# TORCH
# Annual Conference

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April 11, 2019

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## Agenda

- What is the Status of the 1115 Waiver?
- Are you happy with your hospital profitability? What are you doing about it? What is a new service we need to be providing that is profitable?
  - Revenue Cycle Process
- Cost Report and Reimbursement Issues
- Participation in 340b Program
- Contract Updates and Negotiations



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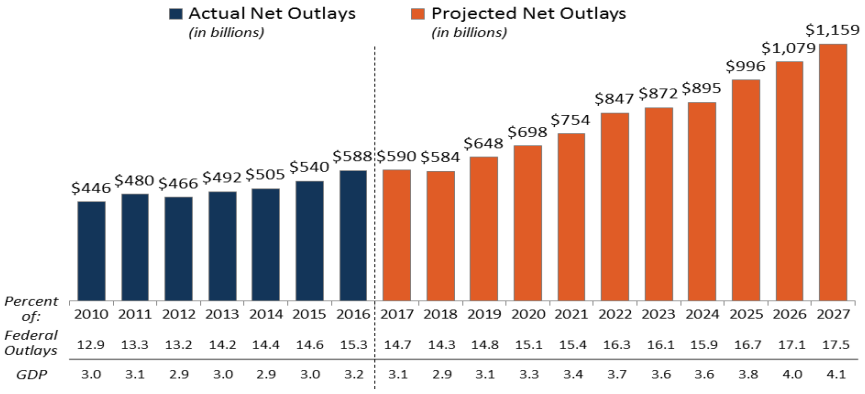
Figure 4

## Actual and Projected Net Medicare Spending, 2010-2027




| Percent of: | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Federal Outlays | 12.9 | 13.3 | 13.2 | 14.2 | 14.4 | 14.6 | 15.3 | 14.7 | 14.3 | 14.8 | 15.1 | 15.4 | 16.3 | 16.1 | 15.9 | 16.7 | 17.1 | 17.5 |
| GDP | 3.0 | 3.1 | 2.9 | 3.0 | 2.9 | 3.0 | 3.2 | 3.1 | 2.9 | 3.1 | 3.3 | 3.4 | 3.7 | 3.6 | 3.6 | 3.8 | 4.0 | 4.1 |

NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of mandatory Medicare spending minus income from premiums and other offsetting receipts.
SOURCE: Congressional Budget Office, An Update to the Budget and Economic Outlook, 2017 to 2027 (June 2017).

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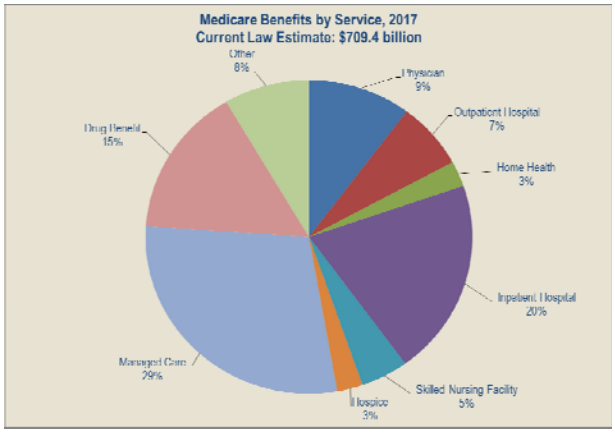
# MEDICARE BENEFITS

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# 1115 Waiver- DSRIP

- The 5 year extension approved December 21, 2017 (DY7-11)
- 4 years of funding – 2 years of level funding followed by 2 years of funding which will decrease each year:
- DSRIP Funding Pool:
  - $3.1B in DY7-8
  - $2.91B in DY9
  - $2.49B in DY10
  - $0 in DY11



# 1115 Waiver- UC

- DY9 UC Applications will be due in September 2019 (10-1-19 to 9-30-20)
  - These will be based on Uninsured Charity Care costs (S-10 reporting) less payments. These will not include the Medicaid Shortfall
- UC Funding Pool:
  - $3.102B in DY7-8
  - $2.3B is default funding amount until actual amount is determined from S-10 Reporting on cost reports- Survey Done in March to Report
  - September 1, 2019 CMS is supposed to finalize the Uncompensated Charity Care UC pool limit for DY9-11

