Understanding the Impact of the 2013 Changes in Medicare Payment Systems

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Agenda

I. First, the Unfinished Business

II. Highlights of the 2013 Medicare Final Rules for Hospitals

III. Medicare Physician Fee Schedule Update

IV. Highlights of the 2013 Medicare Final Rule for Physician Services

V. Other Medicare Physician Fee Schedule Provisions

VI. Potential Implications for Provider-Based Clinics

VII. Other Provider Payment Updates
Unfinished Business

- Sequestration
- SGR “Fix”
In August 2011, Congress and the President reached an agreement to raise the federal debt ceiling, thereby avoiding a technical default on government loans.

The Debt Limit deal required significant cuts in future federal spending – both discretionary and entitlement programs.

Sequestration is a process whereby the Office of Management and Budget is authorized to make across-the-board cuts in federal spending without the need for specific Congressional approval of those cuts.
The across-the-board cuts in federal spending currently scheduled to take place would represent approximately 7 to 8 percent annual cuts in affected non-defense programs, along with about 7 to 8 percent reduction in most defense programs.

Medicare cuts are capped at 2 percent. Medicaid and Veterans programs are exempt from sequestration.
Sequestration was scheduled to take effect in January 1, 2013.

As part of the “fiscal cliff” legislation, sequestration has been postponed until March 1, 2013.

Sequestration can be avoided by Congress reaching agreement on substitute spending cuts, or Congress could act to throw out the whole idea.

Another debt ceiling limit debate is on the horizon; it is likely that some spending cuts will take effect . . . .
SGR “Fix”

- Enter the American Taxpayer Relief Act of 2012 (ATRA) – January 2, 2013 (signing date by President)

- Without ATRA, the final 2013 Medicare fee schedule for physician services
  - Reflected 26.5% reduction in 2013 conversion factor (CF) based on sustainable growth rate (SGR) formula from $34.0376 to $25.0008.
  - Published in the *Federal Register* on November 15, 2012; 483 pages without addendums.

- ATRA provision
  - 0% update to conversion factor for all of 2013 ($34.0230 CF).
  - Essentially, “kicked the can down the road”
Other Notable ATRA Provisions

- Collection of Overpayments by Medicare: Increases the statute of limitations from 3 years to 5 years to recover Medicare overpayments
  - CBO estimates that recoveries could exceed $1.8 billion over next 10 years
- Performance Improvement: The Act continues funding the National Quality Forum (NQF) for activities related to performance improvement. Basically calls for CMS to provide data to providers including utilization data and feedback on quality data
- Physician Work Geographic Adjustment Factor: Extends the 1.0 GAF payment rate floor through December 31, 2013
- Outpatient Therapy Caps: Extends the exception process for medically necessary PT and ST caps through December 31, 2013 (CAHs initially included, but now excluded)
- Revisions to the Medicare End-stage Renal Dialysis (ESRD) Bundled Payment System: Incorporates recommendations from GAO on or after January 1, 2014
Other Notable ATRA Provisions

- Ambulance Add-on Payments: Extends the 3% increase in fee schedule amounts for ground ambulance transports in rural areas and the 2% increase for transports in urban areas through December 31, 2013.

- Inpatient Hospital Payment Adjustment for Low-volume Hospitals: Extends the payment adjustment under ACA through Federal Fiscal Year (FFY) 2013.

- Medicare Dependent Hospitals: Extends MDH payment program through FFY 2013.

- Outpatient Therapy Multiple Procedures: Mandates that multiple therapy procedures increases the reduction from 25% to 50% for therapy services provided after March 30, 2013. Will apply in most all outpatient type settings and include outpatient physical and occupational therapy services.
Other Notable ATRA Provisions

- IPPS Documentation and Coding Adjustment for Implementation of MS-DRGs: ATRA revises TMA, Abstinence Education, and QI Program Extension Act of 2007 and directs the Secretary to offset payment increases from 2010 resulting from MS-DRG implementation that did not reflect actual charges in providers case mix. The Secretary is also directed to make additional adjustments to standardized payment amounts for discharges during FFY 2014-2017 to fully offset the increase in aggregate payments amounts from FFY 2008-2013.

