The Rural Emergency Hospital (REH), a New Hospital Type – 01/19/22

Kristine Sande: All right. Good afternoon, everyone. And thank you for joining us today. I'm Kristine Sande, and I'm the program director of the Rural Health Information Hub. And I'd like to welcome you to today's webinar on Rural Emergency Hospitals.

We are very happy to be partnering with the National Advisory Committee on Rural Health and Human Services on today's webinar. And now I'd like to introduce our first speaker, Dr. Jeff Colyer. Dr. Colyer serves as the chair of the National Advisory Committee on Rural Health and Human Services. He is a physician and the former governor of Kansas. Please welcome Governor Colyer.

Jeff Colyer: Thank you, Kristine. And thank you everyone for joining us at the RHIhub. This is a good conversation because of the dramatic changes that the new rural emergency hospital destination brings forward.

We have a couple of speakers with us today. If we can change slides. Our first speaker will be Dr. Mark Holmes, who is the director at the University of North Carolina for the Sheps Center on Health Services Research. And he's going to be discussing with us some of the reasons why we need a rural emergency hospital and some of the impacts that are going on.

The second speaker will be Kari Bruffett. Kari is our former secretary of health services here in Kansas, and she's currently the vice president for policy at the Kansas Health Institute. And I've known Kari for a long time with a very strong interest in rural health care.

Our next slide, please. I want to give you a little bit of background on the committee. The committee is actually in statute and has an HHS charter. The committee is a number of citizens from across the United States, with human services backgrounds, health backgrounds, also individuals with various interests in healthcare. This committee has been here for a number of years and is extremely active here following the COVID crisis.

Our mission is to advance a mission for rural America. And we want to look at innovations in rural healthcare and in human services. We want to look and highlight the opportunities where we can integrate healthcare services, human services, and non-healthcare sectors. And the issue is, how can we better serve our rural communities by doing this? We're also recommending a number of public policies that advance rural community diversity, vibrancy and resiliency. And we also will engage with the science during our deliberations.

So the committee has a very wide range of health and human service issues. And this is one of the most interesting ones right now. Next slide.

Typically, the committee meets in person, however, last year because of the public health emergency the committee only met virtually. However, the committee has been engaged very directly and pretty aggressively with a number of rural stakeholders and subject matter experts, particularly about the rural emergency hospital model and other issues.

In October, we had a meeting and we voted on a number of REH recommendations. These have actually been transmitted onto the secretary of HHS, and they're published on the National Advisory Commission website. Next slide.

So, why do we need a rural emergency hospital? In December of 2020, Congress created a new type of provider called a rural emergency hospital. Now, this was important because we hadn't had a new hospital or provider type designation since 1997 with the critical access hospitals. But what this really did was, provided a response that we could help with the loss of emergency services, particularly when there are hospital closures.

This type of provider will actually be going live on January 1st next year of 2023. And so, the CMS is beginning its rulemaking for this at this point. So it's very important that we discuss this, and we bring these issues forward. And so, that's why we were very active on this issue. Normally, we're more involved with current issues that have already had statutory language, but now we have new language that we're going to have to start with this rule making.

So, I'm going to turn it over to one of our committee members for the next slide, Mark Holmes, and he's going to discuss rural hospital closures and how the REH model intends to address some of these issues. So Mark, take it away.

Mark Holmes: Thank you, governor. As the governor mentioned, there's lots of concern about rural healthcare on a variety of trends and developments that are happening in rural America. But a lot of it is focused on rural hospital closures. And so, first couple slides here, we'll talk about that and put it in context about one of the drivers and the interest of the rural emergency hospital.

So, as you can see from the slide here, over the past 11 years, we've averaged just over one rural hospital closure per month. Some years have had more closures than others, and the bullet points here list kinds of hospitals that are closing, that should be 24. MDH is not 244. But you can see from the map on the right, which is available at bit.ly/ruralclosures, where these have generally been located, and you could see the time trends, et cetera.

But the point of this slide really is twofold. One is, one of the things that we do as we track these, is we compare complete closures to converted closures. And so, when a rural hospital closes and stops providing inpatient services, sometimes it will become an urgent care clinic, or a nursing facility, or a primary care clinic. But sometimes it completely closes and does not provide any healthcare at all. A car wash, or a condo, a church, a school.

