTE cap of each hospital in the affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (g)(4) of this section.

Section 413.86(g)(7)(iv) represents a change in CMS policy. Prior to the final rule, hospitals, if they chose, could agree to a permanent redistribution of their resident limits upon the agreement's termination. This will no longer be permitted. According to the final rule preamble, this change is effective with agreements *terminating* on or after October 1, 2002.

In a change from the proposed rule, the final rule also added two new sections to the above regulations (see italicized language). The new sections address the requirement that in order to be in an affiliation agreement, there must be resident rotations between the participating hospitals. "If residents rotate from one hospital to another at some point during the period of years required to complete training in a particular program, those hospitals have a 'shared rotational arrangement.'" (67 Fed.Reg. at 50073). While this policy had been stated in earlier rulemakings, it is a new requirement that hospitals must specify in the affiliation agreement the resident count associated with the shared arrangements.

For more discussion on the shared rotational arrangement requirement, including examples, see pages 50071-50074 of the August 1 Federal Register.

While the final regulations appear as part of the DGME regulations, they also apply to IME payments (see 412.105(f)(1)(vi)).

### Analysis

Prior to this final rule, only the definition of an "affiliated group" was set forth in regulation. The requirements relating to the affiliation *agreement* had previously been set forth in the preambles to the August 29, 1997 and May 12, 1998 inpatient PPS final rules. One major difference between prior policy and the final regulations relates to what happens to the participating hospitals' resident limits upon termination of the agreements.

Under prior policy (as set forth in the 1997 and 1998 rules), hospitals that participated in resident limit affiliation agreements could agree to a permanent change of their resident limits, upon termination of the agreement, so long as the aggregate count remains unchanged. Thus, for example, hospitals A and B, above, could specify that upon termination of the resident limit agreement, hospital A would keep a resident limit of 90 permanently and hospital B would keep

a permanent limit of 110. Under the final rule, at the end of the agreement, the hospitals have no choice but to revert to their original resident limits of 100 each.

The AAMC was very disappointed that CMS chose not to continue its prior policy. For those hospitals that are in the midst of an affiliation agreement that includes a permanent change in the resident limits, you should revisit that provision since the final rule change is effective with affiliation agreements *terminating* after October 1, 2002.

The final regulation also addresses the issue of “cross training” among participating hospitals. CMS stated that the regulations only codify policy that was set forth in previous PPS rulemakings. Note that if there are only two participating hospitals, there must be some level of resident rotation between each of the hospitals. If there are more than 2 hospitals, there must be a series of shared rotational arrangements that connect all of the hospitals; each of the hospitals does not have to have a rotational arrangement with all of the other participating hospitals.

It also is important to note that the agreement must also set forth the specific resident count associated with the shared rotational arrangements (see example at pages 50073-74). This requirement imposes an additional burden on hospitals wishing to implement these agreements.

Teaching hospitals that have, or are contemplating, resident limit affiliation agreements should read this section of the August 1 rule carefully.

#### **B. Rotating Residents to Other Hospitals (pages 50077--78)**

The final rule modifies 42 C.F.R. § 413.86(f) (DGME) and 42 C.F.R. §412.105(f) (IME) to explicitly prohibit a hospital from including in its own resident count, resident time spent at other hospitals (“A hospital cannot claim the time spent by residents training at another hospital.”) This prohibition is absolute, and applies even in the case where one hospital is incurring the costs associated with the training time at the other hospital.

#### Analysis

It is important to remember that the policy regarding IME and DGME reimbursements for residents rotating among hospitals is different than when the resident rotates to a *nonhospital* site. Within certain restrictions related to IME payments, a hospital can claim the time a resident spends training at a nonhospital site if the hospital incurs “all or substantially all” of the training costs at the nonhospital site (see 42 C.F.R. §413.86(f)(3)).

### **III. OTHER CHANGES ASSOCIATED WITH INDIRECT MEDICAL EDUCATION (IME) PAYMENTS**

#### **A. Level of the IME Adjustment (page 50057)**

The final rule sets forth the IME adjustment factor that is in current law— a 5.5 payment increase for every 10 percent increase in the intern and resident-to-bed ratio. Specifically, for purposes of the IME calculation, the multiplier would be 1.35.

