

The Rural Emergency Acute Care Hospital (REACH) Act: A Solution for Rural Acute Care Access

Executive Summary

Rural hospital closures have been accelerating over the past few years, which can have a number of negative effects on surrounding communities. According to the University of North Carolina's Center for Health Services Research, 55 Rural Hospitals closed in the United States since January 2010. In 2014, iVantage conducted a study for the National Rural Health Association (NRHA) and found 283 hospitals at risk of closure based upon performance indicators that matched those facilities already forced to close in this decade. Some facilities will close completely and others will convert to a different type of healthcare facility. When facilities close completely, the consequences of traveling great distances for medical care can be life-threatening.

Adverse impacts to the local economy and the loss of timely access to emergency medical care are two major effects of rural hospital closures. According to the National Center for Rural Health Works, the typical rural hospital creates over 140 jobs and generates \$6.8 million in compensation while serving an average population of 14,600. The NRHA estimates that if the 283 at-risk hospitals close, those closures could result in the loss of 36,000 healthcare jobs, 50,000 community jobs and \$10.6 billion in GDP.

Furthermore, time is the most critical factor for achieving successful outcomes in emergency medicine. Emergency medical clinicians refer to this time-sensitive period as the "golden hour." The National Conference of State Legislatures states that 60 percent of trauma deaths in the United States occur in rural areas, where only 15 percent of the population is represented. The disproportionate percentage of trauma deaths in rural areas is likely attributable in large part to a combination of response time to the scene and distance to the nearest emergency room to stabilize trauma victims. The percentage of rural trauma deaths could continue to increase as more rural hospitals close, further limiting access to emergency services and requiring patients to travel longer distances to receive emergency medical care.

Our most basic objective is to sustain emergency services in rural communities so that time-sensitive conditions receive rapid treatment/stabilization. The REACH Act will establish a new Medicare payment designation, the Rural Emergency Hospital to

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sustain emergency services in rural communities. This will allow hospitals to be paid to provide emergency services without having to maintain inpatient beds.

Background

According to the federal Office of Rural Health Policy, research conducted at the University of North Carolina has determined that nearly 20% of residential areas in the United States do not have timely access to acute medical care facilities.¹ Additionally, USA Today published an article dated November 14, 2014 about the increasing rate of rural hospital closures. The article stated that a total of 43 rural hospitals had closed since the beginning of 2010, and every year the number of closures increased.² Healthcare in rural American communities is in trouble and the development of self-sustaining emergency departments is the best solution for ensuring the citizens of rural America have access to crucial emergency services.

Healthcare is a long-standing topic of debate in Congress, especially over the last six years. The passing of the Patient Protection and Affordable Care Act (PPACA) in 2010 was an attempt to close the health coverage gap that exists in the American population. The major battle fought in the PPACA was the insured v. the uninsured, and ensuring affordability for coverage. The PPACA intends to increase access to affordable healthcare for all Americans, but for some, it may have the opposite effect.

The PPACA brought with it payment cuts to hospitals; these cuts have a significant impact on rural hospitals for two primary reasons, the payer mix, and issues with patient volume. Hospitals receive payment for service through three separate payment streams: private payers (private insurance), government payers (Medicare and Medicaid), and self-pay. The payer mix is the varied percentage of each payment stream that makes up the total payments for hospital services. Government payers, especially Medicare, tend to make up a majority of the payer mix for rural hospitals. Additionally,

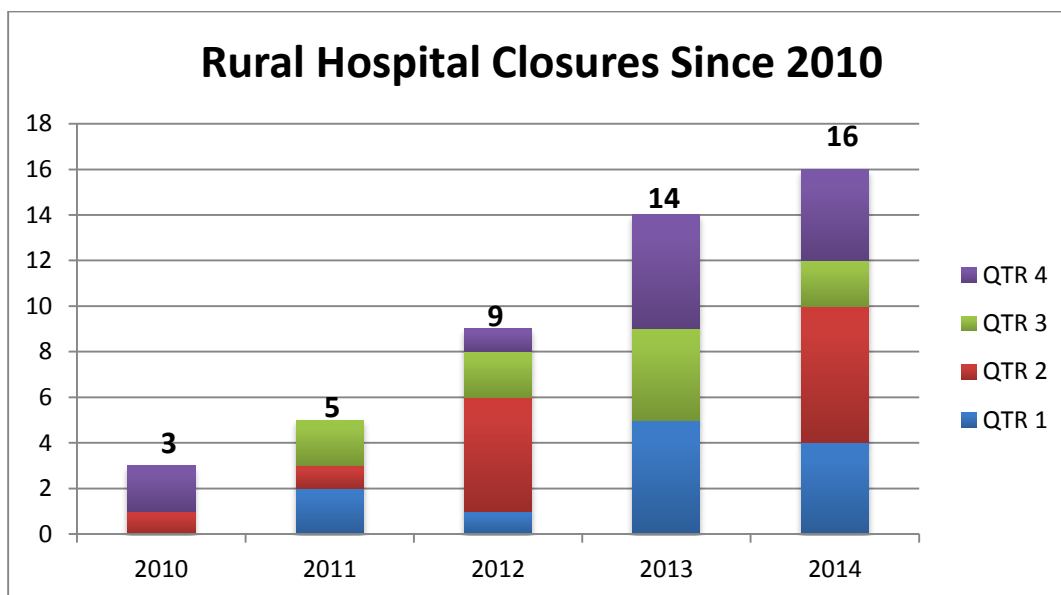
¹ Williams, J. (2013, November 8). What Happens When a Town's Only Hospital Shuts Down? Retrieved May 7, 2015, from <http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2013/11/08/what-happens-when-the-only-hospital-closes>

