REH-TAC

Does the Rural Emergency Hospital Designation make sense for me?

July 12, 2023

RURAL HEALTH REDESIGN CENTER

Goals for the today

- Introduce you to the RHRC, the REH-TAC
- Educate you on the REH designation
- Provide an overview of the TA services available through the RHRC
- Answer your questions

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Rural Health Redesign Center: REH Technical Assistance Center

Who We Are

A collaboration of multiple organizations with unique expertise formed to provide a comprehensive catalog of technical assistance services to support REH consideration and transition

Rural Health Redesign Center
Mathematica
EMS Premier Consulting
JSR Marketing
Hall Render

Leveraging collective experience and a commitment to improving the lives within rural communities, we are equipped to provide thorough technical assistance in alignment with the terms of our cooperative agreement with the Health Services and Resources Administration (HRSA).

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The Rural Health Redesign Center Organization (RHRCO) leadership is passionate about its mission and looks to advance it through its guiding principles.

Our Guiding Principle

We will **S**erve with **E**xcellence through **R**apid **R**esponse to bring **V**alue to **E**very partner community.

1. We are a **service** organization and exist to support rural providers and communities that need our assistance.

2. We perform our work with the highest degree of **excellence** with integrity and ethical standards.

3. We respond to all of our partners quickly through **rapid response** whenever feasible; acknowledging outreach and making a commitment to meet needs within a reasonable amount of time.

4. We provide **value** to our partners through providing high-quality, rural relevant technical assistance and consulting services.

5. We make this same commitment to **every** partner community and customer.

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The RHRCO REH Team – Core Team Members

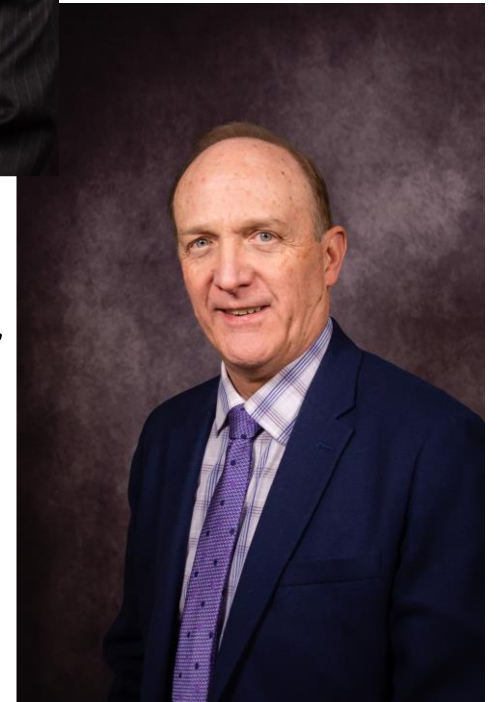
Anna Anna, Program Director

Angela Slemok, Project Manager

Bill Bizzaro, Senior Financial Analyst

Ed Pitchford, Provider Liaison

Gary Rhodes, Provider Liaison



Dan Simmons, Provider Liaison

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The RHRCO REH Support Team Members

Janice Walters, Program Officer

Tracey Dorff, Program Support

Candice Talkington, Strategic Planning Manager

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Mathematica REH Support Team Members

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Senior Fellow

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Advisory Services Analyst

Rachel Campbell-Baier,
Research Associate

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Business Analyst

Haley Flanagan, Advisory
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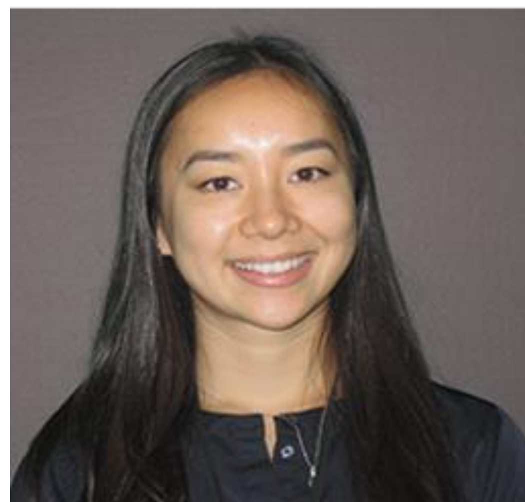

