



Beyond Your Numbers

Critical Access Hospital Medicare Reimbursement Update





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June 8, 2007



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Outline





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Outline


- ✓ Regulatory
 - Final CMS rule limiting necessary providers relocating & related interpretive guidelines
 - Off-site therapy locations
 - Reimbursable bad debts
 - CAHs converting back to PPS hospitals



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Outline

- ✓ Enforcement
 - CRNA cost reimbursement issues
 - Quality improvement organization activities
 - Fiscal intermediary audits
- ✓ Strategies to Improve CAH margins



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2005 CMS Final Rule Set Criteria for Necessary Providers Relocating





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Final CMS Rule Set Criteria for Necessary Providers Relocating


- ✓ The 8/12/05 Final Rule, established criteria for CAHs building replacement facilities & retaining CAH status, if
 - CAH is a designated necessary provider
 - Does not apply to CAHs that meet 35 or 15 mile criteria
 - Relocates to a different site, as defined
 - Completes replacement facility after 1/1/06



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42 CFR §485.610(d)

"A CAH that has a necessary provider designation from the State ... prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location requirement ... based on the necessary provider designation only if the relocated facility meets the requirements as specified ..."




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42 CFR §485.610(d)



The CAH in its new location meets all 3 of the following

- "(i) Serves at least 75 percent of the same service area that it served prior to its relocation;*
- (ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and*
- (iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location."*



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November 2005 CMS Interpretive Guidelines





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Interpretive Guidelines


- ✓ 11/14/05 CMS released revised interpretive guidelines
- ✓ Guidelines are being revised
- ✓ Guidelines extend far beyond regulations
 - Severely limit relocation/replacement by introducing uncertainty
 - Changed other long-standing rules
 - Apply to all CAHs wishing to relocate, not just designated necessary providers



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Interpretive Guidelines


- ✓ Redefines mountainous terrain & secondary roads for hospitals trying to meet CAH location requirements (*i.e.*, 15-mile test)
- ✓ Adds a collocation prohibition
- ✓ Implements CAH relocation regulations



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Mountainous Terrain Guidelines


- ✓ CAH must be located in a mountain range
- ✓ CAH or portions of road must exceed 3,000 feet elevation, with poor travel conditions
- ✓ Consider weather, grades >5%, speed limits <45 mph & other criteria
- ✓ Must be 15 miles of qualifying mountainous terrain to nearest hospital/CAH



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Secondary Roads Guidelines


- ✓ Primary road-any road of 2 contiguous miles with 45 mph speed limit or more
- ✓ Secondary road-any road that's not a primary road
- ✓ Must be 15 continuous miles of secondary roads to nearest hospital/CAH



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CAH Relocation Guidelines


- ✓ Continue to meet state necessary provider guidelines in new location or CAH location criteria
- ✓ Meet all 3% - 75% criteria
 - Same service area
 - Same services
 - Same staff
- ✓ File letter of attestation



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75% of Same Service Area


- ✓ 75% of community continues to utilize CAH
- ✓ Includes Medicare/Medicaid beneficiaries & families below poverty level
- ✓ 75% of patients reside in same zip code areas as those served at prior location
- ✓ 75% of patients have = or < travel distance to new location as old location
- ✓ And any other CMS determined criteria



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75% of Same Services


- ✓ Maintain at least 75% of same services for at least 1 year
- ✓ 75% of billing codes & inpatient/outpatient volumes remain same for at least 1 year
- ✓ No restrictions on adding new services



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75% of Same Staff


- ✓ Provide list of medical staff, contract staff & employees before & after move
- ✓ Meet 75% test for all 3 groups
- ✓ Contract staff include personnel who regularly work 20 or more hours a week at CAH
 - Whether directly contracted or employees of contractor



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Letter of Attestation


- ✓ Send to State Agency & Regional Office "early in the planning stage of its relocation and prior to spending or obligating significant funds and resources"
- ✓ Attest that it will continue to be essentially same provider serving same community at a new location



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Items to Include in Attestation


- ✓ Current & future address
- ✓ Documentation to support attestation
- ✓ Travel distance from current to future location
- ✓ Names, addresses & distances to all hospitals & CAHs that share & surround community



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Items to Include in Attestation


