Advanced Level – Hospital Financial Affairs

Presenter

Deborah Whitley

Partner- FORVIS

July 2022

Today's Goals

- Revenue Sources to help you better understand how you get paid for services
- Importance of Revenue Cycle Process to Hospital Collection Efforts
- Major Healthcare Hot Topics
  - Medicaid 1115 Waiver
  - Pricing Transparency
  - Provider Relief Funds

Health Care Finance Challenges

- Health care finances are certainly different than many industries
  - What other industry willingly accepts 20 to 30% of a bill…and is happy?
- Some unique aspects of health care finance
  - Highly regulated by government
  - Very capital intensive
  - Low margins
  - Challenge to balance community benefits with need to remain financially viable

How did COVID impact Healthcare Challenges?

Statements of Operations and Changes in Net Assets

	2021	2020
Operating Revenues		
Patient service revenue	$ 10,000,000	$ 8,000,000
Other	1,000,000	600,000
Total operating revenues	11,000,000	8,600,000
Operating Expenses		
Salaries and wages	6,000,000	5,000,000
Employee benefits	500,000	400,000
Purchased services and professional fees	3,000,000	2,400,000
Supplies and other	3,500,000	2,300,000
Depreciation and amortization	400,000	275,000
Interest	25,000	20,000
Total operating expenses	13,425,000	10,395,000
Operating Income (Loss)	(2,425,000)	(1,795,000)
Nonoperating Revenues (Expenses)		
Property taxes	2,000,000	1,800,000
Contribution revenue- (Provider Relief Funds)	3,300,000	200,000
Gain on extinguishment of debt (PPP Loan Forgiven)	750,000	-
Total nonoperating revenues	6,050,000	2,000,000
Change in Net Assets	$ 3,625,000	$ 205,000

INCOME PERSPECTIVE (000 OMITTED)

	FY21
Increase in net position	$ 3,625
Less - PPP loan forgiveness	(750)
Less - Provider Relief Funds	(3,300)
Net before Government Support	$ (425)
Less - Property Tax Revenues	(2,000)
Adjusted Net Income	(2,425)

