RURAL HOSPITAL COALITION

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May 3, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program: Requests for Enforcement Discretion

Dear Administrator Verma:

On behalf of the Rural Hospital Coalition, we are writing to formally request that the Centers for Medicare and Medicaid Services ("CMS") amend several Medicare policies and regulations to better enable Medicare-Dependent, Small Rural Hospitals and Sole Community Hospitals to respond to the COVID-19 Public Health Emergency.

The Rural Hospital Coalition is comprised of hospitals designated as Medicare-Dependent, Small Rural Hospitals ("MDHs"), Rural Referral Centers ("RRCs") and Sole Community Hospitals ("SCHs") under the Medicare Program. MDHs, RRCs and SCHs provide rural populations with local access to a wide range of health care services. In doing so, MDHs, RRCs and SCHs localize care, minimize the need for further referrals and travel, and provide services at costs lower than their urban counterparts. These hospitals also commonly establish satellite sites and outreach clinics to provide primary and emergency care services to surrounding underserved communities, a function which is becoming increasingly important as economic factors force many small rural hospitals to close.

Congress and CMS have reconfirmed their commitment to these hospitals repeatedly over the years by providing new protections to ensure their viability and access to hospital services in rural communities. The Coalition shares the common goal of ensuring that federal policies recognize the unique and important role and contributions of these hospitals to the Medicare program and its beneficiaries. Consistent with this mission, the Coalition is requesting that CMS provide certain flexibilities to enable these safety net hospitals on the frontlines of the coronavirus pandemic to serve rural communities across America.

As you are well aware, the COVID-19 global pandemic is placing an enormous strain on the resources and capacity of America's health care system. This is particularly true in rural communities, where health care providers were already operating on thin, often negative, margins and serve particularly vulnerable patient populations.

While we commend CMS for the extraordinary steps that it has taken to reduce regulatory burdens and barriers to respond to COVID-19, CMS has not provided needed regulatory flexibility for these providers. We initially provided these recommendations to CMS on March 20th. The agency has issued two interim final rules providing flexibilities since that time. In neither has the agency addressed these requests. We urge CMS to make the following necessary interim regulatory changes.

A. MDH and SCH Bed Limits

MDHs and SCHs are subject to caps on inpatient beds. Under 42 C.F.R. § 412.108(a)(1)(ii), MDHs must have "100 or fewer beds as defined in § 412.105(b)." Some SCHs qualify for SCH status based on criteria at 42 C.F.R. § 412.92(a)(1)(ii) that limits the SCH to "fewer than 50 beds."

Some of these hospitals are increasing bed capacity (or wish to do so) to prepare for additional COVID-19 caseload. If this surge activity results in exceeding Medicare bed limits, these providers could be jeopardizing their special Medicare designations.

On April 30th, CMS posted an Interim Final Rule with Comment Period (CMS-5531-IFC) in which the agency temporarily afforded flexibility to hospitals with provider-based rural health clinics that because of their association with rural hospitals with 50 or fewer beds are exempt from the national per-visit payment limit. Specifically, CMS revised its methodology for counting beds such that RHCs with provider-based status that were exempt from the national per-visit payment limit in the period prior to the effective date of the PHE (January 27, 2020) would continue to be exempt for the duration of the PHE for the COVID-19 pandemic. CMS reasoned, "we do not want to discourage them from increasing bed capacity if needed." This same hurdle and rationale applies to MDHs and certain SCHs. CMS should afford them the same flexibility and protection.

We urge CMS to issue a notice providing the following flexibilities and protections during the duration of the PHE:

- For MDHs, CMS should use the number of beds from the cost reporting period prior to the start of the PHE as the official hospital bed count for application of § 412.108(a)(1)(ii). Alternatively, CMS could provide that any hospital with MDH status that notifies its Medicare Administrative Contractor (MAC) pursuant to § 412.108(b)(4)(i) of an increase in the number of beds to more than 100 during the PHE will not be subject to revocation of its MDH status.

