A2HA Spring 2019 Meeting

The Medicare Chess Game: New Moves and Strategies for Hospitals and Their Ambulatory Care Venues

HALL RENDER
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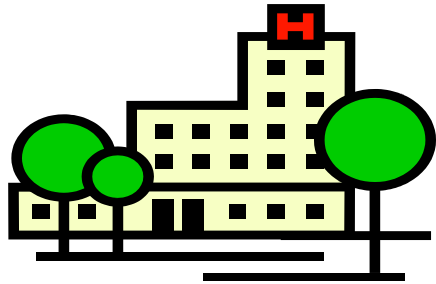
Agenda/Content

- Fly By on Building Blocks
  - Provider Based 603 update
  - 340B Basics
  - The Nuclear Risk -Do you Really Have a Hospital?
  - HwH – Payment and COP
  - Reclass – Rural and Wage Index
- Medicare Chess Game Strategy – Case Studies
  - Provider Based Strategery & § 603 Optimization
  - 2 step reclass – “Rurban” Strategy
  - Provider Consolidation & Spinoffs

Section 603 of BBA of 2015

- Amended SSA § 1833(t) of Hospital Outpatient Prospective Payment System (“HOPPS“ or “APCs”)
- Effective January 1, 2017: Excludes from HOPPS services provided in off-campus outpatient departments of a provider as defined in 42 CFR § 413.65(a)(2) (i.e., Medicare provider-based rule). Exceptions for:
  - Off campus sites in place on 11/2/2015 - grandfathered
  - Main campus & remote location "campus" services
  - Services in off campus Dedicated EDs

Definition of Campus



- So What is “On Campus” of Main Provider or RLOH ?
  - 413.65: “Campus means 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”
  - Final Rule: “a hospital may measure 250 yards from any point of the physical facility that serves as the site of services of the remote location to any point in the PBD”
  - CMS should use same definition for both types of I/P sites
  - Regional Offices have rarely used discretion to enlarge campus

Grandfathered Sites - Eligibility

- Location (street address, including suite #) billing under HOPPS for services furnished prior to 11/2/2015

- Lose excepted status if:
  - location is changed (physical address listed on provider's hospital enrollment form as of 11/1/2015
  - Limited exception for relocation due to factors beyond the hospital's control, with advance CMS approval
  - CHOW to different provider number, unless via merger with auto assignment
- Expansion (space or services) allowed at same location

Dedicated ED Exception

- Adopts EMTALA Definition in 42 C.F.R § 489.24
  - Licensed as ED under state law
  - Held out to public as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
  - provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
    - Determined by representative sample of patient visits
    - During prior calendar year
- Applies on or off campus, GF'd or not

Dedicated ED Exception

- Final Rule clarifies that this includes all items or services “in” a dedicated ED whether emergent or not
  - Ancillary services, etc.
  - Only services only related to an emergent/urgent visit?
- CMS gives no definition of “in” ED
  - There is CLEARLY NOT a 250 yard rule like there is for a remote location of a hospital
  - Within same off campus building that houses ED?
  - Or only portion of multiuse building that is “in” ED?

2017 Final Regulation Redemption

- Issued November 14, 2016
- Reversed position from proposed regulations on several key items
  - No service or volume limitations on grandfathered sites
  - Limited relocations allowed for extraordinary circumstances
- New “payment system” for non-GF’d sites/services
  - Still bill on UB-04 and 1500 POS 19/21/22
  - Paid at 40% APCs in 2018 (was 50% in 2017)
  - Still HOPD/PB’d for cost report, 340B, etc.

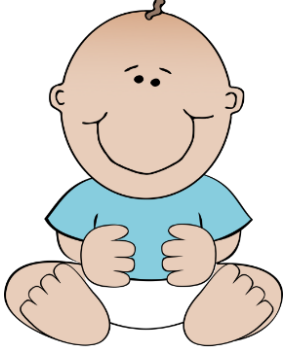
2019 Final Regulations

- Issued November 21, 2017
- Once again CMS did not finalize proposal to limit expansion of services at excepted (grandfathered) locations via clinical families. However, CMS will continue to explore this issue in the future
- Clinic E/M visit services (HCPCS code G0463) at excepted (grandfathered) off-campus PBDs to be paid at lower rates
  - 70% of the OPPS rate in 2019 & 40% in 2021.
  - AHA filed suite challenging these cuts
- CMS cut payment for covered drugs at non-excepted off campus PBDs to ASP-22.5% - same as excepted and on-campus

Services Not Impacted

- The payment limitation does NOT affect certain providers and services
  - Outpatient services paid under another fee schedule (e.g., PT/OT/ST, lab, etc.)
  - Critical access hospitals – not paid under OPPS
  - "Provider-based entities" such as rural health clinics
    - Paid under separate benefit & provider number/CCN
    - E & M visit at RHC not paid under OPPS
    - Non-RHC services at provider-based RHC site?