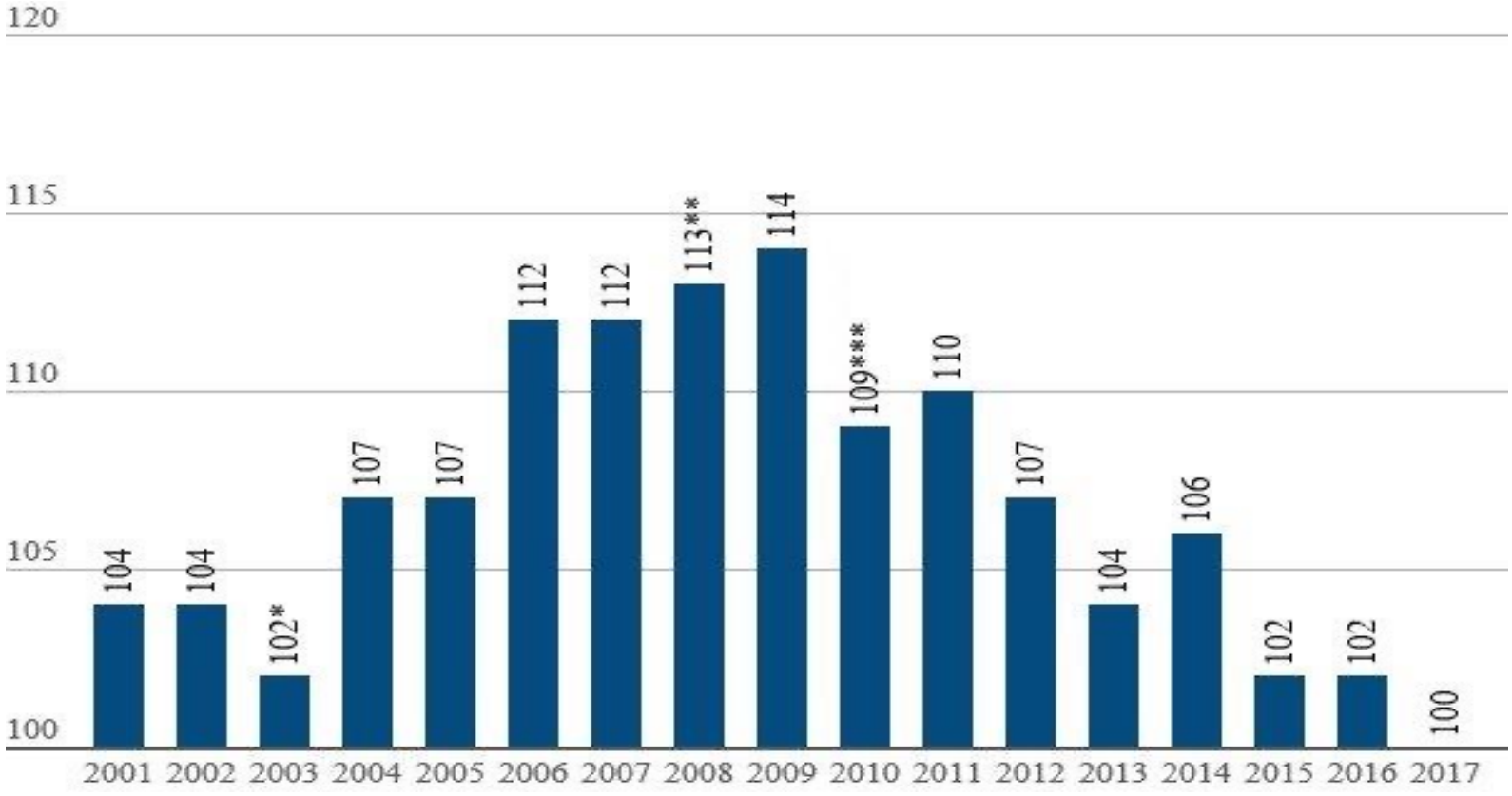
Net Patient Service Revenue

- Understanding this income statement line is often the most difficult
- One of the most “unique” areas of health care
- The challenge
  - ❖ Project how many patients will “choose” not to pay you
  - ❖ Estimate Insurance payments
  - ❖ Forecast denials and unexpected financial class changes
- This is an educated estimate supported by analysis

