

The Rural Emergency Hospital and Value-Based Care August 2021

KEY POINTS

- Rural Emergency Hospital (REH) is a new designation for hospitals that provide emergency and other outpatient services, but no inpatient care services.
- REHs will receive Medicare fee-for-service outpatient payment rates that are five percent higher than acute care prospective payment system (PPS) hospital rates.
- Depending on final rules, the REH additional facility payment could financially support value-based care.
- Anticipated REH proposed rules offer an important opportunity for stakeholder input.

Created by the Consolidated Appropriations Act, 2021, the REH is a new hospital designation to be effective January 1, 2023.¹ An REH will be a rural hospital providing outpatient services (including emergency and observation services), but not providing inpatient care services. An REH may provide skilled nursing facility (SNF) services in a distinct part unit. Medicare REH payment will be primarily fee-for-service rather than value-based. However, REHs may potentially have a role in value-based care by ensuring access to health care, or as a component of a regional health system participating in value-based care models. Conversion from a CAH or rural hospital with less than 50 beds to an REH will require informed hospital and community decision-making.

It is unclear how many rural hospitals will convert to REH status. Using one set of predictors for conversion, researchers at the University of North Carolina estimated that 68 out of 1,673 rural hospitals will consider conversion to REH status. The researchers caution, however, that “because REHs are a new Medicare provider type, the number of rural hospitals that might consider converting to an REH is unknown.”²

The purpose of this Rural Health Value Brief is to summarize the new REH legislation, outline local considerations before REH conversion, and prepare stakeholders to comment when the Centers for Medicare & Medicaid Services (CMS) releases REH proposed rules for public input.

BACKGROUND

Rural Americans expect and deserve timely and high-quality emergency care. In 2018, nearly 25 million rural Americans received emergency department (ED) care.³ The median number of CAH ED visits increased modestly from 1,735 to 2,012 (2010 to 2016).⁴ Despite increased ED visits, the Medicare Payment Advisory Commission (MedPAC) reported that “maintaining emergency access in rural areas is challenging due to declining populations in many rural areas, coupled with a delivery system that is tied to an expensive inpatient delivery model.”⁵ CMS has previously created special hospital demonstrations and designations intended to preserve rural access to hospital and emergency care, including the Medical Assistance Facility demonstration and the Essential Access Community Hospital/Rural Primary

Care Hospital Program. In 1997, the Balanced Budget Act created the CAH designation. Currently, there are 1,353 CAHs operating in 45 states (July 2021).⁶ Despite legislative actions designed to preserve rural hospitals, 181 rural hospitals have closed since 2005.⁷ (University of North Carolina researchers define a hospital closure as facilities no longer providing health care services or facilities no longer providing inpatient care, but continuing to provide some health care services.⁸) In 2017, Senators Grassley, Klobuchar, and Gardner introduced the Rural Emergency Acute Care Hospital (REACH) Act that proposed a rural outpatient-services-only (including emergency services) hospital.⁹ Similar to the proposed REACH Act, the REH legislation seeks to address the persistent rural need for emergency and other outpatient services that might be at risk if hospital closures continue.

LEGISLATION

The REH is a new hospital designation established in Section 125 of the Consolidated Appropriations Act, 2021.¹⁰ The legislation calls for the REH designation to become effective on January 1, 2023. Necessary regulations (e.g., conditions of participation) to implement the REH legislation action have not yet been proposed by CMS. Current CAHs and rural acute care PPS hospitals with fewer than 50 beds will be eligible for REH conversion. An REH may convert back to a CAH or an acute care (PPS) hospital, but it is unclear if hospitals closed in 2021 or 2022 will be able to reopen as an REH.

The legislation established important and often unique REH requirements and limitations.

