APPENDIX C

Inpatient payments for rural hospitals

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As discussed in Chapter 2A on payment adequacy and updates for hospital payments, MedPAC previously issued four recommendations designed to improve payments for rural hospitals that have been considered by the Congress but not yet enacted (MedPAC 2001a, MedPAC 2002). We are reissuing these recommendations. Chapter 2A summarizes the four recommendations, their rationales, and their combined impact on Medicare inpatient payments. This appendix provides additional background, explanation, and support for the four recommendations, as well as impact estimates for each individual policy change.

The four recommendations would:

- implement a low-volume adjustment to the inpatient base rates;
- reevaluate (with an eye toward reducing) the labor share (which determines the portion of the base payment rate that is adjusted by each area's wage index value);
- eliminate the differential in base rates between hospitals in large urban areas (defined as a population above 1 million) and those in other urban and rural areas; and
- raise the cap on most rural hospitals' disproportionate share (DSH) payments.

Implementing a low-volume adjustment

Making Medicare payments approximate an efficient provider's costs requires accounting for factors beyond providers' control that may affect the costs of furnishing services. Patient volume may be one such factor, particularly in small and isolated communities where providers frequently cannot achieve the economies of scale of their larger counterparts, and thus have higher per case costs. The current prospective payment system (PPS) rates do not directly account for the relationship between cost and volume, placing low-volume providers at a financial disadvantage.

The critical access hospital (CAH), sole community hospital, and Medicare-dependent hospital programs benefit many small and isolated hospitals, even though these programs do not directly address the small-scale issue. Eligibility for these programs is not well targeted to low-volume hospitals, however, and payments are based at least partially on hospital-specific costs, which may reflect poor management and other provider inefficiencies. A low-volume adjustment could address these issues more directly; for that reason, MedPAC recommends that the Congress enact such an adjustment.

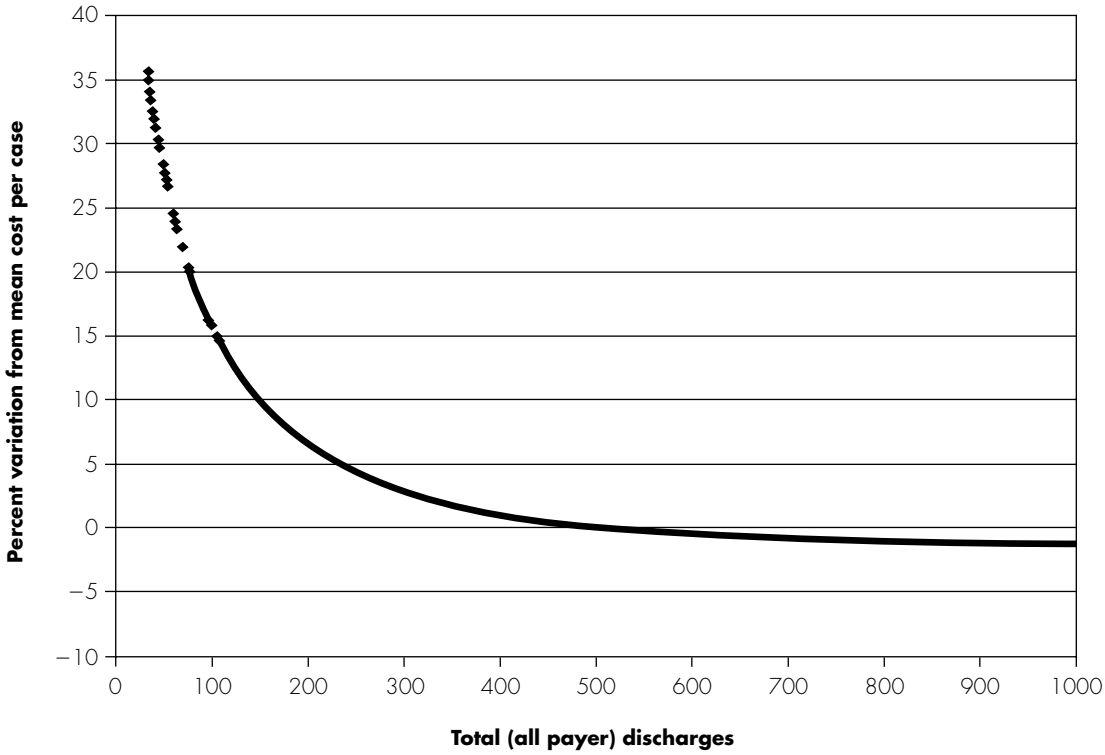
Effects of low volume on costs and financial performance

