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Center for Clinical Standards and Quality

Ref: QSO-24-20-REH

DATE: September 6, 2024
TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: **REVISED**: Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation

Memo Revision Information:
Revisions to: *QSO-23-07-[REH]* ***Original release date:*** *January 26, 2023*

Memorandum Summary

CMS is dedicated to improving access to health care in rural communities and addressing the issues which contribute to health inequities impacting these communities.

• The Consolidated Appropriations Act (CAA), 2021 established Rural Emergency Hospitals (REHs) as a new Medicare provider and allows REHs to participate in the Medicare program and receive payment for items and services furnished on or after January 1, 2023.

• CMS published a final rule establishing REHs as a new Medicare provider and codified the Conditions of Participation (CoP) that REHs must meet in order to participate in the Medicare and Medicaid programs along with REH payment policies, quality measures and enrollment policies.

• CMS is providing *revised* guidance regarding the REH enrollment and conversion process for eligible facilities and *updated* Frequently Asked Questions (FAQs). The *final* interpretive guidance for REHs is pending and will be provided in a future release.

• The national survey database system has been updated to include the REH tags and corresponding regulatory text. CMS will release REH Basic Surveyor Training via the Quality Safety Education Portal (QSEP) website when available.

Background:
In response to rural hospital closures and in an effort to address barriers in access to health care for rural communities, the Consolidated Appropriations Act (CAA), 2021 (CAA) was signed into

law on December 27, 2020, and established Rural Emergency Hospitals (REHs) as a new Medicare provider. Section 125 of the CAA added section 1861(kkk) to the Social Security Act (the Act) and sets forth the statutory authority for REHs.

The conversion of an eligible facility to an REH allows for the provision of emergency department services, observation care, and additional outpatient medical and health services, if elected by the REH, that do not exceed an annual per patient average length of stay of 24 hours. REHs are prohibited from providing inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services. Effective January 1, 2023, this new provider type promotes equity in health care for those living in rural communities by facilitating access to needed services.

Additionally, since REHs provide emergency department services, these facilities must comply with the Emergency Medical Treatment and Labor Act (EMTALA) at section 1867 of the Social Security Act (the Act), the accompanying regulations in 42 CFR § 489.24 and the related requirements at 42 CFR § 489.20(l), (m), (q), and (r). EMTALA requires, among other things, Medicare-participating hospitals with emergency departments to offer a medical screening examination to any individual who comes to the emergency department and requests such an examination and prohibits hospitals with emergency departments from refusing to examine or offer stabilizing treatment to individuals with an emergency medical condition (EMC). Please refer to SOM, Appendix V (Appendix V) for additional guidance related to the EMTALA requirements.

On November 23, 2022, CMS published a final rule (*87 FR 71748*) establishing REHs as a new Medicare provider effective January 1, 2023. The rule finalized the CoPs which REHs must meet to participate in the Medicare and Medicaid programs along with REH payment policies and enrollment policies. CMS established the Conditions of Participation (CoPs) to ensure the health and safety of patients who will receive REH services while taking into consideration the access and quality of care needs of an REH's patient population. The standards for REHs closely align with the current CoPs for Critical Access Hospitals (CAHs) in most cases, while accounting for the uniqueness of REHs and their statutory requirements. The REH CoPs are set forth at new Subpart E of 42 CFR Part 485 and establish a full range of health and safety standards specific to governance, services offered, staffing, physical environment, and emergency preparedness among other requirements. In most instances, the REH policies also closely align to the current hospital and Ambulatory Surgical Center (ASC) standards, such as the policies for outpatient service requirements and the Life Safety Code (LSC), respectively. A general overview of the new REH requirements includes:

- REHs must have a clinician, a doctor of medicine (MD), a doctor of osteopathy (DO), a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care on-call at all times and immediately available by phone or radio contact and available on-site within 30 or 60 minutes depending on if the facility is located in a frontier area.

- The REH emergency department must be staffed 24 hours per day and seven days per week by an individual or individuals competent in the skills needed to address emergency medical care, and the individual(s) must be able to receive patients and activate the appropriate medical resources to meet the care needed by the patient.

