



## [IHA Federal Legislative Position 2009](#) **Rural Prospective Payment System Hospitals**

### ★ **Overview**

The Medicare prospective payment system (PPS) is flawed, causing rural PPS hospitals in Iowa and across the country, to receive disparately low Medicare reimbursements. Currently, eight Iowa hospitals, commonly referred to as “tweener” hospitals, lose more than \$13 million annually from Medicare because they are not large enough to benefit from economies of scale and not small enough to qualify for critical access hospital status. In 2008, Congress attempted to correct this shortfall by inserting the language into several bills. However, because of budget issues and the fact that there are relatively few tweener hospitals nationwide, the correction has not been passed, so the disparity continues.

### ★ **Iowa Hospital Association Position**

IHA supports legislation aimed at correcting this payment flaw. As Congress continues its discussions this year on health care reform, value-based purchasing and other methods aimed at reforming Medicare payment, IHA urges Congress to include language that fixes this shortfall to ensure that all hospitals receive equitable payments under the Medicare program regardless of size or classification. Methods of addressing this issue include:

- **Increase the current inpatient low-volume adjustment to apply to hospitals with fewer than 1,500 Medicare discharges and eliminate the distance threshold.** Currently, the low-volume adjustment is available only for hospitals with 200 or fewer discharges **and** that are 25 miles apart from another Subsection (d) hospital. (The Medicare Modernization Act of 2003 increased the discharge threshold to 800. However, the Centers for Medicare & Medicaid Services (CMS) has only applied this to hospitals with fewer than 200 discharges.) Such a low-volume adjustment should be applied across-the-board to all qualifying rural PPS hospitals. The 25-mile criteria should be eliminated. IHA’s analysis indicates this would benefit Iowa’s rural PPS hospitals by **\$12.4 million**, based on 2007 claim data (the most recently available claim data).
- **Strengthen the MDH benefit by applying 85 percent of the difference between the hospital-specific rate and the wage-adjusted federal rate.** IHA’s analysis indicates this would benefit MDHs by **\$470,000**, based on 2009 data.
- **Apply the unadjusted federal rate rather than the wage-adjusted federal rate to the Medicare Dependent Hospitals (MDH) inpatient base payment.** Presently, for MDHs, if the hospital-specific rate is higher than the wage-adjusted federal rate, 75 percent of that difference is added to the wage-adjusted federal rate. Since the inpatient PPS was

implemented, rural Iowa hospitals have always had a wage index less than 1.0. Because of this, the federal rate is reduced by the wage index. By applying the unadjusted federal rate, Iowa MDHs would benefit by **\$400,000**, based on 2009 data.

- **Expand the 7.1 percent add-on payment to the outpatient base rate to MDHs.** IHA's analysis estimates the impact of this would bring an additional **\$1.5 million** to MDHs, based on 2009 data.
- **Exclude all rural PPS hospitals from the outpatient PPS until CMS designs an equitable reimbursement system.** IHA has surveyed each of the six rural hospitals eligible for Transitional Corridor Payments (TOPs) for outpatient services. Based on the responses, only two of the hospitals have been able to keep a portion of these payments over several years. The intent of these payments was to buffer the impact from moving to the outpatient PPS in 2000, by applying a pre-Balanced Budget Act of 1997 (BBA) payment-to-cost ratio. Because these hospitals have been able to contain their costs at a rate slower than the payments have increased, the TOPs payments have been paid back to the Medicare program when the cost report is settled. The TOPs payments were scheduled to sunset December 31, 2005. The Deficit Reduction Act of 2005 extended these payments for hospitals with fewer than 100 beds and that are not SCHs. Since its implementation, there have been no "fixes" to the outpatient PPS other than the continuation of the TOPs payments and a 7.1 percent add-on for SCHs. Total TOPs payments received in 2008 were \$2.3 million. Total outpatient losses these eight hospitals experienced in 2006 from the outpatient PPS were **\$5.4 million**, compared with \$829,731 in 1997 (pre-BBA).