Louisiana HFMA Summer Conference 2023

# Medicare Regulatory and Litigation Update

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healthcare financial management association

# Agenda

- FY 2024 Payment Rate Update
- S-10
- Uncompensated Care & DSH
- 340B Cuts
- Wage Index
- Capital DSH
- Graduate Medical Education
- Nursing and Allied Health
- CAH Distance Requirements
- Rural Emergency Hospitals

# FY 2024 Payment Rate Update

# Market Basket Update

- "[A] forecast of the price pressures that are expected to be faced in 2024."
- Projected by a financial accounting firm, IHS Global Inc. (IGI).
- 2024 update based on 2018 market basket.

| | Proposed Rule | Final Rule |
|---|---|---|
| Market Basket Update | 3.0 | 3.3 |
| *Data Source* | 2022 Q3 | 2023 Q1 |
| Productivity Adj. | -0.2 | -0.2 |
| Net Increase | 2.8 | 3.1 |

- Lower rates apply to hospitals that did NOT submit quality data and/or are NOT meaningful EHR users.

# Market Basket Update (cont.)

- "[U]pward price pressures are expected to slow in FY 2024 relative to FY 2022 and FY 2023."

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| Market Basket Update | 2.7 | 4.1 | 3.3 |
| *Data Source* | 2021 Q1 | 2022 Q1 | 2023 Q1 |
| Productivity Adj. | -0.7 | -0.3 | 0.2 |
| Net Increase | 2.0 | 3.8 | 3.1 |
| Percent change | | +90% | -18% |

# Measuring Changes in Labor Costs

- Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI)
  - Used to project growth in hospital compensation costs
  - **Does not** capture contract labor
- **Alternative 1**: BLS Employer Cost for Employee Compensation (ECEC)
  - **Does** capture contract labor
  - Commenters: ECEC > ECI
  - CMS: ECEC not appropriate for market basket because it captures changes in employment
- **Alternative 2**: Medicare Cost Report data
  - Commenters: Cost report data can measure changes in Medicare costs (Worksheet D-1) per discharge (S-3, Part I, Col. 13)
  - CMS: Case mix would distort cost report data

# How Material is Contract Labor?

- CMS: Changes in contract labor costs have little impact on hospital price pressures.
  - Per 2021 S-3 data, contract labor accounts for 4% of compensation hours.
  - ECI is appropriate because employed workers account for 96% of hospital compensation hours.
- But do hours alone reflect the materiality of contract labor costs?
  - Contract labor accounts for 9% of total labor costs (per 2021 S-3 data).

# Worksheet S-10

# Worksheet S-10

## New Part II

- Transmittal 18 has split Worksheet S-10 into two parts.
- Part I – The existing Worksheet S-10
  - Uncompensated care for the entire hospital complex, including all subunits
- Part II – The new Worksheet S-10
  - Subset of Part I data
  - Uncompensated care for inpatient and outpatient services billed under the hospital's CMS certification number.
  - Excludes data from psych, SNF, HHA, etc.
- Part II is informational (for now)
  - CMS to consider using Part II to determine Factor 3 in future years

# Worksheet S-10 (cont.)

## New Part II

- Provider Relief Fund (PRF) payments
  - Hospitals cannot report charges for uninsured COVID-19 patients if they received PRF for those patients.
- Insured patients with exhausted coverage
  - Reported as uninsured charity in Column 1 (subject to CCR)
- Inferred contractual relationship
  - If partial payment from a non-contracted insurer as accepted in full, cannot report the balance on S-10.

