

AAMC Summary and Analysis

FISCAL YEAR 2001 MEDICARE INPATIENT PPS PROPOSED RULE: PROVISIONS OF INTEREST TO THE ACADEMIC MEDICAL COMMUNITY

On May 5, 2000, the Health Care Financing Administration (HCFA) 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 (FY) 2001. See *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates; Final Rule*. 65 Fed. Reg. 26282. The proposed rule can be obtained by accessing the AAMC's issue brief on this topic at: <http://www.aamc.org/advocacy/issues/medicare/pps01.htm>

Among other items, the proposed rule includes the update factor for inpatient PPS payments, and changes related to Medicare disproportionate share (DSH) payments, the wage index, and the outlier payment threshold. Of particular importance to the academic medical community, however, are the proposed changes in the methodology for calculating Medicare direct graduate medical education (DGME) payments, as mandated by the Balanced Budget Refinement Act of 1999 (BBRA).

The financial impact analysis included in the proposed rule estimates that due to all of the changes in the proposed rule—including a reduction in the indirect medical education (IME) adjustment from 6.5 percent to 6.25 percent—average per case payments in FY 2001 for all hospitals will increase by 1.2 percent compared to FY 2000 payments. Teaching hospitals with 100 or more residents will see per case increases of only 0.8 percent, compared to 1.1 percent and 1.4 percent for other teaching and nonteaching hospitals, respectively.

Comments on the proposed rule are due July 5, 2000.

I. PPS Payment Rate Update

The proposed rule would implement an increase to the standardized payment amount for hospitals' per case payments under the PPS of 2 percent in FY 2001. This update reflects the requirement in the Balanced Budget Act of 1997 (BBA) that the Medicare payment update equal the increase in the hospital market basket less 1.1 percentage points. As of the publication of the proposed rule, the estimate of the market basket increase was 3.1 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. The AAMC, along with other hospital associations, is seeking legislation to increase the update. Two bills have been introduced, H.R. 3580 and S. 2018, that would set the payment update equal to the full market basket increase for FY 2001.

II. Changes to Direct Graduate Medical Education (DGME) Payments

A. Overview

The proposed rule sets forth a methodology for implementing the changes to DGME payments that were mandated by the BBRA.¹ The changes will affect hospitals' DGME payments for Medicare cost reporting periods beginning on or after October 1, 2000 (FY 2001) through those that begin on or before September 30, 2005 (FY 2005).

The new methodology centers around a national average per resident amount (PRA), and the calculation of a 70 percent "floor" PRA and a 140 percent "ceiling" PRA. The floors and ceilings will vary by geographic area, because the national average per resident amount will be adjusted by the geographic adjustment factor that is used under the Medicare physician fee schedule ("locality adjustment"). Each hospital's PRA(s) will be compared to its corresponding area floor and ceiling amounts to determine whether its DGME payments will be adjusted. Hospitals with PRAs below the 70 percent floor will have the PRA replaced by the floor amount. Hospitals with PRAs above the 140 percent ceiling will have their DGME payments frozen for two years and then have reduced inflation updates for three subsequent years. Hospitals with PRAs between the floor and ceiling amounts will be unaffected by the new methodology.

Analysis— The proposed rule follows closely the language of the BBRA, which was quite prescriptive in setting forth the methodology for determining the national average and floor and ceiling PRA amounts.

It is important to remember that each teaching hospital has two different PRAs—one for primary care residents and one for non-primary care residents.² The national average and floor and ceiling amounts reflect a combined primary care/non-primary care amount. Consequently, under the proposed rule, hospitals will compare each PRA to the floor and ceiling amounts to determine whether one or both PRAs will be affected.

B. Calculation of a Locality-Adjusted National Average Per Resident Amount

The locality-adjusted national average PRA will be based on data from hospital cost reports ending in FY 1997. The national average reflects both primary care and non-primary care PRAs and is weighted by the number of residents at each hospital (that is, PRAs for hospitals with large numbers of residents will contribute more to the national average than hospitals with small numbers of residents). According to HCFA's calculations, the weighted national average PRA for cost reporting periods ending in FY 1997 is \$68,487³.

¹ A complete discussion of this methodology is contained in pages 26309-26312 of the May 5 proposed rule.

² The two amounts resulted when PRAs for nonprimary care residents were not updated in FYs 1994 and 1995, as required by law.

³ Note that the level of the PRA corresponds to total resident costs, *not* total Medicare DGME payments. Medicare pays only a portion of a hospital's PRA, depending on its share of Medicare patient days.

The 1997 national average PRA is then updated to FY 2001 to reflect inflation. The updated amount, however, may be different for each hospital, depending on its cost reporting period. According to the proposed rule, the 1997 amount will be updated by the estimated percentage increase in the consumer price index for all urban consumers (CPI-U) for the period that begins with the month which represents the midpoint of the cost reporting periods for *all hospitals* (which is October 1, 1996) and ends with the month which represents the midpoint of *each individual hospital's* cost reporting period that begins during FY 2001.

