

Critical Access Hospital Reimbursement: Understanding and Avoiding the Pitfalls of Operational Changes

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Presented By:



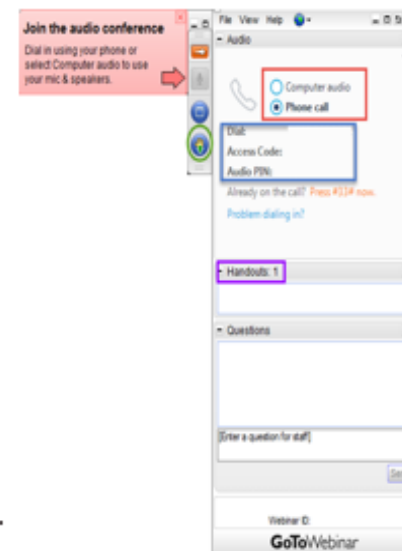
Housekeeping

MHA recently initiated a new presentation feature that allows participants the option to listen via phone or via computer audio if your computer has speakers.

This webinar will be in a "listen only" mode with opportunity to ask questions at the end of the presentation as time allows. All lines have been muted. Please enter any questions via the question feature in your control panel.

If you wish to communicate via phone during the question session please use the "raise your hand" feature in the control panel and your individual line will be unmuted. You must enter the audio PIN for the line to be unmuted.

Thank you for your participation!



Agenda

- About our Firm
- Background
- Payment Methodology
- Avoiding Critical Access Hospital Pitfalls
 - Allowable and Non-Allowable Costs
 - Pricing Increases
 - Physician Hiring Practices
 - Allocation Methodologies
 - Volume Changes and Impact on Cost Report Settlement
 - Other Operational Changes



About TPR Solutions

Third Party Reimbursement Solutions, headquartered in Charlotte, NC, with offices in New York City, NY, Nashville, TN and Sarasota, FL, was created to provide advisory services to hospitals, health systems and related organizations on a local and national level. Our goal is to provide unmatched service and advisory expertise that focuses on hospitals Medicare/ Medicaid reimbursement regulatory issues as well as clinical operations. The key to this mission is the balance between our deep industry experience and relationships, coupled with our superior client service model.

Our business philosophy is simple and straightforward. Throughout all levels of our company we strive to provide proactive and creative solutions that address our client's reimbursement needs. In addition, we aim to develop deep relationships with our client's organizations and strive to become a trusted advisor for all their hospital reimbursement needs.

- TPR employs Medicare & Medicaid regulatory staff, clinical operations specialists as well as Technology and Data Services personnel.
- TPR blends Medicare and Medicaid Regulatory experience with technology innovations for our clients nationally.
- We have collectively provided services in nearly every state and have worked extensively with all current MACs.
- Engagement teams includes Partner and Director talent handling the day to day project details and work



Full Service Reimbursement

TPR's Management team averages over 20 years of consulting, hospital, and intermediary experience addressing the following issues:

- Cost Report Preparation, Review, Adjustments, Appeals, Re-openings
- Wage Index, Geographic Reclasses, Occupational Mix
- Medical Education
- Clinical Operations
- Disproportionate Share
- Allied Health
- Bad Debts
- Mergers and Acquisitions
- Due Diligence
- Medicaid Analysis and Recoupment
- Hospital-based status

