DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

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CMS Defines "Primary Roads"

To be certified as a critical access hospital (CAH), the hospital must be 35 miles or further from the next nearest hospital or CAH, or in the case of mountainous or secondary roads, more than 15 miles from the next nearest hospital or CAH. But wait! Many CAHs don't meet the requirement - why? These likely came under the program when the States could deem a facility a "necessary provider" CAH. The distance requirement was important but not as important as it is now, when states no longer have the ability to deem hospitals as necessary providers (us old folks know this has been since 2006; you youngsters just have to rely on our good story telling).

So, what is the definition of secondary road? It is a road that is not a primary road. I assume when they first wrote that definition, there were cocktails involved and a lot of snickering. Because it is funny.

The definition that matters, then, is "what is a primary road?" In its final 2023 OPPS rule, CMS updated its definition. And I think for a few hospitals out there, it will allow them to become part of the CAH program, congratulations.

Specifically, primary roads are defined as a numbered Federal or state highway with two or more lanes each way. The distance between the potential CAH and the next nearest CAH or hospital must be more than a 35-mile drive on primary roads or have at least 15 miles or more that are one lane highways. Necessary provider CAHs remain grandfathered, but all other CAHs will be reviewed for continued compliance with the distance requirement, utilizing the above definition.

Public Health Emergency

The public health emergency (PHE), must be renewed every 90 days. The current administration promised, if their intent was to NOT renew the PHE, to let us know within 60 days of the expiration of the current 90-day period. That time frame for the current PHE has passed, meaning we can rely on the PHE being extended again in January for an additional 90-days.

As you are aware, there are several flexibilities offered during the pandemic. CMS has listed those in a handy crosswalk you can access here: thanks Shar!

EHR Reporting for Hospitals

Electronic Health Records reporting? Did you mean interoperability? Why yes, both. CMS has indicated that starting in the 2024 calendar year, reporting for hospitals will increase from a continuous 90-days period to a continuous 180-day period.

Rural Health Clinic (RHC) Caps

As of April 1, 2021, all RHC encounter rates are capped at the greater of either the 2020 cost report's cost per encounter or the statutory rates. This raised the question "what about short period cost reports?" to which CMS responded: "good one—a short period is likely not going to be a great measure, so the data should cover a 12-consecutive-month period" (not a *direct* quote). For those of you with new clinics that barely made the cut-off, this change could be significant. We suggest reviewing any 2020 partial year rates to your 2021 rates and calculating if there is a potential payback due if this policy is finalized.

Also, if your clinic happens to be under productivity, remember to request a productivity waiver, as these are easily requested as we are under the PHE. However, if you are consistently using these productivity waivers, you will want to review staffing in your clinic so you can get yourselves back to productivity when the PHE ends. While we love a nice high Medicare rate, we must also remember we are likely losing money on all other payor's claims (and likely on the Medicare claims as well…you know, the whole coinsurance calculation).

American-made National Institute for Occupational Safety & Health (NIOSH) Approved N95 Masks

For PPS facilities: starting with cost reports beginning on or after January 1, 2023, there will be a new cost report form calculating the difference between American-made NIOSH approved N95 masks and those not domestically produced.

To be clear: domestically-produced N95 masks must be truly "all American" (insert vision of a cowboy hat on the mask that has an eagle printed on it). The rule states "all components are grown, reprocessed, reused, or produced in the United States of America." How will you know? You have to get a signed statement from the manufacturer saying these masks meet the definition. Lucky for us, we can rely on them

The form will calculate a cost-per-unit for domestically-produced NIOSH approved masks and non-domestically-approved NIOSH masks. The difference of those amounts will be applied to the total units for domestically-produced NIOSH masks. Medicare will then pay its share based on total Medicare cost to total cost (weighted average of all hospital services).

What I hope you heard – starting January 1, 2023, PPS hospitals need to track:

- The number of domestically-produced NOISH approved N95 masks.
- The amount paid for the above masks
- The number of other NIOSH-approved N95 masks.
- The amount paid for the above masks
- Keep on file (and share with your cost-report preparer!) a copy of the manufacturer's attestation the domestically-produced masks are, well, 100% domestic.

Remember this reporting is for PPS facilities only; CAHs are paid based on cost, so the increased cost is covered "naturally."

The purpose of this increased payment is to ensure that when the next pandemic occurs, we have the ability to produce our own masks meeting the NIOSH standards. Not only do we want to be able to wholly control our supply, but should shortages occur like they did in this pandemic, we want to ensure continued adherence to our level of quality control, rather than relying upon other production in other countries where safety standards may not be as high.

Rural Emergency Hospitals

Rural Emergency Hospitals (REH) were authorized via the 2020 Consolidated Appropriations Act, with the intention of offering an alternative healthcare delivery system for rural areas.

To be an REH, the hospital must have been an existing hospital with fewer than 50 beds as of the date of the Consolidated Appropriations Act (December 2020). A hospital does not have to worry about losing its status as a hospital or CAH, as the rules do allow for an REH to convert back to a hospital or CAH.

REHs are outpatient-only facilities providing emergency and observation care, with a maximum length of stay of 24 hours. This length of stay is an average of all outpatients, so while an individual patient could stay for longer than 24 hours, the average must stay under (this is of particular consideration for those facilities that have long psychiatric holds awaiting a psychiatric bed at a facility). The actual calculation begins with the earlier of registration or triage through the time of discharge. If patients are routinely kept for more than 24 hours, the medical record should delineate the steps taken to discharge the patient.

Payment is based on OPPS plus 5% and a monthly add-on payment.

REHs cannot provide inpatient care but can have a distinct part nursing home.

Below are some highlights of the program:

- The 5% OPPS add-on is just that: an add on to items paid under OPPS. Things excluded (to which payment will be fee schedule payment without a 5% add-on) include outpatient therapy, services paid under clinical laboratory fee schedule, skilled nursing home, ambulance, etc.
- Bundling requirement for PPS facilities also apply here.
- An REH can have a distinct part nursing home but cannot have a distinct part psychiatric or rehabilitation unit.
- Provider-based rural health clinics (RHCs) keep their calculated cap (please note the full year cost data note above).
- The monthly stipend is set to be $272,866 a month for 2023, increasing by the market basket inflation factor each year. For those of you paying attention, that is slightly higher than the proposed amount, as there was an error in CMS' thinking all CAHs would have qualified for low-volume adjustment (someone astute reminded them we have CAHs much closer than 15 miles from the next nearest hospital or CAH).
- Reporting on the above stipend is to be done via filing of Medicare cost reports. That cost report will be the same one you are filling out now, albeit with fewer lines.

- The "application" process will utilize CMS Form 855A, but instead of requesting to be a new facility type, the choice will simply be a "change in information."
- Services provided, besides the statutorily required 24/7 emergency room and observation services, must include:
    - Diagnostic radiology services
    - Basic laboratory services "essential to the immediate diagnosis and treatment of the patient consistent with the nationally recognized standards of care for emergency room services" available 24 hours a day.
- Off-campus locations can be paid at 105% of the OPPS rate.
- REHs are not covered entities with regards to 340B contract drug pricing.

Whether converting to an REH will benefit your facility or community is a big decision requiring both financial and long-term planning analysis. A positive outcome for the first few years can quickly turn negative when the payments are only updated by 1-2% a year while costs continue to climb (think increased costs like ~~champagne~~ in nursing).

Also remember the first rule of hospital finance: much of our costs are fixed costs. Increasing services spreads those costs over more services (e.g. you will need a CFO, building, HR, and such under both).

Closing

If you have questions or would like more information or analysis, please call me at 509-242-0874.