

## 2012 Medicare Issues: New Developments and Old Issues

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## Overview of Topics

- Updates
  - Physician Supervision
  - LSC/COP
  - Provider Based developments
  - Pension Expense
  - Primary Care Bonus
  - Surgery Bonus
  - 855 Changes
  - Patient Notice: No Doc in the House
  - Telemedicine
  - Lab Signatures NOT
  - Value Based Purchasing
  - Shared Savings Program
- Review Status of CAH Program
- COPs etc.
  - Beds
  - PB'd Limitations
  - Cost reimbursement for lab
  - Definition of Campus
  - TRICARE
  - MLR – Tribes
  - HPSA/PFS Bonus/CRNA
  - Excluded Units
  - Relocations



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## Physician Supervision

- The way we were – February 2010
  - Therapeutic Services
    - 2010 Final Rule had required direct supervision for all – doc on campus or w/i off campus PB'd site ("NFL Catch Rule")
    - CAH's in uproar:
      - Observation services, etc.
      - Apparent conflict with CAH COPs
  - Diagnostic Services
    - 2010 Rule applied same general – direct – personal rules for physician offices to hospital O/P
    - BUT – CMS had informally confirmed this was N/A to CAHs – only applied to APC paid hospitals
    - New PR/CR/ICR Coverage N/A in CAHs



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## Physician Supervision

- Developments during 2010
  - March 15 – CMS issues notice of non-enforcement of direct supervision policy for O/P therapeutic services in CAHs
  - July - Proposed CY 2011 HOPPS & PFS Regs released
    - Therapeutic – changed direct to general
      - Include midlevels
    - Diagnostic
  - November – final CY 2011 HOPPS & PFS issued



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## 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 2011 for CAHs AND rural hospitals <100 beds
    - 7/18/2011 Proposed HOPPS Rule – extend thru CY 2012
    - APC Panel to set supervision standards for specific services



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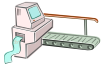
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## Physician Supervision

- The way it is – January 2011 forward –
  - **Diagnostic**
    - General/direct/personal apply as per PFS
    - ONLY physicians – NOT NPPs
    - Same "immediately available" standard on or off campus
    - STILL N/A to CAHs – only APC paid O/P services
  - **PR/CR/ICR**
    - CMS commentary - obviously (you fools) 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



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## DRG Payment Window



- FFY 2011 Final IPPS Rule
  - 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
  - 6/25/2010: assume all related unless hospital attests they are not. Modifier/condition code 51
- CY 2012 Proposed PFS Rule
  - Non PB'd practices bill "global" CPT codes using facility site of service
  - CMS concerned with double payment given expansion of window to more services

## Hospital/CAH LSC



- S&C-11-05-LSC December 17, 2010
  - Life Safety Code Occupancy Classification Update
  - State Operations Manual Appendices A, I & W
    - Appropriate occupancy classifications for separated, non-contiguous or off-site facilities that are part of certified hospital or CAH
  - 3 Levels: application depends on services w/i space
    - Health Care Occupancy – inpatient
    - Ambulatory Health Care Occupancy – "outpatient"
      - 4 or more patients receiving treatment that renders them incapable of taking action for self-preservation under emergency conditions....
      - Distance to exits, backup generator, 1 hour firewalls, sprinklers? Etc....
    - Business Occupancy

## Hospital/CAH LSC



- Key Points:
  - Patient care can occur in business occupancy if most of patients are capable of self preservation
  - Hospitals/CAHs with multiple component facilities may have various occupancy classifications
  - Mixed Use: If a particular component facility is not adequately separated from other building occupancies, the most stringent occupancy classification must apply to the entire building

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## Provider Based Developments

- Regional Office getting tougher?
  - Recently have denied provider based status for several mixed use sites (part free standing, part PB'd)
  - Common entrance, shared registration and waiting areas cause confusion and public awareness cannot be met
  - Will be appealed to DAB
- Department Appeal Board Decision
  - Reversed CMS denial of on campus >250 yards
  - Remanded for reconsideration
  - Campus may be bigger than 250 yards



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## Defined Benefit Pension Expense

- Historical Confusion
  - S-3 wage index report – GAAP, ERISA, cost?
  - Cost report/reimbursement - PRM 2142
    - normal service cost
    - accrued actuarial liability
    - Funding requirement (w/i 1 year of end of cost report)
  - Many wage index appeals across country
- FFY 2012 Final Rule 8/18/2011
  - Adopts Cash Basis, with limits
  - Different rule for S-3 Wage Index
  - Than for Cost Report determination



