

Mandated report: Rural emergency hospitals

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Consolidated Appropriations Act, 2021, requires MedPAC to review payments to REHs annually starting in 2024

- Hospitals can convert to REHs beginning in 2023
- Complete claims data are not available for 2023
- For the 2024 mandated report, we will provide context about the REH program and characteristics of REHs
- Future reports will include data on payments

Mandate: “Each report submitted by the Medicare Payment Advisory Commission under section 1805(b)(1)(C) of the Social Security Act (42 U.S.C. 1395b–6(b)(1)(C)) (beginning with 2024), shall include a review of payments to rural emergency hospitals under section 1834(x), as added by subsection (a).”

Note: REH (rural emergency hospital).

Presentation outline

- 1 Background on Medicare support for rural hospitals
- 2 Declining admissions
- 3 Rural hospital closures
- 4 How the rural emergency hospital (REH) program works
- 5 REH data and site visits

History of inpatient-centric rural hospital special payments

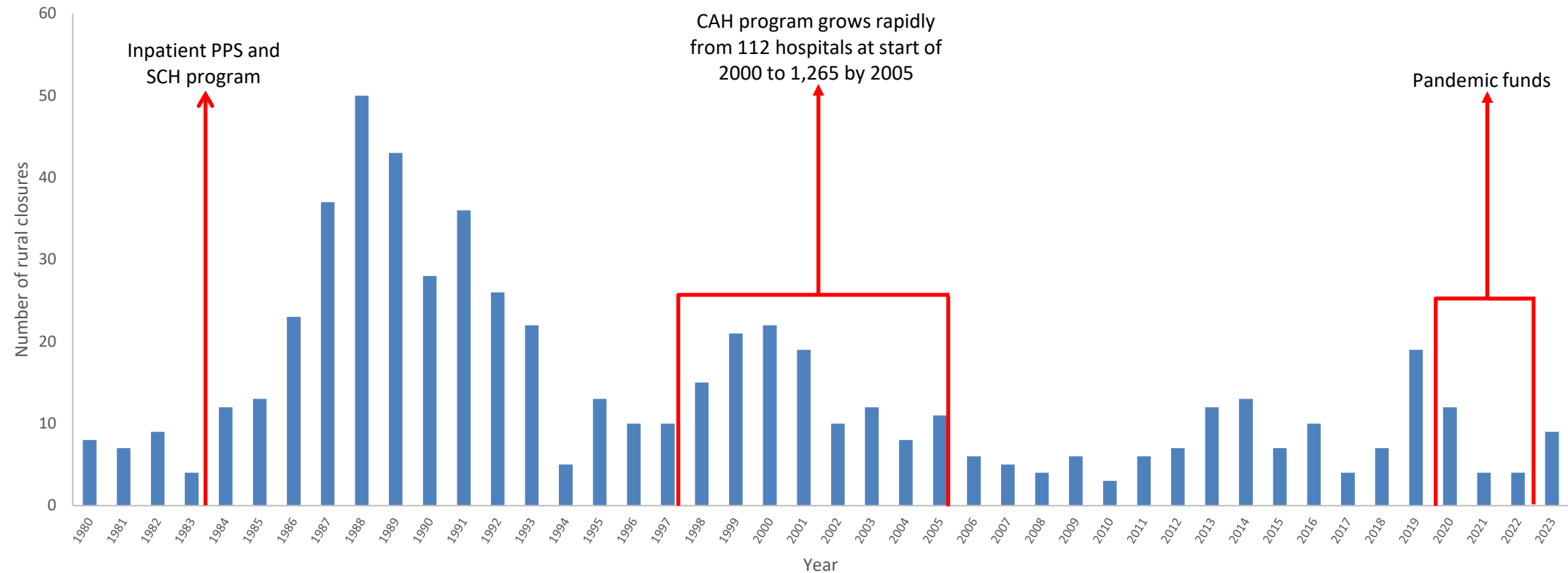
- Higher Medicare rates for inpatient care
 - Rates based on historic costs adjusted for inflation (SCHs and MDHs)
 - Rates based on current costs (CAHs)
 - Up to a 25 percent add-on to inpatient rates (LVHs)
 - SCHs and MDHs can receive the LVH add-on to their adjusted historic costs
 - 95 percent of rural hospitals are SCHs, MDHs, CAHs, or LVHs
- Higher Medicare rates for outpatient care
 - CAHs
 - SCHs (7.1% higher)
 - Only receive higher outpatient rates if they maintain inpatient services

Note: SCH (sole community hospital), MDH (Medicare-dependent hospital), CAH (critical access hospital), LVH (low-volume hospital).

Declining inpatient volumes have undermined Medicare's inpatient-centric payment policies

- Admissions per beneficiary declined by about 45% from 1983 to 2021
- Rural share of admissions has been declining as patients bypass rural hospitals
- The smallest rural hospitals had an average daily census of less than three patients in 2022 (including observation and post-acute swing-bed patients)
- Low volumes led to high costs per case (\$2,400/post-acute day)
- Declining volumes can lead to closures
- Hospitals that closed between 2015 and 2019 had a 54% decline in admissions in the decade prior to closure

Rural hospital closures' relationship to payment policies



Note: PPS (prospective payment system), SCH (sole community hospital), MDH (Medicare-dependent hospital), CAH (critical access hospital), LVH (low-volume hospital).
Source: MedPAC analysis of hospitals participating in Medicare and past reports by the Office of Inspector General and the Government Accountability Office.

