



Medicare Payment  
Advisory Commission

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Michael E. Chernew, Ph.D., Chair  
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July 27, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**RE: File code CMS-3419-P**

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS's) proposed rule entitled "Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals and Critical Access Hospital CoP Updates," *Federal Register* 87, no. 128, pp. 40350–40404 (July 6, 2022). We appreciate CMS's ongoing efforts to administer and improve Medicare's hospital payment policies, particularly given the many competing demands on the agency's staff.

In this letter, we comment on CMS's proposal regarding staffing requirements for rural emergency hospitals (REHs).

**REH staffing requirements**

In June of 2018, the Commission recommended that the Congress allow isolated rural stand-alone emergency facilities that would be open 24 hours a day, 7 days a week, to participate in Medicare.<sup>1</sup> In making this recommendation, the Commission's goal was to have an emergency facility that rural individuals could go to and be assured that someone would be on site when they arrive to either treat or stabilize and transfer them to another facility.

In the Consolidated Appropriations Act (CAA) of 2021, the Congress created a new category of provider, the rural emergency hospital. The legislation requires that:

- (i) "The emergency department is staffed 24 hours a day, 7 days a week."

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<sup>1</sup> Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

(ii) “A physician (as defined in section 1861(r)(1)), nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)) is available to furnish rural emergency hospital services in the facility 24 hours a day.”

In this proposed rule, CMS notes that the statute does not speak to the type of staff that is required to fulfill the requirement that the REH emergency department (ED) be staffed 24 hours a day, 7 days a week. CMS therefore believes that REHs should have the flexibility to determine how to meet this requirement. CMS expects that an individual(s) staffing the ED—such as a nurse, nursing assistant, clinical technician, or emergency medical technician (EMT)—is available to receive patients and activate the appropriate medical resources for the treatment of the patient but does not propose any specific requirements. CMS also proposes that many of the CAH staffing requirements are appropriate for REHs, such that there be a doctor of medicine or osteopathy, PA, NP, or clinical nurse specialist with training or experience in emergency care on call and available by telephone or radio contact and available on site within specified time frames (either 30 or 60 minutes). CMS seeks comment “on the proposed staffing requirements for the provision of emergency services in an REH to gain insight on the appropriateness of not requiring a practitioner to be on-site at the REH at all times.”

### ***Comment***

The Commission does not believe that CMS’s proposed staffing requirements would meet acceptable standards of practice or the goals of the new REH designation. The proposed conditions of participation suggest that, unlike critical access hospitals (CAHs), the REH is required to be open 24 hours a day with some staff in the facility. We concur with this determination. However, the proposed rule suggests that the staff could be a nurse, nursing assistant, or an EMT.

Given our past discussions with CAH employees over the last two decades, we believe a nursing assistant or EMT will be insufficient if a clinician with a higher level of training is not immediately available.

Given the level of investment Medicare’s new monthly fixed payments to REHs represent—which CMS in a separate rule proposes to initially be \$268,294, equivalent to over \$3.2 million per year<sup>2</sup>—we contend that these facilities should not be allowed to meet the 24/7 ED staffing requirements using the standards in the CAH conditions of participation. Instead, the Commission asserts that the Secretary should use his authority to require REHs to have at least one physician, nurse practitioner, clinical nurse specialist, or physician assistant with training or experience in emergency care staffing their ED 24 hours a day, 7 days a week. These clinicians should be required to be physically located on the hospital campus (or in adjacent buildings such

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<sup>2</sup> Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating. Proposed rule. CMS-1772-P.

as a clinic) to meet the REH staffing requirements. The creation of REHs represents a substantial investment by Medicare in maintaining or improving access to ED care among rural beneficiaries. In essence, Medicare will be providing extra funding to make sure rural beneficiaries do not face excessive travel times when seeking emergency care. However, without requiring a clinician to be physically present at REHs 24/7, the Commission is not convinced that the new REH program will achieve its goals, as some REHs might staff their EDs the way they previously have staffed CAHs. For example, during a MedPAC site visit to a CAH, we found that the most advanced staff available 24/7 in the ED was often a licensed practical nurse (LPN). When a patient presented to the ED, the LPN could call an off-site physician located in a neighboring town 25 miles away (which also had a CAH) who would then need to travel to the hospital to treat the patient. The CAH's medical director and administrator both acknowledged that, while this arrangement met CAH conditions of participation, it was insufficient to deal with emergencies, and, in some cases, the hospital administrator directed ambulances to bypass their hospital and travel to a CAH that was staffed 24/7 by a physician, nurse practitioner, or physician assistant. For the REH program to achieve its primary goal of providing emergency access, the CAH conditions of participation are insufficient.

We also note that the CAH CoPs have the expectation that a clinician can arrive at the CAH in 30 or 60 minutes. It is not always clear that they meet this expectation. In a 2007 survey of CAHs, the University of Minnesota Rural Health Research Center found that “respondents in 91% of these hospitals report that physicians can always get to the ED when needed in an appropriate time (as defined by the respondent), but 9% of hospitals indicated that this is not always the case.”<sup>3</sup> This finding reinforces that the CAH CoPs for staffing are insufficient to ensure true emergency-level care capacity at REHs.

### **Standby payments for standby costs**

Rural advocates point to the difficulty of staffing emergency rooms in rural areas. From MedPAC's perspective, that is precisely the reason for the additional fixed payment that REHs will receive. We assert that the purpose of the extra funding, at least as we envisioned in our 2018 recommendation, is to support standby costs and allow the REH to guarantee someone is in the hospital when the patient shows up at the emergency room door.

The key question is whether having someone on call and expected to be available within 30 minutes meets the intent of the REH law. Because the primary purpose of the REH is emergency access—and Medicare is making higher payments to support this access—the facility needs to be open 24 hours a day, staffed 24 hours a day, and have a clinician with training in emergency medicine immediately available.

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<sup>3</sup> Casey, M. M., D. Wholey, and I. S. Moscovice. 2007. *Rural emergency department staffing and participation in emergency certification and training programs*. Minneapolis, MN: Upper Midwest Rural Health Research Center.

**Conclusion**

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a long horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.  
Chair