

September 17, 2021

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: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Hospital Outpatient Prospective Payment System (OPPS) for calendar year (CY) 2022. We appreciate your continued commitment to the needs of the more than 60 million Americans residing in rural areas and look forward to our continued collaboration to improve health care access, outcomes, and quality.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through advocacy, communications, education, and research.

We appreciate CMS' continued emphasis on ensuring care for rural beneficiaries through support of rural providers. The following are suggestions for how NRHA believes this proposed rule can be strengthened. We look forward to our continued collaboration in ensuring Americans living in rural areas have access to critical health services in their local communities and rural providers receive the equitable reimbursements they deserve.

XIX. Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

This year's OPPS proposed rule includes a proposal from President Biden to dramatically increase civil monetary penalties (CMP) for hospitals not in compliance with the Hospital Price Transparency Rule beginning January 1, 2022. Originally, noncompliance with the Hospital Price Transparency Rule resulted in a \$300 per day CMP, no matter the size of the hospital. That meant each facility, no matter bed size, would receive a yearly maximum penalty slated at

\$109,500. NRHA opposes the proposal to drastically increase CMPs for noncompliance with the Hospital Price Transparency Rule. As currently written, the CY 2022 OPPS proposed rule will cause enhanced financial stress to already struggling rural providers.

NRHA asks that CMS consider the challenges facing small, rural hospitals to come into compliance with the price transparency requirements, especially during a COVID-19 pandemic, when attention is appropriately being paid to caring for patients. In particular, rural hospitals do not have the resources or staff to comply with the requirements related to developing and maintaining the machine-readable file of all negotiated prices and therefore should be carved out from the associated CMPs being proposed in this rule.

Within this year's proposed rule, CMS seeks to gather input on several questions regarding the enhanced CMP proposal. NRHA has provided answers to those questions below:

- 1. How should the nature, scope and severity of noncompliance be determined and applied for purposes of assessing CMPs?* NRHA believes it is critical that CMS look at imposing CMPs on a case-by-case basis. We are concerned that imposing this one-size-fits-all regulation on all providers will hurt rural providers more than their urban and suburban counterparts. If CMS decides to not exempt rural providers from being forced to comply with this regulation, NRHA encourages a review of each facility's financial and staff resources to gauge capacity for compliance. Implementing a regulation at the expense of providing care is not something NRHA believes is in the best interest of rural communities. Unfortunately, if this regulation is implemented as written, it will increase the burden placed on rural providers with limited financial resources and staff. Rural providers who can demonstrate they are striving to come into compliance with this regulation should be exempt from the CMP. At a minimum, penalties for noncompliance should be reduced.
- 2. How should a hospital's reason for noncompliance be determined, and are there bases for imposing lower CMPs, such as resource limitations or extreme or unusual circumstances?* NRHA encourages CMS to review each facility on a case-by-case basis to understand where compliance shortfalls may come from. NRHA believes that rural providers should not be penalized severely because they are not able to devote the same amount of staff time and financial resources to compliance as their urban and suburban counterparts. NRHA firmly believes that compliance should not come at the expense of helping patients. CMS should look at each hospital not in compliance and provide hardship waivers for those experiencing staffing shortages, high patient loads, or limited financial resources. As previously stated, rural hospitals do not have the resources or staff to keep up with such an extensive, new requirement and should be exempt from any penalty, or at a minimum face a lower CMP. We believe the CMS estimate that it would take hospitals 12 hours to comply with these requirements is grossly underestimated. To simply generate the payment report and provide comparison to the same charges paid by insurance companies is an extreme burden on rural hospitals, which have limited ability to comply.

- If multiple factors are used to scale the CMP amount, should there be priority or weighting applied to specific factors?* NRHA encourages CMS to reevaluate the CMP amount based on geographical constraints. Most of the providers located in rural areas experience struggles with staffing and having adequate financial resources. Because of this, NRHA believes the CMP should be lowered, if not eliminated entirely, in these rural communities, as outlined in the questions above. This is critical for sole community hospitals (SCH), which by definition are remote, whose competition and market forces are essentially not applicable. The presence of this facility in a remote area is itself a benefit, since they provide local access to high quality care for patients. Enforcing CMPs on these lifesaving, financially strapped facilities will jeopardize their ability to maintain access to care for Medicare beneficiaries.

When CMS initially presented this regulation in the CY 2020 OPSS proposed rule, NRHA strongly opposed what we believed would become an onerous regulation for rural providers. Unfortunately, NRHA members across the country have confirmed that our expectations became reality. During the beginning of the COVID-19 public health emergency (PHE), CMS eliminated several onerous regulations from their agenda. However, CMS did not eliminate this regulation, which has placed hardships on rural hospitals. As anticipated, our members have affirmed it is overly burdensome for rural providers to come into compliance with this regulation. Moreover, NRHA does not believe this regulation provides a benefit to patients in rural communities, as it does not help consumers understand their health care pricing options. This regulation will only continue to hinder rural hospitals striving to provide essential, lifesaving care to patients amid the ongoing COVID-19 pandemic. **NRHA continues to call for CMS to eliminate this onerous regulation for all rural providers.** If full elimination is not feasible, NRHA supports CMS' proposal of use of online price estimator tools that rural hospitals can use in lieu of posting standard charges. **Instead of enhancing the CMP for noncompliant hospitals, NRHA believes CMS should be looking for ways to improve patient understanding of health care costs in a manner that does not require rural and safety net providers to spend valuable staff time and limited financial resources complying with an unnecessary, burdensome regulation.**

II. Proposed Updates Affecting OPSS Payments ... (2) CY 2022 Evaluation of Payments for Opioids and Non-Opioid Alternatives for Pain Management and Comment Solicitation on Extending the Policy to the OPSS

NRHA encourages CMS to extend the current ASC payment policy to provide separate reimbursement for all FDA-approved, non-opioid based pain management options to the OPSS PPS. Approximately 71,000 of the overdose deaths in 2020 involved opioids, meaning 195 Americans died every day from an opioid-related drug overdose. These never-before-seen levels of drug and opioid-related overdose deaths have shattered all previous records and represent a 30 percent increase since 2019, which is also the largest single year increase in drug overdose deaths in more than two decades. Every year, more than 3 million Americans go on to long-term opioid use following a surgical procedure. On average, these patients receive more than 80 opioid pills to manage their postsurgical pain. For many patients, their first exposure to

opioids follows a surgical procedure. The costs of providing additional, higher-cost services, such as administering non-opioid pain management therapies, are challenging in the HOPD setting due to tight operating margins. Rural providers are financially strapped, with little ability to make even small adjustments within a bundled payment environment as they operate. This inequity leaves rural Medicare beneficiaries seeking care from local providers at a significant disadvantage in terms of access to non-opioid pain management therapies.

