Strategies for Success

Health Care NEWS

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Vol. 23, No. 2
August 2005

CMS releases FY 2006 proposed SNF PPS rule

by Monte Aspelmeier, Springfield,
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CMS announced its FY 2006 proposed SNF PPS rule May 16, and some changes may prove significant.

Under Medicare's current SNF PPS, providers are paid a per-diem rate based on the assessed medical and rehabilitative needs of Medicare-eligible beneficiaries.

This inclusive rate covers room, board, nursing services, therapies, drugs, laboratory services and some medical supplies.

CMS says SNF PPS funding for 2006 will basically be the same as 2005; however, it is also considering the elimination of critical assessment criteria, which could significantly reduce the number of beneficiaries who qualify for Medicare Part A skilled nursing services.

Following is a summary of proposed rule changes and how they could affect your SNF.

RUG III classification groups expanded

One of the more significant proposed rule changes is to increase the number of RUG III classification groups from 44 to 53, which will account for the costs of certain medically complex patients who require rehabilitation services, as well as multiple treatments for many illnesses or comorbidities.

The expanded classification groups go into effect January 1, 2006. The current system will remain in place for the first three months of FY 2006 (October 1 to December 31, 2005).

The nine new proposed classifications would combine Rehabilitation and Extensive Services with higher payments than those for beneficiaries who currently receive one of those services.

The new classifications include:

- **RUX** Rehabilitation Ultra High plus Extensive Services High
- **RUL** Rehabilitation Ultra High plus Extensive Services Low
- **RVX** Rehabilitation Very High plus Extensive Services High
- **RVL** Rehabilitation Very High plus Extensive Services Low
- **RHX** Rehabilitation High plus Extensive Services High
- **RHL** Rehabilitation High plus Extensive Services Low
- **RMX** Rehabilitation Medium plus Extensive Services High
- **RML** Rehabilitation Medium plus Extensive Services Low

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Inpatient PPS proposed rule includes major CAH provision

by Tim Wolters, Springfield
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The inpatient fiscal 2006 PPS proposed rule published in the May 4, 2005, **Federal Register** includes significant inpatient policy issues for PPS hospitals. It also includes a major policy move for CAHs that wish to rebuild.

The proposed basic inpatient payment rate increase is 3.2% (2.8% for hospitals not submitting required quality data).

Wage index/labor market issues

The labor share of the payment rate will be 62% of the total for hospitals with a wage index less than or equal to 1.

For those with a wage index greater than 1, the labor share is reduced to 69.7% compared to 71.1% in fiscal 2005. CMS proposes to retain a 10% occupational mix adjustment to the wage index.

CMS will fully implement the

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Manage your product, not productivity

by Karen Vance, Springfield,
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Webster defines productivity as "producing goods and services that have exchange value," which should make productivity easier for an organization to measure. In practice, however, many HHAs still struggle to measure and manage it.

Productivity then & now

Before the switch to Medicare PPS, the HHA product was the visit. In today's Medicare-certified home health, the unit of service with exchange value is the 60-day episode.

Under this system, the episode's outcome becomes the product, yet the health care industry remains focused on the visit.

If productivity is the ability to achieve an outcome efficiently, then can the real HHA product be measured by simply counting visits? Further, how does a manager define his/her own productivity?

To redefine a product, you must redefine productivity: All HHA resources (costs) add value to the product (outcome). This definition encompasses every HHA cost, including management.

Therefore, with efficient resource use, a productive manager can guide staff to advance patients toward targeted outcomes.

Managing the product

The unique position clinical managers have is to manage an episode's clinical and financial outcomes while there is still an opportunity to affect both.

An episode management model can help determine if an episode must be managed because of clinical complexity or financial risk.

Successful models depend on managers who, instead of controlling visit utilization, encourage creative and efficient ways to reach targeted outcomes. This model improves staff satisfaction by eliciting clinical reasoning.

Model protocols prompt staff to consider whether the following tactics are used to advance the patient toward targeted outcomes.

