The Medicare Chess Game: New Moves and Strategies for Hospitals/CAHs and Ambulatory Care Venues

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Agenda/Content

- Ambulatory Care Site Options
- Consolidations and Spin-offs
- New Hospital Campuses
- Micro Hospitals
- Two-Step a/k/a Rurban Reclassification
- Critical Access Hospitals
- Rural Health Clinics
- New Rural Emergency Hospital Provider Type

The Medicare(+) Chess Game

- Goal is to organize operations to optimize fit existing payment systems
- Every move impacts other pieces as part of larger strategy
  - Common to lose in one area to gain elsewhere; or
  - Lose now to gain later
- Not about “gaming” the system
- About more than just Medicare payment
  - 340B Eligibility
  - Medicaid
  - Commercial payers
  - Other considerations

AMBULATORY CARE SITES

Ambulatory Care Sites

- Health systems are looking to expand ambulatory care (outpatient) care services
- BUT, CMS rules limit ability to add new hospital locations
- Must balance limitations on new hospital locations that can result in a decrease in payment against hospital integration and potential 340B child-site status
- Case-by-case assessment: with 340B, IME, operational consistency, Medicaid, etc.

Provider-Based Site Neutral (BBA 2015)

- Amended SSA § 1833(t) of Hospital Outpatient Prospective Payment System (“HOPPS“ or “APCs”)
- Effective January 1, 2017: Excludes from HOPPS services provided in off-campus outpatient departments of a provider as defined in 42 CFR § 413.65(a)(2) (i.e., Medicare provider-based rule). Exceptions for:
  - Off-campus sites in place on 11/2/2015 - grandfathered
  - Main campus and remote location "campus" services
  - Services in off-campus dedicated EDs

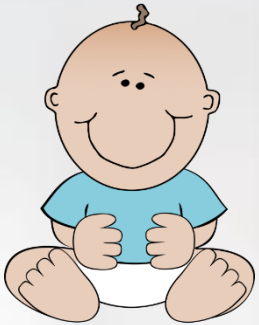
Site Neutral Expanded to E&M

- 2019 Final HOPPS Rule
- Once again, CMS did not finalize proposal to limit expansion of services at excepted (grandfathered) locations via clinical families. However, CMS will continue to explore this issue in the future
- Clinic E&M visit services (HCPCS code G0463) at excepted (grandfathered) off-campus PBDs to be paid at lower rates
  - 70% of the OPPS rate in 2019 and 40% in 2020.
  - AHA filed suit challenging these cuts
- CMS cut payment for covered drugs at non-excepted off-campus PBDs to ASP-22.5% - same as excepted and on-campus

Services Not Impacted by Site Neutral

- The payment limitation does NOT affect certain providers and services
  - Outpatient services paid under another fee schedule (e.g., PT/OT/ST, lab, etc.)
  - Critical access hospitals – not paid under OPPS
  - "Provider-based entities" such as rural health clinics
    - Paid under separate benefit and provider number/CCN
    - E&M visit at RHC not paid under OPPS
    - Non-RHC services at provider-based RHC site?

New (Non-GF'd) Provider-Based Sites



- Opened after 11/2/2015 and NOT:
  - "in" dedicated ED
  - on campus of Main Provider or remote location (within 250 yards)
- Still Provider-Based on the CMS UB-04
  - Identify non-excepted services with "PN" modifier
  - Pay for those services under new *"MPFS"* rates
- Paid at 40% APCs/HOPPS from CY 2019 forward
  - Not so site neutral
  - Still 340B eligible - if hospital to which it is based is

Exceptions to 35-Mile Radius for PB'd

- Provider-based rule has always had exception to 35-mile radius limit for "hospital or CAH with >11.75% DSH payment adjustment"
  - 11.75% is threshold for 340B eligibility (pre-ACA)
  - Must have contract with government entity in which the >35-mile site is located – to care for indigent at site
  - NOT an exception to site neutral reductions, so 40% APCs unless: Dedicated ED, Remote Location
- RHC if based to <50 Bed, Rural Hospital/CAH
  - H/CAH must be rural (non-MSA) deemed status N/A
  - Not changed by new RHC rules, yet…..

