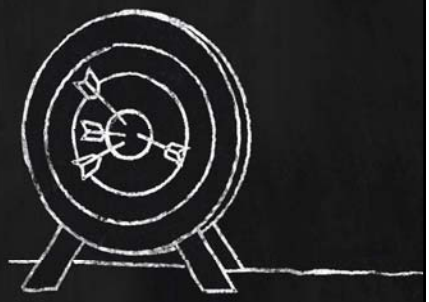
Critical Access Hospital and
Rural Health Clinic Conference

Focusing on the Quadruple Aim

Provider-Based Hospital Departments – Are We Compliant?

May 4, 2017



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AGENDA

- Reasons for Hospital/Clinic Integration
- History of Provider-Based Regulations
- Provider-Based Requirements
- Benefits of Attestation
- Shared Space
- Medicare Options for Physician Clinics Owned by Hospitals
- Evaluating the Benefits
- Helpful Hints

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Reasons for Hospital/Clinic Integration

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Provider-Based

Provider-based is a Medicare billing status and process for physician services that are provided in a hospital outpatient department

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Provider-Based

Reasons for Hospital/Clinic Integration:

- Strengthen relationships
- Diversify hospital services
- Reduce duplication of ancillary services, gain efficiencies
- Enhance public image
- Expand market share
- Utilize hospital's credit rating
- Enhance reimbursement
- Create a unified system

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History of Provider-Based Regulations

History of Provider-Based Regulations

- The final rules for implementing the prospective payment system for outpatient hospital services were issued on April 7, 2000
- Previous to the publication of the provider-based requirements in the Federal Register, the provider-based concept was loosely defined and interpreted
- Various changes were made on August 3, 2000; December 21, 2000; November 30, 2001; and August 1, 2002
- In August 2002, CMS made important distinctions between the requirements for on-campus and off-campus sites
- CMS furnished further clarification of its policies in Program Memorandum A-03-030 published on April 18, 2003

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History of Provider-Based Regulations

- January 1, 2008 — Provider-based locations created or acquired by a CAH must be 35 miles (or 15 miles over secondary roads or mountainous terrain) from another hospital or CAH
  - The rule does not apply to provider-based RHCs
  - Off-campus provider-based arrangements established prior to January 1, 2008, were grandfathered
- November 2, 2015 — Bipartisan Budget Act of 2015 signed
  - Section 603 impacted OPPS hospital off-campus locations
  - Effective January 1, 2017

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History of Provider-Based Regulations

- December 13, 2016 – 21st Century Cures Act signed
  - Provides an exception for off-campus provider-based departments that were mid-build or under development prior to November 2, 2015
  - Must meet all of the following requirements to be eligible for the full OPPS payment rate beginning January 1, 2018:
    - File a provider-based attestation within 60 days after the date of enactment of the Cures Act
    - Submit a change to the 855A enrolling the location
    - Off-campus department meets the definition of "mid-build" and submits certification within 60 days of the enactment of the Cures Act

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History of Provider-Based Regulations

- CMS released "Guidance" in November 2008 regarding regulatory changes and clarification of existing provider-based regulations for CAHs
  - New Requirement: Advance determinations of Compliance required for new provider-based sites
    - CAHs intending to open off-campus provider-based facilities must seek "an advance determination of compliance" from CMS
    - CMS stated that any CAH with an off-campus provider-based facility established on or after January 1, 2008, was required to submit an attestation detailing compliance
      - Regulation states may submit attestation

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History of Provider-Based Regulations

- Clarification: Provider-based determinations are site-specific.
  - If a CAH relocates a grandfathered off-campus provider-based facility after January 1, 2008, the new off-campus site must comply with the distance requirements and all other provider-based rules at the new location. If the new site does not meet the requirements, it must either surrender its provider-based designation or the hospital will lose CAH status.
- Clarification: Off-campus distinct part units, psychiatric and rehab, must meet CAH distance requirements.
- If an OPPS relocates a grandfathered off-campus provider-based facility, the new site will no longer be grandfathered unless it meets specific rules – acts of God.

