Findings Brief
NC Rural Health Research Program
October 2022

Key Considerations for a Rural Hospital Assessing Conversion to Rural Emergency Hospital

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This findings brief provides guidance for rural hospitals considering conversion to a rural emergency hospital (REH). We reviewed recent literature and consulted expert practitioners to develop key considerations included in a conceptual framework. We reviewed sources that were published before the Centers for Medicare & Medicaid Services (CMS) issued the proposed Conditions of Participation (CoPs) and proposed payment rules for REHs[1] in June and July 2022, respectively; however, the considerations described in this findings brief remain relevant.

BACKGROUND

The Consolidated Appropriations Act, 2021[2] established a new Medicare provider type called the Rural Emergency Hospital (REH). Effective January 1, 2023, hospitals meeting specified criteria will be eligible to convert and operate as an REH. A summary of the legislation is provided in Appendix 3. REHs must provide emergency department (ED) and observation services without acute care inpatient services. Hospital outpatient services may be provided at the election of the REH. REHs that provide hospital outpatient services will be eligible for Medicare reimbursement using the Hospital Outpatient Prospective Payment System (OPPS) fee schedule plus five percent. REHs will also receive a fixed monthly payment known as an Additional Facility Payment (AFP).

Currently, facilities can only receive Medicare payment for the ED facility fee and other outpatient services if they are certified by Medicare as a hospital. Medicare requires the provision of inpatient acute care for such certification. This requirement has presented challenges for rural communities where there may not be sufficient patient volume or resources to support the provision of inpatient services, sometimes leading to hospital closures,[3] but where access to emergency services and higher-level outpatient services is still necessary. The REH model may present an alternative; however, there are many factors that must be considered by a hospital when deciding whether or not to convert.

METHODS

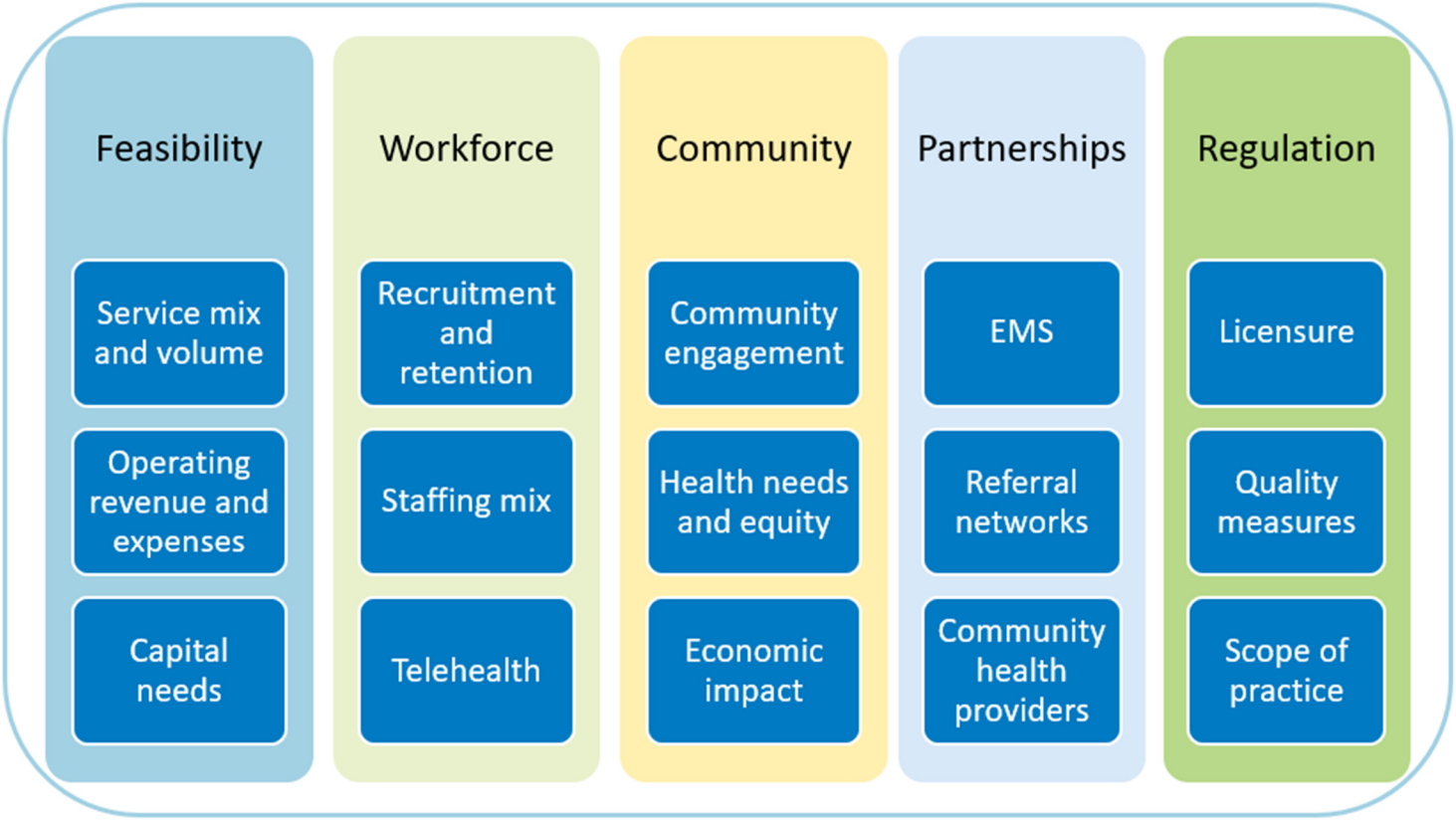
Based on findings from a literature review and consultation with practitioners, we developed a conceptual framework (Figure 1) and checklist (Appendix 1) to organize and guide conversations about key considerations for conversion to an REH.

