

HCFA LEGISLATIVE SUMMARY

June 1, 1983

On April 20, 1983, President Reagan signed into law H.R. 1900 (P.L. 98-21), the Social Security Amendments of 1983. The legislation includes the establishment of a prospective payment system for hospitals. A summary of the provisions of this legislation is attached.



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Attachment

Prospective Payment Provisions
Title VI of the Social Security Amendments of 1983 (P.L. 98-21)

Prospective Payment System

Effective with hospital cost-reporting periods beginning on or after October 1, 1983, Medicare payment for inpatient operating costs will be based on a fixed amount, determined in advance, for each case, according to one of 467 diagnosis related groups (DRGs) into which a case is classified. The prospective payment will be considered payment in full; hospitals are prohibited from charging beneficiaries more than the statutory deductible and coinsurance.

This system replaces the retrospective cost reimbursement system and the cost-per-case limits and rate of increase ceiling created by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), P.L. 97-248, for most hospitals. The new prospective payment system will be structured to be "budget neutral" through FY 1985; that is, payments for Medicare inpatient hospital costs under the prospective payment system will be no more or less than projected under the TEFRA provisions.

Hospitals Covered

The prospective payment system will apply to all Medicare participating hospitals except psychiatric, long-term care (with an average stay greater than 25 days), children's, and rehabilitation hospitals, and hospitals outside of the 50 states and the District of Columbia. Distinct-part rehabilitation and psychiatric units of acute care hospitals are also exempt. These hospitals and hospital units will continue to be reimbursed their reasonable costs subject to the target rate of increase limits enacted in TEFRA.

Special treatment is provided for hospitals which (because of location, weather and travel factors, or absence of other hospitals) are designated by the Secretary as sole community providers. Payment to these hospitals during the transition period and afterwards will be made at the rate specified for the first year of implementation for other hospitals; i.e., 75 percent of the payment would be based on the hospital's cost experience and 25 percent would be on the regional DRG rate. The Secretary must also make adjustments for fixed and core staff costs incurred in the event of a five percent decrease in workload from a previous year due to circumstances beyond the hospital's control.

Exceptions and adjustments may be made, as the Secretary finds appropriate, to account for the special needs of public or other hospitals serving a disproportionately large number of low-income and Medicare Part A patients, hospitals that are national or regional referral centers (including rural hospitals with over 500 beds), hospitals involved extensively in cancer research and treatment, and hospitals in Alaska and Hawaii.

Services Covered

Effective October 1, 1983, all non-physician services provided in an inpatient setting will be paid only as inpatient hospital services under Part A. The Secretary may waive this restriction during the three-year transition period for hospitals that, prior to October 1, 1982, have allowed direct billing under Part B so extensively that the immediate implementation of the restriction would threaten the stability of patient care. Part B billings made under such a waiver will be deducted from payments made to the hospitals under the prospective system. At the end of the waiver period, the Secretary may provide for Part A payment methods appropriate to the organizational structure of the institution.

Transition Period

The prospective payment system will be phased in over a three-year period by cost-reporting periods that begin on or after October 1, 1983. During this time, payment rates will be a blend of hospital-specific amounts based on each hospital's cost experience and national and regional (for nine census divisions) DRG amounts for both urban and rural hospitals.

In the first cost-reporting period under prospective payment, the Medicare payment per discharge will be:

- o 25 percent of the regional DRG rate; plus
- o 75 percent of the hospital-specific rate.

In the second cost-reporting period, the Medicare payment per discharge will be:

- o 50 percent of a combination of national and regional DRG rates (25 percent national, 75 percent regional); plus
- o 50 percent of the hospital-specific rate.

In the third and last cost-reporting period of the system's phase-in, the Medicare payment per discharge will be:

- o 75 percent of a combination of national and regional rates (50 percent national, 50 percent regional); plus
- o 25 percent of the hospital-specific rate.

Effective with hospital cost-reporting periods beginning on or after October 1, 1986, Medicare payment will be 100 percent of the national urban or rural DRG rate for each discharge.

