CASCADE MEDICAL CENTER

Remain a Critical Access Hospital (CAH) or Convert to a Rural Emergency Hospital (REH)

CMC Leadership begin evaluating the pros and cons of becoming a Rural Emergency Hospital in 2022. In August 2023, CMC leadership began working with the Rural Health Redesign Center and its partners, under a Technical Assistance Grant from HRSA, to assess the ramifications and quantify the financial impact of CMC converting to a REH.

Pros and Cons of Converting from CAH to REH

Pros

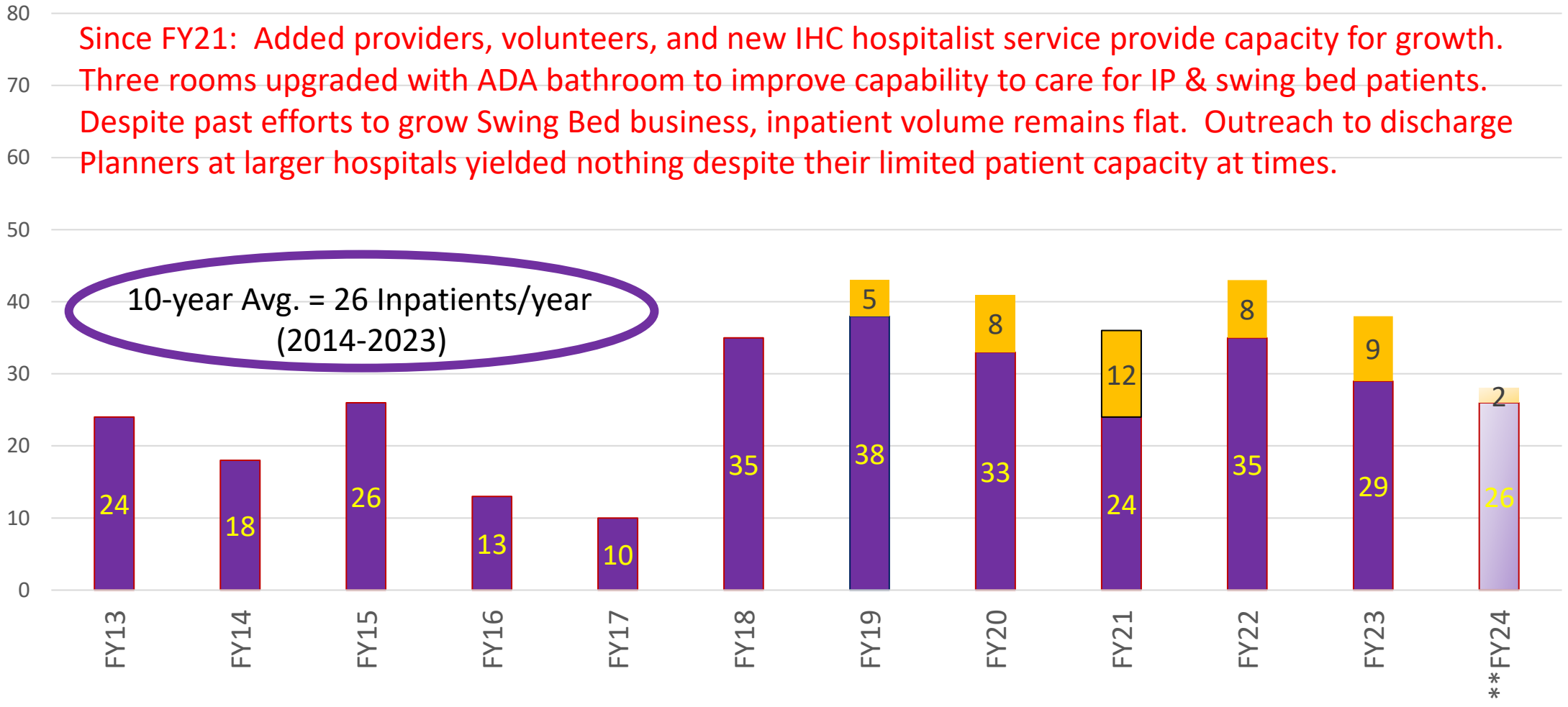
- Estimated **net** revenue (and **net** income) increase of $500k to $900k annually.
- Use additional funds for:
  - Facilities such as ER modernization, PT expansion, Clinic expansion.
  - Quality Improvement initiatives
  - Upgrades to equipment and IT systems
  - New programs and services
- Reduce CMC liability profile of caring for high fall risk patients longer while simultaneously caring for ER patients with the same staff.
- Better alignment of license with what CMC actually does.
- Ability to better focus nurse and provider education on Emergency Medicine where we see 50x more patients than Inpatient medicine.
- Some reduction in costs, $30,000/year or more.

