



...Rural Hospital Bulletin...

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Increasing Access to Capital Financing for Rural Hospitals

In October, President Bush signed the Hospital Mortgage Insurance Act of 2003. This important piece of healthcare legislation makes it easier for rural hospitals to obtain valuable mortgage insurance to fund hospital construction and improvements.

Expressing his strong support of the Act, Representative Bob Ney (R-Ohio) noted that many rural hospitals have aging physical plants, due to a lack of available capital resources to finance major construction upgrades. This problem is exacerbated as rapid advancements in healthcare technology necessitate expensive capital improvements — including the replacement, modernization, or rehabilitation of facilities in order to maintain quality of care for patients.

Another proponent of the legislation, Rep. Sheila Jackson-Lee (D-Texas), added that many rural hospitals were built during the 1950's and 1960's with loans and grants from the Hill-Burton Program (Title VI of the Public Health Service Act), but appropriations for Hill-Burton ended in 1974.

The Hospital Mortgage Insurance Act will help rural hospitals by improving access to the Section 242 Loan Guarantee Program administered by the Federal Housing Administration ("FHA") and the US Department of Housing and Urban Development ("HUD").

Created by the National Housing Act of 1968, the Section 242 Program increases affordable financing for acute care hospitals by protecting against losses (both principal and interest) in case of a default. The credit enhancement provided by this mortgage bond can increase a hospital bond rating from "Junk" to "AA" or "AAA" status, according to the Rural Health Resource Center. Section 242-protected loans may be used for construction re-financing, remodeling, or expansion of new and existing facilities, including major moveable equipment. Architect fees, planner fees, title and recording fees, and other related costs are also eligible.

Since 1968, the Section 242 Program has secured over three hundred hospital loans in forty States and Puerto Rico, according to Rep. Jackson-Lee. The benefit for rural communities has been limited, however. The Program has facilitated \$9.3B in insured loans, of which only \$67M (or less than one percent) has been invested in rural hospitals. In fact, ninety percent of the program's participants have been hospitals located in New York (80%) and New Jersey (10%).

Participation in this vital program has been unavailable for most small rural hospitals because of high profitability and debt service thresholds mandated by law. HUD has made increasing the availability of Section 242 financing for Critical Access Hospitals ("CAHs") a priority. The agency has developed simplified, flexible CAH processing guidelines. Also, when making eligibility determinations, the agency has placed greater emphasis for CAHs on projected financial performance and stability. (HUD typically relies on historical financial statements to measure profitability and debt service thresholds. Reliance on past performance can present a significant disadvantage for new CAHs that have only recently transitioned to cost-based reimbursement for Medicare services.)

The goal of the Hospital Mortgage Insurance Act is to increase rural access to the Section 242 Program by exempting CAHs from an existing statutory mandate that requires fifty percent of patient days in the facility must be for acute care. Rep. Ney explains that this change will allow the Program to insure mortgages for CAHs with long-term care nursing facilities. This is important in small, rural communities, where the population may be too small to support two separate facilities. The original text of Section 242 specifically required that in order to qualify, "not more than fifty per centum of the total patient days for [an acute care hospital] during any year [could be] customarily assignable to the categories of chronic convalescent and rest, drug and alcoholic, epileptic, mentally deficient, mental, nervous and mental, and tuberculosis." The Act has amended that language to exclude CAHs from the requirement. This limited exemption will last for three years, during which time HUD will submit a report to Congress on the exemption's impact to the Section 242 fund.

The Hospital Mortgage Insurance Act also increases access to capital financing for hospitals located in one of the eighteen States that do not have a Certificate of Need program. According to Rep. Gary Miller (R-Calif.), when the Federal Certification of Need Program began, forty-nine states had a corresponding program. However, following a general trend toward deregulation, many States have since repealed the programs or otherwise allowed them to expire, including Arizona, California, Indiana, Kansas, Minnesota, Missouri, Oregon, Pennsylvania, Texas, and Utah. In the past, to be eligible for Section 242 financing, a hospital had to obtain a Certificate of Need or equivalent approval from a State-commissioned feasibility study. The Act now gives HUD the authority to establish the agency's own process for determining the need and feasibility of a proposed hospital project.

