

NOSORH WEBINAR Medicare Payment Issues of Rural PPS Hospitals

November 2009

Agenda

- Special Medicare reimbursement status for rural PPS hospitals
 - Sole community hospital
 - Medicare dependent hospital
 - Rural referral center
- Medicare DSH payments
- Wage index for PPS hospitals
- Outpatient hold harmless
- Medicare bad debts

Medicare Special Treatments/Provisions

Medicare Special Treatments Provisions For PPS Hospitals

- Sole Community Hospital (SCH)
- Medicare Dependent Hospital (MDH)
- Rural Referral Center (RRC)

Medicare Special Treatments Provisions For PPS Hospitals

Hospitals must apply for special status and prove qualifications – Medicare will not automatically “sign you up.”

Based on analysis of Medicare public-use files, many hospitals across the country are eligible for a particular status but either have not applied or were incorrectly denied.

Sole Community Hospital (SCH)

- Eligibility Criteria
 - Located at least 35 miles from a like hospital, or
 - Located in a rural area, is between 25 and 35 miles from a like hospital, and meets one of the following criteria:
 - No more than 25% of all IP or 25% of Medicare IP in its service area may be admitted to other like hospitals within 35 miles or its service area if larger.
 - It must have fewer than 50 beds and would have met the above criteria, except that some patients had to seek care outside the service area due to unavailability of necessary specialty services.
 - Nearby like hospitals are inaccessible for at least 30 days in 2 out of 3 years because of local topography or severe weather.
 - Located in a rural area and is between 15 and 25 miles from a like hospital, but because of local topography or periods of prolonged severe weather conditions, nearby like hospitals are inaccessible for at least 30 days in 2 out of 3 years.
 - Because of distance, posted speed limits and predictable weather conditions, the travel time between the hospital and the nearest like hospital must be at least 45 minutes.

Sole Community Hospital (SCH)

- Benefits
 - For Medicare IP services, paid the highest of:
 - The Federal rate applicable to the hospital, or
 - Adjusted/updated hospital-specific rate based on
 - FY 1982,
 - FY 1987,
 - FY 1996, or
 - FY 2006 cost per discharge
 - » FY 2006 option is available for cost report periods beginning on or after 1/1/2009

Sole Community Hospital (SCH)

- Benefits
 - Receive additional 7.1% above standard Outpatient PPS payment rates on most services
 - Eligible for Outpatient hold-harmless (“TOPs”)
 - If applying for geographic reclassification, an SCH does not have to be within 35 miles of the area for which reclassification is sought, as usually required.
 - SCHs are exempt from TRICARE DRG-based payment system
 - Generally rates are negotiated with TRICARE intermediary

Medicare Dependent Hospital (MDH)

- Eligibility Criteria
 - Hospital must be located in a rural area
 - Hospital must not have more than 100 acute beds
 - Hospital can not also be classified as a SCH
 - Hospital has at least 60% Medicare for inpatient days or discharges during one of the following:
 - FY 1987, or
 - 2 out of 3 most recent settled cost reports
 - In determining Medicare utilization, can take into account Medicare Advantage and Medicare-eligible days.

Medicare Dependent Hospital (MDH)

- Benefits
 - For Medicare IP services, paid the highest of:
 - The Federal rate applicable to the hospital, or
 - A blend of 25% of the Federal rate and 75% of the adjusted/updated hospital-specific rate based on
 - FY 1982,
 - FY 1987, or
 - FY 2002 cost per discharge
 - Current regulations providing for hospital-specific payments only cover discharges through 9/30/11 – may be extended by future legislation?
 - Not capped at 12% for Medicare DSH

Rural Referral Center (RRC)

