

**CMS Update
Region B Annual Meeting
State Offices of Rural Health**

**Mobile, AL
August 7, 2009**

Topics

- What's New?
- IPPS Final Rule
- PFS and OPFS Proposed Rules
- Medicare Contracting
- DSH Adjustment
- CAH Conversions
- And more . . .

What's New

- Leadership
- Resources
 - Health Care Reform
 - CMS Information Related to the Economic Recovery Act of 2009
- CMS Listening Sessions

CY 2010 Inpatient Prospective
Payment System Final Rule
(IPPS Final Rule)



IPPS Final Rule
CAH Lab

- For CAHs to receive reasonable cost reimbursement for outpatient clinical diagnostic lab tests, the patient does not have to be physically present in the CAH at the time the specimen is collected as long as consolidated billing does not apply, and . . .

IPPS Final Rule
CAH Lab

- The individual receives an outpatient service in the CAH on the same day the specimen is collected, or
- The specimen collection is performed by a CAH employee

**IPPS Final Rule
Provider-Based Status**

- CAHs may receive reasonable cost reimbursement for lab services when they operate provider-based clinical diagnostic laboratories which meet applicable provider-based requirements
- Effective 10/1/2010

**IPPS Final Rule
Provider-Based**

- Off-campus clinical diagnostic facilities, provider-based to a CAH , acquired or created on or after 1/1/08, must meet the distance requirements in Section 485.610(e) in order to
 - retain its CAH certification and
 - and be paid on reasonable cost

**IPPS Final Rule
CAH Method 2 (Optional Method)**

CMS made a regulatory correction to conform to Section 1834(g) of the Act

- CAHs that elect Method 2 will be paid reasonable cost for facility services
- Effective for cost reporting periods beginning on or after October 1, 2009

IPPS Final Rule CAH Participation

CAHs located in counties reclassified as urban in FY 2010:

- Can continue operating as a CAH from 10/1/09 through the date it obtains a rural designation or 9/30/11, whichever is earlier
- If it cannot obtain a rural designation, the CAH would be required to convert back to a PPS hospital

CY 2010 Physician Fee Schedule Proposed Rule (PFS NPRM)



CY 2010 PFS NPRM

CMS proposes:

- Use of the American Medical Association's Physician Practice Information Survey (PPIS) data to calculate resource-based practice expense relative value units for most specialties
- That for IDTFs and independent labs that did not participate in the PPIS, continue using the current PE/HR developed using their supplemental survey data

CY 2010 PFS NPRM

- To increase the work Relative Value Unit (RVU) for the Initial Preventive Physical Exam (IPPE) to be = to the work RVU of a level 4 new patient office visit (CPT 99204)

Effect: If finalized, the work RVU for the IPPE would increase from 1.34 to 2.30

CY 2010 PFS NPRM

- To add individual health and behavior assessment and intervention services (HCPCS codes 96150 to 96152) to the list of Medicare telehealth services

CY 2010 PFS NPRM

- To revise the telehealth regulations to restrict physicians and practitioners from using telehealth to furnish the physician visits required under the long-term care regulations

Why?

CY 2010 PFS NPRM

- To revise the telehealth regulations to specify that the HCPCS codes for follow up inpatient telehealth consultations include follow up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities

CY 2010 Outpatient Prospective Payment System/ Ambulatory Surgical Center Proposed Rule with Comment Period (OPPS NPRM) Highlights

OPPS NPRM

CMS is proposing:

- To make payments to rural hospitals for kidney disease education services furnished in outpatient departments for beneficiaries with Stage IV chronic kidney disease
- To continue a budget neutral 7.1 percent payment adjustment for rural Sole Community Hospitals (including Essential Access Community Hospitals)

OPPS NPRM

- Physician assistants, nurse practitioners, certified nurse specialists, and certified nurse-midwives may directly supervise all hospital outpatient **therapeutic** services that they are able to personally perform within their state scope of practice and hospital-granted privileges.

OPPS NPRM

- To refine the definition of “direct supervision” of hospital outpatient **therapeutic** services furnished in a hospital and in on campus provider-based departments of a hospital
- To define “in the hospital”
- To make a technical correction to §410.27 of the regulations to include CAHs

OPPS NPRM

- To define “direct supervision” for on-campus hospital outpatient services to mean the physician or nonphysician practitioner must be present in the hospital or on-campus provider-based department of the hospital and immediately available to furnish assistance and direction throughout the performance of the procedure

