Rural Hospital Closures and the Rural Emergency Hospital (REH)

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Summary

- Dx: Rural hospital closures are a problem
  - 138 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
  - CMS is currently in rule-making mode
  - REH could be a viable model for some communities
  - Legislative action by States is required

Dx: Rural hospital closures are a problem

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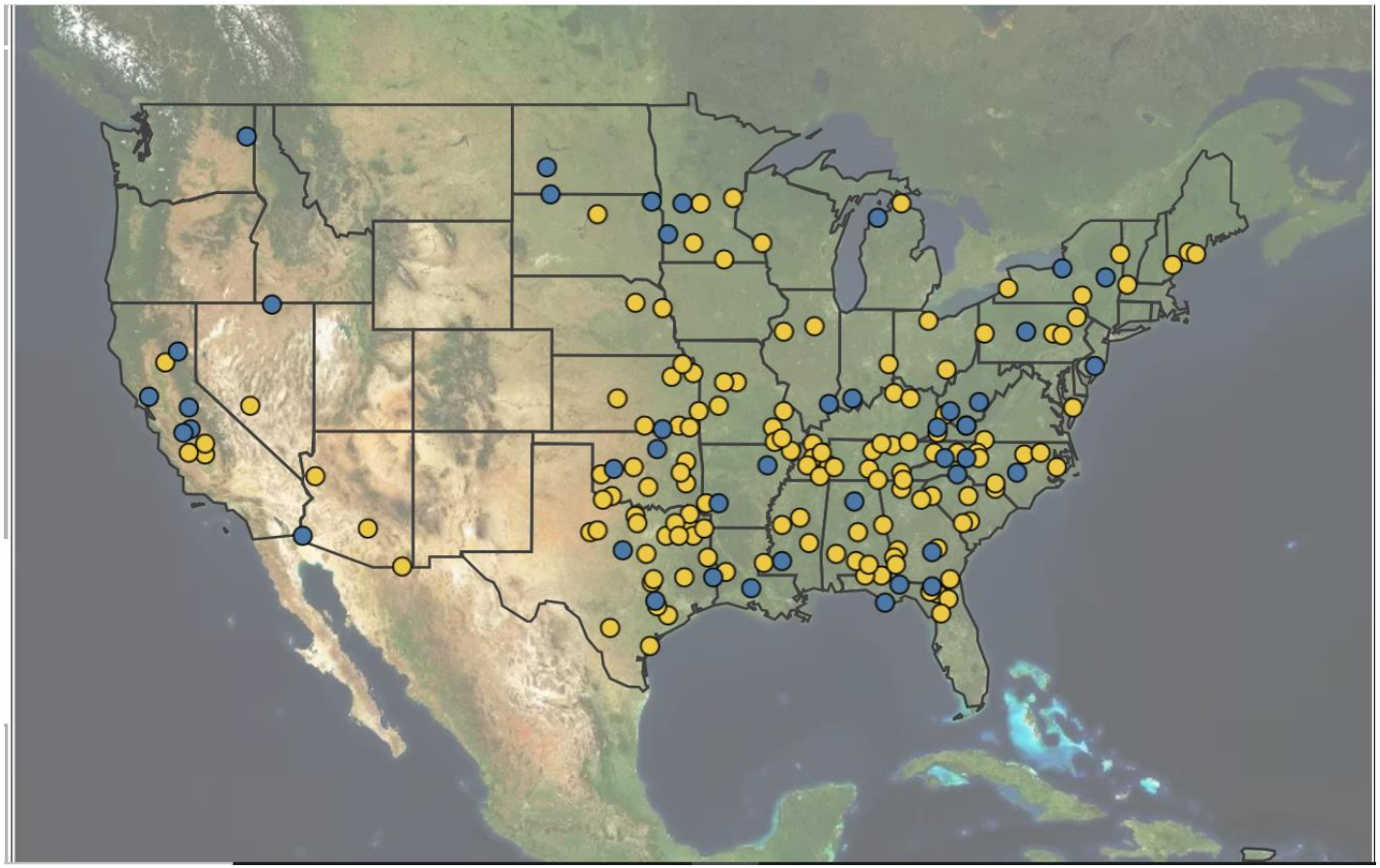
181 Rural Hospital Closures since January 2005