So one of the focuses or foci of this question of the rural emergency hospital is, if we're seeing these closures, what can we do that they're able to provide some healthcare, and not be a complete closure. And I think this is a good point to remind everyone that when a rural hospital closes, it's not just the health effects that I think everyone here understands, but the economic effects as well. And Tee Faircloth mentioned in the chat, the economic effects need to be considered as well when a hospital is either the largest or the second largest, often in many of these communities.

Next slide, please. So there are many drivers of closures. Why do rural hospitals close? And we could spend an hour and a half, if not more on that topic alone. These are summarized from a brief by RUPRI in 2017. And they looked at their assessment of what's behind closures.

And these generally fit in broad buckets. One is a revenue kind of component. When revenue is flat or declining, and costs are going up, that's not a good plan for long term financial sustainability. Revenue may be decreasing for a number of reasons, such as declining population of the community, other trends in health insurance, or healthcare, or plan design that tend to remove care from the rural hospital and migrate it elsewhere. That may be because of, again,

plan design, value based care, it may also be a change in technology. What used to be inpatient is now outpatient.

And then also thinking about the communities that are served by the rural hospital, maybe aged and poor, uninsured, underinsured, higher rate insured through public payers, such as Medicare or Medicaid who reimburse less often than the cost of providing care overall. Next slide.

So, in order to start wrapping our head around these closures, a few years ago, the Sheps Center developed a financial distress index for rural hospitals. And the idea for this is to take multiple factors that we can see about a hospital, it's finances, the community it serves, state policy, et cetera, and put them into buckets. This is a hospital that's at high risk of seeing financial distress. This is a hospital it's at low risk of seeing financial distress. And that gives you sort of a traffic light green, yellow, orange, red kind of quick assessment over where the rural hospital is in terms of its financial position.

In our most recent release, we estimated 210 rural hospitals were at a high risk of financial distress. Those are distributed across the country, but there were some commonalities with where these high risk hospitals are located. They on average tended to serve communities at a higher percent of non-white and black residents, lower rates of high school graduation, higher rates of unemployment and poorer health.

So, if you sort of string these together, what we see are, rural hospitals are closing. And the ones that are at most risk for closing are the ones that are in the communities with the highest need. And so, this is obviously something that bears a lot of concern, and this is where policy steps in to address it. Next slide.

So, what are the basics? What are the high level summary of the rural emergency hospital model? Well, critical access hospitals and small rural hospitals with no more than 50 beds will be eligible to convert. They have to be rural. Yeah, it was already mentioned there.

So, these are on the smaller side, less than 50 beds. In terms of applying... Well, the other thing about the eligibility is they have to be an existing hospital. So that's implicit in this bullet, but they have to. You cannot say, "I want to build an REH." These are hospitals that are converting to an REH.

In order to transition to become REH, you have to have an action plan that outlines how you will modify, retain, add this continue outpatient services, and what you will do with these additional funds, which we'll get to in a moment, in terms of supporting telehealth services, ambulance operating costs, and maintaining the emergency services that are there.

Next slide. What are the requirements in the REH? Well, cannot provide acute care inpatient services, that's the big idea here. Take a hospital and we're closing all of the inpatient side.

Cannot exceed an annual average patient length of stay of 24 hours. So, can't get around this, but say, "Well, we're not going to admit anyone. We're just going to have everyone on observation for 72 hours." It's an average length of stay of less than 24.

Have a transfer agreement to level one or level two, and maintain the staff emergency department 24/7 with a physician, NP, clinical nurse specialist or PA.

So those first four in particular, really provide the high level picture, sort of what we're looking at.

Meet CAH equivalent conditions of participation for emergency services, meet applicable state licensing requirements. And this is one that often gets lost. And just because Medicare and CMS say, we will recognize this new provider type and reimburse them under these rules, doesn't mean that the state has a license for this new provider type. And that's something that's going to require state action in many locations, in order to create the ability for this new provider type to exist.

Quality reporting standards to be established. If there's a SNF DPU, or skilled nursing DPU, have to meet the requirements applicable to those. And then other requirements that the secretary finds necessary.

