Overview of Topics

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- CAH COP – Direct Services
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- Cost reimbursement for lab
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- HPSA/PFSbonus/CRNA
- Excluded Units
- Relocations

Status of CAH Program

- There are approximately 1,300 CAHs in the US, per CMS
- >50% of US rural community hospital
- About 22% of all US hospitals
- **Paid $1.3 billion** > PPS - $1million/CAH
- About 850 are Necessary Provider CAHs
  - 453 have “health clinics” (CMS’s term?)
  - 81 have psych units
  - 20 have rehab units
Current Status of CAH Eligibility Requirements

- CAHs must be >35 miles from a hospital unless:
  - Located in mountainous areas or have only secondary roads (15 miles) OR
  - Received state designation as a "necessary provider"
- States CANNOT issue new NP designations after 12/31/2005
  - Had to have NP designation, AND
  - Be certified as a CAH by January 1, 2006
  - to be grandfathered from 35 mile rule
- Proposals have circulated to reinstate NP authority!
**Current Status of CAH Eligibility Requirements**

- Annual ALOS <96 Hours/4 Days
- Effective 1/1/2004:
  - May operate up to 25 I/P beds in any combination of acute care and swing beds
  - May also have distinct part units:
    - Psych unit of up to 10 beds
    - Rehab unit of up to 10 beds
- Excluded units do NOT count toward
  - 25 bed limit
  - ALOS calculation
- Excluded units paid via applicable PPS- NOT cost

**What CAH’s do NOT have to worry about**

- DRG Payment Window Changes
- Value Based Purchasing Program
- Hospital Readmission Reduction Program
- PT/OT/ST Therapy Caps
- Expiration of Medicare Dependent Hospital Status
- Expiration of Low Volume Adjustment Expansion
- Sole Community Hospital Original Error Reporting

**Too Close for Comfort?**

- Budget Proposal would have revoked CAH status if <10 miles
  - Died a quick death, but like a phoenix…?
  - Some rumors of coming back at 20 miles…
  - Some CAHs/systems running DRG scenarios….
    - Merge/acquire & consolidate to keep at least one CAH
- Proposal to reduce 101% to 100% of costs
- Not out of the woods
  - These and other cuts are likely to continue to come up
  - Rumor of OIG Study…?
Medicare Bad Debt Changes

- Middle Class Tax Relief & Jobs Creation Act of 2012
  - Reduced hospital bad debt payments to 65% (from 70%) for cost reporting periods beginning on or after 10/1/2012 (FFY 2013)
  - CAHs/SNFs: Phases in reduction from 100% for cost reporting periods beginning in:
    - FFY 2013 – 88%
    - FFY 2014 – 76%
    - FFY 2015 – 65%
  - Repeals bad debt moratorium from 1987:
    - For cost reporting periods beginning on or after 10/1/2012

Law Requires Reasonable Collection Efforts

- 42 CFR 413.89 & PRM 310
- Similar to non-Medicare collection efforts
- Moratorium prevented CMS/FI from changing what had been allowed by provider in pre-1987 cost reporting periods
- Cost reports beginning 10/1/2012 or later not protected by lost moratorium
- Review practices to confirm with current CMS policy
- Watch for audit adjustments for prior years

Who can receive what payments

- Eligible Professionals (EP):
  - Medicare OR Medicaid
  - Definition different for Medicare than Medicaid, generally:
    - Medicare = doctors, but not midlevels
    - Medicaid = doctors & midlevels
- IPPS/DRG Hospitals:
  - Medicare AND Medicaid
  - NOT excluded hospitals/units
  - Medicaid $ available for Children's hospitals
- Critical Access Hospitals:
  - Medicare AND Medicaid
- Medicare Advantage Organizations: Medicare only
  - Organized as HMO per PHS 2791(b)(3)
  - Commonly controlled EPs & Hospitals
Medicare EP Payments

- Definition of Eligible Professional
  - Based on SSA § 1861(r) = general Medicare definition of physician
    - M.D.  D.O.
    - Doctor of dental medicine or dental surgery
    - Doctor of podiatric medicine
    - Doctor or optometry
    - Chiropractor
  - CMS received comments on expanding to:
    - Midlevels, CSWs, CRNAs, RNs, OTs, etc
    - CMS said no - hands tied by statute, with no discretion
    - EXCLUDES – “hospital based” physicians

