Rural Emergency Hospitals

Evolution or Revolution?

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†This is not a CPA firm.

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Identity Crisis – Who am I ?

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Identity Crisis – Who do I need to be?

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When a community's ER closes….

- Economic development withers
- Disinvestment occurs
- Community de-population
- Prison system closure
- Mortality rates increase

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REH Overview

- Statutory/Regulatory Framework
- Enrollment process
- Payment Considerations
- Conversion Considerations

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Statutory

- Consolidation Appropriations Act (CAA) of 2021
- 2023 Outpatient Prospective Payment (OPPS) Final Rule — CFR 485.502 – REH defined
- CMS CoPs regulatory guidance
- State licensure / regulatory

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CAA of 2021

Decision Point	Must	May	Can't
Inpatient Acute Care			●
Inpatient swing-bed service			●
Inpatient SNF services		●	
24/7 Emergency room service (CAH-like)	●		
Less than 50 beds **(as of 12/27/2020)**	●		
Located in a rural area **(as of 12/27/2020)**	●		
Observation services	●		
Transfer agreement with Level I or II trauma center	●		
Transition plan to REH	●		
State licensure as REH	●		
Off-campus outpatient services		●	
Originating site for telehealth		●	
Allowed to convert back to CAH or PPS		●	

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Statutory Rigidity

CFR 419.94

The REH statute is "precluded from administrative or judicial review" for purposes of:

- CoPs
- Additional payment rates
- Determination of REH qualification

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Rigid criteria!
CFR 485.506

- <50 beds and rural as of 12/27/2020
- Rural – 1) located outside CBSA or
- 2) reclassed to rural
- Less than 50 beds – based upon available bed days

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FAQs

- Can a qualifying hospital closed after 12/27/2020 reopen/convert to REH?
  YES
- Can REH retain "necessary provider" CAH designation?
  NO
- Can a REH relocate?
  YES, if rural classification is maintained

Source: QSO-23-07-REH

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FAQs - continued

- Transfer agreement: Can the Level I/II trauma center located in another state?
  YES
- Can REH have other transfer agreements?
  YES

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Length of Stay Limitations

- ALOS limit is 24 hours
  - Composite Average
  - Registration or triage til discharge
  - Based upon all visits/procedures; not limited solely to observation services
  - Extraordinary circumstances may be considered

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Off-campus REH services CFR 419.93

§603 amendments would not apply to REHs	• Off-campus PBD would be paid APC+5%
PB RHCs as of December 31, 2020	• status and base rate grandfathered *(pg 72167 FY 2023 OPPS final rule)*

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CMS CoPs CFR 485.500 thru .546

- Similar to CAHs
- Physician or physician extender on-call at all times and available on-site within 30 minutes
- Quality assessment / improvement program

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REH Quality Reporting Program (REHQR) CFR 419.95

Will update specs at least every 12 months

- Substantive changes will be done thru rulemaking
- Non-substantive will be done administratively

Data will be publicly available

- Begin after 3-yr data collection period (2027)
- Providers will have opportunity to review prior to publication

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Current REH Quality Measures

- Current measures:
  - Abdomen CT – use of contrast[1]
  - Median time for ED – Arrival to discharge
  - Hospital visit post colonoscopy (7-day window)[1]
  - Hospital visit post surgery[2] (7-day window)[1]
  - Health Equity Measures[3]
  - Social Drivers of Health (SDOH)[3]

[1] Fully claims based (traditional Medicare only); no additional data collection

[2] Excludes eye surgeries

[3] Proposed for removal (FFY 2026 OPPS)

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Proposed new measure -FY 2026

- Emergency Care Access & Timeliness (eCQM)
  - Alternative to ED median time reporting
  - More comprehensive than ED median time
    - Wait time
    - Left w/o evaluation
    - Transfer boarding time
    - Length of stay
  - Reported as a ratio

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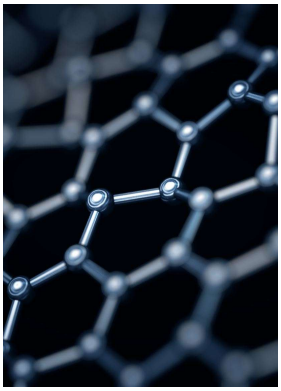
eCQM Reporting

Denominator – all ED visits

Numerator

- >1hr wait time (arrival to H&P eval)
- Patient left ED w/o H&P
- >4 hr ED boarding for transfers
- >8 hrs for ED LOS*

**excludes ED observation stays*



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REH Enrollment

- Document checklist

  - ✓Attestation & action plan
  - ✓Executed transfer agreement w/ Level I or II trauma center
  - ✓List of medical staff
  - ✓Hospital bylaws & Board minutes approving conversion
  - ✓Lease & management agreements, if applicable
  - ✓Planned construction or renovation plans, if applicable
  - ✓Current emergency operations plan approval letter

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REH Enrollment - continued

- Submit 855A
  - Application fees waived
  - Change of info rather than new enrollment
  - Attestation in lieu of site survey; reopened facilities would require on-site survey
  - https://www.cms.gov/files/document/reh-medicare-provider-instructions.pdf
- Remains effective until:
  - REH elects to convert back to PPS/CAH
  - Secretary determines the facility does not meet REH requirements
  - Unlike the conversion to REH, these re-converts would be new/initial enrollments