OIG Work Plan for 2004

The OIG recently published their Work Plan for Fiscal Year 2004. Released annually, the Work Plan previews OIG projects that are scheduled in the upcoming year for each of the major entities within the Department of Health and Human Services:

- Centers for Medicare and Medicaid Services
- Public Health Service Agencies
- Administrations for Children, Family, and Aging

Information is also provided on projects related to issues that cut across departmental programs, including state and local government use of Federal funds, as well as the functional areas of the Office of the Secretary. Some of the projects described in the Work Plan are statutorily required, such as the audit of the department's financial statements, which is mandated by the Government Management Reform Act.

The Work Plan can serve as an invaluable guide for healthcare professionals and organizations to identify the targets of OIG scrutiny and enforcement activity. The 2004 Work Plan covers the full spectrum of healthcare, from medical necessity and coding issues to clinical trials and care provided in nursing homes.

Critical Access hospitals (CAH) and Rural Health Centers (RHC) have been a significant topic of the OIG Work Plan since 2001. CAH's are cost reimbursed and therefore more susceptible to abuse than are the prospective payment systems. Because of this, the OIG has made home-office costs at CAH's a focus of their 2004 Work Plan. The OIG will be reviewing costs to figure out whether home-office costs and related transactions and related party transactions were properly allocated and treated consistently with Medicare rules.

In past years, the OIG has looked at the implementation of the CAH program to assess State compliance with statutory provisions and CMS regulations. In last year's Work Plan, the OIG began looking at costs reported on CAH's to evaluate whether services were provided in accordance with Medicare guidelines and also to analyze utilization patterns to identify potential vulnerabilities to the Medicare program. Since the number of CAH's has steadily grown to 788 nation wide, it is probable that this topic will continue into future OIG Work Plans.

In FY 1996 the OIG implemented some changes in the Medicare certification and reimbursement of Rural Health Clinics (RHC). Rural health clinics are also cost reimbursed. In 1996 the OIG became concerned over the rapid growth of RHC's and the lack of reliable data quantifying the impact, made in necessary for the OIG to take action.

The old certification process did not mandate applicants to document the potential impact of establishing an RHC. Nor was it required to be established in an area of greatest need. There was no limit on the number of clinics that could be established in one area. The OIG at this time recommended that CMS implement requirements for applicants to submit a plan documenting the projected impact and to create geographic limits to eliminate an overabundance of RHC's.

In the OIG Work Plan for FY's 2001, 2002, and now 2004, they examine the changes and impact of this modified certification process. In 2004, the OIG will also examine responses by CMS to prior reports and recent trends in the development and reimbursement patterns of RHC.

Benefits for Rural Hospitals in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was signed into law by President Bush on Monday, December 8. In addition to providing some level of prescription drug coverage for Medicare beneficiaries, the Act also includes a variety of different Medicare program reforms and reimbursement add-ons for healthcare providers, and there are a number of important provisions specifically targeted to help rural providers.

Based on a preliminary review of the legislation, the Congressional Budget Office (CBO) estimates that the Act will increase the government's direct expenditures to rural healthcare providers by \$25B over the next ten years, *i.e.* through 2013. Here is a summary of a few key provisions:

Equalization of Standardized Amount Made Permanent

Section 401 of the Act permanently equalizes Large Urban, Other Urban, and Rural standardized payment amounts under the Medicare inpatient hospital prospective payment system (IPPS).

The Consolidated Appropriations Resolution of 2003 enacted in February 2003 had required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the Large Urban standardized amount. During this temporary period of "equalization," hospitals located in "Other" areas — including rural locations were reimbursed at the Large Urban rate amounts. For discharges occurring on or after October 1, 2003, the Federal rate was to revert back to the separate Large Urban and Other standardized amounts. On October 1, both Houses of Congress approved legislation to extend the equalization period for the first six months of FY 2004, through March 31, 2004.

The Act now equalizes the standardized amounts for Large Urban and Other Area inpatient operating rates on a permanent basis. The CBO estimates that this provision will increase direct expenditures by \$7.6B over the next ten years.

