ESH Assessment Project

Assessment of the Market Need & Necessary Conditions for a State Run LTAC Hospital on the Zambarano Campus in Rhode Island

Town Hall Meeting May 4, 2023

Faulkner CONSULTING GROUP

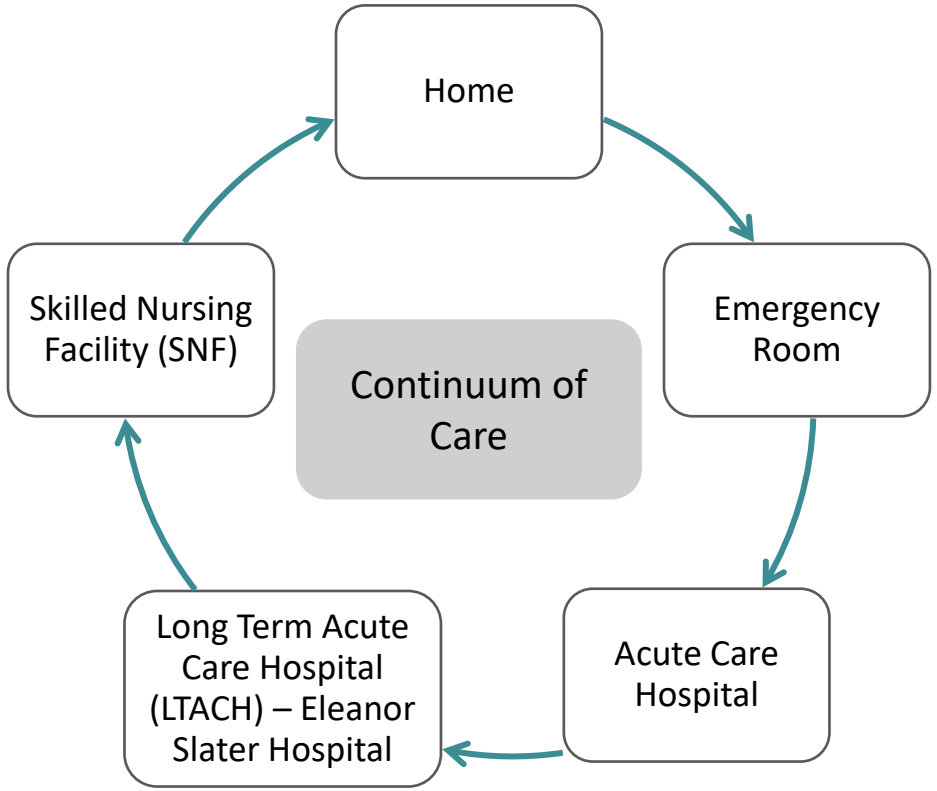
Table of Contents

Background

ESH Vision and Goals

Goal	Return Eleanor Slater Hospital (ESH) to Long Term Acute Care Hospital (LTACH) Functionality in a modern facility
Keeping Care in RI	Provide in-state treatment options for individuals currently being transferred out of state for care
Supporting The Continuum	Provide the next step in the continuum for patients in RI's Intensive Care Units who require prolonged hospital level of care recovery
Creating Options	Provide an alternate care level for ESH patients requiring resource-intensive care, but below hospital level of care
Strategic Planning	Maintain overall IMD mitigation strategy allowing for continued FMAP drawdown

What is a Long-Term Acute Care Hospital?



Definition of a Long-Term Acute Care Hospital (LTACH)

- CMS Certified as a Long-Term Acute Care Hospital
- Patients must meet a hospital level of care (LOC) in order to qualify for admission
- Average length of stay (LOS) is 25 days
- Many patients are transferred directly from intensive or critical care units
- Services provided typically include respiratory therapy, infectious disease management, complex wound care, and traumatic injuries