- For SCHs, CMS should use the number of beds from the cost reporting period prior to the start of the PHE as the official hospital bed count for application of § 412.92(a)(1)(ii). Alternatively, CMS could provide that any hospital with SCH status that notifies its MAC pursuant to § 412.92(b)(3)(ii)(C) of an increase in the number of beds to more than 50 during the PHE will not be subject to revocation of its SCH status.

B. Medicare-dependent Hospital Days and Discharges Criteria

Under 42 C.F.R. § 412.108(a)(1)(iv), to qualify for MDH status, a hospital must demonstrate that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits. CMS looks to "the last three most recent audited cost reporting periods for which [CMS] has a settled cost report." Hospitals managing COVID-19 outbreaks may experience unusual patient admission patterns, which may cause a hospital to admit fewer Medicare beneficiaries. For example, if the MDH does not have adequate ICU space or ventilators, it may refer Medicare beneficiaries to other hospitals that do. These hospitals should be given the flexibility to admit or refer patients as needed, and without concern for the security of their MDH status.

For this reason, we urge CMS to issue a notice providing the following:

- Medicare Administrative Contractors will not revoke hospital MDH status for failure to meet the criteria at § 412.108(a)(1)(iv) during a cost reporting year occurring within the PHE.

C. Sole Community Hospital Distance Criteria

Under 42 C.F.R. § 412.92(a), hospitals are classified as SCHs if, among other things, they are a certain distance away from "other like hospitals." Once approved as a SCH, this classification "remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved."[1] There are two changes in circumstances that could arise as a result of hospitals surging to meet coronavirus capacity needs.

First, a nearby hospital could establish additional bed capacity at an alternative location, or a nearby ambulatory surgery center could convert into a hospital. Both events, among others could affect SCH status. The opening of a new hospital in the SCH's service area is specifically identified as a triggering event that would constitute a "change in the circumstances," and CMS has interpreted this restriction to apply to both the opening of an entire new hospital, as well as the opening of a new location of an existing hospital. Moreover, any such "change in the circumstances" results in cancellation of SCH status under 42 CFR § 412.92(b)(3)(i).

Second, because of changing admission needs and patterns at the SCH or nearby like hospitals, it is conceivable that an SCH that qualifies based on admission criteria at § 412.92(a)(1)(i) may experience that more than 25 percent of residents or 25 percent of Medicare beneficiaries require admission as inpatients to another nearby hospital within a distance inconsistent with the qualifying regulatory requirements. For example, it is conceivable that a nearby like hospital is better equipped – *e.g.*, with ventilators – to admit and treat COVID-19 diagnoses. In such case,

[1] 42 C.F.R. § § 412.92(b)(3)(i).

the SCH may refer more patients than normal to the nearby hospital. If this change in admission experience results from changing admissions because of the coronavirus, SCHs should not lose their designation as a result.

CMS should establish by regulation or policy that existing SCHs will not lose their status due to (1) the temporary opening of a new hospital or new location of a hospital operating under the CMS waiver provisions for hospital "alternative" locations or "hospital without walls," or (2) because of coronavirus-related changes in admission patterns. SCHs in communities requiring additional hospital capacity or experiencing higher complexity patients due to COVID-19 should not be further adversely impacted by having their SCH status cancelled.

Specifically, we urge CMS to issue a notice providing the following:

- Any hospital with SCH status that notifies its Medicare Administrative Contractor pursuant to § 412.92(b)(3)(ii)(A) of an opening of a new hospital or new hospital location in its service area during the PHE will not be subject to revocation of its SCH status.

- Medicare Administrative Contractors may not revoke a hospitals SCH status pursuant to § 412.92(b)(3) for failure to satisfy § 412.92(a)(1)(i) during the PHE.

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Thank you for your consideration of these recommendations. Please contact me at 202.204.1457 or ezimmerman@mcdermottplus.com if you have any questions.

Sincerely,

Eric Zimmerman