HealthTech

REH 101: A compliance guide for Rural Emergency Hospitals.

Cheri Benander RN, MSN, CHC, C-NHCE, HACP-CMS
Director of Clinical Services

January 23, 2026

Presenter

Cheri has over 35 years of experience in various healthcare roles, including clinical, management, administration, compliance, consulting, and education. Her leadership experience has extended to multiple healthcare settings, including acute care, home health, hospice, assisted living, and long-term care.

As a consultant, Ms. Benander has worked collaboratively with leaders and clinical staff to improve productivity, time management, and leadership skills, formulate survey responses, and implement various programs, including compliance.

She received her basic nursing education from Fort Scott Community College and her bachelor's and master's degrees in nursing from the University of Phoenix. She received a graduate Nursing and Healthcare Education certification from the University of Phoenix. Ms. Benander is a Certified Healthcare Compliance (CHC) professional through the Health Care Compliance Association (HCCA) and a Healthcare Accreditation Certified Professional -CMS through the Center for Improvement in Healthcare Quality (CIHQ).

Cheri Benander, RN, MSN, CHC, NHCE-C, HACP-CMS
Director of Clinical Services
Cheri.Benander@health-tech.us
307-202-0315

Feb – Jun 2026 webinars

All webinars are recorded for on-demand viewing.

Unlock the full potential of Care Coordination: What's new in 2026 for program growth and reimbursements?

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: February 13, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4r6IvOt

Compassion fatigue – Building resilience

Presenter: Brian Merry, M.Ed., CEMSO, NRP - Director of EMS
Date: March 6, 2026 | **Time:** 12pm CST
URL: https://bit.ly/49KJOvp

Swing Beds: An important resource for CAH - Part 1

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 3, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4qwYF3R

Swing Beds: An important resource for CAH - Part 2

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 17, 2026 | **Time:** 12pm CST
URL: https://bit.ly/45Pyq08

Continuous survey readiness for CAH - Part 1: Regulatory Requirements

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: May 15, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3Nx2nMa

Continuous survey readiness for CAH - Part 2: Environment of care, life safety and emergency preparedness

Presenter: Michael Jones CHSP, CHCM, CSSGB, FAL, HACP-IC, HACP-CMS, HACP-PE
Date: June 5, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3YPJRkB

Continuous survey readiness for CAH - Part 3: Credentialing and privileging

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: June 26, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3NtJUA9

Disclaimer

HealthTech hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive.

HealthTech and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof.

HealthTech does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel.

HealthTech recommends that hospitals, clinics, their respective personnel, and all other third-party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters

Instructions for Today

- You may type a question in the text box if you have a question during the presentation
- We will try to cover all your questions – if we don't get to them during the webinar, we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded, and the recording will be available on the HealthTech web site: www.health-tech.us

HealthTech

Background

Rural Emergency Hospital

Definition

- Consolidated Appropriations Act of 2021
- New Provider Designation effective Jan 1, 2023
- CAHs and Small Rural Hospitals
- Reinforce Access to Outpatient Medical Services
- Reduce Health Disparities

Definition of Rural Emergency Hospital

MAY

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.**

MAY NOT

The entity must not provide inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services.

(HHS, 2023)

Length of Stay

The annual per-patient average length of stay cannot exceed 24 hours

Time calculation begins with the registration, check-in, or triage of the patient (whichever occurs first) and ends with the discharge of the patient from the REH (which occurs when the physician or other appropriate clinician has signed the discharge order or at the time the outpatient service is completed and documented in the medical record).

(HHS, 2023)

States with Specific REH Licensure Laws

As of 6/17/2024

Arkansas HB 1127 (Enacted 2023)—Creates the Rural Emergency Hospital Act and state licensure for rural emergency hospitals.

Florida SB 644 (Enacted 2024) —Authorizes qualifying hospitals to apply to the Agency for Health Care Administration for designation as a rural emergency hospital.

Illinois HB 240 (Enacted 2023)—Adds rural emergency hospitals to the state's Hospital Licensing Act.

Indiana HB 1457 (Enacted 2023)—Establishes licensing standards for rural emergency hospitals.

Iowa SF 75 (Enacted 2023)—Establishes licensure for rural emergency hospitals and sets forth requirements for hospital conversions to rural emergency hospitals.

