December 20, 2011

Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-8010

Re: CMS-3244-P

The following comments are submitted on behalf of the National Organization of State Offices of Rural Health (NOSORH) in response to the Reform of Conditions of Participation for Hospitals (42 CFR Part 482) and Critical Access Hospitals (42 CFR Part 485) Notice of Proposed Rulemaking issued on October 24th. NOSORH is the national organization of the fifty State Offices of Rural Health. These offices work to improve health and healthcare in rural America. NOSORH is pleased to submit these comments.

NOSORH appreciates CMS's recognition that variation between states is often best handled by state authorities and that some uniform standards may be too strict or inapplicable to local situations, making it difficult for states to provide needed services to some of its most vulnerable populations. Many of the proposed changes in CMS-3244-P will assist Critical Access Hospitals (CAHs) and rural hospitals by:

- Recognizing workforce shortages in rural areas and giving rural facilities flexibility in utilizing its workforce to deliver high quality healthcare;
- Providing increased clarity regarding existing requirements;
- Removing some of the cost burdens facing CAHs; and
- Allowing facilities to redeploy and maximize scarce resources.

The shortage of healthcare workers in rural communities is the greatest rural health issue facing America today. While about 20 percent of the American population – approximately 62 million people – live in rural areas, approximately nine percent of all physicians practice in rural communities. This shortage is only expected to worsen as the demand for healthcare workers nationwide grows faster than the supply over the next several years.

NOSORH appreciates CMS's ongoing commitment to the important aspect of rural healthcare, workforce issues, specifically in its July 2011 revision to medical staff requirements for telemedicine services (76 FR 25563). Due to significant physician shortages, rural facilities rely on a diverse healthcare workforce that includes physicians and non-physician practitioners (NPPs), such as physician assistants and advance practice nurses, to meet the healthcare needs of rural Americans. Several aspects of CMS-3244-P address the important role that NPPs play in care delivery, specifically by revising and clarifying the CoP requirements to allow hospitals to include NPPs on their medical staffs (482.22) and permitting a broader range of practitioners to order, prepare, and administer drugs and biologicals [482.23(c)]. NOSORH supports these proposed changes as a means of promoting efficiencies by giving CAHs the option of utilizing their existing workforce to the full scope of their licenses as approved by state law. These changes also allow CAHs to use their limited physician workforce more effectively and appropriately by shifting these activities to NPPs when authorized by their respective state scopes of practice.

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It is requested that CMS evaluate the physician supervision requirements for certified registered nurse anesthetists for CAHs (42 CFR 485.639) and hospitals (42 CFR 482.52), specifically small rural hospitals. As allowed by CMS and when consistent with state law, many states have elected to opt out of this requirement to increase access to surgical care and better serve their communities. NOSORH appreciates that CMS allows states to exercise the option of exemption and encourages ongoing dialogue and research regarding the need for the existing supervision requirements in the CoP.

NOSORH welcomes the increased clarity provided by some of the proposed CoP changes, specifically the clarifying language around surgical services as an optional service (485.639). The proposed changes will allow CAHs to focus on providing the services their communities need and not devote limited time, effort, and financial resources toward the maintenance of a service perceived as required, but not necessarily needed, by the community. While many CAHs are providing surgical services and facilitating access to this important service for their communities, many are not due to staffing and/or resource limitations. The proposed change will clarify the existing provision and not only provide assurance to existing CAHs, but also assist those small rural hospitals that may be considering whether to seek CAH status.

CAHs and small rural hospitals face enormous fiscal challenges as they provide high quality healthcare for a population that is typically older, more likely to be covered by Medicare/Medicaid, and more likely to have chronic conditions than patients of urban hospitals. As a result of the proposed CoP revisions, these facilities may generate cost savings and be able to reallocate resources to other areas, such as quality improvement, patient safety, and electronic health records. The proposal to revise "Direct Services" [485.602 and 485.635(b)]to "Patient Services" and permitting CAHs to use staff or contracted vendors for service provision will allow CAHs to determine the appropriate and feasible solution for providing these services for their community while still maintaining responsibility and oversight for the services. NOSORH also appreciates the proposed changes to Infection Control (482.42) and the recognition of advancements in technology to reduce the time and effort of maintaining records; specifically, the elimination of the need to keep a separate infection control log when systems already exist for the detection, collection, and analysis for the monitoring and evaluation of preventative interventions. This greatly reduces duplicative record keeping and reduces the chances of a transcription error, benefiting patient safety and documentation reliability.

Thank you again for the opportunity to provide input on the proposed changes to the Medicare Conditions of Participation as outlined in CMS-3244-P. NOSORH supports CMS's efforts to provide greater flexibility and clarity for small rural hospitals and CAHs and believes these changes will provide benefits for rural America and its healthcare facilities.

Sincerely,

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