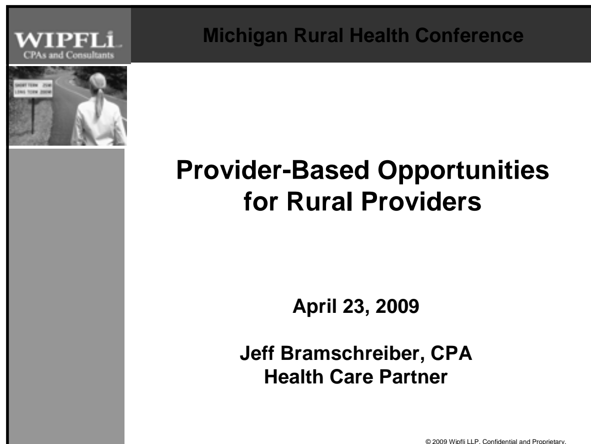

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Presentation Overview

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I. Market Dynamics

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I. Market Dynamics

- Current market dynamics encourage hospitals and physicians to either work closer together or further apart:
  - If further apart, hospitals and physicians will become aggressive competitors;
  - If hospitals and physicians compete against each other at "unhealthy" levels, waste, inefficiency, and strained relations are created;
  - If hospitals and physicians work together a more efficient and effective community delivery system can be achieved.

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I. Market Dynamics

- Payers continue to exert downward pressures on reimbursement to providers whether managed care plans are prevalent or not.
- Medicare intends to decrease physician fee schedule reimbursement in mid-2008 by more than 10%).
- Operating costs continue to rise – especially the human resource component of health service delivery (about 60% of the delivery/provider-side cost structure).

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I. Market Dynamics

Even in smaller/rural areas market forces are present:

- Payers consolidate to produce fewer insurers with many more enrollees and more leverage over providers.
- The provider side consolidates in response – horizontal and vertical consolidations occur.
- Sizable provider organizations compete with each other for patients, while utilization rates and reimbursement are ratcheted down.
- Local hospitals and physicians compete for a shrinking health dollar (e.g., they compete for a profitable ancillary service dollar).

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I. Market Dynamics

- If hospitals and physicians collaborate in new business models, the principal goals are typically:
  - market share retention
  - create leverage to minimize reimbursement constraints
  - new clinical service development
  - cost efficiency enhancement
  - enhanced patient service
  - clinical outcome improvement and;
  - expansion of regional "reach"
- Successful collaboration is often complex and requires careful planning and analysis.

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II. Common Relationships and Structures

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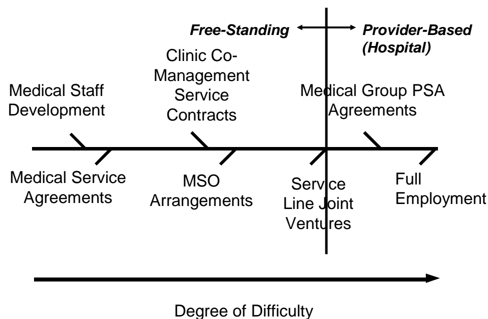
II. Common Physician Relationships



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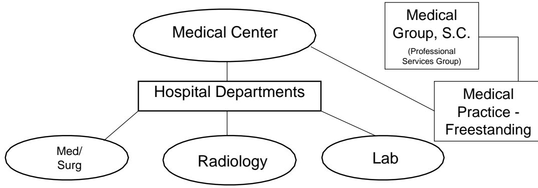
II. Common Hospital/Physician Structures



Hospital-Owned Clinic – Freestanding Clinic

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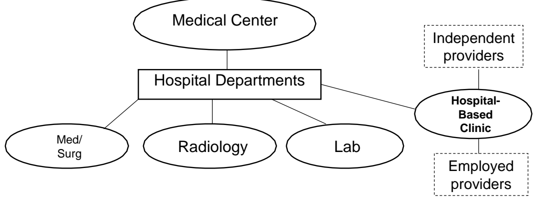
II. Common Hospital/Physician Structures



Hospital-Owned Clinic – Provider-Based Clinic

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III. Medicare Reimbursement Options for Physician Services

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III. Medicare Reimbursement for Physician Services

Health Care Delivery Models

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III. Medicare Reimbursement for Physician Services

Alternative Approaches:

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III. Medicare Reimbursement for Physician Services

Medicare Reimbursement Options for Physician Services

	Clinic Type			
Provider Type:	*Free-Standing Clinic*	*Free-Standing RHC*	***Provider-Based Clinic***	***Provider-Based RHC***
Rural Hospital < 50 beds	A	B	C	**E**
Critical Access Hospital	A	B	**D**	**E**
Hospital > 50 beds	A	B	C	B

A: Global clinic reimbursement on Medicare physician fee schedule.

B: Cost-based reimbursement for all RHC services, professional and facility combined; subject to Medicare maximum limit per encounter.

