Critical Access Hospitals and Cost-Based Reimbursement

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Agenda for Today

• Overview of Critical Access Hospitals

• Overview of Health Care Reform

• Behavioral Changes
  • Providers
  • Patients or “Consumers”

• What’s Next for Rural America

• Questions
Overview of Critical Access Hospitals
Critical Access Hospitals

- Critical Access Hospital (CAH) designation was created by the Balance Budget Act of 1997

- Limitations around location, number of beds, but not services provided

- Provides for reimbursement of cost for services provided to Medicare beneficiaries
Critical Access Hospitals

- Inpatient and Swing Bed Services
  - Reimbursement is made at 101% of reasonable costs
  - Initial payments on a per-diem amount
  - Final reimbursement settled on cost report
  - Coinsurance, Deductibles, and Sequestration apply

- Outpatient Services
  - Reimbursement is made at 101% of reasonable costs
  - Initial payments on a percentage of charges
  - Final reimbursement settled on cost report
  - Coinsurance, Deductibles, and Sequestration apply
Critical Access Hospitals

• Reasonable Costs
  • Excess compensation
  • Prudent-buyer principle
  • Excludes most Professional-Related Costs
  • Certain Non-Reimbursable Cost Centers
    • Dialysis, Home Health, Hospice, Long-Term Care
• Non-Patient Related Costs
  • Donations, Advertising,
Critical Access Hospitals

• Impact on Financial Performance
  • Has provided stability during fluctuations in volumes
  • Shift in patient utilization
  • Better than alternative payment methodology
  • Assist in capital improvement process

• Impact on Operational Performance
  • Caused organizations to become relaxed
  • “Medicare will pay for it”
  • Reinvestment in your organization
Overview of Health Care Reform
Health Care Reform

Better care for individuals

Better health for populations

Lower growth in health care expenditures

Provider
Care Delivery Transformation: From Acute Care to Prevention Track, Predict, Intervene, Manage

Goal:
- Keep People Healthy Longer
- Manage or Mitigate Risk
- Diagnose and Reduce Treatment Delay

Size of Impacted Population

Prevention/Wellness

Disease/Care Management

Continuum of Care

Healthy/“Worried Well”
“At Risk”
Undiagnosed
Chronically III Unmanaged
Chronically III Managed
End of Life

- Early identification and prevention
- New models of care delivery to improve:
  - Collaboration among providers
  - Patient knowledge, self-help and health
  - Increase intervention

Source: The Accountable Care Team presentation – presented by: Greg Caressi, Frost & Sullivan; Jacquelyn Hunt, IHI Fellow Consultant; Sue Scanlin, Continuum Health; Steve Kupsky, Kryptiq
Payment Reform and Strategies

- Value Based Purchasing
- Readmissions Penalties
- Bundled Payments
- Narrow Networks
- Pricing Transparency
- Affiliation Strategies
- ACOs / NRACO
- Insurance Marketplace
• **Value-Based Purchasing**
  - The ACA has already shifted reimbursement from “services provided” to “value provided” for PPS facilities.
  - It is expected that CAHs will also be required to make this shift. This will require CAHs to focus on value indicators, and implement quality and efficiency reporting.
  - Note: We believe there will be an efficiency factor in the future that will reward or penalize CAHs based on their evidenced efficiency.
Value Based Purchasing

• Value-Based Purchasing
  • More hospitals will receive bonuses than penalties in 2016
  • 1,800 will receive bonus payments
  • 1,200 will receive reduced payments
    • Average change was +/- 0.40%

• FFY 2016, reduction increases from 1.50% to 1.75% of the base operating MS-DRG (approx. $1.5B available)
  • 10% Clinical Process of Care
  • 25% Patient Experience (HCAPHS)
  • 40% Outcome
  • 25% Efficiency (spend/beneficiary)
Readmission Penalties

- **Readmissions Penalties**
  - PPS hospitals are already being penalized for readmissions.
    - Up to a 3% reduction!
    - Continually adding the number of conditions that qualify.
    - 2,665 hospitals penalized an average of 0.63%, 39 received the maximum 3% reduction
  - While CAHs are still paid for readmissions today, this is anticipated to change as health care moves to a prevention mandate.
Bundled Payments

• **Bundled Payments**
  • Set price for a pre-defined episode of care
  • Advantages
    • Simplified, single payment
    • Discourages unnecessary care
    • Reduces line-item coding burden
    • Predictable price
  • Most common services so far:
    • Surgery (Orthopedic, General)
      • CMS Comprehensive Care for Joint Replacement (75 MSAs)
Hospital Acquired Conditions

- Hospital Acquired Conditions (HAC) Penalty
  - FY 2015 was a 1% penalty
  - 758 of 3,308 Hospitals were affected last year
  - CMS assessed rates of 10 patient injuries at hospitals
  - Net saver for CMS! ($364MM)
• Pricing Transparency
  • Increases in out-of-pocket deductibles and coinsurance are causing patients to shop and price compare for health care services.
  • Providers need to have transparent pricing and know how to demonstrate the value of their pricing to patients.
Price Sensitivity

Cost-Conscious Behavior Affecting Pillars of Profitability

Consumers Paying More Out-of-Pocket

MRI Price Variation Across Washington, DC

- Price-sensitive shoppers will be acutely aware of price variation
- MRI prices range from $400 to $2,183

Source: Advisory Board Presentation: The Emerging Era of Choice
• **Narrow Networks**
  • As providers examine their ability to serve their community, defining and participating in narrow networks is becoming a reality.
  • Challenges include how to determine whom to partner with, how to prove value/cost to the network and how to prevent the organization from being excluded from such networks.
Where the Medicare ACOs Are
9 Pioneer, 433 Shared Savings Program, and 20 Next Generation ACOs as of April 2016.
Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/2016. LA’s Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as “adoption under discussion.”


