

## CMS publishes MPFS & OPPTS final rules, updates ASC final rule

by Sally Hardgrove, shardgrove@bkd.com, Mark Blessing, mblessing@bkd.com & Tim Wolters, twolters@bkd.com

The November 27, 2007, Federal Register included final rules for the 2008 Medicare physician fee schedule (MPFS) and outpatient prospective payment system (OPPTS).

The MPFS rule also addresses Medicare Part B therapy caps, while the OPPTS rule updates the new ambulatory surgical center (ASC) payment system. It also includes some provisions for critical access hospitals (CAHs) and the inpatient prospective payment system (IPPS).

### MPFS final rule

Because of the growth in Medicare physician expenditures, CMS has established a 10.1% reduction in physician payment rates for 2008. On December 29, 2007,

President Bush signed the *Medicare, Medicaid and SCHIP Extension Act of 2007*, replacing the 10.1% reduction with a 0.5% increase through June 28, 2008. Absent further legislation, the reduction will go into effect on July 1, 2008. CMS will have to publish a new conversion factor in the near future to implement this legislation.

The final rule also provides an overview of the physician quality reporting initiative, through which physicians can receive a 1.5% incentive payment for services on or after July 1, 2007. In 2008, ambulance rates are scheduled for a 2.7% increase.

Medicare Part B therapy caps for 2008 are set at \$1,810 for physical therapy and

speech pathology services, with a separate cap of \$1,810 for occupational therapy. Exceptions to the caps have just been extended through June 30, 2008, but will expire after that date absent further legislation.

### Revisions drive final rule

CMS posted the 2008 OPPTS final rule on its website November 1, 2007; it was published in the Federal Register November 27, 2007. CMS estimates the impact of the final rule will be a 3.3% average increase for all providers.

Changes to the ambulatory payment classification (APC) weights, wage indices  
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## MA no-pay bills required in 2008

by Tim Wolters, twolters@bkd.com

Effective January 7, 2008, hospitals must submit "no-pay" bills to their Medicare contractors for the Medicare Advantage (MA) beneficiaries they treat. The purpose: Capture MA days in the supplemental security income (SSI) fraction used to determine a hospital's disproportionate share (DSH) payments. Change Request 5647, issued by CMS this summer, requires hospitals to bill such claims on Type of Bill 11X with Condition Code 04.

This billing requirement has been in place for a number of years for hospitals with graduate medical education

or nursing and allied health training programs, allowing them to receive appropriate Medicare reimbursement for the portion of these costs applicable to MA patients.

Some in the industry speculate the no-pay bills may actually lower a hospital's SSI fraction, as the percentage of MA beneficiaries eligible for SSI may be lower than the percentage of traditional Medicare beneficiaries with SSI.

However, CMS's instructions appear to make this no-pay billing requirement mandatory. All hospitals should review these requirements to make sure billing procedures are in place starting in January. ■

# CMS publishes MPFS & OPFS final rules,

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and other changes will be budget neutral but will change payment distribution within the system. A driving force behind implementing OPFS in 2000 was the high beneficiary co-insurance responsibility for hospital outpatient services. Beneficiary co-pay has since moved gradually from more than 50% of hospital payment in some cases, to an estimated aggregate average of 26% of total reimbursement in 2008.

The final standard OPFS conversion factor for calendar year (CY) 2008 is \$63.694, factoring in the market basket increase update factor, the required wage index and rural budget neutrality adjustments and the adjustment for pass-through set aside.

The final rule formalizes changes with a potentially significant impact on reimbursement and hospital operations. By statute, it requires the annual payment update factor in CY 2009 and subsequent years be reduced two percentage points for hospitals that don't report quality measures.

The final rule reduced the quality reporting requirements from 10 measures to seven. Acknowledging the infrastructure necessary for hospitals to report outpatient quality data, CMS reduced the initial number of measures and delayed implementing reporting to services provided on or after April 1, 2008, but hospitals must submit a notice of participation to their quality improvement organization (QIO) by January 31, 2008. For final specifications, go to [cms.hhs.gov/QualityInitiativesGenInfo/downloads/QualityOutpatientSpecManual.zip](http://cms.hhs.gov/QualityInitiativesGenInfo/downloads/QualityOutpatientSpecManual.zip).

Hospitals should begin planning how they will gather the required data elements for reporting the emergency department acute myocardial infarction transfer and ambulatory surgery patients.

