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September 13, 2022

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8012
Baltimore, MD 21244-1850
By electronic submission at http://www.regulations.gov

Dear Administrator Brooks-Lasure:

RE: CMS-4203-NC: Medicare Program: Hospital Outpatient Propsectgive Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs… Rural Emergency Hospitals

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to this proposed rule, focused on sections that fall within the scope of our expertise.

**X. Nonrecurring Policy Changes**

*A. Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes*
The Panel supports the establishment and maintenance of continuous patient care with a health care provider, including in-person visits. We agree that, ideally, patients would consult with clinicians (presumably including primary care providers) before and after telehealth visits. We suggest, however, that access to behavioral health services by rural residents (including Medicare beneficiaries) is at least in part a function of patient comfort seeking those services. Use of telehealth services to meet behavioral health needs has accelerated during the public health emergency (PHE). At least some portion of that acceleration is likely due points of access in mental health service shortage areas, and to first-time users of behavioral health services being more comfortable accessing providers via telehealth from their homes than making a visit to the provider (stigma is a factor inhibiting visits in rural places). The first service use may also arise unexpectedly, at a time distant from any previous in-person contact. Therefore, the Panel recommends that CMS investigate the benefits and unintended consequences of a policy allowing first-time behavioral telehealth consultation. Similarly, CMS should study the requirement for a post encounter visit within 12 months. The Panel commends the decision, consistent with section 1834(m)(8)(B)(i) of the Consolidated Appropriations Act of 2022, to delay applying in-person visit requirements until 152 days after the end of the PHE for COVID-19. The Panel commends CMS recognition of the need to allow mental health services using audio-only technology, responsive to patient needs based on “technological limitations, abilities, or preferences. (p 44679 of the *Federal Register*). We would caution that CMS should not create undue burden for hospitals to support the reasons for audio-only. We suggest patient attestation would be sufficient.

**XVI. Requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program**

*Request for comment on six specific measures enumerated in the notice.* The Panel's response to a request for information (RFI) in 2021 suggested adopting these measures that are also listed in the proposed rule (pp 44760 – 44762):

- OP – 2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- OP – 3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP – 18: Median Time From ED Arrival to ED Departure for Discharged ED Patients
- OP – 22: Left Without Being Seen

CMS is considering using OP – 4: Aspirin on Arrival, a measure topped out at the national level. The Panel is reluctant to recommend adopting a measure no longer NQF-endorsed. We do not recommend adopting OP – 20: Door to Diagnostic Evaluation by a Qualified Medical Professional. As stated in the notice, we agree with the concerns about proven relationship to better patient outcome, and variation unrelated to performance of an REH and its clinical personnel. We agree with the National Advisory Committee on Rural Health and Human Services in using the measure of "how well key patient information is communicated from an ED to any health care facility" (p 44762).

*Request for comment on use of telehealth and quality measures related to encounters using telehealth (p. 44763)*: The Panel recommends supporting telehealth usage by REHs as a means of tapping additional clinical expertise, using the framing of Project Echo to support primary care providers in REH facilities.

*Request for comment on quality measures for behavioral health services in rural and rural emergency settings, and how ways REHs could use telehealth*: The Panel endorses CMS interest in how REHs will help meet the behavioral health needs of rural residents. Rural America continues to experience high rates of substance use disorders, suicide, and other dire mental health challenges. An increased use of behavioral health services during the PHE (with associated waivers) increased use of telehealth. REHs, as critical points of access (particularly in noncore counties), will have an important role in maintaining access to behavioral health services. The Panel recently described behavioral health needs of farm families during times of economic distress (https://rupri.org/wp-content/uploads/Economic-Disruption-brief-4-February-2022.pdf), recommending increased use of telehealth and designated rooms/areas in health care facilities for patient-provider interactions – REHs could repurpose space for that purpose. In a 2019 paper focused on behavioral health needs in rural American (https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf), the Panel recommended supporting delivery system models involving Federally Qualified Health Centers, Rural Health Clinics, and rural hospitals. We would now add REHs to that recommendation. We also reiterate our recommendation to modernize telehealth policies to expand use of technology to improve prevention, enhance access to care, and promote recovery.

*Request for comment on potential future quality measures for emergency care services in rural and rural emergency settings (page 44764):* The REH presents an opportunity to require two measures relevant to rural emergency care which are currently available and/or being used in other programs, but which are not currently part of the CMS IQR or OQR programs.

- ED CAHPS (Emergency Department Consumer Assessment of Health Care Providers and Systems): Patient experience of care would be important to assess in a new provider type and is a key consideration in quality. ED CAHPS is now a standardized measure but not yet required in any of the CMS reporting programs.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ED (For those REHs which will do outpatient surgery, there is a related opportunity to require Outpatient Ambulatory Surgery CAHPS.)

- EDTC (Emergency Department Transfer Communication): With REHs focusing on triage and transfer, adequate and timely information sharing with the receiving site is essential. The EDTC Measure assesses this information and is appropriate for both public reporting and for improvement. EDTC is currently a core measure in the MBQIP program for critical access hospitals. https://stratishealth.org/toolkit/emergency-department-transfer-communication/

In addition to focusing on patient experience and coordination of care, the Panel encourages a quality and measurement focus on time-critical emergency care (e.g., heart attack, stroke, trauma, and sepsis), which is core to what REHs will be doing in their communities. The Panel also encourages CMS to consult the 2018 NQF report, MAP Rural Health Final Report – 2018: https://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx. The rural experts who authored this report recommend adoption of currently available measures, of which EDTC and alcohol use screening will be relevant to REHs. The report also recommends future rural measure development in access, transitions, substance use, cost, and clinical outcomes.

