OCH Ozarks Community Hospital

ochonline.com

FROM THE DESK OF

PAUL TAYLOR, J.D.
CHIEF EXECUTIVE OFFICER

Thursday, November 21, 2024

National Rural Health Day: The OCH Story

Thursday, November 21, 2024, is National Rural Health Day. Ozarks Community Hospital is a rural health system that currently consists of a critical access hospital in the Arkansas Ozarks, 13 rural health clinics in the Missouri and Arkansas Ozarks and three other clinics that primarily serve rural patients but are not rural health clinics. Our financial circumstances are representative of what a majority of rural healthcare providers face on this National Rural Health Day. To understand rural healthcare today, it would be instructive to consider its historical context. Our history presents an enlightening paradigm.

If an extraterrestrial alien conducted a rational study of this country's health industry, the alien would conclude that the principal goal of the industry was to generate profit for commercial insurance companies. The insurance companies control the narrative (and the dollars) and have managed to convince most people that insurance companies exist only to solve problems created by providers, patients and the government. I believe the kids call that tactic gaslighting. If the consequences were not so devastating to rural healthcare providers who do not have the resources urban systems have to push back, I would congratulate those insurance companies on playing their game so successfully. As it is, I feel the need to set the record straight while providing a bit of historical context.

When the government transitioned Medicare from a cost-reimbursed methodology for all hospitals to established fee schedules, rural hospitals began failing in alarming numbers. Medicare recognized that rural hospitals, compared to urban hospitals, had 1) a higher percentage of Medicare and Medicaid patients, 2) a lower percentage of better-paying commercial insurance patients, and 3) higher costs of operation per service provided due to lower patient volumes and resource scarcity. To stem the tide of rural hospital closures, Medicare created the critical access hospital program. The basic premise was to allow, under certain strict conditions, these critical access hospitals to continue as cost reimbursed. Provider-based rural health clinics of critical access hospitals were included in that cost-reimbursed methodology.

Today

- We have 25 inpatient/swing beds (IP/SB). [For the reader not familiar with CAH terminology, a swing bed is an inpatient bed that can "swing" to a skill nursing care bed. For this analysis, I am merging the revenue and costs.] Based on current data, we will end the year with IP/SB charge revenue of $30,845,277. That revenue is largely irrelevant because Medicare pays based on a per diem calculated on the allowed cost of caring for those IP/SB patients. We will end the year with 5,000 patient days. Our current combined Medicare per diem is $3,667 (see below under **Costs**). Therefore, we would be paid $18,335,000 if we were cost reimbursed for our IP/SB patient care in 2024.
- We will end 2024 with $85,130,888 in outpatient charges. Our cost reimbursed rate set by Medicare in our latest interim rate review is 53% of charges. Therefore, we would be paid $45,119,370 if we were 100% cost reimbursed by Medicare. Along with those inpatient and outpatient charges, nearly all the providers who treat patients in our hospital are employed by us. We will end 2024 with $16,592,250 in billed professional fees. Medicare reimbursement is not based on costs for professional fees. If we were 100% Medicare, we would be paid around $5 million for those services.
- We will end 2024 with 140,000 total clinic patient visits. The total charge revenue from those clinic visits will be around $38 million. If we were 100% Medicare, we would be paid around $22 million for that service.
- For those keeping score at home, our total reimbursement if we were being paid for all patient care based on Medicare methodology applicable to CAHs and RHCs would be $90 million. What we actually collect will be $55 million. We will depend on other income sources to (attempt to) bridge the gap between what we collect from patient services and what we need to pay the bills. We will not succeed in that attempt.
- Our net patient revenue will be approximately $63 million in 2024. Net patient revenue is calculated by our system based on the amount we would collect if payors paid what they are contractually obligated to pay. Keep in mind, however, that the calculation is not as simple as multiplying all services provided a particular payor's patients by the applicable contract rate. The contractual adjustments written-off to produce a net revenue number also include the impact of such payor tactics as denials based on medical necessity, prior authorization and out of network. Believe it or not, those denials are not always legitimate! [If I were a younger person with social media skills, I would insert a shocked-face emoji.] If we work those denials but are unable to get the payor to change the claim status, then our system will write off the claims as part of our contractual adjustment. Therefore, due to over-aggressive payor tactics in denying valid "clean" claims, our net revenue would be substantially higher than $63 million if payors were legitimately paying claims under our contractual terms with them. Medicare Advantage payors have been particularly egregious in fabricating reasons to deny claims. Over the last three years, our internal analysis shows that Medicare Advantage payors, contractually obligated to pay us the same as Medicare, have paid us over 20% less than Medicare based on each dollar billed. That said, even if we solved the Medicare Advantage negative effect, there would remain an even more significant shortfall if we compared Medicare reimbursement methodology to our general, commercial contracts forced on us by commercial payors. I do not pretend that reality is a recent development. It is one of the reasons the CAH program was created—to offset the fact that rural hospitals are, for the most part, paid less than urban hospitals for the same service. I mention it to emphasize the point that, for a CAH, Medicare cost reimbursement is only as meaningful as the CAH's Medicare payor mix—making the recent dominance of Medicare Advantage over traditional Medicare both insidious and doubly damaging.