² O'Donnell, J., & Ungar, L. (2014, November 13). Rural hospitals in critical condition. Retrieved May 7, 2015, from <http://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicare-aca/18532471/>

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these payment mechanisms are based on volume. The number of services performed translates to more payments and more income. Facilities that struggle with patient volume will also struggle with having enough income to keep their doors open.

The PPACA became law in 2010, and since that time 55 rural hospitals have closed their doors.³ The chart below portrays the number of closures per year from 2010 through 2014, and it is readily evident that the pace of these closures is increasing. As facilities continue to close, access to care in rural areas is threatened.



Source: <http://www.shepscenter.unc.edu/wp-content/uploads/2014/07/Rural-Hospital-Closure-List-and-Map-4-8.pdf>

The Current Situation

Access to care in rural communities has always been a challenge. Recognizing that challenge, Congress has taken action several times over the years to develop models and payment mechanisms to improve access to healthcare in rural America. The most recent model developed was that of the Critical Access Hospital (CAH) designation. Today, a majority of rural hospitals are Critical Access Hospitals. Included in the

³ 8 closures occurred in 2015 added to the 47 depicted in the chart for a total of 55; Rural Hospital Closures: January 2010 - Present - Sheps Center. (n.d.). Retrieved May 7, 2015, from <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

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Balanced Budget Act (BBA) of 1997, the CAH program follows a cost-based reimbursement system, through which Medicare pays CAHs 101% of costs for most inpatient and outpatient services.⁴ This is compared to the traditional Medicare Fee Schedule known as the Medicare Prospective Payment System (PPS) that sets flat reimbursement rates for various hospital and physician services.⁵ The CAH program was based upon proven success in two earlier programs: the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program and the Medical Assistance Facilities (MAFs) demonstration in Montana. These programs were able to produce beneficial outcomes, which led to the desire to implement aspects of each program nationwide and the introduction of the CAH.⁶

Of the nearly 5,000 hospitals in the United States, roughly half of them are in rural areas, and a majority of those are CAHs.⁷ In addition to CAHs, there are three other types of Medicare payment models for rural facilities. Table 1 below depicts all four mechanisms and represents the current rural healthcare landscape.

Table 1: Medicare Payment Classifications of Rural Hospitals

Classification	Payment method	Eligibility criteria
Critical access hospital (CAH)	<ul style="list-style-type: none"> • Reimbursement is 101 percent of allowable costs for inpatient, outpatient, laboratory, therapy services, and post acute services in swing beds (BBA 1997); • If CAH owns and operates the only ambulance service within 35 miles, this service receives cost-based reimbursement; and • While IPPS and OPSS do not apply, Medicare Part A and B deductible and coinsurance rules do except for pneumococcal pneumonia vaccines, influenza vaccines, related administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests. 	<ul style="list-style-type: none"> • Distance from nearest like hospital • Size (<25 beds) • Formerly states could declare hospitals “necessary providers” to qualify* • Provide 24-hour emergency care • Average LOS<=96 hours

⁴ CAH Legislative History. (n.d.). Retrieved May 7, 2015, from <http://www.aha.org/advocacy-issues/cah/history.shtml>

⁵ Physician Fee Schedule. (2015, February 4). Retrieved May 7, 2015, from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/>

⁶ Flex Program. (n.d.). Retrieved May 7, 2015, from <https://www.ruralcenter.org/tasc/flex>

⁷ Holmes GM, et al. Final Report No. 98, (2010, August). A Comparison of Rural Hospitals with Special Medicare Payment Provisions to Urban and Rural Hospitals Paid Under Prospective Payment, <http://www.shepscenter.unc.edu/rural/pubs/report/FR98.pdf>

