Torch Conference 2019

Brandon Durbin
brandon@dhcg.com

1

Format & Topics

The format is going to be a little different this year

Topics:

1. Waiver
2. UHRIP
3. Charity & Reimbursement hot points
4. Managed Care
5. Accounting issues
6. Strategy, the Future, & Other Ideas
7. QIPP

2

Questions?

Text: 214-538-8491

3

Waiver

- Burden Alleviation or Community Benefits programs are dying
  - If they are services "in hospital" they are similar to Dallas and are considered risky.
  - This ruling is based on a Director memo and her interpretation, not law.
  - The LPPF's are the new funding mechanism, although there is no real redistribution or public benefit.
- A few programs will remain for a while, but nobody knows how long.
  - The rural benefit was about $59M per year before LPPF
  - The current benefit is about $28M per year
  - We predict the 2020 benefit be $15M or less.

4

Waiver

- The traditional UCC payment was a combination of shortfalls
  - Uninsured – Charity & Bad Debt
  - Medicaid - Traditional and MCO.
  - Medicaid secondary – Medicare / Medicaid
    - Windfall due to the CHAT lawsuit which has the Medicare cost, but does not offset the Medicare payments. This is about $100M windfall in rural UCC.
- That's all changed!
  - Uninsured Charity is all that is UC
- UHRIP only makes up the MCO shortfall,
  - Capitation to rural was removed
  - You must have Medicaid utilization to benefit.

5

UHRIP issues

- Common Complaints
  - It is difficult to track the benefit
  - We have to wait for our money
  - We don't get much benefit – That is changing, but it is not immediate.
  - The IGT return is not guaranteed
  - It is not run by HHSC…
- And UC is going to be handled the same way….
- CMS rule or prohibition of "Pay to Play"
  - Killed Florida program, due to inability to get over the issues.

6

UHRIP

- To make UHRIP work it takes cooperation by the parties
  - Coalition of the rural publics & privates is needed. Separate interest.
  - Working agreement with main Urban providers
- This is not a simple issue of more money = more profit
  - DSH hospitals can actually lose money
  - IGT and historic benefits can change.
    - IGT is based on 2 year old data
  - Have to have an agreement in the rural pools to reconcile these issues
    - Urbans are not going to do this for you, in most cases, but will participate in some reconciliations
- Non participation will snowball and eliminate these benefits

7

All supplemental payment programs

- They are all linked and can cause unintended benefits or consequences
  - More UHRIP can take away DSH dollars
    - DSH is better than UHRIP based on cost
  - More Charity could make you a DSH hospital
  - UC payments are an offset to DSH
    - Depending on ownership DSH may be better than UC
- The point is that these types of decisions are specific to each provider, and there really is no “general rule”.

8

9

PARO Score Composition

PARO incorporates roughly 9,000 data sources and 2 BILLION records

ASSET CHARACTERISTICS	CONSUMER CHARACTERISTICS	LIFESTYLE / FAMILY STRUCTURE	DEBT CHARACTERISTICS	WILLINGNESS & ABILITY TO PAY
Consumer Transactions	Consumer Loyalty Programs	Household Income	Alternative Finance Sources	Liens
Property Values	US Census	Deceased Records	Check Cashing Access	Wealth Data
Registered Personal Property	Utility Records	Judgments	Credit Header Data	Bankruptcy Data
Licenses & Registrations	Renter Status	Criminal Records		Purchasing Behavior
Deeds		Correctional Institutions		Payday Loans Utilization
Motor Vehicles		Social Media		IRS Aggregate Data
				Tax Assessor Data
				Mortgages

Confidential Information

PARO

10

PARO Results

- Overall, we increased the rural charity for our clients by $84 million
  - For PPS this was an average increase of $1.9M
  - For CAH this was an average increase of $1.4M
  - This first year sets the *maximum* rural amount, as it cannot climb in subsequent years
- Keep in mind, a 25% LIUR (low income utilization rate) will qualify you for Medicaid DSH so more may qualify due to the increase in Charity
  - 2 physician requirement and trauma would still be a factor though

11

What's Next?