Sandra Chao,
Senior Researcher

James Haven,
Researcher

Other Mathematica Team Member not pictured:
Hanna Friedman-Bell, Advisory Services Analyst

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REH Overview

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Rural Emergency Hospital (REH)

The REH is a new Medicare provider type was established on December 27, 2020, and is designed to serve rural communities by:

Effective January 1, 2023

More information: REH provider type rules outlined in the Social Security Act and the [Code of Federal Regulations](#) was effective January 1, 2023

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Eligibility Criteria

To qualify as an REH, the hospital must:

Be in a rural area and licensed as a critical access hospital (CAH) or rural prospective payment system (PPS) hospital as of December 27, 2020, with fewer than 50 beds

Be a licensed Medicare provider

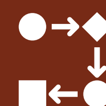
Meet staff training and certification requirements

Meet annual average length of stay requirements*

Meet state licensure requirements for REH

Have an established transfer agreement with a level I or level II trauma center

Meet conditions of participation (similar to a CAH or PPS hospital for emergency services)



Have an action plan including provisions for staffing, a transition plan, and description services offered

*The annual per patient average length of stay (LOS) cannot exceed 24 hours. The LOS begins at the time of registration, check-in, or triage of the patient, whichever occurs first, and ends upon discharge from the REH. District part SNFs are not subject to 24-hour annual average LOS.

More information: Sections 1886(d)(1)(B), 1886(d)(2)(D), and 1886(d)(8)(E) of the Social Security Act

The REH must provide:

24/7 emergency and observation services with an annual average length of stay of less than 24 hours for all REH services

Diagnostic lab and radiological services

A pharmacy drug storage area

Discharge planning overseen by a qualified professional

REHs do not provide inpatient care but have agreements with other hospitals to transfer patients when needed

More information: Section 485 in the Code of Federal Regulations and 1886(d)(1)(B), 1886(d)(2)(D), and 1886(d)(8)(E) of the Social Security Act

REHs can also offer:

- Telehealth
- Outpatient surgery
- Maternal health
- Low-risk labor and delivery services (supported by the necessary emergency surgical procedures)
- Care through a rural health clinic
- Primary care services
- Ambulatory and transport services
- Post-hospital care (non-inpatient)
- Care through a Skilled Nursing Facility
- Behavioral health (including substance use treatment)
- Routine laboratory services*

*Tests such as complete blood count, basic metabolic panel, liver function test, and other routine laboratory tests

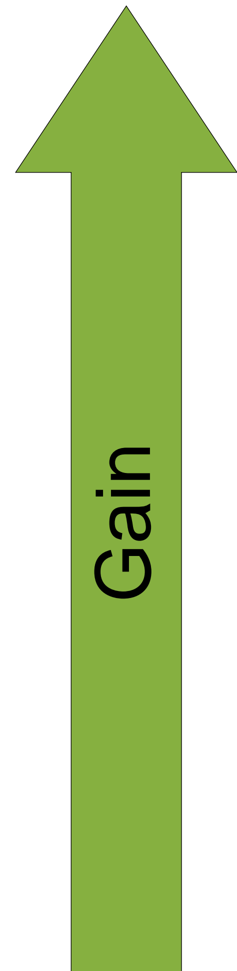
REH Payment Flexibilities

Special payment flexibilities for Medicare FFS only

- Increased payment rates for OPPS, including a monthly facility payment
- Medicaid and commercial payments are not directly impacted
- Not a temporary CMS model or demonstration
- Beginning in 2023, rural hospitals meeting Conditions of Participation may convert to REH

More information: See sections 413.24(f)(4)(ii) and 485.546 in the Code of Federal Regulations

Payment Summary



- REH services: Outpatient Prospective Payment System (OPPS) + 5% for Medicare FFS
- $3.2 million per year in monthly facility payments from CMS

- Close inpatient services (all-payors)
- Close swing bed services/shift to SNF
- Not eligible for 340(B) drug pricing
- Cost-based reimbursement for CAHs

