# THE "RURBAN" STRATEGY:

May 23, 2017

## Two-Step Medicare Reclassifications

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# Speakers

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# Overview

- Two methods for a hospital to virtually reclassify
  - MGCRB wage index reclassification – established 1990
  - Urban to rural a/k/a 412.103 reclassification – established 2000
- Previously, the MGCRB regulations prohibited hospitals with 412.103 rural status from also being reclassified by the MGCRB
- As a result of losing 2 federal appeals cases, CMS removed the prohibition on dual reclassifications
- Creates new opportunities for some urban hospitals
- Hospitals looking at RRC method with June 30 FYE need to start looking at options now because of last quarter rule



# Agenda/Content

- Overview of MGCRB Wage Index Reclassification
- Overview of Urban to Rural Reclassification
- Multiple Reclassifications
  - Prior prohibition
  - Court challenges
  - Policy changes
    - 2016 Interim Final Rule
    - FFY 2018 IPPS Proposed Rule
- 2-step reclass – "Rurban" Strategy
  - New opportunities for urban hospitals
  - Considerations
  - Case studies




# Background

- CMS designates areas as urban or rural for a variety of purposes
- For hospital PPS purposes, CMS has adopted Metropolitan and Micropolitan Statistical Areas as defined by the Office of Management and Budget (OMB)
- Collectively, Metropolitan and Micropolitan Statistical Areas called Core-Based Statistical Areas or CBSAs
- A Metropolitan Statistical Area (MSA) is a CBSA associated with at least one urbanized area that has a population of 50,000+ that comprises the central county or counties containing the core, plus adjacent outlying counties that have a high degree of social and economic integration



