CAH Financial Strategies From Registration to the Cost Report

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Financial Success

- Financial success is not easy nor guaranteed
  - PPS
  - CAH
- Long term success is typically due to two factors
  - Location
  - Development of best practices
- Location is difficult to change, but best practices can be addressed by all providers

Agenda

- Patient Access
- Revenue recognition
  - Charge Capture/Coding
  - Pricing
  - Timely Filing
  - Denial Management
- Managing Staffing Levels
- Physicians
- CAHs - Overhead allocations
- Other services

Patient Access

- Upfront processes are become more important than ever
  - Increasing levels of patient coinsurance and deductibles
  - Increasing mobility
  - Changes in health insurance carriers
- Significant variances in patient access processes

Identity and Responsibility

- Hard to collect if you don't properly identify the patient
  - Photo identification
  - Insurance cards
  - Insurance verification
- Processes must be established
  - Accountability must be assigned
  - After hours included!!

Identity and Responsibility

- Identification of coinsurance, deductibles and copays
  - Identify estimates prior to scheduled services
  - Estimate amounts for non-scheduled services
  - Collect estimated balances
  - Identify loan sources
  - Establish payment plans if necessary/appropriate
  - Includes Emergency Room for non-emergent patients

Identity and Responsibility

- Identification of coinsurance, deductibles and copays
  - Identify charity care recipients
    - Application
    - Presumptive methods
  - Reschedule services or redirect place of service if appropriate

Identity and Responsibility

- Back-end
  - Establish policies
    - Payment plans
    - Collection agencies
  - Follow policies as identified

Revenue Recognition – Charge Capture/Coding

- Best practice facility's capture the revenues for services they are rendering
  - Significant area of opportunity for most facilities
  - Common areas of confusion/lost revenues
    - Emergency Room Evaluation and Management
    - Outpatient nursing procedures
    - Pharmacy

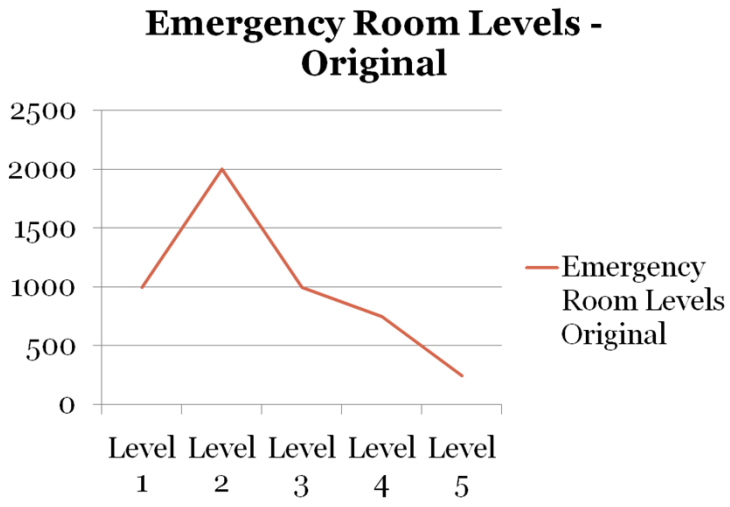
Emergency Room – Evaluation and Management

- Medicare allows providers to establish internal methodology for assignment of E/M levels 1 – 5 (CPT codes 99281 – 99285)
  - "Providers should continue to apply their current internal guidelines to the existing CPT codes. Each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. Hospitals should ensure that their guidelines accurately reflect resource distinctions between the five levels of codes." (Pub. 100-04 Chapter 4 Section 160.)

Emergency Room – Evaluation and Management

- These internally designed methodologies are frequently flawed
  - Originally developed in 2000 without change
    - CMS has acknowledged problems in the process
  - Incorrectly include other reportable services in the determination of levels (i.e., laceration repair, injections, etc.)
  - Frequently result in an E/M assignment and overall distribution that is not reflective of the services rendered

Emergency Room – Evaluation and Management



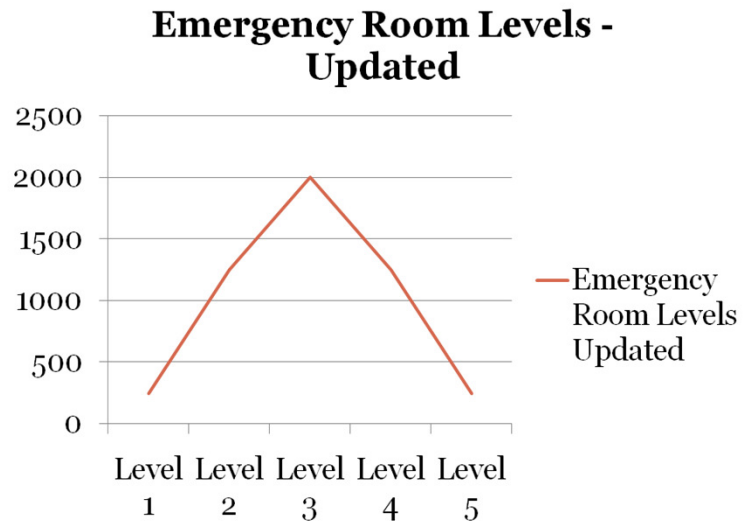
Emergency Room – Evaluation and Management