Yellow = converted closures

Blue = complete closures

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2 Rural Hospital Closures in NE

Hospital	Type	Year	Beds	Current status
MercyOne Oakland Medical Center	CAH	2021	16	Primary care clinic
Tilden Community Hospital	CAH	2014	20	Outpatient/Primary Care/Rural Health Clinic

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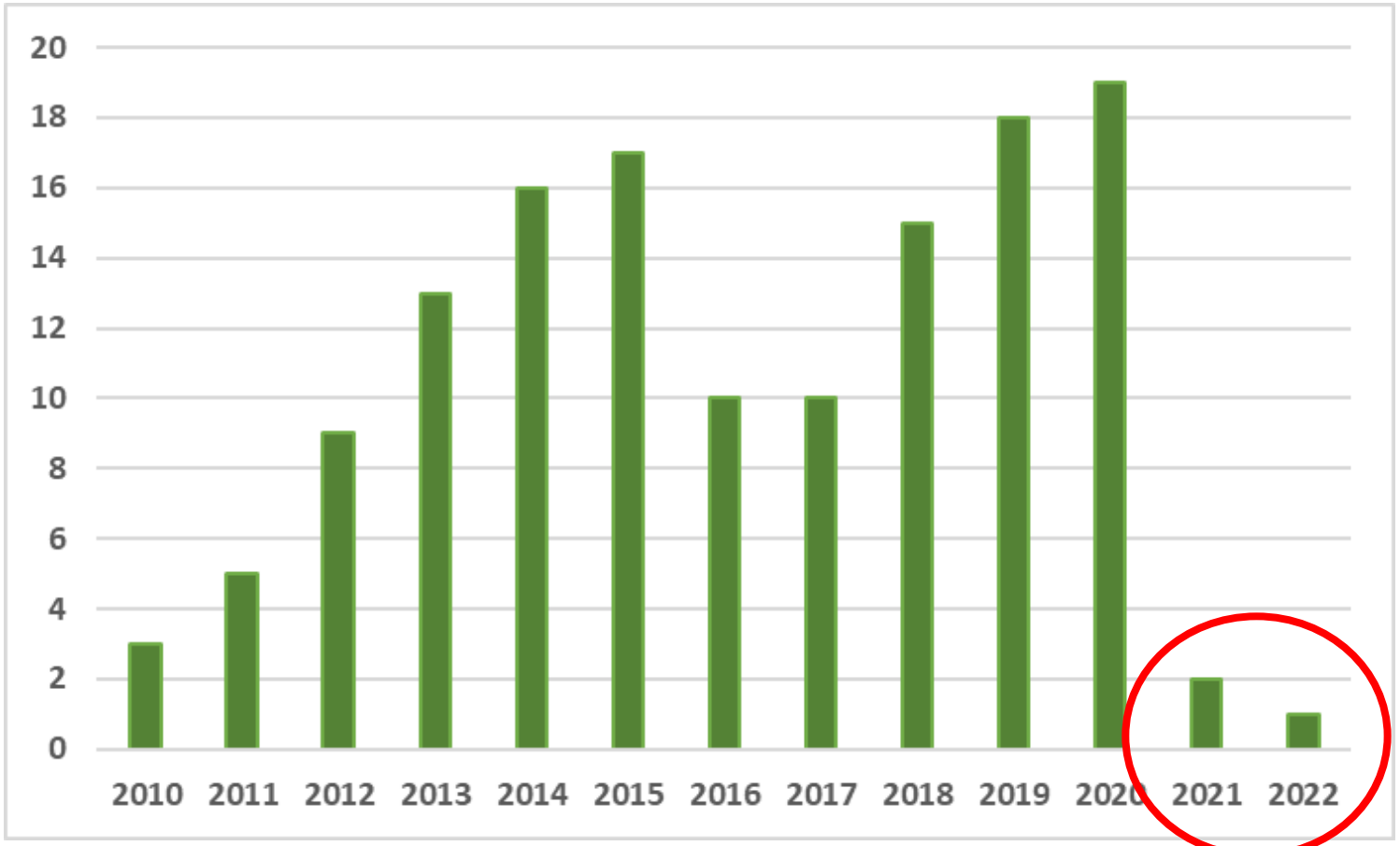
138 Rural Hospital Closures since January 2010



Our problems are over, right?

