

C H A P T E R

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Providers Exempt from the Acute Care Prospective Payment System

R E C O M M E N D A T I O N S

To update and improve payments to providers exempt from the acute care prospective payment system, the Secretary should:

- 4A** Increase the market basket amount in the target amount update formula by 0.4 percentage points for fiscal year 2000.
- 4C** Encourage additional research in case-mix classification for psychiatric patients, with an eye toward developing a prospective payment system for them in the future.

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The Congress should:

- 4B** Adjust the wage-related portion of the target amount caps on exempt providers to account for geographic differences in labor costs.

Providers Exempt from the Acute Care Prospective Payment System

Hospitals and units of hospitals exempt from the acute care prospective payment system are a diverse group of facilities that share a common Medicare payment method established by the Tax Equity and Fiscal Responsibility Act of 1982.

Exempt facilities include rehabilitation, long-term, psychiatric, children's, and cancer hospitals, and rehabilitation and psychiatric units in acute care hospitals. In this chapter, the Commission makes recommendations concerning the annual update to facilities' target amounts under the current system, the national cap on target amounts, and case-mix classification research to further the development of a prospective payment system for patients in psychiatric facilities.

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 - Provider characteristics and trends
 - Updates to target amounts
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History and changes in payment policy

Historically, all Medicare-certified hospitals were paid their full allowable costs, until the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) was implemented in fiscal year 1983. Intended as a temporary measure to control Medicare spending until prospective systems could be implemented, TEFRA established facility-specific limits for inpatient operating costs for all hospitals. When the acute care prospective payment system (PPS) was implemented in fiscal year 1984, certain types of hospitals and units remained under TEFRA rules mainly because the diagnosis-related groups (DRGs) classification system used in the PPS was thought to be a poor predictor of resource use for patients in specialty facilities. In addition, payments based on average costs, as they are under the acute care PPS, were not considered appropriate for providers that have a low volume of Medicare patients, such as children's hospitals.

The TEFRA system has remained in effect longer than expected partly because of difficulties in accounting for the variation in resource use across patients in exempted facilities. The unintended consequences of sustaining that system have included a steady growth in the number of PPS-exempt facilities and a substantial payment inequity between older and newer facilities. In particular, the payment system encouraged new exempt facilities to maximize their costs in their base year to establish high cost limits. Once subject to its relatively high limit, a recent entrant could reduce its costs below its limit, resulting in reimbursement of its full costs plus bonus payments. Further, the limits were based on average costs per discharge and new entrants typically have fewer discharges compared with established facilities. Because average costs drop as the number of discharges rises, TEFRA limits were high relative to average costs of established facilities. By contrast, facilities that existed before they became subject to

TEFRA could not influence their cost limits. Given the relatively low limits of older facilities, they are more likely to incur costs above their limits and thus receive payments less than their costs.

The Balanced Budget Act of 1997 (BBA) made several changes to reduce inequities in the TEFRA system, including imposition of national cost limits. PPS-exempt inpatient operating payments for fiscal year 1998 and beyond are based on a facility's costs per discharge, subject to facility-specific limits established by TEFRA and to national limits established by the BBA.¹ The facility-specific limit (or target amount) is a provider's Medicare-allowable inpatient costs per discharge in a designated base year, inflated to the current year by an annual update factor. The national limit (or target amount cap) applies to the three largest PPS-exempt classes—rehabilitation, long-term, and psychiatric facilities. Each class's cap is set at the 75th percentile target amount for that class in fiscal year 1996, inflated to the current year. Each facility's limit is the lesser of its target and cap amount.

Providers also generally receive either bonus or relief payments. A facility with costs over 110 percent of its limit is eligible for relief payments. The relief payment is equal to half the amount by which a facility's costs exceed 110 percent of its limit, up to 10 percent of the facility's limit.

A facility is rewarded with a bonus payment for keeping its costs under its limit. Under the BBA, the bonus system consists of two possible payments that can total up to 3 percent of a facility's limit. The first of the two possible bonus payments is made if a facility's costs are at or below its limit. The facility receives 15 percent of the amount by which its limit exceeds its costs, up to 2 percent of its limit. A second payment (called a continuous improvement payment) is paid to qualifying facilities. This payment is equal to half the amount by which a facility's current costs are less than its expected costs (that is, its prior year costs adjusted for inflation), up to 1 percent

of its limit. A facility qualifies for the second bonus payment if it has been a PPS-exempt provider for three or more years, and its costs are less than its limit, expected costs, and trended costs (that is, its base year costs adjusted for inflation). The goal of the two-part system is to reward facilities whose costs consistently are less than their limits.