- REHs must develop, implement, and maintain an effective, ongoing, REH-wide, data-driven Quality Assessment and Performance Improvement (QAPI) program, and it must address outcome indicators related to staffing, among other things.

- The annual per-patient average length of stay cannot exceed 24 hours, in accordance with the statute, and the time calculation for this determination begins with the registration, check-in, or triage of the patient (whichever occurs first) and ends with the discharge of the patient from the REH (which occurs when the physician or other appropriate clinician has signed the discharge order or at the time the outpatient service is completed and documented in the medical record).

- REHs must have infection prevention and control and antibiotic stewardship programs that adhere to nationally recognized infection prevention and control guidelines and best practices for improving antibiotic use.

Discussion:

In response to the establishment of REHs as a new Medicare provider and the publication of CoPs, payment policies, and enrollment policies in the *CY 2023 OPPS final rule (87 FR 71748, 72159 (Nov. 23, 2022))*, CMS is providing guidance regarding the enrollment and conversion process for eligible facilities interested in participating in the Medicare and Medicaid programs as an REH. The following sections provide an overview of the enrollment and conversion process.

Eligibility

The following facilities enrolled and certified to participate in Medicare as of December 27, 2020, are eligible to be an REH:

- *A* CAH; or,
- A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Act) with not more than 50 licensed beds located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D) of the Act) (referred to as rural hospital); *(**Note:** This section of the statute uses Metropolitan Statistical Areas as defined by the Office of Management and Budget for defining "rural areas," and is different than other governmental designations such as health professional shortage area, etc.);* or,
- A subsection (d) hospital (as so defined) with not more than 50 beds that was treated as being located in a rural area pursuant to section 1886(d)(8)(E) of the Act (referred to as rural hospital). ***Note**: This section of the Act refers to the urban to rural reclassification process as defined in 42 CFR 412.103. To be eligible for REH designation, the reclassification from urban to rural status must have occurred as of December 27, 2020. Reclassifications which occurred after this date do not meet the REH eligibility requirements. Facilities should submit a copy or documentation of the reclassification to the State Agency (SA) along with the additional information required for enrollment; or,*
- Facilities that were enrolled as CAHs or rural hospitals, *as defined above,* with not more than 50 licensed beds, as of December 27, 2020, which subsequently closed after that date. These facilities would be eligible to seek REH designation if they re-enroll in Medicare and meet all the CoPs and requirements for REHs.

Enrollment
As with all other providers and suppliers, REHs are required to enroll in Medicare to receive payments for services and items furnished to Medicare beneficiaries. The purpose of the provider enrollment process is to help confirm that providers and suppliers seeking to bill Medicare meet all applicable federal and state requirements. The final REH enrollment regulation at 42 CFR §424.575 states that eligible facilities must submit a change of information application, rather than an initial enrollment application, to enroll as an REH. This regulation should expedite the conversion process and decrease provider burden. Prospective REH facilities should complete the Form CMS- 855A change of information application (see section 1) and submit the completed application to their designated Medicare Administrator Contractor (MAC) for review *of compliance with the enrollment requirements* and approval. The MAC will review the change of information application and forward the recommendation of approval to the designated SA *and the CMS location for further review*.

REHs can convert back to a CAH or rural hospital at any time. However, the CAH or rural hospital would then be considered a new CAH or rural hospital and lose any grandfathered exemptions, such as previous necessary provider designation. Facilities would follow the existing enrollment and certification procedures for the initial certification of the elected provider type, including the completion of a new CMS-855A, initial survey, and any applicable fees.

For additional details pertaining to REH enrollment policies, refer to the Medicare Program Integrity Manual, Chapter 10 Medicare Enrollment.

Additional Information
In addition to the Form CMS-855A change of information application, prospective REH facilities must submit additional information for conversion to an REH. This includes an action plan for initiating REH services. The action plan and additional information should be submitted to the SA as described below.

Action Plan
The action plan outlines the facility's plan for conversion to an REH and the initiation of REH specific services including the provision of emergency department services, observation care, and other medical and health services elected by the REH. This should include details regarding staffing provisions and the number and type of qualified staff for the provision of REH services. In addition, the action plan must include a detailed transition plan that lists the following:

- Specific services the facility will retain;
- Specific services the facility will modify;
- Specific services the facility will add; and
- Specific services the facility will discontinue.

