PYA SHORT COURSE: THE CONSOLIDATED APPROPRIATIONS ACT

Introducing the New Rural Emergency Hospital

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Introductions

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The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability

- 25% of rural hospitals vulnerable to closure (453 out of 1,844)
  - 216 rural hospitals identified as “most vulnerable” (97 CAHs, 119 rural PPS)
  - 237 hospitals identified as “at risk” (145 CAHs, 92 rural PPS)
- Key risk factors
  - Case mix index; percentage occupancy; percentage outpatient revenue; average age of plant; percentage capital efficiency; percentage change total revenue; government control status; system affiliation; state-level Medicaid expansion status

The Chartis Center for Rural Health, *The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability* (Feb. 2020)
https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

Effects of Rural Hospital Closures

- Adverse patient outcomes for time-sensitive conditions (sepsis, stroke, heart attack, asthma/COPD)
- Increase costs for emergency medical services
- Increased time and cost of transportation to healthcare services, leading to treatment delay and adverse outcomes
- Outmigration of healthcare providers

MedPAC June 2018 Report

- Many rural hospitals maintain inpatient services only as means to provide emergency services
  - Stand-alone EDs that cannot bill facility fees not financially viable
- Recommend new payment model for outpatient-only hospitals
  - Option limited to isolated communities (at least 35 miles from another facility)
    - Existing hospital, closed facility, de novo (existing hospital option to convert back)
    - Non-isolated hospitals can operate as HOPD to near-by hospital
  - PPS rates + annual payment to cover fixed costs

http://www.medpac.gov/docs/default-source/reports/jun18_ch2_medpacreport_sec.pdf?sfvrsn=0

Consolidated Appropriations Act, 2021

- Amends Social Security Act to create new category of Medicare payment for *rural emergency hospital services*
- Addresses the following:
  1. Eligibility
  2. Timing
  3. Services
  4. Conditions of Participation
  5. Payment
  6. Application Process

1. Eligibility

- Current CAH or rural PPS hospital with 50 or fewer beds
  - Cannot re-open closed hospital as REH
  - Cannot establish *de novo* REH
  - Opportunity for reversion
- Located in a state that provides for licensure of outpatient-only hospitals
  - Require legislative action in your state?
- Approved by appropriate state agency as meeting standards established for such licensure

2. Timing

- Medicare payments for REH services to commence by 01/01/2023
- Expect publication of proposed implementing regulations (including application procedures) sometimes this year
- No timeline for State Medicaid programs or commercial payers to establish REH payment policies

3. Services

- Must provide emergency department and observation services
  - Cannot exceed annual patient average of 24 hours in facility
- May provide additional hospital outpatient services identified by CMS as REH services
- May include distinct-part unit licensed as SNF to provide post-hospital extended care services
- Maintain status as provider-based rural health clinic

4. Conditions of Participation

1. Maintain transfer agreement with Level I or Level II trauma center
2. Meet staffing requirements
   - ED must be staffed 24/7
   - Physician, nurse practitioner, clinical nurse specialist, or physician assistant must be available to furnish services at facility 24/7
   - Satisfy staffing requirements and responsibilities specified in 42 CFR 485.631
3. Provide emergency services consistent with 42 CFR 485.618
4. Adhere to EMTALA requirements
5. Meet to-be-developed quality reporting requirements
6. Satisfy other requirements CMS deems necessary
7. Subject to SNF Conditions of Participation (if distinct-part unit)

5. Payment

- 105% applicable OPPS rate
  - SNF PPS rate for distinct-part SNF services (loss of swing bed cost-based reimbursement)
  - Ambulance fee schedule rate for REH-furnished service (loss of cost-based reimbursement if sole provider within 35 miles of facility)
  - Telehealth originating site
- Additional facility payment (same amount for all REHs)
  - Difference between total amount paid to all CAHs in 2019 and amount that would have been paid under PPS rates divided by total number of CAHs in 2019 (about 1,350)
    - Adjust annually by hospital market basket percentage increase
  - Required reporting on actual use of additional facility payment

6. Application Process

- Detailed transition plan listing services the facility will -
  - ✓ Modify
  - ✓ Retain
  - ✓ Discontinue
  - ✓ Add
- Description of the emergency and observation services applicant intends to provide
- Information regarding how applicant intends to use monthly facility payment
- Other information specified by CMS

Evaluating the REH Opportunity

- Board and community engagement
- Inpatient/outpatient outmigration analysis
- Opportunities for regional collaboration
- Financial analyses

