Rural Emergency Hospital (REH) Model

Frequently Asked Questions

January 2023 (version 1)

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?

According to the Consolidated Appropriations Act, a facility is eligible to enroll as an REH if it is a critical access hospital (CAH) or a rural hospital with 50 beds or less as of the date of enactment of the Consolidated Appropriations Act[ii], which was enacted on December 27, 2020.

When can providers convert to an REH?

Eligible providers may convert to an REH on or after January 1, 2023. The REH designation was created by Section 125 of the Consolidated Appropriations Act of 2021, which was enacted on December 27, 2020, and adds section 1861(kkk) to the Social Security Act.

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% for REH-covered services. Non-REH services (such as laboratory, distinct part Skilled Nursing Facility services) are paid the facility's respective fee schedule and do not qualify for the additional 5% payment. In addition, REHs will receive a monthly facility payment of $272,866 in 2023, with annual increases determined by the hospital market basket.

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.

Can my 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.[iii]

Which states recognize or allow the REH provider designation?

There are several states that have recognized REHs ahead of the launch of the program in January 2023. According to the National Conference of State Legislatures, Kansas, Nebraska, and South Dakota have passed legislation establishing the licensure of REHs as of August 2022.[iv] Michigan passed SB 183 during its December 2022 legislative session, which outlines the process for state licensure of REHs.[v] The Texas Health and Human Services Commission also published a strategic plan that focuses on Medicare patient access in rural hospitals in November 2022.[vi] Federal lawmakers from Iowa have sought clarification from the Centers for Medicare and Medicaid on whether hospitals that have closed prior to the launch of the REH designation could still become REHs and open in the future, indicating a strong interest in the designation there.[vii]

Our CAH closed in 1998, can we reopen as an REH?

A hospital must have been operating as a licensed hospital on December 27, 2020, when the legislation was passed allowing the new designation. As a result, since your hospital closed in 1998, and was not functioning as a hospital as of this date, it is not currently eligible to be reopened as a licensed REH.

Can we revert back to a previous designation after REH conversion?

REHs can convert back to a previous provider type, except in the case of a former CAH that was designated as a CAH through a necessary provider waiver. Converting back to a PPS hospital or CAH would require an initial enrollment application and associated fees.

Conditions of Participation

What services are REHs required to provide?

Rural Emergency Hospitals are required to provide 24-hour emergency services with standards similar to those of Critical Access Hospitals and other hospitals.[viii] 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.

Are there special staffing requirements for REHs?

Per the Final Rule, CMS is requiring 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, similar to 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.

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. Services provided within the distinct part SNF units of an REH, however, are not subject to the 24-hour requirement. The Final Rule summarizes the methodology for computing the average annual per patient length of stay, and states that the 24-hour period begins with the earlier of the registration, check-in, and triage of a patient and ends when the patient is discharged from the REH.[ix]

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."[x]

How are number of beds defined or calculated?

The number of beds is calculated by taking the number of available bed days during the most recent cost reporting period and dividing by the number of days in the most recent cost reporting period.

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

Rural Emergency Hospitals 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.

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)."[xi] 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.

Payment Policies

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%. 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% payment; the payment amounts will be determined in the same way they were determined under OPPS.[xii]

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% reimbursement for OPPS services.

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

The additional REH facility payment for 2023 is $272,866 per month. In subsequent years, this additional facility payment will be increased by the hospital market basket percentage increase.

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

[ii]"Consolidated Appropriations Act, 2021" Available at: https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf

[iii] "Rural Emergency Hospital (REH) Model Summary" National Rural Health Association, April 2021. Available at: https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2021/04-15-21-NRHA-Rural-Emergency-Hospital-overview.pdf.

[iv] "Rural Emergency Hospitals". National Conference of State Legislatures. August 12, 2022. Accessed January 9, 2023. Available at: https://www.ncsl.org/health/rural-emergency-hospitals.

[v] "Rural Emergency Hospital Legislation Passed in Michigan". Michigan Health and Hospital Association. December 9th, 2022. Accessed January 9th, 2023. Available at: https://www.mha.org/newsroom/rural-emergency-hospital-legislation-passed-in-michigan/.

[vi] "Rural Hospital Services Strategic Plan Progress Report." Texas Health and Human Services Commission. November 2022. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/rural-hospital-services-strat-plan-nov-2020.pdf.

[vii] "Grassley, Miller-Meeks Seek Assurance For Keokuk On Potential Rural Emergency Hospital Designation." Chuck Grassley, United States Senator for Iowa. October 5, 2022. Available at: https://www.grassley.senate.gov/news/news-releases/grassley-miller-meeks-seek-assurance-for-keokuk-on-potential-rural-emergency-hospital-designation.

[viii] CMS Final Rule, Conditions of Participation, 72183 – 72211.

[ix] CMS Final Rule, Conditions of Participation, 72184.

[x] CMS Final Rule, Conditions of Participation, 72201.

[xi] "Medicare Outpatient Observation Notice (MOON) Form CMS-10611" Report."HHS. December 2020. Available at: https://www.hhs.gov/guidance/document/medicare-outpatient-observation-notice-moon-form-cms-10611.

[xii] CMS Final Rule, Payment for Services Performed by REHs, 72164.