No change: Rural Health Clinic, Physician payment rates, Non-REH services for PPS hospitals (paid under Medicare Physician Fee Schedule). Beneficiary's cost sharing is not impacted by these changes

More information: Section 1833(t)(1)(B)(v) and (t)(21), 603 amendments to section 1833(t), and1834(I) of the Social Security Act and [Calculation of Rural Emergency Hospital (REH) Monthly Additional Facility Payment for 2023 (cms.gov)]

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Conditions of Participation

The REH CoPs include requirements for health and safety standards similar to a CAH or PPS such as:

- ✓ Staffing (clinical and non-clinical)
- ✓ Nursing services
- ✓ Patient rights agreements
- ✓ Blood product
- ✓ Physical requirements
- ✓ Radiological services
- ✓ Pharmaceutical services
- ✓ Laboratory services
- ✓ Emergency services
- ✓ Infection control

*This list demonstrates a sample list of CoPs and does not represent an exhaustive list.
More information: See pages 72183 – 72211 and sections 482.23, 482.55, 485.516, 485.618, 485.631, and 491.8 in the Code of Federal Regulations

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Conversion Requirements

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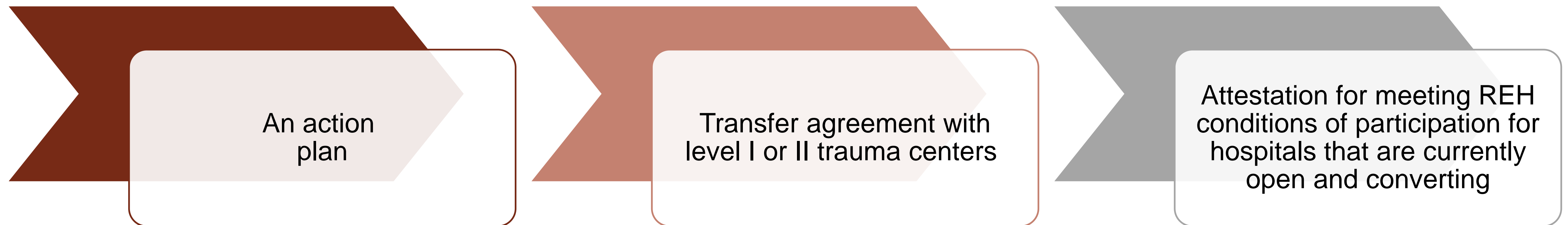
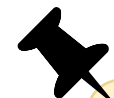
Guidance on REH Conversion Requirements





More details about the requirements and templates can be found in the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo

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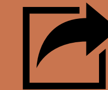
REH Action Plan Must Include

Description of Services

Detailed description of outpatient services that the facility intends to provide

Provisions for Staffing and Services

Provisions for staffing and services provided by the REH



Transition Plan

Plan outlining transitions for all services that the facility will retain, modify, add, or discontinue

Proposed rule supports allowing REHs to be graduate medical education (GME) training sites. See CMS-1785-P proposed rule for more information

Submit with the REH application signed by hospital's legal representative

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Transfer Agreement

A transfer agreement with at least one Medicare certified level I or level II trauma center is required

Intent is to ensure there is a process to transfer patients who require emergency and continued care services beyond the capabilities of the REH

Submit a copy of the transfer agreement to your state agency along with the REH application

More Information: Section 1861(kkk)(2) of the Consolidated Appropriations Act and at new 42 CFR § 485.538 Social Security Act and the Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation memo

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Self-attest to Conditions of Participation (CoPs)

Hospitals that were eligible to convert to an REH prior to December 27, 2020, can self-attest to meeting REH CoPs

Eligible hospitals are not automatically subject to on-site initial survey*

Self-attestation form to be included with REH conversion application

EXHIBIT

(Rev.)

