STROUDWATER

ALL YOU NEED TO KNOW ABOUT CAHs

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OVERVIEW

- CAH History and Designation
- CAH Economics and Payment
- CAH Strategies for Success
- Questions

CAH HISTORY AND DESIGNATION

CAH PROGRAM HISTORICAL OVERVIEW

- Hospital providers are challenged to maintain access to high quality medical care while facing cuts in Medicare reimbursement
- One true benefit to small, rural hospitals derived from the Balanced Budget Act of 1997 (BBA) was the establishment of the Medicare Rural Hospital Flexibility Program (MRHFP)
- A feature of the MRHFP was the creation of the CAH—a hospital that is eligible for generally more favorable, cost-based Medicare reimbursement
- Historically, to qualify for cost-based Medicare reimbursement, CAH status required that a hospital be classified as rural, have a bed limit of 25, with no more than 15 acute patients at one time and an absolute length of stay of less than 96 hours

CAH PROGRAM HISTORICAL OVERVIEW (CONT.)

- The Balanced Budget Refinement Act (BBRA) was passed in 1999 and the Medicare Benefits Improvement and Protection Act (BIPA) was passed in 2000
  - BBRA and BIPA increased the benefit of the CAH program by making the rules less clinically restrictive and expanding the definition of costs that are considered allowable

- The Medicare Modernization Act (MMA) was passed in November 2003. CAH Improvements include:
  - 101% of Costs – 1/1/04
  - Up to 25 Acute Beds – 1/1/04
  - Up to 10-Bed psych and/or rehab unit – 10/1/04
  - On-Call cost reimbursement for ER physicians, PAs, NPs, and Clinical Nurse Specialists – 1/1/05
  - **Necessary Provider status eliminated after 1/1/06**

CAH PROGRAM HISTORICAL OVERVIEW (CONT.)

- Healthcare Reform passed in March 2010. CAH changes include:
  - CAH cost-based reimbursement protected
  - CAHs not required to report quality data
  - 340B discount drug program extended to CAHs
  - Extended Medicare Rural Hospital Flexibility Program through 2012
    - *Now extended through 2022*
  - Other Health Reform Provisions with significant effects on CAHs
    - Accountable Care Organizations
    - Reduced PPS Hospital reimbursement
    - Increased insurance in rural areas
    - Etc.
- All major pieces of healthcare law thus far have protected or improved the CAH program

CAH DESIGNATION

- Medicare Conditions of Participation (COPs) are extensive and include, but are not limited to the following:
  - Operate fewer than 25 inpatient beds
  - Maintain an average length of stay of less than 96 hours for inpatient acute care services
  - Offer 24-hour emergency department, laboratory, and diagnostic x-ray services
  - Located in a rural area
  - Meet federal distance requirement that a CAH must be at least a 35-mile drive on primary roads or 15 miles on secondary roads to the nearest hospital or CAH
    - A CAH acquiring an off-site PBC, unless the entity is a PB-RHC, is required to meet distance requirements based on the location of the acquired entity

CAH DESIGNATION (CONT.)

- Location in a rural area defined as:
  - Outside MSA, or within a rural census tract if in MSA
  - Not classified as an urban hospital by HCFA or Medicare Geographic Classification Review Board
- Located more than 35 miles, or 15 miles in mountainous terrain or secondary roads, from a hospital or another CAH unless certified by the State as a necessary provider
  - Necessary Provider option sunset on December 31, 2005
  - 9/7/07 change in CAH Interpretive Guidelines tightening definition of primary roads
    - In general, Primary Road must be Federal Highway or State Highway with 4 lanes to meet new definition
  - Proposed rule issued on 6/30/22 incorporates definition of “primary road” into regulation for the purposes of calculating distance requirement; “primary road” defined as:
    - Any road in the National Highway System, as codified at 23 U.S.C. section 103(b); or
    - In the Interstate System, as defined at 23 U.S.C. section 103(c); or
    - A US-Numbered Highway (also called “US Routes” or “US Highways”) as designated by the American Association of the State Highway and Transportation Officials (AASHTO), regardless of whether it is also part of the National Highway System
      - CMS seeking comment on “primary road” definition

CAH DESIGNATION (CONT.)

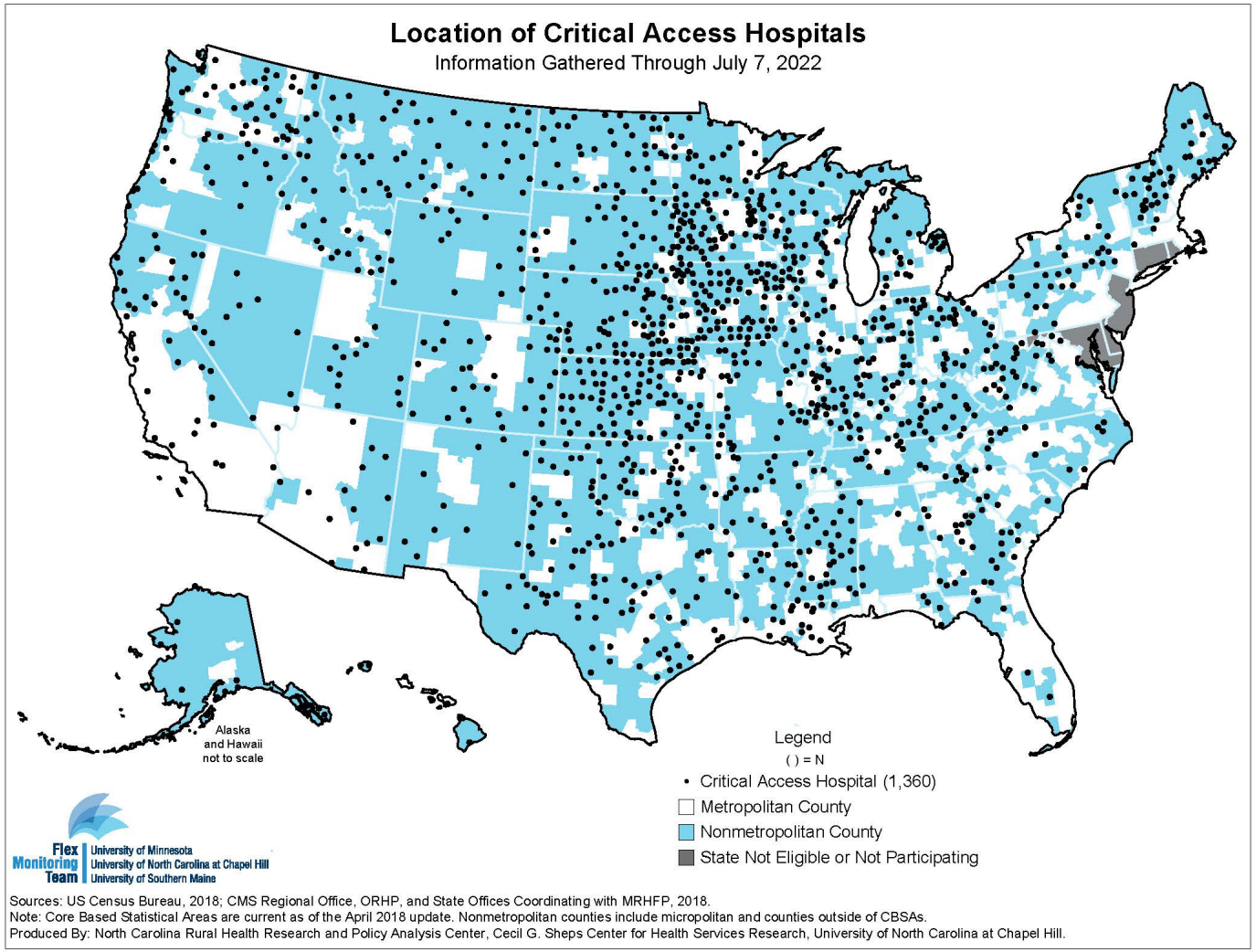
- Further, section 42 CFR 485.610(e)(2) requires that if a CAH operates an off-campus provider-based facility as defined in §413.65(a)(2), except for a rural health clinic (RHC), that was created or acquired on or after January 1, 2008, then the off-campus location must meet the federal distance requirement to the next nearest hospital or CAH
  - 42 CFR 405.2401(b) excludes already-established RHCs from the list of provider-based facilities that must comply with this requirement
  - 42 CFR 413.65(a)(2) defines a campus as the physical area immediately adjacent to the provider's main buildings, other areas, and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any other areas determined by the CMS regional office on an individual case basis to be part of the provider's campus
- Operating a provider-based facility which does not meet the distance requirements would lead to the loss of their CAH designation even if the CAH is designated as a necessary provider

CAH DESIGNATION (CONT.)