# Medicare Uncompensated Care Payment

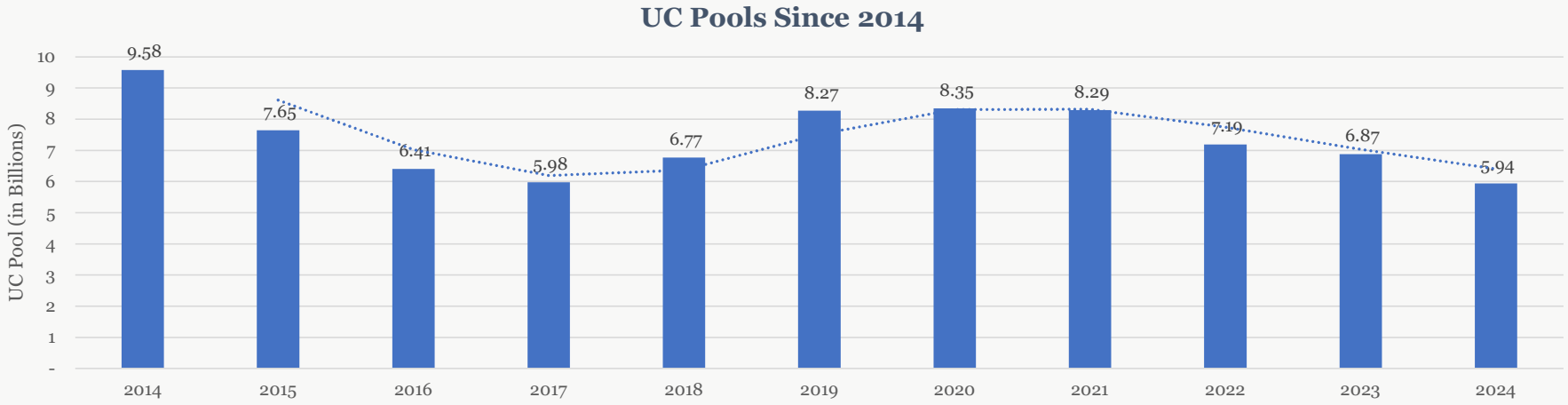
# FY 2024 Uncompensated Care Payment

- **Factor 1**: FY 2024 projected DSH payments before ACA changes x 75%
- **Factor 2**: [1 minus estimated % change in uninsured from FY 2013 – FY 2024]
- **UC Pool**: Factor 1 x Factor 2
- **Factor 3**: Each hospital's UC costs (per S-10)

| | Proposed Rule | Final Rule |
|---|---|---|
| Factor 1 | $10.216 b | $10.015 |
| Factor 2 | 1 – 0.3429 | 1 – 0.4071 |
| | 0.6571 | 0.5929 |
| UC Pool | $6.712 b | $5.938 b |

# The Pie Continues to Shrink

- The FY 2024 UC Pool is the smallest ever.
  - Continues downward trend started in FY 2021
- Average UC Pool from 2014 – 2023: $7.5353 billion
  - $1.6 billion higher than FY 2024 UC Pool



# Uninsured Rate

- **Commenters**: number of uninsured should increase dramatically in FY 2024
  - Expiration of continuous coverage requirements (Families First Coronavirus Response Act)
  - Between 3 and 18 million individuals will lose Medicaid coverage in FY 2024.
- **CMS**:
  - Most of the 18 million who will lose Medicaid coverage have other insurance.
  - Unemployment is stagnant.
  - Expanded eligibility and subsidies for marketplace coverage
  - Continued growth of Medicare enrollment

# Medicare DSH

# Medicare DSH Topics

**Medicare Fraction**

$$\frac{\text{Days Entitled to both Part A and SSI}}{\text{Days Entitled to Part A}}$$

**Medicaid Fraction**

$$\frac{\text{Days Eligible for Medicaid and not Entitled to Part A}}{\text{All Patient Days}}$$

- Who is entitled to Part A?
  - Exhausted and MSP days
  - Part C Days
- Who is entitled to SSI?
  - Unpaid days
  - Matching errors