*Request for comment on potential future quality measures for health equity in rural and rural emergency settings (page 44764)*: The Panel believes a focus solely on clinical care would miss a tremendous opportunity to address broader health needs of rural communities through the actions of REHs to transform how care is delivered. We believe the intent of providing additional payment and requiring plans for how those funds will be used should serve as the basis for REH engagement with public health, community-based organizations and others to address community health needs, including meeting needs of traditionally underserved populations. We have commented on this previously in response to the RFI in 2021. Applications for REH designation should include specific plans for collecting and assessing data that capture social needs in their communities. The data and assessment should be shared with community-based organizations in the REH community and region that can help resolve problems arising from circumstances beyond the reach of clinical treatment, but which can lead to the need for emergency care. As part of more broadly-based policies within health and human services programs, resources could be targeted to screen for social determinants of health and ability to execute treatment plans. Circumstances affecting traditionally underserved populations should be specified and addressed by the community; REHs should have a role in helping the community do so.

*Request for comment on National Quality Forum report's recommendations for addressing low volume issues:* The Panel endorses the NQF report recommendations.

**XVIII: rural Emergency Hospitals Payment Policies, Conditions of Participation, Provider Enrollment, Use of the Medicare Outpatient Observation Notice, and Physician Self-Referral Law Updates**

*Request for comment on whether CMS should adopt a narrower definition of REH services than what is being proposed*: The Panel strongly supports the broadest possible definition of services provided by REHs under the outpatient prospective payment system (OPPS). We concur with the CMS reasoning that Congressional intent in creating the REH designation was to assure access to emergency and outpatient services in rural places at risk for losing those services. CMS is correct in identifying specific services that are vital to the health of rural populations, including behavioral health and clinic visits, which can be sustained by REHs as outpatient services. The Panel cautions, however, that there could be unintended consequences of the

broad definition. CMS will need to carefully monitor development of REHs as a point-of-service in larger systems who use the designation as a means of generating higher payment for services that would otherwise be available at lower prices. We do not see this is as a significant threat to the intent as described by CMS, but even a remote possibility for unintended use of the payment mechanism warrants attention.

*Request for comment on proposal to include REHs as a covered origin and destination for ambulance transport and that an REH that owns and operates an ambulance transportation may enroll in Medicare as an ambulance provider*: The Panel commends CMS for recognizing the need to allow REH-owned ambulance services to enroll in Medicare and receive payment under the ambulance fee schedule (AFS). We do so because high quality ambulance service is an essential component of emergency medical services, and rural hospitals (and by extension REHs) often are the sole providers of those services in their communities.
*Request for comment on requiring that an REH submit an annual report with detailed description of identity of each owner or investor in the REH (page 44792), and previous consideration of an exception to referral and billing prohibitions for ownership or investment in REHs (Page 44791):* The Panel concurs with CMS that an exception to the physician self-referral law's prohibitions on referrals for designated health services (DHS) rendered by the REH. Given the fact that REHs will not be considered 'hospitals' once they convert from being critical access or small rural hospitals, the exceptions that currently exist for providers in the rural context, i.e. the rural provider exception and the whole hospital exception, will not apply to REHs. The panel agrees with CMS that without a broadly-applicable exception to referral and billing prohibitions, the rendering of medically necessary DHS to rural residents and the ability of providers within REHs to make high-quality decisions about the care of rural residents would be significantly limited. The Panel supports a scenario in which REHs are required to submit an annual report detailing the identity of each investor and each owner in the REH in order to mitigate fraud and abuse.

**XIX. Request for Information on Use of CMS Data to Drive Competition in Healthcare Marketplaces**

The Panel welcomes CMS' recent release of data on hospital and SNF changes in ownership and its intention to update the data on a quarterly basis. As CMS recognizes in the request for information, the full range of implications of increased provider consolidation will be critical for access to services for underserved populations, including rural residents. We respond below to the four questions posed for comment.

*1. Additional data from form 855A (PECOS):*
Analysis of the effects of provider consolidation would benefit from CMS releasing data on all practice locations and service areas:

- Hospitals: include hospital – owned clinics
- Community Mental Health Centers (CMHCs) – there could be central location and satellites
- Home Health Agencies (HHAs) – likely to be very geographically dispersed.
- Releasing information on chain home office would also be helpful, especially for SNFs and HHAs.

*2. Changes in ownership for additional types of providers:*
The Panel suggests releasing the same change of ownership information for CMHCs and for HHAs (and sub-units). Both types of providers are particularly important to meeting needs of underrepresented and underserved populations, given their disproportionate likelihood of behavioral health and chronic medical conditions, and the roles these providers have in assuring access to services close to the population most in need.

*3. What additional information would be useful for the public or researchers:*
The Panel encourages continuous interaction with researchers seeking to understand short-term and long-term consequences of mergers, acquisitions, and affiliations for access to comprehensive and continuous services for underserved populations. This requires knowing the interests of regional and national systems in incorporating a variety of provider locations into a single system (such as primary care clinics, federally qualified health center look-alikes, rural health clinics, CMHCs, and hospitals); and tracking conversion of facilities after being part of a larger system. A pertinent example starting in 2023 will be conversion of small rural hospitals (particularly CAHs) into the new REH classification.

*4. Use of the PECOS data given questions of validity and revalidation beginning in 2016*
The Panel echoes ASPE's concern about the validity of the self-reported data in PECOS. We welcome completion of initial round of revalidation. We do not believe that it would be particularly valuable (given resource constraints and data collection burden) to extend that effort prior to 2016. We urge CMS to explore additional means of verifying provider accuracy in reporting "ultimate parents" or other owners in the ownership chain.

Respectfully submitted,

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