Converting to a rural emergency hospital

- Hospitals can apply to convert beginning in 2023
- Hospitals eligible to convert are those that, as of December 27, 2020, were either:
 - CAHs or
 - PPS hospitals with 50 or fewer beds in a rural area
- Converting to an REH is voluntary
 - Can convert back to a full-service hospital
 - CAHs seeking to convert back must meet distance requirements

Note: CAH (critical access hospital), PPS (prospective payment system), REH (rural emergency hospital). REHs must also meet other requirements not listed on this slide.

Services furnished by rural emergency hospitals

- REHs cannot maintain
 - Acute inpatient beds
 - Swing beds
- REHs must have an ED staffed 24/7 and offer hospital observation care services
- REHs have the option to furnish other services
 - Distinct part SNF services
 - Other outpatient care
- REHs must maintain an average LOS of 24 hours or less
- REHs must have a transfer agreement with a Level I or II trauma center

Note: REH (rural emergency hospital), ED (emergency department), SNF (skilled nursing facility), LOS (length of stay).

Rural emergency hospitals are paid using a mix of fixed payments and FFS payments

1

REHs receive fixed monthly payments from Medicare

- In 2023, fixed payments per REH of \$3.2 million annually
- Increases annually based on hospital market basket growth
- Can be used flexibly based on local needs

2

REHs receive 105 percent of OPPS rates for all OPPS services

- Services include emergency department visits, observation, and other OPPS services (e.g., clinic visits)

3

REHs receive standard rates for other services

- Skilled nursing services paid at SNF PPS rates
- Lab tests paid under the clinical laboratory fee schedule
- RHCs maintain their provider-based payment rates

Beneficiary outpatient cost sharing will decrease substantially if an REH used to be a CAH

Note: FFS (fee-for-service), REH (rural emergency hospital), OPPS (outpatient prospective payment system), SNF (skilled nursing facility), RHC (rural health clinic). Fixed monthly payments total \$3.2 million annually after adjusting for sequestration.

Before converting to REHs, hospitals often furnished a low volume of inpatient care and were located near another hospital

- As of mid-October, 17 hospitals have converted to REHs
- Prior to converting, hospitals often furnished a low and declining volume of inpatient care
 - From 2011 to 2021, average total (all-payer) inpatient admissions declined 57 percent
 - In 2021, averaged less than 1 total (all-payer) inpatient admission per day
- All but 1 REH is located less than 35 miles from next nearest general acute care hospital
- Findings suggest the new REH designation is aligned with the shift away from inpatient care that already happened in rural communities

Notes: REH (rural emergency hospital).

Additional characteristics of 17 hospitals before converting to REHs



HOPD services were declining but at a slower rate than inpatient services

- From 2012 to 2022, FFS outpatient volume declined at ~1/2 the rate of FFS inpatient volume
- Six hospitals had flat or increasing FFS outpatient volume
- In 2022, hospitals averaged 12 FFS outpatient visits per day



Special payments from FFS Medicare

- All but 1 received special payments
- 5 CAHs were paid based on their costs
- 12 PPS hospitals
 - 5 LVH + SCH
 - 3 LVH + MDH
 - 3 LVH
 - 1 no special payment designation



Most hospitals were under significant financial pressure

- Financial pressure persisted despite special payments from FFS Medicare
- Prior to converting, median total (all-payer) profit margin was -13 percent in 2022

Note: REH (rural emergency hospital), HOPD (hospital outpatient department), FFS (fee-for-service), CAH (critical access hospital), LVH (low-volume hospital), SCH (sole community hospital), MDH (Medicare-dependent hospital). Due to data limitations, outpatient volume figures do not include Medicare Advantage, Medicaid, or commercially insured patients or patients without insurance.

Takeaways from REH interviews and site visits

- Hospitals' representatives said their facilities would have closed without the option to convert to an REH
- All the hospitals had or planned to reduce nurse staffing costs (e.g., reduce use of contract nurses)
- Hospitals' plans to use fixed monthly payments varied substantially across communities
- Communities' most prominent concern was the loss of inpatient services

Notes: REH (rural emergency hospital).

Reasons that hospitals closed rather than converted to REHs

- We identified eight rural hospital closures in fiscal year 2023
- Three had more than 50 beds and were therefore not eligible to convert to an REH
 - Two are planning to reopen
- Two closed but are exploring reopening as REHs
- One converted to a 24/7 ED with outpatient department, but state regulations were not in place to become an REH
- One converted to an outpatient department of a neighboring hospital
- One was two miles from another CAH

Notes: REH (rural emergency hospital), CAH (critical access hospital).

Next steps and discussion

Next steps

- Include today's materials in the March 2024 report to the Congress
- Analyze REH payments for the March 2025 report to the Congress
- Continue to monitor the development of the new REH designation

Discussion

- Questions about the work presented
- Are there additional REH analyses you would like to see in future?

Note: REH (rural emergency hospital).

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