CAH Emergency Department Standby Time

$63+ Million Left on the Table Annually

Introduction

Medicare reimburses for Emergency Department provider standby time to help Critical Access Hospitals provide emergency services regardless of patient volumes. In most cases, the CAH emergency department is a cost center that can generate significant revenue as it relates to reimbursement of Part A standby time; however, CAHs must perform time studies that document Part A provider time on the CMS cost report. Historically, CAHs have struggled to effectively implement time study programs that meet Medicare Cost Report requirements in an accurate, defensible and efficient manner.

Under-stating ED standby time reduces reimbursement and the majority of CAHs are leaving money on the table

CFOs constantly look for ways to improve their hospital's financial health and often one of the best ways to accomplish this is by improving the accuracy of ED time studies. Wintergreen recently collaborated with VersaBadge to analyze historical, publicly available cost report data across all CAHs. VersaBadge works with more than 150 CAHs throughout the country to automate a wide range of time studies, leveraging a combination of proprietary location technology and software to deliver results with exceptional accuracy. We evaluated CAH-specific performance against an ED provider patient care time benchmark of 20-minutes per patient to quantify potential reimbursement gain.

What We Learned

There is a material, widespread opportunity for CAHs to improve their cost reporting processes and reimbursement accuracy. If every CAH met the 20-minute industry standard in 2021, the total reimbursement opportunity for traditional Medicare nationwide was **over $63 million**; this does not include Medicare Advantage plans nor states where Medicaid reimburses CAHs the same as Medicare for ED standby time. It is noteworthy that the **top nine states** account for **over 50 percent** of the total reimbursement opportunity.

889

Critical Access Hospitals

Had an opportunity in 2021 to improve ED standby time reimbursement

In healthcare, we recognize that variation is the enemy. According to our analysis, there is wide variation on the capture of ED standby time and related Medicare reimbursement across individual CAHs, states and regions. When we calculated the median opportunity for CAHs in each state based on the 20-minute standard, we discovered that while some states have modest median opportunities, 11 states have **$100,000+ median** potential reimbursement gains for the subject hospitals that have additional reimbursement opportunity. See **Appendix A** for a state-by-state summary of total and median ED visits and potential reimbursement opportunities.

Barriers

CMS indicates a preference for electronic time study data; however, many CAHs still conduct tedious, manual time-in-motion studies that require an observer to follow providers throughout their shifts and record their time allocations. This method is labor intensive, invasive and often inaccurate, in part due to overstatement of Part B patient care time that occurs at the clinicians' desk. Observers often assume that providers are charting on patients during the full time that they are at the computer, when a substantial amount of that time is not patient care related. Alternatively, many CAHs fulfill the time study requirement by having providers self-report their time allocations. Providers often have a propensity to overstate their patient care time, thus reducing reimbursable Part A time; moreover, compliance and defensibility of these time studies often become an issue under CMS audit. A third method leverages EHR data, often calculating patient care time based on admit and discharge times. While straightforward to administer, this method can attribute the full amount of time that a patient is physically present in the ED to patient care time, drastically overstating Part B time and significantly reducing reimbursement of Part A time.

Medicare reimburses CAHs for Emergency Department standby time but nearly 3 out of 4 CAHs do not effectively leverage this opportunity

Opportunities and Next Steps

In a post-COVID environment, CAHs must focus on tangible operational improvements. With increased financial pressure and unprecedented staff turnover, deploying an accurate, easy to administer time study program is imperative for CAHs. For a list of operational improvement ideas that can be implemented promptly, please refer to the **CALL TO ACTION** document on the Wintergreen website.

In addition, the VersaBadge platform was developed in partnership with CAHs and offers a suite of products designed specifically for the rural health care sector. In addition to time study solutions for calculating ED standby time, RHC FTE calculation, interdepartmental cost allocation, and administrative time capture, VersaBadge helps address increasing concerns around the safety of hospital staff, with a robust duress alerting system that enables caregivers to discreetly request assistance from security and other nearby staff who can aid in de-escalation.

Lilypad®

Acknowledgement. Special thanks to Lilypad, LLC for providing the underlying Medicare cost report data used in the CAH Emergency Department study.

