

Best Practices in Managing Critical Access Hospitals

Presented by
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BKD, LLP

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AZ Rural Flex Program – 2012 Performance Improvement Summit

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Agenda

- Overview of New Reimbursement Regulations
 - ❖ Update Reimbursement & Payment Regulations
 - ❖ Middle Class Tax Relief & Job Creation Act of 2012
 - ❖ Other Important Issues
- Survival Strategies
 - ❖ 1) Systematic Assessment
 - ❖ 2) Strategic Planning
 - ❖ 3) Revenue Cycle Management
 - ❖ 4) Business Strategies
 - ❖ 5) Service Evaluation
 - ❖ 6) CAH Reimbursement Strategies
- New Cost Report Forms
- Health Care Reform Reimbursement Reminders

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Flex Summit Hospital Analysis (FSHA)

- Analysis of hospital's attending the summit of their Medicare cost reports from FYE 2010 (obtained from on-line CR service)
- AZ CAH's total = 14 +1
- AZ Cost Report Analysis = 11 + 1
- Average Bed Size = 23



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Reimbursement Regulations

FY 2012 Inpatient PPS (IPPS) Final Rule



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FY 2012 IPPS Final Rule

- Defined Benefit Pension Costs – cost finding
 - ❖ Pension costs will be recognized on a cash basis only; up to a rolling limit.
 - ❖ Effective for cost reporting periods on or after 10/1/2011
 - ❖ Limit is 150% of the three consecutive reporting periods (cost reports) out of the five most recent reporting periods that produce the highest average
 - ❖ Does have a carry forward policy for funded costs that are in excess of the limit.
 - ❖ CMS to develop a process where funded contributions in excess might be allowable in year they are funded.

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FY 2012 IPPS Final Rule

- Critical Access Hospital Ambulance Services
 - ❖ Changes policy for a CAH to qualify for cost reimbursement for ambulance services
 - ✓ Old Policy was 35 mile rule measured from CAH campus or any ambulance station
 - ✓ New Policy is 35 mile rule measured only from the CAH campus
 - ❖ Effective for CR periods beginning on or after 10/01/11
- FSHA – None in this AZ group have Ambulance Services



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Reimbursement Regulations

FY 2013 Inpatient PPS (IPPS) Proposed now Final Rule



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FY 2013 IPPS Proposed Rule

- Posted on 4/24/12
- Published on 5/11/12
- Comments accepted through 6/25/12
- Final Rule issued 8/1/12, effective 10/1
- Only a few provisions specific to CAHs
- PPS hospitals comments for
 - ❖ Payment Rates
 - ❖ Wage Index
 - ❖ Readmissions

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Reimbursement Regulations

FY 2012 Outpatient OPFS Final Rule



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FY 2012 OPFS Final Rule



- Published in 11-1-2011 Federal Register
- Issued payment policy for Physicians and Nonphysician
- Services paid under the Medicare Physician Fee Schedule (MPFS)
- Physicians saved again, but when will this long standing issue be resolved? (Warning date 12/31/2012)
- Hospital Outpatient Fee Schedule Increase 1.9%

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RHC Rates CY 2012

- Originally Published in the November 4, 2011 Federal Register with an increase to \$79.48 or 1.8%
- Correction published on January 30, 2012
- Upper Payment Limit per visit
 - ❖ Increase from \$78.07 to **\$78.54**
- Reflects a 0.6% payment increase
- FSHA – 6 have RHCs (Limit does not apply) (3 have 2)
 - ❖ Average Per Visit cost = \$192 (over limit get + \$113 ☺)
 - ❖ High Cost at \$316, Lowest at \$107
 - ❖ Average without High or Low = \$186



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Reimbursement Regulations

Final Rule for Other Providers SNF, HHA, Hospice & ESRD



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FY2012 SNF PPS Final Rule

- Overall rate Decrease of 11.1%
- "Parity" or "recalibration" adjustment = 12.6% decrease
- Market basket 2.7%, less 1.0% productivity adjustment = 1.7% net increase
- Cuts apply only to Therapy categories
- Non-therapy rates actually went up slightly by the net market basket increase
- FSHA – 1 have SNFs
 - ❖ Number of SNF beds = 49

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Home Health 2012 Base Rate Update