To help make the most progress during each visit:

- ▲ Use best-practice protocols
- ▲ Have patient/caregiver participate in plan of care

To help make the most progress between visits:

- ▲ Use teamwork and care coordination
- ▲ Increase patient/caregiver's ownership in health management

Episode management documentation allows clinical managers to view both the patient's progress and the resources used, information that supports critical decisions about whether an episode requires additional management.

Collected data can paint a picture of the HHA's financial outcomes by providing utilization statistics:

- ▲ Average payment per episode
- ▲ Average number of visits per episode
- ▲ Average cost per episode
- ▲ Average margin per episode

These numbers are the true dashboard indicators of your HHA's financial performance with Medicare patients.

Productivity models

A productivity model that provides inherent incentives for episode efficiency can help HHAs stay focused on product management.

Successful HHAs have been able to shift their focus from visits to episodes by basing productivity standards on episodes and by encouraging staff to use resources efficiently to increase the number of episodes.

Productivity standards in any form assume employees are willing to comply with such expectations, but clinical managers must still monitor and manage employee time vs. managing episodes.

Paying exempt staff by the visit eliminates the need for productivity standards and—with the proper per-visit formula—is the most efficient way for HHAs to pay only for productive time.

This increases the clinical manager's productivity because it reduces time spent monitoring staff and allows closer scrutiny of episode management.

On the other hand, paying staff by the visit is the ultimate incen-

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Health Care News glossary

ALOS – average length of stay
ARD – assessment reference date
CAH – critical access hospital
CBSA – core-based statistical area
CCI – Correct Coding Initiative
CDM – charge description master
CMS – Centers for Medicare & Medicaid Services
CMHC – community mental health center
CPT /HCPCS codes - current procedural terminology/health care common procedure coding system codes
CT – computerized tomography
DRG – diagnostic-related group
FI – fiscal intermediary
FQHC – federally qualified health center
FTE – full-time equivalent
FY – fiscal year
GAO – General Accounting Office
HHA – home health agency
HIM – health information management
ICD-9-CM – International Classification of Diseases, Ninth Revision, Clinical Modification
IPPS – inpatient prospective payment system
IRF – inpatient rehab facility
IRS – Internal Revenue Service
LCD – local coverage determination
LOS – length of stay
LTC – long-term care
MDS – minimum data set
MedPAC – Medicare Payment Advisory Commission
MMA – *Medicare Modernization Act of 2003*
MSA – metropolitan statistical area
NPI – National Provider Identifier
OCE – Outpatient Code Editor
OIG – Office of Inspector General
OPO – organ procurement organization
OPPS – outpatient prospective payment system
PPS – prospective payment system
RHC – rural health clinic
RUG – resource utilization group
SNF – skilled nursing facility

OIG reports on Medicare post-acute care transfer policy

by Alyssa Dykstra, Louisville, adykstra@bkd.com

An April OIG report reviewed how hospitals complied with Medicare's post-acute care transfer policy for fiscal years 2001 and 2002 and found significant compliance issues that prompted recommendations for further audits and payment recoveries.

The 2006 Medicare IPPS proposed rule reflects a potentially significant increase in the number of DRGs subject to the policy.

What post-acute care transfer policy states

Medicare's post-acute care transfer policy states PPS hospitals that transfer patients under specific DRGs to certain post-acute settings receive a per-diem rate (not to exceed the full DRG payment) rather than the full DRG payment.

Currently, 30 DRGs are subject to the policy. The 2006 proposed rules would increase this number to 231 DRGs.

The policy's post-acute care settings include:

- SNFs (excluding swing bed)
- PPS excluded hospitals, *e.g.*, IRFs, cancer hospitals, psychiatric hospitals, children's hospitals and LTC hospitals
- Home health care, which starts within three days of discharge

OIG report

OIG's **Review of Hospital Compliance with Medicare's Post-acute Care Transfer Policy During Fiscal Years 2001 and 2002** examined 400 claims subject to the policy.

The report found 381 claims were incorrectly coded as if the patient had been discharged to the home, when in fact they were discharged to a setting subject to the transfer policy.

The overpayment for these claims totaled $1,034,588. (Estimated overpayments for the universe of claims reached $72.4 million.)

