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Medicare Special Designations and their Cost Report Considerations

HFS Provider User Meeting
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Medicare Special Designations

- Sole Community Hospital (SCH)
- Medicare Dependent Hospital (MDH)
- Rural Referral Center (RRC)
- Low Volume Payment Adjustment

- *For each of these special designations, a hospital must meet certain requirements and submit an application or request in order to be approved*
- *In most instances a hospital will need to be rural*

Section 401 Hospitals

- Urban hospitals meeting specific conditions can be re-designated as rural for Medicare payment purposes

  §412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

- Most common reason is to qualify as SCH, RRC or CAH
- Previously, regulations prevented Section 401 hospitals from also receiving wage index geo reclass

Section 401 Hospitals

- CMS issued separate Interim Final Rule on same day as FY 17 proposed rule
  - Effective April 21, 2016 although CMS did accept comments through June 17
  - Section 401 hospitals are now eligible to receive a geo reclass
  - Hospitals with an existing geo reclass can retain if newly approved for Section 401
- Results from two separate court rulings in the past year that Congress never gave CMS the authority to forbid Section 401 geo reclasses

Section 401 Hospitals

- Rather than continue fighting in court, CMS reversed their policy “In the interest of creating a uniform national reclassification policy”
- Additionally, CMS confirmed in the FY 17 IPPS Final Rule that Section 401 hospitals are allowed to reclass back to the CBSA in which it is physically located if it qualifies

Section 401 Hospitals

- Number of Section 401 hospitals at time of Final Rule:

FY 2016	64
FY 2017	72
FY 2018	166

Including hospitals in New York City, Los Angeles, Miami and Detroit

Sole Community Hospital (SCH)

- *§412.92 Special treatment: Sole community hospitals*
- 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 that 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.

Sole Community Hospital (SCH)

- Eligibility Criteria (cont.)
  - 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)

- Eligibility Criteria (cont.)
  - If a hospital's circumstances change and it no longer meets eligibility requirements, SCH status is/should be lost
  - CMS expects hospitals to self-report changes in circumstances it should be aware of, such as another like hospital opening nearby
  - If the hospital does not self-report for changes it should be aware of, and CMS later determines that the hospital no longer qualifies, removal of SCH status can be applied retroactively to the date of the change in circumstances
  - CMS has also clarified that If a hospital never should have qualified for SCH status in the first place, SCH status is/should be lost

Sole Community Hospital (SCH)

- Benefits
  - For Medicare IP services, paid the highest of:
    - The Federal rate applicable to the hospital,
    - Adjusted/updated hospital-specific rate based on
      - FY 1982,
      - FY 1987,
      - FY 1996, or
      - FY 2006 costs per discharge
  - Currently rural SCHs receive additional 7.1% above standard Outpatient PPS payment rates on most services

Sole Community Hospital (SCH)

- Benefits (cont.)
  - 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
  - PPACA allows SCHs and RRCs to qualify for 340B with 8% DSH instead of 11.75%
    - Not eligible for 340B pricing for Orphan Drugs

Medicare Dependent Hospital (MDH)

- *§412.108 Special treatment: Medicare-dependent, small rural hospitals.*
- Eligibility Criteria
  - Hospital must be located in a rural area
  - Hospital must not have more than 100 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
  - April 2015 SGR Repeal law extended MDH status through September 30, 2017
    - Provision has expired several times only to be reinstated retroactively by Congress

Medicare Dependent Hospital (MDH)

- Benefits
  - For Medicare IP services, paid the highest of:
    - The Federal rate applicable to the hospital,
    - 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 costs per discharge
  - Effective 10/1/06, MDHs no longer capped at 12% for Medicare Operating DSH

Hospital-Specific Rate Payments

- SCHs and MDHs are eligible to receive the higher of the inpatient operating Federal payment or their Hospital-Specific Rate (HSR) payment
  - SCH HSR is based on the highest rate from 1982, 1987, 1996, or 2006 trended forward
  - MDH HSR is based on the highest rate from 1982, 1987, or 2002 trended forward
  - MDH receives only 75% of the difference, if any, between the HSR and Federal payment
  - Federal payment comes from E Part A line 47
    - Includes DRGs, Outliers, IME, DSH

Hospital-Specific Rate Payments

- Base rate is calculated from hospital's 12-month cost report that began during the eligible year
  - For example, 9/30/06 or 6/30/07 cost report used to determine 2006 base rate
- Rate is trended forward by applying Market Update Factor and Budget Neutrality Factor, plus other adjustments deemed necessary by CMS, to each year

Hospital-Specific Rate Payments

FY 2006 Total Program Inpatient Costs	83,500,000	D-1, II line 53
FY 2006 Medicare discharges	9,600	S-3, I column 13 line 1
FY 2006 cost per case	8,697.92	
FY 2006 Medicare CMI	1.6500	PS&R
FY 2006 Hospital-Specific Rate	5,271.46	
FY 2007 Market Update Factor	1.034	
FY 2007 SCH Budget Neutrality Factor	0.974681	
Updated FY 2007 Hospital-Specific Rate	5,312.69	
FY 2008 Market Update Factor	1.033	
FY 2008 SCH Budget Neutrality Factor	0.995743	
Updated FY 2008 Hospital-Specific Rate	5,464.64	
FY 2009 Market Update Factor	1.036	
FY 2009 SCH Budget Neutrality Factor	0.998795	
Updated FY 2009 Hospital-Specific Rate	5,654.55	

