Texas Critical Access Hospital Conference

June 28, 2017

Presented by
Discovery Healthcare Consulting Group

Critical Access Operations and Reimbursement Strategy – Discussion Points

- Hospital Cost Report and Reimbursement Mechanics - Cost Reimbursement
  - Strategic Planning for Reimbursement
  - Managing OP Services - RHC vs Clinic Reimbursement

    - Adding Cost for new Capital Improvements - Purchase or Lease?
    - Adding Cost for additional Nursing Staff or Ancillary Staff - What is reimbursement impact?
    - Adding a new Physician for ER coverage RHC coverage?
    - Space in the RHC or new RHC - What are the rules on provider based RHC or clinic?
    - How do I maximize my reimbursement in “non-cost based items” - BD, Medicaid DSH, UC, and others?

- Texas 1115 Waiver, Medicaid Rate Enhancement and Medicaid Going forward

Theory of Hospital Accounting

- Charge for services – Consistent among Payers

- Payment is defined by the Payer
  - Medicare pays on either Diagnosis Basis or Cost
  - Medicaid now pays a modified fee amount / percentage of cost, subject to a Lower of cost/paymt
  - Commercial payers / Managed Care payers
    - Medicare rates
    - Fee Schedule "Established rate"
    - "Percentage of charges"
    - Negotiated Rate
  - Outside Contracted Payers (State contracts - i.e prison)
  - Self-Pay / Uninsured

- Contractual Adjustments
- Incentive Payments

Percent of Collections – Average of Total Revenue

- Medicare Utilization
  - Inpatient Days are about 55% - 65% Medicare
  - Approx 52% of Revenue

- State Funding
  - Medicaid – 6% - 12%
  - Uncompensated Supplemental – 7%
  - Other Supplemental – 7%, declining, E H R, B D, etc.
- Commercial and other – 25 - 35%

Medicare Cost Report

- Two Areas of Consideration in Cost Reimbursement
  - Routine Cost Per Diem
    - Inpatient Acute Care Services
  - Cost / Charge Ratio
    - Inpatient Ancillary Services
    - Outpatient Ancillary Services

Cost Report Theory

- Let's take a deeper look

- Cost Per Diem
  - Obvious Stmt Cost / Day!!
  - Cost / Days & Visits Defined
  - Medicare Census and Utilization

- Ancillary Cost / Charge Ratio
  - Ratio of Cost / Charges
  - Ancillary Dept?
  - Adding a service – Impact?
  - What happens when we add space?
  - All about Mcare and Mcaid Utilization?

Cost Reimbursement Strategic Planning

- Cost Per Diem
  - Total Cost / Total Days X Medicare Days
  - Total Patient Volume – Medicare Volume
    - Consistency
- Ancillary Cost / Charge Ratio
  - Total Cost / Total Charges X Medicare Charges
  - (Like Kind Services – Matching Principle)
- Match High Cost Items with High Utilization
- Be Careful about Increasing Charges, other than in years of higher volume, lower program utilization or increase in costs.

Bringing it all Together!!

- Reimbursement Formula
  - Total Cost / Total Days
    - Times Medicare Days = Per Diem Reimbursement
  - Cost / Charge Ratio
    - Times Medicare Charges = Ancillary Reimbursement
  - HHA, Ambulance, and Non-reimbursable Cost Centers
- Is an increase in Cost a Benefit or Determent to Routine Cost per Diem?
  - Mechanics of Cost Report - Let's answer the questions.
    - Adding Cost for new Capital Improvements
    - Adding Cost for additional Nursing Staff
    - Adding a new Physician or space in the RHC
    - Adding Space and Cost to expand EMS or HHA services

Medicaid Reimbursement

- Medicaid Transition to Managed Care Model
  - Cost to Standard Dollar Amount (SDA) for Inpatient and Outpatient has been a contracted amount
  - No Cost Report Settlement for Managed Care.

- Medicaid reimburses on lower of Cost or SDA in each year

  - If Cost is higher, there is no settlement
  - If Cost is lower, this would result in a negative settlement back to Medicaid.

RHC (Rural Health Clinic) Background

- The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas.

RHC Qualifications

- RHC must be rural or non-urbanized AND one of the following:
  - A Medically Underserved Area (MUA)
  - A geographic Health Professional Shortage Area (HPSA)
  - A population group HPSA
  - Must have HRSA re-certify as meeting these criteria, if RHC is relocated.

RHC Certifications

- RHC may be housed in a permanent or mobile structure.

- RHC may be freestanding or provider-based.
  - Provider based attestation for under 50 beds required as cost reimbursed.

- RHC must provide:
  - One Midlevel practitioner employed 50 percent of the time
  - Provide routine diagnostic and laboratory services.
  - Be able to provide first response emergency care including drugs.
  - Physician supervision

Hospital-Based RHC Reimbursement

- Medicare
  - The Medicare RHC reimbursement per visit cost is not capped if the hospital operates less than 50 beds. You all have 25 licensed beds.
  - Adjusted Cost per Visit – in more detail (not based on revenue or charges).
    - Practitioner Productivity Standard
    - Visits vs Procedures
- Medicaid
  - The Texas Administrative Code for Rural Health Clinic reimbursement at TAC I, Part 15 Rule 355.8101 states "New RHCs will file a projected cost report within 90 days of their designation as an RHC to establish an interim base rate.... The interim base rate will be set at 80% of the anticipated reasonable costs for hospital-based RHCs with 50 beds or less.
  - Final Settlement/Base rate will be established by the settled cost report based on cost per visit.