- *Review of literature*. Studies, summaries, and commentaries about the new REH model have been produced by the American Hospital Association (AHA), Bipartisan Policy Center (BPC), Illinois Critical Access Hospital Network (ICAHN), National Advisory Committee on Rural Health and Human Services (NACRHHS), National Rural Health Association (NRHA), Rural Policy Research Institute (RUPRI), as well as consultants such as Rural Health Solutions (RHS) (see Appendix 2 for a list of source documents). These documents were reviewed to identify important considerations, issues, questions, and potential problems in a decision to convert from a hospital to an REH. Our synthesis of the considerations from the various sources is presented on the following pages, with Appendix 2 providing references to the supporting evidence driving each conclusion.
- *Consultation with practitioners*. Meetings were held with Chief Executive Officers (CEOs) of several CAHs, emergency medicine physicians who practice in rural settings, and accountants and consultants for rural hospitals.

Conceptual framework. The framework includes considerations across five key domains: Feasibility, Workforce, Community, Partnerships, and Regulation. We gave particular attention to the financial implications of the transformation. Table 1 provides a basic financial framework for considering the incremental revenues, costs, and avoided costs that may be expected if a hospital converts to an REH by eliminating inpatient care.

Checklist. Appendix 1 contains a list of questions drawn from the literature review and consultation with practitioners that may help hospital leaders structure a conversation with interested parties.

Figure 1. Conceptual Framework of Key Considerations for Conversion to an REH



Feasibility

Feasibility refers to the financial sustainability of the REH model of care. The determination of financial sustainability will differ based on whether a hospital proposes to design and develop a new physical facility or convert an existing hospital building to an REH. Under either option, there are questions that must be answered regarding service mix and volume, operating revenue and expenses, and capital needs. Some financial effects of conversion are clear, while others may be unintended consequences of the loss of acute inpatient care.

Service mix and volume

One of the key assumptions in projecting financial outcomes is determining which services will be offered and at what expected volumes. Eliminating inpatient care may affect the utilization and therefore financial sustainability of non-inpatient services and volumes. Providers may be less willing to perform outpatient surgery at an REH without the backup of local inpatient capacity, and patients may be hesitant to receive certain procedures from a facility without inpatient care.[4] Eliminating inpatient care may also affect patients' propensity to bypass the local hospital. If a patient must travel to a referral hospital for a surgical or other procedure, they may be more likely to go back to the referral hospital for any follow-up care, resulting in the loss of outpatient visits, labs, ancillary services, and other downstream services at the local REH.[5] In contrast, there may be benefits of eliminating inpatient care, such as the ability to repurpose space to expand access to specialty clinics or other community services.