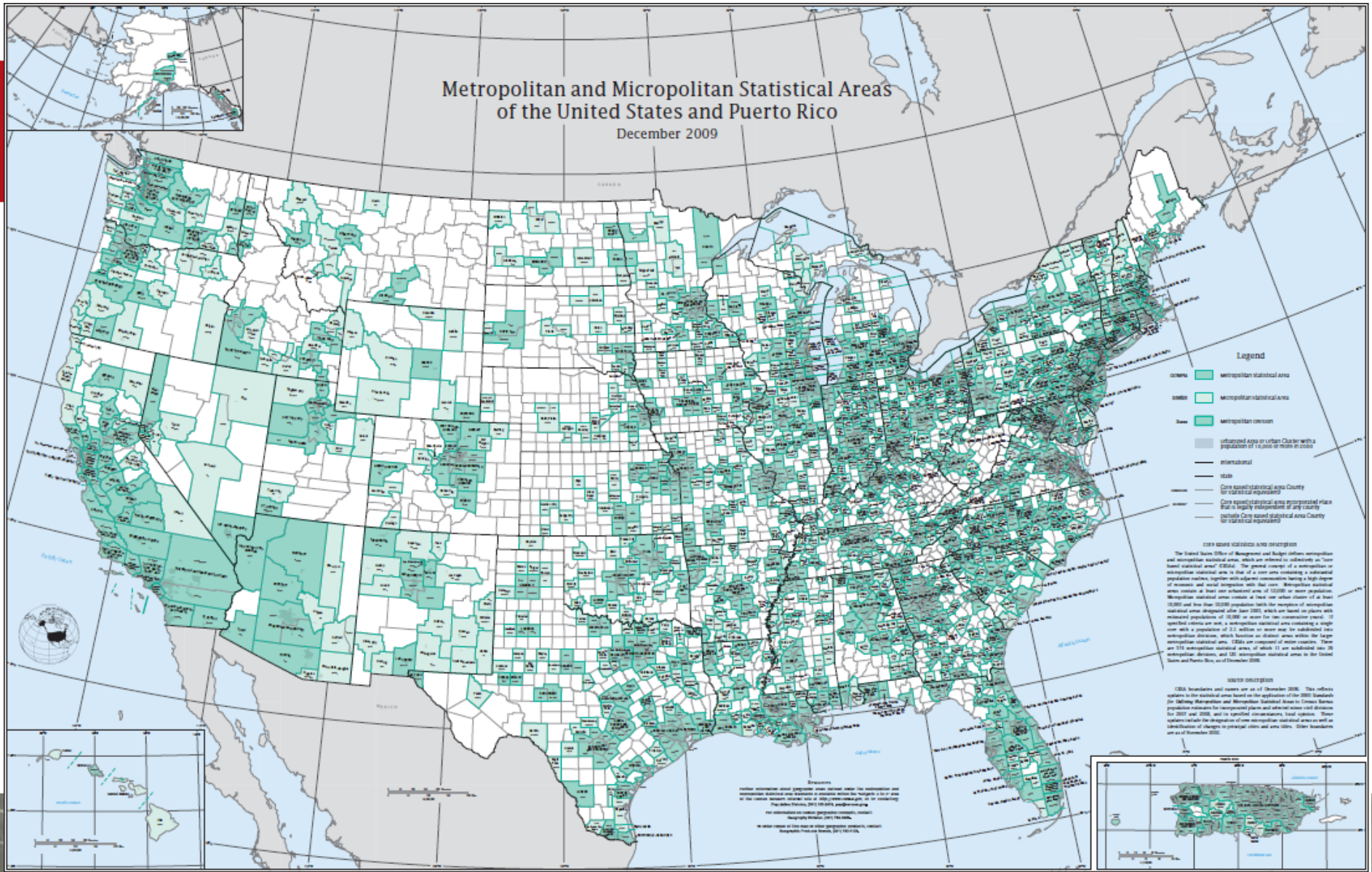
# Background

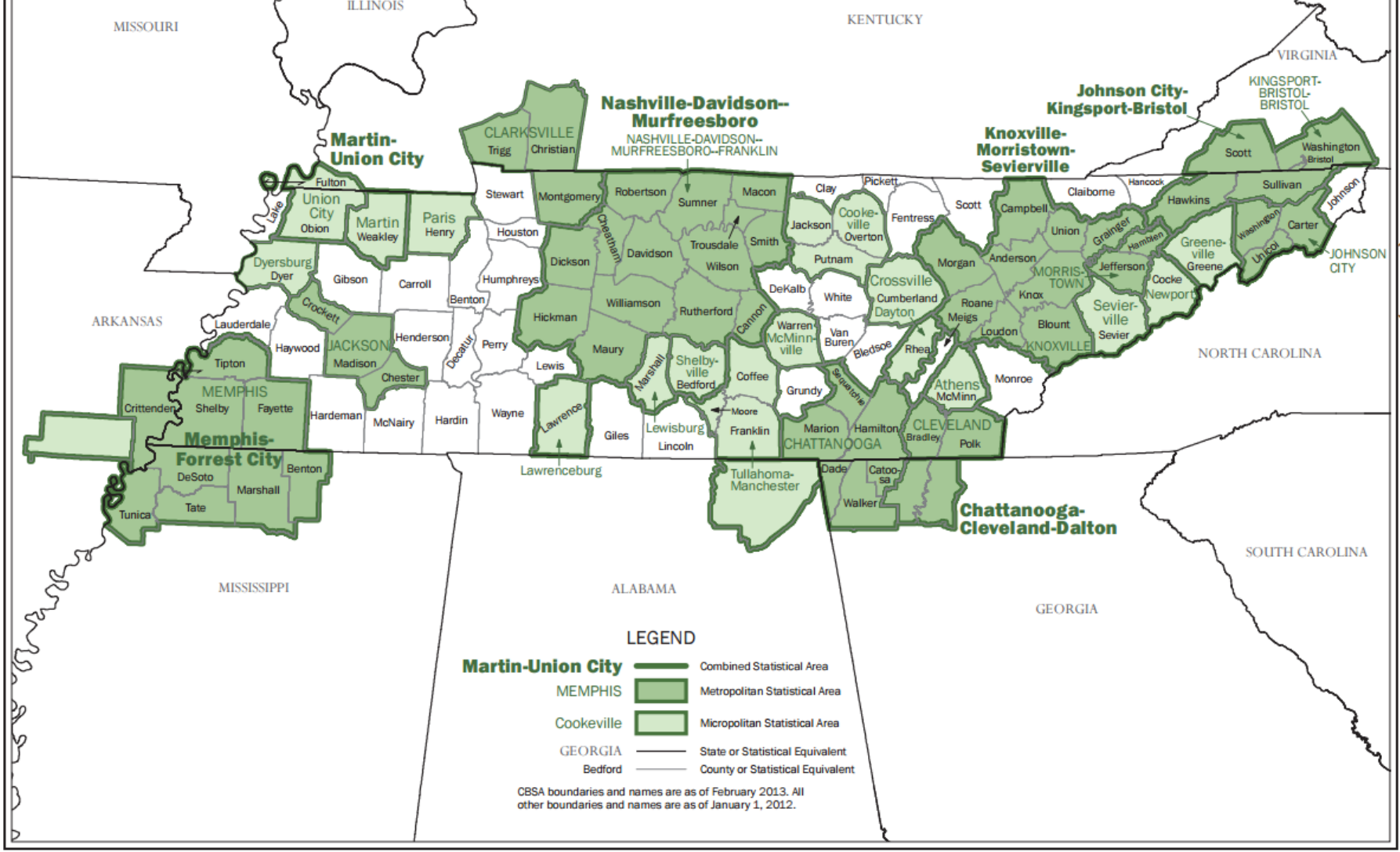
- An "urban area" is defined as an area within an MSA or a metropolitan division
- 11 largest MSAs divided into metropolitan divisions
- A "rural area" is defined as any area outside an urban area
- Urban/rural status typically adjusted and redefined every 10 years, based on the national census
- Approximately 460 different urban and rural areas for IPPS/OPPS
- CMS releases updated wage indices for areas each year as part of the IPPS rulemaking process