To determine whether low-volume hospitals have higher costs than other hospitals, we examined the relationship between total (all payer) inpatient volume and Medicare costs per discharge.[1] Our analysis showed a statistically significant relationship between discharge volume and costs per discharge, after controlling for cost-related factors in the payment system.[2] The volume and cost relationship is most pronounced for facilities with fewer than 200 discharges per year

1 Although Medicare payments are intended to cover the costs of treating Medicare patients, a hospital's total volume of service determines its unit costs of production.

2 These factors include case mix as measured by diagnosis related groups, base rate (separate for hospitals in large urban areas and those in other urban and rural areas), area wage index value, outlier frequency, and teaching intensity.

FIGURE C-1 **Hospital discharge volume and hospital cost per case, 1997**



Source: MedPAC analysis of cost report and MedPAR data from CMS.

(Figure C-1), which have per case costs that are more than 20 percent above average. The relationship becomes relatively flat after about 500 discharges.

Low-volume hospitals account for only a small fraction of acute care facilities; 2 percent of hospitals have fewer than 200 discharges and 11 percent have fewer than 500 discharges. The vast majority of these facilities—85 percent—are in rural counties.

Hospitals' financial performance under Medicare's inpatient PPS is strongly related to inpatient volume: Margins rise as volume increases (Table C-1). The aggregate inpatient margin is negative for hospitals with 500 or fewer discharges, while hospitals in larger-volume groups have margins ranging from 5 to 17 percent.[3] This strongly indicates that low-

TABLE C-1 **Medicare inpatient margin, by discharge volume, 1999**

Total discharges	Margin	Percent of hospitals with negative margin
< 200	−16.4%	66.7%
201 to 500	−2.1	50.2
501 to 1,000	4.6	39.0
1,001 to 2,500	5.0	37.7
2,501 to 5,000	6.5	32.7
5,001 to 10,000	10.1	24.0
10,001 to 20,000	12.3	19.4
> 20,000	17.4	7.4

Note: The Medicare inpatient margin reflects the change in disproportionate share payments enacted by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Analysis based on data from two-thirds of the hospitals covered by prospective payment in 1999, which includes some that have since been designated critical access hospitals.

Source: MedPAC analysis of cost report and MedPAR data from CMS.

3 We show the Medicare inpatient margin for this calculation, despite the fact that it overstates hospitals' financial performance under Medicare in the absolute, because it is inpatient costs that are affected by a hospital's volume of discharges.

volume providers are disadvantaged by rates based on average volume and that current programs targeted to rural providers do not fully correct for this problem.

Access considerations

The issue of a low-volume adjustment is most critical for isolated hospitals, where the facility is important for maintaining beneficiaries' access to care. Such facilities, because of their market circumstances, have little ability to grow and take advantage of economies of scale and scope of services realized by larger facilities. Adjusting payments for a low-volume facility that is near other facilities, on the other hand, is not a priority because beneficiaries' access to care is less likely to be affected. In fact, the close proximity of other hospitals may be one of the primary reasons for the hospital's low volume of service.

Low-volume hospitals are more isolated than those with higher volume, but most low-volume hospitals would not meet the 35-mile distance standard used for designating sole community hospitals. Just over half of low-volume hospitals are more than 25 road miles from the nearest hospital, and 86 percent have no potential competitors within 15 miles.

RECOMMENDATION 2A-2:

The Congress should enact a low-volume adjustment to the rates used in the inpatient PPS. This adjustment should apply only to hospitals that are more than 15 miles from another facility offering acute inpatient care.

The Commission believes that a low-volume adjustment would strengthen the current inpatient PPS by aligning payments better with efficient providers' costs. The adjustment should reflect the basic underlying relationship between patient volume and costs per discharge, avoiding cliffs (points in the formula where a small change in volume would produce a large change in payment) that might provide inappropriate incentives.