## Other OPFS changes

The rule finalized revisions to the conditions of participation (CoPs) for hospitals, which clarified time frame requirements for history and physical (H&P) exams, as well as post-anesthesia evaluation requirements.

Revisions also attempt to address the perceived difference in requirements for documenting services provided to inpatients vs. same-day surgery or a procedure

requiring anesthesia. The recommended revisions are based on the significant confusion providers say they experienced when implementing the 2007 final rule.

CMS made final its proposal to package seven categories of ancillary and supportive payments into one payment for the independent service with which they are billed. CMS also finalized the creation of five composite APCs that provide a single, flat reimbursement rate for multiple major services commonly performed on the same day.

In addition to two composite APCs originally proposed (low-dose prostate brachytherapy, including placement of needles for application of the radioelement and cardiac electrophysiological evaluation and ablation), CMS created two composite APCs for extended assessment and management (of which observation care is a part) and a composite rate replacing the longstanding limit on per diem payment for mental health services. CMS states its long-term goal is migration toward an episodic payment mechanism driven by a major procedure, with other services and procedures packaged into the composite APC rate.

CMS finalized packaging for seven additional categories of supportive and ancillary services, including observation; radiologic guidance (fluoroscopy, ultrasound and stereotactic localization); image processing; intraoperative services (post-fracture films and electrophysiology); imaging supervision and interpretation (imaging components of most interventional radiology procedures); diagnostic radiopharmaceuticals; and contrast media.

Table 10 in the final rule lists the nearly 300 HCPCS codes included in seven packaging categories. Of note, CMS also created "Q," a new status indicator for procedures that are conditionally packaged based on the presence or absence of independent, separately payable procedures.

Because CMS wants hospitals to continue to bill packaged procedure codes, the outpatient code editor (OCE) will return to provider (RTP) claims for nuclear medicine studies that don't also report a HCPCS code and associated charges for a diagnostic radiopharmaceutical. This will provide data for consideration in the development of

potential revisions to the 2008 OPFS.

Packaged reimbursement for radiopharmaceuticals and contrast media may not be material to many providers; however, hospitals continue to struggle with charge capture and coding of interventional radiology procedures. In many cases, imaging charges associated with these procedures are the only line items that hit the bill.

Hospitals must challenge current charging and billing practices to confirm all service components, including those with packaged payment, are billed in an appropriate and comprehensive manner. Rather than eliminate all payment for the resources required to deliver observation, CMS created two composite APCs that include observation as a component. CMS believes the assignment and payment of composite APCs will be transparent to providers and should not affect billing practices.

The OCE, in conjunction with the PRICER, will determine the appropriate status indicator, APC and payment for every code on a claim. CMS eliminated any diagnosis requirement for payment of the Extended Assessment and Management Composite APCs.

To be considered for payment of the composite rate, a claim must contain eight or more units of an observation HCPCS code, as well as a Level 5 office visit Evaluation and Management (E/M) code, a Level 4 or 5 emergency department E/M code or G0379 (direct admission to Observation).

In addition, a status indicator "T" procedure cannot be billed on the same day or one day earlier than the date of service for the observation code. If an encounter meets all three criteria, it will be paid a composite payment under APC 8002 or 8003. If the claim does not meet the criteria, the PRICER will reimburse whatever separately payable HCPCS codes were billed. In all circumstances, payment for the observation code G0378 is packaged.

Although the final rule affords more payment for resource consumption associated with observation than originally proposed, hospitals should continue to evaluate their practices related to patient placement in observation. As reimburse-

# updates ASC final rule . . .

ment for observation decreases, both for Medicare and commercial payers, it is critical for providers to tighten case-management processes to place patients into the correct status (post-acute placement, discharge to home or admit to inpatient) quickly and lessen unnecessary observation stays.

Hospitals must balance the need to quickly place patients into the correct status with the advice they receive from QIOs to put patients into observation and QIO-heightened scrutiny on the appropriateness of 24-hour inpatient stays.

It remains critical for providers to refine their charge capture, coding and documentation processes to make sure payment is accurate in an environment of reduced reimbursement.

## Reimbursement mechanism

As part of the OPPS final rule, CMS published an update November 27 to the ASC final rule; beginning January 1, 2008, the rule will dramatically alter payment for technical services provided in an ASC.