# Who is Entitled to Part A?

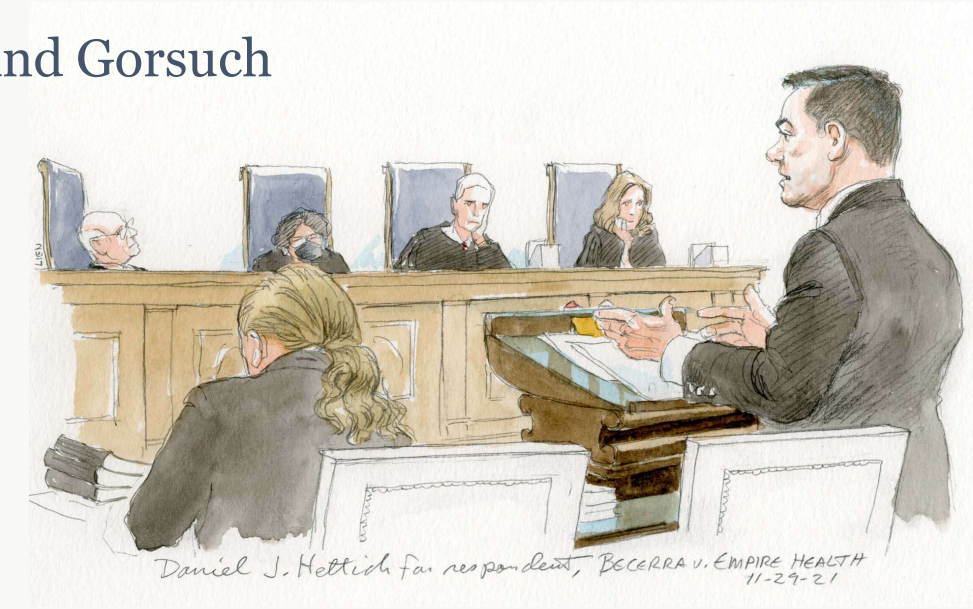
*Empire v. Becerra*

- Are patients entitled to Part A benefits on days that their Part A benefits are exhausted?
- **Hospitals**: No. Entitlement requires payment.
- **CMS**: All Part A beneficiaries are entitled to Part A. Whether Medicare pays on a given day is irrelevant.
- **Circuit Split**: Ninth Circuit sided with hospitals. DC and Sixth Circuits sided with CMS.

# Who is Entitled to Part A?

*Empire v. Becerra*

- Supreme Court sided with CMS.
  - 5-4 decision.
  - Majority: Kagan, Thomas, Breyer, Sotomayor, and Barrett
  - Dissent: Kavanaugh, Roberts, Alito, and Gorsuch
- Holding
  - Entitled is synonymous with eligible
- Implications
  - Decision upheld the status quo
  - No change in hospital payment



# Who is Entitled to Part A?

*Allina*

- Are patients enrolled in Part C entitled to Part A?
  - Over a decade of litigation on this question
- *Allina I* (2014)– Invalidated on procedural grounds CMS's 2004 rulemaking in which it first announced that Part C days would be regarded as entitled to Part A
- FY 2014 – CMS issues new rule correcting procedural error for FY 2014 onward
- *Allina II* (2019)– Rejected CMS's attempt to apply Part C prior to FY 2014 (in the advance of a valid rulemaking)

# Who is Entitled to Part A?

*Allina*

- August 6, 2020 - CMS proposed retroactive rule applying its Part C policy to FYs 2004 – 2013.
- June 9, 2023 – CMS finalized proposal.
- Next steps: litigation over whether CMS has authority to use retroactive rulemaking
- CMS:
  - Cannot calculate DSH payments without retroactive rulemaking
  - Because there was no Part C policy prior to 2013
  - *Empire* has held that our interpretation of the statute reflects its clear meaning

# Who is Entitled to SSI?

## Effect of *Empire* on SSI

- *Empire* court interpreted "entitled to Part A" broadly
  - Entitled = eligible
  - Payment not required
- CMS interprets "entitled to SSI" narrowly
  - Entitled to SSI = received SSI payments
- Considering *Empire*, should payment be required for SSI entitlement?
- Question is now pending before D.C. Circuit in *Advocate Christ*
  - Oral argument held April 14, 2023

# Who is Entitled to SSI?

*Pomona Valley Hospital v. Azar*

- Is CMS miscounting SSI paid days even under its own policy?
- Hospital alleges that CMS understated its Medicare fraction by 20-25%.
  - Reconstructed its Medicare fraction using SSI "aide codes" from California Medicaid
- PRRB Hearing
  - The MAC did not present evidence to counter hospital's calculation.
  - Board upheld CMS's calculation anyway
- Board decision focused on potential flaws in hospital's calculation
  - Aide codes capture patient days that are not counted in Medicare fraction.
  - Differences in eligibility timing might explain discrepancies.

