OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

CAH Finance and Operations Webinars

May 11, 2023

CAH Reimbursement Heuristic: Using Medicare Cost Report to Reveal Opportunities

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being

OHSU

OREGON OFFICE
ORH
of RURAL HEALTH

Webinar Logistics

- Audio muted and video off for all attendees.
- Select to populate the ··· to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/resources-and-technical-assistance-cahs.

OHSU

Upcoming CAH Operation and Finance Webinars

June 8, 12 p.m. - 1:00 p.m.
10 CAH Revenue Cycle Priorities: What to Review Immediately

July 13, 12 p.m. - 1:00 p.m.
The Post-Acute Care Lever: Hospital Swing Beds

Aug. 3, 12 p.m. - 1:00 p.m.
How to Build Revenue: Front-End Competencies

Aug. 31, 12 p.m. – 1:00 p.m.
The No Surprises Act: Revenue Protections and Transactional Compliance

Sept. 14, 12 p.m. – 1:00 p.m.
Fund Your Mission: Practice Steps to Move from Volume to Value

OREGON OFFICE of RURAL HEALTH

OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

Jonathan Pantenburg is a Principal at Wintergreen. He is an accomplished, results-driven senior executive with nearly 20 years of progressively responsible experience advising profit, nonprofit, and governmental entities. Over the past six years, Jonathan has worked with entities ranging from independent practices to multi-state health care systems on how to leverage rural opportunities to improve financial and operational performance. Prior to that, Jonathan served as chief financial officer and chief operating officer for a 21-bed nonprofit critical access hospital.

OHSU

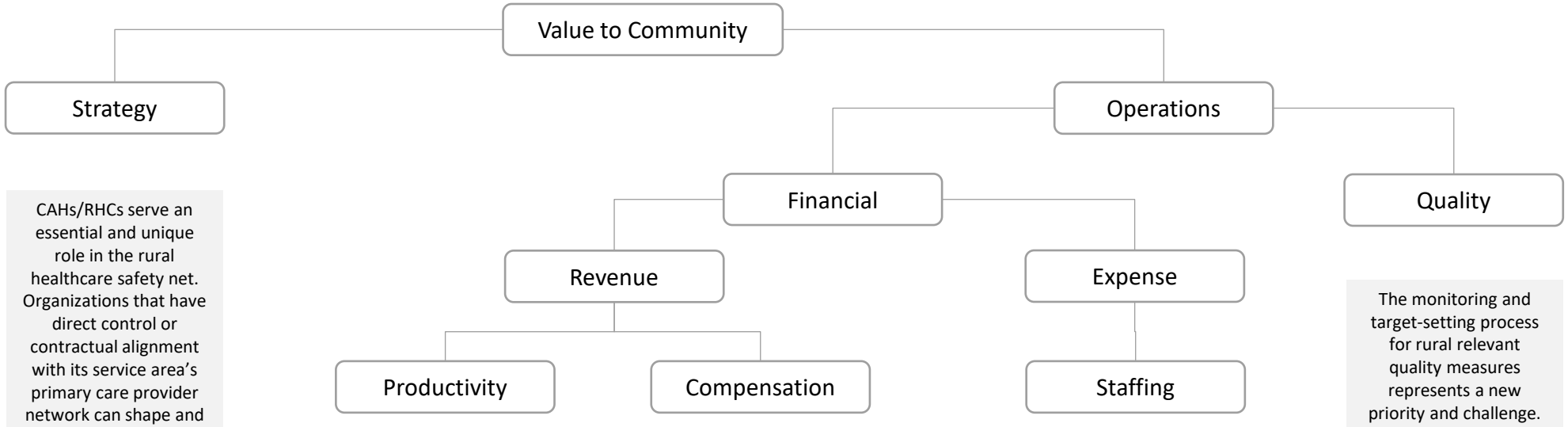
CAH Reimbursement Heuristic

Using Medicare Cost Report to Reveal Opportunities

May 11, 2023

WINTERGREEN

Performance Model



CAHs/RHCs serve an essential and unique role in the rural healthcare safety net. Organizations that have direct control or contractual alignment with its service area's primary care provider network can shape and guide how prevention, education and patient care processes are implemented across the service area.

In rural America, we've learned to do more with less. This principle should apply to all service areas, when appropriate, by working with staff to work at the top of their license.

Compensation scale and design are key drivers of performance and satisfaction. How staff are paid can vary widely but compensation models should be tailored to your market realities.

Staff are the single most important asset and should be the primary focus for leaders. Having the right mix of motivated professionals is the key to performance.

The monitoring and target-setting process for rural relevant quality measures represents a new priority and challenge. Quality measures will also increasingly influence reimbursement via Value Based Payment programs.

