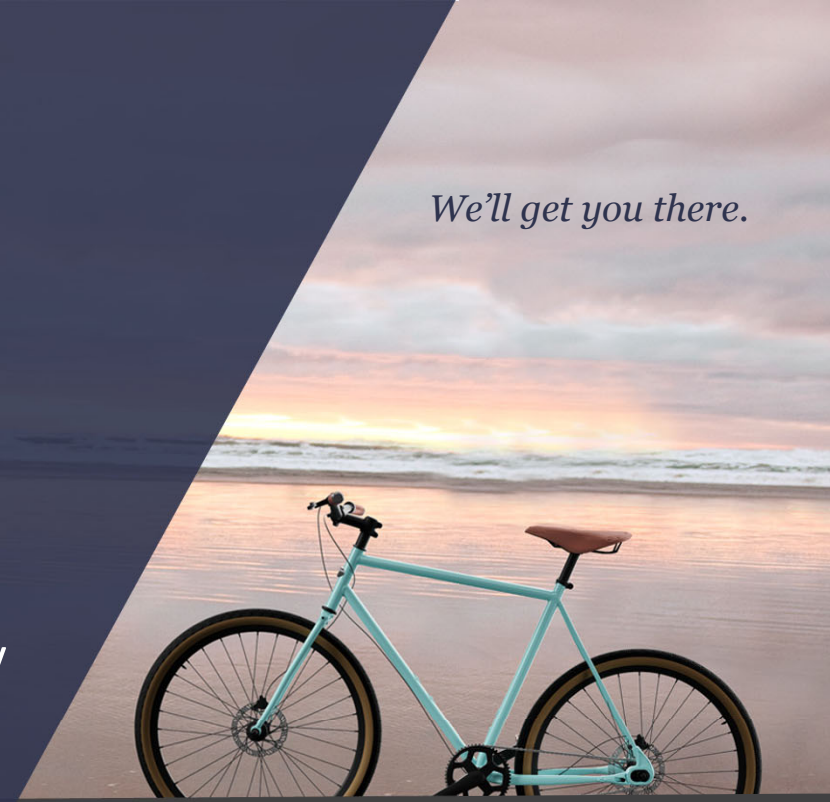

A Candid Analysis of the Rural Emergency Hospital Model

New Mexico Fall HFMA Conference

Matthew Borchardt

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Agenda

- What Do We Know About REH's?
- Estimating Financial Benefit
- Case Study
- Is REH Status Right For You?
- Next Steps To Consider

What do we Know About REH's?

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Challenges in Rural Healthcare

Since 2005, 181 rural hospitals have closed — 138 of those happened in 2010 and later. That's according to research from the Rural Health Research Program in conjunction with the Sheps Center for Health Care Research at the University of North Carolina.

Inpatient admissions continue to decrease….

What does the future of rural hospitals look like?

What options are out there?

What is the best way to provide sustainable high value health care?

Purpose and History Behind Legislation

- Medicare Payment Advisory Commission (MedPAC) research indicated hospital closures were linked to:
  - Lost market share compared to other hospitals
  - Fewer Medicare beneficiaries using hospital services
  - Inpatient admissions declining significantly prior to closure
  - Findings indicated the facilities saw: "… large declines in inpatient admissions across all payers in the years before closure. Most of this decline was attributable to patients bypassing their local hospital in favor of other hospitals." At the same time, patients were still using the emergency department and other outpatient services.
  - MedPac and Sheps Center research showed that of 181 closures, only 99 were fully closed. Others were converted to urgent care centers or other, non-acute hospitals
  - "… large declines in inpatient admissions across all payers in the years before closure. Most of this decline was attributable to patients bypassing their local hospital in favor of other hospitals." At the same time, patients were still using the emergency department and other outpatient services

Purpose and History Behind Legislation

- Rural Emergency Hospital (REH) status created under the Consolidated Appropriations Act of 2021
  - Facility type will not provide inpatient acute care services
  - Continues to provide outpatient services including emergency care, observation care, and other outpatient ancillary services including provider-based clinics, radiology, laboratory, therapies, etc.
- REH status available beginning January 1, 2023
- November 1, 2023 CMS published the 2023 OPPS Final Rule!

Have We Been Here Before?

- Was anyone around when CMS provided a new model in 1999?!? Also known as CAH! And much like CAH's changes and tweaks will happen.

- What were some of there concerns then?
  - What will the community think?
  - How will the new regulations impact us? i.e. Length of stay
  - Will Medicare continue to pay these larger rates?

