

Hospital Payment Changes in Medicare Legislation: Something for Almost Everyone

By Eric P. Zimmerman

Zimmerman is a partner in the Washington, D.C., office of McDermott, Will & Emery. He can be reached at (202) 756-8148 or via e-mail at ezimmerman@mwe.com.

On June 27, the House and Senate separately approved legislation that, among other things, would establish a prescription drug benefit under the Medicare program. The bills, H.R. 1 in the House and S.1 in the Senate, would, if enacted, bring about the most significant changes to the Medicare program since its inception nearly 40 years ago.

Notwithstanding the media focus on the proposed Medicare drug benefit, hospitals are more concerned with proposed changes to Medicare reimbursement policies for inpatient and outpatient services. The bills each contain nearly two-dozen program payment changes that would directly affect every Medicare-participating hospital in the country.

While the bills cannot accurately be characterized as "giveback" bills, at least along the lines of the previous two enacted major Medicare payment bills, both would improve payments for most hospitals. Hospitals and Critical Access Hospitals located in rural areas are likely to realize the greatest reimbursement improvements, as congressional leaders are aggressively striving to rectify perceived program payment disparities between rural and urban providers. Hospitals in small urban areas also would see some improvements, as would hospitals with teaching programs.

Not all the news is good, however. The House bill also would return hospitals to less than full market basket updates for inpatient services.

This article identifies and summarizes the 10 changes that would most significantly affect hospital payment over the next 10 years.

1. Standardized Amount

The single greatest reimbursement increase, estimated by the Congressional Budget Office (CBO) to cost nearly \$8 billion over 10 years, is a provision (\$402 in the House bill and \$ 401 in the Senate bill) that would permanently eliminate the disparity between the standardized amounts applied to hospitals in "large urban" areas and all other hospitals used for payment purposes under the inpatient prospective payment system (PPS).

Although the disparity was temporarily suspended by legislation enacted earlier this year, it is scheduled to be reimposed for services furnished after Sept. 30, 2003, and hospitals outside "large urban" areas will once again receive a lower standardized amount.

2. Disproportionate Share Hospital Payment (DSH) Adjustments

Rural hospitals historically have benefited little from DSH payment adjustments. Historically, under the inpatient PPS, the qualification criteria and formula for DSH adjustments were significantly more favorable for urban providers. As a result, according to a June 2001 report by the Medicare Payment Advisory Commission (MedPAC), prior to enactment of changes implemented in 2001, nearly 97 percent of DSH payments made under the Medicare program were made to hospitals located in urban areas.

Congress took a step toward diminishing these disparities in the Benefits Improvement and Protection Act of 2000 (BIPA) by equalizing the qualification criteria and improving the payment adjustment formulas applicable to hospitals in rural areas. Nonetheless, the payment adjustment formulas remain significantly more favorable for hospitals in urban areas.

The recently-approved House (\$401) and Senate (\$404) bills would, to varying degrees, take steps toward eliminating the remaining disparities. The Senate bill would consolidate the variety of DSH payment formulas established under BIPA, and subject all hospitals, regardless of geographic location, to the same DSH payment formulas presently used to adjust payments to urban hospitals with more than 100 beds.

The House bill would implement a nearly identical change, but would cap the payment adjustments for rural hospitals at 10 percent. Hospitals designated as rural referral centers would be exempt from this cap

and therefore receive the same payment adjustments as urban hospitals. The House provision is consistent with a recommendation made by MedPAC in 2001, which reasoned that equalizing the payment adjustment formulas might result in "unnecessarily large payment increases for some rural hospitals."

Perhaps one advantage to rural hospitals in the House provision is the effective date. Under the House bill, hospitals in rural areas would realize improved DSH payments sooner, because the provision would become effective for services furnished on and after Oct. 1, 2003. The Senate provision would become effective one year later.

3. Labor Share

Medicare payments to hospitals are adjusted by the wage index to reflect the relative cost of labor in the area in which the hospital is located. For purposes of making payments for inpatient services, the wage index is multiplied against the portion of the standardized amount intended to compensate the hospital for the labor-related costs of furnishing care.

This portion is known as the "labor share," and accounts for 71.1 percent of the total standardized amount. Rural hospitals complain that this percentage overstates the proportion of costs rural hospitals devote to labor, thereby punishing hospitals with a wage index of less than 1.0.

The House (§416) and Senate (§402) bills both include provisions that would lower the portion of the standardized amount adjusted by the wage index to 62 percent, except for those hospitals that would be disadvantaged by this change, i.e., hospitals that are in areas with a wage index of 1.0 or higher. The House bill provides that this change would apply to services furnished on or after Oct. 1, 2003. The Senate bill delays the effective date one year to Oct. 1, 2004.

All hospitals, regardless of geographic location, that are located in, or that reclassify into areas with a wage index less than 1.0, would benefit by this change. This change likely would not affect a hospital's ability to seek wage index geographic reclassification, or the implementation of such reclassification.

Both bills provide that this change would not be implemented in a budget neutral manner, unlike virtually all other statutory and regulatory changes affecting the wage index.