CMS estimates a total increase in payments to ASCs of about \$240 million in CY 2008. This reimbursement pickup will be fully offset by the expected savings resulting from reduced Medicare spending in hospital outpatient departments (HOPDs) and physicians' offices on services that will migrate from these settings to ASCs.

CMS currently reimburses the technical component of services at an ASC based on one of nine payment categories, while the physician is reimbursed for the professional component of services based on the MPFS.

In the final rule, CMS expanded the list of procedures covered in an ASC by almost 800 procedures, resulting in approximately 3,300 covered procedures that will be reimbursed when provided in an ASC.

The payment rate for the technical component is set at an average of approximately 65% of the APC rate, or what a hospital would receive if the procedure were performed in a hospital-based setting. The physician will continue to receive reimbursement for the professional component of services through the MPFS.

The list of ASC-covered surgical procedures and payment rates was finalized in the 2008 OPPS/ASC final rule issued

November 27, 2007. It included some changes to allowable procedures and payment rate levels from the ASC final rule originally published August 2, 2007.

Many of the covered procedures eligible for reimbursement in an ASC have traditionally been performed in physician offices. The payment for these office-based procedures is capped at the lesser of the ASC rate or the nonfacility practice expense component of the MPFS in the final rule.

Under the new reimbursement mechanism, CMS will begin paying separately for covered ancillary services that were historically bundled into the ASC payment category. However, to qualify for separate payment, the ancillary service must be integral to the covered surgical procedure, and it must also be provided immediately before, during or after the covered procedure.

Examples of such ancillary services include imaging services and certain drugs or biologicals. In addition, CMS will reimburse ASCs for brachytherapy sources for the treatment of prostate cancer and corneal tissue acquisition. It will also reimburse ASCs for high-cost implantable devices at the same rate hospital outpatient departments receive.

CMS will phase in the change in ASC technical component reimbursement levels over a four-year period beginning in 2008, with full implementation of the rates as determined by the new methodology in 2011. Payment rates will also be wage adjusted.

Compared to the current method, the

change under the new CMS methodology varies widely depending on the mix of procedures performed in a given ASC. The FY 2008 OPPS/ASC final rule provides an estimate of how the change will affect the surgical specialty groups in the box below.

The changes in reimbursement shown above include volume changes, so they are not intended to reflect projected changes in the payment for an individual procedure.

In fact, CMS estimates more than 75% of ASC reimbursement for 2008 relates to procedures in the eye and ocular system or digestive system. While the percentage changes in payments seem extreme in many of the other categories, the gross dollars involved are relatively minor.

To exclude ancillary services considered covered in an ASC, CMS proposes to revise the *Stark Law* definitions of "radiology and certain other imaging services" and "outpatient prescription drugs." This change would mean a physician with a financial interest in an ASC could refer patients to its services without fear of violating self-referral prohibitions.

Quality-measure reporting requirements are missing from the ASC final rule; however, effective in 2008, PPS hospitals will be required to report quality indicators for outpatient services, as well as for their inpatient business.

The absence of cost data in most ASCs makes it difficult to determine whether the

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Surgical Specialty Group	Estimated 2008 % Change (75/25 transition)	Estimated 2008 Percent Change (without effect of transition)
Eye & ocular system	2%	3%
Digestive system	-4%	-16%
Nervous system	3%	-4%
Musculoskeletal system	24%	94%
Integumentary system	8%	32%
Genitourinary system	11%	43%
Respiratory system	16%	64%
Cardiovascular system	24%	94%
Auditory system	23%	80%
Hemic & lymphatic systems	31%	124%
Other systems	27%	108%

# Transaction due diligence: one size won't fit all

by David Kottak, dkottak@bkd.com

**W**ebster defines due diligence as “appropriate attention”—an essential aspect of any proposed transaction. As more health care providers explore new and varied relationships with each other, it's critical to thoroughly understand the business risks a due diligence process can help them avoid.

## Ask tough questions up front

Ask difficult questions early in the transaction evaluation process. Is the transaction or venture beneficial to all parties? How does the transaction benefit each of the parties involved? More importantly, what can go wrong?

In many cases, these are the kinds of questions key stakeholders don't ask on the front end of a transaction because they feel there are no better options. That's where transaction due diligence is a helpful tool. Because it examines what is sought by all parties at the table, this tool can provide an objective, arms-length perspective in the evaluation process.