Additionally, the facility must include a description of services that the facility intends to furnish on an outpatient basis if elected by the REH. The facility must also include information regarding how the facility intends to use the additional facility payment. This includes a description of the services that the additional facility payment would be supporting such as the operation and maintenance of the facility and furnishing of services (i.e., telehealth services, ambulance services, etc.).

Eligible facilities *should* submit the action plan and additional information on *the facility's* letterhead *using* the *exhibit* model *action plan* template attached to this memo. *(**Note:** Facilities should submit their action plan as a separate document for easy posting. CMS will provide notification before posting of the action plans on a CMS website.)* The submission should be signed by the facility's legal representative/administrator. The SA will forward the action plan and *additional* information along with its recommendation for approval or denial to the designated CMS location for review and approval of the action plan components. The CMS location will make a final determination and notify the MAC once the enrollment package is complete and has been reviewed and approved *or denied*.

The action plan and information should include all the required elements as specified. Missing or incomplete information may delay the conversion and enrollment process for eligible facilities applying to become an REH.

Also, in accordance with section 1861(kkk)(2)(A) of the Act, action plans will be available to the public and will eventually be posted on the CMS website. Additional information will be forthcoming once the process is finalized.

Transfer Agreement
Under section 1861(kkk)(2) of the Act and at new 42 CFR § 485.538 Condition of Participation: Agreements, the REH is required to have a transfer agreement with at least one Medicare-certified hospital that is designated as a level I or level II trauma center. The agreement is intended to ensure an appropriate referral and transfer process is in place for patients requiring emergency care and continued care services beyond the capabilities of the REH. In order to document compliance, a copy of the transfer agreement should be submitted to the SA along with the action plan.

Attestation
An REH is required to meet the CoPs for Rural Emergency Hospitals set forth at new Subpart E of 42 CFR Part 485 (§ 485.500 - § 485.546). Other than the requirement that the REH submit its agreement with a nearby trauma center, eligible facilities converting to an REH that self-attest to meeting the REH *requirements* will not require an automatic on-site initial survey as eligible facilities are expected to be in full compliance with the existing CAH and hospital requirements at the time of the request for conversion. Additionally, the CAH and hospital CoPs closely align with the REH requirements (with the exception of rules regarding inpatient acute care services) and are consistent with REH requirements. Facilities that were eligible as of December 27, 2020, which subsequently closed and re-enrolled in Medicare, will require an initial on-site survey by the SA *to ensure the facility is operational and in compliance with the REH requirements. While the SA will perform an initial on-site survey in accordance with the current FY Mission & Priority Document (MPD) to evaluate compliance with the REH CoPs*, *these facilities must also submit an attestation for the applicable eligibility requirements, rural status, and rural reclassification criteria if applicable.*

*All eligible f*acilities *must* submit the attestation *of* compliance along with the action plan, *a* copy of the transfer agreement, *and if applicable, documentation of rural reclassification* to the SA. The attestation *should* be completed on facility letterhead *using* the *exhibit* model *attestation of compliance* template provided in the attachment to this memo. The attestation *of compliance* should be signed by the facility's legal representative or administrator. The SA will review the additional information for completeness and confirm compliance with any applicable state

licensure requirements. Once complete, the SA will forward the additional information to the CMS location, along with a recommendation for certification or denial. The CMS location is responsible for making the final determination for certification of the REH. *A denial for REH certification will not impact the existing enrollment as a CAH or applicable rural hospital*.

