

Agenda

- Refresh on RHC Cost Per Visit Limit Legislation with Detailed Discussion on Opportunities to Look for
- Rural Emergency Hospital Status
- Q&A/Other Topics?





Topical Agenda

Operating Under the New RHC Rules

- Historical RHC Rate setting
- Consolidated Appropriations Act Dec 2020
 - ♦ Freestanding RHC impacts
 - ♦ RHC in a Hospital with less than 50 beds
- Strategic Areas to Look at
- Operational Considerations Going Forward





RHC Rates prior to 4/1/2021

Rural Health Clinics attached to a rural hospital with less than 50 beds;

 Uncapped cost per visit, updated annually with the filing of the Medicare cost report

Freestanding Rural Health Clinics

- Paid the lesser of (1) Cost per visit or (2) Published per visit limit (currently \$87.52 effective 1/1/2021)





Catalyst for a Change in RHC Payment Rates

- How did this payment reform come about?
 - ♦ Large push for site-neutral payments in Washington.
 - ♦ The per visit cap on independent and hospital-based RHCs with more than 50 beds was well below cost. This led to the closing of hundreds of RHCs
 - Average cost per visit per NARHC over \$130 per visit
 - Per visit cap \$87.52 effective 1/1/2021
 - Average per visit payment for uncapped RHCs was about\$237
 - Many with significantly higher rates





Historical - National Average AIR with Per Visit Limit

National RHC All Inclusive Rate (AIR)







5-year look-back - National

- Average increase in RHC cost per visit is about 5.03%
 - Excludes FY2020 global pandemic. If FY2020 were included this would be
 7.56%

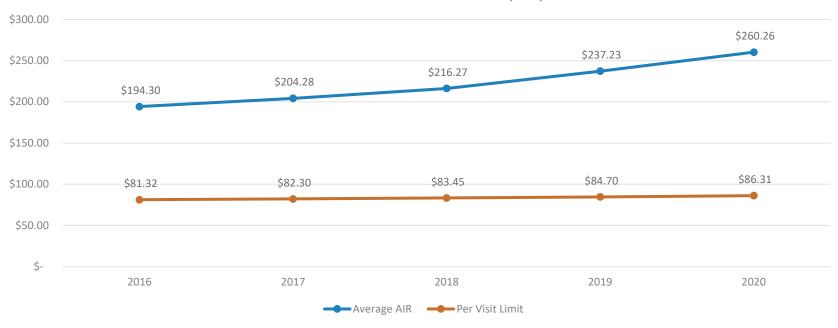
	2016	2017	2018	2019	2020
Average AIR	\$ 194.42	\$ 208.56	\$ 218.88	\$ 225.19	\$ 259.28
Per Visit Limit	\$ 81.32	\$ 82.30	\$ 83.45	\$ 84.70	\$ 86.31
Maximum AIR	\$ 694	\$ 1,087	\$ 891	\$ 1,415	\$ 3,173
Minimum AIR	\$ 40	\$ 5	\$ 66	\$ 24	\$ 70
Dollar Increase		\$ 14.13	\$ 10.33	\$ 6.31	\$ 34.09
% increase		7.27%	4.95%	2.88%	15.14%
% increase		7.27%	4.95%	2.88%	15.14%





Historical - Iowa Average AIR with Per Visit Limit

Iowa RHC All Inclusive Rate (AIR)







5-year look-back - Iowa

- Average increase in RHC cost per visit for lowa was about
 6.90%
 - Excludes FY2020 global pandemic. If FY2020 were included this would be
 7.60%

	2016	2017	2018	2019	2020
Average AIR	\$ 194.30	\$ 204.28	\$ 216.27	\$ 237.23	\$ 260.26
Per Visit Limit	\$ 81.32	\$ 82.30	\$ 83.45	\$ 84.70	\$ 86.31
Maximum AIR	\$ 340	\$ 389	\$ 408	\$ 559	\$ 553
Minimum AIR	\$ 77	\$ 97	\$ 100	\$ 100	\$ 136
Dollar Increase		\$ 9.98	\$ 11.99	\$ 20.96	\$ 23.03
% increase		5.13%	5.87%	9.69%	9.71%