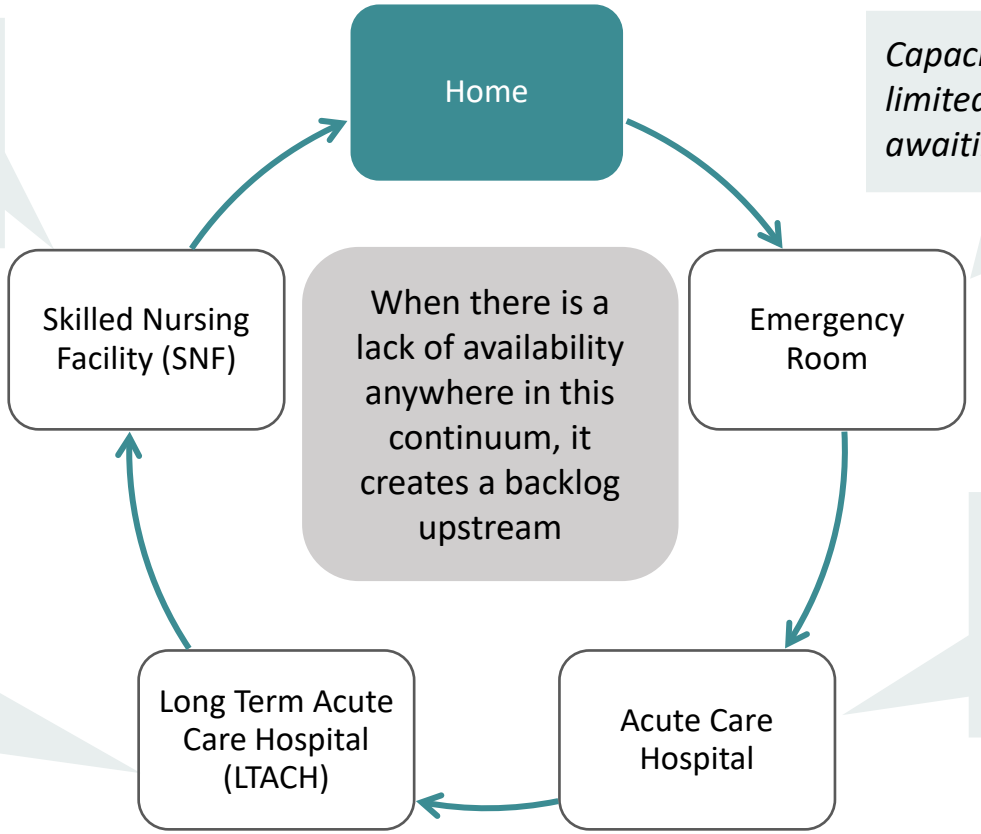
- ***ESH has shifted*** over recent years to meet the State's need for a long-term care facility for our most vulnerable residents with complex medical and behavioral health conditions, resulting in a ***lack of available LTACH beds in RI***.
- Current patients who need LTACH services are either being ***sent out of state*** or are ***remaining in acute care hospitals*** longer than necessary, unnecessarily utilizing a bed that is needed for other patients.

Why does RI need an LTACH Hospital?

Without the availability of LTACH beds in RI, acute care hospitals beds will remain backlogged with patients who could be cared for in an LTACH, in turn impacting ER wait times

RI SNFs have capacity to take patients but are not equipped to care for the level of complexity of some non-hospital LOC patients. This creates a backlog in both acute care and LTACH hospitals.

National and RI: LOS varies between 15 days to life depending on needs of the patient



Capacity to see patients in a timely manner is limited by the number of patients in the ER awaiting hospital beds.

National and RI: Average LOS = from 2.75 hours to ~24 hours or more if waiting for a bed to become available

A lack of community discharge options for complex non-hospital LOC patients creates a backlog, leaving almost no LTACH bed availability. This is a contributing factor to the long LOS in acute care hospitals.

National: Average LOS LTACH = 25 days
ESH: Average LOS = 16 years.

*ERs are backed up due to limited acute care beds caused, in part, by a lack of LTACH beds. Therefore, some patients are remaining here for **hundreds** of days longer than necessary.*

National: Average LOS = 5.5 days.
RI: Average LOS = 5.76 with some patients remaining for 450 days or longer

Hospital Interview Feedback:

We have upwards of 20 patients today who have between 50 – 150-day lengths of stay who may qualify for LTACH services, and this is common. This is not beneficial to any part of the system.

Project Overview: Key Sources

Objective: *Determine the state's current and future need for a state-run Long-Term Acute/Subacute level of care setting(s) for medically complex patients who may be best served by a modernized facility(ies) on the Zambarano campus*

Research Sources

1. RI Specific data

Rhode Island Dept of Health Hospital Discharge Data Set (RIDOH HDDS) and RI Medicaid claims extract

2. National Landscape Review and Benchmarks

CMS certified LTACH beds and NJ CON LTACH bed need estimation approach

3. Regulatory Review

RI SPA, SSA and Code of Federal Regs

Local Subject Matter Expert Interviews

4. Hospital Interviews

CharterCare: Our Lady of Fatima, Roger Williams	• Chief Executive Officer • Systems Chief Operating Officer • Vice President of Quality, Risk Performance Management • Vice President of Operations • Systems Director of Case Management • Roger Williams Director of Case Management • Lady of Fatima Director of Case Management
Lifespan: Rhode Island Hospital, Miriam, Newport Hospital	• Lifespan Chief Executive Officer • Miriam Hospital President
Landmark Medical Center	• Chief Executive Officer • Chief Medical Officer • Director of Case Management and Resource Utilization • Director of Med/Surg Telemetry • Assistant Director of Case Management • Chief Nursing Officer
Care New England: Kent County Hospital	• President and Chief Executive Officer • Chief Medical Officer • Senior Director of Case Management • Pulmonologist and Sleep Physician

Summary of Findings

LTACH Service Models

In order to assess need we first needed to define the LTACH service model – how would this entity be structured? Who would it serve?