- As of April 9th, Novitas is mailing out S-10 letters to confirm LN. 20
  - May 24th is deadline for revisions to S-10 for CR's beginning in FY 2019
- PARO will be conducted on an annual basis based on your year-end
  - Results delivered and will coincide with CR due date going forward
- Detail HIPPA compliant data will be required to be submitted starting FY18
  - Total Bad Debt & Charity must be maintained for submission, not just Medicare
- Contact Information for PARO

shonnac@dhcg.com
806-776-0603

12

Medicare Supplemental Payments on Cost Report

- Low Volume Payment Adjustment (LVPA)
  - Recently passed in the Bipartisan Budget Act of 2018
  - 5 year extension for the LVPA-- but with revisions
  - Reverse Sliding scale from 0 – 25% of the Medicare claims payment
  - Criteria for Low Volume in past and for FY 2018
    - Less than 1600 **Medicare** discharges
    - 15 road miles from closest hospital
  - Criteria for Low Volume for FY 2019 –FY 2022
    - Less than 3800 **total** discharges
    - 15 road miles from closest hospital

13

Example of LVPA Adjustment

Calculation of Add-on to DRG:	Past Method (past and FY 2018)	Future Method (FY 2019-2022)
Medicare Discharge	388	
Total Discharge		1008
Calculation	=0.25-((388-200)*0.00017857)	=0.25-((1009-200)*0.0000657894)
Add-on to DRG	21.6429%	19.6776%

Changes to LVPA will open the doors for more hospitals to qualify for low-volume, but with an increased population will come a decrease in payments seen for many hospitals.

14

WHY DO PAYORS SUDDENLY WANT TO RENEGOTIATE CONTRACTS?

15

How did we get here?

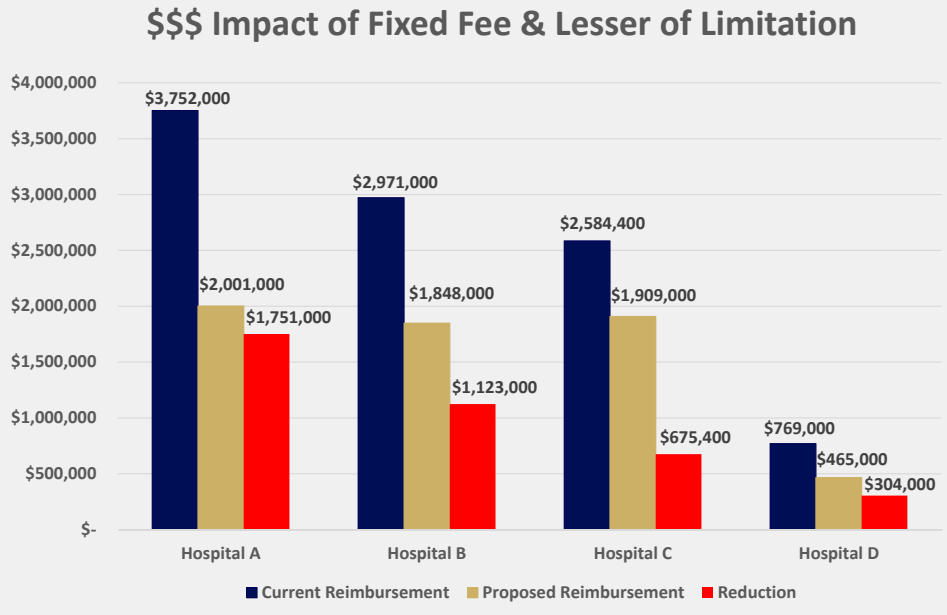
- Pass-through billing for lab claims
  - Billing for testing/processing a specimen not actually performed by hospital
- "We did not participate in pass-through billing"
  - Unfortunate that Rural Healthcare suffers as a whole for only a few bad actors
- New contract is necessary to eliminate payor's risk and recoup losses
  - Expect a fixed fee methodology for lab

16

Is Commercial Payor Reimbursement Methodology Changing?

- Most outdated contracts reimburse a percentage of billed charges
- New preferred methodology moves to a fixed rate methodology:
  - Inpatient: DRG or Per Diem
  - Outpatient: Fee Schedule
- Different than PPS for Medicare
  - Now limiting you to the lesser of charge or the contracted rate:
    - Often piecemeal – by line item
    - They win under all scenarios

17



18

How do I Counter Propose?

