Critical Access Hospital Finance – Operations and Reimbursement

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Introduction

- No other industry operates in the same manner as health care

- Critical Access Hospitals operate differently than other health care providers

Agenda

- What financial partners need to know about reimbursement
- Why is it so difficult?
- Strategies
- HIT Funding

Reimbursement Theory

- Methods of reimbursement
  - Fee schedule
  - Charge based
  - Cost based

Reimbursement Theory – Fee Schedule

- Diagnostic Related Groups (DRGs)
  - Inpatient reimbursement based on a fixed payment according to the diagnosis of the patient
  - For the most part charges and length of stay are irrelevant
  - Several hundred DRGs
  - Focus on chart documentation and HIM skills to improve reimbursement

Reimbursement Theory – Fee Schedule

- Common Procedure Terminology (CPT)
  - Payment made based on an established 5 alpha numeric identifier (CPT)
  - Codes for individual procedures
  - Typically lower of charge or fee schedule
  - Focus on documentation, HIM skills, and charge capture process to improve reimbursement

Reimbursement Theory – Charges

- Full charges or percentage of charge
  - We like these payors!
  - Dwindling number of payors
  - Critical Access Hospital may be treated more favorably
  - Allows facility to chart its financial course

Reimbursement Theory – Cost

- Reimbursement based on actual costs
  - Full cost
  - Partial cost
  - Blends
  - Submission of cost report
  - Profit??

Reimbursement Theory

- Reimbursable versus non-reimbursable services
  - Reimbursable – Medicare participates in cost
  - Non-reimbursable – Medicare does not participate in cost

Reimbursement Theory

- Reimbursable examples
  - Medical/Surgical
  - Operating Room
  - Lab
  - Radiology
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Respiratory Therapy
  - Emergency Room
  - Cardiology
  - Pharmacy
  - Supplies
  - Cardiac Rehab
  - Swing Bed
  - Provider-based Clinic

Reimbursement Theory

- Non-reimbursable examples
  - Home Health
  - Hospice
  - Skilled Nursing Facility (Can vary by state)
  - Assisted Living
  - Meals on Wheels
  - Daycare (some costs may be reimbursable)
  - Non Provider-based Clinics
  - Wellness Centers

Reimbursement Theory

- Allowable versus unallowable costs
  - Costs are deemed unallowable if they are not related to patient care
    - Patient phones/television
    - Advertising
    - Physician recruitment (except Rural Health Clinic)
    - Lobbying

Reimbursement Theory

- Allowable versus unallowable costs
  - Costs in excess of established limits are unallowable
    - Contracted
      - Physical Therapy
      - Occupational Therapy
      - Speech Therapy
      - Respiratory Therapy
    - Employee or contract
      - Provider-based physicians
      - Reasonable cost limitations apply

Reimbursement Theory

- Allowable versus unallowable costs
  - Non-patient revenues are offset against cost as a recovery of cost
    - Interest income (to extent of interest expense)
    - Copies of medical records
    - Cafeteria

Reimbursement Theory

- Medicare cost based reimbursement
  - Medicare reimburses costs based on Medicare utilization in the departments in which costs are reported
    - Direct costs
      - Salary
      - Supplies
    - Allocated costs (overhead)
      - Housekeeping
      - Laundry
      - Dietary
      - Administrative and general

Reimbursement Theory

- Overhead allocation methodologies
  - Methodologies determine how overhead costs will be allocated to various departments and subsequently determine Medicare's reimbursement of costs
  - Methodologies can be changed with approval from Medicare
  - Buildings – square footage
  - Moveable equipment – square footage or actual

Reimbursement Theory

- Overhead allocation methodologies
  - Benefits – gross salary
  - Administrative & general – accumulated cost
    - Fragmented administrative & general
  - Maintenance & repair – square footage or time study
  - Operation of plant – square footage

Reimbursement Theory

- Overhead allocation methodologies
  - Laundry – pounds or patient days
  - Housekeeping – square footage or time study
  - Dietary – meals or patient days
  - Cafeteria – full time equivalents (FTEs)
  - Nursing Administration – hours of service
  - Medical Records – gross revenue or time study

