United States Government Accountability Office

GAO

Report to Congressional Requesters

April 2013

MEDICARE

Legislative Modifications Have Resulted in Payment Adjustments for Most Hospitals

This Report Is Temporarily Restricted Pending Official Public Release.

G A O

Accountability * Integrity * Reliability

GAO-13-334

GAO
Accountability * Integrity * Reliability

Highlights

Highlights of GAO-13-334, a report to congressional requesters

April 2013

MEDICARE

Legislative Modifications Have Resulted in Payment Adjustments for Most Hospitals

Why GAO Did This Study

To help control the growth of hospital spending, give hospitals an incentive to provide care efficiently, and ensure beneficiary access, Congress created the IPPS in 1983. Yet, Congress can enhance Medicare payments to certain hospitals by changing the qualifying criteria for IPPS payment categories, creating and extending exceptions to IPPS rules, or by exempting certain types of hospitals from the IPPS. The Institute of Medicine and the Medicare Payment Advisory Commission have stated that such practices undermine the integrity of the IPPS.

GAO was asked to review legislation that altered payments to certain hospitals. In this report, GAO (1) identified provisions of law that enhanced Medicare payments for only a subset of hospitals and (2) examined the extent to which hospitals qualified for adjustments to the IPPS or exemptions from the IPPS in 2012.

To conduct this work, GAO reviewed provisions enacted from 1997 to 2012 to identify those that adjusted payments to a subset of IPPS hospitals or exempted hospitals from the IPPS. GAO analyzed data to learn the number, location, and size of hospitals affected by these provisions and budgetary estimates for the first year of implementation, where available. GAO also analyzed 2012 data on 4,783 general hospitals to determine the number and types of adjustments they received, the extent to which they qualified for multiple adjustments, and the number exempted from the IPPS.

The Department of Health and Human Services reviewed a draft of this report, and provided technical comments, which we incorporated as appropriate.

View GAO-13-334. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

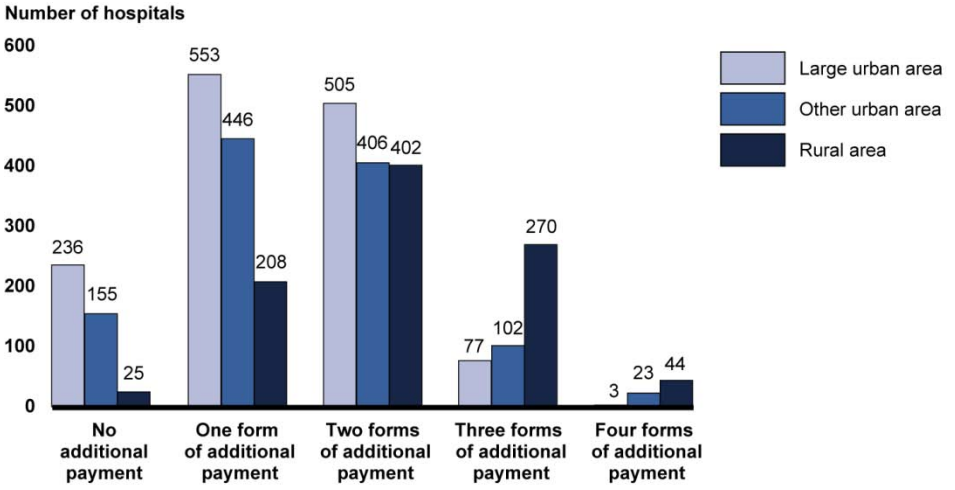
What GAO Found

Over time, Congress has modified how Medicare reimburses certain hospitals under the inpatient prospective payment system (IPPS), which pays hospitals a flat fee per stay, set in advance, with different amounts for each type of condition. GAO identified numerous statutory provisions that individually increased Medicare payments to a subset of hospitals.

- Seven provisions enabled hospitals to be paid under a different geographic wage index, which is used to address variation in labor costs.
- Five provisions modified the classification criteria allowing IPPS hospitals to qualify for supplemental payments through the Medicare disproportionate share hospital (DSH) program or other types of special treatment.
- Three provisions created and modified criteria for classifying small rural providers as Critical Access Hospitals (CAH), which are exempt from IPPS and instead are paid under an alternative methodology.

In general, while such provisions were designed to affect only a subset of hospitals, nearly all of the 4,783 hospitals in GAO's review qualified for an adjustment or exemption from the IPPS in 2012. About 91 percent were subject to an IPPS payment adjustment or were excluded from the IPPS entirely. Most hospitals, over 63 percent, qualified for at least one of four categories of increased payment, with DSH payments being the most common. Under the CAH program, 28 percent of hospitals were exempt from the IPPS. The remaining hospitals, 9 percent, received IPPS payments that were unadjusted for the modifications included in GAO's review. Moreover, many IPPS hospitals qualified for multiple categories of payment adjustments. These findings suggest that the way Medicare currently pays hospitals may no longer ensure that the goals of the IPPS—cost control, efficiency, and access—are being met.

Inpatient Prospective Payment System (IPPS) Hospitals Qualifying for No, One, or Multiple Forms of Payment Adjustments, by Location, 2012



Source: GAO analysis of Centers for Medicare & Medicaid Services data.

Contents

Letter 1

Background 5
Numerous Statutory Provisions Have Resulted in Increased Medicare Payments to Certain Hospitals 11
IPPS Payment Adjustments or Exclusions Affected Nearly All Hospitals 27
Concluding Observations 31
Agency Comments 31

Appendix I Estimated Effect of Nationwide Budget Neutrality of Rural Floor on Hospital Payments by State, Fiscal Year 2012 and 2013 33

Appendix II Hospitals by Provider Type 35

Appendix III GAO Contact and Staff Acknowledgments 36

Table

Table 1: Inpatient Prospective Payment System (IPPS) Hospitals Qualifying for Additional Medicare Payments by Category and Location, 2012 29

Figures

Figure 1: Examples of Eligibility Criteria for Sole Community Hospitals 8
Figure 2: Examples of Eligibility Criteria for Rural Referral Centers 9
Figure 3: Eligibility Criteria for Medicare-Dependent Hospitals 10
Figure 4: Number of Hospitals Newly Designated as Critical Access Hospitals (CAH), 1998-2011 24
Figure 5: Percent of Each State's Hospitals Designated as Critical Access Hospitals (CAH), June 2012 26
Figure 6: Inpatient Prospective Payment System (IPPS) Hospitals Qualifying for No, One, or Multiple Forms of Payment Adjustments, by Location, 2012 30

Figure 7: Distribution of Inpatient Prospective Payment System (IPPS) Hospitals and Critical Access Hospitals (CAH), by Provider Type, 2012 35

Abbreviations

BBA	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CAH	Critical Access Hospital
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
DPP	disproportionate patient percentage
DSH	disproportionate share hospital
Flex Program	Medicare Rural Hospital Flexibility program
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
IME	indirect medical education
IOM	Institute of Medicine
IPPS	inpatient prospective payment system
MDH	Medicare-dependent hospital
MedPAC	Medicare Payment Advisory Commission
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSA	metropolitan statistical area
PPACA	Patient Protection and Affordable Care Act of 2010
RRC	rural referral center
SCH	sole community hospital
the Board	Medicare Geographic Classification Review Board

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO
Accountability * Integrity * Reliability
United States Government Accountability Office
Washington, DC 20548

April 17, 2013

The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Richard Burr
Ranking Member
Subcommittee on Primary Health and Aging
Committee on Health, Education, Labor and Pensions
United States Senate

In 2011, the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—paid hospitals about $147 billion for inpatient services provided to beneficiaries in fee-for-service Medicare, accounting for about one-quarter of all Medicare expenditures.[1] To help control the growth of hospital spending, give hospitals an incentive to provide care efficiently, and ensure beneficiary access to care, Congress created the inpatient prospective payment system (IPPS) in 1983.[2] Under this system, Medicare pays hospitals a flat fee per stay, set in advance, with different amounts for each type of condition. These payment rates are also influenced by such factors as the relative hourly wage in the area where the hospital is located and whether the hospital qualifies for additional payments. For hospitals not paid under IPPS, other Medicare payment methodologies apply.

Congress can enhance Medicare payments to certain hospitals by changing the qualifying criteria for IPPS payment categories, creating and extending exceptions to IPPS rules, or exempting certain hospitals from the IPPS altogether. Specifically, Congress may allow hospitals meeting

[1]Medicare Parts A and B are known as Medicare fee-for-service. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services.

[2]See Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65 (1983) (codified, as amended, at 42 U.S.C. § 1395ww). Medicare also pays hospitals for services provided to beneficiaries in outpatient departments under the outpatient prospective payment system, implemented in 2000.

certain criteria to receive additional Medicare payments, and may revise some of the qualification criteria to enable more hospitals to benefit. For example, legislation has extended statutory provisions set to expire, or allowed certain hospitals to continue receiving additional payments after qualifying criteria have changed, through grandfathering. Often such efforts were intended to ensure beneficiary access to care or to help hospitals recruit and retain physicians and other medical professionals. However, some Medicare payment experts have expressed concerns about exceptions to the IPPS, extensions of certain provisions, and other forms of payment adjustments. They contend that such practices have a cumulative effect on the cost of the program, do not adequately target providers most in need, and undermine the integrity of the IPPS.[3]

In light of these issues, you asked us to review Medicare payment legislation that has benefited certain hospitals by creating new criteria or changing existing criteria for a hospital's classification, or modifying payments for hospitals that fit a narrow profile. In this report, we (1) identify provisions of law that enhanced Medicare IPPS payments for only a subset of hospitals, and the characteristics of affected hospitals and budgetary estimates, if any; and (2) examine the extent to which hospitals qualified for adjustments to, or exemptions from, the IPPS in 2012.