To avoid problems with annual volume variation and to encourage stability in the level of the adjustment over time, the volume adjustment should be set for an individual facility based on a multiyear average volume. The level of the adjustment should be periodically reexamined to reflect improvements made in the inpatient PPS that might affect the measured relationship between volume and cost.[4]

To illustrate the financial impact of a low-volume adjustment, we simulated an adjustment that increases payments by up to 25 percent and drops to zero for hospitals with 500 or more discharges.[5] This formula, for example, would provide a 20 percent increase in payments for hospitals with 100 discharges and a 10 percent increase for those with 300 discharges. We limited the add-on to hospitals more than 15 miles from the nearest acute care facility. About 10 percent of all PPS hospitals would qualify, and about a quarter of these already receive some assistance from the sole community or Medicare-dependent program but would benefit more from the low-volume adjustment. The increase in payments probably would enable some critical access hospitals to come back into the PPS (if these facilities were allowed to reverse their CAH status), because the adjusted base payment rate would better reflect their underlying cost structure.[6] Similarly, many hospitals might decide not to become CAHs if a low-volume adjustment were available.

Reevaluating the labor share used in geographic adjustment

The labor share, which CMS revises periodically in updating the market basket index, is an estimate of the national average proportion of hospitals' costs associated with inputs directly or indirectly affected by local wage levels. The labor share is used to determine the portion of the PPS base payment rate to which the wage index is applied for geographically adjusting rates. For inpatient hospital services, CMS has set the labor share at 71.1 percent—its estimate of the share of hospitals' total expenses comprising wages and salaries, fringe benefits, and other labor-related cost elements using locally purchased inputs (Table C-2). For reasons detailed

TABLE C-2 **Components of national labor share for inpatient care**

Category	Share
Total labor-related	71.1%
Wages and salaries	50.2
Employee benefits	11.2
Nonmedical professional fees	2.1
Postage	0.3
All other labor-intensive	7.3

Note: All other labor-intensive includes business services, computer processing, landscape and horticultural services, building maintenance and repair, laundry services, auto repair, payments to membership organizations, appliance repair, and indirect business taxes.

Source: CMS analysis of hospital data from Medicare cost reports, U.S. Census, Bureau of Economic Analysis, and American Hospital Association.

4 Examples of policy changes that could affect the cost and volume relationship include case-mix refinements, such as all patient refined diagnosis related groups, and an occupational mix adjustment to the wage index, both of which the Commission has recommended in past reports.

5 The payment adjustment we simulated produces a multiplier that is applied to the PPS base payment rate for a case, similar to the way the indirect medical education and disproportionate share adjustments are applied. Only hospitals with fewer than 500 discharges would have their payments adjusted. The low-volume adjustment multiplier = [1.25 − (0.0005 x d)] if d < 500; otherwise the mulitplier = 1.0, where d = total inpatient acute care discharges.

6 Rural hospitals that have fewer than 15 beds (25 including swing beds) and are located more than 35 miles from the nearest hospital offering similar services (or alternatively have been designated in a comprehensive state plan as a critical access hospital for care in isolated rural areas) can apply to become a critical access hospital. These hospitals receive full cost-based payment for both inpatient and outpatient services.

below, MedPAC recommends that the Secretary reevaluate (with a view toward reducing) the labor share for inpatient payments.

Rationale for reducing the labor share

The input categories included in the labor share were originally selected in 1983 when the hospital inpatient PPS was adopted. Most of these inputs are still purchased largely in local markets. However, some categories such as postage are likely purchased in national markets and not influenced by local wage levels. Still others (data processing and accounting services, for instance) may include some inputs that are purchased in national markets and some that are bought locally. As a result, the national average labor share may be somewhat lower than the current estimate of 71.1 percent.

This problem could be addressed by reexamining CMS's construction of the national labor share. This would likely result in a lower labor share, which would reduce the proportion of the national base payment amount adjusted by the wage index. Hospitals located in low-wage markets (wage index less than 1.0) would receive higher payments, while those located in high-wage markets would receive lower payments. Overall, this policy change would transfer payments from urban to rural hospitals. Some urban hospitals would benefit, however, because they are located in markets with wage indexes below 1.0, and some rural hospitals would receive reduced payments because they are located in market areas with wage indexes above 1.0.