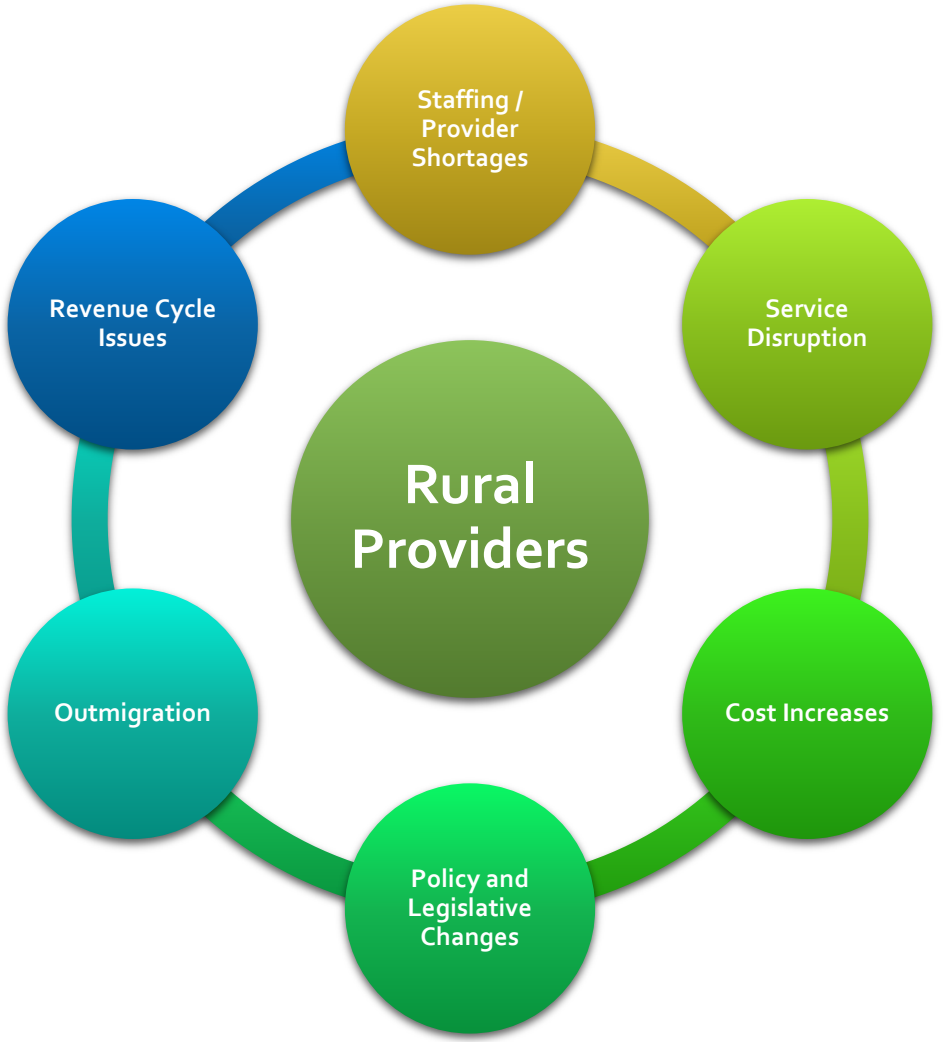
The Current Landscape

- Rural providers continue to experience cost increases, while having to address staffing shortages, outmigration, and significant policy/legislative changes

- The past few years have fundamentally changed how many patients receive healthcare services
  - Organizations must take a proactive approach to address these changes

CTA

Evaluate the current organizational landscape and make necessary changes to improve financial performance

