March XX, 2022

The Honorable Xavier Becerra
Secretary
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

The Critical Access Hospital Coalition, with critical access hospitals (CAHs) across the country, appreciates the Administration's support of CAHs and health care providers during the COVID-19 pandemic.

We all eagerly await the end of the pandemic, but we urge the Administration to ensure that the Medicare and Medicaid waivers and flexibilities permitted during the COVID-19 Public Health Emergency (PHE) are not ended abruptly. This would cause significant disruption to our facilities that are already struggling with limited staffing and financial resources. We need advance notice to plan to return to the previous requirements and we urge the Administration to ensure that we have until at least the end of this calendar year to adjust.

Furthermore, we encourage the Administration to evaluate making some of these waivers permanent because they have significantly increased our capacity for providing access to patient care so desperately needed in many rural areas of the country. To the extent that Congressional authority is required to make these waivers permanent, we urge you to work with the Congress for swift passage.

We have prioritized below the waivers that have been most critical for CAHs and urge that they be made permanent:

CAH Length of Stay. CMS waived the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation for number of beds and length of stay at 42 CFR§485.620.

During the PHE CAHs have had the ability to flex up to meet the needs of our communities when the demand is high. This has eliminated the need for our staff to search for another facility that can take the patient and then transfer patients to that facility. This has saved on Medicare costs for ambulance services, freeing ambulances up to be used for a true emergency and has eliminated the need for hospital staff and resources to ride with the transport.

CAHs that formerly performed very short length of stay surgeries and visits now are treating more complex patients that often require a longer length of stay. Having to find another hospital with bed availability to care for them is often difficult and less advantageous for the patient and

the family. Additionally, when other hospitals are on diversion, CAHs are unable to transfer the patient.

Physical Environment. CMS waived certain physical environment requirements under the Medicare conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at CAHs. This waiver allows CAHs to surge when needed to accommodate patients which is especially critical when other hospitals are on diversion.

Responsibilities of Physicians in CAHs. CMS waived the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at 42 CFR § 485.631(b)(2). The physician is still required to be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." This waiver allows CAHs to utilize nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed.

This waiver is especially critical to maintain the cardiac and pulmonary rehabilitation programs required to address the explosion of cardiac and pulmonary issues in post-covid patients.

Telehealth Waivers. The numerous waivers ranging from an expanded number of providers allowed to provide care to the use of audio-only technology has allowed CAHs to expand specialty care throughout the community and into the patients' homes.

Allowing for audio-only is especially important as not all rural patients have access to video capability through a phone or computer. Expanding the number of eligible practitioners to be allowed to bill from a distant site has expanded access.

Expanding telehealth has consumed significant time for training and implementation, but it has been extremely beneficial to patients who would have otherwise foregone care. After all the time and effort that has been invested, it will be challenging to explain to patients that the care they previously received through telehealth is no longer available.

3**-Day Prior Hospitalization**. CMS waived the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for people who experience dislocations, or are otherwise affected by COVID-19. The ability to transition patients to a SNF as soon as it becomes the best option for the patient allows acute inpatient beds to be made available for the next patient requiring admission in a timelier manner.

Thank you for your continued efforts to ensure that Critical Access Hospitals remain available to provide care in rural communities throughout the country.

Sincerely,