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Classification	Payment method	Eligibility criteria
Sole community hospital (SCH)	<ul style="list-style-type: none"> • Inpatient reimbursement is the greatest aggregate of the federal rate applicable to the hospital or the updated hospital-specific rate based on fiscal year 1982, 1987 (OBRA 1989), 1996 (BBRA 1999), or 2006 costs per discharge (MIPPA 2008); • Disproportionate share adjustment (DSH): <ul style="list-style-type: none"> • If DSH patient percentage (DPP) > 20.2%: Adjustment = 5.88% + .825*(DPP-20.2%) • If DSH patient percentage (DPP) =< 20.2%: Adjustment = 2.5% + .65*(DPP-15%) • Adjustment may not exceed a cap of 12%. (MMA 2003); and • Volume decline adjustment: If caseload falls by 5% due to circumstances beyond the SCH's control, it may receive payments necessary to fully compensate for fixed costs (OBRA 1989). 	<ul style="list-style-type: none"> • > 35 miles from nearest like hospital OR • 25-35 miles from nearest like hospital AND <ul style="list-style-type: none"> • Bed size (<50) OR • Exclusive Medicare service in area OR • Closer hospitals are inaccessible. OR • Other hospitals are 15-24 miles but are inaccessible • Driving time to next hospital >45mins.
Medicare-dependent hospital (MDH)	<ul style="list-style-type: none"> • Inpatient reimbursement is the PPS rate plus 75% of the amount by which costs per discharge for Medicare patients from 1982, 1987 (OBRA 1993), or 2002 trended forward (DRA 2005) exceed the PPS rate; • Disproportionate share adjustment <ul style="list-style-type: none"> • Same as SCH • No cap (DRA 2005); and • Volume decline adjustment: If caseload falls by 5% due to circumstances beyond the MDH's control, it may receive payments necessary to fully compensate for fixed costs (renewed through 2011 in DRA 2005). 	<ul style="list-style-type: none"> • Rurality • Bed size (<100 beds) • Not SCH eligible • > 60% inpatient discharges to Medicare patients
Rural referral center (RRC)	<ul style="list-style-type: none"> • Reimbursement is based on the urban PPS rate (OBRA 1989); and • Disproportionate share adjustment: <ul style="list-style-type: none"> • Same as SCH • No cap, and; • Exempt from demonstrating two of three criteria for geographic reclassification: Proximity to the re-designation area and that its wages exceed 106 percent of area's average wage. 	<ul style="list-style-type: none"> • Rurality • High case-mix intensity and sufficient supply of specialists OR • Size (>275 beds) OR • High referral volume

BBA: Balanced Budget Act; IPPS: Inpatient perspective payment system; OPSS: Outpatient perspective payment system; DRA: Deficit Reduction Act; OBRA: Omnibus Budget Reconciliation Act; BBRA: Balanced Budget Refinement Act; LOS: Length of Stay.

*The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated this provision, effective January 2006.

When the CAH program was first established there was a rush of facilities that converted to the new designation because of its favorable payment mechanism. The 101% of cost reimbursement is the most attractive payment mechanism under Medicare

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for rural facilities. Until 2006 states were able to get a waiver from the distance requirement for CAH designation by determining a facility to be “necessary provider” hospital. However, the Medicare Modernization Act of 2003 (MMA) eliminated the State’s ability to waive the distance requirement for conversion to CAH designation. Therefore, the conversion of facilities to the CAH designation has leveled off since 2006.

Initial success of the CAH program in improving the financial situation of many rural facilities tempered the concerns of rural healthcare for a few years in the early 2000’s. However, the economic and financial crisis in 2008/2009 reignited concerns over cost containment in federal health spending, and conversely, access to care for rural communities. In 2013, the Office of the Inspector General (OIG) conducted an investigation to find out how many CAHs would fail to meet the distance requirement if forced to re-enroll in the program. The results of the investigation reported that 64% of CAHs would lose their CAH designation if forced to re-enroll. MedPac, CBO and OIG estimate that converting these facilities to PPS reimbursement could result in savings for the government of 17-28%.⁸ However, the OIG analysis ignores the effects that the loss of CAH designation would have on the financial viability of affected hospitals and on the access to care by people in the communities served by those hospitals.

