1

Overview of today's discussion points

RHC Payment Changes & Strategies 01

CAH CCRs vs. Medicare Utilization 02

Rural Emergency Hospital Program 03

2

2

01

RHC Payment Changes & Strategies

3

Consolidated Appropriations Act of 2021

4

Consolidated Appropriations Act, 2021

To maintain financial health and viability, rural health clinics (RHCs) having been facing the following since The Act:

1. **All newly-certified RHCs are set at the same cap**
2. **"Grandfathered RHCs" are defined**
3. **RHCs must optimize their reimbursement**
4. **Clinics will want to analyze current and future reimbursement models**

5

5

Caps for "newly certified" or freestanding RHCs

- New limitations for independent RHCs, those with hospitals greater than 50 beds, and all "new" provider-based RHCs with hospitals less than 50 beds.

2023	$126.00
2024	$139.00
2025	$152.00
2026	$165.00
2027	$178.00
2028	$190.00

After 2028 and in subsequent years, the cap is increased by the Medicare Economic Index (MEI).

6

6

Caps for "grandfathered RHCs"

- Existing provider-based RHCs furnishing services as of December 31, 2020, where bed availability was less than 50 beds, will establish a base year rate based on the finalized 2020 Medicare cost report OR the first finalized Medicare cost report which contains the clinic's expenses for a full year.
- This base year rate ("limit") will be increased annually by the Medicare Economic Index (MEI).

7

7

Maximize Medicare Reimbursement

1. Has your rate been finalized and have you reserved for future adjustments?
2. Is there an opportunity to increase the rate?
3. Be mindful of future rate changes.
4. Keep existing "grandfathered" certifications.
5. Utilize any RHCs with the highest rates for future expansion.

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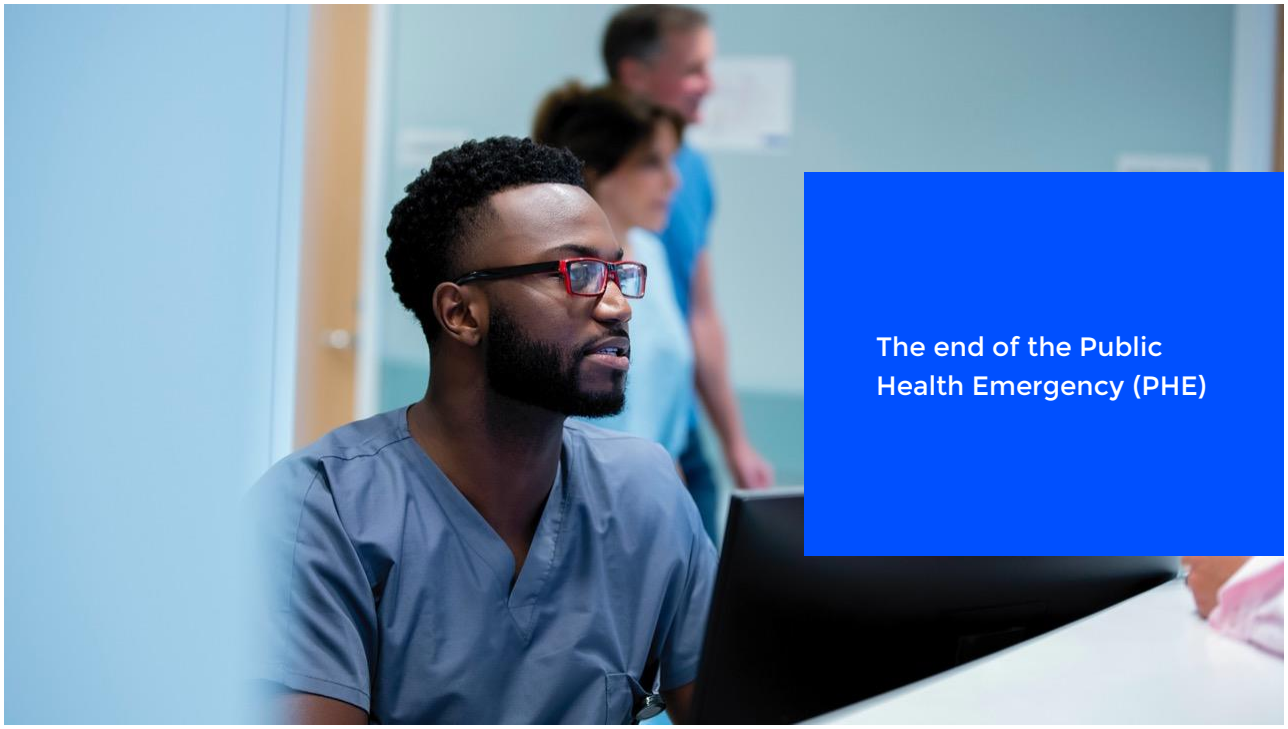

9

Ending of RHC-specific waivers

- Staffing requirements – Nurse Practitioner (NP), Physicians Assistant (PA), or Certified Nurse Midwife (CNM) must be available to provide patient care at least 50% of the time the RHC is open.
- Temporary Expansion Locations – additional use of permanent locations billed under an already certified RHC will no longer be allowed.
- Bed Count for Provider-based RHCs – "grandfathered RHCs" must meet the 50 bed or less requirement in order to keep their grandfathered payments.
- Home Nursing Visits – an official home health shortage area designation will need to be in place in order to bill for visiting nurse services.
- Virtual Communication Services – digital evaluation and management codes will no longer be a part of the definition of a G0071.

