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Thank you for joining today's webinar. We will begin promptly at 1:00 pm Central.

The Rural Emergency Hospital (REH), a New Hospital Type

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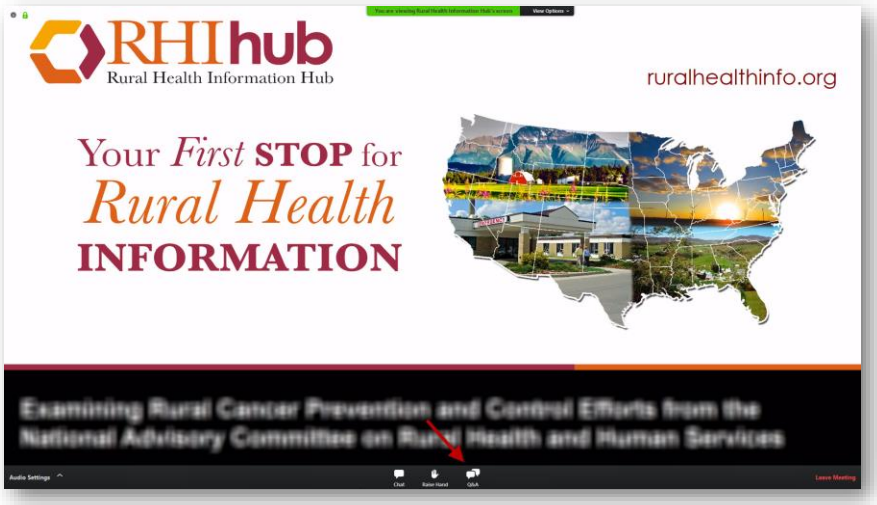
Your *First* **STOP** for *Rural Health* **INFORMATION**

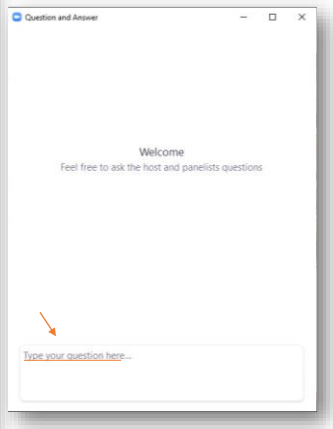
The Rural Emergency Hospital (REH), a New Hospital Type

Housekeeping

- Slides are available at www.ruralhealthinfo.org/webinars/rural-emergency-hospital
- Technical difficulties please visit the Zoom Help Center at support.zoom.us

If you have questions…





NACRHHS
National Advisory Committee on Rural Health and Human Services

Rural Emergency Hospital

Policy Brief Webinar

January 19, 2022

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Webinar Speakers

Governor Jeff Colyer, MD
Chair | National Advisory Committee on Rural Health and Human Services
Board Certified Craniofacial/Plastic Surgeon | University of Kansas

Mark Holmes, PhD
Director | Cecil G. Sheps Center for Health Services Research
University of North Carolina

Kari Bruffett
Vice President for Policy | Kansas Health Institute

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Background on the Committee

- The Committee is a federally chartered independent citizens' panel whose charge is to advise the Secretary of HHS on issues related to how HHS and its programs can better serve rural communities.
- Our Mission: We will advance our Vision for rural America by:
  - Examining rural health care and human services innovations
  - Highlighting opportunities that integrate health care services, human services, and non-health sectors
  - Recommending public policies that advance rural community diversity, vibrancy, and resiliency
  - Engaging science and evidence during our deliberations
- Chaired by former Kansas Governor, Dr. Jeff Colyer, the Committee members' experience and expertise cover a wide range of rural health and human services issues.