*Analysis*—The BBA had mandated that the IME adjustment be reduced over time to 5.5 percent. The Balanced Budget Relief Act of 1999 (BBRA) and BIPA delayed the onset of the 5.5 percent level. Under current law, however, the IME percentage add-on in FFY 2003 will equal 5.5 percent. Three bills have been introduced—H.R. 1556, S. 839, and S. 2447--that would permanently maintain Medicare IME payments at the 6.5 percent level.

## **B. IRB Limit and Residency Program Closures (pages 50058—60)**

### Background

In addition to mandating a resident limit for purposes of IME payments, the BBA also imposed a cap on the intern and resident-to-bed (IRB) ratio—a key component in determining a teaching hospital’s IME payment level. In general, the IRB may not exceed the ratio calculated during the prior cost reporting period.

In the August 1, 2001 inpatient PPS final rule, CMS provided for a temporary adjustment to the resident limits of hospitals that take on and complete the training of residents from residency programs that have closed. However, no provision was made to address the receiving hospital’s IRB limit in this situation.

### Final Rule

The final rule makes provisions to adjust the IRB ratios of hospitals that take on and complete the training of displaced residents so that these hospitals receive the proper level of IME payments. The final rule preamble contains several examples that illustrate the changes.

### Analysis

The AAMC had advocated that hospitals not be penalized, by virtue of the IRB cap, for training residents from closed hospitals or programs. Thus, we are pleased by CMS’ decision to modify their regulations accordingly.

The precise changes are quite technical in nature. Teaching hospitals should review the discussion and examples on page 50059 to make sure they understand this change.

## **C. Counting Beds (pages 50060--61)**

In the final rule preamble, CMS decided NOT to proceed with its proposal to establish a “floor” occupancy rate of 35 percent for purposes of the IME and disproportionate share (DSH) methodologies. That is, if a hospital’s reported bed count resulted in an occupancy rate below 35 percent, the applicable bed count for that hospital would be the number of beds that would result in an occupancy rate of 35 percent.

### Analysis

Bed counts factor into the IME methodology because of the IRB ratio. The DSH adjustment is based on nine different formulae, which include a bed count as one of the factors. Relatively speaking, larger bed counts result in lower IRB ratios, which result in lower IME payments. By

contrast, larger bed counts result in higher DSH adjustments. CMS had proposed its change because the Agency wanted to “exclude beds that represent an excessive level of unused capacity.” (Proposed Rule, 67 Fed. Reg. at 31462). CMS believes that small urban hospitals, in particular, might be maintaining excess beds in order to qualify for higher DSH payments (Proposed Rule, 67 Fed. Reg. at 31463).

Given that the AAMC Council of Teaching Hospitals and Health Systems members have occupancy rates above 35 percent, CMS’ proposal would not have had any practical impact on the COTH membership. However, the AAMC opposed the policy based on principle (i.e. there already is significant guidance as to which beds may be counted for purposes of these methodologies; occupancy rates should not be used as a means to subvert valid methodologies).

CMS decided to retract its proposal in order to do “a more comprehensive analysis of [the Agency’s] bed and patient day counting policies.” (67 Fed. Reg. at 50061).

#### **IV. Other Change Affecting Direct Graduate Medical Education (DGME) Payments: Calculating a PRA for Newly Participating Hospitals (pages 50067-69)**

##### Background

DGME payments are based on a hospital’s “per resident amount (PRA).” A new teaching hospital is assigned a PRA that is equal to the *lower* of its actual allowable direct GME costs per resident or a weighted average PRA based on the PRAs of surrounding teaching hospitals. According to the final rule, existing policy requires fiscal intermediaries to calculate the weighted average PRA, based on 1984 PRAs trended forward, rather than using current year PRAs.