10

10

Extension of distant site RHC services

- RHCs will continue to have the ability to provide distant site telehealth services through the end of 2024 – note that these services will not be paid at the all-inclusive encounter rate (AIR) but will continue to be paid at the lesser of fee schedule or actual charge.
- Telehealth services to be provided through non-HIPAA-secure communications technology will end with the PHE, and providers will have 60 days to get into compliance. The HIPAA privacy rule will not prevent providers from offering covered audio-only telehealth services, however.
- RHCs permanently have the ability to provide mental health services via telehealth and these services are paid at the AIR (effective 1/1/2022). The in-person mental health visit requirement has been waived until 12/31/2024.

11

11

RHC Strategies

12

12

Strategy: Mobile RHCs

- Mobile RHCs for Medicare use an existing Medicare RHC rate:
  - So, in theory, if a hospital developed a mobile RHC, it may not be subject to the new Medicare RHC caps
- No new certification – The RHC is basically an extension of the existing RHC
  - RHC conditions of participation do not have to be met in the mobile unit as long as the clinic as a whole (permanent and mobile unit) meet the requirements
  - Must provide services in a rural area and that location must have a current shortage designation
  - Services in the location must have a consistent schedule

13

13

Strategy: Mental health services

- Beginning in 2022, Medicare pays mental health telehealth services as a "distant site" paying at the AIR
  - Patients must have been seen within the last 12 months (there are exceptions to the rule)
- This change in reimbursement allows RHCs to contract with remote behavioral health providers to offer telehealth visits and receive their AIR payment

14

14

Strategy: Addition of RHC-defined practitioners

- Beginning 1/1/2024, the following additional RHC practitioners will be recognized by CMS and with services paid at the AIR
  - Marriage and Family Therapists
  - A Mental Health Counselor is recognized as an individual who
    - "(A) possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services described in paragraph (3); "(B) is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished; "(C) after obtaining such a degree has performed at least 2 years of clinical supervised experience in mental health counseling; "(D) meets such other requirements as specified by the Secretary."

15

15

Strategy: HOPD to RHC or stay as existing HOPD?

- As the Medicare cap continues to grow, it may be advantageous to convert existing hospital outpatient department (HOPD) clinics to RHCs
  - Why? Medicare RHC rates may eventually be higher than the Medicare fee for service rates
  - HOPD status could be advantageous depending on the service mix; specialty services are often reimbursed higher by Medicare in a HOPD
  - The 2021 increases in the Medicare physician fee schedule may be a factor
- Does the state recognize HOPD status?

16

16

Strategy: Change of address

- "Grandfathered" RHCs can move and keep the existing RHC rate intact (note that Health Professional Shortage Area (HPSA)/Medically Underserved Area (MUA), rural, and conditions of participation must be met).
- Does your organization have a larger clinic that does not currently have RHC status? Could you move an already existing certification to that location and recertify and smaller/less Medicare & Medicaid-utilized clinic?

17

17

Strategy: Review the Medicaid RHC rate

- Make sure your RHC Medicaid rates are maximized
- Has your clinic considered a change in scope of services request?

Note: A loss in Medicare RHC reimbursement may be offset by a gain in Medicaid RHC reimbursement. RHC status may still make sense depending on your state's RHC reimbursement rates and your clinic's payer mix.

18

18

Strategy: Productivity Standard Exception Request

- RHC productivity exemptions were NOT included in the Section 1135 waivers for the COVID-19 public health emergency.
- During the pandemic, The Centers for Medicare & Medicaid Services (CMS) provided guidance to the Medicare Administrative Contractors that burdens should be eased during this timeframe and staffing shortages or lack of volumes due to COVID-19 could be a reason to grant an RHCs request for exemption to the productivity standards; however, there is no specific waiver for the exemptions.
- RHCs can continue to request exemptions to the standards with the understanding that the Medicare Administrative Contractors (not CMS) make the decision whether or not to grant the exception.
- What justifications might your clinic have after the end of the PHE?

