CAH CFO-Administrator FORUM

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Cost Report Myths, Locums Lookbacks, and 5 Keys to Increasing Your Financial Performance

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AGENDA

- Welcome and Introductions
- Top 5 Finance Strategies for Rural Hospitals
  - Questions
- Locums Lookback
  - Questions
- Cost Report Strategies – Getting paid for what you are doing
  - Questions
- Drawing

The Top 5 Finance Strategies for Rural Hospitals

Why Financial Performance Matters for CAHs

- Critical Access Hospitals (CAHs) play a vital role in rural health care.
- Financial sustainability ensures continued access to care for underserved communities.
- Maximizing revenue and optimizing costs allows for reinvestment in services and infrastructure.

Objective:

- Explore five key strategies to improve financial performance and ensure long-term viability.
- Provide actionable insights tailored to CAHs' unique challenges.

Key #1 – Maximizing Cost-Based Reimbursement

- Understanding Medicare's Cost-Based Reimbursement:
  - Ensure accurate cost reporting to maximize Medicare reimbursement.
  - Allocate expenses correctly to optimize reimbursement rates.
- Leveraging Medicaid & State-Based Funding Programs:
  - Identify supplemental funding opportunities and grants for CAHs.
  - Work with state agencies to access available rural healthcare support.
- Reducing Uncompensated Care:
  - Implement a strong financial assistance program.
  - Improve patient eligibility screening for Medicaid and charity care.

Key #2 – Optimizing Revenue Cycle Management (RCM) for CAHs

- Improving Billing Accuracy & Efficiency:
  - Reduce denials through accurate coding and documentation.
  - Train staff on CAH-specific billing regulations and compliance.
- Enhancing Patient Collections:
  - Offer financial counseling and payment plan options.
  - Utilize digital payment solutions for improved collection rates.
- Leveraging RCM Partnerships:
  - Consider outsourcing RCM to specialized rural healthcare vendors.
  - Use analytics to track cash flow, outstanding claims, and payer mix trends.

Key #3 – Managing Operational Costs Without Compromising Care

- Staffing Optimization for Rural Healthcare:
  - Cross-train employees to maximize efficiency in low-volume settings.
  - Utilize telehealth to reduce provider shortages and expand service access.
- Supply Chain & Procurement Strategies:
  - Partner with Group Purchasing Organizations (GPOs) for cost savings.
  - Standardize procurement processes to reduce waste and negotiate better contracts.
- Facility & Energy Cost Management:
  - Implement energy efficiency measures to reduce overhead costs.
  - Leverage grants and state programs for facility upgrades and sustainability initiatives.

Key #4 – Expanding High-Value Service Lines in CAHs

- Understanding Community Healthcare Needs:
  - Conduct needs assessments to identify service gaps in the rural population.
  - Expand outpatient services to reduce hospital admissions and increase revenue.
- Leveraging Telemedicine & Specialty Partnerships:
  - Use telehealth to offer specialty services without requiring full-time specialists on-site.
  - Partner with larger healthcare systems to provide specialty care access.
- Focusing on Preventive & Chronic Care Management:
  - Implement care coordination programs to manage high-cost chronic conditions.
  - Utilize Remote Patient Monitoring (RPM) for chronic disease management reimbursement.

Key #5 – Enhancing Payer Contracts & Alternative Payment Models

- Negotiating Favorable Contracts with Payers:
  - Demonstrate value-based care capabilities to secure higher reimbursement rates.
  - Work with payers to develop rural-focused payment models.
- Exploring Alternative Payment Models (APMs):
  - Participate in Accountable Care Organizations (ACOs) and bundled payment models.
  - Engage in risk-sharing agreements that benefit rural hospitals.
- Maximizing Grants & Federal Funding Programs:
  - Identify CAH-eligible funding sources such as HRSA grants and CMS rural health programs.
  - Stay informed on policy changes that impact CAH reimbursement.

Case Study – Real-World CAH Financial Improvements

- Example: XYZ Critical Access Hospital
  - Before: High expenses, declining reimbursements, challenges in service expansion.
  - After Implementing These Strategies:
    - 15% increase in Medicare reimbursement through cost report optimization.
    - 20% reduction in operational costs by improving supply chain efficiency.
    - Increased revenue from telehealth and new outpatient service lines.
- Key Takeaway: Small operational and financial adjustments can lead to long-term sustainability.

