Final REH Conditions of Participation

Average length of stay: NRHA raised concerns about the 24-hour average length of stay in our NPRM comments. CMS was constrained in its ability to make exceptions, for example for psychiatric patients requiring a transfer, due to requirements in the statute. CMS notes that the 24-hour time frame is an average, so some patients may stay longer than 24 hours and some may stay for a much shorter period, which will in theory even out the average length of stay.

CMS added instructions for measuring the length of stay for each patient at 42 CFR § 485.502. The time calculation 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.

Detailed conversion plan: Section 1861(kkk)(4)(A)(i) of the statute requires that a hospital or CAH seeking REH conversion submit a detailed transition plan at the time of the submission of their revised CMS Form 855-A. NRHA asked CMS to address procedures for this detailed plan because they were not in the proposed rule. CMS responded that details surrounding the transition/conversion plan will be addressed in future rulemaking.

Eligibility: NRHA asked whether CAHs and small rural hospitals with less than 50 beds that closed after December 27, 2020, could convert to an REH. CMS clarified that hospitals that closed after this date may seek conversion because they were open on December 27.

Bed count: The methodology for determining if a rural hospital has no more than 50 beds 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. This is the same methodology used for determining beds in Medicare dependent small rural hospitals.

Laboratory services: CMS finalized the CoPs for laboratory services as proposed with a slight modification, adding that REHs must provide lab services consistent with the patient population. This means that REHs have flexibility to determine what services to offer based upon the needs of their community/patient population.

Additional outpatient services: CMS reiterated that REHs may provide additional outpatient medical and health services per the needs of the community. This would include low risk labor and delivery services, substance use disorder treatment and other behavioral health services, surgical services, or outpatient rehabilitation services.

CMS highlighted our NRHA’s comments inquiring about an inpatient psychiatric distinct part unit. CMS noted that the statute does not authorize distinct part units other than a distinct skilled nursing facility, thus REHs may not operate a distinct inpatient psychiatric unit.
Provider-based Rural Health Clinics: NRHA asked CMS for clarification on REHs operating provider-based RHCs. CMS clarified that the statute states that a rural emergency hospital may be considered a hospital with less than 50 beds for purposes of the exception to the payment limit for RHCs and thus this implicitly states that REHs may continue operating RHCs. CMS did not add additional CoPs regarding RHCs.

Staffing and Staff Responsibilities: CMS finalized its staffing regulations with one modification at 42 CFR § 485.528. CMS is clarifying in the requirement that the emergency department be staffed 24/7 by at least one individual by adding that it must be staffed “by an individual or individuals competent in the skills needed to address emergency medical care” who “must be able to receive patients and activate the appropriate medical resources to meet the care needed by the patient.” There is no mention of how competency or skills are measured, such as by a certification.

Quality Assessment and Performance Improvement (QAPI): These final regulations mirror those that CAHs must follow. CMS finalized one slight modification at 42 CFR § 485.536(a)(2) to add that REHs must measure, analyze, and track staffing as another quality indicator, in addition to the proposed adverse patient events.

Agreements: CMS finalized CoPs requiring agreements with level I or II trauma centers as proposed. NRHA asked that CMS allow REHs to enter into agreements with the closest inpatient psychiatric facility in order to transfer patients that need more acute behavioral health services. CMS clarified that REHs are able to decide whether to enter into an agreement with such a facility based on community needs without CMS establishing a CoP.

Skilled Nursing Facility (SNF) distinct part unit: CMS added language to the SNF CoP clarifying that the distinct part unit must be separately licensed and certified. This is not a new requirement as it was discussed in the preamble to the proposed rule.

Provisions that are finalized as proposed:

- Medical staff – § 485.512
- Provisions of services – § 485.514
- Emergency services – § 485.516
- Radiologic services – § 485.520
- Pharmaceutical services – § 485.522
- Additional outpatient services – § 485.524
- Antibiotic stewardship and infection prevention – § 485.526
- Nursing services – § 485.530
- Discharge planning – § 485.532
- Patient’s rights – § 485.534
- Agreements – § 485.538
- Medical records – § 485.540
- Emergency preparedness – § 485.542
- Physical environment – § 485.544

Final REH Payment Policies
Covered outpatient services: CMS proposed to define “REH services” as all covered outpatient department services that would otherwise be paid under OPPS when provided by an OPPS hospital. CMS did not adopt any changes to covered outpatient services. NRHA commented that REHs should be able to maintain Method II billing after converting from a CAH; however, CMS contends that Method II is only for CAHs, and they are statutorily prohibited from allowing REHs to bill this way.

