



What Is the Rural Emergency Hospital Program and Considerations for Converting

Disclaimer

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Learning Objective: Gain insight into approaches and models that help sustain access to care in rural communities

Presentation Overview

REH Federal Eligibility & Program Requirements

Pros, Cons & Other Trade-Offs in Evaluating REH model

Application and Implementation Consideration

RHRC Support & Technical Assistance for Rural Hospitals during Evaluation, Transition, and Post Conversion





Rural Emergency Hospital Federal Eligibility & Program Requirements

Why the Rural Emergency Hospital Designation

According to Chartis 182 rural hospitals have closed since 2010.



Rural Emergency Hospital Eligibility Criteria



To qualify as an REH
the hospital must

- Be located in a rural area
- Be licensed as a critical access hospital (CAH) or rural prospective payment system (PPS) hospital with fewer than 50 beds
- Be a certified Medicare provider and licensed as of December 27, 2020
- Meet conditions of participation (similar to a CAH or PPS hospital for emergency services)**

Rural Emergency Hospital (REH)

The REH is a new Medicare provider type established on December 27, 2020 offering payment flexibilities for Medicare FFS and is designed to serve rural communities by:



Averting potential closure of rural hospitals



Allowing continuation of essential services



Advancing health through access to care

Effective January 1, 2023

This is not a temporary or demonstration model

More information: REH provider type rules outlined in the Social Security Act and the [Code of Federal Regulations](#) was effective January 1, 2023

The REH must provide:



24/7 emergency and observation services with an annual average length of stay of less than 24 hours for all REH services



Diagnostic lab and radiological services



A pharmacy drug storage area



Discharge planning overseen by a qualified professional



REHs do not provide inpatient care but have agreements with other hospitals to transfer patients when needed

REHs can also offer services such as:



- Ambulatory and transport services
- Behavioral health services (including substance use treatment)
- Care through a rural health clinic
- Care through a distinct part skilled nursing facility
- Low-risk labor and delivery services (supported by the necessary emergency surgical procedures)
- Outpatient surgery
- Post-hospital care (non-inpatient)
- Primary care services
- Routine laboratory services*
- Telehealth

*Tests such as complete blood count, basic metabolic panel, liver function test, and other routine laboratory tests



Pros, Cons & Other Trade-Offs in Evaluating the REH Model

REH and CAH: What's the Difference?



- Ø Regulatory and licensure differences
- Ø Key operational differences such as staffing, reporting, and services

Payment Summary



Gain

- Increased payment for REH services:
 - Outpatient Prospective Payment System (OPPS) + 5% for Medicare FFS
- \$3.6 M per year in monthly facility payments from CMS as of January 2026

- Close inpatient services (all-payers)
- Close swing bed services/shift to SNF
- Not eligible for 340(B) drug pricing
- Cost-based reimbursement for CAHs



Lose

No payment changes to rural health clinics, physicians, non-REH services for PPS hospitals (paid under Medicare respective fee schedules)

No Medicare required changes to Medicaid, Medicare Advantage, or Commercial payers (see later slide for more information about other payers)