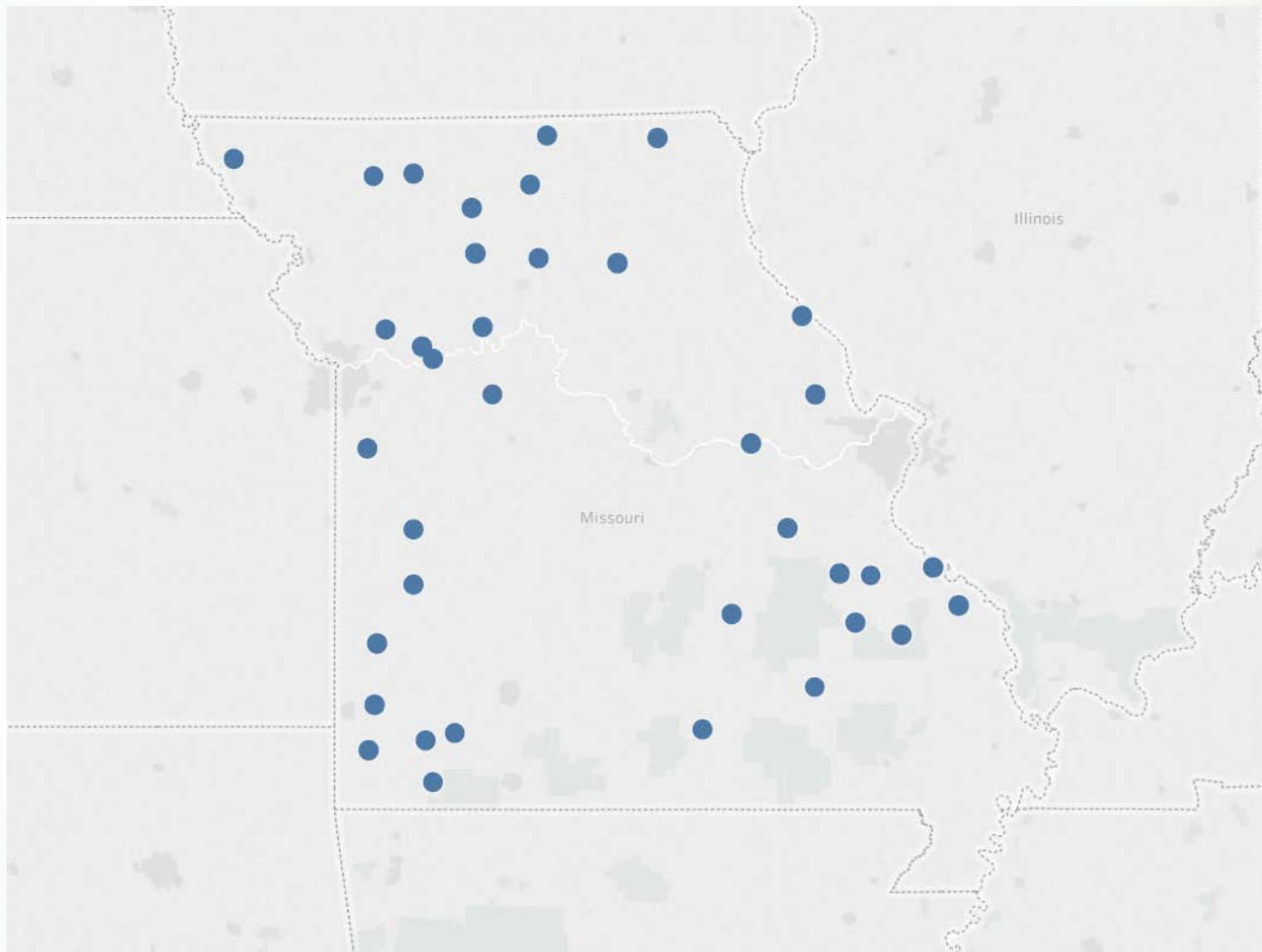


Background

- In the 1990's, several hundred hospitals closed across the US because of financial losses from the PPS system. In 1997, the Balanced Budget Act created the CAH provider type.
- Medicare pays for the same services from CAHs as for other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days). However, CAH payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.
- CAHs receive cost based reimbursement for inpatient and outpatient services provided to Medicare patients.
 - Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101% of costs on all of their hospital Medicare business.
 - Medicare Cost Reports



