RURAL HEALTH REDESIGN CENTER

Mathematica
Progress Together

Rural Emergency Hospital (REH) Model

Frequently Asked Questions

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Version 25

Contents

Background

The Rural Emergency Hospital (REH) is a new provider type designed by the Centers for Medicare & Medicaid Services (CMS) to reduce the number of rural hospital closures through innovative payment reform and prioritizing close alignment between outpatient services and rural community healthcare needs. The REH designation is the first new rural provider type since the critical access hospital (CAH) was established in 1997. CMS published policies governing REHs in the 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center final rule on November 23, 2022[1].

General Questions

1. What types of healthcare facilities are eligible to enroll as an REH?

A facility is eligible to enroll as an REH if it was a CAH or a rural hospital with fifty certified beds or less as of the date of enactment of the Consolidated Appropriations Act, which was December 27, 2020.[2]

2. What are the benefits of converting to an REH?

Financial or operational benefits from REH conversion are highly dependent on the circumstances of the hospital. Rural hospitals facing a high likelihood of closure may benefit from enhanced payments made available to REHs. REHs will receive the OPPS rate plus an additional 5 percent for REH-covered services. Non-REH services (such as laboratory, distinct part Skilled Nursing Facility [SNF] services) are paid according to the facility's respective fee schedule and do not qualify for the additional 5 percent payment. In addition, REHs will receive a monthly facility payment of $291,455, before sequestration is removed, in calendar year 2025.

REHs also have the flexibility to determine the appropriate licensure and credentials for a 24/7 staffed emergency department. Hospital leadership can elect to provide additional outpatient services that meet the needs of the community.

3. Which states have legislation that supports the REH provider designation at the state level?

As the REH provider designation became active for Medicare on January 1, 2023, states have varied in their legislative and regulatory response to recognizing the provider type. The National Conference of State Legislatures tracks legislation and regulatory action in states related to REHs. To access the most recent information about state-level legislation related to REHs go to the Health Costs, Coverage and Delivery State Legislation database and filter on "Payment and Delivery Reform" under "Market" in the topic search section. You can also filter by state and status (as in, adopted, enacted, to the governor) of the legislation.

4. Do administrative changes such as ownership or a new Provider Transaction Access Number (PTAN) affect REH eligibility?

No, if the hospital was in operation before December 27, 2020, administrative changes have no bearing on REH eligibility. If the hospital converts to an REH with an ownership change, its change of information application (Form CMS-855A) must include updated information about the hospital's ownership. This includes, but is not limited to, disclosing in Sections 5 and/or 6 the new owner(s) and any new managing

employees, deleting the old owners in Sections 5 and/or 6, etc. All liabilities incurred while operating as the CAH or applicable rural hospital would transfer to the REH.

5. Our rural hospital closed prior to December 27, 2020; can we reopen as an REH?

No, a hospital must meet all REH requirements and have been operating as a licensed hospital on the date the legislation passed allowing the new REH designation. As a result, since the hospital closed prior to December 27, 2020, and was not functioning as a hospital as of this date, it is **not** eligible to be reopened as a REH.

6. Our hospital is scheduled to close, can we reopen as an REH?

Hospitals that are scheduled to but have not closed are eligible to convert to an REH if they meet all the Conditions of Participation (CoP) and requirements for REHs. Prospective REHs should complete the change of information application (Form CMS-855A) and submit the completed application to CMS for review prior to closure. If the hospital continues operating while CMS reviews the application, it is eligible to self-attest that the hospital meets the REH requirements and will not require an automatic on-site initial survey.

More information on eligibility and processes for converting/reopening as an REH is available in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo.

7. If a hospital was open as a designated CAH or rural PPS hospital prior to 12/27/2020 and has since closed, can it reopen as an REH?

Hospitals that have closed but were open as of December 27, 2020 are eligible to reopen as an REH if they re-enroll in Medicare and meet all the CoPs and requirements for REHs. These hospitals are required to undergo an on-site survey to ensure the facility is operational and in compliance with REH requirements. These facilities must also submit an attestation for the applicable eligibility requirements, rural status, and rural reclassification criteria if applicable. Hospitals that have reopened and started operating as a rural PPS are still eligible for REH conversion, as long as the facility meets the eligibility requirements for REH conversion as established by statute and regulation,

8. More information on eligibility and processes for converting/reopening as an REH is available in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo. We encourage facilities to reach out to the SA and/or the Medicare Administrative Contractor (MAC) to discuss any details related to reopening the hospital, REH conversion and the facility specific details that may apply. How does my REH maintain certification when relocating?

The REH must maintain rural status or continue to be in an area designated or reclassified as rural in accordance with 42 CFR §412.103. When an REH plans to relocate, it must update the change of information application (Form CMS-855A) and submit it for reapproval. More information is available in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo.

9. Can CMS waive or alter the REH eligibility requirements?

No, the REH eligibility requirements are established in statute.

