HRSA
Health Resources & Services Administration

Rural Emergency Hospitals

SORH Region D Meeting

Reno, NV

June 8, 2022

Kristi Martinsen
Director, Hospital State Division
Federal Office of Rural Health Policy (FORHP)

Vision: Healthy Communities, Healthy People

Agenda

- Background
- Rural Emergency Hospital Model
  - CMS Requirements
  - National Advisory Committee Recommendations
- REH Technical Assistance
- Community Considerations
- Questions

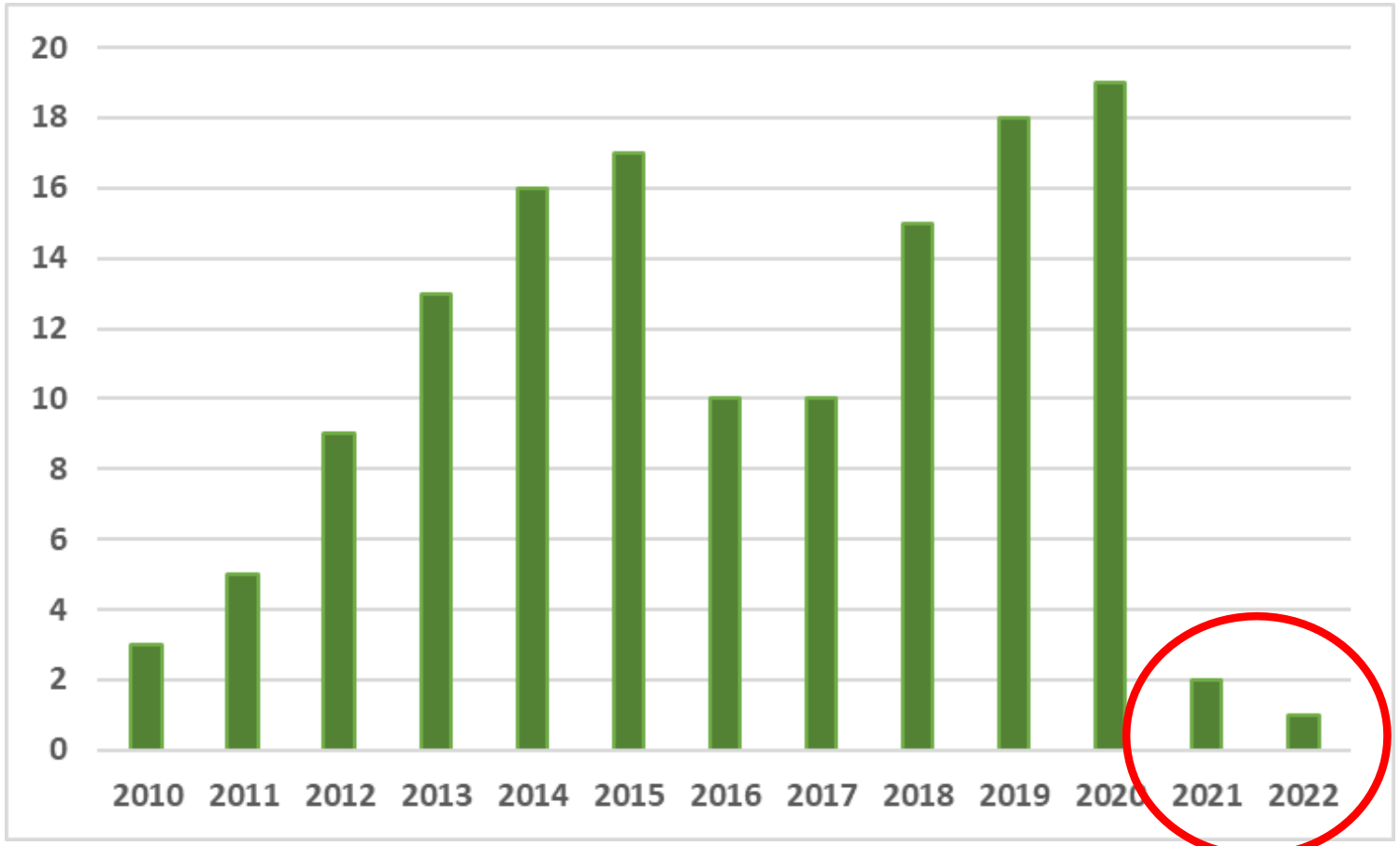
Acknowledgements

- FORHP coordinated a robust panel at the National Rural Health Association Meeting, May 11, 2022
- Information included in this presentation references materials from those presentations
  - George Pink & Margaret Greenwood-Erickson, North Carolina Rural Health Resource Center – data on hospital closures
  - Emily Cook – information on statutory vs regulatory issues
  - Pat Schou, NACRHHS Member: Community Considerations

