POLSINELLI What a law firm should be.℠

SEPTEMBER 2022 | VOL. 12

Health Care Reimbursement and Payor Dispute Update

POLSINELLI REIMBURSEMENT TEAM NEWSLETTER

Co-Location and the Provider-Based Rules – No News is…Good News?

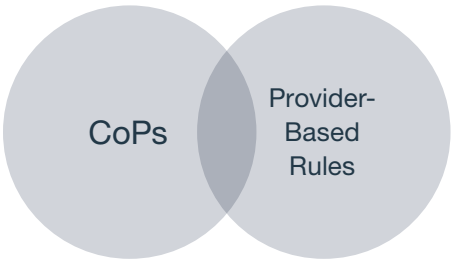
Sarah R. Kocher
Counsel
New York

On July 15, the Centers for Medicare & Medicaid Services ("CMS") released the 2023 Outpatient Prospective Payment System proposed rule ("OPPS Proposed Rule"), with notable provisions such as enrollment and payment policies for the newly established "rural emergency hospital" provider type. Also notable is a topic that is not addressed in the OPPS Proposed Rule – co-location. The OPPS Proposed Rule does not include any discussion of, or even nod to, the status of co-location under the Medicare Provider-Based rules. For hospitals attempting to create an effective strategy around co-location and have been riding a rollercoaster of CMS guidance on this topic, the lack of concrete guidance is likely frustrating…but no news may ultimately be good news for hospitals.

An Overview of Co-Location

Co-location can take a range of forms, but generally occurs when a Medicare provider such as a hospital shares space with another health care entity. CMS regulates co-location under two primary sets of rules and guidance: (1) Medicare Conditions of Participation ("CoPs")[1] and (2) Medicare Provider-Based rules.[2]

The distinction between the CoPs and the Provider-based rules is important. CoP and Provider-Based guidance come from separate divisions within CMS – the CMS Quality, Safety & Oversight Group, for updates and guidance relating to the CoPs, and the CMS Payment Policy Group, for updates and guidance involving the Provider-Based rules. Further, although there is some overlap between the CoPs and Provider-Based rules, the CoPs and Provider-Based rules have distinct sets of requirements for compliance, as well as distinct penalties for failure to comply.



The CoPs and Provider-Based rules do not directly address co-location, but for nearly a decade, CMS interpreted the CoPs and Provider-Based rules as prohibiting a hospital from sharing nearly any space with another health care provider.[3] Then, in November 2021, CMS issued final updates to the Medicare State Operations Manual, laying out a pathway for co-location under the general acute care hospital CoPs.[4] Despite this opening under the CoPs, there has been no counterpart CMS guidance regarding co-location under the Medicare Provider-Based rules. The Payment Policy Group has not formally (or, to our knowledge, informally) endorsed the recent CoP guidance around co-location, and it also has not issued its

[1] 42 CFR 482 et seq.
[2] 42 CFR 413.65.
[3] During this period, and without issuing any formal rulemaking to that effect, CMS cited hospitals and initiated recoupment actions where a hospital had less than full physical separation from any other health care providers in the same building (for example separate suites with separate entrances and waiting rooms).
[4] QSO-19-13-Hospital (November 12, 2021), *"Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities (Revised)."* A copy of this guidance can be found here.

CONTINUED ON PAGE 2

CONTINUED FROM PAGE 1

Table of Contents

own updated guidance on co-location under the Provider-Based rules. And with the lack of any discussion around co-location in the OPPS Proposed Rule, CMS is not engaging in formal rulemaking regarding co-location under the Provider-Based rules at this time. But where does this leave hospitals?

The Status of Co-Location and the Provider-Based Rules.