And you've seen a few bullets here that get the governor's point of, the rules are not yet released. The secretary is developing these rules. And that's one of the reasons that the NACRHHS came up with the recommendations we did. Next slide.

Reimbursement, always a key question. So how will these REHs get paid? They will have an outpatient, for outpatient services, the OPPS rate plus 5%. So a 105% of the OPPS rate. There will also be this additional facility payment or AFP, that is sent out by formula in the statute. The high level vision is, what did we pay all critical access hospitals in 2019. What would those critical access hospitals have gotten from Medicare if they were not CAHs, take that difference and divide it by the number of CAHs. And then that's the additional facility payment that will be available to each of the REHs that will get recomputed each year.

So, one of the questions and one of the key questions, and maybe sources of debate with rural emergency hospitals is, who is it that's going to convert. Are there going to be three, are there going to be 300? Are these going to be high performers? Are these going to be low performers? Are these places that probably would've closed if this didn't exist, or are these places that are capitalizing on this new model?

And there's a lot of questions about that. So what we did is, we partnered with the National Rural Health Resource Center on one of their task 90 calls, and wanted knowledge and assistance in the partnership of that group. And sort of picked the brain of those on the call and said, "Who do you think might consider this?"

And so we came up with three rules based on that feedback. We looked at small rural hospitals, including CAHs that had a negative total margin for three years in a row. So these are unprofitable hospitals. Had a net patient revenue of less than 20 million. So they're on the smaller side. And have an average daily census of acute combined of less than three. So, also smaller on the ADC standpoint.

So, unprofitable, small from a revenue standpoint, and not a lot of use of inpatient services and acute and swing combined. After we applied that filter, the most recent data, we identified 68 rural hospitals that we call potential converters. Again, these is all based on these rules that we developed as a prediction of who would convert. They were predominantly located in four states, Kansas, Texas, Nebraska, and Oklahoma.

Kansas in particular had almost one quarter of these 68 themselves. And when you look at those who we protected to convert, versus those who we did not meet these three tests, the converters had a higher percent of unemployed and a lower population density.

And so, that gives us a sense of sort of like who might these conversions be. But again, that's based on these rules that we came up with, that we thought might be predicting hospitals that would consider conversion. I also just want to say that most states had at least one of these, so it's not just that they were in these four states. And we have a brief on this that was released last year, that has by state, how many of the 68 are located in each one. So that concludes the boring part of the session. So I'm going to kick it off to Kari to review our recommendations. Kari.

Kari Bruffett: Thank you, Mark. I'm Kari Bruffett, I'm the vice president for policy at the Kansas Health Institute. As was mentioned earlier, I'm a member of the National Advisory Committee on Rural Health and Human Services. But I will tell you, I am not the biggest expert on rural hospitals that's on the National Advisory Committee, we've got critical access hospital CEOs, we have people with experience serving rural communities directly as providers.

I do have some policy experience both in state government and at the federal level, and have a great interest in the importance of this issue for Kansas. So I noticed a few comments in the chat about issues that we're going to talk about here in a moment. And one of them is that Kansas and the Kansas Hospital Association and health leaders in Kansas have been looking for many years at a model that could be similar to what the rural emergency hospital designation is looking to implement.

And in fact, the Kansas legislature has adopted legislation that would empower and enable the rural emergency hospital to work in Kansas. But there are a lot of policy recommendations that the committee discussed. If you go ahead to the next slide, we had several virtual briefings from subject matter experts. And I know many of us on the committee like me talked to folks in our home states and our colleagues from across the country who raised many of the questions that I'm seeing in the chat here as well, that I know we're going to get to. Some of them we'll get to in the slides ahead.

We came together and came up with 16 recommendations, and five policy considerations to send to the secretary. The formulation of these recommendations, like with any it's pretty iterative process, we were able to go back and forth and really talk about the language and try to take what we were learning in our home states and our home communities, and have that contribute to the recommendations we are providing to the secretary.

