Rural Hospital Closures and an Overview of the Rural Emergency Hospital (REH)

George H Pink PhD

G Mark Holmes PhD

North Carolina General Assembly

Access to Healthcare and Medicaid Expansion Committee

February 18, 2022

This presentation uses funded by Federal Office of Rural Health Policy, Award #U1GRH03714

Summary

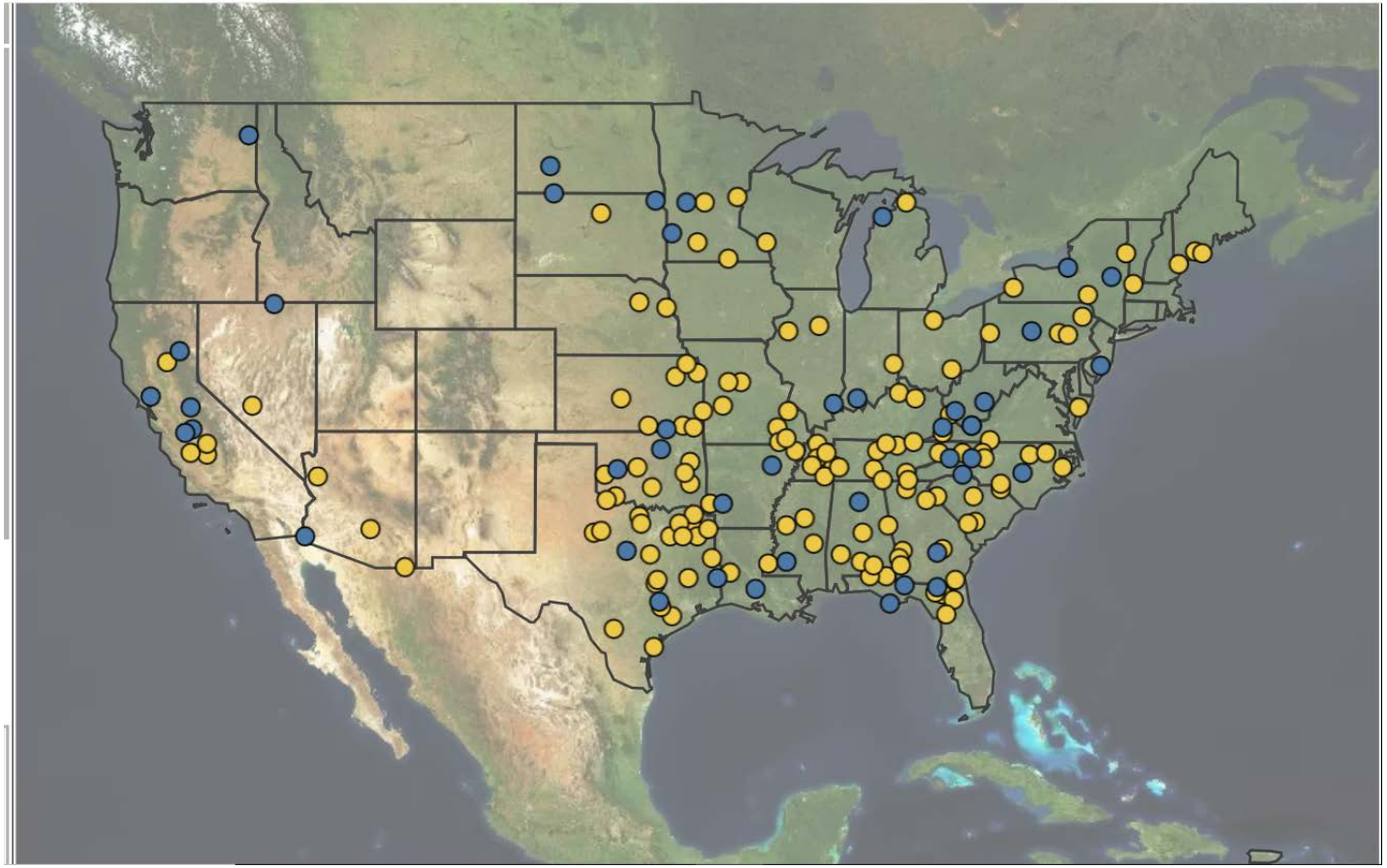
- Dx: Rural hospital closures are a problem
  - 11 rural hospitals have closed in NC since January 2005
  - Patients in affected communities are probably traveling between 5 and 30 or more miles to access inpatient care
  - Closures could resume after covid funding is gone
- RX: Rural Emergency Hospitals may be a solution
  - Need for a new model of rural health care
  - CMS is currently in rule-making mode
  - REH could be a viable model for some NC communities
  - Legislative action would be required