Cons

- Public perception of CMC may change
- Loss of Inpatient & Swing services may require us to transfer some patients to McCall or Boise (estimate ~ 1 patient per month)
- Patient surges may make it harder to transfer patients to Boise due to their high census (same as today). However, in those cases we would be allowed to retain and care for the patient as long as needed.
- Unknown availability of ground transport to transfer patients (same as today)
- Unknown long-term financial risk of REH – no one knows what health care legislation will occur for REH or CAH over the next 5-30 years.

Cascade Inpatient & Swing Volumes by Fiscal Year

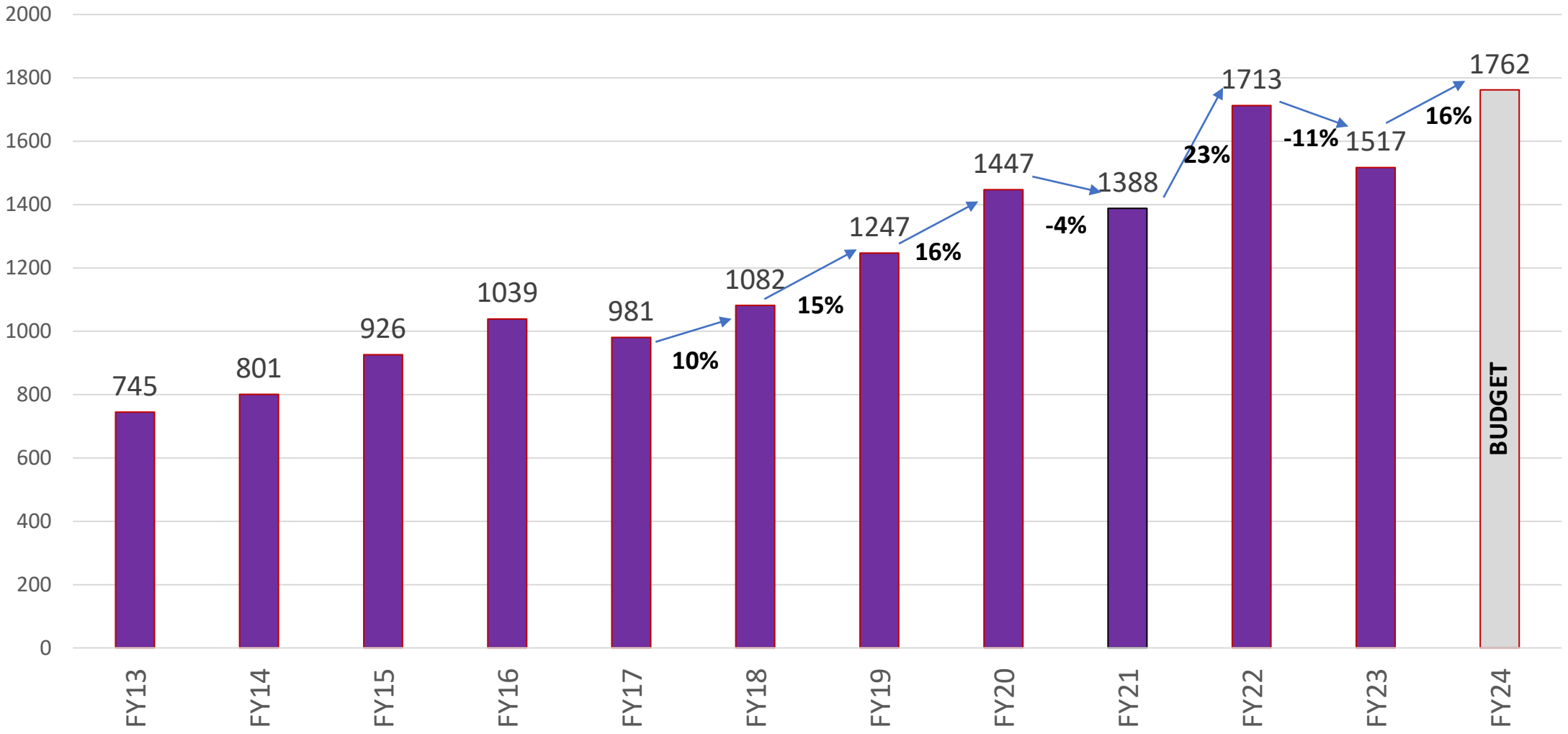
Since FY21: Added providers, volunteers, and new IHC hospitalist service provide capacity for growth. Three rooms upgraded with ADA bathroom to improve capability to care for IP & swing bed patients. Despite past efforts to grow Swing Bed business, inpatient volume remains flat. Outreach to discharge Planners at larger hospitals yielded nothing despite their limited patient capacity at times.