Calculation of Hospital-Specific Costs

The portion of the Medicare payment per discharge based on hospital cost experience will be the hospital's target amount as calculated under the TEFRA rate-of-increase limits, without regard to Section 223 limits, penalties or bonuses, and with annual updates for inflation. Adjustments can be made to base year costs to make them comparable to the inpatient costs under the prospective system. For example, the base year costs for nonprofit hospitals whose employees now would be covered under Social Security (based on another provision of the law) will be increased to reflect additional costs that would have been incurred in the base year if the hospital had been in the Social Security system.

Calculation of DRG Rates

Using the most recent cost report data available, allowable inpatient operating costs per discharge will be determined for individual hospitals. The costs then will be updated for fiscal year 1983 by the estimated national average rate of inflation in hospital costs. For fiscal year 1984, the hospital per discharge costs will be updated by the projected national hospital marketbasket rate of inflation plus one percent. The per discharge costs then will be standardized by excluding estimated indirect medical education costs and by adjusting for variations in case-mix and area wages. Urban (by Metropolitan Statistical Area) and rural averages then will be computed for the United States and the nine census divisions. The standardized average amounts will be reduced to offset additional payments for unusually long-stay or expensive cases (i.e., outliers) and to achieve budget neutrality, if necessary, with projected reimbursement under the TEFRA limitations. The standardized amounts also will be adjusted by the estimated cost of inpatient services billed under Part B in the base year that now will be payable under the prospective rate. The DRG-specific rates for urban and rural areas in the United States and the regions then will be calculated by applying a weighting factor reflecting the relative hospital resources used for discharges within the various DRGs. Finally, the DRG-specific rates will be adjusted to reflect differences in area hospital wages compared to the national average wage level.

Annual Increases

For fiscal year 1985, the standardized amounts will be increased by the projected rate of increase in the hospital marketbasket plus one percent. These standardized amounts could be reduced for outlier payments and to achieve budget neutrality.

Beginning with fiscal year 1986, the annual increase in DRG rates will be determined by the Secretary. The increases must take into account amounts necessary for the "efficient and effective delivery of medically appropriate and necessary care of high quality." The Prospective Payment Assessment Commission will review evidence concerning factors that may affect the level of the annual increase and provide its recommendations to the Secretary not later than April 1 of each year. The Secretary will publish the proposed annual increase factor in the Federal Register by June 1 and the final annual increase factor by September 1 of each year.

DRG Recalibration

The Secretary must adjust the DRG classifications and weighting factors for fiscal year 1986 and at least every four years thereafter to reflect changes in treatment patterns, technology, and other factors affecting hospital resource utilization.

The Prospective Payment Assessment Commission will consult with the Secretary and make recommendations on the need for adjustments based on its evaluation of new practices, technologies, and treatment modalities. The Commission will also report to Congress on its evaluation of adjustments made by the Secretary.

Atypical Cases ("Outliers")

Payments in addition to the DRG rate will be made for cases which exceed the mean length of stay for the DRG by a fixed number of days, or by a certain number of standard deviations (whichever is the fewer number of days). At a hospital's request, the Secretary may make additional payments for cases whose costs exceed a fixed multiple of the appropriate DRG rate or other fixed amount. The additional payment will approximate the marginal costs of care beyond the outlier cut-off criteria (days or dollar amounts).

The total proportion of outlier payments cannot be less than five percent nor more than six percent of total DRG-related payments in any year.

Capital Expenses

General

Capital-related expenses are specifically excluded from the prospective payment system until October 1, 1986. Until that time, they will be reimbursed on a reasonable cost basis. The Secretary must report to Congress, within 18 months, on a method to incorporate capital-related costs (including return on equity) into the prospective payment system.

The law specifies that when capital-related costs are brought into the prospective system there is no assurance that capital expenditures obligated on or after implementation of that system will be treated in the same manner as expenditures obligated before the implementation date.

Return on Equity

Effective for cost-reporting periods beginning on or after the date of enactment, the rate of return on equity for inpatient hospital services in proprietary hospitals will be reduced from one-and-one-half times to the average rate of interest paid during the cost-reporting period by the Federal Treasury on the assets of the Hospital Insurance Trust Fund.

Section 1122 Review

If legislation is not enacted before October 1, 1986 to deal with capital, Medicare payment will be made for capital projects obligated after September 30, 1986 only if the expenditures have been approved under Section 1122. States will be required to enter into agreements with the Secretary to establish Section 1122 agencies if they have not already done so.