Model Attestation of Compliance for Rural Emergency Hospital Enrollment and Conversion

(Date of Request)

Name of Facility

Street Address

City, State, ZIP code

Dear (State Agency),

[**Name of facility**] is requesting enrollment and conversion to a Rural Emergency Hospital (REH). [**Name of facility**] is an eligible facility because as of December 27, 2020, the facility was operating as (choose one of the following options):

1. A critical access hospital
2. A hospital, as defined in section 1861(d)(1)(B) of the Social Security Act (the Act), with not more than 50 beds located in a county (or equivalent unit of local government) that is considered rural (as defined in section 1881(d)(2)(D) of the Act)
3. A hospital, as defined in section 1881(d)(1)(B) of the Act, with not more than 50 beds that was treated as being located in a rural area that has had an active reclassification from urban to rural status as specified in 42 C.F.R. § 412.103 as of December 27, 2020

I understand that as an REH, [**Name of facility**] must meet all the Conditions of Participation (CoPs) in 42 CFR Part 485, Subpart E, including but not limited to the following:

____ §485.514 CoP: Provision of Services

____ §485.516 CoP: Emergency Services

____ §485.526 CoP: Infection prevention and control and antibiotic stewardship programs

____ §485.528 CoP: Staffing and staff responsibilities

____ §485.534 CoP: Patient Rights

____ §485.538 CoP: Agreements **(attach copy of transfer agreement with a certified level I or II trauma center)**

____ §485.544 CoP: Physical Environment

Sample Attestation Form

*Facilities that were eligible as of December 27, 2020, which subsequently closed and re-enrolled in Medicare would require an initial on-site survey by the state agency.

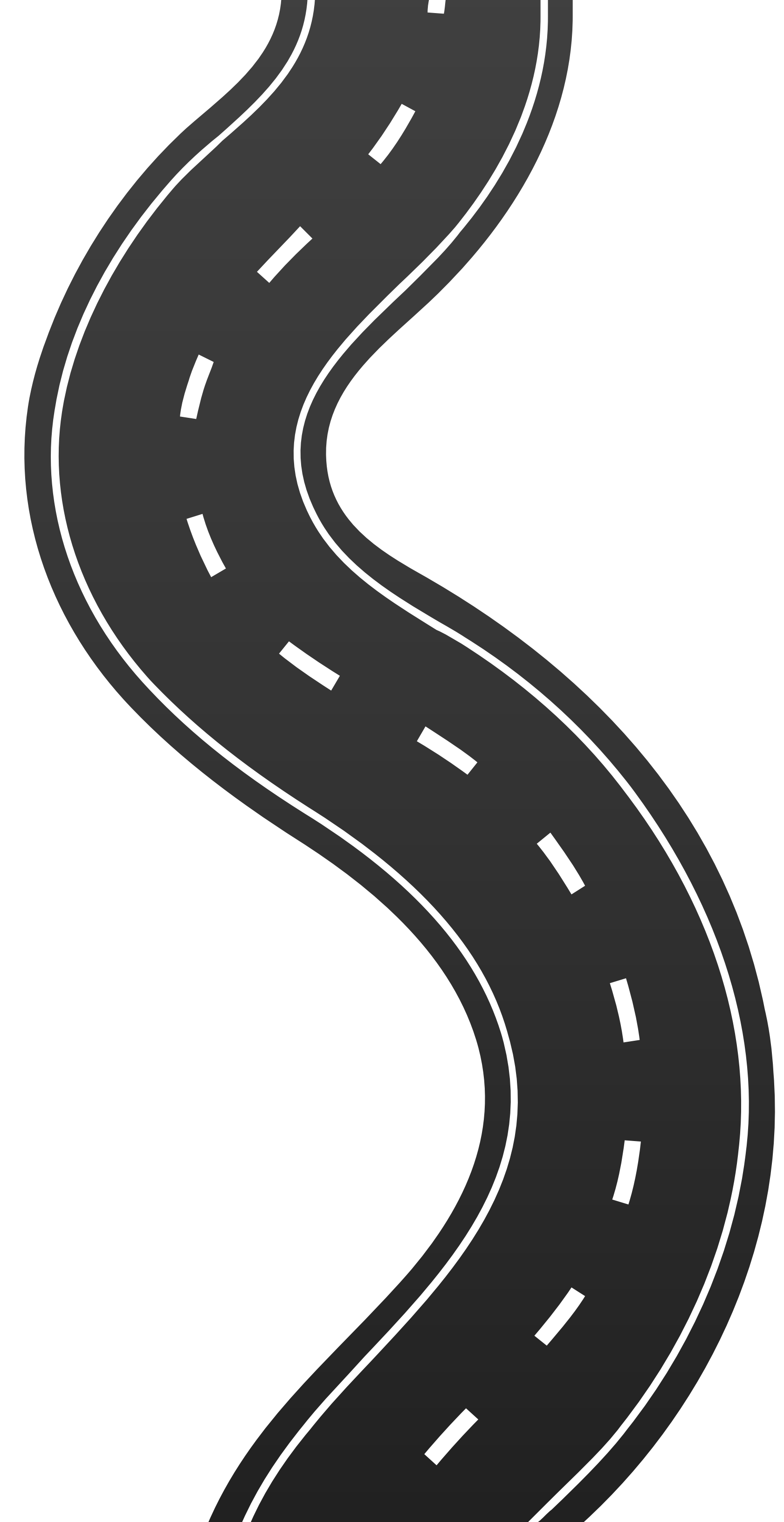
More information: Subpart E of 42 CFR Part 485 (§ 485.500 - § 485.546) Social Security Act and the [Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation]() memo

