Update on Rural Emergency Hospital Classification

August 24, 2024

forvis mazars

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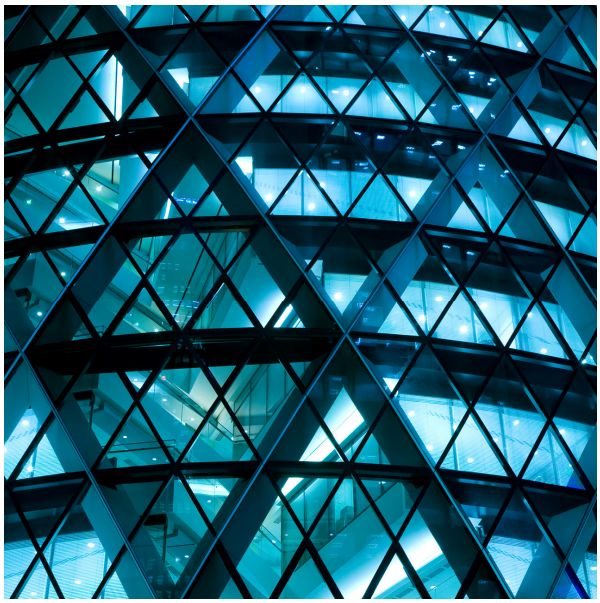
Agenda

1. Challenges of Healthcare in rural America
2. Rural Emergency Hospital (REH) creation
3. Conditions of participation
4. Payment policy
5. Arkansas specifics
6. Remaining challenges
7. Questions



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Challenges of Healthcare in rural America

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Challenges of Healthcare in rural America

- Americans in rural areas make up 20% of population
  - OFTEN EXPERIENCE
    - Shorter life expectancy
    - Higher mortality rates
    - Higher poverty rates
    - Fewer doctors
    - Greater distance to travel for care
- 75 complete hospital closures between 2010 and 2022

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Rural Emergency Hospital (REH) creation

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REH Creation

- Rural emergency hospital model created in the Consolidated Appropriations Act, 2021, signed into law December 27, 2020

Statutory requirements –

- Annual per patient average of 24 hours (includes outpatient and ED visits not just observation)
- Provides emergency department services and observation care
  - May provide outpatient services
- Emergency department staffed 24/7
- Physician, NP, PA, or CNS must be available 24/7
- Transfer agreement with level I/II trauma center
- Must submit action plan to convert
- State must have REH licensure laws

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REH Creation

CMS estimates as many as 68 CAHs or hospitals will convert to REH

Statute establishing REH prohibits administrative and judicial review of REH CoPs, determination of payment amounts, and determination of REH eligibility

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REH Creation

- **Eligibility** –
  - Rural hospital (or hospital treated as being rural) with <50 beds or CAH,
    - Treated as rural – active reclassification under 42 CFR § 412.103 as of December 27, 2020
    - Bed Count – based on the cost reporting period that 12/27/2020 falls within
  - Open as of December 27, 2020

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Conditions of Participation

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Conditions of Participation (COP)


Services


Staffing


Infection Control


Quality Reporting


Transfer Agreements


Emergency Preparedness


Discharge Planning


Patient Rights


Physical Environment

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COP: Services optional

- May provide additional outpatient services
  - Low-risk labor and delivery
  - Outpatient surgeries
- May provide outpatient behavioral health treatment services
- May establish SNF unit, but must be distinct unit
  - Separately licensed and certified
  - SNF regulations and CoPs apply (42 CFR 483)
- May be originating site for telemedicine
  - Agreements required with distant sites
- Discharge planning required, even though no inpatient services

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COP: Services Radiologic

- Must provide diagnostic radiologic services, plus additional radiologic services based on need of patients served
- Patient Safety
  - Storage and disposal of radioactive materials
  - Inspection of equipment
  - Exposure meters or badge tests for radiation workers
  - Provider privileges
- Personnel
  - FT or PT radiologist supervisor
  - Qualified personnel for use of equipment and procedure administration
- Records
  - Reports signed by performing radiologist
  - Records retained for at least 5 years (reports, films, image records, etc.)