Operating revenue and expenses

Projecting operating revenue and expenses is critical to understanding the financial sustainability of an REH. This is a complex analysis, requiring careful consideration of the local context. There are three key components to the operating analysis presented below – lost revenue, new sources of revenue, and avoided costs. The components are discussed in general terms; payer mix, managed care penetration, and other financial factors are nuances not presented here.

Lost revenue from the elimination of inpatient care and the loss of cost-based reimbursement for CAHs. Converting to an REH will result in the loss of revenue generated from inpatient and swing bed services. In addition, there may be other reductions in revenue that need to be considered. Under the current legislation, REHs are not eligible for the 340B Drug Pricing Program, which is a significant source of income for many rural hospitals. There may also be losses in local tax support for the hospital or other sources of non-operating income that help sustain the facility. On the outpatient side, OPPS + 5% will usually be less than the cost-based reimbursement received by CAHs, resulting in an incremental loss of outpatient revenue. Finally, there may be downstream revenue losses related to service changes or service volume (e.g., fewer surgeries, increased patient bypass behavior).

*Incremental revenue from the Additional Facility Payment and new se*rvices. Revenue losses may be partially or fully offset by new sources of revenue resulting from the AFP and any potential new service offerings. The proposed payment rule published in July includes an AFP of $268,294 per month.[6] For PPS facilities, the OPPS + 5% will result in revenue gains for covered outpatient services. A major source of uncertainty at this time is how commercial payers and Medicaid plans will reimburse for services provided by an REH.

Avoided costs from the elimination of inpatient care. Eliminating inpatient care may allow the facility to avoid some operating expenses; however, it will be necessary to carefully evaluate what costs can truly be eliminated. If REHs eliminate inpatient-only positions, they may avoid some operating expenses (e.g., salary expenses may decrease for the REH). If these staff support other services, then only a portion of salary expenses (or none) may be avoidable. There may also be other costs, such as supplies, laundry, or cafeteria that can be reduced if an REH ceases providing inpatient care.

Start-up costs and capital needs

Conversion to an REH will require consideration of whether an existing building can be adapted, or whether a new physical facility is required. Under either scenario, start-up and capital costs (building and equipment) will need to be estimated, and a financing source will need to be identified.

A framework for financial analysis

Table 1 provides a basic framework for conducting a financial analysis of the consequences of converting from a rural hospital to an REH. The table shows that there are two bottom line questions:

- Is there a funding source to pay for the start-up and capital costs required for conversion to an REH?
- Is there a positive net operating cash flow after conversion to an REH?

Table 1. Assessment of Start-up Costs, Capital Costs, and Change in Operating Revenue and Expenses*

	Line-item description
	Start-up costs (personnel time, fees)
1	Certificate of need application costs and fees (if applicable)
2	Staff costs associated with preparation of CMS REH application
3	Licensing
4	Consulting/accounting
5	Contracting/relationship development [Emergency Medical Services (EMS), referral center]
6	Space and workflow redesign
7	Total start-up costs (1+2+3+4+5+6)
	Capital costs
8	Land
9	Building/Renovations
10	Equipment
	Total capital costs (8+9+10)
	Change in operating revenue
11	Add: Additional facility payment
12	Add: Medicare OPPS X 1.05
13	Subtract: Inpatient revenue including acute, swing, labs, ancillary services, professional fees (cost-based reimbursement for CAHs, IPPS for others)
14	Subtract: Medicare outpatient revenue (cost-based reimbursement for CAHs, OPPS for others)
15	Subtract: Other lost revenue (e.g., 340B, tax support for salaries and benefits)
16	Total change in operating revenue (11+12-13-14-15)
	Change in operating expenses assuming outpatient staffing and resources remain the same*
17	Subtract: Inpatient-only nursing and support staff costs
18	Subtract: Inpatient agency nursing costs
19	Subtract: Inpatient ancillary costs
20	Subtract: Inpatient supplies
21	Subtract: Avoidable inpatient overhead costs
22	Add: REH incremental costs (quality measurement, ambulance, contracts)
23	Total change in operating expenses ((17+18+19+20+21) – 22)
24	***Net change in operating net cash flow*** **(16+23)**
25	Current hospital operating net cash flow
	Projected REH operating net cash flow (24+25)

*Note: Downstream effects such as bypass, changes in outpatient surgery, added/lost revenue from other payers such as Medicaid, Medicare Advantage, and private insurance, and expanded services are not included in Table 1.