Although CMS has not issued any recent guidance regarding co-location under the Provider-Based rules, there have been adjacent developments at the federal level that will likely impact any position that CMS ultimately takes. First, in *Azar v. Allina Health Services,* the United States Supreme Court held that CMS must utilize notice-and-comment rulemaking when establishing a "substantive legal standard" that would govern the scope of Medicare benefits, payment conditions, or eligibility to furnish services.[5] In a follow-up to *Allina,* on December 3, 2020, the Office of the General Counsel of the Department of Health & Human Services ("OGC") released Advisory Opinion 20-05 to clarify that a "substantive legal standard" subject to notice-and comment rulemaking is any requirement "not otherwise mandated by statute or regulation." Because the Provider-Based regulations do not directly address co-location, and applying OGC's own standards, any guidance regarding co-location under the Provider-Based regulations would arguably be subject to notice-and-comment rulemaking.

As an illustration of the impact of *Allina* on co-location, an Administrative Law Judge ("ALJ") recently held that CMS's restrictive interpretation of the Provider-Based regulations violated *Allina* and CMS's obligation to engage in notice-and-comment rulemaking. In this 2021 Department of Health & Human Services Departmental Appeals Board decision, the ALJ found that a Cleveland Clinic Foundation's sleep study facility met Provider-Based requirements even though it was co-located with a Marriott hotel.[6] The ALJ set aside CMS's argument that the facility could not meet the Provider-Based regulatory definition for "Department of a Provider" if it did not have "separate space physically partitioned off by a door or wall" and an exclusive entrance; the ALJ acknowledged that this may be a "reasonable requirement," but determined that she was "unable to impose such a specific requirement based on the text in the definition."[7] The ALJ went on to conclude that under *Allina*, she could not "implement CMS's ad hoc interpretations when there is ambiguity."[8] Importantly, CMS denied this particular attestation and argued the case pre-*Allina* and also prior to issuing updates to the State Operations Manual with respect to co-location under the CoPs. It is unclear whether CMS would continue with such a restrictive view of co-location today, but this case illustrates that CMS would face an uphill battle continuing such a view without first engaging in notice-and-comment rulemaking.

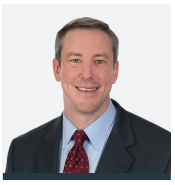
And to that point, the lack of any proposed rulemaking regarding co-location in the 2023 OPPS Proposed Rule is, if not outright good news for hospitals, not bad news either.

---

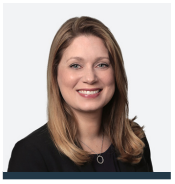
[5] 139 S. Ct. 1804 (2019).
[6] *The Cleveland Clinic Foundation v. Centers for Medicare & Medicad Services, DAB CR5903, Department of Health & Human Services Departmental Appeals Board Civil Remedies Division (July 14, 2021).*
[7] Id. at 24.
[8] Id. at 24-25.

Increased Scrutiny for Provider-Based Facilities

Adrienne E. Frazior
Shareholder
Dallas



R. Ross Burris, III
Shareholder
Atlanta



Jessica M. Andrade
Shareholder
Seattle

A rise in provider-based facilities—and their costs to the Medicare program—has the Health and Human Services-Office of Inspector General concerned about the significant cost difference when Medicare beneficiaries obtain services in provider-based facilities versus freestanding facilities.

A provider-based facility is attached to a hospital but separate from the main inpatient portion of the hospital. Medicare allows this arrangement for enrollment and billing purposes.[1] The facilities are considered "provider-based" to their "main provider" the hospital and can bill and collect for services as part of the hospital.

Such arrangements allow hospitals to promote uniformity through an integrated health care system and allow for greater control over ancillary services. However, some groups are critical that these arrangements result in higher costs to the Medicare program and to beneficiaries. Recent events show an increased focus on these facilities.

$22 Million Settlement Related to Provider-Based Services

In May of 2021, the United States Department of Justice announced a $22 million settlement for fraudulent billing practices arising out of claims submitted through off-campus hospital-based facilities. The settlement results from multiple qui tams filed by four relators.[2]

The United States partially intervened for the purposes of settlement in the matters on June 4, 2021. Between July 12, 2013 and May 12, 2014 four relators brought three civil false claims actions against the University of Miami, a nonprofit, private university in Coral Gables, Florida. The University of Miami provides medical care at Jackson Memorial Hospital, also named in some of the suits, and its own hospitals and clinics.

