Rural Emergency Hospitals

August 2022

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AGENDA

- REH Overview
- Conditions of Participation
- Payment Policy
- REH Questions/Comments
- Evaluating REH
- Questions

Disclaimer

All information provided is of a general nature & is not intended to address the circumstances of any particular individual or entity. Additionally, a majority of the information contained herein is proposed & should be further examined once final rules have been published. Although we endeavor to provide accurate & timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the particular situation.

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REH Overview

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Rural Emergency Hospitals (REH)

- 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 & 2022
- REHs authorized in Consolidated Appropriations Act of 2021

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REH Overview

- An eligible facility is a CAH or subsection (d) with ≤50 beds as of December 27, 2020, located in a county (or equivalent) in a rural area or treated as rural through redesignation (1,716 potentially eligible)
- Payment process begins January 1, 2023
- Summary other requirements include (but not limited to) the following

  - Provide Emergency Department Services & Observation Care
  - Annual patient average of 24 hours or less (individual patients may be kept over 24 hours when necessary)
  - Cannot provide IP services (distinct SNF exception)
  - Transfer agreement with a Level I or Level II trauma center
  - Other conditions of participation

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REH Overview

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

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

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REH (CY 23 Proposed Rules)

- REH Health & Safety CoP Proposed Rule Federal Register issued 7/6/22
  - Comment by 8/29/22
- CY 2023 OPPS Proposed Rule Federal Register issued 7/26/22
  - Includes REH Payment Policy, Quality, Physician Referral, & Enrollment proposals
  - Comment by 9/13/22
- CY 2023 OPPS Final Rule to include both CoPs & Payment policies

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REH Conditions of Participation

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REH Conditions of Participation

- Services
- Staffing
- Infection Control
- Quality Improvement
- Transfer Agreements
- Physical Environment
- Discharge Planning
- Patient Rights
- Medical Records

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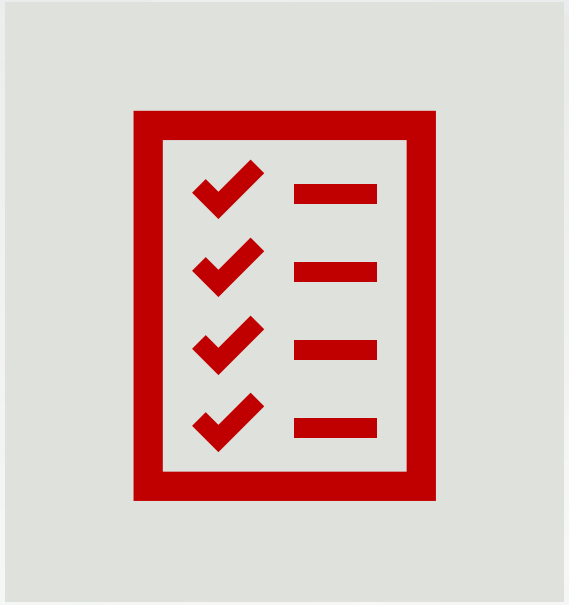
REH CoP: Emergency Services & Staffing



- Emergency Department services available 24/7
- Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist on-call & immediately available by phone and on-site within specified time frames
- 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 & 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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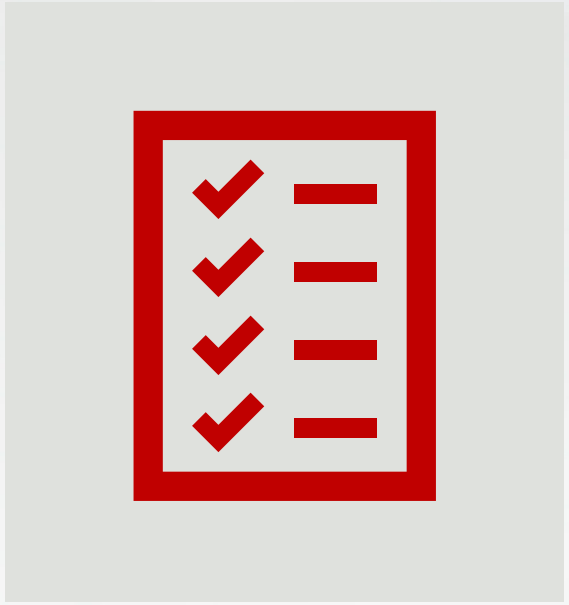
REH CoP: Optional Services