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History of Provider-Based Regulations

- Clarification: Termination of Medicare Provider Agreement for non-compliant provider-based locations.
  - The first time a CAH is found to be out of compliance with the distance requirements it is subject to termination of its Medicare provider agreement.
  - The offending CAH would have 90 days to prove to CMS the determination was incorrect or convert the provider-based clinic to a freestanding clinic.
  - Alternative: The CAH would need to apply for Medicare certification as an acute-care hospital and receive reimbursement under the DRG payment system.

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History of Provider-Based Regulations

- Bipartisan Budget Act of 2015

  As of January 1, 2017, PPS hospitals are no longer able to receive full OPPS payments for any facility that had not billed provider-based prior to November 2, 2015, unless they become excepted under the Cures Act.

  - The law does not affect on-campus hospital departments.
  - Critical Access Hospitals (CAHs) are excluded from the amendment to the law.

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History of Provider-Based Regulations

January 1, 2017 – Billing

- Professional billing:
  - POS 19 – "Off Campus – Outpatient Hospital"
  - POS 22 – "On Campus – Outpatient Hospital"
- Technical (facility) billing:
  - "PO" modifier for all excepted off-campus provider-based outpatient department services. 100% OPPS rate. Does not apply to Critical Access Hospitals.
  - "PN" modifier for all non-excepted services on the facility bill in off-campus provider-based outpatient departments. 50% OPPS rate. Does not apply to Critical Access Hospitals.

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History of Provider-Based Regulations

- Bipartisan Budget Act of 2015
  - Rural Health Clinics (RHCs) that are owned and operated by hospitals are excluded from the amendment to the law because they are not departments of a hospital, rather they are provider-based entities due to their separate enrollment and certification process. In addition, RHCs are not paid under OPPS. Therefore, hospitals should be able to establish new off-campus provider-based RHCs on or after November 2, 2015.
  - However, for provider-based RHCs that are established after November 2, 2015, there is some question as to how the off-campus payment for non-RHC services will be paid.

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History of Provider-Based Regulations

Regulation References:

- 42 CFR 482 (Hospital CoP)
- 42 CFR 488 Subpart A (Accreditation & Survey Rules)
- 42 CFR 489 (Provider Agreement)
- 42 CFR 413.65 (Provider-based)
  - Transmittal A-03-030 (Sample Attestation)
  - 42 CFR 485.610(e)(2) (CAH Distance Requirements)
- Section 148 of MIPPA (CAH Lab - effective July 1, 2009)
- Bipartisan Budget Act of 2015 (PPS – effective January 1, 2017)
- CMS 2017 OPPS rules (effective January 1, 2017)
- 21st Century Cures Act – December 13, 2016

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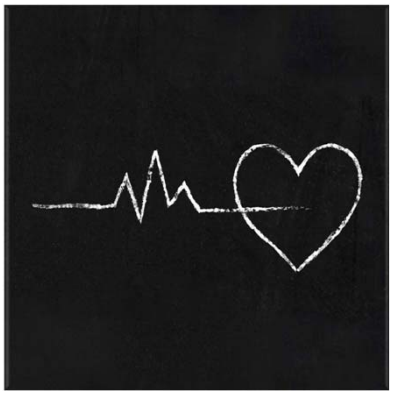

Provider-Based Requirements

Requirements

Provider-Based Requirements:

1. Distance requirement
2. Operate under the same license as the main provider (unless otherwise required by State law)
3. Clinical integration
   - Integrated medical staff
   - Integrated medical records
   - Quality monitoring

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Requirements

Provider-Based Requirements (Continued):

4. Public awareness
   - Signage
   - Name badges
   - Advertising
   - Patient bills
   - Registration forms
   - Telephone

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Requirements

Provider-Based Requirements (Continued):

5. Ownership
   - If the department is off-campus, it must be 100% owned by the provider
   - If it is on-campus and a joint venture, it must be on the campus of the billing facility
6. Control
   - Same governing body
   - Common bylaws
   - Main provider's governing body has final approval over administrative decisions, contracts, and personnel matters

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Requirements

Provider-Based Requirements (Continued):

7. Administration and supervision
   - Same supervision as any other department
   - Reporting relationship
   - Professional staff must have hospital privileges
8. Financial integration
   - Must be included in hospital trial balance
   - Must be included in the allowable cost centers on Medicare cost report, same as any other hospital department