- REH services must include ED services and observation care, and an REH may choose to provide other outpatient services.
- REHs cannot provide acute care inpatient services.
- An REH ED must be staffed 24 hours a day, 7 days a week by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
- REHs must comply with Emergency Medical Treatment and Labor Act (EMTALA) regulations.
- REHs must have an annual per patient average length of stay of 24 hours or less.
- REHs must have a transfer agreement with a level I or level II trauma center.
- REHs may continue to operate a licensed skilled nursing facility (SNF) as a distinct part unit (DPU).
- For the hospital-based rural health clinic (RHC), REHs may operate as a hospital with less than 50 beds, and thus qualify for the RHC per-visit payment limit exception.
- REHs may serve as a telehealth originating site (i.e., where the patient is located).
- REHs will receive fee-for-service payments for outpatient department (OPD) services plus five percent. Plus, REHs will receive an additional facility payment. See details below. REHs are not paid through CAH cost-based reimbursement or the inpatient PPS.
- Potential REHs must submit an application that lists specific services that will be changed during the conversion to an REH and a description of how the additional facility payment will be used.

Medicare REH payments will be based on the Hospital Outpatient Prospective Payment System plus five percent (added to reflect higher REH costs). Plus, Medicare will provide an additional facility payment (Medicare subsidy amount). The additional facility payment is established by first calculating the difference between all payments to CAHs in 2019 and all payments that would have been made to CAHs in 2023 under the Inpatient Prospective Payment, the Outpatient Prospective Payment, and Skilled Nursing Facility payment systems. The difference is then divided by the total number of CAHs in the country. One twelfth of the resulting amount is paid monthly to REHs. The REH will be required to keep detailed information regarding how the REH uses the additional facility payment. All REHs will receive the same additional facility payment, regardless of REH size or volume. The National Rural Health Association provides the following example.¹¹

- Assume total Medicare cost-based payments to all CAHs in 2019 was \$14 billion.¹²
- Assume the estimated PPS payments for the CAH services would have been \$10 billion.

- There were 1,350 CAHs on July 19, 2019. Assume all are included in the above payments.
- In this example, additional facility payment for each REH in 2023 would be \$2,962,962 (\$14B - \$10B = \$4B/1,350).

The REH legislation requires REH quality reporting but does not specify the quality measures to be used. However, the legislation states that quality measures must be reliable in the case of low volumes and must be publicly reported on the CMS website. The legislation does not link any financial incentives to quality reporting or performance.

REH AND VALUE-BASED CARE

The Rural Health Value team defines *value-based care* (VBC) as health care that lowers overall costs (or cost trajectory) while concurrently providing better care (including clinical quality, patient safety, and patient experience) and/or improving community health and well-being. *Value-based payment* is payment for VBC services independent of service volumes. In contrast, REH payment is based on the OPD services payment schedule and is volume-based. While the new REH payment is primarily fee-for-service, the REH additional facility payment could support value-based care.

Depending on to-be-established CMS regulations and/or the REH application process, the additional facility payment (a fixed monthly payment made to REHs) *could* be value-focused. For example, the application process and REH operation could:

- include a plan to serve community need,
- address social determinants of health to improve community health and wellbeing,
- facilitate local interagency collaboration, and
- measure and address community health in quality improvement plans.

In addition, REHs could provide value in a *regional* health care system that organizes health care to optimize clinical quality, operational efficiency, and patient experience. REHs could:

- help ensure viability of essential local health care services (e.g., emergency, and primary care) ^{13,14} that otherwise could be jeopardized by hospital financial distress,
- sustain timely access to emergency medical services,
- bolster local public health agencies and disaster preparedness,
- support primary care as the foundation of a high-performance rural health care system,¹⁵ and
- maintain a local rural health system presence (even without inpatient care) that provides important benefits including local citizens' sense of safety and security, local jobs, business attraction, and overall community livability; all of which contribute to value.

LOCAL DECISION-MAKING

During the REH conversion consideration, an eligible hospital should complete a comprehensive financial pro forma that compares the financial impact of maintaining current hospital designation versus conversion to an REH. Important financial considerations include service area population change, outpatient service volume change, inpatient services contribution margin, and disruptors that may decrease ED and primary care utilization. That said, the status quo is not risk free, and pro formas should include candid estimations of demographic and payment changes likely to impact future hospital financial viability.