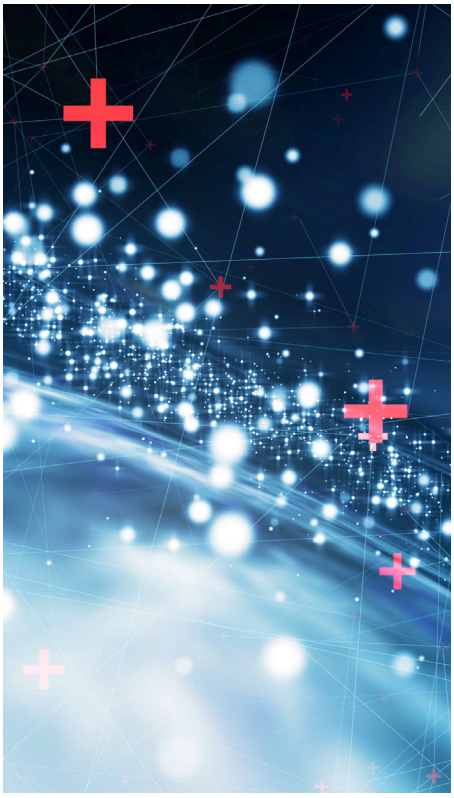
In addition to purportedly billing for medically unnecessary laboratory tests, the United States alleged that the University of Miami knowingly engaged in improper billing relating to its provider-based facilities. The United States alleged that the University of Miami violated certain requirements that must be met for Medicare to allow medical systems to convert physician offices into provider-based facilities. For instance, the United States asserted that the University of Miami failed to give notice to Medicare beneficiaries explaining the higher costs of receiving services at the provider-based facilities over physician offices—even after being notified by a Medicare Administrative Contractor of the requirement to do so and of deficiencies in the University of Miami's notices.

As part of the settlement agreement, the University of Miami also agreed to enter into a corporate integrity agreement with the Department of Health and Human Services.

The case was handled jointly by the United States Attorney's Office in the Southern District of Florida and the Civil Division's Fraud Section representing a partnership between multiple divisions within the Department of Justice to tackle these types of false claims investigations. This may signal an uptick in resources devoted to investigating provider-based facilities.

Data Analysis Used to Investigate and Audit Provider-Based Facilities

While the University of Miami case was initiated by relators with first-hand knowledge of the practices at the university, not all cases are generated this way. The Department of Justice utilizes data mining and statistical analysis to uncover similar schemes. When a certain service or provider registers as an anomaly, investigators take notice and initiate an investigation into the alleging billing impropriety. In recent years, this has led to more proactive DOJ investigations targeting spikes and outliers in Medicare data, rather than the "pay and chase" style investigations of the past.



[1] 42 CFR § 413.65.

[2] *University of Miami to Pay $22 Million to Settle Claims Involving Medically Unnecessary Laboratory Tests and Fraudulent Billing Practices*, Press Release, Department of Justice, Office of Public Affairs- May 10, 2021 (July 8, 2022), http://www.justice.gov/opa/pr/university-miami-pay-22-million-settle-claims-invovling-medically-unnecessary-laboratory

CONTINUED ON PAGE 4

CONTINUED FROM PAGE 3

Using data in uncovering these schemes has also prompted audits to determine the source of higher costs within the Medicare program. In June of 2022, the Health and Human Services- Office of Inspector General announced an audit conducted of reimbursement rates for evaluation and management services provided at provider-based facilities versus free-standing facilities.[3]

The audit was conducted due to Three Medicare Payment Advisory Commission reports to Congress and a prior OIG report that found an increase in purchases of physician practices by hospitals operating the practices as provider-based facilities. The OIG opined this rise was due to the higher reimbursement rates and beneficiary coinsurance payments for services rendered in provider-based facilities than for freestanding facilities.

