SPA 23-0014 REH: Responses to Comment Letter from NMHA

HSD appreciated the comments and is working with CMS on allowable reimbursement methodologies. In the interest of timing to get our SPA submitted, HSD will continue to submit with the established methodology currently outlined in the proposed SPA.

1. On page 6.1, in the paragraph beginning "New providers…" does the reference to "previous cost report submissions" mean an REH cost report or a previous Prospective Payment System (PPS) cost report? If it is the latter, there cannot be a situation where a hospital converting to REH would not have a previous PPS cost report. If it is the former, clarifying that it is an REH cost report would clear up any confusion.
   HSD Response: There are two possibilities for new REHs. The first is like the current CMS approved REH, where they have cost reports as they have transitioned from a hospital provider type (201). The other would be if the facility was built to be an REH and was never a provider type 201.

2. In the same paragraph, if the question above means REH cost report, how will the "median of current Rural Emergency Hospital Facility Specific Rates" be calculated for the first REH, when there is no existing data from which to establish a median?
   HSD Response: For the first type we would go through the same process as the current CMS approved REH. In the second circumstance we would give the provider the Median. Currently this would mean they get the current CMS approved REH's rate because that is the only REH with an approval and has gone through the cost report submissions.