Kansas HB 2208 (Enacted 2021)—Enacts the Rural Emergency Hospital Act and creates a category of licensure to enable certain state hospitals to receive federal health care reimbursement as rural emergency hospitals.

Kansas SB 42 (Enacted 2023) —Exempts rural emergency hospitals from the hospital provider assessment.

Kansas SB 287 (Enacted 2024) —Expands licensure of rural emergency hospitals to include hospitals that met the criteria between January 2015 and December 2020.

Michigan SB 183 (Enacted 2022)—Establishes licensure for rural emergency hospitals.

Missouri HB 402 (Enacted 2023) —Modifies the definition of hospital to include any facility designated as a rural emergency hospital by CMS for the purpose of the hospital licensing law.

Montana HB 312 (Enacted 2023)—Provides for rural emergency hospital designation and establishes requirements for designation.

(NCSL, 2024)

States with Specific REH Licensure Laws

Nebraska LB 697 (Enacted 2022)—Provides for the licensure of rural emergency hospitals and requires coverage for REH services.

Nevada AB 277 (Enacted 2023)—Establishes rural emergency hospitals as a unique type of medical facility licensed within the state. Requires the State Board of Health to adopt regulations for licensure of rural emergency hospitals.

New Mexico SB 245 (Enacted 2023)—Allows rural health facilities to apply for rural emergency hospital licensure and establishes rural emergency hospital licensure requirements.

New York SB 4007 (Enacted 2023)—Adds rural emergency hospital to "hospital" definition in N.Y. Pub. Health Law § 2801, allowing for the establishment or incorporation of rural emergency hospitals.

North Carolina HB 259 (Enacted 2023) —Adds provisions to implement the federal rural emergency hospital designation. Exempts the conversion of a critical access hospital or acute care hospital to a rural emergency hospital from certificate of need review.

Oklahoma SB 293 (Enacted 2023) – Defines rural emergency hospital and includes rural emergency hospital within the definition of hospital.

South Dakota HB 1123 (Enacted 2022)—Establishes licensure for rural emergency hospitals.

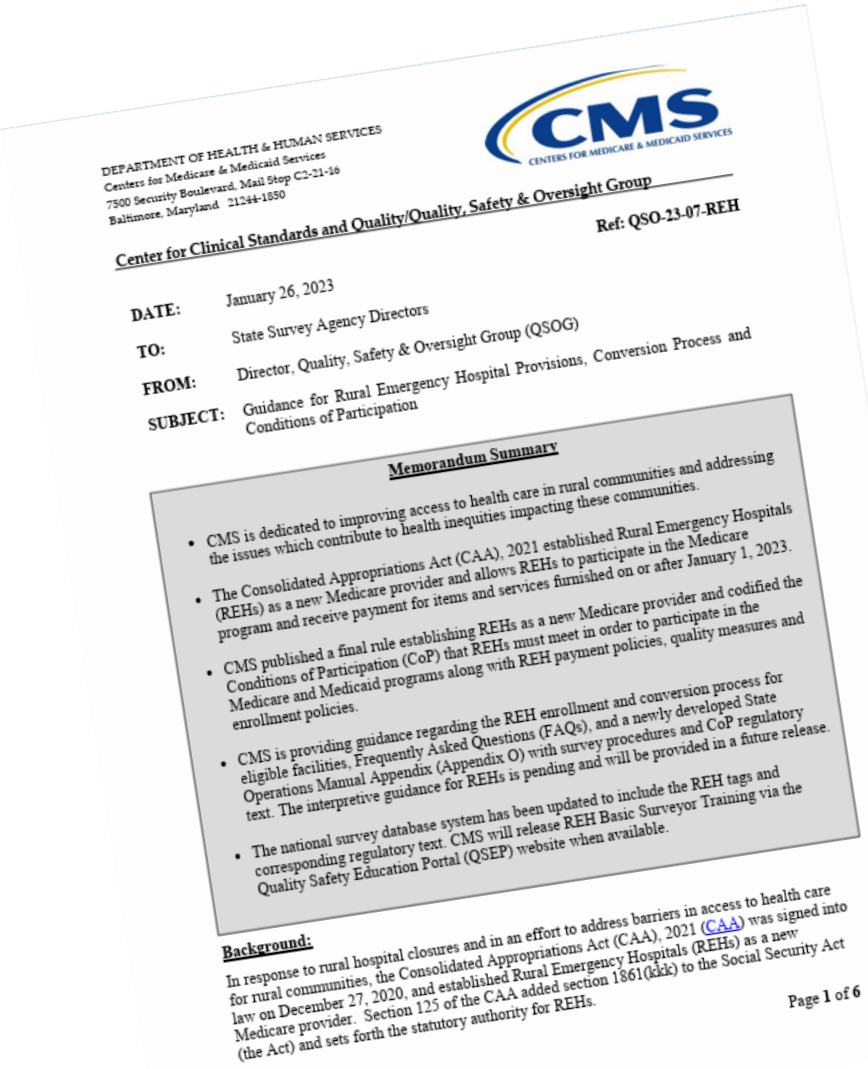
Texas SB 1621 (Enacted 2019)—Creates a license for certain rural medical facilities, including limited services rural hospitals.