Task 3: Model Options

	Viable		Not Viable	
	Option 1	**Option 2**	**Option 3**	**Option 4**
Definition	**Single license hospital** Patient Focus – Medicaid/Duals	**Single license hospital** Patient Focus: All Payor *(incl. Medicare/Commercial)*	**Two Facility Licenses** as an LTACH Plus Skilled Nursing (SNF) / Long-Term Care (LTC) Facility	**Specialized SNF only –** Sunset LTACH License *ONLY IF* *LTACH bed need estimates indicate insufficient need*
Level of Care	• *Hospital Level of Care +* • *Extended Care/Non-Hospital Level of Care*		• *Hospital Level of Care +* • *SNF Level of Care*	*Extended Care/ Non-Hospital Level of Care Only*

	• Single license hospital models should enable ESH to:
	  • Continue to provide both hospital and non-hospital level services
	  • Maintain Medicaid cost-based reimbursement for all services without risk, and
	  • Better manage risk of IMD classification
			• Possible cost-based reimbursement implications
			• High risk of IMD classification
				• No available LTACH services in RI
				• Possible cost-based reimbursement implications
				• High risk of IMD classification for remaining ESH hospital patients
				• Potential UPL implications

Conclusion:
Single License Models Options 1 & 2 appear to be the most viable, warranting further assessment

Assessment Considerations

Successfully attracting Medicare and Commercial Markets would increase referral rates to ESH; However,

(1) this broad market approach adds meaningful risk and requires substantive investments; and

(2) ESH will need to carefully monitor extended care services (ECS) beds and actively develop community alternatives in order to retain sufficient capacity to support hospital LOC patients

Single License Hospital Options

	1	2a	2b
Target Market	Medicaid, Duals	+ Medicare FFS, Self Pay	+ Med Advantage, Commercial
Total ESH Bed Need (Hospital LOC/ECS beds)	**85** (19/66)	**94** (22/72)	**119** (30/89)
General Level of Difficulty	**Low/Medium**	**Medium/High**	**High**

Duals: Medicare & Medicaid Eligible FFS: Fee-For-Service

Necessary Conditions

1	Win Adequate Referrals
2	Develop Capacity in Several Skilled Care Areas
3	Meet IMD† rule
4	Adequate Medicare/Commercial Payment
5	Monitor ECS Capacity & Develop Alternative Community Discharge Options
6	Maintain Medicaid cost-based reimbursement

BHDDH/ESH may consider that model options are not mutually exclusive but rather a progression, focusing on Medicaid and Dually Eligible patients to start (Option 1) while expanding community capacity and branching into Medicare and Commercial markets in parallel (Options 2a & 2b) – i.e., building a facility for model options 2a and 2b but staffing only for the beds required in Option 1.

† Institutions of Mental Disease (IMDs) are health care facilities over 16 beds which have over 50% psychiatric patients and as such are not eligible for federal reimbursement for patients aged 18 to 65.

Key Condition: ECS Planning

Total ESH bed need and continued availability of hospital LOC beds is highly dependent upon the Extended Care Services (ECS) population

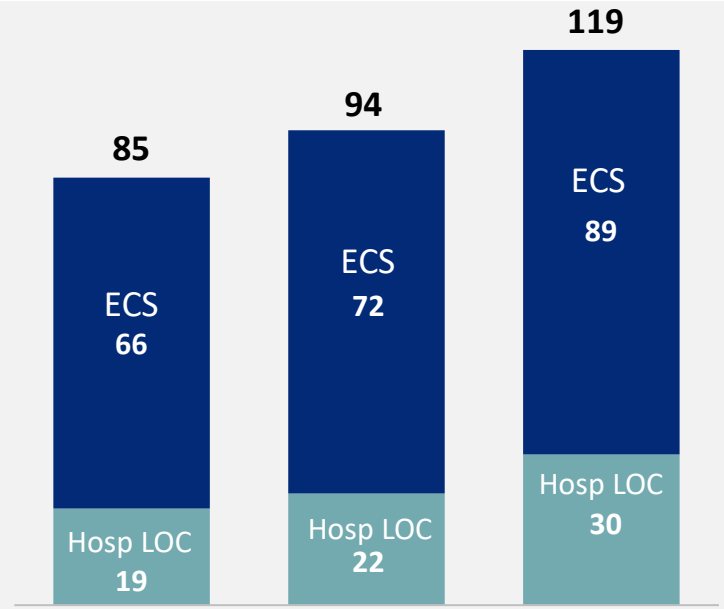
Key Challenges/Risks

- ESH is not permitted to admit patients below hospital LOC
  - Extended care services are limited to existing ESH patients and new hospital LOC LTACH admissions patients who no longer require hospital LOC but for whom there is no appropriate discharge option
- ESH must work with community partners to develop discharge options to maintain Medicare Certification – this capacity development will be essential to:
  - Avoid ECS bed overflow and prevent backups in acute care hospitals
  - Reduce ECS beds required over time and allow ESH to continue to serve its primary purpose of admitting more hospital LOC patients by expanding market share

Hospital Interview Feedback:

Estimate of 5% of LTACH patients requiring ECS is a good goal but may be significantly understated.