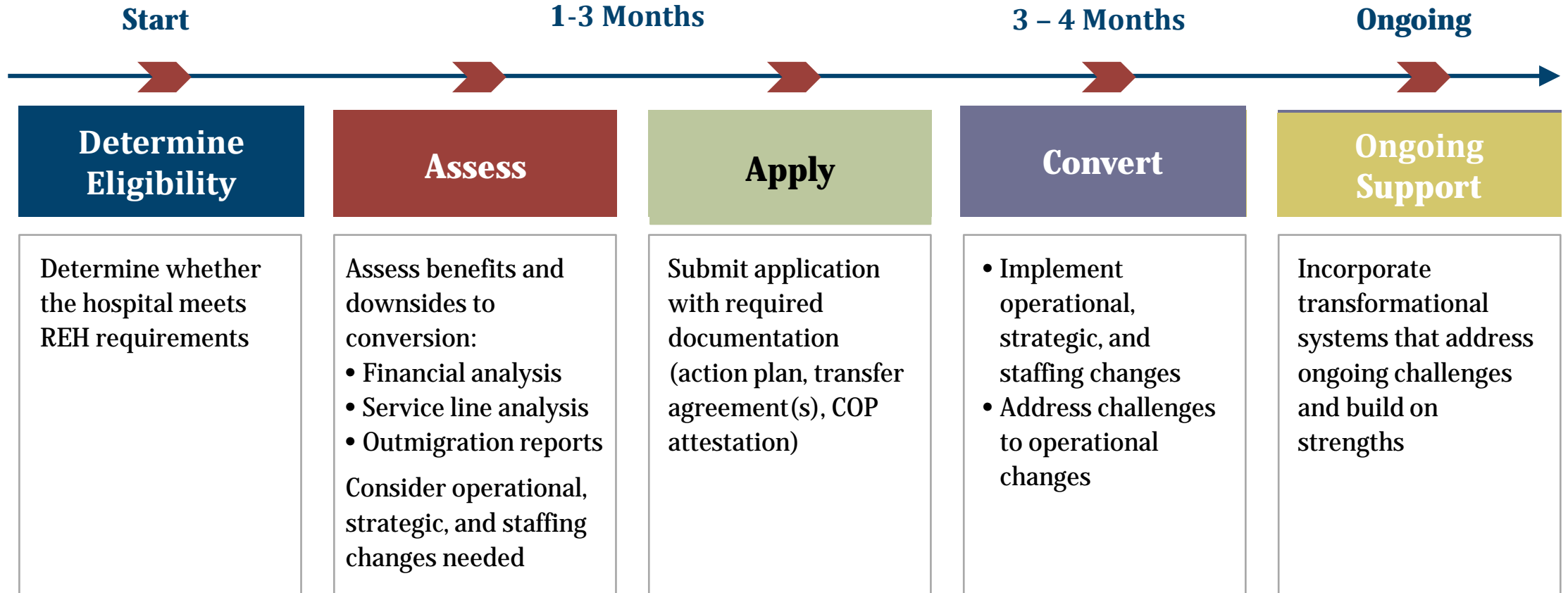
No changes to beneficiary cost sharing

More information: [Section 1833\(t\)\(1\)\(B\)\(v\) and \(t\)\(21\), 603 amendments to section 1833\(t\), and 1834\(l\) of the Social Security Act and Calculation of Rural Emergency Hospital \(REH\) Monthly Additional Facility Payment for 2023 \(cms.gov\)](#)