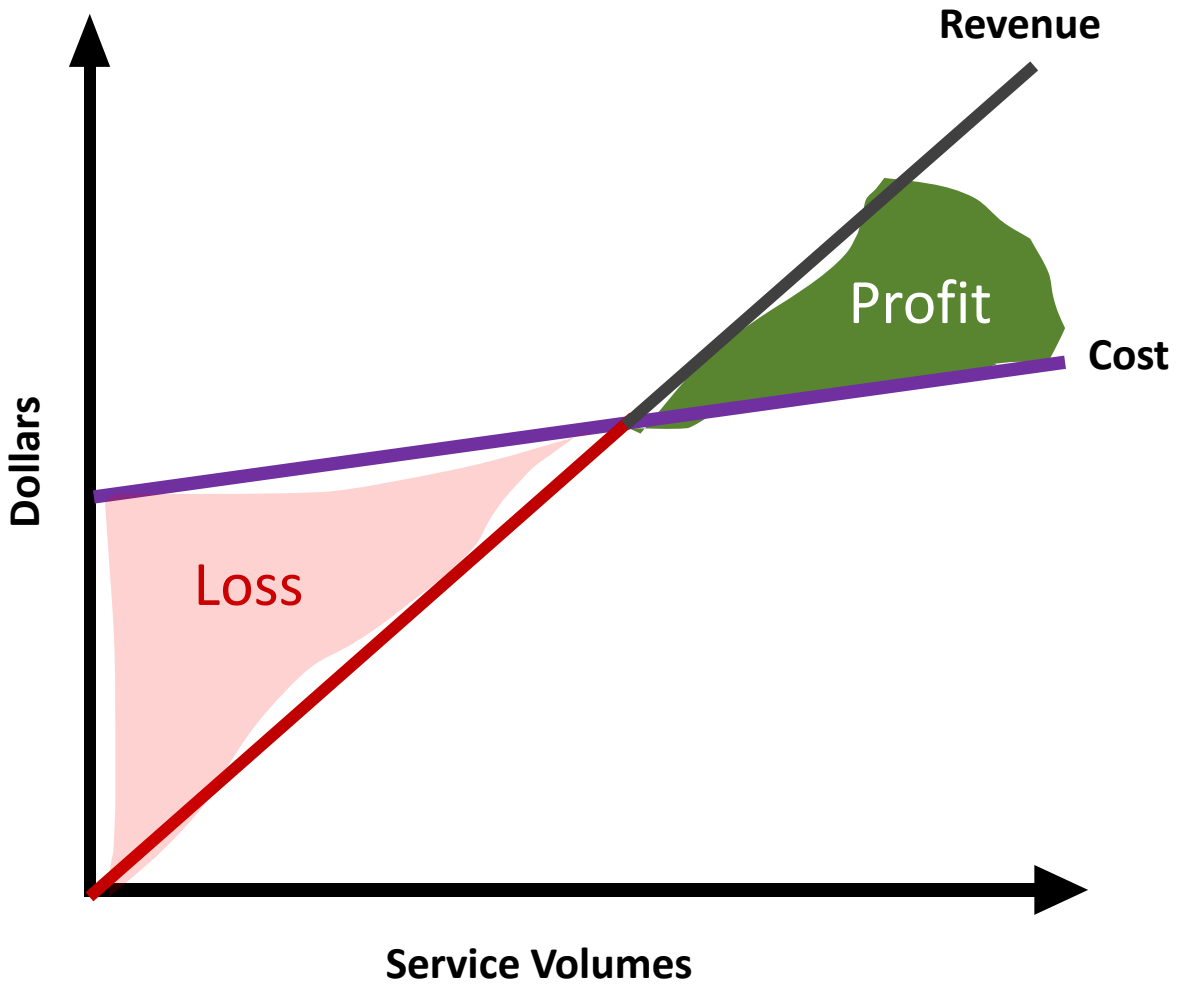


CAH Reimbursement Overview

- **CAH Reimbursement Methodology**
  - CAHs receive cost-based reimbursement for inpatient and outpatient services provided to Medicare and, in some states, Medicaid patients
    - Cost based reimbursement provides significant advantages to CAHs by allowing them to get paid at 101% of costs for the Medicare and Medicaid revenue
  - Cost based reimbursement enables CAHs to complete certain capital initiatives that would otherwise not be available to PPS hospitals
    - When a CAH completes a facility replacement, addition, and or renovation, the amounts expensed as deprecation and interest will increase reimbursements received from cost-based payors
      - For example, if a CAH spends $1M per year on depreciation and interest for the facility, and the CAH is 50% cost-based, meaning Medicare and Medicaid make up 50% of the charges, the hospital would receive an additional $500K / year due to the facility initiative
        - Under the same scenario, the CAH would receive 50% of the total capital cost, as depreciated, and interest from cost-based payors of the term of the loan and depreciable life of the asset
  - The above is for educational purposes as CAH cost-based reimbursement is based on allowable and unallowable expense and the allocation of expenses to cost-based and non-cost-based departments

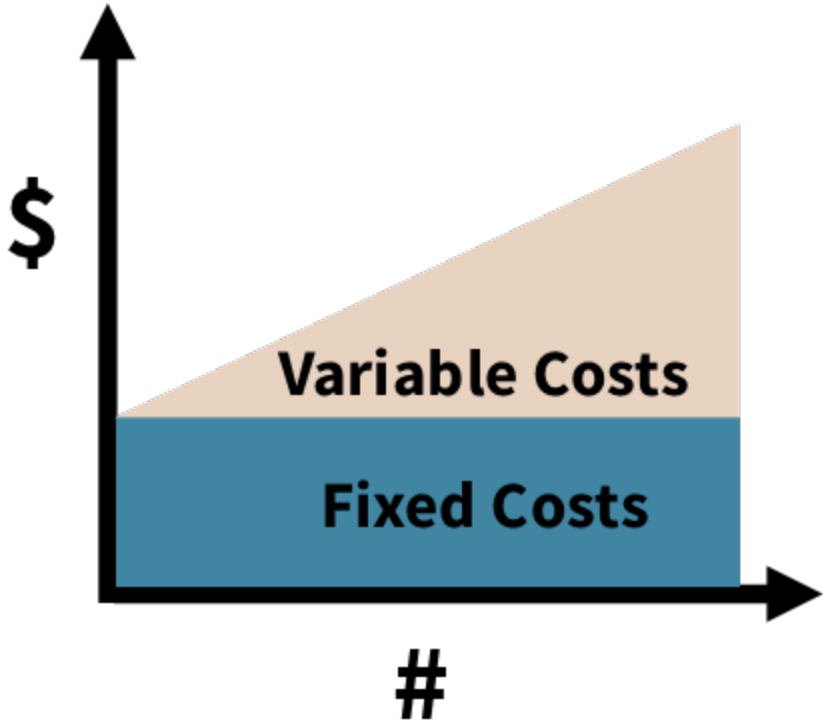
Economic Philosophy

- The financial solvency of a CAH is dependent upon the realization that revenue (volume) and expenses both contribute to the financial position of an organization
  - Value is unlocked by marginal revenue gains that help dilute down a high fixed cost environment
  - Organizations need to understand the different and impact of contribution margin
  - Cost-based reimbursement will not generate profit and only cover the costs for those proportional services
  - CAHs need to break down the silos between quality and finance for improved outcomes



