Provider-Based Designations: Navigating the Changes
DISCLAIMER

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AGENDA

• Provider Based Requirements
• Commercial Payor Considerations
• BBA Section 603 and Beyond
• Medicare Enrollment Changes
• Rural Health Clinics
• Current Environment Considerations
Provider Based Requirements
What is Provider-Based Status?

• Relationship between a main provider and another facility whereby the other entity is considered a subordinate part of the main provider

• Determination of provider-based status is governed by the regulation at 42 CFR 413.65 and further explained in Program Memorandum Transmittal A-03-030

• The Medicare/Medicaid provider-based status regulatory requirements apply to a facility if the status of the facility as provider based or freestanding affects: (i) Medicare or Medicaid payment amounts; (ii) the scope of benefits available to a Medicare beneficiary in or at the facility; and (iii) the deductible or coinsurance liability of a Medicare beneficiary in or at the facility.
Provider Based Requirements & Strategies

3 Types of provider-based facilities/organizations

- Department of a provider (hospital outpatient departments)
- Provider-based entities
  - Rural health clinics (RHC)
  - Skilled Nursing Facilities (SNF)
  - Home Health Agencies (HHA)
- Remote location of a hospital
  - Furnishes IP services under a hospital’s certification and CMS certification number
Provider Based Requirements

Requirements applicable to all facilities or organizations (413.65):

1. Licensure
   • Operate under the same State license

2. Clinical Services Integration
   • Clinical privileges
   • Monitoring and oversight
   • Medical Director reporting relationship with CMO
   • Unified medical record retrieval
   • IP and OP service integration

3. Financial Integration
   • System integration
   • Shared income and expenses
   • Identifiable on main provider trial balance
   • Reported on allowable line of the cost report
Provider Based Requirements

Requirements applicable to all facilities or organizations:

4. Public Awareness

• Signage
• Letterhead
• Shared Space
  • Co-mingling prevents a hospital from satisfying the conditions of participation
  • Are shared registration areas, waiting rooms, and hallways okay?
  • CMS training proxies on shared space
  • No regulatory guidance…yet! November 2018 AHLA webinar with CMS representation suggests new guidance in the first quarter of 2019.
Provider Based Requirements

Requirements applicable to all facilities or organizations:

5. Additional obligations of all hospital outpatient departments:
   a) Compliance with EMTALA
      • On-campus
      • Dedicated Emergency Department
      • Not applicable to provider-based entities
   b) Site-of-service code
      • 11 = Physician Office
      • 15 = Mobile Unit
      • 19 = Off Campus Outpatient Hospital
      • 22 = On Campus Outpatient Hospital
   c) Compliance with provider agreement
   d) Physicians must comply with the non-discrimination provisions in § 489.10(b)
Provider Based Requirements

Requirements applicable to all facilities or organizations:

5. Additional obligations continued…

   e) All Medicare patients, for billing purposes, must be treated as hospital outpatients

   f) Subject to payment window provisions

   g) Written notice to beneficiary
      
      • Amount of potential liability; or

      • Estimate if care needed can not be determined

   h) Hospital outpatient departments must meet applicable health and safety rules for Medicare participating hospitals.
Provider Based Requirements

Additional requirements applicable to off-campus provider based clinics

1. Ownership and Control
   • 100% owned by the main provider
   • Same governing body
   • Organizational documents
   • Administrative decisions, personnel policies, medical staff appointments

2. Administration and Supervision
   • Direct supervision and administrative accountability
   • Overhead integration (billing, records, HR, etc.)

3. Location…
Campus – within 250 yards of main hospital buildings

• 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.

• Excerpt from OPPS Final Rule… “any point of the physical facility that serves as the site of services of the remote location to any point in the PBD”

• Case-by-case

• Differences in hospital campus composition
Provider Based Requirements

Off campus – within 35 miles (except RHC)
  • “As the crow flies”

CAUTION for CAH –
  • CMS final OPPS rule FY 2008
    • Any new off-campus provider based location (except RHC) for CAH must meet the
      CAH location requirements – consequence: loss of CAH designation!
Potential Advantages of Provider-Based Designation

- Potential higher reimbursement. (Have to look at all payors in the aggregate)
  - On-Campus vs. Off-Campus

- Reimbursement for Medicare Bad Debts
  - Only if excepted…

- Increased coordination with hospital-physicians

- Increased clinical integration with hospital

- Greater flexibility in financing and efficiencies with admin or shared staff

- 340B Drug Discount Program
Potential Disadvantages of Provider-Based Designation

• Increased costs related to hospital wage and benefit scales, more costly facilities, and less effective cost management.

