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,

The Kansas Hospital Association is pleased 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 (REHs) and Critical Access Hospitals (CAHs). 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.1 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 state and rural hospitals face significant 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 population in rural Kansas continues to get older. The largest age group in over half of Kansas counties is 70 years or older. These adults often have more complex health conditions and require access to health care on a frequent basis.

- Most of Kansas is classified as frontier (37 out of 105 counties) or rural (89 out of 105 counties). Older residents in these counties often face transportation challenges which makes accessing health care services outside their community challenging.

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

- The way in which hospitals deliver care 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 available 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 Congress authorized the REH Program. 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.

As referenced in the Proposed Rule, 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 those hospitals most likely to consider REH conversion. Of the 68 rural hospitals identified in the report, 16 are in Kansas, more than twice the number in any other state.²

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.

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

The success of the REH Program is critical to preserving access to essential health care services in rural communities. Thus, CMS should do all that it can to eliminate uncertainty from the REH conversion process.

² The report is available at https://www.ruralhealthresearch.org/alerts/422
Rural hospitals evaluating this opportunity need to know exactly what will be required to convert and operate as an REH. As we learned through CAH conversion process over twenty years ago, concerns over the unknown often outweigh the potential benefits of moving forward.

Following publication of the Proposed Rule, KHA convened a work group of rural hospital leaders, many of whom participated in the TAG and the development of the PHC Model. This work group reviewed the proposed CoPs critically, identifying opportunities to bring greater certainty to the rules, to eliminate administrative burden, and to accommodate the realities of rural health care.

We had anticipated CMS would use the CAH CoPs as the model for the REH CoPS. The CAH CoPs have proven sufficiently flexible to meet rural providers’ unique circumstances. With the accompanying State Operations Manual, they provide a well-defined set of rules for operating a smaller facility to meet specific community needs. Several proposed REH CoPs, however, are based on the more detailed hospital CoPs. This adds more uncertainty for CAHs evaluating operational changes associated with REH conversion. It is also contrary to the core purpose of the REH Program: maintaining access to care by reducing overhead expense.

**Proposed 42 CFR 485.502 - Definitions**

The proposed definition of an REH incorporates the statutory requirement that the facility’s “annual per patient average length of stay [not exceed] 24 hours.” In the preamble, CMS considers and dismisses stakeholders’ recommendation to exclude certain patients from the length of stay calculation due to difficulties associated with transfers, assuming “this will occur at a frequency that will not seriously affect the REH’s average length of stay.”

Given an REH would be subject to corrective action if its average annual length of stay exceeded 24 hours, staff are likely to find themselves in the position of having to micro-manage the time each patient spends in the facility to offset for uncontrollable circumstances, including the lack of available ambulance transport or the lack of available beds at the receiving facility. In Kansas, for example, it is not unusual to wait several days for an open bed at an inpatient psychiatric facility. Thus, REH staff would have to be constantly vigilant to maintain a sufficient reserve of time to account for these outliers. This added administrative burden serves no purpose, other than to satisfy an overly narrow reading of statutory language.

KHA urges CMS to include clarifying language to exclude from the calculation of annual per patient average length of stay those patients whose transport to another facility was delayed for more than 12 hours from the time the decision to transport was made due to circumstances beyond the REH’s control.

**Proposed 42 CFR 485.506 - Designation & Certification of REHs**

KHA asks CMS to clarify which beds will be counted to determine a PPS hospital’s eligibility for REH conversion. KHA proposes CMS use the methodology specified in 42 CFR 412.05(b), which also is used to determine a rural health clinic’s provider-based status. See 42 CFR 413.65(e)(3)(vi)(A).

KHA also requests CMS clarify that any subsequent reclassification of the area in which an REH is located from rural to urban will not impact the REH’s status.
Proposed 42 CFR 485.510 - Governing Body and Organizational Structure

This is the first of several proposed REH CoPs that impose the same requirements as the corresponding hospital CoP. The proposed REH governing body CoP uses language from 42 CFR 482.12, specifically (1) the introductory paragraph requiring a governing body or individual “legally responsible for the conduct of the hospital,” (2) subsection (a) regarding medical staff oversight, and (3) subsection (e) regarding contracted services. (The proposed REH CoP does not include the sections of the hospital CoP regarding chief executive officer, care of patients, or institutional budget.)

