WHITE PAPER # 5 FRONTIER HEALTH SYSTEM REIMBURSEMENTS

I. Current Legislation and Regulations

Over the past 25 years, Congress has authorized a number of Medicare payment adjustments to address concerns among rural providers that administered pricing systems, such as prospective payment systems or fee schedules do not necessarily work well in low-volume communities, particularly those where Medicare patients make up a significant portion of the payer mix. As a result, a number of special designations within Medicare are designed to take into account the unique aspects of rural and Frontier health care delivery. The creation of the Critical Access Hospital (CAH) designation in 1997 allows for hospitals with 25 or fewer beds, meeting federally defined distance criteria, to have flexibility on certain Medicare Conditions of Participation and to receive cost-based reimbursement from Medicare for hospital inpatient and outpatient services. CAHs are not subject to the Inpatient Prospective Payment Systems (IPPS) and Hospital Outpatient Prospective Payment Systems (OPPS).

As a special recognition of their small size, CAHs can also focus on serving the elderly Medicare population by using their 25 beds as swing beds to provide skilled nursing care. Recognizing the need for these facilities to have flexibility in providing both levels of care under one roof, the Medicare swing-bed payment rate, paid based on costs, is often higher than the traditional prospective skilled nursing facility rate. CAHs can also use the Method II billing authority to handle billing for their physicians, and as a result, receive up to 115% of the Medicare physician fee schedule rate for professional services while receiving 101% of costs for the "technical" component of physician services.

The Frontier Community Health Integration Demonstration is authorized under Section330A of the Public Health Service Act and is also guided by authorization of Section 123 of P.L. 110-275, the Medicare Improvements to Patients and Provider's Act of 2008 (MIPPA). The purpose of the Frontier Community Health Integration Demonstration is to develop and test new models for the delivery of health care services in frontier areas through improving access to, and better integration of, the delivery of health care to Medicare beneficiaries. The authorizing legislation defines a frontier Critical Access Hospital (CAH) as a CAH located in a county with a population of 6 people or fewer per square mile and a daily acute-care census of 5 patients or less. The legislation also identifies four "frontier-eligible" states: Alaska, Montana, North Dakota and Wyoming.

In response to the MIPPA legislation and subsequent funding by Congress, the Health Resources and Service Administration/Office of Rural Health Policy (HRSA/ORHP) awarded an 18-month cooperative agreement to the Montana Health Research and Education Foundation (MHREF) to inform the development of a new frontier health care service delivery model. Actual design and implementation of the demonstration are the responsibility of the Center for Medicare and Medicaid Services (CMS).

To better identify and communicate the challenges and solutions for health care delivery in frontier communities, a Framework Document and subsequent topical white papers are being developed by MHREF and shared with the CMS. This is White paper #5 in this series.

Medicare currently reimburses CAHs using the cost report step-down method, which allocates general service costs to both reimbursable and non-reimbursable cost centers. Overhead expenses are allocated to revenue-producing areas resulting in fully allocated department costs. Entities that do not directly relate to hospital-based care, including hospice, home health, nursing home, and wellness center services, are reimbursed on a fee-for-service (FFS) payment system. Under the Medicare ambulance benefit, if a CAH

or an entity that is owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35-mile drive of that CAH or entity, the CAH is paid based on reasonable cost for the ambulance services. Baseline productivity standards are applied to all Rural Health Clinics (RHCs) - including those co-located with Frontier CAHs - and require 4,200 annual visits for each 1.0 FTE physician and 2,100 annual visits for each 1.0 FTE mid-level practitioner.

Additionally, several other temporary adjustments exist to enhance the Medicare rate for Frontier physicians and Frontier ambulance payments. Many CAHs operate provider-based Rural Health Clinics (RHCs), which receive cost-based reimbursement for ambulatory services from both Medicare and Medicaid. Although those payments are usually capped at a particular rate, provider-based RHCs at hospitals with less than 50 beds are not subject to the cap.