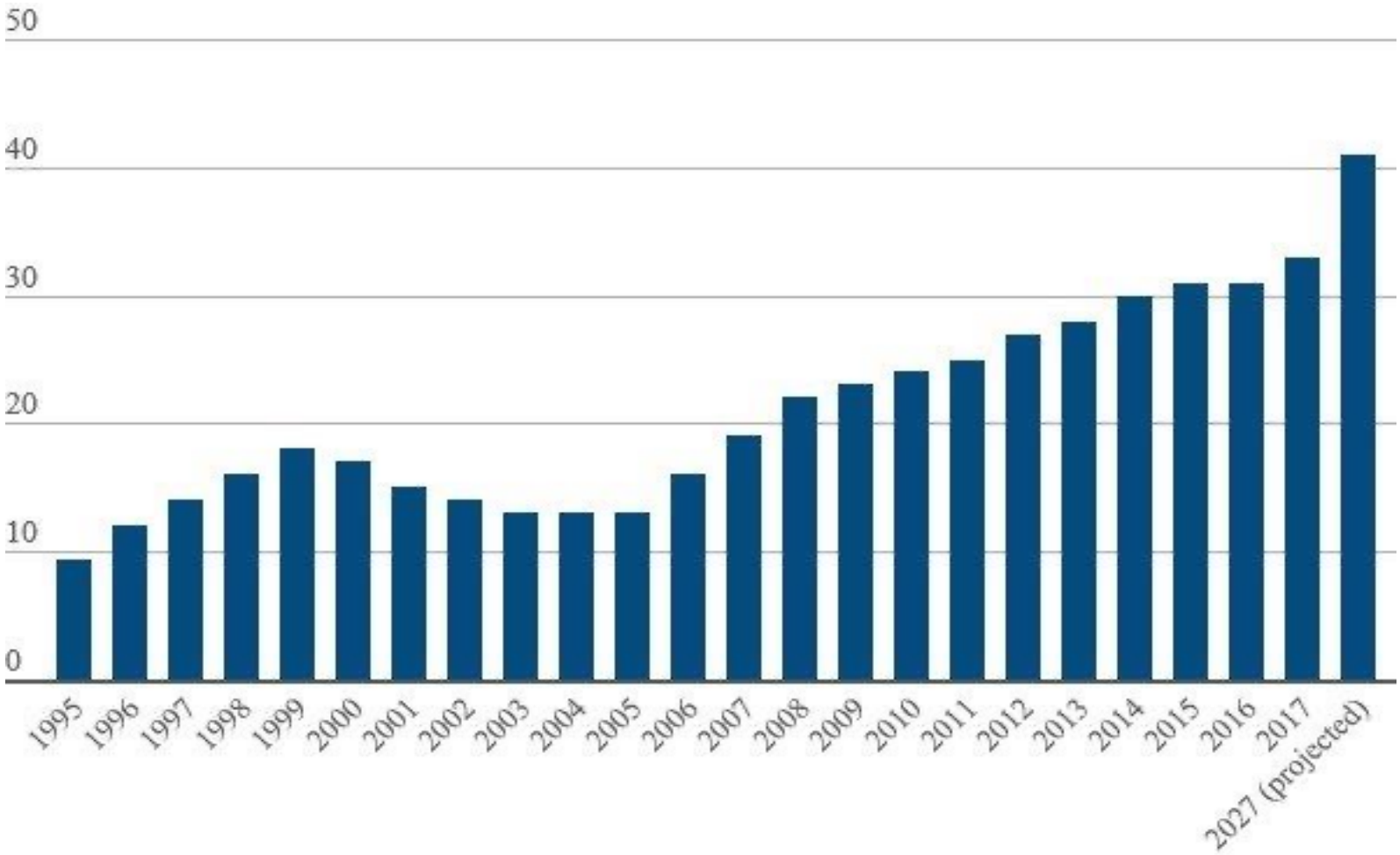
NPSR Key Terms

- Gross Charges
  - The “full” charge of a provider
  - Based on data in the Charge Description Master (CDM)
- Contractual Adjustments
  - The difference in the Gross Charge and the amount a provider has contractually agreed to accept
  - Providers cannot attempt to collect this difference
  - Most often associated with Medicare, Medicaid and managed care/commercial insurance payers
- Bad Debts and Charity
  - Amounts that a provider is allowed to collect but cannot or does not
  - Charity is usually based on documented indigent status and has little to no collection effort
  - Bad debts occur after substantial collection effort

