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001 memo	Sheila Lieber to Harriet Rabb re: Proposed Outlier Legislation (5 pages)	08/02/1999	P5 DMS 4/6/15

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August 4, 1999

Note to Rich Tarplin

Attached is the memo we received from the Department of Justice regarding the proposed legislative fix for the outlier litigation. Also attached are the answers to the questions you asked Harriet Rabb regarding this matter. If I can provide you with any further information, please call me at 690-6318.

Anna D. Kraus

Anna D. Kraus

cc: John Callahan
Harriet Rabb
Jane Horvath
Jennifer Boulanger

PRIVILEGED AND ~~CONFIDENTIAL~~

August 2, 1999

Note To: Harriet Rabb

SL From: Sheila Lieber

Re: Proposed Outlier Legislation

As you know, the district court in County of Los Angeles v. Shalala, 992 F. Supp. 26 (D.D.C. 1998) concluded that the methodology utilized by the Secretary to compute outlier payments over the past sixteen years violates the statute. Although we have appealed the decision to the D.C. Circuit, given the language of the statute, the outcome of the appeal is uncertain. The appeal has been fully briefed, and is scheduled for argument on September 7, 1999.

If the plaintiffs prevail in the D.C. Circuit, the decision would, as a practical matter, have nationwide effect since any hospital may elect to pursue a challenge to its outlier payments in the District of Columbia. In that event, virtually all PPS payments made during about ten of the last sixteen years may have to be reprocessed by HCFA, and a substantial number would have to be retroactively adjusted (upward or downward). Although the County of Los Angeles case dealt solely with FFY 1985 and FFY 1986, several additional cases are pending in the District of Columbia which challenge the outlier thresholds for FFY 1991 through 1997 on the same basis. Retroactive adjustments may be required not only for the years challenged but each year in the future. Even if plaintiffs do not prevail in the D.C. Circuit, litigation regarding HCFA's outlier policies would simply shift to other jurisdictions. Given the provisions in the statute governing group appeals, an adverse decision in any one of these jurisdictions may affect numerous hospitals located in other jurisdictions.

It is our understanding that a proposal has been made to amend 42 U.S.C. § 1395ww(d)(5)(A) to clarify the statutory provisions governing Medicare payments for outlier cases. For the reasons summarized in the attached draft report language (which we prepared for HCFA's use), we believe that a legislative clarification of the statute is essential, and should be supported by HHS. If we can provide any further assistance, feel free to contact me.

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Current Law: Section 1886(d)(5)(A)(ii) of the Act authorizes the Secretary to make additional payments for outlier cases if a hospital's cost of treatment exceeds certain "fixed" thresholds established by the Secretary each fiscal year. 42 U.S.C. § 1395ww(d)(5)(A)(ii). The Secretary is required to set the amount of outlier payments at a level that must "approximate the marginal cost of care" beyond the thresholds established. Id., § 1395ww(d)(5)(A)(iii). The statute also requires that "the total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. § 1395ww(d)(5)(A)(iv).

Amendment: Section ____ of the bill amends section 1886(d)(5)(A)(iv) to provide as follows: "Before the beginning of each federal fiscal year, the Secretary shall fix thresholds, as described in this subparagraph, at a level which the Secretary projects will result in additional payments under this subparagraph for discharges in such fiscal year that are not less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." The purpose of the amendment is to make clear that subsection (iv) is not intended to require the Secretary to make retroactive adjustments in outlier payments in circumstances where actual outlier payments ultimately differ from the level initially projected by the Secretary. The Committee therefore expressly rejects the interpretation of the statute adopted by the court in County of Los Angeles v. Shalala, 992 F. Supp. 26 (D.D.C. 1998), which conflicts with Congress' intent that outlier thresholds be established based upon estimates or projections of payments by the Secretary before each federal fiscal year begins.

For the past 16 years, the Secretary has established outlier thresholds for each diagnosis related group ("DRG") before the beginning of each fiscal year at levels that the Secretary projected would result in outlier payments falling within the five to six percent range prescribed in clause (iv) of section 1886(d)(5)(A) of the statute. However, in some fiscal years, the incidence of outlier cases, and payments made for those cases, fell short of the agency's expectations, resulting in aggregate nationwide payments that were less than five percent. In other fiscal years, aggregate nationwide payments exceeded the agency's projections. Since the inception of the Prospective Payment System, the agency has consistently maintained that the statute does not require nationwide retroactive adjustments in outlier payments to ensure that they fall within the five to six percent range specified in the statute. Instead, the agency has adhered to the view that this provision merely requires that outlier thresholds be established at a level projected to result in outlier payments of five to six percent of total payments based

upon data available at the time outlier thresholds are established (i.e., prior to each fiscal year). The Secretary's construction of the statute is consistent with the original explanation of the outlier provision in S. Rep. No. 98-23, at 51 (1983) in which the Senate Finance Committee explains that "Total expected payments resulting from this policy will be not less than 5 percent, nor more than 6 percent, of total medicare payments to hospitals for inpatient care . . . ." (Emphasis added).

In County of Los Angeles v. Shalala, the district court rejected the Secretary's interpretation of the statute, and concluded that subparagraph (iv) of the statute requires the Secretary to make retroactive adjustments in outlier payments to ensure that the total amount of outlier payments nationwide equal five to six percent of the Secretary's projection of total DRG prospective payments for that fiscal year. Such retroactive adjustments would require the Secretary to reprocess payments well after the close of each federal fiscal year (once or perhaps multiple times as more final data becomes available) for virtually all Medicare cases, a result that is fundamentally at odds with the basic prospective nature of the payment system in that it creates enormous uncertainty concerning how much a hospital will ultimately be paid when it treats a patient. Under the agency's construction, the hospital knew that, once it hit the threshold, its marginal cost of care would be covered. Under the district court's interpretation of the statute, neither the Secretary nor individual hospitals will know how much hospitals will be paid for outlier cases until years after the services are rendered (and any ensuing litigation is concluded) when the Secretary accumulates reasonably final data concerning the expenditures made for outlier cases in a given fiscal year.

The interpretation adopted by the D.C. district court undermines the underlying purpose of the outlier provisions. The special payment mechanism for outliers was created to provide hospitals with assurance that they would be compensated for the extra costs associated with cases that involve extraordinarily costly hospital stays. For that reason, the statute requires that outlier payments approximate the "marginal cost of care" above the threshold established by the Secretary for each DRG. The district court's construction of subsection (iv) would make the ultimate payment made to each hospital for outlier cases depend not upon that hospital's "marginal cost of care" for unusually costly cases, but instead the fortuity of how many outlier cases ultimately occur nationwide in any given fiscal year, and how costly those cases are in the aggregate on a nationwide basis. Consequently, payments for outliers would bear no rational relationship to the extra costs incurred by hospitals for outlier cases as Congress intended. In fiscal years which have fewer (or less costly) outliers than expected on a nationwide basis, individual hospitals would (under the district court's interpretation of the statute) receive more than their marginal cost of care. In fiscal years which happen to have an

unexpectedly high number of outliers nationwide (e.g., the Secretary has projected that outlier payments will be approximately 6.5% and 6.2% of total PPS payments for FFY 1998 and 1999, respectively), payments to hospitals would have to be reduced retroactively to an amount that is substantially less than their marginal cost of care.

For these reasons, the Committee believes that the court's construction of the statute is incompatible with both the basic prospective nature of the payment system created by Congress and the objectives of the particular provisions governing outlier cases. The bill, as proposed, is intended to codify and reaffirm Congress' original intent, which is best reflected by the Secretary's consistent interpretation of the statute since the inception of the prospective payment system, that outlier payments are to be based on individual DRG thresholds established in advance of each fiscal year. The bill also makes clear that the five to six percent standard is to be applied by the Secretary based upon projections made at the time outlier thresholds are established before the beginning of each federal fiscal year, and does not provide a basis for retroactive adjustments in outlier payments during or after the close of the fiscal year.

Outlier Fix Qs and As

Q: Has the outlier fix legislation been introduced? If so, by whom?

A: The outlier fix legislation has not been introduced. Jennifer Boulanger mentioned that Representative Stark had indicated some interest in it.

Q: What committee has jurisdiction over the outlier fix litigation?

A: Jennifer Boulanger informs me that the Ways and Means Committee would have jurisdiction.

Q: How will the outlier fix legislation be scored by CBO?

A: Jane Horvath had preliminary discussions with CBO, and CBO thought the court cases were not far enough along to allow them to determine how the outlier fix legislation should be scored.

Q: What will be the effect of enactment of the outlier legislation on pending cases?

A: If the fix is enacted before the D.C. Circuit rules on its pending case, the D.C. Circuit would take into account the Congressional action and, presumably, reverse the district court's finding that HCFA is liable. The case is scheduled for oral argument on September 7. The D.C. Circuit could rule at any time thereafter. If the legislative fix is not enacted before the D.C. Circuit rules and the D.C. Circuit rules against HCFA, we could seek a writ of certiorari from the Supreme Court. If the legislative fix is enacted before the Supreme Court acts, we may be able to convince the Court to grant certiorari, vacate the D.C. Circuit opinion and remand for further consideration in light of the legislative fix. If the legislative fix is not enacted before the Supreme Court acts, it is unlikely that the Supreme Court would be interested in the case, and the judgment of the D.C. Circuit would become final. (A very rough estimate of the potential liability in the pending cases is "tens of millions" of dollars plus interest. If the D.C. Circuit were to rule against HCFA and no legislative fix were enacted, potential liability in the cases that could be brought by hospitals throughout the country is estimated to be several billion dollars.)

In the Ninth Circuit litigation regarding the outlier issue, the Ninth Circuit did not reach the statutory construction issue that the legislative fix is intended to address, but found HCFA's methodology for determining outlier payments to be arbitrary and capricious and gave instructions regarding how the methodology should be revised. HCFA and the plaintiffs are working out the methodology, and the lawyers working on the case inform me that the negotiations have reached a point where it is unlikely that enactment of the legislative fix would affect HCFA's liability (which is estimated to be between $11 and $12 million plus interest).

To: Mike H.
Fr: Chris J

What do you think?

Status?

July 30, 1999

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

Michael Hash, Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-1005-P
Room 309-G
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington DC 20201

RE: HCFA-1005-P

Dear Mr. Hash:

The National Association of Public Hospitals & Health Systems (NAPH) is pleased to offer its comments on the Health Care Financing Administration's (HCFA's) proposed rule implementing a prospective payment system (PPS) for hospital outpatient services, published in the September 8, 1998 *Federal Register* (63 Fed. Reg. 47552). NAPH represents approximately 100 metropolitan area hospitals and health systems across the country. These hospitals and systems are uniquely reliant on governmental sources of financing to support care to Medicare, Medicaid, and uninsured patients, with over 82 percent of services to such patients. These hospitals also provide many preventive, primary and costly tertiary services to their entire communities, not just to the poor and elderly. These services include a wide variety of around-the-clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters. Finally, most NAPH members also serve as major teaching hospitals.

We will limit our comments to areas that disproportionately impact safety net hospitals, which, like NAPH members, have a special mission – usually written into statute – to serve all individuals, regardless of their ability to pay. Given the complexity of the proposed new system and the scope of changes involved, we prefer to focus on issues of unique interest to our members, however, we support the comments offered by the American Hospital Association on the broad range of issues impacting all hospitals.

NAPH's recommendations are may be summarized as follows:

- Adjustments to reflect the additional costs of providers of low income care and teaching hospitals need to be implemented.
- The adjustment for low income care should be based on MedPAC's recommended low income cost variable, not the disproportionate share

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hospital (DSH) patient percentage that is currently used for inpatient Medicare services.

- Provider based entity requirements must not preclude FQHCs from receiving Medicare outpatient hospital reimbursement because they conflict with FQHC requirements.

- EMTALA obligations should not be extended to departments of hospitals or to hospital-based entities either on or off campus. HCFA's definition of "comes to the emergency department" must not extend EMTALA obligations to parts of the hospital campus that are not equipped to handle emergencies.

- HCFA should exempt outpatient cancer therapy (not just cancer hospitals) from PPS until it is able to determine appropriate reimbursement levels for such care.

