CENTER *for* RURAL AFFAIRS

A Tool for Rural Health Care in Nebraska: The Rural Emergency Hospital Designation

By Jillian Linster, interim policy director | November 2023

I. Introduction

Rural hospitals provide vital health care services to their communities, but many have been forced to close in recent years because of increasing financial challenges. To help keep essential facilities open, Congress created a new type of licensure in December 2020 that provides supportive funding to maintain small rural hospital operations under certain conditions.[1]

The Rural Emergency Hospital (REH) designation became effective at the start of 2023 for states that have passed legislation to regulate the new federally established health care provider type.[2] Nebraska is 1 of just 15 states with laws in place to enact the program, although no Nebraska hospital has yet committed to pursuing the licensure.[3]

This brief examines the status of rural hospital services in Nebraska, details of the REH designation, concerns regarding its implementation, and the potential impact of REH facilities on health care in rural Nebraska.

II. Hospital service needs in rural Nebraska

The 671,616 people who live in rural Nebraska—35% of the total population—rely on just 214 rural health care facilities.[4] Most of those are designated Rural Health Clinics, which provide needed medical services through the employment of primary care providers (physicians, nurse practitioners, etc.) and support staff. While Rural Health Clinics work to provide outpatient primary care and basic laboratory services, those needs do not encompass all the health care requirements of rural residents, particularly in emergency situations.[5]

Rural Health Clinics in Nebraska are supplemented by rural hospitals, which provide a greater range of care, including inpatient services—any type of patient care that requires a stay of one or more nights (childbirth, surgery, rehabilitation, serious illness, etc.)—and 24/7 emergency services. Rural hospitals are categorized according to the type of Medicare reimbursement they receive. Nebraska has 71 rural hospitals operating under two designations: 8 Prospective Payment System hospitals receive Medicare payments on the basis of a fixed, predetermined

1 "Public Law 116-260 (Part 1) - Consolidated Appropriations Act, 2021." 116th Congress (2019-2020), Dec. 27, 2020, congress.gov/bill/116th-congress/house-bill/133/text. Accessed September 2023.

2 Ibid.

3 "Rural Emergency Hospitals." National Conference of State Legislatures, June 26, 2023, ncsl.org/health/rural-emergency-hospitals. Accessed September 2023.

4 "Nebraska." Rural Health Information Hub (RHIhub), Oct. 17, 2022, ruralhealthinfo.org/states/nebraska. Accessed October 2023.

5 "Rural Health Clinics (RHCs)." Rural Health Information Hub (RHIhub), Sept. 12, 2023, ruralhealthinfo.org/topics/rural-health-clinics. Accessed October 2023.

amount; and 63 Critical Access Hospitals (CAHs) receive flexible, cost-based reimbursement.

The CAH designation was created by Congress in 1997 as a way to address the closure of more than 400 rural hospitals across the country during the 1980s and early 1990s. By providing CAHs with cost-based Medicare reimbursement, capital improvement funding, and the ability to be flexible in their staffing and services along with special access to educational resources, technical assistance, and/or grants, this facility designation aims to improve the financial resilience of rural hospitals and increase rural communities' access to health care through federal support.[6] Of the 71 rural hospitals serving Nebraska, 89% are CAHs, making this provider type an essential resource in the health care system that supports rural life in this state.

Still, closure rates for rural hospitals across the country have continued to gradually rise over the past two decades.[7] In Nebraska, two CAHs—Tilden Community Hospital and MercyOne Oakland Medical Center—have closed in the past nine years.[8] While special financial assistance during the pandemic offered some relief to strained hospital budgets, the imminent end of that funding means closures are expected to increase once more. The most recent data suggest that at least two additional rural hospitals in Nebraska are at immediate risk of closing due to their high rate of financial losses on patient services.[9] In the face of record high labor, supply chain, and drug costs, and with private insurance companies reimbursing hospitals at a lower rate than the cost of care, staying open often becomes financially unsustainable for small rural facilities.[10]

III. Details of the Rural Emergency Hospital designation

In late 2020, the federal government created the REH designation as an alternative to rural hospital closure. Instead of permanently ending services, CAHs and other small rural hospitals have the option to convert to REHs and receive extra resources. The new designation comes with some restrictions, but REH facilities become eligible for additional federal funding to help keep their doors open.

