Critical Access Hospitals


August 21, 2017
Welcome

Purpose:

The purpose of this call is provide a comprehensive presentation on Critical Access Hospitals as it relates to current billing processes, the Quality Payment Program, and the Health Resources and Services Administration (HRSA) addressing Quality Measurement and Policy Resources for Critical Access Hospitals.
Agenda

• Welcome & Purpose
• Agenda
• Overview of CAH Billing Practices
• CAHs and Quality Payment Program: Special Considerations
• Quality Measurement and Policy Resources for Critical Access Hospitals
• Closing
Overview of CAH Billing

Cindy Pitts
Center for Medicare
Standard Payment Method (Method I) or Election of Optional Payment Method (Method II)

- **Standard Payment (Method I)**
  - CAH Method I bills for facility/technical services only.
  - The physician/practitioners are not required to reassign their benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bills for their professional services.
  - Facility/technical services are billed on a UB-04 claim. The claim must include the type of bill (TOB) 85X, appropriate revenue codes and CPT/HCPCS codes along with other required data element.
  - Facility/technical services are reimbursed at 101 percent of reasonable costs. Deductible and coinsurance are applicable.
Overview of CAH Billing

- Optional Payment Method (Method II)
  - For Method II a provider has the option to reassign their benefits to the CAH. If a physician/practitioner has reassigned their benefits to the CAH, the CAH will bill for that particular physician’s/practitioner’s professional service rendered in the outpatient CAH.
  - Optional Payment Method, includes both facility services and professional services furnished to its outpatients by a physician or practitioner who has reassigned his or her billing rights to the CAH.
  - Facility/technical services and the professional services are billed on a UB-04 claim. The claim must include the TOB 85X, appropriate revenue codes and CPT/HCPCS codes and the professional services, revenue code 096x, 097x or 098x in addition, to CPT/HCPCS codes along with other required data element.
  - For physician/practitioner professional services that have been reassigned to the CAH – the professional services are payable at 115 percent of the amount that otherwise would be paid for the practitioner’s professional services, after applicable deductions are applied, under the Medicare PFS. Deductible and coinsurance are applicable.
  - For additional details regarding specifics to CAH billing guideline please refer to:
    - The Medicare Claims Processing Manual, chapter 4, section 250

What questions do you have about the CAH Billing Process?

**Hit *1 to get into queue**
**Enter your response in the chat box**
Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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QUALITY PAYMENT PROGRAM
Merit-based Incentive Payment System (MIPS)
Clinicians have two tracks to choose from:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

*If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.*

**Advanced APMs**

Advanced Alternative Payment Models (APMs)

*If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*
What is MIPS?

Combines legacy programs into a single, improved program

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals

Example of the Legacy Program Phase Out for PQRS

- Last Performance Period: 2016
- PQRS Payment End: 2018
What is MIPS?

Performance Categories

- Quality
- Cost
- Improvement Activities
- Advancing Care Information

• Comprised of four performance categories
• Provides MIPS eligible clinician types included in the 2017 Transition Year with the flexibility to choose the activities and measures that are most meaningful to their practice
When Did MIPS Officially Begin?

Performance period
• Performance period opens January 1, 2017.
• Closes December 31, 2017.
• Clinicians care for patients and record data during the year.

March 31, 2018
• Deadline for submitting data is March 31, 2018.
• Clinicians are encouraged to submit data early.

Feedback available
• CMS provides performance feedback after the data is submitted.
• Clinicians will receive feedback before the start of the payment year.

January 1, 2019
• MIPS payment adjustments are prospectively applied to each claim begin January 1, 2019.
Who is Included in MIPS?

MIPS eligible clinicians billing more than $30,000 a year in Medicare Part B allowed charges AND providing care for more than 100 Medicare patients a year.

MIPS eligible clinicians include:

- Physicians*
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
Who is Exempt from MIPS?

Clinicians who are:

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000 a year
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of their Medicare payments
  - OR
  - See 20% of their Medicare patients through an Advanced APM
Special Status

- Special status affects the number of total measures, activities or entire categories that an individual clinician or group must report for MIPS.

- To determine if a clinician’s participation should be considered special status under the Quality Payment Program, CMS retrieves and analyzes Medicare Part B claims data. Calculations are run to indicate a circumstance of the clinician's practice for which special rules would apply.

