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Reimbursement Models of the Future – A Look at Proposed Models

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Introduction – CAH reimbursement

- What is going to happen with CAH reimbursement? Will it change? How will it change? We will look at proposed alternative reimbursement models for rural facilities and how they might impact your facility and community. If these models come into play, what strategy/solution is best for your community? We will discuss the benefits of these proposed models along with the unforeseen challenges they might create.

CAH reimbursement – Topics for discussion

- Historical perspective
- Proposed models
  - Theory
  - Pros and cons
  - Potential strategies
- Conclusions

Historical Perspective

- Balanced Budget Act (BBA) of 1997
  - Create the CAH program

- Balanced Budget Refinement Act (BBRA) of 1999
  - Corrected **unanticipated** adverse payment and regulatory consequences
  - Replaced 96 hour length of stay limitation with an annual average 96 hour limitation
  - Added Method II billing option
  - Eliminated Lab coinsurance for Medicare outpatients
  - Allowed for-profit hospitals to participate in the program

Historical Perspective

- Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
  - Provided for cost based reimbursement for Swing Bed SNF services
  - Allowed for cost reimbursement for offsite emergency room on-call physicians
  - Option for cost based reimbursement for certain ambulance services
- Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003
  - Expands on-call emergency room costs to include mid-levels (**unanticipated consequence**)
  - Reimbursement at 101% of cost
  - Eliminates reimbursement to require all physicians participate in Method II (**unanticipated consequence**)
  - Allows for distinct part units
  - Revises bed limitation
  - Eliminates ability for new CAHs to be certified a necessary providers versus meeting mileage requirements

Historical Perspective

- The Medicare Improvements to the Patients and Providers Act (MIPPA) of 2008
  - Allows for 101% cost reimbursement for Medicare beneficiaries without regard to where the specimen was collected

- American Recovery and Reinvestment Act
  - Included the creation of IT grants and loans program for CAHs to help investment in new technologies

- Affordable Care Act
  - Allowed CAHs to participate in the 340B program communities

Historical Perspective

- OIG Report – August 2013
  - "Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Re-enroll in Medicare"
- OIG Report – October 2014
  - "Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals"
- OIG Report – March 2015
  - "Medicare Could Have Saved Billions at Critical Access Hospitals if Swing Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates"

Historical Perspective

- Critical Access Hospitals are closing
  - 80 rural hospitals have closed since 2010
  - 673 more have been identified as vulnerable to closure
- Causes of closure
  - Declining populations in certain markets
  - Workforce shortages
    - Practitioners
    - Staff
  - Lack of Medicaid expansion
  - Other
- These challenges and changes have led to the proposal of new rural models

Context of Discussion

- Proposal
- Concerns
- Opportunities
- Call to action
  - Need to avoid unanticipated consequences

Proposed Models

- MedPAC – January 2016
  - Model 1: Emergency Department
  - Model 2: Clinic with Ambulance

Proposed Models

- Emergency Department
  - 24/7 emergency department
  - Reimbursement methodology
    - Fixed grant for standby costs
    - Hospital outpatient PPS
  - No inpatient (acute) services
  - Swing Bed SNF services reimbursed based on PPS rates
  - CAH or PPS hospital could elect this reimbursement model

Proposed Models

- Emergency Department – Concerns
  - Grant size – adequate to cover standby and fixed costs
    - Emergency call cost can easily exceed $1 million per year
    - Ancillary availability costs – standby
    - Lower ancillary volumes to cover fixed costs
  - Impact on providers with newer facilities and debt load
    - Model would seem to favor providers with older facilities
  - Will there be limitations?
    - Therapies
    - Surgical procedures

Proposed Models

- Emergency Department – Concerns
  - How will clinic services be reimbursed?
    - Rural health clinics
      - Cost without limit?
    - Provider based clinics
      - OPPS?
  - Impact on ability to recruit providers into this model
    - No inpatients
    - Limited ancillaries
    - Limited colleagues
  - Would Medicare consider this a qualifying destination for ambulance services?
    - Hospital
    - Critical Access Hospital
    - Skilled Nursing Facility
    - Beneficiary's home
    - Dialysis facility for ESRD patient who requires dialysis

Proposed Models

- Emergency Department – Concerns
  - How will commercial payors view this model?
    - Institutional versus professional reimbursement fee schedules
    - Ambulance coverage?
  - How will this model promote population health?
    - Concern if no primary care access
      - Potentially limits access to poor and elderly for wellness services
      - Long term negative impact on quality and total cost of care