II. Proposed Updates Affecting OPSS Payments ... E. Proposed Adjustment for Rural SCHs and Essential Access Community Hospitals under Section 1833(t)(13)(B) of the Social Security Act (the Act) for CY22

Under current CMS policy, Medicare payments to rural SCHs for outpatient services are increased by 7.1 percent. **NRHA applauds CMS' proposal to continue this payment adjustment for rural SCHs and encourages CMS to make the adjustment permanent, or at a minimum signal an intent to continue this adjustment in the future.** CMS has repeatedly and consistently extended the 7.1 percent payment adjustment since it was first finalized in CY 2006, but the agency has always kept open the possibility that it may discontinue the policy in the next year. While this payment adjustment is helpful to the hospitals that receive it, many are unable to take full advantage of the additional revenues because they cannot rely on the adjustment being there from year to year. The additional revenues may help close negative margins, but the monies cannot be invested in new services or capacities for the communities these hospitals serve, because they cannot be counted on from year-to-year. CMS could ensure that the recipients of these additional reimbursements are able to put those additional monies to maximum benefit for rural beneficiaries by making the 7.1 percent adjustment permanent or make an affirmative statement about an intent to continue this policy until the agency proposes to reconduct the analysis; then cease to propose to continue the policy in each rulemaking notice.

V. Proposed OPSS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals, B. Proposed OPSS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status

NRHA applauds the continued exemption of rural SCHs from Part B drug payment reduction proposals when drugs are purchase through the 340B program. We encourage CMS to: 1) Make the rural SCH 340b payment policy exception permanent, and 2) extend the 340b payment policy exception to Medicare Dependent Hospitals (MDH) and Rural Referral Centers (RRC). Rural hospitals, particularly rural PPS hospitals, are financially vulnerable. [Since 2010, 138 rural hospitals have closed, half of which were non-SCH rural hospitals paid under the PPS system.](#) Unfortunately, the rural hospital closure crisis has continued at an alarming rate during COVID-19, with another 453 hospitals are vulnerable to closure. During 2020 alone, 19 rural hospitals shuttered their doors, many of those coming at the height of the ongoing COVID-19 PHE.

While rural SCHs have been exempted from this payment adjustment—and are proposed to continue to be exempted in the current proposed rule, MDHs and RRCs are not and continue to be subject to the 340B payment reductions. CMS has recognized that SCHs, MDHs, and RRCs play a vital role in the rural health care infrastructure. If an SCH fails, a community is left without access to inpatient hospital services, and residents must travel great distances to access this care. The uncertainty provided under the current policy—i.e., not knowing if CMS will extend the policy for rural SCHs from year-to-year—inhibits investment in services in rural communities, and further strains the rural health care safety net. Further, many 340B participating hospitals—particularly rural safety net facilities, like MDHs and RRCs—are indispensable to their communities, and the discounts they receive through the 340B program play an essential role in allowing these facilities to provide care to otherwise underserved communities.

While CMS exempted rural SCHs from the 340B payment adjustments, MDHs and RRCs remain subject to these reduced payments. CMS has cited hospital operating margins, closure rates of rural hospitals, low-volume, and existing special payment designations among reasons for excepting rural SCHs, but not other rural safety net providers. MDHs and RRCs also play a vital role in the rural health care infrastructure, and exhibit some of the very same characteristics CMS used to justify exempting rural SCHs from the cuts. MDHs, SCHs and RRCs are all safety net providers that play an important role in maintaining access to health care services in isolated rural communities. Policies that further reduce payments to these facilities jeopardize both their short- and long-term viability.

X. Proposed Nonrecurring Policy Changes D. Comment Solicitation on Temporary Policies To Address the COVID-19 PHE

In response to the COVID-19 PHE, CMS used their emergency rulemaking power to implement several flexibilities to address the PHE, such as preventing the spread of infection and supporting diagnosis of COVID-19. Many of these flexibilities are set to expire at the conclusion of the PHE. **NRHA is extremely supportive of continuation of a number of temporary policies to address the COVID-19 PHE.** The COVID-19 pandemic continues to ravage rural communities, with three times the mortality rate than their urban counterparts. Continuation of these flexibilities is essential to rural providers seeking to maintain services to beneficiaries in this time of crisis. **In particular, NRHA encourages CMS to extend and make permanent the following waivers:**

- **Critical Access Hospital (CAH) length of stay.** CMS has waived the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation for number of beds and length of stay requirements.
- **Flexibility for Medicare Telehealth Services.**
 - Eligible practitioners. 1135 waivers expanded the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health

care professionals who were previously unable to bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

- Audio-only telehealth for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.
- Telemedicine. CMS waived provisions related to telemedicine for hospitals and for CAHs, making it easier to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.

The nation's substance-use and mental health epidemics have continued to grow in the backdrop of the COVID-19 pandemic. NRHA believes all flexibilities that allow for improved access to behavioral health care services are especially important to rural providers and beneficiaries.

1. *The extent to which hospitals have been billing for mental health services furnished to beneficiaries in their homes through communication technology during the PHE, and whether continued demand for such care is anticipated.*

Demand for mental health services through communication technology, including audio-only services, is and will continue to be significant in rural areas. Allowing for at home telehealth utilization, particularly in our most rural communities, is critical to increasing mental health care access for vulnerable populations. Mental health services are incredibly important for an elderly population that represents just 13 percent of the population, but 20 percent of suicide deaths. Since rural America has a higher elderly population than their urban counterpart, allowing all rural providers to be eligible to provide these services is critical to ensuring the mental health care of the population. NRHA is extremely supportive of the COVID-19 flexibilities that have allowed CAHs to provide outpatient services via telehealth during the PHE, and we believe that these flexibilities should be continued beyond the PHE for mental health services as well as all others. Given the toll the ongoing COVID-19 pandemic is placing on Americans mental health needs, NRHA believes it is critical that CMS ensures all rural providers, including CAHs, can fully provide these services via telehealth.

2. *The degree to which providers relied on the flexibility to allow the presence of the physician for purposes of direct supervision requirements via audio/video real-time communications technology. This flexibility is set to expire at the end of the PHE or December 31, 2021, whichever is later.*

NRHA strongly encourages continuation of the flexibilities around direct supervision requirements via audio/video real-time communications technology for rural Medicare beneficiaries. During the PHE, audio-only services have been a vital linkage to care for many patients. This is especially important in rural communities with limited broadband connectivity,

both physically and financially. Affordability of broadband services is a barrier to accessing audio-video telehealth visits for many rural seniors, which makes audio-only visits essential for those beneficiaries. Nationwide, rural communities report a shortage of psychiatrists, clinical psychologists, psychiatric nurse practitioners, social workers, and counselors (addiction, pastoral, school, professional, marriage and family, among others). In fact, only 3% of metropolitan counties (urban) were without any mental health provider during 2015 compared to 13% of nonmetro (rural) counties. Given the significant behavioral health care provider shortages in rural areas, continued flexibility of direct supervision requirements for audio/video telehealth services is critical to maintaining access for rural beneficiaries.