Of the 381 miscoded claims, the highest number (232 claims) involved patients who received home health services after discharge. The claims were miscoded as discharges to home instead of transfers to home health services within three days of discharge.

CMS plans to implement several OIG suggestions to combat this problem:

- Instruct FIs to recover the $1,034,588 in overpayments from the sample claims
- Monitor hospitals that have a high number of adjusted claims related to recently implemented system edits
- Develop a strategy to identify and collect overpayments

Rationale

OIG conducted an extensive analysis of the Medicare Provider Analysis and Review (MedPAR) data for fiscal years 2003 and 2004 to monitor the effects of the policy.

OIG outlined several findings:

- An increase in post-acute care utilization did not necessarily mean a decrease in the geometric mean length of stay (LOS)
- The percentage of post-acute care transfer cases for the current 30 DRGs ranged from 15%-76%
- Among DRGs not currently included in the policy, many had a high percentage of post-acute transfer cases

In light of these findings, OIG reviewed all DRG data. Of the 550 DRGs present, 319 were ruled out as potential post-acute care transfer DRGs because they were deactivated, had no cases on file, had a geometric mean LOS less than three days or were short-stay transfer cases.

This left 231 DRGs for possible inclusion in the policy. These DRGs had three common characteristics:

- At least 2,000 total post-acute care transfer cases
- At least 20% of all cases in the DRG were discharged to post-acute care
- At least 10% of all discharges to post-acute care were before the geometric mean LOS for the DRG

Based on this rationale, OIG believes it appropriate to consider major revisions to the criteria used to include a DRG within the policy.

Recommended actions

Review your charts to assess the accuracy of the discharge disposition codes. Initiate staff education and process improvement as warranted.

It is imperative to assess case management's role in monitoring and managing the policy. With intense focus on managing LOS, it is reasonable that some patients may be transferred prematurely, affecting both patient and financial outcomes.

Educate physicians—who ultimately control the discharges—and redesign processes so they promote positive patient outcomes first and the appropriate revenue to the provider second.

Summary

Ineffective management of the post-acute care transfer policy can result in decreased net revenue and increased compliance risk.

The April 2005 OIG report outlines the extraordinary frequency with which compliance issues are occurring.

As the policy potentially expands, CMS and hospitals will both be focused on compliance.

Contact your BKD Health Care Group advisor for assistance in both effectively managing this transfer policy and meeting compliance.❑

BKD Health Care Group Writers' Bureau

Article	Author	Publication	Date
"Keeping Clean for Compliance"	**Larry Fogel**, **Joe Watt**, Kansas City	**Healthcare Financial Management**	June 2005

CMS releases FY 2006. . .

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▲ **RLX** Rehabilitation Low plus Extensive Services

Each new RUG category will require a minimum activities-of-daily-living (ADL) score of 7 or higher. CMS also invites comments about proposed changes to the **Minimum Data Set Manual**.

SNF payment reductions offset by payment increases

CMS proposes to amend the current RUG III system by removing the existing 6.7% and 20% add-ons beginning January 1, 2006, a change that could reduce SNF payments by approximately $1.02 billion.

However, beginning January 1, 2006, CMS wants to increase the nursing case-mix weight for all 53 RUG groups by 8.4%, which will permanently increase RUG payments almost 3%. This increase will be in effect from January 1 to September 30, 2006, and CMS estimates a $510 million increase in SNF payments.

Starting October 1, 2005, CMS also proposes a full market-basket increase of 3%, which it estimates would increase total SNF PPS payments by another $510 million.

On the whole for FY 2006, CMS estimates "an exact offset" for the net effect of removing the current add-ons and the increases in the market-basket update and nursing case-mix adjustments.

These proposed rates would apply to hospital swing-bed programs other than those operated by CAHs. Swing beds in CAH settings will be paid on a reasonable-cost basis.

In addition, the proposed rule retains the 128% adjustment for SNF residents with AIDS, enacted under the MMA.

Finally, the proposed rule adopts CBSAs as the means to classify providers as urban or rural, using 2000 census data.

Thus, some SNFs previously classified as rural will now be considered urban and vice versa. Table A in the proposed rule includes a crosswalk of changes in wage index values by county.