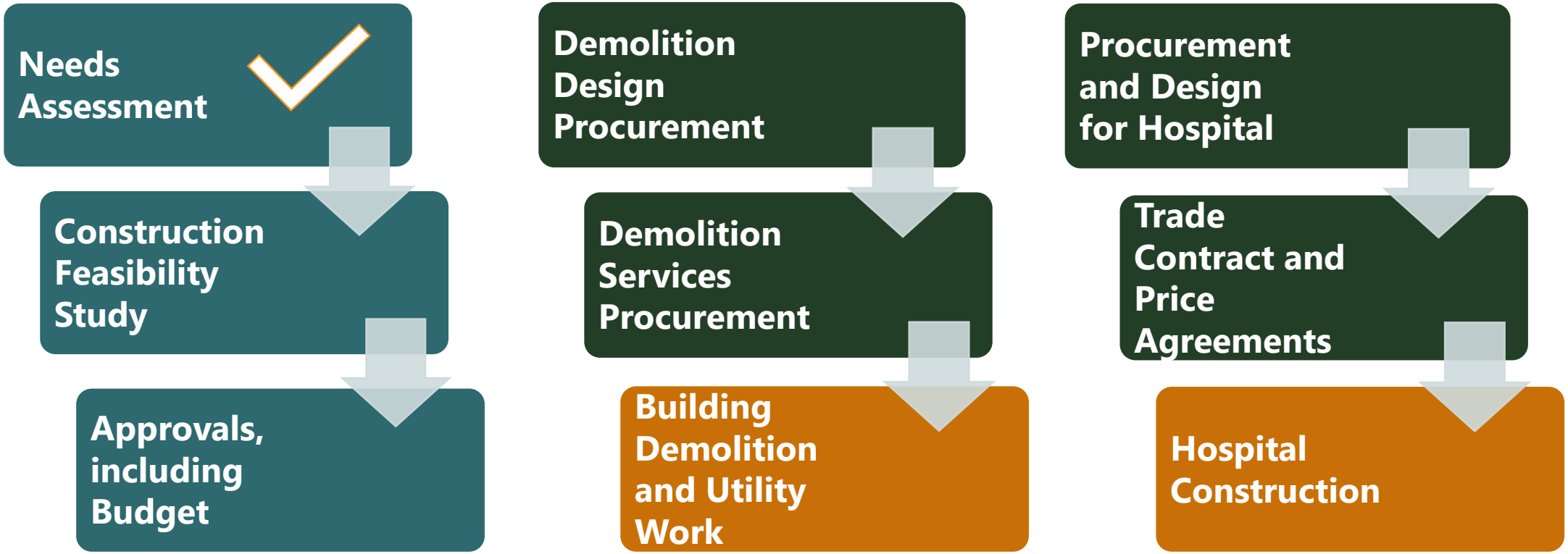
Total Bed Need & ECS Share



ECS % of Total	Facility Beds		
	77%	76%	75%
	ESH Beds (including 78 hosp. LOC beds in Cranston)		
	40%	42%	45%

Faulkner CONSULTING GROUP

CAPITAL PROJECT PROCESS: NEXT STEPS



NOTE: Contracting method for project assumes construction manager at-risk (CMaR). Different delivery method will affect major activities.

Appendix

Needs Assessment

Approach to Estimating ESH Bed Need

An estimate of LTACH bed need in Rhode Island was identified using the four steps outlined below and validated through interviews with local hospitals