XVII. Request for Information on Rural Emergency Hospitals

Congress created the Rural Emergency Hospital (REH) designation established in Section 125 of the Consolidated Appropriations Act, 2021. Within this year's OPPTS proposed rule, CMS has begun the process of establishing the designation through this request for information (RFI). NRHA would like to express thanks to CMS for their due diligence in collecting significant stakeholder feedback before establishing the REH designation criteria in next year's OPPTS proposed rule, ahead of the REH designation launch date of January 1, 2023. We commend CMS for its recognition of the complex challenges and considerations posed by the model and the rural communities it serves.

NRHA is optimistic the REH model will address a persistent rural need for emergency and other outpatient services at-risk following hospital closures. Despite legislative actions designed to preserve rural hospitals, 181 rural hospitals have closed since 2005.ⁱ The REH model could go a long way toward slowing the alarming rate of closure crisis and maintaining health care access to some of the most disadvantaged and marginalized communities in our country. In 2018, nearly 25 million rural Americans received emergency department (ED) care.ⁱⁱ In many rural communities access to emergency services and higher-level outpatient services is still necessary despite insufficient patient volume or resources to support the provision of inpatient services.ⁱ The REH model will offer rural communities a new, viable health care delivery option that holds promise for stabilizing, maintaining, and expanding access to critical services in rural communities.

Approximately 68 rural hospitals (or 5 percent) of rural hospitals are predicted to consider conversation to become a REH.ⁱⁱⁱ The hospitals most likely to transition to this designation are in already poor financial standing.^{1,iii} Imposing regulations that are difficult to comply with will only add to the vulnerability these facilities face. As you will see in our answers to the RFI below, NRHA hopes that CMS does not view this as a new model created for the sake of innovation, rather a lifeline for small rural communities at risk of losing access to care. As such,

¹ The three prediction criteria for REH conversation include: 1) long-term unprofitability (three consecutive years of a negative total margin; three consecutive years of negative operating margin); 2) average acute and swing daily census less than three; and 3) net patient revenue less than \$20 million.

NRHA recommends continuation of existing CoPs for rural PPS and CAHs as much appropriate. Further, it is imperative that CMS understands that **strong reimbursement and financial payments are the crux of success for this model.** The pathway to converting to the REH designation needs to be seamless through a **simplified application process and technical assistance support for robust planning and community engagement.**

NRHA is pleased with CMS' decision to gather information on the needs in rural communities before moving forward with setting up the new designation and are hopeful the agency will continue expansive rural engagement to support a robust and accessible model. If helpful, NRHA is prepared to assemble a group of rural hospital leaders and financial consultants, who best understand the financial and operational intricacy of rural hospitals, to assist CMS with future REH regulation development. In the interim, our feedback and recommendations on the REH RFI questions can be found in the attachment.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care for rural beneficiaries. If you would like additional information, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain at ccochran@nrharural.org.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

Attachment: Response to Rural Emergency Hospital RFI**Type and Scope of Services Offered**

1. *What are the barriers and challenges to delivery emergency department services customarily provided by hospitals and CAHs in rural and underserved communities that may require different or additional CoPs for REHs (for example, staffing shortages, transportation, and sufficient resources)?*

The delivery of emergency department services in rural areas experience unique challenges related to patient demographics, low volumes, high fixed costs, long distances, and workforce shortages. These factors are critical considerations in the development of the CoPs of REHs to ensure access to care and stability for these transitioning providers.

Rural providers typically serve lower patient volumes who are on average sicker, older, and more likely to be uninsured than their urban counterparts.^{iv} Rural beneficiaries' tendency to be poorer and in worse health are factors closely associated with both readmission and emergency department (ED) use in the general population.^v However, overall utilization of the ED in rural communities is lower than in urban communities due to the smaller populations and barriers to accessing care in rural areas.^v After adjusting for demographic, health status, and hospital characteristics, Medicare beneficiaries in rural settings maintained a significantly greater risk of ED use of 30 days' post discharge compared with urban beneficiaries.^v When ED visits occur, they are frequently the result of preventable complications related to cardiovascular or respiratory diagnosis, infections, and procedural site complications.^v

To ensure the REH model is successful, it is imperative that CMS establishes a reimbursement policy that accounts for the financial situation of rural providers. Facilities interested in converting to the new REH designation are likely on the brink of closure, with narrow, if not negative, operating margins. The payments to REHs must reflect the higher fixed costs, low patient volumes, longer transfer times, and staffing costs associated with providing emergency care in rural areas.^{iv}

Further, it is necessary that CMS understands the challenges REHs will face to comply with minimum staffing requirements.^{iv} Practicing emergency medicine in rural communities is challenging. Rural hospital EDs must be staffed to handle a wide range of emergency situations, but other demands on rural physicians' time and limited ED patient volume may complicate ED staffing.^{vi} Family physicians and internists account for the largest number of physicians staffing rural EDs.^{vi} Nursing coverage usually comes from other areas of the hospital to cover the ED, with the use of nurses who work exclusively in the ED varies significantly by ED volume, averaging 4% for hospitals with less than 1,000 annual visits.^{vi} In larger facilities, ED coverage would be comprised of a blend of medical staff, contracted coverage, and physician assistant and/or nurse practitioner coverage with a physician on-call.^{vii} Persistent provider shortages, coupled with low patient volumes, will require a significant amount of flexibility in the CoPs for REHs.

- 2. An REH must provide emergency and observation services and may elect to provide additional services as determined appropriate by the Secretary. What other outpatient medical and health services, including behavioral health services, should the Secretary consider as additional eligible services? In particular, what other services may otherwise have a lack of access for Medicare beneficiaries if an REH does not provide them?*

Rural beneficiaries should be able to conveniently and confidently access services such as primary care, dental care, behavioral health, emergency care, and public health services. Unfortunately, access to these basic services can be challenging in rural communities. To address these gaps, NRHA believes the REH designation should have the flexibility to offer several types of services in their communities, as needed, including extra medical and social support services, mental and behavioral health services, substance use disorder treatment (*see question 4 response*), and support for maternity care (*see question 5 response*). In addition to emergency, observation, and traditional outpatient services, it is important for lab, imaging, therapy, mental health, and opioid treatment to be clarified as eligible services for Medicare beneficiaries receiving care at an REH. These outpatient care services may not be readily available, if not provided through the REH.