It also helps outline practical business risks and issues, such as required regulatory approvals, proposed federal and state program payment changes, income tax-related matters (including tax-exempt issues) and operational synergies that could be gained subsequent to the transaction.

The scope, approach and timing related to transaction due diligence varies greatly and typically depends on its individual risk assessment of the transaction. One size does not fit all when approaching transaction due diligence.

It's critical to focus effort and attention on areas with the highest degree of risk and, at the same time, approach the transaction objectively to provide an overall framework for managing risk. In other words, just because a particular area of the transaction doesn't appear to have a high level of risk doesn't mean it's risk free.

A thorough due diligence work list might include procedures for obtaining and evaluating the following:

- **Corporate organizational documents**
  - ✓ Articles of incorporation, partnership agreements, etc.
  - ✓ Bylaws and operating agreements
  - ✓ Listings of officers, trustees and board of directors
  - ✓ Conflict-of-interest statement and disclosures
  - ✓ Board of director and committee minutes, including annual reports
- **Regulatory & compliance documentation**
  - ✓ Corporate ethics and compliance programs and policies
  - ✓ Licensure documentation, including Medicare/Medicaid certification
  - ✓ Certificate-of-need applications and status of judicial proceedings
  - ✓ Engineering and safety reports concerning owned property
  - ✓ Accreditation letters, including follow-up progress reports
  - ✓ Audit reports issued by regulatory agencies that have inspected the facility
  - ✓ Listing of properties owned, leased or operated
  - ✓ Internal Revenue Service (IRS), state and local tax filings and audit results
  - ✓ Medicare/Medicaid cost report filings, including audit results
- **Financial & accounting documents**
  - ✓ Audited financial statements and related management letters
  - ✓ Description of charity-care policy and community benefit reports
  - ✓ Interim period financial (including statistical) information
  - ✓ Significant financing agreements (notes, leases, bonds, etc.)
  - ✓ Listing of loans with related parties
  - ✓ List of basic terms of gifts and endowments
- ✓ Inventory listings, including property, equipment and supplies
- ✓ Details for intangible assets recorded
- **Personnel documents**
  - ✓ Organizational chart for employees
  - ✓ Employee manuals and handbooks
  - ✓ Positions funded in whole or in part by grants or contracts
  - ✓ Information regarding union organization activity
  - ✓ Insurance policies including deductibles and tail coverage options
  - ✓ Listing of matters resolved by compensation
  - ✓ Listing of matters referred to insurance carrier
- **Other matters**
  - ✓ Detailed analysis of information systems platforms
  - ✓ Summary of recent patient surveys, responses and follow up
  - ✓ Description of any religious guidelines for patient care
  - ✓ Copy of policy related to abortion, sterilization or other birth-control matters

If a transaction has a perceived strategic value, if the purchase price or working-capital reconciliation can't be adjusted or if management is fearful of either slowing down or derailing the deal—these are issues that often become a transaction team's rationale for lack of focused effort in these areas.

However, an effective due diligence process can add tremendous value in many other areas. It can assist in post-merger integration, identify key strengths and weaknesses within the “target's” management team, help senior executives develop the overall strategic direction for the combined entity and a variety of other items.

Contact your BKD Health Care Group Advisor if you're considering a transaction or have questions about transactional business risks or due diligence activities. ■

# RAS a cue to prepare for RAR

by Jim Brown, jbrown@bkd.com

The Auditing Standards Board (ASB) of the American Institute of Certified Public Accountants (AICPA) recently issued eight consecutive Statements on Auditing Standards (SAS)—Nos. 104 through 111. The new standards are known collectively as the “Risk Assessment Suite” (RAS or the Suite).

RAS is effective for financial statement audits for periods beginning on or after December 15, 2006, and applies to all not-for-profit and governmental healthcare entities, as well as to for-profit healthcare entities not registered with the Securities and Exchange Commission (SEC).

The new standards expand on the guidance for information gathering, brainstorming and other concepts of SAS 99, the previously effective fraud standard.

## RAS objectives

RAS was issued to improve audit quality and effectiveness. It was developed by the ASB in response to recommendations made in an in-depth study by the former Public Oversight Board’s “Panel on Audit Effectiveness.” The Suite is also intended to enhance public confidence in auditors.

