Background on the New Rural Emergency Hospital Model

A confluence of issues are plaguing the finances of rural hospitals in Colorado. These include, but are not limited to, the financial challenges created by the COVID-19 pandemic, low-reimbursement from public payers like Medicare and Medicaid, workforce shortages, increased regulatory burden from state and federal policymakers, and dramatic increases in expenses for labor, drugs, and supplies. Historically, rural hospitals at risk of closure are also those in communities of the highest need, as measured by factors such as poorer rates of health, higher rates of poverty, and lower rates of high school graduation. When a rural hospital closes, it has a devastating impact on patient access and health care outcomes. In 2020, 29 Colorado hospitals had a negative operating margin based on Medicare cost reports.

Rural Emergency Hospital Background: To increase options for communities that can no longer sustain a full slate of inpatient services, Rural Emergency Hospitals (REHs) are a new provider type established by Congress in the Consolidated Appropriations Act, 2021, to maintain access to critical, emergency, and outpatient services when it is no longer viable for a hospital to operate inpatient services. REHs will operate as a new type of rural hospital that provides 24-hour emergency services but does not provide inpatient care.

Purpose: The REH model provides a new option for rural hospitals to maintain emergency services in communities when a full slate of inpatient services is no longer financially viable. To support robust access to appropriate services, it is critically important that hospitals have options to scale appropriately based on community need or financial pressures and that the regulatory/licensure framework supports those transitions should they become necessary.

Status: CMS recently released its 2023 Outpatient Prospective Payment System Ambulatory Surgical Center (OPPS-ASC) final rule, which includes the REH Conditions of Participation (CoPs). The final rule specifies that REHs must always have a clinician on-call and available on-site within 30 minutes (rural area) or 60 minutes (frontier area). The rule also specifies that REHs cannot furnish inpatient services, with the exception of distinct part skilled nursing facilities (SNFs). This determination did not address requested swing bed flexibility advocated for by CHA and other entities. ***The REH provider type will be available federally starting January 2023; however, without action by the Colorado General Assembly, Colorado hospitals would not be able to pursue this option.****

> ***Note:** The Colorado General Assembly would need to establish a licensure option and address Medicaid reimbursement for this option to be available in Colorado. Legislation to address the licensure option has already been enacted in Kansas, Nebraska, and South Dakota. Learn more from the National Council of State Legislatures.

Eligibility: Only Critical Access Hospitals (CAHs) or small rural hospitals with no more than 50 beds can convert to an REH – no new REHs can be constructed. This parameter ensures that there will not be a shift to REH proliferation that threatens existing rural hospitals. The REH provider type is purely

intended to support ongoing access in communities where access is threatened due to rural hospital financial sustainability.

Considerations: Eligible rural hospitals should consider the factors below when evaluating the REH model to determine if conversion is a viable option:

- **Flat or declining revenue:** For example, a rural hospital experiencing rising costs and a declining local population may determine the revenue challenge is such that continuing to provide inpatient services is not a sustainable option.
- **Dependence on local tax:** If a hospital relies heavily on local tax appropriations to support operational costs, an analysis of trends over the last five to 10 years may help determine if the current model is sustainable.
- **Inpatient/outpatient shifts:** As health care innovations and changes to plan design create more opportunity for the safe delivery of care in an outpatient setting, trends may point to a decreasing need for local inpatient services.
- **Rethinking scope of care:** Consider whether current service offerings are aligned with community need. A hospital that transitions out of inpatient care may have additional financial resources to help advance the hospital's mission.
- **Pressures on outpatient services:** The REH model is intended to support outpatient services like primary care, maternity care, and behavioral health – services that can be difficult to maintain under other provider models when reimbursement challenges create budgetary pressures.

An interested facility should evaluate its financial data to ensure that a conversion to REH status would be financially viable and sustainable. Additionally, it is critically important that an interested facility collaborates with its community to ensure the community supports ongoing access to services and REH conversion.