NRHA recommends CMS include outpatient hospital-based behavioral health as optional services, both in person and via telehealth, in the REH setting. In rural communities, residents have fewer mental health resources available, report facing greater stigma and barriers to diagnosis and treatment, and reside in communities with significant behavioral health workforce shortages.^{viii} Lack of providers and lack of insurance results in many beneficiaries with mental illness going to the ED for care. Nearly 1 in 20 ED visits carried a primary/secondary diagnosis of mental disorder.^{viii} However, rural residents who presented to the ED for a MH/SA diagnosis are more likely than urban residents to present with a primary diagnosis of mental health disorder and are more likely to be on public assistance and age 65 or older.^{ix} Rural residents diagnosed with a primary/secondary mental disorder in the ED are more likely than urban to be female, 65 years of age or older, covered by Medicaid or Medicare, and dual eligible.^{viii} Further, only 3 percent of metropolitan counties were without any mental health provider in 2015 compared to 13 percent of nonmetropolitan counties.^{viii} To help diminish this disparity, NRHA believes that REHs should be given significant flexibility to provide and/or collaborate with others in the community to provide critical behavioral and mental health services to beneficiaries, including crisis response teams.

- 3. What, if any, virtual or telehealth services would be appropriate for REHs to provide and what role could virtual care play in REHs?*

Telemedicine services should be a vital component of the REH and should be reimbursable for an REH as broadly as CMS can allow. NRHA recommends CMS monitor whether the proposed REH reimbursement rate and structure is set at an appropriate level for REH providers to maintain necessary telehealth service capabilities.

Telehealth is increasingly being used to improve access to specialized emergency care for the 60 million rural Americans and decrease disparities between rural and urban trauma outcomes.^x Trauma is the leading cause of death for Americans under the age of 44 and is associated with

significant morbidity and mortality.^{xi} Rural trauma patients have disproportionate high injury mortality rates, but only about half of rural Americans live within 30 minutes of an ED. To address the needs of rural trauma patients, ED-based telemedicine services are increasingly critical.^{xi} Tele-ED, paired with the policy clarification from CMS, increases rural hospitals' options to address physician shortages and challenges with ED coverage, ultimately improving access to care for rural communities. For rural residents, ED telemedicine offers improved access to experienced specialists, timely care, and appropriate treatment. NRHA believes it is critical that REHs can utilize telehealth flexibilities to provide rural beneficiaries with the greatest variety and access to care possible.

As a key source of care in most rural communities, ED often face challenges with providing specialty care such as trauma and behavioral health. NRHA believes allowing telehealth services at an equal capacity within an REH to what is provided in CAHs and RHCs is critical to the health of the community. Previous experience show that access to telehealth services in rural Eds can lead to improved patient care and increased support for rural providers.^{xii} Further, telemedicine consultations within rural hospitals have been associated with more rapid interhospital transfers.^x

In these low-volume EDs, telehealth can provide immediate access to a provider who can perform an evaluation, order tests, and arrange transportation for transferring patients, if appropriate. As previously mentioned, NRHA recommends the inclusion of tele-ED trauma and behavioral/mental health services as options within the telehealth capacity of the new REH designation. However, access to other specialty services, including radiology and obstetric services, may also be critical access points within these facilities. Due to the COVID-19 PHE, telehealth flexibilities have been expanded drastically, particularly for rural providers. We encourage CMS to make these flexibilities permanent, when at all possible, for rural providers to ensure access to care for rural beneficiaries, and we applaud their inclusion in the CY22 Medicare Physician Fee Schedule proposed rule. In particular, it is critical REHs can serve as originating site providers for telehealth services in rural areas.

Since these will most likely but existing, struggling rural hospitals transitioning to REH status, NRHA urges CMS to adopt telehealth CoPs that are similar to designations that new REHs are transferring from. For example, a 2013 memorandum from CMS clarified that CAHs could use a physician at a telehealth hub to fulfill the requirements under their conditions of participation and the Emergency Medical Treatment and Active Labor Act (EMTALA) related to physician coverage for the ED.^{xiii} Further, NRHA urges CMS to implement telehealth CoPs that are easy to navigate for new REH designated facilities so they can provide telehealth services to beneficiaries upon converting.

4. Should REHs include Opioid Treatment Programs, clinics for buprenorphine induction, or clinics for treating stimulant addiction in their scope of services? Please discuss the barriers that could prevent inclusion of each of these types of services.

Over the past two decades, the United States has experienced a dramatic increase in the number of drug-related overdose deaths, driven largely by the ongoing opioid epidemic. While there is high prevalence of opioid misuse across the United States, there is evidence suggesting that use of opioids may be more lethal for those living in rural areas.^{xiii, xiv} Although a shortage of these

programs exists nationally, the gap is widest in rural areas, where 88.6 percent of large rural counties lack a sufficient number of opioid treatment programs.^{xiv} One impact of the higher rates of opioid misuse and related overdoses has been an increased strain on emergency departments.^{xiii} For rural physicians, barriers to prescribing buprenorphine include time constraints and a lack of mental health or psychosocial support services for patients, specialty backup for complex problems, and confidence in their ability to manage OUD.^{xiv} To help address the challenges facing rural communities, it is critical that rural providers, including REHs, have the option to provide opioid treatments as necessary.

5. *What, if any, maternal health services would be appropriate for REHs to provide and how can REHs address the maternal health needs in rural communities? What unique challenges or concerns will the providing of care to the maternal health population present for an REH?*

In rural communities, pregnant women travel longer distances to receive maternity care and give birth compared to their urban counterparts.^{xv} Further, rural hospitals across the United States have been increasingly closing their obstetric units because of these shortages.^{xv} Further yet, rural communities with a higher proportion of non-Hispanic Black residents were more likely to lose obstetric care than predominantly white rural communities.^{xv} Serious health risks are associated with losing hospital-based obstetric services, including increases in preterm delivery, out-of-hospital births, and emergency room births.^{xv} With growing numbers of rural hospitals closing obstetric units, facilities like REHs without regular obstetric care, may be faced with difficulties in providing needed care for local pregnant residents.^{xv}

Understanding the potential need for REHs to provide prenatal and/or emergency maternal health services, NRHA suggests the CoPs allow for use of telehealth to help provide maternal health services in their communities. Additionally, NRHA recommends REHs be allowed to have the capacity for providing outpatient pre- and post-natal services to women living in rural areas. NRHA believes that coordination between REHs and regional hospitals that have obstetric care could help bridge the care gap for pregnant women in rural communities. Additionally, NRHA believes that the REH could work with a regional facility to enhance their telehealth network to provide some of the prenatal care within the REH, even without a devoted obstetric unit.

Health and Safety Standards, Including Licensure and Conditions of Participation

6. *The statute requires that REHs meet the requirements for emergency services (set forth at § 485.618) that apply to CAHs. Which hospital emergency department requirements (set forth at § 482.55) should or should not be mandated for REHs and why or why not? Are there additional health and safety standards that should be considered? What are they, why are they important, and are there data that speak to the need for a particular standard?*

The REH model was intended to be an alternative safety net facility for full-service hospitals struggling on the brink of closure. Without this model, impacted rural communities may lose an essential access point for health services. Thus, NRHA believes CoPs for REHs should be maintained from the designation type (i.e. PPS or CAH) an REH is converting from, minus inpatient services. Further, we do not believe it appropriate to add any requirements (CoP, operating, financial, reporting, quality) beyond the scope that CAH and rural PPS hospitals

currently operate under, minus anything related to inpatient services, with REH CoPs most closely aligning with CoPs for CAHs, since they apply to on the smallest of hospitals.

