



## How PFS changes will affect reimbursement



by Phil Brummel, [pbrummel@bkd.com](mailto:pbrummel@bkd.com)

Once again, Congress froze the payment rate for physician services in December under the *Tax Relief and Health Care Act of 2006* (TRHCA), averting the scheduled 5% reduction. However, the final physician fee schedule (PFS) contains several other changes that will affect your Medicare reimbursement and will likely affect your practice in other areas as well.

This article focuses primarily on changes surrounding the relative value unit (RVU) tables, which will affect the largest population of

the physician community. (See page 2 sidebar “Determining Your Reimbursement Under PFS Methodology.”)

### Other concerns have impact

As a result of TRHCA’s changes to RVUs and the PFS, an obvious concern is to analyze

its direct impact on your Medicare reimbursement; however, there also are other concerns that may be more difficult to identify, including contracts with non-Medicare payors, internal standard fees, physician compensation and practice benchmarking:

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## CMS proposes major DRG revisions

by Tim Wolters, [twolters@bkd.com](mailto:twolters@bkd.com)

In the May 3, 2007, **Federal Register**, CMS proposes the most dramatic restructuring of the diagnosis-related groups (DRGs) used in the inpatient prospective payment system (IPPS) since its inception.

Restructuring (adjusting DRG weights based on the severity of a patient’s condition) would take effect October 1, 2007. Access the proposed rule at [bkd.com/050307proposedrule.pdf](http://bkd.com/050307proposedrule.pdf). In mid-May, CMS published slight corrections to the proposed DRG weights and payment rates.

- DRG 291 – with MCC
- DRG 292 – with CC
- DRG 293 – without CC/MCC

The following compares the total standard operating and capital payment for the old DRG in fiscal year (FY) 2007 and the new MS-DRGs in FY 2008:

DRG Number	Weight	Payment Amount
DRG 127	1.0490	\$5,561.29
MS-DRG 291	1.4760	\$7,875.07
MS-DRG 292	1.0169	\$5,425.58
MS-DRG 293	0.7265	\$3,876.18

The wide variation between the weights for the MS-DRGs demonstrates the significant impact the proposed MS-DRG system could have on hospitals. While the overall impact is intended to be budget neutral, CMS estimates urban hospitals will experience a 0.2% increase in payments because of the MS-DRG system and the transition to cost-based DRG weights, with a 1.8% decrease expected for rural hospitals.

For the impact table by individual hospital, visit [bkd.com/ipsimpact.xls](http://bkd.com/ipsimpact.xls). A crosswalk between the old DRG system and new MS-DRG system is available at [bkd.com/crosswalk.xls](http://bkd.com/crosswalk.xls).

In a controversial proposal, CMS plans to reduce the standardized payment amount 2.4%

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### MS-DRG restructuring

The proposal would replace the current 538 DRGs with 745 Medicare Severity DRGs (MS-DRGs). First, current DRGs would be consolidated to 335 base MS-DRGs. Of these, 106 would be split into two subgroups, and 152 would be split into three subgroups, arriving at 745 total MS-DRGs.

Subgroups would be determined based on the presence of complications or comorbidities (CCs) or major CCs (MCCs). Table 6J in the proposed rule lists 1,389 secondary diagnoses designated as MCCs. Table 6K lists 2,913 secondary diagnoses designated as CCs.

An example of the MS-DRG restructuring would be current DRG 127, Heart Failure & Shock, which would be split into the following three MS-DRGs:

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**Medicare reimbursement** - Certainly, all practices should perform a comparative analysis to understand the anticipated increase or decrease in Medicare reimbursement resulting from the changes in the RVU tables and, accordingly, the PFS.

Generally, the top 20 to 30 codes based on the amount of previous year Medicare reimbursement, provide a sufficient population to analyze.

Download both the RVU and geographic practice cost index (GPCI) tables from the CMS web site: [cms.hhs.gov](http://cms.hhs.gov). The PFS for your geographic area may be available from your carrier, and, in some cases, annual practice management software updates may already include the updated RVUs and PFS.

**Payor contracts** - With payor contracts, it's important to understand each payor's basis for establishing reimbursement for your services. In many cases, the basis may be RVUs or it

may contain other relationships to the Medicare PFS. If you find this is the case, clarify the specifics as you enter negotiations for the new contract year and ask the following:

- Does the contract specify an RVU table?
- Does the fee schedule apply the GPCI to the RVUs?
- Are the 2006 or 2007 RVU tables being used? If 2007 tables are used –
  - ✓ Does the fee schedule reflect “fully implemented” or “transitional” practice expense RVUs?
  - ✓ Does the fee schedule apply the budget neutrality adjustor to “work RVUs”?

**Internal standard fee schedule** - We recommend physician practices continually monitor their internal standard fees for services. The importance of this process is magnified when there are significant changes to reimbursement amounts from various payors.

Changes to Medicare reimbursement often cause changes in the reimbursement from other payors. Compare your actual reimbursement on explanation of benefits (EOBs) to payor fee schedules—if they exist—to ensure reimbursement matches your contract.

In addition, compare the actual reimbursement for each payor to your standard internal fee. Generally, payors will reimburse the lesser of your standard fee or their fee schedule. If you receive 100%, assess whether there is reasonable support to increase your standard fee for that specific service.

**Physician compensation** - The degree to which the above changes will affect physician compensation depends on the compensation design for your group: Is compensation primarily based on production or straight salary? Even in the case of straight salary, it is presumed there is an acceptable relationship between revenue generated by physicians and compensation.