# Who is Entitled to SSI?

*Pomona Valley Hospital v. Azar*

- Hospital appealed to D.C. District Court.
- District Court holding:
  - It was insufficient for the PRRB to simply "poke holes in what the plaintiff had provided."
  - Should have "examined the accuracy of what CMS did."
  - Remanded the case back to the PRRB to solicit evidence from CMS responsive to the evidence presented by the hospital.
- CMS appealed to D.C. Circuit.
  - Oral argument held September 6, 2022.
  - Judges were generally hostile to the government's position.

# 340B Cuts

# 340B Rate Cuts

- Statute gives CMS two ways to calculate payment rates for 340B drugs.
  - Average hospital acquisition cost based on survey data, or
  - If no survey is available, average sales price "as calculated and adjusted by the Secretary as necessary for purposes of this [provision]…."
- Before 2018
  - CMS used option 2 to calculate Medicare payments for 340B drugs.
  - Adjusted the rate to average sales price (ASP) plus 6 percent.
- CY 2018 OPPS final rule
  - Reduced Medicare payment for 340B drug to ASP minus 22.5 percent.
  - Applies a positive budget-neutrality adjustment for non-drug items and services

# *American Hospital Association v. Becerra*

- Hospitals challenged CMS's new payment methodology in federal court
- Plaintiffs assailed CMS for effectively creating a third, extra-statutory methodology for calculating 340B payment rates.
- Supreme Court: CMS's rate cut violates the Medicare statute.
- CMS acquiesced in CY 2023 OPPS final rule
  - Back to ASP + 6%

# Proposed Rule on Remedies for 2018 - 2022

- Issued July 11, 2023
  - Comment deadline: September 5, 2023
- CMS proposes to make lump sum payments to affected hospitals
  - Calculate what hospital would have received at ASP + 6%
  - Deduct what hospital was paid at ASP – 22.5%
  - Pay difference to hospital
- CMS estimates hospitals will receive $10.5 billon
  - $1.5 billion already paid in reprocessed claims for 2022

# Proposed Rule on Remedies for 2018 – 2022 (cont.)

- CMS proposes to apply a negative budget-neutrality adjustment on a prospective basis
  - To recoup the additional funds paid in 2018 – 2022 due to the positive budget-neutrality adjustment for non-drug items and services
- Estimated prospective adjustment: $7.8 billion
- CMS would reduce payments for non-drug items and services by 0.5% annually starting in CY 2025
  - Exception for "new" hospitals
  - Estimated recovery period of 16 years

# Wage Index

# New Rural Wage Index Calculation

- In FY 2024, CMS changed how the rural wage index is calculated
- The wage data of urban hospitals that have reclassified as rural is now treated the same as the wage data of geographically rural hospitals
- Rural reclassification statute
  - "For purposes of this subsection…[CMS] shall treat [a reclassified rural hospital] as being located in the rural area…of the State in which the hospital is located."
- "[T]his subsection" = subsection (d) = IPPS
- Agency has historically interpreted narrowly

# New Rural Wage Index Calculation (cont.)

- *Geisinger Community Medical Center v. Secretary*
  - "Congress must have intended that [rural reclassification] apply comprehensively over subsection (d)…because the language '[f]or purposes of this subsection' would not have any purpose or meaning if it did not"
- *Lawrence Memorial Hospital v. Burwell*
  - "By using the broad language 'for purposes of this subsection,' Congress mandated that specified hospitals be treated as rural for the purposes of the entire section"
- *Bates County Memorial Hospital v. Azar*
  - "Congress enacted a general command to treat [reclassified rural hospitals] as rural for purposes of Subsection (d)"
- FY 2024 Final Rule
  - "[T]he best reading of section 1886(d)(8)(E)'s text … is that it instructs CMS to treat [reclassified rural] hospitals the same as geographically rural hospitals for the wage index calculation."