To determine potential cost savings to the Medicare program, the audit compared evaluation and management services performed at provider-based facilities from 2010 to 2017 with what beneficiaries would have paid for these same service types at freestanding facilities. They compared each set of data from the same eight states. The audit uncovered a cost-savings difference of $1.3 billion to the Medicare program and $334 million to Medicare beneficiaries. Had the services been provided at freestanding facilities, beneficiaries would have paid at a lower rate and had to pay only one co-pay instead of two.

More Scrutiny for Provider-Based Facilities on the Horizon

As a result of the audit, the OIG recommended action to equalize payments for evaluation and management services in both facilities including legislation. As the OIG report and other agency statements increase awareness of increased pricing due to provider-based billing, we can expect greater scrutiny by enforcers. Where DOJ or HHS OIG are investigating an entity, expect scrutiny of provider-based billing arrangements and consult counsel to make sure arrangements are compliant.

[3] Medicare and Beneficiaries Paid Substantially More to Provider-Based Facilities in Eight Selected States in Calendar Years 2010 Through 2017 Than They Paid to Freestanding Facilities in the Same States for the Same Type of Services. https://oig.hhs.gov/oas/reports/region7/71802815.asp

Proposed Updates Impacting Critical Access Hospitals

Ross E. Sallade
Home Health, Home Care and Hospice Chair
Raleigh

Colleen E. Guinn
Associate
Denver

Many rural facilities have been anticipating the proposed requirements for Medicare's new Rural Emergency Hospital ("REH") provider type, which the Centers for Medicare & Medicaid Services released in early July. Whether or not facilities are considering a transition in provider type, though, the proposed rule also contains significant updates for existing Critical Access Hospitals ("CAHs").

For years, CAH distance requirements have been a point of contention and confusion for providers and regulators. Currently, definitions and explanations regarding those distance requirements live in the State Operations Manual ("SOM"), including language adopted in 2015 that defines a "primary road." The existing SOM definition of a primary road is:

1. Any United States highway, including any road:
   - In the National Highway System, as defined in 23 U.S. Code §103(b); or
   - In the Interstate System, as defined in U.S. Code §103(c); or
   - Which is a US-Numbered Highway (also called "U.S. Routes" or "U.S. Highways") as designated by the American Association of the State Highway and Transportation Officials (AASHTO), regardless of whether it is also part of the National Highway System; or
2. A numbered State highway with two or more lanes each way; or
3. A road shown on a map prepared in accordance with the U.S. Geological Survey's Federal Geographic Data Committee (FGDC) Digital Cartographic Standard for Geologic Map Symbolization as a "primary highway, divided by median strip."

CMS is now proposing to incorporate a streamlined definition of primary road in the CAH regulations. Specifically, CMS proposes to define primary roads of travel for determining the driving distance of a CAH and its proximity to other providers as:

1. A numbered Federal highway, including interstates, intrastates, expressways or any other numbered Federal highway; or
2. A numbered State highway with two or more lanes each way.

In its proposal, CMS is considering whether the definition of primary road will include numbered Federal highways with two or more lanes, similar to the description of numbered state highways, and exclude numbered Federal highways with only one lane in each direction.

Accompanying this updated definition, CMS is proposing to create a new review process for CAH recertification, which will run on a three-year cycle. CMS anticipates that this new process will focus on hospitals being certified in proximity to a CAH, and will focus less on road classifications. Under this system, CAHs with no other hospitals within 50 miles will be automatically re-certified.

A CAH that was certified by the state as being a necessary provider of health care services to residents in the area on or before January 1, 2006 will be able to maintain its status, as this exemption from the distance requirement stems from statute rather than CMS regulation.

Additionally, CMS is proposing to establish new patients' rights CoPs for both CAHs and REHs. The new rules would also allow hospitals, CAHs and REHs to utilize a unified and integrated medical staff shared by multiple facilities within a health care system and would mirror the hospital CoPs for infection control and quality assessment within a unified system.

