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Rural Emergency Hospitals: CMS' New Provider Type Crucial for Survival of Rural America's Hospitals

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In recognition that one in five Americans call a rural community "home,"[1] CMS adopted a new Medicare provider type for a Rural Emergency Hospital (REH) effective January 1, 2023.[2] REH status gives rural hospitals an option to continue treating patients without having to staff and maintain inpatient services, allowing them to focus on emergency care and outpatient services.

So far, 21[3] out of the "389 rural hospitals 'most likely' to consider converting to REH,"[4] have made the switch to REH status. The low turnout may be due in part to the limitations imposed by REH status. For example, unlike typical hospitals, a REH is prohibited from providing inpatient services and is only permitted to furnish outpatient services, emergency services, and observation care.[5] The initial policies further limit the facilities eligible for REH status to only two *current* provider types: by *converting* either a critical access hospital (CAH) or a hospital located in a rural area with no more than 50 beds. Thus, REH status is currently unattainable for new facilities.[6] Fortunately, CMS does permit any facility that converts to a REH to reverse course if such status is not as beneficial as hoped.

Recent Developments

As of June 2024, CMS and Congress are still working to clarify the REH rules.[7] For example, on April 29, 2024, the bipartisan "Rural 340B Access Act of 2024" was introduced in the U.S. House,[8] which seeks to correct an "oversight" made by Congress when it created REHs by including REHs as eligible for the 340B Program.[9]

Currently, REH eligibility is limited to CAHs and certain rural hospitals if they participated in Medicare as of December 27, 2020.[10] To address this limitation, on May 8, 2024, the "Second Chances for Rural Hospitals Act"[11] was introduced in the U.S. House, which along with its Senate counterpart, the "Rural Health Sustainability Act,"[12] would extend the REH eligibility deadline to January 1, 2014. This would allow hospitals that closed between 2014 and 2020 to be eligible for REH

designation. These two pieces of legislation would also amend the definition of "rural" to be defined by the Health Resources and Services Administration (HRSA) Office of Rural Health Policy rather than the Office of Management and Budget (OMB), which has allegedly wrongly categorized rural communities as urban.[13]

Another piece of legislation that is a bit more comprehensive was introduced in the U.S. Senate on May 15, 2024, titled the "Rural Emergency Hospital Improvement Act."[14] This Act would, for example: (i) change the eligibility deadline to January 1, 2015; (ii) allow REHs to maintain or create a unit for inpatient psychiatric care and obstetric care and allow for limited inpatient rehabilitation services; (iii) require additional funding for laboratory services; (iv) clarify REH eligibility for certain grants; and (v) authorize certain Skilled Nursing Facility (SNF) transfers.[15]

General Considerations Before Converting to a REH

Financial Benefits

The main financial benefit of converting a hospital into a REH is that CMS will provide a monthly facility payment, adjusted annually for inflation.[16] Additionally, the hospital will receive payment at a rate of 105% of the Outpatient Prospective Payment System (OPPS) for services that qualify as "REH Services," defined as "emergency services" and "other medical and health services."[17] Services that do not qualify as REH Services include ambulance services, SNF services,[18] laboratory services, diagnostic and radiology services, and outpatient rehabilitation services.

Efficiency and Importance of Inpatient and Skilled Nursing Care

Assessing the efficiency of inpatient care and the needs of the community are important in determining what services sustain the hospital's revenue. The costs of operating inpatient services for some rural hospitals means operating at a loss, and ultimately, impending closure.[19] For example, a rural Georgia hospital was using only 10% of its inpatient beds.[20] Therefore, hospitals considering converting should evaluate whether the burden of offering inpatient services would be justified.