Rural Hospital Closures

Definitions

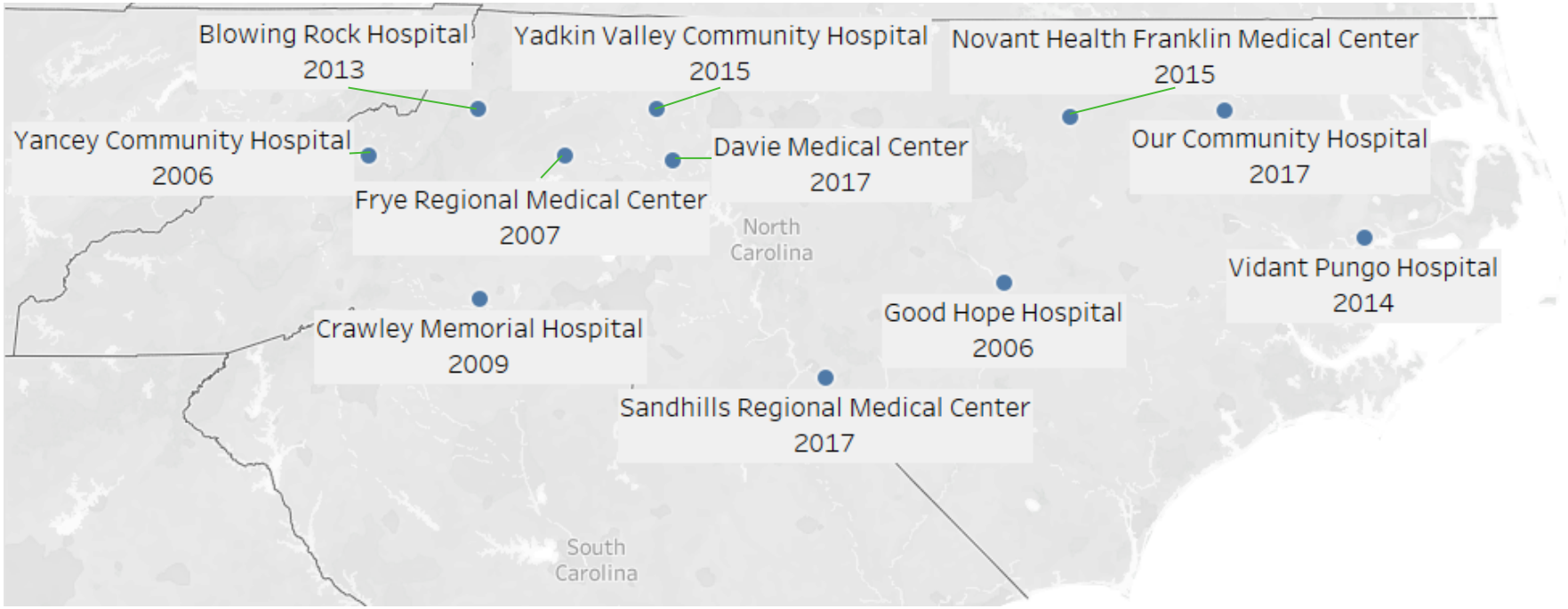
- ***What is a rural hospital?*** Any short-term, general acute, non-federal hospital that is a) not located in a metropolitan county OR b) is located in a RUCA type 4 or higher OR c. is a Critical Access Hospital.
- ***What is a closed hospital?*** *A facility that stopped providing general, short-term, acute inpatient care.*
- ***Are there different types of closures?*** A *complete closure* is a facility that no longer provides health services. A *converted closure* is a facility that closed its inpatient unit but continues to provide other health services, like emergency, rehabilitation, and/or outpatient services, at the same physical location.
- ***Do closed hospitals reopen?*** Sometimes a hospital closes but reopens in another location. We make a judgment as to whether access to inpatient services in the rural community was considerably affected by the move. A move across town or outside city limits would generally not be considered a “closure”; reopening in a community 10-15 miles away, however, likely would.

