REPORT TO CONGRESS

DEPARTMENT OF HEALTH AND HUMAN SERVICES STUDY OF URBAN MEDICARE-DEPENDENT HOSPITALS

Kathleen Sebelius
Secretary of Health and Human Services
2010

EXECUTIVE SUMMARY

Section 3142 of the Affordable Care Act directs the Secretary of Health and Human Services to "…conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act…" Section 3142 calls for an analysis of the Medicare inpatient margins of urban Medicare-dependent hospitals (UMDHs) as compared to other hospitals receiving one or more additional Medicare payments and adjustments under various provisions of section 1886 of the Security Act. The Secretary is directed to submit a report to Congress containing the results of the study together with recommendations for legislation and administrative action, as appropriate. This report contains findings from the study required by section 3142, along with recommendations based on those findings.

Section 3142 defines an UMDH as a subsection (d) hospital that does not receive any additional Medicare payments or adjustments under section 1886 of the Social Security Act, and for which more than 60 percent of the hospital's inpatient days or discharges must have been attributable to inpatients entitled to benefits under Part A, during two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report. We used Medicare cost reports, prospective payment historical impact files, and Medicare Provider Analysis and Review (MedPAR) files to identify UMDHs. In order to compare the Medicare inpatient margins of UMDHs with other facilities, it was also necessary to identify other categories of hospitals that receive additional Medicare payments and adjustments. Other hospital types identified for the analysis included Medicare-dependent small rural hospitals (MDHs); sole community hospitals

(SCHs); rural referral centers (that were not also a MDH or SCH); critical access hospitals; teaching hospitals (with or without disproportionate share hospital operating payments); and non-teaching hospitals receiving disproportionate share hospital operating payments. We also identified non-Medicare dependent hospitals (hospitals that neither received additional Medicare payments nor met the criteria to be classified as an UMDH) as a separate comparison group.

Our study used Medicare cost report data to analyze Medicare inpatient operating margins, defined as [(the sum of Medicare operating payments minus the sum of Medicare operating costs) divided by (the sum of Medicare operating payments)] multiplied by 100. Under this formula the payments and costs of larger hospitals will be more influential and the resulting amount is equivalent to a weighted average of the Medicare inpatient operating margins of the hospitals under analysis. Total (all-payer) facility margins were also calculated as a measure of overall financial condition. Total facility margins reflect the relationship between total revenues and costs, including both operating costs and capital costs for inpatient, outpatient, skilled nursing facility, and other types of services.

Key findings are summarized as follows:

1. Urban Medicare-dependent hospitals were found to have lower Medicare inpatient operating margins than hospitals that receive additional payments or adjustments beyond the basic diagnosis-related group (DRG)-based prospective payment system (IPPS) rate. In FY 2008, the average Medicare inpatient operating margin of UMDHs was -12.0 percent, compared to -1.2 percent for hospitals receiving additional payments or adjustments. Non-Medicare dependent hospitals had an average Medicare inpatient operating margin of -23.4 percent. These patterns

were consistent over the period FY 2006 through FY 2008. At the individual hospital level, there was substantial variation in Medicare inpatient operating margins. Among UMDHs, 24.1 percent had a Medicare inpatient operating margin of less than -25.0 percent and about one-third had Medicare inpatient operating margins of -5 percent or higher.

2. The reasons for low Medicare inpatient operating margins among UMDHs could not be determined from this analysis. UMDHs do not have unusually high Medicare costs, do not have a high percentage of outlier payments, and do not have other features (e.g., high average length of stay or low occupancy rates) that might be expected to produce high costs or low Medicare inpatient operating margins. In contrast, hospitals that did not meet the statutory criteria to be considered an UMDH and that did not receive any additional Medicare payments did have Medicare costs that were higher than those of UMDHs, controlling for other factors.

3. The relationship between Medicare dependency and costs may be explained by greater downward pressure on costs among Medicare-dependent hospitals. That is, if Medicare payments are below a hospital's costs, a hospital with a high proportion of Medicare cases will have a greater incentive to reduce its costs than a hospital with a low proportion of Medicare cases. This is consistent with the Medicare Payment Advisory Commission's (MedPAC's) assertion that hospitals with greater financial pressure tend to respond to the stronger incentives to constrain costs.

4. Total facility margins did not show as much variation across hospital categories as Medicare inpatient operating margins. Overall, the UMDHs had the lowest average total facility margin (-

0.1 percent) and non-Medicare dependent hospitals had the highest (3.6 percent), although there was variation in total facility margins within each category. UMDHs may have less capacity to achieve large positive margins on their non-Medicare business, given their dependence on Medicare.

RECOMMENDATION

This analysis revealed low Medicare inpatient operating margins for UMDHs relative to hospitals receiving additional payments and adjustments. However, the pattern of low Medicare inpatient operating margins was not limited to hospitals that are highly Medicare-dependent, and Medicare inpatient operating margins were, in fact, lower for hospitals that were less Medicare dependent. In order to fully consider whether a payment adjustment for UMDHs is warranted, more information is needed than a comparison of Medicare inpatient operating margins. Margins are based on payments and costs, and the relationship between these factors, as well as the relationship between Medicare inpatient operating margins, costs, and Medicare dependency, needs to be further explored.

This report provides a preliminary analysis of the readily available data on differences in margins and costs between UMDHs and other groups of hospitals, but it does not provide sufficient information to conclude that the Secretary should recommend a payment adjustment for UMDHs similar to that given to rural small Medicare-dependent hospitals. We therefore recommend that a review be conducted to evaluate the appropriateness of current Medicare payment policies under the IPPS, especially related to hospitals that do not currently receive additional payments or adjustments. The review could be conducted by the Department of Health and Human

Services or by an independent organization. We would expect that an independent review would most likely be perceived by the industry as unbiased.