West Virginia HB 2993 (Enacted 2023)—Establishes the Rural Emergency Hospital Act and provides for rural emergency hospital licensure.

(NCSL, 2024)

Standards and Guidelines

CMS Appendix O



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group **Ref: QSO-23-07-REH**

DATE: January 26, 2023
TO: State Survey Agency Directors
FROM: Director, Quality, Safety & Oversight Group (QSOG)
SUBJECT: Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation

Memorandum Summary

- CMS is dedicated to improving access to health care in rural communities and addressing the issues which contribute to health inequities impacting these communities.
- The Consolidated Appropriations Act (CAA), 2021 established Rural Emergency Hospitals (REHs) as a new Medicare provider and allows REHs to participate in the Medicare program and receive payment for items and services furnished on or after January 1, 2023.
- CMS published a final rule establishing REHs as a new Medicare provider and codified the Conditions of Participation (CoP) that REHs must meet in order to participate in the Medicare and Medicaid programs along with REH payment policies, quality measures and enrollment policies.
- CMS is providing guidance regarding the REH enrollment and conversion process for eligible facilities, Frequently Asked Questions (FAQs), and a newly developed State Operations Manual Appendix (Appendix O) with survey procedures and CoP regulatory text. The interpretive guidance for REHs is pending and will be provided in a future release.
- The national survey database system has been updated to include the REH tags and corresponding regulatory text. CMS will release REH Basic Surveyor Training via the Quality Safety Education Portal (QSEP) website when available.

Background:

In response to rural hospital closures and in an effort to address barriers in access to health care for rural communities, the Consolidated Appropriations Act (CAA), 2021 (CAA) was signed into law on December 27, 2020, and established Rural Emergency Hospitals (REHs) as a new Medicare provider. Section 125 of the CAA added section 1861(kkk) to the Social Security Act (the Act) and sets forth the statutory authority for REHs.

Page 1 of 6

State Operations Manual

Appendix O – Survey Protocol, Regulations and Interpretive Guidelines for Rural Emergency Hospitals