- Prior hospital status (non-profit, public, or for-profit)
- Makes available 24-hour emergency care “determined by the State as adequate” to ensure access to emergency services
- Network agreement with referral hospital
- Has no more than 25 total beds, including swing beds, with acute beds historically limited to 15 at any given time, now 25 (MMA)
  - Swing beds may be used for patients who have had acute stays of 3 days or longer

CAH LOCATIONS

- Currently 1,360 CAHs Geographically distributed throughout USA (source: Flex Monitoring Team)
  - Grown from 916 in 2004



CAH ECONOMICS

CAH ECONOMICS – OVERVIEW

- Rural Hospital Cost Structure
  - Variable Cost
    - Definition: Expenses that change with changes in activity
    - Examples: Pharmaceuticals, reagents, film, food
  - Fixed Cost
    - Definition: Expenses that do not change with changes in activity
    - Examples: Rent, utilities
  - Mixed Cost (Step Fixed Costs)
    - Costs that remain fixed through a range of volume growth, then jump to next level
    - Examples: Salaries and benefits
  - Rural hospitals have inordinately high fixed costs relative to revenue (e.g., ER Standby, acute care nursing costs, etc.)
  - High-fixed-cost nature of rural hospitals focuses efforts in several areas
    - Volume
    - Unit price increases
    - Fixed cost reduction or transition to variable expenses

CAH ECONOMICS – FOOD FOR THOUGHT

- Maximizing CAH benefit does not result in profitability
- Like any business
  - Profits = (average revenue per unit - average cost per unit)*Units
    - Average revenue per units = Total revenue / Total Units
    - Average cost per units = Total costs / Total Units
  - Achieving profits requires that hospitals increase fees for services generated and/or reduce per unit costs
    - Strategy 1: Reducing total costs
    - Strategy 2: Increase fees
    - Strategy 3: Increasing units of service
    - Strategy 4: ????

CAH REIMBURSEMENT

- Payment for Medicare inpatient and Part “A” outpatient services on the basis of “reasonable cost” (+1%)
- Many States have extended CAH reimbursement rules to their Medicaid programs
  - Reimbursement varies by State; understanding of Medicaid reimbursement methodologies is imperative to evaluating reimbursement impacts
- Medicare Advantage Plans pay CAHs based on costs
  - Most often without settlement on the year-end cost report
- How CAH status lowers risk for rural hospitals
  - Inpatient and outpatient (non-professional) costs paid on cost-based reimbursement for Medicare and (some states) Medicaid
  - High Medicare and Medicaid occupancy rates
  - Focus on outpatient services
    - Often opportunity for margin as a CAH
- Many CAHs are protected from potentially high costs associated with investing in capital projects due to cost-based reimbursement for expenses such as depreciation and interest

CAH ECONOMICS – QUESTIONS AND ANSWERS

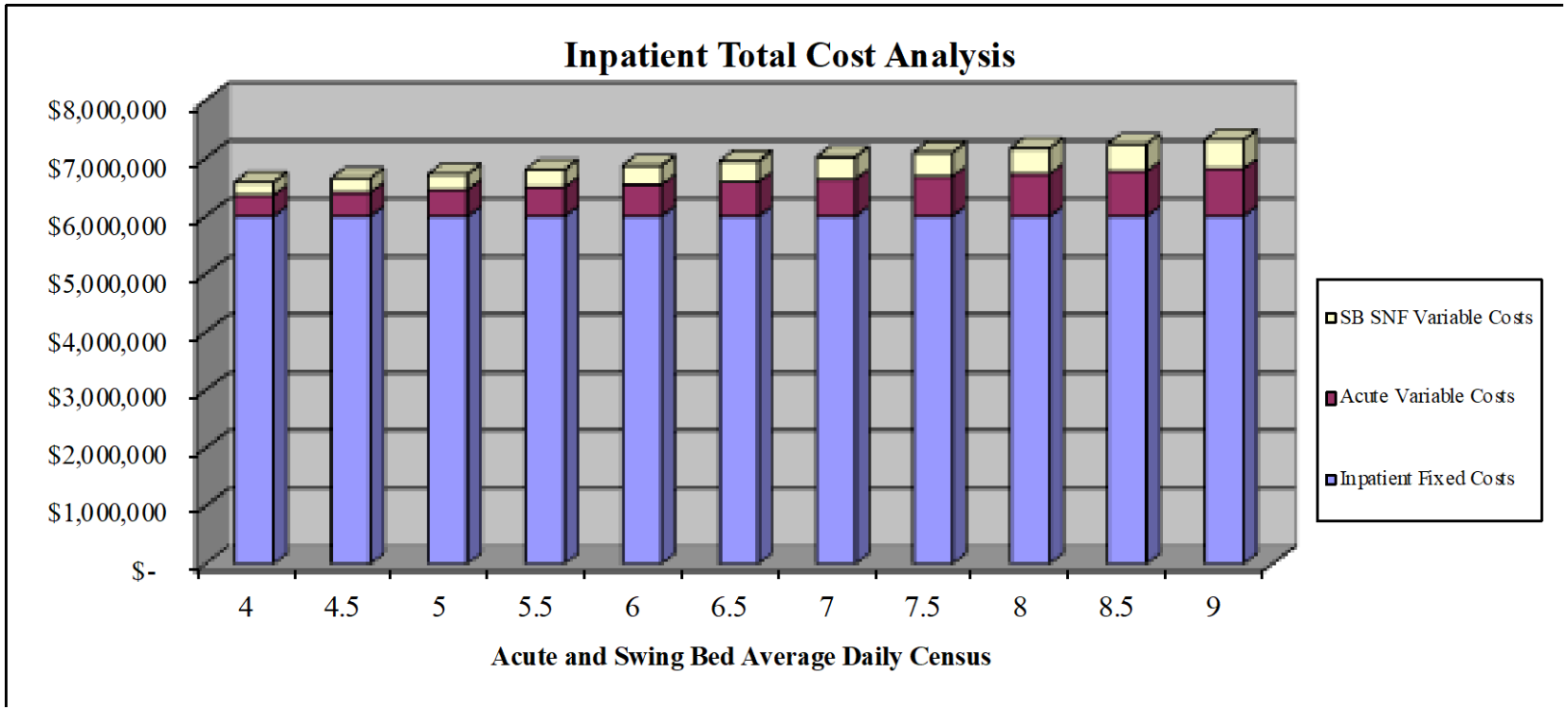
- Hypothetical Model Used to Evaluate CAH Economics

Hypothetical Model Assumptions:

Expenses:		
Inpatient:		
Acute Variable Costs/Day	$	250
Swing-Bed SNF Variable Costs/Day	$	150
Total Fixed Rountine and Ancillary Costs	$	6,000,000
Outpatient:		
Outpatient Variable Costs/Unit	$	50
Total Fixed Outpatient Costs	$	10,000,000
Revenue:		
Inpatient:		
Acute Revenue/Day (Non-Cost Based)	$	1,400
Swing-Bed SNF Revenue/Day (Non-Cost Based)	$	500
Swing-Bed NF Revenue/Day (Non-Cost Based)	$	250
Outpatient:		
Outpatient Revenue Per Unit (Non-Medicare)	$	200
Payer Mix:		
Inpatient:		
Medicare/Medicaid Acute Payer Mix		70%
Medicare Swing-Bed SNF		100%
Outpatient:		
Medicare/Medicaid Outpatient Payer Mix		50%