KHA urges CMS to instead use the relevant CAH CoPs to establish the standards for REHs, given the greater flexibility afforded by those regulations as compared to the hospital CoPs. Specifically, 42 CFR 485.627(a) sets out the governing body requirements under which CAHs now operate:

The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH’S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

As discussed in the following section, the CAH CoP on staffing and staffing responsibilities, 42 CFR 485.631, establish medical staff requirements. Finally, the CAH CoP regarding provision of services, specifically 42 CFR 485.635(c)(4), assigns the governing body responsibility for oversight of services furnished under contract.

Proposed 42 CFR 485.512 – Medical Staff

The language of this proposed CoP is from the hospital CoP on medical staff, 42 CFR 482.22, except for those provisions on inpatient care. As discussed below, CMS also is proposing to incorporate into the REH CoPs (specifically, proposed 42 CFR 485.528) the more flexible rules it has developed for CAH medical staffs set forth in the CAH CoP on staffing and staffing responsibilities, 42 CFR 485.631. KHA urges CMS not to impose on REHs the detailed requirements to which hospitals with large medical staffs are subject. For a CAH considering REH conversion, the uncertainty surrounding compliance with these new medical staff requirements creates an unnecessary hurdle. Given the underlying purpose of the REH Program is to reduce burden to maintain rural access to care, CMS should strive to streamline these processes to fullest extent possible.

Proposed 42 CFR 485.514 – Provision of Services

This proposed CoP is based on the standard on patient care included in the broader CAH CoP on provision of services, 42 CFR 485.635. KHA supports the inclusion of these requirements for REHs.

CMS has elected not to incorporate other standards included in the CAH CoP in the REH CoP, including laboratory services (subsection (b)(2)), radiology services (subsection (b)(3)), and nursing services (subsection (b)(d)), instead proposing to impose separate CoPs on these subjects mostly based on the corresponding hospital CoPs. As explained more fully in the following sections, KHA urges CMS to incorporate the entirety of 42 CFR 485.635 in this CAH CoP (with the exception subsection (f) on patient rights) in place of adopting separate CoPs.
**Proposed 42 CFR 485.516 – Emergency Services**

As required by the authorizing statute, CMS proposes REHs be held to the same standards set forth in the CAH CoPs for emergency services, 42 CFR 485.618. This includes the requirement that a physician or non-physician practitioner must be on-site within 30 minutes (or 60 minutes in specified circumstances).

KHA urges CMS to consider revising 42 CFR 485.618 (and, by extension, the requirements to which REHs will be subject) to permit the on-site requirement to be satisfied by a physician or non-physician practitioner available by telehealth. Specifically, CMS should authorize a CAH’s governing body on the recommendation of its medical staff to determine those circumstances in which such virtual presence would be appropriate.

Over the last few years, several Kansas CAHs have elected to contract with third parties for tele-emergency services. Under these arrangements, staff in the CAH emergency department can involve a specialist at a distant site in a patient’s care within a just few minutes. These CAHs also bear the expense of maintaining full-time call coverage as required by the CoPs, although the burden imposed on these physicians and non-physician practitioners is reduced due to the availability of tele-emergency services.

Rural hospitals report that their patients have been well-served by physicians immediately available via telehealth to address their emergent and urgent conditions. The cost to the CAH or REH of securing telehealth coverage would 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 they are unwilling to assume the heavy call coverage responsibilities required from rural providers.