According to the Rural Health Research & Policy Analysis Center (RHRC) at the University of North Carolina at Chapel Hill, there is variation in the levels of financial pressure on the various types of rural hospitals. In a study published by the RHRC in August of 2010, researchers found that CAHs, MDHs, and R-PPS hospitals had the most financial trouble, while SCHs were somewhat more financially stable and RCCs performed relatively well as a group.⁹ They concluded that, “the financial performance of CAHs relative to other hospital classifications suggests that low volumes, payment from other payers (private insurance, Medicaid, and self-pay), and uncompensated care still have a substantial impact on the financial condition of these hospitals.” Furthermore, “the hospitals under a lot of pressure should be of greater concern to

⁸ Holmes M, Pink GH. (2013, December). Change in Profitability and Financial Distress of Critical Access Hospitals from Loss of Cost-Based Reimbursement. NC RHRP Findings Brief.

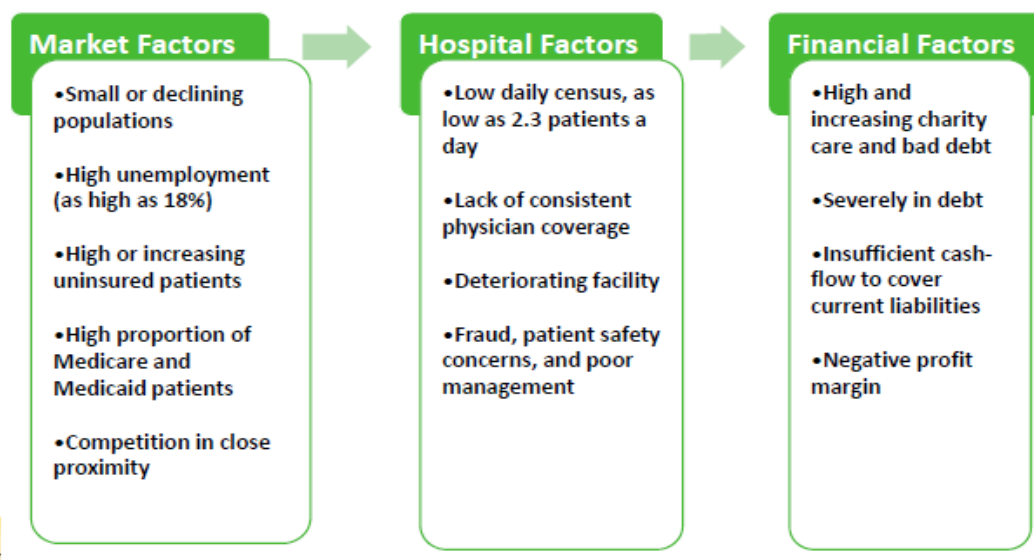
⁹ R-PPS; Rural-Payment Prospective System Hospitals are hospitals that operate on the traditional Medicare reimbursements system (PPS).

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policy makers and those concerned with access to hospital care by people who live in rural America.”¹⁰ This information further supports the need for a more careful look at how to approach the future of rural healthcare.

There are a number of factors that contribute to hospital closures. A combination of market, hospital and financial factors appear to be precipitating rural hospital closures as outlined in the figure below. While market factors related to population size and demographics are arguably difficult or impossible to change, other market, hospital and financial factors are more readily modified. Today, there are roughly 1,330 Critical Access Hospitals around the country. According to a report from iVantage analytics, there are 283 CAHs at risk for closure in the U.S. and low average daily bed census has been identified as a possible contributing factor.¹¹ Empty beds still generate a cost, and when a majority of those beds remain empty for long periods of time the reimbursements from the few beds that are filled aren’t enough to make up for it.

Figure 2. Factors leading to rural hospital closures¹²



¹⁰ Holmes GM, et al. Final Report No. 98. Page 3.

¹¹ iVantage Health Analytics Report. Rural Hospital Closures Escalating. 2014.

¹² GH Pink, et al. Rural Hospital Closures: What happens before and after. NRHA CAH Conference, Kansas City MO. October 2, 2014

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The Adverse Effects of Rural Hospital Closures

The National Rural Hospital Association (NRHA) is one of the major voices for rural healthcare on Capitol Hill. Concerned about the rapid increase of rural hospital closures and the poor financial health of a large number of Critical Access Hospitals, the NRHA began to lobby Congress for the cancellation of the PPACA cuts to hospitals in order to halt future closures. In a recent mass email sent out to congressional staff, the NRHA pleaded for the elimination of cuts to rural hospitals:

Since 2010, [50] rural hospitals have closed. Right now, 283 more are on the brink of closure leaving 700,000 patients on the brink of losing access to local emergency room care.

During a medical emergency, timely access to care matters. Just four days after one hospital closed, a 48-year-old woman suffered a heart attack and died just as the helicopter arrived to airlift to the nearest hospital, now 75 miles away.

