OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

CAH Finance and Operations Webinars

June 20, 2024

Interface: How Primary Care and CAH Operations Can Work Together

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

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Webinar Logistics

- Audio is muted for all attendees.
- Select to populate the ··· to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/resources-and-technical-assistance-cahs.

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CAH Operation and Finance Webinars

July 18, 2024 | 12 p.m. – 1 p.m. | Register here
Beyond Coexisting: Building a Thriving Relationship Between Finance and Human Resources

August 15, 2024 | 12 p.m. – 1 p.m. | Register here
Behavioral Health: Leveraging RHCs to Expand an Essential Service

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Nicole Thorell previously served as the Chief Nursing Officer and Director of Risk and Quality at a critical access hospital for over ten years. In this role she had oversight of all nursing functions including medical-surgical, swing bed, obstetrics, emergency department, surgery, outpatient specialty clinic, and four rural health clinics. Nicole received her diploma in nursing from Bryan College of Health Sciences, and her Bachelor of Science in Nursing, Master of Science in Nursing from Kaplan University and her Family Nurse Practitioner from the University of Nebraska Medical Center. Nicole became a TeamSTEPPS master trainer in 2009, received her LEAN Six Sigma green belt in 2013 and her Just Culture Certification in 2015.

Jonathan Pantenburg is a Principal at Wintergreen. He is an accomplished, results-driven senior executive with nearly 20 years of progressively responsible experience advising profit, nonprofit, and governmental entities. Over the past six years, Jonathan has worked with entities ranging from independent practices to multi-state health care systems on how to leverage rural opportunities to improve financial and operational performance. Prior to that, Jonathan served as chief financial officer and chief operating officer for a 21-bed nonprofit critical access hospital.

How Primary Care and Hospital Operations Can Work Together

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Objectives

- Review the Rural Environment and Performance Improvement Model
- Discuss practice designation types
  - Federally Qualified Health Centers (FQHC)
  - Provider-based Clinic
  - Rural Health Clinics (RHC)
    - Includes Provider-based Rural Health Clinics (PB-RHC)
  - Free-Standing Health Clinic (FSHC)
- Evaluate reimbursement trends and strategic opportunities
- State integration opportunities

The Rural Environment

Market

One in five Americans live in rural communities

Barriers

Highly fragmented provider community with various clinic designations

Entrenched need for autonomy and cultural resistance to change -- coupled with trust issues