The No Surprises Act: Unsettled Issues as to Provider Reimbursement

Joshua D. Arters
Associate
Nashville

Rachel M. Roberson
Associate
Nashville

The No Surprises Act ("NSA") went into effect on January 1, 2022, which means all individuals with commercial health coverage are now protected against "surprise" balance bills when they receive certain out-of-network ("OON") health care services.[1] However, important unsettled issues remain as to how disputes over reimbursement rates for services subject to the NSA are resolved during the NSA's independent dispute resolution ("IDR") process.

Congress set forth specific factors that neutrals (known as "IDR entities") resolving reimbursement disputes under the NSA must consider when determining appropriate OON rates. Congress chose not to give any more or less weight to any of these factors. However, in an interim final rule[2] ("IFR") issued by the federal executive agencies responsible for implementing the NSA, IDR entities were instructed to apply a rebuttable presumption that the "appropriate" OON rate is the insurance company's "QPA" (generally speaking, the median in-network or "INN" rate as calculated by the insurance company). In other words, the IFR as drafted imposed a "QPA presumption" and permitted IDR entities to consider the other statutory factors only when such factors "clearly demonstrate" that the insurance company's unilaterally calculated QPA is "materially different" from the appropriate OON rate.

Roughly three weeks after the IFR's publication, the plaintiffs in *Texas Medical Association, et al. v. U.S. Dept. of Health and Human Serv's, et al.*[3] ("TMA") filed suit in the Eastern District of Texas challenging the IFR. The plaintiffs argued that the IFR's QPA presumption directly conflicted with the NSA and would result in IDR entities disproportionately relying on one insurer-calculated benchmark. On February 28, 2022, the court issued a 35-page decision agreeing with the plaintiffs. As we discussed in more depth in our previous update (linked here), the court noted that "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate" and found this is exactly what the federal agencies tried to do with the IFR's QPA presumption. The court decided to strike down the offending portions of the IFR instead of allowing the federal agencies an opportunity to establish further justification for the IFR because, according to the court, there was "nothing the [agencies] can do on remand to rehabilitate or justify the challenged portions of the [IFR] as written." The court also determined that its ruling should apply nationwide and not just to the named plaintiffs in the case.[4]

Despite the *TMA* decision, federal agencies continued to apply the QPA presumption to OON air ambulance services because the specific portions of the IFR at issue in the *TMA* case were located in sections of the IFR applicable to hospitals and other hospital-based providers, not air ambulance providers. This prompted an air ambulance provider in *LifeNet, Inc. v. U.S. Dept. of Health and Human Serv's, et al.*[5] ("*LifeNet*") to file suit in the same District Court seeking the same relief. On July 26, 2022, the court issued a 23-page decision that followed its previous ruling in *TMA*, and struck down the provisions of the IFR imposing the QPA presumption to air ambulance services, which we discussed in more detail in our previous update (linked here).

As a result of the *TMA* and *LifeNet* decisions, IDR entities are now prohibited from imposing any presumption that the insurer calculated QPA is the appropriate OON rate on a nationwide basis. However, there are also currently six other lawsuits pending[6] involving similar, if not identical, arguments against the QPA presumption as well as challenges to other portions of the IFR.[7] While some litigation has been stayed, it is unclear whether any court will issue another ruling before the Biden-Harris Administration releases a Final Rule implementing the NSA's IDR process. This Final Rule is currently being reviewed for clearance by the White House Office of Management and Budget, but there is no timeline for the review period.

