Health Financial Systems User Meeting 2016

Critical Access Hospital Issues

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Areas of Focus

- History of Critical Access Hospitals (CAH)
- Review of past Office of Inspector General (OIG) studies
- Review of recent Center for Medicare and Medicaid Services (CMS) interpretations
- Review of recent Medicare Administrative Contractor (MAC) interpretations
- Future of CAHs

CAH History

CAH Facts

- Created in the 1997 Balanced Budget Act to ensure that hospital care is accessible to beneficiaries in rural communities.
- Meet location requirements or be designated prior to 1/1/2006 as a "necessary provider".
    - More than 35 miles from nearest hospital or CAH (15 miles in mountainous terrain or only secondary roads).
- More than 1,300 CAHs make up nearly 30% of acute care hospitals in the US.
- CAHs have a presence in all but five states.

CAH History

- Reimbursed at 101% of reasonable inpatient (including Swing Bed) and outpatient costs. (Traditional hospitals receive approximately 93% of their costs).
- Receive approximately 5% of total Medicare payments to hospitals.

OIG Studies

August 2013

- Focused on CAH Location Requirements
  - Found that nearly two-thirds of CAHs would not meet the location requirements.
    - 849 CAHs (64%) would not meet location requirements
    - 88% of the 849 are necessary providers

OIG Studies

August 2013 (cont.)

- OIG Recommendations
  1. Seek legislative authority to remove necessary provider exemption.
  2. Revise the CAH conditions of participation to include additional location-related requirements.
  3. Ensure periodic reassessment of CAH's compliance to location-related conditions of participation.
  4. Ensure application of uniform definition of mountainous terrain to all CAHs.

  (CMS concurred with 1, 3 and 4)

OIG Studies

October 2014

- Focused on Medicare Beneficiary's payments for Outpatient Services at CAHs.
  - Found that Medicare beneficiaries paid nearly half the costs of outpatient services at CAHs.
  - Found the average percentage of costs that beneficiaries paid in coinsurance increased 2 percentage points between 2009 and 2012.
  - For 10 outpatient services frequently provided at CAHs, beneficiaries paid between 2 and 6 times the amount in coinsurance than they would have paid for same services at acute-care hospital (IPPS).

OIG Studies

October 2014 (Cont.)

- OIG Recommendation
  1. CMS seek legislative authority to modify how coinsurance is calculated for outpatient services received in CAHs

(CMS neither concurred nor did not concur with the OIG recommendation.)

OIG Studies

Other Observations

- CAHs receiving "enhanced" payments or "additional" payments by being paid 101% of reasonable costs.
- Seeing more hospital outpatient interim rates set below 20%.

CMS Interpretations

- Location Requirements
- Provider Based Entities

CAH Location Requirements

- Being reviewed during Revalidation Process
- Not applicable to Necessary Providers
- Definition of "nearest hospital"
    - Excluded IHS/Tribe-owned Hospitals
    - Included IPPS, Psychiatric, Rehab, Cancer, LTCH, or Children Hospitals
- Recent Example

Provider-based Clinics

Applicable Regulations
42 CFR 413.65

Unique Cost Report Implications:

- Cost reimbursement for technical services (nonphysician staffing/plant) vs fee schedule/non-reimbursable cost center on cost report
- Removal of Physician costs per Worksheet A-8-2
  - Allowable – Administrative/Directorships
- Removal of Physician Billing costs per Worksheet A-8
- Identifying facility revenue (technical fees) for Worksheet C

Provider-based Clinics

Recent Developments

- Shared Space between Provider-based Clinic and Physician Specialists
- Insufficient coinsurance notification to beneficiaries
- New legislation effective November 2, 2015

Provider-based Clinics

Shared Space Issue

CMS recent guidance involving shared space between provider-based clinic and visiting specialists:

- Any leased space to visiting specialists must:
  1. Be a separate clinic space
  2. Have its own entrance/waiting area
  3. Have signage that clearly identifies it as not being part of the hospital's clinic
- Recent actions resulted in CMS terminating provider-based status immediately for the hospital's clinics.