C: Medicare physician fee schedule payment for professional services, reduced for hospital site-of-service; APC payment for facility component.

D: Medicare physician fee schedule payment for professional services, reduced for hospital site-of-service, increased by 15% for Method II Billing; cost-based CAH payment for facility component.

E: Cost-based reimbursement for all RHC services, professional and facility combined; not subject to Medicare maximum limit per encounter, i.e., full cost reimbursement.

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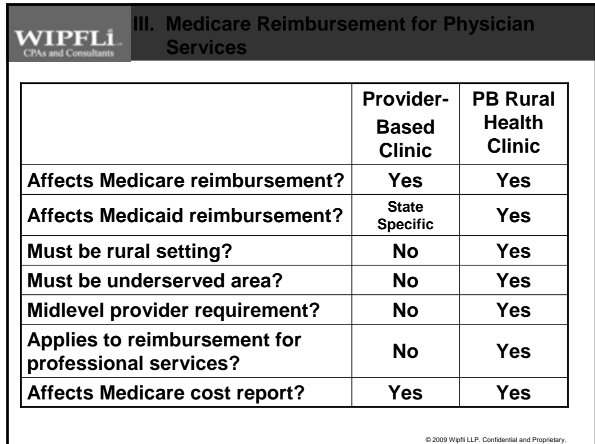
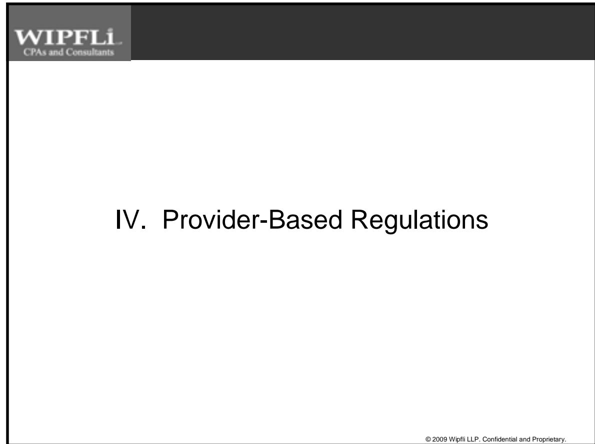
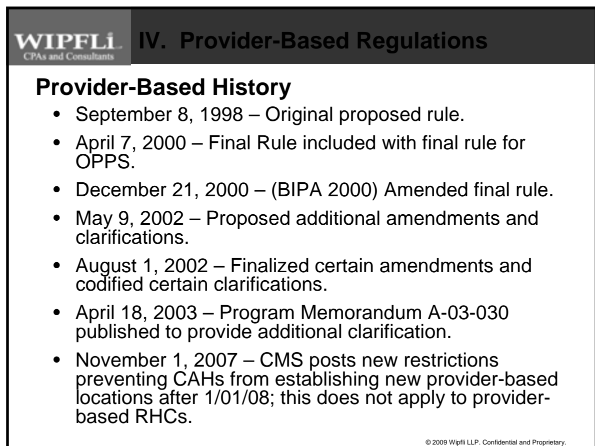


	Provider-Based Clinic	PB Rural Health Clinic
Affects Medicare reimbursement?	Yes	Yes
Affects Medicaid reimbursement?	State Specific	Yes
Must be rural setting?	No	Yes
Must be underserved area?	No	Yes
Midlevel provider requirement?	No	Yes
Applies to reimbursement for professional services?	No	Yes
Affects Medicare cost report?	Yes	Yes





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IV. Provider-Based Regulations

Provider-Based Requirements

- As of 1/1/08, CAHs are prevented from establishing new, off-site provider-based locations that are within the Necessary Provider distance requirement from another hospital.
- This limitation does not apply to provider-based rural health clinics.
- Provider-based locations considered "under development" as of 12/31/07 are also exempt.
- Penalty for violating this provision is loss of CAH.

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IV. Provider-Based Regulations

Provider-Based Requirements

- **Less stringent requirements for "on-campus" locations.**
- **"On-campus" defined as within 250 yards of main buildings.**

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IV. Provider-Based Regulations

"On-Campus" Requirements

- **Licensure**
  - **Operated under the same license only if state law permits.**
- **Clinical Integration**
  - **Clinical privileges, Chief Medical Officer, quality assurance and utilization review, medical records integration (unified retrieval systems).**
- **Financial Integration**
  - **Shared income & expenses, cost center on MCR**
  - **Costs included in the main provider's trial balance**
- **Public Awareness**
  - **Held out as part of hospital**

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IV. Provider-Based Regulations

"Off-Campus" Requirements

- **All "On-Campus" Requirements, Plus**
- **Operation Under the Ownership & Control of the Main Provider**
  - **100% owned by the provider, same governing body, common bylaws & operating decisions of the governing body, final responsibility & administrative decisions.**
- **Administrative & Supervision**
  - **Direct supervision, accountability, integration (HR, billing, payroll).**
- **Located in Immediate Vicinity**
  - **Not more than 35 miles away, or must meet 75/75 service area test (not applicable to RHCs).**