19

19

Strategy: Productivity Standard Exception Request

Example Calculation of Productivity Standards:

	FTEs	Actual Visits in RHC	Minimum Required Visits
Physicians	1.50	3,500	6,300
Physician Assistants	0.90	1,500	1,890
Nurse Practitioners	0.80	2,000	1,680
Certified Nurse Mid-Wives	-	-	-
		7,000	9,870
Total Allowable RHC Costs		$ 2,000,000	$ 2,000,000
Calculated Cost Per Visit		$ 285.71	$ 202.63
Medicare Visits		1,750	
Reimbursement Impact of Productivity Limits		$ (145,390)	

20

20

Wipfli/NARHC Rural Health Clinic Benchmark Report

Category/Indicator	12/31/2018 RHC Values	12/31/2018 Mean WA	12/31/2018 Mean Western	12/31/2018 Mean Nation	12/31/2019 RHC Values	12/31/2019 Mean WA	12/31/2019 Mean Western	12/31/2019 Mean Nation	12/31/2020 RHC Values	12/31/2020 Mean WA	12/31/2020 Mean Western	12/31/2020 Mean Nation
Number of Facilities	1	77	461	2,361	1	80	460	2,468	1	75	481	2,610
Encounters per FTE:												
Physicians	4,062	3,707	4,020	3,976	4,252	3,454	3,821	3,901	3,475	2,916	3,367	3,472
Physician Assistants	2,335	3,205	3,483	3,188	1,792	3,398	3,539	3,147	1,243	2,578	2,936	2,747
Nurse Practitioners	0	2,909	3,106	2,865	2,509	2,513	3,032	2,876	1,914	2,338	2,698	2,604
Clinical Psychologist/Social Worker	1,174	1,500	1,630	1,498	1,058	1,300	1,549	1,499	734	1,062	1,502	1,276
Total Encounters	15,719	1,103,592	5,639,341	25,258,132	16,269	1,181,644	5,953,776	27,179,505	13,014	712,184	5,034,987	25,365,033
Midlevel Staffing Ratio	27%	47%	54%	55%	29%	49%	54%	56%	31%	50%	55%	57%
Midlevel Visit Ratio	18%	42%	45%	46%	16%	44%	46%	48%	15%	46%	47%	48%
Cost per Encounter:												
Physician	128.93	121.98	117.16	100.70	135.87	129.90	126.06	106.66	178.42	162.13	144.13	118.82
Physician Assistant	136.17	75.65	56.55	50.35	194.18	76.08	52.40	52.27	299.11	104.32	66.97	61.74
Nurse Practitioners	0.00	37.97	60.55	49.08	83.84	41.26	62.94	50.39	268.49	69.45	68.80	57.03
Clinical Psychologist/Social Worker	112.26	25.65	41.37	41.89	116.10	37.72	42.22	35.42	191.96	107.96	70.30	45.88
Total Health Care Staff Cost	44.98	34.89	36.90	28.47	49.01	39.84	38.10	29.45	86.01	48.38	44.86	33.93
Cost per FTE:												
Physician	523,720	431,088	400,033	353,962	577,746	424,386	440,036	379,073	620,081	434,770	431,047	374,521
Physician Assistant	318,026	242,482	196,983	160,513	347,979	258,539	185,465	164,467	371,683	268,927	196,629	169,598
Nurse Practitioner	0	110,447	188,086	140,591	210,322	103,708	190,874	144,893	513,964	162,370	185,660	148,515
Clinical Psychologist/Social Worker	131,810	38,486	67,460	62,760	122,832	49,033	65,410	53,085	140,899	114,698	105,574	58,528
Total Healthcare Staff Costs per Provider FTE	173,304	123,603	149,905	101,996	187,613	132,508	147,659	103,654	255,550	133,338	152,359	106,538
Clinic Cost per Encounter:												
Total Health Care Staff	174.81	123.97	108.43	96.18	188.17	132.20	117.69	101.58	281.10	168.02	134.14	114.66
Total Direct Costs of Medical Services	181.46	137.70	140.47	119.80	191.57	148.36	146.53	123.78	288.69	190.56	169.20	138.80
Clinic Overhead	15.52	33.38	24.18	24.69	15.94	32.60	26.26	26.60	22.76	37.62	30.74	30.63
Parent Provider Overhead Allocated	90.61	74.78	96.79	81.06	92.45	81.13	99.30	83.63	136.31	137.63	122.94	96.63
Allowable Overhead (Clinic and Parent)	106.13	108.05	119.74	104.83	108.39	113.24	123.31	109.18	156.92	170.93	147.82	124.39
Allowable Overhead Ratio (Clinic and Parent)	100%	100%	99%	99%	100%	100%	98%	99%	99%	98%	96%	98%
Total Allowable Cost per Actual Encounter	287.59	245.75	259.58	223.78	299.96	260.81	269.68	232.15	445.61	359.85	316.79	262.48
Total Allowable Cost per Adjusted Encounter	284.83	231.68	248.80	213.77	298.94	241.95	254.33	221.30	444.99	332.74	300.67	252.83
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(8.07)	(4.27)	(5.66)	(6.21)	(6.48)	(4.11)	(5.66)	(6.77)	(10.87)	(8.29)	(6.99)	(8.21)
Rate per Adjusted Encounter	276.76	227.41	243.14	207.56	292.46	237.84	248.67	214.53	434.12	324.45	293.68	244.62
Total Medicare Encounters	5,718	312,883	1,396,321	6,362,621	5,552	335,391	1,499,683	6,730,574	4,598	199,901	1,233,603	5,907,972
Medicare Percent of Visits	36%	28%	25%	25%	34%	28%	25%	25%	35%	28%	25%	23%
Injection Cost:												
Cost per Pneumococcal Injection	409.54	300.86	298.73	280.61	260.83	289.85	299.05	295.95	160.67	298.58	310.18	329.20
Cost per Influenza Injection	48.14	81.67	92.14	79.87	57.59	80.19	91.03	85.69	62.03	87.03	97.72	140.66