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Requirements

Provider-Based Requirements (Continued):

9. Provider must employ all non-management staff who provide patient care. Clinic management and providers who are paid by Medicare under a fee schedule may be contracted
10. Medicare patients must be registered as hospital patients
11. Non-discrimination provisions apply to providers
12. EMTALA obligations
    - On campus – apply as part of hospital
    - Off campus – apply if held out as Urgent Care or > 1/3 patient visits are unscheduled

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Requirements

Provider-Based Requirements (Continued):

13. Inpatient of hospital – 3-day payment window applies to all facility components for services in the provider-based entity AND all diagnostic and related therapeutic professional components
14. Off-campus sites must provide notice of dual co-insurance to each Medicare patient before service is provided (unless emergent service)

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Benefits of Attestation

Benefits of Attestation

Benefits of submitting an attestation:

- An attestation is a voluntary signed statement by the provider stating it meets all required provider-based criteria
- Triggers self-review of criteria
- Provides written support of compliant process
- Educates staff on requirements
- CMS recoups excess payment, if provider is found to be non-compliant. If CMS accepts the attestation following the review, it will limit recoupment if the facility is later determined to be out of compliance. Without a reviewed attestation on file, CMS can recoup as far back as the applicable statute of limitations allows.

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Shared Space

Shared Space

CMS regional offices are increasingly restrictive in their review and approval of shared space/mixed-use sites.

- Mixed-Use Sites: Provider-based vs. Freestanding
  - No formal guidance in regulations or otherwise
  - Only CMS enforcement practice: learned through attestations and discussion with CMS representatives
- CMS requiring more separation of the freestanding vs. provider-based space (*However, not necessarily including Rural Health Clinics – discussed later*)
- CMS recently trained accrediting organizations, such as the Joint Commission, on shared-space arrangements in provider-based settings

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Shared Space

What will CMS be looking for when reviewing?

- All certified hospital space, departments, services, and/or locations:
  - Must be under hospital's control 24/7
  - Cannot be "part-time" with the hospital and "part-time" with another hospital, ASC, physician office, or any other activity
  - Required to be "the hospital" 24/7, however, outpatient departments are not required to be open for business 24/7

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Shared Space

What will CMS be looking for when reviewing (Continued)?

- Features such as:
  - Shared entry ways
  - Interior hallways
  - Treatment rooms
  - Waiting rooms
  - Registration

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Shared Space

What will CMS be looking for when reviewing (Continued)?

- Building plans that do not clearly define hospital space as a distinct space are an indicator of mixed-use
- CMS enforcement position appears to be based on:
  - State Operations Manual § 2026 and the CoP requirement that a hospital or a department be a "singular unit" dedicated in its entirety to hospital purposes and the treatment of hospital patients
  - Public awareness requirement

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Medicare Options for Physician Clinics Owned by Hospitals

Medicare Options For Physician Clinics

- Physician Office
  - "Freestanding" from a billing, not location, standpoint
- Hospital or Critical Access Hospital Outpatient Department (HOPD)
  - Synonymous with Provider-Based Clinic/Department
  - Billing and payment similar to emergency room visit
- Rural Health Clinic (RHC)
  - Freestanding
  - Hospital-Based RHC (Provider-based "entity," not department)

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Medicare Options For Physician Clinics

Medicare Reimbursement Options for Physician Services

Provider Type:	Free-Standing Clinic	Free-Standing RHC	Provider-based Clinic	Provider-Based RHC
Rural Hospital < 50 beds	A	B	C	E
Critical Access Hospital	A	B	D	E
Hospital > 50 beds	A	B	C	B

Clinic Type

A: Global clinic reimbursement on Medicare physician fee schedule.

B: Cost-based reimbursement for all RHC services, professional and facility combined; subject to Medicare maximum limit per encounter.

C: Medicare physician fee schedule payment for professional services, reduced for hospital site-of-service; APC payment for facility component.

D: Medicare physician fee schedule payment for professional services, reduced for hospital site-of-service; cost-based CAH payment for facility component.

E: Cost-based reimbursement for all RHC services, professional and facility combined; not subject to Medicare maximum limit per encounter, i.e., full cost reimbursement.