Source: Kaiser Family Foundation Website – Health Reform
It is Not a Matter of IF, but WHEN???

- Cost reductions will become a reality in the future.

- Those that implement cost savings the earliest will create the greatest advantages.

- There has never been a more important time than now to challenge the status quo.

- Shift has caused demand for data to be at all-time high
Behavioral Changes
Behavioral Changes

- Health Care Reform is driving the need for change
- More information available
- More responsibility / accountability
- How “Data Drive Results”
AHA US Inpatient Days per 1,000 Population

US Inpatient days per 1,000

Source: AHA Hospital Statistics Guide
AHA US Admissions per 1,000 Population

Source: AHA Hospital Statistics Guide
AHA US Outpatient Visits per 1,000 Population

US Outpatient visits per 1,000

Source: AHA Hospital Statistics Guide
AHA US Emergency Room visits per 1,000 Population

Source: AHA Hospital Statistics Guide
Operational Intelligence

- In this era of health care, facilities must look at all areas of opportunities for operational improvement
  - Operational costs
  - Capital costs
  - Reimbursement opportunities
  - Quality scores
- To maintain or improve in these areas organizations need to look at statistics (such as benchmarks and data) to make better decisions
Time to Innovate!

• The approach hospitals have used in the past will no longer be what works in the future.
• Providers will be required to innovate with:
  • Technology, (tele-health, mobile/online care options),
  • Better training and development (Continuous Learning),
  • Value propositions (internal & external clients),
  • Accountability
Transform With Operational Intelligence
Data Driven Organization

• Must be able to use data to drive patient care decisions

• Need a “virtual integrated health care delivery information system”

• Data will help you manage chronic illnesses, reduce ED visits and readmissions, track patients throughout their care cycle
Data Driven Organization

• Without data providers cannot really be accountable for care
• Look at using patient navigators/care teams
  • They need to:
    • be familiar with patient care,
    • be able to work with all providers a patient needs,
    • and understand medical records and other data systems
• Be able to compare quality and cost data internally and externally
Data Driven Organization

• Departmental / Operational Performance
  • Accountability
  • Labor Management
  • Continuous Improvement
  • Impact on Reimbursement
  • Maintaining High-Quality Care
Disruptive – Technologies
Patients

- Patients
  - Convenience
  - Outcomes
  - Personal Attention

- Consumers
  - Convenience
  - Outcomes
  - Personal Attention
### Consumer Preferences

**What Does “Convenience” Mean to You?**

<table>
<thead>
<tr>
<th>Convenience</th>
<th>18-29</th>
<th>30-49</th>
<th>50-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Extended Hours</strong></td>
<td>Clinic is open 24/7 highest-ranked convenience attribute</td>
<td>Time to First Available</td>
<td>Ancillary On-site</td>
<td>I can get lab tests or x-rays done at clinic highest attribute</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>After-Hours Access</td>
<td>These cohorts preferred After-hours access over Weekend access</td>
<td>Weekend Availability</td>
<td>These cohorts preferred Weekend access over After-hours access</td>
</tr>
<tr>
<td><strong>Value</strong></td>
<td>Eliminating Out-of-Pocket Charges</td>
<td>Visit will be free was these cohort's top preference across all 50 clinic attributes</td>
<td>Convenience &gt; Free</td>
<td>Time to first available and Ancillaries on-site over Free visit</td>
</tr>
<tr>
<td><strong>Reputation</strong></td>
<td>What Reputation?</td>
<td>These cohorts cared less about reputation than the 65+ cohort—no reputation factors appeared in their top 20 attributes. Their highest reputation factor was Clinic's patient satisfaction survey scores are in top 10% for my area</td>
<td>Brand/Affiliation</td>
<td>4 of top 20 clinic attributes were on reputation</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Cutting Edge Technology and Provider Credentials</td>
<td>Treatment by a doctor instead of a nurse practitioner and Clinic has latest, cutting-edge technology were the highest-ranked quality preferences across all cohorts, both were preferred over Clinic's quality scores are in the top 10% for my area for all cohorts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Advisory Board Presentation: Blueprint for Growth 2020; 2014 Primary Care Consumer Choice Survey, Marketing and Planning Leadership Council
How Do I Respond?

• Continue to deliver excellent care
• Continue to be driver for rural health care
• Be innovative and engage with the community
• Promote healthy living and healthy lifestyles
• Be the LEADER!
What’s Next for Rural America?
Top Issues for 2016

- Mobile Apps and Wearables
- Telehealth
- High Deductibles and Patient Responsibilities
- Collaboration and Mergers Amongst Healthcare Providers and Insurers
- Alternative Payment Models
- Cybersecurity/Identity Theft
- Behavioral Health
- Consumerism
- Shared Economy (Uber)
Questions?

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Thank You!

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