



National Advisory Committee On Rural Health and Human Services



Alternative Models to Preserving Access to Emergency Care Policy Brief July 2016

Editorial Note: During its April 2016 meeting in Beaufort, South Carolina, the National Advisory Committee on Rural Health and Human Services (the Committee) examined some alternatives for provision of emergency care and ancillary services in the light of the recent surge in rural hospital closures. The Committee was concerned with how a rural community could maintain timely access to emergency and other core healthcare services in communities too small to support a full-service hospital but needing more services than offered by a typical primary care clinic. The Committee heard from government officials, rural health services researchers, and hospital administrators to get a broad view of the issue.

RECOMMENDATIONS

1. The Committee recommends that any model for Rural Free-Standing Emergency Departments must include a supplemental base payment, separate from fee for service payments for Emergency Department visits (see page 6).
2. The Committee recommends that the Department seek comment on use of a combination of distance and demographic or social determinants of health such as poverty and health outcomes when setting eligibility criteria for any demonstration project on alternative models (see page 9).

INTRODUCTION

Concern over access to health care is usually heightened when a rural hospital closes, since these facilities often serve as the focal point for care in their communities. As a result, the closure of rural hospitals is a long-standing issue that this Committee has addressed repeatedly since it was created in 1988. The Committee first sent a report to the Secretary in 1989 and the first recommendations the Committee issued dealt with Medicare payment policy for rural hospitals. The implementation of the Prospective Payment System (PPS) during the 1980s was linked to the closure of approximately 400 rural hospitals by the early 1990s.

Over the past 30 years, Congress and a number of Administrations have created new hospital designations, revised Medicare payment formulas and created grant programs to support rural hospitals. These policy changes were largely effective and stabilized rural hospital financial operations until 2013, when a new wave of rural hospitals closures began. In the past six years, 75 rural hospitals have closed or ceased operations¹, prompting new concerns about access to essential services in rural communities.

¹ as of 6/30/2016 <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

The closures have led to a new policy discussion about whether an alternative model of care is needed in those areas that are too small to support a full-service hospital but which need more services than can be offered in an ambulatory clinic. This policy brief is a departure for the Committee, which usually focuses on how to improve existing policies and programs to serve rural communities. In this brief, the Committee will examine some of the initial proposals for a new model of care and lay out principles that the Secretary and the Department of Health and Human Services should use in assessing policy options for an alternative model of care in rural communities.

BACKGROUND

Rural hospital closure rates are increasing nationally and these closures may affect access to basic inpatient, outpatient and emergency medical services. Seventy-five rural hospitals have ceased inpatient care since January 2010. The average distance of the closed rural hospital from the nearest remaining hospital is around 15 miles. Research findings indicate that 8% of rural hospitals (approximately 180) were at high risk of financial distress in 2013.

Initial analysis identifies a number of factors affecting a hospital's decision to close or suspend operations. Among them, 1) low patient volume and declining inpatient utilization² across rural hospitals, resulting in declining revenues for facilities with already thin operating margins; 2) financial risk³ often related to payer mix (i.e., rural hospitals are more dependent on public payers and have a smaller proportion of private insurance); and 3) reorganizations and decisions by health systems to eliminate inpatient beds and focus on outpatient care.

Much of the Committee's work over the past few years has focused on reimbursement and other policies that would enable essential rural hospitals to survive. In [Implications of Proposed Changes to Rural Hospital Payment Designations](#) the Committee examined proposals from several different quarters that would have either reduced rural hospital payments, reduced the number of rural hospitals paid under payment systems other than standard PPS, or have combined both policies. In the 2012 Policy Brief, [Options for Rural Health Care System Reform and Redesign](#), the Committee made recommendations to the Secretary on ways to place rural health care delivery solidly in the new world focused on measureable quality and value.

² There has been an across the board reduction in inpatient utilization in hospitals in the US. MedPAC. (November 2014). "Rural hospital occupancy rates declined 47 to 41% (2006-2013)" <http://www.medpac.gov/documents/november-2014-meeting-presentation-beneficiary-access-to-hospital-care-and-how-service-volume-affects-hospital-costs.pdf> ; American Hospital Association. (2015). "Table 3.1: Trends in inpatient utilization in community hospitals, 1993 – 2013." *Trendwatch Chartbook 2015*. <http://www.aha.org/research/reports/tw/chartbook/2015/table3-1.pdf>

³ Reiter KL, Noles M, Pink GH. (October 2015). "Uncompensated care burden may mean financial vulnerability for rural hospitals in states that did not expand Medicaid." *Health Affairs*. <http://content.healthaffairs.org/content/34/10/1721.abstract>

At its recent meeting in Beaufort, S.C., the Committee examined alternative models that could continue to provide critical services in rural communities that have experienced hospital closure or that can no longer support a small, limited service hospital.

