Rural Health Open Door Forum
Moderator: Jill Darling
February 20, 2020
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the question-and-answer session, please press 1. Today's conference call is being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn the meeting over to Jill Darling. Thank you. You may begin.

Jill Darling: Thanks, (Diane). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communication and welcome to the first Rural Health ODF of 2020. We have a short agenda today so I'll just go through my little spiel real quick and then we'll get started.

This Open Door Forum is open to everyone, but if you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries please contact CMS at press@cms.hhs.gov.

And I will hand the call off to our co-chair (John Hammarlund).

(John Hammarlund): Thanks so much, Jill. Hi everybody. This is (John Hammarlund) emanating from an usually sunny and blue sky Seattle, Washington today. Thank you all very much for joining us for the first ODF Rural Health call for 2020. As Jill said, we have a short agenda today, but hopefully not short on importance and details.

We always appreciate, however, any feedback you can give us about agenda topics that you would like to hear from us in the future. So I'm going to

remind you of the email box where you can send your ideas for future agenda items. It is ruralhealthodf -- that is all one word -- ruralhealthodf@cms.hhs.gov.

We've got some great speakers here today from our CMS Baltimore headquarters along with some other staff joining them in our headquarters. And of course as always we have many of our regional rural health coordinators joining the call from the different 10 regional offices around the country. So, again, we're delighted to have you on the call and without further ado, I'll hand it back to Jill so she can start us on our way.

Jill Darling: Great. Thank you, (John). First up we have (Avareena Cropper), who will go over the rural maternal request for information.

(Avareena Cropper): Thank you. Hello everyone and good afternoon. Thank you, Jill and (John), for having me and giving the Office of Minority Health an opportunity to talk about our request for information to this audience. So, I am from the Office of Rural - Office of Minority Health at CMS and the Administrator Seema Verma, announced a rural maternal request for information at the National Rural Health Association Policy Institute, which happened about two weeks ago.

And so before I go into detail, I want to say everything I'm covering today, and I will say this again at the end and that everything that will be found and what I be discussing today can be found at go, so G-O, .cms.gov/rural -- R-U-R-A-L -- health. And the request for information is open through the end of the day close of business on April 12.

So this RFI is you know, the acronym we will be using today, built off a forum that was held last summer. In June of 2019, CMS in collaboration with

HRSA, the Health Resources and Service Administration, with other organizations hosted an interactive stakeholder forum, entitled “A Conversation on Maternal Health in Rural Communities: Charting a Path to Improved Access, Quality and Outcomes”, which was designed to gain a better understanding of the challenges, potential opportunities and priorities regarding maternal health care in the United States.

And so what came out of that discussion really is an understanding that a woman's health before pregnancy is critical to achieving safe outcomes for her and her baby, and optimizing physical and mental health during preconception not only increases the likelihood of a healthy pregnancy, delivery and postpartum experience but also positions the mother and her baby for a lifetime of better health.

Following high quality wellness and preconception care, prenatal care can reduce the risk of pregnancy complications for both the mother and her baby. Therefore, safe, effective and high quality health care before, during and after pregnancy is important in improving family health outcomes and transforming health care in rural communities.

Since 2010 health care deserts have grown as a result of rural hospitals closing or limiting their services, including those services essential to pregnancy-related health care. The closures also affect the availability of pediatric inpatient services and pediatric specialties, including neonatal intensive care.

And so our RFI we are seeking public comments on opportunities to improve health care access, quality and outcomes for women and infants in rural communities during this continuum of care of before, during and after pregnancy. This includes reduction of health disparities across the continuum

within rural communities, and racial and ethnic disparities within these communities.

This notice also includes a request for information regarding readiness of rural providers which includes emergency medical services to handle obstetric emergencies and emergencies related to birth, pregnancy and after birth in our rural communities.

So the response to this RFI will be used to inform future work by CMS in developing and refining the programs and policies that - so that we can ensure rural families have access to high quality care. And so if you have insights, interest, connections within your networks, we look forward and encourage comment from you. Again, the deadline is April 12. And please feel free to share this link within your networks and your colleagues. You know, dissemination is key here because we really want to understand rural communities and the challenges and the opportunities that can be put forward.

