Early Learnings

From the Rural Health Redesign Center and its Rural Emergency Hospital Technical Assistance Center

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Background

The rural emergency hospital (REH) is a new Medicare provider type created to address the growing concern over rural hospital closures. The goal of this new designation is to provide a means to preserve access to essential services for rural residents, and to decrease the likelihood of hospital closures. Rural hospitals often have low patient volumes which yield insufficient revenue, and consequently are at significant risk of closing. As of this writing, over 150 rural hospitals have closed or converted since 2010[1], leaving their surrounding communities with reduced access to critical health services, negatively impacting employment and the local economy.

The Consolidated Appropriations Act (CCA), 2021, added a new section to the Social Security Act to establish REHs as a new Medicare provider type. As of January 2023, critical access hospitals (CAH) and small rural hospitals with no more than 50 beds that were open as of December 27, 2020 may opt to convert to the REH in accordance with the conditions of participation outlined in the CY 2023 hospital outpatient prospective payment and ambulatory surgical center payment system (OPPS) Final Rule. The REH is the first Medicare provider type since the United States Congress created the CAH designation via the Balanced Budget Act of 1997.

The Rural Health Redesign Center (RHRC), the Rural Emergency Hospital Technical Assistance Center

The Rural Health Redesign Center was awarded a Cooperative Agreement by the Health Resources and Services Administration (HRSA) to provide Rural Emergency Hospital (REH) technical assistance to rural hospitals that meet eligibility requirements and are investigating the Rural Emergency Hospital designation as a means to maintaining access to healthcare in their communities. The RHRC through its REH-Technical Assistance Center (REH-TAC) provides a range of services including education, financial modeling. application tools, Board of Director and Community education and marketing tools, strategic planning, and a host of other services to support hospitals in the assessment journey. Support is tailored to the needs of the individual communities and allows for both

[1] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

1:1 education and guidance as well as interaction with other organizations who are on a similar journey. The services provided by the REH-TAC are at no cost to hospitals.

The Rural Health Redesign Center (RHRC) was established in 2020 with a vision of helping rural communities thrive through improved health. The organization was founded as a 501c3 nonprofit. The mission of the RHRC is to protect and promote access to care in rural communities through innovation in healthcare delivery. This mission has been executed by providing high-quality, rural relevant technical assistance that is tailored to the needs of providers and communities and helps to enhance the services delivered. The RHRC offers a variety of technical assistance, a sampling of which includes strategic planning, value-based care, and population health.

REH Eligibility Requirements

To qualify as an REH the hospital must meet the eligibility requirements. The hospital must be licensed as a Critical Access Hospital (CAH) or a rural prospective payment system (PPS) hospital as of December 27, 2020 with fewer than 50 beds. Once converted, while the REH cannot provide any inpatient care, it must provide Emergency Services and Observation care, and is allowed to provide a host of other outpatient services to meet the needs of their communities.

REH Designation Reimbursement

The CCA of 2021 specified special Medicare payment features for REHs, including an annual facility payment of over $3.2 million in 2023. The monthly facility payment will increase yearly according to the hospital market basket rate. The newly designated REH will also receive an additional 5% paid for the OPPS services. Other significant payment and cost containment features include transitioning from cost-based reimbursement to fee schedules (i.e., for CAHs) More information about REH conditions of participation and payment rules can be found on the Rural Health Redesign Center (RHRC) REH technical assistance resources and the CMS website.

REH Anticipated Impact

Prior research[2] attempted to estimate the number of rural hospitals that would consider converting to the REH. They applied three measures to predict that 68 hospitals would potentially convert to be an REH. These measures include three years negative total margin, average daily census (ADC) less than three, and net patient revenue less than $20 million. They also looked at the characteristics of rural hospitals that have low-volume emergency departments (EDs) that may seek to convert to REH. Compared to hospitals with high-volume EDs, these low ED volume facilities were more likely to be government-owned, have low average daily census, and have a Rural Health Clinic. These studies were

[2] https://www.shepscenter.unc.edu/programs-projects/rural-health/projects/rural-emergency-hospitals/

done using publicly available data in anticipation of hospitals submitting applications for conversion.

Early learnings of the RHRC and its Technical Assistance Center

As of the writing of this report, the RHRC has engaged with over 100 hospitals seeking information regarding a potential REH conversion, of which 55.7% have been interested in assessing the financial implications of becoming a REH. The following table presents early findings on the characteristics of rural hospitals seeking technical assistance on REH conversion from the RHRC REH Technical Assistance Center **(REH-TAC)**.

Table 1. Characteristics of Small Rural Hospitals Exploring REH Conversion

	CAH	PPS
Bed count	17	47
Daily IP census (days)	3.1	7.4
Net patient revenue, 2022 (millions)	$14.0	$27.6
Operating Income, 2022 (millions)	-$1.1	$-6.7
Margin, 2022 (Operating Income/NPR, %)	-8.2%	-24.4%
Share of IP Gross Revenue, 2022 (%)	22%	30%
Annualized 340B Revenue (millions)[1]	$0.35	$1.2
Number of hospitals seeking financial modeling support	38	20
Total number of hospitals seeking TA[2]	104	

Data is pulled from the Hospital Cost Report Information System (HCRIS) for hospital fiscal year 2021. All figures, except counts, reflect an average across TA-seeking hospitals, by type of hospital (CAH or PPS). Includes only hospitals in the first REH-TAC cohort that received financial modeling support. 11 of the 58 hospitals did not have FY2022 data available, so FY 2021 was used instead.
CAH = critical access hospital.
PPS = prospective payment system hospital.
[1] As reported by the hospital. Data does not come from HCRIS.
[2] 30 entities other than independent hospitals sought TA (not reflected in table). These include health systems, state offices of rural health and state agencies.

Conclusion

Rural Emergency Hospital is a new hospital designation specifically created to preserve healthcare in rural America and is the only new CMS hospital designation in the past 20 years. While it may hold promise to enable rural communities to move towards re-imagining care delivery for their residents, as with many other reform activities, the initial design and requirements may need modification to fully address the needs of rural communities. Among hospitals seeking technical assistance, hospital leaders frequently

voice concerns about the need to discontinue the provision of swing bed care. Swing beds are a critical source of care delivery in rural communities for post-acute and rehab needs not often available through other providers. In addition to swing-bed care, rural hospitals often provide other types of care, such as behavioral health services in distinct part units that the REH is not allowed to own. Other concerns raised by hospitals include the loss of 340-B drug program revenue, Medicare Advantage and Medicaid reimbursement practices for the REH services, and the inability of some CAHs with necessary provider status to convert back to this designation if REH proves to be an unsustainable path post-conversion. Additional concerns voiced regarding conversion to REH include the passing of state-specific facility licensing and payment rules that address mandatory staffing requirements and state payment subsidies that may no longer be available to the REH.

From the RHRC's engagement to date, Boards of directors, executive leadership, and communities have a difficult decision to make in assessing if the REH opportunity is right for them. While the goal of ensuring access to care remains in the community as an alternative to closure is a noble one, overcoming the hurdles of foregoing all inpatient care and the other concerns highlighted in this brief to achieve this goal require difficult choices. As with all change, more time is needed to assess the success of the REH designation to see if the new structure produces sustainable rural healthcare, but early learnings indicate that there are still many that are adopting a wait-and-see approach to assess outcomes as part of the decision -making process.