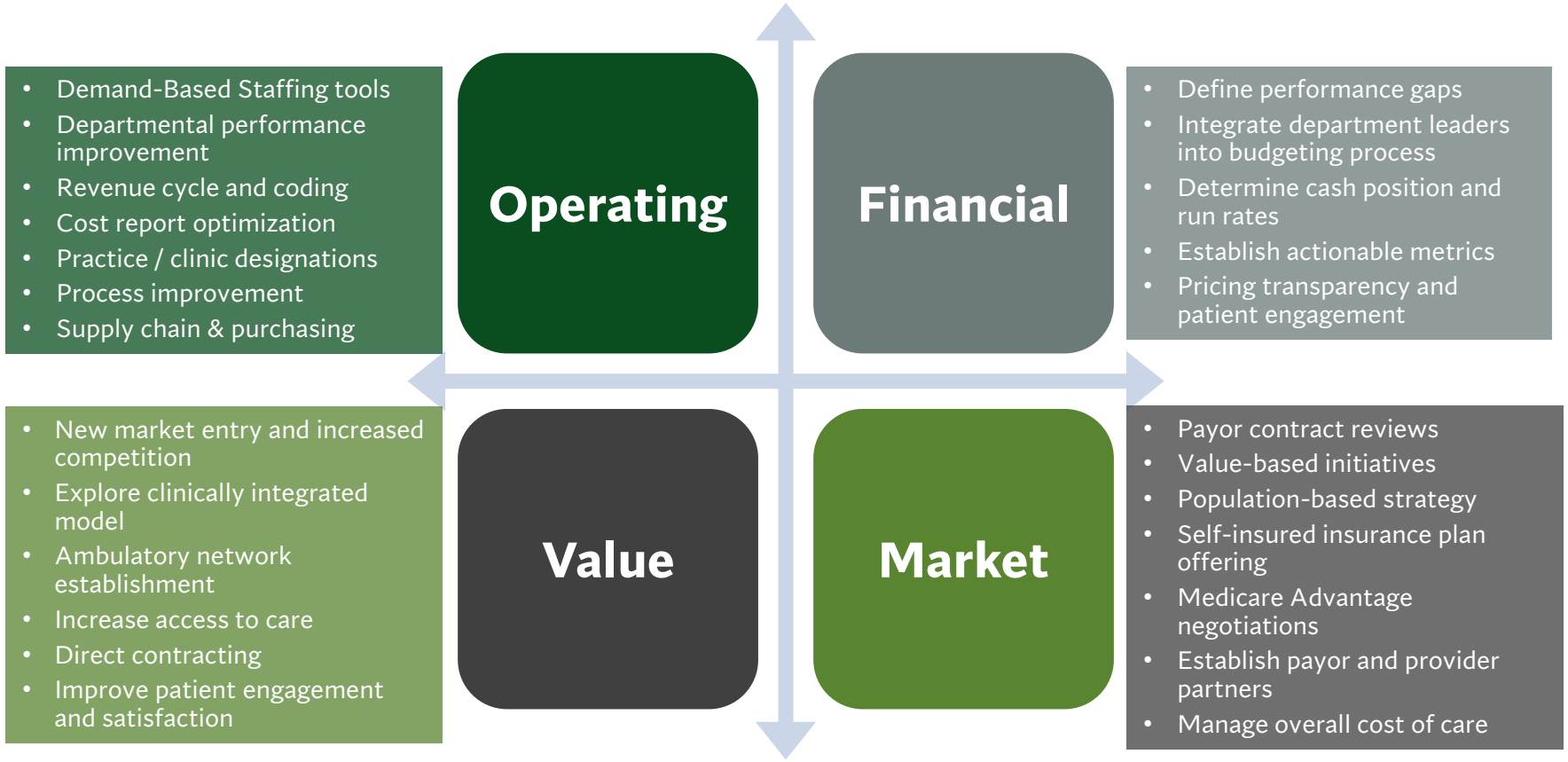
CAH Financial & Operational Best Practices

- Fixed costs are those which exist irrespective of volume
  - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional IP day
  - Incremental medical supplies, pharmaceuticals, food for patient meals
- In comparison to fixed costs, variable costs represent only a fraction of IP costs
  - As volume grows, fixed costs are diluted faster than variable costs grow



Performance Improvement Opportunities

Organizations must focus and establish plans for each of the four identified areas to improve the organizational position



Cost Report Opportunities

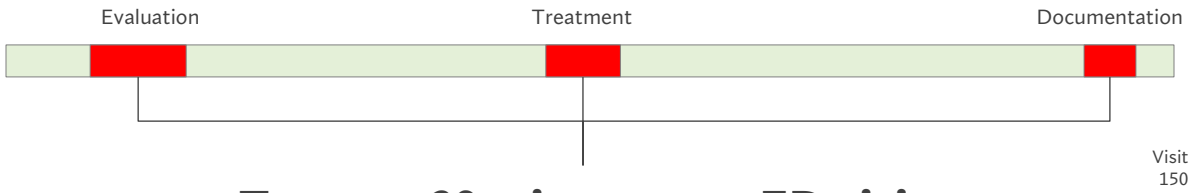
ED Provider Time Studies

To ensure that Critical Access Hospitals can provide emergency services 24/7, regardless of low patient volumes, CMS reimburses for Emergency Department provider stand-by time

What's included?

A critical access hospital (CAH) may be reimbursed through its cost report for the reasonable cost it incurs compensating a physician for the time the physician spends in the emergency room (ER) awaiting the arrival of patients and furnishing other services to the provider (provider component). Before this cost may be claimed, the CAH must determine the amount of time the ER physician spends with patients (professional component) vs. the time spent furnishing otherwise allowable services that do not directly relate to the care of one individual patient (provider component.)

