HEALTHcents

Eastern Michigan Chapter

October 2002

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President's Message

Feel that nip in the air? I think that's a sign that Fall has arrived. Ah, Fall – colorful leaves, apple cider and warm doughnuts, the Lions (I guess we can skip that part), and…the FALL CONFERENCE! Yes, it's that time of year. Come and join us at the Ypsilanti Marriott on Thursday and Friday, October 17 and 18. There'll be great speakers, great camaraderie, and a possibility of golf. Who could ask for anything more?

I'd like to remind those of you who received sponsorship packets to pass them on to decision makers in your organizations, please. Only one was sent out per institution, so TAG, you're it! If you mistakenly took them for junk mail (we're hurt!), please contact Jim Birchler or Cindi Long for a replacement. We really need your support.

See you at the Conference! Diane

This Week!!

2002 FALL CONFERENCE

October 17 & 18, 2002
Ypsilanti Marriott

Dinner Speaker: Lila Lazarus, Channel 4 Health Reporter
Keynote Speaker: Kenneth Raske, President of the Greater NY Hospital Association

For additional information, please contact Kelli Oliver (313)937-3764

Upcoming Member Meeting

The next Member Meeting will be on November 19, 2002 on the 8th floor of the Medical Building at Providence Hospital. This meeting is being hosted in conjunction with the Managed Care Committee. Although, we do not have a firm program set up at this point, the agenda will be as follows:

7:30 to 8:30 am Board Meeting
8:00 to 8:30 am Registration/Continental Breakfast
8:30 to 9:00 am Member Meeting
9:00 to 10:30 am Managed Care Presentation
10:30 am Adjournment

Cost will be
Early Registration $30 Member $40 Nonmember
At Door $40 Member $50 Nonmember
Registration information will be emailed to chapter members in the next week.

Thanks to our Chapter Champion, Standard Federal Bank - a Player in healthcare in southeastern Michigan!

Membership/Member Involvement Committee News

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The HFMA's 2002-2003 Strength in Numbers, Health in Numbers Member-Get-A-Member Campaign has begun. Win gift certificates, apparel awards, even a chance at a $2,500 Grand Prize! - All for the excellent cause of growing our association. Encourage prospective recruits to visit www.hfma.org/join. When you provide a prospective member with an application, please make sure that your name appears in the 'sponsor' area, in order to receive proper credit.

"COMPLIANCE CORNER"

Kenneth R. Marcus, Esq.
Compliance Committee Chairperson

The Department of Health and Human Services Office of Inspector General ("OIG") was quite active in recent weeks, as the following summary indicates:

- The OIG issued its annual work plan on October 3, 2002. The Work Plan describes a number of projects the OIG plans to undertake in fiscal year 2003. The IG will review several nursing home industry issues, including the accuracy of quality, patient, and operation data collected from a variety of sources. The OIG also states that it will continue to closely scrutinize issues involving prescription drugs, including illegal use and marketing of pharmaceuticals. Other of projects related to Medicare, Medicaid, and other programs and agencies under the HHS umbrella. For the complete text of the Work Plan, go to the OIG web site:

  http://www.ahla.org/docs/ASK2002/OIG_FY2003_Wkplan.pdf

- In Advisory Opinion No. 02-13, issued on September 27, 2002 the OIG disapproved a drug company's proposal to establish and fund a non-profit foundation to subsidize cost-sharing amounts incurred by financially needy patients using its drug. The OIG found that the proposal "would result in a patient's physician receiving full payment for prescribing [the manufacturer's drug] (i.e. payment from Medicare for 80% of the Medicare allowable amount and the 20% copayment from the Foundation)." Moreover, the OIG said, the proposal would provide the drug manufacturer "with an obvious financial advantage over competing drugs in the market." For the complete text of the Work Plan, go to the OIG web site:

  http://oig.hhs.gov/fraud/docs/advisoryopinions/2002/ao0213.pdf

- On October 3, 2002 the OIG also published a Draft Compliance Program Guidance for Pharmaceutical Manufacturers. For the complete rule, go to:
  http://www.ahla.org/docs/ASK2002/67fr_62057.pdf

- On September 25, 2002, the OIG issued a proposed rule that would expand the current anti-kickback safe harbor for certain waivers of beneficiary coinsurance and deductible amounts for persons covered by Medicare SELECT supplemental insurance. For the complete rule, go to:
  http://www.ahla.org/docs/ASK2002/67fr_60202.pdf