And so, again, the link to get access to the RFI by going to go.cms.gov/ruralhealth and will remain open by COB of April 12, so ingrain that into your memory. And I'm looking forward and the Office of Minority Health, is looking forward for your feedback. Thank you.

Jill Darling: Great. Thank you so much. And next we have (Scott Cooper), who will go over the hospital and critical access hospital history and physical requirements.

(Scott Cooper): Thank you, Jill. This is Captain (Scott Cooper) in the Clinical Standards Group, the Center for Clinical Standards and Quality here in the central office of CMS in Baltimore. I'm the hospital lead for the conditions of participation

for hospitals and also assist with the team that covers the critical access hospitals, the CAHs, CoPs.

What I wanted to talk to everyone today about is a recent rule that we published -- actually we had two major rules that published concerning hospitals and critical access hospitals on September 30, 2019. The one, with the provision that I'm discussing, was the Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction.

Just a little bit of background on that rule. We heard from stakeholders there were some research studies about minor, predominantly ophthalmological, procedures, cataract surgeries, where the comprehensive history and physical as currently required in the hospital CoPs was a bit excessive. The stakeholders thought that it caused burden for hospitals, for practitioners, the surgeons involved, and for patients.

And it was generally applied to ambulatory surgical centers, but since hospitals have their own ambulatory outpatient surgical departments, we decided that it should also be proposed for those provider types. So what we ended up in that September 30 rule was finalizing, after proposal, basically an option, an allowance to allow hospitals the flexibility to basically establish a medical staff policy describing the circumstances under which they could use a pre-surgery or pre-procedures assessment for an outpatient instead of the comprehensive medical history and physical as currently required.

This involved three of the CoPs, Medical Staff, Medical Records Services, and also Surgical Services. So, in order to exercise the option, and again it is an option, it's not a requirement, a hospital would document - they would have to document that assessment in the patient's medical record and that the policy must consider, so they must contain in that policy around that, the patient's

age, any diagnoses, the type and number of surgeries and procedures scheduled to be performed, any comorbidities that the patient might have, and the level of anesthesia required for the surgery and procedure.

Along with that, they would have to include any nationally recognized guidelines or standards of practice for the assessment of specific types of patients prior to specific outpatient surgeries and procedures, and then also consider applicable state and local health and safety laws. So, this would apply to all hospitals, including small hospitals and small rural hospitals.

I believe we got a question on why we did not propose and finalize this for critical access hospitals and the reason for that primarily is that there was not a specific requirement that was similar. There wasn't an equivalent requirement [in the CAH CoPs] for this comprehensive H&P that hospital patients must have within 30 days and then the requirements around an update if they had an H&P within 30 days of an admission.

There is a requirement for an H&P in the critical access hospital CoPs. And within the guidelines, it's expected that if there has not been a H&P done on a patient, because we recognize that critical access hospitals do perform these same types of outpatient ambulatory procedures, minor procedures that might be done in the CAH, that they would at least have to have a note prior to the procedure assessing the patient for that procedure. So, that is basically why we did not propose the same thing since there was not an equivalent requirement.

That's all I have for that.

Jill Darling: All right. Thank you so much, (Scott). (Diane), we'll please open the lines for Q&A.

Coordinator: Thank you. We will now begin the question-and-answer session. If you'd like to ask a question, please press star, 1. You'll be prompted to record your name. To withdraw your request, please press star, 2. And again if you do have a question, please press star, 1 and make sure you do record your name. Thank you.

(Jeremy Levin): (Jeremy Levin), Rural Wisconsin Health Co-Operator.

Coordinator: Your line is open.

(Jeremy Levin): Thanks. Quick question and I guess clarification. One question, curious on the status of the draft guidance on co-location, that memo that came out midyear last year, and clarifying on the H&P requirements for CAHs. So since there wasn't a similar requirement, there isn't a similar allowance for that pre-procedural assessment? Thank you.

(Scott Cooper): This is (Scott). I can take the second portion of that. That is correct. There really isn't because it's a much broader requirement under the critical access hospital CoPs. There were no timeframes, you know, there was no question of timing for the H&P to be done, you know. And as I said, that - it occurs, that particular requirement is in three different CoPs in the hospital CoPs.

But with regard to the co-location guidance, I'm not sure. Jill, do we have anybody from the Quality, Safety, and Oversight Group on?