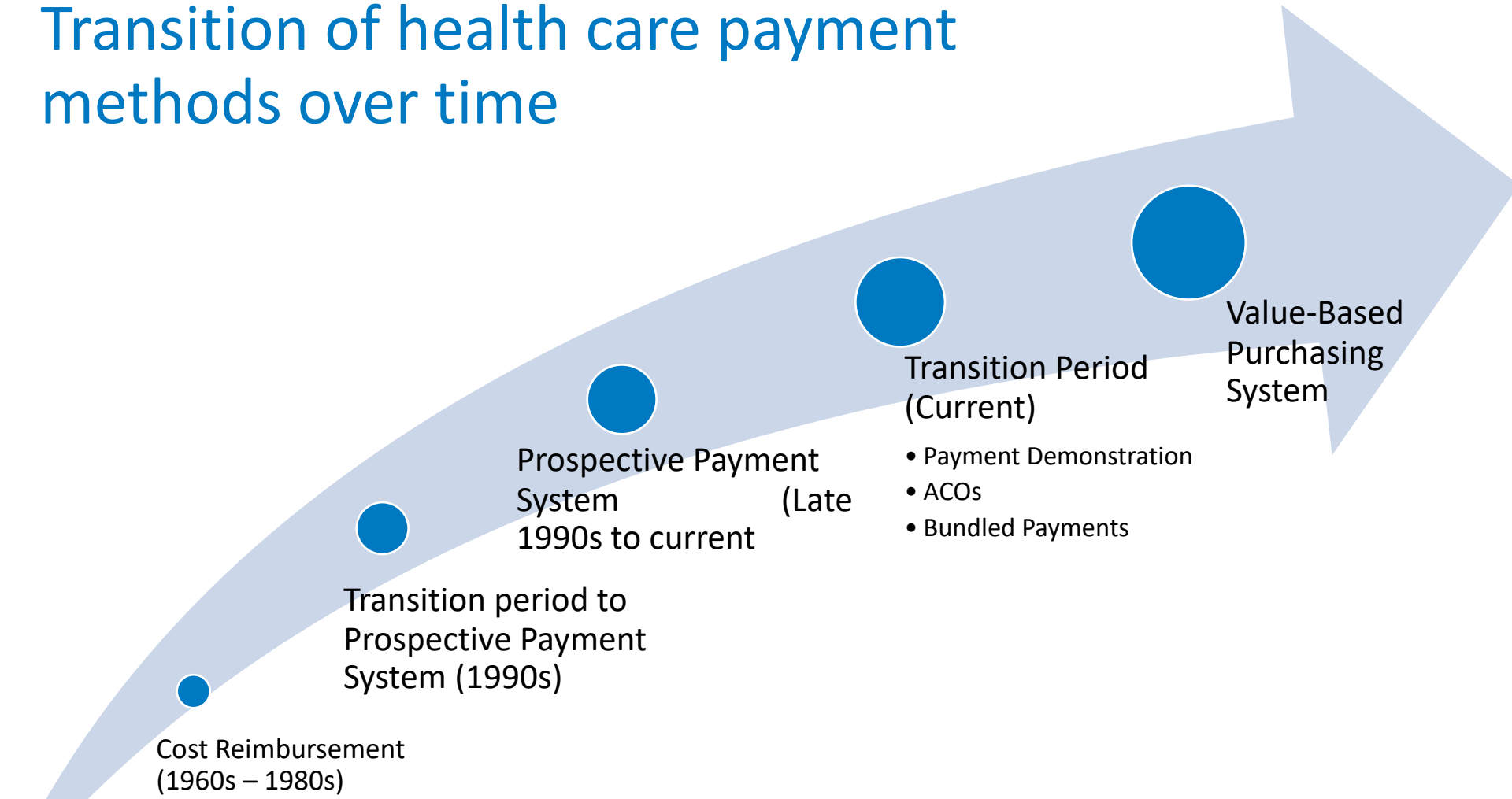
Medicare Private Plan Payments Relative to Traditional Medicare Spending



Medicare Private Plan Penetration (%)