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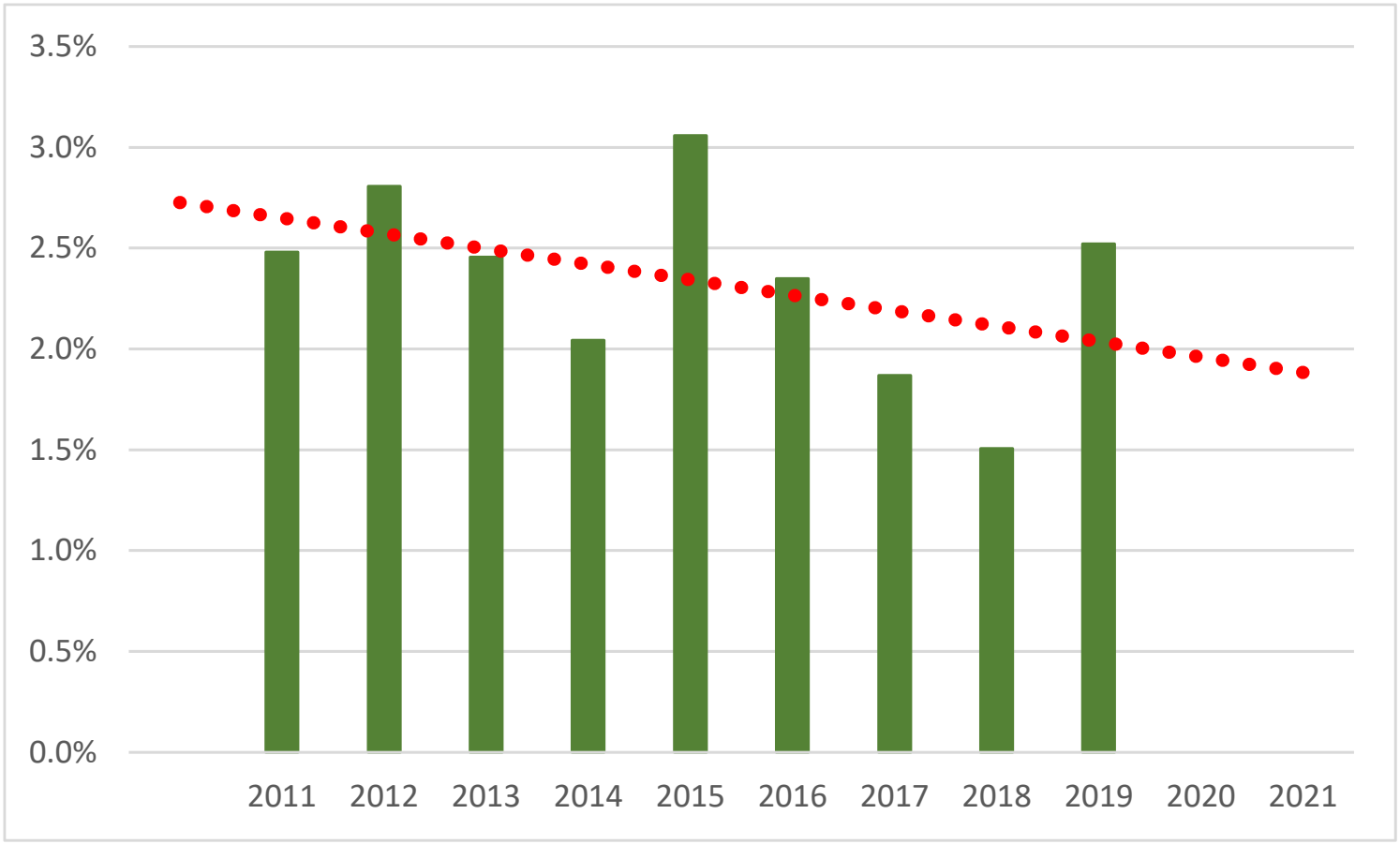
The median total margin of rural hospitals was trending downwards before COVID funding



