August XX, 2022

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare and Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, SW,

Room 445-G

Washington, D.C. 20201

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

Dear Administrator Brooks-LaSure,

[YOUR ORGANIZATION] is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospitals (CAH). We appreciate CMS’ continued commitment to the needs of the more than 60 million Americans that reside in rural areas.

[BRIEF PARAGRAPH EXPLAINING YOUR ORGANIZATION AND IMPORTANCE OF REH CONDITIONS OF PARTICIPATION]

[YOUR ORGANIZATION] thanks CMS for the opportunity to comment on this proposed rule.

**I.B. Statutory Authority and Establishment of Rural Emergency Hospitals as a Medicare Provider Type**

[YOUR ORGANIZATION] understands that hospitals closed prior to passage of the Consolidated Appropriations Act, 2021, on December 27, 2020, are statutorily prohibited from converting to an REH. However, wesuggest that CMS clarify that hospitals that closed after December 27, 2020, are eligible for conversion to REH status. This action is not contrary to the statute and would provide needed clarification for our community.

340B is a valuable program for rural hospitals. While we anticipate that a change to the 340B statute would be required to allow REHs to participate, we stress the importance of this action and urge the Administration to work alongside Congress to ensure this change is made. [Explain how 340B has been valuable to your hospital.] Without REH participation in 340B, far fewer hospitals will consider converting as 340B payments are vital to the financial viability of rural hospitals.

**II.A.6. Governing Body and Organizational Structure of the REH**

**We applaud CMS’ efforts to allow maximum flexibility in REH structure and staffing.** In particular, we support the option for the governing body to grant medical staff privileges to nurse practitioners (NP) and physician assistants (PA), as allowable under state scope of practice laws. Authorizing NPs and PAs to practice at the top of their education and license mitigates some workforce challenges that rural communities face.

[Explain how your organization uses non-physician providers to furnish care. Emphasize that this helps address workforce shortages.]

**II.A.8: Emergency Services**

[YOUR ORGANIZATION] supports CMS’ proposal to adopt CAH emergency services CoPs for personnel. Specifically, staffing flexibilities are crucial as workforce remains a pressing and enduring challenge for rural providers. [Add examples from your community.] Allowing a physician, PA, NP, or clinical nurse specialist (CNS) to be on call within thirty minutes of the REH provides needed flexibility. It is appropriate, given the expected low volume of patients and services, that a practitioner is not required to be on-site at all times. [Elaborate on how this is necessary in your area or for your hospital.]

**II.A.12. Additional Outpatient Medical and Health Services**

[YOUR ORGANIZATION] commends CMS for recognizing that REHs should furnish outpatient services according to the needs of the community it serves. We applaud CMS for not placing limits on the types of outpatient services that REHs may choose to furnish. Allowing an REH to provide outpatient services that are typically delivered at a physician’s office, or another point of entry increases access to health care for rural communities. [Explain specifically how your organization will benefit from this and what outpatient services furnished by an REH will be most beneficial.]

[YOUR ORGANIZATION] requests clarification from CMS on provider-based rural health clinics (RHC). Consistent with legislative intent[[1]](#footnote-1), CMS must provide guidelines for REH operation of provider-based RHCs. As the CoPs stand, it is unclear whether REHs are authorized to operate provider-based RHCs. Many hospitals [or insert your hospital here] considering converting to an REH currently operate provider-based RHCs. CMS must allow REHs to maintain operation of existing provider-based RHCs at grandfathered by April 1, 2021, that meet the qualifications in section 1833(f)(3)(B) of the Social Security Act, at the special payment rules that establish a payment limit based on the specified provider-based RHC’s per visit payment amount (or AIR) instead of the national statutory payment limit[[2]](#footnote-2) and this must be explicitly stated in the CoPs.[[3]](#footnote-3) [Explain how REHs retaining provider-based RHCs are crucial to your hospital or community considering conversion. Emphasize the important role RHCs play in the rural health safety net.]

CMS should further consider allowance of a distinct part [inpatient psychiatric and/or inpatient rehabilitation facility], like the distinct part skilled nursing facility. The [inpatient psychiatric and/or rehabilitation unit] would be physically distinct and fiscally separate for cost-reporting purposes and thus would not threaten the outpatient nature of the REH or the 24-hour patient stay average. The [psychiatric and/or rehabilitation unit] could make use of vacated space from the CAH or small rural hospital’s conversion out of inpatient care into an REH. [Insert how this/these addition(s) to REH services would be valuable to your community.]