So just a point of clarification for those who've not dug into any of the committees reports before recommendations. The difference between recommendations of considerations. A recommendations is something that the agency HHS and the secretary can act on. The consideration tends to be something that the agency or the secretary working with Congress, or perhaps some external partner can act on. So it's not a direct agency action, but it's still something that the committee feels rises to the level of importance where it's necessary to include it in the brief. So it doesn't make it less important. It's just a different kind of issue, a way to present an issue that we think are important.

There were, as we mentioned, 16 recommendations and five considerations. We'll go through most, but not quite all of them, in the interest of time. We did bucket them. We'll highlight

some of the most notable ones during the webinar. And I think we'll have the opportunity in answering some questions probably to address some of the others as well.

So they're organizing the four categories, providing flexibility and support for rural emergency hospitals. I think that's tied to a lot of what I'm seeing in the chat. Quality care measures, finance, which Mark's talked about a little bit as well. And we know is a critical issue with the additional facility payment. And then some other issues and considerations that we'll talk about as well.

So yes, we can go to the next slide. You're already there. You beat me there. And again, to start with the flexibility and support, this was something we heard strongly from folks on the committee who have experience working as administrators of critical access hospitals, or rural PPS hospitals, as well as many of the folks we heard from in our meetings as well, is this flexibility and support for the hospitals and communities might be considering this rural emergency hospital designation is going to be critical.

So some examples, critical access hospital conditions of participation. One of the things that was discussed could be informative. When you're thinking about the REHs, but it's clear that the rural emergency hospital is different, more limited clinical operations. So, the committee believed that 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 recognize the diversity of situations that might have arise for each rural emergency hospital.

So if you look at these three recommendations, these are examples. It's going to be important to have flexibility to define the requirements related to the 24 hour observation period, and the reasonable expectation on that time period. One example of concern is that ambulance services needed to transfer patient may not be available in a timely manner. So that was some of the considerations that the committee looked at.

In addition for the second recommendation here, the committee has supported efforts to promote colocation of services in rural communities. So a few of the recommendations relate to considerations that would allow for that colocation with a rural emergency hospital model.

So with an establishment of an REH, HHS has the opportunity to promote that notion. So perhaps REH converters might be in hospitals that have available space to lease to other services. It might include like RHCs, skilled nursing facilities, and later we'll talk about swing beds. But as a distinct part units of the REH and dialysis clinics, for example.

And then for recommendation three, related to the survey process, the challenge the committee talked about for CMS will be to account for the small size, the scale of the REH, and to take that into account in a way that reduces the administrative burden, both for the initial and the ongoing survey and oversight processes for rural emergency hospitals.

So, a few more recommendations related to flexibility and support. Go to the next slide.

So, the committee after talking about the experience folks had, and talking to others in their home states and other places, I definitely believe that REHs will need even more staffing flexibility than critical access hospitals have, given the role of those facilities in their communities.

The waivers given to critical access hospitals during the public health emergency were discussed as perhaps a model that could be used for REHs under sort of normal non-public health emergency circumstances. So in providing that kind of flexibility, the committee would recognize the REHs would need to meet all applicable states, staffing, educational training, scope of practice requirements and so on.

Another example, maybe as you can see, it's numbered down a little bit differently, recommendation 14, but certainly is related to the support side of the flexibility and support, and is acknowledging that attracting and retaining healthcare providers remains an ongoing issue in the rural communities.

There are a lot of range anyway of workforce, loan repayment, scholarship programs that provide lifeline on this issue to many communities. So, as the REH providers are approved, the committee thought it was important for HHS to update, make sure it's updating its eligibility for those programs to also include the rural emergency hospitals.

And then, I'll add another one. It's not on the slide here too. Because I think I saw something about this as well, it relates back to one of the earlier recommendations we discussed too, the committee also recommended the secretary ensure that rural emergency hospitals have flexibility in establishing transfer agreements that linked transfer to level one or level two trauma centers to patient need.

So, while making sure it's clear that that also allows transfers to other hospital as clinically indicated.

Okay. Shifting gears now to talk a little bit about the quality care measures in the rural emergency hospitals. So, sort of another example of recognizing both flexibility and acknowledging what we can learn from existing measures and existing processes. So, for one of the recommendations here, the MBQIP was designed by HRSA to promote voluntary quality reporting to critical access hospitals.