# UC Model- FY9

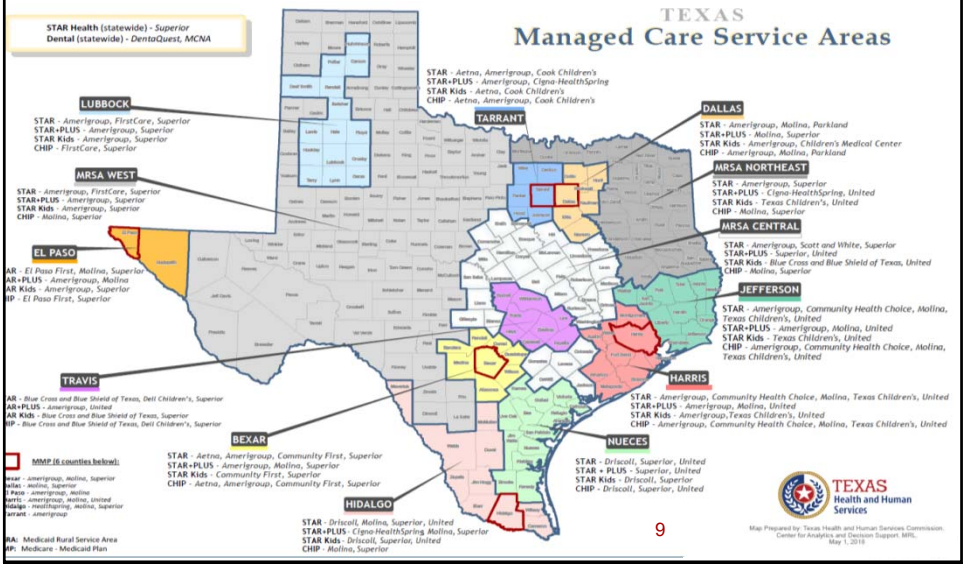
| | Medicaid Shortfall | Uninsured Shortfall | DY7 Total Payment | 2018 S-10 Uninsured Charity Care Cost | Uninsured Variance |
|---|---|---|---|---|---|
| 1 | 1,600,000 | 1,800,000 | 1,700,000 | 2,100,000 | 300,000 |
| 2 | 3,000,000 | 1,000,000 | 1,500,000 | 1,300,000 | 300,000 |
| 3 | 500,000 | 800,000 | 1,100,000 | 700,000 | (100,000) |
| 4 | 900,000 | 900,000 | 1,100,000 | 1,000,000 | 100,000 |
| 5 | 8,000,000 | 4,800,000 | 7,500,000 | 3,600,000 | (1,200,000) |



# Uniform Hospital Rate Increase Program

- UHRIP Final Rule Published March 31, 2017
  - When HHSC will direct an MCO to provide a uniform percentage rate increase to hospitals in the MCO's network in a designated service delivery area (SDA) and
  - HHSC may direct the MCO's to increase rates for all or a subset of services
- Based on the worksheets and applications due to HHSC- Rural hospitals should start seeing an increase in reimbursement via UHRIP in Program Year 3