181 Rural Hospital Closures since January 2005



NC RHRP
NC Rural Health Research Program

11 Rural Hospital Closures in NC since January 2005



There may be other rural hospitals that you think have closed; they do not meet our definition of "rural" and/or "closed"

NC RHRP
NC Rural Health Research Program

11 rural hospitals in NC have closed since 2005

Hospital	City	# of Beds	Year
Mission Family Health Center (Yancey Comm Med Ctr)	Burnsville	6	2006
Good Hope Hospital	Erwin	43	2006
Frye Regional Medical Center Alexander Campus	Taylorsville	23	2007
Crawley Memorial Hospital	Boiling Springs	60	2009
Blowing Rock Hospital	Blowing Rock	25	2013
Vidant Pungo Hospital	Belhaven	25	2014
Yadkin Valley Community Hospital	Yadkinville	15	2015
Novant Health Franklin Medical Center	Louisburg	70	2015
Sandhills Regional Med Ctr	Hamlet	64	2017
Our Community Hospital	Scotland Neck	20	2017
Davie Medical Center – Mocksville	Mocksville	10	2017

Why did they close? (As reported by news media)

Market Factors

- Small or declining populations
- High unemployment (as high as 18%)
- High or increasing uninsured patients
- High proportion of Medicare and Medicaid patients
- Competition in close proximity

Hospital Factors

- Low daily census
- Lack of consistent physician coverage
- Deteriorating facility
- Fraud, patient safety concerns, and poor management

Financial Factors

- High and increasing charity care and bad debt
- Severely in debt
- Insufficient cash-flow to cover current liabilities
- Negative profit margin

The operating reality of rural hospitals

Market

- Market structure: competitors are larger, more complex, and far
- Population served: smaller numbers and more who are older, sicker, lower income, unemployed, un- and -underinsured

Hospital

- Workforce: recruitment and retention; impacts service mix and profitability (eg surgery)
- Technology: lower access to capital => less IT (e.g. EHR); broadband

