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The Rural Emergency Hospital: A Clear-Eyed Assessment of the New Model

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Agenda

- An Overview of the REH
- Background on the Committee
- Considerations for Hospitals Thinking of Converting
- Committee Policy Recommendations
- Q&A

An Overview of the Rural Emergency Hospital (REH)

George H Pink PhD
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Need for a new model

- Rural hospital closures
  - 137 closures since 2010
  - 180 closures since 2005
- Declining inpatient utilization
  - In a soon-to-be-released study, we found the average percent of revenue coming from outpatient services increased from 66.5% in 2011 to 74.2% in 2019.
- Access to emergency services
  - JAMA Network Open, November 19, 2021. Association of Rural and Critical Access Hospital Status With Patient Outcomes After Emergency Department Visits Among Medicare Beneficiaries, Margaret Greenwood-Ericksen, MD, MS et al,. http://dx.doi.org/10.1001/jamanetworkopen.2021.34980

Need for a new model – access to emergency care

- **Question:** Do 30-day outcomes differ after rural vs. urban hospital-based ED visits and in the subset of rural hospitals classified as critical access?
- **Findings:** In this cohort study of 473, 152 matched urban and rural Medicare beneficiaries, **risk-adjusted all-cause mortality after rural vs. urban ED visits was similar, particularly for potentially life-threatening conditions.** Critical access hospitals had similar outcomes.
- **Meaning:** These findings underscore the importance of rural and critical access EDs for treatment of life-threatening conditions among Medicare recipients and have important policy implications given the continued increase in rural hospital closures.

Legislative Origin of REH

- The Consolidated Appropriations Act 2021 creates a new facility called a “rural emergency hospital” (REH) that is defined as a facility that provides:
  - emergency department (ED) care
  - observation care
  - outpatient services
  - optional skilled nursing facility (SNF) care in a distinct part unit
- REHs do not provide acute care inpatient services
- Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) will apply
- REH can be an originating telehealth site

REH Eligibility and Application

- *Hospital eligibility to become a REH.*
  - Critical Access Hospitals (CAHs) and rural hospitals with 50 beds or less
- *Application to become a REH*.
  - an action plan for initiating REH services
  - a list of services that will be provided on an outpatient basis
  - information about how the additional facility payment will be used
  - State approval of REH licensure

REH Requirements

- Must not exceed an annual per patient average of 24 hours;
- Must be staffed 24 hours a day, 7 days a week by a physician, nurse practitioner, clinical nurse specialist, or physician assistant;
- Must meet the Medicare licensure requirements and staffing responsibilities of an ED;
- Must have a transfer agreement in place with a level I or II trauma center;
- Must meet conditions of participation applicable to CAH emergency services and hospital EDs;
- Must meet the DPU requirements if REH is a DPU of a SNF.

REH Medicare Payment

Type of payment	Method Used to Calculate Funding
Monthly additional facility payments	Calculated as 1/12th of the excess of (if there is any): the total amount that was paid for Medicare beneficiaries to all CAHs in 2019; minus the estimated total amount that would have been paid for Medicare beneficiaries to all CAHs in 2019 if payment had been made for inpatient hospital, outpatient hospital, and SNF services under the applicable PPS; divided by the total number of CAHs in 2019
Outpatient	Current OPPS X 1.05
Outpatient copayment	Based on current OPPS
SNF DPU	Current SNF PPS
Ambulance	Current ambulance fee schedule
Rural Health Clinic	Same rate as <50 bed hospital (payment limit exception)

REH Quality metrics and evaluation reports

- Beginning in 2023, REHs will be required to submit data for quality measurement.
- Quality measures will be made public and will be posted on the CMS website.
- Reports will be conducted to evaluate the impact of REHs on the availability of healthcare and health outcomes in rural areas after 4 years, 7 years, and 10 years of enactment.

Some open questions about REHs

- How many hospitals might convert to a REH?
- What will be the amount of the monthly additional facility payments?
- Other questions:
  - REH eligibility / Conditions of Participation?
  - How will REHs affect EMS?
  - Will effective transfer agreements be established?
  - Will REH staffing be available?
  - What quality metrics will be used and reported?