Long-term unprofit-ability has not gone away

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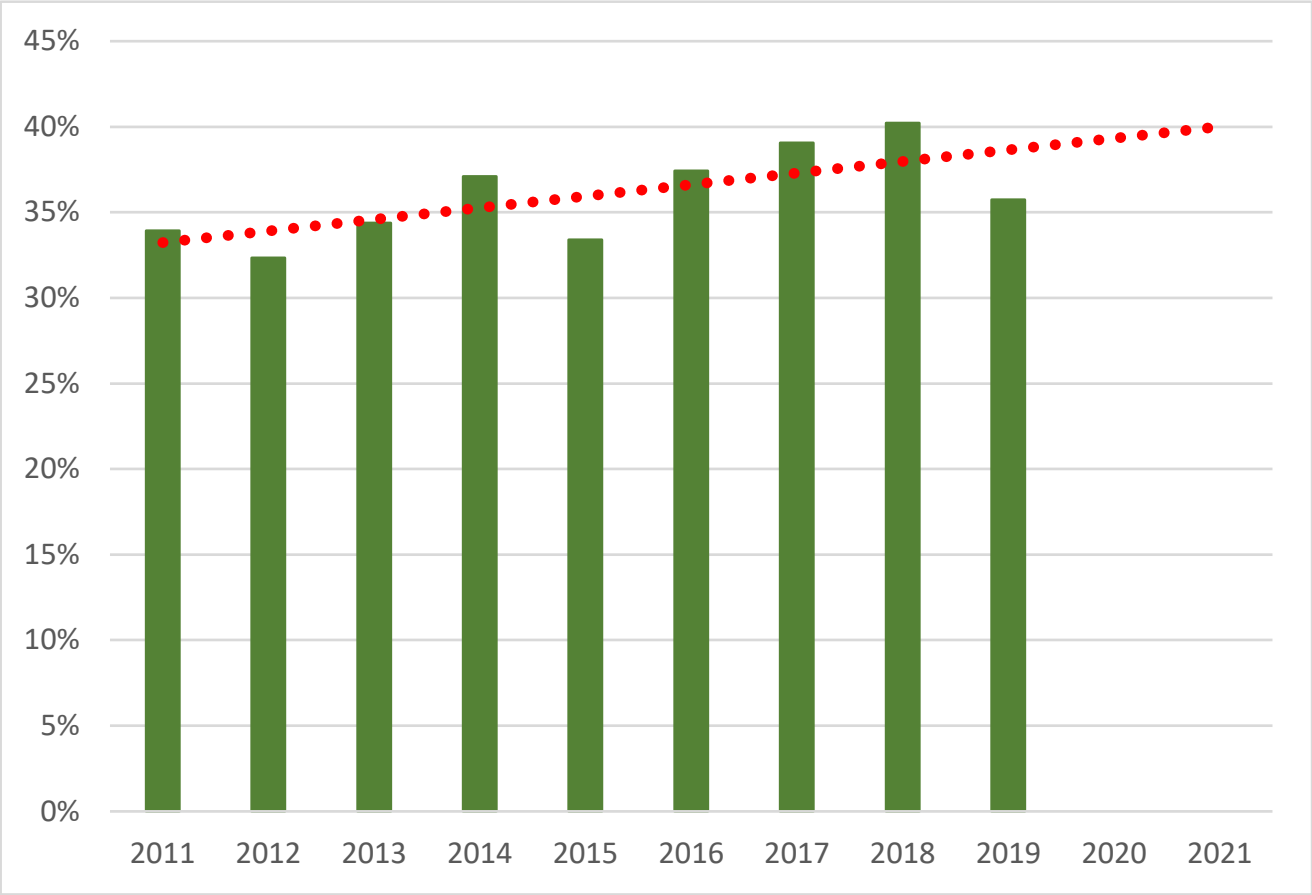
The percentage of rural hospitals with a negative total margin was trending upwards before COVID funding