Background

- Increasing Rural hospital closures
  - 138 rural hospitals have closed since January 2010
  - Patients in affected communities are probably traveling between 5 and 30 or more miles to access inpatient care
  - Closures could resume after covid funding is gone
- Rural Emergency Hospitals may be a solution
  - Need for a new model of rural health care
  - CMS is currently in rule-making mode
  - REH could be a viable model for some communities
  - Legislative action by States is required

138 Rural Hospital Closures since January 2010

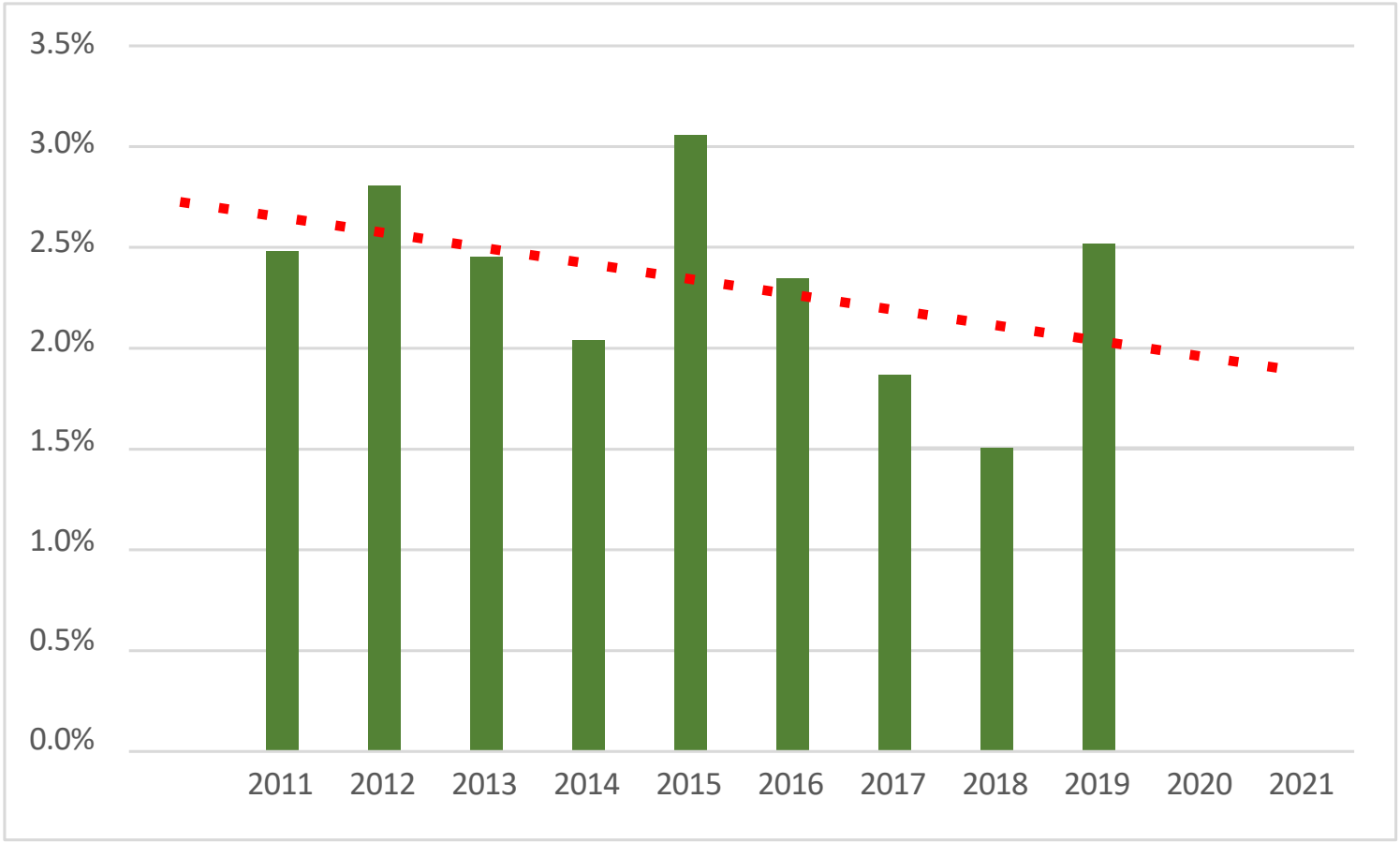


Our problems are over, right?