- These circumstances are applicable for clinicians in: Health Professional Shortage Area (HPSA), rural, non-patient facing, hospital-based, and small practices

- More information, including explanations of the special status calculations, can be found at: https://qpp.cms.gov/participation-lookup/about.
Pick Your Pace for Participation for the 2017 Transition Year

**Participate in an Advanced Alternative Payment Model**

Some practices may choose to participate in an Advanced Alternative Payment Model in 2017.

### MIPS

**TEST**

- **Submit Something**
  - Submit *some* data after January 1, 2017
  - Neutral or small payment adjustment

**PARTIAL YEAR**

- **Submit a Partial Year**
  - Report for 90-day period after January 1, 2017
  - Neutral or positive payment adjustment

**FULL YEAR**

- **Submit a Full Year**
  - Fully participate starting January 1, 2017
  - Positive payment adjustment

Note: Clinicians do not need to tell CMS which option they intend to pursue.

**Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.**
GUIDANCE FOR CLINICIANS
AT CRITICAL ACCESS HOSPITALS
MIPS Participation for Clinicians in Critical Access Hospitals (CAHs)

- Clinicians who are practicing in a CAH that bills under Method I or Method II and who have not assigned their rights to the facility, are eligible to participate in MIPS. The payment adjustment will apply to those Medicare Part B services billed under the Physician Fee Schedule (PFS) only.

- MIPS clinicians in Method I CAHs (CAH I):
  - The payment adjustment would apply to payments made for items and services that are Medicare Part B allowed charges billed by the MIPS clinicians
  - The payment adjustment would not apply to the facility payment to the CAH itself

- MIPS clinicians practicing in Method II CAHs (CAH II):
  - For those who have assigned their billing rights to the CAH, CMS would apply the MIPS payment adjustment to the Method II CAH payments
  - For those who have not assigned their billing rights to the CAH, the MIPS payment adjustment would apply in the same way as for MIPS clinicians who bill for items and services in Method I CAHs
Claims-based Reporting for CAH II Clinicians
MIPS Quality Performance Category

• For the 2017 performance period, CAH II clinicians can submit data for the MIPS Quality performance category using the claims-based reporting mechanism via the CMS 1450 form
  - They would need to continue to add their NPI to the CMS-1450 claim form for analysis of MIPS reporting at the NPI level

• Claims-based data submission is available to individual MIPS eligible clinicians only. To submit data via claims, a clinician:
  - Selects the appropriate MIPS Quality measures
  - Reports the measures through routine billing processes

• See the Quality Payment Program website for information on how to submit data for all the performance categories: https://qpp.cms.gov/mips/individual-or-group-participation
What are the Performance Category Weights?

Weights are assigned to each category based on a 1 to 100 point scale.

2017 Transition Year Performance Category Weights:

- **Quality**: 60%
- **Cost**: 0%
- **Improvement Activities**: 15%
- **Advancing Care Information**: 25%
Select 6 of the approximately 300 available quality measures (minimum of 90 days)
- Or a specialty set
- Or CMS Web Interface measures
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians can receive between 3 and 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Quick Tip:
It’s easier for a clinician who participates longer to meet the case volume criteria needed to receive more than 3 points
MIPS Scoring for Quality
(60% of Final Score in Transition Year)

Total Quality Performance Category Score = Points earned on required 6 quality measures + Any bonus points

Maximum number of points*

Quick Tip: Maximum score cannot exceed 100%

CMS Web Interface Reporter
total score

- for groups with complete reporting and the readmission measure
  120 POINTS

- for groups with complete reporting and no readmission measure
  110 POINTS

Other submission mechanisms total score

- for 6 measures + 1 readmission measure
  70 POINTS

- if readmission measure does not apply
  60 POINTS
MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

• Attest that you completed up to 4 improvement activities for a minimum of 90 days. (Or, just 1 activity if you are doing the “test” option of Pick Your Pace.)
• You can earn **up to 40 points** in the Improvement Activities category. Points are assigned as follows:

<table>
<thead>
<tr>
<th>Activity weights for groups of more than 15 clinicians</th>
<th>Flexible activity weights for groups of 15 or fewer clinicians, non-patient facing clinicians, and clinicians in a health professional shortage or rural area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medium</strong> = 10 points</td>
<td><strong>Medium</strong> = 20 points</td>
</tr>
<tr>
<td><strong>High</strong> = 20 points</td>
<td><strong>High</strong> = 40 points</td>
</tr>
</tbody>
</table>

\[
\text{Improvement Activities Performance Category Score} = \frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \times 100
\]

**Quick Tip:** Maximum score cannot exceed 100%
MIPS Scoring for Advancing Care Information
(25% of Final Score in Transition Year)

**Base score** (worth 50% of Advancing Care Information score)
- Clinicians must submit a numerator/denominator or Yes/No response for all required measures.