Missouri Critical Access Hospitals



Missouri Critical Access Hospitals

Provider #	Hospital Name	City
26-1301	ELLETT MEMORIAL HOSPITAL	APPLETON
26-1302	MADISON MEDICAL CENTER	FREDERICKTOWN
26-1303	COMMUNITY HOSPITAL ASSOCIATION INC	FAIRFAX
26-1305	PUTNAM COUNTY MEMORIAL HOSPITAL	UNIONVILLE
26-1306	SULLIVAN COUNTY MEMORIAL HOSPITAL	MILAN
26-1307	PERSHING MEMORIAL HOSPITAL	BROOKFIELD
26-1308	WASHINGTON COUNTY MEMORIAL HOSPITAL	POTOSI
26-1309	WRIGHT MEMORIAL HOSPITAL	TRENTON
26-1310	SCOTLAND COUNTY MEMORIAL HOSPITAL	MEMPHIS
26-1311	PERRY COUNTY MEMORIAL HOSPITAL	PERRYVILLE
26-1312	HARRISON COUNTY COMMUNITY HOSPITAL	BETHANY
26-1313	SAMARITAN MEMORIAL HOSPITAL	MACON
26-1314	HERMANN AREA DISTRICT HOSPITAL	HERMANN
26-1315	PARKLAND HLTH CTR - BONNE TERRE	BONNE TERRE
26-1316	ST JOHN S HOSPITAL - AURORA	AURORA
26-1317	ST. JOHN S HOSPITAL - CASSVILLE	CASSVILLE
26-1318	SALEM MEMORIAL DISTRICT HOSPITAL	SALEM
26-1319	LINCOLN COUNTY MEDICAL CENTER	TROY
26-1320	LAFAYETTE REGIONAL HEALTH CENTER	LEXINGTON
26-1321	HEDRICK MEDICAL CENTER	CHILLICOTHE
26-1322	EXCELSIOR SPRINGS MEDICAL CENTER	EXCELSIOR SPRINGS
26-1323	CEDAR COUNTY MEMORIAL HOSPITAL	EL DORADO SPRINGS
26-1324	CASS REGIONAL MEDICAL CENTER	HARRISONVILLE
26-1325	BARTON COUNTY MEMORIAL HOSPITAL	LAMAR
26-1327	RAY COUNTY MEMORIAL HOSPITAL	RICHMOND
26-1328	NORTHWEST MEDICAL CENTER	ALBANY
26-1329	COX-MONETT HOSPITAL	MONETT
26-1330	STE. GENEVIEVE CO. MEMORIAL HOSP	STE. GENEVIEVE
26-1331	FREEMAN NEOSHO HOSPITAL	NEOSHO
26-1332	CARROLL COUNTY HOSPITAL	CARROLLTON
26-1333	PIKE COUNTY MEMORIAL HOSPITAL	LOUISIANA
26-1334	CAH ACQ COMPANY 6 LLC (1-70)	SWEET SPRINGS
26-1335	ST. JOHN S HOSPITAL - ST. FRANCIS	MOUNTAIN VIEW
26-1336	IRON COUNTY HOSPITAL	PILOT KNOB
26-1337	MISSOURI BAPTIST HOSPITAL SULLIVAN	SULLIVAN
26-1338	MERCY HOSPITAL CARTHAGE	CARTHAGE
26-1339	SOUTHEAST HEALTH CENTER OF REYNOLDS	ELLINGTON

Background

A hospital that already participates in Medicare and seeks CAH status must meet these criteria to be certified and remain certified as a CAH:

- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural. If a CAH becomes located in an urban area due to changes in Office of Management and Budget (OMB) delineations, that CAH will have a 2-year transition period to reclassify as rural in accordance with the regulations at 42 CFR 412.103.
- Demonstrate compliance with CAH CoPs at 42 CFR Part 485 Subpart F at the time of application for CAH certification and all times subsequent to the initial certification.
- Furnish 24-hour emergency care services 7 days a week, using either on-site or on-call staff, with specific on-site response timeframes for on-call staff.
- Maintain no more than 25 inpatient beds that may also be used for swing bed services. It may also operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds. CAH distinct part units (DPUs) must also be in compliance with all hospital CoPs in addition to CAH CoPs.
- Have an annual average length of stay (LOS) of 96 hours or less per patient for acute care (excluding swing bed services and beds within DPUs). This requirement cannot be assessed on initial certification but applies subsequent to CAH certification.
- Be located more than a 35-mile drive from any hospital or other CAH or located more than a 15-mile drive from any hospital or other CAH in an area with mountainous terrain or only secondary roads. Alternatively, if the facility does not meet either of these distance criteria, it must be certified as a CAH prior to January 1, 2006, based on State designation as a "necessary provider" of health care services to residents in the area



Payment Methodology

- Reimbursed based on Cost for inpatient and outpatient services
- Paid at 101% of costs on all of their hospital Medicare business.
- Cost is estimated using cost accounting data from Medicare cost reports.
- Not subject to the Inpatient Prospective Payment System (IPPS) or the Hospital Outpatient Prospective Payment System (OPPS).
- Subject to Medicare Part A and Part B deductible and coinsurance amounts. The copayment amount for most outpatient CAH services is 20% of applicable Part B charges and is not limited by the Part A inpatient deductible amount.
- CMS encourages communication with patients about charges provided by CAH.



Payment Methodology

- Reasonable Cost Payment Principles That Do NOT Apply to CAHs
 - Payment for inpatient or outpatient CAH services is not subject to these reasonable cost principles:
 - Lesser of cost or charges
 - Reasonable compensation equivalent limits
- In addition, in general, payments to a CAH for inpatient services are not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions applicable to hospitals paid under the IPPS and OPPS.
- “However, if a patient receives outpatient services at a CAH that is wholly owned or operated by an IPPS hospital and is admitted as an inpatient to that IPPS hospital, either on the same day or within 3 days immediately following the day of those outpatient services, the outpatient services are subject to payment window provisions.”