Application and Conversion Process

1. How does my hospital apply to convert to an REH?

The application process for converting to an REH includes a change of information application (Form CMS-855A). An eligible hospital can apply by submitting the Form along with an action plan, a transfer agreement, an attestation of compliance, and if applicable, a rural reclassification. The complete process for eligible facilities to convert to an REH, including State Agency (SA) and CMS review and approval roles/criteria, is outlined in the Medicare Enrollment of Rural Emergency Hospitals[3] and the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memos.

2. How long will it take a hospital to complete the conversion process and begin receiving the new Medicare reimbursements and facility payment?

Assuming the state has passed and implemented licensing regulations for REHs, the time it takes for the application to be approved and for a hospital to convert to an REH can take several months or more. Timing depends on multiple factors such as application completeness, hospital eligibility status, hospital readiness, and state office staff availability. The CMS location and the SA maintain contact with the hospital about the application status. Note the timeline includes any actions the provider must complete to meet the REH CoPs. Please reach out to your SA or CMS location for more details on the approval timeline.

3. What are the action plan submission requirements?

The action plan outlines the hospital's conversion plan and must include a detailed description of the following elements as outlined in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo:

- Provision of ED, observation care, and other health services elected by the REH including details about staffing for REH services.
- A transition plan that outlines the services that the facility will retain, modify, or discontinue.
- A description of additional outpatient services that the facility intends to provide.

An action plan template is provided in the final exhibit of the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation.

The hospital should submit the action plan to the SA including information noted above on a facility letterhead using the exhibit model action plan template provided as an attachment to the memo. The hospital's legal representative or administrator must sign the action plan. The SA will forward the action plan along with the recommendation for approval or denial of REH certification to the designed CMS location for final review and approval.

4. Are REHs required to have agreements with an acute care hospital?

REHs must have a transfer agreement with a level I or level II trauma center. According to the final rule, REHs must "have in effect an agreement with at least one Medicare-certified hospital that is a level I or level II trauma center for the referral and transfer of patients requiring emergency medical care beyond the capabilities of the REH."[4] An REH is permitted to have additional transfer agreements with facilities that are not level I or level II transfer facilities, although this is not required.

5. What are the transfer agreement requirements?

An REH must have a transfer agreement with at least one Medicare hospital certified as level I or level II trauma center in place. The agreement ensures there is a process for transferring patients who need continued care beyond what the REH can provide. The REH must submit a copy of the transfer to the SA along with the application for conversion to an REH.[5]

6. When can hospitals convert to an REH?

Eligible hospitals may convert to an REH on or after January 1, 2023. Congress established REHs as a new Medicare provider through Section 125 of the Consolidated Appropriations Act of 2021, which added section 1861(kkk) to the Social Security Act. To convert to an REH, hospitals must follow all applicable health and safety standards and regulations at the time of conversion.

7. Can we convert back to our previous designation after REH conversion?

Yes. REHs can convert back to their prior designation as a CAH or rural hospital. At that time, the hospital would be considered a new CAH or rural hospital and would lose any grandfathered privileges. For example, if a CAH that is grandfathered as a "Necessary Provider" converts to an REH, it would lose its necessary provider designation upon converting back to an REH. The necessary provider waiver was tied to a special provision, which allowed a hospital to be deemed a CAH under certain conditions and ended December 31, 2005. A CAH designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation after January 1, 2006, as outlined in 42 CFR §485.610© and 42 CFR §485.610(d). Given that the waiver is no longer effective, a necessary provider CAH that converts to an REH may not be able to again be licensed as a CAH unless it can meet all current CAH distance requirements and CoPs. Converting back to would require an initial enrollment application and associated fees.

8. Will there be an initial CMS survey once the transition to an REH takes place prior to change of service line?

Eligible facilities converting to an REH that meet the CoPs and are in full compliance with the existing CAH and hospital requirements at the time of the request for conversion will not require an automatic onsite initial survey. However, hospitals that were eligible to convert to an REH as of December 27, 2020, that subsequently closed and re-enrolled in Medicare will require an initial on-site survey by the SA to ensure the facility is operational and in compliance with the REH requirements. These facilities must also submit an attestation to the applicable eligibility requirements, rural status, and rural reclassification criteria if applicable. Hospitals can find detailed information about survey requirements in Appendix O of the

Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo and additional information on updated survey requirements is available in updated guidance.

9. Can a state allow hospitals to convert to an REH through an existing emergency hospital statute?

Yes, states can allow hospitals to convert through an existing emergency hospital statute if they choose.

10. Will hospitals that convert to a REH be issued a new PTAN?

Yes, a new PTAN number will be issued in the final CMS approval letter.

11. If a hospital designated as a Medicare Dependent facility converts to an REH, but then decides to convert back, when can the hospital qualify again as a Medicare Dependent facility?