21

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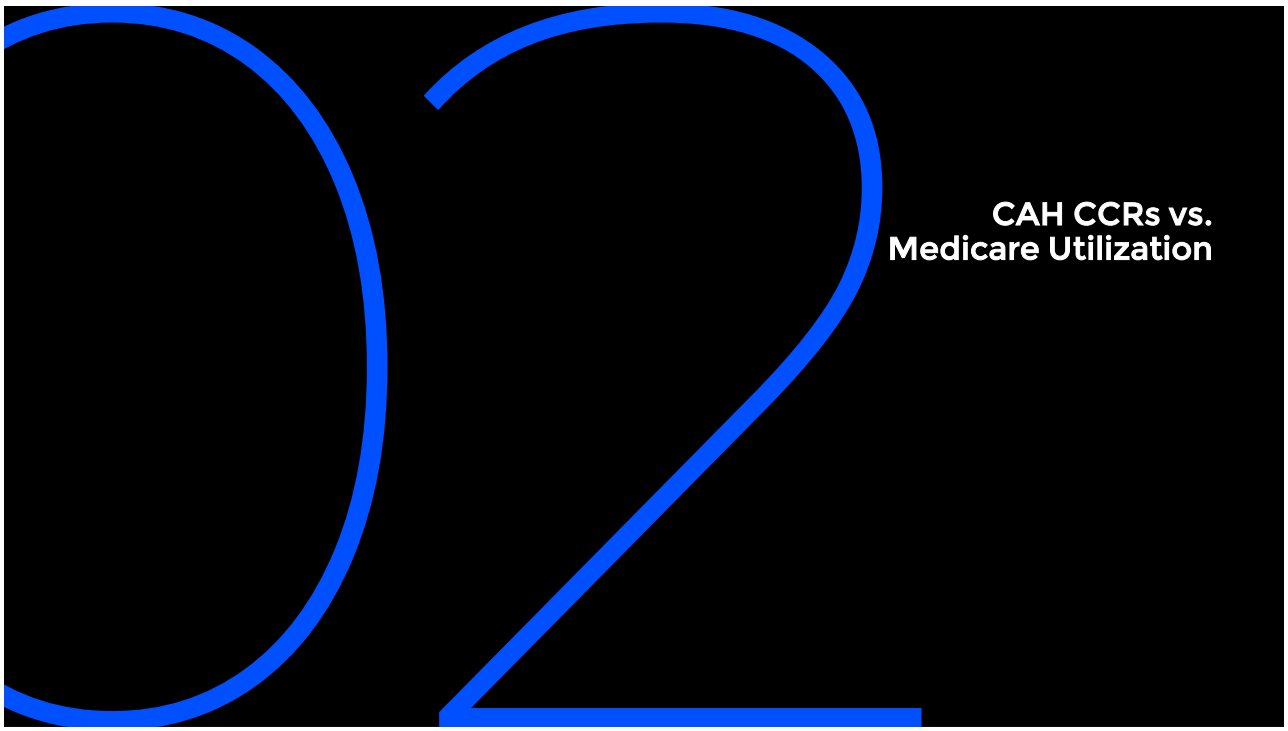
21



22

Evaluate Cost-to-Charge Ratios

23

- What additional data is found on the cost report that can be used to evaluate other hospital departments:
  - Cost-to-Charge Ratios

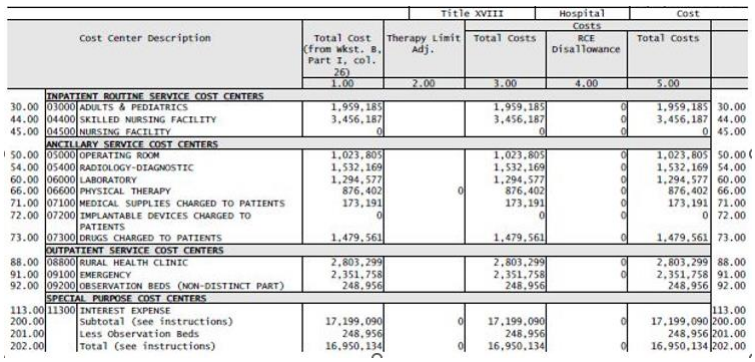
- What is a "cost-to-charge" ratio?