IMPACT OF HOSPITAL CLOSURES

Following the large number of closures in the 1980s and early 1990s, researchers tried to quantify the impact of hospital closures on people and communities. Published findings showed declines in access to care and increased distance rural residents had to travel to access services, including emergency care.⁴

A recent article in the journal *Health Affairs* found that hospital closure had no measurable impact on local hospitalization rates or mortality rates.⁵ The study focused on closure of 195 hospitals from 2003-2011. Most of the closed hospitals in the study were urban hospitals and only 22% were rural. The National Rural Health Association (NRHA) and others have raised concerns with the conclusions of this study. Mortality is only one possible outcome of diminished health care access, the study did not focus on hospital closures in isolated areas which did not have access to other sources of care, nor did it examine loss of services such as hospital-based clinics which may close along with a hospital. Given the smaller number of rural hospital closures in the sample, this study had limited statistical power to detect changes in outcomes for rural Medicare beneficiaries. It did not assess the potentially increased burden on rural residents, who would have to bear the costs and inconvenience of increased travel distance and time.⁶

A Findings Brief “A Comparison of Closed Rural Hospitals and Perceived Impact” from the North Carolina Rural Health Research Program examined 47 recent hospital closures and found that “26 hospitals no longer provide any health care services (“abandoned”), and 21 continue to provide a mix of health services but no inpatient care (“converted”). These closures have affected approximately 800,000 people in the markets with abandoned hospitals and 700,000 people in the markets with converted hospitals.” The abandoned hospitals served “a higher proportion of non-Whites (26%), particularly Blacks (14%), compared to converted rural hospitals (11% and 2%, respectively) and were located farther away from other hospitals.” Those who lived in the Hospital Service Areas (HSAs) of the abandoned hospitals were concerned about increased travel time to receive care. News reports from areas with closed hospitals have blamed greater travel time for deaths that have occurred, but these are individual cases and not reflected in broader data.⁷

⁴ Rosenbach ML, Dayhoff DA. (Fall 1995). “Access to care in rural America: impact of hospital closures.” *Health Care Finance Review*. <http://www.ncbi.nlm.nih.gov/pubmed/10153469>

⁵ Joynt KE, Chatterjee P, Orav EJ, Jha AK. (May 2015). “Hospital closures had no measurable impact on local hospitalization rates or mortality rates, 2003-11.” *Health Affairs*.
<http://content.healthaffairs.org/content/34/5/765.abstract>

⁶ Slabach BA. (May 2015). “Health Affairs implies hospital closures don’t matter.” *NRHA Blog*.
<http://connect.nrharural.org/blogs/brock-slabach/2015/05/06/health-affairs-implies-hospital-closures-dont-matter>

⁷ (October 2014). “Closure of rural hospital ripples across Hyde County waters.” *Capitol Broadcasting Company*.
<http://www.wral.com/closure-of-rural-hospital-ripples-across-hyde-county-waters/14054183/>

ASSESSING CURRENT POLICY OPTIONS

The scope of current rural hospital closures has generated significant attention from policymakers. The Medicare Payment Advisory Commission (MedPAC) and national stakeholders such as the NRHA, and the American Hospital Association (AHA) are engaging around the issue. MedPAC has consistently stated that rural beneficiaries' access to emergency services needs to be preserved and agree that, in certain circumstances, preserving emergency access will require supplemental payments beyond standard fee-for-service (FFS) rates. 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. AHA's Task Force on Ensuring Access in Vulnerable Communities is working to confirm the characteristics of vulnerable rural and urban communities and identify strategies and federal policies to help ensure access to care in these small, rural communities.

The Committee has also created the opportunity to look at different ways to organize and provide access to essential services in rural communities beyond the current available provider types. In this brief, the Committee will assess four policy options. The first is the Frontier Extended Stay Clinic model, which was the focus of a prior Committee Policy Brief. The second is the rural Free-Standing Emergency Department. The third focuses on recent options discussed by MedPAC. The fourth assesses recent Congressional proposals. It is worth noting that the Committee has concerns about the viability of each of these models, but also believes that lessons can be learned from each model and inform the longer-term discussion on how best to pay for and organize essential services in rural communities.