Providers furnish services to patients during an ED visit but not for the entire duration

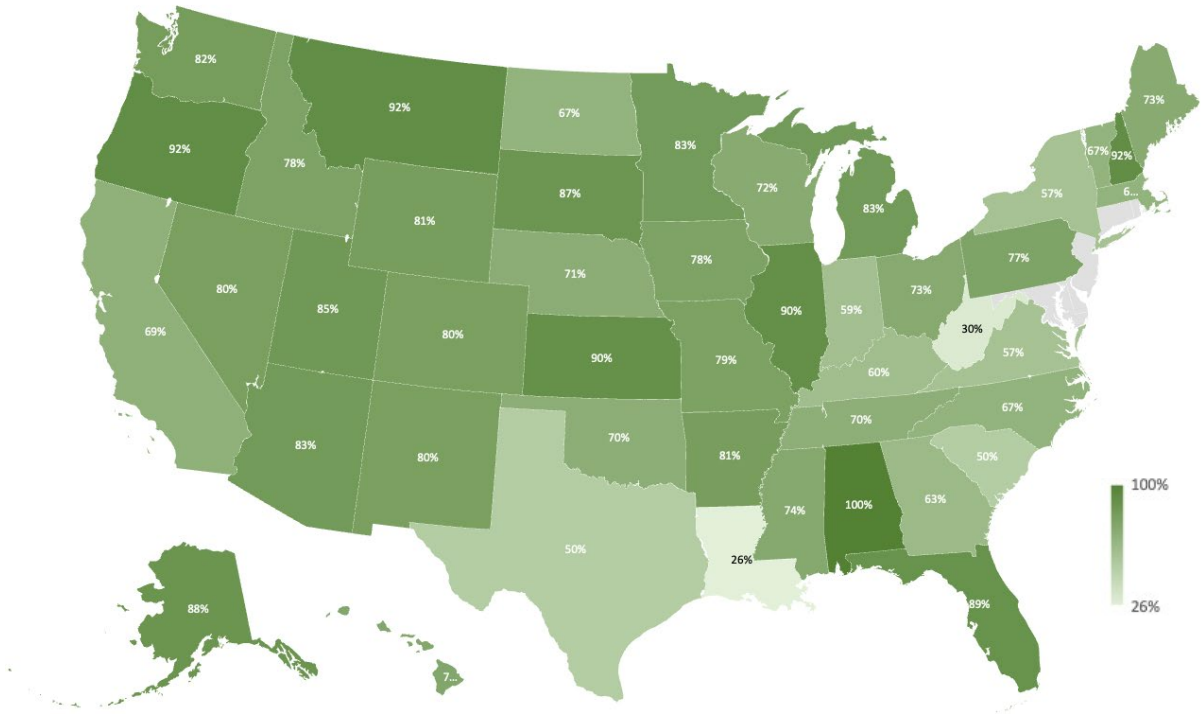


Target = 20 minutes per ED visit

		Current (30 Min/Visit)	Proposed (20 Min/Visit)	Variance
Total Cost		$ 2,776,769	$ 2,845,612	$ 68,843
Total Charges		$ 4,632,279	$ 4,632,279	$ -
	RCC	0.599439	0.614301	0.014862
Medicare Charges		$ 1,459,434	$ 1,459,434	$ -
Medicare Reimb:		**$ 874,842**	**$ 896,531**	**$ 21,689**

ED Provider Opportunity

Map A: Percentage of CAHs with Reimbursement Opportunity by State (FY 2021)



All 45 States

45 of 45 states have an opportunity to increase reimbursement

The states with the lowest percentage are **Louisiana** (5 of 19 CAHs or 26%) and West Virginia (6 of 20 CAHs or 30%)

The states with the highest percentage are **Alabama** (3 of 3 CAHs or 100%), **New Hampshire** (11 of 12 CAHs or 92%), **Montana** (35 of 38 CAHs or 92%) and **Oregon** (23 of 25 CAHs or 92%)

Note: Data set includes 1,189 of 1,359 critical access hospitals
Data Source: December 2022 Medicare Cost Report release for CAH fiscal year 2021
Additional Analysis: Refer to the ED Standby Time study published at www.wintergreenme.com

RHC Consolidation

- **RHC Cost Report Consolidation**
  - Entities that operate more than one RHC have the opportunity to consolidate cost reports
    - Must receive prior approval from MAC
    - Can improve reimbursements for organization
    - Reduces administrative burden
    - Establishes single reimbursement rate across practices
    - *Note: Due to the Consolidated Appropriations Act of 2021, limitations exist regarding which RHCs can consolidate*

	RHC 1	RHC 2	RHC 3	RHC 4	RHC 5	Combined	Consolidated
CCN	16-3483	16-3470	16-8538	28-8538	16-8577		28-8538
UPL	209.15/213.54	273.56/279.30	275.97/281.77	346.16/356.49	344.96/352.20		346.16/356.49
Total Allowable Cost	$ 524,491	$ 368,805	$ 1,178,192	$ 110,353	$ 1,000,813	$ 3,182,654	$ 3,182,654
Adjusted Visits	1,820	882	4,463	273	2,908	10,346	10,346
Cost / Visit	$ 288.18	$ 418.15	$ 263.99	$ 404.22	$ 344.16	$ 307.62	$ 307.62
Reimb / Visit	$ 211.37	$ 274.79	$ 263.99	$ 352.89	$ 344.16	$ 294.48	$ 307.62
Medicare Visits	301	211	1,226	106	1,215	3,059	3,059
Reimbursement	$ 63,621	$ 57,980	$ 323,652	$ 37,406	$ 418,154	$ 900,813	$ 941,015
					Variance:	**$**	**40,202**