- ✓ Time table for relocation
- ✓ Letter from State Office of Rural Health that it has made preliminary determination on CAH
- ✓ Identification of sources & references for all support



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After Attestation


- ✓ RO will make preliminary determination
- ✓ After relocation, CAH advises of any changes in attestation
- ✓ RO makes "final determination" after relocation
- ✓ At RO discretion, RO may conduct additional review 1 year after relocation



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If Relocated CAH Fails to Meet All Criteria

- ✓ CMS considers the relocation a cessation of business (voluntary termination of provider agreement) & start of new business
- ✓ Forfeit CAH status
- ✓ May apply for new provider agreement
- ✓ May reapply for CAH status



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Off-site Therapy Locations





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Off-site Therapy Locations


- ✓ Medicare's provider-based rules have generally not applied to outpatient off-site therapy locations operated by PPS hospitals
 - Because payment was same
 - Changed due to expiration of moratorium; caps on payments to freestanding therapy providers applied 1/1/06



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Off-site Therapy Locations


- ✓ Provider-based rules have always applied to off-site therapy providers operated by CAHs
 - Location must be provider-based to receive cost reimbursement for therapy services
- ✓ Provider-based rules consider
 - Located on campus-must meet specific tests
 - Remote locations have additional tests
 - Ownership & control by main provider
 - Administration & supervision
 - Within 35 miles (with exceptions)



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Off-site Therapy Locations

- ✓ Additional provider-based rules apply to
 - Joint ventures
 - Management contracts
 - Furnishing all services under arrangements
 - Additional obligations



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Bad Debts





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Bad Debts


- ✓ Bad debts for CAH deductible & coinsurance are reimbursable when (PRM 1 §310)
 - Reasonable collection effort
 - Actually uncollectible when claimed
 - Sound business judgment that no likelihood of recovery



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Bad Debts


- ✓ Recent changes
 - Moratorium does not apply to CAHs
 - Collection agency activity
 - 120-day rule restarting
 - Must bill Medicaid rule



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Bad Debt Moratorium


- ✓ Prevented FIs from changing policy on allowable bad debts after 1987
- ✓ Hard to prove what FI accepted in 1987
- ✓ CMS position-moratorium does not carry over to a new provider (a CAH)



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Collection Agencies


- ✓ Not uncollectible if agency is still working the account
- ✓ Agency must notify that collection efforts have ceased
- ✓ CAH must document collection agency returned the account



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120-day Rule


- ✓ PRM 1 states 120 days from date of first bill to patient
- ✓ Many FIs now require the 120 days restart with any payment



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Bad Debts-Action Items

- ✓ Review/revise written collection policies considering Medicare's rules
 - What accounts go to collection agency?
- ✓ Utilize PRM 1 §312-document indigency, collection rules don't apply
- ✓ Bill all Medicaid cross-over claims



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CAHs Converting Back to PPS Hospitals





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CAHs Converting Back to PPS Hospitals


- ✓ CMS policies are not all published
- ✓ CMS considers the PPS hospital a new provider
 - Assigns new provider number
 - SCH or MDH status must be reapplied for
 - The new provider will have no base years
 - SCH/MDH status of little or no benefit
 - Position is inconsistent with other CMS policies






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CAHs Converting Back to PPS Hospitals

- ✓ 5/3/07 IPPS Proposed Rule *Federal Register*, page 24787 describes a circumstance where CMS believes reverting to PPS status is inappropriate
- ✓ CMS may require CAHS to justify conversion back to PPS hospitals






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<h2>CRNA Cost Reimbursement Issues</h2>	
	
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<h2>CRNA Cost Reimbursement Issues</h2>	
<ul style="list-style-type: none"> ✓ Effective 1/1/07 CMS denied CRNA cost reimbursement to CAHS <ul style="list-style-type: none"> ▪ Located in Lugar counties ▪ Located in urban counties ▪ Stated the CAHS did not meet the location criteria for receiving CRNA cost reimbursement 	
	

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<h2>CRNA Cost Reimbursement Issues</h2>	
<ul style="list-style-type: none"> ✓ One fiscal intermediary has begun to allocate CRNA compensation between <ul style="list-style-type: none"> ▪ Time worked ▪ Time on-call ✓ Disallowing cost of on-call time 	
	