Transition of health care payment methods over time

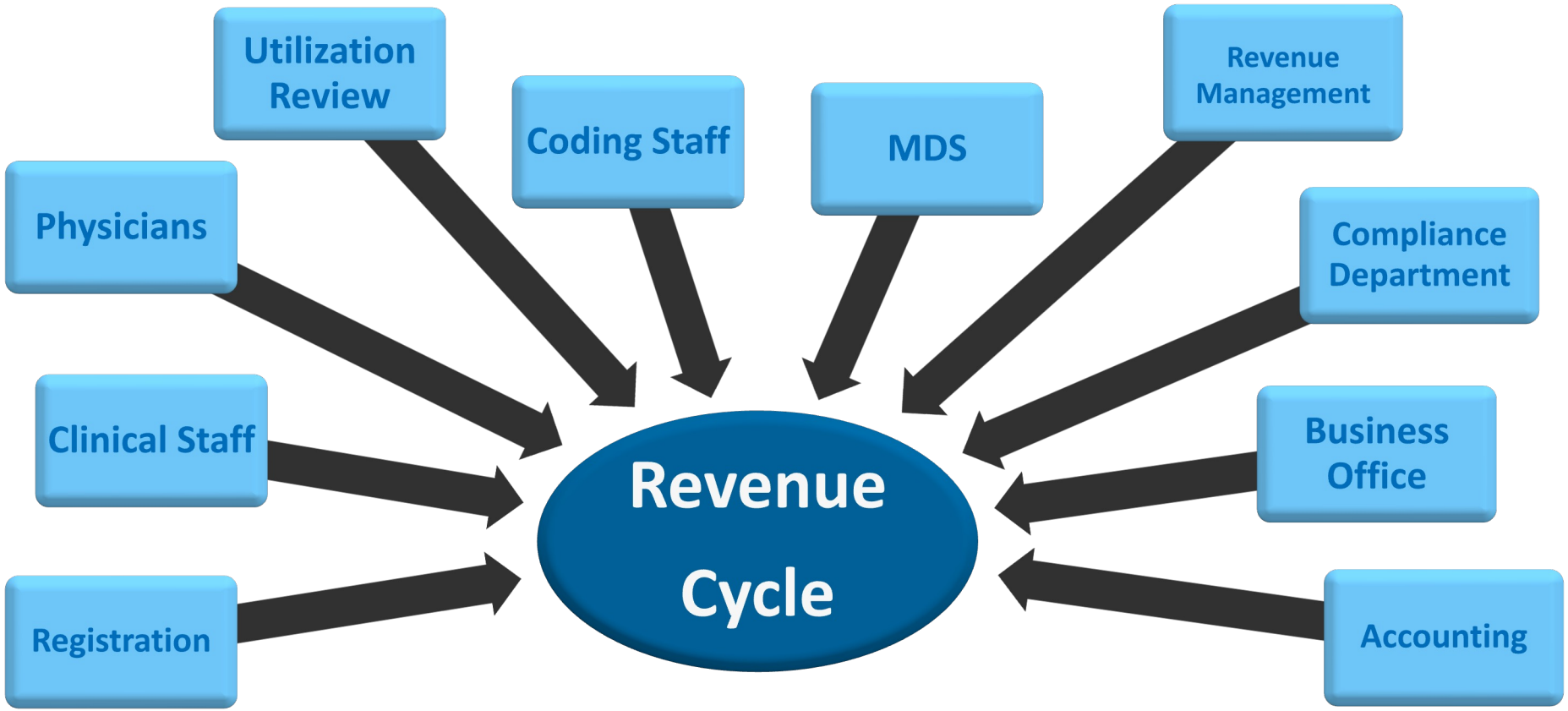


What is the Revenue Cycle?

- Fundamentals –
  - Charges
  - Cash

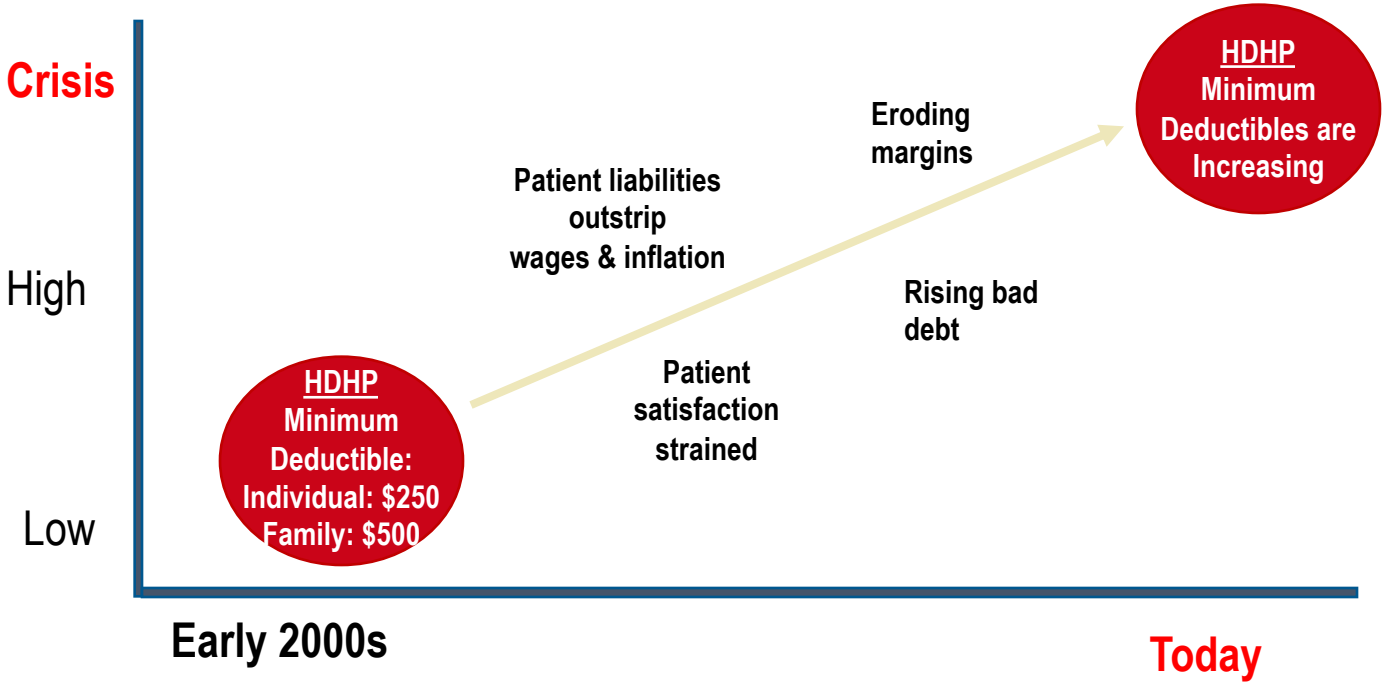
- Revenue Cycle is a combination of processes whose end result is cash (net revenue)