To address these issues, we limited our review to statutory provisions enacted since 1997 and to the class of short-term acute care general hospitals then paid under the IPPS.[4] We included in our review those provisions that subsequently adjusted payments to only a subset of IPPS hospitals or exempted hospitals from the IPPS during this period. The

[3]A. Bruce Steinwald, President, Bruce Steinwald Consulting, *Congress Should Not Extend Expiring Exceptions to Medicare Payment Policies Without Compelling Evidence Based on Beneficiary Need,* testimony before the Subcommittee on Health, Committee on Ways and Means, September 21, 2011; Institute of Medicine, *Geographic Adjustment in Medicare Payment Phase I: Improving Accuracy* (Washington, D.C.: September 2011); Institute of Medicine, *Geographic Adjustment in Medicare Payment Phase II: Implications for Access, Quality, and Efficiency* (Washington, D.C.: July 2012); and Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Healthcare Delivery System* (Washington, D.C.: June 2012).

[4]This scope excluded facilities not paid under the IPPS—psychiatric, rehabilitation, children's, long-term care, and cancer hospitals, as well as religious nonmedical health care institutions. We also excluded Maryland hospitals because they too are subject to a separate payment methodology.

provisions covered in our review may be ongoing, time-limited, or expired—as indicated. However, we excluded provisions that simply modified reimbursement to all hospitals in a previously established category of IPPS hospitals. We also excluded provisions that simply granted an extension of time to previously enacted payment rules.

To identify and describe statutory provisions within our scope, we interviewed CMS officials and health care policy researchers with expertise in the area of Medicare hospital payment systems. We also reviewed literature on Medicare's hospital payment history and congressional committee and conference reports related to the statutory provisions identified.[5] This resulted in our review of provisions from the following laws:

- Balanced Budget Act of 1997 (BBA);
- Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA);
- Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA);
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA);
- Deficit Reduction Act of 2005;
- Tax Relief and Health Care Act of 2006;
- Medicare, Medicaid, and SCHIP Extension Act of 2007;
- Medicare Improvements for Patients and Providers Act of 2008;
- Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA);[6]

[5]In this report, we describe statutory provisions within our scope that were identified through interviews with experts or literature review. Therefore, this list of provisions is not exhaustive.

[6]In this report, references to PPACA include any amendments made by HCERA.

- Medicare and Medicaid Extenders Act of 2010;
- Temporary Payroll Tax Cut Continuation Act of 2011;
- Middle Class Tax Relief and Job Creation Act of 2012; and
- American Taxpayer Relief Act of 2012 (ATRA).

To determine characteristics of hospitals affected by these provisions, we analyzed data on the number, size, and location of hospitals using two sources: CMS's fiscal year 1997 through 2013 impact files, as applicable,[7] and the Flex Monitoring Team—a federally funded consortium of three rural health research centers.[8] To report estimates of budgetary effects, we used data published by CMS and the Congressional Budget Office (CBO).[9] We generally reported data on the first year of a provision's implementation, if available. Unless otherwise noted, however, data on affected hospitals and Medicare fee-for-service spending were projections issued prior to the implementation of the provisions rather than actual effects. In order to assess the reliability of the data we analyzed, we reviewed CMS's documentation on the impact files, interviewed CMS officials familiar with the data, and compared impact file data to data in relevant federal register notices. We found these data sufficiently reliable for the purpose of this engagement.

To assess the extent to which hospitals qualified for a Medicare payment adjustment in 2012, we analyzed CMS and Flex Monitoring Team data on 4,783 short-term acute care general hospitals, as of July 2012. These

[7]CMS's impact files provide hospital-level data the agency uses to estimate payment impacts of various policy changes in proposed and final rules published in the Federal Register. CMS usually prepares impact files in the summer preceding each federal fiscal year, based on the most recent data available at the time. Impact files include data on all Medicare acute care general hospitals. Because Maryland hospitals are not paid under the IPPS, we removed Maryland data from our analysis of the impact files.

[8]The Flex Monitoring Team is comprised of rural health research centers at the Universities of Minnesota, North Carolina–Chapel Hill, and Southern Maine. These universities received a 5-year cooperative agreement award from the federal Office of Rural Health Policy to continue to monitor and evaluate rural hospital programs. To be consistent with other information in this report, we used June 30, 2012, data from the Flex Monitoring Team.

[9]Given the purpose of these estimates, CMS's projected budgetary impact data are not subsequently verified or compared to actual expenditures.

data allowed us to report the number of hospitals that had their payments adjusted, the types of adjustments they received, and the extent to which they qualified for multiple adjustments.

We conducted this performance audit from June 2012 to March 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings based on our audit objectives.

Background

The IPPS provides incentives for hospitals to operate efficiently by paying a predetermined, standardized amount for an entire inpatient episode of a given type rather than the actual costs incurred in providing the care. CMS calculates IPPS payments through a series of adjustments applied to separate national base payment rates covering operating and capital expenses.[10] Specifically, the agency adjusts the base payment rates for patients in different diagnosis-related groups, assuming that cases falling into a particular grouping address similar clinical problems that are expected to require similar amounts of hospital services.[11] CMS then applies an area wage index to account for geographic differences in labor costs. Finally, CMS determines whether supplemental Medicare payments or other types of special treatment, such as those provided to certain rural hospitals, are applicable.

Area Wage Index

CMS adjusts hospital payments under IPPS using the area wage index, to account for variation in labor costs across the country, as these costs are largely beyond any individual hospital's ability to control. The wage

[10]Medicare sets the base payment rates for the operating and capital costs that reasonably efficient hospitals are expected to incur in providing covered inpatient services. Operating payments cover labor and supply costs and capital payments cover costs for depreciation, interest, rent, and property-related insurance and taxes. CMS updates these rates annually.

[11]Medicare categorizes all hospital inpatient care into medical-severity adjusted, diagnosis-related groupings. Inpatient episodes are first grouped by principal diagnosis and then subdivided by the nature of co-morbidities or complications, if any. Each grouping has a numeric weight, which signifies the average cost of stays assigned to that grouping relative to the average cost of other inpatient stays.

index reflects how average hospital wages in each geographic area compare to average hospital wages nationally, set as 1.0. Thus, Medicare payment to a hospital in an area with lower wages is generally below the national average payment and the payment to a hospital in a higher wage area is generally above the national average. CMS considers each distinct urban area as a single labor market, but it considers all rural areas within a state as a single labor market and therefore assigns them the same wage index.[12] If its wage index does not fully account for its relative labor costs, a hospital may qualify to be reclassified to a higher wage index area in order to receive higher Medicare payments. To request a reclassification to another geographic area, hospitals may apply to the Medicare Geographic Classification Review Board (the Board), an entity established by Congress. Among various criteria for reclassification, a hospital must demonstrate close proximity to the area for which it is seeking redesignation.

Medical Education Payments

Medicare reimburses teaching hospitals and academic medical centers for both the direct and indirect costs of their residency training programs. Direct graduate medical education payments cover the direct costs of resident training, such as salaries and benefits. The indirect medical education (IME) adjustment—a percentage add-on to IPPS rates—reflects the higher patient care costs associated with resident education. The size of the IME adjustment depends on the hospital's teaching intensity, which is generally measured by a hospital's number of residents per bed.

Medicare Disproportionate Share Hospitals

The Medicare disproportionate share hospital (DSH) adjustment generally provides supplemental payments to hospitals that treat a disproportionate number of low-income patients.[13] To qualify for this payment adjustment,

[12]CMS uses definitions from the Office of Management and Budget to define its urban and rural areas. Core Based Statistical Areas are either metropolitan (population of at least 50,000) or micropolitan (population of at least 10,000 and fewer than 50,000). In this report, we refer to both of these areas as "urban." We refer to all nonurban areas as "rural."

[13]See 42 U.S.C. § 1395ww(d)(5)(F).

a hospital's disproportionate patient percentage (DPP)[14]—the share of low-income patients treated by the hospital—must generally equal or exceed a specific threshold level determined by a statutory formula.[15] The amount of Medicare DSH payment adjustment varies by hospital location and size.

Types of Rural Providers under IPPS

Rural hospitals may qualify for special treatment in determining payment rates under IPPS, although some urban hospitals may also qualify, through three programs: sole community hospitals (SCH), rural referral centers (RRC), and Medicare-dependent hospitals (MDH).[16] In some cases, hospitals may qualify for more than one of these rural provider types, allowing them to receive multiple adjustments to their IPPS payment rates.

Sole Community Hospitals

The SCH program provides payment adjustments to hospitals that are the only source of inpatient care in their community. To be designated as an SCH, a hospital must be located at least 35 miles from other like hospitals paid under the IPPS. Alternatively, if a hospital is located fewer than 35 miles from the nearest hospital, it may qualify as an SCH if it is located

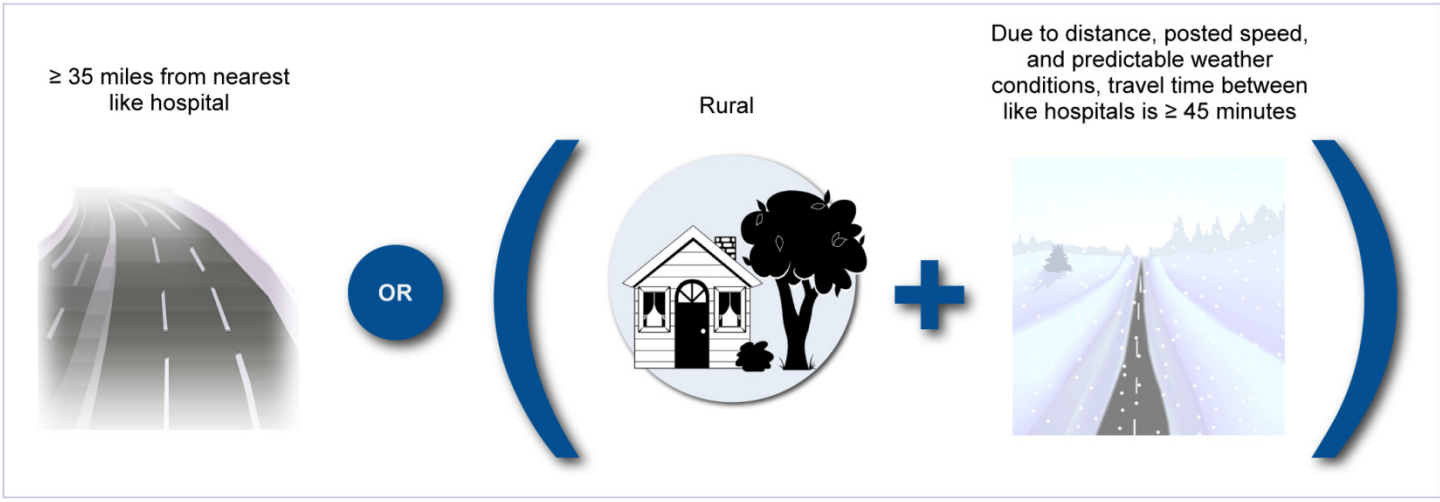
[14]The DPP is generally computed as the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income (the federal program that provides cash benefits to eligible low-income individuals who are aged, blind, or disabled) and the percentage of total patient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A.

