September 17, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

BY ELECTRONIC SUBMISSION

Re: Request for Information on Rural Emergency Hospital Program [CMS-1753-P]

The Kansas Hospital Association (KHA) appreciates this opportunity to submit the following response to CMS’ Request for Information (RFI) regarding the Rural Emergency Hospital (REH) Program established in Section 125 of the Consolidated Appropriations Act of 2021 (CAA). Founded in 1910, KHA strives to be the leading advocate and resource for our state’s 123 community hospitals, including 82 critical access hospitals (CAHs).

In 2011, the KHA Board of Directors identified the need for KHA to look to the future of rural health care and "get in front of the issue" by designing our own future. As a result, the Board appointed the Rural Health Visioning Technical Advisory Group (TAG).

Over the next several years, the TAG focused on five areas of work: 1) establishing a case for change and principles for the future of rural health care in Kansas; 2) identifying and reviewing best practices and emerging models to learn from and guide hospitals; 3) finding or developing models that could be an option for small rural communities to sustain access to primary care; 4) developing scenarios of the future to assist members in structuring leadership discussions about their role and future; and 5) providing resources for members to evaluate collaboration and affiliation.

The TAG’s work culminated in the development of the Primary Health Center (PHC) Model. Like a REH, a PHC would not provide inpatient services. In developing the model, the TAG addressed many of the same issues CMS now raises in the RFI. KHA had been prepared to submit the PHC Model to the Center for Medicare & Medicaid Innovation (CMMI) as a demonstration project prior to CMMI’s announcement of Community Health Access and Rural Transformation (CHART) Model and Congressional approval of the REH Program.

1 For a detailed explanation of the model, see https://www.kha-net.org/CriticalIssues/AccessToCare/RuralIssues/Resources/d129578.aspx?type=view
Our rural hospitals face numerous challenges, including the following:

- The overall health of Kansans has declined more than any other state over the past 30 years. Residents in rural areas suffer from higher rates of chronic health conditions.

- The population in rural Kansas has been shrinking and will continue to do so. The economic impact of declining population is particularly significant for rural hospitals.

- The number of uninsured patients in rural Kansas continues to grow.

- The way in which health care is delivered in our state has changed. Many common procedures no longer require an overnight hospital stay. Current data shows that 37 Kansas hospitals have fewer than two patients staying overnight on any given day. Technology and specialists needed for complex procedures are delivered at a regional level rather than locally.

Kansas hospitals are committed to working on efforts that provide flexibility for rural communities while sustaining access to care. For this reason, our members were pleased when the REH Program was established. It shares many similarities to the PHC Model and we believe the services allowed would be a good fit for many communities struggling to sustain their hospitals. A July 2021 report from the North Carolina Rural Health Research Program applied three measures – negative total margin, low average daily census, and low net patient revenue - to identify such hospitals. Of the 68 rural hospitals identified, 16 are located in Kansas, more than twice the number in any other state.¹

We are pleased to report that our State Legislature responded quickly to this new opportunity with the introduction of the rural emergency hospital act to provide for the licensure of rural emergency hospitals in Kansas. This bill was signed into law by the Governor in April 2021.

This summer, KHA convened a work group of rural hospital leaders to discuss the REH Program and responses to the RFI. The following commentary reflects the work group’s discussions as well as experience gained through the development of the PHC Model.

**Type and Scope of Services Offered**

1. **Staffed Emergency Department**

The CAA requires an REH to have a “physician …, nurse practitioner, clinical nurse specialist, or physician assistant … available to furnish rural emergency hospital services in the facility 24 hours a day.” In defining “available to furnish … services” by regulation, CMS should be informed by the

¹ The report is available at [https://www.ruralhealthresearch.org/alerts/422](https://www.ruralhealthresearch.org/alerts/422)
lessons learned by Kansas rural hospitals using telehealth emergency room support services over the past several years. These lessons have been reinforced during the COVID-19 public health emergency (PHE). Rural hospitals report that their patients have been well-served by physicians immediately available via telehealth to address their emergent and urgent conditions. Rather than defining availability as the number of minutes in which a physician or non-physician practitioner must arrive at the facility, CMS should permit an REH to meet this requirement by securing 24/7 access via telehealth to emergency physicians.