The Frontier Extended Stay Clinic

For the purposes of this brief, the Committee revisited its past work assessing the Frontier Extended Stay Clinic (FESC) demonstration highlighted in the, 2012 Policy Brief, [Options for Rural Health Care System Reform and Redesign](#). Primarily an Alaskan model, under this demonstration, frontier clinics were located at least 75 road miles away from the nearest hospital, or the nearest hospital was inaccessible from the clinic by public roads. In addition to their normal clinic services, FESCs were authorized to keep patients for extended periods of time (up to 48 hours) and deliver 24-hour emergency and after-hours care not otherwise available in remote areas. Their service mix made FESCs a unique provider type in rural, not quite a hospital but significantly more than a clinic. A preliminary assessment of the FESC model conservatively estimated that the FESC consortium saved almost \$14 million in transfer costs by avoiding nearly 1,800 medical evacuations between August 2005 and September 2010. However, the FESC demonstration was not without its challenges in terms of staffing and financial viability. Even with the authorized Medicare and Medicaid reimbursement each clinic required an estimated additional \$1 million per year over that same five year span to provide extended-stay and 24/7 emergency-level services. At that time, the Committee recommended that CMS continue this program and consider expanding it beyond frontier areas.

The FESC demonstration has since ended and results were mixed. In its [2014 Report to Congress](#), CMS noted that the pilot improved patient access and experience of care. The report also noted the availability of extended stay services in frontier communities reduces Medicare spending for emergency transfers and hospitalizations, but these savings are outweighed by the

cost of building and maintaining extended stay capacity. Despite the challenges with the FESC demonstration, the Committee believes there are lessons learned that are worth noting, specifically that even an enhanced fee-for-service payment may be insufficient to cover high fixed costs in a low-volume environment.

The Rural Free-Standing Emergency Department (RFED)

One example of a state-wide effort to address the rural hospital closure crisis is in Georgia. The Department of Community Health (DCH) adopted rules effective May 19, 2014 that allow rural hospitals to reduce the scope of services provided and operate as a rural free standing emergency department, providing an alternative to closing down operations for rural hospitals which may be struggling with funding operations on a full service scale. It also provided for rural hospitals that recently ceased operations (and have either maintained a current DCH license or their license expired within the last 12 months) to re-open their doors. In the two years since, no organization has applied for the new designation as a rural free standing emergency department, with stakeholders citing the financial viability of the model as a major concern.

Rural emergency departments have very high fixed standby costs of coverage compared to the volume of services provided and generally, a much less favorable payer mix compared to the hospitals' other services. In full-service hospitals, the ED's operations are subsidized by the hospital's other operations. An additional financial benefit that rural hospitals receive from operating their EDs is the admissions that come through the ED. If the RFED is not part of a hospital, then there is no financial benefit from inpatient services to offset the losses from ED operation.

A recent report from the University of North Carolina's Rural Health Research Center examined the financial underpinnings of MedPAC's first option, Rural Free-standing Emergency Departments (RFED). Their findings were:⁸

- RFEDs currently do not receive any rural-specific designation under federal regulations; as such, RFEDs must take the form of a hospital-owned freestanding emergency department to be eligible for facility fee reimbursement by the Centers for Medicare and Medicaid Services.
- The annual total cost to operate a low, medium, and high volume RFED is estimated to be \$5.5, \$8.8 and \$12.5 million, respectively. The average visit cost per patient declines with greater volume (\$600, \$370 and \$347 for low, medium and high volume RFEDs, respectively).
- Low patient volumes, high rates of uninsured patients, minimum staffing requirements, provider shortages, federal reimbursement policies, and other rural factors must be considered in assessing the financial viability of an RFED.

Given that low patient volumes, high rates of uninsured patients, difficulty meeting minimum staffing requirements, and provider shortages are endemic in rural areas, the financial viability of RFEDs based solely on differential Medicare and Medicaid reimbursement is difficult to envision. Even compared to a small rural hospital, the RFED would have fewer services over

⁸ Williams JD, Song PH, Pink GH. (November 2015). "Estimated Costs of Rural Freestanding Emergency Departments." <https://www.ruralhealthresearch.org/publications/995>

which to spread its administrative costs. Medicare beneficiary utilization of such EDs is generally much less than the hospital's other services. Medicare patients often comprise less than 25% of total ED utilization⁹. Since so few Medicare patients are seen in the ED, even paying 200% of Medicare costs or 400% of Medicare FFS reimbursement would not make these RFEDs financially stable, thus requiring significant ongoing subsidies to remain viable.