Under certain criteria, facilities may retrospectively apply for exceptions payments. The most common criterion under which facilities apply is when their current costs are substantially higher than base year costs because of changes in patient or service mix (HCFA 1998).

In addition to enacting national limits for the three largest classes of exempt providers, the BBA also altered the payment method for new providers in those classes. With regard to payment, new hospitals are defined as those operating in their first two full cost-reporting years; distinct-part units are paid under new provider rules during only their first full reporting year. Previously, new facilities were paid their full Medicare-allowable costs, during which time their targets were determined. Effective in fiscal year 1998, payments to new providers are subject to limits derived from the targets of established exempt providers.² New providers' limits equal 110 percent of the median target amount of established facilities in each provider class in fiscal year 1996. These limits are wage-adjusted and inflated to the fiscal year in which the new provider first receives payment under TEFRA. Fiscal year 1999 limits are \$8,686 for new psychiatric hospitals and units; \$17,077 for new rehabilitation hospitals and units; and \$22,010 for new long-term hospitals (Federal Register 1998).

Provider characteristics and trends

To be exempt from the acute care PPS, specialty facilities must meet criteria

1 Medicare-allowable capital costs are reimbursed on a facility-specific basis. As of fiscal year 1998, psychiatric, rehabilitation, and long-term providers are subject to a 15 percent capital payment reduction. Cancer and children's hospital capital costs are reimbursed fully.

2 New children's facilities will continue to be paid their full Medicare-allowable costs.

mainly related to patient diagnosis and facility staffing. For exempt rehabilitation hospitals and units, for example, at least 75 percent of the inpatient population must require intensive rehabilitation for 1 or more of 10 specified neurological conditions, musculoskeletal conditions, or burn injuries. In addition, their Medicare patients have a medical need for and ability to undergo three or more hours of therapy daily. The facility also must have a multidisciplinary staff and procedures for precertification screening and ongoing patient evaluations.

Exempt psychiatric hospitals and units must treat patients with a psychiatric principal diagnosis and have a multidisciplinary team that includes a board-certified or board-eligible psychiatrist and a director of psychiatric nursing services. In addition, these facilities must provide psychological, social, and therapeutic services commensurate with patient needs and have procedures for ongoing patient assessment and treatment plan evaluation.

A hospital may be exempt and classified as a long-term hospital if its

average length of stay is longer than 25 days and it is not otherwise classified as a rehabilitation or psychiatric hospital. Long-term hospitals are a diverse group furnishing services such as comprehensive rehabilitation, respiratory therapy, cancer and trauma treatment, and pain and wound management. Medicare does not recognize long-term units of acute care hospitals as exempt providers.³

Children's hospitals are exempt if most of their inpatients are under age 18. The majority of Medicare beneficiaries in these hospitals are eligible due to end-stage renal disease. Beneficiaries represent a small fraction of children's hospital patients. In 1996, they accounted for about 2,400 children's hospital discharges, or less than 1 percent of total discharges from these facilities.

Cancer hospitals were not exempt from the acute care PPS in the original legislation in 1983, although the Health Care Financing Administration (HCFA) allowed certain cancer hospitals to receive operating payments under TEFRA rules. Under the Omnibus Budget Reconciliation Act of 1989, the

Congress specifically exempted certain cancer hospitals from the acute care PPS. Those hospitals must have been recognized by the National Cancer Institute as a comprehensive cancer center or clinical cancer research center as of April 1983. The facility must be organized primarily for cancer research or treatment, and at least 50 percent of total discharges must have a principal diagnosis of neoplastic disease. Cancer hospitals not exempt before 1991 can become so only through legislative action. The BBA designated an additional facility, bringing to 10 the number of exempted cancer hospitals.

