Medicare Reimbursement Update and Financial Improvement Tools for Rural Hospitals

Presented by
Ann King White, CPA
BKD, LLP

June 9, 2016

Agenda

- Reimbursement Update
  - Current Status for CAH hospitals
  - Medicare Inpatient PPS Proposed Rule - FFY 2016
  - Final Rule CY 2016 for OPPS and Other Providers

- Preparing for the Future
  - CAH Metrics and Financial Measures
    1. Profitability
    2. Revenue
    3. Liquidity
    4. Capital Structure
    5. Operational Measures

Flex Conference Hospital Analysis

- Analysis of Western CAHs including Hospital’s attending the conference
  - Medicare cost reports from FYE 2014 & 2015
  - Obtained from on-line Cost Report service
- CHA Hospitals census = 110
- Average Bed Size
  - Hospital average bed size at 19
  - Smallest at 4, Largest at 25

Reimbursement Update

Inpatient PPS (IPPS)
FFY 2017 Proposed and
FFY 2016 Final Rule
Reimbursement Current Status for CAHs Hospitals

- CAH hospitals on holding pattern, same as PY
- Sequestration at 2% cut all Health Care
- Cost Reimbursement still at 101% less 2% = 99%
  - But this is an area that has brought discussion to reduce by 1%
  - So From 101% reimbursement to 100%, then with 2% sequestration would mean reimbursement at 98%

PROPOSED CHANGES TO HOSPITALS EXCLUDED FROM IPPS

- CMS is selecting CAHs to participate in the Frontier Rural Community Health Integration Project Demonstration (FCHIP)
  - Developed to test new models for the delivery of health care services, improve access, and better integrate delivery of acute care to Medicare beneficiaries
  - Period of performance August 1, 2016 – July 31, 2019
  - Goal is to maintain budget neutrality for the demonstration project
  - If Medicare payments increase during the demonstration project the increase in Medicare payments will be recouped from all CAHs through a reduction in Medicare payments over a three year period of cost reporting years, beginning in calendar year 2020

FFY 2017 IPPS Proposed Rule

- Published on 4/18/16
- Comments accepted through 6/17/16
- Final Rule expected 8/1/16, effective 10/1/16
- Limited comments specific to CAHs

FFY IPPS - Base Rate

- 2016 to 2017 Proposed increase of $51.86
- 2015 to 2016 an increase of $33.46
- 2014 to 2015 an increase of $73.23
- 2013 to 2014 an increase of $33.82

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<th>Operating</th>
<th>Capital</th>
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Impact for Quality Reporting and MU

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<td>(2.10)</td>
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<td>Operating Payment Rate</td>
<td>1.55%</td>
<td>(0.55)</td>
<td>0.85%</td>
<td>(1.25%)</td>
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Wage Index Issues

• New CBSAs
  - Garfield County, OK (Enid) is now CBSA 21420
  - Bedford County is now part of Lynchburg, VA
  - Macon, GA is now Macon-Bibb County, GA
• No changes in the methodology proposed
  - If a hospital has since terminated participation their data remains in the WI unless it is not reasonable
  - If a hospital has become a CAH before 1/22/16, their data was excluded from the wage index
• Proposed national average hourly wage $41.0651
  - Prior year final was $40.2555 or 2.0% increase
  - Based on data submitted by MACs by end of February
• Frontier states (Montana, North Dakota, South Dakota, Wyoming & Nevada) guaranteed 1.0 WI

DSH & UNCOMPENSATED CARE

• Proposed Uncompensated Care – FY 2018 and after
  - Proposed to begin using S-10 data for allocation of uncompensated care beginning in FY 2018
  - To be consistent with FY 2017 proposed changes, use 3 years of cost report data for S-10 allocation
    - Medicaid days from FY 2012 and FY 2013 cost reports
    - FY 2014 and FY 2015 published SSI ratios.
    - FY 2014 S-10 uncompensated care data

Payment Adjustment - Low-Volume Hospitals

• Current extension of temporary changes to payment adjustment for low-volume hospitals extended through FFY 2017 (9/30/17).
  - Hospitals must submit request by 9/1/2016
  - Less than 1,600 discharges
  - More than 15 road miles from any other IPPS hospital
Acute Care Volume Indicators and Reimbursement

