



RURAL EMERGENCY HOSPITAL

POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

OCTOBER 2021

—NACRHH—

National Advisory Committee on Rural Health and Human Services

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EDITORIAL NOTE

In October 2021, the National Advisory Committee on Rural Health and Human Services (hereinafter referred to as “the Committee”) convened its 89th meeting virtually to examine two topics, Behavioral Health and Primary Care Integration and the Rural Emergency Hospital (REH), a new type of rural hospital created by Congress in 2020. This policy brief address the REH model. Prior to the meeting, the Committee heard from a variety of policy experts, academics, and community stakeholders for their perspectives on the potential opportunities and challenges for the REH provider designation.

ACKNOWLEDGEMENTS

The Committee would like to acknowledge those whose comments and insights helped make the October 2021 meeting and this policy brief possible.

The Committee would like to thank all the following individuals for sharing their expertise: Emily Cook, JD (McDermott Will & Emery); George Pink, PhD (University of North Carolina); Margaret Greenwood-Ericksen, MD, MPH (University of New Mexico); the Patterson Foundation; and the subject matter experts in the Federal Office of Rural Health Policy.

POLICY RECOMMENDATIONS

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.

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 5: The Committee recommends that the Secretary ensure that Medicare Conditions of Participation allow the REH administrator to meet the requirement for a Nursing Home Administrator or that a licensed Nursing Home Administrator from a nearby facility can serve in that role.

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.

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 9: The Committee recommends that the Secretary direct the Assistant Secretary for Planning and Evaluation to study and model the appropriateness of the Additional Facility Payment to maintain emergency and outpatient services as well as provide community benefits in the first year of REH implementation.

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.

Recommendation 11: The Committee recommends that the Secretary ensure that REHs have flexibility in establishing transfer agreements that link transfer to Level I or II trauma centers to patient need while also allowing transfers to other hospitals as clinically indicated.

Recommendation 12: The Committee recommends that the Secretary, working through the Assistant Secretary for Planning and Evaluation, assess whether REH eligibility should be expanded to meet health care access challenges in rural communities.

Recommendation 13: The Committee recommends that the Secretary work with Congress to provide needed technical assistance to communities considering the REH model.

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.

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.

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INTRODUCTION

In December 2020, Congress passed the Consolidated Appropriations Act (CAA) of 2021¹ (Public Law 116-260), which, in Section 125, created a new Medicare provider type called the Rural Emergency Hospital (REH). The REH will be a new rural hospital type that does not provide inpatient care but will provide 24-hour emergency services. By creating the REH, Congress has established the first new rural provider type in over 20 years when the Critical Access Hospital (CAH) was created in 1997 under the Balanced Budget Act (Public Law 105-33). The REH comes as a response to an ongoing period of hospital closures in rural communities and to the concerns of access to emergency services in rural areas. Policymakers believe the REH will provide an option for communities that are perhaps too small to support a full-service hospital but need more than ambulatory care. As per the legislation, a CAH or small rural hospital with no more than 50 beds can convert to the REH provider type and begin providing services beginning January 1, 2023. In the intervening months, the Centers for Medicare & Medicaid Services (CMS) will create and finalize regulations for the REH. The Committee will assess a range of questions for CMS and other policymakers to consider as it develops and finalizes the REH regulations. In keeping with the Vision, Mission, and Values² that govern the Committee, all deliberations, insights, and recommendations presented in this policy brief are offered through the lens of a diverse rural America made up of communities of healthy people with access to providers who offer world-class health care and human services. In particular, the Committee notes the implications the REH program also offers an innovative way for rural communities to integrate care and services sectors.

BACKGROUND

Rural Hospital Closures

Between January 1, 2010, and October 1, 2021, 138 rural hospitals closed, including 93 Prospective Payment System (PPS) hospitals and 45 CAHs.³¹ While there has been considerable attention in the media on rural hospital closures, a related and ongoing concern is the financial viability of the remaining facilities. During the past decade, policymakers have recognized that rural communities need options other than full-service hospitals, to ensure access to essential services. The CAA created the REH provider type to give rural communities with struggling rural hospitals an option between a traditional acute-care hospital and complete closure.

The impact of rural hospital closures is varied, but is often detrimental to the communities they once served. When a rural hospital closes, mortality in that community increases,⁴ the local economy suffers as health care jobs are lost, and residents must travel further to seek care.⁵

The University of North Carolina (UNC) Sheps Center for Health Services Research tracks rural hospital closures and the impact these closures have on rural communities. By their definition, a “closed hospital” is one that stopped providing short-term, general, acute inpatient care.⁶ A hospital closure could be classified as either: (1) a complete closure with no health care services available at the former hospital site, or (2) a converted closure that provides services other than inpatient care (e.g., outpatient, emergency, urgent care, skilled nursing, or rehabilitation services). This distinction between fully closed and converted is important to keep in mind when thinking about what a rural hospital closure means for a community and why that might vary from case to case.