# Metropolitan and Micropolitan Statistical Areas of the United States and Puerto Rico

December 2009

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Johnson City-Kingsport-Bristol
Nashville-Davidson--Murfreesboro
NASHVILLE-DAVIDSON--MURFREESBORO--FRANKLIN
Knoxville-Morristown-Sevierville
Martin-Union City
CLARKSVILLE
Trigg
Christian
Fulton
Lake
Union City
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Weakley
Paris
Henry
Stewart
Houston
Humphreys
Carroll
Gibson
Dyersburg
Dyer
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Benton
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Tipton
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JACKSON
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Decatur
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Lewis
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McNairy
Hardeman
MEMPHIS
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DeSoto
Marshall
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Robertson
Sumner
Macon
Clay
Pickett
Jackson
Cookeville
Overton
Fentress
Putnam
Dickson
Cheatham
Davidson
Trousdale
Smith
Wilson
DeKalb
White
Crossville
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Dayton
Williamson
Rutherford
Cannon
Hickman
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Warren
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Jefferson
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Washington
Bristol
Carter
Unicoi
Johnson
JOHNSON CITY
Lawrenceburg
Tullahoma-Manchester
Dade
Catoosa
Walker
Chattanooga-Cleveland-Dalton
ARKANSAS
MISSISSIPPI
ALABAMA
GEORGIA
SOUTH CAROLINA
NORTH CAROLINA
LEGEND
Martin-Union City
Combined Statistical Area
MEMPHIS
Metropolitan Statistical Area
Cookeville
Micropolitan Statistical Area
GEORGIA
State or Statistical Equivalent
Bedford
County or Statistical Equivalent
CBSA boundaries and names are as of February 2013. All other boundaries and names are as of January 1, 2012.

# Background

- The Medicare program also has an in-between status called "Lugar status"
- These "Lugar counties" would otherwise be rural based on OMB labor market area delineations
- Because of their proximity and commuting patterns to one or more MSAs, they are treated as being a part of the MSA to which the greatest number of workers in that county commute
- Hospitals in these counties are referred to as "Lugar hospitals"



# MGCRB Reclassification

- Hospitals can apply to the Medicare Geographic Classification Review Board (MGCRB) to receive the wage index of a nearby urban or rural area
- Reclassification available on individual, county-wide group or state-wide basis; no state-wide reclassifications have ever been approved
- Applications must be submitted on MGCRB forms and received by the MGCRB on or before the first business day in September
- The MGCRB has 180 days to approve or deny applications – end of February
- Administrative appeal rights for denied applications; no court review



# MGCRB Reclassification

- If approved, the hospital receives the wage index of the target reclassified area beginning the following October 1 for IPPS and January 1 of the following year for OPPS
- Approved reclassifications are effective for a 3-year period
- Regulations allow for withdrawals, terminations and reinstatements each year in the event the home geographic area wage index exceeds the reclassified wage index
- Rural hospitals reclassified to an urban area only treated as urban for wage index purposes; rural for all others
- Regulations for MGCRB criteria and procedures at 42 CFR 412.230 et. seq.