In addition to the proposed REH CoP for emergency services, CMS also proposes conforming amendments to the EMTALA regulation, 42 CFR 489.24, to make REHs subject to the law’s requirements. KHA urges CMS to make one additional amendment to the definition of “comes to the emergency department” in subsection (b)(4). Presently, that section permits a hospital (as defined for purposes of EMTALA) to direct a non-hospital owned ambulance not on hospital property to transport the patient to another facility if the hospital is on diversionary status. Given REH’s provide more limited services and, that in some cases, transporting a patient to an REH would cause unnecessary delay in the patient receiving appropriate evaluation and treatment, CMS should add new language to subsection (b)(4) to avoid such circumstances, i.e., permitting an REH to direct a non-REH owned ambulance not on REH property to transport the patient to another facility if the REH determines it does not have the capabilities to evaluate or treat the patient.

**Proposed 42 CFR 485.518 – Laboratory Services**

This proposed CoP is not based on the corresponding hospital CoP, 42 CFR 482.27, or the relevant portion of the CAH CoP on provision of services, 485.635(b)(2)). It requires an REH to provide to “laboratory services essential to the immediate diagnosis and treatment of the patient consistent with nationally recognized standards of care for emergency services.” KHA recommends CMS delete this vague provision, instead incorporating the relevant portion of the CAH CoP, which lists six specific laboratory tests as the minimum standard.
**Proposed 42 CFR 485.520 – Radiologic Services**

This proposed CoP is based on the on the hospital CoP for radiologic services, 42 CFR 482.26. Rather than imposing these prescriptive requirements on REHs, CMS should opt for the flexibility afforded by the relevant portion of the CAH CoP on provision of services, 42 CFR 485.635(b)(3).

**Proposed 42 CFR 485.22 – Pharmaceutical Services**

This proposed CoP is based on the hospital CoP for pharmaceutical services, 42 CFR 482.25. Again, KHA asks CMS to afford REHs the flexibility found in the relevant provisions of the CAH CoPs, specifically 42 CFR 485.623(b)(3) and 42 CFR 485.635(a)(3)(iv) and (v).

**Proposed 42 CFR 485.524 – Additional Outpatient Medical and Health Services**

KHA supports CMS’ proposal not to place restrictions on the types of additional outpatient services an REH may provide. However, KHA believes the standards CMS proposes to impose on these services are unnecessarily prescriptive. Regarding subsection (a), CMS should retain the language consistent with the CAH CoP for patient services at 42 CFR 485.635(b)(1) and delete the remaining language (including subsections (a)(1) through (a)(5). The requirements imposed in these subsections – including referral arrangements, patient/family “communications systems,” and “established relationships” with other hospitals - go beyond the requirements for hospitals and CAHs, and thus create more uncertainty for those considering the REH Program.

Subsection (b), the standard for personnel for additional outpatient and medical health services [sic], and subsection (c), orders for outpatient medical and health services, are based on subsections (b) and (c) of the hospital CoP for outpatient services, 42 CFR 482.54. The CAH CoPs do not include similar provisions. While these provisions are appropriate for a facility with a large medical staff offering a full range of outpatient services, they only add unnecessary burden for a small facility like an REH.

Subsection (d) regarding surgical services is based on the CAH CoP, 42 CFR 485.639. KHA supports the inclusion of this provision in the REH CoPs.

**Proposed 42 CFR 458.526 – Infection Prevention and Control and Antibiotic Stewardship Programs**

This provision is based on the corresponding CAH CoP incorporating the changes to that provision in the Proposed Rule. KAH supports this language, noting its comments below regarding the proposed change to the CAH CoP.

**Proposed 42 CFR 485.428 – Staffing and Staffing Responsibilities**

KHA supports the inclusion of this proposed REH CoP, derived from the CAH CoP on staffing and staffing responsibilities, 42 CFR 485.631, and as discussed above, believes its inclusion makes the proposed REH CoP on medical staff, 42 CFR 485.512, unnecessary.

KHA asks CMS to provide clarification regarding emergency department staffing requirements. Subsection (a) states the department “must be staffed [24/7] to receive patients and activate the appropriate medical resources.” Subsection (b) states “[a] registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the REH has one or more patients receiving emergency care or observation care.” One could interpret these provisions to permit an REH to staff the emergency department with a nursing assistant, provided an RN, CNS, or LPN is on-call to respond when a patient presents in the emergency department. If CMS
intends otherwise, it should address this matter directly, as required staffing levels are a key consideration when evaluating the REH opportunity.