Most of you all know this. Under the current statute, all the PPS hospitals are required to submit quality data while critical access hospitals, since they're not paid by PPS, don't have those same quality reporting requirements and HRSA used funding from the Flex program to support voluntary critical access hospital quality reporting.

So there are a number of set of existing quality measures that were most relevant for critical access hospitals, given the size and scale. And so those include patient safety, inpatient care transitions, outpatient and patient engagement.

And so, among those four areas, the committee really focused on three of those being particularly relevant to rural emergency hospitals. So that being in the list here, as you see the outpatient, patient safety and care transitions recommendations seven though talks about the fourth MBQIP measure of the patient engagement is majored using the HCAPS survey.

The committee discussed that being perhaps less relevant, or maybe at least not ideal for rural emergency hospitals, given some of the data collection limitations. So actually in lieu of this measure, the committee recommended that the secretary work with stakeholders to develop more appropriate low cost measures. And this could be really a good model for major development or data collect development for other kind of rural providers as well, moving forward.

Financing. And most questions about financing will definitely defer to Mark, or others to answer as well. But there are a couple recommendations that we're applying to the appropriate financing. Oh, it looks like the intros on this slide doesn't quite say that, but the rest of it does.

So, the committee did discuss potential reimbursement issue. And again, I've seen it in the chat. I haven't seen the more recent messages in the chat. A lot of the focus was on the facility payment, the additional facility payment, which as Mark describes as a fixed monthly payment in addition to the reimbursements for services.

In calculating that AFP, CMS will need to like make a number of decisions to determine what critical access hospitals would've been paid under the various perspective payment systems. And these decisions will be critical in determining what the amount of that AFP is. So there is language in the legislation that notes accounting for SNF (28:29) services, skilled nursing facility services, but it doesn't explicitly include swing beds, which provide both inpatient and skilled nursing facility services as you all know.

The committee believes the languages should as intended, it should include to swing beds services provided in critical access hospitals. And so, have some language here in the recommendation to line with that as well.

Recommendation 10 similarly looked at rural emergency hospitals are intended to be that local source of outpatient and emergency care, insurers need to include these facilities as in network providers. So, one of the recommendations that the committee discussed and included in its brief was requiring the qualified health plans in the federally facilitative marketplaces that are required to contract with, excuse me, a specified percentage of essential community providers to treat low income and medically underserved individuals to make sure that those critical access hospitals, many of whom are probably already signed up as those ECPs, that would allow rural emergency hospitals, either the converters that were ECPs or converters that would become ECPs to qualify as essential community providers, under the category of other ECP provider.

So hopefully that would encourage the inclusion in the insurance networks as well, and acknowledge the importance of those rural providers in the rural communities.

Moving on to some additional recommendations. Couple of these, actually, I think I saw a question about the 340B. So, there are critical access hospitals and other specified providers that serve a disproportionate care of low income patients, or eligible providers for the 340B program.

However, as we understand it, in order to include REH as covered entities, that would require a change to the statute. So, you see the language here is the committee recommending the secretary work with Congress to expand eligibility for 340B drug pricing to include rural emergency hospitals. The committee definitely believed that REHs should be eligible to participate in 340B, many have likely been eligible before converting to an REH if they're considering that they will be providing outpatient services, including prescription drugs.

Recommendation 16, another model of, or another suggestion that was discussed as well was, ensuring that considerations for sovereign nations, for tribal providers and communities be included as the secretary and the agency are thinking about the rural emergency hospital model moving forward. CMS has already had an all tribes webinar, seeking input on potential implications of the REH for the Indian Health Service and tribal hospitals. Committee believes

that's an important first step by CMS and formally consulting with the tribes as they develop their rules for the rural emergency hospital designation.

A couple other things that aren't on here that I think I have time to add as well. And were at least referenced indirectly in the chat, if not directly, were some broader concerns looking at what potentially, some that looked at maybe what might be missing in the authorizing language as well, that either the agency could do or perhaps could work with Congress or other partners to do.

So, the statute requires the secretary, for example, conduct three studies to evaluate the impact of rural emergency hospitals, and on the availability of healthcare and health outcomes of rural areas. But those are scheduled four, seven and 10 years after enactment.