These provisions have largely helped rural CAHs become more economically viable and thereby enhance access to a base level of acute, emergency, outpatient, ambulatory and emergency care services in rural communities. In some Frontier communities, however, a number of providers still struggle financially due to low volumes and the need to provide a large array of local services. Frontier CAHs are small, isolated CAHs that provide Frontier communities with a continuum of healthcare largely under one corporate infrastructure. In most instances, these Frontier CAHs are the only health care providers serving the community.

II. Explanation of the Problem

Medicare reimbursement for both inpatient and outpatient services is currently based on Medicare-related costs as determined by the Medicare cost report at 101% of cost, regardless of charges. The intent was to ensure that CAHs do not lose money on Medicare patients and the extra one percent represents an implicit capital-related payment. As a result, there is limited opportunity for Frontier CAHs to achieve an operating margin on Medicare business. At low service volumes, Medicare reimbursement per unit of service (patient day, outpatient equivalent, etc.) is generally higher than market-based charges, negotiated per diems, or fee schedules. This occurs as a direct result of relatively high fixed overhead costs being only minimally diluted on a per unit basis due to the low units of service.

When Frontier CAHs combine the CAH cost methodology with standard Medicare FFS methodology (for entities, such as home health, hospice, nursing home services, public health and wellness centers, ambulance, etc.) the current reimbursement model dilutes Medicare revenue as the CAH payment is only allocated for the portion of costs attributed to providing Medicare services. In essence, the Medicare cost-based payments for inpatient and outpatient services are spread over the FFS Medicare services (i.e., home health, hospice, ambulance) or are spread over the non-Medicare services (i.e., public health, assisted living, nursing home services). This dilutes the per-visit CAH payment rate since all these extra services increase the denominator (total services) while the numerator (CAH cost-based services) stays the same.

In Frontier settings, Medicare CAH payments are usually the only payer covering its costs. Frontier CAHs tend to lose money when operating home health agencies or ambulance units. They also lose money on

nursing home services given that the dominant payer for such services is the Medicaid Program which pays well below actual costs. While it makes sense from a community perspective to offer a full range of services, in a frontier area the net effect is lower per-visit reimbursement for the CAH since it is allocating costs to non-Medicare areas. Ironically, if the CAH divests itself of these other services, they typically have neither the patient volumes or the revenue streams to be economically viable. As a result, Frontier CAHs are often left in a no-win situation. To meet community need, they destabilize the CAH financially. By divesting of the additional services, the Frontier CAH is more financially stable but the ancillary services often fail.

While policymakers may promote concepts like the Triple Aim[1] and coordinated care, the real challenge occurs when success is measured against a backdrop of reimbursement that fails to support it. In a low-volume FFS world where tight operating margins exist and Medicare is the only payer covering its costs, it seems nearly impossible to achieve the objectives supporting the cost, quality, and access objectives outlined in the Triple Aim. These facilities are stuck in the middle. They cannot survive in a PPS world, because they do not have the volume or enough private pay to achieve success. Contrastingly, a cost based environment provides cost accounting incentives to remove the hospital from involvement in non-cost based covered activities or non-allowable cost activities by diluting the per encounter rate.

The primary goal of this demonstration is to develop a reimbursement system focused on creating a more flexible reimbursement framework that encourages consolidation across the care settings in a way that promotes improved outcomes without putting the hospital and associated providers at risk of failing financially given their low volume and thin operating margins – a model that fully supports and promotes the Triple Aim of better health for populations, better care for individuals, at lower costs.

