

...Rural Hospital Bulletin...

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

Trends in Rural Hospital Closure

Over the past decade, the closure of hospitals has created concern throughout the healthcare industry, including government leaders and the general public. Of particular concern were the reasons for the closures. In May 1989, the Office of Inspector General (OIG) published a report discussing the trends of urban and rural hospital closures. The report was so well received that the OIG was encouraged to continue a yearly analysis to determine specific trends. In June 2003, the OIG released a report discussing cause and effects of rural hospital closures during 1990-2000.

In their report, the OIG reviewed 208 closed rural hospitals. This represented 7.8% of all rural hospitals nationally. Compared to national statistics, the rural hospitals that closed during this 11-year span were smaller and had less Medicare and Medicaid utilization. The rural hospitals that closed reported lower occupancy rates and annual income as compared to rural hospitals nationally. For example, hospitals that closed reported an average of 39.6 beds as opposed to 75.4 beds nationally. Net income was also considerably lower, at a reported \$1,488 compared to \$799,560 nationally.

Officials associated with nearly all rural hospitals that closed reported the decision for closure was based on business-related decisions or a low number of patients. As stated in the report, from 1998 through 2000, 58 rural hospitals closed. The primary reasons for the closures were:

- Business decisions – 43% based on relocation, consolidation, or a merger
- Number of patients – 24% experienced low occupancy rates
- Medicare / Medicaid reimbursement – 10% reported insufficient reimbursements
- Other – 22% reported various other reasons

In the 208 rural communities that experienced a hospital closure, 138 had inpatient hospital care within 20 miles from the

closed hospital. Residents in 185 of those communities had access to inpatient care within 30 miles from the closed hospital. Only 11% or 23 communities had a 30-mile or greater distance to another inpatient facility.

The report names three factors that attribute to a reduced impact of rural hospital closure; hospital openings, critical access hospitals, and rural health clinics. Between 1990 – 2000, 92 rural hospitals either opened or re-opened, reducing the national impact of the closing rural hospitals. There are currently 604 critical access hospitals (CAHs) operating in rural areas across the county. This classification is intended to increase the level of reimbursement from Medicare to small rural hospitals thus helping to avoid closure. Finally, rural health clinics (RHC) have been used as alternatives to hospitals. Of 58 rural hospitals that closed from 1998 – 2000, 40 of those facilities converted to a RHC.

The OIG also reported on the closure of urban hospitals. The report stated that 296 urban hospitals closed, 10% of all urban hospitals nationally. The primary reasons for their closure were as follows:

- Competition – 27% reported closure due to competition with nearby hospitals.
- Business decisions – 26% reported reason for closure due to relocation, consolidation, or a merger
- Number of patients – 14% attributed closure to low occupancy
- Medicare / Medicaid reimbursements – 10% reported insufficient reimbursements
- Other / unspecified - 21% reported various other reasons or did not state reason.

During the 11-year period under review, Massachusetts experienced no rural hospital and 12 urban hospital closures.

CAH's to Feel Impact of Medicare Reimbursement Change

On September 11, 2002, CMS released a Transmittal updating the Provider Reimbursement Manual (Pub. 15-2), which provided for significant changes to be made in the calculation of the Part B (other/outpatient) settlements for Critical Access Hospitals. Specifically, for cost report periods beginning on/after July 1, 2002, the settlement amount due to/from the Program would reflect a new calculation for the amount of coinsurance deducted from each CAH's reasonable cost.

Prior to the release of this Program Transmittal, the amount of coinsurance deducted from the CAH's reasonable cost during the settlement process was the product of 20% of the reasonable outpatient costs less billed deductibles for the period. Effectively, the Part B coinsurance deduction for most CAH's amounted to roughly 20% of reasonable costs.

Under the methodology outlined in the Program Transmittal, CAH's are now required to reflect the coinsurance (offset) using a new "greater of..." calculation. For cost reporting periods beginning on/after July 1, 2002, CAH's must now take into consideration the amount of coinsurance billed to the Program Beneficiaries during the settlement process. As stipulated in Section 3630.2 of the Provider Reimbursement Manual, CAH's are to offset the amount due from the Program by the greater of: (1) the amount of coinsurance billed to the beneficiary (e.g. 20% of applicable charges), or

(2) 20% of reasonable costs less deductibles. Further, if the CAH elects to bill beneficiaries a discounted amount, it is required to report the full amount (e.g. 20% of applicable charges) in the calculation of coinsurance during the settlement process.