4. Outpatient Services

The Social Security Act provides various protections against reimbursement losses under the outpatient PPS. For example, all hospitals receive supplemental payments for the first three years of the payment system if payments made under the PPS are less than the hospital's adjusted reasonable costs from calendar year 1996.

For most hospitals, these supplemental payments diminish over the three-year period and ultimately terminate altogether. For certain classes of hospitals—children's hospitals, cancer hospitals, and hospitals located in rural areas with fewer than 100 beds—the protections do not diminish over time, and, in some cases—children's hospitals and cancer hospitals—the protections remain indefinitely. The protections for small rural hospitals, however, are set to expire for services furnished after calendar year 2003.

The House (§407) and Senate (§423) bills would extend the "hold harmless" protection for small rural hospitals. The House bill would extend the protection for two years. The Senate bill, on the other hand, would allow the protection to lapse in 2004, and then resume for services furnished in 2005.

The two bills also would extend the "hold harmless" protection to all hospitals located in rural areas and designated as sole community hospitals (SCHs), regardless of bed size. Here, too, the two bills differ on the affected period. The House bill would extend the "hold harmless" protection to rural SCHs for the same two year period as small rural hospitals, i.e., 2004 and 2005. The Senate bill would extend the protection for one year only: 2006.

The Senate bill also includes a provision (§424) that would provide a 5 percent increase in payments for clinic and emergency room services furnished by small rural hospitals and SCHs for services furnished on and after Jan. 1, 2005, and before Jan. 1, 2008. The House bill does not include a similar provision.

5. Teaching Hospitals

The House (§406) and Senate (§§410 and 411) bills include provisions revising resident limits for

reimbursement for a teaching hospital's direct medical education costs. The Senate bill (§ 418) also would slightly inflate indirect medical education payments from the current 5.5 percent adjustment to 5.53 percent for fiscal years 2004 and 2005, but the increase would be well less than the 7.5 percent adjustment sought by teaching hospitals.

6. Essential Rural Hospitals

Since implementation of the inpatient PPS, Congress has directed the Centers for Medicare and Medicaid Services (CMS) to confer various designations on hospitals, primarily rural hospitals, meeting certain characteristics. Rural Referral Centers, Sole Community Hospitals, Medicare Dependent Hospitals, and Critical Access Hospitals are among the more common and enduring. Hospitals with these designations are commonly eligible for special payment treatment under the inpatient PPS, and to a lesser extent under the outpatient PPS.

The House bill (§403) would establish a new designation for hospitals with more than 25 licensed acute care beds located in rural areas, that CMS determines are essential, because closure would "significantly diminish the ability of Medicare beneficiaries to obtain essential health care services." The new designation would appropriately be called "Essential Rural Hospital" status.

The House bill identifies a series of factors that CMS must consider to determine whether a facility qualifies as an "essential" provider. Among the mandatory factors are (1) the hospital furnishes inpatient services to a "high percentage" of beneficiaries in the community, (2) "almost all" physicians furnishing services in the area have privileges at the hospital, (3) "the hospital inpatient score for quality of care is not less than the median hospital score for quality of care for hospitals in the State," as established under utilization and quality control peer review organization standards, and (4) if the hospital were to close there would be (a) a "significant amount" of time needed for residents to reach emergency treatment, resulting in a "potential significant harm" to beneficiaries with critical illnesses or injuries, (b) an inability in the community to stabilize emergency cases for transfers, and (c) no other nearby hospital with the physical and clinical capacity capable of taking over the hospital's typical admissions. The statute also provides a series of other factors that CMS may consider at its discretion.

Qualifying hospitals would be paid 102 percent of reasonable costs for inpatient and outpatient services. These changes would be effective for services furnished on and after Oct. 1, 2004.

The broad and vaguely defined qualifying criteria suggest that this status might be available to a large number of hospitals. However, CBO appears to assume that relatively few hospitals would qualify for the new status, given that it predicts the provision will cost only \$400 million over 10 years. Given the generosity of the payment for qualifying hospitals, the overall cost impact estimate likely would be higher if a large number of hospitals were expected to qualify.

Of note, a qualifying hospital would not be permitted to be dually designated as an Essential Rural Hospital and an SCH, RRC, or MDH. In light of the qualifying criteria, most eligible hospitals likely already would qualify for SCH status. As such, potentially-eligible hospitals would have to choose between the Essential Rural Hospital status and other designations that it may have.

Hospitals with Critical Access Hospital status would not be eligible for this designation because of the bed limitation.

7. Critical Access Hospitals (CAHs)

The House and Senate bills each include a number of provisions that would make the popular Critical Access Hospital program even more advantageous for designated facilities. The House bill (§405) increases reimbursement to CAHs for inpatient, outpatient, and extended care services from reasonable costs to 102 percent of reasonable costs, and permits hospitals that experience seasonal occupancy variations additional flexibility with respect to bed limits.

Both bills expand coverage for on-call services to include physician assistants, nurse practitioners, and clinical nurse specialists, in addition to physicians, an important change given that many CAHs are unable to routinely staff on-call periods with physicians, and are presently unable to seek reimbursement for on-call periods staffed by non-physicians. The House bill also would restore the ability of CAHs to seek periodic interim payments.