# New Rural Wage Index Calculation (cont.)

- Rural wage index is calculated based on the highest AHW resulting from one of three calculations
- New methodology revises those calculations
- Wage data of reclassified rural hospitals now treated the same as geographically rural hospitals

| | Old Methodology | New Methodology |
|---|---|---|
| Calculation 1 | Geo rural | Geo rural plus reclassed rural |
| Calculation 2 | Geo rural less Geo rural w/ MGCRB | Geo rural plus reclassed rural less geo and reclassed rural w/ MGCRB |
| Calculation 3 | Geo rural plus reclassed rural w/o MGCRB plus out-of-state hospitals | Geo rural plus reclassed rural plus out-of-state hospitals |

# Impact of the New Rural Wage Index Calculation

- Increased the rural wage index of nearly every state
- Increased the rural floor budget neutrality adjustment (RFBNA) by 54%
  - 1.42% ➔ 2.18%
- Increased the 25th percentile wage index, thereby increasing the quartile adjustments nationwide
  - 0.854 ➔ 0.8667

# Impact on Rural Louisiana

| | Old Methodology | New Methodology |
|---|---|---|
| Calculation 1 | 34.54 | 38.9 |
| Calculation 2 | 34.15 | 34.23 |
| Calculation 3 | 34.56 | 38.9 |
| Highest AHW | 34.56 | 38.9 |
| National AHW | 50.34 | 50.34 |
| WI before RFNBA | 0.6865 | 0.7727 |
| RFBNA | 0.985838 | 0.978183 |
| WI after RFBNA | 0.6768 | 0.7558 |
| 25th Percentile | 0.8654 | 0.8667 |
| Quartile Adj. | (0.8654 - 0.6768) / 2 = 0.1772 | (0.8667 – 0.7558) / 2 = 0.0555 |
| **WI after Quartile** | **0.7654** | **0.8113** |

# Impact on Urban Louisiana

## After rural floor and RFBNA, but before quartile adjustments

| CBSA | Old Methodology | New Methodology | Percent change |
|---|---|---|---|
| Alexandria | 0.8793 | 0.8724 | -0.78% |
| Baton Rouge | 0.8123 | 0.8060 | -0.78% |
| Hammond | 0.7597 | 0.7558 | -0.51% |
| Houma-Thibodaux | 0.6855 | 0.7558 | +10.26% |
| Lafayette | 0.7492 | 0.7558 | +0.88% |
| Lake Charles | 0.7927 | 0.7866 | -0.77% |
| Monroe | 0.7577 | 0.7588 | -0.25% |
| New Orleans | 0.8179 | 0.8115 | -0.78% |
| Shreveport | 0.7907 | 0.7846 | -0.77% |

# Impact on Urban Louisiana

## After rural floor, RFBNA and quartile adjustments

| CBSA | Old Methodology | New Methodology | Percent change |
|---|---|---|---|
| Alexandria | 0.8793 | 0.8724 | -0.78% |
| Baton Rouge | 0.8332 | 0.8364 | +0.38% |
| Hammond | 0.8069 | 0.8113 | +0.55% |
| Houma-Thibodaux | 0.7698 | 0.8113 | +5.39% |
| Lafayette | 0.8016 | 0.8113 | +1.20% |
| Lake Charles | 0.8234 | 0.8267 | +0.40% |
| Monroe | 0.8059 | 0.8113 | +0.67% |
| New Orleans | 0.8360 | 0.8391 | +0.38% |
| Shreveport | 0.8224 | 0.8257 | +0.40% |

# Low Wage Index Hospital Policy

## A.K.A. Quartile Adjustments

- Adjustment for hospitals with wage index values below 25th percentile
- Equal to half the difference between the hospital's otherwise final wage index and the 25th percentile wage index.
- Example:
  - 25th percentile: 0.84
  - Hospital's otherwise final wage index: 0.74
  - Adjustment: (0.84 – 0.74) ÷ 2 = 0.05
  - Hospital's quartile-adjusted wage index: 0.79

# Low Wage Index Hospital Policy (cont.)

A.K.A. Quartile Adjustments

- Budget neutralized by adjustment to standardized amount
  - -0.26% in FY 2024
- Stated policy objective: to give low wage index hospitals additional funding to increase their wage index values
- Initially announced as a temporary policy for FYs 2020 through 2023
- Extended for fifth year in FY 2024
  - Agency says it needs data from "additional fiscal years" before making a decision to modify or discontinue the policy.