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## Defined Benefit Pension Expense

- Wage Index Reporting
  - Reportable DBPE = 3 year averages
  - Based on years before and after cost report year used for wage reporting
  - Plus 1/10<sup>th</sup> of any prefunding balance
    - Sum of contributions over allowed S-3 DBPE
    - For years ending with cost report used for FFY 2012 wage index (generally CR's ending in 2008)
  - New method used for FFY 2013 wage index
    - wage index process beginning in October 2011
  - See Federal Register 8/18/2011 Page 51,589-90 for an example



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## Defined Benefit Pension Expense



- Method used for cost determination
  - Cost reports beginning on or after 10/1/2011
  - Cash basis
  - Subject to limit:
    - 150% of 3 consecutive reporting periods of 5 most recent that produces the highest average
    - disallowed excess carries forward
  - Hospitals with contributions in excess of limit may request an exception to show excess is
    - reasonable and necessary
  - See Federal Register 8/18/2011 Page 51696-7 for an example

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## Primary Care Bonus – PFS

Expanding access to primary care and general surgery services

### Primary Care



- 10% Medicare primary care service payment bonus
  - Eligible providers = Physician (family, internal, geriatric, peds), PA, Clinical nurse specialist who
    - Provided at least 60% primary care services in preceding TBD period;
  - "Primary Care Services" - defined by CPT codes
  - **In addition to 10% HPSA physician bonus payment & CAH 115% for Method II**
  - NO RURAL REQUIREMENT
  - Services between January 1, 2011 and January 1, 2016
  - See CMS Transmittal 2161 2/25/2011 for CPT list & other info

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## Surgery Service Benefits - PFS

Expanding access to primary care and general surgery services

### General Surgery



- 10% Medicare primary care service payment bonus
- Eligible providers – Physician who
  - furnishes the payable service **in a HPSA**
  - Eligible procedures – procedures with 10 or 90 day global PFS payment period
- In addition to 10% HPSA physician bonus payment
- Services between January 1, 2011 and January 1, 2016

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## Form 855 Changes



- Medicare Enrollment Application Revised
  - 855A, 855B, 855I, 855R, 855I, 855O, 855S
  - Effective July 2011
  - Form 855A
    - Hospitals & HHAs must list "main/primary" location
    - Section 5 – Ownership and Managing Control (Organizations)
      - 5% or > direct or indirect ownership interest
      - 5% or > direct or indirect mortgage or security interest
        - \$ security value/total assets of provider
    - Section 6 – O & MC (Individuals)
      - Still list directors
      - Also list 5% or > mortgage or security interest holders
        - bondholders?
  - Form 855O – Ordering & Referring Physicians & NPPs

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## Form 855 Filing Fee - \$505

- Applies to Institutional Providers & Suppliers
  - 855A, 855B, 855S
  - NOT physician or NPPs (and their org's)
  - Unless filing for DMEPOS (IDTF, ASC, etc?)
- Basic Rules - Applies when:
  - New enrollment, re-enrolling, re-validating, adding a new practice location (Whether manually filed or via PECOS)
  - Must pay via www.Pay.gov (credit/debit card or check)
- Non-refundable unless:
  - Hardship exception subsequently approved
  - Rejected prior to initiation of screening process
  - Denied due to moratorium



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## Form 855 Filing Fee - \$505

- Hardship Exception Request
  - Must submit with application
  - Must be "strong argument" with "comprehensive documentation."
- Factors include:
  - considerable bad debt, significant charity care
  - Presence of substantive partnerships with those that furnish care to disproportionate low-income population
  - DSH funding
  - Presidentially declared disaster area



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## ■ ■ ■ Patient Notification: No Doc in the House



- Proposed CY 2012 HOPPS 7/18/2011
  - 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
    - I/P 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



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## ■ ■ ■ Telemedicine Update



- Final Rule 5/5/2011 Revised Hospital & CAH COPs for credentialing and privileging
  - Changed requirement that all practitioners go thru same C&P process
  - Effective 7/5/2011 can have separate process for T/M Practitioners
  - Hospital/CAH can rely on "distant site" hospital/CAH
    - Written contract
    - T/M practitioner privileged at distant site
    - T/M practitioner licensed in state where patient treated
    - Must receive evidence of distant site review of performance and must send performance info to distant site, including adverse events and complaints