Workforce

Conversion to an REH will change staffing needs and mix. With provider and nurse shortages, the REH will need to determine how to recruit and retain primary care physicians, specialists, advanced practice providers (APPs), nurses, and therapists when there is no option for patients to be admitted to an inpatient setting. The Workforce domain of the framework includes recruitment and retention, staffing mix, and telehealth.

Recruitment and retention

Recruitment and retention of staff with the required training and the relevant experience needed to thrive in an REH setting is an important consideration. An REH may require staff members to be flexible and cross-trained to accommodate different tasks during their shifts. REH staff may have to be supplemented with contract physicians, nurses, and/or visiting providers to ensure a viable complement of clinical staff (e.g., tele-consults). In some circumstances, an REH may need to contract for administrative, billing, information technology, and other support services. Recruitment of some providers, such as specialists, may be difficult without inpatient facilities.

Staffing mix

Patient volume will dictate the number and discipline of clinicians working in the ED at a given time. Fluctuations in volume may require REHs to increase or decrease health professionals as necessary. Applicable state laws and Medicare Conditions of Participation (CoPs) need to be considered as well as medical oversight when determining the appropriate ED staffing mix.

Telehealth

Using telehealth can help expand services provided without having onsite specialists. Current legislation allows for REHs to act as a telehealth originating site. REHs must determine how telehealth will be used within their facility, starting with whether the available broadband infrastructure is sufficient to accommodate telehealth usage, and whether contracts with consulting health professionals are or can be put in place.

Community

For many rural communities, the local hospital is the primary employer and a source of civic pride. A proposed conversion to an REH and associated loss of inpatient care may have substantial workforce impacts and trigger strong reactions from community members and local leaders. Extensive communication with and involvement of the community may help overcome resistance to a conversion if it is deemed beneficial for meeting community needs. Community considerations we discuss include community engagement, health and equity needs, and economic and employment impact.

Community engagement

Assessing and establishing community support for the conversion to an REH is critical. Communicating with key stakeholders and members of the community about why conversion is necessary will foster an understanding of how the REH will serve the community. Identification and use of trusted thought leaders in the community could serve as a valuable source of community input for the REH and mitigate concern about the conversion.

Health needs and equity

Possibly serving as the only acute health care provider within a community, REHs should strive to continue to meet community health needs with a focus on health equity. A thorough understanding of community health needs and careful planning are required to ensure individuals continue to have access to essential services. With the loss of inpatient care, some patients will require transportation to inpatient facilities outside of the community resulting in additional costs for fuel, lodging, or medical transportation via ambulance.

Economic and employment impact

Conversion to an REH and loss of inpatient facilities may impose direct and indirect costs on the community. Direct costs could include loss of jobs from one of the largest employers in town, loss of jobs from community providers, loss

of taxes paid by the hospital and employees, and loss of jobs and tax revenue if businesses leave or decide not to locate in the community. For example, hospitals employ many Registered Nurses (RNs), Licensed Practice Nurses (LPNs), Certified Nursing Assistants (CNAs) and other inpatient staff. REHs must determine whether these staff can be deployed in other areas, and whether training is required. Indirect costs to the community could include increased travel costs for poor, elderly, disabled, and other patients, and increased cost of attracting teachers and other public sector workers. This may require strategies to mitigate the impact and working with local business leaders to plan for the effects of the conversion.

Partnerships

The REH model requires well-established partnerships with other health care providers, organizations and agencies. Although many of these partnerships may be similar to those already in existence for an inpatient hospital, considerable attention will need to be paid to EMS and trauma centers. REHs will need to have the capacity to transfer patients quickly and safely for higher levels of care. We organized partnership considerations under three categories: EMS, referral networks, and community health and social service providers.

EMS

A community with an REH will require local EMS to have an expanded role. In addition to transporting patients to the REH, EMS will transport patients to trauma centers and other higher care level facilities. Local EMS capacity could be stretched with the expanded volume of patient transfer, and it will be important for local EMS to prepare for the greater load. There may also be a need for more use of air ambulances for patients whose health needs exceed those that can be served at the REH, which may have financial implications for patients.[7]

Referral networks

An REH must have a transfer agreement with a Level I or Level II trauma center. If the transfer agreement is viewed as a partnership, then it could be possible to create a system that makes transfers easy for the patient, the REH, and the trauma center. REHs may also consider establishing transfer agreements for patients requiring inpatient care but not from a trauma center. Additional transfer agreements could provide standby capacity for the community to receive inpatient care when a Level I or Level II trauma center is close to capacity. Extension of existing and creation of new referral relationships, especially those for maternity care, psychiatric and behavioral health patients, may be necessary.