Source: CMS MLN CAH Handbook



Payment Methodology

- Medicare “HMO”
 - Claims related to Medicare Advantage patients are not cost based.
 - Recommendation: Negotiate 101% of cost you are paid from Traditional Medicare.



Financial Impacts of CAH

- Profitability
 - Critical Access Hospitals must conduct business with the underlying cost per unit at standards that allow CAHs to profit from Non Medicare and Medicaid payors.
 - Per Diem Costs
 - RCC (Ratio of Cost to Charges)
 - Rate Sensitivity: Increase in services prices = Lower RCC and less reimbursement
 - Influencing Cost per unit:
 - Cost Allocation Accuracy
 - Maximum Utilization
 - Decreasing Cost



Cost Allocation Methodology

- A-6 Reclassifications
 - Home Office
 - B-1 Statistics
 - Directly Assigned Costs
 - Physicians
 - A-8 Offsets
 - Interest Expense
-
- All Critical Access Hospitals should gain an understanding of each of the above items in order to maximize profitability.
 - A review of cost reports should be completed to find common preparation errors. Incorrect allocation of expenses and statistics are the most common errors, and directly affect bottom line.



Cost Allocation Methodology

- Utilized to Allocate overhead costs on Medicare cost report.
- Accuracy matters!
- Single allocation methodology used
 - Once cost center is closed no additional costs can be allocated back to it. Stats that would allocate costs back to a previously allocated cost center are merely excluded
- The most common issue relates to allocation statistics not being properly documented throughout the year. Be as accurate as possible when accumulating statistics.
 - Time Studies
 - Square Footage (Unoccupied space will be recorded as non-reimbursable costs)
 - Patient days
 - Laundry, Dietary, Central Supply, Medical Records
 - CRNAs
 - A&G Cost Centers – Splitting into numerous cost centers usually results in increased reimbursement when Critical Access Hospitals have significant non-reimbursable cost centers.



Cost Allocation Methodology

- Non-Reimbursable Services
 - SNF
 - Gift Shop
 - Marketing
 - Psych/Rehab
 - Hospice
 - Physician Private Offices

- 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

- Recommendation: Be sure to analyze recording of these services. Would hospital benefit by restructuring departments to remove from entire cost report, or can these expenses be allocated to other reimbursable cost centers within the hospital?



Allowable and Non-Allowable Costs

- Expenses must be reasonable and related to patient care. Examples of allowable costs in a Critical Access Hospital include the following:

Type of Expense	Allowable or Non-Allowable
Public education	Allowable
Employee recruitment	Allowable
Taxes based on income	Non-Allowable
Sales tax	Allowable
Property taxes	Allowable
Entertainment	Non-Allowable
Civic organizations	Allowable
Legal fees	Depends on activity
Collection agency fees	Allowable
Political/lobbying costs	Non-Allowable



Pricing Strategies

- Nationally, Critical Access Hospitals have been behind IPPS hospitals in retaining appropriate pricing
- Pricing Methodologies
 - Driven by Market
 - Strategic Pricing
 - Analysis of other payor data to determine gaps.
 - Services Producing Loss
 - Is it still beneficial to community and financially for hospital to keep these services?
- Spending money does not always translate to increased reimbursement
 - Only portion of additional costs will be reimbursed
 - Payor Mix
 - Bottom Line Impact!



Maximizing Net Revenue

- A charge master review should be performed periodically to:
 - Review charges
 - Review for proper coding (education for coders)
 - Eliminate outdated codes
 - Compare coding with other facilities for possible overlooked codes



Optimizing CAH Reimbursement

- Swing Beds
 - CAHs must have an average annual length of stay of 96 hours or less per patient pertaining to their acute care beds.
 - CAHs should implement swing beds – Key for optimal revenue.
 - Improving overall patient care

- Growth Opportunities
 - Relationship with Larger systems

- Proactive Approach
 - Monitor financial statements regularly
 - Prepare interim cost reports
 - Review allowances and settlements (payables vs. receivables)
 - Request interim rate adjustments



Cost Report Settlement

- Inpatient
 - Worksheet E-3, Part V
 - Line 1 – Program Operating Cost flows from D-1, Part II Line 49 (Total Program Inpatient Cost Calculation)
 - Line 5 – Primary Payer Payments
 - Line 6 – Total Costs - 101% of Line 1 – Line 5
 - Line 20 and Line 23 – Deductibles and Coinsurance
 - Line 25 and Line 27 – Bad Debts (Paid at 65%, same as IPPS)
 - Line 30.01 – Sequestration Amount Calculated

Final settlement will equal the total reimbursable costs incurred by or on behalf of the CAH for furnishing covered care to the CAH's Medicare enrollees (less applicable deductible and coinsurance).



