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Enabling Care Close to Home

IS CONVERTING YOUR RURAL OR CRITICAL ACCESS HOSPITAL TO A RURAL EMERGENCY HOSPITAL RIGHT FOR YOU?

"Building Outpatient Capacity and Service Lines to Better Serve our Local Community"

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Executive Summary

Created by the Consolidated Appropriations Act of 2021, the Rural Emergency Hospital (REH) is a new Medicare hospital provider designation and payment model that will go into effect on January 1, 2023. [1] For approved hospitals, converting to an REH will increase facility revenue and help save critical access to care in rural communities. An REH will shift from providing inpatient care services to focusing on outpatient services (including emergency, observation, ambulatory, and, potentially, skilled nursing, and ambulance services). REHs will receive 5% more for the outpatient care as well as a potentially substantial monthly Additional Facility Payment (AFP) to support additional investments in the local community health needs. Because this model allows hospitals to reduce the costs of supporting inpatient infrastructure while providing additional funding for outpatient services, this transformational opportunity can increase hospitals' financial viability. Outpatient services, including unscheduled care, and primary, behavioral, and specialty care can be augmented through both virtual and population health programs with reduced startup costs.

Conversion to an REH will require intentional strategic planning, financial modeling, current operations efficiency analysis, provider compensation models, new service line development and experienced implementation resources, supporting technology/analytics experience, as well as comprehensive communication programs engaging hospital and community decision-makers. Rural Health Solutions© has demonstrated expertise in supporting organizations through the evaluation and implementation of this potentially transformational initiative.

Scope of the Problem

Out of the 3,395 short term acute care hospitals in the US, there are approximately 2,000 rural hospitals, with 1,353 of them being Critical Access Hospitals (CAHs).[2] Between January 1, 2010, and October 1, 2021, 138 rural hospitals closed, including 93 Prospective Payment System (PPS) hospitals and 45 CAHs.[3]

The threats to rural access to healthcare are well known. Recent studies have identified consistent threats to their mission, including:

- 50% of rural hospitals have < 25 inpatient/swing beds
- 90% of CAHs have average daily census of < 5 inpatients
- 50 CAHs have net revenue < $5MM/year
- >50% of CAH net revenue comes from government payors
- >40% of CAHs have negative operating margin
- Average rural hospital Medicare margins are negative 7.4%
- 60% of hospital closures in the last 5 years were rural

Rural hospitals have found it increasingly difficult to develop new services to improve the health of their communities in the face of decreasing volumes and revenue combined with increasing costs. The most prominent challenges faced by rural hospitals center around financial viability, including:

- Locations that are subject to workforce shortages, lower patient care volumes, declining population, and higher relative costs.
- Modest budgets with limited flexibility in cash flow making necessary capital investments in equipment or facilities difficult.
- The changing demographic of rural populations to one that is older, sicker due to multiple chronic conditions, more likely to be under- or uninsured, and has fewer resources to care for themselves or their families.
- Lack of access to high-quality emergency, primary, specialty and behavioral health care services and providers.
- An ever-changing service delivery model where enhanced technology capabilities are required, including clinical applications such as electronic health records and registries; artificial, clinical, and business intelligence tools; and cybersecurity systems.
- Changing reimbursement models, regulations/compliance requirements, and increasing quality reporting complexity.

Given both persistent and recent challenges, such as the COVID-19 pandemic, rural hospitals are finding it increasingly difficult to cover the high fixed costs of operating the hospital and maintaining access to services while pursuing new pathways to improve their community's access to quality care.

Government initiatives to reduce the financial vulnerability of rural hospitals and improve access to essential services in rural communities, while substantial, have been historically insufficient to meet the myriad local healthcare needs while also fund the development of new programs.

In December 2020, Congress authorized the creation of the Rural Emergency Hospital (REH) Medicare provider designation that creates enhanced payment to rural hospitals for maintaining and growing access to emergency and ambulatory care, while ceasing to provide inpatient care. The program also includes an additional facility payment (AFP) provided monthly to these hospitals to support further development of their outpatient community services.

This legislation allows forward-thinking rural healthcare leaders to move away from a financial model that relies on cost containment initiatives built on service- and workforce-reductions and instead transition to one that provides opportunities to increase services and revenue.

Rural Emergency Hospital Provider Status – A New Paradigm for Rural Healthcare Organizations

CAHs and rural hospitals with less than 50 beds, who meet eligibility requirements, can now apply for conversion to Rural Emergency Hospital (REH) provider designation status, which begins January 1, 2023. To achieve this designation, rural hospitals will need to discontinue inpatient care and expand outpatient services. REHs may also provide, as needed, ambulance and transportation services, as well as skilled nursing care in a Distinct Part Unit (DPU) (under a separate licensed unit). REHs must also meet eligibility and program requirements as detailed in Appendix 1.

