JONES DAY

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MEDICARE ISSUES NEW PROPOSED RULES REGARDING INPATIENT PROSPECTIVE PAYMENT SYSTEM

The Deficit Reduction Act of 2005 ("DRA"), enacted February 8, 2006, made several changes to the Medicare inpatient prospective payment system ("IPPS"). In short, the DRA is estimated to reduce Medicare spending by more than $6 billion over the next five years. A recent proposed rulemaking by the Centers for Medicare & Medicaid Services ("CMS") suggests that although a number of hospitals may see decreases in Medicare payments, many others will realize potential increases. Specifically, on April 25, 2006, CMS published a proposed rule in the Federal Register (the "Proposed Rule") regarding the IPPS for fiscal year ("FY") 2007. The estimated market basket increase for FY 2007 is 3.4 percent, resulting in increased payments to acute-care hospitals of approximately $3.3 billion, according to CMS. Additionally, CMS contends that more than 1,000 hospitals in rural areas would see an average increase of 6.7 percent.

As with other significant changes in the Medicare payment methodology, the Proposed Rule includes a variety of potential opportunities as well as pitfalls for providers. One significant change in the Proposed Rule is CMS's shift in basing diagnosis-related group ("DRG") relative weights on the estimated cost of providing care rather than on charges. This and several other major points of the Proposed Rule are discussed below. The Proposed Rule invites comments regarding the proposed changes to the current IPPS structure. Public comments must be received by CMS no later than June 12, 2006. Any final rule adopted after the public comment period ends will be effective for hospital discharges on or after October 1, 2006.

DRG RECALIBRATION OF RELATIVE WEIGHTS

Previously, CMS recalibrated DRG weights periodically based on charge data for Medicare discharges. CMS now states that using gross charges as a basis for setting the DRG weights causes bias in the weighting process. It insists that more-expensive hospitals (*i.e.*,

teaching and specialty hospitals) tend to treat certain cases more commonly than others, causing DRG weights to be artificially high for other hospitals. Additionally, CMS is concerned with varying percentage markups for charges such as routine days, intensive-care days, and various ancillary services, which cause bias in DRG weights. An example given by CMS is that a charge-based methodology may result in high weights for DRGs using more ancillary services relative to DRGs that use more routine services. Therefore, CMS is proposing a shift to a hospital-specific relative value cost center methodology ("HSRVcc") to recalibrate DRG weights. CMS intends to apply the HSRVcc methodology to remove the bias introduced by hospital characteristics (*i.e.*, teaching, disproportionate share, location, size, etc.) and then scale the weights to costs using national cost center cost-to-charge ratios derived from cost report data.

DRG RECLASSIFICATION

Together with the shift to an HSRVcc proposal with regard to DRG weighting methodology, CMS is proposing a refinement to the current DRG system to identify with more specificity the illness severity of patients under a respective DRG. To that end, CMS is proposing an increase in the number of DRGs from 526 under the current system to 861 under a new "consolidated severity-adjusted DRG system." By introducing new subclasses to the current DRG system together with the HSRVcc DRG weighting methodology, CMS contends payment will be more accurate. With respect to outliers, CMS contends that by shifting to a consolidated severity-adjusted DRG system, it will have better recognition of illness severity, thereby potentially reducing an outlier case to a non-outlier case level to the extent a patient could be properly recategorized with a new and more specific DRG based on illness severity. The Proposed Rule suggests that implementation will occur beginning FY 2008 but alludes to possible implementation as early as FY 2007. Delayed implementation is intended primarily to allow hospitals additional time to plan for this shift and because of incomplete analysis of the effects on outlier threshold, measure of real case mix vs. apparent case mix, and the impact on indirect medical education and disproportionate share hospital ("DSH") percentage add-on adjustments. Although the Proposed Rule promotes the consolidated severity-adjusted DRG methodology, CMS is interested in public comments on whether there are better alternatives to this proposal. CMS is also proposing an annual update of the long-term-care DRG classifications and relative weights for use under the long-term-care hospital prospective payment system. Separately, the Proposed Rule sets forth numerous disease-specific DRG reclassifications.