- Eligibility Criteria
 - Located in a rural area AND has 275 or more beds, OR
 - The hospital reflects the following three elements
 - At least 50% of the hospital's Medicare patients are referred from other hospitals or from physicians who are not on the staff of the hospital
 - At least 60% of the hospital's Medicare patients live more than 25 miles from the hospital
 - At least 60% of all services the hospital furnishes to Medicare patients are furnished to patients who live more than 25 miles from the hospital, OR
 - The hospital meets items 1 and 2 below and one of items 3, 4, or 5 below:
 1. Have a case mix index (CMI) meeting specified threshold
 2. Has at least 5,000 annual discharges
 3. More than 50% of the hospital's active medical staff are specialists who meet certain conditions.
 4. At least 60% of all discharges are for inpatients who reside more than 25 miles from the hospital
 5. At least 40% of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff

Rural Referral Center (RRC)

- Benefits
 - Not capped at 12% for Medicare DSH
 - If applying for geographic reclassification, an RRC
 - does not have to be within 35 miles of the area for which reclassification is sought, as usually required
 - is not required to demonstrate that its average hourly wage (AHW) is at least 106% of the average in the area in which it is located in order to qualify, as usually required

Disproportionate Share Hospital (DSH)

Medicare has established additional add-on payments for hospitals that serve a significant population of low income patients.

Low Income patients tend to have more health issues and do less preventative health maintenance and thus increase the amount of resources required to serve their needs.

The DSH payment is a means of covering some of the additional costs to the treating facilities.

DSH Calculation Components

Expressed as a percentage, calculated as follows:

- Number of "low income" Medicare patients served by the Hospital ("Medicare Proxy")
- Medicaid percentage of total patient days ("Medicaid Proxy")

Patient days include only those days attributable to areas of the hospital subject to PPS reimbursement – Excludes:

- Hospital based distinct part units (separate exempt psych, rehab, burn units)
- Hospital based SNFs

DSH Calculation Formula

Medicaid Fraction + Medicare Fraction = Total Medicaid Days Percentage

The Medicaid Days percentage is used to determine if the minimum threshold of 15% has been achieved. Once the percentage has been met then a DSH payment rate is calculated (See Sample on Slide 23) and multiplied by the Total Medicare DRG's (excluding outliers after 1998) to come up with Total DSH Payments.

There is also a bump in payments for hospitals whose Medicaid Days exceed 20.2% of their Total Acute Days.

What Makes Up The Medicaid Fraction (Proxy)?

Expressed as a percentage, calculated as follows:

Numerator – number of patient days for patients eligible for assistance under State Title 19 Plan (regardless of payment), but not receiving Medicare Part A benefits (includes HMO days)

- Excludes observation and swing bed days

Denominator – total number of hospital inpatient acute days

- Excludes observation and swing bed days

Medicaid days need to be adjusted for LDRP days. Typically the Fiscal Intermediary (FI) has adjusted one full day for each occurrence. We suggest that you do a study of the L&D population and come up with an average pre-delivery time (the difference between when the patient came into the hospital in labor and when they gave birth). The range can vary but a suggested guideline is 10-16 hrs.

What Makes Up The Medicare Fraction (Proxy)?

Expressed as a percentage, calculated as follows:

Numerator – number of patient days for patients entitled to Medicare Part A benefits and entitled to Supplemental Security Income (SSI) benefits (excluding State Supplementation)

- CMS computes each hospital's Medicare Proxy using Medicare billing data – matched against SSI enrollment data obtained from the Social Security Administration

Denominator – total number of hospital inpatient acute days

- Excludes observation and swing bed days

The Medicare Fraction is provided by CMS in the form of the SSI% each August

Medicare Exhausted benefit days are not included in this fraction

You are able now to ask CMS for the detail of the calculation and appeal the rate if needed.