## Determining your reimbursement under PFS methodology

To determine how changes in the Medicare physician fee schedule (PFS) may affect your practice, have a basic understanding of the methodology CMS uses to reimburse physicians for their services. The following is a brief refresher of PFS and the relative value unit (RVU).

Since 1992, the basis for Medicare reimbursement for physician services has been national uniform RVUs. Total RVUs consist of three components:

- Physician work component
- Practice expense (PE) component
- Malpractice expense component

CMS assigns RVUs to each service (CPT/HCPCS code) for each component, based on surveys and analysis of actual practice data. The fee for each service is calculated by multiplying total RVUs by a conversion factor (CF), which was scheduled for a 5% decrease but, thanks to TRHCA, remains at \$37.8975 for 2007.

To complicate the calculation even more, the national RVU is adjusted by geographic practice cost indices (GPCI) for each state or locality, so each of the three components is assigned a separate GPCI. And, starting in 2007, CMS implemented a budget neutrality (BN) adjustor that only applies to “work RVUs.” For 2007, the BN adjustor is 0.8994.

Today, the formula for calculating total RVU looks like this:

$$\begin{aligned} &\text{Work RVU} \times \text{Work GPCI} \times \text{BN Adjustor} \\ &\text{Plus: PE RVU} \times \text{PE GPCI} \\ &\text{Plus: Malpractice RVU} \times \text{Malpractice GPCI} \\ &\text{Equals: Total RVU} \end{aligned}$$

Multiplying total RVU times the 2007 CF (\$37.8975) yields the reimbursement amount for each service provided.

For 2007, CMS significantly modified both practice expense RVUs and work RVUs. Practice expense RVUs were changed as a result of revisions to the methodology used to analyze practice expense data.

Because of the magnitude of the changes, CMS decided to transition the new practice expense RVUs into the fee schedule over four years, from 2007 to 2010. Accordingly, the RVU tables published by CMS contain “2007 Fully Implemented Practice Expense RVUs,” as well as “2007 Transitional Practice Expense RVUs.”

Work RVUs were changed as a result of a scheduled five-year review. The revised work RVUs place a much heavier emphasis on evaluation and management (E&M) services.

Because several E&M services are high volume, the projected national increase in CMS's payments to physicians (based on the revised work RVUs) would have exceeded budgetary constraints as prescribed by law. Therefore, the budget neutrality adjustor was established. ■

Do the changes in reimbursement skew that relationship? It's possible the change in RVUs may cause revenue to increase or decrease even though physicians' work levels remain substantially unchanged. Should such changes in revenue result in corresponding changes in compensation?

For practices where compensation is predominantly production based, what is the measure of production? If you use total RVUs or work RVUs, there may be significant swings in compensation that may potentially cause compensation disparities between physicians within the group. Disparities are based on variances in the types of services provided to patients, particularly if the group is comprised of multiple specialties.

As noted above, non-Medicare payors also may or may not adopt the revised RVU tables. Changes in production-based compensation may increase at a higher rate than revenue. Further, if your compensation design is based on RVUs, you may want to clarify exactly which tables to use, *i.e.*, fully implemented vs. transitional, and whether the work RVU is modified by the budget neutrality adjustor.

**Benchmarks** - Most practices use nationally or regionally published survey data to benchmark productivity, compensation and operations. The inherent concern with survey data is it's always one to two years old by the time it's published. We believe the changes to RVU tables may potentially have a significant impact on data used in such surveys.

As an integral part of your practice assessment, continue to compare your numbers to industry benchmarks; however, over the next couple of years, use extra caution when measuring your practice against historical survey reports.

The TRHCA contains numerous other provisions unrelated to RVUs. Find further explanation on CMS's web site or the web sites of various professional organizations, *e.g.*, the Medical Group Management Association at [mgma.com](http://mgma.com).

### **PQRI could affect all providers**

Also worthy of immediate discussion is the TRHCA-authorized physician quality reporting system CMS is to establish. The statutory program, titled the Physician Quality Reporting

Initiative (PQRI), provides a financial incentive for eligible professionals to participate in a voluntary quality reporting program and could affect virtually all providers of medical services.

Eligible professionals who successfully report a designated set of quality measures may earn a bonus payment (subject to a cap) of 1.5% of total allowed charges for covered Medicare physician fee schedule services.

It is important to note the data must be reported via CPT designations on claims with dates of service from **July 1 to December 31, 2007**. The 2007 PQRI expands and replaces the 2006 Physician Voluntary Reporting Program (PVRP), which was implemented as the first step toward pay for performance for physician practices. The 2007 PQRI not only adds the incentive of the 1.5% bonus, it also increases the number of performance measures from 16 to 74.

Determine which of the 74 performance measures are applicable to eligible professionals in your practice, then report on at least three of those measures. (In general, eligible professionals include physicians, midlevel providers and therapists who provide services to Medicare patients.)

Also, note that, although you may want to decrease provider and support staff work load, you may not be able to simply choose measures for low-volume services because you may then be subject to the cap. Further, to meet the requirements for achieving the bonus, multi-specialty practices may need to choose different measures for each specialty.

This program is still voluntary, but we believe the amount of the incentive is significant enough that every practice should, at a minimum, spend the time to investigate the cost and benefits of participating in the PQRI.

