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Eligibility of Rural Hospitals for the 340B Drug Discount Program

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DSH Adjustment Percentage and 340B Eligibility

The 340B drug discount program is available to twelve categories of health care entities. One such category includes any general acute care hospital which: (1) is owned or operated by a unit of state or local government, is a public or private non-profit hospital which has formally been granted government powers, or is a private non-profit hospital under contract with a state or local government to provide indigent care; (2) has a Medicare disproportionate share hospital (“DSH”) adjustment percentage greater than 11.75 percent; and (3) has certified that it will not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

Prior to Medicare reform legislation in 2003, the DSH adjustment percentage threshold of 11.75 percent made it impossible for most rural hospitals to be eligible for the 340B program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) has made it significantly easier for many rural hospitals to meet the 11.75 percent threshold and obtain access to the 340B program (if the other program criteria are also satisfied). The following provides general background information on the DSH adjustment and guidance to rural hospitals on how to calculate their DSH adjustment percentages in order to determine potential eligibility for the 340B program.

What Is DSH?

The DSH adjustment is an add-on to the DRG-based payments of the inpatient acute care hospital prospective payment system (“PPS”). Under PPS, hospitals in the same geographic area generally receive the same payment amount for providing care to a patient with a given diagnosis. The DSH adjustment is a percentage add-on to this PPS payment that is available to hospitals that serve a disproportionate number of indigent patients. The determination of whether a hospital serves a disproportionate number of indigent patients is based on a methodology prescribed by Congress, as implemented by the Centers for Medicare and Medicaid Services (“CMS”), and is discussed in detail below. The basis for this add-on is the recognition that indigent patients are often sicker and more costly to treat.

Disproportionate Patient Percentage

A hospital’s disproportionate patient percentage (“DPP”) determines three issues of significance for rural hospitals. First, it determines whether a hospital qualifies for a DSH payment adjustment. A rural hospital must have a DPP of at least 15 percent to qualify for a DSH payment adjustment.¹ Second, it determines the amount of a rural

¹ Hospitals are entitled to DSH adjustments based on either of two separate methodologies. The first methodology, which involves the calculation of a DPP, is available to rural hospitals. The second methodology, which does not involve calculation of a DPP, is not available to rural hospitals.

number of categories of hospitals. For example, the statute and regulations distinguish between urban and rural hospitals, small and large hospitals, and sole community hospitals and rural referral centers. In the past, the statute and regulations required hospitals to use significantly different equations to calculate their DSH adjustment percentages depending on how such hospitals were categorized, with the most favorable DSH adjustment methodology reserved for urban hospitals of 100 or more acute care beds and for rural hospitals with 500 or more acute care beds. For example, for a fiscal year ending June 30, 2002, an urban hospital with 200 beds and a DPP of 25 percent would have had a DSH adjustment percentage of 9.84 percent. For that same period, a rural hospital with 200 beds and a DPP of 25 percent would have had a DSH adjustment percentage of 5.25 percent.

The MMA significantly changed the calculation of the DSH adjustment percentage for rural hospitals, placing these hospitals in almost the same position as large urban hospitals with respect to the calculation of DSH adjustment percentages. For discharges occurring on or after April 1, 2004, all rural hospitals will use one of the following two formulas to determine DSH adjustment percentages (the formulas differ based on a hospital's DPP):

If DPP is between 15% and 20.2%, then: $DSH = 2.5 + (0.65)(DPP - 15)$

If DPP is equal to or greater than 20.2%, then: $DSH = 5.88 + (0.825)(DPP - 20.2)$

Notwithstanding these formulas, a rural hospital has a cap on its DSH adjustment percentage of 12 percent, unless the hospital is a rural referral center, has 500 or more beds, or effective for discharges occurring on or after October 1, 2006, is a Medicare-dependent hospital (in which case, it uses the same formula as other rural hospitals, but has no cap).³

The Minimum DPP for 340B Eligibility

Passage of the MMA has made meeting the 11.75 percent threshold for 340B program eligibility significantly easier for most rural hospitals, provided they also satisfy the other eligibility criteria. Pursuant to this legislation, rural hospitals will use the same formula as large urban hospitals to calculate DSH adjustments, except with a cap of 12 percent for rural hospitals that are not rural referral centers, Medicare-dependent hospitals or have fewer than 500 beds. This 12 percent cap will not adversely impact 340B eligibility, since it is higher than the 11.75 threshold.

³ A Medicare-dependent hospital is one that is located in a rural area, has less than 100 beds, a high percentage of Medicare discharges and meets certain other criteria. These hospitals are subject to special payment provisions under Medicare.

Based on the new DSH equations, **rural hospitals must have a DPP of greater than 27.32 percent in order to satisfy the 11.75 threshold for participation in the 340B program.** This is because, pursuant to the equations detailed above:

$$11.75 = 5.88 + (0.825)(27.32 - 20.2)$$

Accordingly, for discharges on or after April 1, 2004, if a rural hospital has a DPP of greater than 27.32, then it will satisfy the DSH requirement for eligibility for the 340B drug discount program.

Enrollment in the 340B Program

CMS has developed a computer program specifically designed to generate a database of DSH adjustment percentages for the Office of Pharmacy Affairs (OPA) which administers the 340B program. OPA relies on this database to tell which hospitals satisfy the DSH adjustment percentage requirement for 340B eligibility. When President Bush signed the MMA and thereby facilitated rural hospitals' ability to meet the DSH adjustment percentage requirement, there was some initial concern regarding when OPA would begin admitting rural hospitals to the 340B program. This was because the 340B community did not know when CMS would include rural hospitals' DSH adjustment percentages in the database it provides to OPA.

Although there was an initial delay in the availability of the relevant data, rural hospitals and their percentages are now included in the database, which OPA posts on its website and updates each quarter. If OPA lists a rural hospital's DSH adjustment percentage as higher than 11.75 percent on the website database, the office considers the hospital to have satisfied the 340B program eligibility criterion. If the rural hospital's percentage is listed as below 11.75 percent but the hospital believes that number is inaccurate, it may still prove its 340B program eligibility through other means.

In the past, OPA has accepted documentation from fiscal intermediaries stating that hospitals' DSH adjustment percentages are greater than 11.75 percent as evidence that the hospitals meet the second eligibility criterion for 340B program participation. Hospitals that have good relationships with their fiscal intermediaries may be able to work with them to provide such documentation to OPA. Some hospitals have reported that fiscal intermediaries are reluctant to offer such documentation, however, and OPA has informed the Public Hospital Pharmacy Coalition (PHPC) that CMS discourages these types of requests because they fall outside the contractual scope of responsibilities for fiscal intermediaries. Nonetheless, PHPC understands that OPA will still accept fiscal intermediaries' letters as proof of hospitals' qualifying DSH adjustment percentages.

Another possible option for illustrating that a rural hospital satisfies the second 340B eligibility criterion is to show OPA that the hospital receives interim payments reflecting a DSH adjustment percentage of 11.75 or higher. OPA may or may not accept such

information as proof that 340B program requirements are satisfied, however. If a rural hospital wishes to rely on this type of information when applying for the 340B program, it should contact OPA to discuss the Office's policies on accepting the information before submitting the application.

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If you have any questions about 340B eligibility and/or DSH adjustment increases for rural hospitals, feel free to contact Bill von Oehsen, Barbara Straub Williams or Claire Holloway at (202) 466-6550.