---

[1] Surprise billing sometimes occurs when patients unintentionally receive emergency or non-emergency services from out-of-network ("OON") providers (i.e., providers who do not participate in the patient's insurance network). Prior to the NSA's enactment, patients often assumed the financial burden for such OON care. While some states have enacted laws addressing this issue in varying ways to protect patients from surprise bills, not all states have. And even those states with existing law on the books are generally unable to regulate many patient encounters, including those encounters with patients who have health coverage under self-funded health benefits plans regulated by the federal Employee Retirement Income Security Act of 1974 ("ERISA"). The NSA addresses this problem on a federal level to "fill the gaps" where states have not enacted (or are unable to enact) laws regulating encounters with patients who have commercial health coverage. Broadly, the NSA does four major things: (1) prohibits balance billing and limits a patient's financial responsibility for certain OON care to the amount for which the patient would be responsible had those services been furnished by in-network ("INN") providers; (2) requires health plans and issuers to reimburse providers directly for such OON care and resolve reimbursement disputes under a statutory independent dispute resolution ("IDR") process; (3) creates protections for uninsured and self-pay patients and a patient-provider dispute resolution process; and (4) imposes additional transparency requirements.

[2] Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021).

[3] No. 6:21-cv-425 (E.D. Tex., filed Oct. 28, 2021).

[4] The federal agencies subsequently appealed the *TMA* decision to the Fifth Circuit but requested a hold on such appeal on May 3, 2022 pending the release of a Final Rule implementing the IDR process.

[5] No. 6:22-cv-162 (E.D. Tex., filed April 27, 2022).

[6] *See Ass'n of Air Medical Services v. U.S. Dep't. of Health and Human Servs.*, No. 1:21-cv-3031 (D.D.C., filed Nov. 16, 2021); A*merican Medical Ass'n v. U.S. Dep't. of Health and Human Servs.*, No. 1:21-cv-3231 (D.D.C., filed Dec. 9, 2021); *American Society of Anesthesiologists v. U.S. Dep't. of Health and Human Servs.*, No. 1:21-cv-6823 (N.D. Ill., filed Dec. 22, 2021); *Georgia College of Emergency Physicians v. U.S. Dep't. of Health and Human Servs.*, No. 1:21-cv-5267 (N.D. Ga., filed Dec. 23, 2021); *Haller v. U.S. Dep't of Health and Human Servs.*, No. 2:21-cv-7208 (E.D.N.Y., filed Dec. 31, 2021); *PHI Health, Ltd., v. U.S. Dep't of Health and Human Servs.*, No. 6:22-cv-95 (E.D. Ky., filed April 29, 2022).

[7] For example, the plaintiffs in two other lawsuits also challenge the IFR's methodology to calculate the QPA as applied to air ambulance services, saying the methodology in the IFR arbitrarily and capriciously excludes features specific to the air ambulance industry. In another case, the plaintiff raises a constitutional argument against the NSA itself, saying the NSA impermissibly delegates the authority to determine physicians' state-based common law claims to an administrative tribunal, deprives physicians of the right to a jury trial under the Seventh Amendment, violates due process under the Fifth and Fourteenth Amendments, and prohibits physicians from recovering the fair value of their services in violation of the Takings Clause of the Fifth Amendment.

CMS Releases Proposed Rural Emergency Hospital Rules

Ross E. Sallade
Home Health, Home Care and Hospice Chair
Raleigh

Colleen E. Guinn
Associate
Denver

The Consolidated Appropriations Act of 2021 created a new Medicare provider type known as the "Rural Emergency Hospital" ("REH"). In anticipation of this new enrollment category, which will be available to rural hospitals beginning January 1, 2023, the Centers for Medicare & Medicaid Services ("CMS") has released proposed conditions of participations ("CoPs") for REHs and has included discussion of REH enrollment and payment in the Hospital Outpatient Prospective Payment System ("OPPS") proposed rule. Rural hospitals across the country will want to carefully read the proposed CoPs and payment rules in order to provide feedback and evaluate whether the transition to REH is right for their facilities and communities.