There needs to be a full cost reporting period to qualify again as a Medicare Dependent Hospital (MDH), based on the criteria for classification as an MDH in regulations at 42 CFR §412.108(a). The newly enrolled/certified hospital would need at least two of the last three most recent audited cost reporting periods for which the Secretary has a settled cost report (consistent with section 1886(d)(5)(G)(iv) of the Social Security Act).

12. Are small rural hospital improvement program (SHIP) hospitals that convert to REH during the grant year eligible to continue using SHIP funds until the end of the current grant year?

Yes, a hospital can continue to use SHIP funds awarded to them after converting to a REH if the funds were awarded before they became an REH.

13. How will an application denial affect my hospital?

A denial for REH certification will not impact the hospital's existing enrollment as a CAH or applicable rural hospital.

Conditions of Participation

General

1. When are we required to stop admitting inpatients when converting to a REH?

Upon approval of the REH application, hospitals are expected to cease all inpatient services as of the effective date assigned by CMS. The hospital's action plan must provide details describing the services it is adding, modifying, and discontinuing, as well as specific details regarding the discontinuation of inpatient services and the transfer of exiting patients if applicable. The CMS location will review the information submitted and provide a final determination. If there are identified concerns during the review, the CMS location will reach out to the facility to request additional information or clarification prior to providing a final determination for REH approval.[6]

2. Can an REH include a rural health clinic (RHC)?

Yes.[7] The REH may have an RHC as a provider location with a separate CMS Certification Number (CCN) from the main provider. That said, an RHC itself would not meet the REH eligibility requirements for conversion to an REH.

3. Can a Federally Qualified Health Center (FQHC) be included as part of a REH's health system?

FQHCs cannot be part of a health system that operates an REH. The requirements for FQHCs include maintaining certain governance autonomy that prohibits an FQHC from being part of a health system, including a health system that operates an REH. The requirements do not, however, prohibit other support, affiliation, or limited-control relationships between a health system and an FQHC. Such arrangements are common but must be carefully structured to comply with specific regulatory requirements and to comply with Health Resources & Services Administration (HRSA) Bureau of Primary Health Care (BPHC) guidance.[8]

4. What charitable requirements does a REH have?

The IRS requires non-for-profit, tax-exempt healthcare facilities to demonstrate community benefit. It is recommended that each individual hospital consult the specialized education programs offered by IRS Exempt Organizations to understand their tax responsibilities.[9]

5. Do REHs still need to meet the established requirements for promoting interoperability?

Based on current policy and CMS guidelines on Eligible Hospital Information, an REH is not an eligible hospital to participate in the Medicare Promoting Interoperability Program. REHs does not need to apply for an exemption.

6. Can an REH still participate in the Medicare 340B Drug Pricing Program?

REHs are not eligible to participate in the Medicare 340B Drug Pricing Program. Therefore, if a facility were to convert to an REH, they would no longer be eligible to participate in and purchase discounted drugs through the 340B Drug Pricing Program.

7. How do the Price Transparency Requirements apply to REHs?

Any licensed hospital compliant with state or local regulatory law is subject to the Price Transparency Final Rule. This includes all hospital locations operating under the same hospital license or approval. For further details and exceptions consult the Hospital Price Transparency FAQs or reach out to the resource mailbox at PriceTransparencyHospitalCharges@cms.hhs.gov.

8. What infection prevention and control data are REHs required to report?

REHs are required to collect and analyze infection prevention and control data related to hospital acquired infections (HAI), healthcare worker (HCW) Influenza vaccinations, HCW COVID vaccinations, antimicrobial stewardship and COVID data. However, REHs are not currently required to report this data to the National Healthcare Safety Network (NHSN). [10]

9. Are there Accreditation Organizations (AO) that have deemed status to survey REHs?

AOs have not been granted deeming status. A deeming option for the REH program will be considered by CMS after it has had adequate time and opportunity to effectively monitor and evaluate the introduction of REHs into the Medicare program as well as each REH's ability to comply with the health and safety requirements of the CoPs.

Since the REH is a new provider type, all REH surveys for a minimum of three years from February 10, 2023 will be conducted by SAs. CMS is requiring SAs to survey REH facilities within 12 months of conversion; there is a provision that allows surveys to extend beyond 12 months. SA reports will be evaluated by CMS for trends. Following the 12-month survey, REH facilities will resume the hospital triennial schedule.[11]

10. Is an REH required to maintain an Organ Procurement, Tissue Bank, or Eye Bank agreement?

There is no requirement for REHs to maintain an Organ Procurement, Tissue Bank, or Eye Bank agreement and there are no requirements for organ procurement organizations/transplant centers to have an agreement with an REH.

11. Are REHs expected to follow CMS ventilation requirements for relative humidity (RH) in surgical and procedural anesthetizing areas?