- Do you think we might think the same thing about REH 20 years from now?

Eligibility For REH Status

- Available only to existing CAHs, rural PPS Hospitals with 50 Beds or fewer (no new hospitals can be created as an REH)
- Emergency and observation services must be provided at all times (by a physician, NP, CNS, or PA) who is available to provide those services
- Must have a transfer agreement with a Level I or II trauma center
- May not operate unless located in a state that has licensed the REH designation and the respective REH is then licensed/approved by the state or local agency
- Prohibited from providing inpatient level care, other than having a distinct skilled nursing unit if desired
- REH may convert back to original designation

Eligibility For REH Status

- May offer outpatient services
- Other important conditions of participation:
  - Clinician available on-site within 30-60 minutes
  - Must maintain an annual average length of stay of 24 hours or less
  - 24/7 Emergency Room Lab services
- Rural Emergency Hospital Quality Reporting Program
  - Must have a Quality Assurance and Performance Improvement (QAPI)
  - Have a QualityNet account

Other REH Highlights in Rules

- REH Provider Enrollment
  - CMS Form 855A
- REH Stark Exemption
  - No longer technically a CAH or PPS
  - Does not believe all exiting prohibitions on physician ownership should apply
  - Very complicated and consult with legal guidance

Estimating the Financial Benefit

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Inpatient Impact Modeling

METHODLOGY HIGHLIGHTS

- CAH based on 101% cost per MCR
- Estimated PPS as follows:
  - Using summarized 2020 facility specific claims data
  - Mapped CAH cases by billed DRG
  - Created average CMI by CAH by applying CMS YE 2020 DRG Weights to DRG level mapped case counts
  - Utilized specific facility CMI data for all but 4 CAH
  - Created state specific non metro DRG rate (weight 1)

CAH Current

101% IP Cost per MCR

Estimated Current PPS

Medicare CAH Inpatient Cases per MCR

X

Facility Specific Medicare CMI

X

State Specific Non Metro DRG (wght 1) Rate

Swing Bed Impact Modeling

METHODLOGY HIGHLIGHTS

- CAH based on Swing Bed Cost per MCR
- Estimated PPS as follows:
  - Created state specific average PDPM PPD rate using 2020 CLA CLArity dataset

CAH Current

Total Swing Bed Costs per MCR

Estimated Current PPS

Program Swing Bed Days per MCR

X

State Specific Average SNF PDPM Rate

Outpatient Impact Modeling

METHODLOGY HIGHLIGHTS

- Created 2 claims based outpatient payment models for *non Metro PPS* hospitals and CAHs (using 2020 claims data)
  1. HCPCS/CPT group level summaries
  2. Revenue code level summaries
  3. Excluded certain services from analysis (clinics, Anesthesia)
- From these models, created state level average PPS payment per unit tables
- Applied PPS per unit payment rates to CAH specific volumes
- Compared 2 different CAH payment models to PPS estimates to evaluate impact
  1. Facility specific claims level CAH payments
  2. Facility specific CCR based payment modeling using MCR data to create OP payment rate
- Created blended impact model by applying equal weighting to 4 different impact modeling approaches (HCPCS Claims, HCPCS MCR, Rev Code Claims, Rev Code MCR)
- Deductibles & co pays assumed to stay constant (used CAH MCR reported)

CAH Current

Blended CAH payments using weighted modeling approach (Claims and MCR)

+

MCR Deductibles & Copayments

Estimated Current PPS

CAH specific volumes

X

State specific PPS average payment rate (non Metro) per volume

+

MCR Deductibles & Copayments

X

105%

(will include in v2)

Average Facility Payment (AFP)

CMS Calculating Monthly Facility Payment

Step 1: The total amount of Medicare spending for CAHs in CY 2019 minus the projected Medicare spending for CAHs in CY 2019 if inpatient hospital services, outpatient hospital services, and skilled nursing services had been paid on a prospective basis rather than at 101 percent of total cost and calculated according to the methodology described.

Total Amount of Medicare Spending for CAHs in CY 2019: $12.08 billion

Total Projected Amount of Medicare Spending for CAHs if Paid Prospectively in CY 2019: $7.68 billion

Step 1 Difference: $12.08 billion - $7.60 billion = $4.40 billion

Step 2: The difference in Step 1 would be divided by the number of CAHs enrolled in Medicare in CY 2019 to calculate the annual payment per individual REH. The annual payment amount would be divided by 12 to calculate the monthly REH facility payment. Each REH would receive the same facility payment.