Prior to making a final determination, the CMS location will confirm eligibility requirements, including bed count, based on the most recent cost report and rural status. Our criteria for determining an applicant's rural status *includes a two-step process*:

- *In the first step*, CMS will follow the guidance for CAHs in SOM Chapter 2, section 2256A *related to the rural location. Under 42 CFR 485.610(b)(1)(i), a rural area is any area that is outside an MSA, as defined by the Federal Office of Management and Budget (OMB). In making a determination regarding the rural location status of an REH, CMS first consults the OMB MSA delineations that had been adopted by CMS, applicable to December 27, 2020, and that were used for the purpose of the final IPPS rule that was in effect. CMS will use the final IPPS rules that can be found on CMS' Acute Inpatient PPS webpage:* https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page

- *In the second step,* CMS will evaluate if the hospital *had a rural reclassification by December 27, 2020. Under 42 CFR 412.103, a prospective payment hospital that is located in an urban area may be reclassified as a rural hospital. To be eligible for REH conversion, the hospital seeking reclassification under this section must have submitted a complete application, in writing to CMS, in accordance with paragraphs (b)(2) and (b)(3) of 42 CFR 412.103 before December 27, 2020.*
    - *An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of 42 CFR 412.103, including data and documentation necessary to support this request.*
    - *The application must have been submitted to the CMS Innovation & Financial Management (IFM) Group by the requesting hospital. The filing date of the application is the date CMS received the application. The effective date is the date that CMS determines that the hospital has met the eligibility criteria for rural reclassification.*
    - *If the hospital reclassification from urban to rural was approved or denied, the hospital would have received a letter from IFM acknowledging receipt and the determination of the hospital's status. An approved reclassification under 42 CFR 412.103 remains in effect without a need for re-approval unless there is a material change in the circumstances under which the classification was approved. A copy of the IFM determination letter should be submitted with the attestation documents. If a hospital needs a copy of its hospital reclassification letter or has questions, it may submit a request and question(s) to its Medicare Administrative Contractor (MAC) or the CMS IFM mailbox noted below, depending on the providers' location:*

        - *Boston and New York - OPOLE_IFM_BOSNY_AR@cms.hhs.gov*
        - *Philadelphia - OPOLE_IFM_PHI_AR@cms.hhs.gov*
        - *Atlanta-OPOLE_IFM_ATL_AR@cms.hhs.gov*
        - *Chicago and Kansas City - OPOLE_IFM_AR@cms.hhs.gov*

- *Dallas and Denver - OPOLE_IFM_DALDENGP_AR@cms.hhs.gov*
- *San Francisco and Seattle - OPOLE_IFM_SFSEA_AR@cms.hhs.gov*

Once the information has been reviewed, confirmed, and approved, the CMS location will complete the certification kit in the current survey database, which includes upload*ing* the action plan, attestation *of compliance*, *a* copy of the transfer agreement, *and if applicable, documentation of rural reclassification.* The CMS location will assign a *new* CCN if approved and forward the approval or denial, as appropriate, along with the effective *date of REH certification* to the MAC via the CMS-2007. The effective date will be the date the application is approved by the CMS location for meeting all REH requirements. For facilities that require an on-site initial survey, the effective date will be the exit day of a survey if no deficiencies are cited, or in the alternative, if deficiencies are noted, the date an acceptable plan of correction was approved (see 42 CFR §489.13).

As part of the enrollment package review, the SA and CMS location will review the materials provided and the *most recent* survey history of the eligible provider. If any health or safety concerns are identified during the review, CMS maintains the discretion to perform an on-site survey at any time to further evaluate compliance with the REH requirements. Otherwise, the survey priorities for REHs will follow the annual Mission and Priority Document (MPD) released each fiscal year (FY) published on the CMS website.

The national survey database system has been updated to include the new REH tags and corresponding regulatory text.

Training: CMS will release REH Basic Surveyor Training via the Quality Safety Education Portal (QSEP) website when available.

For additional information related to the REH eligibility, enrollment, and conversion process, please see the attached FAQs

For additional information related to the REH CoPs and survey process, please see the draft Appendix O *referenced in QSO memo 23-07-REH*, *published on January 26, 2023*, noting *final* interpretive guidance will be forthcoming.

Contact:
For questions or concerns relating to this memorandum, please contact QSOG_REH@cms.hhs.gov.

Effective Date:
Immediately. Please communicate to all appropriate staff within 30 days.