- Revert back to percentage of billed charges…
  - Does not always yield the best reimbursement, especially with low charges
- Does reimbursement cover your cost?
  - Use your most recently filed Medicare cost report to determine your cost
  - Counter propose with rates that cover cost
  - Tax dollars should not be used to subsidize the cost of providing care to the insured population
- Critical Access Hospitals:
  - Do not accept DRG methodology for Inpatient
  - Coding issues, Cost to educate, etc. Counter with a Per Diem rate
- PPS Hospitals:
  - Know your case mix to determine appropriate DRG base rate

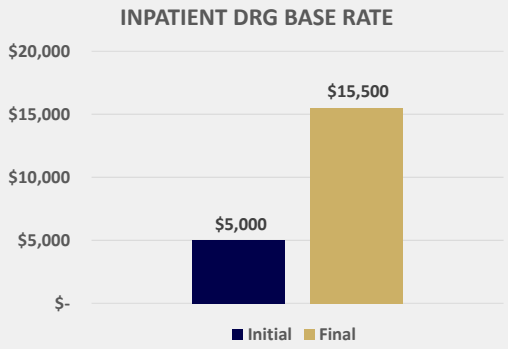
19

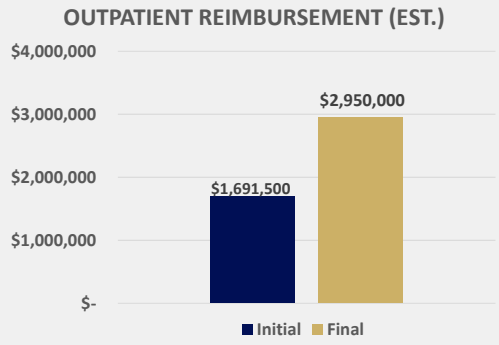
Negotiations: What to Expect?

- Notice of Contract Termination
  - Not always issued
  - Sets 120 day deadline to reach new agreement
- Payor will notify Subscribers 60 days prior to termination date
  - "Strong Arm" tactic to force the hospital to sign a bad contract
  - Send Subscribers in your community a letter **FIRST**
- Laboratory:
  - Will not pay a percentage of billed charge
  - Low reimbursement rates based on fee schedule
- Do not accept "No" as the answer
  - They need you as much as you need them
  - Do not settle for anything less than revenue neutral, and never below cost

20

Are Positive Results Achievable?

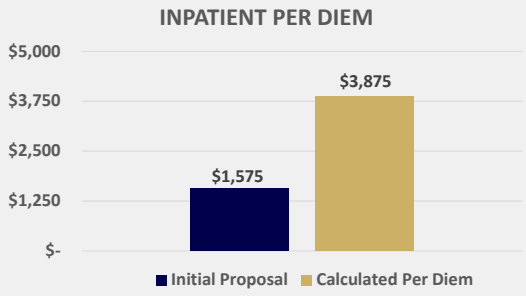


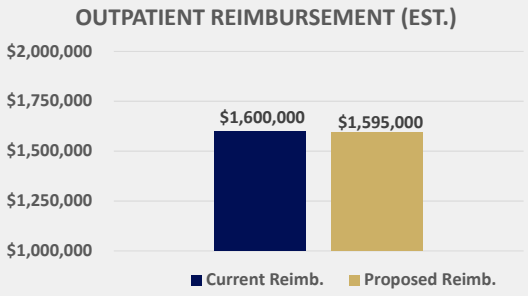


- Outpatient: Lab & ER: Fee Schedule; All Other OP: % of Eligible Charge
- Duration of Negotiations: 6 Months

21

Are Positive Results Achievable? (Continued)





- Termination Rescinded: Reverted back to old contract
- Duration of Negotiations: 6 Months

22

Are Positive Results Achievable? (Continued)

	INITIAL PROPOSAL	FINAL AGREEMENT
INPATIENT:	DRG Methodology	% of Eligible Charge
OUTPATIENT:	All OP: Fee Schedule	Lab: Fee Schedule All Other OP: % of Eligible Charge

- Results: Approximately 56% Increase from Initial Proposal
- Duration of Negotiations: 7 Months