For a more complete understanding, investigate the PQRI at CMS's web site at [cms.hhs.gov/PQRI](http://cms.hhs.gov/PQRI), which includes in-



formative, frequently asked questions (FAQs) from other physician practices, as well as the following:

- PQRI overview
- Statute/regulations/program instructions
- Eligible professionals
- Measures/codes
- Reporting analysis and payment
- Educational resources
- 2008 PQRI information
- Transition from Physician Voluntary Reporting Program (PVRP)

### **RVU-related issues**

RVU-related issues can be very complicated. The narrow focus of this article does not touch on all potential concerns; however, as the provisions of the 2007 Medicare PFS continue to be implemented, consider their impact on RVUs:

- Understand RVUs and how they are used in calculating the Medicare PFS
- Evaluate the direct impact Medicare PFS changes will have on your Medicare reimbursement
- Consider how revisions to the RVU tables will affect reimbursement from non-Medicare payors and in negotiating new contracts with them
- Monitor internal standard fee schedules in relation to changes in the RVU tables
- Assess whether the changes in the RVU tables and Medicare PFS will cause unexpected disparities in physician compensation based on your current compensation design
- Exercise caution when benchmarking your practice against survey data that was collected before the RVU changes were implemented
- Investigate requirements for participating in the 2007 Physician Quality Reporting Initiative ■

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in FY 2008 and again in 2009 due to anticipated improvements in hospital documentation and coding under the new system. The overall estimated 4.8% reduction is based on observations CMS made about the change in coding experienced by Maryland hospitals when they implemented a severity-adjusted DRG system several years ago.

While CMS proposes to move forward with the MS-DRG system, it notes the Rand Corporation has been evaluating five alternative systems for recognizing severity of illness. CMS has requested the MS-DRG system also be evaluated in Rand's final report, due September 1.

## Additional payment & cost report changes proposed

Before considering the impact of the MS-DRG system, CMS proposes an overall 3.3% market basket inflation update to operating DRG rates.

In another controversial move, CMS proposes to freeze capital DRG rates for urban hospitals, eliminate the 3.0% large urban add-on and allow only a 0.8% update for rural hospital capital DRG rates.

Because CMS believes the MS-DRG system will improve the accuracy of coding and reduce the number of outlier cases, it proposes to reduce the outlier fixed-loss threshold from \$24,485 to \$22,940. CMS estimates this will keep total outlier payments close to its goal of 5.1% of overall IPPS payments.

CMS does propose to continue the three-year transition to cost-based DRG weights it began last year. CMS commissioned RTI International to study ways of improving the accuracy of cost information by DRG.

Based on the study and CMS's analysis, CMS plans to revise the hospital Medicare cost report, which may include additional cost centers, *e.g.*, devices, implants and prosthetics; computed tomography (CT) scanning; magnetic resonance imaging (MRI); and intermediate nursing units that provide care above basic acute care but below intensive care.

## Hospital-acquired conditions

The *Deficit Reduction Act of 2006* (DRA) required CMS to identify at least two hospital-acquired conditions that result in higher DRG payments. By October 1, 2007, hospitals will

have to document whether these conditions are present on admission. By October 1, 2008, CMS must provide that hospitals' DRG payments cannot be increased if the condition occurred after admission.

CMS describes 13 different hospital-acquired conditions and proposes six be implemented to comply with this DRA provision:

- Catheter-associated urinary tract infections
- Pressure ulcers
- Object left in surgery
- Air embolism
- Blood incompatibility
- Staphylococcus aureus septicemia

## Wage index issues

The fiscal 2008 wage index will include data from both occupational mix surveys hospitals completed for the first six months of 2006. Expiring September 30, 2007, is the three-year transition to a rural wage index provided to hospitals that became rural under new census definitions implemented in 2004.

CMS briefly addresses the wage index provision of the *Tax Relief and Health Care Act of 2006* (TRHCA) that requires the Medicare Payment Advisory Commission (MedPAC) to issue a report by June 30, 2007, about the current wage index system and proposed revisions.

CMS is expected to publish "one or more" proposed revisions to the hospital wage index next year as part of its fiscal 2009 IPPS proposed rule. Testimony at recent MedPAC meetings has centered on the possibility of using employer data from the Bureau of Labor Statistics to develop county-level wage index factors.

## Specialty hospitals

The proposed moves to MS-DRGs and cost-based DRG weights are both partially intended to address concerns raised by industry groups and others about the impact specialty hospitals have on community hospitals.

CMS proposes additional disclosure requirements that, while applicable to all hospitals, may primarily affect specialty hospitals. First, CMS proposes all patients be notified on admission of any physician ownership of the hospital. The physician owners must disclose in writing their ownership interest to all patients they refer to the hospital. Second, hos-



pitals that do not have physicians present around the clock must notify all patients on admission about plans to address emergency medical needs at a time when no physician is present.

## Other issues

Six new quality reporting measures have been adopted for fiscal 2008, including the Hospital Consumer Assessment of Health Providers and Systems Hospital Survey (HCAHPS). Hospitals must file notification of intent by August 15, 2007, to participate in the fiscal 2008 quality reporting and must collect HCAHPS data starting with July 2007 discharges.

CMS proposes to revise the computation of full-time equivalent interns and residents to exclude vacation and sick leave from both the numerator and denominator, effective with cost reporting periods beginning on or after October 1, 2007.

Under certain circumstances, urban hospitals can elect to be treated as rural hospitals. Current regulations state such hospitals can revoke their rural election, effective at the start of their next cost reporting period; they must provide notice to the CMS regional office not less than 120 days before the end of the current cost reporting period.