- Rebasing State Disproportionate Share Hospital Payments: ACA established a new payment methodology for DSH wherein DSH payments will be reduced in many states that have lowest percent of uninsured and where DSH payments are less dependent on hospital Medicaid or uncompensated care volume. ATRA extends the DSH payment reduction for an additional 10 years through 2022.
Other Notable ATRA Provisions

- Medicare Outpatient Radiology Reduction: Adds a special payment change to reduce outpatient payments for stereotactic radiosurgery by equalizing the payment amount between the services described by the Ambulatory Payment Classifications (APCs) 0127 and 0067. This equates to about a $4,600 reduction for the service described by APC 0127. Rural hospitals, Rural Referral Centers, and SCHs would be exempt from this provision.

- NOTE: The legislation does not include an extension to Medicare outpatient hold harmless payments to rural hospitals and SCHs with less than 100 beds.
Provider offsets from ATRA SGR “fix”

- Reductions to Medicare and Medicaid by $26.5 billion to suspend doc fix and preserve “extenders,” can be summarized as follows:
  - Medicare Inpatient Coding Offset (-$10.5 billion over 10 years): To reiterate it would reduce Medicare inpatient payments in federal fiscal years (FFYs) 2014-2017 to account for what is being referred to as increases in payments during 2008-2013 due to documentation and coding.
  - Medicaid DSH Payment Cut (-$4.2 billion over 10 years)
  - Medicare Outpatient Radiology Reduction (-$300 million over 10 years)
  - Medicare End Stage Renal Disease (ESRD) payment reduction (-$4.9 billion over 10 years)
  - Outpatient therapy multiple procedures (-$1.8 billion over 10 years)
- Note that more than ½ of the cuts directly impact hospitals (~ $15 billion!)
Highlights of the 2013 Medicare Final Rules for Hospitals
Hospital Payment Update for 2013

**Acute Hospital Inpatient Services**

The Centers for Medicare & Medicaid Services (CMS) issued a final rule in August 2012 that includes a 2.3% net increase in Medicare payments to acute care hospitals in FY13.

- This compares with an increase of only 0.9% that was in the proposed rule. The net update is after the market basket update, improvements in productivity, a statutory adjustment factor, and adjustments for hospital documentation and coding changes, among other policies.

- The net 2.3% rate increase does not include a 2% sequestration payment cut that is currently scheduled to take effect on March 1, 2013.

- CMS projects that total Medicare spending on inpatient hospital services will increase by $2.04 billion in FY13 relative to FY12.
Hospital Payment Update for 2013

● Sole Community Hospital (SCH) factors applied to hospital specific rate are set at:
  ● SCH Budget Neutrality Factors = .99841
  ● SCH Documentation and Coding Adjustment Factor = .9480

● SCH Clarifications and Changes to Effective Dates
  ● Currently, SCH status remains in effect without the need for re-approval process unless there is a change in circumstances from the original approval.
  ● Now required to notify MAC/FI within 30 days of a change that could affect the SCH status.

● Low-volume Inpatient Hospitals Payments
  ● Qualifying low-volume hospitals receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like-hospital. This provision was set to expire in FFY 2012. ATRA extended the provision through FFY 2013
Hospital Payment Update for 2013

● Additionally, the August rule implements several of the Affordable Care Act’s provisions for value-based payment.
  • These include a methodology to account for excess readmissions for heart attack, heart failure, and pneumonia, along with a new outcome measure in the value-based purchasing program that rewards hospitals for avoiding central line-associated bloodstream infections.
  • Under the hospital value-based program, CMS will reduce base operating DRG payments beginning with discharges beginning in FFY 2013. Payment reduction will be 1.0% in 2013 and gradually increase to 2% by FFY 2017. These payment reductions will fund value-based incentive payments.
Hospital Payment Update for 2013

Outpatient Hospital Services

CMS issued the final rule for Medicare Outpatient Prospective Payment System (OPPS) on November 15, 2012 to update Medicare payment policies and rates for hospital outpatient services. In calendar year 2013, payment rates for hospital outpatient departments will increase 1.8%.