The Committee therefore recommends that any model for RFEDs must include a supplemental base payment, separate from fee for service payments for ED visits. Given Medicare volume in a typical rural ED, even traditional cost-based payment models will not reliably cover operating costs for a RFED.

The MedPAC Options¹⁰

In its November 24, 2015 [report](#), Models for Preserving Access to Emergency Care in Rural Areas, MedPAC stated that the Commission, researchers, and rural advocates all agree that, in certain circumstances, preserving emergency access will require supplemental payments beyond standard fee-for-service (FFS) rates and offered potential options for discussion.

MedPAC Option 1:

The first option is to pay these isolated hospitals outpatient PPS rates and a fixed supplemental amount to preserve their emergency department (ED) and ambulance service along with any ancillary services that the Community identifies as needed and economically viable. The fixed supplemental payment would be based on the difference between the current enhanced Medicare rates minus the standard fee-for-service rate. The rationale behind this approach is that stand-by emergency capacity is the essential desired service, and therefore Medicare should support this service. Additionally, unlike cost-based models, hospitals would no longer have an incentive to offer services for which their costs are not competitive (e.g., MRI and swing bed services). The local community could also be required to provide some of the funding for the emergency department and other services given that many rural communities already use a levy or special tax to support their rural hospitals.

The Committee has expressed concern as to whether the proposed formulation of the base payment plus local funding for this option will be sufficient to leverage the flexibility required to meet the needs of the community without the participation of state Medicaid, private insurers and other payers, given the high fixed cost and low Medicare volume RFED.

MedPAC Option 2:

The second option is for a community that is too small to support a 24-hour emergency department. The option would create a primary care clinic that would be open 8-12 hours a day with an adjacent ambulance service operating 24/7, creating a clinic by day, and a stabilize-and-

⁹ Commercial Insurance payment in the rural ED steadily fell from an average of 33% in 2007 to 26.7% in 2012. Medicare payment in the rural ED has moved from 30% to 22.9% over the same period. Medicaid payment in the rural ED has moved from 18.9% to 17.9% over the same period. Self-Payment in the rural ED has moved from 15% to 12.0% over the same period. Other forms of payment in the rural ED have moved from 3.1% in 2007 to 20.5% in 2012. <https://www.ivantagehealth.com/wp-content/uploads/2013/09/6th-Annual-ED-Study-vF2.pdf>

¹⁰ MedPAC Staff. (November 2015). "Models for preserving access to emergency care in rural areas." MedPAC. <http://www.medpac.gov/blog/november-2015/november-2015/2015/11/24/models-for-preserving-access-to-emergency-care-in-rural-areas>

transfer model by night. Medicare could pay PPS rates for primary care visits and ambulance transports but also provide a fixed supplemental amount¹¹ to support the capital costs of operating a primary care practice, the standby costs of the ambulance service, and costs of uncompensated care. Similar to option 1, the local community may also be required to contribute funding. The Committee has also expressed concern as to whether the proposed formulation of the base payment and local funding for this option will be sufficient to leverage the flexibility required to meet the needs of the community given the high fixed cost and low Medicare volume RFED without the participation of state Medicaid, private insurers and other payers.

Other Options

Other recent proposals have suggested other models for hospitals with 50 or fewer beds which would allow them to convert to Rural Emergency Hospitals (REHs). These would provide emergency and outpatient services, but not inpatient care. REHs would receive enhanced reimbursement rates of 110% of reasonable costs for Medicare services.

Another proposal for a Community Outpatient Hospital (COH) model would enable rural hospitals with 50 or fewer beds to convert to a COH which would offer 24/7 emergency care and observation services and transfer patients requiring acute inpatient care. The facility could offer other outpatient services, telehealth, and post-acute care using swing beds. Medicare payment for services provided by a COH would be 105% of reasonable cost.

Given that a Critical Access Hospital's (CAH) inpatient unit typically has a higher share of Medicare utilization of services than outpatient services, the cost-based payments for Medicare inpatient services cover a significant portion of facility fixed costs. It is not clear whether any of these outpatient models offer viable financial options for at-risk rural hospitals given the unique implications of cost-based reimbursement already used to support CAH operation.

DISCUSSION AND RECOMMENDATIONS

The Committee sees it as a positive development that these proposals are being discussed and that they all expressly make the point in one way or the other the need to figure out a rural financing model that acknowledges on the front end the high fixed costs vs low volume reality. The Committee also recognizes this as more than just a Medicare issue but that state Medicaid, private payers and local support also have a role to play.