Addressing Common CAH Concerns

- "We struggle with staff shortages."
  - Solution: Cross-training, telehealth partnerships, and provider recruitment incentives.
- "Our reimbursement rates are too low."
  - Solution: Ensure accurate cost reporting and negotiate payer contracts effectively.
- "We can't afford to expand services."
  - Solution: Explore grant funding, community partnerships, and alternative revenue streams.

Conclusion & Call to Action

- Key Takeaways:
  - Maximizing cost-based reimbursement ensures financial stability.
  - RCM improvements enhance cash flow and reduce denials.
  - Operational efficiencies control costs without compromising care quality.
  - Expanding service lines diversifies revenue and meets community needs.
  - Strengthening payer contracts and exploring APMs boost sustainability.
- Next Steps:
  - Conduct an internal financial review focusing on CAH reimbursement strategies.
  - Implement at least one of these key financial improvements within the next quarter.
  - Monitor performance metrics and adjust strategies as needed.
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Locums Look Back

Today's Goal

TALK ABOUT THE LOCUM'S LOOK BACK AND WHY EVERY ORGANIZATION SHOULD BE DOING THIS.

BRIEFLY GO OVER WHAT IS A LOCUM'S AND WHAT CREDENTIALING REQUIREMENTS EXIST.

TOUCH ON SOME BILLING COMPLEXITIES.

What is involved in a Locum's Look Back?

Review Contract. Not all Contracts are the same.

Make sure that the billing has been done correctly. Analyze denials.

Match invoices to the hours worked and make sure the invoice is accurate.

Make sure the credentialing requirements have been met.

What is a Locum Tenens?

A substitute Provider who is filling in for a regular Physician during an absence. This could be due to things like:

- Pregnancy
- Vacation
- Illness
- Military Deployment
- Continuing Education

Credentialing Requirements

- Active Medical License.
- DEA registration.
- NPI must be active and up to date. If using the facility NPI it must be linked with modifier.
- Malpractice Insurance Coverage- double check this with the LT Company if you do not have slot coverage.
- Background Checks and References.
- Hospital Privileging.
- Enrollment in Medicare/Medicaid.
- Must have a Provider agreement or a company formal contract.
- Health records if necessary.

Requirements for billing

1. Regular Physician must be unavailable

2. Patients must be regular Patients of the Absent Physician.

3.Locums Physician must be paid Per Diem

4. The 60 day rule.

5. Several billing complexities and modifiers must be used. Q5 and Q6 have their separate usage requirements- ask an expert.

Credentialing Requirements

Examples

Here are five case examples to help illustrate how these questions and answers apply to real-life situations.
1. Retina specialist Dr. Johnson is on vacation for two weeks and arranges for Dr. Smith, a locum tenens physician without a practice, to provide eye care services to Dr. Johnson's patients at the practice during that time.
Billing Modifier: Use -Q6 because the service was furnished by a substitute physician under a reciprocal billing arrangement.

2. Dr. Singh, a comprehensive ophthalmologist, hires a new associate, Dr. Patel, who has not yet been credentialed with insurance payers. Dr. Patel sees patients at the practice while going through the credentialing process.
Billing Modifier: Since Dr. Patel is not a locum tenens physician and is a new associate, do not use either of the locum tenens modifiers. The billing should be done under Dr. Patel's own NPI and once the credentialing process is complete.

3. Dr. Garcia is on maternity leave for three months. Dr. Rodriguez, a physician who works part time with another local practice, is hired to cover her patient load during her absence.
Billing Modifier: Use -Q5 since the service was furnished by a substitute physician under a reciprocal billing arrangement with the practice.

4. Dr. Lee needs to attend a medical conference for four days. Dr. White is contracted to provide eye care services at Dr. Lee's clinic during that period. Dr. White sold a practice and was getting ready to retire.
Billing Modifier: Use -Q5 because the service furnished by a substitute physician without a separate practice under a reciprocal billing arrangement.

5. Dr. Nguyen, a pediatric ophthalmologist, hires Dr. Wang, a newly graduated and credentialed pediatric ophthalmologist without a separate practice on a long-term basis to establish his own practice within Dr. Mitchell's clinic.
Billing Modifier: In this scenario, Dr. Wang is not acting as a substitute or temporary physician but rather establishing his own practice within the clinic. Do not use either of the locum tenens modifiers since it would not be appropriate. Dr. Wang should bill under his own NPI as a separate practicing physician.