NAPH member institutions rely on a patchwork of funding which includes Medicare, Medicaid, and local subsidies to finance the large volumes of care to low income and uninsured individuals. Any diminution in any of these sources seriously threatens their ability to continue to provide such services. In addition, NAPH member institutions provide a variety of specialty services for their entire communities, such as trauma centers and burn units, which are also threatened by such reductions in funding. HCFA argued in the September, 1998 proposed rule that the impact of outpatient PPS for Medicare payments to teaching and DSH hospitals is not significant because their volume of Medicare patients is low, however Medicare is often used as a model by other payers, particularly Medicaid, and as proposed without adjustments, the outpatient PPS could have a much more significant and damaging impact if translated to other payers. As you are aware, payments to public and other hospitals have been reduced significantly by the Medicaid and Medicare provisions of the BBA as well as by private payers in the marketplace. We urge you not to further endanger the viability of public hospitals and the lives of those who depend on them.

OUTPATIENT PPS MUST INCLUDE ADJUSTMENTS FOR DSH AND GME

Of primary importance for NAPH members is the inclusion of adjustments for disproportionate share hospitals (DSH) and graduate medical education (GME) in any outpatient prospective payment system. Because of the high volume of low-income care provided by NAPH members, a DSH adjustment is of crucial importance. Both current Medicare and Medicaid DSH adjustments are seriously flawed due to their failure to account for low income and uninsured care on the outpatient side, particularly as more care is provided in outpatient settings. For

NAPH hospitals, care to the uninsured is even greater for outpatient services (41 percent of outpatient care is for uninsured patients, while only 26 percent of inpatient care is to the uninsured).

Although HCFA characterizes the impact of not including an adjustment as "small and, in some cases, not statistically significant," its own data analyses demonstrate the need for both DSH and GME adjustments. The impact of the new system on providers of low income care and teaching hospitals is disproportionate. HCFA's analysis indicates that hospitals with significant numbers of low-income patients (a DSH patient ratio of 35 percent or higher) will lose 8.4 percent and major teaching hospitals will lose 10.6 percent. We estimate that NAPH members will lose an average of 8.9 percent, which is over 50 percent higher than the loss at the average hospital of 5.7 percent.

The results of HCFA's own regression analyses show that there is a statistically significant difference in cost attributable to teaching intensity and low income care as measured by DSH, *when using weighted regression analyses.* HCFA's unweighted regression analyses revealed statistical significance for teaching intensity only, and not for DSH; however, we understand that HCFA did weighted regression analyses, which were shared with the Association of American Medical Colleges (AAMC), revealing that both teaching and DSH had a statistically significant relationship to cost in the proposed PPS. Weighting the regression by unit or claim is more appropriate than using an unweighted regression, where each hospital's data is given the same impact in the results. In fact, the IME and DSH adjustments on the inpatient side are based on weighted regressions.

NAPH engaged The Lewin Group to determine the significance of DSH and teaching adjustments and to model the impact of such adjustments on payments to NAPH members and DSH hospitals. Lewin confirmed that when a teaching adjustment and DSH adjustment are modeled in combination, the ratios are statistically significant. Each 10 percent increase in IRADCA (intern and resident to average daily census ratio adjusted for outpatient visits), is associated with a 0.7 percent increase in outpatient cost per unit and each 10 percent increase in the DSH percentage is associated with a 0.8 percent increase in outpatient cost per unit (using weighted regressions). The losses to NAPH members when both of these variables are used in combination went from 8.9 percent unadjusted to 6.1 percent with adjustments. Thus, adjusting for IME and DSH brings the losses to NAPH members more into line with the losses of the average hospital in the country.

HCFA's rationale for failing to include DSH and teaching adjustments is not supported by HCFA's own analyses or, more importantly, by any overriding policy considerations. HCFA claims that the effects of teaching intensity and DSH on costs are small and that payment impacts without such adjustments do not vary considerably. However, HCFA's own analysis shows that impacts on different

types of providers vary considerably and are disproportionate for teaching and DSH hospitals. Furthermore, NAPH member losses are 31 percent lower, and more in line with other hospitals, when such adjustments are applied. HCFA argues that a small percentage of Medicare payments are made up by outpatient services. As we mentioned earlier, while the impact on total Medicare payments or on total revenues may be small for certain providers, the proposed outpatient PPS will most likely be adopted by Medicaid and other payers. The overall impact of PPS when applied across all payers would be significant, particularly in a healthcare environment where the site of care is shifting to the outpatient side. Further, the implementation of outpatient PPS is not occurring in isolation. The impact of all Medicaid and Medicare BBA reductions is significant and devastating. Thus, corrections should be made, particularly where data exist to support changes.

Additionally, HCFA argues that adjustments should be based on stronger analytic results than those found with the current data and that payment adjustments should be postponed until data from the initial years of implementation can be examined. If the data quality is acceptable for purposes of establishing an entirely new, and fairly complicated payment system, it should be adequate for use in properly adjusting that system for DSH and IME when regression analyses support those results. HCFA has no reason to believe that data from the initial years of implementation would have any different outcome. Furthermore, delaying the inclusion of these adjustments will create stakeholders in the current system and make it more difficult for HCFA to make changes in the system at a later date if they are implemented in a budget neutral manner, creating "winners" and "losers."

HCFA's last argument for failing to make DSH and IME adjustments is that it will make HCFA's job of standardizing payments across all sites of care more difficult. That same rationale applies to the implementation of the entire PPS, since it differs from payment methodologies in other settings. DSH and teaching hospitals should not be penalized while waiting for HCFA to implement a new universal payment system across all outpatient settings. All elements of payment methodologies in each setting will have to be re-evaluated at that time.

More important than all the arguments articulated is the overriding policy of recognizing the unique role played by DSH and teaching hospitals in providing care to the elderly and to their communities at large. The importance of the public missions served by these providers is recognized on the inpatient side. After the Reagan Administration failed over the course of many years to implement a payment adjustment to recognize the extra costs incurred in treating low-income patients, Congress established a specific DSH inpatient adjustment in statute. The outpatient PPS statute requires the Secretary to include adjustments to the system "determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals." HCFA's analyses show that the payment impacts are not equitable for DSH or teaching hospitals and

that differences in cost can be explained by DSH and teaching variables. Thus, good policy, data, and the statute dictate that HCFA make DSH and teaching adjustments to outpatient PPS.

THE DSH ADJUSTMENT SHOULD BE BASED ON A VARIABLE THAT ADEQUATELY CAPTURES ALL MEASURES OF LOW INCOME CARE

We urge HCFA not only to include an adjustment for DSH, but to include the "correct" adjustment for DSH – the low income cost ratio advocated by the Medicare Payment Advisory Commission (MedPAC) for implementation in the inpatient PPS. The current inpatient DSH patient variable is a proxy for low income care that reflects the volume of Medicaid and low income (or SSI) Medicare patients (and overweights the impact of the latter group). It does not include low-income uninsured and underinsured patients. MedPAC's low-income cost ratio (LICR) includes all forms of low-income care in the numerator (Medicaid, Medicare SSI, state and local indigent care programs, and uncompensated care) and total costs in the denominator. As the number of the uninsured increases and Medicaid enrollment declines due to welfare reform, the inadequacy of the current DSH variable becomes even more acute. On a number of occasions, we have communicated with HCFA about the importance of adding uncompensated care to the inpatient DSH formula and described ways that it could be measured, including income-adjusting uncompensated care to properly capture charity care and not bad debt (a number of states collect and use such data to distribute charity care pools or Medicaid DSH). It makes sense to use the proper formula from the beginning to avoid creating stakeholders for an adjustment that would be changed at some point in the future.

NAPH asked The Lewin Group to model the impact of using MedPAC's recommended variable as a DSH adjustment for the outpatient PPS. Lewin determined that the low income cost ratio was statistically significant. When modeled with an IRADCA, each 10 percent increase in the low income cost ratio was associated with a 0.9 percent increase in outpatient cost per unit. When modeled alone, each 10 percent increase in the low income cost ratio was associated with a 1.4 percent increase in outpatient cost per unit. Once again, the impact of adjusting for provision of low-income care (in this instance, using the LICR) reduced losses for NAPH members to a level more in line with that of other providers. We are happy to work with HCFA on the appropriate DSH variable to use.

PROVIDER-BASED ENTITY REQUIREMENTS MUST NOT CONFLICT WITH FQHC STATUTE

The proposed rule establishes a set of criteria defining when a clinic can be considered part of the hospital outpatient department and reimbursed under the new PPS or considered to be a physician office, freestanding ambulatory surgery center, or freestanding diagnostic imaging center and reimbursed accordingly. These requirements are laid out in Program Memorandum A-96-7 and its subsequent replacements.

NAPH agrees that any entity that seeks hospital-based status should be fully integrated into the main provider. Patients should expect to receive the same quality of care regardless of the location in which that care is provided and as part of a well-coordinated system. However, certain aspects of both current HCFA rules and the proposed regulations are overly burdensome and do not seem to be reasonably related to programmatic interests.

Federally Qualified Health Centers

NAPH is particularly concerned with the failure of the proposed regulations to take into account the specific circumstances of Federally Qualified Health Centers ("FQHCs"). FQHCs are federally designated outpatient programs that are designed to expand access to health care services in medically underserved areas. Many NAPH members have outpatient clinics that are designated as FQHCs by the Health Resources and Services Administration ("HRSA"). The FQHC designation is essential for maintaining enhanced reimbursement available under Medicaid. In the past, HCFA has supported the FQHC mechanism as a means of reaching Medicare beneficiaries, Medicaid recipients and the uninsured in medically underserved areas.

However, certain governance and administrative provisions of the proposed rules would make it virtually impossible for a hospital outpatient clinic to maintain both provider-based designation and FQHC status. More specifically, the proposed rules require that:

- the main provider and the facility or organization seeking status as a provider department have the same governing body;

- the facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the main provider;

- the facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider.

These requirements, and others, often conflict with HRSA's standards for obtaining FQHC status, particularly for public health centers. Among other requirements, HRSA mandates that FQHCs have user-dominated boards. However, HRSA has established two alternative mechanisms whereby public entities may qualify. If the public entity's board is user-dominated, then there is no issue. However, in the event that the public entity's board does not meet the health center composition requirements, a separate health center governing board may be established. Such a board must meet all of HRSA's composition requirements, and perform all responsibilities expected of a governing board, except that the public entity may retain responsibility for fiscal and personnel policies. In such situations, the public entity and FQHC board may be coapplicants for FQHC status. (See Appendix A for the relevant section from HRSA's "Standard Documents for Initial Eligibility as a Federally Qualified Center (FQHC) Look-Alike and Recertification for Continued Eligibility").

HCFA needs to clarify that provider-based entity requirements for purposes of Medicare reimbursement do not conflict with FQHC requirements such that clinics are able to participate in both programs. More specifically, in order to maintain FQHC status, many NAPH members have had to set up separate user dominated boards for their FQHCs. HRSA recognizes and acknowledges this necessity for public health centers, while acknowledging that the FQHC and the hospital are one entity for ownership purposes. HCFA needs to recognize similarly that these separate boards established for the purpose of FQHC qualification do not make these clinics legally distinct from the public entity. Consequently, these boards' existence for the purpose of another federal program should not bar the clinic from obtaining provider-based status. NAPH would welcome the opportunity to work with HCFA on this issue.

NAPH is concerned about the application of other elements of HCFA's proposed rule on the definition of "provider based entity" to the real-world circumstances of hospital systems. We concur with AHA's recommendations in these areas.

THE ENTIRE HOSPITAL CAMPUS AND ON- AND OFF-SITE OUTPATIENT DEPARTMENTS OF A HOSPITAL SHOULD NOT ALL HAVE EMTALA OBLIGATIONS THAT ARE INDEPENDENT AND EQUAL TO THE HOSPITAL'S EMTALA OBLIGATIONS

NAPH is uniquely qualified to comment on the proposed revisions to EMTALA obligations, as a representative of safety net hospitals and health systems whose emergency rooms are more typically the recipients of patients transferred from other facilities (either in compliance or in violation of EMTALA). NAPH members are more likely to receive transfers both because NAPH members see patients without regard to financial or insurance status and because NAPH members are often trauma centers serving the entire community.