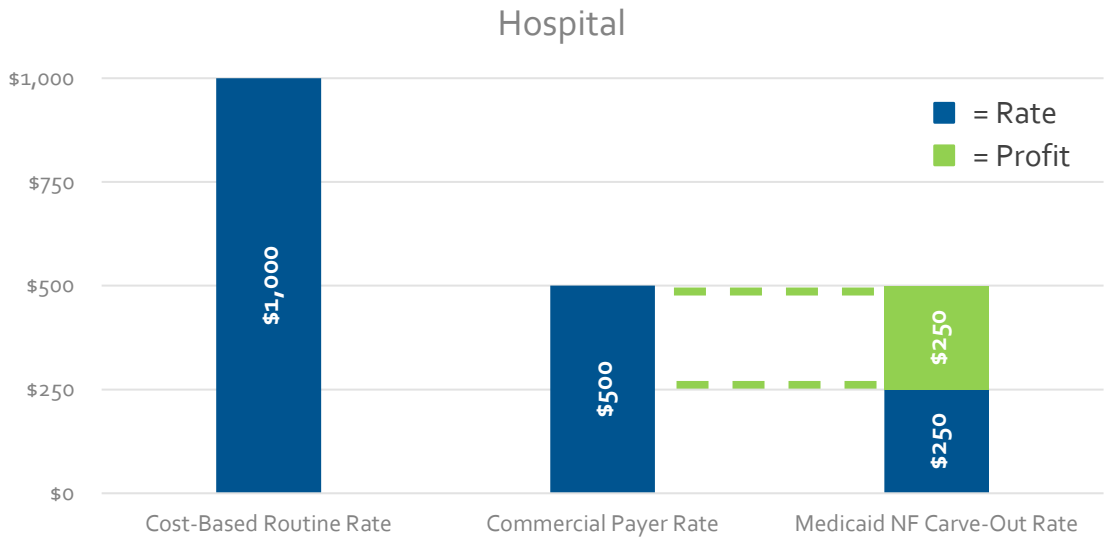
Med/Surg and ICU Integration

- **ICU Integration**
  - Organizations that operate a separate ICU must evaluate the net financial impact of maintaining a distinct unit and realize that integration can:
    - Increase operational efficiencies
    - Improve reimbursements
    - Improve patient care

Adult & Pediatrics, Swing Bed-SNF, and Observation	Current	Proposed	Variance
Routine Cost	$ 4,812,677	$ 4,850,215	$ 9,662,892
Total Days	2,720	2,724	5,444
Routine Rate:	$ 1,769.37	$ 1,780.55	$ 11.18
Medicare & Medicare Adv. Days	1,687	1,687	-
Medicare Routine Reimb:	$ 2,984,921	$ 3,003,786	$ 18,865
Intensive Care Unit			
Routine Cost	$ 37,538	$ -	$ (37,538)
Total Days	4	-	(4)
Routine Rate:	$ 9,384.50	$ -	$ (9,384.50)
Medicare & Medicare Adv. Days	-	-	-
Medicare Routine Reimb:	$ -	$ -	$ -
Total Medicare Routine Reim:	**$ 2,984,921**	**$ 3,003,786**	**$ 18,865**

Swing Bed NF Rate

- **Non-Cost Based Swing Bed Days**
  - Cost-based reimbursement will only ever allow a hospital to break even
  - The opportunity: Non-Medicare or Medicare Advantage (Swing Bed NF) patient days
  - Common misconception: If contracted reimbursement rate is less than cost-based rate, negative financial impact
    - Medicaid NF carve-out rate
      - Carved out of routine costs at statewide
      - Do not negatively impact cost-based rates
  - If contracted reimbursement rates exceed statewide NF carve-out rate, **the hospital makes profit**



Swing Bed Growth

WINTERGREEN

- **Swing Bed Economics**
  - Deliver additional inpatient (IP) rehabilitation services to the community
  - Provide increased reimbursement while assisting in length-of-stay management
  - Help to dilute fixed and step-fixed costs in the nursing unit
  - Financial benefit occurs by increasing the proportion of IP costs that are reimbursed on a cost basis
    - Reduces overall unit costs by diluting fixed costs related to IP services

Base Case

	ADC	Total Days	Cost-Based Mix	Cost-Based Days	Non-Cost-Based Days	Payment Per Day	Non-Cost-Based Payment
Acute (includes ICU)	5.9	2,154	83%	1,787	366	$ 1,750	$ 640,666
Observation	2.7	986	27%	266	719	1,250	899,269
Swing Bed - SNF	3.2	1,168	96%	1,121	47	1,250	58,400
Swing Bed - NF	0.1	37	0%	-	37	250	9,125
Total Days	11.9	4,344		3,175	1,169		$ 1,607,460
Total Acute, SB SNF, Obs		4,307	73%				
Inpatient Fixed Costs		$6,765,480					
Inpatient Variable Costs		1,096,825 [1]					
Swing Bed - NF Carve Out		(6,908)					
Total Inpatient Costs		$7,862,305					
Inpatient Costs Per Day				$ 1,825.47			
Cost-Based Payment				$5,795,451			$ 5,795,451
Total Payment							$ 7,402,911
Inpatient Costs Per Day							7,862,305
Net Margin							**$ (459,393)**

