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HOSPITALS & HEALTH SYSTEMS

August 29, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW,
Room 445-G
Washington, D.C. 20201

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

Dear Administrator Brooks-LaSure,

On behalf of our more than 200 member hospitals and health systems the Florida Hospital Association (FHA) appreciates the opportunity to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospitals (CAH).

In the wake of years of unprecedented rural hospital closures, Congress, in the Consolidated Appropriations Act of 2021 (CAA), created a new designation for small rural and critical access hospitals who may not have otherwise been able to sustain operations given compounding financial, workforce and other challenges. The designation, intended to be a lifeline for hospitals on the brink of closing, would maintain medical services in communities that are already healthcare underserved.

FHA generally supports the efforts of Congress and CMS to implement the REH designation. However, regulatory compliance and the cessation of inpatient services is likely to produce limited adoption by hospitals. Indeed, very few of FHA's eligible members are considering conversion to an REH designation. With our general support in mind, we offer the following which we believe will strengthen the program.

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I.B. Statutory Authority and Establishment of Rural Emergency Hospitals as a Medicare Provider Type

The statute provides that hospitals closed prior to passage of the CAA, on December 27, 2020, are statutorily prohibited from converting to an REH. However, we suggest that CMS clarify that hospitals that closed after December 27, 2020, are eligible for conversion to REH status.

II.A.2: Definitions [Length of Stay]

In the proposed rule, CMS states its intention to limit the average annual length of stay per patient to 24 hours. We understand and appreciate the agency's rationale for this decision, and agree that limiting the annual average length of stay to 24 hours is reasonable. However, we urge CMS to give serious consideration to two specific exceptions to the 24-hour length of stay requirement. First, for those REHs able to offer low-risk childbirth labor and delivery services, it is impractical to expect those patients to be discharged within 24 hours, especially in instances where surgical intervention is required. We understand the 24-hour length of stay is an average of all patients in the REH over the course of a year; however, it is possible that labor and delivery patients could move the REH average beyond the 24-hour limit. Given the nature of these services, we urge CMS to consider expressly excluding labor and delivery patients from the 24-hour annual length of stay requirements.

Second, there are certain patients, like those individuals requiring behavioral health and psychiatric care that could prove to be more difficult to discharge successfully within 24 hours. Oftentimes, even when providers are prepared to discharge these patients, there is no bed available for them in an appropriate facility. These factors fall well outside of the control of the REH, but will play a significant role in determining whether the REH is meeting the average 24-hour length of stay requirement.

Given the implications of these potential hurdles, we urge CMS to afford REHs the opportunity to demonstrate compliance with the 24-hour length of stay requirement by providing documentation that shows their efforts to discharge and transfer a patient. When the REH has taken reasonable steps but is unable to comply through no fault of their own, the agency should deem the REH to be in compliance with the 24-hour average length of stay CoP.

II.A.8: Emergency Services

FHA supports CMS' proposal to adopt CAH emergency services CoPs for personnel. Specifically, staffing flexibilities are crucial as workforce remains a pressing and enduring challenge for rural providers. Allowing a physician, PA, NP, or clinical nurse specialist (CNS) to be on call within thirty minutes of the REH provides needed flexibility. It is appropriate, given the expected low volume of patients and services, that a practitioner is not required to be on-site at all times.

II.A.12. Additional Outpatient Medical and Health Services

FHA commends CMS for recognizing that REHs should furnish outpatient services according to the needs of the community it serves. We applaud CMS for not placing limits on the types of outpatient services that REHs may choose to furnish. Allowing an REH to provide outpatient services that are typically delivered at a physician's office, or another point of entry increases access to health care for rural communities.

II.A.19. Agreements

CMS proposes that a provider designated as an REH must have in effect a transfer agreement with at least one Medicare-certified hospital that is a level I or level II trauma center. We agree with the agency that transfer agreements with level I or level II trauma centers are vital to ensure those patients requiring serious medical care are able to receive it. While we understand the frequency at which REH patients will require level I or level II trauma care likely will be limited, having a transfer agreement in place will establish efficiencies and processes that will be critical in instances where transfer of a patient is medically necessary. In many instances, especially when geographic limitations may make transfer to a level I or level II trauma center impractical, we encourage REHs to have in place a transfer agreement with a closer hospital that has specialists or subspecialists able to address many common reasons for hospitalization, even if that hospital is not a level I or level II trauma center.

We thank you for the opportunity to comment on these important topics. As our rural members continue to navigate the challenging landscape ahead of them, we appreciate CMS' commitment to taking steps to preserve access to health care in rural communities.

We look forward to continuing to work with the agency throughout the implementation of the new REH designation and are encouraged by the proposed changes to current CAH CoPs. Please contact me if you have questions, or feel free to have a member of your team contact Michael Williams, Senior Vice President of Federal Affairs at mwilliams@fha.org.

Sincerely,

Mary C. Mayhew

President and CEO

Florida Hospital Association