[15]An alternative method for qualifying for the Medicare DSH adjustment applies to hospitals that are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their total net inpatient care revenues come from state and local government sources for indigent care (other than Medicare and Medicaid). These hospitals are known as "Pickle" hospitals and qualify for a specific Medicare DSH adjustment.

[16]Federal law and regulations refer to "Medicare-dependent small rural hospitals". In this report, we reference this category of rural providers as "Medicare-dependent hospitals" (MDH).

in a rural area and meets additional criteria.[17] (See fig. 1.) Medicare pays each SCH on the basis of the applicable IPPS rate or the hospital's updated historic cost per discharge, whichever provides the greater aggregate payment.

Figure 1: Examples of Eligibility Criteria for Sole Community Hospitals



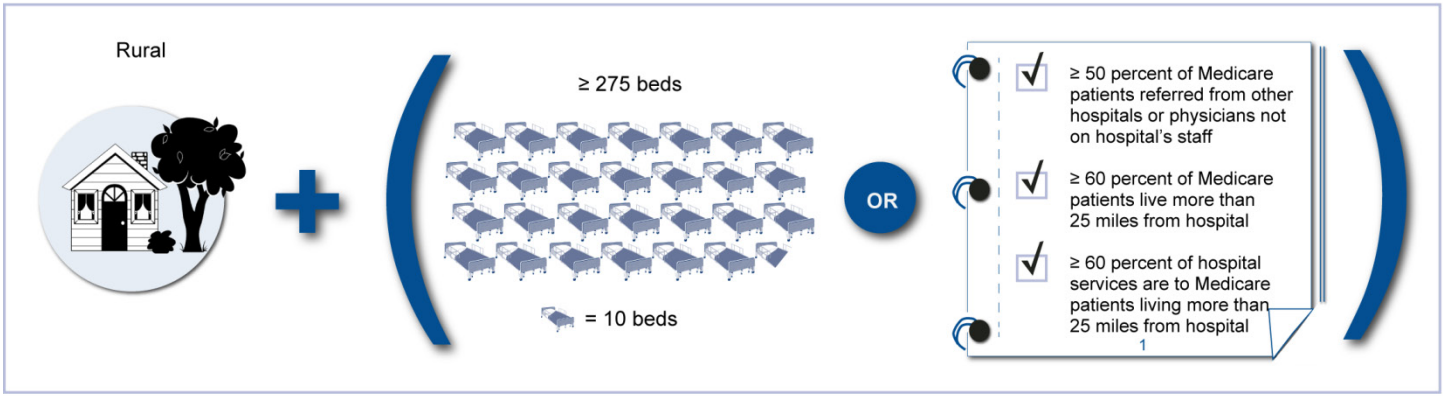
Source: GAO; Art Explosion (images).

[17]See 42 U.S.C. § 1395ww(d)(5)(D)(iii), 42 C.F.R. § 412.92(a). A hospital may also qualify as an SCH if (1) it is located between 25 and 35 miles from another like hospital and meets additional criteria, such as having no more than 25 percent of Medicare beneficiaries in the service area being admitted to other like hospitals within 35 miles, (2) it is located between 15 and 25 miles from other like hospitals and because of local topography or prolonged severe weather conditions, other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years, or (3) because of distance, posted speed, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Rural Referral Centers

The RRC program supports high-volume rural hospitals that treat a large number of complicated cases. In general, a hospital is classified as an RRC if it meets certain location, size, and patient mix criteria,[18] or meets alternative criteria.[19] (See fig. 2.) Medicare provides RRCs with two payment enhancements: a higher DSH payment adjustment than other rural providers and an exemption from some of the applicable criteria for geographic reclassification so that they can be eligible for a higher wage index.

Figure 2: Examples of Eligibility Criteria for Rural Referral Centers



Source: GAO; Art Explosion (images).

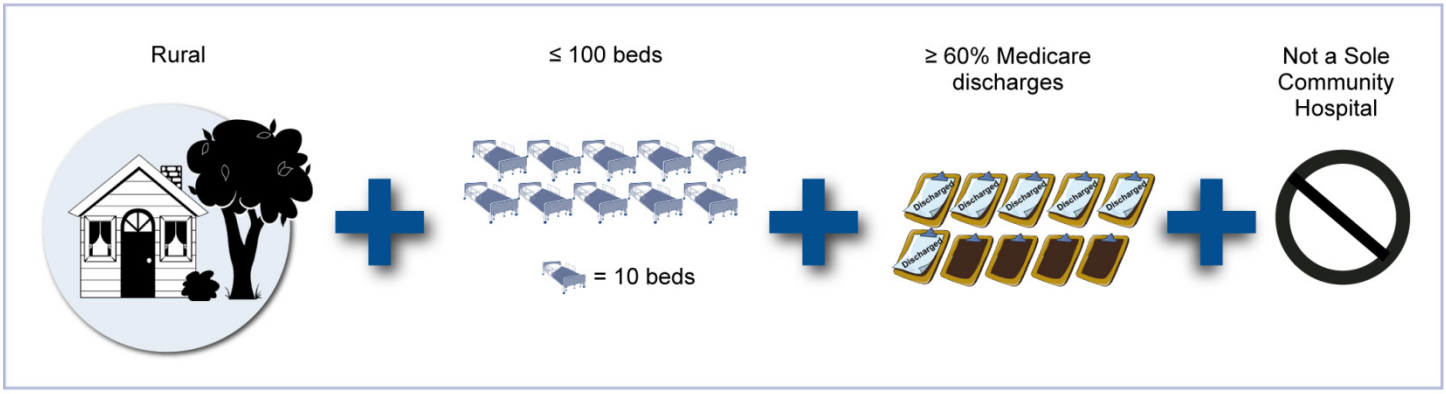
[18]See 42 U.S.C. § 1395ww(d)(5)(C)(i), (ii), 42 C.F.R. § 412.96. A hospital generally may qualify as an RRC if it is in a rural area and has at least 275 beds (subject to certain exceptions). A hospital may also qualify as an RRC if (1) it is located in a rural area, (2) the hospital demonstrates that at least 50 percent of its Medicare patients are referred from other hospitals or physicians not on the hospital's staff, (3) at least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital, and (4) at least 60 percent of the hospital services are provided to Medicare patients living more than 25 miles from the hospital.

[19]Alternatively, a hospital may also qualify as an RRC if it is located in a rural area and meets the following two criteria: (1) For discharges during the most recent fiscal year, its case-mix index is at least equal to the lower of the median for all urban hospitals nationally or the median for urban hospitals located in each region; and (2) its number of discharges is at least 5,000 or the median number of discharges for urban hospitals in the census region where the hospital is located. In addition, the hospital must meet at least one of the following three criteria: (1) More than 50 percent of its medical staff are specialists who meet certain conditions; (2) at least 60 percent of all its discharges are for individuals who live more than 25 miles from the hospital; or (3) at least 40 percent of all inpatients are referred from other hospitals or from physicians not on the hospital's staff.

Medicare-Dependent Hospitals

The MDH classification allows small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges to receive adjustments to their IPPS rates. To qualify as an MDH, a hospital has to meet various criteria regarding location, size, and patient mix, as shown in figure 3. Specifically, MDHs have to be located in a rural area, have 100 or fewer beds, show that at least 60 percent of their inpatient days or discharges were for beneficiaries entitled to Medicare Part A, and not be classified as an SCH.[20] Among other adjustments, MDHs benefit from being paid their IPPS rate plus 75 percent of the amount by which the hospital's updated historic cost per discharge exceeds the IPPS rate. Although the MDH program was originally enacted as a temporary program, it has been extended multiple times and is due to expire for discharges as of October 1, 2013.

Figure 3: Eligibility Criteria for Medicare-Dependent Hospitals



Source: GAO; Art Explosion (images).

Recent IPPS Reviews

The Institute of Medicine (IOM) and Medicare Payment Advisory Commission (MedPAC) recently evaluated the accuracy and adequacy of Medicare hospital payments. In the first of two reports, IOM—a unit of the National Academy of Sciences that addresses health policy—found that the methods CMS uses for determining how Medicare pays hospitals for the same services in different parts of the country did not accurately

[20]See 42 U.S.C. § 1395ww(d)(5)(G)(iv), 42 C.F.R. § 412.108.

reflect regional differences in expenses.[21] It noted, for instance, that the current reclassification process allows almost 40 percent of eligible hospitals to be paid according to a wage index from a labor market outside of their physical location. To improve payment accuracy, it recommended streamlining the sources and application of data used to make adjustments. In its 2012 report, MedPAC—an independent entity that advises Congress on issues affecting Medicare—reviewed the rural special payment adjustments.[22] It found that in some cases the special adjustments did not adequately target isolated small rural providers. MedPAC also reported that certain payment adjustments have overlapping purposes. It recommended using a more consistent targeted payment process to ensure that hospitals can continue to serve beneficiaries without unduly increasing Medicare program costs.[23]

Numerous Statutory Provisions Have Resulted in Increased Medicare Payments to Certain Hospitals

We identified 16 statutory provisions enacted between 1997 and 2012 that modified Medicare payment for inpatient services in a way that benefitted a subset of hospitals. These provisions allow hospitals to receive adjustments to their wage index, alter classification criteria for supplemental payments or other special treatment, or exclude hospitals from the IPPS. Most of the provisions we identified targeted rural hospitals for increased payment.[24]

[21]Institute of Medicine, *Geographic Adjustment in Medicare Payment Phase I: Improving Accuracy*.