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COP: Services Pharmaceutical

- Management and Administration
  - Pharmacist responsible for developing and supervising
  - Adequate number of personnel for ED and OP services
  - Current and accurate records
- Delivery of Service
  - Compounding, packaging, and dispensing under supervision of pharmacist or another qualified individual
  - Drug packaging and dispensing overseen by pharmacist or another qualified individual
  - Drugs and biologicals stored in secured area
  - Adverse patient reactions reported to physician responsible for care
  - Formulary system established by medical staff to assure pharmaceutical quality
- 340B Eligibility
  - Not eligible for 340B based on current legislation
  - Would require HRSA to expand eligibility to REHs

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COP: Infection control

- Emergency Department services available 24/7
- Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist on-call and immediately available by phone and on site within specified timeframes
- RN, Clinical Nurse Specialist, or LPN on duty whenever one or more patients receiving care
- Meet emergency needs of patients in community served
- Emergency services under direction of qualified member of medical staff and integrated with other REH departments
- Basic lab services available 24/7, similar to CAH CoPs
- Emergency services integrated with other departments of REH

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COP: Quality Reporting

- Proposed for REHs through existing QualityNet platform
- Number of hospitals that convert likely to influence quality measures
- Quality challenges due to low numbers of hospitals and services
- Recognizes reporting burden on smaller entity, possible solutions:
  - Use claims-based measure
  - Digital measures vs chart abstraction
- Core measure that apply to REH services (ED/obs)
- Others as applicable based on outpatient services provided

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COP: Quality Reporting

- Example quality measures considered and comments requested:
  - Thrombolytic Therapy with 30 minutes
  - Median time to transfer for acute coronary intervention
  - Aspirin on arrival
  - Median time from ED arrival to departure
  - Door to diagnostic eval time by qualified personnel
  - Left ED without being seen
- Seeking comment on future measures within Telemedicine, Maternal Health, Mental Health, and Health Equity to help address rural health inequities
- See pages 44760–44764 for all-inclusive listing and discussion

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COP: Transfer Agreements

- Must have transfer agreement with at least one Level I or Level II trauma center, regardless of actual transfer protocols
  - Transfer hospital may be located in another state
  - REH may have agreements with Level III or Level IV trauma centers, if desired

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COP: Physical environment

/ The REH must be constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for diagnosis and treatment and for special services appropriate to the needs of the community:

- There must be emergency power and lighting in at least the operating, recovery, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available.
- There must be facilities for emergency gas and water supply.
- The REH must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.
- Diagnostic and therapeutic facilities must be located for the safety of patients.
- Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
- The extent and complexity of facilities must be determined by the services offered.
- There must be proper ventilation, light, and temperature controls in patient care, pharmaceutical, food preparation, and other appropriate areas.

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COP: Emergency preparedness

/ The REH must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

- Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach
- Include strategies for addressing emergency events identified by the risk assessment
- Address patient population, including, but not limited to, the type of services the REH has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans
- Include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation

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COP: Emergency preparedness

- The REH must develop and implement emergency preparedness policies and procedures, based on the emergency plan.
- The policies and procedures must be reviewed and updated at least every 2 years.

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COP: Patient rights

- Inform each patient of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.
- Establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. At a minimum:

(i) Establish a clearly explained procedure for the submission of a patient's written or verbal grievance.

(ii) Specify time frames for review of the grievance and the provision of a response.

(iii) Provide the patient with written notice of its decision that contains the name of the REH contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

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COP: Patient rights

- The patient has the right to:
  - (1) Participate in the development and implementation of their plan of care.
  - (2) Make informed decisions regarding their care, including being informed of their health status, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
  - (3) Formulate advance directives and to have REH staff and practitioners who provide care in the REH comply with these directives, in accordance with §§ 489.100, 489.102, and 489.104 of this chapter.
  - (4) Personal privacy.
  - (5) Receive care in a safe setting.
  - (6) Be free from all forms of abuse or harassment.

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COP: Discharge planning

- An REH must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and their caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and their treatment preferences, ensure an effective transition of the patient from the REH to post-discharge care, and reduce the factors leading to preventable hospital admissions or readmissions.

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Payment policy

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Enrollment

- Enrollment as a REH remains in effect until REH elects to withdraw or Secretary determines the facility does not meet the requirements
- Enrollment authority of CMS applies for REH
  - 855A with supporting documentation
  - Completion of any applicable state surveys
  - Reporting changes to REH enrollment information
  - Revalidation
- Application fee not applicable since change of information
  - Less timely process
  - REHs proposed as low enrollment screening risk (similar to hospitals)

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Enrollment

- Detailed transition plan listing services to be:
  - Modified
  - Retained
  - Discontinued
  - Added
- Description of services the REH anticipates providing (emergency and outpatient)
- Description of how the monthly facility payment will be utilized
- Additional information requested by CMS

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Payment policy

CAA SPECIFIED REH PAYMENT FOR REH SERVICES

- CAA silent on how to pay for other services furnished by REH
- REH CoP to provide certain services that are not covered outpatient dept (OPPS) services
  - Basic lab services
  - Certain diagnostic

- Proposing that any service not meeting the REH service definition (payable under OPPS), be paid similar to fee schedule services performed in a hospital department (additional 5% not applicable)
  - Ambulance service owned by REH paid under Ambulance fee schedule
  - SNF distinct unit paid under SNF PPS

