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Rural Hospital Closures and the Rural Emergency Hospital (REH)

George H Pink PhD

Missouri Hospital Association

September 21, 2022

This presentation uses funded by Federal Office of Rural Health Policy, Award #U1GRH03714

Summary of Findings

1. Hospital closures reduce access and occur more frequently in disadvantaged communities.
2. Rural Emergency Hospitals (REHs) may be a viable alternative to inpatient facilities in some communities facing risk of hospital closure.
3. There are many key considerations for a rural hospital assessing conversion to REH.

Summary of Findings

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2. Rural Emergency Hospitals (REHs) may be a viable alternative to inpatient facilities in some communities facing risk of hospital closure.
3. There are many key considerations for a rural hospital assessing conversion to REH.

So now you can check your email.

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1. Rural hospital closures

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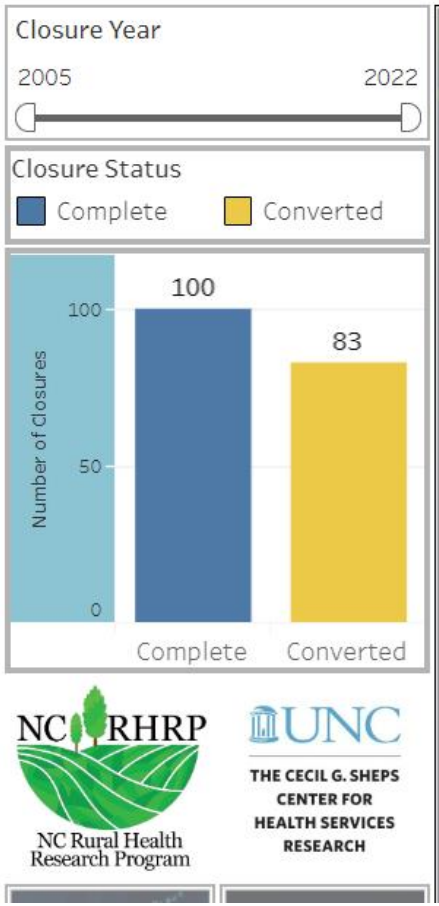
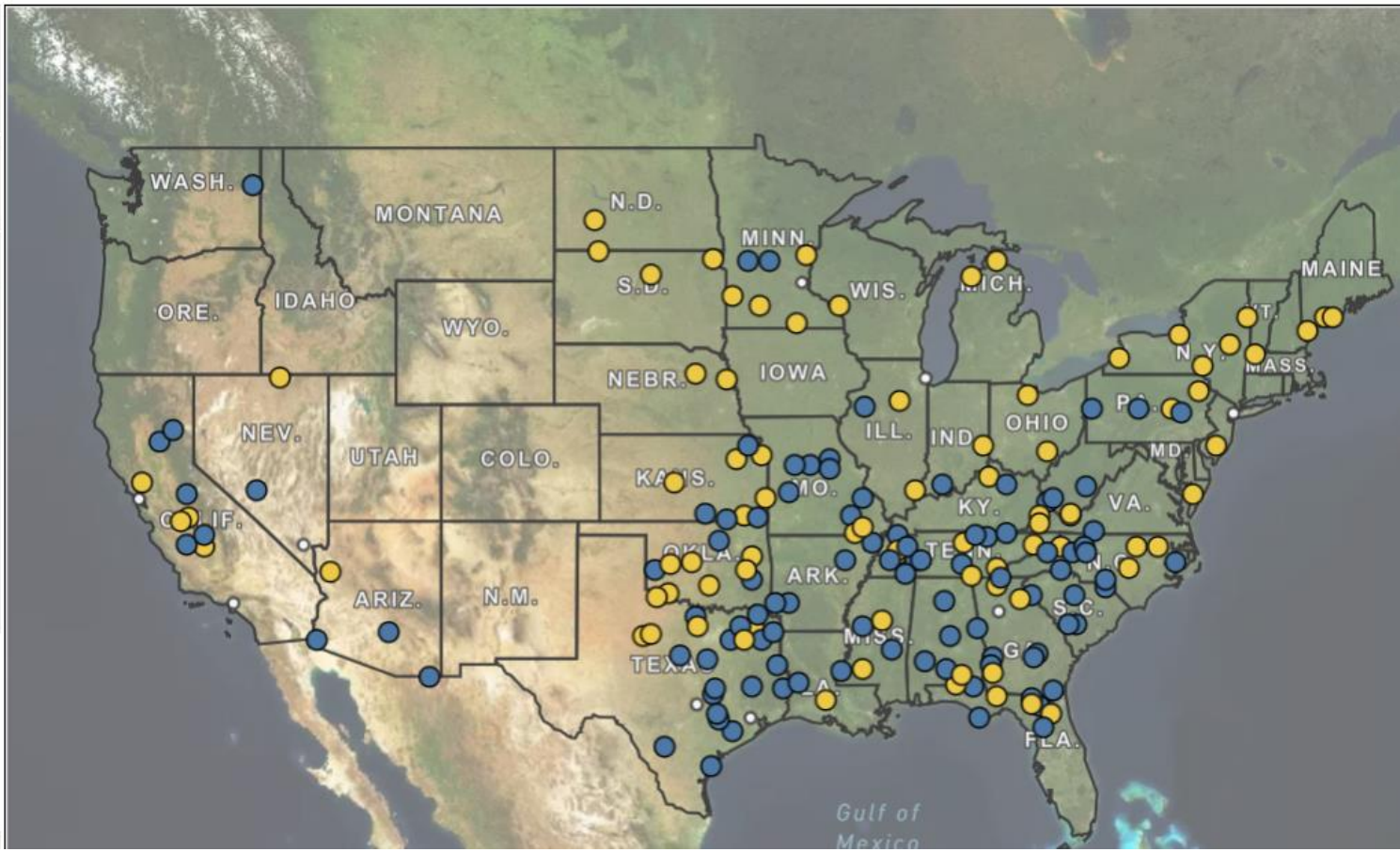
183 Rural Hospital Closures since January 2005