Our Approach

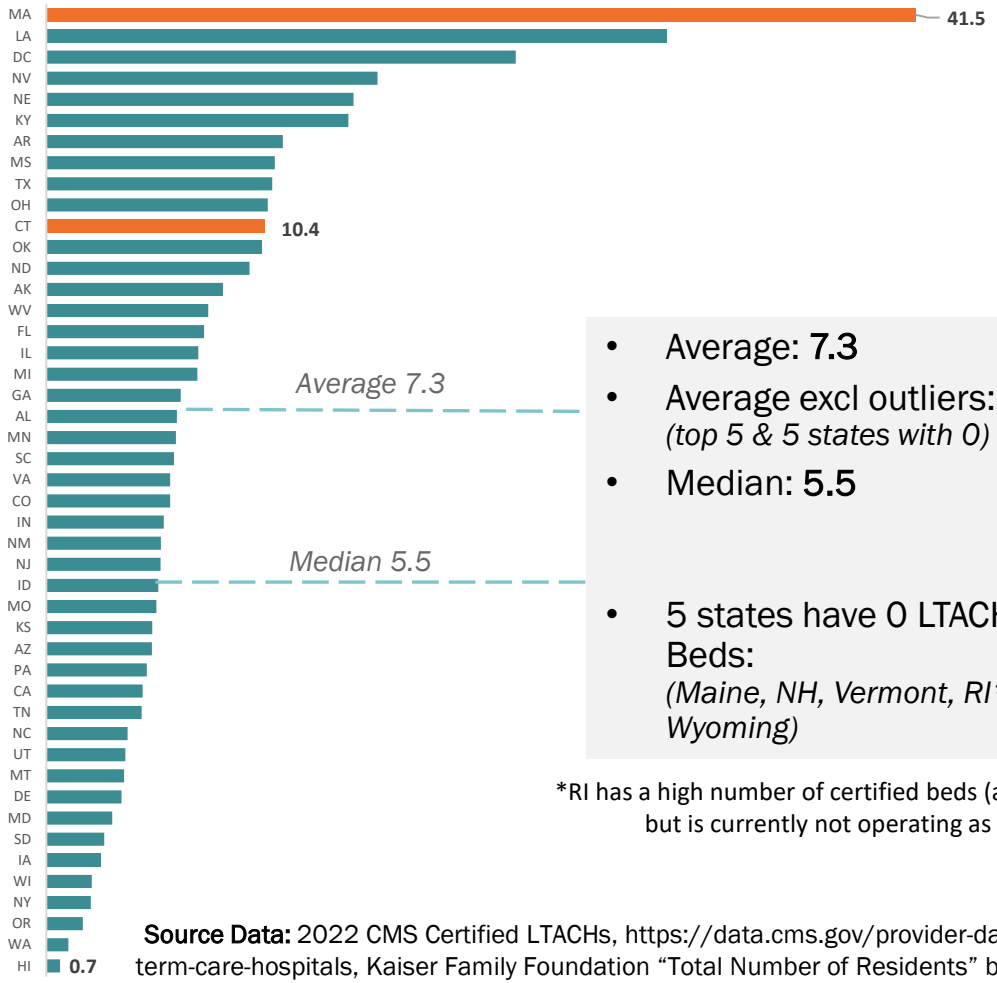
Steps	Description
Step 1: Estimate RI LTACH Admission Candidates	➢ Analyzed RI Hospital Discharge Data Set (HDDS) and a combination of sources to identify actual discharges to LTACHs and 'LTACH-like' patients in RI. ➢ 'LTACH-like' patients are those who meet a set of criteria that would have made them likely candidates for discharge to an LTACH if there had been availability when needed
Step 2: Total RI Hospital LOC Bed Need	➢ Estimates of total RI LTACH admission candidates were then translated into RI LTACH bed need for hospital level of care patients and compared to benchmarks (National and NJ CON method)
Step 3: ESH Specific Hospital LOC Bed Need	➢ Of the universe of potential RI LTACH admissions, an estimated number of patients who might be referred to a future ESH was determined according to mix of payors and diagnoses and then translated into an estimated bed need
Step 4: Incorporate Extended Care Services (ECS)	➢ Patient profiles and considerations were developed for patients who might need extended care through ESH, including existing long-stay patients without alternative discharge options and an estimation of ECS beds needed for a future ESH facility was determined
To Validate: Interviews with RI Short Term Acute Care Hospitals & Hospital Groups	➢ The outcomes of steps 1-4 were shared through interviews conducted with leadership, medical staff, and case managers at Lifespan, CharterCare, Care New England, and Landmark Medical Center. ➢ Hospital interview feedback was used to adjust estimates where appropriate

Total Estimated ESH Bed Need *including both Hospital LOC & Extended Care Services (ECS)*

Comparative National Benchmarks

Annual RI LTACH patients were translated into bed need and validity was assessed *vs.* national benchmarks

Medicare-Certified LTACH Beds Per 100,000 Persons



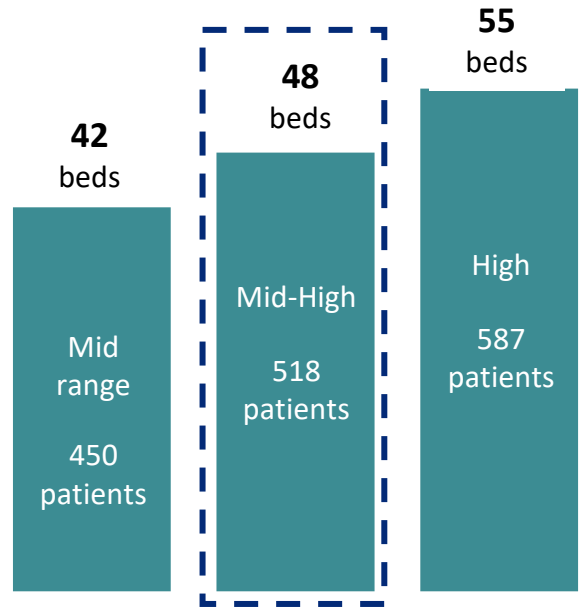
- Average: **7.3**
- Average excl outliers: **6.0**
  (top 5 & 5 states with 0)
- Median: **5.5**
- 5 states have 0 LTACH Beds:
  (Maine, NH, Vermont, RI, Wyoming)*

