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

July 12, 2022

Background & Summary

On June 30, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to establish the conditions of participation (CoPs) that Rural Emergency Hospitals (REHs) must meet to participate in Medicare and Medicaid ("Proposed Rule"). The Proposed Rule is a critical step towards implementation of the Consolidated Appropriations Act (CAA) of 2021 (Pub. L. 116-260), which established the REH as a new type of rural Medicare provider. According to the CAA, REHs are to furnish emergency department and observation care, and other specific outpatient medical and health services, if elected by the REH, that do not exceed an annual per patient average length of stay of 24 hours.

REHs may receive Medicare payment for services at a rate that is 5 percent greater than the Medicare Hospital Outpatient Prospective Payment System (OPPS) payment rate. In addition, REHs receive an additional monthly facility payment. Notably, CMS clarifies that proposed payment and enrollment policies for REHs will be developed through separate rulemaking.

The Proposed Rule establishes a new set of regulations (subpart E in 42 CFR part 485) to incorporate the REH CoPs. The new CoPs are generally consistent with elements of existing CoPs for either Critical Access Hospitals (CAHs) or hospitals. The Proposed Rule also includes potential changes to the CoPs for CAHs.

Comments on the Proposed Rule are due on August 29, 2022. Vizient looks forward to working with members to help inform our letter to the agency.

Conditions of Participation: Rural Emergency Hospital (Proposed Part 485, Subpart E)

As noted by CMS, the proposed CoP requirements are modeled closely after the CoPs for CAHs, but in some instances CMS used existing requirements for hospitals or Ambulatory Surgical Centers (ASCs) to guide proposed requirements.

To develop the proposed CoPs, CMS received comments in response to a request for information on REHs that was included in the calendar year (CY) 2022 OPPS proposed rule, to which Vizient submitted comments. Throughout the Proposed Rule, CMS indicates where it has considered stakeholder feedback and where feedback is requested.

Rural Emergency Hospital Definition

CMS proposes that for the new CoPs, "Rural Emergency Hospital" or "REH" means an entity that operates for the purpose of providing emergency department services, observation care and other outpatient medical and health services specified by the Secretary in which the annual per patient average length of stay does not exceed 24 hours. The entity must not provide inpatient services, except those furnished in a unit that is a distinct part and licensed as a skilled nursing facility to furnish post-REH or post-hospital extended care services.

Regarding the proposed definition, CMS notes that it received comments requesting an increase to the average length of stay (LOS) based on certain circumstances where the LOS would be longer than 24 hours (e.g., inpatient psychiatric care service or inpatient rehabilitation services; bed capacity issues as patients await placement in an inpatient facility). However, CMS declined to modify the annual per patient LOS average of 24 hours due to statutory requirements from the CAA, and because it does not believe cited circumstances would occur at a frequency that would meaningfully affect the annual per patient average LOS.

Basic Requirements for Participating REHs

In the Proposed Rule, CMS indicates that participating REHs would be limited to those facilities that meet the definition of an REH and have a provider agreement[1] in effect to provide services.

Also, CMS proposes to only certify a facility as an REH if the facility was, as of December 27, 2020, a CAH, or a hospital with not more than 50 beds located in a rural county (or treated as being in a rural area). CMS proposes that a potentially eligible hospital located in a metropolitan county must have had an active reclassification from urban to rural status as of December 27, 2020.

CoP: Compliance with Federal, State, and Local Laws and Regulations

Consistent with the requirements for all Medicare and Medicaid participating providers and suppliers, CMS proposes to require REHs to comply with Federal, state and local laws and regulations. CMS also proposes to require that a prospective REH be in a state that licenses REHs under state or applicable local laws. Alternatively, an REH could be approved as meeting standards for licensing by the agency in the state or locality responsible for licensing hospitals.

CMS also proposes to require that the REH ensure that personnel are licensed or meet both applicable standards required by state or local laws to provide services within the applicable scope of practice. While commenters recommended CMS encourage licensure portability among health care practitioners, the agency notes that the proposed standard does not prohibit a practitioner licensed in a different state than where the REH is located from providing care at the REH. CMS reiterates that state law dictates licensure portability and related practice.