For the past several years, the failures of various for-profit, not-for-profit and governmental entities reduced public confidence in audit effectiveness and led to increased scrutiny of auditors by legislators, regulators and others. RAS’s basic premise is to enhance audit effectiveness through improved risk assessment and response (RAR).

Under RAS, auditors will assess what could be materially wrong in the financial statements and will design and perform appropriate and responsive audit procedures:

- Perform risk assessment (information gathering) procedures for a more in-depth and comprehensive

understanding of the audited entity and its environment, including internal control

- Identify significant risks of material misstatement of the financial statements (whether caused by error or fraud) and how entity mitigates them
- Perform more rigorous assessment of specific, potential material misstatements that could result from identified risks
- Develop and perform further audit procedures (tests of controls, analytical procedures and tests of details) appropriate in nature, timing and extent to the identified risks and related specific potential material misstatements

## RAS impact

Because RAS requires greater focus on the more significant areas of audit risk, expect the time and effort you expend in these areas to increase. Overall, RAS is likely to require more time and audit effort, with the greatest demands expected in the initial year, with some reduction of time and effort possible in subsequent years.

As a result of RAS, your audit may proceed differently than in the past: There may be requests for new information, and some that was requested previously may now require a different form or greater detail. External auditors also will require more communication with various entity personnel, as well as the governing body.

The nature, timing and/or extent of further audit procedures may be somewhat different or tailored to respond to identified risks and potential causes of material misstatement for an entity’s financial statements each period.

RAS will increase audit costs for most healthcare and other entities, with the magnitude depending on many factors:

- Entity size and complexity
- Timeliness and thoroughness of an entity’s response to auditor inquiries and assistance requests
- Extent and adequacy of an entity’s documentation

- ✓ Operations, ownership, governance, investments, financing and structure
- ✓ Objectives and strategies and related business/operational risks
- ✓ Measurement and review of financial performance by management
- ✓ Internal control, including use of controls over information technology
- ✓ Antifraud programs and controls
- External industry factors, *e.g.*, political, legal and regulatory environments
- Complexity of transactions and applicable accounting principles
- Expertise of entity accounting personnel
- Number of opinion units for a governmental entity

Successful RAS implementation depends largely on the quality, quantity and timeliness of both the documentation and assistance you provide, as well as the communications with your governing body, audit committee, management and accounting personnel throughout the audit.

## Modernize your approach

BKD has formed a task force comprised of experienced audit and Quality Control professionals, highly skilled in helping health care providers update their existing audit policies, programs, forms and procedures so they are consistent with RAS objectives.

To discuss the implications and application of RAS and RAR to your audit, contact your BKD Health Care Group advisor for an introduction to a member of the task force. ■

# Your medical practice's fee schedule

by Andy Thompson, athompson@bkd.com

If someone were to ask how you developed your practice's fee schedule, what would you answer? First, ask yourself:

- Does my fee for a given procedure cover its cost?
- Is my reimbursement limited because my fees are lower than the contractual rate for my highest payer?
- Do I have a systematic process for establishing fees for new procedures or services?
- Can I easily explain a procedure's fee to staff members and patients?

Once rates have been set for a specific procedure or service, many organizations pay little attention to their fee schedules. When they provide a new service, the fee assigned is likely a guesstimate based on what seems reasonable. Sound familiar? Your fees should have three key attributes:

- Each fee covers the procedure's expense
- Fees are competitive within the market
- Fees don't limit payer reimbursements

Develop your fee schedule according to the costs of providing the services it covers. While not every fee will provide a fixed profit margin, you should still structure your fee schedule so the amounts charged

are generally more than the costs of providing the services.

Most third-party reimbursement is on a payer's fixed schedule, independent of the charge submitted, so it may seem trivial to analyze your fee schedule; however, changes are afoot:

- Uninsured patients are on the rise
- Insured patients are paying higher deductibles and coinsurance amounts
- Many people are adopting high-deductible health plans that are effectively self-pay for the first few thousand dollars' worth of care each year

In the last two cases, the amount you collect from the patient may be determined by the contracted allowable, but if you are not contracted with the payer or have an alternate arrangement, your charges may dictate what you collect from the patient. This shift means medical practices are again relying on the amount charged for payment instead of contracted rates.

Does your fee schedule reasonably compare to local prevailing rates or does sticker shock scare patients away? To stay competitive, do you provide large percentage discounts to self-pay patients? Conversely, do you seem to attract an inordinate amount of self-pay patients in your region?