- Base PPS episode rate
 - ❖ 2011 = \$2,192.07
 - ❖ 2012 = \$2,138.52
- 2.4% Decrease**
- Final Rule Published in 11-4-2011 Federal Register
- FSHA – 1 have HHA

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Middle Class Tax Relief and Job Creation Act of 2012



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Medicare Bad Debts

- PPS hospital bad debt reimbursement reduced from 70% to 65%, for cost reporting periods beginning on or after 10/1/12
- CAH bad debt reimbursement reduced to:
 - ❖ 88% for periods beginning on or after 10/1/12
 - ❖ 76% for periods beginning on or after 10/1/13
 - ❖ 65% for all periods beginning on or after 10/1/14
- SNF crossover bad debt reimbursement reduced to 65% over same schedule as CAH bad debts

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Medicare Bad Debts

- FSHA Averages for Inpatient
 - ❖ Deductibles & Co-Insurance \$196,574
 - ❖ Average Bad Debts \$26,664 or 14%
 - ❖ 4 FCHA's (out of 12) had NO Inpatient Bad Debts (33%)
- FSHA Averages for Outpatient
 - ❖ Deductibles & Co-Insurance \$971,423
 - ❖ Average Bad Debts \$51,152 or 5%
 - ❖ 4 FCHA's (out of 12) had NO Outpatient Bad Debts (33%)

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Medicare Bad Debts

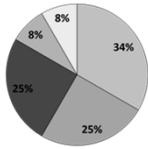
- FCH's who did not claim bad debts, if you just had the average – an extra \$78,000
- If FCH's all moved the Bad Debts claimed
 - ❖ By 5% and extra \$58,400
 - ❖ By 10% an extra \$116,800
 - ❖ How much does a extra staff time cost?
- Bad news they will cut Bad Debts, but you can work to claim more



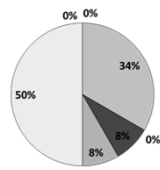
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FSHA Medicare Bad Debts

Inpatient Bad Debts



Outpatient Bad Debts



Inpatient Bad Debts to Deductibles & Co-Insurance is 14%

Outpatient Bad Debts to Deductibles & Co-Insurance is 5%

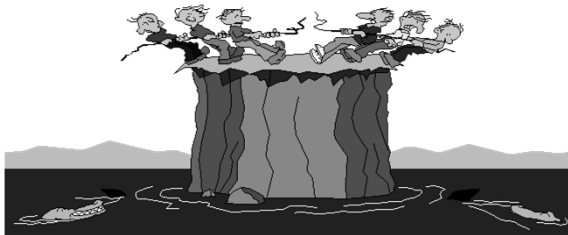
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Miscellaneous Provisions

- Physician fee schedule frozen through 12/31/12
- Work geographic adjustment floor of 1.0 extended through 12/31/12
- Outpatient therapy caps & exception process extended to hospital outpatient services from 10/1/12-12/31/12
- Separate payment of technical component of physician pathology services extended 4 months through 6/30/12
- Ambulance add-ons extended through 12/31/12

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Other Important Issues



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Changes to CHA Conditions of Participation – 5/16/12 Final Rule

- Eliminated requirement that certain services be furnished directly by CAH staff
 - ❖ Diagnostic & therapeutic services
 - ❖ Laboratory services
 - ❖ Radiology services
 - ❖ Emergency procedures
- “At a minimum, we expect the services . . . to be offered by the CAH on-site”

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EHR for Critical Access Hospitals

- Initial response from FI's
 - ❖ CAH's MUST OWN the Hardware and Software to Qualify for EHR Incentive
 - ❖ Can not finance through a capital lease!
- Now CMS has clarified that CAH's can have a Capital Lease which is the same as a “Virtual Purchase Agreement”



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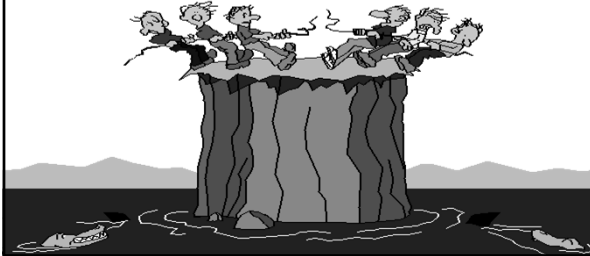
OIG 2012 Work Plan – Overall Focus

