



# ...Rural Hospital Bulletin...

A Publication of the Feeley & Driscoll, P.C. Health Care Services Group

## Medicare Reforms Before Congress Would Benefit Rural Hospitals

The *Rural Community Hospital Assistance Act of 2003* (H.R.937) is currently sitting before the U.S. House Ways and Means Subcommittee on Health. Introduced in February 2003 by Representatives Jerry Moran (R-KS) and Jim Turner (D-TX), this bipartisan proposal is intended to improve access to healthcare services in rural communities by enhancing Medicare reimbursement for small, rural community hospitals and critical access hospitals (CAHs). The bill currently has 24 co-sponsors. Summary of key provisions in the bill:

- **Establishment of Rural Community Hospital Program** – This provision would create a new Medicare payment classification for rural community hospitals (RCHs) with 24-hour emergency care and less than 51 acute care inpatient beds (bed count excludes any distinct-part psychiatric or rehabilitation beds). Inpatient and outpatient Medicare reimbursement for RCHs would equal the higher of reasonable costs or prospective payment rates. RCHs would be exempt from the current 30% reduction to Medicare bad debts. In addition, certain RCH-based home health agencies (HHAs) could opt out of the home health prospective payment system for Medicare services in favor of reasonable cost-based reimbursement.
- **Removing Barriers to Establishment of Distinct Part Units by RCHs and Critical Access Hospitals** – *Under current regulations, CAHs cannot operate distinct-part units, which are only available to hospitals paid under the acute care prospective payment system (PPS). CAHs are themselves PPS-exempt, reimbursed on the basis of reasonable costs. In other words, a CAH cannot operate a PPS-exempt unit because a CAH is not a PPS hospital. CAHs can, however, operate a distinct-part skilled nursing facility (SNF) under current regulations. If this provision of the Act is approved, RCHs and CAHs would become expressly permitted to operate distinct-part exempt units (e.g. psych, rehab). Up to 10 distinct-part beds would be excluded from the CAHs bed count (To be eligible for designation as a*

CAH, a hospital is limited to 15 acute care beds, and up to 10 additional swing beds, so this proposal would allow a CAH to have 15 acute care beds, 10 swing beds, and an additional 10 distinct-part hospital beds, but the 11<sup>th</sup> distinct-part hospital bed would count against the 15 bed limitation.)

- **Improvements to Medicare Critical Access Hospital Program** – This provision would establish reasonable cost-based Medicare reimbursement for HHAs and distinct-part SNFs owned and operated by CAHs. The provision would establish reasonable cost-based Medicare reimbursement for distinct-part psych and rehab units, without regard to the cost limitations usually applicable to such units. The Act also proposes to cover costs for emergency room on-call physician assistants and nurse practitioners. *Current payment guidelines cover CAH costs for emergency room on-call physicians, but not PAs and NPs.* The bill would also relax certain geographic requirements for ambulance companies operated by CAHs.

In addition to the *Rural Community Hospital Assistance Act*, there are a number of other legislative proposals before Congress to safeguard access to healthcare services in rural areas by providing financial relief to rural hospitals. On April 8, for example, Senator Kent Conrad (D-ND) introduced a bill that would permanently equalize the Medicare base payment rate for rural and urban hospitals. Known as the *Health Care Access and Rural Equity Act of 2003* (S.816), the proposal also includes adjustments to wage index and disproportionate share calculations that would benefit rural providers. The bill also offers a number of improvements to the CAH program, including an increase to the hospital bed limit; expanded reimbursement for ambulance services and emergency on-call expenses; and the authorization of periodic interim payments for CAHs. The bill has been referred to the Senate Committee on Finance, and currently has 31 co-sponsors.

On April 29, Senators Sam Brownback (R-KS) and Ben Nelson (D-NE) introduced bill (S.942) that would transition many rural hospitals to a RCH program similar to the structure proposed by the *Rural Community Hospital Assistance Act*, but would raise the CAH bed limit to 50 beds. The bill has been referred to the Senate Committee on Finance, but perhaps because of its very recent introduction, the bill does not yet have any other co-sponsors.

# Analysis of Proposed Draft for Rural Community Hospital Assistance Act of 2003\*

\* Comparison based on proposed provisions of submitted bill language. (Requires legislative and presidential approval before implementation, and may be subject to amendment.)