Ambulatory Care Options Overview

- Hospital-Based
  - Excepted provider-based: On-campus, FSED, pre 11/2/2015 (100% APCs)
  - Off-campus, non-GF'd provider-based (40% APCs)
  - RHCs pre-2021 AIR cost cap = 2020 indexed.
  - RHCs post 2020 AIR = $100/visit increasing to $190 in 2028
- Non-hospital
  - Physician Offices – Medicare Physician Fee Schedule (MPFS)
  - Freestanding RHCs – AIR = $100 increasing to $190 in 2028
  - IDTFs (MPFS)
  - ASCs (ASC Fee Schedule about 60% APCs)
- Post acute/other: SNF, HHA, Hospice, ERSD, CRA, CORF…

Comparison of Ambulatory Care Sites

Venue	Technical	Professional	Drug Cost & Payment
FSg Office	PFS/RVU (non-facility) drug admin CPT codes	PFS	Not 340B Eligible ASP + 6%
PPS HOPD On-Campus	100% APC	PFS/RVU E&M Facility or Procedure code	340B Eligible if Hospital is; ASP – 22.5%* Bundled into APC (if cost < packaging threshold of $130 for 2021)
PPS HOPD GF'd Off-Campus	E/M – 70% APC in 2019 & 40% in 2020 & forward Others 100% APC	PFS/RVU E&M Facility or Procedure code	340B Eligible if Hospital is; ASP – 22.5%* Bundled into APC (if cost < packaging threshold of $130 for 2021)
PPS HOPD Non-GF'd Off-Campus	40% APC in 2019 & forward	PFS/RVU E&M Facility or Procedure Code	340B Eligible if Hospital is; ASP – 22.5%* Bundled into APC (if cost < packaging threshold of $130 for 2021)
CAH Site	101% costs	PFS (facility) + 15% if Method II	340B Eligible 101% cost
RHC Site	100% costs limited to UPL (unless grandfathered)	Global with TC	340B Eligible if Hospital Based -100% costs
Pharmacy	N/A	N/A	Part D ingredient cost plus dispensing fee (plan specific) Part B reimbursement not available for any drug usually self-administered

*Rural SCHs paid at ASP+6%

Strategies in Action

- Health system opening new ambulatory care site
  - Closest system hospital to site is 5 miles away, but hospital 40 miles away is a DSH 340B Covered Entity
  - Can be made provider-based to either because of 340B (11.75%) exemption from 35-mile radius allows to provider-base to hospital 40 miles away
  - Making pb'd to site allows access to drug discounts as 340B child site
- Transferring PB'd infusion site to another system hospital
  - Infusion site on campus of non-340B hospital, gf'd from OPPS cuts
  - Transfer to DSH 340B Covered Entity allows access to drug discounts, which outweigh going down to 40% of APC rate
  - Additional benefit – new host hospital is rural SCH, so exception to 340B OPPS cuts and extra 7.1% on other OPPS payments

Strategies In Action

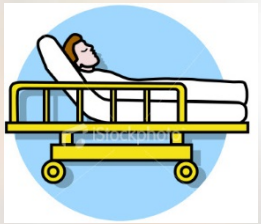
- HC System Flagship: Teaching, DSH, 340B, GF'd PB'd sites
- Wants new patient care site across state line:
  - Better serve patients in outlying catchment area, competition
  - Other state has bed moratorium – so no new I/P beds (for RLOH)
  - O/P Surgery, PC and Specialty Clinics, Infusion/Oncology, Lab, Imaging
- Although 603 applies 60% haircut to Medicare FFS
  - Child-site status for 340B makes finances as PB'd a win
  - Across state lines OK as long as consistent with laws of both states

Add I/P Beds to Expand GF'd PB'd

- Urban Teaching Hospital with Rurban for:
  - Increased wage index and IME increase
  - Acquiring Tier 2 340B status as an RRC
- Operates GF'd Off-Campus (10 miles) O/P only PB'd Site
  - Planning major expansion of services and footprint
  - Will include oncology center
- Not a CON State – Add I/P Beds?