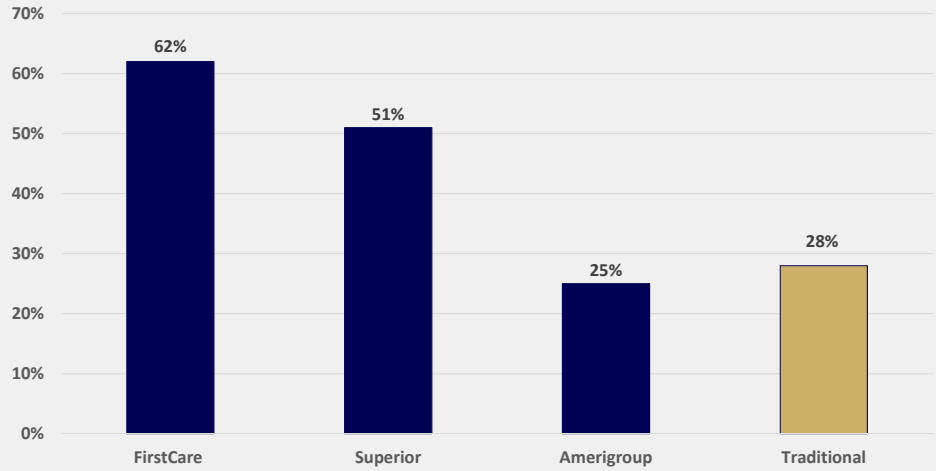
23

What about Medicaid MCO Contracts?

- Make it a priority to reevaluate these contract rates
- Know what you should be getting paid
  - Routinely review detailed paid claims
  - Determine if payment is in accordance with the contract
  - UHRIP payments are normally comingled and not separately identifiable
- Are your Medicaid MCO payors reimbursing less than Traditional Medicaid?
  - Negotiate for higher contract rates
  - Negotiate to remove “lesser of” limitation

24

Example Collection Rate: Medicaid Managed Care vs. Traditional Medicaid



25

Can you Maximize Reimbursement?

- Prepare cost analysis for all major payors
  - Reimbursement should cover your cost
- Strategically Review/Increase Charges
  - CAH: Focus on low Medicare utilization cost centers
- Find your good and bad contracts
  - Negotiate the bad to match the good
- Routinely monitor your paid claims
  - Find what charges are consistently being denied

26

LET ME SEE YOUR RATES!

- Currently, hospitals are not allowed to disclose contracted rates with other hospitals, but…
- Trump administration is considering a rule that would **REQUIRE** hospitals to publicize the prices they negotiate with insurers.
- Federal Register Citation - 84 FR 7424
- Go comment!
  - Comment period closes May 3rd

27

ACCOUNTING STANDARD UPDATES

Andrew Castillo, CPA
P: 806-791-1591
andrew@durbinco.com

28

Major Changes

- Leases- Accounting Standards Update (ASU) 2016-02
- Not-for-Profit Entities - ASU 2016-14
- Accounting for Interest Cost Incurred before the End of a Construction Period - GASB Statement No.89

29

New Lease Standard

- Why the Update?
  - To disclose Off Balance Sheet financing arrangements
- Lease classifications
  - Capital lease – Finance lease
  - Operating lease – Operating lease
- Lease classification criteria
- Lease terms
- Effective date

30

New Lease Standard (Cont'd)

- Lease Asset/Liability Measurement:
  - Lessee Accounting
  - Lessor Accounting
- Variable Payments
- Updated Transition
  - The Update allows for a modified retrospective approach
  - Transition is based on election of practical expedients

31

New Lease Standard (Cont'd)

- Financial Statement Impact
  - Balance sheet impact
  - Income statement impact
  - Cash flows impact
- Cost Report Impact
  - MAC stance on new guidance
  - Differences in reporting under GAAP and the cost report
- Audit Report Impact
  - Possible audit finding/Single Audit finding

32

New Not-for-Profit Entities Standard

- Why the Update?
  - To improve current net asset classification and requirements
- Net Asset Classifications:
  - Net assets with donor restrictions
  - Net assets without donor restrictions
- Enhanced footnote disclosures
  - Composition of net assets with donor restrictions
  - Information regarding an entity's procedures to manage its liquid resources to meet cash needs
  - Required statement of functional expenses
- Effective date

33

GASB Statement No. 89 – Accounting for Interest Costs

- Why the Update?
  - To establish requirements for interest costs incurred before the end of a construction period
- Main provisions
  - Interest costs incurred before the end of a construction period should be treated as period costs
- Cost Report Impact
  - Immediate recognition of interest costs
- Effective date

34

Questions so far?