The federal investment in rural healthcare is a small portion of federal healthcare spending, but it is critical. Rural hospitals, clinics, and centers increase health care access to rural Americans who are typically older, poorer and sicker than their urban counterparts. With approximately 62 million Americans – nearly one in five– living in rural and frontier areas, continued cuts in hospital payments mean more and more Americans will no longer have timely access to needed care.

Rural hospitals not only save lives, but practice with a more holistic, patient centered approach. Resulting in Medicare spending 2.5% less on rural beneficiaries than on urban beneficiaries receiving similar care, saving taxpayer money while providing access to needed care for seniors.

Help rural America - - stop the cuts to rural hospitals and providers. Rural hospitals save lives, provide quality and cost-effective care and provide an economic engine for rural communities.¹³

¹³ Mahn, E. National Rural Hospital Association. (February 9, 2015). Personal Communication.

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While eliminating the cuts may help some rural hospitals remain open, they still face the obstacle of patient volume. The future sustainability of rural healthcare requires a more critical look at the situation and a redefinition of the problem.

The closure of rural hospitals has its biggest impact on local communities. In 2013, 18-month-old Edith Gonzales choked on a grape in her hometown of Center, Texas. Her frantic parents rushed her to the local Shelby Regional Medical Center, but when they arrived they learned that the hospital had closed just a few weeks earlier. Edith's parents then called an ambulance that took Edith to the next closest hospital, which took another 45 minutes. Unfortunately, by the time Edith arrived to the hospital, she had already passed away.¹⁴

A similar incident happened in North Carolina when Portia Gibbs, a 48-year-old woman, suffered a heart attack and died after having to wait 90 minutes for a medical evacuation helicopter to arrive for transportation to the nearest hospital. Unfortunately, she could have made it to Vidant Pungo Hospital (with a travel distance of half the time Gibbs spent waiting on the helicopter), however, Vidant Pungo Hospital had closed just six days before her heart attack, so it was no longer an option. Additionally, there have been other deaths associated with the closure of Vidant Pungo Hospital since Portia's death, including the death of a 16-year-old boy that died after injuries sustained in a farming accident.¹⁵

In life and death situations such as those described above, time is critical. In emergency medicine, there is a term known as the "golden hour." The "golden hour" refers to the one-hour time period (or less) following a traumatic injury or medical emergency where the chances of patient survival are highest if they receive prompt medical attention.¹⁶ According to the National Conference of State Legislatures, 15% of US residents do not have golden-hour access to a Level I or Level II trauma center. This statistic combined with the fact that 60% of trauma deaths in the United States occur in

¹⁴ The Associated Press. (2015, May 1). Rural hospitals struggle to stay open, adapt to changes. Retrieved May 7, 2015, from http://www.nola.com/health/index.ssf/2015/05/rural_hospital_struggle_open.html

¹⁵ Ibid.

¹⁶ Medical Definition of GOLDEN HOUR. (n.d.). Retrieved May 7, 2015, from [http://www.merriam-webster.com/medical/golden hour](http://www.merriam-webster.com/medical/golden%20hour)

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rural parts of the country demonstrate the significance of a lack of emergency medical care in rural America.¹⁷ When a rural hospital begins to have significant financial struggles, one of the first services to go is emergency medicine. This further strengthens the argument for ensuring rural communities have access to emergency care.

In addition to the real-life incidents mentioned above, the hypothetical (yet all too probable) argument for supporting emergency services in rural areas is as follows: When Uncle Joe falls off of his tractor or suffers from a heart attack, what does he need? He needs health care from a trained professional and he needs that care as soon as possible. In other words, Uncle Joe needs an emergency room staffed with professionals that have the knowledge and equipment to treat, stabilize, and transfer him to a higher level of care if it becomes necessary. In these situations (a serious tractor accident, or a heart attack), a hospital located 40 miles away could be too far, with care that would be delivered too late. On the other hand, when Uncle Joe needs a knee replacement, he can afford to drive (or be driven) the 40 miles to a larger-fully equipped hospital facility for the procedure.

Also important to note are the unmistakable effects of rural hospital closures on local economies. Health care can represent up to 20% of a rural economy. The typical critical access hospital creates over 140 jobs in primary employment and \$6.8M in local wages, while serving a population of over 14,000. According to the iVantage report created for the NRHA, the potential closure of 283 at-risk hospitals could result in the loss of 36,000 healthcare jobs, 50,000 community jobs and \$10.6 billion in GDP.¹⁸

Finding the Solution

NRHA put forth an initial proposal that included temporarily halting a number of payment cuts to rural hospitals while funding demonstration programs to test new payment models and delivery systems. They also outlined a transition framework

¹⁷ Rural Health. (n.d.). Retrieved May 7, 2015, from <http://www.ncsl.org/research/health/rural-health.aspx>

¹⁸ iVantage Health Analytics Report. Rural Hospital Closures Escalating. 2014.