I. PURPOSE

Section 3142 of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act (ACA)) directs the Secretary of Health and Human Services to "…conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act…" (see the Appendix). Section 3142 requires an analysis of the Medicare inpatient margins of urban Medicare-dependent hospitals (UMDHs) as compared to other hospitals receiving one or more additional Medicare payments and adjustments under various provisions of section 1886 of the Social Security Act.

Section 3142 defines an UMDH as a subsection (d) hospital that does not receive any additional Medicare payments or adjustments under section 1886(d) of the Social Security Act, such as indirect graduate medical education payments under subsection (d)(5)(B), disproportionate share payments under subsection (d)(5)(F),[a] payments to a rural referral center (RRC) under subsection (d)(5)(C), payments to a sole community hospital (SCH) under subsection (d)(5)(D), or payments to a Medicare-dependent small rural hospital (MDH) under subsection (d)(5)(G). In addition, the hospital must not be a critical access hospital (CAH); these hospitals are paid under section 1814(l) of the Social Security Act. Additionally, more than 60 percent of the hospital's inpatient days or discharges must have been attributable to Medicare inpatients entitled to benefits under Part A, during two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report. For comparison, a MDH is defined by section

[a] Section 3142 incorrectly listed the citation for DSH payments as subsection (d)(5)(A), which is the citation for outliers. The agency is interpreting the statute to refer to DSH and not outliers given the text and nature of the DSH payments as additional payments made to certain qualifying hospitals.

1886(d)(5)(G)(iv) of the Act as a hospital that is located in a rural area, has not more than 100 beds, is not a SCH, and has a high percentage of Medicare days or discharges ("not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled Medicare cost report, were attributable to inpatients entitled to benefits under Part A").

Section 3142 further requires that the study include an analysis of whether payments to Medicare-dependent, small rural hospitals under 1886(d)(5)(G) of the Social Security Act should be made to UMDHs. The Secretary is directed to submit a report to Congress containing the results of the study together with recommendations for legislation and administrative action, as appropriate. This report contains findings from the study required by section 3142 of the Affordable Care Act, along with recommendations based on those findings.

II. BACKGROUND

Section 1886 of the Social Security Act sets forth a system of payment for inpatient hospital stays under Medicare Part A (Hospital Insurance). Subsection (d) of section 1886 mandates a system of payment for the operating costs of acute care hospitals based on prospectively set rates. section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospectively determined rate. Under these inpatient prospective payment systems (IPPS), Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge.[1] Discharges are classified according to a list of diagnosis-related groups (DRGs). The base payment rate

includes a standardized amount, which is multiplied by the DRG relative weight. The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR Part 412, Subparts A through M.

If the hospital treats a high percentage of Medicare and Medicaid low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the Medicare disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the number of applicable low-income patients treated and the statutory formula applied to the hospital. If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of medical residents to inpatient beds.

The costs incurred by the hospital for each Medicare stay are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any eligible outlier payment is added to the DRG-adjusted base payment rate, plus any DSH and IME adjustments.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical

service must demonstrate that it is "new", that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate based on their costs in a base year. For example, SCHs receive the higher of a hospital-specific rate based on their costs in a base year (the highest of fiscal year (FY) 1982, FY 1987, FY 1996, or FY 2006) or the IPPS Federal rate based on the standardized amount. Through the end of FY 2006, a MDH received the higher of the Federal rate or the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. For discharges occurring on or after October 1, 2007, but before October 1, 2012, a MDH will receive the higher of the Federal rate or the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate.

The Medicare Payment Advisory Commission (MedPAC) is "an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program."[2] Among other activities, MedPAC analyzes issues surrounding payment, access to care, and quality of care, and makes recommendations to the Congress. As part of its Medicare payment analysis, MedPAC estimates Medicare margins for inpatient hospital services and incorporates that information in its annual recommendations. MedPAC defines the Medicare inpatient margin as Medicare payments minus

Medicare costs divided by Medicare payments. MedPAC reported that the Medicare inpatient margin for all IPPS hospitals has trended downward since 1997, and has been negative since 2004.[3] In 2008 the margin on Medicare inpatient services was -4.7 percent, with lower margins for urban hospitals, nonprofit hospitals, and nonteaching hospitals.

Low Medicare margins are not necessarily a symptom of overall poor financial condition on the part of hospitals. Stensland et al.[4] found that hospitals with high profits from non-Medicare revenue sources have higher costs than other hospitals, apparently because they have less financial pressure to control costs. Hospitals with higher costs typically have lower Medicare margins because Medicare revenue is based on a fixed payment rate per case. Often hospitals with low Medicare margins and high profits from non-Medicare revenue have more financial resources than hospitals with high Medicare margins.

Negative Medicare margins may call into question the adequacy of Medicare payments for inpatient hospital services. Negative margins also raise questions about how efficiently hospitals control costs given the incentives of a prospective payment system that generally rewards hospitals that find ways to control costs and provide more efficient care. Nonetheless, hospitals with a high proportion of Medicare discharges that do not qualify for special payments may be especially affected by negative Medicare margins because they derive a larger share of their revenues from Medicare business. With fewer non-Medicare discharges, they may be less able to compensate for negative Medicare margins through other revenue sources.

III. STUDY OBJECTIVES

The primary objective as stated in section 3142 of the ACA was to compute Medicare inpatient margins for UMDHs and compare them to Medicare inpatient margins of other categories of hospitals that receive additional Medicare payments and adjustments. We focused our analysis on Medicare inpatient operating margins, excluding capital-related payments and costs. Medicare inpatient operating margins were used for purposes of this study because section 3142 requires us to analyze whether the additional payments currently made to MDHs should be applied to UMDHs, and MDH payments to small rural hospitals under current law are based only on operating costs. The study used data on Medicare payments and costs for beneficiaries in the fee-for-service sector, excluding payments and costs for Medicare Advantage (MA) enrollees, because MDH payments are based on Medicare fee-for-service costs. Specific research questions addressed in the study are outlined below.

1. What are Medicare inpatient operating margins of UMDHs and how do they compare to margins of other categories of hospitals? What is the distribution of such margins?