Swing Bed ADC Increase of 2.0

	ADC	Total Days	Cost-Based Mix	Cost-Based Days	Non-Cost-Based Days	Payment Per Day	Non-Cost-Based Payment
Acute (includes ICU)	5.9	2,154	83%	1,787	366	$ 1,750	$ 640,666
Observation	2.7	986	27%	266	719	1,250	899,269
Swing Bed - SNF	5.2	1,898	96%	1,822	76	1,250	94,900
Swing Bed - NF	0.1	37	0%	-	37	250	9,125
Total Days	13.9	5,074		3,876	1,198		$ 1,643,960
Total Acute, SB SNF, Obs		5,037	73%				
Inpatient Fixed Costs		$6,765,480					
Inpatient Variable Costs		1,242,825 [1]					
Swing Bed - NF Carve Out		(6,908)					
Total Inpatient Costs		$8,001,396					
Inpatient Costs Per Day				$ 1,588.52			
Cost-Based Payment				$6,156,437			$ 6,156,437
Total Payment							$ 7,800,397
Inpatient Costs Per Day							8,001,396
Net Margin							**$ (201,000)**
						Difference:	**$ 258,394**

1- Assumes $275/day marginal Acute/Obs costs and $200/day marginal swing bed SNF and NF costs

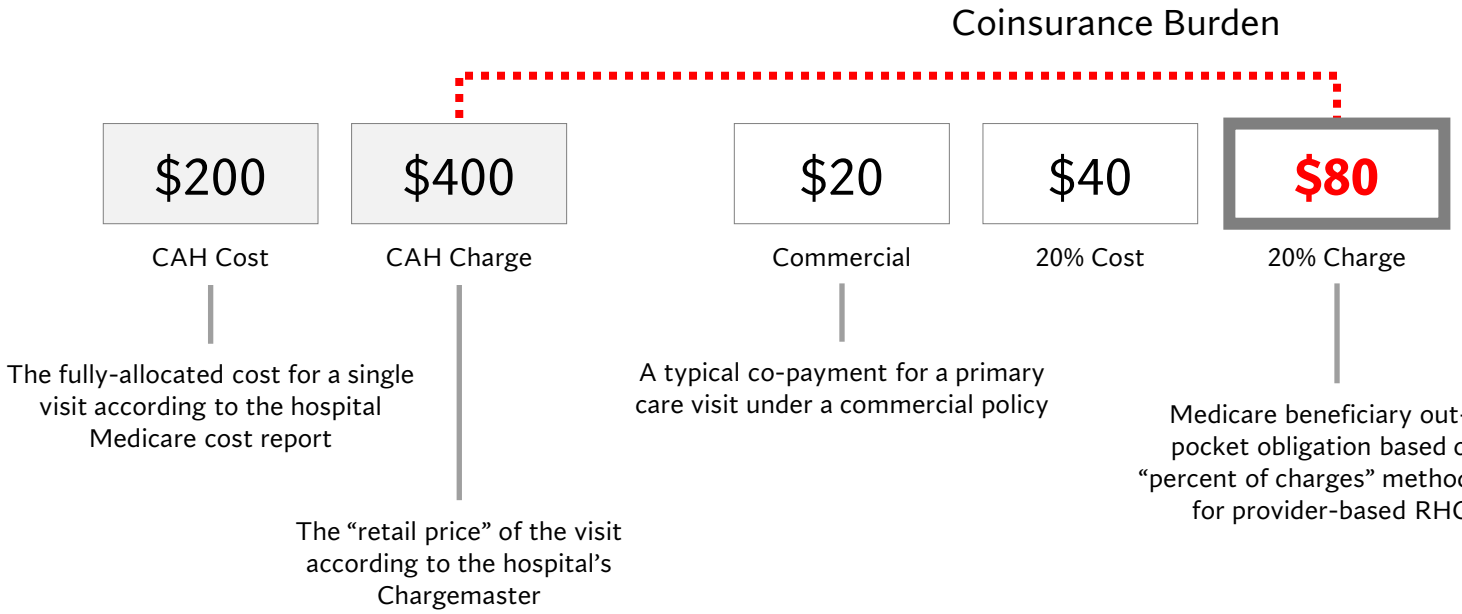
Pricing Methodology

CAHs receive cost-based reimbursement for inpatient acute, swing-bed, and outpatient services delivered to Medicare beneficiaries. Medicare patients at CAHs owe coinsurance on outpatient services based on **20 percent of applicable Part B charges**. In contrast, at hospitals paid using Medicare's outpatient prospective payment system (OPPS), coinsurance is based on 20 percent of the OPPS price under the fee schedule for Ambulatory Patient Classification units.

Because the fee schedule is generally much lower than charges, an unintended consequence of cost-based reimbursement implemented under the Rural Hospital Flexibility Program is that **beneficiaries receiving care at a CAH have a higher coinsurance burden than those going to prospective payment system (PPS) hospitals**.

Source: "Medicare Copayments for Critical Access Hospital Outpatient Services – Update" (MedPAC)

