Rural Emergency Hospital (REH) Model

Frequently Asked Questions

December 2023 (version 13)

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. The policies governing the REH were published in the 2023 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center final rule on November 23, 2022[i].

General Questions

What types of provider facilities are eligible to enroll as an REH?

A facility is eligible to enroll as an REH if it is a critical access hospital (CAH) or a rural hospital with fifty beds or less as of the date of enactment of the Consolidated Appropriations Act, December 27, 2020.[ii]

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 Outpatient Prospective Payment System rate plus an additional 5 percent for REH-covered services. Non-REH services (such as laboratory, distinct part Skilled Nursing Facility 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 $272,866 before sequestration in 2023, with annual increases determined by the hospital market basket. The hospital market basket adjustments are made January 1 to align with the calendar year.

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 services that meet the needs of the community.

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 is currently tracking 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.

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

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** currently eligible to be reopened as a licensed REH.

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

The enrollment process was simplified to allow existing hospitals and CAHs to submit the CMS-855A – change of information application to prevent closure of facilities that may disrupt services in the community. The hospital should submit its enrollment application prior to closure. If the hospital continues operating while the application is reviewed, it is eligible for the attestation of compliance versus. If the hospital closes prior to the REH designation, an on-site survey to ensure CoP compliance is required. More information is available in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo.

How does my REH maintain certification when relocating?

The REH must maintain rural status or continue to be in an area that has been designated or reclassified as rural in accordance with 42 CFR §412.103. When an REH plans to relocate, it must update the CMS-855A form and submit it for

reapproval. More information is available in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo.

Application and Conversion Process

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 – submitting the Form along with an action plan and a transfer agreement. The complete process for eligible facilities to convert to an REH is outlined in the Medicare Enrollment of Rural Emergency Hospitals[iii] and the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memos.

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, 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 State Agency maintain contact with the hospital on the application status. Note the timeline includes any actions the provider must complete to meet the REH Conditions of Participation. Please reach out to your State Agency or CMS location for more details on the approval timeline.

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 outpatient services that the facility intends to provide.

Submit the action plan to the state agency (SA) including information noted above on facility letterhead or on the model template provided as an attachment to the memo. The hospitals' legal representative or administrator must sign the action plan.

The SA plan 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. CMS will notify the Medicare Administrative Contractor (MAC) once the enrollment package is approved and complete.

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

REHs are required to 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."[iv] 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.

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. A copy of the transfer agreement should be submitted to the SA along with the application for conversion to an REH.[v]

When can hospitals convert to an REH?

Eligible hospitals may convert to an REH on or after January 1, 2023. The REH designation was enacted on December 27, 2020, is recognized in Section 125 of the Consolidated Appropriations Act of 2021 and adds 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.

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

REHs can convert back to a previous provider type (CAH or PPS hospital) in accordance with 42 CFR §424, subpart P, except in the case of a former CAH that was designated through a "Necessary Provider" waiver. Converting back to a PPS hospital or CAH would require an initial enrollment application and associated fees.

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(c) 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 conditions of participation.

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

Eligible facilities converting to an REH that meet the Conditions of Participation (CoP) 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. 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 state agency. These facilities do not need to submit an attestation, as an onsite initial survey will determine the hospital's compliance with the REH requirements. You can find more information about survey requirements in Appendix O of the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo.

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

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

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.

Conditions of Participation

General

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

Since REH facilities are prohibited by statute from providing inpatient care, these services should be discontinued prior to the effective date of compliance with the REH requirements. The facility's action plan must provide details describing the services the facility is adding, modifying, and discontinuing as well as specific details regarding the discontinuation of inpatient services. 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.[vi]

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

Yes. An RHC can be part of an REH.[vii]

Can a FQHC be included as part of a REH's health system?

FQHCs cannot be part of a health system that operates a 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 HRSA Bureau of Primary Health Care ("BPHC") guidance.[viii]

What charitable requirements does a REH have?

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

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

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

Can an REH still participate in the Medicare 340B Part B Drug Purchasing Program?

REHs are not eligible to participate in the Medicare 340B Part B Drug Purchasing 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 program.

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.

Average Length of Stay

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 of 24 hours for all REH services provided. This is an aggregated calculation. The Final Rule summarizes the methodology for computing the average annual per patient length of stay, 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.[x] Services provided within the distinct part SNF units of an REH are not subject to the 24-hour requirement.

Do laboratory services count as part of an annual average length of stay calculation?