Background

Under the Consolidated Appropriations Act of 2021, a facility that on December 27, 2020 was a CAH or a rural hospital with 50 beds or fewer will be eligible to enroll as a REH. The law mandates that REHs meet requirements including:

- An annual per patient average of 24 hours or less in the REH;
  - A REH may not provide inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility ("SNF") to furnish post-REH or post-hospital extended care services ;
- Staff training and certification requirements established by regulation;
- Emergency services CoPs applicable to CAHs;
- Hospital emergency department CoPs determined applicable by regulation (the proposed rule largely incorporates CAH CoPs regarding emergency departments);
- A transfer agreement with a level I or level II trauma center.

Proposed Conditions of Participation

Many of the proposed REH CoPs will mirror the current CAH CoPs. For example, the CoPs addressing the hospital governing body, policies, emergency services infection control, discharge planning, medical records, emergency preparedness and physical environment will generally follow the existing CAH CoPs. Some of the proposed CoPs, such as radiology requirements, will align with the existing general acute care hospital CoPs, rather than the CAH CoPs, in order to reflect the REH focus on emergency services.

The staffing CoPs for REHs will also resemble those for CAHs, although with some additional flexibilities. For instance, a physician, nurse practitioner, clinical nurse specialist or physician assistant will not need to be available to furnish patient care services at all times the REH operates. Instead, such a practitioner with training or experience in emergency care must be on call and immediately available by telephone or radio contact and available on-site within specified timeframes.

Some of the proposed REH requirements will depart from the existing CAH requirements. For example, REHs will provide laboratory services that are consistent with nationally recognized standards of care for emergency services, meaning that REH laboratory services will emphasize immediate availability, will be provided 24 hours per day, and the list of laboratory services provided may be more extensive in a REH. Unlike for CAHs, the REH regulations will include a separate CoP governing pharmaceutical services. Nursing services requirements will also differ for REHs in order to reflect the fact that the REH will not furnish inpatient services.

CMS is also proposing to implement a patients rights' CoP that resembles the current requirement for hospitals – this requirement will newly apply to both REHs and CAHs moving forward.

REHs may establish a distinct-part unit that is a SNF, which must meet the long-term care facility requirements and which CMS notes is a departure from a CAH providing swing-bed services.

In addition to primarily providing emergency services and observation care, CMS is proposing to allow REHs to provide additional medical and health outpatient services if the REH can demonstrate that the service is needed based on an assessment of its community. In that context, CMS is considering whether REHs will be permitted to provide low-risk labor and delivery, outpatient surgical services and behavioral health services. If a REH does provide these additional services, it will need to have a system in place for referral from the REH to different levels of care, as the REH cannot provide inpatient services.

A REH must be located in a state that provides for the licensing of such hospitals under state or applicable local law; and is:

- Licensed in the state as an REH; or
- Approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals.

Several states have passed laws providing for specific licensing of REHs, including Kansas, Nebraska and South Dakota. The Kansas and Nebraska laws generally mirror the federal legislation, but South Dakota specifies that REHs must be located in a municipality with a population under fifty thousand people that has no acute inpatient services.

CONTINUED ON PAGE 7

CONTINUED FROM PAGE 6

Proposed Enrollment and Reimbursement

CMS is proposing a relatively straightforward enrollment process for CAHs and hospitals looking to become REHs. Typically, when a provider seeks to change enrollment types they must terminate and newly enroll as the different type. In this unique circumstance, however, CMS will process a REH conversion as a change of information. Timing seems to be a factor in CMS's approach, as it looks to be able to process applications before January 1, 2023.

By statute, REHs will be reimbursed at 105% of the Medicare Hospital OPPS amount for covered outpatient services and will also receive a monthly facility payment.

The 105% rate will apply to all "REH services." CMS is proposing a broad definition of "REH services," which means that any services furnished in an REH that are on the hospital OPPS fee schedule will be reimbursed at 105% (rather than limiting that rate to only specific services). The REH services rate will also extend to off-campus provider-based departments. Services paid on other fee schedules, such as laboratory services, will be reimbursed at their standard fee schedule rate.

