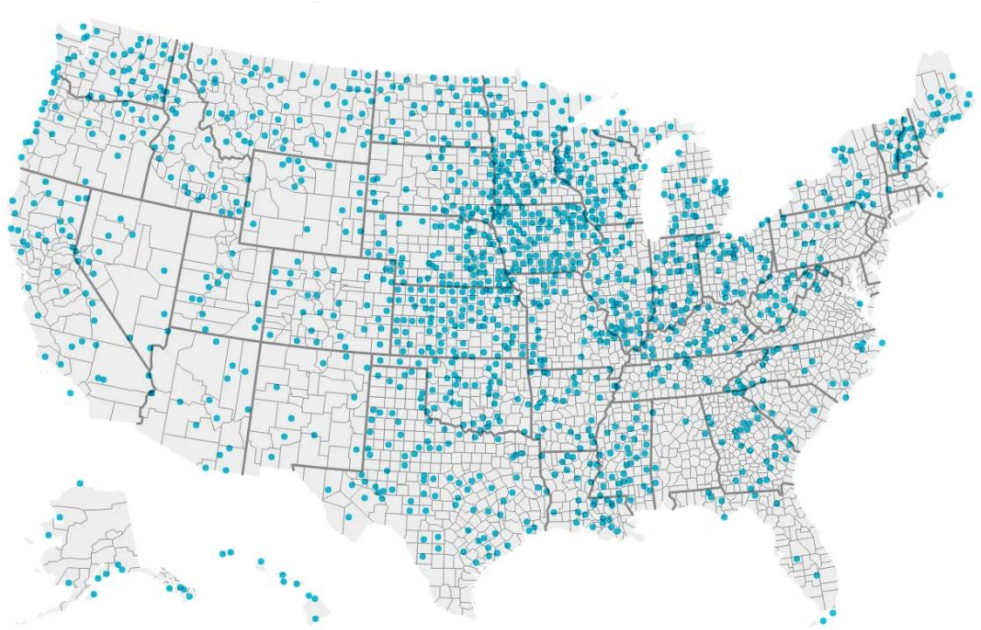
Rural Emergency Hospital
Impact on Hospitals