Changes could affect SNF PPS revenues

Proposed changes in three areas could have a significant impact on facility SNF PPS revenues.

If implemented, these changes would generally have a negative impact on SNFs. In addition, they would cause confusion and require training of SNF staff.

Following are the areas in question:

Look back - CMS has asked for comments on removing the look-back period from the MDS. CMS states, "… analysis indicates that the use of the look-back provision has caused a significant number of residents to classify to the Extensive Services category based solely on services (such as intravenous medications) furnished exclusively during the period before SNF admission."

With the elimination of the look-back period, SNFs will see fewer beneficiaries who qualify for Extensive Services unless facilities are able to admit and care for patients while they still require critical nursing care, *e.g.*, IV medications, IV feeding, suctioning, tracheostomy care, etc., and still exhibit symptoms, such as fevers 2.4 degrees above baseline, vomiting, ADL Index scores above 7, etc.

Eliminate or decrease the grace-day period specifically for the five-day PPS MDS assessment - CMS is considering doing the same for all PPS MDS assessments.

The impact of this proposal may be more powerful when applied to the five-day assessment when beneficiaries are admitted just before a weekend when fewer highly skilled nursing and rehabilitative staff are available to initiate critical services.

For example, if a SNF's rehabilitation staff is unavailable to begin therapies on day one and does not start them until after the weekend, the SNF potentially has only two days to set the ARD and capture enough rehabilitation minutes to place the beneficiary in an appropriate RUG category for the next 14 days.

As a result, the SNF could be underpaid until the next 14-day assessment. The consequences will be more significant if CMS decides to implement the next PPS MDS proposal.

Eliminate projecting anticipated therapy services during the five-day PPS assessment - In the scenario above, SNFs would be required to provide 150 minutes of therapy in two days to meet the criteria for a beneficiary to qualify for Rehabilitation Medium.

However, it is unclear how the requirement of "at least five days across three disciplines" will apply when the SNF has a maximum of only five days to set the ARD.

Should observation count toward three-day requirement?

CMS has asked for comments about another important issue: Should time spent in observation count toward the qualifying three-day hospital stay requirement.

According to CMS, "…the care furnished during observation may be indistinguishable from the inpatient care that follows the formal admission, so that the beneficiaries themselves often learn of the differences only after they were transferred to the SNF and failed to meet the SNF benefit's prior hospital stay requirement." Potentially, this proposed change would be positive for SNFs.

Bottom-line impact

How could changes to the proposed rules affect your SNF's bottom line? In its March 2005 report, MedPAC estimates 2005 profit margins for freestanding SNFs will be 13%.

However, in its May 16 announcement ("Proposed Nursing Home Payment Reforms Increase Accuracy, Predictability of Payment") CMS states it, "… expects refinements in the SNF PPS to still result in positive operating margins on nursing home Medicare business of around 10% next year."

CMS does not explain why there is a 3% predicted difference, with similar projected funding amounts.

A copy of the SNF PPS proposed rule for FY 2006 is available at CMS's web site: **cms.hhs.gov/providers/snfpps**.

Also at its web site are the FY 2006 proposed wage index and crosswalk tables for MSAs and CBSAs: **cms.hhs.gov/providers/snfpps/cms-1282-p-addendum.pdf**.

* * *

The final rule will be published in August. Contact your BKD Health Care Group advisor for more information about how these complex proposed rules could affect you.❑

IRFs may see payment increase when proposed rules finalized

by John Britt, Louisville, jbritt@bkd.com

Inpatient rehab facilities (IRFs) may receive a 2.9% payment increase in 2006 because of a market basket update, adjustments for coding changes and changes to the outlier threshold, according to CMS's May 25, 2005, proposed rule.

If finalized, these changes would represent a $180 million increase in payments compared to 2005. The proposed changes include:

- A 1.9% reduction in the standard payment amount (all facilities)
- A market basket increase of 3.1%
- An increase in the rural payment rate adjustment from 19.1% to 24.1%
- A reduction to the outlier threshold for cases with unusually high costs
- The adoption of the revised core-based statistical area (CBSA) market area definitions

In the wake of the recently published GAO report (April 2005), IRF providers may struggle to meet the census levels they have historically experienced.