- Hospital Quality Measures
- “Present-on-admission” data
- Same-day readmissions
- Payment for outpatient services in 72-hour window
- Hospice & Home Health Care services
- Billing & Payment of DME
- Professional Component Billing of Evaluation and Management (E/M) Services



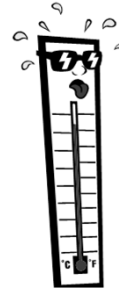
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Survival Strategies for Critical Access Hospitals Under Health Care Reform



Survival Strategies

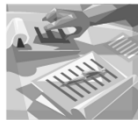
1. Systematic Assessment
2. Strategic Planning
3. Revenue Cycle Management
4. Business Strategies
5. Service Evaluation
6. CAH Reimbursement Strategies



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1) Systematic Assessment Process

- Review hospital operations & utilization data
- Financial & Medicare cost report data
- Market share assessment
- Community demographic studies
- Medical staff composition
- Hospital usage & recruiting plans
- Product line profitability, service mix & payer mix
- Physician Clinic or RHC Operations
- Impact of primary care network



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1) Systematic Assessment Process

ASSESS:

- What strategies have guided the hospital in the past?
- What success has the hospital achieved by following these strategies?
- What changes, if any, should there be for the hospital in the future?



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2) Strategic Planning

Key Questions in Strategic Planning Process

- Where should the hospital be 3 - 5 years from today?
- What are critical factors for the hospital to be successful?
- What are specific goals for the hospital to achieve success



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2) Strategic Planning

Key Elements in Strategic Planning - Consider

- ❖ Community needs
- ❖ Service mix
- ❖ Market share
- ❖ Medical staff
- ❖ Revenues & costs
- ❖ Impact of debt capacity
- ❖ Competition



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2) Strategic Planning



- Model your options – reality check
- Evaluate implications & alternatives
- Revise goals & timing of goals, if necessary
- Revisit goals, options & plan routinely

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3) Revenue Cycle Management



- Health Care Reform
 - Individual mandate was upheld
 - Court did strike down a Medicaid Provision
 - Upheld the law's eligibility expansion
 - Also held that any given state does not have to go along with the expansion as a condition to receiving Federal matching money to help pay for its existing Medicaid plan
 - Health Care Exchanges ? ?
 - Likely at least some people will not be covered

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3) Revenue Cycle Management

- Contracting with third-party payers
 - Review contracts
 - Evaluate contracts for compliance
 - Evaluate denials
 - Renegotiate outdated contracts
 - Align contracts with physician groups



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3) Revenue Cycle Management

- It is not just about days in A/R!
- It is about cash and retaining your cash position!
 - ❖ Prepare & submit clean & timely claims
 - ❖ Claims follow up
 - ✓ Do you know where your denials are?
 - ❖ Adopt stringent point of service collection policies.
 - ❖ Are your collection agencies collecting your cash?
 - ❖ Focus on the A/R aging
 - ✓ Do you have old balances in Medicare, Medicaid, etc.?
 - ✓ Does your team understand why and how to fix?



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FSHA Comparisons

- FSHA Average Days in Cash & Investments
 - ❖ Overall average = 63
- FSHA Average Days in A/R
 - ❖ Overall average = 54
- Moving A/R 10 Days FSHA
 - ❖ Average each CAH gets \$760,000 to \$1 M



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3) Revenue Cycle Management

- Charity Care
 - Evaluate charity care policy
 - Require a Medicaid denial before approving charity care
 - Verify third-party coverage during charity care application process



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3) Revenue Cycle Management

- Charge Description Master Risk Areas
 - ❖ Incorrect revenue codes
 - ❖ Incorrect CPT/HCPCS codes for service provided
 - ❖ Providing a service for which there is no CDM line item
 - ❖ Old items that have not been used in 12 months
- Perform periodic CDM reviews
- Educate coders (ICD-10)



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4) Business Strategies - Budgets

- Prepare meaningful budgets
 - ❖ Involve Department Managers
- Anticipate changes
- Budget revenue based on expectations of demand
- Budget expenses based on expected volume/revenue
- Closely monitor budgets
- Hold departments accountable for their performance



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4) Business Strategies - Pricing

- Develop a defensible pricing strategy
 - ❖ Define or determine pricing goals
 - ❖ What are your main concerns?
 - ✓ Market pricing position or Bottom Line?
 - ✓ Price relativity or sensitivity?
 - ✓ Contract limitations?
 - ❖ How often should we evaluate and update our procedure prices to the market prices?