ⁱ This total does not include hospitals that closed and subsequently reopened.

The 138 rural hospital closures since 2010 occurred all across the United States, but many are concentrated in the South. ⁷ A literature review conducted by the Rural Policy Research Institute (RUPRI) as part of research supported by the Federal Office of Rural Health Policy (FORHP) found a number of factors related to rural hospital closures, including:⁸

- Insufficient revenue for sustaining the cost structure of acute care hospitals; and
- Declining population of the communities and other market conditions that contribute to financial instability; and
- 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; and
- 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; and
- Shifts in health care delivery from inpatient care to outpatient care, resulting in declining inpatient utilization and associated revenue.

As financial distress can be a risk factor for closure, UNC developed a financial distress index, ⁹ and estimated that, in 2020, 210 rural hospitals were at high risk of financial distress. ¹⁰ UNC research found that, overall, rural hospitals and CAHs predicted to be at high risk of financial distress served communities that had a number of common factors including:

- Higher percentages of non-White and Black residents; and
- Lower rates of high school graduation; and
- Higher rates of unemployment; and
- 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.¹¹

Moving Toward a New Model

For more than 30 years, members of Congress and various Administrations have worked with rural health stakeholders to try to identify appropriate health care delivery models that are viable in rural communities. Several special Medicare payment designations and demonstrations have been used to support rural communities. The Sole Community Hospital (SCH) designation began in 1983 to provide alternative payments to hospitals that may be the sole provider in a geographic area. In the late 1980s, the Montana Medical Assistance Facility demonstration tested whether converting a full-service hospital into a low-intensity, short-stay health care service center could preserve basic care in rural areas. In 1990, a Medicare Dependent Hospital designation was established to increase payments to rural hospitals serving a significant portion of Medicare beneficiaries. In the 1990s, the idea of creating a limited-scope hospital in a rural areas was expanded to seven states in the Essential Access Community Hospital and Rural Primary Care Hospital demonstration (EACH/RPCH). ¹² In 1997, Congress created CAHs in the Balanced Budget Act of 1997.

From 2010 through 2013, FORHP and CMS administered the Frontier Extended Stay Clinics (FESC) demonstration primary care clinics in isolated areas to provide Medicare beneficiaries with services over extended periods, including overnight. This model was designed to address the needs of seriously ill or injured patients who could not be transferred to a hospital, or who needed monitoring and observation for a limited period of time. The FESC demonstration had mixed results. ^{13 14} It successfully showed that small frontier ambulatory practices could offer extended-stay services and that patients found value in the service such as saved time, lower transportation costs, and being able to receive care locally.¹⁵

However, low reimbursement rates coupled with low patient volume made the model not financially viable.

The increase in rural hospital closures in recent years has created concerns among stakeholders and policymakers about dwindling access to essential services in rural communities. As a result, members of Congress, advocacy groups, and others proposed plans to address these concerns and eventually coalesced around a new hospital type that would not provide inpatient services, but would focus on outpatient and emergency services.

In 2015, the House and Senate both introduced the “Save Rural Hospitals Act,” to establish a program whereby rural hospitals meeting specified requirements would be eligible for enhanced payment for certain outpatient services and called it the Community Outpatient Hospital (COH) program. The bill attracted attention but did not move toward passage and its sponsors reintroduced it in each new session of Congress over the next five years. During that time, the Medicare Payment Advisory Committee (MedPAC), an independent congressional agency that provides analysis and policy advice on the Medicare program, also weighed in. In its June 2018 report, MedPAC recommended that Congress should “allow isolated rural stand-alone emergency departments (more than 35 miles from another emergency department) to bill standard outpatient prospective payment system (OPPS) facility fees and provide such emergency departments with annual payments to assist with fixed costs.”¹⁶ Finally, during the 2020 Presidential election, then-candidate Joe Biden put forward a proposal that called for more flexibilities for rural hospitals that included the COH provider type put forward by the Save Rural Hospitals Act.¹⁷ Other groups, such as the National Rural Health Association (NRHA)¹⁸ and the American Hospital Association (AHA)¹⁹ have endorsed the Act.

The Rural Emergency Hospital

The culmination of these efforts came in December 2020, when Congress passed the CAA. Section 125 of the CAA established the REH designation under the Medicare program, a new type of rural hospital that would receive enhanced payment on the condition that certain requirements are met.²⁰ The legislation provides guidance as to the eligibility requirements and payment structure, but CMS will have to establish regulations through the rulemaking process prior to January 1, 2023, the statutory effective date.