May 25, 2023

WINTERGREEN

CAH Policy Background



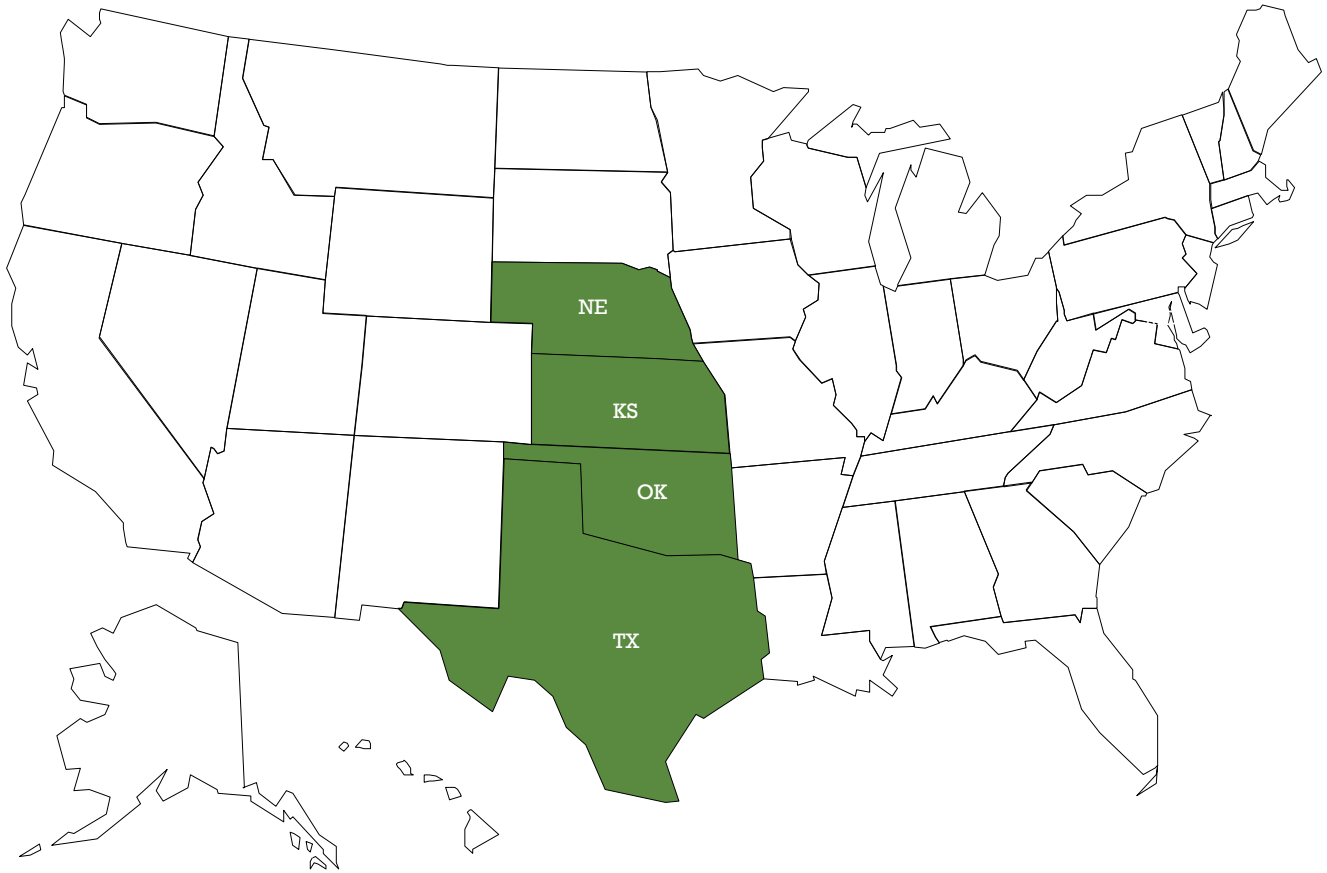
Congress created the Critical Access Hospital (CAH) designation through the Balanced Budget Act of 1997 (Public Law 105-33) in response to over 400 rural hospital closures during the 1980s and early 1990s.

300	1,360
Expected	Current

2021 Crystal Ball

Early Expectations

2021 research by the North Carolina Rural Health Research Program indicated four states were likely to have the highest number of REH candidates. Note however that this was before the facility payment rate was set in 2022.



How Many Hospitals Might Convert to a Rural Emergency Hospital (REH)?
July 2021 George H. Pink, PhD; Kristie W. Thompson, MA; H. Ann Howard, BS; G. Mark Holmes, PhD

REH Policy Background

The REH designation, created as part of the Consolidated Appropriations Act of 2021, seeks to reduce the number of closures of Critical Access Hospitals (CAHs) and certain rural hospitals while maintaining essential services. REHs can provide emergency services, observation care, and additional medical and health outpatient services that do not exceed an annual per patient average of 24 hours.

67	???
Expected	Future

Hurry Up and Wait

Meanwhile, along the way governmental agencies in all states will work on creating the necessary state-specific licensure infrastructure

Early entrants that appear to be **promising candidates** will pursue activities to determine the financial, market, political and cultural feasibility of conversion to REH

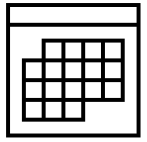
Hospitals that are not obvious candidates but that meet some of the criteria for consideration will investigate the financial feasibility components as both **rule-out** and **due diligence** functions

New Medicare Provider Type

The REH designation, created as part of the Consolidated Appropriations Act of 2021, seeks to reduce the number of closures of Critical Access Hospitals (CAHs) and certain rural hospitals while maintaining essential services. REHs can provide emergency services, observation care, and additional medical and health outpatient services that do not exceed an annual per patient average of 24 hours.