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



GROWTH OF PATIENT LIABILITY EXPOSURE ERODES MARGINS

Minimum deductibles in High Deductible Health Plans (HDHPs) have grown exponentially creating a patient liability crisis.
Patients may never actually meet their high deductible which assures patient liability collection risk for providers.



Key Performance Indicators (KPIs)

Revenue Cycle

Initiative	Hospital X	HBI 2021 Average	HBI 2021 Top Quartile
Front			
Point-of-Service Collections as a % of Net Revenue	0.01%	0.7%	0.9%
Clean Claim Rate	69.6%	> 85.0%	> 85.0%
Back			
Gross Days in AR	58.6	46.8 Days	42.2 Days
Insurance Billed AR > 90 Days	28.9%	22.3%	17.9%
Self Pay AR > 90 Days	61.1%	48.7%	43.2%
Denial Write-Offs as a % of Gross Revenue	3.8%	0.6%	0.2%
Denial Write-Offs as a % of Net Revenue	2.7%	1.7%	0.8%

Point-of-Service Collections

Revenue Cycle

Point-of- Service Collections	Total
Point-of-Service Collections	$4,353
Net Revenue	$34,998,190
Point-of-Service Collections as a % of Net Revenue	0.01%
Average - Point-of-Service Collections as a % Net Revenue	0.70%
Top Quartile - Point-of-Service Collections as a % Net Revenue	0.90%
Opportunity Estimation	
Increase in Point-of-Service Collections to average - 0.7%	241,000
Increase in Point-of-Service Collections to top quartile - 0.9%	311,000

AR Management: Hospital AR

Revenue Cycle

Primary Financial Class	Unbilled AR	Billed AR Days from Discharge					Total AR [1]	% of AR	% of AR 90+ Days
		0-60	61-90	91-180	181-364	365+			
Medicare	$599,465	$3,315,764	$159,824	$371,502	$194,645	-$68,741	$4,572,460	39.5%	10.9%
Managed Care	$111,159	$1,451,092	$400,045	$726,172	$362,021	$249,298	$3,299,788	28.5%	40.5%
Medicaid	$124,547	$1,662,024	$71,997	$60,424	$31,537	$3,237	$1,953,766	16.9%	4.9%
Self-Pay	$38,052	$459,943	$209,720	$350,856	$104,508	$144,913	$1,307,992	11.3%	45.9%
Commercial	$39,935	$229,639	$39,326	$48,695	$11,573	-$7,360	$361,808	3.1%	14.6%
Other	$0	$1,042	-$517	$12,681	$68,228	$4,398	$85,832	0.7%	99.4%
Total AR $	**$913,158**	**$7,119,504**	**$880,395**	**$1,570,330**	**$772,513**	**$325,745**	**$11,581,645**		**23.0%**
% of Total AR $	**7.9%**	**61.5%**	**7.6%**	**13.6%**	**6.7%**	**2.8%**	**100.0%**		
Days in AR	**3.8**	**29.9**	**3.7**	**6.6**	**3.2**	**1.4**	**48.6**		

Financial Class	Unbilled AR	Billed AR Days from Discharge					Total AR	% of AR	% of AR 90+ Days
		0-60	61-90	91-180	181-364	365+			
Self-Pay	$38,052	$459,943	$209,720	$350,856	$104,508	$144,913	$1,307,992	11.3%	45.9%
Self Pay after Insurance [2]	$0	$248,126	$197,730	$420,685	$117,719	$67,463	$1,051,723	9.1%	57.6%