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

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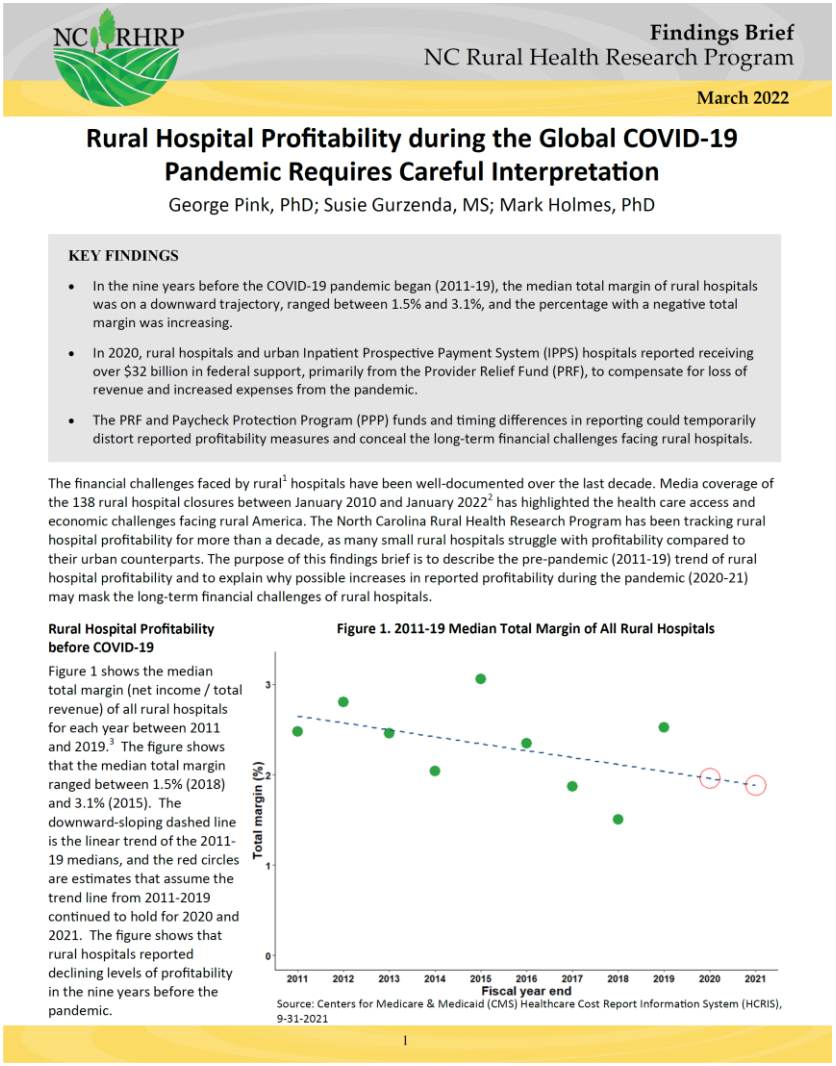
Rural Hospital Profitability during the Global COVID-19 Pandemic Requires Careful Interpretation



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Findings Brief
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March 2022

Rural Hospital Profitability during the Global COVID-19 Pandemic Requires Careful Interpretation

George Pink, PhD; Susie Gurzenda, MS; Mark Holmes, PhD

KEY FINDINGS

- In the nine years before the COVID-19 pandemic began (2011-19), the median total margin of rural hospitals was on a downward trajectory, ranged between 1.5% and 3.1%, and the percentage with a negative total margin was increasing.
- In 2020, rural hospitals and urban Inpatient Prospective Payment System (IPPS) hospitals reported receiving over $32 billion in federal support, primarily from the Provider Relief Fund (PRF), to compensate for loss of revenue and increased expenses from the pandemic.
- The PRF and Paycheck Protection Program (PPP) funds and timing differences in reporting could temporarily distort reported profitability measures and conceal the long-term financial challenges facing rural hospitals.

The financial challenges faced by rural[1] hospitals have been well-documented over the last decade. Media coverage of the 138 rural hospital closures between January 2010 and January 2022[2] has highlighted the health care access and economic challenges facing rural America. The North Carolina Rural Health Research Program has been tracking rural hospital profitability for more than a decade, as many small rural hospitals struggle with profitability compared to their urban counterparts. The purpose of this findings brief is to describe the pre-pandemic (2011-19) trend of rural hospital profitability and to explain why possible increases in reported profitability during the pandemic (2020-21) may mask the long-term financial challenges of rural hospitals.

Rural Hospital Profitability before COVID-19

Figure 1 shows the median total margin (net income / total revenue) of all rural hospitals for each year between 2011 and 2019.[3] The figure shows that the median total margin ranged between 1.5% (2018) and 3.1% (2015). The downward-sloping dashed line is the linear trend of the 2011-19 medians, and the red circles are estimates that assume the trend line from 2011-2019 continued to hold for 2020 and 2021. The figure shows that rural hospitals reported declining levels of profitability in the nine years before the pandemic.

