RHC MODERNIZATION ACT: FINANCIAL IMPACT ON ILLINOIS

ICAHN
Illinois Critical Access Hospital Network

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AGENDA

ICAHN Overview

Financial Impact

Organizational Approach

ICAHN OVERVIEW

Illinois Critical Access Hospital Network

- Established in 2003, not-for-profit corporation as a statewide network
- 58 Rural Hospital Members (52 critical access/6 small rural)
- Quite simply, the mission of our organization is – and always has been *"to strengthen critical access and small, rural hospitals through collaboration"*
- 18 Peer Groups/45 list serves
- Medicare Flex and SHIP Grants
- Hospital programs and services (coding, EPRN, insurance, GPO, IT)
- Education programs >100 per year
- Voice for critical access hospitals, small rural, and rural health clinics
- Partner with Illinois Hospital association, Illinois Rural Health Association, Illinois Department of Public Health, NRHA and others

ICAHN – RURAL HEALTH CLINICS

- 90% of ICAHN members have rural health clinics – some one and others have 15 rural health clinics
- Provides technical assistance survey preparation, start up, operational and regulatory support
- Advocacy state and federal
- ICAHN manages a rural statewide accountable care organization, Illinois Rural Community Care Organization
  - 24 hospitals
  - 93 provider-based rural health clinics
  - Quality and Performance Measures
  - Clinic Transformation
  - Population Health
  - >350 medical providers

HOSPITALS – VALUE OF RURAL HEALTH CLINICS

- Opportunity to secure medical providers – physicians and advanced practice practitioners
- Serve as primary care access point for healthcare – market share
- Financial support for Medicaid and Medicare patients
- Roadmap for clinic operations
- Open door for behavioral and mental health – social services/SDoH
- Answer for small communities that need local health care (can't afford or find a physician)
- Provider-based provides the financial platform
- Emergency preparedness – value during COVID

IRCCO Annual GPRO TREND	2019	2020	2021
CARE-2: Screening for Future Fall Risk	87.93%	86.13%	90.70%
DM-2: Diabetes HbA1c Poor Control (>9%)	15.20%	21.38%	14.86%
HTN-2: Controlling High Blood Pressure	75.22%	70.10%	76.42%
MH-1: Depression Remission at Twelve Months	17.31%	26.42%	20.83%
PREV-5: Breast Cancer Screening	62.04%	67.06%	67.00%
PREV-6: Colorectal Cancer Screening	63.31%	64.47%	64.50%
PREV-7: Influenza Immunization	72.94%	67.33%	78.53%
PREV-10: Tobacco Use: Screening and Cessation Intervention	75.71%	71.13%	80.00%
PREV-12: Screening for Depression and Follow-Up Plan	68.66%	69.79%	83.01%
PREV-13: Statin Therapy for Prevention and Treatment of CVD	82.61%	83.96%	84.08%

Started at 68% in 2015
Clinic Reporting

2021 GPRO/Quality Results – Best Yet

RURAL HEALTH CLINICS – ROLE OF HOSPITAL

- Provides operational support
- Administrative responsibility (i.e., policies and procedures)
- Financial responsibility
- Participate in accountable care organizations/managed care contracts
- Culture
- Clinical Responsibility (i.e. nursing director oversight)
- Medical staff
- Grant programs
- Training sites now for physicians and advanced practice practitioners

RHC MODERNIZATION ACT – HIT RURAL HOSPITALS HARD

- Hospitals no longer have opportunity to open provider-based clinic
  - Impact on both system and independent hospitals
- Costs stymied MEC (cost of goods up 50%; medication and med/surg supplies 10-20%, staff wages)
- Frozen ability to pull in new medical providers
- Modernization of the RHC needed – policies and procedures/include other services
- Telemedicine support

FINANCIAL IMPACT TO ILLINOIS

ILLINOIS RHC DISTRIBUTION

- Illinois saw a 17% increase in the number of RHCs from 2015 to 2020
  - The following table presents the number of RHCs, by cohort, and the number of cost reports filed for each of those clinics

Payment Methodology	Clinic Type	2015		2016		2017		2018		2019		2020		Variance
		Clinics	Cost Reports	Clinics	Cost Reports	Clinics	Cost Reports	Clinics	Cost Reports	Clinics	Cost Reports	Clinics	Cost Reports	Clinics
Cost Based	PB-RHCs	103	64	116	70	131	81	137	86	148	94	159	96	54%
Upper Payment Limit	Hospital-Based 50+ Beds	7	7	7	7	7	8	6	8	2	8	2	3	-71%
	Independent	103	59	97	67	91	61	90	55	89	54	88	53	-15%
	Totals	213	130	220	144	229	150	233	149	239	156	249	152	17%

How has the RHC program expanded the ability of CAHs to increase services in rural communities?