## Current Medicare Reimbursement Structure

## Structure proposed by Rural Community Hospital Assistance Act of 2003

<i>Critical Access Hospitals</i>	<i>Improvements to CAH Program</i>	<i>New RCH Classification</i>	<i>Outcome</i>
CAHs are now allowed a maximum of 15 acute care beds, plus 10 swing beds	Maximum of 15 acute care beds, plus 10 swing beds and up to 10 additional distinct-part hospital beds (the 11th distinct-part hospital bed would count against the 15-bed limitation)	Less than 51 acute care beds (count excludes distinct-part psych or rehab hospital beds)	If passed, this proposal would be a great benefit for rural hospitals with 16-50 beds or hospitals with distinct-part exempt units, who may have considered the advantages of conversion to CAH status but are reluctant because of the need to downsize / limit services
States given considerable flexibility in definition of "rural" to include hospitals in CAH program that might not otherwise qualify	No change	Legislation references standard Medicare definition of "rural," which may be more stringent than state-by-state definitions for purposes of classifying CAH providers	Eligibility for RCH status would be open to smaller pool of "rural" hospitals than CAHs; must meet standard Medicare definition for rural classification (i.e. location outside of Metropolitan Statistical Area)
Subject to somewhat relaxed Medicare conditions of participation, including relaxed staffing requirements	No change	Subject to standard Medicare conditions of participation for hospitals	RCHs would still be subject to the standard CoPs, while CAHs would continue to enjoy relaxed staffing requirements
CAHs must offer 24-hour emergency care (reimbursed for reasonable costs of on-call physicians)	Must offer 24-hour emergency care (Reimbursed for reasonable costs of on-call physicians, physician assistants, and nurse practitioners)	Must offer 24-hour emergency care (on-call costs not covered)	CAHs receive benefit of enhanced reimbursement for on-call emergency providers
Reasonable cost-based reimbursement (subject to 30% reduction to bad debts)	No change	Receives the higher of reimbursement based on reasonable costs or per-case prospective rates (exempt from 30% reduction to bad debts)	Efficient RCHs would have an opportunity for positive operating margins on Medicare services. CAH margins limited by exclusively cost-based nature of Medicare reimbursement.
CAH-based HHAs reimbursed under Medicare prospective payment system for home health services	Reasonable cost-based reimbursement for CAH-based HHAs	Certain RCH-based HHAs could opt out of the home health prospective payment system in favor of reasonable cost-based reimbursement	Both RCHs and CAHs would benefit from cost-based reimbursement for hospital-based home health services
CAH-based SNFs reimbursed under Medicare prospective payment system for skilled nursing services	Reasonable cost-based reimbursement for distinct-part SNF units or a SNF facility owned and operated by CAH	Distinct-part SNFs reimbursed under SNF PPS	CAHs would benefit from cost-based reimbursement for distinct-part SNFs. RCHs would still be subject to SNF PPS.
CAHs not allowed to operate distinct-part psych or rehab hospital units	Reasonable cost-based reimbursement for distinct-part hospitals units, without regard to usual cost limitations (or the new prospective payment systems for these services)	Reimbursement for distinct-part hospitals units subject to usual cost limitations for PPS-exempt units (and the new prospective payment systems for these services, once fully implemented)	CAHs would become able to operate distinct-part units. As noted above, the inability to operate such units has been a sticking point for some hospitals considering CAH conversion.
Qualified CAH-based ambulance services reimbursed on the basis of reasonable costs	Geographic limitations relaxed to include more providers in reasonable cost-based payment structure	Qualified RCH-based ambulance services reimbursed on the basis of reasonable costs	Both CAHs and RCHs would benefit from cost-based reimbursement for hospital-based ambulance services

ments. Payments to the CAH would be 1.15 times the amount that equals 1.10 of the fee schedule amount. Please note that this results in a +26.5% boost, not just +25%!

<b>Incorrect calculation</b>	<b>Correct calculation</b>
\$ 100.00	\$ 100.00
x 1.25	x 1.10
\$ 125.00	\$ 110.00
	x 1.15
	\$ 126.50

### **Financial Benefit — Is it real?**

The financial benefit of all-inclusive billing is clear for healthcare professionals currently furnishing hospital-based outpatient services to CAH patients. Under this option, they become entitled to an automatic +15% bump in reimbursement for the services that they are already performing on a daily basis.

Bringing currently free-standing physicians under the CAH provider-based umbrella in order to qualify for the +15% boost in professional reimbursement may not always make strict economic sense for the physicians. The *free-standing versus provider-based* site-of-service differential could negate most of the payment boost for CAH physician services billed under the all-inclusive method. (Physicians located in a HPSA are entitled to the additional +10% incentive bonus regardless of whether they furnish services to CAH outpatients.)

To demonstrate this point, F&D has performed a preliminary analysis of Medicare reimbursement for some common Evaluation and Management (E/M) visits. The Calendar Year 2003 site-of-service differential ranged from 20% to 60% of the non-facility (*i.e.* free-standing) reimbursement amount, which of course would be greater than the associated boost from all-inclusive billing.

To use the example of a Massachusetts provider outside the Metro Boston area, the non-facility payment amount for a mid-level, new patient visit would be \$91.05 (for services furnished prior to the most recent fee schedule revisions effective March 1, 2003). The facility (*i.e.* hospital-based) amount for the same visit would be \$68.12. The site-of-service differential would be \$23.83, or about 26% of the non-facility amount. In comparison, 115% of the facility amount would be only \$78.34, which is still \$13.61 less than the non-facility amount.

To take another common example, the non-facility payment amount for a mid-level, established patient visit would be \$51.17. The facility amount would be \$33.60. The site-of-service differential would be \$17.57, or about 34% of the non-facility amount. In comparison, 115% of the facility amount would be only \$38.64, which is still \$12.53 less than the non-facility amount.