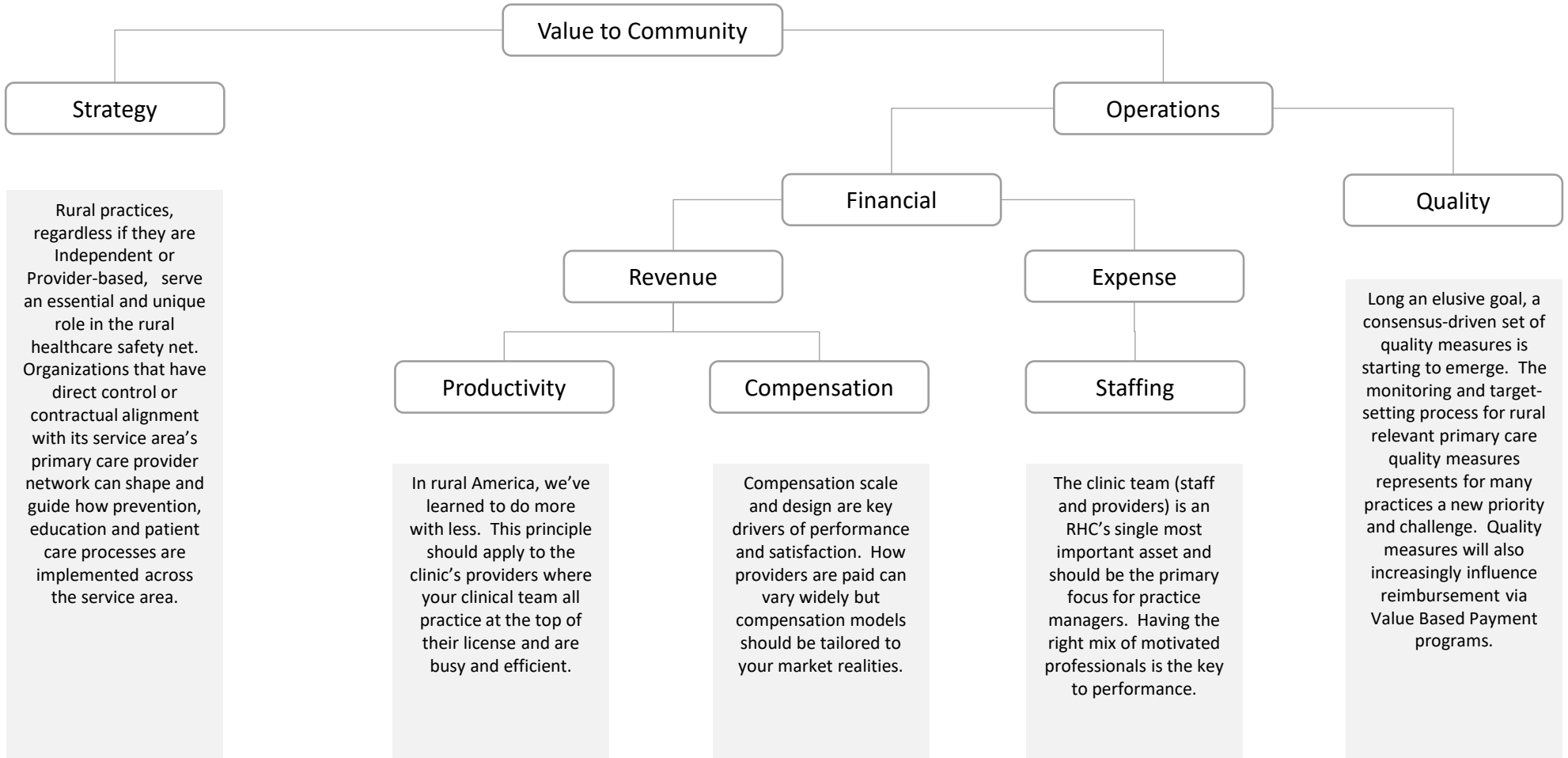
Complex, arcane and fluid regulatory environment tied to optimal reimbursement

Opportunity

Organizations must take steps to improve their operational performance, service delivery, and financial position: specifically looking at the alignment and designation of each rural practice to improve performance

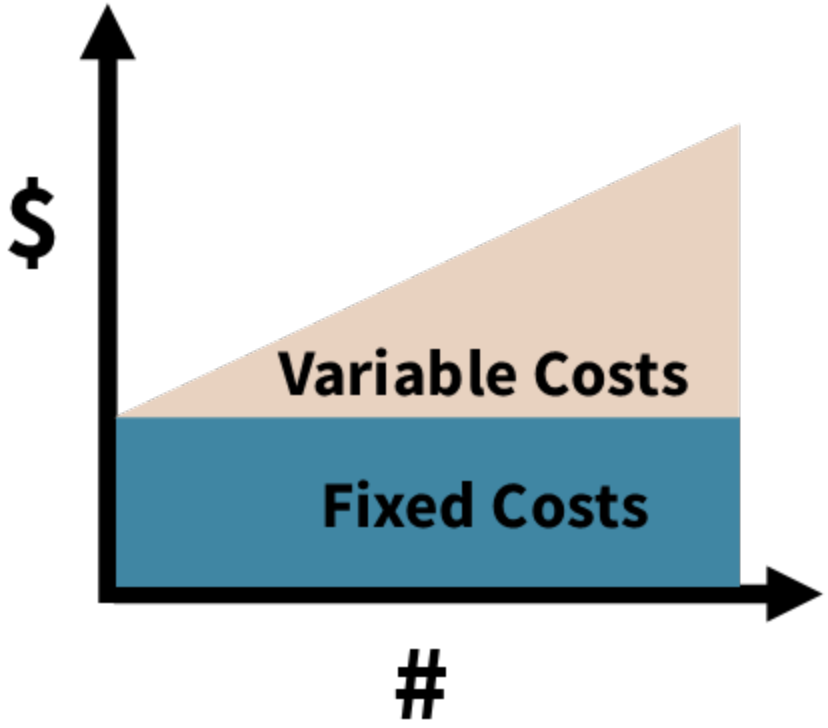
Rural markets are built on relationships that strengthen trust, honor legacy models and provide the type of innovation and expertise that is not present in the current, inefficient industry