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IV. Provider-Based Regulations

Additional Requirements ("Obligations")

- Ensure physicians use correct POS indicators
- Prohibition against anti-dumping
- 72-hour rule applies unless CAH
- Inform beneficiary in writing of potential added financial liability (Not applicable to RHC services or "on-campus" locations)
- Split bill for Medicare patients
- Other payors may be globally billed
- Hospital health and safety rules apply
- Meet "incident to" rules for services provided to patients

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V. Reimbursement Examples

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V. Reimbursement Examples

Examples of Alternative Approaches

1. **Free-standing clinic to provider-based clinic in a CAH.**
2. **Free-standing clinic to provider-based RHC in a CAH.**

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V. Reimbursement Examples – Provider-Based Clinic

Provider-based clinics in critical access hospitals can receive cost-based payments for facility services instead of a fee schedule amount.

- **Reduced professional reimbursement for services performed in hospital department.**
- **Cost-based payment for CAH that may be greater than the site-of-service reduced fee schedule amount.**

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V. Reimbursement Examples – Provider-Based Clinic

Example 1: Free-standing to provider-based clinic in a CAH

	Charge	Hospital Cost/Chrg*	Medicare Allowable**	Enc. Rate	Medicare Reimburses	Coins.	Total
Free-standing clinic - 99213	$ 90.00		$ 57.96		$ 46.37	$ 11.59	$ 57.96
Provider-based clinic							
- Professional fee	$ 50.00		$ 41.45		$ 33.16	$ 8.29	$ 41.45
- Facility fee	$ 40.00	**1.5000**		$ 60.00	$ 48.00	$ 8.00	$ 56.00
Total Payment - PB clinic					$ 81.16	$ 16.29	$ 97.45
Increase in reimbursement/visit					**$ 34.79**	**$ 4.70**	**$ 39.49**
Increase %							**68%**

**Assumed cost-to-charge ratio for hospital-based clinic,for illustration purposes only.*

***Rest of Michigan 2008 Medicare fee schedule, CPT 99213. Standard method billing applied.*

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V. Reimbursement Examples – Provider-Based Clinic

All-Inclusive (Method II) Billing for CAHs

- Allows for all-inclusive cost-based facility services fee plus fee schedule for professional services (not applicable in RHC setting).
- Payment for professional services will be made at 115% of Medicare fee schedule, after Part B deductible and coinsurance.
- No longer requires all facility physicians to participate.
- Effective for cost reporting periods on or after July 1, 2004 (if election was made on or after Nov. 1, 2003).
- If option elected, must use for entire cost reporting period, election made 30 days prior to affected period (FR, 8/1/02, Transmittal 103, 2/20/04).

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V. Reimbursement Examples – Provider-Based Clinic

All-Inclusive (Method II) Billing for CAHs

- Practitioner required to assign benefits to elect Method II.
- CAH must obtain Form 855I, and have practitioner sign an “attestation.”
- Report professional services on separate line of UB-04 (CMS-1450).
- Bill type 85x.
- Use appropriate CPT code
  - HPSA Modifier (QB) – with CPT code
- Revenue codes – 96x, 97x, or 98x

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V. Reimbursement Examples – Provider-Based RHC

General Requirements for RHC Certification

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V. Reimbursement Examples – Provider-Based RHC

Clinics which meet the requirements for provider-based status can avoid the RHC reasonable cost limits.

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V. Reimbursement Examples – Provider-Based RHC

Example 2: Free-standing to provider-based RHC in a CAH

	Charge	Hospital Cost/Chrg*	Medicare Allowable**	Enc. Rate	Medicare Reimburses	Coins.	Total
Free-standing clinic - 99213	$ 90.00		$ 57.96		$ 46.37	$ 11.59	$ 57.96
Provider-based RHC							
- RHC encounter	$ 90.00	**1.5000**		$ 135.00	$ 108.00	$ 18.00	$ 126.00
Total Payment - PB clinic					$ 108.00	$ 18.00	$ 126.00
Increase in reimbursement/visit					**$ 61.63**	**$ 6.41**	**$ 68.04**
Increase %							**117%**

**Assumed cost-to-charge ratio for hospital-based clinic,for illustration purposes only.*

***Rest of Michigan 2008 Medicare fee schedule, CPT 99213. Standard method billing applied.*

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V. Reimbursement Examples – Provider-Based Clinic

Caution for Critical Access Hospitals!!

- **Adding a provider-based clinic may have unintended results.**
- **Costs may be shifted from high Medicare utilized departments in the hospital.**
- **The result may be a <u>decrease</u> in hospital reimbursement.**

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Questions

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For More Information

This presentation was prepared by:

Jeff Bramschreiber, CPA
Health Care Partner
Wipfli LLP
(920) 662-2822
jbramschreiber@wipfli.com

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