Step 1 Difference: $ 4,479,368,256

Number of Medicare CAHs in CY 2019: 1,368

REH Monthly Facility Payment: ($4,479,368,256/1,368)/12 = $272,866 (or $3,219,528 annually)

AFP
$3,274,392

Other Payment Model Assumptions REH Status

- Outpatient Payments Based on 105% of APC Payment plus national average of Critical Access Hospital Benefit
- Non-OPPS services paid under fee schedule (Lab, Therapy, etc)
- PBRHC is “grandfathered” for upper payment limit caps
- AFP of $3.2M for CAH Benefit

Identifying Potential REH Candidates

- Method 1: Net Revenues Loss (MC FFS) (No cost changes)
- Method 2: Net Revenue Loss + IP Acute Nursing Costs
- Method 3: Method 2 result + IP Supply Costs + Dietary Costs + Laundry Costs adjusted for Minimum ER Coverage Costs
- Method 4: Method 3 with Loss of 340B

How Many CAHs could benefit financially from REH Status (Nationally)?

# of Critical Access Hospitals	All CAHs	All PPSs	< 2 IP ADC
Increased Net Revenues (1)	160	56	91
Increased Margin Potential (2)	**756**	**111**	**142**
Increased Margin Potential (Min ER Cost) (3)	656	111	125
Increased Margin Potential - Lose 340B (4)	512	101	116

How Many CAHs could benefit financially from REH Status (New Mexico)?

# of Critical Access Hospitals	All CAHs	All PPSs	< 2 IP ADC
Increased Net Revenues (1)	1	5	4
Increased Margin Potential (2)	**4**	**7**	**4**
Increased Margin Potential (Min ER Cost) (3)	4	7	4
Increased Margin Potential - Lose 340B (4)	3	7	4

Case Study

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Situational Overview

Objective

- Provide an environment for both Sample CAH's management and CLA to define and understand performance implications of certain assumptions, while providing the ability to evaluate the sensitivity of critical assumptions impacting the overall performance of the sample CAH.

Goal

- Provide insights and analysis on the following scenarios for Sample CAH:
  - **Baseline (Maintain CAH Status)**
  - **Changes in Inpatient and Outpatient Services**
  - **Changes in Staffing and Expense Structure**
  - **Average Facility Payment**

Sources

- Projections used to support this analysis include information provided by Sample CAH, and December 31, 2021 audited financial statements. Statements of income, and assembled abbreviated projected statements of cash flows and balance sheets are for a prospective period covering the years ending December 31, 2022 through 2026.

Key Baseline Assumptions (Inflation / Spread)

Net Rate Inflation (Rates)

- **Medicare:** Estimated 3.0% / year (Cost Based)
- **Medicaid**: 1.0% / year
- **Commercial & Other Payors:** 1.5% / year
- **Self Pay:** 1.5% / year
- **Other Operating**: 2.0% / year

Expenses (COLA)

- **Labor:** 3.0% / year
- **Non-Labor:** 3.0% / year

Key Baseline Assumptions (Volume / Other)

Baseline Performance

- Baseline Performance = 2022 Budget

Inflation Growth

- **Inpatient:** 0.0% / year – 35% Contribution Margin
- **Outpatient:** 0.0% / year – 45% Contribution Margin
- **Clinic/Professional**: 0.0% / year – 15% Contribution Margin

Capital Spending & Debt

- Routine Capital Spending
  - 3.0% of Revenue / year for 2022+ ($675k - $850k / year)

Other Assumptions

- **Investment Income:** 3.5% / year (Realized & Unrealized)

Baseline as a CAH with $15.8M Project

Sample CAH / REH Simulation | REH Dashboard | No Assurance is provided. See selected information. | CLAIntuition™

REH CONVERSION

- ☐ No Conversion to REH

REH REVENUE IMPACTS

- No Inpatient Revenue Lost
- No Outpatient Revenue Change
- No Lost Inpatient Volume Captured (System)
- No Additional Home Office Impact