Almost 3,500 Medicare-certified hospitals and hospital units were exempt from the acute care PPS by the end of 1996 (see Table 4-1). Between 1990 and 1996, there was a steady growth in the number of rehabilitation, psychiatric, and long-term facilities. These classes account for over 90 percent of all exempt facilities. Medicare volume has increased slightly faster than total patient volume. In 1996, Medicare beneficiaries accounted for about 70 percent of rehabilitation and long-term hospital

**TABLE
4-1**

Selected Medicare characteristics of facilities exempt from the acute care prospective payment system, 1996

| Type of Facility | Characteristics | | | | | | |
|------------------|---|-----------------------|------------------------------|--|-------------------------------|-----------------------------|-----------------------|
| | Aggregate operating payments (billions) | Number of facilities* | Average facility size (beds) | Medicare share of total patient volume | Average length of stay (days) | Average costs per discharge | Average costs per day |
| Rehabilitation | \$4.6 | 1,097 | 32 | 70% | 16.0 | \$10,793 | \$710 |
| Long-term | 1.7 | 207 | 84 | 68 | 32.9 | 22,766 | 734 |
| Psychiatric | 4.0 | 2,119 | 58 | 42 | 14.8 | 6,858 | 556 |
| Children's | N/A | 71 | 103 | 1 | 8.8 | 11,147 | 1,600 |
| Cancer | N/A | 10 | 232 | 25 | 5.5 | 19,508 | 1,925 |

*Number of facilities as of December 1998. All other data are fiscal year 1996. N/A (breakdown not available).

Source: MedPAC analysis of Medicare actuarial and cost report data from HCFA.

3 Medicare does not recognize long-term units of acute care hospitals as exempt providers because acute hospital PPS payments are derived from average Medicare costs, including those of their long-stay patients. If a hospital were allowed to transfer its long-stay patients onto long-term units and receive separate payments for them, the hospital could inappropriately lower its average cost of patients paid under PPS. Nonetheless, in recent years, several facilities have been identified that are located in the same building or on the campus of acute care hospitals and have average stays longer than 25 days. Concerned that these providers may function as long-term units of acute care hospitals, HCFA implemented additional qualifying criteria for them effective October 1, 1994. Later, the BBA released from HCFA's additional criteria all so-called long-term hospitals-within-hospitals that were PPS-exempt before October 1, 1995.

volume. Medicare patients accounted for 42 percent of patient volume in psychiatric facilities.

Aggregate Medicare inpatient payments to PPS-exempt facilities rose about 17 percent annually in the 1990s, to almost \$11 billion in 1996. That increase was due primarily to growth in the number of exempt facilities and Medicare patient volume, rather than rising payments per discharge.

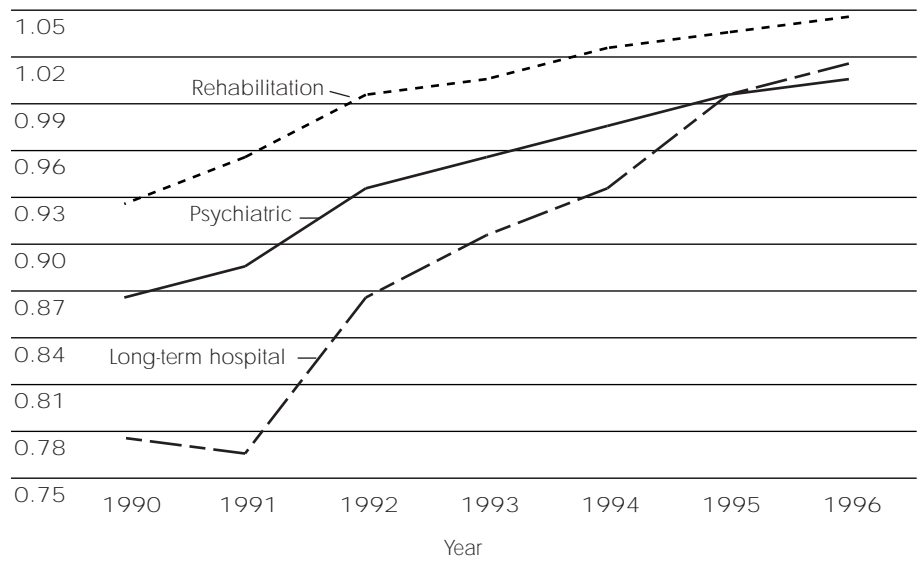
Across the three largest exempt classes, both the average Medicare length of stay and inflation-adjusted costs per discharge have declined since 1990. In 1996, stays in rehabilitation and psychiatric facilities averaged about 16 days, and stays in long-term hospitals averaged 33 days. At almost \$23,000, reported costs per discharge in long-term hospitals were double those in rehabilitation facilities (about \$11,000). Psychiatric facility costs per discharge neared \$7,000. Those facilities have experienced concomitant increases in costs per day in the 1990s. In 1996, costs per day averaged over \$700 in rehabilitation and long-term facilities and about \$550 in psychiatric facilities.