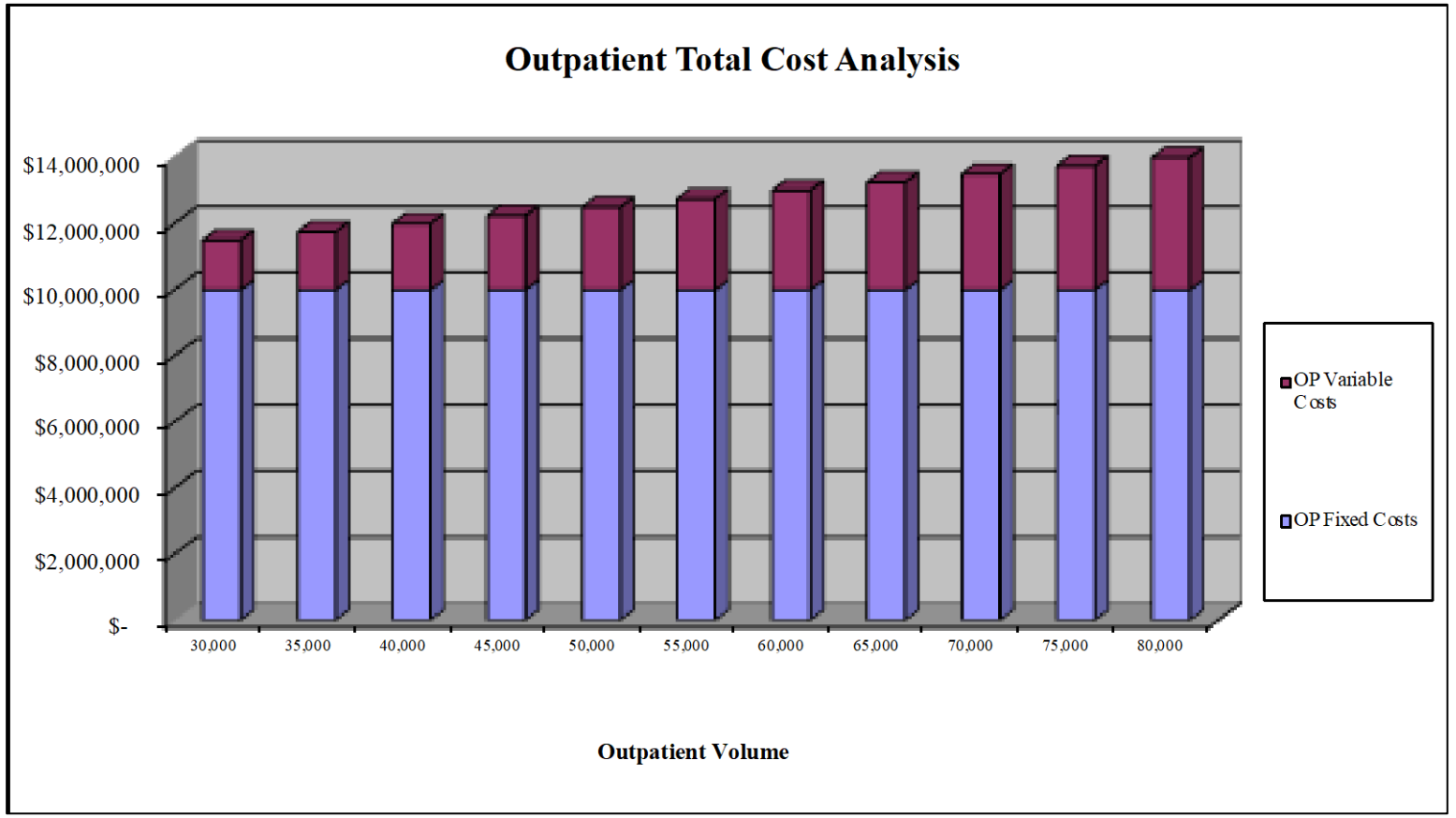
ECONOMIC MODEL: INPATIENT TOTAL COSTS

- **Hypothetical example (continued)**
  - Acute Variable Costs = $250/day
  - Swing Bed Variable Costs = $150/day
  - Fixed Costs = $6,000,000



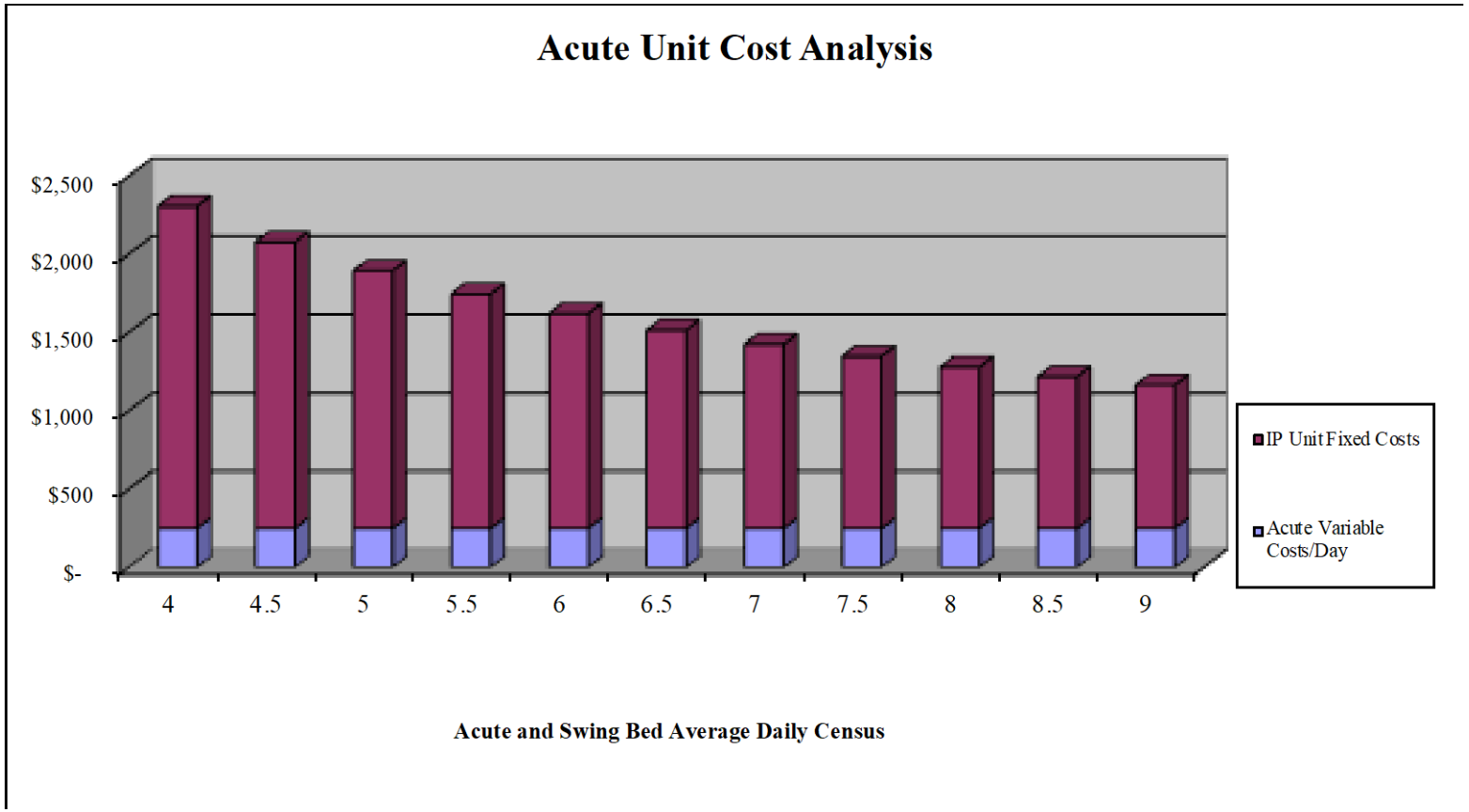
ECONOMIC MODEL: OUTPATIENT TOTAL COSTS

- **Hypothetical example (continued)**
  - Outpatient Variable Costs = $50/unit
  - Outpatient Fixed Costs = $10,000,000