The annual average length of stay calculation only includes patients who received 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 average length of stay calculation.[xi]

Is the ALOS calculated using all outpatients and all payers?

The REH length of stay requirement is applicable to all patients receiving services provided by the REH. Payer status does not impact the ALOS calculation.[xii]

Bed Policy

How are bed counts defined and calculated?

The number of beds is calculated by taking the number of available bed days during the most recent cost reporting period and dividing it by the number of days in the most recent cost reporting period. To qualify as an REH, a CAH or PPS hospital must have **no more** than 50 beds **both** at the time the REH designation was enacted (December 27, 2020) and during the most recent cost reporting period, using the calculation above. The number of licensed beds is not a factor when calculating bed counts for REHs.

Do state rules for bed counts 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.

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.[xiii]

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)."[xiv] 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

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

The Final Rule for REH 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)); an area is also considered rural if it is treated as being located in a rural area based on section 1886(d)(8)(E). *This differs from the 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.[xv,xvi]

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.[xvii]

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.

Quality Reporting

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

Quality measure requirements for REH facilities are not yet finalized but expected to be similar to those required by CAHs.[xviii]

Service Delivery

What services are REHs required to provide?

Rural Emergency Hospitals are required to provide 24-hour emergency services with standards like those of Critical Access Hospitals and other hospitals.[xix] 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 skilled nursing facility.

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

REHs can only operate distinct Skilled Nursing Facilities (SNF). 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.

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

REHs may only offer inpatient services in a distinct part Skilled Nursing Facility. Currently, the federal legislation does not allow REHs to offer inpatient behavioral health and psychiatric care.[xx]

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

The REH cannot offer inpatient care and 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. However, there are no restrictions to providing observation care to hospice patients. REHs are subject to an annual per patient average length of stay which does not exceed 24 hours. See "Is there a limit on the patient's length of stay at an REH?" for more information.

Can a REH own and operate ambulance services? Is this against any federal REH regulations?

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

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

The Centers for Medicare and Medicaid 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.

Can a REH provide OB services?

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

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.

Skilled Nursing Facility

Can a hospital operate a skilled nursing facility after conversion?

According to the Consolidated Appropriations Act, REHs can provide post-hospital extended care services within a distinct part skilled nursing facility (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.[xxi]

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 Conditions of Participation and staffing requirements.

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's must be transferred to the REH SNF unit from another facility.[xxii]

Staffing

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 section 485.528 of CMS' Final Rule.

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

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

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.

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.

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.[xxiii]

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.

How do the Centers for Medicare and Medicaid Services (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 Advanced Practice Registered Nurses (APRN) 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.

Transfers

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.[xxiv]

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.

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 aggregated patient average length of stay (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

The current billing process for a hospital owned EMS 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 Medicare Administrative Contractor (MAC) to ensure that their enrollment information is updated to include the ambulance services they wish to provide.

What are the primary 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.[xxv]

How does the 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.[xxvi]

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.

How does our hospital bill Medicare for REH services?

Submit claims to the Part A Medicare Administrative Contractor (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.[xxvii]

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 Outpatient Prospective Payment System (OPPS) using their current Provider Transaction Access Number (PTAN) until such time as the Centers for Medicare and Medicaid Services (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 Medicare Administration Center (MAC) for additional claims billing assistance.

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

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

OPPs + 5%

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).[xxix]

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 Outpatient Prospective Payment 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.

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.[xxx]

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.[xxxi]

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.[xxxii]

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

OPPS + 5% applies to REH services, which includes emergency, observation, and other outpatient services [xxxiii]. 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.

Monthly Facility Payment

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

The additional REH facility payment is $272,866 per month before sequestration as of October 2023. In subsequent years, this additional facility payment will be increased by the hospital market basket percentage increase on January 1 of the year.

When will the monthly REH facility payments begin?

According to the Centers for Medicare and Medicaid Services (CMS), REH facility payments begin the month in which the Medicare Administrative Contractor (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.

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 Medicare Administrative Contractor (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.

Other Payers

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 determine REH requirements. 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?"

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.

Would Medicare Advantage 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 Medicare Advantage 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 Medicare Advantage payers to understand impacts to MA payments as part of the overall consideration of REH conversion.

Technical Assistance for Converting to an REH

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.

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.

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.

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.

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.

References

[i] "CMS Final Rule", Available at https://www.federalregister.gov/documents/2022/11/23/2022-23918/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment#footnote-355-p72256.

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