RURAL EMERGENCY HOSPITALS: Q&A

August 11, 2022

Healthcare shortages pose an acute threat to rural communities across the United States. With insufficient health resources, residents of rural America frequently experience delays in care, preventable hospitalizations, and poor medical outcomes. In the past 12 years, 138 rural hospitals, including 44 critical access hospitals, have stopped providing inpatient care; 75 of these institutions have closed their doors altogether. Providers attribute many of these closures and reductions in service to a rural facility's competing obligations. Medicare reimbursement is conditioned upon the provision of traditional hospital inpatient acute care, but rural hospitals commonly lack the patient volume necessary to sustain profitability while offering such a breadth of services. Seeking to address this rural healthcare crisis, Congress passed the Consolidated Appropriations Act (CAA) on December 27, 2020.[1] The CAA authorizes the establishment of a new, Medicare-eligible provider type: The rural emergency hospital (REH).

REHs must furnish emergency department and observational care and may also elect to provide an array of outpatient medical and health services. This provider type is limited to facilities which offer an annual per patient average length of stay of no more than 24 hours. A critical access hospital (CAH) or general acute care hospital with 50 or fewer beds participating in Medicare as of December 27, 2020, may apply for conversion and enrollment in Medicare as an REH. Medicare will reimburse for REH services rendered on or after January 1, 2023.

Since the passage of the CAA, the Centers for Medicare and Medicaid Services (CMS) has promulgated two sets of proposed rules on REHs:

1. Conditions of Participation (CoPs): Issued on July 6, 2022, this proposed rule outlines requirements for REH services, training, staffing, governance, and quality reporting.[2] CMS has solicited public comments by or before August 29, 2022.

2. Provider Enrollment, Payment Policies, & Physician Self-Referral: Issued on July 26, 2022, this proposed rule outlines REH Medicare enrollment, payment methodology, and a new exception to the Stark Law.[3] Comments may be submitted electronically or by mail no later than September 13, 2022.

The following Q&As have been created to answer your questions regarding CMS's proposed regulations for REHs.

1. What is a Rural Emergency Hospital?

The CAA defines an REH as a facility enrolled in Medicare which does not provide any inpatient care services (aside from limited services furnished in a distinct part skilled nursing facility (SNF) unit), has a transfer agreement with a level I or II

[1] 116 P.L. 260 § 125.
[2] 87 Fed. Reg. 44502.
[3] 87 Fed. Reg. 40350.

trauma center, fulfills applicable CoPs, and meets requirements for ED staffing, training, and certification.[4] Recent CMS proposals refine the definition of an REH to "an entity that operates for the purpose of providing emergency department services, observation care, and other outpatient medical and health services specified by the Secretary in which the annual per patient average length of stay does not exceed 24 hours."[5] An REH cannot provide acute care inpatient services, except those furnished in a distinct part unit licensed as an SNF to provide post-REH or post-hospital extended care.

2. How will REHs be paid by Medicare?

Medicare will reimburse for REH services rendered on or after January 1, 2023. REH services will be paid at Outpatient Prospective Payment System (OPPS) rates increased by 5%. CMS proposes to apply these favorable rates to "emergency department and observation services as well as, at the election of the REH, other medical and health services furnished on an outpatient basis…."[6]

The proposed rule stipulates that only services considered "covered outpatient department services" will be paid under the REH rate.[7] Other outpatient services, including labs, diagnostics, and rehabilitative care, required by REH CoPs and permitted under the CAA will be reimbursed at the same rate as if the service was rendered by a hospital outpatient department and paid under a fee schedule other than the OPPS, provided the requirements for payment under that system are satisfied. For example, REH lab services will be paid under the Clinical Laboratory Fee Schedule, and REH ambulance services will be paid under the Ambulance Fee Schedule. Likewise, CMS proposes to authorize REHs to establish and operate distinct part SNFs for the provision of post-REH or post-hospital acute inpatient care, which must be billed separately by the SNF and reimbursed under the SNF Prospective Payment System.

Medicare will also offer REHs a fixed monthly facility fee based primarily upon CAH claims data, with annual adjustments accounting for hospital market basket percentage increases. For 2023, CMS proposes that each REH will receive a monthly facility fee of $268,294, for an annual total exceeding $3.2 million.

Under the proposed rule, beneficiary copayments will be calculated in the same way as OPPS, excluding the 5% payment increase.

3. What facilities qualify for conversion to an REH?

CMS may grant REH certification to facilities which, as of December 27, 2020, qualified as: 1) a critical access hospital; 2) a hospital with no more than 50 beds located in a county that is considered rural;[8] or 3) a hospital with no more than 50 beds that was treated as being in a rural area and had an active reclassification from urban to rural status.[9]

4. What is considered "rural" for purposes of qualifying as a REH?

Hospitals with 50 or fewer beds which are considered rural or have had an active reclassification from urban to rural status as of December 27, 2020, may qualify for enrollment as an REH. CMS considers a facility rural if it is located outside of an urban area.[10] Urban areas are located within Metropolitan Statistical Areas, as defined by the Office of Management and Budget.