CoP: Governing Body and Organizational Structure of the REH

Consistent with the CAH CoPs for organizational structure, CMS proposes that REHs have an effective governing body, or responsible individual or individuals, that is legally responsible for the conduct of the REH. CMS further clarifies its expectations regarding the governing body's responsibilities, such as oversight, ensuring the REH is effectively executing its policies and decision-making about the REH's vision, mission and strategies.

Regarding medical staff appointment, CMS proposes requirements consistent with both hospital CoPs and CAH interpretive guidelines[2]. Noting stakeholder concerns regarding provider shortages, CMS proposes to use the term "telemedicine" to make it clear that the credentialing and privileging provisions proposed for REHs are not limited to the narrower subset of services and sites eligible for Medicare telehealth payment. In addition, CMS proposes to establish a more efficient process for REHs to credential and privilege clinicians who provide telemedicine services. Specifically, CMS proposes to allow the governing body of the REH whose patients are receiving the telemedicine

[1] Provider agreement means an agreement between CMS and one of the providers specified in § 489.2(b) to provide services to Medicare beneficiaries and to comply with the requirements of section 1866 of the Act.
[2] Appendix W of the State Operations Manual for the standard for Governing Body or Responsible Individual, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

services to grant privileges based on the recommendations of its medical staff, who would rely on information provided by the distant-site hospital.

CoP: Provision of Services

CMS notes that it received stakeholder comments regarding the need for the agency to remain flexible in the development of the standards related to the provision of services for REHs and that the standards should generally be similar to the CAH requirements. As a result, CMS proposes requirements related to the provision of services that generally align with the CAH CoPs.

Regarding REH written policies, CMS proposes to require that such policies include a description of the services the REH furnishes (including those furnished through agreement or arrangement), policies and procedures for emergency medical services, guidelines for the medical management of health problems, and policies and procedures that address the post-acute care needs of all patients receiving services furnished by an REH. Since REHs, by statute, cannot provide most inpatient services, CMS clarifies that post-acute care for an REH patient is any care the REH patient receives once they are discharged from the REH. CMS also proposes to require that these policies be reviewed at least biennially by a specified group of professional personnel.

CoP: Emergency Services

Generally, CMS proposes to require that REHs provide emergency services that meet the CAH requirements. Regarding hospital emergency services requirements, CMS proposes that REH organization requirements must be similar to those included in hospitals' CoPs. More specifically, REHs must have emergency services that are organized under the direction of a qualified member of the medical staff and are integrated with other departments of the REH.

Regarding personnel requirements, which would be consistent with those of CAHs, including that a practitioner need not be on-site at all times, CMS proposes that there be adequate medical and nursing personnel qualified in emergency care to meet the needs of the facility. To comply with this requirement, CMS expects the REH to conduct an analysis based on the anticipated staffing needs, and once the REH begins providing services the analysis would include actual staffing needs. **CMS seeks comments on the proposed staffing requirements for the provision of emergency services in an REH, including insight on the appropriateness of not requiring a practitioner to be on-site at the REH at all times.**

CoP: Laboratory Services

CMS proposes that REHs provide laboratory services that are determined to be appropriate and necessary based on the level of services provided at the REH. At minimum, REHs must provide basic laboratory services that are essential to the immediate diagnosis and treatment of the patient, consistent with those required to be provided by CAHs (e.g., chemical examination of urine, hemoglobin or hematocrit, blood glucose, examination of stool specimens for occult blood, pregnancy tests, and primary culturing for transmittal to a certified laboratory). Also, CMS proposes to require that REHs have emergency laboratory services available that would be essential to the immediate diagnosis of the patient, 24 hours a day, and that the REH ensure all laboratory services provided are performed in a facility certified in accordance with certain Clinical Laboratory Improvement Amendments (CLIA) requirements.

In addition, CMS encourages, but does not require, REHs to provide several other laboratory services (e.g., a complete blood count, basic metabolic panel, magnesium, phosphorus, liver function tests, amylase, lipase, cardiopulmonary tests, lactate, coagulation studies, arterial blood gas, venous blood gas, quantitative human chorionic gonadotropin, and urine toxicology).

CoP: Radiologic Services

CMS received recommendations that radiological services be provided at REHs. In response, CMS proposes that REHs must provide radiological services that mirror the hospital radiologic requirements (which are also consistent with CAH standards and interpretive guidelines). However, CMS also proposes standards for REHs related to safety, personnel responsibilities, and recordkeeping. Regarding personnel, CMS clarifies that the qualified radiologist requirement can be fulfilled through arrangements with off-site providers via telehealth.