REH Rural Status and Distance Requirements

REH must meet rural status requirements and eligible hospital definitions as of 12/27/2020

REHs are not expected to meet the same distance or mileage requirements relative to other facilitates (other than being an area designated as rural) as CAHs

More Information: State Operations Manual Chapter 2, section 2256A



REH Enrollment and Converting Back

Enrollment status

- Enrollment is effective on the date the state agency, CMS, or CMS contractor survey is completed or on the effective date of the accreditation decision
- REH status remains effective unless:
  - Hospital elects to convert back; or
  - The Secretary determines that the facility no longer meets the REH requirements

Converting Back

- REH can convert back to a CAH or PPS Rural Hospital
- Conversion back to a CAH or PPS requires an initial enrollment application and consideration for being a CAH for PPS Rural Hospital
- CAHs that received their designations through necessary provider waivers cannot convert back

More information: See sections 1866(j)(1)(A) of the Social Security Act and sections 424.500, 424.570, and 485 in the Code of Federal Regulations

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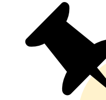
Reporting Requirements

Cost reporting:

- REHs are required to file cost reports
- Cost reporting mirrors current CAH requirements
- For CY 2023, no new reporting or data collection requirements related to REH monthly facility payments



While cost reporting is required, cost-based reimbursement does not apply to REHs

Quality Reporting

- Must report quality measures (pending final approval)
- Must have an account with the Hospital Quality Reporting (HQR) secure portal and have a designated Security Official (SO) during the initial setup
- Likely similar to current CAH and PPS requirements related to outpatient services

More information: See section 1861(kkk)(7) of the Social Security Act and 413.24(f)(4)(ii) and 485.546 in the Code of Federal Regulations

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REH Quality Measurement Reporting Requirements

Proposed measures align with CAH quality reporting requirements and are awaiting final approval

- Submit quality measures for each year beginning in 2023 or each year on or after measures are first specified
- Make data available to the public on the CMS website
- Report on quality measures and reporting requirements outlined in proposed rule 87 FR 44755
- Meet CMS requirements for provider and supplier certification