# Impact of Quartile Adjustments on Louisiana

| CBSA | Before | After | Percent change |
|---|---|---|---|
| Rural Louisiana | 0.7558 | 0.8113 | 7.3% |
| Alexandria | 0.8724 | 0.8724 | 0% |
| Baton Rouge | 0.8060 | 0.8364 | 3.8% |
| Hammond | 0.7558 | 0.8113 | 7.3% |
| Houma-Thibodaux | 0.7558 | 0.8113 | 7.3% |
| Lafayette | 0.7558 | 0.8113 | 7.3% |
| Lake Charles | 0.7866 | 0.8267 | 5.1% |
| Monroe | 0.7558 | 0.8113 | 7.3% |
| New Orleans | 0.8115 | 0.8391 | 3.4% |
| Shreveport | 0.7846 | 0.8257 | 5.2% |

# *Bridgeport Hospital v. Becerra*

- Hospitals above the 25th percentile challenged CMS's authority to adopt the quartile adjustments
- **Plaintiffs**: Statue says wage index must reflect wage levels relative to national average
- **CMS**: Statute is ambiguous
- **Court**: Sided with plaintiffs
  - Policy violates the statute because the benefiting hospitals are paid at a wage index that does not reflect their wage levels
  - The statute "does not leave room for [CMS] to adjust wage index values based on policy considerations."
- CMS has appealed *Bridgeport* and is continuing the policy pending that appeal

# Capital DSH

# Capital DSH

- Adjustment under the capital PPS
- Covers additional capital costs of treating low-income patients
- Eligibility
  - 100 or more beds
  - Located in urban area
  - Qualifies for IPPS DSH
- Until recently, urban hospitals that had reclassified as rural were categorically disqualified
  - Deemed rural for purposes of eligibility

# Capital DSH (cont.)

- *Toledo Hospital v. Azar*
  - Struck down regulation categorically disqualifying reclassified rural hospitals from receiving capital DSH payments
  - Court faulted CMS for failing to explain why the capital costs of a hospital that has reclassified as rural are lower than one that has not
- CMS acquiesced to *Toledo* in the FY 2024 rule
  - Prospective basis only
  - CMS expressly declined to apply retroactively

# Graduate Medical Education

# The Fellow Penalty

- Since 1997, there has been an anomaly in CMS's formula for calculating direct graduate medical education (DGME) payments.
- The formula:

$$\text{Weighted FTEs (uncapped)} \times \frac{\text{FTE cap}}{\text{Unweighted FTEs}} = \text{Reimbursable FTEs}$$

- The anomaly

Hospital training over its FTE cap
+ Some of its residents are fellows
Hospital is penalized (the fellow penalty)

# The Anomaly in Action

| | Cap | Initial Resident FTEs | Fellows | Unweighted FTEs | Weighted FTEs before cap | Weighted FTEs after cap |
|---|---|---|---|---|---|---|
| Year 1 | 100 | 120 | 0 | 120 | 120 | 100 |
| Year 2 | 100 | 120 | 30 | 150 | 135 | 90 |

$$\underset{\text{Weighted FTEs before cap}}{135} \times \frac{100 \text{ FTE Cap}}{150 \text{ Unweighted FTEs}} = \underset{\text{Weighted FTEs after cap}}{90}$$

# *Milton S. Hershey Medical Center v. Becerra*

- Hospitals filed suit challenging the fellow penalty.
  - K&S represented 32 of the hospitals in this case.
- Plaintiffs: CMS's formula violates the statutory weighting factors by weighing fellows at less than 0.5.
- CMS: The statute does not foreclose the fellow penalty.
- Court: Sided with plaintiffs and struck down the rule.

# Aftermath of *Hershey*

- CMS acquiesced to *Hershey* in the final rule.
- Under CMS's new payment formula, hospitals can claim the lesser of (1) their FTE cap, or (2) their weighted FTE count.
  - Effectively removes any penalty for training fellows.

| | Cap | Initial Resident FTEs | Fellows | Unweighted FTEs | Weighted FTEs before cap | Weighted FTEs after cap |
|---|---|---|---|---|---|---|
| Year 1 | 100 | 120 | 0 | 120 | 120 | 100 |
| Year 2 | 100 | 120 | 30 | 150 | 135 | 90 |

# Aftermath of *Hershey* (cont.)

- Retroactivity?
  - Appealed and open years only
  - No reopenings
- How to claim payment under new DGME formula:
  - CRs beginning on or after 10.1.22 ➔ automatically entitled to payment under new formula.
  - CRs beginning before 10.1.22 ➔ Must request permission from MAC to receive payment based on new formula.
- Some MACs granting permission. Others withholding.
- Note on prior and penult. FTEs ☐ Must be updated manually!