Other notable provisions include:

- Rural SCH and essential access community hospitals will continue to be paid 7.1 percent payment for all services and procedures paid under OPPS, excluding some drugs and biologicals and device pass-through payments.
- Hold Harmless TOPs payments to small rural hospitals and SCH ended at 12/31/2012. ATRA did not extend this provision.
Hospital Payment Update for 2013

- Hospital Outpatient Quality Reporting Program
  - No changes were made through the final rule. Hospitals that fail to successfully participate in the program receive a 2% payment reduction. (Note this does not apply to CAHs)

- Payment for Transitional Care Management Services (also see physician update, following):
  - Established 2 codes for service: 99495 (low complexity) and 99496 (high complexity)
  - CMS assigned 99495 to APC 0605 (level 2 hospital clinic visit) and 99496 to APC 0606 (level 3 hospital clinic visit)

- Coding and Payment for Outpatient Visits: Clinic visits, ED visits, and critical care services
  - CMS did not propose and is not adopting any technical changes at this time.
  - However, this continues to be a hot-topic being addressed by MedPac. Look for some changes in the 2014 proposed rule later this year.
Hospital Payment Update for 2013

- Physician Supervision Requirements for Outpatient Services
  - Beginning in calendar year 2011, CMS revised and further defined physician supervision requirements for outpatient services
  - Define Supervision -
    - General Supervision - Furnished under direction and control of physician without physical presence required.
    - Direct Supervision - Physician physically present on campus (location under ownership and operated as part of the hospital) and immediately available to furnish assistance and direction throughout procedure.
    - Personal Supervision - Physician physically present in the room throughout procedure.
  - Two types of services -
    - Diagnostic
    - Therapeutic
Hospital Payment Update for 2013

- Physician Supervision Requirements for Outpatient Services
  - Can be:
    - Physician (MD or DO)
    - Physician assistant *
    - Nurse practitioner *
    - Clinical nurse specialist *
    - Certified nurse midwife *

* If permitted by state law, their scope of practice, and hospital-granted privileges
Hospital Payment Update for 2013

- Physician Supervision Requirements for Outpatient Services
  - In CY 2011, CMS adopted changes for therapeutic and diagnostic services. These provisions are currently applicable for all hospitals. However, for therapeutic services in a CAH or small rural hospital with less than 100 beds, these provisions have not been enforced.
  - In CY 2012, CMS established an independent review process using a Federal Advisory APC Panel to assess the appropriateness of supervision levels for individual hospital outpatient therapeutic services.
  - CMS again extended the non-enforcement of direct supervision requirements for therapeutic services allowing the APC Panel more time to assess.
  - It is not expected that CMS will extend non-enforcement beyond 2013.
  - CMS also clarified in the final rule that supervision requirements do not apply to PT, ST and OT services regardless of whether paid under PPS or cost basis. CMS rationale is that these services are paid on the Medicare Physician Fee Schedule and not OPPS.
  - Note: If “some therapy” is provided that falls under OPPS, those services would be applicable to supervision requirements.
Hospital Payment Update for 2013

● Physician Supervision Requirements for Outpatient Services
  • CMS uses an APC Panel to evaluate and recommend the level of supervision required other than direct supervision. CMS will add two small rural PPS hospital members and two CAH members.
  • CMS continues to extend non-enforcement of the requirement for direct supervision of outpatient therapeutic services in CAHs and small rural hospitals through calendar year 2013.
### Physician Supervision Requirements for Outpatient Services