Instead of writing additional CoPs, NRHA urges CMS to focus on reducing regulatory burdens for interested facilities. In particular, CMS should focus on consolidating emergency/outpatient, SNF, rehabilitation unit, and RHC conditions of participation (including licensure, record-keeping, and life-safety codes) to simplify regulatory burden (within statutory authority). Additionally, NRHA urges CMS to consider allowing hospitals that have closed within the past five years to be eligible to reopen as REHs, assuming they otherwise meet REH eligibility. Similarly, there should be a pathway for REHs to convert back to a CAH or PPS hospital should an REH decide that inpatient services are required for a community.

7. *The REH must meet staff training and certification requirements established by the Secretary. Should these be the same as, or similar to, CAH requirements (Personnel qualifications, §485.604 and Staffing and staff responsibilities, §485.631)? Are there additional or different staff training and certification requirements that should be considered for REHs and why? Are there any staffing concerns that the existing CAH requirements would not address?*

Staffing will be critical for a potential REH to determine which services are possible or available at an REH. Currently, most rural hospitals use more than one type of staffing to cover their ED, including combinations of physicians, physician assistants, and nurse practitioners.^{vi} NRHA recommends that CoPs for CAH staffing requirements be maintained for REHs to account for provider shortages and keep staffing costs low. In many small communities, health care providers are accustomed to “wearing many hats” to leverage scarce resources and retain local services. To that end, NRHA urges CMS to allow staffing to cross over between the REH, SNF, and other facility related services. For example, a physician in a privately owned clinic may also be the REH director and the supervising physician for the physician assistants. A community pharmacist may also be the consultant pharmacist for the REH for perhaps only 0.2 FTE. This type of staff sharing could lower costs and provide a viable way to staff REHs.

8. *What additional considerations should CMS be aware of as it evaluates the establishment of CoPs for REHs? Are there data and/or research of which we should be particularly aware of?*

NRHA believes that while some renovation may be desirable to achieve efficiencies, CoPs for REHs should require minimal renovations and use functional capital equipment already in place. The transitioning facility is already a functioning hospital and thus should not have to meet any new standards in this regard.

Additionally, NRHA is concerned about the impact of REH eligibility to be a Covered Entity (CE) for 340B post conversion. Although rural hospitals view the Rural Emergency Hospital as a modification of an existing rural hospital, it is not clear whether a 340B participating hospital could continue such participation after modifying to an REH. While the authorizing language within the CAA, 2021, doesn't specifically state that an REH is a CE under 340B, we believe it is consistent with the intent of the law for REH's to continue as a 340B eligible provider type.

All Critical Access Hospitals and rural Prospective Hospitals with a certain level of Medicaid patients are both eligible. As most hospitals seeking REH status are certain to be in financial distress, all REHs should have the benefit of 340B to maximize their viability. NRHA members have expressed significant concern that this has yet to be addressed, and we would urge CMS to signal to HHS the appropriateness of current CEs maintaining eligibility post transition to REH.

9. *What, if any, lessons have been learned as they relate to rural emergency services during the COVID-19 pandemic that might be pertinent to consider for policy implementation after the PHE?*

The COVID-19 pandemic has accentuated the fragility of rural systems of care, from pre-hospital transport to ED treatment. Since the beginning of the PHE, NRHA has observed several lessons learned related to provision of care in rural communities. For instance, many pre-hospital services are unable to meet the demands of relatively high-volume periods required under a COVID-19 surge. Additionally, EDs, and by extension REHs in the future, are stretched in terms of workforce. An available bed does not always equate to one that can provide service if adequate staff isn't able to provide services. Lastly, tertiary and quaternary providers were unable to accept transfers due to high COVID-19 volumes in those facilities. This leaves highly complex patients with intense resource needs for local rural hospitals to provide care for. If an REH has no inpatient beds, by definition, these transfer delays could be very difficult to deal with leaving an REH and the rural beneficiary in a very stressful situation.

10. *Are there state licensure concerns for hospitals and CAHs that wish to become REHs? What issues with respect to existing or potential state licensure requirements should CMS consider when developing CoPs for this new provider type? What supports and timelines should be in place for States to establish licensing rules?*

Some states are not positioned to immediately adopt the REH option based on their individual state's hospital licensing regulations. NRHA believes that states should adopt current CAH licensure standards for the REH designation type. In doing so, they should eliminate the need for inpatient beds to qualify. Again, NRHA believes the simpler the CoPs are, the better.

Health Equity

11. *How can REHs address the social needs arising in rural areas from challenging social determinants of health, which are the conditions in which people are born, live, learn, work, play, worship, and age, and which can have a profound impact on patients' health, ensuring that REHs are held accountable for health equity?*

In rural communities, socio-economic characteristics have shaped the health care landscape. For example, research indicates that rural residents use the ED more often than their urban counterparts.^{ix} However, the reason for higher utilization remains unclear. This difference could be the result of rural primary care access barriers, including availability of after-hours care, or could be related to lower education or other factors affecting knowledge of appropriate health care use.^{ix} The REH model may have significant value to vulnerable populations by maintaining local access to care, reducing travel times which frequently causes delays in care, exacerbating

disparities. Further, REH facilities could have the flexibility to provide social supports, such as transportation, food, or housing assistance.

One approach to address SDOH in rural areas is to implement a value-focused element to the additional facility payments. For example, the application process and REH operation could: include to serve community need, address social determinants of health to improve community health and wellbeing, facilitate local interagency collaboration, and measure and address community health in quality improvement plans.^{xvi} Using the additional facility payment funds to support value-based care that demonstrably provides better patient care (clinical quality, patient safety, and patient experiences), would not only work to improve community health, and/or reduce total cost of care, but support and expand essential local services to at-need populations.^{xvi}

However, while significant SDOH disparities exist in rural communities, it is important that CMS establish realistic health equity provisions that take into consideration the financial and workforce realities these providers are facing. Requiring an REH to implement significant health equity/value-based efforts is not going to be easy financially and therefore should be incorporated into any implementation efforts.

12. With respect to questions 1 through 11 above, are there additional factors we should consider for specific populations including, but not limited to, elderly and pediatric patients; homeless persons; racial, ethnic, sexual, or gender minorities; veterans; and persons with physical, behavioral, and/or intellectual and developmental disabilities?