III. Proposed Changes

The proposed Frontier Health System (FHS) model would aggregate all health care service volume within its service area under one integrated, organizational, regulatory and cost-based payment umbrella, spreading fixed costs across these entities and producing lower unit cost care. Additionally, incentives directly related to budget neutrality and pay-for-outcomes, would be implemented by the local Frontier Health System, demonstrating that high quality care is being provided to Frontier patients at lower cost, and savings shared with the Medicare Program.[2]

Under the proposed FHS model, a new provider type and Conditions of Participation (COP) would be established. Health care services aggregated into the new FHS include: hospital ER, inpatient and outpatient; ambulance; swing bed; and an expanded rural health clinic which includes a Visiting Nurse Services (VNS) component providing physical, occupational or speech therapy in the Frontier patient's home as well as preventive and hospice services if home health is not available locally. Essentially, the

[1] Donald M. Berwick, Thomas W. Nolan and John Whittington. "*The Triple Aim: Care, Health, and Cost*". Health Affairs. May 2008 vol. 27 no. 3 759-769.

[2] See White Paper #1, Frontier Referral, Admission and Readmission Patterns and White Paper #3, Frontier Quality Measures and Payment for Outcomes.

proposed COP would be the same as the current CAH COP, with some modifications or "waivers" to existing regulations. Modifications relating specifically to reimbursement are listed in Table 1 below:

TABLE 1: PROPOSED CHANGES

PROPOSED CHANGE	SHORT RATIONALE
Increasing the existing CAH 25-bed limit to 35 beds for Frontier Health Systems.	Achieves budget neutrality and provides cost savings to CMS.
Allowing Frontier Health System hospitals to exempt inpatient psychiatric services with diagnosis codes (290.11-312.34, 780.09, V62.84) from the annual average length of stay calculation.	With an average length of stay between 8 and 12 days, mental health patients are increasing the annual average length of stay for CAHs, threatening their eligibility.
Expansion of RHC VNS services to allow reimbursement of visits to Medicare beneficiaries for Physical therapy (PT), Occupational Therapy (OT) and speech therapy services.	Provides access to VNS services to patients who do not meet current home bound criteria, but have restricted access to care for other reasons.
Permitting a 35-mile waiver for Frontier ambulance services in a few Frontier communities to preserve access to pre-hospital emergency medical services for beneficiaries.	Allows ambulance service to be retained by the frontier CAH increasing coordination between the CAH and EMS.
Modifying productivity screens for RHC medical providers practicing in FHS'.	Improves RHC reimbursement and guarantees access to a medical provider by Frontier beneficiaries.
Allowing flexibility in discrete costing when allocating administration and general costs for Medicare reimbursement.	Allocates overhead costs to non-hospital health care services more accurately and appropriately.

IV. Discussion

In the following section, further justification and analysis is provided for each of the proposed changes outlined in Table 1.

- The current CAH 25-bed limit would be increased to 35 beds for Frontier Health System hospitals only, with the 10 incremental beds limited to nursing facility (NF) level services only. More specifically, C-351 of the CAH COP would be modified to read: "The FHS organization must be certified as a Frontier Health System and may have no more than 35 beds, with 25 beds used for acute and swing bed patients and the incremental 10 beds limited to nursing facility level services." This will be further explored later in this paper, using a case study to demonstrate the potential cost savings that could be realized if 10 additional patients above the 25-bed limit are allowed. In order to qualify for FHS provider status, the facility's annual acute average daily census may not exceed 5, and the facility must meet MIPPA criteria for the F-CHIP demonstration. This automatically limits application of the 35-bed limit to only 71 CAHs in AK, MT, ND, and WY. Not only is budget neutrality achieved by increasing the CAH bed limit to 35, but it also provides cost savings to CMS. Elderly FHS patients who are seeking nursing care are frequenting the CAHs because there is no nursing facility available to them. Oftentimes these patients do not rise to the level of acuity for a Skilled Nursing Facility (SNF)or are in a community that lacks access to these services. These patients are susceptible to readmissions or may end up in the Emergency Departments. As a result, CMS is paying more since the Medicaid per diem costs of a nursing facility patient for a month are significantly more than a single hospitalization. Although this change assumes that Medicare would begin to cover costs that were not previously covered, the cost of care per patient would actually be lowered, providing savings to the Medicare program and CMS. This would also indirectly benefit the Medicare program by lowering readmissions and admissions rates.