/s/

Karen L. Tritz
Director, Survey & Operations Group

David R. Wright
Director, Quality, Safety & Oversight Group

Attachment(s)- (1) REH FAQs (*Revised*) (2) Exhibit: Model Attestation *of Compliance* Template (*Revised*), (3) Exhibit: Model Action Plan Template (*Revised*)

Resources to Improve Quality of Care:

Check out CMS's new Quality in Focus interactive video series. The series of 10–15 minute videos are tailored to provider types and aim to reduce the deficiencies most commonly cited during the CMS survey process, like infection control and accident prevention. Reducing these common deficiencies increases the quality of care for people with Medicare and Medicaid. Learn to:

- *Understand surveyor evaluation criteria*
- *Recognize deficiencies*
- *Incorporate solutions into your facility's standards of care*

See the Quality, Safety, & Education Portal Training Catalog, and select Quality in Focus

Get guidance memos issued by the Quality, Safety and Oversight Group by going to CMS.gov page and entering your email to sign up. Check the box next to "CCSQ Policy, Administrative, and Safety Special Alert Memorandums" to be notified when we release a memo.

Rural Emergency Hospitals

Frequently Asked Questions (FAQs)

Revised, 9/6/24

Q1. What is a Rural Emergency Hospital?

A1. The Consolidated Appropriations Act (CAA), 2021 (Pub. L. 116-260) was signed into law on December 27, 2020. In this legislation, Congress established a new rural Medicare provider type: Rural Emergency Hospitals (REHs). These providers furnish emergency department services and observation care, and other *additional* outpatient medical and health services, if elected by the REH, that do not exceed an annual per patient average length of stay of 24 hours.

Q2. What facilities are eligible to become an REH?

A2. Effective January 1, 2023, hospitals that were Critical Access Hospitals (CAHs) or rural hospitals paid under the inpatient prospective payment system (or one treated as such under section 1886(d)(8)(E) of the Social Security Act *("the Act")* with not more than 50 *certified* beds, participating in Medicare as of December 27, 2020, may submit an enrollment application to convert to and enroll in Medicare as an REH. This includes eligible facilities that were CAHs or rural hospitals with not more than *50 certified* beds as of the date of enactment of the CAA and then subsequently closed after that date. These facilities would be eligible to seek REH designation after the closure of the facility. However, *prior to the conversion* to an REH, these facilities must be re-enrolled in Medicare and meet all the requirements for REHs.

Q3. What services are REHs permitted to provide?

A3. REHs are eligible to furnish emergency department services, observation care and, if elected by the REH, other *additional* outpatient medical and health services that do not exceed an annual per patient average length of stay of 24 hours. CMS has defined "REH services" to include all covered outpatient services (as defined in section 1833(t)(1)(B) of the Act (other than clause (ii) of such section)) when furnished by an REH. Such services could include radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health *services*. The REH can provide additional medical and health services if the services align with the health care needs of the community served by the REH. REHs are not eligible to provide inpatient services, with the exception of post-hospital extended care services furnished in a distinct part unit licensed as a skilled-nursing facility (SNF).

Q4. What is the process for *an* eligible facility to convert to an REH?

A4. The complete process for eligible facilities to convert to an REH was *initially* outlined in the QSO-23-07-REH memo. *Updates to the initial guidance are provided via QSO memo 24-20 - REH. All* memos are available on the CMS website at: https://www.cms.gov/medicare/provider-enrollment-andcertification/surveycertificationgeninfo/policy-and-memos-to-states-and-regions.

Q5. Can eligible facilities that are in the midst of an enforcement action convert to an REH?

A5. To convert to an REH, facilities must be in substantial compliance with all applicable *federal and state* health and safety standards and regulations at the time of conversion.

Q6. Can REHs relocate and maintain certification as an REH? If so, what is the process?

A6. Yes, but the REH must maintain rural status or continue to be located in an area that has been designated or reclassified as rural in accordance with 42 CFR § 412.103. When an REH plans to relocate, it must update the CMS-855A form and submit it for reapproval.

Q7. Can REHs convert back to *their prior designation* of a CAH or hospital?