**Performance score** (worth up to 90% of Advancing Care Information score)
- Report **up to 9** Advancing Care Information Measures OR up to 7 2017 Advancing Care Information Transition Measures

**Bonus score** (worth up to 15% of Advancing Care Information score)
- Receive 5% for reporting on Public Health and Clinical Data Registry Reporting measures
- Receive 10% for CEHRT to report certain Improvement Activities

**Advancing Care Information Performance Category Score =**

- **Base Score**
- **Performance Score**
- **Bonus Score**

**Quick Tip:** Maximum score cannot exceed 100%
Calculating the Final Score Under MIPS

**Final Score** =

\[
\begin{align*}
\text{Clinician Quality performance category score} & \times \text{actual Quality performance category weight} \\
+ \text{Clinician Cost performance category score} & \times \text{actual Cost performance category weight} \\
+ \text{Clinician Improvement Activities performance category score} & \times \text{actual Improvement Activities performance category weight} \\
+ \text{Clinician Advancing Care Information performance category score} & \times \text{actual Advancing Care Information performance category weight}
\end{align*}
\times 100
\]
RESOURCES AND TECHNICAL ASSISTANCE
Technical Assistance

CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

To learn more, view the Technical Assistance Resource Guide: [https://qpp.cms.gov/resources/education](https://qpp.cms.gov/resources/education)
Quality Payment Program Resources

- Quality Payment Program website: [qpp.cms.gov](http://qpp.cms.gov)
- Small, Underserved, and Rural Practices Webpage
  - Includes contact information for the Small, Underserved, and Rural Support technical assistance organizations
  - Highlights the available options for small practices, especially those in rural and underserved locations
- Resource Library
  - Contains helpful resources, such as *A Quick Start Guide to MIPS*, and fact sheets on the MIPS performance categories
Group Activity 2

What challenges are CAHS experiencing related to the Quality Payment Program?

What policy related questions do you have?

**Hit *1 to get into queue**

**Enter your response in the chat box**
Quality Payment Program

QUALITY PAYMENT PROGRAM
QUALITY MEASUREMENT AND POLICY RESOURCES FOR CRITICAL ACCESS HOSPITALS

Yvonne Chow, MBQIP Coordinator
Kerri Cornejo, Policy Analyst
Federal Office of Rural Health Policy (FORHP)
Health Resources and Services Administration (HRSA)
Mission

FORHP collaborates with rural communities and partners to support programs and shape policy that will improve health in rural America.
State Offices of Rural Health
50 States
$172K federal - 3:1 match

Small Hospital Improvement Program
47 States
~1600 small rural hospitals/~$9000 per hospital
$~15million

Flex Program
45 states
~1340 CAHs,
$22 million

Other resources, grants
RQITA; TASC; FMT
NOSORH
CBD and OAT Grants
Policy & Research
Flex Program Areas

- Quality Improvement Medicare Beneficiary Quality Improvement Program (MBQIP)
- Financial and Operational Improvement
- Population Health Management and EMS Integration
- CAH Designation
- Integration of Innovative Models

State Flex Programs: [https://www.ruralcenter.org/tasc/flexprofile](https://www.ruralcenter.org/tasc/flexprofile)
Medicare Beneficiary Quality Improvement Project

- Reporting common, rural-relevant CMS measures
- Measuring outcomes and demonstrating improvements
- Sharing best practices
Location of Critical Access Hospitals
Information Gathered Through July 12, 2017

Legend
- Critical Access Hospital (1,341)
- Metropolitan County
- Nonmetropolitan County
- State Not Eligible or Not Participating

Note: Core Based Statistical Areas are current as of the July 2015 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
# Current MBQIP Core Measures for Flex FY15-FY18

