



**IROQUOIS**  
*Healthcare Association*

# Critical Access Hospital (CAH) Medicaid, Indigent Care Pools and Medicare: Reimbursement Updates and Opportunities

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Presented By:



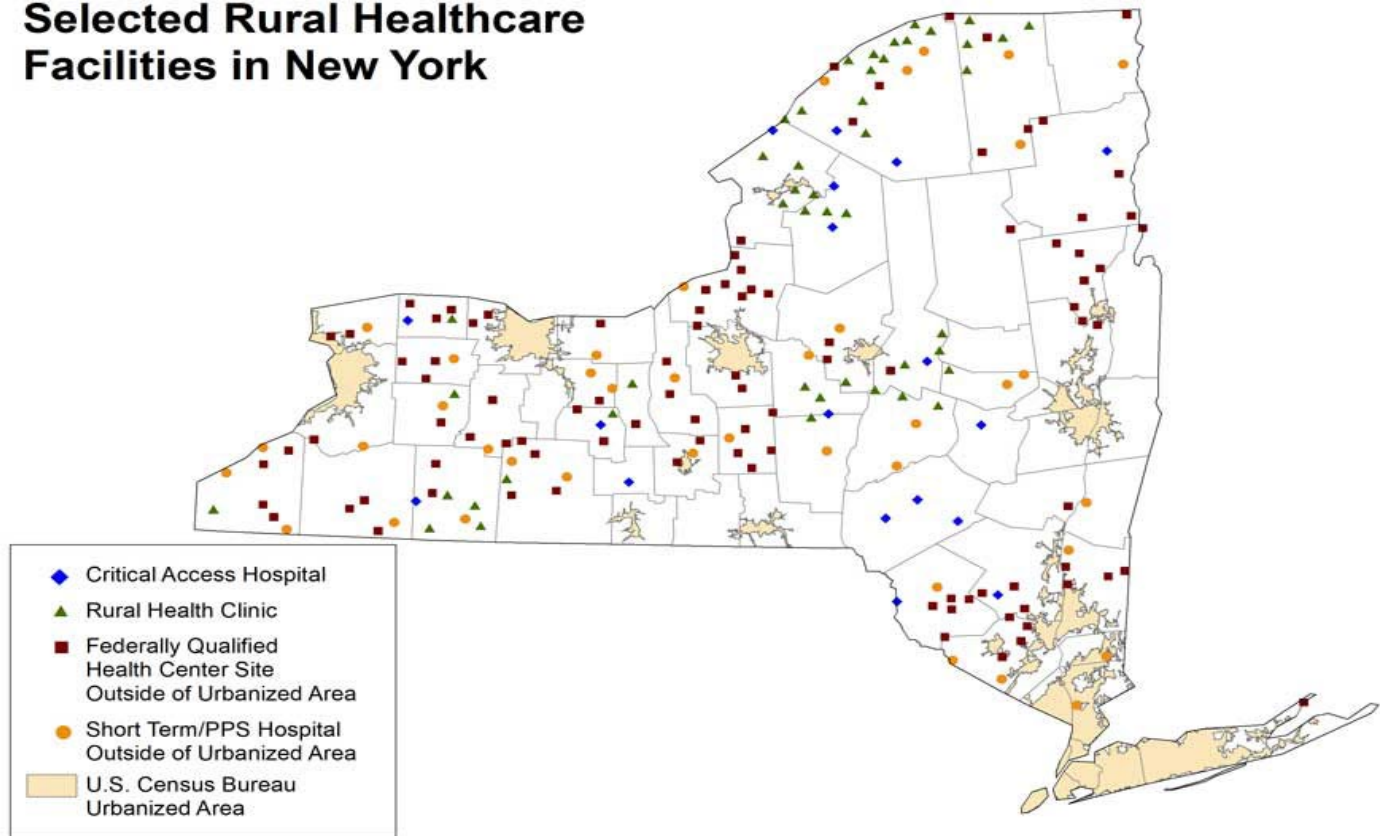
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# Agenda