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## ■ ■ ■ Telemedicine Update

- If Distant Site is NOT a hospital/CAH
  - Same requirements as for a distant hospital
  - PLUS written agreement must require distant site to provide services in a manner that allows hospital/CAH to meet basic COP medical staff requirements
- Implementing these options will require medical staff bylaw amendments



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## ■ ■ ■ Telemedicine Update

- Eligible sites for patient receiving T/M
  - Hospital, CAH, SNF, RHC, FQHC, physician office, hospital/CAH based ESRD, CMHC
  - Rural HPSA, non-MSA or demo project
- Eligible Practitioners
  - Physician, PA, NP, CNS, Nurse midwife, clinical psychologist, CSW, registered dietician/nutrition
- Interactive telecommunication system
- PC Payment (where practitioner located)
  - Paid same as if treatment in person
- Facility payment (where patient located)



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## ■ ■ ■ Telemedicine Update

- Eligible Services
  - Initial & follow up I/P consultations
  - Office or other o/p visits
  - individual psychotherapy
  - Pharmacologic management
  - Psychiatric diagnostic exams
  - ESRD related services
  - Medical nutrition therapy
  - Neurobehavioral status exam
  - Health behavior assessment
  - Subsequent hospital and SNF care
  - Kidney disease & diabetes education/management



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## ■ ■ ■ Telemedicine Update

- Proposed addition for 2012
  - Smoking cessation services
- Requested but denied by CMS
  - Critical care services
  - Domiciliary & rest home E&M services
  - Genetic counseling services
  - Online E&M
  - Data collection services
  - Audiology



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## Physician Lab Signatures-NOT

- 11/29/2010 Medicare Final PFS 2011
  - Physician or NPP signature required on all lab requisitions for hospitals/CAHs/etc
- 12/2010 CMS suspended enforcement thru 1<sup>st</sup> quarter 2011
- 2/2011 further delay for replay booth review
- 6/30/2011 CMS Published Proposed rule retracting requirement
- "It was a good death"



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## Hospital DRG VBP Program

- Deficit Reduction Act of 2005 required CMS to develop a plan to implement a VBP program for hospital beginning in 2009
- CMS submitted VBP plan to Congress in 2007
- November 2008, Senators Max Baucus and Charles Grassley released draft legislation requiring CMS to implement a VBP program
- Language became part of the Patient Protection and Affordable Care Act (Affordable Care Act)



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## Hospital DRG VBP Program – Final Rule

- Final Rule published on May 6, 2011
- Starting October 2012, Medicare will "reward hospitals that provide high quality care for their patients through the new Hospital Value-Based Purchasing (VBP) program" (CMS Fact Sheet)
- Incentive payments for hospitals that meet or exceed performance standards
- Funded by reducing base operating DRG payments for each discharge by 1% (2% by 2017)
- CMS estimates that \$850 million in DRG payments will be redistributed under VBP Program



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## ■ ■ ■ Hospital DRG VBP Program – Final Rule

- Includes:
  - performance measures
  - performance standards
  - scoring methodology
  - methodology for translating hospitals' Total Performance Scores into value-based incentive payments
- Adjusts current operating DRG payment amount based on quality standards and comparisons



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## ■ ■ ■ Hospital DRG VBP Final Rule

- What it is NOT:
  - More money into the system – budget neutral
  - Bundling (beyond current levels)
    - By Provider: Hospital, SNF, HHA, Hospice, ASC etc.
    - Does not combine any of these, nor physician services
  - Capitation
    - Global – (per member per month)
    - Episode of Care
    - Condition Specific
  - Shared savings (ACO concepts)



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## ■ ■ ■ Hospital DRG VBP Program – Impact

- In Context: Total payments = \$85 billion
  - FFY 2013 - \$850 million or 1%
  - FFY 2014 - \$1.062 billion or 1.25%
  - FFY 2015 - \$1.275 billion or 1.5%
  - FFY 2016 - \$1.487 billion or 1.75%
  - FFY 2017 - \$1.7 billion or 2.0%
- Budget Neutrality means:
  - Everyone gets 99% of what they would have otherwise received (98% by FFY 2017)
  - The difference is redistributed