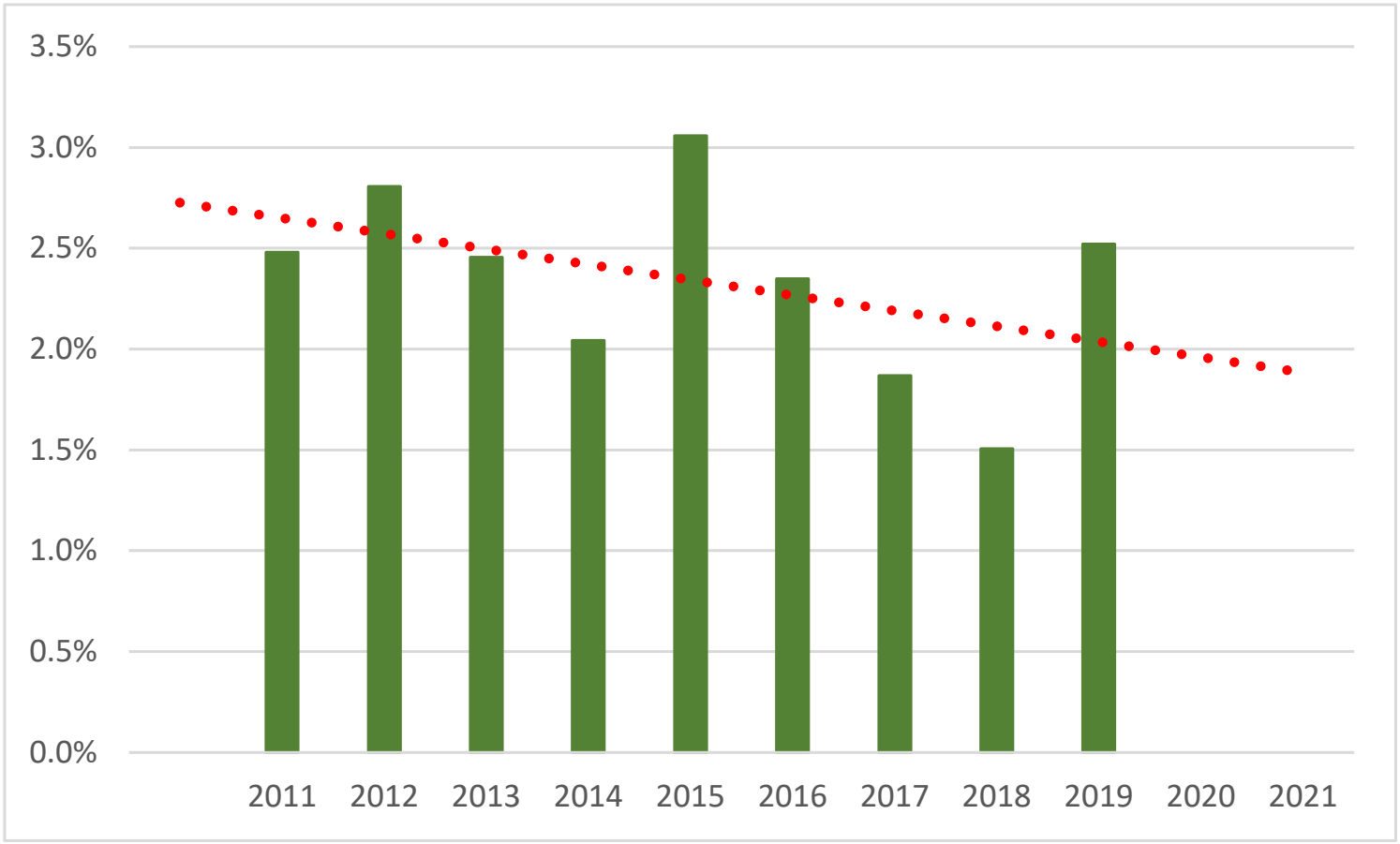
Financial

- Low volumes: more vulnerable to variation (loss of one doc)
- Payer mix: greater proportion of Medicare, Medicaid, and self-pay
- Service mix: lower complexity, primarily outpatient