Because, on average, rural America is older, sicker, and poorer than their urban counterpart, NRHA urges CMS to consider the population-base residing in an REH community, who are more likely to be uninsured or underinsured, has a pre-existing condition, and is older than their urban counterpart. Allowing REHs to offer a flexible range of health care and social support services will strengthen access to care for all rural residents, including minority populations, who often experience poorer health outcomes.^{xvii} Based on data from 2010, children have also been found to have higher rate of ED use for non-emergent conditions compared to adults, with the rate of ED for non-emergent conditions generally higher in rural areas. Further, rural African Americans showed ED visit rates twice that of rural White residents. Lastly, rural visits were more likely to be a person older than 65 compared to visits to urban EDs. These realities should be remembered when moving forward with implementation of the REH designation.

13. How can the CoPs ensure that an REH's executive leadership (that is, its governance, or persons legally responsible for the REH) is fully invested in and held accountable for implementing policies that will reduce health disparities within the facility and the community that it serves? With regards to governance and leadership, how can the CoPs:

- a. Encourage an REH's executive leadership to utilize diversity and inclusion strategies to establish a diverse workforce that is reflective of the community that it serves;*
- b. Ensure that health equity is embedded into a facility's strategic planning and quality improvement efforts; and*
- c. Ensure that executive leadership is held accountable for reducing health disparities?*

NRHA believes that these elements can be listed as requirements for leadership in the CoPs, and the related State Operations Manual can outline elements of what would be acceptable to meet that standard. However, NRHA reiterates that CMS should be cautious of the facilities transitioning to REH designation status and their financial and workforce shortfalls. These facilities do not have excess financial and staffing resources to accommodate overly burdensome regulations.

14. An important first step in addressing health disparities and improving health outcomes is to begin considering a patient's post-discharge needs and social determinants of health prior to discharge from a facility. How can health equity be advanced through the care planning and discharge planning process? How can the CoPs address the needs for REHs to partner with community-based organizations in order to improve a patient's care and outcomes after discharge?

It is important for CMS to understand the patient population that REHs will be working with and the unique social determinants and lack of access to services facing them. As previously mentioned, rural beneficiaries' proclivity to be poorer and in worse health are factors closely associated with both readmission and emergency department (ED) use in the general population.^v Further, research indicates that rural Medicare beneficiaries are at greater risk of an ED visit during a post-discharge period.^v Lastly, after adjusting for demographic, health status and, finally, hospital characteristics, beneficiaries in these settings maintained a significantly greater risk of ED use of 30 days' post-discharge compared with urban beneficiaries.^v Therefore, any care planning and discharge planning requirements and CoPs put into place need to acknowledge the potential shortage of health care workforce and community-based organizations to support transitions of care. A possible resource for rural communities as they assess the SDOH and local partners is the use of the Community Health Needs Assessment as a tool for identifying and prioritizing health needs of the community, frequently in participation with local public health. The findings from the needs assessment can then be used to develop a hospital transformation action plan.

15. In order to ensure that health care workers understand and incorporate health equity concepts as they provide culturally competent care to patients, and in order to mitigate potential implicit and explicit bias that may exist in healthcare, what types of staff training or other efforts would be helpful?

NRHA encourages CMS to be careful in implementing overly burdensome policies that will be difficult for compliance in rural communities. As NRHA outlined above, one of the biggest challenges facing rural providers is workforce shortages, which NRHA expects to be the case for REH designated facilities as well. NRHA urges CMS to understand the workforce realities and not require burdensome training and reporting requirements. Burdening an REH with these kinds of requirements with their financial and workforce realities could ultimately be a hinderance to care for rural beneficiaries.

16. Finally, how can the CoPs ensure that providers offer fully accessible services for their patients in terms of physical, communication, and language access with the resources they have available to them?

Again, NRHA urges CMS to work to emulate the existing CoP requirements for PPS and CAHs. NRHA doesn't believe it makes sense to make REH CoPs more stringent and prescriptive than those for PPS and CAHs, especially given the financial and workforce realities outlined above.

Collaboration and Care Coordination

17. How can CMS and other Federal agencies best encourage and incentivize collaboration and coordination between an REH and the healthcare providers, entities, or organizations with which an REH routinely works (for example, requirements related to the Emergency Medical Treatment and Active Labor Act, transfer agreements, and participation in EMS protocols), to help the REH successfully fulfill its role in its community? Healthcare providers, entities, and organizations with which an REH might typically work and interact might include, for example, federally qualified health centers, rural health clinics, state and local public health departments, Veterans Administration and Indian Health Service facilities, primary care and oral health providers, transportation, education, employment and housing providers, faith-based entities, and others.

Currently, rural hospitals provide first-line treatment for emergency patients and inpatient care for less-complex patients. They also play a crucial role in stabilizing patients and coordinating transfers to tertiary care for individuals who need a higher level of care.^{vii} REHs could provide value in a regional health care system that organizes health care to optimize clinical quality, operational efficiency, and patient experience. Specifically, REHs could:^{xvi}

- Help ensure viability of essential local health care services (e.g., emergency and primary care) that otherwise could be jeopardized by hospital financial distress.
- Sustain timely access to emergency medical services.
- Bolster local public health agencies and disaster preparedness.
- Support primary care as the foundation of a high-performance rural health care system.
- Maintain a local rural health system presence that provides important benefits including local citizens' sense of safety and security, local jobs, business attraction, and overall community livability.

Additionally, while the authorizing legislation requires that an REH have in effect a transfer agreement with a level I or level II trauma center, stakeholders should assess local emergency medical services availability and develop plans to bolster those services if needed.^{xvi} A regional health care strategy (inpatient care, certain outpatient services, and telehealth) should be included in emergent and non-emergent transfer agreements.

REHs may play an important role in providing primary care services through their relationships with Rural Health Clinics (RHCs). It is unclear if those hospitals would still be considered an operator of a provider based RHC if the hospital status is changed to an REH. High rates of potentially preventable hospitalizations and emergency department (ED) visits indicate limited primary care access. RHCs use, intended to increase access to primary care, are associated with a

27% increase in potentially preventable hospitalizations and a 24% increase in potentially preventable ED visits among older Medicare enrollees.^{xviii} To that end, the new provider-based Rural Health Clinic reimbursement grandfathering policies proposed in the CY22 Medicare Physician Fee schedule should be applied to PPS and CAH facilities that convert to REH status. It is vitally important for those hospitals converting to REH to continue with the higher reimbursement rates associated with provider (hospital) based clinics in order to maintain primary care access in those communities losing some hospital services with the REH conversion. It should also be clarified that a “grandfathered” provider based RHC (prior to the recent change in payment methodology) maintain the “grandfathered” rates.

The creation of the REH model will bring up a number of areas related to rural health care that will likely need regulatory clarification. For example, hospitals qualify for SCH status by virtue of being a certain distance from a “like hospital.”^{xvi} In current regulation, CAHs are not considered like hospitals. NRHA could encourage CMS not to consider an REH a “like hospital,” and thereby having an impact on nearby SCH’s eligibility requirements.

