October 2024

Observed Factors Influencing REH Conversion Decisions

Insights from the Rural Emergency Hospital Technical Assistance Center's Financial Modeling Process

by Janice Walters, Tracey Dorff, and Anna Anna

The Rural Emergency Hospital Technical Assistance Center is supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration, US Department of Health and Human Services, Grant #UR347053. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Background

The Rural Emergency Hospital (REH) is a Medicare provider type created by Congress to address the growing concern over rural hospital closures. The goals of this new designation are to provide a means to preserve access to essential services for rural residents and to decrease the likelihood of hospital closures. The Centers for Medicare & Medicaid Services (CMS) establishes regulations for REHs.[i] As of January 2023, Critical Access Hospitals (CAHs) and small rural hospitals with no more than 50 beds that were open as of December 27, 2020, may opt to convert to the REH designation in accordance with the conditions of participation (COPs) outlined in the CY 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Final Rule. The REH is the first Medicare provider type added since Congress created the CAH designation via the Balanced Budget Act of 1997.

The Federal Office of Rural Health Policy (FORHP) was funded by Congress to provide technical assistance to prospective REHs.[ii] To deliver this technical assistance, the Rural Health Redesign Center (RHRC) was awarded a Cooperative Agreement by FORHP to serve as the national REH Technical Assistance Center ('TAC'). Through the TAC, hospitals have access to a range of services including education, financial modeling, application tools, stakeholder engagement and communication toolkits, strategic planning, and more. Support is tailored to the needs of the individual communities and allows for 1:1 education and interaction with other organizations on a similar journey. The services are provided by the TAC at no cost to hospitals. In 2024, the TAC also launched its REH Network, which offers ongoing assistance and peer-to-peer learning experiences to any converted REH nationwide that chooses to participate.

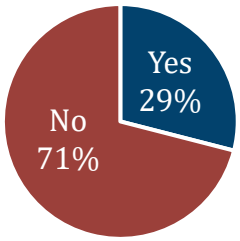
In addition to this technical assistance, FORHP provides funding to support the tracking of state REH policies and licensure by the National Conference of State Legislators (NCSL)[iii] and the National Academy for State Health Policy (NASHP)[iv] and to support the coordination and dissemination of information with the State Offices of Rural Health (SORHs).

Introduction and Overview

As of June 2024, the TAC has conducted comprehensive financial modeling for approximately 60 hospitals to evaluate the potential benefits and challenges of converting to an REH. This modeling includes a customized approach for each organization, taking into consideration the REH alternative funding mechanisms (including fixed facility payment and 5% OPPS fees schedule enhancement), the revenue forfeiture from required service line changes (e.g., inpatient, inpatient swing bed, 340B savings, supplemental payments, etc.) and potential operational cost improvements.

This brief summarizes the key findings from the financial modeling activities and discusses common barriers identified by hospitals considering conversion. While the REH conversion is a viable option for some hospitals, barriers exist for others. This document is not intended to capture all lessons learned associated with the TAC's activities in this context, but rather to identify the common themes of why hospitals have chosen not to advance with REH conversion. The TAC has engaged with over 120 rural hospitals interested in the REH conversion, with roughly 50% of them seeking assistance with financial modeling. At

Figure 1. Percentage Modeled with Favorable Financial Models



the time this report was drafted, roughly 30 hospitals had chosen to advance with conversion, which indicates that this is a viable solution for some rural communities. To build upon the framework that Congress has created to sustain healthcare in rural communities, it is important to understand the following key findings about why it is not a viable solution for others.