Decisions will also need to be made about physical plant and staff. Discontinuation of inpatient services may require important hospital space repurposing and hospital staff reassignment decisions. Inpatient hospital space and staff might be redirected to community use for health with multiple users (e.g., community-based organizations), skilled nursing facility or other long-term care options, rehabilitation center, wellness center, primary care center, and others.

Since an REH will not provide inpatient services, local emergent and non-emergent medical transportation become that much more critical. Although the REH legislation requires that an REH have in effect a transfer agreement with a level I or level II trauma center, stakeholders should assess local emergency medical services (including ambulance and non-emergent medical transportation modality) availability and develop plans to bolster those services if needed.

Local governing bodies and rural community members may have questions about REH conversion. Like conversion-to-CAH discussions two decades ago, rural communities may be concerned about their hospital being “downsized” or becoming a “Band Aid station.” Therefore, local stakeholders should provide input into the REH-conversion decision. Community dialogues should include current inpatient utilization trends, alternatives to inpatient care, planned medical care transfer services and protocols (emergent and non-emergent), opportunities to strengthen local emergency and primary care services, and risk for hospital closure (and consequent loss of essential local services) if no change is made.

QUESTIONS REGARDING ANTICIPATED PROPOSED RULES

The REH legislation directs the Secretary (of the U.S. Department of Health and Human Services) to establish rules and regulations to operationalize the legislation. Thus, the Secretary will likely publish REH proposed rules and request comment. Several regulatory questions will deserve stakeholder consideration and input. Please see this brief’s addendum referencing the just-released CMS request for information.

Eligibility – Will hospitals closed in 2021 and 2022 be eligible to reopen as REHs? How will changes in rural geographic definition affect REH eligibility?

Application – Will technical assistance (TA) be available for typically under-resourced rural hospitals to prepare financial pro formas, secure transfer agreements, redesign physical space and repurpose staff, convert swing beds to SNF DPU, and facilitate community conversation about REH conversion? What information will be required for the REH application, and will TA be available for application preparation?

OPD Payment – Will sequestration payment reductions be applied to REHs? How will participation in ACOs and other alternative payment models impact REH payment? How will space be shared between REHs and RHCs to determine RHC cost?

Additional Facility Payment – How will 2019 fee-for-service rates be calculated for CAHs? How will swing bed cost-based reimbursement rates be converted to PPS rates? How will REHs be required to use additional facility payment funds?

Quality – What clinical quality and patient safety measures are most appropriate for REHs? Will TA be available to help REHs measure, report, and improve clinical quality and patient safety? Currently, CAHs have TA resources available through the Medicare Rural Hospital Flexibility (Flex) Program, but there are no provisions for similar resources available to REHs. Will community health measures be included in REH quality measure requirements? How quickly will REH quality measures be publicly reported at the facility level?

OPPORTUNITIES TO INFORM REH RULEMAKING

To support incorporation of value-based care principles, and facilitate REH conversion and success, stakeholders may wish to offer their perspective on key REH issues to CMS during the anticipated proposed rule comment period. Issues to consider may include:

- Allowing hospitals closed in 2021 and 2022 to reopen as REHs.

- Reducing regulatory burden through consolidated REH, SNF, rehabilitation unit, and RHC conditions of participation (including licensure, record-keeping, and life-safety codes). State regulatory change may be necessary.
- Providing TA for REH preparatory work (e.g., financial pro forma, transfer agreement, and community discussions), application development, and REH initialization.
- Using additional facility payment funds to support value-based care that demonstrably provides better patient care (clinical quality, patient safety, and patient experiences), improves community health, and/or reduces total cost of care. Consider pay-for-reporting followed by pay-for-performance.
- Encouraging use of the additional facility payment to support and expand essential local services (primary care, emergency medical services, public health, and others).
- Including community engagement and community health requirements in the application process.
- Including a regional health care strategy (e.g., inpatient care, certain outpatient services, and telehealth) in emergent and non-emergent transfer agreements.
- Excluding the additional REH fee-for-service payment (five percent) and the additional facility payment in accountable care organization total Medicare cost calculations.
- Considering how REHs might fit into existing value-based payment models and designing future value-based payment REH models that:
 - Align REH additional facility payment, primary care capitation, and public health funding. Then allow local or regional resource allocation based on local or regional health care needs.
 - Discontinue REH fee-for-service payments and substitute REH global budgets.
 - Add capitated primary care payment (part of total primary care payment)¹⁶ to the REH global budget.