Provider-based Clinics

Shared Space Issue

Solutions

1. Relocate visiting specialists to dedicated space, i.e. - not being utilized by any other hospital department
2. Contract for services of visiting specialists and bill provider-based methodology
3. Convert provider-based clinic to freestanding clinic

RHC Implications

Provider-based Clinics

Insufficient Coinsurance Notification Issue

Per 42 CFR 413.65(d)(5) and (g)(7)(i): (Off-Campus Only)

The hospital must provider written notice to the beneficiary, before delivery of the services, of –

(A) The amount of the beneficiary's potential financial liability; or

Provider-based Clinics

(B) If the exact type and amount of care needed are not known, an explanation that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility and a statement that the patient's actual liability will depend upon the actual services furnished by the hospital.

Provider-based Clinics

New Legislation **(Does Not Affect CAHs, be aware)**

Sec. 603 of Bipartisan Budget Act of 2015

- Enacts site-neutral payment reductions for Medicare services furnished in new off-campus provider-based (PB) hospital outpatient departments (HOPDs) that are not dedicated emergency departments.

- "new" defined as an entity that started billing Medicare outpatient services on or after Act's date of enactment (November 2, 2015)

Provider-based Clinics

- New off-campus PB HOPDs would not be eligible for reimbursement from CMS OPPS beginning January 1, 2017.

- Instead, these entities would be reimbursed from other Medicare Part B payment systems as appropriate:
  - Physician Fee Schedules
  - Ambulatory Surgery Center Payment System
  - Clinical Laboratory Fee Schedules

Provider-based Clinics

- Off-campus PB HOPDs billing under the OPPS before the bill's enactment date would be grandfathered in and would not be subject to the site-neutral payment reductions and could continue to bill Medicare and receive payments under OPPS beyond January1, 2017.

MAC Interpretations

- B-1 Statistics
- Related Organization Costs
- ER Availability
- HITECH
- Rural Health Clinics

B-1 Statistics

- Making a Change
- Simplified Methodology

Changing B-1 Statistics

Making a change?

Applicable Regulations:
PRM 15-1, 2313
PRM 15-2, 4020

- Provider must make a written request to its MAC ninety (90) days prior to the end of that cost reporting period they want the change to be effective for.

- MAC has sixty (60) days to make a decision or the change is automatically accepted.

Changing B-1 Statistics

- Provider must maintain both sets of statistics until an approval is granted.
- Provider must include supporting documentation and a thorough explanation of why the alternative approach should be used.

Changing B-1 Statistics

Advantages

- More accurate allocation of costs
- Less burdensome on staff

Disadvantages

- May reduce Medicare reimbursement
- Don‘t forget about Medicaid reimbursement (Hospital & SNF)

Simplified Cost Allocation Methodology

Applicable Regulations:

- PRM 15-1, 2313
- PRM 15-2, 4020

- Must use the statistical bases listed in the PRM (No deviations).
- Once elected, must be used for no less than 3 years, unless a change of ownership occurs.
- 90-day and 60-day rule previously discussed applies (need approval from MAC).

Simplified Cost Allocation Methodology

- Statistics

Building and Fixtures	Square Feet
Movable Equipment	Square Feet
Maintenance and Repairs	Square Feet
Operation of Plant	Square Feet
Housekeeping	Square Feet
Employee Benefits	Salaries
Cafeteria *	Salaries
Administrative and General	Accumulated Costs
Laundry and Linen	Patient Days
Dietary **	Patient Days
Social Service	Patient Days
Maintenance of Personnel	Eliminated and moved to A&G
Nursing Administration	Nursing Salaries
Central Services and Supply	Costed Requisitions
Pharmacy	Costed Requisitions
Medical Records and Library	Gross Patient Revenue
Nursing School *	Assigned Time
Interns and Residents	Assigned Time
Paramedical Education	Assigned Time
NonPhysician Anesthetist	100% to Anesthesiology

Simplified Cost Allocation Methodology

* Contract labor is not included and is not grossed up.

** If this is a meals on wheels program, a Worksheet A-8 adjustments is required.

B-1 Statistics

Reminder

- Any change in allocation bases (or order of allocation) must be approved by the MAC.

- Possible consequences if prior approval not obtained:
  1. MAC must reject the cost report.
  2. MAC will disallow all costs/statistics for those cost centers affected by the unapproved change.
  3. MAC may accept prior year's statistics, if reasonably related to current year's costs.