New (Non-GF'd) Sites



- Opened after 11/2/2015 and NOT:
  - "in" dedicated ED
  - on campus of Main Provider or remote location (250 yards)
- Still Provider Based on the CMS UB-04
  - Identify non-excepted services with "PN" modifier
  - Pay for those services under new MPFS rates
- Paid at 40% APCs/HOPPS in 2019
  - not so site neutral
  - Still 340B eligible

New Site APS – In Action

- And now there are three options…
  - Full APCs – Grandfathered, on-campus/RLOH, excepted (DED)
  - 40% APCs – Non GF'd/off-campus/excepted provider-based sites
  - Freestanding – PFS or other applicable systems (ASCs…)
- General Observations
  - Before wage/labor adjustment & packaging/bundling:
    - 40% APC > MPFS for most HCPCS/CPTs (2300+ of 2600+)
    - PFS>100% APC for 61; PFS> 40% APC for 297
  - 40% APC vs. ASC Rates: ASC > 40% APC for 900+ of 1200+
  - Case-by-case assessment: with 340B, IME, operational consistency, Medicaid, etc.

What to Do Now

- Be aware that given risks to grandfathered or excepted status, provider-based compliance risks are heightened
- Maintain documentation for grandfathered locations
  - CMS noted that it and its contractors will continue to conduct audits of hospital billing to ensure off-campus provider-based departments are billing appropriately
  - CMS expects hospitals to maintain proper documentation showing which off-campus locations have excepted status
- Provider-based sites opened after 11/02/15
  - Should be using PN modifier for DOS after 12/31/16

What to Do Now

- Make sure each hospital location is included in Medicare enrollment profile
- Also a good idea to confirm that locations match for Medicaid, commercial payers, and 340B
- Starting April 2019, Medicare billing edits will return claims that identify a service location that is not an exact match to a Medicare enrolled location

Use 340B Exception to 35 miles?

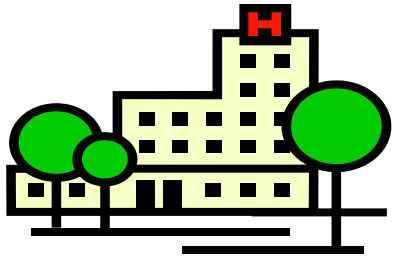
- Provider based rule has always had exception to 35 mile radius limit for “hospital or CAH with >11.75% DSH payment adjustment”
- 11.75% is threshold for 340B eligibility (pre-ACA)
- Must have contract with government entity in which the >35 mile site is located – to care for indigent at site
- NOT an exception to site neutral reductions, so 40% APCs unless: Dedicated ED, Remote location

340B Program - Overview

- Estimated Savings: 25-50% of a drug's Average Wholesale Price (GPO is typically 15-20% savings)
  - Applies to all eligible drug purchases, not just Medicare
- Manufacturers that want to receive Medicaid payment for drugs required to enter into Pharmaceutical Pricing Agreement ("PPA")
- 340B Program savings – used in support of hospital's non-profit mission
- Pass-through NOT required, except by Medicaid and certain Medicaid Managed Care plans

340B Covered Entity

- Non-profit hospitals/CAHs only: By PTAN, not I/P Campus
- PPS Hospitals
  - DSH >11.75% payment ratio (before 75% UCP reduction)
  - SCH/RRC DSH >8% payment ratio
- CAHs – automatic
- Children's & Cancer Hospitals
- Second Tier: SCH/RRC via 8%, FS'g Cancer Hospitals & CAHs
  - Not eligible to use 340B discount for "orphan drugs"
  - Can use GPO or 340B



340B Program – CE Eligible Facility

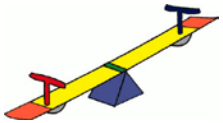
- What is an eligible "facility"?
  - 340B COPDs only delivered to/administered at main provider or child site
- Child site "facility" must appear on the most recent as-filed cost report in a reimbursable cost center and enrolled with HRSA OPA
  - Clinics, services or departments
  - Significant transactional implications
  - Even if provider-based for Medicare purposes

- Provider-based elements→ reimbursable→ child site designation→
  - "… a covered entity shall not resell or otherwise transfer the drug to a person who is not a patient of the entity …"

340B Medicare Payment Cuts

- Effective 1/1/2018: Drugs purchased with 340B discount AND
  - Billed to Medicare as HOPD Paid at ASP-22.5% (was +6%)
  - NOT APPLICABLE to Non-GF'd/excepted provider based site – was paid at ASP +6% (same as non-hospital)
- 1/1/2019: Drugs purchased with 340B discount paid at ASP-22.% at non-GF'd/excepted sites as well
- Exemption from payment cut for:
  - Rural SCH – including deemed rural via 42 CFR 412.103
  - Children's Hospitals
  - PPS exempt Cancer Hospitals