CoP: Pharmaceutical Services

CMS proposes three standards for REHs' pharmaceutical services regarding pharmacy management and administration, delivery of services and administration of drugs. Additionally, CMS proposes that a registered pharmacist direct the pharmaceutical services. Should staffing a pharmacist be an issue, CMS provides that REHs can have a drug storage area that is under the supervision of another qualified individual. In these instances, the facility must establish qualifications for the individual with oversight of the drug storage area for competency purposes and ensure that someone is fulfilling the role who meets those requirements.

CoP: Additional Outpatient Medical and Health Services

In addition to the provision of emergency services and observation care, REHs may also provide outpatient medical and health services as specified in rulemaking. CMS received stakeholder comments recommending that REHs be permitted to provide additional outpatient services that include radiology, laboratory, outpatient rehabilitation, surgical, maternal health and behavioral health services. CMS proposes to allow REHs to provide these services but expects that the REH be able to demonstrate that the service is needed based on a community assessment.

Regarding maternal health, CMS requests input on whether REHs should be permitted to provide low-risk labor and delivery and whether the agency should require that the REH provide outpatient surgical services in the event surgical labor and delivery intervention is necessary.

CMS recognizes that the provision of behavioral health services, including substance use disorder treatment, is a challenge in rural communities. CMS anticipates that some REHs may be interested in being opioid treatment providers and clarifies that providing these services is not prohibited by statute, so long as the treatment remains an outpatient service.

In addition, since REHs do not provide inpatient services, CMS proposes to require that an REH have a system in place for referrals to different levels of care, and that the REH have established relationships with hospitals that have the capacity and resources available to deliver care that is beyond the scope of care delivered at the REH.

Should REHs decide to provide additional outpatient services, CMS proposes additional requirements for an REH performing outpatient surgical services. CMS anticipates that, like ASCs, REHs would provide surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.

Finally, CMS proposes to require that the REH have effective communication systems in place between the REH and patients (or responsible individuals) and their family, ensuring that the REH is responsive to their needs and preferences.

CoP: Infection Prevention and Control and Antibiotic Stewardship Programs

CMS proposes a CoP for infection prevention and control and antibiotic stewardship programs for REHs that are similar to requirements for hospitals and CAHs. Specifically, CMS proposes that each REH has facility-wide infection prevention and control and antibiotic stewardship programs that are

coordinated with the REH quality assessment and performance improvement (QAPI) program, for the surveillance, prevention, and control of hospital acquired infections (HAIs) and other infectious diseases and for the optimization of antibiotic use through stewardship. In the Proposed Rule, CMS provides additional information regarding the medical staff, and nursing and pharmacy services, as well as documentation regarding the evidence-based used of antibiotics in all departments and services of the REH, documenting improvements in proper antibiotic use, training, and additional responsibilities of the infection preventionist(s)/ infection control professional(s).

In addition, similar to hospital CoPs, CMS proposes a standard for REHs that would provide additional flexibility by allowing a single system governing body in certain circumstances. Generally, CMS proposes that if an REH is part of a system of multiple, separately certified hospitals, CAHs, and/or REHs that use a single system governing body, then that system may elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all its member facilities, including any REHs. However, this election can be made only after the single system governing body determines that it is in accordance with all applicable state and local laws. CMS clarifies that each separately certified REH subject to the system's single governing body would need to demonstrate certain elements of the unified and integrated infection prevention and control and antibiotic stewardship programs and that it had a designated qualified individual (or individuals) with expertise in infection prevention and control in antibiotic stewardship responsible for certain tasks (e.g., communicating with the system's unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining certain policies and procedure, providing education and training).

Lastly, CMS proposes three standards for REHs that are consistent with recent changes made to the hospital and CAH infection control CoPs related to the COVID-19 public health emergency (PHE). Those three requirements are related to: electronic reporting of data related to viral and bacterial pathogens and infectious diseases of pandemic or epidemic potential when a PHE has been declared; electronic reporting of COVID-19 and seasonal influenza, including related inventory supplies and usage rates until April 30, 2024 (unless the Secretary specifies an earlier date); and ensuring staff are fully vaccinated for COVID-19 until November 4, 2024, unless the Secretary specifies an earlier date. CMS notes that the November 4, 2024, timeline relates to a 3-year statutory deadline for a Medicare interim final rule to be published as a final regulation.