Of course, this analysis only presents one side of the equation. By bringing currently free-standing physicians under the CAH provider-based umbrella, the hospital may also be able to appropriately recoup cost-based reimbursement for the technical component of the outpatient visits. However, this would present a potential benefit to the CAH, not an incentive to the physicians themselves. Also, the cost-based nature of CAH reimbursement limits the opportunities for operating margin enhancement on Medicare services.

On the other hand, while the all-inclusive payment rate may be lower than the free-standing rate, the hospital-based physician would not have to cover office overhead expenses; so more of the reimbursement amount can go directly to the physician's compensation.

CAHs need to keep in mind the stringent new Medicare regulations that clarify when a provider-based arrangement is sufficiently integral and subordinate to a main provider to qualify for the many benefits hospital-based reimbursement. These new regulations are being phased-in on the basis of the provider's first cost reporting period beginning on or after July 1, 2003.

### **Election of All-Inclusive Methodology**

The all-inclusive election must be made in writing, made on an annual basis, and delivered to the FI before the start of each affected cost reporting period. The mandatory advance notice period is 30 days before the start of each affected cost reporting period. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

### **Implementation of All-Inclusive Method**

Under the all-inclusive payment method, all services, both institutional and professional, must be submitted on a single HFCA-1450 ("X12 837") claim submitted to the FI. Facility services are listed along with the appropriate revenue code. Professional services are listed on a separate line, along with the appropriate procedure code and one of the following Revenue Codes: 96x, 97x, or 98x. The details of the all-inclusive billing process can be found in the Medicare Hospital Manual at § 415.22 - **Payment for Services Furnished by a CAH.**

The all-inclusive rate option may be challenging for some CAHs to implement from an operations perspective, especially for hospitals with little experience billing for professional services. However, we believe that now is the best time for CAHs and local physicians to seriously consider the advantages of this option, as many providers are already taking a close look at retooling their billing processes for compliance with the new electronic claim format and codes sets mandated by the Health Insurance Portability and Accountability Act of 1996.

The implementation of the all-inclusive billing methodology will require a high level of coordination and communication with your intermediary, not to mention changes to internal hospital billing practices. You should not necessarily expect that your local intermediary will have any experience implementing the all-inclusive methodology with CAHs. Due to implementation difficulties nationwide, the roll-out of the all-inclusive billing methodology has been stalled across the country until recently. However, a number of the technical issues were addressed by the issuance of CMS Transmittal 1860 (July 31, 2002), and intermediaries are now presumably "ready" for implementation.

**If you have any questions or would like to discuss further any of the issues discussed in this issue with one of our health care specialists, please contact us at (617) 742-7788 or**

**Douglas J. McGregor - DougM@fdcpa.com**  
**Mark J. Rich - MarkR@fdcpa.com**  
**Stephen J. Doneski - SteveD@fdcpa.com**



## **All-Inclusive Payment Methodology for CAH Outpatient Services**

*CAHs can receive up to 126.5% of Medicare Fee Schedule for physician services!*

Critical Access Hospitals are allowed to elect one of two methods of payment for outpatient services:

1. The first choice is the standard “reasonable cost plus professional services” method. Under this method, hospital or technical component charges are billed to the fiscal intermediary (FI) for cost-based reimbursement, while physician and other professional services are billed to the Medicare Part B carrier separately and paid for under the Medicare physician fee schedule.
2. The second choice allows CAHs to bill the intermediary for outpatient services at an all-inclusive rate, rather than billing hospital and physician outpatient services separately.

The relevant regulation is 42 CFR § 413.70(b) - *Payment for Outpatient Services Furnished by a CAH.*

In general, unless a CAH elects to be paid under the all-inclusive rate, the amount of payment for outpatient services of a CAH is based on “the reasonable costs of the CAH in providing CAH services to its outpatients.” This would not include any costs of physician services or other professional services to CAH outpatients. Such professional services are billed to the Medicare carrier separately.

However, a CAH may elect to be paid for outpatient services under the alternative all-inclusive methodology. If the CAH elects payment under this second method, payment

to the CAH for each outpatient visit will be the sum of (a) the reasonable cost of CAH services, plus (b) 115% of the Medicare physician fee schedule amount for physician services (*for services performed on or after July 1, 2001*).

The all-inclusive billing methodology is not limited solely to doctors. The +15% bump is applicable to all licensed professionals who otherwise would be entitled to bill the carrier under Medicare Part B.

Moreover, these professionals do not need to be hospital employees in order to receive the enhanced reimbursement. There is no requirement for employment. The bump is for all professionals - employed, contracted, privileged, *et cetera* - furnishing services to CAH outpatients.

The all-inclusive method can provide a significant payment boost, designed to incent healthcare professionals to remain in rural areas / perform services for CAHs.

### **HPSA Incentive Payments**

In addition, physicians who provide covered professional services in any rural or urban health professional shortage area (HPSA) are entitled to a +10% incentive payment. *Unlike the all-inclusive payment increase described above, the HPSA incentive bonus applies only to physicians, not to other healthcare professionals.*

If a CAH electing the all-inclusive billing methodology is located within a HPSA, the physicians providing professional services in the CAH are still eligible for HPSA incentive pay-