CMS does not require a categorical waiver for humidity levels in anesthetizing locations. Certified REH facilities must comply with the 2012 NFPA 99, which references The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Appendix D 170 (2008), allowing 20-60% relative humidity (RH) in surgery and critical care areas. The ASHRAE ventilation guidelines permit RH as low as 20%; however, organizations are expected to follow manufacturer instructions for use (IFU) of sterile supplies and medical equipment. RH below 30% may not be compatible with some IFUs. Refer to the following documents for more specific information:

- Potential Adverse Impact of Lower Relative Humidity (RH) in Operating Rooms (ORs) S&C: 15-27
- ASHRAE Addendum D

Average Length of Stay

1. Is there a limit on the patient's length of stay at an REH?

REHs are not to exceed an average annual per patient length of stay (ALOS) of 24 hours for all REH services provided. This is an aggregated calculation. The Final Rule summarizes the methodology for computing the ALOS, and states that the time calculation for determining the length of stay of a patient receiving REH services begins with the registration, check-in, or triage of the patient (whichever occurs first) and ends with the discharge of the patient from the REH. The discharge occurs when the physician or other appropriate clinician has signed the discharge order, or at the time the outpatient service concludes and documented in the medical record. Documentation of why the patient is in the facility longer than 24 hours is essential to maintain in the medical record.[12] Services provided within the distinct part SNF units of an REH are not subject to the 24-hour requirement.

2. Do laboratory services count as part of an ALOS calculation?

The ALOS calculation only includes patients who receive REH services. Laboratory services covered under the Clinical Laboratory Fee Schedule (CLFS) and outpatient rehabilitation services are not considered an REH service. Patients who received laboratory services grouped with other REH primary care or hospitals services covered under the OPPS fee are considered in the total annual ALOS calculation.[13]

3. Is the ALOS calculated using all outpatients and all payers?

The REH ALOS requirement is applicable to all patients receiving services provided by the REH. Payer status does not impact on the ALOS calculation.[14]

Bed Policy

1. How are the number of certified beds determined or counted?

To determine if a facility meets the eligibility requirement of no more than 50 beds, the bed count will be determined by calculating the number of available bed days during the most recent cost reporting period divided by the number of days in the most recent cost reporting period. (Note: Bed count is determined based on the number of Medicare-certified beds versus state licensed beds). The most recent cost report that captures bed count as of December 27, 2020 will be used to determine eligibility for REH conversion.[15]

2. Do state rules for bed count supersede federal guidelines for bed count rules?

State rules do not supersede federal guidelines for bed counts, though states may choose to enact guidelines that are more stringent than federal guidelines.

3. Are REHs required to have observation beds?

Currently, there is no specific requirements outlined for observations beds, simply that 24/7 observation care is required.[16]

4. Will REHs be required to use the Medicare Outpatient Observation Notice (MOON)?

REHs will not be subject to the MOON. The MOON requires that hospitals and CAHs use MOON to notify Medicare beneficiaries "(including health plan enrollees), that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH)."[17] According to CMS, because REHs are not included under the definition of hospital in the Social Security Act, they are not subject to the same MOON requirements as CAHs.

Location

1. For the purposes of qualifying for REH status, how does CMS define a rural designation?

The final rule for REHs defers to section 1886 of the Social Security Act to define a rural hospital. A rural area is defined in section 1886(d)(2)(D)), which uses Metropolitan Statistical Areas as defined by the Office of Management and Budget for defining rural areas. An area is also considered rural if it is treated as being located in a rural area based on section 1886(d)(8)(E), which refers to the urban to rural

reclassification process as defined in 42 CFR §412.103. To be eligible for REH designation, the reclassification from urban to rural status must have occurred as of December 27, 2020.

This differs from the HRSA Federal Office of Rural Health Policy definition, so hospitals should review whether they classify as rural or urban on Worksheet S-2 Part 1 of their cost report that covers Dec 27, 2020, which should align with the criteria from section 1886 of the Social Security Act. Hospitals geographically designated as a rural hospital based on the Social Security Act or reclassified as rural for CMS payment purposes meet the rural definition for an REH conversion. A hospital must also meet all other REH conditions to be eligible for an REH status.[18,19]

2. If a hospital is reclassified as rural after Dec 27, 2020, are they eligible for REH?

No. Hospitals reclassified as rural after December 27, 2020 are not eligible for REH designation.[20]

3. What are REH location requirements related to other facilities?

According to the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo, an REH must meet all rural requirements and follow the guidance for CAHs in State Operations Manual Chapter 2, section 2256A, with the exception that REHs are not expected to meet any distance or mileage requirements other than being located in a rural area or an area designated as rural.

4. Are there any distance requirements regarding off-campus outpatient departments and REHs? For example, a physical therapy department that is more than 250 yards from a hospital campus.

Yes, there are distance requirements regarding off-campus outpatient departments and REHs. The requirements are the same as they are for regular hospitals. That means the physical therapy department that is more than 250 yards from the campus of the REH in question would be considered an off-campus outpatient department.