##### Final Rule

Under the final rule (42 C.F.R. §§413.86(e)(5)(I)(B) and(C)), fiscal intermediaries will use PRAs from teaching hospitals’ most recently settled cost reports for purposes of calculating the weighted average PRA. In addition, the weighted average will reflect both primary care and non-primary care PRAs.<sup>1</sup>

#### **V. TRANSFER PAYMENT POLICY (pages 50048--52)**

##### Background

Medicare patients who are sent from one acute care hospital to another are viewed as “transfers.” Under Medicare’s transfer payment policy, a full diagnosis-related group (DRG) payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed 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 either a PPS-exempt

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<sup>1</sup> This is because in FFYs 1994 and 1995, an inflation update was provided for primary care PRAs, but not for non-primary care PRAs.

hospital or unit, skilled nursing facility, or home health agency, will also be treated as transfers, receiving per diem payments, not to exceed the full DRG payment.

In the proposed rule, CMS had proposed to expand the post-acute care transfer policy to include additional DRGs. Two options were presented. The first would expand the policy to all DRGs. According to CMS, this option would result in \$1.9 billion less in Medicare program payments to hospitals. The second option would expand the policy to a subset of DRGs, CMS suggested 13, that have high rates of discharges to post-acute facilities. This option would result in about \$916 million less in payments to hospitals. The savings would result because hospitals that would discharge patients to post-acute care facilities prior to the corresponding DRG's average length of stay would receive less payment because of the per diem methodology.

### Final Rule

In final rule preamble, CMS announced that the Agency has decided NOT to expand the post-acute care transfer policy for FFY 2003. CMS stated that commenters raised many issues that the Agency will need to consider and that more research will be conducted to determine if the policy should be expanded in FFY 2004 or subsequent years.

### Analysis

CMS' decision is welcome news. The AAMC will continue to monitor this issue closely.

## **VI. Outlier Payment Threshold (pages 50122-25)**

The final rule increases the fixed loss cost threshold for outlier payments equal to a case's DRG payment plus any IME and DSH payments, and any additional payments for new technologies, plus **\$33,560**. The threshold is applicable for both operating and capital outlier payments. As in past years, hospitals will receive 80 percent of the costs that exceed the threshold levels.

### Analysis

The FFY 2003 cost threshold is 60 percent higher than the \$21,025 level in FFY 2002—continuing a series of outlier threshold increases that have occurred over the past several years. Such a drastic increase will result in significant payment reductions for teaching hospitals that treat outlier cases.

CMS states that a primary reason for the increase is due to higher than expected outlier payments made in recent years. 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 7.7 percent of total payments in FFY 2001, and 6.9 percent for FFY 2002—amounts significantly more than the 5.1 percent payment "pool." Thus, in order to reduce future outlier payments to the projected 5.1 percent, CMS believes it must increase the outlier threshold.

The final outlier threshold is \$110 higher than what had been proposed. The difference is because in the final rule, CMS decided to revise its methodology for calculating the threshold.

Rather than looking at the rate of growth in costs, CMS decided to use a methodology that measures the rate of change in charges. Per case costs are determined by applying a hospital's cost-to-charge ratio (CCR) for a previous period (for example, 1999 or 2000) to the charges that are reflected on a current claim for each case (costs are not provided on the claim). (A historical CCR is used because it is obtained from hospital cost report data that lag behind claims data.) Thus, per case costs are heavily influenced by charge growth. Consequently, CMS felt that using a methodology that examined charge, rather than cost, growth is more appropriate. Under the revised methodology, CMS believes that a threshold of \$33,560 will result in outlier payments equal to 5.1 percent.

The AAMC is very concerned about the impact of this change on teaching hospitals. We will be conducting analyses and monitoring this issue closely over the upcoming year.

## **VII. PAYMENTS FOR NEW TECHNOLOGIES (pages 50009-20)**

### 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 thresholds related to "new," "significant improvement" over the current service, and "inadequate payment" under the DRG system. (See the September 7, 2001 final rule for a more complete discussion of these criteria.) The additional payments are to be funded by reducing the standardized payment. CMS had set a target limit of one percent of estimated total operating PPS payments for the new technology payments. If CMS estimates that the new technology payments will exceed the one percent target, it will reduce these payments until the one percent level is attained.