Capital expenditures made by health care facilities will be exempt from Section 1122 review if 75 percent of their patients who are expected to use the service are health maintenance organization (HMO) or competitive medical plan (CMP) enrollees; if the services and facilities are needed for an HMO or CMP to operate efficiently and economically; and if the services are not otherwise readily accessible to an HMO or CMP due to at least one of the following reasons:

- o the facilities do not provide common services at the same site;
- o the facilities are not available under a contract of reasonable duration;
- o full and equal medical staff privileges are not available;
- o the arrangements are not administratively feasible; or
- o the services are more costly than if provided directly by the HMO or CMP.

In addition, effective upon enactment, the financing of Section 1122 reviews will be made from general revenues. Hospitals will be required to make their capital budgets available to the Section 1122 or other appropriate agency. States may set their own dollar thresholds for review, not to exceed a maximum of \$600,000.

Medical Education Expenses

Direct Costs

The direct costs of approved educational programs are specifically excluded from the prospective payment and will be paid on the basis of reasonable cost.

Indirect Costs

The indirect costs of medical education are not included in the prospective payment and will be paid at twice the factor used to adjust for such costs, by applying the same methodology currently in effect.

Cost Reporting

A system of cost reporting for hospitals under the prospective payment system will be maintained during the three-year transition period and for at least two years afterward (until the end of fiscal year 1988).

Administrative and Judicial Review

Administrative and judicial review is permitted except for the DRG classification and weights and the level of the payment necessary to maintain budget neutrality in fiscal years 1984 and 1985.

Group appeals must now be made in the judicial district in which the greatest number of such providers is located. Appeals to the Provider Reimbursement Review Board for action for judicial review brought by providers under common ownership or control will have to be brought as a group when the matter involves a common issue.

State Cost Control Systems

The Secretary has the authority to approve Medicare payment under a state cost control system if the system meets the four requirements enacted in TEFRA plus two additional requirements. To qualify, state systems must:

- o apply to substantially all acute care hospitals in the state;
- o apply to at least 75 percent of all inpatient revenues or expenses;
- o provide assurances that payors, hospital employees, and patients are treated equitably;
- o provide assurances that the state's system will not result in greater Medicare expenditures over a three-year period;
- o not preclude HMOs or CMPs from negotiating directly with hospitals concerning payment for inpatient services; and
- o prohibit payments under Part B for nonphysician services provided to inpatients, unless waived in accordance with regulations which the Secretary is required to publish.

The Secretary can neither deny a state's application because it is not based on a DRG payment methodology, nor require that Medicare expenditures under the state system be less than would have been made under the Federal prospective payment system.

The Secretary shall approve state applications which meet the preceding requirements plus additional requirements that the system must:

- o be operated directly by the state or entity designated by state law;
- o use prospective methodology;
- o provide for hospital reports, as required by the Secretary;
- o provide satisfactory assurances that it will not result in admission practices which will reduce treatment to low income, high cost, or emergency patients;

- o not reduce payments without 60 days notice to the Secretary and to hospitals; and
- o provide satisfactory assurances that, in developing the program, the state has consulted with local officials concerning the impact on public hospitals.

The Secretary must respond to states applying under these conditions within 60 days following submission of the request.

Existing State Programs

States now operating approved cost control systems (Maryland, New Jersey, New York, and Massachusetts) will be allowed to continue as long as they meet the requirements for which the Secretary has authority to grant approval.

The Secretary must modify the demonstration agreements with the states of New York and Massachusetts, if requested by the state or another party to the agreement, so that the demonstrations are not required to keep the state rate of increase in Medicare hospital expenditures one-and-one-half percentage points below the national rate of increase.

The Secretary must judge the effectiveness of the existing state systems during the three cost-reporting periods beginning on or after October 1, 1983. For the purpose of the evaluation, those States have the option of having either the rate of inflation in aggregate payments or payments per admission or discharge compared to the national rate of increase.

Reduction in Payments

If the cost of a state system exceeds the amounts that would have been paid under the Federal system over a three-year period, the Secretary may reduce subsequent payments to hospitals by the amount in excess.