Also, KHA requests CMS to address whether having an RN, CNS, or LPN on duty at the rural health clinic attached to an REH can also serve as the required on-duty personnel for the REH.

Finally, KHA proposes CMS revise subsection (c)(2) as follows:

A doctor of medicine or osteopathy must be present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the REH, and is available through direct radio or telephone communication or electronic communication for medical direction, consultation, supervision, assistance with medical emergencies, and patient referral.

This proposed revision is consistent with the changes CMS approved for the COVID-19 public health emergency for CAHs. Our member CAHs report these arrangements have worked well, given near immediate access available through enhanced technologies. Permitting these services to be furnished via telehealth for REHs is appropriate given these facilities’ limited resources.

Proposed 42 CFR 485.530 – Nursing Services

The language of this proposed CoP is not consistent with the relevant CAH or hospital CoP. Again, in the interests of consistency and flexibility, KHA recommends CMS incorporate the relevant provision in the CAH CoP on provision of services, 42 CFR 485.635(d), into that REH CoP, eliminating those provisions specific to inpatient care.

Proposed 42 CFR 485.532 – Discharge Planning

This proposed CoP is consistent with the relevant CAH CoP, 42 CFR 485.642, but it imposes duties for which an REH should not be responsible given it does not have inpatient beds. Specifically, CMS should (1) incorporate language to clarify that an REH is not responsible for discharge planning for any patient for which it arranges a transfer to a hospital or CAH; and (2) revise section (a)(6) to limit the requirement for regular re-evaluation to patients receiving observation services.

Proposed 42 CFR 485.534 – Patient’s Rights

This provision includes the same language as the proposed CAH CoP. KHA supports this language, noting its comments below regarding the effective date for these requirements.

Proposed 485.536 – Quality Assurance and Performance Improvement

For this CoP, CMS proposes to use the hospital CoP, 42 CFR 482.21, with minor changes. KHA urges CMS to replace this provision with the CAH CoP. When CMS finalized the CAH CoP for QAPI in 2019, the agency revised its proposed language – which reflected the existing hospital CoP - to “eliminate unnecessary prescriptiveness” and thus “allow each CAH the flexibility to implement its QAPI program in the most efficient manner for its unique circumstances.” 82 Fed. Reg. 51,785 (Sept. 30, 2019). For example, the proposed language for 42 CFR 485.641(c) included the language in red, which CMS deleted in the final rule:
The CAH’s governing body or responsible individual is ultimately responsible for the CAH’s QAPI program and is responsible and accountable for ensuring that the QAPI program meets the requirements of paragraph (b) of this section and that:

1. Clear expectations for safety are communicated, implemented, and followed throughout the CAH.
2. The QAPI efforts address priorities for improved quality of care and patient safety.
3. All improvement actions are evaluated and modified as needed.
4. Adequate resources are allocated for measuring, assessing, improving and sustaining the CAH’s performance and reducing risk to patients.
5. The determination of the number of distinct improvement projects is made annually.
6. The CAH develops and implements policies and procedures for QAPI that address what actions the CAH staff should take to prevent and report unsafe patient care practices, medical errors, and adverse events.

The corresponding provision in the proposed REH CoPs states as follows, closely mirroring the language CMS deleted from the proposed CAH CoP:

The REH’s governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the REH), medical staff, and administrative officials are responsible and accountable for ensuring the following:

1. That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
2. That the REH-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.
3. That clear expectations for safety are established.
4. That adequate resources are allocated for measuring, assessing, improving, and sustaining the REH’s performance and reducing risk to patients.

KHA encourages CMS to recognize that REHs should have the same flexibilities as CAHs now enjoy in implementing and operating their QAPI programs to meet the specific needs of their communities.