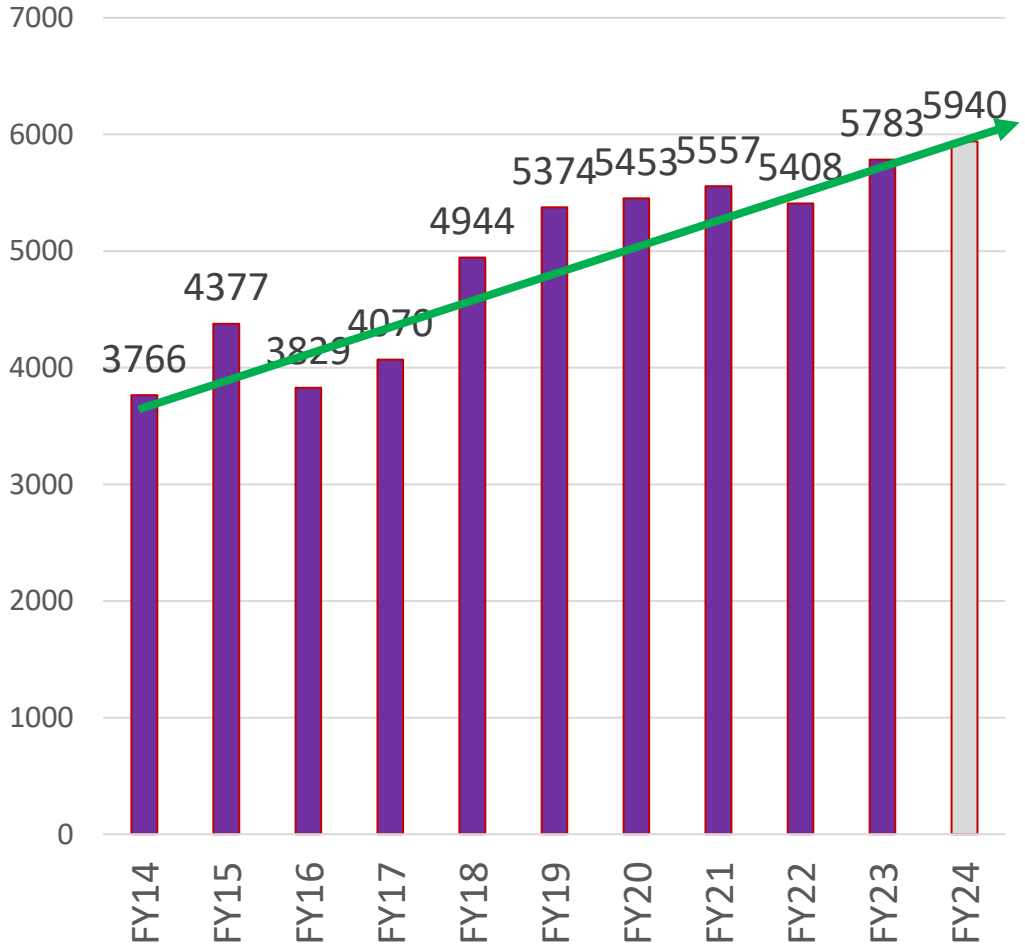
**FY24 Oct 1 - March 31 = 13 IP, 1 Swing. Straight line annualization projects to 26 IPs and 2 Swings for the year.

"Swing" patient is one who starts in Inpatient status and then stays longer as a Skilled Nursing Care patient.

