

The Challenges Faced by Healthcare Facilities to Stay Afloat in
Today's Rapidly Changing Environment

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Long-term care facilities and hospitals in today's health care environment are finding it increasingly difficult to survive on their own as a result of rising costs from Medicare fraud and abuse, the necessary need to control costs under the Medicare prospective payment system (PPS), the cost of corporate compliance, and the losses from managed care organizations. The smaller health care facilities are more at risk than the larger more established facilities. Smaller facilities typically have fewer resources in terms of capital, collateral to obtain financing, and professional staff with a technical knowledge in the areas of marketing, law, fund development, and capital replacement. And consequently health care facilities are doing what they need to do to survive such as merging, forming strategic alliances, forming Group Purchase Organizations, buying, selling, affiliating, creating Integrated delivery Systems (IDS) for risk-sharing, and finding other ways to control costs and increase reimbursement. As discussed later, the most necessary and determining factor for survival is a health care organization's ability to control and reduce costs. "In the past decade the United States has witnessed the beginning of a major restructuring of its health care delivery and financing systems. The nation's hospitals are merging, consolidating, and aligning at a frantic pace. Physicians and hospitals are forging new strategic alliances, and hospitals are

reinventing themselves as systems incorporating primary care, wellness, home health, long-term care, and related components of the continuum of care. The emerging organizational model that embraces many of these factors is known as an Integrated Delivery System (IDS). Health care providers increasingly are viewing such IDS as critical organizational forms for delivering higher-quality seamless health care, while pooling resources and sharing risks in a turbulent managed care environment."¹

In an analysis of the reasons why health care costs are rising, there is one that stands out from the rest - fraud and abuse. "U.S. adults cite health care fraud as the leading reason for rising health care costs, according to a recently released survey. Twenty-three percent ... ranked fraud higher than waste and inefficiency (17 percent), medical needs associated with older people needing more care (16 percent), and new technologies (11 percent), as reasons for health care costs rising."² As a result of the many fraudulent claims that have been filed against the Medicare and Medicaid programs by hospitals and skilled nursing facilities, the government has enacted new regulations giving them authority to investigate and prosecute any facility that "knowingly, willfully and intentionally deceives Medicare to receive reimbursement for otherwise uncovered services as indicated in the published compendium of government rules and regulations."³ A good example

of fraud and abuse is illustrated by the company Fresenius and its U.S. subsidiary, Fresenius Medical Care North America, an international dialysis provider, that settled a lawsuit to pay Medicare \$486 million for fraud-and-abuse charges. Out of the \$486 million, \$101 million were criminal fines.⁴

A lot of the information contained in the following pages regarding PPS, Medicare reimbursement, and fraud and abuse are based upon the 15 years of knowledge and experience that I have obtained from working in the health care industry by attending various seminars and preparing actual Medicare cost reports. Another challenge that health care facilities face today is the complicated burden of billing Medicare under PPS which increases the chances of billing errors, thereby increasing the organization's vulnerability to Medicare fraud-and-abuse charges for both intentional and unintentional errors. The reason that health care facilities are so vulnerable with respect to Medicare billing is because of the 44 different Resource Utilization Groups (RUGs) that must be used when billing for each individual Medicare patient in both hospitals and skilled nursing facilities. Each of the 44 different RUG categories represent a certain acuity level for any given Medicare patient, according to how much assistance or nursing care is needed for each patient. "Record keeping for the Medicare Prospective Payment System (PPS) is a daunting prospect. The assessments

and documentation for 44 Resource Utilization Grouping (RUGs) and the rules governing this area are complicated and demand study and attention to detail. The penalties for mistakes are severe: at best, reimbursement at a "default rate" leading, in time, to red ink and possibly bankruptcy, and at worst, prosecution for Medicare fraud and abuse."⁵