2. What is the recent trend in Medicare inpatient operating margins for UMDHs and other categories of hospitals?

3. How do UMDHs differ from other categories of hospitals with respect to bed size, location, occupancy rate, case mix, and other features?

4. What are the total facility margins (incorporating revenue from all sources) of UMDHs?

5. How do Medicare operating costs per discharge vary among hospitals and what factors account for the differences? Variation in Medicare operating costs may help explain some of the patterns in Medicare inpatient operating margins.

IV. DATA

Three primary data sources were used.

1. Cost report data. The Healthcare Cost Report Information System (HCRIS) is a Centers for Medicare and Medicaid Services (CMS) database, available from 1996 onward, containing cost report data submitted by Medicare-certified hospitals. HCRIS includes revenue and costs for Medicare and other payers, and is the basis for computing hospital margins.

2. Prospective payment historical impact files (impact files) are annual hospital-specific files created by CMS to analyze the impact of adjustments to the IPPS. Impact files can be used to readily identify hospitals that receive various additional payments and special adjustments (e.g., IME payments). These files also contain data such as average case mix, wage index measures, location, and other hospital characteristics.

3. Medicare Provider Analysis and Review (MedPAR) file. This file is primarily derived from claims data and contains one record for every inpatient hospital stay undergone by a Medicare beneficiary in fee-for-service. Certain data associated with Medicare Advantage patients are included as well.

V. METHODS

The study sample comprised short-term acute care hospitals and CAHs treating Medicare patients in FY 2008. With the exception of CAHs (as noted below), we limited the sample to subsection (d) acute care hospitals paid under IPPS because UMDHs fall within that category and any payment adjustment to UMDH hospitals would be made within the context of IPPS. The study sample therefore included UMDHs and hospitals receiving additional payments and adjustments under IPPS and CAHs. We also included hospitals not receiving additional payments or adjustments under IPPS that did not meet the criteria for being Medicare-dependent in order to explore the relationship between Medicare dependency and margins. CAHs were included in the sample of providers receiving additional payments or adjustments, even though they are not subsection (d) hospitals, because they are specifically mentioned in section 3142.

Our first step was to identify hospitals receiving additional Medicare payments and adjustments, as described in section 3142. We included in this group any hospitals receiving facility-level additional payments and adjustments, but not additional case-based payments such as outlier payments and add-on payments for new technologies. Case-based payments were not included in the definition of additional payments and adjustments because all examples provided in the statute are facility-level adjustments. All providers except CAHs were identified from the FY

2011 impact file, which contains data from FY 2008 and FY 2007 cost reports. CAHs are not paid under IPPS, and so are not included on the impact files; for this study, CAHs were identified from HCRIS records for FY 2008. Maryland hospitals and Indian Health Service hospitals were deleted from the sample because, although they are subsection (d) hospitals, they are exempt from the IPPS.

The impact file was used to identify specific categories of IPPS providers receiving additional payments or adjustments as follows: MDHs; SCHs; and RRCs (that were not also a MDH or SCH). The impact file also identified teaching hospitals and hospitals receiving disproportionate share (DSH) operating payments. Hospitals receiving indirect medical education (IME) payments and no DSH operating payments were classified as teaching hospitals. Those receiving DSH operating payments and no IME payments were classified as DSH hospitals. Those receiving both IME and DSH operating payments were classified as teaching hospitals. Providers not receiving additional payments or adjustments and not defined as CAHs were further divided into UMDHs and non-Medicare-dependent hospitals. A hospital was categorized as an UMDH if more than 60 percent of inpatient days or discharges were attributable to Medicare beneficiaries entitled to benefits under Part A in two out of the three most recent cost reporting periods for which a settled cost report was available. Non-Medicare dependent hospitals were defined as hospitals that neither received additional Medicare payments or adjustments as described above, nor met the criteria to be classified as an UMDH. Non-Medicare dependent hospitals were included as a separate comparison group to further explore the relationship between Medicare dependency and margins.

In determining whether hospitals met the 60 percent threshold for Medicare inpatient days or discharges, we counted all days and discharges attributable to beneficiaries entitled to Part A, including those attributable to MA patients and those not covered for payment. Data from MA and non-covered stays were included because Medicare beneficiaries who have enrolled in a MA plan or whose stay is not covered for payment under Part A continue to meet all statutory criteria for entitlement to Part A benefits. The FY 2011 IPPS final rule adopted a similar criterion for identifying MDHs, which also must meet the 60 percent threshold. An inspection of the Medicare cost report data suggested there is currently substantial underreporting of MA and non-covered days and discharges, presumably because these data do not currently affect payments for non-teaching hospitals. In order to more accurately identify hospitals meeting the UMDH criteria, we developed adjustment factors for MA and non-covered days and discharges using MedPAR files. Using this method, 139 hospitals were identified as UMDHs (out of a total of 4,695 hospitals).

We note that while section 3142 refers to "urban" Medicare-dependent hospitals, the statutory definition of such hospitals in Section 3142 does not restrict them to urban areas. We therefore did not limit our definition of UMDHs to those located in urban areas, although we do provide a separate breakdown of UMDH data by geographic (i.e. urban or rural).

For each study hospital, Medicare inpatient operating margins were computed from the FY 2008 cost report, which was the most recent cost report available for most hospitals. If a FY 2008 cost report was not available, FY 2007 was used (55 hospitals). If no cost report was available for FY 2007 or FY 2008 the hospital was not included in the study (67 hospitals). We used both settled

and non-settled cost reports for the analysis of margins. A settled cost report is a Medicare cost report for which the Medicare contractor has completed its review process and has issued a Notice of Program Reimbursement. Seventeen percent of the cost reports used for the margins analysis were settled reports. By using FY 2008 and FY 2007 cost reports (whether they were settled or not) in the analysis of margins we were able to include the most recent data available. The use of the most recently available cost reports for the margins analysis differs from our use of only settled cost reports for the identification of Medicare-dependent hospitals because only settled cost reports are used in determining Medicare dependency for identifying MDHs.