Historical MEI

• CY 2015 0.80%

• CY 2016 1.10%

• CY 2017 1.20%

• CY 2018 1.40%

• CY 2019 1.50%

• CY 2020 1.90%

• CY 2021 1.40%

CY 2022 2.10%

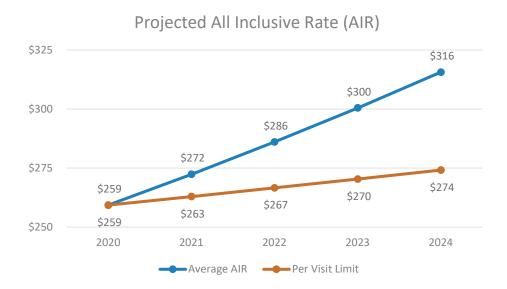
With perceived inflation on food and gas prices, would your employees accept these rates for compensation increases?





Projected- National Average AIR with facility specific cap

Use average increase 5.03% to assumed MEI of 1.4%

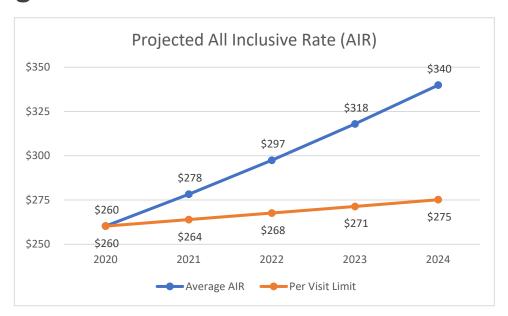






Projected- Iowa Average AIR with facility specific cap

Use average increase 6.90% to assumed MEI of 1.4%







Consolidated Appropriations Act - 2021

- Updated per visit payment limits through 2028.
- The limit increases 13% from 2021 to 2022. The limit continues to increase through 2028.
- In 2028 the limit will be \$190. This will increase thereafter based on the Medicare Economic Index (MEI)
- Applicable to RHCs other than those described in 3B (in a hospital with less than 50 beds as of 12/31/2020)

```
"(2) In establishing limits under subsection (a) on
14
15 payment for rural health clinic services furnished on or
16 after April 1, 2021, by a rural health clinic (other than
17 a rural health clinic described in paragraph (3)(B)), the
18 Secretary shall establish such limit, for services pro-
19 vided—
             "(A) in 2021, after March 31, at $100 per
20
21
        visit:
             "(B) in 2022, at $113 per visit:
22
             "(C) in 2023, at $126 per visit:
23
24
             "(D) in 2024, at $139 per visit;
25
             "(E) in 2025, at $152 per visit;
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2226

"(F) in 2026, at \$165 per visit;
"(G) in 2027, at \$178 per visit;
"(H) in 2028, at \$190 per visit; and
"(I) in a subsequent year, at the limit estab-
lished under this paragraph for the previous year in-
creased by the percentage increase in the MEI appli-
cable to primary care services furnished as of the
first day of such subsequent year.





Hospital-based RHC – Per visit cap