Adjustment to Labor-Related Share of Standardized Amounts

The standard operating payment rate per discharge is comprised of an average standardized amount that is divided into a labor-related component and a non-labor related component. The labor-related share represents the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. For FY 2004, as in past years, the labor-related component has remained at 71.066%.

When determining prospective payments to hospitals, Medicare adjusts the labor-related standardized national reimbursement amounts to account for geographic differences in hospital wage costs. This adjustment is performed by means of a local area wage index (AWI), which acts as a relative measure comparing area average hourly wages to a national average.

Section 403 of the Act sets the labor-related component at 62% beginning in Fiscal Year 2005 (*i.e.* effective for discharges occurring on or after October 1, 2004). Because the AWI for rural areas tends to be lower in relation to the national average, decreasing the labor-related component of the operating payment rate from 71% to 62% will have the effect of increasing payments to rural hospitals. The CBO estimates that this provision will increase direct expenditures by \$5.2B over the next ten years.

Hold Harmless from Outpatient Prospective Payment System

Under Section 411, the "hold harmless" period for hospital outpatient services would be extended by two years (*i.e.* until 2006) for small rural hospitals with fewer than one hundred beds and sole community hospitals (SCHs) located in rural areas. During this time period, Medicare will also review the prospective payment system rates.

The Balanced Budget Refinement Act of 1999 had created a temporary hold harmless for rural hospitals with one hundred or fewer beds. These hospitals were protected from any losses under outpatient PPS for the duration of the transitional period that followed the implementation of the new system. The hold harmless period has now been further extended by the Act until 2006. The CBO estimates that this provision will increase direct expenditures by \$0.3B through 2006.

Disproportionate Share Hospitals

Section 402 of the Act mandates that Medicare disproportionate share hospital (DSH) add-on payments for rural and small urban hospitals would be increased to a twelve percent cap (effective for discharges occurring on or after April 1, 2004).

The Medicare DSH add-on provides additional reimbursement for qualifying hospitals that serve a significantly disproportionate percentage of low-income or indigent patients. Hospitals whose disproportionate patient percentage exceeds a minimum threshold are eligible for DSH add-on payments intended to cover related operating and capital costs. Following the enactment of Benefits Improvement and Protection Act of 2002, all hospitals (rural and urban, large and small) are eligible to receive DSH payments once their DSH percentage exceeds fifteen percent

The size of a hospital's DSH adjustment is based on the sum of the percentage of patient days attributable to (1) patients eligible for both Medicare Part A and Supplemental Security Income (SSI); and (2) patients eligible for Medicaid but not Medicare Part A. For most rural and small urban hospitals, DSH add-on payments are currently capped at a max of 5.25% of base payment amounts. Section 402 of the Act increases the applicable cap to twelve percent. The CBO estimates this provision will increase direct expenditures by \$2.7B over the next ten years.

Low-Volume Hospital Payment Increase

Section 406 of the Act calls for a new Medicare inpatient hospital payment adjustment for low-volume hospitals with fewer than eight hundred total inpatient acute care discharges (not just limited to discharges covered by Medicare Part A). This provision will become effective for FY 2005 (beginning with discharges occurring on or after October 1, 2004.)

The amount of the actual payment increase will be determined by Medicare based on the relationship between a hospital's number of discharges and additional incremental costs (not to exceed a twenty-five percent increase.) The CBO estimates that this provision will increase direct expenditures by \$0.1B over the next ten years.

Critical Access Hospitals

Section 405 of the Act includes a number of improvements for the critical access hospital (CAH) program. The CBO estimates that these provisions will increase direct expenditures by \$0.9B over the next ten years.

Reimbursement Based on 101% of Reasonable Costs - The cost-based reimbursement methodology for Medicare inpatient and outpatient services by CAHs will be enhanced to 101% of reasonable costs (effective January 1, 2004). The final version of the Act does not expand cost-based reimbursement to home health agencies and distinct-part SNFs owned and operated by CAHs.