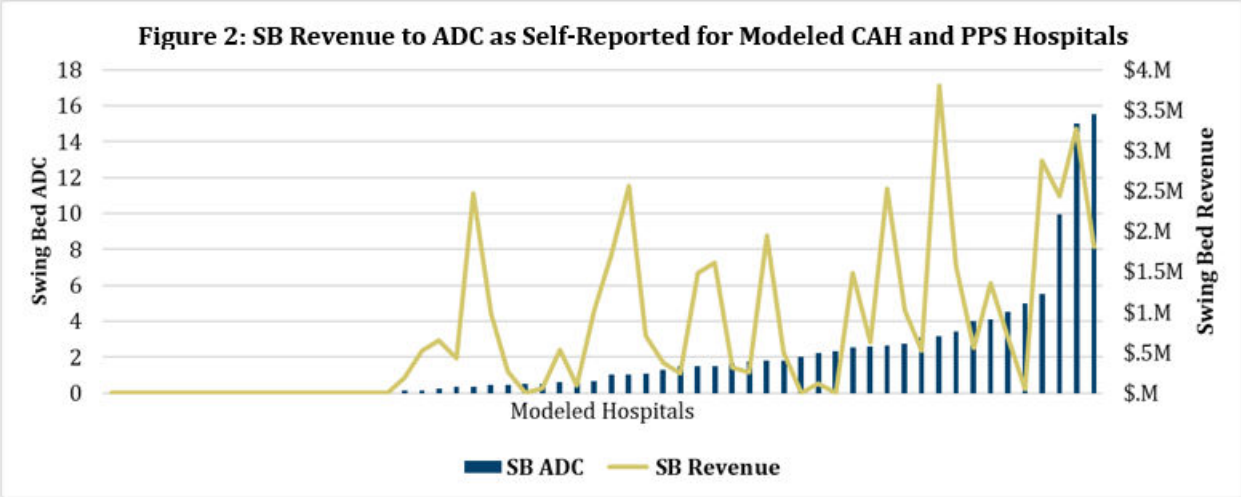
Financial Viability of Conversion

For CAH hospitals supported by the TAC for financial modeling, REH conversion would produce financial benefit for 29% of facilities (see Figure 1). For PPS hospitals, this varied slightly in that the modeling produced favorable results 30% of the time. Roughly 40 of the financial models created were on behalf of CAHs. The majority of those that show a favorable model, both CAH and PPS, have converted or are in the process of converting to a REH. Most conversions involved hospitals or CAHs with low swing bed utilization and minimal 340B program impact, where the fixed facility payment offset the revenue or savings forfeitures.

Average Daily Census (ADC) and Swing Bed (SB) Care

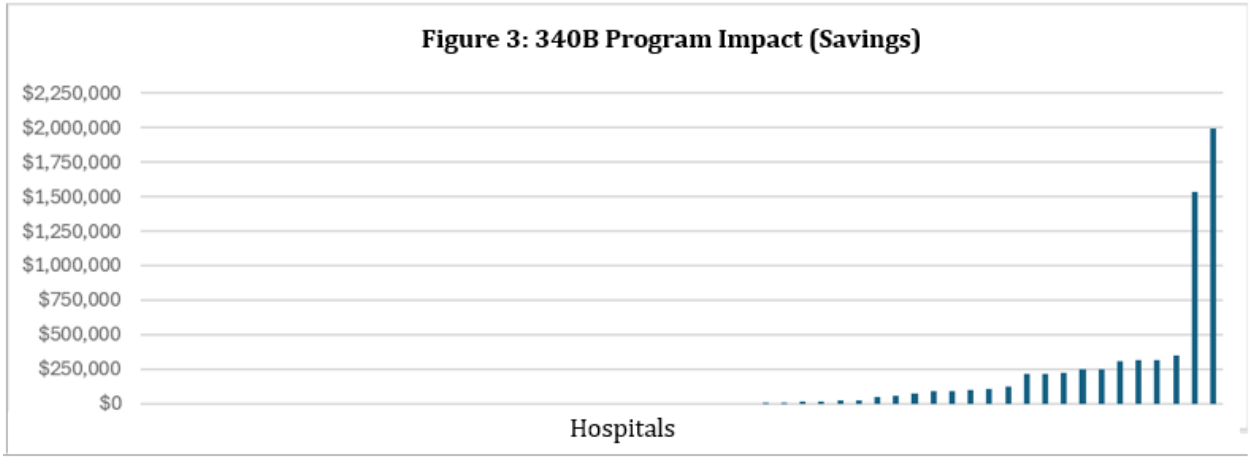
The term "swing bed" (SB) is often a reference to the provision of skilled nursing care within the rural hospital instead of a skilled nursing facility. The flexibility of SB care in rural hospitals allows for skilled nursing care to be provided within the facility, which is typically where the patient receives increased therapy services and fewer acute care services. SB patients no longer qualify for inpatient care due to clinical improvement for the acute condition, yet still qualify for skilled nursing care. The ability to provide SB care in rural hospitals allows patients to receive the lower level of care in the local hospital and rehabilitate close to home.

The average daily census (ADC) for hospitals that received a financial model and provided SB services was 2.71 SB patients per day. This level of service on average generated $1,064,000 of revenue for the rural hospital annually. The high SB revenue, typically provided within the CAH, deterred many hospitals from pursuing conversion as these services were viewed as vital to the community. The inability to provide skilled nursing care has been identified as the most significant barrier to conversion when the hospital is the sole provider of short-term rehabilitation and skilled care for its residents in the local community. While REHs are allowed by statute to operate separate and distinct skilled nursing facilities, meeting these requirements has proved challenging, as described later in this document. Figure 2 identifies the distribution of SB services across modeled hospitals.