Hospital O/P Clinic Department

- No Midlevel required
- Same Ownership
- Same Administration & Supervision as all other departments
- Reimbursement
  - Medicare
    - CAH – OP Extension of Hospital – Paid on C/C Ratio
  - Medicaid
    - 75 %Cost of clinic + Physician Fee Schedule
- Payment for procedures is additional payment
- Recommended Filing a Provider-Based Attestation Form

Physician Recruiting Tips

- Interviewing/Selection
  - What are you looking for/needing?
  - Right Fit (Organizational, Personality, Local Connection)
  - Work requirements/expectations
  - Risky Propositions
  - Offer letter's (Major points)
- Onboarding
  - Orientation/Integration
  - Training
  - Feedback and action

RHC Operations Tips

- Patient Satisfaction is Key
- Remove Access Obstacles
- Coding
- Procedures in the Clinic
  - https://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf
- Utilization of APP's and Scribes
- Telehealth

Common Provider Challenges

- Providers not documenting visits
- Billing tickets submitted late or not at all
- Meeting volume expectations once employed

Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:
  - What can we claim?
  - What information should my Bad Debt List include?
  - When can I claim Medicare Bad Debts on Cost Report?
- 42 CFR 413.89(f) requires that the uncollectible Medicare **deductible** and **coinsurance** be charged off as bad debts in the accounting period when the bad debt is determined to be worthless. Jan 18, 2017
- Two Categories of Bad Debt: Indigent / Medicaid and Non-Indigent (i.e. Medicare)
  - No collection effort required for indigent / Medicaid but must bill Medicaid to ensure there is no obligation by the State to pay
  - Regular Medicare bad debt must exhaust all collection efforts before it can be claimed for reimbursement on the Medicare cost report

Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:
  - 42 CFR 413.89(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:
    - (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
    - (2) The provider must be able to establish that reasonable collection efforts were made.
    - (3) The debt was actually uncollectible when claimed as worthless.
    - (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.
  - Reasonable Collection Effort – 120 days without payment being made
  - Collection Efforts can include the combination of in-house efforts and outside collection agency
  - Bad Debt logs should include – Patient demographics, 1st Bill date, W.O. Date and/or returned from collection agency, Medicaid Number (appl), recoveries or payments made, unpaid deductible / coinsurance amounts

Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:
- Set up processes to:
- Exclude non-allowable coinsurance and deductible amounts (Part B physician amounts)
- Track associated coinsurance for recurring patients
- Claim out of state Medicaid patients (includes validating other state EOB codes)
- Bill Medicaid for total charges (charges must match those billed to Medicare)
- Claim Medicaid Managed Care patients
- Create and use a separate transaction code solely used for Medicare bad debt write-offs
- Examine policies annually (Bad Debt/Charity)
- Prepare bad debt logs correctly before submission

Medicare Reimbursement Reporting Tips

- Medicare Bad Debt Reporting Tips:
- Organize and store supporting documentation for audit
  - Medicare and Medicaid remits
  - Patient account detail
  - Proof of write-off date
  - Proof of collection attempts
  - **Proof of accounts returned from collection agencies**
  - Charity Financial application and support
  - Proof fee reimbursed amounts have been removed from bad debt log
  - Proof consistently treating Medicare and non-Medicare accounts the same – this should be included into your Policy.

Technical Correction Needed for 96-hour Stays

- CAH patients (on average) must be discharged within 96 hours
- Conflicts occur when patient stay exceed 96 hours –Medical Review or RAC audit
- In FY 2014 and 15, Medicare rules emphasize the need of a certification on each patient in order for hospitals to be paid
- Resulting in CAHs may be denied payment for patient stays exceeding 96 hour limit

EHR Programs and CMS' consideration CMS movement toward gathering information

- CMS transition
  - Payment Structures have been focused toward the Systems;
  - Payment Appropriations will now move toward an initiative of the outcomes and clinical data reporting.
    - Charity Care and Uninsured Reporting (DSH and UC)
    - Cost Report – DRG and Payment Rate Statistics
    - DSRIP Matrix Measures (Tx. reporting, but CMS is attentive)
    - Hospital Inpatient Quality Reporting Program (Hosp. IQR)- OIG Validated
    - Hospital Outpatient Quality Reporting (Hosp. OQR)
    - Accountable Care Organizations (ACO)
    - Physician Quality Reporting System (PQRS)
    - Clinical Quality Measures Reporting (CQM)
    - American Hospital Association Survey (AHA Survey)
    - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

EHR Programs and CMS' consideration
CMS movement toward gathering information

- CMS transition
  - Newly Developed Program Departments within HHSC
    - Office of Enterprise Data and Analytics (OEDA)
    - Office of Clinical Standards and Quality (OCSQ)
    - Office of National Coordinator for Health Information Technology
    - Office of Prevalence in Multiple Chronic Conditions (MCC)
    - National Impact Assessment of CMS Committee (part of the ACA)
    - Consortium for Quality Improvement and Survey & Certification Operations (CQISCO)
    - Quality Improvement Organizations (QIO) act under CMS
    - CMS Dallas Regional Office
      - Division of Survey and Certification Operations – local component of CQISCO
      - Provider Quality Assurance
    - Office of Inspector General (OIG Work Plan)
      - $400M appropriated toward of Quality Initiatives and validating proper reporting of quality / core statistical measures

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Thank You!

Presented by:
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