

A combined fully prospective update would yield an increase of 2.3 percent under the Commission's recommendation. The total increase to payments, however, would be about 3.3 percent due to expected increases in the case-mix index (see Table 2-3).

**Recommendation 4: Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates**

**For fiscal year 1996, payments based on hospital-specific base-year costs for sole community hospitals should be updated by the same factor as the rate for all other PPS hospitals. Furthermore, it is no longer necessary to calculate a separate update for these hospitals.**

This recommendation would result in a 2.1 percent update to the hospital-specific rates for fiscal year 1996, consistent with the Commission's recommendation for the PPS update. Since the update is based on current projections of the fiscal year 1996 increase in the market basket index, its effective value may be modified as more current forecasts become available.

Following OBRA 1989, certain hospitals have been paid the higher of three amounts: the PPS rate, their own 1982 base-year costs updated to the current year, or their updated 1987 base-year costs. Sole community hospitals, which meet criteria related to distance from other hospitals or market share, qualify for this special treatment. Small rural Medicare-dependent hospitals—rural hospitals with fewer than 100 beds and at least a 60 percent Medicare share of total discharges or inpatient days—were also paid on the basis of hospital-specific rates through fiscal year 1994. These Medicare-dependent hospitals are now paid on the basis of the PPS rate.

Current law requires that the hospital-specific rates for sole community hospitals be updated at a rate equal to market basket minus 2.0 percentage points in fiscal year 1996, the same as for other PPS hospitals. ProPAC believes the update for these hospitals should be no different from that applied to all other PPS hospitals. Although these hospitals are accorded special treatment under PPS because they may face higher historical costs due to their special circumstances, they should be able

to control their cost increases as other hospitals do. The factors considered in the Commission's update framework for PPS hospitals therefore are appropriate for these hospitals as well.

Recent data show that sole community hospitals have higher PPS and total margins than most other hospital groups. The Commission will continue to monitor the financial condition of sole community hospitals for signs of potential stress, but will no longer provide a separate recommendation unless conditions warrant it.

**Recommendation 5: Update Factor for PPS-Excluded Hospitals and Distinct-Part Units**

**For fiscal year 1996, the target amounts for PPS-excluded hospitals and distinct-part units should be updated to account for the following:**

- **The projected increase in the HCFA PPS-excluded hospital market basket index, currently estimated at 3.9 percent;**
- **An adjustment of zero percentage points to reflect the difference between the ProPAC and HCFA market baskets;**
- **A negative adjustment of 1.6 percentage points to correct for substantial error in the fiscal year 1994 market basket forecast; and**
- **An adjustment of zero percentage points for scientific and technological advances.**

**This would result in an update factor of 2.3 percent.**

When PPS was established, prospective payment based on DRGs could not be applied universally, so certain providers were excluded. Five types of specialty hospitals (psychiatric, rehabilitation, long-term, children's, and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are now exempt from PPS. These providers are excluded primarily because DRGs fail to predict their resource costs accurately.

PPS-excluded hospitals and distinct-part units are subject to the payment limitations and incentives established in the Tax Equity and Fiscal