Hospitals wishing to become an REH must meet the statutory requirements laid out in the CAA. These requirements fall into the four broad categories below.²¹

- **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 “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; and
 - Other requirements that CMS puts in place.
- **Requirements:** An REH must:
 - Not provide acute care inpatient services; and
 - Not exceed an annual average patient length of stay of 24 hours; and

- o Have a transfer agreement in place with a Level I or II trauma center; and
 - o 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
 - o Meet CAH-equivalent Conditions of Participation (CoPs) for emergency services; and
 - o Meet applicable state licensing requirements; and
 - o Meet quality reporting standards established by the HHS Secretary; and
 - o Meet requirements applicable to skilled nursing facilities in the case where the REH includes a distinct part unit; and
 - o 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.
- 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.

FEDERAL PROGRAMS

The REH provider type will have implications for many different federal entities, starting with CMS, which is responsible for rulemaking for the REH. Below is listed the federal entities for which the REH will have implications.

CMS

Section 125 of the CAA charges CMS with finalizing the regulations to create the REH provider type. CMS is also responsible for setting Medicare payment rates, establishing CoPs, surveying the facilities, and monitoring ongoing compliance. In advance of rulemaking, CMS has issued a Request for Information on the REH to solicit comments from stakeholders. Additionally, CMS held an All Tribes webinar in October of this year, seeking input on the potential implications of the REH for the Indian Health Service (IHS) and Tribal Hospitals.

Health Resources and Services Administration (HRSA)

The FORHP is located in HRSA and is charged in Section 711 of the Social Security Act (SSA) with advising the HHS Secretary on rural health issues. In addition, FORHP administers the grants specified under Section 1820(g) of the SSA to support CAHs under the Medicare Rural Hospital Flexibility (Flex) Program, and hospitals with fewer than 50 beds under the Small Hospital Improvement Program (SHIP). These grant programs are administered in partnership with the states and focus heavily on technical assistance. The Flex Program's goals are to support CAHs to enhance the quality of rural health care, improve financial and operational performance, integrate with rural Emergency Medical Services (EMS) agencies, enhance rural communities through population health improvement, and develop innovative models of care. The statutory REH language does not mention the administration of technical assistance. However, given FORHP's statutory charge, it is reasonable to expect that the office will have the experience and interest in the implementation of the REH and its ongoing impact on rural communities.

REHs also could potentially participate in programs operated under HRSA's Office for the Advancement of Telehealth. The statutory language allows REHs to be telehealth originating sites, meaning that they can serve as locations where patients physically go to access telehealth. The new REHs also may benefit from HRSA's workforce programs, particularly the National Health Service Corps, Nurse Corps Repayment Program, and State Loan Repayment Program. These programs provide loan repayment and other support for clinicians willing to practice in underserved areas.

Other HHS Entities

Other HHS entities will also likely be involved with the REH before or after it becomes a provider type. Those entities are listed below:

- The Indian Health Service: The mission of the IHS is to "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."²² Some tribal hospitals could be candidates to convert to an REH, which means that the REH model has implications for the IHS mission.
- The Substance Abuse and Mental Health Services Administration: REHs may also be of interest to other HHS programs meant to support mental health and substance abuse, which are primarily operated by the Substance Abuse and Mental Health Services Administration (SAMHSA). While REHs are bound by legislation to only provide outpatient and emergency services, this may include ambulatory behavioral health services, including substance use disorder treatment.
- The Administration for Children and Families and the Administration for Community Living: REHs can also play a role in addressing social determinants of health, which often have a substantial impact on rural communities. REHs could be eligible for programs operated by other HHS entities like the Administration for Children and Families and the Administration for Community Living.
- The Centers for Disease Control and Prevention (CDC) could potentially engage REHs for public health and infection control initiatives in the future.

Other Federal Entities

REHs will be operating in rural areas, meaning that they could potentially interact with other federal programs that address economic, agricultural, nutritional, educational, and technological issues. Entities that work on these issues include the Department of Labor and its Employment Training Administration, the Department of Agriculture, and the Federal Communications Commission. These entities may be interested in supporting REHs as a new provider type in improving access to care, and REHs may find these entities useful in their efforts to improve health care.

POLICY RECOMMENDATIONS

The Committee is encouraged that CMS issued a Request for Information in its proposed Calendar Year 2022 Medicare Outpatient Prospective Payment System Rule.²³ This policy brief seeks to add to that public submission and offer a range of recommendations and considerations for the Secretary when finalizing the REH regulations. For the purposes of this brief, the Committee initially focused on key issues related to potential CoPs, quality reporting requirements, the structure and design of the REH payments, emergency medical transfer, and other HHS-actionable policy issues. The brief also

includes an examination of issues that go beyond that which was specified in the legislation that HHS may want to consider in future budget and policymaking activities.