- ✓ **New York State (NYS) Medicaid**
  - How the Inpatient Rates are Developed
- ✓ **Indigent Care Pools**
  - The Basics and Key Drivers
- ✓ **Medicare Reimbursement**
  - Background and Recent Regulatory Changes
  - Examples of Items that Impact Costs
- ✓ **Areas of Continued Focus and Possible Opportunities to Consider**
  - Reimbursement Drivers

# Critical Access Hospitals (CAHs) & Rural Health Clinics (RHCs) in New York

## Selected Rural Healthcare Facilities in New York



# NYS Medicaid CAH Inpatient Rates

- Similar to Medicare, based on NYS ICR costs
  - The NYS Department of Health (DOH) has been using a 2005 base year
  - This base year is then modified by removing “Non-Projectable costs”, namely Capital costs
  - A “roll factor” is then applied, which is a series of inflation factors that updates the cost from 2005 dollars, to current dollars
  - A cost per diem is created by dividing the updated cost by 2005 patient days
  - This per diem is then compared to the regional average per diem of peer CAHs
  - The Hospital will then receive the lower of its own per diem, or 110% of the regional average

# NYS Medicaid CAH Inpatient Rates (Cont'd)

- Capital Costs
  - The Hospital will receive a per diem add-on for capital
  - This add-on is based on current year budgeted capital costs that the hospital submits to the DOH divided by budgeted days
  - The DOH will eventually reconcile the submitted budgeted capital with the actual audited capital when that year's ICR is finalized
  - This will result in a liability or receivable on the part of the hospital
  - Until a new base year is determined by the DOH, capital is the only item that a CAH can use to find improvements in its rates
- Future Outlook
  - Although the DOH has stated its intention to move to a new base year for CAHs several times over the recent years, there are no concrete plans to do so in the near future

# NYS Indigent Care Pool

- Indigent Care Pool (ICP) basics
  - The NYS DOH administers a pool that is funded by various sources with the purpose of compensating hospitals for the level of Uninsured and Charity patients that they serve
  - The distribution formula estimates the “cost” of these patients, and then distributes to each hospital their percentage of cost, compared to the overall cost of the entire State of New York
  - The distribution formula has a number of other complicating factors, such as the Medicaid Inpatient Utilization Rate (MIUR)
- The Drivers of an individual hospital’s distribution
  - The data that the DOH uses to determine the distributions comes from the ICR data from two years prior (2019 ICR drives the 2021 distributions)
  - The ICR exhibits that drive the distributions are:
    - Exhibit 30 for the MIUR data, especially the Medicaid eligible days and discharges
    - Exhibits 32 and 33 for the Uninsured and Charity volumes
  - It has been observed that hospitals misreport the critical information in these exhibits

# Medicare: CAH Background

A hospital already participating in Medicare and seeks CAH status must meet these criteria to be certified and remain certified as a CAH:

- Be located in a rural area – or designated rural
- Demonstrate compliance with CAH conditions of participation
- Transfer agreement to accommodate inpatient transfer and referral
- Furnish 24-hour emergency care services 7 days a week
- Maintain no more than 25 inpatient beds that may also be swing bed
- Have an acute annual average length of stay (LOS) of 96 hours or less
- Credentialing and quality assurance arrangements with a member of a health network
- Be located more than a 35-mile drive from any hospital or other CAH (or a 15-mile drive if mountainous terrain or areas with only secondary roads available).