# COVID-19 Beds

- Many hospitals added beds during the pandemic to accommodate influx of COVID-19 patients
- CMS adopted an emergency rule allowing hospitals to exclude COVID beds from the cost report
- Transmittal 18 added a line to the cost report to enter beds to be excluded from IME calculations
- COVID-19 beds should be readily identifiable (for audit)
- What if COVID-19 beds were used for other purposes?

# Nursing and Allied Health

# NAH on the Chopping Block

- MACs are disallowing NAH programs at an alarming rate
  - Based on findings that hospitals do not meet provider-operated criteria
- Common fact patterns:
  - Offsite rotations (hospital does not employ offsite preceptors)
  - W-2s issued by health system instead of provider
  - Independent school board (often required by accreditation standards)
  - Affiliation agreement appears to give some control to an educational institution

# Written Record > Reality

- Who controls the program?
  - The PRRB and Courts will give great weight to governing documents (bylaws, affiliation agreements, etc.).
  - Even if they do not reflect which party actually exercises control over the program.
- *Stormont-Vail* Case
  - Affiliation agreement – University "shall supervise and administer, through the School of Nursing, student services such as admissions, student records and financial accounts for all students."
  - At PRRB hearing, the provider presented witnesses who testified that the affiliation agreement does not reflect the reality of the situation.
  - PRRB – Affiliation agreement demonstrates that the university controls the program. "[T]here is inadequate physical documentation in the record to support and corroborate the testimony."
- DC Circuit had previously held that an affiliation agreement constituted per se "substantial evidence" in support of an agency disallowance. *Community Care Foundation v. Thomas*

# *Medical University Hospital Authority v. HHS*

- Concerned reimbursement for the pharmacy program of the Medical University Hospital Authority (MUHA)
  - Largest teaching hospital in South Carolina
- MAC and the PRRB found that MUHA did not operate the program
- Board found that MUHA did not directly incur all the costs of the program
  - Some costs were initially incurred by the parent, Medical University of South Carolina (MUSC)
  - Did not matter that the Hospital reimbursed the University for those costs
- Board found that affiliation agreement appeared to give the University final say over administration and curriculum
  - The Hospital retained complete control over its program in practice

# *Medical University Hospital Authority v. HHS*

- Federal court reversed PRRB
- Court ruled that MUHA was the legal operator of its program
- Court found PRRB construed "directly incurred" too narrowly
  - It was not necessary for MUHA to incur the costs of its program in the first instance.
  - It is sufficient that MUHA reimburses MUSC for those costs.
- Court also found PRRB erred in holding hospital does not control the program.
  - Hospital's day-to-day control of the program satisfies the administrative control prong of the regulation.
  - "[T]he Board's decision grossly underestimates MUHA's entitlement to reimbursement and results in the shifting of costs to non-Medicare patients."

# NAH Managed Care Payments

$$\text{NAH Managed Care Payment} = \frac{\frac{\text{NAH Part A payments}}{\text{Total Patient Days}} \times \text{Part C Days}}{\frac{\text{NAH Part A payments}}{\text{Total Patient Days}} \times \text{Part C Days}} \times \text{NAH Payment Pool (capped at \$60 m)}$$

The hospital's data

All hospitals' data

- Change Request 11642 (issued Dec. 14, 2020)
  - Directed MACs to revisit NAH Managed care payments from 2002 – 2018.
  - Updated "all hospitals' data" in the denominator of the ratio
  - Invariably resulted in lower payments/recoupments.

# Consolidated Appropriations Act of 2023

## Section 4143

- Directed CMS to recalculate the NAH Managed Care payment pools for 2010 through 2019.
  - Without application of the $60 million cap.
- CMS must recalculate payments for hospitals using updated payment pools.
  - Subject to reopening rules.
- But only for hospitals that were operating NAH programs as of the date of enactment (Dec. 29, 2022).
- Implemented in Change Request 13122
  - MACs to reopen settled cost reports and apply updated payments by December 29, 2023

# 2024 Final Rule

- MACs to make supplemental payments to make hospitals whole for recoupments made under Change Request 11642.
- If the recalculated NAH managed care payment amount under CR 13122 is less than the amount that was recouped, MACs would pay the difference.
- “[T]he amounts previously recouped under CR 11642…will be returned to hospitals, and recoupments that would have occurred under CR 11642…if not for the enactment of Section 4143 of the CAA 2023 will not occur.”

