Rural Emergency Hospitals

National Academy for State Health Policy

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Overview and Conditions of Participation

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Background

- Rural hospital and Critical Access Hospital closures
- Lack of access to services
- Consolidated Appropriations Act, 2021 (CAA) (Section 125, pg. 1779)
- Enacted on December 21, 2020

Statutory Requirements

- Must convert from either a rural hospital with not more than 50 beds or a Critical Access Hospital
- Must provide emergency services
- Must furnish observation care
- May provide other outpatient services as specified by the Secretary through rulemaking

Statutory Requirements (cont’d)

- May not exceed an annual per patient average length of stay of 24 hours
- May not provide any acute care inpatient services
- Are permitted to provide Skilled Nursing Facility (SNF) services in a distinct part SNF
- Eligible for payment for items and services furnished on or after January 1, 2023

Statutory Requirements (cont'd)

- Note: the statute does not prohibit an IHS hospital or CAH from converting to an REH
- Must be staffed 24/7
- Must have a transfer agreement with a level I or level II trauma center
- Must have an action plan for initiating REH services
- REHs may convert back to its prior designation as a CAH or rural hospital

REH Conditions of Participation

- Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates, CMS-3419-F (87 FR 71748)
- Published November 23, 2022 in the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Payment Rule (CMS-1772-FC)

Policy Development Approach

- Request for Information (RFI) published in the CY 2022 Outpatient Prospective Payment System – Ambulatory Surgical Center Payment Systems Proposed Rule on August 4, 2021 (CMS-1753-P, 86 FR 42018)
- Standalone Proposed Rule published on July 6, 2022 (CMS-3419-P, 87 FR 40350)
- Intra and interagency collaboration
- Public-facing stakeholder calls

Policy Development Approach

- CoPs are based on the statutory requirements
- Closely mirrored the REH CoPs after the CAH CoPs
- Mirrored some of the REH CoPs after the hospital and Ambulatory Surgery Center CoPs

Health and Safety Standards/CoPs

The CAA requires the following*:

- REHs must be staffed 24/7
- A physician, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish REH services 24 hours a day
- REHs must meet the applicable CAH staffing and staffing responsibilities requirements under 42 CFR 485.631

**Not an exhaustive list of requirements, only a highlight of some that are in the CAA*

Health and Safety Standards/CoPs

The CAA requires the following:

- REHs must have a transfer agreement with a level I or level II trauma center
- REHs must meet the CAH emergency services requirements at 42 CFR 485.618 and the applicable hospital emergency department requirements
- REHs are subject to the EMTALA requirements under section 1867 of the Social Security Act

Note: *Not an exhaustive list of requirements, only a highlight of some that are in the CAA*

Health and Safety Standards/CoPs

Requirements for REHs that generally reflect the CAH standards (or in some cases are less stringent than the CAH CoPs):

- Staffing
- Medical records
- Emergency Preparedness
- Laboratory services
- Infection control
- Discharge planning
- Quality assessment and performance improvement program

Health and Safety Standards/CoPs

Additional requirements for REHs:

- Medical staff
- Radiologic services
- Pharmaceutical services
- Laboratory services
- Emergency services
- Infection control
- Staffing
- Nursing services
- Patient's rights
- Agreements
- Physical environment

Health and Safety Standards/CoPs

- Additional outpatient services:
  - ✓ May include, but are not limited to radiology, laboratory, outpatient rehabilitation, surgical, behavioral health (including substance use disorder treatment), and maternal health services.
  - ✓ REHs may opt to provide low-risk labor and delivery services that are supported by the necessary emergency surgical procedures.

Key Contacts

- **Health and safety standards/Conditions of Participation:** Kianna Banks, kianna.banks@cms.hhs.gov

- **REH survey and certification process/subregulatory guidance:** QSOG_REH@cms.hhs.gov

Sustaining Rural Health Care in Kansas

The Rural Emergency Hospital

April 2023

Key Activities

- 2012-2013 – Group created, principles developed, case for change
- 2014 - 2015 – Primary Health Center concept created, paper test
- 2017 – 2018 – Discussions with CMMI, federal bills introduced
- 2019 – Push at federal level, launched Community Conversations
- 2020 – Community Conversation in Oberlin, stakeholder conversations, CHART Model released, REH established
- 2021 – Media Briefing, Regional Conversations, REH State Legislation
- 2022 – Conditions of Participation and Payment Rules Released
- 2023 – REH starts, Community Conversations

Laying groundwork

- Lots of research – build a case
- Educate Hospitals – get their buy-in
- Educate Partner Organizations
- Educate Policy Makers
- Educate the Public

Making the Case for Change

- Review the health care challenges facing Kansas
  - Population shifts
  - Uninsured rates
  - Workforce challenges
  - Public health funding
  - Overall health ranking

- Discuss the rural hospital dilemma
  - Shift to more outpatient services
  - Basics of finance
  - Financial status of KS hospitals
  - Regulatory challenges

Partner Organizations

- Health care organizations
  - Medical society, family physicians, pharmacy, public health, long term care, FQHCs, EMS, mental health centers, health foundations, etc.
- Health insurance companies
- Local government associations
- Rural interested groups
  - Farm Bureau, extension service, bankers, education, AARP
- Key State/Federal officials

Statutory Language

- Used current CAH statutes as a starting point
- Created a new licensure category for REH
  - Mirrored language in Consolidated Appropriations Act
- Inserted the words “and REH” in several places
- Did not attempt to dictate any specific payment details

Key Talking Points

- Preserving access to care is the priority
- KS hospitals are struggling
- Not a requirement – just another tool in the tool box
- Kansas based solution
- Not dictating payment rates, just assuring that services paid by REHs will be covered

Ongoing Activities

- State Rules and Regulations
- Amend language in Medicaid Provider Assessment Program to include REHs
- Necessary Provider issue
- REH 2.0 bill

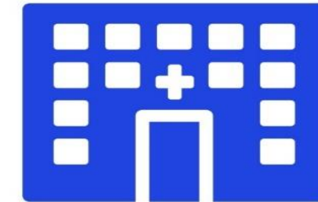
Rural Emergency Hospital

Clinic

Limited hours
No Emergency Services
No Inpatient Stays
Primary Care
Telemedicine

Rural Emergency Hospital

Open 24/7
Emergency Services
Limited Stays
Primary Care
Telemedicine



Hospital

Open 24/7
Emergency Services
Inpatient Stays
Telemedicine

Annual average length of stay cannot exceed 24 hours per patient.

Services Provided by REH

REQUIRED SERVICES

- Emergency care
- Lab services
- Radiology/Imaging
- Pharmacy

SUPPORTIVE SERVICES

- Telemedicine
- Transportation

OPTIONAL SERVICES

If community has a need, may be added:

- Primary health care, including prenatal care
- Management of chronic conditions
- Urgent care
- Outpatient surgery
- Outpatient rehabilitative services
- Outpatient behavioral health
- Specialty care (via telemedicine or visiting specialists on site)
- Skilled nursing unit

Additional Resources

Find information on the rural emergency hospital, community conversations and other resources on KHA Website.

https://www.kha-net.org/CriticalIssues/ AccessToCare/RuralIssues/

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