The trends of declining lengths of stay and little growth in costs per discharge have contributed to a steady improvement in financial performance among PPS-exempt providers (see Figure 4-1). With payments to rehabilitation hospitals and units exceeding reported costs by 5 percent in 1996, that provider class performed the best financially under Medicare. Payments exceeded costs by 2 percent and 1 percent, respectively, in long-term and psychiatric facilities.

Despite the overall financial gains suggested by ratios of payments to costs, the lack of any cost limits on new PPS-exempt facilities prior to the BBA fueled a financial disparity between older and newer facilities (see Table 4-2). That difference is greatest among older and newer long-term hospitals and psychiatric units. For example, almost 30 percent of long-term hospitals that have operated under TEFRA limits since 1990 or earlier

FIGURE 4-1

Payment-to-cost ratios for three classes of providers exempt from the acute care prospective payment system, 1990-1996



Source: MedPAC analysis of Medicare Cost Report data from HCFA. □

were paid less than their reported costs in 1996. By contrast, fewer than 5 percent of newer long-term hospitals were reimbursed less than their costs in that year.

Overall, PPS-exempt facilities comprise a set of inpatient providers that have responded to their industry environments and to a common set of Medicare payment rules that have encouraged growth in the number of providers. Aggregate spending has been increasing at a rapid pace, reflecting both increased patient volume and payment inequities across providers. Through passage of the BBA, the Congress signaled concern about these trends when it enacted cost limits for new providers, made several payment policy changes for existing facilities, required implementation of a PPS for rehabilitation hospitals and units by October 2000, and required a report by October 1999 on prospective payment for long-term hospitals (see Chapter 5). Against this backdrop, the Commission presents its recommendations on updating target amounts, modifying the cap on target

amounts, and encouraging new case-mix classification research regarding psychiatric patients.

Updates to target amounts

For fiscal years 1999 through 2002, the BBA established a provider-specific formula to update PPS-exempt target amounts (see Figure 4-2). The formula specifies a larger update to providers whose costs exceed their targets and a smaller (as low as zero) update to those whose costs are less than their targets. Overall, the formula is designed to narrow the gap between a facility's target amount and costs and to help lessen payment inequities among PPS-exempt facilities.

The update formula is based on the projected annual increase in HCFA's market basket index for PPS-exempt facilities. The facility-specific amounts vary depending on the difference between a facility's costs and target amount for the most recent year reported. For example, a provider's fiscal year 2000 update amount

TABLE 4-2

Facility financial performance, by year subject to the Tax Equity and Fiscal Responsibility Act, 1996

| Type of facility | 1990 or earlier | | After 1990 | |
|---------------------|----------------------------|--|----------------------------|--|
| | Ratio of payments to costs | Share of facilities paid less than their costs | Ratio of payments to costs | Share of facilities paid less than their costs |
| Rehabilitation | 1.05 | 15.3% | 1.06 | 6.9% |
| Hospitals | 1.08 | 5.4 | 1.07 | 4.8 |
| Units | 1.04 | 17.4 | 1.06 | 7.4 |
| Psychiatric | 1.00 | 29.9 | 1.03 | 15.1 |
| Hospitals | 1.02 | 21.4 | 1.01 | 19.5 |
| Units | 1.00 | 33.8 | 1.04 | 13.8 |
| Long-term hospitals | 0.97 | 28.6 | 1.06 | 4.5 |

Source: MedPAC analysis of Medicare Cost Report data from HCFA.