```
12 subparagraph (B), the Secretary shall establish such limit,
13 with respect to each such rural health clinic, for services
14 provided—
15
             "(i) in 2021, after March 31, at an amount
16
        equal to the greater of—
17
                 "(I) the per visit payment amount applica-
18
             ble to such rural health clinic for rural health
19
             clinic services furnished in 2020, increased by
20
             the percentage increase in the MEI applicable
21
             to primary care services furnished as of the
22
             first day of 2021; or
23
                 "(II) the limit described in paragraph
24
             (2)(A); and
```





Hospital-based RHC – Per visit cap

- New per visit cap for previously uncapped RHCs
- Cap is equal to the greater of;
 - The per visit payment amount for RHC services furnished in 2020, increased by the MEI
 - The limitations in place on freestanding RHCs (\$100 effective 4/1/2021)
- Effective date is for services furnished on or after 4/1/2021





- Exception to Productivity Limits
- Verify FTEs reported
- Reporting of Telehealth Visit Counts
- Methodology to Carve out of Telehealth cost, Chronic Care
 Management costs, or other non-RHC costs





	Ī	Worksheet M	-2		
	Number of			Minimum	Greater of
	FTE		Productivity	Visits (col. 1	col. 2 or col.
	Personnel	Total Visits	Standard (1)	x col. 3)	4
	1	2	3	4	5
1 Physician	1,228	0.65	4,200	2,730	
2 Physician Assistant	1,664	0.67	2,100	1,407	
3 Nurse Practitioner	-	-	2,100	-	_
4 Subtotal	2,892	1.32	_	4,137	4,137
9 Physician Services Un	der Agreemen	ts			
			Total Visits		4,137

	-	RHC #1
	Worksheet M-2	
Total Costs	10	573,494
Nonreimb. Costs	11	10,399
Cost of All Svc	12	583,893
Ratio of RHC/FQHC Svc	13	0.98
Total Facility O/H	14	-
Parent O/H Allocated	15	512,602
Total Overhead	16	512,602
O/H applicable to RHC	19	503,472
Total Allowable RHC Cost	20	1,076,966

V	Vorksheet M-3	
Total RHC Cost	1	1,076,966
Vaccines	2	21,077
Cost less Vaccines	3	1,055,889
Total Visits	4	4,137
Physician Visits Under Agreement	5	-
Total Adj. Visits	6	4,137
Rate for Prog. Covered Visits	9	\$ 255.23
Prog Covered Visits	10	925
Total Prog Cost	16	236,088





	١	Norksheet M	-2		
	Number of			Minimum	Greater of
	FTE		Productivity	Visits (col. 1	col. 2 or col.
	Personnel	Total Visits	Standard (1)	x col. 3)	4
	1	2	3	4	5
1 Physician	1,228	0.65	1,889	1,228	
2 Physician Assistant	1,664	0.67	2,100	1,407	
3 Nurse Practitioner	-	-	2,100	-	_
4 Subtotal	2,892	1.32		2,635	2,892
9 Physician Services Ur	nder Agreemen	ts	-		<u> </u>
			Total Visits		2,892

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Vaccines	2	21,077
Cost less Vaccines	3	1,055,889
Total Visits	4	2,892
Physician Visits Under Agreement	5	-
Total Adj. Visits	6	2,892
Rate for Prog. Covered Visits	9	\$ 365.11
Prog Covered Visits	10	925
Total Prog Cost	16	(337,727)





- Request a reduction to the Physician productivity standard
- Increased Medicare reimbursement in FY2020 of about \$101,000
- Increase in Base Year 2020 All Inclusive Rate (AIR) from \$252 to \$365. An increase of \$113 per visit or 45%