Navigating the intricacies of locum tenens billing and reimbursement is essential for accurate and compliant coding and billing practices. Always refer to payer policies and guidelines for specific information and ensure compliance with the appropriate modifiers and documentation requirements to streamline the billing and reimbursement process.

Key Billing Takeaways

1. Billing is complicated. Ask an expert.

2. The Practice cannot employ the Locum's Physician.

3.Stop billing under the Physician after 60 days. You must then use the substitute Physician's NPI and Tax ID, obtain a permanent NPI, or use another Locums provider.

4. Maintain proper documentation.

5. Check your contracts with Commercial Payors.

6. If the regular Physician has retired, resigned, or is terminated then you must use the facilities NPI or obtain a new one from the Provider.

Question: Should we just credential the Provider permanently?

Do you have the bandwidth?

This can be outsourced cost effectively.

Question: It is ok to not bill for Locums because we are only using them short-term.

The short answer is no. You must bill for services rendered.

Locums Contracts

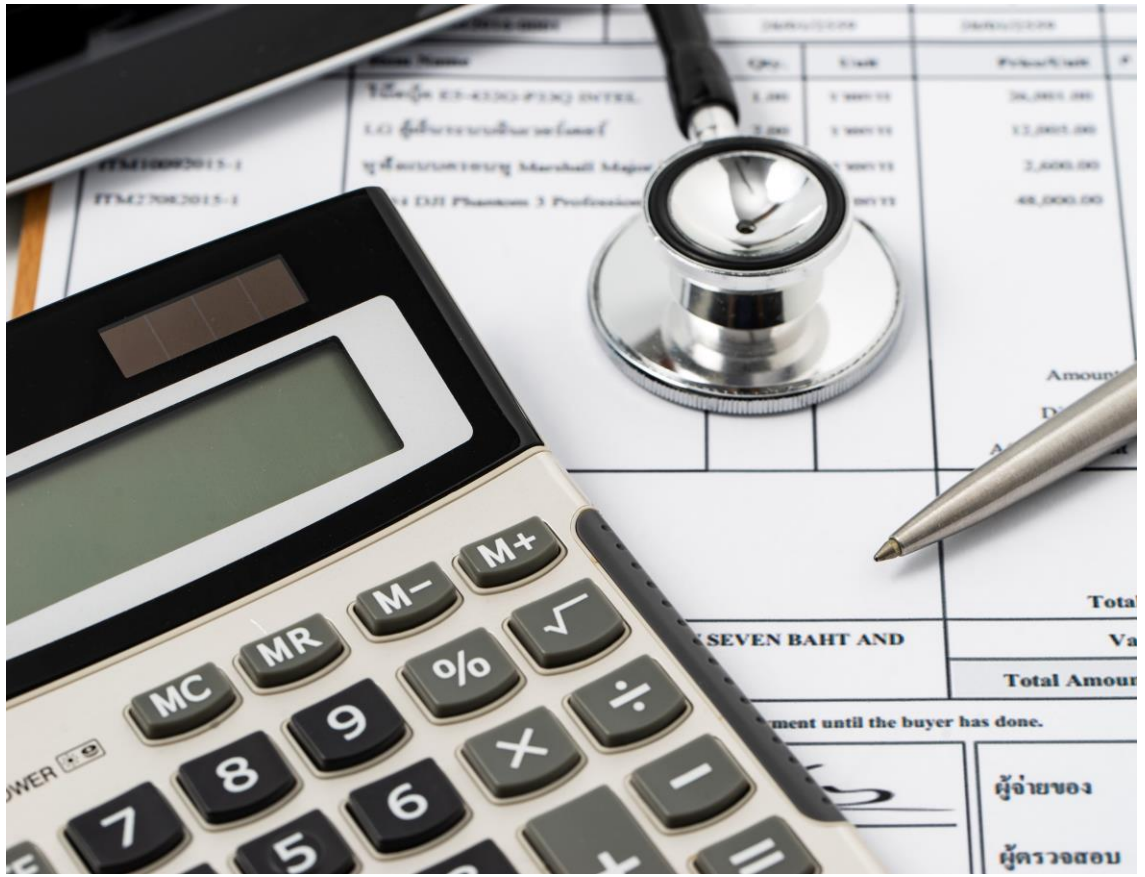
Remember the billing requirements.