When deciding whether to convert a hospital into a REH, the facility should also consider the importance of its skilled nursing care. If a nursing home is important to the facility's strategy and mission, then inpatient and swing beds likely add a marginal cost, while helping to spread out the overhead. If such is the case, then converting to a REH might not be a good idea.[21]

In addition to removing inpatient and swing bed services, at least one hospital has closed its labor and delivery department because REHs can only provide "low-risk" labor and delivery.[22] Since it did not have enough of these types of patients or reimbursements for inpatients services, it no longer made financial sense to keep the unit open.[23] However, removing these services likely comes with community backlash, so including a public relations firm may be beneficial to appropriately convey and manage communications.

New Opportunities

There are several new opportunities created by REH status that facilities should consider. First, the opportunity to get creative with outpatient services. With the space opened from removing inpatient services and the additional funding, some REHs are (i) offering more clinics, (ii) enhancing outpatient and emergency medical services through the expansion of emergency department and outpatient services capability, (iii) focusing on quicker access to life-saving care, and (iv) streamlining patient transfers.[24]

Second, establishing an REH may create an opportunity to explore new partnerships under the Stark Law flexibility discussed below. REHs need partners to provide advanced services, and every relationship is a chance to create new revenue streams in an attempt to reach financial sustainability and better patient care for our rural communities.

Regulatory Considerations Before Converting to a REH

REH Staffing

REH staffing requirements are different from other hospitals, so a facility's staffing is important to consider when determining whether to convert to a REH. A key attraction to converting to a REH is the potential cost savings due to lower salary expenses. Because REHs provide limited medical services,[25] physicians and advanced care providers may be "on call" and within a certain distance from the facility, resulting in lower costs. CMS also allows nurses, clinical technicians, EMTs, or other auxiliary medical personnel to fulfill the role for 24/7 on-site staffing, also resulting in lower costs.[26]

Services

In addition to the two required categories of care—24-hour emergency services and observational services—REHs may provide outpatient services, including: radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health services.[27] A REH may also own and operate an ambulance service.[28] Additional outpatient services that may be offered include opioid treatment, maternal health care, and outpatient surgery.[29] Like CAHs, a REH may serve as a "telehealth originating site," while providing an optional, more efficient alternative path to certain geographically unavailable specialists or specialty services.[30]

Stark Law Flexibilities

In CMS' REH proposed rule, it proposed to (1) add a new Stark exception for ownership or investment interests in an REH and (2) revise certain existing Stark exceptions concerning compensation arrangements to which an REH is a party.[31] Said exceptions would have broadly permitted physicians to own and invest in REHs.[32] Though CMS did not adopt these exceptions.

To the extent that a REH furnishes Designated Health Services (DHS), which include clinical laboratory, radiology, and certain other ancillary services, along with outpatient prescription drugs, the Stark restrictions would apply to those services. However, "[b]ecause an REH is not considered a hospital under the Stark law and is not one of the other specific types of entities to which the exceptions currently apply,"[33] CMS revised certain exceptions to apply to REHs, including those for (i) physician recruitment, (ii) obstetrical malpractice insurance subsidies, (iii) retention payments in rural and underserved areas, (iv) electronic prescribing items and services, (v) assistance to compensate a non-physician practitioner, and (vi) timeshare arrangements.[34] In general, these exceptions are consistent with those for hospitals, rural health clinics, and federally qualified health centers. CMS further clarified that REHs located in rural areas may be eligible to rely on the rural ownership exception as long as substantially all (not less than 75%) of the DHS it furnishes is to residents of rural areas.[35] As such, any arrangement with a REH should be carefully structured to comply with an applicable Stark exception and with the federal Anti-Kickback Statute (AKS).

Impact on Distinct Part Units

Other than a SNF, a REH cannot operate distinct part units, such as psychiatric units and inpatient rehabilitation units.[36] As such, if a hospital considering converting to a REH operated distinct part units other than SNFs, it will have to consider what it will do with its distinct part units if it in fact converts. For SNFs, "[g]iven that a 3-day prior inpatient care stay is required for beneficiaries to receive Medicare SNF services and an REH visit does not constitute an acute inpatient stay, the REH cannot provide the qualifying staff and therefore the patient's must be transferred to the REH SNF unit from another facility."[37] Moreover, SNF unit services would be paid at the SNF per diem rate.