5. Can a provider-based outpatient department of a hospital apply to convert to an REH instead of the main campus of the hospital?

No, converting a provider-based location that has the same CCN as the main provider would not be considered to meet the intent for conversion to an REH as the statute and regulations contemplate conversion of the entire hospital or CAH and not its individual parts (including psych and rehabilitation units).

6. Can REHs co-locate and lease space?

Yes, REHs may co-locate and lease space within the facility. All co-located hospitals must demonstrate independent compliance with the applicable CoPs. Please refer to QSO Memo 19-13 for additional information regarding hospital co-location.

Quality Reporting

1. Are there any CMS guidelines for reporting quality measures for an REH?

In the CY 2024 OPPS/ambulatory surgical center (ASC) final rule with comment period, CMS finalized a new quality reporting program for REH facilities: Rural Emergency Hospital Quality Reporting (REHQR) Program. The REHQR Program currently includes the reporting of four measures: 1) Abdomen CT Use of Contrast Material, 2) Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients, 3) Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy, and 4) Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery.[21]

2. Will organizations be able to sample the ED Arrival to Discharge measure in the Rural Emergency Hospital Quality Reporting (REHQR) Program?

Sampling for the REHQR Program will follow the same process as the Outpatient Quality Reporting (OQR) Program.[22]

Service Delivery

1. What services are REHs required to provide?

REHs are required to provide 24-hour emergency services and observation care with standards like those of CAHs and other hospitals.[23] They are also required to provide certain laboratory services dependent on the needs of the population they serve, radiological services, pharmaceutical services, and discharge planning. REHs can also offer additional outpatient services and can serve as originating sites for telehealth, though they are not required to do so. These services may include behavioral health, maternal health, or non-required laboratory and radiological services. REHs can also operate a distinct part SNF.

2. Would a distinct part unit for rehabilitation services be covered in lieu of swing beds? At what rate?

REHs can only operate distinct SNFs. If the rehabilitation services are provided within a SNF, reimbursement will be made in accordance with the SNF Prospective Payment System fee schedule. Rehabilitation services would be paid to the SNF as part of the per diem payment, which is adjusted according to patient severity. Further information on SNF billing can be found on the CMS spotlight of Skilled Nursing Facility PPS.

3. Can an REH operate an inpatient behavioral health or psychiatric care unit?

REHs may only offer inpatient services in a distinct part SNF. Currently, federal legislation does not allow REHs to offer inpatient behavioral health and psychiatric care.[24]

4. Can an REH provide hospice, end of life care, or respite care as observation?

Not as an inpatient service. The REH is prohibited from offering inpatient care and services except those furnished in a unit that is a distinct part licensed as a SNF to furnish post-hospital extended care services. That said, REHs may provide end of life care that is not hospice care or inpatient care on a short-term outpatient basis, such as in an ED setting. However, keep in mind that REHs are subject to an annual per

patient ALOS which may not exceed 24 hours. The time calculation for determining the length of stay of a patient receiving REH services begins with the registration, check-in, or triage of the patient (whichever occurs first) and ends with the discharge of the patient from the REH. The discharge occurs when the physician or other appropriate clinician has signed the discharge order, or at the time the outpatient service is completed and documented in the medical record.

5. Can REHs own and operate ambulance services? Is this against any federal REH regulations?

The REH CoPs do not prohibit REHs from owning or operating an ambulance service.

6. Can a REH provide low-risk labor and delivery (L&D) services?

CMS sought input in the proposed rule on whether low-risk L&D (including outpatient surgical services in the event surgical labor and delivery intervention is necessary) should be allowed. In response, CMS expects REHs will provide various outpatient services which may include low-risk labor and delivery, but this is not required.

7. Can a REH provide OB services?

A REH may provide "low risk" outpatient obstetric (OB) care. OB patients will be counted in the annual ALOS calculation, which cannot exceed an annual average of 24 hours.

8. Are emergency services required to convert to a REH? Can they be established after conversion?

Emergency services are a requirement for REH conversion and participation. These services must be active and operational at the time of application for REH conversion.

9. Can a REH establish and maintain outpatient provider-based services?

Yes, REHs may establish outpatient provider-based entities which address the health care needs of their community and following the existing CMS requirements and guidelines for provider-based facilities. REHs are prohibited by statute and regulation from providing any inpatient services except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services.

Skilled Nursing Facility

1. Can a hospital operate a SNF after conversion?

According to the Consolidated Appropriations Act, REHs can provide post-hospital extended care services within a distinct part SNF. Outside of these services provided in the distinct part SNF, REHs may not furnish any other inpatient services. Medicare payments for these services provided in the distinct part SNF will be paid under the SNF prospective payment system.[25]

2. If an REH elects to have a distinct part SNF unit, what is involved in converting to a SNF Prospective Payment System?