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<h2>Quality Improvement Organizations</h2>	
	
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<h2>Quality Improvement Organizations</h2>	
<ul style="list-style-type: none"> ✓ Some QIOs issuing CAH admission denials <ul style="list-style-type: none"> ▪ CAH admissions must meet criteria ▪ Many UR/case management staffs no longer monitoring for this ▪ Action items <ul style="list-style-type: none"> • Reorient UR/case management to monitor criteria compliance • Appeal denials 	
	

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<h2>Fiscal Intermediary Audits</h2>	
	
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Fiscal Intermediary Audits


- ✓ Inconsistent audit focus on CAHs among FIs, but increasing
- ✓ Be proactive, anticipate audit
- ✓ Evaluate cost reporting accuracy



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Fiscal Intermediary Audits


- ✓ Risk areas
 - Physician time studies
 - ER physician stand by/on call
 - Allocation statistics
 - Liquidation of liabilities



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Fiscal Intermediary Audits


- ✓ Risk areas, continued
 - Cost allocations
 - Access to records paragraph
 - Funded depreciation
 - Necessary borrowing



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Physician Time Studies


- ✓ Minimally acceptable time studies
 - PRM 1 §2313.2 mentions FI approval
 - 1 full week per month
 - Rotating weeks
 - Contemporaneous
 - Provider specific



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ER Physician Standby (on site)


- ✓ PRM 1 §2109.3 requires
 - Time records-standby, patient care, other
 - Signed contract & allocation agreement
 - Evidence that alternative methods of obtaining the coverage were explored before signing agreement
 - Other criteria



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ER Physician On-call (not on site)

- ✓ Available to CAHs only, CFR §413.70
 - Not on CAH premises, or working or on call elsewhere
 - Immediately available by phone, radio
 - Generally, 30 min. response time
 - Written contract requiring response when needed



Cost Allocation Statistics

- ✓ Worksheet B-1- action items
 - Review B-1 stats with CR preparer
 - Are they accurate?
 - Are they kept regularly?
 - Are there alternatives to improve reimbursement?
 - FI must approve changes



Liquidation of Liabilities

- ✓ Accrued liabilities must be paid within 1 year
 - If not, allowable when paid
 - Accrued vacation is specific exception
- ✓ Some must be paid within 75 days of FYE—owners' comp, contributions to self insurance funds/pools



Cost Allocations

- ✓ Assign costs to correct department
 - Salaries based on where people work
 - Routine supplies-where used
 - Billable supplies should match charges



Cost Allocations

- ✓ Don't net revenues & expenses especially
 - Collection agency fees-record as cost, not a reduction to recoveries
 - Expenses paid or subsidized by grant funds



Access to Records Paragraph in Contracts

- ✓ Contracts must contain a clause allowing government access to contractor's records to verify nature & extent of services rendered
- ✓ Cost not allowable if clause is omitted
- ✓ PRM 1 §2440



Access to Records Paragraph in Contracts


- ✓ Applies if cost \$10,000 or more in 12 months
 - Aggregate multiple contracts
- ✓ Clause must provide for access
 - Up to 4 years after service
 - To contractors' related parties' records



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Access to Records Paragraph in Contracts


- ✓ Applies to contracts for
 - Management & clinical services
 - Linen & dietary services
 - Legal & accounting services
 - Insurance & building/equipment leases
 - Information systems



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Example Wording From PRM 1 §2440.4


Until the expiration of four years after the furnishing of the services provided under this contract, (Contractor) will make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General, and their representatives, this contract and all books, documents, and records necessary to certify the nature and extent of the costs of those services.



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Example Wording From PRM 1 §2440.4


If (Contractor) carries out the duties of the contract through a subcontract worth \$10,000 or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General, and their representatives to the related organization's books and records.



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Funded Depreciation


- ✓ Must reduce allowable interest expense by interest income in cost report
- ✓ Exception for investment income on funds qualifying as funded depreciation
- ✓ Rules, PRM 1 §226 - must be followed!