# MGCRB – Individual Reclass

- For individual reclassification, a hospital must meet 3 criteria
- Home area wage test
  - Applicant's 3-year average hourly wage (AHW) is at least equal to a specified threshold of the AHW of other hospitals in its home area
  - 108% for urban hospitals and 106% for rural hospitals
  - Waived for hospitals that are or have ever been classified as a rural referral center (RRC)
  - Does not apply for single hospital MSAs



# MGCRB – Individual Reclass

- Target area wage test
  - Applicant's 3-year AHW is at least equal to a specified threshold of the AHW of other hospitals in the target area
  - 84% for urban hospitals and 82% for rural hospitals
  - 82% for hospitals that are or have ever been classified as an RRC
- Proximity criteria
  - Applicant must show it is within a specified distance of the target area
  - 15 miles for urban hospitals and 35 miles for rural hospitals
  - A hospital that is currently an RRC or sole community hospital (SCH) may reclassify to the closest urban area or another rural area (if closer than any other urban area) even if greater than the 15 or 35 miles proximity criteria



# Urban to Rural Reclass

- Urban to rural a/k/a Section 401 a/k/a 412.103 reclassification
- Regulations at 412.103 allow hospitals located in urban areas to reclassify as rural if they meet certain criteria
  - Located in a rural census tract of an MSA based on the Rural-Urban Commuting Area (RUCA) codes
  - Located in an area designated by any law or regulation of the state in which it is located as a rural area, or the hospital is designated as a rural hospital by any state law or regulation
  - Would qualify as a SCH or RRC if actually located in a rural area



# Urban to Rural Reclass

- Application for 412.103 reclassification must be mailed to the CMS Regional Office
- Hospitals can apply for 412.103 reclassification at any time during the year
  - If applying for RRC status, must file during the hospital's last cost reporting quarter to be effective as of the start of the upcoming cost reporting year
- CMS has 60 days to approve or deny application



# Urban to Rural Reclass

- CMS has 60 days to approve or deny application
- Rural status effective as of the date received by the CMS RO
- Treated as rural for all “subsection (d)” purposes – i.e., IPPS purposes
- Still urban for other purposes
  - Direct GME – SSA § 1886(h)
  - Capital PPS? – SSA § 1886(g)



# Urban to Rural Reclass

- Rural status is effective unless there is a change in the circumstances under which the classification was approved or until cancelled by the hospital
- Cancellation
  - Non-RRCs: provide at least 120 days notice prior to end of cost reporting period; cancellation effective as of start of next cost-reporting period
  - RRCs: provide at least 120 days notice prior to end of FFY; cancellation effective as of start of FFY; must have rural status for at least one full 12-month cost-reporting period



# Multiple Reclassifications

- Two methods for a hospital to reclassify
  - MGCRB wage index reclassification
  - Urban to rural a/k/a 412.103 a/k/a Sec. 401 reclassification
- When CMS implemented the regulations for rural reclassification at 42 CFR 412.103, it amended the MGCRB regulations to prohibit hospitals with 412.103 rural status from also being reclassified by the MGCRB
- CMS was concerned that hospitals would use both reclassification processes to "game" the system



# Multiple Reclassifications

- Providers challenged CMS and won in 2 federal appellate court decisions
  - *Geisinger Community Medical Center v. Secretary*, United States Department of Health & Human Services (3rd Cir. 2015)
  - *Lawrence & Memorial Hospital v. Burwell* (2nd Cir. 2016)
- CMS conceded nationally in Interim Final Rule published in Fed. Reg. on April 21, 2016



