How Hospitals and Nursing Homes are Reimbursed for Care Provided

Kevin Krawiecki, Vice President, Fiscal Policy, HANYS

Three-part series

Today's session

1. Insurance in New York state and why it matters to hospital reimbursement.
2. How hospitals and nursing homes are reimbursed for care provided.
3. The role of supportive funding in Medicare and Medicaid reimbursement.

Major insurance types and who sets the payment rates

Payer	Who sets the payment rates
Medicaid fee-for-service	Government
Medicaid managed care (most Medicaid enrollees)	Negotiated between provider and plan (Medicaid FFS is typical starting point)
Medicare FFS	Government
Medicare Advantage (majority of Medicare enrollees)	Negotiated between provider and plan (Medicare FFS is typical starting point)
Essential Plan	Based on Medicaid (with recommended percent add-on – currently 400%)
Commercial (self insured, large group, small group, individual market)	Negotiated with payer

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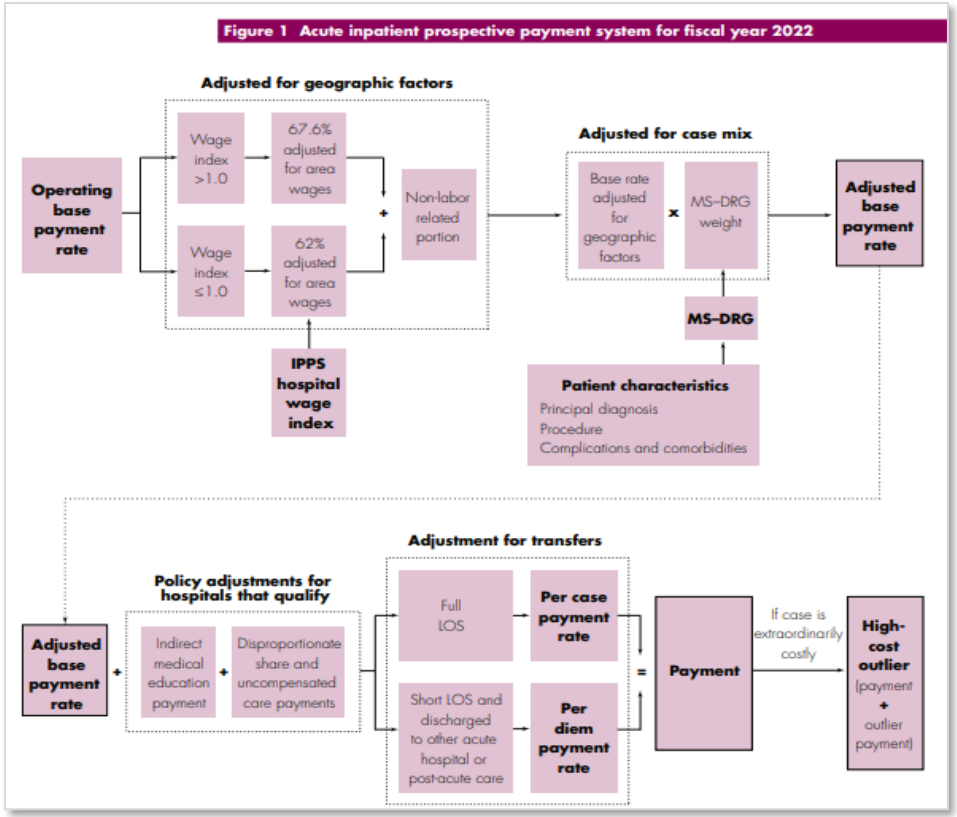
Example of how Medicare pays hospitals via its Prospective Payment Systems

(and other payers)



Source: MedPAC

Simplifying how Medicare and other payers pays for care

Wage index and other geographic and facility-level policy adjustments influence payment level for each patient served.