<table>
<thead>
<tr>
<th>PATIENT SERVICE LOCATION</th>
<th>TYPE OF SERVICE</th>
<th>TYPE OF SERVICE</th>
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<tbody>
<tr>
<td></td>
<td>Diagnostic</td>
<td>Therapeutic</td>
</tr>
<tr>
<td><strong>ON CAMPUS</strong></td>
<td>General</td>
<td>Direct**</td>
</tr>
<tr>
<td></td>
<td>CAH's exempt from MPFS requirements (Assumed General)</td>
<td>Personal</td>
</tr>
<tr>
<td><strong>OFF CAMPUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal - must be physician; (no midlevels allowed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal - must be physician; (no midlevels allowed)</td>
</tr>
</tbody>
</table>

**Observation and Infusion Therapy - Direct at first; once practitioner has determined that patient is stable (as defined by EMTALA), can change to general supervision.**
Physician Payment Update
For 2013
Medicare Fee Schedule Payments for 2013

- Medicare Payment Advisory Commission (MedPac) recommendation to Congress, March 15, 2012
  - Repeat recommendations to Congress of October 14, 2011
  - Repeal of the Sustainable Growth Rate (SGR) formula
  - 10 year plan of 0% change for primary care and 5.9% reduction each in years 1 to 3 followed by 0% for specialists.

- Proposed 2013 Medicare fee schedule for physician services – July 6, 2012
  - Reflected 27% reduction in 2013 conversion factor based on sustainable growth rate (SGR) formula
  - Various other provisions proposed and public comments solicited
Medicare Fee Schedule Payments for 2013

- Final 2013 Medicare fee schedule for physician services – November 1, 2012
  - Reflected 26.5% reduction in 2013 conversion factor based on sustainable growth rate (SGR) formula from $34.0376 to $25.0008
  - Various other provisions finalized and public comments published
  - Published in the Federal Register on November 16, 2012; 483 pages without addendums.

- American Taxpayer Relief Act of 2012 (H.R. 8) – Signed into law on January 2, 2013
  - 0% update to conversion factor for all of 2013 ($34.0230 CF)

- Postponed the 2% across-the-board sequester reduction for two months
  - Congress must revisit sequester to prevent the automatic reduction in Medicare reimbursement on or before March 1, 2013.
Medicare Fee Schedule Payments for 2013

Currently
(as of 02/01/2013)

- All changes from Final 2013 Medicare fee schedule for physician services – November 1, 2012, are effective, except for the conversion factor update, through the end of CY2013.

- The Medicare fee schedule for physician services effective January 1, 2013, with the revised conversion factor are to have been published by Medicare contractors no later than January 23, 2013.

- CMS instructed Medicare claims administration contractors to hold claims for 2013 services paid under the Medicare Physician Fee Schedule for the first 10 business days of 2013 (similar to last year).
Highlights of the November 2012 Medicare Final Rule for Physician Services for 2013

Overall Reimbursement

- CMS has completed the transition the Practice Expense (PE) Relative Value Units to the Physician Practice Information Survey (PPIS).
- 2013 is the last year of a four-year transition process; PE RVUs are now determined at 100% of the PPIS data, except for specialties excluded from this survey.
- Although budget neutral overall, the changes in the PE RVUs cause a payment shift among medical specialties based on the services provided.
- Multiple procedure payment reduction (MPPR) expanded to the technical component of certain cardiovascular and ophthalmology diagnostics.
The Sustainable Growth Rate (SGR) formula remains in effect and will continue to result in reductions in physician payment for services under the Medicare fee schedule unless addressed by Congress.

- Recall that MedPac recommends that Congress repeal the SGR formula.

One year “fix” of SGR impact approved by Congress on January 1, 2013 resulting in a 0% update for 2013.