More information: See section 1861(kkk)(7) of the Social Security Act and

Technical Assistance Available

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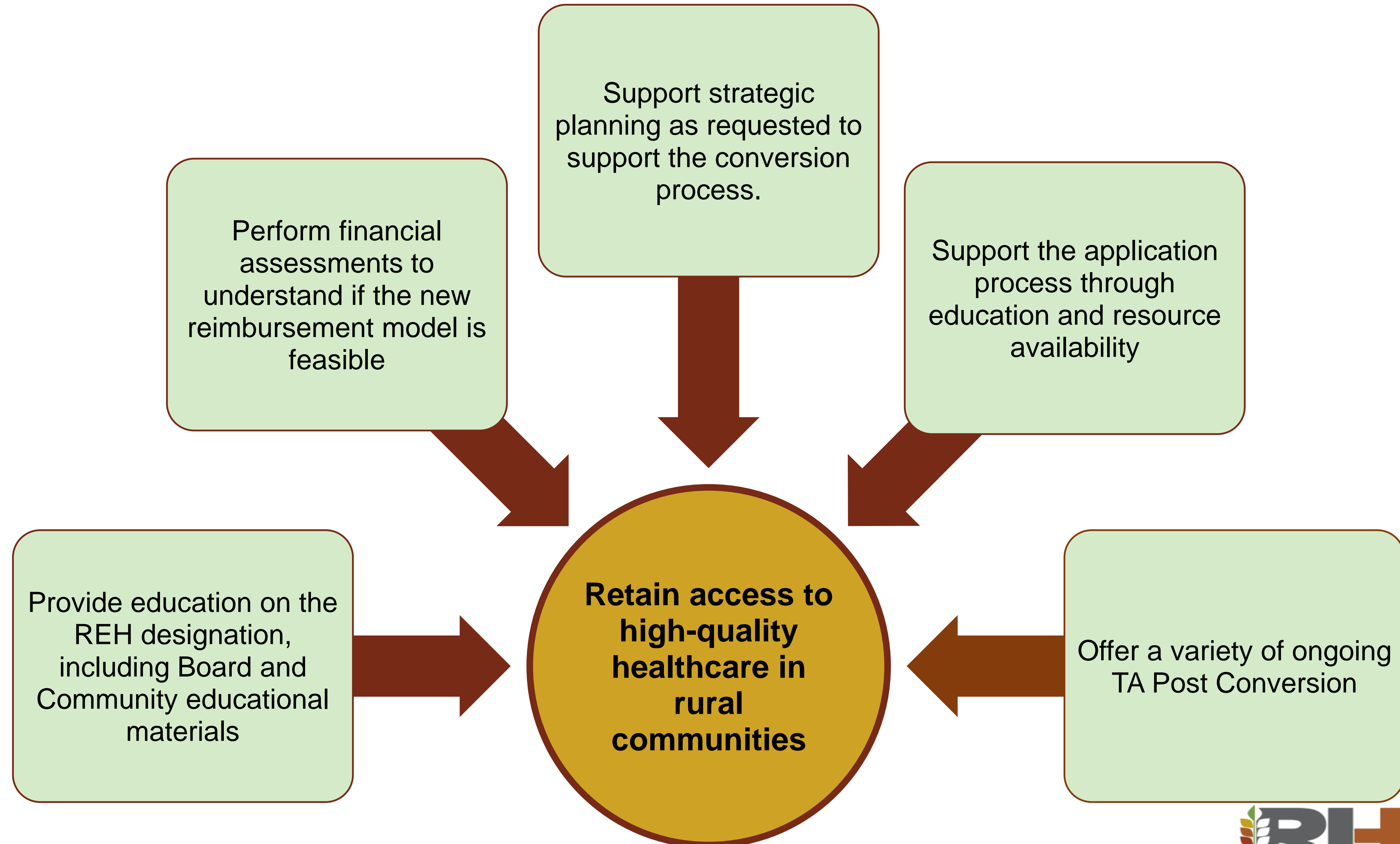
What We Do: TA Services Provided