Add I/P Beds to Expand GF'd PB'd

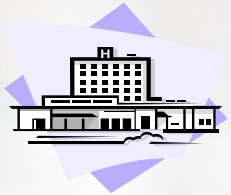
- Without I/P Beds
  - Ok to swap/change services at current address
  - Footprint expansions - maybe, but not clear
  - No within-250-yards leeway to add PB'd
  - As either RLOH or new P# will be excepted as on campus
- With Beds as Either RLOH or New Hospital:
  - Eliminates any § 603 GF issues
  - Anything on campus will be excepted from § 603
  - Full APC payment

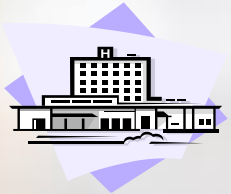


CONSOLIDATIONS AND SPIN-OFFS

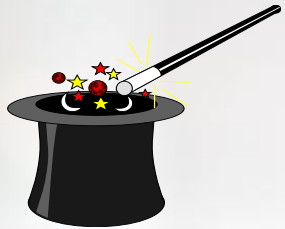
Provider Consolidation and Spin-Offs

- 1 hospital or 2 (or more)?
  - 1 provider number with multiple campuses (I/P), or
  - Separate provider numbers for each campus
  - What is or is not part of DRG provider number:
    - Psych units/hospitals
    - Children's hospital or service line?
- Why does it matter?
  - DSH, IME/DME, Wage Index-reclass
  - 340B
  - Medicaid
- Can't be just reimbursement driven
  - Lots of other implications
  - Market, med staff, operations





Provider Consolidation and Spin-Offs



- Special application of provider-based rule
  - All PB'd requirements must be met
- "Remote location of a hospital"
  - Site separate from the "main provider" with I/P services
- Single provider structure
  - One Medicare provider #
  - Multiple campuses (separate licenses OK if required by state law)
- One site must be "main provider"
- Other site(s) must be "remote location(s)" and are considered off-campus for PB'd rule:
  - Split-billing notice, JVs, management contracts…

Provider Consolidation and Spin-Offs

- Consider DRG Payment Window
  - Multi-campuses of single provider all within same window
  - Separate hospitals are not, unless in same corporation or parent-sub
- Can be applied to excluded hospitals
  - Rehab, psych, LTCH, CAH
- Spin-off = vice versa
  - Fail some part of PB requirements
  - Requires separate provider #
- Hospital-in-Hospital Payment Rules N/A
  - Only applies to excluded hospitals, not acute

Provider Consolidation and Spin-Offs

- Consolidation example
  - 2 system hospitals:
    - large urban hospital - teaching program, 15% DSH adjustment, 340B CE
    - smaller suburban hospital – no teaching program, 9% DSH, not 340B eligible
  - Breakeven on Medicare FFS payments, but smaller hospital can no longer start teaching programs
  - Combined hospital still had DSH adjustment >11.75%, so 340B eligible, additional drug savings of $1 million/year
- Spin-off Example
  - Hospital had 2 campuses; downtown teaching campus and suburban campus
  - Spun off suburban campus, which raised DSH above 11.75% to get 340B

NEW HOSPITAL CAMPUSES

New Hospital Campuses

- When considering the construction of new inpatient hospital campus, there are two options that should be balanced:

1 Provider # - RLOH	2nd Provider #
No start-up revenue lag	Start-up revenue lag as “nonpar” hospital
No new capital cost $	New hospital capital cost
No new GME cap	Build new GME cap
Included as 340B site likely	340B not likely at least for awhile
Same reclass benefits as Main Campus	Not part of reclass payment benefit

New PPS Hospital – Medicare Capital Cost Reimbursement

- Must be a new acute care hospital
- NOT applicable to:
  - Replacement facility even if new location and/or CHOW
  - Close and subsequently reopen
  - Newly participating in Medicare (but open > 2 years)
  - Excluded hospital (LTCH, Rehab, Psych) converts to acute care

New PPS Hospital Capital Cost

- Eligible for 85% Cost Reimbursement for:
  - First 2 full cost report years
  - Can be almost 3 years by opening just after beginning of fiscal year
- Front end load costs
  - 150% accelerated depreciation –
    - "cash flow from depreciation does not cover debt service"
    - Requires FI approval
  - Capital asset study – shorten useful lives
  - Lease for short term
- Then regular capital PPS applies