Hospital-Specific Rate Payments

Updated FY 2009 Hospital-Specific Rate	5,654.55	
FY 2009 Medicare Discharges	9,800	S-3, I column 13 line 1
FY 2009 DRG Weight	1.6800	PS&R
FY 2009 Hospital-Specific Rate Payment	93,096,508	E Part A line 48
FY 2009 Federal Payments	91,500,000	E Part A line 47
Additional Hospital-Specific Payments	1,596,508	

Volume Decrease Adjustment

- Available to SCHs and MDHs
- Cost report must be final settled before adjustment can be finalized
- Adjustment only possible if total Medicare IP operating cost, excluding passthrough costs, exceeds DRG payments, including outlier payments
- Request must be submitted within 180 days of NPR date

Volume Decrease Adjustment

- Eligibility Criteria:
  - The provider's total discharges for the cost report period must decrease more than 5 percent compared to the preceding cost report period
  - The decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control
    - Examples cited by CMS include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects

Volume Decrease Adjustment

- Necessary Support:
  - Circumstances - an outline of the circumstances that resulted in the decrease of discharges. This must include a narrative description of the occurrence, date of its onset, and how it affected the number of discharges.
  - Semifixed costs - a narrative description of actions taken by hospital to reduce semifixed costs
  - Core Staff and Services - comparison of FTEs and salaries in both cost reporting periods with an identification of core staff and services (those departments that are components of Medicare inpatient operating cost) in each center and the cost. The provider must justify the selection of core staff and services and include minimum staffing requirements imposed by state regulations/or any other external source.

Volume Decrease Adjustment

- Adjustment Calculation:
  - Medicare will pay as a lump sum amount the difference between the lesser of a) the prior year Medicare Inpatient Operating Cost increased by the PPS update factor or b) the Medicare Inpatient Operating Cost for the year of the cost report in question and the DRG payments for the cost report in question. This amount is reduced by the cost of any nursing staffing that Medicare deems excessive. The "excess" is determined by a formula that compares the hospital's paid nursing hours per patient day with the average in the hospital's census region.

Volume Decrease Adjustment

- Important Changes in FY 2018 IPPS Final Rule:

CR periods beginning prior to 10/1/2017	CR periods beginning on or after 10/1/2017
VDA = Hospital's Medicare Fixed Costs less **Total** MS-DRG Revenue	VDA = Hospital's Medicare Fixed Costs less **Fixed** MS-DRG Revenue
CY Fixed Costs Capped at PY Fixed Costs After Update Factor Applied	No longer comparing to PY
Hospital must show that staffing levels in IP areas decreased proportional to volume decrease	Hospitals no longer have to "explicitly demonstrate"

Volume Decrease Adjustment

- Important Changes in FY 2018 IPPS Final Rule (cont.):
  - CMS emphasizes these changes are strictly prospective
  - Acknowledges *"…there may have been inconsistencies in volume decrease adjustment determinations made by some MACs*"
  - Hospitals should consider appealing adverse decisions if "new" methodology would provide beneficial result

Rural Referral Center (RRC)

- *§412.96 Special treatment: Referral centers.*
- 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

Rural Referral Center (RRC)

- Eligibility Criteria (cont.)
  - 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 (see next slide)
    2. Has at least 5,000 annual discharges (at least 3,000 if an osteopathic hospital)
    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)

- Eligibility Criteria (cont.)
  - Case Mix requirement per FY 2018 IPPS final rule:

Region	Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.4192
2. Middle Atlantic (PA, NJ, NY)	1.5133
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5405
4. East North Central (IL, IN, MI, OH, WI)	1.5896
5. East South Central (AL, KY, MS, TN)	1.5086
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.6344
7. West South Central (AR, LA, OK, TX)	1.6950
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7580
9. Pacific (AK, CA, HI, OR, WA)	1.6473

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
  - PPACA allows SCHs and RRCs to qualify for 340B with 8% DSH instead of 11.75%
    - Not eligible for 340B pricing for Orphan Drugs

Low Volume Payment Adjustment

- Adjustment has existed since 2005, but previous regulations had made it nearly impossible for hospitals to qualify
- For Federal FY 2011 and 2012 PPACA loosened the two qualification requirements:
  - First, a hospital has to be located at least 15 road miles from another acute PPS hospital instead of the previous requirement of at least 25 miles
  - Second, a hospital must have less than 1,600 Medicare-eligible discharges
    - Previously only hospitals with less than 200 total discharges could qualify for the additional payment.

Low Volume Payment Adjustment

- Congress has subsequently extended multiple times, currently through 9/30/17 (under April 2015 SGR repeal law)
- Qualifying hospitals receive an add-on based on Medicare discharges:
  - Linear sliding scale, from 25% for =< 200 Medicare discharges to 0% for >= 1600 Medicare discharges
  - Formula is [(4/14) – (Medicare discharges/5600)]
  - CMS publishes the number of discharges for all hospitals that might qualify, based on most recent MedPAR data

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