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
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
• 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
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
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
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
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
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
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
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.
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)
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
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
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<th>Description</th>
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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
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
Allowable Costs for Incentive

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

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