New I/P Campus – To Be or Not To Be…

New Hospital Provider

- Start-up gap for survey (can be months)
  - Must clear deficiencies (-$3.5m)
- Delay in billing for tie-in notice assigning new # (but can bill retro to last day of survey)
- Start-up stub period + 2 full cost report years of capital cost reimbursement (+11.5m)
- Must build history for: DSH, 340B, wage index reclass, etc.
- GME naive hospital so can start new programs and build new cap for system
- **WINNER = NEW PROVIDER # by $6 million**
  - **$8m above vs. about $2m as RLOH**

Remote Location of Existing Hospital

- No start-up delay – add to 855A and bill
- Step into shoes of Main Provider
  - Wage index reclass
  - DSH, IME, etc. (but could dilute or help)
  - Net gain $600k/year
  - 340B status of Main Provider Savings $250k/year
  - Net gain over 2.5 years = $2.1m
- No new capital cost reimbursement
- If Main Provider has GME Caps, then no opportunity to build new programs

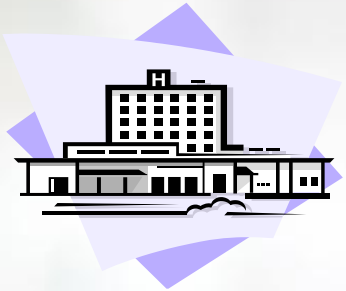
MICRO HOSPITALS

Mini-Me: Micro Hospital Strategy

- a/k/a Neighborhood Hospitals – closer to patients' homes
  - 10-15 beds, ADC <5, ALOS ??
  - ER, Ancillaries, ORs?
- Micro-investors looking to:
  - Form JV with system and/or
  - Manage and operate sites
- Options:
  - JV to own and operate micro sites
  - Mini "remote location of hospital" managed by operator (or not)

What is a Hospital for Medicare?

- CMS Updated Guidance Must be "Primarily Engaged" in Providing Inpatient Services – Taking Aim at "Micro-Hospitals"
  - S&C Memo: 17-44 9/6/2017
  - SOM A-0022 § 482.11
- N/A to CAHs and PPS-Excluded Psych Hospitals
  - Separate guidance for CAHs – community needs a factor
- Primarily Engaged
  - State license as a hospital is necessary, but NOT sufficient
  - Capacity/potential to provide I/P is NOT sufficient
  - Acute care medical necessity, expecting 2-midnight stay
  - For survey must have 2 or more I/Ps = starting point only



Hospital Definition Update from CMS

- Factors CMS ROs should consider include:
  - Number of provider-based off-campus EDs
  - # I/P beds relative to facility size and services offered
    - For Example: 4 I/P beds, 6-8 ORs, 20 ED bays and 10 ambulatory surgery beds is most likely not primarily engaged in I/P care
  - Volume of O/P surgery vs. I/P surgery
  - Advertise as specialty or surgery hospital
  - Patterns of ADC over course of week
  - Staffing schedules

Hospital Definition Update from CMS

- CMS National Office perspective…???:
  - Not a requirement that >50% of revenue or volume be I/P
  - Will approach as a 2-step process
  - Step 1: Sufficient/legitimate I/P volume?
    - If so, then do not proceed to Step 2
    - I/P volume or revenue in comparison to O/P not considered
  - Step 2: If I/P activity insufficient:
    - Then proceed to compare to O/P per S&C 17-44
    - If O/P substantial, then initiate denial/revocation of hospital status
  - N/A to "Micro remote locations" on site-specific basis
    - Applies to ALL sites under same hospital provider #

Micro Hospital JV Example

- New Hospital(s) in Separate Legal Entity
- Separate Licensure, Accreditation, Certification/COPs
  - Start-up revenue gap for new Provider #
  - Must meet Primarily Engaged test for each Provider #
  - Won't benefit from System/Flagship DSH, IME, 340B, wage index reclass, etc. – must qualify on own
  - Separate commercial payor contracting
- New Hospital Capital – 85% Medicare costs: startup + 2 full years
- New Provider # could build new GME Cap

Micro Specialty Hospital Example

- Multi-hospital system with 250-Bed Flagship
  - Deemed rural RRC and SCH, 340B, teaching, etc.
  - Orthopedic practice dominated by independent group with own POH
- System decided to build 10-bed ortho/sports medicine campus
  - Initially opted for separate hospital provider # to have exclusive med staff for system-employed orthos
  - Chose state survey vs. deeming authority
  - Model fit S&C Memo 17-44 micro profile, CMS would NOT approve state survey
- After 6 months, reversed course and made site micro remote location