Reimbursement Theory

- Medicare cost based reimbursement
  - Interim payments made based on percentage of charges submitted and/or per diem
  - Interim rates based on prior year cost to charge ratio/per diem
  - Final costs are calculated using departmental specific cost-to-charge ratio
  - Routine Med/Surg and skilled swing bed costs calculated based on cost per day

Reimbursement Theory

- Medicare cost based reimbursement
  - Example
    - Medicare will reimburse high percentage of direct costs incurred in Med/Surg due to high Medicare utilization
    - Medicare will reimburse lower percentage of direct costs incurred in the departments with lower Medicare utilization (i.e., Emergency Room, Physical Therapy, etc.)

Reimbursement Theory

- Medicare cost based reimbursement
  - Example
    - Medicare will provide no additional reimbursement for direct costs incurred in non-reimbursable cost centers
    - Overhead costs incurred by the entity will be reimbursed by Medicare based on the Medicare utilization in the departments in which the costs are subsequently allocated

Reimbursement Theory

- Factors impacting year-to-year cost settlements
  - Volume
  - Medicare utilization
  - Changes in charges
  - Changes in expenses

Reimbursement Theory

- Volume
  - Significant increases in volume tend to lead to year-end payable to Medicare
  - Significant decreases in volume tend to lead to year-end receivable from Medicare
- Medicare utilization
  - Changes in Medicare utilization impacts percentage of costs Medicare will reimburse
  - Department specific

Reimbursement Theory

- Changes in charges
  - Increases in charges that exceed increases in expenses can result in overpayment on interim basis
  - Results in payable at final settlement
  - Decreases in charges can result in opposite effect

Reimbursement Theory

- Changes in expenses
  - Increases in expenses that exceed increases in revenues can result in overpayment on interim basis
  - Results in receivable at final settlement
  - Decreases in expenses can result in opposite effect

Reimbursement Theory

- Impact of non-reimbursable cost centers
  - Prior to CAH licensure, many services were added if the net revenues from a new service could cover the direct costs of providing the service without major emphasis on the ability to cover the overhead expenses allocated to the new services
  - Under CAH reimbursement, the goal of all non-reimbursable cost centers should be to cover the direct costs and the cost report impact of redirecting overhead allocations from the reimbursable to non-reimbursable cost center

Reimbursement Theory

- Impact of non-reimbursable cost centers
  - Understanding the impact of non-reimbursable cost centers is crucial in the long term planning of any healthcare organization
  - May not change the decision, but will lead to a more informed decision
  - Requires organization to change their method of evaluating new and existing programs
  - May result in entities identifying alternative methodologies for providing services

Why Is It So Difficult?

- Cost plus 1% ≠ profit
  - Unallowable costs
  - Where does the profit come from?
- Rules/interpretations change
  - Legislation
  - Medicare final rules
  - Medicare transmittals
  - Medicare Audit Contractor interpretations (many retroactive)

Why Is It So Difficult?

- Some rules make no sense
  - Rural Health Clinic – cost based on visits
  - Critical Access Hospital – cost based on days and charges
  - Lab performed by Critical Access Hospital on specimen collected in free standing clinic – may be fee schedule or cost
- Medicare Advantage
  - Not required to complete settlement
  - Don’t often understand billing rules

Why Is It So Difficult?

- Challenges in managing costs as methodology to improve financial position
  - Example #1
    - Decrease $100,000 in salary in Med/Surg
    - Reduce Medicare reimbursement $85,000
    - $15,000 net impact
  - Example #2
    - Decrease $15,000 in cost in assisted living
    - No reduction in reimbursement
    - $15,000 net impact

Why Is It So Difficult?