Medicare Balancing Act

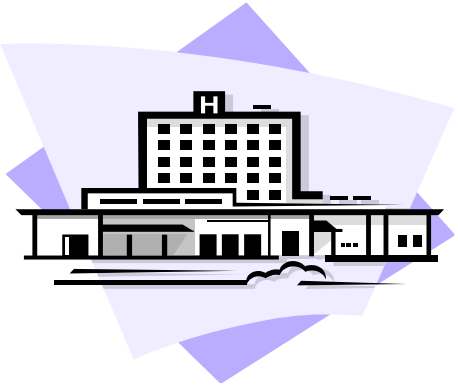


Venue	Technical	Professional	Drug Cost & Payment
FSg Office	PFS/RVU (non-facility) drug admin CPT codes	PFS	Not 340B Eligible ASP + 6%
PPS HOPD On-Campus	100% APC	PFS/RVU E&M Facility or Procedure code	340B Eligible if Hospital is; ASP – 22.5% Bundled into APC (if cost < packaging threshold of $125 for 2019)
PPS HOPD GF'd Off-Campus	E/M – 70% APC in 2019 & 40% in 2021 Others 100% APC	PFS/RVU E&M Facility or Procedure code	340B Eligible if Hospital is; ASP – 22.5% Bundled into APC (if cost < packaging threshold of $125 for 2019)
PPS HOPD Non-GF'd Off-Campus	40% APC in 2019	PFS/RVU E&M Facility or Procedure Code	340B Eligible if Hospital is; ASP – 22.5% Bundled into APC (if cost < packaging threshold of $125 for 2019)
CAH Site	101% costs	PFS (facility) + 15% if Method II	340B Eligible 101% cost
RHC Site	100% costs (<50 bed)	Global with TC	340B Eligible if Hospital Based -100% costs
Pharmacy	N/A	N/A	Part D ingredient cost plus dispensing fee (plan specific) Part B reimbursement not available for any drug usually self-administered

The Nuclear Risk – Not Even a Hospital?

Hospital Definition Update from CMS

- Primarily Engaged in Providing Inpatient Services
  - S&C Memo: 17-44 9/6/2017
  - SOM A-0022 § 482.11
- N/A to CAHs and PPS Excluded Psych Hospitals
- Primarily Engaged
  - State license as a hospital is necessary, but NOT sufficient
  - Capacity/potential to provide I/P is NOT sufficient
  - Acute care medical necessity, expecting 2 midnight stay
  - For survey must have 2 or more I/Ps = starting point only



Hospital Definition Update from CMS

- Factors CMS ROs should consider include:
  - Number of provider based off campus EDs
  - # I/P beds relative to facility size & services offered
    - For Example: 4 I/P beds, 6-8 ORs, 20 ED bays & 10 ambulatory surgery beds is most likely not primarily engaged in I/P care
  - Volume of O/P surgery vs. I/P surgery
  - Advertise as specialty or surgery hospital
  - Patterns of ADC over course of week
  - Staffing schedules
- Aimed at the micro hospital strategy (Mini-me)

Hospital Definition Update from CMS

- CMS National Office perspective…???:
  - Not a requirement that >50% of revenue or volume be I/P
  - Will approach as a 2 Step process
  - Step 1: Sufficient/legitimate I/P volume?
    - If so then do not proceed to Step 2
    - I/P volume or revenue in comparison to O/P not considered
  - Step 2: If I/P activity insufficient:
    - Then proceed to compare to O/P per S&C 17-44
    - If O/P substantial then initiate denial/revocation of hospital status
  - N/A to “Micro remote locations” on site specific basis
    - Applies to ALL sites under same hospital provider #

Prior Case Law on "Primarily Engaged"

- Arizona Surgical Hospital, LLC, DAB, Docket No. A-03-24 (July 23, 2003).
  - Arizona Surgical Hospital (ASH) held a special hospital license issued by AZDHS, the state agency charged with responsibility for licensing, inspecting, and regulating health care institutions in Arizona.
  - Due to a series of complaint investigations, AZDHS ultimately barred ASH from accepting inpatient admissions for a fixed period of time.
  - CMS conducted a survey of ASH during the period of the inpatient admission ban, and CMS concluded that ASH was not primarily engaged in providing services to inpatients and did not qualify as a hospital for purposes of the Medicare statute. CMS then terminated ASH's Medicare provider agreement.
  - ASH argued, unsuccessfully, that its hospital policies, procedures, records and correspondence were "all designed by [ASH] to carry out the functions of a hospital." In essence, ASH argued that because it was designed and structured to function as a hospital, the fact that it did not have (nor could have) inpatients during the AZDHS ban was irrelevant.
  - The DAB disagreed, finding that ASH could not be "primarily engaged" in providing services to inpatients when it was not "engaged" in providing those services at all. The DAB also noted that ASH functioned primarily as an outpatient surgical facility before the AZDHS ban, admitting only 11 inpatients off 150 surgical procedures a month.