How many hospitals might convert to a REH?

- Using one set of predictors for conversion, 68 rural hospitals are predicted to consider conversion to REHs. REH converters are predicted to be:
  - Government owned, Critical Access Hospitals (CAHs), and not system-affiliated.
  - Almost half of predicted REH converters are located in four states: Kansas, Texas, Nebraska, and Oklahoma.
  - In counties with a higher median percentage of unemployed and a lower population density.
- The predicted number of REH converters is an estimate only: different selection criteria would result in a different set of potential REH converters.

GH Pink, KW Thompson, HA Howard, GM Holmes. How Many Hospitals Might Convert to a Rural Emergency Hospital (REH)? NC Rural Health Research Program Findings Brief July 2021. https://www.shepscenter.unc.edu/download/23091/

What will be the amount of the monthly AFP?

- Size of CMS monthly additional facility payments may determine conversion
- For example, assume:
  - Total Medicare cost-based payments to all CAHs in 2019 was $14 billion*
  - The estimated PPS payments for the CAH services would have been $11B**.
  - 1,350 CAHS are included in the above payments.
- Additional facility payment (AFP) for each REH in 2023: ($14B - $11B = $4B / 1,350) = $2.2 million

* MedPac estimated $10B to all CAHs in 2015.

** On March 10, 2011, the Congressional Budget Office (CBO) released a report entitled “Reducing the Deficit: Spending and Revenue Options.” In this report, the CBO states that hospitals benefiting from the special adjustments for CAHs, MDHs, and SCHs are paid about 25% more, on average, for inpatient and outpatient services than the payments that would otherwise apply.

Other REH payment questions

- What will be the complete scope of services eligible for payment at enhanced REH rates?
- Will rural health clinics of the converting hospital maintain grandfathering provisions regarding Medicare cost limits?
- Will the REH be able to elect Method II payment (115% of physician fee schedule) for outpatient provider-based physician services?
- How will state Medicaid programs pay for REH services?
- No mention of capital in legislation - existing hospital buildings will not be usable for REHs

Other questions

- REH eligibility / Conditions of Participation?
- How will REHs affect EMS?
- Will effective transfer agreements be established?
- Will REH staffing be available?
- What REH quality metrics will be used and reported?

Conclusion

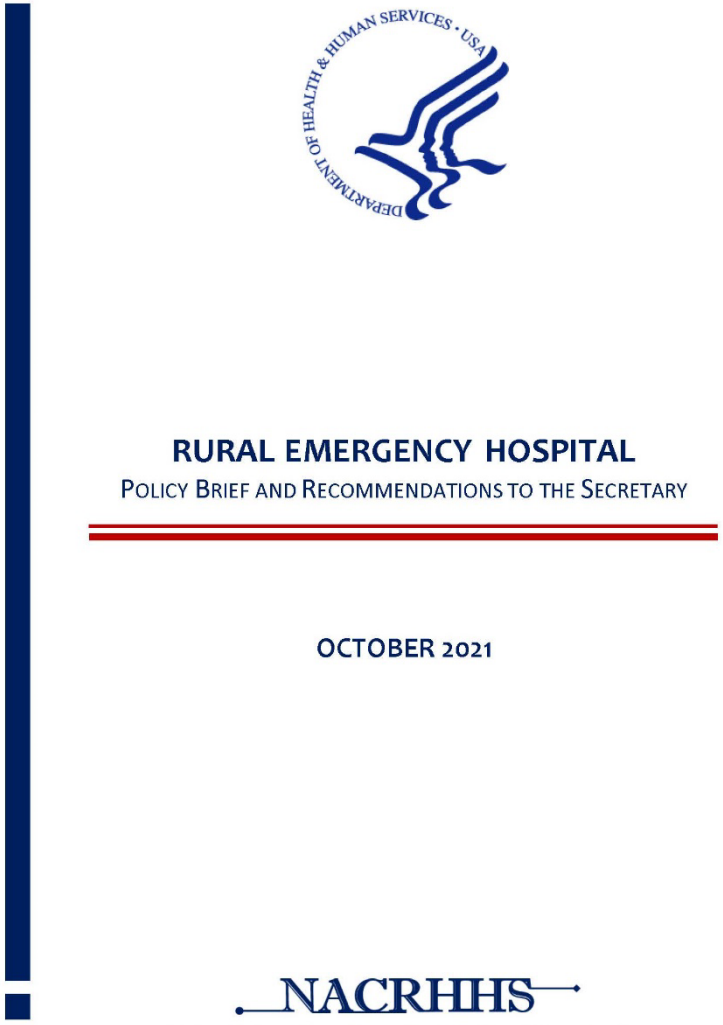
- REH could be an important step for preserving access to emergency and outpatient services in rural areas, particularly in communities that face the risk of rural hospital closures.
- Details about the requirements for operating as an REH remain subject to future rulemaking and guidance.
- It will be important for CMS to engage with interested hospitals to ensure that the REH regulations and guidance facilitate adoption and implementation of REHs to serve the healthcare needs of rural communities.

