

The New Kid on the Block: The Micro-Hospital Reimbursement Environment

The U.S. healthcare reimbursement environment has been in flux over the last decade, with:

- (1) The repeal of the *sustainable growth rate* (SGR);
- (2) The introduction of several *value-based reimbursement* (VBR) programs;
- (3) The continued implementation of bundled payment programs; and,
- (4) Several other reforms as implemented under landmark legislation such as the *Patient Protection and Affordable Care Act of 2010* (ACA) and the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

Previous issues of *Health Capital Topics* introduced the concept of micro-hospitals, and discussed the current regulatory environment surrounding these novel entities. In the third installment of this five-part series, the impact of the current healthcare reimbursement environment on micro-hospitals will be discussed in further detail.

Micro-hospitals are licensed as general acute care hospitals,¹ and they are reimbursed as such by public and private payors (e.g., under the *inpatient prospective payment system* [IPPS]). However, given their small size and volume of services compared to traditional hospitals, micro-hospitals may have the advantage of remaining exempt from certain reimbursement regulations, e.g., mandatory quality reporting under VBR programs such as the *Merit-based Incentive Program* (MIPS).² This exemption is beneficial for micro-hospitals because they can take advantage of the inpatient payment rates (which are typically higher than outpatient payment rates), but when compared to standard hospitals, micro-hospitals do not have the same financial overhead (core expenses) associated with inpatient costs. However, because of this potential advantage, i.e., having higher reimbursement rates than *ambulatory surgery centers* (ASCs) and other outpatient facilities, as well as less in overhead expenses, federal payors may be more stringent about the “hospital” status of micro-hospitals, and the associated reimbursement. For example, in 2016, a Pennsylvania-based, four-bed ASC-turned-micro-hospital, Wills Eye Hospital, was denied hospital Medicare coverage because it failed to show that its staffing levels and percentage of inpatient procedures

significantly changed following its transition from ASC status.³

The *Centers for Medicare & Medicaid Services*’ (CMS) attention to (and seeming disapproval of) micro-hospitals was further evidenced on September 6, 2017, when CMS released new guidance regarding how Medicare defines a “hospital” for reimbursement purposes.⁴ The guidance states that an entity may only be defined as a hospital if it is “*primarily engaged*” in providing inpatient services.⁵ While no specific definition of the term “*primarily engaged*” was given, CMS indicated that it would consider several factors when determining whether the entity is eligible for Medicare certification, including, but not limited to, the following guidelines for hospitals:

- *Average Daily Census* (ADC) should be ≥ 2 ;
- *Average Length of Stay* (ALOS) should be ≥ 2 ;
- The number of off-campus emergency departments should not be “*unusually large*”;
- The number of inpatient beds in relation to the size of the facility should be *sufficient*;
- The volume of outpatient surgical procedures to inpatient surgical procedures should be *appropriate*;
- The ADC should *not consistently* drop to zero on the weekends;
- Staffing schedules should reflect a 24/7 provision of services; and,
- The facility should be advertised as a “*hospital*.”⁶

In addition, CMS stated that if the facility under review did not have at least two inpatients present on the day of survey, it would not conduct the certification survey, necessitating rescheduling and a preliminary review of the factors listed above.⁷ On December 12, 2017, *The Joint Commission* similarly announced that they will not conduct accreditation surveys at facilities “*without at least two active inpatients*.”⁸

This regulation may be problematic for *independently* functioning micro-hospitals with a small number of inpatient beds and/or with a focus on emergency or surgical procedures with a short ALOS. However, for those micro-hospitals that fall under the same *CMS Certification Number* (CCN) as another hospital or health system, they will be judged as a collective,

allowing the micro-hospitals to take advantage of the longer ADC and ALOS estimates of its larger counterparts in the system to maintain its hospital billing status.⁹ *Emerus*, introduced in Part 1 of this series,¹⁰ has developed most of its current micro-hospitals in partnership with existing healthcare systems,¹¹ which will allow them to continue qualifying as hospitals under this new CMS guidance.