CONCLUSION

The REH is a new rural hospital designation that establishes a new Medicare provider type which provides only emergency department and other outpatient services. While the new REH payment is primarily fee-for-service, REH additional facility payment, application requirements, transfer agreement details, and operational regulations could be designed to support value-based care. It is important for stakeholders to participate in the rule-making process to ensure that REH regulations support rural community health and advance health care value.

ADDENDUM

In late July 2021, as this Rural Health Value Brief was about to be released, CMS issued a Request for Information (RFI) on REHs as part of the Calendar Year (CY) 2022 Outpatient Prospective Payment System/Ambulatory Surgical Center Proposed Rule. The RFI seeks to inform CMS policymaking regarding REHs. CMS requests input on the following issues:

- Type and Scope of Services Offered
- Health and Safety Standards, Including Licensure and Conditions of Participation
- Quality Measurement
- Payment Provisions
- Enrollment Process

The Rural Health Value Team encourages interested parties to consider this brief as they prepare comments for the CMS RFI. CMS will utilize the information captured through the RFI to develop proposed REH regulations. The proposed regulations (with opportunity for comment) should be released in 2022 as part of the CY 2023 Outpatient Prospective Payment System/Ambulatory Surgical Center Proposed Rule.

END NOTES

- ¹ Consolidated Appropriations Act, 2021. § 125. Public Law No: 116-260. December 27, 2020.
- ² Pink GH, et al. How Many Hospitals Might Convert to a Rural Emergency Hospital (REH)? Findings Brief NC Rural Health Research Program. July 2021. Accessed July 26, 2021. <https://www.shepscenter.unc.edu/product/how-many-hospitals-might-convert-to-a-rural-emergency-hospital-reh/>.
- ³ Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project (HCUP). Accessed May 4, 2021. <https://www.hcup-us.ahrq.gov/faststats/NationalTrendsEDServlet>.
- ⁴ Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2018. Accessed May 4, 2021. http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf
- ⁵ Ibid. Page 46.
- ⁶ Flex Monitoring Team. Historical CAH Data. Accessed July 30, 2021. <https://www.flexmonitoring.org/historical-cah-data-0>
- ⁷ University of North Carolina. Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures. Accessed July 30, 2021. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>
- ⁸ Ibid.
- ⁹ Rural Emergency Acute Care Hospital Act. Accessed May 4, 2021. <https://www.grassley.senate.gov/download/reach-act-text>
- ¹⁰ Consolidated Appropriations Act, 2021. § 125. Public Law No: 116-260. December 27, 2020.
- ¹¹ National Rural health Association. Rural Emergency Hospital (REH) Summary. April 15, 2021. Accessed May 4, 2021. <https://www.ruralhealthweb.org>
- ¹² MedPAC estimated Medicare cost-based payments at \$10B to all CAHs in 2015.
- ¹³ Mueller, K.J. and MacKinney, A.C. (2006), Care Across the Continuum: Access to Health Care Services in Rural America. The Journal of Rural Health, 22: 43-49. <https://doi.org/10.1111/j.1748-0361.2006.00010.x>
- ¹⁴ MacKinney, et al. Characteristics & Challenges of Rural Ambulance Agencies. January 2021. Accessed May 28, 2021. <https://rupri.org/2021/02/04/characteristics-challenges-rural-ambulance-agencies/>
- ¹⁵ RUPRI Health Panel. The High Performance Rural Health Care System of the Future. September 2, 2011. Accessed May 28, 2021. <https://rupri.org/2011/09/02/high-performance-rural-health-care-system-future/>
- ¹⁶ Emanuel EJ, Mostashari F, Navathe AS. Designing a Successful Primary Care Physician Capitation Model. JAMA. 2021;325(20):2043–2044. doi:10.1001/jama.2021.5133. Accessed May 31, 2021. <https://jamanetwork.com/journals/jama/fullarticle/2780026>

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