ER Volumes by Fiscal Year

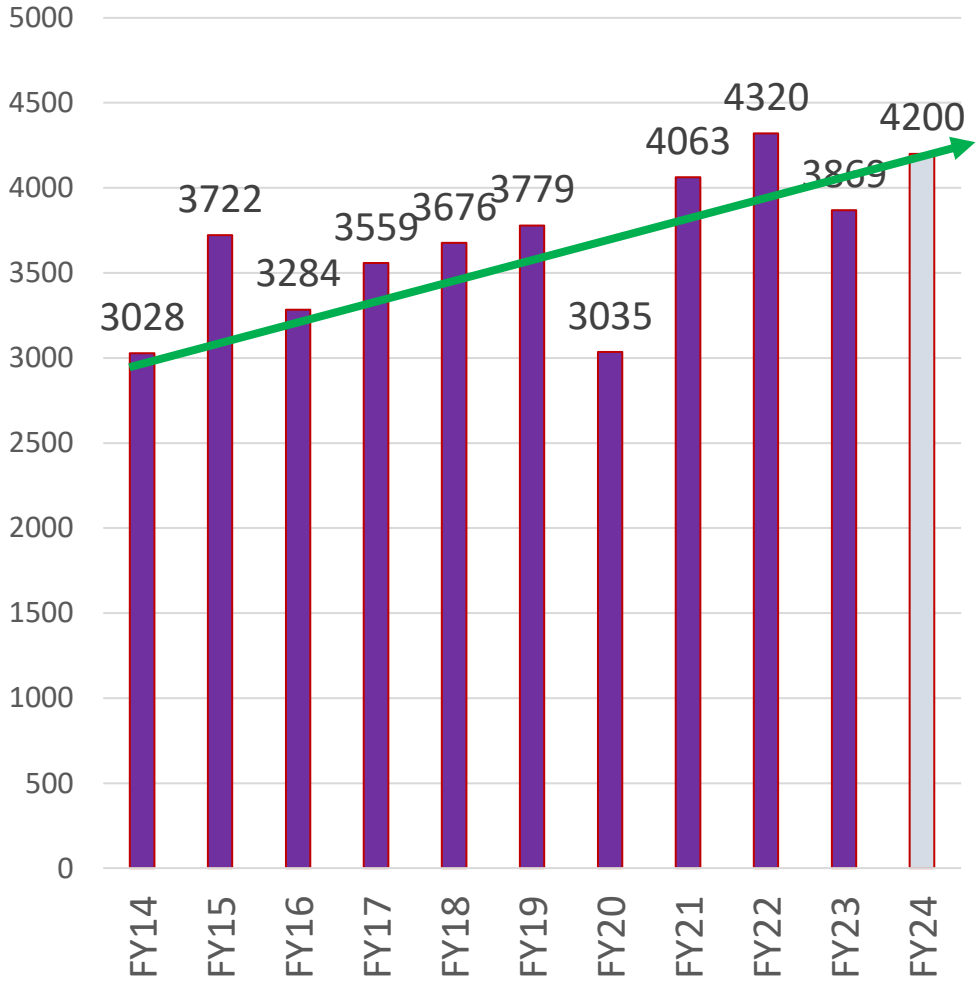


Clinic Visits by Fiscal Year



FY24 Assumptions: Added providers drive new Capacity. Donnelly Clinic.

PT Volumes by Fiscal Year



FY24 Assumptions: No more physical capacity. Volume is volatile. Staff up and market service. Offer at-home PT

Community Impact of Conversion

CASCADE MEDICAL CENTER

- CMC's Medical Director and CNO completed a retrospective review of all Inpatient and SwingBed (longer stay skilled nursing care) admissions for FY22 and FY23 to determine the placement if CMC had been a REH at that time.
- All 65 Inpatient Cases, consisting of 54 unique patients, over the 2 year period were examined.
- Of the 65 admitted inpatients over 2 years, if CMC were REH:
  - 31 would still have been cared for at CMC, in OBSERVATION status, and NOT transferred. The 31 patients had an Average Stay of 1.5 days.
  - 34 would have been transferred to another facility. Of those 34:
    - 6 were transferred anyway to a higher level of care
    - 6 were transferred anyway to a nursing home
    - 22 patients cared for here as inpatients/swing and then were discharged to home would have been transferred if we were REH (11 per year)

