RURAL EMERGENCY HOSPITALS: CMS PUBLISHES PROPOSED ENROLLMENT AND PAYMENT POLICIES FOR NEW MEDICARE PROVIDER TYPE

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On 26 July 2022, the Centers for Medicare & Medicaid Services (CMS) published the 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule (the OPPS Proposed Rule or the Rule).[1] In addition to proposals related to the OPPS and ASC payment system for calendar year 2023, the Rule also proposes a number of provisions related to the new rural emergency hospital (REH) provider type, including policies addressing REH enrollment and payment, quality reporting, and the federal physician self-referral law (Stark Law). Comments on the OPPS Proposed Rule must be received by 13 September 2022.

As discussed in a recent client alert that described the proposed Conditions of Participation (CoPs) for REHs (the REH CoP Proposed Rule),[2] the REH provider category was established by section 125 of the Consolidated Appropriations Act, 2021.[3] Rural hospitals with not more than 50 beds and critical access hospitals (CAHs) that were enrolled in Medicare as of 27 December 2020 may apply to convert to and enroll in Medicare as an REH, and Medicare-enrolled REHs will receive payment for REH Services (as defined below) provided on or after 1 January 2023. CMS states in the OPPS Proposed Rule that the final policies for REHs, including those applicable to the CoPs, quality measures, enrollment, and payment, will be published in the 2023 OPPS final rule.[4]

This client alert focuses on the REH enrollment and payment provisions in the OPPS Proposed Rule.[5]

PROPOSED ENROLLMENT AND PAYMENT PROVISIONS FOR REHS

Summary

The OPPS Proposed Rule sets forth, in relevant part, CMS's proposed policies for REH enrollment, scope of REH Services, and payments to REHs. In regard to enrollment, CMS proposes to permit CAHs and rural hospitals to enroll as REHs without having to terminate their existing enrollments and to allow an REH to convert back to a CAH or rural hospital, as applicable. The proposals on scope of REH Services largely mirror the policies proposed in the REH CoP Proposed Rule; REHs will be permitted to furnish services that meet the definition of “REH Services” as well as certain additional “non-REH Services.” Finally, the OPPS Proposed Rule offers several new proposals regarding payment to REHs, including payment for REH Services and non-REH Services, as well the proposed monthly facility payment amount and the implications of provider-based status on payments to REHs.

Proposed REH Enrollment Provisions

CMS proposes to codify enrollment rules for REHs in 42 C.F.R. § 424.575, which would be added to subpart P ("Requirements for Establishing and Maintaining Medicare Billing Privileges").[6] In relevant part, this new subsection would implement the following policies[7] regarding REH enrollment:

- The entity seeking convert from a small rural hospital or CAH to an REH will submit a Form CMS-855A[8] change of information (CHOI) under § 424.516 instead of an initial enrollment.
- Given that REH enrollment will be effectuated through a CHOI submission, application fees will not apply.
- Enrollment as an REH, or conversion from an REH back to a rural hospital or CAH[9], will not require termination of the provider's existing enrollment.[10]
- As with other Medicare-enrolled providers and suppliers, the REH will be required to comply with all applicable provisions in subpart P to enroll and maintain enrollment in Medicare, including, but not limited to:
  - Submitting all required supporting documentation with the enrollment application, per § 424.510(d)(1) and (d)(2)(iii).
  - Completing any applicable state surveys, certifications, and provider agreements, per § 424.510(d)(5).
  - Reporting changes to any of the REH's enrollment information, per § 424.516.
  - Periodic revalidation, per § 424.515.
  - Undergoing risk-based screening, per § 424.518. In this regard, CMS proposes adding REHs to the limited screening category.[11]

Proposed Scope of "REH Services" and "Non-REH Services"

In addition to emergency services and observation care, section 1861(kkk)(1)(A) of the Social Security Act (the Act) authorizes REHs to provide outpatient medical and health services, as specified by the secretary of the US Department of Health & Human Services (Secretary) through rulemaking.[12] In the REH CoP Proposed Rule, CMS proposed to allow REHs to provide additional medical and health outpatient services that are commonly furnished in a physician's office or at another entry point into the health care delivery system, including, but not limited to, radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health services, as further described in the REH CoP Proposed Rule.[13]