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founded in community needs assessments. Perhaps the best criticism comes from their very own proposal:

A community could choose from a menu of services to design a system that meets the needs of their community in a meaningful way through a CHNA¹⁹. As an example, Kinsley, KS set the stage for this model. *After the hospital and the entire community was blown away by a tornado, the community engaged in a planning process to decide what form of health care system would replace what they had* (a CAH and RHCs) before the storm. *After deliberation, they chose to replace what they had* because no Medicare reimbursement mechanism... met their needs...

Community needs assessments are important. Yet, left in the hands of the community without alternative payment mechanisms, we will likely continue to retain a hospital infrastructure that includes several hundred hospitals within close geographic proximity while watching additional closures take place elsewhere.

As previously mentioned, the most basic objective is to sustain basic emergency services in rural communities so that time-sensitive conditions receive rapid treatment/stabilization. That is, if a hospital cannot remain financially viable as a full service hospital, and no neighboring facilities exist to provide similar services, then conversion to an emergency facility would be beneficial to the community. Preserving local emergency services without inpatient medical/surgical capacity means that additional services must be available elsewhere. Encouraging the conversion of some failing hospitals to emergency hospitals may mean supporting a broader strategy of regionalized healthcare.

Freestanding Emergency Departments Under Current Policy

Freestanding emergency departments are not a new concept, but have struggled in rural areas due to low reimbursement, low patient volumes and high operating costs. That being said, rural emergency departments have seen a 14% increase in utilization

¹⁹ CHNA= Community Health Needs Assessment

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between 2007 and 2013. Most visits (>50%) are for low acuity issues. About 5% of patients presenting to rural EDs require admission (less than half national admission rate for all hospitals) and 4% of patients are transferred from rural EDs to other facilities with advanced capabilities.²⁰

Currently, there are two different types of freestanding emergency departments popping up around the country: hospital outpatient departments (HOPDs) and independent freestanding emergency departments (IFSEDs). HOPDs are extensions of other hospitals or medical centers and receive their licensure through the main hospital they are connected to. IFSEDs, on the other hand, operate independently from other facilities and are not recognized by Medicare as emergency departments. This puts IFSEDs at a disadvantage to HOPDs because Medicare won't pay the facility fee that hospitals benefit from when they accept Medicare, unless the IFSED is licensed as they are in Texas. Since IFEDs are not regulated or recognized at the federal level, states have different laws and regulations or sometimes a lack of regulations governing the operation of IFSEDs.²¹ Either way, the lack of federal recognition of IFSEDs makes operating one in a rural area unrealistic.

Most freestanding emergency departments in operation today are HOPDs. There are, however a few IFSEDs in operation that are privately owned for-profit centers in urban areas. These facilities cannot accept Medicare and Medicaid payments and, therefore, don't have to abide by the Emergency Medical Treatment & Labor Act (EMTALA), which requires facilities that accept federal reimbursements to treat all patients regardless of their ability to pay. In order to address this issue, Texas passed laws that require privately owned emergency departments to follow guidelines similar to EMTALA. Conversely, states such as Illinois have prohibited the private ownership of FSEDs, likely due to concerns related to EMTALA.²² This model for IFSEDs, which relies on private payer insurance, would not work in rural areas because there would not

²⁰ iVantage report. Acuity determined according to the Agency for Healthcare Research Patient Severity Index.

²¹ American College of Emergency Physicians. (2013, July). Freestanding Emergency Departments: an Information Paper.

²² American College of Emergency Physicians | News Room - Fact Sheets. (n.d.). Retrieved May 7, 2015, from <http://newsroom.acep.org/index.php?s=20301&item=30089>

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be enough private payer traffic to sustain the facility. On the other hand, IFSEDs in a rural setting that accepted Medicare and Medicaid would still be unable to survive because of the current federal payment structure.

The current Medicare payment structure for hospitals incentivizes inpatient care and treat emergency department as a loss leader. In a financially healthy hospital the emergency department helps to generate inpatient volume. However, if the emergency department does not generate enough patient volume, it is likely the hospital will not be able to generate enough income to cover costs associated with running the emergency department. In order for freestanding emergency departments to become a feasible option for rural healthcare, the Medicare payment structure has to change in order to support emergency care without inpatient volume. Just as the rural facilities flocked to the CAH model, a new model would have to be created to incentivize eligible facilities to move to a freestanding emergency department model.