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REH – Action Plan

- Submitted to State Licensing Agency
  - Licensure ⇨ CMS ⇨ MAC
- Outline provision of services
  - Retain, modify, add or discontinue
- Use of additional facility payment
  - Cost report serves as proxy for now

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REH – Payment Considerations

- Service offerings OPPS
  - CFR 419.91
- Service payments – CFR 419.92
  - OPD services: APC + 5%
  - SNF : PDPM
  - Non-OPD services: @ respective method, i.e. FFS, AIR, etc
  - Additional Facility Payment (subsidy)
    - Fixed sum of difference in PPS and CAH pmts
    - Monthly (FY 2025 $285,625.90 net of seq.)
    - Increased annually by MB (2025 annual $3.4m)
- No change in reimb for provider-based RHCs

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Profile of REH Candidate

- Low to moderate IP supplemental payments
- Little to no Medicaid DSH payments
- Low ADC (acute +SWB)
- Small to negative margin on geri-psych DPU
- Little to no 340B benefit

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Conversion Considerations -Financial

Review initial / high level projections

- Carefully consider assumptions; identify needed modifications
- Identify significant operational/financial changes since the most recent cost report

Deep dive into expense savings due to inpatient closure

- Are you prepared to reduce staff?

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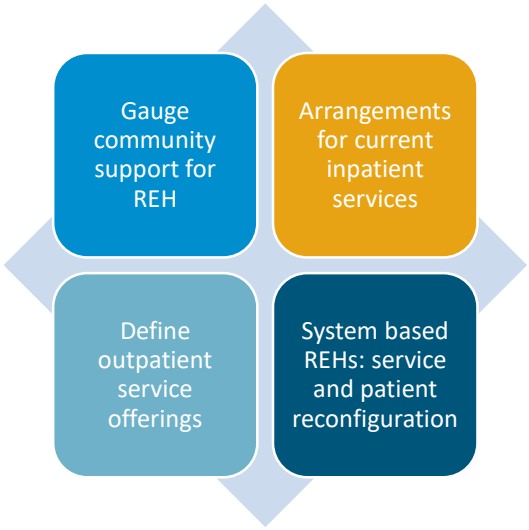
Conversion Considerations - Operational



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Cost reporting implications

- New REH provider number XX-07XX
- Terminating cost report on PPS provider number
- REH will use same cost report forms (2552-10)
  - Additional facility payment reported on W/S E, Part B line 28.50
- Timing of Medicare bad debts on PPS accounts
  - WPS guidance - PRM 15-1 §2176.2

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Current REH Stats

- Nationally – 43
- Mississippi - 7
- Arkansas - 5
- Oklahoma - 4
- Texas – 4
- Louisiana - 1

As of September 2025

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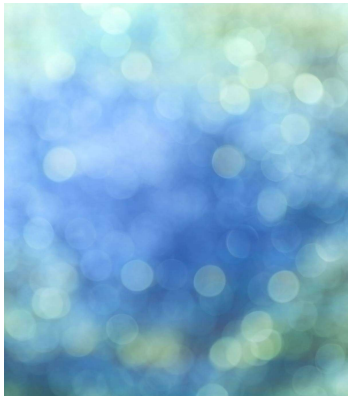
Who should I be?

- What your community needs
- What your community will support
- What your finances can sustain
- **The right answer is a WIN!**



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Potential improvements to REH Statute

- Expanding definition of rural to include designations of the Federal Office of Rural Health Policy (FORHP)
  - Trapped rural hospitals
- Retention of “necessary provider” CAH status
- Participation in 340B program
- Widen prerequisite opening date
- Participation on uncompensated care pool
- More favorable Medicaid reimbursement
  - Statutory fix for definition of REH for Medicaid purposes

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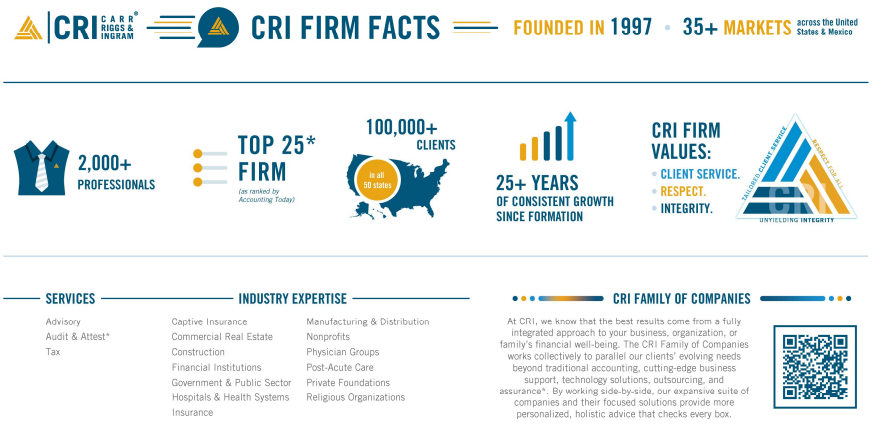
CRI Firm Facts



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- Today's Presenter -

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