NC RHRP
NC Rural Health Research Program

Following slides from the FORHP funded NC Rural Research Center's Presentation at the NRHA Annual meeting 5-11-22

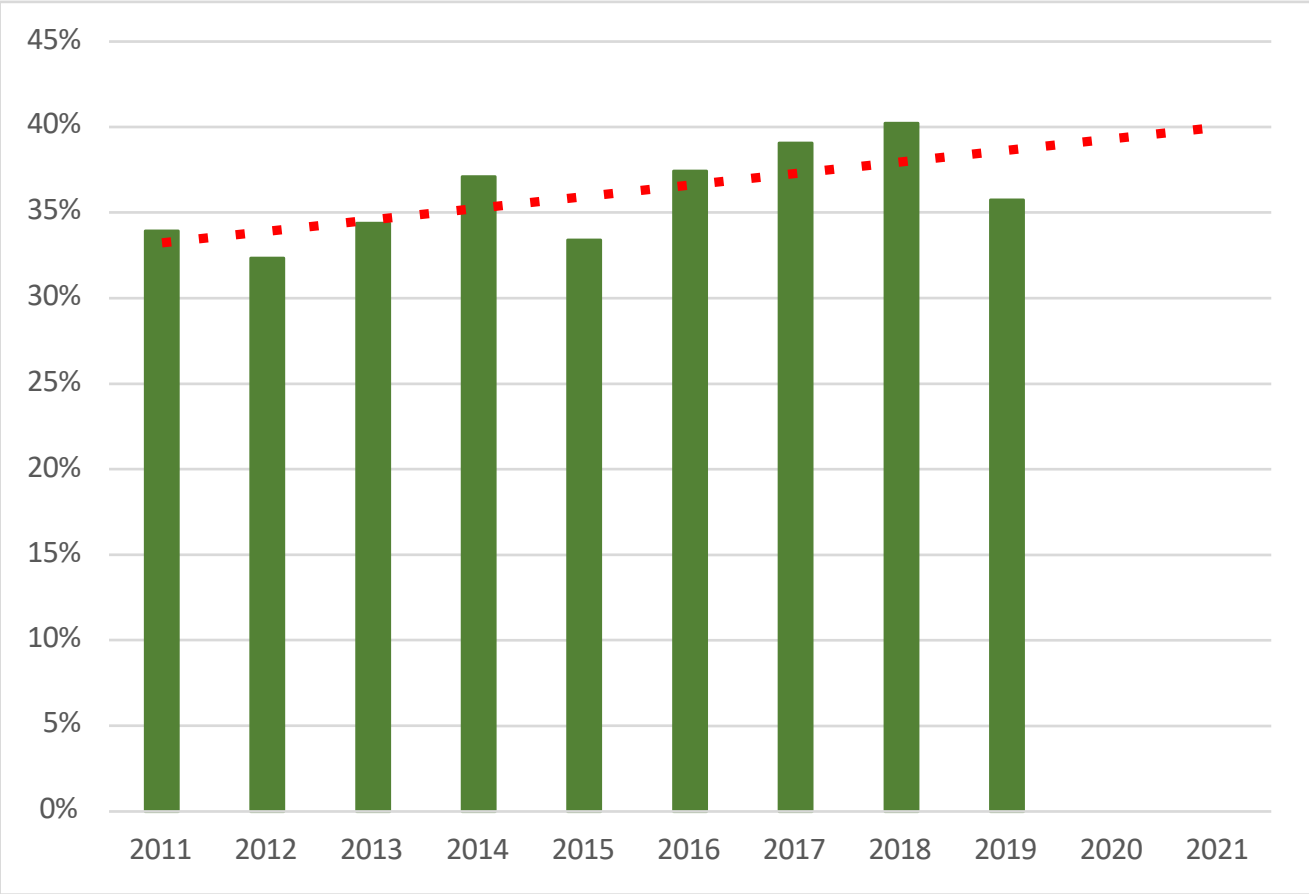
The median total margin of rural hospitals was trending downwards before COVID funding



Long-term unprofit-ability has not gone away

NC RHRP
NC Rural Health Research Program

The percentage of rural hospitals with a negative total margin was trending upwards before COVID funding



PRF and other COVID funding probably provided a lifeline for many rural hospitals

NC RHRP
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Community consequences of closure

- Access to health care:
  - Loss of local access to emergency and inpatient care
  - Loss of providers that depend on acute care hospital
  - Loss of other local health services
- Direct costs:
  - Loss of jobs from large or largest employer in town
  - Loss of taxes paid by hospital and employees
  - Loss of jobs and tax revenue if businesses leave
- Indirect costs:
  - Increased travel costs for poor, elderly, disabled, and other patients
  - Increased cost of attracting teachers and other public sector workers