*RI has a high number of certified beds (all at ESH) but is currently not operating as an LTACH

Source Data: 2022 CMS Certified LTACHs, https://data.cms.gov/provider-data/topics/long-term-care-hospitals, Kaiser Family Foundation "Total Number of Residents" based on ACS 1-Year Estimate https://www.kff.org/other/state-indicator/total-residents

A range of LTACH admission candidates was estimated to be between 450 and 587. Based on hospital interviews, a mid point of 518 admission candidates was selected for bed modeling.

Total Estimated LTACH Bed Need in Rhode Island
LTACH Hospital LOC ONLY (not including ECS)



FCG Estimates of Staffed Beds Needed for RI Residents (80% Occupancy)

Total ESH LTACH Bed Need

Total ESH bed need ranges from 85-119 depending upon the scenario; however, it is estimated that the vast majority of beds will, over time, be filled by Extended Care Services (ECS) patients

Taking the identified hospital LOC bed need & combining with the ECS bed need gives us an estimate of the total number of beds needed at ESH

	Target Market Options		
	Option 1: *Medicaid, Duals, Uninsured*	**Option 2a:** *+ Medicare FFS, Self Pay*	**Option 2b:** *+ Medicare Adv, Commercial*
Potential LTACH Patients & ESH Referral Rates			
Statewide Potential LTACH Patients	518 patients annually		
Medicaid & Dual/Medicare FFS & Self Pay/Med Adv & Commercial Referral Rates	90/0/0%	90/25/0%	90/40/40%
ESH Share of Total LTACH Market	40%	46%	62%
Potential LTACH Patients Admitted to ESH	207 pts	238 pts	322 pts
Estimated Bed Need (Yr. 30 steady state, 80% occupancy)			
Statewide LTACH Bed Need	48 beds needed statewide (LTACH Hospital LOC only)		
ESH LTACH Bed Need (Filled/**80% occupancy**)	15/**19 beds**	18/**22 beds**	24/**30 beds**
ESH Extended Care Beds (Filled/**80% occupancy**)	52/**66 beds**	58/**72 beds**	71/**89 beds**
Total ESH Bed Need *(Hospital LOC + ECS beds)*	**85** *(19/66)*	**94** *(22/72)*	**119** *(30/89)*
General Level of Difficulty	***Low/Medium***	***Medium/High***	***High***

Summary of Key Findings from Hospital Interviews

Hospital interviews confirmed much of the shared analysis and provided additional context that led to refinements of final estimates

Interview Objectives

- Confirm estimate of potential LTACH patients and payors using Hospital Discharge Data
- Understand hospital perceptions of ESH and check referral assumptions
- Provide additional qualitative input on RI's long term care landscape

Key Takeaways:

- **There is a significant unmet need for LTACH services in RI**
  - Hospital leadership, medical staff, and case managers all expressed a **significant need for LTACH services** in Rhode Island
  - In reviewing potential patient estimates, hospitals confirmed the validity of FCGs approach, and the general feedback was that **potential LTACH patient estimates could be understated**.
- **There is also a significant unmet need for long term care services for medically complex patients in RI**
  - Hospitals have patients staying hundreds of days longer than necessary due to a lack of community discharge options
  - Interviewees indicated ESH's future LTACH would encounter the same issues, and initial estimates of 5% of LTACH patients requiring ECS may be significantly understated.
  - ESH will soon fill its beds with long stay ECS patients if additional capacity for long stay complex pts is not developed in nursing homes
- **Payor may not be a significant driver of referrals, but hospital reputation is a factor**
  - There is a lack of available LTACH placement across patients with all insurance types
  - Hospitals did not think that payor mix would be a significant driver for where they would ideally refer patients for LTACH services
  - However, hospitals noted the challenge of translating hospital recommended referrals into member choice and selection of ESH
  - In addition, commercial and Medicare Advantage payors may limit choice to Centers of Excellence (TBD - not yet assessed)
  - BHDDH will need to investigate options regarding rebranding ESH to improve the hospital's reputation and to highlight the LTACH availability

Hospital Interview Feedback:

Our beds are full, we need you.

Are you planning to change the ESH name or rebrand? This will matter to families.