[22]Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Healthcare Delivery System*.

[23]In addition, in a 2012 report on the effects of exceptions and adjustments to the wage index, CMS stated that modifications to the wage index have created or further exacerbated distortions in labor market values. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Report to Congress: Plan to Reform the Medicare Wage Index* (Washington, D.C.: 2012).

[24]Although a majority of the provisions we identified targeted rural hospitals, because rural hospitals tend to be smaller than urban hospitals, they are likely to receive correspondingly smaller payment increases.

Some Provisions Have Enabled Hospitals to Qualify for a Different Wage Index

We identified seven statutory provisions that have enabled hospitals to receive Medicare payment under a higher or nearby wage index. Some provisions moved hospitals in specific, named counties into different wage index areas, or set a minimum wage index for hospitals meeting certain criteria. Other provisions allow hospitals to reclassify from an urban to a rural area. Still others enable rural hospitals near urban areas to qualify for the higher wage index of the nearby area.

Rural Floor

Section 4410 of BBA established a rural floor by requiring that the area wage index for a hospital in an urban area of a state could not be less than the area wage indexes for hospitals in that state's rural area. The provision applied to patient discharges beginning in fiscal year 1998, and specified that the implementation of the rural floor must be budget neutral—that is, any changes in the wage index for hospitals subject to the floor may not increase or decrease aggregate Medicare payments for the operating costs of inpatient services.[25] Initially, this upwards adjustment only applied in states with at least one rural IPPS hospital. The rural floor provision increased the wage index for hospitals in urban areas that had been paid under a lower wage index than the rural areas of that state. In order to compensate for the increased wage indexes of urban hospitals receiving the rural floor, CMS initially applied a nationwide budget-neutrality adjustment to account for the additional payment to these hospitals.

In fiscal year 2009, CMS changed this policy and began phasing in a revised rural floor budget-neutrality adjustment that would be calculated and applied on a state-by-state basis instead of on a nationwide basis. To do so, the agency blended the nationwide and state-by-state budget neutrality formulas for fiscal year 2009 and fiscal year 2010.[26] As a result, within each state, some hospitals' wage index increased, while other hospitals' wage index decreased, in order to ensure that total Medicare payments to hospitals in that state remained the same.

[25]BBA, Pub. L. No. 105-33, § 4410, 111 Stat. 251, 402-3 (1997) (codified, as amended, at 42 U.S.C. § 1395ww note). A House of Representatives report accompanying the BBA stated that this provision addressed "an anomaly that exists with the way area wage indexes are applied which result in some urban hospitals being paid less than the average rural hospital in their states." H.R. Rep. No. 105-149 at 1305.

[26]*Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates*, 73 Fed. Reg. 48,434 (Aug. 19, 2008).

Section 3141 of PPACA reversed this policy by requiring that any adjustments to the wage index must be applied on a budget-neutral basis through a uniform national adjustment beginning in fiscal year 2011.[27] The application of the national budget-neutrality requirement has resulted in a transfer of Medicare payments from hospitals in states where no hospitals qualified for the rural floor to hospitals in states where at least one hospital qualified for this adjustment. (For information on the impact of this provision by state, see app. I.) In fiscal year 2012, the effect of this PPACA provision was that

- hospitals in seven states (Alaska, California, Colorado, Connecticut, Massachusetts, New Hampshire, and New Jersey) and Puerto Rico received increased hospital payments;
- hospitals in Massachusetts received the largest increase in payments—nearly $275 million—five times greater than New Jersey, the next largest recipient;
- to pay for the rural floor in these states, hospital payments in other states were adjusted downward by as much as 0.5 percent, with a median state reduction of $7.3 million; and
- hospitals in five states saw declines of over $20 million: New York ($47.5 million), Texas ($34 million), Florida ($29 million), Illinois ($26 million), and Michigan ($21 million).

Specific County and Area Reclassifications (Expired)

Section 152 of BBRA reclassified hospitals in seven named counties or areas, deeming them to be located in specifically named large metropolitan areas, thus enabling them to qualify for the wage index of that area.[28] This provision benefitted hospitals in these counties that competed for labor with nearby hospitals in higher wage areas. The BBRA limited this reclassification to discharges during fiscal year 2000 and fiscal year 2001. Hospitals in the following specified counties were reclassified:

[27]PPACA, Pub. L. No. 111-148, § 3141, 124 Stat. 119, 441 (2010) (codified, as amended, at 42 U.S.C. § 1395ww note).

[28]BBRA, Pub. L. No. 106-113, App. F, § 152, 113 Stat. 1501A-321, 334 (1999).

- Iredell County, North Carolina, was deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina metropolitan statistical area (MSA);
- Orange County, New York, was deemed to be part of the large urban area of New York, New York;[29]
- Lake County, Indiana, was deemed to be located in the Chicago, Illinois MSA;
- Lee County, Illinois, was deemed to be located in the Chicago, Illinois MSA;
- Hamilton- Middletown, Ohio, was deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana MSA;
- Brazoria County, Texas, was deemed to be located in the Houston, Texas MSA; and
- Chittenden County, Vermont, was deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA.

Urban to Rural Reclassification

Section 401 of BBRA allowed certain urban hospitals, beginning January 1, 2000, to request to be reclassified as rural hospitals for payment purposes under the IPPS.[30] Generally, these hospitals may seek a lower wage index in a rural area in order to receive higher payments as a rural provider type, such as an SCH. According to CMS, the provision benefits hospitals that are within an urban area, but are isolated from the metropolitan core by distance or physical features. Under the BBRA provision, to qualify for this reclassification, a hospital must submit an application and meet one of the following criteria:

[29]In explaining the reclassification of Iredell County and Orange County, a Senate committee report stated that Iredell County is still classified as rural for purposes of Medicare reimbursement, even though the county is almost completely surrounded by three MSAs. Orange County hospitals compete directly for personnel with neighboring counties that are reimbursed on the higher New York City wage index. More specifically, these hospitals receive reimbursement that is 26 percent less than neighboring counties solely based on the MSA to which it is classified. S. Rep. No. 106-199.

[30]BBRA, Pub. L. No. 106-113, App. F, § 401, 113 Stat. 1501A-321, 369 (codified, as amended, at 42 U.S.C. § 1395ww(d)(8)).

- be located in a rural portion of an MSA or an area defined as rural by the state;
- be designated as a rural hospital by the state;
- would qualify as a rural, regional, or national referral center, or as an SCH if the hospital was located in a rural area; or
- meet other criteria established by CMS.

By fiscal year 2013, 46 urban hospitals, comprising 1.3 percent of IPPS hospitals, had been reclassified by CMS as rural under this provision. Seven states—California, Florida, Missouri, New York, Pennsylvania, Texas, and Virginia—had more than two qualifying hospitals.

Outmigration Adjustment

Section 505 of MMA required that HHS establish a process, beginning in fiscal year 2005, by which the agency may increase the wage index for hospitals located in counties where potential employees commute to higher wage index areas.[31] The provision benefits hospitals located in counties where a higher than average percentage of hospital employees reside in that county but work in another county that has a higher wage index. Hospitals in qualifying counties receive an average of the differences between the higher and lower wage indexes, weighted by the percentage of hospital workers in the qualifying county who work in the higher-wage areas.

In the first year of implementation, fiscal year 2005,

- the wage index increased for 555 eligible hospitals, representing nearly 14 percent of IPPS hospitals;
- eligible hospitals had an average of 140 beds;
- California, Texas, and Michigan had the most eligible hospitals with 89, 44, and 40 hospitals, respectively;

[31]MMA, Pub. L. No. 108-173, § 505, 117 Stat. 2066, 2293 (2003) (codified, as amended, at 42 U.S.C. § 1395ww(d)(13)). The MMA imposed certain broad parameters for this provision, including limiting the adjustment determinations for 3-year periods and requiring HHS to impose criteria for the process, such as defining which counties may qualify and establishing thresholds of at least 10 percent for migration to higher wage index areas.

- Massachusetts, Michigan, and Connecticut had the most qualifying hospitals as a percentage of all hospitals in the state with 45, 31, and 29 percent, respectively; and
- Utah, Minnesota, and Georgia benefited from the largest Medicare payment adjustment as a result of their qualifying status.

Onetime Appeal of Wage Index Reclassification by the Board (Expired)

Section 508 of MMA required HHS to establish a process by January 1, 2004, so that a hospital denied a request to be reclassified to the wage index of another area in its state could submit a onetime appeal to the Board.[32] The provision required the Board to grant appeals of and reclassify qualifying hospitals, defined as those hospitals that did not originally qualify for reclassification on the basis of distance or commuting requirements but met other criteria such as quality factors, as specified by HHS. The provision limited reclassifications to a three-year period for appeals filed by February 15, 2004. The provision also capped additional Medicare expenditures resulting from these reclassifications to $900 million over the initial 3-year period. We found that, in its first year of implementation,

- 130 hospitals, or approximately 3 percent of all IPPS hospitals, qualified for this adjustment; and
- four states—Connecticut, Michigan, North Dakota, and Pennsylvania—had at least 10 qualifying hospitals each.

While originally enacted as a onetime and time-limited provision, Congress extended reclassifications made under this provision numerous times until they expired on March 31, 2012.

Frontier States

Section 10324 of PPACA established a hospital wage index floor adjustment, beginning with discharges as of fiscal year 2011, for hospitals located in frontier states.[33] The provision defined a frontier state as one in which at least 50 percent of counties have a population of fewer than 6 people per square mile and set the wage index in these areas at no lower than 1.0. In other words, while the wage index for all other states is

[32]MMA, Pub. L. No. 108-173, § 508, 117 Stat. at 2297 (codified, as amended, at 42 U.S.C. § 1395ww note).