Proposed Models

- Emergency Department – Community
  - How will community accept this model?
    - Reduction in staffing
      - Schools
      - Infrastructure
    - Reduction in services
    - Increased out migration?
    - Impact on employers and staff
      - Ability to recruit staff
      - Staff time away from work to access needed services

Proposed Models

- Emergency Department – Opportunities
  - Swing Bed PPS and Hospital OPPS reimbursement may resolve some issues critical access hospitals encounter
    - ACO impact
    - Bundled payment impact
  - Preserve access for smaller facilities that have not committed to large projects with outstanding debt

Proposed Models

- Emergency Department – Call to Action
  - Clarification of size and methodology for grants
  - Coverage of ambulance services
  - Limitation of services
  - Impact on RHC reimbursement
  - Impact on recently updated facilities
  - Incentives to attract providers

Proposed Models

- Clinic with ambulance
  - 8 or 12 hour clinic days
  - 24/7 ambulance
  - Reimbursement methodology
    - Fixed grant for ambulance standby capacity and uncompensated care costs
    - PPS rates for clinic services (example – FQHC Rate)

Proposed Models

- Clinic with ambulance – Concerns
  - Grant size – adequate to cover standby and fixed costs
    - Ambulance call cost can be significant in comparison to fee schedule
    - Ancillary availability costs
    - Lower ancillary volumes to cover fixed costs
  - Ancillary reimbursement
  - Access to care after normal clinic hours
  - Impact on providers with newer facilities and debt load
  - Impact on ability to recruit providers into this model

Proposed Models

- Clinic with ambulance – Concerns
  - Would Medicare consider this a qualifying destination for ambulance services?
    - Hospital
    - Critical Access Hospital
    - Skilled Nursing Facility
    - Beneficiary's home
    - Dialysis facility for ESRD patient who requires dialysis
  - How will commercial payors view this model?
    - Ambulance?

Proposed Models

- Clinic with ambulance – Community
  - How will community accept this model?
    - Reduction in staffing
      - Schools
      - Infrastructure
    - Reduction in services
    - Increased out migration?
    - Impact on employers and staff
      - Ability to recruit staff
      - Staff time away from work to access needed services

Proposed Models

- Clinic with ambulance – Opportunities
  - Preserve access for smaller facilities that have not committed to large projects with outstanding debt
  - May reduce the amount of on-call time for local providers

Proposed Models

- Clinic with ambulance – Call to Action
  - Clarification of size and methodology for grants
  - Coverage of ambulance services
  - Services after clinic hours
  - Reimbursement for ancillary services
  - Impact on recently updated facilities
  - Incentives to attract providers

Proposed Models – Rural Emergency Hospital

- Senate 1130 – 115th Congress
  - Introduced May 16, 2017
  - Sponsored by Sen. Chuck Grassley (R-IA)
  - Rural Emergency Hospital
    - 24/7 emergency room and observation
      - Less than 24 hour average
      - Less than 1 midnight
    - No inpatient beds
    - Designation as a rural emergency hospital (REH)
  - Reimbursement methodology
    - 110% of reasonable cost
    - Includes telehealth and ambulance
      - No mileage requirement on ambulance noted in Senate Bill
      - Appears to address coverage of ambulance from REH to CAH or PPS hospital – silent on coverage to REH

Proposed Models

- Senate 1130 – Concerns
  - Impact on providers with newer facilities and debt load
  - Telemedicine reimbursement – only for ER services
  - Are on-call emergency room provider costs reimbursed?
  - How will clinic services be reimbursed?
    - Can they have clinic?
    - Rural health clinics
      - Cost without limit?
    - Provider based clinics
      - ??

Proposed Models

- Senate 1130 – Concerns
  - Ambulance coverage to REH?
  - Impact on ability to recruit providers into this model
  - How will commercial payors view this model?
    - Ambulance?

Proposed Models

- Senate 1130 – Community
  - Access to regular clinic services
  - How will community accept this model?
    - Reduction in staffing
      - Schools
      - Infrastructure
    - Reduction in services
    - Increased out migration?