(Anita Moore): Hi, (Scott) and everybody on the call. This is (Anita Moore). I am with the Quality, Safety and Oversight Group and the co-location guidance, along with the burden reduction guidance, is currently in draft form. We are planning to have it go through our legal counsel within the next couple of weeks.

And once they have reviewed, which may take a couple of months, we're not quite sure how long because it's pretty extensive with the burden reduction guidance and co-location guidance. Once OGC has reviewed then we will clean it up before it's published. So we're not looking for it to go public until later this spring.

Jill Darling: We'll take next question, please.

Coordinator: Thank you. And again as a reminder if you do have any further questions or comments, please press star, 1 and record your name. We do have a question from (Bruce Ermand). Your line is now open.

(Bruce Ermand): Yes. Hi. Thank you very much. This is Dr. (Ermand). I work with Common Spirit Health. With the discussion that's happened in the memos regarding outpatient history and physical examinations and the relaxation of the burden of documentation related to these, there's been a question that's started to arise from various physicians and surgeons who are performing non-inpatient only list procedures at the hospital setting that have, you know, significant medical complexity, but the question comes up now whether they are allowed to use short form H&Ps or are allowed to reduce their burden of documentation prior to hospital stay as well. I'm curious if CMS has any guidance on that.

(Scott Cooper): This is (Scott) again. As (Anita) mentioned, and she was specifically talking about the critical access hospital guidance, but with regard to the hospital guidance around this that is also still, I believe, under development. I'm not sure if we have anybody on from the Quality, Safety, and Oversight Group, the hospital team, with regard to guidance. [Note – the hospital guidance has been drafted and will be sent to OGC when the critical access hospital guidance is sent for review (Anita Moore).]

There is - I will refer you to the rule that I spoke about that was published September 30, 2019, and it's in the *Federal Register*. It's Volume 84. And actually it's Page 517 - I think it goes back to 51732 is where it starts. So, in the preamble to that, with public comments and our responses, there's a lot of discussion around that that gets into the details about having a policy in place in order to do the more focused, abbreviated, if you will, H&P as opposed to the more comprehensive. So it's - and then also if there's any state law around that. So, that's an important component of that.

(Bruce Ermand): Thank you.

Coordinator: All right. And our next question comes from (Dale Gibson). Your line is open.

(Dale Gibson): Thank you. You know, since the implementation of the MBI there's been a lot of problems with correct numbers, changing of numbers. Have you all thought about anything that you all can do to improve the switch?

(John Hammarlund): This is (John Hammarlund). Can you just give a little bit more details for us? I'm not sure we have anybody on the phone who's going to be able to answer to this definitively but if you can provide just a little bit more for instances we can try to take the question back.

(Dale Gibson): Okay. There's a lot of problems, incorrect numbers coming across from CWF. They don't seem to have the correct numbers. There's a lot of issues where, you know, if you're on Medicare and you lose your card, you call in to get a new number. So there's, you know, I may have this number today and someone may check eligibility today and my number works. Tomorrow I have a new number. And there seems to be a lot of that.

(John Hammarlund): Okay. Thank you. Jill, unless there's somebody there in the room with you, I think we'll have to take this question back to be able to get a definitive answer.

Jill Darling: Unfortunately we don't have anyone in the room, sir, but if you don't mind emailing that question into our ruralhealthodf@cms.hhs.gov, we'll get it to the right person.

(John Hammarlund): Yes. Thank you for doing that.

Jill Darling: Thank you.

Coordinator: I show no further questions. Again, as a reminder if you do have any further questions or comments, please press star, 1 and record your name. Again, please press star, 1.

Jill Darling: All right well…

Coordinator: I show no further questions.

Jill Darling: Okay. Great. Thanks, (Diane). (John), do you have any closing remarks?

(John Hammarlund): No, other than to, again, ask you that if you have agenda items that you would like us to address on future calls to please let us know. Use that email address box that Jill just gave you, ruralhealthodf@cms.hhs.gov. We would like to help build the agendas around the issues that are important to you. And with that we just thank you very much again for participating on today's call and we extend our thanks to our speakers.

Coordinator: Thank you. This concludes today's conference call. Thank you for participating. You may disconnect at this time.

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