- Estimated budgetary impact of approximately $26B, funded primarily through reductions in hospital reimbursement.
## Overall Reimbursement

### Recent Medicare Conversion Factors:

<table>
<thead>
<tr>
<th>Year</th>
<th>Factor</th>
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<tbody>
<tr>
<td>2009</td>
<td>$36.0666</td>
</tr>
<tr>
<td>2010 (1/01/2010)</td>
<td>$36.0791</td>
</tr>
<tr>
<td>2010 (6/01/2010)</td>
<td>$36.8729</td>
</tr>
<tr>
<td>2011</td>
<td>$33.9764</td>
</tr>
<tr>
<td>2012</td>
<td>$34.0376</td>
</tr>
<tr>
<td>2013</td>
<td>$34.0230</td>
</tr>
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</table>
### Example: Changes for Office Visits:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Transitioned</td>
<td>Initial</td>
</tr>
<tr>
<td></td>
<td>Office Medicare</td>
<td>Office Fee</td>
</tr>
<tr>
<td></td>
<td>Total RVUs</td>
<td>Office Fee</td>
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<tr>
<td>99201 Office/outpt visit new</td>
<td>1.25</td>
<td>$43</td>
</tr>
<tr>
<td>99202 Office/outpt visit new</td>
<td>2.13</td>
<td>$73</td>
</tr>
<tr>
<td>99203 Office/outpt visit new</td>
<td>3.09</td>
<td>$105</td>
</tr>
<tr>
<td>99204 Office/outpt visit new</td>
<td>4.72</td>
<td>$160</td>
</tr>
<tr>
<td>99205 Office/outpt visit new</td>
<td>5.86</td>
<td>$199</td>
</tr>
<tr>
<td>99211 Office/outpt visit est</td>
<td>0.58</td>
<td>$20</td>
</tr>
<tr>
<td>99212 Office/outpt visit est</td>
<td>1.25</td>
<td>$43</td>
</tr>
<tr>
<td>99213 Office/outpt visit est</td>
<td>2.07</td>
<td>$71</td>
</tr>
<tr>
<td>99214 Office/outpt visit est</td>
<td>3.06</td>
<td>$104</td>
</tr>
<tr>
<td>99215 Office/outpt visit est</td>
<td>4.11</td>
<td>$140</td>
</tr>
</tbody>
</table>

Conversion Factor
- 2012: 34.0376
- 2013: 25.0008

Conversion Factor Change
- 0.2%
- 26.55%

-0.04%
## Overall Reimbursement

### Selected Specialty Impact of RVU Changes

*(not including conversion factor changes)*:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Work &amp; Malpractice RVUs</th>
<th>Practice RVUs</th>
<th>Combined</th>
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</thead>
<tbody>
<tr>
<td>CARDIOLOGY</td>
<td>-1%</td>
<td>-2%</td>
<td>-2%</td>
</tr>
<tr>
<td>EMERGENCY MEDICINE</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>FAMILY PRACTICE</td>
<td>2%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>GENERAL SURGERY</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>INTERNAL MEDICINE</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>-3%</td>
<td>0%</td>
<td>-3%</td>
</tr>
<tr>
<td>ORTHOPEDIC SURGERY</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>RADIATION ONCOLOGY</td>
<td>0%</td>
<td>-7%</td>
<td>-7%</td>
</tr>
<tr>
<td>RADIOLOGY</td>
<td>0%</td>
<td>-3%</td>
<td>-3%</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>0%</td>
<td>-1%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

* Federal Register/Vol. 77, No. 222/Friday, November 16, 2012, 69344.
Overall Reimbursement

Impact on individual physicians and/or groups will vary based on:

- Volume and mix of services to Medicare patients
- RVU changes on individual services provided
- New codes and services (e.g. Transitional Care Management)
- Application of the Multiple Procedure Payment Reduction

Understanding the impact is important for planning.
Other Medicare Physician Fee Schedule Provisions
RVUs and Misvalued Codes

- **Work RVUs**
  - 2012 was the last year for 5-year review (now annual process)

- **Practice Expense (PE) RVUs**
  - CMS has completed the transition of the PE RVU to the Physician Practice Information Survey (PPIS) except for specialties excluded from this survey. Although budget neutral overall, this results in payment shifts among specialties.
    - Utilization data for Cardiac Electrophysiology and Sports Medicine will be newly incorporated into 2013 rate-setting

- **Malpractice RVU**
  - Next review will be 2015
RVUs and Misvalued Codes

- Misvalued Codes (review required by Congress)
  - 36 CPT codes were nominated for review
  - CMS is adjusting the PE inputs for seven of these codes, including two that it proposed not to adjust in the 2013 proposed fee schedule
  - As a result of reviewing "Harvard-valued" services, overall reimbursement for radiation therapy will be reduced.
Multiple Procedure Payment Reduction Policy

- Medicare pays the full rate for interpretation of the first service but applies a 25% reduction to the payment for the PC of second and subsequent advanced imaging furnished by:
  - The same physician, to the same patient, in the same session, on the same day.