Admissions and Quality Review - Contracts with Peer Review Organizations (PROs)

Requirements for PRO Agreements

Effective October 1, 1983, hospitals under a prospective payment system (Federal or state) would have to contract for review services with a PRO, if one exists in their areas. Beginning October 1, 1984, hospitals must have a contract with a PRO as a condition for Medicare payment. If there is no PRO in the area, the hospital will not receive payment. Hospitals which have contracted with a PRO that is subsequently terminated by the Secretary will not be penalized for 6 months while the Secretary contracts with a new PRO.

The 12-month waiting period for intermediaries to qualify as PROs would begin on the date the Secretary enters into contracts or on October 1, 1983, whichever is earlier.

PRO Review Functions

The specified functions of a PRO include reviewing:

- o the validity of diagnostic information provided by hospitals;
- o the completeness, adequacy, and quality of care provided;
- o the appropriateness of admissions and discharges; and
- o the appropriateness of care for which outlier payments are made.

Payments to PROs

PRO review is considered a Part A hospital cost but the RO will be paid directly by the Secretary on the basis of a rate per review. The Secretary will determine the review rate, which can be no less than the fiscal year 1982 review rate for both direct and administrative costs, adjusted for inflation. PRO funding will come from the Hospital Insurance Trust Fund and will not be subject to appropriations.

Penalties

Based on PRO findings, the Secretary may deny payment for unnecessary or multiple admissions, or require hospitals to take necessary action to correct unacceptable medical or other practices.

Studies, Demonstrations and Reports

The Secretary is required to study and report to Congress on the following:

- o Capital-Related Costs - The method by which capital-related costs such as return on equity, associated with inpatient hospital services can be included in the prospective payment system. Due date: October 1984.
- o Annual Impact Report - The impact in the previous year of the prospective payment methodology on providers, beneficiaries, and other payors of hospital care, and the impact of computing DRG rates by census division, rather than on a national basis. The report must include recommendations for appropriate legislative changes. Due date: by the end of each year for 1984 through 1987.
- o Skilled Nursing Facilities (SNFs)
 - The impact of hospital prospective payment systems on SNFs and recommendations concerning SNFs. Due date: by December 31, 1983.
 - Requires the Secretary to conduct demonstrations with hospitals in areas with critical shortages of SNFs to study the feasibility of providing alternative systems of care or methods of payment.

- The effect of a single limit of SNF reimbursement on hospital-based SNFs, given the differences (if any) in the patient populations served by such facilities and by community-based SNFs. Due date: by December 31, 1983.
- o Inpatient Physicians' Services - Requires the Secretary, during fiscal year 1984, to begin the collection of data necessary to compute, by DRGs, the amount of physician charges for services furnished to hospital inpatients classified in those DRGs. The report to Congress must include recommendations on the advisability and feasibility of determining payments for inpatient physicians' services on a DRG-type classification. Due date: 1985.
- o Urban/Rural Rates - the feasibility and impact of eliminating or phasing out separate urban and rural DRG rates. Due date: at the end of 1985 as part of the 1985 annual impact report.
- o Prospective Payment for Exempted Hospitals - the feasibility and methodology by which hospitals not included in the prospective payment system can be paid on a prospective basis for inpatient services. Due date: at the end of 1985 as part of the 1985 annual report.
- o Payments for Outliers and Modifications to the DRGs - the appropriateness of factors used to compensate hospitals for outlier cases and the feasibility and advisability of modifying the DRGs by the application of severity of illness, intensity of care or other factors. Due date: at the end of 1985 as part of the 1985 annual report.
- o All Payer System - the feasibility and desirability of all inpatient hospital payers participating in a prospective payment system, including consideration of cost-shifting to nonfederal payers and the impact on health insurance costs and premiums paid by employers and employees. Due date: at the end of 1985 as part of the 1985 annual report.
- o Impact on Admissions - the feasibility of making a volume adjustment in the DRG rates or requiring preadmission certification in order to minimize the incentive to increase admissions. Due date: at the end of 1985 as part of the 1985 annual report.
- o Impact of State Systems - the overall impact of state hospital payment systems approved under the Social Security Act on the Medicare and Medicaid programs, on payments and premiums under private health insurance plans, and on tax expenditures. Due date: at the end of 1986 as part of the 1986 annual report.
- o Sole Community Providers - requires the Secretary to study and make legislative recommendations on an equitable method of reimbursing sole community providers, taking into account their unique vulnerability to substantial variations in occupancy. Due date: by April 1, 1985.