Community consequences of closure

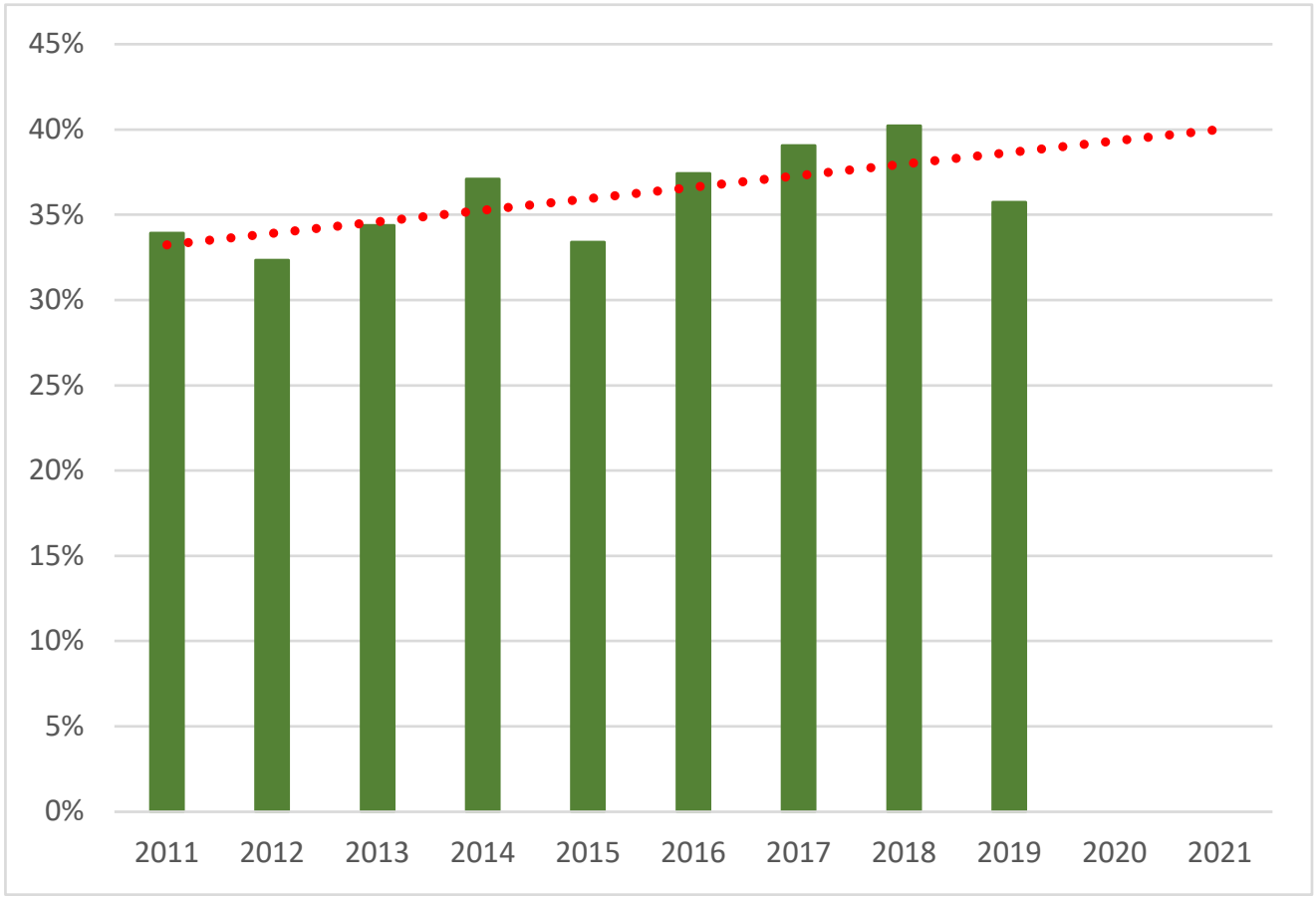
- Access to health care:
  - Loss of local access to emergency and inpatient care
  - Loss of providers that depend on acute care hospital
  - Loss of other local health services
- Direct costs:
  - Loss of jobs from large or largest employer in town
  - Loss of taxes paid by hospital and employees
  - Loss of jobs and tax revenue if businesses leave
- Indirect costs:
  - Increased travel costs for poor, elderly, disabled, and other patients
  - Increased cost of attracting teachers and other public sector workers

The median total margin of U.S. rural hospitals has fallen 2011-2019



NC RHRP
NC Rural Health Research Program

The percentage of U.S. rural hospitals with a negative total margin has increased 2011-2019