The purpose of the EMTALA statute is to protect patients with emergency conditions from being neglected when a patient requests treatment. In particular, the statute is concerned with hospitals "dumping" patients without financial ability to pay for the needed services and thus jeopardizing the health of the patient. As such, the EMTALA statute and implementing regulations focus on requiring a hospital to conduct appropriate screenings for medical conditions and to stabilize any emergency conditions found before transferring the patient to another facility. However, HCFA's proposed rules to expand the scope of EMTALA to outpatient hospital departments, to other on-campus hospital based entities and to the entire hospital campus, stray further and further from the purpose of the EMTALA statute.

Under the proposed § 413.65(g), outpatient hospital departments and all on-campus hospital based entities would be required to comply directly with the screening and stabilization requirements contained in § 489.24. This expansion is not appropriate. Many outpatient hospital departments and hospital-based entities have inadequate staffing or experience to fully comply with EMTALA. The proposed rule appears to require that an off-campus outpatient facility affiliated with a hospital but otherwise totally unprepared to handle emergencies would be required to comply fully with EMTALA. An off-campus outpatient facility may or may not have the resources to stabilize the patient for EMTALA purposes, even if the affiliated hospital would have such resources. From the perspective of the hospital-affiliated outpatient department, the hospital-affiliation inappropriately creates the EMTALA requirements. There is no reason why an outpatient clinic not affiliated with a hospital should not have EMTALA obligations but one with similar capabilities that is affiliated with a hospital should have the full range of EMTALA obligations. Applying EMTALA in this situation is bad health policy. While there may be situations where an outpatient department may be able to perform an appropriate emergency screen, the outpatient department in an emergency situation should be free to alert and involve true emergency care personnel, whether at the affiliated hospital, a non-affiliated hospital, or at an ambulance service, in order to best handle the emergency situation without fear of noncompliance with EMTALA.

HCFA may require that outpatient facilities have procedures for assessing and addressing emergency situations, but should not require compliance with EMTALA. The proposed regulation applies EMTALA to all outpatient hospital departments and all on-campus hospital based entities without any regard for the capabilities of those departments and entities. As AHA notes in its comments, literally-read, the proposed regulation requires that outpatient departments establish on-call arrangements. Requirements of this sort are clearly inappropriate. It may well be that outpatient facilities should be prepared to address emergency situations. However, it is inappropriate to use EMTALA, a statute designed to prevent discriminatory patient dumping, to inappropriately bootstrap preparedness for outpatient facilities. These changes expand significantly the EMTALA obligations of hospitals and their related facilities. In some cases, the regulations create unclear obligations and make confusing distinctions without any appropriate

basis. In fact, in some instances, the proposed regulations may do a grave disservice to patients in an emergency situation and frustrate the intent of the EMTALA statute. HCFA should revise the proposed sections to clarify that outpatient departments and hospital-based entities do not have EMTALA obligations independent of the hospital's EMTALA obligations and allow outpatient departments and hospital-based entities to respond to emergencies in the best interests of the patient. NAPH supports the comments made by AHA in their more extensive comments regarding the application of EMTALA to outpatient departments and provider-based entities and regarding the definition of "comes to the emergency department."

HCFA's proposed expansion of the definition of "comes to the emergency department" in § 489.24(b) to include the entire main hospital campus, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus and is paid under Medicare as an outpatient department of the hospital, is similarly without rational basis and is an improper expansion of the scope of the EMTALA statute. Although NAPH agrees that it would be artificial to view an individual requesting emergency services from a hospital as outside the protection of EMTALA because he or she is not technically in the emergency department, it does not necessarily follow that the entire main hospital campus, including outpatient departments, should have the same obligations as an emergency department.

NAPH recognizes that there may be other areas equipped to deal with emergencies besides the emergency department. For example, if a hospital sees certain types of emergency cases outside the emergency department (e.g., the labor and delivery area for pregnant women), then presenting to that area should be the equivalent of coming to the emergency department for EMTALA purposes. Similarly, if a person attempts to reach the emergency department and, because of his or her condition, is unable (e.g., collapses on the sidewalk or in a car outside the emergency department), it would be artificial to say he or she has not come to the emergency department when someone else comes into the emergency department and requests assistance on their behalf. HCFA should revise its proposed rules to reflect the emergency care capabilities of the various places on a hospital campus and should not extend full EMTALA obligations to all parts of the main hospital campus.

Finally, the distinction made between the EMTALA obligations of hospital-based entities and hospital departments located off the main campus of the hospital is arbitrary and problematic. Under § 413.65(g)(1), hospital outpatient departments located either on or off the main premises of the hospital must comply with § 489.24. On the other hand, § 489.24 applies only to hospital-based entities located on the main campus. There seems to be little reason for a distinction between these two types of entities for the purpose of the EMTALA statute.

In summary, the proposed regulations, both in terms of the application of EMTALA obligations to hospital outpatient departments and hospital based

entities and in terms of the definition of "comes to the emergency department," should be significantly revised. Through the proposed rules, HCFA is using EMTALA inappropriately to address the preparedness of various facilities, including outpatient facilities, for emergency care. While this area may need attention, wholesale extension of EMTALA without regard for the emergency capabilities or public health consequences inherent in such a decision is inappropriate. Lastly, some of our members have identified situations where their efforts to divert inappropriate utilization of the emergency room to other, more appropriate, settings have conflicted with EMTALA requirements. We believe that there must be a rational balance of patients' access to emergency care provided in a non-discriminatory fashion with efforts to encourage utilization of outpatient services in the most appropriate setting. We would be happy to meet with you to discuss these concerns.

CANCER CARE SHOULD BE EXEMPTED FROM PPS UNTIL APPROPRIATE PRICING CAN BE DETERMINED

NAPH did not evaluate the adequacy of specific APCs; we rely on the work of AHA and others to address those problems. Nevertheless, we determined that one of our members which is a cancer hospital is projected to lose over $7 million, or 41 percent of its outpatient payments as a result of PPS. We understand that prices for cancer APCs were based on single treatment claims, which were few in number and do not reflect the practice of cancer therapy. We strongly urge that you reassess the reimbursement of cancer therapy, and exempt all outpatient cancer treatment from prospective payment until you are able to establish adequate reimbursement rates. We do not believe that it is an adequate solution just to exempt cancer hospitals, because many hospitals provide significant levels of cancer therapy and would be unduly harmed by inadequate rates. We strongly urge you to address this problem to avoid impacting hospitals' ability to provide cancer care to patients who need it.

CONCLUSION

In conclusion, we appreciate the complexity of converting to a prospective pricing system for outpatient Medicare services. We encourage HCFA to permit an adequate implementation period and we concur with AHA's recommendations in that regard. Furthermore, we recommend that HCFA implement a transition period for PPS implementation, as it has done in other areas when new reimbursement systems are implemented, to permit hospitals to adjust to the

impact of the new system. We look forward to working with you in the specific areas where we have offered comments. If you have any questions, please contact Lynne Fagnani at (202) 414-0101.

Sincerely,

Larry S. Gage

Larry S. Gage
President

APPENDIX A – HRSA's "Standard Documents for Initial Eligibility as a Federally Qualified Center (FQHC) Look-Alike and Recertification for Continued Eligibility"

An FQHC must be governed by a Board of Directors which is representative of the community being served and which has full authority and responsibility to establish program policies. The governing board is legally responsible for ensuring that the FQHC is operating in accordance with applicable federal, state and local laws and regulations. The governing board carries out its legal and fiduciary responsibility by providing policy level leadership and by monitoring and evaluating all elements of the FQHC's performance.

The governance requirements for FQHCs are unique among health service programs and are the basis for ensuring that each FQHC is responsive to the needs of the community. The requirements presented below are essential for assuring a responsive board with the necessary authority/responsibility over the FQHC's operations.

1. *To meet basic eligibility requirements, the applicant must be a private non-profit organization or public entity.*

   • ***NOT WAIVABLE***

2. *The governing board must have at least 9 but no more than 25 members.*

   • ***WAIVABLE*** *for Medicaid for up to six months, if a documented plan for meeting the requirement exists.*

3. *At least 51% of the governing board's members must be active users of the FQHC and must reasonably represent the individuals served by the center in terms of such factors as ethnicity, race and sex, and should be representative with respect to age and economic status. These factors are not, however, meant to impose quotas. As a general rule, user board members should live in the service area.*

   • ***WAIVABLE*** *for Medicaid for up to six months, if a documented plan for meeting the requirement exists.*

4. *No more than half of the non-user members may be health professionals, which is defined as deriving more than 10% of their income from the health care industry. Generally, non-user members should live and/or work in the community in which the FQHC is located. The individual's leadership role in the community and functional expertise should be major criteria in selecting members.*

• ***NOT WAIVABLE***

5. *For private, non-profit entities, the governing board must have the authority, among other things, to: 1) approve the center's budget and major resource decisions, 2) set center policies, and 3) approve the selection and dismissal of a project director or chief executive officer for the center.*

   • ***WAIVABLE*** *for Medicaid for up to six months, if a documented plan for meeting the requirement exists.)*

6. *For public entities, the governing board must have the three authorities outlined above, but the public agency may retain the authority to establish general fiscal and personnel policies. Where responsibilities are split between the governing board and the public entity, the public agency and the board should detail their arrangement in writing to clearly identify the authorities, duties and responsibilities of each entity. The preferred method of meeting this requirement is to have the governing board incorporate separately and to apply as a co-applicant for FQHC designation.*

   • ***WAIVABLE*** *for Medicaid for up to six months, if a documented plan for meeting the requirement exists.)*

7. *The by-laws or written corporate policies of the applicant must include provisions that prohibit conflict of interest or the appearance of conflict of interest by board members, employees, consultants and those who provide services or furnish goods to the applicant. No board member may be an employee of the center or be an immediate family member of an employee.*

• ***NOT WAIVABLE***

CHARLES E. SCHUMER
NEW YORK

United States Senate

WASHINGTON, DC 20510

July 20, 1999

The President
The White House
Washington, DC 20500

Dear President Clinton:

I write to share my concerns about the devastating cuts the Balanced Budget Act of 1997 (BBA) is imposing on New York health care facilities and to ask for your help. New York facilities face a staggering $545 million in reduced reimbursements over five years if the proposed outpatient prospective payment system (PPS) is fully instituted. While the BBA did address some problems with Medicare, many New York facilities will be forced to provide lower quality care if the full BBA cuts are implemented.

For example, the Medicare cuts threaten Rochester's Strong Memorial Hospital's ability to fund the Poison Control and Information Center. The center, which receives 30,000 calls each year, prevents numerous unnecessary emergency room visits and has saved thousands of lives. Because of BBA cuts, Long Island College Hospital in Brooklyn, which serves a diverse, low-income community, may be unable to meet its operating costs in the near future. I am convinced that, with your leadership, the Health Care Financing Administration (HCFA) can ameliorate some of the most damaging Medicare cuts facing New York's health care facilities.

In the ten years before the BBA was enacted, New York health care facilities engaged in a momentous effort to cut waste and fat. In 1997, the BBA required all U.S. health care facilities to cut out waste and unnecessary treatments in order to strengthen Medicare, but I have visited numerous hospitals across the State and I know there is no more fat to cut. If faced with additional cuts, the facilities will have to cut muscle and bone; that is, vital programs and staff. New York now needs the Administration's help in making administrative changes in four key areas.

Most importantly, I believe HCFA's proposal to adjust the amount Medicare beneficiaries pay for hospital outpatient services is, as 78 Senators recently wrote Administrator DeParle, "a misrepresentation of Congressional intent and threatens the integrity of a broadly supported compromise." HCFA's proposal, which would reduce hospital payments by 5.7 percent, alone will cost New York's hospitals about $200 million over five years. I request HCFA address this administratively by implementing the adjustment as intended by Congress. Additionally, to help ensure good health care in New York, HCFA administratively should:

- Eliminate the volume and expenditure caps. Developed to cut out fraud and waste, they should not limit payments to efficient hospitals focusing on the special needs of their communities.

some flex
statute is silent
push from policy pers
winners & losers

Adjust the caps for inpatient psychiatric and rehabilitation reimbursements to reflect the high wage costs that hospitals face in expensive areas such as New York. This would save New York hospitals about $65 million over five years.