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Funded Depreciation


- ✓ Board must establish
- ✓ Board should approve transactions
- ✓ Designated in accounting records
- ✓ Available for use
- ✓ Can't be borrowed funds



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Funded Depreciation


- ✓ Must use for patient care related capital purposes
- ✓ Must add investment income from FD to fund
- ✓ May lend FD funds to the general fund for working capital



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Unnecessary Borrowing


- ✓ If a borrowing, or a portion of a borrowing, is considered unnecessary, interest expense on the borrowing, or unnecessary portion of borrowing, is not an allowable cost
- ✓ Repayment of funds borrowed is applied first to allowable portion of loan (PRM 1 §202.2)



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Unnecessary Borrowing

- ✓ Generally, borrowing is unnecessary when other funds are available
- ✓ Plan for this early in project development
 - Strategies are available



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Strategies to Improve CAH Margins





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Missouri Hospital Association Top Ten List Strategies to Improve CAH Margins


1. Operate CAH as a Business
2. Develop a Bed Management Strategy
3. Design a Revenue Cycle Management Program
4. Improve Medicare Reimbursement
5. Avoid the Medicare Cash Flow Trap
6. Develop Appropriate Pricing Strategies
7. Improve Clinic Performance
8. Manage Labor and Non-Labor Resources
9. Evaluate Capital Expenditures and Needs
10. Evaluate New Products and Services



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Operate CAH as a Business


- ✓ Forget Medicare cost based myth
- ✓ Maximize productivity & minimize expenditures
- ✓ Prepare meaningful budgets
- ✓ Closely monitor budget & hold departments accountable for performance
- ✓ Develop dynamic strategic business plan & quantify financial implications
- ✓ Establish financial benchmark goals



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Develop Bed Management Strategy


- ✓ Utilize hospital acute care beds effectively
- ✓ Effectively utilize swing-bed program
 - Understand swing bed payment
- ✓ Determine if case management process is working effectively
- ✓ Educate physicians & staff
 - Bed management
 - Third-party payer coverage rules
 - Best practices



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Develop Bed Management Strategy


- ✓ Evaluate use of observation beds
- ✓ Evaluate feasibility of excluded units
- ✓ Evaluate attached long-term care facilities
- ✓ Evaluate skilled nursing unit
- ✓ Evaluate swing-bed program



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Develop Bed Management Strategy


- ✓ Partner with local long-term care providers
 - Training Nursing Assistants & other sharing initiatives
 - Discharge Routine SNF Patients to local providers, especially when they are ultimately destined for nursing home
 - Keep complex & high cost patients
 - Strategy depends on individual CAH's circumstances



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Understand CAH Swing Bed Payment

- ✓ CAH reimbursement is 101% of cost
 - Ancillary cost
 - Routine cost
- ✓ Same methodology for acute & swing bed patients




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Understand CAH Swing Bed Payment

- ✓ Ancillary cost is computed using each department's ratio of costs to charges times Medicare charges
 - Example

Medicare PT charges	\$50,000
PT RCC	<u>80%</u>
PT cost	\$40,000
(plus 1%)	




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Understand CAH Swing Bed Payment

- ✓ Routine cost is computed using the combined acute/swing bed per diem times Medicare days
 - Example


Medicare swing bed	
Days	600
Per diem	\$ <u>725</u>
Swing bed cost	\$435,000
(plus 1%)	



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Understand CAH Swing Bed Payment


- ✓ Increasing swing-bed days can increase reimbursement
- ✓ Examples
 - Comparison of Swing-bed Reimbursement Methodologies handout
 - Reimbursement Change for Adding Swing-bed Days handout



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Understand CAH Swing Bed Payment


- ✓ Points to remember. . . .
 - Don't be fooled by high swing bed interim per diem payment
 - Reimbursement system is same for both acute & swing bed services for CAHs
 - Must meet acute discharge & swing bed admission criteria for swing bed admission



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CMS Solidified 25-bed Limit


- ✓ Effective December 2003 MMA removed
 - CAH 15 acute patient limit
 - Requirement to have swing beds in order to have 25 beds
- ✓ CMS revised State Operations Manual in April 2004 to clarify (enforce) 25-bed limit



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Design a Revenue Cycle Management Program


