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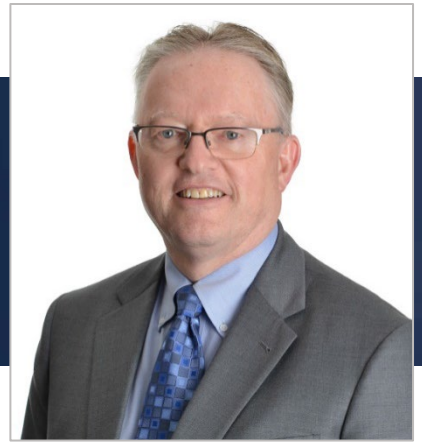
CPAs & BUSINESS ADVISORS

RURAL EMERGENCY HOSPITAL PROGRAM

April 2023

PRESENTER



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AGENDA

- Rural Emergency Hospital (REH) Program Overview
- Who Might Participate
- Calculating The Impact
- Questions

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REH PROGRAM OVERVIEW

REH PROGRAM OVERVIEW

- Created in the Consolidated Appropriations Act of 2021:
  - 75 closures from 2010 to Feb 2020.
- November 1, 2023 – CMS published the 2023 Hospital Outpatient Prospective payment System and Ambulatory Surgical Center Payment System Final Rule:
  - Finalized REH provisions related to:
    - Payments
    - Enrollment
    - Conditions of Participation
    - Quality reporting, and
    - Physician self-referral (Stark)

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REH PROGRAM OVERVIEW

- Major Provisions:
  - Effective January 1, 2023.
  - Available to rural hospitals with not more than 50 beds and CAHs enrolled in the Medicare program as of December 27, 2020 (Consolidated Appropriations Act date).
  - Must apply for enrollment in the Medicare program:
    - Medicaid providers must enter into provider agreements with State Medicaid agencies to participate.
  - Must provide emergency department services and observation care.
  - May elect to provide certain other outpatient services:
    - CMS provided "Maximum flexibility" to continue to provide care to patient population.
  - Cannot provide any acute care services but…

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REH PROGRAM OVERVIEW

- Major Provisions:
  - May operate a distinct part skilled nursing facility:
    - Reimbursement under SNF prospective payment system.
  - Meet applicable state licensing requirements:
    - Are you in a certificate of need state?
  - Transfer agreement with Level I or II trauma center.

REH PROGRAM OVERVIEW

Swing Bed Services

- While an REH by definition may not provide acute inpatient hospital care, it may establish a distinct part unit, licensed and certified as a SNF, to furnish post-REH or post-hospital extended care services.
- As with other SNF distinct part units, CMS notes that the unit in the REH must be physically distinguishable from the REH, must be fiscally separate for cost reporting purposes, and the beds in the certified distinct part SNF unit of an REH must meet the requirements applicable to distinct part SNFs.

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REH PROGRAM OVERVIEW

Final rule largely followed originally proposed policies.

Facilities converting to REH **can bypass** traditional Medicare provider enrollment process for new entities:

- Submit Form CMS-855A change of information (CHOI).

REH that elects to return to its prior CAH/PPS enrollment status **cannot bypass** traditional Medicare provider enrollment process:

- CAHs must meet current mileage requirements.
- Necessary provider status does not apply.

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REH PROGRAM OVERVIEW

Enrollment:

- Must contain "Action Plan" signed by legal representation or administrator regarding:
  - Staffing provisions and type of qualified staff for provision of REH services.
  - Detailed transition plan that lists the following:
    - Specific services facility will retain;
    - Specific services facility will modify;
    - Specific services facility will add;
    - Specification services facility will discontinue (such as inpatient services).

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REH PROGRAM OVERVIEW

Enrollment:

- Action Plan must also include information on how facility intends to use the additional facility payment:
  - Description of services that payment would support, or operation and maintenance of facility or furnishing of additional services.
- Must include Transfer Agreement.
- Attestation – Self-attest to REH Conditions of Participation – signed by legal representative or administration.