Prior Case Law on "Primarily Engaged"

- Willis Eye Hospital, DAB, Docket No. A-16-78 (October 25, 2016).
  - CMS and DAB both found that the undisputed evidence established that Wills, a former ambulatory surgical center (ASC) which had added four inpatient beds, was not "primarily engaged" in providing services to inpatients as required by the statutory definition.
  - CMS based this determination on its interpretation that "[b]eing 'primarily engaged' in providing inpatient services means actually providing for the most part inpatient services" and that "[a]n institution that provides a greater volume of outpatient services than inpatient services is not primarily engaged in providing inpatient services and therefore not eligible to participate in the Medicare program as a hospital."
  - CMS further found that, even if each of Wills' four inpatient hospital beds "were filled seven days per week with a different patient, that would constitute 1460 patients, or about 17%" of the "8400 out-patient surgeries per year" that Wills "estimates that it performs" at its location seeking hospital status.
  - Willis argued, unsuccessfully, that "the evolution of ophthalmology itself toward treatments that allow patients to go home the same day" has "limited" the number of ophthalmology inpatients the hospital has "at any one time." Due to such technological advancements, Willis felt that it performed hospital-level services on a efficient outpatient basis. The DAB disregarded this argument in light of the statutory language regarding "inpatient" services.

CMS I/P Requirement for CAHs

- 42 CFR 485.635 – Patient Services
- State Operations Manual – Appendix W C-0281
  - Updated 4-7-2015: CAH furnishes acute care I/P services
  - Factors to assess
    - Volume of ER services
    - Number of certified I/P beds
    - Dedicated observation beds? Ratio to acute care I/P beds?
    - Average occupancy rate & volume of admissions
    - Volume of observation patients
    - % of ED visits admitted to CAH vs. transferred
    - Range complexity & volume of O/P services

CMS I/P Requirement for CAHs

- No specific formula: surveyors s/b alert to disproportionate relationships among CAH's various services. For example:
  - 4 I/P beds, ADC = 3, but 18 observation beds @ 85%
  - 24/7 physician staffed ED – 9,000 visits/year & offers extensive O/P – chemo, advanced imaging, sleep lab, O/P surgery, but transfers almost all patients needing I/P to other hospitals
  - AHRQ data shows: 8.3% ED resulted in I/P admit at rural sites vs. 16% in non-rural hospitals
  - If CAH admits at least 8% annually then compliant
- Manual includes 3 examples of problematic scenarios

Hospital Within Hospital Basics

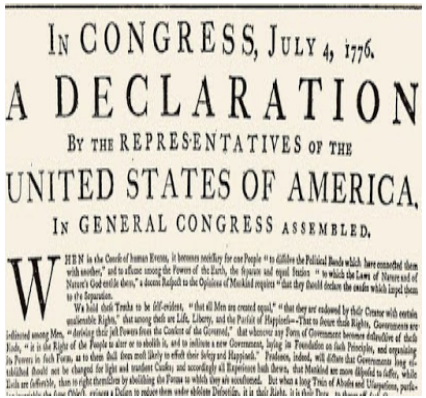
- 2 Sets of Rules
  - Payment HwH @ 42 CFR 412.22 for DRG excluded hospitals
  - COP Issue = CMS Enforcement Position that each provider number must be able to demonstrate that it independently meets COPs (no physical or operational co-mingling)
- Payment HwH Applicable to:
  - Children's, LTCH, Rehab, Psych, Cancer
  - N/A to co-located DRG paid hospitals (Women's, Surgery, etc.)
  - pre-1996 co-located grandfather rule
  - Uses 250-yard campus definition in provider based rule
- COP Applicable to all providers: H, CAH, SNF, etc…

HwH Payment Rules

- If w/i 250 yards of DRG paid hospital & NOT GF'd, then to be excluded from DRGs must:
  - Not be under common control of host/landlord hospital:
    - Uses Medicare related party definition of "significant influence"
    - No bright line <50% test – all the facts & circumstances
  - Separate CEO from host/landlord
  - Separate CMO & Medical Staff
- 10/1/2017 CMS eliminated:
  - Basic hospital functions test
  - N/A to co-located excluded hospitals

HwH CoP Rules

- 42 CFR 482.12 SOM Appendix A A-0043
- If part of "system" that includes separately certified hospitals (or other providers) – can choose governance/corporate structure:
  - Separate legal entity/board for each provider; or
  - All in one legal entity
- But each provider must be able to independently demonstrate its compliance with the COPs – independent of any other facility. There is no survey of a "system"


IN CONGRESS, JULY 4, 1776.

A DECLARATION

BY THE REPRESENTATIVES OF THE

UNITED STATES OF AMERICA,

IN GENERAL CONGRESS ASSEMBLED.

HwH CoP Rules

- May adopt identical policies & procedures, BUT documentation must be clear how they apply to specifically named hospital/provider
- Governing body policies & procedures must be presented that clearly apply to each hospital/provider
  - "System/legal entity has adopted the following policy" is not acceptable. Must state [H/CAH/SNF] has adopted
  - Minutes of governing body must be clear which provider actions apply to
  - Departments of separate providers cannot be operationally integrated

HwH CoP Rules

- Policies & procedures for nursing services may be identical for each provider but must operate separately
- Same person could be Director of Nursing for multiple providers, so long as able to carry out all duties, but must be clearly identified separate "chain of command" for each
- Nurse may work in multiple providers but must have separate work schedules for each provider
- Likewise quality process and indicators may be identical but must be separately tracked by each provider