- EP – Hospital Based Definition
  - At least 90% of Medicare services use place of service (POS) codes:
    - 21 = inpatient hospital
    - 23 = emergency room, hospital
  - Proposed rule also included POS 22 (outpatient hospital)
    - Would have precluded for provider based clinics
  - Industry & politicians cried foul - LOUDLY
  - Continuing Extension Act of 2010 (4/15/10) legislatively reversed CMS proposal
  - Will use claims from prior calendar year
    - CMS plans to provide info re HB’d status ASAP
    - “No later than early in each payment year”

- 75% of covered Medicare PFS allowed charges up to $24,000/year/EP
  - BUT limited to following maximums/year
  - Based on 1st CY eligible and up to 4 following years
  - DOES NOT APPLY in RURAL HEALTH CLINICS – Not paid by PFS

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Medicare EP for Method 2 CAHs

- When billed for CAH provider based ambulatory clinic (NOT RHC) – should be eligible
  - Not Place of Service 21 (I/P) or 23 (ER) so not “hospital based” for EHR purposes
  - Services paid under PFS – would be with POS code 22 if not under Method 2
  - BUT no POS code on UB-04 for Method 2
- Potentially leaves $44,000/EP on table
- Fix is being sought…..stay tuned
- IF eligible for Medicaid EHR Funding then this would be a moot point. EPs cannot get Medicare and Medicaid $$
- EP funding is separate from CAH funding

CRNA & Pain Management

- Medicare PROPOSED PFS CY 2013 would allow CRNAs to provide pain management services, when:
  - CRNA is legally authorized to perform within scope of practice under state law
  - Amends 410.69 to include in CRNA covered services “medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the state in which the services are furnished.”
  - Would take effect 1/1/2013
- CRNA = traditionally surgical related anesthesia
- Wisconsin Scope of Practice include…???
  - Yet to be determined

Pathology TC Expiration

- “Covered Hospitals” have been exempt from hospital bundling rule on technical component of pathology services for patients
  - CH = contract on 7/22/1999 under which an independent lab furnished TC for I/P or O/Ps and billed Medicare directly
  - Independent Labs serving CHs have been allowed to continue to bill directly – paid under physician fee schedule
- Grandfather Rule Expired June 30, 2012
  - Has happened before and been retroactively reinstated
  - Some think this may be it
- Affected Hospitals should be paying lab for TC and billing Medicare under hospital provider number
  - Pay lab – % charges? % of PFS ??
Physician Supervision

- The way it is - January 2011 forward: Therapeutic
  - N/A to PT/OT/ST & ESRD
  - Direct supervision generally required, but
    - Extended duration non-surgical services convert to general
      after stabilization occurs
    - Observation, infusions, injections,...
    - Physicians & "NPP" acting w/i scope of practice
  - NPPs = CP, PA, NP, CNS, CNMW, LCSW
- Must be "immediately available" on or off campus
- NFL Catch rule eliminated for off campus
- BUT – continue non enforcement through 2012 for CAHs
  AND rural hospitals <100 beds
- CY 2012 Final Rule 11/30/3011
- 7/30/2012 Proposed HOPPS Rule – extend thru CY 2013
- APC Panel to set supervision standards for specific services

Physician Supervision

- The way it is – January 2011 forward –
  - Diagnostic
    - General/direct/personal apply as per PFS
    - ONLY physicians – NOT NPPs
    - STILL N/A to CAHs – only APC paid O/P services
  - PR/CR/ICR
    - CMS commentary - obviously hospital here includes
      CAHs so these services can be covered in covered in
      CAHs
    - ONLY physicians NOT NPPs
    - NON enforcement for CAHs & <100 beds applies here
      also for CY 2011

DRG Payment Window

- Effective June 30, 2012
  - Non-diagnostic O/P (diagnostic not affected)
    - clinically associated with I/P stay
    - by wholly owned or operated entity are within
      window
  - Previously: ICD-9-CM diagnosis code had to match
  - Assume all related unless hospital attests
    they are not. Modifier/condition code 51
- No Change to scope of window: services by
  admitting DRG hospital and any entity wholly
  owned or operated by admitting hospital
**DRG Payment Window**

- Not Applicable to CAHs because not paid under DRGs
- BUT – this is where CAH is admitting hospital
- IF CAH is wholly owned or operated by admitting DRG Hospital – then services at CAH w/i 3 day window are not separately billable by CAH !!!!
- Wholly owned = direct 100% subsidiary
  - Sibling corp NOT wholly owned
- Wholly operated – not so well defined, but would be comprehensive management arrangement
- Services @ RHC/FQHC not covered even if WO/WO by DRG hospital (all inclusive rate)