Payment for REH services: CMS is finalizing its proposed payment policy of the OPPS rate plus 5% for all REH services. REH services will be processed using the OPPS claims processing system with a specific flag for REH providers to use to indicate that the services should be paid the REH rate. Beneficiary copayments will be calculated before the 5% extra payment is included. NRHA stresses that even though REHs will use this claims processing system and the OPPS rate, REHs are NOT paid under OPPS; the OPPS rate is simply used to determine REH payment rates.

For non-REH services, meaning services not covered by OPPS like laboratory services covered by the Clinical Laboratory Fee Schedule, CMS will not pay the additional 5%. CMS stated that it is precluded from doing so by the REH statute.

CMS also clarified that provider-based RHCs may maintain their excepted status under section 1861(kkk)(6)(B) of the Social Security Act when their associated hospital converts to an REH.

Monthly payments: CMS is finalizing its monthly payment calculation with a slight modification. Part of the monthly payment calculation is estimating overall CAH spending in 2019. In CMS’ proposed calculation, they assumed that all CAHs meet the 15-mile requirement for the low volume payment adjustment. However, NRHA pointed out in its comment that this is not necessarily true because of CAHs with necessary provider status. This misstep in the calculation would reduce the monthly payments. In the final rule, CMS identified those CAHs that do not meet the low volume adjustment criteria and increased the monthly payment. For CY 2023, the final monthly payments to each REH increased from the proposed rule. REHs will receive $272,866 per month, or about $3.2 million for the year. The proposed rate was $268,294. Each year the monthly payments will be increased by the hospital market basket percentage.

Miscellaneous payment provisions: CMS is allowing REHs to continue their current cost reporting formats to report costs to avoid any additional burdens. CMS notes that if for some reason an REH-specific cost report is needed, they will create one.

CMS responded to NRHA’s comment concerning 340B payment. We recognized that allowing REHs to participate in 340B was likely outside of their scope of authority. CMS agreed, stating that it was outside of their scope because the Health Resources and Services Administration regulates the 340B program.

CMS also responded to our comment concerning REHs as Graduate Medical Education eligible facilities. CMS replied that they could not adopt this policy in the final rule without including it in the proposed rule to obtain public comments, but that it will be considered for future rulemaking.

CMS noted that IHS hospitals interested in conversion may need extra resources to make the transition feasible. CMS explained that this was not within the scope of the CY 2023 OPPS rulemaking, but it will consider policy suggestions for alternative payment methodologies for IHS facilities that convert to REHs in future rulemaking.
Final Critical Access Hospital (CAH) CoP Updates

Definition of Primary Roads:

Review process. In the final rule, CMS explains the new data-driven review procedure for CAH distance requirements. As stated in the proposed rule, CMS sees this review process as focusing on hospitals in proximity to the CAH rather than the road classifications. CMS will review all hospitals and CAHs within a 50-mile radius of a CAH during each review of eligibility and then again on a 3-year basis. For CAHs with no new hospitals in a 50-mile radius, the CAH will immediately be recertified. CAHs with new hospitals in that radius will receive additional review based upon the 35- and 15-mile primary road and mountainous terrain definitions.

Additionally, NRHA asked that CMS exclude REHs from the 35- or 15-mile requirement for CAHs. CMS clarified that REHs within a 35- or 15-mile radius of a CAH will not disqualify the CAH from eligibility because REHs cannot provide inpatient services and thus would not overlap or duplicate services provided at a CAH.

Definition of primary roads. CMS agreed with NRHA’s comment that one-lane Federal highways should not be included in the definition of primary roads. Therefore, CMS is modifying its proposed definition of primary roads to include only numbered Federal highways with two or more lanes each way, similar to the description of numbered State highways, and exclude numbered Federal highways with only one lane in each direction. This is a big win for CAHs that would otherwise be threatened by

CMS also clarified that it will continue to allow a CAH to qualify for application of the “secondary roads” criterion (i.e., not a primary road) if there is a combination of primary and secondary roads between it and any hospital or other CAH, so long as more than 15 of the total miles from the hospital or other CAH consists of areas in which only secondary roads are available.


For additional information, contact Alexa McKinley (amckinley@ruralhealth.us).