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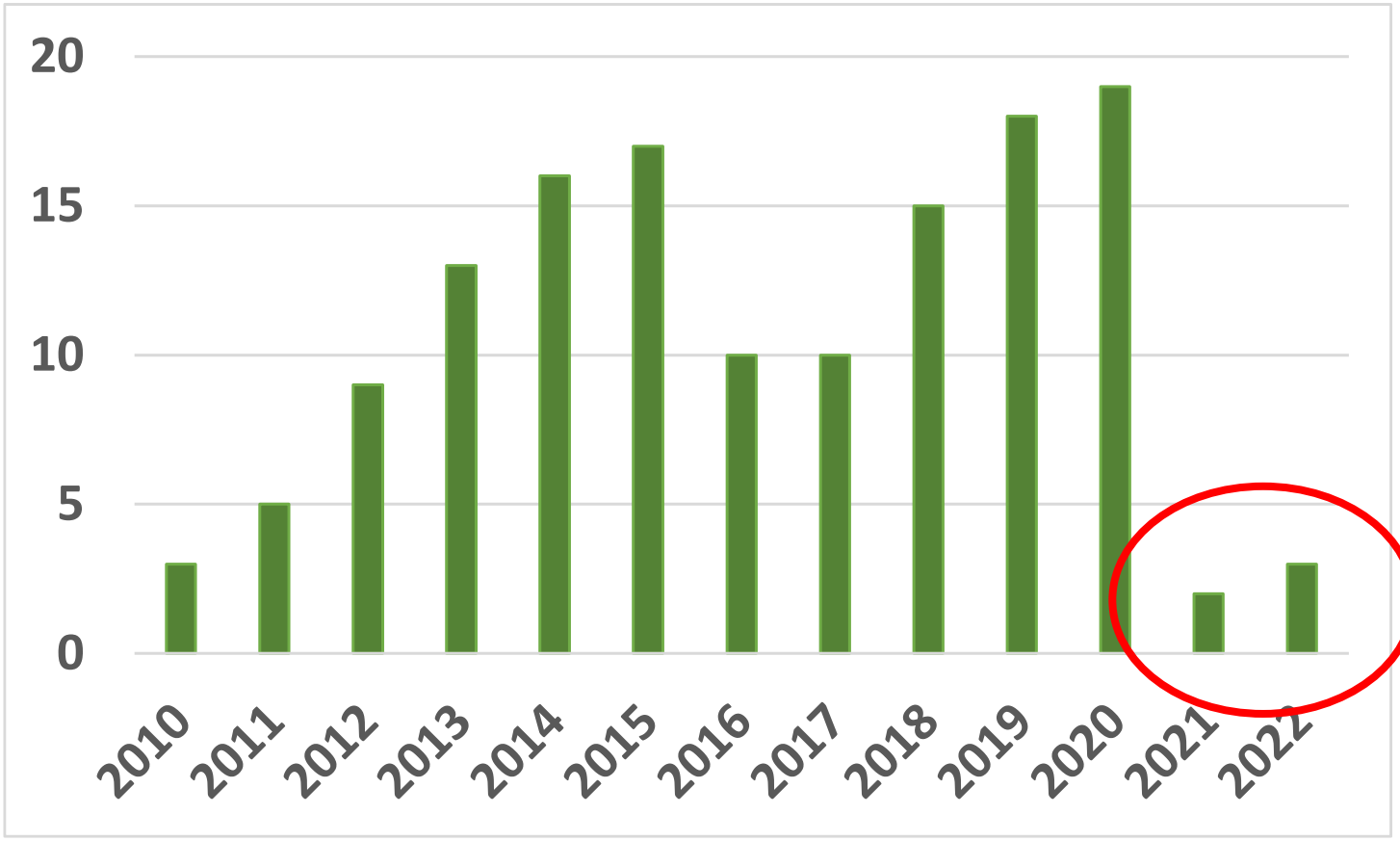
Missouri closures

Hospital	Type	Year	Beds
Callaway Community Hospital	PPS	2022	18
Audrain Community Hospital	SCH	2022	40
Pinnacle Regional Hospital	PPS	2020	46
Black River Community Medical Center	PPS	2019	3
I-70 Community Hospital	CAH	2019	15
Southeast Health Center of Ripley County	MDH	2018	21
Twin Rivers Regional Medical Center	PPS	2018	100
SoutheastHEALTH Center of Reynolds County	CAH	2016	21
Parkland Health Center- Weber Rd	RRC	2015	98
Sac-Osage Hospital	SCH	2014	47

140 Rural Hospital Closures since January 2010



Our problems are over, right?