Ease the transition to the nursing facility PPS for states participating in the "Nursing Home Case Mix and Quality Demonstration," by providing additional compensation to these facilities. This would provide New York skilled nursing facilities as much as $40 million in relief through 2002.

I look forward to continue to work with you and your staff to improve Medicare and strengthen the nation's health care system. Your recently proposed Medicare proposal is a good start and I plan to work in the Congress to see that it is enacted. I do ask, however, that you work with me to ensure that New York health care systems are able to provide the excellent level of care for which they are known around the world.

Sincerely,

Charles Schumer

Charles E. Schumer
United States Senator

no admin authority
statute is clear; also no policy rationale b/c they have higher reimbursement anyway BUT could do Part B add on.

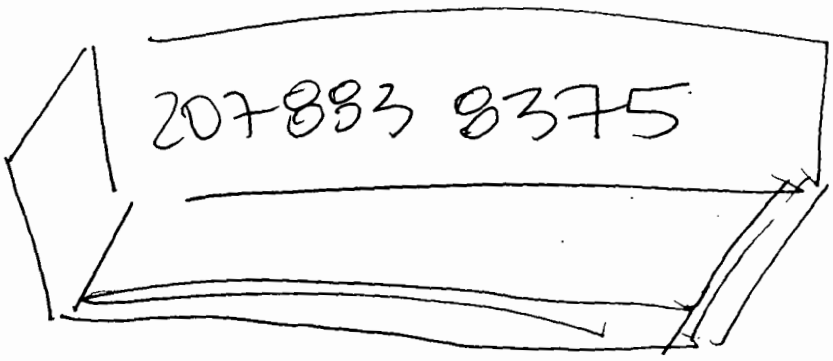
Ken Choe

spoke w/ Joe Guerra;
the possible alternative legal theory on OPD:

DES has discretion in estimating the charge growth — we are directed to look at 1996 data — adjust that using estimated charge growth → 1999 (making up for data) charge growth → other places; will not be entire $16B —
if worth exploring we should go back to ~~HCFA~~

find out how much —

how much across the board


207883 8375

FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages: 10 Date: 8/13

To: Deborah From: Valerie

Fax: 450-5557 Fax: **202-690-8168 or 205-5157**

Phone: _____ Phone: 690-5512

REMARKS: background letters

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 22 1999

The Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515

Dear Mr. Rangel:

Thank you for your letter regarding the calculation of the 75th percentile payment caps. You express concern that these payment caps were not adjusted for wage area differences. Under such a wage adjustment, the hospitals within each class would be capped at different numbers, reflecting different wage adjustments for different geographic areas. You also express concern that not making such adjustments could seriously harm high wage areas and have a devastating impact on psychiatric and rehabilitative services for Medicare beneficiaries. I regret the delay in this response.

HCFA published a final rule with comment on changes to the hospital inpatient prospective payment systems (PPS) in the Federal Register on August 29, 1997. We received a number of comments on the issue of wage adjusting the TEFRA cap in response to this rule. HCFA carefully considered these comments and published a final rule on changes to the hospital inpatient PPS in the Federal Register on May 12. We understand and generally agree with the policy rationale in favor of applying a wage adjustment calculation. However, we believe the silence of the statutory language, the statutory scheme, and the legislative history, viewed together, strongly argue against making a wage adjustment in applying the TEFRA caps. A detailed discussion of this matter is in the final rule which is enclosed.

Thank you for bringing your concerns to my attention. A similar letter is being sent to the other cosignors of your letter.

Sincerely,

Donna E. Shalala

Enclosure

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Donna E. Shalala

Enclosure

IRHFP Preamble
26348-55
FR Text 26352-60

federal register

Tuesday
May 12, 1998

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 410 et al.

Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates; Final Rule

SA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
EXECUTIVE SECRETARIAT

SECRETARY'S CORRESPONDENCE

From: CONGRESSIONAL, DE(NY) OS#: 06/15/1998 0024

On Behalf Of: DOL: 05/13/1998

Type: Congressional Dt Inc Rec'd: 06/15/1998 Code: Correspondence

Org: NEW YORK CONGRESSIONAL DELEGATION
Add: WASHINGTON, DC Due in OS/ES:06/29/1998

Subject:
(LTR FORWARDED FROM JANET MURGUIA AT THE WHITE HOUSE FOR HHS RESPONSE)--LTR SIGNED BY REP. CHARLES RANGEL AND 15 OTHER MEMBERS OF THE NEW YORK CONGRESSIONAL DELEGATION, EXPRESSING DISAPPOINTMENT WITH HCFA DECISION NOT TO ADJUST NEW MEDICARE PAYMENT CAPS ON PSYCHIATRIC AND REHABILITATION HOSPITALS FOR REGIONAL DIFFERENCES IN WAGE COSTS.

Assigned to: HCF On: 06/15/1998

Action: SEC SIG ES Dep: White PC: Donohue

Info Copies: CCC ASL AMB OGC ASP ESS WHITE DONOHUE

Interim (Y/N): Interim Signed:
Reply Rec'd in OS/ES: Final Signed:

OPDIV/STAFFDIV ROUTING SECTION
(Recipient should sign & date when received)

SENT TO	DATE	TIME	RECEIVED BY	DATE	TIME
CHPP	6/16				

Comment:

File Index: PO-2-3 Scheduling ID: CCC: OLH

THE WHITE HOUSE

WASHINGTON

June 1, 1998

MEMORANDUM FOR RICHARD TARPLIN
DEPARTMENT OF HEALTH AND HUMAN SERVICES

FROM: JANET MURGUIA
LEGISLATIVE AFFAIRS

SUBJECT: PRESIDENTIAL CORRESPONDENCE

Enclosed please find a copy of a letter that was sent to the President from Rep. Charles Rangel (D-NY) and others.

I do not believe this letter requires a Presidential response at this time. Please review the attached letter and have the Secretary respond directly to the Member(s) of Congress. Please forward a copy of the response to Peter Greenberger, Office of Legislative Affairs.

Thank you very much for your assistance in this matter. If you have any questions, please feel free to call Peter Greenberger at 456-7500.

Enclosure

6-15-98-0024

Congress of the United States
Washington, DC 20515

MAY 22 5:13

May 13, 1998

Honorable William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

We are writing to express our extreme disappointment with the decision of the Department of Health and Human Services (HHS) not to adjust new Medicare payment caps on psychiatric and rehabilitation hospitals and units for regional differences in wage costs. This decision, which subjects all psychiatric and rehabilitation units in the country to the same dollar cap, regardless of legitimate differences in cost, will have a devastating impact on psychiatric and rehabilitation services for Medicare beneficiaries in the New York metropolitan area. The rehabilitation cap will have a particularly severe impact on burn units not just in New York, but in metropolitan areas across the country.

This decision is especially troubling given the fact that Congress has granted the HHS Secretary considerable discretion in implementing the new payment caps. Unlike other provisions of the Balanced Budget Act of 1997 that afford little room for interpretation, the provision that appears to impose a new payment cap on psychiatric and rehabilitation units merely instructs the Secretary to estimate the 75th percentile cost. It is still our view that the Department can take action to prevent unnecessarily severe cuts to institutions in New York that are particularly harmed by the Department's action. We urge you to immediately direct the Health Care Financing Administration to find a way to resolve this serious problem before permanent damage is done to the ability of health care providers in the New York area to continue to provide critical health care services to elderly New Yorkers.

We look forward to your response.

Sincerely,

Michael R. McNulty

Gary L. Ackerman

Curtis Lamey

Mark Foley

Jerold Nadler

Thomas Manton

Charles E Schumer

Sydney M. Yates

Louise M. Slaughter

José E. Serrano

Sue Kelly

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 1 1999

The Honorable Daniel Patrick Moynihan
United States Senate
Washington, D.C. 20515

Dear Senator Moynihan:

Thank you for your letter regarding the calculation of the 75th percentile payment caps. You express concern that these payment caps were not adjusted for wage area differences. Under such a wage adjustment, the hospitals within each class would be capped at different numbers, reflecting different wage adjustments for different geographic areas. You also express concern that not making such adjustments could seriously harm high wage areas and have a devastating impact on psychiatric and rehabilitative services for Medicare beneficiaries. I regret the delay in this response.

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Thank you for bringing your concerns to my attention.

Sincerely,

Donna E. Shalala

Enclosure

federal register

Friday
August 29, 1997

Part IV

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 400, 409, et al.

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates; Final Rule

UNITED STATES SENATE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510-6300

DATE: 4/23/99

TO: Chris Jennings

FAX NUMBER:

FROM: David Mexon

(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES: 2 (including cover)

MESSAGE:

If you have trouble receiving this fax, please call (202) 224-7675

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, DC 20515

Dan L. Crippen
Director

April 23, 1999

Honorable Edward M. Kennedy
Chairman
Committee on Health, Education,
Labor and Pensions
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

At your request, we have completed a cost analysis of S. 6, the Patients' Bill of Rights, as introduced. Consistent with our understanding that you will supply CBO with legislative language clarifying your intent with regard to certain issues, we estimate this legislation, revised to accomplish these changes, will add 4.8% to private health insurance premiums over a period of years.

Sincerely,

Dan L. Crippen

Identical letter sent to Honorable Tom Daschle, Democratic Leader.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1125
HTTP:// WWW.AAMC.ORG

September 10, 1999

TO: Chris Jennings and Jeanne Lambrew

FROM: Richard M. Knapp, Ph.D
Executive Vice President

RE: Data on the Impact of the Balanced Budget Act of 1997

This cover memorandum and attachment represents the Association of American Medical College's (AAMC's) response to your data request dated August 13, 1999. The AAMC represents approximately 300 major teaching hospitals that receive Medicare payments; all 125 accredited U.S. medical schools; 86 professional and academic societies; and the nation's medical students and residents.

As we have discussed with you and your staff, provisions in the Balanced Budget Act of 1997 (BBA)—particularly cuts in the indirect medical education (IME) adjustment and disproportionate share (DSH) payments—are contributing to a financial crisis at teaching hospitals. This situation threatens to affect the special contributions of teaching hospitals, including training our nation's future physicians, providing care to the uninsured, and providing an environment in which clinical research can flourish. Moreover, these institutions provide highly specialized services, such as regional trauma centers, burn units, and pediatric intensive care units. The future of these unique services and missions of teaching hospitals is in jeopardy, as many teaching hospitals have already reduced their work forces and are now considering scaling back these essential services.

We believe the following attached documents provide an important data assessment of the BBA on teaching hospitals. In addition, we are continuing to seek information concerning the financial status of our member hospitals. We would be happy to review with you any findings we obtain from our initiatives.

1. **An AAMC chart series entitled "Assessing the Impact of the Balanced Budget Act of 1997 (BBA'97) on the Financial Status of AAMC Council of Teaching Hospital (COTH) Member Hospitals" and a companion document that describes methodological details and assumptions.**

   This series uses Medicare data from the Medicare Cost Report PPS XIV (1997) Minimum Dataset to project total margins. This dataset is the most recently available source of Medicare data. We previously had provided you with this same analysis

using data from the PPS XIII (1996) Minimum Dataset. The results we obtained from the more recent analysis are virtually identical with our earlier results.

Our results complement those conducted by other entities: if not modified, the BBA could result in devastating consequences for teaching hospitals. Among other findings, our analysis indicates that:

- The total margin for the typical major teaching hospital (an intern and resident to bed ratio (IRB) of 0.25 or more) could fall to nearly zero by 2002, and

- Half of major teaching hospitals could face **negative** overall margins in 2002.

2. **A reported prepared by the Health Care Advisory Board entitled "Medicare Payment Reform: Executive Briefing on Health System Financial Performance Under the Balanced Budget Act of 1997."**

   This report examines and makes observations about a number of BBA provisions juxtaposed with a number of financial and other health care indicators. Specific observations concerning major teaching hospitals can be found on pages 22-23 of the report.

CC: Robert M. Dickler, AAMC Senior Vice President

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

Ernest Valente, Ph.D.
Karen Fisher, J.D.
Robert D'Antuono
Robert Dickler

Division of Health Care Affairs
Association of American Medical Colleges

September, 1999 Update Using FY 1997 Data

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

METHODOLOGICAL DETAILS:

What was the analytical approach?

What data were used?

What assumptions were made for the analysis?

