

August 15, 2022

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted Electronically to www.regulations.gov

Re: Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates [CMS-3419-P]

Dear Administrator Brooks-LaSure:

The American Nurses Association (ANA) appreciates the opportunity to provide comment on the Centers for Medicare & Medicaid Services' (CMS') Rural Emergency Hospitals (REHs) Conditions of Participation (CoP) proposed rule. As the agency considers how to incorporate REHs into Medicare and the existing hospital system, through this comment letter we urge CMS to:

- **Ensure proper staffing levels at REHs including:**
 - **Nursing services**
 - **Emergency department staff;**
- **Encourage REHs to offer more services than the legislatively mandated minimum services;**
- **Ensure full practice authority for advanced practice registered nurses (APRNs) as permitted by state-specific regulations; and**
- **Ensure that discharge planning is offered to patients who require it.**

Staffing Levels

ANA appreciates CMS' efforts to ensure that all hospitals that take part in the Medicare program maintain appropriate nurse staffing. ANA encourages CMS to base hospital staffing levels on the ANA 2020 Principles for Nurse Staffing.¹ The comments below are based on these principles. While ANA is pleased that CMS has referred to these principles in previous rulemaking, they are not reflected in the proposed CoP for REHs and ANA strongly urges CMS to incorporate them in the final rule.

Nurses have been on the frontlines of the COVID-19 pandemic, which has resulted in unprecedented levels of burn out. Many nurses have chosen to leave the profession, contributing to nursing shortages at all levels of care, especially in hospitals. ANA thanks CMS for proposing proper nurse staffing at REHs, but as the proposed rule was vague in how to define proper staffing, ANA would like to offer more detailed regulatory options on maintaining proper staffing.

¹ American Nurses Association. Principles for Nurse Staffing, 3rd Edition. 2020. Available online at <https://www.nursingworld.org/PrinciplesForNurseStaffing>

ANA believes that proper nurse staffing varies depending on a number of factors, including patient acuity and nurse experience. The number of patients is one indicator for how many nurses should be assigned, but it should not be the only factor that hospitals are expected to consider. Patient acuity levels are as relevant as patient volume in an emergency department. A high volume of patients with minor conditions could mean a need for relatively fewer nurses assigned. However, REHs could experience the exact opposite situation, where relatively fewer patients present with extremely high needs. The final CoPs for REHs should require staffing plans that account for levels of need as well as volume, to ensure that everyone in the emergency department is receiving proper care in a timely manner.

Nurse experience is another factor that needs to be considered when determining the proper staffing of emergency departments. Recently graduated RNs may require more mentoring and collaborative support than more experienced RNs. Required oversight can be virtual, and ANA strongly supports virtual supervision, but it needs to be especially accessible when less experienced practitioners are beginning their careers.

Similarly, ANA agrees with CMS that telehealth should be encouraged to expand staffing capacity as appropriate. Telehealth is an excellent tool for both patient care and clinical supervision, e.g., consultations and other components of the visit when staff is not available at the REH. While telehealth availability does not obviate the need for REHs to account for proper on-site staffing, telehealth flexibilities can enhance REH staffing. CMS should continue to consider regulatory relief to broaden the telehealth rules.

Nursing Services

ANA agrees with CMS that REHs need not be required to maintain the same level of nursing care that is provided at Critical Access Hospitals, which provide inpatient care. However, ANA also believes that RN care should always be available on site at REHs. Rural patients typically travel great distances to access care. Healthcare personnel may also live at a distance from their worksite. In emergency situations, time is of the essence. Therefore, REHs must be held accountable for maintaining adequate staff levels at all times, even if such level is higher than comparable emergency departments in urban areas. ANA notes that added costs to the REH would be accounted for in the relatively higher rates that CMS proposed for REHs in the Hospital Outpatient Prospective Payment System (HOPPS) proposed rule.

Finally, ANA agrees with CMS that REHs must provide nursing services consistent with recognized standards of practice as well as having a director of nursing who is a licensed RN and who is responsible for the operation of the nursing services.

Emergency Departments

ANA agrees with CMS in the proposed rule that the emergency department in REHs must be staffed 24 hours a day, seven days a week in order to fulfill their essential mission of emergency care in underserved areas. Accordingly, ANA disagrees with 42 CFR §485.528(a)(4) as proposed. Having a nurse on duty when there are patients in the emergency room is not sufficient, but rather the emergency room should always have an RN, APRN, or licensed practical nurse on duty. Health emergencies can arise at any time and if nurses are not available in the emergency department, time-sensitive life-saving care could be delayed.

Nurses are essential members of the healthcare team. Therefore, ANA agrees with subparagraph (C)(2)(d), which states that nurse practitioners and clinical nurse specialists participate in the development, execution, and review of policies and participate with physicians in periodic reviews of patient records. CMS should consider extending such participation to all APRN roles.

Services Additional to Those That are Legislatively Mandated

CMS should explore strategies to encourage REHs to offer more services than the legislatively mandated minimums. By definition, REHs are in remote locations, probably the only care facilities available for miles in any direction, and possibly the only source of care for many patients. Given the distances patient must travel, REHs should be incentivized to enhance their service offerings to help patients avoid further travel to receive needed care.

ANA is aware that staffing shortages may hamper efforts to offer additional services. However, we encourage CMS to consider inducements for both the hospitals to offer services and for providers to relocate and serve REHs. For instance, the proposed rules specifically mention maternity care. CMS, along with other HHS divisions such as the Health Resources and Services Administration, should assess the support needed for all REHs to offer low-risk maternity care, while engaging with hospitals that are able to accept high-risk maternity patients.

Practice authority for advanced practice registered nurses (APRNs) as permitted by state-specific regulations

APRN practice continues to be unnecessarily restricted in about half the states due to outdated state licensing rules. However, for the benefit of patients in those states that have granted full practice authority for APRNs, ANA urges CMS to avoid adding restrictions through federal requirements.

In particular, ANA opposes CMS' proposed physician supervision requirements. Physician supervision requirements are not explicitly mentioned in the REH authorizing legislation (Consolidated Appropriations Act of 2021). In many states, certified registered nurse anesthetists (CRNAs) practice without physician supervision, but the proposed rule specifically states that CRNAs, with minimal exception, must be under the supervision of a physician. The supervision requirements in the proposed rule do not advance health equity and could be counterproductive to the purpose of REHs to expand access to quality services in rural areas. Removing supervision requirements will strengthen the healthcare workforce to ensure timely delivery of quality services and care and will reduce long-standing barriers to practice, all of which will improve health equity and increase access to care.

Discharge Planning

ANA applauds CMS for proposing that REHs perform discharge planning when needed but disagrees that discharge planning requires a physician's request. Patients do not always see physicians for their care. Nurse practitioners and other APRNs are qualified to request the plan when they provide healthcare for the affected patient. ANA proposes adding APRNs to the category of providers who can request discharge planning.²

² The Consensus Model for APRN Regulation defines four APRN roles: nurse practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM), and Certified Registered Nurse Anesthetist (CRNA). In addition to defining the four roles, the

ANA thanks CMS for including RNs in the list of providers who develop the plans. Nurses, through their regular interactions with patients, are uniquely qualified to develop discharge plans and understand what patients require after leaving the hospital.

Conclusion

ANA appreciates the opportunity to submit these comments and looks forward to continued engagement with CMS. Please contact Ingrida Lusic, Vice President, Policy and Government Affairs, at (301) 628-5081 or Ingrid.Lusic@ana.org, with any questions.

Sincerely,



Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer/EVP

cc: Ernest Grant, PhD, RN, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FAAN, ANA Chief Executive Officer

Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.