340B Drug Pricing Program Impact

Only 47% of modeled hospitals reported any 340B savings. The level of 340B activity within modeled hospitals varied greatly, with only two generating more than $500,000 of benefit (see Figure 3). However, the potential loss of 340B benefit has been a significant consideration for some hospitals, particularly those with established retail pharmacy programs as they receive significant savings in the form of lower drug acquisition costs. This makes REH conversion less attractive for some potential applicants.



Distinct Part Units (DPUs)

The inability to maintain distinct part units (DPUs) like inpatient psychiatric units, rehabilitation units, or detox units poses a substantial barrier to conversion. Having to shed these important services to become an REH has caused some hospitals to postpone the decision to convert with the hope that subsequent statutory changes will allow them to maintain these important services for their communities.

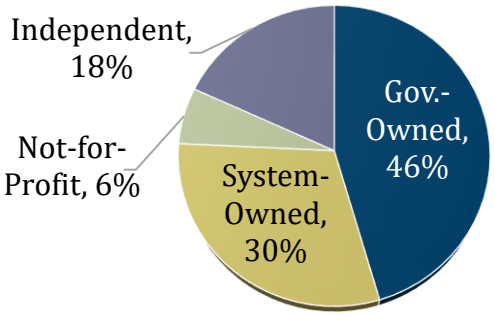
While REHs can operate distinct Skilled Nursing Facilities (SNFs), many small rural hospitals find doing so nearly impossible due to separate conditions of participation (COPs) and staffing requirements. In one instance, a hospital that chose to convert to an REH intended to open a DPU nursing facility as allowed by REH statute. However, due to the

separate COPs and life-safety code requirements for DPUs in comparison to hospital-based units, converting the unit was cost prohibitive for the organization. This issue is compounded by the aging infrastructure in many hospitals considering or pursuing REH conversion. Significant funding would be required to bring old buildings up to current codes in order to meet COP and life-safety code requirements. Allowing the REH to continue to provide skilled nursing care through regulatory flexibilities could make the designation more appealing and allow for the needs of these rural communities to be met.

Necessary Provider (NP) Status of CAHs

Thirty-three CAHs across 18 states that have necessary provider (NP) designations[v] have reached out to the TAC for education and assistance. Most of the CAHs self-reported as being government (county, state) or system owned, as indicated in Figure 4. Many have chosen not to move forward with financial modeling given the inability to convert back due to necessary provider status no longer being available. To convert back to a CAH from an REH, the rural hospital would need to meet all current CAH conditions of participation, which many necessary provider-designated CAHs could not meet. The fear of the inability to revert to cost-based reimbursement if REH does not prove viable has prevented many hospitals from moving forward with trying the REH designation.

Figure 4. Self-Reported Ownership Structure of NP Designated CAHs



Hospital Size

The TAC has encountered a few hospitals that are interested in converting but unable to meet eligibility criteria due to the "less than 50 staffed beds" requirement. These hospitals often perceive themselves to be operating similarly to other REH-qualified facilities in terms of patient volume and service scope. While this has been identified as a potential conversion barrier, it occurs relatively infrequently, and these inquiries tend to come from system-owned or -affiliated rural hospitals.

Conclusion

The TAC's experience indicates that the REH conversion has offered benefits for some rural hospitals. As of the writing of this report, 30 hospitals have adopted the new designation; however, as described here, it is not yet a viable solution for others. Rural health care leaders have expressed concerns that an REH conversion could further limit access to essential care for their communities. If these barriers are addressed, it is conceivable that more eligible rural hospital leaders would pursue the REH designation to sustain the healthcare needs of their communities.

Connect With The TAC

If you are interested in receiving updates and key findings from the TAC, subscribe to our newsletter or visit the RHRC website. To receive support from the TAC, contact us at REHSupport@rhrco.org.

References

[i] CMS. (2023). Rural Emergency Hospitals. https://www.cms.gov/medicare/health-safety-standards/guidance-for-laws-regulations/hospitals/rural-emergency-hospitals

[ii] Section 711 of the Social Security Act (42 U.S.C. 912); Consolidated Appropriations Act, 2022 (P.L. 117-103), Division H, Title II

[iii] NCSL. (2024). Rural Emergency Hospitals. https://www.ncsl.org/health/rural-emergency-hospitals#toc2

[iv] NASHP. (2023). Rural Emergency Hospitals: Legislative and Regulatory Considerations for States. https://nashp.org/rural-emergency-hospitals-legislative-and-regulatory-considerations-for-states

[v] The "Necessary Provider" waiver was tied to a special provision, which allowed a hospital to be deemed a CAH under certain conditions and ended December 31, 2005, as outlined in 42 CFR 485.610(c) and 42 CFR 485.610(d).