Cascade REH FAQs

- Can CMC switch back to CAH?
  - Most likely. CMC would have to reapply. We likely will lose grandfathered CAH status, but currently qualify under new guidelines because SH55 is only 1 lane each direction.
  - CMC would be required to meet modern facility requirements (standards in place at the time of application to convert back to CAH)
- Can we keep patients longer than 24 hours?
  - Yes, in Observation status. We simply can't exceed 24 hours as the AVERAGE Length of Stay for all ER patients.
- Can we start a Nursing Home?
  - Yes, within building or in a separate building is allowed.
- Can we start new Outpatient services?
  - Yes, including outpatient surgery, endoscopy, low risk maternity, specialty clinics.
- Will Feds change REH program, revoke status/funding, or add new requirements?
  - Unknown
- Will feds make program more appealing or add new funding?
  - Annual payment indexed to rise each year. Other than that, some program evolution and fine tuning is expected, but nothing known at this time.

CMC Provider & Nursing Input (REH Advantages)

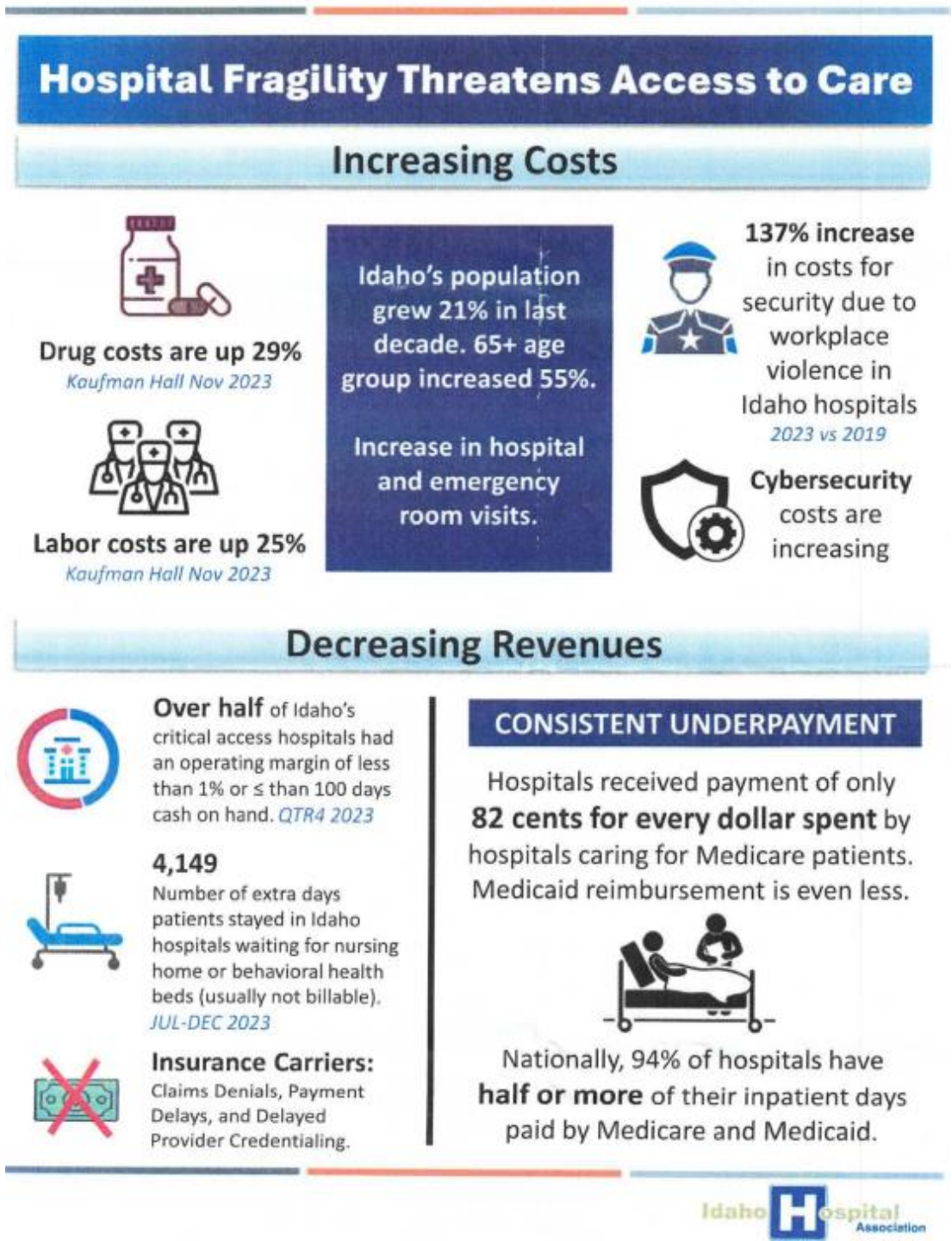
- Federal Support: Transitioning to an REH may unlock access to federal grants and additional funding aimed at strengthening rural healthcare infrastructure.
- Focus on Outpatient and Emergency Services – improving quality by specialization
- Service Adaptation: The shift towards REH status encourages hospitals to focus on outpatient and emergency services, reflecting the changing landscape of healthcare where there's a growing emphasis on outpatient care.
- Cost Efficiency: By concentrating resources on emergency and outpatient services, hospitals can potentially reduce overhead costs associated with inpatient care, which can be financially beneficial given the lower patient volumes in rural settings.
- Community Impact: Transitioning to an REH can help ensure that critical emergency services remain available in rural communities, addressing the essential healthcare needs without the financial strain of maintaining inpatient beds that may not be utilized to their full capacity.
- Sustainability: This model can contribute to the long-term sustainability of healthcare services in rural areas, ensuring that residents have access to necessary care without traveling long distances.
- Reduced Requirements: REHs have different regulatory requirements than CAHs, potentially reducing the burden of compliance and allowing for more flexibility in operations and staffing, which can lead to cost savings.
- Increase RN staffing efficiency by reducing the need to bounce between the ED and IP care.
- Increase the probability of tertiary care centers accepting transfers from the REH due to EMTALA rules (the inability of the REH to admit inpatients).
- Decrease IP insurance denials and the need for Physicians to conduct a Peer to Peer review with insurance company medical directors to justify the inpatient admission.
- Increase patient safety and decrease patient falls due to transferring Long Term Care (LTC) patients to more appropriate care centers with more ancillary staff.
- Create the opportunity to increase ED space by renovating current IP rooms into additional ED space.