# Map of all Texas Medicaid Managed Care Service Delivery Areas (SDAs)




9

# Uniform Hospital Rate Increase Program

| | Year 1 | | Year 2 | | Year 3 | | | |
|---|---|---|---|---|---|---|---|---|
| SDA | Total | % of Total | Total | % of Total | Total | % of Total | Total | % of Total |
| Bexar | 57,139,156 | 10.1% | 119,851,657 | 9.7% | 147,810,009 | 9.2% | 324,800,822 | 9.5% |
| Dallas | 95,985,810 | 16.9% | 200,175,734 | 16.2% | 243,420,250 | 15.2% | 539,581,794 | 15.9% |
| El Paso | 17,287,320 | 3.0% | 40,535,008 | 3.3% | 50,623,366 | 3.2% | 108,445,694 | 3.2% |
| Harris | 136,999,852 | 24.1% | 281,251,720 | 22.8% | 356,058,210 | 22.3% | 774,309,782 | 22.8% |
| Hildalgo | 37,915,076 | 6.7% | 101,860,699 | 8.3% | 149,333,673 | 9.3% | 289,109,448 | 8.5% |
| Jefferson | 11,883,723 | 2.1% | 21,738,142 | 1.8% | 28,404,668 | 1.8% | 62,026,533 | 1.8% |
| Lubbock | 21,888,697 | 3.9% | 44,285,571 | 3.6% | 54,957,574 | 3.4% | 121,131,842 | 3.6% |
| MRSA Central | 37,934,754 | 6.7% | 66,967,544 | 5.4% | 81,522,833 | 5.1% | 186,425,131 | 5.5% |
| MRSA Northeast | 29,294,017 | 5.2% | 71,932,303 | 5.8% | 103,730,136 | 6.5% | 204,956,456 | 6.0% |
| MRSA West | 33,679,715 | 5.9% | 69,342,235 | 5.6% | 89,682,235 | 5.6% | 192,704,185 | 5.7% |
| Nueces | 17,947,878 | 3.2% | 36,419,322 | 3.0% | 47,070,929 | 2.9% | 101,438,129 | 3.0% |
| Tarrant | 70,071,047 | 12.3% | 115,384,850 | 9.4% | 169,991,878 | 10.6% | 355,447,775 | 10.5% |
| Travis | - | 0.0% | 63,299,706 | 5.1% | 77,394,240 | 4.8% | 140,693,946 | 4.1% |
| Total | 568,027,045 | 100.0% | 1,233,044,491 | 100.0% | 1,600,000,001 | 100.0% | 3,401,071,537 | 100.0% |

10

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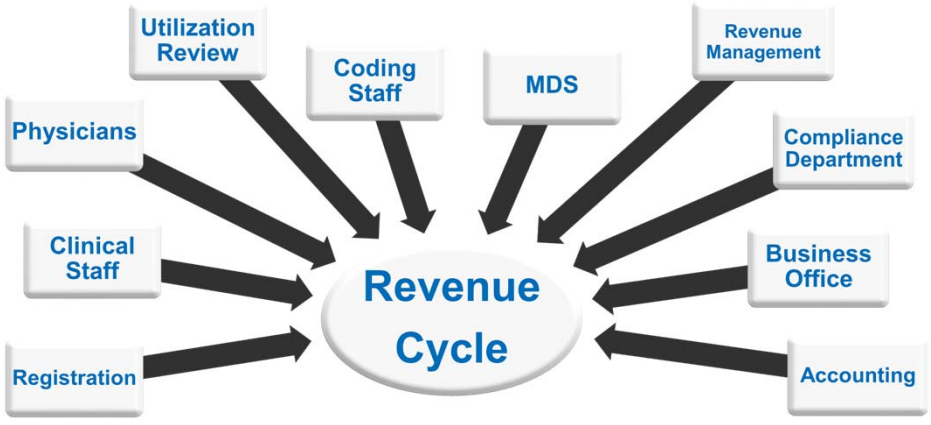
# Local Provider Participation Fund (LPPF)

- **What is the LPPF?**
  - A county administered fund that is utilized to help local safety net providers access supplemental payments
  - The only organizations that can pay into the fund are the hospitals in your counties.
  - Individual taxpayers do not pay $1
  - LPPF must comply with federal healthcare and tax regulations
- **Who can legally pursue LPPFs?**
  - Counties with more than one hospital
  - Cities with more than one hospital (County and City may not both have LPPFs)
  - Hospital Districts





# Who's Responsible for Revenue Cycle Process? is a combination of processes whose end result is cash (net revenue)



# Key Revenue Cycle Management Indicators

| Key Performance Indicator | KPI | |
|---|---|---|
| Days from Discharge to Bill | 3-5 days | 12 days |
| Clean Claim Rate | 95% | 75% |
| Rebill % of Total Primary Claims Billed | <5% | No Report |
| Registration Accuracy Rate | 97% | 75% |
| Gross Days in A/R | 40-50 days | 55 days |