REH EXPENSE IMPACTS

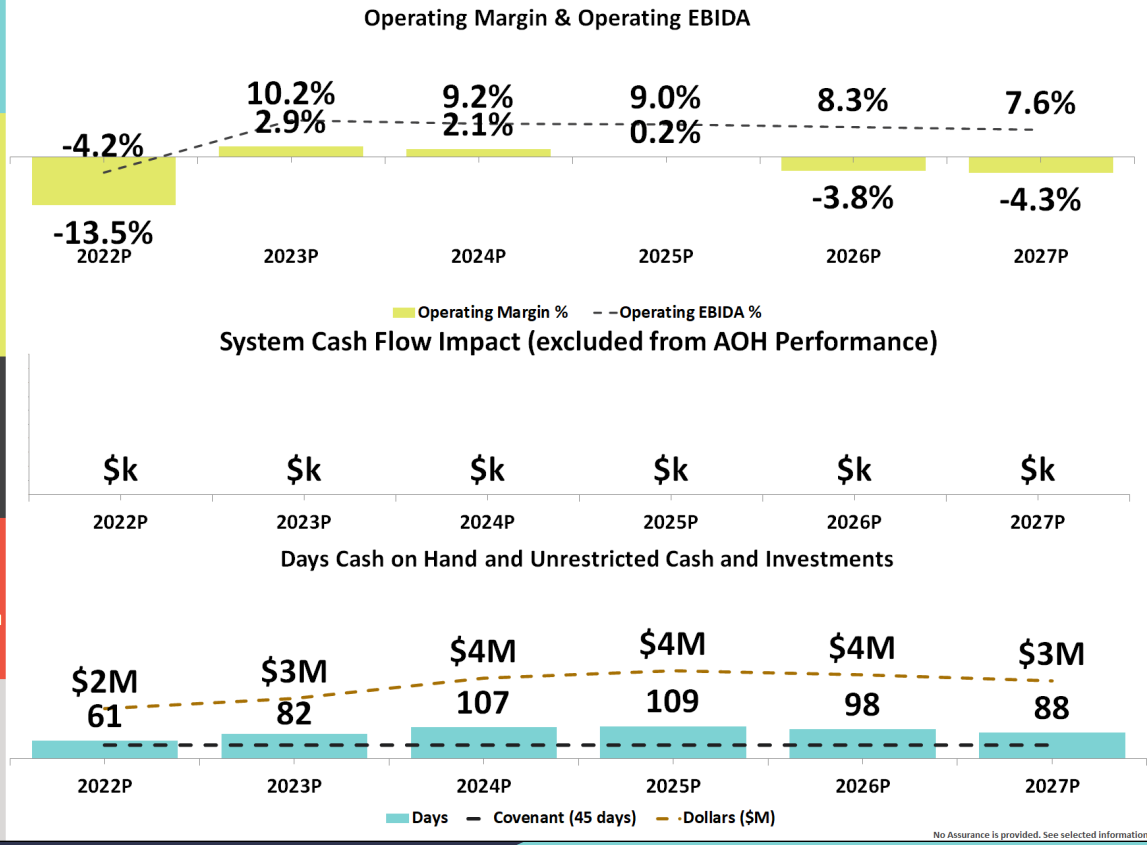
- No Targeted Labor Cost Reductions
- No Targeted Non-Labor Cost Reductions

AVERAGE FACILITY PAYMENT

- No Average Facility Payment
- ☑ New Building in 2024 $15.8M

PERFORMANCE IMPROVEMENT

- ☐ No Net Labor Performance Improvement
- ☐ No Net Non Labor Performance Improvement



REH Expense Impact Analysis

After a detailed departmental expense analysis, the table on the right depicts the expenses changes that could be achieved if the CAH was converted to an REH