**Welcome Changes to CAH CoPs**

- Critical Access Hospitals
  - Eliminates direct services requirement (by employees only) for services including diagnostic and therapeutic, laboratory, radiology and emergency services
  - Allows CAHs to provider certain services through contracts with other providers or temporary agencies rather than being required to provide them directly

**Patient Notification: No Doc in the House**

- **FINAL CY 2012 HOPPS 11/30/2011**
  - Adds notice requirement to Patient Notification for hospitals and CAHs
  - If MD or DO is not present 24/7 (NPPs don’t count)
  - Written notice to patient before
    - Inpatient stay
    - O/P visit for observation, surgery or any other procedure requiring anesthesia
  - Must receive signed acknowledgment from patient
    - Before admitting patient or providing O/P service for which notice required
  - Post conspicuous notice likely to be seen by all patients entering dedicated ED
Hospital Therapy Caps

- The Middle Class Tax Relief & Job Creation Act of 2012 made several changes to the Therapy Caps
  - Applies to Hospital Outpatient Services for 2012
  - Added Manual Exception process
  - Requires Physician/NPP reporting

Hospital O/P Therapy Services

- Hospital outpatient therapy services will be subject to the Therapy Caps for the period of October 1 through December 31, 2012
  - All claims paid for hospital outpatient therapy services since January 1, 2012 will be applied toward the Therapy Cap limits as of October 1, 2012
  - Temporary!
    - On January 1, 2013 Hospital outpatient services no longer apply toward the Therapy Caps
- CAHs will continue to be exempt from the Therapy Caps during 2012 & after
  - BUT NOT if provided in non-provider based site !!!

Therapy Cap Mechanics

- Medicare imposes financial limitations on outpatient therapy services (“Therapy Caps”)
  - Currently, do not apply to services provided in a hospital outpatient department
- Therapy Caps are applied on a per-beneficiary, per-calendar year basis
  - Therapy Cap is $1880 for 2012
  - Two separate caps:
    1) Occupational Therapy
    2) Physical Therapy and Speech and Language Pathology combined
**Therapy Cap Tracking**

- The lesser of the Medicare Fee Schedule amount or actual charges is applied toward the Therapy Cap
  - Includes Medicare deductible and coinsurance amounts
- Tracking the Therapy Caps
  - CMS applies services toward the Therapy Caps in the order of the dates that the claims are received
  - Medicare contractors track a beneficiary's therapy services using the Common Working File
- Services that exceed the Therapy Caps will not be paid unless they qualify for an exception

**Beneficiary Notice**

- Providers should notify beneficiaries at the time of service that the beneficiary will be responsible for all of the costs of therapy services above the Therapy Caps (unless the services qualify for an exception)
- Providers may use either the Advanced Beneficiary Notice of Noncoverage or a form of their own design
- A cost estimate may also be included in the notice
- CMS recommends the following language:
  - "Services do not qualify for exception to therapy caps. Medicare will not pay for [Insert: physical therapy and speech-language pathology or occupational therapy] services over $1,880 in 2012 unless the beneficiary qualifies for a cap exception."

**Exceptions & Certifications**

- Automatic Exception Process was extended but is set to expire on 12/31/2012
  - Has been set to expire many times but always extended
- Manual Exception Process –
  - CMS will implement on 10/1/2012
  - But will also expire on 12/31/2012
- Beginning October 1, 2012, the physician or non-physician practitioner who is responsible for a therapy plan of care must certify the claim for therapy services using his or her National Provider Number
CAH Provider Based Limit

- Final 2008 HOPPS rule – 11/27/07:
  - Any off campus location opened or acquired after 1/1/08 that meets provider based requirements must be >35/15 in MSR areas mile drive from any other hospital or CAH
  - Applies to excluded psych and rehab units also
- Essentially includes all PB'd sites in determining whether 35/15 mile/NP Location Rules Met
- Failure to comply: CAH status subject to termination unless the CAH terminates the off campus arrangement
  - Converting to free-standing should be sufficient
  - Not closing site

CAH Provider Based Limit

- Sites operated and qualified as provider based before 1/1/08 are grandfathered
  - "created or acquired after 1/1/08"
  - Converting free standing pre 1/1/08 site to PB’d after 1/1/08 is not grandfathered
  - CMS approval/attestation not required
- Relocation of pre-1/1/08 PB’d site loses grandfather status - it is site specific!!!
  - May be outside CAH's control - lease termination
- Changes at grandfathered site:
  - Addition of footprint or services
  - Construction of new building to replace old
  - Should be able to keep status – but confirm with regional office