Provision of REH Services

In light of the statutory definition and the proposals in the REH CoP Proposed Rule, CMS proposes in the OPPS Proposed Rule to define "REH Services" as "all covered outpatient department services, other than inpatient hospital services as described in section 1833(t)(1)(B)(ii), that would otherwise be paid under the OPPS."[14] In this regard, CMS notes its rationale in proposing a broad definition of REH Services is to provide maximum flexibility for REHs to tailor the services provided to the needs of their individual communities.[15] By contrast, CMS explains that a narrow definition that limits REH Services to emergency services only could result in a facility that converts to an REH ceasing to furnish other covered outpatient services previously provided by the facility, which could limit access to such services for patients.[16]

Provision of Non-REH Services

The Rule also addresses the provision of services furnished by an REH that are not REH Services (non-REH Services), such as laboratory services paid under the Clinical Laboratory Fee Schedule (CLFS) and certain diagnostic services not paid under the OPPS.[17] Given that REHs must be capable of providing non-REH Services in order to fulfill the applicable statutory requirements for REHs and the proposed CoPs for REHs in the REH CoP Proposed Rule, CMS proposes in the OPPS Proposed Rule to permit REHs to furnish non-REH Services that are consistent with the statutory requirements governing this provider type and the proposed REH CoPs.[18]

Proposed REH Payment Provisions

CMS proposes to codify payment rules for REHs in a new subpart K of 42 C.F.R. part 419.[19] These proposals include payment for REH Services at OPPS payment rates increased by 5%, payment for non-REH Services at the same rate the service would be paid if performed in a hospital outpatient department (OPD), and monthly facility payments to REHs of nearly US$269,000 per month.

Payment for REH Services

As to REH Services, CMS proposes to set payments at the OPPS rate for the equivalent covered OPD service using the existing OPPS payment policies and rules, increased by 5% (the REH Service Payment Rate).[20] The REH would submit claims for REH Services through the OPPS claims processing system with an REH-specific payment flag created by CMS, which would trigger payment at the REH Service Payment Rate. Beneficiary copayment amounts for REH Services, however, would be determined consistent with the OPPS rules, without taking into account the 5% increase.[21]

While payments for REH Services will be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 in the same manner as OPPS payments, CMS notes that payments for REH Services would not impact OPPS budget neutrality because REH Services are not covered OPD services. For the same reason, REH claims would not be used for OPPS rate setting.[22]

Payment for Non-REH Services

For non-REH Services, such as laboratory services paid under the CLFS and outpatient rehabilitation services, CMS proposes to pay REHs at the same rate the service would be paid if performed in a hospital OPD, provided the requirements for payment under the applicable non-OPPS payment system are met. Because such services are non-REH Services, the additional 5% payment increase will not apply.[23] CMS proposes reimbursing an entity owned and operated by an REH that provides ambulance services under the ambulance fee schedule.[24] If an REH provides post-hospital extended care services in unit that is a distinct part skilled nursing facility, Medicare will make payment through the skilled nursing facility prospective payment system.[25]

Payment for Off-Campus Provider-Based Departments (PBDs) of an REH

CMS proposes that items and services furnished by off-campus PBDs of REHs are not applicable items and services under sections 1833(t)(1)(B)(v) or (t)(21) of the Act. If finalized as proposed, the effect of this proposal is that the payment adjustment under section 603 of the Bipartisan Budget Act of 2015 (Section 603) that applies to nonexcepted items and services furnished by nonexcepted off-campus PBDs of hospitals paid under the OPPS would not apply to off-campus PBDs of REHs.[26] CMS is, however, seeking comments on an alternative where Section 603 would apply to off-campus PBDs if it applied prior to conversion to an REH and would apply to new off-campus PBDs created by the REH after conversion.[27]

Monthly REH Facility Payment

Section 1834(x)(2) of the Act provides for an additional monthly facility payment to an REH. CMS describes the requirements of sections 1834(x)(2)(B) and 1834(x)(2)(C) for calculation of the monthly payment for CY 2023 as follows:

(1) Calculate the total amount paid to all CAHs under Medicare in 2019, including beneficiary copayments, minus the estimated total amount that would have been paid under Medicare to CAHs in 2019 if payment were made for inpatient hospital, outpatient hospital, and skilled nursing facility services under the applicable prospective payment systems for such services during 2019.

(2) Divide the difference by the number of CAHs enrolled in Medicare in 2019 to calculate the annual amount of this additional facility payment per individual REH for 2023.