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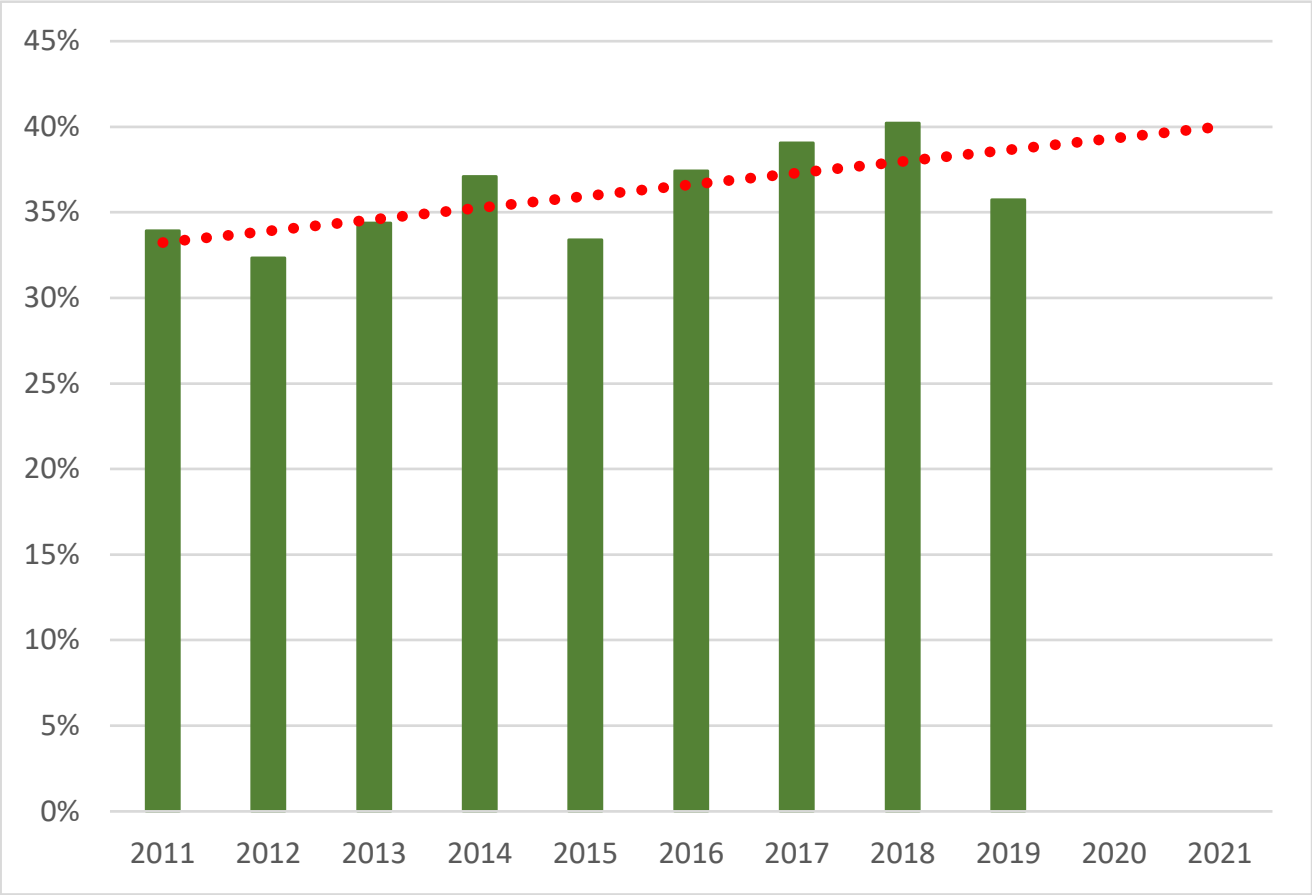
The percentage of rural hospitals with a negative total margin was trending upward before COVID funding



PRF and other COVID funding probably provided a lifeline for many rural hospitals