# CAH & RHC Recent Regulatory Changes

- Critical Access Hospital (CAH)
  - Swing bed/Skilled Nursing Facility (SNF) limits waived by CMS during the pandemic
  - 96 hour length of stay limit waived by CMS during the pandemic
  - Sequestration waived in 2021, 0% through 03/31/22, 1% to 06/30/22, then 2%
  - PHE (Public Health Emergency) Extended until 7/15/22
  - No cost report filing extensions in effect at this time
- Rural Health Clinics (RHC)
  - Cost Caps implemented 04/01/2021 unless RHC is “grandfathered”
  - RHC physicians can provide services at hospice
  - Covid 19 monoclonal antibody products covered/cost reimbursed
  - Mental Health telehealth visits covered as of 01/01/2022
- Rural Emergency Hospital designation (REH)
  - Coming January 2023 (CMS still needs to provide clarifications)



# Payment Methodologies

- Medicare – CMS pays CAHs most inpatient and outpatient services at 101% of reasonable costs.
- Reasonable Cost Payment Principles That Do NOT Apply to CAHs
  - Lesser of cost or charges
  - Reasonable compensation equivalent (RCE) limits
- CAH are not subject to the 1-day or 3-day preadmission payment window provisions (wholly owned by IPPS hospital exception).
- Tricare – ensure they are at 101% cost payment rate.
- Medicare “HMO”
  - Claims related to Medicare Advantage patients may not be cost based.
  - Recommendation: Negotiate 101% of cost you are paid from Traditional Medicare.

# Examples of Items Affecting Costs

- Reclassifications may impact the Ratio of Costs-to-Charges (RCCs).
- Statistics should be accurate and current to properly allocate overhead costs.
- Statistical step-down methods can be proposed and changed, if needed.
  - The simple step-down allocation method should be modeled and considered.
- Physician costs on A-8-2 are a major area to ensure proper splits (A vs. B).
- Adjustments to costs should be closely monitored so that they are compliant and not overstated.
- RCCs drive the Medicare Outpatient reimbursement.
- Total Days and Total Allowable Costs are the key drivers for the Inpatient Medicare reimbursement.
- Non-reimbursable cost centers (NRCC) may over-allocate overhead costs (e.g., Marketing costs). Consider adjusting on A-8 vs reporting as a NRCC on A.
- Identify home office costs, where applicable.

# Cost Report Settlements

- **Settlement Factors**
  - Fluctuation in Expenses and Charges
    - Reimbursable cost and charge changes can impact your RCCs
  - Volume Changes
    - Large increases tend to lead to payables to Medicare
    - Large decreases tend to lead to receivables from Medicare

# Ambulance Transports

- Paid at 101% of cost if the CAH is the only provider
- Owned and operated or a supplier contracted
- 35 mile drive requirement
- CAH can be paid at 101% of costs if the ambulance service is greater than 35 miles and it is the closest provider or supplier of ambulance services.

# Outpatient Services: Method I or Optional Method II

<b>Method</b>	<b>Facility Services</b>	<b>Physician Services</b>
Method I	101% of Reasonable Costs	Medicare physician fee schedule
Method II	101% of Reasonable Costs	115% of Allowable Amount (generally Medicare physician fee schedule)

- Physician must re-assign billing rights to CAH using CMS-855R.
- Hospital must make election to be paid under Method II.
- Election remains in effect until hospital terminates election. No need to make annual election.

# CRNA Pass-Through Costs

- Certified Registered Nurse Anesthetists (CRNA's) can be reimbursed at cost if the following conditions are met:
  - CRNA's must be employed or contracted by the hospital
  - The hospital is located in a rural area or has reclassified as rural
  - Anesthetists' total hours may not exceed 2,080 hours per year
  - Procedures requiring anesthesia did not exceed 250 procedures
  - Anesthetists agree not to bill for services in the hospital
  - Prior to January 1 each year, the Hospital must prove the prior year volume of anesthesia services did not exceed 800 procedures.

