

Rural Emergency Hospital Designation: What You Need to Know

The rural emergency hospital (REH) model is a Medicare provider designation created to preserve essential health care access in rural communities where inpatient volume and reimbursement struggle to support full hospital operations. It allows eligible critical access hospitals (CAHs) and small rural hospitals to convert their licensure to focus on 24-hour emergency care and certain outpatient services. In exchange for capping the annual average patient length of stay at 24 hours and complying with other program requirements, the REH model provides facilities with a fixed monthly financial subsidy and a 5% increase in Medicare outpatient payments.

Criteria to Qualify as an REH:

- **Status:** Must be a rural area facility licensed as a CAH or rural outpatient prospective payment system (OPPS) hospital as of Dec. 27, 2020, with fewer than 50 beds.
- **Inpatient Restrictions:** Must not provide acute inpatient care. The annual average length of stay per patient must not exceed 24 hours.
- **Required Services:** Must provide 24-hour emergency services, observation care, outpatient procedures, laboratory services, diagnostic radiologic services, and pharmaceutical services.
- **Transfer Agreements:** Must have an established transfer agreement with a Level I or Level II trauma center.

Key Considerations for REH Conversion

The decision to become designated as an REH involves weighing fixed monthly payments against the loss of inpatient revenue streams and specific grant funding and supplemental payment opportunities. Below are the pros and cons of converting to an REH.

MEDICARE PAYMENT

Anticipated pros: Fixed subsidies: **\$3.5 million annually** (~\$295k/month), plus a **5% add-on** for Medicare outpatient services.

Anticipated cons: Lower outpatient reimbursement rates: The 105% OPPS rate is often lower than the 101% of cost reimbursement CAHs currently receive.

DISPROPORTIONATE SHARE HOSPITAL (DSH)

Anticipated pros: N/A

Anticipated cons: Ineligible for DSH funds: Since DSH is an inpatient adjustment for hospitals determined by the percentage of inpatient days provided to low-income patients, by changing provider type and no longer maintaining inpatient services, REHs would generally not be eligible for Medicare and Medicaid DSH funds.

MEDICAID SUPPLEMENTAL

Anticipated pros: N/A

Anticipated cons: Loss of Medicaid supplemental payments: Transitioning to REH status eliminates the ability to earn supplemental payments based on inpatient utilization because REHs cannot have inpatient beds. By changing provider type, it may also make REHs ineligible for most hospital-based Medi-Cal supplemental payment programs (including managed care directed payments).

FLEX FUNDING

Anticipated pros: N/A

Anticipated cons: Ineligible for FLEX: REHs are not eligible for the Medicare Rural Hospital Flexibility (FLEX) Grant program available to CAHs.

PHARMACY (340B)

Anticipated pros: N/A

Anticipated cons: Ineligible for 340B: REHs are not currently recognized as "covered entities" for the 340B drug pricing program and cannot participate in the program.

OPERATIONS

Anticipated pros: Lower overhead: REHs do not have to maintain 24/7 inpatient staffing, kitchens, or laundry.

Anticipated cons: Loss of swing beds: REHs cannot provide post-acute rehab in acute care beds via swing beds because they cannot provide acute inpatient care. (REHs can operate distinct skilled-nursing facilities but cannot swing beds back and forth.)

STAFFING

Anticipated pros: Focus: Hospital staff can be dedicated entirely to the emergency department and outpatient procedures.

Anticipated cons: Recruitment: It may be harder to attract physicians who want to manage a broad range of clinical cases beyond emergency care.

Disclaimer: The information above outlines general considerations. These factors may apply differently to various hospitals and systems. Each organization must conduct its own independent analysis of these factors to determine if the REH model is a viable financial, operational, and strategic fit for their facility.

Other Resources to Assist with Organizational Analysis

- [CMS Guidance on the REH Model](#)
- [Rural Health Redesign Center](#)
- [Rural Health Information Hub](#)
- [American Hospital Association Podcast: Benefits & Challenges of Converting to an REH](#)
- [American Hospital Association Podcast: Converting to REH](#)