---

[4] 42 U.S.C. § 1395x.
[5] 87 Fed. Reg. 44502.
[6] 87 Fed. Reg. 44502.
[7] *See* 42 U.S.C. § 1395l(t)(1)(B) (defining OPD services).
[8] A hospital under this section must be considered rural under 42 U.S.C. § 1395ww(d)(2)(D).
[9] A hospital under this section must have undergone a reclassification from urban to rural under 42 U.S.C. § 1395ww(d)(1)(B).
[10] 42 U.S.C. § 1395ww(d)(2)(D).

A hospital located within an urban area may qualify as rural if, as of December 27, 2020, it met one of the following criteria:

1. The facility is located in a rural census tract of a Metropolitan Statistical Area;

2. The facility is located in an area designated by state law as a rural area, or the state has designated the facility as a rural hospital;

3. The facility would qualify as a rural, regional, or national referral center or a Sole Community Hospital if the hospital were located in a rural area; or

4. The facility meets other criteria as specified by the Secretary.[11]

In the coming months, CMS is expected to promulgate policy on counting 50 beds for the purpose of determining REH eligibility.

5. What services must an REH provide?

An REH must provide emergency department and observation care, with the ED staffed 24 hours a day, 7 days a week. CMS proposes to require REHs to maintain a transfer agreement with a level I or II trauma center for referral and transfer of patients requiring emergency medical care exceeding the capabilities of the REH. The contracting level I or II trauma center may be located in a state other than the state where the REH is located. Further, a transfer agreement with a level I or II trauma center need not supplant a facility's pre-existing agreement with a level III or IV trauma center.

Under the proposed CoPs, an REH must provide basic laboratory services that are essential to the immediate diagnosis and treatment of a patient. REHs must provide the same lab services which are available in a CAH: Chemical examination of urine, hemoglobin or hematocrit, blood glucose, examination of stool specimens for occult blood, pregnancy tests, and primary culturing for transmittal to a certified lab. CMS encourages REHs to provide additional lab services to include complete blood count, basic metabolic panel ("chem 7"), magnesium, phosphorus, liver function tests, amylase, lipase, cardiopulmonary tests (troponin, brain neurologic peptide, and d-dimer), lactate, coagulation studies (prothrombin time, partial thromboplastin time, and international normalized ration), arterial blood gas, venous blood gas, quantitative human chorionic gonadotropin, and urine toxicology. An REH must be CLIA certified.

CMS's proposed requirements regarding REH radiological services mirror the radiologic CoPs applied to hospitals. These standards require REHs to verify that radiology care is rendered by qualified personnel, protect patients and staff from radiation hazards, and tailor the variety of radiologic services available to meet local demands.

The proposed CoPs stipulate that an REH must maintain a supervised pharmacy or drug storage area stocked with medications and devices to meet the facility's anticipated needs. The REH must appoint a registered pharmacist or other qualified individual in accordance with state law to direct pharmaceutical services.

6. What services may an REH provide?

CMS proposes to permit REHs to offer an array of services beyond required emergency and observational care. Under the proposed rule, an REH would be permitted to offer outpatient care including, but not limited to, radiology, laboratory, rehabilitation, surgical, opioid treatment, maternal health, ambulatory, and behavioral health services. With regard to outpatient surgical services, CMS expects that REHs, like ambulatory surgical centers, will offer services which do not require hospitalization and where the expected duration of care does not exceed 24 hours following admission.

[11] 42 U.S.C. § 1395ww(d)(1)(B).

CMS proposes to allow an REH to establish a unit that is a distinct part SNF for the provision of post-REH or post-hospital extended care and services. The distinct part SNF is separately licensed in some states, and always separately certified by Medicare. If an REH elects to establish a distinct part SNF, the facility must be physically distinguishable from the REH and will be reimbursed separately under Medicare's prospective payment system for SNFs. A distinct part SNF of an REH is not subject to the REH's length of stay restrictions capping the annual, per patient average length of stay at 24 hours or fewer.

7. What are the state licensure requirements for an REH?

CMS proposes that an REH must be located in a "state that provides for the licensing of such hospitals under state or applicable local law."[12] Further, the proposed CoPs stipulate that an REH must be licensed in the state as an REH or be approved as meeting standards for licensure by the relevant state or local hospital licensing agency.

8. How must an REH be staffed?

Per the CAA, the emergency department of an REH must be staffed 24 hours a day, 7 days a week. CMS proposes to grant REHs flexibility in determining how to staff an ED to meet this requirement. Individuals staffing the REH must be competent enough to receive patients and activate appropriate medical resources for treatment, including notifying the on-call physician of a patient's arrival. REH stand-by staff may include nurses, nursing assistants, clinical technicians, or emergency medical technicians.

