CAH Cost Report Opportunities



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Cost Report Opportunities

CAH Financial and Operational Best Practices

- **Method II Billing**
  - On Row 106.00, hospital selected "N" for the all-inclusive method of payment for outpatient services. Method II allows the CAH to receive a cost-based payment for facility services, plus 115% of fee schedule payment for professional services for outpatient services
    - Under Method II, professional services are billed to and reimbursed by Part A
  - Action Item: If the hospital has elected Method II, the cost report should be updated to reflect that election
    - If not currently Method II, evaluate implementing Method II realizing that the transition to Method II does require MAC approval
- **Observation Days**
  - Observation Days were greater than the 25% benchmark set when evaluating the distribution of beds between the Observation and Acute levels of care
  - Action Item: Evaluate the scope of practice driving inpatient admissions and leverage available solutions to ensure the appropriate care setting for patients requiring inpatient care

CAH Financial and Operational Best Practices

- **Rural Health Clinic Cost Report Consolidation**
  - Although the hospital operates multiple RHCs, the hospital failed to consolidate the RHC cost reports which would allow the hospital to establish a single Upper Payment Limit (UPL), blend the productivity across the collective RHCs, and reduce the administrative burden associated with competing multiple cost reports
  - Action Item: Engage Cost Report preparer around whether the hospital can pursue the consolidation of the RHC Cost Reports
    - Due to the Consolidated Appropriations Act of 2021, restrictions are now in place that limit the ability to consolidate RHC Cost Reports going forward for new and established RHCs
- **Hospitalist Coverage**
  - The hospital removed a material amount of provider compensation from Adult & Pediatrics associated with the professional services provided in that unit
  - Action Item: Evaluate the integration of the inpatient providers into the Rural Health Clinic (RHC) to leverage the RHC reimbursement rate for Swing Bed patients
    - When integrating the providers, the hospital must keep track of costs applicable for acute/observation services to remove as an unallowable cost.

CAH Financial and Operational Best Practices

- **Gross and Net Days Accounts Receivable**
  - Some hospitals reported greater than 45 days gross and net days AR and other hospitals reported a higher net days AR than gross days AR
    - Reporting higher net days AR than gross could signify contractual adjustment issues and or pricing issues
  - Action Item: Evaluate revenue cycle functions and make operational changes, as necessary, to ensure both gross and net days AR accurately reflect the collective patient accounts and implement performance improvement plans to achieve the AR benchmark of 45 days.

- **Adult & Pediatrics Room Square Footage**
  - The hospital reported less than 250 square feet per patient room which likely does not include patient support areas such as the nurses' stations and dedicated hallways within the unit
  - Action Item: Evaluate reported square footages, at least annually, to ensure the hospital has appropriated allocated square footage to each revenue and non-revenue generating department

CAH Financial and Operational Best Practices

- **Nursing Administration**
  - The hospital allocates Nursing Administration cost to departments that do not require direct nursing supervision such as Physical Therapy, Diagnostic Imaging, and the Laboratory
    - Some organizations will often use the Nursing Administration cost report category to allocate charge nurses and floor supervisors instead of directly allocating the cost to appropriate departments
  - Action Item: Evaluate organizational charts and operational oversight to ensure Nursing Administration is only allocated to those departments requiring direct nursing supervision
- **Swing Bed NF Rate**
  - The hospital failed to report a Swing Bed NF rate on Worksheet D-1 which may have led to an overstatement of allowable costs used for establishing the daily routine rate
  - Action Item: Evaluate the Medicare cost report and work with the cost report preparer to ensure the inpatient routine service cost per diem is accurate and based on allowable cost

CAH Financial and Operational Best Practices

- **Physician Private Offices**
  - The hospital operates at least one free-standing provider-based practice as a non-reimbursable cost center which does not leverage any of the available reimbursement opportunities afforded to rural providers
  - Action Item: Evaluate the integration of specialty practices into a Rural Health Clinic, or establish as a provider-based clinic, to leverage reimbursement advantages
    - This is particularly important for CAHs due to the dilutive impact of operating non-reimbursable cost centers under a CAH.
- **Rehabilitation Services**
  - The hospital experienced a negative cost adjustment for rehabilitation services since the costs associated with those services were greater than what is allowable
  - Action Item: Since CAHs receive cost-based reimbursement from Medicare for rehabilitation services, the hospital must evaluate the costs associated with outsourced rehabilitation services based on staff availability and the services provided