### Final Rule

Of the four new technology applications analyzed by CMS, only one has been approved for additional payments in FFYs 2003 and 2004: Xigris.<sup>TM</sup> This is an Eli Lilly product used to treat patients with severe sepsis. CMS estimates that the average cost for a one-time 96-hour course of therapy for an average adult patient is \$6,800 (24 micrograms/ kg/hour for 96 hours or 70kg per person). Under the payment methodology (which mandates that payments not exceed 50 percent of the costs of the new drug), hospitals using Xigris are eligible for additional payments of up to \$3,400.

To implement the budget neutrality requirement, CMS estimated that based both on the payment level and the anticipated volume of cases of Xigris, the total additional payments would total \$74.8 million. The PPS standardized amount has been reduced correspondingly.

The applications that CMS determined did not meet the criteria for additional payments were: Bone Morphogenetic Proteins (BMPs), Zyvox<sup>TM</sup>, and Renew<sup>TM</sup> Radio Frequency Spinal Cord Stimulation Therapy.

## Analysis

Applications for new technology add-on payments for FFY 2004 are due by early October, 2002. The relevant address is listed on page 50010 of the final rule.

### **VIII. THE DISPROPORTIONATE SHARE (DSH) ADJUSTMENT**

#### **A. Counting Beds (pages 50060--61)**

See discussion under IME section, III C, above.

#### **B. Level of the DSH Adjustment**

While not addressed in the proposed rule, it is worth noting that the DSH payment reductions that were specified in the BBA and subsequent legislation end effective in FFY 2003. Thus, FFY 2003 DSH payments will not reflect the three percent reduction that was applied to FFY 2002 DSH payments.

### **IX. CHANGES TO THE HOSPITAL WAGE INDEX (pages 50020--32)**

The Medicare hospital wage index adjusts DRG payments to reflect differences in labor costs across geographic areas. The FFY 2003 wage index will be based on data from FFY 1999 hospital cost reports.

#### **A. Increase in the Labor-Related Share (pages 50041--42)**

##### Background

The proportion of the PPS standardized rate to which the wage index is applied is known as the “labor-related share.”

##### Final Rule

CMS rescinded its proposal to increase the labor-related share to 72.5 percent. Consequently, for FFY 2003, the share will remain at its current level of 71.1 percent.

##### Analysis

Most major teaching hospitals are in market areas that have a wage index greater than one. Consequently, a higher labor share would have meant slightly higher DRG payments for these institutions.

CMS’ decision is not particularly surprising given that its enthusiasm for the change was very equivocal in the proposed rule. Moreover, a number of commenters, including the Medicare Payment Advisory Commission (MedPAC), advocated for a *reduction* in the labor share, which would have negatively impacted most major teaching hospitals.

CMS stated that it plans further analysis to determine an appropriate methodology for arriving at a labor-related share. Any future revisions will be proposed in a future rulemaking and subject to public comment. The AAMC will be monitoring this issue closely.

**B. Removal of Wage Costs Related to GME and Certified Registered Nurse Anesthetists (CRNAs) (pages 50021-22)**

Background

In FFY 2000, CMS began a five-year phase-out of salaries related to teaching physicians, residents and CRNAs in the calculation of the wage index. Under that schedule, the FFY 2003 wage index would blend 20 percent of a wage index with GME and CRNA costs included and 80 percent of a wage index with GME and CRNA costs removed.

Final Rule

Under the final rule, 100 percent of the GME and CRNA costs will be removed from the calculation of the FFY 2003 wage index, rather than the scheduled 80 percent. .

Analysis

The AAMC is disappointed by CMS' decision. The Agency relied on several rationales for its decision to go directly to the 100 percent removal despite objections from a number of commenters. First, its data analysis indicated that the majority of metropolitan statistical areas (MSAs) would benefit from the acceleration. Second, MedPAC had recommended going directly to 100 percent in FFY 2002. Finally, the Agency asserted that removing the DGME and CRNA costs is appropriate policy, therefore, it believes that the 100 percent removal is proper.