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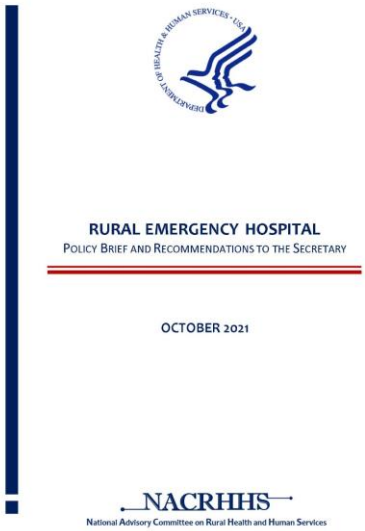

The Committee meets twice a year to:

- Examine important issues that affect the health and well-being of rural Americans
- To hear directly from rural stakeholders in healthcare and human services

Following each meeting, the Committee produces policy briefs to the HHS Secretary with recommendations on policy or regulatory matters that are within the Secretary's purview.

Committee's Policy Briefs:

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

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Why the Rural Emergency Hospital?

- In December 2020, Congress created a new type of Medicare provider called the Rural Emergency Hospital (REH) as a response to loss of emergency services in rural areas due to hospital closures.
- By creating the REH, Congress has established the first new rural provider type since the Critical Access Hospital (CAH) was created in 1997.
- The REH provider type will go live on January 1, 2023.
  - CMS rulemaking will begin this year.
- The Committee felt that it was important to weigh in on this promising new model before CMS rulemaking began.

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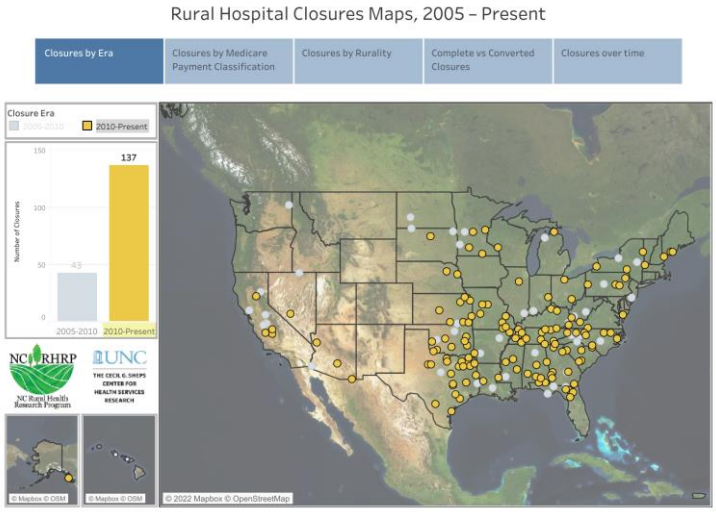
Rural Hospital Closures

- Between January 1, 2010, and October 1, 2021, 138 rural hospitals closed.
  - 12 Sole Community Hospitals (SCH)
  - 244 Medicare Dependent Hospitals (MDH)
  - 44 Critical Access Hospitals (CAH)
  - 57 Prospective Payment System (PPS) hospitals.



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Drivers of Closures

- Insufficient revenue for sustaining the cost structure of acute care hospitals.
- Declining population of the communities and other market conditions that contribute to financial instability.
- Populations that are aged, poor, uninsured, and underinsured, leading to a high percentage of patient revenue from public payers (Medicare, Medicaid, etc.), who often reimburse less than the cost of providing care.
- Growing trends in health insurance and plan design that can increase bad debt and charity care burdens of hospitals, such as high deductible health plans and narrow provider networks.
- Shifts in health care delivery from inpatient care to outpatient care, resulting in declining inpatient utilization and associated revenue.

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Financial Distress

- Financial distress can be a risk factor for rural hospital closure.
- UNC Sheps Center has developed a financial distress index (FDI).
  - In 2020, it estimated that 210 rural hospitals were at a high risk of financial distress.
- Generally, these hospitals shared these commonalities:
  - Higher percentages of non-White and Black residents
  - Lower rates of high school graduation
  - Higher rates of unemployment
  - Worse health status as measured by percentage of individuals who self-report as being in fair or poor health, obese adults, tobacco using adults, and number of premature deaths

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The Basics of the REH Model

- Eligibility: CAHs and small rural hospitals with no more than 50 beds that meet criteria set forth by the Act, as well as other requirements to be established by CMS, will be eligible to convert to an REH.