For PPS hospitals, CMS proposes such notice be required not less than 120 days before the end of the federal fiscal year and after being paid as rural for at least one 12-month cost reporting period. The revocation would be effective October 1, the start of the next federal fiscal year.

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The proposed rule contains numerous other provisions not recapped here. Contact your BKD Health Care Group advisor for information on how the proposed rule will affect your operations and Medicare reimbursement. ■

## In Brief

### Other recent inpatient rules

CMS recently released the final long-term care hospital (LTCH) and inpatient psychiatric facility (IPF) rules effective July 1, 2007, as well as proposed rules for skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). Following is a brief summary of each of these rules.

**LTCH final rule** - The May 11, 2007, **Federal Register** included updates to the LTCH PPS rates, effective July 1, 2007. CMS believes recent case-mix changes are due to improved coding by LTCHs rather than actual changes in patient acuity.

Due to perceived coding improvements, CMS is implementing outlier policy changes, as well as a reduced payment update that will result in an estimated decrease of 3.8% in the average LTCH payment rate. The actual DRG classifications will still be updated on October 1, consistent with the update to the acute-care DRG system.

CMS will significantly expand the so-called "25 percent rule" to include both co-located and freestanding hospitals. In general, this rule will limit payments to LTCHs that admit more than 25% of their patients from a single referring hospital. CMS is adopting a three-year transition down to a 25% referral level. Once fully adopted, CMS expects this change to reduce payments to LTCHs \$170 million per year.

Regular IPPS hospitals will be affected by a revision to the requirement that hospitals incur "all or substantially all" of the costs of residents' training in nonhospital settings.

Effective for cost reporting periods beginning on or after July 1, 2007, hospitals must document they incurred at least 90% of the total cost of the residents' salaries and fringe benefits and the portion of the cost of teaching-physicians' salaries attributable to the medical education.

Providers may base teaching-physicians' costs on actual data or on the assumption three hours per week are spent on teaching activities, with compensation based on the national average for physician compensation by specialty area.

**IPF notice** - The May 4, 2007, IPF notice was issued without CMS having issued a proposed rule. IPFs are still in the midst of a transition to the IPF prospective payment system (PPS), with 75% of payments determined prospectively for cost reporting periods beginning in calendar 2007, and 100% determined prospectively for periods beginning in 2008.

CMS sets a 3.3% market basket update to IPF rates effective July 1, 2007. Because the PPS transition was more beneficial to freestanding IPFs, CMS estimates the average IPF will experience a 3.1% increase in payments next year, while hospital-based IPFs will experience only a 1.1% increase.

**SNF proposed rule** - The May 4, 2007, SNF proposed rule would set a 3.3% market basket update to SNF rates effective October 1, 2007. Because the updated wage data would be used to construct the proposed payments, CMS estimates rural SNFs will see an average payment increase of 3.9%, while urban SNFs will see an average payment increase of 3.2%. Comments will be accepted until June 29, 2007.

**IRF proposed rule** - The May 8, 2007, IRF proposed rule would set a 3.3% market basket update to IRF rates effective October 1, 2007. Compliance with the requirement that inpatients fall into one of 13 designated medical conditions will increase from 60% to 65% for cost reporting periods beginning on or after July 1, 2007.

CMS believes IRF outlier payments have been excessive this year, and proposes to increase the outlier threshold from \$5,534 to \$7,522, thereby reducing outlier payments. With wage index and other changes factored in, CMS estimates urban IRFs will see a 2.4% net increase in payments, while rural IRFs will see a 2.6% increase. Comments will be accepted until July 2, 2007.

### CMS to publish NPPES

The long-awaited National Plan & Provider Enumeration System (NPPES) dissemination notice was published in the **Federal Register** May 30, 2007. The NPPES health care provider data—required to be disclosed under the *Freedom of Information Act*—will be made available June 28, 2007. Arriving 30 days after its publication date, the notice describes how NPI data will be shared with health care providers and others who need it to process claims for payment.

Health care providers should review their NPPES data and make any necessary edits or deletions before June 28, 2007, to ensure data disclosed by CMS is accurate. For more information, visit [cms.hhs.gov/NationalProvidentStand/](http://cms.hhs.gov/NationalProvidentStand/). ■

## Refinements planned for home health PPS

by Mark Sharp, [msharp@bkd.com](mailto:msharp@bkd.com)

On April 27, CMS released the long-awaited proposed rule on refinements to the Medicare home health PPS, which includes the most significant changes since its October 2000 implementation.

The proposed rule was published in the May 4, 2007, **Federal Register** (available at [bkd.com/docs/industry/050407proposedrule.pdf](http://bkd.com/docs/industry/050407proposedrule.pdf)). The anticipated implementation date for these refinements is January 1, 2008, after the required comment period and the crafting of the final rule.

### Changes include surprises

While industry leaders have anticipated many of the proposed refinements, there are also some surprises—some good, some not. Key proposed changes include:

- Implementation of three separate therapy thresholds for increased payment at six, 14 and 20 visits to replace the current and controversial 10-visit therapy threshold. These thresholds would be combined with a "smoothing" method, which will increase case-mix weights on a graduated basis for any additional therapy visits between six and 14 and between 14 and 20.

- Refinement of the PPS case-mix model based on a "four-equation" model. This proposed change results from CMS studies showing subsequent episodes of care, on average, are more costly, and patient characteristics predicting resource utilization differ from start-of-care episodes.

