



THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

**Description of HAP Report of
Three-Year Estimated Projections
Health Care Reform Impact on Medicare Provider Payments**

April 2010

Three-Year Estimated Projections—Health Care Reform Impact on Medicare Provider Payments:

This model provides hospitals with an estimate of the short-term Medicare payment implications of the recently signed health care reform laws. The three-year time frame limits the review to the time period before most of the coverage expansion provisions of the law take effect.

This model creates hospital-specific, Congressional district, state, and U.S. reports with projected impacts for the first three years of Medicare hospital payments under the new health care reform laws (the Patient Protection and Affordable Care Act [PPACA] of 2010 and the Health Care and Education Affordability Reconciliation Act [HCEARA] of 2010). The reports also note the details of the various payment provisions and the respective rate years that are applicable.

The major Medicare payment provisions affecting hospitals during 2010, 2011, and 2012 are:

- Reductions to Medicare update factors for productivity.
- Reductions to Medicare update factors in addition to productivity offsets.
- Rural add-on for home health care providers.
- One-year extension of the Section 508 wage index reclassifications.
- One-year extension of the outpatient PPS transition corridor for small rural hospitals, and expansion to include all sole community hospitals.

Limitations to the Three-Year Estimated Projections:

A few of the Medicare payment policy changes that are scheduled to take effect during this three-year period (e.g., inpatient payment adjustment for low volume hospitals and home health cap on outlier payments) are not modeled. This analysis also does not model Medicaid payment changes, nor does it include financial impacts on hospice providers, ambulance services, ambulatory surgery centers, laboratories, or durable medical equipment providers.





There are several major payment provisions that fall outside of the three-year window including: value-based purchasing, effective rate year (RY) 2013; readmissions payment policy, effective RY 2013; disproportionate share payment reductions, effective RY 2014; hospital-acquired conditions payment reductions, effective RY 2015; home health rural add-on expiration at the end of RY 2015; and home health payment rate rebasing, effective RY 2014.

Data Sources:

- Medicare Inpatient Revenue: CMS' Final 2010 Inpatient PPS impact file.
- Medicare Outpatient Revenue: CMS' Proposed 2010 Outpatient PPS impact file or the 2006 Medicare Cost Reports for hospitals excluded from the impact file.
- Medicare Inpatient Rehabilitation Revenue: CMS' final 2009 IRF rate setting file or the 2006 Medicare Cost Reports for hospitals excluded from the impact file.
- All other post-acute care settings: 2006 Medicare Cost Report data.
- National Impacts: Congressional Budget Office (CBO) analysis of H.R. 4872, released on March 18, 2010.

This data has been augmented by national data put out by CMS' Office of the Actuary on freestanding skilled nursing facility and home health Medicare PPS expenditures and Medicaid disproportionate share payments.

Methods:

All market basket freezes, productivity offsets, coding adjustments, and rebasing reductions were applied to estimated revenues, by year, by provider. In the cases of home health and skilled nursing facility payment reductions, state totals were increased by the proportion of freestanding to hospital-based payments. All other payment settings include freestanding providers.

Impacts of the proposed one-year extensions of Section 508 wage index reclassifications and outpatient prospective payment system (OPPS) hold harmless were estimated using hospital-specific estimated revenues before and after the proposed extensions.