Figure 1. 2011-19 Median Total Margin of All Rural Hospitals

Source: Centers for Medicare & Medicaid (CMS) Healthcare Cost Report Information System (HCRIS), 9-31-2021

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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 public sector workers

Closures are a big deal in affected communities

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Need for a new model

- Rural hospital closures
  - 138 closures since 2010
  - 181 closures since 2005
- Declining inpatient utilization
  - In a soon-to-be-released study, we found the average percent of revenue coming from outpatient services increased from 66.5% in 2011 to 74.2% in 2019.
- 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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Need for a new model – access to emergency care

- **Question:** Do 30-day outcomes differ after urban vs. rural (and CAH) ED visits?
- **Method**: Cohort study of 473, 152 matched Medicare beneficiaries treated at urban vs. rural (and CAH subset) EDs
- **Findings:**

<u>Less Hospitalization</u>

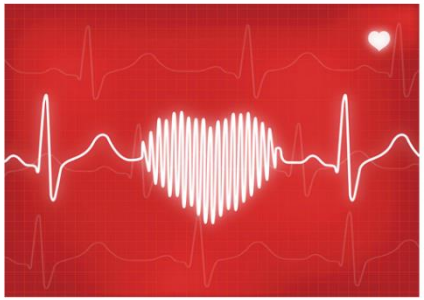
Rural ED

<u>Similar Mortality</u>

Rural ED

Urban ED

Similar mortality for LIFE-THREATENING conditions
(stroke, sepsis, AMI)



- **Meaning:** These findings underscore the importance of rural and critical access EDs for treatment of life-threatening conditions among Medicare recipients and have important policy implications given the continued increase in rural hospital closures.

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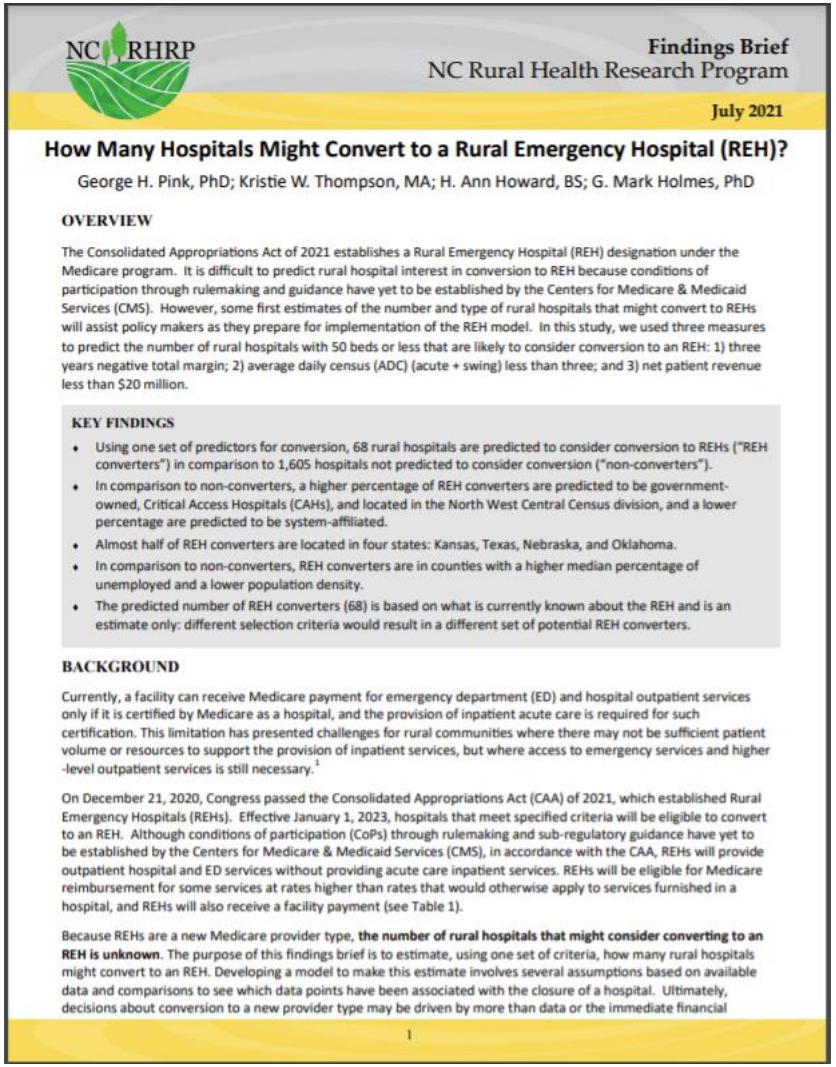
Rx: Rural Emergency Hospitals may be a solution



