

August 29, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3419-P
P.O. Box 8016
Baltimore, MD 21244-8010

Submitted electronically via <https://www.regulations.gov>

Re: CMS-3419-P, RIN 0938-AU92, Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of our more than 450 member hospitals and health systems, the Texas Hospital Association (THA) appreciates the opportunity to provide comments on the above-referenced proposed rule for the CoPs for REHs. THA strongly supported creation of the REH designation, which offers financially distressed rural hospitals a new Medicare reimbursement option that preserves access to care in their communities while protecting their financial position.

These comments address CMS' proposals regarding the following issues:

- A. Proposed definition of REH;
- B. Proposed condition of participation: compliance with federal, state, and local laws and regulations
- C. Proposed condition of participation: governing body and organizational structure of the REH – telemedicine requirements;
- D. Proposed condition of participation: additional outpatient medical and health services;
- E. Proposed condition of participation: infection prevention and control and antibiotic stewardship programs;
- F. Proposed condition of participation: discharge planning;
- G. Proposed condition of participation: quality assessment and performance improvement program (QAPI program);
- H. Proposed condition of participation: agreements; and
- I. Proposed change to Critical Access Hospital conditions of participation: status and location

A. Proposed definition of REH

THA recognizes that the definition of “rural emergency hospital services” is defined by the statute¹ as services provided by a rural emergency hospital that do not exceed an annual per-patient average of 24 hours. However, THA **recommends** CMS re-analyze the statute and congressional intent to determine CMS' ability to increase the annual per-patient average length of stay from 24 hours to either 36 or 48 hours. Hospitals that want to

¹ 42 USC 1395x(kkk)(1)(A)

maintain maternity services in rural communities that would not have them otherwise would benefit greatly from an increased length of stay as it broadens the array of services the facilities could provide. Additionally, because CMS has discretion in how it calculates the average length of stay calculation, we recommend, at minimum, excluding from the calculation inpatient stays that were lengthened due to the lack of an available bed at an inpatient facility. THA would support action by CMS, or Congress if necessary, to increase the annual per-patient average length of stay as noted herein.

We highlight below two other features of the proposed REH definition that may present challenges for hospitals considering REH conversion:

1. Hospitals converting to REH status will forfeit their option to obtain cost-based reimbursement for swing beds. If the REH wanted to continue offering skilled nursing, it would need to convert swing beds into a distinct licensed skilled nursing facility (SNF). In so doing, the REH will be required to meet the SNF CoPs, which are more demanding than requirements of swing beds. If a hospital currently operating swing beds could not achieve the SNF CoPs, patients may lose a local option for skilled nursing.
2. Distinct licensed SNFs are the only inpatient services permitted for reimbursement under REH status. Rehabilitation units are not included. This could create a scenario where patients treated outside their community on an inpatient acute care basis could not return to their community for needed rehabilitation care.

B. Proposed condition of participation: compliance with federal, state, and local laws and regulations

Recommendation: THA recommends CMS recognize an REH licensed under state and local regulations that contemplate “REH or similar” designations as an REH under federal statute.

Background: CMS proposes to require REHs to be located in a state that provides for the licensing of REHs under state or applicable local law. In 2019, Texas passed Senate Bill 1621 amending Texas Health and Safety Code Chapter 241 to provide for state licensing of “limited services rural hospitals” contingent upon Congress creating a specific payment program specifically for limited services rural hospitals. This legislation was passed in anticipation of REH creation at the federal level before it was named or defined. Texas law does not name REHs specifically but does define, describe, and provide licensure standards for an analogous concept.

C. Proposed condition of participation: governing body and organization structure of the REH-telemedicine requirements

Recommendation: THA supports CMS’ proposal to allow REHs to abide by similar requirements for critical access hospitals (CAHs) for telemedicine credentialing and privileging processes.

Background. As CMS notes, hospitals that may consider transition to an REH “may lack the resources to carry out the traditional credentialing and privileging process for all of the physicians and practitioners that may be available to provide telemedicine services.”² Allowing REH medical staff responsible for credentialing and privileging to rely on information provided by the distant-site hospital would, as CMS notes,

² 87 FR 40350, 40354.

continue to relieve the burdens that would be imposed upon an REH by requiring traditional methods of privileging and credentialing. Additionally, it eases the transition for a qualifying rural hospital or CAH to an REH if the qualifying rural hospital or CAH does not have to make significant revisions or additions to its credentialing standards.

D. Proposed condition of participation: additional outpatient medical and health services

THA **supports** CMS' proposal to allow REHs to provide additional outpatient medical and health services that include radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health services. While it is more likely that hospitals considering the REH conversion will not be among those providing labor and delivery services, as noted in subparagraph A, if CMS can provide additional flexibilities such as increasing the length of stay, this may allow hospitals to maintain labor and delivery services, among others. Texas hospitals strongly support efforts to increase availability of maternal health services statewide and to keep these services in communities where the patients live.