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4) Business Strategies - Pricing

- Develop a defensible pricing strategy
 - ❖ Review the impact of proposed prices on gross and net revenue
 - ❖ Consider if a multi-year plan is necessary to avoid large increases or decreases in specific procedure changes in one year
 - ❖ Consider the impact on current and future contracts with payers



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4) Business Strategies - Pricing

- Develop a defensible pricing strategy
 - ❖ Review the impact of proposed prices on gross and net revenue
 - ❖ Consider if a multi-year plan is necessary to avoid large increases or decreases in specific procedure changes in one year
 - ❖ Consider the impact on current and future contracts with payers
 - ❖ Consider Medicare Cost Report impacts



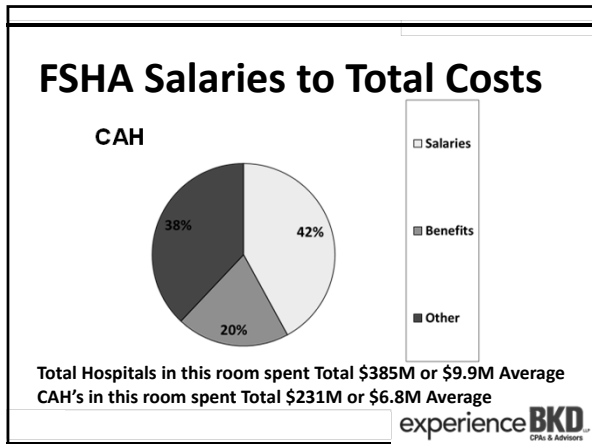
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4) Business Strategies - Labor

- Hospital's largest cost
- But this is Very Hard- how much can be cut?
- Prepare an FTE analysis
 - ❖ If you cannot benchmark yourself get help
 - ❖ Then take action with a Staffing Plan
 - ✓ Obtain board and leadership buy-in
 - ✓ But when the action gets taken buy-in can waiver ☹
 - ❖ Then budget to the agreed plan
- Reduce/eliminate agency staffing



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- ### 4) Business Strategies -Benchmarks
- Select top financial and operational indicators
 - Select meaningful benchmarks
 - Prepare a 24-month trend line
 - Focus on trends
 - Assess the trends and explain variances
 - Measure against state and Top 25 most profitable CAHs
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- ### 4) Business Strategies – Cash Flow (Medicare)
- Avoid significant cost report underpayments
 - Be very aware of the cost report overpayments
 - ❖ Remember Interim Rates adjusted late into next year
 - ❖ Consider one-time costs included in prior year
 - FSHA's Receivable (Payable) for 2010
 - ❖ Receivable Total \$314,000 or \$52,000 average
 - ❖ Payable Total (\$1.3M) or (\$220,000)
 - ❖ CAH's net average overpayment was 5%
-
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- ### 4) Business Strategies – Cash Flow (Medicare)
- Be aware of :
 - Fluctuations in Adult & Pediatric, Swing-bed SNF & Observation days
 - Changes in Medicare utilization
 - Increases and/or decreases in cost
 - Shifts in inpatient and outpatient services
 - Prepare an interim cost report
 - Estimate cost report settlement monthly or quarterly
-
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- ### 5) Service Evaluation - Existing
- Evaluate departments not cost-based
 - ❖ Skilled Nursing Facility / HHA / Hospice
 - ❖ Nonreimbursable cost centers
 - Carefully evaluate new services
 - Prepare a department operating analysis
 - Evaluate departments - winners and losers
 - Determine action steps
 - Evaluate strategies
 - Make conscious decisions based on outcomes
-
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5) Service Evaluation

- Sample Calculation

	Direct Cost & Overhead	Total Gross Revenues	Gross Contribution Margin	Net Patient Revenues**	Net Operating Margin
ADULTS & PEDS	2,660,165	3,138,114	477,949	1,926,936	(733,229)
OPERATING ROOM	821,815	934,005	112,190	573,519	(248,296)
RADIOLOGY	1,605,288	4,918,218	3,312,930	3,019,995	1,414,707