Increase to Acute-Level Bed Limit to Twenty-Five Beds - The Act increases the number of acute-level beds for a CAH to twenty-five. Prior to this expansion, CAHs could provide no more than fifteen beds for acute inpatient care. An exception to the old fifteen-bed limit was made in the past for "swing bed" facilities, which were allowed to have up to twenty-five inpatient beds used interchangeably for acute or SNF-level care, provided that not more than fifteen beds are used at any one time for acute care. This exception was not particularly useful in states that did not allow for licensure of swing beds, like Massachusetts (where only a very limited number of "grandfathered" facilities are allowed to maintain swing beds).

The old fifteen-bed restriction has now been increased for all CAHs to twenty-five acute beds, regardless of whether the hospital maintains swing beds (effective January 1, 2004). The allowable bed count for a CAH may actually exceed twenty-five, when you consider distinct-part beds (see next item below).

CAHs Allowed to Operate Distinct-Part Hospital Units - Effective October 1, 2004, the Act establishes new eligibility rules that allow hospitals with up to ten distinct-part psychiatric or rehabilitation beds to become CAHs.

Under current regulations, CAHs could not operate distinct-part units, which are only available to hospitals paid under the acute care prospective payment system. CAHs are themselves PPS-exempt, reimbursed on the basis of reasonable costs. A CAH cannot operate a PPS-exempt unit because a CAH is not a PPS hospital. CAHs can, however, operate a distinct-part SNF under current regulations. Distinct-part unit beds will not be included in the twenty-five acute-level bed count for CAHs.

Unfortunately, the Act does not establish reasonable cost-based Medicare reimbursement for CAH services provided in distinct-part units. Instead, Medicare reimbursement will be based on the new PPS that apply for these two respective provider types.

Limited to Hospitals Located Thirty-Five Miles from Another Hospital - Effective January 1, 2006, the Act rescinds the authority of individual states to waive the thirty-five mile requirement for CAH eligibility. However, the Act does "grandfather" all CAHs that have been certified as "necessary providers" before that date.

As you know, under the current eligibility criteria, a CAH must be located more than a thirty-five mile drive from any other hospital or CAH. (In mountainous terrain or in areas with only secondary roads available, the mileage criterion is actually fifteen miles.) However, a hospital may be state-certified as a "necessary provider" of healthcare services to residents in the area. In most states, these certifications are determined by the State Office of Rural Health on case-by-case basis.

Effective January 1, 2006, states will no longer have the authority to designate hospitals as "necessary providers" in order to qualify for CAH designation. After that date, all new CAHs will have to meet the minimum mileage criteria.

Emergency On-Call Reimbursement for Non-Physician Practitioners - The Act extends emergency on-call payments to physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs).

Funding for Rural Flexibility Grant Program - The Act re-authorizes \$35 million a year in Rural Flexibility Grants for each of the next four years, for a grand total of \$140 million.

Consolidated or "All-Inclusive" Billing Clarification - Currently, CAHs are allowed to elect one of two methods of payment for outpatient services:

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 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.

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.

For CAHs that choose the second option, payment for each outpatient visit will be sum of (a) the reasonable cost of CAH services, plus (b) 115% of the Medicare physician fee schedule amount for physician services. The fifteen percent bump to fee schedule rates is not limited exclusively to physician services. The bonus is applicable to all licensed professionals who otherwise would be entitled to bill the carrier under Medicare Part B. Also, professionals do not need to be hospital employees in order to receive the enhanced reimbursement. The bonus is for all professionals — employed, contracted, privileged, *et cetera* — furnishing services to CAH outpatients. The all-inclusive billing method can provide a significant payment boost, designed to incent healthcare professionals to remain in rural areas / perform services for CAHs.

The Act eliminates a barrier for receiving the physician bonus for outpatient CAH services by mandating that Medicare cannot require, as a condition for receiving reimbursement under the all-inclusive methodology, that each (and every) physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services. However, the Act does specify that the incentive bonus will not apply to any physicians and practitioners who have not assigned their billing rights to the hospital.

Reinstatement of PIP Reimbursement Methodology - The Act reinstates the periodic interim payments (PIP) for CAHs, and develops alternative timing methods to achieve an appropriate level of cash flow.

Other Benefits for Rural Providers

For a complete summary of other rural provisions in the Medicare prescription drug act, please visit: www.fdcpa.com/medicare.drug.act.htm

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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