Conditions of Participation

The Committee believes CMS should provide as much regulatory flexibility as possible in the CoPs, taking into account the size and scale of the REH. While the CAH CoPs may be informative, it is clear that the REH will be a different and more limited clinical operation. For example, the Committee believes CMS should exercise caution in setting any sort of formal guidance related to patient acuity levels that would trigger a transfer to a high-level facility to provide flexibility and to recognize the diversity of situations for each REH. It also will be important to flexibly define the requirements related to 24-hour observation period for REHs and the "reasonable expectation" on that time period. The Committee's concern is that the ambulance services needed to transfer a patient may not be available in a timely manner.

CMS also may want to review key lessons learned from the FESC demonstration, which has some basic similarities to the REH.^{24 25} In that demonstration, challenges arose, such as storage of blood products and the quantity of those products that had to be maintained. It may be that the correct CoP balance for the REH is somewhere between the CAH and FESC standards.

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.

Co-located services/Provider-based entities

Historically, the Committee has supported efforts to promote co-location of services in rural communities. With the establishment of the REH, HHS has an opportunity to promote this notion as REH converters may be in hospitals that have available space to lease to other services. This could include RHCs, skilled nursing facilities (SNFs) as distinct-part units of the REH, or dialysis clinics. The challenge for CMS will be to account for the small scale and size of the REH and to take that into account in a way that reduces administrative burden in the initial and ongoing survey and oversight processes.

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.) encourage co-location.

Staffing

The Committee also notes a number of CoP staffing considerations. The statutory language is clear that the CoPs for CAH emergency services (42 CFR § 485.618) apply to REHs. However, during the COVID-19 Public Health Emergency (PHE), CMS waived the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at 42 CFR § 485.631(b)(2).²⁶ CMS explains their reasoning for this waiver is

that “this will allow the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed.”²⁷ The Committee believes REHs will need even more staffing flexibility than CAHs, given their smaller size and staffing. The waivers given to CAHs during the PHE represent a model that they could use for REHs under normal, non-PHE, circumstances. In providing this flexibility, the Committee recognizes that REHs would need to meet all applicable state staffing, educational training, and scope of practice requirements.

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.

It is likely that some of the hospitals that convert to REHs will have previously offered skilled nursing care services through Swing Beds. As they transition to REH status, these facilities may still need to offer these services. While the legislation made no allowance for swing beds in the traditional sense, it did allow for an REH to have an associated Skilled Nursing Facility (SNF) distinct-part unit. However, Medicare SNF CoPs require a certified licensed nursing home administrator. This requirement may pose an extra burden on the REH.

Recommendation 5: The Committee recommends that the Secretary ensure that Medicare Conditions of Participation allow the REH administrator to meet the requirement for a Nursing Home Administrator or that a licensed Nursing Home Administrator from a nearby facility can serve in that role.

Quality Reporting

The REH authorizing language includes a considerable amount of flexibility and discretion for the HHS Secretary in requirements for reporting on quality, and it acknowledges the challenges of quality measurement when there are low patient volumes. The Committee believes that CMS would benefit from building on the success of the CAH Medicare Beneficiary Quality Improvement Project (MBQIP)²⁸ and as well as the lessons learned from the CMS-sponsored National Quality Forum (NQF)²⁹ rural quality measurement reports. For example, the NQF work to inform the Measure Applications Partnership (MAP) Rural Health Final Report of 2018³⁰ identified a core set of rural-relevant measures that included measures related to emergency care. NQF’s work is ongoing.

MBQIP

The MBQIP was designed by HRSA to promote voluntary quality reporting by CAHs. Under current statute, all PPS hospitals are required to submit quality data to receive their full Medicare payment update. CAHs, which are not paid using the PPS, do not have the same quality reporting requirements. HRSA, through FORHP, used funding from the Flex program to support voluntary CAH quality reporting. The MBQIP identified a set of existing quality measures that were the most relevant for CAHs, given their size and scale, and worked with those facilities to support quality reporting. The MBQIP currently includes measures in four areas: Patient Safety/Inpatient, Patient Engagement, Care Transitions, and Outpatient. Of these four areas, the Committee believes that three are relevant to REHs while the fourth, Patient Engagement, measured using the Hospital Consumer Assessment of Healthcare Providers and Systems survey, is less relevant given data collection limitations.

The Committee believes that the current outpatient and emergency department MBQIP measures most relevant to REHs are:

Core MBQIP Measures

Care Transitions	Outpatient	Patient Safety
Emergency Department Transfer Communication (EDTC) <i>1 composite; 8 elements</i> • All EDTC Composite • Home Medications • Allergies and/or Reactions • Medications Administered in ED • ED provider Note • Mental Status/Orientation Assessment • Reason for Transfer and/or Plan of Care • Tests and/or Procedures Performed • Test and/or Procedure Results	AMI: • OP-2: Fibrinolytic Therapy Received within 30 minutes • OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention ED Throughput • OP-18: Median Time from ED Arrival to ED Departure for <i>Discharged</i> ED Patients • OP-22: Patient Left Without Being Seen	HCP/IMM-3 (formerly OP-27) - Health Care Professionals Flu Vaccination Rate Antibiotic Stewardship: Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey

Additional MBQIP Measures

Care Transitions	Outpatient	Patient Safety
Discharge Planning Medication Reconciliation	Chest Pain/AMI • Aspirin at Arrival • Median Time to ECG ED Throughput • Door to Diagnostic Evaluation by a Qualified Medical Professional	COVID HCP vaccination measure *Not currently an additional measure

The Committee urges CMS to design an initial measure set for REHs that focuses on measures where the low volume of cases allows for statistical relevance. For example, the ED Transfer Communication measure that is the foundation of the MBQIP likely will be a critical measure for REHs, given that it is focused on emergency services. CMS may also want to consider adjusting the measures over time as more experience is gained with the initial REH cohort. Given the low-volume nature of an REH, the Committee believes that there may be some benefit in considering longer data quality metric reporting periods to improve statistical reliability. Statistical approaches to address low volume, such as borrowing strength, were the subject of the 2020 MAP Rural Health Report from NQF³¹ and could be considered. There may also be some benefit in looking at measures that could be rolled up into a summary quality measure.

The Committee discussed whether patient satisfaction, the Patient Engagement area in MBQIP, should be a metric and be part of CMS' considerations. The challenge with current patient satisfaction measures is the expense of gathering the information and the low response rate by beneficiaries in the survey process. Several committee members believe that REHs are an appropriate setting to try out new and lower-cost/intensity ways to measure the patient experience. As CMS continues to develop patient satisfaction

measures for outpatient and emergency department settings, consideration of data collection methods appropriate to low volume and low resource settings will help expand patient experience quality measurement to include 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.

Reimbursement

The statute's provisions regarding the REH Medicare reimbursement are fairly prescriptive (as noted on page 4). As the Committee assessed the potential reimbursement issues, it focused mostly on the calculation of the AFP, which is a fixed monthly payment in addition to reimbursements for services. The statute specifies that this monthly payment is calculated by taking 1/12th of the difference between actual Medicare payments made to CAHs in 2019, using cost-based reimbursement methods, and what CAHs would have been paid under the Medicare prospective payment system for inpatient hospital, outpatient hospital, and skilled nursing facility services. The aggregate amount of the difference then is divided by the number of CAHs operating in 2019 to calculate a per-CAH amount. The AFP would be updated annually by the Medicare hospital market basket percentage.

In calculating the AFP, CMS will need to make several decisions on how to determine what CAHs would have been paid under the various prospective payment systems, and these decisions will be critical in determining the amount of the AFP. The CAA language notes accounting for SNF services, but it does not explicitly include swing beds, which provide both inpatient and skilled nursing facility services. The Committee believes that the CAA language is intended to include swing bed services provided in CAHs.

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.

Congress did not specify how this monthly payment must be used, but they did require that REHs maintain detailed information on how the payment was spent and provide records to HHS upon request. As REHs are unlikely to have patient volumes sufficient to cover the cost of care as well as the cost of keeping the doors open (e.g., building maintenance, utilities, salaries), the AFP could provide a consistent revenue stream. The AFP also has the potential to allow the community to benefit from a care model that is not tied to an inpatient model but still able to offer essential services such as emergency care and outpatient services. However, if the AFP is not high enough, many facilities that might have considered REH status will not because it will make more business sense to remain a full-service hospital, even if they remain at financial risk.

The statute requires that the Secretary conduct three studies to evaluate the impact of REHs on the availability of health care and health outcomes in rural areas four years, seven years, and ten years after enactment of the CAA.³² The first mandated study is due to Congress in July of 2025. Additionally, MedPAC is required to review payments to REHs beginning with 2024. However, the first of these mandated reports will not be published for several years after the implementation of the REH provider type in 2023. The

Committee noted that decisions at the beginning of REH implementation may determine how successful the new provider type is at maintaining and improving access to care in rural areas. In particular, the amount of the AFP is likely to be a critical factor in the success or failure of new REHs.

Recommendation 9: The Committee recommends that the Secretary direct the Assistant Secretary for Planning and Evaluation to study and model the appropriateness of the Additional Facility Payment to maintain emergency and outpatient services as well as provide community benefits in the first year of REH implementation.

Because REHs are intended to be a local source of outpatient and emergency care, it will be critical that insurers include these facilities as in-network providers. Under the Federally-Facilitated Marketplaces, Qualified Health Plans are required to contract with a specified percentage of Essential Community Providers (ECPs) that treat low-income and medically underserved individuals. It is likely that many hospitals considering converting to be REHs, especially CAHs, are already signed up as ECPs. Allowing REHs to qualify as an ECP under the Other ECP Provider category will encourage their inclusion in insurance networks.

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.