<table>
<thead>
<tr>
<th>Core Improvement Initiatives</th>
<th>Patient Safety</th>
<th>Patient Engagement</th>
<th>Care Transitions</th>
<th>Outpatient</th>
</tr>
</thead>
</table>
|                            | OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (Facilities report a single rate for inpatient and outpatient settings) | Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:  
  - Communication with Doctors  
  - Communication with Nurses  
  - Responsiveness of Hospital Staff  
  - Pain Management  
  - Communication about Medicines  
  - Discharge Information  
  - Cleanliness of the Hospital Environment  
  - Quietness of the Hospital Environment  
  - Transition of Care | Emergency Department Transfer Communication (EDTC)  
  7 sub-measures; 27 data elements; 1 composite  
  - EDTC-1: Administrative Communication (2 data elements)  
  - EDTC-2: Patient Information (6 data elements)  
  - EDTC-3: Vital Signs (6 data elements)  
  - EDTC-4: Medication Information (3 data elements)  
  - EDTC-5: Physician or Practitioner Generated Information (2 data elements)  
  - EDTC-6: Nurse Generated Information (6 data elements)  
  - EDTC-7: Procedures and Tests (2 data elements)  
  - All-EDTC: Composite of All 27 data elements | OP-1: Median Time to Fibrinolysis  
OP-2: Fibrinolytic Therapy Received within 30 minutes  
OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention  
OP-4: Aspirin at Arrival  
OP-5: Median Time to ECG  
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients  
OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional  
OP-21: Median Time to Pain Management for Long Bone Fracture  
OP-22: Patient Left Without Being Seen |
| IMM-2: Influenza Immunization | | | | |
Opportunities

- Coordination between state Flex programs, QIN-QIOs, and SURs

- Technical assistance that complements CAHs quality improvement program, even for voluntary reporting

- Alignment of quality improvement activities with MIPS quality improvement activities
  - Example of a crosswalk between MBQIP and QIN-QIO activities/priorities: National Quality Reporting Crosswalk for CAHs

- National Quality Forum report: Performance Measurement for Rural Low-Volume Providers
MBQIP Resources

MBQIP Information Posted at: https://www.ruralcenter.org/tasc/mbqip

• Quality Improvement Implementation Guide and Toolkit for CAHs

• National Quality Reporting Crosswalk for CAHs


• MBQIP Monthly https://www.ruralcenter.org/tasc/mbqip/mbqip-monthly

• Study of HCAHPS Best Practices in High Performing Critical Access Hospitals
  https://www.ruralcenter.org/resources/study-hcahps-best-practices-high-performing-critical-access-hospitals
Hospital-State Division Grants

State Offices of Rural Health
50 States
$172K federal - 3:1 match

Small Hospital Improvement Program
47 States
~1600 small rural hospitals/~$9000 per hospital
$~15million

Flex Program
45 states
~1340 CAHs,
$22 million

Other resources, grants
RQITA; TASC; FMT
NOSORH
CBD and OAT Grants
Policy & Research
State Offices of Rural Health

A resource for rural health issues within each state

https://nosorh.org/nosorh-members/nosorh-members-browse-by-state/

- Share information on rural health issues and resources from state and federal levels
- Provide technical assistance to rural communities
- Encourage recruitment and retention of health professionals in rural areas
- Coordinate activities within the state to avoid duplication of effort and activities
Other FORHP Resources

State Offices of Rural Health
- 50 States
- $172K federal - 3:1 match

Small Hospital Improvement Program
- 47 States
- ~1600 small rural hospitals/~/$9000 per hospital
- ~15million

Flex Program
- 45 states
- ~1340 CAHs,
- $22 million

Other resources, grants
- RQITA; TASC; FMT
- NOSORH
- CBD and OAT Grants
- Policy & Research
Policy Research Division

• Reviewing Regulations, Legislation, and Policies
• Providing Health Policy Research
• Translating Policy Issues for Rural Stakeholders

FORHP Policy Email: If you have rural health policy questions, please contact us at RuralPolicy@hrsa.gov.
Rural Policy Resources

• Get policy updates from the Federal Office of Rural Health Policy (FORHP)

• Sign-up for the weekly FORHP Announcements newsletter
  - E-mail Michelle Daniels at mdaniels@hrsa.gov with the subject line “Subscribe”

• Learn more about value-based payment initiatives from Rural Health Value
  - https://cph.uiowa.edu/ruralhealthvalue/
Yvonne Chow, MBQIP Coordinator, Hospital State Division

Kerri Cornejo, Policy Analyst, Policy Research Division

Federal Office of Rural Health Policy (FORHP)
Health Resources and Services Administration (HRSA)

Email: ychow@hrsa.gov and kcornejo@hrsa.gov

Web: hrsa.gov/ruralhealth/

Twitter: twitter.com/HRSAgov

Facebook: facebook.com/HHS.HRSA
What are some insights and best practices you’ve seen related to CAHs and the Quality Payment Program?

**Hit *1 to get into queue**

**Enter your response in the chat box**
Closing: Give Us Your Feedback

What worked about this event?
What could we have done better?
What would you like future calls to focus on?

**Enter your response in the chat box**