The cost to the REH of securing telehealth coverage will be significantly less than having to pay local physicians and non-physician practitioners to assume these additional responsibilities, making resources available for the REH to provide additional services. Based on their experience, rural Kansas hospital leaders believe telehealth coverage will improve their ability to recruit physicians and non-physician practitioners to their communities, as many have been unwilling to assume the heavy call coverage responsibilities required from rural providers.

2. **Responsibilities of the Doctor of Medicine or Osteopathy**

The CAA requires an REH to meet “[a]pplicable staffing and staffing responsibilities” from those required for CAHs under 42 CFR 485.631. For a CAH, section 485.631(b)(2) requires a “doctor of medicine or osteopathy [to be] present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH” in addition to being “available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral.” The State Operations Manual (SOP) clarifies that “[b]eing “present” in the CAH means being physically on-site in the CAH.” We would suggest the SOP definition be expanded to allow for telehealth presence to be allowed.

3. **24-Hour Length of Stay**

The CAA states services furnished in an REH cannot “exceed an annual per patient average of 24 hours.” The calculation of this average for compliance purposes should exclude those patients for whom transport to another facility is delayed for reasons beyond the REH’s control including, for example, delay in securing an available bed at a receiving hospital and delay in transporting the patient due to weather or lack of available ambulance services. REH staff should not be expected to micro-manage the time each patient spends in the facility to account for uncontrollable circumstances.

4. **Outpatient Services**

An REH should be permitted to offer any hospital outpatient service it furnished prior to conversion to an REH, provided it satisfies the applicable Condition of Participation for that service (e.g., laboratory, radiology, and rehabilitation therapy services in compliance with 42 CFR 485.635; surgical services in compliance with 42 CFR 485.639). An REH should be permitted to provide these services directly or under arrangement with a third party.
As CMS notes in the RFI, it is likely there will be services to which a rural community will not have access if not furnished by its REH. An REH, however, cannot provide services for which there is not sufficient reimbursement to cover its operating costs. REHs will be challenged to provide those services with higher fixed costs due to low patient volumes. From the program’s launch, CMS should carefully monitor the adequacy of REH reimbursement to support essential local services, as opposed to waiting to complete the statutorily-mandated studies years later.

5. Virtual Care

Virtual care holds great promise in promoting health equity, but only if there is equal access to these services. Unfortunately, Medicare payment policy unnecessarily limits access to these services. Following the end of the COVID-19 public health emergency, providers will be limited to providing virtual services for their established patients. This, in effect, means a Medicare beneficiary may access virtual services only if the beneficiary’s provider furnishes them. At present, only a small number of providers make these services available to their patients. In 2019, the most recent year for which utilization data is publicly available, fewer than 24,000 practitioners billed Medicare for chronic care management services (CPT® 99490). This represents approximately 10% of the primary care physicians participating in the Medicare program. As a result of the established patient requirement, the majority of Medicare beneficiaries are denied access to virtual services.

Medicare beneficiaries residing in underserved and rural areas are more negatively impacted. A higher percentage of these Medicare beneficiaries lack an established relationship with a primary care provider due to provider shortages. And rural providers are less likely to have the resources needed to establish virtual services programs in their practices.

As a matter of health equity, these beneficiaries should not be denied access to virtual services. Instead, providers capable of furnishing these services across a broader population should be able to initiate services with a beneficiary with which the provider does not have an established relationship following a virtual visit to secure consent, confirm diagnoses, and establish the care plan. (In most cases, this virtual visit would not be a billable telehealth service, given the statutory and regulatory limits on restrictions on Medicare coverage for telehealth services.) To ensure continuity of care for those beneficiaries with a primary care provider, the virtual care provider should share relevant information on a regular basis with any provider identified by the beneficiary. These types of collaborative care arrangements benefitting rural residents should be encouraged by Medicare payment policy, not limited by the established patient requirement.