If you answered yes to any of the questions above, there's a chance a significant

disparity exists between your fee schedule and the local market. Even if your fee schedule is well in tune with your local market, it doesn't mean it isn't costing you revenue with your contracted payers.

Most payers—including Medicare fee-for-service payers—pay the lesser of either the charge submitted or the contracted rate. BKD has worked with many organizations that lost thousands of dollars in reimbursement because the charges they submitted for some or all of the services provided were less than the allowable amount from their payers.

In these days of waning reimbursement, no one wants to give up revenue they have earned for services provided. When was the last time you compared your fee schedule to your highest payers to ensure your charges were greater than, or at least equal to, the payer reimbursement rate?

To avoid these pitfalls, analyze your fee schedule for weaknesses. Compare your fees to private contractual rates, Medicare rates and published local prevailing rates. If your fees aren't meeting the needs of your organization, move to a fee schedule based on relative value units (RVUs):

- RVUs are an objective, numerical measure of the resources used to provide a service
- MPFS is based on RVUs

## Medicare revalidation process requires timely response

by Jennifer Wormington, jwormington@bkd.com

Last year, CMS approved new regulations designed to help ensure accurate Medicare provider and supplier records. With the exception of suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), all providers and suppliers must now periodically certify the accuracy of enrollment information if they want to maintain their Medicare billing privileges.

Revalidation requires full completion of CMS Form 855, the Medicare enrollment application. DMEPOS suppliers are re-

quired to revalidate their enrollment information every three years, while all other suppliers and providers are on a five-year enrollment revalidation schedule.

To revalidate enrollment information, CMS began sending providers a letter this year, requesting they return a completed Form 855 within 60 days. Every provider will receive this request over the next four years and every five years thereafter.

Those failing to complete the revalidation process on time and in accordance with CMS guidelines could have Medicare enrollment and billing privileges revoked, also resulting in the termination of the provider agreement.

To be reinstated, providers or suppliers must apply as new providers or suppliers with the Medicare program and be surveyed (if applicable). In this situation, there would be a period for which the provider or supplier would not be Medicare certified and could not receive Medicare payments for any services rendered, which would be disastrous for most providers.

BKD urges all providers and suppliers to respond to CMS's revalidation requests as quickly as possible and can help you with the revalidation process. Contact your BKD Health Care Group advisor for more information. ■

# —friend or foe?

- Private fee-for-service reimbursement rates paid by commercial insurance plans are often based on the MPFS and therefore tied to RVUs
- CMS routinely updates RVU values for new procedures and changes to current procedures

The advantages of an RVU-based fee schedule are that your practice can consider costs, local competition and contracted payment rates when it establishes the

amount to charge per RVU. Once established, it's easy to apply to new services or procedures.

This type of fee schedule can also help your practice arrive at consistently priced services and allows some flexibility. For instance, you may decide to have a different charge per RVU for your evaluation and management (E&M) services than you use for procedures or other services.

RVU-based fee schedules are like using

any other method: You can't just "set it and forget it." To improve revenue while maintaining market competitiveness, analyze and adjust your fee schedule at least annually.

Variations in expenses, regional reimbursement rates, payer mix, service mix and organizational goals drive differences in fee schedules; therefore, there is no best rate every practice can use. Take time to tailor your fee schedule to your organization and make it work for you. ■

## PACPRI goals & their impact on SNFs

by Eric Doerhoff, edoerhoff@bkd.com

One of the many changes resulting from the *Deficit Reduction Act of 2005* (DRA) is the Post Acute Care Payment Reform Initiative (PACPRI). Beginning January 1, 2008, a three-year demonstration project will test PACPRI, and a report detailing its findings will be submitted to Congress in 2011.

PACPRI's primary goals: provide data to guide payment policy in Medicare's post-acute care (PAC) program settings; standardize the format for sharing health information with PAC sites (regardless of the setting); and evaluate patient outcomes following treatment at different PAC settings.

To achieve these goals, CMS has contracted RTI International to gather the necessary data during the upcoming demonstration program.

### Data collected with CARE

The three-year demonstration will be conducted in 10 different geographic areas of varying population density, demographics and PAC provider availability. RTI anticipates approximately 150 hospitals will volunteer to participate. The 2011 report to Congress will include participant data gathered by RTI and CMS. Data collection will use Continuity Assessment Record and Evaluation (CARE), a newly developed standardized patient assessment tool.