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Payment policy

Off-Campus Provider-Based Departments

- Does not interpret Section 603 as applying to off-campus PBD of REH
  - Section 603 neutralized payments at new off-campus provider-based locations
- Could disincentivize providers if applied, especially CAH since Section 603 not applicable
  - Off-campus location previously paid at cost under CAH would be paid as fee schedule (not OPPS) if Section 603 applicable to REH

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Payment policy

Additional Monthly Payment Methodology Proposed

- CY 2024 Monthly amount = $276,233.58 (net of sequestration) ($3,314,802.96 annual)
  - Amount is to be updated based on the hospital market basket
- Methodology to determine additional payment:
  - Total paid to CAHs under Title 18 minus estimated amount if paid under PPS / # CAHs
    - Statute Includes:
      - Inpatient
      - SNF
      - Inpatient Rehab
      - Inpatient Psych
      - Inpatient Swing Beds
      - Outpatient
    - CMS proposes to also include through other payment sub-systems:
      - Clinical lab
      - Physician services
      - Ambulance services
      - *i.e.*, other services that are reported on a CAH IP/OP or SNF claim form

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Payment policy

Additional Monthly Payment Methodology Proposed (continued)

- Utilize CY 19 claims from CAHs including co-payments
- CAH claims detail does not include supplemental payments as received through PPS
  - CMS estimating the following under PPS:
    - DSH, UCC, Low Volume, Outliers, IME, etc.
- Determined no feasible way to estimate VBP, Readmission penalty, HAC penalties
- DSH/UCC – utilized closest rural hospital data and used validation approach using poverty data by ZIP code
- Low Volume – assumed all would qualify of being > 15 miles from another hospital (Necessary Providers?)
- Swing Bed reimbursement estimated under SNF PPS (CAHs do not have same coding requirements)

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Payment policy

Additional Monthly Payment Methodology Proposed (continued)

- Summary of REH Monthly Calculation
  - Total Amount of Medicare Spending for CAHs in CY 2019: $12.08 billion
  - Total Projected Amount of Medicare Spending for CAHs if Paid Prospectively in CY 2019: $7.68 billion
  - Step1 Difference: $12.08 billion – $7.68 billion = $4.40 billion
- Number of Medicare CAHs in CY 2019: 1,368
  - REH Monthly Facility Payment: ($4,404,308,465/ 1,368) / 12 = $268,294
  - REH Annual Facility Payment =$3,219,524

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Payment policy

Additional Monthly Payment Methodology Proposed (continued)

- For CY 2024 and each subsequent year, propose to update previous year annual facility payment by the hospital market basket increase
- REH to report on how monthly payments utilized to provide healthcare services
  - CMS has indicated it believes the standard hospital cost report will suffice for this purpose

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Arkansas specifics

- At the state level, REHs must meet certain licensure requirements, including:
  - Be located in a state that provides for licensing of such hospitals under state or local law
  - Be licensed under such law
  - Be approved by the state or local agency as meeting the standards for such license
  - Meet Conditions of Participation (CoPs) applicable to CAHs regarding emergency services and hospital emergency departments
  - Not exceed an annual per patient average of 24 hours of services
  - Not provide any acute care inpatient hospital services (other than post-hospital extended care services provided in a distinct part unit licensed as a skilled nursing facility (SNF))
  - Was a CAH or small rural hospital with no more than 50 beds on December 27, 2020 (the date of enactment of the CAA)
- Arkansas Medicaid intends to pay cost for outpatients claims, pending CMS approval
- No official word on OP provider assessment participation

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Key considerations

Evaluating REH?

- Evaluation of the financial differences under REH versus current state as PPS (<50beds) or CAH includes the following types of considerations (not all-inclusive):
  - / Elimination of inpatient routine and ancillary revenues
  - / Operating and expense changes under REH
  - / Ineligible for 340B (Remove 340B drug savings and retail pharmacy revenues)
  - / Service line volume consideration of changes, as well as new service opportunities
  - / Rural Health Clinic grandfathering provision for those meeting criteria at December 31, 2020
  - / Provider-based locations off campus not subject to site neutrality, eligible for +5% of OPPS
  - / Reconfiguration of physical plant and space utilization
  - / Acute and post-acute strategy within a health system to provide care in a more efficient setting
  - / Medicaid reimbursement

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Remaining challenges

- MGCRB reclass options applicable for REHs?
- 340B (Currently not eligible?)
- If provider exceeds average of 24 hours
- Additional clarification on residents training in a CAH
- <=50 bed criteria clarification (licensed, available)
- Cost Reporting Instructions? Costing of Observation vs ED care?
- No additional payment for non-REH services (Consider 5% add-on to Fee Schedules)?
- Medicare Advantage not considered for monthly additional payment
- What do you do with existing subproviders
- Can you convert back to CAH

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Questions

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