** Gross Revenues less bad debts and contractuals

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5) Service Evaluation –Medical Staff

- Adequate Medical Staff to serve your community
 - ❖ Anticipate future physician shortage
 - ❖ Hospitalist program
 - ❖ Community Health Needs Assessment
- How are you paying the Medical Staff?
 - ❖ Contracts outdated and costing you excessive dollars?
 - ❖ Monitor physician productivity
 - ❖ Typically Medicare does not share in your cost
 - ❖ If you can get reimbursement, know what time studies are needed



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5) Service Evaluation - Existing

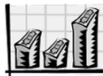
- Develop Bed Management Strategy
 - ❖ Utilize hospital acute care beds effectively
 - ❖ Enhance utilization of swing-bed program
 - ❖ Evaluate alternative use of acute care beds
 - ❖ Educate physicians & staff
 - ✓ Bed management
 - ✓ Third-party payer coverage rules
 - ✓ Best practices



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6) CAH Reimbursement Strategies

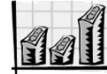
- Assign costs to appropriate cost centers
 - ❖ Direct costs
 - ❖ Indirect costs
- Review cost allocation statistics, like square footage
- Review cost allocations
 - ❖ Highly Medicare Utilized Cost Center
 - ❖ Non-reimbursable cost centers
- Request MAC approval of cost finding changes if warranted



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6) CAH Reimbursement Strategies Utilization Issue

- Key points to remember
 - ❖ Medicare pays
 - ✓ Its share ... based on Medicare utilization of each department's cost
 - ❖ Utilization is measured by
 - ✓ Nursing units - days
 - ✓ Ancillary departments – charges
 - ❖ Overhead costs are reimbursed based on where those costs are allocated & then on Medicare utilization of those departments



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Utilization Issue

- Example (Typical?) Medicare CAH utilization

❖ ICU	80%
❖ Medical/surgical	70%
❖ Physical therapy	35%
❖ Surgery	30%
❖ ER	20%

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Utilization Issue

- Example #1
 - ❖ \$200,000 of nursing costs classified as ER when nurses actually work in med./surg.

Medicare pays	\$200,000 x 20% = \$ 40,000
Should pay	\$200,000 x 70% = <u>\$140,000</u>
Reimbursement lost	\$100,000

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Utilization Issue

▪ Example #2

- ❖ \$200,000 of nursing costs classified as med./surg. when nurses actually work in long-term care area

Medicare pays \$200,000 x 70% = \$140,000

Should pay \$200,000 x 0% = \$ 0

Excess reimbursement \$140,000

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6) CAH Reimbursement Strategies

- Review physician contracts & evaluate time studies
- Claim ER availability & on-call costs
- Protect funded depreciation
- Claim proper depreciation
 - Capitalization policy
 - Election of useful life
 - Separate building components
 - Idle square footage



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6) CAH Reimbursement Strategies

- Capture all qualifying Medicare bad debts
- Properly match total costs to total charges and Medicare charges to total charges
- Elect Option II billing, if beneficial
- Claim bonus payments for Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA)
- Evaluate direct assignment of costs for offsite locations



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6) CAH Reimbursement Strategies Medicare Cash Flow

- Avoid significant cost report underpayments
- Be very aware of the cost report overpayments
 - ❖ Remember Interim Rates adjusted late into next year
 - ❖ Consider one-time costs included in prior year
- FCHA's Receivable (Payable) for 2010
 - ❖ Receivable Total \$2.7M or \$136,000 average
 - ❖ Payable Total (\$1.9M) or (\$94,000)
 - ❖ CAH's net average underpayment was 10%



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Medicare Cost Report New Forms 2552-10



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New CR Forms Highlights

- Reformatted questions
- More Title XIX information
- Obsolete lines, columns, worksheets eliminated
- Subscripts eliminated
- No longer submit separate 339 Questionnaire (in S-2)

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WS S-10 Uncompensated Care

- **Now required for Critical Access Hospitals**
- Computes difference between net revenue & cost for:
 - ❖ Medicaid
 - ❖ SCHIP
 - ❖ Other state or local government indigent programs
 - ❖ Charity
 - ❖ Bad Debt
- **Uses overall CCR (see changes to Worksheet C)**
- **Data should exclude physician and/or other professional services for all lines**

