Centers for Medicare & Medicaid Services FY 2005 Inpatient Prospective Payment System Final Rule Critical Access Hospital Issues

The Centers for Medicare & Medicaid Services (CMS) put on display August 3 a final rule revising the Medicare hospital inpatient prospective payment system (PPS) for FY 2005. The rule also implements a number of provisions contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), including a number of regulatory changes affecting critical access hospitals (CAHs). The final rule can be accessed on the CMS website at http://www.cms.hhs.gov/providers/hipps/frnotices.asp (select part 3 for the CAH provisions) and will be available on August 11 on the Federal Register website at http://www.access.gpo.gov/su_docs/fedreg/a040811c.html. The provisions of the final rule are effective October 1, 2004.

This document provides a summary of the actions finalized by CMS regarding CAH issues.

Payment Amounts

Prior to the enactment of the MMA, Medicare provided payment to CAHs for inpatient, outpatient and skilled nursing facility services on the basis of costs. Section 405(a) of the MMA provides for payment at 101% of the reasonable cost of the CAH in providing these services, effective for services furnished during cost reporting periods beginning on or after January 1, 2004. CMS finalized its proposal to revise regulations to incorporate the change in the payment percentage made by the MMA. The agency did not respond to IHA's comments regarding the lack of direction to its fiscal intermediaries to calculate interim rates for CAHs to reflect 101% of cost, consistent, with congressional intent, but rather indicated it received no public comment on this proposal.

Condition of Application for Special Professional Service Payment Adjustment

The Social Security Act provides for two methods of payment for outpatient CAH services. A CAH will be paid under a reasonable cost method unless it elects payment under an optional method, also known as method II. Under this option, the CAH submits bills for both facility and professional services to the fiscal intermediary and Medicare makes payment for the facility services at the same level that would apply under the reasonable cost method (increasing to 101% for cost reporting periods beginning on or after January 1, 2004), but services of professionals to outpatients are paid at 115% of the amount that would have otherwise been paid under the physician fee schedule. Section 405 of MMA amended the Social Security Act by specifying that CMS may not require, as a condition for a CAH to make an election of the optional method of payment, that each physician or other practitioner providing professional services in the CAH must assign billing rights to the CAH with respect to the services. However, the optional payment method does not apply to those physicians and practitioners who have not assigned such billing rights.

CMS finalized its proposal to revise regulations to implement the changes made by section 405(d)(1) of the MMA by specifying that a CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method II option. The agency also finalized, without change, regulatory language clarifying that such an election must be made at least 30 days before the start of the cost reporting period for which the election is made, and that the provision would apply to all services furnished to outpatients during that cost reporting period by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with Medicare reassignment regulations.

Coverage of Costs for Certain Emergency Room On-Call Providers

Under existing regulations, Medicare payments to a CAH may include the costs of compensation and related costs of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the reasonable cost of outpatient CAH services. Section 405(b) of the MMA expands the reimbursement of on-call emergency room providers beyond physicians to include physician assistants, nurse practitioners, and clinical nurse specialists for the costs associated with covered Medicare services furnished on or after January 1, 2005.

In the final rule, CMS revised current regulations to include the expanded list of emergency room on-call providers for whom reimbursement for reasonable compensation and related costs in a CAH would be available. In addition, the agency finalized a conforming change to regulations governing the standard for emergency room personnel who are on call under the CAH conditions of participation to include clinical nurse specialists.

Authorization of Periodic Interim Payments

Current Medicare law allows for payments to be made on a periodic interim payment (PIP) basis for specified covered Medicare services. Section 405(c)(1) of the MMA amends the statute by adding the ability for the program to provide for payments for inpatient services furnished by CAHs on a PIP basis, effective for payments made on or after July l, 2004. The MMA also directs the Secretary to develop alternative methods for the timing of the payments under the PIP method. CMS states in the proposed rule that existing regulations already allow for payments under the PIP method to providers for certain Medicare covered services. Under the proposed rule, the agency suggested additions to the existing regulations to specify inpatient services furnished by CAHs as an additional type of covered service for which PIP is available, effective for payments made on or after July 1, 2004.

The proposed rule also addressed a longstanding CMS policy that payment will be made biweekly under the PIP method, unless the provider requests a longer fixed interval (not to exceed 1 month) between payments. Further, the agency stated that this provision grants adequate flexibility for the timing of payments under the PIP method to all qualifying providers, including CAHs.

CMS finalized the above proposals for FY 2005 and provided some additional clarification on the application of PIP for CAHs in response to comments. In the final rule, CMS clarified that fiscal intermediaries have some flexibility in administering PIP but that the agency expects its contractors to begin PIP for providers, including CAHs, within a reasonable time after the intermediary has determined the provider qualifies for PIP and not just at the beginning of a cost report period. In addition, CMS stated the regulations do allow for PIP to be made to CAHs prior to the completion of a full 12 month cost report under cost-based reimbursement so long as the hospital can provide sufficient information to the intermediary in order for the intermediary to be satisfied that PIP will result in accurate payments.