- In Advisory Opinion 02-12,dated August 30, 2002, the OIG approved an arrangement proposing to (i) contract with managed care organizations and employer-based health plans to enroll their members in an on-line clinical compliance program and (ii) sell advertising on its web site to advertisers, including, but not limited to, pharmacies and pharmaceutical companies.
  For the complete text, go to: http://www.ahla.org/docs/ASK2002/OIG_AO_0212.pdf

- On August 30, 2002, the OIG issued a Special Advisory Bulletin entitled "Offering Gifts and Other Inducements to Beneficiaries." For the complete text, go to:
  http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf

- On August 12, 2002, the OIG issued Advisory Opinion 02-11, approving an arrangement in which a State University Hospital authority proposed to make charitable contributions to a State University Endowment Association to support and promote education and research at a State University School of Medicine. For the complete text, go to:
  http://www.ahla.org/docs/ASK2002/ao0211.pdf

- The Compliance Committee is conducting a concurrent session entitled "Compliance 2000: Beyond the Basics" at the HFMA Fall Conference In Ypsilanti on October 17, 2002. The Compliance Committee will conduct regular meetings commencing in November 2002. Meetings will continue to explore a variety of compliance topics. To be added to the mailing list for Compliance Committee meeting notices, *contact HFMA Administrative Assistant Susan Stokes at:* susanstokes@hfma-emc.org

HOSPITAL BASED PHYSICIAN COMPLIANCE UPDATE

By: J. Kay Felt
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Hospital based physicians need practice manager support in order to comply with JACHO standards on disclosing unanticipated outcomes of care. Since July of 2001, the Joint Commission on Accreditation of Healthcare Organizations has surveyed hospitals for compliance with Standard RI 1.2.2:

> **Patients and, when appropriate, their families, are informed about the outcomes of care, including unanticipated outcomes.**

The primary burden rests on responsible physicians, dentists, podiatrists and other licensed independent practitioners who are permitted to treat without direction or supervision by others.

An "unanticipated outcome" is any outcome of a treatment or procedure that differs significantly from the expected outcome. It could be negative or positive, and includes, but is not limited to, JCAHO defined Sentinel Events:

1. Death
2. Serious physical injury, major permanent loss of limb or bodily function, or psychological injury, not related to the patient's illness or injury
3. Risk of death or serious physical injury
4. Suicide in a protected unit
5. Infant abduction or discharge to an unauthorized person
6. Rape
7. Hemolytic transfusion reaction or blood incompatibility
8. Surgery on the wrong patient or wrong body part
9. Others as determined by policy

A recognized risk that is disclosed and documented as part of informed consent is not an unanticipated outcome.
One year later, there are still many questions about this standard. These must be addressed before JCAHO surveys next. Ideally, there should be a well publicized organizational policy. Also, physicians and other responsible decision makers should be prepared for surveyors to question them on how they and the institution comply.
Practice managers should:

- Develop policies and procedures;
- Provide education, role playing and other support for physicians for whom the task of giving bad news does not come naturally;
- Help physicians learn to transmit bad news without admitting liability and prepare patients for their future care;
- Helping physicians decide whether to have a trusted colleague, practice or department leader, or hospital personnel present when making disclosures.

NEWSLETTER SUBMISSION DEADLINES

November 4, 2002	**December 2, 2002**	**January 6, 2003**	
February 3, 2003	**March 7, 2003**	**April 7, 2003**	**May 2, 2003**

Please note that the Newsletter will be published monthly with your cooperation. Any information for inclusion should be sent to Maryanne VanHaitsma (248)549-2703 mvanhait@dmc.org



MAJOR CHANGES IN MEDICARE'S PROVIDER-BASED STANDARDS

By: Maria Abrahamsen

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Services furnished by programs and facilities that are integral parts of a provider are generally reimbursed as though furnished by the provider. In some cases, provider-based sites are reimbursed at higher rates than equivalent free-standing sites. Other services (e.g. community mental health centers) are covered by Medicare *only* if operated as provider-based.

Prior to January 10, 2001, hospitals and other providers were subject to a relatively short and general list of standards required in order for a facility to qualify as a provider-based site (the "Old Standards"). New, more extensive standards (the "New Standards") became effective for cost reporting periods beginning on or after January 10, 2001, except for the grandfathered sites inferred to below.

On August 1, 2002, CMS published final revised provider-based regulations, which include the following key changes.