Transferring Patients

- CMC already has a transfer agreement in place with Saint Alphonsus, a level II Trauma Center
- St. Luke's – McCall supportive of developing a transfer agreement to help expedite transfers from Cascade to McCall
  - St. Luke's has transfer agreements with other hospitals
  - St. Luke's has 13 general inpatient beds and an ADC of 5 (has the capacity to accept patients from CMC)

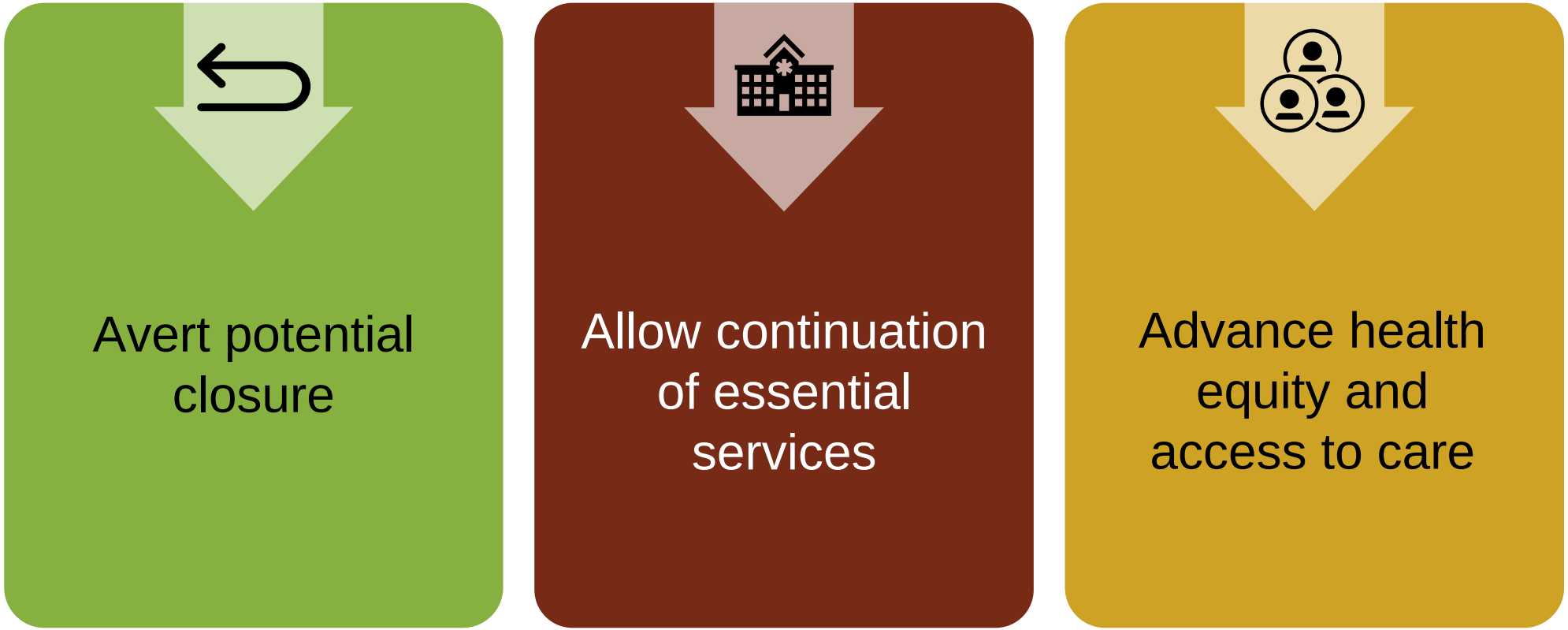
Appendix

Idaho Hospital Association 2024 Infographic illustrating financial Challenges facing Idaho Hospitals



Rural Emergency Hospital (REH)

New Medicare provider type established on December 27, 2020, and designed to:



REH provider type became effective on January 1, 2023

More information: REH provider type rules outlined in the Social Security Act and the Code of Federal Regulations

REH: A Medicare Provider Type

Special payment flexibilities for Medicare FFS only

- Increased payment rates for OPPS, including a monthly facility payment
- Not a temporary CMS model or demonstration
- Medicaid and commercial payments are not directly impacted
- Beginning in 2023, rural hospitals meeting Conditions of Participation may convert to REH

More information: See sections 413.24(f)(4)(ii) and 485.546 in the Code of Federal Regulations

The REH must provide:

- 24/7 emergency and observation services with an annual **average** length of stay of less than 24 hours for all REH services