Direct Costs per Department (excluding professional costs)	+ / -	Reclassifications and Adjustments	+	Allocated Overhead Costs		
					=	Cost-to-Charge Ratio
Gross Hospital Charges per Department (excluding professional charges)						

- Where can we find the cost-to-charge ratios?
  - Medicare cost report: Worksheet C, Part I, Column 9

24

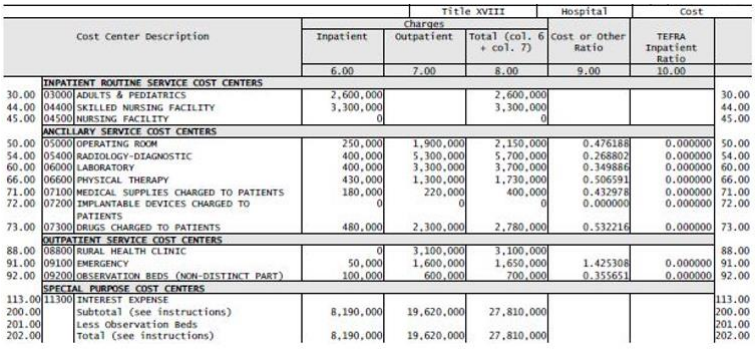
- Worksheet C of the Medicare cost report reports gross patient service revenue and calculates the cost-to-charge ratio by department.



		Cost Center Description	Total Cost (from Wkst. B, Part I, Col. 26)	Therapy Limit Adj.	Title XVIII Total Costs	Hospital Costs RCE Disallowance	Cost Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,959,185		1,959,185	0	1,959,185	30.00
44.00	04400	SKILLED NURSING FACILITY	3,456,187		3,456,187	0	3,456,187	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,023,805		1,023,805	0	1,023,805	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,532,169		1,532,169	0	1,532,169	54.00
60.00	06000	LABORATORY	1,294,577		1,294,577	0	1,294,577	60.00
66.00	06600	PHYSICAL THERAPY	876,402	0	876,402	0	876,402	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	173,191		173,191	0	173,191	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,479,561		1,479,561	0	1,479,561	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,803,299		2,803,299	0	2,803,299	88.00
91.00	09100	EMERGENCY	2,351,758		2,351,758	0	2,351,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	248,956		248,956		248,956	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,199,090	0	17,199,090	0	17,199,090	200.00
201.00		Less Observation Beds	248,956		248,956		248,956	201.00
202.00		Total (see instructions)	16,950,134	0	16,950,134	0	16,950,134	202.00

- Column 1 equals cost from Worksheet B, Part 1, Column 26.

25



		Cost Center Description	Charges Inpatient	Charges Outpatient	Title XVIII Total (col. 6 + col. 7)	Hospital Cost or Other Ratio	Cost TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,600,000		2,600,000			30.00
44.00	04400	SKILLED NURSING FACILITY	3,300,000		3,300,000			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	250,000	1,900,000	2,150,000	0.476188	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	400,000	5,300,000	5,700,000	0.268802	0.000000	54.00
60.00	06000	LABORATORY	400,000	3,300,000	3,700,000	0.349886	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	430,000	1,300,000	1,730,000	0.506591	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,000	220,000	400,000	0.432978	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,000	2,300,000	2,780,000	0.532216	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,100,000	3,100,000			88.00
91.00	09100	EMERGENCY	50,000	1,600,000	1,650,000	1.425308	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,000	600,000	700,000	0.355651	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,190,000	19,620,000	27,810,000			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,190,000	19,620,000	27,810,000			202.00

- How can we use the cost-to-charge ratios in Column 9?

26

Comparison of 3 CAH's cost-to-charge ratios by selected departments:

Cost Centers	CAH 1	CAH 2	CAH 3
Operating room	0.350409	0.818695	0.982771
Radiology-diagnostic	0.164251	0.412490	0.652277
Laboratory	0.181033	0.344558	0.452772
Respiratory therapy	0.631174	0.215670	0.721440
Physical therapy	0.325362	0.925510	1.322770
Occupational therapy	0.267368	0.994645	1.415288
Speech pathology	0.383660	1.150835	1.218436
Electrocardiology	0.113512	0.352114	0.432185
Medical supplies charged	0.270247	0.917240	0.982441
Implantable supplies and devices	0.897039	0.852223	0.931940
Drugs charged to patients	0.391307	0.522381	0.512851
Cardiac rehab	0.541354	0.942237	1.425887
Chemotherapy	0.414898	0.741253	0.882443
Provider-based clinic	0.952500	1.851178	2.057281

- What observations can be made?
- How can we use this information? Next step . . . additional analysis?