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REH PROGRAM OVERVIEW

- Conditions of Participation:
  - Final rule largely followed originally proposed policies and closely align with current CAH conditions of participation (excluding inpatient).
  - Staffing: Must have a clinician on-call at all times and available on-site within 30 or 60 minutes (depending on location).
  - Staffing: ER must be staffed at all times by an individual that has the skills needed to address emergency medical care:
    - CMS did not specify the licensure, qualifications, or credentialing.
    - Final rule does not prohibit a provider licensed in one state from providing care in another state (in-person or virtual).
    - REH can be originating site for telemedicine.

REH PROGRAM OVERVIEW

- Conditions of Participation:
  - Quality: CMS will eventually implement a Rural Emergency Hospital Quality Reporting (REHQR) Program:
    - Must have an account with Hospital Quality Reporting (HQR) secure portal.
    - Will develop requirements in future rule making:
      - CMS also sought comment on several measures under consideration including rural emergency department services, rural behavioral and mental health, rural maternal health, rural telehealth services, and health equity.

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REH PROGRAM OVERVIEW

- Conditions of Participation:
  - Quality: Must establish a QualityNet account for reporting:
    - Report quality measures that reflect a significant volume of services.
    - Preference is to select measures endorsed by the National Quality Forum.
  - Quality: Must maintain a data-driven Quality Assurance and Performance Improvement (QAPI) program:
    - Measure, analyze, and track staffing as an indicator related to health outcomes and medical error reduction.

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REH PROGRAM OVERVIEW

- Conditions of Participation:
  - Length of Stay: The annual per-patient average length of stay cannot exceed 24 hours:
    - Time calculation begins with the registration, check-in, or triage of the patient and ends with the discharge of the patient from the REH.
    - Methodology set by statute and could not be altered.
    - Document instances > 24 hours.

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REH PROGRAM OVERVIEW

- Conditions of Participation:
  - Lab Services: Must provider laboratory services (directly or by contract):
    - Emergency lab services available 24 hours a day.
    - Encouraged, but not required, to provide the following:
      - Blood count, basic metabolic panel, magnesium, phosphorus, liver function, amylase, lipase, cardiopulmonary, lactate, coagulation, arterial blood gas, venous blood gas, chronic gonadotropin, and urine toxicology.
      - Must be consistent with the patient population served.
  - Radiology: Must provide radiology services
    - REH requirements mirror existing CAH requirements.

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REH PAYMENTS

REH PAYMENTS

- The Payment Model:
  - Outpatient Prospective Payment System (OPPS) + 5%:
    - No impact on beneficiary copayments.
    - Includes off-campus locations.
    - CAH Method II billing and other PPS add-on payments not recognized.
    - Utilize the OPPS claims processing system with REH flag to trigger 5%.
  - Services not covered under the OPPS:
    - Reimbursed under fee schedule:
      - Lab services, therapy services, and mammography.
    - Post-hospital extended care SNF).
    - Ambulance fee schedule.

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REH PAYMENTS

- The Payment Model:
  - Off-Campus Provider Based Departments:
    - OPPS + 5%.
    - PBRHC - If PBRHC was entitled to 'grandfathering' by being in existence on December 31, 2020, it would continue status under REH conversion.
    - Loss of status would be counterintuitive to REH purpose.
  - Sequestration applies.
  - Cost reporting:
    - REH will continue to use their current cost reporting formats.

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REH PROGRAM OVERVIEW

- The Payment Model:
  - Additional subsidy:
    - Difference between CY 2019 PPS payments and CY 2019 CAH payments, divided by total number of CAHs, divided by 12 months.
    - Finalized at $272,866 per month but subject to 2% sequestration:
      - ($12.08B - $7.60B = $4.4B / 1,368 CAHs = $3,274,392)
    - Increased in subsequent years by the hospital market basket percentage increase.