**C. Collection of Occupational Mix Data (pages 50020-21)**

BIPA mandates that, beginning in FFY 2005, the hospital wage index be adjusted to reflect the occupational mix of employees. The initial data collection is to be completed by September 30, 2003. In both the proposed and final rules, CMS stated that the Agency is still working on developing a data collection tool. CMS will issue instructions as to the type of data to be collected in advance of actually requiring submission of the data by hospitals. In the final rule, CMS stated that when it is developed, the Agency will publish details of the methodology in the Federal Register and provide for public comment.

Additional discussion on the inclusion of occupational mix data in the wage index calculation can be found in the FFY 2002 inpatient PPS final rule (66 Fed. Reg. at 39860 (August 1, 2001)).

## Analysis

The inclusion of an occupational mix adjustment into the Medicare wage index could have important implications for teaching hospitals. Many teaching hospitals tend to have a more expensive “mix” of employees, which under the current wage index methodology can result in a higher wage index for the area where the hospital is located. The inclusion of an occupational mix adjustment would essentially only recognize differences across geographic areas in terms of the price hospitals must pay for a particular labor category—the fact that a hospital might have a larger quantity of higher-priced employers (i.e., a richer “mix”) would no longer be reflected in the index. Consequently, it is possible that wage indices for areas where teaching hospitals are located could be reduced.

The AAMC has been monitoring this issue closely and will continue to do so. We will inform COTH members when CMS issues its data collection instructions.

## **X. REBASING THE HOSPITAL MARKET BASKET (pages 50032-44)**

CMS has rebased and revised the hospital market basket—which is used as the basis for updating the PPS standardized payment. The “basket” in the phrase “market basket” refers to the mix of goods and services hospitals purchase to furnish inpatient care. Each type of good and service, 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. CMS historically rebases the market basket every five years.

Among other changes, the market bases reflects FFY 1997, rather than FFY 1992 cost data. The source for wage data also has been changed to better reflect salary changes in hospitals. Finally, the new market basket reflects a separate component to account for changes in blood prices.

## Analysis

Having an updated and accurate hospital market basket is critical because of its role in determining the update to the DRG standardized payment rate. We are happy to see that CMS is moving to a wage proxy that more closely reflects wage changes within the hospital industry—the current index reflects a blend of wages reflecting both hospitals and the general economy.

In response to comments that data more recent than 1997 should be used, CMS noted that the 1997 cost reports are the most complete and that comparisons with 1998 and 1999 data indicate that using more recent data would not produce dissimilar results compared to 1997.

## **XI. CHANGES TO DRG CLASSIFICATIONS (pages 49985--50009)**

The final rule includes a number of changes to the DRGs, including creating a new DRG for heart assist devices (DRG 525—Heart Assist System Implant). In response to comments, CMS also decided in the final rule to rescind its proposal to make extensive changes to the multiple

DRG categories in MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period).

The final rule also includes the creation of two new DRGs for cases that involve drug eluting stents (DRG 526—Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI, and DRG 527—Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without AMI). Given that drug-eluting stents have not yet received FDA approval but that it is expected in the next 6 months or so, CMS has decided the new DRGs would not be activated until April 1, 2003.

### Analysis

The creation of new DRGs for drug-eluting stents will help ensure appropriate payment for these higher-costing cases. CMS' analyses indicated that the estimated increase in using drug-eluting stents compared to currently available stents is \$3,996. The new DRG payment weights will reflect this differential.

Teaching hospitals with a significant number of neonatal cases may want to provide comments to CMS about how the DRG categories within MDC 15 should be addressed. While Medicare reimburses only a few neonatal cases, CMS recognizes that these DRGs often are used by other payers. CMS worked with the National Association of Children's Hospitals and Related Institutions (NACHRI) to develop the changes it proposed. A number of commenters, however, raised concerns about the proposed changes. CMS is seeking comments from hospitals about appropriate changes. These comments must be received by this December 1, 2002 so that the Agency can consider them in anticipation of next year's proposed rulemaking. If you are interested in this issue, please contact Karen Fisher, in the AAMC's Division of Health Care Affairs (202-862-6140) and she can work with you in sharing your views with CMS.

