U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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June 27, 2013

The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Richard Burr
Ranking Member
Subcommittee on Primary Health and Aging
Committee on Health, Education, Labor and Pensions
United States Senate

Subject: *Medicare: Ownership Status of Inpatient Prospective Payment System Hospitals That Qualify for Payment Adjustments*

In 1983, Congress created the inpatient prospective payment system (IPPS) to help control the growth of hospital spending and give hospitals a strong incentive to provide care efficiently.[1] Under this system, Medicare pays hospitals a flat fee per stay, set in advance, with different amounts for each type of condition. Payment rates are also influenced by such factors as the relative hourly wage in the area where the hospital is located and whether the hospital qualifies for additional payments.

Congress can enhance Medicare payments to certain hospitals by changing the qualifying criteria for IPPS payment categories, creating and extending exceptions to IPPS rules, or exempting certain types of hospitals from the IPPS. Often such efforts are intended to help ensure beneficiary access to care or to help hospitals recruit and retain physicians and other medical professionals. In April 2013, we reported that numerous statutory provisions have been enacted from 1998 through 2012 to increase Medicare payments to a subset of hospitals.[2] We also reported that nearly all hospitals in our review qualified for an IPPS payment adjustment or were excluded from the IPPS entirely in 2012.

In response to these findings, you asked us to provide information about the ownership status of the IPPS hospitals included in our review, particularly those hospitals qualifying for payment adjustments in 2012. To address this issue, we analyzed two datasets from the Centers for Medicare & Medicaid Services (CMS): the fiscal year 2013 impact file and the 2013 Hospital Compare database. We used the impact file to identify hospitals paid under the IPPS as of July 2012, those hospitals that received payment adjustments, the category of adjustments for which

[1]See Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65 (1983) (codified, as amended, at 42 U.S.C. § 1395ww).

[2]GAO, *Medicare: Legislative Modifications Have Resulted in Payment Adjustments for Most Hospitals*, GAO-13-334 (Washington, D.C.: Apr. 17, 2013).

they qualified, and the extent to which they qualified for multiple categories of adjustments.[3] We merged those data with Hospital Compare using Medicare provider identification numbers in order to associate each hospital with one of nine ownership categories, allowing us to classify them as nonprofit, for-profit, government-owned, or physician-owned.[4] In order to assess the reliability of the data we analyzed, we reviewed CMS's documentation on both data sets and interviewed CMS officials familiar with the data sets. We found these data sufficiently reliable for the purpose of this engagement.

This work is based on our initial April 2013 report and our subsequent analysis of hospital ownership data, and was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings based on our audit objectives. This follow-on work was prepared in May and June 2013.

Background

We found in our previous report that, in 2012, payment adjustments affected the vast majority of IPPS hospitals in our review. Among the 3,455 IPPS hospitals, 3,039 hospitals, or 88 percent, qualified for at least one of the following four categories of upward payment adjustments.[5]

- *Medicare disproportionate share hospital (DSH)*. The Medicare DSH adjustment generally provides supplemental payments to hospitals that treat a disproportionate number of low-income patients. The amount of Medicare DSH payment adjustment varies by hospital location and size.

- *Indirect medical education (IME)*. Medicare reimburses teaching hospitals and academic medical centers for indirect costs of their residency training programs through an IME adjustment. The size of the IME adjustment depends on the hospital's teaching intensity, which is generally measured by a hospital's number of residents per bed.

- *Wage index reclassification*. CMS adjusts hospital payments under IPPS using the area wage index to account for variation in labor costs across the country. If a hospital's wage index does not fully account for its relative labor costs, the hospital may qualify to be reclassified to a higher wage index area in order to receive higher Medicare payments. To request a reclassification to another geographic area, hospitals may apply to the Medicare Geographic Classification Review Board.

[3]The impact files provide hospital-level data CMS uses to estimate payment impacts of various policy changes in proposed and final rules published in the Federal Register. CMS usually prepares impact files in the summer proceeding each federal fiscal year, based on the most recent data available at the time. Impact files include data on all Medicare acute care general hospitals except critical access hospitals, children's hospitals, and other facility types that are not paid under the IPPS. In addition, because Maryland hospitals are not paid under the IPPS, we removed Maryland data from our analysis of the impact files.

[4]Information on hospital characteristics reported in CMS's Hospital Compare database is submitted by hospitals through the CMS Certification and Survey Provider Enhanced Reporting system. We used data as of April 2013.

[5]The remaining 416 hospitals, about 12 percent, received IPPS payments that were unadjusted for the types of modifications included in our review.

- *Rural provider type*. Rural hospitals may qualify for special treatment in determining payment rates under IPPS, although some urban hospitals may also qualify, through three programs: sole community hospitals (SCH), rural referral centers (RRC), and Medicare-dependent hospitals (MDH). Generally, the SCH program provides payment adjustments to hospitals that are the only source of inpatient care in their community; the RRC program supports high-volume rural hospitals that treat a large number of complicated cases; and the MDH program provides payment adjustments to small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges.