WAGE INDEX

Wage Index

- Wage Index reflects the relative hospital wage level for each geographic area compared to the national average
- Geographic areas are based on the Core Based Statistical Areas (CBSA) defined by the Office of Management and Budget
 - Metropolitan Statistical Areas (MSAs) – CBSAs with populations > 50,000
 - Micropolitan Areas – CBSAs with populations >10,000 but < 50,000
 - MSAs = urban for CMS purposes, while Micropolitan Areas and areas outside of any CBSA = rural

Wage Index

- Sources of data for Wage Index:
 - Cost Report
 - Worksheet S-3 Parts II and III
 - CMS 339
 - Exhibit 6
 - Occupational Mix Survey
- A three-year average hourly wage (AHW) is used for wage index calculations
- There is a four-year lag prior to wage data being included in the AHW
 - FY 2009 wage index based on FY 03, 04 and 05 cost report data

Wage Index

Because the wage index is one of the few factors remaining under Medicare's prospective payment system that is based on a hospital's specific information, hospitals should explore potential opportunities to enhance their wage index and ensure their data is accurately reported.

Because the wage index is a relative measure of all PPS providers, hospitals that are not diligent in assessing their wage data are at risk of falling further behind those facilities that effectively explore wage index enhancement opportunities.

Wage Index

- Occupational Mix Survey
 - Adjustment applied to a provider's wage index to adjust for that provider's choice of staff
 - Collected every three years
 - Most recent survey covering 7/1/07-6/30/08 was collected September 2008.

Wage Index

- Geographic Reclassification
 - Allows providers meeting specific requirements to reclass to another geographic area for purposes of receiving higher wage index
 - Application is submitted to Medicare Geographic Classification Review Board (MGCRB) and is generally due 13 months prior to when reclassification would go into effect – September 1, 2009 is deadline for reclasses beginning in FY 2011
 - Reclassifications are in effect for three years, but provider can elect to withdraw reclassification during the three-year period, and also elect to reinstate reclassification the following year if still within the three-year window

Wage Index

- Geographic Reclassification
 - General requirements
 - Proximity – hospital must be within 35 miles (rural)/15 miles (urban) of targeted CBSA
 - Hospital's average hourly wage must be at least 86% (rural)/88% (urban) of targeted CBSA
 - Hospital's average hourly wage must be at least 106% (rural)/108% (urban) of current CBSA
 - Exceptions to requirements
 - SCHs do not have to meet proximity rule – eligible to reclass to nearest urban or rural CBSA
 - Hospitals with RRC status at the date of review by the MGCRB do not have to meet proximity rule, and hospitals that ever held RRC status do not have to meet 106%/108% test

Wage Index

- Geographic Reclassification
 - Hospitals that are reclassified receive the reclassified wage index of the targeted CBSA
 - Reclassified wage index is often slightly lower than base wage index for each CBSA.

Wage Index

- Geographic Reclassification
 - Providers also have the option of group application
 - All providers within a county must apply
 - Providers' county must be contiguous to targeted CBSA
 - Providers' AHW must be 85% of targeted CBSA
 - Rural providers must also meet specific commuting patterns – in general 25% of workers in county must commute to target CBSA or vice-versa
 - Urban providers must be in a county that is in the same Combined Statistical Area (CSA) as published by the US Census Bureau, or the same CBSA, as the targeted CBSA

Wage Index

- Lugar Counties – Rural counties that meet certain conditions (including specific commuting patterns) are considered Lugar Counties, and hospitals located in those counties are paid as if they are urban
 - Receive the reclassified wage index of the urban area to which they are redesignated
 - Receive the large urban add-on if applicable, not subjected to 12% DSH cap and eligible for capital DSH payments
 - Currently there are ~90 Lugar Counties

Wage Index

- Out-Migration Adjustment – Rural counties with at least 10% of resident hospital employees who commute to an urban CBSA are eligible for add-on to wage index
 - Also known as Section 505 Wage Adjustment
 - Providers that are reclassified are not eligible to receive out-migration adjustment
- Rural Floor – Regulations stipulate that wage index for any urban CBSA cannot be lower than that state's rural wage index
- Section 401 Hospitals – Regulations allow for urban hospitals meeting specific conditions can be redesignated as rural
 - Most common reason is to qualify as SCH
 - Cannot be reclassified for wage index