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals: *Analysis Plan*

BBA PROVISIONS	ANALYTICAL APPROACH
• INPATIENT – PPS Update Reductions – DSH Reductions – IME Multiplier Reductions – Capital Payment Reductions – Change in Transfer Definition • OUTPATIENT – FDO Elimination – Outpatient PPS	• MARGIN ANALYSIS – Projected Margins Under BBA • REVENUE REDUCTION PROJECTIONS – Project Status Quo and BBA PPS Standardized Operating Amounts – Project IME and DSH Reductions – Project Other BBA Provisions as Possible

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals: *BBA Provisions Included in Analysis*

BBA Provision	Fully Projected	Provisionally Projected	Not Included
PPS Update	X		
DSH	X		
IME	X		
Transfers		X	
Outliers			X
Medicare Mgd. Care			X
Capital		X	
FDO		X	
Outpatient		X	
Bad Debt			X
PPS Excluded Subprov (Psych., Rehab.)			X
SNF Units Hospital-Based HHAs			X

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals: *Data Details*

- Used Medicare Cost Report PPS XIV Minimum Dataset (FFY 1997)
- Used MedPAC margin calculations
- Used MedPAC data edits for extreme values
- Built upon projection methodology developed by the Greater New York Hospital Association
- Excluded non-PPS hospitals
- Excluded hospitals in regulated States (Maryland)
- Excluded rural hospitals
- Excluded sole community provider hospitals
- Excluded hospitals with fewer than 90 beds
- 1,904 hospitals included (230 COTH, 660 other teaching, 1,014 non-teaching)

Impact of BBA '97 Provisions on Financial Status of COTH Member Hospitals: *Assumptions*

- **Assumed Constant 1997 - 2002:**
  - Non-Medicare Market Conditions
  - Casemix Index (used FFY[1] 1999)
  - Area Wage Index (used FFY 1999)
  - IRB Ratio (used FFY 1997)
  - Outlier Payments as a Percent of Other Than Outlier Payments (used CRY[2] 1997)
  - IME Payments as a Percent of PPS DRG Payments (used CRY1997)
  - DSH Payments as a Percent of PPS DRG Payments (used CRY 1997)
- **Assumed to Increase at HCFA Projected Market Basket Rate:**
  - Status Quo Inpatient Revenues and Expenses (PPS and Total)
  - Non-Medicare Inpatient Revenue
  - Medicare and non-Medicare Costs
  - Status Quo Outpatient Payments
- **Other Assumptions:**
  - Medicare Admissions Increase by HCFA Projections

[1]Federal Fiscal Year
[2]Cost Report Year (Hospital Fiscal Year)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

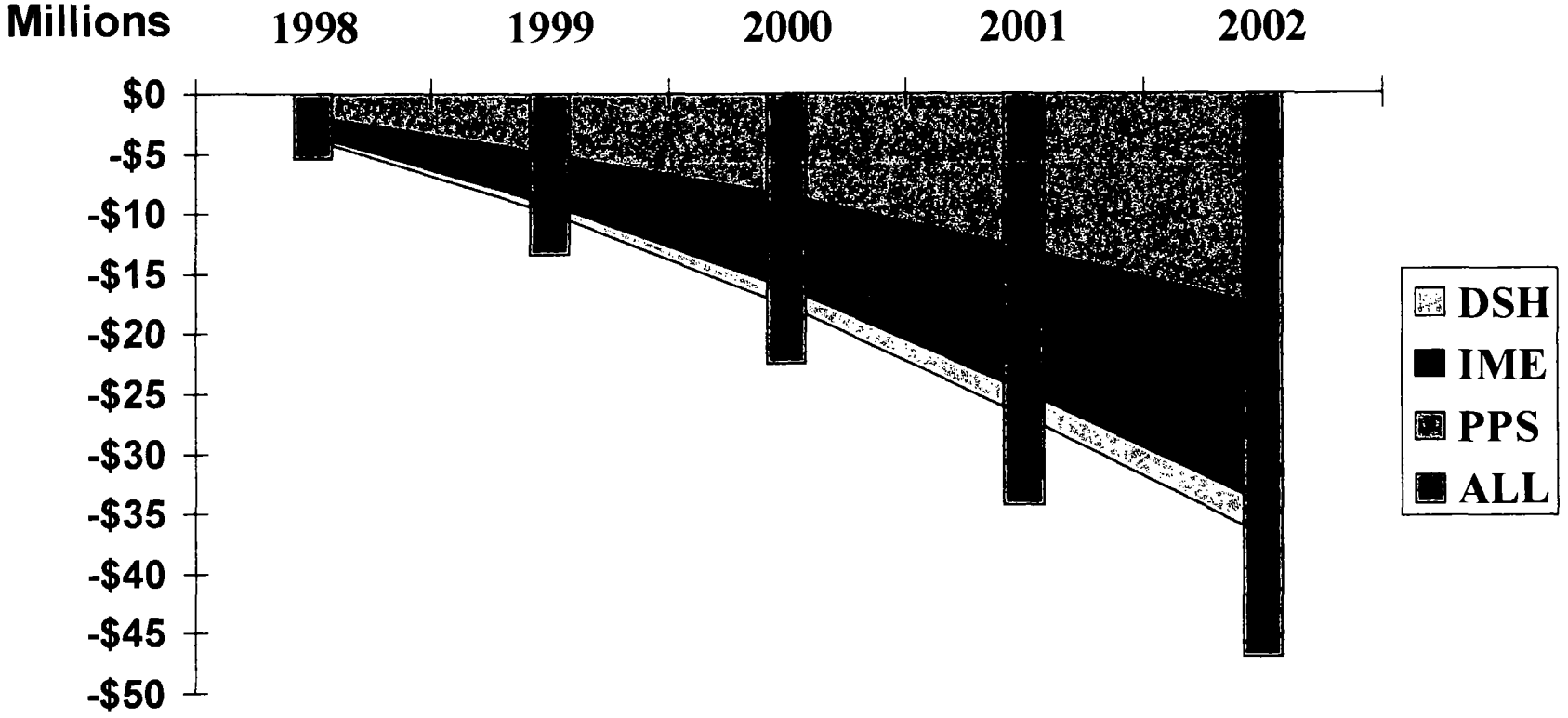
Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

BBA IMPACT:

How much revenue will the typical hospital lose when BBA 1997 is in full effect?

Impact of BBA '97 on Hospital Financial Status

Cumulative Financial Impact of BBA '97 on Typical COTH Hospital 1998-2002



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Difference between projected payments under "status quo" and "BBA" scenarios.
ALL includes PPS, IME, DSH, Capital and Outpatient payment reductions.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Impact of BBA '97 on Hospital Financial Status
COTH, Other Teaching, Non-Teaching

Cumulative Financial Impact on Typical Hospital, 1998-2002

	COTH	OTHER	NON-TEACHING
PPS	-$17.7	-$9.0	-$5.3
IME	-$16.5	-$1.5	$0.0
DSH	-$2.8	-$0.6	-$0.2
ALL	-$47.0	-$17.0	-$9.0

SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Difference between projected payments under "status quo" and "BBA" scenarios.
ALL includes PPS, IME, DSH, Capital and Outpatient payment reductions.

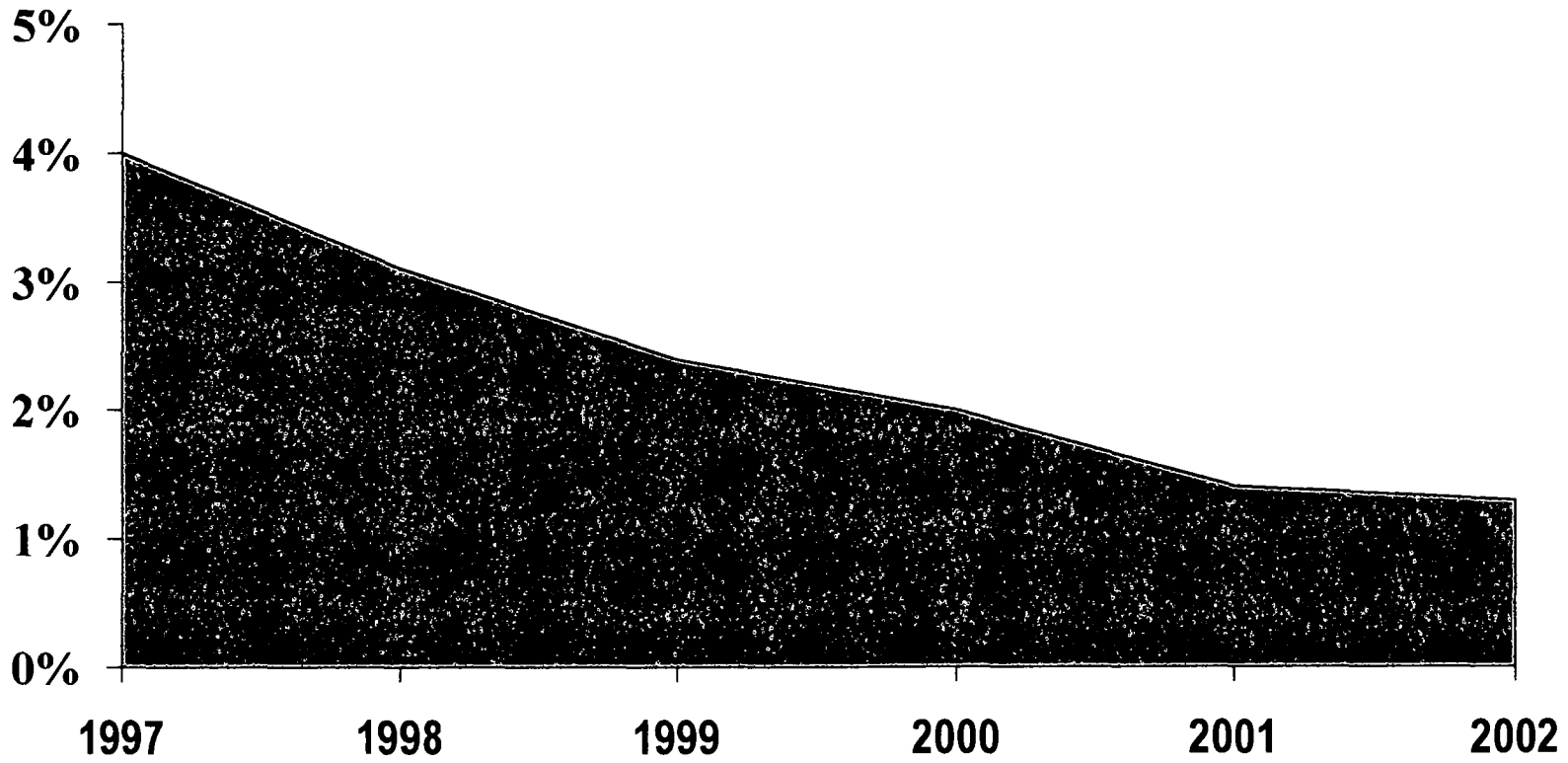
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

BBA IMPACT ON COTH HOSPITALS:

What is the combined impact of all currently projected BBA '97 provisions on the financial status of a typical COTH member hospital 1997 -2002?