Application and Implementations Considerations

REH Conversion Process

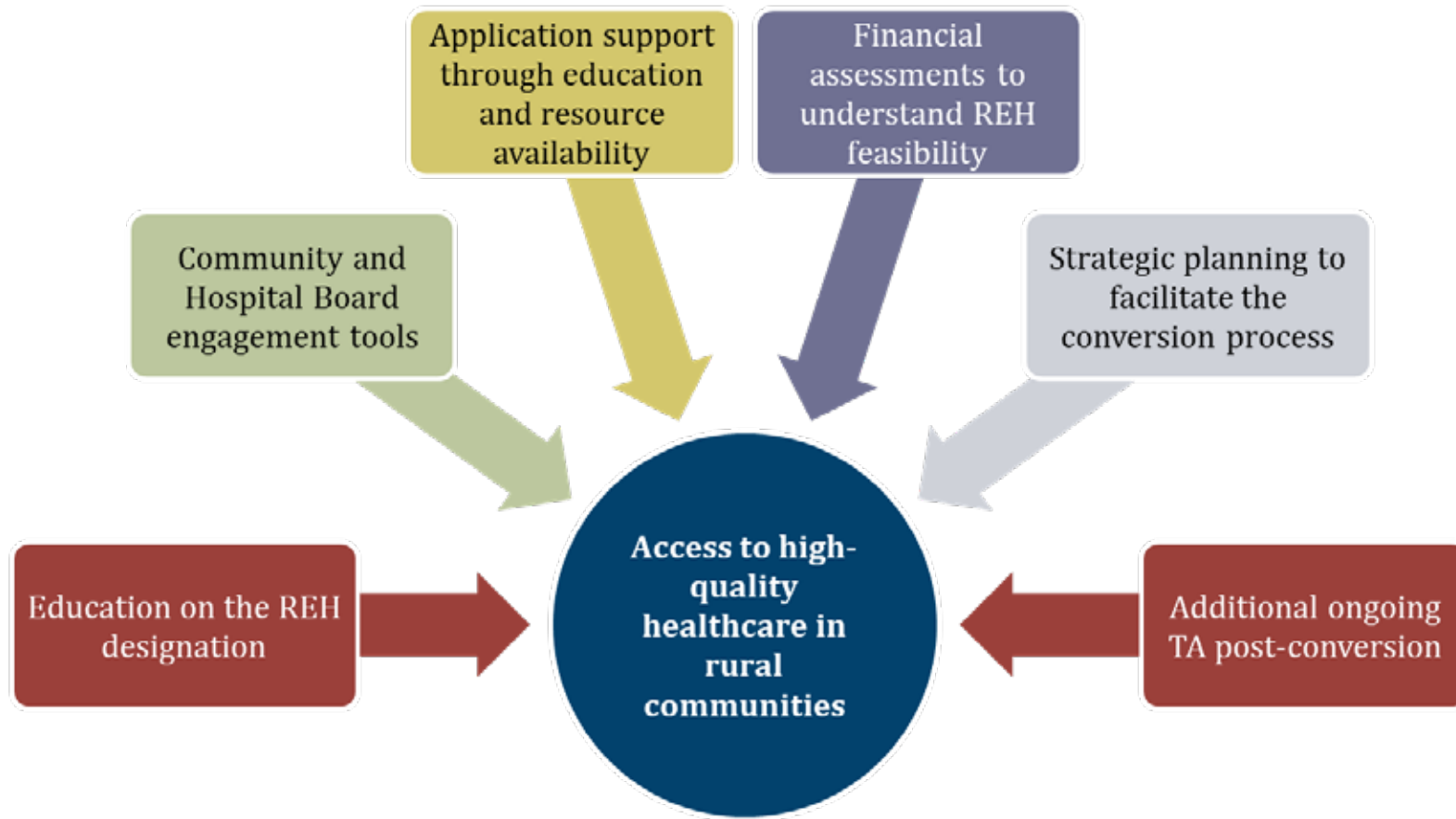


Please reach out to the RHRC if this timeline creates a barrier to consideration



REH TAC
Technical Assistance

REH Technical Assistance Center



“ [We] participated in the Cohort process and found it extremely beneficial to network with other organizations across the country navigating similar issues with the new designation.

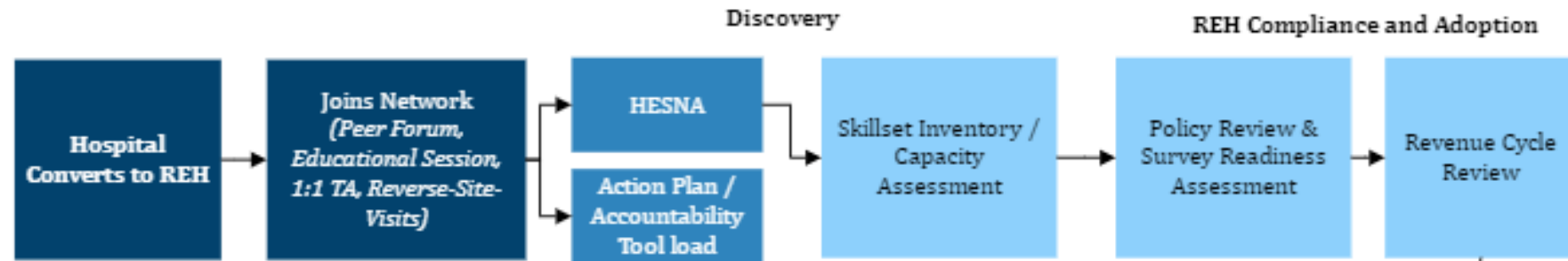
The website has been a valuable reference tool in our journey.

We look forward to continuing the conversation as we move into the execution phase of the REH.