- Diagnostic lab and radiological services
- A pharmacy drug storage area
- Discharge planning overseen by a qualified professional

REHs do not provide inpatient care but have agreements with other hospitals to transfer patients when needed

More information: Section 485 in the Code of Federal Regulations and 1886(d)(1)(B), 1886(d)(2)(D), and 1886(d)(8)(E) of the Social Security Act

REHs can also offer:

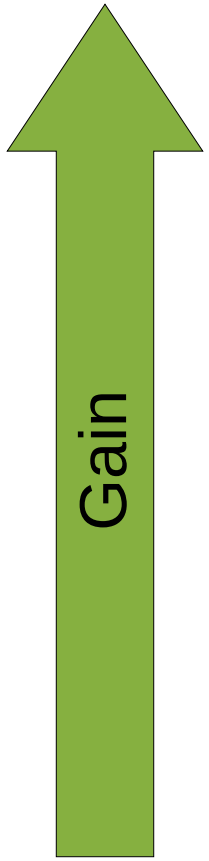
- Telehealth
- Outpatient surgery
- Maternal health
- Low-risk labor and delivery services (supported by the necessary emergency surgical procedures)
- Care through a rural health clinic
- Primary care services
- Ambulatory and transport services
- Post-hospital care (non-inpatient)
- Care through a Skilled Nursing Facility
- Behavioral health (including substance use treatment)
- Routine laboratory services*

*Tests such as complete blood count, basic metabolic panel, liver function test, and other routine laboratory tests

What will change from the community perspective

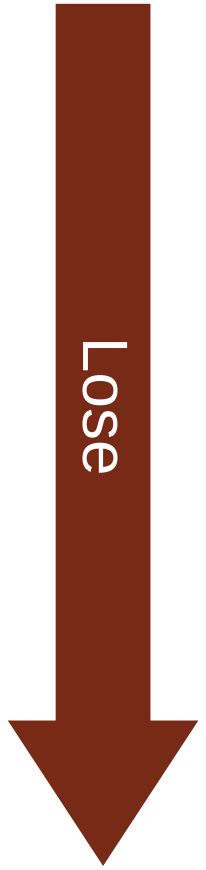
- Could see an increase in higher acuity inpatient transfers to other hospitals
- EMS may increase direct transports to other facilities reducing outpatient revenue
- Higher transfer volumes could pose EMS issues
- Can no longer provide any inpatient care
- Swing-bed patients may need to leave the community
- Other provider organizations may be called on to maintain other distinct part services in the community