Proposed Models

- Senate 1130 – Opportunities
  - 110% reasonable cost reimbursement could be significant improvement
  - Improve access to telehealth services?
  - Preserve access for smaller facilities that have not committed to large projects with outstanding debt

Proposed Models

- Senate 1130 – Call to Action
  - Coverage and reimbursement for ambulance transportation to REH
  - Telehealth reimbursement for non-emergency situations
  - Allowability of emergency room provider costs
    - Physician and mid-levels
    - Onsite and offsite
  - Impact on RHC reimbursement

Proposed Models – Save Rural Hospitals Act

- House of Representatives 2957 – 115th Congress
  - "Save Rural Hospitals Act"
  - Introduced June 20, 2017
  - Sponsored by Rep. Sam Graves (R-MO)
  - Miscellaneous
    - Eliminate Medicare sequestration for rural hospitals, SCHs and MDHs
    - Reverse cuts to reimbursement of bad debt for CAH and rural hospitals
    - Extend payment level for low volume hospitals and Medicare dependent hospitals
    - Delay meaningful use penalties for rural hospitals
    - Eliminate rural DSH reductions
    - Make increased Medicare payments to rural ground ambulances permanent
    - Extend Medicaid primary care payments
    - Equalizing beneficiary copays in CAHs
    - Eliminate 96 hour physician certification requirement in CAHs
    - Rebasing of supervision requirements
    - Reforming practices of Recovery Audit Contractors under Medicare

Proposed Models – Save Rural Hospitals Act

- House of Representatives 2957 – 115th Congress
  - Community Outpatient Hospital
    - 24/7 Emergency Room and Observation services
    - Does not provide care over 2 or more consecutive nights
    - No inpatient beds
    - Trauma resource requirements
    - Services
      - Community outpatient hospital
      - Rural health clinic
      - Federally qualified health center (or look-alike)
    - Payment methodology
      - 105% of reasonable costs
      - Telehealth services included as reasonable costs

Proposed Models – Save Rural Hospitals Act

- House of Representatives 2957 – Concerns
  - Impact on providers with newer facilities and debt load
  - Are on-call emergency room provider costs reimbursed?
  - Will there be limitations on services that can be provided?
    - Therapies?
    - Surgical Procedures?
  - Are RHCs and FQHCs included in 105%?
  - Ambulance coverage to Community Outpatient Hospital
  - Impact on ability to recruit providers into this model
  - How will commercial payors view this model?
    - Ambulance…

Proposed Models

- House of Representatives 2957 – Opportunities
  - 105% reasonable cost reimbursement could be significant improvement
    - Especially if RHC and FQHC included
  - Improve access to telehealth services
  - Preserve access for smaller facilities that have not committed to large projects with outstanding debt

Proposed Models

- House of Representatives 2957 – Community
  - How will community accept this model?
    - Reduction in staffing
      - Schools
      - Infrastructure
    - Reduction in services
    - Increased out migration due to loss of inpatient services?
      - Appears to not be as significant as other models

Proposed Models

- House of Representatives 2957 – Call to Action
  - Any limitations on outpatient ancillary services
  - Coverage and reimbursement for ambulance services by Community Outpatient Hospital
  - Allowability of emergency room provider costs
    - Physician and mid-levels
    - Onsite and offsite
  - Impact on RHC and FQHC reimbursement

Proposed Models - Conclusions

- The proposed models do not currently eliminate CAH status
  - Partially or completely
- There are consistencies in the models
  - Outpatient
  - Emergency Room
  - Ambulance
  - Telehealth

Is There Support for Rural Health Care in Congress?

- Support for rural health care was very strong from the mid-1990s' until the last several years
  - Critical Access Hospitals
  - Sole Community Hospitals
  - Medicare Dependent Hospitals
  - Low Volume Hospitals

- Support seemed to have dwindled in the recent years
  - Both parties

Is There Support for Rural Health Care in Congress?

- Currently appears to be bipartisan interest in ensuring there is access to health care in the rural setting
  - Congressional leaders appear to be reaching out to various groups for input

Conclusions

- Potential strategies for those that may need to consider future models
  - Gain a strong understanding of what your community needs from you
    - Understand your community health needs assessment
    - How do you fit these needs in the community?
    - Continually engage in discussions with employers about the changing face of health care
    - Focus on primary care and sustainable outpatient services
  - Continue to monitor long term commitments to brick and mortar
  - Monitor current and new proposed models
- Be an active voice

Questions?

This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general informational purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.

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Thank You!

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