1. Which hospitals are **eligible**?
2. What are the **requirements**?
3. How are they **reimbursed**?

REH: Eligibility



December 27, 2020

Hospital status on the date of the Act

CAH

Critical Access Hospitals
Cost-based reimbursement from Medicare in addition to several other benefits such as the ability to participate in the 340B program

PPS

Rural Hospitals (<50 beds)
Hospitals under section 1886(d)(8)(E) of the Social Security Act including Sole Community Hospitals, Medicare Dependent Hospitals, etc.

REH: Path Forward

Criteria for Consideration

A

Performance

Has your hospital met its financial objectives in the past 3-5 fiscal years?

B

Scale

Is your inpatient census relatively low and declining over the past 3-5 years?

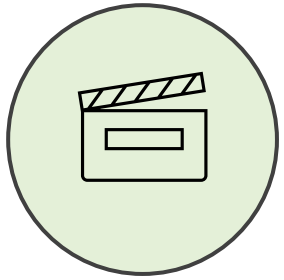
C

System

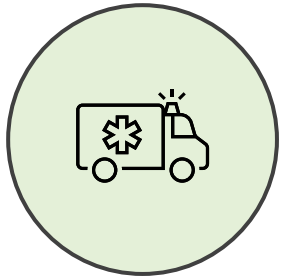
Is your hospital owned or managed by a larger, multi-hospital health system?

Rural Emergency Hospital: Requirements

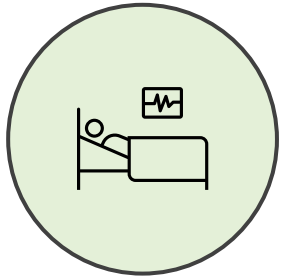
REH: Requirements



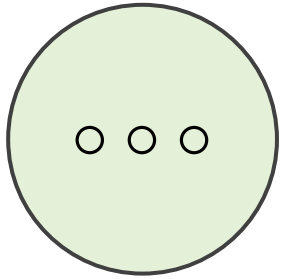
Action Plans



Emergency

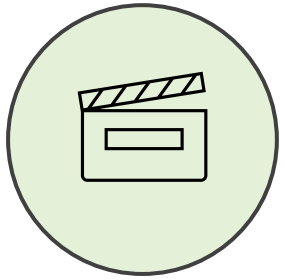


Inpatient



Other

REH: Requirements (1 of 4)



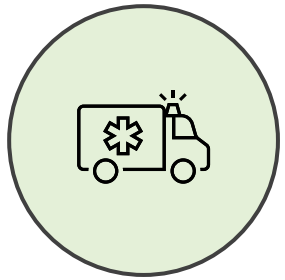
Action Plans

New Reporting Requirement

Existing hospitals seeking the REH designation must have an **action plan** for initiating and providing emergency services, including:

- Specific services the facility will retain, modify, add and discontinue
- Identify how the facility will use the additional facility payments

REH: Requirements (2 of 4)



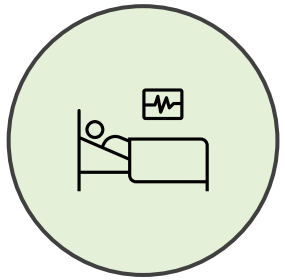
Emergency

Staffing and Operations Requirements

An emergency department of an REH will be considered **staffed** if meeting the following conditions:

- Staffed 24 hours a day, 7 days a week
- A physician or APP available to provide REH services 24 x 7
- Meet other staffing requirements as defined in the CoP

REH: Requirements (3 of 4)



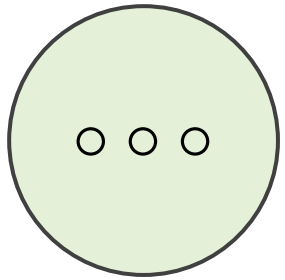
Inpatient

No Acute Inpatient Beds

REHs are prohibited from providing acute care inpatient services

- Some exceptions exist (e.g., post-acute care services in a dedicated SNF
- Will no longer be able to provide Swing Bed services
- Cannot exceed an annual average patient length of stay of 24 hours

REH: Requirements (4 of 4)



Other

State Licensure

- State-approved REH license (OK does not)