CAH Provider Based Limit

- After 12/31/2007 - CAH corporation is NOT prohibited from:
  - Operating free standing sites, just PB’d. So lose option to get:
    - Cost on hospital cip facility services
    - 15% bonus for Method II professional billing
  - Opening Hospital Based - Rural Health Clinics
    - Exempt because not part of hospital provider
    - Have separate provider number
  - Sites under development before 1/1/08
    - Need CMS approval of prior plans/commitments
    - Were not required to file before 1/1/08
- Law does NOT limit PPS hospitals from opening PB’d sites within 35 miles of a CAH!!!
CAH Provider Based Limit

• CMS Guidance 12/21/08 and 6/12/09
  – CAHs seeking a PB'd determination for newly created or acquired off campus sites **MUST** submit an attestation to Regional Office to determine location requirements
  – Regulation 413.65 says PB'd Attestations Optional
  – Follow Guidance
  – PB'd site may meet tests even though campus does not
  – And, remember 15 mile rule

Off Campus Clinic Location Example

Definition of Campus

• So What is "On Campus" ????
  – "Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus"
  – Affects:
    • Ability to open new PB’d services given 12/31/07 restrictions
    • Relocation test
    • Provider based: on vs. off campus
**Definition of Campus**

- **On Campus Case Study**
  - CAH in midwest – Region 5 state
  - Key to lines
    - Blue = Owned land + 250 yards
    - Red = hospital building + 250 yards
    - Orange = hospital operated ambulance + 250 yards
    - Green = expansion parcel for new building to house PT/OT, various o/p ancillary & hospital admin/support, & physician offices
  - Portion of new building would be within Red & Orange 250 yard rules
  - Is the building on campus?
    - If yes, does it expand 250 yard footprint?

**Definition of Campus**

- **Take aways**
  - "Main buildings" not defined – CMS generally interprets as primarily I/P care.
  - Only main buildings enlarge footprint via 250 yard rule
  - Region 5 rarely has approved discretionary expansion
  - Maybe if nothing but open space between main buildings and new structure
Provider Based - Mixed Use

- CMS has become increasingly restrictive in its review and approval of mixed use sites
  - Generally, CMS seems to be headed toward requiring more separation of the freestanding vs. provider based space
- The analysis for provider-based locations is very fact-specific, especially for these co-located facilities
  - Considerations include for example:
    - how the areas are segregated by suites or walls
    - the use of shared registration or waiting rooms

Provider Based - Mixed Use

- Recently, CMS Chicago Regional Office denied a provider-based attestation based, in part, on co-location issues
  - Denial was based on failure to meet several provider based requirements including:
    - the public awareness standard
    - definition of "Department of Provider"
    - terms of Provider Agreement

Provider Based - Mixed Use

- In its denial, Region 5 included comments suggesting that it may not be possible (in their opinion) to satisfy these requirements unless:
  - There is an exclusive entrance, and waiting /registration areas
  - Permanent walls
  - A separate suite that is recognized by USPS (if not the whole building)
  - Signage indicating that the facility includes both free standing and provider based services
- Contrary to our prior experience with Region 5
  - So this case may involve a situation where a provider just very poorly identified the components of the facility
  - OR, it may indicate a change in CMS' view of these situations
**Provider Based - Mixed Use**

- An “unofficial” attestation circulated by Region 5 includes the following question:
  - If the provider-based facility is a department of a hospital, please describe the physical setting of the premises. For example, is the department in a building that houses other, freestanding, healthcare providers or suppliers? If so, describe how the hospital department is separated from these freestanding spaces.

**Provider Based RHCs**

- “Provider Based Entity” – not a hospital O/P department
  - obtains its own separate (from CAH) provider number
  - Subject to separate RHC CoPs
  - Exempt from some PB’d requirements, including:
    - License, distance, public awareness, off campus notice of split billing
  - Not all services covered/billable under RHC P#:
    - Effectively only physician & midlevel office visits
  - Other non-RHC covered services (ancillaries) must be billed separately:
    - Hospital/CAH provider # if PB’d
    - Physician office # if not PB’d
  - CMS Position – to bill non-RHC services @ RHC site under hospital/CAH Provider # must meet ALL PB’d requirements for those services at that site.