…hugely exciting and helpful…

Necessary Conditions

Summary of Necessary Conditions

Successfully attracting Medicare and Commercial Markets would would increase referral rates to ESH, but adds meaningful risk and requires substantive investments

	Single License Hospital Options		
	Target Market 1: *Medicaid, Duals*	**Target Market 2a:** *+ Medicare FFS, Self Pay*	**Target Market 2b:** *+ Medicare Adv, Commercial*
Total ESH Bed Need *(Hospital LOC + ECS beds)*	**85** *(19/66)*	**94** *(22/72)*	**119** *(30/89)*
General Level of Difficulty	***Low/Medium***	***Medium/High***	***High***

Level of effort to meet each Necessary Condition

	Necessary Condition	Timing	Target Market 1	Target Market 2a	Target Market 2b
1	Win Adequate Referrals	Immediate			
2	Develop Capacity in Several Skilled Care Areas	Immediate			
3	Meet IMD rule	Longer term			
4	Adequate Medicare & Commercial Payment	Medium Term			
5	Monitor ECS Capacity & Develop Alternative Community Discharge Options	Medium Term			
6	Maintain Medicaid Cost Reimbursement	Ongoing			

Importance of Monitoring ECS Capacity & Developing Community Discharge Options

ESH must carefully plan patient outflows by working with community-based organizations to develop/incentivize additional discharge options for complex patients to maintain hospital LOC capacity.

- ESH currently has a population of high complexity patients whose needs remain too resource intensive for Rhode Island nursing homes* and those patients require a longer stay at ESH while awaiting appropriate discharge.
- While building a new facility will help provide additional capacity for new LTACH eligible admissions, even with ESH implementing careful screening to limit patient admissions to those who are expected to improve and be discharged in a timely manner, there is an expectation that the hospital will continue to care for high complexity patients who will require an extended stay.
- Hospital interview feedback identified that the estimated 5% of ESH hospital LOC patient admissions requiring ECS may be too low. Several interviewees indicated that many patients may be difficult for ESH to discharge when they no longer need hospital LOC services.
- To maintain hospital LOC capacity and Medicare certification, ESH must work with community organizations to build discharge options for ECS patients.

Key Risks

- **Limited/No LTACH hospital LOC capacity**
  - A lack of community discharge options for ESH would perpetuate the LTACH gap in Rhode Islands continuum of care, causing backlog in acute care hospitals
- **Losing Medicare Certification**
  - If ESH exceeds 78 ECS patients at any time, the hospital will no longer primarily be providing hospital LOC (across both campuses) which is required to maintain certification
  - If ESH does not prioritize developing alternate community discharge options, as is required to keep ECS patients moving, ESH will face future CMS audit trouble and risk losing its certification and federal match

*Outside of RI, nursing homes have successfully developed the capacity to care for medically complex patients once they no longer require hospital level of care.

Next Steps

Next Steps

Note: Blue Font indicates next steps only required for Target Market 2a/b

	Necessary Conditions	Timing	Next Steps
	Build an Appropriate and Adequate Facilities	Immediate	❑ Build a new facility on the Zambarano campus to replace the aging Beazley building, initially constructed as a tuberculosis sanatorium
1	Win Adequate Referrals	Immediate	❑ Work with hospitals to participate in discharge planning - Continue to develop ESH clinical liaison relationships and referral and admissions protocols to streamline the application/admissions process ❑ Develop intensive and effective rebranding plan (hire a marketing/branding vendor) ❑ Perform initial assessment of Medicare Advantage and Commercial plans interest & requirements
2	Develop Capacity in Several Skilled Care Areas	Immediate	❑ Development of excellence and capacity in several skilled care areas (vent, wounds and other areas) and create and share educational materials for ESH staff and partner hospitals
3	Meet IMD rule	Longer term	❑ Build/enhance tracking tools to regularly monitor IMD status ❑ Begin any necessary preparations required should ESH need to move a psych floor from the Regan building into the new psychiatric hospital due to IMD risk
4	Adequate Medicare & Commercial Payment	Medium Term	❑ Confirm extended care services are permitted by Medicare – pursue as part of rate negotiation for non-hospital level services. ❑ Evaluate estimated Medicare/Commercial hospital LOC reimbursement rates to assess sufficiency of payment. ❑ Conduct a fiscal analysis of GR impacts of each target market – considering anticipated future ESH ongoing costs and total (Medicaid + Medicare) reimbursements depending upon patient mix ❑ Explore negotiations with CMS to pay for ECS using a two-tier payment system on the basis of being a public hospital serving a high-proportion of low-income patients
5	Monitor ECS Capacity & Develop Community Discharge Options	Ongoing	❑ Develop clear admissions criteria and protocols for monitoring ECS capacity ❑ Partner with Medicaid to incentivize additional community-based discharge options for complex, non-hospital LOC patients
6	Maintain Medicaid Cost Reimbursement	Ongoing	❑ Continue to review requirements for maintaining Medicaid Cost Based Reimbursement for continued compliance

