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CMS Guidance on Rural Emergency Hospitals

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On January 1, 2023, Medicare began paying for services provided at Rural Emergency Hospitals (REHs), a newly created provider type established to preserve access to emergency health care in rural areas and avert closure of rural hospitals. The new REH category, which was created by Congress in Section 125 of the Consolidated Appropriations Act of 2021, provides increased reimbursement to certain critical access hospitals (CAHs) and rural hospitals that meet the requirements for and elect to convert to an REH. The Centers for Medicare and Medicaid Services (CMS) finalized regulations implementing REH requirements and payment methodology in the CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule.

Eligibility and Conditions of Participation

A CAH or rural hospital with less than 50 beds as of December 27, 2020 (including a hospital that closed after December 27, 2020), may be eligible to convert to an REH. Among other requirements, an REH must:

- be enrolled in Medicare;
- not provide acute care inpatient services;
- have a transfer agreement with a level I or level II trauma center;
- be licensed as an REH by their state (in a state that licenses REHs);
- not exceed an annual per-patient average of 24 hours of services;
- have a staffed emergency department 24 hours a day, 7 days a week;
- have a physician, nurse practitioner, clinical nurse specialist, or physician assistant available to furnish REH services at the facility 24 hours a day; and
- meet applicable staffing requirements (similar to those for CAHs).

The REH CoPs largely track existing CAH CoPs.

Reimbursement

REHs must provide emergency services and observation care, but are prohibited from providing acute inpatient services (except post-hospital extended care services in a distinct part-skilled nursing facility unit). REHs may also choose to provide other covered outpatient department services (collectively, REH Services) that are reimbursable under the Hospital Outpatient Prospective Payment System (OPPS). REH Services are paid at 105 percent of the OPPS rate, while other non-REH Services (e.g., laboratory services paid under the Clinical Laboratory Fee Schedule and certain diagnostic tests not paid under the OPPS) are reimbursed at applicable fee schedule rates.

An REH also receives an additional monthly facility payment that was calculated using 2019 CAH reimbursement. The monthly REH facility payment for 2023 is $272,866, aggregating to almost $3.3 million annually. This rate will be increased by the hospital market basket percentage each year beginning with 2024.

This means that physician services previously reimbursed under the CAH method II billing methodology before a CAH's conversion would be reimbursed under the physician fee schedule for an REH. However, off-campus

provider-based departments of an REH will also receive the 5 percent payment increase when furnishing REH Services.

Enrollment

To facilitate conversion for interested hospitals, CMS has created an abbreviated application process for converting to an REH. Eligible providers need only file an 855A change of information application rather than an initial enrollment application. No application fee is required and converting entities will be in the "limited" enrollment screening category. However, REHs that wish to convert back to a CAH or other hospital type in the future will have to complete the initial application process.

Stark Implications

There may be opportunities for physician investments in an REH, but parties should be aware of limitations in doing so. REHs are not considered "hospitals" for purposes of the Physician Self-Referral Law, commonly referred to as the Stark Law. Therefore, the Affordable Care Act's prohibition on non-grandfathered physician investment does not apply. As such, the rural ownership exception of 42 C.F.R. §411.356(c)(1) often should be available to an REH, as long as at least 75 percent of the REH's "designated health services" are furnished to residents of rural areas.

Notably, CMS did *not* finalize a proposed REH exception, because CMS was persuaded by commenters that the rural ownership exception should suffice and a broader exception was unwarranted. While the rural ownership exception under the Stark Law may be relatively easy for most REHs to satisfy, any physician investment arrangements in REHs should be carefully structured to also comply with the Anti-Kickback Statute.

Takeaways

While the increased payment rate and facility payment are tempting, CAHs and rural hospitals considering a REH conversion should carefully assess the financial impact of the reimbursement changes, loss of acute inpatient services, reporting requirements, and organizational changes needed to adjust operations to meet REH requirements. State licensure requirements also must be considered. While some states already have freestanding emergency facility licensing provisions, other states have had to scramble to create and implement new license categories to allow facilities to take advantage of the new REH designation. Facilities considering or pursuing conversion should confirm licensing requirements and timeframes to determine their impact on operational objectives.

For more information about REH conversion considerations, please contact Joseph Keillor, Kathleen R. Salsbury, or any member of Baker Donelson's Health Law team.