- Different rules in different states
  - Critical Access Hospital
  - Nursing Home
- Difficulty finding trained staff
  - Not offered as a specific college program
    - No reimbursement training for nurses
    - No reimbursement training for Doctors
    - No reimbursement/billing training for others

Strategies

- Do not accept status quo
- Facilities should ask questions regarding the reimbursement impact of all major financial decisions
- Monitor ongoing changes in regulations and interpretations

Strategies

- Do not be afraid to reverse previously made decisions
- Analyze impact of alternative allocation methodologies
  - Initial
  - Rule changes
  - Product line changes

Strategies

- Pricing
  - CAHs appear to have fallen behind PPS counterparts in maintaining appropriate pricing
    - PPS versus CAH
    - CAH versus CAH
    - Charges still important
    - Medicare is not the only payor

Strategies

CPT Code	Description	Volume	10th %	25th %	50th %	75th %	90th %
36415	Routine venipuncture	71,835	$ 10	$ 12	$ 17	$ 22	$ 27
36430	Blood transfusion service	484	$ 166	$ 370	$ 530	$ 739	$ 886
66984	Cataract surg w/iol, 1 stage	910	$ 816	$ 1,336	$ 2,297	$ 2,793	$ 3,091
70553	Mri brain w/o & w/dye	303	$ 2,194	$ 2,194	$ 2,414	$ 2,675	$ 3,122
71020	Chest x-ray	11,003	$ 100	$ 159	$ 192	$ 234	$ 241
74160	Ct abdomen w/dye	1,138	$ 1,141	$ 1,204	$ 1,356	$ 1,710	$ 1,900
80048	Metabolic panel total ca	17,838	$ 58	$ 62	$ 101	$ 111	$ 136
80053	Comprehen metabolic panel	33,161	$ 73	$ 104	$ 131	$ 173	$ 191
93005	Electrocardiogram, tracing	10,151	$ 98	$ 112	$ 139	$ 158	$ 216
97001	Pt evaluation	3,851	$ 98	$ 135	$ 162	$ 197	$ 225
99281	Emergency dept visit L1	1,636	$ 100	$ 103	$ 137	$ 187	$ 282
99283	Emergency dept visit L3	9,657	$ 159	$ 214	$ 254	$ 358	$ 500
99285	Emergency dept visit L5	5,895	$ 375	$ 411	$ 593	$ 807	$ 1,083

Strategies

- Pricing Methodologies
  - Across the board
  - Strategic
  - Market Driven
- Non-Medicare
  - Impact may not be minimal
  - Often less discomfort than managing costs

Strategies

- Pricing Methodologies
  - Strategies
  - Analyze MedPar or other commercial data to determine gap
  - Educate board on issues identified
  - Identify short term and long term strategies for financial performance

Strategies

- Identify profitability of all service lines
  - Determine “tolerable loss” for community or mission driven services.
    - Clinics
    - Assisted Living
    - Wellness Center
    - Service Lines
  - Determine whether you are really getting the desired benefit from these loss leaders

Strategies

- Identify alternative methodologies for providing existing services that will improve financial position without eliminating services
  - Nursing Home versus Swing Bed
  - Separate corporations
    - Stand alone
    - System sponsored

Strategies

- Identify alternative methodologies for providing existing services that will improve financial position without eliminating services
  - Sell product lines
  - Give product line away

Strategies

- Identify opportunities to expand service lines
  - Onsite
  - Offsite

HIT Funding

- Funding available for HIT expenditures related to EHR
  - Meaningful Use
  - Cost based
  - Medicare Share
  - Allowable Costs for Incentive

HIT Funding

- Meaningful Use
  - Must meet criteria of meaningful use
  - Submit payment request

HIT Funding

- Cost Based
  - Incentive to CAHs will be based on identified depreciable cost and Medicare utilization

HIT Funding

- Medicare Share
  - Ratio of Medicare and Medicare Advantage days to total inpatient days
    - Ignores swing bed
    - Adjusted to reflect level of charity care

HIT Funding

- Allowable Costs for Incentive
  - “computers and associated hardware and software necessary to administer EHR technology”
  - Does not include cost for EHR in other settings

HIT Funding

- Strategies
  - Maximize Medicare Share
  - Understand impact on timing of implementation
  - Identify allowable costs
  - What for changes in interpretations

Questions