There have been some concerns expressed about the widespread use of freestanding emergency departments. Emergency care is more expensive than many other forms of healthcare. Freestanding emergency departments charge the same as emergency rooms attached to hospitals. These charges can easily exceed \$1,000 for a single visit, which raises concerns over increases in emergency department utilization and the potential risk of these factors leading to higher insurance premiums.²³ In the case of the Emergency Hospitals, this concern could be even greater considering the necessity for increased reimbursement as compared to traditional emergency departments. Vivian Ho, a health economist at Rice University in Houston says, "It's a great added benefit (for patient convenience), but I think it will lead to overall higher costs for everyone."²⁴

The “patient convenience” that Ms. Ho was referring to is related to the urban freestanding emergency departments that have opened up all over the state of Texas. The purpose of the rural Emergency Hospital is not about convenience, it’s about

²³ Galewitz, P. (2013, July 14). Stand-alone emergency rooms popping up. Retrieved May 7, 2015, from <http://www.usatoday.com/story/money/business/2013/07/11/stand-alone-emergency-rooms-popping-up/2510779/>

²⁴ Ibid.

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necessity. It may stand to reason that if the only medical facility in a rural community is an Emergency Hospital that it will see all of the bumps, bruises, and stuffy noses that otherwise belong in a primary care office. However, Emergency Hospitals will continue to provide outpatient care, which already provides a majority of the income for CAHs. Furthermore, the alternative solutions do not present opportunities for real savings. Eliminating the cuts to rural hospitals to enable them to remain in business translates to a cost for the federal government. On the other hand, moving forward with the cuts to hospitals and allowing critical access and other rural hospitals to close will severely impact access to care in rural areas. Access issues can later translate to higher healthcare costs when patients postpone care because of the inconvenience or inability to travel long distances. Therefore, the Emergency Hospital may generate some increased cost; it can be argued, however, that some amount of equity in access to care between urban and rural communities makes the Emergency Hospital a justifiable expense.

Rural Emergency Hospitals

Rural America is looking for a response to the recent closures and there are looming concerns regarding the future sustainability of rural healthcare. New legislation could provide that response and make rural freestanding emergency departments a viable option for rural healthcare. That legislation is currently being called the Rural Emergency Acute Care Hospital (REACH) Act of 2015.²⁵ The REACH Act would amend title XVIII of the Social Security Act in order to create a new Medicare payment model that will support a rural freestanding emergency department. The new Medicare payment designation is presently being called the Rural Emergency Hospital (REH). Facilities that will be eligible for transition to the REH designation include current CAH and Rural PPS hospitals with less than 50 beds in operation as of January 1, 2015, or any hospital fitting that same description that has closed in the previous five years. REHs will be required to provide emergency medical care 24 hours a day, 7 days a week

²⁵ Discussion Draft: Rural Emergency Acute Care Hospital Act (2015). Unpublished Draft.

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by on-site staff. In addition to emergency care, REHs must also provide observation care for cases that require short-term monitoring. Similar to the 96-hour rule at Critical Access Hospitals, the REH will have a 24-hour observation rule (or more than one midnight). However, the 24 hour rule will be applied on the basis of an annual average to give physicians flexibility in the treatment of individual patients.²⁶

The REACH Act further specifies that REHs will not offer any inpatient service or operate any inpatient beds. Since REHs will only provide emergency care, patients that require a higher level of care will have to be transferred to another facility with those capabilities. In order to ensure the transfer of patients to other facilities, REHs must have protocols in place for the timely transfer of patients who require a higher level of care or inpatient admission. These protocols are not specified in the bill, but are likely to include transfer agreements with other hospitals or independent ambulance transport companies.

The reimbursement rate for services furnished at a Rural Emergency Hospital is a pivotal component of the REACH Act. The rate is set at 110 percent of reasonable costs, a notable increase from the 101 percent that is the current rate for Critical Access Hospitals. The rate had to be set high enough to attract eligible facilities to convert with the reasonable expectation of good financial performance. At the same time the rate could not be so high that it provided an unfair advantage to REHs over other participating Medicare facilities. Most importantly, the rate had to be set high enough to at least partially cover the expenses of operating a 24-hour emergency room.

One of the initial concerns in setting the reimbursement rate at 110 percent was the possible impact it could have on the beneficiary's share of the payment. A report published by the Department of Health and Human Services Office of the Inspector General published in October 2014 found that beneficiaries already pay more for a given service at a CAH than they would for the same service at an urban facility²⁷. To ensure the beneficiary does not incur additional costs based on the reimbursement rate, the

²⁶ Discussion Draft: Rural Emergency Acute Care Hospital Act (2015).

²⁷ Levinson, D., & et al. (2014). Medicare Beneficiaries Paid Nearly Half Of The Costs For Outpatient Services At Critical Access Hospitals. OIG Report.

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REACH Act specifies that the beneficiary co-payment shall be equivalent to the co-payment amount charged at a CAH for the same service.