Of the four categories, the DSH adjustment had the broadest reach, affecting payments to about four in five IPPS hospitals. Nearly one in three hospitals qualified for an IME adjustment, one in three qualified for a wage index reclassification adjustment, and almost one in five received a rural provider type adjustment.

Results

We found that the proportion of the 3,039 IPPS hospitals in our review that qualified for at least one of four categories of payment adjustments was higher among nonprofit and government-owned hospitals than among for-profit hospitals.[6] On average, about 97 percent of government-owned hospitals and about 90 percent of nonprofit hospitals received at least one form of increased payment in 2012. In contrast, roughly 80 percent of for-profit hospitals qualified for a payment adjustment that year. (See table 1.)

[6]In our analysis, categories of upward payment adjustments for hospitals are defined as: DSH adjustment; IME adjustment; wage index reclassification; and special treatment of SCH, MDH, or RRC rural provider types. Because these categories are not mutually exclusive, a hospital could qualify for more than one type.

Table 1: Number and Percent of Inpatient Prospective Payment System (IPPS) Hospitals Qualifying for Increased Payment, by Ownership Type, 2012

Ownership type	Number of IPPS hospitals	IPPS hospitals that qualified for increased payment	
		Number	Percentage
Nonprofit	**2,000**	**1,798**	**89.9%**
Private	1,178	1,050	89.1
Church	353	319	90.4
Other	469	429	91.5
For-profit[a]	**737**	**587**	**79.6**
Government-owned	**621**	**600**	**96.6**
Hospital district or authority[b]	296	290	98.0
Local	207	200	96.6
State	61	57	93.4
Federal[c]	57	53	93.0
Physician-owned[d]	**29**	**9**	**31.0**
Unknown	**68**	**45**	**66.2**
Total	**3,455**	**3,039**	**88.0%**

Source: GAO analysis of CMS data.

Notes: Categories of upward payment adjustments for hospitals are defined as: Medicare disproportionate share hospital (DSH) adjustment; indirect medical education (IME) adjustment; wage index reclassification; and special treatment of rural provider types.

[a]Private for-profit hospitals include those owned by sole proprietors, limited liability corporations, partnerships, and corporations.

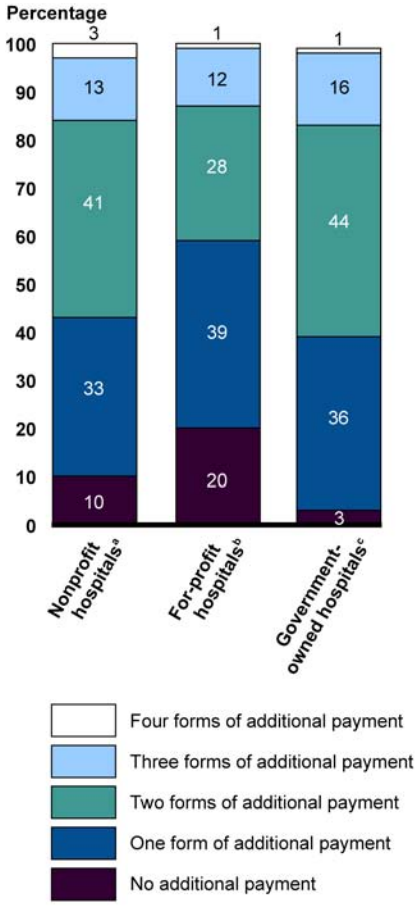
[b]Public hospitals owned by a special hospital district created by a state, or by a public authority created by a state. For example, a state university hospital might be operated by a public authority.

[c]Federal hospitals are limited to Indian Health Services hospitals.

[d]Private hospitals whose individual owners have their own Medicare provider identification number or National Provider Identification number.

For-profit hospitals were more likely to receive no, or only one form of, additional payment, whereas government-owned and nonprofit hospitals were more likely to receive two or three forms of additional payment. (See fig. 1.)

Figure 1: Percent of Nonprofit, For-Profit, and Government-Owned Inpatient Prospective Payment System (IPPS) Hospitals Qualifying for No, One, or Multiple Forms of Increased Payment, 2012



Source: GAO analysis of CMS data.

Notes: Categories of upward payment adjustments for hospitals are defined as: Medicare disproportionate share hospital (DSH) adjustment; indirect medical education (IME) adjustment; wage index reclassification; and special treatment of rural provider types.

[a]Nonprofit hospitals include church-owned, private, and certain other types of hospitals.

[b]Private for-profit hospitals include those owned by sole proprietors, limited liability corporations, partnerships, and corporations.

[c]Government-owned hospitals include hospital district or authority, local, state, and federal hospitals.

Agency Comments

The Department of Health and Human Services reviewed a draft of this report and did not have any general comments. The department provided technical comments, which we incorporated where appropriate.

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As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from its date. For further information regarding this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Copies of this report will be sent to the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Rosamond Katz, Assistant Director; Kate Nast; Katherine Perry; and Kathryn Richter.

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