Multiple Reclassifications

- Two methods for a hospital to reclassify
  - MGCRB wage index reclassification
  - Urban to rural a/k/a 412.103 a/k/a Sec. 401 reclassification
- When CMS implemented the regulations for rural reclassification at 42 CFR 412.103, it amended the MGCRB regulations to prohibit hospitals with 412.103 rural status from also being reclassified by the MGCRB
- CMS was concerned that hospitals would use both reclassification processes to "game" the system

Multiple Reclassifications

- Providers challenged CMS and won in 2 federal appellate court decisions
  - Geisinger Community Medical Center v. Secretary, United States Department of Health & Human Services (3rd Cir. 2015)
  - Lawrence & Memorial Hospital v. Burwell (2nd Cir. 2016)
- CMS conceded nationally in Interim Final Rule published in Fed. Reg. on April 21, 2016

2016 Interim Final Rule

- A hospital with a MGCRB wage index reclassification can be approved for a 412.103 reclassification and keep its MGCRB reclassification
- A hospital with 412.103 rural status can use the less stringent wage index and proximity criteria applicable to rural hospitals (106% and 82% wage tests, 35-mile proximity) for MGCRB reclassification (instead of 108% and 84% wage tests, 15-mile proximity)
- For home area wage test, compare to hospitals in area hospital actually located; not hospitals in the state rural area

2016 Interim Final Rule

- Can get MGCRB reclassification back to home urban area
- A hospital with dual reclassifications will be treated as urban for wage index purposes and rural for other Medicare purposes
- A Lugar hospital that receives a 412.103 reclassification will still receive the urban wage index based on its Lugar status

2019 Final Rule

- SCH/MDH effective date the date of filing
- CMS clarified rules for multi-campus hospitals applying for 412.103 reclass or SCH/MDH/RRC status
- Changed lock-in date for 412.103 reclass – approval must be made within 60 days of Notice of Proposed Rule Making to be included in upcoming FFY rural wage index (usually mid-June)

The "Rurban" Strategy

- Allows urban hospitals to reclassify to rural and apply for MGCRB reclassification using the more flexible rural wage index reclassification rules
- Urban hospitals should carefully evaluate options to consider the impact of:
  - Timing requirements and applications
  - Impact on all inpatient and outpatient payments, not just wage index
  - Could impact other payors as well (including Medicare Advantage)
  - 340B eligibility and effective dates
  - In some cases, the strategy may necessitate short-term pain for a long-term gain…

The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - Sole Community Hospital Status, Rural Referral Center Status, Medicare Dependent Small Rural Hospital Status
  - 340B Status
    - Ordinary method for 340B eligibility is to have a DSH adjustment of at least 11.75%
    - SCHs and RRCs may qualify if their DSH adjustment is at least 8%
    - BUT, subject to the Orphan Drug exclusion
    - Quarterly enrollment process for 340B

The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - Medical Education Payments
    - MGCRB reclass does not impact medical education payments, but 412.103 reclass may
    - For medical education payments, 412.103 reclassification treats he hospital as rural for some purposes and urban for other

Rural for:

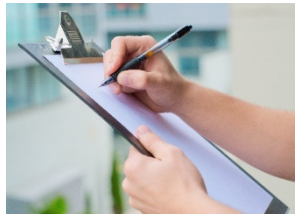
  - 30% upward adjustment to existing IME FTE cap under 413.79(c)(2)(i)
  - Can build new program IME FTE cap under 413.79(e)(3)

The "Rurban" Strategy

- Medical Education Payments (cont.)
  - Urban for DGME FTE cap (i.e., no DGMTE FTE cap increase and cannot build new DGME FTE cap)
  - If hospital returns to urban status before 10 years, it loses the cap increases
  - If rural status remains for 10 years, changes may become permanent
  - Can take several years for the IME benefits to fully kick in year rolling average and IRB ratio lookback

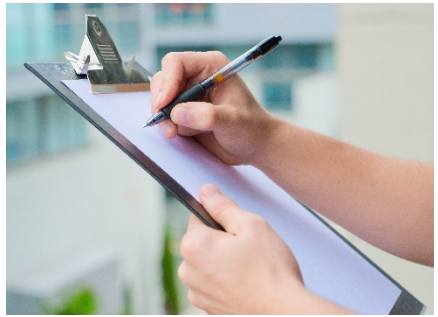
The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - Operating DSH cap of 12% for certain categories of hospitals
  - Loss of capital DSH payments
  - Bundled payment programs
    - Treated as rural for Comprehensive Care for Joint Replacement and the proposed Cardiac Bundled Payment
    - Stop-loss thresholds under the programs are lower for rural hospitals, but rural hospitals have the same upside gain potential as urban hospitals



The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - May impact other payors: Medicaid, TRICARE, commercial
  - Does not impact exempt units/facilities
    - rehabilitation
    - psychiatric



The "Rurban" Strategy

Filing deadlines and effective dates for hospitals applying for 412.103 reclass, RRC status, MGCRB reclass and 340B based on cost-reporting year end:

