Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

NOVEMBER 2022

RURAL EMERGENCY HOSPITALS

On Nov. 3, the Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2023 outpatient prospective payment system (OPPS) final rule. Within this rule, CMS finalized policies and procedures specific to rural emergency hospitals (REHs), including CMS-3419-F which finalizes Conditions of Participation (CoPs) for REHs. This fact sheet summarizes the REH portion of the CY 2023 OPPS final rule. For a summary of CMS-3419-F, see IHA's Rural Emergency Hospital – CoPs fact sheet.

Definition REH Services: "REH services" are all services paid under the OPPS when furnished in an OPPS hospital as defined by the Social Security Act (SSA), section 1833(t)(1)(B) with the exception of services described in section 1833(t)(1)(B)(ii) (i.e. inpatient hospital services).

Payment for REH Services: CMS finalized the following payment policies for REH services:

- The payment rate for an REH service will be the OPPS rate for the equivalent covered outpatient department service increased by 5%;
- REH claims will be processed within the OPPS claims processing system. This system will be updated to include an REH-specific payment flag, resulting in the REH-specific payment rate stated above; and
- Beneficiary copayments for REH services will reflect the copayment amounts determined under the OPPS for the equivalent covered outpatient department services. REH copayments will exclude the 5% payment increase that applies to the REH service payment.
- The CY 2023 monthly REH facility payment will be $272,866. This is higher than the amount stated in the proposed rule due to a calculation error. This payment amount will increase by the hospital market basket in future years.

Other Outpatient Services: REHs must provide other types of outpatient services that are not paid under OPPS. These include basic lab services and certain diagnostic services as specified under the REH CoPs.

REHs may also provide outpatient and medical health diagnostic and therapeutic items and services including but not limited to radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health services.

Outpatient services that do not meet the definition of REH services will be paid at the same rate the service would be paid if performed in a hospital outpatient department, provided that the requirements for the relevant payment system are met.

Packaging of Laboratory Services: If a lab service would be packaged into an OPPS payment for a primary service or services furnished by a hospital that is paid under OPPS, then it will be packaged into the REH payment for the analogous primary service or services when furnished by

an REH. If the lab service would have been paid separately under the Clinical Laboratory Fee Schedule (CLFS) if furnished by a hospital that is paid under OPPS, it likewise will be paid under the CLFS at the CLFS rate when furnished by a REH.

Distinct Part Unit Skilled Nursing Facility (SNF): Payment for post-hospital extended care services furnished by a distinct part unit SNF within an REH will be paid under the SNF prospective payment system.

340B: CMS did not address comments requesting changes to eligibility requirements for the 340B drug pricing program to allow REH participation. CMS stated that 340B eligibility is under the authority of the Health Resources and Services Administration (HRSA).

Graduate Medical Education: CMS may consider the idea of designating REHs as graduate medical education eligible facilities through future rulemaking.

Off-Campus Provider-Based Department of an REH: Items and services furnished by an off-campus provider-based department (PBD) of an REH that meet the definition of REH services will receive the REH services payment of OPPS plus 5%. Items and services furnished by off-campus PBDs that do not meet the definition of REH services will be paid under the applicable payment system, provided the requirements for payment under that system are met.

Rural Health Clinics: If a provider-based rural health clinic (RHC) was entitled to "grandfathering" by virtue of being in existence on Dec. 31, 2020 and forward, then that RHC can continue to utilize the exceptions set out in SSA section 1833(f) if its associated hospital converts to an REH.

Rural Emergency Hospital Quality Reporting (REHQR) Program: In general, CMS solicited comment on potential REHQR quality measures and various methodologies for assuring measure applicability and validity. Finalized requirements beginning Jan. 1, 2023 are for REHs to establish a QualityNet account and designate a Security Officer (SO).

If a facility already has a QualityNet account, it can fulfill this requirement by updating its existing account with its new REH CMS Certification Number (CCN).

An SO is initially required to enable a QualityNet account. While CMS recommends that REHs have and maintain an SO, it also notes that it is not necessary or required to maintain an SO once the QualityNet account is established.

REH Provider Enrollment: All enrolling and enrolled Medicare providers and suppliers, irrespective of type and including REHs, must comply with the regulatory provisions generally incorporated in 42 CFR part 424, subpart P. Requirements include, but are not limited to, the following:

- Completion and submission of the applicable enrollment application, which, for REHs, is the Form CMS-855A (Medicare Enrollment Application: Institutional Providers; OMB control number 0938-0685);
- Submission of all required supporting documentation with the enrollment application;
- Completion of any applicable State surveys, certifications, and provider agreements;
- Reporting changes to any of the REH's enrollment information;
- Revalidation of enrollment; and

- Undergoing risk-based screening.

While an REH must submit a Form CMS-855A to enroll, it does not have to pay an application fee. This is because the facility would report its conversion from a CAH or a section 1886(d)(1)(B) hospital to an REH, rather than newly enrolling in the Medicare program.

Providers are also placed into provider enrollment screening categories and requirements based on CMS' assessment of the risk of fraud, waste, and abuse posed by a particular category of provider or supplier. Hospitals currently fall within the limited screening category, and CMS is also categorizing REHs in the limited screening category.

Effective Date of Billing Privileges: The provider agreement or approval is effective on the date the state agency, CMS, or CMS contractor survey is completed (or on the effective date of the accreditation decision, as applicable) if, on that date, the provider or supplier meets all applicable federal requirements. Among these federal requirements are the enrollment requirements in Part 424, subpart P. CMS determines the date on which all enrollment requirements have been met.

Physician Self-Referral Law Update: CMS did not finalize its proposal to establish a Physician Self-Referral Law exception for ownership or investment in an REH. Because they are not "hospitals," REHs located in rural areas may use the rural provider exception in section 1877(d)(2) of the SSA.

The rural provider exception is available to entities located in rural areas and has one substantive requirement: the entity must furnish substantially all (not less than 75%) of the designated health services it provides to residents of rural areas. This means that the REH must furnish not less than 75% of the designated health services that it furnishes (such as radiology and other imaging services) to residents of a rural area, but would not need to monitor the residence of patients to whom it provides any services that are not considered designated health services.

Applicability of Certain Exceptions for Compensation Arrangements Involving REHs: Section 1877(e) of the SSA and 42 CFR §411.357 includes exceptions to the Physician Self-Referral Law's referral and billing prohibitions for compensation arrangements between entities and physicians (or immediate family members of physicians) that satisfy all requirements of the exception. The Secretary of Health and Human Services is modifying the exceptions in 42 CFR §411.357(e), (r), (t), (v), (x), and (y) to make them applicable to compensation arrangements involving an REH.

Contact:

Cassie Yarbrough, Senior Director, Medicare Policy
630-276-5516 | cyarbrough@team-iha.org

Sources:
Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; etc. Filed on Nov. 3, 2022. Available from: https://www.federalregister.gov/public-inspection/2022-23918/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment. Accessed Nov. 3, 2022.