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NATIONAL RURAL HEALTH ASSOCIATION

RURAL EMERGENCY HOSPITAL (REH) MODEL SUMMARY

Introduction

Rural hospital closures are at crisis levels with over 135 rural hospitals closing since 2010 and more than 450 identified as vulnerable to closure based on performance levels.^{3, 4} When a rural hospital closes, the mortality rate in that community increases, the local economy declines, and disinvestment in the community ensues.² Rural closures increase travel times for patients and lead to outmigration of health care professionals' post-closure, which severely dismembers patients' access to care and exacerbates health disparities. Despite insufficient patient volumes and resources to support inpatient services, access to emergency services and higher-level outpatient services remains necessary.

Section 125 of the Consolidated Appropriations Act of 2021 (CAA) created the Rural Emergency Hospital (REH) model as a new Medicare provider type. The designation is effective as of January 1, 2023. The REH model will offer the opportunity for current Critical Access Hospitals (CAHs) and rural Prospective Payment System (PPS) hospitals with fewer than 50 beds to convert to REH status to furnish certain outpatient hospital services in rural areas, including emergency department and observation services.⁵

NRHA has long advocated for a new service delivery and payment model that would enable small rural hospitals to sustain access to vital health care services for their patients. Although many questions remain regarding the implementation of the REH model, NRHA applauds Congress for creating this new provider type. NRHA believes the REH model will be an opportunity for vulnerable rural communities to maintain an essential access point for health services. It will be critical for NRHA membership to engage in the REH implementation process, including monitoring the Centers for Medicare and Medicaid Services' (CMS) development of the Conditions of Participation (COPs) and calculations of payment methodologies.

Significant considerations of the REH:¹

- No provision of acute care inpatient services
- An average per patient length of stay not to exceed 24 hours
- Have a transfer agreement in place with a Level I or II trauma center
- Maintain a staffed emergency department, including staffing 24 hours a day, seven days a week by a physician, nurse practitioner, clinical nurse specialist or physician assistant
- Meet CAH-equivalent Conditions of Participation (CoPs) for emergency services
- Meet applicable state licensing requirements, to be developed
- Be permitted to operate a distinct part skilled nursing facility (SNF) or off-campus provider-based departments, however neither are eligible for the enhanced payments available to REHs
- Develop an implementation plan for conversion to REH status
- For those facilities that maintain a SNF, the REH must comply with CoPs applicable to SNFs
- May convert back to a CAH or PPS hospital
- Must meet quality reporting standards as determined by the Secretary
- May be an originating site (where the patient is) for telehealth services

Payment Analysis

The CAA creates a new category of Rural Emergency Hospital Services (REHS). REHS will be paid by Medicare at a rate higher than the otherwise applicable payment under the Medicare Outpatient Prospective Payment System (OPPS). Payments to the REH will be Based on the following methodology:

- (1) *REHS*: The legislation defines the payment for REHS beginning January 1, 2023 as the amount that would otherwise apply to covered outpatient services under the OPPS. The OPPS amount will be increased by 5% to reflect the higher costs of the REH. Beneficiary coinsurance will be computed based on the OPPS methodology.
- (2) *Additional facility payment*: The legislation provides for an additional facility payment (AFP) which will be made monthly to the REH (1/12th of the annual amount as determined by the Secretary). The computation of the AFP, called the Medicare subsidy, is described in the law as follows:
 - a. In 2023: an amount equal to the difference of all payments to CAHs in 2019 and what is estimated those CAHs would have been paid if the payments would have been made under inpatient prospective payments (IPPS), OPPS and skilled nursing facility (SNF-PPS) payment systems. The difference is divided by the total number of CAHs in 2019.
 - b. In 2024 and subsequently: the 2023 “base” amount (as determined in (a)) will be increased by the hospital market basket percentage increase.

An example:

- Assume total Medicare cost-based payments to all CAHs in 2019 was \$14 billion¹.
- Assume the estimated PPS payments for the CAH services would have been \$10B.
- There were 1,350 CAHs on July 19, 2019. Assume all are included in the above payments.
- AFP for each REH in 2023 will be \$2,962,962 ($\$14B - \$10B = \$4B / 1,350$).

Policy and Advocacy Considerations and Recommendations

While the CAA provided broad parameters for the REH model, CMS will need to establish CoPs for REHs through rulemaking and guidance. The following are questions consideration in REH implementation:¹

- Will hospitals that close before January 1, 2023 be eligible to reopen as REHs?
- What will be the complete scope of services eligible for payment at enhanced REH rates?
- What are the steps and timing considerations for conversion to an REH?
- What CoPs will be imposed on REHs?
- What quality and data reporting will be required of REHs?
- What supports and timelines are in place for States to establish licensing rules?
- Will REHs have access to federal and state resources through the Medicare Rural Hospital Flexibility (Flex) Program?
- Will provider-based rural health clinics of the converting hospital maintain grandfathering provisions regarding Medicare upper payment 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?

The creation of the REH designation provides another option for rural communities to ensure access to essential health services, including emergency care. Rural communities will need assistance to assess the

¹ MedPac estimated Medicare cost-based payments at \$10B to all CAHs in 2015.

viability of this option for meeting local need and how it fits into the larger rural framework. There are number of important areas of technical assistance:

- *Application process:* Hospitals must develop and submit an implementation plan, which should include a transition plan with an evaluation of community need and transition plan for services maintained, discontinued, added, or modified.
- *Licensure:* States will have to revise existing licensure statutes and regulations to allow eligible and interested facilities to apply.
- *Quality measurement:* CMS must develop, test, and implement a quality measurement reporting system that allow for meaningful reporting in a low-volume environment.
- *Financial and operational site assessments:* Applicant facilities and their communities will need to do a significant amount of financial analysis to ensure that the REH will be financially viable and sustainable for their community.
- *Scale and implementation:* Advocates will assess how many hospital conversions are anticipated and what technical assistance needs to be provided.

Sources:

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