- Applies to CT, CTA, MRI, MRA, and ultrasound.

- Last year, CMS intended to consider services from all physicians in the same group practice, but was unable to implement this change due to operational issues. These have been resolved so MPPRs will now also be applied to physicians in the same group.
Multiple Procedure Payment Reduction Policy

In addition, CMS will begin applying the MPPR for:

- Second and subsequent nuclear medicine procedures (CPT codes 78306 and 78320) – 50% reduction.
- MPPR also expanded to the technical component of certain cardiovascular and ophthalmology diagnostics.
  - Second and subsequent cardiovascular diagnostic procedures – 25% reduction.
  - Second and subsequent ophthalmology procedures – 20% reduction.

The complete list of services subject to the MPPR for diagnostic cardiovascular and ophthalmology services is contained in Addendum X of and Tables 12 and 13 on pages 68942 and 68943.
Quality Initiatives

● Value Based Payment Modifier
  • CMS will begin gradually phasing in the value-based payment modifier initiative, and will use 2013 data to determine payments for 2015. The modifier will initially apply to groups with 100+ eligible professionals. CMS initially proposed applying the modifier to groups of 25 or more providers.

● Physician Quality Reporting System
  • CMS basically left PQRS intact, although the final rule contains several efforts to "better align quality reporting requirements across programs to reduce burden and complexity."
Quality Initiatives

● E-Prescribe

  • CMS finalized two additional exemptions for participating in the eRx incentive program, including eligible professionals or group practices that
    – Achieve meaningful use during certain prescription adjustment reporting periods and
    – Demonstrate intent to participate in the EHR incentive program and adoption of EHR technology.
Potential Implications for Provider-Based Clinics
Provider-Based Clinics

- Hospitals often structure integrated physician practices as provider-based clinics (i.e., hospital outpatient departments).
- Provider-based clinics receive more favorable Medicare reimbursement as outpatient departments.
- Medicare reimbursement for physician services performed in a hospital outpatient includes:
  - Physician fee schedule (reduced by site of service) for professional services
  - Hospital APC (or cost for CAH)

- Can result in Medicare reimbursement increase of 60 – 80%.
Proposed changes continue to be introduced to reduce provider-based clinic reimbursement:

- December 15, 2011, MedPac report to Congress suggested eliminating the payment differential for provider-based clinics.
- H.R. 3630 passed by the House of Representatives on December 13, 2011, would have eliminated the provider-based payment differential for office visits (CPT 99201 – 99215); provision was dropped from final.
- MedPac Report to Congress, March 2012, Chapter 3: Hospital inpatient and outpatient services.
- MedPac presentation of December 6, 2012 addressing physician office services shift to hospital outpatient billing.

"Payments to hospitals for these two services (office E/M and EKG)…were $1.5 billion above physician office rates in 2011."
Provider-Based Clinics

MedPac RECOMMENDATION 3-2, March 2012:

The Congress should direct the Secretary of Health and Human Services to reduce payment rates for evaluation and management office visits provided in hospital outpatient departments so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician office. These changes should be phased in over three years. During the phase-in, payment reductions to hospitals with a disproportionate share patient percentage at or above the median should be limited to 2 percent of overall Medicare payments.