Each element from the OASIS assessment factored in determining case-mix weight may result in different case-mix scores within each of the following four equations:

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# Interest rate swaps: understanding business risks

by Tom Watson, [twatson@bkd.com](mailto:twatson@bkd.com)

As few as 10 years ago, it was rare to see a not-for-profit or governmental hospital enter into an interest rate swap agreement (swap). When you found one that had, it was usually a very large and complex health system. Over the last few years, financial advisors and underwriters have approached more and more hospitals about swaps. Today, these instruments have become almost commonplace in the tax-exempt financing arena.

Despite growing use, swaps remain very complex financial vehicles that carry unique business risks and accounting issues. Whether you are contemplating or currently participate in a swap arrangement, there are issues your hospital must understand.

## What is a swap?

A swap is an agreement between an issuer, *i.e.*, a hospital, and a third-party (the counterparty) where the parties agree to exchange certain cash flows. Characteristics of a swap include:

- Little to no up-front payment for entering the agreement
- The ability to “early-settle” the agreement with a cash payment
- An underlying benchmark index measure, *i.e.*, BMA or LIBOR, and a notional amount (typically, the par value of certain series of bonds)

Payments under swap agreements are generally net-settled on a monthly basis. That is, one party pays the other the net difference in the amounts due to or from the other party based on the type of swap agreement.

## Typical swap structures

The two swap structures generally used by health care entities are “variable-to-fixed” agreements and “fixed-to-variable” agreements.

**Variable-to-fixed swaps** - These swaps are used to convert a variable-rate bond issue to a synthetic fixed rate. Under this arrangement, a hospital agrees to pay the counterparty a fixed rate each month and receives a variable rate in exchange.

This structure is used to limit the volatility a hospital faces with variable-rate bonds by “fixing” the amount of cash the hospital pays in in-

terest. Theoretically, the variable-rate payments received from the counterparty will offset the variable interest paid to bond holders.

**Fixed-to-variable swaps** - Fixed-to-variable swaps are somewhat more of a gamble than the variable-to-fixed version. These swaps convert fixed-rate debt to a synthetic variable rate, a structure often used when a hospital has what it perceives to be fixed-rate bonds that accrue interest at above-market rates, and the hospital wants to take advantage of lower variable rates in the bond market.

Under this structure, the hospital continues to pay a fixed rate to its bond holders; however, the hospital receives a fixed-rate payment from the counterparty each interest period and pays a variable rate to the counterparty.

The fixed-rate payments received from the counterparty offset some or all of the interest paid to bond holders, while the hospital hopefully pays a lower net variable-interest rate to the counterparty. A risky aspect to this structure occurs if variable rates increase to the point they exceed the fixed rate paid on the bonds.

## Accounting for swaps

There are two distinct types of accounting for swaps under Statement of Financial Accounting Standards (SFAS) No. 133—hedge and nonhedge accounting. (Note: SFAS 133 does not apply to governmental health care entities electing to only apply SFAS statements issued before November 30, 1989, that do not conflict with Governmental Accounting Standards Board (GASB) pronouncements.)

Under both hedge and nonhedge accounting, the fair value of the future cash flows of the swap is recorded in the hospital's balance sheet.

**Swaps not using hedge accounting** - If a swap does not qualify for hedge accounting, then the changes in these fair values are included in the hospital's performance indicator, or bottom line. These changes can be very significant even with only small changes in market interest rates.

**Swaps using hedge accounting** - If a swap qualifies for hedge accounting, the effective portion of changes in the fair value of the swap agreement are either included outside the bottom line (typical with variable-to-fixed-rate cash flow hedges) or are offset with changes in the fair value of the debt being hedged (typical

with fixed-to-variable fair value hedges.) That is, a swap liability would be offset with a corresponding entry for the change in fair value of long-term debt that was hedged.

Effectiveness can be described as how well the swap works. For example, if a variable-to-fixed swap is designed to make a hospital's net-interest costs 4.5% (after all payments to bond holders and the net payments or receipts from the counterparty), but the payments under the swap actually result in a net-interest cost of 4.6%, the swap is marginally ineffective.

Under SFAS 133, the change in the fair value of the ineffective portion of the swap is included in the bottom line. In general, most well-designed swaps are 95% or more effective, typically resulting in immaterial charges to hospital bottom lines.

## Qualifying for hedge accounting

As discussed, not all swaps qualify for hedge accounting. Though a detailed discussion of hedge accounting requirements is beyond the scope of this article, hospitals must generally document the following at the inception of the swap: (1) the risk being hedged and (2) that the swap is highly effective at inception and is expected to be highly effective over its term and (3) how effectiveness will be tested.

Effectiveness testing is usually based on the behavior of similar swaps in the market. Quarterly testing of the ongoing effectiveness of the swap is usually performed, though another frequency may be acceptable. Hospitals should engage a qualified financial services firm to compute the swap's initial and ongoing effectiveness.

## GASB derivatives project

GASB is considering issuing its own standard on accounting for derivatives, including interest rate swaps. An exposure draft of its proposed standard was issued in 2006 with the proposed standard significantly different than SFAS 133. Governmental hospitals will need to review this new standard for potential changes in how they must account for swaps. GASB is expected to issue a final statement this summer.