- Application: In order to transition to become an REH, an existing hospital must submit an action plan for initiating rural emergency hospital services, including:
  - A detailed action plan that lists the specific services that the facility will retain, modify, add, and discontinue; and
  - The outpatient services that will be offered; and
  - How the facility will use the additional funds it receives including telehealth services, ambulance services, operating costs, and maintaining the emergency.
  - Other requirements that CMS puts in place.

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The Basics of the REH Model cont.

- Requirements: An REH must:
  - Not provide acute care inpatient services; and
  - Not exceed an annual average patient length of stay of 24 hours; and
  - Have a transfer agreement in place with a Level I or II trauma center; and
  - Maintain a staffed emergency department, including staffing 24 hours a day, seven days a week by a physician, nurse practitioner, clinical nurse specialist, or physician assistant; and
  - Meet CAH-equivalent Conditions of Participation (CoPs) for emergency services
  - Meet applicable state licensing requirements
  - Meet quality reporting standards established by the HHS Secretary
  - Meet requirements applicable to skilled nursing facilities in the case where the REH includes a distinct part unit
  - Meet other requirements that the Secretary finds necessary in the interest of the health and safety of individuals who are furnished care at an REH.

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The Basics of the REH Model cont.

- Reimbursement:
  - Medicare payments for outpatient services will be made at the OPPS rate, plus a 5% add-on to that rate. There will also be an Additional Facility Payment (AFP) that will be a fixed monthly payment.
  - CMS will determine the amount of the AFP, however, the legislation provides a formula for 2023 that is based on 2019 reimbursements to CAHs.
  - Starting in 2024, REH's fixed monthly payment amounts will be based on the 2023 payments and increased each year by the hospital market basket percentage increase.

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Potential REH Converters

- The Sheps Center at UNC estimated potential REH converters based on their FDI and what we know about the REH model based off the statutory language.
- Key findings include:
  - Using one set of predictors for conversion, 68 rural hospitals are predicted to consider conversion to REHs ("REH converters") in comparison to 1,605 hospitals not predicted to consider conversion ("non-converters").
  - Almost half of REH converters are located in four states: Kansas, Texas, Nebraska, and Oklahoma.
  - In comparison to non-converters, REH converters are in counties with a higher median percentage of unemployed and a lower population density.
  - The predicted number of REH converters (68) is based on what is currently known about the REH and is an estimate only: different selection criteria would result in a different set of potential REH converters.

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Policy Recommendations

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Policy Recommendations

- The Committee was briefed by subject matter experts, rural stakeholders, and academics on the different aspects of the REH.
- The Committee submitted 16 policy recommendations to the HHS Secretary.
  - Also included five additional policy considerations to the HHS Secretary.
- Policy Recommendation can be understood in four categories:
  - Providing REHs flexibility and support
  - Applying Quality Care Measures in REHs
  - Financing REHs
  - Additional Recommendations/Considerations

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Providing REHs Flexibility and Support

- The Committee made recommendations related to the operational flexibility of REHs including the length of stay, staffing, and sharing facility space.

Recommendation 1

The Committee recommends that the Secretary provide flexibility in the 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.

Recommendation 2

The Committee recommends that the Secretary allow for flexible staffing across the various clinical parts of an REH or in any other clinical operation it offers.

Recommendation 3

The Committee recommends that the Secretary ensure a flexible survey process for REHs that allows for the use of shared space (waiting rooms, furniture, entrances, etc.) to encourage co-location.

Providing REHs Flexibility and Support

- The Committee also made recommendations about specific ways to help REHs with staffing flexibility and workforce issues.

Recommendation 4

The Committee recommends that the Secretary 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.

Recommendation 14

The Committee recommends that the Secretary 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.

Applying Quality Care Measures in REHs

- The Committee made recommendations about applying appropriate quality measures for REHs.

Recommendation 6

The Committee recommends that the Secretary require REHs to report on the applicable measures specified in the CAH Medicare Beneficiary Quality Improvement Project (MBQIP) for Outpatient, Patient Safety, and Care Transitions.