Community health and social service providers

Managing the health of a local population requires additional services outside of an REH, and converters should be intentional on how they engage local social and community services to meet community needs.

Regulation

CMS regulations governing the REH model will be finalized in Fall 2022. However, the REH is a new type of provider, and there is uncertainty about how this model of care will manifest in practice. Hospitals should expect new and revised CMS regulations and be prepared for new issues to emerge as the model rolls out. In addition, states will have policies, regulations, and practices regarding REHs, and these could evolve over time as well. Regulatory considerations include licensure, quality measures, and scope of practice laws.

Licensure

Most states have made little progress in licensure and Certificate of Need (CON) provisions for REHs. Early leaders such as Kansas[8] may provide a blueprint for other states, but each state will develop its own approach consistent with local statutes, regulations, culture, and circumstances. However, guidance for states to consider as they develop these details is sparse. Coordination with local and state authorities will be needed to ensure regulatory adherence.[9]

Quality measures

REHs will be required to report quality measures. Although the exact parameters of reporting are not finalized as of publication of this paper, converters should discuss creating a robust reporting system to meet the legislative

requirements. Before converting, hospitals should determine if they are realistically able to meet the CoPs including the quality reporting aspect given the small sample size that may be inherent in some REHs. Even though there is no accreditation process currently in place for REHs, an accreditation process may arise, and potential converters should be aware of this during any conversion decision.

Scope of practice

As the workforce model of the REH takes shape, leadership should consider the applicable state scope of practice laws. Scope of practice laws may determine the staffing mix of an REH and are a key consideration when deciding staffing.

CONCLUSION

The decision to convert from a hospital to an REH is complex and non-trivial, and much uncertainty remains. Interested hospitals can begin preparing by engaging in discussions and analyses to assess the benefits and costs of converting to this new model of care.

APPENDIX 1

Checklist of Considerations*

*Note: The checklist is informed by a review of existing literature and consultation with practitioners and is not meant to be exhaustive.

Feasibility

Service mix and volume

- ☐ What changes may occur in the number of surgeries, labs/ancillaries, outpatient procedures?
- ☐ Will providers be less willing to perform surgeries or other procedures without inpatient care as a back-up?
- ☐ Will the cessation of inpatient care affect patient bypass for ED and other outpatient care?
- ☐ Can inpatient space be repurposed to expand specialty clinics or community services?

Operating revenue and expenses

- ☐ What will be the loss in inpatient, swing bed and 340B revenue?
- ☐ What will be the loss of revenue from decreased outpatient surgical volume in the likely case that there are no operating rooms or surgical staff?
- ☐ Will there be any loss of government revenue such as county appropriations or revenue from local property tax?
- ☐ Will the Additional Facility Payment be sufficient to cover the fixed costs of an REH?
- ☐ How will the Additional Facility Payment be used?
- ☐ Will the OPPS + 5% be sufficient to cover the fixed and variable costs of Medicare outpatient volume?
- ☐ Are there any opportunities for new revenue from expanded specialty services?
- ☐ How will commercial payers, Medicare Advantage, and Medicaid plans compensate REHs?
- ☐ What will be the cost savings from elimination of inpatient-only nursing and support staff, ancillary costs, supplies, and overhead?

Capital needs

- ☐ Can the current space be adapted for an REH?
- ☐ What will be the capital costs of any changes to building and equipment?
- ☐ If necessary, how much would a new building and equipment cost? Is financing and/or grant funding available?

Workforce

Recruitment and retention

- ☐ Will providers stay when there is no inpatient service?
- ☐ How will the REH recruit and retain staff with required training and relevant experience?
- ☐ Will the REH supplement the workforce with contract physicians, nurses or visiting provider agreements?
- ☐ Will the REH contract or retain administrative, billing, IT, etc. services?