- May provide additional outpatient services
  - + Low-risk labor & delivery
  - + Outpatient surgeries
- May provide outpatient behavioral health treatment services
- May establish SNF unit, but must be distinct unit
  - + Separately licensed & certified
  - + SNF regulations & 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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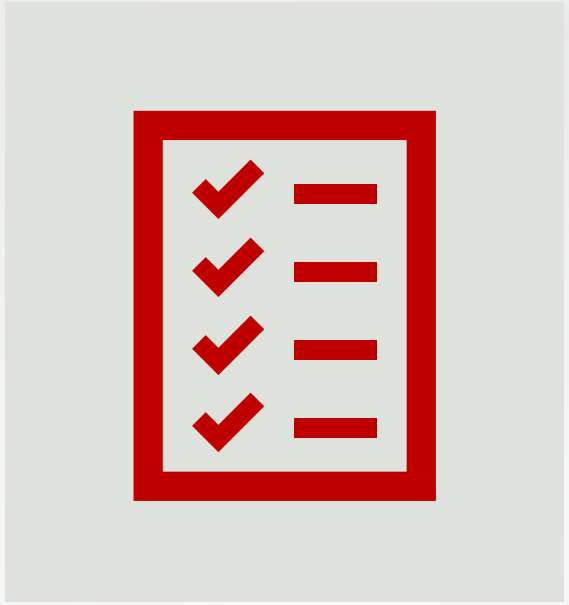
REH CoP: Radiologic Services

Radiologic services mirror hospital imaging requirements



- Must provide diagnostic radiologic services, plus additional radiologic services based on need of patients served
- Patient Safety
  - + Storage & 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 & procedure administration
- Records
  - + Reports signed by performing radiologist
  - + Records retained for at least 5 years (reports, films, image records, etc.)

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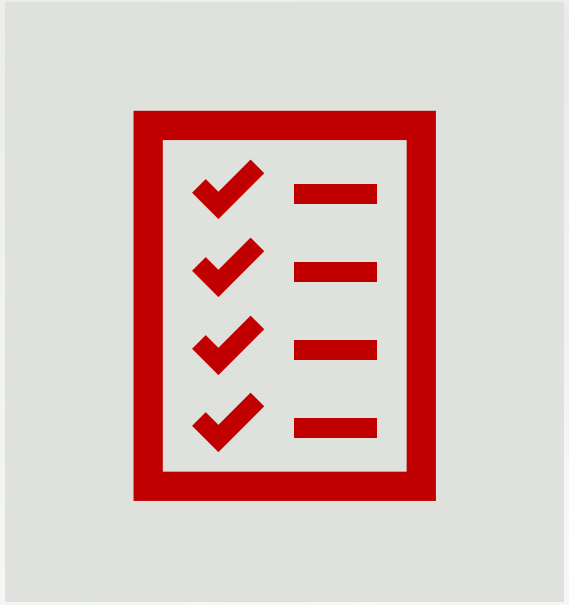
REH CoP: Pharmaceutical Services

Pharmaceutical services mirror hospital imaging requirements



- Management & Administration
  - + Pharmacist responsible for developing & supervising
  - + Adequate number of personnel for ED & OP services
  - + Current & accurate records
- Delivery of Service
  - + Compounding, packaging, & dispensing under supervision of pharmacist or another qualified individual
  - + Drug packaging & dispensing overseen by pharmacist or another qualified individual
  - + Drugs & 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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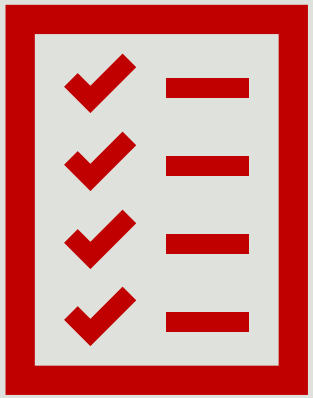
REH CoP: Agreements