Medicare operating payments were obtained from worksheet E, Part A of the Medicare cost report; for teaching hospitals an adjustment was made to remove the portion of the IME payments attributable to MA patients. The reason for the adjustment to teaching hospital data is that Medicare cost reports do not identify most payments and costs attributable to MA patients and therefore Medicare inpatient operating margins must be derived from payments and costs in fee-for-service only. Medicare operating costs were obtained from worksheet D1 of the Medicare cost report, with an adjustment to remove routine and ancillary service pass through costs not covered by inpatient operating payments under IPPS. The Medicare inpatient operating margin for any given category of hospitals except CAHs was defined as [(the sum of Medicare operating payments minus the sum of Medicare operating costs) divided by (the sum of Medicare operating payments)] multiplied by 100. Under this formula the payments and costs of larger hospitals will be more influential and the resulting amount is equivalent to a discharge-weighted average of the Medicare inpatient operating margins of the hospitals under analysis. It should be noted that some of the details of our methodology may differ from those used by MedPAC in

their margin analyses. For CAHs, the Medicare inpatient operating margin was defined to be 0.01, based on the Medicare payment methodology for these hospitals, which generally sets payments at one percent above costs. Individual hospitals were eliminated from the study if their Medicare costs or payments were less than $5,000, or if their Medicare inpatient operating margin was less than -100 percent or greater than 50 percent (i.e., if Medicare costs were more than twice payments or vice versa). This condition was imposed because Medicare inpatient operating margins less than -100 percent or greater than 50 percent may be unrealistic and therefore create concerns about the accuracy of the underlying data. The final sample consisted of 4,603 hospitals, of which 137 were UMDH hospitals.

Total (all-payer) facility margins were also calculated as a measure of overall financial condition. Total facility margins reflect the relationship between total revenues and costs, including both operating costs and capital costs for inpatient, outpatient, skilled nursing facility, and other types of services. Data on total revenues and costs were obtained from worksheet G3 of the Medicare cost report.

Regression analysis was used to examine factors associated with Medicare operating costs per discharge at the individual hospital level, and specifically to determine whether low Medicare inpatient operating margins of UMDHs might be explained by higher than expected costs. Consistent with common practice, the natural logarithm of cost per discharge was analyzed as the dependent variable because of the asymmetry (skewness) of the distribution of costs per discharge. Independent variables included factors incorporated into the payment system that are related to costs (e.g., case mix index, wage index, teaching and disproportionate share adjustment

factors) and hospital characteristics that may influence costs (e.g., location, bed size, and occupancy rate). Hospitals that were eligible for separate payment rates (RRCs, SCHs, and MDHs) were separately identified in the model. UMDHs and non-Medicare dependent hospitals were also separately identified.

VI. FINDINGS

The average Medicare inpatient operating margin for all acute care hospitals was -2.8 percent in FY 2008 (Table 1). Among hospitals that met the study requirements as an UMDH, the average Medicare inpatient operating margin was -12.0 percent. Hospitals receiving at least one type of additional payment or adjustment had an average Medicare inpatient operating margin of -1.2 percent, varying from -5.2 percent for Medicare DSH hospitals not receiving IME payments to 1.0 percent for CAHs. Non-Medicare dependent hospitals (that is, hospitals that neither received additional Medicare payments nor met the criteria to be classified as an UMDH) had the lowest average Medicare inpatient operating margin (-23.4 percent) of all hospital types. Average total facility margins did not vary across categories of hospitals to the same degree as Medicare inpatient operating margins, varying from -0.1 percent for UMDHs to 3.6 percent for non-Medicare dependent hospitals.

UMDHs had occupancy rates, case mix, and wage index values that were similar to hospitals receiving additional payments and adjustments. The percent of Medicare outlier payments, a measure of the percent of extremely high cost cases, was relatively low (3.3 percent) in UMDHs and relatively high in non-Medicare dependent hospitals (6.0 percent). Unadjusted Medicare

operating costs per discharge were somewhat lower in UMDHs than in hospitals receiving additional payments and adjustments ($8,943 and $9,730 respectively).

The UMDHs tended to be concentrated in eastern States (Table 2). About 45 percent were located in large urban areas as classified on the impact file, 48 percent were in other urban areas, and only 7 percent were located in rural areas. The UMDHs tended to be medium-sized (100-499 beds); there were no extremely large UMDHs (more than 500 beds) and the percent of UMDHs with 1-99 beds (48.9 percent) was slightly lower than for the other major hospital payment categories.

Medicare inpatient operating margins did not show a strong trend between FY 2006 and FY 2008 (Table 3). Among all acute care hospitals, the average Medicare inpatient operating margin was between -3.3 percent and -2.3 percent during that time. UMDHs had average Medicare inpatient operating margins between -12.1 percent and -11.8 percent across the three years. Other categories of hospitals showed similarly small variations in average Medicare inpatient operating margins across the three years.

In contrast, all categories of hospitals experienced a decline in total facility margins between FY 2006 and FY 2008, with most of the decline occurring between FY 2007 and FY 2008. Overall, average total facility margins declined from 6.0 percent in FY 2006 to 1.2 percent in FY 2008. Among UMDHs, average total facility margins declined from 5.4 percent to -0.1 percent, and among hospitals receiving additional payments and adjustments, average total facility margins declined from 6.0 percent to 1.0 percent. The decline of total facility margins in FY 2008 is

attributed to the recent economic downturn, which produced a drop in investment income and an increase in bad debt.

At the individual hospital level, there was substantial variation in Medicare inpatient operating margins (Table 4). Of the UMDHs, 32.1 percent had a Medicare inpatient operating margin of less than -20.0 percent and 50.4 percent had margins between -20.0 percent and -0.1 percent. About 17.5 percent of UMDHs had positive Medicare inpatient operating margins. Among non-Medicare dependent hospitals, 59.2 percent had Medicare inpatient operating margins of less than -20.0 percent and only 9.5 percent had positive Medicare inpatient operating margins.