Rural Emergency Hospital Reimbursement Methodology

REH service payments are based on the outpatient prospective payment system (OPPS) payment schedule and are volume based. REHs will be eligible for Medicare reimbursement for outpatient care at a higher rate (105%) than the acute care prospective system (PPS) hospital rates.

In addition, qualifying hospitals will receive an additional facility payment (AFP) that will be a fixed monthly payment to finance additional community outpatient services. While the basic REH payment continues to be fee-for-service, the AFP funding allows for the adoption and expansion of services to support the community. The application for REH provider designation status requires documentation of a plan for the use of these AFPs.

Potential AFP programs to deploy include population health and telehealth programs, funding the development of community need plans, facilitating local stakeholder collaboration, and implementing community-focused quality improvement plans. AFPs may also be used to augment primary and specialty care services and fund the adoption of hospital-based EMS and transportation services. Initial estimates for the AFP suggest that it could be as high as an additional $1MM to $3MM/year.

Type of Payment	Method Used to Calculated Funding
Outpatient	Current Outpatient Prospective Payment Systems (OPPS) x 1.05
Outpatient Copayment	Based on Current OPPS
SNF DPU	Current SNF PPS
Ambulance	Current Ambulance Fee Schedule
Monthly Additional Facility Payment (AFP)	Total Amount Paid for Medicare Beneficiaries to all CAHs in 2019; minus the estimated total amount CAH payments for Medicare beneficiaries for inpatient, outpatient, and SNF service under the Prospective Payment System (PPS); divided by the total number of CAHs in 2019

Figure 1: Proposed REH Reimbursement Methodology

Additional requirements for REH selection will be published by Center for Medicare and Medicaid Services (CMS) in Q1 2022, allowing for hospitals to begin the planning and implementation process now. Once additional CMS requirements are identified, the list of criteria for conversion will likely expand. The actual decision to pursue this designation will need to be done a facility-by-facility basis.

Determining If Your Rural Hospital Should Seek Designation as a Rural Emergency Hospital

The financial viability of rural health facilities remains the highest priority for consideration of early conversion. The North Carolina Rural Health Research Program (NCRHRP) identified key prediction criteria to undertake an REH Conversion to ensure hospital financial viability:

- Long term unprofitability (as defined as 3 years negative margin (<0))
- Average daily census < 3
- Net patient revenues < $20 MM/year [4]

Factors to Consider for Applying for Rural Emergency Hospital (REH) Designation

The Rural Emergency Hospital represents an important step toward preserving and expanding access to emergency and outpatient services in rural areas, particularly in communities that face the risk of imminent closure. Evaluation of the opportunity to convert to an REH requires a comprehensive evaluation of current and future-desired competencies as well as an assessment of current and future operational and financial performance to determine the financial viability of such a conversion.

The most important components of this evaluation process include:

- evaluating current ED/outpatient services for operational efficiency/productivity.
- reviewing provider compensation/incentive programs.
- determining the services to be provided based on community needs.
- defining the current community benefit and future state.
- designing the necessary infrastructure.
- determining the financial benefits of conversion.

To ascertain the financial viability of the REH conversion, organizational planning should include creating a *pro forma* that compares the fiscal impact of maintaining current hospital designation compared to conversion to an REH with its resource planning needs. Considerations should also be given to current/planned strategic initiatives that could impact ED and primary care utilization as well as:

- evaluation of inpatient services contribution margin.
- service area population changes.
- outpatient service volume changes.
- EMS contracted rates and run volume.

Community benefit analysis should first start with a gap analysis of current and desired outpatient capabilities and alternatives to inpatient care. This provides opportunities to strengthen emergency and primary care services with consideration of hours of operation, weekend services and provider mix. Additional services that should be considered include expanded primary care services, primary/urgent/specialty telemedicine services, population health programs, as well as infusion and hemodialysis services. Post-acute care services can include medical home programs, SNF beds in a distinct part unit (DPU), rehabilitation center, and hospice. The benefit analysis should also include a scenario where no changes are made to current Medicare provider status, so that the potential associated risk of hospital closure and loss of essential services can be compared.

Successful conversion will require close collaboration with the hospital governing body, community stakeholders, providers and staff, EMS providers, and current referral partners. Alignment with these entities should occur prior to any decision to seek designation.

Conversion to a Rural Emergency Hospital – Where are the Opportunities?

While inpatient care remains a core business for most larger hospitals and health systems, outpatient services have begun to command an increasing share of strategic attention for rural facilities. With increased reimbursement for outpatient services and the introduction of the Additional Facility Payment (AFP), REH designation presents a financial model to increase community outpatient services while reducing inpatient costs. Rural Health Solutions© believes that two service will predictably increase overall volumes and incremental net revenue.