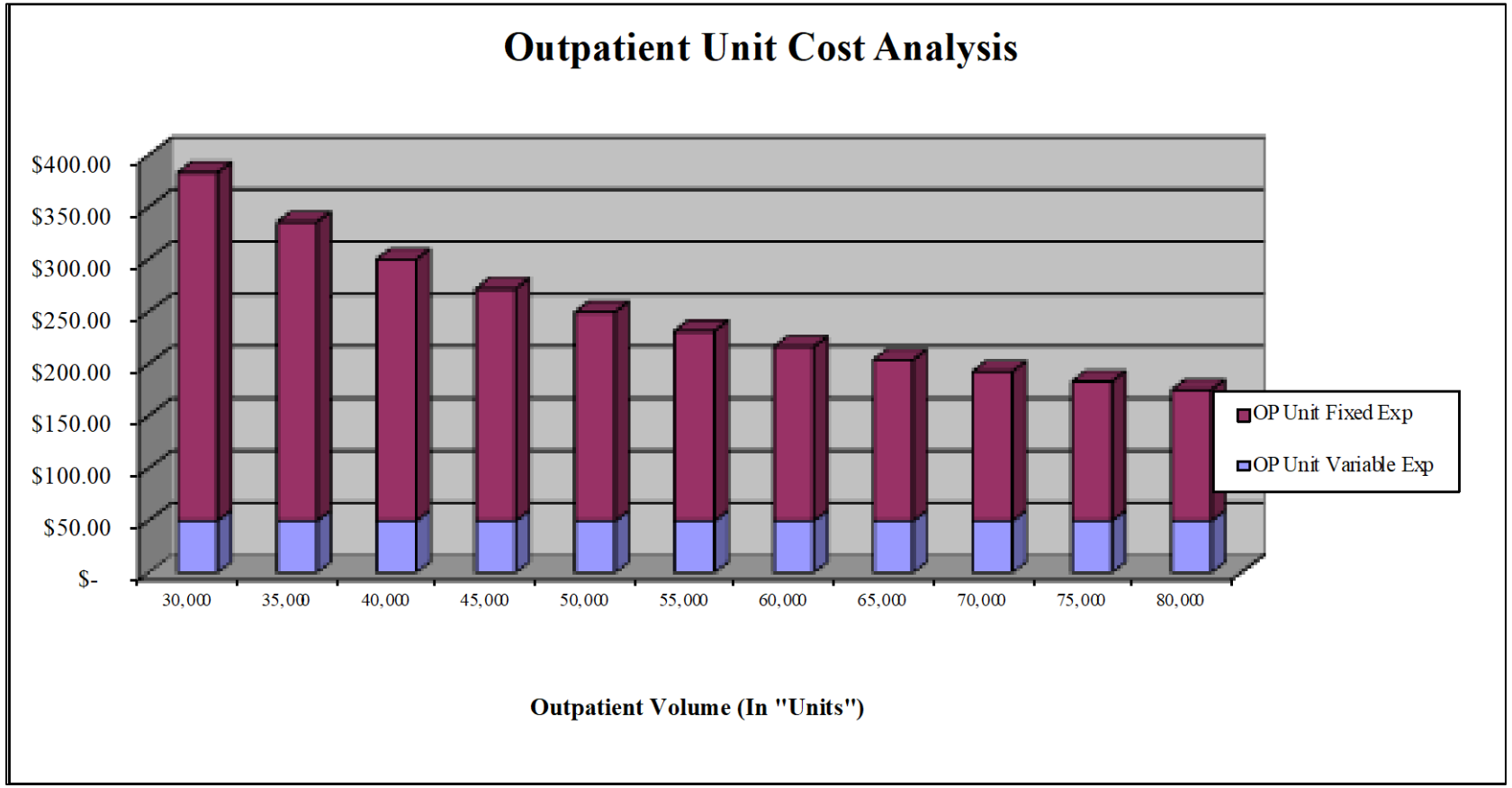
ECONOMIC MODEL: INPATIENT PER UNIT COSTS

- **Hypothetical example (continued)**
  - As volume increases, fixed costs are allocated over large base
  - Result → lower Unit Cost



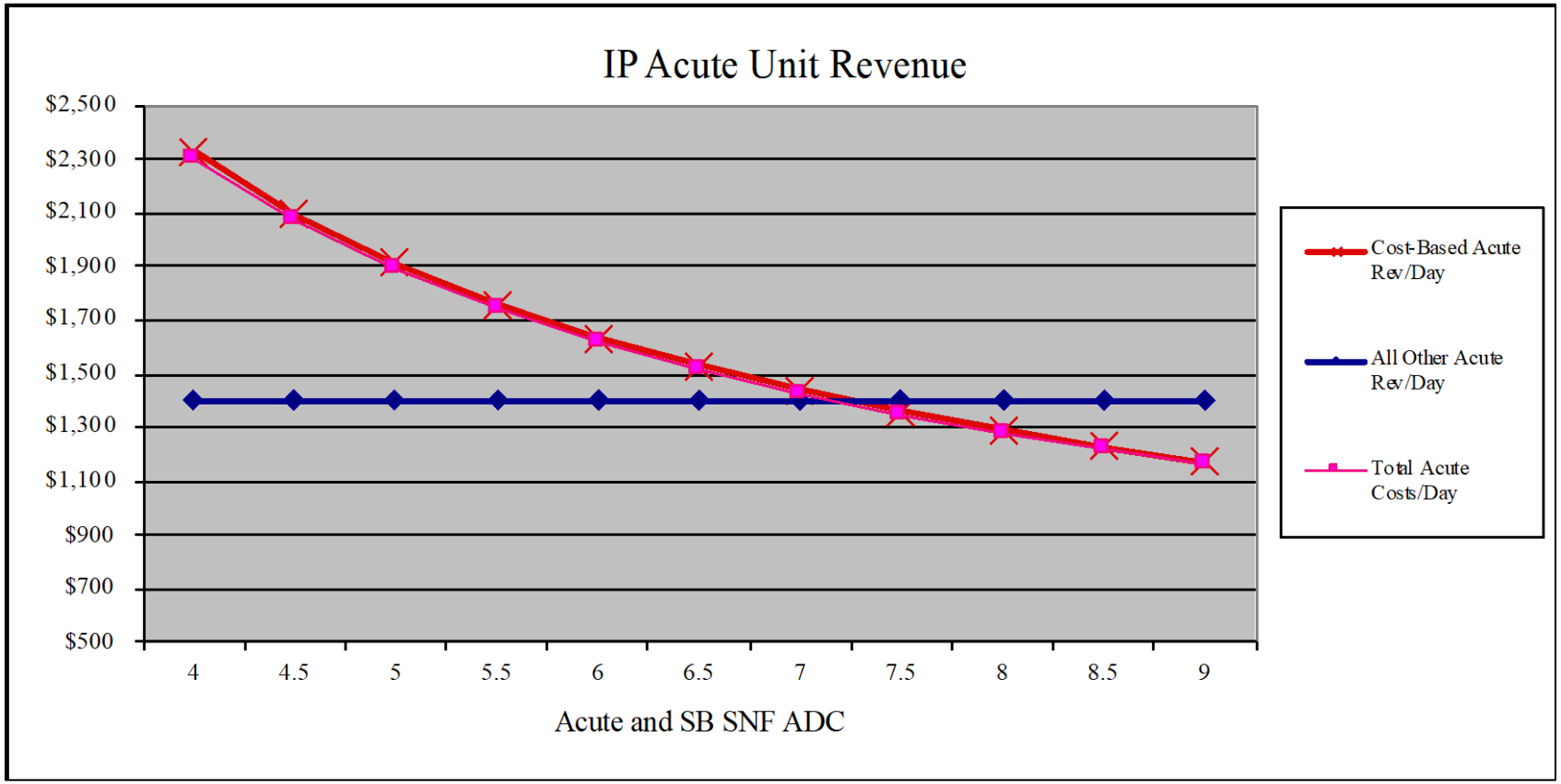
ECONOMIC MODEL: OUTPATIENT PER UNIT COSTS

- **Hypothetical example (continued)**
  - Same applies to Outpatient costs!