A7. REHs can convert back to *their prior designation* of a CAH or rural hospital. At that time, the CAH or rural hospital would be considered a new CAH or rural hospital, therefore, losing any grandfathered privileges. For example, if a CAH grandfathered as a "necessary provider" *(see 42 CFR. § 485.610)* converts to an REH, it would lose its "necessary provider" designation and may not regain it if it reverts back to a CAH. Facilities would follow the existing enrollment and certification procedures for the initial certification of the elected provider type, including the completion of a new CMS-855A and *payment of* any applicable fees.

Q8. What are the required elements for the action plan? Is a specific format or form required to be submitted for the facility action plan?

A8. The action plan outlines the facility's plan for conversion to an REH and the initiation of REH-specific services. The action plan *requirements are located at 42 CFR § 488.70, Special Requirements for Rural Emergency Hospitals and* include the following elements:

- The provision of emergency department services, observation care, and other medical and health services elected by the REH including details regarding staffing provisions and the number and type of qualified staff for the provision of REH services.
- A detailed transition plan that lists the specific services that the facility will retain, modify, add, and discontinue.
- A description of *additional* services that the facility intends to furnish on an outpatient basis, if elected.
- Information regarding how the facility intends to use the additional facility payment. This includes a description of the services that the additional facility payment would be supporting such as the operation and maintenance of the facility and furnishing of services (i.e. telehealth services, ambulance services etc.).

The facility *should* submit the action plan and additional information noted above on facility letterhead *using* the *exhibit* model *action plan* template provided as an attachment to the *QSO-24-20 -REH* memo. The plan should be signed by the facility's legal representative/administrator.

Q9. How do facilities submit the action plan?

A9. Section 1861(kkk)(4)(A)(i) of the Act requires that a hospital or CAH seeking REH conversion submit a detailed action plan at the time they submit their revised form CMS-855A. The action plan should be submitted to the state agency (SA). *The action plan must include all the required elements as specified.* The SA will forward the action plan*,* along with the recommendation for approval or denial of certification to the designated CMS location for review and approval of the action plan components. The CMS location will make a final determination and notify the MAC *to deny or approve the enrollment application. The MAC will send the final approval or denial letter to the provider, SA, and CMS location.*

Q10. When should the *required* transfer agreement be submitted to CMS? Are there any required elements for the transfer agreement with a Medicare-certified hospital that is a level I or level II trauma center?

A10. A copy of the transfer agreement should be submitted to the SA along with the action plan. CMS requires that the Medicare-certified level I or level II trauma center meets certain licensure requirements, including being licensed as a hospital in a state that provides for the licensing of hospitals under state or applicable local law or approved by the agency of such state or locality responsible for licensing hospitals, as meeting standards established for licensing established by the agency of the state. The level I or level II trauma center may be located in a state other than the state where the REH is located. The level I or level II trauma center must be licensed or designated by the state or local government authority as a level I or level II trauma center or verified by the American College of Surgeons as a level I or level II trauma center.

Q11. Will the REH need to have an initial survey conducted? What information is required for self-attestation, and is there a specific format or form for submission? How often will REHs be surveyed?

A11. Eligible facilities that are existing CAHs and hospitals converting to an REH may attest to meeting the REH *requirements* and will not require an automatic on-site initial survey as eligible facilities are expected to be in full compliance with the existing CAH and hospital requirements (as applicable) at the time of the request for conversion. Facilities that were eligible as of December 27, 2020, that subsequently closed and re-enrolled in Medicare would require an initial on-site survey by the SA *to ensure the facility is operational and* in compliance with the REH requirements. *While the SA will perform an initial on-site survey in accordance with the current FY Mission and Priority Document (MPD) to evaluate compliance* with the *REH CoPs*, *these facilities must submit an attestation for the applicable eligibility requirements, rural status, and rural reclassification criteria if applicable.* For *all eligible facilities*, the attestation allowing the facility to submit a general statement of compliance with the REH requirements and provisions of care *should* be completed on facility letterhead *using the exhibit* model *attestation of compliance* template provided in memo QSO-*24 -20*--REH. Subsequent REH surveys will be conducted as outlined in the annual MPD.

Q12. Are REHs eligible to be deemed by a CMS-approved accreditation organization (AO)?