# Revenue Cycle Process Step 1

- Scheduling of an appointment or Registration
  - Collection of patient/guarantor/payer information
  - Verification of insurance
  - Certification of need
  - Pre-certification
  - Pre-determination
  - Medical necessity
  - Patient encounter
  - Need a provider order for the services
  - Need patient consent

# Poor Processes

1. Department is not obtaining Advance Beneficiary Notices (ABNs) when Medical Necessity is checked at time of registration
2. No point of service (POS) collections are requested and financial responsibility is not discussed at time of registration
3. Registration Errors create denials



# Patient Registration- Top Denial Reasons

1. Patient not eligible on date of service
2. Transposed digits for SSN or DOB
3. Wrong Insurance plan, policy # or group # missing or invalid
4. Does not meet Medical Necessity
5. Duplicate medical record numbers
6. No prior-authorization obtained
7. Not credentialed
8. Timely filing
9. Patient Name not listed in correct order
10. Missing prior-authorizations or pre-certifications

## Revenue Cycle Process Step 2

- Need documentation of the encounter
  - Need charges for the patient encounter
  - Verification of charges – balancing
  - Need the encounter to be clinically approved by the payer – Utilization Management. Need certification of the appropriate level of care
  - Need the encounter coded by Medical Information Management specialists
    - ✓ Inpatient – DRG
    - ✓ Outpatient – APC, CPT, HCPCS



## Billing- Optimize Billing and Claim Submissions

- Create biller-specific productivity and error reporting and trend results
- Ensure a process exists for claim submission in a timely and accurate manner that meets federal, state and other billing guidelines

# Revenue Cycle Process
# Step 3

- Need a bill – a culmination of the information provided by all of the above
  - Demographics
  - Payer
  - Charges
  - Certification
  - Codes
- Bill is submitted to the payer
- Payer processes the bill

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# Revenue Cycle Process

- Provider receives payment, denial or a request for additional information:
  - If the claim is paid
    - ✓ Was it paid correctly – yes or no?
    - ✓ Is there a balance? – move to the next responsible party
  - If the claim is denied
    - ✓ Do we have enough information to appeal?
    - ✓ Request for additional information
    - ✓ Do we have the additional information requested
  - If ignored
    - ✓ We need to determine why

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# Denials

- Build accountability within the department
- Enable a process to identify trends and be proactive on corrective action
- Activate a denial tracking system
- Avoid front-end registration errors and medical necessity errors
- Access on-line system to compare expected versus actual payments





## Chargemaster- one of most complex master files subject to frequent updates

- Database of code and charge information
- Maintained by Revenue Management
- Charges attach to codes (CPTs) and dollar amounts
- CPT – Current Procedural Terminology

## Possible areas to improve

- Chart reviews to ensure appropriate charge capture of services
- Provide annual Medicare Compliance billing training to the billers
- Hospital coders are properly trained in ICD-10
- Pricing



## Top Strategies for Proper Cost Reporting

- Medicare Bad Debts
- Match Revenues and Expenses by Cost Center
- Square Footage Reporting controls Capital Costs to Cost Centers
- Cost Allocations to offsite and Non-Reimburseable cost centers
- Shared Department Employee

# Medicare Bad Debts

- Currently reimbursed at 65% of allowable Bad Debts
- Several proposals to cut reimbursement to 25%
- Reasonable collection effort
  - ✓ Consistent with collection policy-Treat Medicare and Non-Medicare bad debts the same
- Deemed to be Uncollectible
  - ✓ Remains unpaid more than 120 days
  - ✓ Returned from a collection agency
- Crossover Medicare as primary and Medicaid as secondary
- Written off during the fiscal year of cost report
- Medicare HMOs are not allowable





# Match Revenues and Expenses by Cost Center

- Core Principles
  - Match total cost to total charges
  - Match total Medicare charges and total charges
- Improper matching of costs and charges may result in an inaccurate determination of Medicare Costs
- Reasonable Checks
  - Cost to Charge ratios
    - ✓ Current year to prior year
    - ✓ Greater than 1.0000
  - Medicare Utilization
    - ✓ Current year to prior year

