

2016 Fall Reimbursement Update

**PROVIDER BASED DEPARTMENT GUIDANCE
& OTHER REIMBURSEMENT UPDATES**



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Presentation Agenda



- INTRODUCTION
- PROVIDER-BASED DEPARTMENTS
 - What is a provider-based department?
 - Overview of requirements
 - New proposed regulations
- OTHER REIMBURSEMENT UPDATES
 - Long Term Care Hospitals
 - Home Health
 - Hospice
 - Physician
- QUESTIONS

Introductions



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Provider- Based Departments



- **WHAT IS A PROVIDER-BASED DEPARTMENT?**
- **OVERVIEW OF REQUIREMENTS**
- **NEW PROPOSED REGULATIONS**

Provider-Based Departments

A PROVIDER-BASED DEPARTMENT (PBD).....

- Is an outpatient department (OPD) of a hospital
- Meets Medicare regulations for provider-based status
 - Transmittal A-03-30
 - 42 CFR §413.65
- Registered as a hospital site via a CMS-855A enrollment form
- Generates two charges; i.e. the single charge generated by the physician practice is “split”
 - Professional Services
(1500 → with a POS of 19 or 22 indicating off/on campus)
 - Facility or Technical Fees
(UB → with a “PO” modifier indicating outpatient service)
- Within 35 miles from the hospital

Provider-Based Departments

A PHYSICIAN PRACTICE....

- Is NOT a provider-based department
- Only bills on a CMS-1500
- Bills using Place of Service code 11
 - Professional and technical reimbursement are combined

Place of Service Code(s)	Place of Service Name	Place of Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Provider-Based Departments

THE PBD REGULATIONS DO NOT APPLY TO....

- Ambulatory surgical centers (ASCs)
- Comprehensive outpatient rehab facilities (CORFs)
- Home health agencies (HHAs)
- Skilled nursing facilities (SNFs)
- Hospices
- Inpatient rehab units that are excluded from the IP PPS for acute hospital services
- Independent diagnostic testing facilities furnishing only services paid under a fee schedule (i.e. mammography, labs, etc.)
- Facilities furnishing only physical, occupational, or speech therapy to ambulatory patients, throughout any period during which the annual cap amount on payment for coverage is suspended by legislation
- ESRDs
- Departments that support the services but do not furnish services (i.e. Laundry, Medical Records)
- Ambulances
- Rural health clinics affiliated with hospitals having 50+ beds

Provider-Based Departments

BENEFITS OF BEING PROVIDER-BASED

Enhanced Patient Care

- Clinical Integration
- Hospital Oversight
- Medical Records Integration

Enhanced Reimbursement

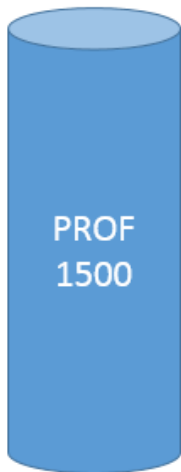
- Enhanced claim level reimbursement
- Reimbursement for Medicare bad debts
- 340b pharmacy benefits if eligible hospital

Provider-Based Departments

ENHANCED CLAIM LEVEL REIMBURSEMENT
VIA “SPLIT BILLING”

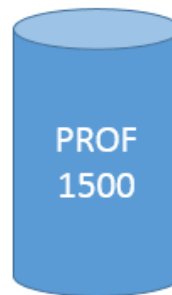
Physician Office

POS 11



Provider-Based Clinic

POS 22



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Provider-Based Departments - Requirements

A) CLINICAL INTEGRATION

- Professional staff have clinical privileges at the hospital & serve on medical staff committees
- Hospital monitors the PBD the same as any other department
(nursing, radiology, lab, pharmacy, medical records, etc.)
- PBD physicians ultimately report to the chief medical officer of the hospital
 - Reflected in organizational chart
- Medical staff committees and hospital committees are responsible for medical activities in the PBD
(quality assurance, utilization review, compliance, infection control, etc.)
- Provider-based departments fall under hospital accreditation standards

Provider-Based Departments - Requirements

B) FINANCIAL INTEGRATION

- Financial operations of the PBD are fully integrated within the financial system of the hospital, as evidenced by:
 - Shared income and expenses
 - Costs of the PBDs are reported as cost centers/departments of the hospital
 - The cost centers/departments are easily identifiable in the hospital's trial balance
 - The PBDs are reported on the hospital's Medicare cost report