Payment Summary:



- REH services: Outpatient Prospective Payment System (OPPS) + 5% for Medicare FFS
- $3.3 million per year in monthly facility payments from CMS – this grows annually

- Close inpatient services (all-payors)
- Close swing bed services/shift to SNF
- Not eligible for 340(B) drug pricing
- Cost-based reimbursement for CAHs



No change: Rural Health Clinic, Physician payment rates, Non-REH services for PPS hospitals (paid under Medicare Physician Fee Schedule). Beneficiary's cost sharing is not impacted by these changes

More information: Section 1833(t)(1)(B)(v) and (t)(21), 603 amendments to section 1833(t), and1834(l) of the Social Security Act and Calculation of Rural Emergency Hospital (REH) Monthly Additional Facility Payment for 2023 (cms.gov)

Benefits of an REH conversion for the Local Community

- Keeps access to basic healthcare services in the local community
- Provides for continued employment and economic stability for the community
- Provides opportunity to focus on population health needs of the local community within the fixed facility payment framework.
- Potential opportunity to partner with other healthcare providers to ensure access to care remains in the community

Conditions of Participation are generally comparable to the current environment

Category	REH Rules	Changes from Current Rules Critical Access Hospital
Emergency services	REH must provide the emergency care necessary to meet the needs of its patients in accordance with acceptable standards of practice	Similar to current rules
Staffing and staff responsibilities	• Governing body to oversee operations • Individual staffed 24/7 with the clinical skills that address emergency medical care • Must always have a physician or other practitioner on-call and available on site within 30 – 60 minutes depending on the location of the hospital (as in Pioneer versus rural)	Similar to current rules, without CAH requirement that a PHYSICIAN be available 24x7
Nursing services	• 24/7 organized nursing service for patient care • Nursing care supervised by a registered nurse • Must meet patient care needs • Considers Conditions for Coverage (CfCs) for ambulatory surgery centers (ASCs)	Similar to current rules without inpatient nursing requirements
Discharge planning	• Discharge to other facility or home with planning process focusing on patient's goals, treatment preferences, and caregiver support	Similar to current rules

*This presentation includes a sample list of REH Conditions of Participation (CoP). See the REH final rule for a complete list of CoPs
More information: See pages 72183 – 72211 and sections 482.23, 482.55, 485.516, 485.618, 485.631, and 491.8 in the Code of Federal Regulations

Conditions of Participation are generally comparable to the current environment

Category	REH Rules	Changes from Current Rules Critical Access Hospital
Laboratory and imaging	• **Laboratory**: Consistent with nationally recognized standards of care for emergency services • **Imaging**: Aligns with standard hospital requirements	Similar to current rules
Quality Assessment and Performance Improvement (QAPI)	• Ongoing QAPI program that includes program and scope, data collection and analysis, program activities for improvement, measures, and reports of staff, residents, and families	Similar to current rules
Infection control and antibiotic stewardship programs	• Must meet patient care needs • Infection control and antibiotic stewardship program performance monitored through QAPI program	Similar to current rules
Pharmacy	• Must have a pharmacy or drug storage area in accordance with accepted professional principles and laws • A registered pharmacist or other qualified individual	Similar to current rules

*This presentation includes a sample list of REH Conditions of Participation (CoP)

More information: See sections 485.518, 485.520, 485.526, and 485.536 in the Code of Federal Regulations

Reporting Requirements

Cost reporting:

- REHs are required to file cost reports
- Cost reporting mirrors current CAH requirements
- For CY 2023, no new reporting or data collection requirements related to REH monthly facility payments

While cost reporting is required, cost-based reimbursement does not apply to REHs

Quality Reporting

- REH must also submit quality measure data to the Secretary each year beginning in 2023
- Reporting requirements are similar to a CAH

More information: See sections 413.24(f)(4)(ii) and 485.546 in the Code of Federal Regulations