- While all facilities will vary, one would anticipate facilities would have a distribution somewhat similar to that of a Bell Curve unless there are explanations for a difference
  - Emergency Room has a higher than normal usage for non-emergent clinic type services
- The number of “points” typically required to reach a specific level usually has little scientific background

Emergency Room – Evaluation and Management

- A review of the resources and points to reach each level can allow the facility to report levels that are more accurately reflecting the services rendered

Emergency Room – Evaluation and Management



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Outpatient Nursing Charges

- Don't forget the procedures!
- Procedure charges (lacerations, IVs, injections, etc.) are frequently missed in the Emergency Room and in other outpatient nursing settings
  - Incorrectly included in E/M assignment
  - Belief that assignment of CPT codes during coding process with capture reimbursement
  - Lack of understanding of billing and reimbursement rules

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Outpatient Nursing Services

- Only way to ensure there is an opportunity to capture revenue is to capture the charge
- Charges for additional procedures in the Emergency Room can range from $50 to over $1,000
  - Average $100 - $200
  - Reimbursed based on charges or fee schedules

Outpatient Nursing Services

- Emergency Room Example:
  - 5,000 annual visits
  - 25% of visits qualify for additional procedure charge
  - Average procedure charge of $150
  - Total gross revenue opportunity = $187,500

Outpatient Nursing Services

- Outpatient nursing procedures
  - Facilities miss these opportunities
    - CAH
    - PPS
  - IV therapy, injections, Foley catheter insertions, etc.

Outpatient Nursing Services

- Outpatient nursing procedures
  - Lost charges occur due to a lack of understanding of what is actually separately reportable
    - Nursing documentation can affect ability to capture charges
      - Start times
      - Stop times
      - Site
      - Drugs

Outpatient Nursing Services

- Outpatient nursing procedures
  - Recommend a team from nursing and HIM meet frequently to discuss documentation and charge capture opportunities

Charge Capture/Coding

- Pharmacy
  - Pharmacy charges are often missing from claims
    - Totally missing
    - Errors in proper reporting of units
  - Overreliance on systems
    - Dispensing units
    - Unit conversion factors
  - Need to develop processes to review and update processes

Pricing

- Charges for rural services frequently is well below that of larger counterparts for the exact same services
  - Often 20-40% below competitors
  - Sometimes consistently below cost
- Lack of appropriate pricing strategy may caused by numerous issues
  - Restraints placed on Management by Board
  - Lack of understanding of reimbursement impact
  - Inability to access market based data

Pricing

- Successful providers have strong pricing strategies
  - Use of market based data
    - Commercial sources
    - MedPar
  - 75th percentile pricing
  - Annual updates to pricing

Timely Filing

- Why capture the charges and then not file them timely?
- All Medicare claims must be filed within 1 year of service
  - Other payors may vary
    - 90 days
    - 30 days?
- Many facilities still missing the deadlines!
  - Monitor write-off's
  - Separate account for tracking

Denials Management

- Advanced Beneficiary Notices / Medical Necessity
  - Need to manage denials
  - ABNs are not an option
    - This is an issue of liability not a determination of proper care

Denials Management

- Advanced Beneficiary Notices / Medical Necessity
  - Track Denials
    - Service
    - Physician
    - Staff performing service
    - Etc.
  - Emergency Room services are not exempt
    - Increased frequency of denials
    - Monitor
    - Follow up with providers

Benchmarking

- Best practice facilities develop strategies for benchmarking
  - External
    - From outside organizations/groups
  - Internal
    - Developed internally based on detailed study or historical data

Benchmarking

- External benchmarks can provide greatest benefit
  - Peer facilities
  - Recommend 75th percentile
  - Must understand the methodology for gathering the statistic (apples to apples comparison)
  - Hardest data to obtain

Benchmarking

- Internal benchmarks can still provide benefits
  - Requires more time to develop

Benchmarking – Trends

- Monitoring trends
  - Recommend monitoring trends for 5 year period
  - Results from monitoring trending can help provide solutions and reduce resistance

Benchmarking – Trends

Department A	2011	Comment
Hours/Statistic	13.0	Over benchmark
Benchmark	10.0	Need 23% reduction

Benchmarking – Trends

- Response from Department A – “Patients will die!”

Benchmarking – Trends

- What made 2009 so different?