Although many hospitals will be adversely affected by the combined HSRVcc and consolidated severity-adjusted DRG system, CMS projects that some hospitals—particularly specialty hospitals—will suffer a more dramatic decline in payments, on average. For example, for specialty hospitals delivering only a specific category of services, such as cardiac or orthopedic care, there are anticipated declines of 11.2 percent and 4.4 percent, respectively (and specialty hospitals, even those without emergency rooms, also would be required to accept emergency transfers within their capacity limits under EMTALA). Although some urban and rural hospitals are estimated to receive overall increases of greater than 5 percent from the combined changes, 8 percent of urban hospitals and 11 percent of rural hospitals are expected to experience payment decreases of greater than 5 percent. An additional 25 percent of urban hospitals and 35 percent of rural providers are expected to experience payment decreases of 1 to 5 percent.

Overall, CMS estimates that those hospitals with more than 60 percent Medicare patients are projected to receive the greatest benefit in payments, with a 7.6 percent increase. Hospitals with fewer than 50 beds are estimated to experience an additional 4.1 percent increase, and hospitals with 50 to 100 beds are projected to receive a 2.54 percent increase. Payments to major and other teaching hospitals are estimated to decrease by about 1 percent, while those to non-teaching hospitals will increase by 1.3 percent. CMS projects that hospitals with less than 20 percent DSH payments will have declines of 0.48 to 1.45 percent, while hospitals with DSH payments greater than 50 percent will experience a 2.3 percent increase.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES

CMS reiterated its commitment to Medicare beneficiary access to new technologies by providing for temporary add-

on payments for appropriate technologies. CMS received three applications for new technology add-on payments for FY 2007. Comments are being solicited regarding whether these technologies meet the criteria for the temporary add-on payments. CMS is also proposing to continue new technology payments for two of the three technologies that were approved for payment in FY 2006. In order to be eligible for additional reimbursement, a product must be: (1) new—that is, less than two to three years old; (2) expensive—that is, it must meet a defined cost threshold in relation to the underlying DRG; and (3) a substantial clinical improvement for the Medicare patient population.

CHANGES TO THE HOSPITAL WAGE INDEX

The Social Security Act requires CMS to make adjustments of standardized amounts "for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The proposed wage index for FY 2007 is based on data submitted for hospital cost-reporting periods beginning on or after October 1, 2002, and ending October 1, 2003. The national average hourly wage increased 5.7 percent compared to the base period for FY 2006. Therefore, the only way to maintain or exceed the previous year's wage index was to match or exceed the national 5.7 percent increase in the average hourly wage. Of the 3,500 hospitals with wage data for both FYs 2006 and 2007, 1,606 hospitals (or 45.9 percent) experienced an average hourly wage increase of 5.7 percent or more.

CMS is proposing to issue two separate reclassified wage indices for affected areas—one effective from October 1, 2006, to March 31, 2007, and a second effective from April 1, 2007, to September 30, 2007. Reclassifications have implications for budget neutrality, and as a result, CMS must apply adjustments to the IPPS standardized amounts to ensure that the effects of geographic reclassification are budget-neutral. Despite two separate wage indices proposed for FY 2007, CMS is proposing to calculate one budget neutrality adjustment factor that will reflect the average of the adjustments for first- and second-half FY reclassifications. CMS indicates that one budget neutrality adjustment factor will be more appropriate than two separate adjustment factors due to administrative ease and less confusion in the health-care communities affected.

The Proposed Rule also contains an occupational mix adjustment to the wage index and an adjustment to the wage index for FY 2007 based on commuting patterns of hospital employees who reside in one county and work in a different area with a higher wage index.

CHANGES TO THE IPPS FOR CAPITAL-RELATED COSTS

The Proposed Rule contains technical corrections respecting the prospective payment system ("PPS") for capital-related costs, including the following: (1) hospitals reclassified as rural will not be eligible for the large urban add-on DSH payments; (2) the same wage index that applies to hospitals under the operating PPS will be used to determine the geographic adjustment factor under the capital PPS; and (3) hospitals located in Alaska and Hawaii will have the same cost-of-living factor applied under the operating PPS as the one used under the capital PPS.