• Increased billing complexities - negative impact from split billing for patients

• Patient coinsurance is a consideration

• Decreased physician control of practice staff and accountability for finances and productivity
Commercial Payor Considerations
Commercial Payor Considerations

Federal Register Volume 65, Number 68 (Friday, April 7, 2000)

• In response to comments from providers on the provider based billing rules applicable to commercial payors, Medicare stated:

“After review of the comments on this section, we have decided to revise it to restrict the requirement for uniform billing to Medicare patients only, thus allowing hospitals to bill other payers in whatever manner is appropriate under those payers’ rules. As revised, Sec. 413.65(g)(6) states that hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.”

• If commercial is primary and Medicare is secondary, Medicare may require the primary payor be split billed in order to process and pay the technical fee.

• Evaluate options of billing Commercial payors as they are currently billed for freestanding practices. Provider Based is a Medicare/Medicaid distinction and Commercial payors are subject to payment arrangements per the terms in those specific contracts.
  • Industry Examples
    • UNC BCBS Bulletin notified patients that certain services at provider based departments would be treated as freestanding clinic services for billing and copayment purposes.

• Further discussion and understanding of commercial contracts and billing specific to your system may be needed.
Bipartisan Budget Act of 2015

• On November 2, 2015, President Obama signed into law the Bipartisan Budget Act of 2015. Effective January 1, 2017, Section 603 of the Budget Act excludes from Medicare’s outpatient prospective payment system (OPPS) new hospital services furnished at an off-campus hospital outpatient department.

• The Act effectively adopts site-neutral payment principles recommended by MedPAC and more recently the GAO, whose December 2015 report concludes that given the trend toward hospital-physician consolidation, Congress should equalize payment rates for similar services provided in different settings to ensure Medicare is not paying too much for health care.
Bipartisan Budget Act of 2015

• Section 603
  • Applies site-neutral payment reductions for new off-campus provider-based outpatient departments. It **excludes:**
    • On-campus departments
    • Critical access hospitals
    • Dedicated emergency departments
    • Provider-based RHCs
  • “New” is defined as an entity that began billing Medicare for outpatient services after the date of the enactment of the Act (11/2/15).
  • No APC payment beginning on and after 1/1/2017.
  • Paid from Medicare Physician Fee Schedule.
    • 50% of APC – 2017
    • 40% of APC – 2018
    • 40% of APC - 2019
  • Off-campus provider-based departments that were billing Medicare before the date of enactment (11/2/15) of the bill are “grandfathered in” nka “excepted” and continued to receive full payment through calendar year 2018.
  • 2019 OPPS Final rule implemented Medicare Physician Fee Schedule payment for E&M services in “excepted” provider-based locations.
CMS Clarification

• Does not apply to on-campus locations.

• Does not apply to remote locations of the hospital.

  “Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this Section.”

  “A remote location of a hospital comprises both the specific physical facility that serves as the site of services for which separate payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at the facility. The Medicare CoPs do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term “remote location of a hospital” does not include a satellite facility as defined in 42 CFR Sections 412.22(h)(1) and 412.25(e)(1) of this chapter.”
340B Implications

• All off-campus provider-based locations are included on the Medicare cost report – 340B eligible

• Expansion of 2017 payment reductions for drugs purchased under 340B program to nonexcepted provider-based departments
  • Drug acquired through 340B paid at ASP minus 22.5% rather than traditional ASP plus 6%
  • CMS notes that nonexcepted PBD are paid MPFS rather than OPPS so the policy didn’t apply

• ASP minus 22.5% to nonexcepted PBDs
  • Exceptions
    • Sole Community Hospitals
    • Childrens Hospitals
    • PPS Exempt Cancer Hospitals

• No changes for 340B Contract Pharmacy
Medicare Enrollment Changes (SE18002 & SE18023)
# 855A Initial Enrollment Process

<table>
<thead>
<tr>
<th><strong>Provider Actions</strong></th>
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<tbody>
<tr>
<td>Contact state agency for certification forms</td>
<td>Complete CMS-855A and submit it to the MAC</td>
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<tr>
<th><strong>MAC Actions (30-60 Days)</strong></th>
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<tbody>
<tr>
<td>Screen &amp; Validate</td>
<td>Submit recommendation of approval to State agency, copy to CMS RO</td>
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<tr>
<th><strong>CMS RO / State Survey Agency (3-9 Months)</strong></th>
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<tbody>
<tr>
<td>On-site survey (if necessary)</td>
<td>If COP’s are met, RO issues provider agreement and assigns provider number</td>
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<th><strong>MAC Actions (1-2 Days)</strong></th>
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<tr>
<td>Processes tie-in</td>
<td>Updates PECOS and claims systems</td>
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Medicare Enrollment Changes CMS855A

- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital
- End-Stage Renal Disease Facility
- Federally Qualified Health Center
- Histocompatibility Laboratory
- Home Health Agency
- Hospital
- Hospice Indian Health Services Facility
- Organ Procurement Organization
- Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
- Religious Non-Medical Health Care Institution
- Rural Health Clinic
- Skilled Nursing Facility
## 855A Enrollment – Reporting Requirements

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<tr>
<th>Up to 180 days prior:</th>
<th>Within 30 days:</th>
<th>Within 90 days:</th>
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| • New Enrollment     | • A change in ownership  
|                      | • An adverse legal action  
|                      | • A change in practice location  | • Managing employees  
|                      | | • AO/DO  
|                      | | • All other changes  |

• For a new enrollment, the effective date is based on the completion of the survey, or the date that the Regional Office determines all requirements are met.

• Providers must be in compliance at the requested effective date (operational & licensed).

• For OP PBD’s, sometimes the MAC can approve. If certification and/or survey is required, the RO will typically approve.
OPPS Billing – Multiple Locations

- MLN Matters Number SE18002
- March 15, 2018
- Effective January 1, 2017
- Off-campus departments may be different payment locality than main provider
  - Service address of the off-campus, outpatient, provider-based department is used to determine payment locality
- Reported in 2310E loop of the 837 institutional claim transaction
- DDE submitters are required to submit the service facility address
- Paper submitters report the address in Form Locator (FL) “01” on the paper claim form
- Address will be an exact match based on the Form CMS – 855A
OPPS Billing – Multiple Locations

• If all services from billing provider address:
  – report the billing provider address only in the billing provider loop and do not report any service facility location

• If all services are from one campus of a multi-campus provider that report a billing provider address:
  – report the campus address where the services were rendered in the service facility location if the service facility address is different from the billing provider address

• If all services are from the same off-campus, OP provider-based department of a hospital facility:
  – report the off-campus OP provider-based department service facility address in the service facility provider loop
• When services on the claim are from multiple locations, if any services performed at billing provider address:
  – report billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E

• When services on the claim are from multiple locations, no services on the claim were performed at billing provider address:
  – report the service facility address from the first registered encounter of the “from” date on the claim
OPPS Billing – Multiple Locations

- MLN Matters Number SE18023
- October 12, 2018
- Compliance begins April 2019
- Reiterates language for including off-campus provider-based location addresses in 2310E loop of the 837 institutional claim transaction
- If claim has a “PO” or “PN” modifier and no services were performed at the billing provider address, implicates need for off-campus location address.
- Populates from a drop down box (practice location screen)
  - Must match 855A locations exactly
    - Rd. vs Road
    - STE vs Suite
- After April 2019 Quarterly release, CMS will direct MACs to permanently activate edits
Provider Based RHC's – An OPPS Exclusion
Provider Based Rural Health Clinic Strategy

• Excluded from Section 603 provisions and OPPS changes to provider based payment rates
  • Exempt from several provisions in provider based rules under 413.65 (i.e. mileage, patient outpatient coinsurance notification)
  • Can be provider based entity to PPS or CAH
    • PB RHC provider based to a Urban or Rural IPPS hospital with less than 50 available beds is reimbursed by Medicare at cost per visit. Above 50 beds is capped at max RHC rate for CY 19 of $84.70.
    • PB RHC to CAH is also reimbursed by Medicare at cost per visit
    • Medicare Advantage reimbursement typically follows Medicare payment rates
    • Medicaid PB RHC reimbursement depends by state
    • Often more beneficial under PPS hospital than CAH
• Strategies within health systems evaluating opportunities where PB RHC opportunities exist
RHC Requirements

• Must be in a non-urbanized area according to U.S. Census data
• Shortage Area Designation in Last 4 Years (1 of Following):
  • Location Health Professional Shortage Area (HPSA)
    • Primary Care Geographic HPSA
    • Primary Care Population Group
  • Medically Underserved Designation (MUA)
• Other RHC Requirements
  • Advanced Practitioner (AP) 50% of time available to see patients
  • At least one AP employed by practice, others can be contract
  • Basic 6 Lab tests available in clinic
  • Written policies, procedures to address clinic operations, clinical protocols, human resources, patient safety, etc
  • RHC survey for certification, space specific. Annual evaluation.
  • Predominantly Primary Care (industry standard of at least 51% primary care services)
  • Can be a Provider Based RHC or Freestanding RHC
PB RHC Billing/Reimbursement

- RHC billed on a UB claim (UB 1450) for professional and technical services. Differs from Hospital Outpatient provider based billing where technical services are billed on hospital UB claim and professional on a CMS 1500.

