Department of Health and Human Services

Centers for Medicare and Medicaid Services

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The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule on Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates.

IDSA represents more than 12,000 infectious diseases physicians, scientists and other health care and public health professionals. Our members work across a variety of health care settings, including hospitals, academic medical centers, outpatient clinics and public health departments. We appreciate the agency’s work to increase access to health care in rural settings, and particularly to strengthen antimicrobial stewardship programs. Below, we highlight priority provisions that we support in the proposed rule and add recommendations.

The REH designation will help address the inequity in access to medical services in rural communities. Sixty million people, an estimated 19% of the U.S. population, live in rural areas that face unique challenges in accessing health care. Within these rural communities, 80% of the population is designated as medically underserved.

Infectious diseases (ID) specialty care is especially limited in many of these areas; 80% of U.S. counties did not have a single ID doctor in 2017. IDSA supports provisions in the proposed rule to provide access to specialty services via telemedicine. This is particularly crucial to ensure hospitals with the REH designation have access to experts to help address issues such as COVID-19, monkeypox, antimicrobial stewardship expertise and the expected increase in infectious complications due to decreasing access to safe [abortions](https://www.idsociety.org/globalassets/google-ad/reducing-access-to-safe-and-legal-abortion-id-impacts--1.pdf).

IDSA also strongly supports the proposed rule’s inclusion of a CoP for infection prevention and control and antibiotic stewardship programs for REHs. Antimicrobial stewardship programs have been found to improve patient outcomes, reduce inappropriate antibiotic use and lower health care costs. All patients, regardless of their geographic location, should be able to access the benefits of antimicrobial stewardship. Rural hospitals face unique challenges in implementing stewardship programs due to limited resources, despite [increasing antimicrobial resistance in rural settings](https://aricjournal.biomedcentral.com/articles/10.1186/s13756-021-00964-1). To combat AMR in these settings, a unified and integrated approach like the one proposed by CMS is essential. To achieve this goal, CMS should work with other federal agencies and Congress to provide critical access hospitals (CAHs) and REHs adequate resources to support stewardship. It is important that stewardship programs in REHs cover both adult and pediatric populations. [A recent study](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8067449/) found that roughly one third of deaths caused by multidrug-resistant (MDR) bacteria were in newborns. This may be exacerbated in rural settings where pediatric care, specifically pediatric ID care, is already limited. On the other end of the lifespan, another [study](https://academic.oup.com/cid/article/74/6/1070/6374434?login=false) found drug-resistant infections led to nearly 450,000 inpatient days and nearly 12,000 deaths among Medicare beneficiaries annually, with resistant infections costing Medicare about $1.9 billion per year.

IDSA additionally supports provisions in the proposed rule regarding COVID-19 and seasonal influenza reporting at REHs. Bolstering reporting will be especially important as novel infectious diseases like COVID-19 emerge in the future. Resources should be provided to ensure that rural settings have adequate reporting capacities because data on emerging infectious diseases and antimicrobial resistance in these settings is crucial to protecting patients’ health.

In determining appropriate diagnostic testing capacity in REHs, it’s important to consider the ongoing laboratory workforce challenges. [Studies](https://ascls.org/addressing-the-clinical-laboratory-workforce-shortage/) have found that prior to the pandemic, the average percentage of vacant positions in laboratories was roughly 7.2%. Increasing vacancies due to high attrition and burnout, combined with a high retirement rate and a rapidly increasing demand for testing, has put immense strain on the laboratory workforce. This is especially true in rural areas, where laboratories were overburdened even prior to COVID-19. Required diagnostic capabilities for REHs should focus on essential tests and avoid unnecessarily overburdening rural hospitals. While many of the basic laboratory services listed should be encouraged and supported at REHs, additional flexibility on requirements may be appropriate. For example, CMS could encourage, rather than require, primary culturing for transmittal. Many rural labs transmit samples instead of cultures, which can then be cultured by a reference laboratory for diagnostic assays. This is preferrable in many cases, as contamination of cultures can occur in transit, and the sample itself may be more useful than a contaminated or poorly inoculated plate. Instead, for some laboratory services it would be more efficient for REHs to provide prompt access to rapid microbiological diagnostics and reserve culturing for labs equipped with more advanced diagnostic capabilities.

In conclusion, thank you for the opportunity to support and inform the agency’s efforts to improve rural access to health care and antimicrobial stewardship programs. If you have any questions, please contact Eli Briggs, IDSA Director of Public Policy, at ebriggs@idsociety.org.

Sincerely,



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President