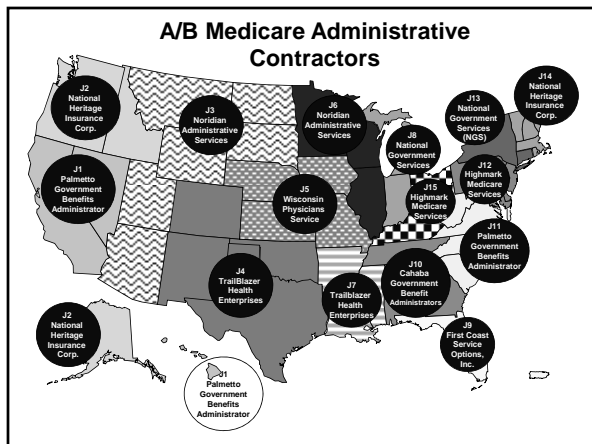
OPPS NPRM

- To require that all hospital outpatient **diagnostic** services furnished directly or under arrangement, whether provided in the hospital, in a provider-based department, or at a nonhospital location, follow the MPFS physician supervision requirements for individual tests

OPPS NPRM

Other proposals regarding:

- Policy changes and payment for services in Ambulatory Surgical Centers
- Adjustment for hospital pharmacy costs
- The Hospital Outpatient Department Quality Reporting Program
- Allowing reimbursement for pulmonary and intensive cardiac rehabilitation services furnished in outpatient departments



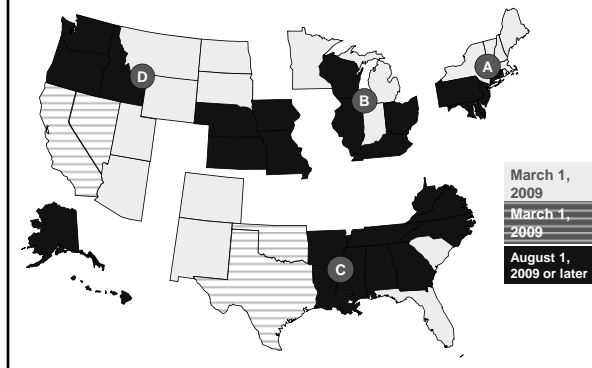
MAC Transitions

- Riverbend to Cahaba (J10) transition will affect 591 RHCs in Region B
- Cutover date was 8/3/09
- Considerations: Listserv, local coverage determinations, electronic funds transfer agreements, electronic data interchange trading partner agreement, ensure claims vendor is aware

MAC Transitions

- When MACs are implemented, newly enrolling providers will be assigned to the MAC for their state, not to the old legacy contractor
- Existing providers that were assigned to specialty contractors in the past (e.g., RHC, FQHC), will remain out of the new MAC jurisdiction until CMS begins the migration process in several years.

RAC Phase In Schedule



Recovery Audit Contractors

Region B RAC: CGI

- Region C RAC: Connolly Consulting, Inc.
- What will be reviewed?
- What claims are affected by a full inpatient denials? Will they be denied?

Disproportionate Share Hospital (DSH) Adjustment

- What are DSH Hospitals?
- Why get approved?
- What is the funding mechanism?

DSH Payments (\$ billions)

- FY 1999: 5.00
- FY 2000: 5.18
- FY 2001: 5.68
- FY 2002: 6.63
- FY 2003: 7.10
- FY 2004: 7.82
- FY 2005: 9.00
- FY 2006: 9.18
- FY 2007: 9.40
- FY 2008: 10.12

Source: CMS, Office of the Actuary

Medicaid and Medicare/SSI Fractions

Medicaid Fraction:	SSI Fraction:	
Days Eligible for Medicaid & Not Entitled to Medicare Part A	Days Entitled to SSI & Entitled to Medicare Part A	+
Total Patient Days	Total Medicare Days	=
Medicare Disproportionate Payment Percentage (DPP)		

Qualifying for DSH

- If a rural hospital's DPP is \geq 15%, it qualifies
- DSH adjustment payments are capped at 12% for:
 - Sole Community Hospitals and Rural Hospitals with > 500 beds
- No cap on DSH adjustment payments for:
 - Rural Referral Centers
 - Medicare Dependent Hospitals
 - Rural Hospitals with 500 or more beds

Percentage of Inpatient Hospitals that Qualify for DSH Payment

- FY 2003: 63%
- FY 2004: 67%
- FY 2005: 71%
- FY 2006: 73%
- FY 2007: 75%
- FY 2008: 75%

Source: CMS, Office of the Actuary

Critical Access Hospital Conversions

Calendar Year	Total # CAHs	New CAHs
2002	727	183
2006	1292	18
2007	1299	12
2008	1307	12
2009 (as of 7/1)	1309	6

- Is the 15 mile requirement being used?

Rural Health Clinics

- Proposed Rule
- Funding for surveys
- Is there to be an accrediting organization for RHCs?

HPSA Bonus Changes

HPSA Bonus Payments – designation status on December 31 governs eligibility for Medicare bonus the following year



Thank You

Lana Dennis
Rural Health Coordinator
Atlanta Regional Office for CMS
Lana.Dennis@cms.hhs.gov
(404) 562-7379