The first mandated study is due to Congress then in July of 2025. And MedPAC also is required to review payments to the rural emergency hospitals beginning in 2024. But the committee thought that it's going to be a few years down the road before those reports would be published. And after the implementation of the REH provider type in 2023.

So, there are a lot of key decisions, particularly we talked about the AFP, for example, the amount of that facility payment is likely to be the, or at least a, if not the critical factor in the success or failure of their rural emergency hospitals.

So, one of the other recommendations was recommended the secretary direct the assistant secretary for planning an evaluation to study and model the appropriateness of the additional facility payment to maintain emergency and outpatient services, as well as provide the community benefits in the first year of the REH implementation.

And the committee also discussed implications of current limits on REH eligibility on and varied healthcare needs of different communities. So, while the statute talks about the hospitals that would be eligible for conversion of being those, that were critical access hospitals or otherwise qualifying hospitals as of the December 27th of 2020 date. The committee also was interested in the possibility of hospitals that may have closed before that date or other potential needs for high needs in isolated rural areas called emergency care deserts.

So, the committee had recommended that the secretary working again with the assistant secretary of planning and evaluation assess whether REH eligibility should be expanded to meet healthcare access challenges in rural communities. So that could be again, either to facilities that had closed prior to the statutory date, or potentially other opportunities to expand the REH model.

And finally, this model may seem pretty complicated, but that should not be a barrier to communities and assessing whether it would work for them. So, one of the recommendations that the committee also had was, that the secretary worked with Congress to provide needed technical assistance to communities considering that REH model to provide funding and support resources for technical assistance for those who are considering REH.

Okay. Now onto the additional considerations. Again, they're very similar to recommendations. They just may perhaps have a different target audience. And there are multiple provisions of, or benefits that are available to critical access hospitals and PPS facilities that are not specified as available to REHs in the legislation they may be. So the committee wanted to ensure that was the case.

The committee believes that Congress and HHS should consider the option of allowing rural emergency hospitals to benefit from those kind of provisions and pursue legislation, if necessary or regulatory action if that would do it, that we'd address a number of these following issues.

So again, allowing employed physicians at an REH to elect method to billing, similar to critical access hospitals. So you see a lot of this is allowing some current flexibility or current options to move forward into the REH model, allowing REHs that offer outpatient services to be able to qualify for CRNA, pass through payment exemption, ensuring there's a clear pathway.

And this was a critical consideration that was discussed too, ensuring that there's a clear pathway for any critical access or PPS hospital that becomes an REH, particularly those that have necessary provider designation to return to full acute care general hospital status and bed size, should they need to in order to meet community need. Thinking that the REH model is to allow communities and hospitals and providers in those communities to determine the needs of the community, so allowing the flexibility, not just to convert to a REH, but to convert back from an REH, if that serves the needs of the community, that was a critical consideration that the committee wanted to be sure to include.

And then also allowing REHs to offer cardiac and pulmonary rehabilitation services, for those services to be ordered and supervised. You all can read the rest of these, I suppose, by an appropriate non-physician practitioner, and allowing rural emergency hospitals to serve as a Medicaid opioid treatment program as well.

So, I think I talked really fast to try to get a few more recommendations in there that were not necessarily on the slides to be able to discuss those. So, I hope that was helpful and not too fast. And I hope then we will have plenty of time though, to go ahead and answer questions, because I think that's what we're ready to do.

Kristine Sande: The first one is maybe something that's on a lot of people's minds, and that is about the timing of the regulations coming out, what do we know about when the proposed and final rules will be released? What do we know about that? Anything?

Jeff Colyer: Yeah. Jeff Colyer here. Usually a lot of the CMS considerations will start taking place in March or so, similar to they do on some of the other proposed rules and the financing side. So, a lot of these discussions are early discussions are happening now with the rule making process to begin an earnest in later or in or early March, I guess, and then continuing on from there.

Kristine Sande: All right. Thank you. All right. The next question is “Kansas, the State Department of Health, the Hospital Association, et cetera, have been designing a new model for free standing emergency care for over a decade. So, how does the rural emergency hospital align with the Kansas vision, and what might be done to advance this vision?” So we have a couple of people from Kansas here. So, would one of you like to talk about that?