Impact of BBA '97 on Projected Median COTH Total Margins



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

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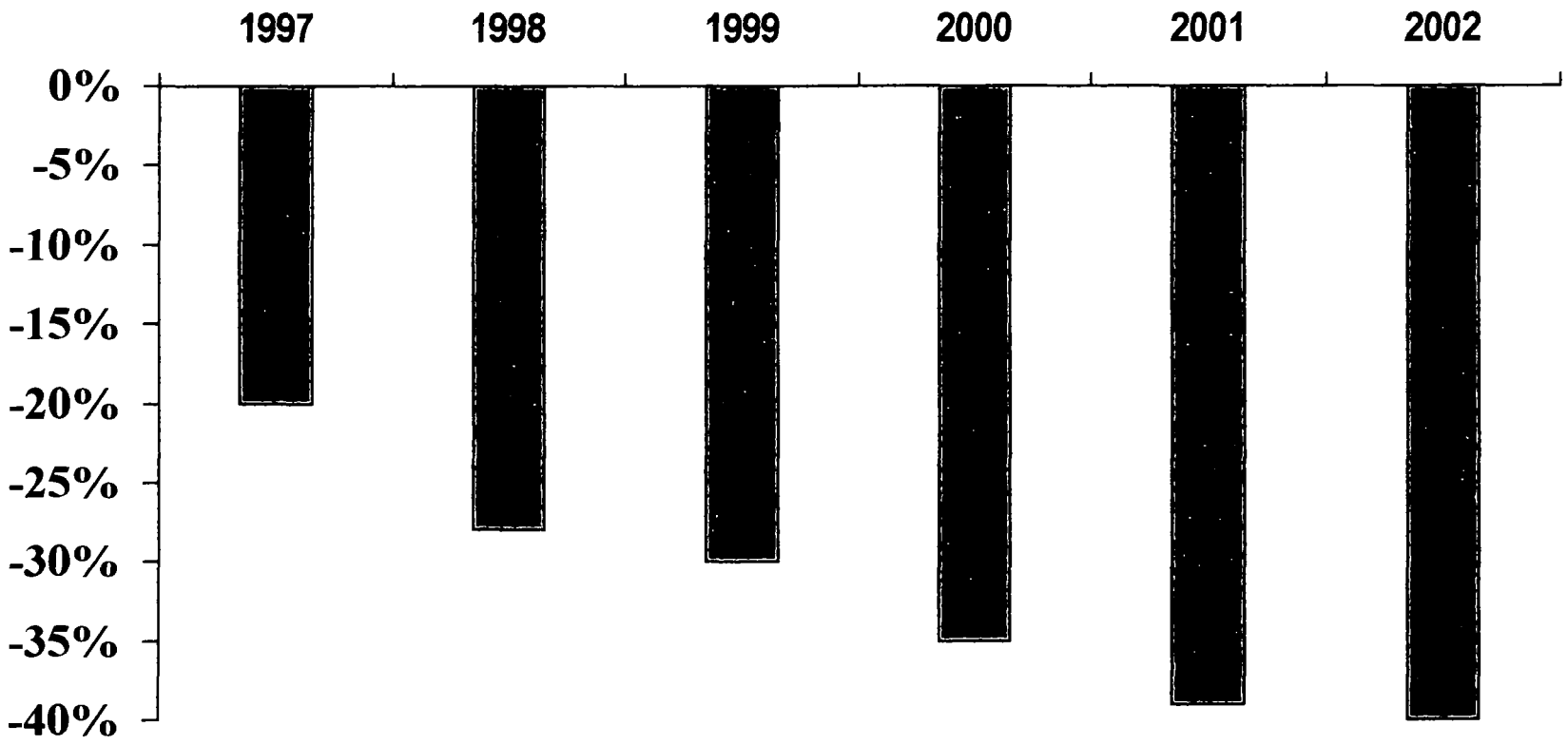
Impact of BBA '97 on Projected COTH Total Margins

Percent of COTH Hospitals with Negative Projected Margins



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.

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Does not include estimate of teaching payments for Medicare Managed Care enrollees.

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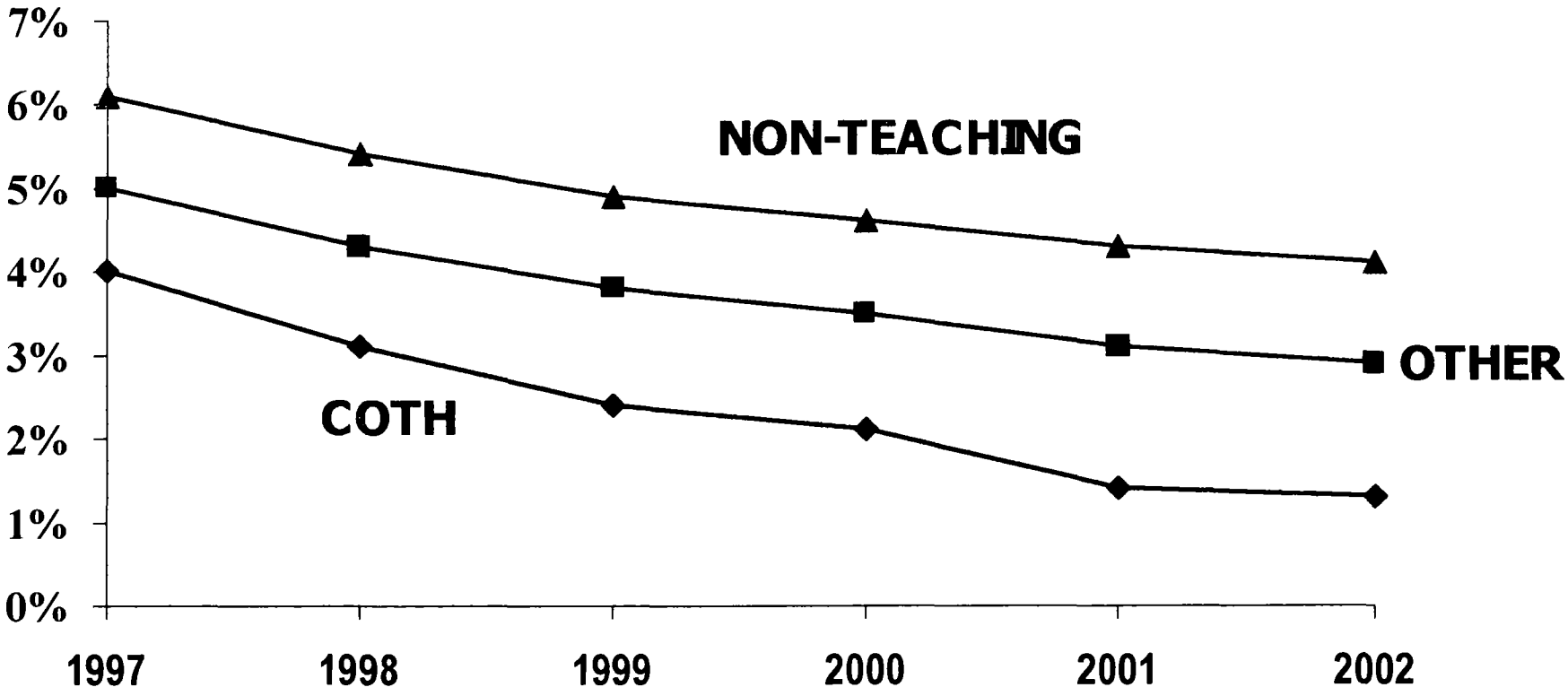
Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

BBA IMPACT ON COTH, OTHER TEACHING, AND NON-TEACHING HOSPITALS:

Does BBA '97 differentially affect the financial status of COTH hospitals, other teaching hospitals, and non-teaching hospitals?

Impact of BBA '97 on Projected Median Total Margins, 1997-2002
COTH, Other Teaching, Non-Teaching



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.
NOTE: Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

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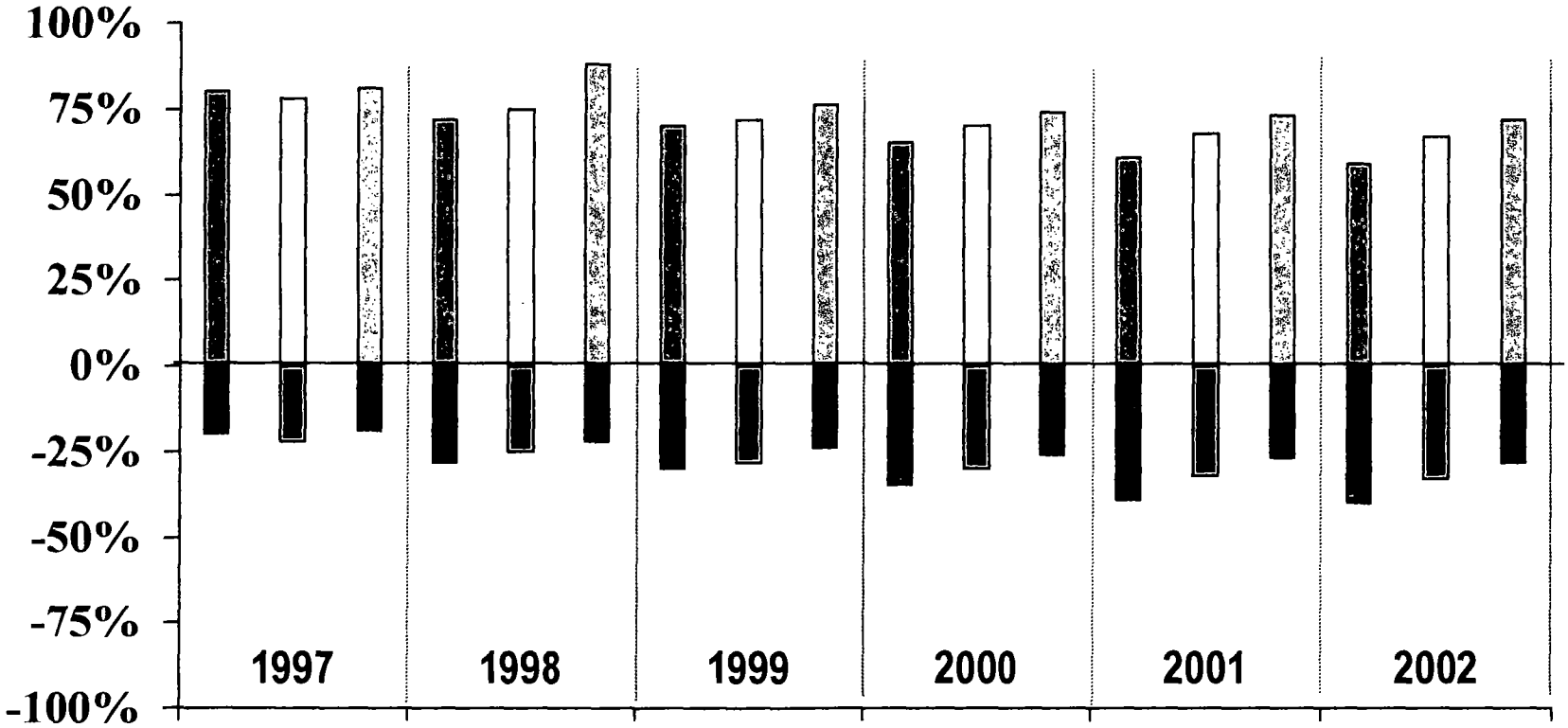
Impact of BBA '97 on Projected Total Margins, 1997-2002
COTH, Other Teaching, Non-Teaching

Percent of Hospitals with Positive and Negative Projected Margins



COTH=green/blue, other teaching=yellow/red, non-teaching=gray/black

SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.