Given the number of new DRG changes, hospitals should review this section of the final rule carefully.

## **XII. CHANGES TO THE PROVIDER-BASED CRITERIA (pages 50078--96)**

CMS proposed a number of changes to the provider-based criteria, some of which were mandated by BIPA. The final rule adopts most of the proposed changes, though with some modifications. CMS also proposed many changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) (also known as the "anti-dumping" law) requirements for provider-based entities. Due to the large number of comments received on the EMTALA changes, the Agency has only made one change final in the current regulation. A second final rule will be published in the near future that will address the other proposed changes.

Among the biggest changes in the final rule is that provider-based facilities located on the main campus of the main provider must meet fewer criteria than those located off-campus. Also of note is that the requirement for submission of an application for provider-based status has been eliminated and is replaced by an optional attestation.

## A. Requirements for All Provider-Based Entities

All entities must meet the requirements regarding:

1. **Licensure.** Be operated under the same license as the main provider, except where not permitted by state law.
2. **Clinical Services.** Have integration of clinical services. This is evidenced in a number of ways including, (1) that the staff at the provider-based entity has clinical privileges at main provider; (2) monitoring and oversight of the entity by the main provider; (3) the relationship between the chief medical officer of the main provider and that of the medical director of the provider-based entity is equivalent to the relationship between the medical director of a department of the main provider and the chief medical officer; (4) the medical staff committee at the main provider is responsible for medical activities in the provider-based entity; medical records for patients in the provider-based entity are integrated into a unified retrieval system (or cross-referenced) of the main provider; and (5) services at the provider-based facility are integrated with the main provider and patients who require further care have access and are referred appropriately to the main provider.
3. **Financial Integration.** Financial operations of the facility or organization are fully integrated with that of the main provider, as evidenced by shared income and expenses.
4. **Public Awareness.** The provider-based entity is held out to the public and other payers as part of the main provider.

## B. Requirements For Off-Campus Facilities

Off-campus facilities or organizations that wish to qualify as provider-based must meet the following additional requirements:

1. **Ownership and Control.** Be operated under the ownership and control of the main provider.
2. **Administration and Supervision.** The reporting relationship between the off-campus facility and organization and the main provider must have the same frequency, intensity, and level of accountability as exists between the main provider and one of its departments.
3. **Location.** The facility or organization must be located within a 35-mile radius of the campus of the hospital. A limited exception is provided for some off-campus facilities with a disproportionate share adjustment greater than 11.75 percent and meet the other criteria.

CMS has clarified that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity not located on the campus of the main provider and no treatment is required under the EMTALA rules, the hospital must provide written notice to the beneficiary, before delivery of services, of the amount of the beneficiary's potential liability. An estimate based on typical or average charges for visits to the facility, along with a statement that the patient's actual liability will depend on the actual services furnished, may be provided.

## C. Grandfathering Provision

BIPA contained a grandfathering provision that is being expanded by CMS. If a facility was treated as provider-based in relation to a hospital on October 1, 2000, it will continue to be considered provider-based until the hospital's first cost reporting period beginning on or after

July 1, 2003. CMS clarifies that “to the extent a grandfathered hospital might benefit from any changes to the regulation, it will receive that benefit as of October 1, 2002 which is the effective date of any revisions.”

### Analysis

For facilities that are not currently provider-based, the changes to the regulation will be effective October 1, 2002. Facilities that are being grandfathered can take advantage of any positive changes as of that date as well. Once the grandfathering provision ends for these facilities, they must comply with the rule’s requirements or cease billing as provider-based.

### **D. Application Requirement**

The mandatory requirement for provider-based determination is being eliminated. As of October 1, 2002, a main provider wishing to obtain a provider-based determination will submit an attestation. **There is no requirement that an attestation be submitted as a precondition to billing for services as a provider-based facility.** The approval of the attestation is the equivalent of a determination that a facility or organization is provider-based. A provider may attest in a single package that each of its facilities in which it intends to bill as provider-based meets the criteria. For facilities located on the campus of the main provider, no documentation is required to be submitted with the attestation.