Related Organization Costs

Applicable Regulations

- PRM 15-1, 1000 (Cost to Related Organizations)
- PRM 15-1, 2150 (Home Office/Chain Operations)

- Cost to Related Organizations
  - Defined as costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership **or** control.
  - Costs are includable in the allowable cost of the provider at the cost to the related organization.

Related Organization Costs

Recent Developments

- Are seeing costs being disallowed by the MAC because there is no ownership.
- As indicated, related organization costs pertain to organizations that are related through either ownership or control.

Related Organization Costs

- Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

- Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Related Organization Costs

Reimbursement Principle

- Intent is to treat the cost of the related organization as if they were incurred by the provider itself.
- Includes all reasonable costs, direct and indirect, incurred in furnishing of services, facilities and supplies to the provider.
- Examples:
  - Joint laundry services
  - Mobile MRIs
  - Administrative services

Related Organization Costs

- Provider must make available adequate documentation to support the costs incurred by the related organization.
  - Access to the related organization's books and records
  - Identification of the organization's total costs and;
  - The basis of allocation of direct or indirect costs to the provider, and other entities served.

Related Organization Costs

Home Office Costs– Chain Organizations

- Consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization.
- May include business organizations which engage in other activities not directly related to health care.
- The Home Office relationship is that of a related organization to the participating providers.

Related Organization Costs

- The home office is not a provider – its costs may not be directly reimbursed by the program.
- Cost are claimed on the hospital's Medicare cost report.
- Management fees are not allowable costs.
- Home Office's reasonable costs of providing the services related to patient care are includable as allowable costs of the provider.

Related Organization Costs

- Costs are reconciled on Worksheet A-8-1 of the Medicare Cost Report.

What we are seeing at the MAC level:

- Costs are being disallowed because there is no Home Office Cost Report.
- Home Offices must submit home office cost reports to the respective MAC in order for the home office costs to be allowable.
- Sufficient documentation that common ownership or control exists

Related Organization Costs

Home Office Cost Reports

Applicable Regulations:
PRM 15-1, 2150.3
PRM 15-1, 2153

- Official CMS Home Office Cost Report - 287-05

- Best Practice is to get Home Office number established with CMS through the MAC

Related Organization Costs

Home Office Cost Reports

- Costs allocated to healthcare facilities and non-healthcare facilities based on auditable allocation methods
  - A. Direct allocations
  - B. Functional allocations
  - C. Pooled allocations
    1. If solely healthcare facilities – must be allocated on either inpatient days or total costs.
    2. If both healthcare and non-healthcare facilities – must use total costs as the basis of allocation.

Related Organization Costs

- Possible MAC adjustments related to Home Office costs:

1. Disallow all home office costs if there is no home office cost report to substantiate costs.
2. Allow lower of current year home office costs from home office cost report or audited costs from audited prior year home office cost report.
3. Allow current year home office costs if prior year has not been audited or is not available.

ER Availability

Applicable Regulations:

- PRM 15-1, 2109
- 42 CFR §413.70
- CMS Pub 100-04, Chapter 3, Section 30.1.3

- Allows for reasonable cost reimbursement for physician on-call costs who is:

1. On call but who is not present on the premises of the CAH involved (deviation from PRM 15-1, 2109 for PPS Hospitals),

ER Availability

2. Is not otherwise furnishing physicians' services, and

3. Is not on call at any other provider or facility.

- Effective January 1, 2005, CAHs may include physician assistants, nurse practitioners and clinical nurse specialists in computing reasonable compensation and related costs for emergency room on-call coverage.

- These non-physician practitioners who are on call do **not** have to be present on the premises of the CAH involved.

ER Availability

Recent Developments

- Seeing more MACs adopting the 8,760 total hours methodology.
- Seeing more scrutiny in the Part A vs Part B splits – if insufficient documentation (time studies), using ER logs and admit/discharge times to determine patient services (Part B) portion.
- Still inconsistencies between MACs regarding Physicians' time studies – 1 week per month (PRM 15-I, 2313.2(E) versus two 2-week time studies.