Revision of Bed Limits

Prior to the enactment of the MMA, CAHs were restricted to 15 acute care beds and a total of 25 beds if the CAH had been granted swing-bed approval. The number of beds used at any time for acute care inpatient services could not exceed 15 beds. Section 405(e) of the Medicare prescription drug legislation amended the Social Security Act to allow CAHs a maximum of 25 acute care beds for inpatient services, regardless of the swing-bed approval. This amendment is effective on January 1, 2004 and applies to CAHs designated before, on, or after this date. However, section 405(e)(3) of the MMA also notes that any election made in accordance with the regulations promulgated to carry out the bed size amendments only applies prospectively. According to the CMS' interpretation provided in the proposed rule, the agency believes this to mean that the increased bed size limitation is to be applied prospectively after April 1, 2004, regardless of when the CAH was designated. Accordingly, CMS implemented this provision via a survey and certification letter on January 1, 2004. Therefore, effective January 1, 2004, this provision allows any currently participating CAH, or applicant for CAH approval, to maintain up to 25 inpatient beds. If swing-bed approval has been granted, all 25 beds can be used interchangeably for acute care or swing-bed services. However, no CAH will be considered to have had 25 acute care beds prior to January 1, 2004.

Authority to Establish Psychiatric and Rehabilitation Distinct Part Units

Section 405(g)(1) of the MMA modified the statutory requirements to allow CAHs to establish distinct part rehabilitation and psychiatric units of up to 10 beds each, which will not be included in the revised total 25 CAH bed count, effective for the cost reporting periods beginning on or after October 1, 2004. In addition, the average 96-hour stay does not apply to the 10 beds in the distinct part units and inpatient admissions; days of inpatient care in these distinct part units are not taken into account in determining the facility's compliance with the requirement for a facility-wide average length of stay that does not exceed 96 hours.

The law also requires that a distinct part rehabilitation or psychiatric unit of a CAH must meet the conditions of participation that would otherwise apply to the distinct part unit of a hospital if the distinct part unit were established by a non-CAH facility. Due to the MMA provision CAHs will now be permitted to operate distinct-part psychiatric and rehabilitation units, and CMS points out its interpretation of the law, consistent with this change, requires the same level of health and safety protection for patients in distinct part

units of a CAH that is currently required for patients in distinct part units operated by non-CAH hospital.

As CAHs were excluded from operating distinct part units prior to the enactment of the MMA, the CAH conditions of participation did not address the necessary requirements and standards for operating such units. Therefore, CMS proposed that, in accordance with the requirements of section 405(g), a rehabilitation or psychiatric distinct part unit of a CAH must meet all of the hospital conditions of participation and the criteria for exclusion from the inpatient PPS; these requirements will only apply to the services provided in the distinct part unit of a CAH and not the entire CAH.

Further, CMS proposed that, for CAHs that establish rehabilitation or psychiatric distinct part units, or both, in their facility, Medicare payment for inpatient services provided in those units would be made under the applicable existing payment methodology described below for inpatient rehabilitation facilities (IRFs) and inpatient psychiatric facilities (IPFs). Presently, IRFs are paid under a per discharge PPS that became effective for cost reporting periods beginning on or after January 1, 2002. At this time psychiatric hospitals and units that are excluded from the IPPS are paid for their inpatient operating costs on a reasonable cost basis, subject to a hospital-specific limit. However, as required by statute, a per diem PPS for Medicare payments for inpatient hospital services furnished in psychiatric hospitals and units was proposed by CMS in November 2003. The agency is in the process of developing the final rule for this proposed rule and when finalized, the IPF PPS will replace the reasonable cost based payment system currently in effect.
CMS finalized the above proposals without change with the exception of a change in response to comments to clarify that payments to a CAH for services in a distinct part rehabilitation or psychiatric unit may resume only after the start of the first cost reporting period beginning after the unit as demonstrated to CMS that it meets the condition of participation requirements for such units.

Waiver Authority for Designation of CAH as a Necessary Provider
Section 405(h) of the MMA adds language to the Social Security Act that terminates a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. Currently, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Under this provision, after January 1, 2006, States will no longer be able to designate a CAH based upon a determination it is a necessary provider of health care. In addition, the MMA included a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. Under this provision, any CAH that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, will be permitted to maintain its necessary provider designation.

The final rule adopts the proposed regulatory changes without modification but in response to comments, CMS does provide necessary clarification on the necessary provider grandfathering process. Specifically, CMS states in the final rule that if a facility

is not a CAH as of January 1, 2006, the ability to be designated as a necessary provider before becoming a CAH will no longer exist after January 1, 2006.

Payment for Clinical Diagnostic Laboratory Tests

Medicare payment for clinical diagnostic laboratory tests provided to the outpatients of CAHs was established through the regulatory process and published in the Federal Register as part of the FY 2004 IPPS final rule published in August 2003. The CMS policy states that payment to a CAH for clinical diagnostic laboratory tests for outpatients is made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH and are physically present at the CAH at the time specimens are collected. Otherwise, payment for these tests is made on a fee schedule basis.

Redefinition of Geographic Areas

Under the Social Security Act, a facility is eligible for CAH designation only if it is located in a county in a rural area or is being treated as being located in rural area. Some facilities currently designated as CAHs are located in areas considered as rural in FY 2004 but as of October 1, 2005 will be located in metropolitan areas because of the most recent census data and implementation of new metropolitan statistical area (MSA) definitions. CMS acknowledged receiving a number of comments on this issue and accordingly addressed its approach in the final rule. The agency is adding a new paragraph to regulations that will allow a CAH affected by this change to continue to retain its CAH status until December 31, 2005, or by obtaining a rural designation through an existing mechanism in the regulations. One method for achieving rural status is through a designation by any law or regulation of the state in which the hospital is located.