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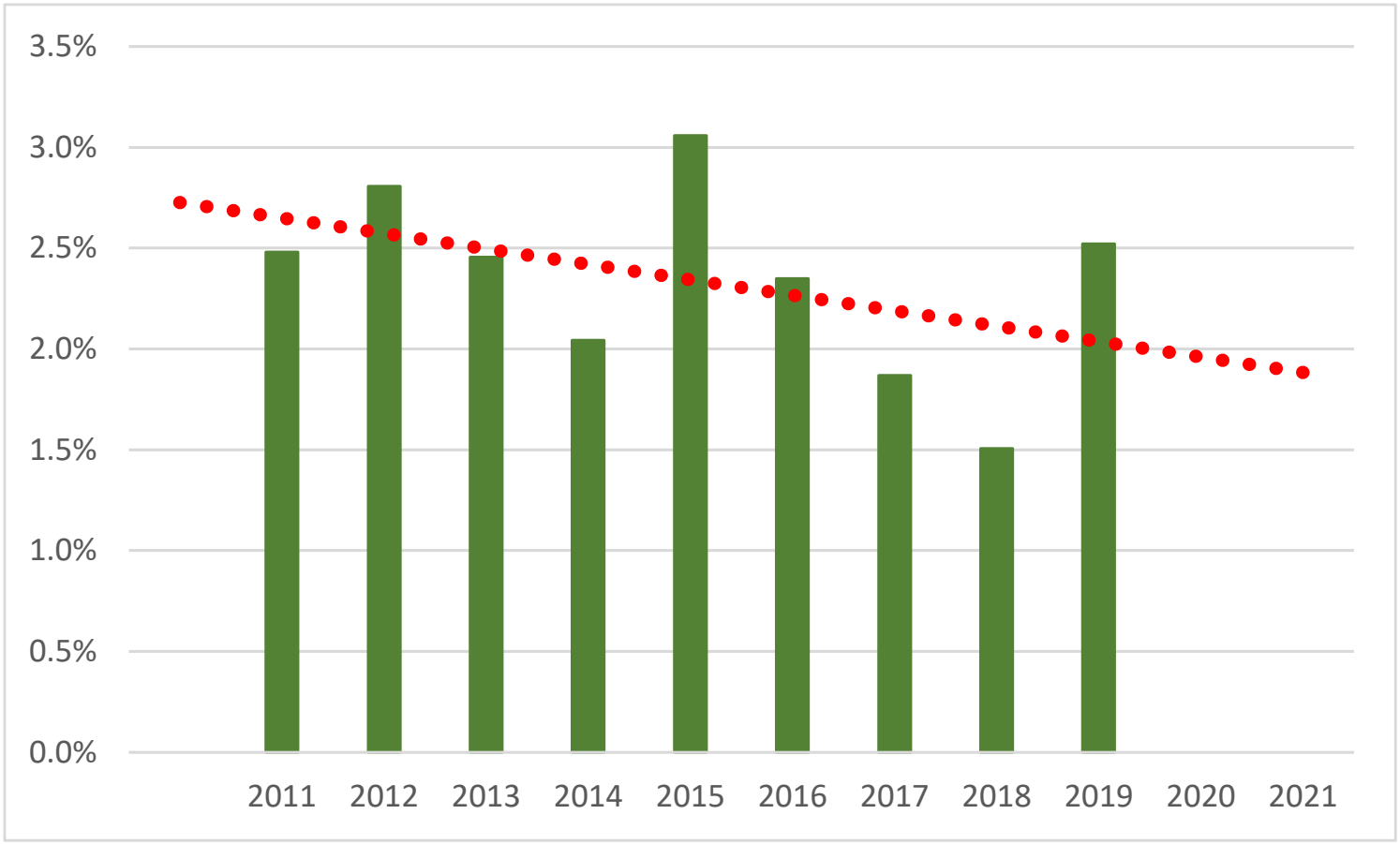
The median total margin of rural hospitals was trending downward before COVID funding



Long-term unprofit-ability has not gone away

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Community consequences of closure

- Access to health care:
  - Loss of local access to emergency and inpatient care
  - Loss of providers that depend on acute care hospital
  - Loss of other local health services
- Direct costs:
  - Loss of jobs from large or largest employer in town
  - Loss of taxes paid by hospital and employees
  - Loss of jobs and tax revenue if businesses leave
- Indirect costs:
  - Increased travel costs for poor, elderly, disabled, and other patients
  - Increased cost of attracting teachers and other workers

Closures are a big deal in affected communities

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Rural hospital closures: Summary

- 140 rural hospitals have closed since January 2010
- Most were in the South and in states that have not expanded Medicaid
- A higher proportion are complete versus converted closures
- Only 10 have closed and reopened as acute care hospitals
- Most are CAHs and PPS hospitals and < 50 beds
- Patients in affected communities are probably traveling between 5 and 30 or more miles to access inpatient care
- Closures dropped in 2021 and 2022 because covid funding was probably a lifeline. Likely resume after covid funding is gone.

2. Rural Emergency Hospital

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Need for a new model

- Rural hospital closures
  - 140 closures since 2010, 183 closures since 2005. (https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/)
- Declining inpatient utilization
  - In a recent study, we found the average percent of revenue coming from outpatient services increased from 66.5% in 2011 to 74.2% in 2019. (https://www.shepscenter.unc.edu/download/24776/)
- Access to emergency care
  - *JAMA Network Open*, November 19, 2021. Association of Rural and Critical Access Hospital Status With Patient Outcomes After Emergency Department Visits Among Medicare Beneficiaries, Margaret Greenwood-Ericksen, MD, MS et al,. http://dx.doi.org/10.1001/jamanetworkopen.2021.34980