	Non-teaching community hospital
Federal base rate	**$6,624**
Wage index-adjusted base rate	$7,993 (AWI @ 1.3056)
Wage index, **quality, teaching and DSH**-adjusted base rate	$8,069 (average quality; non-teaching; low DSH)
Wage index, quality, teaching DSH and **patient**-adjusted base rate	**$5,025** (DRG 195 @ 0.6227)

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	Non-teaching community hospital	Teaching New York City hospital
Federal base rate	**$6,624**	**$6,624**
Wage index-adjusted base rate	$7,993 (AWI @ 1.3056)	$7,993 (AWI @ 1.3056)
Wage index, **quality, teaching and DSH**-adjusted base rate	$8,069 (average quality; non-teaching; low DSH)	$10,956 (average quality; large teaching; high DSH)
Wage index, quality, teaching, DSH and **patient**-adjusted base rate	**$5,025** (DRG 195 @ 0.6227)	**$6,822** (DRG 195 @ 0.6227)

Key components of Medicare's rate-based payments

Topic	Short definition
Wage index	Payment adjustment (upward or downward) for geographic differences in labor costs.
Teaching hospital payment	Additional payments to hospitals with Graduate Medical Education to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals (direct GME payment provided outside of rate).
Disproportionate share hospital payment	Additional payments to hospitals serving the uninsured and/or a high share of low-income patients (Medicaid DSH is paid via pools to all NYS hospitals).

Medicare uses similar payment models for different care settings

Medicare Prospective Payment Systems (PPSs)

1. Inpatient acute
2. Outpatient
3. Ambulatory surgical center
4. Skilled nursing
5. Inpatient rehabilitation
6. Inpatient psychiatric
7. Long-term care hospitals
8. End-stage renal disease
9. Home health

Each has similar design:

- Base amount
- Geographic adjustments
- Policy adjustments
- Patient adjustments

Medicaid and other payers use varying themes based on the Medicare model.

Positive attributes of the **MEDICARE** approach

- Predictable timing and update schedule
  (most rules updated for Oct. 1; others Jan. 1).
- Annual update factor required by law.
- Annual rate rebasing required by law.
- Generally predictable policy adjustments (e.g., DSH/GME).
- Generally predictable special status to recognize payment shortfalls and different types of hospitals.

While the annual **regulatory process** is generally predictable, Medicare funding is always subject to **regulatory and legislative adjustments.**

Special federal status can change payment model

Special status	General criteria	Count in NYS	Main benefit(s)
Rural Referral Center (RRC)	275 or more beds; or must be a rural facility and meet certain criteria based on referral patterns, CMI, discharges, medical staff and volume.	42	Provides advantages for wage index reclassifications; 340B eligibility; improved IME and DSH payment.
Sole Community Hospital (SCH)	Rural hospitals have several alternative criteria based on distance, patient share, travel time and weather conditions; urban hospitals must be located more than 35 miles from other hospitals.	17	Paid the higher of the federal rate or hospital-specific rate for inpatient services; eligible for increased payment if volume decreases significantly; receive 7.1% payment add-on for outpatient services.
Critical Access Hospital (CAH)	Located in a federal or state defined rural area; more than 35 road miles from a similar hospital (15 miles in certain conditions); provides 24-hour emergency services; no more than 25 inpatient beds; annual average length-of-stay of no more than 96 hours.	21	Reimbursed on a “reasonable cost” basis +1% and exempt from various quality reporting/payment programs. Skilled nursing swing beds and other services also paid at 101% of costs.
Medicare Dependent Hospital (MDH)	Located in a rural area; has 100 or fewer beds; at least 60% of the hospital’s acute inpatient days or discharges are attributable to Medicare.	4	Paid the higher of the federal rate or a 25%:75% blend of the federal rate and the hospital-specific rate for inpatient services; eligible for increased payment if volume decreases significantly.
Cancer Hospital (federally recognized)	Congressional exemption to prioritize cancer care and research.	2 (only 11 nationally)	Reimbursed on a “reasonable cost” basis and exempt from certain quality reporting.
Children’s Hospital	Serves inpatients that are predominantly under 18 years of age.	1	
Rural Emergency Hospital (REH)	Rural and CAH with no more than 50 beds; no inpatient services.	0	5% payment add-on for outpatient services and new monthly facility amount.

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Medicaid rates/supportive funding are acutely subject to annual **budget negotiations** as opposed to an **annual regulatory process** like Medicare.

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Next up

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Thank you.

The Statewide Voice for New York's Hospitals and Health Systems