



RUPRI Health Panel

Keith J. Mueller, PhD, Chair
Alva O. Ferdinand, DrPH, JD
Alana, Knudson, PhD
Jennifer P. Lundblad, PhD, MBA
A. Clinton MacKinney, MD, MS
Timothy D. McBride, PhD
<https://rupri.org/>

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RE: Comment on the proposed rule for Medicare hospital outpatient prospective payment system (OPPS) program and the Request for Information (RFI) on Rural Emergency Hospitals (REH)

The Rural Policy Research Institute Health Panel was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to comment in response to the proposed rule for Medicare hospital outpatient prospective payment system (OPPS) program and the Request for Information (RFI) on Rural Emergency Hospitals (REH). Our comments will focus only on the latter, Section XVII of the proposed rule, Federal Register pages 42285 - 42289. We also limit our comments to specific questions, numbered as they are numbered in the RFI. The Panel considers forthcoming Rural Emergency Hospital (REH) policies and regulations an opportunity to facilitate the REH as an integral part of a high-performing rural health system; that is, a rural health system grounded in equity and delivering access, affordability, community health, and quality.¹ We will comment on selected questions from the RFI, using the question numbers as published in the RFI.

Type and Scope of Services Offered

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

RUPRI Health Panel Comment: REHs should be authorized as originating sites for all appropriate telehealth services, including emergency services, behavioral health services, and virtual visits with clinicians in distant locations. More specific delineations of services originating in REHs should be part of decisions made regarding continuing telehealth services authorized during the public health emergency. Stakeholders may include a regional health care strategy in emergent and non-emergent transfer agreements.

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.

¹ Rural Policy Research Institute Health Panel. High-Performing Rural Health System. September 2021.

RUPRI Health Panel Comment: REHs should be allowed to include these programs and clinics, but not required to do so. Any reporting requirements should consider scale and scope of services and resource limitations. The principle inhibiting factor will be recruiting and retaining appropriate staffing. REHs should be required to have the capacity to administer the first dose of buprenorphine and refer patients to a program/clinic for further care, either within the healthcare organization of the REH or elsewhere. If the REH is not the primary substance use disorder treatment home for the patient, that patient should have the ability to maintain continuity of care with their clinic.

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?

RUPRI Health Panel Comment: REHs are likely to face the same challenges faced by small inpatient facilities, such as insufficient patient demand to finance all maternal health services, labor shortages even if there is available revenue, and the need for timely services in certain situations. This is a broader concern in many rural (and inner city) communities. REHs could be encouraged to submit plans for addressing emergency obstetric needs and how they will integrate continuous care with maternal care providers outside their communities.

Health and Safety Standards, Including Licensure and Conditions of Participation

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 particularly be aware?

RUPRI Health Panel Comment: CMS should carefully consider the frequency of surveys regarding compliance with CoPs; for CAHs the frequency is every three years, which seems reasonable. Survey requirements should be aligned across different provider types who are under a single governance structure (e.g., REHs and clinics).

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?

RUPRI Health Panel Comment: Addressing the social needs of a diverse population is supported by having a workforce that is also diverse. REHs should strive to improve workforce development by recruiting and retaining diverse clinical staff and maintaining an inclusive healthcare environment. On a system level, REHs should provide training and educational opportunities to understand areas of opportunity on a micro and macro level to address current social determinants of health initiatives. Rural policy initiatives must address barriers to treatment access and identify solutions to reduce barriers to care.

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 (for example, mental health conditions and substance use disorders), and/or intellectual and developmental disabilities?

RUPRI Health Panel Comment: 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 conditions that affect health status 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.

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? In addition, with regards to governance and leadership, how can the CoPs:

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

RUPRI Health Panel Comment: Applicants for REH designation should describe processes and actions they will take to incorporate the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards), as published by the Office of Minority Health, U.S. HHS:

<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>. Especially relevant to this specific question are the three standards on governance, leadership, and workforce.

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 need for REHs to partner with community-based organizations in order to improve a patient's care and outcomes after discharge?

RUPRI Health Panel Comment: As stated in our response to question 11, REHs should play a leadership role in their communities to identify social determinants of health and work with community-based organizations to address them. To further strengthen abilities to address social determinants affecting the health of individual patients, REHs should be encouraged to include in their applications a plan for sharing information with other organizations. Modern electronic health records include closed-loop referral systems that would be helpful such as NoWPoW, Aunt Bertha, and Unite Us.

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?

RUPRI Health Panel Comment: Training should be provided to implement National CLAS standards. Training should be ongoing and include health equity skills specific to job

descriptions. On a system level, policies could be changed accordingly to improve equitable service delivery.

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?

RUPRI Health Panel Comment: Accessing services not available in the REH will remain a challenge for local residents. We recommend applicants for REH designation consider patient needs for services elsewhere that are integrated with the services provided by the REH. This can be done through telehealth (discussed earlier) and through referrals to transportation services.

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.

RUPRI Health Panel Comment: The application process for entities to become REHs creates an opportunity to bring community providers (clinical and nonclinical) together to develop community-based plans to assure appropriate care is provided, including protocols for EMS. The Panel recommends that a program be established within the federal government, similar to the Medicare Rural Hospital Flexibility Program, to provide grant funding and technical assistance to REHs and community collaborators that leverages the REH designation to instigate collaborations addressing community needs, including EMS.

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 programs, 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 measures, specific to REHs, should be developed?