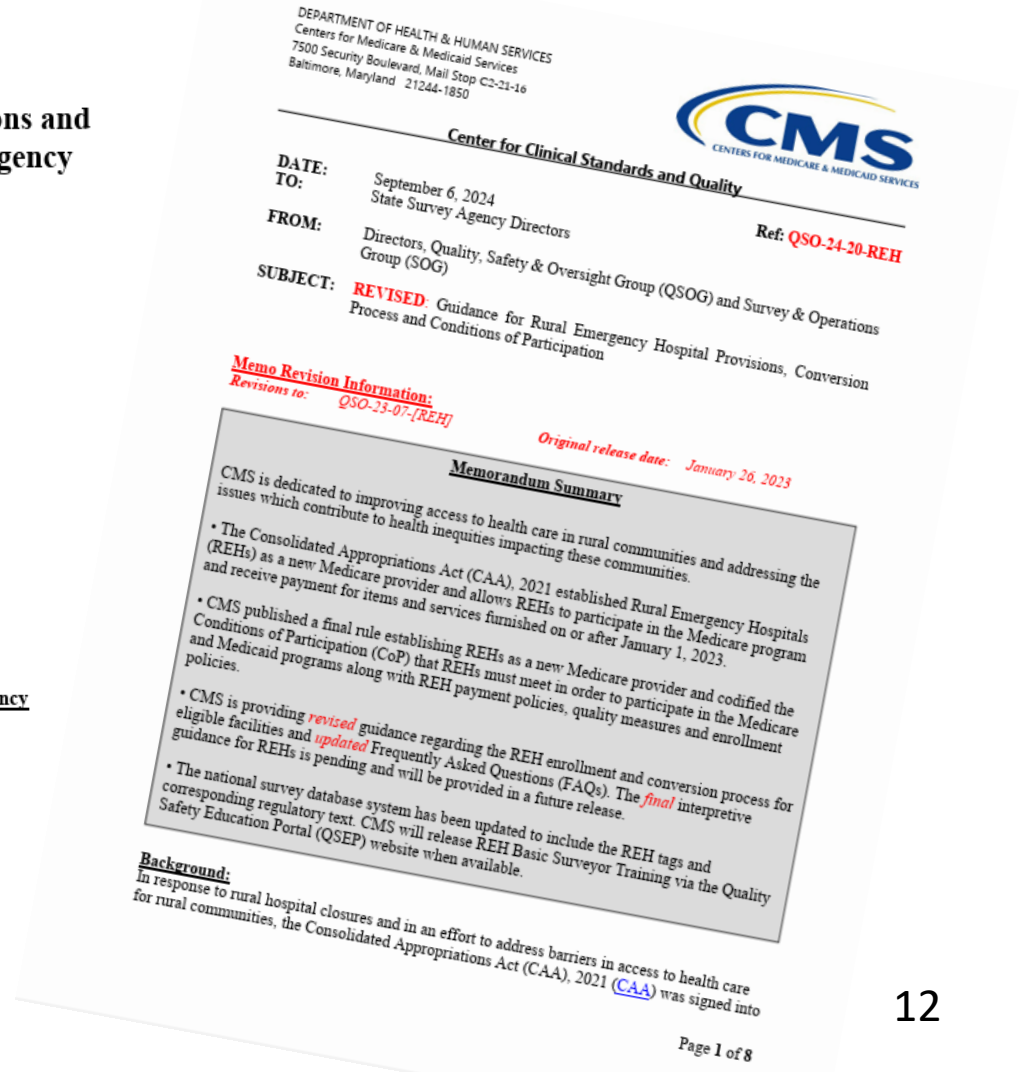
(Rev.)

Part I Survey Protocol

Introduction
Regulatory & Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 – Off-Site Survey Preparation
Task 2 – Entrance Activities
Task 3 – Information Gathering/Investigation
Task 4 – Preliminary Decision Making and Analysis of Findings
Task 5 – Exit Conference
Task 6 – Post-Survey Activities

Part II Regulations and Interpretive Guidelines for Rural Emergency Hospitals

§485.500 Basis & Scope
§485.502 Definitions
§485.504 Basic Requirements
§485.506 Designation and Certification of REHs
§485.508 Compliance with Federal, State and Local Laws and Regulations
§485.510 Governing Body and Organizational Structure of the REH
§485.514 Provision of Services



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality

DATE: September 6, 2024
TO: State Survey Agency Directors **Ref: QSO-24-20-REH**
FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)
SUBJECT: **REVISED**: Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation

Memo Revision Information:
Revisions to: QSO-23-07-[REH]
Original release date: January 26, 2023

Memorandum Summary

- CMS is dedicated to improving access to health care in rural communities and addressing the issues which contribute to health inequities impacting these communities.
- The Consolidated Appropriations Act (CAA), 2021 established Rural Emergency Hospitals (REHs) as a new Medicare provider and allows REHs to participate in the Medicare program and receive payment for items and services furnished on or after January 1, 2023.
- CMS published a final rule establishing REHs as a new Medicare provider and codified the Conditions of Participation (CoP) that REHs must meet in order to participate in the Medicare and Medicaid programs along with REH payment policies, quality measures and enrollment policies.
- CMS is providing *revised* guidance regarding the REH enrollment and conversion process for eligible facilities and *updated* Frequently Asked Questions (FAQs). The *final* interpretive guidance for REHs is pending and will be provided in a future release.
- The national survey database system has been updated to include the REH tags and corresponding regulatory text. CMS will release REH Basic Surveyor Training via the Quality Safety Education Portal (QSEP) website when available.