Performance Improvement Model



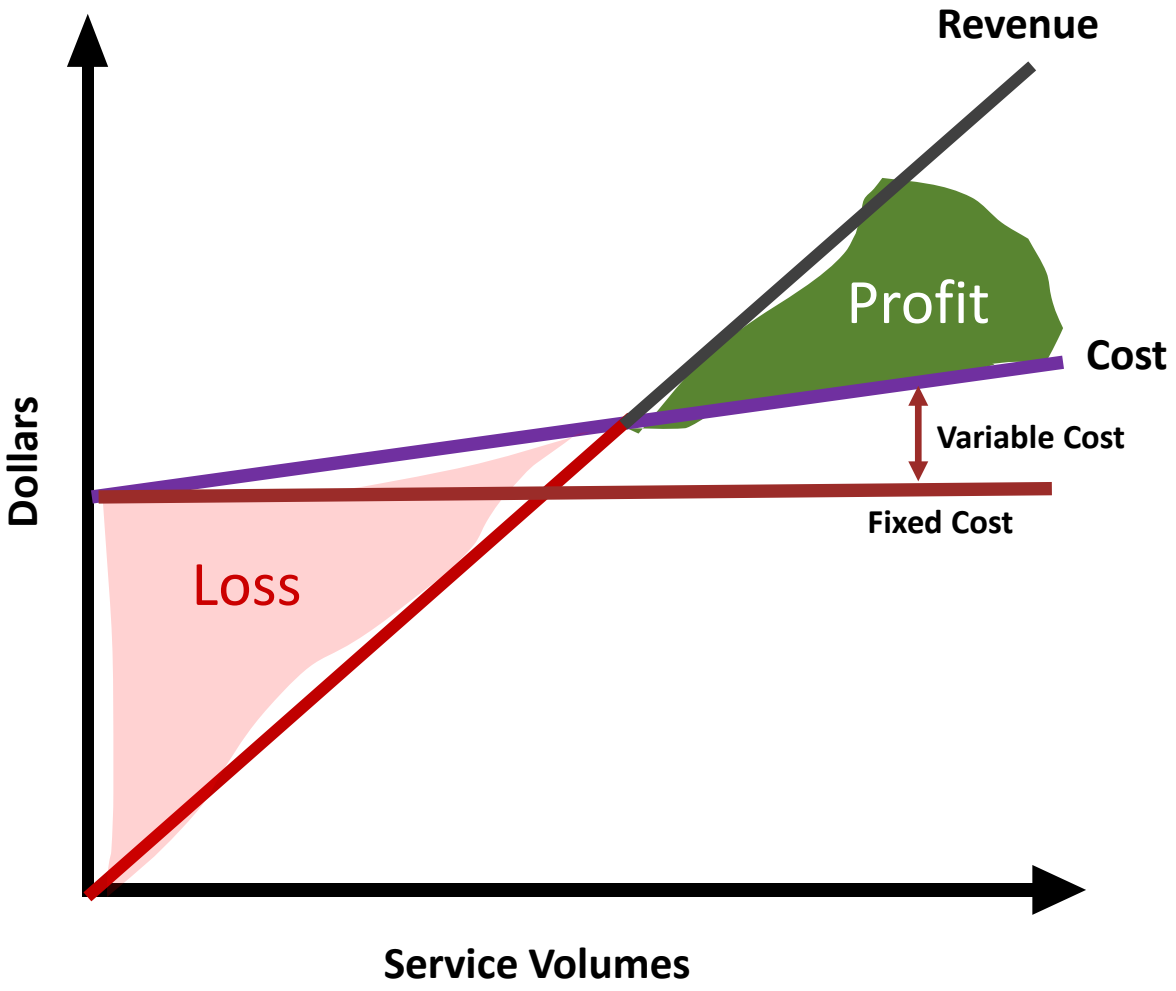
Understanding Your Cost Structure

- Fixed costs are those which exist irrespective of volume
  - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional CAH/RHC visit
  - Incremental medical supplies and pharmaceuticals
- In comparison to fixed costs, variable costs represent only a fraction of CAH/RHC costs
  - As volume grows, fixed costs are diluted faster than variable costs grow



Economic Philosophy

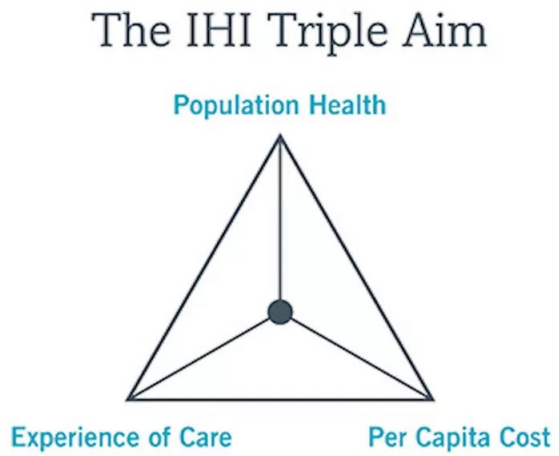
- The financial solvency of a CAH is dependent upon the realization that revenue (volume) and expenses both contribute to the financial position of an organization
  - Value is unlocked by marginal revenue gains that help dilute down a high fixed cost environment
  - Organizations need to understand the different and impact of contribution margin
  - Cost-based reimbursement will not generate profit and only cover the costs for those proportional services
  - CAHs need to break down the silos between quality and finance for improved outcomes



The IHI – Triple Aim

- The United States health care system is the costliest in the world and changes must occur to maintain the sustainability of services and care
  - The IHI Triple Aim framework, developed by the Institutes for Healthcare Improvement (IHI), describes an approach to optimizing health system performance

- IHI believes the United States must develop new designs that simultaneously pursue three dimensions: the Triple Aim
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations; and
  - Reducing the per capita cost of health care[1]
- Generally, in the United States health care environment, no one is accountable for all three dimensions of the IHI Triple Aim and thus lead to the following conceptual design:
  - Focus on individuals and families
  - Redesign of primary care services and structures
