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New Metropolitan Areas Could Affect Medicare Payment, Regulations

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The U.S. Office of Management and Budget recently announced new Metropolitan Areas based on revised standards and 2010 census data. If adopted by Medicare, which they typically are, these changes would affect many aspects of the Medicare program and have broad implications for hospitals, skilled nursing facilities, home health agencies, ambulatory surgery centers, ambulance service suppliers and other provider types. All providers are advised to carefully examine the Centers for Medicare & Medicaid Services' proposal and prepare for the implications.

On February 28, 2013, the U.S. Office of Management and Budget (OMB) announced new Metropolitan Areas based on revised standards and 2010 census data. If adopted by Medicare, as they typically are, these changes would profoundly affect many aspects of the Medicare program, including program payments, special geographic-based designations, eligibility for federal physician self-referral exceptions and Anti-Kickback law safe harbors and grant programs, as well as have broad implications for hospitals, skilled nursing facilities, home health agencies, ambulatory surgery centers, ambulance service suppliers and other provider types. All providers are advised to carefully examine the **Centers for Medicare & Medicaid Services'** (**CMS**) proposal and prepare for the implications.

New Metropolitan Areas

OMB identifies metropolitan areas around the United States using a set of criteria based largely on population density and commuting patterns. Every 10 years, in anticipation of the next decennial census, OMB reviews and occasionally revises the criteria it uses to define metropolitan areas, then issues new designations using those criteria and updated census data.

On June 28, 2010, OMB announced the new criteria it would use to identify metropolitan areas using data from the 2010 census. (75*Fed. Reg*. 37,246 *et seq.*) On February 28, 2013, it announced the revised metropolitan area designations developed using the new criteria and Census 2010 data. (OMB Bulletin 13-0l). View a copy of the bulletin here. View a U.S. map illustrating the new areas here.

In addition to there now being new metropolitan statistical areas (MSAs), the shape of some existing MSAs has changed where counties have been added and deleted.

Medicare Implications

CMS has not yet announced plans to adopt the new MSA definitions, but the agency typically does so. Geographic designation plays a large role in Medicare payment and regulation. If the agency adopts the new designations, many aspects of provider payments and regulation could be affected.

Provider Payments

Under most Medicare prospective payment systems, payments are geographically adjusted by a wage index, which is intended to adjust payments to reflect labor cost variations between localities. CMS uses the MSA designations to identify labor markets and calculate and assign wage index values for providers. CMS calculates a distinct wage index for each MSA and one wage index per state for the areas that lie outside of the MSAs. CMS uses the hospital wage index to adjust payments under the prospective payment systems applicable to inpatient and outpatient hospital services, skilled nursing facilities, home health agencies and ambulatory surgery centers, among others. MSA changes could cause significant wage index swings for some areas for virtually all provider types.

The new MSAs also could present new challenges and opportunities for hospitals with respect to wage index geographic reclassification. If CMS adopts the new MSAs, many existing MSAs will be reconfigured. As such, the wage index of the MSA to which a hospital has reclassified, or the area where it is located, may be affected significantly by this proposed change. The changes also could present new MSA options to hospitals that traditionally qualify for reclassification and new opportunities to hospitals that previously have been unable to qualify for reclassification.

Geographic designation also plays a role in determining, among other things, disproportionate share payment adjustments, ambulance payments, federally qualified health center payments and counting of medical residents for hospital direct and indirect medical education payments.

The new designations also may affect hospitals with or seeking Rural Referral Center, Sole Community Hospital, Medicare Dependent Hospital and Critical Access Hospital status, all of which are contingent upon being located outside of an MSA or being reclassified as such.

Fraud and Abuse Implications

CMS adoption also could affect the availability of certain exceptions under the federal physician self-referral and Anti-Kickback laws. Under the federal physician self-referral proscription, special exceptions are available to physicians with ownership interests in rural providers, and for certain intra-family rural referrals, and the requirements of the recruitment exception are less stringent for recruitments to rural areas. Similarly, under the federal Anti-Kickback statute, special safe harbor protection is available for certain arrangements involving entities located in medically underserved areas, which tend to be located in rural areas.

Physicians and providers who have premised transactions on these exceptions may be forced to re-examine, and perhaps even unwind, such arrangements. Additionally, the geographic area changes could present new opportunities for providers presently located in urban areas that could be moved into rural areas.

Location-Based Grants and Demonstrations

Many federal grant and demonstration programs also are contingent upon urban-rural location. Entities that are re-designated pursuant to the MSA changes could confront challenges to their eligibility, or opportunities to now pursue these funding sources.

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