Until a uniform request or attestation form is available, at a minimum, those providers choosing to submit an attestation should include:

- ❑ The identity of the main provider and the facility or organization for which provider-based status is being sought
- ❑ The provider must also enumerate each facility and state its exact location (street address and whether it is on or off campus)
- ❑ Date on which the facility became provider-based.
- ❑ Documentation in support of the attestation must be submitted with the attestation for facilities located off campus.

Whenever a provider submits an attestation of provider-based status for an on-campus facility, CMS will send a written acknowledgement of receipt of the attestation, review the attestation for completeness, consistency with the criteria in the regulation, and consistency with the information in the possession of CMS at the time the attestation, and make a determination as to whether the facility is provider-based. CMS has not yet specified a time frame for completion of action on an attestation. Providers are not obligated to submit attestations or applications for provider-based status before they begin billing as provider-based. However, if a provider does not submit a complete attestation, and CMS subsequently determines that the provider is billing inappropriately, the provider would be subject to recovery for all prior cost reporting periods subject to reopening.

## Analysis

Even if a provider decides not to submit an attestation, it should review all applicable criteria to ensure that they are met and keep a record of such a review should CMS challenge an entity's designation as provider-based.

### **E. Recoupment of IME and DGME Payments if a Facility is Found Not to be Provider-Based (page 50093)**

In the final rule, CMS discussed what will occur if a provider bills for a facility as provider-based but then the facility is later found to not meet the provider-based criteria. Of particular importance to teaching hospitals is what happens to IME and DGME funds that were received for the time spent by residents in those facilities. For a teaching hospital to claim the time residents spend at nonhospital sites, several criteria must be met, including the existence of a written agreement between the hospital and the nonhospital site. No written agreement is needed if a site is provider-based. However, if a site that a teaching hospital considered to be provider-based is later found not to meet the criteria, then CMS "would recover an amount of payment for both IME and direct GME that would otherwise not have been received by the hospital had the facility been freestanding."

## Analysis

To avoid the possibility of recoupment of IME and DGME funds at a nonprovider site that is found later to not qualify as being provider-based, a hospital may want to submit an attestation for the site. Alternatively, the hospital may want to execute a written agreement with the site that fulfills the requirements necessary for hospitals to receive DGME and IME payments associated with residents training at nonhospital sites (see 42 C.F.R. §413.86(f)(3)).

### **F. Multicampus Hospitals**

The final rule clarifies that if a hospital comprises several sites at which both inpatient and outpatient care are furnished, it will be necessary for the hospital to designate one site as its main campus for purposes of the provider-based rules. Each of the other sites would then be expected to meet the provider-based requirements with respect to that main campus. CMS notes that "the provider-based criteria apply to individual hospitals, not to multihospital systems. . . . Where such a system exists, its hospitals will participate separately in Medicare, and the provider-based criteria will apply separately to each hospital in the chain."

CMS also addressed how the provider-based criteria apply to multicampus hospitals that participate in Medicare under a single provider number but comprise two or more campuses that are physically separate. One of the campuses must be designated by the hospital as the main campus. Facilities at the other campus(es) would be provider-based only if they meet the criteria in relation to the main campus. CMS will normally accept the provider's selection of a main campus, unless the regional office concludes that the campus selected does not actually function as the main campus. Hospital chain organizations, which include a number of separately certified hospitals, would not be considered multicampus hospitals.

**G. EMTALA (page 50078)**

In the final rule, CMS clarified that EMTALA applies only to those departments on the hospital's main campus that are provider-based. It does not apply to provider-based entities located either on or off the hospital campus.

**XIII. SUMMARY**

This year's final rule has a number of important changes that could have a significant impact on teaching hospitals' Medicare payments and other decisions regarding residency education and clinical decision making.

If you have any questions regarding the final rule or this summary, please contact Karen Fisher, [kfisher@aamc.org](mailto:kfisher@aamc.org), 202-862-6140 (all issues except for EMTALA or provider-based) or Ivy Baer, [ibaer@aamc.org](mailto:ibaer@aamc.org), 202-828-0490 (EMTALA and provider-based issues).