  - Population health management
  - Cost control platform
  - System integration and execution



[1] The IHI Triple Aim | IHI - Institute for Healthcare Improvement

Practice Designations

Practice Approach to Revenue Optimization

- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid and must be factored when evaluating primary and specialty providers
  - The table below highlights those differences

Reimbursement Options	FQHC	CAH PBC	<50 Beds PB-RHC	FSHC
330 Grant	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Tort Reform - Malpractice Savings	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No

  - * For non-CAHs, Hospital needs to meet DSH % to qualify for 340B

Reimbursement Trends and Strategic Opportunties

RHC Reimbursement Methodology

- With declining reimbursements, healthcare entities must leverage available reimbursement opportunities to improve financial performance
- The following opportunities are available to hospitals and systems to improve reimbursements when those practices can meet certain eligibility requirements:
  1. Convert eligible practices to a designation that provides the most advantageous reimbursement opportunity
  2. Realign practices within a health system to leverage reimbursement advantages and additional revenue
  3. Integrate specialty practices and providers, when possible, within a PBC or RHC to leverage alternative reimbursement methodologies
  4. Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals such as 340B
     - This opportunity may not lead to a net positive return; however, will increase in functional, contractual, and governance alignment and increase the attributed lives associated with the hospital / health system
     - **Note:** *An RHC owned and operated by a hospital that qualifies for 340B does not have to meet the provider-based rules at 42 CFR 413.65 to be registered as a child site for 340B purposes*