An REH would need to certify their distinct-part SNF unit with Medicare to receive payment under the SNF Prospective Payment System. This requires meeting separate SNF CoPs and staffing requirements.

3. Is an REH's distinct part SNF unit subject to Medicare's 3-day SNF rule, which requires a prior 3-day inpatient stay?

Yes. According to the Medicare 3-day SNF Rule, a beneficiary must have a 3-day prior inpatient stay at a facility such as an acute care hospital or CAH to receive services in SNF. Given that a 3-day prior inpatient care stay is required for beneficiaries to receive Medicare SNF services and an REH visit does not constitute an acute inpatient stay, the REH cannot provide the qualifying staff and therefore the patient must be transferred to the REH SNF unit from another facility.[26]

Staffing

1. Are there special staffing requirements for REHs?

Per the Final Rule, CMS requires that REHs have on staff, at all times, an individual who is "competent in the skills needed to address emergency medical care" in their emergency departments. These competent individuals must be able to receive patients and employ resources to provide the needed care, among other qualifications listed in the Final Rule. Additionally, like the requirements that CAHs are subject to in their provision of emergency services, REHs must have a physician or other practitioner, "on-call at all times and available on-site within 30 or 60 min (depending on if the facility is located in a frontier area)." For more details on staffing requirements, please see 42 CFR §485.528.

2. Are REHs required to have a dietician on staff for assessments or consultations?

No, on-staff dieticians are not required for REHs.

3. Are REHs required to have a utilization management plan or program with a physician advisor?

No, utilization management plans with physician advisors are not a requirement for REHs.

4. Is my hospital required to complete new credentialing for providers when converting to a REH?

Hospitals must be credentialed and certified through Medicare to be eligible for REH conversion. Therefore, hospitals are not required to be recredentialed upon conversion to an REH.

5. Is an REH eligible for a Certified Registered Nurse Anesthetist (CRNA) pass-through?

CRNAs must administer anesthesia under the supervision of an anesthesiologist. CMS has not yet clarified its policy on CRNA pass-through eligibility for REHs. The issue has been recommended for further consideration by the National Advisory Committee on Rural Health and Human Services to the CMS Secretary.[27]

6. Does the CRNA supervision opt-out apply to REH?

CRNA supervision requirements vary by state and CMS requires that the CRNA supervision waiver for REHs must be consistent with state laws.

7. **How does CMS recognize Advanced Practice Registered Nurses (APRNs) versus Certified Nurse Practitioners (CNP) as it relates to REH staffing requirements?**

States can have more stringent requirements for licensure than the federal government—but not less—if those stringent requirements do not adversely impact health and safety.

The National Council of State Boards of Nursing (NCSBN) defines APRNs as an RN who has a graduate degree and advanced knowledge. There are four categories of APRNs: (1) certified nurse-midwife, (2) clinical nurse specialist, (3) certified nurse practitioner, or (4) certified registered nurse anesthetist. These nurses can diagnose illnesses and prescribe treatments and medications. Many states use the title Advanced Registered Nurse Practitioner (ARNP) to put the emphasis on nurse practitioner as the specific role. CMS uses the generic term nurse practitioner, which includes many specialties.

8. **Can REHs serve as eligible host sites for staff enrolled in the National Health Service Corps Scholarship Program or National Health Service Corps Loan Repayment Program?**

No, REHs are ineligible to serve as host sites for staff with a National Health Service Corps loan or scholarship. Please see here for a link to the program: National Health Service Corps.

9. **Are REHs eligible to participate in the National Health Service Corps (NHSC) Loan Repayment Program?**

No, REHs are not eligible for the NHSC Loan Repayment Program. However, if the hospital has a provider-based Rural Health Clinic, that clinic would be an eligible NHSC site. Please see here for a link to the program: National Health Service Corps Loan Repayment Program.

Transfers

1. **Can patients be transferred from an REH to an acute care hospital across state lines?**

CMS' Final Rule does not prohibit REHs from having operating agreements with licensed providers in other states. However, providers should be aware of any state laws that govern the transfer of patients where applicable.[28]

2. **Are there exceptions to the transfer agreement rules for communities only accessible by airplane?**

Currently, there are no REH regulations at the federal level that address communities that are only accessible by airplane, such as a remote island, where patient transfer to an inpatient hospital is cost prohibitive. Some states may be addressing this issue at the state level to meet the unique needs of rural communities. As noted in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo, REHs are not expected to meet the same distance or mileage requirements as a CAH, other than being located in a rural area or an area designated as rural.

3. **How does an REH bill for services when a patient is unable to be transferred to another facility for the next level of care or an inpatient stay?**

In this case, the patient is considered to either be an ED patient or in an observation status and REHs can bill for services accordingly. Documentation of why the patient is in the facility longer than 24 hours is

essential to maintain in the medical record. Note that the annual ALOS for all REH services cannot exceed 24 hours. See "Is there a limit on the patient's length of stay at a REH?," for more details about calculating the ALOS.