NOTE: Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

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Assessing the Impact of the Balanced Budget Act of 1997 (BBA '97) on the Financial Status of COTH Member Hospitals

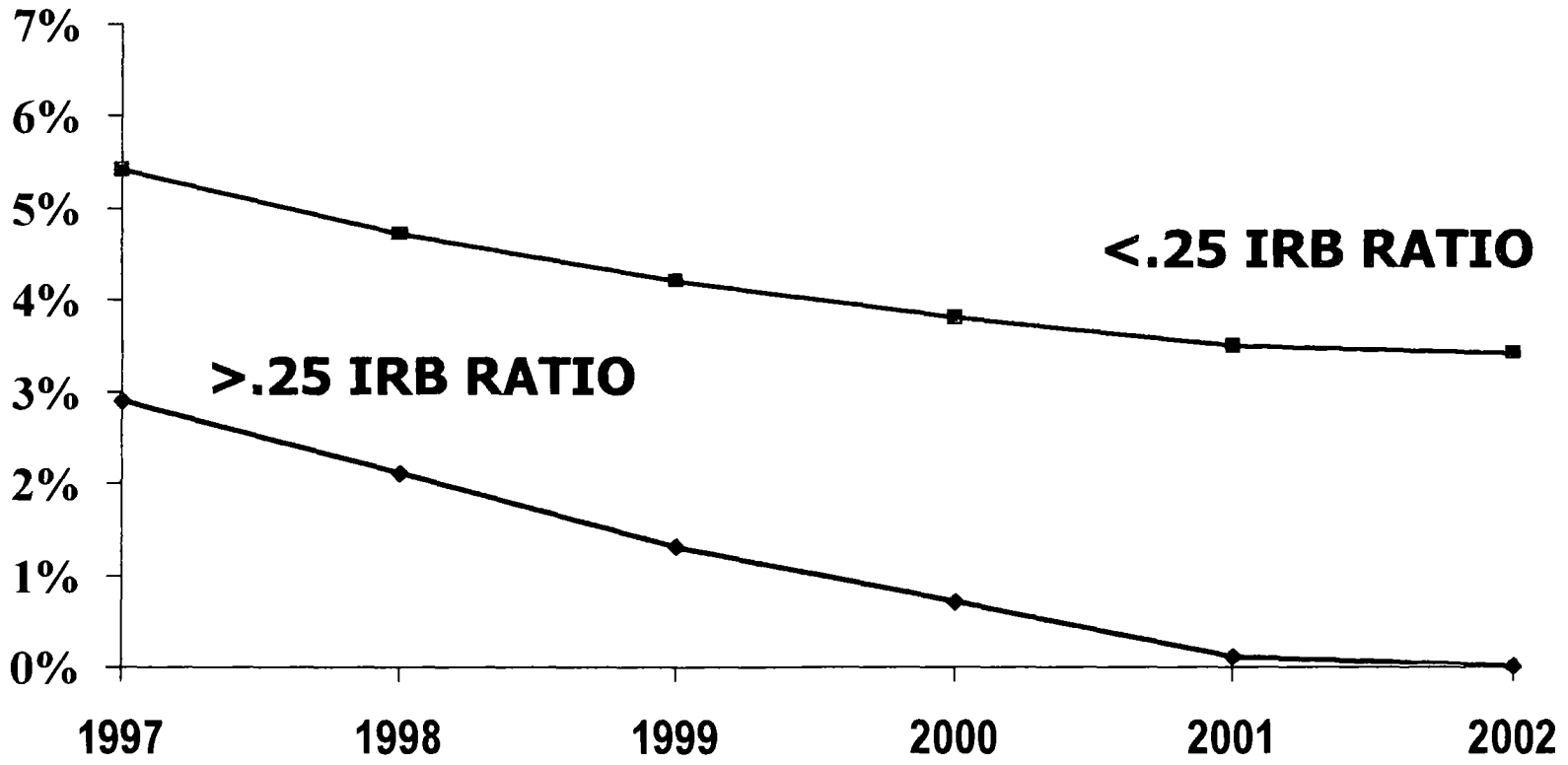
BBA IMPACT ON COTH AND OTHER TEACHING HOSPITALS:

What is the combined impact of all currently projected BBA '97 provisions on the financial status of a typical hospital, 1997 -2002?

HOSPITALS WITH IME RATIO GREATER OR LESS THAN .25

Impact of BBA '97 on Projected Median Total Margins

Hospitals with IRB Ratios Greater than or Less Than .25



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.

NOTE: Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

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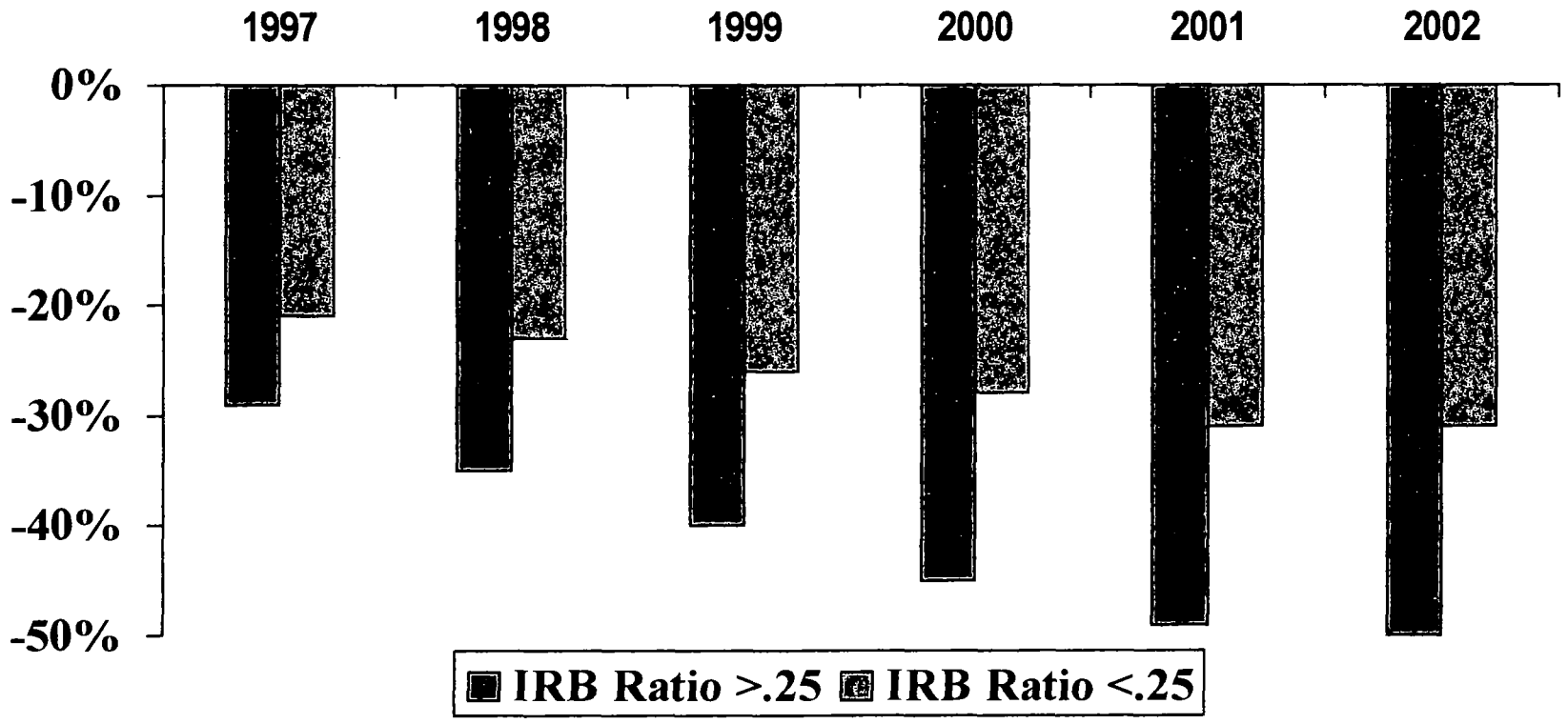
Impact of BBA '97 on Projected Total Margins

Percent of Hospitals with Negative Projected Margins
Hospitals with IRB Ratios Greater than or Less Than .25



SOURCE: PPS XIV Medicare Cost Report Minimum Dataset.

NOTE: Medians of trimmed data. Excludes Maryland, rural, SCH and hospitals with fewer than 90 beds.
Total margins include total hospital revenues and expenses.
BBA impact includes PPS, IME, DSH, Capital and Outpatient payment reductions.
Does not include estimate of teaching payments for Medicare Managed Care enrollees.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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September 1999

**Assessing the Impact of the Balanced Budget Act of 1997 (BBA)
On the Financial Status of COTH Member Hospitals:
Methodology Summary**

The Balanced Budget Act of 1997 (BBA) contained numerous changes to the Medicare program, many of which affect hospital payments. The Association of American Medical Colleges (AAMC) has analyzed the impact of the BBA on the AAMC's Council of Teaching Hospitals and Health Systems (COTH) revenues and financial status by simulating its effects between 1997 and 2002. This document summarizes the methodology for this simulation.

Most of the provisions of the BBA began to take effect in Federal fiscal year (FFY) 1998 (October 1, 1997). Some of the provisions are phased in over a five-year period; all of the provisions are to be fully implemented by 2002. Financial data for the analysis were obtained from the Medicare Hospital Cost Report Information System (HCRIS) which contains data from all hospitals participating in the prospective payment system (PPS) for hospital fiscal years ending before September 30, 1998 ("PPS 14"). The basic approach of the analysis was to project what Medicare reimbursement would have been during each year between 1997 and 2002 if the BBA changes had not been implemented ("status quo"), and contrast these reimbursement levels with projections of reimbursement under the BBA. For analyses of dollar losses under the BBA, the impact was expressed as the difference in Medicare payment projections under the "status quo" and "BBA" Medicare payment projections. Total margins under the BBA were calculated by adding estimated Medicare payments to estimated non-Medicare payments and subtracting Medicare and non-Medicare estimated costs. Medicare payments were estimated using the parameters specified in the BBA. Actual values were used for costs where possible. All future costs and non-Medicare payments were incremented by the Health Care Financing Administration's (HCFA) projected hospital inpatient market basket inflator each year.

Simulation results are presented for three categories of hospitals: COTH members, other teaching hospitals, and non-teaching hospitals. For several of the simulations, results for teaching hospitals (COTH and other teaching combined) were differentiated by whether they had an intern/resident-to-bed (IRB) ratio of greater than or less than 0.25.

In interpreting the analysis projections, it is important to remember several features of the simulation:

- The BBA changes included in this analysis were isolated as the sole source of modifications to revenue and financial status. All other features of the financial

environment were held constant; that is, non-Medicare payments (Medicaid and private-payer) were assumed to be unchanged, except for inflation, throughout the five-year period.

- Where rates of growth were not known from actual data, all revenues and expenses were projected to grow at the rate of increase for the HCFA hospital inpatient market-basket[1] over time, except where anticipated rates of growth were determined by provisions of the BBA.

- About half of PPS hospitals were excluded from the simulation[2] to make all the hospitals included in the analysis comparable to COTH hospitals. The resulting group of 1,904 hospitals included 230 general acute, non-federal COTH hospitals[3], 660 other teaching hospitals, and 1,014 non-teaching hospitals.

- BBA changes occur on Federal fiscal year (FFY) cycles, which are frequently not the same as hospital fiscal years; thus, hospital cost report years often overlap two FFYs. The BBA effects were indexed to hospital fiscal years, so that the dates correspond to hospital fiscal years.

- The number of residents in teaching hospitals is assumed to be constant across the five-year period.

This analysis reflects certain BBA provisions that have a substantial impact on hospital payments. A complex simulation[4] was used to project hospital-level impacts due to the PPS update reductions,[5] indirect medical education (IME) payment reductions,[6] and disproportionate share (DSH) payment reductions.[7] These changes represent the majority of the BBA payment reductions. A less complex approach was applied for the projections involving capital payments,[8] the effects of the transfer redefinition,[9] elimination of the outpatient formula-driven overpayment,[10] and movement to an outpatient PPS.[11] The simulation does not include estimates of outlier changes, bad debt payment reductions, or reductions in payments to PPS-exempt subproviders, skilled nursing facilities (SNFs) and hospital-based home health agencies.

Actual values for payments and costs were included in the simulation wherever possible (for example, actual PPS standardized operating amounts were available for 1996-1999). Other simulation values were set as specified in the BBA. (For example, Medicare disproportionate share payments are progressively discounted, from 1 percent in 1998 to 5 percent in 2002.) Where no actual values were available, values were projected forward using projections from either HCFA or another source, or fixed at a constant value for the entire five-year period. For example, payments and costs were incremented by actual cost growth values from the American Hospital Association (AHA) annual survey until 1997 (the most recent data available). Each year thereafter, these values were incremented by the HCFA hospital inpatient market basket growth rate estimate for that year. The Medicare case mix index used in the analysis was fixed at the hospital-specific value estimated by HCFA for fiscal year 1999 payments (the midpoint of the five-year period).

Interpreting the Analysis Results

The impact of this analysis is best interpreted by comparing the amount that the BBA reduces Medicare payments relative to what those payments would have been if Medicare payment policies were unchanged through 2002. The results show the magnitude of the difference between the simulations' estimate of what payments in the future would have been in the absence of the BBA ("status quo") and the estimate of what the payments will be under the BBA.

It is important to remember that this analysis does not predict what total margins *will be* in 2002; but rather, it expresses the financial pressure that the Medicare reductions will place on hospitals' profitability under two payment policy scenarios. The actual margins in 2002 depend upon a number of factors in addition to Medicare, most important of which are changes in Medicaid and private sector payments, and hospitals' cost growth.