CMS spends a notable portion of the proposed rule explaining how it has calculated the monthly facility payment which will go to all enrolled REHs. The bottom line of these calculations is that REHs will receive approximately $ 268,294 per month. The statute requires that REHs maintain detailed information as to how the facility has used this monthly facility payment and must make this information available upon request. For the time being, CMS believes that this requirement can be met using existing cost reporting requirements (which will apply to REHs).

Comments

The proposed REH CoPs are open for comment through August 29th, 2022. CMS appears especially open to comments on additional services including surgical services, rehabilitation services, maternal care, low-risk labor and delivery, behavioral health services and other outpatient services not yet addressed. The proposed patient's rights CoP may also be an area of commenter interest given that it is a new requirement for both REHs and CAHs.

The proposed hospital OPPS rule is open for comment through September 13th, 2022. In addition to comments on enrollment and reimbursement, CMS is also seeking feedback on quality reporting and a new Stark Law exception applicable to REHs.

POLSINELLI — WHERE THE POLICY, POLITICS AND BUSINESS OF HEALTH CARE COME TOGETHER TO MAKE HEALTH CARE BETTER

The Polsinelli Health Care practice represents one of the largest concentrations of health care attorneys and professionals in the nation. From the strength of its national platform, the firm advises clients on the full range of hospital-physician lifecycle and business issues confronting health care providers across the United States.

Recognized as a leader in health care law, the firm was ranked as the 2018 "Law Firm of the Year" in Health Care by *U.S. News & World Report* "Best Law Firms" for the second time in four years, and continues to hold the national Tier One ranking in Health Care Law. The practice is currently ranked by the American Health Lawyers Association as the largest health care practice in the nation (*AHLA Connections*, 2022) and is nationally ranked by *Chambers USA* 2022.

As one of the fastest-growing health care practices in the nation, Polsinelli has established a team that includes former in-house counsel of national health care institutions, the Office of Inspector General (OIG), and former Assistant U.S. Attorneys with direct experience in health care fraud investigations. Our group also includes current and former leaders in organizations such as the American Hospital Association. Our strong Washington, D.C., presence allows us to keep the pulse of health care policy and regulatory matters. The team's vast experience in the business and delivery of health care allows our firm to provide clients a broad spectrum of health care law services.

Understanding the nuances of Medicare, Medicaid, private and other payor reimbursement is one of the greatest challenges that providers face in today's quickly changing health care world. The Reimbursement Institute's Advisors help organizations clear those hurdles in aim of providing the best care possible.

Stay Connected

Polsinelli frequently writes about topics related to these materials.
Click here to subscribe to receive news and webinar updates.

Upcoming Events

Health Care Briefing

Wednesday, September 21

Join Polsinelli for our Health Care Briefing in Seattle, Washington covering health equity, emerging issues in standard of care and big data including any unique Washington state updates.

Health Care Private Equity Basic Training

Thursday, October 13

Polsinelli invites you to join us for the Health Care Private Equity Basic Training, taking place in Chicago, Illinois. This interactive training session will focus on what non-lawyer advisors, investors and lenders need to know to efficiently and quickly close health care deals by understanding how to smoothly navigate key deal and related regulatory issues that will arise during the merger and acquisition process.

If you have questions or would like more information, please contact Sinead McGuire at smcguire@polsinelli.com

Editorial Board

Barry Alexander
barry.alexander@polsinelli.com

Mary Clare Bonaccorsi
mbonaccorsi@polsinelli.com

Jonathan Buck
jbuck@polsinelli.com

R. Ross Burris, III
rburris@polsinelli.com

Jennifer Evans
jevans@polsinelli.com

Colleen Faddick
cfaddick@polsinelli.com

Bragg Hemme
bhemme@polsinelli.com

David King
dking@polsinelli.com

Blake Reeves
breeves@polsinelli.com

Ross Sallade
rsallade@polsinelli.com

Dmitry Shifrin
dshifrin@polsinelli.com