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Quick Pulse

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CENTERS FOR MEDICARE AND MEDICAID (CMS) ISSUES FINAL RULE FOR ACUTE CARE HOSPITALS

CMS Administrator Dr. Mark McClellan recently announced the new, final, acute care hospital inpatient prospective payment system (IPPS) rule for FY2005. This will be published August 11, 2004, and will go into effect on or about October 1, 2004. The most important change may be that CMS is giving three new technologies additional new technology payments – CRT-Ds, LVADs, and Medtronic's deep brain stimulator system.

Here are the key things that are in the final rule and comments about them by Dr. McClellan and other CMS officials. (*For more details on the final rule, see* **www.cms.gov**)

1. A significant increase in payments for rural hospitals. McClellan said, "The bottom line is that, as a result of the Medicare law, the new payments will provide Medicare beneficiaries with better in-hospital care…It's good news for beneficiaries and for rural hospitals. We are projecting the combined impact will be: a 5.7% increase for urban hospitals and a 6.2% increase for rural hospitals. In FY2005, total Medicare payments to the approximately 3,900 acute care hospitals will be about $105 billion, up from $100 billion in FY2004."

2. Implementation of pay-for-performance. Hospitals reporting specific quality data will receive an inflation update equal to the hospital market basket percentage increase, which is 3.3%. This is the first time that hospital payment rate increases have been related to performance, in this case by providing incentives for giving information to patients and health professionals related to quality of care. As of July 15th, CMS officials reported, the vast majority of hospitals had registered to provide CMS with the data, and therefore are eligible to receive the full market basket update. McClellan said, "For the first time Medicare is paying hospitals for performance, and it is working. As a result of incentives, the vast majority of hospitals will be reporting measures of quality that patients can use to get better care…Hospitals reporting will get an update (increase) of 3.3%…and there will be a 0.4% decrease for those who don't report…We have seen an interest by the majority of acute care hospitals. These payment incentives of reporting can really work. We are going through the data submissions now and will have more specific numbers on how many will get the update. So, payment incentives really do work."

3. Additional enhancements for rural hospitals. These include:

- The number of hospitals which get automatic geographic reclassification because they are in rural areas where people commute to urban areas to work is being increased.
- Critical access hospitals that serve rural areas can now designate up to 25 beds for either acute or post-acute care. The new regulations also let these hospitals set aside units of up to 10 beds for inpatient rehabilitation and psychiatric services, and these units won't count as part of the 25 bed limit. In addition, payments will be

increased from 100% to 101% of reasonable costs for both inpatient and outpatient services rendered by these hospitals.

➢ Low volume, acute care hospitals that are more than 25 road miles from another acute care hospital will get an incremental cost benefit of 25%. McClellan said, "We have determined that for discharges <200/year the costs are higher…so 200 discharges are the threshold for this additional low-volume payment."

➢ The rule establishes a five-year demonstration project to test a separate payment system for inpatient hospital services provided by rural community hospitals. Participating hospitals will be paid on a reasonable cost basis for the first year of the demonstration.

4. New provisions for dealing with new technology and better support for intensive treatment. Dr. McClellan said, "There are changes in payments to help ensure all beneficiaries have access to the newest technology…and that there is more transparency in public input to make sure our payments for these are appropriate…We also are implementing changes so patients who need intensive services will get them, including craniotomy for implantation of chemotherapy [e.g., Guilford's Gliadel Wafer(carmustine)], treatment for burn patients with respiratory failure who need long-term ventilator therapy, LVADs, and other areas."

a. **An increase in payments for intensive services.** LVADs, for instance, will now be paid under the DRG for heart transplants, which will raise payments for LVADs, whether for "bridge-to-transplant" or destination therapy. This DRG will now be called "Heart Transplant or Implant of Heart Assist System."

b. **The outlier threshold is being reduced to $25,800 for FY2005,** down from $31,000 in FY2004 and significantly less than the $35,085 that was in the proposed rule for FY2005. CMS expects that reducing the outlier threshold will make it significantly easier for hospitals to qualify for outlier payments for high cost patients.

c. **Enhancements to DRGs.**

Selected DRG Changes for FY2005

DRG	Procedure	Impact	Final % increase in weight for FY2005 vs. FY2004	Proposed change from FY2004
209	Major Joint & Limb Reattachment Procedures of Lower Extremity	Up more than expected	Up 0.02%	0.83% decrease
515	ICD without Catheterization	Up less than expected	Up 1.82%	2.1% increase
535	ICD with Catheterization with AMI/HE/Shock	Down more than expected	Down 5.62%	5.15% decrease
536	ICD with Catheterization without AMI/HF/Shock	Down more than expected	Down 0.57%	0.17% decrease
516	PCI with AMI	Down more than expected	Down 1.69%	1.24% decrease
517	PCI without AMI	Down more than expected	Down 2.28%	1.89% decrease
526	PCI with Drug-Eluting Stent with AMI	Down more than expected	Down 0.5%	0.24% decrease
527	PCI with Drug-Eluting Stent without AMI	Down more than expected	Down 4.91%	4.6% decrease

d. **New technology payments for two technologies** – CRT-Ds and deep brain stimulation for Parkinson's Disease and essential tremor. An official said, "We also will continue to pay for (Medtronic's) InFuse (bone morphogenic protein) for spinal fusion." Officials could not say how much the additional payments will be for CRT-D. Asked how the increased payment is likely to impact use of CRT-Ds, an official said, "We don't know how this will impact use and uptake of the product…That is something we will be monitoring." CMS officials didn't have an answer for how part of the rule will impact the final CMS decision on ICDs. The CRT-D payment is an increase over and above the DRG payment, which is all that is currently paid for these devices. An official said, "There is an add-on payment for cases that use it and have costs that exceed the normal DRG…By approving them for new technology, we approve the cases that use them for **possible** add on payments reflecting the cost of the new technologies."

5. New provisions related to graduate medical education. The new rule redistributes unused residency slots among teaching hospitals to better reflect changes in the location of residency training, with rural hospitals given first priority. Hospitals also will now receive full payment for up to four years of specialty training when a resident matches simultaneously to a generalized, preliminary year of training, and a subsequent specialty training program.

6. Significant modifications to the proposed rule for long-term care to be sure patients continue to have access to long-term care hospital (LTCH) services when they need them without double billing. Dr. McClellan said, "We understand tremendous need for long-term care for patients with special medical problems that require support but can be associated with long-term care, especially for outlier patients…while also imposing some gradual, reasonable limits for the second amount …Medicare will continue to pay the host hospital for all patients admitted to long-term care...but gradually put limits on total additional payments…which will be phased in over four years …There's no change in policy for 2005. Patients can continue to receive care in a long-term care hospital-within-a-hospital."

7. A number of transition proposals related to labor market changes based on Metropolitan Statistical Areas (MSAs) that are being implemented as a result of the 2000 census. Hospitals in counties that were previously urban and are now considered rural may be negatively affected by the new MSA definitions, but more than 40% of rural hospitals are expected to benefit from the MSA changes. Hospitals with increased payments will get them right away, but hospitals with decreases will have them phased in. ♦