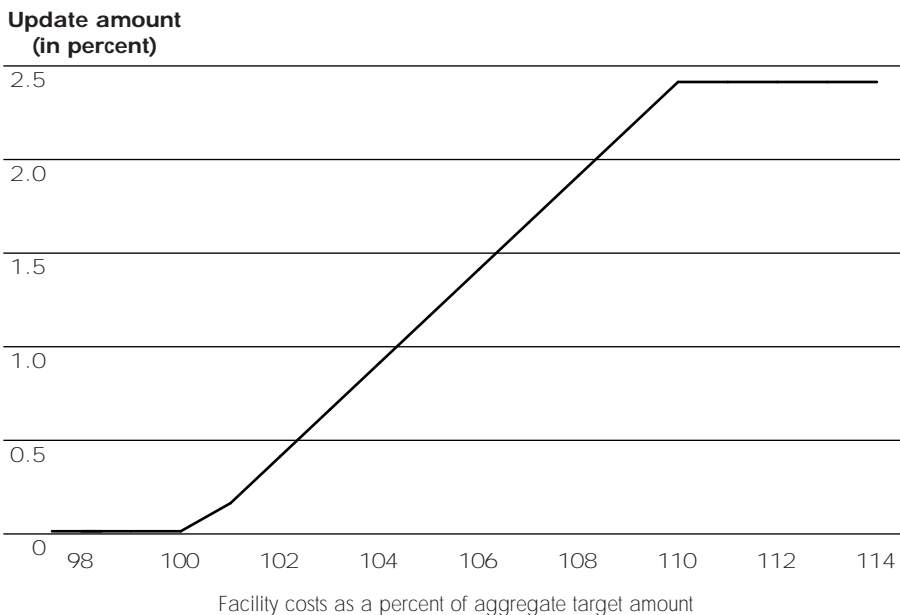
likely will be calculated from its fiscal year 1997 costs and target. Given the current fiscal year 2000 market basket forecast of 2.4 percent for PPS-exempt providers, updates would range from 0.15 percent to 2.4 percent for facilities with costs exceeding their targets and would be zero for those with costs less than their targets.

RECOMMENDATION 4A

The Secretary should increase the market basket amount in the target amount update formula by 0.4 percentage points for fiscal year 2000.

FIGURE 4-2

Target amount update formula, fiscal years 1999-2002



Source: MedPAC analysis of update formula in the Balanced Budget Act of 1997, assuming a market basket amount of 2.4 percent.

The Commission's update framework for PPS-exempt hospitals and units resembles the one it uses for acute care PPS hospitals (see Chapter 3). The input price element of the update framework is based on the forecasted increase in HCFA's PPS-exempt hospital market basket index, which reflects anticipated changes in prices, such as those for labor, supplies, and equipment. The categories and price variables of the PPS-exempt index are the same as those in the PPS market basket, but the PPS and exempt indices differ slightly in their weights for wages, benefits, and pharmaceuticals.

MedPAC's update framework incorporates three adjustments to HCFA's market basket index (see Table 4-3). The first adjustment reflects a difference between HCFA's and MedPAC's weights for the components of the index. The Commission weighs equally the expected growth in employee compensation in the hospital industry and the general economy, whereas HCFA gives less weight to the hospital industry projections. To account for this difference, a -0.1 percentage point adjustment is made to the current market basket forecast. This adjustment reflects the slower projected growth in hospital industry wages compared with other industries, after years of faster growth in hospital wages.

The second adjustment accounts for errors in previous market basket forecasts. Since the index is a forecast of price changes, differences between projected and actual price increases normally occur. Because the update is based on the forecasts, these errors can inappropriately inflate (or understate) the target amounts in each year and over time. MedPAC corrects these errors when actual price data become available, which is two years after forecasts are applied to payments. Because the BBA specified a zero update in fiscal year 1998, however, there is no need for an adjustment for that year in the Commission's fiscal year 2000 update recommendation.

MedPAC's update framework also considers scientific and technological advances in PPS-exempt facilities. This

**TABLE
4-3**

Update framework for target amounts, fiscal year 2000

| Component | Percent |
|--|---------------|
| Fiscal year 2000 market basket forecast | 2.4 |
| Adjustment for HCFA and MedPAC market basket | - 0.1 |
| Correction for fiscal year 1998 forecast error | N/A |
| Adjustment for scientific and technological advances | 0.5 |
| Sum of components | 2.8 or MB+0.4 |
| Basis of update formula in legislation | MB |

Note: MB (market basket). Market basket values and forecasts supplied by HCFA as of December 1998. These are subject to change as more current data become available. N/A (not applicable).

allowance acknowledges changes in treatment patterns and medical or information technologies that may increase costs. Based on its assessment, the Commission concluded that technological improvements required to address the year 2000 computer problem may increase PPS-exempt facility costs in fiscal year 2000 by an estimated 0.5 percent.