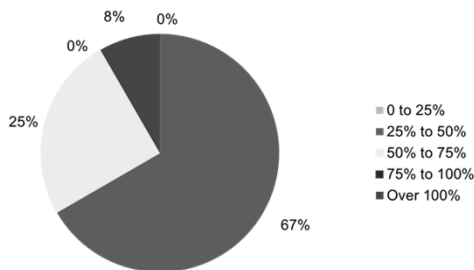
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WS S-10 Uncompensated Care

- **Uses overall Cost to Charge Ratios (CCR)**
- But we know excludes:
 - ✓ Selected costs to do business that Medicare does not share in
 - ✓ Physician services
 - ✓ Other sub-providers part of organization
- FSHA overall Average CCR = 51.57%
- **FIRST TIME ALL HOSPITALS REPORTING**
 - ❖ Different from 990 Schedule H & more than just Non-Profits!

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FSHA Average CCR



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WS A-8 Offsets – Items to note

- CAH HIT Adjustment for Depreciation & Interest (line 32.00)
 - ❖ Applicable only to CAHs
 - ❖ Removes depreciation & interest for EHR items paid under EHR payment methodology
- WS A-8-3 ASHEA limit computation for CAHs contracting for RT, PT, ST &/or OT

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WS A-8 Offsets

- FSHA overall Average A-8 Adjustments Dollars:
 - ❖ Overall average = \$2,154,183
- FSHA overall Average A-8 Adjustments %:
 - ❖ Overall average = 10.28%

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Health Care Reform Reminder Impact on Reimbursement



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Health Care Reform Reimbursement

- Critical Access Hospitals Appear to Initially Avoid Some of the Pain
 - ❖ Few Direct CAH Provisions
- Rural PPS Providers are Not Quite as Fortunate
- Depending on Future of Reform All Providers Will Be Impacted by Changes to Insurance Marketplace

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Health Care Reform Reimbursement

- Possible threats to CAHs
 - ❖ Medicaid DSH cuts in some states
 - ❖ MedPAC study (§3127), CBO ideas, etc.
 - ❖ New Independent Medicare Advisory Board (§3403)
 - ❖ Unraveling of commercial health insurance markets (Title I)
 - ❖ Changes to Medicare Advantage
 - ❖ Payment cuts affecting non-CAH services (SNF, HHA & hospice, physicians, DME, ambulance, etc.)



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Health Care Reform Reimbursement

- Possible threats to CAHs (cont'd)
 - ❖ Compliance & enforcement
 - ❖ Quality reporting & payment for quality
 - ❖ Increased competition
 - PPS hospitals under stress
 - Community health centers with increased funding
 - Others
 - ❖ Inability to recruit physicians & other clinicians
 - ❖ Other consequences (intended & unintended)

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Health Care Reform Reimbursement

- Allows CAHs to participate in 340B discount program for outpatient drugs
 - ❖ Exempts CAHs from the required DSH % (11.75% or 8% for SCHs), other criteria must still be met
 - Government-owned hospital or NFP with government contract for indigent care
 - Outpatient drugs not purchased through a GPO
 - ❖ Effective 1/1/10
 - ❖ May not benefit smaller CAHs or CAHs without an oncology program
 - §7101(a), inclusion of inpatient drugs removed by H.R §4872

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Health Care Reform Reimbursement

- 340B Program Basics
 - ❖ Provides discounts on outpatient drugs purchased by "safety net" providers for eligible patients
 - ❖ Average savings of 25-50% for eligible covered entities on outpatient drugs
 - ❖ Savings can be used to:
 - ✓ Provide discounts on the drugs to the patients
 - ✓ Expand services by the provider to patients
 - ✓ Provide services to more patients

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Preparing for the Future

Health Care Reform or Not ???



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Prepare for the Future

- Fine tune operations
 - ❖ Revenue Cycle
 - ❖ Medicare Cash Flow
 - ❖ Staffing Levels
 - ❖ Adequate Medical Staff
 - ❖ Evaluate & consider eliminating unprofitable services, carefully evaluate new services



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Thank You



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