Expense Impact Analysis

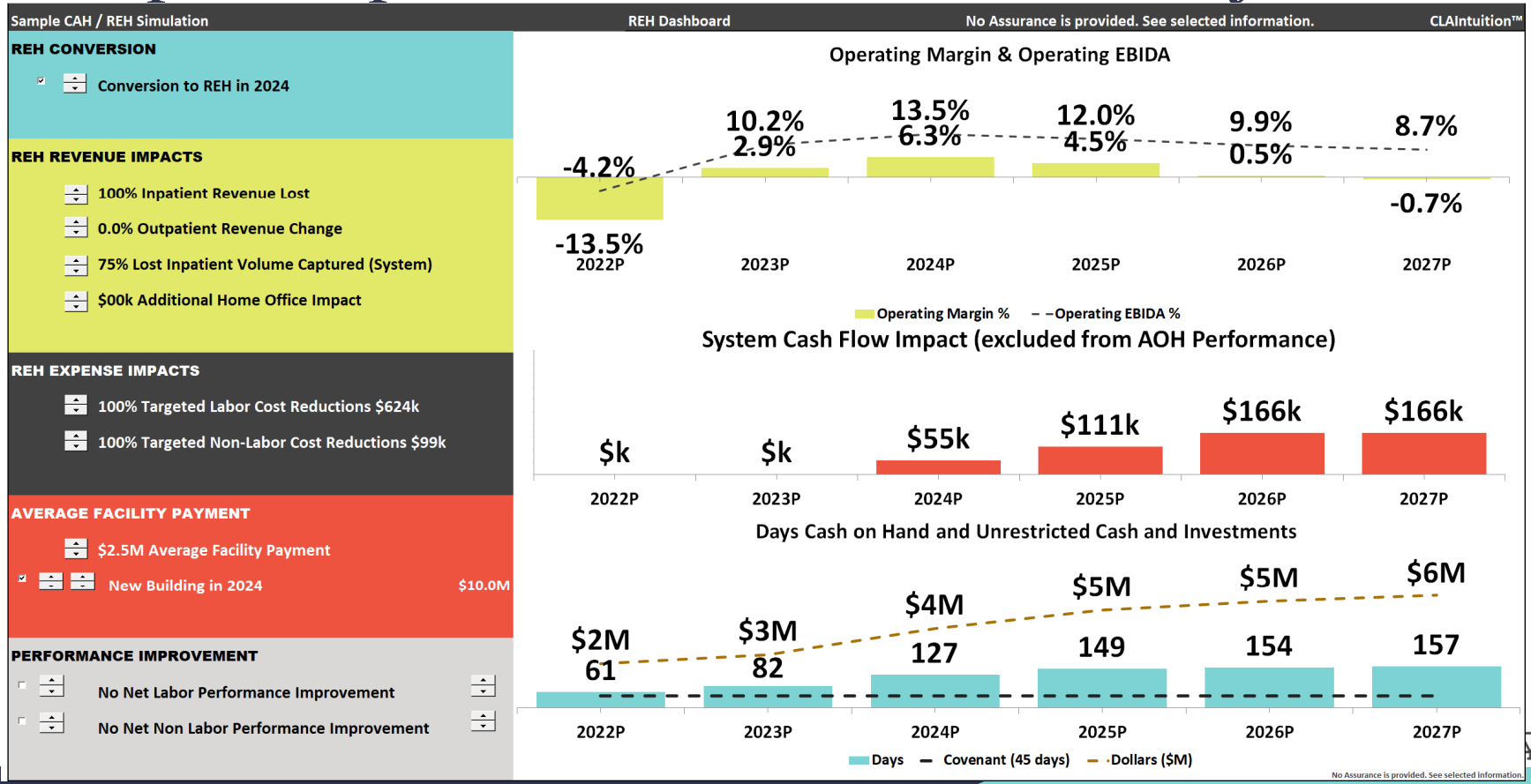
Department	2021 Actual FTEs	2022 YTD FTEs	2023 Budget FTEs	Changes if REH	REH FTEs	Labor Expense Impact	Non-Labor Expense Impact
Acute Care Unit	9.55	9.50	9.92	(9.92)	0.00	(956,455)	(34,834)
EKG	0.00	0.07	0.22	0.00	0.22	0	0
Emergency Room	4.98	4.99	4.63	4.96	9.59	543,294	51,820
Diabetic Education	0.03	0.08	0.09	0.00	0.09	0	0
Occupational Therapy	0.78	0.90	1.00	0.00	1.00	0	0
Physical Therapy	6.02	6.37	6.56	0.00	6.56	0	0
Speech Therapy	0.03	0.04	0.08	0.00	0.08	0	0
Cardiac Rehab	0.28	0.10	0.00	0.00	0.00	0	0
Respiratory Therapy	0.05	0.06	0.10	0.00	0.10	0	0
Laboratory	4.37	5.47	5.84	0.00	5.84	0	0
Radiology	3.18	3.69	2.10	0.00	2.10	0	0
Radiology Professional	0.17	0.16	0.00	0.00	0.00	0	0
Mammography	0.00	0.00	0.30	0.00	0.30	0	0
CT Scanner	0.00	0.00	0.90	0.00	0.90	0	0
Nuclear Medicine	0.00	0.09	0.08	0.00	0.08	0	0
Ultrasound	0.86	1.00	1.00	0.00	1.00	0	0
Pharmacy	0.46	0.30	0.51	0.00	0.51	0	0
Oncology OP Chemotherapy	0.56	0.59	0.60	0.00	0.60	0	0
Nursing Administration	1.87	2.18	2.15	0.00	2.15	0	0
Maintenance	2.23	2.92	3.05	0.00	3.05	0	0
Housekeeping - Hospital	3.20	2.92	2.98	0.00	2.98	0	0
Dietary	8.91	5.86	2.98	(2.98)	0.00	(210,869)	(116,466)
Human Resources	0.06	0.03	0.06	0.00	0.06	0	0
Patient Exerience	0.04	0.07	0.10	0.00	0.10	0	0
Quality Management	0.50	1.01	1.47	0.00	1.47	0	0
Emergency Management	0.30	0.24	0.29	0.00	0.29	0	0
Administration	2.73	2.44	2.52	0.00	2.52	0	0
- Physicians - Oncology Clinic	0.04	0.04	0.05	0.00	0.05	0	0
- Nursing - Oncology Clinic	0.06	0.08	0.18	0.00	0.18	0	0
Oth Providers - Family Practice	0.54	1.10	1.18	0.00	1.18	0	0
Operations - FMLY PRCTC CL	6.20	6.01	5.08	0.00	5.08	0	0
Total	**93.17**	**72.46**	**55.99**	(7.94)	48.05	**(624,029)**	**(99,480)**