[Please do not suggest that we re-negotiate our commercial contracts to mitigate the problem. Like most rural hospitals, we have very little leverage to use in those negotiations—and the commercial Medicare contracts already require payment at Medicare rates: they simply do not pay.]

Let me make certain I am not misunderstood. I am not talking about the difference between gross charges and net patient revenue. I am talking about what we would be paid if we were truly reimbursed across the board for the cost of care as determined by Medicare ($90M) and what we are actually paid under the current state of affairs faced by rural healthcare providers in this country ($55M). I can hear all the experts. Some will say, "The system simply does not work that way." Others will say, "Hire me and I will collect $75 million for you." Others will say, "Your costs are too high." There will be those who say, "It is what it is. There is no more money for rural healthcare. Make it work under the current reality or close." I run this system. I will readily admit that a better manager than me might collect more and reduce costs better, but does anyone think that is the main takeaway from these numbers?

2004-2014-2024

- In 2004, our health system consisted of one hospital in Missouri. Our payor mix was a bit over 90% governmental and self-pay. We had no clinic visits. In 2014, our health system consisted of two hospitals and clinics generating 240,000 clinic visits annually. In 2024, our health system consists of one hospital and clinics generating 140,000 visits.
- In 2004, our Medicare payor mix was 44%. In 2014, our Medicare payor mix was 32%. In 2024, our Medicare payor mix is 12%.
- Medicare Part C had been newly branded as Medicare Advantage in 2004 based on a law passed in 2003. Our "true" Medicare patient population percentage has not changed much over time. Give or take, the total percentage would look like this:
    - 2004 - Medicare 44%;
    - 2014 – Medicare 32%, MA 12%;
    - 2024 – Medicare 12%, MA 32%.
- Our Medicaid payor mix has remained roughly equivalent to our Medicare payor mix over time. It had been as high as 44% when our geographic focus was limited to southwest Missouri before opening the Arkansas CAH in 2008. Our clinics served as a robust primary care provider for Missouri Medicaid in southwest Missouri. Today, our Medicaid payor mix is 18% due to the privatization of Medicaid in Arkansas and Missouri which has converted much of our Medicaid volume to a kind of "Medicaid Advantage" (with the advantage clearly going to the commercial Medicaid payors which do not settle cost reports).

Costs

- Our IP/SB per diems were around $2,600 prior to Covid. I was asked by a Medicare cost report reviewer to explain why our per diems had risen so much recently. My response was "Medicare Advantage." Our average daily census (ADC) had been 19 of 25 licensed beds for the decade prior to Covid. Our post-Covid ADC is now lower. A decade ago, our patient payor mix was 32% traditional Medicare. It is now rattling around 11%-12% in our hospital, with Medicare Advantage reigning supreme. One might argue that, since Medicare

Advantage theoretically pays what Medicare pays, the change in payor mix should have no real financial impact. The reality is that Medicare Advantage will not authorize inpatient admissions or extend swing bed stays. We win over 90% of our appeals of those denials but we do not always appeal, because patients believe what their hyperactive insurance bird dogs tell them about not really needing to be admitted or to stay longer. The consequence is a lower ADC and higher per diems because so much of the cost of care for IP/SB patients is a "sunk" cost that does not follow the ADC on a pro-rata basis. [The same is less true of outpatient service costs which tend to fluctuate more with patient volume.] Do the math. If our ADC remained 19 as it had been for the past decade, our per diem would be around $2,667 instead of $3,667.

- For those who would assert that we obviously do not know how to run a cost-effective hospital, I would introduce the following fact into evidence. In the ramp up to the Affordable Care Act back in 2008-9, our hospital (this was prior to us adding a second hospital) was recognized as the least expensive hospital in the nation under data provided by the Dartmouth Atlas Project. We only knew about it from an article in <u>U.S. News & World Reports</u>. Covid blasted all efforts at cost control to the moon. Add to that the nefarious impact of losing money year after year which has long-term upward pressure on costs. For example, we recently sold our hospital real estate under a sale and lease-back arrangement which netted us some much-needed cash but nearly doubled the cost of that real estate. In terms of cash flow challenges, I would add that Medicare is recouping money in a monthly amount roughly equivalent to that new hospital lease payment. We spent all our Covid money from the government during Covid. We were not able to save it at interest and pay it back all at once as many health systems apparently did.
- I would be remiss in telling this tale if I did not briefly explain why we are now a single hospital system. In 2004 we were operating a 10-bed inpatient geriatric psych unit in our single hospital. It ran at an ADC of 10. We closed the unit in 2014 as a consequence of a Recovery Audit Contractor (RAC) run amok. The RAC recouped 100% of our geri-psych unit payments from Medicare for six months and was preparing to do the same for another 6-month period. The RAC concluded that these patients could have been cared for on an outpatient basis despite the fact that all these patients had been removed from nursing homes for being a danger to the general nursing home population—the reason Medicare "invented" the inpatient geriatric psych program. I asked the RAC: "Where should we have put these geriatric psych patients who were a danger to themselves and others and who had been removed from the only beds available to them—Motel Six? At least there would be a light left on for them when we dumped them at the door." We ultimately recovered all the money "recovered" by the RAC, but the damage had been done and we had to close the unit. When we did so, our ADC in that hospital went from 16 to 6. In 2015, after we completed our three-year accreditation survey with virtually no deficiencies, Medicare notified us that we did not satisfy the federal definition of a hospital as being "primarily engaged in inpatient care" because we were doing so much more outpatient than inpatient service. As I stated, we were doing 240,000 clinic visits. We scratched back, arguing that our push to treat patients in clinics and on an outpatient basis, keeping them out of the ER and hospital beds, was being urged on us by the Medicare program, but Medicare closed the hospital in 2016. We were subsequently forced to close many of our clinics. We appealed, and our appeal resulted in Medicare rewriting the audit guidance regarding the federal definition of a hospital to control bureaucratic overreach. There is, of course, no real remedy for a hospital wrongfully closed and the consequential damages which flow therefrom. We reopened it as a psych hospital in 2018 and promptly sold it because we were desperate for cash.