Table 5 provides more detail on the relationship between Medicare inpatient operating margins and total facility margins at the individual hospital level. In general, there did not appear to be a strong relationship between Medicare inpatient operating margins and total facility margins. Among UMDHs and non-Medicare dependent hospitals, total facility margins were somewhat higher for hospitals with higher Medicare inpatient operating margins; the relationship was not consistent, however. Correlations between Medicare inpatient operating margins and total facility margins were somewhat positive for UMDHs and non-Medicare dependent hospitals (0.19 and 0.24 respectively), but close to zero for hospitals receiving additional payments and adjustments (data not shown in tables).

The level of Medicare dependency (i.e. the percent of hospital inpatient days or discharges attributable to Medicare beneficiaries) was related to Medicare inpatient operating margins (Table 6). Among hospitals not receiving additional payments or adjustments, lower levels of

Medicare dependency were associated with lower Medicare inpatient operating margins. For example, hospitals with less than 30 percent of their days attributable to Medicare had an average Medicare inpatient operating margin of -34.1 percent; those with 70 percent or more of their days attributable to Medicare had an average Medicare inpatient operating margin of -5.9 percent. In contrast, total facility margins tended to be lower for those with high levels of Medicare dependency. Among hospitals not receiving additional payments or adjustments, the correlation between Medicare dependency and Medicare inpatient operating margins was 0.20 and that between Medicare dependency and total margins was -0.13 (data not in tables).

Nearly all of the hospitals meeting the statutory definition of UMDHs were located in urban areas (Table 7). Only 10 out of 137 hospitals were located in rural areas, and they were similar to urban hospitals with respect to Medicare inpatient operating margins, total facility margins, and occupancy rate. Their Medicare operating costs per discharge, case mix index, and wage index were lower than those of hospitals located in urban areas, however. There were few differences between small and large UMDHs (under and over 100 beds). The primary differences were that the occupancy rate in small UMDHs was lower (46.6 percent) than in large ones (59.3 percent) and their average total facility margin was slightly lower (-2.0 percent compared to 0.4 percent).

Medicare operating costs per discharge for UMDHs were not significantly higher or lower than expected, as predicted from the regression analysis (Table 8). Non-Medicare dependent hospitals had higher than expected costs as predicted from the regression, as did RRCs, SCHs,

MDHs, and teaching hospitals. For all hospitals, higher case mix index and wage index levels were associated with higher costs.

VII. CONCLUSIONS

1. Urban Medicare-dependent hospitals were found to have lower Medicare inpatient operating margins than hospitals that receive additional payments or adjustments beyond the normal IPPS rate. In FY 2008 the average Medicare inpatient operating margin of UMDHs was -12.0 percent, compared to -1.2 percent for hospitals receiving additional payments or adjustments. Non-Medicare dependent hospitals had an average Medicare inpatient operating margin of -23.4 percent. These patterns were consistent over the period FY 2006 through FY 2008. At the individual hospital level, there was substantial variation in Medicare inpatient operating margins. Among UMDHs, 24.1 percent had a Medicare inpatient operating margin of less than -25.0 percent and about one-third had Medicare inpatient operating margins of -5 percent or higher.

Low Medicare inpatient operating margins appear to be a characteristic of hospitals that do not receive additional payments or adjustments, but low Medicare inpatient operating margins are not a function of Medicare dependency. That is, among hospitals not receiving additional payments or adjustments, Medicare inpatient operating margins were higher for hospitals with a larger percentage of inpatient days attributable to Medicare beneficiaries.

2. The reasons for low Medicare inpatient operating margins among UMDHs could not be determined from this analysis. UMDHs do not have unusually high Medicare costs, do not have a high percentage of outlier payments, and do not have other features (e.g., high average length

of stay or low occupancy rates) that might be expected to produce high costs or low Medicare inpatient operating margins. In contrast, hospitals that did not meet the statutory criteria to be considered an UMDH and that did not receive any additional Medicare payments did have Medicare costs that were higher than those of UMDHs, controlling for other factors, which may explain their low Medicare inpatient operating margins.

3. The relationship between Medicare dependency and costs may be explained by greater downward pressure on costs among Medicare-dependent hospitals. If Medicare payments are below a hospital's costs, a hospital with a high proportion of Medicare cases will have a greater incentive to reduce its costs than a hospital with a low proportion of Medicare cases. This is consistent with MedPAC's assertion that hospitals with greater financial pressure tend to respond to the stronger incentives to constrain costs.[4] It was beyond the scope of this analysis to determine whether payments are adequate for hospitals that successfully control costs. MedPAC concluded in a recent report to Congress that current Medicare payments are adequate to cover the costs of efficient hospitals, but their analysis did not explicitly compare the situations of hospitals with and without additional payments or adjustments.[3]

4. Total (all payer) facility margins did not show as much variation across hospital categories as Medicare inpatient operating margins. The UMDHs had an average total facility margin of -0.1 percent and non-Medicare dependent hospitals had an average total facility margin of 3.6 percent. Despite the importance of Medicare as a payer, Medicare inpatient operating margins did not drive total facility margins; total facility margins did not vary strongly with Medicare inpatient operating margins, even within the UMDH group.

Overall, the UMDHs had the lowest average total facility margin (-0.1 percent) among the hospital payment categories examined, although there was variation in total facility margins within each category. Other hospital payment categories showed small positive average total margins. UMDHs may have less capacity to achieve large positive margins on their non-Medicare business, given their dependence on Medicare.

RECOMMENDATION

This analysis revealed low Medicare inpatient operating margins for UMDHs relative to hospitals receiving additional payments and adjustments. However, the pattern of low Medicare inpatient operating margins was not limited to hospitals that are highly Medicare-dependent, and Medicare inpatient operating margins were, in fact, lower for hospitals that were less Medicare dependent. In order to fully consider whether a payment adjustment for UMDHs is warranted, more information is needed than a comparison of Medicare inpatient operating margins. Margins are based on payments and costs, and the relationship between these factors, as well as the relationship between Medicare inpatient operating margins, costs, and Medicare dependency, needs to be further explored.