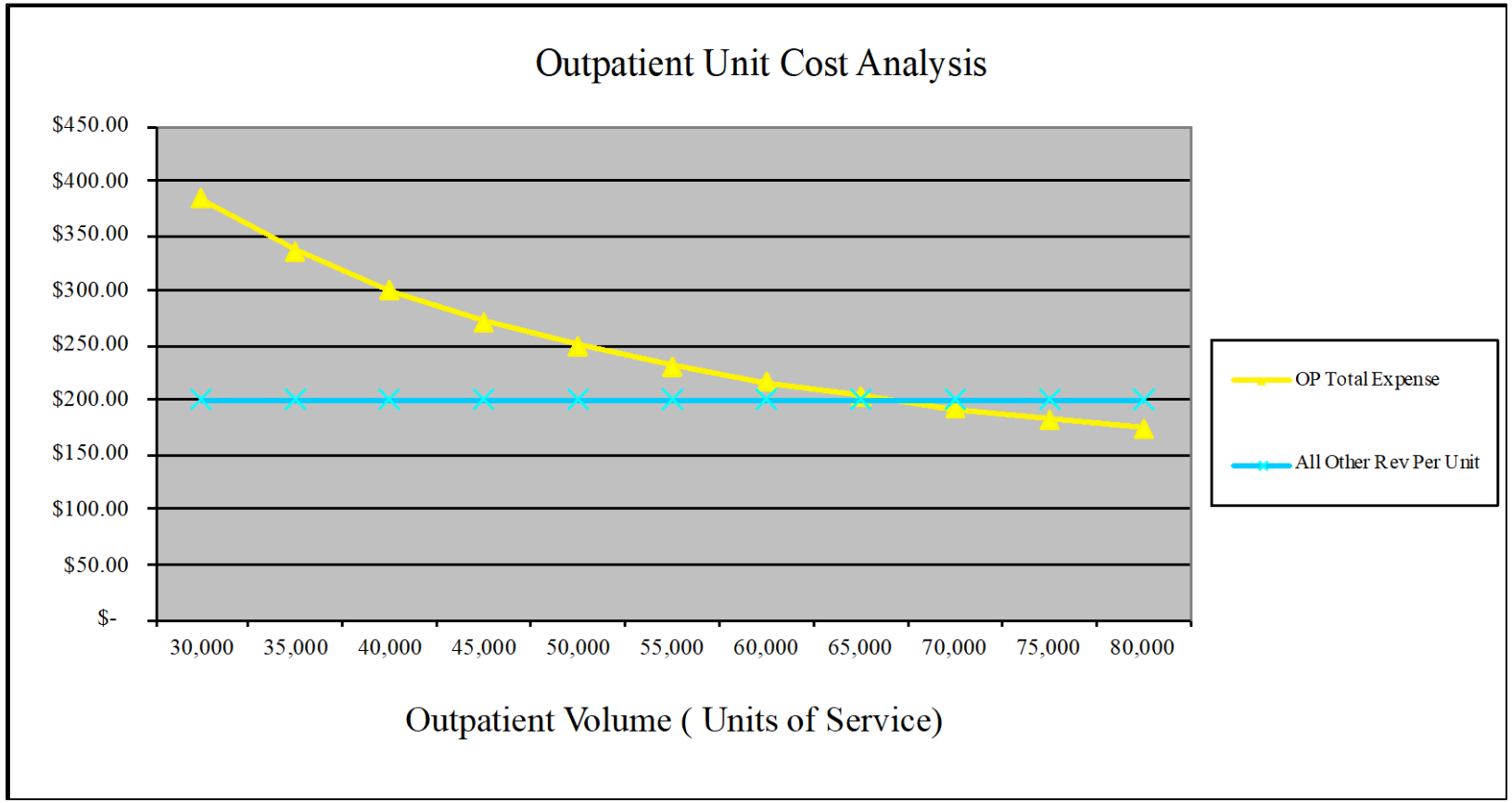
ACUTE PER UNIT REVENUE

- **Hypothetical example (continued)**
  - Non-Cost-Based Per Diems > Cost-Based Per Diems once Acute unit cost falls below $1400
    - Note: Slightly higher acute variable costs cause higher breakeven



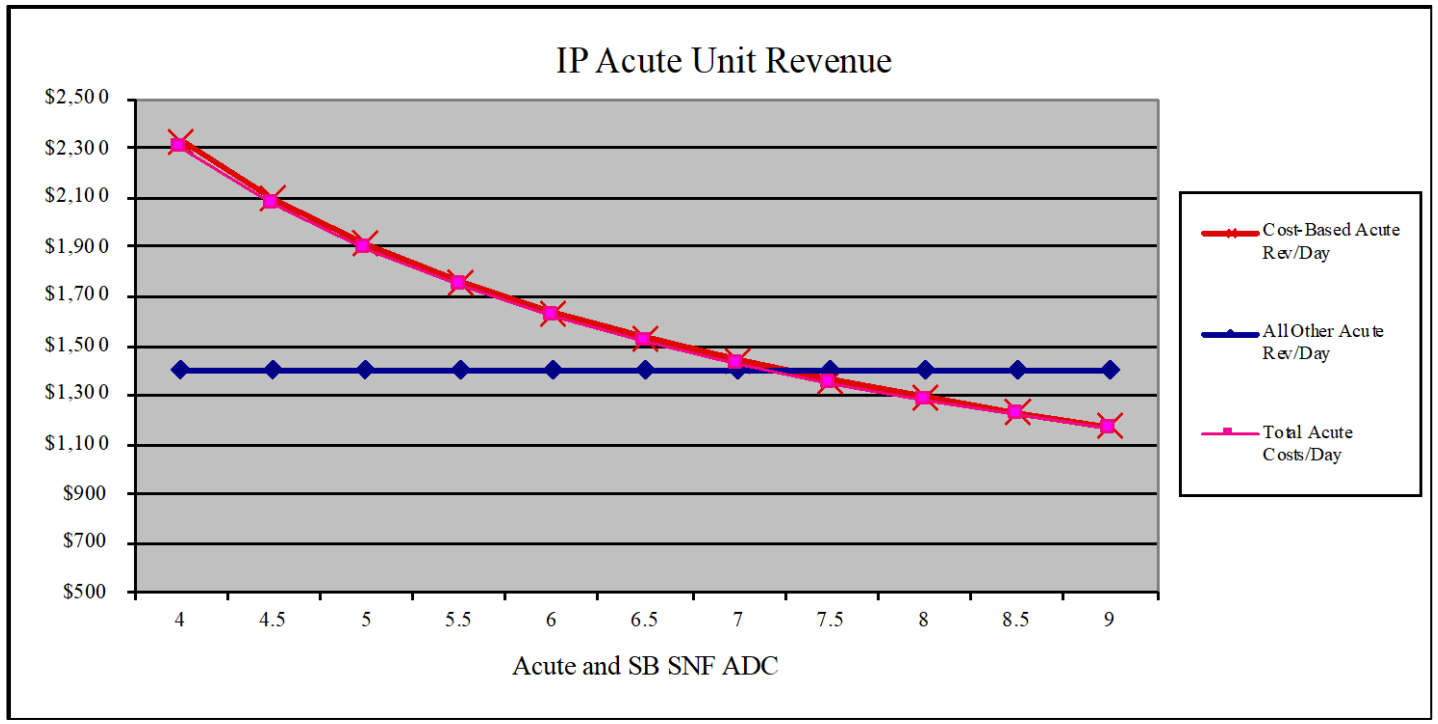
OUTPATIENT PER UNIT REVENUE

- **Hypothetical example (continued)**
  - Non-Cost-Based Payment > Cost-Based Payment once Acute unit cost falls below $200