While CMS may consider the established patient requirement as a protection against fraud and abuse in the provision of virtual services, there are more reasonable safeguards than one which

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2 2019 was the first year for Medicare reimbursement for remote physiologic monitoring under CPT® 99453, 99454, and 99457. Fewer than 1,000 practitioners billed for these services that year.
denies beneficiaries access to care. For example, CMS could require the provider to give a specific notice to new patients receiving virtual services.

Other Medicare payment policies also limit access to virtual care. While CMS reimburses rural health clinics for certain care management services, it refuses RHC reimbursement for remote physiologic monitoring, again denying rural beneficiaries access to these services.

Finally, without adequate broadband, access to virtual services is limited. KHA urges CMS to work with other federal agencies to prioritize those communities transitioning to the REH model for broadband assistance to provide reliable access to care.

6. **Acute Hospital Care At Home**

CMS’ COVID-19 waiver permitting approved hospitals to furnish acute hospital care at home has proven successful in expanding capacity, achieving improved outcomes, and reducing costs. With some modification, this model could provide an REH with an alternative to transferring all patients requiring acute care. Although not specifically authorized by the CAA, CMS could rely on CMMI’s authority to establish a payment model for REHs to deliver acute hospital care at home for Medicare beneficiaries with lower acuity conditions (e.g., pneumonia, heart failure, or COPD without complications) using telehealth, remote monitoring, and regular nursing visits. With reimbursement for these services, an REH can maintain the local health care infrastructure; staff that previously supported inpatient services can transition to delivery care in the home.

**Health Equity**

1. **Ambulance Transportation**

Kansas rural hospital leaders considering REH conversion are deeply concerned that the communities they serve will lose access to essential inpatient services. Today, residents must leave their community to receive tertiary or quaternary care. Transportation issues plague these residents, as Medicare coverage for ambulance services is limited. With an REH, residents would have to travel outside their community to receive any level of acute care (absent the opportunity to receive acute hospital care at home). Unless transportation issues associated with patient transfers are addressed, rural residents will face serious inequities in access to acute care services.

CMS must re-evaluate current Medicare reimbursement rules for ambulance services to align such payment with the REH model. CMS should specifically define what constitutes “medically necessary and reasonable” and “nearest appropriate facility” when an REH patient is transported to another facility for acute care services.

In Kansas, we have experienced these issues first-hand. Since 2015, the hospitals in Independence and Fort Scott, Kansas – each of which served a community of approximately
10,000 - have closed. Each community is now served by an emergency department operated by a hospital in a neighboring town. These hospital leaders – who would be happy to discuss their experiences directly with CMS officials – report numerous challenges in arranging transportation to an acute care facility and back to the patient’s home community. In many cases, overly strict interpretations of “medically necessary and reasonable” and “nearest appropriate facility” have resulted in Medicare beneficiaries being charged thousands of dollars to access acute care services that previously had been available in their local community.

2. **National Health Services Corps**

Achieving health equity for residents of rural and underserved communities begins with securing an adequate number of providers available to meet the community’s needs. Presently, CAHs and rural health clinics are eligible to become a National Health Services Corps-approved site, enhancing their ability to recruit providers to their communities. CMS should work with the Health Resources and Services Administration to ensure REHs have these same opportunities.

3. **Accountability for Reducing Health Disparities**

In the RFI, CMS asks how the REH CoPs can ensure executive leadership is held accountable for reducing health disparities, such as encouraging the use of diversity and inclusion strategies to establish a diverse workforce reflective of the community. Given the available workforce in small, rural communities, CAHs struggle to hire qualified individuals for open positions.

While imposing additional administrative requirements on REHs in the name of promoting health equity may seem reasonable, compliance with such “check-the-box” requirements drains scarce resources with little or no community benefit. Moreover, REHs should not be required to shoulder any greater regulatory burden than PPS hospitals or CAHs, as the CoPs for these providers do not impose accountability for reducing health disparities.

Kansas hospitals have an interest in engaging in activities that address social determinants of health but find the lack of adequate reimbursement for these activities to be a barrier.