This report provides a preliminary analysis of the readily available data on differences in margins and costs between UMDHs and other groups of hospitals, but it does not provide sufficient information to conclude that the Secretary should recommend a payment adjustment for UMDHs similar to that given to rural small Medicare-dependent hospitals. We therefore recommend that a review be conducted to evaluate the appropriateness of current Medicare payment policies

under the IPPS, especially related to hospitals that do not currently receive additional payments or adjustments. The review could be conducted by the Department of Health and Human Services or by an independent organization. We would expect that an independent review would most likely be perceived by the industry as unbiased.

Table 1: Medicare inpatient operating margins and selected hospital characteristics, by hospital payment category, FY 2008

			Urban	Non	---------- Hospitals receiving additional payments or adjustments ----------						
		All	Medicare	Medicare		Rural	Sole	Rural		DSH	Critical
		acute care	dependent	dependent		MDH	community	referral	Teaching	hospitals	access
		hospitals	hospitals	hospitals	All	hospitals	hospitals	centers	hospitals[6]	(no IME)	hospitals
Statistic		(N=4,603)	(N=137)	(N=338)	(N=4,128)	(N=195)	(N=446)	(N=183)	(N=941)	(N=1,103)	(N=1,260)
Medicare inpatient operating margin		-2.8%	-12.0%	-23.4%	-1.2%	-0.1%	-4.0%	-0.8%	0.6%	-5.2%	1.0%
Total facility margin[1]		1.1%	-0.1%	3.6%	1.0%	1.3%	1.4%	1.9%	0.2%	2.7%	2.3%
Medicare operating cost per discharge[2]		$9,712	$8,943	$9,938	$9,730	$6,175	$7,918	$8,155	$11,103	$8,938	$6,247
Occupancy rate[3]		59.2%	56.8%	58.3%	59.4%	37.9%	45.8%	54.5%	68.8%	54.2%	26.1%
Case mix index		1.57*	1.56	1.54	1.58*	1.16	1.37	1.50	1.69	1.48	N/A
Percent outlier payments		5.6%*	3.3%	6.0%	5.6%*	1.5%	3.7%	3.3%	6.8%	4.0%	N/A
Percent Medicare days[4]		47.4%	63.6%	46.9%	46.9%	64.8%	56.3%	56.5%	45.1%	45.5%	60.2%
Average length of Medicare stay		5.2	4.9	5.1	5.3	4.3	4.7	4.9	5.6	5.2	3.6
Pre-reclassification wage index[5]		0.98*	0.99	1.03	0.98*	0.84	0.87	0.86	1.02	0.98	N/A
Post-reclassification wage index[5]		1.00*	1.00	1.03	0.99*	0.86	0.90	0.92	1.02	1.00	N/A

* Excludes critical access hospitals because data were not available.

[1]Excludes hospitals with total facility cost or payments less than $5,000 or with total facility margins of less than -100% or greater than 50% (n=69).

[2]Excludes hospitals with Medicare operating cost per discharge of more than $22,000 (n=1).

[3]Excludes hopsitals with occupancy rates of less than 5% (n=104).

[4]Based on the most recently settled cost report.

[5]Not available for 55 hospitals.

[6]Includes hospitals with and without DSH payments.

Notes: Hospitals were excluded if their Medicare inpatient operating costs or payments were less than $5,000; or if their Medicare inpatient operating margin was less than -100% or greater than 50% (n=92).

Urban Medicare-dependent hospitals do not receive additional payments or adjustments and have more than 60% of their days or discharges attributable to Medicare.

Non-Medicare dependent hospitals do not receive additional payments or adjustments and have 60% or less of their days and discharges attributable to Medicare.

Cost report data from FY 2007 were used for 55 hospitals for which FY 2008 cost report data were not available.

Table 2: Characteristics of acute care hospitals, by selected hospital payment categories, FY 2008

Characteristics	Urban Medicare dependent hospitals (N=137)	Non Medicare dependent hospitals (N=338)	Hospitals receiving additional payments or adjustments (N=4,128)
Geographic location	100.0%	100.0%	100.0%
Large urban areas	44.5%	56.8%	25.6%
Other urban areas	48.2%	34.3%	22.0%
Rural areas	7.3%	8.9%	52.4%
Census division	100.0%	100.0%	100.0%
New England	8.0%	3.9%	3.8%
Middle Atlantic	16.1%	14.2%	8.3%
East North Central	20.4%	14.2%	15.4%
West North Central	10.2%	10.4%	15.1%
South Atlantic	24.8%	12.7%	13.2%
East South Central	2.2%	2.4%	9.4%
West South Central	12.4%	18.3%	14.2%
Mountain	2.9%	8.9%	8.0%
Pacific	2.9%	8.0%	11.6%
Puerto Rico and Territories	0.0%	7.1%	1.0%
Bed size	100.0%	100.0%	100.0%
1-99	48.9%	55.9%	54.2%
100-199	27.7%	25.4%	20.9%
200-299	14.6%	10.1%	10.6%
300-499	8.8%	7.7%	9.6%
500+	0.0%	0.9%	4.8%
Control	100.0%	100.0%	100.0%
Voluntary non-profit	59.1%	49.4%	57.4%
Proprietary	33.6%	45.9%	16.2%
Governmental	7.3%	4.7%	26.4%

Notes: Hospitals were excluded if their Medicare inpatient operating costs or payments were less than $5,000; or if their Medicare inpatient operating margin was less than -100% or greater than 50% (n=92).
Urban Medicare-dependent hospitals do not receive additional payments or adjustments and have more than 60% of their days or discharges attributable to Medicare.
Non-Medicare dependent hospitals do not receive additional payments or adjustments and have 60% or less of their days and discharges attributable to Medicare.
Cost report data from FY 2007 were used for 55 hospitals for which FY 2008 cost report data were not available.