CMS has announced it will proceed with the implementation of the classification criteria for IRFs, which lifts the suspension on the enforcement of the rule. Thus, providers can expect increased scrutiny from their FIs.

To "add insult to injury," some FIs have published draft or final local coverage determinations (LCDs) for IRFs, which, in essence, question the medical necessity of a:

- Single fractured hip
- Single knee replacement
- Single hip replacement
- Single lower extremity amputation

Providers should analyze their level of compliance with the classification criteria and ensure there is a defined plan to meet the threshold on a go-forward basis.

Providers should also review their FI's documented position (LCD or other documentation) to determine if they are at risk for medical necessity denials for these patients who have traditionally been routinely approved for IRF services in the past.

There is an expectation that some IRF distinct-part unit providers will not be able to support a viable census under these external forces.

Based on these forces, providers should analyze their market position and determine how they will be able to meet their patient's rehab needs in the future and stay in business.

These intense regulations do not obviate the need for rehab services; however, providers should assess how they may be able to meet their patients' needs across their continuum.

* * *

Contact your BKD Health Care Group advisor for help analyzing your level of compliance with the classification criteria. We can help you develop a plan for meeting the threshold on a go-forward basis.❑

In brief

NPI makes multiple identifiers obsolete - Beginning May 23, 2005, providers may apply for the National Provider Identifier (NPI), the single provider identifier that replaces the different identifiers physicians and facilities currently use for each health plan they do business with.

Access the application at **nppes.cms.hhs.gov** and use one of three methods to submit it:

- Electronically through the web site
- Download, and mail a hard copy
- With provider permission, a professional organization or health care provider that is your employer can submit an electronic file containing your provider information along with other health care providers.

  We do not recommend this option because it is the responsibility of the submitting entity to make any and all changes to information on file.

  Ask yourself, "Should I depend on someone else to make changes to this important information on a timely basis?"

The benefit of early application is providers will be ready when Medicare and commercial health plans indicate implementation (no later than May 23, 2007). Explicit instructions will be issued in 2006.

Check with your software vendor to be sure the software you currently use will accommodate the new NPI.

New due date for electronic cost report submission - RHCs, FQHCs, CMHCs and OPOs will be required to submit their Medicare cost reports electronically for cost reporting periods ending on or after March 31, 2005.

Hospices and end-stage renal disease facilities had to begin filing their cost reports electronically for cost reporting periods ending on or after December 31, 2004.

Cost reports are due five months after year end. For the first two cost reporting periods subject to electronic filing, a hard copy of the cost report also must be submitted.❑

Monitoring charge master & charge capture critical to success

by Deborah McDaniel, Wichita, dmcdaniel@bkd.com

A significant consideration in compliance and reimbursement is the hospital charge description master (CDM).

Form CDM team to address CMS updates

The data it contains includes information insurance payers and patients receive on the UB-92 claim.

For example, an outpatient receives a CT scan of the head. In addition to other pertinent data required for billing to payers, the claim also should include:

- ▲ A description of the CT scan of the head
- ▲ The charge for the procedure
- ▲ A five-digit code representing the specific CT scan provided
- ▲ A revenue code to appropriately map to the Medicare cost report
- ▲ The date of service

If any of the above information is inaccurate or incomplete, it could have a direct impact on the hospital's billing compliance, reimbursement and cash flows.

CMS routinely publishes updates that affect the CDMs of both CAHs and hospitals paid under the outpatient prospective payment system (OPPS). These changes often require changes to their charge capture and billing processes.

Hospitals should consider forming a CDM team to address CMS updates, claim denial patterns, the addition of new CDM items and department charging questions.

The CDM team should represent ancillary departments, health information management (HIM), the business and finance offices and administration.

To facilitate effective front-end processes, have ancillary department managers maintain CDM line items representing services from their departments in coordination with key contacts in the HIM department and business office.

Document CDM updates with audit trail

Use a CDM coordinator to update the CDM in the hospital's information system (IS). To centralize the process, limit access and keep an audit trail of all CDM changes.

