August 29, 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,

The Louisiana Rural Health Association (LRHA) 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.

LRHA is a membership association that is made up of Louisiana rural health care providers. This includes rural health centers (RHCs); federally qualified health centers (FQHCs); and rural hospitals across the state. Through discussion and exploration, the LRHA works to create a clear understanding of rural health care in Louisiana, its needs and effective ways to meet these needs.

LRHA 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

LRHA 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, we suggest 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.

Many hospitals that qualify to transition to REH designation, including the majority of CAHs in Louisiana, are designated as Necessary Providers. CMS must allow hospitals that are currently designated as Necessary Providers to maintain this grandfather status and related protections.

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. Without REH participation in 340B, far fewer hospitals will consider converting as 340B payments are vital to the financial viability of rural hospitals.

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II.A.2. Definitions

We appreciate CMS addressing commenters' concerns regarding the average length of stay provision. In the proposed rule you state that in accordance with section 1861(kkk)(1)(A) of the Act, services furnished by the REH must not exceed an annual per patient average of 24 hours in the REH.

With that said, our rural hospitals have specific concerns surrounding patients detained under a physician emergency certificate (PEC). These patients are understood to be facing an acute mental health crisis causing them to represent a danger to themselves or others, which require services beyond the scope of REHs. Due to the shortage of psychiatric beds, rural hospitals must often board these patients for periods of time that far exceed 24 hours, which puts a strain on hospital resources. We request CMS study the impact of boarding PEC patients in rural settings to inform future rulemaking activities.

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.

The majority of parishes in Louisiana are designated by HRSA as primary care HPSAs, including all areas where CAHs and Small Rural Hospitals eligible to transition to REHs are located. Only the most urban centers of the state are not designated HPSAs.[i] NPs and PAs can help to close access to care in these areas by practicing at the top of their education as the state scope of practice laws allow. The majority of NPs in the state are primary care providers.[ii]

II.A.8: Emergency Services

LRHA 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. Allowing a physicians, PAs, NPs, or clinical nurse specialists (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.

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

LRHA 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 by allowing REHs to tailor resources to meet the needs of specific communities. For example, preliminary research indicates that Louisiana will be one of the states with the highest OB/GYN shortages in the country.[iii] Therefore, we anticipate that many rural communities in Louisiana will be designated as maternity care health professional target areas (MCTA) by HRSA and patients in these communities will be in need of OB/GYN services.

LRHA requests clarification from CMS on provider-based rural health clinics (RHC). Consistent with legislative intent[iv], 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 in Louisiana that may be 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[v] and this must be explicitly stated in the CoPs.[vi] RHCs play a critical role in the healthcare landscape of Louisiana, serving as the primary care provider for the majority of our most vulnerable patients.

CMS should further consider allowance of distinct part inpatient psychiatric and inpatient rehabilitation facilities, like the distinct part skilled nursing facility. The inpatient psychiatric and rehabilitation units 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 rehabilitation units could make use of vacated space from the CAH or small rural hospital's conversion out of inpatient care into an REH. Several hospitals within Louisiana that may be considering conversion to REH already operate, either directly or through contract, a psychiatric unit and/or a rehabilitation unit. CMS should allow REHs to continue to provide access to these services in their communities.

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). Commentors on this rule, including individuals from Louisiana, have pointed out that "peer-reviewed literature demonstrates that physician supervision of CRNAs does not increase safety for patients, and it will drive up costs for REHs at a time when these facilities are already operating at razor thin margins."[vii] Requiring physician supervision of CRNAs in REHs will lead to further healthcare disparities in rural communities.

II.A.19. Agreements

LRHA 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. Over 90 percent of Louisiana is a Mental Health - Health Professional Shortage Area (HPSA).[viii] For patients needing inpatient psychiatric care, only 3,741 beds are licensed for psychiatric services across the state.[ix] 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.

CMS must explore the possibility of requiring REHs to enter into transfer agreements with an inpatient psychiatric facility to facilitate expedited transfer of patients with acute mental health needs. CMS must also allow an REH to operate a distinct inpatient psychiatric unit to maintain the psychiatric beds currently in CAHs and SRHs that may consider converting to an REH and to provide opportunity for expansion of access to psychiatric beds.

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 Denaé Hebert at dhebert@lrha.org or 337.366.5915.

Sincerely,

Denaé M. Hebert, MBA/HCA, CHC, CRHCP
Executive Director
Louisiana Rural Health Association

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[i] See Well-Ahead Louisiana, Health Professional Shortage Areas, access online at: https://wellaheadla.com/healthcare-access/health-professional-shortage-areas/

[ii] See Louisiana State Board of Nursing, Nurse Supply Report (2020), access online at : http://lcn.lsbn.state.la.us/Portals/0/Documents/2020%20Nurse%20Supply%20Report.pdf

[iii] Geiger Gibson / RCHN Community Health Foundation Research Collaborative, In the Wake of Dobbs, are Community Health Centers Prepared to Respond to Rising Maternal and Infant Care Needs? (July 2022).

[iv] 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)").

[v] 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.

[vi] 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.

[vii] See CMS-2022-0112-0020; CMS-2022-0112-2649

[viii] See https://wellaheadla.com/healthcare-access/health-professional-shortage-areas/

[ix] https://ldh.la.gov/assets/medicaid/hss/docs/HSS_Hospital/Psych_Beds_0122022.pdf