 Proposed 42 CFR 485.538 – Agreements

This proposed CoP implements the authorizing statute’s requirement that an REH have a transfer agreement for patients requiring emergency medical care beyond the REH’s capabilities with a Level 1 or Level 2 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 these trauma centers often cannot accept
transfers due to lack of available beds, many Kansas CAHs – including those most likely to convert to REH status - transfer most patients to Level 3 or Level 4 facilities. The same is true for CAHs in other rural states.

In the preamble, CMS notes an REH may maintain arrangements with Level 3 or Level 4 facilities but will be required to have an agreement with a Level 1 or Level 2 facility. Rather than requiring an REH to invest time and resources into negotiating and maintaining an agreement with a hospital to which the REH will rarely transfer a patient, CMS should create a regulatory exception for those REHs located more than 50 miles from a Level 1 or Level 2 trauma center, permitting these REHs to satisfy this requirement by maintaining arrangements with closer facilities.

KHA also encourages CMS to incorporate into this CoP specifications for an REH’s agreement with a trauma center. To facilitate appropriate transfers and to support their local hospitals, REHs should be held to a standard like 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), REH agreements should identify other areas of collaboration among the network members, e.g., telehealth and virtual services, training, and staffing arrangements.

Many CAHs benefit 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. To facilitate these working relationships, CMS should work with the Office of Inspector General to develop an Anti-Kickback Statute safe harbor to protect these arrangements. 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.

In the proposed rule, the standard regarding agreements for credentialing and privileging telehealth providers are included in the governing body CoP, 42 CFR 485.510. KHA recommends CMS move this standard to this CoP, consistent with the relevant CAH CoP, 42 CFR 485.616(c).


KHA notes subsection (e) of this proposed CoP references “CAH” instead of “REH.”

Proposed 485.544 – Physical Environment

This proposed CoP is based on the hospital CoP for physical environment, 42 CFR 482.41, with some minor differences. KHA urges CMS to instead base this provision on the CAH CoP, 42 CFR 485.623, a streamlined version of the hospital CoP, which is more appropriate for a smaller facility with more limited operations.

Proposed 42 CFR 485.546 – SNF Distinct Part Unit

KHA urges CMS to afford a CAH that has furnished long-term care services in swing beds in compliance with 42 CFR 485.645 adequate time to bring its operations into full compliance with all SNF requirements following REH conversion. As required under 42 CFR 485.645(d), such CAH’s swing bed operations would have met SNF requirements regarding resident rights; admission, transfer, and discharge rights; freedom from abuse, neglect, and exploitation; social services; comprehensive assessment, comprehensive care plan, and discharge planning (with specified exceptions); specialized rehabilitative services; dental services; and nutrition.
To the extent additional time and effort will be required to meet other regulatory requirements (e.g., completion of staff training required by 42 CFR 483.95, processes to complete certain patient assessments required by 42 CFR 483.20), the REH should be afforded one year from the date of conversion to achieve full compliance.

Similarly, the REH will require time to train staff and develop processes to capture required data for the SNF Patient-Driven Payment Model. Thus, CMS should provide by regulation that an REH SNF distinct part unit will continue to be reimbursed at the former CAH’s most recent interim rate for swing bed services for one year unless the REH elects otherwise.

While appreciating the authorizing statute only permits an REH to maintain inpatient beds in a SNF distinct part unit, KHA urges CMS to provide guidance regarding the treatment of distinct part rehabilitation units and psychiatric units operated by a CAH should the CAH elect REH conversion. These facilities provide vital services in rural communities and CMS should develop some method by which these services can be maintained following REH conversion.

**KHA’s Recommended Changes to 42 CFR 410.40 – Coverage of Ambulance Services**

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.

At a minimum, CMS must amend 42 CFR 410.40(d) regarding origin and destination requirements, which presently provides in relevant part:

Medicare covers the following ambulance transportation:

(1) From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.

(2) From a hospital, CAH, or SNF to the beneficiary's home.

(3) From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.

(4) For a beneficiary who is receiving renal dialysis for treatment of ESRD, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.