# CAH with Rural Health Clinics (RHC)

- New Caps Effective 04/01/2021.
- CMS Change request 12185.
- Is your RHC “grandfathered” and exempt?
- A sub-unit of a hospital with less than 50 beds. It appears as if all New York CAHs have under 50 beds.
- NGS should have confirmed your exempt status

# Covid Relief Funding

- Issue surrounding how it is recorded on cost report
- Worksheet G-3 line 24.50 “Covid 19 PHE Funding”
- Both provider relief funds (PRF) and paycheck protection program (PPP)
- Identify this revenue so it does not “mask” the true financial condition
- Using line 24.50 on G-3 allows revenue to be carved out



# Protested Items

- There are potential protested items that should be considered to protect the hospital's appeal rights to certain issues.
  - Caps and reductions to costs
  - Audit disallowances
  - Audit determinations and Notice of Program Reimbursements (NPRs)
  - 340B cuts effective in 2018 of 28.5% rolling forward
  - Any cut to your reimbursement – model and protest
  - Protest lines are on E, part B, E-2, E-3, and M-3 as examples.

# Cost Report Review and Settlement

- Does your Medicare Area Contractor (MAC) desk review and settle without audit?
- Do not allow cost reports to NPR with the as-filed Provider Statistical & Reimbursement Report (PS&R)
  - Why is this important?
    - The PS&R is not a static document
    - Data items may change and affect reimbursement
    - Medicare Days
    - Medicare net reimbursement
    - Interim reimbursement calculations
- Depending on the hospital organization and structure, consider other impacts before the 180 day appeals deadline and before the 3 year reopening window closes.

# TOP 10 List Action Items/Key Takeaways...



# TOP 10 List

## Action Items/Key Takeaways...

1. Know when the Public Health Emergency (PHE) will end and how it will impact your hospital. Currently the PHE is scheduled to end on 07/15/2022. For example, Swing Beds should be used (when needed) for optimal revenue.
2. Review in detail the As, Bs, Cs of the cost report for accuracy
  - Costs, adjustments, statistics and charges
  - Consider A-8 adjustment vs. Non-Reimbursable cost centers
  - Physician compensation – make sure Part A time and costs are captured
  - Exclude non-hospital charges from Worksheet C
3. Total costs and total days drive inpatient reimbursement. Are they accurate?
4. RCCs drive outpatient reimbursement. Do they all make sense?

# TOP 10 List

## Action Items/Key Takeaways...

5. Review cost report settlements timely so that appeals and re-openings can be filed, when needed.
6. Identify issues to protest to preserve your appeal rights.
7. Ensure your PS&R and internal reports are updated timely and are complete.
8. Make sure your pandemic revenue is identified on G-3 line 24.5.
9. Rural Health Clinics (RHC's) – Know your new cap.
10. Tricare and other payors – ensure contracts are at 101% of cost.

# About TPR...

Third Party Reimbursement (TPR) Solutions, LLC provides advisory services to hospitals and health systems on a local and national level. Specifically, our company offers advisory services that focus on Hospital Medicare and Medicaid reimbursement and regulatory issues. The key to our success is a balance between our deep industry expertise and relationships, in conjunction with our superior client service model. TPR's business philosophy is simple and straightforward:

***"To provide proactive and creative solutions that address our clients reimbursement needs and to develop deep relationships within our client organizations thus becoming a trusted advisor for all their Hospital reimbursement needs."***

# About TPR...

- ✓ TPR has offices in New York, New Jersey, Pennsylvania, North Carolina, Georgia, Florida, Texas, Tennessee and Missouri.
- ✓ TPR's management team averages over 27 years of consulting, Big 4, hospital, and intermediary experience addressing the following issues:

- Reimbursement & Finance Functions
- Cost Report Preparation, Review, Adjustments, Appeals, Re-openings
- Medical Education & Allied Health
- Disproportionate Share & UCP
- Wage Index, Geographic Reclasses, Occupational Mix
- Bad Debts
- CAH/Rural/RRC/SCH Strategies
- New York State (NYS) Medicaid and Indigent Care Pools
- Provider Consolidations
- Mergers and Acquisitions
- Health Care Reform Act (HCRA) audits and monitoring
- Hospital-based status

# THANK YOU!

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