(3) Divide the annual payment amount by 12 to calculate the monthly facility payment that each REH will receive.[28]

In the OPPS Proposed Rule, CMS describes in detail the proposed methodology for calculating the amount of the monthly facility payment, including challenges and assumptions inherent in its methodology.[29] Using this methodology, CMS calculates the CY 2023 monthly facility payment amount as US$268,294. CMS is seeking comments on its proposed methodology.[30] For CY 2024 and each subsequent calendar year, CMS proposes that the amount of the additional annual facility payment is the amount of the preceding year's additional annual facility payment, increased by the hospital market basket percentage increase as described under section 1886(b)(3)(B)(iii) of the Act.[31]

REHs are required by statute to maintain detailed information as specified by the Secretary regarding how the additional facility payments are used, and to make such information available to the Secretary upon request.[32] CMS is proposing that such information would be captured on the REH cost report and is not proposing any additional reporting or data collection requirements for CY 2023, although CMS notes that it will monitor this issue.[33]

Preclusion of Administrative and Judicial Review

CMS proposes in 42 C.F.R. § 419.94 that there is no administrative or judicial review under section 1869 of the Social Security Act, section 1878 of the act, or otherwise of the following:

- (a) The determination of whether an REH meets the requirements of subpart K.
- (b) The determination of payment amounts under subpart K.
- (c) The requirements established by subpart K.[34]

WHAT'S NEXT

If these policies are finalized as proposed, the REH CoPs and enrollment and payment provisions for REHs will take effect on 1 January 2023, to align with the date on which CMS has stated Medicare payment for REH Services will be available. Given the payment incentives and enrollment flexibilities proposed for REHs, rural hospitals and CAHs that are eligible for enrollment as an REH may want to assess whether enrollment as an REH would be appropriate for the organization and beneficial to the community in which they operate.

We will continue to monitor these important developments and provide updates on subsequent REH rulemakings.

K&L Gates' Health Care practice routinely assists health systems, hospitals, and other providers and suppliers with legal advice and strategic considerations, including providing advice on enrollment, certification, and reimbursement matters and assisting clients with public comments on proposed and final rulemakings. Contact the authors of this article or another K&L Gates lawyer for assistance with the OPPS Proposed Rule or the new REH provider category.

FOOTNOTES

[1] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating, 87 Fed. Reg. 44,502 (proposed July 26, 2022).

[2] Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REHs) and Critical Access Hospital CoP Updates, 87 Fed. Reg. 40,350 (proposed July 6, 2022) (to be codified in a new subpart E of 42 C.F.R. part 485).

[3] Pub. L. No. 116-260 (Dec. 27, 2020).

[4] OPPS Proposed Rule, 87 Fed. Reg. 44,787–88.

[5] A separate client alert on the Rule's Stark Law proposals for REHs is forthcoming.

[6] OPPS Proposed Rule, 87 Fed. Reg. 44,843.

[7] Id. at 44,788 (to be codified at 42 C.F.R. § 424.575).

[8] Form CMS-855A (Medicare Enrollment Application: Institutional Providers; OMB control number 0938–0685).

[9] OPPS Proposed Rule, 87 Fed. Reg. 44,788. While section 1861(kkk)(4)(B)(i) of the Social Security Act references a “conversion” from an REH back to a CAH or rural hospital, as opposed to a termination and an initial enrollment, note that an REH's ability to convert back to its prior provider category may be limited by a variety of factors, including state certificate of need laws or licensure requirements.

[10] See OPPS Proposed Rule, 87 Fed. Reg. 44,765, 44,788. Note that CMS proposes enrollment as an REH will result in the issuance of a new CMS Certification Number (CCN). The Rule does not address, however, how CMS will process CCN changes resulting from conversions of REHs back to CAHs or rural hospitals.

[11] OPPS Proposed Rule, 87 Fed. Reg. 44,789 (to be codified at § 424.518(a)(1)(viii)).

[12] REH CoP Proposed Rule, 87 Fed. Reg. 40,358.

[13] Id. at 40,358, 40,360 (to be codified at 42 C.F.R. § 485.524(a)).

[14] OPPS Proposed Rule, 87 Fed. Reg. 44,506 (to be codified at 42 C.F.R. § 419.91).

[15] Id. at 44,776.

[16] Id.

[17] Id. at 44,777.

[18] Id. at 44,778 (to be codified at 42 C.F.R. § 419.92(c)).

[19] Id. at 44,842.

[20] Id. at 44,777.

[21] Id.

[22] Id.

[23] Id. at 44,778.

[24] CMS proposes to revise § 410.40(f) to include an REH as a covered origin and destination for ambulance transport. OPPS Proposed Rule, 87 Fed. Reg. 44,778, 44,787.

[25] Id. at 44,778.

[26] Id. at 44,779.

[27] Id.

[28] Id. at 44,779–80.

[29] Id. at 44779–86.

[30] Id. at 44,786.

[31] Id.

[32] Id. at 44,781.

[33] Id.

[34] Id. at 44,842

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