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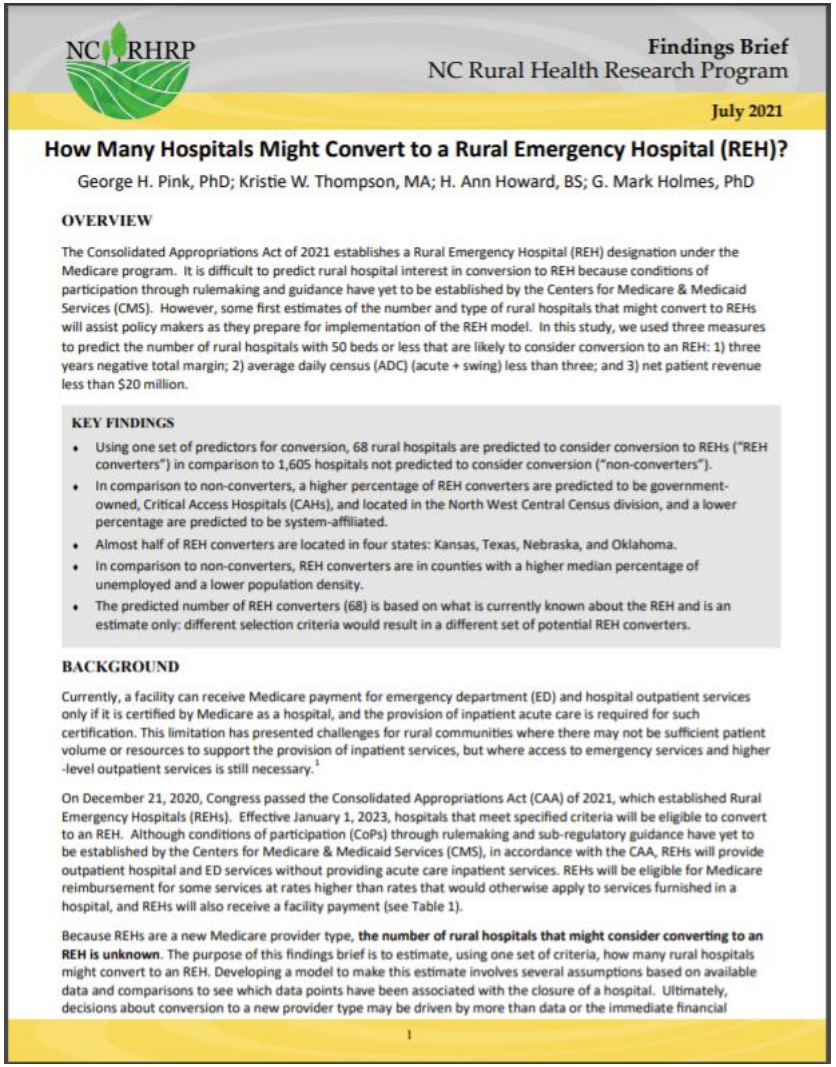
Rx: Rural Emergency Hospitals may be a solution



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Findings Brief
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July 2021

How Many Hospitals Might Convert to a Rural Emergency Hospital (REH)?

George H. Pink, PhD; Kristie W. Thompson, MA; H. Ann Howard, BS; G. Mark Holmes, PhD

OVERVIEW

The Consolidated Appropriations Act of 2021 establishes a Rural Emergency Hospital (REH) designation under the Medicare program. It is difficult to predict rural hospital interest in conversion to REH because conditions of participation through rulemaking and guidance have yet to be established by the Centers for Medicare & Medicaid Services (CMS). However, some first estimates of the number and type of rural hospitals that might convert to REHs will assist policy makers as they prepare for implementation of the REH model. In this study, we used three measures to predict the number of rural hospitals with 50 beds or less that are likely to consider conversion to an REH: 1) three years negative total margin; 2) average daily census (ADC) (acute + swing) less than three; and 3) net patient revenue less than $20 million.

KEY FINDINGS

- Using one set of predictors for conversion, 68 rural hospitals are predicted to consider conversion to REHs ("REH converters") in comparison to 1,605 hospitals not predicted to consider conversion ("non-converters").
- In comparison to non-converters, a higher percentage of REH converters are predicted to be government-owned, Critical Access Hospitals (CAHs), and located in the North West Central Census division, and a lower percentage are predicted to be system-affiliated.
- Almost half of REH converters are located in four states: Kansas, Texas, Nebraska, and Oklahoma.
- In comparison to non-converters, REH converters are in counties with a higher median percentage of unemployed and a lower population density.
- The predicted number of REH converters (68) is based on what is currently known about the REH and is an estimate only: different selection criteria would result in a different set of potential REH converters.

BACKGROUND

Currently, a facility can receive Medicare payment for emergency department (ED) and hospital outpatient services only if it is certified by Medicare as a hospital, and the provision of inpatient acute care is required for such certification. This limitation has presented challenges for rural communities where there may not be sufficient patient volume or resources to support the provision of inpatient services, but where access to emergency services and higher -level outpatient services is still necessary.[1]

On December 21, 2020, Congress passed the Consolidated Appropriations Act (CAA) of 2021, which established Rural Emergency Hospitals (REHs). Effective January 1, 2023, hospitals that meet specified criteria will be eligible to convert to an REH. Although conditions of participation (CoPs) through rulemaking and sub-regulatory guidance have yet to be established by the Centers for Medicare & Medicaid Services (CMS), in accordance with the CAA, REHs will provide outpatient hospital and ED services without providing acute care inpatient services. REHs will be eligible for Medicare reimbursement for some services at rates higher than rates that would otherwise apply to services furnished in a hospital, and REHs will also receive a facility payment (see Table 1).