Table 3: Medicare inpatient operating margins and total facility margins, by hospital payment category, FY 2006-FY 2008

Type of hospital	N	Medicare inpatient operating margins, Year FY 2006	Medicare inpatient operating margins, Year FY 2007	Medicare inpatient operating margins, Year FY 2008	Total facility margins, Year FY 2006	Total facility margins, Year FY 2007	Total facility margins, Year FY 2008
All acute care hospitals	4,227	-2.3%	-3.3%	-2.6%	6.0%	4.8%	1.2%
Urban Medicare-dependent hospitals	129	-11.9%	-12.1%	-11.8%	5.4%	4.1%	-0.1%
Non Medicare-dependent hospitals	264	-20.7%	-22.0%	-22.5%	5.9%	6.5%	4.3%
Hospitals receiving additional payments or adjustments							
All	3,834	-1.0%	-2.0%	-1.1%	6.0%	4.8%	1.0%
Rural MDH	178	-2.2%	0.0%	-0.9%	4.5%	4.1%	1.3%
Sole community hospitals	423	-3.4%	-4.0%	-4.0%	6.2%	4.8%	1.3%
Rural referral centers	173	-0.9%	-2.0%	-0.7%	8.1%	6.6%	1.8%
Teaching hospitals[1]	865	0.9%	-0.2%	0.7%	6.0%	4.3%	0.2%
DSH hospitals (no IME)	1,007	-5.1%	-6.2%	-5.3%	6.0%	5.7%	2.8%
Critical access hospitals	1,188	1.0%	1.0%	1.0%	5.2%	4.2%	2.2%

[1]Includes hospitals with and without DSH payments.

Notes: Hospitals were excluded if their Medicare inpatient operating costs or payments were less than $5,000; or if their total facility costs or payments were less than $5,000; or if their Medicare inpatient operating margin was less than -100% or greater than 50%; or if their total facility margin was less than -100% or greater than 50% in any year.

Table includes only hospitals with cost report data for all three years and complete data on Medicare inpatient operating margins and total facility margins.

Urban Medicare-dependent hospitals do not receive additional payments or adjustments and have more than 60% of their days or discharges attributable to Medicare.

Non-Medicare dependent hospitals do not receive additional payments or adjustments and have 60% or less of their days and discharges attributable to Medicare.

Table 4: Distribution of individual hospitals across levels of Medicare inpatient operating margins, by selected hospital payment categories, FY 2008

Medicare inpatient operating margin interval	Urban Medicare dependent hospitals (N=137)	Non Medicare dependent hospitals (N=338)	Hospitals receiving additional payments or adjustments (N=4,128)
Total	100.0%	100.0%	100.0%
< -30.0%	19.0%	42.9%	5.4%
-30.0% -- -20.1%	13.1%	16.3%	6.8%
-20.0% -- -10.1%	19.7%	17.2%	11.0%
-10.0% -- -0.1%	30.7%	14.2%	13.2%
0.0% -- 9.9%	10.2%	5.9%	45.5%
10.0% -- 19.9%	5.8%	2.1%	10.4%
20.0% +	1.5%	1.5%	7.7%

Notes: Hospitals were excluded if their Medicare costs or payments were less than $5,000; or if their Medicare inpatient operating margin was less than -100% or greater than 50% (n=92).
Urban Medicare-dependent hospitals do not receive additional payments or adjustments and have more than 60% of their days or discharges attributable to Medicare.
Non-Medicare dependent hospitals do not receive additional payments or adjustments and have 60% or less of their days and discharges attributable to Medicare.
Cost report data from FY 2007 were used for 55 hospitals for which FY 2008 cost report data were not available.

Table 5: Medicare inpatient operating margins and total facility margins, by level of Medicare inpatient operating margins and selected hospital payment categories, FY 2008

Medicare inpatient operating margin Interval	Urban Medicare dependent hospitals N	Urban Medicare dependent hospitals Medicare inpatient operating margin	Urban Medicare dependent hospitals Total facility margin	Non-Medicare dependent hospitals N	Non-Medicare dependent hospitals Medicare inpatient operating margin	Non-Medicare dependent hospitals Total facility margin	Hospitals receiving additional payments or adjustments N	Hospitals receiving additional payments or adjustments Medicare inpatient operating margin	Hospitals receiving additional payments or adjustments Total facility margin
< -30.0%	25	-38.1%	-0.8%	137	-44.2%	2.5%	212	-39.5%	0.3%
-30.0% - -20.1%	18	-24.6%	0.5%	55	-25.4%	4.4%	275	-24.0%	0.9%
-20.0% - -10.1%	27	-15.5%	-0.2%	58	-15.4%	3.2%	451	-14.2%	1.3%
-10.0% - -0.1%	42	-4.8%	-1.0%	48	-5.5%	4.1%	535	-4.8%	0.9%
0.0% - 9.9%	14	5.4%	0.1%	19	3.7%	5.5%	1,868	4.3%	0.8%
10.0% +	10	15.8%	9.1%	12	14.0%	9.8%	728	19.2%	1.3%

Notes: Hospitals were excluded if their Medicare inpatient operating costs or payments were less than $5,000; or
if their total facility costs or payments were less than $5,000; or
if their Medicare inpatient operating margin was less than -100% or greater than 50%; or
if their total facility margin was less than -100% or greater than 50% (n=161).
Urban Medicare-dependent hospitals do not receive additional payments or adjustments
and have more than 60% of their days or discharges attributable to Medicare.
Non-Medicare dependent hospitals do not receive additional payments or adjustments
and have 60% or less of their days and discharges attributable to Medicare.
Cost report data from FY 2007 were used for 55 hospitals for which FY 2008 cost report
data were not available.