Viable LTACH Service Models for ESH

The Single License Model – Options 1 or 2 appear to be the most viable, warranting further assessment

	Key Viability Factors	Option 1 Single License Hosp Patient Mix 1 *(Medicaid/Duals)*	Option 2 Single License Hosp Patient Mix 2 *(Mix 1 + M'care/Comm)*	Option 3 Two Facility Licenses – LTACH Plus SNF/LTC Facility	Option 4 SNF Only – Relinquish LTACH License
1	Would there be adequate LTACH patient referrals to ESH?				
	Adequate LTACH referrals				N/A – No Hospital Services
2	What levels of care would ESH be permitted to provide?				
	Hospital LOC				
	Non-Hospital LOC				
3	What levels of care would ESH be permitted to admit?				
	Hospital LOC				
	Non-Hospital LOC				
4	Would ESH be eligible for cost-based Medicaid reimbursement?				
	Hospital Services				N/A – No Hospital Services
	Non-Hospital Level Services				
5	Would Medicare Reimbursement be adequate for ESH?				
	Hospital Services	N/A – No Medicare Pts			N/A – No Hospital Services
	Non-Hospital Level Services	N/A – No Medicare Pts			
6	Would ESH be at risk of IMD classification?				
	IMD Risk				
7	Would ESH be subject to Upper Payment Limits?				
	Subject to UPL				
	Count of High/Moderate Risk Factors	Viable Models		5	6

Potential Patients: Baseline Exclusion Criteria

Baseline Exclusion Criteria – Applied to all cuts of data	
Total Adult (>18) Discharges Reported	
Discharge Status	"hospice"
	"discontinued care"
	"psych"
	"home" --> exclude for LOS < 20 days
Facilities	Bradley
	Butler
DRGs	880; Acute adjustment reaction and psychosocial dysfunction
	885; Psychoses
	876; O.R. procedures with principal diagnosis of mental illness
	886; Behavioral and developmental disorders
	887; Other mental disorder diagnoses
	881; Depressive neuroses
	882; Neuroses except depressive
	884; Organic disturbances and intellectual disability

Bed Modeling Assumptions

We have modeled ESH bed need over a 30-year period using a low to high range of referral assumptions applied to three scenarios

Assumptions by Scenario	Scenario 1:	Scenario 2a:	Scenario 2b:
Potential LTACH Patients	518	518	518
Medicaid & Dual/ Medicare FFS & Self Pay/ Med Adv & Commercial Referral Rates	90/0/0%	90/25/0%	90/40/40%
Patients Requiring ECS	5.5%	5.2%	4.8%
Applied to All Scenarios			
No. Of Years	30 years		
Start Up	3-year phased ramp up of admissions. First year of full implementation in Year 4		
ECS LOS (1 yr./2 yr./5 yr./Life)	35/35/20/10%		
Existing & Future ECS Patient Attrition Rate	10%		
Target Occupancy Rate	80%		

Applied to All Scenarios	
Hospital LOC Admissions (% Vent vs Non-Vent)	
% Vent	8%
% Non Vent	92%
Hospital LOC Avg LOS (Vent vs Non-Vent)	
Vent Avg LOS	40 days
Non-Vent Avg LOS	26 days
Avg LOS	27 days
Hospital LOC Patients Needing ECS by Payor (%)	
Medicare (MC & FFS)	3.5%
Dual	5.5%
Medicaid (MC & FFS)	5.5%
Commercial	3.5%
Self Pay	3.5%
Other/Unknown	5.5%
Simple Avg	*4.5%*

Details of Bed Need Over Time (Scenario 2a)

- Considering an 80% occupancy rate, a maximum of 22 LTACH hospital LOC beds and a total of 101 facility beds would be required, dropping to 94 total beds over time with attrition of current ESH population

Target Market 2a Assumptions:	
Universe of Potential Patients	518
Medicaid & Dual/Medicare FFS/Med Adv & Commercial Referral Rates	90/25/0%
Annual LTACH Admissions (Fully Implemented)	238

Summary of Bed Occupancy Over 30 Years *80% Occupancy*	Min	Max	Est. Steady State *(Year 30)*
LTACH Hospital LOC Beds Required	4	22	22
Total Facility Beds Required	**80**	**101**	**94**

- **Attrition:** By Year 28, all currently existing ESH patient beds are assumed to be vacant, and attrition of new lifelong extended care patients is underway, therefore Year 30 is likely representative of a steady state of occupancy.
- **Total beds utilized** (all patient types) ranges from 64-81, with a steady state of 75. This includes a steady state of 18 LTACH hospital LOC beds **continuously** utilized (see chart on right)
- **Total Bed Need:** Considering an 80% occupancy rate, 22 LTACH hospital LOC beds would continuously be required, and a maximum of 101 total facility beds, which would drop to 94 over time with attrition of current ESH population

Results: Bed Occupancy Over Time