The Prospective Payment System (PPS) was imposed on Medicare as a result of the Balanced Budget Act (BBA) of 1997 which changed the way Medicare is billed and how facilities are reimbursed. The Medicare program is administered by the Health Care Financing Administration (HCFA) and acts as the "middle man" between the government and the health care facilities that are reimbursed under the Medicare. The regulations that govern the Medicare program are published in the Federal Register as a guide for health care facilities to follow. PPS became effective for facilities with cost reporting periods beginning on or after July 1, 1998.⁶

As a comparison, what follows is a description of the old Medicare billing system. Under the old or retrospective Medicare system, each facility would bill and receive payment based on a facility-specific per diem rate that was calculated according to the facility's routine costs, ancillary costs, and capital-related costs. To reiterate, each facility billed using only **one (1)** per-diem rate in comparison to the **44** different

per-diem RUG rates that are currently required with PPS. At the end of each year, each facility receiving Medicare payments was required to prepare and submit a cost report that calculated the aforementioned cost data for each facility. Then a settlement would be calculated to determine whether the facility owed Medicare or vice versa based on comparing the actual and reasonable lower of cost or charges to the total payments received from Medicare. The per diem rates paid to each facility would be based on the prior year's cost information from the Medicare cost report. This procedure was simple compared to today's per-diem Prospective Payment System.

To expound upon this new system - under prospective payment, the facilities can no longer "settle up" at the end of each year like they could under the retrospective system. The calculations of the 44 RUG rates are complicated. And so the explanation that follows is a very simplified version. Under BBA 1997, as reflected in the Federal Register, a base rate is determined on an historical cost basis using the cost data from the 1995 cost report.⁷ This base rate is inflated for each appropriate cost report year using what is called a "basket-rate index"⁸ and then is adjusted by wage-related factors per geographic region. This rate - that only includes a capital-related cost factor and a geographic index - is only part of the total per-diem rate that results in one of the 44 different RUG

categories. For simplification, let's refer to this rate component as the capital portion. This "capital portion" is then adjusted by a case-mix or acuity factor that is determined by the patient's individual level of needs in terms of nursing care, therapy and personal assistance with daily needs. The "capital portion" is added to the "case-mix" portion to arrive at a total per-diem rate that falls into one of the 44 different RUG categories for each patient. To make things more complicated, each patient must be evaluated on the day of admission and re-evaluated on the 5th, 14th, 30th, 60th, and 90th day after admission by a RN to come up with a rating called a Minimum Data Set (MDS).⁹

This MDS is used to determine a certain case-mix or level of need to use in calculating the appropriate rate that fits into one of the 44 RUG categories mentioned above for each patient. And because of the need to continuously calculate and recalculate MDS's for each Medicare patient at each of the required intervals, health care facilities have had to add one more position to their staff. The person in this position is a RN and one that specializes in case management. This position is supervisory over case management and is designed to ensure that the MDS's are being calculated correctly. The RN must be well qualified and well experienced to assume such a responsibility and is referred to as a Case manager in some

facilities. In calculating the MDS, there lies a lot of room for intentional and unintentional errors, which could open up a health care facility to fraud-and-abuse charges.

In addition to the cost of a new case manager position, additional billing clerks are needed to handle the complex and involved process that PPS requires. "In order to be compliant with complex ... billing rules and regulations, hospitals must bill both the patient and Medicare in a manner that is administratively burdensome. The required complex billing mechanisms add to the total cost of health care and are difficult for the average person and Medicare beneficiary to understand."¹⁰ With respect to additional billing clerks, this is true more in larger organizations where there is a higher volume of Medicare patients. It also depends on the case-mix level for a particular health care facility. In other words, one health care facility may have patients that are worse off or require more rehabilitation than another facility.

The case managers and billing clerks who are responsible for calculating the MDS and billing for services provided are in the most vulnerable position for fraud and abuse. They are the ones most likely to make the unintentional errors, which by the way are still subject to fines and penalties if not caught soon enough. The employees of a health care organization most likely to commit fraud are the ones that have the authority or control

such as the top financial person or even the CEO. They could influence the billing clerks to bill for a higher rate than allowed or even to bill Medicare for services that were not even provided - just to increase their total revenues.

