ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

August 26, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Submitted electronically: https://www.regulations.gov

RE: Comments on Conditions of Participation for Rural Emergency Hospitals and Critical Access Hospital Conditions of Participation Updates (CMS-3419-P)

Dear Administrator Brooks-LaSure:

The Alaska Hospital and Healthcare Association (AHHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed conditions of participation (CoPs) for rural emergency hospitals (REHs) and CAHs.

AHHA is a membership organization representing Alaska's hospitals, nursing homes, home health / hospice agencies, and other healthcare partners. Our mission is to advance the shared interests of the healthcare industry to build an innovative, sustainable system of care for all Alaskans. We represent over 65 health care organizations in Alaska including fifteen rural and critical access hospitals (CAHs) who are potentially eligible for the REH program. Ensuring all communities have access to high quality health care is a top priority for our association. We believe a specific emphasis must be paid to the challenges of ensuring access to care in rural communities.

Alaska is exceptionally rural. Alaska's small and rural hospitals provide essential health care services to most of the state outside of the Anchorage/Fairbanks rail belt. These hospitals are cornerstones of the communities they serve. Thirteen of Alaska's rural hospitals are Critical Access Hospitals (CAH) including six tribally operated CAHs. Most Alaska CAHs have co-located nursing home (long-term) beds, which are primarily paid for by Medicaid.

Rural hospitals often have more obstacles to overcome than their urban counterparts. They struggle to attract and retain enough physicians, nurses and other health care providers and they frequently are the only available source of urgent and emergent care for many miles. The rural payer mix generates insufficient revenue to cover high fixed operating expenses. Many rural hospitals lack the operating margins needed to access capital funding to replace or update facilities and purchase necessary health information technology or upgrades. Despite their small size, rural hospitals must maintain a highly trained workforce. Alaska rural hospitals work hard to maintain financially stability and the COVID pandemic has added an extra layer of financial and workforce challenges.

We have long advocated for a new model to better meet the needs of the smallest, low volume critical access hospitals in Alaska. AHHA has supported the development of new models including the Frontier Extended Stay Clinic demonstration (FESC) and the Frontier Community Health Integration Demonstration (F-CHIP). While significant work was invested in both demonstrations

unfortunately, they have not helped to solve the unique problems facing the Alaska CAHs.

As we continue to look for ways to meet the health care needs of rural communities, we appreciate CMS' efforts to assist rural providers. We support the agency's proposal to allow rural providers to continue to serve their communities by becoming a REH. This new model will help preserve necessary health care services in already underserved areas. We are supportive of CMS' proposal to update certain CoPs for CAHs including a system-level compliance approach for certain requirements, establishing a patient's bill of rights and streamlining the CAH distance determination process.

Through this proposed rule, CMS is taking important steps to assist rural hospitals. We do not know if this model will address the unique needs of the most vulnerable small Alaska CAHs. There are many obstacles to making this model work in Alaska. We are committed to working with CMS to ensure the model will support the smallest Alaska CAHs. We recognize that like the adoption of the original CAH model, adoption of the REH model will take time and modifications may be needed. We look forward to continuing to work with the agency to ensure a seamless and thoughtful implementation of these changes.

Our specific comments follow.

RURAL EMERGENCY HOSPITAL DESIGNATION

The new REH designation seeks to address concerns that certain rural hospitals likely will not be able to sustain current operations given financial, workforce and other challenges. If those hospitals were forced to close completely, critical health care services in the area would evaporate, and individuals would be forced to travel much farther to receive needed care. **We support the REH designation and CMS' efforts in the proposed implementation approach to ensure that health care delivery can be preserved in rural communities.**

Specifically, we appreciate the agency's stated intent of aligning many of the proposed REH CoPs with already existing CAH or ambulatory surgical center CoPs. This alignment will make the REH conversion and compliance processes less burdensome for those providers seeking the new designation. While many of the proposed CoPs are in alignment with existing CoPs for other provider types, the agency makes clear that several new, REH-specific CoPs will need to be established given the unique circumstances of the new REH designation. We have comments on the following proposals.