Background:

In response to rural hospital closures and in an effort to address barriers in access to health care for rural communities, the Consolidated Appropriations Act (CAA), 2021 (CAA) was signed into

Page 1 of 8

HealthTech

Enrollment & Conversion Process

Eligibility

Enrolled and Certified to Participate in Medicare as of December 27, 2020.

- **CAH**s; or,
- A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Act) **with not more than 50 beds located in a county** (or equivalent unit of local government) **in a rural area** (as defined in section 1886(d)(2)(D) of the Act) (referred to as rural hospital); or
- A subsection (d) **hospital** (as so defined) **with not more than 50 beds that was treated as being located in a rural area** pursuant to section 1886(d)(8)(E) of the Act (referred to as rural hospital).
- **Facilities that were enrolled as CAHs or rural hospitals with not more than 50 beds as of December 27, 2020 and then subsequently closed after that date**, would also be eligible to seek REH designation if they re-enroll in Medicare and meet all the CoPs and requirements for REHs.

(HHS, 2024)

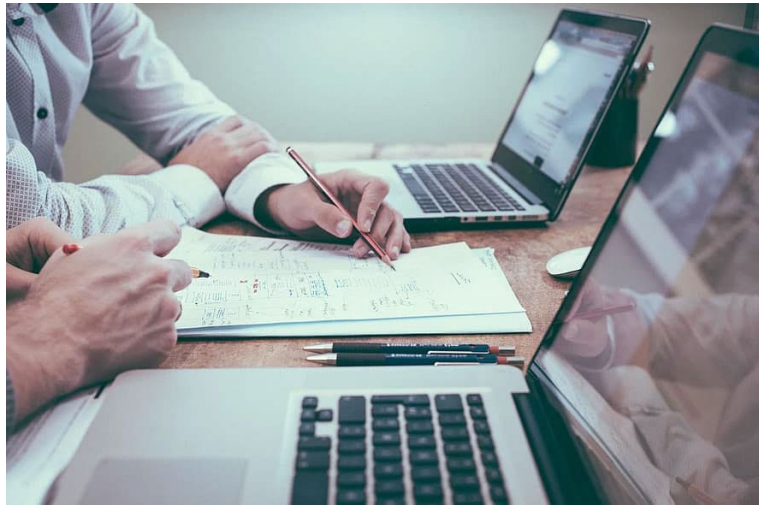
Eligible Services

- Emergency Department Services
- Observation Care
- Other Outpatient Medical and Health Services
  - Imaging
  - Laboratory
  - Outpatient Rehabilitation
  - Surgical
  - Maternal Health
  - Behavioral Health
  - Additional Services that align with the health care needs of the community served.
  - Distinct Part Unit Skilled Nursing Facility

(HHS, 2023)

Enrollment

- Change of Information Application
- Action Plan
- Transfer Agreement
- Attestation



(HHS, 2024)

Application

- Must be enrolled in Medicare
- Complete a change of information application (CMS-855A) as opposed to an initial enrollment application.
- Submit to the Medicare Administrator Contractor (MAC) for review and approval.
- MAC forwards to the designated State Agency and the CMS location for additional review

❖ Eligible facilities closed after December 27, 2020 would need to re-enroll in Medicare.

(HHS, 2024)

Action Plan

- Summary of Conversion Plan
  - Detailed Initiate REH Service Plan- ED, Observation, and other services
  - Plan to discontinue inpatient services and transfer care
- Staffing Details
- List of Retained Services
- List of Modified Services
- List of Added Services
- List of Discontinued Services
- Description of services the Facility plans to provide.
- Information regarding how the facility intends ot use the additional facility payment.
- Model Action Plan Template for Rural Emergency Hospitals

(HHS, 2024)

Transfer Agreement

- Transfer Agreement with at least one Medicare-certified hospital that is a level I or level II trauma center.
- Copy of the agreement submitted with the action plan.

(HHS, 2024)

Attestation

- Self- Attest to meeting REH CoPs
  - Automatic on-site initial survey not required
  - Rural reclassification if applicable
  - Survey History Review
- Facilities that were eligible but subsequently closed
  - Re-enrollment and require an initial on-site survey
  - Attestation for eligibility requirements, rural status, and rural reclassification criteria if applicable.
- Model Attestation of Compliance for Rural Emergency Hospital Enrollment and Conversion

(HHS, 2024)

Survey Process

- No initial Survey for CAH or Rural Hospitals Converting
- Initial survey for facilities that closed and wish to reopen as an REH
- No CMS-approved accreditation organizations
- SA conducts the survey and will do so for at least the first three years.