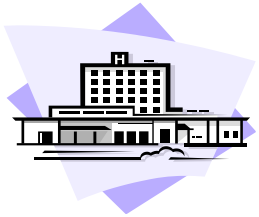
	FYE 3/31	FYE 6/30	FYE 9/30	FYE 12/31
412.103	1/1 - 3/31/2019	4/1 - 6/30/2019	7/1 - 9/30/2019	10/1 - 10/31/2019
RRC Filing	1/1 - 3/31/2019	4/1 - 6/30/2019	7/1 - 9/30/2019	10/1 - 10/31/2019
RRC Effective	4/1/2019	7/1/2019	10/1/2019	1/1/2020
MGCRB Filing	9/1/2019	9/1/2019	9/1/2019	9/1/2019
MGCRB Effective (IPPS)	10/1/2020	10/1/2020	10/1/2020	10/1/2020
MGCRB Effective (OPPS)	1/1/2021	1/1/2021	1/1/2021	1/1/2021
340B Enrollment	7/1 - 7/15/2019	10/1 - 10/15/2019	1/1 - 1/15/2019	1/1 - 1/15/2019
340B Effective	10/1/2019	1/1/2020	3/1/2020	3/1/2020

The "Rurban" Strategy

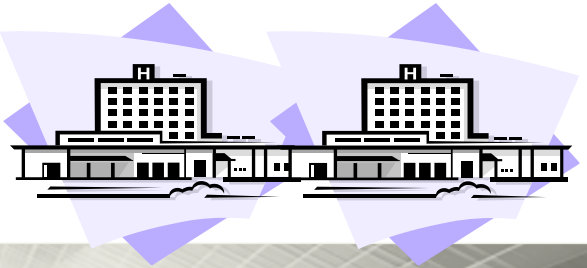
If the hospital is not applying for RRC status, the filing dates get much less complicated:

	Date
MGCRB Filing	9/1/2019
412.103 Filing and Effective	10/31/2019
MGCRB Effective (IPPS)	10/1/2020
MGCRB Effective (OPPS)	1/1/2021

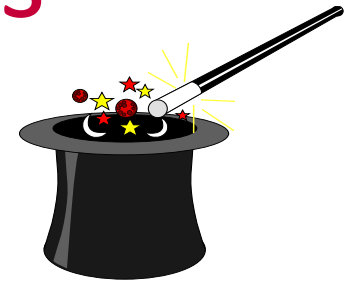
Provider Consolidation & Spin Offs



- 1 hospital or 2 (or more)?
  - 1 provider number with multiple campuses (I/P), or
  - Separate provider numbers for each campus
  - What is or is not part of DRG Provider number:
    - Psych units/hospitals
    - Children's hospital or Service line?
- Why does it matter?
  - DSH, IME/DME, Wage Index-reclass
  - 340B
  - Medicaid
- Can't be just reimbursement driven
  - Lots of other implications
  - Market, med staff, operations



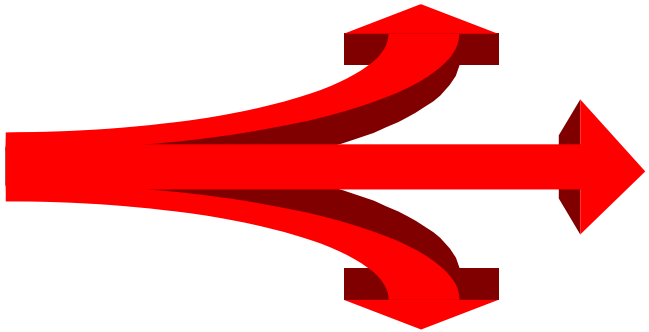
Provider Consolidation & Spin Offs



- Special application of provider based rule
  - All PB'd requirements must be met
- "Remote location of a hospital"
  - Site separate from the "main provider" with I/P services
- Single provider structure
  - One Medicare provider #
  - Multiple campuses (separate licenses OK if required by state law
- One site must be "main provider"
- Other site(s) must be "remote location(s)" & are considered off campus for PB'd rule:
  - Split billing notice, JVs, management contracts…

Provider Consolidation & Spin Offs

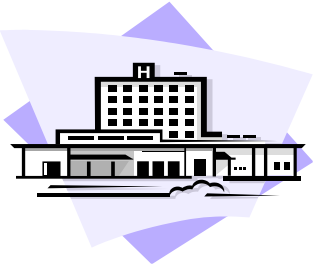
- Consider DRG Payment Window
  - Multi-campuses of single provider all w/i same window
  - Separate hospitals are not, unless in same corporation or parent-sub
- Can be applied to excluded hospitals
  - Rehab, psych, LTCH, CAH
- Spin off = vice versa
  - Fail some part of PB requirements
  - Requires separate provider #
- Hospital-in-Hospital Payment Rules N/A
  - Only applies to excluded hospitals, not acute