27

27

What are some points to consider from the cost-to-charge ratio reviews?

- Are the cost allocations in the cost report up to date and accurate?
- What are the business plans for the CAH?
- If no immediate changes in operations, costs, or revenue are planned, what departments should we focus on if all we had for information was the cost-to-charge ratios for the ancillary departments?

Next steps to consider:

- High cost-to-charge ratio departments
- How do the cost-to-charge ratios compare to the prior year ratios
- Payor mix of high cost-to-charge ratio departments
- Profitability by payor

28

28

CAH Reimbursement "Tool" for Decision Making

29

29

CAH Reimbursement "Tool" for Decision Making

Know What Portion of Each Department is Cost-Based Reimbursed

Do you have a CAH "Tool"?

30

30

CAH Reimbursement "Tool" for Decision Making

THE TOOL	Medicare Medicaid	Cost-Based
Department	Utilization	Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

31

31

CAH Reimbursement "Tool" for Decision Making

- Where would you want to expense the EHR expense that was not eligible for the incentive payment?
- Capital reimbursement is 40%.
- Medical Records is 60%.

THE TOOL	Medicare Medicaid	Cost-Based
Department	Utilization	Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

32

32

CAH Reimbursement "Tool" for Decision Making

- Where would you want to expense new patient beds?
- Adults and Peds = 75%
- ICU = 90%

THE TOOL	Medicare Medicaid	Cost-Based
Department	Utilization	Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

33

33

CAH Reimbursement "Tool" for Decision Making

- Where would you want to expense new patient monitors?
- Adults and Peds = 75%
- ER = 25%

THE TOOL	Medicare Medicaid	Cost-Based
Department	Utilization	Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
SNF	60%	0%
Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
Speech Therapy	30%	30%
Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

34

34

CAH Reimbursement "Tool" for Decision Making

- Given the option, where would you want to expense any new purchases?
- Adults and Peds/ICU = 75%-90%
- Majority of all other cost centers < Adults and Peds/ICU%

THE TOOL	Medicare Medicaid	Cost-Based
Department	Utilization	Reimb.
Capital - Building		40%
Capital - Equipment		various
Employee Benefits		40%
Admin & General		50%
Operation of Plant		30%
Laundry & Linen		15%
Housekeeping		30%
Dietary		15%
Cafeteria		40%
Nursing Admin		20%
Medical Records		60%
Social Services		5%
Adults & Peds	75%	75%
Intensive Care Unit	90%	90%
Nursery	70%	70%
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Operating Room	45%	45%
Labor & Delivery	70%	70%
Anesthesiology	45%	45%
Radiology	47%	47%
Laboratory	60%	60%
Respiratory Therapy	80%	80%
Physical Therapy	60%	60%
Occupational Therapy	90%	90%
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Electrocardiology	80%	80%
Med Supply	40%	40%
Pharmacy	60%	60%
Emergency	25%	25%
Observation Beds	80%	80%
Rural Health Clinic	50%	35%
Home Health	90%	0%
Physician Clinic	40%	0%

35

35

Calculating Contribution Margin

36

36

Contribution Margin

When looking at contribution margins remember to evaluate all factors…

37

Contribution Margin

Calculating Contribution Margin for Hospital Departments

The challenge:

- How do you determine contractual adjustments by department?

While it is not perfect . . .

- One option is to use an average contractual adjustment percent from Medicare cost report Worksheet G-3

38

Contribution Margin

Average Contractual Adjustment %

	2020	2021	2022
Total gross patient service revenue (Wkst G-3, Line 1)	$ 119,149,800	$ 126,727,900	$ 144,677,900
Total contractual adjustments (Wkst G-3, Line 2)	$ 58,169,500	$ 61,925,800	$ 75,053,800
C/A %	48.8%	48.9%	51.9%

39

Contribution Margin

Radiology Department

Medicare Cost Report Reference		2020		2021		2022	
	Revenue:						
Wkst. C, Part 1, Col 8, Line 54	Radiology revenue	$ 16,693,100		$ 17,915,200		$ 19,845,400	
From Internal Records *	Less: - C/A & discounts	8,149,700		8,754,300		10,295,100	
Subtotals	Net Radiology revenue	8,543,400		9,160,900		9,550,300	
	Expenses:						
Wkst. A, Col 1, Line 54	Direct salary expense	1,261,700		1,294,500		1,397,400	
Wkst. A, Col 2, Line 54	Direct other expense	1,094,600		1,153,900		1,091,400	
Wkst. B, Part I, Col 4, Line 54	Employee benefits	202,600		202,500		238,000	
Subtotals	Total direct expenses	2,558,900		2,650,900		2,726,800	
**Or calculated average*	Contribution margin	$ 5,984,500	70.0%	$ 6,510,000	71.1%	$ 6,823,500	71.4%

Considerations:

- Contractual adjustment %
- Cost report excludes professional revenue and expense
- Other information to consider: FTEs and volume statistics
- What other items should a CAH consider if the radiology department manager would suggest lowering prices?