NC RHRP
NC Rural Health Research Program

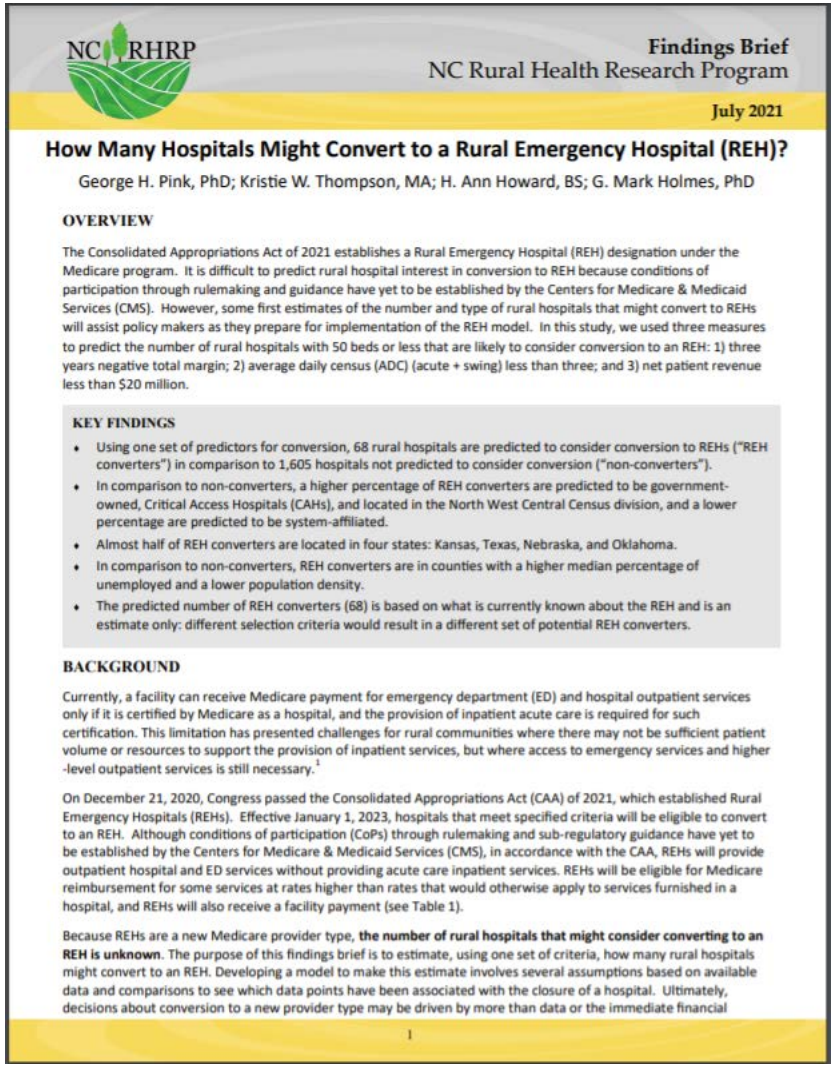
Rural hospital closures: Summary for U.S.

- 138 rural hospitals have closed since January 2010
- Most were in the South and in states that have not expanded Medicaid
- A higher proportion are complete versus converted closures
- Only 10 have closed and reopened as acute care hospitals
- Most are CAHs and PPS hospitals and < 50 beds
- Patients in affected communities are probably traveling between 5 and 30 or more miles to access inpatient care
- Closures dropped in 2021 because covid funding was probably a lifeline. Likely resume after covid funding is gone.

Rural hospital closures: Summary for NC

- 11 rural hospitals have closed since January 2005
- 7 are complete and 4 are converted closures
- 6 are CAHs, 4 are PPS hospitals, 1 is MDH
- 8 are < 50 beds and 3 > 50 beds
- Patients in affected communities are probably traveling between 5 and 30 or more miles to access inpatient care
- No closures since 2017 perhaps because of:
  - NC Rural Health Care Stabilization Fund
  - Health system acquisition and financial support of rural hospitals
  - Provider Relief Funds and Paycheck Protection Program
- Closures could resume after covid funding is gone

Overview of the Rural Emergency Hospital (REH)



NC RHRP

Findings Brief
NC Rural Health Research Program

July 2021

How Many Hospitals Might Convert to a Rural Emergency Hospital (REH)?

George H. Pink, PhD; Kristie W. Thompson, MA; H. Ann Howard, BS; G. Mark Holmes, PhD

OVERVIEW

The Consolidated Appropriations Act of 2021 establishes a Rural Emergency Hospital (REH) designation under the Medicare program. It is difficult to predict rural hospital interest in conversion to REH because conditions of participation through rulemaking and guidance have yet to be established by the Centers for Medicare & Medicaid Services (CMS). However, some first estimates of the number and type of rural hospitals that might convert to REHs will assist policy makers as they prepare for implementation of the REH model. In this study, we used three measures to predict the number of rural hospitals with 50 beds or less that are likely to consider conversion to an REH: 1) three years negative total margin; 2) average daily census (ADC) (acute + swing) less than three; and 3) net patient revenue less than $20 million.

KEY FINDINGS

- Using one set of predictors for conversion, 68 rural hospitals are predicted to consider conversion to REHs ("REH converters") in comparison to 1,605 hospitals not predicted to consider conversion ("non-converters").
- In comparison to non-converters, a higher percentage of REH converters are predicted to be government-owned, Critical Access Hospitals (CAHs), and located in the North West Central Census division, and a lower percentage are predicted to be system-affiliated.
- Almost half of REH converters are located in four states: Kansas, Texas, Nebraska, and Oklahoma.
- In comparison to non-converters, REH converters are in counties with a higher median percentage of unemployed and a lower population density.
- The predicted number of REH converters (68) is based on what is currently known about the REH and is an estimate only: different selection criteria would result in a different set of potential REH converters.