Staffing mix

- ☐ What are safe and efficient staffing models for different volumes at an REH?
- ☐ What level of medical oversight is necessary for Advanced Practice Providers?

Telehealth

- ☐ How will telehealth be used within the facility?
- ☐ Are there health professionals available with whom the REH can contract to provide telehealth consultations?
- ☐ Does the community have the broadband infrastructure to facilitate telehealth?

Community

Community engagement

- ☐ Does the community understand why the conversion is necessary?

- ☐ Will the community use the REH?
- ☐ Will the community contribute to the REH philanthropically?
- ☐ Will the community be engaged and involved with REH operations (boards and committees)?

Health needs and equity

- ☐ What are the equity concerns, and will an REH support equitable health delivery to the community?
- ☐ Is the REH model consistent with the needs of the community?
- ☐ Will the community benefit from local access to ED care?
- ☐ Will access to specialty services increase if inpatient space is repurposed for specialty clinics?
- ☐ Will access to specialty services decline because of the loss of inpatient care and potential impacts on recruitment?
- ☐ Is there a plan to convert back to providing inpatient care?
- ☐ How will patient transportation costs from driving for inpatient care or use of air or ground ambulance transportation be affected?

Economic impact

- ☐ How will the loss of inpatient-related jobs affect the local economy?
- ☐ What are the indirect economic effects of replacement of an inpatient facility by an REH?

Partnerships

EMS

- ☐ Is local EMS prepared, and does it have the capacity to support an REH?
- ☐ Are air ambulance services necessary, and if yes, are they in place?

Referral networks

- ☐ Does the REH have the required transfer agreement with a Level I or Level II trauma center?
- ☐ Where will the REH send patients requiring inpatient care but not care from a trauma center?
- ☐ What referral relationships are required for maternity care, psychiatric and behavioral health patients that use an REH?

Community health providers

- ☐ How will the REH coordinate with local social and community services to provide care?
- ☐ Are the right vendors and suppliers available to provide the materials for operating as an REH?
- ☐ Does the REH have contracts for services such as reference labs that may be lost when converting?

Regulation

Licensure

- ☐ If the state is a Certificate of Need (CON) state, will the REH need and/or be able to get a CON?
- ☐ Does the state offer REH licensure? What is required?
- ☐ How will coordination with the local and state government authorities happen to ensure regulations are being followed?

Quality measures

- ☐ How will quality measures and their subsequent reporting be impacted by conversion?
- ☐ Can the REH meet the Conditions of Participation for an REH?
- ☐ How will the accreditation process for REHs work?
- ☐ What is the mandatory reporting required for REHs, and will the REH be able to handle this?

Scope of practice

- ☐ What are the scope of practice laws in the state, and will REHs be allowed a different level of scope of practice?

APPENDIX 2

Summary of Considerations Identified in Resource Documents

Note: A legend with full organization names is included at the bottom of both appendix tables, 2a and 2b.

Appendix Table 2a

Consideration	Category	Description	Organization	Source	Page #
Feasibility	Service mix and volume	Co-location of clinics (lease space to providers)	BPC NACRHHS ICAHN	**1** **2** **7**	45 11 5
	Operating revenues and expenses	Loss of inpatient revenue	BPC RUPRI	**1** **4**	44 3
		Medicare OPPS + 5%	BPC AHA ICAHN	**1** **3** **7**	40 58 7
		Loss of 340B	NACRHHS ICAHN	**2** **7**	17 9
		Additional Facility Payment	BPC NACRHHS AHA RUPRI NRHA ICAHN	**1** **2** **3** **4** **6** **7**	38 14 58 3 5 7
		Medicaid participation	BPC NRHA ICAHN	**1** **5** **7**	40 2 7
	Capital needs	Infrastructure improvements	BPC RHS	**1** **8**	41 5
Workforce	Recruitment and retention	Recruitment and retention	NACRHHS AHA RUPRI ICAHN RHS	**2** **3** **4** **7** **8**	17 55 4 13 5
		Visiting provider agreements	BPC AHA	**1** **3**	45 52
	Staffing mix	Medical oversight			
		Role of Advanced Practice Providers	NACRHHS AHA	**2** **3**	18 55
	Telehealth	Telehealth supervision	BPC NACRHHS AHA ICAHN	**1** **2** **3** **7**	50 11 51 6
		Technology	BPC NACRHHS RHS	**1** **2** **8**	50 10 6