- 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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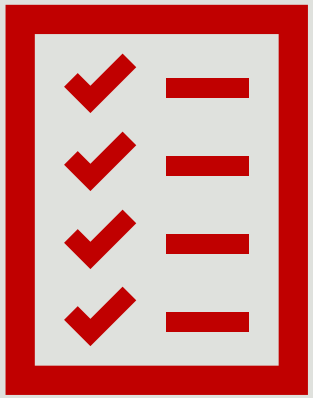
REH Quality Reporting

Quality Reporting – Initial requirements & requesting input



- 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 & services
- Recognizes reporting burden on smaller entity, possible solutions
  - +Use claims-based measure
  - +Digital measures vs. chart abstraction
- Core measures that apply to REH services (ED/obs)
- Others as applicable based on outpatient services provided

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REH Quality Reporting

- Example quality measures considered, & 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, Health Equity to help address rural health inequities
- See pages 44760-44764 for all-inclusive listing & discussion

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REH Enrollment

- Enrollment as an 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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REH Enrollment Documents

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

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REH Physician Referrals/Ownership

- Updates in physician referral regulation to incorporate new provider type REH
- Includes exception provisions related to physician ownership in REHs "proposed REH exception"
- Seeking comment on whether to apply more or fewer requirements related to physician ownership in REHs
- Considering annual report to CMS of ownership detail. Seeking comment on REH disclosure to public related to physician ownership

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REH Payment Policy

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REH Payment Policy

/ For REH payment purposes, REH services are covered outpatient services that would typically be paid under OPPS in an OPPS hospital

- Utilize existing OPPS payment policies
- REH payment equal to OPPS plus 5%
- Utilize OPPS claims processing system, logic to include REH flag
- Additional 5% not subject to patient copayment

/ REH services have no impact on OPPS budget neutrality, not used in OPPS rate setting

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REH 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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REH 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 previous paid at cost under CAH would be paid as fee schedule (not OPPS) if Section 603 applicable to REH

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REH Payment Policy

Off-Campus provider-based departments

- Proposes to codify 42 CFR 419.93 that items & services furnished by off-campus PBD of REHs are not applicable under Section 603
  - + REH services performed at off-campus PBD to receive OPPS plus 5%
- Seeking comment on proposed approach or alternative considerations for off-campus payments
  - + PPS off-campus that were subject to 603, whether to remain subject under REH?
  - + Under this approach, new locations subject to 603?

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REH Payment Policy

Additional Monthly Payment Methodology Proposed

- Monthly amount = $268,294 ($3,219,524 annual)
- 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 subsystems
      - Clinical lab
      - Physician services
      - Ambulance services
      - Other services that are reported on a CAH IP/OP or SNF claim form

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REH Payment Policy

Additional Monthly Payment Methodology Proposed (continued)

- Utilize CY 19 claims from CAHs including copayments
- 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 & 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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REH 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
  - + Step 1 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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REH Payment Policy

Additional Monthly Payment Methodology Proposed (continued)

- For CY 2024 & 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
  - +Initial year will be based off of cost report information
  - +REH required to file annual cost reports

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REH Questions/ Comments

- MGCRB reclass options applicable for REHs?
- PBRHCs – not addressed currently regarding grandfathering provisions
- Swing Beds – does not address Swing Bed but does reference SNF services would be under separate distinct SNF
- 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)
- Closed hospitals prior to 2020 & those closed since REH enactment?
- 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

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Evaluating REH

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REH Example Considerations

Post Acute strategy & discharge planning

Alignment of SNF or other CAH Swing Beds in system

Practices in system, potential alignment with REH for PB reimbursement

Utilization of previous IP space, expand OP services?

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Evaluate the #s

- Evaluate proposed revenue & expense changes
- Analyze the projected differential in current Outpatient reimbursement vs. Outpatient payment under REH
- Impact without 340B
- Potential volume shift to other providers within system
- New or expansion of services

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Let’s Talk…

Q&A

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Thank you!

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