CAH ECONOMICS – QUESTIONS AND ANSWERS

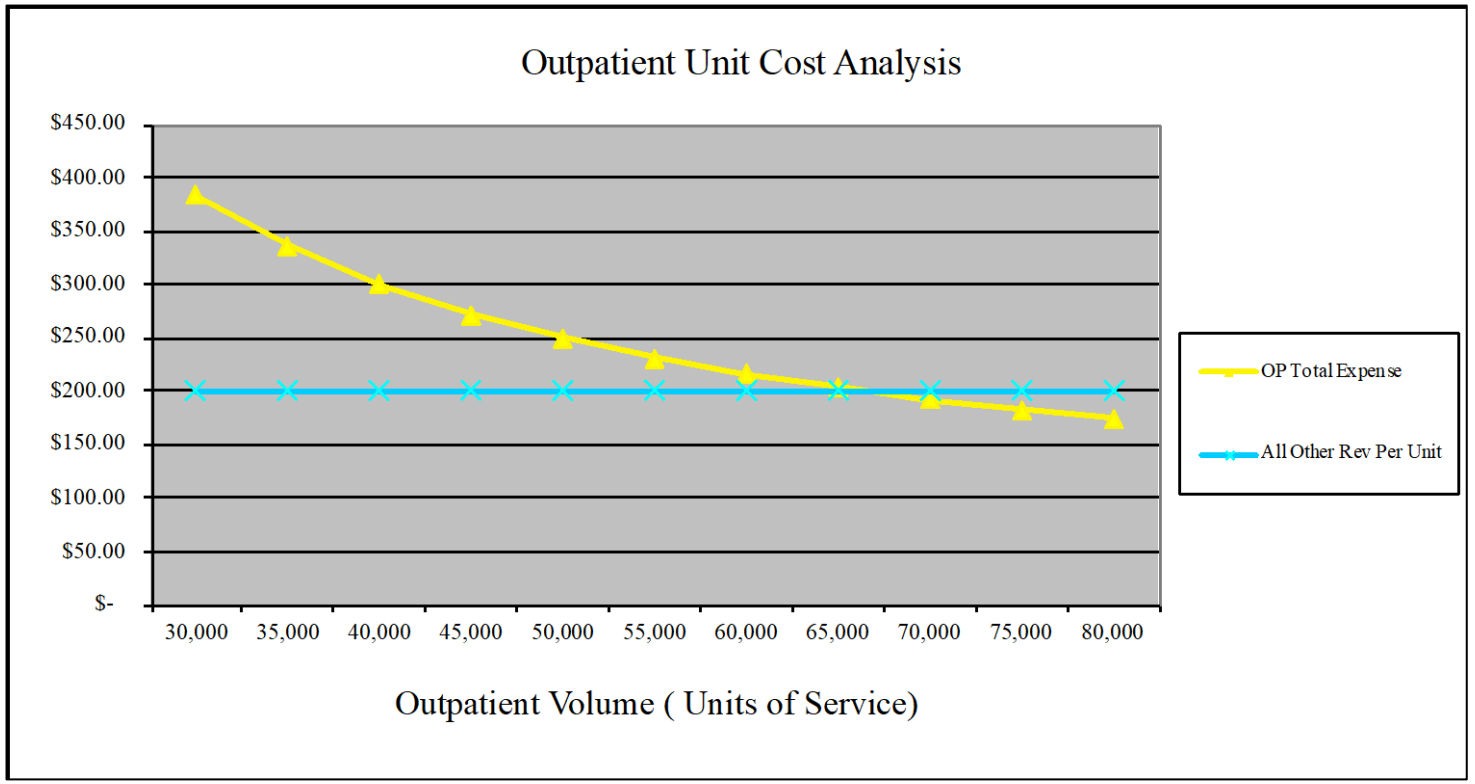
- *How does my hospital generate cash reserves?*
  - A look at Acute Per Unit Revenue
    - Hypothetical Example (continued)



  - Non-Medicare Per Diems > Medicare Per Diems once Acute unit cost falls below $1,400
    - Note: Slightly higher acute variable costs cause higher breakeven

CAH ECONOMICS – QUESTIONS AND ANSWERS

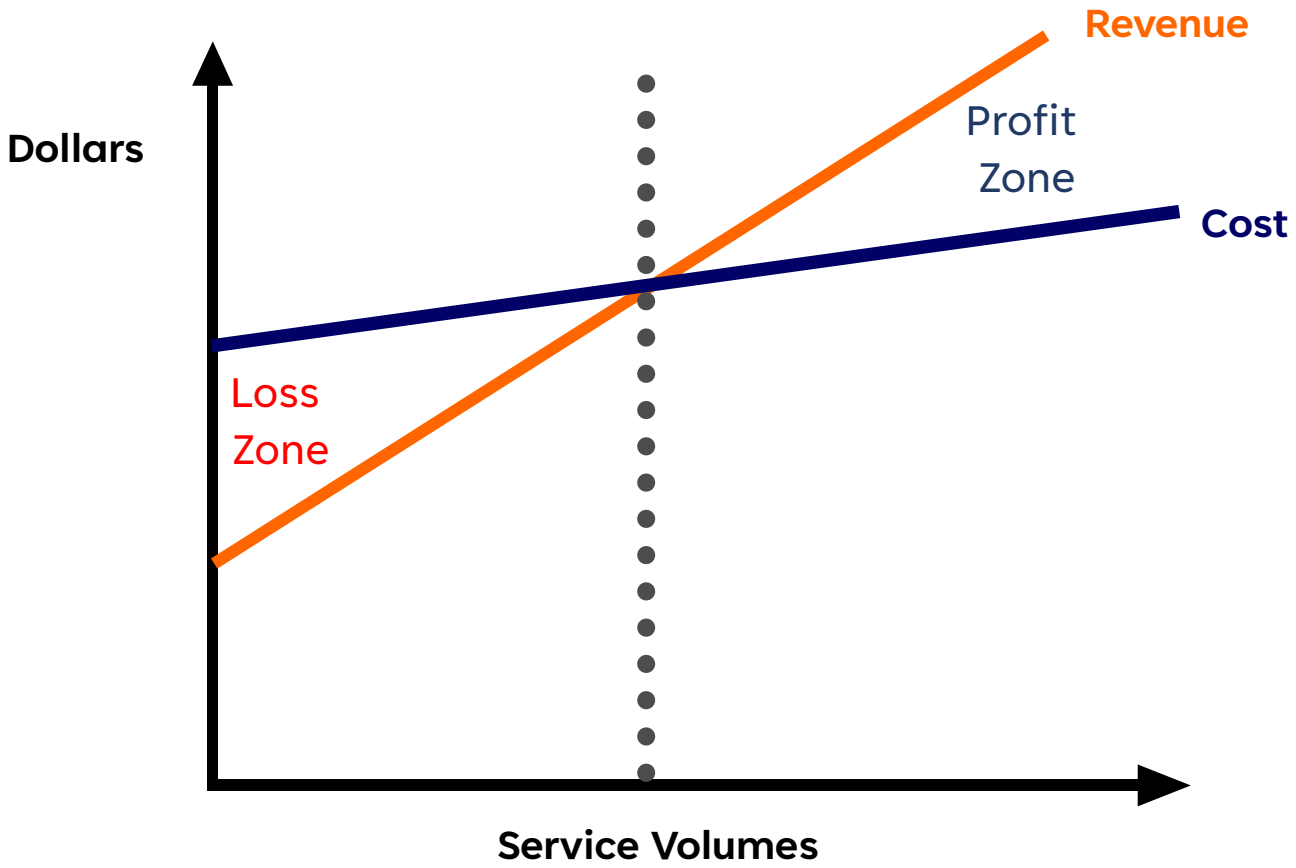
- *How does my hospital generate cash reserves?*
  - A look at OP Per Unit Revenue
    - Hypothetical Example (continued)