Developments since MedPAC's rural report

About a year after our rural report (MedPAC 2001a) was published, CMS rebased the input categories in the hospital market basket, as it does routinely every five years. CMS did not alter the input categories included in the wage component of the market basket, but it revised the weight (share of total costs) for the labor-related inputs based on the latest data, which resulted in a proposal to raise the labor share from 71.1 percent to 72.5 percent.

Around this time, we obtained preliminary results from a multivariate analysis of the factors explaining variation in hospitals' Medicare costs and payments per case. This analysis provided strong evidence that the current labor share of 71.1 percent overstates the labor-related share of national input costs. However, contrary to what many observers have assumed, the study found that the labor-related share of expenses is lower in high-wage markets (most of which are in urban areas) than in low-wage markets (most of which are rural). This pattern occurs because hospitals in major metropolitan areas generally provide more sophisticated services and treat more complex patients, which raises their costs for plants and equipment.

Although CMS remains reluctant to base the labor share calculation on a multivariate analysis approach, because of its complexity and the difficulty of using it to identify a specific point estimate, the agency pulled back its proposal to raise the labor share pending further developmental work.

RECOMMENDATION 2A-3:

The Secretary should reevaluate the labor share used in the wage index system that geographically adjusts rates in the inpatient PPS, with any resulting change phased in over two years.

In the coming year, MedPAC will undertake a follow-up study designed to identify the best labor share value for the hospital industry as a whole. Because the share of labor-related expenses varies according to the circumstances of hospitals, the goal will be to identify the value that minimizes error (that is, results in the smallest possible difference between hospitals' individual labor shares and the national average).

Eliminating the base rate differential

In Medicare's inpatient PPS, the operating base payment rate for hospitals in large urban areas (metropolitan areas with more than 1 million people) is 1.6 percent above the payment rate for other hospitals, and the differential is 3.0 percent for the capital base rate (comprising about 10 percent of the overall rate). Current data do not support this differential, and MedPAC recommends eliminating it.

History of the base rate differential

The current payment differential reflects policy decisions made more than a decade ago. When the Congress established the inpatient PPS, base payment rates for rural hospitals were set 20 percent below those for urban hospitals, and no distinction was made among hospitals in urban areas based on the population of the metropolitan area. This initial differential reflected actual cost differences observed in the base data used to establish the PPS rates.

Starting in 1988, the Congress enacted separate updates for hospitals in large urban, other urban, and rural areas, effectively creating three separate base payment rates, while also substantially reducing the difference in base rates between rural and urban hospitals. Hospitals in large urban areas received higher updates at the time because analysis showed that the higher costs of those hospitals were not fully recognized by PPS payment policies.

In 1990, the operating base rate for rural hospitals was 7.0 percent lower than the rate for other urban hospitals, while the rate for large urban hospitals was 1.6 percent higher than the other urban rate (the current differential). The Omnibus Budget Reconciliation Act of 1990 set update factors to eliminate the gap in payment rates between rural and other urban hospitals by fiscal year 1995, partly because analysis showed that rural

hospital costs were 40 percent below those for urban hospitals while aggregate payments were 45 percent lower.

Rationale for eliminating the differential

Medicare margin data provide support for eliminating the current differential. Inpatient margins for rural and other urban hospitals are substantially lower than those of large urban hospitals (Table C-3). This difference in performance is due in large part to the higher payment rates received by hospitals that qualify for DSH and indirect medical education (IME) adjustments; such hospitals are much more likely to be located in large urban areas. However, even after removing DSH payments and the portion of the IME payment above the measured cost relationship, hospitals in large urban areas still have Medicare margins for the remaining payments that are 3.0 to 3.5 percentage points higher than those of other hospitals. The current base rate differential accounts for about half of this difference in margins.

Statistical analysis also supports eliminating the differential in base rates. When hospitals in large urban areas are compared with all other hospitals, no relationship between large urban location and costs per case is apparent after controlling for cost-related payment adjustments in the inpatient PPS. We found that rural hospital costs were about 2 percent lower than those of large urban hospitals, but this analysis was based on 1997 data and does not account for the 2 percent higher cost growth experienced annually by rural hospitals between 1997 and 2000. If the analysis were run using more recent data, the cost difference between hospitals in large urban and rural areas would likely be much smaller, if not nonexistent.