CHANGES FOR HOSPITALS AND HOSPITAL UNITS EXCLUDED FROM THE IPPS

CMS is proposing policy changes regarding grandfathered hospitals within hospitals ("HwH"), hospital satellites, and satellite units to allow these facilities to reduce their square footage or number of beds without jeopardizing their grandfathered status. CMS is also proposing to revise its regulations to allow for changes in square footage or decreases in the number of beds of the HwH if these changes are necessitated by relocation of a hospital to permit construction or renovation necessary to comply with federal, state, or local law affecting the physical plant or because of catastrophic events (*e.g.*, fires, floods, earthquakes, or tornadoes).

CMS also proposed changes to the methodology for determining long-term-care hospital cost-to-charge ratios and the reconciliation of high-cost and short-stay outlier payments under the long-term-care hospital PPS. Finally, CMS is proposing a technical change relating to the designation of critical-access hospitals as necessary providers.

PAYMENT FOR SERVICES FURNISHED OUTSIDE THE UNITED STATES

CMS is proposing to modify its current language to provide payment for emergency inpatient services if a beneficiary receives treatment from a hospital located outside the United States, provided such hospital is closer to, or substantially more accessible from, the place where the emergency arose than the nearest available adequately equipped hospital within the United States. CMS contends that several existing Medicare regulations specifically refer to services furnished in Mexico and Canada but do not indicate whether it is permissible for Medicare payment to be made in other foreign countries.

LIMITS ON PAYMENTS TO SNFs FOR BAD DEBT

The Proposed Rule would adopt a mandate stemming from the DRA that requires reduction of Medicare payment to skilled nursing facilities ("SNFs") for certain allowable bad-debt amounts. For patients who are not full-benefit, dual-eligible individuals, allowable bad-debt amounts attributable to coinsurance under the Medicare program for an SNF will be reduced by 30 percent. Allowable bad-debt amounts for patients who are full-benefit, dual-eligible individuals will continue to be paid at 100 percent.

QUALITY PATH AND PRICING INFORMATION

CMS is proposing amendments to reflect a 2 percent reduction in the payment update for FY 2007 and subsequent fiscal years for hospitals that do not comply with required reporting of quality data (*i.e.*, the 10 starter-set measures included in the Medicare Prescription Drug Improvement and Modernization Act of 2003 in addition to newly expanded performance measures set forth in a 2005 report issued by the Institute of Medicine beginning in calendar year 2006). CMS is also proposing that hospitals attest to the completeness and accuracy of the expanded data submitted to the QIO Clinical Warehouse.

In addition, CMS is proposing an increase in the transparency of quality and pricing. To that end, it is proposing options such as publishing hospital charges in every region of the country or in selected regions of the country; publishing rates that CMS pays to individual hospitals for DRGs, adjusted to take into account the hospital's labor market area, teaching hospital status, and DSH status; establishing hospital conditions of participation that require hospitals to post their prices and/or post their policies regarding discounts or other assistance for uninsured patients; and publishing the total cost for an episode of care.

PAYMENT FOR GRADUATE MEDICAL EDUCATION

The Proposed Rule contains several changes related to graduate medical education ("GME"). One change pertains to the statutorily required indirect medical education adjustment factor (or multiplier) for FY 2007, which will be set at 1.32. Other changes include clarifications of payment for GME by addressing how to determine the per-resident amounts for merged hospitals and teaching hospitals, counting and appropriately documenting full-time equivalent residents, and counting resident time spent in nonpatient-care activities as part of approved residency programs. In addition to those GME provisions, the Proposed Rule sets forth changes relating to payment for costs of nursing and allied health education programs.

LAWYER CONTACTS

For further information, please contact your principal Firm representative or one of the lawyers listed below. General e-mail messages may be sent using our "Contact Us" form, which can be found at www.jonesday.com.

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