Under a basic pretense, this change in the coinsurance calculation will ultimately be reflected in lower settlement payments from Medicare for those CAH's whose charges exceed their reasonable Part B costs. More than likely, this will result in a reduction in total reimbursement for Medicare services for those same hospitals as they likely receive the full coinsurance requirement from the beneficiaries (e.g. 20% of charges), and receive 80% of costs from the Program. In this scenario, the CAH would likely receive total payments for Medicare services in excess of 100% of its reasonable costs. Under the new methodology, a CAH will only receive (up to) 100% of its reasonable Part B costs.

While this change has been reflected in the Program Manual since September 2002, most providers will not fully understand the impact until the close of their 2003 fiscal year (September 30th, 2003, or December 31st, 2003). Given the impact seen on some of our clients with closed FY 2003 periods, we highly recommend that providers incorporate this change into their current Medicare reimbursement calculations.

As you know, the Department of Health and Human Services (“HHS”) was required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to adopt electronic standards for administrative and financial healthcare transactions. These standards were set by a final rule published in the Federal Register on August 17, 2000. The original deadline for compliance with the new mandatory standards was scheduled for October 16, 2002. However, most covered entities took advantage of the twelve-month compliance extension process created by the Administrative Simplification Compliance Act (“ASCA”). By requesting an extension, covered entities also agreed to begin compliance testing by Wednesday, April 16, 2003.

Both deadlines — for testing and compliance — have now come and gone. Are you ready?

HHS recently issued a three-page formal guidance document addressing the potential ramifications of non-compliance by covered entities — including health plans, healthcare clearinghouses, and healthcare providers who submit electronic transactions. The HHS guidance reaffirms that the law is clear: October 16, 2003 was the deadline for covered entities to comply with HIPAA’s electronic transaction and code sets provisions. After that date, covered entities are not supposed to conduct non-standard transactions. In reality, however, even the Medicare program itself has implemented an emergency contingency plan to continue accepting non-standard transactions for a brief period.

The Centers for Medicare and Medicaid Services (“CMS”) is responsible for enforcing the standards. CMS intends to focus on obtaining “voluntary compliance” by using a complaint-driven approach to enforcement. The agency will not knock on your door, in other words, unless they first receive a complaint. When CMS does receive a complaint about a covered entity, it will notify the entity in writing that a complaint has been filed. Following this notification, the entity will have the opportunity to (1) demonstrate compliance; (2) document its good faith efforts to comply with the standards; and/or (3) submit a corrective action plan.

The “good faith effort” component of the equation is important to understand. The HIPAA statute mandates that HHS may not impose a civil money penalty where failure to comply is based on “reasonable cause” and is not due to “willful neglect.” However, the failure to comply must be remedied within a thirty-day period (unless a special extension is granted on a case-by-case basis).

Otherwise, regulators do have the authority to fine providers who do not comply with the new standards. Violators can be fined \$100 per offense, up to \$25,000 a year.

The HHS guidance states that CMS will not impose penalties on covered entities that deploy contingency plans (in order to ensure the smooth flow of payments), provided that they also have made “reasonable and diligent” efforts to become compliant. In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrable progress. HHS has suggested that organizations who have exercised good faith efforts to correct problems and implement the changes required to comply with HIPAA should be prepared to document these efforts.

CMS is aware that many healthcare providers who submit electronic transactions — especially small and rural providers — have not yet fully operationalized a practical and sustainable HIPAA implementation plan. The agency had strongly urged providers to test the flow of electronic transactions to (and from) payers well in advance of the compliance deadline. In addition, all healthcare providers were encouraged to establish reasonable contingency plans, in the event that unforeseen circumstances prevent the submission of compliant transactions (or in the event that certain payers are not able to process compliant transactions by the deadline).

A technical reading of the HIPAA regulations bars private and government health plans from reimbursing providers for non-standard electronic claims submitted after October 16. However, CMS has indicated that the agency will continue to pay Medicare claims in the short term, as long as the providers filing non-standard claims continue to make a good faith effort to come into compliance. A number of private payers also intend to maintain the capability to accept and process non-standard claims.