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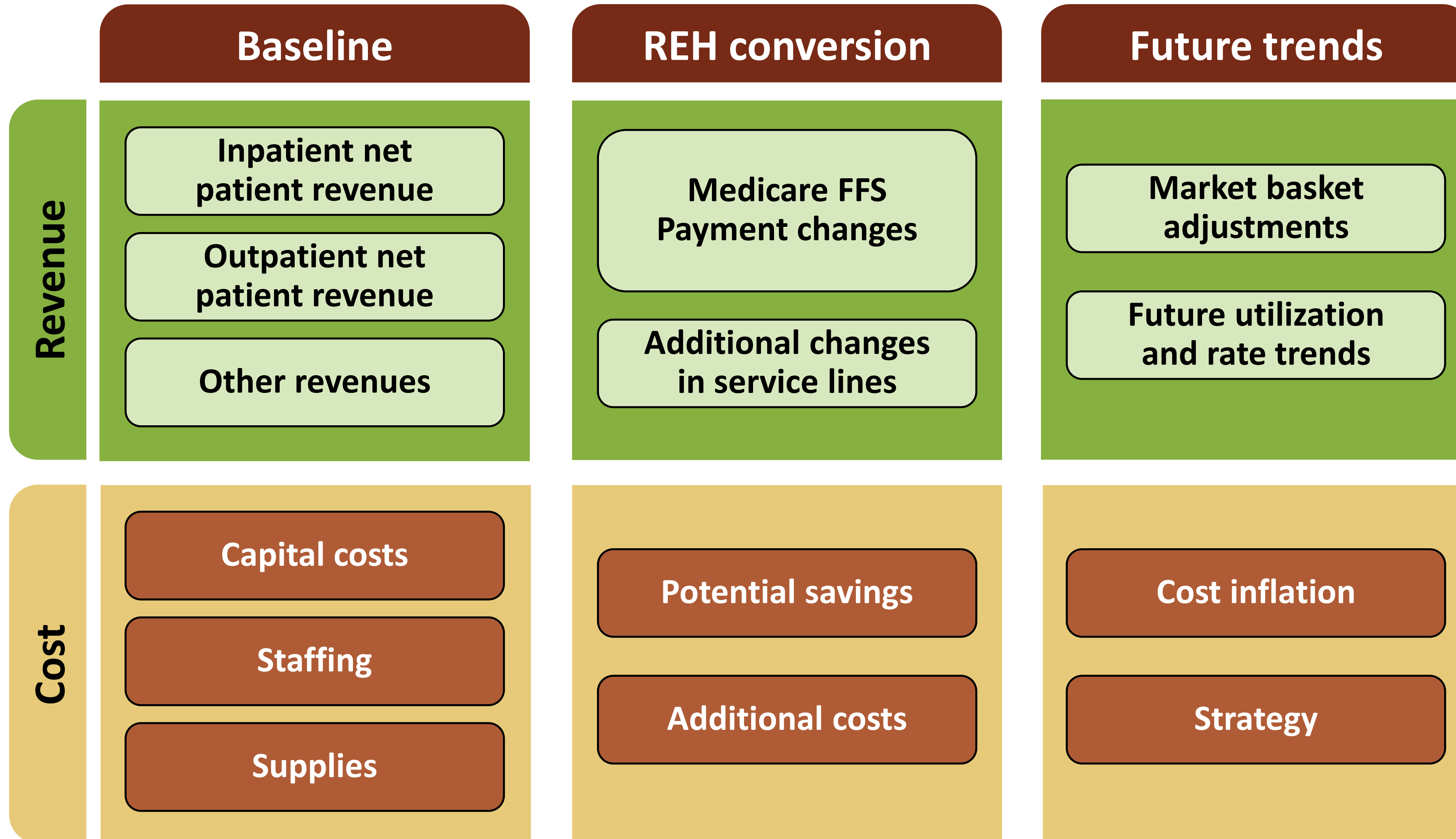
Rural Health Redesign Center: REH Technical Assistance Center

Our Approach

- Work cooperatively with HRSA, State Offices of Rural Health, and Flex Coordinators to identify interested hospitals
- Respond quickly to direct inquiries made through our support line: **REHSupport@rhrco.org**
- Protect the identify of each hospital organization we work with through a NDA
- Provide a full compliment of skilled team members including a liaison with rural relevant subject matter expertise
- Provide a variety of rural relevant TA including financial assessments, outmigration reports, strategic planning, draft transfer agreements, board and community education material, marketing tool kits, legal advice, etc.
- Assist with the application and provide ongoing support

Financial Assessment

- How does REH conversion impact the financial health of your hospital?



Data sources:

Revenue
- Medicare cost reports
- Hospital intake forms
- Medicare FFS claims
- Repriced CAH Medicare claims