A12. *All REH surveys will be conducted by the SA and will continue to be conducted by the SA for at least the first three years from February 10, 2023, which is the date that the first REH was certified by an SA. The purpose of this action is to allow CMS to directly monitor and evaluate the compliance of REHs with the program requirements and ensure the transparency of their survey findings. Currently, there are no AOs with a CMS-approved REH program. A deeming option for the REH program will be considered by CMS after we have had adequate time and opportunity to effectively monitor and evaluate the introduction of REHs into the Medicare program as well as each REH's ability to comply with the health and safety requirements of the CoPs. Please see QSO memo 24-01 for additional information.*

Q13. How are *the number of certified* beds determined or counted?

A13. *To determine if a facility meets the eligibility requirement of no more than 50 beds*, the bed count will be determined by calculating the number of available bed days during the most recent cost reporting period divided by the number of days in the most recent cost reporting period. We use this methodology to determine if Medicare-dependent small rural hospitals meet the required bed count for that program. We believe this is an appropriate methodology for determining if a rural hospital meets the bed count requirement to seek REH designation, as this is a known and existing methodology for small rural hospitals seeking to determine bed count for eligibility in Medicare programs. *(Note: Bed count is determined based on the number of Medicare-certified beds versus state licensed beds.)*

Q14. Can the facility requesting to convert to an REH continue to provide inpatient care while awaiting a final determination for the REH conversion request and application review?

A14. Yes, the facility's action plan is intended to provide details regarding the transition plan for the initiation of REH services along with the services the facility will retain, add, modify, and discontinue. The action plan should provide facility specific details regarding the facility's plan for discontinuation of inpatient services and the transfer of care for existing patients if applicable. Upon approval of the REH application for conversion, facilities are expected to cease all inpatient services as of the effective date assigned by the CMS location.

Q15. Can a facility obtain a reclassification from urban to rural status after December 27, 2020, to meet the REH eligibility requirements?

A15. No. Based on the REH eligibility requirements set forth in the Act, the reclassification must have occurred as of December 27, 2020. Reclassifications that occurred after this date do not meet the eligibility requirements for REH designation.

Q16. Does my hospital meet the rural eligibility requirement if it qualifies as rural under HRSA's definition?

A16. No. The statute uses the Metropolitan Statistical Areas (MSA) as defined by the Office of Management and Budget (OMB) for defining "rural areas' and is different than other governmental designations such as health professional shortage area, or HRSA Federal Office of Rural Health Policy definition of rural, etc. For additional information regarding rural

reclassification, please see 42 C.F.R 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

Q17. Can REHs provide hospice or end of life care?

A17. Not as an inpatient service. REHs are prohibited from providing inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services. End of life care that is not hospice care or inpatient care may still be provided on a short-term outpatient basis, such as in an emergency department setting.

Q18. Can REHs co-locate and lease space?

A18. Yes, REHs may co-locate and lease space within the facility. All co-located hospitals must demonstrate independent compliance with the applicable CoPs. Please refer to QSO Memo 19-13 for additional information regarding hospital co-location.

Q19. ***Can a provider-based outpatient department of a hospital apply to convert to an REH instead of the main campus of the hospital?***

A19. *No, converting a provider-based location that has the same CCN as the main provider would not be considered to meet the intent for conversion to an REH as the statute and regulations contemplate conversion of the entire hospital or CAH and not its individual parts (including psych and rehabilitation units).*

Q20. Can a Rural Health Clinic (RHC) that is a provider-based location of a hospital apply to convert to an REH?

A20. No, an RHC would not meet the REH eligibility requirements for conversion to an REH as set forth in the CAA 2021. The hospital may have an RHC as a provider location with a separate CCN from the main provider. As stated in the CAA, 2021, an REH may be considered a hospital with no more than 50 beds for the purpose of the exception to the payment limit for RHCs under section 1833(f) of the Act. Therefore, the statute provides that an REH may continue its operation of provider-based RHCs that meet the qualifications detailed under section 1833(f) of the Act.

Q21. Can an eligible facility convert to an REH under a new owner or change of ownership?