Proposed/Potential

- Other requirements deemed necessary by the Secretary of HHS
- CAH Conditions of Participation
- Other CMS proposed requirements in the CY23 OPPS/ASC rules

Operations/Payments

- Submit quality data as determined by the Secretary of HHS
- Maintain a transfer agreement with a Level I or II trauma center
- An REH will be considered a hospital with less than 50 beds for the purposes of determining the grandfathered RHC provision

REH: Reimbursement

Facility Payment	**$269,000** per month (CY 2023 annual payment of $3.2M)
REH Services	Medicare OPPS rates plus **5%**
Non-REH Services	Same rates as PPS facilities
Providers	Medicare physician fee schedule

Rural Emergency Hospital: Operational Considerations

REH: Operational Considerations

Scalability in reverse

- People
- Physical Assets
- Support functions
- Other Considerations
- Cash flows

Before we dive in…

- Generally, a disproportionately large share of administrative and general costs are absorbed by inpatient units
- Are your hospital costs able to be reduced to survive on a pure outpatient fee for service model?

REH: Operational Considerations

People

- Union contracts: often, reductions in force result in the lowest wage workers being eliminated, some union contracts will require it based on seniority.
- Physicians and other providers: many are shared costs with inpatient units, can the cost be sustained without the work.
- Does the workload change for support functions?
  - Third Party Contracts: This is new, insurance companies will seek to achieve an edge.
  - Quality: CMS has proposed the quality standards for REHs closely align with CAHs; however, the Secretary does have the authority to implement standards based on the uniqueness of the REH program
- Plant: Will your maintenance team be maintaining the same systems and same footprint?
- Other support functions: Meaningful changes to patient access, coding, billing, or accounting?

REH: Operational Considerations

Physical Assets

Equipment

- Generally, inpatient units are not taxing on movable equipment costs
- They do, however, generally contribute to the overall productivity of ancillary assets
- Are there purchase commitments that will still require servicing?

Plant

- Are your boilers and HVAC systems readily scalable to a smaller footprint?
- Any changes to the parking lot?
- Utility costs are unlikely to change significantly

REH: Operational Considerations

Support Functions

- Finance: If the assumption is that only low census hospitals convert, does the elimination of one department impact the workload of the accounting and revenue cycle functions?
- Quality: Requirements are expected to be similar to other rural hospital COPs.
- Housekeeping: ER is 24/7, can cost be reduced to account for elimination of IP needs?
- Maintenance: Can footprint be changed and are building stressors different?
- HR: Will there be a significant RIF, any changes to benefit structure? Savings?
- Radiology: Efficiency may be reduced.
- Lab: Will there be a reduction in tests, competencies, equipment or staff?
- And how do we think about:
  - Pharmacy
  - Dietary
  - Cafeteria

REH: Operational Considerations

Other Considerations

Third Party Contracts

- How will the advantage plans pay?
- Contracts will need renegotiated
- What are the risks under current commercial contracts?

Community Impact

- How will community perception of care change?
- Physician relationships: Is there an impact to business models outside the hospital?
- Reduction in force impact, both human and financial

REH: Operational Considerations

Cash Flow Impact

- Associated volume changes?
- 340b Program
  - Currently REHs are not listed as an organization that qualifies for the 340B program
  - Unless changed, organizations that convert to an REH may lose the 340B benefit
- Legacy expenses
  - Pension
  - Equipment leases
  - Debt

Rural Emergency Hospital: Path Forward

REH: Path Forward

Although the REH designation went into effect on January 1, 2023, there are several things that remain unknown including the following (some have been covered through proposed, yet not final, rules):

- 340B Program
- Necessary Provider CAHs
- Ambulance Services

The REH is a new designation, not a miracle cure for failing rural hospitals:

- Converting to an REH from another hospital designation will require complex modeling that includes cost analysis, service projections, staffing variations, payor mix, etc.
- Organizations that wish to pursue the REH designation must have a comprehensive understanding of the impact on the net financial position of the organization

Gregory Wolf, Principal
gwolf@wintergreenme.com
(207) 232-3733

Rob Bloom, Advisor