**Will Provider Based Last?**

- MedPAC recommendation
  - Equalize payment rates for non-emergency E/M services for the upcoming budget
  - Projected reduction of $6.8 billion over 10 years
- Middle Class Tax Relief & Job Creation Act HR 3630
  - § 2223 – Parity in Medicare Payments for O/P E&M Office Visits (APC same $$ as PFS)
  - CPT codes 99201-99215 = PFS. CY 2012+
  - Would NOT have affected CAH PB’d
- On February 17, Congress approved MCTR&JCA
  - WITHOUT § 2223!!!!! (for now?)
**Method II Rescue**

- PPACA – HC Reform & 2011 IPPS Final Rule
  - Changed statute to clarify CAHs paid 101% for both Method I and II
    - **Effective retroactively**
    - Effective for cost reporting periods beginning after 10/1/09
  - Was annual election by cost report year
    - Now a one-time election that carries over to subsequent years → Submit at least 30 days before start of cost reporting period
    - Unless revoked by CAH 30 days before start of next cost reporting period
    - Effective for cost reporting periods beginning after 10/1/10

**Cost Reimbursement for Lab**

- Effective 7/1/09: Cost payment if patient is physically present in the CAH (including PB'd dept's, but not entities) when the specimen is collected, OR at least 1 of following:
  - Individual receives o/p services in CAH on the same day the specimen is collected
  - Specimen is collected by CAH "employee"
- Other bundling rules trump cost payment – SNF consolidated billing

**Cost Reimbursement for Lab**

- Individual receives o/p services in the CAH on the same day the specimen is collected, but it is not collected in the CAH:
  - Doesn't matter where specimen is collected
    - Home, Dr's office, back at SNF…
  - Or, who collects it
    - Patient, SNF staff, Dr. office staff…
**Cost Reimbursement for Lab**

- Collected by a CAH employee?
  - W-2 employee of CAH
    - Including employees of CAH PB'd dept's
    - But not employees of PB'd entity (RHC) (hu?)
  - Contracted lab staff?
    - As long as not employed by an entity at site where specimen is collected (SNF employee contracted to CAH) can be considered employee for these purposes
    - No info on how this coordinates with CAH COP that lab services be provided directly

- Specimen collected by employee
  - CAH employee (as defined) must physically perform the specimen collection
  - Not enough to pick up the specimen

  **Example:** CAH employee goes to SNF to do blood draw on part B resident, also picks up urine sample from SNF staff
  - Blood draw – cost reimbursed (851 bill type)
  - Urine sample – fee schedule (141 bill type) (unless patient also received CAH o/p services that day!)

- See the cost reimbursement opportunity?

**CAH TRICARE Reimbursement – Final Rule**

- Effective December 1, 2009 CAHs exempted from the usual TRICARE hospital payment systems
  - Payments instead "based on 101% of reasonable costs"
  - But - no TRICARE cost reports
  - No interim payments & retroactive settlements

  TRICARE will use I/P & O/P cost to charge ratios plus 1% from each CAHs recent (not defined) Medicare cost report
  - No lesser of cost or charges rule – BUT
  - CCRs will be capped at nationally set levels. Initially caps will be:
    - 2.12 for I/P
    - 1.23 for O/P

- Review any TRICARE Provider Agreements
Medicare Like Rates - IHS

- 42 CFR 136.30 requires all Medicare participating hospitals and CAHs to
  - Accept as payment in full
  - Medicare like rates
  - For Contract Health Service authorized services
- MLR for CAHs = interim rates set by FI
- CHS intended as payor of last resort
  - On reservation tribal members
  - Without other coverage
  - Hospitals prohibited from collecting deductible &/or copays

Medicare Like Rates - IHS

- Recently some Tribes have:
  - Bifurcated health plans
    - Tribal member employees with health insurance
    - Benefits capped @ MLR
    - Non-tribal employees receive usual coverage
  - Started paying hospital @ MLR for tribal member employees
    - Usually no CHS advance authorization
    - Often at wrong MLR
- Recourse?
  - Demand advance CHS approval or deny care
  - Get correct MLR
  - Contact legislators

Excluded Units

- CAHs can have up to 10 bed psych &/or rehab
- Paid under psych or rehab PPS – NOT cost
- Process for exclusion
  - Can only be excluded on 1st day of cost reporting period
  - Surveys cannot be retroactive to before date of survey
  - Catch 22 - cannot get survey until operational
  - Need to use some of 25 beds for "unit" pre-exclusion to trigger survey
  - Need lots of advance planning/notice to DHFS and CMS
CAH: Relocations

- At the new location a non-NP CAH must meet all of the CAH Conditions of Participation, including the location requirement:
  - More than 35 miles from any hospital/CAH
  - Or, more than 15 miles of mountainous terrain or secondary roads between it & any other hospital or