Because REHs are a new Medicare provider type, **the number of rural hospitals that might consider converting to an REH is unknown**. The purpose of this findings brief is to estimate, using one set of criteria, how many rural hospitals might convert to an REH. Developing a model to make this estimate involves several assumptions based on available data and comparisons to see which data points have been associated with the closure of a hospital. Ultimately, decisions about conversion to a new provider type may be driven by more than data or the immediate financial

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Legislative Origin of REH

- The Consolidated Appropriations Act 2021 creates a new facility called a "rural emergency hospital" (REH) that is defined as a facility that provides:
  - emergency department (ED) care
  - observation care
  - outpatient services
  - optional skilled nursing facility (SNF) care in a distinct part unit
- REHs do not provide acute care inpatient services
- Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) will apply
- Critical Access Hospitals (CAHs) and rural hospitals with 50 beds or less are eligible to apply for REH

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Proposed Conditions of Participation for REHs

- CMS-3419-P
- Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates
- Dates:
  - Published by CMS on 7-6-2022
  - Comments due by 8-29-2022

https://www.cms.gov/newsroom/fact-sheets/conditions-participation-rural-emergency-hospitals-and-critical-access-hospital-cop-updates-cms-3419

https://www.federalregister.gov/documents/2022/07/06/2022-14153/medicare-and-medicaid-programs-conditions-of-participation-cops-for-rural-emergency-hospitals-reh

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Proposed REH Staffing

- Nurse practitioners (NP) and physician assistants (PA) may be granted medical staff privileges.
- Must have adequate medical and nursing personnel qualified in emergency care to meet needs of facility. CMS is seeking comment on proposed staffing requirements to understand whether a practitioner should be on site at all times.
- Doctor, PA, NP, or clinical nurse specialist with training/expertise in emergency care must be on call and immediately available by phone within specified timeframe.

Proposed REH Emergency Services

- Must have 24-hour emergency services available
- Emergency department must be staffed 24/7, with flexibility to determine how to staff ED
- Registered nurse (RN), clinical nursing specialist, or licensed practical nurse must be on duty when REH has one or more patients receiving emergency care
- Emergency services organized under direction of medical staff and integrated with other departments
- Meet CAH regulations regarding emergency services

Proposed REH Required Services

- *Laboratory*: Basic services available 24/7. Must provide lab services identified in CAH CoPs and CMS recommends providing additional lab tests
- *Imaging*: Must meet acute hospital requirements for imaging services
- *Pharmacy*: Must operate pharmacy or drug storage area under supervision of pharmacist or other qualified individual. Drug packaging, dispensing overseen by pharmacist or physician

Proposed REH Optional Services

- *Additional outpatient services*. CMS is soliciting comments on REHs providing low risk labor and delivery and associated outpatient surgical services
- *Opioid and behavioral health:* Outpatient treatment only
- *Skilled nursing facility*: Distinct part unit for post REH care services. Must be separately licensed and certified and meet regulations at 42 CFR 483 for SNFs.

Proposed REH Optional Services

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Proposed REH Transfers and Referrals

- Must have transfer agreement with a Medicare certified level I or II trauma center for referral and transfer of patients
- Transfer hospital may be located in a different state
- Not precluded from agreements with level III or IV trauma centers

Proposed REH Payment Policies

- 42 CFR Parts 405, 410, 411, 412, 413, 416, 419, and 424, [CMS-1772-P], RIN 0938-AU82
- Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral
- Dates:
  - Filed for public inspection by CMS on 7-15-2022
  - Published on 7-26-2022
  - Comments due by 9-13-2022

https://public-inspection.federalregister.gov/2022-15372.pdf

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Proposed REH Medicare Payment

	Method Used to Calculate Funding
Monthly additional facility payment (AFP)	Total amount of Medicare spending for CAHs in CY 2019: $12.08 billion *minus* Total projected amount of Medicare spending for CAHs if paid prospectively in CY 2019: $7.68 billion *equals* $12.08 billion – $7.68 billion = $4.40 billion Difference of $4,404,308,465 *divided by* Total number of CAHs in 2019: 1,368 *equals* Annual AFP of $3,219,524 divided by 12 months per year = **$268,294** monthly AFP

Proposed REH Medicare Payment

		Method Used to Calculate Funding	
	Outpatient	Current OPPS X 1.05	
	Outpatient copayment	Based on current OPPS	
	SNF DPU	Current SNF PPS	
	Ambulance	Current ambulance fee schedule	
	Rural Health Clinic	Same rate as <50 bed hospital (payment limit exception)	

Proposed REH Medicare Payment

- Monthly payment will increase each year by the hospital market basket percentage increase.
- Each REH receives same monthly amount.
- Copayments are determined without the 5% payment increase.
- If REH provides outpatient services not covered by OPPS, services are paid under respective fee schedules (without a payment increase).
- Services at off-campus provider-based departments would be paid under the OPPS, plus 5% policy.

Other REH payment questions

- How will state Medicaid programs pay for REH services?
- No mention of capital in legislation – many existing hospital buildings will not be usable for REHs

NRHA Comment on REH Payment and CoP

CMS should:

- Recognize that CAHs that convert to an REH will be subject to the same market basket increase as PPS hospitals
- Apply the 5% add-on to the respective fee schedules for laboratory, outpatient therapy services, opioid treatment providers (physician fee), other necessary services
- Allow REHs to elect to be paid under the Optional Payment Method, or Method II (115% of the physician fee schedule)
- Include MA data in the monthly facility payment calculation.