With what appears to be an increasing rate of hospital closures, the need for new models of delivering care is more pressing. The committee commends the Department for past success in using new types of facilities to stabilize the financial structure of rural health care and provide access to care and encourages the Department to continue efforts such as the recent [CMS Request for Information on Concepts for Regional Multi-Payer Prospective Budgets](#). One fact that has become apparent is that cost-based reimbursement for Medicare and Medicaid patients cannot solve all the problems of providing access to care in rural areas.

The Committee expects the Secretary and HHS leadership will be asked to take part in the discussion and therefore offers (within the context of a high fixed cost and low volume reality, a need for a core set of services and ancillaries, state licensure and scope of practice variability, along with the realization that no one model will fit all rural communities) the following common features that it believes must be present for any new model to succeed.

Essential Services:

New models of care offer an opportunity to include needed services that are frequently unavailable in rural areas. The Committee believes that alternative facilities could see these services built into their financial model and rather than simply being a new cost center, the local provision of care would keep health care funding in the community and health care system, while enabling beneficiaries to remain in or near their homes. While some services, such as Emergency care, should be included in any new model, others could be optional.

Eligibility Criteria and Conditions of Participation:

The Committee recognizes that new models of care are frequently seen as imposing new cost rather than seen as more efficient or cost-effective ways of delivering care that would otherwise be provided elsewhere. By carefully establishing eligibility criteria and Conditions of Participation, the Department could allay some of these concerns.

While it is tempting to use distance alone as eligibility criteria, vastly different geographic considerations in different parts of the country make it difficult to set a mileage limit that would be appropriate. In fact, a distance requirement would naturally produce more eligible applicants in the western areas of the country where we see fewer hospital closures than in the southeast, south-central and mid-west areas where there are far more hospital closures. Realizing a combination of distance with community demographics offers a better approach, **the Committee recommends** that the Department seek comment on use of a combination of distance and demographic or social determinants of health such as poverty and health outcomes when setting eligibility criteria for any demonstration project on alternative models.

CORE SERVICES SHOULD INCLUDE:

- Emergency
 - Extended hours of service
 - Extended duration for ED visits
- Diagnostics (radiology, lab, possibly CT)
- Full Service Primary Care (including serious attention to Patient Centered Medical Home model)
- Ambulance transport support
- Telehealth – specialists and behavioral health

OPTIONAL SERVICES COULD INCLUDE:

- Dental
- Behavioral Health
- Home Health
- Hospice
- Post-Acute Care

Conditions of Participation (CoPs) should be aligned with the core services provided by any new models. The CAH CoPs for provision of Emergency care could serve as a model for these new CoPs along with a focus on requirements of other models and activities such as:

- Patient Centered Medical Home (NCQA or other state/national certification)
- Encouraging Tele-ED and tele-behavioral health capacity
- Co-location of Ambulance transportation and EMS

Any new model must be aligned with the current delivery system reform which is shifting its emphasis from quantity of services provided to value based purchasing. The Committee believes this should not impose additional burden on new models as moving from an inpatient-centered to a quality focused outpatient-centered population health emphasis will be integral to the model.

Areas for Future Study:

The Committee realizes the need to look beyond the options examined in this brief. Other areas for further study could include other options and issues such as:

- Transitional care beds¹²
- Colestrip Montana Clinic Model¹³
- Encouraging use of non-physician practitioners to their full scope of practice
- Multi-payer engagement in rural models
- Facilitation of vertical integration of healthcare resources
- Provision of Observation services in the ED setting
- Utilization of Tele-ED services
- Behavioral health care in EDs

CONCLUSION

The Committee sees great benefit in this discussion not only for the small, rural communities affected but also for policy makers and payers. Finding financially viable models that preserve emergency access and provide an essential level of care in these communities will be in the best interest of the entire healthcare system. While the Committee agrees with MedPAC, researchers, and rural advocates that preserving such access will require supplemental payments beyond standard fee-for-service (FFS) rates, we are confident that it can be done in a way that aligns with where the entire healthcare system is moving to provide better care and better health in a cost-effective way.

¹² <http://www.healthforum-edu.com/rural/PDF/2016/BendbutDontBreakFlexibleDeliveryModelsforRuralCommunities2.pdf>

¹³ Colstrip Medical Center is a rural medical clinic serving a population of approximately 2500 and is located 130 miles east of Billings, Montana. The clinic provides routine, urgent, special and preventative health services and also offers 24-hour on-call urgent care services. Colstrip Medical Center also provides specialty and preventive health services. Two full-time physicians, a physician assistant, registered nurses, laboratory and radiology personnel and physical therapists staff the clinic. Mental health services are provided via telemedicine with psychiatrists in Billings.