Providing one base rate for all hospitals would also eliminate the need for geographic reclassification for the base rate.[7] To qualify for base rate reclassification, a hospital must demonstrate that it is close to an area with a higher base rate and that its costs are closer to the amount it would be paid if it were reclassified than to the amount under its current classification. In other words, a hospital with costs above its base rate can be reclassified, whereas a hospital with costs below its base rate cannot. This policy produces an undesirable incentive by rewarding high-cost hospitals with a higher base rate without any other justification.

TABLE C-3

Medicare inpatient margin, by location, 2000

Hospital group	Margin including DSH payments and above-cost IME payments	Margin excluding DSH payments and above-cost IME payments
All hospitals	10.9%	1.5%
Large urban areas	15.3	3.2
Other urban areas	7.2	−0.4
Rural areas	2.6	0.2

Note: DSH (disproportionate share), IME (indirect medical education). Above-cost IME payments are those in excess of MedPAC's estimate of the relationship between teaching intensity and costs per discharge.

Source: MedPAC analysis of Medicare cost report data from CMS.

RECOMMENDATION 2A-4:

The Congress should raise the inpatient base rate for hospitals in rural and other urban areas to the level of the rate for those in large urban areas, phased in over two years.

Raising the cap on disproportionate share payments

Medicare's disproportionate share adjustment for hospital inpatient services is designed to offset the financial pressure of uncompensated care. However, the Commission has concluded that the current system has several design flaws and has previously recommended a major reform of the system. As an interim measure, we recommend raising the cap on DSH payments that currently applies to most rural hospitals.

The current disproportionate share adjustment

Medicare distributes DSH payments through a hospital-specific percentage add-on to the PPS base rate. The add-on for each case is determined by a complex formula and each hospital's share of low-income patients, which is the sum of two ratios—Medicaid patient days as a share of total patient days, and patient days for Medicare beneficiaries who receive Supplemental Security Income (SSI) as a percentage of total Medicare patient days.

Problems with the current system and responses to date

The Commission has previously recommended policy changes to ameliorate two key problems with the existing DSH payment system (MedPAC 2000, MedPAC 2001b):

- The current low-income share measure does not include uncompensated care, and

7 This form of geographic reclassification is awarded less frequently than reclassification to obtain a higher wage index, which responds to inaccuracies in the wage index system caused by the use of metropolitan statistical areas (MSAs) to represent health care labor markets.

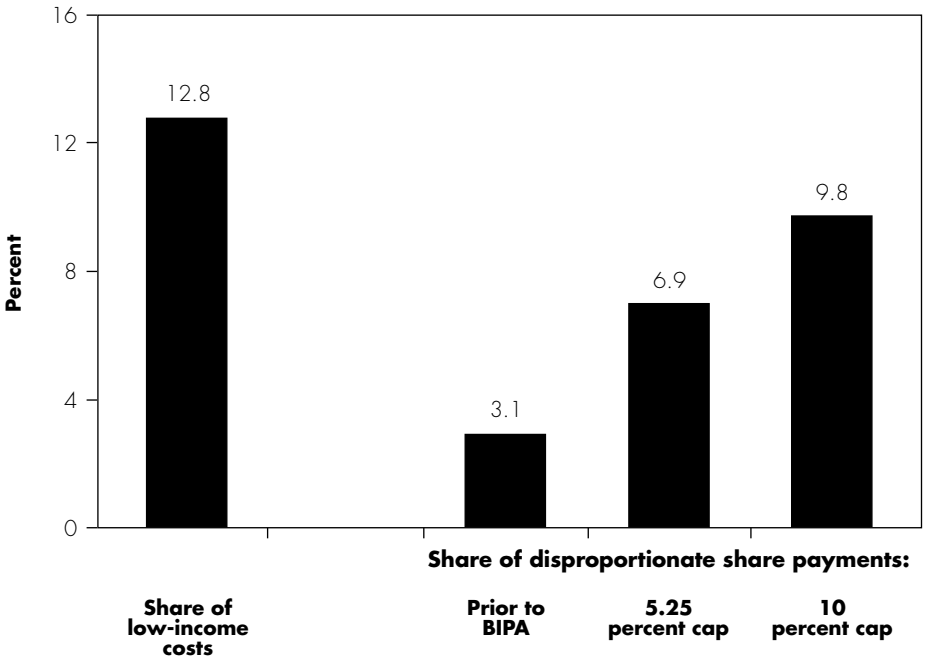
- The system has separate payment rates for 10 hospital groups, with the least favorable rates given to most rural hospitals and to urban facilities with fewer than 100 beds.