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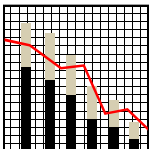
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## ■ ■ ■ Hospital DRG VBP Program – Impact

- So What Can 1%-2% Really Matter?
  - Revenue lost falls to bottom line
  - 1% or 2% on 50% or more of volume...
- Operating Margins?
  - Thomson Reuters March 2011 Report
    - All Hospitals – 2.8%
    - Medium Community – 1.8%
    - Small Community – 3.7%
  - Per WHA Info Center 2009 Report
    - Group 1 <2500 d/c's = 6.7%
    - Group 2 <2501-3500 d/c's = 5.8%
    - Group 3 <3501-6700 d/c's = 6.6%



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## ■ ■ ■ Hospital DRG VBP Program – Who

- Applies to “subsection d” hospitals
  - PPS-DRG Paid facilities
- Does NOT apply to:
  - Excluded hospitals and units:
    - Rehab, psych, long term care, children’s and cancer hospitals.
    - Critical Access Hospitals
- Hospitals that fail to submit quality reporting are excluded from VBP adjustment for that year
  - CMS will monitor “opt out” behavior



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## ■ ■ ■ Hospital DRG VBP Program – Performance Period

- FY 2013 for clinical process of care and patient experience measures:
  - Baseline Period: 7/1/2009 to 3/31/2010
  - Performance Period: 7/1/2011 to 3/31/2012
- FY 2014 for 30-day mortality outcome measures:
  - Baseline Period: 7/1/2009 to 3/31/2010
  - Performance Period: 7/1/2011 to 6/30/2012
- Beyond that – not addressed
- Affects DRG Payment beginning 10/1/12
  - CMS notifies hospital of estimated VBP impact at least 60 days prior (8/1/12)
  - CMS Notifies of final impact for FFY 2013 on 11/1/12



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## ■ ■ ■ Hospital DRG VBP Program – Quality Measures

- Adopts performance measures, drawn from the measures set that hospitals have been reporting on under the Inpatient Quality Reporting program
- CMS adopted 12 of the 17 clinical quality measures initially proposed
- Also includes the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experiences with care survey.
- Clinical measures account for 70% of a hospital's score and HCAHPS 30%
- For FY 2014, will add mortality measures, hospital-acquired condition measures, and two AHRQ indicators



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## ■ ■ ■ Hospital DRG VBP Program – Performance Standards

- Scores calculated by evaluating hospital's achievement and improvement across all three domains (and consistency for patient experience):
  - Clinical Process of Care (FY 2013 and 2014)
  - Patient Experience (FY 2013 and 2014)
  - Outcome (FY 2014 only)
- Hospital will receive the higher of an achievement score and an improvement score



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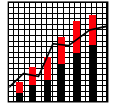
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## ■ ■ ■ Hospital DRG VBP Program – Performance Standards

- Achievement Point:
  - A hospital can earn points for achievement if the hospital performs at least as well as half of all hospitals on a given measure during the performance period.
- Improvement Point:
  - A hospital can earn points for improvement if the hospital exceeds its own baseline period performance.



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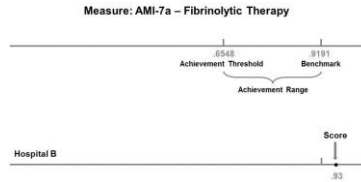
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## Example A (from Final Rule)

Figure 1. Example of Hospital Earning Points by Exceeding Benchmark, Clinical Process of Care and Outcome Measure Scoring Under Three-Domain Performance Scoring Model



Hospital B earns: 10 points for achievement performance exceeding the benchmark  
 Hospital B score: 10 points on this measure

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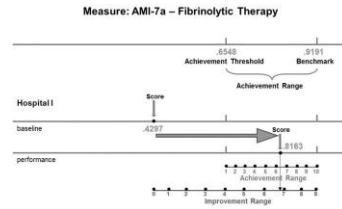
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## Example B (from Final Rule)

Figure 2. Example of Hospital Earning Points by Achievement or Improvement, Clinical Process of Care and Outcome Measure Scoring Under Three-Domain Performance Scoring Model



Hospital I earns: 8 points for achievement  
 7 points for improvement  
 Hospital I score: maximum of either achievement or improvement = 7 points on this measure