Practice Designations

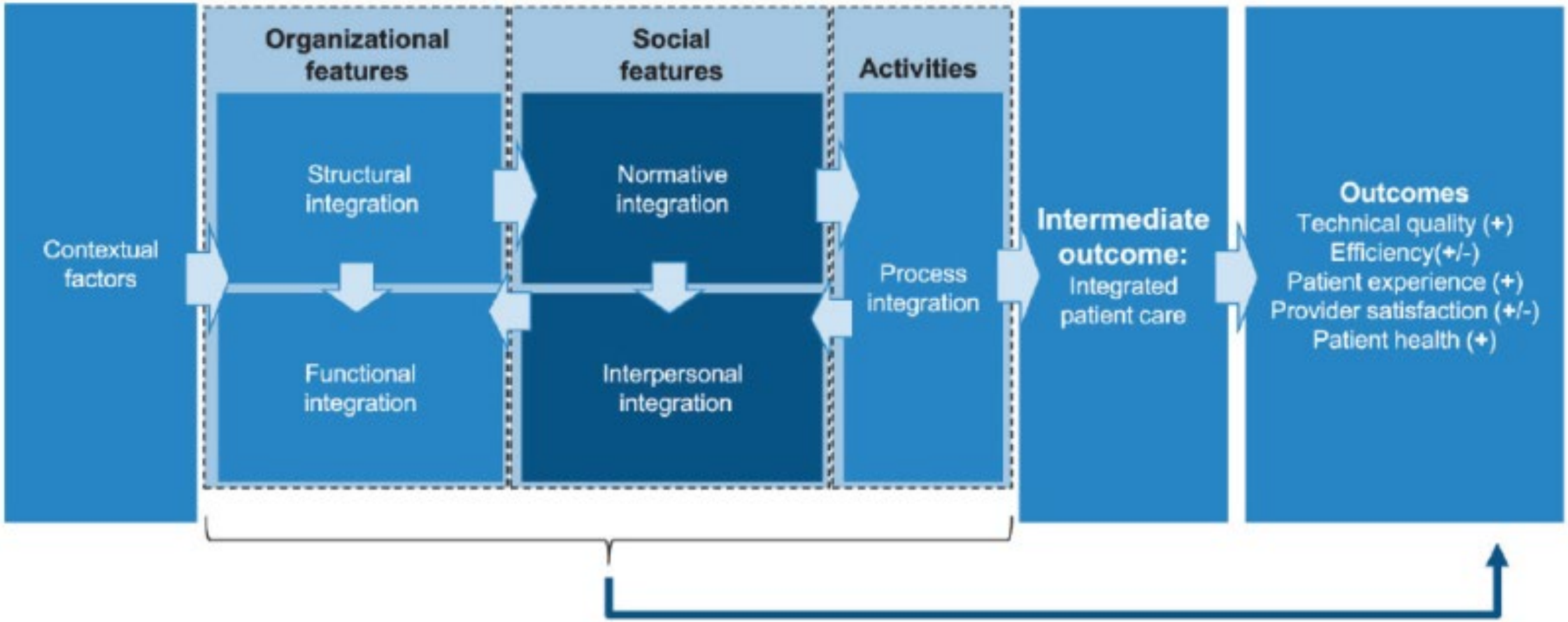
- The following table shows the net financial impact of different designations on a hospital:

			Before Change		After Change
Summary Data	**Scenario #1 PBC**	**After 2019 OPPS Final Rule (PBC)**	**Scenario #2 PB-RHC >50 Beds**	**Scenario #3 PB-RHC <50 Beds**	**Scenario #4 RHC Post 4/1/21**
Medicare / Medicaid Average	$ 149.06	$ 136.86	$ 86.32	$ 187.82	$ 127.92
Annual Visits	28,294	28,294	28,294	28,294	28,294
Reimbursements Received	$ 4,217,643	$ 3,872,319	$ 2,442,338	$ 5,314,296	$ 3,619,368
340B Benefit	n/a	n/a	n/a	n/a	n/a
Variance w/ Before 2019 PBC (Scenario #1)		$ (345,324)	$ (1,775,305)	$ 1,096,653	$ (598,275)
Variance w/ After 2019 PBC (Scenario #1)			$ (1,429,981)	$ 1,441,977	$ (252,951)