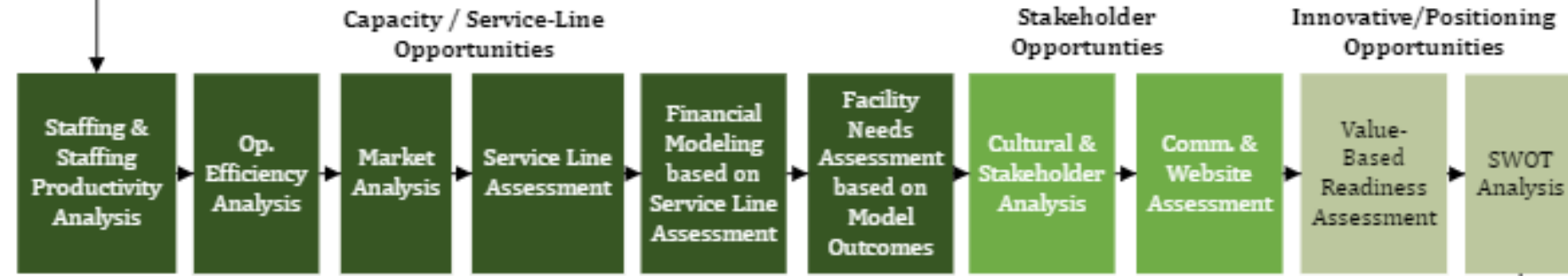
Technical Assistance Services Provided at **NO COST** to hospitals

REH Pathway

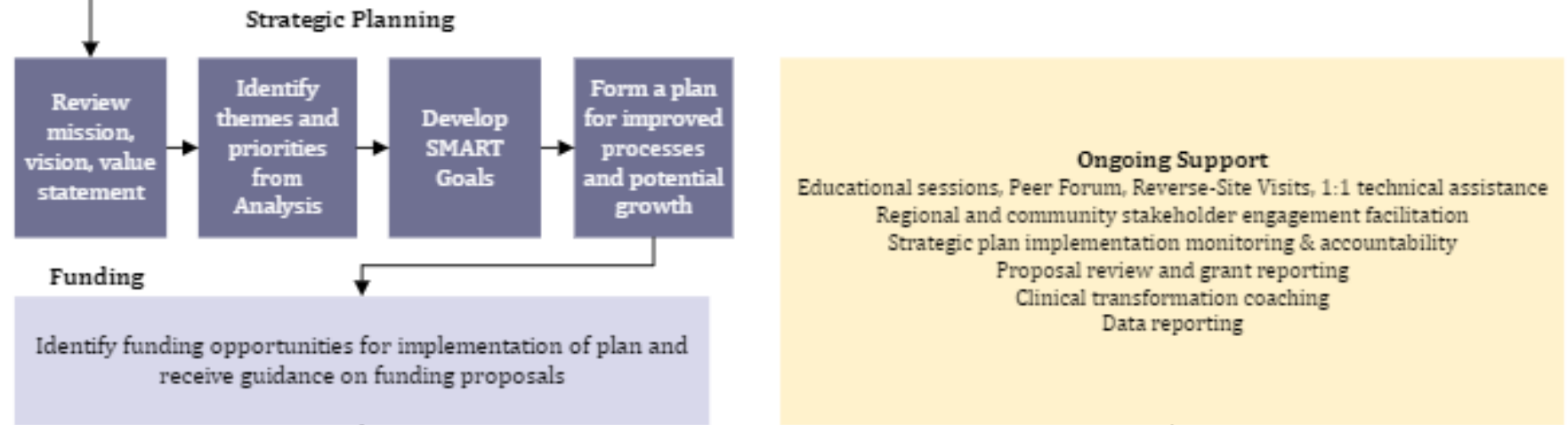
PHASE 1: Transition



PHASE 2: Evaluation



PHASE 3: Transformation



Data from REH Conversion Study

- Finance Improvement
 - Days Cash on Hand Improved from an average of 31 to 94.
 - Hospital Operating Margin has improved from an average of -12% to breakeven -0.01%



Mercy Hospital in Kansas



Aaron Herbel, CEO – Mercy Hospital (KS)

“The conversation was not so much about what the community was losing, but what they were keeping that made it a positive.”

“There is absolutely a need for health care services in rural communities...you’re talking about life and death.”

Conclusions

- REH conversion in a solution that can help many hospitals who are looking to continue core essential services and move into a more stable payment model.
- The conversion and the monthly facility payment helps with a regular payment, but organizations still need to ensure appropriate revenue cycle processes, efficient staffing models, and a focus on growth in outpatient services.



Questions?

Contact Information



Reach out to RHRC if you have questions or would like assistance determining feasibility for conversion

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