"Grandfathered" Facilities – Deadline Extended

Facilities that were treated as provider-based (by the provider and/or by CMS) on October 1, 2000 were "grandfathered" by Congress until October 1, 2002, i.e. until October 2002 these facilities are subject only to the Old Standards and not to the New Standards. **The grandfathering of these facilities has been extended by CMS until the start of their first cost reporting period beginning on or after July 1, 2003**. As of the first post-7/1/03 cost reporting period, grandfathered facilities will be fully subject to the New Standards; the fact that a facility obtained a formal determination for Region V that it was provider-based under the Old Standards will not preclude CMS from determining after July 1, 2003 that the facility does not meet the New Standards. However, *all* provider-based facilities (including those that are grandfathered) are subject, since their cost reporting period beginning on or after January 10, 2001, to the obligations imposed by Medicare on all provider-based facilities, e.g. EMTALA.

On-Campus Location Does Not Guarantee Provider-Based

The August regulations make it clear that **a facility is not *necessarily* provider-based simply because it is located on a hospital's main campus**. Even on-campus facilities must satisfy the applicable provider-based criteria if the facilities are a site at which reimbursable Medicare-covered services are furnished, such as radiation oncology.

Determination Process

Under the rules in effect through September 30, 2002, a facility that is not grandfathered must be determined by CMS to be provider-based before that facility is billed to Medicare as part of the provider. **The new rules eliminate the requirement of a CMS determination, as of October 1, 2002**. After that date (1) obtaining a CMS determination is voluntary, and (2) voluntary determinations will be made by means of CMS' review and acceptance of an attestation form submitted by the provider. Attestations submitted to CMS relating to an *off-campus* facility must be accompanied by supporting documentation, while the provider is merely required to keep on file the documentation that supports an attestation regarding an *on-campus* facility and make such documentation available to CMS on request.

Benefits of Attestation

Although the new regulations will no longer *require* that a provider obtain a provider-based determination from CMS, advantages result from obtaining such a determination. If (1) a facility has been determined by CMS to be provider-based, (2) the facility ceases to qualify as provider-based because of a change in its relationship with the main provider, and (3) the provider notified CMS of the change, then any reduction in reimbursement to freestanding rates will be *prospective* only, beginning as of the time CMS determines the facility does not meet the New Standards. In contrast, if the same facility had not obtained a provider-based determination from CMS, or had not informed CMS of the change in its relationship to the main provider, it would be vulnerable to *retroactive* recoupment of the reimbursement differential for all cost reporting periods that are subject to reopening. Furthermore, while comments to the new regulations do not expressly address the issue, there are good arguments that if CMS *incorrectly* determined a facility to be provider-based, based on a truthful attestation, the facility is protected against *retroactive* recruitment of provider-based reimbursement when CMS later discovers its error.

What Is a "Facility"?

CMS comments to the new regulations emphasize, for the first time, that provider-based determinations will be made by CMS with respect to a specific "facility" rather than with respect to each individual service located within the facility. CMS makes the following disturbing statement, ". . . we emphasize that these rules do not apply to specific services; rather, these rules apply to facilities as a whole. That is, the facility in its entirety must be a subordinated and integrated part of the main provider." The industry will need to press CMS for clarification of this statement. For example, many hospital ambulatory centers include, in a single physical facility, hospital-operated services that are billed as provider-based (e.g. diagnostic services) along with those that are billed as freestanding (such as offices of hospital-employed physicians). There appears to be no public policy reason to deny provider-based status to those *portions* of a single facility that qualify, simply because other services in the building do not.

Continued on page 6

Continuation from page 5

Changes in Provider-Based Criteria

The following criteria, which currently apply equally to on-campus and off-campus facilities that seek provider-based status, will apply only to *off-campus* facilities as of October 1, 2002:

- Operation under the ownership and control of the main provider
- Common administration and supervision with the main provider
- Location within the immediate vicinity of the main provider (it would be redundant to require this of an on-campus facility).

Joint Ventures

The existing regulations deny provider-based status to *all* facilities that are operated as a joint venture – even a joint venture owned by two hospitals or other providers. **The new regulations are more lenient and will permit a facility operated as a joint venture to qualify as provider-based** if the facility (1) is partially owned by at least one provider, (2) is located on the main campus of a provider that is a partial owner (an off-campus joint venture facility is ineligible for provider-based status) even if that provider owns less than a majority of the joint venture, (3) is provider-based with respect to the provider on whose campus the facility is located, and (4) satisfies all other applicable provider-based criteria. A facility may be provider-based with respect to only one provider, regardless of the number of providers that own interests in the facility.