Quality Measurement

18. What existing quality measures that reflect the care provided in rural emergency department settings can be recommended? What existing quality measures from other quality reporting measurers, such as the Hospital Inpatient Quality Reporting and Hospital Outpatient Quality Reporting Programs, are relevant to the services that are likely to be furnished in REHs and should be considered for adoption in the REH context? What measurers, specific to REHs, should be developed?

Ensuring quality of emergency care is important for rural communities. At the national and state levels, increased policy interest in the quality of emergency care is evident in efforts to establish statewide trauma systems, promote the use of protocols for care provided in EDs, implement electronic medical records, and encourage or require reporting on quality measurers involving care that may be provided in the ED setting.^{vi} While emergency care is important in all hospitals, it is particularly important in rural hospitals, where the size and geographic realities increase the importance of transfers from rural hospitals to regional hospitals. Because of their size, rural hospitals are less likely to be able to provide more specialized services, such as cardiac catheterization or trauma surgery.^{xix} This suggests that any quality measurement of REH services need to be finely aligned with services provided in these facilities.

NRHA recommend CMS continue the use of current quality measures related to rural CAHs ED services for REHs. The current Medicare Beneficiary Quality Improvement Program (MBQIP) measures, reported through the Medicare Rural Hospital Flexibility Program at HRSA, include core categories related to patient engagement (HCAHPS and emergency department patient experience), care transitions (ETC, discharge planning), and outpatient AMI and ED throughput.² When possible and appropriate, such indicators should be risk-adjusted for social determinants of health and include access to care measures (where available).

² Full set of measures can be found at <https://www.ruralcenter.org/sites/default/files/MBQIP-Measures2021.pdf>.

19. *Based on experiences in quality reporting by small rural hospitals and CAHs, what barriers and challenges to quality reporting are REHs likely to encounter? What quality reporting strategies should CMS consider to mitigate those barriers?*

CAHs have historically been exempt from national quality reporting programs due to challenges related to measuring improvement in low volume settings, limited resources, and alternate payment methodologies.^{xx} Further, rural hospitals, including CAHs, and likely REHs in the future, may not have a sufficient volume of patients to produce statistically valid results.^{xxi} Rural hospitals which often provide a more limited scope of services may not provide the services that are measured by CMS quality reporting programs or may elect not to report quality data.^{xxi} As such CMS should understand that rural providers may not have the same experience and capacity to participate in quality reporting programs as their urban counterparts for the reasons mentioned above., and therefore should transition any quality reporting program accordingly.

20. *For CAHs, what are the barriers and challenges to electronic submission of quality measures, and will those barriers likely apply to REHs? What similar barriers and challenges could CAHs and REHs experience for chart abstracted measures?*

CMS should develop a Rural Quality Reporting (RQR) program through the National Quality Forum (NQF), using a peer-guided process to select measures and statistical systems for low volume analysis. The RQR can be applied to quality reporting, including the HCAHPS process, which may need to be adapted to the REH environment. A thorough review and analysis should be done using the peer-guided process to ensure that an “urban-centric” quality reporting program isn’t super-imposed to this very rural REH model. Contrary to popular assumption, rural facilities don’t tend to have problems with the electronic submission process but rather reporting data for analysis that is not appropriate for the rural environment, thus making the process worthwhile for the effort expended. Ultimately, the data should be used for performance improvement internally, leading to better patient care at a lower cost.

21. *What factors should be considered for the baseline measure set and how should CMS assess expanding quality measures for REHs? How could quality measures support survey and certification for REHs?*

As described in question 20, NRHA recommends a RQR should be developed using the peer-guided process at the NQF to recommend measures to be used in this REH environment. Without this approach, the data collected and analyzed on the REH may not have the intent effect. If CMS deems additional quality indicators are necessary, NRHA recommends the Department supports the development of rural relevant measures to develop and/or modify measures to address low case volume explicitly, consider rural-relevant sociodemographic factors in risk adjustment, and to create composite measures that are appropriate for rural providers.^{xxi}

22. *What additional incentives and disincentives for quality reporting unrelated to payment would be appropriate for REHs? Are there limitations or lower limits based on case volume/mix or geographic distance that would be appropriate for CMS to consider when assessing the quality performance REHs?*

NRHA believes that any recommendation for pay-for-performance incentives must be built on solid rural-centric quality reporting measures like suggested in the RQR foundation. Creating a system based on data not relevant to care provided in REH or that overly burdensome will be frustrating at best for REHs and at worst not reflective of actual care provided. In addition, rural measures should be aligned across Medicare, Medicaid, and other payers to minimize reporting burden on rural facilities.

23. The inclusion of CAHs within the Overall Hospital Quality Star Ratings provides patients with greater transparency on the performance of CAHs that provide acute inpatient and outpatient care in their area. What factors should CMS consider in determining how to publicly reporting REH quality measure data?

Analysis of 2017 Hospital Quality Star Rating shows that more than one-third of rural hospitals did not receive a star rating (782 rural hospitals), compared with only 12 percent of urban hospitals.^{xxi} With that in mind, CAHs are the most likely to not receive a star rating, while small rural hospitals are less likely than larger rural hospitals to receive a star rating, both of which are likely providers to transition to REH status.^{xxi} Further, 43 percent of the not-rated rural hospitals were in the Midwest census region, also where many of the likely REHs will come from.^{xxi}

To that end, it is clear that rural hospitals are disproportionately affected by the minimum reporting requirements as part the Hospital Quality Star Rating program. While CMS cautions that the absence of a rating does not mean that a hospital provides low quality care, some consumers still equate no rating with failure to report or with poor quality. Requiring REH to submit the same reporting requirements as their larger rural and urban providers puts them at a distinct disadvantage. NRHA again urges CMS to be cognizant of these challenges and to include rural-centric reporting requirements that adequately represent the realities of rural health care.

Payment Provisions

24. Under the law, only existing critical access hospital or subsection (d) hospitals with not more than 50 beds that are located in a rural area are eligible to convert to an REH. While REHs will receive the applicable OPPS rate that would otherwise apply under section 1833(t)(1) of the Act and with an increase of 5 percent under section 1834(x)(1) of the Act as well as an additional facility payment to be made on a monthly basis under section 1834(x)(2) of the Act, we note that rural sole community hospitals (SCHs) currently receive an additional 7.1 percent payment for all services paid through the OPPS. We are seeking comment on the likelihood of rural SCHs deciding to seek to become REHs.

Work done by the Sheps Center at the University of North Carolina at Chapel Hill estimates that six of 68 (or nine percent) of possible REH converters will be SCHs.ⁱⁱⁱ Besides those six, there are 174 SCHs that have fewer than 50 beds but are unlikely to convert.ⁱⁱⁱ It is unlikely SCHs will convert to REH unless they are in financial crisis or close to closure. OPPS payments to REHs will be less than current SCH – although the 7.1 percent is established by CMS and annual subject to renewal or change, including elimination, the REH 5 percent add-on is set by law. If CMS reduces or eliminates the current 7.1 percent SCH add-on, other SCHs may consider the REH model at the 5 percent add-on if inpatient care is not necessary in their service area.