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WHO MIGHT PARTICIPATE

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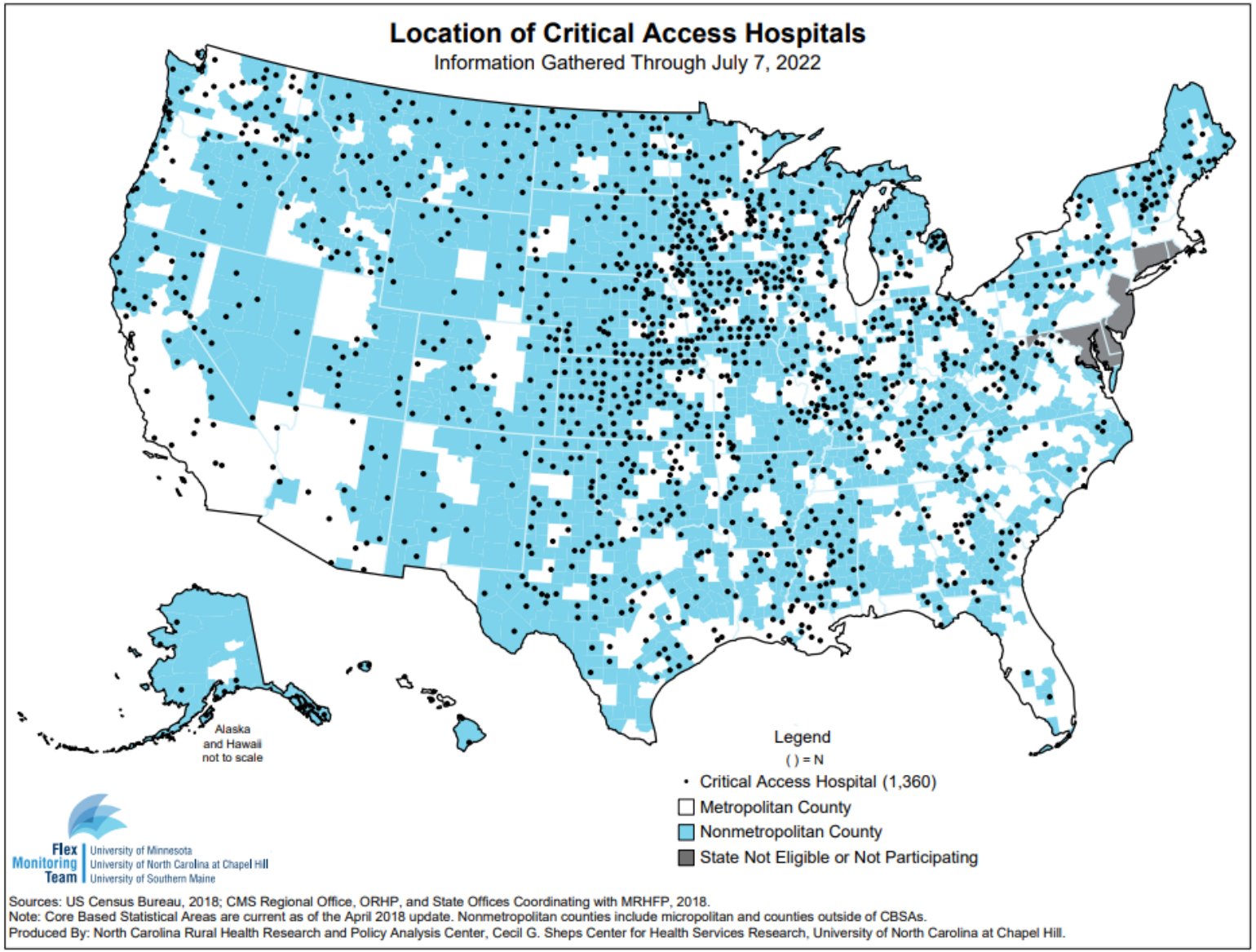

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WHO MIGHT PARTICIPATE

- Facilities with low service area populations
- Facilities with low inpatient volume
- Facilities with low overhead

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CALCULATING THE IMPACT

CALCULATING THE IMPACT

- Things To Consider – Significant Assumption:
  - Existing overhead structure:
    - What stays?
    - What goes?
    - Existing and future capital needs.
  - Services lines:
    - What stays?
    - What goes?
    - Who fills new gaps?

