Overview and Conditions of Participation

Kianna Banks, RN, MS
Technical Advisor
Center for Clinical Standards and Quality
Clinical Standards Group
Background

- Rural hospital and Critical Access Hospital closures
- Lack of access to services
- Consolidated Appropriations Act, 2021 (CAA) (Section 125, pg. 1779)
- Enacted on December 21, 2020
Statutory Requirements

- Must convert from either a rural hospital with not more than 50 beds or a Critical Access Hospital
- Must provide emergency services
- Must furnish observation care
- May provide other outpatient services as specified by the Secretary through rulemaking
Statutory Requirements (cont’d)

• May not exceed an annual per patient average length of stay of 24 hours
• May not provide any acute care inpatient services
• Are permitted to provide Skilled Nursing Facility (SNF) services in a distinct part SNF
• Eligible for payment for items and services furnished on or after January 1, 2023
Statutory Requirements (cont’d)

• Note: the statute does not prohibit an IHS hospital or CAH from converting to an REH
• Must be staffed 24/7
• Must have a transfer agreement with a level I or level II trauma center
• Must have an action plan for initiating REH services
• REHs may convert back to its prior designation as a CAH or rural hospital
REH Conditions of Participation

- Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates, CMS-3419-F (87 FR 71748)

- Published November 23, 2022 in the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Payment Rule (CMS-1772-FC)
Policy Development Approach

• Request for Information (RFI) published in the CY 2022 Outpatient Prospective Payment System – Ambulatory Surgical Center Payment Systems Proposed Rule on August 4, 2021 (CMS-1753-P, 86 FR 42018)

• Standalone Proposed Rule published on July 6, 2022 (CMS-3419-P, 87 FR 40350)

• Intra and interagency collaboration

• Public-facing stakeholder calls
Policy Development Approach

• CoPs are based on the statutory requirements
• Closely mirrored the REH CoPs after the CAH CoPs
• Mirrored some of the REH CoPs after the hospital and Ambulatory Surgery Center CoPs
Health and Safety Standards/CoPs

The CAA requires the following*:

• REHs must be staffed 24/7

• A physician, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish REH services 24 hours a day

• REHs must meet the applicable CAH staffing and staffing responsibilities requirements under 42 CFR 485.631

*Not an exhaustive list of requirements, only a highlight of some that are in the CAA
The CAA requires the following:

- REHs must have a transfer agreement with a level I or level II trauma center
- REHs must meet the CAH emergency services requirements at 42 CFR 485.618 and the applicable hospital emergency department requirements
- REHs are subject to the EMTALA requirements under section 1867 of the Social Security Act

*Not an exhaustive list of requirements, only a highlight of some that are in the CAA*
Health and Safety Standards/CoPs

Requirements for REHs that generally reflect the CAH standards (or in some cases are less stringent than the CAH CoPs):

- Staffing
- Medical records
- Emergency Preparedness
- Laboratory services
- Infection control
- Discharge planning

- Quality assessment and performance improvement program
Health and Safety Standards/CoPs

Additional requirements for REHs:

- Medical staff
- Radiologic services
- Pharmaceutical services
- Laboratory services
- Emergency services

- Infection control
- Staffing
- Nursing services
- Patient’s rights
- Agreements
- Physical environment
• Additional outpatient services:
  ✓ May include, but are not limited to radiology, laboratory, outpatient rehabilitation, surgical, behavioral health (including substance use disorder treatment), and maternal health services.
  ✓ REHs may opt to provide low-risk labor and delivery services that are supported by the necessary emergency surgical procedures.
Key Contacts

• Health and safety standards/Conditions of Participation: Kianna Banks, kianna.banks@cms.hhs.gov

• REH survey and certification process/subregulatory guidance: QSOG_REH@cms.hhs.gov
Sustaining Rural Health Care in Kansas

The Rural Emergency Hospital

April 2023
Key Activities

• 2012-2013 – Group created, principles developed, case for change
• 2014 - 2015 – Primary Health Center concept created, paper test
• 2017 – 2018 – Discussions with CMMI, federal bills introduced
• 2019 – Push at federal level, launched Community Conversations
• 2020 – Community Conversation in Oberlin, stakeholder conversations, CHART Model released, REH established
• 2021 – Media Briefing, Regional Conversations, REH State Legislation
• 2022 – Conditions of Participation and Payment Rules Released
• 2023 – REH starts, Community Conversations
Laying groundwork

• Lots of research – build a case

• Educate Hospitals – get their buy-in

• Educate Partner Organizations

• Educate Policy Makers

• Educate the Public
Making the Case for Change

• Review the health care challenges facing Kansas
  • Population shifts
  • Uninsured rates
  • Workforce challenges
  • Public health funding
  • Overall health ranking

• Discuss the rural hospital dilemma
  • Shift to more outpatient services
  • Basics of finance
  • Financial status of KS hospitals
  • Regulatory challenges
Partner Organizations

- Health care organizations
  - Medical society, family physicians, pharmacy, public health, long term care, FQHCs, EMS, mental health centers, health foundations, etc.

- Health insurance companies

- Local government associations

- Rural interested groups
  - Farm Bureau, extension service, bankers, education, AARP

- Key State/Federal officials
Statutory Language

- Used current CAH statutes as a starting point

- Created a new licensure category for REH
  - Mirrored language in Consolidated Appropriations Act

- Inserted the words “and REH” in several places

- Did not attempt to dictate any specific payment details
Key Talking Points

• Preserving access to care is the priority

• KS hospitals are struggling

• Not a requirement – just another tool in the tool box

• Kansas based solution

• Not dictating payment rates, just assuring that services paid by REHs will be covered
Ongoing Activities

• State Rules and Regulations

• Amend language in Medicaid Provider Assessment Program to include REHs

• Necessary Provider issue

• REH 2.0 bill
Rural Emergency Hospital

Clinic
- Limited hours
- No Emergency Services
- No Inpatient Stays
- Primary Care
- Telemedicine

Rural Emergency Hospital
- Open 24/7
- Emergency Services
- Limited Stays
- Primary Care
- Telemedicine

Hospital
- Open 24/7
- Emergency Services
- Inpatient Stays
- Telemedicine

Annual average length of stay cannot exceed 24 hours per patient.
Services Provided by REH

**REQUIRED SERVICES**
- Emergency care
- Lab services
- Radiology/Imaging
- Pharmacy

**SUPPORTIVE SERVICES**
- Telemedicine
- Transportation

**OPTIONAL SERVICES**
If community has a need, may be added:
- Primary health care, including prenatal care
- Management of chronic conditions
- Urgent care
- Outpatient surgery
- Outpatient rehabilitative services
- Outpatient behavioral health
- Specialty care (via telemedicine or visiting specialists on site)
- Skilled nursing unit
Additional Resources

Find information on the rural emergency hospital, community conversations and other resources on KHA Website.

https://www.kha-net.org/CriticalIssues/AccessToCare/RuralIssues/
Contact Information

Jennifer Findley
jfindley@kha-net.org  (785) 233-7436