Background on the Committee

Joe Lupica

Chairman, Newpoint Healthcare Advisors and

Member, National Advisory Committee on Rural Health and Human Services



- The Committee regularly examines issues affecting health and well-being of rural Americans
  - Hears directly from health and human services stakeholders as well as subject matter experts
  - Prepares Policy Briefs with recommendations to HHS Secretary on policy or regulatory matters within Department's purview

Committee's Policy Briefs:

https://www.hrsa.gov/advisory-committees/rural-health/publications/index.html

Advisory Committee Recommendation Process

REH provider type goes live January 1, 2023, and we expect CMS rulemaking to begin this year

- We voted to weigh-in on this promising new model last year, before CMS rulemaking began
- Prepared Policy Brief after internal and external discussions in several meetings over the past year
- Our members went into detail on merits and wording of each recommendation

Policy Recommendations

The Committee's Policy Briefs provide two levels of input:

- Recommendations:
  - Secretary can act without further approvals
- Additional Considerations:
  - Outside of sole purview of HHS
  - Secretary would seek external legislation/consultation/action
  - Topic still important enough to include in our Policy Brief

Policy Recommendations

16 Recommendations fall into 4 Themes:

1. ***More Flexibility***
2. ***Quality of Care measures appropriate to rural hospitals***
3. ***Financing***
4. ***Support for conversion and operation***

5 Additional Considerations

1. ***Expand Eligibility,*** *including hospitals closed before the Dec 2020 cutoff date.*
2. ***Allow REHs to Revert to Former Status.*** *Need clear pathway to meet evolving community needs.*
3. ***Outpatient Professional Billing.*** *Allow employed physicians to elect Method II billing (115% of Medicare physician fee schedule).*
4. ***Medicare Opioid Treatment Program.*** *Clarify that REHs can participate.*
5. ***Practice Supervision.*** *Allow appropriate non-physician practitioner to order and supervise cardiac and pulmonary rehab.*
6. ***CRNA Passthrough*** *payment exemption for outpatient surgery at an REH.*

Considerations for Hospitals Thinking of Converting

Pat Schou, FACHE

Executive Director, Illinois Critical Access Hospital Network and

Member, National Advisory Committee on Rural Health and Human Services

Should my Hospital Consider REH?

- Has our community demand moved more heavily to outpatient?
- Has the emergency department become our community's main access point for healthcare services?
- Do we have an adequate pipeline of healthcare professionals to match the demand?
- What is the financial position of our hospital?
- What are the needs of the Community?

Understanding Reluctance to Convert

- Past example: CAH program rolled out in 1999, hospital community reluctant to embrace
- Fear: length of stay, image, resources and ability to meet the needs of the community
- Fear: a new payment program – too good to be true and not last
- Understanding this, we suspect there will be similar feelings for potential REH converters
- If the model is a fit for your hospital and community then you can overcome the barriers to conversion

Impact and Value of Emergency Department

- Heavier reliance on EDs among rural population*
    - Rural: 36-64%
    - Urban: 42-45%
- Few urgent care centers in rural communities
- Greater percentage of accidents in rural communities
- “What if I live in a rural community and need care?”
- ACCESS is key.