CALCULATING THE IMPACT

- Things To Consider – Significant Assumption:
  - Changes in staffing levels:
    - Providers
    - Nursing
    - Overhead
      - Do you need dietary and other existing departments?
    - Others

CALCULATING THE IMPACT

- Things To Consider – Significant Assumption:
  - Medicaid participation.
  - Medicare Advantage.
  - Existing Rural Health Clinics:
    - Impact on grandfathered upper payment limit caps.
  - 340B impact:
    - REH is not currently listed as an eligible organization by HRSA.

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CALCULATING THE IMPACT

- Things To Consider – Significant Assumptions:
  - Medicare reimbursement difference:
    - Not as easy as OPPS to CAH calculation.
    - For gross revenues and contractual adjustments, must have some ability to:
      - Split inpatient from outpatient.
      - Split swing bed from acute.
      - Split by payors.
      - Need to identify Medicare Advantage.

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CALCULATING THE IMPACT

- Things To Consider – Significant Assumptions:
  - Medicare reimbursement difference:
    - Claims processing software to reprocess claims for payment estimate:
      - Not practical for most.
      - Time intensive.
    - Sampling strategies.
    - Seeing significant reduction in OP reimbursement.
    - Future updates.

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CALCULATING THE IMPACT

Things To Consider – Significant Assumptions

- Expense changes:
  - Nursing - Acute
  - Nursing - Emergency
  - Swing bed versus SNF
  - Overhead support changes
  - Future inflationary

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CALCULATING THE IMPACT

- Things To Consider – Significant Assumption:
  - Community impact:
    - Access to care
    - Perception
  - Partnering facilities:
    - Filling the gaps

WHAT ARE WE WAITING FOR?

- State direction:
  - Montana legislation pending…..
- Medicaid Reimbursement
  - Montana Medicaid reimbursement unknown.

WHAT ARE WE WAITING FOR?

- Commercial payor reimbursement.
- Community feedback.
- Provider feedback.
- Changes in 340B eligibility.
- Expect much more information to surface during 2nd and 3rd quarter of 2023.

EXAMPLES

EXAMPLE #1

- 25 Bed CAH:
- **$35.6** Million Net Patient Revenue

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EXAMPLE #1

- ($8.3M) lost inpatient revenues
- $0.0M in savings
  - Significant observation volume
- ($1.5M) in lost outpatient revenues
- ($3.9M) in lost Medicare Advantage
- $0.4M net improvement in Medicare bad debts
  - Significant – Driven by low outpatient CAH interim rate
  - Netted against Medicare reimbursement

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EXAMPLE #1

- $2.3M net improvement in Medicare Advantage bad debts
  - Significant – Driven by low outpatient CAH interim rate
  - No additional reimbursement to net against
- $3.2M stipend

- ($7.8M) net loss

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EXAMPLE #2

- 14 Bed CAH
- 6 RHCs
- Part of a system

- $7.5 Million Net Patient Revenue
- Participates in 340B

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EXAMPLE #2

- ($1.4M) lost inpatient revenues
- $0.0M in savings
  - Low volumes already – minimum staff
  - Locations issues between ER and Med/Surg
- ($1.1M) in lost outpatient revenues
- ($0.1M) in lost Medicare Advantage
- $3.2M stipend
- ($0.0M) lost 340B net proceeds