- This provider was about \$10 Million in net patient revenue in FY2020, clinic is about 3% of operations





- As of April 1st, 2022 there were still opportunities nationally as high as \$3.2M
- In Iowa there may still be opportunities as high as \$175,000
- In most cases, future year impacts due to carry forward of cost per visit limit will eventually equal or exceed this opportunity





- Even a perceived small miss in productivity in 2020 can make a large impact over time
- Actual RHC example: \$5.88 per visit times 384 visits = \$2,257 for 2020

									Po	otential Long Term
	Current	Pr	ojected						Im	npact on Medicare
	Cost Per	Futu	re Cost Per		Impact of Not	Сс	rrected	Medicare		Cost Based
	Visit	V	isit (4%	Co	orrecting Per Visit	С	ost Per	Program	Rei	mbursement in the
	Limit	In	flation)		Limit	Vis	sit Limit	Visits		Future
2021	\$ 211.60	\$	217.03	\$	5.43	\$	217.56	384	\$	1,667
2022	\$ 216.04	\$	225.71	\$	9.66	\$	222.13	384	\$	2,968
2023	\$ 220.36	\$	234.73	\$	14.37	\$	226.57	384	\$	4,415
2024	\$ 224.77	\$	244.12	\$	19.35	\$	231.10	384	\$	5,945
2025	\$ 229.27	\$	253.89	\$	24.62	\$	235.73	384	\$	7,564
2026	\$ 233.85	\$	264.04	\$	30.19	\$	240.44	384	\$	9,275
2027	\$ 238.53	\$	274.61	\$	36.08	\$	245.25	384	\$	11,083
									\$	42,917





Reimbursement Opportunity #2 - Overhead Allocations

- Look for duplicate allocations of overhead within the trial balance
 - Capital Costs
 - Employee Benefits
 - Administrative & General
 - Utilities & Maintenance
 - Housekeeping





Reimbursement Opportunity #2 -

Overhead Allocations

- Understanding how you are paid by Medicare for various costs
- Example > This provider was about \$68 Million in net patient revenue; clinic is about 13% of operations

		Impa	ct of Adding	Cost Based
Medicare		\$1,00	0 of Cost To	Reimbursement
Cost Center	Cost Center Description	Со	st Center	Percentage
1.00	CAP COSTS-BLDG & FIXT	\$	286	28.6%
2.00	CAP COSTS-MVBLE EQUIP	\$	263	26.3%
4.00	EMPLOYEE BENEFITS DEPT	\$	242	24.2%
5.01	ADMINISTRATIVE & GENERAL	\$	232	23.2%
5.03	BUSINESS OFFICE & SAFETY	\$	281	28.1%
5.04	DISCHARGE PLANNING	\$	469	46.9%
6.00	MAINTENANCE & REPAIRS	\$	262	26.2%
7.00	OPERATION OF PLANT	\$	261	26.1%
8.00	LAUNDRY & LINEN SERVICE	\$	324	32.4%
9.00	HOUSEKEEPING	\$	261	26.1%
10.00	DIETARY	\$	190	19.0%
11.00	CAFETERIA	\$	272	27.2%
13.00	NURSING ADMINISTRATION	\$	283	28.3%
14.00	CENTRAL SERVICES & SUPPLY	\$	242	24.2%
15.00	PHARMACY	\$	277	27.7%
16.00	MEDICAL RECORDS & LIBRARY	\$	281	28.1%
17.00	SOCIAL SERVICE	\$	487	48.7%
19.00	NONPHYSICIAN ANESTHETISTS	\$	257	25.7%
30.00	ADULTS & PEDIATRICS	\$	545	54.5%
31.00	INTENSIVE CARE UNIT	\$	622	62.2%
88.00	RURAL HEALTH CLINIC - I	\$	125	12.5%
90.00	CLINIC	\$	116	11.6%
190.00	GIFT, FLOWER, COFFEE SHOP	\$	(25)	-2.5%



Reimbursement Opportunity #2 - Overhead Allocations

		WORKSHEE	Γ M-1				
		Salaries	Other	Total	Reclass	Adjustment	Total
FACILITY HEAI	LTH CARE STAFF COSTS	S	0				
1	Physician	2,575,790	-	2,575,790	(52,273)		2,523,517
2	Physician Assistant	309,300	-	309,300	(9,019)		300,281