## Swaps carry certain risks

Swaps are not without risk. If your hospital is considering entering a swap, the following will help you assess its viability:

**Basis risk** - This is the risk that variable pay-

# & accounting treatment

ments received on one leg of the swap do not match the variable interest paid on another leg. For example, variable-rate bonds may be auctioned each week at market rates, but swap payments may be based on a percentage of LIBOR. There is no guarantee the changes in these two variable rates will match.

**Tax risk** - While tax-exempt bonds currently receive favorable tax treatment, Congress could change their status at any time. Any changes could cause interest rates paid on tax-exempt bonds to increase, but the variable leg of the swap might not reflect this tax change.

For example, consider a variable-rate bond issue that becomes taxable: The rates paid to bond holders would be increased to account for the change in tax code. If payments received from the counterparty are based on a rather common index of 67% of LIBOR, there would likely be a mismatch in the variable rate paid to bond holders and the rates received from the counterparty.

**Credit risk** - Changes in a hospital's credit rating can affect the effectiveness of a swap. For example, if a hospital's credit rating declines over the life of a bond issue, the rates it pays on variable rate bonds could increase. Because the variable rate received on the other leg of the swap is set at inception, the swap could lose its effectiveness.

**Mark-to-market value risk** - Swap market values are computed based on the present value of net payments expected over the life of the swap based on current market rates.

Changes in these mark-to-market amounts can be significant with only small changes in market rates after the swap's inception. If a hospital wants to terminate a swap because of unfavorable market conditions or due to refunding of a bond issue, it may be required to pay a significant amount to the counterparty if market rates moved the wrong direction.

**Counterparty risk** - This involves the counterparty's failure to perform its leg of the swap; to avoid this risk, investigate the counterparty's financial strength before entering into the swap.

**Termination events** - Read swap documents carefully to understand when the counterparty can terminate a swap. For example, some swaps allow the counterparty to terminate a

swap if a hospital is downgraded by a national rating agency.

**Bond document analysis** - Most recent bond agreements are written so gains and losses on hedging transactions such as swaps do not affect covenant compliance. If your hospital has older documents, it may need to consult with bond counsel to make sure mark-to-market adjustments on swaps won't inadvertently cause it to fail a debt service coverage covenant.

**Arbitrage risk** - A swap may affect arbitrage compliance and can complicate arbitrage computations. Issuers of tax-exempt debt should specifically discuss this issue with bond counsel before entering a swap agreement.

## Liquidity agreements

With the increasing use of swaps, it has become more commonplace for hospitals to issue variable-rate debt, which is then synthetically converted to a fixed rate. Because the underlying variable-rate debt theoretically matures each time it is remarketed (usually weekly), a liquidity agreement, such as a letter of credit, is used to secure payment of the bonds in case they don't immediately remarket.

## NPI contingency plan doesn't equate to one-year extension

by Rod Walsh, [rwalsh@bkd.com](mailto:rwalsh@bkd.com)

**A**s a covered entity, if you are noncompliant with NPI rules and do not have a contingency plan in place, your organization is at risk for enforcement action. We recommend you pursue "good faith" efforts at NPI compliance, including:

- Immediately obtain your NPI from the NPPES web site at [nppes.cms.hhs.gov/](http://nppes.cms.hhs.gov/)
- Develop and communicate your status and contingency plans to your trading partners
- Share your NPI with any covered entity that requests it
- Contact health plans to determine (1) their readiness status and contingency plan information and the (2) necessary NPI testing and validation steps

Accounting rules require the presentation of the bond's maturity be based on the terms of the underlying liquidity agreement. As such, it is important that any amounts drawn on the letter of credit not be due until at least one year and one day after a liquidity drawing. Otherwise, the bonds could be considered current liabilities on your financial statements.

A careful review of your hospital's liquidity agreement can prevent this problem or indicate a need to amend the agreement.

\* \* \*

Swaps can be effective tools for managing your hospital's capital activities; however, both the accounting and business risks related to these agreements are very complex. Many unnecessary consequences related to swaps can be avoided if the right questions are asked before the documents are executed.

Contact your BKD Health Care Group advisor for more information if you are considering or have questions about a swap transaction. We can help you understand the risks, so you can balance the advantages of swaps against their business risks. ■

- Begin using the NPI as the primary identifier in HIPAA transactions as early as possible

**Note:** Health plans may discontinue their contingency plan at any time. CMS intends to do so with 60-days' notice once a significant number of claims contain the NPI as the primary identifier.

When a contingency plan is lifted:

- Primary providers (billing, pay-to and rendering providers) must be identified by NPIs, or the claims will be rejected
- All other providers are secondary providers; legacy numbers will be accepted until May 23, 2008

Multiple resources regarding NPI topics and contingency planning are available at [cms.hhs.gov/NationalProvidentStand/](http://cms.hhs.gov/NationalProvidentStand/). ■

# Streamlining the Medicare Part A denial process: what CMS recommends SNFs do

by Monte Aspelmeier, [maspelmeier@bkd.com](mailto:maspelmeier@bkd.com)

Up until a few years ago, CMS had not taken a firm stand on what forms or processes SNFs should use to notify beneficiaries they were ineligible for Medicare Part A benefits or that their Medicare benefits would be reduced or terminated. All that changed on October 1, 2003, when CMS established a beneficiary notification process called, the Beneficiary Notice Initiative (BNI).