Payment Policies

General

1. The current billing process for a hospital owned emergency medical service is to bill under WMC EIN/NPI. Would an REH need to create a new legal entity to provide those services under the REH designation?

There are no requirements for obtaining a new NPI for Medicare enrollment purpose. The REH should contact their local MAC to ensure that their enrollment information is updated to include the ambulance services they wish to provide.

2. What are the Medicare reimbursement policies for REH?

Medicare will pay REHs for services determined to be an REH-covered service as defined in the CMS Final Rule. In general, Medicare REH services will be reimbursed at the OPPS rate plus an additional 5 percent. Services that are not REH services but are provided by REHs and consistent with statutory requirements, will continue to be paid under their applicable fee schedule. For example, labs that would have been paid separately under the Clinical Lab Fee Schedule (CLFS) would continue to be paid under the CLFS after conversion to an REH. Regarding beneficiary copayments and coinsurance, these payments for REH services will exclude the additional 5 percent payment; the payment amounts will be determined in the same way they were determined under OPPS.[29]

3. How does the Medicare payment structure change for CAHs that convert to an REH?

CAHs will shift from cost-based reimbursement to a prospective payment system that includes a 5 percent increase in OPPS payment for REH services, as described above. Non-REH services will be paid according to the respective fee schedule.[30]

4. Do beneficiaries have to pay any additional fees or premiums for receiving care at REH?

Beneficiaries do not pay additional fees or premiums for receiving services at an REH. As stated above, beneficiaries' cost-sharing will also not be impacted by the additional 5 percent reimbursement for OPPS services.

5. How does our hospital manage claim submissions while converting to an REH?

Upon application, the REH should continue to bill all outpatient claims under the OPPS using their current PTAN until such time as CMS provides both the effective date of the REH conversion and the new REH PTAN. Claims from the effective date forward will need to be rebilled using the new REH PTAN number. Please contact your MAC for additional claims billing assistance.

6. Will the RHC grandfathered payment change if I become an REH?

An RHC maintains their exception status after an REH conversion.[31]

OPPs + 5%

1. How will CMS apply the additional 5 percent payment?

CMS will calculate the additional 5 percent from the OPPS payment amount and apply it to the final payment. For instance, if the OPPS amount is $100 and the beneficiary's coinsurance is 20% ($20) the allowed OPPS payment amount would be $80. For an REH, CMS will add 5 percent of the $100 OPPS payment ($5) to the total payment which would be $85 ($80 plus $5).[32]

2. Will the 5 percent payment increase be applied to professional services in provider-based clinics?

No, the 5 percent payment increase will only apply to hospital outpatient billing and not to the professional services. The 5 percent increased payment is applicable to REH outpatient services that are paid under OPPS rates. Some provider-based clinics services billed as a hospital outpatient service (such as those provided as part of an oncology clinic) do qualify for a 5 percent payment increase while others (such as a rehabilitation clinic) do not qualify for the increased payment.

3. Does an REH receive an additional 5 percent payment for outpatient services?

In general, outpatient laboratory and imaging services are paid based on the respective fee schedule. However, some lab services bundled under an APC (ambulatory payment code), will include a 5% increase. PPS hospitals should track which lab and imaging services are paid under the standard Medicare fee-schedule versus which are bundled with APCs.[33]

4. Is the 5 percent REH payment subject to sequestration and partial distribution or is it paid in full for REH services each month?

REHs will receive a Medicare payment for covered REH services plus an additional 5 percent. Both the monthly REH facility payment and the 5% payment are subject to sequestration as of October 2023.[34]

5. If an REH owns and operates their own ambulance service, would the 5 percent increased payment apply to emergency transportation services?

Emergency medical transportation services, such and an ambulance, are not paid under the OPPS and therefore not subject to a 5 percent payment increase under REH statutes.[35]

6. What services are included in the OPPS plus 5% calculation?

OPPS + 5% applies to REH services, which includes emergency, observation, and other outpatient services[36]. All services that are paid under the OPPS when furnished in an OPPS hospital, with the exception of acute inpatient services, are REH services when furnished in an REH.

7. Are Intensive Outpatient and Partial Hospitalization services eligible for the 5% payment increase to the OPPS rate?

Yes. Intensive Outpatient and Partial Hospitalization services do receive the 5% add-on payment just like other OPPS services provided by a REH.

Monthly Facility Payment

1. What is the monthly REH facility payment, and will that figure change over time?

The additional REH facility payment is $291,455 per month before sequestration as of January 2025. In subsequent years, this additional facility payment will be increased by the hospital market basket percentage increase on January 1 of the year.

2. When will the monthly REH facility payments begin?

According to CMS, REH facility payments begin the month in which the MAC has set up the provider in the Fiscal Intermediary Standard System (FISS) claims processing system. The provider must be registered as an REH and Medicare eligible to qualify for payment.