- Outcomes:
  - Prior to the change in the RHC reimbursement methodology, the PB-RHC would have been the most advantageous designation; however, under the new reimbursement methodology, the practices would be better served to remain as a PBC until the RHC UPL surpasses the average PBC rate
    - Since the practices were already PBCs, there was no additional 340B benefit by converting the practices to RHCs

Integration Opportunities

Comprehensive Theory of Integration



Singer SJ, Kerrissey M, Friedberg M, Phillips R. A comprehensive theory of integration. Medical Care Research and Review. 2020;77(2):196–207.

Operational Considerations

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Clinically Integrated Network

Structural Integration

- Quality Improvement-clinical and revenue cycle
- Data Sharing and Analysis
- Clinical Accountability
- Legal Protection

Functional Integration

- Clinical Leadership
- Performance Improvement
- Information Technology
- Legal and Contracting Options
- Membership Criteria
- Fund Flows

Normative Integration

- Clinical Guideline Use
- Clinical Variation Reduction
- Efficiency Improvement

Interpersonal Integration

- Care Coordination
- Team-based Care
- Proactive Care

Operational Considerations

- **Internal Referral Process**
  - Structural integration and co-location (e.g. shared space)
  - Fully integrated (single organizational structure with employed staff)
  - Single medical record
  - Shared billing and scheduling systems
  - Shared risk

- **Integrated care initiatives should be:**
  - Patient centered (e.g., address the needs of the patient; is responsive to patient preferences, needs, and values; and ensures that patient values guide all clinical decisions);
  - Expand access to care, decrease burden of illness, optimize care;
  - Delivered in settings preferred by patients;
  - Evidence based;
  - Driven by clinical and care issues and functions not practice and administrative issues;
  - Focused not only on integrating care within practices/facilities but also across practices and care settings; and
  - Focused on both physical health and behavioral health settings

Care Management Services

Medicare allows care management services that include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), principal illness navigation (PIN), general behavioral health integration (BHI), and psychiatric collaborative care model (CoCM) services

Transitional Care Management

- Goal of transitional care management services are to support healthy transition back to the community after hospitalization
- TCM services help to reduce readmissions by closely monitoring many of the risks patients can experience after discharge including; treatment adherence, medication reconciliation and management, patient and family education and support for outpatient services
- Services may be provided to Medicare beneficiaries by their primary care provider when discharged from an appropriate facility as defined by CMS

99495- MDM=Low- Moderate Complexity	99496- MDM=High Complexity
• Initial communication(direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge (Monday-Friday, except holidays) • If 2 or more separate attempts are made in a timely manner, but are unsuccessful and other TCM criteria are met, the service may be reported • **Face-to-face visit or telehealth visit within 14 days of discharge** • Medication reconciliation and management • Date of service reported on the claim is the date of the face-to-face visit. Place of service should correspond to the place of service for the face-to-face. Claims may be submitted after the visit is completed	• Initial communication(direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge (Monday-Friday, except holidays) • If 2 or more separate attempts are made in a timely manner, but are unsuccessful and other TCM criteria are met, the service may be reported • **Face-to-face visit or telehealth visit within 7 days of discharge** • Medication reconciliation and management • Date of service reported on the claim is the date of the face-to-face visit. Place of service should correspond to the place of service for the face-to-face. Claims may be submitted after the visit is completed