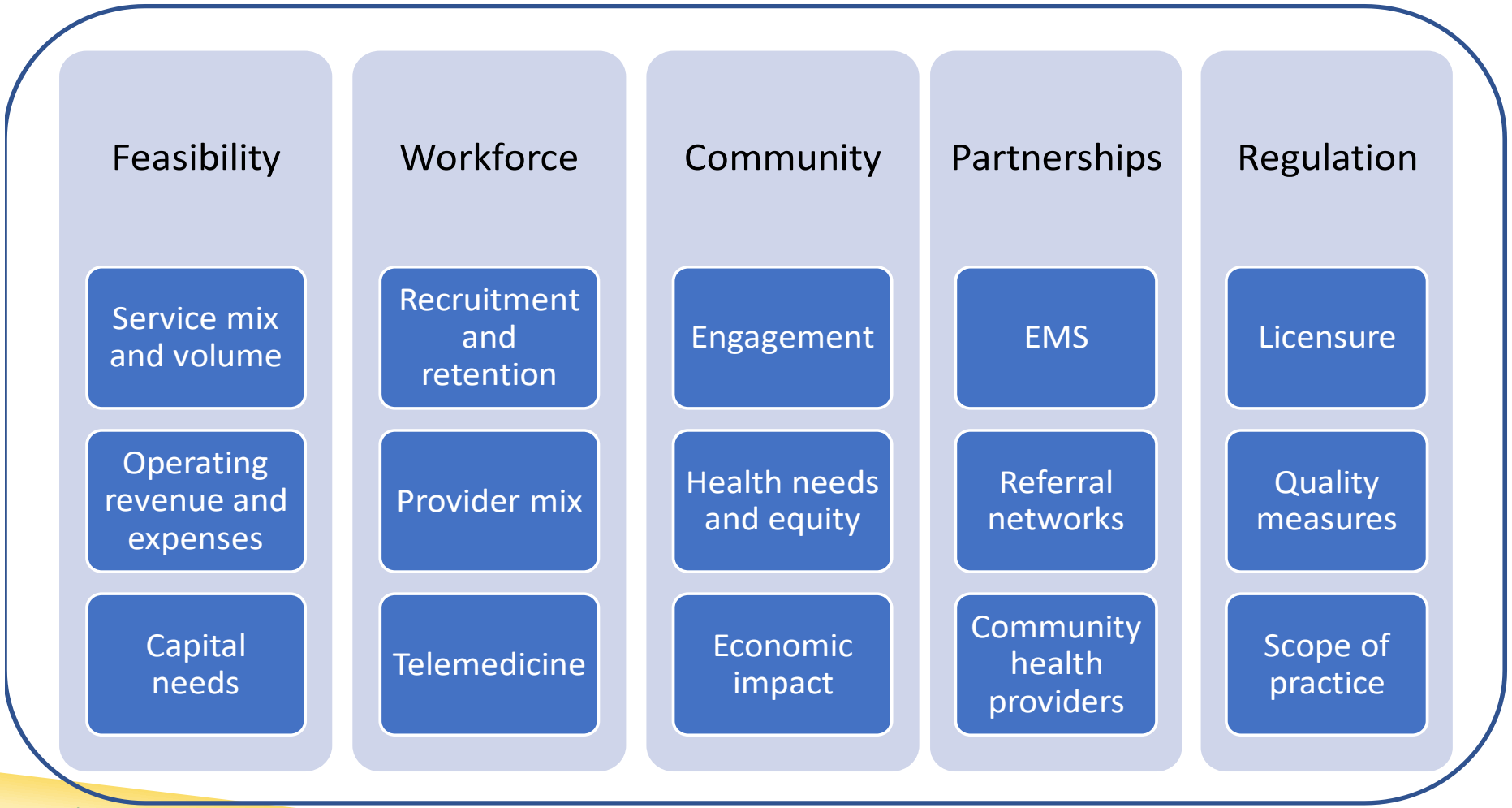
NRHA Comment on REH Payment and CoP

CMS should:

- Require MA plans to pay REHs with the same payment methodology as under traditional Medicare
- Not apply sequestration to either the OPPS rate plus 5% or the additional facility payments.
- Work with Congress to allow REHs to become eligible to participate in the 340B program
- Allow REHs to maintain operation of existing provider-based RHCs at grandfathered by April 1, 2021
- Apply the current bad debt policy of 35% reduction to REHs

3. Key Considerations for a Rural Hospital Assessing Conversion to REH

Key Considerations for a Rural Hospital Assessing Conversion to REH



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Feasibility

- Feasibility refers to the financial sustainability of the REH model of care.
- Considerations:
  - Service mix and volume
  - Operating revenue and expenses
  - Capital needs

Workforce

- Conversion to a REH will change the staffing needs and mix. With providers and nurse shortages, the REH will need to determine how they will recruit physicians, advanced practice providers (APPs), nurses, and therapists when there is no option for patients to be admitted to an inpatient setting.
- Considerations:
  - Recruitment and retention
  - Provider mix
  - Telemedicine