The REACH Act also includes several policy provisions that address the process by which facilities will convert to the new REH designation. The first of these provisions is a requirement that states approve conversions to the REH designation through a Certificate of Need or similar process. Another provision included in the bill is a mechanism that will provide another opportunity for Rural-PPS hospitals that missed the boat on conversion to Critical Access Hospitals.²⁸ The provision will allow states to convert one Rural-PPS hospital to CAH designation with a distance waiver for every CAH in that state that converts to a REH. The Rural-PPS hospitals would have to meet all other criteria to convert to a CAH with the exception of the distance criteria. The result of this policy provision will be a net increase of rural healthcare facilities increasing the access to care in rural America. Another important aspect of the REACH Act is that conversion to the REH designation is voluntary. Facilities will make a determination as to whether the new designation could be right for them.

Another provision allows Critical Access Hospitals that transition to the Rural Emergency Hospital model to revert back to CAH status at any time. Furthermore, these facilities could revert to CAH status not under current regulations, but under the same conditions with which they were first designated. This could play a significant role in helping a CAH decide to try the new model. Essentially, it provides what feels like a safety net for CAHs to revert back to CAH status if they find the new REH model does not work for their facility or community.

Though voluntary, the purpose of the Certificate of Need provision is to ensure an organized transition of hospital facilities across the rural healthcare landscape. The nature of the REH and the requirement for transfer arrangements to more fully equipped facilities encourages a hub and spoke system for rural healthcare. The decisions about how the hub and spoke system will come together are left to the individual states. The concept behind this approach is the belief that states will be able

²⁸ Discussion Draft: Rural Emergency Acute Care Hospital Act (2015).

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to make the decisions that best suit their unique situations. Currently there is no statutory framework for the Certificate of Need process, but an organized method for deciding which facilities convert to REH status is critical to the sustainability of the REH concept.

The following hypothetical example will help explain the importance of a Certificate of Need process: there are three Critical Access Hospitals all located 35 miles or more away from each other and each is struggling financially due to low inpatient volume. If all three facilities had the freedom to convert to the Rural Emergency Hospital designation there would no longer be any inpatient hospital services in any of the three facilities. The breakdown is in the hub and spoke transfer system. In other words, in this scenario there would be three spokes and no hub. As long as one facility remained a full CAH with inpatient services, the neighboring REHs would serve as feeders for the inpatient services at the CAH. Furthermore, communities in which the CAH converted to the REH model would maintain critical medical services in their local area. The alternative to this scenario could unfortunately be one where all three hospitals fail to remain open and close around the same time because they are all operating independently of one another.

The REACH Act also incorporates two provisions to encourage emergency medicine professionals to practice in rural areas, and at Rural Emergency Hospitals in particular. The first adds the specialty of emergency medicine to the list of professions under the National Health Service Corps (NHSC), specifically for Rural Emergency Hospitals. The National Health Service Corps offers loan repayment programs to qualifying physicians that practice at NHSC sites. Previously, emergency medicine was not listed as an eligible specialty, but will now be included for the purposes of staffing REHs with trained emergency medicine personnel. The second provision will allow Medicare reimbursement for hospitals with approved residency programs when their interns and residents conduct emergency department rotations in rural hospital locations. These provisions will encourage trained professionals to staff these new rural facilities and give students in the emergency medicine specialty the chance to experience the unique environment and challenges of rural emergency care.

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Another important aspect of the REACH Act is what is not included in the bill. The bill does not specify how a Rural Emergency Hospital should look beyond the emergency care it would provide and the assurance that patients have timely access to higher levels of care when needed. In other words, the bill encourages individualized structures, which enable REHs to tailor services to suit the needs of their communities. Examples of some of the other services that could be incorporated into an REH include (but are not limited to) outpatient services, skilled nursing facility (SNF) care, infusion services, home health, hospice and telemedicine services. Telemedicine, while not dictated as a mandatory element of REH services, is specifically mentioned in the REACH Act to ensure that telehealth services in an emergency room setting are an allowable cost for the new model. Current law does not allow Critical Access Hospitals to bill Medicare for backup physicians providing services via a telehealth communication systems in their emergency rooms.

When given the choice, every community wants a state of the art hospital with neurosurgeons and other highly trained specialists on standby. Unfortunately, that scenario isn't always realistic, especially in rural communities. The most critical medical service in rural communities for life-threatening situations is emergency medicine. The REACH Act will reconstruct the landscape of rural healthcare in America, making rural emergency medicine both feasible and sustainable. The REACH Act is not the final solution for all rural healthcare issues, but it is a mechanism for starting a much-needed conversation about the future of rural healthcare.