# Match Revenues and Expenses by Cost Center

| Cost Center | Total Costs | Total Charges | Cost to Charge Ratio |
|---|---|---|---|
| Operating Room | 520,000 | 1,000,000 | 0.520000 |
| Radiology | 600,000 | 2,600,000 | 0.230769 |
| Laboratory | 590,000 | 1,800,000 | 0.327778 |
| Medical Supplies | 450,000 | 650,000 | 0.692308 |
| Drugs | 420,000 | 1,500,000 | 0.280000 |
| Emergency Room | 840,000 | 1,000,000 | 0.840000 |
| | | | |
| Total | 3,420,000 | 8,550,000 | 0.400000 |





# Match Revenues and Expenses by Cost Center

| Cost Center | Medicare Charges | Total Charges | Medicare % |
|---|---|---|---|
| Operating Room | 400,000 | 1,000,000 | 40% |
| Radiology | 1,170,000 | 2,600,000 | 45% |
| Laboratory | 810,000 | 1,800,000 | 45% |
| Medical Supplies | 195,000 | 650,000 | 30% |
| Drugs | 750,000 | 1,500,000 | 50% |
| Emergency Room | 350,000 | 1,000,000 | 35% |
| | | | |
| Total | 3,675,000 | 8,550,000 | 43% |

## Square Footage Reporting controls Capital Costs to Cost Centers

- Square Footage is a common basis for allocating the following costs:
  - Building Depreciation
  - Equipment Depreciation
  - Maintenance
  - Operation of Plant
  - Housekeeping



## Cost Allocations to Offsite and Non-Reimburseable cost centers

- Worksheet B, Part I
  - Review Overhead Costs Allocated
- Example Considerations
  - Does the hospital maintenance staff provide maintenance?
  - Does the hospital housekeeping staff clean the space?
  - Do the employees eat at the cafeteria?

## Shared Department Employee

- Employees who supervise or work for 2 or more departments
  - Where is the expense recorded in the g/l?
  - Where is the expense reported on the Cost Report?
- Examples:
  - Physician in Emergency Room and Physician in RHC
  - Floor Nurse and Emergency Room Nurse
- Allocate to various departments based on:
  - Actual time spent
  - Time study
  - Statistics





## Profitability Margin Services

- Mounting Federal Regulations and reduced reimbursement rates compounded with the already complicated strategic financial decisions you have to make everyday cause reason to need drill down data to help you answer your profitability questions
- Discover Department & Service Line contributors to your bottom line
  - Identify profitable departments and service lines
  - Compare multiyear volume, costs and reimbursement trends
  - Determine profitability at the claim level data based on reimbursement received
  - Review direct and indirect cost estimates

# 340B

- According to HHS Secretary Alex Azar the 340B program has grown from $4 Billion in 2009 to $16 Billion in 2016
- Potential savings are significant even with the 2018 legislative reductions (Approx. $1.6 Billion) as CAHs were not affected
- 2020 Proposed Trump Budget
  - Gives HRSA more authority over the 340B program
  - Requires hospitals report their 340B savings and how savings are used
  - Creates a user fee of .1% of 340B drug purchases from a provider



# Managed Care Contracts – Critical to the Bottom Line

- % Charge contracts have been under siege in Texas over the last 15-18 months
- Large payers requiring fee schedules for most areas of the hospital
- As long as Lab is carved out, many contracts are getting back to % of Charge

# Medicare MCO's

| | Medicare Part C Enrollees | Medicare Part C Enrollees | Medicare Total Acute Enrollees | Part C Penetration |
|---|---|---|---|---|
| March 2009 | 520,310 | 2,332,180 | 2,852,490 | 18% |
| March 2014 | 1,005,269 | 2,444,058 | 3,449,327 | 29% |
| March 2019 | 1,640,823 | 2,714,269 | 4,355,092 | 38% |





# Summary

- Healthcare is Changing- Dynamics and Environment
- Operations and Processes must be in place- Strong Revenue Cycle and Business Office Processes
- We need to be ready to adjust for change

## Questions and Answers

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