- Western CAHs Analysis compared to 10 most profitable Western CAHs – Acute Care Medians
  - Volume differences
    - Acute M/C Days Median 443 compared to 610
    - Total Days Median 962 compared to 1404
  - Reimbursement per day
    - Acute M/C Median $1,510 compared to $1,507
    - Ancillary M/C Median $957 compared to $1,302
    - Total M/C Median $2,467 compared to $2,809

Acute Care Volume Indicators and Reimbursement

- Swing Bed comparison
  - What is your utilization?
    - M/C Days 0 to 2,710 (Average 426)
    - M/C Utilization 0% to 100%
  - Does it help your bottom line?
  - What are the threats to this good reimbursement?
  - What are opportunities to collaborate related to CJR Comprehensive Care for Joint Replacement?

Reimbursement Regulations

FY 2016 OPPS Final Rule

- Conversion factor update of 1.9% after productivity and other adjustments
  - CY12: $70.016
  - CY13: $71.131 (1.59% increase)
  - CY14: $72.672 (2.17% increase)
  - CY15: $74.173 (2% increase)
  - CY16: $75.582 (1.9% increase)
Outpatient Indicators and Reimbursement

- Western CAHs compared to 10 most profitable Western CAHs at Median
  - Outpatient Cost to Charge Ratios
    - 49% to 39%
  - Outpatient Revenue per Calendar Day
    - $14,742 to $25,329
  - Outpatient Cost to Medicare Allowable Cost Percentage
    - 16% to 16%

RHC Rates -- CY 2016

- Upper Payment Limit per visit (Does not apply to CAHs)
  - Increase, rates in:
    - 2015 = $80.44
    - 2016 = $81.32
  - Reflects a 1.1% payment increase
- Flex Attendees – 21 have RHCs (Limit does not apply)
  - Average Per Visit cost = $220 (over limit get + $140 Ø)
  - High Cost at $479, Lowest at $144
  - Average without High or Low = $210
- IMPORTANT: Billing Changes and Reimbursement Opportunities for RHCs and Rural Providers including Chronic Care Management (CCM) and Advanced Care Planning (ACP)

Rate Changes for Other Providers 2016

- SNF - Overall rate increase = 2.1%
- HHA – Overall rate increase = 1.9%
- Hospice – Overall rate increase = 1.6%

Preparing for the Future

CAH Metrics and Financial Measures
Financial Indicators and Comparison Benchmarks

1. Profitability
2. Revenue
3. Liquidity
4. Capital Structure
5. Operational Measures

Profitability

Goal for Profitability

Hospitals need to look for ways to be
- More Efficient
- Cost Effective
In the delivery of Services
Keep in mind the Triple Aim:
- Increase efficiency in providing care
- Improve the patient experience
- Improve outcomes
Western CAHs Profitability

  - Net Operating Income (Net Patient Revenue less Expenses)
    - 37 CAHs or 34% had Positive Net Income from Operations
    - 73 CAHs or 66% had Net Operating Losses – Average Loss ($2,000,000)
  - Net Income (including Other Income)
    - 83 CAHs or 75% were Profitable
    - 27 CAHs or 25% had Net Losses – Average Loss ($705,000)

Total Margin % (Median)

EBIDA Margin % (Median)

Revenue
Acute Medicare Utilization

Acute Medicaid Utilization

Western CAHs Outpatient Revenues

  - Outpatient revenue to Total Revenue Range from 56% to 98%
  - Median for Western CAHs was 78%
  - One major source of outpatient revenue was from RHC Clinics
  - Analyze for your hospital where the largest sources of outpatient revenue are and look at departments and specific services.
### Outpatient Revenue to Total %

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<tr>
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<th>Low</th>
<th>High</th>
<th>Western Average</th>
<th>Top 10</th>
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<tbody>
<tr>
<td>Value</td>
<td>56</td>
<td>98</td>
<td>69</td>
<td>68</td>
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</table>