The audit trail can be a CDM maintenance form, e-mail communication or an online module that includes:

- ▲ Who initiated the change
- ▲ The reason it was made
- ▲ What CDM changes were requested
- ▲ When the updates were applied to the CDM
- ▲ When they were checked for accuracy
- ▲ Signatures of all staff members who approved and completed each step

The information above is retained for future reference by the appropriate department in the event clarification is needed for a particular CDM line item.

Assess charge capture process to avoid errors

Unfortunately, even when the CDM is complete and accurate, the accuracy of a claim is often dictated by the process used by department or business office personnel to select and enter CDM charges.

This process is commonly known as charge capture and includes elements from the following operational areas:

- ▲ Method of transmitting/communicating physician orders
- ▲ Scheduling of procedures
- ▲ Charge master maintenance
- ▲ Charging tools, *e.g.*, charge sheets, requisition forms and/or order-entry screens
- ▲ Internal transfer of charge information
- ▲ ICD-9-CM code assignment and transmission
- ▲ CPT/HCPCS coding from charge master and HIM coding staff
- ▲ Billing
- ▲ Claims transmission reports, including CCI and OCE edit messages
- ▲ Denial management

Common findings from a charge capture assessment include:

- ▲ Discrepancies between the charging tools and CDM data
- ▲ Inconsistencies between the charge codes entered by various departmental divisions
- ▲ Lack of charge verification checks by department management
- ▲ Insufficient information regarding the service ordered, *e.g.*, procedure specifications, CT with or without contrast
- ▲ Insufficient understanding of appropriate and/or complete procedure charges
- ▲ IS gaps that translate into compliance concerns and improper reimbursement

The CDM team should develop and implement processes to address these types of findings.

What OIG recommends

OIG recommends having the CDM and charge capture process periodically reviewed by external auditors who are knowledgeable of hospital operations and familiar with federal health care program requirements.

An annual CDM review is an investment in your hospital's future success with compliance and reimbursement.

For more information, contact your BKD Health Care Group advisor. ❑

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IRS focuses on key executive compensation

by Gary Garwitz, Springfield,
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Congress and the IRS have become increasingly concerned about perceived the tax-exempt arena and are focusing more attention and more resources to examine tax-exempt organizations.

In 2006, to help it determine the extent of its examinations, the IRS will ask such organizations to answer a detailed questionnaire about key executive compensation.

The best approach for tax-exempt organizations is to create a "rebuttable presumption" that compensation is reasonable.

Clearing rebuttable presumption hurdles

While many organizations have taken steps to determine the reasonableness of executive compensation, they still may not clear the rebuttable presumption hurdle created by intermediate sanction regulations.

The hurdles you must clear to establish a rebuttable presumption include:

- ▲ Has compensation been approved by the board of directors or a board committee without the disqualified person participating?
- ▲ Has the board relied on "appropriate comparability data" provided by an independent party, such as a compensation survey or appraisal?
- ▲ Has the board included documentation concurrently with the minutes approving the compensation?
- ▲ Careful documentation is required as to the reliance on the documentation, the reasonableness of total compensation and how the board reviews this, either on an annual or expiration-of-contract basis.

In addition to salary, the questionnaire asks for details of any perks or fringe benefits, including:

- ▲ Awards and bonuses
- ▲ Club memberships
- ▲ Company vehicles
- ▲ Corporate credit cards
- ▲ Athletic skyboxes or entertainment suites
- ▲ Executive dining rooms

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Inpatient PPS proposed. . .

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CBSA labor market areas for wage index purposes after a 50/50 hold harmless blend used in fiscal 2005.

The three-year transition for urban hospitals that become rural will continue in fiscal 2006 and 2007.

Proposed post-acute transfer policy expansion

CMS proposes a major expansion of the post-acute care transfer policy (see "OIG Reports on Medicare Post-acute Care Transfer Policy," page 3).

CMS estimates this expansion will result in a 1.1% decrease in DRG payments for the average hospital and also increase the number of DRGs subject to the policy from 30 to 231.

CMS appears to have ignored the statutory language that transfer DRGs must have a disproportionate use of post-discharge services.

