OCHIN

A driving force for health equity

Submitted electronically via regulations.gov

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: *Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and additional policies*

Dear Administrator Brooks-LaSure,

On behalf of OCHIN, we appreciate the opportunity to offer comments on the proposed rule concerning Medicaid policies, Critical Access Hospital policies, and the Medicare Hospital Outpatient Prospective Payment System for calendar year (CY) 2025 (OPPS). OCHIN is a **national nonprofit health information technology innovation and research network** comprised of over 2,000 community health care sites with more than 34,500 providers serving 6.3 million patients and includes Critical Access Hospitals (CAHs), rural and frontier health clinics as well as federally qualified health centers (FQHCs) and local public health agencies in 40 states. We applaud and strongly support the proposed requirement to make continuous enrollment for children part of every state Medicaid plan as this will drive improved health outcomes not only in the short-term, but the long-term as access to care during early development has a lifetime of health effects.

OCHIN: 21ST CENTURY EQUITABLE ACCESS TO HEALTH IT

Since its inception in 2000, the OCHIN collaborative of community providers has focused on expanding access in underserved and rural communities to quality health care services through technology solutions, technical assistance, operational support, informatics, evidence-based research, workforce development and training, and policy. In the OCHIN network, over half of our members' patients are covered under Medicaid, 18 percent are uninsured, 54.3 percent live at or below the federal poverty level, and one in three prefer a language other than English.

OCHIN has also partnered with OSIS, another non-profit technology services organization that is a network of health centers. Together, OCHIN and OSIS collectively support over 39,000 providers serving more than 9.3 million patients. By collaborating to develop affordable and tailored health information technology and services for providers in systemically underserved communities, our partnership with OSIS builds the resilience of both networks and will help transform care for roughly 30% of the estimated 31.5 million health center patients nationwide. Our partnership will also bring greater community healthcare center (CHC) representation to national health equity research and advocacy by augmenting the OCHIN-led **ADVANCE Clinical Research Network** and voluntarily contributing to practice-based research and innovation powered by the largest collection of de-identified community health data in the country.

RECOMMENDATIONS

OCHIN appreciates CMS' continued commitment to the needs of Americans in rural and underserved communities. We also underscore the need for high-quality hosted certified and maintained 21st century health information technology to level the playing field for providers serving in rural and underserved communities. Currently, many rural and underserved providers have not received their fair share of funding to modernize their health information technology systems. Access to hosted and maintained certified health information technology allows providers in rural and underserved communities to better manage patient care, support care coordination (via e-Consults, closed-loop referrals, etc.), and collect and report data. By bringing our providers health IT systems into the 21st century, they can better meet the needs of their patients, including improving child and maternal health outcomes. Therefore, **we urge CMS to prioritize and direct funding that supports providers' adoption of interoperable health information technology that will drive interoperability**.

OCHIN offers the following key recommendations with additional supporting comments contained in the appendix. To advance access to underserved and rural communities, OCHIN urges CMS to:

- **Finalize the proposed requirement that all state Medicaid and CHIP programs provide continuous coverage for children under 19.** Many children and their families face significant challenges maintaining continuous Medicaid coverage due to reasons unrelated to eligibility, including administrative requirements. Churn—where a child is eligible, not eligible, and then eligible again—drives disruption in medical care that impacts their development and health long-term. Continuous coverage not only improves the health status of individuals but lowers the cost of care over the lifetime of a patient. The implications for rural patients are even more pronounced. **Medicaid and CHIP cover almost half of all rural children.** Rural residents are more likely to have a lower-income and face barriers to employment and for individuals that are employed, rural employers are less likely to provide insurance. Medicaid fills in gaps in coverage and access in rural America. In other underserved communities and in the OCHIN network, about 50 percent of our members' patients are covered by Medicaid and continuous coverage is critical for whole patient care. **We strongly support CMS' proposal to make continuous eligibility for children enrolled in Medicaid and CHIP a requirement for state Medicaid plans.**

- **Exempt rural hospitals and CAHs from the proposed Conditions of Participation (COPs).** We are extremely concerned with the current trend of obstetrics unit closures and the impact that complying with requirements in the new COPs will have on the remaining OB units in rural hospitals. **Imposing one-size-fits-all COPs on rural hospitals and CAHs will lead to more OB unit closures.** Imposing additional COPs on already under resourced rural hospitals and CAHs will undermine CMS' goal of improving maternal health outcomes. Rural hospitals disproportionately rely on Medicare and Medicaid reimbursement as they make up most of their patient population. The magnitude of the effect of not complying will have a chilling effect on rural hospitals such that they will preemptively cease providing OB care to preserve their participation in Medicare and Medicaid.

  One way CMS can help improve rural maternal health outcomes is to assist rural hospitals with OB readiness and specialty care access. OCHIN asks CMS to support efforts to establish a virtual specialty network demonstration through CMMI similar to what is outlined in S. 4078/H.R. 7149, Equal Access to Specialty Care Everywhere Act. OCHIN also asks that CMS provide resources, such as technical assistance, to help rural hospitals achieve the goals of improving maternal care. For

example, S. 4079/H.R. 8383, the Rural Obstetric Readiness Act would help prepare rural hospitals and providers to handle the obstetric emergencies that come into their emergency rooms. This would be achieved through supporting facilities with the purchase of necessary equipment and developing a workforce that is able to respond, creating a pilot program to support statewide or reginal networks of obstetric care teams to provide tele-consultation, and creating an obstetric emergency training program for rural facilities that do not have a labor and delivery unit. While this program would be housed in the Health Resources and Services Administration, it can serve as a model for the kind of technical assistance that CMS could help provide.

Thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work together towards our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss further, please contact me at stollJ@ochin.org.

Sincerely,

Jennifer Stoll
Chief External Affairs Officer

APPENDIX

Medicare Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services and Diagnostic Services Furnished to Hospital Outpatients. CMS proposes to continue its flexibility to allow the availability for virtual direct supervision of CR, ICR, and PR services through December 31, 2025. **OCHIN appreciates this extension and urges CMS to finalize it.** A continuation of this policy is key for providers because they need time to reorganize and readjust policies to meet pre-Public Health Emergency (PHE) rules again.

Medicaid Four Walls Exception Extended. States may offer Medicaid clinic services as an optional benefit category. One requirement for this benefit is that Medicaid clinic services be furnished onsite. This is referred to as the "four walls" requirement. CMS proposes to expand the exceptions to the four walls requirement to clinics in rural areas, IHS and tribal clinics, and behavioral health clinics. **OCHIN supports these proposed exceptions as they will foster access to care for rural and tribal communities.**

- CMS is soliciting comments on how to define rural for the purposes of exempting clinics from the four walls requirement. CMS is considering whether to apply a federal definition, allow states to adopt a state or federal definition, or to not define rural at all. **OCHIN suggests that CMS allow states to choose a state or federal definition of rural in order to meet their unique geographic needs.** Oftentimes when CMS applies a broad definition, like Metropolitan Statistical Area (MSA) or non-MSA to policies, certain rural communities are improperly grouped with urban areas. Giving states the ability to choose a state or federal definition that works best for their rural communities will ensure that clinics that would most benefit from the exception are eligible. Alternatively, CMS could use the Federal Office of Rural Health Policy definition[1] of rural to establish exemption criteria.

Shortening the prior authorization timeline for Medicare fee-for-service (FFS) outpatient requests to 7 calendar days. We appreciate that CMS is aligning the timeline for standard outpatient department requests with that of other payers. This proposal will create equity for all patients waiting to access care and will reduce provider burden by streamlining processes across all payers.

Conditions of Participation (COPs) related to the organization, staffing, and delivery of services in an OB unit. We are particularly concerned with the requirements for equipment at proposed § 482.59(b) § 485.649(b). CMS proposes that hospitals and CAHs have a call-in-system, cardiac monitor, and fetal doppler or monitor available to labor and delivery room suites. We ask that CMS clarify its definition of "available." Many rural hospitals and CAHs likely have this equipment available to the unit but not in every labor and delivery room. CMS should allow flexibility around equipment requirements and allow hospitals to have this equipment available in relation to patient needs. For example, if a CAH typically has one patient in its OB unit at any given time, one set of equipment for the unit should be sufficient to meet this requirement.

- **Quality Assessment and Performance Improvement (QAPI) Program.** CMS proposes that hospitals and CAHs that offer OB services be required to use their QAPI programs to assess and improve outcomes and disparities among OB patients. Again, **OCHIN urges CMS to exclude rural hospitals and CAHs from this proposal.** If CMS moves forward with finalizing this proposal, we ask that CMS provides flexibility around the requirement to incorporate Maternal Mortality Review Committee

[1] *See* Health Resources and Services Administration, *Defining Rural Population*, last updated January 2024, https://www.hrsa.gov/rural-health/about-us/what-is-rural.

(MMRC) data and recommendations into hospitals' QAPI programs. Almost every state has a statewide MMRC meaning that their state data or recommendations may be more urban-centric and not relevant to or representative of rural hospitals. CMS should allow hospitals to instead use data and recommendations from any body that is working on OB quality in their area.

Emergency Services Readiness. OCHIN urges CMS against finalizing this addition to emergency services COPs. The new provisions under § 482.55 and § 485.618 would apply to all emergency services. These provisions are redundant as hospitals and CAHs must meet existing emergency services COPs and comply with EMTALA. Adding an additional set of emergency services COPs on rural hospitals and CAHs will be a financial, administrative, and staff burden that many of these struggling providers cannot shoulder.

- The proposed provisions are duplicative for CAHs in particular and must not be finalized. The new proposals would require adequate provisions and protocols to meet the emergency needs of patients. CAHs are already meeting a similar, if not almost identical, standard at § 485.618(b)-(c). Additionally, CMS proposes to add that CAHs must have a physician immediately available by phone on a 24/7 basis to receive emergency calls, provide information on treatment, and refer patients to the CAH or another location. Yet CAHs must currently comply with a similar requirement in § 485.618(d) which requires that a practitioner be on call or immediately available by phone and available onsite within 30 minutes on a 24-hour basis.[2] CMS' proposal would require that a physician, rather than a non-physician practitioner, be available by phone 24/7, which is more difficult to meet in the face of the workforce shortages that CAHs experience. We assert that CAHs are presently meeting an extremely similar standard regarding emergency services and the existing standard was designed with rural workforce limitations in mind. Therefore, new one-size-fits-all standards are not appropriate and will result in additional untenable burdens for CAHs.

[2] In frontier areas, the practitioner must be available within 60 minutes.