Denial Write-offs

Revenue Cycle

Denial Types	Net Annualized Denials
Total Net Denial Writeoffs	$530,628
No Authorization	$220,536
No Timely Filing	$177,391
Non-Covered	$84,997
Medical Necessity	$42,961
Other	$4,743

Net Opportunity	No Authorization	No Timely Filing	Non-Covered	Medical Necessity	Other	Total
10% Reduction	$22,000	$18,000	$8,000	$4,000	$0	$52,000
20% Reduction	$44,000	$35,000	$17,000	$9,000	$1,000	$106,000
30% Reduction	$66,000	$53,000	$25,000	$13,000	$1,000	$158,000

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

Industry Environment at a Glance

- Health Care Spending
- Politics/ Government Regulations
- Competition
- Consumerism
- Patient Care
- Innovation

1115 Waiver Update

Medicaid 1115 Waiver Update

- New letter Dated April 22, 2022 stating CMS is withdrawing the April 16, 2021 letter that terminates the approval of the extension of the Waiver.
- It says the Waiver will be approved and extended based on January 15, 2021 letter.
- UHRIP/ CHIRP are claims based payments and getting clean Medicaid MCO claims are critical to getting paid the enhanced rates.

Medicaid Supplemental Programs

1. **MD DSH & Uncompensated Care**
2. DSHRIP- $0 Remaining
3. QIPP- Nursing Home Program
4. UHRIP- Medicaid Enhancement Rates applied to Claims submitted
5. CHIRP- New - Comprehensive Hospital Increase Program – effective 9-1-2021
6. TIPPS - New - Texas Incentives for Physicians & Professional Services –effective 9-1-2021
7. RAPPS –New –Rural Access to Primary and Preventive Services – effective 9-1-2021
8. Ambulance Average Commercial Reimbursement
9. Behavioral Health Services

Compliance Requirement

- CMS's ***Provider Reimbursement Manual (PRM)*** 15-1 Section 2313.E requires physicians to substantiate their time between Part A non-patient care administrative duties versus Part B patient care
- Federal Fiscal Year 2021 Inpatient Prospective Payment System federal register further reinforced the expectations of a time study
- And CMS further discussed the expectations for time studies when releasing guidance on the COVID-19 PHE

TIME STUDIES IMPACT EVERYONE

- Texas Medicaid 1115 Waiver Uncompensated Care
  - Schedule 1 Costs
  - Large & Small, Urban & Rural, CAH & PPS
- Prior Demonstration Years
  - Different data accepted
  - Proxies, Attestation Letters, etc.
  - Possibly more lenient on data accepted
- Current Demonstration Years
  - Contract language are cues to auditors for time study requirement
  - Seen more disallowed in recent audit/reconciliations than ever before

Pricing Transparency and No Surprises Act

CY 2022 OPPS Final Rule Update

In the CY 2022 OPPS Final Rule, CMS finalized several hospital price transparency policies to further encourage compliance.

The most notable change to the price transparency requirement is an increase to the amount of the monetary penalty for noncompliance using a scaling factor based on hospital bed count. While the previous civil monetary penalty for noncompliance did not exceed $300 per day for any hospital, the updated penalty, effective January 1, 2022, is $10 per day per hospital bed for hospitals with more than 30 beds, which would increase penalties up to $5,500 per day for a hospital with more than 550 beds.

Number of Beds	Penalty Applied per Day	Total Full-Year Penalty
30 or fewer	$300 per hospital	$109,500 per hospital
31 up to 550	$310–$5,500 per hospital (number of beds * $10)	$113,150–$2,007,500 per hospital
More than 550	$5,500 per hospital	$2,007,500 per hospital

Source: CMS CY 2022 OPPS Final Rule

CMS Price Transparency Final Rule

Effective January 1, 2021 - Two primary requirements to publicize standard charges

1 COMPREHENSIVE MACHINE-READABLE FILE

A comprehensive single machine-readable file that makes public all standard charge information for all items & services provided by the hospital

Five Standard Charges

1. Gross charges
2. Payor-specific negotiated charges
3. Discounted cash prices
4. De-identified minimum negotiated charge
5. De-identified maximum negotiated charge