Medicare Chess Game - Hot Moves

- Provider based - 603 limits off campus O/P, so:
  - Add I/P to be RLOH – excepted within 250 yards
  - Free standing EDs
  - Non-excepted – so FFS revenue neutral, BUT 340B child site
- Two Step Reclass:
  - Improve wage index &/or IME
  - Get to/keep 340B anyway possible
  - Get Rural SCH OPPS +7.1% & 340B cut exemption
- Go Micro or not?
- Provider consolidations/spin offs

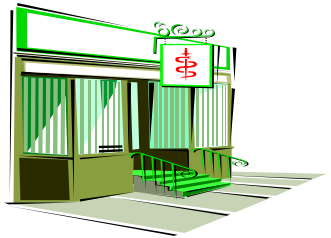
Provider Based "Strategery"



- Choice of Hospital to be Based to:
  - Sites w/i 35 miles of >1 hospital in a system?
    - 340B (11.75%) exemption from 35 mile radius
  - PPS:
    - Rural sole community? Extra 7.1%
    - 340B eligible? Payment cut or not? (GF'd – non GF'd)
    - FTE count for IME/DME
    - Post 11/2/15 Excepted site: ED or remote location of hospital?
    - Non-GF/Excepted site payment comparison to PFS/FS'g
    - Services at PB'd site within DRG window
    - <50 beds – HB'd RHC = cost for professional component
  - IRF/Psych/LTCH - paid APCs for O/P too

Provider Based “Strategery”

- CAH
  - Facility component cost based
  - Professional component - Method II -115%
  - Eligible for 2nd tier 340B status
  - Off campus location restrictions



- HB'd RHC (in HPSA)
  - Exempt from off campus restrictions
  - cost includes professional component

- Cost based reimbursement “dilution effect”
  - HB’d operations pull costs away from CAH I/P & O/P with usually highest Medicare utilization
  - To non-cost based operations: HHA, SNF, etc.
  - To cost based but lower Medicare utilization operations: RHCs

Add I/P Beds to Expand GF'd PB'd

- Urban Teaching Hospital with Rurban for:
  - Increased wage index and IME increase
  - Acquiring Tier 2 340B status as an RRC
- Operates GF'd off campus (10 miles) O/P only PB'd site
  - Planning major expansion of services & foot print
  - Will include oncology center
- Not a CON state – add I/P beds?

I/P Beds at North Campus?

- Without I/P Beds
  - Ok to swap/change services at North Site
  - Footprint expansions- maybe, but not clear
  - No w/i 250 yards leeway to add PB'd
  - As either RLOH or New P# will be excepted as on campus
- With beds as either RLOH or New Hospital:
  - Eliminates any § 603 GF issues
  - Anything on campus will be excepted from § 603
  - Full APC payment

2 Provider #s or 1 - Balancing Act…

- 1 Provider # - RLOH
  - No start up revenue lag
  - No new capital cost $
  - No new GME cap
  - Included as 340B site likely
  - Same “Rurban” payment benefits as Main Campus

- 2nd Provider #
  - Start up revenue lag as “nonpar” hospital
  - New hospital capital cost
  - Build new GME cap
  - 340B not likely
  - Not part of “Rurban” payment benefits

New Provider Based (Non-GF'd) Site

- HC System Flagship: Teaching, DSH, 340B, GF'd PB'd sites
- Wants new patient care site across state line:
  - Better serve patients in outlying catchment area, competition
  - Other state has Bed moratorium – so no new I/P beds (for RLOH)
  - O/P Surgery, PC & Specialty Clinics, Infusion/oncology, Lab, Imaging
- Although 603 applies 60% haircut to Medicare FFS
  - Child site status for 340B makes finances as PB'd a win
  - Across state lines OK as long as consistent with laws of both states

Mismatch of Hospital Location Info

- Hospital with off-campus ambulatory clinic sites
- Some treated as provider-based, some freestanding
- Some listed on Medicare enrollment, some not
- Had several off-campus sites registered as 340B child sites that were not provider-based
- Potential 340B Program diversion issues

PB'd RHC In Your Face Example

- Region 8 - Necessary Provider CAH #1
  - Acquired FS'g RHC in town 25 miles away
  - Across the street (<600 feet) from CAH #2 in that town
- CAH #1 plans to:
  - Convert RHC form FS'g to PB'd
  - Add non-RHC services to be billed under CAH #1 CCN – PT, Imaging, Lab
- Region 8 Approved
  - Because RHC/PBE does not trigger CAH off campus location test
  - Addition of non-RHC services billed as CAH O/P OK too

PB’d RHC On Steroids (& IYF)

- Region 5 CAH – also NP
- Opened PB’d RHC in town 20 miles away & 1 mile from PPS Hospital services to include:
  - Medical Oncology & Infusion
  - Imaging to include CT
  - PT/OT/ST
  - Maybe Rad Onc (Lin Acc) down the road….
- Region 5 Approved – No Impact on CAH status

Mini-Me to Get <50 Bed for RHCs?