Frontier facilities are often forced to make decisions that may not be in the best interest of the residents of the communities they serve. These decisions, oftentimes made for survival purposes, limit access to services their remote communities need.

For example, Liberty Medical Center (LMC) in Chester, Montana was forced for financial reasons to convert from a separate CAH and Nursing Home to a 25 bed CAH and give up its license for Nursing Home services. In the process, access was lost to more than 20 long-term care beds. The need for additional long-term care beds in the community was prevalent then, and continues to be in high demand today. However, due to the cost finding methodology required for CAHs, the facility was forced to discontinue nursing home services. The same issue holds true for Hospice and Home Health services that were also discontinued at LMC.

Additionally, four of the other F-CHIP Workgroup facilities in Montana closed their nursing homes over the past few years for the same reasons stated above, and one facility closed its Home Health services. None of the nine Montana F-CHIP Workgroup facilities currently offer home health, and only three of the nine maintain

- Due to a shortage of mental health services in Frontier communities, the mental health patient population often utilizes the Frontier CAHs for their medical needs. Mental health patients average 8-12 days during their inpatient stays, which increases the annual average length of stay for these hospitals. To be eligible as a CAH, the facility must maintain a length of stay, as determined on an annual average basis of no longer than 96 hours for acute inpatient care. The modified COP would allow Frontier Health System hospitals to exempt inpatient psychiatric services with diagnosis codes (290.11-312.34, 780.09, V62.84) from the annual average length of stay calculation, allowing them to remain as cost-based services[3].

- The modified COP would allow the delivery of, and cost-based reimbursement of, physical, occupational and speech therapy services, as well as services delivered by a home health aide in the Frontier home setting. Aide services would operate through the Rural Health Clinic VNS home care program for FHS only, and would be restricted to their current service population. The Conditions for Coverage for Visiting Nurse Services in the Medicare Benefit Manual, specific to Regulation 90.5, RHC 412.5 "Services Furnished by a Licensed Nurse" (Rev. 1, 10-1-03) would be modified to: "The services must be furnished by a registered nurse, a licensed practical nurse, a licensed vocational nurse, a home health aide or a licensed physical therapist, licensed occupational therapist or licensed speech therapist as allowed under current State scope of practice." A waiver to the current home bound criteria would be allowed for FHS organizations to enable FHS visiting nurse services/providers to care for patients who do not meet current home bound criteria but have restricted access to care for other reasons including limited transportation options, distance to healthcare facility, etc. While there may be home health agencies supposedly servicing these Frontier counties, they fail to provide the therapy services to the Frontier communities where these beneficiaries actually reside.

- The modified COP would allow a waiver, for the Frontier Health System hospitals only, permitting FHS-owned ambulance services to operate in their rational service areas. This can often encompass hundreds or even thousands of square miles, even if another ambulance service is located within 35 miles. Specifically, the ambulance fee schedule guidance (Rev. 103; Issued 02-20-09; Effective Date: 02-05-09; Implementation Date: 03-20-09) would change to: "Payment for ambulance items and services furnished by a CAH, or by an entity that is owned and operated by a CAH, is based on reasonable cost if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH. CMS may waive the 35-mile driving distance separation requirement for ambulance items and services furnished by a Frontier Health System." Converting a PPS ambulance service to a cost-based reimbursed FHS ambulance service would not be budget neutral. However, overall budget neutrality for the FHS model would be achieved through cost savings

[3] This recommendation was not introduced in the Framework Document, but was added after discussions with other eligible states, it was identified as an important part of the Framework.

generated by improving care coordination and preventing unnecessary admission/readmission of Medicare beneficiaries.

