December 17, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Request for Information (RFI) on Regulatory Relief to Support Economic Recovery

Dear Secretary Azar:

On behalf of the Rural Hospital Coalition, thank you for the opportunity to respond to the Request for Information (RFI) on Regulatory Relief to Support Economic Recovery published in the November 25, 2020, Federal Register.

The Rural Hospital Coalition ("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, the Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("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 HHS extend temporarily certain flexibilities to enable these safety net hospitals on the frontlines of the coronavirus pandemic to serve rural communities across America.

Action	Title of Action	Recommendation
144	Rural Health Clinics	Discontinued only following a transition period
166	Hospitals Classified as Sole Community Hospitals (SCHs)	Discontinued only following a transition period
179	Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)	Discontinued only following a transition period

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. We commend HHS and CMS for the extraordinary steps that they have taken to reduce regulatory burdens and barriers to respond to COVID-19 and we urge both to discontinue certain regulatory changes only after the public health emergency (PHE) has ended and sufficient time has passed to allow service delivery and care patterns to normalize.

a. **Action 144: Rural Health Clinics**

In response to the PHE, CMS has 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 implemented a change to the period of time used to determine the number of beds in a hospital at § 412.105(b) for purposes of determining which provider-based RHCs are subject to the payment limit. For the duration of the PHE, CMS is using the number of beds from the cost reporting period prior to the start of the PHE 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) continue to be exempt for the duration of the PHE for the COVID-19 pandemic.

Absent a transition period, certain provider-based rural health clinics could immediately lose limit their exemption from the national per-visit payment. There are complex rules for counting beds, however, CMS generally presumes that beds available at any time during a cost reporting period are available during the entire period. As such, the bed count of a small, rural hospital that expanded the number of beds available to meet surging demand may exceed 50 beds until a future cost reporting period even if the hospital reduces the number of beds in the same period. In this instance, an immediate return to current requirements after the PHE would jeopardize the exemption from the national per-visit payment received by the associated provider-based rural health clinics.

The Coalition finds it reasonable for these requirements to expire after the PHE, but urges HHS to allow for an appropriate transition. Specifically, the Coalition urges HHS to continue using the

number of beds from the cost reporting period prior to the start of the PHE until such time as the number of beds from the cost reporting period following the end of the PHE is available.

b. **Action 166: Hospitals Classified as Sole Community Hospitals (SCHs)**

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." There are three 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. 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 "market share" criteria at § 412.92(a)(1)(i) may experience that more than 25 percent of residents or more than 25 percent of Medicare beneficiaries require admission as inpatients to another nearby hospital within a distance inconsistent with the qualifying regulatory requirements. Third, an SCH that qualifies based on bed requirements at § 412.92(a)(1)(ii) could increase the number of available beds to accommodate an increasing COVID-19 caseload, exceeding Medicare bed limits and jeopardizing their SCH designation.

In recognition of the potential for such changes and their impact on hospitals currently designated as SCHs, CMS waived both the distance requirements at paragraphs (a), (a)(1), (a)(2), and (a)(3) of 42 CFR § 412.92 and the "market share" and bed requirements (as applicable) at 42 CFR § 412.92(a)(1)(i) and (ii) for the duration of PHE. These waivers allow SCHs to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity and promote appropriate cohorting of COVID-19 patients, without risk of losing SCH designation. However, at the end of the PHE standard practices for evaluating eligibility requirements will resume. Such an abrupt end to these waivers could result in current SCHs losing their designation.

The Coalition urges HHS to extend these waivers through the end of the cost reporting year in which the PHE ends. Providing a transition period will help ensure that SCHs are evaluated only after hospital service delivery and care patterns normalize.

c. Action 179: Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)

For hospitals classified as MDHs prior to the PHE, CMS has waived the eligibility requirement at 42 CFR § 412.108(a)(1)(ii) that the hospital has 100 or fewer beds during the cost reporting period, and the eligibility requirement at 42 CFR § 412.108(a)(1)(iv)(C) that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods. Like for SCHs, these waivers allow MDHs to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity and promote appropriate cohorting of COVID-19 patients, without risk of losing the designation. With respect to Rural Hospital Coalition members, this waiver remains critically important as COVID-19 cases continue to climb in rural areas. For example, one coalition member planned to expand their 100 bed capacity to 130 beds in anticipation of a

spring surge. While they did not have to execute at that time, they are now seeing a rapid increase of COVID-19 inpatient admissions and expect to implement the additional 30 bed capacity in the coming weeks.

This waiver also expires at the conclusion of the PHE. Again, while it is reasonable for these requirements to expire after the PHE, the Coalition is concerned that an immediate return to current requirements might jeopardize the ability of MDHs to meet bed, market and/or patient share requirements as service delivery and care patterns normalize.

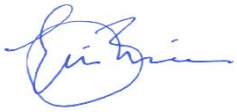
The Coalition urges HHS to provide a transition period by extending this waiver through the end of the cost reporting year in which the PHE ends. Providing such a transition will help ensure that MDHs are evaluated only after hospital service delivery and care patterns normalize.

* * * * *

These regulatory changes have been beneficial to providers and patients, allowing for surge capacity at the heights of the pandemic. As hospital beds and intensive care units (ICUs) continue to fill, it is essential for these providers to have the flexibility to provide appropriate care without risk to their special designations.

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

Sincerely,



Eric Zimmerman