Potential Reimbursement Comparison - Sample States

- Sample States Rural Hospitals <100 beds
  - PPS Hospitals (may include MDH and SCH)
  - No GME or Allied Health
  - Sub-provider components are not considered
- Cost Report Data
  - Most recent available (FY2018 and FY2019 year ends)
  - Data extracted from CMS HCRIS database
  - Supported by PYA Business Intelligence Resources

Sample States: Demographic Information

State	State Total or Average Value	Rural Non-CAH <101 beds Provider ID (Count)	Total Facility Beds
Illinois	Total	14	899
Illinois	Average		64
Kansas	Total	19	1063
Kansas	Average		56
Montana	Total	2	98
Montana	Average		49
Nebraska	Total	2	145
Nebraska	Average		73
Sample States	Total	37	2,205
Sample States	Average		60

Sample States: Inpatient PPS Reimbursement Comparison

State	State Total or Average Value	Rural Non-CAH <101 beds Provider ID (Count)	Total Facility Beds	Total IP PPS Reimb	Total IP PPS Cost	IP PPS Margin	IP Reimb % of Cost
Illinois	Total	14	899	126,870,455	138,457,753	(11,587,298)	91.51%
Illinois	Average		64	9,062,175	9,889,840	(827,664)	91.51%
Kansas	Total	19	1063	112,178,328	117,955,114	(5,776,786)	88.29%
Kansas	Average		56	5,904,123	6,208,164	(304,041)	88.29%
Montana	Total	2	98	23,930,165	26,668,387	(2,738,222)	93.90%
Montana	Average		49	11,965,083	13,334,194	(1,369,111)	93.90%
Nebraska	Total	2	145	30,343,264	40,853,249	(10,509,985)	77.43%
Nebraska	Average		73	15,171,632	20,426,625	(5,254,993)	77.43%
Sample States	Total	37	2,205	293,322,212	323,934,503	(30,612,291)	87.78%
Sample States	Average		60	7,927,627	8,754,987	(827,359)	87.78%

Red = Negative Margin

Difference between current CAH 101% of cost and 87.78% under PPS ***may*** fund "level" payments

Sample States: Outpatient PPS Reimbursement Comparison

State	State Total or Average Value	Rural Non-CAH <101 beds Provider ID (Count)	Total Facility Beds	Total OP PPS Reimb	OP PPS Cost	OP PPS Margin	OP PPS Reimb % of Cost
Illinois	**Total**	**14**	**899**	**123,030,329**	**144,182,378**	**(21,152,049)**	**85.27%**
Illinois	**Average**		**64**	**8,787,881**	**10,298,741**	**(1,510,861)**	**85.27%**
Kansas	**Total**	**19**	**1063**	**75,832,411**	**89,849,936**	**(14,017,525)**	**78.75%**
Kansas	**Average**		**56**	**3,991,180**	**4,728,944**	**(737,764)**	**78.75%**
Montana	**Total**	**2**	**98**	25,031,585	30,887,813	(5,856,228)	81.40%
Montana	**Average**		49	12,515,793	15,443,907	(2,928,114)	81.40%
Nebraska	**Total**	**2**	**145**	**24,655,753**	**33,396,080**	**(8,740,327)**	**72.13%**
Nebraska	**Average**		**73**	**12,327,877**	**16,698,040**	**(4,370,164)**	**72.13%**
Sample States	**Total**	**37**	**2,205**	**248,550,078**	**298,316,207**	**(49,766,129)**	**79.39%**
Sample States	**Average**		**60**	**6,717,570**	**8,062,600**	**(1,345,031)**	**79.39%**
					Current Reimb/Cost Ratio		79.39%
					REH OP Adjustment		105%
					Potential Reimb/Cost Ratio		83.36%

Red = Negative Margin

Difference between current CAH 101% of cost and 79.39% under PPS ***may*** fund "level payments'

Sample States: Total PPS Reimbursement Comparison

State	State Total or Average Value	Rural Non-CAH <101 beds Provider ID (Count)	Total Facility Beds	Total Reimb	Total Cost	Total Margin	Total Reimb % of Cost
Illinois	Total	14	899	249,900,784	282,640,131	(32,739,347)	87.82%
Illinois	Average		64	17,850,056	20,188,581	(2,338,525)	87.82%
Kansas	Total	19	1063	188,010,739	207,805,050	(19,794,311)	83.57%
Kansas	Average		56	9,895,302	10,937,108	(1,041,806)	83.57%
Montana	Total	2	98	48,961,750	57,556,200	(8,594,450)	84.07%
Montana	Average		49	24,480,875	28,778,100	(4,297,225)	84.07%
Nebraska	Total	2	145	54,999,017	74,249,329	(19,250,312)	74.38%
Nebraska	Average		73	27,499,509	37,124,665	(9,625,156)	74.38%
Sample States	Total	37	2,205	541,872,290	622,250,710	(80,378,420)	82.46%
Sample States	Average		60	14,645,197	16,817,587	(2,172,390)	82.46%

How will hospitals be able to cover fixed costs if largest payer only covers 82% of costs?