## BNI & Beyond

To standardize the benefits denial process, the BNI requires that SNF facilities do the following:

- Establish procedures for notifying beneficiaries, FIs and physicians of noncoverage decisions
- Determine noncoverage for SNF services provided to the beneficiary, if applicable
- Inform the beneficiary of this determination in the manner specified by CMS (though CMS does not require SNFs to use the forms it developed under the BNI process, it strongly recommends they do)

The denial process was expanded in July 2005 when CMS implemented the Expedited Determination/Reviews for Original Medicare (CMS Manual System, Pub 100-04, Transmittal 577). For the first time as part of the review process, a third party—the Quality Improvement Organization (QIO)—would request denial notification documentation provided by the SNF to the beneficiary.

First, the BNI was established, and then the Expedited Determination/Reviews for Original Medicare process was added. Throw in the “home-grown” denial forms and processes already used in facilities, and it’s little wonder why there is so much confusion about what is required and what processes are used, so everyone is aware of the beneficiary’s status for Medicare service eligibility.

Facility administrators must remember the sole purpose of the process is to give beneficiaries the information they need to make their own medical-consent decisions. It also clarifies who is responsible for service payments at each

step of the beneficiary’s medical recovery process.

## What CMS recommends

Based on your facility’s pre-admission assessment information—which you obtain before admitting the beneficiary and providing Medicare Part A or Part B covered services—your facility must determine whether the stay qualifies for Medicare coverage. The first determination of noncoverage is generally made by the SNF:

### *You’ve determined the beneficiary or his/her stay does not meet Medicare requirements -*

If for technical reasons, *e.g.*, not having a qualifying three-day hospital stay, it is determined a resident doesn’t qualify for a Medicare Part A stay, issue the resident the “Notice of Exclusion from Medicare Benefits (NEMB-SNF) Form CMS-20014” before admission.

- In place of the NEMB-SNF, the SNF also may use the letter “SNF Determination on Admission” because the stay technically fails to meet the statutory definition of a Medicare benefit.
- Note CMS allows the use of this form or the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) for the same reasons when notifying residents they do not qualify for Medicare Part A coverage.

### *When a beneficiary’s current Medicare services change -*

- Issue the SNFABN when one of the following changes to Medicare Part A services occurs:

- ✓ **Before initiation of Medicare services** - When your SNF advises residents they will not be accepted as Medicare Part A patients because Medicare will not pay for physician orders, provide the SNFABN before services begin (previously, the “SNF Determination on Admission” form).
- ✓ **Reduction of Part A services** - Your SNF must issue this when it proposes a reduction in either a resident’s nursing care or rehabilitation services because the facility expects Medicare

will not pay (previously, the “SNF Determination on Continued Stay” form).

- ✓ **Termination of services** - Issue this notice when your SNF proposes to stop furnishing all Part A services or items because Medicare may not pay for them (previously, the “SNF Determination on Continued Stay” form).
- The SNFABN is evidence of the resident’s knowledge about the likelihood of Medicare denial of payment for services; it notifies the resident of his/her financial liability for expenses incurred for services and items provided for which Medicare does not pay. Provide the SNFABN along with the Notice of Medicare Provider Non-Coverage (Generic Notice) when the resident remains in your SNF after the Medicare qualified stay has ended.

### *You anticipate the beneficiary’s Medicare coverage will end -*

If you anticipate the resident’s Medicare skilled services will end, and the resident will no longer receive Medicare Part A services, issue the resident the Generic Notice at least 48 hours before the last day Medicare services are provided.

- If the resident believes Medicare services should not end at this time, include in your Generic Notice any information the resident needs to contact his/her QIO to request an Expedited Determination. Provide this notice even if Medicare is the secondary payor.
- The Generic Notice is not required if the resident is transferred to a higher level of care (acute-care hospital) or another SNF for skilled services or if Medicare benefits are exhausted.
- Ensure all form replications mirror the notice posted on the BNI website, including structure, wording and font size. Visit the BNI web site: [cms.hhs.gov/BNI/](http://cms.hhs.gov/BNI/).

**Whether residents stay in your facility after they are discharged home** - Residents have access to an Expedited Review by the State QIO if they disagree with your determination (Generic Notice) that services will end. After the

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## Speakers & Writers

### Speakers

**Conference:** Healthcare Financial Management Association Annual National Institute

**Topic:** Rural Medicare PPS Regulatory & Legislative Update (Session C07)

**Speakers:** Brad Brotherton and Tim Wolters

**Date:** June 26

**Topic:** Protecting Your Organization from Fraud & Embezzlement

**Speaker:** Angela Morelock

**Date:** June 27

**Conference:** 13th Annual National Association for Home Care's Financial Management Conference

**Topic:** Benchmarking Dashboards: Heading in the Right Direction

**Speakers:** Mark Sharp, BKD and David Stasiewicz, Addus Healthcare

**Date:** July 19

### Writers

**Publication:** Dennis Barry's Reimbursement Advisor

**Article:** Critical Access Hospital Billing: Method II Billing Requires Annual Election

**Author:** Chris Clark

**Issue:** March 2007

**Publication:** AHLA's The Rap Sheet

**Article:** Medicare Reimbursement Alternatives for Rural Hospitals

**Author:** John Cooper and Tim Wolters

**Issue:** Late spring (April) 2007

**Publication:** hfm

**Article:** A Critical Cause: 10 Steps to Improve Critical Access Hospital Performance

**Author:** Lawrence Fogel and Joseph Watt

**Issue:** May 2007

**Publication:** Compliance Today

**Article:** How to Transform Your Compliance Committee into a Lean, Mean, Fraud-fighting Machine

**Author:** Joseph Watt

**Issue:** May 2007

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## Streamlining the Medicare Part A denial process . . .