Appendix Table 2a continued

Consideration	Category	Description	Organization	Source	Page #
Community	Community engagement	Community needs assessment	BPC AHA RUPRI NRHA NRHA ICAHN RHS	**1** **3** **4** **5** **6** **7** **8**	48 58 3 3 3 7 5
	Health needs and equity	Loss of community access to inpatient beds	BPC NRHA ICAHN	**1** **5** **7**	43 1 12
		Create plan for conversion back to inpatient	NACRHHS AHA ICAHN	**2** **3** **7**	18 64 4
		Loss of surgery	AHA	**3**	54
Partnerships	EMS	EMS capacity	BPC NACRHHS AHA RUPRI NRHA ICAHN RHS	**1** **2** **3** **4** **6** **7** **8**	49 15 63 4 1 14 5
	Referral networks	Transfer of patients	BPC NACRHHS AHA RUPRI NRHA NRHA	**1** **2** **3** **4** **5** **6**	49 15 55 4 1 1
		Behavioral & maternal health	BPC AHA ICAHN	**1** **3** **7**	51-52 53 12
Regulation	Licensure	State licensure	NRHA ICAHN	**5** **7**	3 7
	Quality measures	Quality measures	BPC NACRHHS AHA NRHA ICAHN	**1** **2** **3** **5** **7**	46 12 57 2 8
		Low volume adjustments / accommodations	BPC NACRHHS NRHA	**1** **2** **5**	46 13 3
	Scope of practice	Scope of practice (state laws)			

BPC = Bipartisan Policy Center
NACRHHS = National Advisory Committee on Rural Health and Human Services
AHA = American Hospital Association
RUPRI = Rural Policy Research Institute
NRHA = National Rural Health Association
ICAHN = Illinois Critical Access Hospital Network
RHS = Rural Health Solutions

Appendix Table 2b

Source #	Source Name	Source	URL
1	Rural Emergency Hospital Model (pg. 34 – 59)	BPC, May 2022	https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/04/BPC-Rural-Hospital-Report-4-22-22.pdf
2	Rural Emergency Hospital: Policy Brief and Recommendations to the Secretary	NACRHHS, October 2021	https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2021-rural-emergency-hospital-policy-brief.pdf
3	AHA Comments on CMS OPPS FY22 (REH is on pg. 50 – 65)	AHA, September 2021	https://www.aha.org/system/files/media/file/2021/09/aha-comments-on-cms-cy-2022-opps-asc-proposed-rule-9-17-21.pdf
4	REH and VBC	RUPRI, August 2021	https://ruralhealthvalue.public-health.uiowa.edu/files/REH_Brief.pdf
5	Rural Emergency Hospital (REH) Model Summary	NRHA, April 2021	https://www.ruralhealth.us/getmedia/5668419b-2420-460a-9381-eb74aad97d8f/Rural-Emergency-Hospital-Summary.aspx
6	Rural Emergency Hospital conversion: critical factors for EMS support	NRHA, February 2022	https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Rural-Emergency-Hospital-conversion-Policy-Brief-2022.pdf
7	Rural Emergency Hospitals 101: What you Should Know?	ICAHN, No date provided	Rural Emergency Hospitals 101: What you Should Know? Presented at 2022 NRHA Annual Meeting
8	Is Converting Your Rural or Critical Access Hospital to a Rural Emergency Hospital Right for you?	RHS, No date provided	https://www.rhcsol.com/_files/ugd/3f1f75_1bbe035a52e343f3b1731089a1894ff2.pdf

BPC = Bipartisan Policy Center
NACRHHS = National Advisory Committee on Rural Health and Human Services
AHA = American Hospital Association
RUPRI = Rural Policy Research Institute
NRHA = National Rural Health Association
ICAHN = Illinois Critical Access Hospital Network
RHS = Rural Health Solutions

APPENDIX 3

Summary of the Legislation Related to Rural Emergency Hospitals

The Consolidated Appropriations Act, 2021[2] includes the following provisions for an REH.

Hospital eligibility to become an REH. Eligible hospitals include Critical Access Hospitals (CAHs) and rural hospitals with 50 beds or fewer that were open as of December 27, 2020. They must be located in a county (or equivalent unit of local government) that is in a rural area defined using the Office of Management and Budget (OMB) designation of non-metropolitan statistical area, or a hospital with 50 beds or fewer whose application for reclassification as rural is approved by CMS.