- Medicare reimburses at an All Inclusive Rate (AIR) based on cost per visit
  - Freestanding RHC’s capped at ~$84.70/visit in CY 19.
  - PB RHC to hospital less than 50 beds is uncapped cost/visit which averages between $175 to $250/visit
  - Ancillary services (lab, xray, etc) billed under hospital if provider based

- Medicaid reimbursement typically based on cost established in initial cost report year. Varies by State.
- Commercial payors billed same as regular physician practice
Provider Based RHC Requirements

• Provider Based Requirements under 413.65
  – General requirements
    • Licensure under same license if applicable
    • Integration of clinical services
    • Financial integration and control by main provider
    • Considered provider based entity, not outpatient department of hospital
    • Public Awareness
  – PB RHC’s are exempt from:
    • Being within 35 miles of hospital to which provider based
    • Outpatient hospital coinsurance notification to patient
    • EMTALA
    • CAH off campus location mileage criteria to other hospitals
Potential Advantages/Disadvantages

PB RHC Advantages
- Typically higher reimbursement when PB RHC to a CAH, reimbursed cost per visit by governmental payors
- Recruiting new physicians in rural areas, cost reimbursed.
- Potential to include specialty services/visiting physicians within the RHC and billed RHC for cost reimbursement
- Not a split bill as may be accustomed to in a provider based physician practice
- 340B

PB RHC Disadvantages
- Potential increased Medicare OP coinsurance (based on charge structure)
  - Supplemental Coverage plans will mitigate impact for those who have coverage
  - Unpaid patient portion also eligible to be claimed for Medicare bad debt reimbursement
- Difference in billing from current internal practices, billing module, training
- .5 FTE mid level at each RHC
- Timeframe for conversion (typically 6-9 months)
Example Provider Based RHC Conversion Timeline

**Due Diligence**
- (0 – 30 days)
  - Confirm Practice is Eligible
    - MUA or HPSA designation
    - Designation is within last 4 years
  - Prepare RHC Financial Impact
    - Evaluate the Reimbursement Difference for Hospital
    - Evaluate Patient Coinsurance
  - Assess Compliance Transition
    - Determine steps necessary to meet Provider Based Rules Regulation
    - Determine changes necessary to meet RHC
    - Confirm with top 3 Medicare Advantage Plans
    - Develop internal implementation team

**Transition and Enrollment**
- (31 – 210 days)
  - Assess Structure Changes to operate under hospital Tax ID
  - Internal RHC Policies/Training
    - Develop RHC Policies
    - Conditions of Certification as Outlined in State Operations Manual
  - Payer Contracting Changes (if applicable)
  - RHC Revenue Cycle Module
  - CMS 855A & B Enrollments
  - Enroll with State Agency
    - CMS Form 1561 & 29
  - Survey Ready
    - Survey date is not a controllable date

**Post Successful Survey**
- (211 – 270 days)
  - CMS Issues Tie in Notice/Provider #
    - Request Medicare Initial RHC Payment Rate
    - Use RHC Analysis results
    - Submit and receive approval for Medicare EFT
      - For New Provider Number
    - Submit Final Attestation to MAC
      - Estimated time 45 – 60 days to complete
    - Submit Paperwork to State for Medicaid Number
      - Projected Medicaid Cost Report for Initial Rate
    - Begin Billing with New Provider Numbers

**Annual Requirements**
- (Annual – Ongoing)
  - File Cost Report Every Year
  - Subject to future State Surveys
  - Forward copy of Rate Letters to Medicare Advantage Plans to request same rate for RHC visits
  - Annual Program Evaluation
Current Environment Considerations
Considerations

• Immediate - Ensure 855A enrollment is correct by reviewing PECOS for Section 4 Practice location addresses
  • Make necessary corrections ASAP
• Prepare supporting documentation – Assess status
  • Off-campus locations pre and post 11/2/15
  • Validate proper use of “PO” and “PN” modifiers
  • Validate appropriate POS (11 vs 19 vs 22)
• Consideration of changing landscape
  • Add IP beds to become remote location
  • Add a dedicated ED
  • Add a provider-based RHC
  • Additional on-campus locations
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