To convert, eligible hospitals must:

- Develop and submit an implementation plan to CMS that includes:
    - A transition plan with an evaluation of community need
    - A strategy for maintained, added, or modified services – specifically, facilities must provide an explanation for what they will do with the increased funding from CMS to support telehealth, ambulance operating costs, and the provision of emergency services
    - A transition plan for discontinued services
- Maintain an annual average length of stay that does not exceed 24 hours
- Provide emergency laboratory services 24/7 directly or through contract
- Have a transfer agreement in place with a Level I or II trauma center
- Staff the emergency department 24/7 with an individual who is competent in the skills needed to address emergency care
    - CMS relaxed the proposed rule which would have required that providers with certain credentials be on-site during certain periods; notably, CMS did not specify certain provider types in the final rule (learn more in this K&L Gates legal brief on the topic)

- Measure, analyze, and track staffing as a quality assurance and performance improvement metric
- Meet CAH-equivalent CoPs for emergency services
- Meet state licensing requirements (which do not currently exist in Colorado)

Once converted, REHs may:

- Operate a distinct part SNF or off-campus, provider-based departments (PBDs)
    - These are not eligible for REH enhanced payments
- Serve as a telehealth originating site
- Extend existing Stark Law exceptions for hospitals to allow compensation arrangements (e.g., physician recruitment, retention, etc.)
- Convert back to a CAH or prospective payment system (PPS) hospital

Reimbursement:

- **Medicare:** The model provides a 5 percent Medicare reimbursement boost for covered outpatient services, plus an annual facility fee payment to cover core operational costs (~~$3.2 million per year according to estimates~~). Additional background from Alston & Bird:
    - Pays REH services at a rate equal to the applicable Outpatient Prospective Payment System (OPPS) payment plus 5 percent. The additional 5 percent is not subject to beneficiary copayment.
        - This payment rate extends to off-campus PBDs of an REH, regardless of whether such off-campus PBDs would be excluded from OPPS payment for a hospital.
    - Permits REHs to provide outpatient services that are not otherwise paid under OPPS (e.g., lab services paid under the Clinical Laboratory Fee Schedule), as well as post-hospital extended care services furnished in a distinct part SNF.
        - These services would not be considered REH services and would not receive the 5 percent enhanced payment.
    - Pay a monthly facility payment of $272,866 in calendar year 2023, increasing in future years based on the hospital market basket percentage increase. The monthly facility payment does not vary based on REH provider size.
- **Commercial Insurance**: There is no mandate in statute or regulation – for this model to be viable, insurers would need to include these facilities as in-network providers.
    - To support this practice, the Colorado Department of Health Care Policy and Financing (HCPF) could work with the Colorado General Assembly to expand the definition of "Essential Community Provider" within Section 25.5-5-403 C.R.S. to ensure that insurers are incentivized to maintain inclusion in insurance networks should a hospital need to convert to an REH.
- **Medicaid:** There is an outstanding question regarding how state Medicaid programs will pay for REH services. To ensure operational success, HCPF must be a partner in the effort to ensure that the financing mechanism supports financial viability in these settings should any Colorado

hospitals need to convert – including how payments like the Hospital Provider Fee would be resolved.

Additional Medicaid Implications:

- **CHASE (Colorado Healthcare Affordability and Sustainability Enterprise)/Hosptial Provider Fee:** Supplemental payments from the Hospital Provider Fee are based on Medicaid utilization, which would have significant implications for REH reimbursement. For example, the inpatient supplemental payment is calculated using estimated Medicaid discharges multiplied by a per-diem. If a hospital were to elect to become a REH, it would no longer have Medicaid discharges and its inpatient supplemental payment would become zero. In 2021-2022, the average supplemental payment was $4.4 million.

Proposed Short-Term Legislative Solution: Without legislative action on licensure and Medicaid reimbursement, it would not be possible for a hospital to convert to an REH and continue providing life-saving care to its community. With the recognition that more work needs to be done on both rural hospital sustainability and how best to scope/model an REH provider, the outline below provides a potential framework for an interim policy step.

Enact enabling legislation:

- Directing the Colorado Department of Public Health and Environment (CDPHE) to establish a new REH licensure type
    - Legislation to address this has been enacted in Kansas, Nebraska, and South Dakota; (see the National Conference of State Legislatures for more information)
- Providing HCPF emergency rulemaking authority to establish sustainable reimbursement for REHs and an actionable payment transition plan (a cost plus 20 percent model could address the Medicaid reduction)
- Establishing a HCPF workgroup with interested parties to discuss rural hospital financial challenges, Medicaid reimbursement, and expanding the definition of essential community provider to explicitly include REHs

Additional Considerations:

- **340B:** REHs do not qualify for the 340B program; Congress would need to amend statute to allow REHs to qualify for 340B program savings, which is unlikely.
- **Annual length of stay:** There have been requests for Congress to amend statute to allow for an annual average length of stay of up to 48 hours.

Resources:

- Rural Health Info Webinar (January 2022)
- AHA Rural Hospital Challenges Report (September 2022)
- Example of a Michigan Hospital Converting (September 2022)
- NCSL REH Background (August 2022)
- CMS Fact Sheet (November 2022)

- K&L Gates REH Policies (November 2022)
- Alston & Bird Summary (November 2022)