3	Nurse Practitioner	776,814	-	776,814	(25,124)		751,690
4	Visiting Nurse	-	-	-	-		-
5	Other Nurse	-	-	-	-		-
6	Clinical Psychologist	-	-	-	-		-
7	Clinical Social Worker	-	-	-	-		-
8	Laboratory Technician	-	-	-	-		-
9	Other Facility Health Care Staff Costs	2,030,203	206,389	2,236,592	(60,000)		2,176,592
10	Subtotal	5,692,107	206,389	5,898,496	(146,416)	-	5,752,080
COSTS UNDER	R AGREEMENT						
11	Physician Services Under Agreement	-	1,357,781	1,357,781	(50,801)		1,306,980
12	Physician Supervision Under Agreement	-	-	-			-
13	Other Costs Under Agreement		-	-			-
14	Subtotal		1,357,781	1,357,781	(50,801)	-	1,306,980
OTHER HEALT	TH CARE COSTS						
15	Medical Supplies	-	1,663,543	1,663,543			1,663,543
16	Transportation (Health Care Staff)	-	-	-			-
17	Depreciation-Medical Equipment	-	-	-			-
18	Professional Liability Insurance	-	-	-			-
19	Other Health Care Costs		78,470	78,470			78,470
21	Subtotal (sum of lines 15 through 20)	-	1,742,013	1,742,013	-	-	1,742,013
22	Total cost of Health Care Service	5,692,107	3,306,183	8,998,290	(197,217)	-	8,801,073





Reimbursement Opportunity #2 - Overhead Allocations

- Reclassify \$60,000 of Clinic Coordinator and Clinic Scheduler wages from RHC cost center 88 to Business Office cost center 5.03
- Update other Worksheet B Statistics such as Employee
 Benefits in cost center 4, FTE count in Cafeteria cost center
 11
- Increased Medicare reimbursement of about \$15,000





Reimbursement Opportunity #3 - Ancillary Costs

- Drugs and Supply Costs Related to RHC Verify 2020 Handling
- Laboratory Costs and Billing
- Radiology Costs and Billing





- What statistics are included on RHC line 88
 - Square Footage
 - Gross Wages
 - FTE Count





- Understanding how you are paid by Medicare for various costs
- Example > This provider was about \$13.8 Million in net patient revenue. Four RHCs file consolidated on cost center 88. Clinics are about 11% of operations

		Impact of Adding	Cost Based
Medicare Cost		\$1,000 of Cost To	Reimbursement
Center	Cost Center Description	Cost Center	Percentage
1.00	CAP COSTS-BLDG & FIXT	458	45.8%
2.00	CAP COSTS-MVBLE EQUIP	419	41.9%
4.00	EMPLOYEE BENEFITS	450	45.0%
5.00	ADMINISTRATIVE & GENERAL	422	42.2%
7.00	OPERATION OF PLANT	396	39.6%
8.00	LAUNDRY & LINEN SERVICE	515	51.5%
9.00	HOUSEKEEPING	394	39.4%
13.00	NURSING ADMINISTRATION	705	70.5%
16.00	MEDICAL RECORDS & LIBRARY	382	38.2%
19.00	NONPHYSICIAN ANESTHETISTS	376	37.6%
30.00	ADULTS & PEDIATRICS	799	79.9%
54.00	RADIOLOGY-DIAGNOSTIC	367	36.7%
60.00	LABORATORY	375	37.5%
73.00	DRUGS CHARGED	403	40.3%
76.01	DIABETIC EDUCATION	341	34.1%
88.00	RURAL HEALTH CLINIC	199	19.9%
91.00	EMERGENCY	269	26.9%
190.07	OTHER NON REIMBURSEABLE COST CENTER	(184)	-18.4%





		CAP COSTS-BLDG & FIXT
		1.00
		SQUARE FEET
B-1 Cost All	ocations Statistic Detail	
Line	Department	Current Year Statistic
1	CAP COSTS-BLDG & FIXT	-
2	CAP COSTS-MVBLE EQUIP	-
4	EMPLOYEE BENEFITS	-
5	ADMINISTRATIVE & GENERAL	317
7	OPERATION OF PLANT	153
8	LAUNDRY & LINEN SERVICE	-
9	HOUSEKEEPING	-
13	NURSING ADMINISTRATION	-