CoP: Staffing and staff responsibilities

By law, the emergency department of the REH must be staffed 24 hours a day, 7 days a week. To implement this requirement, CMS proposes to further clarify the type of staff at the REH who should fill this role. To provide flexibility, CMS indicates that staff may include a nurse, nursing assistant, clinical technician, or an emergency medical technician, (EMT). However, CMS expects that the individual staffing the emergency department is competent to receive patients and activate the appropriate medical resources for the treatment of the patient (e.g., notifying a practitioner of the patient's arrival in the emergency department).

CMS proposes that REHs meet the applicable CAH requirements for staffing and staff responsibilities with exceptions. Unlike CAHs, REHs do not need to periodically review and sign the records of all inpatients cared for by certain practitioners because the REH will only be providing outpatient services. In addition, a doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant do not need to be available to provide care at all times the REH operates. Rather, CMS proposes that only the CAH emergency standards apply, which require that those practitioners, with training or experience in emergency care, be on call and immediately available by telephone or radio contact, and available on site within specified timeframes.

CMS also notes that commenters requested that CMS require board-certification of emergency physicians serving as medical directors of the REH. However, due to concerns that such a

requirement would be unduly burdensome, CMS did not propose this requirement but does encourage REHs to have such a physician in this capacity if possible.

CoP: Nursing Services

CMS indicates that it does not believe that all of the nursing services requirements for hospitals and CAHs would be appropriate for REHs, as REHs are outpatient-only providers. As a result, CMS proposes to require that REHs have an organized nursing service that is available to provide 24-hour nursing services. CMS notes that the number of nurses available be based on the number of patients who receive services in the REH and the level of care required by those patients. Consistent with the hospital standards, CMS proposes that the REH have a director of nursing who is a licensed registered nurse and who is responsible for the operation of the nursing services.

CoP: Discharge Planning

CMS indicates that many commenters noted the importance of having in-depth discharge planning requirements for REHs, in part, due to the availability of fewer health care resources in rural environments. As a result, CMS proposes to require that the patient's discharge plan address the patient's goals of care and treatment preferences. CMS further clarifies that discharge planning for patients is not solely a documentation process, but, among other points, reminds providers of their obligation to provide meaningful access to individuals with limited English proficiency and to take appropriate steps to ensure effective communication with individuals with disabilities.

Also, CMS proposes to require that the discharge plan include an evaluation of the patient's likely needs for post-acute care (e.g., hospice, post-REH extended care, home health care, non-health care services and community-based care services) and a determination of the patient's access to those services and service availability. CMS also proposes standards related to the discharge planning process, staffing and the evaluation, development and communication of discharge plans.

When a discharge occurs, CMS proposes to require that the REH transfer or refer the patient, where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge care, and treatment preferences to the appropriate post-acute care service providers and other outpatient service providers responsible for the patient's follow-up or ancillary care.

In addition, CMS notes that there may be instances in which a patient comes to the REH from a nursing home and there is a delay in the patient's return to the nursing home (e.g., nursing home's intent not to accept the patient). In this circumstance, CMS encourages the REH to contact their State's long-term care ombudsman or State Survey Agency.

CoP: Patient's Rights

CMS proposes to establish a new CoP for patient's rights that would set forth the rights of all patients to receive care in a safe setting and provide protection for a patient's emotional health and safety, as well as their physical safety. CMS notes the proposed CoP for REHs aligns closely to the patient's rights CoP for hospitals, but that some of the provisions are less prescriptive to allow for flexibility based on the patient population that REHs serve. CMS proposes various components of the patient's rights CoP for REHs which address the following topics: Notice of Rights; Exercise of Rights; Privacy, Safety and Confidentiality of Patient Records; Use of Restraints and Seclusion; Staff Training Requirements for the Use of Restraints and Seclusion; Death Reporting Requirements; and Patient Visitation Rights.

CMS seeks comments on the appropriateness of the patient's right requirements for restraint and seclusions, the potential need for standards that are more stringent to address patient protections and the feasibility of implementing such requirements in rural communities.