For inpatient rehabilitation (IRF) units, one option is to transfer the unit to another provider.[38] To do so successfully, however, the unit must remain in compliance with its conditions of participation so that it remains classified as an IRF unit.[39] These conditions require that the hospital in which the IRF is a unit have "at least 10 staffed and maintained hospital beds that are paid under the applicable payment system under which the hospital is paid, or at least 1 staffed and maintained hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater."[40] The IRF unit may also convert to an IRF hospital, but that requires meeting certain "separation tests" to be excluded from the specified prospective payment system. These IRF unit conditions of participation are very similar for psychiatric units.[41] Therefore, if the units cannot be separated from the hospital and/or transferred to a new, appropriate owner, while simultaneously meeting the REH's and unit's conditions of participation, then converting to a REH may not be a viable option.[42]

Important Considerations

Before converting a CAH or rural hospital with fewer than 50 beds into a REH, below are a few initial items to consider:

1. Whether it is financially beneficial to cease inpatient operations, including the impact on revenue from follow-up care.
2. Whether REH status is more beneficial than the previous classification (e.g., CAHs, Rural Hospitals, Medicare-Dependent Hospitals, or Sole Community Hospitals (assuming REH status will become available for other hospital types)).
3. Whether the facility will lose access to other favorable payment policies, such as the 340B Drug pricing program.
4. How non-Medicare payers reimburse REHs.
5. Potential resistance from community and leaders who may be concerned about the loss of inpatient services.
6. What to do with distinct part units, other than SNFs.
7. How to structure arrangements with REHs to avoid implicating the federal Stark and AKS laws.

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[1] *See One in Five Americans Live in Rural Areas*, U.S. Census Bureau, (Aug. 9, 2017), https://www.census.gov/library/stories/2017/08/rural-america.html.

[2] *See* 87 Fed. Reg. 71748 (Nov. 23, 2022); 42 C.F.R. § 419.90, *et seq.* (payment to REHs); 42 C.F.R. § 485.500, *et seq.* (REH conditions of participation). As enacted in the Consolidated Appropriations Act (CAA) of 2021. *See H.R.133, 116th Congress (2019-2020): Consolidated Appropriations Act, 2021*, H.R.133, 116th Cong. (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text; *codified at* 42 U.S.C.A. § 1395x(kkk) (defining REH); 42 U.S.C.A. § 1395m(x) (payment rules for REH).

[3] Cass, Andrew, *The 21 rural emergency hospitals by state*, Becker's Hosp. Rev. (Mar. 26, 2024), https://www.beckershospitalreview.com/finance/the-18-rural-emergency-hospitals-by-state.html.

[4] *Rural Health Safety Net Under Renewed Pressure as Pandemic Fades*, Chartis Study, (Feb. 2023), https://email.chartis.com/hubfs/CCRH/2023%20Policy%20Institute/Chartis%20Study_Rural%20Health%20Safety%20Net%2(hsLang=en.

[5] *See* Gratas, Sofi, *A new federal model for rural hospitals may help them stay open. So far, Georgia has only one*, GBP (updated Sept. 18, 2023) https://www.gpb.org/news/2023/09/15/new-federal-model-for-rural-hospitals-may-help-them-stay-open-so-far-georgia-has ("Irwin County Hospital became REH-designated in March, the first in the state to do so. [] Georgia's Department of Community Health said it hasn't received any more applications from hospitals in the state yet looking to become Rural Emergency Hospitals.") ("According to the Centers for Medicare and Medicaid, eight hospitals in the country are registered as Rural Emergency Hospitals as of this month in Texas, Mississippi, Michigan and Georgia, though hospitals in other states have expressed intentions to switch too. The National Institute of Health estimates over 1,500 hospitals are eligible for the designation."); *CMS Fact Sheet: CY 2023 Medicare Hospital Outpatient Prospective payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1772-FC) Rural Emergency Hospitals —New Medicare Provider Type,* CMS Newsroom (Nov. 1, 2022) [hereinafter *CMS REH Fact Sheet*], https://www.cms.gov./newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-1.