CAH Financial and Operational Best Practices

- **Rural Health Clinic Minimum Productivity Threshold**
  - The RHC(s) failed to meet the minimum productivity threshold which reduced reimbursements received from cost-based payors
    - Some of the RHCs failed to pursue a waiver to the minimum productivity threshold in 2020 which was the year used to establish the Upper Payment Limit (UPL) for grandfathered RHCs
  - Action Item: Evaluate the reported FTEs in the RHC to ensure they are an accurate representation of the time providers were scheduled to provide care in the RHC
    - In addition, compare RHC providers to industry benchmarks and ensure a threshold of 4,200 patients seen for each 1.0 FTE physician and 2,100 patients seen for each 1.0 FTE advanced practice provider
    - Note: CMS removed the minimum productivity threshold for RHCs starting in 2025
- **Charge Description Master**
  - Due to the charge structure, the hospital passed on greater than 40% of the total Medicare cost to the beneficiaries in the way of co-insurance and deductibles
    - In addition, several hospitals had ratios of cost-to-charge which were outside peer benchmark hospitals
  - Action Item: Conduct a charge description master (CDM) review to ensure is appropriate based on the services offered and to ensure the hospital is not at a competitive disadvantage when compared to others

CAH Financial and Operational Best Practices

- **Interest Income**
  - The hospital experienced an interest income offset against interest expense due to treasury functions currently applied at the hospital
  - Action Item: Evaluate creation of a Board-designated funded depreciation account to mitigate or reduce the interest income offset experienced
- **Cost Report Settlement**
  - The hospital experienced a substantive settlement based on the finalized cost report which represented greater than 5% of total net patient revenue for the facility.
  - Action Item: Ensure the organization completes interim cost reports, at least quarterly, and files an interim cost report with Medicare to rebase the rates when experiencing a material due from Medicare.
    - This will help with cash flow and also improve reimbursements since Medicare Advantage plans do not go through a reconciliation process like Medicare.