2 CONSUMER-FRIENDLY SHOPPABLE SERVICES

A consumer-friendly list of 'standard charges' for 300 (70 CMS-specified + 230 hospital-selected) "shoppable" services provided by the hospital

Additional Considerations

- Hospitals must group primary shoppable service with ancillary services, *e.g.*, laboratory, radiology, drugs, room & board charges, employed professional charges, etc., customarily provided by hospital
- Hospitals can meet shoppable services requirement by offering an **internet-based price estimator** if the tool meets specific requirements

Health Plan Price Transparency

On October 29, 2020, CMS issued a final rule requiring health plans to make an online price transparency tool that provides cost sharing & other information available to their members

- January 1, 2022- health plans required to make publicly available 3 standardized & regularly updated data files
- January 1, 2023- health plans required to offer an online shopping tool allowing consumers to see the negotiated rate between their provider & their plan and personalized estimate of their out-of-pocket (OOP) cost for 500 of the most shoppable items & services
- January 1, 2024- shopping tools will be required to show the OOP costs for the remaining procedures, drugs, DME and any other items or service the consumer may need

No Surprises Act Overview

- What: No Surprises Act (NSA) was enacted as part of the Consolidated Appropriations Act 2021
- When: Effective date – January 1, 2022
- Why: The NSA rule protects individuals from surprise medical bills

1) Protects consumers from bills resulting from Out-of-Network Emergency care services

2) Protects consumers from bills resulting from Non Emergent care provided by Out-of-Network providers at In-Network facilities

3) Requires both providers and insurance companies to hold patients harmless for anything beyond the In-Network costs

Provider Relief Funds

Reporting Requirements

Portal opens for reporting July 1, 2021

Organizations that received funds prior to June 30, 2020, must report by September 30, 2021

Organizations that received funds after June 30, 2020, will be required to wait to report

	Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)	Deadline to Use Funds	Reporting Time Period
Period 1	April 10, 2020 – June 30, 2020	June 30, 2021	July 1, 2021 – September 30, 2021
Period 2	July 1, 2020 – December 31, 2020	December 31, 2021	January 1, 2022 – March 31, 2022
Period 3	January 1, 2021 – June 30, 2021	June 30, 2022	July 1, 2022 – September 30, 2022
Period 4	July 1, 2021 – December 31, 2021	December 31, 2022	January 1, 2023 – March 31, 2023

SINGLE AUDIT LOOKING AT:

1) For expenditures:
   a. Are you following controls for the COVID related expenditures?
   b. Is there documentation to support that the expenditure was properly approved and occurred within the covered period?
   c. Is there documentation that supports the approval of expense being claimed as related to COVID (preventing, preparing and responding)
2) For lost revenue:
   a. If using Option 1 – Does the calculation agree to financial results and consider all patient related revenues
   b. If using Option 3 – Does the basis for the calculation used have documentation of consideration of the method used and why it is appropriate? Does the calculation agree to relevant financial results and agree with documented method?
   c. If using Option 2 (which would be rare) – Is there documentation that the budget(s) for the covered periods claimed were approved prior to March 27, 2020? Does the calculation agreed to budget and financial results and consider all patient related revenues.

Summary of Single Audits Due Dates by FYE

FYE	Periods included	Deadline for single audit
6/30/2021	Period 1	9/30/2022
7/31/2021	Period 1	**4/30/2022**
8/31/2021	Period 1	5/31/2022
9/30/2021	Period 1	6/30/2022
10/31/2021	Period 1	7/31/2022
11/30/2021	Period 1	8/31/2022
12/31/2021	Period 1 & Period 2	9/30/2022
1/31/2022	Period 1 & Period 2	10/31/2022
2/28/2022	Period 1 & Period 2	11/30/2022
3/31/2022	Period 1 & Period 2	12/31/2022
4/30/2022	Period 1 & Period 2	1/31/2023
5/31/2022	Period 1 & Period 2	2/28/2023

Summary

- Revenue Sources and Revenue Cycle Process
- Medicaid 1115 Waiver
- Pricing Transparency
- Provider Relief Funds

Questions and Answers

Deborah Whitley– FORVIS

Deborah.Whitley@forvis.com

254.776.8244