Care Management Services

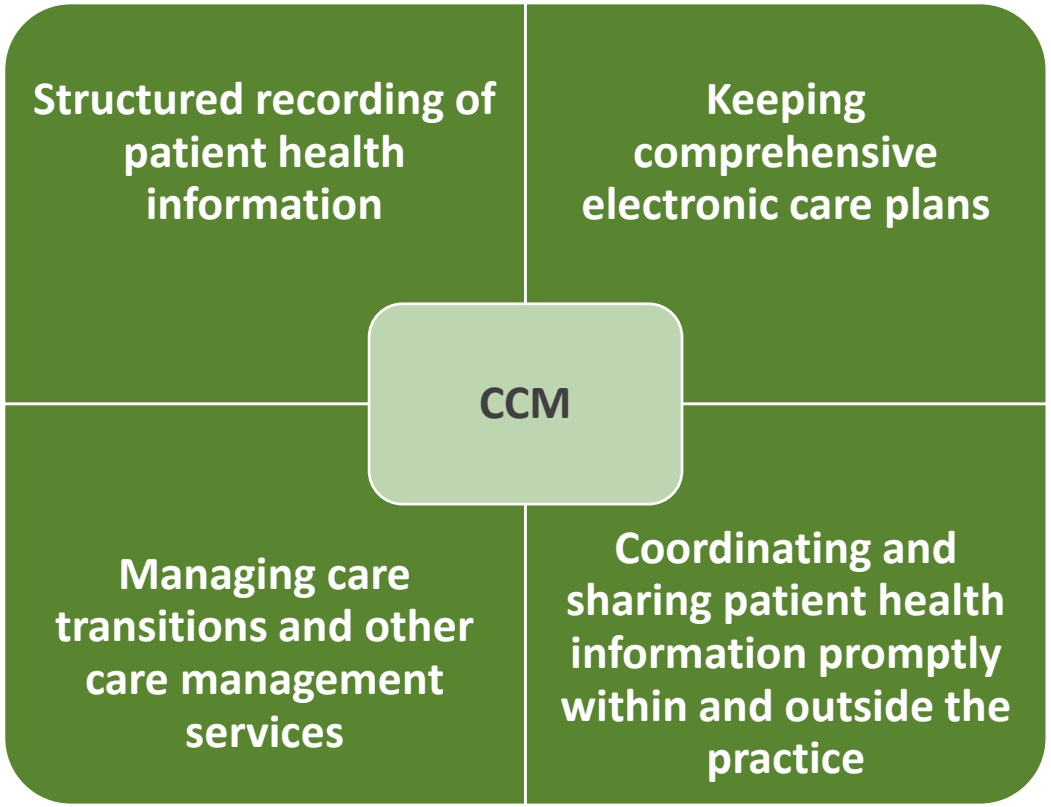
- **Principal Illness Navigation**
  - Covers principal illness navigation services for patients with a serious condition that is expected to last at least 3 months and puts them at high risk for one or more of the following:
    - Hospitalization
    - Nursing home placement
    - A sudden worsening of preexisting symptoms
    - Physical or mental decline
    - Death
  - PIN is a type of care management service that helps patients understand their medical condition or diagnosis and guides them through the healthcare system

Care Management Services

- **Principal Care Management (PCM)**
  - PIN is like Medicare's CCM with a few key differences
    - Under the new PCM codes, specialists may now be reimbursed for providing their patients with care management services that are more targeted within their own area of specialty
    - PCM services may be furnished to patients with a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death and requires a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month
  - General PCM services include:
    - A single complex chronic condition lasting at least 3 months, which is the focus of the care plan;
    - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
    - The condition requires development or revision of disease-specific care plan;
    - The condition requires frequent adjustments in the medication regiment; and
    - The condition is unusually complex due to comorbidities

Care Management Services

- **Chronic Care Management (CCM)**
  - CCM is for members with two or more chronic conditions and includes the management of medications, appointments, and services managed by one healthcare provider
    - Providers can receive payment when at least 20 minutes of qualifying CCM services are provided during a calendar month
  - General CCM services furnished outside of face to face include:
    - Continuous patient relationship with chosen care team member
    - Supporting patients with chronic diseases in achieving goals
    - 24/7 patient access to care and health information
    - Patient receiving preventative care
    - Patient and caregiver engagement
    - Prompt sharing and using patient health information