Micro Remote Location Option

- RLOH = Off-Campus Provider-Based to Flagship
  - PB'd rules prohibit off-campus JVs – management contract OK
- Accreditation and Certification/COPs as part of Flagship
  - Licensure depends on state law: could be separate or satellite
  - Primarily Engaged N/A to each site: P# as a whole
  - No start-up gap: just add to Flagship 855A as new location
  - § 603 Site Neutral Exception within 250 yards
  - Flagship DSH, IME, Wage index apply same as main campus
  - 340B gap until RLOH included on as-filed cost report
  - No new capital cost, nor GME Cap building

RURBAN RECLASSIFICATION

Two-Step Reclassification a/k/a Rurban Strategy

- Potential Goals of Two-Step Reclass a/k/a Rurban Strategy:
  - Improve wage index
  - Get rural status for increased IME
  - Get 340B status based on lower DSH thresholds
  - Get other special rural status
    - SCH, RRC, MDH
    - Rural SCHs OPPS +7.1% and 340B cut exemption

Rurban Strategy – Applicable Rules

- Two methods for a hospital to reclassify its location – virtually
  - MGCRB wage index reclassification under 42 CFR 412.230 et. seq.
  - Urban to rural reclassification under 42 CFR 412.103 – a/k/a Section 401 Reclassification
- If a hospital has 412.103 rural reclass, makes getting MGCRB reclass easier

Hospital Type	Proximity	Home AHW	Target AHW
Urban	15 miles	108%	84%
Rural or Rural Reclass	35 miles (if RRC/SCH, closest area if more)	106% (waived for RRCs)	82%

Rurban Strategy – Applicable Rules

- Also rural for:
  - 30% upward adjustment to existing IME FTE cap under 413.79(c)(2)(i)
  - Can build new program IME FTE cap under 413.79(e)(3)
  - BUT, lose Capital DSH payments
- If the hospital gets RRC or SCH status as well, lowers threshold for 340B Program to 8% DSH adjustment
- Rural SCHs get - 7.1% OPPS add-on & exception to OPPS 340B payment cuts

Rurban Strategy In Practice

- Urban hospital with no existing reclass, already 340B
- Remote 2 hospital MSA – so can't get SCH
- Did § 412.103 to get rural/RRC

- File MGCRB wage index reclass using special access rule (nearest MSA) to MSA 90 miles away
  - Medicare lost revenue = $(6 million) over first 9 months
  - Medicare gain over next 27 months = $11 million
  - Can renew every 3 years thereafter
    - Without down stroke in first 9 months; ~$4 million/year

Rurban to “Buy” Tier 2 340B Status

- Large Metro Suburban Hospital part of 25-hospital system
  - Pre-existing wage index reclass as part of county group
  - DSH >8% below 11.75%
  - § 412.103 to Rural and RRC
  - Pre-existing wage index reclass supersedes rural wage index drop
  - Medicare lost revenue = $(250,000)/year
    - Capital DSH (n/a to rural or deemed rural)
  - Acquire Tier 2 340B status= $3-4m/year cost savings

Rurban for Rural SCH Benefits

- Urban SCH/RRC - 340B eligible
  - Best wage index in state, but adjacent state rural wage index higher, helps OPPS, not I/P due to HSR
- MGCRB rules prohibit urban to rural reclass, so:
  - 412.103 reclass based on state law/regulation
  - Filed rural-to-rural MGCRB wage index to next state
  - Rural SCH gets 7.1% add-on to OPPS payments for rural SCHs
  - MGCRB reclass for capital IPPS & OPPS = ~1.4 million/year
  - CMS exempted Rural (but not urban) SCHs from 28.5% to Medicare-covered 340B drugs = $5 million/year

Rurban for 340B and IME

- Flagship Academic Medical Center of Multi-Hospital System
  - DSH% >8% < 11.75%
  - Urban teaching hospital - significantly over FTE Cap
  - Wage index highest in state
  - 412.103 to rural for RRC, reclass back into home area