Management Contracts

The effect of a management contract on a facility's ability to qualify as provider-based was changed in the new regulations as follows:

- The restrictions regarding use of a management contract will *not* apply to facilities that are located on the provider's main campus.
- An off-campus facility operated under a management contract may be provider-based only if the main provider employs all staff who are directly involved in delivery of patient care at the facility, other than management staff and practitioners eligible for fee schedule payments from Medicare, such as physicians. In other words, a provider-based facility may obtain from a management company the services of personnel who do not provide patient care, such as security, maintenance and clerical personnel. As an alternative, direct patient care personnel may be supplied by a third party, other than the management company, that furnishes patient care personnel to both the main provider and to the facility seeking provider-based status. Staff members who are leased by the provider from the management company are not considered employees of the provider for purposes of the provider-based criteria.

Multi-Campus Hospitals

CMS' comments to the August regulations discuss instances when two or more hospitals are located on separate campuses but covered by a single Medicare certification. One of the hospitals must be designated as the "main provider" and the facilities of the other hospitals must satisfy requirements for being provider-based with respect to the main provider, in order to bill such facilities as part of the hospital.

Application to Medicaid

CMS will allow a state to amend its Medicaid state plan to eliminate the reimbursement distinction between provider-based and freestanding facilities. However, absent such an amendment, **the provider-based requirements apply equally for Medicare and Medicaid purposes**.

Steps to be Taken Now

- If a facility was treated as provider-based on October 1, 2000, and hence is grandfathered, no immediate action is needed to preserve the ability to bill Medicare as provider-based. As of the first cost reporting period beginning on or after January 10, 2001, however, these grandfathered facilities are fully subject to all requirements of provider-based status (e.g. off-campus facilities must furnish Medicare beneficiaries with written notice of potential liability for self-pay portions, and physician services furnished in the facility must be billed with the correct service location code). See the separate article in this newsletter regarding application of EMTALA requirements to provider-based facilities.
- As of the beginning of the grandfathered facility's first cost reporting period beginning on or after July 1, 2003, the provider must submit to CMS an attestation of compliance with the provider-based criteria in order to obtain the benefits of the attestation described above. However, submission of an attestation is voluntary.
- Sites that were not grandfathered, for example facilities established after October 1, 2000 or which began to be treated as provider-based after that date, were technically required to obtain a provider-based determination from CMS in order to bill as provider-based for any cost reporting beginning on or after January 10, 2001. The requirement for a CMS determination will be eliminated effective October 1, 2002. However, there continue to be benefits (described above) to possessing a determination from CMS, either as a result of an application or an attestation.

Calendar of Events – HFMA

OCTOBER 2002

10-17 - 10-18	HFMA-EMC 49th Annual Fall Conference (Ypsilanti Marriott)
10-23	Managed Care Committee Meeting (St. John's Corp office-28000 Dequindre, Warren)
10-24	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

NOVEMBER 2002

11-4	Newsletter deadline
11-19	Member Meeting (Providence Hospital; 8:30AM)
11-21	Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)
11-22	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

DECEMBER 2002

12-2	Newsletter deadline

JANUARY 2003

1-6	Newsletter deadline
1-16	Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)
1-22	Member Meeting (Providence Hospital; 8:30AM)
1-23	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

FEBRUARY 2003

TBD	Annual Bowling Night
2-3	Newsletter deadline
2-20	Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)
2-27	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

MARCH 2003

3-7	Newsletter deadline
3-20	Member meeting - Annual Ins. & Reimb. Update (DoubleTree, Novi; 8:30AM)
3-20	Membership Committee Meeting (following Member Meeting at DoubleTree, Novi)
3-26	Managed Care Committee Meeting (St. John's Corp office-28000 Dequindre, Warren)
3-27	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

APRIL 2003

4-7	Newsletter deadline
4-17	Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)
4-24	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

MAY 2003

5-2	Newsletter deadline
5-15	Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)
5-22	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)
5-22	Membership Committee Meeting (prior to Member Meeting at Fairlane Club)
5-22	Member Meeting - (The Fairlane Club, Dearborn; 5PM)

JUNE 2003

6-12	Annual Golf Outing – Shenandoah Country Club
6-19	Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)
6-26	Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

Dates subject to change if necessary.

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FY 2002-2003

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