(HHS, 2024)

Approval/Denial

- State Agency
  - Reviews for completeness and confirms compliance with licensure requirements.
  - Reviews the most recent survey history
  - Forwards to CMS with a recommendation for certification or denial
- CMS
  - Confirms eligibility requirements
  - Bed count based on the most recent cost report and rural status.
  - Reviews the most recent survey history.

(HHS, 2024)

Once Approved

- Once approved, CMS…
  - Completes certification kit in the current survey database, which includes,
    - Uploading the action plan, attestation of compliance, copy of transfer agreement, and documentation of rural reclassification (if applicable).
  - Assigns a new CMS Certification Number (CCN) and forwards the effective date of REH certification to the MAC
- MAC will send the final approval or denial letter to the provider, SA, and CMS

Cessation of Services

Upon approval of the REH application for conversion, facilities are required to cease all inpatient services as of the effective date assigned by the CMS location.

(HHS, 2024)

Caution

Once a facility converts to an REH, it is allowed to convert back to a CAH or Rural Hospital.

HOWEVER- they lose any grandfathered privileges.

Must submit a **NEW** full initial enrollment application

Demonstrate they meet all **CURRENT** requirements, including:

Location, staffing, and service delivery rules.

Converting back can be difficult for CAH's who received their original CAH designation under older, less stringent "necessary provider" rules.

(HHS, 2024)

HealthTech

Conditions of Participation

Appendix O

Part II Regulations and Interpretive Guidelines for Rural Emergency Hospitals

§485.500 Basis & Scope

§485.502 Definitions

§485.504 Basic Requirements

§485.506 Designation & Certification of REHs

§485.508 Compliance with Federal, State and Local Laws and Regulations

§485.510 Governing Body and Organizational Structure of the REH

§485.514 Provision of Services

§485.516 Emergency Services

§485.518 Laboratory Services

§485.520 Radiologic Services

§485.522 Pharmaceutical Services

§485.524 Additional Outpatient Medical and Health Services

§485.526 Infection Prevention and Control and Antibiotic Stewardship Programs

§485.528 Staffing and Staff Responsibilities

§485.530 Nursing Services

§485.532 Discharge Planning

§485.534 Patient Rights

§485.536 Quality Assessment and Performance Improvement Program

§485.538 Agreements

§485.540 Medical Records

§485.542 Emergency Preparedness

§485.544 Physical Environment

§485.546 Skilled Nursing Facility Distinct Part Unit

(HHS, 2023)

§485.516 Emergency Services

§ 485.516(c) Compliance with CAH Requirements

(c) The REH must meet the requirements specified in § 485.618, with respect to:

(1) 24-hour availability of emergency services
(2) Equipment, supplies, and medication
(3) Blood and blood products
(4) Personnel
(5) Coordination with emergency response systems

(HHS, 2023)

Provider Availability

REHs must have a clinician, a doctor of medicine (MD), a doctor of osteopathy (DO), a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care on-call at all times and immediately available by phone or radio contact and available on-site within 30 or 60 minutes depending on if the facility is located in a frontier area.

(HHS, 2023)

§485.524 Additional Outpatient Medical and Health Services

If the facility provides outpatient medical and health services in addition to emergency and observation care, the medical and health services must be appropriately organized and meet the needs of the patient in accordance with acceptable standards of practice.

(HHS, 2023)

Additional Outpatient Medical and Health Services

Patient Services (O-400, O-402, O-404, O-406, O-408, O-410, and O-412)

- May provide outpatient and medical health diagnostic and therapeutic items and services commonly furnished in a physician's office or at another entry point into the health care delivery system.
- The services must align with the health needs of the community and be based on nationally recognized guidelines and standards of practice
- Services may include, but are not limited to:
  - Radiology, Laboratory, Outpatient Rehabilitation, Surgical. Maternal Health and Behavioral Health
- Have a system in place for referral to different levels of care, including follow-up care, as appropriate
- Have an effective communication system in place between the REH and the patient and their family to ensure the REH is responsible to their needs and preferences
- Have established relationships with hospitals that have the resources and capacity available to deliver care that is beyond the scope of care delivered at the REH

(HHS, 2023)

Additional Outpatient Medical and Health Services

Personnel (O-414, O-416, and O-418)

- Assign one or more individuals to be responsible for outpatient services
- Have appropriate professional and nonprofessional personnel available where outpatient services are offered based on the scope and complexity of the outpatient services.
- For any specialty offered, have a practitioner providing services with experience and training in the specialty services area and in accordance with their scope of practice.