Hospitals depend heavily on computer technology and information systems, and year 2000 malfunctions can potentially compromise patient care, interrupt core practice continuity, and create substantial liability exposure for hospitals. A broad spectrum of services may be affected, from electronic data interchange for patient records, medical research, and billing to medical devices with embedded computer systems. Clinical departments, such as laboratories, also are particularly dependent on automation and susceptible to year 2000 malfunctions. These malfunctions and service disruptions can come from both internal and external sources, such as administrative and clinical information systems; medical devices and equipment; vendors of medical supplies, pharmaceuticals, and food services; and third-party payers.

Unlike MedPAC's update framework for PPS payments, the one for PPS-exempt target amounts does not include a productivity adjustment because TEFRA

bonus payments explicitly reward facilities that control costs through productivity improvements. Additional adjustments for productivity improvements would not be appropriate.

Cap on target amounts

Payments for the three largest exempt classes are based on the least of a facility's costs per discharge, its facility-specific target amount, and its class's cap. The caps are set at the 75th percentile target amount for that class in fiscal year 1996, inflated to the current year. For fiscal year 1999, target amounts for psychiatric facilities are capped at \$10,787 for fiscal year 1999; the targets for rehabilitation providers are capped at \$19,562; and the targets for long-term hospitals are capped at \$38,593 (Federal Register 1998).

RECOMMENDATION 4 B

The Congress should adjust the wage-related portion of the target amount caps on exempt providers to account for geographic differences in labor costs.

The Commission believes that wage adjustments should be applied where appropriate to determine payments for all Medicare providers. The target amount caps, therefore, should account for

differences in area labor costs. Urban providers, which account for almost 75 percent of PPS-excluded facilities, generally incur higher labor costs than do rural ones. Further, the caps enacted by the BBA for newly exempt providers are wage adjusted. However, the caps on existing providers are not adjusted to account for this factor. To recognize this important and measurable source of cost variation, the Commission believes the caps for existing providers should be wage adjusted. The Commission presumes that legislation would be required to do so.

Improvements to psychiatric facility payment

In the long run, the problems inherent in the TEFRA system and the remedies contained in the BBA will primarily affect psychiatric facilities and patients because rehabilitation facilities will cease to be subject to TEFRA payment rules they once come under a prospective system (see Chapter 5).

RECOMMENDATION 4 C

The Secretary should encourage additional research in case-mix classification for psychiatric patients, with an eye toward developing a prospective payment system for them in the future.

Prospective payment for rehabilitation hospitals and units and long-term hospitals would leave psychiatric facilities comprising over 96 percent of all PPS-exempt facilities in the future. In addition, they would represent the only PPS-exempt class subject to the caps on new and existing providers because cancer and children's hospitals are not subject to those provisions.

Commission simulations of TEFRA payments suggest that the BBA provisions

will reduce payment inequities across PPS-exempt facilities (MedPAC 1998). However, the TEFRA system still cannot account for differences in patient mix and treatment patterns, which are key factors associated with variation in patient costs. As a result, some facilities that serve a particularly severe case mix could face unreasonably low payments due to the cap.

It is difficult to assess fully the fairness and adequacy of Medicare payments to psychiatric facilities without an adequate measure of case mix. Since the Congress implemented TEFRA, researchers have explored the potential of several classification systems for psychiatric patients. Work in that area has reaffirmed the inadequacy of DRGs alone to account for resource variation across psychiatric patients and has resulted in more comprehensive diagnosis-based

designs that incorporate additional patient characteristics (English et al. 1986). Factors that improve the predictive ability of classification designs include the type of psychiatric service used, severity of illness, patient age, and marital status (Stoskopf and Horn 1992, Taube et al. 1984). Some designs have used more detailed patient assessments that yield information on a patient's history of mental illness, substance abuse, and prior use of psychiatric services (Fries et al. 1993).

Classification research also has revealed the difficulties of predicting resource use of both acute care and chronic care psychiatric patients within a single design (Fries et al. 1993, Frank and Lave 1986). While designs that predict resource use during inpatient stays have potential for acute care patients, outlier

mechanisms or systems that measure per diem resources are necessary to classify patients with extremely long lengths of stay. Indeed, resource use and practice patterns vary substantially between acute care and chronic care patients and between the facilities that treat predominately one or the other of these patient types.

Collectively, this research suggests that a psychiatric case-mix classification system may be possible; however, a substantial amount of work remains. Given the limitations of the TEFRA payment system, the Commission encourages additional classification research with the goal of further improving the fairness and adequacy of payments to facilities treating psychiatric patients. ■

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