Another problem that is plaguing the health care industry in some states is managed care. In some states, the administration of the Medicare funds is contracted out to managed care organizations. The senior citizens that are living in a state that participates in managed care are now obtaining health care coverage under various managed care organizations. These managed care organizations contract with a variety of skilled nursing facilities (SNF's) or hospitals in that state. The SNF's or hospitals agree to the payment terms that the managed care organization stipulates. The managed care organization sets a predetermined rate that they will pay to the skilled nursing facility or hospital for patients that are covered under their plan and admitted into the same SNF or hospital. The managed care rates are calculated by estimating a certain rate for routine costs plus rehabilitation costs. The facilities that accept these pre-determined rates are taking a risk. Patients that are admitted into a facility under a certain managed care contract may require rehabilitation services that are less costly or more costly than the rate

provided for in the contract. This is where the managed care organizations can cost the health industry a lot of money.

Because of the rising costs of health care from fraud and abuse and managed care organizations plus the complexities, burdens, and vulnerability that PPS presents, health care facilities must either solve the problem on their own or figure out another way to remain in business through mergers, affiliations, strategic alliances and Group Purchase Organizations. No matter how health care facilities stay in business, there are two key things they need to do: develop a corporate compliance program and reduce cost. "In the long-term care industry, those facilities that can understand the necessity of a cost-reduction program and work with the system as it exists will stand a pretty good chance of surviving PPS. It seems unlikely, though, that individual facilities will be able to generate enough savings on their own to keep afloat."¹¹

As fraud and abuse became increasingly more prevalent in the health care industry, facilities were pressured into developing a program within their organization for the prevention and detection of fraud and abuse. This program is commonly known as corporate compliance - again, another costly but necessary position to add to an organization's staff. The employee in this position must have an in-depth and technical knowledge of Medicare billing, reimbursement and a strong

background in creating policies and procedures for the prevention and detection of fraud and abuse. The procedures would involve setting up internal controls within the organization at every possible level from the Billing Clerk, Case Manager, and nurses all the way up to the Chief Financial Officer and Chief Executive Officer. All employees involved in the care-taking and billing need to be educated about such things as medical necessity, RUGs, MDS, and Medicare billable services provided to their patients. Another factor to consider is insurance coverage against possible fraud and abuse.

"Healthcare organizations found to have violated Federal fraud and abuse laws usually negotiate a settlement amount with government representatives. The fines and penalties assessed can be triple damages plus interest, and an additional \$5,000 to \$10,000 per fraudulent claim. ... A common misconception among healthcare provider organizations is that their directors and officers liability (D&O), malpractice, or standard errors and omissions (E&O) insurance policies will cover the cost of Medicare fraud and abuse fines. In reality, ... standard policies do not cover these fines or the organization's internal audit expenses associated with a government investigation."¹²

As mentioned before, the second thing that health care facilities need to do is find a way to reduce their costs. One way to reduce costs for an organization is to team up with other

organizations to form a group purchasing contract to buy supplies and utilities at a bulk discount. This is done through a company that specializes in negotiating group purchase contracts for many facilities combined. One of those companies is called AmeriNet. "Today, AmeriNet is the largest membership-based group purchasing organization (GPO) in the country with over 9,000 members, including nearly 1,000 nursing homes. How does this relate to PPS? Basically, a GPO ... provides a way for a facility to reduce operating costs by using the combined purchasing power of 9,000 fellow members. With contracts for food, medical supplies, incontinence care supplies, office supplies and more, AmeriNet uses the dual-source philosophy- i.e., writing agreements with market leaders rather than with a single source, thus offering members both savings and product choice."¹³