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Medicare Options For Physician Clinics

Physician Office (i.e., Freestanding Clinic)

- Enroll location(s) under 855B Supplier #
- Bill on Form 1500 with Supplier # and Physician NPI
  - POS Code 11 (physician office) – Global
    - Facility/technical component (TC) and
    - Professional component (PC)
- Paid by CPT code – Medicare Physician Fee Schedule (PFS)
- No Entity Level Conditions of Participation (COPs)
- No Medicare co-location (mixed-use) restrictions
- Only compliance issue is Stark laws (if leasing to physician owned group)

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Medicare Options For Physician Clinics

Hospital Outpatient Department (includes CAH)

- Enroll location(s) Enrollment for Site
  - For TC on 855A under Hospital Provider #
  - For PC on 855B under Group Clinic # or CAH Provider
  - Form 855R if physicians reassign Part B# (of Hospital) or to CAH Provider # if Method II
- Split Billing
  - TC on UB-04 Hospital Provider # as O/P Service (APCs/Cost)
  - PC on 1500 (POS code 19/22) – Paid on fee schedule; or
    - If Method II in CAH O/P departments on UB-04, paid on fee schedule +15% (on Medicare payment portion only)

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Medicare Options For Physician Clinics

Hospital Outpatient Department (includes CAH) (Continued)

- Site must meet provider-based requirements
- Site subject to all Hospital COPs previously discussed:
  - CMS's exclusive use interpretation – 24/7/365 for hospital
  - AND, physically segregated from any other provider or supplier operations

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Medicare Options For Physician Clinics

Freestanding Rural Health Clinic (RHC)

- Enroll under 855A as RHC
  - Covers TC & PC for Physician & midlevel service E&M
  - Surveyed – Based on RHC COPs by:
    - Medicare through state DHS, or
    - Accrediting body for deemed status
- Bill for RHC services on UB-04 – Global payment at cost subject to per visit limit (2016 RHC cap is $81.32)
- Bill for ancillary services under Part B clinic supplier #
  - Paid at fee schedule by CPT code
  - Co-location of other provider-types allowed for RHC status

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Medicare Options For Physician Clinics

Provider-Based RHC

- Same RHC COPs as Freestanding RHC
- Must meet most of same provider-based requirements as HOPD
  - Exempt from: 35 mile distance test, public awareness, split billing notice
- If provider-based to <50 bed Hospital, then exempt from the RHC cap
  - Provider-based RHCs often greater than $200 per encounter
  - Bill ancillaries under Hospital Provider #
- **Caution!** CMS Regional Offices differ on application of off-campus provider-based requirements/restrictions and CAH location test related to services billed as Hospital services (i.e., the non-RHC services, like lab and technical component of other diagnostic test)

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Evaluating the Benefits

Provider-Based Clinics

Evaluating Benefits vs. Costs of Converting to Provider-Based Clinic Status

Financial Analysis

- Reimbursement impact
- Conversion costs

Physician Relations

- Employed versus contract physicians
- Productivity measures

Strategic Objectives

- Internal politics
- Community relations/perceptions
- Competition

Helpful Hints

Helpful Hints

- Evaluate your provider-based facilities – Internally audit for compliance with ALL provider-based requirements
- Consider whether your use of space has CHANGED since your originally attested to/claimed provider-based status
- Evaluate each freestanding clinic to which you lease space and how it interacts with your provider-based facilities – keep them separate!
- Ensure billing is properly identified and using the proper modifier(s) and POS code
- For facilities that may no longer meet provider-based criteria, remember that the hospital's ability to take advantage of 340B drug pricing is affected


Questions?
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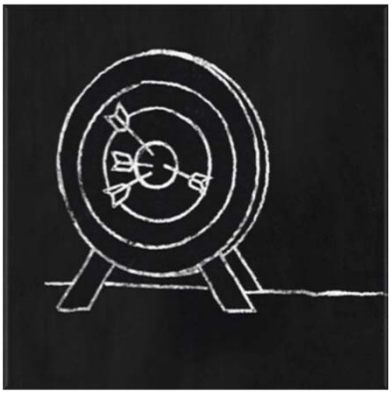

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