Emergency Medical Transfer

The CAA's REH language requires that an REH must have a transfer agreement with a Level I or II trauma center. The statutory language is silent when it comes to what must specifically make up the transfer agreement with the Level I or II trauma center. The Committee believes this requirement makes sense but may be limiting in that it may be beneficial to also have transfer arrangements with other hospitals. For example, transfer agreements with only Level I or II trauma centers may result in rural ambulance services making frequent trips with potentially longer travel times for more geographically isolated REHs. Depending on patient needs, a transfer to a closer hospital that is not a Level I or II trauma center may be medically appropriate. The Committee notes that maintaining multiple transfer agreements may create a financial and administrative burdens on REHs. To ease potential unintended consequences of transfer agreements, CMS should afford REHs flexibility in creating their transfer agreements and allow REHs to establish the number and type of transfer agreements appropriate to their individual circumstances while meeting the statutory requirement of at least one transfer agreement with a Level I or II trauma center.

Recommendation 11: The Committee recommends that the Secretary ensure that REHs have flexibility in establishing transfer agreements that link transfer to Level I or II trauma centers to patient need while also allowing transfers to other hospitals as clinically indicated.

Other Policy Recommendations

The Committee's assessment of the REH also raised a range of other issues that go beyond the core elements of this model as envisioned by Congress. Typically, when a new provider type is created, there are adjustments and modifications made over time. In some of those cases, Congress will clarify its intent or make broader changes to the model. In this section, the Committee will examine other considerations that policymakers should consider as the REH model evolves.

As currently legislated, the only entities that can become REHs are CAHs and rural hospitals with no more than 50 beds that were open as the date of enactment of the CAA, December 27, 2020. The Committee

believes that eligibility may need to be expanded. The Committee believes that in creating the REH the Congress was ultimately focused on ensuring access to care for key services such as emergency services in rural communities. Given 138 hospitals have closed between 2010 and October 2021, there may be rural communities facing severe access challenges where the hospital closed before December 2020 and left a gap in coverage without the option of reopening as an REH.

The Committee discussed the implications of the current limits on REH eligibility and the varied health care needs of different rural communities. The Committee urges consideration of expansion of this designation to include hospitals that closed before December 27, 2020, and to include high-need isolated rural areas, often referenced as "emergency care deserts," regardless of whether they currently or previously had a hospital. The Committee believes that HHS would benefit from an objective analysis of REH eligibility to inform future policy.

Recommendation 12: The Committee recommends that the Secretary, working through the Assistant Secretary for Planning and Evaluation, assess whether REH eligibility should be expanded to meet health care access challenges in rural communities.

The Committee also is concerned that the specified AFP methodology may result in a payment that is insufficient to allow an REH to be financially sustainable. Many rural communities face long-standing disparities and have higher rates of chronic disease, higher poverty, and lower levels of educational attainment.³³ Factors such as these create broader structural challenges. The Committee believes that there may be some benefit to considering an additional adjustment to the AFP that accounts for these factors.

As noted earlier, the REH represents a different way of structuring care in a rural community that may create some challenges in the way that services are delivered. For example, typically a Medicare beneficiary comes to an emergency department and then may be admitted, stabilized, and then discharged for post-acute skilled care. In the REH model, the patient may be stabilized while in the emergency department and under observation status. They may only need skilled nursing care before being discharged home. However, the SNF "3-day rule" would still apply to the REH in the absence of a waiver. Therefore, in the REH model, the patient would then need to be transferred to another hospital to meet the 72-hour inpatient-admission requirement before receiving the skilled care they need. It will be important for HHS and Congress to assess whether the REH model offers a way to better link patients to needed skilled care without having to first incur an inpatient admission.

The Committee is also concerned about how to create incentives for REHs to be seen as valuable entities in value-based models, such as Accountable Care Organizations. However, the unique nature of REHs and the lack of cost and quality data may dissuade participation in value-based models. It will be important for HHS to take steps to avoid such an unintended consequence by ensuring that participation requirements in those models specifically allow for participation by REHs.

As communities consider whether the REH model makes sense for their needs, there will be a concurrent need for technical assistance. When the CAH designation was created, Congress also authorized and supported the Flex program, which provides funds to states to help communities to convert their hospitals to CAH status. It also then supported those CAHs to focus on quality and performance improvement.

Unfortunately, the REH statutory language did not include a similar companion program. The Committee believes this oversight may affect the ability of rural communities to assess whether conversion to an REH is the appropriate path. For any community considering REH conversion, they will need to conduct

financial and service feasibility analysis. They also will need help in putting together the application required in the legislation where they will explain how they will use the AFP. The Committee believes that states would also have an important role to play in this technical assistance.

Each REH will need to be licensed. That means states will have to create new licensure regulations to govern REHs. There is a need to develop model language that could be the basis of those state statutes to allow for the licensure of REHs.

Recommendation 13: The Committee recommends that the Secretary work with Congress to provide needed technical assistance to communities considering the REH model.