Ideas to Ponder…

35

Strategies

- We still need to think disruptive….
  - Maybe - Cancel managed care contracts unless they pay at least cost.
  - Examine - Cooperatives, where the provider makes the profit, not the vendor.
  - Possibly - Forget local rivalries for the benefits of collaboration.
  - Explore - Innovative ventures

36

Bad Strategies to Avoid

- Lab arrangements
  - We have NEVER recommended a lab deal or firm.
  - It exploits a billing arrangement, that was ignored for the benefit of rural providers.
- We need to stay away from cost report and billing tricks.
- We have to stay away from promoting unnecessary care
  - It is very bad politics

37

Innovative Ventures

- We need service lines that provide necessary and high quality care
- Care that is efficient and prudent
- Where the Hospital can align with physicians
  - Hospitals JV with physicians for various product lines
    - Not a giveaway but an accretive strategy
  - Use the rural exception
  - We visited two last week in other states.
    - Imaging in the hospital was a JV with local physicians.
    - Cancer Center is a JV with a branded teaching facilities physicians.
  - We are working on a in hospital surgery JV with physicians.
  - These services are billed by the hospital, but provided by a JV with partners.
- How can you take referrals away from urban centers?
- How can you become a regional rural provider?

38

What will rural health look like in 20 years

- We have had many programs that have propped up and kept rural hospitals open.
- These programs may have provided seed money for transition, but
  - With Waiver programs ending.
  - Managed care and other centralization.
  - Community face difficult choices
    - Several hospitals will close
      - But many more will shrink and only offer minimal community services
    - Some will grow.
  - While we all want hospitals that are thriving, growing, and providing high quality, efficient and expanding services, that is not possible.
    - Regionalization?
    - Multi Hospital systems?
    - Hub and Spoke network of PPS and CAH rural providers
    - How to have geographic coverage and emergency services are difficult questions.

39

QIPP

Year 3

State Fiscal Year 2020 (09/01/2019 – 08/31/2020)

40

QIPP Year 3 - General

- Funding $600M (announced 02/05/2019)
- Total Eligible Facilities: 777
- Enrollment period has been designated as March 17, 2019 to April 16, 2019.
- Private Nursing Facility Enrollment Cut-Off lowered from 76% to 65%
- IGT reserve lowered from 10% to 7%
- Suggested inter-governmental transfer responsibilities will be received on April 25, 2019

41

QIPP Year 3 – General (continued)

- NSGOs participating in the IGT QIPP funding process must make their IGT declaration of intent by May 10, 2019. The expected settlement dates are:
  - First half due on June 3, 2019
  - Second half due on Dec. 3, 2019
- New Quality Metric Structure
- New Financing Components
  - Component 1 at IGT + 10% (NSGO homes only)
  - Component 2 at 30% of remaining funds after Component 1 & 4
  - Component 3 at 70% of remaining funds after Component 1 & 4
  - Component 4 at 16% of program funding (NSGO homes only)

42

QIPP Year 3 – Component 1

Quality Assurance and Performance Improvement (QAPI) Meetings

One Metric – Facility holds a QAPI meeting each month in accordance with quarterly federal requirements. Monthly attestation required.

As part of their QAPI process, the nursing facility (NF) will be required to discuss the Component 2 workforce development metric to review progress that is being made to improve the workforce in areas such as recruitment and retention, turnover, and vacancy rates.

HHSC will perform quarterly QAPI reviews on a representative sample of providers. If selected, the NF will have 14 days to submit the following records at the request of HHSC:

- Minutes from QAPI meetings;
- Sign-in or attendance sheets;
- Policies and outcomes developed in/as a result of meetings;
- Records related to results of actions taken in/as a result of meetings; and
- Records demonstrating owner/operator involvement in meetings.

43

QIPP Year 3 – Component 2

Workforce Development

Three equally weighted quality metrics for Component 2

Metric 1: NF maintains four additional hours of registered nurse (RN) staffing coverage per day, beyond the CMS mandate.

Metric 2: NF maintains eight additional hours of RN staffing coverage per day, beyond the CMS mandate.

Metric 3: NF has a staffing recruitment and retention program that includes a self-directed plan and monitoring outcomes.

Funds for Component 2 will be distributed monthly.

44

QIPP Year 3 – Component 3

Minimum Data Set CMS Five-Star Quality Measures

Three equally weighted quality metrics for Component 3

Metric 1: (CMS N015.01) Percent of high-risk residents with pressure ulcers. (Continued)

Metric 2: (CMS N031.02) Percent of residents who received an antipsychotic medication. (Continued)

Metric 3: (CMS N035.02) Percent of residents whose ability to move independently has worsened. (New)

Funds for Component 3 will be distributed quarterly.

45

QIPP Year 3 – Component 4

Infection Control Program

Three equally weighted quality metrics for Component 4

Metric 1: (CMS N024.01) Percent of residents with a urinary tract infection.

Metric 2: Percent of residents whose pneumococcal vaccine is up to date.