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resident notifies the QIO and requests an Expedited Review, the QIO will notify your SNF an Expedited Determination has been requested.

- The day you receive notice, you must provide the resident or their representative the Detailed Explanation of Non-Coverage (Detailed Notice) no later than the close of business that day.
- The QIO is responsible for contacting the SNF to request copies of the resident's medical record to use in making the determination. The SNF provides copies of both notices (Generic and Detailed) to the QIO.
- Following a review of the information provided, the QIO will make a determination and inform all involved parties. Generally, CMS expects the QIO review to take 72 hours.

**If the beneficiary disagrees with the QIO's determination** - The resident may request a reconsideration of the QIO decision by a Qualified Independent Contractor (QIC) under a similar process. When the QIO/QIC makes a decision at the end of the expedited review

process, the SNF can then bill for the period reviewed in accordance with the QIO/QIC decision on the coverage for that period.

**When the beneficiary has Medicare Advantage** - The Medicare Advantage Expedited Review process is basically the same as that used for "regular" Medicare Part A residents, with this exception: CMS designed notices specifically for those enrolled in Medicare Advantage.

- Form CMS-10095-A corresponds to the Generic Notice. It also must be provided to the resident at least 48 hours before termination of services.
- Form CMS-10095-B, upon notification from the QIO, is issued to the resident by the SNF no later than the close of business on the day the QIO gives the facility notice.

**When a SNF has "distinct part" Medicare beds and admits the resident to a noncertified bed** - The Advanced Beneficiary Notice (ABN) is issued when the SNF places a resident in a noncertified portion of its facility because the facility has determined the resident does not require a Medicare-covered level of care or for any other reason. The SNF must

notify the resident in writing that services in a noncertified bed are not covered.

- While the intent of the ABN is to protect the resident from the liability of charges incurred without foreknowledge, the timely issuance of an ABN also protects the SNF from providing services without reimbursement. (CMS replaced the "Non-certified Bed Letter" with the ABN form CMS-R-131-G.)
- A detailed description and instructions for completing all of CMS's denial forms is available at [cms.hhs.gov/BNI/](http://cms.hhs.gov/BNI/).

\* \* \*

As you strive to meet CMS's notification requirements, it pays to make the denial process as uncomplicated as possible.

If your Medicare denial process is confusing and not regularly followed, contact your BKD Health Care Group advisor for more information or for help finding better solutions to notify residents of their Medicare benefit status. ■

# Refinement planned for home health . . .

*continued from page 5*

1. Early episodes (1<sup>st</sup> or 2<sup>nd</sup>) with fewer than 14 therapy visits
2. Early episodes (1<sup>st</sup> or 2<sup>nd</sup>) with 14 or more therapy visits
3. Later episodes (3<sup>rd</sup>+) with fewer than 14 therapy visits
4. Later episodes (3<sup>rd</sup>+) with 14 or more therapy visits

The four-equation approach results in 153 HHRG classifications compared to the current 80.

- Elimination of the highly controversial M0175 (pre-admission inpatient location) from case-mix consideration due to its administrative intensity, as well as its inability to accurately predict resource utilization.
- Additional diagnoses and clinical variables will be added to the case-mix model, with an emphasis on how diagnoses, clinical conditions and comorbidities interrelate with each other factored into the case-mix scoring.
- A new base PPS rate of \$2,300.60 (compared to the current \$2,339.00) will be used for episodes beginning in 2008. Because the new case-mix model won't be implemented until January 1, 2008, an interim base PPS rate of \$2,355.96 will apply for episodes beginning in 2007 and ending in 2008.

These base PPS rates were adjusted for two primary factors—a market basket increase and an administrative adjustment for case-mix creep. The proposed market basket increase is 2.9%.

The case-mix creep adjustment amounts to a 2.75% decrease in 2008 with additional 2.75% decreases in 2009 and 2010 to account for what CMS considers increases in case-mix weight due to improved OASIS scoring rather than changes in patient characteristics.

- Unbundling of nonroutine supply payments from the base PPS rate and the base case-mix model. Payments for nonroutine supplies (NRS), or billable supplies, will be based on one of five severity levels determined by 39 patient characteristics considered in the OASIS assessment. The NRS payments for the five severity levels range from \$12.96 per episode to \$367.34 per episode. The above base PPS rate for episodes beginning in 2008 is inclusive of a reduction for the unbundling of the NRS payment.
- Low-utilization payment adjustment (LUPA) episodes will continue to apply for episodes with four or fewer visits along with the usual per-visit payment approach. However, CMS proposes adding \$92.36 to each LUPA episode encountered in initial episodes or LUPA-only episodes. The additional payment will not apply to subsequent episodes. CMS has proposed this LUPA add-on for the recognized, higher up-front costs of performing admission visits. The above base PPS rate for episodes beginning in 2008 is inclusive of a reduction for this LUPA add-on.
- Elimination of the significant change in condition (SCIC) adjustment, which is much to the delight of home health providers because of the confusion and inaccurate payments it has caused.

## Stay tuned

Comments on the proposed rule are due June 26, 2007. Changes to the proposed refinements could be made based on comments CMS receives. A final rule on the PPS refinement is expected by October 2007 to provide sufficient time for a January 1, 2008, implementation.

In the meantime, contact your BKD Health Care Group advisor for more specifics on the proposed refinements or for assistance in assessing how these refinements will affect your agency. ■

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