The Balanced Budget Refinement Act of 1999 (BBRA) mandated that CMS collect data on uncompensated care from all PPS hospitals beginning with fiscal year 2002 cost reports, which may pave the way for including uncompensated care in the calculation of hospitals' low-income shares. Then the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) partially implemented our recommendation by applying the most liberal current threshold (minimum low-income share needed to qualify for a payment adjustment) to all hospitals. We estimate that this made about 840 additional rural hospitals (40 percent of all rural facilities) eligible to receive DSH payments. However, BIPA caps the DSH add-on that most rural hospitals can receive at 5.25 percent, while some urban facilities currently receive far higher adjustments.

Since MedPAC's complete reform package probably cannot be implemented until at least fiscal year 2005 because of the time required to collect and process uncompensated care data, an appropriate interim step is needed to bridge the gap between the BIPA provision and the system MedPAC envisions.

FIGURE C-2

Rural hospitals' shares of low-income patient costs and disproportionate share payments



Note: The 5.25 percent cap on the disproportionate share add-on was enacted by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and went into effect on April 1, 2001. Low-income costs for this analysis include Medicaid and uncompensated care.

Source: MedPAC analysis of data from the American Hospital Association annual survey of hospitals and impact file data from CMS.

RECOMMENDATION 2A-5:

The Congress should raise the cap on the disproportionate share add-on a hospital can receive in the inpatient PPS from 5.25 percent to 10 percent, phased in over two years.

Although there is no right level for the cap, a cap of 10 percent would bring DSH payments for rural hospitals to roughly the midpoint between the amount that BIPA produced and the amount implied by the proportion of the care furnished by rural hospitals to the two largest groups of low-income patients. Rural facilities were responsible for 12.8 percent of the care provided to Medicaid and uncompensated care patients nationally in 1999 (Figure C-2), but with the DSH payment rules in effect at the time, only 3.1 percent of payments went to rural providers.[8] BIPA rules increased rural hospitals' share of payments to 6.9 percent, and raising the cap to 10 percent would lift this share to 9.8 percent.

The Congress should not remove the DSH payment cap altogether now, for two reasons. First, it would result in some hospitals receiving large increases in their DSH payments, only to have their payments cut again if uncompensated care is later brought into the system used to distribute payments.

Second, eliminating the cap might result in unusually large payment increases for some rural hospitals, and the aggregate increase in payments would be three times that of our recommended approach. The current DSH distribution formula is graduated, offering a higher payment rate for the mostly public, inner-city hospitals with the largest low-income shares. This was done in an attempt to compensate for these hospitals' unusually large uncompensated care burdens and their low Medicare penetration (often below 20 percent). Applying this formula in rural areas, where hospitals have much higher Medicare penetration (often above 70 percent), could result in windfall-level

8 Because uncompensated care data from the Medicare cost reports are not yet available, this analysis is based on data from the American Hospital Association annual survey of hospitals.

payment adjustments. If the Congress approves revamping the DSH payment system to bring uncompensated care into the low-income share calculation, it should consider avoiding this problem by applying a single formula to all hospitals without a graduated rate structure.

Impact of recommendations

Three of our four recommendations to improve rural hospital payments call for a two-year phase-in schedule. To display the full impact, Table C-4 shows the one-year increase in inpatient payments resulting from each of the recommendations and Table C-5 (p. 260) shows the two-year increase for each. The combined impact of all four policy changes, reflecting their interactive effects, is presented in Chapter 2A.

Implementing a low-volume adjustment (which we are recommending for immediate implementation) would increase aggregate inpatient payments by less than 0.1 percent. But despite the small overall impact, this policy change would increase payments for hospitals with fewer than 200 discharges by about 8 percent and for those with 201 to 500 discharges by 4 percent. In addition, the aggregate impact might be somewhat larger if critical access hospitals are allowed to return to the PPS to take advantage of the higher payments afforded by this policy change.