[33]PPACA, Pub. L. No. 111-148, § 10324, 124 Stat. at 959 (codified, as amended, at 42 U.S.C. § 1395ww(d)(3)(E)).

a ratio of the average hourly hospital wage in the area to the national average, if the wage index of a frontier state is lower than the national average—or less than 1.0—this provision adjusts the wage index to 1.0. Prior to implementation, CMS projected that

- five states would meet the criteria to be designated as a frontier state: Montana, Nevada, North Dakota, South Dakota, and Wyoming;
- 48 out of 82 IPPS hospitals in those states would be eligible for a modified wage index that is at least 1.0; and
- IPPS payments would increase by approximately $50 million in the first year.

Provisions Modifying Classification Criteria for IPPS Supplemental Payments or Other Types of Special Treatment

We identified five statutory provisions that have affected the number of hospitals that qualify for IPPS supplemental payments or other types of special treatment. Most of these provisions modified the classification criteria for payment adjustments, thereby expanding the number of hospitals that qualify for higher payments.

DSH Qualifying Criteria

Section 211 of BIPA revised the Medicare threshold criteria for DSH, resulting in an increased number of hospitals qualifying for a payment adjustment.[34] Effective for discharges as of April 1, 2001, this provision allowed hospitals, regardless of location and size, to receive a DSH adjustment with a DPP of 15 percent or greater. Originally, different types of hospitals qualified for a DSH adjustment on the basis of varying DPP thresholds. For instance, urban hospitals with 100 or more beds qualified for a DSH payment with a minimum DPP of 15 percent, whereas urban hospitals with fewer than 100 beds qualified for a DSH payment adjustment with a minimum DPP of 40 percent. CMS reported that this adjustment of the DPP qualifying threshold

- added 1,191 primarily rural and small urban hospitals to those already receiving a DSH adjustment; for example, 351 additional rural hospitals with fewer than 100 beds and 244 additional urban hospitals

[34]BIPA, Pub. L. No. 106-554, App. F, § 211, 114 Stat. 2763A-463, 483 (2000) (codified, as amended, at 42 U.S.C. § 1395ww(d)(5)(F)(v)). In addition, the provision also modified the DSH payment formulas for SCHs, RRCs, small rural hospitals, and urban hospitals with fewer than 100 beds.

with fewer than 100 beds started receiving a DSH adjustment after implementation;

- would increase Medicare spending by $60 million from fiscal year 2001 through fiscal year 2002; and
- would not negatively affect any hospitals.

Section 402 of MMA modified the formulas used to calculate the DSH payment adjustment for certain hospitals, thereby increasing payments to these hospitals.[35] Specifically, effective with discharges as of April 1, 2004, the DSH adjustment formula used for large urban hospitals was applied to other types of hospitals, including SCHs, RRCs, other rural hospitals with fewer than 500 beds, and urban hospitals with fewer than 100 beds.[36] In addition, this provision capped this DSH payment adjustment at 12 percent of the hospital's IPPS rate, while exempting RRCs from this cap.[37] For instance, an urban hospital with fewer than 100 beds that qualifies for a DSH payment adjustment of 18.1 percent is capped at the maximum 12 percent payment adjustment.

Low-Volume Adjustment

Section 406 of MMA established a new payment adjustment for low-volume hospitals beginning in fiscal year 2005 that accounts for the higher costs per discharge at hospitals that admit a relatively small number of patients.[38] To qualify, hospitals had to be located more than

[35]MMA, Pub. L. No. 108-173, § 402, 117 Stat. at 2264 (codified, as amended, at 42 U.S.C. § 1395ww(d)(5)(F)).

[36]Additional provisions have modified the Medicare DSH payment adjustment for all qualifying DSH hospitals, not a subset, and are, therefore, not included in our scope. For example, section 3133 of PPACA permanently reduces Medicare DSH payments by 75 percent beginning in fiscal year 2014 and provides DSH hospitals with additional payments based on a formula that includes certain factors such as the hospital's reduction in DSH funds, percentage change in the uninsured under 65 population, and uncompensated care provided by the hospital. 42 U.S.C. § 1395ww(r). According to CMS, this provision is estimated to save the Medicare program approximately $50 billion through fiscal year 2019.

[37]Section 5003 of the Deficit Reduction Act of 2005 also exempted MDHs from the 12 percent cap, effective for discharges as of fiscal year 2007. Pub. L. No. 109-171, § 5003(d), 120 Stat. 4, 31 (2006) (codified, as amended, at 42 U.S.C. § 1395ww(d)(5)(F)(xiv)(II)).

[38]MMA, Pub. L. No. 108-173 § 406, 117 Stat. at 2269 (codified, as amended, at 42 U.S.C. § 1395ww(d)(12)).

25 miles from another hospital and have fewer than 800 total discharges annually. The provision required CMS to determine, on the basis of empirical data, applicable percentage increases, not to exceed 25 percent, in payments for qualifying low-volume hospitals.[39] CMS explained in issuing the final rule implementing this MMA provision that the agency analyzed data and determined that hospitals with fewer than 200 discharges a year have sufficiently higher costs relative to payments to justify receiving a payment adjustment, but that hospitals with 200 to 800 discharges a year did not. CMS provided the maximum 25 percent payment adjustment only to those qualifying hospitals that were located more than 25 miles from another hospital and had fewer than 200 discharges in a given year. CMS reported that

- CBO estimated this provision would increase Medicare program expenditures by less than $50 million annually, and
- only three hospitals—one located in Florida and two located in South Dakota—received a low-volume payment adjustment in fiscal year 2005. All were small (30 or fewer beds) rural hospitals classified as SCHs.

Section 3125, as amended by section 10314, of PPACA temporarily revised the qualifying criteria for a low-volume hospital designation making it easier for hospitals to receive the payment adjustment.[40] Effective for fiscal year 2011 and fiscal year 2012,[41] this provision decreased the required distance from the nearest hospital from 25 miles to 15 miles. In addition, it changed the maximum number of annual discharges allowed from 800 total patients to 1,600 Medicare Part A beneficiaries. The provision also required that payment adjustments for qualifying low-volume hospitals be calculated using a continuous sliding

[39]The provision effectively gave CMS the authority to set the maximum number of discharges hospitals could have in a given year to receive a payment adjustment, as long as it was fewer than 800 total discharges.

[40]PPACA, Pub. L. No. 111-148. §§ 3125, 10314, 124 Stat. at 425, 944 (codified, as amended, at 42 U.S.C. § 1395ww(d)(12)).

[41]Section 605 of the American Taxpayer Relief Act of 2012 extended these payment adjustments through fiscal year 2013. Pub. L. No. 112-240, § 605, 126 Stat, 2313, 2349 (2012) (to be codified at 42 U.S.C. § 1395ww(d)(12)). According to CBO, this provision was estimated to increase Medicare spending by $300 million in fiscal year 2013.

scale, paying up to an additional 25 percent to hospitals with 200 or fewer annual Medicare Part A discharges.

As a result of these changes, both the number of hospitals receiving the low-volume payment adjustment and the estimated Medicare expenditures rose substantially. CMS reported that

- over the 2-year period, fiscal year 2011 and fiscal year 2012, the provision was estimated to cost Medicare approximately $880 million; and
- the number of hospitals that received a payment adjustment rose to approximately 645—or about 18 percent of IPPS hospitals—in fiscal year 2011 from 3 hospitals the year before.

We found that, in fiscal year 2011,

- at least 40 percent of IPPS hospitals in each of 6 states received a low-volume adjustment: Wyoming (67 percent), Vermont (50 percent), New Mexico (43 percent), Minnesota (42 percent), Alabama (41 percent), and Mississippi (41 percent); and
- recipient hospitals were relatively small,[42] predominately located in rural areas, and likely to also receive a DSH payment adjustment.

MDH Qualifying Criteria

Section 212 of BIPA modified one aspect of the MDH classification criteria. Effective for cost reporting periods beginning April 1, 2001, it changed the data source used to determine whether at least 60 percent of a hospital's discharges were Medicare beneficiaries. This provision allowed a hospital to base this determination on two of the three most recently audited fiscal year cost reporting periods.[43] Prior to this change, discharge data were based on cost reporting periods beginning in 1987.

This provision did not initially have a significant effect on the number of qualifying hospitals or on Medicare payments. CMS estimated that a total of 139 hospitals—all of which had previously been designated as

[42]These hospitals had an average bed size of 55, compared to a Medicare-wide IPPS hospital average bed size of 183.

[43]BIPA, Pub. L. No. 106-554, App. F, § 212, 114 Stat. at 2763A-485 (codified, as amended, at 42 U.S.C. § 1395ww(d)(5)(G)(iv)(IV)).

MDHs—would qualify as an MDH using this revised data source. The agency further estimated that Medicare would spend an additional $10 million in the first year of implementation. It is likely that this provision had a greater effect on the number of hospitals qualifying for an MDH classification in later years because it allowed hospitals to use recent, rather than outdated, cost reports.

Provisions Creating and Modifying Qualifying Criteria for CAHs

In 1997, Congress established the Critical Access Hospital (CAH) program, under which qualifying small rural hospitals are excluded from the IPPS and receive Medicare payment based on the reasonable costs of providing services.[44] In effect, CAHs receive higher payments for providing services to Medicare beneficiaries than they would under the IPPS. Specifically, section 4201 of BBA allowed states to apply for approval to create a Medicare Rural Hospital Flexibility program (Flex Program), under which states must designate at least one hospital as a CAH.[45] To be designated as a CAH, hospitals had to meet the following qualifying criteria:

- type of organization: nonprofit or public hospital;
- services: must provide 24-hour emergency services deemed necessary for ensuring access in each area served by the CAH;
- location: rural county or other rural area in states with approved Flex Programs;
- size: no more than 15 acute care inpatient beds;
- average inpatient stay: no more than 4 days (subject to certain exceptions)
- patient access: (a) located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous

[44]BBA, Pub. L. No. 105-33, § 4201, 111 Stat. at 369 (codified, as amended, at 42 U.S.C. §§ 1395f(l), 1395i-4).

[45]CAHs are an outgrowth of the Medicare Assistance Facility Demonstration Project in Montana and the seven-state Essential Access Community Hospital/Rural Primary Care Hospital demonstration program established by Congress in 1989. The BBA replaced these initiatives in 1997 with the state-administered Flex Program.

terrain or only secondary roads, or (b) designated by the state as a necessary provider of health care services to residents in the area.