- The actual volume of RHC visits to clinics owned and operated by Frontier Health Systems is often too small to meet the productivity screens. Failure to meet the productivity screens reduces RHC reimbursement and threatens the loss of access to a medical provider by Frontier beneficiaries. The COP's existing productivity screens for RHC medical providers practicing in Frontier Health Systems would need to be slightly modified. Currently, RHC-503, 40.3 – Screening Guidelines for RHC/FQHC Health Care Staff Productivity (Rev. 1, 10-01-03) requires "at least 4,200 visits per year per full time equivalent physician" and "at least 2,100 visits per year per full time equivalent physician assistant or nurse practitioner" for every physician, physician assistant or nurse practitioner employed by the clinic. The COP would be modified by reducing the number of visits required by each full time equivalent provider to 2,100 for physicians and 1,050 for mid-level providers, respectively. In turn, Frontier beneficiaries would be guaranteed access to a medical provider, thus leading to preventive care, better care, and better outcomes.

- Most of the 71 Frontier CAHs utilize the step-down cost report reimbursement method for the allocation of general service/overhead cost centers. The step-down method "recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue" (42 C.F.R. Sec. 413.24). For services that do not directly relate to hospital-based care (e.g. assisted living, public health, etc.), there is a need for flexibility in allowing discrete costing when allocating administration and general costs. The step-down method often allocates too much overhead to non-hospital related services, such as wellness centers and assisted living facilities. Discrete costing[4] utilizes statistical surrogates to allocate costs to a separate entity prior to engaging in step-down cost finding. Allowing discrete costing as part of the step-down method could more accurately and appropriately allocate overhead costs to these non-hospital health care services. The modified COP would allow flexibility in the cost report to provide integrated, coordinated health care for patients residing in Frontier communities. Specifically,

    - Allow the expense of patient care coordination as an allowable expense on the cost report.

[4] Discrete costing uses statistical estimates to allocate overhead costs to a separate legal entity prior to using the step-down process to allocate overhead costs between a Provider's revenue-producing and non-revenue-producing departments.

- Allow the administrative support costs (including billing services) and square footage provided to public health and non-owned ambulance services as allowable expenses on the cost report.
- Allow nursing and medical staff expenses to train Frontier ambulance service EMTs or paramedics.

The proposed FHS is a modified shared savings model which includes long term care and nursing services through the extra 10 CAH NF level beds. In order to improve care to Medicare beneficiaries and lower costs, the FHS model would require an integrated, budget-neutral payment system that aligns reimbursement methodologies with all services. The goal is to achieve an operating margin by driving the average unit cost of service below the prevailing non-Medicare reimbursement levels by aggregating services and diluting fixed overhead over a large pool of patient volume and services.

The six reimbursement proposals for Medicare beneficiaries in the new FHS model could potentially incur additional funding from CMS. The achievement of budget neutrality[5] regarding these proposals would come in the form of cost savings generated by improving care coordination and preventing the admission and/or readmission of Medicare beneficiaries to more expensive emergency, acute, and long-term care settings.

A pro forma cost analysis for Liberty Medical Center, located in Chester, Montana, is shown in Figure 1. Liberty Medical Center is one of the nine Montana F-CHIP facilities, showing a cost savings of $169,706 per year if ten additional Medicare swing bed patients were allowed in the new Frontier Health System model. Nearly all costs for additional NF level patients over and above the 25-bed limit are fixed costs. Please note the total cost (including mostly fixed cost) of providing care for the additional 10 NF level patients, plus the original 25 patients, is spread over an increased number of patients (35). With 10 additional NF level beds, Medicare would be paying less overhead costs.

[5] Budget neutrality is discussed in further detail in White Paper #1 and White Paper #4.