**Collaboration and Care Coordination**

1. **Transfer Agreements**

The CAA requires an REH to have a transfer agreement with a Level I or Level II trauma center. In Kansas, however, there are only three Level 1 trauma centers (two in Wichita and one in the Kansas City metro area) and two Level 2 trauma centers (one in Topeka and one in the Kansas City metro area). Given the distance to these facilities (for many over 100 miles) and the fact they often cannot accept transfers due to lack of available beds, CAHs frequently transfer patients to Level III or Level IV facilities based on the patient’s specific needs. A CAH that discontinues inpatient services will need to arrange for transfers of lower acuity patients for
whom it previously provided inpatient services; there are currently in place arrangements to transfer higher acuity patients.

To facilitate appropriate transfers and to support their local hospitals, REHs should be held to a standard similar to the CAH requirement regarding participation in rural health networks as specified in 45 CFR 485.603. In addition to the elements included in section 485.603 (transfers, communication systems, and transportation), these network agreements should identify other areas of collaboration among the network members, e.g., telehealth and virtual services, training, and staffing arrangements.

A regional plan to assure emergent and non-emergent transportation will be needed. Consideration of additional funding for transportation costs is urged.

Many CAHs benefit greatly from the relationship they have with their supporting hospital. As KHA worked on the PHC Model, we noted an even greater need for some type of “partner” facility to provide clinical and operational support. The CAA is silent on whether such a relationship will be available for a REH. We encourage CMS to address this in the COPs.

Additionally, to facilitate collaboration and care coordination among an REH and the hospitals to which it transfers patient, CMS should promulgate appropriate Anti-Kickback Safe Harbors and Stark Law exceptions protecting an REH’s financial arrangements with rural health network participants. As Kansas rural hospital leaders report, compliance concerns relating to the fraud and abuse laws have limited the scope of collaborative arrangements among hospitals. Similar concerns should not restrict the close working relationships REHs must foster with regional hospitals to ensure access to care for their communities.

**Quality Measurement**

1. **Measure Selection**

When considering quality measures for the REH, KHA urges CMS to start small, automate as much as possible, and make sure the measures are rural relevant. Some of the Medicare Beneficiary Quality Improvement Project (MBQIP) measures may be applicable to REHs, such as the Emergency Department Transfer of Communication Measures. OP-22 and OP-18 also may be applicable. Patient experience should be included in some way. Other areas to consider would be time from arrival to being seen, time to transfer on a few specific critical diagnosis, healthcare worker immunization rates, antibiotic prescribing rates, and/or opioid prescribing rates.

CMS should limit reporting requirements to measures with broad application as opposed to those focused on a specific patient population. The relatively small number of patients served in rural facilities can skew the story told by numbers. If a facility has served only a handful of patients that meet a specific measure criteria, a single missed measure can result in a low overall score.
KHA also has found that small patient populations make it challenging to get good response rates for patient experience in the traditional way that HCAHPS is conducted. We have been piloting a few projects in Kansas through our FLEX program to get patient experience information at the time of discharge for both inpatients and swing beds. Hospitals have reported a much higher rate of return and find the information more meaningful than the results obtain with traditional patient surveys.

Small rural hospitals often have a single individual responsible for quality reporting, and that individual usually wears many additional hats. We have seen significant turnover in these positions; it is not uncommon for 20 percent of our members to have a new quality director in any given year. This certainly creates a barrier to consistent and accurate reporting. Pulling information from claims or EHRs can reduce burden on staff, but this also can be problematic. Small facilities do not have IT staff capable of pulling the information themselves, so they have to turn to the vendor who charges a hefty fee for assisting with this kind of project.

2. **Technical Assistance - FLEX Program Participation**

In addition to imposing quality reporting requirements on REHs as specified by the CAA, CMS also must provide technical support for these organizations. Unfortunately, the CAA does not include conforming amendments to include references to rural emergency hospitals in the provision establishing the Medicare rural hospital flexibility program, 42 USC 1395i-4(g)(1). However, this oversight should not limit the agency’s authority to promulgate regulations permitting REH participation in the FLEX Program’s funding for quality improvement, quality reporting, performance improvement, and benchmarking in the same manner CAHs now participate in the program.