Application to become an REH. To apply for certification as an REH, a hospital or CAH must submit 1) an action plan for initiating REH services, including a transition plan that specifies what services will be retained, modified, added, or discontinued; 2) a list of services that will be provided, such as primary and pediatric care; and 3) information about how the AFP will be used, including a description of the services covered. States must approve the licensure of REHs.

REH requirements. REHs must 1) not exceed an annual per-patient average length of stay of 24 hours; 2) be staffed 24 hours a day, seven days a week by a physician, nurse practitioner, clinical nurse specialist, or physician assistant; 3) meet the licensure requirements and staffing responsibilities of an ED; 4) have a transfer agreement in place with a Level I or Level II trauma center; 5) meet CoPs applicable to CAH emergency services and hospital EDs (as determined applicable by the Secretary of the Department of Health and Human Services); 6) meet the distinct part unit (DPU) requirements if the REH has a skilled nursing facility (SNF) DPU.

Medicare Payment for REHs. According to the legislation outlined in the Consolidated Appropriations Act, 2021, REHs will be paid for covered outpatient services using the Hospital Outpatient Prospective Payment System (OPPS) fee schedule plus an additional 5%. The legislation currently only applies to fee-for-service Medicare, while Medicaid, Medicare Advantage, and private insurers have not yet indicated their method for reimbursing REHs. REHs will also receive an Additional Facility Payment (AFP) from CMS paid monthly. For 2023, the AFP is calculated as the difference between a) all Medicare payments to CAHs in 2019 and b) the estimated Medicare payments to all CAHs in 2019 if they were reimbursed under the OPPS, Inpatient Prospective Payment System (IPPS), and Skilled Nursing Facility prospective payment system (SNF PPS), with the difference then divided by the total number of CAHs. The result is the annual AFP amount, which is divided by 12 to get a monthly payment. Starting in 2024, the AFP will be the previous year's amount updated by the hospital market basket percentage increase. Facilities must track and report how the AFP is used.

Quality metrics and evaluation reports. Beginning in 2023, under the Consolidated Appropriations Act, 2021, REHs will be required to submit data for quality measurement. In selecting quality measures, the Secretary shall consider ways to account for REHs that lack sufficient case volume to ensure that the performance rates for such measures are reliable. Quality measures will be made public and will be posted on the CMS website. Evaluations are required to assess the impact of REHs on the availability of health care and health outcomes in rural areas after four years, seven years, and 10 years of enactment.

REFERENCES AND NOTES

1. Proposed REH Conditions of Participation (CoPs) were issued by the Centers for Medicare & Medicaid Services (CMS) on June 30, 2022 with comments due by August 29, 2022 (https://www.federalregister.gov/d/2022-14153). Proposed REH payment policies were issued by CMS on July 26, 2022 with comments due September 13, 2022 (https://www.federalregister.gov/d/2022-15372).
2. H.R.133 - Consolidated Appropriations Act, 2021. 116th Congress (2019-2020). Available at: https://www.congress.gov/bill/116th-congress/house-bill/133/text. Accessed 10-7-2022.
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8. H.B. 2261 - Enacting the rural emergency hospital act to provide for the licensure of rural emergency hospitals. Kansas State Legislature. Available at: http://www.kslegislature.org/li/b2021_22/measures/documents/hb2261_00_0000.pdf. Accessed 10-7-2022.
9. The National Conference of State Legislatures (https://www.ncsl.org/research/health/rural-emergency-hospitals.aspx) and the National Academy of State Health Policy (https://www.nashp.org/medicares-new-rural-emergency-hospital-designation-considerations-for-states/) recently published initial state resources and they will be adding more over time.

Suggested Brief Citation

Reiter K, Grant TJ, Gurzenda S, Budko A, Greenwood-Ericksen M, Pink G. *Key Considerations for a Rural Hospital Assessing Conversion to Rural Emergency Hospital.* NC Rural Health Research Program, UNC Sheps Center. October 2022.

This study was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement # U1CRH03714. The information, conclusions and opinions expressed in this brief are those of the authors and no endorsement by FORHP, HRSA, HHS, or The University of North Carolina is intended or should be inferred.