40

Contribution Margin

Physical Therapy Department

Medicare Cost Report Reference	Revenue:	2020		2021		2022	
Wkst. C, Part 1, Col 8, Line 66	PT revenue	$3,261,400		$3,184,400		$3,952,500	
From Internal Records*	Less: - C/A & discounts	1,591,600		1,557,200		2,051,300	
Subtotals	Net PT revenue	1,669,800		1,627,200		1,901,200	
	Expenses:						
Wkst. A, Col 1, Line 66	Direct salary expense	545,800		549,100		636,900	
Wkst. A, Col 2, Line 66	Direct other expense	156,100		202,400		181,700	
Wkst. B, Part 1, Col 4, Line 66	Employee benefits	87,600		85,900		108,500	
Subtotals	Total direct expenses	789,500		837,400		927,100	
**or calculated average*	Contribution margin	$ 880,300	70.0%	$ 789,800	71.1%	$ 974,100	71.4%

Question:

- If the hospital would contract PT services to a nursing home, how could this analysis be used to assist with structuring a rate?

41

41

Contribution Margin

There's not a magic contribution margin:

- Contribution margin depends on your operations and charge structure.
- Within a hospital, we would expect the contribution margin to stay relatively similar to prior periods or understand why any changes have occurred.

42

42

43

Rural Emergency Hospitals overview

- To be eligible for REH status, hospitals must have 50 or fewer beds and either be in a rural area or have an active rural reclassification
- REHs are required to provide 24-hour emergency services, laboratory services, diagnostic radiological services, pharmacy or drug store area, and discharge planning by qualified professional
- REHs can also provide other outpatient services such as behavior health, radiology, and outpatient rehab. An REH may also establish a separate, distinct part unit licensed as a Skilled Nursing Facility
- REHs must meet Critical Access Hospitals CoPs for Emergency Services
- Cannot have per-patient averages exceed 24 hours (individual patient stays can exceed 24 hours)
- Can provide observation care and additional medical outpatient services
- All covered outpatient services provided by REHs will receive an additional 5% increase in payment of the standard OPPS rate that would be paid (none of this additional 5% would be charged to beneficiary coinsurance)
- In addition to the 5% increase, REHs will also receive an additional monthly facility payment from Medicare. This facility payment will increase annually by the market basket percentage which is established by CMS. The current established facility payment for 2023 will be $272,866 per month
- A hospital that converted to an REH is able to convert back to their previous provider type *as long as the conditions of participation are met.*

44

Rural Emergency Hospitals drawbacks

- *REHs are not considered an eligible provider for 340B drug pricing*
- REH-designated hospitals can no longer provide inpatient or swing-bed care and must have a transfer agreement with at least one Medicare-certified hospital designated as a Level I or Level II trauma center. (REHs can provide SNF services; however, must gain licensure and create a distinct part unit for SNF services which may have previously been done under a hospital's swing bed license.)
- With this being a brand-new provider type there are a lot of unknowns and there could be several changes to this provider type in the future periods
- Not all states have established REH rules yet regarding REH's
- Hospitals that are currently operating with an inpatient unit would have to make determinations on what to do with staff that would no longer be needed (terminations or transfers to other locations)
- Community perspective of no longer offering inpatient services and handling of employees who would no longer be needed
- REHs that would make the determination to transition back to old hospital type could have challenges filling positions

45

45

Rural Emergency Hospitals Medicare payment overview

Type of service	PPS Hospital	CAH	REH
Inpatient	DRG	101% of Allowable Cost	N/A
Outpatient Procedures (surgery, radiology, etc.)	APC Sole Community Hospital is Reimburse at APC +7.1%	101% of Allowable Cost (except for screening mammography and orthotic DME items)	APC +5%
Lab	Fee Schedule	101% of Allowable Cost (except for reference lab)	Fee Schedule
Therapies	Fee Schedule	101% of Allowable Cost	Fee Schedule
Swing Bed	RUG	101% of Allowable Cost	N/A