Figure 1: Medicare Cost Savings Pro Forma; Adding 10 Beds (25 to 35) to Liberty Medical Center, Chester MT
Prepared by Ron Gleason, CPA/CEO, Liberty Medical Center and Reviewed by Eric Shell, CPA/Principal, Stroudwater Associates

Liberty Medical Center
Comparison of Medicare Cost for Liberty Medical Center if Ten More Long-Term Care Patients Per Day Were Allowed

		Actual 2010 Costs and Actual 2011 Patient Days		Assumes Additional Days Are All Non-Medicare		Assumes Medicare Days Are Proportional to 2011 Actual
Total General Inpatient Routine Service Costs per June 30, 2010, Cost Report		2,230,847		2,230,847		2,230,847
Additional Staffing Costs for Additional Long-Term Care Patients				186,810		186,810
Additional Food Costs for Additional Long-Term Care Patients				27,061		27,061
Additional Supply Costs for Additional Long-Term Care Patients				30,382		30,382
Additional Overhead Allocation - Administration				80,000		80,000
Additional Overhead Allocation - Laundry				10,000		10,000
Additional Overhead Allocation - Cafeteria				5,000		5,000
Additional Overhead Allocation - Medical Records				7,500		7,500
				2,577,600		2,577,600
Actual 2011 Long Term Care Patient Days	7,830		7,830		7,830	
Additional Days if Ten Additional Beds were Allowed to be Used for Long Term Care (10 X 365)			3,650		3,650	
			11,480		11,480	
Medicare Swing Bed Days	242		242		355	
Total Non-Medicare Swing Bed Days	7,588		11,238		11,125	
Average Medicaid Statewide Payment Rate	159.50		159.50		159.50	
Cost Reduction Related to Non-Medicare Days		1,210,286		1,792,461		1,774,438
Medicare Reimbursable Costs		1,020,561		785,139		803,163
Total Acute Care Days plus Medicare Swing Bed Days		434		434		547
Medicare Cost Per Patient Day		2,351.52		1,809.08		1,468.30
Medicare Acute Care days plus Medicare Swing Bed Days		380		380		493
Medicare Share of Reimbursable Costs		893,578		687,450		723,872
Savings to the Medicare Program				206,127		169,706

As a result, the cost of care per patient is lowered, providing savings to the Medicare program and CMS. In the Figure 1 cost analysis, Liberty Medical Center would need to add an estimated $346,753 in annual variable cost for additional Certified Nursing Assistant (CNA) staffing, food and supply costs, and overhead to provide care to the additional 10 swing bed patients. Increasing the bed limit for the new FHS model up to 35 beds should undoubtedly provide additional cost savings. At least 3 of the 9 Montana F-CHIP facilities would potentially generate an estimated $169,706 each in annual cost savings to CMS if the bed limit were increased to 35 beds, compiling a total of about $509,118 in annual savings to CMS.

V. Conclusion

There is an overwhelming need for the use of consistent reimbursement methodologies across CAH inpatient and outpatient services, swing bed services, rural health clinic services, nursing homes, home health services, hospice, ambulance services, and expanded Visiting Nurse Services (as part of a Rural Health Clinic). Consistent reimbursement practices across different lines of service delivery would have the ability to provide meaningful incentives and successfully integrate Frontier health care services. By improving care coordination through the proposed Pay for Outcomes Shared Savings model, cost savings would be generated and ultimately pay for the relatively small additional cost for care coordination

activities and expanded VNS services. Also, an integrated payment system (not an all-inclusive payment rate) for FHS would reduce unit cost by diluting overhead expense over an expanded number of units of service, improve care, and increase patient quality.

The issue at hand is specific to the disparate Frontier CAH reimbursement systems that are creating incentives to separate healthcare in Frontier rural areas that would benefit from consolidation of services under one corporate structure. In order to achieve this, specific modifications to the current COP and regulations will be required, as well as development of a refined reimbursement model that brings as many services under one cost-based reimbursement umbrella as possible in addition to providing access to services currently not being provided. There is a definitive opportunity to expose the Frontier regions to a healthcare model that exemplifies the Triple Aim.