- In order to understand the cost impact the Medicare program can have on rural hospitals which are both more dependent on Medicare and have fewer resources to push back against Medicare when its bureaucrats do what bureaucrats are prone to do, I will add two more instances that stand out due to their impact on our operation and our infrastructure.
    - In 2018, one of our RHCs was undergoing a Medicare survey and the surveyor determined that the RHC was not doing at least 51% primary care. The issue was an internist on staff at the clinic who was also boarded in addictionology and was prescribing Suboxone to patients suffering from an opioid addiction. We asked the surveyor to review the medical charts of the patients being prescribed Suboxone, but the word from above was that all visits by a Suboxone prescriber would be assumed to be behavioral and not primary care—an assumption made completely without chart review. We were given two weeks to solve the deficiency. Well over 50% of the patients being prescribed Suboxone were Medicaid or self-pay. At that time, there were no other providers in the area accepting Medicaid or self-pay patients—which was why our internist was so busy. We were able to relocate the provider to another clinic which had higher visit numbers, but Medicare never asked what became of those patients, some of whom would have died had they gone off Suboxone and returned to taking opioids or street drugs in desperation. I will add that we believe our advocacy following this event played some part in the recent reform which no longer allows a surveyor to apply a strict interpretation of "more primary care than not" as a bean-counter litmus test for an RHC. The impact of fighting against Medicare bureaucratic irrationality, including the actions taken in anticipation of the unexpected, is an added cost rural healthcare struggles to afford. It costs more to be paranoid and afraid of the dark.
    - Along those lines, we also had the, we believe, unique experience of having all our employee health insurance costs disallowed by a Medicare auditor based on a misinterpretation of the regulations pertaining to allowed employee insurance costs. Not unlike many health systems, we self-insure a portion of employee health costs through a TPA cutting checks from our funds and from a premium-paid insurance company covering higher-dollar claims. The MAC reduced our allowed costs by millions of dollars triggering a huge negative settlement. Our appeal took six years to work its way to Maryland. Sitting outside the courtroom before the hearing began, the judges sent word to the MAC that they should settle without the necessity of a hearing and pay us back. It is not paranoia when they really are out to get you.

I am old, old enough to remember the bargain and promise originally made by the cost reimbursed critical access hospital and rural health clinic programs. Most of what I hear from the healthcare industry in general about rural healthcare in particular is that we do not provide the same quality care as our urban counterparts, that we are not as well managed, that our costs are too high and, mostly, that we should be thankful that the government bails us out through cost reimbursement. I say that rural healthcare would be fine if the government had remained faithful to its original promise. I would love to advocate for a total cost-reimbursed, "Medicare for All" CAH reform, but I am realistic enough to advocate simply for a reform which would allow CAHs to bill Medicare for all Medicare and Medicare Advantage patients, with Medicare then having the power to recover funds from the Medicare Advantages. In theory, this reform would not cost the Medicare program any money, and no one but the insurance companies, their shareholders, their lobbyists, politicians and people swayed by slick marketing campaigns care if a reform shrinks MA profits. So, it should be easy.

Speaking of my dreams, I envision a program reform which would allow CAHs to bill Medicare for all Medicare and Medicare Advantage patients using the Medicare prospective payment fee schedules to process the claims instead of the CAH's Chargemaster, with the MAC paying the claims as filed and adding a monthly stipend based on the most recent cost report (and interim rate reviews) to cover the difference between the prospective payment and the cost of the service. This reform would have the added benefit of restoring the "universal" Medicare co-insurance patient responsibility instead of the current 20% of the CAH's charges. This reform would cost the Medicare program money due to the decreased patient responsibility. I suspect that, as has been our history, if this reform were to happen, it will take place too late to do OCH any good.

Paul Taylor, J.D.
Chief Executive Officer
Ozarks Community Hospital