The Senate bill (§405) also would allow CAHs to develop distinct-part units with up to 25 total beds, and

would exempt the beds in distinct-part psychiatric and rehabilitation units from the total bed limits counted to qualify for CAH status.

8. Low Volume Adjustment

Whereas the House bill adopts many of the provider payment reduction recommendations made earlier this year by MedPAC, the Senate bill adopts many of MedPAC's June 2001 proposed changes to improve payment to rural providers. One such MedPAC recommendation included in the Senate bill (§403) is a provision that would establish a payment adjustment for rural hospitals with fewer than 2,000 annual discharges that also are located more than 15 miles from other "like hospitals."

The "like hospital" standard is not defined in the statute, but is defined in Medicare regulations. SCH eligibility is based in large part on being a certain distance from other "like hospitals," and CMS has defined the term at 42 C.F.R §412.92(c)(2).

The bill does not define the amount of the payment adjustment, and instead leaves it to the Secretary's discretion. The bill does, however, specify that the amount of the adjustment cannot exceed 25 percent of payments, and that it must be set to gradually decrease as volume increases. The Senate provision would be effective with cost reporting periods beginning on or after Oct. 1, 2004.

This provision likely would be most appealing to hospitals that presently do not qualify for other rural designations, such as CAH, SCH, MDH and RRC, and that otherwise are not entitled to the special payment considerations attendant those designations.

However, this change also could be helpful to hospitals with SCH or MDH status, which are paid the higher of a cost-based rate or the federal rate, and which may find that the low-volume adjustment makes federal rates more advantageous than cost-based payments.

9. Geographic Reclassification

The House bill (§504) would establish a new wage index reclassification opportunity, which may help hospitals that presently cannot qualify. To be eligible, a hospital would have to demonstrate that its average hourly wage is greater than the AHW of all of the hospitals in its area, and that at least 10 percent of employees reside in an area with a higher wage index.

Qualifying hospitals would receive incremental adjustments to their wage index based on the wage index of the area in which the employees reside and the number of employees residing in the higher wage areas.

Because qualifying hospitals would not get the full wage index of the neighboring area, this opportunity likely would not be as valuable to hospitals as traditional wage index reclassification. However, it could provide some incremental wage index improvement to hospitals that presently cannot otherwise qualify.

The change likely would provide no benefit to hospitals that are the only provider in their area. Among the qualifying criteria, a hospital must show that its AHW is greater than the AHW of all hospitals in its area, including the applicant. If the applicant were the only hospital in its area, it probably would be unable to satisfy this criterion.

This language perpetuates a similar problem for hospitals seeking wage index reclassification under the traditional avenue. A hospital that is the only provider in its area—common in small urban areas where one county comprises the Metropolitan Statistical Area—likewise cannot satisfy the test that requires that its AHW be 108 percent of the AHW of hospitals in its area. CMS has taken a strict interpretation of this regulation, and disqualified hospitals in this circumstance from reclassifying.

The Senate bill does not have a similar provision, but does include some incredibly vague language (§419) that would allow the Secretary to "waive criteria for purposes of reclassification" for discharges occurring in fiscal year 2004. The provision was inserted to accommodate Senators seeking legislative reclassifications or reclassification "rifleshots," as they are known, but it is unclear whether or exactly how CMS would use this authority.

10. Market Basket Update

With the good, must come the bad. The House bill (§501) would decrease the market basket index adjustment used to update inpatient PPS payments. Under current law, hospital payments would increase by a full market basket index adjustment factor in fiscal year 2004. Under the House bill, however,

payment increases would be held to the market basket index minus 0.4 for fiscal years 2004 through 2006. The Senate bill would leave the market basket adjustment alone. The hospital lobby is vigorously opposing the House proposal.

Commentary

Of course, the bills each contain numerous other provisions not summarized here that would directly and indirectly impact hospital payment. The two measures also include dozens of changes affecting payments to other providers, suppliers, and physicians, as well as Medicare+Choice plans and preferred provider organizations, in addition to the prescription drug benefit provisions. The two bills and a variety of explanatory materials can be accessed from the official web site of Congress at <http://thomas.loc.gov/>.

The House and Senate must now set about the task of reconciling the differences between the two bills. While most of the contention will be with the prescription drug benefit provisions and other systemic reforms, which vary considerably between the two bills, the hospital payment provisions also will be a central focus of the negotiation.

One item affecting many of the provisions that will have to be worked out, particularly as more time passes, is the effective date of the proposed changes. The two chambers are expected to begin negotiations in July, but a final bill likely will not be ready for the president much before the end of this congressional session, if that soon.

Consequently, the next federal fiscal year likely will begin without final congressional action on these bills. If Oct. 1 comes around, and a final bill has not yet been enacted, it may be more difficult for Congress and CMS to implement these changes effective for fiscal year 2004. Instead, implementation may have to be postponed until mid-way through fiscal year 2004, or even to the start of fiscal year 2005.