Impact of the Cost Growth Estimate

When making projections, this analysis assumed that hospital costs would grow at the projected increase in the hospital market basket. Actual costs have grown more slowly than the market basket increase estimate in recent years; consequently, others who have projected the impact of the BBA have included a cost growth assumption that is one percentage point less than the market basket increase. Clearly, the BBA will have a smaller negative effect on total margins than our analysis projects if the growth in hospital costs falls below the full market basket increase.

However, there are several reasons why it is more appropriate to assume that costs will grow at the rate of the market basket increase. First, many believe that recent trends (i.e., actual costs growing slower than the market basket) are in large measure the result of myriad "one-time" cost reduction efforts. Continuing to reduce costs in this fashion will be strongly resisted because such reductions would seriously damage the ability of teaching hospitals to perform their special missions of teaching, research, and service to the underserved. Second, some AAMC COTH member institutions report that their costs are beginning to rise sharply, in part due to rising pharmaceutical costs and a nursing shortage that is driving up labor costs. Thus, cost growth is likely to increase in the near future. Finally, it is important to remember that the recent trend of costs growing slower than the market basket is a new phenomenon. Historically, cost growth trends for hospitals have exceeded market basket estimates far more frequently than they have not. Consequently, our assumption of costs growing merely at the rate of inflation--i.e. the market basket increase—was deemed conservative.

Changes in Private Payer and Medicaid Revenues

For projection purposes, this analysis assumed that non-Medicare revenues would grow at the same rate as costs, which we projected to equal the increase in the hospital market basket. This permits our analysis to focus solely on changes in total margins that are due

to changes in Medicare reimbursement. If non-Medicare revenues grow at a rate slower than costs, the impact on total margins will be lower than what we have projected. A recent analysis indicates that private payer revenues grew slower than costs between 1992 and 1997.[12] Consequently, if this trend continues, actual total margins in 2002 may be lower than our estimates.

Teaching Payments for Medicare Managed Care Enrollees

The BBA calls for Medicare to begin making IME and DGME payments that are associated with Medicare managed care enrollees treated by teaching hospitals, effective January 1, 1998. These payments are being phased in over 5 years in 20 percent annual increments.[13] This analysis does not include any assumptions concerning these payments because it is not possible to make meaningful estimates.

The Congressional Budget Office (CBO) estimated Medicare managed care teaching payments as part of their BBA savings analysis;[14] however, there are no corresponding impact estimates on patient care payments to teaching hospitals that result from BBA reductions to Medicare managed care payment rates. Consequently, including estimates of Medicare managed care teaching payments only, without a corresponding estimate of changes in Medicare managed care patient payments, would overstate the net payments teaching hospitals receive from Medicare managed care activity. Further, even if estimates about changes in payments to teaching hospitals for Medicare managed care patients were available, it is reasonable to assume that these estimates would reflect reductions, which would offset any additional teaching payments.

In addition, no data currently exist about the impact of the Medicare managed care teaching payments at the hospital level (CBO's estimates are national level). The number of Medicare managed care enrollees in a given market who are treated in teaching hospitals is not known and exceedingly difficult to estimate. Medicare managed care penetration is highly variable across the areas in which teaching hospitals are located, and it is unlikely that these figures reflect the number of Medicare managed care enrollees treated by hospitals, let alone teaching hospitals. Thus, accurate estimates of the scope of Medicare managed care payments at the hospital level--both teaching and patient care--are virtually impossible to calculate.

End Notes

[1] Inpatient hospital market basket growth projections: 1998, 3.0%; 1999, 2.7%; 2000, 2.8%; 2001, 2.7%; 2002, 2.6%; 2003, 2.7% (source: HCFA Office of the Actuary)

[2] Rural hospitals, sole community provider hospitals, Maryland hospitals, and hospitals with fewer than 90 beds were excluded from the simulation. Also excluded were hospitals with fewer than 330 days reported on their cost reports. Hospitals with extreme values were excluded from any analyses involving the extreme variable.

[3] The BBA impact simulation excluded COTH hospitals located in Maryland (because they are under a waiver from Medicare PPS) and Canada, as well as VA and PPS-exempt members.

[4] This methodology was based on a BBA impact model developed by the Greater New York Hospital Association.

[5] PPS standardized operating amounts were reduced by actual amounts through FFY 2000. Thereafter, the updates were reduced by the estimated increases in the hospital market less 1.1 percentage points in 2001; and less 1.1 percentage points in 2002 (source: section 4401 of the BBA). Diagnosis-related group (DRG) per case payments were estimated using the PPS standardized operating amount that corresponds to each hospital, the FFY 1999 estimated case-mix index, and the FFY 1999 reclassified hospital wage index. For each hospital, per case payments were then multiplied by the number of Medicare cases, as increased by HCFA projections. These projections were: 1997, 1.8%; 1998, 0.5%; 1999, 0.8%; 2000, 0.7%; 2001, 0.8%, 2002, 1.0% (source: HCFA Office of the Actuary, December, 1998). Outlier payments were estimated by multiplying projected inlier payments by the 1997 ratio of outlier payments to inlier payments. Medicare inpatient case-level payment DRG payments equal the sum of projected inlier and outlier payments.

[6] IME payment changes were determined by multiplying the projected DRG payment by the 1997 function of the intern/resident-to-bed ratio $[(1+IRB)^{.405}]$ and then by the following IME multiplier as specified in the BBA: 1.89 in1997; 1.72 in 1998; 1.6 in 1999; 1.47 in 2000; 1.35 in 2001; and 1.35 in 2002. (Source: Section 4621 of the BBA)

[7] The information that determines the level of DSH payments (Medicaid days and Medicare SSI days) was assumed to be constant over the period. Methodologically, DSH payments in the status quo projections were based on the ratio relationship between DSH payments and DRG payments in 1997. These amounts were then reduced by the following percentages pursuant to the BBA: 1% in 1998, 2% in 1999, 3% in 2000, 4% in 2001, 5% in 2002. (source: Section 4403 of the Balanced Budget Act of 1997)

[8] For the status quo scenarios, inpatient capital payments for all hospitals were increased according to HCFA estimates (1998, 2.4%; 1999, 1.8%; 2000, -0.3 %; 2001, -0.5%;

2002, 4.3%. For the BBA impact, the status quo amounts were reduced by 17.8 % (source: 63 Fed. Reg. at 41121 (July 31, 1998)).

[9] Impact of change in the definition of "transfer": hospitals with100 or more residents (proxy for COTH hospitals), -0.6%; hospitals with less than 100 residents (other teaching), -0.7% non-teaching hospitals, -0.7% (source: HCFA impact analysis; 63 Fed. Reg. at 25681 (May 8, 1998)).

[10] Impact of changing outpatient payment formulas (eliminating the "formula-driven overpayment"): Major teaching hospitals (IRB ratios of 0.25 or higher) (proxy for COTH hospitals), -8.0%; other teaching hospitals (IRB ratio<0.25), -8.6%; non-teaching hospitals, -9.4% (source: AAMC analysis of data in Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy at page 105, March, 1999)

[11] The analysis projects the impact of the hospital outpatient PPS effective FFY 2001, which corresponds to HCFA's estimate as to when they expect the PPS to begin. The estimated impact of the outpatient PPS incorporated into hospitals with 100 or more residents (proxy for COTH hospitals), -10.6%; hospitals with<100 residents (other teaching), -4.4%; non-teaching hospitals, -5.1% (source: HCFA correction notice impact analysis of outpatient proposed rule; 64 Fed. Reg. at 35262 (June 30, 1999)).

[12] Presentation by Stuart Guterman, Principal Research Associate, The Urban Institute, before the Council on the Economic Impact of Health System Change (June 14, 1999).

[13] 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and thereafter. These amounts are being "carved out" of the Medicare managed care plan capitated rates on a similar phase-in schedule.

[14] "Budgetary Implications of the Balanced Budget Act of 1997," Congressional Budget Office, December 1997.

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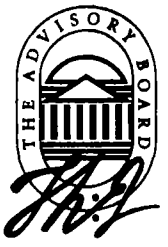
HEALTH CARE ADVISORY BOARD
ECONOMICS BRIEF



MEDICARE PAYMENT REFORM

Executive Briefing on Health System Financial Performance Under the Balanced Budget Act of 1997

The Advisory Board Company ~ Washington, D.C.

Copies of the BBA Relief letter went to:

Senator Pat Roberts
Senator Sam Brownback
Representative Todd Tiahrt
Representative Jerry Moran
Representative Jim Ryun
Representative Dennis Moore
Don Wilson – KHA
Linda Rouse – NRHA Government Affairs
John T. Supplitt – AHA
Senator Trent Lott – Senate Majority Leader
Representative Bill Thomas
Representative Dennis Hastert – Speaker of the House
Senator William Roth
Representative Bill Archer

RUSSELL REGIONAL HOSPITAL

July 30, 1999

The Honorable Sam Brownback
United States Senator
Room 303
Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Brownback:

It was brought to my attention that there is a lack of focus on the part of rural hospitals in correcting portions of the Balanced Budget Act of 1997 (BBA). I was asked to prioritize my concerns with the BBA in an effort to focus on a few of the most important areas needing revision. Attached are the top six (6) priorities, rank-ordered from most important (1.) to less important (6.) for Russell Regional Hospital. I am also attaching a summary worksheet of the financial impact for each of these items.

1. Reduced Rate of Growth for DRG payments, Section 4401(a) of the BBA.

2. Reduced Inpatient Capital Payments, Section 4402 of the BBA.

3. Outpatient Formula-Driven Overpayment (FDO), Section 4521 of the BBA.

4. Reduction in Bad Debt Payment Levels, Section 4451 of the BBA.

5. Reduction in Home Health per-Visit Cost Limits, Section 4601 and 4602 of the BBA.

6. Reduction in Disproportionate Share payments (DSH), Section 4403 (a) of the BBA.

As a result of the BBA, we have been forced to close our Home Health services. Without BBA relief, it will be increasingly difficult to keep our hospital open.

200 South Main (785) 483-3131 Russell, Kansas 67665-0593

People are alive today because of the services provided by Russell Regional Hospital. Without the hospital and/or the ability to provide new technology and add professional staff, our aging population will be forced to travel distances that will be measured in hours rather than minutes. These people are facing a loss in access to healthcare just when they need healthcare the most.

I understand the need to control costs, but I urge you to reconsider the impact the BBA is having on rural healthcare.

Sincerely,

Bruce W. Garrett
Administrator/CEO

BWG/tt

Attachment

KANSAS HOSPITAL ASSOCIATION
BBA97 MEDICARE REIMBURSEMENT IMPACT SUMMARY
STATE OF KANSAS

			FY98	FY99	FY00	FY01	FY02
170030	Provider:	170030 - RUSSELL REGIONAL HOSPITAL					
170030	City:	RUSSELL					
170030	Congress Dist:	1					
170030	Class:	SOLE COMMUNITY HOSPITALS					
170030							
170030	Reduced Rates	of Growth for DRG Payments	(40,758)	(70,540)	(99,834)	(119,418)	(139,801)
170030							
170030	Formula Driven	Overpayment Elimination	(22,797)	(22,797)	(22,797)	(22,797)	(22,797)
170030							
170030	Payment Cuts:	Reduced Inpatient Capital Payments	(42,587)	(48,671)	(54,755)	(60,838)	(60,838)
170030		Reduced DSH Payments					
170030		Placement of cap on TEFRA limits					
170030		Change in TEFRA Relief Payment Formula					
170030		Change in TEFRA Bonus Payment Formula					
170030		Reduction in TEFRA Capital Payments					
170030		Bad Debts	(7,292)	(11,668)	(13,126)	(13,126)	(13,126)
170030		Indirect Medical Education Payments					
170030		Home Health Per Visit Cost Limits	(16,327)	(16,327)	(16,327)	(16,327)	(16,327)
170030		Home Health Per Beneficiary Limitation	(15,532)	(15,532)	(15,532)	(15,532)	(15,532)
170030							
170030		Total Payment Cuts	(81,738)	(92,198)	(99,740)	(105,823)	(105,823)
170030							
170030	Grand Total		(145,293)	(185,535)	(222,371)	(248,038)	(268,421)
170030							
170030							
170030	Total Expense		5,911,736	5,911,736	5,911,736	5,911,736	5,911,736
170030							
170030							
170030							
170030							