ILLINOIS AVERAGE COST PER VISIT

- Prior to the Act, PB-RHCs were eligible for an uncapped payment rate while RHCs that are owned and operated by hospitals with 50 beds or greater, as well as Independent RHCs, were subject to a capped per visit payment rate
  - The following tables compare the average cost per visit with the average adjusted cost per visit for the combined IL RHCs
    - **PB-RHCs vs Non-PB-RHCs**

Type	Cost	Visits	Cost / Visit	Adjusted Visits	Adj Cost / Visit	Variance / Visit
PB-RHCs	$ 349,568,583	1,350,817	$ 258.78	1,419,128	$ 246.33	$ (12.46)
Non-PB-RHCs	176,009,939	1,053,600	167.06	1,080,579	162.88	(4.17)
Total:	$ 525,578,522	2,404,417	$ 218.59	2,499,707	$ 210.26	$ (8.33)

Has staffing shortages impacted the ability of RHCs to provide care and meet productivity?

ILLINOIS AVERAGE COST PER VISIT

- The new RHC reimbursement methodology subjects all RHCs to an UPL, regardless of whether those practices are grandfathered as PB-RHCs
  - The following tables present the average annual cost increase for the PB-RHCs and non-PB-RHCs

PB-RHCs

Type	2015	2016	2017	2018	2019	2020
Total Cost NV	$ 184,609,583	$ 222,458,470	$ 261,598,616	$ 295,057,139	$ 329,864,307	$ 349,568,583
Actual Visits	983,623	1,145,326	1,255,059	1,331,824	1,410,253	1,350,817
Total:	$ 187.68	$ 194.23	$ 208.44	$ 221.54	$ 233.90	$ 258.78
Annual Increase:		3.49%	7.31%	6.29%	5.58%	10.64%
Annualized Increase:					6.64%	

Non-PB-RHCs

Type	2015	2016	2017	2018	2019	2020
Total Cost NV	$ 139,498,965	$ 178,163,454	$ 182,164,579	$ 185,659,193	$ 185,385,687	$ 176,009,939
Actual Visits	1,009,312	1,293,434	1,271,907	1,246,326	1,185,802	1,053,600
Total:	$ 138.21	$ 137.74	$ 143.22	$ 148.97	$ 156.34	$ 167.06
Annual Increase:		(0.34%)	3.98%	4.01%	4.95%	6.86%
Annualized Increase:					3.86%	

Are the CAHs seeing a material change (+/-) in the average annual cost increase?

TRENDED RHC IMPACT

- The following table compares the net impact to reimbursements received from Medicare under the prior reimbursement methodology and the new RHC reimbursement methodology
  - Due to the number of PB-RHCs, IL would receive $356K less in reimbursements from Medicare in 2021 and the loss is trended to increase to $14.9M

Type	Medicare Visits	2021 Old	2021 New	2021 Variance	2022 Old	2022 New	2022 Variance	2023 Old	2023 New	2023 Variance	2024 Old	2024 New	2024 Variance
PB-RHCs	338,374	$ 260.85	$ 251.25	$ (3,247,684)	$ 276.50	$ 256.53	$ (6,757,660)	$ 293.09	$ 261.91	$ (10,548,830)	$ 310.68	$ 267.42	$ (14,638,126)
Non-PB-RHCs	248,520	$ 87.52	$ 99.83	$ 3,058,891	$ 89.36	$ 112.04	$ 5,636,104	$ 91.23	$ 123.88	$ 8,113,631	$ 93.15	$ 134.60	$ 10,301,208
Combined		$		(188,794)	$		(1,121,556)	$		(2,435,199)	$		(4,336,918)

Location	Medicare Visits	2025 Old	2025 New	2025 Variance	2026 Old	2026 New	2026 Variance	2027 Old	2027 New	2027 Variance	2028 Old	2028 New	2028 Variance
PB-RHCs	338,374	$ 329.32	$ 273.04	$ (19,045,226)	$ 349.07	$ 278.76	$ (23,791,140)	$ 370.02	$ 284.62	$ (28,897,388)	$ 392.22	$ 290.60	$ (34,386,976)
Non-PB-RHCs	248,520	$ 95.11	$ 145.23	$ 12,455,709	$ 97.10	$ 155.89	$ 14,608,738	$ 99.14	$ 166.60	$ 16,765,037	$ 101.22	$ 176.66	$ 18,748,031
Combined		$		(6,589,518)	$		(9,182,402)	$		(12,132,351)	$		(15,638,945)

How will the projected position impact the ability to maintain services in rural communities?

ORGANIZATIONAL APPROACH

ACTION NOW: IMPROVE PRODUCTIVITY

- Advanced Practice Practitioner and Physician requirements
- Annual well visits…billable
- Patient discharge from the hospital – clinic appointment and bill E and M or Transitional Care Management
- Chronic Care Management…billable
- Community Outreach – build your population/panel base
- Behavioral Health
- Quality Improvement

ADVOCACY NEEDED

- Financial win for the free-standing rural health clinics – critically important (no change)
- RHCs move to report quality and participate population – save payer dollars through better utilization and health
- Collaboration among the rural health players needed
- RHC is the centerpiece for rural community – Access point for primary care
- Rural infrastructure become a concern if RHCs fail
- Action Now

THANK YOU

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