BACKGROUND

Currently, a facility can receive Medicare payment for emergency department (ED) and hospital outpatient services only if it is certified by Medicare as a hospital, and the provision of inpatient acute care is required for such certification. This limitation has presented challenges for rural communities where there may not be sufficient patient volume or resources to support the provision of inpatient services, but where access to emergency services and higher -level outpatient services is still necessary.[1]

On December 21, 2020, Congress passed the Consolidated Appropriations Act (CAA) of 2021, which established Rural Emergency Hospitals (REHs). Effective January 1, 2023, hospitals that meet specified criteria will be eligible to convert to an REH. Although conditions of participation (CoPs) through rulemaking and sub-regulatory guidance have yet to be established by the Centers for Medicare & Medicaid Services (CMS), in accordance with the CAA, REHs will provide outpatient hospital and ED services without providing acute care inpatient services. REHs will be eligible for Medicare reimbursement for some services at rates higher than rates that would otherwise apply to services furnished in a hospital, and REHs will also receive a facility payment (see Table 1).

Because REHs are a new Medicare provider type, **the number of rural hospitals that might consider converting to an REH is unknown**. The purpose of this findings brief is to estimate, using one set of criteria, how many rural hospitals might convert to an REH. Developing a model to make this estimate involves several assumptions based on available data and comparisons to see which data points have been associated with the closure of a hospital. Ultimately, decisions about conversion to a new provider type may be driven by more than data or the immediate financial

1

NC RHRP
NC Rural Health Research Program

Need for a new model of rural healthcare

- Rural hospital closures
  - 137 closures since 2010
  - 180 closures since 2005
- Declining inpatient utilization
  - In a soon-to-be-released study, we found the average percent of revenue coming from outpatient services increased from 66.5% in 2011 to 74.2% in 2019.
- Access to emergency services
  - *JAMA Network Open*, November 19, 2021. Association of Rural and Critical Access Hospital Status With Patient Outcomes After Emergency Department Visits Among Medicare Beneficiaries, Margaret Greenwood-Ericksen, MD, MS et al,. http://dx.doi.org/10.1001/jamanetworkopen.2021.34980

NC RHRP
NC Rural Health Research Program

Legislative Origin of REH

- The Consolidated Appropriations Act 2021 creates a new facility called a “rural emergency hospital” (REH) that is defined as a facility that provides:
  - emergency department (ED) care
  - observation care
  - outpatient services
  - optional skilled nursing facility (SNF) care in a distinct part unit
- REHs do not provide inpatient care
- REH can be an originating telehealth site

NC RHRP
NC Rural Health Research Program

REH Eligibility and Application

- Hospital eligibility to become a REH
  - Critical Access Hospitals (CAHs) and rural hospitals with 50 beds or less
  - Operating as of December 2020
- Application to become a REH
  - an action plan for initiating REH services
  - a list of services that will be provided on an outpatient basis
  - information about how the additional facility payment will be used
  - State approval of REH licensure (note! – needs leg. action)

REH Requirements

- Must not exceed an annual per patient average of 24 hours;
- Must be staffed 24 hours a day, 7 days a week by a physician, nurse practitioner, clinical nurse specialist, or physician assistant;
- Must meet the Medicare licensure requirements and staffing responsibilities of an ED;
- Must have a transfer agreement in place with a level I or II trauma center;
- Must meet conditions of participation applicable to CAH emergency services and hospital EDs;

REH Medicare Payment

Type of payment	Method Used to Calculate Funding
Monthly additional facility payments	Calculated as 1/12th of the excess of (if there is any): the total amount that was paid for Medicare beneficiaries to all CAHs in 2019; minus the estimated total amount that would have been paid for Medicare beneficiaries to all CAHs in 2019 if payment had been made for inpatient hospital, outpatient hospital, and SNF services under the applicable PPS; divided by the total number of CAHs in 2019
Outpatient	Current OPPS X 1.05
Outpatient copayment	Based on current OPPS
SNF DPU	Current SNF PPS
Ambulance	Current ambulance fee schedule
Rural Health Clinic	Same rate as <50 bed hospital (payment limit exception)

Some open questions about REHs

- How many hospitals might convert to a REH?
- What will be the amount of the monthly additional facility payments?
- Other questions:
  - REH eligibility / Conditions of Participation?
  - How will REHs affect EMS?
  - Will effective transfer agreements be established?
  - Will REH staffing be available?
  - What quality metrics will be used and reported?