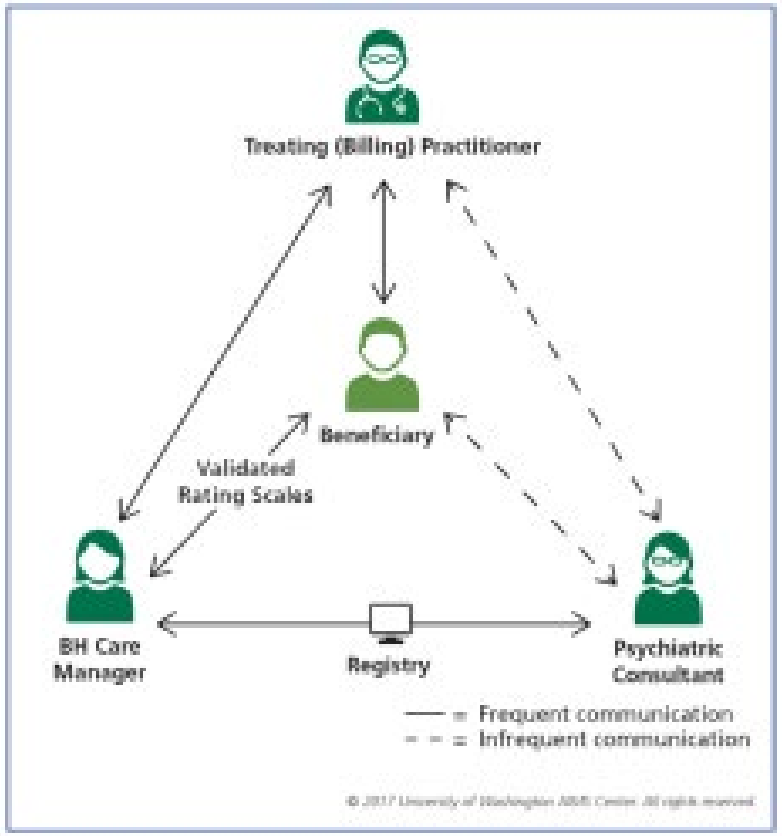


Care Management Services

- **General Behavioral Health Integration (BHI)**
  - BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
  - RHCs can receive payment when at least 20 minutes of qualifying BHI services are provided during a calendar month
  - General BHI services include:
    - An initial assessment and ongoing monitoring using validated clinical rating scales;
    - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
    - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
    - Continuity of care with a designated member of the care team

Care Management Services

- **Psychiatric Collaborative Care Model (CoCM)**
  - Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant and includes the following:
    - Regular psychiatric inter-specialty consultations with primary care team
    - Regular review of treatment plan by primary care team
    - Specific requirements for the RHC providers, behavioral health care manager, and psychiatric provider
    - At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service
    - Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes
    - Does not include administrative activities such as transcription or translation services



Patient Centered Medical Home (PCMH)

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Patient-centered medical home is a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare, whether you're being seen at the doctor's office, if you become hospitalized or recuperating at home, through ongoing preventative care

Why become a PCMH as a value-based strategy	Medicare has moved to change how it structures payment from a quantity to a quality approach Medicare will provide incentives for better processes and outcomes Medicaid programs have made enhanced payments to providers who achieved certain distinctions or process measures
Benefits of a PCMH strategy	Make primary care more accessible, comprehensive and coordinated. Provides better support and communication Creates stronger relationships with your providers Improves patient outcomes Lowers overall healthcare costs
Benefits of a PCMH to the Bottom Line	A more efficient use of practice resources, resulting in cost savings A practice equipped to take advantage of payment incentives for adopting medical home functions A practice is better prepared for enhanced payment under MIPS or Alternative Payment Models, to participate in an ACO, and provide chronic care management services

Questions

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ORH Announcements

Next Community Conversations | July 25 | 12:00 p.m.
Rural Health Resource Round-up - *Register here*

October 2-4, Bend, OR | 41st Annual Oregon Rural Health Conference
(*More information here*)

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