- Consequences
  - **$11 million DROP in revenue first year** (Medicare FFS, Advantage and other)
  - 340B as Tier 2 RRC >8%, no orphan drugs, but $50 million/year savings
  - IME lift from 30% cap increase ($6.5m Yr 2, $10.3m Yr 3, $11.6m/Yr 3+)
  - Can increase IME FTE Cap with new teaching programs (but not GME Cap)

Ultimate Case Study: All in One

- 10-Hospital System – Mix of Small Urban and Rural
  - Flagship: High DSH, 340B eligible, teaching, no reclass ops
  - Suburban Site: Low DSH, not 340B, possible reclass to next state
- Step 1: Merge into two-campus single provider
  - FFS = wash, BUT extends 340B to Suburban campus = $6.5m/yr
- Step 2: Rurban Reclass
  - 340B + Rurban reclass to nearby MSA for $16m/yr = $22.5m/yr
- Step 3: Obtain SCH Status
  - 340B + $27m/yr HSR & 7.1% APC = $33.5m/yr

CRITICAL ACCESS HOSPITALS

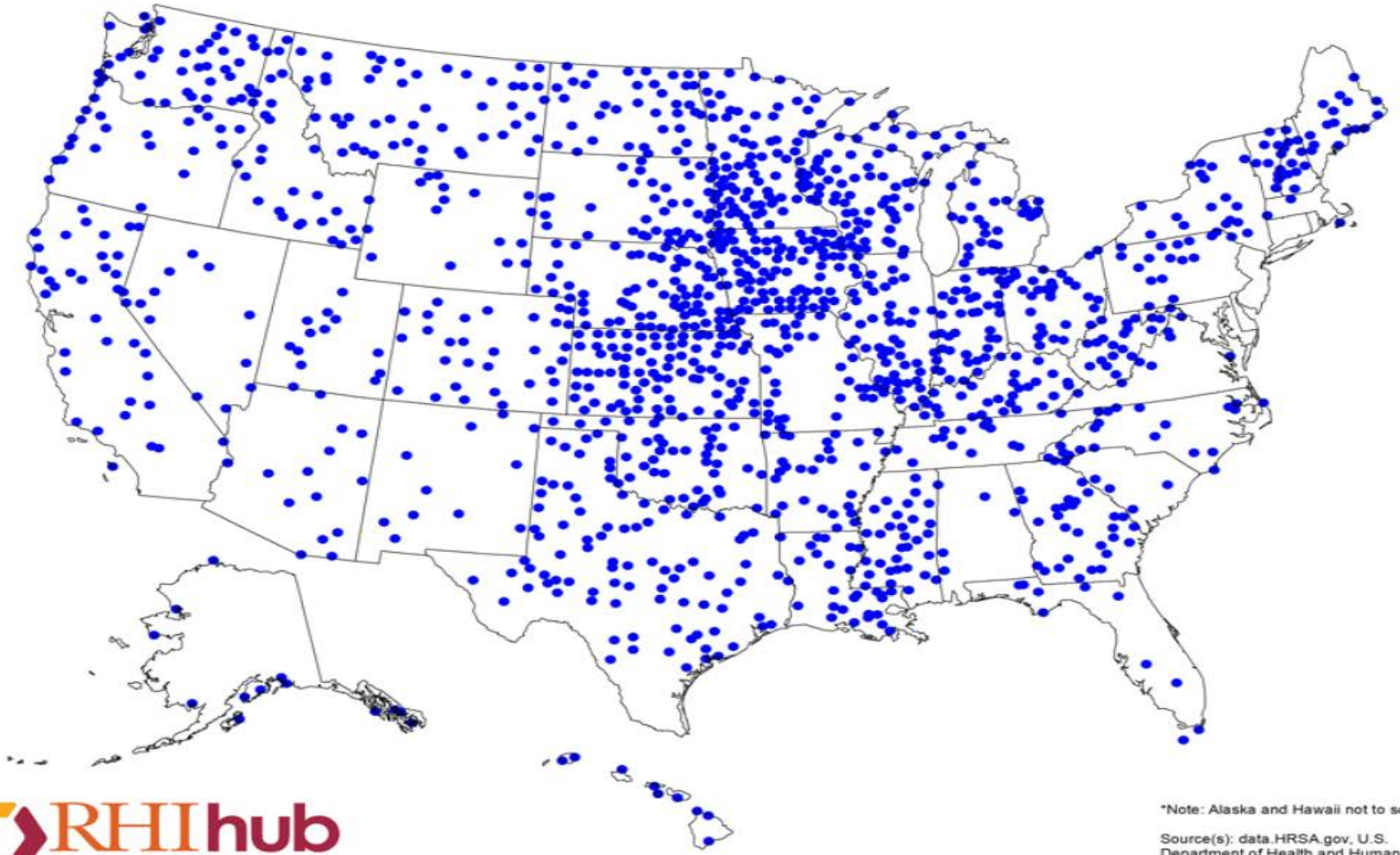
CAH Requirements

- CAHs must be located:
  - In a rural county (non-MSA) or have a 412.103 deemed rural designation from CMS
  - >35 miles from a hospital unless:
    - Located in mountainous areas or have only secondary roads (15 miles) OR
    - Received state designation as a "necessary provider“ (no new NP designations)
- Must have 25 or fewer acute care inpatient beds
- Average length of state of 96 hours or less
- Provide emergency care services 24/7

CAH Benefits

- Cost-based reimbursement (101%) for inpatient and outpatient services provided to Medicare patients
- Professional component - Method II - 115%
- Eligible for 2nd Tier 340B status

Critical Access Hospitals



RHIhub
Rural Health Information Hub

*Note: Alaska and Hawaii not to scale

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, January 2021

Spin-Off Strategy

- Goal: mitigate cost-based reimbursement “dilution effect”
- Provider-based operations pull overhead costs away from CAH I/P and O/P with usually highest Medicare utilization to non-cost-based operations:
  - HHA, SNF, ESRD, etc.
  - And now RHCs
- Recent Example: CAH operates Dialysis unit within same corporation and on cost report
- Strategy: Spin off Dialysis unit into separate, but affiliated legal entity
  - Breaks link under dialysis rules, so not on cost report
  - Move to separate building on campus, reduces facility O/H allocation
  - Dialysis paid same under its PPS