CoP: Quality Assessment and Performance Improvement (QAPI) Program

In the Proposed Rule, CMS proposes to require that every REH develop, implement and maintain an effective, ongoing, REH-wide data-driven QAPI program. CMS considered requests that the agency weigh the clinical and administrative limitations that rural providers experience. CMS indicates that where appropriate, it proposed requirements that minimize burden while maintaining the ability of the REH to engage in quality improvement activities and programs. As such, CMS proposes a QAPI program framework that contains the following five parts: (1) Program and Scope; (2) Program data collection and analysis; (3) Program activities; (4) Executive responsibilities and (5) United and integrated QAPI program for an REH in a multi-hospital system.

CMS requests feedback regarding possible unintended consequences should REHs participate in a unified and integrated QAPI program. In addition, CMS seeks information regarding how the integrated health system's governing body can ensure that they consider the REH's unique circumstances and any significant differences in patient populations and services offered at the REH. **CMS also seeks comments regarding how the integrated health system's governing body would ensure that an REH participating in a unified and integrated QAPI program provided the appropriate level of care to patients being treated in the REH, including being appropriately transferred to another facility when necessary.**

CoP: Agreements

By law, REHs must have in effect a transfer agreement with a level I or level II trauma center. To implement this requirement, CMS proposes to that REHs must have an agreement with at least one Medicare certified hospital that is a level I or level II trauma center for the referral and transfer of patients requiring emergency medical care beyond the capabilities of the REH. CMS notes that commenters previously indicated that due to access issues, many rural CAHs currently transfer patients to level III or level IV trauma centers based on the patient's specific needs. CMS clarifies that an REH can also have a transfer agreement with a hospital that is not a level I or level II trauma center. CMS also reiterated that requirement under the Emergency Medical Treatment and Labor Act (EMTALA) apply to REHs.

CoP: Medical records

CMS indicates that the maintenance of a medical records system is a longstanding requirement in both the hospital and CAH CoPs. As such, the agency proposes that REHs must also maintain a medical records system where the records must be legible, complete, accurately documented, readily accessible, systematically organized and that a designated member of the professional staff is responsible for maintaining the records. Regarding record retention, CMS proposes to require the REH to maintain the confidentiality of record information and to ensure records are retained for at least 5 years from date of last entry, and potentially longer (e.g., state statute).

CMS also proposes a standard for electronic notifications if the REH utilizes an electronic medical records system or other electronic administrative system. Specifically, CMS proposes to require the REH to demonstrate that the system's notification capacity is fully operational, sends notifications with at least specified patient information, as appropriate, and facilitates the exchange of health information when the patient is registered, discharged, or transferred from the REH's emergency department. CMS also proposes to require that the REH make a reasonable effort to ensure that the system sends notifications to certain recipients (e.g., post-acute and primary care providers).

CoP: Emergency Preparedness

As a result of various types of emergencies, CMS proposes emergency preparedness requirements that mirror the existing CAH emergency preparedness requirements. In addition, CMS proposes to require that the REH establish and maintain an emergency preparedness program that addresses the following four elements: (1) risk assessment and planning; (2) policies and procedures; (3)

communication; and (4) training and testing. In the Proposed Rule, CMS proposes additional requirements related to each element.

CMS also proposes that if an REH is part of a healthcare system that elects to have a unified and integrated emergency preparedness program, the REH may participate in the healthcare system's coordinated emergency preparedness program. If elected, CMS proposes additional requirements.

CoP: Physical Environment

Regarding physical environment requirements for REHs, CMS proposes requirements similar to Hospitals, CAHs and Ambulatory Surgical Centers. In the Proposed Rule, CMS references the 2012 Edition of the Life Safety Code (LSC)[3] and the 2012 Edition of National Fire Protection Association (NFPA) 99, "the Health Care Facilities Code" which provides fire safety requirements for new and existing buildings. In the REH physical environment CoP, CMS indicates that chapters 7, 8, 12 and 14 of NFPA 99 would not apply to REHs, and CMS proposes to allow for certain aspects of the LSC and NFPA 99 to be waived under limited circumstances (e.g., for certain time periods where adherence would result in unreasonable hardship and the waiver would not adversely affect the health and safety of patients). CMS also proposes that the LSC would not apply in a state if CMS finds that a fire and safety code imposed by state law adequately protects patients.