25. *In order to calculate the additional annual facility payment for rural emergency hospitals required by section 1834(x)(2) of the Act, CMS will need to compare all CY 2019 payments to CAHs with an estimate of the total amount of payment that would have been made to CAHs in CY 2019 if CAHs were paid through the inpatient, outpatient, and skilled nursing facility prospective payment systems, rather than receiving Medicare payment at 101 percent of the reasonable costs of these services. Are there any claims or other payment reporting issues that CMS should consider when calculating the hypothetical estimated payment under the prospective payment systems for services furnished by CAHs in CY 2019?*

The success of the REH program as an essential access point in rural communities will be contingent on a Medicare payment that is sufficient to afford the cost of providing services and ideally to provide additional critical services to their communities. During the REH conversion consideration, an eligible hospital will need to complete a comprehensive financial pro forma that compares the financial impact of maintaining current hospital designation versus conversion to an REH. Important financial considerations include services area population change, outpatient service volume change, inpatient services contribution margin, and disruptors that may decrease ED and primary care utilization.

NRHA believes that the success of the REH designation is directly tied to having an adequate facility payment that is reflective of the actual cost of providing care. NRHA recommends CMS use a claims-based approach with calculating the estimated facility payment. NRHA believes that CMS should not consider Medicare Disproportionate Share Hospital (DSH), SCH (including the 7.1 percent OPDS add-on), Medicare Dependent Hospital (MDH), low volume or other rural-specific payments when determining the amount the REH may have received under the IPPS, OPDS, or SNF methodology. These amounts vary and many are determined by CMS annually and are subject to change. Lastly, NRHA firmly believes that Medicare sequestration payment reductions should not be applied to REHs as the provider type was not in existence when the provision suspending sequestration was passed by Congress.

It is unclear if the 5% add-on to the outpatient payment is an adequate amount of funding to provide ongoing financial stability for facilities that transform to the REH model. CMS should evaluate the REH reimbursement structure on an ongoing basis to ensure it can support sustained transformation among rural hospitals, particularly in communities that are most at-risk of losing all hospital services if the local facility closes. Additionally, CMS should broadly evaluate the role Medicaid could play in the REH program, including whether policy changes are required to ensure access to care for Medicaid and dual-eligible beneficiaries living in rural areas.

26. *We also are seeking comment on whether the claims forms used by CAHs to report inpatient hospital services, outpatient hospital services, and skilled nursing services contain all of the necessary information in order that the claims could be processed by the applicable CMS prospective payment systems. We are seeking this information because section 1834(x)(2)(C) of the Act requires as a part of the calculation to determine the additional facility payment for CY 2023 for CMS to estimate what CAHs would have received for payment of inpatient hospital services, outpatient hospital services, and skilled nursing facility services if those services were paid through their respective prospective payment systems. We want to know what barriers, if any, we may face when attempting to use CAH claims to perform this calculation. If the CAH claims are missing information that would be required to process the*

claims through a prospective payment system, what challenges could CAHs face in collecting the missing information and submitting it to CMS for processing.

As outlined in the answer to question 25 above, it is important to note that SNF payments to PPS hospitals for swing beds are subject to the SNF-PPS methodology. They claim that “scoring is based, in part, on the Minimum Data Set (MDS) completed for the PPS-swing bed patient.”³ However, the MDS is not required or completed by CAHs. Therefore, the scoring of the payment difference between SNF-PPS and CAH cost-based payment should take this lack of claims data into consideration.

27. The statute requires that a facility seeking to enroll as an REH must provide information regarding how the facility intends to use the additional facility payment provided under section 1834(x)(2) of the Act, including a detailed description of the services that the additional facility payment would be supporting, such as furnishing of telehealth and ambulance services, including operating the facility and maintaining the emergency department to provide covered services. What challenges will providers face to maintain and submit what will likely be similar detailed information about how their facility has spent the additional facility payment for rural emergency hospitals as required by section 1834(x)(2)(D) of the Act? What assistance or guidance should HHS consider providing to facilities to meet this reporting requirement?

NRHA believes that future reporting on intended uses of the additional facility payment should be kept to a minimum. The REH will be a relatively small organization with limited resources, as outlined in our response throughout this RFI. As such, these sparse resources should not be consumed by requiring substantial reporting recourses. In most cases, the additional payment will be necessary to maintain operations and continue providing essential health services to the community. Each REH will be required to complete a cost report in a manner consistent with other hospitals. Reporting to fulfill this requirement should be contained in the annual cost report and not subject to other separate reporting requirements. Additional information required of the REH should not be significant. Technical assistance to meet this requirement should be available to each REH through the Rural Hospital Medicare Flexibility program at HRSA.

Enrollment Process

28. The statute requires that an eligible facility must submit an application to enroll as an REH in a form determined by the Secretary. In accordance with the requirements of the CAA, the application for enrollment must include an action plan for initiating REH services, including a detailed transition plan that lists the specific services that the facility will retain, modify, add and discontinue. What suggestions do facilities who are considering enrolling as REHs want us to take into account in developing the enrollment requirements?

In speaking with our members, NRHA firmly believes that the enrollment process should be as simple as possible and that technical assistance (TA) is needed for the application process. Under-resourced rural providers will need assistance preparing financial pro formas, secure

³ The CMS Revised Swing Bed MDS Assessment Training Manual can be accessed at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/downloads/sbmanual.pdf>

transfer agreements, redesign physical space and repurpose staff, convert swing beds to SNF DPU, and facilitate community conversation about REH conversion. It must be remembered that hospitals looking to convert are likely close to closure and will have most likely have few financial and human resources to compile an application, nor hire consultants. NRHA believes application development and REH initialization support could be done through the Rural Hospital Medicare Flexibility program at HRSA. Further, the approach used for rural PPS hospitals to convert to CAH may be a good template to follow and one that HRSA has experience implementing.

NRHA believes it is important for CMS to encourage community engagement and community health requirements in the application process. Rural facilities and communities will need adequate data in order to make informed decisions about their application process. NRHA encourages CMS to provide site needed Medicare claims data. Further, communities may want to complete a market assessment to establish service area, utilization, service needs for the community, and the like, but they will likely need technical assistance funding in to do so.

29. What considerations should be taken into account regarding the steps and timing for conversion to an REH?

It is important for CMS to remember that the hospitals transitioning to the REH designation, while likely struggling, are already meeting current CoPs. The operational, regulatory, and quality reporting requirements, etc. should not be more restrictive than what they're currently subjected to, and if anything should be more flexible. Most of these facilities will be coming from an under-resourced and under-staffed, likely burnt-out, perspective, so the enrollment, CoP, and quality reporting requirements should be as minimal as possible, while still maintaining sufficient standards.

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