CARE is an 11-section, 26-page document designed by RTI to serve as a single, comprehensive patient assessment to measure the health and functional status of Medicare acute discharges at the time of

discharge. It will direct acute discharge planners to transfer patients to specific PAC sites based on CARE feedback.

During the demonstration project, this data will also be compiled to track discharge settings to evaluate patient outcomes at different PAC sites.

### Industry impact felt by LTCs

The impact on the LTC industry could be felt as early as 2012. With the CARE tool designed to assist in discharge planning, including the PAC destination, there is the potential for particular patients with a specific diagnosis, functional status, etc., to be directed to one PAC site over another.

This could direct patients traditionally

cared for in a SNF setting to a different PAC site, such as an inpatient rehab facility (IRF), long-term acute-care hospital (LTAC) or home health agency (HHA).

CMS also indicates CARE-based data will be used to determine the appropriateness of the various reimbursement methodologies used among different PAC sites. This could potentially require changes to PAC Medicare payment systems and/or the amounts paid to treat certain conditions and diagnoses.

In summary, it's safe to say the true impact of these changes has yet to be determined; however, it merits a watchful eye by the LTC industry. ■

## Writers & Speakers

### Writers

**Publication:** ADVANCE for Long-Term Care Management

**Article:** Streamlining the Medicare Part A Denial Process: What CMS Recommends SNFs Do

**Author:** Monte Aspelmeier

**Issue:** November/December 2007

**Publication:** Medical News

**Article:** Pardon the Interruption

*An article highlighting upcoming issues of concern to a variety of health care providers*

**Author:** David Kottak

**Issue:** November 2007

**Publication:** McKnight's Long-Term Care News Online

**Article:** Expert: Fraud costs mount; managers most likely culprits

Article features an interview with Angela Morelock, BKD Forensics & Dispute Consulting

**Issue:** October 24, 2007

### Speakers

**Conference:** Eli Research & Audioeducator.com

**Topic:** Nail the New Medicare Billing Requirements for Hospice

**Speaker:** Aaron Little

**Date:** January 23, 2008, 1 p.m. Eastern time

For a complete listing of state and regional events, see our Events Calendar on [bkd.com](http://bkd.com).

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reimbursement rates are reasonable. Some commentators predict low-volume ASCs, particularly some single specialty providers, will be unable to stay in business.

As with any significant change in reimbursement, financial success under the new ASC PPS may depend heavily on effective cost management.

## CAH and IPPS issues

CMS also chose to address some CAH issues in the OPFS final rule, with changes effective January 1, 2008. First, CAHs can't enter into new co-location arrangements or modify the type and scope of services offered by a current co-located facility.

Second, CAHs can't create or acquire new provider-based locations unless they

are 35 miles from the nearest hospital or CAH (or 15 miles in the case of areas with mountainous terrain or only secondary roads.)

In a clarification of the proposed rule, CMS specifies that provider-based rural health clinics are excluded from this new provision. CMS also indicates that regional offices will issue determinations about the creation of new provider-based locations that are under development before January 1, 2008.

CMS also finalized the October 1, 2007, IPPS payment rates to implement provisions of Public Law 110-90, which required it cut in half the 1.2% behavioral adjustment due to implementation of the new MS-DRG system.

The final rates that incorporate only a 0.6% cut are included in the OPFS final rule. CMS clarified hospital-specific payment rates for sole community and Medicare-dependent hospitals will not be subject to the behavioral adjustment cut.

\* \* \*

Contact your BKD Health Care Group advisor to learn how these rules or the recently signed legislation will affect your Medicare reimbursement. ■

## Save the Date . . . February 6, 2008

### Hot Topics for Tax-Exempt Health Care Providers

BKD Health Care Group members Brian Todd and Michael Engle will present this **free**, one-hour webcast. They will discuss the IRS Form 990 updates affecting tax-exempt health care providers, including:

- ✓ Updates to IRS redesigned 990, including Schedules H & K
- ✓ FIN 48
- ✓ Guidance for reporting charity care & bad debt
- ✓ IRS compliance initiatives
- ✓ IRS 2008 implementing guidelines

10 a.m. Central time, Wednesday, February 6, 2008

Register online at [www.bkd.com/webcast/healthcare](http://www.bkd.com/webcast/healthcare)

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