What to look for in a contract that can be costly. Not all contracts are alike.

- Buyouts
- Travel and Miscellaneous fees
- Overtime and call back fees

Making sure you are paying correctly

- Process of paying locums invoices must have checks and balances.
- Case study on incorrect invoicing.



Cost Report Strategies

Cost Report as a Strategy

- CAH's often fail to use their cost report as a strategy, but rather as a compliance filing
- Accounting should support this function
  - Cost centers
    - There is options to customize this process and get it approved by the MAC
  - Statistics – what are you tracking each month?

Key Strategy #1 – Medicare Bad Debt

- 12/15/2022 OIG did an audit of cost report bad debt reporting and notated improvements are needed to bad debt tracking for compliance to be accurate
  - MAC's asked to expand their review of this process
  - First year resulted in a 5% audit effect reduction in reimbursement
- Documentation requirements increased
  - Logs – this process needs to be mapped properly, and patient demographics properly tracked
- 65% reimbursement for this eligible benefit

Key Strategy #2 – Time Studies

- ER Time Studies
  - This is the most common desk audited section
  - Physician specific
    - Admin v. patient time is required
- Medical Records Time Studies
  - Why would you do this?
- Rotating weeks rule!

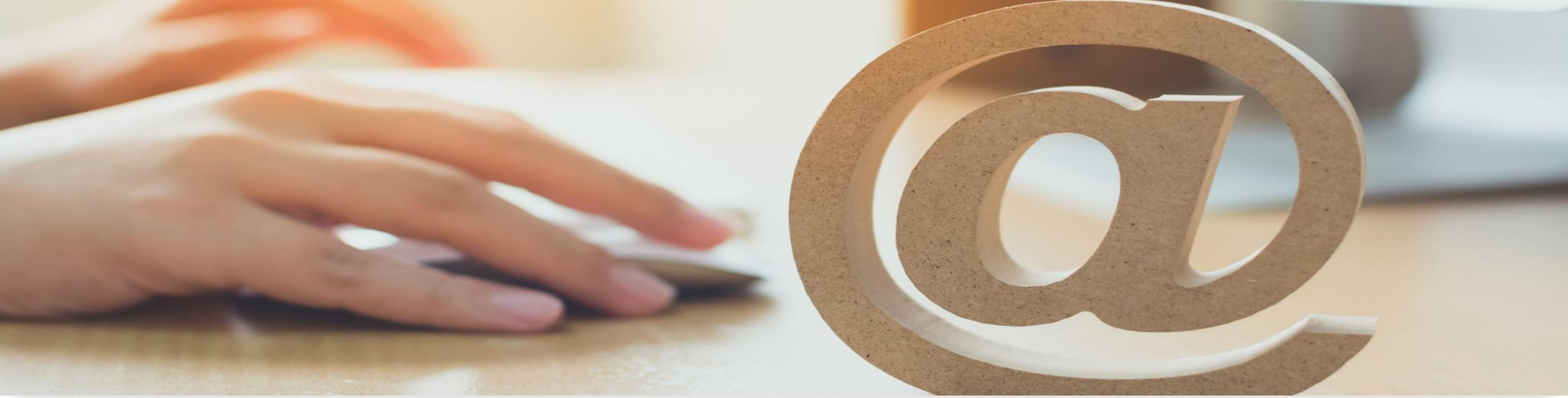
Key Strategy #3 – Statistics/Cost to Charge Ratio

- Take the time to evaluate your cost to charges
  - Evaluate revenue cycle as a result
    - Too far out of alignment can create a flag
    - Charge master evaluation or charge capture
  - All charges should have mapped expense, and all expense should match a charge

How does this affect your overall strategy?

- Medicare payer mix – if higher, then cost report must be a driver
  - Outpatient Medicare co-pays – monitor this
- Medicaid programs – how does this relate to the cost report in your state?
- Commercial payers – are they paying based on your charge master or Medicare fee schedule?
  - Rate letter changes
- Interim cost reports – these are a must and not just the IRR
- Upcoming changes
  - Vaccine administration changes
  - Productivity requirement changes

Questions



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