ER Availability

Miscellaneous Issues

- Time studies for Mid-levels versus Physicians
- PRM 15-1 2109 requirements – Do Not Overlook
- Combining Mid-levels and Physician for ER coverage

HITECH

- Incentive payments ending after FFY 2015 (now Calendar Year 2015).

- CAHs that are not meaningful users of certified EHR technology beginning in FY 2015 will be subject to payment adjustments:
  - FY 2015 – reimbursement reduced from 101% to 100.66%
  - FY 2016 – reimbursement reduced from 101% to 100.33%
  - FY 2017 – reimbursement reduced form 101% to 100%
  - Each subsequent FY reimbursement will be reduced to 100%

HITECH

Recent Developments

- A lot of confusion surrounding allowable EHR costs.
  - Year 1 EHR incentive payment should be calculated based on the Net Book Value as of the beginning of the cost reporting period of any assets purchased prior to the beginning of the cost reporting period plus any assets purchased during the cost reporting period.
  - Year 2 and subsequent years the EHR incentive payment should be calculated on any assets purchased during the cost reporting period.
  - Are seeing many deviations from this by the MACs.

HITECH

- A lot of confusion surrounding applicable cost reporting period to settle EHR payments.
    - Should always be the cost reporting period that begins in the FFY attested to. Example: 6/30 YE provider attests for FFY 2014 to meaningful use. Cost report to be used for incentive payment is the 7/1/2014 to 6/30/2015 cost report.

Example – Claiming Asset in Wrong Year.

Assumptions:

- 6/30 Cost Reporting Period
- MU Year 1 FFY 2013 (7/1/2013 to 6/30/2014 CR Period)
- MU Year 2 FFY 2014 (7/1/2014 to 6/30/2015 CR Period)
- Asset valued at $300,000 purchased on 1/1/2014 with 5 year life
- Medicare Share 90%
- Capitalization policy = ½ year's depreciation in year of acquisition
- Provider did not claim asset in Year 1 but did claim in Year 2.

Claimed on 6/30/2014 CR

Cost	$300,000
1st YR Depr.	$30,000
Amount Claimed as EHR	$300,000
EHR Incentive Payment	$270,000

Claimed on 6/30/2015 CR

Cost	$300,000	
1st YR Depr.	$30,000	
Amount Claimed as EHR	$270,000	NBV @ 7/1/2014
EHR Incentive Payment	$243,000	
Diff	($27,000)	

HITECH

- Seeing a long time lag between the Notice of Program Reimbursement date and the demand letter from the HITECH Payment Contractor

Rural Health Clinics

Applicable Regulations

CMS Pub 100-02, Chapter 13
PRM 15-2, 4010 and 4066 (Worksheet S-8 and M-Series)

Rural Health Clinics

Unique Features of RHCs

- Per Visit Cost limitations – 2015 = $80.44 2016 = $81.32
- RHCs attached to Hospitals with less than 50 beds exempt from cost limitations
- Productivity Standards
  - Physicians – 4,200 per FTE
  - Midlevels – 2,100 per FTE
- Can apply annually for an exception to the productivity standards

Rural Health Clinics

Other RHC Opportunities:

- Hospitals with multiple RHCs can elect to file consolidated M-series.
- Election made to MAC before filing the Medicare Cost Report (varies among MACs)
- Benefits include combining visits for comparison to productivity standards.

Future of CAHs

- Why CAHs are important to me!!!
  - Major stabilizer of rural communities
    - Major employer
    - Major economic development factor
  - Major component to the continuum of care in an aging community
  - Accessibility to healthcare services in communities with the least mobile populations

Future of CAHs

- Increased scrutiny by CMS and MACs
  - Location Requirements
  - Full Desk Reviews and on-site Audits
- Less Inpatient and more Outpatient
- Fewer services with emphasis on Emergency Room services

Future of CAHs

- Possible Changes
  - Decertify all CAHs within 10 mile radius of another hospital
  - Reduce Medicare payments to 100 Percent

  (Both of the above changes were in the FY2014 proposed budget and would save an estimated $690 million and $1.4 billion respectively over 10 years)

  - Decertify all CAHs not meeting location requirements
  - Revert Swing Bed payments back to SNF PPS payments
  - Impose outpatient coinsurance limit equal to inpatient deductible amount – similar to IPPS hospitals

Thank You!

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