RUPRI Health Panel Comment: Of the current Outpatient Quality Reporting (OQR) measures, those most likely to be relevant to REHs will be measures:

- 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

- OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
- HCP/IMM3: Health Care Personnel Influenza Immunization (an IQR measure which includes staff in outpatient departments)
- XXXX (coming soon): COVID-19 Vaccination Coverage Among Health Care Personnel Measure

However, in the current OQR proposed rule, measures OP-2 and OP-3 are proposed to be removed, and a new combined measure is proposed beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination. This new combined measure – ST-Segment Elevation Myocardial Infarction (STEMI) electronic clinical quality measure (eCQM) – would be the first eCQM in OQR.

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, sharing information adequately and timely with the receiving site is essential. The EDTC Measure assesses this 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, which is core to what REHs will be doing in their communities, for example, heart attack, stroke, trauma, and sepsis. 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.

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?

RUPRI Health Panel Comment: REHs will be particularly impacted by low-volume performance measurement issues.

- The Panel commends the low-volume strategies suggested in the National Quality Forum 2019 report, Addressing Low Case-Volume in Healthcare Performance Measurement of Rural Providers, in which, “CMS tasked NQF with eliciting expert input on promising statistical approaches that could address the low case-volume challenge,

as it pertains to healthcare performance measurement of rural providers.” [NQF: MAP 2019 Recommendations from the Rural Health Technical Expert Panel Final Report \(qualityforum.org\)](#)

- Another potential mitigation is to prioritize measures that are broadly applicable (vs. condition specific). EDTC, EDCAHPS, and OP-18 are examples of such cross-cutting measures.
- Another potential barrier is staff time and expertise to participate in quality reporting as staff are likely to have multiple varied responsibilities in a low-volume environment (mitigated to a certain degree with appropriate technical assistance).

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?

RUPRI Health Panel Comment: There are two primary barriers and challenges anticipated for REHs related to electronic submission of quality measures, one is the lack of relevant measures and the other is the wide variability in electronic health records:

- Current hospital eCQMs required by CMS in the IQR and Promoting Interoperability requirements are related to inpatient care and not relevant to outpatient care. There are no current eCQMs in the OQR program, although one measure is proposed.
- While CAH electronic health record adoption is widespread, there is variation in the capabilities of the EHR vendors typically serving CAHs to accommodate eCQMs efficiently. Significant costs may be required to add EHR capabilities and ensure technically proficient staff needed for data collection and submission by REHs.

CMS has proposed that all quality measures should be digital by 2025. It is important that resources and support are available to keep small rural facilities (CAHs or REHs) aligned with this overall direction of quality measurement such that there continues to be opportunities for CAHs and REHs to demonstrate their level of quality for comparable services.

It may be worth exploring whether any claims-based measures are an option for REHs, to reduce data collection burden. Claims-based measures are another CMS priority, including some hybrid measures which use clinical data submitted electronically to enhance risk adjustment done currently just using claims. However, none of the ED measures are currently claims based.

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?

RUPRI Health Panel Comment:

- Balanced set of measures which assess Safe, Timely, Effective, Efficient, Equitable, Patient-Centered care (the IOM aims).
- Consideration of low volumes.
- Alignment of the required quality measures appropriate to REH services across the CoPs (including Quality Assessment Performance Improvement requirements) and publicly reported measures.
- Caution when comparing quality data pre- and post-conversion to REH due to service mix variability between REH status and CAH/PPS status.

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 of REHs?

RUPRI Health Panel Comment: As with all sites of care, public reporting of quality measures is important for clinicians and health care organizations, and for the people that they serve. However, for a new type of health care organization designation, a stable set of metrics and the testing of those metrics is necessary before public reporting. This is an opportunity for good quality metric design and reporting processes to be phased in, with technical assistance to REHs provided along the way. An opportunity to incentivize quality reporting would be to offer rural health clinical documentation training programs. A clinical documentation improvement specialist or physician advisor within the REH or partnered with the REH remotely to provide advice could help improve documentation and coding competency may help increase accuracy and optimize the case mix index.

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 report REH quality measure data?

RUPRI Health Panel Comment:

- The Panel recommends a quality measurement and reporting glide path since the REH is a new designation – for example, reporting for one year confidentially during which an REH receives their data back, then one year of public reporting REH performance in the aggregate, then reporting at the facility level. As each new REH is certified, they could be placed on a 2-3 year glide path before their facility-specific results are publicly reported.
- Patients are not likely to be selecting a specific REH when seeking emergency care. As a result, public reporting of quality measures for REHs is more about quality as a leadership endeavor (attention is the currency of leadership and improvement requires measurement) than it is about consumer decision making.

Payment Provisions

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?

RUPRI Health Panel Comment: The REH additional facility payment is an opportunity for the REH to become an integral part of a high-performing rural health system; that is, a rural health system grounded in equity and delivering access, affordability, community health, and quality.²

² Rural Policy Research Institute Health Panel. High-Performing Rural Health System. September 2021.

Thus, the REH application should stipulate how the REH will advance these four rural health goals. For example, the additional facility payment might be used to ensure equitable health care, expand primary care access, improve operational efficiency, address community health needs, and/or advance clinical quality.

The REH will likely be an under-resourced health care facility. Therefore, CMS should minimize REH application and performance reporting burden while ensuring accountability to community. Technical assistance should be made available during the REH application process (e.g., technical assistance for financial projections, community engagement, and inter-hospital agreements). Standard reporting templates should be employed to collect consistent REH performance information. These performance data may then be used to inform REH quality measure development.

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?

RUPRI Health Panel Comment: CMS should consider allocating funding to provide technical assistance to prospective applicants, using expertise in rural health systems planning and innovation.

The Panel appreciates the opportunity to offer comments on this proposed rule.

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Keith J. Mueller, PhD, Chair
Alva O. Ferdinand, DrPH, JD
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