- Predicted improvement to cost reimbursement = $500k/year

Multi-Campus CAHs

- It is possible to have a multi-campus CAH
- Rare but can be a way to preserve CAH status in some cases
- Recent Example:
  - System with two CAHs 20 miles apart
  - One was grandfathered NP, other was not
  - Originally okay because considered mountainous terrain
  - Rules changed risking CAH status of non-NP CAH
  - One option was to make a single multi-campus CAH
  - Both locations still need to meet 35-mile test from other hospitals/CAHs but not each other

RURAL HEALTH CLINICS

RHC Conditions of Participation

- RHC COPs at 42 CFR 491 (Surveyed and certified like other providers)
  - Location requirements
    - In rural area – different definition than MSA used for hospitals
    - In HPSA/MUA
  - Facility, medical records, organization and staffing requirements
  - RHC must be primarily engaged (>50%) in RHC services:
    - Often misinterpreted as primary care, but
    - Guidance indicates office visits by physicians/APPs of any specialty
- Staffing
  - Advanced Practice Practitioner (APP) on site 50% of time operated
    - PA, NP, Nurse-midwife, CSW or Clinical Psychologist
  - At least 1 employed PA or NP, additional APPs can be contracted for
  - Physician must be medical director and participate in care/collaboration with APPs as required by state law

Provider-Based RHCs

- RCHs can be either freestanding or provider-based
- "Provider Based Entity" – not a hospital O/P department
  - Separate provider number
  - Subject to separate RHC CoPs
  - Exempt from some PB'd requirements, including:
    - **35-mile requirement if PB'd to rural H/CAH with fewer than 50 beds**
    - Public awareness
    - Off-campus notice of split-billing
    - Don't count as a CAH off-campus site for CAH location test

RHC Payments

- RHCs are paid a flat rate for each encounter/RHC covered service: the RHC payment or All-Inclusive Rate (AIR)
- Not all services covered/billable under RHC provider number
  - Effectively only physician and mid-level office visits
  - Non-RHC covered services (ancillaries) must be billed separately:
    - Hospital/CAH provider # if PB'd
    - Physician office # if freestanding
- CMS Position – non-RHC services at RHC site do NOT trigger application of CAH location test (even though billed on CAH #)