TABLE C-4

One-year impact on Medicare inpatient payments of four recommendations to improve payments for rural hospitals

		Change in payments for each recommendation			
Hospital group	**Baseline margin**	**Implement low-volume adjustment**	**Reduce labor share to 68 percent**	**Eliminate base rate differential**	**Raise DSH cap to 10 percent**
All hospitals	10.3%	*	0.0%	0.3%	0.1%
Urban	11.3	0.0%	–*	0.3	*
Rural	3.9	*	0.1	0.6	0.6
Large urban	13.6	0.0	–0.1	0.0	*
Other urban	7.7	0.0	0.1	0.8	*
Rural referral	3.9	0.0	0.1	0.6	0.6
Sole community	4.6	0.1	0.1	0.3	0.1
Small rural Medicare-dependent	7.2	0.2	0.2	0.7	0.5
Other rural < 50 beds	3.7	0.2	0.2	0.8	1.0
Other rural ≥ 50 beds	2.5	*	0.2	0.8	1.1
Major teaching	20.7	0.0	–0.1	0.2	0.0
Other teaching	9.6	0.0	*	0.4	*
Nonteaching	5.4	*	*	0.4	0.2

Note: DSH (disproportionate share). Baseline margin is the actual 2000 margin adjusted to reflect the increase in disproportionate share payments implemented in 2001 and the decrease in indirect medical education payments implemented in 2003. Analysis excludes critical access hospitals.
* Less than 0.05 percent

Source: MedPAC analysis of impact file and MedPAR data from CMS.

Although our recommendation that CMS reevaluate the labor share used in the hospital wage index system does not specify an exact value for the labor share, we simulated an illustrative reduction to 68 percent from the current 71.1 percent. CMS would implement this change budget neutrally, which would increase payments for rural and other urban hospitals by 0.2 percent while decreasing payments for large urban hospitals by the same amount.

Eliminating the differential in base payments rate for hospitals in rural and other urban areas would raise payments for hospitals in these areas by 1.2 percent. This increase is less than the 1.6 percent differential in base rates under current policy because many of the hospitals paid cost-related rates under the sole community hospital and Medicare-dependent programs would not be affected by the policy change.

Raising the cap on DSH payments to 10 percent would increase rural hospitals' payments by 1.2 percent on average. Although urban hospitals with fewer than 100 beds would see similar increases, there are so few of these facilities that the increase for all urban hospitals is less than 0.1 percent.

Our recommendations generally provide the largest payment increases to hospitals that do not benefit from any of the existing programs aimed at helping rural hospitals—the rural referral, sole community, and small rural Medicare dependent programs. The only exception is the low-volume adjustment that likely would not benefit such hospitals if they have more than 50 beds. Hospitals not helped by current programs have the lowest Medicare inpatient margins under current policy—3.7 percent for those with fewer than 50 beds and 2.5 percent for those with more than 50 beds. Raising the cap on DSH payments produces the largest difference, with hospitals not helped by any current program receiving an increase of over 2 percent compared with less than 1 percent for all other rural facilities.

TABLE C-5

Two-year impact on Medicare inpatient payments of four recommendations to improve payments for rural hospitals

Hospital group	Baseline margin	Change in payments for each recommendation: Implement low-volume adjustment	Reduce labor share to 68 percent	Eliminate base rate differential	Raise DSH cap to 10 percent
All hospitals	10.3%	*	0.0%	0.7%	0.2%
Urban	11.3	0.0%	–*	0.6	*
Rural	3.9	*	0.2	1.2	1.2
Large urban	13.6	0.0	–0.2	0.0	*
Other urban	7.7	0.0	0.2	1.5	*
Rural referral	3.9	0.0	0.2	1.2	1.2
Sole community	4.6	0.1	0.1	0.6	0.3
Small rural Medicare-dependent	7.2	0.2	0.4	1.4	0.9
Other rural < 50 beds	3.7	0.2	0.4	1.7	2.1
Other rural ≥ 50 beds	2.5	*	0.4	1.6	2.2
Major teaching	20.7	0.0	–0.2	0.3	0.0
Other teaching	9.6	0.0	*	0.7	*
Nonteaching	5.4	*	*	0.9	0.4

Note: DSH (disproportionate share). Baseline margin is the actual 2000 margin adjusted to reflect the increase in disproportionate share payments implemented in 2001 and the decrease in indirect medical education payments implemented in 2003. Analysis excludes critical access hospitals.
* Less than 0.05 percent

Source: MedPAC analysis of impact file and MedPAR data from CMS.

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