Providers who know today that they are not ready for HIPAA should contact their payers immediately to clarify instructions regarding the submission of non-compliant transactions. Non-compliant providers should also consider investigating the need for emergency sources of credit to address any potential cash flow issues resulting from the inability to submit standard transactions. In addition, providers should not just assume that they will be able to circumvent the HIPAA standards by submitting paper claims for reimbursement. For example, please note that Section 3 of ASCA mandated that after October 16, 2003, no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services for which a claim is submitted other than in standard electronic form. *No more paper claims for Medicare, in other words* (with very narrow exceptions for small providers, and in rare instances where a standard transaction has not been created).

The Centers for Medicare and Medicaid Services final rule updating the Medicare hospital inpatient payment regulations for Fiscal Year 2004 – 68 Federal Register 45,488 (August 1, 2003) – did not include any major payment changes for Critical Access Hospital reimbursement. The rule did include one potentially significant clarification regarding payment for outpatient laboratory services furnished by a CAH, however.

You may recall that the Benefit Improvement and Protection Act of 2000 (“BIPA 00”) included a number of provisions beneficial to CAHs. Perhaps most importantly, BIPA 00 § 201 clarified that CAHs are reimbursed on a reasonable cost basis for outpatient clinical diagnostic laboratory services furnished to CAH patients.

This provision reversed the impact of a typographical error in § 403(e) of the Balanced Budget Refinement Act of 1999 (“BBRA 99”) – which inadvertently subjected CAHs to the Medicare laboratory fee schedule. In an interim final rule published in the Federal Register on June 13, 2001 – 66 Federal Register 32,171 (June 13, 2001) – CMS noted that prior to the enactment of BBRA 99, lab services furnished by a CAH to Medicare outpatients had always been – like other Medicare outpatient CAH services – reimbursed on a reasonable cost basis, subject to the Part B deductible and coinsurance provisions. However, when a provision in BBRA 99 attempted to eliminate the Part B coinsurance and deductible for lab tests furnished by a CAH on an outpatient basis, an unintentional drafting typo in the legislative language also subjected CAHs to the lab fee schedule. This provision was effective with respect to services furnished on or after November 29, 1999.

BIPA 00 then stepped in to correct the error by clarifying that payment for these services should be made on a reasonable cost basis. The amendment was made retroactive to cover services furnished on or after November 29, 1999.

To prevent any misunderstandings, CMS further revised the payment regulations at 42 CFR § 413.70(b)(3)(iii) in the June 13, 2001 interim final rule to clarify that payment to a CAH for lab tests for individuals who are not inpatients of the CAH is made on a reasonable cost basis only if the individuals are outpatients of the CAH at the time the specimens are collected. Outpatient status is determined under the definition in § 410.2, which provides that an “outpatient” is a person who has not been admitted as

an inpatient but is registered as an outpatient and receives services (rather than supplies alone) from the CAH. The effective date of this change to the regulatory language was June 13, 2001.

In the new final rule issued August 1, CMS has now further clarified that reasonable-cost based reimbursement for lab services will apply only when the patient is physically present in the CAH at the time the specimens are collected. All other lab services will be reimbursed under the Medicare Laboratory Fee Schedule.

Given the level of legislative and regulatory confusion surrounding this issue, many CAHs had been understandably confused about reimbursement for lab services, and this clarification can mean a significant reduction in payment for any CAHs that had been claiming cost-based reimbursement for all lab services. In addition to decreased Medicare reimbursement caused by variances between fee schedule rates and reasonable costs, it bears emphasis that CAHs may also lose additional reimbursement because, as pointed out by several attendees during a recent CMS Rural Health Open Door Forum, any fee schedule payment amounts would be reported as revenue on the Medicare cost report, potentially bringing down the hospital’s effective cost-to-charge ratio.

CMS has acknowledged, “We recognize that CAHs may appropriately function as reference laboratories, by performing clinical diagnostic laboratory tests on specimens from persons who do not meet the “outpatient” definition but have the specimens drawn at other locations, such as physician offices.” However, “Payment for clinical diagnostic laboratory tests for these other individuals (that are persons who are not patients of the CAH when the specimens are collected) will be made in accordance with [the laboratory fee schedule].”

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

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