For a rural hospital to be eligible for REH designation, it must have been open on Dec. 27, 2020; maintain no more than 50 beds; and employ sufficient staff to provide around-the-clock emergency services and adequate patient observation. Once converted to an REH, the facility is prohibited from providing inpatient care. While the REH may offer some outpatient services, the average patient visit must not exceed 24 hours. An REH also must have a transfer agreement with a high-level trauma center for patients requiring more extensive care.[11]

A hospital operating under an REH license receives several benefits from the federal government, including a 5% increase in Medicare reimbursement and a monthly facility payment.[12] These extra funds are intended to offset the costs of running an REH and enable the rural hospital to remain open to provide emergency services to

6 "Critical Access Hospitals (CAHs)." Rural Health Information Hub (RHIhub), Sept. 3, 2021, ruralhealthinfo.org/topics/critical-access-hospitals. Accessed September 2023.

7 "Rural Hospitals at Risk of Closing." Center for Healthcare Quality & Payment Reform, October 2023, ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf. Accessed October 2023.

8 "Rural Emergency Hospitals: 16 Hospitals Have Converted to Rural Emergency Hospitals since January 2023." The Cecil G. Sheps Center for Health Services Research, University of North Carolina, 2023, shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals. Accessed October 2023.

9 "Rural Hospitals at Risk of Closing." Center for Healthcare Quality & Payment Reform, October 2023, ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf. Accessed October 2023.

10 Ibid.

11 "Public Law 116-260 (Part 1) - Consolidated Appropriations Act, 2021." 116th Congress (2019-2020), Dec. 27, 2020, congress.gov/bill/116th-congress/house-bill/133/text. Accessed September 2023.

12 Ibid.

the community when it might otherwise be forced to close.

Between January and October 2023, 17 hospitals outside of Nebraska completed the REH conversion: 5 in Texas, 3 in Oklahoma, 2 each in Georgia and Mississippi, and 1 each in Kansas, Louisiana, Michigan, New Mexico, and Tennessee.[13]

IV. Analysis of the REH designation

Federal and state licensure requirements govern the way health care facilities operate according to their designated category of service. A community clinic, for example, cannot turn into a nursing home without a change in designation and the corresponding license. The REH designation is the first new rural provider type created in more than 20 years (since the CAH designation), and it represents the outcome of a long-term cooperative effort among members of government, advocacy groups, public health officials, rural communities, and other engaged parties to produce a practical and effective response to rising rural hospital closure rates.[14] However, it is not meant to be a universal solution to the extensive and complex problems that threaten rural health care access.

The REH option is a narrowly applicable stopgap measure to save small, independently owned rural hospitals at imminent risk of permanently closing. If a rural health care facility is otherwise operating sustainably, there is no reason or incentive for desiring the conversion, and it is not an eligible licensure for the creation of a new provider. Furthermore, if operating for a time as an REH enables a facility to regain financial stability, it is able to return to its previous (CAH or other) status, along with all corresponding operational privileges, including inpatient care.

While REH licensure prevents a facility from offering inpatient care services as a measure to help limit operating costs, there is a notable exception for skilled nursing facilities, which can be maintained on the same site as distinct units with their own appropriate licensure; however, such nursing facilities do not receive the extra 5% Medicare reimbursement.

The stipulation against inpatient care has raised concerns that the REH designation might actually reduce access to needed health care. If a rural hospital is the only source of inpatient services in a community and the facility converts to an REH, local residents requiring inpatient care would be forced to travel greater distances to receive it. Beyond mere inconvenience, that travel often represents greater expense in terms of fuel costs and time away from work, and sometimes increased medical risk. Also, even larger area hospitals may be reluctant to admit rural transfer patients, as they face their own financial challenges.[15] Insufficient hospital income is almost never about a lack of patients to serve but rather the rates at which facilities are reimbursed for the costs of patient service.[16]

Another concerning issue is the impact of the REH designation on Emergency Medical Services (EMS). Emergency medicine in rural areas depends not only on hospital facilities but also on EMS as a vital part of health care access. However, no support for EMS was written into the law that created the REH designation, despite the significant impact the stipulations of the new licensure are likely to have on EMS operations serving hospitals that choose to convert.[17]

13 "Rural Emergency Hospitals: 16 Hospitals Have Converted to Rural Emergency Hospitals since January 2023." The Cecil G. Sheps Center for Health Services Research, University of North Carolina, 2023, shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals. Accessed October 2023.