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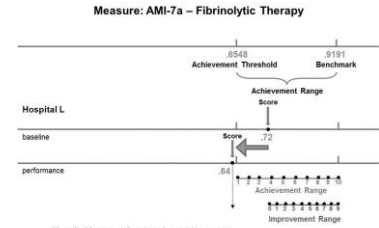
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## Example C (from Final Rule)

Figure 3. Example of Hospital Earning No Points, Clinical Process of Care and Outcome Measure Scoring Under Three-Domain Performance Scoring Model



Hospital L earns: 0 points for achievement  
 0 points for improvement  
 Hospital L score: maximum of either achievement or improvement = 0 points on this measure

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## Hospital DRG VBP Program – Incentive Payment



- As noted earlier, VBP incentive pool funded by reducing participating hospitals' base operating DRG payments by 1%
- Hospitals that meet or exceed performance standards will receive an increase in DRG payment amount
- Increase determined by: DRG payment amount X value-based incentive payment percentage
- Higher achievement/improvement scores = higher value-based incentive payment percentage
- **Not all hospitals will earn back the 1% reduction**

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## Hospital DRG VBP Program – Impact

Sample VBP Incentive Payment Calculation						
Annual Medicare Revenue	% of DRG payment withheld	\$ amount withheld	VBP % increase in payment (after withholding)	Incentive Payment	Net loss/gain %	Net loss/gain
\$20,000,000.00	1.00%	\$200,000.00	0.02360%	\$4,720.00	-0.98%	(\$195,280.00)
\$20,000,000.00	1.00%	\$200,000.00	1.8170%	\$363,400.00	0.82%	\$163,400.00
\$20,000,000.00	2.00%	\$400,000.00	0.04720%	\$9,440.00	-1.95%	(\$390,560.00)
\$20,000,000.00	2.00%	\$400,000.00	3.6340%	\$726,800.00	1.63%	\$326,800.00

In the Final Rule, CMS estimates that the lowest-scoring hospital for FY 2013 will receive a 0.0236 percent increase in payments and that the highest-scoring hospital will receive a 1.817 percent increase in payments under the program.

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## VBP – Who is Next

- LTCH, Rehab, Psych, Cancer and Hospice
  - Quality Reporting in 2014
  - Pay for performance pilots by 2016
- SNFs ASCs and HHAs
  - VBP implementation plans by 10/1/2011
- Physician Fee Schedule
  - Quality data reporting bonus payments
  - Value based payment modifier by 2015
- DRG Hospitals
  - Readmission reduction program - 10/1/2013
  - Hospital acquired conditions 1% reduction – 10/1/2015



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## VBP – Applied to CAHs???

- Failure to Achieve Meaningful Use as a Role Model? Penalty is:
  - FFY 2015 101% down to 100.66%
  - FFY 2016 101% down to 100.33%
  - FFY 2017 and later 100%
  - Applies to all inpatient costs
- Not much of a stretch to:
  - Knock 1% - 2% off of 101%
  - Pay everyone 99% - 100% of Medicare Costs
  - Take the 1%-2% and redistribute based on quality scores



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## Shared Saving Program

- Accountable Care Organizations
- Medicare will start contracting with ACOs in January 2012
- 3-year contract with CMS
- Evidence-Based Medicine:
  - To participate in the shared savings program, the ACO must document in its application its plans to:
    - Promote evidence-based medicine;
    - Promote beneficiary engagement;
    - Report internally on quality and cost metrics; and
    - Coordinate care



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## Shared Saving Program

- Who is eligible to form ACOs:
  - ACO professionals in group practice arrangements
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospital and ACO professionals
  - Hospitals employing ACO professionals
  - Such other groups of providers of services and suppliers as the Secretary determines appropriate
- ACO Professionals = physicians
- CAHs can participate but not form



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## Shared Saving Program

- Quality of Care Measures and ACO Performance Scoring:
  - The ACA requires the secretary to implement measures to assess the quality of care furnished by an ACO. This includes:
    1. Measures of clinical processes and outcomes;
    2. Patient (and where practicable) caregiver experience of care;
    3. Utilization (e.g. hospital readmission rates).



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## Shared Saving Program

- ACO Submission of Quality Data
- Following the performance period each ACO is required to report on 65 proposed quality measures with respect to services furnished to assigned ACO beneficiaries during the performance period.
- In order to be eligible to share in savings must meet the 65 specified measures.