Table 6: Medicare inpatient operating margins and total facility margins, by percent of hospital days attributable to Medicare beneficiaries, FY 2008

Percent of hospital days attributable to Medicare[1]	Hospitals not receiving additional payments or adjustments N	Medicare inpatient operating margins	Total facility margins	Hospitals receiving additional payments or adjustments* N	Medicare inpatient operating margins	Total facility margins
All	465	-18.9%	2.3%	2,814	-1.3%	1.0%
0 - 29	55	-34.1%	6.5%	250	7.6%	2.5%
30 - 39	65	-23.4%	6.0%	327	0.3%	1.7%
40 - 49	89	-27.2%	2.5%	601	-2.1%	0.8%
50 - 59	118	-20.1%	2.5%	888	-2.6%	0.3%
60 - 69	112	-14.6%	0.4%	612	-3.8%	-0.1%
70 +	26	-5.9%	-1.2%	136	3.3%	2.4%

* Does not include critical access hospitals because their Medicare margins are 0.01 by definition.

[1]Based on the most recently settled cost report.

Notes: Hospitals were excluded if their Medicare inpatient operating costs or payments were less than $5,000; or
if their total facility costs or payments were less than $5,000; or
if their Medicare inpatient operating margin was less than -100% or greater than 50%; or
if their total facility margin was less than -100% or greater than 50% (n=161).
Urban Medicare-dependent hospitals do not receive additional payments or adjustments
and have more than 60% of their days or discharges attributable to Medicare.
Non-Medicare dependent hospitals do not receive additional payments or adjustments
and have 60% or less of their days and discharges attributable to Medicare.
Cost report data from FY 2007 were used for 55 hospitals for which FY 2008 cost report
data were not available.

Table 7: Medicare inpatient operating margins and selected hospital characteristics for urban Medicare-dependent hospitals, by bed size and location, FY 2008

	Location		Bed size	
Statistic	Urban (N=127)	Rural (N=10)	1 - 100 (N=68)	> 100 (N=69)
Medicare inpatient operating margin	-12.1%	-10.3%	-11.2%	-12.3%
Total facility margin[1]	-0.1%	-1.4%	-2.0%	0.4%
Medicare operating cost per discharge	$9,060	$6,770	$8,948	$8,942
Occupancy rate	56.7%	59.0%	46.6%	59.3%
Case mix index	1.58	1.27	1.65	1.55
Percent outlier payments	3.4%	1.5%	1.9%	3.6%
Percent Medicare days[2]	63.5%	66.5%	65.1%	63.3%
Average length of Medicare stay	4.9	4.6	4.3	5.1
Pre-reclassification wage index[3]	0.99	0.89	0.97	0.99
Post-reclassification wage index[3]	1.00	0.93	0.98	1.00

[1]Excludes hospitals with total facility cost or payments less than $5,000 or with total facility margins of less than -100% or greater than 50% (n=1).

[2]Based on the most recently settled cost report.

[3]Not available for 2 hospitals.

Notes: Hospitals were excluded if their Medicare inpatient operating costs or payments were less than $5,000; or if their Medicare inpatient operating margin was less than -100% or greater than 50% (n=2).

Urban Medicare-dependent hospitals do not receive additional payments or adjustments and have more than 60% of their days or discharges attributable to Medicare.

Cost report data from FY 2007 were used for 2 hospitals for which FY 2008 cost report data were not available.

Table 8: Factors associated with Medicare operating costs per discharge: ordinary least squares regression, FY2008

Dependent variable: Log(Medicare operating costs per discharge)		
Independent variable	Coefficient	p-value
Intercept	8.6941	< 0.0001
Log(case mix index)	0.9976	< 0.0001
Log(wage index)	0.8421	< 0.0001
Location		
Large urban area	Ref.	--
Other urban area	0.0287	0.001
Rural area	0.0018	0.895
Number of beds	0.0001	< 0.0001
Census region		
New England	Ref.	--
Middle Atlantic	-0.0447	0.013
East North Central	-0.0073	0.685
West North Central	0.0214	0.289
South Atlantic	-0.0260	0.160
East South Central	-0.1292	< 0.0001
West South Central	-0.0270	0.162
Mountain	0.0466	0.024
Pacific	0.0949	< 0.0001
Puerto Rico and Territories	0.0757	0.076
Occupancy rate	-0.0605	0.007
Log(IME*+1)	0.3452	< 0.0001
Log(DSH**+1)	0.0190	0.557
Hospital payment categories		
Rural referral center	0.0513	0.001
Sole community hospital	0.0634	< 0.0001
Medicare-dependent small rural hosp.	0.0291	0.081
Non-Medicare dependent hospital	0.0542	< 0.0001
Urban Medicare-dependent hospital	-0.0188	0.271
N	3,240	
R-square	0.772	

*IME stands for indirect medical education and refers to the resident-to-bed ratio.

**DSH refers to the disproportionate share hospital patient percent.

Notes: Analysis does not include critical access hospitals because some variables were not available.

Hospitals were also excluded if their Medicare inpatient operating costs or payments were less than $5,000; or if their Medicare inpatient operating margin was less than -100% or greater than 50%; or they had fewer than 50 Medicare discharges; or their Medicare operating cost per discharge was more than $22,000; or if their occupancy rate was less than 5%.

Urban Medicare-dependent hospitals do not receive additional payments or adjustments and have more than 60% of their days or discharges attributable to Medicare.

Non-Medicare dependent hospitals do not receive additional payments or adjustments and have 60% or less of their days and discharges attributable to Medicare.

Cost report data from FY 2007 were used for 55 hospitals for which FY 2008 cost report data were not available.

REFERENCES

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Appendix

SEC. 3142. HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to Medicare-dependent, small rural hospitals under subsection (d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) URBAN MEDICARE-DEPENDENT HOSPITAL DEFINED.—For purposes of this section, the term ‘‘urban Medicare-dependent hospital’’ means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act (42 U.S.C. 1395f(l)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a Medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and
H. R. 3590—324

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.