Red = Negative Margin

Difference between current CAH 101% of cost and 82.46% under PPS ***may*** fund "level payments'

REH Payment Opportunity Considerations

- 105% applicable OPPS rate
  - Increased reimbursement may not be sufficient to cover increased fixed costs with no inpatient volume to absorb some of the costs.
  - Therapy costs may also move to physician fee schedule, consistent with Ambulance fee schedule rate treatment
  - Managed care implications (movement away from percent-of-charge based payments)
- Additional facility payment (same amount for all REHs) 
  - Ultimate source of funds:
    - IP differential/ OP differential or Combination
    - Add on payments (IME; DSH; VBP; HAC; HRR)
    - Special provider types (MDH; SCH; RRC) of CAHs in 2019 (about 1,350)
  - Adjust annually by hospital market basket percentage increase
  - Required reporting on actual use of additional facility payment
  - ***May be key to survival, depending on size and duration of funding***

Transition Planning Considerations

- Detailed transition planning should identify:
  - Modify
  - Retain
  - Discontinue
  - Add

Transition Planning Considerations: *Modify*

- Cost Structure
  - True staffing needs and consideration of severance costs (salaries and benefits)
  - Space planning and modernization addressing revised service offerings
  - Purchased service arrangements for professional and support services
- Service delivery approach
  - Transfer (placement) agreements
  - Necessary practitioners
  - Maximizing scheduling and patient throughput given time limitations
- Organizational Structure
  - Financing structure and bond documents
  - Governance aligned with modified patient care experience and community needs
  - Affiliations and clinical alliances

Transition Planning Considerations: *Retain*

- Services
  - Required services such as Emergency and Observation
  - Profitable outpatient services or services that build facilities brand eminence
  - Services based on identified community need (i.e. cardiac rehabilitation or outpatient substance abuse) even if not “profitable”.
- Practitioners and professional staff
  - Staff necessary to deliver required services
  - Necessary to deliver other designation outpatient services
  - Support staff to continue essential services in an efficient manner
- Other
  - Favorable managed care contracts for agreed upon (continuing) patient care services
  - Service arrangements with favorable “buy versus make” analysis
  - Affiliations and clinical alliances necessary to operate under new guidance

Transition Planning Considerations: *Discontinue*

- Services
  - Inpatient Nursing services (other than observation)
  - Ancillary services more directly related to inpatient hospitalizations than outpatient care model
  - Less profitable services that don't contribute to brand eminence or required to meet a community need.
- Practitioners and professional staff
  - Arrangements with practitioners related to discontinued operations
  - Patient care staff related to discontinued operations
  - Support functions that can be out-sourced
- Other
  - Facilities not directly connected to continuing services
  - Contracts related to expansion of any inpatient services

How will hospitals be able to cover fixed costs?

Transition Planning Considerations: *Add*

- Services
  - Profitable outpatient services for which there is an identified need
  - Services with the potential to build brand eminence
  - Services that will expand hospital network and access to care to offset loss of inpatient services (RHC; HHA; Skilled or subprovider units)
- Practitioners and professional staff
  - Arrangements with practitioners aligned to new service offerings
  - Patient care staff related to new operations
  - Resources necessary to ensure accurate and compliant billing and collection related to new services and payment delivery system.
- Other
  - Equipment necessary for new services
  - New clinical alliances to capture more activity related to new service offerings.

Transition Planning Considerations: *Analytics*

- Services
  - Identify current services and match to appropriate fee schedule or payment formula
  - Complete procedure level costing and demand analysis to support adding or discontinue services
  - Use CHNA and community input to identify appropriate services that focus on community needs needs.
- Practitioners and professional staff
  - Benchmarking and compensation valuation analysis
  - Operational assessment focusing on appropriate staffing for existing and new service offerings and support functions
- Other
  - Managed care contract evaluation
  - Facility planning and valuation to establish monetization opportunities and realistic capital needs
  - Assessment of governance and alliances for alignment with new delivery model

How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services