REPORT CARD	
MEASUREMENT PERIOD	PERFORMANCE
ACUTE CARE	A
CHRONIC DISEASE MANAGEMENT	A
PREVENTIVE CARE	C
POPULATION HEALTH	B
QUALITY OF CARE	A
VALUE	C
WELL-BEING	B
WELLNESS	B
WOUND CARE	B

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## Shared Saving Program

- Providers in an ACO will receive shared savings based upon meeting cost savings benchmarks developed by CMS.
- Providers and suppliers will continue to receive fee-for-service payments under Part A and B
- Shared savings eligibility requires the ACO to meet:
  - All contract requirements;
  - Quality performance standards; and also
  - Achieve savings under an established benchmark that exceeds the ACO's assigned "minimum savings rate"



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## Shared Saving Program

- Two risk-sharing models:
- One-sided risk model: savings are shared for the first 2 years. In year 3, both savings and losses are shared (50% of the savings are shared).
- Two-sided risk model: savings and losses are shared for all 3 years (60% of the savings are shared).



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## Shared Saving Program

- From Inside Looking Out
  - For services avoided at controlled providers
    - Trigger payment @50%-60% of what would have been paid if services had been done
    - But → For doing no services
    - As long as variable costs >40%-50%
    - Or seen the other way: if fixed costs <50%-60%
    - This is a winning proposition
  - For services that would have been done at unrelated providers:
    - Receive 50%-60% of revenue they would have otherwise received
    - No cost – other than incremental investment in quality and care management process



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## Shared Saving Program

- From Outside Looking In
  - For services ACO manages away from you
    - Revenue Lost
    - Fixed costs remain
    - ACO gets 50%-60% of what you would have
  - Have needed services
  - Contractual collaboration?
    - Share info
    - Participate in clinical pathways etc..
    - Get some financial participation in shared savings



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## ■ ■ ■ Beyond Current VBP/SSP ...

- ACA 3023: National Pilot Program on:
  - Hospital, physician & post acute care bundling
  - 1/1/2013 for 5 years, with authority to expand
- ACA 3052: Grants for development of medical home models
- ACA 2704: 8 state demo project for Medicaid hospital-physician bundling
- and more....



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## ■ ■ ■ Strategy?



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## ■ ■ ■ Old School

- Volume, volume, volume
- More Service Lines
- More Patients
- More Services to Patients
- Big pipeline – many service lines
- Lots going through it
- Some leakage didn't hurt the pocketbook



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## Preaching to the Choir

- Wisconsin hospitals/healthcare already at or near the top – so keep it up:
- Because current mechanisms are still layered on top of fee for service:
  - Volume still matters, but ...
  - Leakage (quality declines) could put a big dent in margins and therefore sustainability
- So... Quality, Quality, Outcomes....
  - Invest in quality process
  - Patient satisfaction
  - Focus on fewer service lines?



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## After Quality....

- Forces of:
  - Expanded Bundling Initiatives
    - to include physician services, and
    - spectrum of providers
  - ACO Implementation
- Will dictate mechanisms for:
  - coordination of treatment protocols & outcomes management
  - sharing of economics across provider types
- Collaboration by contract....?
- Even more..... Integration ?
  - Vertical & Horizontal



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## 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



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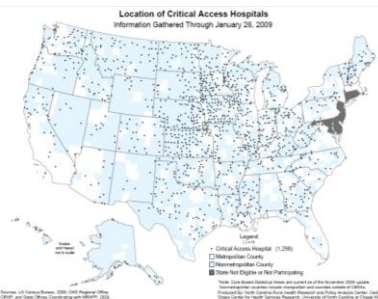
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## CAH Program



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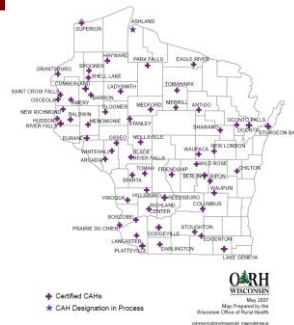
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## Wisconsin's Critical Access Hospitals



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## 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!