- o Information Transfer Between Parts A and B - examine ways to coordinate an information transfer between Parts A and B of Medicare, particularly where a denial of coverage is made under Part A but no adjustment is made in the reimbursement to admitting physician(s). Due date: by April 1, 1985.
- o Uncompensated Care Costs - the appropriate treatment of uncompensated care costs and adjustments that might be appropriate for large teaching hospitals in rural areas. Due date: by April 1, 1985.
- o Making Hospital Cost Information Available - the advisability of hospitals making information available on the cost of care to patients financed by public and private payers. Due date: by April 1, 1985.
- o The Territories, Puerto Rico, and the Virgin Islands - a methodology for including hospitals located outside of the fifty States and the District of Columbia under a prospective payment system. Due date: by April 1, 1984.

Prospective Payment Assessment Commission

Membership

The Director of the Congressional Office of Technology Assessment (OTA) will provide for appointment of a 15 member commission of independent experts by April 1, 1984 for a term of 3 years. Initial terms may be shorter so that the terms of no more than seven members expire in any year. The membership must provide expertise and experience in the provision and financing of health care and must include, at least, physicians, registered nurses, employers, third-party payers, individuals with expertise in the conduct and interpretation of biomedical, health services, and health economics research, and individuals with expertise in the research and development of technologic and scientific advances in health care.

Nominations for commission members will be sought from national organizations representing physicians (including medical specialty organizations), registered nurses, skilled health professionals, hospitals (including teaching hospitals), manufacturers of health care products, the business community, health benefit programs, employers, and the elderly.

Authority

Subject to the review of OTA, the Commission may:

- o employ and fix compensation for up to 25 persons, as necessary to carry out its functions;
- o seek necessary assistance and support from appropriate Federal agencies, including access to relevant information to assure coordination of activities;

- o award grants or contracts, including those for original research and experimentation, including clinical research. Clinical services provided as part of a research project must have the Secretary's concurrence for reimbursement. The authority to conduct clinical research is also extended to the Secretary as it relates to the Commission's duties and functions;
- o make advance or other payments related to its work;
- o provide transportation and subsistence to unpaid volunteers; and
- o prescribe necessary rules and regulations for its internal organization and operation.

Duties and Functions

- o Review and provide recommendations to the Secretary on DRG recalibrations for FY 1986 and at least every four years thereafter;
- o Review and provide recommendations to the Secretary on the annual increase factor beginning with FY 1986; and
- o In order to make recommendations on DRG recalibrations, collect and assess information on the safety, efficacy and cost-effectiveness of new and existing medical and surgical procedures and services, including regional variation in medical practice, lengths of hospitalization and other patient-care data, with special attention to treatment patterns for costly or inappropriate care not conducive to increasing quality.

Support and Oversight

Necessary appropriations will be made from the Medicare Trust Funds (85 percent from the Hospital Insurance Trust Fund and 15 percent from the Supplementary Medical Insurance Trust Fund) to fund the Commission's activities.

The OTA has unrestricted and immediate access to all deliberations, records and data of the Commission and must report annually to Congress on the functions and progress of the Commission and on the status of the assessment of medical procedures and services.

Other Title VI Provisions

Delay of Single Reimbursement Limit for Skilled Nursing Facilities (SNFs)

The effective date for the single reimbursement limit for hospital-based and community-based SNFs is delayed to cost reporting periods beginning on or after October 1, 1983.

Shift in Medicare Premiums to Coincide with Cost-of-Living Increase

The Part A and Part B premiums will remain at the June 1983 amounts through December 1983, after which premium adjustments will be made on a calendar year basis. The Part B premium will be set at one-half the actuarial rate from January 1984 through December 1985.

The Secretary will develop and promulgate new premiums during the September prior to the calendar year in which the premiums will be effective. The actuarial assumptions and other bases for arriving at adequate premium amounts will be issued at the same time.

On Lok Demonstration

Within 30 days following enactment the Secretary must approve, with appropriate terms and conditions, the applications of the On Lok Senior Health Services (dated July 2, 1982) and the California Department of Health Services (dated November 1, 1982) for a 36-month waiver of certain Medicare and Medicaid requirements to carry out a demonstration project for capitated reimbursement of comprehensive long-term care services.