3. What determines the effective date of a REH designation? How does this affect the Monthly Facility Payments?

A hospital's designation as a REH is officially determined by the date of certification on the final approval letter from their MAC. The monthly facility payment will not start until after the final CMS approval letter. Hospitals are first approved by their state, then the state recommends approval to CMS, and CMS sends the final approval to their MAC.

Payers

1. What do I need to know about Medicaid payment for REH services?

REH is a Medicare provider type, and each state will need to consider how to adjust their Medicaid payment rules for REHs. Some states are reviewing the implications of the REH provider type and may choose to offer Medicaid payments for REH and non-REH services. For more details, see question in general category, "Which states have legislation that supports the REH provider designation at the state level?"

2. How will Medicaid pay the REH if my state has licensed/authorized REHs to operate as a Medicaid provider?

Medicaid payment policies for REHs (including payment methods and amounts) differ across states and between Medicaid fee for service (FFS) and managed care delivery systems.

In Medicaid FFS, states can determine specific payment rates as well as use of supplemental payments for REHs. States detail their payment methodologies through state plan amendments (SPA). REHs as well as hospitals considering converting to an REH should work with their state Medicaid agencies (SMA) to understand the state's Medicaid payment policies for REHs and determine ways to support REHs. For example, states can submit state plan amendments to CMS to pay REHs at the OPPS+5% rate.

In capitated Medicaid managed care, states set actuarially sound per member per month rates paid to managed care plans. Like for other hospital types, the plans then have flexibility to determine the rates they will pay REHs in their networks. REHs can consider working with their SMAs to determine how the state can support REHs paid through managed care, for example through use of state directed payments that require plans to pay REHs at particular rates, such as Medicare rates or average commercial rates.

3. What do I need to know about commercial payment for REH services?

Some hospitals may have commercial contracts tied to Medicare payments and may require new negotiations between the hospital and the payer and/or a change in the current contract agreement when converting to an REH. Hospitals are encouraged to reach out to commercial payers and inquire as part of the REH consideration process.

4. How does our hospital bill Medicare for REH services?

Submit claims to the Part A MAC using the 837 Institutional (837I) or the paper claim Form CMS-1450. Use Types of Bill 013x (Hospital Outpatient) and 014x (Hospital Other Part B). Remember not to bill for inpatient hospital services. More information about how to access the paper Form CMS-1450 and billing details are available from your MAC.[37]

5. Would Medicare Advantage (MA) plans be held to the Medicare payment methodology?

No. Currently, the REH provider status is recognized only by Medicare Fee-For-Service. Some hospitals may have MA contracts that require new negotiations between the hospital and the payer and/or a change in the current contract agreement when converting to an REH. Hospitals are encouraged to reach out to MA payers to understand impacts to MA payments as part of the overall consideration of REH conversion.

6. Can CAHs that use Method II billing continue this practice once designated as an REH?

No. CAHs that convert to a REH will lose the option to bill for professional services under Method II billing.

Technical Assistance for Converting to an REH

1. What steps should a facility consider taking when converting to an REH?

The first step is for hospital leaders to gain a complete understanding of the REH designation and whether an REH can meet the specific healthcare needs of the community, including access to other hospitals and facilities. If it appears that REH conversion could be a viable option, the financial assessment would be the recommended next step. The REH-TAC facilitates a process including performing a detailed financial analysis whereby hospital leaders can determine the financial impact of an REH conversion.

2. Who do I contact if I want help deciding whether to convert to an REH?

The Rural Health Redesign Center offers no-cost technical assistance to facilities interested in converting to an REH. In addition to offering resources and education, interested parties can apply to receive specialized assistance with the application process, financial feasibility analysis, and post-conversion transformation services. This technical assistance is at no cost to the facility, regardless of whether they pursue the conversion process or not.

3. What the financial modeling tool that is available for facilities to determine whether to convert to an REH include and what is the cost of the tool?

A financial modeling is provided by REH-TAC at no cost to the hospital. The tool is a customized financial projection model that illustrates future financial performance as an REH versus remaining as a CAH or small rural hospital. The model is based on multiple data sources including Medicare cost reports, Medicare claims (repriced for CAHs), and an intake data form provided by the hospital. Assumptions on revenue and cost growth as well as verification of the baseline data are supplied by the hospital as part of this process.

4. What is the State Flex Program and how do I find my state's Flex Coordinator?

The State Flex program offers training and technical assistance to build capacity, support innovation, and promote sustainable improvement in the rural health care system. You can find your state's flex coordinator contact information on the State Flex Programs website.

5. Can I participate in a cohort if my state does not have approved legislation for REH?

Any REH eligible hospital interested in learning more about the REH designation, application, and conversion process are welcome to join a cohort. Note that the hospital may not apply for REH conversion until it is approved at the state level.

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