Prior to implementation, CMS reported that approximately 51 facilities in seven states—those participating in the demonstration program that preceded the CAH program—would be eligible to become CAHs. While the CAH program was expected to grow, CMS was not able to estimate reliably how many additional states would choose to participate or the potential cost of the CAH program to Medicare.

Section 403 of BBRA made a number of changes to qualifying criteria for the CAH program.[46] First, the provision changed the inpatient length of stay requirement from a maximum of 4 days to an annual average of 4 days. Second, the provision removed the requirement that eligible hospitals must be nonprofit or public, allowing for-profit hospitals to qualify as CAHs, if so approved by their state. Third, the provision permitted a state to designate as a CAH not only a currently operating hospital, but closed facilities or facilities that were previously hospitals but currently operate as a state-licensed health clinic or health center, if the facilities meet all other criteria.[47] Data indicate that in the 2 years following the enactment of BBRA in 1999, 411 hospitals were newly designated as CAHs.

Section 405 of MMA made further changes to the CAH program, which included alterations to the qualifying criteria.[48] First, the provision permanently increased the bed limit for CAHs from 15 beds to 25 beds. Second, it allowed CAHs to establish separate inpatient rehabilitation or psychiatric care units with no more than 10 beds, with such services paid under the relevant prospective payment system (rather than the CAH

[46]BBRA, Pub. L. No. 106-113, App. F, § 403, 113 Stat. at 1501A-370 (codified, as amended, at 42 U.S.C. § 1395i-4(c)(2)).

[47]A House of Representatives committee report discussing this provision explained that it would strengthen and provide increased flexibility for the CAH program, and a Senate committee report added that the change to an annual 4 day length of stay average would provide increased flexibility and choice for rural health care delivery setting. The provision also eliminates increased administrative burdens for these providers. See H.R. Rep. No. 106-436 at 68, S. Rep. No. 106-199 at 27.

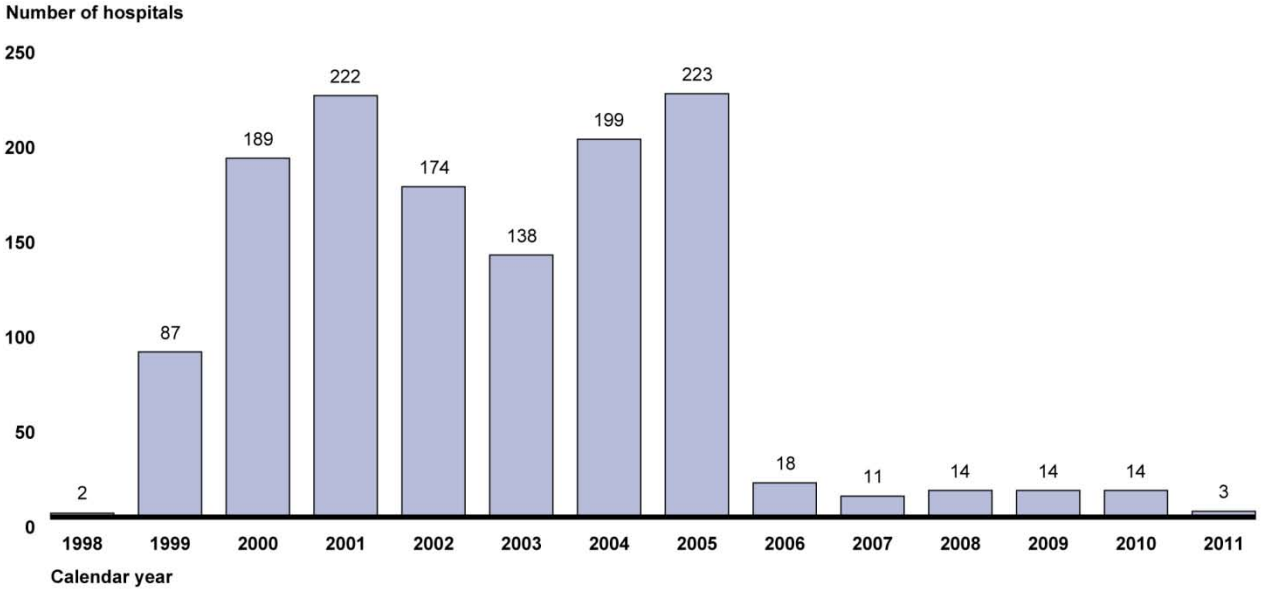
[48]See MMA, Pub. L. No. 108-173, § 405(e), (g), (h), 117 Stat. at 2266 (codified, as amended, at 42 U.S.C. § 1395i-4(c)(2), (h)).

reasonable cost basis).[49] Third, effective January 1, 2006, the provision eliminated the ability of a state to designate a hospital as a necessary provider, so that states could no longer waive the 35-mile distance requirement to designate a hospital as a CAH. However, the provision grandfathered all CAHs that had already received their CAH status by being designated as a necessary provider.

CBO estimated that these changes to the CAH program under this provision would increase Medicare program expenditures by approximately $100 million annually, according to CMS. Data show that in 2004 and 2005, the 2 years following enactment of MMA, 422 new CAHs joined the program. However, the number of new CAH designations dropped sharply in 2006 with the elimination of the necessary provider designation. (See fig. 4.)

[49]In 2003, we reported that among the existing 620 CAHs at the time, 25 previously operated an inpatient rehabilitation or psychiatric care unit but had to close as part of becoming a CAH. In addition, we identified 683 rural hospitals as "potential CAHs" on the basis of their having an annual average of no more than 15 acute care patients per day. About 14 percent (93) of these potential CAHs operated a rehabilitation or psychiatric care unit and about half of those 93 potential CAHs had a net loss on Medicare services, indicating that they might benefit from becoming a CAH. See GAO, *Medicare: Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered*, GAO-03-948 (Washington, D.C.: Sept. 19, 2003).

Figure 4: Number of Hospitals Newly Designated as Critical Access Hospitals (CAH), 1998-2011



Source: Flex Monitoring Team.

Note: A small number of hospitals were designated as CAHs prior to 1998. No new hospitals were designated as CAHs from January 1, 2012, through June 30, 2012.

The CAH program has grown to a total of 1,328 hospitals as of 2012.[50] The majority of CAHs have the maximum 25 inpatient beds. In addition, CAHs are largely concentrated in the central states, although all but five states have at least one CAH.[51] We found that the states with the largest percentage of hospitals designated as CAHs are North Dakota and Montana, with about 84 percent and 79 percent, respectively. (See fig. 5.) Furthermore, according to MedPAC, 17 percent of CAHs are 35 or more miles from the nearest hospital, 67 percent are between 15 miles and 35 miles from the nearest hospital, and 16 percent of CAHs are fewer

[50]According to MedPAC, the CAH payment system resulted in approximately $2 billion in higher payments to CAHs in 2010 than to hospitals receiving prospective payment for the same inpatient and outpatient services.

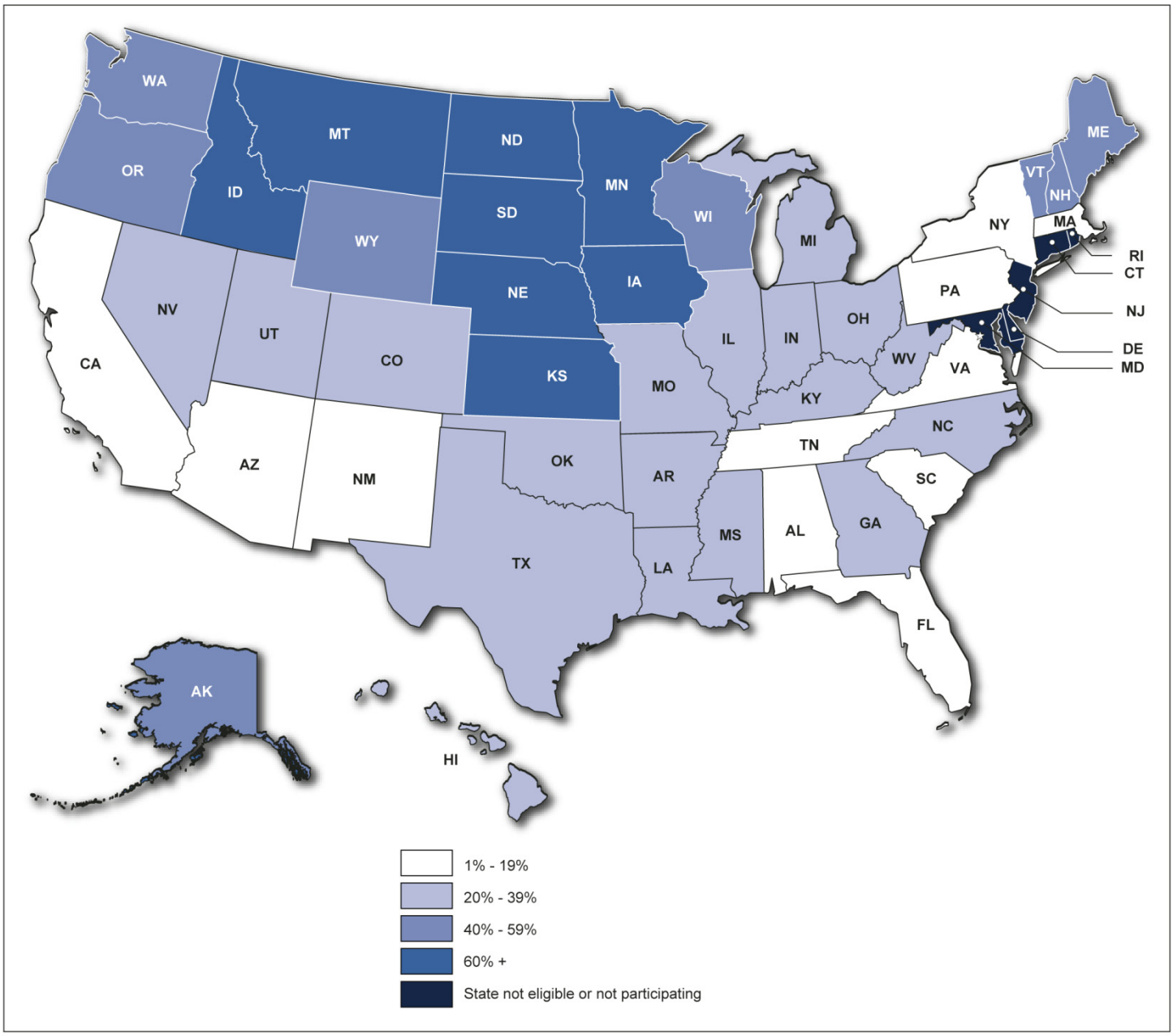
[51]Five states—Connecticut, Delaware, Maryland, New Jersey, and Rhode Island—do not participate in the Flex Program and, therefore, may not designate any hospitals in those states as CAHs.

than 15 miles from the nearest hospital.[52] These data indicate that not all CAHs meet current qualifying criteria.[53]

[52]MedPAC, *Report to the Congress: Medicare and the Healthcare Delivery System*.