Providers will self-report vaccination data and submit documentation through QIPP portal

Metric 3: Facility has an infection control program that includes antibiotic stewardship. The program incorporates policies and training as well as monitoring, documenting, and providing staff with feedback.

The metric encompasses a list of nine infection control elements that each facility must incorporate into its infection control program. Seven of the nine elements must be present each reporting period for the facility to meet the quality metric.

Funds for Component 4 will be distributed quarterly.

46

QIPP Participation by Provider Type

Provider Type	QIPP Year 3 Eligible Providers	QIPP Year 2 Providers	QIPP Year 1 Providers
Non-state Government Owned (NSGO)	459	466	430
Private	318	95	84
Total	777	561	514

47

QIPP NSGO Rates Per Medicaid Day

Component	QIPP Year 3 NSGO Rate Per Medicaid Day	QIPP Year 2 NSGO Rate Per Medicaid Day	QIPP Year 1 NSGO Rate Per Medicaid Day
Component 1 Value	$ 32.30	$ 24.32	$ 24.33
Component 2 Value	$ 3.66	$ 6.85	$ 6.48
Component 3 Value	$ 8.54	$ 12.73	$ 12.03
Component 4 Value	$ 11.21	$ -	$ -
Total Value	$ 55.71	$ 43.90	$ 42.84

48

QIPP NSGO Rates Compared to Private

NF Type	QIPP Year 3 Rate per Medicaid Day	QIPP Year 2 Rate per Medicaid Day
NSGO NF Incentive per Medicaid Day	$ 26.35	$ 21.79
Private NF Incentive per Medicaid Day	$ 12.20	$ 19.58

QIPP Year 3 levels the playing field between the NSGO facilities with a manager versus the private NF in the program with the lower Medicaid % utilization

49

QIPP Year 3 Revenue Estimates

QIPP Year 3 estimated changes from Year 2

- Total Funding to increase from 400 Million to 600 Million;
- Estimated average IGT increase will be approximately 34% over previous year;
- Estimated average Revenue increase will be approximately 29% over previous year;
- Actual amounts will depend on NF changes in base year Medicaid days & final enrollment for QIPP Year 3.

50

QIPP Year 3 Concerns

- Component 1 - QAPI Audits - Records demonstrating owner/operator involvement in meetings;
  - Regular monthly attendance by HD staff;
  - Record of a review of the QAPI meeting by HD staff
  - This portion of the audit could result in recoupment of Component 1 if the involvement is not acceptable by HHSC;
- Component 2 – Additional RN Coverage – the funding associated with RN coverage either 4 or 8 hours is not sufficient to add actual RN coverage.
  - NF and HD may want to look at Telehealth programs for coverage and potentially based on pre-split funding to achieve additional lapse funding;
- Component 3 – 5 Star Metrics – Year 2 Components 2&3 have been shifted to 3 metrics and the funding will be an all or nothing based on either 5% improvement or base line. Basically Component 2 has been removed and only Component 3;

51

QIPP Year 3 Concerns

- Component 4 - Infection Control Program – New Component:
  - Metric 1: (CMS N024.01) Percent of residents with a urinary tract infection;
  - Metric 2: Percent of residents whose pneumococcal vaccine is up to date;
  - Metric 3: Facility has an infection control program that includes antibiotic stewardship. The program incorporates policies and training as well as monitoring, documenting, and providing staff with feedback
  - Since Metric 2 is only an annual process per resident there is a risk that pneumococcal vaccine could be missed without ability to improve;
  - Antibiotic stewardship may require HD involvement to be accepted by HHSC;

52

QIPP General Concerns

- SB 1050 – Texas Nursing Home Quality Act – If passed what impact would this have on the QIPP Program?
- SB 786 - relating to health care liability insurance for certain nursing facility – If passed the public hospital districts would be required to have professional liability for each NF.
- Civil Monetary Fines and Penalties incurred by Managers have the potential impact to affect the Hospital Districts. This can be problematic if your lease agreement is via a sub-lease and the Manager does not have an ownership interest.
- Federal Matching Share (FMAP) – as the state share matching share improves this can negatively impact the comparison of NGSO NF as compared to the Private NF

53

Brandon Durbin
Brandon@dhcg.com
Shonna Cannaday
Shonnac@dhcg.com
Aaron Milligan
aaronm@durbinco.com
Andrew Castillo
Andrew@durbinco.com
Chris Dockal
cdockal@dhcg.com
cdockal@healthsupportmgmt.com

54