Community

- For many rural communities, the local hospital is the primary employer and a source of civic pride. A proposed conversion to a REH and associated loss of inpatient care may 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.
- Considerations:
  - Engagement
  - Health needs and equity
  - Economic impact

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Partnerships

- The REH model requires well-established partnerships with other health care providers, organizations and agencies. Considerable attention will need to be paid to emergency medical services (EMS) and trauma centers. REHs will need to have the capacity to transfer patients quickly and safely for higher levels of care.
- Considerations:
  - EMS
  - Referral networks
  - Community health providers

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Regulation

- 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.
- Considerations:
  - Licensure
  - Quality measures
  - Scope of practice

Summary

- Dx: Rural hospital closures are a problem
  - 140 rural hospitals have closed since January 2010
  - Patients in affected communities are probably traveling between 5 and 30 or more miles to access inpatient care
  - Closures could resume after covid funding is gone
- Rx: Rural Emergency Hospitals may be a solution
  - Need for a new model of rural health care
  - REH could be a viable model for some communities
  - Legislative action by States is required

Conclusion

- CMS is attempting to ensure that the REH regulations and guidance facilitate adoption and implementation of REHs to serve the healthcare needs of rural communities.
- REH could be an important step for preserving access to emergency and outpatient services in rural areas, particularly in communities that face the risk of rural hospital closures.

Conclusion

- CMS is attempting to ensure that the REH regulations and guidance facilitate adoption and implementation of REHs serve the healthcare needs of rural communities.
- REH could be an important step for preserving access to emergency and outpatient services in rural areas, particularly in communities that face the risk of rural hospital closures.

But (there is always a but)

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Conclusion

There are concerns that:

- Large systems may replace affiliated rural hospitals by REHs to save money or reduce losses.
- Venture capital firms may see REHs primarily as investment opportunities.
- Under the current Act:
  - Facilities that closed prior to 12-27-2020 cannot apply for REH
  - Provision of acute inpatient services in swing beds is not allowed
  - Participation in 340B program is not allowed

North Carolina Rural Health Research Program

Location:

Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
Website: http://www.shepscenter.unc.edu/programs-projects/rural-health/
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Resources

North Carolina Rural Health Research Program
http://www.shepscenter.unc.edu/programs-projects/rural-health/

Rural Health Research Gateway
www.ruralhealthresearch.org

Rural Health Information Hub (RHIhub)
https://www.ruralhealthinfo.org/

National Rural Health Association
www.ruralhealthweb.org

National Organization of State Offices of Rural Health
www.nosorh.org

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  County-Level 14-Day COVID-19 Case Trajectories
  New Research Product
- **May 18, 2020**
  Estimated Reduction in CAH Profitability from Loss of Cost-Based Reimbursement for Swing Beds
  New Research Product
- **May 14, 2020**
  Rural-Urban Residence and Mortality Among Three Cohorts of U.S. Adults
  New Research Product
- **May 13, 2020**
  Most Rural Hospitals Have Little Cash Going into COVID
  New Research Product
- **May 12, 2020**
  Characteristics of Counties with the Highest Proportion of the Oldest Old
  New Research Product

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Appendix – Other Proposed REH CoPs

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Proposed REH Required Services

- *Discharge services*:
  - Must implement a planning process to identify, at an early stage in provision of services, anticipated post discharge goals, preferences, and needs
  - Must perform discharge planning evaluation that includes patient's likely need for services following care
  - Must be developed by, or under supervision of, an RN, social worker, or other qualified personnel
  - Must assist patients and families in choosing post acute care provider by sharing data on quality measures

Proposed REH QUAPI

- Data driven Quality Assessment and Performance Improvement program containing 5 parts:
  - Program and scope;
  - Program data collection and analysis;
  - Program activities;
  - Executive responsibilities; and
  - Unified and integrated QAPI program for REH in a multi-hospital system
- Mandatory COVID-19, seasonal flu and acute respiratory illness reporting
- Mandatory COVID-19 vaccinations of staff

Proposed REH QUAPI

CMS is seeking comment on:

- Measures recommended by the National Advisory Committee on Rural Health and Human Services and additional suggested measures for the REHQR;
- Quality measures for rural telehealth, behavioral and mental health, emergency services, maternal health services, and equity; and
- How to address concerns over reliability and validity of measures due to low volume.

Proposed REH Other CoPs

- Infection prevention & antibiotic stewardship
- Patient's rights
- Medical records
- Emergency preparedness planning
- Physical environment
- Telemedicine

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Proposed REH Enrollment Policy

Must comply with applicable provider enrollment requirements found at 42 CFR 424, Subpart P to enroll in Medicare:

- Complete and submit enrollment form, CMS-855A. REH would not pay enrollment fee when submitting the form
- Complete any applicable state surveys, certifications, and provider agreements
- Revalidate enrollment every 5 years

Proposed REH Other Policies

- REHs do not need to provide Medicare Outpatient Observation Notice for patients receiving care > 24 hours
- Physician self-referral:
  - Radiology, imaging, lab services are considered services under the self-referral law
  - Once an entity is enrolled in Medicare as an REH, the physician self-referral law would prohibit a physician from making a referral for designated health services to the REH if the physician (or an immediate family member of the physician) has a financial relationship with the REH