REH Revenue Impact Analysis

During the conversion to an REH's there are significant changes to the revenue structure of the hospital. A detailed analysis was performed on the facility including:

- Closing the inpatient service line of the hospital
- Estimated outpatient revenue impacted based on the inpatient closure
- Converting remaining Medicare revenue from cost based to PPS + 5%
- Estimated amount of lost Inpatient capture by the Health System
- Home office reimbursement impact

Sample Hospital as a REH with $10M Project



Is REH Status Right For You?

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Is REH Status Right for You?

- Patient Considerations?
  - Still access to all outpatient service levels?
  - No longer inpatient services
    - How many really use inpatient services?
    - Could this impact surgical procedures offered?
  - Swing Beds
    - Alternative skilled nursing facility options?
      - Other providers?
      - Open SNF with Beds?

Is REH Status Right for You?

- Financial Considerations
  - Changes in reimbursement (No longer cost based)
  - Facility specific analytics
  - Cost and staffing structure changes
  - Network considerations
  - Inflationary factors
  - How will this look over time?

Is REH Status Right for You?

- Staffing Considerations
  - Currently many facilities are struggling for staffing
  - Under REH less “off hour” shifts to staff
  - Still need potential on call time for Emergency Coverage including ancillary services
  - Telehealth Opportunities

Is REH Status Right for You?

- Community Perception
  - Taking away our hospital?
  - Argument: What percentage of your population has been an inpatient?
  - Stronger outpatient services under REH?

Potential Hurdles and Unknowns to REH Status

Try to take the emotion out of the decision

- Community Perception?
- Quality implications?
- Future scope of services allowed?
- How will REH impact / integrate with EMS?
- How will the AFP impact Total Cost of Care?
- How will other payors (MA / Commercial) pay us?

Potential Hurdles and Unknowns to REH Status

- State licensing issues?
- 340B?
- Will staffing retention be easier with an REH?
- Setting up a Transfer Agreement?
- How far will average facility payment go?
- Actual Inflation versus MEI Updates
- Others?

At the end of the day **ACCESS** is key for our patients!

What Type of Hospitals Are Going to Convert?

While there are many different reasons why Hospitals might not convert to REH, there will be hospitals willing to test out this new model including:

- CAH's that are part of Health Systems
- Limited Balance Sheet Strength
- Poor Operating Margin Strength
- Rural PPS (Tweener) Hospitals (That missed out on CAH)
- Opportunistic Curve Breakers

What Are Your Concerns?

We would like to open this up to the crowd!

- Have you or your community thought about REH Status?
- Are their areas that concern you?
- Change you see needing to be made before you would consider?

Next Steps to Consider

- Start discussions with major stakeholders
- Facility Specific Financial Modeling
  - Understand the potential financial impact over time
    - Narrow down the high-level analysis for facility specific situation
    - Understand knows and unknowns in order to make a more informed decision
  - MEI Inflation Factors Versus Actual Inflationary Pressures
- Assess Patient Care Impact
  - Will financial impact allow for better patient care over time
  - Consider perceived patient care impact – ACCESS is key

Thank You!!!

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Telehealth Rates MLN Matters SE20016 (cms.gov)