C) OWNERSHIP

- PBD must be 100% owned by the hospital (separate rules for a joint venture)
- PBD must ultimately operate under the same license, governing body and bylaws as the hospital

Provider-Based Departments - Requirements

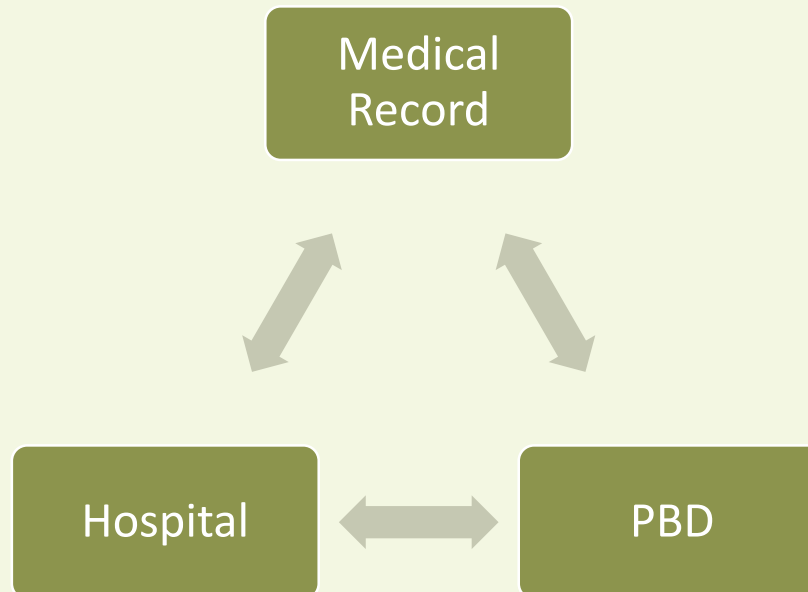
D) ADMINISTRATIVE INTEGRATION

- CEO should have final responsibility for administrative decisions --- (approval of contracts with outside parties, responsibility of personnel policies, employment status of direct patient care clinic staff, final approval of medical staff appointments, etc.)
 - i.e. the PBD should have the same reporting relationships with the hospital as any other department of the hospital.
 - Reflected in organizational chart
- General functions at the PBD should be the same as the hospital in the majority of cases --- (Administrative duties, payroll, accounts payable, maintenance, housekeeping, medical records, billing, collections, advertising, human resources, purchasing, etc.)
- IP/OP Integration = Accept the same insurances / issue referrals

Provider-Based Departments - Requirements

E) MEDICAL RECORDS INTEGRATION

- One of the most difficult requirements to meet
- Hospital clinical staff have access to medical records of patients treated in the clinics and vice versa – unified retrieval system
 - Process(s) documented in an approved policy



Provider-Based Departments - Requirements

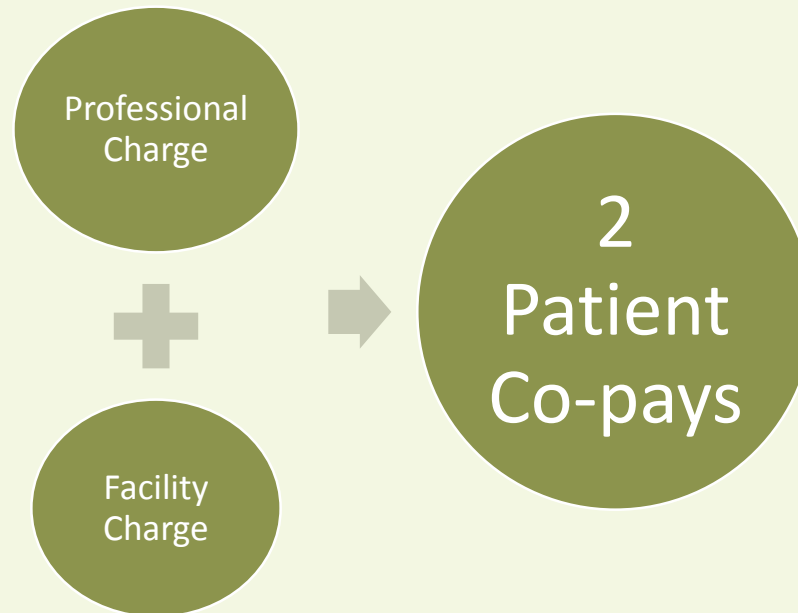
F) BILLING

- Split billing
 - Use of multiple billing structures through chargemaster(s)
 - Professional coding vs Facility coding
 - Use of proper site of service codes
 - CANNOT bill a Medicare patient more than any other patient
- Commercial payor notification
 - Split billing is required for Medicare/Federal payors
 - Get in writing, how majority of commercial payors want you to bill
 - Most won't accept a UB04
 - May need to renegotiate some commercial contracts; not looking to increase reimbursement – but to keep it the same as if billing under POS 11 as a physician office