- Community Hospital: Rural SCH, 340B, some GF'd PB'd Sites
  - In HPSA so PB'd RHCs exempt from UPL if <50, ADC 55=ish
  - Town 15 miles away near Interstate looking for I/P Site
- Create New I/P campus as Separate Provider?
  - <50 would allow PB'd RHCs to Mini-Me, but not 340B child sites
  - PE test would need to limit ADC to <4 to keep SCH under 8% test, so CH still >50 beds
  - Rural SCH impact = $2.5 – 3 m/year
- Create new I/P campus as RLOH?
  - Site >25 miles from other hospitals so could keep SCH as 2 campus P#
  - All O/P w/i 250 yards exempt from 603, site = child site
  - Expand GF'd sites, Add new PB'd RHCs – subject to UPL, OR non-GF'd PB'd, but all 340B
  - Can't always have your cake and eat it too….

Rurban Strategy Wage Index

- Urban hospital with no existing reclass, already 340B
- Remote 2 hospital MSA – so can't get SCH
- Did § 412.103 to get rural/RRC
- File MGCRB wage index reclass using special access rule (nearest MSA) to MSA 90 miles away
  - Medicare lost revenue = $(6 million) over 1st 9 months
  - Medicare gain over next 27 months = $11 million
  - Can renew every 3 years thereafter
    - Without down stroke in 1st 9 months; ~$4 million/year

Rurban for Wage Index & 340B

- Urban teaching hospital with no existing reclass
  - § 412.103 to RRC & wage index reclass to adjacent MSA
  - Medicare lost revenue = $(650,000) over 1st 9 months
  - Medicare gain over next 27 months = $6 million
  - Acquired Tier 2 340B status at 8% RRC threshold= $3-4m/year
  - 30% increase in IME FTE Cap –
    - ~$1 million by year 3 of reclass
  - Can renew every 3 years thereafter
    - Without down stroke in 1st 9 months; ~$2.8 million/year

Rurban for Rural SCH Benefits

- Urban SCH/RRC - 340B eligible
  - Best wage index in state, but adjacent state rural wage index higher, helps OPPS, not I/P due to HSR
- MGCRB rules prohibit urban to rural reclass, so:
  - 412.103 reclass based on state law/regulation
  - Filed rural to rural MGCRB wage index to next state
  - Rural SCH gets 7.1% add-on to OPPS payments for rural SCHs
  - MGCRB reclass for capital IPPS & OPPS = ~1.4 million/year
  - CMS exempted Rural (but not urban) SCHs from 28.5% to Medicare covered 340B drugs = $5 million/year

Mini-Me: Micro Hospital Strategy

- a/k/a Neighborhood Hospitals – closer to patients' homes
  - 10-15 beds, ADC <5, ALOS ??
  - ER, Ancillaries, ORs?
- Micro-investors looking to:
  - Form JV with system and/or
  - Manage & operate sites
- Options:
  - JV to own & operate micro sites
  - Mini "Remote location of hospital" managed by operator (or not)

Micro Hospital Joint Venture

- New Hospital(s) in Separate Legal Entity
- Separate Licensure, Accreditation, Certification/COPs
  - Start up revenue gap for new Provider #
  - Must meet Primarily Engaged test for each Provider #
  - Won't benefit from System/Flagship DSH, IME, 340B, wage index reclass, etc. – must qualify on own
  - Separate commercial payor contracting
- New Hospital Capital – 85% Medicare costs: startup + 2 full years
- New Provider # could build new GME Cap

Micro Remote Location Option

- RLOH = Off-Campus Provider-Based to Flagship
  - PB'd rules prohibit off campus JVs – management contract OK
- Accreditation & Certification/COPs as part of Flagship
  - Licensure depends on state law: could be separate or satellite
  - Primarily Engaged N/A to each site: P# as a whole
  - No start up gap: just add to Flagship 855A as new location
  - § 603 Site Neutral Exception w/i 250 yards
  - Flagship DSH, IME, Wage index apply same as Main Campus
  - 340B gap until RLOH included on as filed cost report
  - No new capital cost, nor GME Cap building

CAH - ESRD Spin Off (cost

- CAH – 25 beds, ADC 10-ish
- Operates ESRD unit w/i same corporation so treated as hospital based for cost report
- Spin off Dialysis into separate, but affiliated legal entity (LLC)
  - Breaks HB'd link under dialysis rules, so not on cost report
  - Move to separate building on campus, reduces facility O/H allocation
  - Dialysis paid same under its PPS
- Predicted improvement to cost reimbursement = $500k/year

Ultimate Case Study: All in 1

- 10 Hospital System – Mix of Small Urban and Rural
  - Flagship: High DSH, 340B eligible, Teaching, no reclass ops
  - Suburban Site: Low DSH, Not 340B, Possible Reclass to next state
- Merge into 2 campus single provider
  - FFS = wash, BUT extends 340B to Suburban campus = $6.5m/yr
- Merge into single provider, Suburban campus made Main Site
  - 340B + Rurban to next state for $16m/yr = $22.5m/yr
- Merge into single provider and obtain SCH Status
  - 340B + $27m/yr HSR & 7.1% APC = $33.5m/yr

Please visit the Hall Render Blog at http://blogs.hallrender.com for more information on topics related to health care law.

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