# 2016 Interim Final Rule

- A hospital with a MGCRB wage index reclassification can be approved for a 412.103 reclassification and keep its MGCRB reclassification
- A hospital with 412.103 rural status can use the less stringent wage index and proximity criteria applicable to rural hospitals (106% and 82% wage tests, 35-mile proximity) for MGCRB reclassification (instead of 108% and 84% wage tests, 15-mile proximity)
- For home area wage test, compare to hospitals in area hospital actually located; not hospitals in the state rural area



# 2016 Interim Final Rule

- Can get MGCRB reclassification back to home urban area
- A hospital with dual reclassifications will be treated as urban for wage index purposes and rural for other Medicare purposes
- A Lugar hospital that receives a 412.103 reclassification will still receive the urban wage index based on its Lugar status



# FFY 2018 IPPS Proposed Rule

- CMS clarified that RRC applications must be submitted during the final quarter of the cost-reporting year
- Hospitals that are relying on RRC or SCH status for MGCRB reclassification must submit evidence of approval to the MGCRB by the first business day after January 1 (i.e., after the September 1 MGCRB application submission deadline)
- SCHs or RRCs utilizing the special access rule can apply for reclassification to their home urban area or the closest urban area outside of its geographic home



# The "Rurban" Strategy

- Allows urban hospitals to reclassify to rural and apply for MGCRB reclassification using the more flexible rural wage index reclassification rules
- Urban hospitals should carefully evaluate options to consider the impact of:
  - Timing requirements and applications
  - Impact on all inpatient and outpatient payments, not just wage index
  - Could impact other payors as well (including Medicare Advantage)
  - 340B eligibility and effective dates
  - In some cases, the strategy may necessitate short-term pain for a long-term gain…



# The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - Sole Community Hospital Status, Rural Referral Center Status, Medicare Dependent Small Rural Hospital Status
  - 340B Status
    - Ordinary method for 340B eligibility is to have a DSH adjustment of at least 11.75%
    - SCHs and RRCs may qualify if their DSH adjustment is at least 8%
    - BUT, subject to the Orphan Drug exclusion
    - Quarterly enrollment process for 340B



# The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - Medical Education Payments
    - MGCRB reclass does not impact medical education payments, but 412.103 reclass may
    - For medical education payments, 412.103 reclassification treats the hospital as rural for some purposes and urban for other
    - Rural for:
      - 30% upward adjustment to existing IME FTE cap under 413.79(c)(2)(i)
      - Can build new program IME FTE cap under 413.79(e)(3)

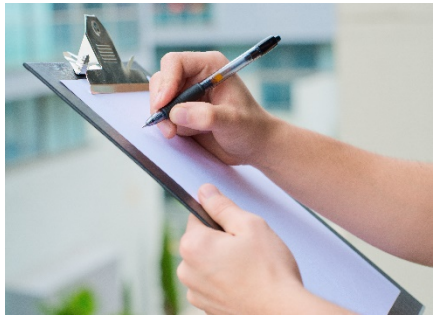
# The "Rurban" Strategy

- Medical Education Payments (cont.)
  - Urban for DGME FTE cap (i.e., no DGMTE FTE cap increase and cannot build new DGME FTE cap)
  - If hospital returns to urban status before 10 years, it loses the cap increases
  - If rural status remains for 10 years, changes may become permanent
  - Can take several years for the IME benefits to fully kick in du year rolling average and IRB ratio lookback



# The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - Operating DSH cap of 12% for certain categories of hospitals
  - Loss of capital DSH payments
  - Bundled payment programs
    - Treated as rural for Comprehensive Care for Joint Replacement and the proposed Cardiac Bundled Payment
    - Stop-loss thresholds under the programs are lower for rural hospitals, but rural hospitals have the same upside gain potential as urban hospitals





# The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - May impact other payors: Medicaid, TRICARE, commercial
  - Does not impact exempt units/facilities
    - rehabilitation
    - psychiatric