  - Non-Medicare OP Rev > Medicare OP Rev once OP unit cost falls below $200

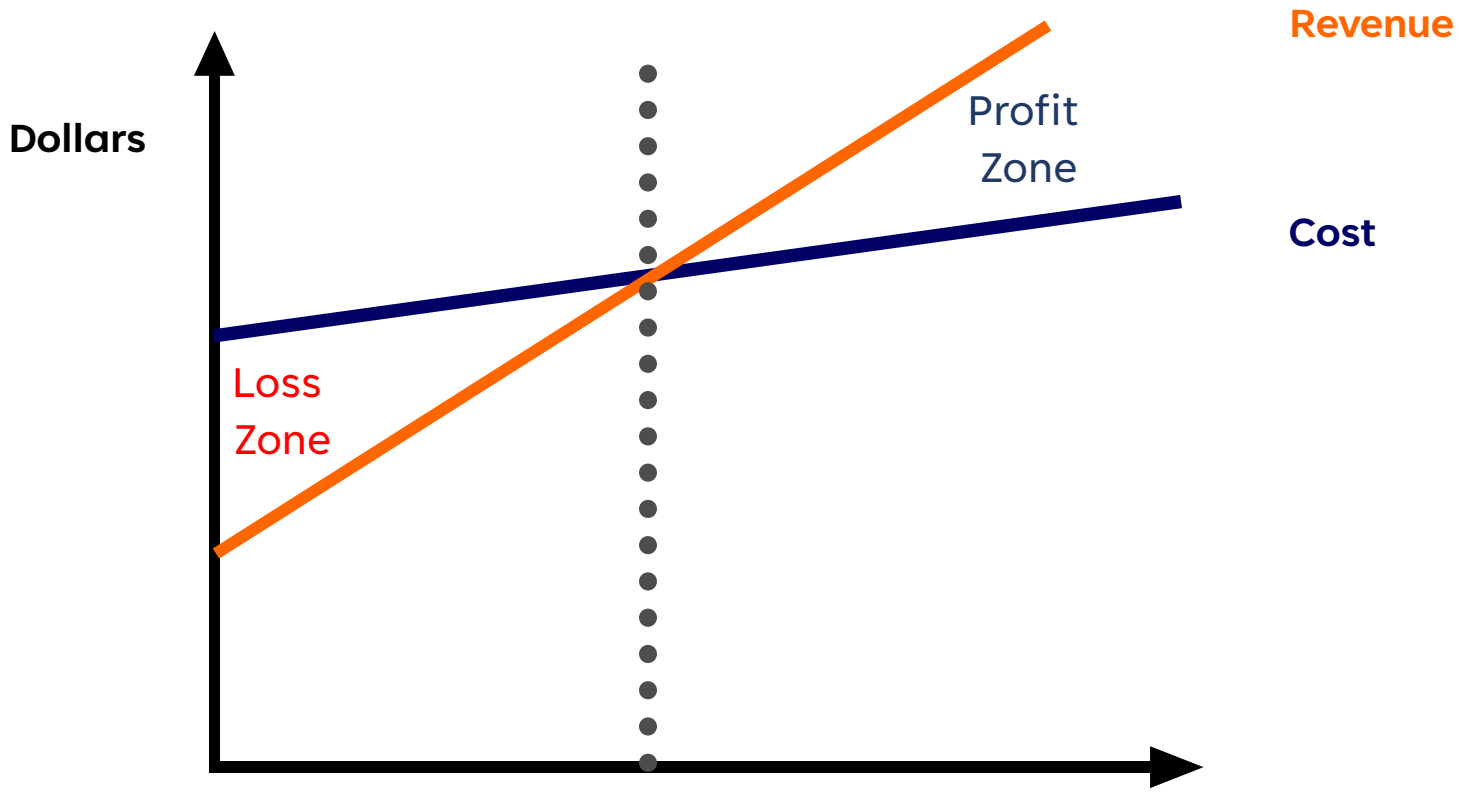
CAH ECONOMICS – QUESTIONS AND ANSWERS

- *How does my hospital generate cash reserves?*
  - **Strategy 1: Decrease Expenses**
    - Fixed nature of standby costs, regulatory costs, etc. often make this a difficult option - Most rural hospitals have expenses right



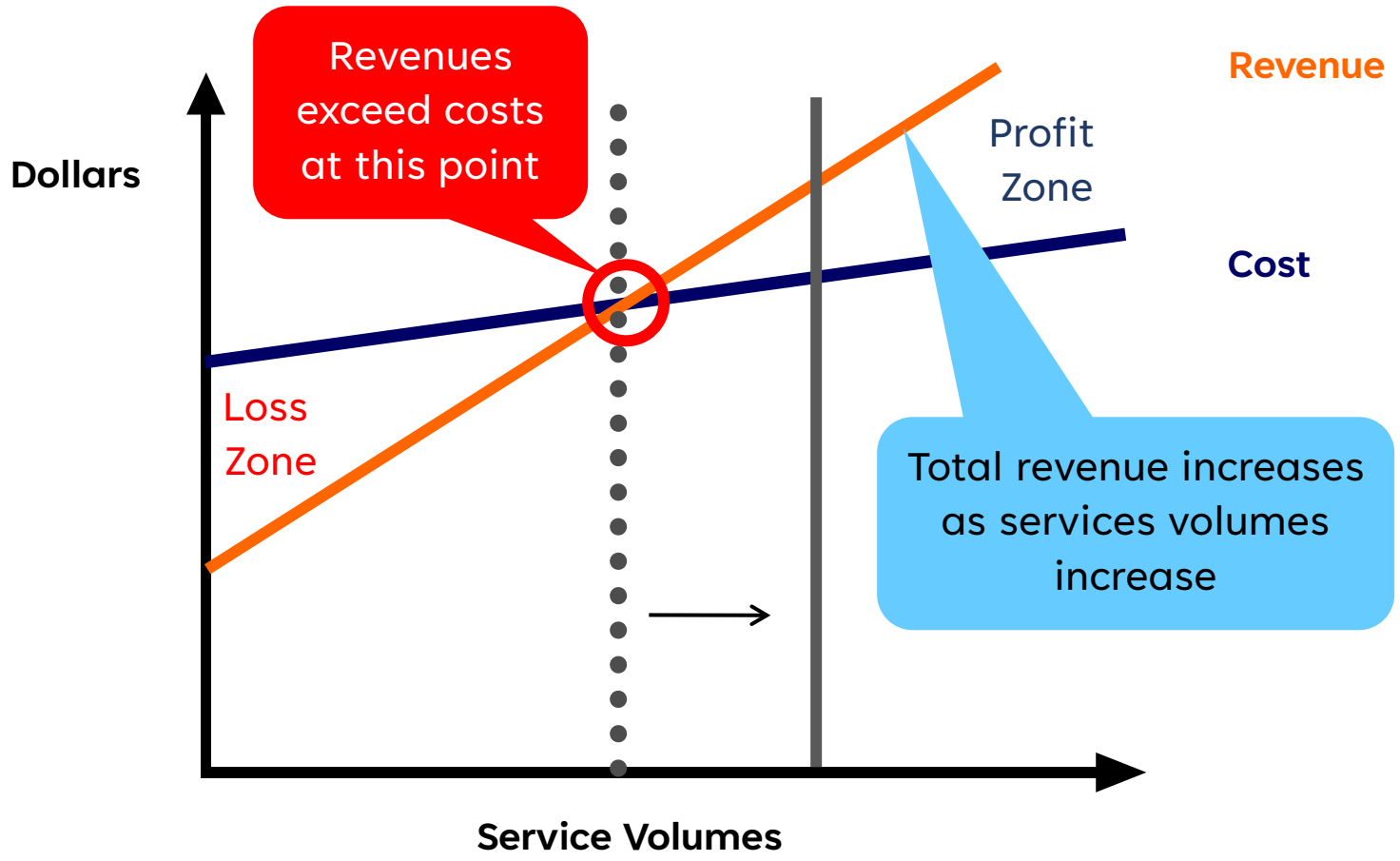
CAH ECONOMICS – QUESTIONS AND ANSWERS

- *How does my hospital generate cash reserves?*
  - **Strategy 2: Increase Fees**
    - Charge master update
    - Renegotiate third party contracts
    - Better Revenue cycle functions



CAH ECONOMICS – QUESTIONS AND ANSWERS

- *How does my hospital generate cash reserves?*
  - **Strategy 3: Increase Volumes**
    - More volume reduces the average cost per unit of service by spreading the high fixed costs over more patients



CAH ECONOMICS – QUESTIONS AND ANSWERS

- *How does my hospital generate cash reserves?*
  - **Strategy 4: Grow Non-Medicare Business**
    - *Strategy assumes incremental margin on non-Medicare offsets reduction in Medicare per unit revenue*