Example: PB-RHC Visit



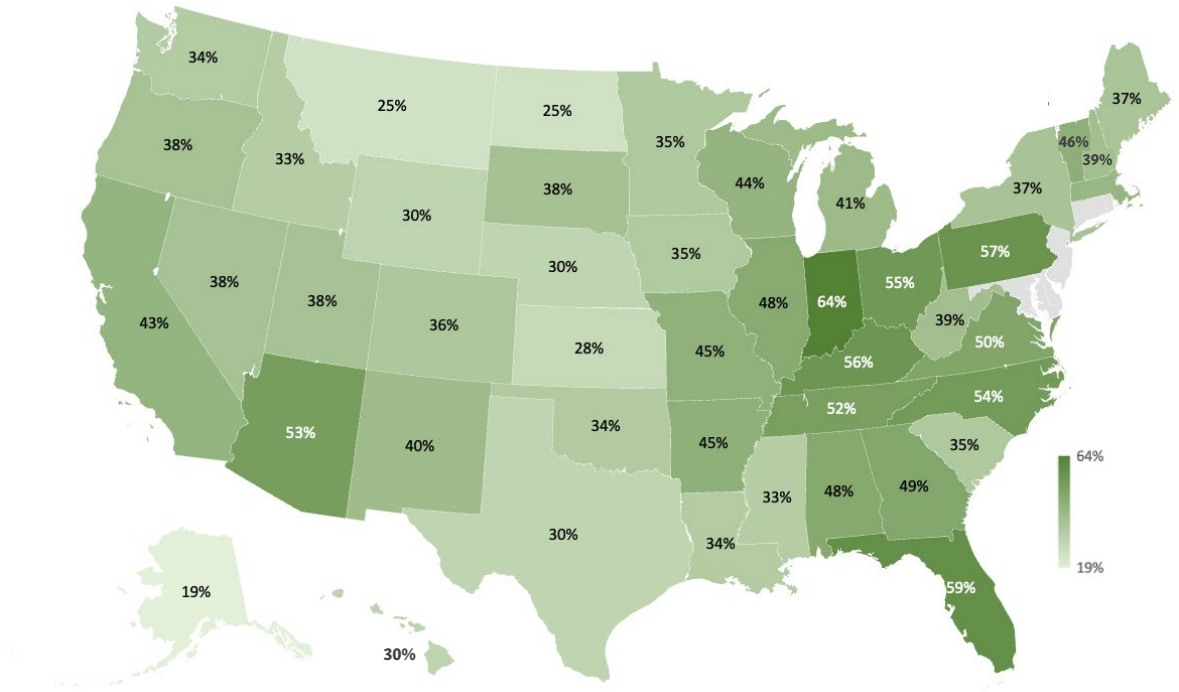
40%

of the cost of care is passed to the Medicare beneficiary via coinsurance ($80/$200)

High prices disproportionately impact Medicare Beneficiaries

Where is the Highest Patient Burden?

Map A: Median Percent of Medicare Outpatient Cost Passed to Beneficiaries by State (FY 2021)



64% *Indiana*

The range among the state median opportunity values is significant

19% *Alaska*

Note: Data set includes 1,300 of 1,359 critical access hospitals
Data Source: December 2022 Medicare Cost Report release for CAH fiscal year 2021.
Additional Analysis: Refer to the Medicare Cost Shifting study to be published at www.wintergreenme.com.

Additional Cost Report Opportunities

- Bad Debt
  - Establish a bad debt process (policies and procedures) that determines when to send claims to collections and for pulling back claims from collections to deem as worthless
    - The CAH must pull a claim back from collections and deem worthless prior to inclusion on the Cost Report

- Charge Description Master (CDM)
  - Monitor the ratio of cost-to-charges (RCC) on Worksheet C
    - The RCCs often highlight pricing issues or improper allocation of expenses
      - Respiratory Therapy RCC: 0.016878
      - Intravenous Therapy RCC: 0.052087
      - Diabetes Education RCC: 0.016717
      - Medical Supplies RCC: 1.037691
      - Implantable Devices RCC: 1.065079
      - Clinic RCC 3.792755

Additional Cost Report Opportunities

- Overhead Allocation Methodologies
  - Evaluate the methodology and stats used to allocate overhead costs on Worksheet B-1 particularly in the following areas:
    - Medical Records
    - Buildings and Fixtures (square footage)
    - Nursing Administration

- Interest Income
  - Engage cost report preparer, and if possible, establish a board-designated funded depreciation account to reduce the interest income offset
    - Most CAHs experience an interest income offset by not leveraging a board-designated funded depreciation account

Additional Cost Report Opportunities

- Method II
  - Critical Access Hospitals can elect Method II as a reimbursement opportunity where the hospital will submit a consolidated claim that includes both the professional and technical charges to Medicare
    - Electing Method II will improve reimbursements for outpatient services from Medicare

- Departmental Profitability
  - Organizations need to evaluate the profitability and contribution margins of each program to determine the net financial impact on the organization
    - For example, an organization was operating a Home Health program with $1.6M in fully-allocated cost and 7,400 visits of which 2,245 were Medicare
      - The organization received $420,000 ($187 / visit average) from Medicare, but would need to receive an average of $231 for non-Medicare business

Questions

Jonathan Pantenburg, Principal
Jpantenburg@wintergreenme.com

808.853.8086

ORH Announcements

- **2023 Forum on Aging in Rural Oregon**: May 15-17 in Seaside, Ore.

- **2023 Oregon CAH Quality Workshop**: May 16-17 in Seaside, Ore.
  Questions? Contact Stacie Rothwell | rothwels@ohsu.edu

- **June 8, 12 p.m. | 10 CAH Revenue Cycle Priorities: What to Review Immediately**
  (register here)
  Sometimes operational changes take time to manifest; sometimes, they don't. This presentation focuses on areas to review within your revenue cycle that can improve payment immediately (and retrospectively). This review will provide top areas of focus that can increase cash flow, enhance revenue, improve contractual performance and minimize denials.

OREGON OFFICE of RURAL HEALTH

OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

Thank you!

Sarah Andersen
Director of Field Services
ansarah@ohsu.edu

OHSU