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## 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



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## OIG Audit



- CAH selected for OIG Office of Audit Services Review – 10-1-07 for 2004-06 years
- Initial Request
  - Ownership, org chart, job descriptions, list of all employees
  - Policies & procedures as related to CoPs, cost reports, accounting
  - Annual reports, audited F/Ss & surveys of CAH
  - Chart of accounts
  - Cost reports & workpapers
  - List and copies of agreements with related parties

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## OIG Audit

- 3-4 OIG OAS personnel spent 4 months @ CAH
  - No CPAs or staff with prior cost report or COP background
  - Asked for depreciation and asset records, serial #s, for hospital beds
  - CAH set up point person for process and logged all info provided to OIG



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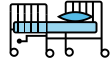
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## OIG Audit



- Preliminary Findings:
  - Failed CoPs due to >25 beds
  - Bed roster included:
    - 4 swap out beds stored in non-patient areas for replacement parts
    - 2 bassinets for infants to swap for adult beds when needed
  - Claimed unallowable costs of:
    - 2005 - \$61,912 penalties for late lease payments
    - 2006 - \$1,033 lobbying costs

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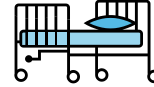
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## OIG Audit



- CAH Response
  - Notified FI on costs
    - FI reopened 2005 to adjust
    - FI passed on 2006 – too small to bother
  - Fought tooth & nail on 25 beds
    - VP-Nursing had been at hospital association conference that discussed a CMS Open Door forum in which CMS speakers said swap out beds not counted
    - We had position that such beds stored in non-patient areas should not count
  - After much back & forth, OIG Final Report in 12/2009 agreed on bed count issue

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## 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 M/SR 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

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## 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



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## 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 o/p 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!!!



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## 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



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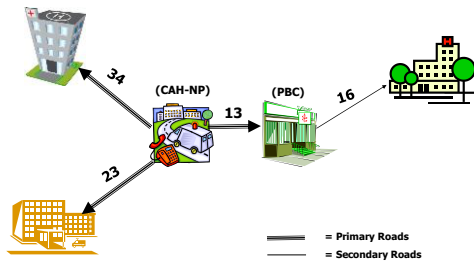
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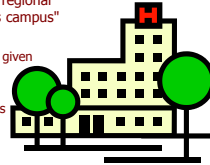
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## Off Campus Clinic Location Example



## 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?




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## 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

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## 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 1<sup>st</sup> 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

**CAUTION**

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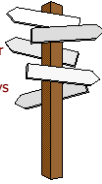
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## CAH: Relocations

- 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 CAH
  - Primary roads = Federal highways & state highways with 2 or more lanes in each direction
- Midwest states may not have originally used 15 mile rule. CMS has approved a NP switching to 15 mile status to allow a move



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## NP CAH Relocation

- CMS Position not CAH friendly
- If relocating NP CAH does not satisfy original NP criteria AND 75% tests then - deemed a closed business
  - CAH provider agreement is terminated
  - Would need to recertify as a PPS hospital
- CMS position that it can reassess NP and 75% up to 1 year AFTER move – **Blind Leap Effect!**



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## Method II Rescue



- PPACA – HC Reform & 2011 IPSS Final Rule
  - Changed statute to clarify CAHs paid 101% for both Method I and II
    - **Effective retroactively**
    - FIs should not apply 100% to Method II electing CAHs for cost reporting periods beg'g on or 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



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## 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



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## 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...



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## 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) (huh?)
  - 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



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## Cost Reimbursement for Lab

- 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?



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## CAH TRICARE Reimbursement – Final Rule

- Currently CAHs paid same as any other hospital – I/P DRGs and O/P fee schedule
- 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



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## 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



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## 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



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## Health Professional Shortage Area

### Why do I care?

- National Health Service Corps LRP
  - Assigned professionals can only be sent to HPSAs
- FQHCs – MUPs
- RHCs
- 10% PFS Bonus Payments
- J-1 Waivers: Waiver of the "return home" requirement (2 year) in return for 3 year HPSA/MUA stay
- CMS proposing to score ALL existing MUA/HPSA upon publication of the Final Rule
- Consider "Governor's HPSA" – only RHC



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## Hospital Based RHC

- Must be in a HPSA
- Exempt from rate/visit because CAH's < 50 bed hospital
- Cost reimbursement for:
  - Facility component AND
  - Professional component
- Non-RHC services at site billed as hospital services
- Provider based 35 mile rule N/A
- Provider based public awareness rule N/A



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**2012 Medicare Issues: New  
Developments and Old Issues**

**Thank you!**

By: David H. Snow  
Hall, Render, Killian, Heath & Lyman, PC  
August 30, 2011