When one or more patients are receiving emergency or observation care in an REH, a nurse, clinical nurse specialist, or a licensed practical nurse must be on duty. As proposed in the CoPs, an REH must have an organized nursing service which is available to provide 24-hour nursing care. The facility must retain sufficient nursing staff to sustain REH operations, based on the number of patients receiving care and the level of care required by those patients. CMS further proposes that the REH must appoint a director of nursing who is a licensed registered nurse to oversee the operation of nursing services.

CMS does not believe that it is necessary to mandate that a doctor of medicine or osteopathy, nurse practitioner (NP), clinical nurse specialist, or physician assistant (PA) be on-site at all times in an REH, as is required in a CAH. Instead, CMS proposes to require that a doctor of medicine or osteopathy, a PA, an NP, or a clinical nurse specialist with training or experience in emergency care be on call and immediately available by telephone or radio contact, and available on-site within specified timeframes.

Of note, although CMS recommends that an REH appoint a board-certified emergency physician to serve as medical director, it is not required.

9. Can an REH rely on health system resources to meet Medicare's conditions of participation for REHs?

As drafted in the proposed CoPs, an REH may be part of a unified system governing body and a unified system medical staff. Further, in accordance with local and state laws, an REH within a multi-hospital system may take advantage of a unified and integrated Quality Assessment and Performance Improvement Program (QAPI) to fulfill reporting requirements. Under its proposed rule, CMS requires a health system's governing body to be responsible and accountable for ensuring that each of its separately certified REHs meets the QAPI program requirements. Rule-makers believe this allowance will benefit REHs lacking the time, resources, or staff to implement a facility-specific QAPI program by facilitating access to the resources and expertise of a multi-hospital system.

CMS's proposed CoPs require REHs to establish and abide by emergency preparedness plans, in addition to antibiotic stewardship programs and infection prevention/control programs. REHs operating as a part of a healthcare system with

[12] 87 Fed. Reg. 44502.

multiple separately certified hospitals, CAHs, and REHs, are permitted to participate in the system's coordinated emergency preparedness plans as well as its unified and integrated infection prevention/control programs and antibiotic stewardship programs.

10. Can an REH have physician ownership?

Under the Stark Law, a physician cannot make a referral for designated health services payable by Medicare to an entity with which the physician or an immediate family member has a financial relationship, unless the elements of an exception are met.[13] Commonly used exceptions for CAHs and other small, rural facilities will be unavailable or inapplicable to entities which elect to enroll as REHs. Therefore, CMS seeks to encourage the expansion of rural health resources by establishing a relatively broad new exception to the physician self-referral law which would permit physicians to own and invest in REHs. To satisfy the exception, all of the following criteria must be met:

1. The entity is enrolled in Medicare as an REH.

2. The ownership or investment interest is in the entire REH and not merely in a distinct part or department of the REH.

3. The REH does not directly or indirectly condition any ownership or investment interest held or to be held by a physician (or an immediate family member of a physician) on the physician making or influencing referrals to the REH or otherwise generating business for the REH.

4. The REH does not offer any ownership or investment interests to a physician (or an immediate family member of a physician) on terms more favorable than the terms offered to a person that is not a physician (or an immediate family member of a physician).

5. Neither the REH nor any owner of or investor in the REH directly or indirectly provides loans or financing for any investment in the REH by a physician (or an immediate family member of a physician).

6. Neither the REH nor any owner of or investor in the REH directly or indirectly guarantees a loan, makes a payment toward a loan, or otherwise subsidizes a loan for a physician (or an immediate family member of a physician) that is related to acquiring any ownership or investment interest in the REH.

7. Ownership or investment returns are distributed to each owner of or investor in the REH in an amount that is directly proportional to the ownership or investment interest in the REH of such owner or investor.

8. Physicians (or immediate family members of physicians) who have ownership or investment interests in the REH do not directly or indirectly receive any guaranteed receipt of or right to purchase other business interests related to the REH, including the purchase or lease of any property under the control of any other owner of or investor in the REH or located near the premises of the REH.

9. The REH does not offer a physician (or an immediate family member of a physician) the opportunity to purchase or lease any property under the control of the REH or any other owner of or investor in the REH on more favorable terms than the terms offered to a person that is not a physician (or an immediate family member of a physician).

With a looming statutorily required effective date of January 1, 2023, CMS is expected to finalize regulations on this new provider type in the coming months. The establishment of the rural emergency hospital poses an exciting

[13] 42 U.S.C. § 1395nn.

opportunity for critical access hospitals and other rural facilities to enhance profitability and expand networks of care. For additional inquiries regarding rural emergency hospitals, please contact Emily Towey or another member of at Hancock, Daniel & Johnson, PC.'s Licensure, Certification and Enrollment practice group.