UPDATE RHC Payment Changes

- Example of how legislative changes impact reimbursement strategy
- Pre-Consolidated Appropriations Act, 2021:
  - Freestanding and RHCs PB'd to Hospitals with 50+ beds subject to an Upper Payment Limit (UPL)
  - RHCs PB'd to Hospitals/CAHs with <50 beds paid based on costs with no limit
- Post-Consolidated Appropriations Act, 2021:
  - Increased UPL to $100 beginning 4/1/2021
  - Followed by annual increases (**up to $190 for 2028**)
  - UPL applies to all new non-grandfathered RHCs
- Grandfathered provider-based RHCs not subject to UPL (PB'd to hospitals with fewer than 50 beds and certified on or before December 31, 2020)
  - BUT: no longer paid at uncapped cost per visit. Instead, paid at greater of 2020 cost per visit updated by the Medicare Economic Index or the increased UPLs

Rethinking RHC Strategy

- Strategy was to make RHC provider-based to <50 bed hospital or CAH (though non-CAH ideal)
- Medicare payment difference between uncapped cost per visit was almost always higher than OPPS payment for non-RHC PB site
- CAA changes the analysis
- May still be better but now compare OPPS payment to RHC UPL trended forward
- No financial advantage to making provider-based to <50 bed hospital or CAH (still advantage if need exception to 35-mile requirement)

Rethinking RHC Strategy

- Example:
- 5-Hospital System
  - 2 Urban PPS: Both DSH and Tier 1 340B, Rurban for RRC and better reclass
  - 3 CAHs – Tier 2 340B, Hospital-based RHCs
  - Converted most ambulatory sites to provider-based 10+ years ago
  - 4 years ago, got as many sites PB'd RHC status to CAHs as possible
- New Thinking:
  - RHCs grandfathered paid 2020 cost/visit indexed forward
  - Exception to 35-mile requirement because both PPS are DSH
  - If new higher UPL close to or higher than 2020 cost/visit **trended forward**, transfer RHCs via CHOW to PPS Hospitals
    - Stops cost dilution away from CAHs
    - Can get Tier 1 340B status

PB'd RHC In-Your-Face Example

- Region 8 - Necessary Provider CAH #1
  - Acquired FS'g RHC in town 25 miles away
  - Across the street (<600 feet) from unaffiliated CAH #2 in that town
- CAH #1 wanted to:
  - Convert RHC from FS'g to PB'd
  - Add non-RHC services to be billed under CAH #1 CCN – PT, Imaging, Lab
- Region 8 Approved
  - Does not trigger CAH off-campus location test
  - Addition of non-RHC services billed as CAH O/P okay too

PB'd RHC On Steroids (and in-your face)

- Region 5 CAH – Necessary Provider
- Opened PB'd RHC in town 20 miles away and 1 mile from PPS Hospital, services to include:
  - Medical Oncology and Infusion
  - Imaging to include CT
  - PT/OT/ST
  - Maybe Rad Onc (Lin Acc) down the road….
- Region 5 Approved – No Impact on CAH status
- Must watch RHC "primarily engaged" test
  - >50% services are RHC services – physician/APP visits

RURAL EMERGENCY HOSPITALS

New Rural Emergency Hospital Designation

- New REH designation created by Consolidated Appropriations Act, 2021
- Goal is to maintain access to emergency care services in rural areas
- Eligible hospitals
  - CAHs or Rural PPS Hospitals with 50 or fewer beds
  - **In existence as of 12/27/20** (not available for closed or new hospitals)
- Services
  - No inpatient services
  - Average patient length under 24 hours
  - Emergency (CAH equivalent standards) and observation services
  - Other medical and health services on outpatient basis as specified by HHS
- Must meet other requirements: state law, staffing, transfer agreement with Level I or II trauma center

New Rural Emergency Hospital Designation

- Does it make sense? TBD
- Payment and 340B
  - OPPS: 105% of APC rate
  - Monthly facility payment (based on average CAH benefit in 2019 over PPS)
  - SNF: PPS rates but no cost-based swing bed reimbursement
  - MPFS: no Method II?
  - RHC services: maintain grandfather status?
  - No 340B eligibility?
- Implementation
  - Designation effective January 1, 2023
  - Lot of details need to be filled in via rule-making

For more information on these topics visit hallrender.com.

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