Attracting and retaining health care providers remains an ongoing issue for rural communities. HHS administers a range of workforce loan repayment and scholarship programs that provide a lifeline on this issue. As the REH providers are approved, HHS will need to update its eligibility for these programs to include REHs.

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.

The 340B Drug Pricing Program, administered by HRSA, helps eligible providers purchase certain outpatient drugs from manufacturers at a significantly reduced price.³⁴ Currently, CAHs and other specified types of hospitals that serve a disproportionate share of low-income patients are eligible providers that may participate in the 340B program. Section 340B(a)(4) of the Public Health Service Act specifies which covered entities are eligible to participate in the program, and including REHs as covered entities would require a change to the statute. The Committee believes that REHs should be eligible to participate in the 340B Program because many are likely to have been eligible before converting to an REH, and they will be providing outpatient services, including prescription drugs.

Recommendation 15: The Committee recommends that the Secretary work with Congress to expand eligibility for the 340B Drug Pricing Program to include REHs.

The Committee identified two other areas of consideration related to the REH that will require special attention. The first focus area concerns the applicability of this new provider type to serve rural tribal populations. The Committee believes the model may be a valuable option to serving geographically isolated tribal areas. This issue is discussed in more depth in Appendix A. The Committee believes that there may need to be some adjustments made and that those changes may be best identified through a formal HHS-Tribal consultation process.

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.

The second focus area relates to the impact the REH may have on the provision of emergency medical services in rural communities. Rural areas already face significant challenges in offering sustainable EMS. As the Committee assessed the REH model, it became clear there may be new challenges in how the REH affects the provision of EMS but also some opportunities to re-think how these services are provided and to promote integration of services. Some of these EMS concerns are beyond the scope of CMS, but are worth noting and are discussed in more detail in Appendix B.

Other Policy Considerations

Multiple provisions or benefits that are available to CAHs and PPS facilities are not specified as available to REHs under the legislation. The Committee believes the Congress and HHS should consider the option of allowing REHs to benefit from those provisions and pursue legislation and regulatory action that would address the following issues:

- 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.

CONCLUSION

The Committee is convinced that the REH model will fill an important need in rural communities and fully supports its implementation, particularly as the model capitalizes on continued innovation and rural values, which are key tenets of the Committee's Vision, Mission, and Values. The model requires integration and coordination among rural health clinics, trauma centers, and related services, which allows communities to meet their care and service access needs. This will be particularly true for those communities that are not large enough to support a full-service hospital but still need more than a clinic.

The Committee commends the Congress for designing the model around the AFP and allowing each facility the flexibility to use those funds to best meet local need. As noted, there are concerns about the level of that payment but the its conceptual framework offers communities a path forward to preserve access to services in a way that is difficult to do under current reimbursement mechanisms. The Committee's recommendations offer a mix of practical considerations to inform future rulemaking by CMS on the REH, as well as, longer-term considerations that go beyond the model as currently authorized.

Communities considering conversion to the REH will have to address a number of important questions about the implications for local residents and determining the appropriate mix of viable health care services and whether that is best delivered via a rural inpatient hospital or through a REH. In the development of this policy brief, the Committee benefited from the experience of the Patterson Foundation, which worked with communities facing difficult choices about how to ensure a sustainable care model in rural Kansas. That experience, which involved consolidation of two hospitals into a single hospital, benefitted from a clear and transparent community engagement process.³⁵ State Offices of Rural Health, foundations and other stakeholders may be able to play a role in helping communities work through this process.

The Committee believes that the REH represents a markedly different way to support access to rural health care services. When the CAH designation was created, policymakers had a sense of how things would evolve because it was informed by the prior EACH/RPCH demonstration. In the case of the REH there is no preceding program. Consequently, the Committee believes that the required report to Congress will be critically important in making adjustments to the REH program.

APPENDIX A – Indian Health Service Considerations on the REH Designation

The Committee believes the REH designation could also be a potential model for tribal communities, but suggests HHS consult formally with the tribes as it develops final rules. The Committee commends CMS for already holding an All Tribes webinar seeking input on the potential implications of the REH for IHS and Tribal Hospitals. The Committee believes this is an important first step by CMS in formally consulting with tribes as they develop their rules for the REH.

In the course of preparing this policy brief, the Committee recognized that there is a tribal consultation process, which serves as an enhanced form of communication by which the United States Federal Government ensures meaningful and timely input by American Indian and Alaskan Native (AI/AN) tribal officials in the development of regulatory policies that have tribal implications. This is an established practice within HHS and the Committee believes it would be particularly beneficial as the REH designation is developed and implemented.