Medical education

CMS clarifies that a former rural hospital that qualified for an FTE cap increase will be able to retain this increase if it becomes urban because of CMS's implementation of CBSAs.

However, a hospital that reclassifies from urban to rural under Section 1886(d)(8)(E) of the *Social Security Act of 1935*—and subsequently receives an increase in its FTE cap for indirect medical education reimbursement—would lose additional FTE slots if it rescinds its rural reclassification.

Disproportionate share

As required under Section 951 of MMA, CMS will begin making Supplemental Security Income patient data available for hospital cost reporting periods that include December 8, 2004.

Hospitals will be able to verify such data, possibly to improve their disproportionate share reimbursement. A subsequent **Federal Register** notice will furnish details on data usage.

As to verifying Medicaid data, CMS notes such data is available from individual states on a voluntary basis. For states that don't make it available, CMS will consider modifying state plans to require the data be made available to hospitals.

CAH relocation

A hospital's ability to become a CAH based on a state designation of the facility as a necessary provider expires January 1, 2006.

CMS proposes if a CAH builds a new facility, it may potentially have to requalify as a CAH at the new location.

For hospitals that achieve CAH status based on a state designation, the result may be that the new facility does not qualify as a CAH, forcing it to return to PPS reimbursement.

CMS proposes a CAH can retain its status if the new facility is within 250 yards of the current building or on land contiguous to the current CAH and is owned by the CAH before December 8, 2003, the date the MMA was effective.

A CAH can also retain its status if it can document it undertook construction plans for the new facility before December 8, 2003.

In addition, the new facility must serve at least 75% of the same service area and provide at least 75% of the same services with at least 75% of the same staff.

The above December 8, 2003, dates are problematic and will prevent many CAHs from being able to rebuild in the future unless they have adequate space on their current campuses.

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There are numerous other proposed changes not summarized above. For more information about their impact on your operations, contact your BKD Health Care Group advisor.❑

IRS focuses on key executive. . .

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- Loans
- Outplacement services
- Qualified employee discounts
- Life insurance for employee or spouse
- Relocation expenses
- Employer-paid vacations and spousal or dependent travel
- Wealth management
- Retirement plans (both qualified and nonqualified)
- Other fringe-benefit plans

Penalties for noncompliance can be severe and are based on excess benefits; they can go up to 200% of the transaction.

In addition to penalties assessed against the organization, they also can be assessed against any key executives, board members and personnel from management or administration who were involved in the transaction.

Documentation is key

While many organizations make an effort to determine the reasonableness of executive compensation, they may not have the documentation to create a strong defense.

Steps tax-exempt entities can take to strengthen documentation:

- Become familiar with the rules on intermediate sanctions and the rebuttable presumption
- Document how the board has attempted to comply with the rules
- Because it is available to the public, review in detail the annual Form 990; it is often the first source of questions from the IRS, attorneys and the media

The tax rules and the annual Form 990 change often. Be sure your organization is attempting to comply with the often-changing rules.

* * *

Contact your BKD Health Care Group or tax advisor for assistance with compliance or for more information about rebuttable presumption hurdles and how to clear them.❑

Manage product. . .

continued from page 2. . .

tive for increasing visits, so this payment methodology must include an episode management model that manages outcomes and monitors the number of visits per episode.

With close scrutiny and control of the product, the incentive for staff to increase their personal income will only add new episodes to both their caseloads and to the HHA.

Marketing visits included in the per-visit payment structure empower staff to add agency volume. Increasing episode volume adds to HHA profitability when the episodes are managed appropriately.

Product, not productivity

HHA success depends on knowing and managing the true product.

In concert with a per-visit payment structure, an episode management model properly focuses on clinical and financial outcomes by managing all resources so they add value to the product.

Contact your BKD Health Care Group advisor for assistance in developing an episode management model for your HHA.❑

BKD Health Care Group Speakers' Bureau

Topic	Speaker/Office	Seminar	Location & Date
RHC Cost Reports & CAH Reimbursement Issues	**John Sheehan**, St. Louis, **Tim Wolters**, Springfield	NRHA - Critical Access Hospital Conference	Kansas City 10/4 - 10/7

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