16	MEDICAL RECORDS & LIBRARY	27
19	NONPHYSICIAN ANESTHETISTS	-
30	ADULTS & PEDIATRICS	-
54	RADIOLOGY-DIAGNOSTIC	-
60	LABORATORY	362
73	DRUGS CHARGED	-
76.01	DIABETIC EDUCATION	-
88	RURAL HEALTH CLINIC	9,742
91	EMERGENCY	-
190.07	OTHER NON REIMBURSEABLE COST CENTER	-
101	TOTAL	10,601





- Reclassify Administrative, Maintenance, Medical Records, and Lab square footage out of clinic cost center 88
- Update other Worksheet B Statistics that use square footage as the approved statistical basis; Operation of Plant and Housekeeping
- Increased Medicare reimbursement of about \$5,000 annually





- List 3-5 things to consider when onboarding a new RHC physician
 - Ramp up period for new providers
 - Medical Directorship
 - Emergency Room coverage needs
 - Alternative Roles





- Previously, those exempt from cost per visit limitation would have 20% to 35% of a new provider's cost covered by Medicare
- Reimbursement now potentially impacted by both the productivity standards as well as cost per visit limits





NEW DROVIDER ADDED WITH CONTRACT ALL IN DHO

DURING RAMP UP PERIOD		
	_ Cur	rent Staffing
Total RHC Cost	\$	1,055,889

Total RHC Cost	\$ 1,055,889	\$ 250,000	\$ 1	1,305,889
Physician FTEs	0.65	1.00		1.65
Physician Assistant FTEs	0.67	-		0.67
Visits	2,892	2,000		4,892
Minimum Visit Requirement	4,137	4,200		8,337
Medicare % of Visits	32%	32%		32%
Medicare Visits	925	640		1,565
Cost Per Visit	\$ 255.23	\$ 59.52	\$	156.64
Assumed Cost Per Visit Limit	N/A	\$ 257.00	\$	257.00
Paid Cost Per Visit	\$ 255.23	\$ 59.52	\$	156.64
Cost Based Reimbursement From Medicare Program	\$ 236,088	\$ 38,077	\$	245,090

Incremental Cost Based Reimbursement \$ 9,002

Add New Provider (1 FTE at \$250,000 All

to RHC)

Revised

Staffing



RAMP UP PERIOD					Add New vider (1 FTE		
				\$250,000		Revised	
	Cu	rrent Staffing		plit Role)		Staffing	
Total RHC Cost	\$	1,055,889			\$ ^	1,180,889	
Physician FTEs		0.65		0.50		1.15	
Physician Assistant FTEs		0.67		-		0.67	
Visits		2,892		2,000		4,892	
Minimum Visit Requirement		4,137		2,100		6,237	
Medicare % of Visits		32%		32%		32%	
Medicare Visits		925		640		1,565	
Cost Per Visit	\$	255.23	\$	59.52	\$	189.34	
Assumed Cost Per Visit Limit		N/A	\$	257.00	\$	257.00	
Paid Cost Per Visit	\$	255.23	\$	59.52	\$	189.34	
Cost Based Reimbursement From Medicare Program	\$	236,088	\$	38,077	\$	296,253	
Incremen	tal Cost Ba	ased Reimburse	men	From RHC	\$	60,165	
Salary Attributed to ER Coverage or Administrative Roles Estimated CAH Cost Based Reimbursement %			\$	125,000 45%			
Incremental Cost Bas	sed Reimbu	ursement From	ER/A	dmin Roles	\$	56,250	
		ost Based Reim			_		





Reimbursement Opportunity #6 - Adding a new RHC

- Cap for all providers established on or after 12/31/2020
- Operational considerations
- Medicare Utilization
- Contracts that follow Medicare
- Retail 340B Impact
- Impact may change over time with higher limits





Other Payment Topic - Vaccines

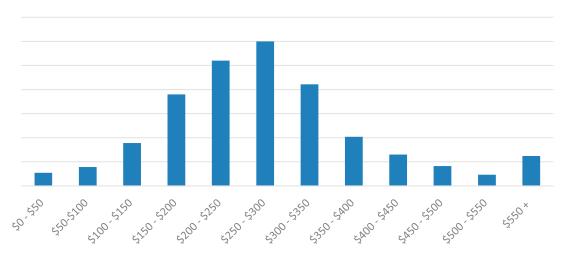