### Outpatient Medicare Utilization

<table>
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<tr>
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<th>Low</th>
<th>High</th>
<th>Western Average</th>
<th>Top 10</th>
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<tbody>
<tr>
<td>Value</td>
<td>10</td>
<td>47</td>
<td>30</td>
<td>25</td>
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</table>

### Improve Revenue Realization

- Analyze charge payer %’s by procedure
- Restructure charges to take advantage of procedures with higher % of charge payers
- OR consider reducing charges to capture market share for competitive pricing and consumer shopping
- Update the hospital’s Charge Description Master (CDM)
Take a closer look at Medicare Payments

- Re-examine that all Medicare payments are correct
- Verify the relationship between coding and payments

How Do Your Third Party Payers pay...

- Depends on the payer and services provided to the patient
  - Fee for service
  - Fixed payments
  - Payments based on Medicare methodology
  - Contracts with payer
- AUDIT these payments

Medicare Bad Debts

- All Medicare Bad Debts now reimbursed at 65%
- Western CAHs Median for Inpatient
  - Deductibles & Co-Insurance Median = $131,000
  - Average Bad Debts $7,300 or 5.6%
- Western CAHs Median for Outpatient
  - Deductibles & Co-Insurance $862,000
  - Average Bad Debts $43,500 or 5%

Hospitals with No Medicare Bad Debts:

- 22 out of 110 Western CAHs or 20%

Western CAHs Medicare Bad Debts

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Bad Debts to Deductibles &amp; Co-insurance is 8%</td>
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</tbody>
</table>

- No Bad Debts
- Under $25,000
- Under $50,000
- Under $100,000
- Under $250,000
- Over $250,000
Liquidity

Cash is still King

Western CAHs Liquidity

  - Current Ratio range from negative (3%) to 21%
    - Average 4.3%
  - Days Cash on Hand range from negative (2%) to 837 Days
    - Average 118 Days
  - Net Days in Accounts Receivable range from 25 to 120 Days
**Net Days in Accounts Receivable**

- Western Average: 50
- Top 10: 49
- A Rated: 50
- BBB Rated: 47

**Capital Structure**

**Debt to Capitalization (%)**

- Western Average: 34
- Top 10: 38
- AA: 19
- A: 29
- BBB: 36

**Debt Financing**

- **A word of caution**
  - Typical financing structures (i.e. long-term revenue bonds) for major facility improvements can generate strong cash flow in early years but could have insufficient cash flow to make the payments in later years
  - CHA cost reimbursement higher in early years from Depreciation and Interest
  - Important to understand your forecast model
Operational Measures

**Average Daily Census**

<table>
<thead>
<tr>
<th>Acute Low</th>
<th>Acute Mid</th>
<th>Acute High</th>
<th>Acute Top 10</th>
<th>SB Mid</th>
<th>SB High</th>
<th>SB Top 10</th>
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**Acute Beds & Swing Beds**

**Staffing Levels**
- Hospital’s largest cost
- Western CAHs Median FTEs = 177
- Prepare an FTE analysis
  - If you cannot benchmark yourself get help
  - Then take action with a Staffing Plan
    - Obtain board and leadership buy-in
    - But when the action gets taken buy-in can waiver 
  - Then budget to the agreed plan
- Reduce/eliminate agency staffing
- Goal is to manage staffing

**Medicare Cost Report Worksheet**

**S-10 Uncompensated Care**
- Uses overall Cost to Charge Ratios (CCR)
- But we know excludes:
  - Selected costs to do business that Medicare does not share in
  - Physician services
  - Other sub-providers part of organization
- Western CAHs overall Average CCR = 64%
- Top 10 CAHs overall Average CCR = 44%
- Different from 990 Schedule H & more then just Non-Profits!
Prepare for the Future

- Fine tune operations
  - Revenue Cycle
  - Medicare Cash Flow
  - Staffing Levels
  - Adequate Medical Staff
  - Evaluate & consider eliminating unprofitable services, carefully evaluate new services

How do you increase revenues without increasing costs?

If the future is keeping patients well thus less health care costs?
What resources do you need?
Is the future focus on Community and Health?

Thank You

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