(HHS, 2023)

Additional Outpatient Medical and Health Services

Orders (O-420)

- Outpatient medical and health services must be ordered by a practitioner who meets the following conditions:
  - Is responsible for the care of the patient.
  - Is licensed in the state where they provide care to the patient.
  - Is acting within their scope of practice under state law.
  - Is authorized in accordance with state law and policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services. This applies to the following:
    - All practitioners who are appointed to the REH's medical staff and who have been granted privileges to order the applicable outpatient services.
    - All practitioners not appointed to the medical staff, but who satisfy the requirements for authorization by the medical staff and the REH for ordering the applicable outpatient services for their patients.

(HHS, 2023)

Additional Outpatient Medical and Health Services

Surgical Services (O-422, O-424, O-426, O-428, O-430 and O-432)

- Surgical procedures must be performed safely by qualified practitioners who have been granted clinical privileges.
- The REH designates the practitioners who are allowed to perform surgery
  - Doctor of medicine or osteopathy, dental surgery, dental medicine or podiatric medicine.
- Anesthetic risk and evaluation by a qualified practitioner immediately before surgery to evaluate the risk of the procedure and the risk of anesthesia, and before discharge for proper anesthesia recovery.
- The REH designates the person who is allowed to administer anesthesia to REH patients.
- In those cases, in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioners.
- In those cases, in which an anesthesiologist's assistant administers anesthesia, they must be under the supervision of the anesthesiologist.
- All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.

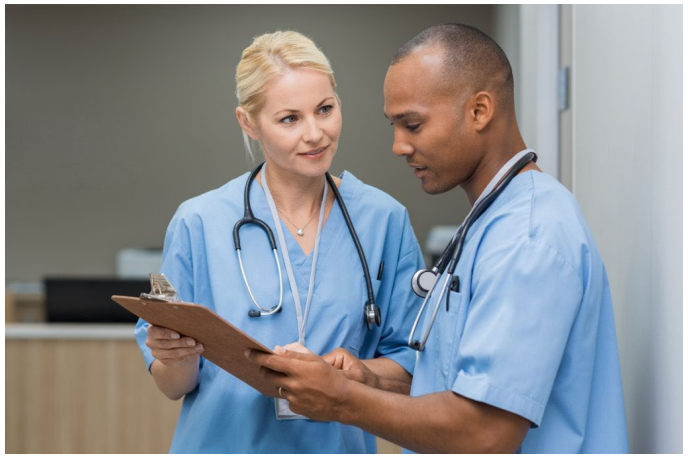
(HHS, 2023)

§485.528 Staffing and Staff Responsibilities

§485.528 (a) Standard: Emergency Department Staffing

(a) The emergency department of the REH must be staffed 24 hours a day, 7 days a week by an individual or individuals competent in the skills needed to address emergency medical care.

This individual(s) must be able to receive patients and activate the appropriate medical resources to meet the care needed by the patient.



(HHS, 2023)

§485.534 Patient Rights

Restraints or Seclusion

- §485.534 (e) Standard: Restraints or Seclusion
  - O-702- Right to be free from physical or mental abuse, corporal punishment, restraint, or seclusion
  - O-704- Definition of a restraint and seclusion
  - O-706- Restraint or Seclusion can only be used when less restrictive interventions are ineffective
  - O-708- Type/technique of restraint or seclusion must be the least restrictive
  - O-710 – Written policies and procedures related to the use of restraint and seclusion

(HHS, 2023)

§485.534 Patient Rights

Restraints or Seclusion

- §485.534 (f) Standard: Restraints or Seclusion: Staff Training Requirements
  - O-712- Safe implementation by trained staff
  - O-714- Patient-centered competency-based training and education
  - O-716- Training must include alternatives to the use of restraint and/or seclusion