- Influenza, pneumococcal, & COVID-19 vaccines and their administration will be paid at 100% of reasonable cost through the Medicare cost report
- COVID-19 Vaccine for 2020 & 2021 include Original Medicare and Medicare Advantage





Other Payment Topic – National Pneumococcal cost per injection 2019

National RHCs - 2019 Pneumococcal cost per injection - Average \$289.75

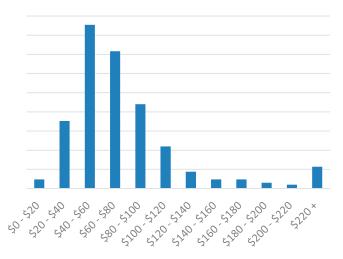






Other Payment Topic – National Influenza cost per injection 2019

National RHCs - 2019 Influenza cost per injection -Average \$84.45

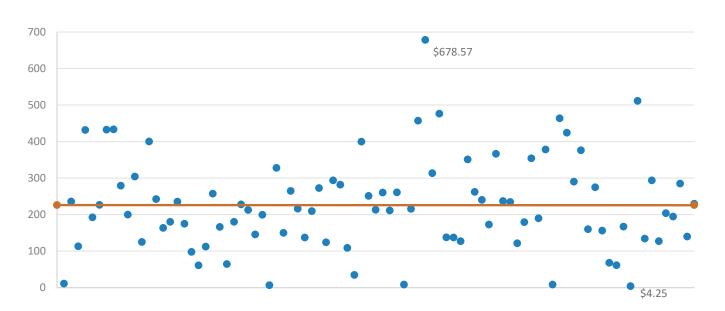






Other Payment Topic – Iowa Pneumococcal cost per injection 2019

Iowa RHCs - 2019 Pneumococcal cost per injection - Average \$226.17

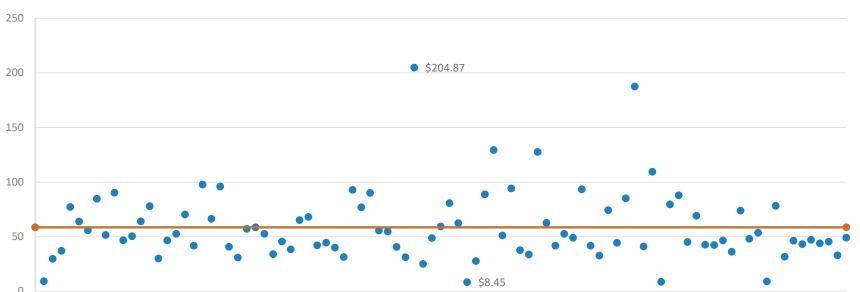






Other Payment Topic – Iowa Influenza cost per injection 2019

Iowa RHCs - 2019 Influenza cost per injection - Average \$58.60







Other Payment Topic - Telehealth

- 2020 fee schedule payment \$92.03, effective 1/1/2021 this was updated to \$99.45
- Reported as 'Other than RHC service' on the Medicare cost report, not subject to cost-based reimbursement
- Advocacy groups are working to have telehealth visits counted as normal clinic RHC encounters





Other Future Strategic Thoughts to Consider

- Componentization of Cost Centers
- Capital Cost Center Identification
- Building Replacement
- Coinsurance Implications
- Physician Services Under Agreement
- Consider complete strategic evaluation of cost reports with a "fresh set of eyes" mentality





Topical Agenda

- Purpose and History Behind Legislation
- Eligibility for REH Status
- Estimated Financial Benefit of REH Status
- Is REH Status Right for You?
- Potential Hurdles and Unknowns to REH status
- Next Steps to Consider



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
- Additional Final Rule expected but not yet released





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
- Must meet certain conditions of participation
- 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 skilled nursing unit if desired





Eligibility For REH Status

- Must maintain an annual average length of stay of 24 hours or less
- May offer outpatient services
- REH may convert back to original designation





Estimated Financial Benefits of REH Status

- Outpatient Payments Based on 105% of APC Payment plus national average of Critical Access Hospital Benefit
- National CAH benefit estimated from various sources around \$2.4M to \$2.7M
- CLA analytics utilize an estimate of \$2.5M for CAH Benefit
- Facility specific cost and revenue stream changes to service lines also need to be analyzed





Rural Emergency Hospital (REH) Financial Implications

- In December 2021, CLA conducted an extensive facility level analysis of the potential implications of REH status for the nation's critical access hospitals
- Based on 2019 cost report and claims data
- Based on facility specific analysis of average CAH vs.
 PPS payment differential for 1,189 evaluated sites
 - Included only sites with sufficient and reasonable data