- $0.6M net gain
- $0.3M system retained inpatient revenues

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EXAMPLE #3

- 19 Bed CAH
- 35 Bed SNF – to be spun off to system
- Part of a system

- $13.7 Million Net Patient Revenue
- Does not participate in 340B

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EXAMPLE #3

- ($1.7M) lost inpatient revenues
- $0.0M in savings
  - Issues with locations between ER and Med/Surg
- ($1.3M) in lost outpatient revenues
- ($0.6M) in lost Medicare Advantage
- $3.2M stipend

- $0.4M net gain
- **$1.1M system retained inpatient revenues**

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EXAMPLE #4

- 20 Bed CAH
- Part of a system

- $7.2 Million Net Patient Revenue
- Participates in 340B

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EXAMPLE #4

- ($1.6M) lost inpatient revenues
- $0.3M in savings
- ($1.6M) in lost outpatient revenues
- ($0.2M) in lost Medicare Advantage
- $3.2M stipend
- $0.0M in lost 340B

- $0.1M net gain
- $0.2M system retained inpatient revenues

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EXAMPLE #5

- 19 Bed CAH
- 1 RHC

- $17.1 Million Net Patient Revenue
- Participates in 340B

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EXAMPLE #5

- ($3.8M) lost inpatient revenues
- **$0.0M in savings**
- ($1.1M) in lost outpatient revenues
- ($0.2M) in lost Medicare Advantage
- $3.2M stipend
- **($0.9M) in lost 340B**

- ($2.8M) net loss

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HYPOTHETICAL SITUATIONS

- Benefits for PPS providers
- New opportunities to collaborate
- Opportunities to explore leading edge strategies
- What potential opportunities would you like to discuss/explore?

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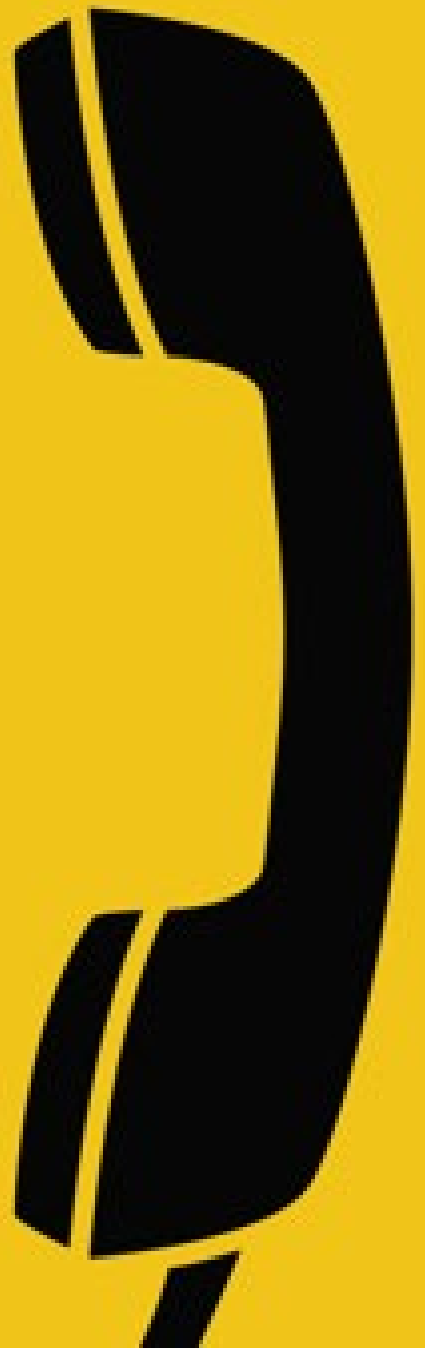
CALL TO ACTION

- Become informed
- Think creatively
  - There are definitely new opportunities
- Board education and discussions
- Financial analysis (if applicable)



Resources Available

- No cost to provider
- Technical Assistance video call
- C-Suite, department heads, trustees
- Facility specific discussions

Resources Available

- Does not include calculations
- Contact – Jack King or Ralph Llewellyn

QUESTIONS?

THANK YOU!

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