APPENDIX A

CAH ED Standby Time by State (FY 2021)

		OPPORTUNITY		STATE MEDIANS		
STATE	**CAHs**	**COUNT**	**PCT**	**ER VISITS**	**OPPORTUNITY**	**TOTAL VALUE**
AK	8	7	88%	5,572	$56,935	$326,930
AL	3	3	100%	9,271	$73,494	$151,335
AR	21	17	81%	6,708	$65,842	$1,148,160
AZ	12	10	83%	6,687	$136,207	$1,112,093
CA	32	22	69%	8,527	$106,330	$3,112,535
CO	30	24	80%	4,152	$48,478	$2,119,587
FL	9	8	89%	9,678	$9,621	$168,557
GA	16	10	63%	5,673	$18,955	$216,897
HI	8	6	75%	1,868	$36,571	$387,685
IA	82	64	78%	3,964	$41,585	$3,347,198
ID	27	21	78%	4,904	$47,289	$1,526,444
IL	42	38	90%	6,356	$107,512	$4,986,332
IN	17	10	59%	10,675	$147,653	$1,341,676
KS	80	72	90%	1,493	$16,924	$2,062,108
KY	15	9	60%	9,270	$60,374	$486,743
LA	19	5	26%	5,982	$47,436	$201,041
MA	3	2	67%	12,328	$151,478	$193,716
ME	11	8	73%	11,048	$106,966	$848,376
MI	30	25	83%	8,362	$72,290	$2,007,558
MN	75	62	83%	3,648	$37,691	$3,685,591
MO	33	26	79%	6,431	$49,047	$1,736,826
MS	27	20	74%	4,405	$38,514	$766,337
MT	38	35	92%	2,624	$29,987	$2,335,687
NC	15	10	67%	11,342	$23,172	$385,678
ND	36	24	67%	1,962	$11,391	$783,950
NE	62	44	71%	2,207	$16,051	$1,169,183
NH	12	11	92%	8,933	$162,997	$1,708,375
NM	10	8	80%	8,398	$154,718	$1,057,891
NV	10	8	80%	4,084	$76,254	$929,474
NY	14	8	57%	8,803	$15,878	$192,513
OH	26	19	73%	10,463	$81,636	$1,781,969
OK	37	26	70%	2,304	$17,192	$1,045,921
OR	25	23	92%	10,456	$148,720	$3,706,282
PA	13	10	77%	9,259	$104,310	$1,105,624
SC	4	2	50%	8,349	$61,996	$111,184
SD	38	33	87%	1,871	$15,167	$1,178,652
TN	10	7	70%	8,803	$22,445	$188,896
TX	80	40	50%	4,023	$10,384	$1,136,389
UT	13	11	85%	3,672	$68,525	$844,119
VA	7	4	57%	12,033	$167,100	$528,511
VT	6	4	67%	14,892	$102,925	$447,235
WA	39	32	82%	5,003	$94,119	$3,707,767
WI	58	42	72%	6,220	$100,893	$5,920,801
WV	20	6	30%	9,395	$93,009	$418,701
WY	16	13	81%	3,718	$96,744	$1,224,354

Note: Data set includes 1,189 of 1,359 Critical Access Hospitals

Data Sources: December 2022 Medicare Cost Report release for CAH fiscal year 2021
Definitive Healthcare Emergency Department Volume Estimates fiscal year 2021

APPENDIX B
Methodology

Date of Analysis: January 2023

To conduct the ED Standby Time study, we utilized two national databases. First, we used the publicly-available Medicare cost report file released in January 2023 to establish cost and charge data for every CAH. Second, we used annual ED volume estimates from Definitive Healthcare. Our analysis focused on 2021 fiscal year data for every eligible CAH; we excluded all CAHs that did not have professional time in the cost report and all CAHs that did not have ED visit volume data in Definitive Healthcare; this resulted in a study cohort of 1,189 of a potential 1,359 facilities.

Note several study limitations: a.) ED volumes are based on 3rd party estimates rather than actual Emergency Department volume statistics; b.) the analysis is subject to the reliability and validity of data provided by CAHs to Medicare; and c.) data integrity may be impacted by the applicability of ED time studies for on-call providers and accuracy of data insights for CAHs with ED providers who float to other departments. Last, ED time studies may not be relevant for some CAHs that only incur costs for patient care time per certain contracts with ED staffing companies.