(HHS, 2023)

§485.534 Patient Rights

Restraints or Seclusion

- §485.534 (g) Standard: Death Reporting Requirements
  - O-718- Must report deaths associated with the use of restraints or seclusion
  - O-720- Must report the following information to CMS **no later** than the close of business on the next business day following knowledge of the patient's death:
    - Each death that occurs while a patient is in restraint or seclusion
    - Each death that occurs within 24 hrs after the patient has been removed from restraint or seclusion
    - Each death known to the REH that occurs within 1 week after the restraint or seclusion, where it is reasonable to assume that the use of the restraint or placement in seclusion contributed directly or indirectly to the patient's death.
  - O-722- When no seclusion has been used and when the only restraints used are applied exclusively to the patient's wrist and are composed solely of soft, non-rigid, cloth-like materials, the REH staff must record in an internal log or other system the following information.
    - Any death that occurs while a patient is in such restraints
    - Any death that occurs within 24 hrs. after a patient has been removed from such restraints.

(HHS, 2023)

§485.534 Patient Rights

Restraints or Seclusion

- §485.534 (g) Standard: Death Reporting Requirements
  - O-724- Staff must document in the patient's medical record the date and time the death was:
    - Reported to CMS (if applicable)
    - Recorded in the internal log or other system for deaths (if applicable)
  - O-726- For deaths recorded in the internal log, the following must be documented
    - Each entry must be made no later than seven days after the date of the death of the patient
    - Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis.
    - The information must be made available in either written or electronic form to CMS immediately upon request.

(HHS, 2023)

§485.546 Skilled Nursing Facility Distinct Part Unit.

If the REH provides skilled nursing facility services in a distinct part unit, the services furnished by the distinct part unit must be separately licensed and certified and comply with the requirements of participation for long-term care facilities

(HHS, 2023)

Appendix O

Part II Regulations and Interpretive Guidelines for Rural Emergency Hospitals

§485.500 Basis & Scope

§485.502 Definitions

§485.504 Basic Requirements

§485.506 Designation & Certification of REHs

§485.508 Compliance with Federal, State and Local Laws and Regulations

§485.510 Governing Body and Organizational Structure of the REH

§485.514 Provision of Services

§485.516 Emergency Services

§485.518 Laboratory Services

§485.520 Radiologic Services

§485.522 Pharmaceutical Services

§485.524 Additional Outpatient Medical and Health Services

§485.526 Infection Prevention and Control and Antibiotic Stewardship Programs

§485.528 Staffing and Staff Responsibilities

§485.530 Nursing Services

§485.532 Discharge Planning

§485.534 Patient Rights

§485.536 Quality Assessment and Performance Improvement Program

§485.538 Agreements

§485.540 Medical Records

§485.542 Emergency Preparedness

§485.544 Physical Environment

§485.546 Skilled Nursing Facility Distinct Part Unit

(HHS, 2023)

CAH Survey Readiness

All webinars are recorded for on-demand viewing.

Continuous survey readiness for CAH - Part 1: Regulatory Requirements

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: May 15, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3Nx2nMa

Continuous survey readiness for CAH - Part 2: Environment of care, life safety and emergency preparedness

Presenter: Michael Jones CHSP, CHCM, CSSGB, FAL, HACP-IC, HACP-CMS, HACP-PE
Date: June 5, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3YPJRkB

Continuous survey readiness for CAH - Part 3: Credentialing and privileging

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: June 26, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3NtJUA9

Resources

- Department of Health & Human Services (HHS). (2023, January 26). Center for Clinical Standards and Quality/Quality, Safety & Oversight Group: QSO-23-07-REH: Guidance for rural emergency hospital provisions, conversion process, and conditions of participation
- Department of Health & Human Services (HHS). (2024, September 6). Center for Clinical Standards and Quality/Quality, Safety & Oversight Group: QSO-24-20-REH-REVISED: Guidance for rural emergency hospital provisions, conversion process, and conditions of participation
- National Conference of State Legislatures (NCSL). (2024). Rural Emergency Hospitals. https://www.ncsl.org/health/rural-emergency-hospitals#toc2

Questions?

Thank you.

HealthTech

Cheri Benander
Cheri.benander@health-tech.us