Finally, to reflect differences in labor costs across areas, the 2001 national average PRA will be multiplied by the 1999 geographic adjustment factor (GAF)⁴ for the physician fee schedule area where the hospital is located, to arrive at a locality-adjusted weighted national average PRA for each hospital.

Analysis—Because of the requirement that the 1997 national average PRA be updated to the midpoint of each hospital's cost reporting period in FY 2001, each cost reporting cycle will have its own national average PRA.

Appendix 1 contains a list of the weighted national average PRAs for each cost reporting period. Note that the values in Appendix 1 are based on *projections* of the CPI-U increases. According to HCFA staff, these numbers will be subject to revision to reflect actual changes in the CPI-U, when that information becomes available.

As indicated in the proposed rule, the national average PRAs will also be adjusted by the 1999 GAF for the Medicare physician fee schedule area in which the hospital is located. These values are set forth in Addendum F of the October 31, 1997 physician fee schedule final rule (62 Fed. Reg. at 59257) and published in Appendix 2 to this document.

C. Calculation of "Floor" and "Ceiling" PRAs

The "floor" PRA is calculated by multiplying each hospital's locality-adjusted national average PRA by 70 percent. The "ceiling" is equal to the locality-adjusted national average multiplied by 140 percent.

D. Impact of Floor and Ceiling on Individual Hospitals' PRAs

1. Hospitals with PRAs below the 70 percent floor

For cost reporting periods beginning in FY 2001, hospitals with PRAs (either primary care or non-primary care, or both) that are below the 70 percent floor will have those amounts replaced by the floor amount. The new PRA will then be updated in future years by the increase in the CPI-U. If both primary care and non-primary care amounts are below the floor levels, the same floor level amount will be

⁴ The GAF is an average of the three geographic index values used to adjust physician payments for different wage areas.

used to determine DGME payments for both primary care and non-primary care residents.

2. Hospitals with PRAs above the 140 percent ceiling

The determination of whether the 140 percent ceiling will affect a hospital's PRA will differ depending upon the fiscal year:

FY 2001—For cost reporting periods beginning in federal FY 2001 (October 1, 2000 through September 30, 2001), if the hospital's **FY 2000** PRA exceeds 140 percent of the **FY 2001** locality-adjusted national average PRA, the hospital's FY 2001 PRA is frozen at the FY 2000 PRA and is not updated by the CPI-U factor for FY 2001.

FY 2002—For cost reporting periods beginning in FY 2002 (October 1, 2001 through September 30, 2002), if the hospital's **FY 2001** PRA exceeds 140 percent of the **FY 2002** locality-adjusted national average PRA, the hospital's PRA is frozen at the FY 2001 PRA and is not updated by the CPI-U factor for FY 2002.

FYs 2003 through 2005—For cost-reporting periods beginning in FYs 2003, 2004, and 2005, if the hospitals' PRA for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for the **same** previous cost reporting period, the hospital's PRA will be updated by the increase in the CPI-U for the current year less two percentage points (although the update cannot be less than zero).

3. Hospitals with PRAs greater than or equal to the 70 percent floor or less than or equal to the 140 percent ceiling

Hospitals with PRAs that are greater than or equal to the 70 percent floor or less than or equal to the 140 percent ceiling are unaffected by the new methodology. For FY 2001 cost-reporting periods and beyond, these hospitals' PRAs will continue to be updated by the increase in CPI-U, as set forth under 42 C.F.R. §413.86(e)(3)(i).

4. General rule for hospitals with PRAs that exceed the ceiling amounts

If a hospital's PRA exceeds the ceiling and would otherwise be adjusted according to the regulations, in any given current year (FY 2001 through FY 2005), its PRA will not be reduced below the ceiling amount.

Analysis—Once again, the proposed rule preamble states that it is implementing the BBRA requirements, especially in the case of PRAs that exceed the ceiling amounts. It is important that hospitals with PRAs that are close to the floor and ceiling amounts review both the BBRA and proposed rule language, to better understand the proposed methodology and potential implications on DGME payments.

III. IME Changes

The proposed rule changes the IME adjustment factor to implement the BBRA requirement that the IME adjustment for FY 2001 be equal to a 6.25 percentage add-on.

Analysis—The BBA had mandated that the IME adjustment in FY 2001 be set such that the IME percentage add-on would equal 5.5 percent. The BBRA increased this to the 6.25 percent level. The AAMC is seeking legislation to maintain IME payments at current levels. Two bills have been introduced, HR 4239 and S 2394, to maintain Medicare IME payments at the FY 2000 level of 6.5 percent for the foreseeable future.

IV. DSH Changes

The proposed rule implements the BBRA requirement to reduce the Medicare DSH payment that a hospital would otherwise receive in FY 2001 by 3 percent, and by 4 percent in FY 2002.

Analysis—The BBRA provisions result in less DSH payment reductions than originally set forth in the BBA. Under the BBA, DSH payments would have been reduced by 4 percent in FY 2001 and 5 percent in FY 2002. Under both the BBA and BBRA, no reductions will occur in FYs 2003 and beyond.