- Facility level impact broken down between inpatient, swing bed and outpatient CAH vs. PPS estimates
 - CAH average IP CMI based on claims data
 - Swing bed impact utilized 2019 and 2020 average state SNF RUGS and PDPM rates based on claims data
 - Outpatient PPS rate simulations based on claims level analysis on HCPCS and APC modeling of non metro PPS outpatient claims by state

Average CAH Benefit vs. PPS (Per Facility) Low \$2,400,000 High= \$2,700,000





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





Rural Emergency Hospital Status

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

			Median REH
			Benefit % of
# of Critical Access Hospitals	All CAHs	<2IP ADC	Op Rev*
Increased Net Revenues (1)	68	68	5.5%
Increased Margin Potential (2)	508	373	5.9%
Increased Margin Potential (Min ER Cost) (3)	350	228	4.0%
Increased Margin Potential - Lose 340B (4)	234	185	3.8%





Rural Emergency Hospital Status

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

			Median REH
			Benefit % of
# of Critical Access Hospitals	All CAHs	<2IP ADC	Op Rev*
Increased Net Revenues (1)	1	1	5.6%
Increased Margin Potential (2)	25	25	7.3%
Increased Margin Potential (Min ER Cost) (3)	20	20	6.5%
Increased Margin Potential - Lose 340B (4)	12	12	4.9%





Is REH Status Right for You?

Financial Considerations

- Facility specific analytics
- Network considerations
- Inflationary factors
- How will this look over time?





Is REH Status Right for You?

Patient Considerations?

- Still access to all outpatient service levels
- No longer inpatient services, yet how many are really ever inpatients?
 - 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?

• Staffing considerations

- Currently many facilities are struggling for staffing
- Under REH Less off hour shifts to staff
- Still need for potential on call time for Emergency Coverage including ancillary services





Is REH Status Right for You?

Community Perception

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





Potential Hurdles and Unknowns to REH Status

- Community Perception?
- State licensing issues?
- 340B?
- Will staffing retention be easier with an REH?
- How far will additional inpatient benefit payment go?
- Actual Inflation versus MEI Updates
- Others?





Next Steps to Consider

Facility Specific Financial Modeling

- Understand the potential financial impact over time
 - ♦ Narrow down higher level analyses for facility specific situation
 - Create a dashboard to understand knows and unknowns in order to better visualize benefits and risks
 - ♦ Layer in capital needs impact over the long term
- MEI Inflation Factors Versus Actual Inflationary Pressures

Assess Patient Care Impact

- Will financial impact allow for better patient care over time
- Beneficiary coinsurance may likely be lower
- Will network resources be available to cover inpatient cases
- Consider perceived patient care impact





Other Topics/Q&A

- Questions on RHC Cost Per Visit Limits or Rural Emergency Room Status?
- Other questions?





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