As previously mentioned, if an individual facility can not survive on their own, they will need to consider other alternatives such as mergers, affiliations, and Integrated Delivery Systems (IDS). As the following quote reveals, there has been much activity in the area of mergers and acquisitions most recently. "There were 135 announced mergers and acquisitions in the healthcare services industry during the second quarter of 2000, according to the 2000 Health Care Merger and Acquisition Report. ... The deals represented a 17 percent

increase over the first quarter of 2000 and the first increase in two years.”¹⁴ One step down from a full-asset merger is for two or more healthcare organizations to form what is called an Integrated Delivery System (IDS). An IDS is a group of organizations coming together to form an affiliation to improve efficiencies and effectiveness by sharing resources to achieve cost-reducing synergies and to spread the risk of managed care contracts. Another advantage gained by forming an IDS is to secure greater market penetration and increase total revenues.¹⁵ With all of the pressures in the healthcare industry of regulations and increasing costs, some of the smaller facilities as well as some of the larger ones have no choice but to form affiliations just to stay in business. “Under pressure to remain competitive and financially secure in a rapidly changing health care industry, these affiliations, termed IDSs, have been touted as the organizational model of the future.”¹⁶ For healthcare facilities to remain in business and stay in business well into the future it comes down to “the survival of the fittest” - only those facilities that have enough resources and find a way to reduce costs will survive today’s turbulent industry.

ENDNOTES

- ¹ Robert Jantzen and Patricia R. Loubeau, "Risk-Sharing integration efforts in the hospital sector," *Health Care Management Review*, (Spring 1999) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pdqweb>>; accessed 21 April 2001.
- ² Amanda Levin, "Study: Fraud cited as leading contributor to rising health care costs," *National Underwriter*, (March 29, 1999) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 20 April 2001.
- ³ Carla Arevalos Eddy, Aaron Liberman, and Thomas Falen, "Medical care compliance program—a year 2000 recipient perspective of Medicare claims," *The Health Care Manager*, (December 2000) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 20 April 2001.
- ⁴ Mark Taylor, "Whopping settlement for Fresenius," *Modern Healthcare*, (January 24, 2000) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 20 April 2001.
- ⁵ Anonymous, "AANAC's PPS review: Questions and answers from the American Association of Nurse Assessment Coordinators (AANAC)," *Nursing Homes*, (March 2001) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 20 April 2001.
- ⁶ "Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities." *Federal Register* 63, no. 91 (12 May 1998): 26252 [on-line]. Available from <<http://www.hcfa.gov/medicare/fr12ma98.pdf>>; accessed 25 April 2001.
- ⁷ "Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities." *Federal Register* 63, no. 91 (12 May 1998): 26252 [on-line]. Available from <<http://www.hcfa.gov/medicare/fr12ma98.pdf>>; accessed 25 April 2001.

ENDNOTES

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- ⁹ "Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities." Federal Register 63, no. 91 (12 May 1998): 26252 [on-line]. Available from <<http://www.hcfa.gov/medicare/fr12ma98.pdf>>; accessed 25 April 2001.
- ¹⁰ Carla Arevalos Eddy, Aaron Liberman, and Thomas Falen, "Medical care compliance program—a year 2000 recipient perspective of Medicare claims," *The Health Care Manager*, (December 2000) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 20 April 2001.
- ¹¹ Barbara Conte, "Why GPOs are part of the PPS toolkit," *Nursing Homes*, (July 1999) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 21 April 2001.
- ¹² Sheila Callison, "Securing insurance protection against fraud and abuse liability," *Healthcare Financial Management*, (July 1999) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 21 April 2001.
- ¹³ Barbara Conte, "Why GPOs are part of the PPS toolkit," *Nursing Homes*, (July 1999) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 21 April 2001.
- ¹⁴ Anonymous, "Merger and acquisition activity on the rise for the first time in two years," *Healthcare Financial Management*, (September 2000) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 9 April 2001.

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- ¹⁵ Thomas P. Weil, "Management of integrated delivery systems in the next decade," Health Care Management Review, (Summer 2000) [on-line]. Available from <<http://mdusa.lib.umd.edu/proxy/fs/umi/pqdweb>>; accessed 9 April 2001.
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