The Indian Health Service (IHS) is the division of HHS Department of Health and Human Services (HHS) tasked with overseeing the provision of culturally competent and comprehensive health services to AI/AN people nationwide.³⁶ The IHS emphasizes decentralizing care operations in order to incorporate community input into their services and respond to specific health needs.³⁷ This decentralized approach for health care is accomplished through health services from the IHS, a tribal health program (THP), or an urban Indian organization (as those terms are defined in 25 U.S.C. section 1603).³⁸ Tribal health needs in rural areas are served by both the IHS and THP centers with the primary difference between the two being the organization that oversees the facility. Individual tribes or tribal organizations can elect to exercise their right to self-determination under the Indian Self-Determination and Education Assistance Act to assume control over health programs, with associated funding, that the IHS was administering.³⁹ Approximately 60 percent of IHS's budget is currently allocated towards THP.⁴⁰ Federal operations of the IHS also maintain a decentralized approach to care by managing health centers through 12 Area regional offices. These Area offices ensure that specific health needs are recognized and met through their service units.⁴¹

The REH will be the first new rural-specific designation created by Congress since it passed legislation in 1997 to form CAH. CAHs were designed to help keep eligible rural hospitals financially viable so that they could continue to stay open and provide vital health care services in underserved areas.⁴² When the CAH designation was developed, there was not a formal consultation process with IHS. Adoption of a tribal CAH model developed slowly. There were some policy regulations and other structural challenges that affected this. For example, the CAH designation's regulatory structure is heavily focused on serving the Medicare population and the financial benefits of CAH status is linked to the Medicare share of the population to be served. Many tribal hospitals have a lower Medicare share than the average rural hospital. IHS staff also noted that there were eligibility requirements that were in conflict with IHS and THP hospital regulations. Despite those challenges, a few tribal facilities in Arizona were early conversions to CAH status. Still, it was not until 2015 that CMS revised the regulations with 42 CFR 485.610(c) to allow IHS and THP hospitals, in addition to other necessary providers, to forgo specific distance requirements and achieve CAH eligibility.⁴³ Now, 30 percent of IHS and THP hospitals in the country are CAHs, demonstrating the structure of this payment designation may better meet the needs of hospitals serving AI/AN populations.⁴⁴

A tribal consultation process could help identify any potential barriers to tribal REHs that could then inform future HHS policy and legislative action. As is required in that process, HHS and the participating tribal entities would be able to develop an impact statement and communications with the tribes should share with HHS and the Office of Management and Budget director ahead of finalizing the REH policies. By collaborating with CMS, IHS and the tribal governments, policymakers can ensure that the REH

regulations will be appropriate for tribal nations. In going through this process, HHS and the tribal participants can also identify any statutory changes that might be necessary. Given the prescriptive nature of the REH implementing language in the Consolidated Appropriations Act, 2021 (CAA), HHS may have some statutory limitations in crafting REH policies that address any potential tribal concerns. The consultation process can help identify any areas that might need legislative changes to address tribal concerns. This engagement can also ensure that IHS and THP health care facilities that change status as Medicare Providers will be able to maintain revenue streams in accordance with their unique funding structure.

APPENDIX B – Emergency Medical Services (EMS)

While the Committee believes the creation of the REH provides new opportunities to preserve emergency department services in rural communities, there are a number of issues related to the provision of rural ambulance services that merit further attention.

In many ways, the REH will operate like a typical emergency department of a rural hospital with one significant exception. It will not have the ability to admit a patient for inpatient services. Instead, REH patients can be treated for a period not to exceed an annual per patient average duration of 24 hours. These requirements are different from other small rural hospitals such as CAHs that have more flexibility in how they can treat patients. For example, a CAH or other small rural hospital can move a patient from the emergency department to observation and then to a full inpatient admission or initiate a transfer to another hospital. REHs, by their very design, will either need to discharge or transfer patients on average during that 24-hour period. While this feature of the REH makes sense in terms of its scope, unintended consequences may arise. For example, demand for ambulance services to stand by at the REH for the potential transfer could increase. This increased number of transfers may stress an already taxed rural ambulance service and lead to service gaps in rural communities if ambulances are transferring patients and unavailable to respond to other emergency calls.

The Committee believes that there may be future opportunities to further leverage the new REH model to support and integrate ambulance services in rural communities. Nothing in the CAA REH language precludes REHs from owning and operating an ambulance service. An REH-owned ambulance service would be paid under the Medicare fee schedule in section 1834(l) of the Social Security Act, just as with any other ambulance service. The question is whether that will be a financially viable mode of service delivery. In the future, the Administration and Congress may consider adjustments to the REH model, in which case, the Committee believes assessing different ways to encourage co-location of EMS in the REH model is worth considering. This may provide an opportunity to think creatively about how to adequately finance ambulance services in REH communities. It may also create incentives to use EMS staff inside the REH facility when not completing transfers to other hospitals or transferring patients from the community to the REH. Hypothetically, some policymakers may point to the AFP as a way to support EMS. The Committee disagrees, noting that the ongoing challenges of rural ambulance services in terms of staffing and infrastructure go beyond the capacity of the AFP.

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