Recommendation 7

The Committee recommends that the Secretary work with rural stakeholders to develop low-cost and efficient methods to appropriately measure patient experience quality of care in REHs.

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Financing REHs

- The Committee made recommendations about apply appropriate quality measures for REHs.

Recommendation 8

The Committee recommends that the Secretary ensure that calculation of the Additional Facility Payment includes services provided in CAH swing beds as part of the actual Medicare payments made to CAHs in 2019.

Recommendation 10

The Committee recommends that the Secretary include REHs as Essential Community Providers at 45 CFR § 156.235 for Qualified Health Plans through the Federally-facilitated Marketplaces.

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Additional Recommendations

- The Committee made additional recommendations that policymakers should consider.

Recommendation 15

The Committee recommends that the Secretary work with Congress to expand eligibility for the 340B Drug Pricing Program to include REHs.

Recommendation 16

The Committee recommends that the Secretary engage in a formal consultation process with tribal communities on possible options for adapting the REH model to serve tribal communities.

Additional Considerations

- Allowing employed physicians at an REH to elect Method II billing similar to CAHs for outpatient professional services, which reimburses 115% of what would otherwise be paid under the Medicare Physician Fee Schedule.
- Making REHs that offer outpatient surgery services able to qualify for the Certified Registered Nurse Anesthetist (CRNA) pass through payment exemption.
- Ensuring that there is a clear pathway for a CAH or PPS hospital that becomes an REH, particularly those CAHs with Necessary Provider designations, to return to full acute care general hospital status and bed size should they need to in order to meet community need.
- Allowing REHs to offer cardiac and pulmonary rehabilitation services and for those services to be order and supervised by an appropriate non-physician practitioner (e.g., nurse practitioners and physicians assistants).
- Allowing REHs to serve as a Medicare Opioid Treatment Program.

For More Information

To find out more about the Committee, please visit our website at http://www.hrsa.gov/advisorycommittees/rural/ or contact:

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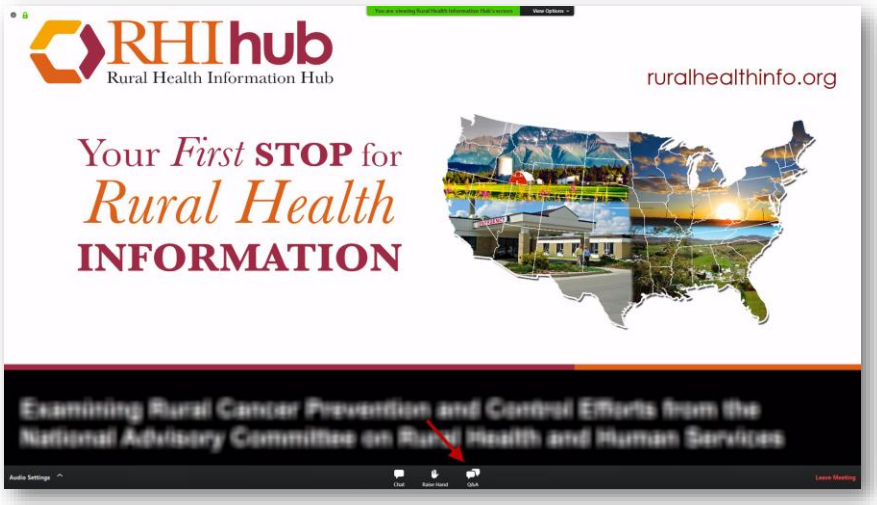
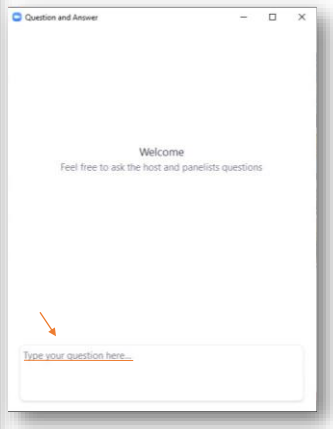
Questions?





Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website