Jeff Colyer: Kari, I'll toss it to you. You were pretty active in that discussion last year.

Kari Bruffett: And actually very, and I noticed in the chat we've got folks from the Kansas Hospital Association, including Jennifer Finley, who I consulted with a lot during our discussions with the National Advisory Committee as well.

So, there are similarities and there's hopefully what we hope from the work of the committee, is that the lessons that folks like the folks in Kansas at the host hospital association and hospitals

have been doing for many years to think about what this kind of model could look like will help inform what the agency, or how the agency implements the rural emergency hospital. So it's not a one to one model for exactly what Kansas has looked at before, but there's a lot of enthusiasm if the model can have flexibility and can have the resources and funding, and to be able to think about this as a potential for hospitals.

So yeah, I do think what we tried to do, was learn lessons, and hope that we can help include those in our recommendations to the secretary. And so that the agency can move those forward as they think about rural emergency hospital rules and flexibility, hopefully, and resources.

Kristine Sande: So the next question says, "I'm still not sure if the rural emergency hospital can provide skilled care previously swing, and get REH payment, or if that would have to be changed to distinct part unit status payment. What do we know about that? Or is that something we have to wait for the rules for?"

Mark Holmes: When there's silence, that means no one is sure. My read is that swing would not be allowed, they would have to convert to a DPU.

Kristine Sande: All right. So, "who would act as a fiduciary for a rural town when a large urban health system chooses to increase its profits and convert to REH? They control the hospital." I don't know. Is that maybe beyond what the committee can answer?

Jeff Colyer: I think I won't answer Tee's question, but I'll address it.

Kristine Sande: Okay.

Jeff Colyer: I mean, I think that is one of the concerns of this, is that, and this is something I sort of alluded to, whereas some people think the REH will be a step down... Oh, no, is a soft landing for a hospital that was going to close, at least this may be something that they can operate and continue to provide something to the community.

Others are worried that this will be viewed as an opportunity to take a hospital that was doing just fine, and convert to REH, and essentially divest to some extent of healthcare in the rural community. And in particular, that this concern is around a large system where rural health is not a core part of the business model for it, so to speak.

I think that is something that I think we all will have to watch just because it's a law of unintended consequences. I think the vision for this is that the REH is exactly the, what can we do if a hospital's unsustainable? What can we do so that community at least gets something? But if instead it becomes an opportunity to further erode services in rural America, I think we'll have to take, we meaning all of us will have to take a hard look at this and make sure that it's accomplishing the policy goals.

Kristine Sande: Okay. So the last question I'm seeing in the Q&A right now is, "any idea if there will be a Medicare cost report settlement for REHs to true up Medicare cost like there isn't a CAH model?"

Kari Bruffett: I think we can't answer for CMS, probably. It's probably the best way to answer that. It was something that we discussed a bit in committee too, is like, what will be the administrative expectations and the sort of finance side expectations? We talked about quality measures a little bit, but also on the finance side.

So, I think the theme, although we didn't have a recommendation specific to this point, the theme of reducing, or minimizing the administrative burden as much as possible, yet still getting good information for good policy making I think was consistent among the recommendations. So I think thematically, that's probably what we would say about the use of cost reports.

Mark Holmes: Can I respond to one of the KHA comments? Any thoughts on how to get a community to be with giving up inpatient beds in the middle of a pandemic when they're finally being used?

I mean, I think the notion of a town hall meeting, great news you all, we are closing our inpatient wing is probably not one that's going to go over well in any community. And so, that's this exactly this notion of, what is the function? What new niche is this REH going to fill in terms of, how will it be viewed on the continuum of rural health care? And if this is the alternative to a complete closure and no healthcare being provided, but communities will not see that counterfactual of what happens when it's completely closed. They'll only see it as an REH.

And so, I think there will be definitely a role for helping communities and the healthcare provider, particularly the REH understand the reality of this approach.

Kari Bruffett: If I can piggyback on that Mark, a little bit too. So, one of the things, and the Kansas Hospital Association has been very good about this. They've had public meetings and regional meetings throughout the state talking about this model.

But one of the things we did hear as a committee from communities where they'd made some very significant changes to their healthcare delivery systems and the importance of community engagement, and really involving not just the decision makers, the folks in the authority, but really involving the community at the grassroots level in that decision.