REH Summary for U.S.

- REH could be an important step for preserving access to emergency and outpatient services in rural areas, particularly in communities that face the risk of rural hospital closures.
  - Some worry that this may provide coverage for large systems to close inpatient services
- Details about the requirements for operating as an REH remain subject to future rulemaking and guidance.
- It will be important for CMS to engage with interested hospitals to ensure that the REH regulations and guidance facilitate adoption and implementation of REHs to serve the healthcare needs of rural communities.

REH Summary for NC

- REH could be a viable model for some NC communities. Which ones?
  - Will the community accept a REH?
  - Is the hospital business primarily outpatient?
  - Is the ED a major access point for healthcare?
  - Is there an adequate pipeline of healthcare professionals?
  - What is the financial position of the hospital?
  - What are specific community needs, such as behavioral health?
  - Can the community and local government support the hospital?
  - Is there telemedicine adaptability– digital access to services?

Possible NC legislative actions re REHs

- REHs will require a statute recognizing and licensing them as a health care facility. Kansas has already passed a law: (http://www.kslegislature.org/li/b2021_22/measures/documents/hb2261_00_0000.pdf)
- REH payment for Medicaid patients
- Capital for REH construction / facility renovation
- Technical assistance to hospitals / communities interested in conversion to REH

NC RHRP
NC Rural Health Research Program

North Carolina Rural Health Research Program

Location:

Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
Website: http://www.shepscenter.unc.edu/programs-projects/rural-health/
Email: ncrural@unc.edu

Colleagues:

Mark Holmes
Ann Howard
George Pink
Kristie Thompson
Kristin Reiter
Julie Perry
Susie Gurzenda

NC RHRP
NC Rural Health Research Program

Resources

North Carolina Rural Health Research Program
http://www.shepscenter.unc.edu/programs-projects/rural-health/

Rural Health Research Gateway
www.ruralhealthresearch.org

Rural Health Information Hub (RHIhub)
https://www.ruralhealthinfo.org/

National Rural Health Association
www.ruralhealthweb.org

National Organization of State Offices of Rural Health
www.nosorh.org

NC RHRP
NC Rural Health Research Program

Rural Health Research Gateway

The Rural Health Research Alert email provides periodic updates when new publications become available. Alerts are available by email and posted on our Facebook and Twitter accounts.

Recent Updates

- **May 22, 2020**
  County-Level 14-Day COVID-19 Case Trajectories
  New Research Product
- **May 18, 2020**
  Estimated Reduction in CAH Profitability from Loss of Cost-Based Reimbursement for Swing Beds
  New Research Product
- **May 14, 2020**
  Rural-Urban Residence and Mortality Among Three Cohorts of U.S. Adults
  New Research Product
- **May 13, 2020**
  Most Rural Hospitals Have Little Cash Going into COVID
  New Research Product
- **May 12, 2020**
  Characteristics of Counties with the Highest Proportion of the Oldest Old
  New Research Product

ruralhealthresearch.org/alerts

Connect with us

info@ruralhealthresearch.org

facebook.com/RHRGateway

twitter.com/rhrgateway

For more than 30 years, the Rural Health Research Centers have been conducting policy-relevant research on healthcare in rural areas and *providing a voice for rural communities in the policy process.*

Rural Health Research Gateway

The Rural Health Research Gateway ensures this research lands in the hands of our rural leaders.

ruralhealthresearch.org

Connect with us

info@ruralhealthresearch.org
facebook.com/RHRGateway
twitter.com/rhrgateway

Funded by the Federal Office of Rural Health Policy, Health Resources & Services Administration.