(5) During a Public Health Emergency, as defined in § 400.200 of this chapter, a ground ambulance transport from any point of origin to a destination that is equipped to treat the condition of the patient consistent with any applicable state or local Emergency Medical Services protocol that governs the destination location. Such destinations include, but are not limited to, alternative sites determined to be part of a hospital, critical access hospital or skilled nursing
facility, community mental health centers, federally qualified health centers, rural health clinics, physician offices, urgent care facilities, ambulatory surgical centers, any location furnishing dialysis services outside of an ESRD facility when an ESRD facility is not available, and the beneficiary's home.

Specifically, CMS should revise section 410.40(d) as follows:

1. Amend subsections (1) and (2) to reference REHs as well as hospitals, CAHs, and SNFs.

2. Add a new subsection addressing coverage for facility-to-facility transfers for emergency services: “From a hospital, CAH, or REH to a hospital or CAH for emergency services not available at the hospital, CAH, or REH to which the patient came.”

3. Add a new subsection addressing coverage for hospital-to-SNF transfers: “For a beneficiary who qualifies for SNF or swing bed services following an inpatient stay, from a hospital or CAH to a hospital, CAH, or SNF in the beneficiary’s home community for SNF or swing bed services.”

These clarifications regarding coverage for ambulance services to align with the REH Program are necessary to ensure appropriate transportation is available to and from communities served by REHs. 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. Presently, each community is 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 the Medicare coverage rules have resulted in beneficiaries being charged thousands of dollars to access acute care services that previously had been available in their local community.

**Proposed Changes to 42 CFR 685.610 – Status and Location**

KHA had had the opportunity to review the thorough and thoughtful comments prepared by the National Rural Health Association regarding the proposed changes to this CoP. KHA fully supports NRHA’s comments and urges CMS to take action consistent with them.

**Proposed Changes to 42 CFR 485.614 – Patient Rights**

KHA fully supports expanding those protections of patient rights included in the hospital CoPs to CAHs. However, CAHs should be afforded adequate time to establish processes and train staff to ensure full compliance. KHA urges CMS to delay the effective date for these requirements by at least one year, like the delay in the effective date for the infection control and QAPI CoPs.

**Proposed Change to 42 CFR 485.631 – Staffing and Staff Responsibilities: Unified and Integrated Medical Staff for CAH In a Multi-Facility System**

Under this proposal, a CAH that “is part of a system consisting of multiple separately certified hospitals, CAHs, and/or REHs” can elect to participate in the system’s unified and integrated medical staff, provided certain conditions are satisfied. KHA requests CMS clarify what constitutes a “system” for purposes of this provision.
Specifically, KHA encourages CMS to include rural health networks (as defined by 42 CFR 485.603) as “systems.” These networks are intended to foster collaboration among hospitals and CAHs in a region to improve patient outcomes. The members of a rural health network should have the opportunity to pursue collaboration through a unified and integrated medical staff, bringing additional resources to CAHs and their medical staffs while reducing administrative burden.


CMS proposes similar changes to these two CoPs to permit the governing body of “a system consisting of multiple separately certified hospitals, CAHs, and/or REHs ... that is responsible for the conduct of two more hospitals, CAHs, and or REHs” to elect to have a unified and integrated program “for all of its member facilities,” provided that the governing body remains “responsible and accountable for ensuring that each of its separately certified CAHs meets all of the requirements” of the applicable CoP.

Many affiliation arrangements between CAHs and larger health systems involve some level of continued local control over the CAH’s facilities and/or operations. For example, under a management services agreement, the local board may remain responsible for monitoring the system’s performance under that agreement. KHA encourages CMS to clarify that systems participating in these types of arrangements with CAHs (and REHs) may initiate and maintain unified and integrated programs, provided the CAH’s (or the REH’s) governing body retains responsibility for program oversight at its facility.

KHA thanks CMS for the opportunity to submit these comments and its continued work to support access to affordable, high quality health care services in rural communities. 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 finalizes 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 & CEO  
Kansas Hospital Association