So, when we talked about technical assistance a little bit before, we were talking about maybe a Flex like program for rural emergency hospitals. But we also discussed that the need to be able to support that kind of engagement and that effective engagement of the community. So, that probably doesn't solve or answer the question about the context of the current pandemic and people's concerns about inpatient beds. But there is that acknowledgement that this is not just a technical decision. This is a significant decision that impacts communities closure.

Obviously, we've seen all the research that shows the effective closures, hospital closures have on communities, but changing into a different model will as well. And I think the committee acknowledges that, and hopes that that support for communities and considering this we'll take that into account.

Kristine Sande: Any other thoughts from any of our speakers at this point?

Mark Holmes: I think I can answer both of the new Q&As. The grandfather RHC retain their Medicare all-inclusive rate. I don't think we know. And I think that's going to be addressed in the rule making process. And will OB services be allowed in REH? I think OB usually means labor. Depending on what you mean by OB. And if we interpret this as labor and delivery, to the extent that it's inpatient, no. If you mean maternal health, then yes, but not if it would be required in an inpatient frame work.

Kristine Sande: All right. So then, “any thoughts on how this could impact National Health Service Corps participants and our local EMS systems?”

Mark Holmes: Sorry. Someone was going to go.

Kari Bruffett: Go ahead.

Mark Holmes: I just hate silence, so I speak up. So, Service Corps, again, probably that's a good question. I don't think that we talked about this, but I suspect it will be a similar theme. One of the things will be, is an REH an allowable service location? And that might have to be something that the NHSC looks at from that standpoint. EMS, I think that's too big. I think we don't know. I think there's a lot of ways that that could happen.

Kari Bruffett: Yeah. I will go back to, I can't scooch back on the slides, but the recommendation 14 was that the committee recommends that the secretary expand eligibility for the National Health Service Corps. The Nurse Corp and the state loan repayment program to rural emergency hospitals to help them address that. So that actually is included in the recommendation.

Kristine Sande: And then Tom Morris just popped in here saying that they're talking to National Health Service Corp about that. All right. So then another question, “would an acute care hospital, so not a critical access hospital, be able to keep operating its inpatient rehabilitation unit? Presumably if they switch to an REH.”

Mark Holmes: I think that's another place where the statute is silent. The statute does speak to SNFs, the skilled nursing, and says that they can be a SNF DPU, they would be reimbursed not at the REH rate, but at basically like a SNF PPS. I think the natural extension would be logical that that'd be the same for IRS, but I think that's, again, something that would have to be resolved in the rules.

Kristine Sande: Okay. So then a follow up to the previous question that was regarding EMS says, "I was just thinking that EMS in so many rural communities is so frail, and just curious if this is an opportunity to help support those systems.” Thoughts on that?

Mark Holmes: It's a great opportunity. Go ahead.

Kari Bruffett: This is probably less relevant to the rural emergency hospital, but the overall issue of rural EMS is something that the committee has prioritized to potentially be one of our coming topics. So not just it through the lens of the rural emergency hospitals. So I think that can be something we should also take into account as a committee when we're looking at EMS, that, are there potential other opportunities to try to use the REH model to help support that.

Kristine Sande: All right. And then “beyond the 115% physician fee-bump, will the 10% HPSA bump also apply?” Does anyone know the answer to that question?

Jeff Colyer: I think that's one of the things to request of CMS as they're going through their rule making.

Kristine Sande: Let's see. Tom Morris says, "To the extent they are billing on the PFS for the professional component, maybe.”

Mark Holmes: Yeah, I think that's right. I mean, I think to the extent that most of my answers have been, someone's going to have to create a subpart queue that says, and also REHs, so that they're permitted to be included in. I think the HPSA bump applies to everyone. So that's more of a, let's just make sure it's included.

So I'm more optimistic that if nothing happens, they'd get the HPSA bump, but I think it is something to watch for in the proposed rule when it comes out.

Kristine Sande: The slides used for the webinar are available on the RHIhub website. In addition, a recording and a transcript of today's webinar will be made available on the RHIhub website. Thanks again for joining us and have a great day.