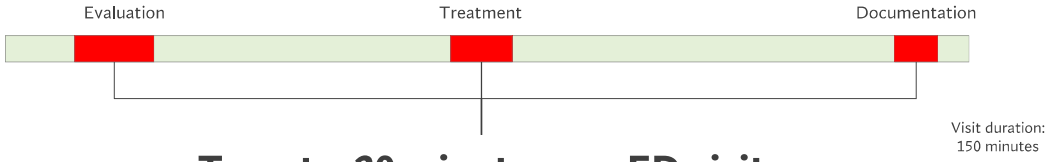
ED Provider Time Studies

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

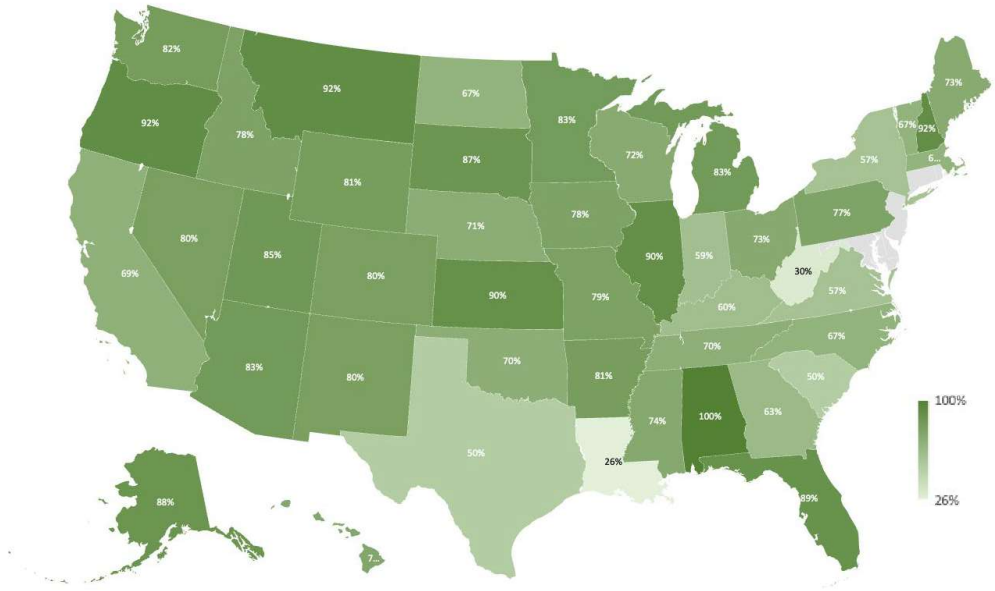


Target = 20 minutes per ED visit

		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

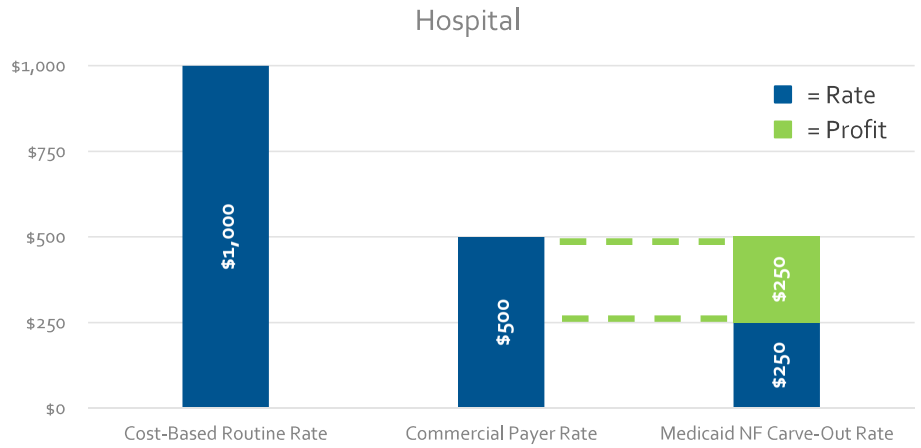
RHC Consolidation

- **RHC Cost Report Consolidation**
  - Entities that operate more than one RHC can 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**

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

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- **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

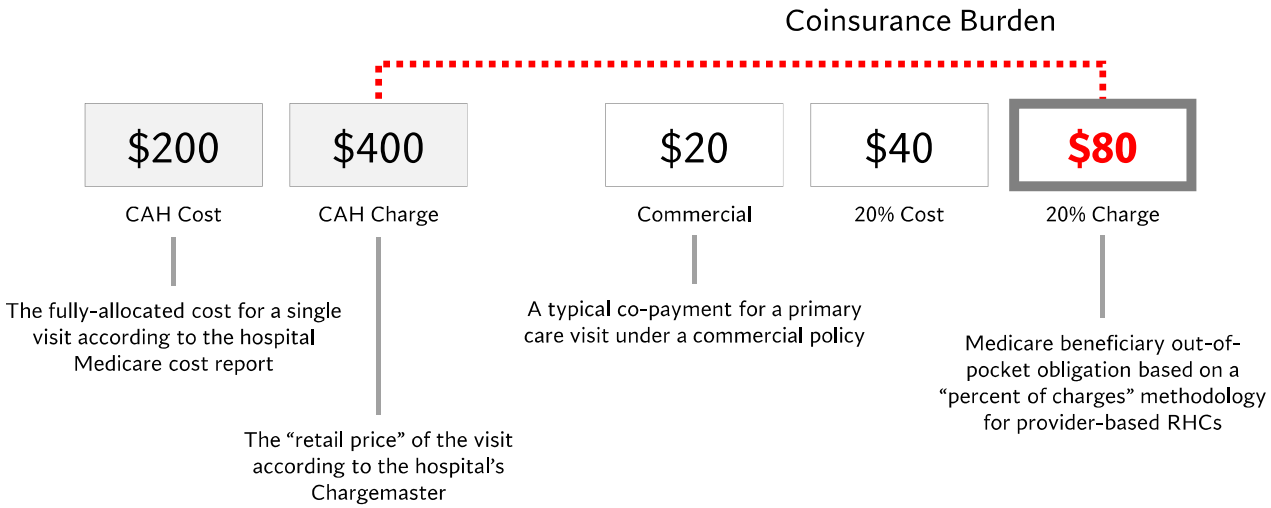
Pricing Methodology

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



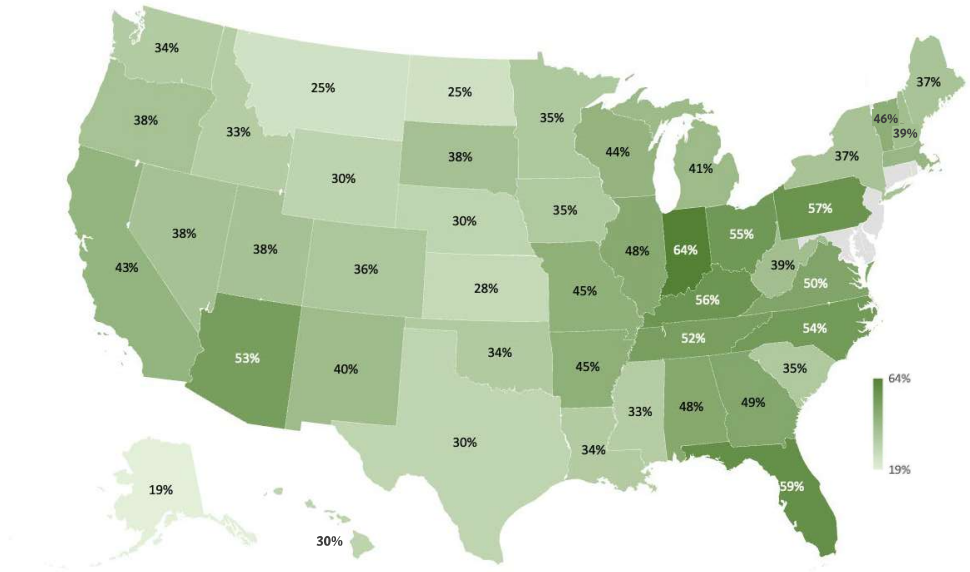
40%

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

- 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



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