# Changes to CAH Distance Rules

# CAH Distance Rules

- CAHs generally must be a certain driving distance from other hospitals to qualify for CAH status
  - Default rule: 35 miles
  - Exception: In the case of mountainous terrain or in areas with only secondary roads available, a CAH must be more than 15 miles from the nearest hospital
- Exception for "necessary providers."
- Periodic recertification for CAHs.
  - Currently on hold because of COVID.

# Secondary Roads

- Secondary road: any road that is not a "primary road."
- Evolving definition of primary road:
  - 2007 – Numbered federal highways & numbered state highways w/ more than 2 lanes.
  - 2015 – Replaced reference to numbered federal highways with any US highway in the National Highway System.
- 2015 definition expanded the universe of primary roads.
  - Numbered highway system is primarily interstates.
  - National highway system is broader. It encompasses all roads that are important to the national economy, defense and mobility.
- Created an existential crisis for many existing CAHs.

# 2022 Rule Change

- CMS reverted back to the pre-2015 definition of primary road.
  - Replaced reference to U.S. Highways in the National Highway system to numbered federal highways.
- CMS also changed the 35-mile criterion
  - CMS modified the regulation to specify that the route must be entirely on primary roads.

# Implications

- Change to definition of primary road
  - Should make it easier for new CAHs to become CAHs.
  - Should allow most existing CAHs to remain CAHs (though CMS says it will only save 3-4 CAHs)
- Change to 35-mile criterion
  - This change will make it harder for hospitals to become CAHs.
  - This change may also jeopardize the status of many existing CAHs.

# Rural Emergency Hospitals

# Rural Emergency Hospitals

- What is a Rural Emergency Hospital (REH)?
  - Rural hospital that provides emergency department and other outpatient services.
  - Cannot provide inpatient services
- REHs receive enhanced Medicare payments
  - Payment policies set forth in OPPS proposed rule
- Subject to enrollment and conditions of participation
- Enrollment opened on January 1, 2023

# Rural Emergency Hospitals

## Legislative purpose

- Currently, a hospital must offer inpatient hospital services to enroll in Medicare
- Offering inpatient hospital services is not always viable for rural hospitals
  - Research links rural hospital closures to low inpatient volume
- Rural hospital closures are depriving rural areas of emergency room services
  - High rate of trauma deaths in rural areas
  - Likely attributable to distance to nearest emergency room
- Solution: permit rural hospitals to enroll in Medicare without offering inpatient hospital services
  - So rural hospitals can provide emergency medical services without having to maintain inpatient beds

# Rural Emergency Hospitals

## Payments for REH services

- Enhanced OPPS payments
  - 105% of OPPS rate for covered outpatient services
- CMS proposes to use the OPPS claims processing system to process REH payments
  - Agency will update the system to include an REH-specific payment flag, which will trigger the 5% rate increase
  - Additional 5% will be determined as if copayment had not occurred (required by statute)
- REH payments are not covered OPD services
  - No impact on OPPS budget neutrality
  - Not to be used for OPPS rate setting purposes

# Rural Emergency Hospitals

## Monthly facility payment

- Statute requires CMS to calculate a monthly facility payment for REHs
- Calculated as follows:
  - Total payment to CAHs in 2019
  - Less estimated total payment to CAHs in 2019 had they been paid under PPS
  - Divided by total number of CAHs in 2019
  - Divided by 12 (months)

# Rural Emergency Hospitals

## Monthly facility payment (cont.)

- Monthly facility payment

| | Step | Value |
|---|---|---|
| A | Total payment to CAHs in 2019 | $12.08 billion |
| B | Total projected amount of Medicare spending for CAHs if paid prospectively in CY 2019 | $7.68 billion |
| C | Difference (A – B) | $4.4 billion |
| D | Number of CAHs in 2019 | 1,368 |
| E | Monthly payment (C ÷ D) ÷ 12 | $268,294 |

- To be updated annually by hospital market basket increase

# Questions?

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