[6] *See* 87 FR 71748, at 71753; 42 U.S.C.A. § 1395x(kkk)(3).

[7] *See Pub. 100-04, Medicare Claims Processing, Transmittal 12321, Change Request 12820* (Oct. 18, 2023), https://www.cms.gov/files/document/r12321cp.pdf ("The purpose of this change request (CR) is to provide the background, policy, and contractor instructions to test and implement the enrollment, billing, and payment for Rural Emergency Hospitals, effective January 1, 2023."); *Pub. 100-04, Medicare Claims Processing, Transmittal 12820, Change Request 12820* (Nov. 17, 2023), https://www.cms.gov/files/document/r12369cp.pdf ("Transmittal 12321 issued October 18, 2023, is being rescinded and replaced by Transmittal 12369, dated November 17, 2023, to revise the policy section, clarifying the REH monthly facility amount and provider reporting period in the policy section."); *Pub. 100-04, Medicare Claims Processing, Transmittal 12373, Change Request 13457* (Nov. 22, 2023), https://www.cms.gov/files/document/r12373cp.pdf (furnishing the annual update to the REH monthly facility payment for calendar year 2024).

[8] H.R. 8144 - 118th Congress (2023-2024): *Rural 340B Access Act of 2024*, H.R. 8144, 118th Cong. (2024), https://www.congress.gov/bill/118th-congress/house-bill/8144.

[9] *Bergman Introduces Bill to Improve Rural Emergency Hospital Designation and Keep Rural ERs Open*, Congressman Jack Bergman, Press Release (Apr. 29, 2024), https://bergman.house.gov/news/documentsingle.aspx?DocumentID=1248.

[10] 42 U.S.C. § 1395x(kkk)(3).

[11] H.R. 8246 - 118th Congress (2023-2024): Second Chances for Rural Hospitals Act, H.R.8246, 118th Cong. (2024), https://www.congress.gov/bill/118th-congress/house-bill/8246/text.

[12] S. 4201 - 118th Congress (2023-2024): *Rural Health Sustainability Act,* S. 4201, 118th Cong. (2024), https://www.congress.gov/bill/118th-congress/senate-bill/4201.

[13] *Hyde-Smith Bill Would Help Restore Emergency Healthcare Services in Rural America: Miss. Senator Introduces 'Rural Health Sustainability Act' to Broaden Rural Emergency Hospital Designation Eligibility to At-Risk or Closed Rural Hospitals*, Senator Cindy Hyde-Smith, Press Release (Apr. 23, 2024), https://www.hydesmith.senate.gov/hyde-smith-bill-would-help-restore-emergency-healthcare-services-rural-america.

[14] *Sen. Moran Introduces Legislation to Help Save Rural Hospitals*, Senator Jerry Moran, Press Release (May 15, 2024), https://www.moran.senate.gov/public/index.cfm/2024/5/sen-moran-introduces-legislation-to-help-save-rural-hospitals#:~:text=The%20Rural%20Emergency%20Hospital%20Improvement%20Act%20would%3A,27%2C%202020. *See also* S. 4322 - 118th Congress (2023-2024): *A bill to amend title XVIII of the Social Security Act to make improvements relating to the designation of rural emergency hospitals*, S. 4322, 118th Cong. (2024), https://www.congress.gov/bill/118th-congress/senate-bill/4322/cosponsors.

[15] *Sen. Moran Introduces Legislation to Help Save Rural Hospitals*, Senator Jerry Moran, Press Release (May 15, 2024), https://www.moran.senate.gov/public/index.cfm/2024/5/sen-moran-introduces-legislation-to-help-save-rural-hospitals#:~:text=The%20Rural%20Emergency%20Hospital%20Improvement%20Act%20would%3A,27%2C%202020.