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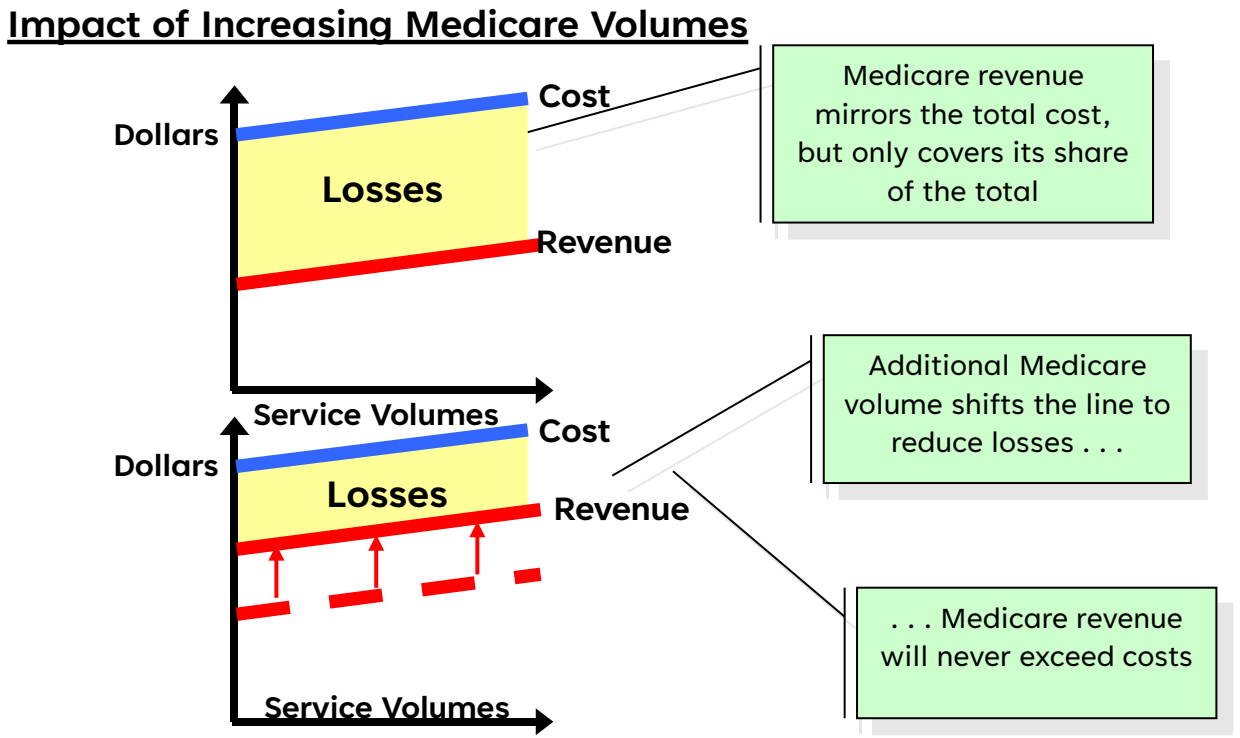
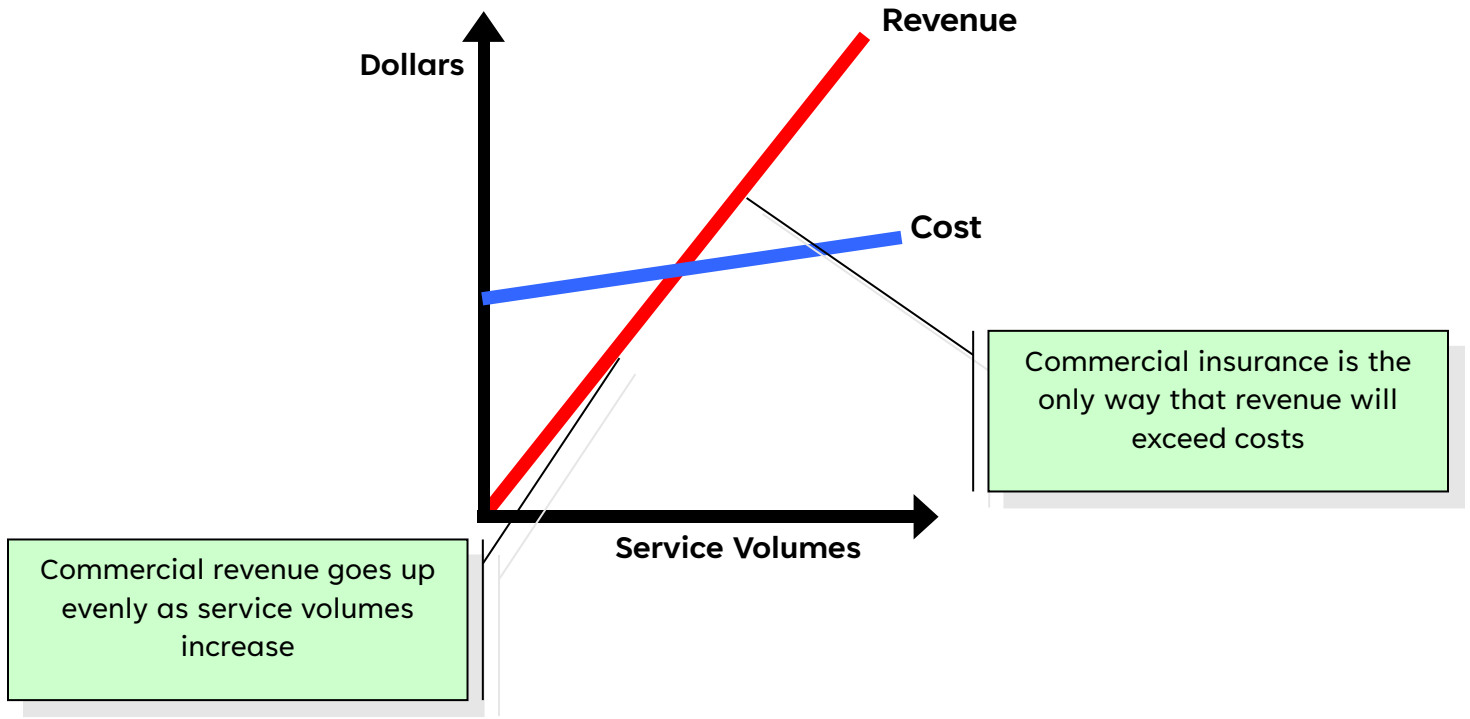


CAH ECONOMICS – QUESTIONS AND ANSWERS

- *How does my hospital generate cash reserves?*
  - Strategy 4: Grow Non-Medicare Business (continued)
    - Commercial revenue is the only potential source of profit
      - Overall services must be increased to exceed unit costs

Commercial Revenue Are Tied Directly to Volumes



CAH STRATEGIES FOR SUCCESS

FINANCIAL AND OPERATIONAL BEST PRACTICES

- The following best practice opportunities areas were derived from the 100+ Stroudwater CAH site visits conducted over the last five years
  - ❑ Strategy
  - ❑ Economic Philosophy
  - ❑ Inpatient Services
  - ❑ Emergency Services
  - ❑ Clinical Departments
  - ❑ Departmental Profitability
  - ❑ Quality Improvement
  - ❑ Information Technology
  - ❑ Cost Report Improvement
  - ❑ Revenue Cycle
  - ❑ Management Accounting
  - ❑ Staff Benchmark Analysis
  - ❑ Provider Complement/Practice Management
  - ❑ Provider Alignment
  - ❑ Service Area Rationalization
  - ❑ Alignment Strategy
  - ❑ Payment System Transformation
  - ❑ Population Health Management
- Based on Stroudwater experience, nearly all successful CAHs exhibit the same three overall attributes: abundance mindset, understanding of CAH economics (economic philosophy), and a measurement culture

ABUNDANCE MINDSET

- The most important performance driver for a rural hospital is the overall mindset of the staff, management team and trustees where their commitment centers on abundance and growth
- Stephen Covey coined the idea of *abundance mentality* or *abundance mindset*, a concept in which a person believes there are enough resources and successes to share with others
- This is contrasted with the *scarcity mindset* (i.e., destructive and unnecessary competition), which is founded on the idea that, if someone else wins or is successful in a situation, that means you lose; not considering the possibility of all parties winning (in some way or another) in each situation (zero-sum game)

ECONOMIC PHILOSOPHY

- Understanding the fundamental economic principles impacting CAH financial performance
  - Understand the difference between variable costs, fixed costs, and fully allocated costs
    - Value is unlocked by the marginal revenue gain in a high fixed cost environment
  - Recognize that, as a CAH, you cannot cut your way to success from an expense perspective
  - Recognize that nearly all paying services create positive contribution
  - Economic imperative is the development of 1,000s of mini “contribution margins” to cover fixed costs of CAH
  - Cost-based reimbursement will only cover costs and not generate aggregate profit

DEVELOPING A MEASUREMENT CULTURE

- *"If you can't measure it, you can't manage it."* – Peter Drucker
- CAHs that have a measurement culture outperform those who do not
- CAHs can create a measurement culture through the following:
  - Establish, target, track, and manage performance indicators
  - Utilize available benchmark data to drive improved performance
  - Provide data to department managers
  - Hold managers accountable for their respective areas
  - Engage employees with participation incentives

QUESTIONS?

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