Cost Report Settlement

- Outpatient
 - Worksheet E, Part B
 - Line 1 program outpatient operating cost pulled flows from D, Part V (Total Program Outpatient Cost Calculation)
 - Line 25 and Line 26 – Deductibles and Coinsurance
 - Line 27 - automatically calculated:
 - For critical access hospitals (CAHs), enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 200). Add back the aforementioned 101% of lab and 101% of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.'
 - Line 34 and Line 36 – Bad Debts (Paid at 65%, same as OPPS)
 - Line 40.01 Sequestration Adjustment - automatically calculated



Cost Report Settlement

- **Settlement Factors**
 - Medicare Utilization
 - Changes have impact on percentages of reimbursable costs (Specific to each department)
 - Fluctuation in Charges and Expenses
 - Increase in charges exceeding expense increase may result in interim overpayment
 - Volume Increases and Decreases
 - Large increases tend to lead to payables to Medicare Program
 - Large decreased tend to lead to receivables from Medicare Program



Ambulance Transports

- CAH can be paid for ambulance transports or for CAH-owned ambulance transports at 101% of cost if the CAH is the only provider of ambulance service within 35 miles of the CAH.
- CAH can be paid at 101% of cost if ambulance service is greater than 35 miles and it is the closest provider or supplier of ambulance services.



Outpatient Services: Method I or Optional Method II

Method	Facility Services	Physician Services
Method I	101% of Reasonable Costs	Medicare physician fee schedule
Method II	101% of Reasonable Costs	115% of Allowable Amount (generally Medicare physician fee schedule)

- Physician must re-assign billing rights to CAH using CMS-855R.
- Hospital must make election to be paid under Method II.
- Election remains in effect until hospital terminates election. No need to make annual election.



Telehealth Services

- Can qualify as originating site (site where service is rendered) if it meets the following criteria:
 - Hospital is located in county outside of a Metropolitan Statistical Area (MSA)
 - Hospital is located in a rural Health Professional Shortage Area (HPSA) located in a rural census tract.
 - Each calendar year, the geographic eligibility of an originating site is established based on the status of the area.
- Payment received is 80% of Medicare Physician fee schedule.



Medical Education Issues

- CAH does not receive IME or GME for residents training at their facility.
- CAH receives 101% of cost.



CRNA Pass-Through

- CAH may be eligible to receive reasonable costs for CRNA services if the following conditions are met:
 - CRNA's must be employed by the hospital or CAH or obtained under arrangement.
 - The hospital or CAH is located in a rural area and is not deemed to be located in an urban area or the hospital or CAH has reclassified as rural.
 - The hospital or CAH may employ or contract with more than one anesthetist; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
 - Must provide data to demonstrate that its volume of surgical procedures requiring anesthesia services did not exceed 250 procedures.
 - Each qualified non-physician anesthetist has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.



CRNA Pass-Through (cont'd)

- To maintain its eligibility for reasonable cost payment, a qualified hospital or CAH must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 800 procedures.
- The hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 800 procedures.
- For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.



Incentive Payments

- Physicians (including psychiatrists) who furnish care in a CAH located within a HPSA are eligible for a 10% HPSA bonus payment for outpatient professional services furnished to a Medicare patient. If physician has reassigned billing rights using CMS-855R and CAH has elected Optional Payment Method II, the CAH will receive 115% of the applicable Medicare physician fee schedule multiplied by 110%.



S-10 and Critical Access Hospitals

- Critical Access Hospitals do not receive DSH or Uncompensated Care Reimbursement
- Complete S-10 for Accuracy
- Not a settlement item



340B and CAH

- The 340B Drug Pricing Program (340B Program) enables certain qualifying Critical Access Hospitals to register with the program and purchase covered outpatient drugs at 340B prices, which can offer significant savings on pharmaceuticals.
- Program intent is to allow entities to utilize the savings from the program to better care for this underserved population.
- If you are a critical access hospital, it is worth your time to look to see if you qualify for the 340B program
 - Apexis Prime Vendor Help Desk: 1-888-340-2787
 - <https://www.340Bpvp.com>
 - Paid by HRSA to assist with 340B “how to questions”



340B and CAH

- Next Steps
 - Expand to more drugs and more locations
 - 340B eligible clinics owned by hospital
 - Clinic administered medications
 - \$50,000-\$200,000 yearly savings
 - Contract with Pharmacy
 - Build your pharmacy services program
 - Create an indigent patient medication program
 - Expand clinical pharmacy services to improve medication management for all patients
 - Create new pharmacy services at your facility



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