* 2019 ED Use Statistics - Becker’s

What are the Community's Needs?

- Take away the emotion… "We are not closing our Hospital!"
- What type of healthcare? Are inpatient beds needed? Hospital care has changed – more care at home and in an OP setting "hospital without walls"
- More focus on mental and behavioral health and social support systems
- Can the community support the hospital? Local government support?
- Openness to telemedicine– digital access to services
- Easy access and coordinated care

Basic Healthcare – primary and emergency services

New Models – No Size Fits All

- Like CAH… REH program will need tweaks as it's implemented
- Again, "We are not closing our hospital!" Can I make this work?
- Address concerns – what ifs?
  - Healthcare crisis – pandemic and disasters
  - Payment model…is it enough?
  - Quality and standards ensure safety
  - Emergency Medical Services support
  - Recruitment and retention of good staff
  - Emergency Department care – will that decrease?
  - Emergency Medical Services – will this change?

How do we make REHs work in the real world?

The Committee Recommendations

Pat Schou, FACHE
Member, National Advisory Committee on Rural Health and Human Services

Joe Lupica, JD, FACHE
Member, National Advisory Committee on Rural Health and Human Services

Committee Recommendations - Flexibility

- Flexibility in enforcement of the 24-hour average length of service requirement at REHs
  - To account for unexpected service volume surges (flu, COVID, accidents, etc.) and relative availability of ambulance service transfer to an acute care hospital.
- Flexible staffing across the various clinical parts of an REH or in any other clinical operation it offers.
- Flexible survey process for REHs that allows for the use of shared space (waiting rooms, furniture, entrances, etc.) to encourage co-location.

Committee Recommendations - Flexibility

- Allow the MD or DO to be on-call, either in person or via electronic communication, to provide medical direction, consultation, and supervision for the services in the REH.

- Expand eligibility for the National Health Service Corps, the Nurse Corps, and the State Loan Repayment Program to REHs to help them address rural workforce needs and support a funding request to account for the additional eligible entities.

Committee Recommendations - Quality

- Quality Improvement reporting
  - Medicare Beneficiary Quality Improvement Performance
  - Care Transitions – outpatient and emergency department most relevant
- Rural stakeholders develop low-cost and efficient measures for patient satisfaction
- Essential Community Providers – part of health system
  - Emergency Medical Transfer
  - Transfer agreement/acceptance
- Not a band-aid station

Committee Recommendation - Finance

- Verify/secure Additional Facility Payment – keep REHs even in the playing field (*test the numbers*)
- Test % outpatient payment rate
- Facility Financial analysis support
- Licensure
- Acceptance by all payers and network adequacy
  - Including Medicaid
- Ability for new services/meet community needs
- Participate in accountable care organizations/managed care programs

Committee Recommendations - Support

- Provide technical assistance for evaluation and conversion (i.e.. Flex program)
- Participate in 340 B program
- Participate in National Health Services Corp and other loan repayment programs
- Adapt program to accommodate tribal facilities
- Consideration of participation in other rural and healthcare programs

REH model will…

- Require a new hospital license – still regulated
- Preserve the hospital as the hub and central access point
- Provide a framework for safety and quality and yet provide administrative flexibility
- Provide financial support to remain viable
- Look at healthcare in a new and efficient manner – Innovate
- Build relationships with other providers/advance care
- Stabilize access for smaller rural hospitals and their communities
- Seek to provide care locally

Next Steps: Options are . . . *Optional!*

- Begin discussions – “open the door” to the idea
- Take time to see the opportunities
- Conduct a financial analysis
- Evaluate your community health needs assessment
- Have a conversation with your medical providers
- Remember – you will still be a hospital!
- Re-visit your strategic plan
- Seek outside technical assistance
- Let us how the model can be improved

Remember: REH is an Option to Keep Your Rural Community Strong

North Carolina Rural Health Research Program

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For More Information on the Committee

Visit the Committee's website at http://www.hrsa.gov/advisorycommittees/rural/

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