COMMISSIONER VOTES: YES 14, NO 2, NOT VOTING 1, ABSENT 0
Medicare Updates for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
2013 Medicare RHC/FQHC Maximum Payment Rates

RHC Reimbursement Limits *

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tr>
<td>Maximum</td>
<td>$74.29</td>
<td>$75.63</td>
<td>$76.84</td>
<td>$77.76</td>
<td>$78.07</td>
<td>$78.54</td>
<td>$79.17</td>
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<td>Increase</td>
<td>2.8%</td>
<td>1.8%</td>
<td>1.6%</td>
<td>1.2%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

* Effective 7/1/2001, all RHCs that are provider-based to a hospital of <50 beds (staffed) regardless of MSA (but are in rural area as defined by Census Bureau) are not limited to independent reimbursement limit.

Updates for Medicare RHC rates have not kept pace with increases in Medicare Part B payments. The Medicare RHC reimbursement advantage for independent RHCs is limited. However, there is still a significant RHC reimbursement advantage for Medicaid services, even for independent RHCs.
# 2013 Medicare RHC/FQHC Maximum Payment Rates

## FQHC Reimbursement Limits *

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010*</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td>$99.17</td>
<td>$100.96</td>
<td>$102.59</td>
<td>$108.81</td>
<td>$109.24</td>
<td>$109.90</td>
<td>$110.78</td>
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<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Maximum</td>
<td>$115.33</td>
<td>$117.41</td>
<td>$119.29</td>
<td>$125.20</td>
<td>$126.22</td>
<td>$126.98</td>
<td>$128.00</td>
</tr>
<tr>
<td>Increase</td>
<td>2.8%</td>
<td>1.8%</td>
<td>1.6%</td>
<td>1.2%*</td>
<td>0.4%</td>
<td>0.6%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

* plus $5.00
(MIPPA 2008)
Rural Health Clinic/Federally Qualified Health Centers Update

- RHC/FQHC Benefit Policy Manual – Released Friday, February 1, 2013
- Proposed Rules for various providers announced Monday, February 4, 2013 – Note that Wipfli is still analyzing the potential affects of this new proposed rule (slides are not included at this time)
Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 13, RHC and FQHC Services

- Includes some errors . . .

“A clinic located on an island that otherwise meets the requirements for RHC certification is not required to employ an NP or PA, although it is still required to have an NP or PA at least 50% of the time that the RHC is in operation”
Some “clarifications” are even more confusing . . .

“This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit an RHC physician from providing on-call services for an emergency room, as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility.”

“It is expected that the sharing of the physician with the hospital emergency department would not be a common occurrence.”
The Bottom Line . . .

- The published changes in the RHC Policy Manual will receive significant attention from the RHC community, and further revisions are likely to be made.

- Substantial changes to your RHC based on the new Policy Manual revisions are not recommended at this time.
Other Regulatory Updates to Consider

- Medicaid Primary Care Match
- Medicaid Expansion
- Transitional Care Codes
- Medicare Bad Debts
- 3-Day Payment Window
- Payment for Global Surgical Split-care in Method II CAH
Medicaid Primary Care Match

Family practitioners, internists, and pediatricians will receive fee-for-service Medicaid payment increases beginning Jan. 1, 2013, under a CMS final rule published Nov. 6, 2012, in the Federal Register.

The services to receive increased Medicaid payment are those billed with E/M codes 99201-99499—including those not reimbursed by Medicare—and vaccine administration codes 90460-90461 and 90471-90474.

There is a two-year limit on this increase. Implementation is pending.
## Medicaid Fee Schedule Amounts