Closures are a big deal in affected communities

NC RHRP
NC Rural Health Research Program

Rural Emergency Hospital Model

- REH Statute – Consolidated Appropriations Act of 2021 (December 27, 2020), Section 125 – Medicare Payment for Rural Emergency Hospital Services
- Was a critical access hospital or rural hospital with not more than 50 beds
  - Not provide acute care inpatient services
  - Not exceed an annual per patient length of stay of 24 hours
  - Have a transfer agreement in place with a Level I or II trauma center
  - Maintain a staffed emergency department, including staffing 24/7 by a physician, nurse practitioner, clinical nurse specialist or physician assistant
  - Meet CAH-equivalent CoPs for emergency services
  - Meet applicable state licensing requirements
  - Annually report certain quality data

REH Statutory Payment Provisions

- OPPS rate, plus a 5% add-on
- Fixed monthly payment
  - Calculated for 2023 by reference to 2019 reimbursement for CAHs as compared to what CAHs would have received were they not CAHs
  - Increased in subsequent years by the hospital market basket percentage increase
- Services not paid under OPPS and off-campus outpatient services are subject to the otherwise applicable payment rate

REH Services

- Mandatory Services
  - Emergency
  - Observation
- Optional Services
  - Outpatient hospital services
    - ✓ On or off campus
  - Distinct part Skilled Nursing Unit
  - Rural Health Clinic
  - Ambulance Services

Not permitted under the statute

- Acute inpatient services
  - No exception for acute inpatient services furnished in swing beds
- Participation in 340B Program
  - 340B Statute governs the types of providers that can participate in the 340B Program
  - Rural Emergency Hospitals are not included in that list
- Regulations cannot be contrary to the statute
  - The law would need to be changed to allow REHs to provide acute inpatient services or to participate in the 340B Program

Determined under CMS rulemaking

- Specific outpatient services must be defined by rulemaking
- Based on request for comment, may include:
  - Telehealth distant site
  - Opioid treatment services
  - Maternal health services

Quality Reporting

- Statutory requirement:
  - The Secretary shall establish quality measurement reporting requirements for rural emergency hospitals, which may include the use of a small number of claims based outcomes measures or surveys of patients with respect to their experience in the rural emergency hospital, in accordance with the succeeding provisions of this paragraph
- Subject to CMS Rulemaking
  - Specific quality measures
  - Method of reporting
  - Inclusion of claims-based outcome measures
  - Inclusion of patient experience surveys

National Advisory Committee for Rural Health and Human Services

National Advisory Committee on Rural Health and Human Services (NACRHHS)

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

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

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 the 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 for the doctor of medicine or osteopathy to be on-call, either in person or remotely (e.g., via telephone or electronic communication), to provide medical direction, consultation, and supervision for the services provided 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 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
  - Medicaid
- Ability for new services/meet community needs
- Participate in accountable care organizations/managed care programs

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 Policy Considerations – legislative and regulatory

1. ***Expand Eligibility,*** *including for hospitals closed before the Dec 2020 cutoff date*
2. ***Reversion to Former Status.*** *Need clear pathway to meet evolving community needs by allowing REH to return to prior status.*
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 by appropriate non-physician practitioner to order and supervise cardiac and pulmonary rehab.*
6. ***CRNA Passthrough*** *payment exemption for REHs that offer outpatient surgery*

REH National Technical Assistance Center

The REH TA Center program is intended to support eligible rural hospitals throughout the process of conversion to the REH model. The award recipient will provide technical assistance (TA) to rural hospitals and communities by:

- Assessing feasibility of the REH model;
- Assisting with the application to CMS for REH designation; and
- Providing ongoing support to REHs implementing new services and achieving REH compliance standards.

- $2.5 million/year, 5 years (pending availability of future funding
- Applications due July 27, 2022
- https://www.grants.gov/web/grants/view-opportunity.html?oppId=339575

New models – not one size fits all

- Like CAH…changes/tweaks are needed to implement the REH program
- Address concerns – what ifs?
  - Healthcare crisis – pandemic and disasters
  - Payment model…is it enough? For profit systems?
  - 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 REH work in the real world?**

Community Considerations

- Has the hospital business moved fully to an outpatient type model?
- Has the emergency department become the main access point for healthcare services?
- Is there an adequate pipeline of healthcare professionals?
- What is the financial position of the hospital?
  - Outpatient
  - Surgery…other
- What are the needs of the Community
- Recruiting healthcare professionals

Next steps for a community to consider

- Begin discussions – “open the door” to the idea
- Takes time to see the opportunities
- Conduct a financial analysis
- Evaluate your community health needs assessment
- Remember – must be a hospital
- Talk with your medical providers
- Re-visit your strategic plan and include as potential financial security to stay open
- Seek outside technical assistance
- Share your ideas on how the model can be improved (2023 rules)
- Most important: Option to Keep Your Rural Community Strong

Questions

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