- ✓ Contracting
 - Review & negotiate contracts with third party payers
- ✓ Patient Admitting & Registration
 - Design patient access system to produce "clean claim"
- ✓ HIM
 - Develop effective health information system to provide for management of patient documentation & final code assignments



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Design a Revenue Cycle Management Program


- ✓ Patient Accounting
 - Maximize cash flow by developing & following effective policies & procedures
 - Submit timely claims
 - Prepare clean claims
 - Minimize denials & appeal them whenever possible
 - Employ effective collection efforts to minimize bad debts



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Improve Medicare Reimbursement


- ✓ Review cost finding allocation statistics (*e.g.*, square footage)
- ✓ Review cost allocations to non-reimbursable cost centers
- ✓ Claim all allowable costs
- ✓ Identify all non-allowable costs
- ✓ Assign costs to the appropriate cost centers
- ✓ Elect Method II billing if beneficial



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Improve Medicare Reimbursement

- ✓ Receive HPSA bonus payments
- ✓ Capture all qualifying Medicare bad debts (100% reimbursed)
- ✓ Claim proper depreciation (capitalization policy, election of useful life, idle square footage, etc.)
- ✓ ER standby & on-call arrangements



Avoid the Medicare Cash Flow Trap

- ✓ Closely monitor Medicare interim rates
- ✓ Be aware of changes such as volume fluctuations, inpatient & outpatient shifts, price increases, cost increases & decreases, etc.
- ✓ Prepare interim cost reports
- ✓ Prepare monthly or quarterly monitoring calculations
- ✓ If Medicare overpays CAH & hospital spends the cash, it's very difficult to repay the liability
- ✓ Interest on loans to repay Medicare overpayments is a non-allowable cost



Develop Appropriate Pricing Strategies

- ✓ Evaluate departments that are winners & losers
- ✓ Prepare departmental operating analysis
- ✓ Evaluate market prices
- ✓ Implement a CDM management program
- ✓ Perform a strategic pricing analysis
- ✓ Make non-Medicare business profitable



Improve Clinic Performance

- ✓ Evaluate how physicians are compensated
- ✓ Evaluate a provider based RHC model
- ✓ Evaluate provider based clinic model
- ✓ Review clinic operations
- ✓ Evaluate arrangements with physicians conducting specialty clinics



Manage Labor & Non-Labor Resources

- ✓ Labor costs & productivity
 - Compare actual results to benchmarking sources
- ✓ Perform salary survey
- ✓ Perform benefit analysis
- ✓ Conduct employee attitude survey
- ✓ Reduce hospital turnover rate



Manage Labor & Non-Labor Resources

- ✓ Non-labor costs
 - Restrict who can sign contracts
 - Evaluate make vs. buy
- ✓ Implement competitive bid policy
- ✓ Capitalize on group purchasing contracts
- ✓ Consider cost sharing with other hospitals
- ✓ Evaluate lease versus purchase



Evaluate Capital Expenditures and Needs


- ✓ Evaluate age & condition of physical plant
- ✓ Prepare equipment needs analysis
- ✓ Prepare capital expenditure budget (5-year plan)
- ✓ Prepare debt capacity study
- ✓ Evaluate lease vs. buy
- ✓ Preservation of capital
- ✓ Funded depreciation
- ✓ Excess working capital
- ✓ Avoid financing cash flow trap



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Evaluate New Products & Services


- ✓ Evaluate community need
- ✓ Evaluate competitive issues
- ✓ Interview community leaders, physicians, staff, etc.
- ✓ Perform R&D of new products & services
- ✓ Prepare financial profitability analysis
- ✓ Perform Financial & Reimbursement analysis before adding new products & services



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Summary of Strategies


- ✓ Operate CAH as a business
- ✓ Use a bed management strategy
- ✓ Fine-tune revenue cycle management program
- ✓ Conduct a comprehensive review of Medicare payment program
- ✓ Closely monitor Medicare payment rates
- ✓ Monitor physician & mid-level productivity & level of compensation



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Summary of Strategies

- ✓ Evaluate pricing strategies
- ✓ Manage labor & non-labor expenses by benchmarking & by closely monitoring budget
- ✓ Evaluate capital expenditures based upon needs & develop a strategic capital plan
- ✓ Evaluate new products & services based upon community need & financial feasibility



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Thank You!

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