[53]According to its fiscal year 2013 work plan, HHS's Office of the Inspector General announced plans to review CAHs to profile variation in size, services, and distance from other hospitals, among other things.

Figure 5: Percent of Each State's Hospitals Designated as Critical Access Hospitals (CAH), June 2012



Source: GAO analysis of CMS and Flex Monitoring Team data; Map Resources (map).

Provision for Other Forms of Increased Medicare Payment (Expired)

Section 1109 of HCERA authorized $400 million in Medicare payments to qualifying hospitals in low-spending counties over 2 years, fiscal year 2011 and fiscal year 2012.[54] This provision defined qualifying hospitals as acute care hospitals located in a county that ranked within the lowest quartile of age, sex, and race adjusted spending per beneficiary enrolled in fee-for-service Medicare parts A and B. CMS allocated the additional payments to each qualifying hospital in proportion to its share of Medicare inpatient payments for all qualifying hospitals, based on fiscal year 2009 IPPS payments for operating expenses. In implementing this provision,

- CMS made payments to about 400 hospitals, which accounted for 11 percent of all IPPS hospitals and approximately 8 percent of IPPS beds;
- Medicare expenditures increased $150 million in fiscal year 2011 and $250 million in fiscal year 2012;
- on average, qualifying hospitals had 135 to 137 beds;
- half of qualifying hospitals were in urban areas and half were in rural areas; and
- states with the most hospitals receiving this payment were New York (50 hospitals), Wisconsin (40 hospitals), Virginia (31 hospitals), Oregon (21 hospitals), and Iowa (20 hospitals).

IPPS Payment Adjustments or Exclusions Affected Nearly All Hospitals

We found that, in 2012, payment adjustments to, or exclusions from, the IPPS affected nearly all of the 4,783 hospitals in our review.[55] Of these hospitals—IPPS hospitals and CAHs—91 percent were subject to a payment adjustment under the IPPS or were excluded from the IPPS entirely. Specifically,

- 3,039 hospitals, or over 63 percent, qualified for at least one of the following four types of payment adjustments under the IPPS: a DSH

[54]HCERA, Pub. L. No. 111-152, § 1109, 124 Stat. 1029, 1051 (codified, as amended, at 42 U.S.C. § 1395ww note).

[55]For the number of hospitals qualifying for each rural provider type adjustment and as CAHs, see app. II.

adjustment, an IME adjustment, a wage index adjustment, or a rural provider type adjustment for an RRC, SCH, or MDH designation;

- 1,328 hospitals, or about 28 percent, qualified as CAHs, excluding them from the IPPS; and
- 416 hospitals, or about 9 percent, received IPPS payments that were unadjusted for the modifications included in our review.

Among the 3,455 IPPS hospitals, the vast majority qualified for one of the four categories of upward payment adjustment in 2012. The DSH adjustment had the broadest reach, affecting payments to about 4 in 5 of IPPS hospitals. Nearly 1 in 3 hospitals qualified for an IME adjustment, 1 in 3 qualified for a wage index adjustment, and almost 1 in 5 received a rural provider type adjustment. Each of these categories of increased payment benefited hospitals in both urban and rural areas. The DSH and IME adjustments applied mostly to urban hospitals' payments, whereas the wage index adjustment was applied to more rural hospitals' payments. Although rural provider type adjustments generally supported payment to rural hospitals, about 20 percent of recipients were urban hospitals.[56] (See table 1.)

[56]According to CMS, urban hospitals may qualify for a rural provider type adjustment in one of three ways. An urban hospital may qualify as an SCH if it is located more than 35 miles from other like hospitals (not including CAHs). A hospital may remain an SCH, MDH, or RRC through grandfathering if it is located in an area redesignated as urban after the hospital received its rural provider type designation. Finally, a hospital may apply for redesignation into a rural wage index area by meeting certain criteria.

Table 1: Inpatient Prospective Payment System (IPPS) Hospitals Qualifying for Additional Medicare Payments by Category and Location, 2012

	Categories of hospital payment adjustments			
Hospitals by location[a]	**Disproportionate share hospital (DSH)**	**Indirect medical education (IME)**	**Wage index**	**Rural provider type[b]**
Large urban area hospitals	999	581	210	16[c]
Other urban area hospitals	897	389	258	112[c]
Rural hospitals	859	61	559	519
Total	**2,755**	**1,031**	**1,027**	**647**

Source: GAO analysis of CMS data.

Notes: CMS made these estimates in July 2012 for payments in 2013. These types of increased payment are not mutually exclusive, so a hospital could qualify for more than one type of increased payment.

[a]Large urban areas have a population of at least 1 million; other urban areas have a population of fewer than 1 million; all areas not defined as urban are considered rural. In July 2012, there were 1,374 hospitals in large urban areas, 1,132 hospitals in other urban areas, and 949 hospitals in rural areas.

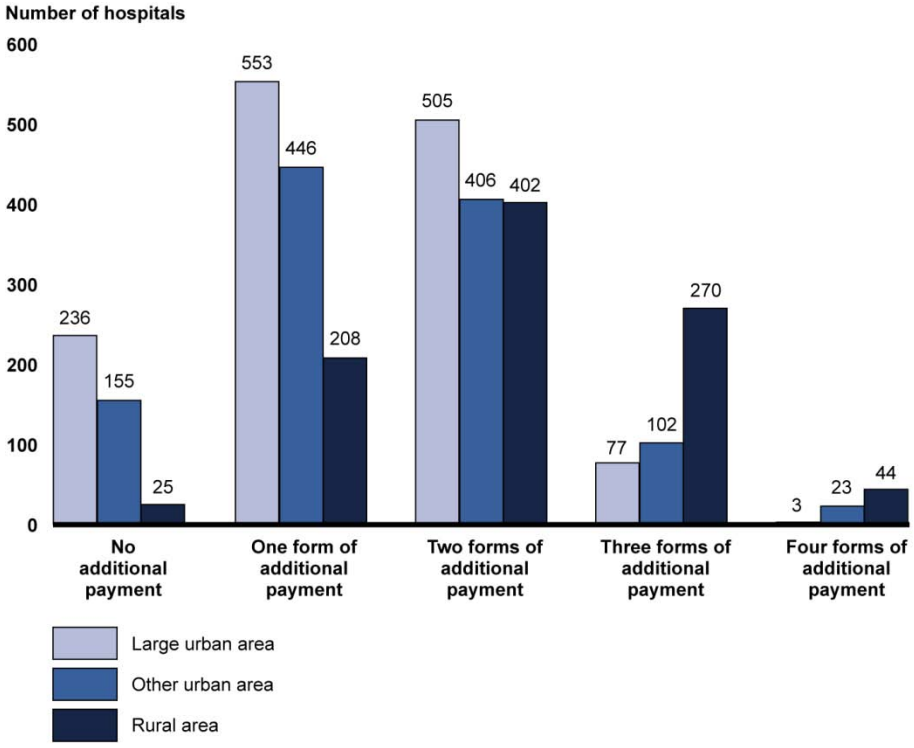
[b]Data on rural provider types exclude Medicare-dependent hospitals (MDH) because at the time, the program was set to expire on September 30, 2012. However, the American Taxpayer Relief Act of 2012 extended the program until October 1, 2013.

[c]Hospitals may be included through grandfathering, reclassification from an urban wage index area to a rural wage index area, or modified access requirement (such as being located more than 35 miles from other like hospitals).

Among the 3,039 IPPS hospitals receiving additional payment, the majority qualified for more than one category of payment adjustment. In 2012, roughly half of IPPS hospitals received two forms of adjustments and 13 percent qualified for three forms of adjustments. Two percent of IPPS hospitals qualified for four forms of adjustments, but no state had more than 10 hospitals qualifying for four forms of increased payment. The remaining IPPS hospitals, almost a third of the total, qualified for a DSH adjustment alone. By location, we found that most hospitals in urban areas qualified for one or two forms of increased payment, whereas most hospitals in rural areas qualified for two or more forms of additional pay. (See fig. 6.)

Of the 416 hospitals that did not qualify for IPPS payment adjustments, nearly all were in urban areas and were distributed across most states. Generally, they were substantially smaller than the average urban hospital, typically having 98 beds compared to 224 beds.

Figure 6: Inpatient Prospective Payment System (IPPS) Hospitals Qualifying for No, One, or Multiple Forms of Payment Adjustments, by Location, 2012



Source: GAO analysis of CMS data.

Note: The number of IPPS hospitals totaled 3,455. CMS made these estimates in July 2012 for payments in 2013. Large urban areas have a population of at least 1 million. Other urban areas have a population of fewer than 1 million. The four forms of IPPS hospitals payment adjustments include wage index reclassification, indirect medical education (IME) payment, disproportionate share hospital (DSH) adjustment, or rural provider type adjustment.