**Payment Provisions**

1. **Fixed Payment Amount**

Per the CAA, the REH fixed monthly payment for 2023 will be the difference between the total amount paid to all CAHs in 2019 and the estimated total amount that would have been paid under the inpatient hospital, outpatient hospital, and SNF prospective payment systems divided by the total number of CAHs in 2019. Whether the REH model is a viable option largely will depend on the fixed payment amount. To permit hospitals to fully evaluate the viability of the REH model for their communities, KHA urges CMS to include the specific calculation and the amount of the fixed payment in its proposed rule for the program, as well as the specific formula for future annual updates based on hospital market basket percent increases.

Regarding the calculation, CMS should utilize the per diem rate for inpatient hospital and swing bed services and the ratio of cost to charges for hospital outpatient charges each CAH received in 2019 without regard to final settlement. To calculate the SNF PPS payment CAHs would have received, CMS should use the RUG-IV model for the entire year, disregarding the transition to the
Patient Driven Payment Model at the beginning of FFY 2020. Finally, the six CAHs that closed in 2019 (including two in Kansas) should be excluded from the calculation because they did not operate and did not receive payments for the full year.

The CAA requires the fixed payment be updated annually based on a “hospital market basket percent increase.” Beginning in 2020, the COVID-19 pandemic upended most hospitals’ cost structures. It is unclear whether or how future adjustments based on a hospital market basket index will adequately capture the recent turbulence in hospital costs and utilization and its longer-term reverberations. If CMS does not accurately account for the effect of the pandemic in determining future market basket increases, the amount of unreimbursed REH cost will be significant and the effect of the omission likely will be magnified over time. KHA recommends that CMS adopt regulations that explicitly accommodate the effect of the pandemic.

The CAA requires that an REH maintain and submit detailed information regarding its use of the fixed payment. KHA urges CMS to provide transparency as to what reporting processes will be mandated and how the information will be used.

2. **Use of OPPS to Reimburse REHs**

The OPPS system is established based on assigning the resources consumed by full-service hospitals into weights used to pay for outpatient services. Because an REH will provide limited services, utilizing the OPPS APC weighting system to determine reimbursement may not provide sufficient alignment of the resources needed to care for REH patients. KHA recommends that CMS create a new weighting scale for REHs based on REH resource consumption. Although this would not be possible until enough historical REH claim data have been received, KHA urges CMS to begin drafting proposed language that would be used to establish REH weights.

3. **Other Payers**

In developing regulations and implementing the REH Program, CMS should, to the fullest extent possible, direct or encourage other payers to implement substantially similar REH payment policies, including state Medicaid programs, Medicare Advantage plans, federal employee benefit plans, and qualified health plans. Such consistency across payers would eliminate uncertainty and thus enhance REH planning and operations. In the experience of those Kansas hospitals that transitioned to the CAH model, inconsistent treatment from payers hindered the transition, as these hospitals had to adapt to different rules and processes.

Again, to the fullest extent possible, CMS should direct or encourage other payers to fairly reimburse REHs in a manner that accounts for these facilities’ higher cost structures. According to the Center for Healthcare Quality and Payment Reform, the majority of rural hospitals with less than $20 million in annual expenses experienced losses on patients with private health

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3 For a list of hospital closures by year, see https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
insurance plans and self-pay patients that were greater than losses on Medicare, Medicaid, and uninsured charity care patients combined. These payers should share responsibility for ensuring the rural residents for whom they provide health insurance coverage maintain access to local care.

Finally, CMS should direct or encourage other payers to either eliminate or expedite prior authorizations for REH transfers to other hospitals for inpatient care. Hospitals have long complained about the slow turnaround times, as well as lack of prior authorization approvals by Medicare Advantage plans.

4. **Post-Acute Care**

Hospitals report that one of the most problematic aspects of the REH model is the requirement to discontinue swing bed services. Today, CAH swing beds make available skilled nursing facility services for rural residents who would otherwise be forced to remain miles away from their home following an inpatient admission. An analysis of Medicare Part A claims data from 2014 to 2017 performed for the University of Kansas Health System demonstrated that Kansas swing beds had lower readmission rates and shorter lengths of stay as compared to Kansas skilled nursing facilities. As measured by a 90-day episode starting on the inpatient anchor discharge date, the total cost of care associated with a swing bed stay is comparable to a SNF stay. Although the SNF daily rate is significantly lower, the swing beds’ shorter lengths of stay and fewer hospital readmissions positively impact the total cost of care.