CoP: Skilled Nursing Facility Distinct Part Unit

By law, REHs are permitted to establish a unit that is a distinct part licensed as a skilled nursing facility (SNF) to furnish post-REH or post-hospital (in the event the services were provided at a hospital or a CAH) extended care services (or SNF services). In the Proposed Rule, CMS further describes a "distinct part SNF", and indicated it is not subject to the REH's LOS limits of less than an annual per patient average of 24 hours. CMS proposes that REHs seeking to establish a distinct part SNF would need to meet the requirements for long-term care facilities.[4]

Quality Reporting Requirements

Per statute, CMS must establish quality measurement reporting requirements for REHs (e.g., claims-based measures, patient experience surveys) and REHs are to begin submitting measure data beginning in 2023 (at the earliest). In the Proposed Rule, CMS clarifies that quality measure specifications and quality reporting requirements for REHs will be developed in future rulemaking.

Additionally, CMS notes that Quality Improvement Organization requirements and survey requirements that apply to hospitals and CAHs will also apply to REHs.

Conversion Estimates

In the Proposed Rule, CMS provides information collection request estimates for REHs to better estimate burden. In developing such estimates, CMS indicates it relies heavily on one study[5] which estimates that of the 1,673 hospitals (mostly CAHs) eligible to convert to an REH, only 68 would convert to REH status. **CMS notes that the study essentially predicted that only those hospitals and CAHs facing the most severe financial difficulties would be the most likely to convert. CMS requests comments regarding this conversion assumption.**

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[3] The NFPA 101® 2024 edition of the LSC (including the technical interim amendments (TIAs)) provides minimum requirements, with due regard to function, for the design, operation and maintenance of buildings and structures for safety to life from fire. Its provisions also aid life safety in similar emergencies.

[4] 42 CFR part 783, subpart B

[5] The North Carolina Rural Health Research Program's (NC RHRP's) study titled, "How Many Hospitals Might Convert to a Rural Emergency Hospital (REH)?", available at: https://www.ruralhealthresearch.org/alerts/422

Proposed Changes for Critical Access Hospital Conditions of Participation

Condition of Participation: Status and Location (Adding definition of "Primary Roads")

In the Proposed Rule, CMS notes that generally, a CAH must meet certain criteria for designation, including certain distance requirements relative to other hospitals or CAHs. Specifically, a CAH must "be located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital'' or be ''certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area''. A 2013 HHS Office of the Inspector General report[6] found that approximately 63 percent of CAHs would not meet the distance requirement if required to re-enroll in Medicare, but a majority of these CAHs meet the alternative, ''necessary provider'' eligibility option. The report also recommended that CMS periodically reassess CAH's compliance with the location-related CoPs.

CMS provides an overview if anticipated review procedures and outlines how it will apply the CAH distance requirements, including by proposing to incorporate a definition of primary road in the CAH distance requirement. CMS proposes that a primary road of travel for determining the driving distance of a CAH and its proximity to other providers is a numbered Federal highway, including interstates, intrastates, expressways or any other numbered Federal highway; or a numbered state highway with two or more lanes each way. **CMS seeks feedback on whether the definition of primary roads should 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**.

CoP: Patient's Rights

CMS proposes establishing a new CoP for CAHs regarding patient's rights. CMS proposes requirements that mirror those requirements for hospital patient's rights requirements. Similar to the proposed requirements for REHs, CMS provides certain requirements that are less prescriptive than those for hospitals. The proposed requirements address: Notice of Rights; Privacy, Safety, and Confidentiality of Patient Records; Use of Restraints and Seclusion; Staff Training Requirements for the Use of Restraints or Seclusion; Death Reporting Requirements, and Patient Visitation Rights.

Additional CoPs

CMS also proposes CoPs for staffing and staff responsibilities, infection prevention and control and antibiotic stewardship programs and quality assessment and performance improvement programs. Generally, CMS aims to align these CoPs standards with those proposed for REHs.

What's Next?

CMS is anticipated to release additional information on REHs including quality, enrollment and payment in the upcoming Calendar Year (CY) 2023 outpatient prospective payment system (OPPS) proposed rule. CMS is accepting comments on this Proposed Rule until August 29, 2022.

Vizient's Office of Public Policy and Government Relations looks forward to hearing member feedback on the Proposed Rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Jenna Stern, AVP of Regulatory Affairs and Public Policy in Vizient's Washington, D.C. office.

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[6] Most Critical Access Hospitals Would Not Meet the Location Requirements If Required to Re-Enroll in Medicare (OEI–05–12–00080)