Provider-Based Departments - Requirements

G) PATIENT IMPACT

- Plan communications to patients / signage
- Plan 'scripting' for staff interaction with patients
- Medicare Beneficiary Notice
 - Required for off-campus departments / every visit



Provider-Based Departments - Requirements

H) PUBLIC AWARENESS

- PBDs should be held out to the public as a part of the hospital
- Signage
 - Interior & exterior signage
 - EMTALA
 - Letterhead
 - Registration forms
 - Business cards
 - Answering phone / recordings
- Floorplans
 - PBD is in a separate and distinct area
 - Shared space is a hot topic for CMS

Provider-Based Departments - Requirements

MEDICARE PROVIDER-BASED ATTESTATIONS

- Voluntary process and used by hospitals as an 'insurance policy'
- CMS and other organizations are looking much closer at PBDs and if they meet the requirements to bill as such / holding hospitals to the highest standards
- Filed for each clinic address
- Each attestation includes a questionnaire, organizational documents, narratives describing integrated processes, policies, pictures, maps, etc.

Provider-Based Departments - Recent Regulations

BIPARTISAN BUDGET ACT OF 2015 (SECTION 603)

Exclusion of enhanced hospital payments for new provider-based off-campus departments (PBD)

- Off-campus clinics billing as PBD prior to **November 2, 2015** are grandfathered in and can continue to receive enhanced reimbursement under OPSS.
- Off-campus clinics wanting to convert to PBD after the date of enactment will only receive enhanced reimbursement through 12/31/2016. On 1/1/2017 clinics will be reimbursed under the physician fee schedules (which is generally lower than OPSS).
- On-campus clinics, clinics located within 250 yards of the hospital, off-site emergency departments, CAH Hospitals and provider-based Rural Health Clinics are not affected by these regulations.

The Act did not impact the ability of hospitals to create new PBDs, but only the ability to receive enhanced Medicare reimbursement.

Provider-Based Departments - Recent Regulations

BIPARTISAN BUDGET ACT OF 2015 (SECTION 603)

Unanswered questions (pending CMS implementation)

- Exception for mid-build building projects?
- Split billing be required for new off-campus locations?
- What about a pre-existing PBD slated to be relocated across town?
- Impact to Medicare enrollment and cost reporting obligations?
- Implications for hospital survey and certification requirements?
- How will this impact the 340B program?

Provider-Based Departments - Recent Regulations

FY2017 OPPS PROPOSED RULE (released 7-6-2016)

Implementation of site neutral payments / Bipartisan Budget Act

To continue to be paid under OPPS....

- Limits the expansion of services for grandfathered off-campus PBDs.
Use of clinical families of services based on APCs;
Timeline? Billing summary?
- Limits the ability to relocate/expand grandfathered off-campus PBDs
- Limits the ability to change ownership of grandfathered off-campus PBDs

Rule proposes how non-grandfathered PBD's will bill for services starting 1-1-2017.

- CY2017 – Medicare Physician Fee Schedule
(speculated - at a non-facility rate POS 11)

Many questions still unanswered → Final rule expected in November 2016.

Provider-Based Departments - Recent Regulations

Table 21 – Proposed Clinical Families of Services for Purposes of Section 603 Implementation (based on APCs)

Advanced Imaging		Minor Imaging	
Airway Endoscopy		Musculoskeletal Surgery	
Blood Product Exchange		Nervous System Procedures	
Cardiac/Pulmonary Rehab		Ophthalmology	
Clinical Oncology		Pathology	
Diagnostic Tests		Radiation Oncology	
Ear, Nose, Throat		Urology	
General Surgery		Vascular/Endo/Cardio	
Gastrointestinal		Visits & Related Services	
Gynecology			

Other Reimbursement Updates

- **LONG TERM CARE**
- **HOME HEALTH**
- **HOSPICE**
- **PHYSICIAN**



Long Term Care Hospitals



FY 2017 Final Rule Update

FINALIZED 8/2/2016

- Payment rate update of 1.75%
- Continued phase-in of The Pathway for SGR Reform Act of 2013 that established two different types of LTCH PPS payment rates depending on whether the patient meets certain clinical criteria
- CMS projects that the phase-in will cut LTCH PPS payments by 7.1% (\$363M)