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Washington Medicare 2013 fees</th>
<th>Washington Medicaid 2012 fees (HPSA Adult)</th>
<th>Projected Increase in Washington Medicaid fees</th>
<th>% Inc</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 Office/outpatient visit, new</td>
<td>$44</td>
<td>$24</td>
<td>$20</td>
<td>86%</td>
</tr>
<tr>
<td>99202 Office/outpatient visit, new</td>
<td>$75</td>
<td>$40</td>
<td>$35</td>
<td>87%</td>
</tr>
<tr>
<td>99203 Office/outpatient visit, new</td>
<td>$108</td>
<td>$58</td>
<td>$51</td>
<td>88%</td>
</tr>
<tr>
<td>99204 Office/outpatient visit, new</td>
<td>$164</td>
<td>$87</td>
<td>$77</td>
<td>88%</td>
</tr>
<tr>
<td>99205 Office/outpatient visit, new</td>
<td>$204</td>
<td>$108</td>
<td>$95</td>
<td>88%</td>
</tr>
<tr>
<td>99211 Office/outpatient visit, est</td>
<td>$21</td>
<td>$11</td>
<td>$9</td>
<td>86%</td>
</tr>
<tr>
<td>99212 Office/outpatient visit, est</td>
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<td>$24</td>
<td>$20</td>
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</tr>
<tr>
<td>99213 Office/outpatient visit, est</td>
<td>$73</td>
<td>$39</td>
<td>$34</td>
<td>89%</td>
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<tr>
<td>99214 Office/outpatient visit, est</td>
<td>$107</td>
<td>$57</td>
<td>$50</td>
<td>88%</td>
</tr>
<tr>
<td>99215 Office/outpatient visit, est</td>
<td>$143</td>
<td>$76</td>
<td>$67</td>
<td>87%</td>
</tr>
</tbody>
</table>
Medicaid Primary Care Match

What happens when the 2-year sunset provision occurs (after 2014)?

Can States afford to continue paying?

Will this be the next SGR?
Medicaid Expansion

If state adopts (many have already) -

Americans who earn less than 133% of the poverty level (about $14,000 for an individual and $29,000 for a family of four) will be eligible to enroll in Medicaid.

States will receive 100% federal funding for the first three years to support Medicaid expansion, phasing to 90% federal funding in subsequent years.

What happens when the 3-year federal funding at 100% is reduced to 90%?

Can States afford to pay?
Included in the “Middle Class Tax Relief and Job Creation Act of 2012” were several provisions that affect Medicare reimbursements to hospitals and other providers (helped fund part of the 2012 SGR “fix”).

- Medicare reimbursable bad debts for PPS hospitals and skilled nursing facilities currently paid at 70% will be reduced to 65% on a three-year phase-in starting in 2013.

- Effects bad debts claimed by RHC/FQHCs and CAHs that currently claim 100% reducing the amount by:
  - 88% of the amount allowable effective FFY 2013*.
  - 76% of the amount allowable effective FFY 2014*.
  - 65% of the amount allowable effective FFY 2015* and thereafter.

*Cost reports beginning in applicable federal fiscal year (FFY)
3-Day Payment Window

- **Question:** Are Critical Access Hospitals (CAHs) subject to the payment window?

- **Answer:** If the admitting hospital is a CAH, the payment window policy does not apply. However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) hospital and the wholly owned or wholly operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window. The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, longterm care hospital, children’s hospital, or cancer hospital.
**3-Day Payment Window**

- **Question:** Does the 3-day window (or 1-day window) include the 72 hours (or 24 hours) directly preceding the inpatient hospital admission?

- **Answer:** The 3-day payment window applies to services provided on the date of admission and the 3 calendar days preceding the date of admission that will include the 72 hour time period that immediately precedes the time of admission but may be a longer than 72 hours because it is a calendar day policy. The 1-day payment window applies to the date of admission and the entire calendar day preceding the date of admission and will include the 24 hour period that immediately preceded the time of admission but may be longer than 24 hours.
Global Surgical Split – CAH Method II

Change Request Transmittal R2574CP, Dated 10/26/12:

- **Effective Date:** 1/1/2013

- Allows providers to include surgical split care for CAHs on bill type 85X with revenue codes 96X – 98X with modifier -54 (surgical care only) and/or modifier -55 (postoperative management only).

- Method II billing allows for outpatient hospital services provided in a CAH to be included on the outpatient claim form (combined with other O/P services using the appropriate revenue code as noted above).

- CAH receives an additional incentive payment of 115% of the Medicare Physician Fee Schedule payment amount (based on hospital place of service code, “22,” after coinsurance and deductible have been applied).

- Does not apply to inpatient or RHC services – outpatient only, and any type of physician or non-physician practitioner.
For More Information

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