The multiple types of adjustments to Medicare payments vary in their financial effect, and can substantially affect a hospital's revenue. Take, for example, a beneficiary who undergoes coronary bypass surgery with angioplasty and has a major complication or comorbidity. When this surgery is performed at a teaching hospital in a large urban area that treats a high percentage of low-income patients, the total operating payment from Medicare comes to about $63,600.[57] Specifically, in fiscal

[57]The IPPS per-discharge payment is comprised of two parts: one that provides for operating expenses and another for capital expenses. This calculation is only for the operating payment.

year 2013, the IPPS operating base rate for that case, adjusted for the local wage index, is approximately $41,500. Added to that amount is about $14,100 for IME and roughly $8,000 for Medicare DSH. Thus, the two payment adjustments increase the amount this hospital would receive for this discharge by more than 50 percent.

Concluding Observations

The IPPS streamlines how Medicare pays hospitals and gives hospitals an incentive to economize by paying a fixed amount, set in advance. Over time, however, numerous statutory provisions have been enacted that provide, grandfather, or extend additional payments to IPPS hospitals or exclude a substantial number of hospitals from the IPPS altogether. This piecemeal approach to modifying the original IPPS—a patchwork of individual "fixes"—has had the cumulative effect of most hospitals receiving modifications and add-ons to the basic payment formula that increase Medicare spending. In fact, over 90 percent of hospitals were subject to either IPPS payment adjustments or exemptions in 2012. These changes address characteristics of the hospital market such as competition for labor, challenges to rural hospitals, and the need to support Medicare-participating hospitals in certain markets. In addition, organizations such as IOM and MedPAC have recently made recommendations to strengthen the data used in geographic adjustments, and to hone the targeting of rural special payment adjustments. Taken together, these findings and recommendations suggest that, 30 years after the IPPS was implemented, the way Medicare currently pays hospitals may no longer ensure that the goals of the payment system—cost control, efficiency, and access—are being met.

Agency Comments

HHS reviewed a draft of this report and did not have any general comments. The agency provided technical comments, which we incorporated where appropriate.

As we agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from its date. We will send copies of this report to the Secretary of Health and Human Services. The report will also be available at no charge on our website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

James Cosgrove
Director, Health Care

Appendix I: Estimated Effect of Nationwide Budget Neutrality of Rural Floor on Hospital Payments by State, Fiscal Year 2012 and 2013

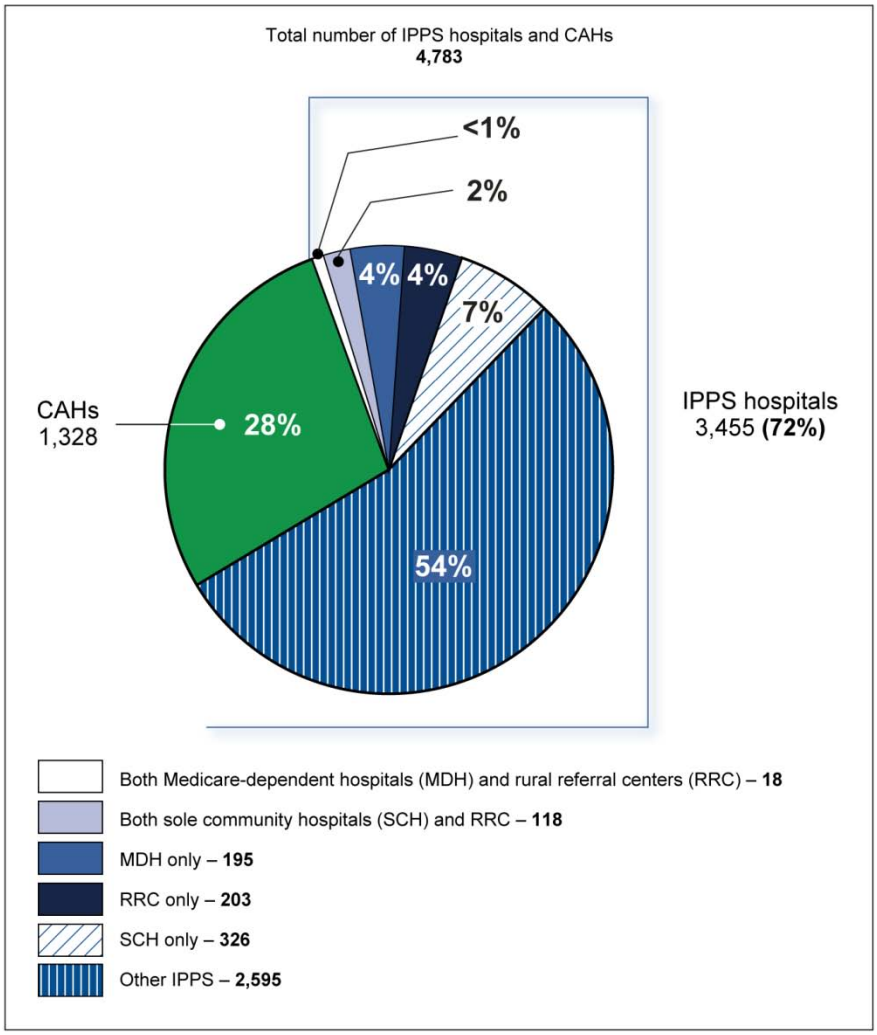
	Fiscal year 2012				Fiscal year 2013			
State	Number of hospitals	Number of hospitals receiving rural floor or imputed floor	Percent change in payments	Difference (in millions of dollars)	Number of hospitals	Number of hospitals receiving rural floor or imputed floor	Percent change in payments	Difference (in millions of dollars)
Massachusetts	61	60	8.7%	$274.8	61	60	5.7%	$188.0
California	308	100	0.2	20.3	311	180	0.9	98.5
Arizona	57	0	-0.5	-8.8	58	45	1.7	31.4
Connecticut	32	12	1.9	30.0	32	11	1.0	16.7
New Jersey	67	39	1.4	54.2	65	29	0.4	14.4
New Hampshire	13	9	1.5	6.3	13	9	2.1	10.0
Colorado	46	7	0.4	4.3	46	7	0.5	5.8
Alaska	6	4	1.7	2.3	6	4	1.5	2.3
Rhode Island	11	0	-0.6	-2.2	11	4	0.5	2.1
Puerto Rico	51	12	0.1	0.1	52	13	0.1	0.1
Wyoming	11	0	0.0	0.0	11	0	-0.1	-0.2
North Dakota	6	0	-0.3	-0.8	6	4	-0.2	-0.6
Montana	12	1	-0.3	-0.8	12	1	-0.3	-0.7
Vermont	6	0	-0.3	-0.6	6	0	-0.3	-0.7
South Dakota	19	0	-0.3	-0.9	18	0	-0.3	-0.8
Idaho	15	0	-0.4	-1.0	14	0	-0.3	-1.0
Hawaii	14	0	-0.4	-1.1	14	0	-0.4	-1.1
New Mexico	28	0	-0.3	-1.6	27	0	-0.3	-1.5
Utah	32	2	-0.4	-1.7	32	0	-0.4	-1.8
Delaware	5	0	-0.5	-2.0	6	0	-0.5	-2.1
Maine	20	0	-0.4	-2.1	20	0	-0.5	-2.4
Nebraska	23	0	-0.4	-2.4	23	0	-0.4	-2.5
Washington, DC	7	0	-0.5	-2.5	7	0	-0.5	-2.5
West Virginia	32	3	-0.3	-2.2	33	2	-0.3	-2.9
Nevada	24	0	-0.5	-3.7	24	4	-0.4	-3.2
Kansas	55	1	-0.4	-3.5	55	0	-0.4	-3.5
Oregon	33	3	-0.4	-3.5	33	0	-0.5	-4.1
Iowa	34	5	-0.3	-3.0	34	0	-0.4	-4.4
Wisconsin	64	2	-0.4	-6.4	65	8	-0.3	-5.0
Arkansas	47	0	-0.4	-5.0	45	0	-0.5	-5.2
Mississippi	64	0	-0.5	-5.6	66	0	-0.4	-5.5

	Fiscal year 2012				Fiscal year 2013			
State	Number of hospitals	Number of hospitals receiving rural floor or imputed floor	Percent change in payments	Difference (in millions of dollars)	Number of hospitals	Number of hospitals receiving rural floor or imputed floor	Percent change in payments	Difference (in millions of dollars)
Oklahoma	85	2	-0.4	-5.7	85	0	-0.4	-5.7
South Carolina	55	0	-0.4	-7.2	56	5	-0.3	-5.9
Washington	48	2	-0.4	-7.3	48	5	-0.3	-6.3
Louisiana	97	10	-0.5	-7.2	98	7	-0.4	-7.1
Tennessee	99	11	-0.3	-7.7	97	10	-0.3	-7.4
Alabama	95	6	-0.4	-7.5	96	3	-0.4	-8.2
Kentucky	65	1	-0.4	-8.5	65	0	-0.4	-8.4
Minnesota	51	0	-0.5	-8.1	51	0	-0.5	-8.6
Virginia	81	2	-0.4	-10.8	79	1	-0.4	-10.1
Missouri	80	4	-0.4	-10.5	76	2	-0.4	-10.9
Indiana	89	1	-0.5	-11.1	89	0	-0.5	-11.7
Georgia	108	0	-0.5	-13.0	108	0	-0.4	-12.7
Ohio	138	9	-0.4	-15.8	139	8	-0.4	-15.0
North Carolina	89	4	-0.4	-15.5	88	0	-0.4	-16.4
Pennsylvania	152	16	-0.4	-17.3	154	14	-0.4	-17.5
Michigan	100	0	-0.5	-21.4	96	0	-0.5	-21.2
Illinois	130	0	-0.5	-26.3	130	8	-0.5	-26.2
Florida	168	5	-0.4	-29.1	169	8	-0.4	-28.3
Texas	320	4	-0.5	-34.0	325	2	-0.4	-33.0
New York	170	2	-0.5	-47.5	168	0	-0.5	-46.8

Source: CMS.

Appendix II: Hospitals by Provider Type

Figure 7: Distribution of Inpatient Prospective Payment System (IPPS) Hospitals and Critical Access Hospitals (CAH), by Provider Type, 2012



Source: CMS.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, Rosamond Katz, Assistant Director; Alexander Galuten; Katherine Perry; Kathryn Richter; and Hemi Tewarson made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Please Print on Recycled Paper.