E. Proposed condition of participation: infection prevention and control and antibiotic stewardship programs

Recommendation: THA **recommends** that CMS consider additional flexibilities for infection prevention and control and antibiotic stewardship programs that are proposed for this REH CoP due to the workforce challenges rural hospitals are currently facing.

Background: CMS proposes a condition of participation regarding antibiotic stewardship programs and infection prevention that tracks the CAH CoP finalized in 2019 and amended elsewhere in the current proposed rule. Our rural hospital members have emphasized the need for flexibility and simplification in this area due to the limited clinical and administrative staff hours available given current workforce challenges. Statewide, our hospitals are challenged to fill positions with permanent staff as labor costs have increased 19.5% through November 2021 from pre-pandemic levels. Rural hospitals struggle to compete with hospitals in larger markets on salary and benefits, and are experiencing high vacancies and turnover.

F. Proposed condition of participation: discharge planning

Recommendation: THA **requests** that CMS reconsider the requirement for REHs to provide “discharge planning” with respect to the provision of rural emergency hospital services and instead only require “discharge instructions” when an REH discharges a patient who has received emergency care.

Background: Requiring an REH to maintain and comply with discharge planning requirements similar to hospitals providing inpatient services could result in undermining CMS' goals of encouraging rural hospitals to convert to an REH, especially since an REH is prohibited from providing inpatient healthcare services. If an REH is required to maintain an annual per-patient average of a 24-hour length of stay to remain eligible for the REH designation, requiring a discharge planning evaluation be completed within this 24-hour period may not be realistic or feasible. THA supports ensuring that patients receive appropriate discharge instructions should a patient require continuing care following the treatment provided by an REH. However, REH staff may not be able to determine the availability of appropriate services following discharge within this 24-hour period on a regular basis. Requiring REH medical staff and personnel to provide emergency care that treats and stabilizes a patient, while simultaneously planning for their discharge may cause an over-extension of

already limited resources and staff. Additionally, CMS has determined that the statutory requirements do not support EMTALA waivers for REHs to divert patients to other hospitals if they require a higher level of care than the REH is able to provide.³ This confirms that if this rule is adopted, REHs will be required to ensure compliance with discharge planning requirements that are more appropriate for inpatients and not emergency services and observation care. Therefore, THA requests clarification and/or increased flexibilities for REHs with respect to discharge planning.

G. Proposed condition of participation: quality assessment and performance improvement program (QAPI program)

Recommendation: THA **supports** CMS' proposals to mirror the REH QAPI Program requirements to the CAH QAPI Program, minus the requirements applicable to inpatient services in the CAH program.

H. Proposed condition of participation: agreements

Recommendation: THA **agrees** with and supports CMS' determination that the requirement for an REH to have at least one patient transfer agreement with a Level I or Level II trauma center would not then preclude an REH from maintaining any preexisting agreement with a Level III or Level IV trauma center, or entering into an agreement with Level III or Level IV trauma center. Given this determination has been made by CMS, we would encourage and welcome inclusion of this determination in the final rule § 485.540.

I. Proposed change to Critical Access Hospital conditions of participation: status and location

THA requests that CMS provide clarification on whether a current CAH facility that converts to an REH maintains its necessary provider certification for purposes of exemption from CAH distance requirements outlined in the proposed rule. CMS stated that a 2013 Health and Human Services Office of Inspector General report found that "CMS does not have the authority to decertify most of these CAHs based on failure to meet the distance requirement, as a majority of those CAHs are 'necessary provider' CAHs and therefore exempt from the distance requirement as noted in section 1820(h)(3) of the Act." One CAH has inquired on whether they would retain their "necessary provider" certification if they chose to convert to an REH but determine a need to revert back to CAH status. THA supports a confirmation by CMS that a CAH maintains its necessary provider certification regardless of its designation as a CAH or REH.

THA also requests that CMS reconsider its proposal to identify as noncompliant and subject to enforcement action CAHs that do not meet the regulatory distance and location requirements upon a three-year review cycle. This proposal seems to place the burden on current CAHs to be aware of other hospitals' plans to begin operating within their markets. Texas is one of twelve states without certificate of need laws,⁴ which quickens the time to completion for new hospital projects and puts existing CAHs in danger of failing this review if a new hospital enters the area in short order. CMS has not described what action a CAH is meant to take when they become aware of a new hospital located closer than distance requirements permit, nor has CMS named what enforcement actions are proposed against the CAH. The proposal as drafted is unclear and could be overly punitive to existing CAHs.

³ 87 FR 40350, 40369

⁴ National Conference of State Legislatures. (2021). Certificate of need (CON) state laws. Available at <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

Thank you for consideration of these comments and commitment to protecting access to care in rural communities. We look forward to working with CMS on these issues in the future. Should you have any questions or comments, please contact me at hdelagarza@tha.org or (512) 465-1003, or Anna Stelter, Senior Director, Financial Policy at astelter@tha.org or (512) 465-1556.

Respectfully submitted,

/s/Heather De La Garza

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