Outpatient PPS

Hold Harmless

Outpatient Hold Harmless

- Difference between “pre-PPS cost” and PPS payments
- Pays 85% of difference
- Rural PPS hospitals 100 or fewer beds
- Sole community hospitals
- Expires 12/31/09

MEDICARE BAD DEBTS

Medicare Bad Debts

- Allowable
 - Unpaid deductibles and coinsurance for Medicare covered services
 - Regular Medicare
 - Medicaid Crossover (dual eligible)
 - Medicare Indigent
 - Hospital (IP/OP), Psych and Rehab
 - Subject to 30% reduction in reimbursement
 - SNF, CAH's & RHC's
 - Crossover not Subject to 30% reduction
 - Effective 10/1/06 SNF regular bad debts (not crossover) have been subject to the 30% reduction

Medicare Bad Debts

- Not Allowable
 - Deductibles and coinsurance from professional fees such as CRNA & physician services. (i.e. billed on a 1500 or under Option II of a CAH)
 - Deductibles and coinsurance resulting from non-allowable services (Service not covered by Medicare)
 - Deductibles and coinsurance resulting from fee schedule payments (i.e. Therapy, Ambulance, and Lab fee schedule payments) (See handout for explanation)

Medicare Bad Debts

- Criteria to be allowable
 - Reasonable collection efforts must be made.
 - Providers must issue bills, collection letters and telephone calls or personal contacts which constitute genuine, rather than token, collection efforts.
 - Hospital credit & collection policies must be followed regardless of patient payor type
 - The debt was actually uncollectible when claimed as worthless and there is no likelihood of future recovery.
 - For regular Medicare bad debts, PRM Section 310.2 states that the "presumption" that a bill is uncollectible if reasonable collection efforts have been pursued for more than 120 days from the date the first bill was mailed to beneficiary.
 - The 120 days does not begin until the provider has made a serious demand for payment. This bill should identify an amount owed by the beneficiary. Some providers send informational statements to the beneficiary upon discharge. These information statements do not constitute the beginning of the 120 day period.
 - Bad Debts are allowable in the period determined to be bad and written off
 - Recoveries received during the current cost reporting period must be used to reduce current period bad debts

Medicare Bad Debts

- Medicaid Crossovers (Dual Eligibles) and Medicare Indigent
 - Reasonable collection efforts, as mentioned previously, may be waived for Medicare indigent patients
 - Unpaid amounts for Medicaid crossovers can be claimed and written off as soon as the claim has been adjudicated on a Medicaid remittance advice.
 - Medicare indigent bad debts can be claimed and written off upon the determination of indigency based on the Hospital's WRITTEN charity care policy.
 - *Many providers are missing out on OP crossover bad debt reimbursement.*

Medicare Bad Debts

- *Many intermediaries are recently enforcing new interpretations regarding when a bad debt is allowable for Medicare reimbursement.*
- *If collection efforts are still taking place after the 120 day period then an account should not be written off and claimed as Medicare bad debt unless the provider can document that its policy has not changed since the Bad Debt Moratorium of August 1, 1987.*
- Moratorium for Bad Debts from OBRA 1987
 - The moratorium states that if an intermediary was allowing the provider to write-off bad debt at the time they were sent to a collection agency prior to August 1, 1987, then the intermediary must continue applying that same principle when allowing write-offs in the current year provided that all the criteria set forth in PRM Section 310 are being met.
- **Moratorium is NOT applicable to CAH**

How can SORH help?

- Know about the different Medicare payment opportunities
- Know the rural PPS hospitals in your state and their classification
- Encourage the hospitals to look for opportunities – seek outside assistance
 - Look for “urban” hospitals who serve rural areas
 - Dixon Hughes is willing to help

How to Contact Us

Dixon Hughes is ready to help define opportunities

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