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December 22, 2011

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS-3244-P, Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation.

Dear Dr. Berwick:

The National Rural Health Association (NRHA) is pleased to offer comments on the CMS proposed rule on reforming and simplifying the Conditions of Participation (CoPs) for Critical Access Hospitals (CAHs). We appreciate your continued commitment to the needs of the 62 million Americans residing in rural areas, and look forward our continued collaboration to improve health care access and quality in these areas.

NRHA is a non-profit membership organization with more than 21,000 members nation-wide 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 government advocacy, communications, education and research.

As you know rural providers, hospitals and patients face a number of challenges in the delivery quality health care. Long distances, under insurance and lack of providers are significant hurdles to beneficiaries' access to care. Narrow margins, inability to recruit and uncertain payer mixes are similarly daunting to the dedicated professionals working in rural environments.

We, therefore, appreciate CMS' continued emphasis on narrowing the gap between rural patients and their providers. We are also appreciative of CMS' desire to simplify CoPs for CAHs and to provide flexibility to these vital safety net facilities. This letter outlines suggestions for which the NRHA believes this notice of proposed rulemaking (NPRM) can be strengthened. We look forward to our continued collaboration in ensuring the one-quarter of Americans.

I. Definitions and Provisions of Services:

CFR § 485.635(b) requires that all CAHs providing “diagnostic and therapeutic services that are commonly furnished in a physician’s office or at another entry point into the health care system”, laboratory services, radiology services, and emergency procedures provide CAH employed staff for these services. The regulation prohibits the use of “contract services” or those services provided by contracted health care providers not directly employed by the CAH.

As stated in the NPRM, a long standing inability to recruit a strong medical workforce has produced significant challenges to delivery. Lack of financial incentives for physicians and non-physician practitioners and many other unique factors have long contributed to an enormous shortage of rural health care workforce and, therefore, meaningful access for all rural Americans. The current limitation on contracted services has exacerbated this shortfall and made it more difficult to provide needed services. The resulting gap in access to certain services has forced rural patients to travel longer distances to access critical care.

NRHA is pleased with CMS’ decision to modify its limitation on contract services.

II. Other modifications

CMS asked for comments on a number of the issues presented in the NPRM and for further input generally. NRHA has long been concerned with the CMS’ decision to reinterpret statute by requiring direct supervision of outpatient therapy services. In our comment on the NPRM for the OPPTS we noted that the “general level” of supervision for the included services has always been considered acceptable from a quality and safety point of view.

Procedures that were only performed 30 years ago by physicians are now considered under the normal professional and training scope of lower level nurse practitioners. Additionally, the training expectations for certain outpatient therapeutic services are such that it is more likely a much larger part of a lower level provider’s scope of training than that of physicians. We continue to believe that a general level of supervision is both adequate and clinically appropriate for outpatient therapy services.

NRHA appreciates and agrees with CMS’ sentiment that patient safety is the most important factor and the basis of the proposal to set a default “direct supervision” setting. Nonetheless we reaffirm the position that a general level of supervision for the services in question has typically been considered safe, sufficient, and a normal standard for practice. The fact that CMS continues to insist on the direct supervision standard as its default standard is a continuing cause for concern for many small rural hospitals.

III. Regulatory Modifications

Backed by a strong network of rural providers, NRHA believes quality improvement and CoP modifications can be implemented quickly and effectively in rural settings. Because of their smaller nature there are less bureaucratic hurdles and changes can be easily embraced.

However, these small facilities may also face significant challenges in administering and implementing changes. Many facilities have relatively small administrative staffs and large scale changes can be burdensome to put into practice. We encourage CMS to allow for significant latitude and flexibility in helping these facilities maintain access and comply with regulatory requirements.

Thank you for the chance to offer comments on this proposed rule, and for your consideration on our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to care. If you would like additional information, please contact David Lee at dlee@nrharural.org, or 202-639-0550.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is centered below the word "Sincerely,".

Alan Morgan
Chief Executive Officer
National Rural Health Association