A21. Yes, an eligible facility may convert to an REH under a new owner or change of ownership. In this instance, the change of information application must include all changed information about the facility's ownership. This includes, but is not limited to, disclosing in Sections 5 and/or 6 the new owner(s) and any new managing employees, deleting the old owners in Sections 5 and/or 6, etc. In this case, all liabilities incurred while operating as the CAH or applicable rural hospital would transfer to the REH.

Q22. Can CMS waive or alter the REH eligibility requirements?

A22. No, the eligibility requirements for REH conversion are established in statute in section 1861(kkk) of ("the Act"), which sets forth the statutory authority for REHs, including the eligibility requirements.

EXHIBIT

(Rev.)

Model Attestation of Compliance for Rural Emergency Hospital Enrollment and Conversion ***(NOTE:*** *Provider must place this attestation on facility letterhead)*

(Date of Request)

Name of Facility

Street Address

City, State, ZIP code

Dear (State Agency),

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

☐A critical access hospital (CAH); or

☐A hospital, as defined in section 1886(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 1886(d)(2)(D) of the Act; or

☐A hospital, as defined in section 1886(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 of **December 27, 2020**[1].

> ***(Attach copy or documentation of reclassification). NOTE:*** *To be eligible for REH designation, the reclassification from urban to rural status must have occurred ON OR PRIOR TO* ***December 27, 2020****. Reclassifications which occurred after this date do not meet the REH eligibility requirements. Facilities must submit a copy or documentation of the reclassification to the State Agency (SA) along with the additional information required for enrollment.*

I understand that as an REH, [**Name of facility]** must *be in compliance with* all *applicable Medicare* Conditions of Participation (CoPs) in 42 CFR Part 485, Subpart E.

Based upon *the information above* and *the submitted documentation*, I attest that, with the exception of providing acute care inpatient services prior to the effective date of CMS approval, **[Name of facility]** currently meets and will continue to meet all of the requirements for Rural Emergency Hospitals set forth in the statute and implementing regulations in Subpart E of 42 C.F.R. Part 485. I further attest that **[Name of facility]** will not, as of the effective date of CMS

[1] 42 C.F.R. §412.103 Special Treatment: Hospitals located in urban areas and that apply for reclassifications as rural.

approval as an REH, provide any acute care inpatient services, other than those described in 1861(kkk)(6)(A).

[Name of Facility]

I understand that the Centers for Medicare & Medicaid Services or the state survey agency of the state where **[Name of facility]** is located may conduct an on-site survey at any time to validate and determine compliance with all applicable requirements for REHs.

Signature: _____

(*The Attestation should be signed by the Administrator or Legal Representative of the REH*)

Title: _____

Date: _____

EXHIBIT

(Rev)

Model Action Plan Template for Rural Emergency Hospitals

(Note: Please place on facility letterhead and submit as a separate document as this document will be made public and posted on the CMS website in the future)

Facility Name:

Current CCN:

Summary of Conversion Plan:

[Include details regarding the facility's efforts to initiate REH services for the provision of emergency care, observation care and other medical and health services *elected by the facility*. Include details regarding the *facility's plan for* discontinuation of inpatient services and transfer of care outside of the REH's capabilities *including a copy of the transfer agreement with a certified level I or II trauma center.* Include staffing details for the provision of REH services (number and type of qualified staff).]

List the specific services the facility will retain (including a distinct part skilled nursing facility, if applicable):

List the specific services the facility will modify:

List the specific services the facility will add (including a distinct part skilled nursing facility if applicable):

List the specific services the facility will discontinue: [***Note: Upon approval of the REH application for conversion, facilities are required to cease all inpatient services, as of the effective date assigned by the CMS location.***}.]

Provide a description of services the facility elects to provide on an outpatient basis (such as behavioral health services, laboratory, radiology, maternal health, surgical services outpatient rehabilitation):

Provide information regarding how the facility intends to use the additional facility payment. This includes a description of the services that the additional facility payment would be supporting such as the operation and maintenance of the facility and furnishing of services (i.e. telehealth services, ambulance services etc.).

Signature: _____

[The Action Plan should be signed by the Administrator or Legal Representative of the REH.]

Title: _____

Date: _____