Cost
- Medicare cost reports

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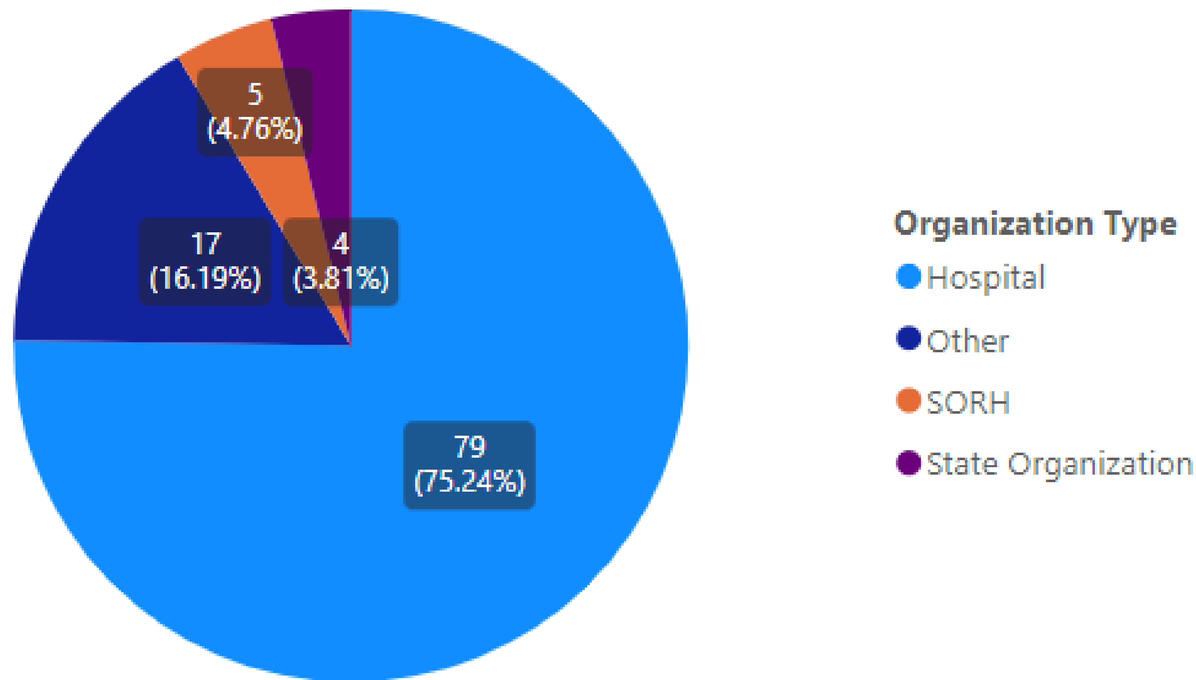
REH-TAC Outreach Activities

Almost 80 hospitals from across 35 states have reached out to the REH-TAC thus far. This number changes weekly

REH-TAC Outreach Activities as of June 30th.



- Roughly 51% of hospitals that have outreached are interested in advancing to the financial assessment phase.
- The REH-TAC is currently working with 27 hospitals as part of its 2nd cohort with financial modeling.
- There is no obligation to advance with application upon completion of financial modeling or working with the REH-TAC.

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Early Outreach Learnings

Census

- Inpatient census less than 6 on average
- Swing Bed Census less than 2 on average

Other

- Most believe there is adequate EMS in the community, although not all.
- Most already have transfer agreements in place, but not all

Revenue

- Acute inpatient revenue <$5M on average
- Swing Bed revenue <$1M on average
- 340(B) < $750K on average
- Medicare payer mix <50% or less

REH-TAC Learnings

Identified Conversion Barrier
No Swing Bed Alternative in the Community
Loss of Swing Bed Revenue for the CAH
Loss of 340(B) Revenue for the CAH
EMS capacity in rural communities

Legislative Considerations
Consideration for Frontier Extended Stay Clinics becoming REHs.
Consideration for rural hospitals that have converted to outpatient campuses of larger organizations
Eligibility to reopen hospitals that closed prior to December 27, 2020.
Flexibility for some level of inpatient care
Other Inpatient Distinct Units such as Psych - current regs state only distinct SNF.
Post December 27, 2020 bed size reductions to less than 50 beds
REH 340B Eligibility

Part of our work is to educate on what we are hearing from the rural community at large

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Rural Health Redesign Center: REH Technical Assistance Center

Contact Information

www.rhrco.org

Interested in receiving support from the REH-TAC?

Scan the QR code and complete our brief request form.

Learn more about this project or access the intake form at www.rhrco.org/reh-tac

Work of the REH-TAC is funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services

Questions and Answers

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