Iowa Hospital Priorities

This proposal provides a three-pronged approach to providing help to Iowa’s rural hospitals. The proposal is designed to help hospitals right size to maintain access to critical services in their communities and to provide adequate payment for those essential services.

1. Create a new hospital designation - Rural Emergency Hospitals

   A. Eligibility Criteria

   “Rural emergency hospital” is defined as a facility that:

   i. As of the date of the bill’s enactment, was a CAH or was a hospital with less than 50 licensed beds or with less than 50 staffed beds in a rural area (or such a hospital treated as being located in a rural area), or (2) was such a CAH or hospital that had ceased operations within the 5 years prior to the bill’s enactment;

   ii. Provides 24-hour emergency medical care and observation care that does not exceed an annual per-patient average of 24 hours or more than 1 midnight;

   iii. May include a unit of the facility that is licensed as a distinct part SNF;

   iv. May provide all services currently allowed as a CAH with the exception of acute inpatient care and has protocols in place for the timely transfer of patients who require acute care inpatient services or other inpatient services;

   v. Provides for the transport of patients who require acute care inpatient services or other inpatient services from the rural emergency hospital to a hospital or CAH, either by the rural emergency hospital’s ambulance service provider or through another ambulance service supplier;

   vi. Has an REH network agreement with a non-REH hospital similar to a CAH network agreement.

   B. Services Provided

   “Rural emergency hospital services” are all services currently provided by a CAH with the exception of acute inpatient care.

   C. Reimbursement

   Payment for rural emergency medical center services involves:

   i. Payment for rural emergency hospital outpatient services, which includes 120% of allowable cost reimbursement for all facility services currently included in the CAH program, with the exception of acute inpatient care.

   ii. Payment for EMS/transportation services, which is equal to 120% of cost reimbursement.

   iii. Payment for covered home health services, which is equal to 120% of cost reimbursement.

   iv. Payment for extended care services, which is equal to 120% of cost reimbursement.

   v. Rural emergency hospitals that fail to meet certain performance thresholds based on quality will be subject to financial penalties.
**D. Critical Access Hospital (CAH) Distance Requirement and Redesignation**

For each CAH located in a State that is certified as a rural emergency hospital, the State will have the option to waive the distance requirement in SSA §1820(c)(2)(B)(i)(I) with respect to another facility located in the State that is seeking designation as a CAH.

A rural emergency hospital that was previously designated as a CAH may elect to be redesignated as a CAH and retain its necessary provider status at any time.

**E. Additional Provisions for REH**

i. For purposes of payment for telehealth services under SSA §1834(m), a rural emergency hospital will be treated as a telehealth “originating site” generally and a telehealth “distant site” when the originating site is the patient’s home.

ii. A rural emergency hospital shall be treated as a CAH for purposes of 340B and its provider-based clinics/departments will continue their eligibility as child sites.

iii. Financial assistance will be available to rural emergency hospitals in connection with activities including:
   a. Altering the rural emergency hospital’s cost structure and facilitating lower cost-based spending for Medicare; and
   b. Reconfiguring existing facilities to rural emergency hospitals through the use of capital/infrastructure funding.

2. Critical Access Hospitals

A. Stabilize CAHs

a. Establish an 18-month window for rural hospitals to apply to seek conversion to CAH designation by using the conversion criteria listed below.

b. To reflect the outpatient orientation of care in rural communities, home health and emergency medical services (EMS) should be included in CAH cost plus reimbursement.

c. Enable efficient co-location of RHC, provider-based and specialty physicians

B. Conversion Criteria

Allow small, rural hospitals to apply to seek conversion to Critical Access Hospital (CAH) designation if they meet criteria as set forth below:

i. Located in a rural area. This means outside a Metropolitan Statistical Area as classified by the Office of Management & Budget;

ii. Current designation as a Sole Community Hospital (SCH), Medicare Dependent Hospital (MDH) or “tweener” hospital;

iii. Reduction in inpatient licensed beds to 25 or less; and

iv. Meet CAH distance or necessary provider verification requirements. The process for State designation of necessary provider will be reopened annually to enable States to identify and accommodate changing trends in health care access. The designation process would be based on the former process in place prior to January 1, 2006.
The Secretary of Health and Human Services shall establish an annual application process. Applicant hospitals would agree to abide by CAH Conditions of Participation and Conditions of Payment. Applicant hospitals would not be able to receive CAH reimbursement until inpatient beds have been reduced and any state certification requirements have been met.

3. **Infrastructure Funding for Right Sizing and/or Modernization**

Many rural hospitals have outdated facilities and equipment and lack funds to “right size” their facilities to meet community needs. Eligible rural hospitals would be eligible to apply for one-time capital/infrastructure funding for an eligible construction and/or modernization project.

The purpose of this funding is restricted to refurbishing the hospital infrastructure to include upgrades related to mechanicals and safety concerns or to enable the hospital to transition, or be repurposed, to a smaller and/or more efficient facility. This funding may be used for relocation to a new facility if the applicant can demonstrate that a new facility is more cost-effective than remodeling or refurbishing the current facility.

The applicant must demonstrate that capital/infrastructure funding is aligned to the health and wellness needs of the community served and must identify the essential service lines that will be provided. Financial assistance opportunities would include both federal grants and loans.

**A. Eligible rural hospitals would be hospitals limited to:**

1) Hospitals that are converting to a CAH designation (as proposed in recommendation #1):
   i. Located in a rural area;
   ii. Current designation as a Sole Community Hospital (SCH), Medicare Dependent Hospital (MDH) or “tweener” hospital;
   iii. Reduction in inpatient licensed beds to 25 or less; and
   iv. Meet CAH distance or necessary provider verification requirements. The process for State designation of necessary provider will be reopened annually to enable States to identify and accommodate changing trends in health care access. The designation process would be based on the former process in place prior to January 1, 2006; or

2) Hospitals that are significantly reducing their inpatient footprint:
   i. Located in a rural area;
   ii. Current designation as a Sole Community Hospital or Rural Referral Center (RRC),
   iii. Reduction in inpatient staffed beds to 50 or less.

**B. Eligible construction, including relocation, and/or modernization project must include the following purpose(s):**

1) Eliminate or prevent safety hazards which under Federal, State, and/or local fire, building or life safety codes or regulations, will, in the judgment of the Secretary result in one or more of the following:
   i. Loss of licensure for the facility,
ii. Closing of all or a substantial part of the facility,

iii. Loss of eligibility for reimbursement under title XVIII or title XIX of the Social Security Act; or

2) Avoid noncompliance with State licensure or voluntary accreditation standards where noncompliance will, in the judgment of the Secretary, result in one or both of the following:

i. Loss of licensure for the facility,

ii. Loss of accreditation resulting in loss of eligibility for reimbursement under title XVIII or title XIX of the Social Security Act.