In addition to Medicare’s scrutiny of the status of micro-hospitals, it appears that the *Medicare Payment Advisory Commission* (MedPAC) is also focusing some of its recommendations on micro-hospitals. During its April 5, 2018 public meeting regarding reducing reimbursement for urban free-standing emergency departments,¹² MedPAC briefly discussed the commissioners’ interest in further deliberating “*the micro-hospital issue*” in future meetings.¹³ In particular, the commission expressed concern regarding the appropriate utilization versus cost of

point-of-care facilities used for unscheduled care, e.g., micro-hospitals, urgent care centers, and minute clinics; one commissioner described the conflict related to these entities as “*how to balance the gaming potential versus the legitimate innovation.*”¹⁴

The reimbursement levels set by federal and state governments often act as benchmarks for all healthcare reimbursement, including commercial insurers and third-party payors.¹⁵ As the largest payor of healthcare in the U.S., the federal government drives any potential expectation of future return on investment through stringent provider reimbursement regulation, as well as regulating the very existence of provider entities.¹⁶ As a result, any potential future research and subsequent recommendations by MedPAC and/or CMS with regard to reimbursement for micro-hospitals is likely to have a significant impact on their future financial viability within the healthcare marketplace.

- 1 “Are Micro-Hospitals Part of Your Network Development Strategy?” Navigant, 2016, https://www.navigant.com/-/media/www/site/insights/construction/2017/gcp_microhospitals_tl_final_011317.pdf (Accessed 4/25/18), p. 1.
- 2 Otherwise MIPS-eligible clinicians or groups with “*less than or equal to \$90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries*” are exempt from MIPS reporting. “Quality Payment Program Year 2: Final Rule Overview” Centers for Medicare & Medicaid Services, 2018, <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf> (Accessed 4/24/18), p. 2.
- 3 “Micro Hospital Fails to Meet the Definition of a Hospital for Medicare Enrollment” By David M. Johnston, Bricker & Eckler, December 8, 2016, <http://www.bricker.com/industries-practices/health-care/insights-resources/publications/micro-hospital-fails-to-meet-the-definition-of-a-hospital-for-medicare-enrollment> (Accessed 4/19/18).
- 4 “Advanced Copy – Revisions to State Operations Manual (SOM) Hospital” S&C Memo: 17-44-Hospitals, Centers for Medicare & Medicaid Services, September 6, 2017, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-44-Revised-102717.pdf> (Accessed 4/19/18).
- 5 *Ibid*, p. 1-2.
- 6 *Ibid*, p. 4-5.
- 7 *Ibid*, p. 3.
- 8 “New accreditation approach could curtail growth of micro-hospitals” By Virgil Dickson, Modern Healthcare, December 16, 2017, <http://www.modernhealthcare.com/article/20171216/NEWS/171219920> (Accessed 7/24/18); “Immediate Change to Eligibility Requirements for Deemed Status Hospitals” The Joint Commission, Dec. 12, 2017, https://www.jointcommission.org/assets/1/18/Immediate_Change_to_Eligibility_Requirements_for_Deemed_Status_Hospitals.pdf (Accessed 7/24/18).
- 9 CMS, September 6, 2017, p. 3; “CMS Guidance Impacts Micro Hospitals” Hall, Render, Killian, Heath & Lyman, PC, October 5, 2017, <http://www.hallrender.com/2017/10/05/cms-guidance-impacts-micro-hospitals/> (Accessed 4/19/18).
- 10 For more information, see “The New Kid on the Block: An Introduction to Micro-Hospitals” Health Capital Topics, Vol. 11, No. 5 (May 2018), https://www.healthcapital.com/hcc/newsletter/05_18/HTML/MICRO/convert_microhospitals_hc_topics_5.18.18.php (Accessed 7/24/18).
- 11 “About Us” Emerus, 2018 <http://www.emerus.com/about/> (Accessed 4/24/18).
- 12 For more information, see “MedPAC Votes to Lower Urban Freestanding Emergency Department Payments” Health Capital Topics, Vol. 11, No. 5 (May 2018), https://www.healthcapital.com/hcc/newsletter/05_18/HTML/MEDPAC/convert_medpac_fsed_5.23.18_final.php (Accessed 7/24/18).
- 13 “Public Meeting” Medicare Payment Advisory Commission, April 5, 2018, <http://www.medpac.gov/docs/default-source/default-document-library/april-2018-meeting-transcript.pdf?sfvrsn=0> (Accessed 4/20/18), p. 48.
- 14 *Ibid*, p. 19-20, 48-49.
- 15 “How the Government as a Payer Shapes the Health Care Marketplace” By Tevi D. Tory, American Health Policy Institute, 2015, p. 3-4. http://www.americanhealthpolicy.org/Content/documents/resources/Government_as_Payer_12012015.pdf (Accessed 7/13/16).
- 16 “Obtaining Greater Value From Health Care: The Roles of the U.S. Government” By Stephen C. Schoenbaum, et al., Health Affairs, Vol. 22, No. 6, November/December 2003, p. 184-85.



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