# The "Rurban" Strategy

Filing deadlines and effective dates for hospitals applying for 412.103 reclass, RRC status, MGCRB reclass and 340B based on cost-reporting year end:

| | FYE 3/31 | FYE 6/30 | FYE 9/30 | FYE 12/31 |
|---|---|---|---|---|
| 412.103 | 1/1 - 3/31/2017 | 4/1 - 6/30/2017 | 7/1 - 9/30/2017 | 10/1 - 10/31/2017 |
| RRC Filing | 1/1 - 3/31/2017 | 4/1 - 6/30/2017 | 7/1 - 9/30/2017 | 10/1 - 10/31/2017 |
| RRC Effective | 4/1/2017 | 7/1/2017 | 10/1/2017 | 1/1/2018 |
| MGCRB Filing | 9/1/2017 | 9/1/2017 | 9/1/2017 | 9/1/2017 |
| MGCRB Effective (IPPS) | 10/1/2018 | 10/1/2018 | 10/1/2018 | 10/1/2018 |
| MGCRB Effective (OPPS) | 1/1/2019 | 1/1/2019 | 1/1/2019 | 1/1/2019 |
| 340B Enrollment | 7/1 - 7/15/2017 | 10/1 - 10/15/2017 | 1/1 - 1/15/2017 | 1/1 - 1/15/2017 |
| 340B Effective | 10/1/2017 | 1/1/2018 | 3/1/2018 | 3/1/2018 |



# The "Rurban" Strategy

If the hospital is not applying for RRC status, the filing dates get much less complicated:

| | Date |
|---|---|
| MGCRB Filing | 9/1/2017 |
| 412.103 Filing and Effective | 10/31/2017 |
| MGCRB Effective (IPPS) | 10/1/2018 |
| MGCRB Effective (OPPS) | 1/1/2019 |



# Rurban Strategy Case Studies

- #1: urban teaching hospital with no existing reclass
  - § 412.103 to RRC & wage index reclass to adjacent MSA
  - Medicare lost revenue = $(650,000) over 1st 9 months
  - Medicare gain over next 27 months = $6 million
  - Acquired 340B status under lower 8% RRC threshold
    - Kicks in 7/1/2017, savings = $3-4 million/year
  - 30% increase in IME FTE Cap –
    - ~$1 million by year 3 of reclass
  - Can renew every 3 years thereafter
    - Without down stroke in 1st 9 months; ~$2.8 million/year



# Rurban Strategy Case Studies

- #2: urban hospital with no existing reclass; 12/31 FYE
  - § 412.103 to RRC & wage index reclass using special access rules to MSA 90 miles away, next closest 100+ miles away
  - Medicare lost revenue = $(6 million) over 1st 9 months
  - Medicare gain over next 27 months = $11 million
  - Can renew every 3 years thereafter
    - Without down stroke in 1st 9 months; ~$4 million/year



# Rurban Strategy Case Studies

- #3: urban SCH with existing MGCRB reclass
  - 412.103 reclassification to based on state law/regulation
  - Gets 7.1% add-on to OPPS payments for rural SCHs
  - Filed new MGCRB to another urban area within 35 miles with higher wage index
  - Paid based on HSR for operating IPPS payments
  - Benefit of MGCRB reclass is for capital IPPS & OPPS
    - ~1.4 million/year



# Rurban Strategy Case Studies

- #4: urban SCH with no existing MGCRB reclass
  - 412.103 reclassification
  - MGCRB reclassification back to home area
  - Dropped down to rural floor for about 10 months
  - Gets 7.1% add-on to OPPS payments for rural SCHs
  - No IPPS down stroke because paid under HSR



# Rurban Strategy Case Studies

- #5: urban hospital with existing MGCRB reclass
  - Applied for 412.103 reclassification to obtain SCH status
    - via 25 mile market share test (available because reclassed as rural)
    - urban hospitals can only use 35 mile test for SCH status
  - Increase IPPS payments because paid under HSR
  - Plus, gets urban wage index for OPPS via existing MGCRB reclass
  - And, 7.1% add-on to OPPS payments for rural SCHs
  - $10+ million/year



# Rurban Strategy Case Studies

- #6: urban hospital with no existing MGCRB reclass
  - Home area at state rural floor
  - higher wage index target area 33 miles away
  - Didn’t meet home aware wage test
  - Filed for 412.103 reclass/RRC status
  - Avoided home area wage tests and can use the 35 mile proximity test
  - Qualified for 340B based on lower RRC threshold



Please visit the Hall Render Blog at http://blogs.hallrender.com for more information on topics related to health care law.

For reclassification advice, contact Baker Healthcare Consulting or Hall Render: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