We also urge CMS to reconsider its supervision requirements for certified registered nurse anesthetists (CRNA). CRNAs often serve as the sole anesthesia provider in rural hospitals. They are more likely to work in areas with lower median incomes and higher uninsured or Medicaid beneficiary populations, both of which often overlap with rural areas. To continue CMS’ commitment to flexibility for REHs, it must remove the requirement for an operating practitioner to supervise a CRNA administering anesthesia at the proposed § 485.524(d)(3)(ii). [Elaborate on the importance of CRNAs and how this change would be beneficial in your community or hospital.]

**II.A.19. Agreements**

[YOUR ORGANIZATION] proposes that CMS acknowledge the difficulty of finding placements for mental and behavioral health patients requiring a transfer, and work within its authority to address this issue. An emergency department may be the only access point for rural patients experiencing an acute mental health crisis. We are concerned that when an REH is faced with a patient requiring mental health care outside of an REH’s scope, there likely will not be available inpatient psychiatric beds for transfer or the transfer process will exceed 24 hours.

[Add information about the lack of mental health care in your area, including psychiatric beds.]

CMS must explore pathways to solve this issue and ensure psychiatric patients are able to receive the care that they need.

**B.1.a: Adding the Definition of “Primary Roads”**

We thank CMS for clarifying the critical access hospital (CAH) distance requirements by adding the definition of “primary roads.” We support the definition of primary roads and believe it will provide essential confirmation of CMS policy in this area.

However, we advocate for clarifying the definition to exclude Federal numbered highways with one lane in each direction. One lane Federal highways are common in rural areas and, in many instances, are not comparable to two or three lane highways because of sporadic maintenance varying by state. In many instances, Federal one lane highways do not differ from state one lane highways, which are excluded from the proposed definition.

[Insert example of a one lane federal highway in your state that should not be considered a primary road and why].

We also urge CMS to clarify its proposals for CAH distance verification. In the preamble of this proposed rule, CMS notes that it will review CAH certification status by looking at the 50-mile radius around a CAH. We would like CMS to clarify whether the 50-mile radius is 50 road miles or “as the crow flies.” It is imperative that hospitals understand the methodology behind CMS’ review process. [Insert example of how road miles vs. “as the crow flies” this would affect your hospital and explain which one would be beneficial.]

Relatedly, we request that CMS make two changes to the CAH distance requirements. First, we ask that CMS specifically exclude REHs from the distance determination for CAHs. Considering that REHs only provide emergency department services, furnish no inpatient services, and can optionally furnish outpatient services, REHs serve a different purpose than CAHs or PPS hospitals. [Explain the potential ramifications of not excluding REHs to your area or hospital.]

Second, we urge CMS to codify sub-regulatory guidance from the State Operations Manual (SOM), Chapter 2, at 2256A.[[4]](#footnote-4) This guidance explains that the proximity of IHS and Tribal hospitals or CAHs and non-IHS or Tribal hospitals or CAHs to each other is not considered when accounting for CAH distance requirements.[[5]](#footnote-5) CMS already follows this at a sub-regulatory level, so codifying this guidance into regulation would not change the verification process except to give hospitals clear expectations.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. If you would like additional information, please contact [YOUR NAME OR REPRESENTATIVE] at [EMAIL] or [PHONE NUMBER].

Sincerely,

[E-SIGNATURE]

Your Name

Your Title (if applicable)

Your organization

1. 42 U.S.C. § 1395x(kkk)(6)(B) (“A rural emergency hospital may be considered a hospital with less than 50 beds for purposes of the exception to the payment limit for rural health clinics under section 1833(f)”). [↑](#footnote-ref-1)
2. Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for

Calendar Year (CY) 2022, Centers for Medicare and Medicaid Services (Nov. 19, 2021) <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/R11130CP.pdf>. [↑](#footnote-ref-2)
3. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral. 87 Fed. Reg. 44502. [↑](#footnote-ref-3)
4. Centers for Medicare and Medicaid Services, State Operations Manual, Chapter 2 – The Certification Process, 2256A, 241 (March 11, 2022) <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf>. [↑](#footnote-ref-4)
5. *Id.* [↑](#footnote-ref-5)