[16] 42 C.F.R. § 419.92(b). *See* 87 Fed. Reg. 71748, at 72137 ("To estimate the number of facilities that are likely to consider conversion to an REH, one study analyzed 1,673 rural hospitals on three criteria: (1) 3-years negative total margin; (2) average daily census of acute and swing beds being less than three; and (3) net patient revenue less than $20 million."); *Id.* at 72257 ("The reasons why some would convert are presented in the NC RHRP study and include low levels of inpatient revenue, low levels of swing bed nursing care revenue, and negative financial margins over a period of years.").

[17] 42 C.F.R. § 419.92(a).

[18] A SNF may be a distinct part unit of a REH, but it continues to receive payment as an SNF unit. 42 C.F.R. § 419.92(c)(2).

[19] *See* Gratas, *supra* note 5.

[20] *Id.* A hospital administrator in Arkansas converted his hospital to a REH, effective September 1, 2023, stating that: "[o]nly about 5% of our patients were actually inpatient extended stay patients, so for us and other rural facilities, I don't think that people look to rural facilities for their extended stay inpatient care[.] Over the past 12 months, the hospital has had an average daily patient census in the single digits—maybe two or three." My Ly, *Pocahontas hospital set to be first in state to receive new designation for rural hospitals*, Ark. Democrat Gazette (Aug. 28, 2023), https://www.arkansasonline.com/news/2023/aug/28/pocahontas-hospital-set-to-be-first-in-state-to/.

[21] Hospitals that have converted to REH status had to give up inpatient services and swing bed services. *Community Cornerstones: Conversations with Rural Hospitals in America, The Benefits and Challenges of Converting to a Rural Emergency Hospital*, AHA's Rural Podcast Series (June 14, 2023) [hereinafter, AHA REH Podcast], https://www.aha.org/advancing-health-podcast/2023-06-14-benefits-and-challenges-converting-rural-emergency-hospital.

[22] *See Gratas*, *supra* note 5; *AHA REH Podcast*, *supra* note 21.

[23] *See Gratas*, *supra* note 5.

[24] Volkert, Dennis, *Sturgis Hospital receives 'Rural Emergency' designation*, Wilcox Newspapers (Aug. 3, 2023); Frost, Amy, *Sturgis Hospital Achieves Historic Milestone as Michigan's First Rural Emergency Hospital*, Sturgis Hosp. (Aug. 3, 2023), https://sturgishospital.com/sturgis-hospital-achieves-historic-milestone-as-michigans-first-rural-emergency-hospital/.

[25] 42 C.F.R. § 485.528 (REH condition of participation: staffing and staff responsibilities).

[26] *Id.*

[27] *See* 42 C.F.R. § 485.524(a) ("The REH may provide outpatient and medical health diagnostic and therapeutic items and services that are commonly furnished in a physician's office or at another entry point into the health care delivery system that include, but are not limited to, radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health services. If the REH provides outpatient and medical health diagnostic and therapeutic items and services, those items and services must align with the health needs of the community served by the REH.").

[28] 42 C.F.R. § 419.92(c)(1).

[29] *Id.*

[30] 87 Fed. Reg. 71748, at 72147.

[31] *Id.* at 72222.

[32] *Id.*

[33] *Id.* at 72215.

[34] *Id.* at 72254.

[35] *Id.* at 72223.

[36] *See id.* at 71785 ("Pursuant to section 1861(kkk)(2)(B) of the Act, REHs may not provide acute care inpatient hospital services other than post-hospital extended care services furnished by a distinct part unit licensed as a skilled nursing facility. Therefore, REHs are considered to be non-IPPS hospitals."); 42 C.F.R. § 419.92(c).

[37] 87 Fed. Reg. 71748, at 72206.

[38] 42 C.F.R. § 412.29(c)(3).

[39] *Id.*

[40] 42 C.F.R. § 412.25(a)(iii).

[41] 42 C.F.R. § 412.23(a).

[42] 42 C.F.R. § 412.22(e).

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