A. Population Health

REHs will be able to use AFP funds to develop service lines to provide better patient care as measured by quality, safety, and patient experience. Population health programs fulfill these criteria nicely, and can include disease management, cancer and immunization screening, and wellness evaluations. Additional services that can be instituted in these programs include:

- Initial Preventive Physical Examination (IPPE).
- Annual Wellness Visit (AWV).
- Chronic Care Management.
- Transition Care Management.

Resource planning will need to focus on engaging experienced leadership, staffing, and supporting technology/analytics.

B. Augmented Virtual Care Strategies

Resource constraints in rural communities are a common rate-limiting step to providing existing services as well as service line development. Virtual care strategies are very promising options to help maintain or supplement access to health care services in vulnerable rural communities that have difficulties recruiting or retaining an adequate health care work force. Virtual care strategies have the potential to provide improved access to care, better care and outcomes at lower costs, and workforce stability. Successful telehealth programs in rural environment can potentially expand hours of operation for primary care, specialty care services, and behavioral health services. Use of outsourced telehealth programs can increase services and revenues with minimal additional startup costs, thus lowering overall cost of care.

Conclusion

For some rural hospitals, converting to a rural emergency hospital will provide greater financial security while also allowing for better and more innovative community outpatient care. RHS' Rural Emergency Hospital Conversion Assessment offers the opportunity for both the hospital and its community to determine if there is value in pursuing REH conversion. Interested organizations can use RHS to assist them in accelerating their care delivery models to be more successful in their community.

If appropriately planned with supporting virtual and population health programs, many rural healthcare organizations that have traditionally been constrained in patient volume may see rapid increases in their outpatient services and revenues with this initiative.

How Rural Health Solutions© (RHS) Can Help Rural Hospitals Considering Rural Emergency Hospital Designation

With experienced rural health consultants and a full-service strategic advisory consulting team, RHS has a defined approach to work effectively and efficiently to determine the value proposition that REH conversion potentially offers to rural hospitals.

We complete a financial pro forma and conduct a community needs assessment as well as current operations service line assessment. Our evaluations cover the entire organization, from the Hospital Board, community stakeholders, leadership and managers, to the front-line staff. Based on that information, a potential future state is created with desired augmented outpatient service lines. If desired, RHS can create all necessary application requirements for submissions to CMS that meet the regulatory requirements.

Once an organization decides to start a new program, RHS has defined optimization programs for key service lines, programs, and supporting analytics and quality programs for ED, perioperative services, and ambulatory clinics. RHS can provide the necessary telehealth technology, quality programs and supporting analytic systems to augment any desired service line programs. Finally, RHS can provide experienced staff for each of the new service areas and initiate the program while long-term recruitment takes place. Our staffing division can also provide the necessary resources to staff new service lines or provide on-site providers/nursing/hospital team members to support current operations. This approach accelerates the desired strategies implementation and accelerates cash flow growth.

Contact Rural Health Services for more information at info@ruralhealthsol.com or visit our website at www.rhcsol.com.

References

1 Consolidated Appropriations Act of 2021. H.R. 133, § 125. Public Law No: 116-260. December 27, 2020. https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf

2. https://www.definitivehc.com/blog/how-many-hospitals-are-in-the-us#:~:text=Most%20common%20hospital%20types%20by%20number%20of%20facilities,%20%20398%20%205%20more%20rows%20

3. University of North Carolina. Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures

4. Pink GH, et al. How Many Hospitals Might Convert to a Rural Emergency Hospital (REH)? Findings Brief NC Rural Health Research Program. July 2021. https://www.shepscenter.unc.edu/product/howmany-hospitals-might-convert-to-a-rural-emergency-hospital-reh/.

Appendix 1

Requirement for REH Program Participation

The REH Model has certain requirements for program participation.

Hospital Eligibility to Become an REH.

Eligible hospitals include CAHs and hospitals with 50 beds or less that are 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 (MSA), or a hospital with 50 beds or less that is re-classified by CMS as rural.

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, including EMTALA.
4) have a transfer agreement in place with a level I or II trauma center.
5) meet conditions of participation 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.

Application Requirements to Become an REH.

A. 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 additional facility payment will be used, including a description of the services covered.

B. States must approve the licensure of REHs.

Quality Metrics and Evaluation Reports.

Beginning in 2023, in accordance with the CAA, REHs are required to submit data for quality measurement to CMS to be publicly reported on the CMS website. In selecting those measures, the Secretary shall take into consideration ways to account for REHs that lack sufficient case volume to ensure that the performance rates for such measures are dependable.

CMS will conduct evaluations of the impact of REHs on the availability of health care and health outcomes in rural areas after 4, 7, and 10 years of enactment.