QUALITY REPORTING PROGRAM

- Continues 2% cut for LTCHs that do not submit required data
- Added 3 claims based measures and one assessment based measure

Home Health



CY 2017 Proposed Rule Update

PROPOSED 6/27/2016

- Projected reduction in overall payments of 1%
- 2017 is the final year of the four-year phase-in of the rebasing adjustments to payment rates
- Second year of cuts to account for case mix growth unrelated to acuity
- Change in Outlier Payment calculation from cost per visit to cost per unit

QUALITY REPORTING PROGRAM

- Adopting 4 measures in CY 2018 for payment determination, 3 of which are claims based
- 4th measure requires HHAs to submit OASIS assessments as a condition of payment and also for quality measurement purposes

VALUE BASED PURCHASING

- Provides clarification on public reporting and updates on changes to the program that will begin CY 2018 in 9 states

Medicare Payment Reform Model

HOME HEALTH VALUE-BASED PURCHASING MODEL

- Effective January 1, 2016, The Centers for Medicare & Medicaid Innovation (CMS Innovation Center) implemented the Home Health Value-Based Purchasing (HHVBP) Model. This new model is designed to support greater quality and efficiency of care among Medicare-certified Home Health Agencies (HHA) across the nation.
- All Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee will compete on value in the HHVBP model, where payment is tied to quality performance.
- Winner/Loser model starting at 3% in 2018 up to 8% in 2022
- Payment adjustments based on benchmark and achievement thresholds at the state level

Hospice



FY 2017 Final Rule Update

FINALIZED 7/29/2016

- Net payment increase of 2.1% (\$350M)
- Cap now being updated by the payment updated percentage rather than using the consumer price index for urban consumer. \$28,404.99 for 2017
- Cap year aligns with FFY in 2017 (10/1/16 - 9/30/17)

QUALITY REPORTING PROGRAM

- Outlines CAHPS Survey implementation, respondents, and eligibility
- Participation in survey data is required for FY2019 & FY2020 annual payment updates
- Must collect survey data on an ongoing basis from 1/1 - 12/31/17 for the FY2019 payment update. Two year lag going forward
- CMS expects to begin public reporting of quality measures in CY 2017 via a Compare site

Medicare Payment Reform Model

MEDICARE CARE CHOICES MODEL

- Allows Medicare beneficiaries to receive hospice-like support services from certain hospice providers while concurrently receiving services provided by their curative care providers.
- CMS will evaluate whether providing these supportive services can improve the quality of life and care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures.
- Under current payment rules, Medicare and dually eligible beneficiaries are required to forgo curative care in order to receive services under the Medicare or Medicaid Hospice Benefit.
- Approximately half of the participating hospices will begin providing services under the model on January 1, 2016. The remaining participant hospices will provide services under the model starting January 1, 2018.

Medicare Payment Reform Model

MEDICARE CARE CHOICES MODEL (CONT.)

- Participating hospices will provide services under the model that are currently available under the Medicare Hospice Benefit for routine home care and respite levels of care, but cannot be separately billed under Medicare Parts A, B, and D.
- Services will be available around the clock, 365 calendar days per year and CMS will pay a per beneficiary per month fee ranging from \$200 to \$400 to participating hospices when delivering these services under the model.
- CMS has expanded the model from an originally anticipated 30 Medicare-certified hospices to over 140 Medicare-certified hospices and extended the duration of the model from 3 to 5 years. This is expected to enable as many as 150,000 eligible Medicare beneficiaries to experience this new option and flexibility.

Physician



Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

REPLACES THE SUSTAINABLE GROWTH RATE WITH THE QUALITY PAYMENT PROGRAM

- Program is made up of two payment models; Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advances APM)
- Currently a proposed rule, expected to be finalized by November 1
- Designed to create a new framework for rewarding health care providers for giving better care, not just more care, by combining existing quality reporting programs into one new system
- Pushes all eligible clinicians into two sided risk approach to payment

Quality Payment Program - MIPS

ELIGIBLE CLINICIANS

- Medicare Part B clinicians - Physicians, Physicians Assistants, Nurse Practitioners, Clinical Nurse Specialists, CRNAs
- Excludes newly enrolled in Medicare, less than \$10,000 in Medicare charges and 100 Medicare patients, or significantly participating in an Advanced APM

