Society of Hospital Medicine
Empowering hospitalists.
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November 7, 2023

The Honorable Adrian Smith
House of Representatives
502 Cannon House Office Building
Washington, DC 20515

The Honorable Terri A. Sewell
House of Representatives
1035 Longworth House Office Building
Washington, DC 20515

Dear Representatives Smith and Sewell,

The Society of Hospital Medicine (SHM) is pleased to offer its support for the Critical Access Hospital Relief Act of 2023 (H.R. 1565). This legislation will remove the requirement that physicians who work in Critical Access Hospitals (CAHs) certify, with reasonable certainty, that an individual patient should expect to be discharged or admitted to another hospital within 96 hours.

Requiring clinicians to certify each individual patient will have a LOS of fewer than 96 hours creates significant administrative burden. It is unrealistic to expect providers to predict a patient's LOS with such a high degree of accuracy. CAHs must meet an annual patient length of stay (LOS) average of 96 hours or less, meaning hospitals already track this data at the institutional level. Therefore, requiring individual clinicians to certify each individual patient's LOS creates duplicative and unnecessary administrative work. In many cases, it also creates inappropriate pressure to transfer patients to other sites.

In rural America, unnecessary transfers to tertiary care centers result in patients being separated from their homes, communities, and support systems, which increases the stress associated with hospitalizations. Since a single patient's LOS has a negligible impact on the hospital's annual average LOS, providers should be able to determine whether a transfer is in the best interest of their patient without the pressure of certifying their LOS will not exceed 96 hours.

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Hospital beds at community hospitals and tertiary care centers are often at capacity. Transferring patients to these sites, many of which are far from their home communities, is a poor use of resources. It further strains hospital capacity, contributing to boarding severely ill patients in emergency departments, as community hospital beds are occupied by patients who could have been cared for in their local community.

For example, a hospitalist who works at a hospital in Michigan's remote Upper Peninsula reports that patients, many of whom have complex needs, are often transferred to care sites 50-100 (or more) miles due to anticipated LOS. During the winter months, however, travel can be dangerous and limited. It is difficult to transfer patients and it is difficult for families to support and visit the patient. Patients are being unnecessarily transferred due to projected LOS, even though their local hospital can meet their medical needs.

Due to the unique CAH payment structure, 96-hour rule was developed is to guard against increased costs to Medicare resulting from extended CAH hospitalizations. Instead of protecting Medicare's solvency, however, the 96-hour rule produces unnecessary and costly administrative requirements. These requirements do not benefit patients and create undue pressure to transfer patients, which can be detrimental to patient care.

As rural health care access, which is already limited, continues to contract due to facility closures, staffing shortages, and scarce resources, the 96-hour physician certification rule redirects already limited resources away from bedside care. SHM is pleased to offer our support for this legislation, and we stand ready to advocate for its passage.

Sincerely,

Kris Rehm

Kris Rehm, MD, SFHM
President, Society of Hospital Medicine