In the preamble to the proposed rule, HCFA points out that, effective with cost reporting periods beginning on or after October 1, 2001, the BBRA requires hospitals to submit data on their cost reports of the costs they incur in providing inpatient and outpatient hospital services for which the hospitals are not compensated, including non-Medicare bad debt, and charity care. This requirement will be set forth in the cost report instructions for FY 2002.

The rationale for this new collection requirement relates to the Medicare DSH methodology. The current DSH formula accounts only for costs associated with Medicaid patients and Medicare patients eligible for Supplementary Security Income (SSI). The Medicare Payment Advisory Commission (MedPAC) has recommended that the DSH formula be modified to reflect all costs associated with caring for poor patients. However, Medicare has never collected this type of data. According to the conference report of the BBRA, the data collection requirement will allow Congress and HCFA to assess the impact of a revised DSH formula on hospitals' DSH payments.

V. Changes to the Hospital Wage Index

The FY 2001, the Medicare hospital wage index will be based on data submitted by hospitals for cost reporting periods that began in FY 1997. The wage index will also reflect the second year of a five-year phase-out of costs related to teaching physicians, residents, and certified registered nurse anesthetists (CRNAs); other physician costs, such as those associated with hospital administrative functions, will be retained in the wage

index calculation. For FY 2001, the wage index will be based on a blend of 60 percent of an average hourly wage including the teaching physician, resident, and CRNA costs, and 40 percent of an average hourly wage excluding these costs.

The FY 1997 cost reports, which supply the data for the 2001 wage index, do not distinguish between physician costs that are associated with teaching and those costs associated with hospital administrative functions. Accordingly, HCFA conducted a survey to determine what proportion of total physician costs were associated with teaching activities. For those hospitals that responded to the survey, their wage data were modified to obtain a value that excludes the reported teaching physician costs. However, if teaching hospitals did not complete the survey, and HCFA verifies that the hospitals has otherwise unidentified teaching physician costs, HCFA proposes to remove 100 percent of the reported physician costs, on the presumption that all of the costs are associated with teaching functions.

Analysis—HCFA's proposal to remove 100 percent of the teaching physician costs differs from last year, when HCFA chose to remove 80 percent of the total physician costs, on the assumption that 20 percent of the costs were associated with administrative functions.

VI. Proposed Change in the Outlier Payment Threshold

Under the proposed rule, HCFA plans to increase the fixed loss cost threshold for outlier payments to be equal to a case's diagnosis-related group (DRG) payment plus any IME and DSH payments, plus \$17,250. 65 Fed. Reg. at 26329. In FY 2000, the threshold was the DRG payment plus any IME and DSH payments, plus \$14,050. As in past years, hospitals will receive 80 percent of the costs that exceed the threshold levels.

Analysis—The FY 2001 cost threshold is significantly higher than in FY 2000, which had represented a significant increase over the FY 1999 level. 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, HCFA 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, HCFA estimates that outlier payments represented 7.5 percent of total payments in FY 1999, and 6.1 percent for FY 2000.

APPENDIX I

Projected Updated National Average Per Resident Amounts for Cost Reporting Periods Beginning in FY2001, Using the CPI (U) - All Items

(1)	(2)	(3)	(4)	(5)	(6)
National Average PRA for All Cost Reporting Periods Ending in FY 1997*:	Midpoint of All Cost Report Periods Ending in FY 1997:	Cost Reports Beginning in:	Midpoint of Cost Report Period:	Projected Update Factor for Midpoint of Cost Report**:	Projected Updated National Average PRA (Col. 1 x Col. 5)
\$68,487	October 1, 1996	October 1, 2000	April 1, 2001	1.10509	\$75,684
\$68,487	October 1, 1996	November 1, 2000	May 1, 2001	1.10653	\$75,783
\$68,487	October 1, 1996	December 1, 2000	June 1, 2001	1.10796	\$75,881
\$68,487	October 1, 1996	January 1, 2001	July 1, 2001	1.11006	\$76,025
\$68,487	October 1, 1996	February 1, 2001	August 1, 2001	1.11282	\$76,214
\$68,487	October 1, 1996	March 1, 2001	September 1, 2001	1.11559	\$76,403
\$68,487	October 1, 1996	April 1, 2001	October 1, 2001	1.11723	\$76,516
\$68,487	October 1, 1996	May 1, 2001	November 1, 2001	1.11774	\$76,551
\$68,487	October 1, 1996	June 1, 2001	December 1, 2001	1.11826	\$76,586
\$68,487	October 1, 1996	July 1, 2001	January 1, 2002	1.12028	\$76,725
\$68,487	October 1, 1996	August 1, 2001	February 1, 2002	1.12382	\$76,967
\$68,487	October 1, 1996	September 1, 2001	March 1, 2002	1.12737	\$77,210

*Weighted national average per resident amount for cost reporting periods ending during FY 1997 as estimated by the Health Care Financing Administration in the Medicare PPS 2001 proposed rule (65 Fed. Reg. at 26310).

**Update projections provided by HCFA. Note, the official PRA values will be determined by the actual increase in the CPI-U.