<table>
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<td>$37,356</td>
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Under the CAA, an REH may include a distinct part unit licensed as a skilled nursing facility to furnish post-hospital extended care services reimbursed under the SNF prospective payment system. The CAA does not include any enhanced payment to account for the lower patient volumes in rural areas.

Kansas rural hospital leaders considering REH conversion have expressed concern regarding this abrupt transition to SNF PPS, given the lack of infrastructure needed to perform MDS assessments and required quality reporting. CMS should develop a transition plan to support

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4 Available at [https://ruralhospitals.chqpr.org/Problems.html](https://ruralhospitals.chqpr.org/Problems.html)

5 The University of Kansas Health System would be pleased to share the complete methodology and results of this analysis with CMS, if requested.
this transition, including establishing supplemental payments as part of SNF PPS to maintain essential services in these rural communities.

Also, KHA urges CMS to closely monitor the conversion and the loss of local skilled nursing services. We believe the agency should report annually on capacity and supply of these services, along with wait and drive times beneficiaries are experiencing in accessing an appropriate placement as a result of REHs’ inability to stand up and support a distinct part licensed SNF facility.

5. **Outpatient Therapy Services**

While the CAA includes an enhanced payment for REHs for services reimbursed under OPPS, it makes no provision for services that would be reimbursed under the Medicare Physician Fee Schedule, such as outpatient therapy services. However, the same reason for including enhanced reimbursement for OPPS services applies to outpatient therapy services – lower patient volumes result in a higher per-service costs. CMS should incorporate into the Medicare Physician Fee Schedule additional reimbursement for services furnished in an REH comparable to the additional payment under OPPS.

6. **Rural Health Clinic Status**

The CAA provides that an REH is “considered a hospital with less than 50 beds for purposes of the exception to the payment limit for rural health clinics....” To eliminate any confusion, however, CMS should clarify that an REH-based rural health clinic will continue to be reimbursed in the same manner as it was prior to REH conversion, i.e., the clinic’s grandfathered status will not be impacted by the conversion.

The small volumes that exist for both a clinic and an REH present an opportunity for resource sharing (space, workforce and equipment) among the entities. We encourage CMS to allow for these kinds of flexibilities to promote more efficient operations.

7. **Method II Billing**

The CAA does not address whether an REH may elect Method II billing for physician services in the same manner as CAHs pursuant to 42 USC 1395m(g)(2)(B). If possible, CMS should afford this opportunity to REHs, for the same reasons it is now available to CAHs.

**Enrollment Process**

1. **State Operations Manual and Surveyors**

KHA urges CMS to publish the completed chapter for the State Operations Manual concerning the REH Program at the same time it publishes final regulations for the program. This will eliminate any ambiguity regarding program operations, thus providing hospital leaders with
critical information in deciding whether to pursue conversion to an REH. CMS also should require training for those surveyors who will evaluate a facility’s compliance with REH Program requirements to reduce the risk of confusion and misinterpretation of those requirements.

2. **Reversion**

The CAA states an REH may elect to convert back to its prior designation as a CAH or PPS hospital subject to requirements established by CMS. As part of those requirements, CMS should clarify that an REH that previously held a CAH necessary provider designation may convert back to that designation without consideration of the factors specified in 42 CFR 485.610(d) regarding facility relocation. Without clear language, CAHs will be very reluctant to convert to an REH.

Communities that have lost their hospitals to closure in the recent past have expressed interest in the REH Model, although the CAA limits the opportunity to hospitals currently in operation. KHA urges CMS to allow those recently closed entities to be eligible for the REH model.

Again, thank you for the opportunity to provide input on the development of the REH Program. With more than ten years’ investment in identifying and evaluating rural models of care, KHA stands ready to provide any assistance CMS may request as the agency develops proposed regulations governing the REH Program. If CMS would find it helpful to visit a community whose hospital may be a good candidate for conversion to better understand the population served, services needed, and distance from other services involved, we would be happy to coordinate that opportunity.

Sincerely,

Chad Austin
President and Chief Executive Officer