Department A	2011	2010	2009	2008
Hours/Statistic	13.0	12.2	9.8	10.8
Benchmark	10.0	10.0	10.0	10.0

Benchmarking

- Many facilities would experience better financial performance if they could just get the majority of their departments to operate at their best historical levels of performance
- Many facilities would experience better financial performance if they would just adhere to their staffing plans

Benchmarking – Recent Example

Generic Health Center Cost Saving Summary

Department	Opportunity	2013 Savings (Cost)	Net Impact After Cost Report Considerations
Med/Surg, Swingbed, Observation, OB	Staffing efficiency	$ 745,000	$ 209,000
Swingbed (increase by 365 days)	Increased Revenue	$ 150,000	$ 150,000
Emergency Room	Staffing efficiency	$ 152,000	$ 96,000
Surgery	Staffing efficiency	$ 123,000	$ 66,000
Wound/Infusion Clinic	Staffing efficiency	$ 81,000	$ 42,000
Laboratory	Staffing efficiency	$ 136,000	$ 72,000
Radiology	Staffing efficiency	$ 42,000	$ 26,000
Pharmacy	Staffing efficiency	$ 41,000	$ 11,000
340b Drug Pricing Program	Cost savings	$ 200,000	$ 180,000
Infection Control/ Employee Health	Staffing efficiency	$ 8,000	$ 5,000
Cardiac Rehab	Staffing efficiency	$ 30,000	$ 6,000
Clinic (PB RHC)	RHC Conversion	$ 700,000	$ 700,000
Non-Mission related services	Divestiture	$ 100,000	$ 100,000
Business Office	Staffing efficiency	$ 69,000	$ 42,000
Dietary	Staffing efficiency	$ 26,000	$ 9,000
Maintenance	Staff Addition	$ (51,000)	$ (31,000)
Accounting	Staffing efficiency	$ 18,000	$ 12,000
Administration	Staff Restructure	$ (32,000)	$ (21,000)
		$ 2,538,000	**$ 1,674,000**

Physicians

- Most facility's employ or contract for their physicians
  - Many fail to align their relationships
    - Integration does not equal alignment
    - Must work together for alignment
  - Many fail to manage physician services
    - Losses are expected
    - Not sure of proper strategies

Physicians

- Loses are common, but not unmanageable
  - Determine "tolerable loss"
    - Level of loss anticipated/tolerable
    - Can be based on preliminary projections or comparison data
  - Manage to "tolerable loss"
    - Celebrate when losses are less than tolerable loss versus focusing on the loss

Physicians

- Strategies
  - Address support staffing levels in clinic operations
    - Utilize benchmarks
    - Recognize how support staff can improve efficiency of clinic practice
  - Explore alternative reimbursement methodologies
    - Many providers still have freestanding clinics
      - Rural Health Clinics
      - Provider Based Clinics

Physicians

- Strategies
  - Rural Health Clinics – Understand them!
    - Understand what is an RHC visit
      - Clinic, Home, Nursing Home, Swing Bed
        - Swing bed frequently missed
      - Medically necessary face-to-face with physician or mid-level
        - Billing
        - Cost Report
        - Frequently overstated
        - Results in understatement of actual cost per visit
      - Understand FTE calculations

Physicians

- Strategies
  - Manage staffing levels for productivity standard
  - Pricing still important!
    - Reimbursement = 80% cost, 20% charge

Physicians

- Strategies
  - Provider Based Clinics
    - Don't be afraid of them
    - Develop adequate timeline for implementation to ensure compliance with all required regulations and billing processes

Physicians

- Strategies
  - Compensation
    - Transition to RVU
      - May require a transition period
      - Separate out other responsibilities
        - Emergency Room coverage
        - Directorships
        - Supervision
        - Other administrative

Overhead Allocations - CAHs

- Proper cost report reimbursement can only occur if overhead allocations are properly monitored
  - Accuracy of statistics
  - Appropriateness of methodology

Overhead Allocations - CAHs

- Accuracy of statistics
  - Inaccurate statistics = inaccurate reimbursement
  - Ensure departmental staff understand the purpose for gathering statistical information and the impact on final reimbursement
- Appropriateness of methodology
  - Ongoing review of allocation methodologies
  - Most providers performed detailed review when originally licensed as a CAH
  - Opportunities for changes in methodology frequently exist

Overhead Allocations - CAHs

- Common areas of opportunity
  - Fragmenting of Administrative and General
    - Business Office
    - Registration/Admitting
    - Information Technology
    - Others
  - Housekeeping
  - Medical Records

Other Services

- Less is often times more
- Overall financial performance can be significantly impacted by the addition of non-hospital services
  - Home health
  - Hospice
  - Physicians
  - Ambulance
  - Nursing Homes
  - Assisted Living
  - Etc.

Other Services

- The reimbursement methodology for many of these other services is not intended for smaller organizations/volumes
  - Difficult to make ends meet for larger organizations

Other Services

- Rural providers frequently lack management time, commitment, or expertise to operate these other services
  - Have seen many home health agencies sold by CAH to freestanding entities
    - Staffing levels improve
    - Compensation levels managed to more appropriate levels

Other Services

- Exception
  - Retail Pharmacy portion of the 340B program can be the exception to this process
    - Net revenues can exceed $1,000,000
      - Over $200,000 is common
    - Make sure to address cost report implications
      - Cannot ignore on the cost report
      - Will offset some of the benefit, but not negate it

Closing

- The more successful rural providers have developed ongoing strategies to take advantage of opportunities while minimizing the financial threats
- These strategies are not all inclusive and are continuously developing. Don't be afraid to challenge past decisions and to reverse course when appropriate

Questions?

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