PAYMENT

- FFS Rate Increases
 - 0.5% 2016 - 2019
 - 0.0% 2020 - 2025
 - 0.25% 2026 forward
- Bonus/Penalty
 - +/- 4% 2019 (REVISED 9/8/16, see later slide)
 - +/- 5% 2020
 - +/- 7% 2021
 - +/- -% 2022 onward

Quality Payment Program - MIPS (cont)

WHAT IT IS

- MIPS combines parts of PQRS, Value-based payment modifier and EHR into one single program for measuring eligible clinicians.
- Will be given a composite score ranging from 0-100 based on performance that will determine bonus/penalty

CATEGORIES

- Quality
 - Replaces PQRS and Quality/Outcomes portion of Value-Based Modifier
- Advancing Care Information
 - Replaces EHR
- Clinical Practice Improvement Activity
 - New category addressing care coordination, patient safety, access, and engagement
- Resource Use
 - Replaces Cost Portion of Value-Based Modifier

Quality Payment Program - MIPS (cont)

QUALITY MEASURES 50%

- Report on 6 measures (over 200 to choose from) covering;
- Patient Outcomes
- Appropriate Use
- Patient Safety
- Efficiency
- Patient Experience
- Care Coordination

ADVANCING CARE INFORMATION 25%

- Protecting patient health information
- eRx
- Patient electronic access
- Coordination of Care
- Health Information Exchanges
- Public Health & Clinical Data Registries

Quality Payment Program - MIPS (cont)

CLINICAL PRACTICE IMPROVEMENT 15%

- Over 90 activities focusing on;
- Expanded practice access
- Population Management
- Coordination of care
- Beneficiary Engagement
- Patient Safety and Practice Assessment
- Emergency Preparedness & Response
- Integrated Behavior and Mental Health

RESOURCE USE (COST) 10%

- Based on claims data and no additional reporting is needed.
- Lower cost of care = better performance

Quality Payment Program - Advanced APM

PAYMENT MODEL DESIGNED TO INCENTIVIZE PARTICIPATION IN ALTERNATIVE PAYMENT MODELS

- Program is for clinicians participating in certain two-sided risk models;
 - ❑ Next Generation ACOs
 - ❑ Medicare Shared Savings Program Tracks 2, 3
 - ❑ Comprehensive End Stage Renal Disease Care Model
 - ❑ Comprehensive Primary Care Plus (CPC+)
 - ❑ Oncology Care Model Two-Sided Risk Arrangement

Quality Payment Program

- Advanced APM

ADDITIONAL QUALIFICATIONS

- Use of Certified EMR technology - 50% of providers in Year 1, 75% in year 2
- Base incentive payments on MIPS comparable measures
- Bear certain financial risk for losses for percentage of payments/patients at risk
 - 25% / 20% in 2019-2020 (Medicare only)
 - 50% / 35% in 2021-2022 (May include non-Medicare)
 - 75% / 50%
- ❖ If these thresholds are not met, the eligible clinician can participate in MIPS.

Quality Payment Program

- Advanced APM

BENEFITS TO ADVANCED APM PARTICIPATION

- FFS rate increases start off the same as MIPS with 0.5% updates in 2016 - 2019 and 0.0% in 2020 - 2025. However, in 2026 Advanced APM participants are awarded for their participation by receiving 0.75% annual updates as opposed to the 0.25% for MIPS participants.
- Additionally, Advanced APM participants will receive a 5% lump sum bonus payment based on estimated aggregate Medicare payment for the year prior. This is designed to help cushion any losses that may be sustained in the APM to encourage providers to stick with the APM. These bonus payments run annually from 2019 - 2024.
- Finally, participation in an Advanced APM means you are excluded from MIPS reporting.

When does this all start?

NOW!!

- While payment adjustments for MIPS won't happen until 2019, they will be based on what you do two years prior. That's 2017.
- For each bonus/penalty year in MIPS the basis of that adjustment will be the year two years prior.

Recent Revisions to MIPS

CMS ANNOUNCEMENT 9/8/16

- MIPS is now broken into 3 levels to ease the pace of implementation, so long as you choose one of these 3 levels you will not receive a negative adjustment in year one.
- The first option is to just report any data from January 1, 2017 or after and there will not be a negative adjustment in year one.
- The second option is to submit data for a reduced number of days and still qualify for a small bonus payment if submission includes data on how the practice is using technology and how it's improving. This effectively delays the data collections start date.
- The third option is full adoption of the MIPS system as proposed.
- Final Rule is expected to drop in November.

Questions



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