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Findings Brief
NC Rural Health Research Program

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
- REH can be an originating telehealth site

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REH Eligibility and Application

- *Hospital eligibility to become a REH.*
  - Critical Access Hospitals (CAHs) and rural hospitals with 50 beds or less
- *Application to become a REH*.
  - an action plan for initiating REH services
  - a list of services that will be provided on an outpatient basis
  - information about how the additional facility payment will be used
  - State approval of REH licensure

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REH Requirements

- Must not exceed an annual per patient average of 24 hours;
- Must be staffed 24 hours a day, 7 days a week by a physician, nurse practitioner, clinical nurse specialist, or physician assistant;
- Must meet the Medicare licensure requirements and staffing responsibilities of an ED;
- Must have a transfer agreement in place with a level I or II trauma center;
- Must meet conditions of participation applicable to CAH emergency services and hospital EDs;
- Must meet the DPU requirements if REH is a DPU of a SNF.

REH Quality metrics and evaluation reports

- Beginning in 2023, REHs will be required to submit data for quality measurement.
- Quality measures will be made public and will be posted on the CMS website.
- Reports will be conducted to evaluate the impact of REHs on the availability of healthcare and health outcomes in rural areas after 4 years, 7 years, and 10 years of enactment.

REH Medicare Payment

Type of payment	Method Used to Calculate Funding
Monthly additional facility payments	Calculated as 1/12th of the excess of (if there is any): the total amount that was paid for Medicare beneficiaries to all CAHs in 2019; minus the estimated total amount that would have been paid for Medicare beneficiaries to all CAHs in 2019 if payment had been made for inpatient hospital, outpatient hospital, and SNF services under the applicable PPS; divided by the total number of CAHs in 2019
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)

Q1: What will be the amount of the monthly AFP?

- Size of CMS monthly additional facility payments may determine conversion
- For example, assume:
  - Total Medicare cost-based payments to all CAHs in 2019 was $14 billion*
  - The estimated PPS payments for the CAH services would have been $11B**.
  - 1,350 CAHS are included in the above payments.
- Additional facility payment (AFP) for each REH in 2023: ($14B - $11B = $4B / 1,350) = $2.2 million

* MedPac estimated $10B to all CAHs in 2015.

** On March 10, 2011, the Congressional Budget Office (CBO) released a report entitled "Reducing the Deficit: Spending and Revenue Options." In this report, the CBO states that hospitals benefiting from the special adjustments for CAHs, MDHs, and SCHs are paid about 25% more, on average, for inpatient and outpatient services than the payments that would otherwise apply.

Q2: Other REH payment questions

- What will be the complete scope of services eligible for payment at enhanced REH rates?
- Will rural health clinics of the converting hospital maintain grandfathering provisions regarding Medicare cost limits?
- Will the REH be able to elect Method II payment (115% of physician fee schedule) for outpatient provider-based physician services?
- How will state Medicaid programs pay for REH services?
- No mention of capital in legislation - existing hospital buildings will not be usable for REHs

Q3: Operational questions

- REH eligibility / Conditions of Participation?
- How will REHs affect EMS?
- Will effective transfer agreements be established?
- Will REH staffing be available?
- What REH quality metrics will be used and reported?

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Conclusion

- REH could be a step for preserving access to emergency and outpatient services in rural areas, particularly in communities that face the risk of rural hospital closures.
- Details about the requirements for operating as an REH remain subject to future rulemaking and guidance.

Conclusion

It will be important for:

- **CMS** to engage with interested hospitals to ensure that the REH regulations and guidance facilitate adoption and implementation of REHs to serve the healthcare needs of rural communities.
- **Hospitals** that are interested in conversion to REH to pay attention to CMS rulemaking this year and be ready to comment when proposed rules are published

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North Carolina Rural Health Research Program

Location:

Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
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Susie Gurzenda, MPH
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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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