46

46

Rural Emergency Hospitals Medicare payment overview

Type of service	PPS Hospital	CAH	REH
O/P Clinics (facility component)	APC Sole Community Hospital is Reimburse at APC +7.1%	101% of allowable cost	APC +5%
O/P Clinics (professional component)	Fee schedule (reduced for site of service)	Fee schedule plus 15% for CAHs Electing Method II Billing (reduced for site of service)	Fee schedule
CRNA services	Fee schedule (unless elect cost if less than 800 procedures/year)	Fee schedule (unless elect cost if less than 800 procedures/year and 1 FTE/year)	Fee schedule
Other professional services	Fee schedule – Except for professional services in a rural health clinic, then generally based on allowable cost	Fee schedule plus 15% for CAHs Electing Method II Billing (except for professional services in a rural health clinic setting then generally based on allowable cost)	Fee schedule – Except for professional services in a rural health clinic, then generally based on allowable cost
Outlier payments	Cost – generally insignificant for rural providers	N/A	Cost – generally insignificant for rural providers

47

47

Example of high-level analysis REH conversion

Description	REH Conversion Financial Impacts
Additional REH Add-On Payment	$ 3,270,000
5% Addition to OPPS Payments	80,000
Loss of 340B Status	(70,000)
Loss of SCH Status	(130,000)
Loss of Inpatient Revenue	(1,500,000)
Decrease of Expense Due to Closure of IP Unit (Includes Overhead, IP Unit, and Ancillary)	1,240,000
CAH Increased IP, Swing & OP Reimbursement	N/A
Estimated Medicare Advantage Plan Impact	N/A
Estimated CAH Method II Impact	N/A
Estimated 340B Impact	N/A
Estimated Illinois Medicaid CAH Add-On and Direct Payment Changes	N/A
Total Additional Income	$ 2,890,000

48

48

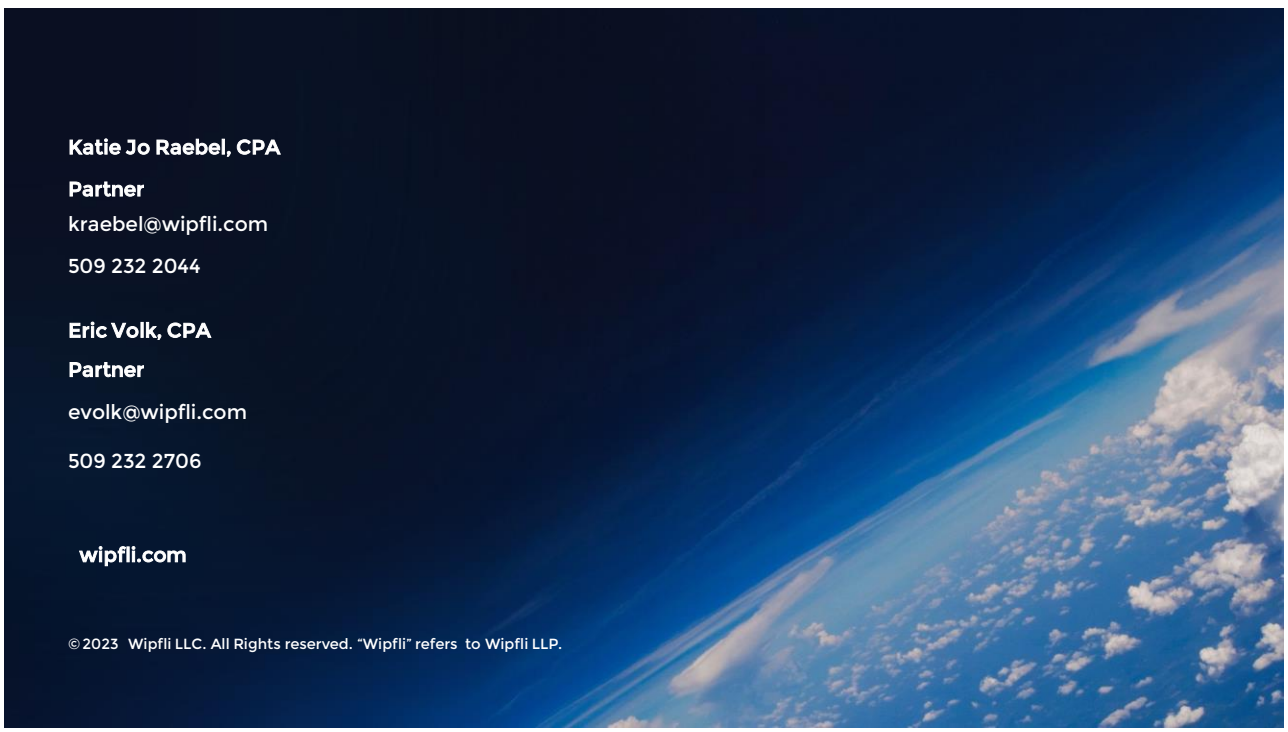
Q & A

Things to think about

- The RHC designation can still be a win
- Use the cost report as a tool and strategize for the future
- Optimize reimbursement

49

49



50