Provision of Low-Risk Labor and Delivery Services and Related Outpatient Surgical Services

CMS seeks comments on the ability of an REH to provide low-risk childbirth-related labor and delivery services. Already in Alaska, four CAHs have stopped providing birthing services and other CAHs are only able to serve very low risk pregnant woman. We do not anticipate that hospitals in Alaska that choose to pursue REH model would be able to provide labor and delivery. **Regardless, we support the proposal to allow REHs to provide labor and delivery services.**

In instances where REHs are able to provide low-risk childbirth labor and delivery services, the agency asks whether there should be a requirement that the REH also provide outpatient surgical services. In Alaska, the CAHs that are no longer offering birthing services stopped partly due to the challenges in maintaining the services to provide surgical labor and delivery intervention when necessary. This is essential in Alaska since most of the CAHs are not on the road system and transfer to another facility requires transfer by air or boat and may not be possible during inclement weather. It is our expectation that REHs choosing to **offer labor and delivery services also should be required to have the capacity to perform certain services, including having the necessary staff, equipment and medications to ensure that the patient can be treated or stabilized and**

transferred depending on the severity of the complication. CMS should consider other approaches to ensuring the skills and resources needed will be on hand to provide life sustaining care in the event of an unexpected complication during delivery**.**

Appropriateness of Provider On-Call and Proximity
The agency seeks comments on if it is appropriate for an REH to allow a provider with training or experience in emergency medicine, to be on-call and immediately available by telephone or radio contact and available on-site within a specified timeframe. We are supportive of including this provision, which is similar to what is required of CAHs. Given the unique circumstances of REHs, we ask the agency to carefully consider the appropriateness of the CAH timeframe in making its determination. Moreover, while we support this approach, we want to be clear that in lieu of one of the listed medical professionals being present at the REH, a nurse or other health care worker must be on site at all times to ensure admission and initial care and treatment of individuals when they arrive at the REH.

Annual per Patient Average Length of Stay Not to Exceed 24 Hours
In the proposed rule, CMS states its intention to limit the average annual length of stay per patient to 24 hours. **We urge CMS to give serious consideration to allowing specific exceptions to the 24-hour length of stay requirement.**

First, we are concerned that remote CAHs may sometimes need to care for patients for more than 24 hours due to challenges with transferring to another facility due to weather conditions or transportation delays. In Alaska is it much more complicated than putting a patient in an ambulance and transporting by road and a plane or boat may be 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 very small volume facilities could exceed the average 24-hour limit due to inability to transfer patients due to external factors.

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 two potential hurdles to discharging within 24 hours, 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.

Established Transfer Agreements with Level I or Level II Trauma Centers

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 that transfer agreements to trauma centers are vital to ensure those patients requiring serious medical care can receive it. However, in Alaska there are no level 1 trauma centers and the only level II trauma centers are in Anchorage. 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.

UPDATES TO CRITICAL ACCESS HOSPITAL CONDITIONS OF PARTICIPATION

In its rule, CMS proposes three changes to current CAH CoPs. First, the agency proposes updating the current location and distance requirements for CAHs. All Alaska CAHs are more than 50 miles by road from another CAH or only accessible by air or water. We urge CMS to remember those CAHs that are on islands or inaccessible by roads and be certain any changes do not impact eligibility for these uniquely Alaska facilities. While we don't believe any of the CAHs in Alaska would be impacted by this change we **support CMS' plan to utilize a data-driven, more efficient and streamlined approach to CAH location and distance requirement compliance.**

Second, the agency seeks to establish a CoP for patient's rights that would set forth the rights of all patients to receive care in a safe setting and provide protection for a patient's emotional health and safety and physical safety. The newly established CoP would include requirements for the CAH to inform patients of their rights; address privacy and safety; adhere to confidentiality of patient records; ensure appropriate use of restraint and seclusion; and adhere to patient visitation rights. These provisions already exist for other provider types and will help to ensure that CAH patients and their families are treated properly and safely while also formally requiring the safeguarding of patient medical information. **We support the proposal to include these important protections as CAH CoPs.**

Finally, CMS proposes to allow CAHs that are part of a system to use a unified and integrated systems approach for certain CoP requirements. Specifically, this system-level approach would apply to requirements for infection control and prevention and antibiotic stewardship programs, medical staff and quality assessment and performance programs. **We support CMS' intention of allowing CAHs to utilize system-level approaches to comply with these provisions.** For those providers that are part of a larger system, allowing for compliance at a system-level where possible allows for increased efficiency and coordination that previously was not permissible under the CoPs.

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 CMS throughout the implementation of the new REH designation.

Please contact me if you have questions at 907-586-4068 or by email jmonk@alaskahha.org

Sincerely,

Jeannie Monk, MPH
Senior Vice President

CC: U.S. Senator Lisa Murkowski
U.S. Senator Dan Sullivan