14 "Rural Emergency Hospital: Policy Brief and Recommendations to the Secretary." National Advisory Committee on Rural Health and Human Services, October 2021, hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2021-rural-emergency-hospital-policy-brief.pdf. Accessed September 2023.

15 Beard, McKenzie, and Rachel Roubein. "Rural Hospitals Say They're Stuck Between a Rock and a Hard Place." The Washington Post, Jan. 17, 2023, washingtonpost.com/politics/2023/01/17/rural-hospitals-say-they-stuck-between-rock-hard-place. Accessed September 2023.

16 Ibid.

17 Bosak, Julie, and Jed Hansen. "Rural Emergency Hospital Conversion: Critical Factors for EMS Support." National Rural Health Association, February 2022, ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Rural-Emergency-Hospital-conversion-Policy-Brief-2022.pdf. Accessed September 2023.

Rural EMS providers are often volunteers who will see greater demands on their time when REH patients need to be transferred to other trauma centers for further care. Despite lower labor costs thanks to volunteers, rural EMS agencies still incur high expenses for necessities such as vehicles and emergency medical equipment. The fixed nature of those expenses means that the cost incurred every time EMS serves a rural patient is higher than the operating costs in more densely populated urban areas with more frequent calls for service. The price of buying an ambulance is the same in Ogallala as it is in Omaha, but when it gets used four times as often, the cost borne per patient interaction is much lower in an urban setting than a rural one. Also, when demand for rural EMS increases because REH facilities can only care for patients for a limited amount of time, insufficient volunteer capability is likely to lead to significantly higher staffing costs, further compounding the financial burden.[18]

Various policy advisers and advocacy groups focused on rural health care have recommended that some adjustments are likely to be advisable as the development and adoption of the new provider designation is carried out. Reasonable accommodations may include, for example, reopening some already-closed rural facilities, permitting a greater number of beds in certain circumstances, and/or allowances for some short-term inpatient care at REHs.[19,20,21,22]

V. Conclusion

The closure of rural hospitals hurts community health care and the local economy; it harms lives as well as livelihoods. Local health care facilities keep rural Nebraskans healthy and support job growth across the region.[23] Conversion to the newly created REH designation provides a useful option for facilities at imminent risk of shutting down. Even with restrictions on inpatient care, it is better for a rural community to have some emergency services locally available than to have no health care at all.

Careful evaluation of a facility's individual circumstances can lead to a sound decision regarding the usefulness and long-term sustainability of potential REH licensure for individual rural hospitals around the state. Although this new facility designation is not a universal solution to the problems faced by rural health care providers, it does provide an additional tool to help address existing challenges. Adaptive licensure requirements and assistance with the evaluation and conversion process can provide the necessary support to those facilities that would benefit from the REH designation, keeping rural hospitals open and health care accessible for more rural Nebraskans.

About the Center for Rural Affairs

Established in 1973, the Center for Rural Affairs is a private, nonprofit organization with a mission to establish strong rural communities, social and economic justice, environmental stewardship, and genuine opportunity for all while engaging people in decisions that affect the quality of their lives and the future of their communities. This institution is an equal opportunity provider and employer.

18 Ibid.

19 "National Advisory Committee on Rural Health & Human Services." Health Resources & Services Administration, August 2023, hrsa.gov/advisory-committees/rural-health. Accessed October 2023.

20 "National Rural Health Association." National Rural Health Association, 2023, ruralhealth.us. Accessed October 2023.

21 "Nebraska Rural Health Association." Nebraska Rural Health Association, 2023, nebraskaruralhealth.org. Accessed October 2023.

22 "Nebraska Hospitals." Nebraska Hospital Association, 2023, nebraskahospitals.org. Accessed October 2023.

23 "Rural Hospitals: The Beating Heart of a Local Economy." National Rural Health Association, June 18, 2018, ruralhealth.us/blogs/ruralhealthvoices/july-2018/rural-hospitals-the-beating-heart-of-a-local-econ. Accessed October 2023.